



## Darke County General Health District Vital Statistics APPLICATION FOR CERTIFIED COPIES

<b>Birth Certificate</b> \$23.00 per certified copy	<b>Death Certificate</b> \$23.00 per certified copy	<b>MAILING ADDRESS</b> Send completed application with Money Order and Self-Addressed stamped envelope to: Darke County General Health District 300 Garst Ave. Greenville, OH 45331
<b>Fetal Death Certificate</b> \$23.00 per certified copy		

**Today's Date:** \_\_\_\_\_

**RECORD INFORMATION** *(Information about the person on the requested record)*

<b>Full name</b> <i>(for birth, indicate child's FULL name as shown on the original birth record):</i> _____		If name was changed since birth, indicate new name: _____	
<b>Date of Birth:</b> _____	<b>Date of Death:</b> _____	<b>City and County where event occurred:</b> _____	
<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Parent	<b>Full Name before first marriage:</b> _____	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Parent	<b>Full Name before first marriage:</b> _____

**CHARGES** *Please include check or money order (do not send cash) made payable to "Darke County General Health District."*

<b>Birth:</b>	Please indicate if you are requesting the certificate for any of the following purposes: <input type="checkbox"/> Dual Citizenship <span style="margin-left: 200px;"><input type="checkbox"/> Genealogy</span> <input type="checkbox"/> Out of Country Marriage <span style="margin-left: 100px;"><input type="checkbox"/> International Legal Business</span>	<b>Number of birth record copies:</b> _____ x \$23.00 = \$ _____ # _____ # _____ # _____ # _____ Receipt # _____
<b>Death:</b>	I am requesting a copy with the SSN included because I am: <input type="checkbox"/> The deceased's spouse, or lineal descendant <input type="checkbox"/> The deceased's executor, attorney, or legal agent <input type="checkbox"/> A representative of an investigative government agency <input type="checkbox"/> A private investigator <input type="checkbox"/> A funeral director (or agent responsible for disposition of the body) acting on behalf of the deceased's family <input type="checkbox"/> A veteran's service officer <input type="checkbox"/> An accredited member of the media <b>You must attach a copy of your identification showing you are an authorized requestor.</b>	<b>Number of death record copies:</b> _____ x \$23.00 = \$ _____ # _____ # _____ # _____ # _____ # _____ # _____ Receipt # _____
<b>Fetal Death:</b>		<b>Number of fetal death record copies:</b> _____ x \$23.00 = \$ _____
<b>Total Amount Due:</b>		\$ _____

**APPLICANT 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.

<b>Applicant Name:</b>	<b>Email:</b>
<b>Street Address:</b>	<b>Phone Number:</b>
<b>City, State, &amp; ZIP:</b>	<b>Signature of Applicant:</b>



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<input type="checkbox"/> <b>Mother</b> <input type="checkbox"/> <b>Father</b> <input type="checkbox"/> <b>Parent</b>	<b>Full Name before first marriage:</b>	<input type="checkbox"/> <b>Mother</b> <input type="checkbox"/> <b>Father</b> <input type="checkbox"/> <b>Parent</b>	<b>Full Name before first marriage:</b>

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