

(1) PLACE OF BIRTH

County of *Charleston*Township of *Charleston*or
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

79323

Registration District No. *4008*Registered No. *654*

(For use of Local Registrar)

(2) Full Name of Child

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

BOY OR GIRL?

Girl(4) Twin or Triplet? ☐(5) Number in order of birth ☐(6) Are Parents Married? *Y*(7) DATE OF BIRTH *Aug 4* 191*6*

(Name of Month) (Day) (Year)

FATHER.

(8) FULL NAME *William Henderson*(9) PRESENT POSTOFFICE OF FATHER *Charleston, S.C.*(10) COLOR OR RACE *W*(11) AGE AT LAST BIRTHDAY *29* (Years)(12) BIRTHPLACE *SC*(13) OCCUPATION *Grocery Merchant*(14) Number of children born to mother, including present birth *1*

MOTHER.

(14) NAME BEFORE MARRIAGE *Emily Grier*(15) PRESENT POSTOFFICE OF MOTHER *Charleston, S.C.*(16) COLOR OR RACE *W*(17) AGE AT LAST BIRTHDAY *27* (Years)(18) BIRTHPLACE *SC*(19) OCCUPATION *Domestic*(20) Number of children of this mother now living, including present birth *1*

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

(21) I hereby certify that I attended the birth of this child, who was *alive* at *7:30* A.M. (Born alive or stillborn) (Hour A.M. or P.M.) on the date above stated.(23) (Signature) *Edith W. Allen*

(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) Recd. *Aug 15 1916*(28) *C. F. Parker*

Local Registrar

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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