

Form No. 1

## (1) PLACE OF BIRTH

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County of Edgefield  
 Township of .....  
 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  
**20823**

Registration District No. 1808. Registered No. 76  
 (For use of Local Registrar)

St.; ..... Word)  
 (No. ....  
 (If birth occurs in a hospital or other institution, give name of same instead of street and number.)

(2) Full Name of Child David Earl Cartledge If child is not yet named, make supplemental report as directed

(3) SEX OR IDOL	(4) Twin or Triplet To be answered only in case of Twin or Triplet	(5) Number in order of birth	(6) Are Parents Married	(7) DATE OF BIRTH (Month) (Day) (Year) <u>7/9</u> <u>1923</u>
FATHER			MOTHER	
(8) FULL NAME	(9) PRESENT POSTOFFICE OF FATHER		(14) NAME BEFORE MARRIAGE	(15) PRESENT POSTOFFICE OF MOTHER
(10) COLOR OR RACE	(11) AGE AT LAST BIRTHDAY	(16) COLOR OR RACE	(17) AGE AT LAST BIRTHDAY	(18) BIRTHPLACE
(12) BIRTHPLACE	(13) OCCUPATION		(19) OCCUPATION	
(20) Number of children born to mother, including present birth			(21) Number of children of this mother now living, including present birth	

**CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE**

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

(23) (Signature) .....  
 (24) State whether Physician or Midwife ..... (25) Address of Physician or Midwife .....

Given name added from a supplement-  
 tal report

(26) Witness ..... (Signature of Witness necessary only  
 when question 22 is signed by mark)

(27) Filed 5/9/23 (28) Local Registrar .....

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