

(1) PLACE OF BIRTH

CERTIFICATE OF BIRTH

STATE OF SOUTH CAROLINA

Bureau of Vital Statistics

State Board of Health

No. — For State Registrar Only

15919

County of *York*

Township of *Green Springs*

or

Inc. Town of

or

City of

Registration District No.

Registered No. *41*

(For use of Local Registrar)

St. *41* Ward

(No. *41*)

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

(2) Full Name of Child

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

3 SEX OR *girl* (4) Twin or Triplet *No* (5) Number in order of birth *1* (6) Are Parents Married? *Yes* (7) DATE OF BIRTH *May 22 1923*
(Name of Month) (Day) (Year)

FATHER.

MOTHER.

8 FULL NAME *William McArthur*

(14) NAME BEFORE MARRIAGE *Estelle West*

9 PRESENT POSTOFFICE OF FATHER *Green Springs*

(15) PRESENT POSTOFFICE OF MOTHER *Green Springs*

10 COLOR OR RACE *white* (11) AGE AT LAST BIRTHDAY *36* (Year)

(16) COLOR OR RACE *white* (17) AGE AT LAST BIRTHDAY *36* (Year)

12 BIRTHPLACE

(18) BIRTHPLACE

13 OCCUPATION

(19) OCCUPATION *Teacher*

20 Number of children born to mother, including present birth *2*

(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 *born alive* on the date above stated.

(23) (Signature) *W. J. Smith*

(24) State whether Physician or Midwife

(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

June 8 1923 (28) *W. J. Smith* 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.

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