

1976 79

CERTIFICATE OF LIVE BIRTH  
STATE OF NEW MEXICO



DEPARTMENT OF  
HEALTH -  
SOCIAL  
SERVICES

1. PLACE OF BIRTH a. COUNTY		2. USUAL RESIDENCE OF MOTHER (Where does mother live?) a. STATE		b. COUNTY	
b. CITY (If outside corporate limits, write RURAL) OR TOWN		c. CITY (If outside corporate limits, write RURAL) OR TOWN		d. STREET ADDRESS	
3. CHILD'S NAME (Type or Print) a. (First)		b. (Middle)		c. (Last)	
4. SEX	5a. THIS BIRTH Single <input type="checkbox"/> Twin <input type="checkbox"/> Triplet <input type="checkbox"/>	5b. IF TWINS, DATE OF BIRTH	6. DATE OF BIRTH	7. FULL NAME a. (First)	
8. FULL NAME a. (First)		b. (Middle)		c. (Last)	
9. AGE (At time of this birth) YEARS		10. BIRTHPLACE (State or foreign country)		11a. USUAL OCCUPATION	
12. FULL MAIDEN NAME a. (First)		b. (Middle)		c. (Last)	
14. AGE (At time of this birth) YEARS		15. BIRTHPLACE (State or foreign country)		16. PARENT'S MAILING ADDRESS FOURTEEN DAY PRE-NOTICE:	
17. INFORMANT'S NAME		18a. SIGNATURE		18b. ATTENDANT AT BIRTH M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> Midwife <input type="checkbox"/> Other <input type="checkbox"/>	
19. DATE REC'D BY LOCAL REG.		20. REGISTRAR'S SIGNATURE		21. DATE ON WHICH GIVEN NAME ADDRESS BY (Registrar)	
22. Was Mother tested for syphilis? Yes <input type="checkbox"/> No <input type="checkbox"/>		23. Length of pregnancy in weeks		24. Infant's Wt. at birth Lbs.	
25a. State any complications of pregnancy and labor		25b. State any operation for ocular injury		25c. Describe any birth injury	
26a. State any complications of pregnancy and labor		26b. Was prophylactic drug used in baby's eyes? Yes <input type="checkbox"/> No <input type="checkbox"/>		26c. State drug:	

**NOT A VALID CERTIFICATE**

BINDING MARGIN ONLY  
DO NOT WRITE IN THIS SPACE