

FORM NO. 2

(1) PLACE OF BIRTH

County of SaludaTownship of No. 5or
Inc. Town ofor
City of

(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

50362

(2) Full Name of Child

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

(3) BOY OR GIRL? girl(4) Twin or Triplet? No(5) Number in order of birth
To be numbered only in case of Twins or Triplets(6) Are Parents Married? Yes(7) DATE OF BIRTH Apr. 17, 1906
(Name of Month) (Day) (Year)

FATHER.

(8) FULL NAME

James Jacob Smith

(9) PRESENT POSTOFFICE OF FATHER

Chappells R.R. 2

(10) COLOR OR RACE

White(11) AGE AT LAST BIRTHDAY 29
(Years)

(12) BIRTHPLACE

Edgefield Co. S.C.

(13) OCCUPATION

Farming

Number of children born to mother, including present birth

5

MOTHER.

(14) NAME BEFORE MARRIAGE

Sara Elizabeth Poyar

(15) PRESENT POSTOFFICE OF MOTHER

Chappells R.R. 2

(16) COLOR OR RACE

White(17) AGE AT LAST BIRTHDAY 30
(Years)

(18) BIRTHPLACE

Edgefield Co. S.C.

(19) OCCUPATION

Housewife

(20) 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 at
(Born alive or stillborn) (Home A. M. or P. M.)
on the date above stated.

(23) (Signature)

(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

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(28)

Local Registrar

Registrar

Registrar

When there was no attending physician or midwife, then the father, householder, etc., should make this report. If a child breathes even once, it must not be reported as stillborn. No report is due until the fifth month of pregnancy.