JEFFERSON COUNTY HEALTH DEPARTMENT
APPLICATION FOR CERTIFIED COPIES

RECORD INFORMATION: *(Information about the person you are requesting the record for)*

Full name on birth or death certificate: First / Middle / Maiden/Last	**If name was changed since birth, indicate new name: (i.e. adoption, legal name change, paternity, etc.)**
Date of Birth: and/or **Date of Death:**	**City and County where event occurred:**

☐ **Mother** ☐ **Father** ☐ **Parent**	Full First	Full Middle	Maiden or Last Name	☐ **Mother** ☐ **Father** ☐ **Parent**	Full First / Full Middle / Maiden or Last Name

CHARGES: WE ACCEPT CASH, CHECK, MONEY ORDER, OR CREDIT/DEBIT CARD-FEE CHARGED

Birth:	**If you do not need a birth certificate for any of the following reasons, skip this section.** Otherwise please indicate what the certificate is needed for: ☐ Dual Citizenship ☐ Genealogy ☐ Out of Country Marriage ☐ International Legal Business	**Number of copies requested:** _____ x $28.00 = $_____
Death:	**All death certificates will be issued without a social security number unless identification is provided confirming you are one of the below listed authorized requestors:** ☐ The deceased's spouse or descendent ☐ The deceased's executor, attorney, or legal agent ☐ A representative of 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 office ☐ An accredited member of the media **You must attach a copy of your identification showing you are an authorized requestor along with a copy of a valid driver's license.**	**Number of copies requested:** _____ x $28.00 = $_____ **Burial Permit** _____ x $10.00 =_____
Fetal Death:		**Number of fetal death record copies requested:** _____ x $28.00 = $_____
Total Amount Due:		$_____

PURCHASER'S 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.

Purchaser's Name:		Email:	
Street Address:		Phone Number:	
City, State, & ZIP:		Purchaser's Signature:	

MAILING ADDRESS

Send completed application with required fee to:

Jefferson County Health Department
500 Market Street, 6th Floor
Steubenville OH 43952

FOR OFFICE USE ONLY:

Order Number:	Date:
State File Number:	Permit/Other:

(Rev: 06/2026)