ARIZONA STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
STANDARD CERTIFICATE OF BIRTH

State File No. _181_

Registered No. _422_

V

1. PLACE OF BIRTH

County _Gila_   State _Arizona_

District or Township _____   or Village _____

City _Miami_   No. _R.R. Canon_   St., _____ Ward

(If birth occurred in a hospital or institution, give its NAME instead of street and number)

2. Full name of child _Miguel Lugo_

{If child is not yet named, make supplemental report, as directed.

3. Sex of Child _Male_

| 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 _Sept. 29 - 1928_
Month   Day   Year

8. FATHER

Full name _Federico Lugo_

9. Residence (Usual place of abode) _Miami,_

If non-resident, give place and state. _Arizona._

10. Color or race _Mex._

11. Age at last birthday _28_ (Years)

12. Birthplace (city or place) _Chihuahua_
(State or country) _Mex._

13. Occupation
Nature of industry _Miner_

14. MOTHER

Full maiden name _Refugia Casillas_

15. Residence (Usual place of abode) _Miami_

If non-resident, give place and state. _Arizona._

16. Color or race _Mex._

17. Age at last birthday _20_ (Years)

18. Birthplace (city or place) _Sonora_
(State or country) _Mex._

19. Occupation
Nature of industry _Housewife_

20. Number of children of this mother _1_

(Taken as of time of birth of child herein certified and including this child).

(a) Born alive and now living _1_
(b) Born alive but now dead _____
(c) Stillborn _____

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 alive_ at _9-53_ A. 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.

Given name added from a supplemental report _____
Month, day, year

Signature _Cyril M. Cron M.D._

Physician

(Physician or midwife)

Address _Miami, Arizona._

Filed _Oct 10_, 19_28_   _C.E. ____

Registrar.

Registrar.

_436-929-73?_