Reset Form

APPLICATION FOR SEARCH OF CERTIFIED OR NON-CERTIFIED COPY OF DEATH RECORD

State Form 49606 (R7 / 5-18)
INDIANA STATE DEPARTMENT OF HEALTH

DEATH RECORDS IN THE STATE OF INDIANA VITAL RECORDS DIVISION BEGIN WITH YEAR 1900. Prior to 1900, Death Records were filed ONLY with the local health departments in the county where the death actually occurred. Deaths that occurred between years 1900 through 1917 require the name of the city and/or county of death to help locate the record.

FEES ARE ESTABLISHED BY INDIANA LAW (IC 16-37-1-11). Each individual record search carries a fee of $8.00; this fee is non-refundable. Additional certified copies of the same record purchased at the same time are $4.00 each. If the record is not found in the proposed year, an additional search of two (2) years prior and two (2) years after the proposed year is conducted.

***IDENTIFICATION IS REQUIRED according to 410 IAC 18-4-2. Requests for death certificates sent without proper identification will be returned to the requester without processing.* Please complete all items below as required pursuant to IC 16-37-1-10 (a).**

Name of Deceased ***(Legal name at time of Death)***	Stillborn? ☐ Yes ☐ No
Date of Death *(Month, Day, Year)* ***Do Not Leave Blank (must have at least a year).***	
Deceased Date of Birth *(if known) (Month, Day, Year)*	
Name of Deceased Parent 1 *(if known)*	Name of Deceased Parent 2 *(if known)*
City of Death	County of Death
Certificate Type: *(Please check all that apply.)* ☐ With Cause of Death ☐ Without Cause of Death ☐ Non-Certified ☐ Certified ***(must meet requirements)***	Total Fee(s) and number of Certificates *(Please check one.)* ☐ (1) $8.00 ☐ (2) $12.00 ☐ (3) $16.00 ☐ (4) $20.00 ☐ (5) $24.00
Delivery Preference ☐ Regular Mail ☐ Express Courier, Signature upon delivery required (*Additional fee required; please call agency for current rate.)*	
Your Relationship to the Deceased	
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)* ***Mailing address must match the identification provided or your request is subject to be denied and returned.***	
Daytime Telephone Number *(including area code)*	Today's date *(Month, Day, Year)*
Mail completed application (s) with a check or money order payable to the Indiana State Department of Health, along with a photocopy of a Government, State, or Military valid identification and required documentation, if applicable, to: Indiana State Department of Health, Vital Records, P O Box 7125, Indianapolis, IN 46206-7125. For more information visit the website at www.in.gov/ISDH.	

FOR OFFICE USE

Date Received *(Month, Day, Year)*	Receipt Number	Volume Number
Certificate Number	Application Number	Initials of Verifier