



## APPLICATION FOR CERTIFIED COPIES

### PURCHASER INFORMATION

Purchaser Name		Email	
Street Address		Phone	
City State ZIP		Signature of Purchaser	

Payment Method:	<input type="checkbox"/> <b>Check</b>	<input type="checkbox"/> <b>Credit Card</b>
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Credit/Debit Card #:	- - -	Exp Date:	
		CCV:	

<b>BIRTH CERTIFICATE REQUESTS</b>  Circle if any these reasons apply for obtaining certified copy  * Dual Citizenship * Genealogy * Out of Country Marriage * International Legal Business	<b>First Name</b>	<b>Middle Name</b>	<b>Last Name at Birth (maiden name)</b>	Number of copies  _____ x \$25 =  _____
	<b>Date of Birth</b>	<b>Gender (Male/Female)</b>	<b>County or City of Birth</b>	
	<b>Mother</b>			
	<b>First Name</b>	<b>Middle Name</b>	<b>Last Name at Birth (maiden name)</b>	
	<b>Father</b>			
	<b>First Name</b>	<b>Middle Name</b>	<b>Last Name</b>	

<b>DEATH CERTIFICATE or FETAL DEATH CERTIFICATE REQUESTS</b>	<b>First Name</b>	<b>Middle Name</b>	<b>Last Name</b>	Number of copies  _____ x \$25 =  _____
	<b>Date of Death</b>	<b>Gender (Male/Female)</b>		
	You may request a copy of the death certificate with the Social Security Number included if you are (check applicable box):			
	<input type="checkbox"/>	The deceased's parent, spouse, partner or descendent (child, grandchild, great-grandchild)		
	<input type="checkbox"/>	The deceased's executor, attorney or legal agent		
	<input type="checkbox"/>	A representative of an 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 officer		
	<input type="checkbox"/>	An accredited member of the media		
<b>You must attach a copy of your identification showing you are an authorized requestor.</b>				

Mail or email (DO NOT FAX):

Knox Public Health  
11660 Upper Gilchrist Rd  
Mt Vernon OH 43050  
(740) 392-2200 Option 7

[vitalstats@knoxhealth.com](mailto:vitalstats@knoxhealth.com)

Office Use Only			
Date:		Receipt #:	
Certificate #s:		Emp Initials:	
Date req mail/phn:		Date Mailed:	