THE CITY OF NEW YORK
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
OFFICE OF VITAL RECORDS
CORRECTIONS UNIT

APPLICATION FOR THE CORRECTION OF A CERTIFICATE OF DEATH

(TO BE FILED ONLY BY THE NEXT OF KIN)

STATE OF NEW YORK
COUNTY OF _____ } SS:

(1) _____ being duly sworn and state that _____ he/she is _____ years of age and resides at _____
(Street and Number)
_____
(Borough) (City) (State) (Zip Code)
that _____ he/she is the _____ of _____ who
(Relationship) (Name of Deceased)
died at _____ Borough of _____
(Street and Number of Institution)
in the City of New York on _____ whose death certificate number _____
(Month/Day/Year–yyyy)
is on file in the Office of Vital Records of the Department of Health and Mental Hygiene.

(2) Applicant further says that the said certificate of death on file contains the following errors and/or omissions:

ITEM IN ERROR	AS IT APPEARS	AS IT SHOULD BE

(3) Documentary evidence, submitted in support of this application, includes:

_____
_____
_____

ALL FOREIGN LANGUAGE DOCUMENTS MUST HAVE CERTIFIED ENGLISH TRANSLATION

(4) Applicant submits herewith a certified photostatic copy of the original record of death obtained from Department of Health and Mental Hygiene and further states that this application **covers all errors** therein and supplies all information missing from the original record.

Wherefore, the applicant requests the Commissioner of Health and Mental Hygiene of the City of New York to approve this application and to make the appropriate changes, as aforesaid, on the original certificate of death.

Subscribed and sworn to before me this

_____ day of _____, _____ _____ Signature
Year–yyyy

_____
Notary Public or Commissioner of Deeds

ALTERED APPLICATIONS WILL NOT BE ACCEPTED.

When the application and affidavit is signed outside the United States or its dependencies they must be signed before the United States Consul or his representative and must bear the seal of the Consul.

VR 61 (Rev. 8/02)

DO NOT WRITE ON THIS SIDE – TO BE COMPLETED BY THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE

No. .....

The City of New York
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
Office of Vital Records

Borough of .....

Application to correct record of DEATH of

.....
(Name)

.....
(Date of Death)

.....
(Certificate Number) (Year–yyyy)

List of alterations requested:

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The City of New York
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
Office of Vital Records

Date: ..... , Year .....

This is to certify that I have examined the original record which this application seeks to correct.

I have also examined the documents submitted and I find sufficient evidence to support this application. There are no omissions or apparent errors in the original record that have not been covered. This application is, therefore, approved.*

The evidence submitted with this case does not fully meet the requirements set forth in the New York City Health Code; the application is therefore forwarded to the City Registrar for consideration with recommendation that it be

..... *
(Approved) (Denied)

.....
(Date)

.....
Deputy City Registrar

***Cross out paragraph which does not apply.**

Approved:

.....
(Date)

.....
City Registrar

Summary of documentary evidence submitted and salient facts contained herein: