Howell County Health Department
180 Kentucky Avenue
West Plains, Missouri 65775
(417) -256-7078
www.howellcountyhealth.com

Public Health
Prevent. Promote. Protect.

Beginning March 1, 2011, applicants must show identification when requesting certified copies of a vital record at the state health department or a local public health agency. **Mail-in requests must be notarized by an acceptable notary public and include a self-addressed stamped envelope to return the document in.**

Missouri law requires a fee for each certified copy that is issued. See fee amounts below. Please make check or money order payable to: **Howell County Health Department.**

BIRTH NUMBER OF COPIES ________ (FIRST COPY ISSUED $15; EACH ADDITIONAL COPY $15)

FULL NAME ON CERTIFICATE ______________________________

ALSO KNOWN AS (INDICATE IF BIRTH COULD BE RECORDED UNDER ANOTHER NAME) ______________________________

DATE OF BIRTH ______________ PLACE OF BIRTH (CITY, COUNTY, STATE) ______________________________ SEX FEMALE ☐ MALE ☐

FULL NAME OF FATHER/CO-PARENT ______________________________

FULL MAIDEN NAME OF MOTHER/CO-PARENT ______________________________

DEATH NUMBER OF COPIES _______ (FIRST COPY ISSUED $14; EACH ADDITIONAL COPY OF THE SAME RECORD ORDERED AT THE SAME TIME $11)

FULL NAME ON CERTIFICATE ______________________________

DATE OF DEATH ______________________________ DATE OF BIRTH ______________________________

SEX FEMALE ☐ MALE ☐ PLACE OF DEATH (CITY, COUNTY, STATE) ______________________________

FULL NAME OF FATHER ______________________________

FULL MAIDEN NAME OF MOTHER ______________________________

(PLEASE PRINT THE FOLLOWING INFORMATION)

APPLICANT'S NAME ______________________________ PHONE NUMBER ______________________

APPLICANT'S ADDRESS ______________________________

CITY______________________________ STATE______________ ZIP______________ COUNTY______________

PURPOSE FOR CERT. REQUEST ______________________________

YOUR RELATIONSHIP TO PERSON NAMED ON RECORD______________________________

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.

WARNING: False application for a certified copy of a vital record is a crime.

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FOR OFFICE USE ONLY

DATE ______________________________ PAID ______________________________

CERTIFICATE NUMBER ______________________________ CASH CHECK / M/O DEBIT