



APPLICATION FOR DEATH CERTIFICATE

Questions? Call 706-321-6130
or visit www.columbushealth.com

****VALID PHOTO ID REQUIRED****
FOR PERSON REQUESTING CERTIFICATE
AND CREDIT CARD HOLDER, IF DIFFERENT
COPY OF ID MUST ACCOMPANY MAIL/FAX REQUESTS

Full Name of Deceased: _____
First Middle Last (as shown on Certificate)

Date of Death: _____ Funeral Home: _____
Month Day Year

Place of Death: _____
Hospital City State County

The above fees have been established in accordance with Chapter 31-10 of the Official Code of Georgia. Pursuant to O.C.G.A. Chapter 31-10, Section 31: Any person who willfully or knowingly supplies false information on this form to be used for any purpose of deception with intent to defraud; willfully uses or attempts to use any certificate of birth or death or copy of any record, knowing that such certificate was issued upon a record which was false or which relates to the birth or death of another person may be fined not more than \$10,000 or imprisonment for not more than five (5) years, or both, upon conviction.

Printed Name of Person Requesting Certificate- If born outside Georgia, certified birth certificate must be presented to verify relationship.

Mailing Address: _____

Phone: _____

Relationship to Deceased: _____

► Signature _____ Date _____

****Fees are Non-Refundable****

First Copy \$25.00
Each Additional Copy \$5.00

Total Copies Requested _____

Payment for mail requests are by Debit/credit, money order, or cashier's check.

**Mail to: Columbus Health Dept. Vital Records
P.O. Box 2299
Columbus, GA 31902-2299**

Payment for fax requests are by Debit/Credit Card ONLY. Fax to: 706-321-6135

FOR OFFICE USE ONLY:

Type of ID Verified _____ Total Fee Rec'd _____ Employee's Initials _____
Visa _____ MC _____ Disc _____ AMEX _____ Debit _____ Cash _____ MO _____ CC _____

CREDIT CARD INFORMATION: Shred this section before filing

Card Number: _____

_____ Exp Date: _____ Three Digit Security Code (on back): _____

Name as it appears on card: _____