

Form No. 3

## (1) PLACE OF BIRTH

County of Lancaster

Township of .....

or

Inc. Town of .....

or

City of Korucu

(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

File No. - For State Registrar Only

24357

Registration District No. 20-A Registered No. 263

(For use of Local Registrar)

(No. 20-A St.; ..... Ward)

## (2) Full Name of Child

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

(3) BOY OR GIRL <u>Boy</u>	(4) Twin or Triplet	(5) Number in order of birth	(6) Are Parents Married <u>Yes</u>	(7) DATE OF BIRTH <u>12-23</u> (Name of Month) (Day) (Year)
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## FATHER

(8) FULL NAME W. Foxworth(9) PRESENT POSTOFFICE OF FATHER Korucu(10) COLOR OR RACE W (11) AGE AT LAST BIRTHDAY 41 (Year)(12) BIRTHPLACE Union Co(13) OCCUPATION Conductor RR(20) Number of children born to mother, including present birth 7

## MOTHER

(14) NAME AND MARRIAGE Hessie Shockley(15) PRESENT POSTOFFICE OF MOTHER Korucu(16) COLOR OR RACE W (17) AGE AT LAST BIRTHDAY 37 (Year)(18) BIRTHPLACE Marion Co(19) OCCUPATION Housewife(21) Number of children of this mother now living, including present birth 6

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

(22) I hereby certify that I attended the birth of this child on the date above stated.

(23) (Signature) L. H. Smith

(24) State whether Physician or Midwife

(25) Address of Physician or Midwife

(If name added from a supplemental report)

(26) Witness (Signature of Witness necessary only when question 22 is signed by mark)

(27) Filed 9-15-23 P. H. DuShane Local Registrar

\*When there was no attending physician or midwife, then the father, householder, etc., should make this report. 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.