

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

01/26/2008

(b)(6)

(b)(6)

foreign language

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

Claim Number: 08-IJ6-B011

Name: (b)(6)

Date of Incident: 9-Jun-07

Date Received: 14-Apr-08

Summary: Her son was out at a store and was shot by CF and died at the CSH

Circle Decision, Fill-in Date, and initial

DENY	INVESTIGATE	<u>PAY</u> - \$ <u>12,000</u>
DATE	DATE	DATE <u>14 Apr 2008</u>
INIT	INIT	INIT (b)(3), b(6)

- Insufficient Evidence
- Combat Exception
- US Involvement
- Lack of Causation
- Statute of Limitations
- Not a Proper Claimant
- Non-Cognizable Claim

NOTES: CERP



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

26 Apr 2008

SUBJECT: Claim # 08-I2A-B011

(b)(6)

Baghdad, Iraq

Dear Sir:

You have submitted a claim seeking compensation for the loss of your loved one. I have thoroughly reviewed your claim pursuant to the Foreign Claims Act (FCA), Title 10, United States Code §2734, Army Regulation 27-20, and Department of the Army Pamphlet 27-162 Claims Procedures.

Allow me to express my sympathy for the loss of your loved one. In accordance with the cited references and the investigation into your claim, I find that your claim is compensable. Accordingly, the 4th Infantry Division Claims Office will compensate you for your losses in the amount of ~~\$6000.00~~ \$12,000.00 (3), b

If you are dissatisfied by this action, you may request reconsideration of the decision in accordance with AR 27-20. Any such request must be based on new or additional evidence and should be forwarded to this office. While there is no prescribed format for such a request, it must describe the legal and/or factual basis for relief. Any request for reconsideration should be made in writing within 30 days of your receipt of this letter. Thank you for your kind attention.

Sincerely,

(b)(3), b(6)

MAJ, JA
Foreign Claims Commission I2A

1ST BRIGADE COMBAT TEAM
4TH INFANTRY DIVISION
FOREIGN CLAIMS OFFICE

Claim Settlement/Witness Agreement
Claim # 08-I2A-B011

I, (b)(3), b(6) of Baghdad, Iraq, hereby agree to accept the sum of ~~\$6000.00~~ ^(2,000.00) U.S. dollars as payment in full satisfaction and final settlement of any and all claims against the United States of America, its commissioned and noncommissioned officers, agents, and employees which have been asserted or which may be asserted arising from the incident occurring on or about June 9, 2007 at Baghdad, Iraq, involving U.S. Forces. (3), b(

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 the said incident. This release / 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 this incident.

It is understood that the amount tendered is accepted as full satisfaction and final statements and that the award is made pursuant to the Foreign Claims Act, 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.

(b)(6)

Claimant's Signature

Name: (b)(6)

Address: Baghdad, Iraq

(b)(6)

Witness: Print and Sign

(b)(6)

WITNE

(b)(6)



Office of the U.S. Treasury Department Financial Attaché
Embassy of the United States of America - Baghdad, Iraq



Serial Number Accountability Record

The purpose of this form is to record the serial numbers on USD \$100 notes thereby providing a tracing mechanism to the Iraqi recipient. **Pay agents** should turn this form in to their respective finance offices as part of the reconciliation process. **Finance offices** should retain this form with their original reconciliation file, and provide a scanned copy to (b)(6) 2msn.com.

DATE OF TRANSFER: 26 Apr 08

PAY AGENT NAME: _____ (b)(3), b(6)

NAME OF IRAQI FIRM BEING PAID: Foreign Claim #: 08-I2A-B011

NAME OF PERSON ACCEPTING PAYMENT ON BEHALF OF FIRM:

(b)(6)
Print given name, father's first name, grandfather's first name, tribal name

\$100 note serial numbers:

(b)(2)High	_____ through	(b)(2)High	_____ and,
	_____ through		_____ and,
	_____ through		_____ and,
	_____ through		_____ and,
	_____ through		_____ and,
	_____ through		_____ .

* Use additional forms if needed.
SNAR Report

Claims Form

طلب تعظم

Name: (b)(6) _____ الاسم:

Address: Baghdad (b)(6) _____ العنوان:

(b)(6)

(b)(6)

I am Iraq أنا

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

b. A permanent resident of: Above address ب. عنواني 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)

please see medical case report

أنتي أتطلب لدي حكومي الولايات المتحدة للأضرار والإصابات التي 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.)

kid death

الممتلكات المتضررة مملوكة من: (إذا كان عذا التظلم قدم من قبل ممثل أو قريب أو عائل فالرجاء احطار المستمكات التي تخولكم وتوكلكم للتقدم بهذا التظلم، أو أي دليل من ممثلين رسميين. إملأ التظلم بالأسفل للأفراد المتقتمين بالشكوي للإصابات أو الأضرار التي أصابهم.)

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

البلد أو المحافظة

المدينة

القرية

تظلمي قدم في:

My claim arose on: Jun 9 2007
Month Day Year

تظلمى قدم فى: _____
شهر يوم المس

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 was being in vegetable shop
at Aldousa area car shooting him and transferred to the

باختصار اشرح ما حدث والاضرار التي اصابتك جراء ذلك ، سواء كانت جسدية او ممتلكات . (الرجاء استعمال خلفية هذه الورقة ان لم تكن
الاسطر لتكفى)

CSH and he died there

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 Ruled	15000
Total: 15000	

اشرح بالتفصيل متى تضرر والكلفة للممتلكات او للإصابات الجسدية وتكلفتها (الرجاء اضافة الثبوتات والمتمسكات والفواتير الضرورية
لكل شئ لوحة)

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 الجسدي المتضرر بما يوازي:

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

\$ 15000

I.D.

اطالب بتعويض للأضرار يوازي (اكتب بالدولار الأمريكي او العملة المحلية)

العملة المحلية

\$

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

سابقاً (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 علمي 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 اسفل هذا التظلم فان تقسم على ان كل المعلومات المقدمة في هذا التظلم هي صحيحة وحقيقية. أي شخص يحاول تقديم تظلم كاذب أو مختلق أو يزور التظلم ضد حكومة الولايات المتحدة الأمريكية سوف يواجه عقوبات جنائية حادة ويحاكم من قبل السلطات.

(Signature of Claimant)

(توقيع التظلم) الرجاء كتابة الاسم والتوقيع

Subscribed to me this 26 day of Jan, 2008.

(Signature of Witness)

(Printed Name)

Standard Form 1034 (EO) 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			DATE VOUCHER PREPARED		SCHEDULE NO	
DEPARTMENT OF THE ARMY HQ, 1st Brigade Combat Team, 4th Infantry Division Office of the Command Judge Advocate APO AE 09361			26 Apr 08		PAID BY 24th Finance Company APO AE 09352 CAMP LIBERTY DSSN: 5579	
			CONTRACT NUMBER AND DATE			
PAYEE'S CLAIM #: 08-I2A-B011 (b)(6) NAME AND ADDRESS Baghdad, Iraq			REQUISITION NUMBER AND DATE		DATE INVOICE RECEIVED	
					DISCOUNT TERMS	
					PAYEE'S ACCOUNT NUMBER	
					GOVERNMENT B/L NUMBER	
SHIPPED FROM			TO	WEIGHT		
NUMBER AND DATE OF ORDER	DATE OF DELIVERY OR SERVICE	ARTICLES OR SERVICES <i>(Enter description, item number of contract or Federal supply schedule, and other information deemed necessary)</i>	QUANTITY	UNIT PRICE COST 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 10 U.S.C. 2734 upon the claim of the above named claimant for property damaged, lost, destroyed, captured, or abandoned in service.				\$12,000 \$6000
(3), (b)						
\$12,000						
(3)(b)						
\$6000						
(Use continuation sheet(s) if necessary) (Payee must NOT use the space below) TOTAL						
PAYMENT:		APPROVED FOR	EXCHANGE RATE	DIFFERENCES		
<input type="checkbox"/> PROVISIONAL		= \$	= \$1.00			
<input checked="" type="checkbox"/> COMPLETE		BY:				
<input type="checkbox"/> PARTIAL		SFC (b)(3), b(6)				
<input type="checkbox"/> FINAL		TITLE				
<input type="checkbox"/> PROGRESS		1BCT, 4ID FOREIGN CLAIMS PAY AGENT	(Sign) (b)(3), b(6)			
<input type="checkbox"/> ADVANCE		Pursuant to authority vested in me, I certify that this voucher is correct and proper for payment.				
26 Apr 2008		(b)(3), b(6)	(b)(3), b(6)	MAJ, JA Foreign Claims Officer		
(Date)		(Authorized Certifying Officer)	(Title)			
ACCOUNTING CLASSIFICATION						
(b)(2)High						
PAID BY	CHECK NUMBER	ON ACCOUNT OF U.S. TREASURY	CHECK NUMBER	ON (Name of bank)		
	CASH	DATE	PAYEE			
	\$ 6000	26 Apr 08	(b)(6)			
				PER		
				TITLE		
<small> 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. </small>						
Previous edition usable						
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.						

HOSPITAL REPORT OF DEATH

NAME AND LOCATION OF HOSPITAL
211 SH, BAGHDAD, IRAQ

FOR USE BY THE PROponent AGENCY IS OFFICER OF THE SURGEON GENERAL
Instructions - Medical Officer in attendance will: *without delay to the Registrar or Administrative Officer*
Preparation: *one copy only, its serial through 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100*
Print or *re entries.* *number of copies.*

SECTION A - ATTENDING MEDICAL OFFICER'S REPORT

PERSONAL DATA

(b)(6)	2. TIME OF DEATH (Hour-day-month-year)	3. MEDICAL EXAMINER/ CORONER'S CASE
	0107 9 JUNE 2007	<input type="checkbox"/> YES <input type="checkbox"/> NO
	4. RELIGION	5. CHAPLAIN NOTIFIED
		<input type="checkbox"/> YES <input type="checkbox"/> NO
6. NAME, ADDRESS AND RELATIONSHIP OF RELATIVE OR FRIEND PRESENT AT DEATH		
Patient's name (Last, first, middle initial) Grade, Social Security Account No., Register Number and Ward Number		

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, ashenia, etc. It means the disease, injury, or complication which caused death)	DUE TO (for as a consequence of)	
	GSW HEAD	DOW
7b. ANTECEDENT CAUSES (Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last)	DUE TO (for 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	10. TYPED OR PRINTED NAME AND GRADE OF MEDICAL OFFICER IN ATTENDANCE	
9 JUNE 2007	CHRISTOPHER H. HOYT MAJ	(b)(3), b(6)

SECTION B - ADMINISTRATIVE

TYPE OF ACTION	HOUR	DAY	MONTH	YEAR	OFFICER
12. TELEGRAM TO NEXT OF KIN OR OTHER AUTHORIZED PERSON					
13. POSTMORTEM 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)	21. AUTOPSY ORDERED BY (Signature)	
<input type="checkbox"/> YES <input type="checkbox"/> NO		
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

CERTIFICATE OF DEATH (OVERSEAS) Acte de décès (D'Outre-Mer)				
NAME OF DECEASED (Last, First, Middle) (b)(6)	Nom du décédé (Nom et prénoms)	GRADE Grade	BRANCH OF SERVICE Arme	SOCIAL SECURITY NUMBER Numéro de l'Assurance Sociale 101-00-2633
ORGANIZATION Organisation		NATION (e.g., United States) Pays IRAQ	DATE OF BIRTH Date de naissance (b)(6)	SEX Sexe <input checked="" type="checkbox"/> MALE Masculin <input type="checkbox"/> FEMALE Féminin
RACE Race		MARITAL STATUS État Civil		RELIGION Culte
CAUCASOID Caucasique		SINGLE Célibataire		PROTESTANT Protestant
NEGROID Négróide		MARRIED Marié		CATHOLIC Catholique
<input checked="" type="checkbox"/> OTHER (Specify) Autre (Spécifier) IRAQI		WIDOWED Veuf		JEWISH Juif
SEPARATED Séparé				
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 Maladie ou condition directement responsable de la mort.		GSW HEAD	DOW
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 <input type="checkbox"/> YES Oui <input type="checkbox"/> 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 <input type="checkbox"/> YES Oui <input type="checkbox"/> NO Non
DATE OF DEATH (Hour, day, month, year) Date de décès (l'heure, le jour, le mois, l'année) 0167 9 JUNE 2007		PLACE OF DEATH Lieu du décès 28TH CSH BAGHDAD, IRAQ	

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.

Signature (b)(3), b(6)	TITLE OR DEGREE Titre ou diplôme MAJ/MD
INSTALLATION OR ADDRESS 28TH CSH BAGHDAD, IRAQ	
Date 9 JUNE 2007	(b)(3), b(6)

DD FORM 2064 APR 1977

REMOVE, REVERSE, AND RE-INSERT CARBONS BEFORE COMPLETING THIS SLIP

DISPOSITION OF REMAINS		GRADE	LICENSE NUMBER AND STATE	OTHER
NAME OF MORTUARIAN PREPARING REMAINS				
INSTALLATION OR ADDRESS		DATE	SIGNATURE	
NAME OF CEMETERY OR CREMATORY		LOCATION OF CEMETERY OR CREMATORY		
TYPE OF DISPOSITION <input type="checkbox"/> BURIAL <input type="checkbox"/> CREMATION <input type="checkbox"/> REMOVAL (Specify)			DATE OF DISPOSITION	
REGISTRATION OF VITAL STATISTICS				
REGISTRY (Town and Country)		DATE REGISTERED	FILE NUMBER	OTHER
			STATE	
NAME OF FUNERAL DIRECTOR	ADDRESS			
SIGNATURE OF AUTHORIZED INDIVIDUAL				

DD FORM 2064, APR 1977 (BACK)

USAPA V1.00

foreign language

she said that her son
had accident when he got



foreign language

Foreign Language Text

foreign language

foreign language

foreign language

Pilo



HER SON got shot while he
was in vegetable shop.

foreign language

foreign language

HER SON GOT A SHOT AND TRANSFERED
TO THE CSU AND HE DIED THERE

Foreign Language Tex

foreign language

foreign language

foreign language

foreign language

foreign language

foreign language

Witne-
1. da ma n- was her
bitter

foreign language

Foreign Language Text

foreign language

foreign language

foreign language

Some un.
Scyjug

foreign language

foreign language

Witness
Name Saying

foreign language

foreign language

foreign language

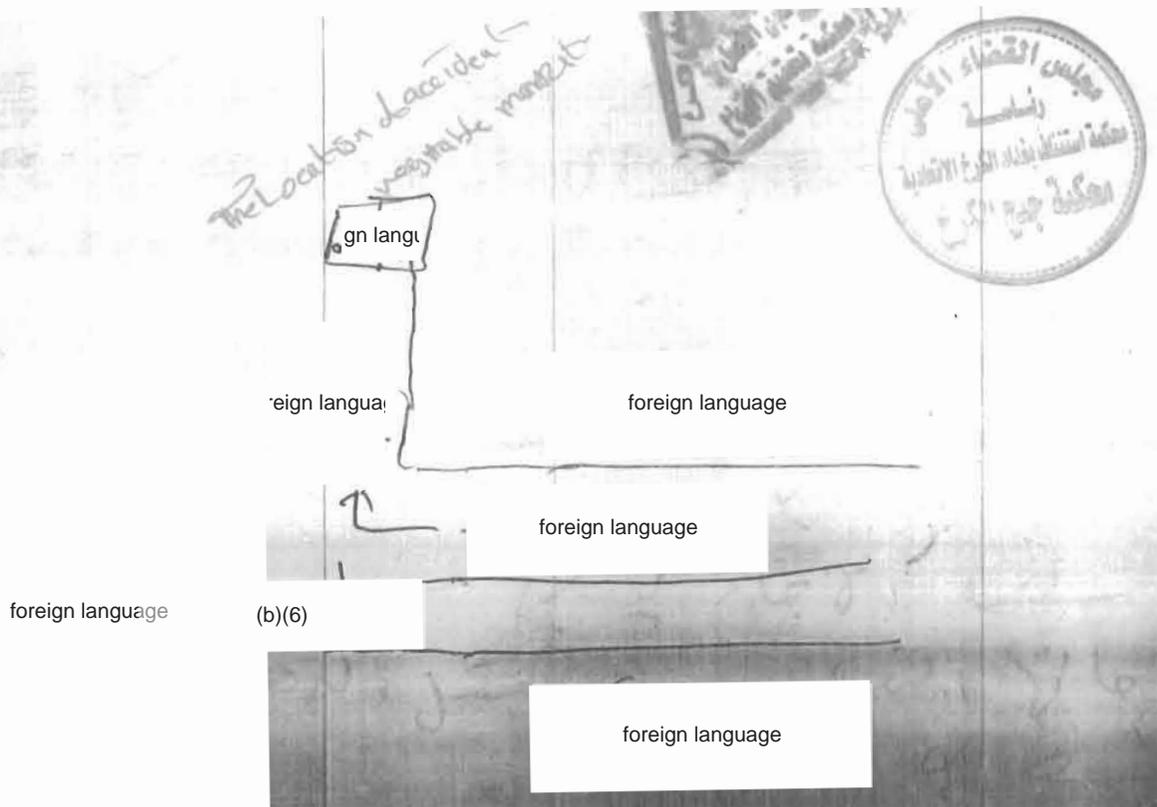
Witness
Sami Sagias

foreign language

foreign language

foreign language, (b)(6)

foreign language



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Police on
all the Ph
claim

foreign language

foreign language

Foreign Language Text, (b)(6)

Page 27 redacted for the following reason:

foreign language, b(6)

Foreign Language Text, (b)(6)

Foreign Language Text, (b)(6)

Death Order

(b)(6)

Foreign Language Text, (b)(6)