

## (1) PLACE OF BIRTH

## CERTIFICATE OF BIRTH

File No. — For State Registrar Only

County of *York* STATE OF SOUTH CAROLINATownship of *Salisbury* Bureau of Vital Statistics

or Inc. Town of ..... State Board of Health

City of ..... (No. .... St.; .... Ward)

Registration District No. *31.1.7*Registered No. *85*  
(For use of Local Registrar)

(If birth occurs in a hospital or other institution, give name of street and number.)

## (2) Full Name of Child

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

(3) SEX OF CHILD *Girl* (4) Twin or Triplet? *No* (5) Number in order of birth *1* (6) Are Parents Married? *yes* (7) DATE OF BIRTH *Sept 15 1922*  
(Name of Month) (Day) (Year)

FATHER: (8) FULL NAME *Wm. H. Smith* (14) NAME BEFORE MARRIAGE *Mother Smith*  
(9) PRESENT POSTOFFICE OF FATHER *Summit SC* (15) PRESENT POSTOFFICE OF MOTHER *Summit SC*  
(10) COLOR OR RACE *White* (11) AGE AT LAST BIRTHDAY *40* (16) COLOR OR RACE *White* (17) AGE AT LAST BIRTHDAY *38*  
(12) BIRTHPLACE *Lexington SC* (18) BIRTHPLACE *Lexington SC*  
(13) OCCUPATION *Farmer* (19) OCCUPATION *Housewife*  
(20) Number of children born to mother, including present birth *1* (21) Number of children of this mother now living, including present birth *1*

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

(22) I hereby certify that I attended the birth of this child, who was ... *alive* ... at *8 A.* M.,  
(Born alive or stillborn) (Hour of M. or P. M.)  
on the date *above stated*.(23) (Signature) *D. W. ...*

(24) State whether Physician or Midwife

(25) Address of Physician or Midwife *Summit SC*

Given name added from a supplemental report

(26) Witness

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

(27) Local Registrar

(28) *R. O. ...*

\*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 be reported as stillborn. No report is desired of stillbirths before the fifth month of pregnancy.

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