

**(1) PLACE OF BIRTH**County of *Sp. L. L. L.*Township of *Sp. L. L. L.*or  
In Town of .....

City of .....

**CERTIFICATE OF BIRTH**

STATE OF SOUTH CAROLINA

Bureau of Vital Statistics

State Board of Health

File No. — For State Registrar Only

**15845**Registration District No. *4001-2*Registered No. *16*

(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***W. L. L. L. L.*

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

3. SEX OR  
GROWTH4. Twin  
or Triplet?(5) Number in  
order of birth(6) Are  
Parents  
Married?

(7) DATE OF

BIRTH *426 1 33*  
(Name of Month) (Day) (Year)**FATHER.**8. FULL  
NAME9. PRESENT  
POSTOFFICE  
OF FATHER10. COLOR  
OR  
RACE(11) AGE AT LAST  
BIRTHDAY

12. BIRTHPLACE

13. OCCUPATION

**MOTHER.**(14) NAME BEFORE  
MARRIAGE(15) PRESENT  
POSTOFFICE  
OF MOTHER(16) COLOR  
OR  
RACE(17) AGE AT LAST  
BIRTHDAY

(18) OCCUPATION

(19) Number of children of this mother  
now living, including present birth**CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE**(20) I hereby certify that I attended the birth of this child, who was  
on the date above stated.

(Born alive or stillborn: (Hour A. M. or P. M.)

(21) (Signature)

(22) State whether Physician or Midwife

(23) Address of Physician or Midwife

Given name added from a supplement-  
al report

(24) Witness

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

(25) Filed

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(26) C. L. Mayberry

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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