

NAME OF BIRTH

York

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

No. **38036**

Registration District No. **4412** Registered No. **268**
(For use of Local Registrar)

(No. St. Ward)
(If birth occurs in a hospital or other institution, give name of same instead of street and number.)
Name of Child **Edgar** If child is not yet named, make supplemental report as directed

(1) Sex **B** (2) Twin or Triplet **X** (3) Number in order of birth **X** (4) Age of Parent **28** (5) DATE OF BIRTH **10-19-28**
To be answered only in case of Twin or Triplet (Date of Month) (Day) (Year)

FATHER.
Name **James Franklin Robins**
Present Postoffice of Father **Rose Hill**
(11) AGE AT LAST BIRTHDAY **25** (Year)
County **York Co**
Twp. **Twelve**

MOTHER.
(12) NAME OF MOTHER **Matilda Belle Macgregor**
(13) PRESENT POSTOFFICE OF MOTHER **Rose Hill**
(14) COLOR OR RACE **W** (15) AGE AT LAST BIRTHDAY **24** (Year)
(16) BIRTHPLACE **York Co**
(17) OCCUPATION **Dom**
(18) Number of children of this mother now living, including present birth **3**

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was at M.
on the date above stated. (Born alive or still born) (Hour A. M. or P. M.)
(19) (Signature) **Donald Rife**
(20) State whether Physician or Midwife (21) Address of Physician or Midwife

Name added from a supplemental report
(22) Witness (Signature of Witness necessary only when question 22 is signed by mark)
(23) Filed **12/11/28** (24) Local Registrar

19 .. Registrar
If 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.