OFFICE of VITAL STATISTICS

VOID IF ALTERED OR ERASED

STATE OF ONTARIO

CERTIFICATE OF LIVE BIRTH

LOCAL FILE NUMBER | BIRTH NUMBER

CHILD

1. CHILD'S NAME (First, Middle, Last)	2. DATE OF BIRTH (Month, Day, Year)	3. TIME OF BIRTH
ANNE ELIZABETH KING	02/14/1982	9:14 am

4. SEX	5. CITY, TOWN, OR LOCATION OF BIRTH	6. COUNTY OF BIRTH
F	Toronto General Hospital	Canada

7. PLACE OF BIRTH: ☒ Hospital ☐ Freestanding Birthing Center ☐ Clinic/Doctor's Office ☐ Residence ☐ Other (Specify)

8. FACILITY NAME (If not institution, give street and number): 200 Elizabeth Street Toronto, ON M5G 2C4, Canada

CERTIFIER/ATTENDANT

9. I certify that this child was born alive at the place and time and on the date stated. Signature ▶ [signature]

10. DATE SIGNED (Month, Day, Year): 02/16/82

11. ATTENDANT'S NAME AND TITLE (If other than certifier) (Type/Print) Name: Gerald Spencer ☒ M.D. ☐ D.O. ☐ C.N.M. ☐ Other Midwife ☐ Other (Specify)

12. CERTIFIER'S NAME AND TITLE (Type/Print) Name: Jane Cutsinger ☐ M.D. ☐ D.O. ☒ Hospital Admin. ☐ C.N.M. ☐ Other Midwife ☐ Other (Specify)

13. ATTENDANT'S MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 100 Grant St. Toronto, ON M5G 2C4, Canada

14. REGISTRAR'S SIGNATURE ▶ [signature]

15. DATE FILED BY REGISTRAR (Month, Day, Year): 02/18/1982

MOTHER

16a. MOTHER'S NAME (First, Middle, Last)	16b. MAIDEN SURNAME	17. DATE OF BIRTH (Month, Day, Year)
Doris Anne King	Harrison	12/2/1953

18. BIRTHPLACE (State or Foreign Country)	19a. RESIDENCE—STATE	19b. COUNTY	19c. CITY, TOWN, OR LOCATION
Ontario, Canada	Ontario	Canada	Toronto

19d. STREET AND NUMBER | 19e. INSIDE CITY LIMITS? (Yes or no) | 20. MOTHER'S MAILING ADDRESS (If same as residence, enter Zip Code on

FATHER

21. FATHER'S NAME (First, Middle, Last)	22. DATE OF BIRTH (Month, Day, Year)	23. BIRTHPLACE (State or Foreign Country)
James Patrick King	10/15/1951	Ontario

INFORMANT

24. I certify that the personal information provided on this certificate is correct to the best of my knowledge and belief. Signature of Parent or Other Informant ▶ [signature]

INFORMATION FOR MEDICAL AND HEALTH USE ONLY

	25. OF HISPANIC ORIGIN? (Specify No or Yes—If yes, specify Cuban, Mexican, Puerto Rican, etc.)	26. RACE—American Indian, Black, White, etc. (Specify below)	27. EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	College (1-4 or 5+)
MOTHER	25a. ☒ No ☐ Yes Specify:	26a. White	27a. 12	2
FATHER	25b. ☒ No ☐ Yes Specify:	26b. White	27b. 12	4

28. PREGNANCY HISTORY (Complete each section)

LIVE BIRTHS (Do not include this child): 28a. Now Living Number ___ ☐ None; 28b. Now Dead Number ___ ☐ None; 28c. DATE OF LAST LIVE BIRTH (Month, Year)

OTHER TERMINATIONS (Spontaneous and induced at any time after conception): 28d. Number ___ ☐ None; 28e. DATE OF LAST OTHER TERMINATION (Month, Year)

29. MOTHER MARRIED? (At birth, conception, or any time between) (Yes or no)

30. DATE LAST NORMAL MENSES BEGAN (Month, Day, Year)

31. MONTH OF PREGNANCY PRENATAL CARE BEGAN—First, Second, Third, etc. (Specify)

32. PRENATAL VISITS—Total Number (If none, so state)

33. BIRTH WEIGHT (Specify unit)

34. CLINICAL ESTIMATE OF GESTATION (Week

35a. PLURALITY—Single, Twin, Triplet, etc. (Specify)

35b. IF NOT SINGLE BIRTH—Born First, Second, Third, etc. (Specify)

36. APGAR SCORE: 36a. 1 Minute | 36b. 5 Minutes

37a. MOTHER TRANSFERRED PRIOR TO DELIVERY? ☐ No ☐ Yes If Yes, enter name of facility transferred from:

37b. INFANT TRANSFERRED? ☐ No ☐ Yes If Yes, enter name of facility transferred to:

[signature], State Registrar

THE ABOVE SIGNATURE CERTIFIES THAT THIS IS A TRUE AND CORRECT COPY OF THE OFFICIAL RECORD ON FILE IN THIS OFFICE.

THIS DOCUMENT IS PRINTED OR PHOTOCOPIED ON SECURITY PAPER WITH A WATERMARK

WARNING:

B1426036

CERTIFICATION OF VITAL RECORD

VOID IF ALTERED OR ERASED