ARIZONA STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
STANDARD CERTIFICATE OF BIRTH

State File No. 165
Registered No. 159

1. PLACE OF BIRTH

County _Gila_   State _Arizona_

District or Township _____ or Village _____

City _Miami_ No. _25_ _Grover Canon_ St. _____ Ward
(If birth occurred in a hospital or institution, give its NAME instead of street and number)

2. Full name of child _Maria in Gracis Lemon_   If child is not yet named, make supplemental report, as directed.

3. Sex of Child _Female_ | To be answered ONLY in event of plural births. | **4. Twin, triplet or other** _____ | **6. Legitimate?** _yes_ | **7. Date of birth** _Apr. 16 - 1927._ Month Day Year
| | | **5. No., in order of birth** _____ | |

8. **FATHER**	**14.** **MOTHER**
Full name _Benito Lemon_	Full maiden name _Ramona De La Cruz_
9. Residence (Usual place of abode) _Miami_ If non-resident, give place and state. _Arizona_	**15 Residence** (Usual place of abode) _Miami_ If non-resident, give place and state. _Arizona_
10. Color or race _Mex_ **11. Age at last birthday** _35_ (Years)	**16 Color or race** _Mex._ **17. Age at last birthday** _25_ (Years)
12. Birthplace (city or place) _Jalisco_ (State or country) _Mex._	**18. Birthplace** (city or place) _Jalisco_ (State or country) _Mex._
13. Occupation Nature of industry _Miner_	**19. Occupation** Nature of industry _Housewife_

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 _2_
- (b) Born alive but now dead _1_
- (c) Stillborn _____

21. Were precautions taken against ophthalmia neonatorum? _Yes_

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _born_ at _5-30_ p.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 _Cyril M. Crow M.D._
Physician
(Physician or midwife).

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

Address _Miami, Arizona._

Filed _May 10, 1927_   _C. E. Ivm_

_____ Registrar   Registrar

435-416-949