Brown County Health Department

Application for Ohio Certified Death Record Copies

Please ensure all pertinent information is included with your request, including full name, date of death, and where the death occurred. If this form is not complete and a record cannot be found with the information given, the form and payment will be returned to the applicant (in the case of mail in requests).

MAIL COMPLETED APPLICATION WITH REQUIRED FEE AND SELF ADDRESSED STAMPED ENVELOPE TO:

Brown County Health Department, Vital Statistics
9116 Hamer Road
Suite 101
Georgetown, OH 45121
(937) 378-6892

❒ Death Certificate
$25.00 per certified copy

❒ Fetal Death Certificate
$25.00 per certified copy

APPLICANT INFORMATION (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.

Applicant Name:		Email:	
Street Address:		Phone Number:	
City, State, & Zip:		Signature of Applicant:	

RECORD INFORMATION (the person on the requested record)

Full Name (Decedents full name at time of death):

Date of Birth:	Date of Death:	City and County Where the Death Occurred:	
◉ Mother ○ Father ○ Parent	Name Before First Marriage:	○ Mother ◉ Father ○ Parent	Name Before First Marriage:

FEES (Please make checks / money orders payable to the Treasurer, State of Ohio)

DEATH:

❒ No, I do not need the Social Security Number included. ❒ Yes, I request a copy with the SSN included. (If yes, and the death occurred within the last 5 years of today's date you must attach a copy of your identification showing you are an authorized requestor.) **See below for authorized requestors.*	Number of Death Record Copies: _____ x $25.00 = $_____

FETAL DEATH OR STILLBIRTH :

Did the stillbirth event occur at 20 weeks or less gestation? *(This information will help us determine how the record has been filed.)* ❒ Yes ❒ No	Number of Fetal Death Record Copies: _____ x $**25.00** =

TOTAL AMOUNT DUE: **Do** NOT **send cash. Make check/money order payable to Brown County Health Department** $_____

OFFICE USE ONLY

Audit Number(s):			SFN:	
Date Processed:	Initials:	Payment Type:	Receipt #:	Receipt Date:

***Authorized requestors:** Spouse or legal partner, natural or adopted child, natural or adopted grandchild, natural or adopted great-grandchild, Veteran's Affair's officer or official, local, state or federal law enforcement official or agency, funeral director or authorized representative, executor or administrator of the decedent's estate, agent with power of attorney, any person authorized by law to act on behalf of the decedent or the decedent's estate.*