

APPLICATION FOR STILLBIRTH CERTIFICATE

| | | | |
|-------------------------------|--|--|-----------------------------------|
| Stillbirth Information | NAME OF STILLBORN. Print the entire name as it currently appears on the fetal death record. | | |
| | GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Undet. (Gender will not be listed for Undetermined) | DATE OF STILLBIRTH (Month/Day/Year) | PLACE OF STILLBIRTH - CITY |
| | NAME OF HOSPITAL (If delivery occurred outside of a hospital, list the street address where the delivery occurred.) | | |
| | MOTHER'S FULL NAME (As of the Date of Stillbirth) (First/Middle/Last) | MOTHER'S BIRTH SURNAME | |
| | FATHER'S FULL NAME (As of the Date of Stillbirth) (This item may be left blank if mother was unmarried and no AOP was filed.) | | |
| Applicant Information | ONLY THE PARENT OF THE STILLBORN MAY FILE AND OBTAIN A COPY OF A STILLBIRTH CERTIFICATE FOR THAT EVENT. THE PARENT MUST SUBMIT A VALID GOVERNMENT ISSUED PHOTO IDENTIFICATION AND PAYMENT OF \$15.00. | | |
| | Requestor Name (Print or Type). Requestor <u>must</u> attach a copy of picture identification | Telephone Number (Include Area Code) | |
| | Requestor Complete Mailing Address (include apartment number if applicable) | City/State/Zip Code | |
| Copies & Fees | Number of Copies requested. _____ Fee: \$15.00 per copy Make Checks Payable to: Treasurer, State of CT | Mail Request and identification to: State Registrar of Vital Records Department of Public Health Vital Records-MS#11VRS 410 Capitol Avenue Hartford, CT 06134-0308 | |
| Applicant Signature | SIGNATURE OF MOTHER | | DATE SIGNED |
| | SIGNATURE OF FATHER | | DATE SIGNED |