06 T: (b)(6)
06I57T002 (06I04T006)
PA: A0027-20bDAJA
Filed: 8 Jul 06

02

(b)(6)

17000

DUMMY TOOL

08ISO TOOL

CLAIMS CHRONOLOGY SHEET

CLAIMANT'S NAME: (b)(6)
FILE NUMBER: 06-[illegible]
AMOUNT CLAIMED: $ 12000 AT:
DATE OF INCIDENT: JAN 6 06 DATE CLAIM FILED: JUL 8 06

DATE	STATUS OF CASE	FOLLOW-UP DATE
14 JUL 06	ENTERED JAGC NO CPT 3)(b	(b)(3)(b)(6)
30 JUL 06	(b)(5), (b)(2)High	
8 DEC 06		
12/16/06	more information	
12/16/06	(b)(6) paid - closed	

Tort and Special Claims-Pro Version

Home | Search | Administrator | Reports | Log Out | Request Assistance

SSG (b)(3)(b)(6) NCOIC of Client Services Thursday, 04 January 2007

Closed Claims - Claim Data - 06I57T002 (b)(6)

Fiscal Year: 01-Oct-2006 - 30-Sep-2007

Current Month: 01-Jan-2007 - 31-Jan-2007

I57 - I57 (Iraq)

Quick Search Go

Advanced Search

Updated Users' Guide

New Manual Claim

New Claim

New Claim-Quick Entry

New PCE

My Assigned Claims

PCEs

Open Claims

Closed Claims

- Claim Data
- Claim Summary
- Claimant Info
- Claimant Attorney
- Companion Claims
- Claim Transaction
- Mirror File
- POCs
- Medical Records
- Witness List
- CCRB
- Expert List
- Claim Chronology
- Investigative Plan
- E-mail
- Documents
- AAO Info
- Reverse Mirror File

Pending Retirements

Retired Claims

Transfers

User Activity

Mirror Files

My Tasks and Reminders

Printer Friendly Copy (MS Word) Printer Friendly (Adobe Acrobat) Printer Friendly-*Expanded* (Adobe Acrobat) Create File Labels (Avery 5162/5262 Compatible)

Claimant's Assertion

US Forces raided her hours and arrested her son and husband. Her husband died and left her with ten children. He was the main source of support.

Claimant Information

Claimant	(b)(6)
Insured, or Name of Deceased in Estate	No Name entered
SSN:	(b)(6)
DOB:	
Home Phone:	
Address:	
Claimant Attorney:	
Amount Claimed:	$12,000.00

Claim Information

Claim ID:	(b)(6)
Companion Claim(s):	
Incident	None Entered.
Incident Date:	06-Jan-06
Date Filed:	08-Jul-06
Filed in This Current Owning	(b)(2)High
Chapters:	CHAPTER 10 - FOREIGN CLAIMS
Damage	UNKNOWN
Basis Codes:	UNKNOWN
Incident	OTHER

The Army Team

Field Office Investigator:	SSG (b)(3)(b)(6) at (b)(3)(b)(6)
Field Office Attorney:	None Chosen. See POCs
Area Action Officer	None Chosen.
HQ	None Chosen. See POCs
HQ	None Chosen. See POCs

Final Disposition

Action	Date	Who	Amount
Final Payment Claim	18-Dec-06	I57 (Iraq)	$12,000.00

Uploaded Documents

Document	Upload Date	Who

Claim Retirement Information

Shipment	Box	Date

(b)(2)High

Standard Form 1034
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
DEPARTMENT OF THE ARMY
15th Finance Battalion
Camp Liberty, Iraq
APO AE 09344
DSSN

DATE VOUCHER PREPARED

SCHEDULE NO.

CONTRACT NUMBER AND DATE

REQUISITION NUMBER AND DATE

PAID BY
15th Finance Company
Camp Liberty, Iraq
APO AE 09344
DSSN: 5779

PAYEE'S NAME AND ADDRESS

(b)(6)

DATE INVOICE RECEIVED

DISCOUNT TERMS

PAYEE'S ACCOUNT NUMBER

SHIPPED FROM | TO | WEIGHT

GOVERNMENT B/L NUMBER

NUMBER AND DATE OF ORDER	DATE OF DELIVERY OR SERVICE	ARTICLES OR SERVICES (Enter description, item number of contract or Federal supply schedule, and other information deemed necessary)	QUANTITY	UNIT PRICE COST	UNIT PRICE PER	AMOUNT (1)
06-I04-T006		Claim Payment Final Payment of FCA Claim# In full settlement of the amount allowed by the Secretary of the Army, or an officer duly designed for such purposed under authority of 31 U.S.C 3721 and AR 27-20, Chapter 10, upon the claim of the above named claimant for property damaged, lost, destroyed, captured, or abandoned in service.	1			$ 12000.00
(Use continuation sheet(s) if necessary)		(Payee must NOT use the space below)			TOTAL	12000.00

PAYMENT:
- ☐ PROVISIONAL
- ☐ COMPLETE
- ☐ PARTIAL
- ☒ FINAL
- ☐ PROGRESS
- ☐ ADVANCE

APPROVED FOR 1 =$ 12000.00

EXCHANGE RATE =$1.00

DIFFERENCES

BY: (b)(3)(b)(6) MSG

Amount verified; correct for

TITLE: Pay Agent

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

Pursuant to authority vested in me, I certify that this voucher is correct and proper for payment.

16 Dec 06 (Date)

(b)(3)(b)(6) (Authorized Certifying Officer) 2

CPT, Certifying Officer 157/160 (Title)

ACCOUNTING CLASSIFICATION

(b)(2)High

Account Classification Verified: 1st CAV, 15th Finance Office, Disburing NCOIC

PAID BY

CHECK NUMBER	ON ACCOUNT OF U.S. TREASURY	CHECK NUMBER	ON (Name of bank)
CASH $	DATE	(b)(6)	

PER

TITLE

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.

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.

NSN 7540-00-900-2234
USAPPC V1.00

PAYMENT REPORT

TO: DFAS, DSSN _____ DATE: 16 Dec 06

A. Payment Data:

(1) Submitting agency/office: United States Army Claims Service
(2) **Office Code**: I57
(3) Agency/Office mailing address: MNC-I, OSJA, Camp Victory, Iraq APO AE 09342
(4) Date Filed: 29 Jun 06
(5) **Claim Number**: 06-I04-T006
(6) **Amount Claimed**: $ 12,000
(7) Fund Cite: (b)(2)High
(8) **Payee**: ___
(9) **Address**: IRAQ
(10) SSN: N/A
(11) **Payment Amount**: $ 12,000
(12) Type Payment: PF
(13) For EFT Payments: ABA Routing Number: _____
(14) For EFT Payment: Account Name and Number: _____
(15) For EFT Payment: Name and Address of financial institution: _____
(16) For EFT Payment: Account is (checking) (savings) Circle appropriate account

B. Acceptance by Claimant. (Note: This form should not be signed by the claimant if another release is signed by the claimant is attached.)

1. The claimant, do hereby accept the within – stated award, compromise, or settlement as final and conclusive on my heirs, executors, administrators or assigns; and agree that said acceptance constitutes a complete release by me, my heirs, executors, administrators or assigns of any and all claims, demands, rights, and causes of action of whatsoever kind in nature, arising now or in the future from, and by reason of any and all known and unknown, foreseen and unforeseen bodily and personal injuries (including wrongful death), damages to property, breaches of contract or law, and any other acts or omissions, and the consequences therefore resulting, and to result, from the same subject matter that gave rise to the claim by reason of the same subject matter. I further agree to reimburse, indemnify and hold harmless the United States, its agents, servants and employees from any and all claims or causes of action, including wrongful deaths that [illegible] acts or omissions that gave rise to the claim(s) by reason of the sam

(b)(6)

Date: 16 Dec 06 _____(Claimant)

C. AGENCY CERTIFYING OFFICER

Pursuant to authority vested in me, I certify that this Payment Report is correct and proper for payment

16 Dec 06 (b)(3)(b)(6) FCC
(Date) (Signature Authorizing Certifying Officer) (Title)

Date Payment Recorded in Record: 16 Dec 06

A separate payment report must be completed for each claimant

This information is required in accordance with 31 U.S.C. 1304. The data you furnish will be used to certify your claim for payment. Failure to provide the information may result in your claim not being processes for payment.

قبول بالتوقيع من قبل المدّعي (المطالب)

I, the claimant by signing this document and accepting payment, am releasing the United States Military and the United States Government from any further liability resulting from this claim and accepting this payment as final settlement on this claim.

أنا المدعي (المطالب) بالأمضاء و بالتوقيع على تلك الاستمارة و الموافقة على العرض (المبلغ) أنا [illegible] عن حقي الكامل و الأعفاء الكامل للقوات العسكرية الأمريكية أو حكومة الولايات المتحدة [illegible] من أي مسئولية مقبلة تنتج من المطلب و الموافقة على المبلغ المعروض على انة عرض [illegible] و ليس من حقي و\أو الورثة من بعدي و\أو اية شخص متضرر أو غير متضرر القيام بأي عمل قانوني او غير قانوني ضد القوات العسكرية الأمريكية أو الولايات المتحدة [illegible]

[redacted]anguage

[redacted]ang

Name of Claimant:

Amount Received: $ 12,000

FCC #: T57

Date Received: 12/16/06

[redacted](b)(6)

OSJA POC: (DSN) 318-822-2864

Claimant's Signature:

[redacted](3)(b)

24459

HEADQUARTERS
MULTI-NATIONAL CORPS – IRAQ
BAGHDAD, IRAQ
APO AE 09342

REPLY TO
ATTENTION OF:

FCC I57

16 December 2006

CLAIM OF: (b)(6)
CLAIM NUMBER: 06-104-T006

Dear Sir or Ma'am:

This notice constitutes final administrative action on your claim against the United States.

Foreign Claims Commission (FCC) I57 has investigated and considered the claim under the Foreign Claims Act (FCA), Title 10, United States Code, Section 2734, as implemented by Army Regulation (AR) 27-20, Chapter 10. The claim is cognizable solely under the FCA as it concerns an inhabitant of Iraq. The Federal Tort Claims Act, Title 28, United States Code, Section 2680(k), is not applicable as it excludes claims arising in foreign countries. Under the FCA, a claim for death or personal injury may be allowed whether or not the negligent act complained of was made within the scope of employment.

FCC I57 offers you $12,000 to settle your claim. To accept this settlement offer, please sign and return the enclosed forms and an appointment will be made to meet you and to issue payment.

If you are dissatisfied by this action, AR 27-20 provides that you may request that the decision be reconsidered. Any such request must be forwarded to this office for FCC consideration. There is no prescribed format for such a request. However, it should describe the legal and/or factual basis for relief. Any request for reconsideration must be made, in writing, within 30 days of receipt of this letter.

The FCC's action on reconsideration is final and conclusive by law.

Sincerely,

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

CPT, U.S. Army
FCC I57

I. TO: United States Army Foreign Claims Commission Today's Date: 2/16/2006

II. FROM: Name (English): (b)(6)

Name (Arabic)

(a) **Circle one:** Claimant / Attorney/ Authorized representative/ Parent/ Brother/Sister/ Son/Daughter

→ [Attorney or representative MUST attach proof of authorization.] Other:

(b) IRAQI IDENTIFICATION NUMBER: (b)(6)

(c) DETAINEE IDENTIFICATION NUMBER: (b)(6)

III. ADDRESS of person filing claim:

(English): Foreign Language Text

(Arabic):

IV. HOME OR CELL PHONE NUMBER:

(a) I, the above named claimant/attorney/representative, certify that I (or the person on whose behalf I am making this claim) am a resident of .

(b) I hereby make a claim against the UNITED STATES GOVERNMENT for damages or injuries caused by the following military unit:

(c)The property damaged is owned by: her husband

(d) The incident happened on 6/1/2006 (Date) at Falluja (city/town/neighborhood/highway name & number)

V. The facts of the incident are as follows: As she said. She was sleeping with her Family in their house. at 12.2n at mid night. The U.S forces came ~~to~~ with 10-15 (b)(2)High (b)(6) to search the house beside their house. Her husband (b)(6) went out to see if there was atheif out side and check every thing. The U.S forces put the lights in his face and shoot him in his chest. The intered to the house and destroyed every thing and arrested her husband and her son after one week the released her son but she found her husband dead after four months in the hospital at 8/5/2006. She didn't check with the U.S forces because what was happend in Falyja and she had ten children to feed them.

[Use back of sheet if needed. Be sure to include any photographs, statements from witnesses, documents proving ownership of damaged or destroyed property, death certificates, medical bills and repair estimates.]

VI. The following is a detailed list of what was damaged or destroyed and the estimates for repair if damaged and replacement if destroyed:

ITEM	PRICE

TOTAL $12,000

(a) I had insurance for the following: _____

(b) My insurer is: _____

VII. My total claim in U.S. Dollars against the United States Government is: $ 12,000,

and in Iraqi Dinars is: _____.

CLAIM WILL NOT BE VALID IF US DOLLAR AMOUNT IS LEFT BLANK

This is my total claim resulting from this incident. I understand that if I accept a settlement of this claim that I will not receive any other money for this incident. I also understand that if my claim is denied, I will have the opportunity to appeal the decision but will likely need to provide new evidence in order to have my claim approved.

(b)(6)

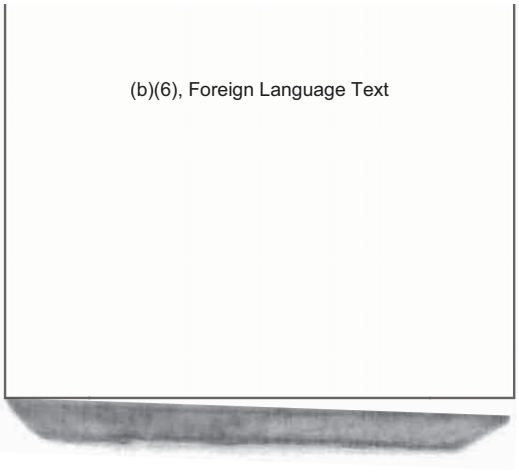
(Signature of Claimant)

CLAIM WILL NOT BE VALID IF SIGNATURE IS LEFT BLANK

The claimant was assisted in completing this claim form by:

(Name)

(Contact Information: e-mail, address, DSN/DNVT, etc.)


(b)(6), Foreign Language Text

(b)(6), Foreign Language Text

REPLY TO
ATTENTION OF:

FICI-JA-C

Claim of (b)(6), 06-I04-T006

ACTION

1. Facts: The claimant alleges that on 6 January 2006, U.S. Forces raided her house and arrested her son and her husband. They had a family of ten children. The U.S. Forces destroyed everything in her house. Her son was released a week later and her husband was found dead in the hospital four months later. The amount requested is $12,000 for the claim.

2. Opinion: The FCA permits compensation for damages caused by the negligent and wrongful acts of US forces. Upon review of the claim, payment is granted.

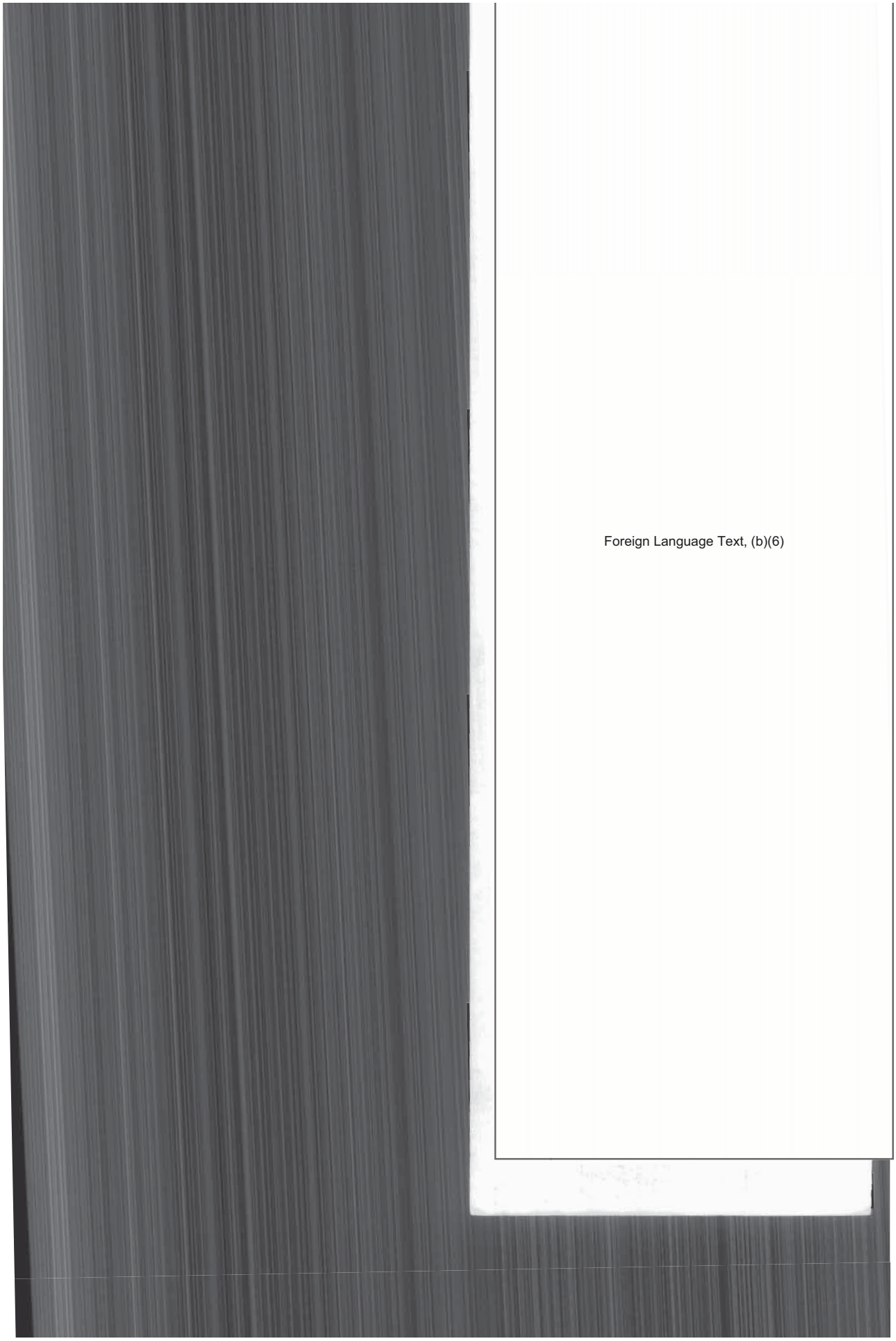
3. Authority: The Foreign Claims Act (10 U.S.C. § 2734) as implemented by AR 27-20, Chapter 10.

4. Action: The claim will be paid in the amount of $12,000

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

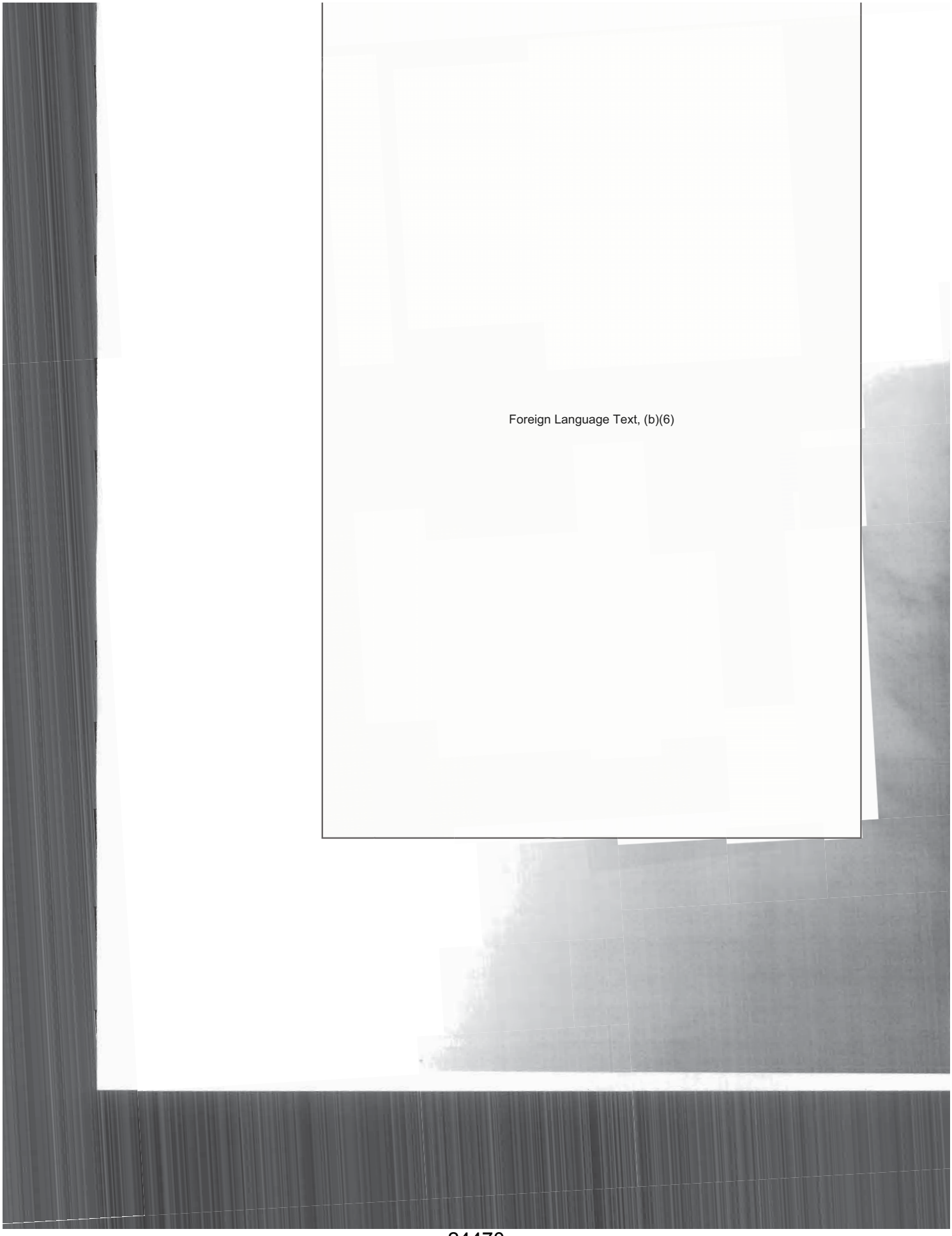
CPT, U.S. Army
FCC I57

UNCLASSIFIED/OFFICIAL USE ONLY


Foreign Language Text, (b)(6)

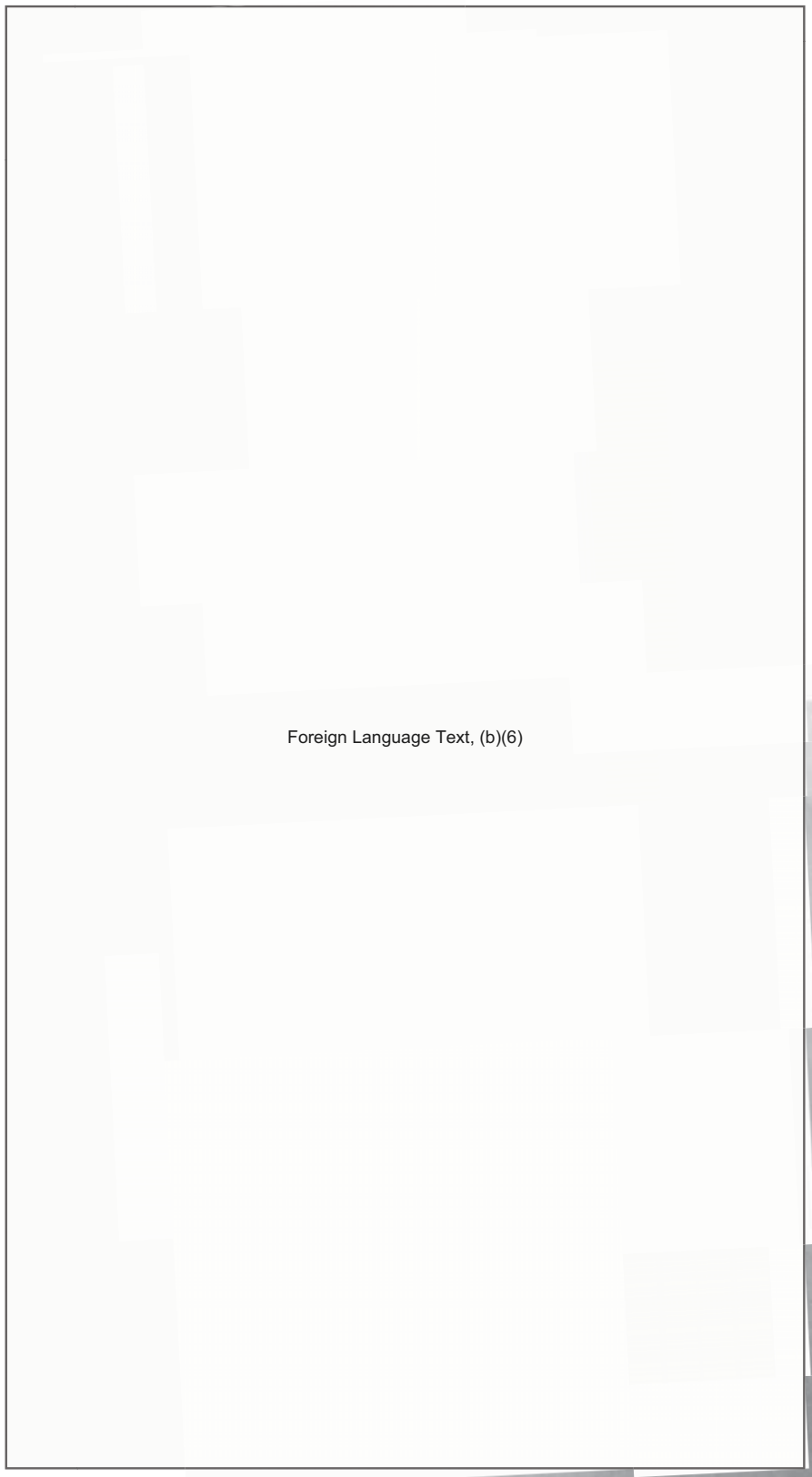

Foreign Language Text, (b)(6)

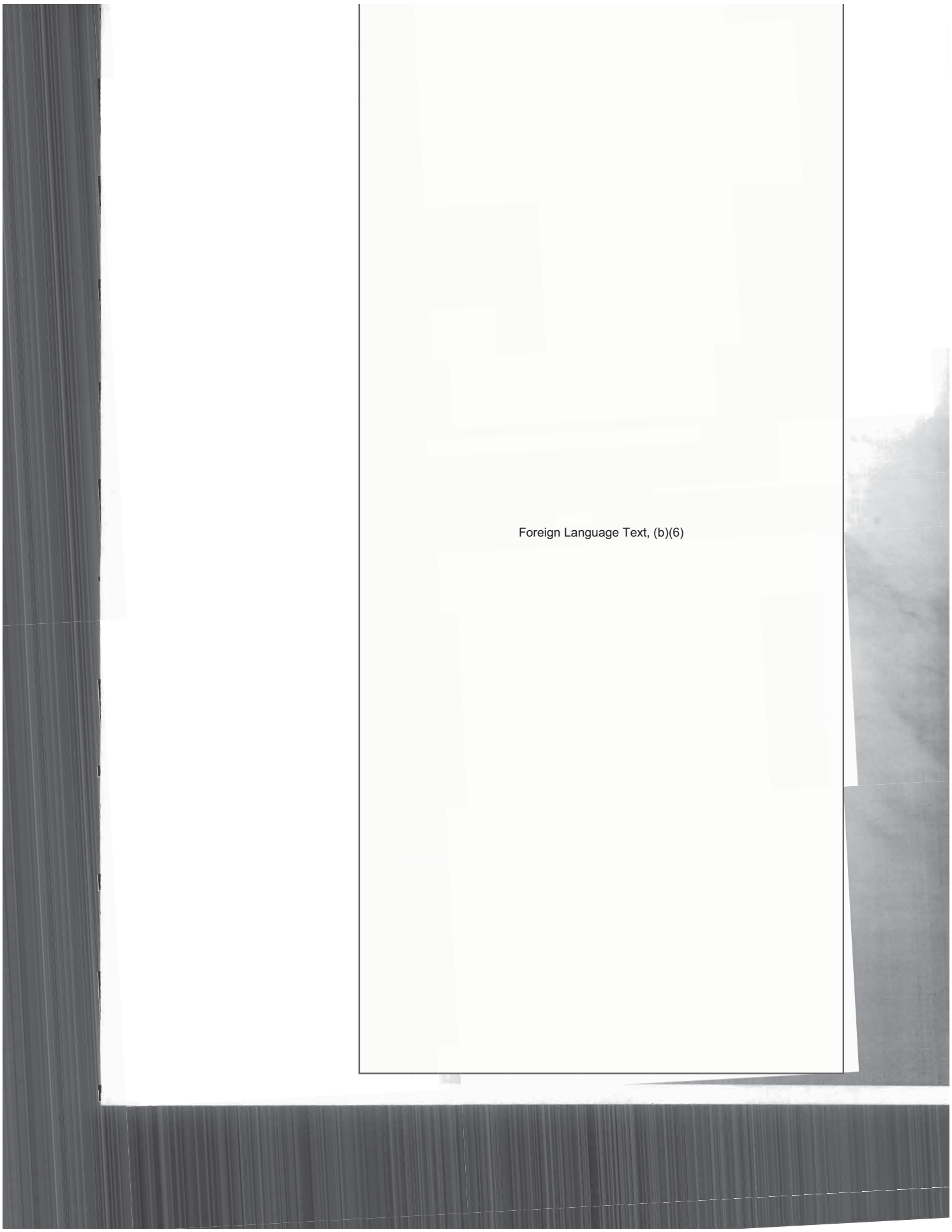

Foreign Language Text, (b)(6)


Foreign Language Text, (b)(6)


Foreign Language Text, (b)(6)

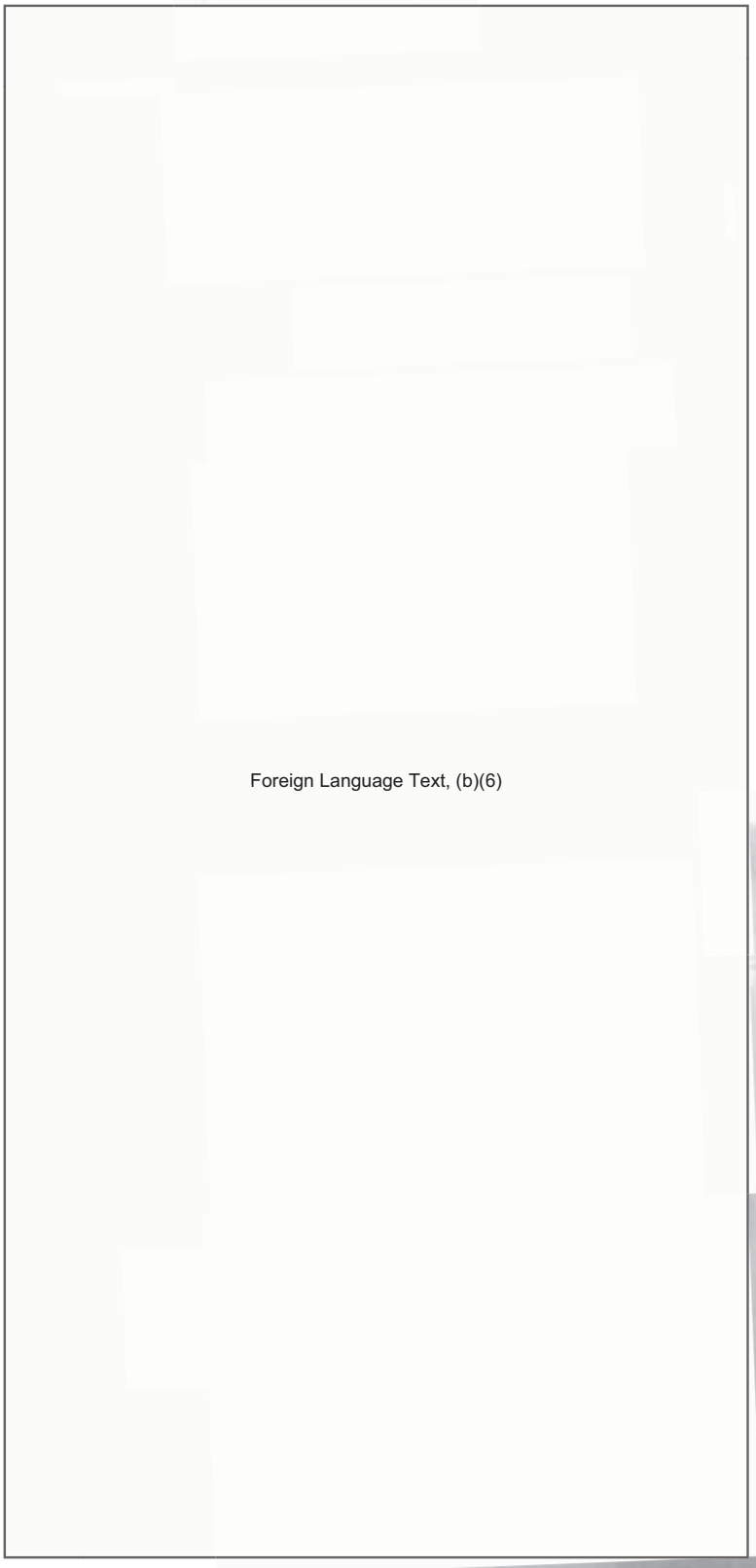
Foreign Language Text, (b)(6)

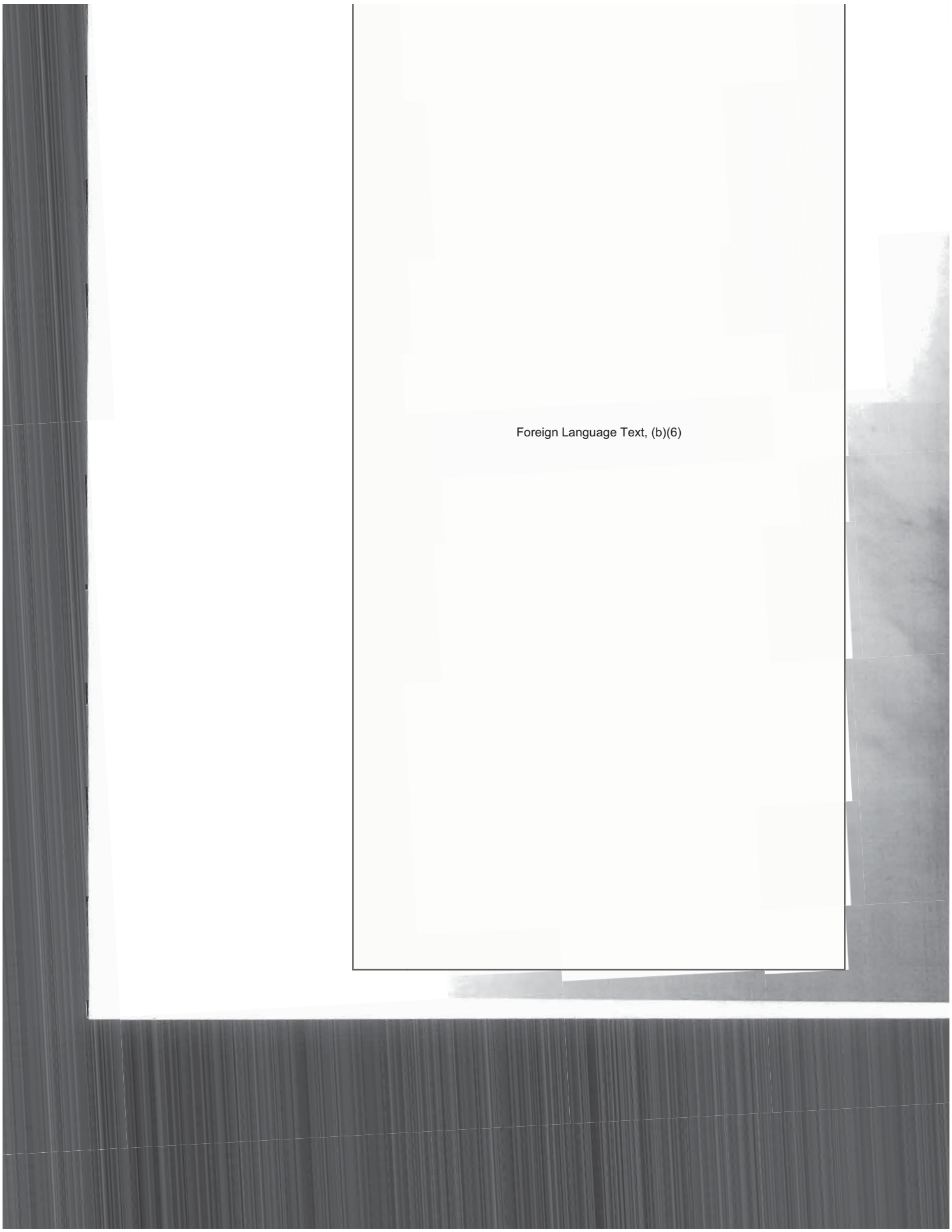

Foreign Language Text, (b)(6)

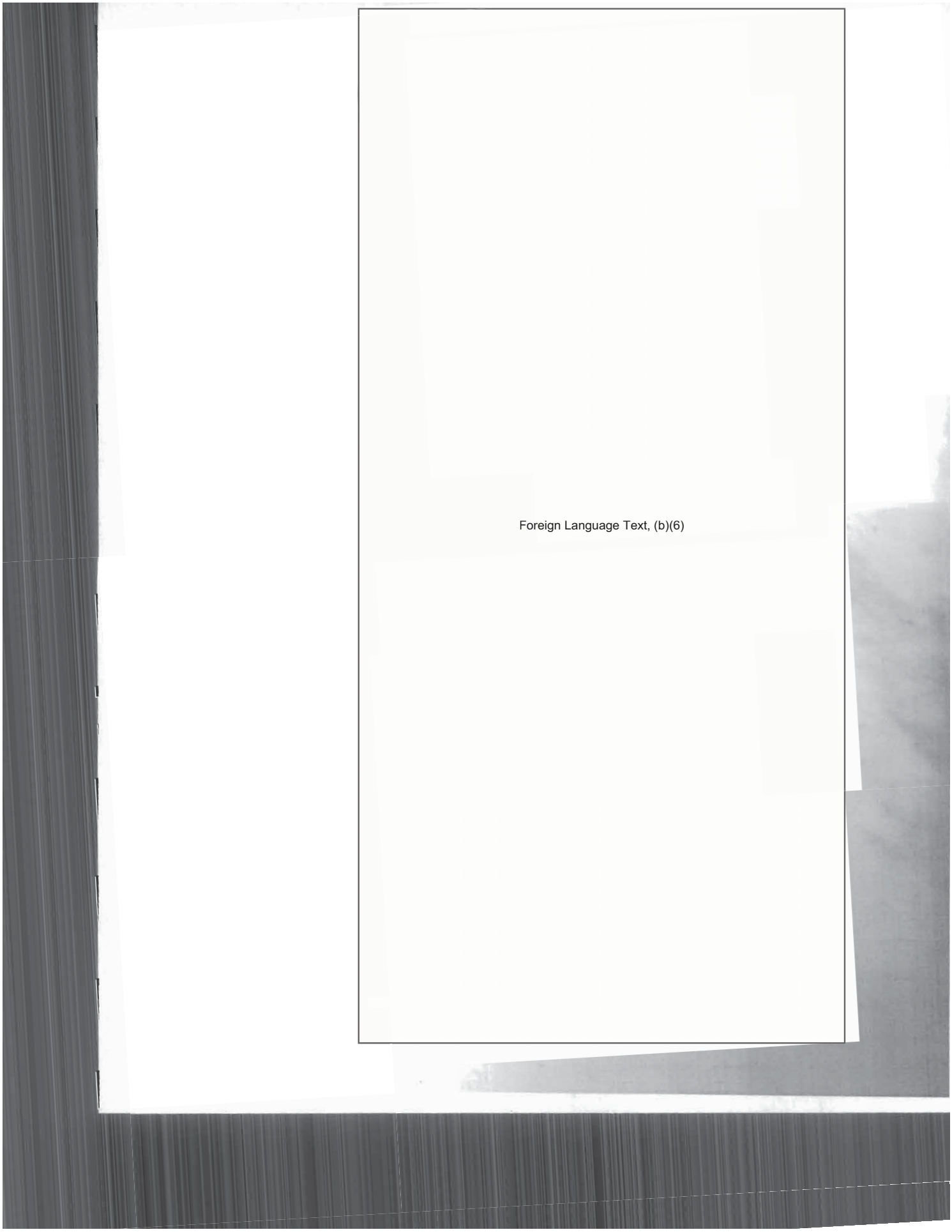

Foreign Language Text, (b)(6)

Foreign Language Text, (b)(6)


Foreign Language Text, (b)(6)


Foreign Language Text, (b)(6)


Foreign Language Text, (b)(6)


Foreign Language Text, (b)(6)

Foreign Language Text, (b)(6)

- Same copy of Death registration

FOREIGN CLAIMS WORKSHEET

Amount Claimed: $ 12,000 Date Reviewed: 30 Jul 06

Date of Incident: 6 Jan 06

Pay: $

Deny:

Need more info:

Need more translation:

NOTES:

Need to check Sig Acts

Family - House destroyed - Rebuilt on new land

Name: (b)(6)

DoB: (b)(6)

Occupation: (b)(6)

Lives: (b)(6) - Falujah

After he took the oath he stated the folowing

On Jan 5th 2004 Mr (b)(6) was Shot by US. Forces. He was treated by American Medic in their medical facillity - On Jan 12, 2004 he was deceased for the result of his wond shot.

Judge (b)(6)

Witness (b)(6)

Witness statement

Date: Jan 26 - 2006

Name: (b)(6)

DoB: 1961

Lives: AL-Taramseem - (b)(6)

After He took the oath he stated the folowing:-

On Jan 12, 2004 Mr (b)(6) has passed away for the result of his wond that caused by shooting from US-forces. who were took him to an Amerieam medical ~~Facility~~ Facillity

Judge (b)(6)

Witness (b)(6)

(b)(6), Foreign Language Text

Witnesses Statements

(b)(6), Foreign Language Text

(b)(6), Foreign Language Text

Foreign Language Text

Foreign Language Text

Claimant Statement

Foreign Language Text, (b)(6)

Page 40 redacted for the following reason:
- -
Foreign Language Text, (b)(6)

Death Registration

Deceased name:

(b)(6)

Foreign Language Text, (b)(6)

Date of death:
Jan 12, 2004

Foreign Language Text, (b)(6)

Foreign Language Text, (b)(6)

Reason for death: Bulets shot

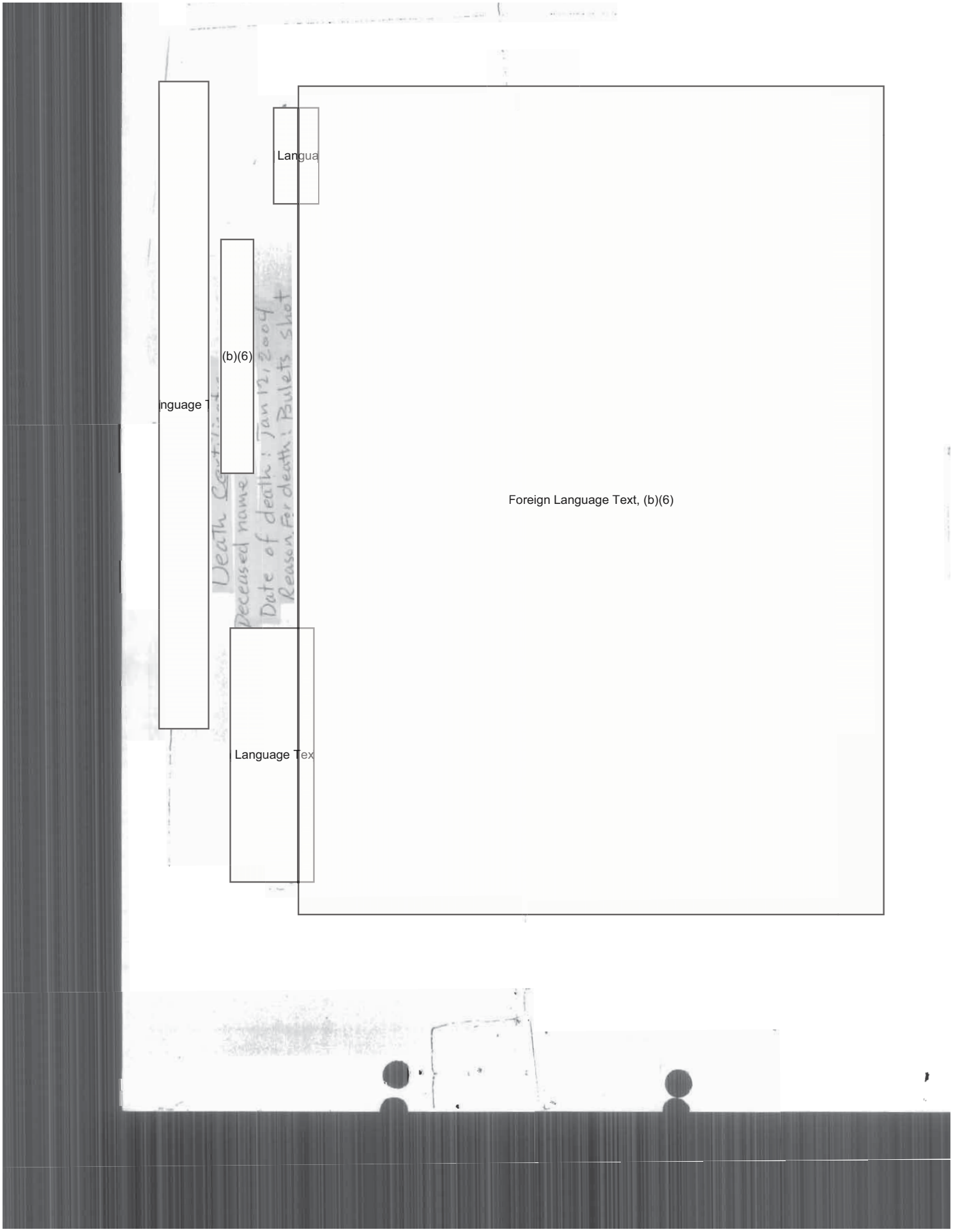
Foreign Language Text

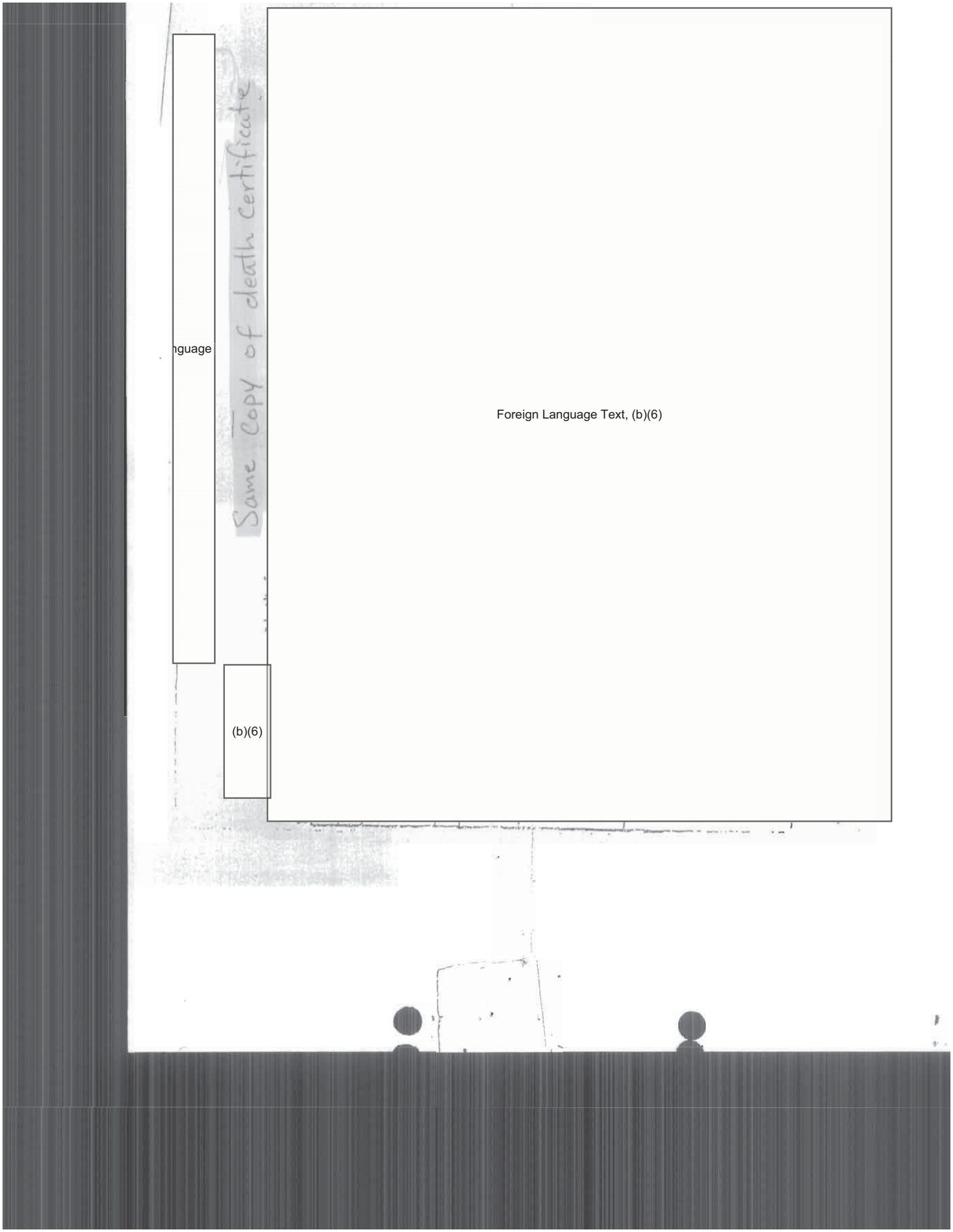
Foreign Language Text, (b)(6)

Foreign Language Text, (b)(6)

Foreign Language Text, (b)(6)

Death Registration
Same Copy


Langua
(b)(6)
nguage T
Death Certificate
Deceased name
Date of death: Jan 12, 2004
Reason for death: Bullets shot
Foreign Language Text, (b)(6)
Language Tex


nguage
Same copy of death certificate
Foreign Language Text, (b)(6)
(b)(6)

ORGANIZATION Organisation: N/A

NATION (e.g., United States) Pays: IRAQ

DATE OF BIRTH Date de naissance: N/S

SEX: ☒ MALE Masculin ☐ FEMALE Féminin

RACE Race
- ☐ CAUCASOID Caucasique
- ☐ NEGROID Négroïde
- ☒ OTHER (Specify) Autre (Spécifier)

MARITAL STATUS État Civil
- ☐ SINGLE Célibataire
- ☐ MARRIED Marié
- ☐ WIDOWED Veuf
- ☐ DIVORCED Divorcé
- ☐ SEPARATED Séparé

RELIGION Culte
- ☐ 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 n'(est)

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 attaque et le décès

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH[1]
Maladie ou condition directement responsable de la mort

Illegible Text, Nonresponsive

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

MODE OF DEATH
Condition de décès
- ☐ NATURAL Mort naturelle
- ☐ ACCIDENT Mort accidentelle
- ☐ SUICIDE Suicide
- ☐ HOMICIDE Homicide

AUTOPSY PERFORMED Autopsie effectuée ☐ YES Oui ☒ NO Non

MAJOR FINDINGS OF AUTOPSY Conclusions principales de l'autopsie

CIRCUMSTANCES SURROUNDING DEATH DUE TO EXTERNAL CAUSES
Circonstances de la mort suscitées par des causes extérieures

NAME OF PATHOLOGIST Nom du pathologiste

SIGNATURE Signature

DATE Date

AVIATION ACCIDENT ☐ YES Oui

(b)(6)

DATE OF DEATH (Hour, day, month, year)
Date de décès (l'heure, le jour, le mois, l'année)
12 Jan 2004

PLACE OF DEATH Lieu de déc
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

NAME OF MEDICAL OFFICER Nom du médicin militaire ou du médicin sanitaire

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

TITLE OR DEGREE Titre ou diplôme
MD

GRADE Grade
O4

INSTALLATION OR ADDRESS Installation ou adresse
ZE-H CSH BAGHDAD IRAQ

DATE Date
12 Jan 04

SIGNA

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

[1] State disease, injury or complication which caused d
[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 complicanon 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 2064, APR 1977 REPLACES DA FORM 3565, 1 JAN 1972 AND DA FORM 3565-RIPASI, 26 SEP 1975, WHICH ARE OBSOLETE USAPA V1.00

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	(b)(6)	
SIGNATURE OF AUTHORIZED INDIVIDUAL			

DD FORM 2064, APR 1977 (BACK) USAPA V1.00

(b)(6)

(b)(6)

ORGANIZ

N/A

DATE OF BIRTH
Date de naissance

N/A

SEX Sexe

[X] MALE Masculin

[ ] FEMALE Féminin

RACE Race

CAUCASOID Caucasique

NEGROID Négroïde

OTHER (Specify)
Autre (Spécifier)

MARITAL STAT

SINGLE Célibataire

MARRIED Marié

WIDOWED Veuf

Etat Civil

DIVORCED
Divorcé

SEPARATED
Séparé

RELIGION Culte

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 sujet

STREET ADDRESS Domicile à (Rue)

CITY, 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

ANY [illegible]

MORBID CONDITION, IF ANY GIVING RISE TO THE ABOVE CAUSE
Maladie morbide, s'il y a lieu, ayant donné la cause primaire

UNDERLYING CAUSE, IF ANY GIVING RISE TO PRIMARY CAUSE
Raison fondamentale, s'il y a lieu, ayant suscité la cause primaire

Illegible Text, Nonresponsive

OTHER SIGNIFICANT CONDITIONS[2]
Autres conditions significatives

MODE OF DEATH
Condition de décès

NATURAL
Mort naturelle

ACCIDENT
Mort accidentelle

SUICIDE
Suicide

HOMICIDE
Homicide

AUTOPSY PERFORMED Autopsie effectuée — YES Oui — [X] NO Non

MAJOR FINDINGS OF AUTOPSY Constatations principales de l'autopsie

CIRCUMSTANCES SURROUNDING DEATH DUE TO EXTERNAL CAUSES
Circonstances de la mort dues aux causes extérieures

NAME OF PATHOLOGIST Nom du pathologiste

SIGNATURE Signature

DATE Date

AVIATION ACCIDENT Accident d'Avion — [ ] YES Oui — [X] NO Non

DATE OF DEATH (Hour, day, month, year)
Date de décès (Heure, le jour, le mois, l'année)

12 Jan 2004

PLACE OF DEATH Lieu de décès

(b)(6)

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 il apparaît que le décès est survenu à l'heure indiquée et à la suite des causes énumérées ci-dessus

NAME [illegible] du médecin militaire ou du médecin sanitaire

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

MATTMC

TITLE OR DEGREE Titre ou diplôme

MD

GRADE Grade

O4

INSTALLATION OR ADDRESS Installation ou adresse

ZBK CSH SHAHBAD IRAQ

DATE Date

12 Jan 04

SIGNATURE

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

[1] State disease, injury or complication which caused death.
[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 entraîné la mort, sans en indiquer la manière de mourir, telle que l'arrêt du cœur, etc.
[2] Préciser la condition qui a contribué à la mort, mais n'ayant aucun rapport avec la maladie ou la condition qui a entraîné la mort.

DD FORM 2064, APR 1977 REPLACES DA FORM 3555, 1 JAN 1972 AND DA FORM 3555-R(PASI), 26 SEP 1975, WHICH ARE OBSOLETE

NAME OF MORTICIAN PREPARING REMAINS

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

VITAL STATISTICS

REGISTRY (Town and County)

DATE REGISTERED

FILE NUMBER

STATE

OTHER

NAME OF FUNERAL DIRECTOR

ADDRESS

SIGNATURE OF AUTHORIZED INDIVIDUAL

DD FORM 2064, APR 1977 (BACK)

USAPA V1.00

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

NAME OF DECEASED (Last, First, Middle) Nom du décédé (Nom et prénoms)

(b)(6)

GRADE Grade

BRANCH OF SERVICE Arme

N/A

SOCIAL SECURITY NUMBER

(b)(6)

ORGANIZATION Organization

N/A

DATE OF BIRTH Date de naissance

N/A

SEX

☒ MALE Masculin

☐ FEMALE Féminin

RACE Race

CAUCASOID Caucasoïde

NEGROID Négroïde

OTHER (Specify) Autre (Spécifier)

X

MARITAL STATUS

SINGLE Célibataire

MARRIED Marié

WIDOWED Veuf

DIVORCED Divorcé

SEPARATED Séparé

RELIGION Culte

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 suivant

STREET ADDRESS Domicile à (Rue)

CITY, 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'inscrire qu'une cause par ligne.

INTERVAL BETWEEN ONSET AND DEATH Intervalle entre attaque et le décès

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Maladie ou condition qui a directement provoqué la mort

Illegible Text, Nonresponsive

MORBID CONDITION, IF ANY Etat morbide, s'il y a eu, ayant donné la cause primaire

UNDERLYING CAUSE, IF ANY, GIVING RISE TO PRIMARY CAUSE Raison fondamentale, s'il y a eu, ayant donné la cause primaire

OTHER SIGNIFICANT CONDITIONS[2] Autres conditions significatives[2]

MODE OF DEATH Condition de décès

NATURAL Mort naturelle

ACCIDENT Mort accidentelle

SUICIDE Suicide

HOMICIDE Homicide

AUTOPSY PERFORMED Autopsie effectuée ☐ YES Oui ☒ NO Non

MAJOR FINDINGS OF AUTOPSY Conclusions principales de l'autopsie

NAME OF PATHOLOGIST Nom du pathologiste

SIGNATURE Signature

DATE Date

CIRCUMSTANCES SURROUNDING DEATH DUE TO EXTERNAL CAUSES Circonstances de la mort suscitées par des causes extérieures

AVIATION ACCIDENT Accident d'Avion ☐ YES Oui ☒ NO Non

DATE OF DEATH (Hour, day, month, year) Date de décès (l'heure, le jour, le mois, l'année)

2 Jan 2004

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.
J'ai examiné les restes mortels du défunt et j'atteste 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 ... ou du officier sanitaire

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

TITLE OR DEGREE Titre ou diplôme

MD

GRADE

CPT

INSTALLATION OR ADDRESS Installation ou adresse

28th CSH BAGHDAD IRAQ

DATE Date

12 Jan 04

SIGNATURE

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

[1] State disease, injury or complication which caused death.
[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 provoqué la mort, sans en indiquer le mode, 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 la condition qui a provoqué la mort.

DD FORM 2064, APR 1977 REPLACES DA FORM 3565, 1 JAN 1972 AND DA FORM 3565-R(PAS), 26 SEP 1978, WHICH ARE OBSOLETE.

(b)(6)

(b)(6)

ORGANIZATION Organisation

N/A

DATE OF BIRTH Date de naissance

N/A

SEX Sexe

MALE Masculin

FEMALE Féminin

RACE Race

CAUCASOID Caucasoïde

NEGROID Négroïde

OTHER (Specify) Autre (Spécifier)

MARITAL STAT

SINGLE Célibataire

MARRIED Marié

WIDOWED Veuf

DIVORCED Divorcé

SEPARATED Séparé

RELIGION

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 sujet

STREET ADDRESS Domicile à (Rue)

CITY TOWN AND STATE (Include ZIP Code) Ville (Code postal compris)

MEDICAL STATEMENT

CAUSE OF DEATH (Enter only one cause per line)

Cause du décès (N'indiquer qu'une cause par ligne)

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

Illegible Text, Nonresponsive

OTHER SIGNIFICANT CONDITIONS

Autres conditions significatives

MODE OF DEATH

NATURAL

ACCIDENT

SUICIDE

HOMICIDE

AUTOPSY PERFORMED Autopsie effectuée YES Oui NO Non

MAJOR FINDINGS OF AUTOPSY

NAME OF PATHOLOGIST Nom du pathologiste

SIGNATURE Signature

DATE Date

CIRCUMSTANCES SURROUNDING DEATH DUE TO EXTERNAL CAUSES

AVIATION ACCIDENT Accident d'Avion YES Oui NO Non

DATE OF DEATH (Hour, day, month, year)

Date de décès (l'heure, le jour, le mois, l'année)

12 Jan 2004

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

J'ai examiné les restes mortels du défunt et 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 fonctionnaire

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

TITLE OR DEGREE Titre ou diplôme

MD

GRADE Grade

O-4

INSTALLATION OR ADDRESS Installation ou adresse

28 CSH BAGHDAD IRAQ

DATE Date

12 Jan 04

SIGNATURE

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

1 State disease, injury or complication which caused death.

2 State conditions contributing to the death, but not related

1 Préciser la nature de la maladie, de la blessure ou de la complication qui a entraîné la mort, sans oublier la manière de mourir, telle qu'une chute de cheval ou

2 Préciser la condition qui a contribué à la mort, mais n'ayant aucun rapport avec la maladie ou la condition qui a entraîné la mort.

DD FORM 2064, APR 1977 REPLACES DA FORM 2668, 1 JAN 1972 AND DA FORM 2665-R(PAS), 26 SEP 1975, WHICH ARE OBSOLETE

(REMOVE, REVERSE, AND RE-INSERT ... ONS 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	**VITAL STATISTICS**	
REGISTRY (Town and County)	DATE REGISTERED	FILE NUMBER
		STATE / OTHER
NAME OF FUNERAL DIRECTOR	ADDRESS	
SIGNATURE OF AUTHORIZED INDIVIDUAL		

DD FORM 2064, APR 1977 (BACK)

USAPA V1.00

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

VITAL STATISTICS

REGISTRY (Town and County)

DATE REGISTERED

FILE NUMBER

STATE

OTHER

NAME OF FUNERAL DIRECTOR

ADDRESS

SIGNATURE OF AUTHORIZED INDIVIDUAL

DD FORM 2064, APR 1977 (BACK)

USAPA V1.20

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

NAME OF DECEASED (Last, First, Middle) Nom du décédé (Nom et prénoms)
(b)(6)

GRADE Grade: N/A

BRANCH OF SERVICE Arme: N/A

SOCIAL SECURITY NUMBER Numéro de l'Assurance Sociale
(b)(6)

ORGANIZATION Organisation: N/A

NATION (e.g. United States) Pays: IRAQ

DATE OF BIRTH Date de naissance: N/A

SEX Sexe: ☒ MALE Masculin ☐ FEMALE Féminin

RACE Race	MARITAL STATUS État Civil		RELIGION Culte	
☐ CAUCASOID Caucasique	☐ SINGLE Célibataire	☐ DIVORCED Divorcé	☐ PROTESTANT Protestant	☐ OTHER (Specify) Autre (Spécifier)
☐ NEGROID Négroïde	☐ 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 [illegible]

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 attaque et le décès

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 [illegible] 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

Illegible Text, Nonresponsive

OTHER SIGNIFICANT CONDITIONS[2]
Autres conditions significatives[2]

MODE OF DEATH Condition de décès

☐ NATURAL Mort naturelle
☐ ACCIDENT Mort accidentelle
☐ SUICIDE Suicide
☐ HOMICIDE Homicide

AUTOPSY PERFORMED Autopsie effectuée ☐ YES Oui ☒ NO Non

MAJOR FINDINGS OF AUTOPSY Conclusions principales de l'autopsie

NAME OF PATHOLOGIST Nom du pathologiste

SIGNATURE Signature

DATE Date

CIRCUMSTANCES SURROUNDING DEATH DUE TO EXTERNAL CAUSES
Circonstances de la mort suscitées par des causes extérieures

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)
12 Jan 2009

PLACE OF DEATH Lieu de déc
BAGHDAD IRQ

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 mentionnées ci-dessus.

NAME OF MEDICAL OFFICER Nom du médecin militaire ou du médecin sanitaire
(b)(3)(b)(6)

TITLE OR DEGREE Titre ou diplôme: MD

GRADE Grade: O4

INSTALLATION OR ADDRESS Installation ou adresse: ZEB CSH BAGHDAD IRAQ

DATE Date: 12 Jan 09

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

[1] State disease, injury or complication which caused death.
[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 2064, APR 1977 REPLACES DA FORM 3565, 1 JAN 1972 AND DA FORM 3565-R(PASI), 26 SEP 1975, WHICH ARE OBSOLETE. USAPA V1.00

ORGANIZATION Organisation: N/A

NATION (e.g., United States) Pays: IRAQ

DATE OF BIRTH Date de naissance: N/K

☒ MALE Masculin ☐ FEMALE Féminin

RACE Race	MARITAL STATUS État Civil		RELIGION Culte
☐ CAUCASOID Caucasique	☐ SINGLE Célibataire	☐ DIVORCED Divorcé	☐ PROTESTANT Protestant
☐ NEGROID Négroïde	☐ MARRIED Marié	☐ SEPARATED Séparé	☐ CATHOLIC Catholique
☒ OTHER (Specify) Autre (Spécifier)	☐ WIDOWED Veuf		☐ 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 Domicile 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: CARDIAC ARREST

Illegible Text, Nonresponsi

ANTECEDENT CAUSES	MORBID CONDITION, IF ANY, LEADING TO PRIMARY CAUSE
Symptômes précurseurs de la mort:	UNDERLYING CAUSE, IF ANY, GIVING RISE TO PRIMARY CAUSE

Illegible Text, Nonresponsive

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 d'Avion ☐ YES Oui ☒ NO Non

DATE OF DEATH (Hour, day, month, year)
Date de décès (l'heure, le jour, le mois, l'année): 12 Jan 2004

PLACE OF DEATH Lieu de déc: 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

NAME OF MEDICAL OFFICER Nom du médicin militaire ou du médicin sanitaire: (b)(3)(b)(6)

TITLE OR DEGREE Titre ou diplôme: MD

GRADE Grade: O4

INSTALLATION OR ADDRESS Installation ou adresse: ZEB CSH BAGHDAD IRAQ

DATE Date: 12 Jan 04

SIGNATURE: (b)(3)(b)(6)

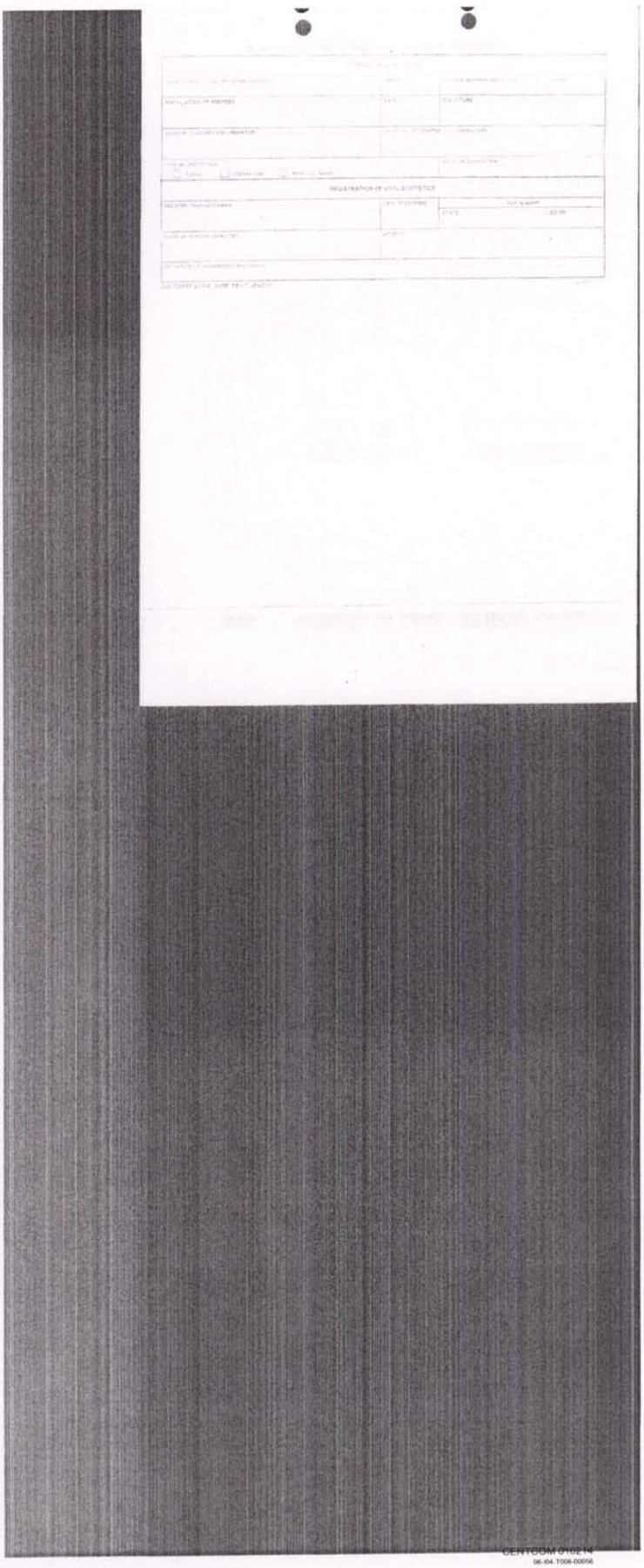
[1] State disease, injury or complication which caused death, but not related to the disease or condition causing death.
[2] State conditions contributing to the death, but not related to the disease or condition causing death.
[1] Préciser la nature de la maladie, de la blessure ou de la complication 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.

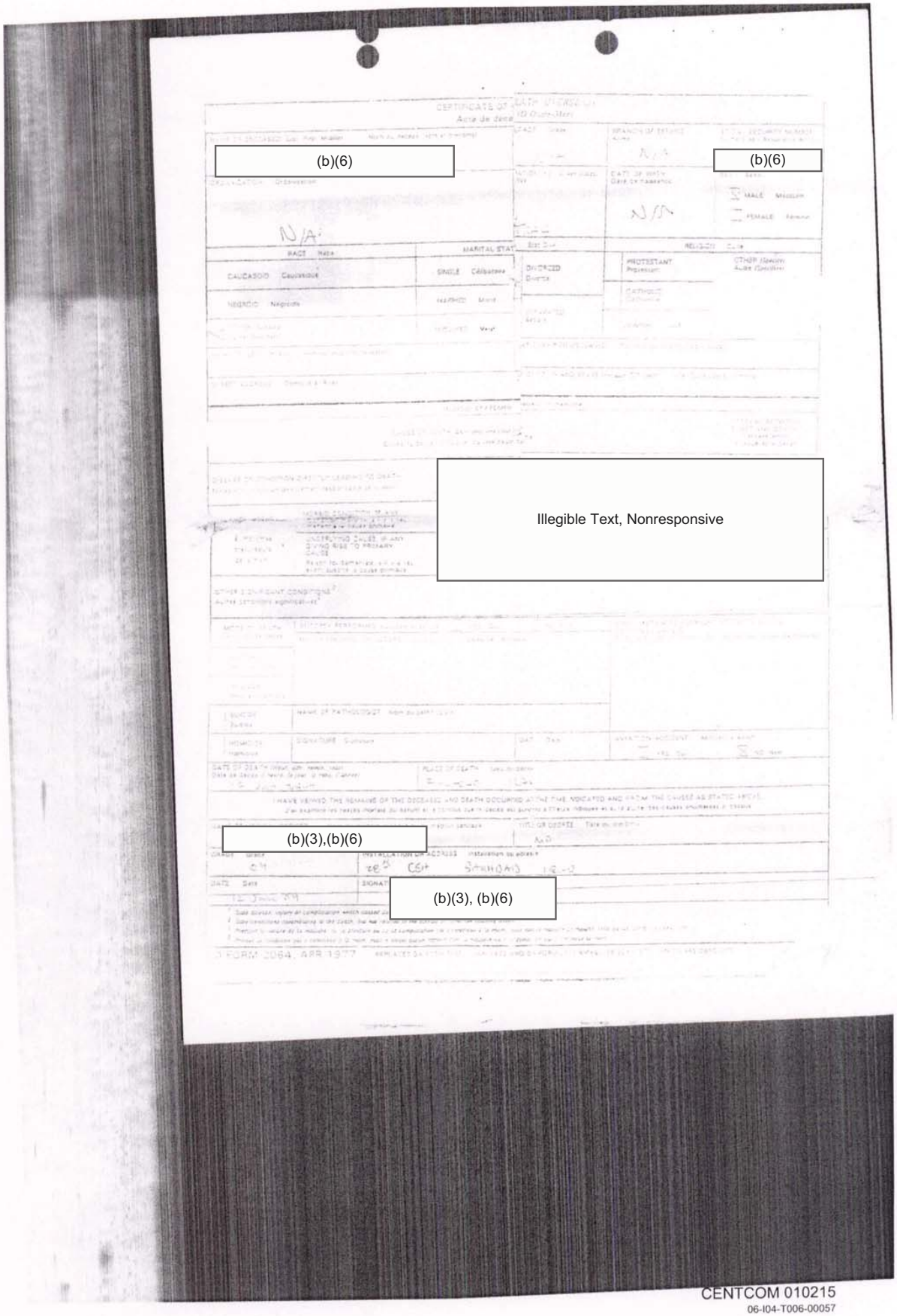
DD FORM 2064, APR 1977 REPLACES DA FORM 3565, 1 JAN 1972 AND DA FORM 3565-R/PASI, 28 SEP 1975, WHICH ARE OBSOLETE. USAPA V1.00

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




(b)(6)
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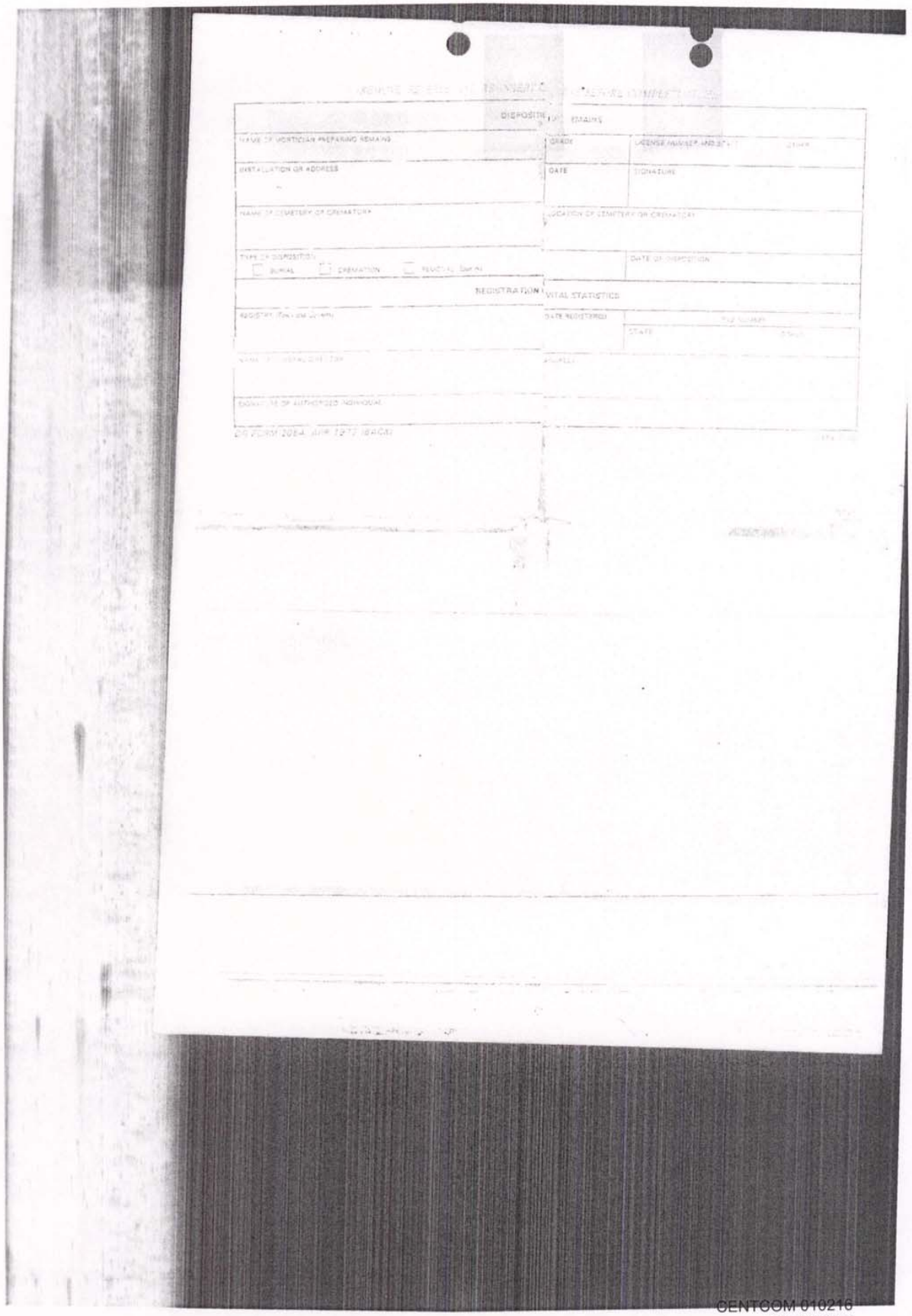
(b)(3), (b)(6)
CENTCOM 010215
06-I04-T006-00057



DISPOSITION OF REMAINS

NAME OF MORTICIAN PREPARING REMAINS

GRADE

LICENSE (NUMBER AND STATE)

INSTALLATION OR ADDRESS

DATE

SIGNATURE

NAME OF CEMETERY OR CREMATORY

LOCATION OF CEMETERY OR CREMATORY

TYPE OF DISPOSITION

☐ BURIAL ☐ CREMATION ☐ PRIVATE (Specify)

DATE OF DISPOSITION

REGISTRATION

VITAL STATISTICS

REGISTRY (Name and address)

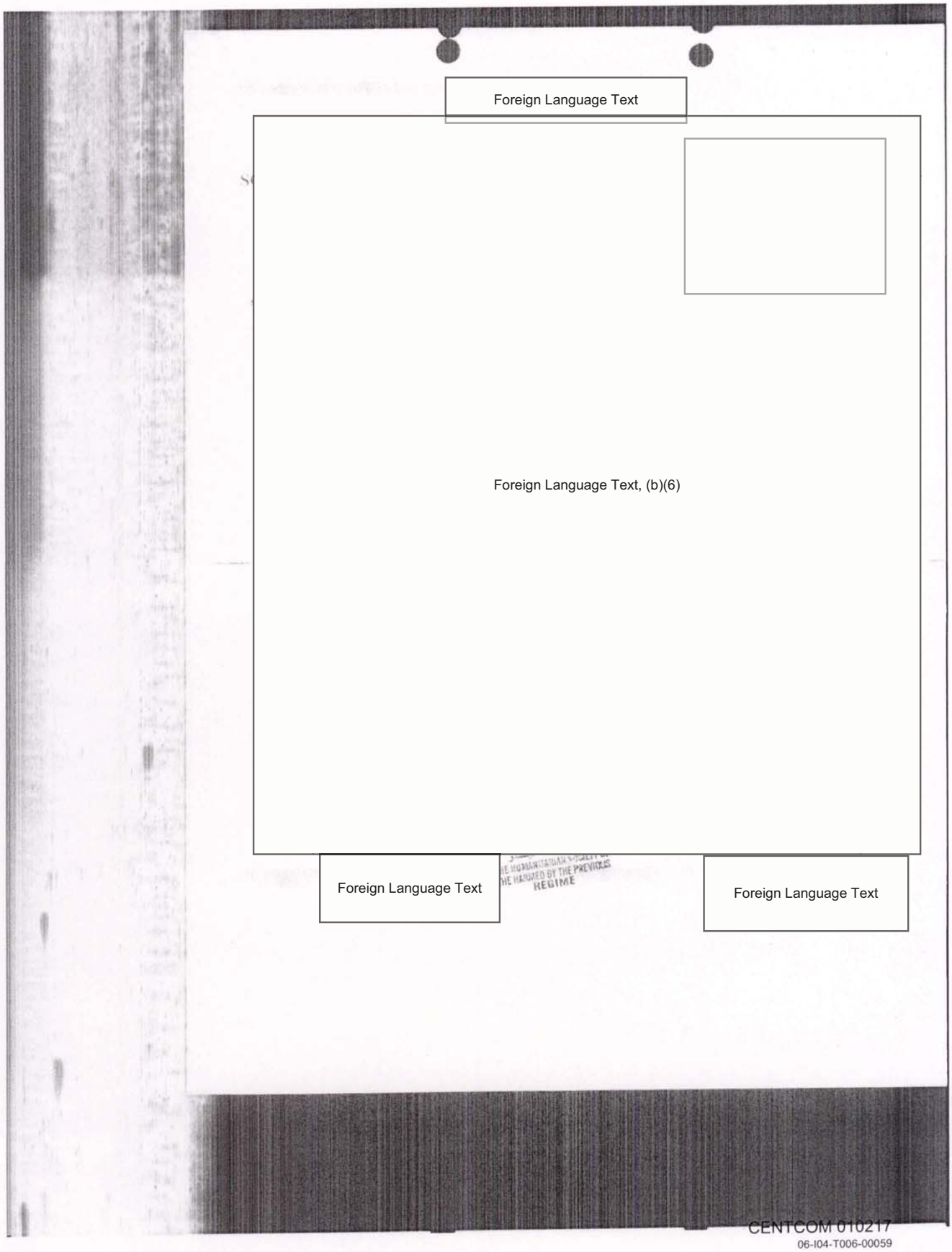
DATE REGISTERED

STATE

NAME OF INSTALLATION

SIGNATURE OF AUTHORIZED INDIVIDUAL

DD FORM 2064, JUN 1972 (BACK)



CENTCOM 010217
06-I04-T006-00059

Foreign Language Text

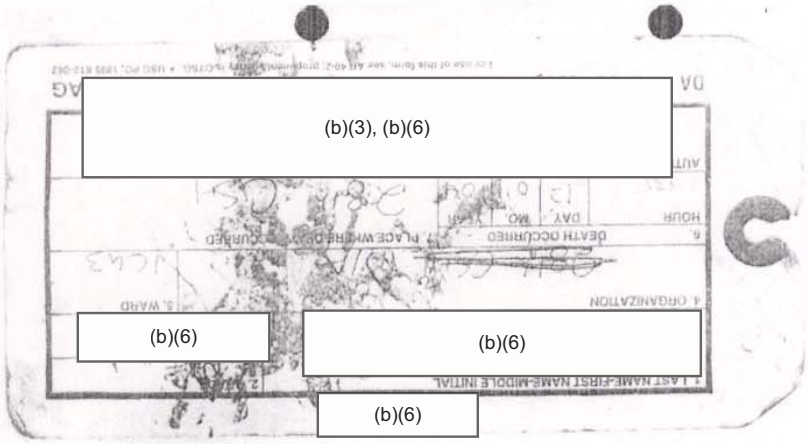
THE HUMANITARIAN SOCIETY OF THE HARMED BY THE PREVIOUS REGIME

Foreign Language Text

Foreign Language Text

Foreign Language Text

Foreign Language Text



Foreign Language Text, (b)(6)

CENTCOM 010219
06-I04-T006-00061

Pages 7 through 9 redacted for the following reasons:
- -
Already Reviewed and Redacted for Release

(b)(6)

CENTCOM 010223
06-I04-T006-00065