

(1) PLACE OF BIRTH

County of Charleston

Township of

or Inc. Town of

City of Charleston

CERTIFICATE OF BIRTH

STATE OF SOUTH CAROLINA

Bureau of Vital Statistics

State Board of Health

No. 10-For Use of Local Registrar

85100

Registration District No. 57 Warren

Registered No.

(For use of Local Registrar)

St. Ward)

(If birth occurs in a hospital or other institution, give name of same instead of street and number.)

(2) Full Name of Child Thomas Benjamin Webb (If child not yet named, make supplemental report as directed)

(3) SEX OF CHILD <u>Male</u>	(4) Type of Toilet To be answered only in event of Toilet or Toilet	(5) Number in order of birth	(6) Age from birth <u>Yes</u>	(7) DATE OF BIRTH <u>Nov 12 23</u> (Name of Month) (Day) (Year)
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FATHER.		MOTHER.	
(8) NAME OF FATHER <u>Lucius B. Welch</u>	(10) NAME OF MOTHER <u>Wilhelmina Bennett</u>	(9) PRESENT RESIDENCE OF FATHER <u>Charleston S.C.</u>	(11) PRESENT RESIDENCE OF MOTHER <u>Charleston S.C.</u>
(12) COLOR OR RACE <u>White</u>	(13) AGE AT LAST BIRTHDAY <u>29</u> (Year)	(14) COLOR OR RACE <u>White</u>	(15) AGE AT LAST BIRTHDAY <u>20</u> (Year)
(16) BIRTHPLACE <u>Sumner S.C.</u>	(17) BIRTHPLACE <u>Charleston S.C.</u>	(18) OCCUPATION <u>Fireman</u>	(19) OCCUPATION <u>Domestic</u>
(20) Number of children born to mother, including present birth <u>2</u>	(21) Number of children of this mother now living, including present birth <u>2</u>		

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

(22) I hereby certify that I attended the birth of this child, who was 240 on the date above stated.(23) (Signature) X. J. Smith

(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 11 22 23 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.

FIRST-GEN. No. 1 THE OTHER, No. 2, etc. In question 1