

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: _____

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**** FEE: **\$12.00** PER CERTIFICATE AND **\$6.00** FOR EACH ADDITIONAL COPY

****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.#: _____