

OGLALA SIOUX TRIBE  
Social Service Office



BURIAL ASSISTANCE REQUEST

Next of Kin: \_\_\_\_\_ Contact Number: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_  
District: \_\_\_\_\_ Tribal Member: YES or NO Tribe: \_\_\_\_\_  
Relationship to Deceased: \_\_\_\_\_

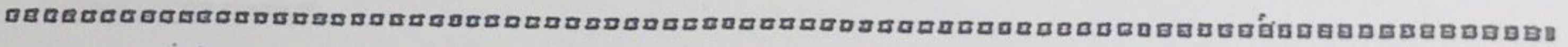
INFORMATION OF DECEASED

Name: \_\_\_\_\_  
Maiden Name (If applicable): \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Date of Death: \_\_\_\_\_

Off Reservation Only

Enrollment Number: \_\_\_\_\_ State: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



For Office Use Only

Approved: Yes No Amount Approved: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_