Parke County Health Department

116 W High Street Room 12
Rockville, IN 47872
parkehealth@parkecounty-in.gov

Phone: 765-569-6665
FAX: 765-569-4061
parkecounty-in.gov

All requests require proper identification and proof of relationship to the person whose record is being requested.

Indiana Code 410 IAC 18-4-2

FEE

$10.00 per copy

Acceptable payment types are cash, check, money order, Discover, Visa, or Mastercard. When paying by credit or debit cards, you must either pay in person or print a "Credit/Debit Authorization Form" before research will be done. There is either a 3% convenience fee or a $1 minimum (if transaction is under $33.00) for all debit and credit card transactions.

Please remit with payment and a self addressed, stamped envelope to the Parke County Health Department when submitting form.

Please mail the completed Application Request Form, payment, and a self-addressed stamped envelope to:

Parke County Health Department
116 W High Street Room 12
Rockville, IN 47872

If you have any questions, please call the Parke County Registrar at 765-569-6665.

The applicant must have a direct interest and the certificate is necessary for the determination of personal or property rights or for the compliance with state or federal law.

Indiana Code 410 IAC 18-4-1.

PAGE 2 IS ONLY REQUIRED REMITTANCE UNLESS PAYING WITH DEBIT OR CREDIT CARD.

APPLICATION FOR CERTIFIED COPY OF DEATH CERTIFICATE

Records begin with 1882

Fees: $10.00 per copy

To be completed by the individual making a request to obtain a record.

All requests require proper identification and proof of relationship to the person whose record is being requested.

Please read the application thoroughly and **COMPLETE ALL ITEMS.**

Acceptable payment types are cash, check, money order, Discover, Visa, or Mastercard. When paying by credit or debit cards, you must either pay in person or be reachable by phone BEFORE research will be done. There is either a 3% convenience fee or a $1 minimum (if transaction is under $33.00) for all debit and credit card transactions.

When mailed, please send stamped, self-addressed envelope in addition to this application to:

Parke County Health Department 116 W. High St. Room 12 Rockville, In 47872

Number of copies requested_____ (Fees: $10.00 per copy)

1. Full name of deceased:_____
2. Date of death:_____
3. Place of death:_____
4. Your relationship to deceased:_____
5. Purpose for which record is to be used:_____

Requested by: Your name_____
(Please print)

Date:_____ Your Signature:_____

Phone:_____ Mailing address:_____

City: _____State: _____Zip: _____

Parke County Health Department
116 W. High St. Room 12
Rockville, In 47872

Health Department use only:

Filed_____ I.D._____

Book #_____ Drivers License #_____

Page #_____ State Issue ID_____ Military ID_____

Date Issued_____ Employment ID_____ School ID_____

Clerk_____ Passport_____ Other_____

Cash Received $_____

Fee Due $_____

Credit/Debit Card Payment Authorization Form

Please complete and sign this form to authorize the Parke County Health Department to make a debit to your credit/debit card listed below. By signing this form you give us permission to debit your account for any fees due.

Please complete the information below:

I, _____ authorize the Parke County Health Department to charge my

credit card account for the amount due for licenses, permits, or vital record searches and productions on or after

_____.

Signature: _____

Signature Date: _____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

Name:_____

Billing Address: _____

City, State, Zip: _____

Phone#: _____ Email: _____

****Disclaimer: The Parke County Health Dept will not retain credit/debit card information, upon authorization of applicable fees, everything below the dotted line will be destroyed.**

Office Use Only:

Authorization Number: _____ Initials: _____

Date of transaction: _____

Account Type: Visa MasterCard Discover

Account Number: _____ Expiration Date: _____

3 Digit Security Code: _____