

(1) PLACE OF BIRTH

County of Chestnutfield SCTownship of C.H.

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

23954

Registration District No. 2-3 Registered No. 101.....
(For use of Local Registrar)

(If birth occurs in a hospital or other institution, give name of same instead of street and number.)

(2) Full Name of Child Chyde Ballard Adams If child is not yet named, make supplemental report as directed(3) BOY OR GIRL Boy (4) Twin or Triplet No (5) Number in order of birth 1 (6) Are Parents Married yes (7) DATE OF BIRTH Aug 12 23
(Month of Birth) (Day) (Year)

FATHER.

(8) FULL NAME Ben J Adams(9) PRESENT POSTOFFICE OF FATHER Chestnutfield SC(10) COLOR OR RACE White (11) AGE AT LAST BIRTHDAY 23
(Year)(12) BIRTHPLACE SC(13) OCCUPATION Farmer(14) Number of children born to mother, including present birth 2

MOTHER.

(14) NAME BEFORE MARRIAGE Martha Hunter(15) PRESENT POSTOFFICE OF MOTHER Chestnutfield SC(16) COLOR OR RACE White (17) AGE AT LAST BIRTHDAY 26
(Year)(18) BIRTHPLACE SC(19) OCCUPATION Housewife(20) Number of children of this mother now living, including present birth 2

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

(21) I hereby certify that I attended the birth of this child, who was born alive at 2 P.M. on the date above stated. (Born alive or stillborn) (Hour A. M. or P. M.)(22) (Signature) W. J. Seal(23) State whether Physician or Midwife Phys(24) Address of Physician or Midwife Chestnutfield SC

Given name added from a supplemental report

(25) Witness

(Signature of Witness necessary only when question 25 is signed by mark)

(26) Filed Aug 8 1923 (27) M. S. Watson
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 desired of stillbirths before the fifth month of pregnancy.

Form No. 4

Registration District No. 1203

Primary Reg. District No.

STATE OF SOUTH CAROLINA
STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

Supplemental Report of Births

Place of Birth

City or Town

Street and House No.

Township of

County

ChesterfieldCourt HouseChesterfield

File Number*

Registered Number* 101

SEX OF CHILD*

BoyTwin,*
Triplet,
or Other?

and

Number*
in order
of birth2nd

DATE OF BIRTH*

Aug.171923

Month

Day

Year

FATHER

FULL
NAMEBen J.Adams

MOTHER

FULL
MAIDEN
NAMEMartinaHunterI HEREBY CERTIFY that the child described herein has
been named:Clyde Ballard Adams

Given name in full

Surname

as reported by

Father

Father or Mother

(Signed)

Mrs. M. S. Watson

Local Registrar

*These items to be entered by the Registrar before giving out this form.