

This is to certify, that the following is a correct certification of birth as filed in the Bureau of Vital Statistics, New York State Department of Health.



STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

\_\_\_\_\_ Date  
Primary Dist. No. \_\_\_\_\_

\_\_\_\_\_ Secretary of Health

- 1. PLACE OF BIRTH
- County \_\_\_\_\_
- Township \_\_\_\_\_
- Borough \_\_\_\_\_
- City \_\_\_\_\_

File No. \_\_\_\_\_

Registered No. \_\_\_\_\_

- 2. Full name of child \_\_\_\_\_ 3. Sex \_\_\_\_\_ 4. Birthdate \_\_\_\_\_, 19\_\_\_\_  
(Month, day, year)
- 5. Name of father \_\_\_\_\_ 6. Maiden name of mother \_\_\_\_\_

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child who was \_\_\_\_\_ at \_\_\_\_\_ at \_\_\_\_\_ m. on the date above stated.  
(born alive or stillborn)

Do not accept this certification unless the raised seal of the Department of Health is affixed hereon.

(Signed) \_\_\_\_\_ M.D.  
D.O.  
Midwife

Address \_\_\_\_\_

Filed \_\_\_\_\_ 19 \_\_\_\_\_ Registrar

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