

Mercer County Health District

APPLICATION FOR CERTIFIED COPIES

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

Full names 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:			
<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Parent	Full First	Full Middle	Maiden or Last Name	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Parent	Full First Full Middle Maiden or Last Name
CHARGES: Credit Card Convenience Fee based on price per copy 1 copy= \$1.50, 2-3 copies= \$2.50, 4-7 copies= \$5.00					
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: <input type="checkbox"/> Dual Citizenship <input type="checkbox"/> Genealogy <input type="checkbox"/> Out of County Marriage <input type="checkbox"/> International Legal Business				Number of copies requested: _____ x \$28.00 = \$ _____
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: <input type="checkbox"/> The deceased's spouse or descendent <input type="checkbox"/> The deceased's executor, attorney, or legal agent <input type="checkbox"/> A representative of 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 office <input type="checkbox"/> 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 \$28.00 = \$ _____
Fetal Death:					Number of fetal death record copies requested: _____ x \$28.00 = \$ _____
Total Amount Due:					\$ _____ <input type="checkbox"/> Cash <input type="checkbox"/> Check # _____ <input type="checkbox"/> Credit

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:		Purchaser's Signature:	

MAILING ADDRESS *Please include check or money order (do not send cash or credit) made payable to:*

Mercer County Health District
220 W Livingston St, Ste B152
Celina, OH 45822

(Rev: 8/2016)

FOR OFFICE USE ONLY:

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