

**TENNESSEE DEPARTMENT OF HEALTH
OFFICE OF VITAL RECORDS**

APPLICATION FOR VERIFICATION OF FACTS OF DEATH

THIS APPLICATION MUST BE ACCOMPANIED BY A CHECK OR MONEY ORDER FOR \$10.00

Name and mailing address of where verification is to be sent:

_____ DATE _____ 19_____
 Name of individual or requesting agency

_____ TELEPHONE #: _____

_____ Street Address

_____ City State Zip

IN ORDER FOR THE DEATH INFORMATION TO BE VERIFIED, PLEASE COMPLETE ITEMS 1-5. THE \$10.00 FEE IS CHARGED FOR SEARCH OF THE DEATH FILES FOR THE ONE YEAR NOTED IN ITEM 2 FOR THE PURPOSE OF PROVIDING INFORMATION ON THE RECORD REQUESTED. THE FEE IS CHARGED EVEN IF THE RECORD IS NOT FOUND AND NO INFORMATION CAN BE PROVIDED. IF MORE THAN ONE YEAR NEEDS TO BE SEARCHED, PLEASE INCLUDE \$10.00 FOR EACH ADDITIONAL YEAR.

1. Full Name of Deceased: _____
 First Middle Last

2. Date of Death: _____

3. Place of Death: _____
 City County State

4. Residence at Time of Death: _____
 City County State

5. Decedent's parents: Mother _____
 First Middle Last

Father _____
 First Middle Last

CHECK THE INFORMATION BELOW THAT YOU WANT VERIFIED FROM THE ORIGINAL DEATH CERTIFICATE (IF IT IS AVAILABLE):

- | | | |
|---|---|--|
| <input type="checkbox"/> 1. Name of Decedent | <input type="checkbox"/> 11. Marital Status | <input type="checkbox"/> 21. Mailing Address |
| <input type="checkbox"/> 2. Sex | <input type="checkbox"/> 12. Spouse's Name | <input type="checkbox"/> 22. Method-Place of Disposition |
| <input type="checkbox"/> 3. Date of Death | <input type="checkbox"/> 13. Decedent's Occupation (Kind of Business) | <input type="checkbox"/> 23. Funeral Director |
| <input type="checkbox"/> 4. Social Security Number | <input type="checkbox"/> 14. Decedent's Residence | <input type="checkbox"/> 24. Embalmer |
| <input type="checkbox"/> 5. Age | <input type="checkbox"/> 15. Race | <input type="checkbox"/> 25. Name and Address of Funeral Home |
| <input type="checkbox"/> 6. Date of Birth | <input type="checkbox"/> 16. Education | <input type="checkbox"/> 26. Medical Examiner's Name and Address |
| <input type="checkbox"/> 7. Birth Place | <input type="checkbox"/> 17. Father's Name | <input type="checkbox"/> 27. Physician |
| <input type="checkbox"/> 8. Was Decedent Ever in Armed Forces | <input type="checkbox"/> 18. Mother's Name | <input type="checkbox"/> 28. Date Certificate Filed |
| <input type="checkbox"/> 9. Place of Death | <input type="checkbox"/> 19. Informant's Name | |
| <input type="checkbox"/> 10. Facility Name and Address | <input type="checkbox"/> 20. Relationship | |

Is there other information you want? _____

MAIL THIS APPLICATION TO:

Office of Vital Records
 Tennessee Department of Health
 C3-324 Cordell Hull Building
 Nashville, TN 37247-0350

(Do not write in shaded area.)

This form is not a death certificate. The information is transcribed from the original document.
This cannot be used as a legal document.

1. Name of Decedent: _____
2. Sex: _____
3. Date of Death: _____
4. Social Security Number: _____
5. Age: _____
6. Date of Birth: _____
7. Birth Place: _____
8. Was Decedent Ever in Armed Forces: _____
9. Place of Death: _____
10. Facility Name and Address: _____
11. Marital Status: _____
12. Spouse's Name: _____
13. Decedent's Occupation - Kind of Business: _____
14. Decedent's Residence: _____
15. Race: _____
16. Education: _____
17. Father's Name: _____
18. Mother's Name: _____
19. Informant's name: _____
20. Relationship: _____
21. Mailing Address: _____
22. Method - Place of Disposition: _____
23. Funeral Director: _____
24. Embalmer: _____
25. Name and Address of Funeral Home: _____
26. Medical Examiner's Name and Address: _____
27. Physician: _____
28. Date Certificate Filed: _____

Other Information: _____



We were unable to locate a certificate
with the information given.

(Do not write in shaded area.)

VERIFIED BY: _____

TITLE: _____

DATE VERIFIED: _____