Form No. 1

(1) PLACE OF BIRTH

County of Saluda

Township of 5

or

Inc. Town of

or

City of

CERTIFICATE OF BIRTH

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

File No.—For State Registrar Only
32065

Registration District No. 3904 Registered No. 43
(For use of Local Registrar)

(If birth occurs in a hospital or other institution, give name of same instead of street and number.) (No. ..... St.; ..... Ward)

(2) Full Name of Child Thomas Johnson Jr. If child is not yet named, make supplemental report as directed

(3) BOY 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 (Name of Month) (Day) (Year)
Boy			yes	Sept 2 1922

FATHER

(8) FULL NAME Tom Johnson

(9) PRESENT POSTOFFICE OF FATHER Chappells

(10) COLOR OR RACE Col (11) AGE AT LAST BIRTHDAY 44 (Years)

(12) BIRTHPLACE SC

(13) OCCUPATION Public servs

(20) Number of children born to mother, including present birth 8

MOTHER

(14) NAME BEFORE MARRIAGE Missie Bantin

(15) PRESENT POSTOFFICE OF MOTHER Chappells

(16) COLOR OR RACE Col (17) AGE AT LAST BIRTHDAY 38 (Years)

(18) BIRTHPLACE SC

(19) OCCUPATION Housework

(21) Number of children of this mother now living, including present birth 5

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

(22) I hereby certify that I attended the birth of this child, who was born alive at 11 A. M., on the date above stated. (Born alive or stillborn) (Hour A. M. or P. M.)

(23) (Signature) Winnie Lanagan [redacted] Midwife

(24) State whether Physician or Midwife

(25) Address of Physician or Midwife Chappells S C

Given name added from a supplemental report

..... 19 .....
Registrar

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

(27) Filed Aug 5 1922 (28) D J Jeter
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.

BUREAU OF COLUMBIA, S. C.

HOSPITAL BIRTH. IF BORN IN A HOSPITAL OR OTHER INSTITUTION, GIVE NAME OF SAME INSTEAD OF STREET AND NUMBER. IF FOREIGN BORN, SO STATE. IF TWIN OR TRIPLET, STATE THE FACT AND GIVE NUMBER IN ORDER OF BIRTH. IF THE CHILD IS DEAD, SO STATE. IF NOT YET NAMED, MAKE SUPPLEMENTAL REPORT AS DIRECTED. IF ILLEGITIMATE, SO STATE. IF MARRIED, GIVE MAIDEN NAME OF MOTHER. IF DIVORCED, GIVE NAME OF HUSBAND BY WHOM LAST MARRIED. IF WIDOWED, GIVE NAME OF LAST HUSBAND. IF FATHER OF ILLEGITIMATE CHILD, AND MARK THE