

(1) PLACE OF BIRTH

County of *Florence*

Township of

Inc. Town of

City of *Florence*

(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

42783

Registration District No. *30-A* Registered No. *264*

(For use of Local Registrar)

(No. *501 W. Paul* St. *4* Ward)

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

(2) Full Name of Child *Brandon Jerry Thrasher*(3) BOY OR GIRL? *Girl* (4) Twin or Triplet? *No* (5) Number in order of birth *Sub* (6) Are Parents Married? *Yes* (7) DATE OF BIRTH *Dec. 13* (Name of Month) (Day) (Year)

FATHER

(8) FULL NAME *Charles A. Tharp*(9) PRESENT POSTOFFICE OF FATHER *Florence S.C.*(10) COLOR OR RACE *White* (11) AGE AT LAST BIRTHDAY *36* (Years)(12) BIRTHPLACE *Waverly, S.C.*(13) OCCUPATION *Superman*(20) Number of children born to mother, including present birth *Sub*

MOTHER

(14) NAME BEFORE MARRIAGE *Beatrice Jordan*(15) PRESENT POSTOFFICE OF MOTHER *Florence S.C.*(16) COLOR OR RACE *White* (17) AGE AT LAST BIRTHDAY *30* (Years)(18) BIRTHPLACE *Mount Pleasant, S.C.*(19) OCCUPATION *Housewife*(21) Number of children of this mother now living, including present birth *Five*

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

(22) I hereby certify that I attended the birth of this child, who was *White* at *5:50* P.M. (Born alive or stillborn) (Hour A.M. or P.M.) on the date above stated.(23) (Signature) *L. H. Huggins*

(24) State whether Physician or Midwife (25) Address of Physician or Midwife

Given name added from a supplemental report

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

(27) Filed *Dec. 13* (28) *C. C. Craft* 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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Form No. 10.
 WHEN PLACED, WITH SIGNATURES, IN A SEPARATE BLANK FOR EACH CHILD, AND MARK THE
 N.B.—In case of TWINS OR TRIPLETS use a SEPARATE BLANK FOR EACH CHILD, AND MARK THE
 FIRST-BORN, No. 1, THIS OFFICE, No. 2, etc., in question 5.