

Form No. 1

(1) PLACE OF BIRTH

County of LynchburgTownship of Lynchburgor
Inc. Town of Lynchburgor
City of Lynchburg

CERTIFICATE OF BIRTH

STATE OF SOUTH CAROLINA

Bureau of Vital Statistics

State Board of Health

File No.—For State Registrar Only

19313

Registration District No. 3002 Registered No. 76

(For use of Local Registrar)

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

(3) BOY OR GIRL? <u>girl</u>	(4) Twin or Triplet? <u>To be answered only in event of Twins or Triplets</u>	(5) Number in order of birth <u>23</u>	(6) Are Parents Married? <u>yes</u>	(7) DATE OF BIRTH <u>June 18, 22</u> (Name of Month) (Day) (Year)
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FATHER.

(8) FULL NAME Corrie McLevel(9) PRESENT POSTOFFICE OF FATHER Lynchburg 22(10) COLOR OR RACE Negro (11) AGE AT LAST BIRTHDAY 23
(Years)(12) BIRTHPLACE Low S. C.(13) OCCUPATION Farming(20) Number of children born to mother, including present birth 1

MOTHER.

(14) NAME BEFORE MARRIAGE Francis Moore(15) PRESENT POSTOFFICE OF MOTHER Lynchburg S.C.(16) COLOR OR RACE Negro (17) AGE AT LAST BIRTHDAY 19
(Years)(18) BIRTHPLACE Low S. C.(19) OCCUPATION House work(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 born alive at 8 P. M., on the date above stated. (Born alive or stillborn) (Hour A. M. or P. M.)(23) (Signature) Marion Anderson(24) State whether Physician or Midwife Midwife (25) Address of Physician or Midwife Lynchburg S.C.

Given name added from a supplemental report

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

(27) Filed 7/8 (28) J. F. McIntosh 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.

REMARKS: REGISTERED BY STATE REGISTRAR. IF BIRTH OCCURS IN A HOSPITAL OR OTHER INSTITUTION, GIVE NAME OF SAME INSTEAD OF STREET AND NUMBER. IF CHILD IS NOT YET NAMED, MAKE SUPPLEMENTAL REPORT AS DIRECTED. PRINT NAME, ADDRESS, AND SIGNATURE OF PHYSICIAN OR MIDWIFE. NO. 1. THIS FORM, No. 1, 1931, IS OBSOLETE.