

PLACE OF BIRTH

County of *Spartanburg*
 or
 Township of *Cross* Author

or
 City of

(No.) (St.)
 City of (If birth occurs in a hospital or other institution, give name of same instead of street and number.)

Full Name of Child

(1) SEX OR GENDER *Girl* (2) Type or Degree *To be answered only in case of Twins or Triplets* (3) Number in order of birth *1* (4) Are Parents Married *Yes* DATE OF BIRTH *Oct 29 1923* (Day) (Month) (Year) make noted

FATHER.
 (5) FULL NAME *Albie Mead*
 (6) PRESENT POSTOFFICE OF FATHER *Cross SC*
 (7) COLOR OR RACE *White* (8) AGE AT LAST BIRTHDAY *25* (Year)
 (9) BIRTHPLACE *State of Missouri*
 (10) OCCUPATION *Bridge work*

MOTHER.
 (11) NAME BEFORE MARRIAGE *Marian Casey*
 (12) PRESENT POSTOFFICE OF MOTHER *Cross SC*
 (13) COLOR OR RACE *White* (14) AGE AT LAST BIRTHDAY *24* (Year)
 (15) BIRTHPLACE *Cross SC*
 (16) OCCUPATION *House keeper*
 (17) Number of children of this mother now living, including present birth *1*

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

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

(19) (Signature) *H. H. D.* (20) Address of Physician or Midwife *Cross SC*

Given name added from a supplemental report

(21) Witness (Signature) *SC*

(22) Filed *Oct 6 1923* when question 22 is signed by mark

(23) Filed *Oct 6 1923* (24) *C. D. Hanna* 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.

CERTIFICATE OF BIRTH

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

Registration District No. *4003*

No. for use of Local Registrar

30215

Registered No. *77*
 (For use of Local Registrar)