

## (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.)

## CERTIFICATE OF BIRTH

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

No. 1a.—For State Registrar Only

22753

Registration District No. ....

Registered No. 74  
(For use of Local Registrar)

(No. 1 ..... St. 1 ..... Ward)

## (2) Full Name of Child

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

(3) BOY OR  
GIRL(4) Twin  
or Triplet  
To be answered only in event of Twin or Triplet(5) Number in  
order of birth(6) Are  
Parents  
Married(7) DATE OF  
BIRTH .....  
(Name of Month) (Day) (Year)

## FATHER.

(8) FULL  
NAME(9) PRESENT  
POSTOFFICE  
OF FATHER(10) COLOR  
OR  
RACE(11) AGE AT LAST  
BIRTHDAY .....  
(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(17) AGE AT LAST  
BIRTHDAY .....  
(Years)

(18) BIRTHPLACE

(19) OCCUPATION

(21) Number of children of this mother  
now living, 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. (Born alive or stillborn) (Hour A. M. or P. M.)(23) (Signature) *Louise Nelson*

(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 23 is signed by mark)

(27) Filed ..... 19 ..... (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.