

**Borough of Collingswood  
Office of Vital Statistics  
678 Haddon Ave.  
Collingswood, NJ 08108  
856-854-0720 ext. 110 or 120**

**APPLICATION FOR A CERTIFIED COPY OF A VITAL RECORD**

**Mail in requests: Please enclose payment, a self addressed envelope a copy of you photo identification or two forms of ID without a photo. There is an \$15.00 fee for each certified copy issued. Please make checks payable to the Borough of Collingswood.**

Name of Applicant		Relationship to Person Named on Requested Record (Proof may be required)	
Street Address			
City	State	Zip Code	Telephone Number
Signature of Applicant		Reason for Request	Date of Application

<input type="checkbox"/> <b>Birth</b>	Full Name of Child at Time of Birth		No. of Copies Requested
	Place of Birth (City, Town Township)		County
	Date of Birth	Mother's Full Maiden Name	Father's Name
	If child's name was changed, indicate new name and how it was changed		

<input type="checkbox"/> <b>Marriage</b>	Name of Husband / Civil Union Partner		No. of Copies Requested
	Maiden Name of Wife / Civil Union Partner		Date of Ceremony
<input type="checkbox"/> <b>Civil Unions</b>	Place of Ceremony		County

<input type="checkbox"/> <b>Domestic Partner</b>	Name of Partner		No. of Copies Requested
	Name of Partner		Date Registered
	Place where Domestic Partnership was Registered		County

<input type="checkbox"/> <b>Death</b>	Name of Deceased		No. of Copies Requested
	Date of Death	Place of Death (City, Town, Township)	County
	Mother's Full Maiden Name		Father's Name

**\*PLEASE FILL OUT PAGE 2 WHEN APPLYING FOR A COPY OF A DEATH RECORD**

## REQUEST FOR A COPY OF A CERTIFIED DEATH RECORD

I, \_\_\_\_\_, \_\_\_\_\_  
(APPLICANT) (RELATIONSHIP)

to decedent , hereby authorize the issuance of certification of the death record of \_\_\_\_\_ disclosing the cause of death section. I certify that the above information, supplied by me is true. I am aware I am subject to punishment if I have falsely supplied the above information.

\_\_\_\_\_  
(SIGNATURE)