

DEATH

Application for Certified Copy of Death Record
Pennsylvania Department of Health • Division of Vital Records
 (Records available from 1906 to the present)

DEATH

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.

Signature of person making request: _____

Signature required on ALL requests. Must be 18 years of age or older to apply. If under 18, eligible requestor must sign above.

PRINT or TYPE your name & **CURRENT** address.

Name: _____

Relationship to Person

Named on Certificate: _____

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: _____)

PHOTO ID REQUIRED: The individual requesting the record must send a legible copy of his/her **VALID GOVERNMENT ISSUED PHOTO ID** with completed application. (Examples: State issued driver's license or non-driver photo ID with requestor's **current address** or passport. If possible, enlarge photo ID on copier by at least 150%.)

PRINT or TYPE information below with regard to person named on requested certificate: Number of copies: _____

Name at Death: _____ Sex: Male Female

Date of Death: _____ Place of Death: _____
 (Month/Day/Year) (County) (City/Boro/Township in Pennsylvania)

Social Security #: _____ Age at time of death: _____ Date of Birth: _____

Full Maiden Name of Mother: _____

Full Name of Father: _____

Funeral Director: _____

DEATH: \$9.00 each

No fee may be required for death records of active or inactive members of the Armed Forces and their dependents. Please complete the following:

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

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

If fee is required, make check or money order payable to: VITAL RECORDS. Complete this application and mail with legible copy of ID and a self-addressed stamped envelope to: Division of Vital Records, 101 South Mercer St., PO Box 1528, New Castle, PA 16101.

You are welcome to visit one of our public offices in the following cities:

- ◆ New Castle, PA, 101 South Mercer St., Room 401.
- ◆ Philadelphia, PA, Philadelphia State Office Bldg, Room 1009, 1400 West Spring Garden St.
- ◆ Erie, PA, 1910 West 26th St.
- ◆ Pittsburgh, PA, Pittsburgh State Office Bldg, Room 512, 300 Liberty Ave.
- ◆ Harrisburg, PA, Health and Welfare Bldg, Room 129, 7th and Forster Sts.
- ◆ Scranton, PA, Scranton State Office Bldg, Room 112, 100 Lackawanna Ave.

ON-LINE ORDERING and additional information available on our website: www.health.state.pa.us/vitalrecords