# Ashtabula City Health Department- Vital Statistics Application for Ohio Certified Copies

Public Health
Prevent. Promote. Protect.
Ashtabula City Health Department

**MAIL COMPLETED APPLICATION WITH REQUIRED FEE AND SELF ADDRESSED STAMPED ENVELOPE**

**TO:** Ashtabula City Health Department
4239 Lake Ave
Ashtabula, OH 44004
440.992.7123

**Check Appropriate Box:**
- ❒ Birth Certificate- $25.00
- ❒ Death Certificate- $25.00

** Credit Cards will be charged a minimum fee of $3.00*

## APPLICANT INFORMATION: (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.

| | | | |
|---|---|---|---|
| **Applicant Name:** | | **Email:** | |
| **Street Address:** | | **Phone Number:** | |
| **City, State, & Zip:** | | **Signature of Applicant:** | |
| **Ethnicity or Race:** | □ White □ Asian □ Pacific Islander □ Latino □ African □ Black □ Indian □ Hispanic □ Native American □ Mixed □ Other: _____ | | |
| **Relationship to person on requested record:** | □ Self □ Child □ Aunt □ Parent □ Spouse □ Sibling □ Uncle □ Grandparent □ Friend □ Funeral Home □ Other: _____ | | |

**Fields with the asterisks can be left blank for death certificate requests.*

## RECORD INFORMATION: (the person on the requested record)

| | | | |
|---|---|---|---|
| **First:** | **Middle:** | **Last:** (Maiden name-for birth cert. only) | **If Name Has Changed Since Birth, Indicate New Full Name:** |
| **Date of Birth:** | **Date of Death:** | **City and County Where the Birth/Death Occurred:** | |
| ***Mother's First, Middle and Maiden Name:** (Before First Marriage) | | ***Father's First, Middle and Last Name:** | |

## PURPOSE FOR REQUEST: (check box)

- ❒ Dual Citizenship
- ❒ Genealogy
- ❒ International Legal Business
- ❒ Marriage Certificate
- ❒ Driver's License
- ❒ Passport
- ❒ School
- ❒ Work
- ❒ Legal Purposes
- ❒ Housing
- ❒ Other: _____

## DEATH REQUEST: (check box)

**Deaths Only:**
- ❒ **No,** I do not need the Social Security Number included.
- ❒ **Yes,** I request a copy with the SSN included. **See below for authorized requestors.*

## FEES:

**Number of Birth/Death Record Copies:**

_____ x $25 = $_____

**TOTAL AMOUNT DUE:** Do NOT send cash. Make checks / money orders payable to Ashtabula City Health Department. $_____

***Authorized requestors:** Spouse or legal partner, natural or adopted child, natural or adopted grandchild, natural or adopted great-grandchild, Veteran's Affair's officer or official, local, state or federal law enforcement official or agency, funeral director or authorized representative, executor or administrator of the decedent's estate, agent with power of attorney, any person authorized by law to act on behalf of the decedent or the decedent's estate.*

## Debit/Credit Card Information: (complete this section for mail/phone request only)

| | | |
|---|---|---|
| **Cardholder's Name:** | | |
| **Card #:** | | |
| **Exp. Date:** | **CVV #:** | |
| **Billing Address:** (If different from above address) | | |
| **City:** | **State:** | **Zip:** |
| **Cardholder's Signature:** | | |

## For Office Use Only: LEAVE BLANK

| | |
|---|---|
| **Date:** | □ Cash □ Check #_____ □ Debit/Credit Card |
| **Audit #:** | **VA copy Audit #:** |
| **Exchanged (old) Audit #:** | **Clerk Initials:** |

(Rev.08/2025)