Form V. S. 1—30m—3-25-25

COMMONWEALTH OF KENTUCKY

State Board of Health
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

File No.

Registered No. 825[illegible]

1 PLACE OF DEATH

County Muhlenberg

Vot. Pct. ....

Inc. Town Paradise

City ....

Registration District No. 1089

Primary Registration District No. 6823

(No. .... St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Sam P. Vanlandingham

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed or Divorced (Write the word): Single

6 DATE OF BIRTH: Dec (Month) .... (Day) 1851 (Year)

7 AGE: 74 yrs. 9 mos. .... ds.

IF LESS than 1 day .... hrs. or .... min?

8 OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer) ....

9 BIRTHPLACE (State or country): Kentucky

PARENTS

10 NAME OF FATHER: A. W. Vanlandingham

11 BIRTHPLACE OF FATHER (State or country): Illinois

12 MAIDEN NAME OF MOTHER: Margrit Weir

13 BIRTHPLACE OF MOTHER (State or country): Kentucky

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. L. Vanlandingham

(Address) Drakesboro Ky

15 Filed Sept 22, 1925 W. S. Cundiff Registrar

By Laura A. Brown

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept (Month) 17 (Day), 1925 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 13, 1925, to Sept 17, 1925, that I last saw him alive on Sept 17, 1925, and that death occurred on the date stated above at 4 P.m.

The CAUSE OF DEATH* was as follows:

Blood Poison

(Duration) 2 yrs. .... mos. .... ds.

Contributory (Secondary): Infected Sore

(Duration) 2 yrs. .... mos. .... ds.

(Signed) Geo L Emersly, M. D.

Sept 21, 1925 (Address) Rockport Ky

*State the Disease Causing Death, or, in deaths from Violent Causes state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

at place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19 PLACE OF BURIAL OR REMOVAL: Weir Cemetery

DATE OF BURIAL: 9/18/, 1925

20 UNDERTAKER: E. J. Anderson

ADDRESS: Central City Ky

11—3164

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. See instructions on back of certificate.