

(1) PLACE OF BIRTH

County of Spartanburg

Township of

The TOWN of Lovayton

CITY of

CERTIFICATE OF BIRTH

STATE OF SOUTH CAROLINA.

Bureau of Vital Statistics

State Board of Health

File No.—For State Registrar Only

66329

Registration District No. 1405 Registered No. 584
(For use of Local Registrar)

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 Robert Humphries, care } If child is not yet named, make supplemental report as directed

(3) BOY OR GIRL? Male (4) Twin or Triplet? No (5) Number in order of birth 1 (6) Are Parents Married? Yes (7) DATE OF BIRTH June 15, 1916
(Name of Month) (Day) (Year)

FATHER.

(8) FULL NAME Emmie Moore

(9) PRESENT POSTOFFICE OF FATHER Lovayton

(10) COLOR OR RACE White (11) AGE AT LAST BIRTHDAY 23 (Years)

(12) BIRTHPLACE North Carolina

(13) OCCUPATION man with apartment

(16) Number of children born to mother, including present birth Two (2)

MOTHER.

(14) NAME BEFORE MARRIAGE Wynthe Hoyle

(15) PRESENT POSTOFFICE OF MOTHER Lovayton

(16) COLOR OR RACE White (17) AGE AT LAST BIRTHDAY 19 (Years)

(18) BIRTHPLACE Tennessee

(19) OCCUPATION Wife

(21) Number of children of this mother now living, including present birth Two (2)

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

(22) I hereby certify that I attended the birth of this child, who was at 2 a M., on the date above stated. (Born alive ~~or stillborn~~) (Hour A. M. or P. M.)

(23) (Signature) A. W. Boyer

(24) State whether Physician or Midwife (25) Address of Physician or Midwife

Physician Spartanburg

(Given name added from a supplemental report)

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

2/21/14 191.....

(27) F.M.D. 2/21/14 191..... (28) E. F. Parker Local Registrar

M. B. ... 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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Form No. 10. To be filled out by the physician or midwife attending the birth. In case of twins or triplets use a separate form for each child. Do not mark (4).