Ashtabula City Health Department
Vital Statistics
APPLICATION FOR CERTIFIED COPIES

Has the name changed since birth?: YES NO If yes, enter information below after name change

Birth Certificate Requests:

(Information about the person on the requested record)

PRINT FULL NAME AT BIRTH:

DATE OF BIRTH:

PRINT Mother's Full name before first marriage:

PRINT Father's Full name before first marriage:

Please indicate if you are requesting the certificate for:

□ Dual Citizenship
□ Genealogy
□ Out of County Marriage
□ International Legal Business
□ Identification
□ Other

Number of birth record copies:

_____ **x $25.00 =**

$_____

Death Certificate Requests:

Fetal Death Certificate requests should also complete this section

PRINT FULL NAME OF DECEASED:

DATE OF DEATH:

You MUST complete this section to obtain a copy of the death certificate with the Social Security Number included. You are: (choose one)

□The deceased's spouse, or lineal descendant
□ The deceased's executor, attorney, or legal agent
□ A representative of an investigative government agency
□ A private investigator
□ A funeral director (or agent responsible for disposition of the body) acting on behalf of the deceased's family
□ A veteran's service officer
□ An accredited member of the media

You must attach a copy of your identification showing you are an authorized requestor.

Number of death/fetal death record copies:

_____ **x $25.00 =**

$_____

Total Amount Due: **$**_____

FILL OUT YOUR INFORMATION BELOW:

Please PRINT clearly as this will be used for your receipt, mailing address, and/or for future contact to complete your record request.

Ethnicity or Race: (Check all that Apply)	□ White □ Asian □ Pacific Islander □ Latino □ African □ Black □ Indian □ Hispanic □ Mixed □ Native American □ Other: _____		
Applicant Name (You):		Relationship to above request: **(Circle one)**	Self/Spouse/Parent/Child/Sibling/Grandparent/ Aunt/Uncle/Friend/Funeral Home/Other
Street Address:		Phone Number:	
City, State, & ZIP:		Signature of Applicant:	

MAILING ADDRESS

Send application with required fee & self addressed stamped envelope to:

Ashtabula City Health Department
4239 Lake Avenue
Ashtabula, OH 44004

For Office Use Only: LEAVE BLANK

□ **Cash** □ **Check #:** _____ □ **Debit/Credit Card**	**Date:**
VA Form Audit # on Certificate:	**Audit # on certificate:**
Exchanged Audit # on Certificate:	**Clerk Initials:**