

## (1) PLACE OF BIRTH

County of .....

Township of .....

or

Loc. Town of .....

or

City of .....

(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

26482

Registration District No. 73A

Registered No. 114  
(For use of Local Registrar)

(No. .... St.; .... Ward)

## (2) Full Name of Child

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

3) BOY OR GIRL?	4) Twin or Triplet?	5) Number in order of birth	6) Are Parents Married?	7) DATE OF BIRTH
	To be answered only in event of Twins or Triplets		YES	JULY 31, 1922 (Name of Month) (Day) (Year)

## FATHER.

1) FULL NAME

2) PRESENT POSTOFFICE OF FATHER

10) COLOR OR RACE

(11) AGE AT LAST BIRTHDAY 23  
(Years)

12) BIRTHPLACE

13) OCCUPATION

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

## MOTHER.

(14) NAME BEFORE MARRIAGE

(15) PRESENT POSTOFFICE OF MOTHER

(16) COLOR OR RACE

(17) AGE AT LAST BIRTHDAY 23  
(Year)

(18) BIRTHPLACE

(19) OCCUPATION

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

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

(2) I hereby certify that I attended the birth of this child, who was ... Alive ... at 5:30 P.M. on the date above stated.  
(Born alive or stillborn) (Hour A. M. or P. M.)(23) (Signature) C. H. Blake, M. D. B. S.

(24) State whether Physician or Midwife

(25) Address of Physician or Midwife  
Greenville, S. C.

Physician

Given name added from a supplemental report

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

(27) Filed 8/1/22 19 ... (28) W. A. Williams Local RegistrarWhen 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.

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