

HOSPITAL REPORT OF DEATH

NAME AND LOCATION OF HOSPITAL

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FOR USE OF THIS FORM SEE AR 4040. THE PROPONENT AGENCY IS OFFICE OF THE SURGEON GENERAL.

TF 31ST CSH CAMP BUCCA, IRAQ APO AE 09375

Prepare, in one copy only, Items 1 through 10 and sign Item 11.
Print or type entries.

Instructions - Medical Officer in attendance will:
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)
ABDUL ABDUL HAMEED
US91Z-186925CI
REGISTER#25853

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)
0745 09 JUNE 2007

4. RELIGION
ISLAM

6. NAME, ADDRESS AND RELATIONSHIP OF RELATIVE OR FRIEND PRESENT AT DEATH

3. MEDICAL EXAMINER/ CORONER'S CASE
 YES NO

5. CHAPLAIN NOTIFIED
 YES NO

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

7a. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death)

DUE TO (or as a consequence of)
PENETRATING TRAUMA TO HEAD

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) MORTAR BLAST
(2)

8. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

a.
b.

9. DATE
09 June 2007

10. TYPED OR PRINTED NAME AND GRADE OF MEDICAL OFFICER IN ATTENDANCE
F. ...

(b)(3); 10 U.S.C. 130(b); (b)(6)

SECTION B - ADMINISTRATIVE ACTION

TYPE OF ACTION	HOUR	DAY	MONTH	YEAR	INITIALS OF RESPONSIBLE OFFICER
12. TELEGRAM TO NEXT OF KIN OR OTHER AUTHORIZED PERSON					
13. POST ADJUTANT GENERAL NOTIFIED					
14. IMMEDIATE CO OF DECEASED NOTIFIED					
15. INFORMATION OFFICE NOTIFIED					
16. POST MORTUARY OFFICER NOTIFIED					
17. RED CROSS NOTIFIED					
18. OTHER (Specify)					
19.					

SECTION C - RECORD OF AUTOPSY

20. AUTOPSY PERFORMED (If yes, give date and place)
 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

MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE

SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)

9 JUNE 2007

DEATH NOTE

PT BROUGHT TO CBH During MASSAL
2 MASSIVE PENETRATING TRAUMA TO HEAD
φ Pulse φ Respiration
Pronounced DDA.

(b)(3):10 U.S.C. 130(b),(b)(6)

HOSPITAL OR MEDICAL FACILITY

STATUS

DEPART./SERVICE

RECORDS MAINTAINED AT

SPONSOR'S NAME

SSN/ID NO.

RELATIONSHIP TO SPONSOR

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle, ID No or SSN, Sex; Date of Birth; Rank/Grade.)

REGISTER NO.

WARD NO.

ABDUL ABDUL HAMEED
(b)(6) M

02 JAN 1987
DETAINEE

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRM (41 CFR) 201-9.202-1

USAPA V2.00

STATEMENT OF IDENTIFICATION

For use of this form, see AR 638-2; the proponent agency is ODCSPER

NAME OF DECEASED (Last, First, MI)	GRADE	SSN	BRANCH OF SERVICE	DATE OF INCIDENT
ABDUL. ABDUL HAMEED	SI	(b)(6)	DETAINEE	09JUN07
ORGANIZATION AND BASE			PLACE OF DEATH/INCIDENT	
DETAINEE			CAMP BUCCA	

CONDITION OF REMAINS (Describe briefly in Narrative below)

<input checked="" type="checkbox"/> Recognizable	<input type="checkbox"/> Not Recognizable	<input type="checkbox"/> Commingled	<input type="checkbox"/> Mutilated
<input type="checkbox"/> Burned	<input type="checkbox"/> Decomposed	<input type="checkbox"/> Semi-Skeletal	<input type="checkbox"/> Skeletal

MEANS OF IDENTIFICATION (Check all appropriate boxes. Specify supporting data in Narrative below)

<input type="checkbox"/> Fingerprint Comparison	<input type="checkbox"/> Footprint Comparison	<input type="checkbox"/> Dental Comparison	<input type="checkbox"/> Anatomical Comparison
<input type="checkbox"/> Skeletal Comparison	<input type="checkbox"/> Personal Effects	<input type="checkbox"/> Visual Recognition	<input type="checkbox"/> Identification Tag(s)
<input checked="" type="checkbox"/> Other (Explain in Narrative)			

ENCLOSURES

<input type="checkbox"/> DD Form 565	<input type="checkbox"/> DD Form 890	<input type="checkbox"/> DD Form 891	<input type="checkbox"/> DD Form 892
<input type="checkbox"/> DD Form 893	<input type="checkbox"/> DD Form 894	<input type="checkbox"/> DD Form 897	<input type="checkbox"/> ID Card
<input type="checkbox"/> DD Form 369	<input type="checkbox"/> FD 258	<input type="checkbox"/> AF Form 137	<input type="checkbox"/> SF 603
<input type="checkbox"/> Dental X-Rays	<input type="checkbox"/> SF 88	<input type="checkbox"/> SF 93	<input checked="" type="checkbox"/> DD Form 2084
<input type="checkbox"/> SF 601	<input type="checkbox"/> Photo	<input checked="" type="checkbox"/> SF 600	<input checked="" type="checkbox"/> DD FORM 3894

NARRATIVE AND SUMMARY (Continue on reverse or use additional sheets, if required)

IDENTIFIED THROUGH D.M.S., IRIS SCAN AND PHOTOGRAPH.

CERTIFICATE OF DEATH

For use of this form, see AR 190-8; the proponent agency is OCSPER.

INTERN.

SERIAL NUMBER

US91Z-186925C1

FROM: TF 31st CAMP BUCCA, IRAQ APO AE 09375

TO:

NAME (Last, first, MI) ABDUL ABDUL HAMEED		GRADE N/A	SERVICE NUMBER ISN (b)(7)(E)
NATIONALITY IRAQ	POWER SERVED	PLACE OF CAPTURE/INTERMENT AND DATE SALAH AD DIN, IRAQ	
PLACE OF BIRTH SALAH AD DIN, IRAQ		DATE OF BIRTH 02 JANUARY 1987	
NAME, ADDRESS, AND RELATIONSHIP OF NEXT OF KIN		FIRST NAME OF FATHER	
PLACE OF DEATH CAMP BUCCA, IRAQ	DATE OF DEATH 09 JUNE 2007	CAUSE OF DEATH PENETRATING TRAUMA TO HEAD	
PLACE OF BURIAL	DATE OF BURIAL		IDENTIFICATION OF GRAVE

PERSONAL EFFECTS (To be filled in by Office of Deputy Chief of Staff for Personnel)

RETAINED BY DETAINING POWER
 FORWARDED WITH DEATH CERTIFICATE TO (Specify)
 FORWARDED SEPARATELY TO (Specify)

BRIEF DETAILS OF DEATH/BURIAL BY PERSON WHO CARED FOR THE DECEASED DURING ILLNESS OR DURING LAST MOMENTS (Doctor, Nurse, Minister of Religion, Fellow Inmate). IF CREMATED, GIVE REASON. (If more space is required, continue on reverse side).

DO NOT WRITE IN THIS SPACE CERTIFIED A TRUE COPY	DATE 9 JUNE 2007	(b)(3); 10 U.S.C. 130(b); (b)(6)
	SIGNATURE OF COMMANDING OFFICER (b)(3); 10 U.S.C. 130(b); (b)(6)	
	(b)(3); 10 U.S.C. 130(b); (b)(6)	ADDRESS TF 31 CAMP BUCCA APO AE 09375
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