

(1) PLACE OF BIRTH

County of

Township of

or
Inc. Town of

City of

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

(2) Full Name of Child Isabella Elofson

File No.—For State Registrar Only

6366

CERTIFICATE OF BIRTH

STATE OF SOUTH CAROLINA

Bureau of Vital Statistics

State Board of Health

Registration District No. 35Registered No. 97
(For use of Local Registrar)(3) SEX—OR—
GIRL?(4) Twin
or Triplet?

To be answered only in event of Twins or Triplets

(5) Number in
order of birth(6) Are
Parents
Married?

(7) DATE OF

BIRTH.....2.....23.....22
(Name of Month) (Day) (Year)

FATHER.

(8) FULL
NAMEL. E. Elofson(9) PRESENT
POSTOFFICE
OF FATHERAnderson(10) COLOR
OR
RACEW(11) AGE AT LAST
BIRTHDAY.....41.....
(Years)

(12) BIRTHPLACE

Newbury St

(13) OCCUPATION

Labar(20) Number of children born to
mother, including present birth7

MOTHER.

(14) NAME BEFORE
MARRIAGEMaud Warren(15) PRESENT
POSTOFFICE
OF MOTHERAnderson(16) COLOR
OR
RACEW(17) AGE AT LAST
BIRTHDAY.....33.....
(Years)

(18) BIRTHPLACE

Greenwood St

(19) OCCUPATION

Housewife(21) Number of children of this mother
now living, including present birth5

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

(22) I hereby certify that I attended the birth of this child, who was155..... M.,
on the date above stated. (Born alive or stillborn) (Age in M. or P. M.)

(23) (Signature)

(24) State whether Physician or Midwife

(25) Address of Physician or Midwife

Given name added from a supplement
report

(26) Witness

(Signature of Witness necessary only
when question 23 is signed by mark)F. B. CRAYTON,

(27) Filed

(28) ANDERSON, S. J.*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.If a child breathes even once, it must not be reported as stillborn. No report is desired of stillbirths
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