

**MEDINA COUNTY HEALTH DEPARTMENT – VITAL STATISTICS
APPLICATION FOR CERTIFIED COPY**

PLEASE PRINT CLEARLY

BIRTH CERTIFICATE

DEATH CERTIFICATE

NUMBER OF COPIES _____ **(\$22.00 Each)**

FULL NAME (ON THE CERTIFICATE) _____

DATE OF OCCURRENCE _____ **LOCATION** _____

Requester Name _____

Requester Signature _____

Type of Payment:

Check _____ **Money Order** _____ **Visa/MasterCard** _____ **TOTAL DUE:** _____

Signature of Card Holder _____

Card # _____ **Expiration Date** _____

Daytime Phone# _____

Mailing Address _____

City _____ **State** _____ **Zip** _____

Mail this request to:

**Medina County Health Department
Attn: Vitals
4800 Ledgewood Dr.
Medina, OH 44256**

Requests are generally processed the day they are received.