Application to Local Registrar for Copy of Death Record

NEW YORK STATE DEPARTMENT OF HEALTH
Vital Records Section

PLEASE CONMPETE FORM AND ENCLOSE FEE
FEE: $10.00 per copy or No Record Certification. Please do not send Cash or Stamps.

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 OCCURING 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 AND ADDRESS WHERE RECORD SHOULD BE SENT
Name _____
Address _____
City _____ State _____ Zip Code _____

DOH-294A (6/2000)