

## (1) PLACE OF BIRTH

County of Anderson  
 Township of Rockville  
 or  
 Inc. Town of .....  
 or  
 City of .....

## CERTIFICATE OF BIRTH

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

Registration District No. 3-12

File No.—For State Registrar Only

3093

Registered No. ....  
 Registered No. ....  
 (For use of Local Registrar)

(2) Full Name of Child Richard Johnson  
 (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.)

2. BOY OR GIRL Boy 4. Twin or Triplet? ☒ 5. Number in order of birth 1 6. Sex Male 7. DATE OF BIRTH Jan 15 1923  
 To be reversed only in event of Twin or Triplet. (Name of Month) (Day) (Year)

FATHER  
 8. FULL NAME Richard Johnson  
 9. PRESENT POSTOFFICE OF FATHER Rockville S.C.  
 10. COLOR White 11. AGE AT LAST BIRTHDAY 36  
 12. RACE White 13. BIRTHPLACE Anderson S.C.  
 14. OCCUPATION Farmer  
 20. Number of children born to father, including present birth 6

MOTHER  
 15. NAME BEFORE MARRIAGE Alma Johnson  
 16. PRESENT POSTOFFICE OF MOTHER Anderson S.C.  
 17. COLOR White 18. AGE AT LAST BIRTHDAY 35  
 19. RACE White 21. BIRTHPLACE Anderson S.C.  
 22. OCCUPATION Housewife  
 23. Number of children of this mother, new living, including present birth 6

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

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

(23) (Signature) Alma Johnson  
 (24) State whether Physician or Midwife Physician (25) Address of Physician or Midwife Anderson S.C.

Given name and age of child's supplemental report

(26) Witness (Signature of Witness necessary only when question 27 is signed by mark)  
 (27) Alma Johnson (28) J. R. Wright 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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MARGIN RESERVED FOR BINDING. WHEN MAKING REVISIONS, PRINTED TYPE USE A SLICED TYPE WRITER. FULL NAME OF CHILD, FULL NAME OF FATHER, FULL NAME OF MOTHER, FULL NAME OF PHYSICIAN OR MIDWIFE, FULL NAME OF WITNESS, FULL NAME OF LOCAL REGISTRAR, No. 1, Full of child No. 2, etc. in question 6.