

**Delaware General Health District
APPLICATION FOR VITAL STATISTICS RECORD**

(Check One) **Birth Certificate** **Death Certificate**

Number of Copies Requested _____ X \$20.00 per copy = total due _____

1. Requested Record: (Please Print)

(Please Print Information as it appears on the certificate being requested)

Full Name	
Date of Birth or Death	
Father's Full Name	
Mother's Full Maiden Name	

3. Requestor's Information (Please Print)

Today's Date		Telephone Number	
Printed Name		Signature	
Street Address			
City		State	Zip

Mail completed form and self addressed stamped envelope to: Delaware General Health District
P.O. Box 570, Delaware, Ohio 43015

FOR OFFICE USE ONLY

Date Request Received	Date Request Processed	# Copies Issued	Audit #
Prepared By:	Request Denied – Reason <input type="checkbox"/>		