



FUNERAL HOMES DEATH CERTIFICATE REQUEST FORM



No. of copies: _____ (\$26.00 each)
 MAIL: _____ No. of amendments: _____
 No. of fetal copies: _____ (\$23.00 each)
 PICK UP: _____ No. of permits: _____ (\$12.00 each)
 Non-contagious ltr: _____ (\$25.00 each)
 Total Amount: \$ _____

DEATH CERTIFICATE INFORMATION				
Name on Certificate: _____				
First	Middle	Last		
Date of Death: _____		City of Death: _____		
APPLICANT INFORMATION				
SWORN STATEMENT				
I, _____, swear under penalty of				
Printed Name				
perjury under laws of the State of California, that I am an authorized person, as defined in California Health and Safety Code Section 103526 (c) and am eligible to receive a certified copy of the death record identified on this application form.				
Sworn this _____ day of _____, 20____ at _____				
Name of establishment: _____				
Mailing Address: _____				
Street	City	State	Zip Code	
Phone: (____) _____		Email Address: _____		
Signature: _____				
<u>Office Use Only</u>				
Banknote# _____				
Print Name: _____		Signature: _____		
Name of person receiving copies				
Local Registrar: _____			Date: _____	
275 Beck Avenue MS 5-285, Fairfield CA 94533 P (707) 784-8060 F (707) 784-8060 vitalstatistics@solanocounty.com				