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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 <u>this record</u> purchased <u>this same day</u> cost $15.00 each.**
   How many do you want? _____ (Payable to: Town of Foster)

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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VS-82D (Rev. 08/01/07)