Certified Death Certificate Request Form

Cass County Health Department
512 High St.
Logansport, IN 46947
(574) 753-7761

Name of Deceased: ____

Date of Death: _______________ **Date of Birth**: ___________________

County of Death (Where this person passed away) _____________________

Requestor's Relationship to Decedent: ______________________________

Purpose of Request: ____

Requestor's Name: ____

Requestor's Address: ____

Requestor's Phone Number: ____________________________________

Requestor's Signature: ____

Total Fee ($10 per certificate) **Cash or Money Order ONLY (no personal checks accepted)** and **a valid photo ID** ***Mail in requests need to include a self addressed, stamped envelope.**

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Office Use

Requested __________ Total Fee ______________

Receipt # ________________ Request Date ______________