S. No. 2
M—8-43
5-17-39
X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 4 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 30146

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1013

1. PLACE OF DEATH:
(a) County Buchanon
(b) City or town St Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 2711 So 23rd /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community 73 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Buchanon
(c) City or town St Joseph
(If outside city or town limits, write "RURAL")
(d) Street No. 2711 So 23rd
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME John S. Highland
3. (b) If veteran, name war —
3. (c) Social Security No. Not Given
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Ora F
6. (c) Age of husband or wife if alive 61 years
7. Birth date of deceased Jan 16 1872 (Month) (Day) (Year)

8. AGE: Years 73 Months 8 Days 3 If less than one day hr. min.

9. Birthplace St Joseph (City, town, or county) Mo. (State or foreign country)
10. Usual occupation Carpenter
11. Industry or business
FATHER
12. Name Louis Highland
13. Birthplace Unknown (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Nanna Ellen Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)
16. (a) Informant Ora F. Highland
(b) Address St Joseph Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-22-45 (Month) (Day) (Year)
(c) Place: burial or cremation Mt Auburn Cem
18. (a) Signature of funeral director Freeman & Son Inc
(b) Address St Joseph Mo.
19. (a) 9-22-45 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 19 year 1945 hour 2 minute 07 P.M.
21. I hereby certify that I attended the deceased from Aug 3, 1945, to Sept 19, 1945 that I last saw ~~him~~ alive on Sept 19, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Bronchopneumonia	4 days
Due to	
Due to	
Other conditions Fracture left hip / Cancer (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) Broken hip
(b) Date of occurrence Aug 3 1945 1:31
(c) Where did injury occur? St Joseph Buchanan Co (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Public place (Specify type of place)
While at work? No (e) Means of injury Automobile
23. Signature John D. Byrne (M. D. or other)
Address St Joseph Date signed 9-20-45

1428 (Licensed Embalmer's Statement on Reverse Side)

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: Robert L Gogh

Licensed Embalmer No.: 3308

P. O. Address: St Joseph, 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.

S. No. 2B
FM—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Oct

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1013

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St Joseph (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)

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

3. (a) PRINT FULL NAME John S. Highland

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 Jan (Month) 16 (Day) 1 (Year)

8. AGE: Years 73 Months 8 Days 3 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept 19 year 1945 hour minute M.

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

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy No autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) Struck by automobile

(b) Date of occurrence

(c) Where did injury occur? St. Joseph (City or town) Buchanan (County) Mo (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature John S. Highland (M. D. or other)

Address St. Joseph Mo Date signed 10-5-45

SUPPLEMENTARY

30146