PLEASE RETURN THIS FORM TO: VITAL RECORDS, 2600 SKYLAND DRIVE, NE, ATLANTA, GA 30319

Please indicate below the type and number of copies requested and forward this form with either a money order or certified check for the correct amount, made payable to Vital Records.

[ ] Full size copy $15.00
Additional copies
$5.00 each at this time

[ ] Total number of copies Requested

[ ] Amount Received
$_____

[ ] Photocopy of valid photo ID

BIRTH CERTIFICATE REQUESTS

FILL IN INFORMATON BELOW CONCERNING PERSON WHOSE BIRTH CERTIFICATE IS REQUESTED

Name at birth:_____
(first) (middle) (last)

Date of birth:_____ Age: _____ Race: _____ Sex: _____

Place of birth:_____
(hospital) (city) (county) (state)

Full name of father: _____

Full name of mother before marriage: _____

DEATH CERTIFICATE REQUESTS

FILL IN INFORMATION BELOW CONCERNING DECEDENT

Name: _____

Date of death:_____ Age: _____ Race: _____ Sex: _____

Place of death:_____
(hospital) (city) (county) (state)

If married, name of husband or wife: _____
Occupation of deceased:_____
Funeral director's name:_____
Name of doctor: _____
Place of burial: _____
(city) (county) (state)

MAILING ADDRESS

List below the name and address of the person to whom the certificate is to be mailed and indicate their relationship to the person whose name is on the certificate:

Name:_____ Relationship: _____

Address: _____
(No. & Street or RFD and Box No.) (Apt. No.)

_____
(city) (state) (zip code)