Standard Form 1034 (EG)
Revised October 1987
Department of the Treasury
1 TFM 4-2000
1034-121

PUBLIC VOUCHER FOR PURCHASES AND SERVICES OTHER THAN PERSONAL

VOUCHER NO.

U.S. DEPARTMENT, BUREAU, OR ESTABLISHMENT AND LOCATION

DEPARTMENT OF THE ARMY
3d Finance Company
Camp Falcon, Iraq
APO AE 09364
DSSN: 5579

10DATE VOUCHER PREPARED: 20050721

CONTRACT NUMBER AND DATE: (b)(2)High

REQUISITION NUMBER AND DATE: NONE

SCHEDULE NO.

PAID BY
3d Finance Company
APO AE 09364

DSSN: 5579

CLAIM #: 05-IM6- T588699

PAYEE'S NAME AND ADDRESS
(b)(6)
Baghdad, Iraq

DATE INVOICE RECEIVED

DISCOUNT TERMS

PAYEE'S ACCOUNT NUMBER

SHIPPED FROM | TO | WEIGHT | GOVERNMENT B/L NUMBER

NUMBER AND DATE OF ORDER	DATE OF DELIVERY OR SERVICE	ARTICLES OR SERVICES (Enter description, item number of contract or Federal supply schedule, and other information deemed necessary)	QUANTITY	UNIT PRICE COST	UNIT PRICE PER	AMOUNT
		In full settlement of the amount allowed by the Secretary of the Army, or an officer duly designated for such purposes under authority of 31 U.S.C. 3721 and AR 27-20, Chapter 10, upon the claim of the above named claimant for property damaged, lost, destroyed, captured, or abandoned in service.				$7,000.00
(Use continuation sheet(s) if necessary)		**(Payee must NOT use the space below)**		**TOTAL**		$7,000.00

PAYMENT:
- ☐ PROVISIONAL
- ☒ COMPLETE
- ☐ PARTIAL
- ☐ FINAL
- ☐ PROGRESS
- ☐ ADVANCE

APPROVED FOR =$

EXCHANGE RATE =$1.00

DIFFERENCES

BY: SSG (b)(3),(b)(6)
HQ, 4 BDE, 3 ID, (FWD)

TITLE: PAYING AGENT

$7,000.00 (b)(3),(b)(6)

(b)(3),(b)(6)

Pursuant to authority vested in me, I certify that this voucher is correct and proper for payment.

4 Aug 05 (Date)

(Authorized Certifying Officer)[2]

(b)(3),(b)(6), CPT, USA
HQ, 4 BDE, 3 ID (FWD), FCC IM6
(Title)

ACCOUNTING CLASSIFICATION

(b)(2)High $7,000.00

PAID BY

CHECK NUMBER	ON ACCOUNT OF U.S. TREASURY	CHECK NUMBER	ON (Name of bank)
CASH	DATE	(b)(6)	
$ $7,000.00	13 Aug 05		

[1] When stated in foreign currency, insert name of currency.
[2] If the ability to certify and authority to approve are combined in one person, one signature only is necessary; otherwise the approving officer will sign in the space provided, over his official title.
[3] When a voucher is receipted in the name of a company or corporation, the name of the person writing the company or corporate name, as well as the capacity in which he signs, must appear. For example: "John Doe Company, per John Smith, Secretary", or "Treasurer", as the case may be.

PER

TITLE

Previous edition usable

NSN 7540-00-900-2234

PRIVACY ACT STATEMENT
The information requested on this form is required under the provisions of 31 U.S.C. 82b and 82c, for the purpose of disbursing Federal money.
The information requested is to identify the particular creditor and the amounts to be paid. Failure to furnish this information will hinder discharge of the payment obligation.

4th Brigade Combat Team – Claims Info. Sheet
3d Infantry Division

#20

ATTORNEY (b)(3)(b)(6)

Today's Date 05-15-2005

CLAIMANT NAME (b)(6) ID NUMBER (b)(6)
PHONE NUMBER
DISTRICT: (b)(6)
ADDRESS Other:

CLAIM INFORMAITON
- ☐ Injury ☒ Death ☐ FCA Damage
- ☐ ☐ Confiscation (☐ Car; ☐ Weapon; ☐ Other)
- ☐ FCA/Solatia ☐ Real Estate ☐ Other
- ☐ Reconsideration
- ☒ Shooting ☐ Bombing ☐ Raid ☐ Vehicle Accident ☐ Arrest ☐ UXO/IED ☐ Other

DATE OF INCIDENT	01-08-2005	LOCATION OF INCIDENT	Baghdad-Ameriej	AMOUNT CLAIMING	$ 2500

FCA CLAIMS SUPPORTING DOCUMENTS
- ☐ Proof of Ownership ☐ Receipts ☐ Diagram ☒ Police Report ☐ Statements ☐ Pictures
- ☒ US Note ☐ Hospital Report ☒ Judicial Decision
- ☐ Other :
- ☒ Death Certificate ☒ Medical Reports (☐ Iraqi ☒ US) ☒ US Note ☐ Division of Property Form from the court

Name of Deceased: (b)(6) Age: (b)(6)
Marital Status: ☐ Single ☒ Married (number of wives/kids _ (b)(6)
Nature of injury:
- Is it permanent?
- Will injury require follow up surgeries?
- Does this injury affect the individual's ability to earn a living?

GENERAL INFORMATION
- Are there any discrepancies in the evidence? /
- Do the medical records confirm the "story"? Yes
- Do the pictures confirm the "story"? /
- Other notes regarding evidence: /
- Is this related to any other claims? /

TRANSLATOR NOTES:

In date of 01-08-2005 The claimant husband (b)(6) was work at (b)(6) when he was diedly shot by US forces who were shooting randomly after a road side IED explosion the forces transport him to CASH hospital (IRN SINA), he died at the same day because of intensive injury. Death reports from the Hospital is attached.

Translator Estimate of damages: $ 2500

NCOIC NOTES

IED EXPLODED AND U.S. FORCES RANDOMLY SHOT HUSBAND. RECOMMEND APPROVAL FOR $7000.

ATTORNEY NOTES ☒ Approved $7,000.00 ☐ Denied (Circle) Evidence Combat Ops Other

(b)(3),(b)(6)

Paid 13 Aug 05 CF SHOOTING

Pages 3 through 6 redacted for the following reasons:
- -
Foreign Language
Foreign Language, (b)(6)

(b)(6)

FOR SEIL & RAINT

(b)(6)

8 JAN 1.15 PM

(b)(6)

FOB ST. MICHAEL – MAHMUDIYA
WEDNESDAY 0900-1600

This lady need to come into the Base and see some one about a problem she has. this case can only be handled by the unit there. she is try to get a Claim about her brother he was shot. The area was Kowarish which he was shot.

Spc (b)(3),(b)(6)

DNVT 531-5046

23 ARRES

Pages 9 through 10 redacted for the following reasons:
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Foreign Language, (b)(6)

CERTIFICATE OF DEATH *(OVERSEAS)*
Acte de décès *(D'Outre-Mer)*

NAME OF DECEASED *(Last, First, Mid* ... lom et prénoms)	GRADE Grade	BRANCH OF SERVICE Arme	SOCIAL SECURITY NUMBER Numéro de l'Assurance Sociale
(b)(6)	CIV		

ORGANIZATION Organisation	NATION *(e.g., United States)* Pays	DATE OF BIRTH Date de naissance	SEX Sexe
	IRAQ		[X] MALE Masculin [ ] FEMALE Féminin

RACE Race	MARITAL STATUS État Civil	RELIGION Culte
[ ] CAUCASOID Caucasique [ ] NEGROID Négroïde [X] OTHER (Specify) Autre *(Spécifier)* Iraqi	[ ] SINGLE Célibataire [ ] MARRIED Marié [ ] WIDOWED Veuf [ ] DIVORCED Divorcé [ ] SEPARATED Séparé	[ ] PROTESTANT Protestant [ ] CATHOLIC Catholique [ ] JEWISH Juif [ ] OTHER *(Specify)* Autre *(Spécifier)*

NAME OF NEXT OF KIN Nom du plus proche parent	RELATIONSHIP TO DECEASED Parenté du décédé avec le susdit
STREET ADDRESS Domicile à (Rue)	CITY OF TOWN AND STATE *(Include ZIP Code)* Ville (Code postal compris)

MEDICAL STATEMENT Déclaration médicale

CAUSE OF DEATH *(Enter only one cause per line)* Cause du décès (N'indiquer qu'une cause par ligne)		INTERVAL BETWEEN ONSET AND DEATH Intervalle entre l'attaque et le décès
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH[1] Maladie ou condition directement responsable de la mort.[1]	GSW TO PORTAL VEIN	
ANTECEDENT CAUSES — Symptômes précurseurs de la mort. — MORBID CONDITION, IF ANY, LEADING TO PRIMARY CAUSE Condition morbide, s'il y a lieu, menant à la cause primaire	HEMORRHAGE	
UNDERLYING CAUSE, IF ANY, GIVING RISE TO PRIMARY CAUSE Raison fondamentale, s'il y a lieu, ayant suscité la cause primaire		
OTHER SIGNIFICANT CONDITIONS[2] Autres conditions significatives[2]		

MODE OF DEATH Condition de décès	AUTOPSY PERFORMED Autopsie effectuée	CIRCUMSTANCES SURROUNDING DEATH DUE TO EXTERNAL CAUSES Circonstances de la mort suscitées par des causes extérieures
[ ] NATURAL Mort naturelle [ ] ACCIDENT Mort accidentelle [ ] SUICIDE Suicide [ ] HOMICIDE Homicide	MAJOR FINDINGS OF AUTOPSY Conclusi NAME OF PATHOLOGIST Nom du pathol	
	SIGNATURE Signature / DATE Date	AVIATION ACCIDENT Accident à Avion [ ] YES Oui [ ] NO Non

Foreign Language Text

DATE OF DEATH *(Hour, day, month, year)* Date de décès *(l'heure, le jour, le mois, l'année)*	PLACE OF DEATH Lieu de décès

I HAVE VIEWED THE REMAINS OF THE DECEASED AND DEATH OCCURRED AT THE TIME INDICATED AND FROM THE CAUSES AS STATED ABOVE.
J'ai examiné les restes mortels du défunt et je conclus que le décès est survenu à l'heure indiquée et à, la suite des causes énumérées ci dessus

NAME OF MEDICAL OFFICER Nom du médicin militaire ou du médicin sanitaire	TITLE OR DEGREE Titre ou diplômé
(b)(3),(b)(6)	MD
GRADE Grade: O3	INSTALLATION OR ADDRESS Installation ou adresse: Baghdad, Iraq
DATE Date: 8 Jan 05	(b)(3),(b)(6)

[1] *State disease, injury or complication which caused death, but not mode of dying such as heart failure, etc.*
[2] *State conditions contributing to the death, but not related to the disease or condition causing death.*
[1] *Préciser la nature de la maladie, de la blessure ou de la complication qui a contribué à la mort, mais non la manière de mourir, telle qu'un arrêt du coeur, etc.*
[2] *Préciser la condition qui a contribué à la mort, mais n'ayant aucun rapport avec la maladie ou à la condition qui a provoqué la mort.*

DD FORM 2064, APR 1977 REPLACES DA FORM 3565, 1 JAN 1972 AND DA FORM 3565-R(PAS), 26 SEP 1975, WHICH ARE OBSOLETE. USAPA V1.00

(b)(6)

HOSPITAL REPORT OF DEATH

FOR USE OF THIS FORM, SEE AR 40-2; THE PROPONENT AGENCY IS OFFICE OF THE SURGEON GENERAL

NAME AND LOCATION OF HOSPITAL: 86th CSH, Baghdad, IRAQ

Instructions - Medical Officer in attendance will:
Prepare, in one copy only, Items 1 through 10 and sign Item 11. Print or type entries.
Send form, without delay to the Registrar or Administrative Officer of the Day, for necessary action and for preparation of required number of copies.

SECTION A - ATTENDING MEDICAL OFFICER'S REPORT

PERSONAL DATA

1. PATIENT DATA *(Patient's ward plate will be used to imprint identifying*

(b)(6)

Patient's name (Last, first, middle initial) Grade, Social Security Account No., Register Number and Ward Number

2. TIME OF DEATH *(Hour-day-month-year)*: 1825

3. MEDICAL EXAMINER/ CORONER'S CASE: ☐ YES ☐ NO

4. RELIGION

5. CHAPLAIN NOTIFIED: ☒ YES ☐ NO

6. NAME, ADDRESS AND RELATIONSHIP OF RELATIVE OR FRIEND PRESENT AT DEATH

CAUSE OF DEATH

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
7a. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury, or complication which caused death)*	DUE TO *(or as a consequence of)* CSW TO PORTAL VEIN	<1 HOUR
7b. ANTECEDENT CAUSES *(Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last)*	DUE TO *(or as a consequence of)* (1)	
	(2)	
8. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	a.	
	b.	

9. DATE: 8 JAN 2005

(b)(3),(b)(6)

OF MEDICAL OFFICER: MD

(b)(6)

ENDANCE

SECTION B - ADMINISTRATIVE ACTION

TYPE OF ACTION	HOUR	DAY	MONTH	YEAR	INITIALS OF RESPONSIBLE OFFICER
12. TELEGRAM TO NEXT OF KIN OR OTHER AUTHORIZED PERSON					
13. POST ADJUTANT GENERAL NOTIFIED					
14. IMMEDIATE CO OF DECEASED NOTIFIED					
15. INFORMATION OFFICE NOTIFIED					
16. POST MORTUARY OFFICER NOTIFIED					
17. RED CROSS NOTIFIED					
18. OTHER *(Specify)*					
19.					

SECTION C - RECORD OF AUTOPSY

20. AUTOPSY PERFORMED *(If yes, give date and place)*: ☐ YES ☐ NO

21. AUTOPSY ORDERED BY *(Signature)*

22. PROVISIONAL PATHOLOGICAL FINDINGS

23. DATE	24. TYPED NAME AND GRADE OF PHYSICIAN PERFORMING AUTOPSY	25. SIGNATURE OF PHYSICIAN PERFORMING AUTOPSY
26. DATE	27. TYPED NAME AND GRADE OF REGISTRAR	28. SIGNATURE OF REGISTRAR

DA FORM 3894, OCT 72 REPLACES DA FORM 8-257, 1 JAN 61, WHICH WILL BE USED. WSAPPC V2.00

(b)(6) 8-Jan-05 (nephew)

CERTIFICATE OF DEATH *(OVERSEAS)*
Acte de décès *(D'Outre-Mer)*

NAME OF DECEASED *(Last, First, Middle)* Décédé (Nom et prénoms) (b)(6)	GRADE Grade CIV	BRANCH OF SERVICE Arme	SOCIAL SECURITY NUMBER Numéro de l'Assurance Sociale
ORGANIZATION Organisation	NATION *(e.g., United States)* Pays IRAQ	DATE OF BIRTH Date de naissance	SEX Sexe ☒ MALE Masculin ☐ FEMALE Féminin

RACE Race	MARITAL STATUS État Civil	RELIGION Culte
☐ CAUCASOID Caucasique	☐ SINGLE Célibataire	☐ DIVORCED Divorcé
☐ NEGROID Négroïde	☐ MARRIED Marié	☐ SEPARATED Séparé
☒ OTHER (Specify) Autre *(Spécifier)* Iraqi	☐ WIDOWED Veuf	☐ PROTESTANT Protestant ☐ CATHOLIC Catholique ☐ JEWISH Juif ☐ OTHER *(Specify)* Autre *(Spécifier)*

NAME OF NEXT OF KIN Nom du plus proche parent	RELATIONSHIP TO DECEASED Parenté du décédé avec le susdit
STREET ADDRESS Domicile à (Rue)	CITY OF TOWN AND STATE *(Include ZIP Code)* Ville (Code postal compris)

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ANTECEDENT CAUSES Symptômes précurseurs de la mort. — MORBID CONDITION, IF ANY, LEADING TO PRIMARY CAUSE Condition morbide, s'il y a lieu, menant à la cause primaire	HEMORRHAGE	
UNDERLYING CAUSE, IF ANY, GIVING RISE TO PRIMARY CAUSE Raison fondamentale, s'il y a lieu, ayant suscité la cause primaire		
OTHER SIGNIFICANT CONDITIONS[2] Autres conditions significatives[2]		

MODE OF DEATH Condition de décès	AUTOPSY PERFORMED Autopsie effectuée ☐ YES Oui ☐ NO Non	CIRCUMSTANCES SURROUNDING DEATH DUE TO EXTERNAL CAUSES Circonstances de la mort suscitées par des causes extérieures
☐ NATURAL Mort naturelle	MAJOR FINDINGS OF AUTOPSY Conclusions principales de l'autopsie	
☐ ACCIDENT Mort accidentelle		
☐ SUICIDE Suicide	NAME OF PATHOLOGIST Nom du pathologiste	
☐ HOMICIDE Homicide	SIGNATURE Signature / DATE Date	AVIATION ACCIDENT Accident à Avion ☐ YES Oui ☐ NO Non
DATE OF DEATH *(Hour, day, month, year)* Date de décès *(l'heure, le jour, le mois, l'année)*	PLACE OF DEATH Lieu de décès	

I HAVE VEIWED THE REMAINS OF THE DECEASED AND DEATH OCCURRED AT THE TIME INDICATED AND FROM THE CAUSES AS STATED ABOVE.
J'ai examiné les restes mortels du défunt et je conclus que le décès est survenu à l'heure indiquée et à, la suite des causes énumérées ci dessus

NAME OF MEDICAL OFFICER Nom du médecin militaire ou du médecin sanitaire	TITLE OR DEGREE Titre ou diplôme
Grade	INSTALLATION OR ADDRESS Installation ou adresse
Date	SIGNATURE Signature

[1] *Disease, injury or complication which caused death, but not mode of dying such as heart failure, etc.*
[2] *Other conditions contributing to the death, but not related to the disease or condition causing death.*
[1] Préciser la nature de la maladie, de la blessure ou de la complication qui a contribué à la mort, mais non la manière de mourir, telle qu'un arrêt du coeur, etc.
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FORM 2064, APR 1977 REPLACES DA FORM 3565, 1 JAN 1972 AND DA FORM 3565-RIPASI, 26 SEP 1975, WHICH ARE OBSOLETE. USAPA V1.00

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Foreign Language, (b)(6)

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