

Name: _____

Date: _____

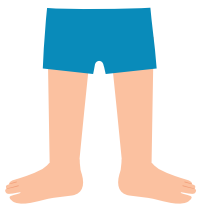
PARTS OF THE BODY

Fill in the blanks with the help of given column.











Ear

Lip

Leg

Eye

Foot