

**DEFIANCE COUNTY HEALTH DEPARTMENT**  
1300 EAST SECOND ST., SUITE 100, DEFIANCE, OHIO 43512

**REQUEST FOR DEATH CERTIFICATE**

Date \_\_\_\_\_

Number of copies requested \_\_\_\_\_

**PLEASE PRINT**

Name of Deceased \_\_\_\_\_

Date of Death \_\_\_\_\_

Place of Death \_\_\_\_\_

Applicant's Name \_\_\_\_\_

**Applicant's Signature** \_\_\_\_\_

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

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

**Office use only:** Security Paper # \_\_\_\_\_ Registration # \_\_\_\_\_