

CERTIFICATE OF BIRTH

STATE OF SOUTH CAROLINA

Bureau of Vital Statistics
State Board of Health

FILE NO. FOR REGISTRATION
3127

Registration District No.

Registration No.

212

NAME OF CHILD

BOYER HOSPITAL

(For use of Local Registrar)

Ward

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

1. FULL NAME OF CHILD **ARSHIELA SARA STONEY**

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

2. SEX
Boy

3. AGE or
TODDLER

4. Number in order
of BIRTH

5. DATE OF BIRTH
Feb. 27, 1923

6. NAME OF MOTHER
Isabella STONEY

To be answered only in event of Twins or Triplets

FATHER

Courtney CASTELLA Lewis

New York, N.Y.

10. COLOR
Colored

11. AGE AT LAST
BIRTHDAY **36**
(Years)

12. BIRTHPLACE
Charleston, S.C.

13. OCCUPATION
Carpenter

MOTHER

14. NAME BEFORE
MARRIAGE **Isabella STONEY**

15. PRESENT
RESIDENCE **Charleston SC**

16. COLOR **Colored** 17. AGE AT LAST
BIRTHDAY **42**
OR BIRTHDAY (Years)

18. BIRTHPLACE
Johns Island, S.C.

19. OCCUPATION
Domestic

20. Number of children of this mother
now living, including present birth **2**

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was **BORN ALIVE** **5:15 PM M.**
(Born alive or stillborn) (Hour A.M. or P.M.)

W. M. Jones, M. D.

21. Signature

22. Date whether Physician or Midwife

23. Address of Physician or Midwife

Give name added from a supplementary report

24. Witness

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

25. Filed

3/3/23

19

J. M. Green, M.D.

Local 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 is reported as stillborn. No report is desired of stillbirths before the fifth month of pregnancy.

For filing

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