

Form 2

1. Morton, Gail Frances Kepner
FULL NAME OF CHILD MAIDEN SURNAME OF MOTHER

2. PLACE OF BIRTH: (A) COUNTY Los Angeles
(B) CITY OR TOWN Los Angeles
(C) NAME OF HOSPITAL OR INSTITUTION Queen of Angels Hospital
(D) MOTHER'S STAY BEFORE DELIVERY: 1 hr IN THIS COMMUNITY 1 hr.

3. USUAL RESIDENCE OF MOTHER: (A) LENGTH OF RESIDENCE IN CALIFORNIA: 17
(B) STATE California
(C) COUNTY Los Angeles
(D) CITY OR TOWN Hermosa Beach
(E) STREET AND NUMBER 63 - 8th St.

4. SEX Female 5. TWIN OR TRIPLET IF SO—BORN
1st 2d 3d

6. NUMBER OF MONTHS OF PREGNANCY 9 7. DATE OF BIRTH July 11, 1946
MONTH BY NAME DAY YEAR

FATHER OF CHILD
8. FULL NAME Morton, James Albert
9. COLOR OR RACE White 10. AGE AT TIME OF THIS BIRTH 35 YEARS
11. LENGTH OF RESIDENCE IN CALIFORNIA 35 YEARS
12. BIRTHPLACE Los Angeles, California
13. USUAL OCCUPATION Restaurant Owner
14. INDUSTRY OR BUSINESS Valory Restaurant
21. CHILDREN BORN TO THIS MOTHER:
(A) HOW MANY OTHER CHILDREN OF THIS MOTHER ARE NOW LIVING? 1
(B) HOW MANY OTHER CHILDREN WERE BORN ALIVE BUT ARE NOW DEAD? 0
(C) HOW MANY CHILDREN WERE BORN DEAD? 0

MOTHER OF CHILD
15. FULL MAIDEN NAME Kepner, Karlyne Burtram
16. COLOR OR RACE White 17. AGE AT TIME OF THIS BIRTH 37 YEARS
18. BIRTHPLACE Kokomo, Indiana
19. USUAL OCCUPATION Housewife
20. INDUSTRY OR BUSINESS Own Home
22. MOTHER'S MAILING ADDRESS FOR REGISTRATION NOTICE:
63 - 8th Street
Hermosa Beach
California

23. I HEREBY CERTIFY, THAT I ATTENDED THE BIRTH OF THIS CHILD WHO WAS BORN ALIVE AT THE HOUR OF 8:49 A.M. ON THE DATE ABOVE STATED AND THAT THE INFORMATION GIVEN WAS FURNISHED BY Mrs. James A. Morton RELATED TO THIS CHILD AS Mother

24. DATE RECEIVED BY LOCAL REGISTRAR JUL 22 1946
25. REGISTRAR'S SIGNATURE James A. Morton
26. GIVEN NAME ADDED _____ DATE _____ BY _____ REGISTRAR _____

ATTENDANT'S OWN SIGNATURE Karlyne Burtram
M.D., MIDWIFE OR OTHER M.D. DATE SIGNED 7-11-46
ADDRESS 947 West 8th Street, L.A.

27. (A) PREGNANCY, COMPLICATIONS OF: None
(B) LABOR, COMPLICATIONS OF: None INDUCED? No
(C) WAS THERE AN OPERATION FOR DELIVERY? No STATE ALL OPERATIONS:
(D) WAS A PROPHYLACTIC DRUG USED IN THE BABY'S EYES? Yes
IF YES, STATE DRUG AgNo3 1%

(E) DID THE BABY HAVE ANY CONGENITAL MALFORMATION? No DESCRIBE: _____
BIRTH INJURY? No DESCRIBE: _____
(F) WAS A SEROLOGICAL TEST MADE FOR SYPHILIS IN THIS MOTHER? Yes
IF SO, AT WHAT PERIOD OF GESTATION? 12-26-45 Mos.
IF NOT, WHY NOT? _____

Read and approved by _____