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 $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 _____

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**_____

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.

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.