APPLICATION FOR CERTIFIED COPY OF BIRTH CERTIFICATION

INSTRUCTIONS

Recording of births began in this office January 1, 1910. The law requires a fee of $10 for a search of the files. This fee entitles you to a certified copy, if available. Additional copies are $10 each. Fee must accompany application.

NO CASH BY MAIL PLEASE. Make check or money order payable to Missouri Department of Health.

Mail this application to:
Missouri Department of Health
Bureau of Vital Records
P.O. Box 570
Jefferson City, Missouri 65102-0570

ALL FORMS OF CERTIFICATE
$10.00 EACH

INFORMATION ABOUT PERSON WHOSE BIRTH CERTIFICATE IS REQUESTED (TYPE OR PRINT ALL ITEMS EXCEPT SIGNATURE)

1. FULL NAME OF PERSON*
FIRST NAME
MIDDLE NAME
LAST NAME (MAIDEN NAME)
IF THIS BIRTH COULD BE RECORDED UNDER ANOTHER NAME, PLEASE INDICATE THE NAME

2. DATE OF BIRTH
MONTH
DAY
YEAR

3. SEX

4. RACE

5. PLACE OF BIRTH
CITY OR TOWN
COUNTY
STATE
HOSPITAL OR STREET NO.
ATTENDING PHYSICIAN

6. FULL NAME OF FATHER
FIRST NAME
MIDDLE NAME
LAST NAME

7. FULL MAIDEN NAME OF MOTHER
FIRST NAME
MIDDLE NAME
LAST NAME (MAIDEN)

* IF NEWBORN, PLEASE WAIT 6 TO 8 WEEKS BEFORE REQUESTING.

PERSON RequestsING CERTIFIED COPY (IF LEGAL GUARDIAN OF REGISTRANT, SEND ALONG GUARDIANSHIP PAPERS)

8. PURPOSE FOR WHICH CERTIFIED COPY IS TO BE USED

9. RELATIONSHIP (MUST BE REGISTRANT, MEMBER OF IMMEDIATE FAMILY, LEGAL GUARDIAN, OR LEGAL REPRESENTATIVE)

10. SIGNATURE OF APPLICANT

DATE SIGNED

12. ADDRESS OF APPLICANT

STREET ADDRESS
CITY OR TOWN
STATE
ZIP CODE

THIS COUPON MUST BE COMPLETED AND WILL BE USED TO ADDRESS OUR REPLY

NAME OF PERSON CERTIFICATION IS REQUESTED FOR

PLEASE PRINT OR TYPE THE NAME AND ADDRESS OF THE PERSON TO WHOM THE RECORD IS TO BE RETURNED.

NAME

ADDRESS (NUMBER AND STREET)
CITY
STATE
ZIP CODE

YOUR FEE RECEIPT IS ON THE REVERSE SIDE