

# MARION 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:			If name was changed since birth, indicate new name: (i.e. adoption, legal name change, paternity, etc.)				
First	Middle	Maiden/Last					
Date of Birth:	and/or	Date of Death:	City and County where event occurred:				
OMother OFather OParent	Full First	Full Middle	Maiden/Last Name	OMother OFather OParent	Full First	Full Middle	Maiden/ Last Name

**CHARGES: \$ 25.00 PER COPY**

<b>Birth:</b>	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: <input type="radio"/> Dual Citizenship <input type="radio"/> Genealogy <input type="radio"/> Out of Country Marriage <input type="radio"/> International Legal Business	Number of copies requested:  x \$25.00 = \$
<b>Death:</b>	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: <input type="radio"/> The deceased's spouse or descendent <input type="radio"/> The deceased's executor, attorney, or legal agent <input type="radio"/> A representative of investigative government agency <input type="radio"/> A private investigator <input type="radio"/> A funeral director (or agent responsible for disposition of the body) acting on behalf of the deceased's family <input type="radio"/> A veteran's service office <input type="radio"/> 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 \$25.00 = \$
<b>Fetal Death:</b>		Number of fetal death record copies requested: x 25.00 = \$
<b>Total Amount Due:</b>		<b>\$</b>

## 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:	
Street Address:		Phone Number:	
City, State, & ZIP:		Signature:	

### MAILING ADDRESS

*Send completed application with required fee to*

**Marion Public Health**  
**181 South Main Street**  
**Marion, Ohio 43302**



### FOR OFFICE USE ONLY:

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