

(1) PLACE OF BIRTH

County of *York Co*Township of *Edin*

Inc. Town of

City of

CERTIFICATE OF BIRTH

STATE OF SOUTH CAROLINA

Bureau of Vital Statistics

State Board of Health

File No. — For State Registrar Only

26707

Registration District No. *4405*Registered No. *61*
(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 *Hollis Hans Hoffman* *not yet named, make supplemental report as directed*(3) BOY OR GIRL *B*(4) Twin or Triplet? *X*(5) Number in order of birth *X*(6) Are Parents Married? *X*(7) DATE OF BIRTH *Feb 12 29*

(Name of Month) (Day) (Year)

FATHER. *Frank Louis Hoffman*MOTHER. *Margaret May Workman*(9) PRESENT POSTOFFICE OF FATHER *Waco N.C.*(10) PRESENT POSTOFFICE OF MOTHER *Waco N.C.*(11) COLOR OR RACE *W*(11) AGE AT LAST BIRTHDAY *37*

(Year)

(12) COLOR OR RACE *W*(12) AGE AT LAST BIRTHDAY *33*

(Year)

(13) BIRTHPLACE *Yonkers Co. N.C.*(14) BIRTHPLACE *Cheshire Co. N.H.*(15) OCCUPATION *Electrician*(16) OCCUPATION *Dom*(17) Number of children born to mother, including present birth *8*(18) Number of children of this mother now living, including present birth *6*

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

(19) I hereby certify that I attended the birth of this child, who was M.,
on the date above stated. (Born alive or stillborn) (Hour A. M. or P. M.)(20) (Signature) *L. A. Rivers, M.D.*

(21) State whether Physician or Midwife

(22) Address of Physician or Midwife

Given name address from a supplement-
ary report*L. A. Rivers, M.D.**10/14/43* 19

Registrar

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

(24) Filed *9/13/43* 19

(25) 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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