PublicHealth COOPER COUNTY PUBLIC HEALTH CENTER
17040 KLINTON DR., BOONVILLE, MO 65233
Phone: 660-882-2626
FAX: 660-882-2586

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.

Missouri law requires a non-refundable search fee for each five-year search of the files. If eligibility requirements are met and a record is found, applicant is entitled to certified copies. A statement will be issued if no record is found. FEE MUST ACCOMPANY APPLICATION. FEES ARE VALID FOR ONE YEAR. Check or money order payable to: Missouri Department of Health and Senior Services.

State recording of birth and death records began January 1, 1910.

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 _____, SUBJECT TO THE PENALTY OF PERJURY, 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 CONTAINED IN THIS APPLICATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

➢ 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.