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

State File No. *126*

Registered No. *49*

1. PLACE OF BIRTH

County *Gila*   State *Arizona*

District or Township _____ or Village _____

City *Miami*   No. *717 C Live Oaks* St., _____ Ward
(If birth occurred in a hospital or institution, give its NAME instead of street and number)

2. Full name of child *Ricardo Luna*
{If child is not yet named, make supplemental report, as directed.}

3. Sex of Child	To be answered ONLY in event of plural births.	4. Twin, triplet or other _____	6. Legitimate?	7. Date of birth
Boy		5. No., in order of birth _____	*Yes*	*Feb 7 1929* Month Day Year

8. FATHER	14. MOTHER
Full name *Mercas Luna*	Full maiden name *Rosa Avalos*
9. Residence *717 C Live Oak St* (Usual place of abode) If non-resident, give place and state.	15. Residence *717 C Live Oak St* (Usual place of abode) If non-resident, give place and state.
10. Color or race *Mexican* 11. Age at last birthday *28* (Years)	16. Color or race *Mexican* 17. Age at last birthday *21* (Years)
12. Birthplace (city or place) *Villa Hidalgo* (State or country) *Jalisco Mex*	18. Birthplace (city or place) *Chalguatila* (State or country) *Jalisco Mexico*
13. Occupation Nature of industry *Miner*	19. Occupation Nature of industry *House Wife*

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 *2* (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 *alive* at *5-20* 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. }

Signature *Rosa Leutes*

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

(Physician or midwife).

Address *806 Sullivan St*

Filed *Feb 11* 19 *29*   *C. E. Finn*

Registrar. _____   Registrar.

931-207-916