

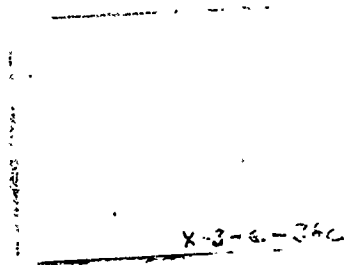
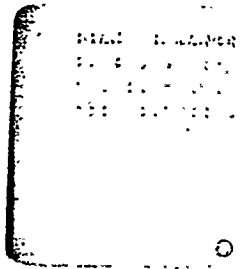


**PEOPLES
TEMPLE**

OF THE
DISCIPLES OF CHRIST
P.O. Box 15023
San Francisco
California 94115

Eleanor M. Beam

X-3-e-36a



X-3-6-360

Time of birth 11:00 PM
Weight 10 lb 12 oz

MAR 10 1961

INTERNATIONAL CERTIFICATES OF
VACCINATION

AS APPROVED BY
THE WORLD HEALTH ORGANIZATION
(EXCEPT FOR ADDRESS OF VACCINATOR)

CERTIFICATS INTERNATIONAUX DE
VACCINATION

APPROUVÉS PAR
L'ORGANISATION MONDIALE DE LA SANTÉ
(SAUF L'ADRESSE DU VACCINATEUR)

TRAVELER'S NAME—NOM DU VOYAGEUR

ADDRESS—ADRESSE (Number—Numéro) (Street—Rue)

(City—Ville)

(County—Département) (State—État)



U.S. DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE

PHS-731 (REV. 9-69)

FOLD HERE TO PLACE WITH PASSPORT

For sale by Superintendent of Documents
Government Printing Office — Washington, D.C., 20402
Price 10 cents — \$5.00 per 100

X-3-e-36e

REMARKS CONCERNING VACCINATIONS—REMARQUES CONCERNANT LES VACCINATIONS

Date	Notes	Physician's signature and address Signature et adresse du médecin

This information is to assist any physician called upon to treat an ill traveler.
 Cette information est pour aider le médecin qui peut être appelé pour traiter un voyageur malade.

Date	Rh type type Rh	Blood group Groupe sanguin	Name and address of physician—Signature et adresse du médecin

Name and address of person to notify in case of emergency.
 Nom et adresse de la personne à aviser en cas d'urgence.

REMARKS concerning state of health, medical treatments or known sensitivities:
 REMARQUES concernant l'état de santé, traitements médicaux, ou sensibilités connues:

OPHTHALMIC INFORMATION (Prescription Glasses)

	Sphere	Cylinder	Axis	Prism	Base
(OD) Ocular Dexter					
(OS) Ocular Sinister					
Add _____	Base Curve _____				
Other _____					

INTERNATIONAL CERTIFICATE OF VACCINATION OR REVACCINATION AGAINST CHOLERA
 CERTIFICAT INTERNATIONAL DE VACCINATION OU DE REVACCINATION CONTRE LE CHOLERA

This is to certify that _____ Sex _____
 Je soussigné(e) certifie que _____ Sexe _____

whose signature follows _____ date of birth _____
 dont la signature suit _____ né(e) le _____

has on the date indicated been vaccinated or revaccinated against cholera.
 a été vacciné(e) ou revacciné(e) contre le choléra à date indiquée.

Date	Signature, professional status, and address of vaccinator Signature, qualité professionnelle, et adresse du vaccinateur	Approved stamp Cachet d'authentification
1.		1.
2.		2.
3.		3.
4.		4.
5.		5.
6.		6.

7.		7.
8.		8.
9.		9.
10.		10.
11.		11.
12.		12.

THE VALIDITY OF THIS CERTIFICATE shall extend for a period of 6 months, beginning 6 days after the first injection of the vaccine or, in the event of a revaccination within such period of 6 months, on the date of that revaccination.

The approved stamp mentioned above must be in a form prescribed by the health administration of the country in which the vaccination is performed.

Any amendment of this certificate, or erasure, or failure to complete any part of it, may render it invalid.

LA VALIDITÉ DE CE CERTIFICAT couvre une période de six mois commençant six jours après la première injection du vaccin ou, dans le cas d'une revaccination au cours de cette période de six mois, le jour de cette revaccination.

Le cachet d'authentification doit être conforme au modèle prescrit par l'administration sanitaire du territoire où la vaccination est effectuée.

Toute correction ou rature sur le certificat ou l'omission d'une quelconque des mentions qu'il comporte peut affecter sa validité.

INTERNATIONAL CERTIFICATE OF VACCINATION OR REVACCINATION AGAINST SMALLPOX
CERTIFICAT INTERNATIONAL DE VACCINATION OU DE REVACCINATION CONTRE LA VARIOLE

This is to certify that Lleanor Beane sex
 Je soussigné(e) certifie que Lleanor Beane sexe
 whose signature follows Lleanor Beane date of birth
 dont la signature suit Lleanor Beane né(e) le
 has on the date indicated been vaccinated or revaccinated against smallpox with a freeze-dried or liquid vaccine certified to fulfill the recommended requirements of the World Health Organization.
 a été vacciné(e) ou revacciné(e) contre la variole à la date indiquée ci-dessous, avec un vaccin tyophilisé ou liquide certifié conforme aux normes recommandées par l'Organisation mondiale de la Santé.

Date	Show by "X" whether indicated par "X" s'il s'agit de	Signature, professional status, and address of vaccinator Signature, qualité professionnelle, et adresse du vaccinateur	Origin and batch no. of vaccine Origine du vaccin et numéro du lot	Approved stamp Cachet d'authentification
1a	Primary vaccination performed Primovaccination effectuée			
1b	Read as successful prise Unsuccessful prise prise			
2	Revaccination	<u>OVERSEAS MEDICAL</u> <u>10 Calle</u> <u>San Francisco</u>	<u>JK</u> <u>1190</u>	<u>201901</u>
3	Revaccination			
4	Revaccination			
5	Revaccination			

THE VALIDITY OF THIS CERTIFICATE shall extend for a period of 3 years, beginning 8 days after the date of a successful primary vaccination* or, in the event of a revaccination, on the date of that revaccination. The approved stamp mentioned above must be in a form prescribed by the health administration of the country in which the vaccination is performed.
 Any amendment of this certificate, or erasure, or failure to complete any part of it, may render it invalid.
 LA VALIDITÉ DE CERTIFICAT couvre une période de trois ans commençant huit jours après la date de la primovaccination effectuée avec succès (prise) ou, dans le cas d'une revaccination, le jour de cette revaccination. Le cachet d'authentification doit être conforme au modèle prescrit par l'administration sanitaire du territoire où la vaccination est effectuée.
 Toute correction ou rature sur le certificat ou l'omission d'une quelconque des mentions qu'il comporte peut affecter sa validité.
 *See Item 1, Instructions to Physicians

22 NOV 1950

INTERNATIONAL CERTIFICATE OF VACCINATION OR REVACCINATION AGAINST YELLOW FEVER
 CERTIFICAT INTERNATIONAL DE VACCINATION OU DE REVACCINATION CONTRE LA FIÈVRE JAUNE

This is to certify that Je soussigné(e) certifie que ELEANOR BEAM Sex F
 whose signature follows dont la signature suit Eleanor Beam date of birth
 né(e) le

has on the date indicated been vaccinated or revaccinated against yellow fever.
 a été vacciné(e) ou revacciné(e) contre la fièvre jaune à la date indiquée.

Date	Signature and professional status of vaccinator Signature et qualité professionnelle du vaccinateur	Origin and batch number of vaccine Origine du vaccin employé et numéro du lot	Official stamp of vaccinating center Cachet officiel du centre de vaccination
1. 22 NOV 1976	<u>Vallancourt/MC</u> JOHN A. VAILLANCOURT, M.D. MEDICAL DIRECTOR, USPHS U.S. PUBLIC HEALTH SERVICE HOSPITAL SAN FRANCISCO, CALIFORNIA 94118	<u>1578 FG</u> Merrell-National Laboratories Division of Merrell, Inc.	
2.			

THIS CERTIFICATE IS VALID only if the vaccine used has been approved by the World Health Organization and if the vaccinating center has been designated by the health administration for the country in which that center is situated.

THE VALIDITY OF THIS CERTIFICATE shall extend for a period of 10 years, beginning 10 days after the date of vaccination or, in the event of a revaccination, within such period of 10 years, from the date of that revaccination.

Any amendment of this certificate, or erasure, or failure to complete any part of it, may render it invalid.

CE CERTIFICAT N'EST VALABLE que si le vaccin employé a été approuvé par l'Organisation mondiale de la Santé et si le centre de vaccination a été habilité par l'administration sanitaire du territoire dans lequel ce centre est situé.

LA VALIDITÉ DE CE CERTIFICAT couvre une période de dix ans commençant dix jours après la date de la vaccination ou, dans le cas d'une revaccination au cours de cette période de dix ans, le jour de cette revaccination.

Toute correction ou rature sur le certificat ou l'omission d'une quelconque des mentions qu'il comporte peut affecter sa validité.

INSTRUCTIONS TO TRAVELERS

The International Certificate of Vaccination or Revaccination is an official statement that you are adequately protected against a disease which could be a threat to the United States and other countries. It is second in importance only to the passport in permitting uninterrupted international travel. **IT MUST BE COMPLETE IN EVERY DETAIL.** When incomplete or inaccurate it is not valid and may cause the traveler to be detained at the United States or foreign ports of entry.

The following suggestions will be of help to you in properly completing the Certificates:

1. Complete the cover sheet of the booklet *before* presenting it to your physician.
2. On the Certificates which will be required for your travel: (a) print your name on the first line; (b) sign your name on the second line; and (c) indicate your sex and date of birth.
3. Vaccination against smallpox and cholera may be given by a licensed physician in the United States. When your physician has completed his part of the Certificate, take it to your health department to have it stamped. Vaccinations against yellow fever may be administered only at official Yellow Fever Vaccination Centers. International Certificates of Vaccination against Yellow Fever must be stamped with the official stamp of the vaccination center which administered the yellow fever vaccine.
4. It is the traveler's responsibility to have the smallpox, cholera, and/or yellow fever certificates validated with an "approved stamp." **THE CERTIFICATES ARE NOT VALID WITHOUT AN "APPROVED STAMP."** In the United States, "approved stamps" are: (a) the "Uniform Stamp" of the local or State Health Officer; (b) the stamp assigned to official Yellow Fever Vaccination Centers; (c) the seal of the Public Health Service; (d) a stamp authorized by the Public Health Service; (e) the stamp of the Department of Defense; or (f) the seal of the Department of State.
5. Information concerning immunizations required for travel to foreign countries may be obtained from your local or State health department.

DO NOT THROW THIS BOOKLET AWAY. YOU MAY HAVE OCCASION TO USE THE CERTIFICATES FOR FUTURE TRAVEL AND AS A RECORD OF YOUR VACCINATION HISTORY.

INSTRUCTIONS TO PHYSICIANS

INFORMATION REQUESTED ON EACH CERTIFICATE MUST BE COMPLETE FOR THE CERTIFICATE TO BE VALID.

1. The space for primary vaccination against smallpox is to be used *only* when a person receives his vaccination for the *first* time. If unsuccessful, a new certificate must be used for a repeat primary vaccination.
2. The dates on each certificate are to be written with the day in arabic numerals, followed by the month in letters and the year in arabic numerals. Example: 1/Jan/70
3. The *physician's* written signature must appear on the certificate; a signature stamp is not acceptable.
4. If smallpox vaccination is contraindicated, you should provide the patient with a written statement, on your letterhead, indicating the nature of the contraindication. The contraindications officially recognized by the Public Health Service are: (a) eczema and other forms of chronic dermatitis in the individual or household contact; (b) and altered state of immunity due to serious disease or drug treatment; (c) pregnancy; and (d) infancy (under one year of age).
5. Information concerning official immunization requirements for international travel and the location of Yellow Fever Vaccination Centers in your area may be obtained from your local or State health department.

WILBERT A. ROTH, M.D.
3838 CALIFORNIA ST., SUITE 512
SAN FRANCISCO, CALIFORNIA 94118

X-3-e-36d

WILBERT A. ROTH, M.D.
3838 CALIFORNIA STREET
SAN FRANCISCO, CA. 94118
221-7200

November 22, 1976

To Whom it May Concern:

re: Eleanor Beam

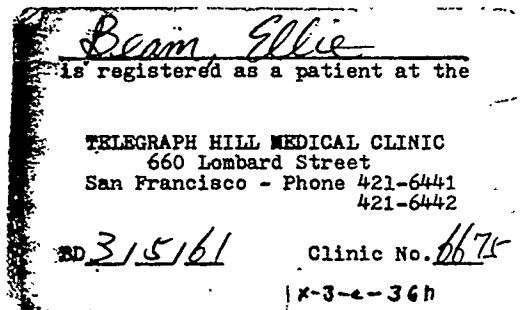
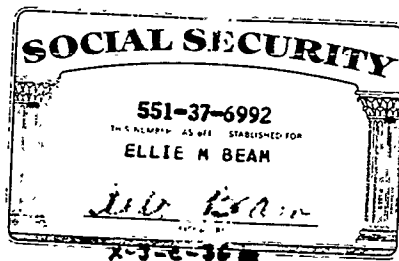
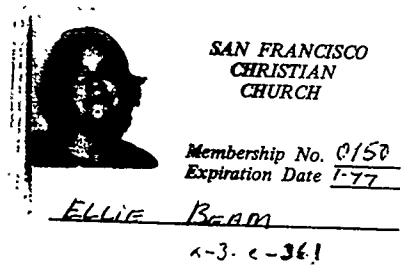
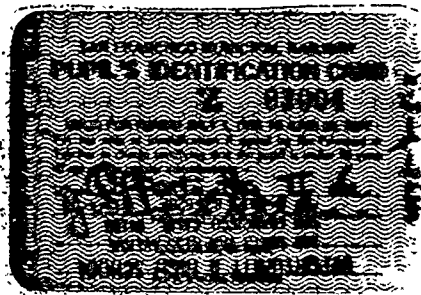
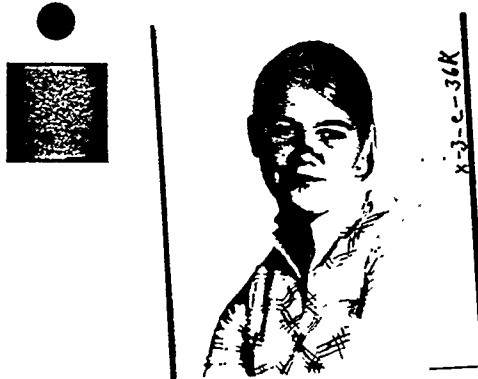
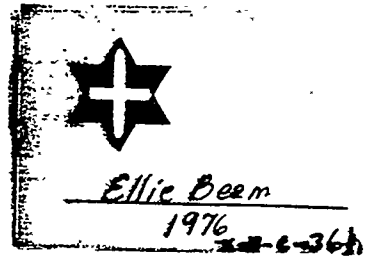
11/8/76 GC Culture was negative.

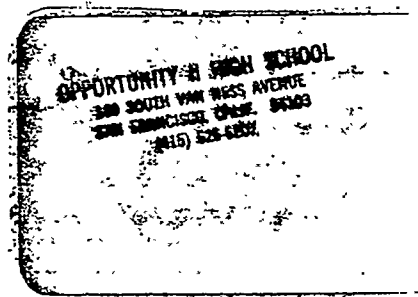
11/8/76 Blood Count was within normal limits.

11/15/76 Pap smear was normal.

W. A. Roth

X-3-e-36g





Contact any social security office immediately if you:

- ▶ lose your card—to get a duplicate card.
- ▶ change your name—to get a card in your new name.
- ▶ are unable to work because of a severe disability expected to last a year or more.
- ▶ are 62 or older—to ask about retirement checks.
- ▶ are within 2 or 3 months of age 65, even if you don't plan to retire—to sign up for Medicare.

U.S. Department of Health, Education, and Welfare
Social Security Administration
Form 04-702 Rev. 11-72

