

b(6)-4

CERTIFICATE OF DEATH (OVERSEAS) Acte de décès (D'Outre-Mer)			
NAME OF DECEASED Nom (Prénoms)	GRADE Grade DETAINÉ	BRANCH OF SERVICE Arme DETAINÉE	SOCIAL SECURITY NUMBER Numéro de l'Assurance Sociale
ORGANIZATION Organisation (e.g., United States)	DATE OF BIRTH Date de naissance	SEX Sexe <input checked="" type="checkbox"/> MALE Masculin <input type="checkbox"/> FEMALE Féminin	
RACE Race	MARITAL STATUS État Civil	RELIGION Culte	
CAUCASOID Caucasique	SINGLE Célibataire	PROTESTANT Protestant	OTHER (Specify) Autre (Spécifier)
NEGROID Négróide	MARRIED Marié	CATHOLIC Catholique	
OTHER (Specify) Autre (Spécifier) ARAB	WIDOWED Veuf	JEWISH Juif	
NAME OF NEXT OF KIN Nom du plus proche parent UNKNOWN	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) b(6)-2	

MEDICAL STATEMENT Déclaration médicale	
CAUSE OF DEATH (Enter only one cause per line) Cause du décès (N'indiquer qu'une cause par ligne)	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <sup>1</sup> Maladie ou condition directement responsable de la mort:	OSW to Abdomen
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 renal failure
	UNDERLYING CAUSE, IF ANY, GIVING RISE TO PRIMARY CAUSE Raison fondamentale, s'il y a lieu, ayant suscité la cause primaire Traumatic injury secondary to Gun shot wound to the abdomen
OTHER SIGNIFICANT CONDITIONS <sup>2</sup> Autres conditions significatives	

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 Heart	
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) 23 Nov 03 1113 hrs	PLACE OF DEATH Lieu du décès b(6)-2
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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 MEDIC Nom du médecin militaire ou du médecin sanitaire M.D.	TITLE OR DEGREE Titre ou diplôme M.D.
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GRADE Grade OS	INSTALLATION OR ADDRESS Installation ou adresse b(6)-2
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DATE Date 23 Nov 03	SIGNATURE Signature b(6)-4
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<sup>1</sup> State disease, injury or complication which caused death, but not the primary cause of death, e.g., pneumonia, etc.  
<sup>2</sup> State conditions contributing to the death, but not related to the disease or injury causing death.  
<sup>1</sup> Préciser la nature de la maladie, de la blessure ou de la complication qui a contribué à la mort, mais ne la manière de mourir, telle qu'un arrêt du coeur, etc.  
<sup>2</sup> 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.

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### HOSPITAL REPORT OF DEATH

NAME AND LOCATION OF HOSPITAL

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

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)

*[REDACTED]* *ETA (DETAINEE)*

*[REDACTED]*

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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)

*0113*

3. MEDICAL EXAMINER/ CORONER'S CASE

YES  NO

4. RELIGION

*UNKNOWN*

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)

*PSW to chest/ABDOMEN*

*13 DAYS*

7b. ANTECEDENT CAUSES (Morbidity conditions, if any, giving rise to the above cause, stating the underlying condition last)

DUE TO (or as a consequence of)

(1)

(2)

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

a. *ARDS*

b. *Renal Failure*

9. DATE

*23 NOV 2003*

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

*[REDACTED]* *b(6)-2*

11. SIGNATURE OF MEDICAL OFFICER IN ATTENDANCE

*[REDACTED]*

#### 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

**BATES PAGE MEDCOM 23869 HAS BEEN  
WITHHELD IN ITS ENTIRITY PURSUANT TO  
FOIA EXEMPTIONS 6 AND 7, 5 U.S.C.  
552(B)(6) AMD (B)(7)(C).**

**Photo depicting deceased.**

**MEDCOM 23869**