MAY 25 1927

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

Do not use this space. Dr. Williams ✓10862

1. PLACE OF DEATH
County Audrain — Registration District No. 24 — File No.
Township Saltrivier — Primary Registration District No. 3002 — Registered No. 49
City Mexico (No. ..... St. ..... Ward)

2. FULL NAME Henry Landers
(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 8 – 1841

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
86	2	15	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY) W. Virginia

PARENTS
10. NAME OF FATHER Bill Landers
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ✓
(STATE OR COUNTRY) — —
12. MAIDEN NAME OF MOTHER — — ✓
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ✓
(STATE OR COUNTRY) — —

14. INFORMANT Mrs. Henry Landers
(Address) Mexico Mo.

15. FILED April 26th 1927 Ira S. Milligan REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr. 28 1927

17. I HEREBY CERTIFY, That I attended deceased from April 10, 1927, to April 23, 1927 that I last saw him alive on April 23, 1927, and that death occurred, on the date stated above, at 2 PM m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Valvular disease
Chronic Cardiac
92H
95B
162 (duration) 5 yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Senility
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED?
IF NOT AT PLACE OF DEATH? —
DID AN OPERATION PRECEDE DEATH? no DATE OF .....
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) R. S. Williams, M. D
, 19 (Address) Mexico Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Mexico Mo. — DATE OF BURIAL: Apr. 25 1927

20. UNDERTAKER: McPherson Bros. — ADDRESS: Mexico Mo.

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.

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BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

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1. PLACE OF DEATH
County Audrain — Registration District No. 26 — File No.
Township — Primary Registration District No. 3002 — Registered No. 49
City Mexico (No. ..... St. ..... Ward)

2. FULL NAME Henry Landers

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

SUPPLEMENTAL

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): M

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE — YEARS — MONTHS — DAYS — If LESS than 1 day, ... hrs. or ..... min.

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

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER Bill Landers
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) West Virginia
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Unknown

14. INFORMANT .....
(Address)

15. April 26th, 1927 Ira S. Milligan
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr. 23 1927

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....
.....
.....
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(SECONDARY)
..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) ....., M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL — DATE OF BURIAL 19

20. UNDERTAKER — ADDRESS

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.

S-10862