(1) PLACE OF BIRTH

County of Charleston

Township of St. Paul's

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

File No.—For State Registrar Only
32180

Registration District No. 410 Registered No. 14
(For use of Local Registrar)

(No. ..... St.; ..... Ward)

(2) Full Name of Child William Washington

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
Boy	1	1	Yes	Jan 3 1923
	To be answered only in event of Twins or Triplets			(Month) (Day) (Year)

FATHER

(8) Full Name: William Washington

(9) Present Postoffice of Father: Adamsville

(10) Color or Race: Col (11) Age at last birthday: 30 (Years)

(12) Birthplace: Charleston S.C.

(13) Occupation: Farmer

(20) Number of children born to mother, including present birth: 4

MOTHER

(14) Maiden Name before marriage: Minnie Glover

(15) Present Postoffice of Mother: Adamsville S.C.

(16) Color or Race: Col (17) Age at last birthday: 22 (Years)

(18) Birthplace: Charleston S.C.

(19) Occupation: House Wife

(21) Number of children of this mother now living, including present birth: 3

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

(22) I hereby certify that I attended the birth of this child, who was born alive (born alive or stillborn) on the date above stated. at 12 M. (Hour A. M. or P. M.)

(23) (Signature) Celia Bonaud

(24) State whether Physician or Midwife: Mid Wife

(25) Address of Physician or Midwife: Adamsville S.C.

Given name added from a supplemental report

..... 19.....
Registrar

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

(27) Filed ..... 19 .... (28) 11 A.M. P.M. [illegible]
Local Registrar

*When there was no attending physician or midwife, then the father, householder, etc., should make [illegible]. If a child breathes even once, it must not be reported as stillborn. No report is desired of [illegible] before the fifth month of pregnancy.

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 5.

Bureau of Columbia, Columbia, S. C.

Form No. 4
Registration District No. .....
Primary Reg. District No. .....

STATE OF SOUTH CAROLINA
STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

Supplemental Report of Births

CORRECTED

RECEIVED FOR BINDING

Place of Birth
City or Town Adams Run
Street and House No. .....
Township of .....
County Charleston

File Number* 40-35180.

Registered Number* .....

SEX OF CHILD M | Twin,* Triplet, or Other? (2) | and | Number* in order of birth

DATE OF BIRTH* Jan. 3 - 1923
Month Day Year

FATHER
FULL* NAME William Washington

MOTHER
FULL* MAIDEN NAME Minnie Glover

*These items to be entered by the Registrar before giving out this form.

I HEREBY CERTIFY that the child described herein has been named:

York W. William Washington
Give name in full. Surname.

as reported by William Washington
Father or Mother

(Signed) Emma P. Bryant
Local Registrar
Witness