**State of Illinois**
Illinois Department of Public Health

# Application for Search of Birth Record Files of a Deceased Infant

| Section A - Birth Information | | |
|---|---|---|
| **NAME** (First, Middle, Last) | | |
| **PLACE OF BIRTH** (Hospital, City or Town, County) | | |
| **DATE OF BIRTH** (Month, Day, Year) | **SEX** | **BIRTH CERTIFICATE NUMBER** (if known) |
| **FATHER/CO-PARENT'S CURRENT LEGAL NAME** (First, Middle, Last) | | |
| **FATHER/CO-PARENT'S NAME PRIOR TO FIRST MARRIAGE/CIVIL UNION** (First, Middle, Last) | | |
| **MOTHER/CO-PARENT'S CURRENT LEGAL NAME** (First, Middle, Last) | | |
| **MOTHER/CO-PARENT'S NAME PRIOR TO FIRST MARRIAGE/CIVIL UNION** (First, Middle, Last) | | |

| Section B - Child's Information | Section C - Applicant Information | |
|---|---|---|
| **FULL LEGAL NAME OF INFANT** (First, Middle, Last) | **NAME** (First, Middle, Last) | |
| | **STREET ADDRESS** | |
| **DATE OF BIRTH** (Month, Day, Year) | **CITY, STATE, ZIP CODE** | |
| **PLACE OF DEATH** (City, State) | **SOCIAL SECURITY NUMBER** | |
| **ARE YOU THE MOTHER OF THE DECEASED INFANT?** ❑ Yes ❑ No | **DRIVER'S LICENSE/STATE ID NUMBER** | **STATE ISSUED** |

I affirm, under the penalties for perjury, that the representations made on this application are true to the best of my knowledge and belief.

Work Telephone _____

_____ _____ Home Telephone _____

Signature Date

| | |
|---|---|
| **Certified Copy $15.00** | I have received at least one certified copy of this record prior to this request. ❑ Yes ❑ No |

## Application Instructions

The application must be completed by the mother listed on the birth certificate of the deceased child. To qualify for a copy of a birth record for a deceased infant without the deceased stamp, the child must have died within 90 days of the birth. Additionally, the request must be made within nine months from the date of death.

Only the mother of the child named on the birth certificate is entitled to order one certified copy of the birth certificate that is not marked "DECEASED." The cost for the certified copy is $15. The application must be fully completed (all boxes) or it will be returned to the requestor.

DO NOT SEND CASH — Make check or money order payable to Illinois Department of Public Health.

Mail to: Division of Vital Records
110 West Lawrence Ave.
Springfield, IL 62704-2610