

FILED JAN 25 1900

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

43539
Do not use this space.

1. PLACE OF DEATH
(a) County PLATTE Registration District No. 691 441
(b) Township _____ Primary Registration District No. 691
(c) City or Camden Point (d) Street No. _____ St.
(e) Length of residence in city or town where death occurred _____ yrs. mos. da. (f) How long in U.S., if of foreign birth? _____ yrs. mos. da.
2. PRINT FULL NAME ARCHIE CAMPBELL LEAVELL
(a) Residence, No. Camden Point St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX MALE 4. COLOR OR RACE WHITE 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) MARRIED
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF SUDIE McCORMICK
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 14, 1863
7. AGE YEARS 77 MONTHS 9 DAYS — If LESS than 1 day, _____ hrs. or _____ min.
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired Druggist
9. Industry or business in which work was done, as saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____
12. BIRTHPLACE (CITY OR TOWN) Camden Point (STATE OR COUNTRY) Missouri
13. NAME Archie Thomas Leavell
14. BIRTHPLACE (CITY OR TOWN) Kentucky (STATE OR COUNTRY) _____
15. MAIDEN NAME Elizabeth Jane Logan
16. BIRTHPLACE (CITY OR TOWN) Kentucky (STATE OR COUNTRY) _____
17. INFORMANT Mrs. Sydnie Leavell (ADDRESS) Camden Point, Mo.
18. BURIAL, CREMATION, OR REMOVAL PLACE Camden Point DATE _____ 19_____
19. FUNERAL DIRECTOR (NAME) W. R. Vaughn (ADDRESS) Weston, Mo.
20. FILED Feb 14, 1900 R. R. Idnell Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec. 14, 1900
22. I HEREBY CERTIFY, That I attended deceased from Dec 9, 1900, to Dec 14, 1900
I last saw him alive on Dec 12, 1900 Death is said to have occurred on the date stated above, at Essex, Mo.
The principal cause of death and related causes of importance were as follows:
arterial stenosis
cardiac hypertrophy
hypertension
hypertrophy of heart
Other contributory causes of importance:
Arteriosclerosis
hypertrophy of heart
hypertension
Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____
23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____ 19_____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. _____
Manner of injury _____
Nature of injury _____
24. Was disease or injury in any way related to occupation of deceased? No
If so, specify _____
(Signed) E. R. Hulst M. D.
(Address) Camden Point, Mo.

Date of onset
1933

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.

1940
99

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..... *W. R. Vaughn*

Licensed Embalmer No. *4023*

P. O. Address *Weston, 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, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 43539

Registration District No. 691

Primary Registration District No. 4413

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Platte

(b) City or town Camden Point
(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 Archie Campbell Leavelle

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 77 Months 9 Days - If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local 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

19. MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 14
year 1940 hour _____ minute _____ M.

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

Immediate cause of death Myocardial Stenosis Duration _____
Cardiac Hypertrophy
Diphtheria

Due to injury to hip joint

Due to _____

Other conditions pneumonia Alcohol
(Include pregnancy within 3 months of death)

General nephritis + arthritis

Major findings: _____

Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following: Death
(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence Dec 14 1940

(c) Where did injury occur? In County road (State County)
(City or town) (County) (State)

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

While at work? While driving (Specify type of place) fall from car
(e) Means of injury

23. Signature E.R. Howell M.D. (M. D. or other) _____
Address Camden Point Mo Date signed Feb 14 1941

SUPPLEMENTAL

S-43539