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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.* 99

Place of Birth Miami County Dade No. _____ St. _____

SEX OF CHILD*	Twin Triplet or other?	and	Number in order of birth
M			
DATE OF BIRTH* <u>Feb</u> <u>13</u> <u>1922</u>			
(Month) (Day) (Year)			
FULL NAME	FATHER		
<u>Alexandro Obiedo</u>			
FULL MAIDEN NAME	MOTHER		
<u>Hortencia Corral</u>			

I HEREBY CERTIFY that the child described herein has been named

Oscar Obiedo (Give name in full) (Surname)

Parent out (Parent's Signature)

Do not now (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.

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666-213-833

RECEIVED

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