VS-31
(Rev. 5/92)

COMMONWEALTH OF KENTUCKY
DEPARTMENT FOR HEALTH SERVICES

State Registrar of Vital Statistics

APPLICATION FOR DEATH CERTIFICATE

Please Print or Type All Information Required on This Form.

Full Name of Deceased _____

Date of Death _____ (Mo.) (Day) (Year)

KY County in Which Death Occurred _____

Did Death Occur In a Hospital? ☐ Yes ☐ No

Age at Death _____

If "Yes" Give Name of Hospital _____

Name of Attending Physician _____

Name of Funeral Director _____

Address _____ (Street) (City) (State)

Name of Applicant _____

Address _____ (Street) (City) (State)

_____ Phone _____
Signature of Applicant (A/C) (Number)

Official Use Only

Vol. _____

Cert. _____

Year _____

Date _____

Initials _____

A **$6.00** fee must accompany this application. The fee cannot be returned. If certificate is on file you will receive a copy. Additional copies are **$6.00** each. Make check or money order payable to "Kentucky State Treasurer". When complete, mail the entire form to: **Vital Statistics, 275 East Main Street, Frankfort, Kentucky 40621.**

Please Indicate Quantity Desired _____

Print Name and Mailing Address of Person to Receive the Certificate.
This Portion is a Mailing Insert and will be used to Mail the Copy you Have Requested.

_____
Name

_____
Street Number & Name

_____
City - State - Zip Code