Death

Miami County Public Health
APPLICATION FOR CERTIFIED COPIES

RECORD INFORMATION: *(Information about the person you are requesting the record for)*

Full name on birth or death certificate: First Middle Maiden/Last	**If name was changed since birth, indicate new name: (i.e. adoption, legal name change, paternity, etc.)**

Date of Birth:	**Date of Death:**	**City and County where event occurred:**

□ **Mother** □ **Father** □ **Parent**	Full First Full Middle Maiden or Last Name	□ **Mother** □ **Father** □ **Parent**	Full First Full Middle Maiden or Last Name

CHARGES:

We accept cash, check, money order, MC, Visa and Discover

Birth:	**If you do not need a birth certificate for any of the following reasons, skip this section.** Otherwise please indicate what the certificate is needed for: □ Dual Citizenship □ Genealogy □ Out of Country Marriage □ International Legal Business	**Number of copies requested:** _____ **x $24 = $**_____
Death:	**All death certificates will be issued without a social security number unless identification is provided confirming you are one of the below listed authorized requestors:** □ The deceased's spouse or descendent □ The deceased's executor, attorney, or legal agent □ A representative of investigative government agency □ A private investigator □ A funeral director (or agent responsible for disposition of the body) acting on behalf of the deceased's family □ A veteran's service office □ An accredited member of the media **You must attach a copy of your identification showing you are an authorized requestor along with a copy of a valid driver's license.**	**Number of copies requested:** _____ **x $24 = $**_____
Fetal Death:		**Number of fetal death record copies requested:** _____ **x $24 = $**_____
Total Amount Due:		**$**_____

PURCHASER'S INFORMATION: *(Information about the person requesting the record)*

Please print clearly as this will be used for your receipt, mailing address, and/or for future contact to complete your record request.

Purchaser's Name:		Email:	XXXXXXXXXXXXXXXXXXXX
Street Address:		Phone Number:	
City, State, & ZIP:		Purchaser's Signature:	

MAILING ADDRESS

Send completed application with required fee to:

Miami County Public Health
510 W Water St Suite 130
Troy Ohio 45373

FOR OFFICE USE ONLY:

Date:	**Certificate #:**
Receipt #:	**Check #:**

*Please fax form to 937-573-3501 or email to vitalrecords@miamicountyhealth.net
*You will receive a call for payment information once the application has been received.