

Form No. 8

(1) PLACE OF BIRTH

County of

Township of

or 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

18902

Registration District No. 802

Registered No. 21

(For use of Local Registrar.)

(No. _____ of _____ Ward)

(If birth occurs in a hospital or other institution, give name of same instead of street and number.)
(2) Full Name of Child Lillian Boston (If child is not yet named, make supplemental report as directed)(1) BOY OR GIRL Girl

(4) Twin or Triplet?

(5) Number in order of birth

(6) Are Parents Married? Yes

(7) DATE

BIRTH 24 1923
(Name of Month) (Day) (Year)

To be answered only in event of Twins or Triplets

FATHER

(1) FULL NAME

(2) PRESENT POSTOFFICE OF FATHER

(3) COLOR OR RACE negro

(4) BIRTHPLACE

(5) OCCUPATION

(6) AGE AT LAST BIRTHDAY 49
(Years)

(14) NAME BEFORE MARRIAGE

(15) PRESENT POSTOFFICE OF MOTHER

(16) COLOR OR RACE negro

(17) BIRTHPLACE

(18) OCCUPATION

(19) Number of children of this mother, now living, including present birth

(20) 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 Born alive at S.P.M.
(Born alive or stillborn) (Hour A. M. or P. M.)
on the date above stated.(23) (Signature) A. S. Gardner(24) State whether Physician or Midwife midwife(25) Address of Physician or Midwife St. Matthews S.C.

Given name added from a supplemental report

(26) Witness Mrs. Kelle

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

(27) Filed July 1 1923(28) July 1 1923

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 28th month of pregnancy.