

(1) PLACE OF BIRTH

County of Cleveland
 Township of Wing
 or
 Inc. Town of.....
 or
 City of

CERTIFICATE OF BIRTH

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

File No.—For State Registrar Only

14390

Registration District No. 1312 Registered No. 24
 (For use of Local Registrar)

(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 Lewis Ethna Pack 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 Jun 28 22
 To be answered only in event of Twins or Triplets (Name of Month) (Day) (Year)

FATHER.

(8) FULL NAME Martin Pack(9) PRESENT POSTOFFICE OF FATHER Gardina S C(10) COLOR OR RACE negro (11) AGE AT LAST BIRTHDAY 35
 (Years)(12) BIRTHPLACE Sumter Co(13) OCCUPATION Farming(20) Number of children born to mother, including present birth 7

MOTHER.

(14) NAME BEFORE MARRIAGE Ela McFadden(15) PRESENT POSTOFFICE OF MOTHER Gardina S C(16) COLOR OR RACE negro (17) AGE AT LAST BIRTHDAY 26
 (Years)(18) BIRTHPLACE Cleveland Co(19) OCCUPATION House work(21) Number of children of this mother now living, including present birth 7

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

(22) I hereby certify that I attended the birth of this child, who was... alive at 9.9 M.,
 on the date above stated. (Born alive or stillborn) (Hour A. M. or P. M.)

(23) (Signature) Lettie Trusdale(24) State whether Physician or Midwife (25) Address of Physician or Midwife Lynchburg S C

Given name added from a supplemental report

(26) Witness
 (Signature of Witness necessary only when question 23 is signed by mark)(27) Filed 3/29 1922 (28) J. H. D. [Signature]
 Registrar 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.

Form No. 1
 (1) PLACE OF BIRTH
 County of
 Township of
 or
 Inc. Town of
 or
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 (If birth occurs in a hospital or other institution, give name of same instead of street and number.)
 (2) Full Name of Child
 (3) BOY OR GIRL
 (4) Twin or Triplet?
 To be answered only in event of Twins or Triplets
 (5) Number in order of birth
 (6) Are Parents Married?
 (7) DATE OF BIRTH
 (Name of Month) (Day) (Year)
 FATHER.
 (8) FULL NAME
 (9) PRESENT POSTOFFICE OF FATHER
 (10) COLOR OR RACE
 (11) AGE AT LAST BIRTHDAY
 (Years)
 (12) BIRTHPLACE
 (13) OCCUPATION
 (20) Number of children born to mother, including present birth
 MOTHER.
 (14) NAME BEFORE MARRIAGE
 (15) PRESENT POSTOFFICE OF MOTHER
 (16) COLOR OR RACE
 (17) AGE AT LAST BIRTHDAY
 (Years)
 (18) BIRTHPLACE
 (19) OCCUPATION
 (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... at... M., on the date above stated.
 (Born alive or stillborn) (Hour A. M. or P. M.)
 (23) (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
 (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.