Date: _____

## *LOGAN COUNTY HEALTH DISTRICT*

### *APPLICATION FOR CERTIFIED COPY OF DEATH CERTIFICATE*

*Name of Deceased: _____ **Date of Death:** _____

* Decedent place of death must be Logan County

Applicant's Name: _____

Street Address: _____

City, State, Zip: _____

Phone: _____

Signature: _____

***Qty Requested:** _____ **= 22.00 ea.**

***Please make check or money order payable to:**
***Logan County Health District*** - please include your driver's license # on check.

***Please send application, check or money order with a self-addressed stamped envelope to:***

Logan County Health District
***Attn: Vital Statistics Registrar***
310 S. Main St.
Bellefontaine, OH 43311
Phone: 937.592.9040 x103

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***Health District Use Only***

Vol # _____ Receipt # _____

Cert # _____ Check No. _____

Audit No. _____ Date Received _____