

Form No. 1

(1) PLACE OF BIRTH

County of

Township of

or
Inc. Town ofor
City of

(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

7660

Registration District No.

Registered No.
(For use of Local Registrar)

(No. St. Ward)

(2) Full Name of Child

If child is not yet named, make
supplemental report as directed(3) BOY OR
GIRL(4) Twin
or Triplet(5) Number in
order of birth(6) Are
Parents
Married?

(7) DATE OF

BIRTH (Name of Month) (Day) (Year)

To be answered only in event of Twin or Triplet

FATHER.

(8) FULL
NAME(9) PRESENT
POSTOFFICE
OF FATHER(10) COLOR
OR
RACE(11) AGE AT LAST
BIRTHDAY

(Year)

(12) BIRTHPLACE

(13) OCCUPATION

(20) Number of children born to
mother, including present birth(14) NAME BEFORE
MARRIAGE(15) PRESENT
POSTOFFICE
OF MOTHER(16) COLOR
OR
RACE(17) AGE AT LAST
BIRTHDAY

(Year)

(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

(When name added from a supplement-
al report)

(26) Witness

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

(27) Filed

July 30, 1923

(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.