



JACKSON COUNTY HEALTH DEPARTMENT  
 313 SOUTH LIBERTY, INDEPENDENCE, MO 64050  
 OPERATED BY TRUMAN MEDICAL CENTER

HOURS: MONDAY – FRIDAY 8:00 AM – 4:00 PM  
 PHONE: (816) 404-6419  
 APPLICATION FOR A VITAL RECORD

**Applicants must show identification when requesting certified copies of a vital record.  
 Mail-in requests must be notarized by an acceptable notary public and payable by money order to JACOHD.**

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. If paying in person, all forms of payment are acceptable with the exception of personal checks and American Express. 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.

**I. 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 \_\_\_\_\_

**II. 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 \_\_\_\_\_

**III. PLEASE 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. \_\_\_\_\_

**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 \_\_\_\_\_

<b>FOR MAIL-IN APPLICATIONS: REQUESTS MUST BE NOTARIZED. ALSO, PLEASE ENCLOSE A SELF ADDRESSED STAMPED ENVELOPE ALONG WITH A MONEY ORDER OR CASHIER'S CHECK.</b>		
NOTARY PUBLIC EMBOSSEER 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.**