

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

State File No. 209  
Registered No. \_\_\_\_\_

PLACE OF BIRTH

County Gila State Arizona  
District or Township San Carlos or Village \_\_\_\_\_  
City \_\_\_\_\_ No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
(If birth occurred in a hospital or institution, give its NAME instead of street and number)

2. Full name of child Stillborn Jackson (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 3/29/29  
Month Day Year

8. FATHER  
Full name Wiley Jackson  
9. Residence (Usual place of abode) San Carlos, Ariz.  
If non-resident, give place and state.

14. MOTHER  
Full maiden name Belle James  
15. Residence (Usual place of abode) San Carlos, Ariz.  
If non-resident, give place and state.

10. Color or race 4/4 Indian Age at last birthday 42 (Years)

16. Color or race 4/4 Indian 17. Age at last birthday 21 (Years)

12. Birthplace (city or place) San Carlos, Ariz.  
(State or country)

18. Birthplace (city or place) White River, Ariz.  
(State or country)

13. Occupation  
Nature of Industry common labor

19. Occupation  
Nature of Industry housewife

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 0  
(b) Born alive but now dead 2  
(c) Stillborn \_\_\_\_\_

21. Were precautions taken against ophthalmia neonatorum?  
no

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was still born at 2 P. 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 C. H. Sawyer M.D.  
(Physician or midwife)

Given name added from a supplemental report \_\_\_\_\_ Address San Carlos, Ariz.

Month, day, year \_\_\_\_\_ Filled \_\_\_\_\_, 19 \_\_\_\_\_ C. H. Sawyer Registrar

Registrar

Registrar

015-329-212

NOTE: RETURN must be made for each, and the date of birth stated.

N.B.—In case of \_\_\_\_\_ with one of \_\_\_\_\_