



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: \_\_\_\_\_

**\*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.

Street Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Signature: \_\_\_\_\_

**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

---

**Health District Use Only**

Vol # \_\_\_\_\_

Receipt # \_\_\_\_\_

Cert # \_\_\_\_\_

Check No. \_\_\_\_\_

Audit No. \_\_\_\_\_

Date Received \_\_\_\_\_