3rd ID Foreign Claims Cover Sheet

File #: 6-IA3-290

Name: (b)(6)

POA/ATT: (b)(6)

Date Received: 27 Dec 05 **Date of Incident:** 10 Aug 05

Claim Amount: $4,500 **Location:** Balad

Next Apt: 10 Jan 06

Translation:

Further Investigation:

#11356 TF-3-69 patrol margin BP fire 2x warning shots @white truck vehicle was driving to close to BP1

Contact S-2 ☐ **Check Sigacts** ☑

Approved ☐ **Denied** ☑ C/E 12/30/05

or #11388 TF 5-7 IED hit convoy - white truck trailing convoy, then does U turn. Attempted to hide. Disabling shot fired hitting driver

☐**Goodwill Payment recommended:**_____

☐**Approved:**_____ ☐ **Denied:**_____

☐**MVA** ☐**RAID** ☐**LOST** ☐ **NEG FIRE** ☐**REAL**

☐**OTHER:**_____

Vehicle scratch - Nothing. | Driver treated on the scene + went to Balad hospital

Pages 2 through 3 redacted for the following reasons:
- -
foreign language, (b)(6)

DEPARTMENT OF THE ARMY
OFFICE OF THE STAFF JUDGE ADVOCATE
HEADQUARTERS, 101ST AIRBORNE DIVISION (AIR ASSAULT)
OPERATION IRAQI FREEDOM, COB SPEICHER
TIKRIT, IRAQ, APO AE 09393

AFZB-JA-C 30 December 2005

MEMORANDUM OF OPINION

SUBJECT: Claim of (b)(6) 06-IA3-271

1. **Identifying Data:** (b)(6) by Attorney (b)(6)

2. **Date and place the incident occurred giving rise to the claim**: The claim occurred on 10 August 2005 in Balad, Iraq.

3. **Amount of claim and date it was filed:** Claimant filed a claim for $4,500 on 27 Dec. 2005.

4. **Jurisdiction:** This request is presented for consideration under the provisions of the Foreign Claims Act, 10 USC Section 2734, as implemented by Chapter 10, Army Regulation 27-20. This claim was properly filed in a timely manner.

5. **Facts:** The Claimant alleges that CF had blocked a road where the decedent was traveling. The deceased then turned onto a side road to avoid the CF. As he turned, the CF fired on his vehicle. The claimant's son was allegedly shot. A SIGACTS investigation for the relevant time period revealed that an IED hit CF convoy, a white truck was seen trailing the convoy, and then made a U-turn and attempted to hide. The CF fired a disabling shot, wounding the driver. The driver was treated at the scene and then went to Balad hospital.

6. **Opinion:** Under AR 27-20, paragraph 10-3, Claims arising "directly or indirectly" from combat activities of the U.S. Armed Forces are not payable. AR 27-20 defines combat activities as, "Activities resulting directly or indirectly from action by the enemy, or by the U.S. Armed Forces engaged in armed conflict, or in immediate preparation for impending armed conflict." Here, the Claimant's damage was caused from the actions of CF against AIF. Accordingly, this claim is non compensable because it is incident to a combat activity.

7. **Recommendation:** The claim is denied.

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

CPT, JA
Claims Judge Advocate

Page 5 redacted for the following reason:
- - - - - - - - - - - - - - - - - - - -
foreign language

Pages 7 through 8 redacted for the following reasons:
- -
foreign language

Page 10 redacted for the following reason:
- - - - - - - - - - - - - - - - - - - -
foreign language

Pages 12 through 16 redacted for the following reasons:
- -
foreign language

Claims Form

To: United States Army Foreign Claims Commission.
From: Name: (b)(6)
POA/ATT: (b)(6)
Power of Attorney provided and interpreter approved: ✓ original seen - good match
Decedents: (b)(6)

Hometown: _____ Iraqi Resident: _____

My claim arose at: Balad
(Town) (City) (Country)
My claim arose on: 10 AUG 05
Month Day Year
Proof of Ownership: Original seen, VIN match
Interpreter Approved: _____

Death Certificates (Name, Cause of Death, Age, and Time of Death Consistent with Claimant allegations): American death certs
COD → IED & GSW → "found on side of road"
Interpreter Approved: _____

Legal Expert Opinion: $1,500
Interpreter Approved: _____

Witness Statement (Consistent?): 1) 2 pm 2) Wife 3) Mother → No eyewitnesses
Interpreter Approved: _____

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.)
CF had blocked road - Decedent turned onto a side road to avoid CF. As he turned, CF fired on vehicle.
(C's son was shot)
identified decedent b/c small village

Evidence: Release of Remains information, photos

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
Damage to vehicle	$1,500
Wrongful death	$3,000

Total: $4,500

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

The name and address of my insurer (if any) is:

(Name) (Address)

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

$ 4,500 local

(b)(6)

Subscribed before me this 27 day of Dec, 2005.

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

(Signature)

Pages 19 through 29 redacted for the following reasons:
- -
foreign language

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 الأسف العميق والأعتذار لفقدان احبابكم و تتمنى ان تقدم
و ترجع اليكم البقايا الادمية الخاصة بالمرحوم\ .....
الى نسب اهلة القريب الاولى الية. مع العلم بأن البقايا الادمية تم معاملتها بكل الاحترام واللطف التى
تتطلبها تقاليد وعادات الديانة الاسلامية او الديانة المسيحية و تمت معاملتها بنفس المعاملة التى
تلقاها الموتى من قوات التحالف. الشخص المتسلم للبقايا الادمية يدرك جيدا بان قوات التحالف قامت
بالعمل اللازم و بكل اساليب الاحترام التامة.
و في حالة وجود او ادراك آية انتهاك للعادات و التقاليدالمحلية فبكل الاسف انة ليس عمدا و غير
مقصود كليا من جانب قوات التحالف.
مع العلم جميع المتاع الشخصية التى وجدت مع البقايا سوف ترجع اليكم بالقائمة المرفقة.

اسم الشخص للتاكد و اثبات االبقايا الدمية \ ..... (b)(6)
Person verifying identity

اسم الشخص المستلم \ ..... (b)(6)
Person receiving remains

العلاقة بالمرحوم \ ..... (b)(6)
Relationship to deceased

التاريخ \ ١٢/٨/٢٠٠٥
Date

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.

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و ترجع اليكم البقايا الادمية الخاصة بالمرحوم\ .....
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بالعمل اللازم و بكل اساليب الاحترام التامة.
و في حالة وجود او ادراك آية انتهاك للعادات و التقاليدالمحلية فبكل الاسف انة ليس عمدا و غير
مقصود كليا من جانب قوات التحالف.
مع العلم جميع المتاع الشخصية التى وجدت مع البقايا سوف ترجع اليكم بالقائمة المرفقة.

اسم الشخص للتاكد و اثبات االبقايا الدمية \ ..... (b)(6)
Person verifying identity

اسم الشخص المستلم \ .... (b)(6) .....
Person receiving remains

العلاقة بالمرحوم \ ..... (b)(6) .....
Relationship to deceased

التاريخ \ ..... ١٢ / ٨ / ٢٠٠٥ .....
Date

CENTCOM 004988

DEPARTMENT OF THE AIR FORCE
332nd Air Force Theater Hospital
Balad Air Base, Iraq

11 August 2005

MEMORANDUM FOR THE GUARDS AT NORTH GATE CAMP ANACONDA

FROM: 332nd EMDG/SGH
Air Force Theater Hospital - Balad

SUBJECT: Transfer of the Human Remains of Patient 3810

1. Please allow the family of patient (b)(6) o bring a vehicle, after the appropriate security measures, into the personal search area parking lot to allow a transfer of human remains. We are expecting the transfer of the remains to occur on or around 12 August 2005.

2. Please call Mortuary Affairs directly at DSN 318-443-7241, DNVT 550-0425 and they will arrange to come to the gate to coordinate the transfer. If you cannot reach Mortuary Affairs please call either myself, Lt Col (b)(3)(b)(6) or SMSgt (b)(3)(b)(6) at DSN (b)(2)High DNVT (b)(2)High Thank you for your assistance in this matter.

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

Superintendent, Professional Services

T:\SGH\Remains Processing\Remains Transfer Letter.doc

Unknown

(b)(6)

PATIENT'S IDENTIFICATION (For plate imprint, typewriter or hand)

PATIENT'S DEPOSIT RECORD

For use of this form, see AR 40-2; the proponent agency is the Office of The Surgeon General.

I have been informed that any funds or valuables in my possession while a patient in this hospital are retained at my own risk and that I may and should deposit same in the patient trust fund.

I do ☐ *do not* ☐ *wish to make a deposit at this time.*

Patient's signature (or witness's, if patient is unable to sign)

FUNDS & VALUABLES RECEIVED IN FULL *(Patient's or witness's signature and date)*

FUNDS

DATE	DEPOSITS	WITHDRAWALS	BALANCE	SIGNATURE

VALUABLES

NUMBER	DESCRIPTION OF VALUABLES	DEPOSITS		WITHDRAWALS	
		DATE	SIGNATURE (Custodian)	DATE	SIGNATURE (Patient or intermediate individual)
1	watch				

DA FORM 1 DEC 77 3696 REPLACES EDITION OF 1 AUG 76, WHICH MAY BE USED.

★U.S.GPO:1991-0-301-988

CENTCOM 004990

USE BALL POINT PEN
PRESS HARD

AUTHORIZATION AND TREATMENT STATEMENT

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

ADMISSION *(CLINIC PERSONNEL OR PROVIDER FILLS IN CIRCLED ITEMS)*

1. REGISTER NO.	2. NAME (Last, First, Middle Initial) Unknown					3. RELIGION	
4. ADMIT CODE 5603	5. MEDICAL TREATMENT FACILITY [illegible]			6. TIME OF ADM 10Aug05		7. DATE OF ADM 1052	8. TYPE OF CASE BI
9. [illegible] (b)(3)(b)(6)	10. BENEFIT TYPE CIV	11. GRADE	12. AFSC	13. AVIATION SVC CODE	14. RATING	15. LENGTH OF SVC	16. AGE
17. [illegible]	20. ZIP CODE	21. CURRENT ORGANIZATION				22. INPATIENT UNIT	
23. [illegible] ADM CODE	24. FACILITY OF INITIAL ADMISSION			25. DATE INITIAL ADM		26. ROOM	27. BED
28. PRIOR ADM YES NO	29. [illegible] SERVICE(S)					30. ADMISSION CLERK	
31. EMERGENCY ADM [illegible]	32. NAME AND ADDRESS OF SPONSOR						
33. PRIMARY ADMISSION DIAGNOSIS GSW Head	34. SECONDARY ADMISSION DIAGNOSIS						
35. DATE OF INJURY							
36. PROFIT VALUATION OR CASE/SPRING YES NO	As I have read and understand the Privacy Act and Disengagement Statements on the reverse of this form.	SIGNATURE OF PATIENT OR SPONSOR				37. ADMITTING PROVIDER	

TREATMENT

38. DIAGNOSES - PROCEDURES Foundation of Road		39. PROVIDERS OF CARE

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

مجلس القضاء الأعلى
رئاسة
محكمة استئناف صلاح الدين الابتدائية
محكمة التحقيق في الملل
طبق الأصل

40. YES ☐ BRIEF LOD not applicable ☐ AF Form 348 (Check ☐ if continued on reverse) (Check ☐ if continued on reverse)

ADMINISTRATIVE DATA (Change in physical profile required ☐ YES (Prepare AF Form 422) ☐ NO) (Meal Card ☐ YES ☐ NO)

(Check ☐ if continued on reverse)

(b)(3)(b)(6)	42. DATE OF DISPOSITION 4Aug05	43. TIME OF DISPOSITION 1052	44. CC OF WHOLE BLOOD	45. CC OF PACKED CELLS	46. CONVALESCENT LEAVE TAKEN	RECOMMENDED
(b)(3)(b)(6)			48. SIGNATURE OF PATIENT AFFAIRS OFFICIAL			

PREVIOUS EDITION WILL BE USED.

CENTCOM 004991

USE BALL POINT PEN
PRESS HARD

AUTHORIZATION AND TREATMENT STATEMENT

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

ADMISSION *(CLINIC PERSONNEL OR PROVIDER FILLS IN CIRCLED ITEMS)*

1. REGISTER NO.	2. NAME (Last, First, Middle Initial) Unknown						3. RELIGION	
4. CLINIC CODE 5602	5. MEDICAL TREATMENT FACILITY 732 EMDG				6. TIME OF ADM 10 Aug 05	7. DATE OF ADM 1052	8. TYPE OF CASE BI	
9. [illegible]	10. BENEF TYPE CIV	11. GRADE	12. AFSC	13. AVIATION SVC CODE	14. RATING	15. LENGTH OF SVC	16. AGE	
18. [illegible]	19. ZIP CODE	21. CURRENT ORGANIZATION					22. INPATIENT UNIT	
23. [illegible] ADM CODE	24. FACILITY OF INITIAL ADMISSION			25. DATE INITIAL ADM		26. ROOM	27. BED	
28. PRIOR ADM ☐ YES ☐ NO	29. [illegible] SERVICE(S)					30. ADMISSION CLERK		
31. EMERGENCY ADDRESS [illegible]				32. NAME AND ADDRESS OF SPONSOR				
33. PRIMARY ADMISSION DIAGNOSIS GSW Head				34. SECONDARY ADMISSION DIAGNOSIS				
35. [illegible]								
36. [illegible] VALUABLES [illegible] ☐ YES ☐ NO	[illegible] have read and understand the Privacy Act and Disengagement Statements on the reverse of this form.			SIGNATURE OF PATIENT OR SPONSOR			37. ADMITTING PROVIDER	

TREATMENT

38. DIAGNOSES - PROCEDURES Roadside of Road	39. PROVIDERS OF CARE

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

[illegible] ☐ YES ☐ [illegible] LOD not applicable ☐ AF Form 348 *(Check ☐ if continued on reverse)* *(Check ☐ if continued on reverse)*

ADMINISTRATIVE DATA *(Change in physical profile required ☐ YES (Prepare AF Form 422) ☐ NO)* *(Meal Card ☐ YES ☐ NO)*

(Check ☐ if continued on reverse)

41. DISPOSITION	42. DATE OF DISPOSITION	43. TIME OF DISPOSITION	44. CC OF WHOLE BLOOD	45. CC OF PACKED CELLS	46. CONVALESCENT LEAVE TAKEN	RECOMMENDED
(b)(3)(b)(6)	[illegible] 05	1052				
(b)(3)(b)(6)			48. SIGNATURE OF PATIENT AFFAIRS OFFICIAL			

PREVIOUS EDITION WILL BE USED.

CENTCOM 004992

I.

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

1. NAME OF DECEASED *(Last, First, Middle)* Nom du décédé (Nom et prénoms)	GRADE Grade	BRANCH OF SERVICE Arme	SOCIAL SECURITY NUMBER Nu[redacted]
Unknown	—	CIV	(b)(6)
ORGANIZATION Organisation	NATION *(e.g., United States)* Pays	DATE OF BIRTH Date de naissance	SEX Sexe
—	IRAQ	—	☒ MALE Masculin ☐ FEMALE Féminin

RACE Race	MARITAL STATUS Etat Civil		RELIGION Culte	
CAUCASOID Caucasique	SINGLE Célibataire	DIVORCED Divorcé	PROTESTANT Protestant	OTHER *(Specify)* Autre *(Spécifier)*
NEGROID Négroïde	MARRIED Marié		CATHOLIC Catholique	
OTHER (Specify) Autre *(Spécifier)*	WIDOWED Veuf	SEPARATED Séparé	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 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.[1]	Open head injury / exposed brain matter pulseless / Asystole	
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		
ANTECEDENT CAUSES Symptômes précurseurs de la mort. — 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 VIEWED THE REMAINS OF THE DECEASED AND DEATH OCCURRED AT THE TIME INDICATED AND FROM THE CAUSES AS STATED ABOVE.
[redacted] je conclus que le décès est survenu à l'heure indiquée et à, la suite des causes énumérées ci-dessus.

N[redacted]	[redacted] sanitaire	TITLE OR DEGREE Titre ou diplôme
(b)(3)(b)(6)		MD
G[redacted]	[redacted]DRESS Installation ou adresse	
DATE Date	SIGNATURE Signature	

[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.*

CENTCOM 004993

DD FORM [illegible] DEFINITES DA FORM [illegible] 1 JAN [illegible] AND DA FORM [illegible] (PAS) 25 SEP 75 WHICH ARE OBSOLETE.

AUTHOR
PRINCIP
ROUT

FOR USE OF THIS FORM, SEE AR 40-400; THE PROPONENT AGENCY IS OFFICE OF THE SURGEON GENERAL.

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)*

Unknown

(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)*

1052 10 Aug 05

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)* IED blast to head / asystole	
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)** IED blast	
	(2)	
8. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	a.	
	b.	

9. DATE

10 Aug 05

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

11. SIGNATURE OF MEDICAL OFFICER IN ATTENDANCE

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

SECTION B - ADMINISTRATIVE

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

Unknown

(b)(6)

PATIENT'S IDENTIFICATION *(For plate imprint, typewriter or hand)*

PATIENT'S DEPOSIT RECORD
For use of this form, see AR 40-2; the proponent agency is the Office of The Surgeon General.

I have been informed that any funds or valuables in my possession while a patient in this hospital are retained at my own risk and that I may and should deposit same in the patient trust fund.

I do ☐ *do not* ☐ *wish to make a deposit at this time.*

Patient's signature (or witness's, if patient is unable to sign)

FUNDS & VALUABLES RECEIVED IN FULL *(Patient's or witness's signature and date)*

FUNDS

DATE	DEPOSITS	WITHDRAWALS	BALANCE	SIGNATURE

VALUABLES

NUMBER	DESCRIPTION OF VALUABLES	DEPOSITS		WITHDRAWALS	
		DATE	SIGNATURE *(Custodian)*	DATE	SIGNATURE *(Patient or intermediate individual)*
1	watch				

DA FORM 1 DEC 77 **3696**

REPLACES EDITION OF 1 AUG 76, WHICH MAY BE USED.

★U.S.GPO:1991-0-301-988

FOR USE OF THIS FORM, SEE AR 40-562; THE PROPONENT AGENCY IS OFFICE OF THE SURGEON GENERAL.

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)*

Unknown

(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)*

1052 10 Aug 05

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)* IED blast to head / asystole	
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) IED blast	
	(2)	
8. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	a.	
	b.	

9. DATE 10 Aug 05

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

10. [illegible]

11. SIGNATURE OF MEDICAL OFFICER IN ATTENDANCE

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

SECTION B - ADMINISTRATIVE A[illegible]

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

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

NAME OF DECEASED *(Last, First, Middle)* Nom du décédé (Nom et prénoms): Unknown	GRADE Grade: —	BRANCH OF SERVICE Arme: CIV	SOCIAL SECURITY NUMBER Nu: (b)(6)
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 Etat Civil		RELIGION Culte	
CAUCASOID Caucasique	SINGLE Célibataire	DIVORCED Divorcé	PROTESTANT Protestant	OTHER *(Specify)* Autre *(Spécifier)*
NEGROID Négroïde	MARRIED Marié		CATHOLIC Catholique	
OTHER (Specify) Autre *(Spécifier)*	WIDOWED Veuf	SEPARATED Séparé	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 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.	Open head injury / exposed brain matter pulseless / Asystole
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	
ANTECEDENT CAUSES Symptômes précurseurs de la mort. — 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:

...EASED AND DEATH OCCURRED AT THE TIME INDICATED AND FROM THE CAUSES AS STATED ABOVE.
...t et je conclus que le décès est survenu à l'heure indiquée et à la suite des causes énumérées ci-dessus.

N... (b)(3)(b)(6) ...icin sanitaire

TITLE OR DEGREE Titre ou diplôme: MD

G... ADDRESS Installation ou adresse:

DATE Date:

SIGNATURE Signature:

[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 0004 ... DEFINITES DA FORM 2555 ... AND DA FORM 2555-R (PAS) 26 SEP 75 WHICH ARE OBSOLETE.

DEPARTMENT OF THE AIR FORCE
332nd Air Force Theater Hospital
Balad Air Base, Iraq

11 August 2005

MEMORANDUM FOR THE GUARDS AT NORTH GATE CAMP ANACONDA

FROM: 332nd EMDG/SGH
Air Force Theater Hospital - Balad

SUBJECT: Transfer of the Human Remains of Patient 3810

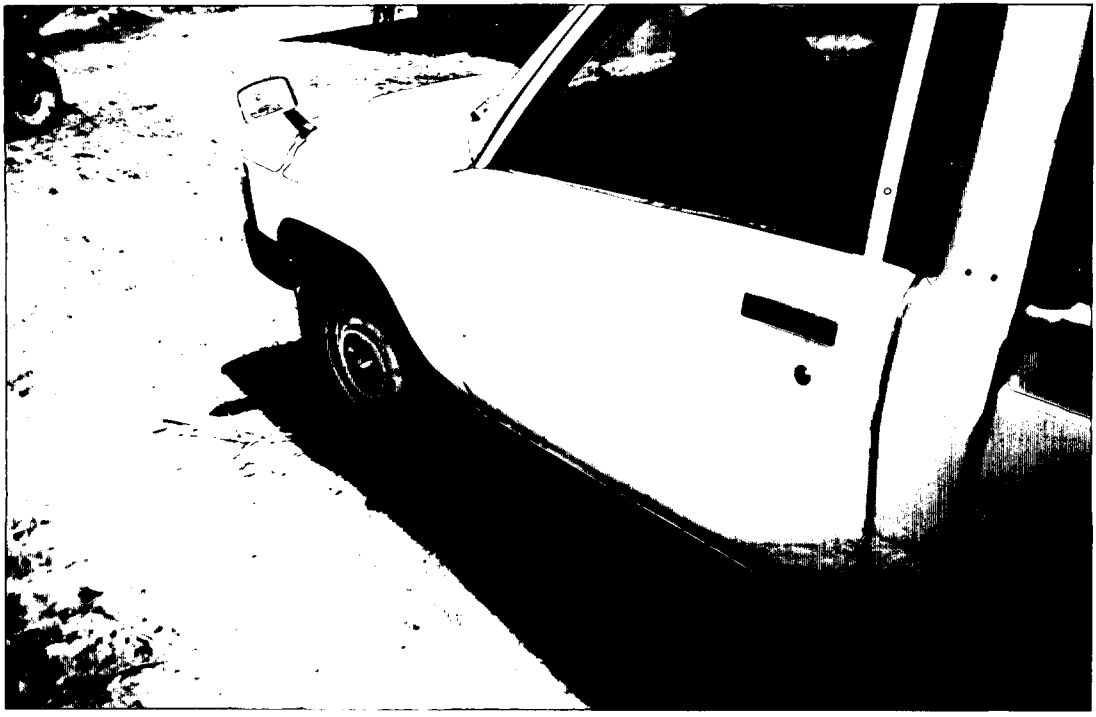
1. Please allow the family of patient (b)(6) to bring a vehicle, after the appropriate security measures, into the personal search area parking lot to allow a transfer of human remains. We are expecting the transfer of the remains to occur on or around 12 August 2005.

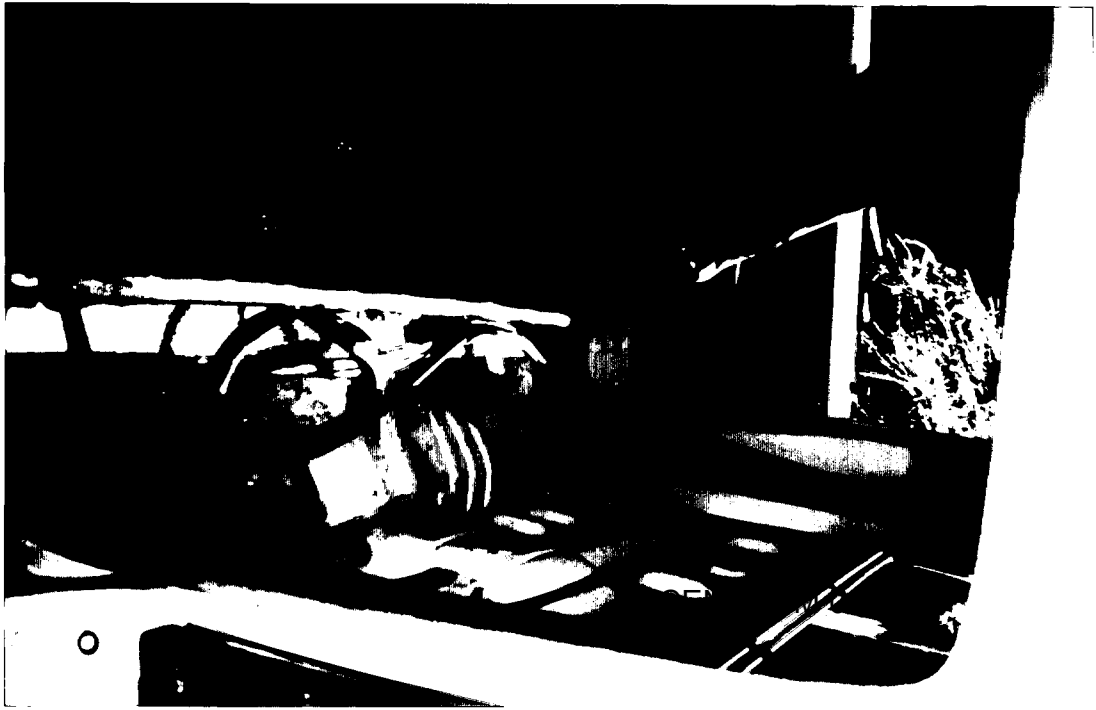
2. Please call Mortuary Affairs directly at DSN (b)(2)High, DNVT (b)(2)High and they will arrange to come to the gate to coordinate the transfer. If you cannot reach Mortuary Affairs please call either myself, Lt Col (b)(3)(b)(6) or SMSgt (b)(3)(b)(6) at DSN (b)(2)High DNVT (b)(2)High Thank you for your assistance in this matter.

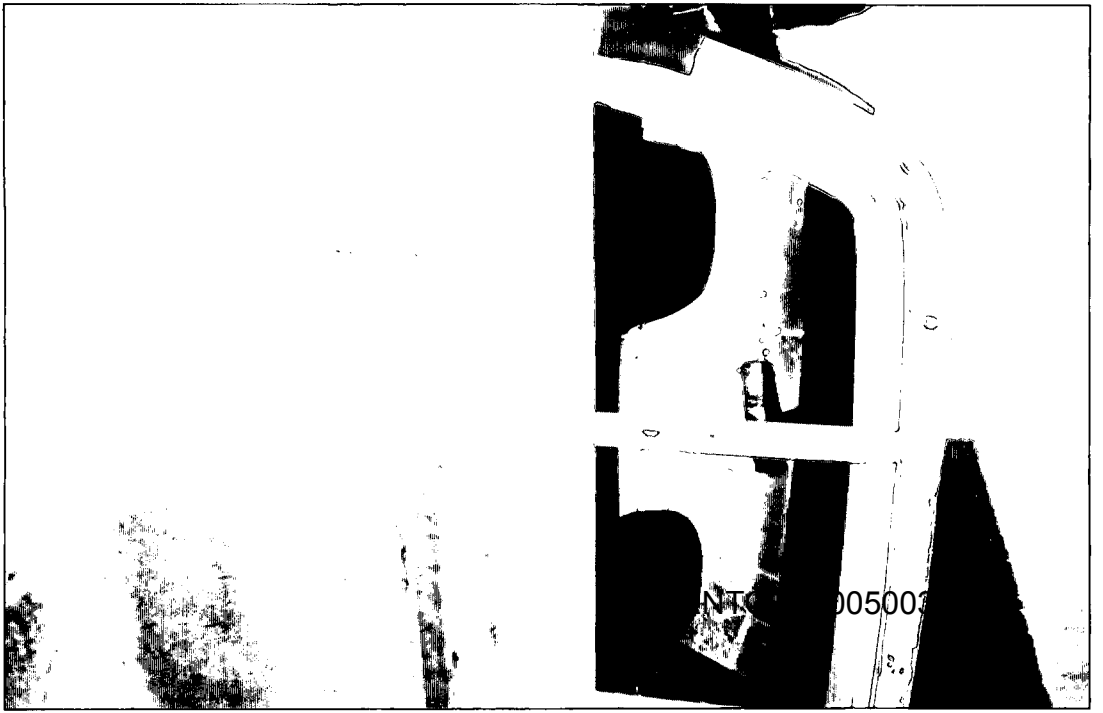
(b)(3)(b)(6)

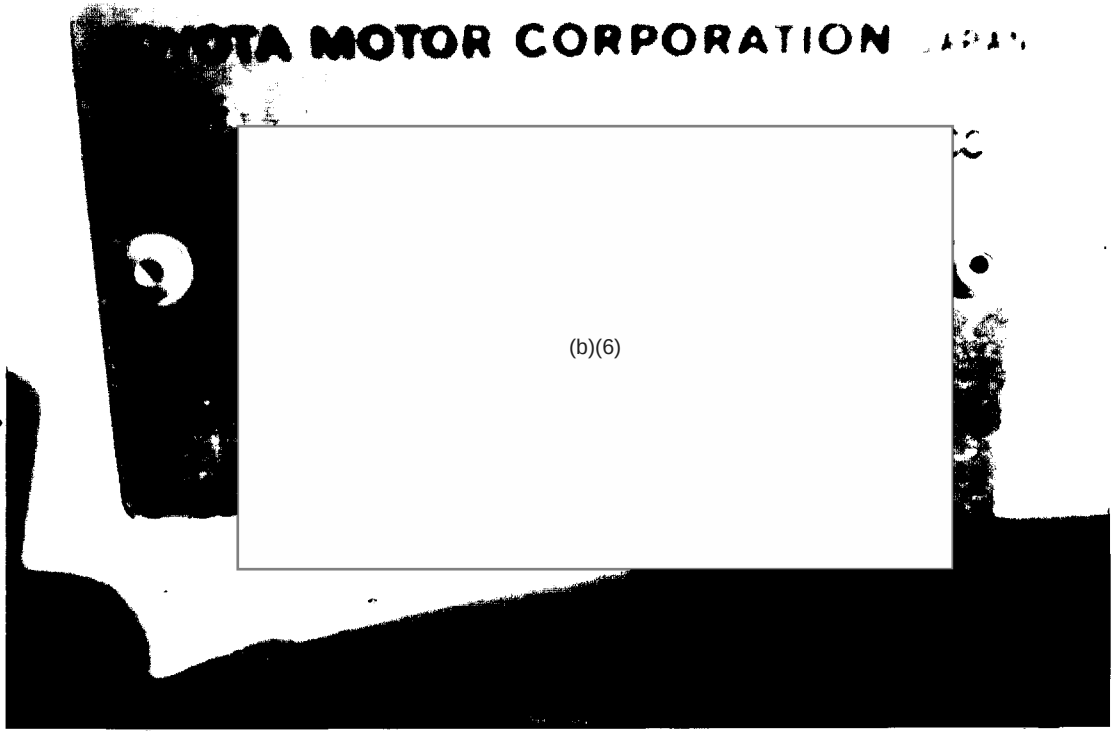
Superintendent, Professional Services

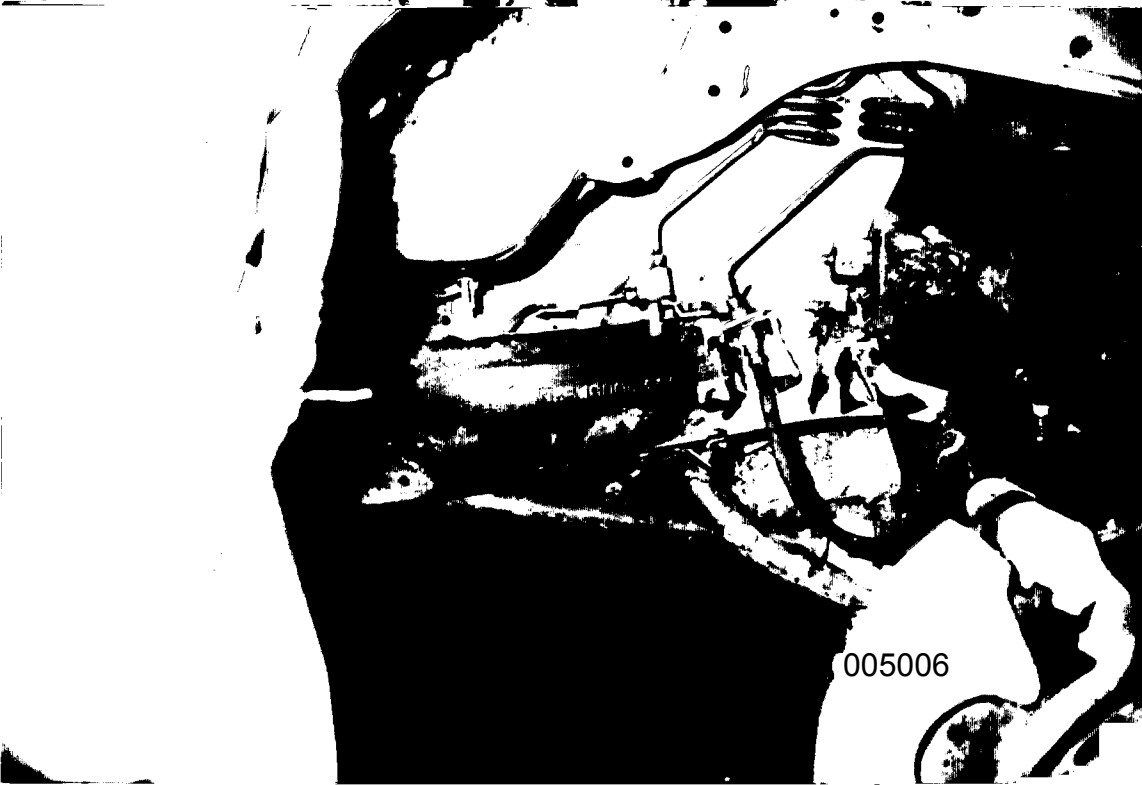
00500






NTS 005003


TOYOTA MOTOR CORPORATION JAPAN
(b)(6)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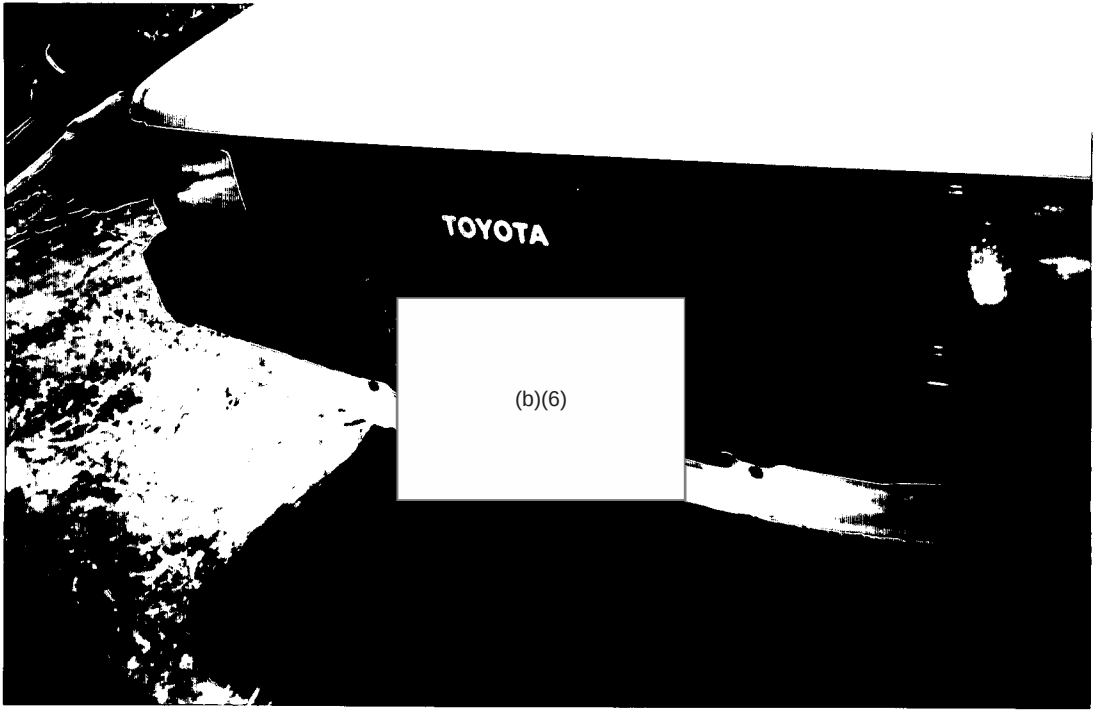
TOYOTA
(b)(6)

CENTCOM 005

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(b)(6)