

(1) PLACE OF BIRTH

County of Charleston

Township of

or

Inc. Town of Charleston

or

City of

CERTIFICATE OF BIRTH

STATE OF SOUTH CAROLINA

Bureau of Vital Statistics

State Board of Health

File No.—For State Registrar Only

17840

Registration District No. 9Registered No. 810

(For use of Local Registrar)

(No. 165-H-1119 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 Baby Hamilton

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

(3) BOY OR GIRL Boy(4) Twin or Triplet? No(5) Number in order of birth 1(6) Are Parents Married? Yes(7) DATE OF BIRTH June 25-24

(Name of Month) (Day) (Year)

FATHER.

(8) FULL NAME Willie Bailey(9) PRESENT POSTOFFICE OF FATHER Charleston(10) COLOR OR RACE Col. (11) AGE AT LAST BIRTHDAY 22 (Years)(12) BIRTHPLACE Charleston(13) OCCUPATION laborer(20) Number of children born to mother, including present birth 1

MOTHER.

(14) NAME BEFORE MARRIAGE Bertha Hamilton(15) PRESENT POSTOFFICE OF MOTHER Charleston(16) COLOR OR RACE Col. (17) AGE AT LAST BIRTHDAY 19 (Years)(18) BIRTHPLACE Charleston(19) OCCUPATION Domestic(21) Number of children of this mother now living, including present birth 1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

(22) I hereby certify that I attended the birth of this child, who was B. M. Bailey at 3 P. M., on the date above stated. (Born alive or stillborn) (Hour A. M. or P. M.)(23) (Signature) B. M. Bailey(24) State whether Physician or Midwife Midwife(25) Address of Physician or Midwife W. E. Baker Hospital

Given name added from a supplemental report

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

(27) Filed 6/29/24 (28) B. M. Bailey 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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