



APPLICATION FOR BIRTH AND DEATH CERTIFICATE (Vital Records)

****MAIL-IN requests MUST BE NOTARIZED and signed****

Person applying for record **MUST** present picture identification.

BIRTH CERTIFICATE: Number of Copies _____

Cost: \$15.00 each

We can only access state records from **1920-Current**

| | | |
|-----------------------------------|------------------|----------|
| Birth Name on Certificate (First) | (Middle) | (Last) |
| Date of Birth (Month) | (Day) | (Year) |
| Place of Birth (City) | (County) | (State) |
| Hospital | | |
| Race | Sex (Circle one) | |
| | Male Female | |
| Father's Name (First) | (M.I.) | (Last) |
| Mother's Name (First) | (M.I.) | (Maiden) |

DEATH CERTIFICATE: Number of Copies _____

Cost: \$13.00 for first copy; \$10.00 for each additional copy

We can only access state records from **1980-Current**

| | | |
|-----------------------------|------------------|----------|
| Name on Certificate (First) | (Middle) | (Last) |
| Date of Death (Month) | (Day) | (Year) |
| Place of Death (City) | (County) | (State) |
| Date of Birth (Month) | | |
| | (Day) | (Year) |
| Race | Sex (Circle one) | |
| | Male Female | |
| Father's Name (First) | (M.I.) | (Last) |
| Mother's Name (First) | (M.I.) | (Maiden) |

| | |
|--|------------------------|
| Applicant's Printed Name: | Day Time Phone Number: |
| Current Address: (Street or P.O. Box) | (City) (State) (Zip) |
| Purpose for Certificate Request: | |
| Your Relationship to Person Named on Record (IF LEGAL GUARDIAN, MUST PROVIDE GUARDIANSHIP PAPERS): (Self, Mother, Father, Spouse, etc.) If Legal Representative, indicate legal relationship: | |
| 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) | |
| USE RUBBER STAMP IN CLEAR AREA BELOW | | |

WARNING: False application for a certified copy of a vital record is a crime. Applicants must show picture identification when requesting certified copies of a vital record. Mail-in requests must be notarized by an acceptable notary public. **FEE MUST ACCOMPANY APPLICATION.** Please enclose a self-addressed stamped envelope with your request and a check or money order payable to:

Gasconade County Health Department
300 Schiller St., Hermann, MO 65041
573-486-3129
www.GasconadeCountyHealth.com

| FOR OFFICE USE ONLY | |
|-----------------------|-----------------------------|
| Certificate No: _____ | ID: _____ |
| Payment Amt: \$ _____ | By: Cash or Check/MO# _____ |