

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

Attn: Vital Statistics

4239 Lake Ave

Ashtabula, OH 44004

440.992.7123

Check Appropriate Box:

- ☐ Birth Certificate- \$25.00
☐ Death Certificate- \$25.00

**This form is used for both birth & death requests*

**Method of Payments Accepted: Cash, check, money order, debit/credit card*

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

APPLICANT INFORMATION: (the person requesting the record) (YOURSELF)

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:	
Relationship to person on requested record:	<input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Aunt <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Sibling <input type="checkbox"/> Uncle <input type="checkbox"/> Grandparent <input type="checkbox"/> Friend <input type="checkbox"/> Funeral Home <input type="checkbox"/> Other: _____		

-Birth Requests: Complete all fields below EXCEPT date of death

-Death Requests: Complete all fields below EXCEPT fields with asterisks (*) can be left blank

RECORD INFORMATION: (the person on the requested record) (WHO IT IS FOR)

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)	DEATH REQUEST: (check box if applicable)	FEES:
<input type="checkbox"/> Dual Citizenship <input type="checkbox"/> Genealogy <input type="checkbox"/> International Legal Business <input type="checkbox"/> Marriage Certificate <input type="checkbox"/> Driver's License <input type="checkbox"/> Passport	<input type="checkbox"/> School <input type="checkbox"/> Work <input type="checkbox"/> Legal Purposes <input type="checkbox"/> Housing <input type="checkbox"/> Other: _____	Deaths Request Only: <input type="checkbox"/> No, I do not need the Social Security Number included. <input type="checkbox"/> Yes, I request a copy with the SSN included. <i>*See below for authorized requestors.</i>
TOTAL AMOUNT DUE: Do NOT send cash. Make checks / money orders payable to Ashtabula City Health Department.		Number of Birth/Death Record Copies: Qty: _____ x \$25 = \$ _____

***Authorized requestors:** Spouse or legal partner, natural or adopted child, natural or adopted grandchild, natural or adopted great-grandchild, Veteran's Affairs 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:	<input type="checkbox"/> Cash <input type="checkbox"/> Check # _____ <input type="checkbox"/> Debit/Credit Card <input type="checkbox"/> OVRs Pymnt
VA Copy Audit #:	Audit #:
Exchanged (old) Audit #:	Clerk Initials:

(Rev.11/2025)