SKOKIE HEALTH DEPARTMENT
APPLICATION FOR SEARCH OF DEATH RECORD FILES

DECEASED'S FULL NAME: _____

DATE OF DEATH: _____ NUMBER OF COPIES REQUESTED: _____

FEE: $12.00 for the first copy and $7.00 for each additional copy ordered at the same time.
You may pay by CASH, CHECK or CREDIT CARD (Master Card, Visa, or Discover) I certify that I am a relative, funeral director, duly authorized agent, have a vested property interest and therefore am entitled to purchase death certificates for the above named individual. **If requesting certificates by mail you must include a copy of a valid photo ID.**

SIGNATURE: _____

PRINTED NAME: _____

RELATIONSHIP TO THE DECEASED: _____

ADDRESS: _____

CITY/STATE: _____ZIP CODE: _____

DAYTIME PHONE NUMBER: _____

Credit Card: TYPE_____ No: _____Exp. Date: _____

DO NOT WRITE BELOW THIS LINE! OFFICE USE ONLY!

Receipt for Certified Copies of Death Certificates

I acknowledge receipt from the Skokie Health Department of _____ certified copies of the death certificate for _____.

Payment Amount: _____ Cash ____ Check ____ Credit ____

Name: _____

Driver's License #:_____

Signed: _____

Funeral Home: _____
(Leave blank if not applicable.)

Date: _____

Doc# 440828