

## (1) PLACE OF BIRTH

County of YorkTownship of Haystackor  
Inc. Town of .....or  
City of .....

## CERTIFICATE OF BIRTH

STATE OF SOUTH CAROLINA

Bureau of Vital Statistics

State Board of Health

File No. - For State Registrar Only

9554

Registration District No. 4407Registered No. 9

(For use of Local Registrar)

(If birth occurs in a hospital or other institution, give name of same instead of street and number.)

(2) Full Name of Child Cuba Lawrence

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) Age? Ye (7) DATE OF BIRTH (Name of Month) (Day) (Year) Feb 16 1924

To be answered only in case of Twin or Triplet

## FATHER

(8) FULL NAME Walter Lawrence(9) PRESENT POSTOFFICE OF FATHER Charleston, S.C.(10) COLOR OR RACE White (11) AGE AT LAST BIRTHDAY (Year) 64(12) BIRTHPLACE S.C.(13) OCCUPATION Farm(20) Number of children born to mother, including present birth 3

## MOTHER

(14) NAME BEFORE MARRIAGE Wm. Cook(15) PRESENT POSTOFFICE OF MOTHER Charleston, S.C.(16) COLOR OR RACE White (17) AGE AT LAST BIRTHDAY (Year) 35(18) BIRTHPLACE York Co(19) OCCUPATION Newspaper(21) Number of children of this mother now living, including present birth 3

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

(22) I hereby certify that I attended the birth of this child, who was at 9 P.M. on this 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

Given under oath and signed in presence of witnesses

(26) Witness

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

(27) Feb 16 1924 (28) W. B. Prior Local Registrar

When this certificate is filed, the parent, hospital, or other institution, should make this return to the State Board of Health, or to the local health officer, and report to doctor of stillbirths.