

## (1) PLACE OF BIRTH

County of *Chas.*

Township of .....

Inc. Town of .....

City of *Chas.*

## CERTIFICATE OF BIRTH

STATE OF SOUTH CAROLINA

Bureau of Vital Statistics

State Board of Health

Registration District No. *9 A*

Registered No. ....

(For use of Local Registrar)

(No. *91 Queen*)

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

*Fannie Baby Shepard*

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

(3) Sex *Female* (4) Type or Figure *To be reported only in event of Twin or Triplets* (5) Number in order of birth *Yes* (6) Date of Birth *Nov 10 1923* (Based on Month) (Day) (Year)

## FATHER.

(8) Full Name *Allen & Shepard*(9) Present Residence of Father *Chas. S. C.*(10) Color *C* (11) Age at last birthday *23* (Year)(12) Birthplace *Rockville S. C.*(13) Occupation *Farmer*(14) Number of children born to mother, including present birth *3*

## MOTHER.

(16) Name before marriage *Allen & Shepard*(17) Present Residence of Mother *Chas. S. C.*(18) Color *C* (19) Age at last birthday *21* (Year)(20) Birthplace *Chas. S. C.*(21) Occupation *Washer*(22) Number of children of this mother now living, including present birth *2*

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

(23) I hereby certify that I attended the birth of this child, who was... on the date above stated. (Day of week) (Hour of day) (P. M.)

(24) (Signature) *Julia Johnson*

(25) State whether Physician or Midwife

(26) Address of Physician or Midwife

Given name added from a supplemental report

(27) Witness *Julia Johnson* (Signature of Witness necessary only when question 23 is signed by mark)(28) Filed *11/20 1923* (29) *Julia Johnson* 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.