

35742

County of
Township of
OR
Inc. Town of
OR
City of

STATE OF SOUTH CAROLINA
Bureau of Vital Statistics
State Board of Health

Registration District No. 3405 Registered No. 53
(For use of Local Registrar)

City of _____ (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 James H. Hawkins If child is not yet named, make supplemental report as directed

<p>3) BOY OR GIRL? <u>Girl</u></p>	<p>4) Twin or Triplet? <u>0</u></p>	<p>5) Number in order of birth <u>1</u></p>	<p>6) Sex of child <u>Female</u></p>	<p>7) Parent's Marital Status <u>Yes</u></p>	<p>BIRTH <u>DATE</u> <u>11/11/72</u></p> <p>(Name of Month) (Day) (Year)</p>
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FATHER

3. FULL NAME *Hawkins*

PRESENT POSTOFFICE OF FATHER 2 Clair St.

(10) COLOR OR RACE *W* (11) AGE AT LAST BIRTHDAY *24* (Years)

12 BIRTHPLACE

1. OCCUPATION

Number of children born to mother, including present birth

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

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

(26) (Signature) <u>Dr. Richard W. Cline</u>	(25) Address of Physician or Midwife
(24) State whether Physician or Midwife	

Given name added from a supplement-
tal report

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

Nov 9 22 *G. H. Mayson*
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.