

**MAJIN REVERSED FOR HINDING.**

UNIVERSITY OF CALIFORNIA, CALIFORNIA 9 5

County of .....

Township of .....

Inc. Town of.....

of \_\_\_\_\_  
 City of \_\_\_\_\_

(If birth occurs in a hospital or other institution, give name of same instead of street and number.)

(2) Full Name of Child William Callison If child is not yet named, make supplemental report as directed.

3 BOY OR  
GIRL

(4) Twin or Triplet?

(5) Number in order of birth

(5) Are Parents Married?

(7) DATE OF BIRTH 24 5 1922  
(Name of Month) (Day) (Year)

**FATHER.**

(8) FULL NAME

9) PRESENT  
POSTOFFICE  
OF FATHER

4 (M) COLOR  
OR  
FACE

(17) AGE AT LAST BIRTHDAY

12 BIRTHPLACE

13) OCCUPATION

29) Number of children born to mother, including present birth

**CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE:**

(22) I hereby certify that I attended the birth of this child, who was on the date above stated.

(23) (Signature)

(23) (Signature)		(25) Address of Physician or Midwife	
(24) State whether Physician or Midwife			

Midway

Address of Physician or Midwife

Given name added from a supplement-  
tal report

(28) Witness

(Signature of Witness necessary only  
when question 23 is signed by mark)

67 Filed

(28) 12/11/20 Local Registrar.

When there was no attending physician or midwife, then the father, householder, etc. should make this return. If a child breathes even once, it must not be reported as stillborn. No report is desired of stillbirths before the fifth month of pregnancy.