

(1) PLACE OF BIRTH

County of *Franklin*

Township of *12-4-18*

or Inc. Town of *12-4-18*

or City of *12-4-18*

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

# CERTIFICATE OF BIRTH

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

File No. For State Registrar Only

87505

Registration District No. *4006*

Registered No. *164*

(For use of Local Registrar)

St.; ..... Ward

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

(2) Full Name of Child *John Webb*

(3) BOY OR GIRL *girl*

(4) Twin or Triplet?

(5) Number in order of birth

(6) Are Parents Married? *yes*

(7) DATE OF BIRTH *11/14/1916*

MOTHER.

(8) FULL NAME *John Webb*

(14) NAME BEFORE MARRIAGE *Bessie Mathis*

(9) PRESENT POSTOFFICE OF FATHER *Trough SC*

(15) PRESENT POSTOFFICE OF MOTHER *Trough SC*

(10) COLOR OR RACE *White*

(11) AGE AT LAST BIRTHDAY *22*

(16) COLOR OR RACE *White*

(17) AGE AT LAST BIRTHDAY *22*

(12) BIRTHPLACE *Tenn.*

(18) BIRTHPLACE *SC*

(13) OCCUPATION *Mill oper.*

(19) OCCUPATION *Housewife.*

(20) Number of children born to mother, including present birth *4*

(21) Number of children of this mother now living, including present birth *2*

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

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

(23) (Signature) *M. D.*

(24) State whether Physician or Midwife

(25) Address of Physician or Midwife *Franklin, SC*

Given name added from a supplemental report

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Registrar

(26) Witness

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

(27) Filed *11/20/16*

(28)

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.

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