

Conneaut City Health Department

APPLICATION FOR CERTIFIED COPIES

Conneaut City
Health Department



Public Health
Prevent. Promote. Protect.

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

Full name on birth or death certificate:							
First	Middle	Maiden/Last					
Date of Birth:		and/or	Date of Death:		City and County where event occurred:		
<input type="checkbox"/> Mother	Full First	Full Middle	Maiden or Last Name	<input type="checkbox"/> Mother	Full First	Full Middle	Maiden or Last Name
<input type="checkbox"/> Father				<input type="checkbox"/> Father			
<input type="checkbox"/> Parent				<input type="checkbox"/> Parent			

CHARGES:

[Any additional payment information, such as types of payment accepted, goes here]

<u>Birth:</u>	<p><u>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:</u></p> <p><input type="checkbox"/> Dual Citizenship <input type="checkbox"/> Genealogy</p> <p><input type="checkbox"/> Out of Country Marriage <input type="checkbox"/> International Legal Business</p>	<p><u>Number of copies requested:</u></p> <p style="text-align: center;">_____ x \$fee = \$ _____</p>
<u>Death:</u>	<p>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:</p> <p><input type="checkbox"/> The deceased's spouse or descendent</p> <p><input type="checkbox"/> The deceased's executor, attorney, or legal agent</p> <p><input type="checkbox"/> A representative of investigative government agency</p> <p><input type="checkbox"/> A private investigator</p> <p><input type="checkbox"/> A funeral director (or agent responsible for disposition of the body) acting on behalf of the deceased's family</p> <p><input type="checkbox"/> A veteran's service office</p> <p><input type="checkbox"/> An accredited member of the media</p> <p>You must attach a copy of your identification showing you are an authorized requestor along with a copy of a valid driver's license.</p>	<p><u>Number of copies requested:</u></p> <p style="text-align: center;">_____ x \$fee = \$ _____</p>
<u>Fetal Death:</u>		<p><u>Number of fetal death record copies requested:</u></p> <p style="text-align: center;">_____ x \$fee = \$ _____</p>
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:			
Street Address:		Phone Number:	
City, State, & ZIP:		Purchaser's Signature:	

MAILING ADDRESS

Send completed application with required fee to:
 Conneaut City Health Department
 327 Mill Street
 Conneaut, Ohio 44030

FOR OFFICE USE ONLY:

Order Number:	Date:
State File Number:	Permit/Other: