APPLICATION FOR SEARCH AND CERTIFIED COPY OF DEATH RECORD



State Form 49606 (R4 / 9-11)
Approved by State Board of Accounts, 2011
INDIANA STATE DEPARTMENT OF HEALTH

DEATH RECORDS IN THE STATE VITAL RECORDS OFFICE BEGIN WITH 1900. Prior to 1900, records of death are filed ONLY with the local health department in the <u>county where the death actually occurred</u>. For deaths occurring from 1900 to 1917, the city and/or county of death is required in order to locate the record.

FEES ARE ESTABLISHED BY LAW (IC 16-37-1-11). Each search for a record costs \$8.00. The fee is non-refundable. Included in one search is a 5-year period: the reported year of death and, if the record is not found in that year, the 2 years before and after. For records prior to 1917, the search covers a 5-year period and only one county. A certified copy of the record, if found, is included in the search fee. Additional copies of the same record purchased at the same time are \$4.00 each.

IDENTIFICATION IS REQUIRED according to IC 16-37-1-7 (SEE REQUIREMENTS AND ACCEPTABLE DOCUMENTATION LIST). Request for death certificates sent without proper identification will be returned to the requester without processing. Please complete <u>all</u> items below as required pursuant to IC 16-37-1-10 (a):				
Name of Deceased *				Stillborn? Yes No
*If decedent was a married, divorced, or widowed woman, ISDH must have her legal name at the time of death. Please do not give the maiden name of woman who changed her name by marriage during her lifetime).				
Date of Death (Month, Day, Year)				
City of Death		County of Death		
Total Certificates With Cause of Death Withou	Total Fee (s)			
Delivery Preference Regular Standard Mail Express Courier, Signature upon delivery required (Additional fee, please call agency for current rate.)				
Date of Birth of Deceased (if known)				
Name of Father	Maiden Name of Mother			
Your Relationship to the Individual Named on the Requested Certificate				
Purpose for which the record is to be used				
Printed Name of Applicant		Signature of Applicant		
Mailing Address (Number, Street, City, State and ZIP Code) ADDRESS MUST MATCH THE IDENTIFICATION PROVIDED.				
Daytime Telephone Number (including area code)		Today's date (Month, Day, Year)		
Send this application(s) with a check or money order payable to the Indiana State Department of Health, along with copy of a Government, State, or Military valid identification, and/or required documentation to: Vital Records, Indiana State Department of Health, P O Box 7125, Indianapolis, IN 46206-7125. (IF IDENTIFICATION DOES NOT MATCH THE ADDRESS PROVIDED YOUR REQUEST WILL NOT BE PROCESSED). Web address www.in.gov/ISDH				
FOR OFFICE USE				
Date Received (Month, Day, Year)	Receipt Number		Volume Number	
Certificate Number	Application Number		Initials of V	Verifier