ATTENDING PHYSICIAN O.

This supplemental report is to be pasted beneath the original.

ARIZONA STATE BOARD OF HEALTH Vol. 5-28 #109

BUREAU OF VITAL STATISTICS

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

SUPPLEMENTARY REPORT OF BIRTH

Local Registrar's No.*.....

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

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

DATE OF BIRTH* May 1 (Month) (Day) 192 8 (Year)

FULL* NAME FATHER J. W. Caretto

FULL* MAIDEN NAME MOTHER Lucy Sassoe

I HEREBY CERTIFY that the child described herein has been named

Pete Anton Caretto
(Given name in full) (Surname)

X Mrs. John W. Caretto
(Father's or Mother's Signature)

X R D Kennedy
(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.
Local registrars must mail supplement[illegible] its immediately to state registrar.

PLEASE WRITE PLAIN AND IN INK.

Supplementary report must be returned within 15 days