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| PLEASE COMPLETE FORM AND ENCLOSE FEE | | | | |
| **Fee: $10.00 per copy** | | | | |
| PLEASE PRINT OR TYPE | | | | |
| Name of Deceased  First Middle | Last | Date of Death or Period to be Covered by Search | | |
| Name of Father of Deceased  First Middle | Last | Social Security Number of Deceased | | |
| Maiden Name of Mother of Deceased  First Middle | Last | Date of Birth of Deceased  Month/Day/Year | | Age at Death |
| Place of Death  Name of Hospital or Street Address Village, Town or City County | | | | |
| Purpose for Which Record is Required | | | | |
| What was your relationship to the deceased?  In what capacity are you acting?  If attorney, name and relationship of your client to deceased \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of Applicant  Date  Address of Applicant | | | | |
| COMPLETE FOR DEATHS OCCURRING AS OF JANUARY 1, | | | 1988 | | |
| Number of copies requested with confidential cause of death  \_\_\_\_\_ Number of copies requested without confidential cause of death | | | | | |
| PLEASE PRINT NAME ANDADDRESS WHERE RECORD SHOULD BE SENT | | | | | |
| Name  Address  City  State  Zip Code | | | | | |

# DOH-294A (6/2000)