

Alliance City Health Department

APPLICATION FOR CERTIFIED COPIES

Please print clearly as this will be used for your receipt, mailing address, and/or for future contact to complete your record request.

Purchaser's Name:

Phone Number:

Email:

Address:

Purchaser's Signature: _____

Record Information: (Information about the person you are requesting the record for)

Name -First, Middle, Maiden/Last: _____

Date of Birth and /or Date of Death: _____ City & County where event happened: _____

Credit/Debit Exp : CVV:

CHARGES- Method of Payment: CASH CHECK

CARD NUMBER:

Death: All Death certificates will be issued without a Social Security Number unless identification is provided confirming you are one of the below listed authorized requestors:

- The Deceased's Spouse or Descendent
- The Deceased's executor/attorney/legal guardian
- A representative of investigative government agency
- A private Investigator
- A funeral Director
(or agent responsible for disposition of the body)
- A veteran's service Officer
- An Accredited member of the Media

Number of Copies Requested:

_____ X **\$25.00** = _____
VA Copy Requested: _____
Affidavit Requested: _____
Of Supplemental copies req.: _____
Burial Permits req: _____ X **\$10.00** = _____

MAILING ADDRESS- send completed application with required FEE to:

VITAL RECORDS
537 E. MARKET ST.
ALLIANCE, OHIO 44601