

(1) PLACE OR NUMBER

County of CharlestonTownship of Charleston

Inc. Town of

City of

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

Registration District No. 1200No. 730Registered No.
(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 Rosemary Green If child is not yet named, make supplemental report as directed

(1) SEX OF CHILD <u>Girl</u>	(2) Type of Birth <u>Normal</u>	(3) Number in order of birth <u>1</u>	(4) Date of Birth <u>Jan 16 1923</u>
(5) FULL NAME OF FATHER <u>Shofford Green</u>		(6) FULL NAME OF MOTHER <u>Paula Green</u>	
(7) PRESENT RESIDENCE OF FATHER <u>Capeland S.C.</u>		(8) PRESENT RESIDENCE OF MOTHER <u>Capeland S.C.</u>	
(9) COLOR OF FATHER <u>White</u>	(10) AGE AT LAST BIRTHDAY <u>35</u>	(11) COLOR OF MOTHER <u>White</u>	(12) AGE AT LAST BIRTHDAY <u>32</u>
(13) BIRTHPLACE <u>S.C.</u>	(14) OCCUPATION <u>Farmer</u>	(15) BIRTHPLACE <u>S.C.</u>	(16) OCCUPATION <u>House-keeper</u>
(17) Number of children born to mother, including present birth <u>4</u>	(18) Number of children of this mother now living, including present birth <u>3</u>		

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

(19) I hereby certify that I attended the birth of this child, who was born alive on the date above stated. (Born alive or stillborn) (Born A. M. or P. M.)(20) (Signature) Shofford Green (21) Address of Physician or Midwife Capeland S.C.

(22) State whether Physician or Midwife

(23) Given name added from a supplemental report

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

(25) Filed 1/20 1923 (26) 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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