LAGRANGE COUNTY HEALTH DEPARTMENT
304 N. TOWNLINE RD. - STE 1
LAGRANGE, IN 46761
260-499-4182 Ext - 221
www.lagrangecountyhealth.org

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 CERTIFICATE AND **$6.00** FOR EACH ADDITIONAL COPY

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

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

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

//
For Health Dept. Use Only:

Date Received: _____ No Record Found: _____

Book: _____ Page: _____ Cert.#: _____

my documents: death form