



**MONTGOMERY COUNTY HEALTH DEPARTMENT
APPLICATION FOR A VITAL RECORD**

400 Salisbury
Montgomery County Health Department

Public Health
Protect. Promote. Prevent.

Applicants must show identification when requesting certified copies of a vital record at the Montgomery County Health Department. Mail-in requests must be notarized by an acceptable notary public.

Missouri law requires a non-refundable search fee for each five-year search of the files. If eligibility requirements are met and a record is found, applicant is entitled to certified copies. A statement will be issued if no record is found. **FEE MUST ACCOMPANY APPLICATION. FEES ARE VALID FOR ONE YEAR.** Check or money order payable to: **MONTGOMERY COUNTY HEALTH DEPARTMENT.**

State recording of birth and death records began January 1, 1910.

BIRTH NUMBER OF COPIES _____ (FIRST COPY ISSUED \$15; EACH ADDITIONAL COPY \$15)
 FULL NAME ON CERTIFICATE _____
 ALSO KNOWN AS (INDICATE IF BIRTH COULD BE RECORDED UNDER ANOTHER NAME) _____
 DATE OF BIRTH _____ PLACE OF BIRTH (CITY, COUNTY, STATE) _____
 HOSPITAL _____ SEX FEMALE MALE RACE _____
 FULL NAME OF FATHER _____
 FULL MAIDEN NAME OF MOTHER _____

DEATH NUMBER OF COPIES _____ (FIRST COPY ISSUED \$14; EACH ADDITIONAL COPY OF THE SAME RECORD ORDERED AT THE SAME TIME \$11)
 FULL NAME ON CERTIFICATE _____
 DATE OF DEATH _____ SEX FEMALE MALE RACE _____
 PLACE OF DEATH (CITY, COUNTY, STATE) _____
 FULL NAME OF SPOUSE _____
 FULL NAME OF FATHER _____
 FULL MAIDEN NAME OF MOTHER _____

PLEASE ENCLOSE A SELF ADDRESSED STAMPED ENVELOPE WITH YOUR REQUEST (PRINT THE FOLLOWING INFORMATION)

APPLICANT'S NAME _____ PHONE NUMBER _____
 APPLICANT'S STREET ADDRESS _____
 APPLICANT'S CITY/TOWN _____ STATE _____ ZIP _____
 PURPOSE FOR CERTIFICATE REQUEST _____
 YOUR RELATIONSHIP TO PERSON NAMED ON RECORD (IF LEGAL GUARDIAN, MUST PROVIDE GUARDIANSHIP PAPERS). IF LEGAL REPRESENTATIVE, INDICATE LEGAL RELATIONSHIP. _____

➤ **MAIL-IN REQUESTS MUST BE NOTARIZED. ALL APPLICATIONS MUST BE SIGNED.**

I _____, SUBJECT TO THE PENALTY OF PERJURY, DO SOLEMNLY DECLARE AND AFFIRM THAT I AM ELIGIBLE TO RECEIVE A CERTIFIED COPY OF THE VITAL RECORD(S) REQUESTED ABOVE AND THAT THE INFORMATION CONTAINED IN THIS APPLICATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

➤ **APPLICANT'S SIGNATURE** _____ **DATE** _____

NOTARY PUBLIC EMBOSSEER SEAL	STATE _____	COUNTY _____
	SUBSCRIBED, DECLARED AND AFFIRMED BEFORE ME,	
	THIS _____ DAY OF _____, 20 _____	
	NOTARY PUBLIC SIGNATURE _____	MY COMMISSION EXPIRES _____
NOTARY PUBLIC NAME (TYPED OR PRINTED) _____		