

(1) PLACE OF BIRTH

County of

Township of

or
Inc. Town ofor
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 *Leanne Olan*

File No.—For State Registrar Only

269

CERTIFICATE OF BIRTH

STATE OF SOUTH CAROLINA

Bureau of Vital Statistics

State Board of Health

Registration District No. 1400

Registered No. 15

(For use of Local Registrar)

(3) BOY OR GIRL? *Girl*

(4) Twin or Triplet?

(5) Number in order of birth

(6) Are Parents Married? *Yes*

(7) DATE OF BIRTH

1/18 1922
(Name of Month) (Day) (Year)

FATHER

(8) FULL NAME *Linnear Olan*

(9) PRESENT POSTOFFICE OF FATHER

(10) COLOR OR RACE *Col* (11) AGE AT LAST BIRTHDAY *29*
(Years)

(12) BIRTHPLACE

(13) OCCUPATION

(20) Number of children born to mother, including present birth *9*

MOTHER

(14) NAME BEFORE MARRIAGE *Ada Olan*

(15) PRESENT POSTOFFICE OF MOTHER

(16) COLOR OR RACE *Col* (17) AGE AT LAST BIRTHDAY *30*
(Years)

(18) BIRTHPLACE

(19) OCCUPATION

(21) Number of children of this mother now living, including present birth *8*

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

(22) I hereby certify that I attended the birth of this child, who was *born* at *4:20* A.M., on the date above stated. (Born alive or stillborn) (Hour A.M. or P.M.)(23) (Signature) *Bessie Robinson*(24) State whether Physician or Midwife *Widow*

(25) Address of Physician or Midwife

Given name added from a supplemental report

(26) Witness

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

(27) Filed *10*

1922

(28)

John Casper

*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.