

## (1) PLACE OF BIRTH

County of Greenville  
Township of Bolesor  
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

File No.—For State Registrar Only

Registration District No. 2201 Registered No. 4327  
(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? girl(4) Twin  
or Triplet?(5) Number in  
order of birth

To be answered only in case of twins or triplets

(6) Are  
Parents  
Married?(7) DATE OF  
BIRTH Feb. 18

(Name of Month) (Day) (Year)

(8) FULL  
NAME

FATHER

MOTHER

(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 born 11 P.M.  
on the date above stated. (Born alive or stillborn) (Hour A. M. or P. M.)(23) (Signature) [Signature]

(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 Mar 22

(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.

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