

Form No. 1

(1) PLACE OF BIRTH

County of Greenville

Township of P. Abbeville

or
Inc. Town of

or
City of

(If birth occurs in a hospital or other institution, give name of same instead of street and number.)

CERTIFICATE OF BIRTH

STATE OF SOUTH CAROLINA

Bureau of Vital Statistics

State Board of Health

Registration District No. 9. 4. 8. 7.

File No. — For State Registrar Only

7661

Registered No. 1. 1. 1.
(For use of Local Registrar)

(No. St.; Ward)

(2) Full Name of Child

If child is not yet named, make supplemental report as directed

3 BOY OR GIRL Girl

4 Twin or Triplet

5 Number in order of birth

6 Are Parents Married? Yes

7 DATE OF

BIRTH Feb. 20, 1910
(Name of Month) (Day) (Year)

To be answered only in event of Twin or Triplet

FATHER.

MOTHER.

8 FULL NAME

14 NAME BEFORE MARRIAGE

9 PRESENT POSTOFFICE OF FATHER

15 PRESENT POSTOFFICE OF MOTHER

10 COLOR OR RACE

11 AGE AT LAST BIRTHDAY

(Years)

16 COLOR OR RACE

17 AGE AT LAST BIRTHDAY

(Years)

12 BIRTHPLACE

18 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 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 supplemental report

(26) Witness

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

(27) Signed Feb 20, 1910

(28) 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.