Printed by the Fromberg Herald.

County File No. 2664

Form V. S. No. 11.

Registration No. 39

STATE OF MONTANA,
County of Carbon

CERTIFICATE OF BIRTH

Date of Birth April 24, 1923 Place White

Name of Child Edmund Eugene Zann Sex Male Color White

Living or Stillborn living No. of Child 1st, 2nd, etc 2nd

Name of Parents* Joe Zann Color White

Martha Delarenti Color White

Residence Red Lodge, Montana

Occupation of Father Coal Miner

Birthplace of Father Italy

Birthplace of Mother Italy

Red Lodge, Montana E.M. Adams M. D.

June 25, 1923 19 K.D. Holmgren M.D.

*Give maiden name of mother. Registrar.

STATE OF MONTANA, County of Carbon. } ss.

I, George J. McDonald County Clerk of Carbon County, Montana, do hereby certify that the above is a full, true and correct copy of the record in the above names as the same appear in the files of the office of the County Clerk of said Carbon County, Montana.

In Witness Whereof, I have hereunto set my hand and the Seal of said office this 12th day of August, 19 41

By Ted A. Schmitz Deputy

George J. McDonald
County Clerk.
Carbon County, Montana

STATE OF CALIFORNIA

CERTIFICATION OF VITAL RECORD

CITY AND COUNTY OF SAN FRANCISCO

California State Board of Health
BUREAU OF VITAL STATISTICS
STANDARD CERTIFICATE OF BIRTH

State Index No. .....

Local Registered No. 8490

[If birth occurred in a hospital or institution, give its NAME instead of street and number.]

PLACE OF BIRTH

City and County of SAN FRANCISCO (No. St. Francis Hospital St.; Ward)

FULL NAME OF CHILD Joseph Richard Waters [If not named, make supplemental report, as directed.]

PERSONAL AND STATISTICAL PARTICULARS

SEX OF CHILD: Male

Twin, Triplet, or Other: (To be answered only in event of plural births)

Number in Order of Birth:

DATE OF BIRTH: December (Month) 22 (Day) 1919 (Year)

FATHER

FULL NAME: Joseph John Waters

RESIDENCE: San Francisco, 2503 Clement St., City Calif. State

COLOR OR RACE: White

AGE AT LAST BIRTHDAY: 23 (Years)

BIRTHPLACE: San Francisco (State or Country) Calif.

OCCUPATION (a) Trade, profession, or particular kind of work: Car Conductor

(b) General nature of industry, business, or establishment in which employed (or employer): United Railroads

Was a prophylactic for Ophthalmia Neonatorum used? Yes

If so, what? Silver Nitrate 1%

MOTHER

FULL MAIDEN NAME: Carrie Margaret Sylvia

RESIDENCE: San Francisco, 2503 Clement St. City Calif. State

COLOR OR RACE: White

AGE AT LAST BIRTHDAY: 23 (Years)

BIRTHPLACE: Yreka, (State or Country) Siskiyou Co.

OCCUPATION (a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

Number of children born to this mother, including present birth: 1

Number of children of this mother now living: 1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive (Born alive or stillborn) at 6.18 A.M. P on the date above stated.

"Where 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. B. Thompson

Dated Dec 22 1919

Physician (Physician, midwife, father, etc.)

Address 2253 Clement St

Given name added from a supplemental report Oct. 13, 1920

M. J. Registrar

DEC 26 1919

WILLIAM C HASSLER Registrar or Deputy

Form 3. 45300 4-19 1934

STATE OF CALIFORNIA, CITY AND COUNTY OF SAN FRANCISCO
This is to certify that the image reproduced hereupon is a true copy of the record on file in the SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH as of the date issued.

2006 JUN 23 AM 11:00

002389124

DATE ISSUED

Mitchell Katz, M.D.
Health Officer and Local Registrar

This copy is not valid unless prepared on an engraved border, displaying the date, seal and signature of the City and County Health Officer.

ANY ALTERATION OR ERASURE VOIDS THIS CERTIFICATE

STATE OF HAWAII

CERTIFICATE OF LIVE BIRTH

FILE NUMBER 151

DEPARTMENT OF HEALTH
61 10641

1a. Child's First Name (Type or print)	1b. Middle Name					1c. Last Name	
BARACK	HUSSEIN					OBAMA, II	
2. Sex	3. This Birth	4. If Twin or Triplet, Was Child Born	5a. Birth Date	Month	Day	Year	5b. Hour
Male	Single [X] Twin [ ] Triplet [ ]	1st [ ] 2nd [ ] 3rd [ ]		August	4,	1961	7:24 P.M.
6a. Place of Birth: City, Town or Rural Location						6b. Island	
Honolulu						Oahu	
6c. Name of Hospital or Institution (If not in hospital or institution, give street address)				6d. Is Place of Birth Inside City or Town Limits? If no, give judicial district Yes [X] No [ ]			
Kapiolani Maternity & Gynecological Hospital							
7a. Usual Residence of Mother: City, Town or Rural Location			7b. Island			7c. County and State or Foreign Country	
Honolulu			Oahu			Honolulu, Hawaii	
7d. Street Address				7e. Is Residence Inside City or Town Limits? If no, give judicial district Yes [X] No [ ]			
6085 Kalanianaole Highway							
7f. Mother's Mailing Address						7g. Is Residence on a Farm or Plantation? Yes [ ] No [X]	
8. Full Name of Father						9. Race of Father	
BARACK	HUSSEIN		OBAMA			African	
10. Age of Father	11. Birthplace (Island, State or Foreign Country)		12a. Usual Occupation			12b. Kind of Business or Industry	
25	Kenya, East Africa		Student			University	
13. Full Maiden Name of Mother						14. Race of Mother	

159- 1018159

UNITED STATES OF AMERICA
DEPARTMENT OF STATE

Certification of Report of Birth

of a United States Citizen

This is to certify that the birth of IMA SAMPLE (Name) sex FEMALE

born at DESOLATION (City) MONGOLIA (Country)

on APRIL 1, 1996 (Date) was registered with the Consular Service of the United States and a Consular Report of Birth was issued at BISHKEK, KYRGYZSTAN (City / Country)

on SEPTEMBER 10, 1996 (Date)

Father	PARENTS	Mother
DADDY SAMPLE		MOMMY SAMPLE
Date of Birth APRIL 1, 1970		Date of Birth APRIL 1, 1975

CONDOLEEZZA RICE
Secretary of State

Authentication Officer, Washington, D.C.

OCTOBER 27, 2005
Date

FORM DS-1350

WARNING: This certificate is not valid if it has been altered in any way whatsoever or if it does not bear the raised seal of the office of issuance.

Abbreviations must not be made. This form to Physicians, Midwives or others, but must use it only for preparing County Clerk's (or Local Registrar's) Copies.

Local Registrars MUST NOT issue

STATE OF ILLINOIS
Department of Public Health - Division of VITAL STATISTICS

COUNTY CLERK'S RECORD

CERTIFICATE OF BIRTH

Registered No. 209 (Consecutive No.)

1. PLACE OF BIRTH

County of Cook

Registration Dist. No. 4318

(Show on line below the name of place where Birth occurred; give either City (or Village) or Township (or Road District), not both.)

Township, or Road District, or Village, or City, of Oak Park

Primary Dist. No. 4318

Street and Number, No. West Suburban Hospital St., ... Ward, ... Hospital

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

2. FULL NAME OF CHILD Marion Charlotte Anderson (If child is not yet named, make supplemental report, as directed)

3. Sex of Child: Female

4. Twin, triplet, or other? ..... (To be answered only in event of plural births)

5. Number in order of birth .....

6. Legitimate? Yes

7. Date of birth February 28th, 1923 (Month) (Day) (Year)

FATHER

8. FULL NAME Charles Anderson

9. RESIDENCE (P. O. Address) Chicago, Illinois

10. COLOR White

11. AGE AT LAST BIRTHDAY 31 Years

12. BIRTHPLACE (City or Place) .....
(Name State if in U. S.) Illinois
(Name Country, if Foreign) .....

13. OCCUPATION Clerk
(Nature of Industry) .....

MOTHER

14. FULL MAIDEN NAME Emma Heilmann

15. RESIDENCE (P. O. Address) 5003 Irving Park Blvd.

16. COLOR White

17. AGE AT LAST BIRTHDAY 27 Years

18. BIRTHPLACE (City or Place) .....
(Name State if in U. S.) New Hampshire
(Name Country, if Foreign) .....

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 1 (b) Born alive but now dead ..... (c) Stillborn .....

WHAT TREATMENT WAS GIVEN CHILD'S EYES AT BIRTH? Crede'

21. CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive at 7:55 P. M., on the date above stated.

*When there is no attending physician or midwife, then the father, mother, householder, etc., shall make this return. See Sec. 12 vital statistics law.

22. [Signature] R.C. Oldfield, M. D. Midwife (Physician or Midwife)

Address 104 N. Oak Park Ave., Telephone O.P.8600

Date Certificate Signed ..... (Month) (Day) 19.... (Year)

23. Given name added from a supplemental report ..... (Month) (Day) 19.... (Year)

..... Registrar

24. Filed March 8th., 1923 F.S. Needham, MD. Registrar

Post Office Address Oak Park, Illinois

STATE OF LOUISIANA
CERTIFICATION OF VITAL RECORD

2268263

STATE OF LOUISIANA
CERTIFICATE OF LIVE BIRTH

Birth No. 117 71 30 331

IMPORTANT: Black Ink or Typewriter Ribbon Mandatory By State Law.

THIS CHILD (Type or print names. Do not use numerals for month of birth.) Please abbreviate month.

1A. CHILD'S LAST NAME: Jindal
1B. FIRST NAME: Piyush
1C. SECOND NAME:
2A. DATE OF BIRTH (MONTH DAY YEAR): June 10, 1971
3. SEX—GIRL OR BOY?: Boy
4. THIS BIRTH: Single [X] Twin [ ] Triplet [ ]
5. IF TWIN OR TRIPLET, WAS CHILD BORN: 1st [ ] 2d [ ] 3d [ ]
2B. HOUR OF BIRTH: 12:27 PM

PLACE OF BIRTH 94 171

6A. PLACE OF BIRTH (CITY, TOWN, OR LOCATION): Baton Rouge
6B. PARISH OF BIRTH: East Baton Rouge
6C. NAME OF HOSPITAL OR INSTITUTION—(IF NOT IN HOSPITAL OR INSTITUTION GIVE STREET ADDRESS OR LOCATION): Woman's Hospital
6D. IS PLACE OF BIRTH INSIDE CITY LIMITS? Yes [X] No [ ]

USUAL RESIDENCE OF MOTHER 171 (Where does mother live?)

7A. USUAL RESIDENCE OF MOTHER (CITY, TOWN OR LOCATION): Baton Rouge
7B. PARISH: East Baton Rouge
7C. STATE: Louisiana
7D. STREET ADDRESS—(IF RURAL INDICATE LOCATION): Physics Department LSU
7E. IS RESIDENCE INSIDE CITY LIMITS? Yes [X] No [ ]

FATHER OF CHILD

8A. FULL NAME OF FATHER: Amar Jindal
8B. CITY AND STATE OF BIRTH (IF NOT IN U.S.A. NAME COUNTRY): India
8C. AGE (AT TIME OF THIS BIRTH): 28
8D. COLOR OR RACE OF FATHER: Indian

MOTHER OF CHILD

9A. FULL MAIDEN NAME OF MOTHER: Raj Gupta
9B. CITY AND STATE OF BIRTH (IF NOT IN U.S.A. NAME COUNTRY): India
9C. AGE (AT TIME OF THIS BIRTH): 27
9D. COLOR OR RACE OF MOTHER: Indian

INFORMANT'S CERTIFICATION

I certify that the above stated information is true and correct to the best of my knowledge.
10. SIGNATURE OF PARENT OR OTHER INFORMANT: A Jindal — Parent [X] Other [ ]
11. DATE OF SIGNATURE: 6-10-71
12. MOTHER'S MAILING ADDRESS: Physics Department LSU, BAton Rouge, La. 70803

ATTENDANT'S CERTIFICATION

I certify that I attended this birth and that the child was born alive on the date stated above.
13. SIGNATURE OF ATTENDANT: Rabelais R. Ray Rabelais — M.D. [X] Midwife [ ] Other [ ]
14. DATE OF SIGNATURE: 6-13-71

REGISTRAR'S CERTIFICATION

15. DATE ACCEPTED BY LOCAL REGISTRAR: AUG 11 1971
16. SIGNATURE OF LOCAL REGISTRAR: A. S. Bennett, M.D.
17. DATE FILED BY STATE REGISTRAR: AUG 13 1971

MAY 06 201

002268263

I CERTIFY THAT THIS IS A TRUE AND CORRECT COPY OF A CERTIFICATE OR DOCUMENT REGISTERED WITH THE VITAL RECORDS REGISTRY OF THE STATE OF LOUISIANA, PURSUANT TO LSA – R.S.40:32, ET SEQ.

Darlene W Smith
STATE REGISTRAR

WARNING: It is illegal to alter or counterfeit this copy.

STATE OF HAWAII

CERTIFICATE OF LIVE BIRTH

FILE NUMBER 151

DEPARTMENT OF HEALTH 61 10641

1a. Child's First Name (Type or print): BARACK
1b. Middle Name: HUSSEIN
1c. Last Name: OBAMA, II

2. Sex: Male
3. This Birth: Single [X] Twin [ ] Triplet [ ]
4. If Twin or Triplet, Was Child Born: 1st [ ] 2nd [ ] 3rd [ ]
5a. Birth Date: Month August, Day 4, Year 1961
5b. Hour: 7:24 P.M.

6a. Place of Birth: City, Town or Rural Location: Honolulu
6b. Island: Oahu

6c. Name of Hospital or Institution (If not in hospital or institution, give street address): Kapiolani Maternity & Gynecological Hospital
6d. Is Place of Birth Inside City or Town Limits? If no, give judicial district: Yes [X] No [ ]

7a. Usual Residence of Mother: City, Town or Rural Location: Honolulu
7b. Island: Oahu
7c. County and State or Foreign Country: Honolulu, Hawaii

7d. Street Address: 6085 Kalanianaole Highway
7e. Is Residence Inside City or Town Limits? If no, give judicial district: Yes [X] No [ ]

7f. Mother's Mailing Address:
7g. Is Residence on a Farm or Plantation? Yes [ ] No [X]

8. Full Name of Father: BARACK HUSSEIN OBAMA
9. Race of Father: African

10. Age of Father: 25
11. Birthplace (Island, State or Foreign Country): Kenya, East Africa
12a. Usual Occupation: Student
12b. Kind of Business or Industry: University

13. Full Maiden Name of Mother: STANLEY ANN DUNHAM
14. Race of Mother: Caucasian

15. Age of Mother: 18
16. Birthplace (Island, State or Foreign Country): Wichita, Kansas
17a. Type of Occupation Outside Home During Pregnancy: None
17b. Date Last Worked:

I certify that the above stated information is true and correct to the best of my knowledge.
18a. Signature of Parent or Other Informant: Stanley Ann Dunham Obama (Parent [X] Other [ ])
18b. Date of Signature: 8-7-61

I hereby certify that this child was born alive on the date and hour stated above.
19a. Signature of Attendant: David A Smilan (M.D. [X] D.O. [ ] Midwife [ ] Other [ ])
19b. Date of Signature: 8-8-61

20. Date Accepted by Local Reg.: AUG - 8 1961
21. Signature of Local Registrar: U K Lee
22. Date Accepted by Reg. General: AUG - 8 1961

23. Evidence for Delayed Filing or Alteration:

STATE OF MICHIGAN
CERTIFICATE OF LIVE BIRTH

State File Number: **121-582-0882827** Date Filed: **March 17, 1947**
Child's Name (First, Middle, Last, Suffix): **Willard Mitt Romney**
Date of Birth: **March 12, 1947**
Gender: **Male**
Child's Birthplace: **Detroit, Wayne County**
Mother's Name Before First Married: **Lenore Lafount**
Mother's Birthplace: **Utah** Mother's Age: **36**
Father's Name: **George Romney**
Father's Birthplace: **Mexico** Father's Age: **39**

I hereby certify that the above is a true and correct representation of the birth facts on file with the Division for Vital Records, Michigan Department of Community Health.

Certified by: Alan Gerland

Date Issued: **January 18, 2012**
AFS: 2249411

OFFICE of VITAL STATISTICS

CERTIFICATION OF BIRTH

STATE FILE NUMBER: **109-1962-200000**

CHILD'S NAME: **SAMPLE SAMPLE SAMPLE**

DATE OF BIRTH: **DECEMBER 30, 1962**

SEX: **FEMALE**

COUNTY OF BIRTH: **DUVAL**

DATE FILED: **DECEMBER 30, 1962**

MOTHER'S MAIDEN NAME: **SAMPLE SAMPLE SAMPLE**

FATHER'S NAME: **SAMPLE SAMPLE SAMPLE**

DATE ISSUED: **MARCH 22, 2005**

John Hancock, **State Registrar**

THE ABOVE SIGNATURE CERTIFIES THAT THIS IS A TRUE AND CORRECT COPY OF THE OFFICIAL RECORD ON FILE IN THIS OFFICE.
THIS DOCUMENT IS PRINTED OR PHOTOCOPIED ON SECURITY PAPER WITH A WATERMARK.

WARNING:

CDC

B1426036

CERTIFICATION OF VITAL RECORD

VOID IF ALTERED OR ERASED

VOID IF ALTERED OR ERASED

THE CITY OF NEW YORK

VITAL RECORDS CERTIFICATE

CERTIFICATION OF BIRTH

This is a certification of name and birth facts on file in the Office of Vital Records, Department of Health and Mental Hygiene, City of New York.

DATE OF BIRTH JUNE 14, 1946 CERTIFICATE No. 07624

BOROUGH QUEENS DATE FILED 06-17-46 DATE ISSUED 05-22-12

NAME DONALD JOHN TRUMP ***

SEX MALE

MOTHER/PARENT'S NAME MARY MAC LEOD

FATHER/PARENT'S NAME FRED C. TRUMP

Steven P. Schwartz, Ph.D.
City Registrar

The City of New York

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N 0 0 1 5 3 4 3 1

ANY ALTERATION OR ERASURE VOIDS THIS CERTIFICATE

OFFICE of VITAL STATISTICS

VOID IF ALTERED OR ERASED

U.S. STANDARD

CERTIFICATE OF LIVE BIRTH

LOCAL FILE NUMBER — BIRTH NUMBER

CHILD

1. CHILD'S NAME (First, Middle, Last)
2. DATE OF BIRTH (Month, Day, Year)
3. TIME OF BIRTH
4. SEX
5. CITY, TOWN, OR LOCATION OF BIRTH
6. COUNTY OF BIRTH
7. PLACE OF BIRTH: ☐ Hospital ☐ Freestanding Birthing Center ☐ Clinic/Doctor's Office ☐ Residence ☐ Other (Specify)
8. FACILITY NAME (If not institution, give street and number)

CERTIFIER/ ATTENDANT

9. I certify that this child was born alive at the place and time and on the date stated. Signature ▶
10. DATE SIGNED (Month, Day, Year)
11. ATTENDANT'S NAME AND TITLE (If other than certifier) (Type/Print) Name ☐ M.D. ☐ D.O. ☐ C.N.M. ☐ Other Midwife ☐ Other (Specify)
12. CERTIFIER'S NAME AND TITLE (Type/Print) Name ☐ M.D. ☐ D.O. ☐ Hospital Admin. ☐ C.N.M. ☐ Other Midwife ☐ Other (Specify)
13. ATTENDANT'S MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
14. REGISTRAR'S SIGNATURE ▶
15. DATE FILED BY REGISTRAR (Month, Day, Year)

MOTHER

16a. MOTHER'S NAME (First, Middle, Last)
16b. MAIDEN SURNAME
17. DATE OF BIRTH (Month, Day, Year)
18. BIRTHPLACE (State or Foreign Country)
19a. RESIDENCE—STATE
19b. COUNTY
19c. CITY, TOWN, OR LOCATION
19d. STREET AND NUMBER
19e. INSIDE CITY LIMITS? (Yes or no)
20. MOTHER'S MAILING ADDRESS (If same as residence, enter Zip Code on

FATHER

21. FATHER'S NAME (First, Middle, Last)
22. DATE OF BIRTH (Month, Day, Year)
23. BIRTHPLACE (State or Foreign Country)

INFORMANT

24. I certify that the personal information provided on this certificate is correct to the best of my knowledge and belief. Signature of Parent or Other Informant ▶

INFORMATION FOR MEDICAL AND HEALTH USE ONLY

	25. OF HISPANIC ORIGIN? (Specify No or Yes—If yes, specify Cuban, Mexican, Puerto Rican, etc.)	26. RACE—American Indian, Black, White, etc. (Specify below)	27. EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	College (1-4 or 5+)
MOTHER	25a. ☐ No ☐ Yes Specify:	26a.	27a.	
FATHER	25b. ☐ No ☐ Yes Specify:	26b.	27b.	

28. PREGNANCY HISTORY (Complete each section)

LIVE BIRTHS (Do not include this child)		OTHER TERMINATIONS (Spontaneous and induced at any time after conception)
28a. Now Living Number ____ ☐ None	28b. Now Dead Number ____ ☐ None	28d. Number ____ ☐ None
28c. DATE OF LAST LIVE BIRTH (Month, Year)		28e. DATE OF LAST OTHER TERMINATION (Month, Year)

29. MOTHER MARRIED? (At birth, conception, or any time between) (Yes or no)
30. DATE LAST NORMAL MENSES BEGAN (Month, Day, Year)
31. MONTH OF PREGNANCY PRENATAL CARE BEGAN—First, Second, Third, etc. (Specify)
32. PRENATAL VISITS—Total Number (If none, so state)
33. BIRTH WEIGHT (Specify unit)
34. CLINICAL ESTIMATE OF GESTATION (Weeks)
35a. PLURALITY—Single, Twin, Triplet, etc. (Specify)
35b. IF NOT SINGLE BIRTH—Born First, Second, Third, etc. (Specify)

36. APGAR SCORE
36a. 1 Minute
36b. 5 Minutes

37a. MOTHER TRANSFERRED PRIOR TO DELIVERY? ☐ No ☐ Yes If Yes, enter name of facility transferred from:

37b. INFANT TRANSFERRED? ☐ No ☐ Yes If Yes, enter name of facility transferred to:

John Hancock, State Registrar

THE ABOVE SIGNATURE CERTIFIES THAT THIS IS A TRUE AND CORRECT COPY OF THE OFFICIAL RECORD ON FILE IN THIS OFFICE.
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WARNING:

CDC

B1426036

CERTIFICATION OF VITAL RECORD

STATE OF CALIFORNIA

CERTIFICATION OF VITAL RECORD

COUNTY [redacted]

CERTIFICATE OF LIVE BIRTH

STATE OF CALIFORNIA

USE BLACK INK ONLY

STATE FILE NUMBER

LOCAL REGISTRATION NUMBER

THIS CHILD	1A. NAME OF CHILD - FIRST	1B. MIDDLE	1C. LAST		
	2. SEX	3A. THIS BIRTH: SINGLE, TWIN, ETC.	3B. IF MULTIPLE, THIS CHILD 1ST, 2ND, ETC.	4A. DATE OF BIRTH - MM/DD/CCYY	4B. HOUR - 24 HOUR CLOCK TIME
PLACE OF BIRTH	5A. PLACE OF BIRTH - NAME OF HOSPITAL OR FACILITY		5B. STREET ADDRESS - STREET AND NUMBER OR LOCATION		
	5C. CITY		5D. COUNTY		
FATHER/PARENT	6A. NAME OF FATHER/PARENT - FIRST	6B. MIDDLE	6C. LAST	6D. BIRTHPLACE - STATE/COUNTRY	6E. DATE OF BIRTH - MM/DD/CCYY
MOTHER/PARENT	7A. NAME OF MOTHER/PARENT - FIRST	7B. MIDDLE	7C. LAST - MAIDEN NAME	COUNTRY	
INFORMANT AND BIRTH CERTIFICATION	I CERTIFY THAT I HAVE REVIEWED THE STATED INFORMATION AND THAT IT IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE	12A. PARENT, NEXT OF KIN, OR OTHER RELATIVE		12B. RELATIONSHIP TO CHILD	
	I CERTIFY THAT THE CHILD WAS BORN ALIVE AT THE DATE, HOUR, AND PLACE STATED			12C. LICENSE NUMBER	
	13D. TYPED NAME, TITLE AND MAILING ADDRESS OF ATTENDANT			14. TYPED NAME AND TITLE OF CERTIFIER IF OTHER THAN ATTENDANT	
LOCAL REGISTRAR	15A. DATE OF EXAMINATION - MM/DD/CCYY	15B. STATE FILE NO. - STATE USE ONLY	15C. LOCAL REGISTRAR - LOCAL USE	15D. DATE ACCEPTED FOR REGISTRATION - MM/DD/CCYY	

1TRANSLATE.COM

CERTIFIED COPY OF VITAL RECORDS

STATE OF CALIFORNIA
COUNTY OF CONTRA COSTA } SS

DATE ISSUED [redacted]

This is a true and exact reproduction of the document officially registered and placed on file in the office of the CONTRA COSTA COUNTY DEPARTMENT OF HEALTH SERVICES. [redacted]

CONTRA COSTA COUNTY HEALTH OFFICER

This copy not valid unless prepared on engraved border displaying seal and signature of Contra Costa County Health Officer.

ANY ALTERATION OR ERASURE VOIDS THIS CERTIFICATE