

Claim # 197 M
USARCS# 05-118-T-472
Claimant's Name _____
Date Received 3 Dec 02
Date Closed _____

U.S. GOVERNMENT
PURCHASE ORDER-INVOICE-VOUCHER

DATE OF ORDER 13 September 2005	ORDER NO. APF 3ID 52560828
------------------------------------	-------------------------------

PRINT NAME AND ADDRESS OF SELLER (Number, Street, and State)* (Phone)

P
A
Y
E
E

(b)(6) 05-IJ8-T472, 197M

Furnish Supplies or Services to (Name and address)

SUPPLIES AND SERVICES	QTY	UNIT PRICE	AMOUNT
Death	1		\$1500
Personal Injury	0		\$0
Property Damage	0		\$0

AGENCY NAME AND BILLING ADDRESS* P A Y O R 3 rd Finance Company, 3 rd Soldier Support Battalion APO-AE 09352	TOTAL \$1500
	DISCOUNT TERMS
	DATE INVOICE RECEIVED

ORDERED BY (Signature and title)
SFC (b)(6), (b)(3) SFC JPO

PURPOSE AND ACCOUNTING DATA (b)(2) High \$50,000.00

PURCHASER - To sign below for over-the-counter delivery of items

RECEIVED BY (b)(6), (b)(3) CPT (b)(3), (b)(6)

TITLE CONDOLANCE PAY AGENT DATE 14 SEP 05

SELLER

PAYMENT RECEIVED PAYMENT REQUESTED \$1500

NO FURTHER INVOICE NEED BE SUBMITTED

SELLER (b)(6)	DATE
Signature (b)(6)	<u>14 SEP 05</u>
I certify that this account is correct and proper for payment in the amount of \$1500	DIFFERENCES
	NONE
(b)(3)(b)(6)	ACCOUNT VERIFIED CORRECT FOR
	BY

Authorized certifying officer (b)(6) CPT

PAID BY CASH DATE PAID 14 SEP 05 VOUCHER NO.

OR (Check No.)

*PLEASE INCLUDE ZIP CODE
STANDARD FORM 44A (Rev 10-83)
PRESCRIBED BY GSA
FAR (48 CFR) 53.213(c)



DEPARTMENT OF THE ARMY
HEADQUARTERS, 3D INFANTRY DIVISION (FORWARD)
CAMP LIBERTY, IRAQ
APO-AE 09352

REPLY TO
ATTENTION OF:

AFZP-CoS

12 August 2005

MEMORANDUM THRU Comptroller, 3d Infantry Division

FOR Commanding General, 3d Infantry Division

SUBJECT: Condolence Payment Recommendation of Foreign Claim Number 05-IJ8-T472

1. NAME OF RECIPIENT: (b)(6)
2. DATE OF INCIDENT OR DAMAGE: 7/9/2005
3. LOCATION OF INCIDENT OR DAMAGE: Yousifiyah
4. DESCRIPTION: Claimant's husband was riding in a pickup truck when it was engaged by US forces at a checkpoint. The vehicle did not respond to the unit's escalation of force measures before the shooting. Claimant was shot in the head and airlifted to the CSH where he later died. The incident is confirmed by a CIR from the 48th BCT.
5. JUSTIFICATION: By making this condolence payment, MND-B demonstrates to the family and community its sympathy for this unfortunate loss. This demonstration will have a positive effect on both the community and local Iraqi leaders.
6. AMOUNT OF PAYMENT: \$1500
7. POINT OF CONTACT: CPT (b)(6), (b)(3) @id3.army.mil,
VOIP (b)(2)High

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

COL, FA
Acting Chief of Staff

I concur with the payment

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

LTC, JA
Acting Staff Judge Advocate

CENTCOM 003347

MAHMUDIYAH CLAIMS FORM

CLAIMANT INFORMATION

NAME: _____ (b)(6)
 ADDRESS: YOUSIFIYAH ID#: _____
 OCCUPATION: HOUSEWIFE CITIZENSHIP: IRAQ

INCIDENT INFORMATION

TYPE OF CLAIM: () Vehicle Accident SAF () Raid () Detainee Property
 () Occupied Land () Other

LOCATION OF INCIDENT: YOUSIFIYAH DATE OF INCIDENT: 9 July 05

DESCRIPTION OF INCIDENT: Claimants' (b)(6) was shot + killed @ US checkpoint

UNIT INVOLVED: UNK

CLAIM INFORMATION

OWNER OF PROPERTY: <u>NA</u>	BREAKDOWN OF CLAIM:	<u>ITEM</u>	<u>AMOUNT</u>
TOTAL AMOUNT CLAIMED: <u>\$2500</u>		_____	_____
INSURED?: <u>Y/N</u> AMOUNT: <u>NA</u>		_____	_____

CLAIMANT ATTESTATION

HAS CLAIM BEEN FILED BEFORE?: Y / N LOCATION AND OUTCOME: _____

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 فإن تقسم على أن كل المعلومات المقدمة في هذا التظلم هي صحيحة وحقيقية. أي شخص يحاول تقديم تظلم كاذب أو مخلق أو يزور التظلم ضد حكومة الولايات المتحدة الأمريكية سوف يواجه عقوبات جنائية حادة ويحاكم من قبل السلطات.

(DATE)

(Signature of Claimant)
(توقيع التظلم) الرجاء كتابة الاسم والتوقيع

1

1

;

;

foreign language, (b)(6)

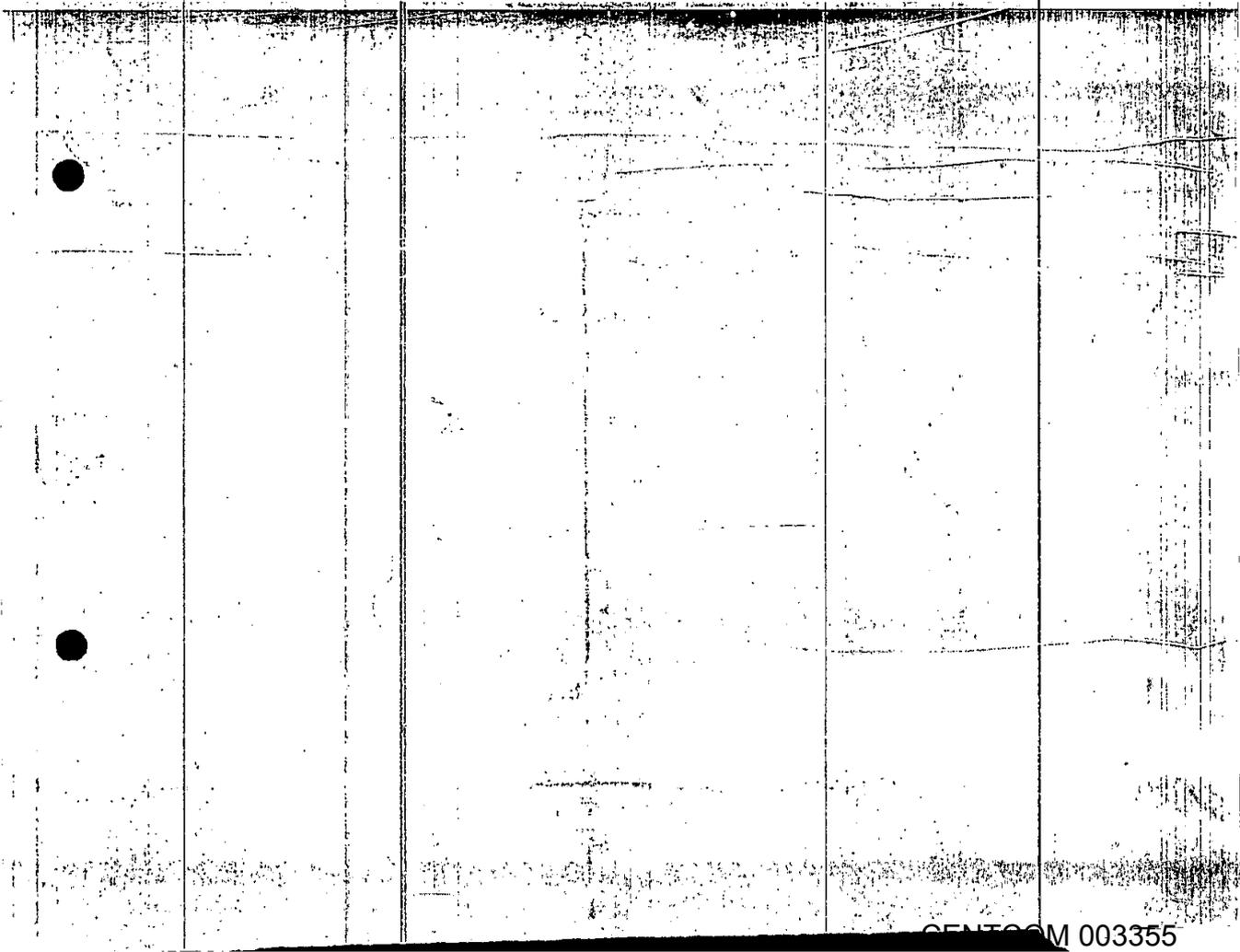
foreign language, (b)(6)

Foreign Language Text

foreign language, (b)(6)

foreign language, (b)(6)

foreign language, (b)(6)



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

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 <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, asphyxia, etc. It means the disease, injury, or complication which caused death)	DUE TO (or as a consequence of)	
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	10. TYPED OR PRINTED NAME AND GRADE OF MEDICAL OFFICER IN ATTENDANCE	11. SIGNATURE OF MEDICAL OFFICER IN ATTENDANCE

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) <input type="checkbox"/> YES <input type="checkbox"/> 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



Welcome MAJ (b)(6), (b)(3) , 332 EMDG-BALAD

Patient Reg./Update

Patient Search

Patient Info.

Reports

F

Patient Treatment Management

SSN 100003360

?

NAME

?

SSN	NAME	SEX	RANK	BRANCH
100003360	UNKNOWN	M	N/A	UNKNOWN
DIAGNOSIS:		OPEN WND HEAD NEC-COMPL		
ATTACHMENTS: 0 files		AF3899: Create		

STATUS	LOCATION	DATE	FACILITY
INPATIENT	ICU-3-332 EMDG	7/10/2005 10:05:49 PM	332 EMDG-BALAD
INPATIENT	PENDING INP-332 EMDG	7/9/2005 9:07:00 PM	332 EMDG-BALAD

FACILITY	AUTHOR	DATE	NOTES	Edit	Delete
332 EMDG-BALAD	(b)(6), (b)(3)	7/9/2005 9:07:00 PM	GSW HEAD	Edit	Delete
332 EMDG-BALAD	(b)(6), (b)(3)	7/9/2005 9:28:11 PM	9 July 05 Adm Note - (b)(6) yo male admitted as transfer from the 86th CSH...he ran a check point and sustained a GSW to the head, (R) thigh and (L) leg. He was seen at the CSH and intubated for a GCS of 3. CT of his head and abd were done and revealed a large injury to the (R) hemisphere with an epidural hematoma; the abdominal study shows a fragment in the rectum. He was treated with Mannitol ancef. ER eval: 129, 120/70 Primary survey - intubated, collar placed, pupils mid-point and rective, large open wound at mid-parietal scalp with exposed brain, penetrating wound of the mid dorsal thigh and proximal medial thigh, penetrating wound of the mid LLE with obvious fracture...palpable pulses. Secondary survey - unchanged Trauma labs CXR ordered Adm Dx: GSW head, (R) thigh and	Edit	Delete

332 EMDG- BALAD		7/10/2005 12:47:33 AM	LLE fragment in the rectal vault Disp: NS, Ortho Cx, to CT for repeat head study ER eval: 129, PROCEDURE HX - ID/close scalp wound, R frontal ventriculostomy, diverting colostomy, presacral space exploration, ID right thigh wound, ID and ex-fix of L tib fx: needs repeat ID on Monday or Tuesday	Edit	Delete
332 EMDG- BALAD	(b)(6), (b)(3)	7/11/2005 7:38:45 AM	ventric drained 440 cc. to OR tomorrow for leg washout and procto for pelvic frag	Edit	Delete
332 EMDG- BALAD		7/12/2005 7:29:15 AM	Withdraw care.	Edit	Delete

PENDING RTD PENDING RHS FOLLOW UP APPT

Type notes here:

SAVE NOTES

Procedure Hx

REFRESH PAGE

USE BALL POINT PEN
PRESS HARD

AUTHORIZATION AND TREATMENT STATEMENT

(THIS FORM IS SUBJECT TO THE PRIVACY ACT OF 1974 - See Reverse)

i. ADMISSION (CLINIC PERSONNEL OR PROVIDER FILLS IN CIRCLED ITEMS)											
1 REGISTER NO		NBSUF		2 NAME (Last, First, Middle Initial)				3 RELIGION			
4 FACILITY CODE 5602		5 MEDICAL TREATMENT FACILITY 332 EMDG				6 TIME OF ADM 2250		7 DATE OF ADM 9 Jul		8 TYPE OF CASE IST	
9 EMP SSN (b)(6)		10 BENEF TYPE		11 GRADE	12 AFSC	13 AVIATION SVC CODE		14 RATING		15 LENGTH OF SVT	
16 SEX M	17 RACE STATUS	18 HAIR COLOR Brown	19 ZIP CODE		20 CURRENT ORGANIZATION Civilian				21 INPATIENT UNIT (2)		
22 FAC INT ADM CODE		23 FACILITY OF INITIAL ADMISSION				24 DATE INITIAL ADM		25 ROOM		26 BED	
27 PRIOR ADM <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28 CLINIC SERVICE 3)				29 ADMISSION CHECK Cycled					
30 EMERGENCY ADRESSEE RELATIONSHIP						31 NAME AND ADDRESS OF SPONSOR					
32 PRIMARY ADMISSION DIAGNOSIS Fish Head						33 SECONDARY ADMISSION DIAGNOSIS LCE					
34 CAUSE OF INJURY											
35 DEPOSIT VALUABLES OR SAFEKEEPING <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		36 I have read and understand the Privacy Act and Disengagement Statements on the reverse of this form.				37 SIGNATURE OF PATIENT OR SPONSOR				38 COMMITTING PROVIDER	
ii. TREATMENT											
39 DIAGNOSIS - PROCEDURES Admit JPTA - (b)(6), (b)(3) Disposition JPTA - 24HR								40 PROVIDERS OF CARE			
LOD: <input type="checkbox"/> YES <input checked="" type="checkbox"/> EPTS, LOD not applicable <input type="checkbox"/> AF Form 348 (Check <input type="checkbox"/> if continued on reverse) (Check <input type="checkbox"/> if continued on reverse)											
41 ADMINISTRATIVE DATA (Change in physical profile required <input type="checkbox"/> YES (Prepare AF Form 422) <input type="checkbox"/> NO) (Meal Card <input type="checkbox"/> YES <input type="checkbox"/> NO)											
(Check <input type="checkbox"/> if continued on reverse)											
42 DISPOSITION				43 DATE OF DISPOSITION		44 TIME OF DISPOSITION		45 CC OF WHOLE BLOOD		46 CC OF PACKED CELLS	
47 CONVALESCENT LEAVE TAKEN				48 CONVALESCENT LEAVE RECOMMENDED							
49 SIGNATURE OF ATTENDING HEALTH CARE PROVIDER						50 SIGNATURE OF PATIENT AFFAIRS OFFICIAL					

F IMT 560, 19870101, V2

PREVIOUS EDITION WILL BE USED.

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

NAME OF DECEASED (Last, First, Middle) Nom du décès (Nom et prénoms)		GRADE (Grade)	BRANCH OF SERVICE (Arme)	SOCIAL SECURITY NUMBER (Numéro de l'Assurance Sociale)
(b)(6)				
RACE (Race)		NATION (e.g., United States) Pays	DATE OF BIRTH (Date de naissance)	SEX (Sexe) <input type="checkbox"/> MALE (Masculin) <input type="checkbox"/> FEMALE (Féminin)
CAUCASOID (Caucasique)		SINGLE (Célibataire)	RELIGION (Culte)	
NEGROID (Négréoïde)		MARRIED (Marié)	PROTESTANT (Protestant)	
OTHER (Specify) Autre (Spécifier)		WIDOWED (Veuf)	CATHOLIC (Catholique)	
			JEWISH (Juif)	
NAME OF NEXT OF KIN (Nom du plus proche parent)		RELATIONSHIP TO DECEASED (Rapport du décès avec le suicidé)		
STREET ADDRESS (Adresse à l'usage)		CITY OR 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:	Penetrating Brain Injury
ANTECEDENT CAUSES ¹ Symptômes précurseurs de la mort:	4 days
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?	

MODE OF DEATH (Condition de décès)	AUTOPSY PERFORMED (Autopsie effectuée) <input type="checkbox"/> YES (Oui) <input checked="" type="checkbox"/> NO (Non)	CIRCUMSTANCES SURROUNDING DEATH DUE TO EXTERNAL CAUSES (Circonstances de la mort attribuées par une cause externe)
NATURAL (Mort naturelle)	MAJOR FINDINGS OF AUTOPSY - Conclusions principales de l'autopsie	
ACCIDENT (Mort accidentelle)		
SUICIDE (Suicide)		
HOMICIDE (Homicide)	SIGNATURE (Signature)	DATE (Date)
		AVIATION ACCIDENT (Accident d'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)	PLACE OF DEATH (Lieu de décès)
04:15 14 JULY 2005	AFTH, BALAD.

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 médecin militaire ou du médecin sanitaire)	TITLE OR DEGREE (Titre ou diplôme)
(b)(6), (b)(3)	MD
GRADE (Grade)	INSTALLATION OR ADDRESS (Installation ou adresse)
O4	AFTH, BALAD, IRAQ
DATE (Date)	SIGNATURE (Signature)
14 JULY 2005	(b)(6), (b)(3)

¹State disease, injury or complication which caused death, but not mode of dying such as heart failure, etc.
²State conditions contributing to the death, but not related to the disease or condition causing death.
¹Préciser 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.
²Préciser 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 1300 (REV. 1-75) PREVIOUS EDITIONS ARE OBSOLETE. GPO: 1975 O - 358-101



MULTI-NATIONAL FORCES - IRAQ

The Multinational Force-Iraq deeply regrets the loss of your loved one and wishes the return of the human remains of _____ to his/her primary next of kin. The remains have been treated with the same respect and courtesies required by Muslim or Christian tradition and have been treated with the same respect and courtesy as those of the Coalition forces. The person receiving the remains acknowledges that Coalition forces have provided the remains in a respectful manner. Any perceived violation of local customs is wholly unintentional on the part of Coalition forces. All personal effects that were found with the remains are being turned over and an inventory is attached.

القوات المتعددة الجنسية - العراق تتقدم بكل الأمانة والاحترام والافتقار اليكم وتتمنى ان تقدم
و ترجع اليكم البقايا الادمية الخاصة بالمرحوم (b)(6), Foreign Language Text
الى نسب اهله القرين الاولى الية. مع العلم بأن البقايا الادمية تم معاملتها بكل الاحترام والالطف التي
تتطلبها تقاليد وعادات الديانة الاسلامية او الديانة المسيحية وتمت معاملتها بنفس المعاملة التي
تلقاها الموتى من قوات التحالف. الشخص المتسلم للبقايا الادمية يدرك جيدا بان قوات التحالف قامت
بالعمل اللازم وبكل اساليب الاحترام التامة.
و في حالة وجود او ادراك أية انتهاك للعادات و التقاليد المحلية فبكل الاسف انه ليس عمدا و غير
مقصودا كليا من جانب قوات التحالف.
مع العلم جميع المتاع الشخصية التي وجدت مع البقايا سوف ترجع اليكم بالقائمة المرفقة.

Foreign Language Text, (b)(6)

اسم الشخص للتأكد و اثبات البقايا الادمية

Person verifying identity

Foreign Language Text, (b)(6)

اسم الشخص المستلم

Person receiving remains

(b)(6), Foreign Language Text

العلاقة بالمرحوم

Relationship to deceased

Foreign Language Text, (b)(6)

التاريخ

Date