

MISSOURI DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS

**APPLICATION FOR CERTIFIED COPY OF BIRTH CERTIFICATION**

<b>INSTRUCTIONS</b>			<b>COPIES REQUESTED</b>		
The law requires a fee of \$15.00 for each certified copy issued. Additional copies are \$15.00 each. Mail-in requests must be notarized by an acceptable notary public. <b>FEE MUST ACCOMPANY APPLICATION. No cash by mail please.</b>			Birth Certification: (Certification of facts of birth contained in original record)		
<b>MAKE CHECK OR MONEY ORDER PAYABLE TO:</b> RIPLEY COUNTY HEALTH CENTER			How Many <div style="border: 1px solid black; width: 100px; height: 20px; margin: 0 auto;"></div>		
<b>MAIL THIS APPLICATION TO: (OR BRING COMPLETED FORM TO):</b> RIPLEY COUNTY HEALTH CENTER 1003 EAST LOCUST STREET DONIPHAN, MISSOURI 63935			<b>\$15.00 EACH</b> AMOUNT OF MONEY ENCLOSED \$		
<b>OFFICE HOURS</b> 7:00 a.m. - 5:30 p.m. Monday thru Thursday 573-996-2181			RECORDS ARE FILED BY YEAR OF THE EVENT AND THEN ALPHABETICALLY BY THE NAME OF THE PERSON AT THE TIME OF THE EVENT. THEREFORE, AT LEAST THE MONTH AND YEAR OF BIRTH AND THE FIRST AND LAST NAME OF THE REGISTRANT MUST BE GIVEN BEFORE A SEARCH CAN BE MADE		
<b>INFORMATION ABOUT PERSON WHOSE BIRTH CERTIFICATE IS REQUESTED (TYPE or PRINT all items EXCEPT SIGNATURE)</b>					
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			3. SEX		4. RACE
MONTH	DAY	YEAR	SEX	RACE	
5. PLACE OF BIRTH					
CITY OR TOWN			COUNTY		STATE
HOSPITAL OR STREET NUMBER		ATTENDING PHYSICIAN NAME		<input type="radio"/> PHYSICIAN <input type="radio"/> MIDWIFE <input type="radio"/> OTHER	
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)	
* IF NEWBORN, PLEASE WAIT 6 TO 8 WEEKS BEFORE REQUESTING					
<b>PERSON REQUESTING CERTIFIED COPY</b>					
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					
					11. DATE SIGNED
12. NAME AND ADDRESS OF APPLICANT (TYPE OR PRINT)					
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.			NAME		
			ADDRESS (NUMBER AND STREET)		
			CITY, STATE, ZIP CODE		
COMPLETE ONLY IF CERTIFICATIONS ARE TO BE MAILED.					
► 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.