State of Connecticut
Department of Public Health
Vital Records 6/05;10/1/09
VS-7

# APPLICATION FOR STILLBIRTH CERTIFICATE

<table>
<tr><td rowspan="5">Stillbirth Information</td><td colspan="3">NAME OF STILLBORN. Print the entire name as it currently appears on the fetal death record.</td></tr>
<tr><td>GENDER<br>☐ Male ☐ Female ☐ Undet.<br>(Gender will not be listed for Undetermined)</td><td>DATE OF STILLBIRTH<br>(Month/Day/Year)</td><td>PLACE OF STILBIRTH - CITY</td></tr>
<tr><td colspan="3">NAME OF HOSPITAL (If delivery occurred outside of a hospital, list the street address where the delivery occurred.)</td></tr>
<tr><td colspan="2">MOTHER'S FULL NAME (As of the Date of Stillbirth) (First/Middle/Last)</td><td>MOTHER'S BIRTH SURNAME</td></tr>
<tr><td colspan="3">FATHER'S FULL NAME (As of the Date of Stillbirth) (This item may be left blank if mother was unmarried and no AOP was filed.)</td></tr>
<tr><td rowspan="3">Applicant Information</td><td colspan="3">ONLY THE PARENT OF THE STILLBORN MAY FILE AND OBTAIN A COPY OF A STILLBIRTH CERTIFICATE FOR THAT EVENT. THE PARENT MUST SUBMIT A VALID GOVERNMENT ISSUED PHOTO IDENTIFICATION AND PAYMENT OF $30.00.</td></tr>
<tr><td colspan="2">Requestor Name (Print or Type). Requestor must attach a copy of picture identification</td><td>Telephone Number (Include Area Code)</td></tr>
<tr><td colspan="2">Requestor Complete Mailing Address (include apartment number if applicable)</td><td>City/State/Zip Code</td></tr>
<tr><td>Copies & Fees</td><td colspan="2">Number of Copies requested._____<br><br>Fee: $30.00 per copy<br>Make Money Orders Payable to: Treasurer, State of CT</td><td>Mail Request and identification to:<br><br>State Registrar of Vital Records<br>Department of Public Health<br>Vital Records-MS#11VRS<br>410 Capitol Avenue<br>Hartford, CT 06134-0308</td></tr>
<tr><td rowspan="2">Applicant Signature</td><td colspan="3">SIGNATURE OF MOTHER DATE SIGNED</td></tr>
<tr><td colspan="3">SIGNATURE OF FATHER DATE SIGNED</td></tr>
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