

## (1) PLACE OF BIRTH

## CERTIFICATE OF BIRTH

STATE OF SOUTH CAROLINA

Bureau of Vital Statistics

State Board of Health

No. 10.—For State Registrar Only

28242

County of Florence

Township of .....

or

Inc. Town of .....

or

City of Florence

Registration District No. 20A Registered No. 2823

(For use of Local Registrar)

(No. 2823) (Ward)

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

(2) Full Name of Child Charles H. (If child is not yet named, make supplemental report as directed)

(3) SEX OF CHILD Male	(4) Twin or Triplet To be answered only in event of Twin or Triplet	(5) Number in order of birth 1	(6) Age at Birth 1 yr 1 mo	(7) DATE OF BIRTH (Month of Month) (Day) (Year) Apr 1 23
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(8) FULL NAME OF FATHER Off Mr. Langhain	(9) FULL NAME OF MOTHER Mrs. J. Smith
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(10) PRESENT POSTOFFICE OF FATHER Flem	(11) PRESENT POSTOFFICE OF MOTHER Flem
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(12) COLOR OR RACE W	(13) AGE AT LAST BIRTHDAY 23	(14) COLOR OR RACE W	(15) AGE AT LAST BIRTHDAY 23
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(16) BIRTHPLACE Fayetteville N.C.	(17) BIRTHPLACE Flem Co
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(18) OCCUPATION Flagman	(19) OCCUPATION Dr.
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(20) Number of children born to mother, including present birth 2	(21) Number of children of this mother now living, including present birth 2
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## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

(22) I hereby certify that I attended the birth of this child, who was born alive or stillborn (How - A. M. or P. M.) on the date above stated.

(23) (Signature) D. H. Smith

(24) State whether Physician or Midwife (25) Address of Physician or Midwife

(Given name added from a supplemental report)

(26) Witness (Signature of Witness necessary only when question 22 is signed by mark)

(27) Filed \$ 15.15 12.3 (28) P. A. Pughman, M.D. 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.