has been translated

(b)(6)

March 31 2008

(b)(2)High

(b)(2)High

Claim Number: 08-IJ6-A142

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

Name: (b)(6)

Date of Incident: 15-Sep-07
Date Received: 21-Apr-08

Summary: son killed during cf shooting.

Circle Decision, Fill-in Date, and initial

DENY	INVESTIGATE	PAY - $_____
DATE 22 Apr 2008	DATE	DATE
INIT b)(3), (b)(6)	INIT	INIT

___ Insufficient Evidence
X Combat Exception child hit and killed during firefight
___ US Involvement
___ Lack of Causation
___ Statute of Limitations
___ Not a Proper Claimant
___ Non-Cognizable Claim

NOTES:

X **CERP**

Recommend CERP Payment of $2,500 for death.

DEPARTMENT OF THE ARMY
HEADQUARTERS, 1ST BRIGADE COMBAT TEAM
4TH INFANTRY DIVISION
FOB FALCON, BAGHDAD, IRAQ APO AE 09361

REPLY TO
ATTENTION OF

CERP RELEASE AND SETTLEMENT AGREEMENT

I, (b)(6) of **Baghdad, Iraq,** hereby agree to accept the sum of **$2500.00** (U.S. Dollars) as payment in full satisfaction and final settlement of any and all claims against the United States of America.

In consideration thereof, I hereby release and forever discharge the United States of America, including its officers, agents, and employees from all liability, claims and demands of whatsoever nature arising from said incident. This release and settlement specifically includes all current or potential claims, including attorney fees, if any, arising from or related to property damage, injury, and/or death resulting from events on 15-Sep-07.

It is understood that the amount tendered is accepted as full satisfaction and final settlement and that the award is made pursuant to the Foreign Claims Act, Title 10, U.S.C. § 2734, and is not to be construed as an admission of liability on the part of, but as a release of, the United States of America, its officers, agents, and employees.

Dated this _____ day of _____ 2008, at Baghdad, Iraq.

_____
Claimant Signature
Name: (b)(6)
Address: Baghdad, Iraq

_____
Witness Signature

_____
Witness Signature

DEPARTMENT OF THE ARMY
HEADQUARTERS, 1ST BRIGADE COMBAT TEAM
4TH INFANTRY DIVISION
FOB FALCON, BAGHDAD, IRAQ APO AE 09361

REPLY TO
ATTENTION OF:

AFYB-IN-CDR

MEMORANDUM FOR RECORD

SUBJECT: Condolence Payment - (b)(6)

1. I have conducted an initial review of the circumstances surrounding the events of 15-Sep-07, which resulted in a claim by (b)(6)

2. In accordance with the applicable statues and the investigation into your claim, the claim is not compensable. After a search of records of the date in question, the evidence provided showed that damages were the result of combat operations. Damages directly or indirectly related to combat operations are not compensable. I do, however, authorize the payment of CERP condolence funds to (b)(6) in the amount of $2500.00. I have determined that a condolence payment is necessary and appropriate for the damage caused by U.S. Forces.

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

COL, AR
Commanding

I have reviewed the proposed condolence payment authorized by COL (b)(3), (b)(6) He is authorized to approve payments in the stated amount. Based on the circumstances of the accident, the use of CERP funds to make a condolence payment complies with the MNC-I CJ8 SOP, Money as a Weapons System, dated 1 February 2008.

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

MAJ, JA USAR
Foreign Claims Commissioner

Pages 6 through 8 redacted for the following reasons:
- -
(b)(5), (b)(2)High, (b)(6), (b)(3)
Already Reviewed and Redacted for Release

Claims Form

6 Foreign Langua

Name: (b)(6) الأسم:

Address: (b)(6) العنوان:

Phone Number (b)(6)

I am Iraq

أنا

a. A national citizen of: Iraq أ. أحمل جنسية:

b. A permanent resident of: above address ب. عنوانى الدائم:

c. Employed by: ت. أعمل لدي:

I hereby make a claim against the United States Government for damages or injuries caused by: (Name, Organization, Military Department, Address and Telephone Number)

(b)(6) , E/2-2 SCR

أننى أتظلم لدي حكومى الولايات المتحدة للأضرار والإصابت التى نجمت من:(المنظمة ، الوحدة العسكرية)

The property damaged is owned by: (If the claim is made as an agent, parent, or guardian, attach a power of attorney or other evidence of authority and fill in the form below for party sustaining the damage or injuries.)

الممتلكات المتضررة مملوكة من: (إذا كان عذا التظلم قدم من قبل ممثل أو قريب أو عائل فالرجاء أحطار المستمسكات التى تخولكم وتوكلكم للتقدم بهذا التظلم ، أو أي دليل من ممثلين رسميين.
إملأ التظلم بالأسفل للأفراد المتقدمين بالشكوي للإصابت أو الأضرار التى أصابتهم.)

My claim arose at: Aldorah (Town) Baghdad (City) Iraq (Country)

البلد أو المحافظة المدينة القرية تظلم قدم في:

My claim arose on: September 15 2007
Month Day Year

تظلمى قدم فى:
السن يوم شهر

Give a brief statement of the accident or incident on which the claim for damages to property or for personal injury is based. (Use back of this sheet if necessary.)

She said that while her son going to their neighbour there were fr C.F walking in the area during that time her son exposed shooting when C.F opened fire towards anoth time direction.

بإختصار أشرح ما حدث والأضرار التى أصابتك جراء ذلك ، سواء كانت جسدية أو ممتلكات . (الرجاء أستعمال خلفية هذه الورقة إن لم تكن الأسطر لتكفى)

List in detail the amount of property damage and itemized expenses resulting from the property damage or personal injury; (Attach bills and receipts, if applicable.)

Item	Amount
Kid has been killed	$15000

Total: $15000

أشرح بالتفصيل متي تضرر والكلفة للممتلكات أو للإصابات الجسدية وتكلفتها (الرجاء أضافة الثبوتات والممتمسكات والفواتير الضرورية لكل شئ لوحدة)

الشئ المتضرر	تكلفته

إجمالي التكلفة:

I was insured to the following extent against the damage or injury I have sustained:

No insurance

لدي تأمين على الممتلكات أو الضرر الجسدى المتضرر بما يوازي:

I claim as damages: (Indicate amount in U.S. dollars and local currency)

$ 15000 I.D. ___

أطالب بتعويض للأضرار يوازي (أكتب بالدولار الأمريكى أو العملة المحلية)

$ _____ العملة المحلية _____

I (have/ have not) previously filed a claim relating to the incident described above.

سابقا (قمت) (لم أقم) بتقديم بلاغ لهذه الحادثة المذكورة بالأعلى

To the best of my knowledge, another claim (has/ has not) been filed relating to the incident described above.

لحسن علمى طلب تظلم (قدم) (لم يقدم) لهذه الحادثة المذكورة بالأعلى

NOTE: BY SIGNING BELOW, YOU ARE SWEARING THAT THE INFORMATION PROVIDED IN THIS CLAIM IS ACCURATE AND TRUTHFUL. ANYONE WHO ATTEMPTS TO FILE, OR CONSPIRES TO FILE, A DUPLICATE OR FRAUDULENT CLAIM AGAINST THE UNITED STATES GOVERNMENT WILL FACE CRIMINAL PROSECUTION.

ملاحظة: بالتوقيع أسفل هذا التظلم فأن تقسم على أن كل المعلومات المقدمة فى هذا التظلم هى صحيحة وحقيقية . أي شخص يحاول تقديم تظلم كاذب أو مختلق أو يزور التظلم ضدحكومة الولايات لمتحدة الأمريكية سوف يواجه عقوبات جنائية حادة ويحاكم من قبل السلطات .

_____
(Signature of Claimant)
(توقيع التظلم) الرجاء كتابة: الأسم والتوقيع

Subscribed to me this 30 day of March, 2008.

_____
(Signature of Witness)

_____
(Printed Name)

DEPARTMENT OF THE ARMY
Eagle Company, 2nd Squadron, 2nd Calvary Regiment
Building 681, Vilseck, Ge, APO AE 09112

AFZH-BAE-B 26 MAR 2008

MEMORANDUM FOR RECORD

SUBJECT: Request for condolence payment for accidental death of Iraqi citizen.

1) On 15 September 2007, Eagle Company received contact from houses to the east of COP 860. (b)(6) was brought to COP 860 approximately 10 minutes after the conclusion of the firefight with head trauma. He was taken to the CSH, but passed away shortly after arrival. This memorandum is to assist the family of (b)(6) o collect condolence money for the death of their child.

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

1LT, FA
FSO, E/2-2 SCR

foreign language, (b)(6)

(b)(6), foreign language

DEATH SERTIFICATE

13. POST ADJUTANT [illegible]
14. IMMEDIATE CO OF DECEASED NOTI
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. USAPA V2.01

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 data if available)*	2. TIME OF DEATH *(Hour-day-month-year)*	3. MEDICAL EXAMINER/ CORONER'S CASE
(b)(6)	2109 15 SEP 2007	☐ YES ☒ NO
(b)6 Foreign Language	4. RELIGION	5. CHAPLAIN NOTIFIED ☐ YES ☒ NO
Patient's name (Last, first, middle initial) Grade, Social Security Account No., Register Number and Ward Number	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 consequen* GUNSHOT WOUN (b)6 Foreign Language	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 consequen* (1)	
	(2)	
8. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	a.	
	b.	

9. DATE	10. TYPED OR PRINTED NAME AND GRADE OF MEDICAL OFFICER	11. SIGNATURE OF MEDICAL OFFICER IN ATTENDANCE
15 SEPTEMBER 2007	(b)(3), (b)(6) MAJ	(b)(3), (b)(6)

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

PRIVACY ACT STATEMENT

AUTHORITY: 10 USC Sections 1481 through 1488, EO 9397, Nov. 1943 (SSN).

PURPOSE AND USE: This form is used to establish initial identification of deceased personnel.

DISCLOSURE: Personal information provided on this form is given on a voluntary basis. Failure to provide this information, however, may result in improper identification of the deceased person and person making visual identification.

3. TENTATIVELY IDENTIFIED DECEDENT

a. NAME *(Last, First, Middle Initial) (or Unidentified)*	b. GRADE	c. SSN	d. ORGANIZATION	e. STATUS	f. DATE OF STATUS *(YYYYMMDD)*
(b)(6)		(b)(6)		Deceased	20070915

4. PLACE OF RECOVERY *(Include grid coordinates)*	5. DATE OF RECOVERY *(YYYYMMDD)*	6. EVACUATION NUMBERS a. #1	b. #2
BAGHDAD, IRAQ			

7. INVENTORY OF EFFECTS

a. QUANTITY	b. DESCRIPTION	c. RECEIVED	d. CONDITION	e. DISPOSITION
0	NOTHING FOLLOWS			

8. FUNDS/NEGOTIABLE INSTRUMENTS/OTHER HIGH VALUE ITEMS TRANSMITTED WITH EFFECTS

a. QUANTITY	b. DESCRIPTION	c. RECEIVED	d. CONDITION	e. DISPOSITION

9. EFFECTS INVENTORIED ABOVE REPRESENT *(X as appropriate)*

☐ ALL KNOWN EFFECTS ☐ ALL KNOWN EFFECTS RECOVERED FROM UNIT ☐ ALL KNOWN EFFECTS RECOVERED FROM REMAINS

10. PREPARING OFFICIAL

a. NAME *(Last, First, Middle Initial)*	b. GRADE	c. ORGANIZATION
(b)(3), (b)(6)	E-4	28TH CSH

d. SIGNATURE	e. DATE SIGNED *(YYYYMMDD)*
(b)(3), (b)(6)	20070915

11. RECEIVING OFFICIAL

a. NAME *(Last, First, Middle Initial)*	b. GRADE	c. ORGANIZATION
(b)(6)		

d. SIGNATURE	e. DATE SIGNED *(YYYYMMDD)*
(b)(6)	

12. RECEIVING OFFICIAL

a. NAME *(Last, First, Middle Initial)*	b. GRADE	c. ORGANIZATION

d. SIGNATURE	e. DATE SIGNED *(YYYYMMDD)*

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

NAME OF DECEASED *(Last, First, Middle)* Nom du décédé (Nom et prénoms)	GRADE Grade	BRANCH OF SERVICE Arme	SOCIAL SECURITY NUMBER Numéro de l'Assurance Sociale
(b)(6)			(b)(6)

ORGANIZATION Organisation	NATION *(e.g., United States)* Pays	DATE OF BIRTH Date de naissance	SEX Sexe
	IRAQ	12 DEC 2000	☒ MALE Masculin ☐ FEMALE Féminin

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

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 Declaration 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]		GUNSHOT WOUND TO HEAD	1 HOUR
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		
	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
2109 15 SEP 2007	28TH CSH BAGHDAD, IRAQ

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 médicin militaire ou du médicin sanitaire	TITLE OR DEGREE Titre ou diplômé
(b)(3), (b)(6)	MD
GRADE Grade: O4	INSTALLATION OR ADDRESS Installation ou adresse: 28TH CSH BAGHDAD, IRAQ
DATE Date: 15 SEPTEMBER 2007	SIGNATURE (b)(3), (b)(6)

[1] *State disease, injury or complication which caused death, not the 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 ayant causé la mort, et non le mode de mort, tel que l'arrêt du cœur, etc.*

Foreign Language Text, (b)(6)