

Form No. 1

## (1) PLACE OF BIRTH

County of LeeTownship of S. Charles

or

Inc. Town of .....

or

City of .....

## CERTIFICATE OF BIRTH

STATE OF SOUTH CAROLINA

Bureau of Vital Statistics

State Board of Health

File No.—For State Registrar Only

43410

Registration District No. 3007Registered No. 66  
(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

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

3) BOY OR GIRL girl

4) Twin or Triplet?

5) Number in order of birth

6) Are Parents Married? yes7) DATE OF BIRTH Aug 10 22  
(Name of Month) (Day) (Year)

## FATHER

8) FULL NAME James Addison9) PRESENT POSTOFFICE OF FATHER S. Charles

10) COLOR OR RACE

11) AGE AT LAST BIRTHDAY 32  
(Years)12) BIRTHPLACE St. 313) OCCUPATION laborer20) Number of children born to mother, including present birth 6

## MOTHER

14) NAME BEFORE MARRIAGE Mary Anderson15) PRESENT POSTOFFICE OF MOTHER S. Charles16) COLOR OR RACE C17) AGE AT LAST BIRTHDAY 36  
(Years)18) BIRTHPLACE St. 319) OCCUPATION laborer21) Number of children of this mother now living, including present birth 5

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

(22) I hereby certify that I attended the birth of this child, who was born at 4 P  
on the date above stated. (Born alive or stillborn) (Hour A. M. or P. M.)(23) (Signature) Delia McCall(24) State whether Physician or Midwife Mid(25) Address of Physician or Midwife S. Charles

Given name added from a supplemental report

(26) Witness

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

(27) Filed the 19 22(28) Paul L. Evans  
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.