

(1) PLACE OF BIRTH

County of SpartanburgTownship of Spartanburgor
Inc. Town of Wadsworthor
City of Spartanburg

CERTIFICATE OF BIRTH

STATE OF SOUTH CAROLINA

Bureau of Vital Statistics

State Board of Health

File No.—For State Registrar Only

16794

Registration District No. 4008Registered No. 116
(For use of Local Registrar)

St.; Ward)

If child is not yet named, make supplemental report as directed

(2) Full Name of Child

(3) SEX OF CHILD? yes
GIRL?(4) Twin or Triplet? No
To be answered only in event of Twins or Triplets(5) Number in order of birth 1st(6) Are Parents Married? yes(7) DATE OF BIRTH 5-5-22
(Name of Month) (Day) (Year)

FATHER.

(8) FULL NAME Will Mahaffey(9) PRESENT POSTOFFICE OF FATHER Spartanburg(10) COLOR OR RACE white(11) AGE AT LAST BIRTHDAY 28
(Year)(12) BIRTHPLACE N.C.(13) OCCUPATION mill Operator(20) Number of children born to mother, including present birth 1

MOTHER.

(14) NAME BEFORE MARRIAGE Hellie Rhody Garre(15) PRESENT POSTOFFICE OF MOTHER Spartanburg(16) COLOR OR RACE white(17) AGE AT LAST BIRTHDAY 28
(Year)(18) BIRTHPLACE N.C.(19) OCCUPATION House Wife(21) Number of children of this mother now living, including present birth 1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

(22) I hereby certify that I attended the birth of this child, who was Alive at 7 A.M. on the date above stated.
(Born alive or stillborn) (Hour A.M. or P.M.)(23) (Signature) S. A. Coleman

(24) State whether Physician or Midwife

(25) Address of Physician or Midwife

Given name added from a supplemental report

(26) Witness
(Signature of Witness necessary only when question 23 is signed by mark)(27) Filed May 16, 1922 (28) C. F. Parker
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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WHEN FATHER, MOTHER, OR OTHER PERSON HAS BEEN INFORMED OF THE BIRTH OF THIS CHILD, AND MARK THE DATE OF SUCH INFORMATION IN THE SPACE PROVIDED HEREON. No. 1. THIS FORM IS TO BE FILED IN THE OFFICE OF THE STATE BOARD OF HEALTH, COLUMBIA, S. C. No. 2. In case of TWINNING OR TRIPLETTING, the mother should mark the date of each birth in the space provided hereon. No. 3. This form is to be filled out by the attending physician or midwife, or by the father, householder, etc., if no attending physician or midwife is present. No. 4. This form is to be filled out by the father, householder, etc., if no attending physician or midwife is present. No. 5. This form is to be filled out by the father, householder, etc., if no attending physician or midwife is present. No. 6. This form is to be filled out by the father, householder, etc., if no attending physician or midwife is present. No. 7. 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