



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
 BUREAU OF VITAL RECORDS
APPLICATION FOR MISSOURI VITAL RECORD - BIRTH/DEATH

Lafayette County Health Department
 547 South Business Highway 13
 Lexington, Missouri 64067

Applicants must show identification when requesting certified copies of a vital record at the state health department. **Mail-in requests must be notarized by an acceptable notary public.**

Missouri law requires a non-refundable search fee for each five-year search of the files. If eligibility requirements are met and a record is found, applicant is entitled to certified copies.

FEE MUST ACCOMPANY APPLICATION. Cash, Credit/Debit payable to: Lafayette County Health Department. No personal checks accepted. (Money order acceptable if mailing in application) State recording of birth and death records began January 1, 1910.

BIRTH/FETAL DEATH REPORT/STILL BIRTH (\$15.00 PER COPY)

SELECT ONE: <input type="checkbox"/> BIRTH <input type="checkbox"/> FETAL DEATH REPORT <input type="checkbox"/> STILL BIRTH		NUMBER OF COPIES _____	TOTAL DUE _____
FULL NAME ON CERTIFICATE _____			
ALSO KNOWN AS (INDICATE IF BIRTH COULD BE RECORDED UNDER ANOTHER NAME) _____			
DATE OF MO BIRTH (MM/DD/YYYY)	PLACE OF MO BIRTH (CITY, COUNTY, STATE)		
HOSPITAL (IF APPLICABLE)	SEX		<input type="checkbox"/> Female <input type="checkbox"/> Male
PARENT ONE: FULL NAME	LAST NAME BEFORE 1 ST MARRIAGE		
PARENT TWO: FULL NAME	LAST NAME BEFORE 1 ST MARRIAGE		

DEATH (\$14.00 1ST COPY; \$11 ADDITIONAL COPIES)

NUMBER OF COPIES _____		TOTAL DUE _____	
FULL NAME ON CERTIFICATE _____			
DATE OF BIRTH (MM/DD/YYYY)	SEX <input type="checkbox"/> Female <input type="checkbox"/> Male		
DATE OF MO DEATH (MM/DD/YYYY)	PLACE OF MO DEATH (CITY, COUNTY, STATE)		
FULL NAME OF SPOUSE _____			
PARENT ONE: FULL NAME	LAST NAME BEFORE 1 ST MARRIAGE		
PARENT TWO: FULL NAME	LAST NAME BEFORE 1 ST MARRIAGE		

APPLICANT - THE INDIVIDUAL OR ENTITY REQUESTING A COPY OF A VITAL RECORD. MUST COMPLETE THE FOLLOWING:

APPLICANT'S NAME		APPLICANT'S PHONE NUMBER	
APPLICANT'S STREET ADDRESS		APT, FL, SUITE	
APPLICANT'S CITY/TOWN		APPLICANT'S STATE	APPLICANT'S ZIP
PURPOSE FOR CERTIFICATE REQUEST	APPLICANT'S EMAIL ADDRESS		

YOUR RELATIONSHIP TO PERSON NAMED ON RECORD (IF LEGAL GUARDIAN, MUST PROVIDE GUARDIANSHIP PAPERS). IF LEGAL REPRESENTATIVE, INDICATE LEGAL RELATIONSHIP.

REMEMBER: ENCLOSE A SELF ADDRESSED STAMPED RETURN ENVELOPE, NECESSARY DOCUMENTS, AND FEES WITH YOUR REQUEST. ALL APPLICATIONS MUST BE SIGNED. MAIL-IN REQUESTS MUST BE NOTARIZED.

SUBJECT TO THE PENALTY OF PERJURY, I DO SOLEMNLY DECLARE AND AFFIRM THAT I AM ELIGIBLE, PURSUANT TO CHAPTER 193, RSMO AND 19 CSR 10-10, 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 (MM/DD/YYYY) _____
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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