

Form No. 1.

(1) PLACE OF BIRTH

County of

Township of

or  
Inc. Town of

or

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

## CERTIFICATE OF BIRTH

STATE OF SOUTH CAROLINA.

Bureau of Vital Statistics

State Board of Health

File No.—For State Registrar Only

71080

Registration District No. 204

Registered No. 45  
(For use of Local Registrar)

St.; ..... Ward)

If child is not yet named, make  
supplemental report as directed(3) BOY OR  
GIRL? boy(4) Twin  
or Triplet?(5) Number in  
order of birth 1(6) Are  
Parents  
Married? no(7) DATE OF  
BIRTH Aug 21 1916  
(Name of Month) (Day) (Year)

## FATHER.

(8) FULL  
NAME(9) PRESENT  
POSTOFFICE  
OF FATHER(10) COLOR  
OR  
RACE Colored(11) AGE AT LAST  
BIRTHDAY 20

(Years)

(12) BIRTHPLACE

(13) OCCUPATION

(20) Number of children born to  
mother, including present birth

## MOTHER.

(14) NAME BEFORE  
MARRIAGE(15) PRESENT  
POSTOFFICE  
OF MOTHER(16) COLOR  
OR  
RACE Colored(17) AGE AT LAST  
BIRTHDAY 17

(Years)

(18) BIRTHPLACE

(19) OCCUPATION

(21) Number of children of this mother  
now living, including present birth 1

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

(22) I hereby certify that I attended the birth of this child, who was alive at 5:15 a.m.,  
(Born alive or stillborn) (Hour A. M. or P. M.)  
on the date above stated.

(23) (Signature)

(24) State whether Physician or Midwife

(25) Address of Physician or Midwife

Given name added from a supplement-  
tal report

(26) Witness

(Signature of Witness necessary only  
when question 23 is signed by mark)

(27) Filed

Aug 22 1916

(28)

H. C. Mark 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.