

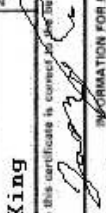


## STATE OF ONTARIO

VOID IF ALTERED OR ERASED

VOID IF ALTERED OR ERASED

LOCAL FILE NUMBER		CERTIFICATE OF LIVE BIRTH		BIRTH NUMBER	
1. CHILD'S NAME (First, Middle, Last) <b>ANNE ELIZABETH KING</b>	2. DATE OF BIRTH (Month, Day, Year) <b>02/14/1982</b>	3. TIME OF BIRTH <b>9:14 am</b>			
4. SEX <b>F</b>	5. CITY, TOWN, OR LOCATION OF BIRTH <b>Toronto General Hospital</b>	6. COUNTY OF BIRTH <b>Canada</b>			
7. PLACE OF BIRTH: <input checked="" type="checkbox"/> Hospital <input type="checkbox"/> Free-standing Birthing Center <input type="checkbox"/> Clinic/Doctor's Office <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify):		8. FACILITY NAME (If not matches, give street and number) <b>200 Elizabeth Street Toronto, ON M5G 2C4, Canada</b>			
9. I certify that this child was born alive at the place and time and on the day stated.  Signature:  <b>Jane Cutsinger</b> Date: <b>02/16/82</b>		11. ATTENDANT'S NAME AND TITLE (If other than certified) (Type/print) <b>Gerald Spencer</b> Name: _____ <input checked="" type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> C.N.M. <input type="checkbox"/> Other Midwife <input type="checkbox"/> Other (Specify):			
12. CERTIFIER'S NAME AND TITLE (Type/print) <b>Jane Cutsinger</b> Name: _____ <input type="checkbox"/> M.D. <input checked="" type="checkbox"/> Hospital Admin. <input type="checkbox"/> C.N.M. <input type="checkbox"/> Other Midwife <input type="checkbox"/> Other (Specify):		13. ATTENDANT'S MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
14. REGISTRAR'S SIGNATURE  <b>Doris Anne King</b>		15. DATE FILED BY REGISTRAR (Month, Day, Year) <b>02/18/1982</b>			
16a. MOTHER'S NAME (First, Middle, Last) <b>Doris Anne King</b>		16b. MAIDEN SURNAME <b>Harrison</b>		17. DATE OF BIRTH (Month, Day, Year) <b>12/2/1953</b>	
18. BIRTHPLACE (State or Foreign Country) <b>Ontario, Canada</b>		19a. RESIDENCE—STATE <b>Ontario</b>		19b. CITY, TOWN, OR LOCATION <b>Toronto</b>	
19c. STREET AND NUMBER		20. MOTHER'S MAILING ADDRESS (If same as residence, enter Zip Code on			
21. FATHER'S NAME (First, Middle, Last) <b>James Patrick King</b>		22. DATE OF BIRTH (Month, Day, Year) <b>10/15/1951</b>		23. BIRTHPLACE (State or Foreign Country) <b>Ontario</b>	
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 (14 or 5+)	
25a. <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Specify:		26a. <b>White</b>		27a. <b>12</b>	
25b. <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Specify:		26b. <b>White</b>		27b. <b>12</b>	
28. PREGNANCY HISTORY (Complete each section) <b>OTHER TERMINATIONS</b> (Specify date and indicate if any two after conception)		29. MOTHER MARRIED? (At birth, conception, or any time between) (Yes or no)		30. DATE LAST NORMAL MENSTRUATION BEGAN (Month, Day, Year)	
28a. Live Births (Do not include this child)		29a. <b>White</b>		30a. <b>2</b>	
28b. Now Living		29b. <b>White</b>		30b. <b>4</b>	
28c. Number _____ None <input type="checkbox"/> None <input type="checkbox"/> None <input type="checkbox"/>		31. MONTH OF PREGNANCY PRENATAL CARE BEGAN—First, Second, Third, etc. (Specify)		32. PRENATAL VISITS—Total Number (If none, so state)	
28d. DATE OF LAST LIVE BIRTH (Month, Year)		33. BIRTH WEIGHT (Specify unit)		34. CLINICAL ESTIMATE OF GESTATION (Weeks)	
28e. Number _____ None <input type="checkbox"/> None <input type="checkbox"/>		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? <input type="checkbox"/> No <input type="checkbox"/> Yes, enter name of facility transferred here:			
37b. INFANT TRANSFERRED? <input type="checkbox"/> No <input type="checkbox"/> Yes, enter name of facility transferred here:					



State Registrar

THE ABOVE SIGNATURE CERTIFIES THAT THIS IS A TRUE AND CORRECT COPY OF THE ORIGINAL RECORD ON FILE IN THIS OFFICE.  
THIS DOCUMENT IS PRINTED ON PHOTO-COPIED SECURITY PAPER WITH A WATERMARK.

CDC



B1426036

CERTIFICATION OF VITAL RECORD