

(1) PLACE OF BIRTH

County of *Robertson*

Township of .....

or  
City of *Arcadia P.O.*

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

File No.—For State Registrar Only

12136

Registration District No. *4.008*Registered No. *86*  
(For use of Local Registrar)

(No. .... St.; .... Ward)

(2) Full Name of Child

*Boyce Lee Foster Jr*

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

3 SEX OR  
SEX(4) Twin  
or Triplet?(5) Number in  
order of birth(6) Are  
Parents  
Married?

(7) DATE OF

BIRTH

*4-2-25*  
(Name of Month) (Day) (Year)

FATHER.

*Foster*

MOTHER.

(14) NAME BEFORE  
MARRIAGE*Maudie Hafe*(15) PRESENT  
POSTOFFICE  
OF MOTHER*Arcadia S.P.*(16) COLOR  
OR  
RACE*white*(17) AGE AT LAST  
BIRTHDAY*27*  
(Years)

(18) BIRTHPLACE

*Linn*

(19) OCCUPATION

*Dom*(21) Number of children of this mother  
now living, including present birth*3*

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

(20) I hereby certify that I attended the birth of this child, who was ..... at ..... 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

Give some address from a supplement-  
ary report*Thos. P. L. L. L.**11-11-17*

Registrar

(26) Witness

(Signature of Witness necessary only  
when question 23 is signed by mark)(27) Filed *Apr. 14* 19*23*(28) *Wm. L. Foster*  
Local RegistrarWhen 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.