

(1) PLACE OF BIRTH **CERTIFICATE OF BIRTH**

County of *Spartanburg, S. C.* STATE OF SOUTH CAROLINA.

Bureau of Vital Statistics
State Board of Health

File No. — For State Registrar Only
62018

Township of

or
Inc. Town of

or
City of *Spartanburg*

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

Registration District No. *40-A*

Registered No. *196*

(For use of Local Registrar)

(2) Full Name of Child. *Carl*

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

(6) Are Parents Married? *Yes*

(7) DATE OF BIRTH *Nov 8 1916*

(Name of Month) (Day) (Year)

To be answered only in case of Twin or Triplets

FATHER.

(8) FULL NAME *J. A. Fox*

(9) PRESENT POSTOFFICE OF FATHER *Spartanburg*

(10) COLOR OR RACE *white*

(11) AGE AT LAST BIRTHDAY *6*

(Years)

(12) BIRTHPLACE *S.C.*

(13) OCCUPATION *Farmer*

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

MOTHER.

(14) NAME BEFORE MARRIAGE *Maggie Werley*

(15) PRESENT POSTOFFICE OF MOTHER *Spartanburg S.C.*

(16) COLOR OR RACE *white*

(17) AGE AT LAST BIRTHDAY *33*

(Years)

(18) BIRTHPLACE *S.C.*

(19) OCCUPATION *Domestic*

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

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

(22) I hereby certify that I attended the birth of this child, who was *alive*, at *1 P.M.*, on the date above stated. (Born alive or stillborn) (Hour A. M. or P. M.)

(23) (Signature) *J. R. Brown*

(24) State whether Physician or Midwife (25) Address of Physician or Midwife *City*

Given name added from a supplemental report

(26) Witness

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

(27) Filed *June 1916*

(28)

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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Form No. 10. MAILED RESERVED FOR BINDING. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—In case of TWINS OR TRIPLETS use a SEPARATE BLANK for each child, and mark the FIRST-BORN, No. 1. THE OTHER, No. 2, etc., in question 3.

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