JACKSON COUNTY HEALTH DEPARTMENT
313 SOUTH LIBERTY, INDEPENDENCE, MO 64050
APPLICATION FOR A VITAL RECORD

HOURS: MONDAY – FRIDAY 8:00 AM – 4:00 PM
PHONE: (816) 404-6419

Beginning March 1, 2011, applicants must show identification when requesting certified copies of a vital record.
Mail-in requests must be notarized by an acceptable notary public.

If eligibility requirements are met and a record is found, applicant is entitled to certified copies. **FEE MUST ACCOMPANY APPLICATION**. FEES ARE VALID FOR ONE YEAR. Check or money order payable to: **Jackson County Health Department.** Birth records from 1920 to the present. Death records from 1980 to the present.

☐ I would like to make a $1.00 donation to support homeless families & provide financial assistance to organizations addressing homelessness in Jackson County.

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 $13; EACH ADDITIONAL COPY OF THE SAME RECORD ORDERED AT THE SAME TIME $10)

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 _____ 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 IS TRUE UNDER THE PAINS AND PENALTIES OF PERJURY.

- **APPLICANT'S SIGNATURE** _____ **DATE** _____

NOTARY PUBLIC EMBOSSER SEAL	STATE	COUNTY
	SUBSCRIBED, DECLARED AND AFFIRMED BEFORE ME , THIS _____ DAY OF _____ , 20 _____	**USE RUBBER STAMP IN CLEAR AREA BELOW**
	NOTARY PUBLIC SIGNATURE / MY COMMISSION EXPIRES	
	NOTARY PUBLIC NAME (TYPED OR PRINTED)	

WARNING: False application for a certified copy of a vital record is a crime.