

Application for Commemorative Certificate of Nonviable Birth

Only the patient of a nonviable birth may request a commemorative certificate of nonviable birth.

PLEASE TYPE OR PRINT LEGIBLY

Full name of baby (if chosen) _____
(If no name is chosen commemorative certificate will reflect the name Baby and the last name of the patient)

Month, day, and year of loss _____

City or town of loss _____ County of loss _____

Month, day and year granted _____

Father full current legal name (if known) _____

Mother full current legal name _____

SIGNATURE OF REQUESTOR _____

Type or Print Name _____

Street Address _____

City, State, Zip _____

Telephone Number _____

Email Address _____

Today's Date _____

(Please enclose a photocopy of your photo ID [i.e. current driver's license] when mailing in this request).

(Please make checks payable to Vital Records)

Only exact amount will be accepted.

Number of certified copies _____ **x \$19.00 each = \$** _____ **Total**

Mail to:
 Vital Records
 PO Box 95065
 Lincoln, NE 68509-5065

(Please enclose a stamped, self-addressed business size envelope)

FOR OFFICE USE ONLY

Check MO Cash

Amount Received _____

Date Received _____

By Whom Received _____

PROOF OF IDENTIFICATION;

DL STATE ID OTHER
