

FILED DEC 9 1943

Registration District No. **611** Primary Registration District No. **6258-3843** Registrar's No. _____

1. PLACE OF DEATH:

(a) County **NEWTON**
 (b) City or town **PURPALE Fine Mills Pa**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
(7 miles south of Joplin, Mo)
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **none**
 (Specify whether years, months or days) **in air travel**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Michigan** (b) County **Waynes**
 (c) City or town **Detroit**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **2958 Northwestern**
 (If rural, give location)
 (e) Citizen of foreign country? **no** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **ROBERT S. GROGAN**

3. (b) If veteran, name war **none** 3. (c) Social Security No. **Unknown**

4. Sex **male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **single**
 6. (b) Name of husband or wife **none** 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **August 26 1917**
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	26	3	2	_____ hr. _____ min.

9. Birthplace **Obion County Tennessee**
 (City, town, or county) (State or foreign country)

10. Usual occupation **Aviation Student**

11. Industry or business **U. S. Army**

12. Name **James Hershel Grogan**

13. Birthplace **unknown**
 (City, town, or county) (State or foreign country)

14. Maiden name **Grace P. Grogan**

15. Birthplace **unknown**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Post Records**

(b) Address **Coast Coffeyville Kan**

17. (a) Removal **Removal** (b) Date thereof **Nov 29, 1943**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **W. P. ...**

18. (a) Signature of funeral director **[Signature]**

(b) Address **Coffeyville Kansas**

19. (a) **12-4-43** (b) **Nettie Norris**
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov** day **28**
 year **1943** hour **11 PM** minute **00** 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 **Injuries sustained in air crash. (See reverse)**
 Due to _____

Due to _____
 Other conditions (Include pregnancy within 3 months of death) **1738**

Major findings: Of operations **none** 34
 Of autopsy **none**

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) **accident 12-2**
 (b) Date of occurrence **Nov 28, 1943**
 (c) Where did injury occur? **Joplin Newton Kas**
 (City or town) (County) (State)
 (d) Did injury occur in or about home, or farm, in industrial place, in public place?
farm
 (Specify type of place) **airplane**
 While at work? **[Signature]** (e) Means of injury **crash**
 23. Signature **[Signature]** (M. D. or other) **Coroner**
 Address **[Signature]** Date signed **12-1-43**

MOTHER FATHER

PHYSICIAN
 Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—HAND WRITE

cause of Death:

1. Wounds, lacerated of abdomen, with partial evisceration of liver and small intestine.
2. Fracture, compound, comminuted, depressed, skull
3. Fracture compound, comminuted, left + right femur, tibia, fibula and feet.
4. Burns, 3rd degree, over 90% of body.

APR 10 1944

REC 2 21943

RECEIVED: 12-5-43
 District Health Officer No. _____
 District File Number 1243-228
 Date Filed 12-7-43

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.

This subject was delivered to me at Mills Funeral Home via Army ambulance and embalming was completed in our rooms under Kansas Laws.

Signed *Chas. H. Kauras* (Kauras)

Licensed Embalmer No. 1330

P. O. Address *Coffeyville Kansas*

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.

Registration District No. 101-248 Primary Registration District No. 625-8 Registrar's No. _____

1. PLACE OF DEATH:

- (a) County Newton
 (b) City or town Rural Five Mile
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
7 miles S. of Joplin, Mo
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether
 years, months or days)

3. (a) PRINT FULL NAME Roberts Hogan

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

4. Sex M 5. Color W race _____
 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
 alive _____ years

7. Birth date of deceased: Aug 26 1926
(Month) (Day) (Year)

8. AGE: Years 26 Months 3 Days _____ If less than one day _____ min.

9. Birthplace Ill.
(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) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2nd Year 1943 Minute _____ M.

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

Duration _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
 Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline
 the cause to
 which death
 should be
 charged sta-
 tistically.

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)
 (c) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

APR 10 1944

38784