Reset Form

APPLICATION FOR SEARCH AND CERTIFIED COPY OF DEATH RECORD

State Form 49606 (R5 / 11-14)
Approved by State Board of Accounts, 2014
INDIANA STATE DEPARTMENT OF HEALTH

DEATH RECORDS IN THE STATE VITAL RECORDS OFFICE BEGIN WITH 1900. Prior to 1900, records of death were filed ONLY with the local health department in the county where the death actually occurred. Deaths that occurred between 1900 through 1917 require the name of the city and/or county of death to locate the record.

FEES ARE ESTABLISHED BY LAW (IC 16-37-1-11). Each individual record search carries a fee of $8.00; this fee is non-refundable. When performing the search, if the record is not found in the suggested year, an additional search of two (2) years before and after that year is performed. Additional certified copies of the same record purchased at the same time are $4.00 each.

IDENTIFICATION IS REQUIRED according to IC 16-37-1-7 ***(SEE REQUIREMENTS AND ACCEPTABLE DOCUMENTATION LIST.) (DO NOT SEND ORIGINAL IDENTIFICATIONS.)*** **Request for death certificates sent without proper identification will be returned to the requester without processing. Please complete all items below as required pursuant to IC 16-37-1-10 (a):**	
Name of Deceased	Stillborn? ☐ Yes ☐ No
**If decedent was a married, divorced, or widowed woman, ISDH must have her legal name at the time of death. Only list maiden name if you legally returned to that name.*	
Date of Death *(Month, Day, Year)*	
City of Death	County of Death
Total Certificates With Cause of Death _____ Without Cause of Death _____	Total Fee (s)
Delivery Preference ☐ Regular Mail ☐ Express Courier, Signature upon delivery required (*Additional fee, please call agency for current rate.*)	
Date of Birth of Deceased *(if known) (Month, Day, Year)*	
Name of Parent 1	Maiden Name of Parent 2
Your Relationship to the Individual Named on the Requested Certificate	
Purpose for which the record is to be used	
Printed Name of Applicant	Signature of Applicant
Mailing Address *(Number, Street, City, State and ZIP Code)* ***ADDRESS MUST MATCH THE IDENTIFICATION PROVIDED.***	
Daytime Telephone Number *(including area code)*	Today's date *(Month, Day, Year)*
Send this application (s) with a check or money order payable to the Indiana State Department of Health, along with copy of a Government, State, or Military valid identification, and or required documentation to: Vital Records, Indiana State Department of Health, P O Box 7125, Indianapolis, IN 46206-7125. ***(IF IDENTIFICATION DOES NOT MATCH THE ADDRESS PROVIDED YOUR REQUEST WILL NOT BE PROCESSED.)*** **Web address www.in.gov/ISDH**	

FOR OFFICE USE		
Date Received *(Month, Day, Year)*	Receipt Number	Volume Number
Certificate Number	Application Number	Initials of Verifier