

(1) PLACE OF BIRTH

County of *Spaulding*Township of *Spaulding*Incl. Town of *Spaulding*City of *Spaulding*

(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

66295

Registration District No. *4007* Registered No. *74*

(For use of _____ at Registrar)

(No. _____ St.; _____ Ward)

2. Full Name of Child

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

(8) BOY OR GIRL? *Girl*

(4) Twin or Triplet?

(5) Number in order of birth *7*(6) Are Parents Married? *Yes*(7) DATE OF BIRTH *June 6* (Name of Month) (Day) (Year)

FATHER.

(9) FULL NAME

Jim Rockley

(10) PRESENT POSTOFFICE OF FATHER

Reedville S.C.(11) COLOR OR RACE *White*(12) AGE AT LAST BIRTHDAY *40* (Years)

(13) BIRTHPLACE

Spaulding Co.

(14) OCCUPATION

Farmer(15) Number of children born to mother, including present birth *7*

MOTHER.

(16) NAME BEFORE MARRIAGE

Ida West

(17) PRESENT POSTOFFICE OF MOTHER

Reedville S.C.(18) COLOR OR RACE *White*(19) AGE AT LAST BIRTHDAY *38* (Years)

(20) BIRTHPLACE

Spaulding Co.

(21) OCCUPATION

Housekeeper(22) Number of children of this mother now living, including present birth *6*

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

(23) I hereby certify that I attended the birth of this child, who was *alive* at *10* P.M. (born alive or stillborn) (Hour A. M. or P. M.) on the date above stated.(24) (Signature) *D. D. Howard*

(25) State whether Physician or Midwife (26) Address of Physician or Midwife

Given name added from a supplemental report

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

(28) *July 9* 191*6* (29) *H. H. H. H.* 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.

fifth month of pregnancy.

Form No. 10. MARYLAND BUREAU OF VITAL STATISTICS. WITH PLAIN. WITH LEADING LINE. THIS IS A PERMANENT FORM. IN CASE OF TWIN OR TRIPLETS USE A SEPARATE BLANK FOR EACH CHILD, AND MARK THE FIRST-BORN. No. 1. THE OTHER, No. 2, etc. in question 8.