



**Will County Health Department  
and Community Health Center**  
501 Ella Avenue Joliet, IL 60433

Email address: [vitalrecords@willcountyhealth.org](mailto:vitalrecords@willcountyhealth.org)

**HOURS OF OPERATION**  
Monday – Friday 8:30am – 4:00pm  
(Closed daily Noon to 1pm)  
Holiday Exceptions  
**Office: 815-727-8639**  
**Fax: 815-846-1556**

**VITAL RECORD CERTIFIED COPY OF DEATH REQUEST**

**A Valid Driver’s License, State ID, Matricula or Passport is required with your request.**

**DECEDENTS FULL NAME:**

FIRST \_\_\_\_\_ MIDDLE \_\_\_\_\_ LAST \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

DATE OF DEATH \_\_\_\_\_

PLACE OF DEATH \_\_\_\_\_

**WHAT IS YOUR RELATIONSHIP TO THE DECEDENT NAMED ON THE CERTIFICATE, OR WHAT DO YOU NEED THE COPIES FOR?**

\_\_\_\_\_

**YOUR INFORMATION:**

FIRST \_\_\_\_\_ MIDDLE \_\_\_\_\_ LAST \_\_\_\_\_

STREET ADDRESS \_\_\_\_\_ CITY, STATE, ZIP \_\_\_\_\_

DAYTIME PHONE \_\_\_\_\_

**FEE:** 1 for \$16.00 and \$8.00 for each additional certified copy of the same certificate that is purchased at the same time. Example 1=\$16, 2=\$24, 3=\$32, 4=\$40 Note: **Out of state checks will not be accepted**, ID and check name and address must match. Use of credit or debit cards will add on an additional service charge. **Number of copies requested?** \_\_\_\_\_

**SWORN STATEMENT:** *Under penalty of perjury I affirm that the representations made on this application are true to the best of my knowledge and belief.*

**SIGNATURE:** \_\_\_\_\_ **DATE SIGNED:** \_\_\_\_\_

----- Do no write below this line -----

**FOR OFFICE USE ONLY**

JM / JC

AMT PAID \_\_\_\_\_

CA / MO / CC / CK# \_\_\_\_\_

RECT \_\_\_\_\_