APPLICATION FOR CERTIFIED COPY OF DEATH CERTIFICATE
PUBLIC HEALTH –VITAL RECORDS
COUNTY OF LOS ANGELES DEPARTMENT OF HEALTH SERVICES

FULL NAME OF DECEASED	DATE OF DEATH (MO.-DAY-YR.)
PLACE OF DEATH (HOSPITAL AND ADDRESS)	
NAME AND ADDRESS OF APPLICANT	

RECEIPT OR LOG NO.		
CERTIFICATE NO.		
	NUMBER COPIES	FEE*
PAID		$
FREE*		

☐ **PICK UP**

OR IF CERTIFICATE IS TO BE MAILED, FILL IN BELOW:

MAIL TO: _____

ADDRESS: _____

_____

CITY, STATE: _____

ZIP CODE: _____

***FEE $13.00 EACH**

****FOR PURPOSES SPECIFIED BY LAW (SPECIFY):**

_____

PUBLIC HEALTH
VITAL RECORDS, ROOM L-1
313 N. FIGUEROA STREET
LOS ANGELES, CA 90012
(213) 240-7816

BNPNS#:_____

SWORN STATEMENT

I, _____, swear under penalty of perjury under the 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 of the following individuals(s):

NAME OF PERSON LISTED ON CERTIFICATE	RELATIONSHIP TO PERSON LISTED ON CERTIFICATE

Sworn this _____day of _____,20____at_____,_____.
(Day) (Month) (City) (State)

_____
Signature of Applicant

NOTE: If submitting your order by mail, you must have your sworn statement notarized using the Certificate of Acknowledgment