

## (1) PLACE OF BIRTH

County of York  
 Township of Haywards  
 or  
 Inc. Town of York  
 or  
 City of \_\_\_\_\_

## CERTIFICATE OF BIRTH

STATE OF SOUTH CAROLINA  
 Bureau of Vital Statistics  
 State Board of Health

Registration District North 07Registered No. 149  
(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 John Neil Presnell

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

(1) SEX OF CHILD Boy (2) Type of Twin To be reported only in case of Twin or Triple (3) Number in order of birth 1 (4) Are Parents Married Yes (5) DATE OF BIRTH Nov 4, 1923  
 (Name of Month) (Day) (Year)

## FATHER

(6) FULL NAME John Neil Presnell  
 (7) PRESENT POSTOFFICE OF FATHER York  
 (8) COLOR OR RACE White (9) AGE AT LAST BIRTHDAY 34  
 (Year) (10) BIRTHPLACE York  
 (11) OCCUPATION Farmer

## MOTHER

(12) NAME BEFORE MARRIAGE John  
 (13) PRESENT POSTOFFICE OF MOTHER York  
 (14) COLOR OR RACE White (15) AGE AT LAST BIRTHDAY 34  
 (Year) (16) BIRTHPLACE York  
 (17) OCCUPATION Farmer

(18) Number of children born to mother, including present birth 1(19) Number of children of this mother now living, including present birth 1

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

(20) I hereby certify that I attended the birth of this child, who was born alive at 2:20 P. M. on the date above stated. (Born alive or stillborn) (Hour, M. or P. M.)(21) (Signature) John Neil Presnell

(22) State whether Physician or Midwife

(23) Address of Physician or Midwife York

Given name added from a supplemental report

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

(25) Filed Dec - 2 1923 (26) 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.

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