

(1) PLACE OF BIRTH

County of Charleston

Township of

or
Inc. Town of

or

City of Charleston

(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

27381

Registration District No. 325

Registered No.

(For use of Local Registrar)

St.: Ward:

(2) Full Name of Child Baby Richardson

If child is not yet named on the supplemental report as directed

(1) BOY
OR
GIRL Boy(4) Twin
or Triplet? 1(3) Number in
order of birth

To be answered only in event of Twin or Triplets

(6) Are
Parents
Married? Yes(7) DATE OF
BIRTH Sept 3 1923

(Name of Month) (Day) (Year)

(8) FULL
NAME

FATHER

(9) PRESENT
POSTOFFICE
OF FATHER(10) COLOR
OR
RACE Col(11) AGE AT LAST
BIRTHDAY 23

(Years)

(12) BIRTHPLACE

(13) OCCUPATION

(20) Number of children born to
mother, including present birth3(14) NAME BEFORE
MARRIAGE

MOTHER

(15) PRESENT
POSTOFFICE
OF MOTHER(16) COLOR
OR
RACE Col(17) AGE AT LAST
BIRTHDAY 21

(Years)

(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 born alive
on the date above stated.

(Born alive or stillborn)

Hour A. M. or P. M.

(23) (Signature)

(24) State whether Physician or Midwife

(25) Address of Physician or Midwife

Given name added from a supplement-
tal report

(26) Witness

(Signature of Witness necessary only
when question 22 is signed by mark)

(27) Filed

2 1923

J. Mendenhall, M.D.
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.