

(1) PLACE OF BIRTH
County of York
Township of York
or
Inc. Town of York
or
City of York

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

File No. - For State Registrar Only
19454

Registration District No. 4303 Registered No. 2239
(For use of Local Registrar)

(No. 4303 St. 4303 Ward 4303)
(If birth occurs in a hospital or other institution, give name of same instead of street and number.)

(2) Full Name of Child Simmons If child is not yet named, make supplemental report as directed

3 SEX OF CHILD Boy 4 Type or Triplet None 5 Number in order of birth 1 6 Are Parents Married Yes 7 DATE OF BIRTH 4/3/1923
(Name of Month) (Day) (Year)

8 FATHER'S FULL NAME DW Simmons
9 PRESENT POSTOFFICE OF FATHER Henningsville
10 COLOR OR RACE W 11 AGE AT LAST BIRTHDAY 44 (Year)
12 BIRTHPLACE SC
13 OCCUPATION Farmer
14 Number of children born to father, including present birth 10

15 MOTHER'S FULL NAME Kellie A Cox
16 PRESENT POSTOFFICE OF MOTHER Henningsville
17 COLOR OR RACE W 18 AGE AT LAST BIRTHDAY 46 (Year)
19 BIRTHPLACE SC
20 OCCUPATION Housewife
21 Number of children of this mother now living, including present birth 9

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

(22) I hereby certify that I attended the birth of this child, who was 19 M., on the date above stated. (Born alive or stillborn) (Hour A. M. or P. M.)

(23) (Signature) Atkins (24) State whether Physician or Midwife Physician (25) Address of Physician or Midwife Jolmanville, SC

Give name added from a supplemental report
(26) Witness L. C. Poston (Signature of Witness necessary only when question 22 is signed by mark)
(27) Filed July 12, 1923 (28) L. C. Poston 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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