PLACE OF BIRTH

ARIZONA STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

ORIGINAL CERTIFICATE OF BIRTH

1. County of..............................

District of..............................

Town of..............................

or

City of.............................. No............................. St., ...Ward
(If birth occurred in a hospital or institution, give its NAME instead of street and number)

State Index No............ 164 a

County Registrar No........ 234

Local Registrar No........ 234

2. Full name of child _Nora Francis Livingston_ { If child is not yet named, make supplemental report, as directed.

3. Sex of Child	To be answered ONLY in event of plural births.	4. Twin, triplet or other............	6. Legitimate? _yes_	7. Date of birth _4 . 16 - 27_
		5. No., in order of birth............		Month Day Year

8. FATHER	14. MOTHER
Full name _Arthur Livingston_	Full maiden name _Liza Stewart_
9. Residence (Usual place of abode) _Globe_	15 Residence (Usual place of abode) _Globe_
If non-resident, give place and state.	If non-resident, give place and state.
10. Color or race _W. Amr._	11. Age at last birthday _42_ (Years)	16 Color or race _W. Amn._	17. Age at last birthday _37_ (Years)
12. Birthplace (city or place) _Texas_	18. Birthplace (city or place) _Texas_
(State or country)	(State or country)
13. Occupation Nature of Industry _Iron Kufer._	19. Occupation Nature of Industry _H.W._

20. Number of children of this mother (Taken as of time of birth of child herein certified and including this child.)	(a) Born alive and now living _4_	21. Were precautions taken against ophthalmia neonatorum? _yes._
	(b) Born alive but now dead _0_	
	(c) Stillborn _0_	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was.................. _alive_ .... at .. _10:30_ .... m. on the date above stated.
(Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Signature.................................. (Physician or midwife).

Address..................................

Given name added from a supplemental report..........................
Month, day, year

Filed _June 11,_ 19_27_ _C. E. Ann_ Local Registrar.

Filed.........................., 19.......

.... Registrar

.... County Registrar.

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