



**Stone County Health Department**  
Application for a Vital Record  
[www.stonecountyhealthdepartment.com](http://www.stonecountyhealthdepartment.com)

**109 E. 4<sup>th</sup> Street**  
Galena, MO 65656  
417-357-6134

Beginning March 1, 2011, applicants must show identification when requesting certified copies of a vital record at the Stone County Health Department. **Mail-in requests must be notarized by an acceptable notary public.**

**Mail requests to: Stone County Health Department**  
**109 E. 4<sup>th</sup> Street**  
**Galena, MO 65656**

**FEE MUST ACCOMPANY APPLICATION.** Check or money order payable to: **Stone County Health Department.**  
State recording of birth and death records began January 1, 1910.

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**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) \_\_\_\_\_  
HOSPITAL \_\_\_\_\_ SEX FEMALE ☐ MALE ☐ RACE \_\_\_\_\_  
FULL NAME OF FATHER \_\_\_\_\_  
FULL MAIDEN NAME OF MOTHER \_\_\_\_\_

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**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 \_\_\_\_\_ SEX FEMALE ☐ MALE ☐ RACE \_\_\_\_\_  
PLACE OF DEATH (CITY, COUNTY, STATE) \_\_\_\_\_  
FULL NAME OF SPOUSE \_\_\_\_\_  
FULL NAME OF FATHER \_\_\_\_\_  
FULL MAIDEN NAME OF MOTHER \_\_\_\_\_

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**PLEASE ENCLOSE A SELF ADDRESSED STAMPED ENVELOPE WITH YOUR REQUEST (PRINT THE FOLLOWING INFORMATION)**

APPLICANT'S NAME \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_  
APPLICANT'S STREET ADDRESS \_\_\_\_\_  
APPLICANT'S CITY/TOWN \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
PURPOSE FOR CERTIFICATE REQUEST \_\_\_\_\_  
YOUR RELATIONSHIP TO PERSON NAMED ON RECORD (IF LEGAL GUARDIAN, MUST PROVIDE GUARDIANSHIP PAPERS). IF LEGAL REPRESENTATIVE, INDICATE LEGAL RELATIONSHIP. \_\_\_\_\_

I \_\_\_\_\_ 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 IS TRUE UNDER THE PAINS AND PENALTIES OF PERJURY.

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

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**MAIL-IN REQUESTS MUST BE NOTARIZED**

NOTARY PUBLIC EMBOSSEER SEAL	STATE _____	COUNTY _____
	SUBSCRIBED, DECLARED AND AFFIRMED BEFORE ME ,	
	THIS _____ DAY OF _____ , 20 _____	
	NOTARY PUBLIC SIGNATURE _____	MY COMMISSION EXPIRES _____

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