

NOV 24 1930

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

32686

1. PLACE OF DEATH

County Greene
Township Wright
City Wintona (No. _____ St. _____ Ward _____)

Registration District No. 330
Primary Registration District No. 3017

File No. _____
Registered No. _____

2. FULL NAME

Darwin Carl Thogmartin

(a) Residence No. _____ St. _____ Ward _____
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 3 - 1924

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>6</u>	<u>4</u>	<u>5</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Wintona Mo
(STATE OR COUNTRY)

10. NAME OF FATHER Olto Thogmartin

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Merico Mo
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Bernie McFarquhar

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Merico Mo
(STATE OR COUNTRY)

14. INFORMANT Olto Thogmartin
(Address) Wintona Mo

15. FILED 9 Oct 30 E. D. Duffy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10/9 1930

17. I HEREBY CERTIFY, That I attended deceased from Oct 7 1930 to Oct 9 1930
that I last saw alive on Oct 9 1930, and that death occurred, on the date stated above, at 11a

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Laryngeal diphtheria
10 (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) None
(duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH,

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) O. B. Rocks, M. D.

10/9, 1930 (Address) Wintona Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Spickard Mo Masonic 10/11 1930

20. UNDERTAKER ADDRESS

Chas C Schooner Spickard Mo

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

