

POLK COUNTY HEALTH CENTER

CERTIFICATE # _____

DATE ISSUED _____

APPLICATION FOR CERTIFIED COPY OF DEATH CERTIFICATION

PAID BY: CHECK CASH OTHER

| | | | |
|--|---|----------------------------|------------------|
| <p>The law requires a fee of \$13.00 for each certified copy issued. Additional copies are \$10.00 each. FEE MUST ACCOMPANY APPLICATION. NO CASH BY MAIL PLEASE.</p> <p>MAKE CHECK OR MONEY ORDER PAYABLE TO: POLK COUNTY HEALTH CENTER</p> <p>MAIL THIS APPLICATION TO: POLK COUNTY HEALTH CENTER 1317 W. BROADWAY P.O. BOX 124 BOLIVAR, MO 65613-0124</p> | <p>DEATH CERTIFICATION (Certification of facts of death contained in Original record)</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%; text-align: center; vertical-align: middle;"> <p>\$13.00 EACH</p> </td> <td style="width: 30%; text-align: center; vertical-align: middle;"> <p>HOW MANY?</p> </td> </tr> </table> <p>AMOUNT OF MONEY ENCLOSED</p> <p>RECORDS ARE FILED BY YEAR OF THE EVENT AND THEN ALPHABETICALLY BY THE NAME OF THE PERSON AT THE TIME OF THE EVENT. THEREFORE, AT LEAST THE MONTH AND YEAR OF DEATH AND THE FIRST AND LAST NAME OF THE REGISTRANT MUST BE GIVEN BEFORE A SEARCH CAN BE MADE.</p> | <p>\$13.00 EACH</p> | <p>HOW MANY?</p> |
| <p>\$13.00 EACH</p> | <p>HOW MANY?</p> | | |

Information about person whose death certificate is requested. (PRINT all items **EXCEPT SIGNATURE**)

| | | |
|---------------------------|-------------|-----------|
| 1. FULL NAME OF DECEASED* | | |
| First name | Middle name | Last name |

| | | | | | |
|--------------------|-----|------|-----|--------|---------|
| 2. DATE OF DEATH * | | | | 3. SEX | 4. RACE |
| MONTH | DAY | YEAR | AGE | SEX | RACE |

| | | |
|------------------------|-------------|-----------|
| 5. FULL NAME OF SPOUSE | | |
| FIRST NAME | MIDDLE NAME | LAST NAME |

| | | |
|------------------------|-------------|-----------|
| 6. FULL NAME OF MOTHER | | |
| FIRST NAME | MIDDLE NAME | LAST NAME |

| | | |
|------------------------|-------------|-----------|
| 7. FULL NAME OF FATHER | | |
| FIRST NAME | MIDDLE NAME | LAST NAME |

| | |
|---|--|
| PERSON REQUESTING CERTIFIED COPY | |
| 8. PURPOSE FOR WHICH CERTIFIED COPY IS TO BE USED | 9. RELATIONSHIP (MUST BE REGISTRANT, MEMBER OF IMMEDIATE FAMILY, LEGAL GUARDIAN OR LEGAL REPRESENTATIVE) |

| | |
|----------------------------|-----------------|
| 10. SIGNATURE OF APPLICANT | 11. DATE SIGNED |
|----------------------------|-----------------|

| | | |
|---|-------|----------|
| 12. ADDRESS OF APPLICANT (PLEASE PRINT) | | |
| STREET ADDRESS | | |
| CITY OR TOWN | STATE | ZIP CODE |

| | |
|---|---|
| <p>PLEASE PRINT OR TYPE THE NAME AND ADDRESS OF THE PERSON TO WHOM THE RECORD IS TO BE RETURNED. COMPLETE ONLY IF CERTIFICATES ARE TO BE MAILED. </p> | <p>NAME _____</p> <p>ADDRESS _____</p> <p>CITY, STATE, ZIP CODE _____</p> |
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