HD1107F REV 08//07

DEATH

Application for Certified Copy of Death Record

Pennsylvania Department of Health ♦ Division of Vital Records

DEATH

PART 1: By my signature below, I state I am the person whom I represent myself to be herein, and I affirm the information within this form is complete and accurate and made subject to the penalties of 18 Pa.C.S. §4904 relating to unsworn falsification to authorities. In addition, I acknowledge that misstating my identity or assuming the identity of another person may subject me to misdemeanor or felony criminal penalties for identity theft pursuant to 18 Pa.C.S. §4120 or other sections of the Pennsylvania Crimes Code. (Note: Signature must agree with name listed in Parts 2 and 5 of this form.)

Signature of person making request *(Do not print)*: _____

Signature required on **ALL** requests. Must be 18 years of age or older to apply. If under 18, immediate family member must request record.

PART 2: PRINT or **TYPE** name of individual requesting record and his/her **current mailing address**.

Name: _____ Relationship to Person Named on Record: _____

Address: _____

City: _____ State: _____ Zip: _____

Daytime phone number: (_____) _____ - _____ E-mail Address: _____

Intended Use of Certified Copy: ☐ Social Security/Benefits ☐ Insurance ☐ Financial Institution ☐ Genealogy

☐ Estate Settlement ☐ Other (List reason: _____)

PART 3: PRINT or **TYPE** information below regarding person who died: **Number of copies:** _____

Name at Death: _____ Sex: ☐ Male ☐ Female

Date of Death: _____ **Place of Death:** _____

(Month/Day/Year - Records available from 1906 to the present) (County) (City/Boro/Twp. in Pennsylvania)

Social Security #: _____ Age at Time of Death: _____ Date of Birth: _____

Full Maiden Name of Mother: _____

Full Name of Father: _____

Funeral Director: _____

PART 4: DEATH: $9.00 each. *If fee is required, make check/money order payable to:* **VITAL RECORDS.**

Fees will be waived for individuals who served or are currently serving in the Armed Forces and their dependents *(complete the following)*:

Armed Forces Member's Name: _____ Service Number: _____

Relationship to Armed Forces Member: _____ Rank and Branch of Service: _____

PART 5: VALID GOVERNMENT ISSUED PHOTO ID REQUIRED

- **Individual requesting record must include a legible copy of his/her valid government issued photo ID that verifies name and mailing address as listed in Part 2 above.**
- Examples: State issued driver's license or non-driver photo ID *(if address has been changed, include copy of update card).*
- If possible, enlarge photo ID on copier by at least 150% (copies of ID will be shredded upon review).
- If acceptable ID not available, visit our website at www.health.state.pa.us/vitalrecords for further information.

Mail with self-addressed, stamped envelope to:

DIVISION OF VITAL RECORDS (ATTN: DEATH UNIT)
101 SOUTH MERCER STREET
PO BOX 1528
NEW CASTLE, PA 16103

Have you?

- ✓ **Signed your name in Part 1** *(do not print)*
- ✓ **Listed your name and current mailing address in Parts 2 and 5**
- ✓ **Completed all items in Part 3** *(enter unknown if information unavailable)*
- ✓ **Enclosed payment** *(or completed Part 4 for waiver of fee)*
- ✓ **Enclosed legible copy of ID** *(must agree with your name and address in Parts 2 and 5)*

Print or type name and address in the space provided below
***(must agree with name and current address in Part 2 and ID documentation)*:**

Name
Street
City, State, Zip Code

For EXPEDITED ON-LINE ORDERING or additional information, visit our website: www.health.state.pa.us/vitalrecords