

N. B.—In case of TWINS OR TRIPLETS use a SEPARATE BLANK FOR EACH CHILD, and mark the FIRST-BORN, No. 1. THE OTHER, No. 2, etc., in question 6.

(1) PLACE OF BIRTH

County of York

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

Registration District No. 1906

File No.—For State Registrar Only

34288

Registered No. 80
(For use of Local Registrar)

(2) Full Name of Child

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

(3) BOY OR GIRL

(4) Twin or Triplet?

(5) Number in order of birth

(6) Are Parents Married?

(7) DATE OF

BIRTH Oct 9 22
(Name of Month) (Day) (Year)

FATHER.

MOTHER.

(8) FULL NAME

(14) NAME BEFORE MARRIAGE

(9) PRESENT POSTOFFICE OF FATHER

(15) PRESENT POSTOFFICE OF MOTHER

(10) COLOR OR RACE

(11) AGE AT LAST BIRTHDAY

(Years)

(16) COLOR OR RACE

(17) AGE AT LAST BIRTHDAY

(Years)

(12) BIRTHPLACE

(18) BIRTHPLACE

(13) OCCUPATION

(19) OCCUPATION

(20) Number of children born to mother, including present birth

(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 St. M.
on the date above stated. (Born alive or stillborn) (Hour A. M. or P. M.)

(23) (Signature)

(24) State whether Physician or Midwife

(25) 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) Filed

10/23/22

(28)

L. C. Hester
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.

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