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ARIZONA STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL STATISTICS

(This return should preferably be made by the person who made the original)

SUPPLEMENTARY REPORT OF BIRTH County Registrar's No.*

Place of Birth Miami County Gila No. _____ St. _____
(Registration District)

SEX OF CHILD*	Twin Triplet or other?	}	and	}	Number in order of birth
Male					

I HEREBY CERTIFY that the child described herein has been named

MANUEL ARAUJO RODRIGUEZ

(Give name in full) (Surname)

DATE OF BIRTH* November 16 1927
(Month) (Day) (Year)

FULL* NAME Jose Leon Rodriguez
FATHER

FULL* MAIDEN NAME Filomena Araujo
MOTHER

Manuel Araujo Rodriguez
Parents deceased. Spelling verified
(Parent's Signature)

(Signature of Physician or Midwife)

From Baptismal Record.

*These items to be entered by the local registrar before giving out this form

Blank supplemental reports of birth may be obtained from the local registrar.
© 10M 1-45

MARGIN RESERVED FOR BINDING
USE PERMANENT INK

499-1116-616