

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

SEX OR
GIRL(4) Twin
or Triplet?(5) Number in
order of birth(6) Are
Parents
Married?

(7) DATE OF

BIRTH

(Name of Month) (Day) (Year)

(3) FULL
NAME(8) PRESENT
POSTOFFICE
OF FATHER(10) COLOR
OR
RACE

(12) BIRTHPLACE

(13) OCCUPATION

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

FATHER

(11) AGE AT LAST
BIRTHDAY

(13) OCCUPATION

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

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

(22) I hereby certify that I attended the birth of this child, who was
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-
al report

(26) Witness

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

(28)

Local Registrar

When there was no attending physician or midwife, the householders, etc., should make this return.
If a child breathes even once, it is a birth. No report is desired of stillbirths.

CERTIFICATE OF BIRTH

STATE OF SOUTH CAROLINA

Bureau of Vital Statistics

State Board of Health

File No.—For State Registrar Only

18382

Registration District No. 1601

Registered No. 40
(For use of Local Registrar)

St.; (set number) Ward)

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

RECEIVED BY COLUMBIA, COLUMBIA, S. C.