

18846
NEW JERSEY STATE DEPARTMENT OF HEALTH

BIRTH No. 129-

(Will be inserted by State Office.)

974M

1. PLACE OF BIRTH		2. USUAL RESIDENCE OF MOTHER (Where does mother live?)	
a. COUNTY	Burlington	a. STATE	b. COUNTY
b. CITY	(Check box and give name)	c. CITY	(Check box and give name)
BOROUGH		BOROUGH	
TOWNSHIP	Mansfield	TOWNSHIP	
c. NAME (If not in hospital or institution give street address or location)		d. STREET ADDRESS	
OF HOSPITAL		OF MOTHER	
OR INSTITUTION		IF RURAL, P.O. ADDRESS	
3. CHILD'S NAME		a. (First)	
(Type or Print)		Arthure	
		b. (Middle)	
		James	
		c. (Last)	
		Weeast	
4. SEX	5a. THIS BIRTH	6b. IF TWIN OR TRIPLET (This child born)	6. DATE (Month) (Day) (Year)
Male	Single <input type="checkbox"/> Twin <input type="checkbox"/> Triplet <input type="checkbox"/>	1st <input type="checkbox"/> 2nd <input type="checkbox"/> 3rd <input type="checkbox"/>	OF BIRTH September 30, 1919
FATHER OF CHILD			
7. FULL NAME		8. COLOR OR RACE	
a. (First)		b. (Middle)	
Ford		-----	
		c. (Last)	
		Weeast	
9. AGE (at time of this birth)	10. BIRTHPLACE	11a. USUAL OCCUPATION	11b. KIND OF BUSINESS OR INDUSTRY
YEARS			
MOTHER OF CHILD			
12. FULL MAIDEN NAME		13. COLOR OR RACE	
a. (First)		b. (Middle)	
Helen		May	
		c. (Last)	
		Pullen	
14. AGE (At time of this birth)	15. BIRTHPLACE	16. CHILDREN PREVIOUSLY BORN TO THIS MOTHER (Do NOT include this child)	
YEARS		a. How many OTHER children are now living?	
		b. How many OTHER children were born alive but are now dead?	
		c. How many children were stillborn (born dead after 20 weeks' pregnancy)?	
17. INFORMANT			
I hereby certify that this child was born alive on the date stated above at _____ m.		18a. SIGNATURE	
		18b. ATTENDANT AT BIRTH	
		M.D. <input type="checkbox"/> MIDWIFE <input type="checkbox"/> OTHER (Specify)	
		18c. ADDRESS	
		18d. DATE SIGNED	
19. DATE REC'D BY LOCAL REG.	20. REGISTRAR'S SIGNATURE	21. DATE ON WHICH GIVEN NAME ADDED BY (Registrar)	
FOR MEDICAL AND HEALTH USE ONLY (This section MUST be filled out)			
22a. LENGTH OF PREGNANCY WEEKS	22b. WEIGHT AT BIRTH LBS. OZS.	23. LEGITIMATE YES <input type="checkbox"/> NO <input type="checkbox"/>	24a. Was a Blood Test for Syphilis made during pregnancy?
25. What Preventive for Ophthalmia Neonatorum was used?		24b. Date Specimen Taken	

For Congenital Deformity report on form available from hospital record room.