

N. B.—In case of more than one child at a birth, a SEPARATE RETURN must be made AND RETURNED IN THE order of birth stated.

PLACE OF BIRTH  
*Gila*

ARIZONA STATE BOARD OF HEALTH

1. County of *Gila*  
District of \_\_\_\_\_  
Town of \_\_\_\_\_  
or *Globe*  
City of \_\_\_\_\_

BUREAU OF VITAL STATISTICS  
ORIGINAL CERTIFICATE OF BIRTH

State Index No. *159*  
County Registrar No. \_\_\_\_\_  
Local Registrar No. *53*

2. Full name of child *Florence Patricia Hollin* (If child is not yet named, make supplemental report, as directed.)

3. Sex of Child *F* To be answered ONLY in event of plural births. 4. Twin, triplet or other. 5. No., in order of birth. 6. Legitimate? *yes* 7. Date of birth *March-13-1926* (Month Day Year)

8. FATHER  
Full name *Peter Hollin*

14. MOTHER  
Full maiden name *May Jane Murphy*

9. Residence (Usual place of abode) *Pinal St. Globe*  
If non-resident, give place and state.

15. Residence (Usual place of abode) *Pinal St. Globe*  
If non-resident, give place and state.

10. Color or race *W.*  
11. Age at last birthday *38* (Years)

16. Color or race *W.*  
17. Age at last birthday *32* (Years)

12. Birthplace (city or place) *Ireland*  
(State or country)

18. Birthplace (city or place) *Ireland*  
(State or country)

13. Occupation *Foreman in Concentrator Mill works*  
Nature of industry

19. Occupation *Housewife*  
Nature of industry

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*  
(b) Born alive but now dead *0*  
(c) Stillborn *0*

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 *GA* 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 *W. W. Horst* (Physician or midwife)

Address \_\_\_\_\_

Given name added from a supplemental report \_\_\_\_\_  
Month, day, year \_\_\_\_\_  
Registrar \_\_\_\_\_

Filed *3/31* 19 *26* *W. W. Horst* Local Registrar.  
Filed *Mar 31* 19 *26* *W. W. Horst* County Registrar

685-313-448