

Form No. 1

1. PLACE OF BIRTH

County of SpringfieldTownship of Jackor
Inc. Town of IrmoCity of Irmo

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

Registration District No. _____

Registered No. _____

(For use of Local Registrar)

(No. _____ 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 Levinus Leon DeLoache

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

3. SEX OR
AGE4. AGE OF
INFANT5. NUMBER IN ORDER
OF BORN

6. DATE OF BIRTH

To be answered only in case of Twins or Triplets

(Name of Month) (Day) (Year)

7. FULL NAME OF FATHER M. A. DeLoache8. PRESENT POSTOFFICE OF FATHER Irmo9. COLOR OR RACE White 10. AGE AT LAST BIRTHDAY 36 (Years)11. BIRTHPLACE Ga12. OCCUPATION Oil Mill Employee13. Number of children born to mother, including present birth 714. FULL NAME OF MOTHER Puby Ben Baker15. PRESENT POSTOFFICE OF MOTHER Irmo16. COLOR OR RACE White 17. AGE AT LAST BIRTHDAY 28 (Years)18. BIRTHPLACE Ala19. OCCUPATION Domestic20. Number of children of this mother now living, including present birth 12

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

22. I hereby certify that I attended the birth of this child, who was born alive on the date above stated. (Born alive or stillborn) (Hour A.M. or P.M.)23. Signature R. C. Mathias M.D.24. State whether Physician or Midwife 25. Address of Physician or Midwife Irmo

Given name added from a supplemental report

26. Witness _____

(Signature of Witness necessary only when question 24 is signed by mark)

27. Filed _____ 28. _____ 29. _____

Registrar

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.