cause the blindness of the child unless

asos de ceguedad en asilos es deb

MARGIN RESERVED FOR BINDING
USE PERMANENT INK

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.* 87

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

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

DATE OF BIRTH* January 25, 1910 (Month) (Day) (Year)

FATHER

FULL* NAME Robert E. Lee

MOTHER

FULL* MAIDEN NAME Alphareta Cluff

I HEREBY CERTIFY that the child described herein has been named

Carl Hall Lee
(Give name in full) (Surname)

✓ Marie Noff Sister
(Parent's Signature)

M
(Signature of Physician or Midwife)

*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 12-46

335-125-136