

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:** Babat

Next Apt: 10 ban ale

Translation:

Further Investigation:

Contact S-2 **Check Sigacts**
Approved **Denied** C/E

#11356 TF-3-109 patrol margin BP
fire 2X warning shots
@ white truck vehicle
was driving to
close to BPI

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 Babat hospital

CENTCOM 004958

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 [REDACTED] (b)(6) 06-IA3-271

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

[REDACTED]
(b)(3)(b)(6)

CPT, JA
Claims Judge Advocate

CENTCOM 004961

Page 5 redacted for the following reason:

foreign language

CENTCOM 004963

25730

Pages 7 through 8 redacted for the following reasons:

foreign language

CENTCOM 004966

25732

Page 10 redacted for the following reason:

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CENTCOM 004968

25734

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 - goes with

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 cert

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 CP. As he

turned, CF fired on vehicle.

(C's son was shot.)

Identified deceased b/c small village

Evidence: Please see of Remains information, photos

CENTCOM 004974

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.)

<u>Item</u>	<u>Amount</u>
Damages to vehicle	\$1,500
Wrongful death	\$3,000
Total:	<u>\$4,500</u>

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)

CENTCOM 004975

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 أحبابكم و نتمنى ان تقدمونا و ترجع اليكم البقايا الادمية الخاصة بالمرحوم كريمة مهلا الى نسب اهلة القريب الاولى اليه. مع العلم بأن البقايا الادمية تم معاملتها بكل الاحترام واللطف التي تتطلبهها تقاليد و عادات الديانة الاسلامية او الديانة المسيحية و تمت معاملتها بنفس المعاملة التي تلقاها الموتى من قوات التحالف. الشخص المتسلم للبقايا الادمية يدرك جيداً بان قوات التحالف قامت بالعمل اللازم و بكل اساليب الاحترام التامة. و في حالة وجود او ادراك ايّة انتهاءك للعادات و التقاليد المحلية فبكل الاسف انه ليس عمداً و غير مقصود كلباً من جانب قوات التحالف. مع العلم جميع المتابع الشخصية التي وجدت مع البقايا سوف ترجع اليكم بالقائمة المرفقة.

(b)(6)

اسم الشخص للتاكيد و اثبات البقايا الادمية /

Person verifying identity

(b)(6)

اسم الشخص المستلم /

Person receiving remains

(b)(6)

العلاقة بالمرحوم /

Relationship to deceased

٢٠٠٥ / ٨ / ١٤

Date

CENTCOM 004987

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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(b)(6)

اسم الشخص للتاكيد و اثبات البقايا الادمية
Person verifying identity

(b)(6)

اسم الشخص المستلم
Person receiving remains

(b)(6)

العلاقة بالمرحوم
Relationship to deceased

٢٠٠٣ / ٨ / ١

التاريخ
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 [REDACTED] (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 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 [REDACTED] (b)(3)(b)(6) or SMSgt [REDACTED] (b)(3)(b)(6) at DSN [REDACTED] (b)(2)High [REDACTED] DNVT [REDACTED] (b)(2)High [REDACTED]. Thank you for your assistance in this matter.

[REDACTED]
(b)(3)(b)(6)

Superintendent, Professional Services



Unknown

(b)(6)

PATIENT'S IDENTIFICATION (or 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)

**DA FORM 3696
DEC 77**

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

★ U.S.GPO:1991-O-301-988

CENTCOM 004990

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. NUMBER MC

2. NAME (Last, First, Middle Initial)

Unknown

3. RELIGION

AF FORM 348
10-034. MEDICAL TREATMENT FACILITY
NAME5. TIME OF
ADM6. DATE OF
ADM

7. TYPE OF CASE

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

8. BENEFICIARY

9. GRADE

10. RATING

11. AFSC

12. CIVIC CODE

13. VETERAN CIVIC CODE

14. LENGTH OF SVC

15. AGE

16. BIRTHDAY

17. CURRENT ORGANIZATION

18. DATE OF INITIAL ADMISSION

19. ROOM

20. BED

21. INPATIENT UNIT

22. ADMISSION CLERK

23. SPONSOR'S NAME

24. SPONSOR'S ADDRESS

25. DATE INITIAL ADM

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USE BALL PUNISHER
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)

REF ID: GYER NO.		2.) NAME (Last, First, Middle Initial)		3. RELIGION	
4.) CASE CODE 5600	6.) TREATMENT FACILITY 113 HAVING	7.) TIME OF ADM 104605	8.) DATE OF ADM 1052	9.) TYPE OF CASE BT	
10.) BIRTH TYPE (b)(6)	11.) GRADE	12.) AFSN	13.) VARIATION CVC CODE	14.) RATING	15.) LENGTH OF SVC
16.) M	17.) ZIP CODE	18.) CURRENT ORGANIZATION	19.) INPATIENT UNIT		
20.) DATE OF INITIAL ADM	21.) DATE OF INITIAL ADM	22.) ROOM	23.) BED		
24.) PRIORITY <input checked="" type="checkbox"/> P <input type="checkbox"/> H	25.) DUR. OF SERVICE (D) 1 MONTH	26.) ADMISSION CLERK			
27.) SPONSOR'S NAME John Doe	28.) NAME AND ADDRESS OF SPONSOR 123 Main Street, Anytown, USA	29.) SECONDARY ADMISSION DIAGNOSIS Hypertension			
30.) STATEMENT OF VALIDATION <input checked="" type="checkbox"/> I, John Doe, have read and understood the Privacy Act and Dissemination Statements on this form. <input type="checkbox"/> H, I have read this form.		31.) SIGNATURE OF PATIENT OR SPONSOR		32.) ADMIITTING PROVIDER	
33.) TREATMENT Foundations of Law					
34.) PROVIDERS OF CARE					
(b)(3)(b)(6)					

D. TYPES

2F-13, LQD not applicable

AF Form 348

(Check if continued on reverse)

(Check if continued on reverse)

ADMINISTRATIVE DATA / Define a physical profile required

4321

(Meal Card YES NO)

(Check if continued on reverse)

41. DISPOSITION  (b)(3)(b)(6)	42. DATE OF DISPOSITION 12/21/08	43. TIME OF DISPOSITION 05 1052	44. CC OF WHOLE BLOOD	45. CC OF PACKED CELLS	46. CONVALESCENT LEAVE TAKEN RECOMMENDED	
				48. SIGNATURE OF PATIENT AFFAIRS OFFICIAL 		
PREVIOUS EDITION WILL BE USED.						

PREVIOUS EDITION WILL BE USED.

CENTCOM 004992

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

1. NAME OF DECEASED (Last, First, Middle)		Nom du décédé (Nom et prénom)		GRADE Grade	BRANCH OF SERVICE Armée	SOCIAL SECURITY NUMBER Numéro de sécurité sociale
Unknown					CIV	(b)(6)
ORGANIZATION Organisation		NATION (e.g., United States) Pays		DATE OF BIRTH Date de naissance	SEX Sexe	
		IRAQ			<input checked="" type="checkbox"/> MALE Masculin	<input type="checkbox"/> FEMALE Féminin
RACE Race		MARITAL STATUS Etat Civil		RELIGION Culte		
CAUCASOID Caucasiqne	SINGLE Célibataire	DIVORCED Divorcé	PROTESTANT Protestant		OTHER (Specify) Autre (Spécifier)	
NEGROID Nigroïde	MARRIED Marié	SEPARATED Séparé	CATHOLIC Catholique			
OTHER (Specify) Autre (Spécifier)	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 OR 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.		Open head injury/exposed brain matter maltraius / Aby stöle				
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)		PLACE OF DEATH Lieu de décès				
I HAVE WRITTEN THE DETAILS OF THE DECEASED AND DEATH OCCURRED AT THE TIME INDICATED AND FROM THE CAUSES AS STATED ABOVE. 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)	>Title or Degree Titre ou diplôme					
G DRESS Installation ou adresse	MD					
DATE Date	SIGNATURE Signature					

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 cœur, 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.

CENTCOM 004993

AUTHOR
PRINCIPAL
ROUT

CENTCOM 004994

25746

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)

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

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, asthma, etc. It means the disease, injury, or complication which caused death)

DUE TO (or as a consequence of)

IED blast to head / systole

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

(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)

21. AUTOPSY ORDERED BY (Signature)

 YES 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

Unknown

(b)(6)

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

DA FORM 1 DEC 77 3696

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

★ U.S.GPO: 1991-0-301-988

CENTCOM 004996

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)

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

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, asthma, etc.; it means the disease, injury, or complication which caused death)

DUE TO (or as a consequence of)

IED blast to head / mystic

7B. ANTECEDENT CAUSES (Mild 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

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

11. SIGNATURE OF MEDICAL OFFICER IN ATTENDANCE

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

SECTION B - ADMINISTRATIVE

10. 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)

21. AUTOPSY ORDERED BY (Signature)

 YES 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.

USAPA V2.01

CENTCOM 004997

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	
Unknown					CIV	(b)(6)	
ORGANIZATION Organization				NATION (e.g., United States) Pays	DATE OF BIRTH Date de naissance	SEX Sexe	
				IRAQ		<input checked="" type="checkbox"/> MALE Masculin <input type="checkbox"/> FEMALE Féminin	
RACE Race		MARITAL STATUS Etat Civil		RELIGION Culte			
CAUCASOID Caucasiq	SINGLE Célibataire	DIVORCED Divorcé	PROTESTANT Protestant	OTHER (Specify) Autre (Spécifier)			
NEGROID Nigroïde	MARRIED Marié	CATHOLIC Catholique	JEWISH Juif				
OTHER (Specify) Autre (Spécifier)	WIDOWED Veuf	SEPARATED Séparé					
NAME OF NEXT OF KIN Nom du plus proche parent		RELATIONSHIP TO DECEASED Parenté du décédé avec le susdit					
STREET ADDRESS Domicile(s) (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)							
<i>Open head injury / exposed brain matter posterior / Aystole</i>							
INTERVAL BETWEEN ONSET AND DEATH Intervalle entre l'attaque et la mort							
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Maladie ou condition directement responsable de la mort.							
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							
ACCIDENT Mort accidentelle							
SUICIDE Suicide	NAME OF PATHOLOGIST Nom du pathologiste						
HOMICIDE Homicide	SIGNATURE Signature		DATE Date	AVIATION ACCIDENT Accident à Avion			
DATE OF DEATH (Hour, day, month, year) Date de décès (l'heure, le jour, le mois, l'année)		PLACE OF DEATH Lieu de décès					
DISEASE AND DEATH OCCURRED AT THE TIME INDICATED AND FROM THE CAUSES AS STATED ABOVE. Et je conclus que le décès est survenu à l'heure indiquée et à la suite des causes énumérées ci-dessus.							
N G		ICIN SANITAIRE	TITLE OR DEGREE Titre ou diplôme <i>MD</i>				
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 cœur, 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.							

THIS FORM IS OBSOLETE AND IS BEING USED IN ACCORDANCE WITH THE REGULATIONS WHICH ARE OBSOLETE.

CENTCOM 004998



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

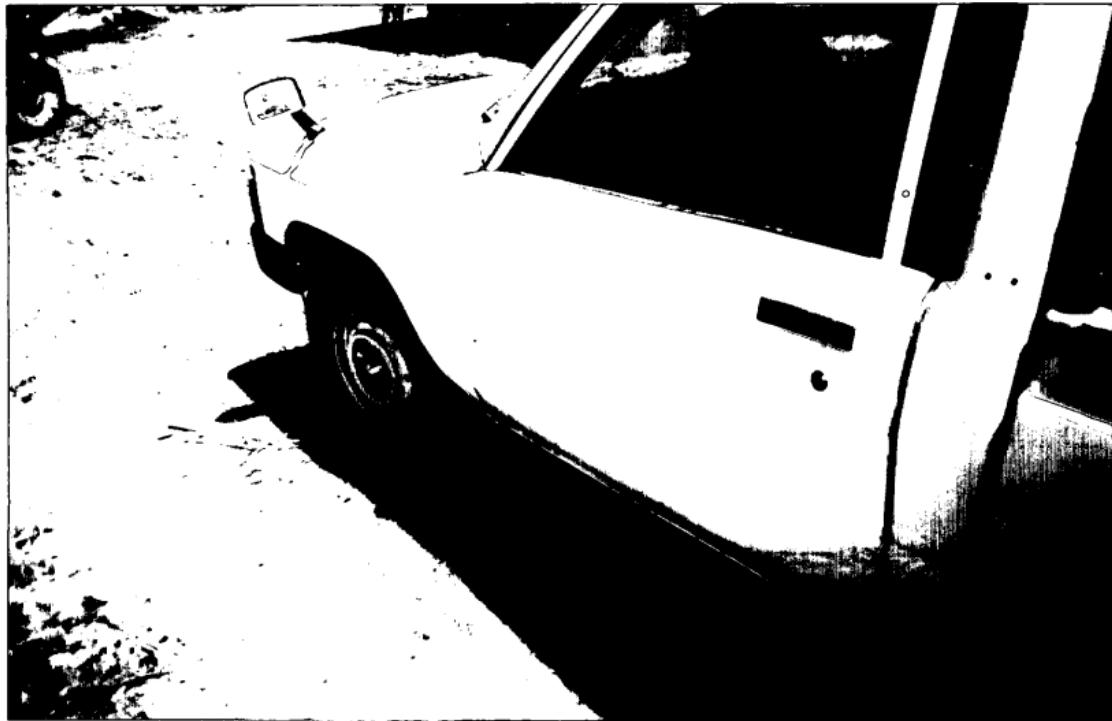
1. Please allow the family of patient [REDACTED] (b)(6) to bring a vehicle, after the appropriate security measures, into the personal search area parking lot to allow a transfer of human remains. We are expecting the transfer of the remains to occur on or around 12 August 2005.
2. Please call Mortuary Affairs directly at DSN [REDACTED] (b)(2)High, DNVT [REDACTED] (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 [REDACTED] (b)(3)(b)(6) or SMSgt [REDACTED] (b)(3)(b)(6) at DSN [REDACTED] (b)(2)High DNVT [REDACTED] (b)(2)High. Thank you for your assistance in this matter.

[REDACTED]
(b)(3)(b)(6)

Superintendent, Professional Services



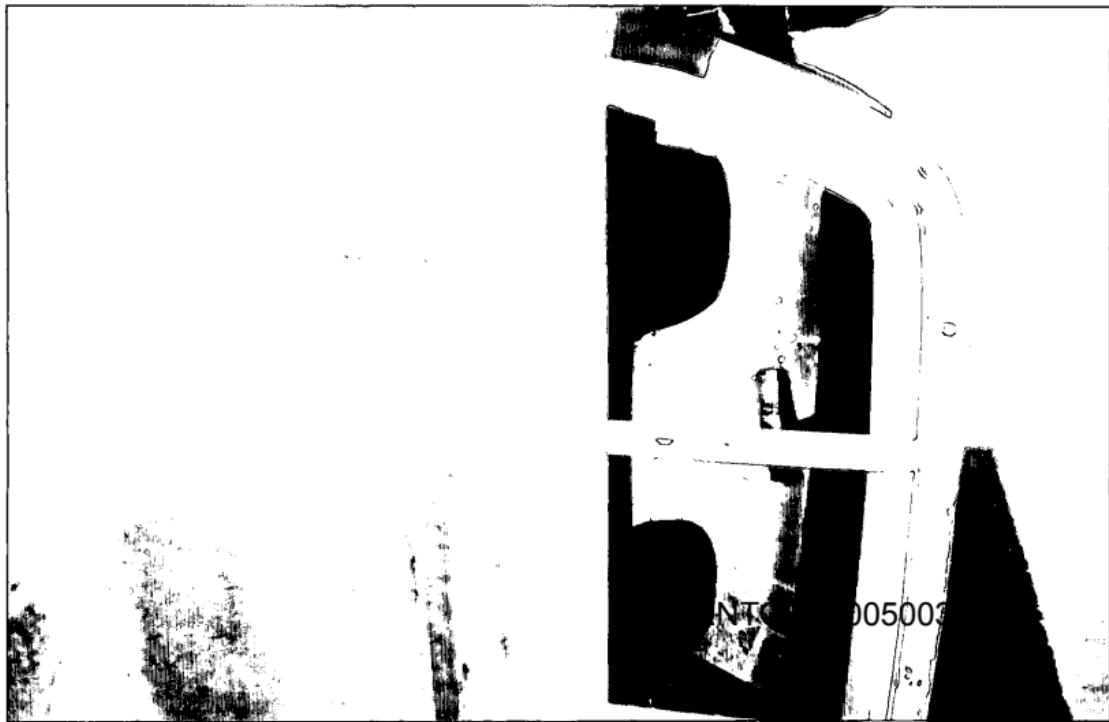
25752



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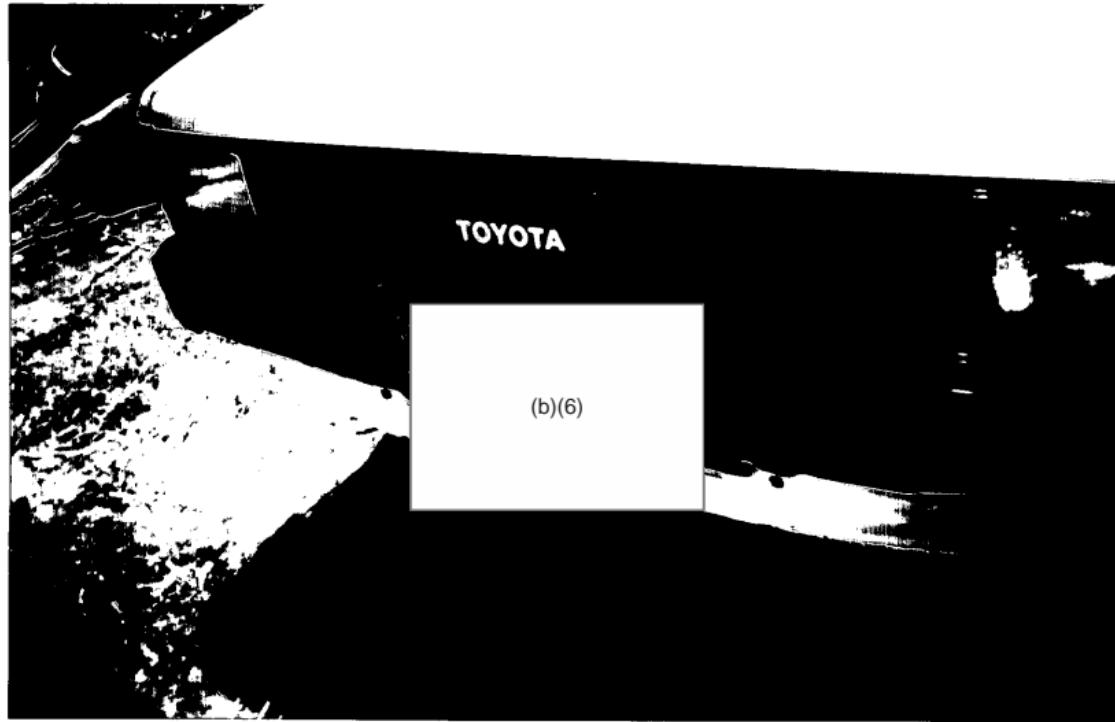
MITSUBISHI MOTOR CORPORATION JAPAN

(b)(6)

25757



25758



(b)(6)

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CENTCOM 005

25760



25761

MITSUBISHI MOTOR CORPORATION JAPAN

(b)(6)

25762