NEWTON COUNTY HEALTH DEPARTMENT

4117 S 240 W Suite 500

MOROCCO, IN 47963

219-285-2052

newtoncofd-vr@localhealth.in.gov

APPLICATION FOR CERTIFIED CERTIFICATE OF DEATH

Name of Deceased: _____

Date of Death: _____

Place of Death: _____County: _____

Date of birth of deceased: (if known) _____

Father's name: _____

Mother's Maiden name: _____

Relationship to person named on record: _____

Signature of Applicant: _____

Address: _____

Number of Copies Requested: _____ Amount Enclosed: _____
PLEASE PROVIDE READABLE COPY OF DRIVERS LICENSE OR PICTURE ID

$10.00 Charge for each copy; $10.00 search fee (if information cannot be given)

OFFICE USE ONLY:

Certificate# _____Receipt # _____ Date: _____