

# THE CITY OF NEW YORK

## VITAL RECORDS CERTIFICATE

VITAL RECORDS  
DEPARTMENT OF HEALTH  
DATE FILED BOROUGH OF MANHATTAN

**CERTIFICATE OF BIRTH**  
Birth No. \_\_\_\_\_

156-83-311505

**MAY 5 3 12 PM '83**

1. FULL NAME OF CHILD	(Type or Print) First Name <b>LATOYA</b>	Middle Name <b>TYRAIA</b>	Last Name <b>SMALLS</b>
2. SEX <b>FEMALE</b>	3a. NUMBER OF CHILDREN born of this pregnancy 3b. If more than one, number of this child in order of birth	4a. DATE (Month) OF CHILD'S BIRTH <b>APRIL</b>	(Day) (Year) <b>28, 1983</b>
4b. HOUR <b>12:43</b>	<input type="checkbox"/> AM <input checked="" type="checkbox"/> PM		
5. PLACE OF BIRTH NEW YORK CITY a. BOROUGH OF <b>BROOKLYN</b>	b. NAME OF HOSPITAL, if not in hospital, street address <b>CUMBERLAND HOSPITAL</b>		c. TYPE OF PLACE <input checked="" type="checkbox"/> Hospital <input type="checkbox"/> Home <input type="checkbox"/> Other
6a. MOTHER'S FULL MAIDEN NAME <b>LAVINA BROWN</b>		6b. MOTHER'S AGE at time of this birth <b>19</b>	6c. MOTHER'S BIRTHPLACE, State or foreign country <b>BROOKLYN N.Y.</b>
7. MOTHER'S USUAL RESIDENCE a. State <b>NEW YORK</b>		b. County <b>KINGS</b>	c. City, town or location <b>BROOKLYN</b>
		d. Street and house number <b>80 MONUMENT WALK</b>	e. Inside city limits of 7c? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
8a. FATHER'S FULL NAME <b>TYRONE OSCAR SMALLS</b>		8b. FATHER'S AGE at time of this birth <b>20</b>	8c. FATHER'S BIRTHPLACE, State or foreign country <b>NEW YORK</b>
9a. NAME OF ATTENDANT AT DELIVERY <b>J. FU</b>		9b. I CERTIFY THAT THIS CHILD WAS BORN ALIVE AT THE PLACE, DATE AND TIME GIVEN.	
Information added or amended  (Reason)  Date _____ City Registrar _____		C.N.M. R.N. D.O. M.D.  Signed _____ Name of Signer _____ Address <b>39 AUBURN PLACE</b> Date Signed <b>APRIL 28, 1983</b> 19____	
		C.N.M. R.N. D.O. M.D.  _____	
		_____	
		_____	

**BUREAU OF VITAL RECORDS**      **DEPARTMENT OF HEALTH**      **THE CITY OF NEW YORK**

Print here the mailing address of mother. →  
Copy of this certificate will be mailed to her when it is filed with the Department of Health.

Name	<b>MS. LAVINA BROWN</b>
Address	<b>80 MONUMENT WALK #1A</b>
City	<b>BROOKLYN</b> State <b>NY.</b> Zip Code <b>11205</b>



This is to certify that the foregoing is a true copy of a record on file in the Department of Health and Mental Hygiene. The Department of Health and Mental Hygiene does not certify to the truth of the statements made thereon, as no inquiry as to the facts has been provided by law.

Do not accept this transcript unless it bears the security features listed on the back. Reproduction or alteration of this transcript is prohibited by §3.19(b) of the New York City Health Code if the purpose is the evasion or violation of any provision of the Health Code or any other law.

April 18, 2023

*Gretchen Van Wye*  
Gretchen Van Wye, PhD, City Registrar



1340000533296

