

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 8 1944

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28488

Registrar's No. 283

Registration District No. 277

Primary Registration District No. 3052

1. PLACE OF DEATH:

(a) County Pettis
(b) City or town Sedalia
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Bothwell Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 days (Specify whether)
In this community 45 years (years, months or days)

3. (a) PRINT FULL NAME Leon Henry Archias, Sr.

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Mary Loretta McCabe Archias 6. (c) Age of husband or wife if alive 72 years
7. Birth date of deceased February 12 1869
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
75 6 16 hr. min.

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

10. Usual occupation Merchant

11. Industry or business RETAIL MERCHANDISE

12. Name Leon Joseph Archias
13. Birthplace Donzere France
(City, town, or county) (State or foreign country)
14. Maiden name Margaret Anna Wellaeur
15. Birthplace Augusta Georgia
(City, town, or county) (State or foreign country)

16. (a) Informant Leon H. Archias, Jr.
(b) Address Sedalia, Missouri

17. (a) Burial (b) Date thereof Aug. 31, 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery
18. (a) Signature of funeral director McLaughlin Bros.

(b) Address Sedalia, Missouri

19. (a) 8-29-44 (b) Anna Berger
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pettis
(c) City or town Sedalia
(If outside city or town limits, write "RURAL")
(d) Street No. 1213 W. 4th (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug 28 day _____
year 44 hour 11 minute _____
21. I hereby certify that I attended the deceased from July 1 - 44
_____ 19____ to Aug 28 1944
that I last saw him alive on Aug 28 1944
and that death occurred on the date and hour stated above.
Immediate cause of death Pneumonia complicated

Due to _____
Due to R. Edward Harnage

Other conditions: Thence Jaison
(Include pregnancy within 3 months of death)

PHYSICIAN
THERMIST
ADDITIONAL
Major findings: SUPPLEMENTARY
Of operations INFORMATION
Of autopsy REQUESTED
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: gun wound
(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)
(c) Means of injury gun
23. Signature J. A. P. Harnage (M. D. or other) MD
Address Sedalia Mo Date signed Aug 28

11222 (Licensed Embalmer's Statement on Reverse Side)

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

FEB 18 1948

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

9-7-47

APR 15 1953

DEC 19 1952

DEC 17 1952

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

L. F. Parker

Licensed Embalmer No.

3848

P. O. Address

Sedalia 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Sept.

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County Pettis
(b) City or town Sedalia
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Bartmore Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 45 yr. (Specify whether years, months or days)

3. (a) PRINT FULL NAME

Leon H. Archias Jr.

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 32 years

7. Birth date of deceased Feb. 12 (Month) (Day) (Year)

8. AGE: Years 75 Months 6 Days 12 If less than one day min.

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

10. Usual occupation

11. Industry or business

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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (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) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 18 year 1944 hour 10 minute 15 M.

21. I hereby certify that I attended the deceased from 1944 to 1944 that I last saw him alive on Aug 18 and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac decompensation
R. Cerebral Hemorrhage
Due to Uremic Poison
Due to Chronic Nephritis

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

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) Date signed

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

SUPPLEMENTAL

28488