

Form No. 1

## (1) PLACE OF BIRTH

County of .....

Township of .....

OF

Inc. Town of .....

OF

City of .....

## CERTIFICATE OF BIRTH

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

File No. — For State Registrar Only

1589

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

## (2) Full Name of Child

1) BOY OR GIRL *Boy* 4) Twin or Triplet  
To be answered only in event of Twin or Triplet

6) Are Parents Married? *Yes*

7) DATE OF BIRTH *Set 15, 22*  
Name of Month (Day) (Year)

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

## FATHER.

8) FULL NAME *Dill Sparks*

9) PRESENT POSTOFFICE OF FATHER *Parksville S. C.*

10) COLOR OR RACE *W. Yrs* (11) AGE AT LAST BIRTHDAY *48*  
(Year)

12) BIRTHPLACE *Edgefield Co*

13) OCCUPATION *Farmer*

20) Number of children born to mother, including present birth *4*

## MOTHER.

14) NAME BEFORE MARRIAGE *Carrie Chambers*

15) PRESENT POSTOFFICE OF MOTHER *Parksville S. C.*

16) COLOR OR RACE *W. Yrs* 17) AGE AT LAST BIRTHDAY *33*  
(Year)

18) BIRTHPLACE *Edgefield Co*

19) OCCUPATION *Housework*

21) Number of children of this mother now living, including present birth *3*

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

(22) I hereby certify that I attended the birth of this child, who was *born alive* at *10 A.M.*  
on the date above stated. (Born alive or stillborn) (Hour A. M. or P. M.)

(23) (Signature) *Queta Ann Sparks*

(24) State whether Physician or Midwife

(25) Address of Physician or Midwife

Given name added from a supplemental report

(26) Witness *Walter B. Carledge*

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

*Mar 1, 22* (27) *Th. Carledge*  
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. If reported as stillborn. No report is desired of stillbirths before the sixth month of pregnancy.