NEW YORK STATE DEPARTMENT OF HEALTH
Vital Records Section

Supplemental Report of Given Name

FOR OFFICE USE ONLY
Receipt No.
Register No.
Recorded District No.
State No.
Year

Please Print or Type

Surname of Child	Sex of Child	Place of Birth
Child's Date of Birth	Mother's Maiden Name First Middle Last	
Twin, Triplet or Other? Number in order of Birth (To be answered only in event of plural births.)	Father's Name First Middle Last	

I hereby certify that the child described herein has been named

First Middle

Sworn to Before me This

_____ Day of _____ , _____ Signed _____

_____
(Notary Public)

Present Mailing Address

Name _____

Address _____

City _____ State _____ Zip Code _____

INSTRUCTIONS

PURPOSE: This form may be used only to add the given name to a birth certificate if the given name was omitted at the time the birth certificate was originally filed. This form may not be used to correct errors. For correction of errors, please request the appropriate form from the New York State Department of Health or your local Registrar of Vital Statistics.

SIGNATURE: This form must be completed and signed by:

The Individual - If 18 years of age or older. -- OR -- A Parent - If the child is a minor (under age 18).

COPY: If you want a certified copy of the birth certificate after the given names have been added, please enclose a $30.00 check or money order, payable to the New York State Department of Health.

RETURN TO: Vital Records Section
Correction Unit
P.O. Box 2602
Albany, NY 12220-2602

FOR REGISTRAR OF VITAL STATISTICS

My signature on this form indicates that the local record has been amended.

_____ Registrar _____ Date

DISTRICT # _____
REGISTER # _____
STATE FILE # _____

STATE OF NEW YORK
DEPARTMENT OF HEALTH
VITAL RECORDS SECTION

Medical/Burial Death Correction Report

Name of Deceased	Date of Death (MONTH DAY YEAR)	Place of Death

DISPOSITION

20A. 1 ☐ BURIAL 2 ☐ CREMATION 3 ☐ REMOVAL 4 ☐ HOLD 5 ☐ DONATION 6 ☐ ANATOMICAL GIFT — MONTH DAY YEAR

20B. PLACE OF BURIAL, CREMATION, REMOVAL OR OTHER DISPOSITION:

20C. LOCATION; *(City or town and state)*

21A. NAME AND ADDRESS OF FUNERAL HOME:

21B. REGISTRATION NUMBER:

22A. NAME OF FUNERAL DIRECTOR:

22B. SIGNATURE OF FUNERAL DIRECTOR:

22C. REGISTRATION NUMBER:

23A. SIGNATURE OF REGISTRAR:

23B. DATE FILED: MONTH DAY YEAR

24A. BURIAL OR REMOVAL PERMIT ISSUED BY:

24B. DATE ISSUED: MONTH DAY YEAR

CERTIFIER

25A. CERTIFICATION: To the best of my knowledge, death occurred at the time, date and place and due to the causes stated.

Certifier's Name: *License No.:* *Signature:* Month Day Year

Certifier's Title: 0 ☐ Attending Physician 0 ☐ Physician acting on behalf of Attending Physician 1 ☐ Coroner 2 ☐ Medical Examiner / Deputy Medical Examiner *Address:*

25B. If coroner is not a physician, enter Coroner's Physician's name & title: *License No.:* *Signature:* Month Day Year

25C. If certifier is not attending physician, enter Attending Physician's name & title: *License No.:* *Address:*

26A. Attending physician attended deceased: FROM Month Day Year TO Month Day Year

26B. Deceased last seen alive by attending physician: Month Day Year

26C. Pronounced Dead by M.E. or Coroner: ON Month Day Year AT Time M

27. MANNER OF DEATH: NATURAL CAUSE ☐ 1 ACCIDENT ☐ 2 HOMICIDE ☐ 3 SUICIDE ☐ 4 UNDETERMINED CIRCUMSTANCES ☐ 5 PENDING INVESTIGATION ☐ 6

28. WAS CASE REFERRED TO CORONER OR MEDICAL EXAMINER? 0 ☐ NO 1 ☐ YES

29A. AUTOPSY? NO ☐ 0 YES ☐ 1 REFUSED ☐ 2

29B. IF YES, WERE FINDINGS USED TO DETERMINE CAUSE OF DEATH? NO ☐ 0 YES ☐ 1

CONFIDENTIAL **SEE INSTRUCTION SHEET FOR COMPLETING CAUSE OF DEATH** **CONFIDENTIAL**

CAUSE OF DEATH

30. DEATH WAS CAUSED BY: ENTER ONLY ONE CAUSE PER LINE FOR (A), (B) AND (C). — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. IMMEDIATE CAUSE: (A)

DUE TO OR AS A CONSEQUENCE OF: (B)

DUE TO OR AS A CONSEQUENCE OF: (C)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO CAUSE GIVEN IN PART I(A):

DID TOBACCO USE CONTRIBUTE TO DEATH? 0 ☐ NO 1 ☐ YES 2 ☐ PROBABLY 3 ☐ UNKNOWN

31A. IF INJURY, DATE: Month Day Year HOUR: M

31B. INJURY LOCALITY: *(City or town and county and state)*

31C. DESCRIBE HOW INJURY OCCURRED:

31D. PLACE OF INJURY:

31E. INJURY AT WORK? NO ☐ 0 YES ☐ 1

31F. IF TRANSPORTATION INJURY, SPECIFY: 1 ☐ Driver/Operator 2 ☐ Passenger 3 ☐ Pedestrian 4 ☐ OTHER *(specify)*

32. WAS DECEDENT HOSPITALIZED IN LAST 2 MONTHS? NO ☐ 0 YES ☐ 1

33A. IF FEMALE: 0 ☐ Not pregnant within last year 1 ☐ Pregnant at time of death 2 ☐ Not pregnant, but pregnant within 42 days of death 3 ☐ Not pregnant, but pregnant 43 days to 1 year before death 4 ☐ Unknown if pregnant within last year

33B. DATE OF DELIVERY: MONTH DAY YEAR

FOR RECORD PURPOSES ONLY

Affirmation to be completed by Funeral Director (Item 20A-24B) or Certifying Physician (Item 25A-33B):

I affirm under penalties for perjury that the information given in the facsimile of the certificate of death for the deceased person identified above is true and correct information to be added to the original certificate of death and the local registrar's record.

Signature	Title or Relationship to Deceased	Date

To be completed by registrar of vital statistics:

The above information has been added to the local record of death on file in this office.

Registrar's Signature	District Number	Date