

LAGRANGE COUNTY HEALTH DEPARTMENT
304 N. TOWNLINE RD. - STE 1
LAGRANGE, IN 46761-1319
260-499-4182 Ext - 221

www.lagrangecountyhealth.org (Click on Death Certificate Form)

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: \$9.00 PER CERTIFICATE AND \$4.00 FOR EACH ADDITIONAL COPY**

****** 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.#: _____