

## (1) PLACE OF BIRTH

County of York  
 Township of York  
 or  
 Inc. Town of .....

**CERTIFICATE OF BIRTH**  
 STATE OF SOUTH CAROLINA  
 Bureau of Vital Statistics  
 State Board of Health

Registration District No. 3504 Registered No. 3341  
 (For use of Local Registrar)

City of ..... (No. .... 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 Willard J. J. If child is not yet named, make supplemental report as directed

(3) SEX OF CHILD Male (4) Twin or Triplet No (5) Number in order of birth 2 (6) Date of Birth 3-2-23  
 To be answered only in event of Twin or Triplet (7) (Month) (Day) (Year)

## FATHER.

(8) FULL NAME Willard  
 (9) PRESENT POSTOFFICE OF FATHER Newry  
 (10) COLOR OR RACE Caucasian (11) AGE AT LAST BIRTHDAY 24  
 (12) BIRTHPLACE Anderson  
 (13) OCCUPATION Public worker  
 (14) Number of children born to mother, including present birth 3

## MOTHER.

(15) NAME BEFORE MARRIAGE Eva Reed  
 (16) PRESENT POSTOFFICE OF MOTHER Anderson  
 (17) COLOR OR RACE Caucasian (18) AGE AT LAST BIRTHDAY 24  
 (19) BIRTHPLACE Anderson  
 (20) OCCUPATION House work  
 (21) Number of children of this mother now living, including present birth 0

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

(22) I hereby certify that I attended the birth of this child, who was born (Sex) alive or stillborn (Date) 3-2-23 on the date above stated.

(23) (Signature) [Signature]

(24) State whether Physician or Midwife

(25) Address of Physician or Midwife Anderson

Given name added from a supplemental report

(26) Witness

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

(27) Filed 4/10/23

(28)

10 Registrar

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