Information Page — Mail-in Application for Copy of Death Certificate

General Instructions

- **Do not** use this application for *fax requests.*
- Use this application if you are the spouse, parent or child of the deceased.
- If you are **not** the spouse, parent or child of the deceased, then you must submit with this application a copy of documentation establishing a lawful right or claim (see below).
- Use this application only if the death occurred in New York State *outside* of New York City. **Do not** use this application if the death occurred in any of the five (5) boroughs of New York City.
- **Do not** use this application for *genealogy requests*.
- Print a copy of this application, complete and sign.
- **Mail** application with check or money order and a copy of any required documentation (see below) to:

For regular handling send by first class mail, registered mail, certified mail or U.S. Priority Mail to:

Certification Unit
Vital Records Section
New York State Department of Health
P.O. Box 2602
Albany, NY 12220-2602

For priority handling (add $15.00 per copy ordered) send by U.S. Postal Express or other overnight carrier **only** to:

Certification Unit
Vital Records Section / 2nd Floor
New York State Department of Health
800 North Pearl Street
Menands, NY 12204

What is a lawful right or claim?

- If the applicant is not the spouse, parent or child of the decedent, a lawful right or claim must be documented. An example of a lawful right or claim would be a death record needed by the applicant to claim a benefit.
- Documentation would consist of a copy of a court order or an official letter verifying that a copy of the requested death record is required from the applicant in order to process a claim.

Fees: If no record is on file, a **No Record Certification** will be issued and the fee is **not** refunded.

- **For regular handling:** The fee is $30.00 per copy. — Total for one (1) copy is $30.00. Total for two (2) copies is $60.00, etc.
- **For priority handling:** The fee is $30.00 + $15.00 per copy — Total for one (1) copy is $45.00. Total for two (2) copies is $90.00, etc. *Please send the application by overnight carrier to ensure priority handling.*
- Send check or money order payable to the New York State Department of Health. Do not send cash.

Note: Payment submitted from foreign countries must be made by a check drawn on a United States bank or by international money order. **Do not send cash.**

Processing Time

- Up to six (6) weeks when ordered with priority handling and submitted by overnight carrier.
- A minimum of twelve (12) to fourteen (14) weeks when ordered without priority handling.
- For faster processing, you may wish to use your credit card and submit your request by *e-mail*, *fax*, or *telephone*.

Completing the Form

- If you are using Adobe Reader®5.0 or newer (available as a free download from *www.adobe.com*) you can fill in the form directly in Adobe Reader by clicking on the appropriate space and entering the information (use the TAB key to move to the next field, shift-TAB to move backwards). Print the completed form, sign and mail to above address.
- You can print out a blank copy of the form and then type or print the required information.
- Be sure to sign the form before mailing and include a check or money order made payable to the New York State Department of Health along with copies of any required documentation.

NEW YORK STATE DEPARTMENT OF HEALTH
VITAL RECORDS SECTION

Mail-in Application for Copy of Death Certificate

Please complete, sign, and mail with check or money order.

You may enter the required information directly into this PDF document (see instruction sheet for details) and print out a copy ready for signature, or print out a blank copy and **print or type** the required information before signing.

Name of Deceased: *First* *Middle* *Last*

Social Security No. of Deceased:

Date of Death or Period to be Covered by Search: (*mm/dd/yyyy*) *From* *To*

Date of Birth of Deceased: *mm / dd / yyyy*

Age at Death:

Maiden Name of Mother of Deceased: *First* *Middle* *Maiden Last*

Death Certificate No.: *(If known)*

Name of Father of Deceased: *First* *Middle* *Last*

Local Registration No.: *(If known)*

Place of Death: *Name of Hospital or Street Address* *Village, town or city* *County*

Purpose for which Record is Required:

What is your relationship to person whose record is required?

In what capacity are you acting?

If attorney, give name and relationship of your client to person whose record is required:

Submit documentation of a lawful right or claim if you are not the spouse, parent or child of the deceased.

Signature of Applicant: ▶

Date Signed: Month Day Year

Regular Handling ☐ $30.00 x
(Check Only One) OR
Priority Handling ☐ $45.00 x ____ Copies = $ ____

Address of Applicant:
(Applicant's Name)
(Street)
(City) *(State)* *(Zip)*

Telephone No.: ( ) ____

Please print or type the name and address where record should be sent: *(If delivery is to a P.O. Box or third party, you must submit with this application a* **notarized** *statement signed by the applicant and a copy of the applicant's drivers license.)*
(Name)
(Street)
(City) *(State)* *(Zip)*