

(1) PLACE OF BIRTH

County of Charleston  
Township of .....  
or  
Inc. Town of .....  
or  
City of Charleston  
(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  
**29235**

Registration District No. 9A Registered No. 1366  
(For use of Local Registrar)  
(No. 26 Summit St. St.; ..... Ward)

(2) Full Name of Child

Medford

(3) BOY OR GIRL Boy (4) Twin or Triplet? No (5) Number in order of Birth 1 (6) Are Parents Married? No (7) DATE OF BIRTH Sept 14 22  
To be answered only in event of Twins or Triplets  
If child is not yet named, make supplemental report as directed  
(Name of Month) (Day) (Year)

FATHER.

(3) FULL NAME Ernest Howard  
(9) PRESENT POSTOFFICE OF FATHER Charleston  
(10) COLOR OR RACE Col (11) AGE AT LAST BIRTHDAY 30  
(12) BIRTHPLACE Charleston (Years)  
(13) OCCUPATION Porter

MOTHER.

(14) NAME BEFORE MARRIAGE Lillie Johnson  
(15) PRESENT POSTOFFICE OF MOTHER Charleston  
(16) COLOR OR RACE Col (17) AGE AT LAST BIRTHDAY 23  
(18) BIRTHPLACE Charleston (Years)  
(19) OCCUPATION Cook

(20) Number of children born to mother, including present birth 2  
(21) Number of children of this mother now living, including present birth 2

**CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\***

(22) I hereby certify that I attended the birth of this child, who was Alice at 8-30 M.,  
on the date above stated. (Born alive or stillborn) (Hour) (M. or P.M.)  
(23) (Signature) Alice Bryant  
(24) State whether Physician or Midwife Midwife (25) Address of Physician or Midwife 155 Short St.

Given name added from a supplemental report

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

(27) Filed 9/19 19 22 (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.

Form No. 4

Registration District No. ....

Primary Reg. District No. ....

STATE OF SOUTH CAROLINA  
STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS

# Supplemental Report of Births

Place of Birth { City or Town Charleston  
Street and House No. 26 Cromwell St  
Township of .....  
County Charleston

File Number\* .....  
Registered Number\* 1366

SEX OF CHILD\* Male Twin,\* } and { Number\*  
Triplet, } in order  
or Other? } of birth

DATE OF BIRTH\* Sept. 14, 1922  
Month Day Year

FATHER  
FULL NAME Gray Howard

MOTHER  
FULL MAIDEN NAME Lillie Johnson

\*These items to be entered by the Registrar before giving out this form.

I HEREBY CERTIFY that the child described herein has been named:

Richard H. Johnson  
Given name in full Surname

as reported by Lillie Johnson  
Father or Mother

(Signed) Annabellance  
Local Registrar

7/1/30