



JACKSON COUNTY HEALTH DEPARTMENT
 313 SOUTH LIBERTY, INDEPENDENCE, MO 64050
 OPERATED BY UNIVERSITY HEALTH

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(First, Middle, Last) _____
 ALSO KNOWN AS (INDICATE IF BIRTH COULD BE RECORDED UNDER ANOTHER NAME) _____
 DATE OF BIRTH _____ PLACE OF BIRTH (CITY, COUNTY, STATE) _____
 SEX FEMALE MALE
 PARENT ONE: FULL NAME(MAIDEN NAME) _____
 PARENT TWO: FULL NAME (MAIDEN NAME) _____
 WERE THE PARENTS MARRIED AT TIME OF BIRTH: YES NO

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(First, Middle, Last) _____
 DATE OF DEATH _____ SEX FEMALE MALE
 PLACE OF DEATH (CITY, COUNTY, STATE) _____
 FULL NAME OF SPOUSE _____
 PARENT ONE:FULL NAME(MAIDEN) _____
 PARENT TWO:FULL NAME(MAIDEN) _____

III. PLEASE PRINT THE FOLLOWING INFORMATION

APPLICANT'S NAME: _____ PHONE NUMBER _____
 APPLICANT'S EMAIL ADDRESS: _____
 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.