

Ohio Department of Health  
Bureau of Vital Statistics  
P.O. Box 15098  
Columbus, Ohio 43215-0098

**STATE OF OHIO  
DEPARTMENT OF HEALTH  
BUREAU OF  
VITAL STATISTICS**

<b>DO NOT WRITE IN THE THIS SPACE</b>	
Date of Receipt	
Volume No.	Certificate No.
Date Issued	
Certification No.	

**APPLICATION FOR CERTIFICATE OF PUBLIC RECORD**

SECTION 5905.18 R.C.; CERTIFICATE OF PUBLIC RECORD WITHOUT CHARGE.

WHEN A COPY OF ANY PUBLIC RECORD IS REQUIRED BY THE VETERAN'S ADMINISTRATION TO BE USED IN DETERMINING THE ELIGIBILITY OF ANY PERSON TO PARTICIPATE IN BENEFITS MADE AVAILABLE BY THE VETERAN'S ADMINISTRATION OR IN THE FURTHERANCE OF ANY PROCEEDINGS UNDER SECTIONS 5905.01 TO 5905.19, INCLUSIVE, OF THE APPLICANT FOR SUCH BENEFITS, ANY PERSON ACTING ON HIS BEHALF, OF THE AUTHORIZED REPRESENTATIVE OF THE VETERAN'S ADMINISTRATION WITH A CERTIFIED COPY OF SUCH RECORD.

Application is hereby made for a certified copy of the \_\_\_\_\_ certificate of:  
*Birth or Death*

_____	_____	_____
<i>Name</i>	<i>Date of occurrence</i>	<i>Place of occurrence</i>
_____	_____	_____
<i>Name</i>	<i>Date of occurrence</i>	<i>Place of occurrence</i>
_____	_____	_____
<i>Name</i>	<i>Date of occurrence</i>	<i>Place of occurrence</i>

**CERTIFICATION**

This is to certify that an official copy of the record indicated above is required by the U.S. Veteran's Administration in connection with a claim on account of \_\_\_\_\_ who served in \_\_\_\_\_ in the U.S. \_\_\_\_\_  
*Army, Navy Air Force, or Marine Corps*

THIS CERTIFICATION MUST BE SIGNED BY THE BENEFICIARY OR AN OFFICIAL OF THE U.S. VETERAN'S ADMINISTRATION; AN OFFICER OF A POST, COUNCIL OR STATE DEPARTMENT OF THE AMERICAN LEGION, THE UNITED SPANISH WAR VETERANS; THE GRAND ARMY OF THE REPUBLIC OF VETERANS OF FOREIGN WARS OR THE STATE COMMISSIONER OF SOLDIERS CLAIMS OR AMERICAN RED CROSS, DISABLED AMERICAN VETERANS OF THE WORLD WAR, AND AMVETS, DEPARTMENT OF OHIO.

BENEFICIARY

OR

OFFICIAL OR OFFICER

Signature \_\_\_\_\_  
Street Address \_\_\_\_\_  
City - State \_\_\_\_\_  
Date \_\_\_\_\_

Signature \_\_\_\_\_  
Title \_\_\_\_\_  
\_\_\_\_\_  
*Post Number*                      *Name and Organization*  
Location \_\_\_\_\_  
Date \_\_\_\_\_

ONLY ONE SIGNATURE IS REQUIRED