

(1) PLACE OF BIRTH

County of *Charleston S.C.*

CERTIFICATE OF BIRTH

STATE OF SOUTH CAROLINA
Bureau of Vital Statistics
State Board of HealthNo. *32102*Township of *Charleston S.C.*or
Inc. Town of *Charleston S.C.*Registration District No. *9*Registered No. *1000*
(For use of Local Registrar)City of *Charleston S.C.*(No. *3* ... *Home street* ... *1.2* ... Ward)
(If birth occurs in a hospital or other institution, give name of same instead of street and number.)(2) Full Name of Child *Walter Edmund Ferguson*

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

(3) SEX OR CHILD *Boy* (4) Type of child *me* (5) Number in order of birth *6* (6) Sex of mother *Yes* (7) DATE OF BIRTH *Nov 14 1923*
(Name of Month) (Day) (Year)

FATHER.

(8) FULL NAME *Walter Edmund Ferguson*(9) PRESENT RESIDENCE OF FATHER *Charleston S.C.*(10) COLOR *Colored* (11) AGE AT LAST BIRTHDAY *35*
(Year)(12) BIRTHPLACE *Charleston S.C.*(13) OCCUPATION *Painter*

MOTHER.

(14) NAME BEFORE MARRIAGE *Bessie Glover*(15) PRESENT RESIDENCE OF MOTHER *Charleston S.C.*(16) COLOR *Colored* (17) AGE AT LAST BIRTHDAY *32*
(Year)(18) BIRTHPLACE *Charleston S.C.*(19) OCCUPATION *housewife*(20) Number of children born to mother, including present birth *5* *3 living*(21) Number of children of this mother now living, including present birth *5* *3 living*

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

(22) I hereby certify that I attended the birth of this child, who was *born* *Nov 14 1923* *2 A.M.*
on the date above stated. (Born Day or Night) (Hour A. M. or P. M.)(23) (Signature) *Amelia A. Jones*(24) State whether Physician or Midwife *midwife* (25) Address of Physician or Midwife *312 Reid St.*

Given name added from a supplemental report

(26) Witness *Walter D. Swallow Ferguson*
(Signature of Witness necessary only when question 22 is signed by mark)(27) Filed *11/20* *1923* *11/2*

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.

FIVE MONTHS OF PREGNANCY