(b)(6)

760-3
19-MAR-2005

Deny - Combat

CENTCOM 005880

This man, (b)(6)
Is Innocent
89th ENG
Fired warning
Shot. It
accidentally Richotch
+ hit the truck

(b)(6)

CENTCOM 005882

Pages 6 through 7 redacted for the following reasons:
- -
(b)(6)

DEPARTMENT OF THE ARMY
HEADQUARTERS, 256th BRIGADE COMBAT TEAM
CAMP AL-TAHREER, IRAQ
APO AE 09344

REPLY TO
ATTENTION OF:

April 25, 2005

Claims Office

SUBJECT: Claim # 760-3

(b)(6)

Dear (b)(6) :

You have submitted a claim seeking compensation for damages allegedly caused by U.S. Forces. 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 your loss, however, in accordance with the cited references and after investigating your claim, I find that your claim is **not compensable** for the following reason: Loss Resulted from a Combat Operation. Accordingly, your claim must be denied.

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.

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

Major, U.S. Army
Foreign Claims Commission

760 - 3
19 - MAR - 2005

Government Information Centre
Baghdad Al Radwania

Claims Form

To: United States Army Foreign Claims Commission
From: **Name:** (b)(6)
Address: Baghdad (b)(6)

I am

a. A citizen and national of: Iraq
b. A permanent resident of: Baghdad (b)(6)
c. Employed by: (b)(6)
d. Check one ( ) An insurer ( ) Not an insurer
e. Check one (X) A subrogee( ) Not a subrogee

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

Multi National Forces

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.) (b)(6)

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

My claim arose on: Jan. (Month) 6th (Day) 2005 (Year)

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.)

On Jan-6th,05 at 6:30 A.M and when my husband was going to Baghdad, the Multi National Forces shote him in his Car for no reason and he die after they moved him to Ibn Sina hospital, thats why I ask for Compensation.

CENTCOM 005887

Describe nature and extent of property damage or personal injury sustained as result as a result of the above incident.

Killing my husband by the Multi National Forces by shooting his Car.

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
1- The blood money for killing my husband	$4000
2-	
3-	
4-	
5-	
6-	

Total: $4000

I was insured to the following extent against the damager 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)

$ 4000 **local** 5,800,000

(b)(6)

(Signature of [illegible])

Subscribed before me this 19th day of March 2005

(Print Name)

(b)(6)

(Signature)

CENTCOM 005889

GENERAL INFORMATION CENTAR,
AL-RADHWANYA, BAGHDAD, IRAQ

"THE CLAIM'S CONTAINS"

The Claimant name:- (b)(6)

- I.D. Card + Living Card + Ration Card
- pictures for the dead person (b)(6)
- The investigation paper of Al Mahmodiya Police Station which says that the victim had been killed by the Multi National Forces
- The medical report for the victim issued by Ibn Sina hospital
- Death certificate issued by the Judical medical hospital for the victime
- paper from Multi National forces admitting by them mistake unit for this accident

Government Information Centre
Baghdad Al Radwania
مركز المعلومات الحكومي

General Information Center/Al-Radhwanya
Date:- 19 March 05

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)			
ORGANIZATION Organisation	NATION *(e.g., United States)* Pays	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)*	☐ 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 Domicilé 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]		Acute Respiratory Insufficiency	30 min
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	Acute Lung Injury	6 days
	UNDERLYING CAUSE, IF ANY, GIVING RISE TO PRIMARY CAUSE Raison fondamentale, s'il y a lieu, ayant suscité la cause primaire	GSW to L shoulder (E) chest	6 days
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
1735 12 01 2008	ICU 2

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
GRADE Grade	INSTALLATION OR ADDRESS Installation ou adresse
DATE Date	SIGN (b)(3),(b)(6)

[1] *State disease, injury or complication which cause* ... *re, etc.*
[2] *State conditions contributing to the death, but no*
[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] *Préiser 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.*

(REMOVE, REVERSE, AND RE-INSERT CARBONS BEFORE COMPLETING THIS SIDE)

DISPOSITION OF REMAINS

NAME OF MORTICIAN PREPARING REMAINS	GRADE	LICENSE NUMBER AND STATE	OTHER
INSTALLATION OR ADDRESS	DATE	SIGNATURE	
NAME OF CEMETERY OR CREMATORY	LOCATION OF CEMETERY OR CREMATORY		
TYPE OF DISPOSITION ☐ BURIAL ☐ CREMATION ☐ REMOVAL *(Specify)*		DATE OF DISPOSITION	

REGISTRATION OF VITAL STATISTICS

REGISTRY *(Town and Country)*	DATE REGISTERED	FILE NUMBER	
		STATE	OTHER
NAME OF FUNERAL DIRECTOR	ADDRESS		
SIGNATURE OF AUTHORIZED INDIVIDUAL			

DD FORM 2064, APR 1977 (BACK)

USAPA V1.

HOSPITAL REPORT OF DEATH

R USE OF THIS FORM, SEE AR 40-2: THE PROPONENT AGENCY IS OFFICE OF THE SURGEON GENERAL.

NAME AND LOCATION OF HOSPITAL

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)*

(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)*: 1735 12 01 2005

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)* Acute Respiratory Insufficiency	30 min
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) Acute lung Injury	6 days
	(2) GSW (L) shoulder (L) chest	6 days
8. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	a.	
	b.	

9. DATE: 12 Jan 05

10. TYPED OR PRINTED NAME AND GRADE OF MEDICAL OFFICER IN ATTENDANCE: (b)(3),(b)(6) CDL

11. SIGNA... ...ANCE: (b)(3),(b)(6)

SECTION B - ADMINISTRATIVE ACTION

TYPE OF ACTION	HOUR	DAY			...F 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

USAPPC V2.00

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

MILITARY OPERATIONS RECORD OF PERSONAL EFFECTS OF DECEASED PERSONNEL	1. DATE *(YYYYMMDD)*	2. PAGE OF PAGES

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.

. TENTATIVELY IDENTIFIED DECEDENT

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

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

. INVENTORY OF EFFECTS

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

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

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

0. PREPARING OFFICIAL

a. NAME *(Last, First, Middle Initial)*	b. GRADE	c. ORGANIZATION
d. SIGNATURE		e. DATE SIGNED *(YYYYMMDD)*

1. RECEIVING OFFICIAL

a. NAME *(Last, First, Middle Initial)*	b. GRADE	c. ORGANIZATION
d. SIGNATURE		e. DATE SIGNED *(YYYYMMDD)*

2. RECEIVING OFFICIAL

a. NAME *(Last, First, Middle Initial)*	b. GRADE	c. ORGANIZATION
d. SIGNATURE		e. DATE SIGNED *(YYYYMMDD)*

PATIENT'S PERSONAL EFFECTS AND CLOTHING RECORD

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

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, middle initial; grade; social security number, register number medical facility or organization)*

HOSPITAL ITEMS RECEIVED BY PATIENT			
	COAT, PAJAMA		TOWELS, BATH
	TROUSERS, PAJAMA		WASH CLOTH
	CONVALESCENT SUIT		OTHER
	ROBE, BATH		
	SLIPPERS		
	TOWELS, HAND	PATIENT'S INITIALS	

DATE	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
INITIALS OF CUSTODIAN															
INITIALS OF PATIENT															
ITEMS *(Male and Female)*	QUANTITY - PATIENT'S PERSONAL EFFECTS AND CLOTHING														
ANKLETS, WOMEN'S															
BAGS, DUFFEL/BARRACKS															
BATHROBE															
BELT															
BUCKLE															
BLOUSE, SUMMER/WINTER															
BOOTS, COMBAT															
CAP, GARRISON															
CAP, NURSES, WHITE															
CAP, SERVICE															
CAP, UTILITY															
COAT, WOOL															
DRAWERS, SUMMER/WINTER															
DRESS, COTTON															
GLOVES, PR. COTTON/LEATHER															
GLOVES, INSERT															
GLOVES, SHELL															
HANDBAG, LEATHER															
HANDKERCHIEFS															
HAT, SERVICE															
INSIGNIA, CAP/HAT															
INSIGNIA, COLLAR, SHOULDER															
JACKET, UTILITY															
JACKET, FIELD															
JACKET, WOOL															
NECKTIE															
NIGHTGOWNS															
OVERCOAT															
OVERSHOES/RUBBERS															
PAJAMAS															
PONCHO															
PANTIES, WOMEN															
RAINCOAT															
SCARF															
SHIRT															
SHIRTWAIST, WOMEN															

DA FORM 1 OCT 73 4160 REPLACES DA FORM 8-111, 1 OCT 57 WHICH IS OBSOLETE.

ITEMS *(Male and Female)*	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
	QUANTITY - PATIENT'S PERSONAL EFFECTS AND CLOTHING														
SHIRT, WOOL															
SHOES, DRESS/SPORT															
SHOES, LOW-QTR															
SHOES, SERVICE															
SHORTS, UNIFORM, KHAKI															
SKIRT															
SLACKS															
SLIP															
SOCKS, PRS															
STOCKINGS, PRS															
SUIT, EXERCISE, WOMEN															
SWEATER															
TOWELS															
TROUSERS, COTTON, KHAKI															
TROUSERS, WOOL															
UNDERSHIRTS, WINTER/SUMMER															
UNIFORM, NURSES HOSPITAL															
UNIFORM, WOMEN, WINTER/SUMMER															
CIVILIAN															
BELT, COLOR															
CAP/HAT															
COAT, SPORT															
SHIRT, DRESS/SPORT															
SHOES, SPORT, DRESS, COLOR															
SLACK, COLOR															
SUIT, 2 PC, 3 PC															
TOP COAT															
OTHER															

ALL ITEMS IN THE LAST COMPLETED COLUMN HAVE BEEN RECEIVED

DATE	SIGNATURE AND GRADE OF PATIENT	DATE	SIGNATURE AND GRADE OF CUSTODIAN

U.S. GPO: 1999-454-110/15230

Page 22 redacted for the following reason:
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Foreign Language

CENTCOM 005900

Pages 24 through 40 redacted for the following reasons:
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(b)(6), Foreign Language

CENTCOM 005918

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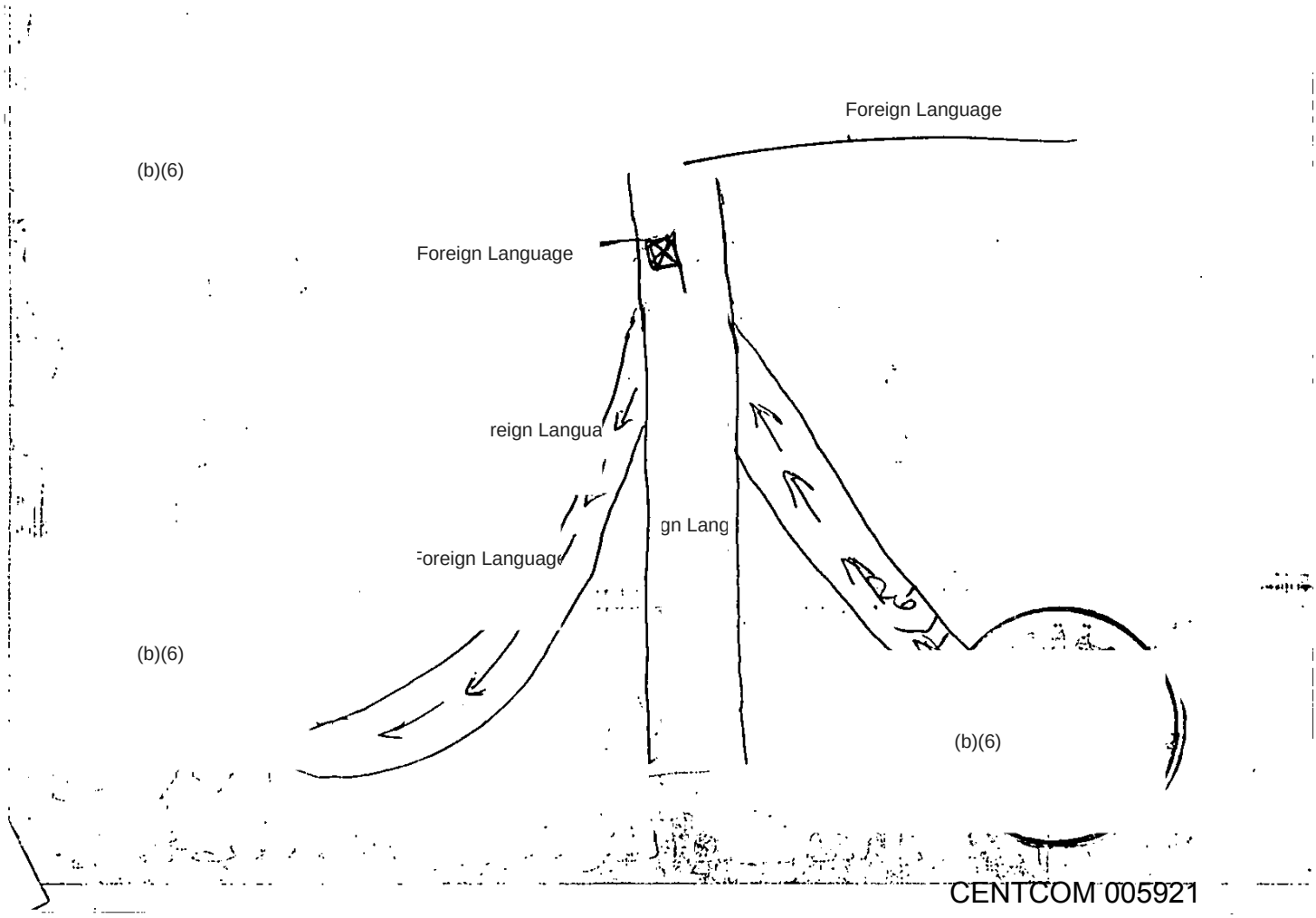
(b)(6), Foreign Language

CENTCOM 005920

Foreign Language



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(b)(6), Foreign Language

CENTCOM 005923

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(b)(6), Foreign Language

CENTCOM 005925

Pages 49 through 51 redacted for the following reasons:
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(b)(6), Foreign Language

CENTCOM 005929

Pages 53 through 56 redacted for the following reasons:
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(b)(6), Foreign Language

CENTCOM 005934

Pages 58 through 59 redacted for the following reasons:
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(b)(6), Foreign Language

CENTCOM 005937

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(b)(6), Foreign Language

Foreign Language Text