



Supervisor: (845) 688-7165
 Police: (845) 688-9902
 Town Clerk: (845) 688-5004
 Justice Court: (845) 688-5005
 Assessor: (845) 688-5003
 ZBA/ZEO/Planning: (845) 688-5008
 Highway: (845) 688-9901
 Fax: (845) 688-2041

"The Heart of the Park... Where the Eagle Soars"

Town of Shandaken P.O. Box 134, 7209 Rte. 28, Shandaken, NY 12480 www.shandaken.us

Joyce Grant – Town Clerk shandakenclerk@yahoo.com 845-688-5004

Certified Copy of Death Record within 50 years of application can be obtained by only:

- Spouse, parent, child, or sibling of the deceased
- Lawful representative of spouse, parent, child, or sibling of the deceased
- To a person with a New York State Court Order issued on a showing of necessity
- To a municipal, state, or federal agency when need for official purposes
- To a person with documented legal right or claim
- To a person with documented medical need.

Cost \$22 per copy.

Copy of ID must be provided with notarized signature below.

I request _____ copy (copies) of the following:

Name of Deceased _____ Date of Death _____

Number of copies requested with confidential cause of death _____

Number of copies requested without confidential cause of death _____

Send check or money order in the amount of \$22 for each copy made payable to "Shandaken Town Clerk" and mail to PO Box 67, Shandaken, NY 12480

Address to send Copies: _____

Signature of Applicant _____ Date: _____

Signature Must Be Notarized

State of _____]
 _____ } ss.
 County of _____]

Subscribed and sworn before me this _____ day of

_____, 202__.

Seal:

 Notary Public

Application to Local Registrar for Copy of Death Record

PLEASE COMPLETE FORM AND ENCLOSE FEE

FEE: \$22.00 per copy of No Record Certification. Please do not send cash.
Mail to: Shandaken Town Clerk – PO Box 67 – Shandaken, NY 12480

PLEASE PRINT OR TYPE

Name of Deceased			Date of Death or Period to be Covered by Search		
First	Middle	Last			
Name of Father of Deceased			Social Security Number of Deceased		
First	Middle	Last			
Maiden Name of Mother of Deceased			Date of Birth of Deceased		Age at Death
First	Middle	Last	Month	Day	Year
Place of Death					
Name of Hospital or Street Address			Village, Town or City		County
Purpose for Which Record is Required					
What was your relationship to the deceased? _____					
In what capacity are you acting? _____					
If attorney, name and relationship of your client to deceased _____					
Signature of Applicant _____				Date _____	
Address of Applicant _____					

COMPLETE FOR DEATHS OCCURRING AS OF JANUARY 1, 1988

___ Number of copies requested with confidential cause of death

___ Number of copies requested without confidential cause of death

PLEASE PRINT NAME AND ADDRESS WHERE RECORD SHOULD BE SENT

Name _____

Address _____

City _____ State _____ Zip Code _____