APPLICATION FOR CERTIFIED COPY OF BIRTH CERTIFICATE

INSTRUCTIONS	COPIES REQUESTED
The Law requires a fee of $15.00 for each certified copy issued. Additional copies are $15.00 each. **FEE MUST ACCOMPANY APPLICATION** Make Check or Money Order Payable to: **City of St. Joseph** Mail this Application To: City of St. Joseph Health Department Patee Market Health Center 904 S. 10th Street, Suite E St. Joseph, MO 64503	HOW MANY AMT ENCLOSED $ **For Office Use Only** Type of ID Presented Type of Payment

INFORMATION ABOUT PERSON WHOSE BIRTH CERTIFICATE IS REQUESTED

(**TYPE** or **PRINT** all items **EXCEPT SIGNATURE**)

1. FULL NAME OF PERSON (IF NEWBORN, PLEASE WAIT 6 TO 8 WEEKS BEFORE REQUESTING)

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			3. SEX	4. RACE
MONTH	DAY	YEAR	SEX	RACE

5. PLACE OF BIRTH

CITY OR TOWN	COUNTY	STATE

6. FULL NAME OF FATHER

FIRST NAME	MIDDLE NAME	LAST NAME

7. FULL MAIDEN NAME OF MOTHER

FIRST NAME	MIDDLE NAME	LAST NAME (MAIDEN NAME)

PERSON REQUESTING CERTIFIED COPY

8. PURPOSE FOR WHICH CERTIFIED COPY IS TO BE USED	9. RELATIONSHIP*

10. SIGNATURE OF APPLICANT	11. DATE SIGNED

12. NAME AND ADDRESS OF APPLICANT (TYPE OR PRINT)

NAME	TELEPHONE NUMBER

STREET ADDRESS

CITY OR TOWN	STATE	ZIP CODE

***MUST BE REGISTRANT, MEMBER OF IMMEDIATE FAMILY, LEGAL GUARDIAN, OR LEGAL REPRESENTATIVE**

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

I _____ 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 IS TRUE UNDER THE PAINS AND PENALTIES OF PERJURY.

APPLICANT'S SIGNATURE _____ DATE _____

State _____
County _____

Subscribed, Declared and Affirmed Before Me,
This _____ Day of _____, 20 ____

Notary Public Signature My Commission Expires

Notary Public Name (Typed or Printed)