

Form No. 1

## (1) PLACE OF BIRTH

County of

Township of

OF

Inc. Town of

OF

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

2730

Registration District No. 4608

Registered No. 9  
(For use of Local Registrar)

## (2) Full Name of Child

Jessie Lane Taylor

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

(3) SEX-OR  
GIRL?(4) Twin  
or Triplet?(5) Number in  
order of birth(6) Are  
Parents  
Married?(7) DATE OF  
BIRTH

To be answered only in event of Twins or Triplets

(Name of Month) (Day) (Year)

(8) FULL  
NAME

## FATHER.

(9) PRESENT  
POSTOFFICE  
OF FATHER(10) COLOR  
OR  
RACE(11) AGE AT LAST  
BIRTHDAY

(12) BIRTHPLACE

(13) OCCUPATION

(14) Number of children born to  
mother, including present birth(14) NAME BEFORE  
MARRIAGE

## MOTHER.

(15) PRESENT  
POSTOFFICE  
OF MOTHER(16) COLOR  
OR  
RACE(17) AGE AT LAST  
BIRTHDAY

(18) BIRTHPLACE

(19) OCCUPATION

(20) Number of children of this mother  
now living, including present birth

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

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

(22) (Signature)

(23) State whether Physician or Midwife

(24) Address of Physician or Midwife

Given name added from a supplement-  
tal report

(25) Witness

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

(26) Filed

7-25-23

(27)

J. E. Mayor  
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.