INTERNATIONAL CERTIFICATE of INOCULATION and VACCINATION

As approved by WORLD HEALTH ORGANIZATION and THE PAN AMERICAN SANITARY ORGANIZATION

TRAVELER'S NAME Dorothea B. Wolf

ADDRESS
73-62 (NUMBER) 255 (STREET)
Glen Oaks Floral Park (CITY, TOWN, OR VILLAGE)
Queens (COUNTY) New York (STATE)

DATE OF BIRTH Nov. 12, 1927 SEX Female

TRAVELER'S SIGNATURE Dorothea B. Wolf

FEDERAL SECURITY AGENCY

U. S. PUBLIC HEALTH SERVICE

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PHS-731 (FQ)
Rev. 12–48

INTERNATIONAL CERTIFICATE OF VACCINATION AGAINST SMALLPOX

This is to certify that— Dorothea B. Wolf

has this day been vaccinated by me against smallpox.

Origin and Batch No. of vaccine P.D&Co 4-560-1

Signature of vaccinator [illegible signature]

Official position (if any) Physician

Place 190-24 115 Ave St Albans Date 8/3/53

IMPORTANT.—In the case of primary vaccination the person vaccinated should be warned to report to a physician between the 8th and 14th day in order that the result of the vaccination may be recorded on this certificate. In the case of revaccination the person should report within 48 hours for first inspection in order that any immune reaction which has developed may be recorded.

[OFFICIAL STAMP]

CERTIFICATION.—I hereby certify that to the best of my knowledge and belief, the above statement is true.

Certifying officer

Official position

Place Date

This is to certify that the above vaccination was inspected by me on the date(s) and with the result(s) shown hereunder:

DATE OF INSPECTION	RESULT*
8/5/53	Reaction of Immunity

Signature of physician [illegible signature]

Official position (if any) Physician

Place 190-24 115 Ave St Albans N.Y. Date 8/5/53

*Use one of the following terms in stating the results, viz.—"Reaction of immunity," "Accelerated reaction (vaccinoid)," "Typical primary vaccina." A certificate of "No reaction" will not be accepted.

This certificate is valid for only 3 years from date of issue.

[OFFICIAL STAMP]

CERTIFICATION.—I hereby certify that to the best of my knowledge and belief, the above statement is true.

Certifying officer

Official position

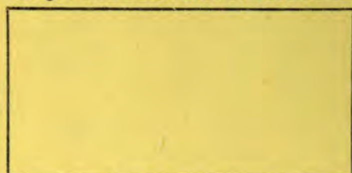
Place Date

INTERNATIONAL CERTIFICATE OF INOCULATION AGAINST YELLOW FEVER

This is to certify that

(age ...... sex ......), whose signature appears below, has this day been inoculated by me against yellow fever.

Origin and Batch No. of vaccine



[OFFICIAL STAMP OF INOCULATING OFFICER]

Signature of inoculating officer

Official position

Place Date

Signature of person inoculated

Home address

N. B. This certificate is not valid:

(a) Unless the vaccine and the method employed have been approved by UNRRA, or WHO, or its Interim Commission.

(b) Until 10 days after the date of the inoculation, except in the case of persons reinoculated within 4 years.

(c) For more than 4 years from the date of the last inoculation.

16—55165-1

INTERNATIONAL CERTIFICATE OF INOCULATION AGAINST CHOLERA

(This certificate is valid for only 6 months from date of last inoculation)

MATERIAL			SIGNATURE OF INOCULATING PHYSICIAN	CERTIFYING PHYSICIAN		OFFICIAL STAMP
DATE	ORIGIN	BATCH NO. AND TYPE		SIGNATURE OF	OFFICIAL POSITION	

RECORD OF OTHER IMMUNIZATIONS (Typhus, Typhoid, Paratyphoid, Plague, Tetanus, etc.)

NATURE OF VACCINE	DATE	DOSE	PHYSICIAN'S SIGNATURE	NATURE OF VACCINE	DATE	DOSE	PHYSICIAN'S SIGNATURE

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