

Registration District No. 398Primary Registration District No. 3019Registrar's No. 226

## 1. PLACE OF DEATH:

(a) County Jackson  
 (b) City or town Independence  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
116 E. Waldo St.  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 2  
 (Specify whether years, months or days) 50 yrs

3. (a) PRINT FULL NAME Charles C. Throtyear3. (b) If veteran, name war none 3. (c) Social Security No. None4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced married6. (b) Name of husband or wife Lillie Throtyear 6. (c) Age of husband or wife if alive 62 years7. Birth date of deceased May 13, 1871  
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day  
69 4 7 hr. min.9. Birthplace Mooresville Mo. 0  
(City, town, or county) (State or foreign country)10. Usual occupation Plaster 211. Industry or business 9

MOTHER FATHER  
 { 12. Name Maxin Francure 9  
 { 13. Birthplace Canada (City, town, or county) (State or foreign country)  
 { 14. Maiden name Katherine Rogers  
 { 15. Birthplace Unknown (City, town, or county) (State or foreign country)

18. (a) Informant Lillie Throtyear  
(b) Address 116 E Waldo Independence17. (a) Removal (b) Date thereof Sept. 23-40  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Mooresville, Mo.18. (c) Signature of funeral director Cato & Speaks(b) Address Independence, Mo.19. (a) Sept. 21, 40 (b) F. L. Cook  
(Date received copy registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
 (c) City or town Independence  
 (If outside city or town limits write "RURAL")  
 (d) Street No. 116 E. Waldo  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept Day 20  
year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.21. I hereby certify that I attended the deceased from \_\_\_\_\_, 1940 to Sept 20, 1940,  
that I last saw him alive on Sept 19, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death

Due to La Thyrond CachexiaDue to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) 57Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? 360

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other) [Signature]Address [Address] Date signed 9-21-40

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by *Me*

....., Registered Apprentice No.....  
working under my personal supervision.

Signed *Roland P. Speaks*

Licensed Embalmer No. *3604*

P. O. Address *Independence*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

If this body is not embalmed, above space should be left blank.

Please notice <sup>surname</sup> name  
in 3 and 12.

Do name Trot year of  
Francure

Please write requested information  
on face of supplemental and return  
in the enclosed franked envelope.  
Thank you.

*Harry F. Parker*

Harry F. Parker, M. D.  
Special Agent, Bureau of the Census

Charles C. Throtyear  
whose father was a  
Frenchman spelled  
his name:

Maxin Francure

The name was changed  
in America from  
Francure to Throtyear

Local Registrar 398  
J. L. Cook M.D.

o. 2B  
-21-40  
JX22659

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. **32189**  
Registrar's No. **226**

Registration District No. **398**

Primary Registration District No. **3019**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County **Jackson**  
(b) City or town **Independence**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether

In this community \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME **Chas. E. Protyear**

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex **m** 5. Color or race **w** 6. (a) Single, widowed, married, divorced **m**

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

8. AGE: Years **69** Months **4** Days **7** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name **Maxine Jeanne**

13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) **Nov 19/1940** (b) **F. Book**  
(Date received by registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_

(c) City or town \_\_\_\_\_ (If outside city or town limits write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month **Sept** day **20** year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.