

**DEPARTMENT OF COMMERCE, BUREAU OF C.**

**STATE OF SOUTH CAROLINA**  
**Bureau of Vital Statistics**  
**State Board of Health**

2644

Township of .....  
or  
Inc. Town of .....  
or  
City of .....

Registration District No. 24 Registered No. 70  
(For use of Local Registrar)

(2) Full Name of Child Little Joseph Williams If child is not yet named, make supplemental report as directed

3) **BOY OR GIRL** *Bo*

4) **Twin or Triple?**  
To be answered only in case of Twin or Triple

5) **Number in order of birth**

6) **For Parents' Signature**

7) **DATE OF BIRTH** *10-1-15*  
(Name of Month) (Day) (Year)

FATHER.		MOTHER.	
(1) FULL NAME	<i>Wm. Joseph Adams</i>	(14) NAME BEFORE MARRIAGE	<i>Wm. Matthews</i>
(2) PRESENT POSTOFFICE OF FATHER	<i>Adrian S.C.</i>	(15) PRESENT POSTOFFICE OF MOTHER	<i>Adrian S.C.</i>
(16) COLOR OR RACE	<i>White</i>	(16) COLOR OR RACE	<i>White</i>
(17) AGE AT LAST BIRTHDAY	<i>29</i> (Years)	(17) AGE AT LAST BIRTHDAY	<i>29</i> (Years)
(18) BIRTH PLACE	<i>Springer S.C.</i>	(18) BIRTH PLACE	<i>North Augusta S.C.</i>
(19) OCCUPATION	<i>Travel Agent</i>	(19) OCCUPATION	<i>Housewife</i>
(20) Number of children born to mother, including present birth	<i>2</i>	(21) Number of children of this mother now living, including present birth	<i>2</i>

**CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE:**

(21) I hereby certify that I attended the birth of this child, who was \_\_\_\_\_  
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 \_\_\_\_\_

Given under oath from a substantiated report

(28) Witness .....  
(Signature of Witness necessary only when question 28 is signed by mark)

(29) Filed 3/21/2025 (30) [Signature] Local Registrar.

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. *Per [Signature]*