

Form No 1.

## (1) PLACE OF BIRTH

County of Charleston  
 Township of Edisto Island

## CERTIFICATE OF BIRTH

STATE OF SOUTH CAROLINA  
 Bureau of Vital Statistics  
 State Board of Health

File No.—For State Registrar Only

80638

OR  
 Inc. Town of

Registration District No. 902Registered No. 186  
(For use of Local Registrar)

OR  
 City of

(No. \_\_\_\_\_)

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

Not named yet

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

(3) BOY OR GIRL?

Boy

(4) Twin or Triplet?

to be answered only in event of Twins or Triplets

(5) Number in order of birth

(6) Are Parents Married?

Yes

(7) DATE OF BIRTH

Oct. 20, 1916  
(Name of Month) (Day) (Year)

## FATHER.

(8) FULL NAME

G. O. H. King

(9) PRESENT POSTOFFICE OF FATHER

Edisto Island

(10) COLOR OR RACE

White

(11) AGE AT LAST BIRTHDAY

38  
(Years)

(12) BIRTHPLACE

Edisto Island

(13) OCCUPATION

Planter

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

6

## MOTHER.

(14) NAME BEFORE MARRIAGE

Minna Rosa Bailey

(15) PRESENT POSTOFFICE OF MOTHER

Same

(16) COLOR OR RACE

Same

(17) AGE AT LAST BIRTHDAY

38  
(Years)

(18) BIRTHPLACE

Same

(19) OCCUPATION

Housewife

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

6

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

(22) I hereby certify that I attended the birth of this child, who was Alive at H. P. M. on the date above stated. (Born Alive or stillborn) (Hour A. M. or P. M.)

(23) (Signature)

Mrs. F. M. Bailey

(24) State whether Physician or Midwife

Midwife

(25) Address of Physician or Midwife

Edisto Island

Given name added from a supplemental report

191

(26) Witness

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

Oct 29, 1916

(27) Filled

1916

(28)

Samuel M. Mable  
Local Registrar

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.

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
N. B.—In case of TWINS OR TRIPLETS use a SEPARATE BLANK for each child, and mark the FIRST-BORN, No. 1, THE OTHER, No. 2, etc., in question 5.

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