# Columbiana County Health District

P.O. Box 309 – 7360 State Route 45 – Lisbon, Ohio 44432
**Phone:** 330-424-0272 – **General Fax:** 330-424-1733 – **Nursing Fax:** 330-424-1843
**Email**: cchd@columbiana-health.org **Web:** www.columbiana-health.org


Awarded 2022

## Office of Vital Statistics ● Application for Certified Birth or Death

**Walk-in Service:**
Monday - Friday 8:00 AM – 4:00 PM
Closed Legal Holidays
(330) 424-0272 X 115
*Any request after 3:45 may not be same day

**Mail:**
Send completed application with required MONEY ORDER fee to:
Columbiana County Health District
Attn: Vital Statistics
P.O. Box 309
Lisbon, OH 44432

**Office use only:**
Date: _____
Rcpt: _____
M.O. _____ Check: _____

**REGISTRANT INFORMATION:** (information about person whose vital record is being requested)

| | | |
|---|---|---|
| Please check one:<br><br>□ Birth $27.00 per certified copy<br><br>□ Death $27.00 per certified copy | Full Name: | |
| | Place of birth or death: | Date of birth or death: |
| | Full name of mother (maiden): | Full name of father: |
| | Relationship to decedent if requesting death certificate: _____<br><br>**Copy of <u>Driver's License</u> and <u>proof of relationship</u> required for all certified death records with social security number on them. See ORC 3705.25 below. Please send <u>copy(s)</u> of proof of relationship. Do not send originals.**<br><br><u>Pursuant to Ohio Revised Code 3705.25:</u> For the first five years after a decedent's death, the social security number will not be included on a certified death record, unless that information is specifically requested to be on the copy by showing proof of relationship and a valid driver's license to the registrar. | |

| | |
|---|---|
| Total number of copies (birth or death): _____ x $27 | $ |

**For Mail Order:** Please include **<u>money order</u>** (do not send cash or check, all checks will be held for three weeks if sent). Made payable to: Columbiana County Health District.

**APPLICANT INFORMATION:** (information about the person requesting the vital record)

| | | | |
|---|---|---|---|
| Applicant Name: | | Phone Number: | |
| Street Address: | | Signature of Applicant: | |
| City, State & Zip Code: | | | |

| | |
|---|---|
| Office use only | SFN: _____ Driver's License No.: _____<br>Audit: _____ Expiration Date: _____ |

Our Vision: "A safe community of healthy people"