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FILE No.—For State Registrar Only
00753

Standard Certificate of Birth

STATE OF SOUTH CAROLINA
Bureau of Vital Statistics
State Board of Health
Registration District No. 44-8

1. PLACE OF BIRTH
County of York
Township of _____
or
Inc. Town of _____
or
City of Rock Hill, S. C. (No. Green St. 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 Leon Bryan Craven
(If child is not yet named, make supplemental report as directed.)
3. Boy or ~~girl~~ If Plural } 4. Twin, triplet or other.....
births } 5. Number, in order of birth.....
6. Premature..... 7. Are Parents Married? Yes 8. Date of birth Dec. 4, 1922
(Month, day, year)

9. Full name Archie Bryan Craven FATHER
10. Residence (mailing address) Rock Hill, S. C.
(If non-resident, give place and State)

18. Name before marriage Edna Ferguson MOTHER
19. Residence (mailing address) Rock Hill, S. C.
(If non-resident, give place and State)

11. Color or race W 12. Age at last birthday 30 (years)
13. Birthplace (city or place) Rock Hill, S. C.
(State or country)

20. Color or race W 21. Age at last birthday 28 (years)
22. Birthplace (city or place) Rock Hill, S. C.
(State or country)

OCCUPATION
14. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Baker
15. Industry or business in which work was done, as silk mill, sawmill, bank, etc. Bakery
16. Date (month and year last engaged in this work) 12/4/22, 19____
17. Total time (years) spent in this work 7

OCCUPATION
23. Trade, profession, or particular kind of work done, as house-keeper, typist, nurse, clerk, etc. Housewife
24. Industry or business in which work was done, as own home, lawyer's office, silk mill, etc. 5
25. Date (month and year) last engaged in this work _____, 19____
26. Total time (years) spent in this work _____

27. Number of children of this mother (At time of birth and including this child) 1 (a) Born alive and now living 2 (b) Born alive but now dead --- (c) Stillborn 1
28. If stillborn, period of gestation _____ months weeks 29. Cause of stillbirth _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was 12-4-22 at 11 P.m. on the date above stated.
(Born alive or stillborn)

I certify that I instilled or had instilled in the eyes of this child at 11:15 M. on above date Argyrol
(Name of Prophylactic)

Cleft Palate no Hare Lip no Other Deformities none (Specify)

(When there was no attending physician or midwife, then the father, householder, etc., should make this return.)

(Signed) W. E. Simpson, M. D.
or W. E. Simpson MD, Midwife

Given name added from a supplementary report _____ (Date of)

Address Rock Hill, S. C.
Filed 3/6, 19 42 Mrs. J. R. Miller Registrar

Registrar

MARGIN RESERVED FOR BINDING
WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
In case of more than one child at a birth, a SEPARATE RETURN must be made for each, and the number of each, in order of birth, stated.
(See instructions on Back of Certificate)

7/1/42