

Date: _____

REQUEST FOR COPY OF DEATH CERTIFICATE
Revised: 10/1/2009

PLEASE PRINT

DO NOT MAIL CASH

FULL NAME				SEX	DATE OF DEATH (or last known to be alive)
FIRST	MIDDLE	LAST		<input type="checkbox"/> M <input type="checkbox"/> F	
PLACE OF DEATH (TOWN)		DATE OF BIRTH (MONTH/DAY/YEAR)		PLACE OF BIRTH (TOWN, STATE OF FOREIGN COUNTRY)	
FATHER'S NAME		MOTHER'S NAME		IF MARRIED, SPOUSES' NAME	

IN ACCORDANCE WITH C.G.S. §7-51a, FOR ANY DEATH OCCURRING AFTER JULY 1, 1997, ONLY THE PARTIES SPECIFIED ON THE DEATH CERTIFICATE, SUCH AS INFORMANT, LICENSED FUNERAL DIRECTOR, LICENSED EMBALMER, CONSERVATOR, SURVIVING SPOUSE, PHYSICIAN, TOWN CLERK, OR REGISTRAR, OR OTHER PERSONS AS AUTHORIZED BY THE DEPARTMENT OF PUBLIC HEALTH, SHALL BE ISSUED A CERTIFIED COPY OF A DEATH CERTIFICATE CONTAINING THE SOCIAL SECURITY NUMBER OF THE DECEDENT. ALL OTHER REQUESTERS WILL RECEIVE A CERTIFIED COPY OF THE DEATH CERTIFICATE WITHOUT THE SOCIAL SECURITY NUMBER.

PERSON MAKING THIS REQUEST:

NAME: _____
FIRST MIDDLE LAST NAME

ADDRESS: _____
NUMBER STREET

TOWN/CITY: _____ STATE: _____ ZIP CODE: _____

RELATIONSHIP TO PERSON NAMED IN CERTIFICATE _____

SIGNATURE: X _____

LEGAL FEE IS \$20.00 PER COPY.

NUMBER OF COPIES WANTED: _____ AMOUNT ENCLOSED \$ _____

PLEASE INCLUDE A COPY OF A PHOTO ID OF THE PERSON MAKING THE REQUEST.

Make checks payable to: East Hampton Town Clerk
20 East High Street
East Hampton, CT 06424

For questions, please feel free to contact this office at (860) 267-2519 x 5.