

WASHINGTON COUNTY HEALTH DEPARTMENT  
VITAL STATISTICS

**IDENTIFICATION REQUIRED TO OBTAIN A DEATH CERTIFICATE**

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**FEE**

**\$10.00 Per Copy**  
**Cash, Cashier Check, or Money Order**  
**(NO PERSONAL CHECKS OR CREDIT/DEBIT CARDS)**

**Please remit payment to the Washington County Health Department when submitting form.**

**Office Hours:**

**•Applications taken 8:00 am - 11:30 and 1:00 pm until 3:30 pm**  
**Monday through Friday**

Please mail the completed Application Request Form and a self-addressed stamped envelope to:

Washington County Health Department  
Vital Records  
806 Martinsburg Road, Suite 100  
Salem, Indiana 47167-5906

If you have questions, please call Vital Statistics at (812) 883-5603.

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The applicant must have a direct interest and the certificate is necessary for the determination of personal or property rights or for the compliance with state or federal law.

**APPLICATION FOR CERTIFIED COPY OF DEATH CERTIFICATE**

Records begin with 1882

Fees: \$10.00 per copy

To be completed by individual making a request to: 1) Inspect vital record or records;  
2) Obtain a certified copy of a vital record. In accordance with Indiana code 16-37-1-8 the following information is required for inspection or to obtain a certified copy of any vital record. Please read this application thoroughly and COMPLETE ALL ITEMS.

**(NO PERSONAL CHECKS OR CREDIT/DEBIT CARDS)**

When mailed, please send stamped, self-addressed envelope in addition to this application to:

Vital Records, Washington County Health Department,  
806 Martinsburg Road,  
Suite 100, Salem, Indiana 47167.

Number of Copies Requested \_\_\_\_\_ (Fees: \$10.00 per copy.)

1. Full Name of deceased \_\_\_\_\_

2. Date of death \_\_\_\_\_

3. Place of Death \_\_\_\_\_

4. Your relationship to Deceased \_\_\_\_\_

5. Purpose for which record is to be used \_\_\_\_\_

Requested by: Your Name (Please Print) \_\_\_\_\_

Date \_\_\_\_\_ Your Signature \_\_\_\_\_

Phone \_\_\_\_\_

Mailing Address \_\_\_\_\_

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

Washington County Health Department

(812)883-5603

FAX (812)883-5017

For Local Office Use

Filed \_\_\_\_\_ ID# \_\_\_\_\_

Book Number \_\_\_\_\_ Drivers License \_\_\_\_\_

Page Number \_\_\_\_\_ State Issued ID \_\_\_\_\_ Military ID \_\_\_\_\_

Entry Number \_\_\_\_\_ Employment ID \_\_\_\_\_ School ID \_\_\_\_\_

Date Issued \_\_\_\_\_ Passport \_\_\_\_\_ Other \_\_\_\_\_

Signature Clerk \_\_\_\_\_

Cash Received \$ \_\_\_\_\_

Fee Due \$ \_\_\_\_\_

Cash Returned \$ \_\_\_\_\_