City of Steubenville □ Vital Statistics

APPLICATION FOR CERTIFIED COPIES TODAYS' DATE:_____

Birth Certificate - ALL Ohio Birth Certificates Available **$25.00** per certified copy	**Death Certificate - City of Steubenville ONLY** **$25.00** per certified copy	Registrar No._____ Audit No._____ VA No._____
Fetal Death Certificate **$25.00** per certified copy	**CASH ONLY** **In person**	**MONEY ORDER** **ONLY by mail**

MAILING ADDRESS

Send completed application with required fee to: **(Also enclose a stamped –self addressed envelope)**

Steubenville Health Dept. P.O. Box 1427, 119 S.Third St. Steubenville, OH 43952

RECORD INFORMATION *(Information about the person on the requested record)*

Full name *(for birth, indicate child's full name as shown on the original birth record)*:		**If name was changed since birth, indicate new name:**	
Date of Birth:	**OR Date of Death:**	**City and County where event occurred:**	
☐ **Mother** ☐ **Father** ☐ **Parent**	**Name before first marriage:**	☐ **Mother** ☐ **Father** ☐ **Parent**	**Name before first marriage:**

CHARGES *For mail in request* - *Please include **money order ONLY** made payable to "Steubenville Health Department" (**do not send cash**)*

Birth:	**Please indicate if you are requesting the certificate for any of the following purposes:** □ Dual Citizenship □ Genealogy □ Out of Country Marriage □ International Legal Business	**Number of birth record copies:** **_____ x $25.00 = $_____**
Death:	**I am requesting a copy with the SSN included because I am:** □The deceased's spouse, or lineal descendant □ The deceased's executor, attorney, or legal agent □ A representative of an investigative government agency □ A private investigator □ A funeral director (or agent responsible for disposition of the body) acting on behalf of the deceased's family □ A veteran's service officer □ An accredited member of the media **You must attach a copy of your identification showing you are an authorized requestor.**	**Number of death record copies:** **_____ x $25.00 = $_____** **Burial Permit's_____ x$3.00=_____**
Fetal Death:		**Number of fetal death record copies:** **_____ x $25.00 = $_____**
Total Amount Due: Cash only-in person request. Money order only by mail. No personal checks or debit cards.		**$_____**

APPLICANT 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.

Applicant Name:		Email:	
Street Address:		Phone Number:	
City, State, & ZIP:		Signature of Applicant:	