

PLACE OF BIRTH		INDIANA STATE BOARD OF HEALTH	
County of <u>Henry</u>		DIVISION OF VITAL STATISTICS	
Township of <u>Harrison</u>		Local No. <u>21452</u>	
Town of .....		State Registered No. ....	
or			
City of .....		(No. ...., St., .... Ward)	
FULL NAME OF CHILD <u>Cris Milton Robbins</u>			
If child is not named, make supplemental report.			
Sex of Child <u>M</u>	Twins, Triplets, or others? <u>=</u>	Number in order of birth <u>=</u>	Legitimate? <u>Yes</u>
(To be answered only in event of plural births)		Date of Birth <u>April 28</u> 19 <u>26</u>	
(Month) (Day) (Year)			
FATHER		MOTHER	
Full Name <u>Oscar E Robbins</u>		Full Maiden Name <u>Grace Foulke</u>	
Postoffice Address <u>New Castle RR 8</u>		Postoffice Address <u>New Castle Ind RR 8</u>	
Color or Race <u>White</u>	Age at last Birthday <u>50</u> (Years)	Color or Race <u>White</u>	Age at last Birthday <u>46</u> (Years)
Birthplace <u>Indiana</u>		Birthplace <u>Indiana</u>	
Occupation <u>Farming</u>		Occupation <u>Housewife</u>	
Number of children born to this mother, including present birth <u>6</u>		Number of children, of this mother, now living, including present birth <u>6</u>	
		Were precautions taken against ophthalmia neonatorum? <u>Yes</u>	
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*			
I hereby certify that I attended the birth of this child, who was <u>Born alive</u> at <u>1</u> A.M.			
(Born alive or Stillborn)			
on the date above stated.			
* When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.		(Signature) <u>J W Horton MD</u>	
Given name added from a supplemental report .....		(Attending physician, midwife, householder)	
Address <u>Kennard Ind</u>			
Filed <u>May 15, 1926</u>		<u>C. Cassidy</u>	
HEALTH OFFICER		HEALTH OFFICER	