

TYPE  
OR PRINT  
IN  
PERMANENT  
INK  
FOR  
INSTRUCTIONS  
SEE  
HANDBOOK  
CHILD

STATE OF SOUTH CAROLINA  
DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL  
CERTIFICATE OF LIVE BIRTH

139-22-050672

BIRTH NUMBER

|   |               |  |   |   |   |
|---|---------------|--|---|---|---|
| CHILD—NAME<br>FIRST MIDDLE LAST<br>1. <b>WILLIAM B. ROLLINS</b>   |               |  | SEX<br>2. <b>M</b>  | DATE OF BIRTH (Mo., Day, Yr.)<br>3a. <b>Nov. 24, 1922</b>                           | HOUR<br>3b. <b>M</b>                          |
| HOSPITAL—NAME (If not in hospital, give street and number)<br>4a.   |               |  | CITY, TOWN OR LOCATION OF BIRTH<br>4b.                                    |   | COUNTY OF BIRTH<br>4c. <b>Spartanburg</b>     |
| I certify that the stated information concerning this child is true to the best of my knowledge and belief.<br>5a. (Signature) <b>[Signature]</b>   |               |  | DATE SIGNED (Mo., Day, Yr.)<br>5b.  | NAME AND TITLE OF ATTENDANT AT BIRTH IF OTHER THAN CERTIFIER (Type or print)<br>5c. |   |
| CERTIFIER—NAME AND TITLE (Type or print)<br>5d.   |               |  | MAILING ADDRESS (Street or R.F.D. No., City or Town, State, Zip)<br>5e.   |   |   |
| REGISTRAR<br>6a. (Signature) <b>[Signature] Doris M. Byars</b>  |               |  | DATE RECEIVED BY REGISTRAR (Month, Day, Year)<br>6b. <b>Oct. 26, 1978</b> |   |   |
| MOTHER—MAIDEN NAME<br>FIRST MIDDLE LAST<br>7a. <b>Laura Mae Seay</b>  |               |  | AGE (At time of this birth)<br>7b. <b>40</b>                              | STATE OF BIRTH (If not in U.S.A., name country)<br>7c. <b>S. C.</b>                 |   |
| RESIDENCE—STATE<br>8a. <b>S. C.</b>   | COUNTY<br>8b. | CITY, TOWN OR LOCATION<br>8c. <b>Spartanburg</b> | STREET AND NUMBER OF RESIDENCE<br>8d.                                     |   | INSIDE CITY LIMITS (Specify yes or no)<br>8e. |
| MOTHER'S MAILING ADDRESS—If same as above, enter Zip Code only<br>9.  |               |  |   |   |   |
| FATHER—NAME<br>FIRST MIDDLE LAST<br>10a. <b>Albert Elmer Rollins</b>  |               |  | AGE (At time of this birth)<br>10b. <b>37</b>                             | STATE OF BIRTH (If not in U.S.A., name country)<br>10c. <b>S. C.</b>                |   |
| I certify that the personal information provided on this certificate is correct to the best of my knowledge and belief. (Signature of Parent or other informant)<br>11a. <b>[Signature]</b> |               |  | RELATION TO CHILD<br>11b.   |   |   |

INFORMATION FOR MEDICAL AND HEALTH USE ONLY

|  |   |   |  |   |   |  |   |
|--|---|---|--|---|---|--|---|
| RACE—MOTHER (e.g., White, Black, American Indian, etc.) (Specify)<br>12. <b>White</b>        |   | RACE—FATHER (e.g., White, Black, American Indian, etc.) (Specify)<br>13. <b>White</b> |  | BIRTH WEIGHT<br>14.   | THIS BIRTH—Single, twin, triplet, etc. (Specify)<br>15a.  | IF NOT SINGLE BIRTH—Born first, second, third, etc. (Specify)<br>15b.                  | IS MOTHER MARRIED? (Specify yes or no)<br>16. <b>Yes</b>                    |
| PREGNANCY HISTORY (Complete each section)  |   |   |  | EDUCATION—MOTHER (Specify only highest grade completed)                               |   | EDUCATION—FATHER (Specify only highest grade completed)                                |   |
| LIVE BIRTHS (Do not include this child)  |   | OTHER TERMINATIONS (Spontaneous and Induced)  |  | Elementary or Secondary (0-12)  | College (1-4 or 5+)   | Elementary or Secondary (0-12)   | College (1-4 or 5+)   |
| 17a. Now living<br>Number—<br>None <input type="checkbox"/>                                  | 17b. Now dead<br>Number—<br>None <input type="checkbox"/> | 17d. Before 20 wks.<br>Number—<br>None <input type="checkbox"/>                       | 17e. After 20 wks.<br>Number—<br>None <input type="checkbox"/> | 18a. Usual Occupation<br>18b. DATE LAST NORMAL MENSES BEGAN (Month, Day, Year)<br>20. | 18c. Business or Industry<br>18d. MONTH OF PREGNANCY PRE-NATAL CARE BEGAN First, second, etc. (Specify)<br>21a. | 19a. Usual Occupation<br>19b. PRENATAL VISITS Total number (If none, so state)<br>21b. | 19c. Business or Industry<br>19d. APGAR SCORE<br>1 min. 5 min.<br>22a. 22b. |
| DATE OF LAST LIVE BIRTH (Month, Year)<br>17c.  |   | DATE OF LAST OTHER TERMINATION (as indicated in d or e above) (Month, Year)<br>17f.   |  | COMPLICATIONS OF PREGNANCY (Describe or write "none")<br>23.                          |   |  |   |
| CONCURRENT ILLNESSES OR CONDITIONS AFFECTING THE PREGNANCY (Describe or write "none")<br>24. |   |   |  |   |   |  |   |
| COMPLICATIONS OF LABOR AND/OR DELIVERY (Describe or write "none")<br>25.                     |   |   |  | CONGENITAL MALFORMATIONS OR ANOMALIES OF CHILD (Describe or write "none")<br>26.      |   |  |   |
| MOTHER'S BLOOD TESTED FOR SYPHILIS? (SPECIFY YES OR NO) MONTH DAY YEAR<br>27a. DATE          |   |   | LABORATORY<br>27b.   |   | WHAT PROPHYLACTIC USED IN EYES? (Specify) TIME USED M.<br>28.   |  |   |

DHEC-609 Rev. 1978

DEATH UNDER ONE YEAR OF AGE  
Enter State File Number of death certificate for this child

MULTIPLE BIRTHS  
Enter State File Number for mate(s)

LIVE BIRTH(S)

FETAL DEATH(S)