

(1) PLACE OF BIRTH **CERTIFICATE OF BIRTH**

County of **Charleston** STATE OF SOUTH CAROLINA.

Township of **Charleston**

City of **Charleston**

Registration District No. **12A**

File No. **27703** For State Registrar Only

Registered No. **5-3**  
(For use of Local Registrar)

(1) Birth occurs in a hospital or other institution, give name of same instead of street and number. (2) Full Name of Child **Dell Eastling**

BOY or GIRL **Boy** (4) Twin or Triplet? (5) Number in order of birth (6) Are Parents Married? (7) DATE OF BIRTH **Sept 1 23**  
(Name of Month) (Day) (Year)

FATHER: FULL NAME **Fred Eastling** (14) NAME BEFORE MARRIAGE **Callie Smith**

PRESENT POSTOFFICE OF FATHER **Charleston S.C.** (15) PRESENT POSTOFFICE OF MOTHER **Charleston S.C.**

COLOR OR RACE **Colored** (16) AGE AT LAST BIRTHDAY **26** (17) AGE AT LAST BIRTHDAY **22**  
(Years) (Years)

BIRTHPLACE **S.C.** (18) BIRTHPLACE **S.C.**

OCCUPATION **Laborer** (19) OCCUPATION **House work**

Number of children born to mother, including present birth **1** (21) Number of children of this mother now living, including present birth **1**

**CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE**

I hereby certify that I attended the birth of this child, who was **born alive** on the date above stated. (Hour A. M. or P. M.)

(22) (Signature) **W. L. Smith** (23) State whether Physician or Midwife (24) Address of Physician or Midwife **Charleston S.C.**

When name added from a supplemental report (25) Witness **W. L. Smith**

(26) Filed **23** (27) Local Registrar **W. L. Smith**

When there was no attending physician or midwife, then the father, householder, etc., should make this return. If 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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