ADAIR COUNTY HEALTH DEPARTMENT

APPLICATION FOR A VITAL RECORD

Beginning March 1, 2011, 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.**

Please Make Check or Money Order Payable To:
Adair Co. Health Department
Mail This Application To: Adair County Health Department
1001 South Jamison
Kirksville, Mo. 63501 Phone 660-665-8491

RE: Errors – I accept this record as is knowing there are errors and understand that if I later have it corrected and return for an up-dated copy, I will be charged again – Signature ______________________________

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 ______________________________

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 ______________________________

PLEASE ENCLOSE A SELF ADDRESSED STAMPED ENVELOPE WITH YOUR REQUEST (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. ______________________________

- **MAIL-IN REQUESTS MUST BE NOTARIZED. 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** ____________________

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.