

(1) PLACE OF BIRTH

County of Greenville
 Township of Lake

CERTIFICATE OF BIRTH

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

File No. For State Registrar Only

52184

Inc. Town of Registration District No. 7009 Registered No. 22
 (For use of Local Registrar)
 City of (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 Cornelius Egerly { If child is not 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 Mar. 15 1916
 (Name of Month) (Day) (Year)

FATHER.

(8) FULL NAME Arthur Egerly
 (9) PRESENT POSTOFFICE OF FATHER Leo SC
 (10) COLOR OR RACE W (11) AGE AT LAST BIRTHDAY 34 (Years)
 (12) BIRTHPLACE Leo SC
 (13) OCCUPATION Farmer
 (14) Number of children born to mother, including present birth 6

MOTHER.

(14) NAME BEFORE MARRIAGE Ellen Humphreys
 (15) PRESENT POSTOFFICE OF MOTHER Leo SC
 (16) COLOR OR RACE W (17) AGE AT LAST BIRTHDAY 24 (Years)
 (18) BIRTHPLACE Leo SC
 (19) OCCUPATION Housewife
 (21) Number of children of this mother now living, including present birth 6

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

(22) I hereby certify that I attended the birth of this child, who was born at 2 P. M., on the date above stated. (Born alive or stillborn) (Hour A. M. or P. M.)

(23) (Signature) Arthur Egerly(24) State whether Physician or Midwife (25) Address of Physician or Midwife Johns River, Ga.

Given name added from a supplemental report
 131....

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

(27) Filed 3/24/16 (28) R. L. Carter 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.

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PRINTED AND SOLD BY THE STATE BOARD OF HEALTH, 100 N. B. ST., COLUMBIA, S. C.
 WHEN FILLING IN THIS FORM, PLEASE PRINT FULL NAMES OF FATHER AND MOTHER, AND FULL NAME OF CHILD, AND MARK THE SEX OF CHILD. IN CASE OF TWINS OR TRIPLETS USE A SEPARATE BLANK FOR EACH CHILD, AND MARK THE FIRST-BORN. NO. 1. THIS OFFICE, NO. 2, ETC., IN QUESTION 8.