

(1) PLACE OF BIRTH

County of York  
Township of Kings  
or  
Inc. Town of .....  
or  
City of .....  
(If birth occurs in a hospital or other institution, give name of same instead of street and number.)

CERTIFICATE OF BIRTH

STATE OF SOUTH CAROLINA  
Bureau of Vital Statistics  
State Board of Health

No. 1a.—For State Registrar Only

5540

Registration District No. 4407 Registered No. 13  
(For use of Local Registrar)

St. .... Ward .....  
(No. .... St. .... Ward .....)

(2) Full Name of Child

If child is not yet named, make supplemental report as directed

(3) BOY OR GIRL Boy  
(4) Twin or Triplet  
(5) Number in order of birth  
To be answered only in event of Twin or Triplet

(6) Are Parents Married Yes  
(7) DATE OF BIRTH 74 3 23  
(Name of Month) (Day) (Year)

FATHER.

MOTHER.

(8) FULL NAME Robert P. ...

(14) NAME BEFORE MARRIAGE Miss Mosier

(9) PRESENT POSTOFFICE OF FATHER SC

(15) PRESENT POSTOFFICE OF MOTHER

(10) COLOR OR RACE White (11) AGE AT LAST BIRTHDAY 3 (Year)

(16) COLOR OR RACE (17) AGE AT LAST BIRTHDAY (Year)

(12) BIRTHPLACE

(18) BIRTHPLACE

(13) OCCUPATION

(19) OCCUPATION

(20) Number of children born to mother, including present birth 3

(21) Number of children of this mother now living, including present birth 1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

(22) I hereby certify that I attended the birth of this child, who was act. 13 AM.  
on the date above stated. (Born alive or stillborn) (Hour, M. or P. M.)

(23) (Signature) [Signature] (24) State whether Physician or Midwife (25) Address of Physician or Midwife

Given name added from a supplemental report

(26) Witness (Signature of Witness necessary only when question 23 is signed by mark)

(27) Filed North 8.23 (28) [Signature] Local Registrar

When there was no attending physician or midwife, then the father, householder, etc., should make this return. If a child breathes even once, it must not be reported as stillborn. No report is desired of stillbirths before the fifth month of pregnancy.

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