

Form No. 1

## (1) PLACE OF BIRTH

County of  Spartanburg   
 Carolina 

Township of .....

or  
Inc. Town of .....or  
(City of .....

## CERTIFICATE OF BIRTH

STATE OF SOUTH CAROLINA  
Bureau of Vital Statistics  
State Board of HealthRegistration District No.  4006  Registered No.  6000   
(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.)(2) Full Name of Child  J. C. Threlkeld  If child is not yet named, make supplemental report as directed3 SEX ON BIRTH  Male  4 Twin or Triplet  No  5 Number in order of birth  1  6 Are Parents Married  Yes  7 DATE OF BIRTH  5-27-23   
(Name of Month) (Day) (Year)8 FULL NAME OF FATHER  J. C. Threlkeld  9 PRESENT POSTOFFICE OF FATHER  Greenville, S.C.  10 COLOR OR RACE  White  11 AGE AT LAST BIRTHDAY  24  12 BIRTHPLACE  S.C.  13 OCCUPATION  Bookkeeper 14 NAME BEFORE MARRIAGE  Earl Bullington  15 PRESENT POSTOFFICE OF MOTHER  Greenville, S.C.  16 COLOR OR RACE  White  17 AGE AT LAST BIRTHDAY  19  18 BIRTHPLACE  S.C.  19 OCCUPATION  Housewife 20 Number of children born to mother, including present birth  1  21 Number of children of this mother now living, including present birth  1 

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

(22) I hereby certify that I attended the birth of this child, who was  J. C. Threlkeld  (Born alive or stillborn) (Date A. M. or P. M.)  
on the date above stated.(23) (Signature)  M. J. ...  (24) State whether Physician or Midwife  Physician  (25) Address of Physician or Midwife  ... 

Give name added from a supplemental report

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

(27) Filed  5-30-23  (28)  J. C. Threlkeld  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.