

RECEIPT# \_\_\_\_\_

**CLARK COUNTY HEALTH DEPARTMENT**

1201 Wall Street  
Jeffersonville, IN 47130  
Phone # (812) 284-6609

APPLICATION FOR CERTIFIED CERTIFICATE OF DEATH

NAME OF DECEASED:

\_\_\_\_\_

DATE OF DEATH:

\_\_\_\_\_  
(If exact date of death is not known, please indicate within five (5)  
years you wish us to search.)

PLACE OF DEATH (city) \_\_\_\_\_

PURPOSE FOR WHICH RECORD IS TO BE USED: \_\_\_\_\_

YOUR RELATIONSHIP TO THE DECEASE: \_\_\_\_\_

SIGNATURE OF APPLICANT: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_

NUMBER OF COPIES REQUESTED (\$15.00 each): \_\_\_\_\_  
(check, cash or money order only)

AMOUNT ENCLOSED: \_\_\_\_\_

IF APPLYING BY MAIL, PLEASE INCLUDE A SELF-ADDRESSED, STAMPED  
ENVELOPE.

Date Issued: \_\_\_\_\_

Issued by: \_\_\_\_\_

Certificate #: \_\_\_\_\_