

## (1) PLACE OF BIRTH

County of Richland

Township of .....

or  
Inc. Town of .....or  
City of Leaksville

(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

5495

Registration District No. 380Registered No. 1103

(For use of Local Registrar)

(2) Full Name of Child Rosa Joseph

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

(3) BOY OR GIRL? g (4) Twin or Triplet? no (5) Number in order of birth 6 (6) Are Parents Married? yes (7) DATE OF BIRTH 1 31 1927  
(Name of Month) (Day) (Year)

## FATHER.

(8) FULL NAME Chuck Joseph(9) PRESENT POSTOFFICE OF FATHER Calasc(10) COLOR OR RACE m (11) AGE AT LAST BIRTHDAY 29 (Years)(12) BIRTHPLACE Syria(13) OCCUPATION Restaurant(20) Number of children born to mother, including present birth 6

## MOTHER.

(14) NAME BEFORE MARRIAGE Sarah Francis(15) PRESENT POSTOFFICE OF MOTHER Calasc(16) COLOR OR RACE m (17) AGE AT LAST BIRTHDAY 26 (Years)(18) BIRTHPLACE Syria

(19) OCCUPATION

(21) Number of children of this mother now living, including present birth 4

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

(22) I hereby certify that I attended the birth of this child, who was born at 11 A M. on the date above stated.  
(Born alive or stillborn) (Hour A. M. or P. M.)(23) (Signature) Dr. Rose(24) State whether Physician or Midwife mid (25) Address of Physician or Midwife Calasc

Given name added from a supplemental report

191....

Registrar

(26) Witness (Signature of witness necessary when question 23 is signed by mother)

(27) Filed 2-25 1927 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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