

Canton City Health Department, Vital Statistics

APPLICATION FOR CERTIFIED COPIES



Public Health
Prevent. Promote. Protect.

****We accept cash, check, money order, debit card, Visa/Master card or Discover card.**

BIRTH CERTIFICATE REQUEST (for OHIO births only)

(Information about the person on the requested record)

Full name (indicate child's full name at birth/adoption): First Middle Maiden/Last			Date of Birth:	Number of copies requested: _____ x \$25.00 = \$_____			
<input type="checkbox"/> Mother	Full First	Full Middle	Maiden or Last Name	<input type="checkbox"/> Mother	Full First	Full Middle	Maiden or Last Name
<input type="checkbox"/> Father				<input type="checkbox"/> Father			
<input type="checkbox"/> Parent				<input type="checkbox"/> Parent			

DEATH CERTIFICATE REQUEST (for City of CANTON deaths only)

(Information about the person on the requested record)

Full name at death: First Middle Maiden/Last			Date of Death:	Number of copies requested: _____ x \$25.00 = \$_____
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For the first 5 years after the date of death, the social security number of the deceased will not be included on the death certificate unless the requester is one of the below listed authorized requestors:

- The deceased's spouse** (copy of the purchaser's photo ID is required)
- A lineal descendant of the deceased - child, grandchild, great-grandchild** (copy of the purchaser's photo ID is required)
- The deceased's executor, attorney or legal agent** (copy of the court papers is required)
- A representative of investigative government agency** (must show their badge)
- A private investigator** (must show their license)
- A funeral director (or agent responsible for disposition of the body) acting on behalf of the deceased's family**
- A veteran's service office** (must present an employee badge or a signed and dated letter on the officer's letterhead)
- An accredited member of the media** (must show employee badge)

Total Amount Due:	\$_____
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PURCHASER'S INFORMATION: *(Information about 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.

Purchaser's Name:		Email:	
Street Address:		Phone Number:	
City, State, & ZIP:		Purchaser's Signature:	

MAILING ADDRESS

If mailing in a record request, send the completed application with required fee to:

Canton City Health Department
Attn: Vital Statistics
420 Market Ave N
Canton, OH 44702
(330) 489-3231
www.cantonhealth.org

FOR OFFICE USE ONLY

Audit Number(s):	
Completed by which CCHD Employee (3 letter initial):	Date: