

Please Print Clearly

Rhode Island Department of Health, Division of Vital Records, 3 Capitol Hill, Rm. 101, Providence, RI 02908-5097

Application for a Certified Copy of a Death Record

Please complete ALL items 1-5 below:

1. Please fill in the information below for the person whose death record you are requesting:

Full name _____

Date of death _____ Place of death (city/town/hospital name) _____

Name of spouse (if married) _____

Mother's full maiden name _____

Father's full name _____

2. Complete one of the following:

I am applying for the death record of:

my parent my spouse my child my grandparent

other relative (specify): _____

my client. I am an attorney representing _____ . The name of the law firm is _____.

my client. I am an insurance company representative. The name of the insurance company is _____.

another person (specify): _____

3. Why do you need this record? (We ask this question so that we can supply you with a certified copy that will be suitable for your needs.)

probate social security vets benefits property title

foreign government other (specify): _____

4. Copies cost \$20.00. Any additional copies of this record purchased this same day cost \$15.00 each. How many do you want? _____ (Payable to: Town of North Smithfield)

5. I hereby state that the information supplied in item #2 above is true and that I am not in violation of Section 23-3-28 of the General Laws of RI (printed on the reverse side of this form).

Please sign _____ signature of person completing this form _____ date signed _____

Print your name _____ (_____) _____ phone # _____

Print your address _____ street or mailing address _____ city/town _____ state _____ zip code _____

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