

(1) PLACE OF BIRTH

County of Anderson

Township of _____

or
Loc. Town of Pickens

or
City of _____

CERTIFICATE OF BIRTH

STATE OF SOUTH CAROLINA

Bureau of VITAL RECORDS

State Board of Health

REGISTRATION NUMBER

31545

Registered No. 86
(For use of Local Registrar)

No. 1 Ward

(No. _____ if birth occurs in a hospital or other institution, give name of same instead of street and number.)

If child is not yet named, make
initial report as shown.

(2) Full Name of Child William G. Slackford

(3) SEX OF CHILD Boy

(4) TIME OF BIRTH

To be answered only in event of Time of Birth

(5) Number in
order of birth

(6) AGE
at time of birth

(7) DATE
BIRTH

(Month) (Day) (Year)

FATHER

(8) FULL
NAME

Bob Slackford

(9) PRESENT
POSTOFFICE
OF FATHER

Greenville S.C.

(10) COLOR
OR
RACE

white

(11) AGE AT LAST
BIRTHDAY

34

(12) BIRTHPLACE

U.S.A.

(13) OCCUPATION

Teacher man

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

1 2

(15) NAME OF
MOTHER

Belle Guest

(16) PRESENT
RESIDENCE
OF MOTHER

Greenville S.C.

(17) COLOR
OR
RACE

white

(18) AGE AT LAST
BIRTHDAY

25

(19) BIRTHPLACE

S.C.

(20) OCCUPATION

Damestic

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

2

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

(22) I hereby certify that I attended the birth of this child, who was

on the date above stated.

(23) (Signature)

(24) State whether physician or midwife

Physician

M.D. or D.M.

Physician

(Given name added from a supplemental
report)

Dr. Alfred W.C.
12/14/43 M.D. B.W. 19
Registrar

(25) WITNESS

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

(26) DATED

May 29, 1943 (27) LOCAL REGISTRAR

*When there was no attending physician or midwife, then the father, householder, etc., should make this report.
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.

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