LAGRANGE COUNTY HEALTH DEPARTMENT
304 N. TOWNLINE RD. - STE 1
LAGRANGE, IN 46761
260-499-4182 Ext - 5
www.lagrangecountyhealth.com

Number of copies requested: ____________________
Amount enclosed: ___________________________

FULL NAME OF DECEASED: ____

DATE OF DEATH: __________________________ PLACE OF DEATH: ___________________________

CAUSE OF DEATH: ____

NAME OF FUNERAL HOME: ____

REASON FOR OBTAINING RECORD: ____

YOUR RELATIONSHIP TO DECEASED: ____

PRINT YOUR NAME: ____

YOUR SIGNATURE: ____

YOUR ADDRESS: ____

YOUR PHONE NUMBER: ____

//

**** FEE: **$12.00** PER CERTIFIED CERTIFICATE

****FEE: **$9.00** **GENEALOGY SEARCHES**, PER NAME SEARCHED

FEES ARE ESTABLISHED BY LAW (IC 16-37-1-11 AND IC 16-37-1-11.5). THE FEE IS NON-REFUNDABLE. INCLUDED IN ONE SEARCH IS A 5-YEAR PERIOD: THE REPORTED YEAR OF PATERNITY AND, IF THE RECORD IS NOT FOUND IN THAT YEAR, THE 2 YEARS BEFORE AND AFTER. A COPY OF THE RECORD, IF FOUND, IS INCLUDED IN THE SEARCH FEE.

**** CASHIER CHECK OR MONEY ORDER ONLY, IF MAILING THIS FORM

**** PLEASE ENCLOSE A SELF ADDRESS, STAMPED ENVELOPE

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For Health Dept. Use Only:

Date Received: ______________________________ No Record Found: ________________________

Book: __________ Page: ________________ Cert.#: _________________________