



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES  
 BUREAU OF VITAL RECORDS  
**APPLICATION FOR COPY OF BIRTH CERTIFICATION**

Certified copies are computer generated and are valid for all legal purposes.

**\*\*\*Mail-in requests must be notarized by an acceptable notary public.\*\*\***

**FEE MUST ACCOMPANY APPLICATION**

Make **MONEY ORDER** payable to: **CAPE GIRARDEAU COUNTY PUBLIC HEALTH CENTER**

**P.O. Box 1839, 1121 Linden St., Cape Girardeau, MO 63702**

Please send a self addressed stamped envelope.

**TYPE OR PRINT ALL ITEMS EXCEPT SIGNATURES**

**Number of Copies Requesting** \_\_\_\_\_ **\$15.00 PER COPY**  Cash  Check# \_\_\_\_\_  Debit  Money Order

FULL NAME ON CERTIFICATE \_\_\_\_\_  
 (FIRST) (MIDDLE) (LAST - MAIDEN)

ALSO KNOWN AS (Indicate if birth could be recorded under another name)

DATE OF BIRTH \_\_\_\_\_ HOSPITAL \_\_\_\_\_  
 MM/DD/YYYY

PLACE OF BIRTH \_\_\_\_\_  
 (CITY) (COUNTY) (STATE)

FULL NAME OF FATHER \_\_\_\_\_  
 (FIRST) (MIDDLE) (LAST)

FULL MAIDEN NAME OF MOTHER \_\_\_\_\_  
 (FIRST) (MIDDLE) (MAIDEN NAME)

**PERSON REQUESTING CERTIFIED COPY**

IF LEGAL GUARDIAN OF REGISTRANT, SEND ALONG GUARDIANSHIP PAPERS.

PURPOSE FOR WHICH CERTIFIED COPY IS TO BE USED	RELATIONSHIP TO PERSON NAMED ON RECORD
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**NAME AND ADDRESS OF APPLICANT (TYPE OR PRINT)**

NAME \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_

ADDRESS \_\_\_\_\_  
 (STREET) (CITY) (STATE) (ZIP CODE)

**APPLICANT'S SIGNATURE** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**\*\*\*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 REQUESTED ABOVE AND THAT THE INFORMATION IS TRUE UNDER THE PAINS AND PENALTIES OF PERJURY.

NOTARY PUBLIC EMBOSSER SEAL	STATE	COUNTY
	SUBSCRIBED, DECLARED AND AFFIRMED BEFORE ME ,	
	THIS _____ DAY OF _____, 20 _____	
	NOTARY PUBLIC SIGNATURE	MY COMMISSION EXPIRES
NOTARY PUBLIC NAME (TYPED OR PRINTED)		

USE RUBBER STAMP IN CLEAR AREA BELOW