

(1) PLACE OF BIRTH

County of *York*Township of *Wm. H.*or
Inc. Town ofor
City of

CERTIFICATE OF BIRTH

STATE OF SOUTH CAROLINA

Bureau of Vital Statistics

State Board of Health

File No. - For State Registrar Only

9555

Registration District No. *4407*Registered No. *10*

(For use of Local Registrar)

(No.)

St.

Ward)

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

(2) Full Name of Child *Bessie King*

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

(3) BOY OR GIRL *Girl*

(4) Twin? or Triplet

(5) Number in order of birth

(6) Age, Female, Married

(7) DATE

Birth *Feb 22 1922*
(Name of Month) (Day) (Year)

FATHER.

(8) FULL NAME *Jim King*(9) PRESENT POSTOFFICE OF FATHER *Chesee S.C.*(10) COLOR OR RACE *W.C.*(11) AGE AT LAST BIRTHDAY *29*
(Year)(12) BIRTHPLACE *S.C.*(13) OCCUPATION *Farm*(14) NAME OF MOTHER *John Littlejohn*(15) PRESENT POSTOFFICE OF MOTHER *Chesee S.C.*(16) COLOR OR RACE *W.C.*(17) AGE AT LAST BIRTHDAY *28*
(Year)(18) BIRTHPLACE *S.C.*(19) OCCUPATION *Housewife*(20) Number of children born to mother, including present birth *4*(21) Number of children of this mother now living, including present birth *4*

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

(22) I hereby certify that I attended the birth of this child, who was *John* at *4 P.M.*
on the date above stated. (Born alive or stillborn) (Hour A.M. or P.M.)
Ruth King

(23) (Signature)

(24) State whether

Physician or Midwife

(25) Address of Physician or Midwife

Given name added from a supplemental report

(26) (Signature)

(27) (Signature of Witness necessary only when question 22 is signed by Mark)

(28) (Signature)

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.