To request a death certificate, print the following form, complete, and bring or mail to the Health Department along with the $13 per certificate fee. Certificates are available immediately if you present the form in person. Allow one week for certificates requested by mail. Please enclose a self-addressed stamped envelope with your request by mail.

Mississippi County Health Department

Application for Certified Copy of Death Certification

Instructions	**Copies requested**	
The law requires a fee of $14.00 for each copy issued. Additional copies are $11.00 each. FEE MUST ACCOMPANY APPLICATION. No cash by mail please.	Death Certification (Certification of facts of death contained in original record)	How Many ( )
Make money order payable to Mississippi County Health Department	Amount of money enclosed $	
Mail or bring this application to: Mississippi County Health Department 1200 E. Marshall St. Charleston, MO 63834	Records are filed by year of death and alphabetically by the name of the deceased at the time of death. Therefore, at least the approximate year of death or last year in which the deceased was known to be alive must be given.	

Information about person whose death certificate is requested. (Type or print all items except signature)

1. Full name of deceased

First Name	Middle Name	Last Name (at time of death)

2. Date of death			**3. Sex, Race, Age**		
Month	Day	Year	Sex	Race	Age

4. Place of death

City or town	County	State

5. Full name of spouse

First Name	Middle Name	Last Name

6. Full name of father

First Name	Middle Name	Last Name

7. Full maiden name of mother

First Name	Middle Name	Last Name

Person requesting certified copy of death record

8. Purpose for which certified copy is to be used (please check)		**9. Relationship to registrant or interest of person requesting certification**
	Insurance claim on policy issued within 2 years of death (a certified copy of the original will be required)	
	Other insurance claims	
	Other (specify)	

10. Signature of applicant

	Date signed

11. Name and address of applicant

Name and address of funeral home or applicant		
Name of individual to receive copies	Street address	
City or town	State	Zip Code

Please print or type the name and address of the person to whom the record is to be returned. Complete only if certifications are to be mailed.	Name
	Address (number and street)
	City, state, zip code
	Home Phone
	Work Phone

» **MAIL-IN REQUESTS MUST BE NOTARIZED. ALL APPLICATIONS MUST BE SIGNED.**

I ____, SUBJECT TO THE PENALTY OF PERJURY, DO SOLEMNLY DECLARE AND AFFIRM THAT I AM ELIGIBLE TO RECIEVE 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** __________________

<table>
<tr><td rowspan="4">NOTARY PUBLIC
EMBOSSER SEAL</td><td colspan="2">STATE</td><td>COUNTY</td></tr>
<tr><td colspan="2">SUBSCRIBED, DECLARED AND AFFIRMED BEFORE ME,

THIS _________DAY OF _____________, 20 __</td><td>USE RUBBER STAMP IN CLEAR AREA BELOW</td></tr>
<tr><td>NOTARY PUBLIC SIGNATURE</td><td>MY COMMISSION EXPIRES</td><td rowspan="2"></td></tr>
<tr><td colspan="2">NOTARY PUBLIC NAME (TYPED OR PRINTED)</td></tr>
</table>

WARNING: False application for a certified copy of a vital record is a crime.