

(1) PLACE OF BIRTH

County of *Freemont*Township of *Ch. Landon*

Inc. Town of

City of

CERTIFICATE OF BIRTH

STATE OF SOUTH CAROLINA

Bureau of Vital Statistics

State Board of Health

File No. — For State Registrar Only

409

Registration District No. *2212*Registered No. *9*
(For use of Local Registrar)

(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 *Broader S. Sullivan*

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

(3) BOY ☒

(4) Twin or Triplet?

(5) Number in order of birth

To be answered only in event of Twins or Triplets

(6) Are Parents Married? *Yes*

(7) DATE OF

BIRTH

(Name of Month) (Day) (Year)

FATHER.

(8) FULL NAME

(9) PRESENT POSTOFFICE OF FATHER

(10) COLOR OR RACE

(11) AGE AT LAST BIRTHDAY

(12) BIRTHPLACE

(13) OCCUPATION

(20) Number of children born to mother, including present birth

MOTHER.

(14) NAME BEFORE MARRIAGE

(15) PRESENT POSTOFFICE OF MOTHER

(16) COLOR OR RACE

(17) AGE AT LAST BIRTHDAY

(18) BIRTHPLACE

(19) OCCUPATION

(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 at M., on the date above stated.

Born alive or Stillborn Hour A. M. or P. M.)

(23) (Signature) *Larry Chapman*

(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

Feb 23

(28)

W. A. Rose

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.