

File No.—For State Registrar Only

County of Lexington  
Township of Chenango  
or  
Inc. Town of.....  
or  
City of .....

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

4905

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

City of ..... (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

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

(1) BOY OR GIRL *Boy* (4) Twin or Triplet? (5) Number in order of birth (6) Are Parents Married? *Yes* (7) DATE OF BIRTH *Jan 19, 1922*  
(June or Month) (Day) (Year)

**FATHER**

2. FULL NAME John B. Brown

9. PRESENT POSTOFFICE OF FATHER 1201 - 10th Ave 2E

(10) COLOR OR RACE Black (11) AGE AT LAST BIRTHDAY 29

12) BIRTHPLACE

13) OCCUPATION

21 Number of children born to mother, including present birth

# MOTHER

(14) NAME BEFORE MARRIAGE

(15) PRESENT POSTOFFICE OF MOTHER *Atlanta, Ga.*

(16) COLOR OR RACE *Black* (17) AGE AT LAST BIRTHDAY *37*

(19) BIRTHPLACE \_\_\_\_\_

(18) OCCUPATION 5400

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

**CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\***

(22) I hereby certify that I attended the birth of this child, who was alin at 11:18 M.  
on the date above stated. (Born alive or stillborn) (Hour A. M. or P. M.)

(23) (Signature) W. J. Gable

(24) State whether Physician or Midwife | (25) Address of Physician or Midwife

Given name added from a supplemental report

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

(27) Filed ..... 19..... (28).....  
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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