

COMMONWEALTH OF PUERTO RICO
DEPARTMENT OF HEALTH
DEMOGRAPHIC REGISTRY

DEATH CERTIFICATE APPLICATION BY MAIL

PART I: INFORMATION ABOUT DECEASED

1. Deceased's Name:		
_____	_____	_____
Father's Last Name	Mother's Last Name	First Name
2. Date of Death (month / day / year)	3. Place of Death (Town and Hospital)	

PART II: APPLICANT'S INFORMATION*

1. Applicant's Name:		2. Relationship: **	
_____	_____	_____	
Father's Last Name	Mother's Last Name	First Name	
3. Applicant's address:		4. Address where you want the certificate to be sent:	
5. Applicant's identification:		6. Applicant's Signature and Date:	
___ Drivers Licence ___ State ID ___ Passport ___ Welfare ___ Other			

Important:

<ol style="list-style-type: none">1. If event occurred from June 21, 1931 to present you can apply to the following address: Department of Health Demographic Registry PO Box 11854, San Juan Puerto Rico 009102. If the event occurred from 1885 to June 1931 you must write to the municipality where the event occurred. Please send a photocopy of a recent, valid IDENTIFICATION WITH PHOTOGRAPHY OF APPLICANT3. Applicant in Puerto Rico: Please send \$5.00 internal Revenue Stamp for each copy requested. Additional copies ordered at the same time are \$4.00 each for the same person.4. Applicant out of Puerto Rico: Please send \$5.00 Money Order for first copy you need payable to Secretary of the Treasury. Additional copies ordered at the same time are \$4.00 each for the same person.5. Please send us a pre-addressed stamped envelope to mail your certificate.

* Applicant—means registrant, parents, their sons or legal representatives.
** Relationship- Relation between the applicant and the registrant. This blank will be filled if the applicant and the registrant are not the same person.