

FILED MAR 31 1943

Registration District No. 149

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
5700 Holmes
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 1 year (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 5700 Holmes
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Carrie E. Luce

3. (b) If veteran, name war none 3. (c) Social Security No. none

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Clint Luce 6. (c) Age of husband or wife if alive about years

7. Birth date of deceased March 17th 1880
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
63 0 6 _____ hr. _____ min.

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

10. Usual occupation Practical Nurse

11. Industry or business Nursing no. 8. S. #

MOTHER FATHER { 12. Name Charles F. Barnes

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

14. Maiden name Addie Ingle

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

16. (a) Informant Mrs. Maude Myers

(b) Address 707 East 30th St.

17. (a) Removal (b) Date thereof Mar 25, 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Webb City, Mo

18. (a) Signature of funeral director Jay Funeral Home

(b) Address 3146 Main St.

19. (a) 3-24-43 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 23rd
year 1943 hour 10 minute 30 A.M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive Common, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Gunshot wound of the head
Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy see above

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

(a) Accident, suicide, or homicide, (specify) suicide
(b) Date of occurrence 3/23/43
(c) Where did injury occur? L.C.M. Jackson Co.
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
about employes home
(Specify type of place) (e) Means of injury firearm
While at work? no
23. Signature C. H. Smith (M. D. or other)
Address Raw Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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

Signed

G. F. Buffington

Licensed Embalmer No.

2756

P. O. Address

R. C. Mo

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

If this body is not embalmed, fact should be so stated above.