

(1) PLACE OF BIRTH

County of *Sumter*Township of *Katlin Oak*Inc. Town of */*City of */*

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

(2) Full Name of Child *Benjamin S. Taylor Jr.*

File No.—For State Registrar Only

66444

CERTIFICATE OF BIRTH

STATE OF SOUTH CAROLINA.

Bureau of Vital Statistics

State Board of Health

Registration District No. *4106* Registered No. *58*
(For use of Local Registrar)

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

(3) BOY OR GIRL? *Bo* (4) Twin or Triplet? *No* (5) Number in order of birth *3* (6) Are Parents Married? *Yes* (7) DATE OF BIRTH *June 17 1914*
(Name of Month) (Day) (Year)

FATHER.

(8) FULL NAME *Benjamin Taylor Sr.*(9) PRESENT POSTOFFICE OF FATHER *Kimbert SC*(10) COLOR OR RACE *Negro* (11) AGE AT LAST BIRTHDAY *26*
(Years)(12) BIRTHPLACE *Sumter Co SC*(13) OCCUPATION *Field Laborer*(20) Number of children born to mother, including present birth *3*

MOTHER.

(14) NAME BEFORE MARRIAGE *Binky Chapman*(15) PRESENT POSTOFFICE OF MOTHER *Kimbert SC*(16) COLOR OR RACE *Negro* (17) AGE AT LAST BIRTHDAY *23*
(Years)(18) BIRTHPLACE *Sumter Co SC*(19) OCCUPATION *House Wife*(21) Number of children of this mother now living, including present birth *3*

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

(22) I hereby certify that I attended the birth of this child, who was *Born alive* at *1130 A.M.* on the date above stated. (Born alive or stillborn) (Hour A. M. or P. M.)(23) (Signature) *M. S. Taylor*(24) State whether Physician or Midwife (25) Address of Physician or Midwife *Kimbert SC*

Given name added from a supplemental report

(26) Witness *W. C. Haller*(Signature of witness necessary only when question *26* signed by mark)(27) Filed *June 1914* (28) *W. C. Haller* 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.

Fifth month of pregnancy.

FORM NO. 10
 PRINTED BY THE
 STATE BOARD OF HEALTH
 COLUMBIA, S. C.