NEW YORK STATE DEPARTMENT OF HEALTH
Vital Records Section

Application to Local Registrar for Copy of Birth Record

CERTIFICATE INFORMATION

Name (First Middle Last)

Date of Birth (M M D D Y Y Y Y)

Place of Birth — Hospital (If not hospital, give street & number) | (Village, Town or City) | County

Father (First Middle Last)

Maiden Name of Mother (First Middle Last)

Number of Copies Requested

Enter Birth No. if Known

Enter Local Registration No. if Known

Purpose for Which Record is Required (Check One)

- ☐ Passport
- ☐ Social Security-Retirement
- ☐ Social Security-SSI
- ☐ Retirement
- ☐ Employment
- ☐ Working Papers
- ☐ School Entrance
- ☐ Driver's License
- ☐ Marriage License
- ☐ Welfare Assistance
- ☐ Veteran's Benefits
- ☐ Court Proceeding
- ☐ Entrance into Armed Forces
- ☐ Other (Specify) _____

APPLICANT INFORMATION

NAME (FIRST MIDDLE LAST)

What is your relationship to person whose record is required?

☐ Self ☐ Parent ☐ Other, specify _____

Telephone No. (___) ___-____

Social Security No. ___-___-____

If attorney, give name and relationship of your client to person whose record is required

(name of client) (relationship)

Signature of Applicant

Date (MM DD YY)

Address of Applicant

Street

City State Zip Code

FOR REGISTRAR'S USE ONLY

(Photocopy ID and attach to application form)

TYPE OF ID

☐ Driver's License

State ____ No. _____

☐ Other ID, specify _____

No. _____

NEW YORK STATE DEPARTMENT OF HEALTH
Vital Records Section

Application to Local Registrar for Copy of Death Record

PLEASE COMPLETE FORM AND ENCLOSE FEE

FEE: $10.00 per copy or No Record Certification. Please do not send cash or stamps.

PLEASE PRINT OR TYPE

Name of Deceased First Middle Last	Date of Death or Period to be Covered by Search	
Name of Father of Deceased First Middle Last	Social Security Number of Deceased	
Maiden Name of Mother of Deceased First Middle Last	Date of Birth of Deceased Month Day Year	Age at Death

Place of Death

Name of Hospital or Street Address _____ Village, Town or City _____ County _____

Purpose for Which Record is Required

What was your relationship to the deceased? _____

In what capacity are you acting? _____

If attorney, name and relationship of your client to deceased _____

Signature of Applicant _____ Date _____

Address of Applicant _____

COMPLETE FOR DEATHS OCCURRING AS OF JANUARY 1, 1988

_____ Number of copies requested with confidential cause of death

_____ Number of copies requested without confidential cause of death

PLEASE PRINT NAME AND ADDRESS WHERE RECORD SHOULD BE SENT

Name _____

Address _____

City _____ State _____ Zip Code _____