

County of San Diego
Township of Heidelberg
or
Inc. Town of
or
City of

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

90615

Registration District No. 7907 Registered No. 101
(For use of Local Registrar)

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

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

(3) BOY OR GIRL <i>Boy</i>	(4) Twin or Triplet? To be answered only in case of Twins or Triplets	(5) Number in order of birth	(6) Are Parents Married? <i>Yes</i>	(7) DATE OF BIRTH (Name of Month) (Day) (Year) <i>Dec 16 1916</i>
FATHER			MOTHER	
(8) FULL NAME <i>Spencer May Craig</i>	(14) NAME BEFORE MARRIAGE <i>Ella Jean Boyd</i>			
(9) PRESENT POSTOFFICE OF FATHER <i>Mountville Pa</i>	(15) PRESENT POSTOFFICE OF MOTHER <i>Mountville Pa</i>			
(10) COLOR OR RACE <i>White</i>	(11) AGE AT LAST BIRTHDAY <i>29</i>	(16) COLOR OR RACE <i>White</i>	(17) AGE AT LAST BIRTHDAY <i>23</i>	
(12) BIRTHPLACE <i>Lancaster Pa</i>		(18) BIRTHPLACE <i>Lancaster Pa</i>		
(13) OCCUPATION <i>Saloon - Seal Store</i>		(19) OCCUPATION <i>House Wife</i>		
(20) Number of children born to mother, including present birth <i>3</i>	(21) Number of children of this mother now living, including present birth <i>3</i>			

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

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

(23) (Signature)

(24) State whether Physician or Midwife

15 Address of Physician or Midwife

Given name added from a supplemental report

(26) Witness

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

(27) **FI**

.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.

N. 3.—In case of twins or triplets use a separate HICANIC FOR EACH CHILD, and mark the N. 3.—in each HICANIC. Mark the HICANIC with the following information: NAME, DATE OF BIRTH, SEX, RACE, and the name of the physician attending the case. Mark the HICANIC with the following information: NAME, DATE OF BIRTH, SEX, RACE, and the name of the physician attending the case.