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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 DeathName 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  DateAddress 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 AddressCity  State  Zip Code |

# DOH-294A (6/2000)