

APPLICATION TO CORRECT, COMPLETE OR AMEND THE DEMOGRAPHIC PORTION OF A DEATH CERTIFICATE

**Changes to the demographic information may only be requested by
the funeral director of record or authorized person per 18 V.S.A. § 5202a**

Name of Decedent: _____ **Date of Death:** _____

Applicant Name: _____ **Title:** _____

Organization: _____

Phone number: _____ **Date of Request:** _____

I request the death certificate for the above-named individual be (*check one*):

_____ **Corrected or completed** within 6 months from date of death as per **18 V.S.A. § 5202a(a)**

_____ **Amended** after 6 months from date of death as per **18 V.S.A. § 5202a(b)**

(*please attach separately supporting documentation for the change*)

1a. Decedent's Legal Name:			2. Sex:		
3. SSN:	4. Age:	5. Date of Birth: / /		6. Birthplace:	
7a. Residence Street and Number:			7b. City or Town of Residence:	7c. State or Foreign Country:	
8a. Ever in U.S. Armed Services?	8b. Veteran of Any War(s)?	8c. If so, What War(s)?			
9. Marital Status:	10a. Birth name of surviving Spouse/Civil Union Partner:			10b. Sex of surviving Spouse/Partner:	
11. Father or Parent's Name:		12. Mother or Parent's Name:		13a. Informant's Name:	
13b. Informant's Relationship to Decedent:		13c. Informant's Mailing Address (Street & Number, City or Town, State, Zip Code):			
14. Decedent's Education Level:		15a. Decedent of Hispanic Origin?:	15b. If Yes, Please Specify:		
16. Decedent's Race:		17. Decedent's Usual Occupation:		18. Kind of Business/Industry:	
20. Place of Death: <i>If death occurred in a hospital:</i> <input type="checkbox"/> Inpatient <input type="checkbox"/> Intensive Care <i>If death occurred somewhere other than a hospital:</i> <input type="checkbox"/> Emergency Room/Outpatient <input type="checkbox"/> Dead on Arrival <input type="checkbox"/> Nursing Home/Long Term Care <input type="checkbox"/> Hospice Facility <input type="checkbox"/> Decedent's Home <input type="checkbox"/> Other (<i>specify</i>)					
21a. Place of Death Facility Name (<i>If not Institution, street name and number</i>):			21b. City or Town:		21c. State:
22a. Method of Disposition:			22d. Place of Final Disposition:		
22e. Location of Final Disposition (<i>City, State</i>):			26. Date of Disposition:		
23a. Name of Funeral Facility/Authorized Person			23b. Address of Funeral Facility/Authorized Person		
Other DEMOGRAPHIC Corrections/Amendments:					

Signature of Authorized Applicant: _____ **Date:** _____

To submit your request: 1) Email the completed form to EDRS@Vermont.gov **OR**
2) Fax the completed form to 802-651-1787