

**STATE OF NEVADA**  
**CERTIFICATION OF VITAL RECORD**

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH**  
**VITAL STATISTICS**

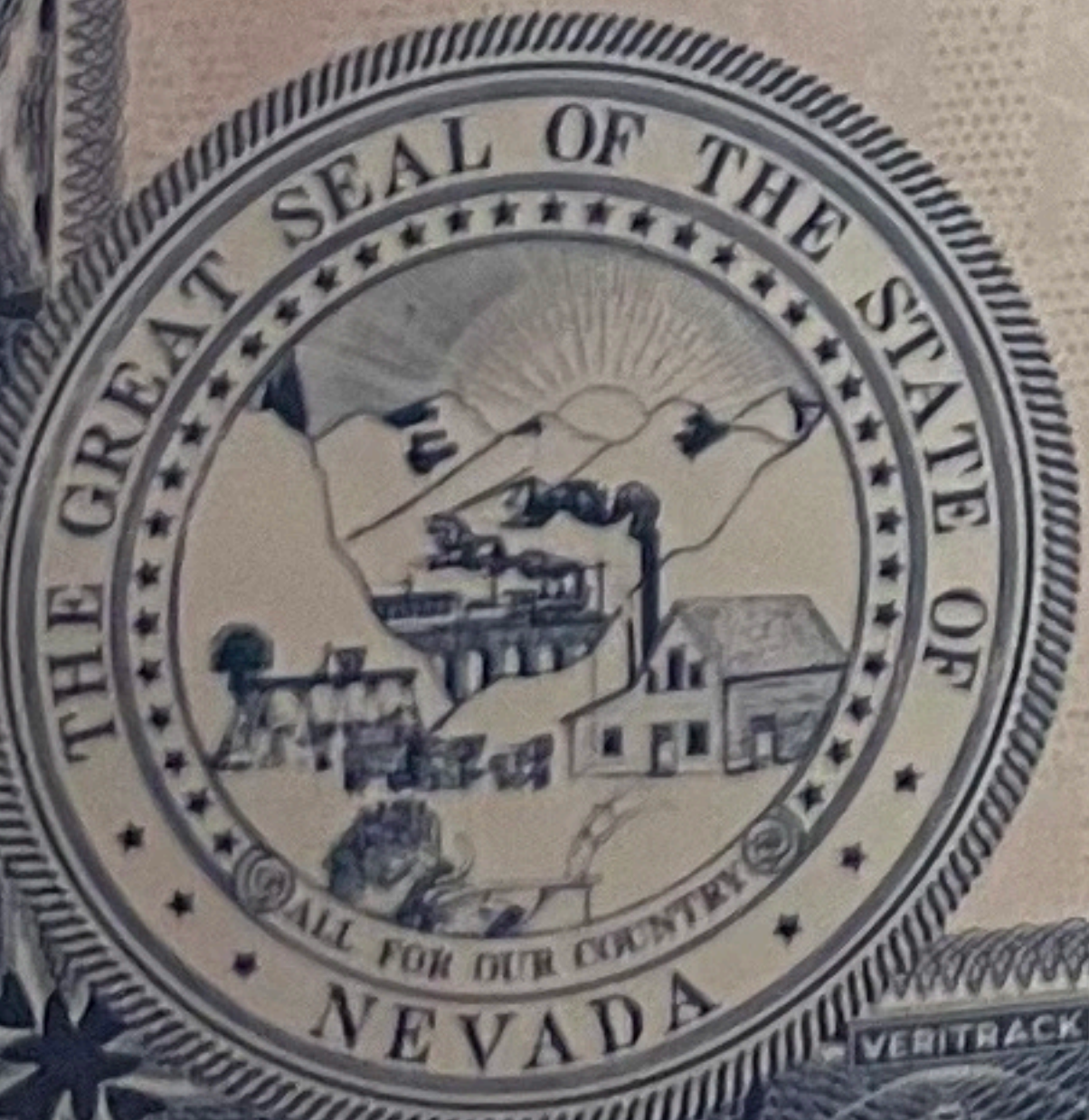
4052934  
CASE FILE NO.

2018031668  
STATE FILE NUMBER

**CERTIFICATE OF LIVE BIRTH**

<b>CHILD</b>	1. CHILD NAME (First, Middle, Last, Suffix) <b>Meronna Meadow DAVIS</b>		2. DATE OF BIRTH (Mo, Day, Yr) <b>November 21, 2018</b>	3. TIME OF BIRTH 14:03 (24Hr)	4. SEX <b>F</b>
	5. FACILITY NAME (If not institution, give street and number) <b>University Medical Center</b>		6. CITY, VILLAGE, OR LOCATION OF BIRTH <b>Las Vegas</b>		7. COUNTY OF BIRTH <b>Clark</b>
<b>MOTHER</b>	8a. MOTHER/PARENT CURRENT LEGAL NAME (First, Middle, Last) <b>Summer La-Rue COLLINS</b>		8b. DATE OF BIRTH (Mo/Day/Yr) <b>June 03, 1983</b>		8c. AGE <b>35</b>
	9. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (Last, Suffix) <b>COLLINS</b>		10. BIRTHPLACE (State, Territory, or Foreign Country) <b>Nevada</b>		
	11a. RESIDENCE OF MOTHER-STATE <b>Nevada</b>	11b. COUNTY <b>Clark</b>	11c. CITY, TOWN, OR LOCATION <b>North Las Vegas</b>		
	11d. STREET AND NUMBER <b>2020 Spanish Town</b>		11e. APT. NO.	11f. ZIP CODE <b>89031</b>	11g. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<b>FATHER</b>	12a. FATHER/PARENT CURRENT LEGAL NAME (First, Middle, Last, Suffix) <b>Tristan Alexander DAVIS</b>		12b. DATE OF BIRTH (Mo/Day/Yr) <b>July 30, 1987</b>	12c. AGE <b>31</b>	12d. BIRTHPLACE (State, Territory, or Foreign Country) <b>Illinois</b>
	<b>CERTIFIER &amp; ATTENDANT</b>		<b>13a. CERTIFIER'S NAME:</b> <u>Susana Flores</u>		
		TITLE <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> HOSPITAL ADMIN <input type="checkbox"/> CNM/CM <input type="checkbox"/> OTHER MIDWIFE <input checked="" type="checkbox"/> MEDICAL RECORDS TECHNICIAN <input type="checkbox"/> OTHER (Specify) _____		<b>14a. ATTENDANT'S NAME</b> <u>Gloria L Martin</u>	
		ATTENDANT'S ADDRESS <u>700 Shodow Lane, Ste 165</u> <u>Las Vegas NV 89106</u>			
		TITLE <input checked="" type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> CNM/CM <input type="checkbox"/> OTHER MIDWIFE <input type="checkbox"/> OTHER (Specify) _____		<b>15. DATE CERTIFIED</b> <u>12 / 05 / 2018</u> MM DD YYYY	
<b>REGISTRAR</b>	16a. REGISTRAR'S SIGNATURE <b>Christine Johnson SIGNATURE AUTHENTICATED</b>		<b>16b. DATE FILED BY REGISTRAR</b> <u>12 / 05 / 2018</u> MM DD YYYY		

"CERTIFIED TO BE A TRUE AND CORRECT COPY OF THE DOCUMENT ON FILE WITH THE REGISTRAR OF VITAL STATISTICS, STATE OF NEVADA." This copy was issued by the Southern Nevada Health District from State certified documents authorized by the State Board of Health pursuant to NRS 440.175.



DATE ISSUED: **MAR 21 2019**  
 Registrar of Vital Statistics  
 By: *[Signature]*  
 This Copy not valid unless prepared on engraved border displaying date, seal and signature of Registrar.  
 SOUTHERN NEVADA HEALTH DISTRICT • P.O. Box 3902 • Las Vegas, NV 89127 • 702-759-1010 • Tax ID # 88-0151573

ANY ALTERATION OR ERASURE VOIDS THIS CERTIFICATE