

STATE OF HAWAII, DEPARTMENT OF HEALTH
OFFICE OF HEALTH STATUS MONITORING

REQUEST FOR CERTIFIED COPY OF **DEATH** RECORD

1	FIRST CERTIFIED COPY	= \$	10.00
<input type="checkbox"/>	ADDITIONAL COPIES AT \$4.00 EACH	= \$	_____
<input type="checkbox"/>	OTHER: _____	= \$	_____
_____	TOTAL COPIES		TOTAL AMOUNT DUE
	_____		_____

NAME OF DECEASED:	FIRST	MIDDLE	LAST	MALE /FEMALE
				<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE

DATE OF DEATH:	MONTH	DAY	YEAR

PLACE OF DEATH:	CITY OR TOWN	ISLAND

SOCIAL SECURITY NUMBER: _____

RELATIONSHIP OF REQUESTOR TO PERSON NAMED ON CERTIFICATE	REASON FOR THIS REQUEST

SIGNATURE OF REQUESTOR:	TELEPHONE NUMBERS
PRINT NAME OF REQUESTOR:	RES:
	BUS:

ADDRESS OF REQUESTOR:	NO. AND STREET OR P.O. BOX

CITY	STATE	ZIP

<p>IF MAILING TO A LOCATION OTHER THAN ABOVE, PLEASE FILL THIS SECTION</p> <p>IF THE INFORMATION GIVEN IS INCORRECT, THE CERTIFICATE WILL FAIL TO REACH THE DESTINATION.</p>	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:100%;">NAME OF PERSON TO RECEIVE CERTIFICATE</td> </tr> <tr> <td>_____</td> </tr> <tr> <td>AGENCY OR ORGANIZATION</td> </tr> <tr> <td>_____</td> </tr> <tr> <td>NUMBER AND STREET OR P.O. BOX</td> </tr> <tr> <td>_____</td> </tr> <tr> <td>CITY</td> <td style="width:30%;">STATE</td> <td style="width:40%;">ZIP</td> </tr> <tr> <td></td> <td></td> <td></td> </tr> </table>	NAME OF PERSON TO RECEIVE CERTIFICATE	_____	AGENCY OR ORGANIZATION	_____	NUMBER AND STREET OR P.O. BOX	_____	CITY	STATE	ZIP			
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AGENCY OR ORGANIZATION													

NUMBER AND STREET OR P.O. BOX													

CITY	STATE	ZIP											

FOR OFFICE USE ONLY			
NR FILE	_____	PENDING:	_____

INDEX SEARCHED FROM	VOLUMES SEARCHED FROM	DATE COPY PREPARED
TO	TO	
YEAR	VOLUME	CERTIFICATE
		RECEIPT NUMBER

*** Be sure to sign the "Signature of Requestor" Box before submitting this form.**

ONCE A REQUEST IS SUBMITTED:

- 1. All fees are non-refundable.**
2. If a vital record is not found, all fees will be retained to cover the cost of the search.
3. Only one name is allowed on the request form.
4. After a request is submitted, additional copies require a new request.

SUBMIT THE COMPLETED REQUEST FORM:

- 1. By postal mail to:** State Department of Health
Office of Health Status Monitoring
Vital Records Issuance Section
PO Box 3378
Honolulu, Hawaii 96801

All fees must be prepaid. Enclose a money order or cashier's check for the exact amount of fees made payable to: Hawaii State Department of Health. Do not send payment in cash or by personal check.

- 2. In-person at:** Room 103, 1250 Punchbowl Street, Honolulu
7:45 AM to 2:30 PM, Monday through Friday (Except Holidays)

Payment of fees must be made by cash, money order, or cashier's check.

Personal checks will not be accepted