CERTIFICATE OF BIRTH

STATE OF SOUTH CAROLINA.
Bureau of Vital Statistics
State Board of Health

File No.—For State Registrar Only
49110

(1) PLACE OF BIRTH

County of Florence Co.

Township of Hannah

Inc. Town of ..... Registration District [illegible] Registered No. ..... (For use of Local Registrar)

City of ..... (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 Ollie Jo Ca Powell. { If child is not yet named, make supplemental report as directed

(3) BOY OR GIRL? girl | (4) Twin or triplet? To be answered only in event of Twins or Triplets | (5) Number in order of birth | (6) Are Parents Married? yes | (7) DATE OF BIRTH Jan 24 (Name of Month) (Day) 1916 (Year)

FATHER.

(8) FULL NAME Lionel Abraham

(9) PRESENT POSTOFFICE OF FATHER Kingstree SC

(10) COLOR OR RACE white (11) AGE AT LAST BIRTHDAY 24 (Years)

(12) BIRTHPLACE Florence Co.

(13) OCCUPATION farm

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

MOTHER.

(14) NAME BEFORE MARRIAGE Pearl Pamela Abraham

(15) PRESENT POSTOFFICE OF MOTHER Kingstree

(16) COLOR OR RACE white (17) AGE AT LAST BIRTHDAY 20 (Years)

(18) BIRTHPLACE Florence Co

(19) OCCUPATION Home work

(21) Number of children of this mother now living, including present birth 2

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

(22) I hereby certify that I attended the birth of this child, who was Live (Born alive or stillborn) at 2 (Hour A. M. or P. M.) 0 M., on the date above stated.

(23) (Signature) Mande Stout M.D. Wife

(24) State whether Physician or Midwife

(25) Address of Physician or Midwife

Given name added from a supplemental report

....., 191....

..... Registrar

(26) Witness ..... (Signature of Witness necessary only when question 23 is signed by mark)

(27) Filed .....191... (28) ..... 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.

Form No. 10.
WRITE PLAINLY. WRITE LONG STROKE INK. NO ABBREVIATIONS. NO ERASURES. REMOVE ONE SHEET ONLY. USE A SEPARATE BLANK for each child, and mark the FIRST-BORN, No. 1. THIS OFFICE, No. 2, etc., in question 5.
N. B.—In case of TWINS OR TRIPLETS use a SEPARATE BLANK for each child, and mark the FIRST-BORN, No. 1. THIS OFFICE, No. 2, etc., in question 5.