

(1) PLACE OF BIRTH

County of Florence
 Township of McMillan
 or
 Inc. Town of
 or
 City of

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

Registration District No. 2 P. 11 Registered No. 23
 (For use of Local Registrar)

File No.—For State Registrar Only
89871

(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 Gessie Williamson If child is not yet named, make supplemental report as directed.

(3) BOY OR GIRL Girl (4) Twin or Triplet? ☒ (5) Number in order of birth (6) Are Parents Married? Yes (7) DATE OF BIRTH Dec 12, 1916
 To be answered only in event of Twins or Triplets (Name of Month) (Day) (Year)

FATHER.

(8) FULL NAME Nathanial Williamson
 (9) PRESENT POSTOFFICE OF FATHER Claussen, S.C.
 (10) COLOR OR RACE negro (11) AGE AT LAST BIRTHDAY 21 (Years)
 (12) BIRTHPLACE S.C.
 (13) OCCUPATION Farm Hand

MOTHER.

(14) NAME BEFORE MARRIAGE Gessie Roberson
 (15) PRESENT POSTOFFICE OF MOTHER Claussen, S.C.
 (16) COLOR OR RACE negro (17) AGE AT LAST BIRTHDAY 20 (Years)
 (18) BIRTHPLACE S.C.
 (19) OCCUPATION Domestic
 (20) Number of children born to mother, including present birth { }
 (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 8 P. M., on the date above stated. (Born alive or stillborn) (Hour A. M. or P. M.)

(23) (Signature) Della Roberson
 (24) State whether Physician or Midwife midwife (25) Address of Physician or Midwife Claussen, 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 Dec 15, 1916 (28) W. H. Claussen 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.

NOT TO BE FILLED IN CASE OF TWINNING OR TRIPLETTING. IN CASE OF TWINNING OR TRIPLETTING, SEE PAGE 2, ETC., IN QUESTION 3.
 FORM 10 OF COLUMBIA, COLUMBIA, S. C.