FILE: 999-1-16 BKI A.G.R.P. 61

TITLE: Death report, page 1-26 Clinical Records or Progress Notes

ORIGIN: Sta.Hospital Fort Mills, P.I.

DATES: 1942 CLASSIFICATION: None

AUTHENTICITY: Microfilmed copies signed and unsigned

SOURCE: Unknown

Extracted by Ges Date _____ Microfilmed yes Date 7/26/45

D-4 C-4

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ARCHIVES FILE NUMBER 999-1-16

TITLE DEATH REPORTS, PAGES 1-26

ORIGIN STA. HOSPITAL FORT MILLS, P. I.

DATES 1942

AUTHENTICITY MICROFILMED COPIES SIGNED AND UNSIGNED

SOURCE UNKNOWN

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DEATH REPORTS
MISC. SOURCES

999-1-16

[illegible]

The below affidavit was received this date from Lieut. Col. Clifford E. [illegible]

AFFIDAVIT

The below listed men are buried as indicated in the Fontana Cemetery:

[illegible], Walter (Indian) — 7/3rd.
Tutte, Montana.

[illegible], Claude — Sask. Co.

[illegible], Edward — Pvt.

Buried at Fontana Cemetery, Fontana, Mountain Province, P.I.

[illegible]
ATTORNEY

Buried at Malinao, Fontana Municipality, Mountain Province, P.I.

Signed/s/ Clifford E. [illegible]
Lieut. Col. Clifford E. [illegible]

1

Form 88 A
Medical Department, U. S. Army
(Revised May 15, 1943)

CLINICAL RECORD
BRIEF

Register No. 2121 Hospital St. Priscilla, Fl Serial No.
Name Capalitas, Ricardo
Grade Civilian Co. KP 40th CA Regt. and Arm or Service
Age 21 Race P Nativity PI
Service Date of admission 4/12/45 19
Source of admission Surgical
Station Fort Wills, Fl
Ward 6 Previous admission
Religion Catholic Home address Tago, Bagabag, Nueva Vizcaya, P.I.
Name and address of nearest relative Mother: Mrs. Serafina Ybanimal, same address.

Fred Fox
(Initials of admitting officer)

Disposition Died Date 4/16/45 19

Final diagnosis: ① Laceration deep L. thigh, posterior aspect.
② Compound Fracture L. Femur, Tibia and Fibula.
③ Shock, Surgical Secondary to ① & ②.
④ Amputation, partial L. leg, thru Tibia & Fibula.
Above on this post 4/16/45 by Fred Fox Lt. (MC) U.S.A.

Additional diagnoses (Complications, special treatment and operations):
None

Line of duty Yes
Condition on completion of case Died

Transfer diagnosis confirmed ~~or not confirmed~~ :
Autopsy None

D. C. Hess
1st Lt. MC

2

4 16 45
Patient admitted with dangerous [illegible]
Died at 4:15 P.M.

DECLASSIFIED
Authority NND 883078

2

Form 88 A
Medical Department, U. S. Army
(Revised May 31, 1943)

CLINICAL RECORD
BRIEF

Register No. 2721 Hospital St. Thomas, PI Serial No.
Name Papillas, Ricardo
Grade Civilian Co. EP 20th QA Regt. and Arm or Service
Age 21 Race P Nativity PI Date of admission 2/12/42 19
Service
Source of admission Command Post Ville, PI
Station
Ward
Previous admission
Religion Catholic Home address Sagabad, Ilaya Visaya, PI
Name and address of nearest relative Mother: Mrs. Serafina Ybanilal, same address.

(Initials of admitting officer)

Disposition Died Date 4/16/42 19

Final diagnosis: (1) Laceration deep L. thigh, posterior aspect.
(2) Compound Fracture L. Femur, Tibia and Fibula.
(3) Shock, Surgical Secondary to 1 + 2 above.
(4) Amputation, partial R. foot. 1-2-3-4 due to enemy action on Bataan prior 4/16/42.

Additional diagnoses (Complications, special treatment and operations):
None

Line of duty Yes
Condition on completion of case Died

Transfer diagnosis confirmed or not confirmed
Autopsy None

[signature]
1st Lt. MC

2

4 16 42 Finished admitted ... to dungeon ... Bataan
... A Died at 4:30 P.M.

DECLASSIFIED
Authority NND 883078

2

TEMPERATURE—TREATMENT—NURSE'S NOTES

Name Tagliotti Riccardo. Grade Cml K-P60 CA. Ward 6.

Date

Medication and Nurse's Notes

Adm. gen. litre from surgery. Pulse weak. at 4 to general at 4:55 P.M.

NURSE'S NOTES

NAME AND RANK OF FINAL PARENT

CLAIM CONCERNING DEPENDENT'S RANK OR RATING

DIVISION | WARD | BED | CASE | MALARIA SUSPECT | SERVICE TRANSFERRED

STATION WHERE ADMITTED | DATE | HOUR

DIAGNOSIS: IF INJURY, GIVE NATURE, WHEN, WHERE INCURRED

Dressing Comp

DATE OF DISCHARGE

Penicillin

Dressing

DISPOSITION | DATE | HOUR

SIGNATURE AND RANK OF OFFICER MAKING ENTRY

FORM 50—SPECIAL SERVICE, U. S. A.

2-a

DEATH REPORTS
MISC. SOURCES

999-1-16

[illegible], Mt. IA, P.I.

[illegible] 1, 1945.

[illegible]

The below affidavit was received this date from Rev. Clifford E. [illegible]:-

AFFIDAVIT

The below listed men were buried as [illegible] stated in the Bontoc Cemetary:

[illegible], Walter (Filipino) — S/Sgt.
Butte, Montana.

[illegible], Claude — Cook Tc.

[illegible], Edward — Sgt.

Buried at Bontoc Cemetery, Bontoc, Mountain Province, P.I.

[illegible]

ALLTECH

Buried at Wai-inet, Bontoc Municipality, Mountain Province, P.I.

Signed/s/ Clifford E. [illegible]
Rev. Clifford E. [illegible].

Form No. 8
Historical Unit, U. S. Army
(Revised May 25, 1943)

CLINICAL RECORD
BRIEF

Register No. 1420 Hospital Sta. Hospital, Ft. Wills, P.I.
Name Tapilitas, Ricardo
Grade Civilian Co. KP 60th CA Regt. and Arm or Service
Age 22 Race F Nativity P.I.
Service
Source of admission Command Date of admission 4/6/42, 19
Station Fort Wills, P.I.
Ward 6
Religion Catholic Previous admission
Home address Naso, Sagaba, Nueva Vizcaya, P.I.
Name and address of nearest relative Mother: Fra. Geralina Ybanibal, same address.

(Initials of admitting officer)

Disposition Died Date 4/10/42, 19

Final diagnosis: (1) Laceration deep L. Thigh, poster. lat aspect.
(2) Compound Fracture R. Femur, Tibia and Fibula.
(3) Shock Surgical severe secondary to 1+ Laboratory.
(4) Amputation partial R. Foot. 1-2-3-4 due to enemy Shell fire on this front 4/6/42 USFFI. U.S.A. P.I.

Additional diagnoses (Complications, special treatment and operations):
None

Line of duty Yes
Condition on completion of case Died

Transfer diagnosis confirmed ~~or not confirmed~~.
Autopsy None

[signature] M.C.

4-16-42
Patient admitted with diagnoses as listed above.
C.A. Died at 4:15 P.M.

TEMPERATURE—TREATMENT—NURSE'S NOTES

Name Tagliatti Ricardo. Grade CW K-P60 CA. Ward 6.

Date | A.M. 1 2 3 4 | P.M. 5 6 7 8 | M | W | Medication and Nurse's Notes

Adm per litter from surgery. Pulse weak. at 4
Pt graded at 4:55 P.M.

(Over)

...ENT—NURSE'S NOTES

Medication and Nurse's Notes

NAME AND ARMY SERIAL NUMBER

GRADE ORGANIZATION REGIMENT & ARM OR SERVICE

DIVISION ORGANIZATION PLACE OF BIRTH NATIVITY SERVICE YEARS

STATION WHERE WOUNDED: DATE HOUR

CIRCUMSTANCES OF INJURY, STATE WHAT, WHEN, WHERE, INCLUDE INCIDENT

Dirty shell comp fracture

LIST OF WOUNDS OR DISEASES

Left thigh
Perforating Wnd. R Foot
Swelling

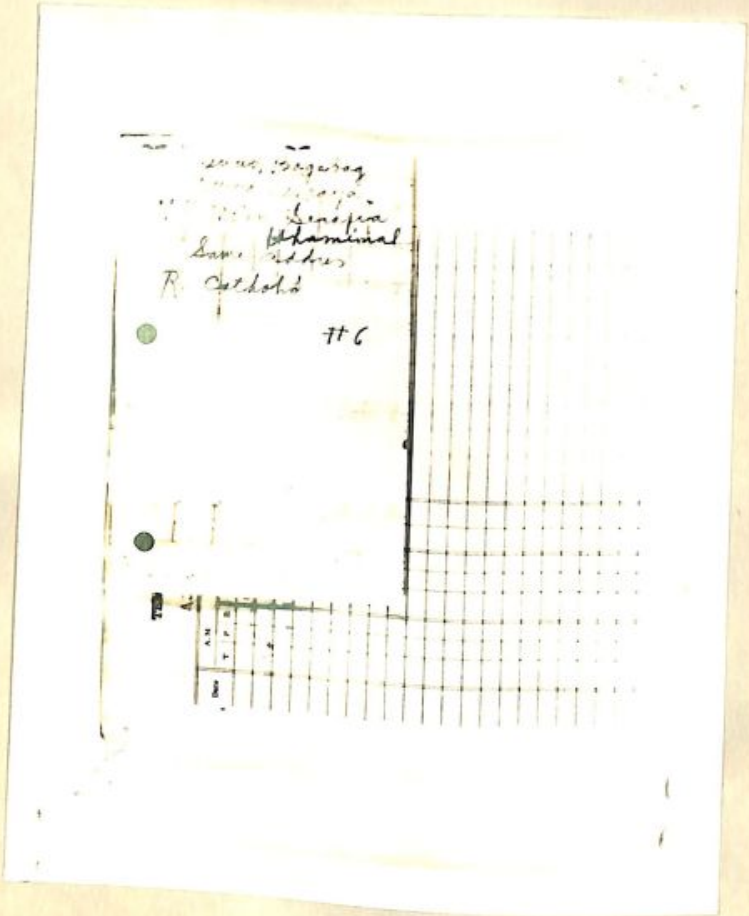
ADMITTED TO SHIP'S POST HOSPITAL AT TIME DATE

DISPOSITION DATE HOUR

GIVEN NAME, SERIAL NUMBER AND ORGANIZATION OF ATTENDING OFFICER

FORM 52b-SPECIAL DEPARTMENT, U. S. N.

2-a



2-B

Form 88 A
Medical Department, U. S. Army
(Revised May 31, 1920)

CLINICAL RECORD
BRIEF

Register No. [redacted] Hospital [redacted]
Name [redacted] Serial No. [redacted]
Grade [redacted] Co. [redacted] Regt. and Arm of Service [redacted]
Age [redacted] Race [redacted] Nativity [redacted]
Service [redacted] Date of admission [redacted] 19
Source of admission [redacted]
Station [redacted]
Ward [redacted] Previous admission [redacted]
Religion [redacted] Home address [redacted]
Name and address of nearest relative [redacted]

Disposition died Date 8:30 PM Apr 30 19 42

Final diagnosis WIA ① Wound, extensive, involving right shoulder and right arm; received about 11 AM at Fort Mills, P.I. when he was struck by large fragment of enemy aerial bomb.

Additional diagnoses (Complications, special treatment and operations)
② Amputation, right shoulder joint - primary
③ Shock, surgical, severe, secondary to wds ① and ②

Line of duty Yes Yes / and 2 and 3
Condition on completion of case died

Transfer diagnoses confirmed or not confirmed
Autopsy

E. Skagg
Major MC

3

4-30-42 Called to ward to see patient at 8:15 PM. Pulse very poor, thready. Infusion started with normal Saline. Preparatory to change to Plasma. Died at 8:30 PM as infusion was flowing in.

E. Skagg
Major MC

OPERATION REPORT

Name Mc Cormick Earl E. Grade Tech 3/c Ward 9

Date April 30 1942 Age

Postoperative diagnosis Traumatic amputation arm
@ shoulder.

Operation Amputation of - at shoulder joint.

Remarks: Condition very fair
pulse 120. Blood transfusion 500 cc
Blood plasma.

Operation began 12:50 ✓ Ended 1:20 PM

Operator May Artmann

Assistants Capt. Hewlett

Anesthesia used Gas

Anesthetist A. Mealer

Specimens forwarded to laboratory for examination

(OVER)

M C

TEMPERATURE—TREATMENT—NURSE'S NOTES

Name Mc Cormick - Grade Ward 9

1942

Date	A M			P M			M	W	Medication and Nurse's Notes
April	1	P	R	1	P	R			
30									admitted 1:10 P.M. from O.R. amputation at arm. Ether anes. condition fair. (Oxygen + Plasma 3 Mass each) dressing moderately saturated w blood. sulfadiazine gm ½ 4 hr thereafter gm ½ 4 hr 1st 24 hrs then gm ½ 6 hr. Liquids when tolerated. Fowler position when resting. 3/4 Morphine gr ¼ @ for restlessness.
				10	120	18			Not completely awake.
									Motor function - Sensation present.
									7:30 Pulse very weak.
5-1-42									5:30 pm O.D. gauze dressing intact. Wound clean. PT
									closed. 1 40 gm.

(Over)

3-a

Form 88 A.
Mimeographed, U. S. Army
(Revised May 31, 1920)

CLINICAL RECORD
BRIEF

Register No. [illegible] Hospital [illegible]
Name [illegible] Serial No. [illegible]
Grade [illegible] Co. Regt. and Arm or Service [illegible]
Age 22 Race [illegible] Nativity [illegible]
Service [illegible] Date of admission [illegible], 19
Source of admission [illegible]
Station [illegible]
Ward 10 Surgical (Gen.) Previous admission
Religion Protestant Home address [illegible]
Name and address of nearest relative [illegible]

(Outside of admitting office)

Disposition Deceased. Date 5 - 9, 1942

Final diagnosis:

(1) Gangrene gas. right leg upper third
Secondary to FX I.
(2) Amputation traumatic incomplete
at right knee.

Patient was stepped at west entrance of Nebula Theatre, when an enemy shell exploded injuring right leg, 10 P.M. 4-25-42. at west entrance of Nebula Theatre.

Additional diagnoses (Complications, special treatment and operations):

Operation. Surgical amputation, upper third of right leg amputation. open stump closure

Line of duty Yes.
Condition on dedication of case Good.

Transfer diagnosis confirmed or not confirmed —
Autopsy None

B. J. Steinbach
Capt. M.C.

1

[illegible]

Doc Smith, Benjamin age 23 3 0 7th A.P. Ward 10

History. Patient was on way to Bolton and when an exploding enemy shell went and I found clearance injured his right leg at 10 P.M. 4-26-42

Surgical Examination
Evacuation of Common Leg. Abdomen
No pathology
Reviewed and Signs Notes

4-25-42 Patient admitted after amputation of right leg upper third. Condition serious. given Hemotransfusion, 200 c.c. W.S.H.
4-26-42 Patient much improved. Little pain given 0.03 grams Morphine sulf. Witchity. W.S.H.
4-29-42 Wound redressed. Tissue of tissue edges gangrenous, Rubber drain removed W.S.H.
5-1-42. Discharge, purulent and frothy, suppuration of granulation, Tissue Negative but, characteristic of suppuration Stated. Sutures removed. Wound opened wide, injected with [illegible] peroxide, and W.S.H.
5- [illegible]
5-2-42 Patient Lt. B. Wetzel Capt. Surgeon Patient
5-4-42 Patient Condition very Critical and much change. Redressed Wound W.S.H.
5-8-42 Patient Condition Critical Tetanus symptoms Wound suppurating with [illegible] and lower discharging J.S.
5-9-42 Patient Temperature rising rapidly. Extreme [illegible] sequence. Heart action poor. W.S.H.
Patient dead at 2.50 P.M. Capt. Steinbach

4

OPERATION REPORT

Name _____ Grade _____ Ward _____

Date _____ 19 _____ Age _____

Preoperative diagnosis

Operation

Remarks

Operation began _____ Ended 11

Operator

Assistant

Anesthesia used _____ Amount

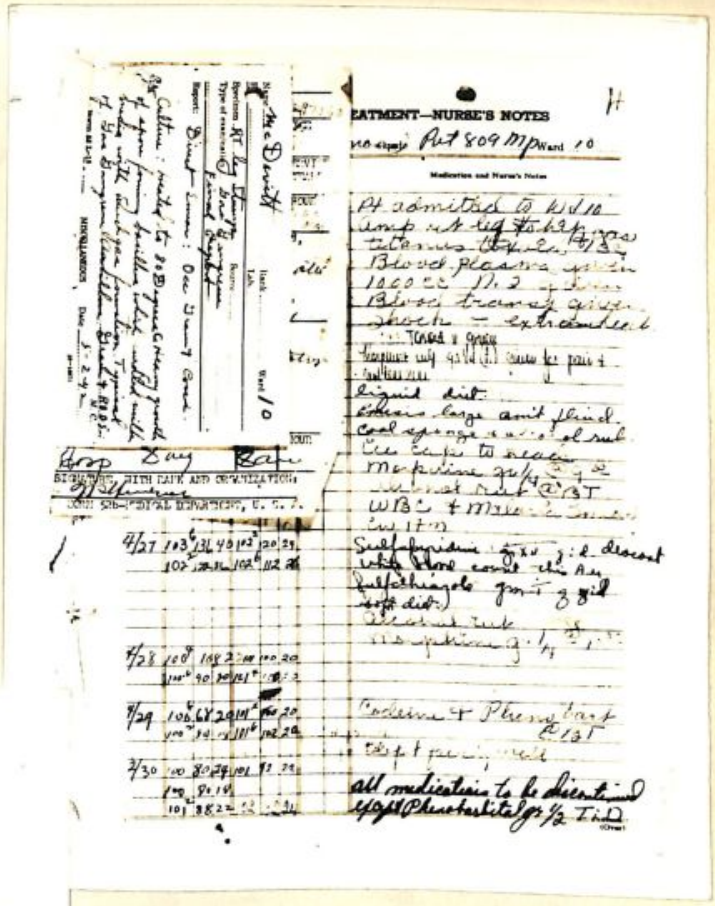
Anesthetist

Specimens forwarded to laboratory for examination

MC

Name M. L. Dewitt Bed No. _____ Ward 10
Lab. No. _____
Diag. _____
Specimen 3 vials Source Rt. Lt. Lung
Type of examination 3 smears for Bac Tuberculosis
Report: Tuberculosis smears (Preliminary Report)
Negative
Slight Staph: Pus almost nil. Occasional Gram + Cocci. Few organisms found resembling Bac bc. Further study pending
MC
Form 88 E-18 Revised Sept. 21, 1950 MISCELLANEOUS Date 5-1-42

4-a



TEATMENT—NURSE'S NOTES

Name Mr. Everett Reynolds Age 43 Adt 809 MP Ward 10

Medication and Nurse's Notes

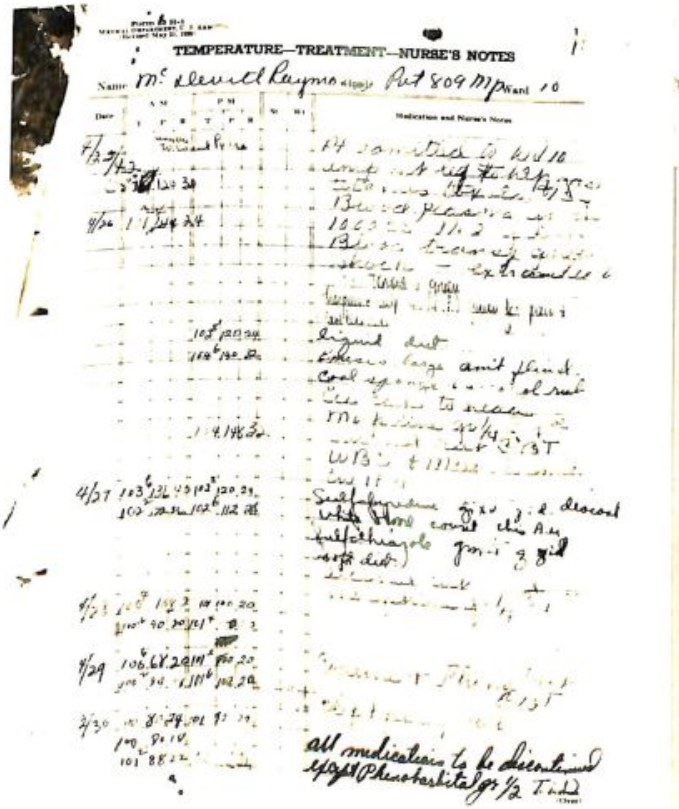
Pt admitted to Ward 10
Amp wt lt leg to hip 4/3/43
Tetanus Toxoid
Blood plasma given
1000 cc 11.2 + Trans
Blood transfusion given
Shock - Extremities
TOAD + Grade
Temperature only 98 to 101 taken by pain
Liquid diet
Fifteen large amt fluid
Coal sponge given to relieve
Side chairs to ward
Morphine gr 1/4 2 3 4
Wound dressed BID BT
WBC + Mixed
Sulfa Tablets
Sulfadiazine gm 1 2 3 4 discont
Sulfathiazole gm 1 2 3 4
soft diet)
Discont Sulfa
Tablets gm 1 2 3 4
Codeine + Phenacetin Caps
#1 BT
all medications to be discontinued
4/28 Phenobarbital gr 1/2 Tid

4/27 103 6 32 48 102 120 24
102 32 24 102 112 28

4/28 100 98 2 PM 100 20
100 90 20 101 2

4/29 100 68 2 PM 100 20
100 90 20 101 2

4/30 100 80 24 101 98 20
100 80 16
101 88 22



TEMPERATURE—TREATMENT—NURSE'S NOTES

Name Mr. Everett Reynolds Age 43 Adt 809 MP Ward 10

Medication and Nurse's Notes

Pt admitted to Ward 10
Amp wt lt leg to hip 4/3/43
Tetanus Toxoid
Blood plasma given
1000 cc 11.2 + Trans
Blood transfusion given
Shock - Extremities
TOAD + Grade
Temperature only 98 to 101 taken by pain
Liquid diet
Fifteen large amt fluid
Coal sponge given to relieve
Side chairs to ward
Morphine gr 1/4 2 3 4
Wound dressed BID BT
WBC + Mixed
Sulfa Tablets
Sulfadiazine gm 1 2 3 4 discont
Sulfathiazole gm 1 2 3 4
soft diet)
Discont Sulfa
Tablets gm 1 2 3 4
Codeine + Phenacetin Caps
#1 BT
all medications to be discontinued
4/28 Phenobarbital gr 1/2 Tid

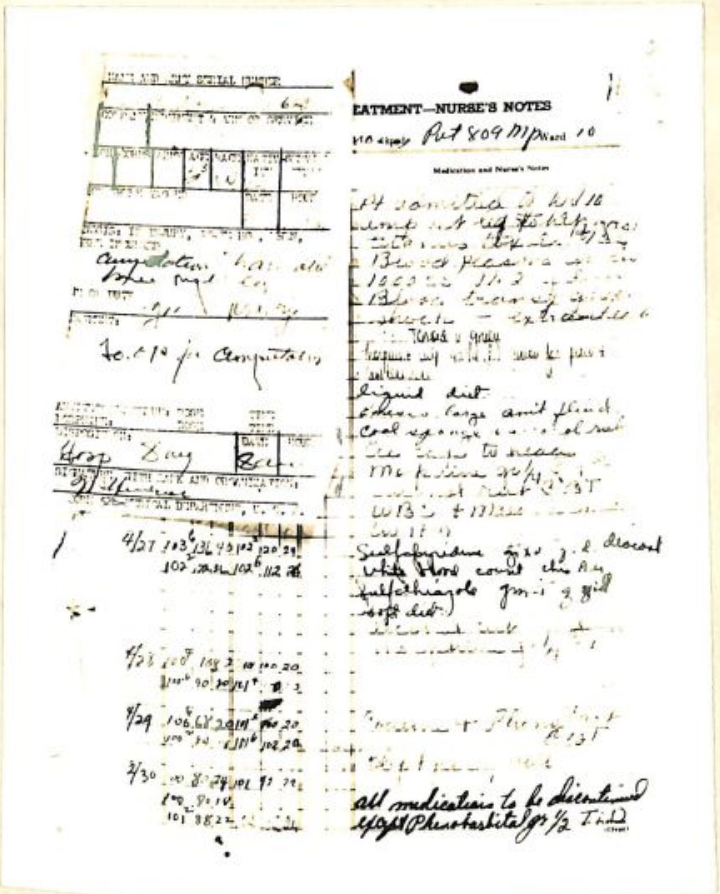
4/27 103 6 32 48 102 120 24
102 32 24 102 112 28

4/28 100 98 2 PM 100 20
100 90 20 101 2

4/29 100 68 2 PM 100 20
100 90 20 101 2

4/30 100 80 24 101 98 20
100 80 16
101 88 22

4 - C



EATMENT—NURSE'S NOTES

Medication and Nurse's Notes

4/27 103 6 136 43 102 120 29
102 102 6 112 76

4/28 100 102 2 110 120 20
100 90 101 2

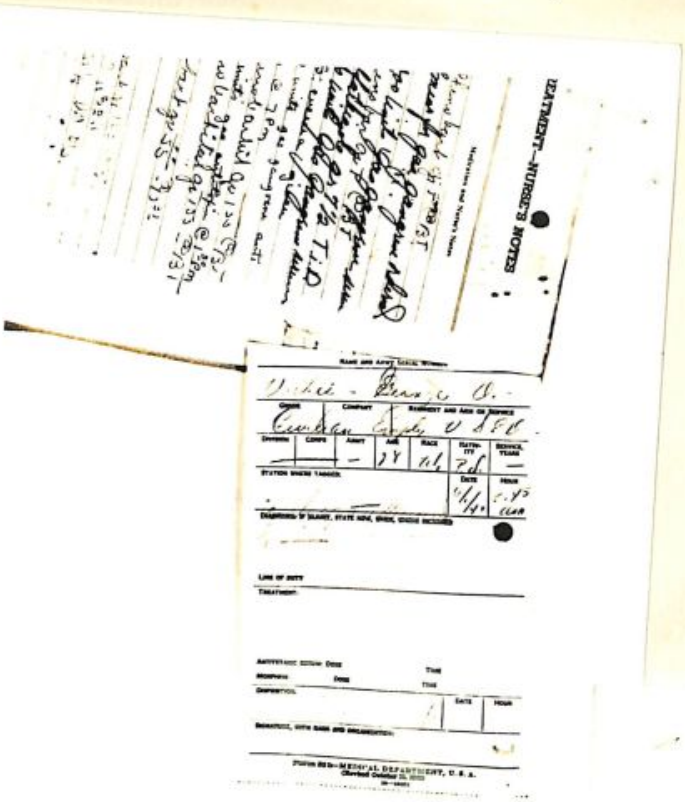
4/29 106 68 29 110 96 20
100 94 110 6 102 29

4/30 100 80 29 101 92 29
100 92 19
101 88 22

Sulfadiazine gm 1 q. 4 hours
White Mixt contd thru Apr
Sulfathiazole gm 1 q 4 hrs
soft diet

all medications to be discontinued
4/30 Phenobarbital gr ½ T.i.d.

4 - D



TEMPERATURE—TREATMENT—NURSE'S NOTES

Date	A.M. T	P	R	P.M. T	P	R	Medication and Nurse's Notes
4-30				101	84	24	Pheno bart gr ¼ [illegible]
5/1	99	80	20	101	92	32	Smear pt gas gangrene Admd
				101	88	20	
				101	86	24	Tpo Limit Gas Gangrene Serum
							Pheno bart gr ¼ @ 8P
5/2	99	88	20	99	92	30	Sulfathiazole gr 7½ T.i.D
	99	90	24	100	90	24	Tpo Limit Gas Gangrene Serum
				103	92	24	6.5: evacuated gallon
5/3	100	96	22				8000 units gas gangrene anti
	100	88	18				toxin @ 7Pm
				99	80	24	Pheno barbit gr ¼ @ 8P
				99	88	24	1800 units gas anti toxin @ 1:30 Pm
							Pheno barbital gr ¼ @ 8P
5/4	98	84	20	100	88	24	
				99	88	26	Pheno bart gr ¼ @ 8P
5/5	98	74	18	100	88	24	
				101	90	24	
5/6	98	104	20	102	100	24	
				101	96	22	
5/7	100	96	22	101	100	26	
				101	94	22	
5/8	99	96	22	100	96	26	
				101	98	26	
				100	98	24	
5/9	101	96	24	101	100	26	
				101	98	24	
				101	98	24	
5/10	103	100	22				morph. S. gr ¼ } at 2:30 pm
	104	100	24				Atropine gr 1/150 } for
							extreme restlessness
							Ceased to breathe @ 2:55 P.m.

4 - E

Form 88 A
Revised May 15, 1942

CLINICAL RECORD
BRIEF

Register No. [illegible] Hospital 31 Ft. Mills, P.I.
Name Krants, Robert A. Serial No. 0-413949
Grade 2nd Lt. Inf. Co. (PS) 91st Regt. and Arm or Service
Age 26 Race W Nativity California
Service 1 year Date of admission 4/12/42, 19
Source of admission Command
Station Ft. Mills, P.I.
Ward 7 C Previous admission
Religion Protestant. Home address Joslapa, California
Name and address of nearest relative Father: Dr. Clarence W. Krants, same address.
(Name)
(Address)
(Institution or attending officer)

Disposition DIED Date APRIL 13/42 19

Final diagnosis: W.I.A.
#1. Compound comminuted fracture of the right ischium
#2. Rupture of urinary bladder, with possible rupture of rectum.
#3. Shrapnel wound of left arm with compound, comminuted fracture of the middle third of the humerus.
#4. Shrapnel wound of the lower third of the right leg with compound, comminuted fracture of the fibula.
Wounds accidentally incurred at Fort Mills, P.I., while on duty, when he was struck by flying shrapnel from a Japanese shell, April 12, 1942.
Additional Diagnoses:
Shock, severe, secondary to above listed wounds and blood loss.
Operations:
#1. Cystotomy
#2. Application of adhesive traction and Thomas splint to left leg. Local anesthesia.
Additional diagnoses (Complications, special treatment and operations):

Line of duty Yes
Condition on completion of case Dead
Transfer diagnosis confirmed or not confirmed
Autopsy

Thomas H. Hewlett
Thomas H. Hewlett, Capt. M.C.

5

[illegible] to ward in profound shock, bleeding from wound in right perineal region. Only fair response to intravenous fluids. 8:00 P.M. under local anes. the following operations performed. Perineal wound packed, Thomas splint applied to left arm.
T.H. Hewlett

4/13/42 Patient in shock still bleeding from perineal wound, pulse very weak, patient's pulse imperceptible part of time - probably has internal bleeding
T.H. Hewlett

4/13/42 P.M. Patient expired.
Death at 2:10 P.M.
T.H. Hewlett

5

17

TEMPERATURE—TREATMENT—NURSE'S NOTES

Name Kranitz, Robert A. Grade 2nd Lt. [illegible] 7

Date	A.M. T	P	R	P.M. T	P	R	M	Wt	Medication and Nurse's Notes
7-12									Admitted to W-7 9-10 [illegible]
									[illegible]
									[illegible]
									5% [illegible] 1000 [illegible]
									intravenously
	98	114	24						[illegible] weak
									[illegible]
									[illegible]
									[illegible]
									[illegible] gangrene [illegible]
									[illegible]
									Catheterized [illegible]
									[illegible] sulfanilamide [illegible]
									250 C.C. Blood plasma IV
									@ 2 30/P.M. followed by 1000 c.c.
									10% glucose in N/S.
									[illegible] 5 P.M. Ret'd to
									Wd @ 5 50/P.M. In shock.
									Condition critical.
				101	88				Sulfa [illegible] @ 8-12-4
									[illegible]
									[illegible] from leg wound.
				103	90				[illegible] Pulse 156 [illegible]
									Taking fluids well.
									[illegible]
									[illegible] catheter.
									[illegible]
									Morph [illegible] @ 12 [illegible] & 4 [illegible]
13	101	140	22						[illegible] slept 2-3 hrs.
									[illegible]
									[illegible]
	101	136	24						[illegible]
									[illegible]

(Over)

TEMPERATURE—TREATMENT—NURSE'S NOTES

Kranitz

Date	A.M. T	P	R	P.M. T	P	R	M	Wt	Medication and Nurse's Notes
									[illegible] catheter
									Taking fluids freely
									Morphine [illegible]
									[illegible] Condition critical
									Respirations labored, gasping
									Ceased breathing [illegible]
									Pronounced dead by Capt. [illegible]

PROGRESS NOTES

Name Gardner, Chas. C. Grade Pvt. Ward 9.

(Complications and changes in diagnosis, with date in each case, should be entered on this sheet)

Admitted in critical condition from E. R. C multiple shrapnel wounds of right chest and right arm. Wounds accurred as a result of a bombardment of Ft. Mills shortly before admission.

Penetrating wounds of chest were cleaned and packed in an attempt to control hemorrhage. Wounds of the arm were debrided and dressed. Traumatic amputation of the right 3rd and 4th fingers were completed.

Patient continues to hemorrhage from chest wounds and shows marked dyspnea. Pulse is weak and thready.

Expired 5 A.M.

(Use both sides of this sheet)

5 - D

Form 28 Civil
War Department, U. S.
(Revised May 31, 1918)

OPERATION REPORT

Name Faulkner C C Grade Ward

Date April 15 1942 Age

Postoperative diagnosis: Schrapnel wounds of C chest Rt thru + thru
1) G.S.W. Shrapnel upper right arm
2) G.S.W. Shrapnel tip of fingers

Operation: Debridement + Suture all wounds
Penicillin in all wounds

Remarks:
Blood Plasma Concentrated 200.

Operation began 10:55 AM Ended

Operator Lt. Col Adams

Assistants

Anesthesia used Local Novocaine 1% Amount

Anesthetist

Specimens forwarded to laboratory for examination:

(over) M.C.

Form 88 Mod
War Department, U. S.
(Revised May 31, 1918)

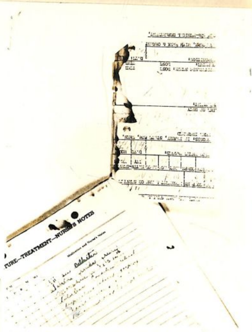
TEMPERATURE—TREATMENT—NURSE'S NOTES

Name Fortner Chas C Grade Pvt 6 60 CA Ward 9th 30

Date	A.M. T	P	R	P.M. T	P	R	Wt	Ins	Medication and Nurse's Notes
4/15/42	Admission 100.6	140	26	103.8	160	32			Came from Dressing Room Shrapnel Chest Rt Multiple Wounds Arms. Hemoglobin 12 grams of blood. Morphine Sulphate gr ¼ H.Y. Pa. Admitted Coffee ground material @ 2 PM & 5 PM Irrational Blood pressure Death of Dr Adams 9:55 PM. Expired @ 7:45 PM

(Over)

5-C



Form 55 A
Medical Department, U. S. Army
(Revised May 31, 1930)

CLINICAL RECORD
BRIEF

30

Register No. [illegible] Hospital SH Ft.Mills,PI
Name F[illegible], Charles C.
Grade Pvt Co. "D" 60th CA Serial No. 17014254
Age 20 Race W Regt. and Arm or Service
Service Nativity Arkansas
Source of admission Command Date of admission 4/15/42, 19
Station Fort Mills,P.I.
Ward 9
Religion Protestant Previous admission
Home address Jacksonville,Arkansas.
Name and address of nearest relative Mother:Mrs.Grace Brown,same address.

ECM
EEM/fwz
(Initials of admitting officer)

Disposition Expired 5:45 P.M. Date 4/15/42, 19

Final diagnosis: Multiple penetrating shrapnel wounds of right chest as result of bombardment of Ft. Mills shortly before admission.

Additional diagnoses (Complications, special treatment and operations):
①. Shrapnel wound upper right arm.
②. " " ē traumatic amputation of 3rd and 4th fingers right hand.

Line of duty Yes W.I.A.
Condition on completion of case Expired.
Transfer diagnosis confirmed or not confirmed
Autopsy

Edwin L. Nelson M.C.

50

NR

5-B

Form 52 A
Medical Department, U. S. Army
(Revised May 31, 1920)

CLINICAL RECORD
BRIEF

Register No. 3421 Hospital Station Hospital Fort Mills, P.I.
Name STROSS, Nathan Serial No. 11015736
Grade Pvt.1/cl Co. "C" Bty. Regt. and Arm or Service 60th CA
Age ... Race W Nativity Mo.
Service ... Date of admission April 12,1942 o:30PM 19...
Source of admission Command
Station Fort Mills, P.I.
Ward 9-Surgical (MA) Previous admission ...
Religion Hebrew Home address 1335 Blackstone St.Louis,Mo.
Name and address of nearest relative FATHER-Mr. Harry Strouss
Same Address
CO/jlb
(Initials of admitting officer)

Disposition Expired Date 4/13/42 19...

Final diagnosis:

Perforating wound penetrating left axilla & hemothorax.

Additional diagnoses (Complications, special treatment and operations):

Line of duty Yes A. U. A.
Condition on completion of case Expired
Transfer diagnosis confirmed or not confirmed
Autopsy

Edwin D. Nelson M.C.

TREATMENT

Name Stross Nathan Grade Pfc Ward 9 — 7

Date	T	P	R	Bp	Urine
4/12/42					

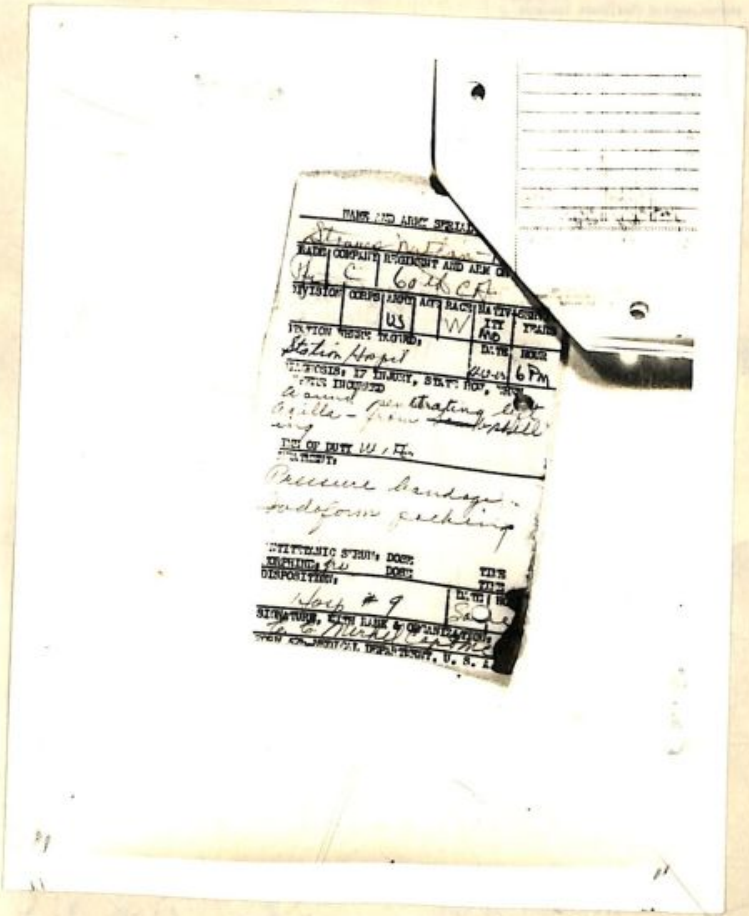
Admitted @ 6:30 PM via litter
Wound penetrating left axilla
mid portion posterior
Keep left arm over chest
Schedule treatment
Mdgn IM @ 6:40 PM
Cond. Severe very poor
Resp. very labored Bucping
Caffeine Sol. Resp. comp @ 7:0 PM
Coramine comp @ 8:0 P.M.
Dr. notified
Dr. seen by Capt. Mallet @ 8:0 P.M.
Resp. ceased, pronounced dead @ 8:30 P.M.
Capt. Mallet

4/13

10.6
PM

(OVER)

6



6-A

Form 88 A
Medical Department, U. S. Army
(Revised May 31, 1943)

CLINICAL RECORD
BRIEF

Register No. [redacted] Hospital Station Hospital Fort Mills,P.I.
Name ZBIKOWSKI, Edmond T/ Serial No. O-313071
Grade Captain Co. 803 Bn. Regt. and Arm or Service Engrs.
Age 31 Race W Nativity
Service 1y. 6/12 Date of admission March 24,1942 @ 5:00 P.M. 19
Source of admission Command
Station Fort Mills,P.I.
Ward S-Surgical (WIA) Previous admission
Religion Home address
Name and address of nearest relative
[redacted]
(Initials of admitting officer)

Disposition Date 19

Final diagnosis: W.I.A.

1. Shrapnel wound,left buttock,severe
2. Fracture,compound,incomplete,neck of left femur, [redacted] #1 and #2 accidentally incurred at Fort Mills,P.I. March 24,1942, while on duty,when patient was struck by shrapnel from an enemy bomb.
3. Psychosis,undiagnosed,with catatonic phases,precipitated by #1.
4. Bronchopneumonia,bilateral both lung bases,developed March 31,1942

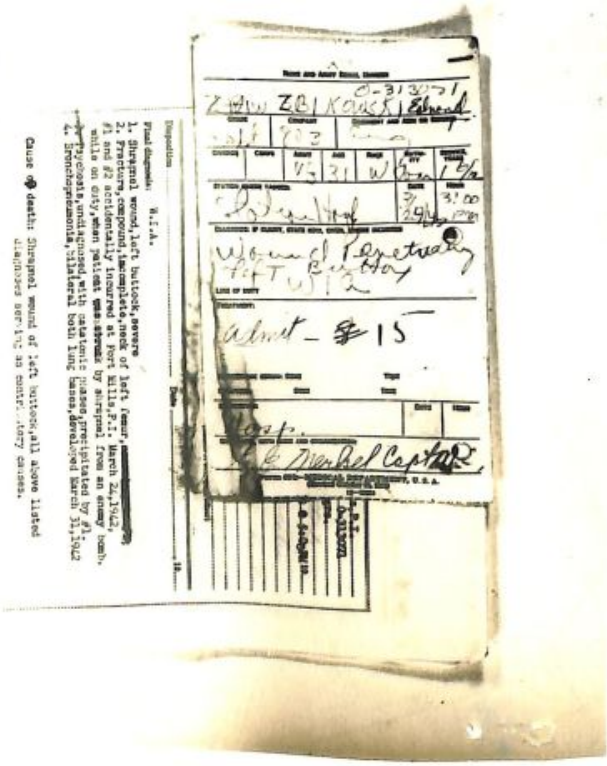
Cause of death: Shrapnel wound of left buttock,all above listed diagnoses serving as contributory causes.

Additional diagnoses (Complications, special treatment and operations):
March 24,1942 Debridement of shrapnel wound. Spinal anesthesia

Line of duty YES
Condition on completion of case DEAD
Transfer diagnosis confirmed or not confirmed
Autopsy NO

Thomas H. Hewlett
Thomas H. Hewlett,Capt. M.C.

7



7

PROGRESS NOTES

Name ZBIKOWSKI, EDMOND T Grade CAPT. ENG. Ward ORTHO.

(Complications and changes in diagnosis, with date in each case, should be entered on this sheet)

3/24/42 Admitted with a severe shrapnel wound of the left buttock with partial destruction of the greater trochanter and incomplete fracture, neck of left femur. Debridement under spinal anesthesia, wound packed open.
T. Hewlett

3/26/42
Patient uncooperative and irrational mental state not fully consistent with psychoneurotic reaction resulting from shell shock.
T. Hewlett

3/28/42
Patient's background of past 6 months as given by Company Med. Officer suggests and unstable personality not readily adaptable to changing situations, suggesting that his recent injury served temporarily to intensify latents. Wound appears clean, still using Eye Abbassinid pack.
T. Hewlett

(1 or both sides of this sheet)

PROGRESS NOTES

Name ZBIKOWSKI, Edmond T. Grade Capt. USED Ward Ortho

(Complications and changes in diagnosis, with date in each case, should be entered on this sheet)

March 30,1942

This patient was admitted to the Orthopedic Section, March 24,1942 with a severe shrapnel wound of the left buttock, incomplete fracture of the neck of the femur and shattering of the greater trochanter of the femur also resulted from same wound. Patient under went debridement under spinal anesthesia and was returned to ward in good condition. During the night he became irrational and [illegible]

The Medical Officer attached to [illegible] Battalion, of which Capt. Zbikowski was commanding officer, reveals that for the past [illegible] he has shown signs suggestive of personality changes, from his history, which he has related to the Medical Officer, one gathers that his was an unstable personality prior to entry into the service and that he found it quite difficult to adapt to changing situations. Since arriving on this post it has been noted that he has readily taken offense where none was intended, he is extremely argumentative and can not tolerate ideas that do not conform to his own. His entire personality picture is that of a Schizoid.

During his period of hospitalization he has been uncooperative and irrational continually, screaming and cursing at intervals and has shown a definite tendency to catatonic phases.

Thomas H. Hewlett
Capt. Med. Corps.

arch 31,194
Condition critical, patient developing pulmonary edema, has not taken any nourishment for nearly forty eight hours, tube feeding attempted without success, temperature gradually rising to higher levels, [illegible] developed a bilateral bronchopneumonia.
Thomas H. Hewlett
Capt. Med. Corps.

April 1, 1942
Condition endangered, patient [illegible] seriously ill.
T.H.H.

(1 or both sides of this sheet)

7-A

PROGRESS NOTES—Continued

April 1, 1942: 7:30 P.M. Patient was given 2,000 cc of 5% glucose + saline with 7½ gr Sodium Amytal. T.H. Hewlett

April 2, 1942
Patient died at 9:35 P.M. while being taken [illegible] developed a circulatory collapse due to overexertion.
Thos. H. Hewlett
Capt M.C.

Form AG 55-[illegible]
Medical Department, U.S. Army
(Revised May [illegible])

TEMPERATURE—TREATMENT—NURSE'S NOTES

Name Zbikowski Edmund Grade Corp. 893 Eng Ward #15

Date (1942 March)	A.M. T	A.M. P	A.M. R	P.M. T	P.M. P	P.M. R	St	Wt	Medication and Nurse's Notes
24				99	88	24			5 P.M. Admitted from Surgery. Shrapnel wounds left buttock & comp. fract. left leg. Also Plasma 500cc given intravenously @ 5 P.M. [illegible] applied to left leg. [illegible] 1/4 @ 5 P.M. [illegible] pain. Water ad [illegible] immediately. [illegible] Sulfanilamide routine [illegible]. Pulse 88 - good quality. Gas gangrene [illegible] 12 cc [illegible] @ 7 P.M. Water freely - Pulse good.
25	100	88	20	101	96	24			Large amt. of dark blood drainage. Dressing reinforced.
	101	90	24	101	112	26			Morph. Sulf. gr 1/4 (H) 12 P.M. Has not voided. Sulfanilamide gr. XX @ 8 P.M. + gr X @ 12 + 4 A.M. Voided [illegible] @ 8 P.M. Confused + irrational. Fluids forced. M.S. gr 1/4 @ 10 P.M.
26	98	100	22	101	[illegible]	[illegible]			Blood [illegible] [illegible] 9-12-3-6-1
				100	120	24			Morph. Sulf. gr 1/4 [illegible]. Very [illegible], [illegible]. Sulfanilamide gr XV 8-12-4-1. Sodium Bromide [illegible] @ 11 P.M. Morph. gr 1/4 H @ 9 P.M. Fluids forced

(Over)

7-B

TEMPERATURE—TREATMENT—NURSE'S NOTES

Capt Zbikowski

Date	A.M. T	A.M. P	A.M. R	P.M. T	P.M. P	P.M. R	Bl	Wt	Medication and Nurse's Notes
4/27/43	100	102	20	99	100	22			Chief Complaint Bronchitis 4th day of illness
	99°	100	20	98	84	22			Morph Sulf gr 1/4 (1/4) gen I.M.
									Phenobarbital gr 1½ @ 9 pm
									Sulfadiazine gm 2 @ 8-12-4-8
									Glucose 5% gm 500 @ 9 pm
									Morph Sulf gr 1/4 (1/4) @ 3 am
									Temp 99° @ 6 AM
									Chief Complaint Bronchitis 3rd day of illness
									Sulfadiazine gm 2 @ 8-12-4-8
									Milk 1/2 AM @ 4 pm 3 PM
									Morphine sulf gr 1/4 @ 9 pm
									Restless trying to sit up
									Morph gr 1/4 @ 8 P.M.
									Sulfadiazine medication @ 8-12-4-8
									Bed changed & back rubbed
									Sulfadiazine gm 2 @ 8 P.M.
									Clinitest tablet gm 2 @ 8 P.M.
									Morph sulf gr 1/4 @ 12 Mid & 4 A.M.
28	99°	100	22	101	104	22			Chief Complaint Bronchitis 4th day of illness
	100	102	24						Sulfadiazine gm 2 @ 8-12-4-8
									Milk 1/2 AM @ 4 pm 3 PM
									Morphine sulf gr 1/4 @ 9 PM
									Restless trying to sit up
									Morph gr 1/4 @ 8 P.M.
									Sulfadiazine medication @ 8-12-4-8
									Bed changed & back rubbed
									Sulfadiazine gm 2 @ 8 P.M.
									Clinitest tablet gm 2 @ 8 P.M.
									Morph sulf gr 1/4 @ 12 Mid & 4 A.M.
29	100	102	22	101	104	24			Restless trying to sit up
				101	102	24			Parenteral Sulfadiazine gm III @ 8 pm
				101	104	22			" gm II @ 8 A.M.
									Throat Culture at 5th P.M.
									Bed linen changed and
									Parenteral Sulf. at 5th P.M.
									Sulfadiazine gm 2 @ 4 AM
									Parenteral Sulf. gr 1/4 @ 7:30 A.M. gm 2
									Clinitest 7:45
									Voided normal urine
									Sufficient to give fluids
									Resting + comfortable
30	99	100	22						

TEMPERATURE—TREATMENT—NURSE'S NOTES

Name Capt Zbikowski Grade Ward

Date	A.M. T	A.M. P	A.M. R	P.M. T	P.M. P	P.M. R	Bl	Wt	Medication and Nurse's Notes
30	100	114	24	102	92	20			Sulfadiazine gm 2 @ 8-12-4-8
				101	110	24			Clinitest 1/10
									Milk 8 oz @ 4 P.M. Glucose 5% gm 500 @ 9 P.M. (8°C) I.V.
									Morphine Sulph. gr 1/4 @ 11:20 A.M.
									Parenteral Sulfadiazine gm III @ 8 P.M.
									Bed changed & back rubbed
									Sulfadiazine gm 2 @ 4 A.M.
									Glucose 5% gm 500 @ 4 A.M.
									Voided normal urine at 6 A.M.
									Chloral Hydrate gm 1 @ 8 P.M.
									Temperature 99° 2/10 A.M. 101° 4/10 P.M.
									Range resting afebrile to 101°
									Resting comfortable at times
									Appetite poor
									Restless at times
31	100	102	20	100	98	22			Chloral Hydrate gm 1 @ 8 P.M.
	101	104	20	98	104	20			Inadvertently medication @ upon bed linen changed, patient made comfortable
									Sulfadiazine gm 2 @ 4-8-12 & 4
									Temp 98° to 101°
									Condition remains the same
									Sulfadiazine gm 2 @ 8 P.M.
4/1/43	100	104	24	103	104	20			Condition remains the same
				102	104	20			Sulfadiazine gm 2 @ 8 P.M.
				101	100	24			Glucose 10% in saline gm 500 started at 2:30 P.M. also 500 Aminfal
									gm 2 @ 8 P.M. Intravenously
									Sufficient fluids taken

7-C

TEMPERATURE—TREATMENT—NURSE'S NOTES

Date	A.M. T	A.M. P	A.M. R	P.M. T	P.M. P	P.M. R	In	Wt	Medication and Nurse's Notes
9/5/41									Feeding frequently Pulse good volume Resp. irregular General condition very weak. Comatose state. Swallows sips of water with great difficulty. Special attendant on duty with patient. Mouth tube passed @ 6 pm Unable to retain Codeine gr ½ hypo @ 6 pm 9th Atropine gr 1/150 hypo @ 9th Nasal tube passed @ 7:10 pm Patient Resting Fluids ordered per nasal tube Glucose 5% normal saline 1:20 pm Left Ad. St Dripping @ 4:8 [illegible] Transmitted Dead Left Ad. St @ 4:30
2	100	90	20	104	124	36			
				103	122	41			
				104	126	?			

7-D

Form 57. A
Medical Department, U. S. Army
(Revised May 31, 1920)

CLINICAL RECORD
BRIEF

Register No. 788 Hospital Station Hospital, Fort Mills, P.I.
Name FRIEDLINE, STANLEY Serial No. 0-389550
Grade 1st Lt. Co. Regt. and Arm or Service CAC
Age 23 Race White Nativity
Service 2 Yrs. Date of admission April 29, 1942
Source of admission Command
Station Fort Mills, P. I.
Ward Previous admission
Religion Home address
Name and address of nearest relative

(Initials of admitting officer)

Disposition Died April 29, 1942. Date April 29, 1942.

Final diagnosis: W.I.A.

(1) Burns, 1st and 2nd degree, involving face, neck, both arms & forearms, hands, and upper torso, incurred during enemy shelling when shell exploded gasoline dump covering officer with burning gasoline, Ft. Mills, P.I. 9:30 a.m. April 29, 1942.

(2) Shock, severe secondary to #1.

Additional diagnoses (Complications, special treatment and operation):

Line of duty Yes
Condition on completion of case Died April 29, 1942 11:30 a.m.

Transfer diagnosis confirmed or not confirmed
Autopsy

R.E. Artman Major MC
R & E Officer

8

Progress Note:

4/29/42 – Admn. w 1st & 2nd degree burns involving face & neck, both arms and hands, and upper half of torso.

Treated in Surgery:
(1) Shock treatment, heat, stimulants, etc.
(2) Blood plasma 250 cc I.V.
(3) Debridement, tannic acid ointment to all burned areas.

Pt. died at 11:30 a.m. without recovering from shock.

R.E. Artman
Major, M.C.
R & E Officer

[illegible], Stanley

Grade	Company	Regiment and Arm or Service
1st Lt	"M"	60th C.A.(A.A.)

Division	Camp	Army	Age	Race	Station	District, State or Z
------	------	US	23	W	P	

Sta. Hosp., Ft.Mills, P.I. — Date: 4/29/1942 — Hour: 10;30 PM

W.I.w. - 2nd degree burns of face, upper portion offbody and head.

Line of Duty: Yes

Treatment:
Blood plasma
Tunic acid dressings,
Died at 12;40 PM

Disposition: Burial, Ft.Mills, PI. — Date: 4/29/1942 — Hour:

[illegible] Comp., [illegible]

Form 8[illegible] MEDICAL DEPARTMENT, U.S.A. (Revised October 15, 1940) 20-[illegible]

8-A

Form 88 A
Medical Department, U. S. Army
(Revised May 15, 1942)

CLINICAL RECORD
BRIEF

Register No. [illegible] Hospital Station [illegible] Serial No. 37000[illegible]
Name [illegible] Grade PVT Co. H Regt. and Arm or Service 59 CA
Age [illegible] Race [illegible] Nativity [illegible]
Service [illegible] Date of admission [illegible], 19[illegible]
Source of admission [illegible]
Station [illegible]
Ward [illegible] (CA) Previous admission [illegible]
Religion [illegible] Home address [illegible]
Name and address of nearest relative [illegible]

[illegible]
(Initials of admitting officer)

Disposition Died Date 5/4/42, 19[illegible]

Final diagnosis Laceration Cerebral Left Temporal region severe Injured Serv. with shell frag 5/3/42 of this post.

WIA-yes

Additional diagnoses (Complications, special treatment, and operations):
(2) Burns 2nd & 3rd Degree Superficial incurred Concurrently & Jointly with above, involving L Arm and Forearm.
WIA-yes.

Line of duty yes
Condition on completion of case Died

Transfer diagnosis confirmed or non-confirmed
Autopsy None

N R Hayden Maj. M.C.

9

5/3/42 During evening shelling of this post 5/3/42 patient was struck by shell fragments.
Admitted unconscious. Noted gp perforating wounds of scalp and skull, L. temporal and forehead area and R. parietal region.
Tetanus Toxoid 1cc and Morph. Sulph. gr ¼ @ were given on by admitting officer, by the officer who first saw him. This morning he had blak. pupils unequal. Drop reflexes all inactive. BP 100/60 Temp 102 Pulse 120 Skull Cranial, Robinski Plantar: Normal
Diagnosis: Cerebral Laceration and Contusion
Probable skull fracture.
N R Hayden Maj M.C.

5/3/42 Nasal Hemorrhage. Bloody Exp. Pressure not successful. Catheterization - Few drops of bloody fluid. Cond. poor.
N R H

5/4/42 Comatose. No localizing signs.
Prognosis - poor.
N R H

Patient examined and found dead 10:20 am
N R H

Form 66-81-1
Revised May 31, 1939

710

TEMPERATURE—TREATMENT—NURSE'S NOTES

Name Abel, Robert H. Grade ..... Ward 6

Date	A.M. T	A.M. P	A.M. R	P.M. T	P.M. P	P.M. R	Bs	Wt	Medication and Nurse's Notes
5-2-42				99⁴					Committed to Ward -6 per litr from Surgery. Order impinging. Chloroform 100 } 8:15 p.m. Gas anesthesia 1/200 } Morphine 30 gr. ½ gr. "H" at 9:00 p.m. for entrance. Prepared for Resp. 1000 c.c. of ½ glucose. 1:2. Cyanotic color gen. Pt. Catheterized this P.M. but no urine obtained. Spinal puncture done, fluid slightly bloody. Bed elevated at head of bed as he may strangle. Bed side apparatus this P.M. Resp. rapid & shallow impeciptic. Expired 10:20 A.M.
3	101	100	36	(24)					
	102⁴			100	100	44			
				101	100	44			
4	103⁴								
05-24									

(Over)

9-A

Form 88 a
Memo Dep't, W. D., A.G.O.
(Revised May 31, 1920)

CLINICAL RECORD
BRIEF

Register No. ..... Hospital ..... Ward .....
Name ..... Serial No. .....
Grade ..... Co. ..... Regt. and Arm or Service .....
Age ..... Nativity .....
Service ..... Date of admission .....
Source of admission .....
Station .....
Ward .....
Religion ..... Previous admission .....
Name and address of nearest relative ..... Home address .....

Disposition Dead Date 5-3 1942

Final diagnosis:

(1) Hemorrhage Traumatic abdominal cause.
(2) Fracture, pelvic. ilium left.
(3) Shock - type Exhaustion and from internal Hemorrhage secondary to #1 I
Soldier was in powder room when enemy artillery caused powder to explode with resulting collapse of walls impinging Soldier for 10 hrs. 5-2-42 2 P.M.
Brought in by Ft. Mills. P.I.

Additional diagnosis (Complications, special treatment and operations):

Special Surg. Consultation Blood Transfusion 2 cc Morphine sulph 1/4 gr

Line of duty Yes. W/R 1920
Condition on completion of case Dead.
Transfer diagnosis confirmed or not confirmed .....
Autopsy Yes

W. J. Hambrecht
Capt M.C. M.C.

10

Barnes James T. ag. 5??? C.A.C. Wardos

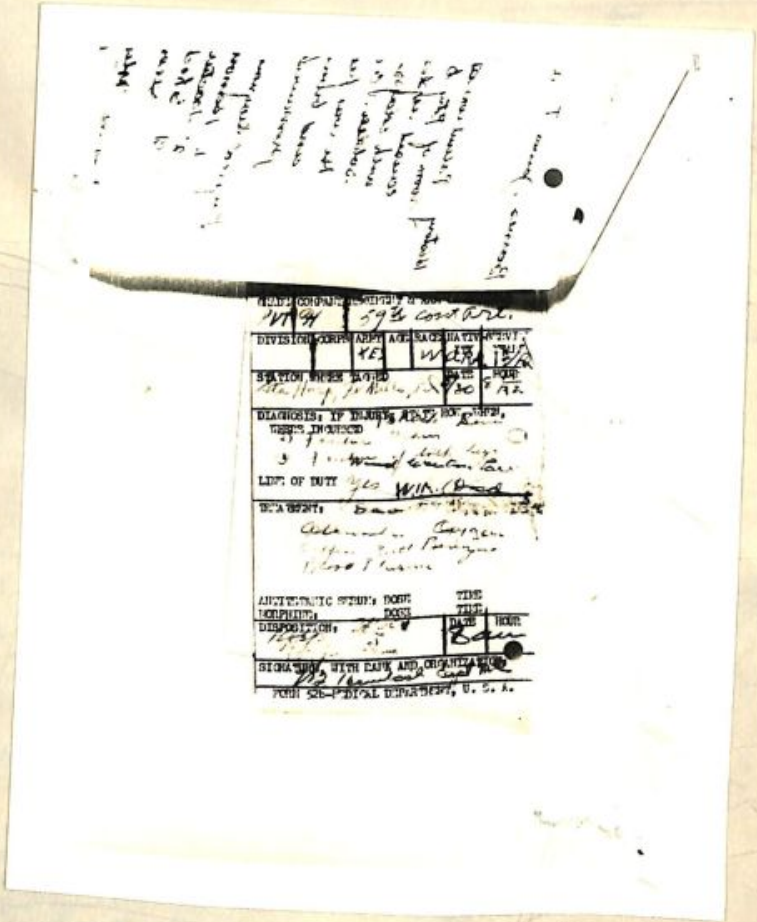
History. Patient was at post of duty in powder room of Fort Drum when enemy artillery caused explosion of powder in powder room with collapse of walls which impinged soldier. Occurred 5-2-42. 2 P.M.
He was freed of impingement at 8 A.M. 5-3-42 and brought to Ft. Mills Hospital in Bay in prone position on stretcher.

Physical diagnosis
1. Hemorrhage, traumatic, abdominal.
2. Fracture, pelvic, ilium left.
3. Shock - type exhaustion and hemorrhage secondary to #1

Progress Notes.
5-3-42 Patient was in prone position on stretcher
Given 500 cc Blood plasma and 1000 cc Normal saline. Caffein Sod. Benzoate gr 7½ i.v.
Patient pronounced dead at 8:55 A.M.
5-3-42

W. J. Hambrecht
Capt M.C.

10



GRADE | COMPANY, BATTERY, TROOP, OR DEPT. | 59th Coast Art.
DIVISION | CORPS | ARMY | AGE | RACE | NATIVITY | SERV.
STATION WHERE TREATED | DATE | HOUR
DIAGNOSIS: IF INJURY, STATE HOW CAUSED, WHERE INCURRED
LINE OF DUTY | Yes | WIA (Bomb)
TREATMENT:
AUTHENTICATING STAFF: DOSE | TIME
COMPLETED: DOSE | TIME
DISPOSITION: | DATE | HOUR
SIGNATURE, WITH RANK AND ORGANIZATION
FORM 52—FEDERAL BUREAU, U. S. A.

10-A

Forms 88 A, 88 B
WAR DEPARTMENT, U. S. ARMY
(Revised May 31, 1920)

CLINICAL RECORD
BRIEF

Register No. [illegible] Hospital [illegible]
Name [illegible], Robert E. Serial No. [illegible]
Grade Pvt. Co. [illegible] Regt. and Arm or Service [illegible]
Age 22 Race [illegible] Nativity Ohio
Service 1-2/12 Date of admission [illegible], 19
Source of admission [illegible]
Station [illegible], Fla.
Ward 10 Previous admission
Religion Protestant Home address Alvin, Texas
Name and address of nearest relative Mother: Mrs. Bernice Pritchard, same address.
RCA/fm
(Initials of admitting officer)

Disposition Dead. Date 5 - 4 1942

Final diagnosis:

Burns, second degree, face, chest arms and back.

Patient was near gas tank of search light motor when enemy shell caused explosion of gasoline with resulting injuries to back, 2:20 P.M. 4-28-42 at Bridge of #1 motor gasoline tank. Malaria 1dll.

Additional diagnoses (Complications, special treatment and operations):

Line of duty Yes
Condition on completion of case Dead.
Transfer diagnosis confirmed or not confirmed
Autopsy Yes

W. J. Isenbeck
Capt M. C. M. C.

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Progress notes

Pat 10.

Pritchard Robert E.

TREATMENT Pvt Co "M" 60 C.A.

History: 5 Alarm was sounded July 4-25-42 at 2 P.M. at gas tank of search light motor when enemy shell caused explosion of gasoline & burning soldier.

Diagnosis: (1) Burns second degree of face chest and arms and back.

Treatment. Patient in shock. Burns 4-28-42 and spray to skin. Codein 1/2 gr Morphine given in O.P. M. 3 gr 1/4

4-30-42 Patient respiration slow and irregular. Hyperpyrexia. Nasal saline.

5-2-42. Given nasal saline subcutaneously. Skin edematous. Patient unconscious. Condition P.M. 3.42 very poor.

5-3-42. Patient temperature very high Voids, [illegible] Patient given oxygen died at 1.05 P.M.

5-3-42

W. J. Isenbeck
Capt M.C.

11

TREATMENT

Name Prichard Robert E. Grade Pvt. Co. "C" 60 CG Ward Ent 10

Date | T | P | R | T | P | R |

4/30/45

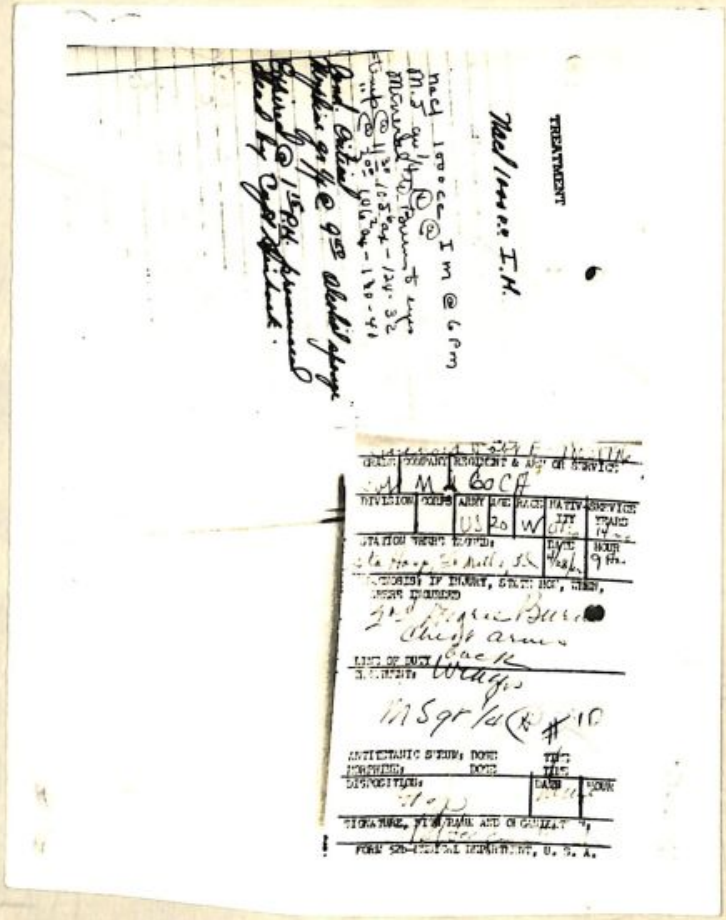
Pt adm per litter. 2nd degree burn. chest, arms, back.
Fluids forced.
Abdomen soft, BS ++
Foley inserted to bedside unit
Nacl pt. gr ¼ @ 5pm.
Tannic acid spray to be used.
Area
Intake 1260 cc
Morphine gr ¼ @ 7pm
Urine complete
4/30 48 122 16 98 22 Intake 1680 Neubleising
Urine Voided 900 cc
Morphine gr ¼ @ 9pm RH
M.S. gr ¼ @ 9pm
much difficulty in voiding
Very restless & nervous at
Condition as @ time
M.S. gr ½ @ 1am
Output 1200
Intake 1000 cc

5/1 100 92 34
100.6 34
Morphine gr ¼ @ 8am Cond. fair.
Blood Pressure
103 78 28 Leg cc Head RH
103 78 26 adrenalin 11 cc at 11 am
Urine last voided
Sulfadiazine gr X T.i.D
Morphine gr ¼ @ 12 pm
Dressing done in Chow Hall @ 12 noon
M.S. gr ½ @ 1pm 1pm 3pm
much drainage present.
Good Color
Vital Output?
Fluids from exit Intake
Intake 1100

TREATMENT

	T	P	R	
5/1	104.6	132	40	Nacl 1000 cc I.M.
	104	120	36	
	104	110	30	
	103	106	26	Nacl 1000 cc Im @ 6pm
				M.S. gr ½ @
				Mineral Oil to burns eyes
5/2	105	124	32	Urine @ 1pm 105 cc - 124 - 32
5/3	106	124	42	" @ 2pm 106 cc - 120 - 41
	103	120	40	Good Color
				Morphine gr ¼ @ 9pm Alcohol sponge
				Expired @ 1:15 PM pronounced
				Dead by Capt Prichard.

11-A



TREATMENT

Med/surg I.V.

Med 100 cc IM @ 6p3

MS gr ½ @ 9p3

Amt Urine 9p3 about 4 oz.

Regular diet @ 9p3

Bed @ 15th Capt Robinson

60 CA

M

US 20 W

9 Pm.

Sta Maye Ste Mill, SK

Pvt Rogers Burn

Shell arm

Lacer

Wounds

MSgr ½ @ #10

11-B

Form 88 A
Bureau of Medicine & Surgery, U. S. Navy
(Revised May 31, 1941)

CLINICAL RECORD
BRIEF

Register No. 1432 Hospital Station Hospital, Fort Mills, P.I.
Name [illegible], Earl Carlos Serial No. 207-03-38
Grade CQM Ca. — W/O 2 51 Regt. and Arm or Service USS Navy
Age 32 Race [illegible] Nativity [illegible]
Service [illegible] Date of admission Dec. 27, 1941 @ 11:00 AM
Source of admission Par 6 b (5) AR 70-010
Station Fort Mills, P.I.
Ward Orthopedic
Religion [illegible] Home address [illegible]
Name and address of nearest relative [illegible] T.H
(Relation of relative above)

Disposition Died Date 10:45 pm Oct 23, 1942

Final diagnosis: Patient sustained a fracture, dislocation of the spine at about the level of the 10th dorsal vertebra with immediate paraplegia when a bulkhead fell on him during an explosion that resulted from a bomb dropped by an enemy plane on Dec 24/41. He was sitting down and when the explosion occurred he was pitched forward on the deck and was never able to alter his position.

Additional diagnoses (Complications, special treatment and operations):
Bilateral pneumonia, hypostatic 12/27/41.

Line of duty Yes
Condition on completion of case DD
Transfer diagnosis confirmed or not confirmed
Autopsy No

See Consent Record for final entry.
Expired 2:30 pm
Next of kin notified

M.C.

12

JSD NO. 15 Book Chit ISSN Ward 2
Name MARTIN, E.C. Female (Name-Grade-Ser. No.)
Part to be examined (or treated) Entire system, dorsal spine
Clinical diagnosis (Include operation) Fracture, spine, dorsal, 10th
Date 12-27-42 19 Ser. No. 207-03-38 Rank or Grade CQM USN M.C.

Roentgenological Report No. 1
Date 12-27-42 19
Roentgenological X-ray investigation of the spine shows a fracture of approximately the 10th dorsal vertebra with a dislocation forward of the upper portion of the body of the vertebra. There is an associated compression fracture with separation of the bony elements of the vertebrae with marked displacement forward of the upper portion of the body of the vertebra. There is posterior tilting of the posterior fragments.

C.O. USS Lt. Comdr. (MC) U.S.N.

RADIOLOGIST REPORT
Date 19
M.C.

12

Form 88-B
Medical Department, U. S. A.
(Revised May 31, 1928)

PROGRESS NOTES

Name Harbin, Earl C. Grade CMM USN Ward 7

(Complications and changes in diagnosis, with date in each case, should be entered on this sheet)

10/20/41 Resting comfortably - J.H.H.

11/7/42 Urine clear. Microscopic clear, patient complains of the area of pain over 1st lumbar vertebrae - paralysis complete. J.H.Hewlett

2/6/42 Little variation in general condition. J.H.Hewlett

2/14/42 Area marked by decubitus ulcer gradually increasing in size unfavorable in therapeutic measures. No return of sensation or motion - Hewlett

3/10/42 no change in general condition J.H.H.

3/29/42 Patient plays up & entertains responding to Sulfanilamide J.H.Hewlett

4/20/42 Little variation during past month, exudation due to atrophy & lower extremities becoming involved J.H.Hewlett

5/4/42 condition unchanged.

5/15/42 Unchanged. Hewlett

(Use both sides of this sheet)

Form 88-D
Medical Department, U. S. A.
(Revised May 31, 1928)

TEMPERATURE—TREATMENT—NURSE'S NOTES

Name Harbin, E. Grade CMM - USN/NAVY Ward 7

Date	A.M. T	P	R	P.M. T	P	R	BM	Wt	Medication and Nurse's Notes
2/6				99°	72	20			ulcer 6 cm x 4cm. Complains of unendurable burning sensation. Ordered Aspirin gr x q 4 hr.
				100°	96	22			Catheterized with 1050 cc. urine. Retained Catheter anchored. Bladder irrigation 5 Ed Boric acid 2-4 To be turned Q.T.D
									Turned on R side @ 8:30 PM
									Cod gr ii Aspirin gr X Q 1:30 PM
									Urine bacteria gm II C 3.6 m.
28	99°	88	22	99°	88	22			Codeine gr ½ Aspirin gr X
									Turned on L side @ 10 PM Turned on left side 4:30 PM turned @ 6:00
									Output 300 — cc
									Codeine gr ½ Q for pain @ 6:00
									Cod gr ii V Asp gr X Q 4 hrs.
									Turned Back during night
									Output 700 c.c.
27	97°	96	18						BLADDER IRRIGATED B.I.D.
									WEAK WATER EDEMA - RETAINED
									HIGHLY COLORED.
									TURNED ON ABDOMEN THIS A.M.
									CODEINE GRT ½ C.M.
									FLUIDS FORCED
									Codeine gr ½ at 7 PM
30	99°	96	18	100°	90	20			Cod Asp gr ii Q 4 hrs for pain
				101°	96	22			
31	99°	92	22	99	96	20			Bladder irrigated Bladder irrigated & turned Cod Asp gr ii Temp 99° 6 P.M. Cod gr ii Asp gr X @ 6 P.M. Cod gr ii Asp gr X @ 12 midnight
1-1-42									Turned on R side 6 A.M.

(Over)

12-A

TEMPERATURE—TREATMENT—NURSE'S NOTES

1941

Harbin, Cornelius

Date	A.M. T	P	R	P.M. T	P	R	Bl	Wt	Medication and Nurse's Notes
12/31									Sulfanilamide gr ½ } Soft toilet gr x. } Ord for 5 days then gm Sulfathiazole 0.3 } Soft toilet gr x } Void. S.S. Enema, tonic Dressing changed 3% Iodine following irrigation. Cream in Abdomen Rhe – Soft diet. Void. P 36° } Pain Comfort. }
1942 Jan 1				100°	99	24			Sulfanilamide gr ½ c soda Bicarb gr x 8-1-6 Bladder irrigation Bid Cod. gr x Asp gr x c 3 pm
2	99	80	24	99°	92	20			Sulfanilamide gr x 8-1-6 Bladder irrigation ¶ Boric acid Bids Soft diet Tonic ordered 6 pm
3	99°	96	18	99°	92	16			Cod gr x Aspirin gr x 8 pm Sulfanilamide gr x 8-12-4 Bladder irrigation Bid
4	98°	88	20	98°	88	20			Laxative gr ½ 6 pm S.S. enema 6 am Sulfanilamide gr ½ 8-12-4 Bladder irrigation Bid
5	98°	88	20	98	88	20			Cod gr x Asp gr x 9 pm Soft diet. Sulfanilamide gr ½ 6 & 10 Ointment 875 8 pm 3 times

11 Pages

11

TEMPERATURE—TREATMENT—NURSE'S NOTES

Name Harbin, E Ward Comm. US Navy Ward

Date	A.M. T	P	R	P.M. T	P	R	Bl	Wt	Medication and Nurse's Notes
1942 1.5									Laxative gr ½ 9 pm Cod gr x Asp gr x 10 AM Sulfanilamide gr ½ c Soda 8-12-4 Tonic ord. Ointment 725 @ 6 pm Laxative gr ½ 11 AM Aspirin gr x 3:30 pm 7-1 Diet as tol.
6	98	80	20	98°	92	20			Sulfanilamide gr ½ c Soda 8-12-4 Tonic ord. Ointment 725 @ 6 pm Laxative gr ½ 11 AM Aspirin gr x 3:30 pm 7-1 Diet as tol.
7	98	88	20	98°	92	20			Discontinue Sulfanilamide Irrigate bladder 8-4 ¶ Boric Sol. Tonic ord. Dressing bid - turn from side to side frequently Ointment @ 6 pm bid Aspirin gr x 3 pm for discomfort
8	98°	88	20	98°	92	20			Irrigate bladder bid ¶ Boric sol. instill Argyrol 50% to. Soft diet. Drainage 1500 c c " 6 P.M. 2000 c c Aspirin gr x 3 pm for discomfort
9	98°	76	18	99°	94	20			Bladder irrigation Bid ¶ Boric Sol then instill Argyrol 50% Drainage 700 c c Ointment bid @ 6 pm Catheter changed. Aspirin gr x 4 pm for discomfort
10	98	80	20	99°	100	24			Bladder irrigation Bid ¶ Boric Sol. Output 1225 Argyrol 50% in Ethyl Bid

12-B

TEMPERATURE—TREATMENT—NURSE'S NOTES

Harbin E

Date 1942	A.M. T	P	R	P.M. T	P	R	W	Wt	Medication and Nurse's Notes
1-11	98	96	22	100	90	18			Bladder irrigated & Boric Sol
				102	96	22	@4:30		follow & Argyrol 5% Bid
				99	92	20			Pt turned from side to side frequently Soft diet
									Turned to Bm frequently
									Night child 8PM.
12	98	84	18	99	78	22			Bladder irigation & Boric
				101	92	22			then instill Argyrol 5%
									Soft diet
									Drainage @ 10 a.m. 110 c.c.
									@ 3 P.M. 470 c.c.
13	98	92	22	100	102	22			Output- 5th 7th 1250 cc
				101					Bladder irrigation Bid
									Spec Care to back
									Soft diet
14	98	88	18	99	88	20			Output 1000 cc
				101	92	20			Bladder irrigated & Boric
									Sol followed & Argyrol 5%
									Bid - Spec Care to back
									Drainage 1075 c.c.
15	98	84	20	100	98	20			Output 9th 9th 1200 cc.
				101	92	20			Drainage
									Irrigate bladder Bid Soft diet
16	99	92	22	101	96	20			Output 1000 cc
				101	98	20			Same Treatment
									Output 7th-7th 500 cc
17	98	92	20	98	96	20			Output 9th 7th 1000 cc
									Bladder irrigation Bid
									Soft diet - Spec care to back
									Dis continue Argyrol & Boric
									Irrigations
									Regular Diet

Continued on next Page

TEMPERATURE—TREATMENT—NURSE'S NOTES

W 11

Name Harbin E. Grade Cmm USN Ward 7

Date 1942	A.M. T	P	R	P.M. T	P	R	W	Wt	Medication and Nurse's Notes
									Disc Boric & Argyrol Irrigation
									Irrigate C Pot Permanganate
									1-5000 Sol 8 am & 4 PM
									irrigate until water returns
									Clear.
									Ephedrine gr ½ C amytal gr III
									@ 11 am
									To ward from 10th this P.M.
									Amytal & ephedrine gr ½ @ 4 PM
									& 4 AM p.r.n.
18	99	100	22	100	90	18			Encouraging & Normal care [illegible]
				100	94	20			Dr. Richards Sick to Quarters
									Output- 1200 cc
									Irrigate bladder C Pot Perm
									8 am & 4 PM daily (1-5000 sol)
									Soft diet Spec Care to back
									Ephedrine gr ½ & Amytal gr ½ @ 12 m
19	98	96	22	100	92	18			Encouraging & Normal care gr ½ & gr
				100	94	20			Ephedrine & Amytal @ 7th
									Same Treatment to bladder
20	99	96	23	100	96	20			Output- 1475 cc
				101	110	18			I.S. evening 12th
				101	102	20			Night Child @ 3PM
21	99	84	20	99	76	22			Codeine & Aspirin 8th
	99	82	18	99	88	18			Urine blood tinged [illegible]
									Cystoscopic [illegible]
22	98	98	20	99	92	20			Output 1025 cc
				99	96	20			Bladder irrigated as usual manner
				99	98	22			Output 6 AM - 6 PM 550 cc
									CASCARA & MINERAL OIL H.S.
23	98	90	20	98	90	18			[illegible]
				99	92	20			Output- 850 cc
									Urine well [illegible]
									[illegible]

12-C

TEMPERATURE—TREATMENT—NURSE'S NOTES

Harbin

Date	A.M. T	P	R	P.M. T	P	R	BM	Wt	Medication and Nurse's Notes
1944									
24	98[6]	80	20	99[2]	90	16			Output 1200 cc
				99[8]	98	16			Blanket sponging to knees & forearms
									irrigation discharged
25	99	80	20	100[4]	88	20			Output 1850 cc
				100[4]	86				1 Fleet enema, irrigation by
									Continued undisturbed
26	99	80	20	99[4]	88	20			Output 1400 cc
	98[6]	82	20	100[2]	96	18			Cath urine & Jones absent to urin
									Intra - Kapiff test & wound an
									possible. Blanket sponging cont'd
27	98[6]	80	20	100[4]	92	18			No change in treatment
	99[6]	82	20	100	84	18			Irritation of scrotum improved
									S.S. enemas given
28	98	76	18	101	88	20			Scrotum inflamed - B kept
	99[4]	82	20	101[4]	96	22			dressed. Cath'n changed
									Blanket irrigation discontinued
29	99[6]	88	20	102[2]	94	20			Output
	101[6]	88	22	102[2]	100	22			Catheter undisturbed. Balance
									of Foley draining to dependent
30	99[6]	84	20	103[6]	96	22			11 ounces 8 P.M. & few minutes
	100[4]	86	20						Blanket irrigation discontinued - Balance of
									Foley draining to dependent
				102[6]	88	20			Buttocks still 12+ - Enteral back opened
31	99[4]	82	20	101	86	20			to bare tissue - moist to dependent
	99[4]	80	20	100[8]	84	20			Condition of sore progressively worse
									Foley removed voluntarily
February 1	99[6]	96	22	100	86	20			No change - treatment contd
				102[4]	92	20			Very Apathetic
2	98[4]	94	20	100	84	20			Continued undisturbed
				100	92	20			S.S. enemas given
3	99+	2		101[8]	88	22			Urine voided from 12 midnight to 6 A.M.
	99[4]	88	22	102	96	22			No change Output 725 cc
4	98[8]	84	20						

12-D

TEMPERATURE—TREATMENT—NURSE'S NOTES

Harbin

Date 1942	A.M. T	P	R	P.M. T	P	R	N	Wt	Medication and Nurse's Notes
14	98	72	18	98	72	20		S	Light treat 15 min B.D. Pressure area Massaged Balsam Peru Dressing. Right Heel Sandbag Catheter changed. Output – 1000 cc 7 pm
15	98	72	18					O	Treatments continued
16	98	72	18	99	72	18		T	Treatments cont. Improvement Pressure area 2nd day Mineral Oil gtt i 8 pm Caseara gtt 1200 cc 7 pm Output
17	98	72	18	100	80	20		E	Treatments continued Improvement Bedsore dressed & Balsam of Peru Output 800 7 pm
18	98	66	18	100	88	20		E	Treatments continued Condition about the same. Output – 900 cc 7 pm
19	98	72	18	100	80	20		O	Treatments continued No change in condition
20	98	72	18	100	92	20		O	Caseara gtt / Mineral Oil gi / 8 pm Dressings cont. Treatments cont.
21	97	66	18	98	84	18		O	Treatments continued Dressings cont.
22	98	80	20	100	80	20		T	Treatments cont. Improvement
23	98	72	18	100	84	20			Complaint of pain in left side of lower abdomen. Position changed often.

TEMPERATURE—TREATMENT—NURSE'S NOTES

Name Harbin E Grad. – Jr. Sr. – H S Ward 7

Date 1942	A.M. T	P	R	P.M. T	P	R	Wt	Medication and Nurse's Notes
24	101	80	20	100	76	18		Pressure area on left hip. Cold packs for temperature – no drugs
	99	84	ok	103	80	18		Catchet Mineral Oil 3iiss @ 8pm. Cascara 3ss Pressure area massaged.
25	101	80	20	100	76	18		2nd ZINC STEARATE TO BE MIXED PRESSURE SORE.
	99	84	ok	101	80	18		3S EDEMA - EFF.
								BLADDER IRRIGATED B.I.D.
26	97	100	20	100	90	20	S	Dsg changed wet.
	99	82	20	98	80	20		CASCARA & MINERAL OIL 6 pm
27	98	74	18					CATH. JAMS
	98	80	18	98	84	18		
				98	78	18		Dsg wet.
28	98	70	18	98	84	18		3S EDEMA - EFF.
				98	82	18		TREATMENT CONT. Dsg changed
29	99	82	22	99	90	20		Treatments cont.
	98	82	18					CASCARA & OIL 7 pm
30	99	82	20	100	90	20		Treatments cont.
	98	82	18	100	84	20		3S EDEMA EFF
2	98	72	18	98	88	20	S	CATHETER CHANGED
								TREATMENT CONT.
3	98	80	20	100	84	20		3S EDEMA - EFF.
4	98	80	20	100	88	20		TREATMENT CONT.
								TREATMENT CONT.
5	97	70	18	100	84	18		3S EDEMA - EFF
6	98	88	20	100	84	20		Routine care – catheter changed
				102	84	18		Cascara & Mineral Oil 6 pm
7	98	78	18	101	84	20		3S EDEMA EFF

12-E

TEMPERATURE—TREATMENT—NURSE'S NOTES

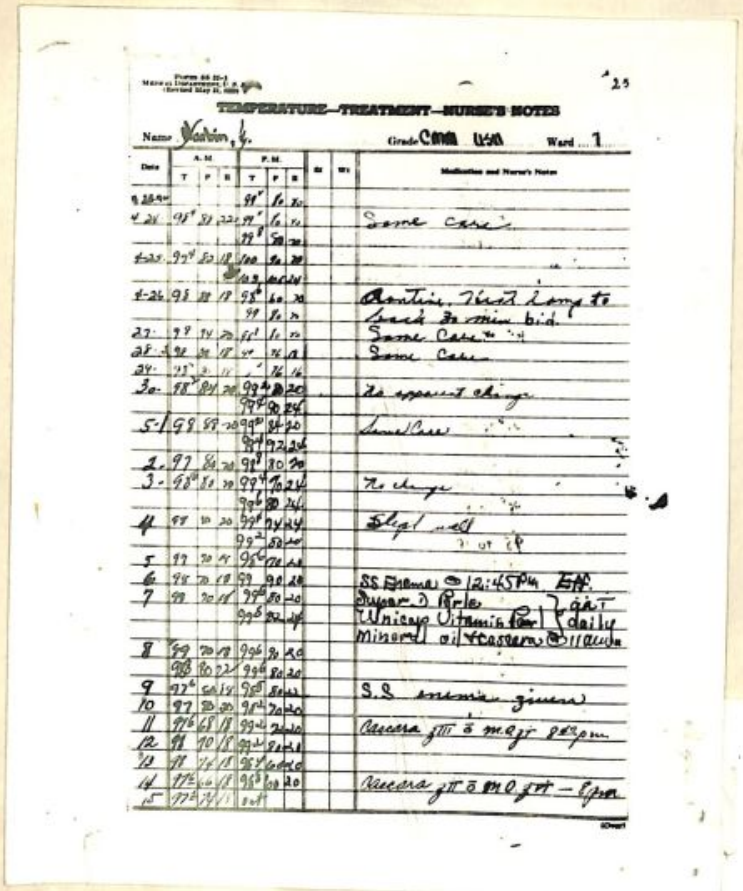
Hughes

Date	A.M. T	P	R	P.M. T	P	R	M	Wt	Medication and Nurse's Notes
9 AP				100	84	20			
9	98	80	18	100	96	20			TREATMENT SAME - cold sponge.
				100	84	18			Cascara x ... SAT 8 pm
9	98	82	8	100	88	20			BgSS enema - eff.
				100	88	20			CARE SAME
10	98	88	20	100	88	20			
	99	80	20	100	96	20			Cascara x ... at 8 pm
11	98	80	20	100	96	22			SS enema - eff
				100	84	20			CARE SAME
12	98	80	18	101	90	20			TREATMENT SAME.
	101	88	22	99	84	18			Urine spec. to LAB.
									Elix TR. Benzoin 3 T TID
13	98	88	20	101	88	22			SS enema this AM.
				101	90	22			MEDICATION + TREATMENT SAME
									Cascara x ... at 8 pm
14	98	80	18	100	88	20			CARE SAME
				99	88	20			
15	98	80	18	101	84	18			Medications + Treatment same.
	100	84	18	101	90	20			
16	98	88	18	100	84	20			OUTPUT 7:00 1850 cc
				100	84	20			Cascara x ... at 8 pm
17	99	80	18	100	88	20			Catheter changed — routine care.
	99	88	18	99	88	20			SS enema - fair result
18	98	88	18	100	88	20			CARE SAME
	99	80	18	101	90	20			
19	99	88	20	102	96	20			Had chilly reaction for 1/2 hr after
	100	84	20	102	102	20			enema this AM
									COMPLAINS HARSER - VOMITED
									X2 TODAY.
20	102	100	20						STILL COMPLAINS OF CHEST PAIN
	102	96	20	102		100	20		CHEST SUCTIONED ALL A.M.
	100	104	20						
21	100	96	20						SUPERVISOR GETTING CBC TAKEN

TEMPERATURE—TREATMENT—NURSE'S NOTES

Date	A.M. T	P	R	P.M. T	P	R	M	Wt	Medication and Nurse's Notes

12-F

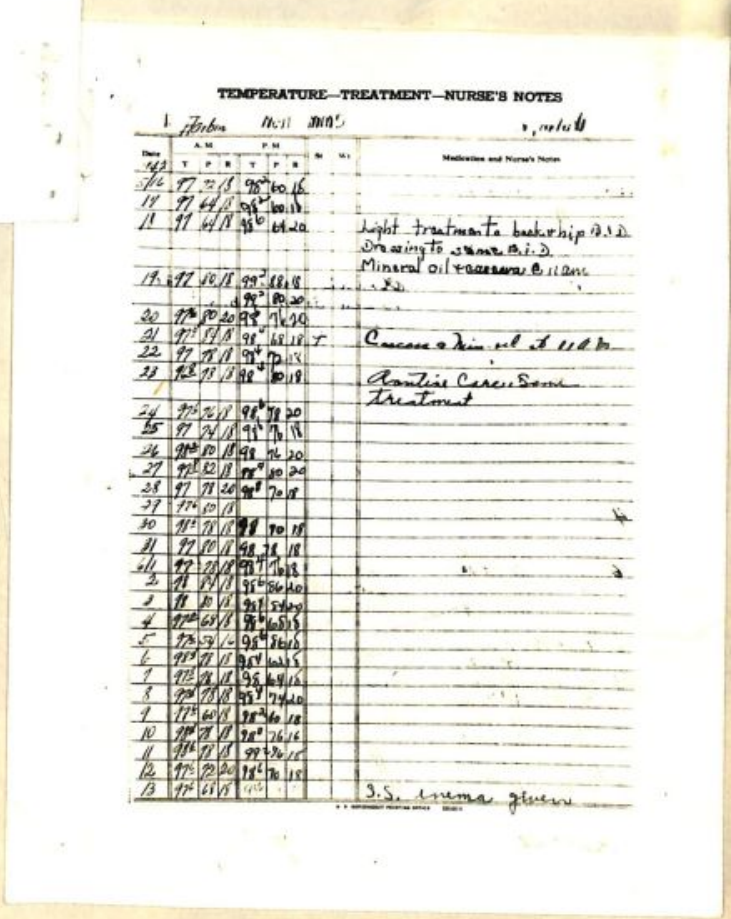


TEMPERATURE—TREATMENT—NURSE'S NOTES

Name Hobson, L. Grade CAMA USN Ward 1

Date	A.M. T	P	R	P.M. T	P	R	Ht	Wt	Medication and Nurse's Notes
4-24	98°	80	22	99°	16	20			Some Case.
4-25	99°	80	18	99°	80	20			
4-26	98	88	18	98°	60	20			Aconite, Tinct Lomp to each 3ss min b.i.d.
27	99	84	20	99°	16	20			Some Case
28	98	86	18	99°	76	20			Some Case
29	98	84	20	99°	80	20			No apparent change
30	98°	84	20	99°	80	24			
5-1	98	82	20	99°	84	20			Some Case
2	97	84	20	99°	72	24			
3	98°	86	20	99°	80	20			No change
4	98	80	20	99°	76	24			Stopl ord
5	97	80	18	98°	80	24			
6	98	80	18	99	90	20			SS Enema @ 12:45 PM EA
7	98	80	18	99°	80	20			Sugar of Milk, Unicap Vitamin tab, Mineral oil tr cascara @ 11 AM daily
8	99	80	18	99°	84	20			
9	97°	84	18	98°	80	20			S.S. enema given
10	97	80	20	98°	80	20			
11	97°	68	18	99°	72	20			Cascara gtt x major person
12	98	90	18	99°	84	18			
13	98	76	18	98°	60	20			
14	97°	80	18	98°	80	20			Cascara gtt x AM & gtt — Epsom
15	97°	84	18	Soft					

(Over)



TEMPERATURE—TREATMENT—NURSE'S NOTES

1 Hobson Neill MM's

Date	A.M. T	P	R	P.M. T	P	R	Ht	Wt	Medication and Nurse's Notes
4/17	97	72	18	98°	60	16			
18	97	64	18	98°	60	18			
19	97	64	18	98	64	20			Light treatments back ship B.I.D. Dressing to sacrum B.I.D. Mineral oil tr cascara @ 11 AM. SS
19	97	80	18	99°	88	18			
				98°	80	20			
20	97°	80	20	98°	76	20			
21	97°	84	18	98°	68	18			T Cascara Min ml S 11 AM
22	97	78	18	99°	70	18			
23	98	78	18	98°	80	18			Aconite Cases Some treatment
24	97°	76	18	98°	78	20			
25	97	74	18	99°	76	18			
26	97°	80	18	98	76	20			
27	97°	82	18	98°	80	20			
28	97	78	20	98°	76	18			
29	97°	80	18						
30	97°	78	18	98	80	18			
31	97	80	18	98	78	18			
6/1	97	78	18	98°	76	18			
2	98	74	18	98°	86	20			
3	98	80	18	98°	84	20			
4	97°	68	18	98°	68	18			
5	97°	80	18	98°	84	18			
6	98°	78	18	98°	80	18			
7	97°	78	18	98°	84	18			
8	97°	78	18	98°	74	20			
9	97°	80	18	98°	80	18			
10	98°	78	18	98°	76	16			
11	98°	78	18	99°	80	16			
12	97°	72	20	98°	76	18			
13	97°	68	18						S.S. enema given

12-G

H

TEMPERATURE—TREATMENT—NURSE'S NOTES

Name Harbin, E Grade CMM USN Ward 7

Date 1942	A.M. T	P	R	P.M. T	P	R	Bl	Wt	Medication and Nurse's Notes
6/14	100	98	20						Neuralgia
	98	80	20						
15	97	76	18						
	100								Slight chill c 12
									[illegible]
									[illegible]
16	100	96	22						Sulfanilamide gr X q.i.d.
	98	69	22	25	78	18			
	97	76	20						Vomited 4 P.M. dose of Sulfanilamide.
									Is to be given Soda Bicarb. gr X
									Q.4.P. c Sulfanilamide.
									Feels much better.
									Had not slept at all. Still feels
									sick at the stomach (No Rx)
17	100	84	20	98	80	18			
				100					Nausea & vomiting
18	98	78	18	98	76	18			Liquid diet
									Sulfanilamide gr X q.i.d.
19	98	84	20	98	80	18			Sodium bicarb gr X q.i.d.
20		84	20	98	86	18			
	99	90	20						Routine Care
21	98	78	18	98	78	18			
22	97	68	20						
23	99	96	18	99	78	20			
24	98	108	18						
25	97	96	16	98	70	18			Bladder Irrigation daily
26	97	69	16	100	92	18			Regular diet
Aug 1	98	64	16						

(Over)

#3

TREATMENT

Name Harbin, E Grade CMM USN Ward 7

Date 1942	AM T	P	R	PM T	P	R	Dr.	MEDICATION & TREATMENT
3/21	99	80	20	101	90	20	TE	S.S. ENEMA - EFF.
				103	104	22		BORIC BLADDER IRRIGATION
								B.I.D.
								Disc. Tr. BROMIDES
				12 mn 103	100	20		Sulfanilamide gr X q 4 h,
22	98	80	20	101	98	22		MEDICATION & TREATMENT SAME.
				101	100	20		
23	99	92	20	101	92	20	TE	CARE SAME
	99	88	18	104	100	20		S.S. ENEMA EFF.
								Regurgitated after supper. Vomited small
								amount curdled fluid.
24	99	100	20	101	88	18		DISC. RIGHT DOSE OF SULFANILAMIDE
				100	92	20		CARE SAME
25	99	100	20	101	88	20	TE	TREATMENT SAME
				100	100	22		S.S. ENEMA - EFF.
26	98	96	20	99	84	18		MEDICATION & TREATMENT SAME
								CATHETER CHANGED.
27	98	88	20	100			TE	S.S. ENEMA - EFF.
				101	88	18		MEDICATION & TREATMENT SAME
28	98	100	20	99	80	18		SULFANILAMIDE GR X Q.I.D
29	98	100	20	99	80	20	TE	S.S. ENEMA - EFF.
				98	84	20		MEDICATION & TREATMENT SAME
30	98	88	18	98	80	18		
31	98	96	20	99	80	18	TE	MEDICATION & TREATMENT SAME
								DISC. SULFANILAMIDE
								S.S. ENEMA EFF.
4/1	98	100	20	99	84	18	S	TREATMENT SAME
				98	80	18		
2	98	88	20	97	84	18		
3	98	88	20	99	78	18		
				99	78	20		
4	98	88	18	98	84	18		

(over)

12-H

TREATMENT

Harbin

Date	AM P	R		PM P	R		
1942							Medication & Nursing Notes
7x	98	94	18	99	80	18	
				99	92	18	
6	98	84	18	99	32	18	
7	98	82	20	99	80	20	
8	98	80	20	99	88	20	Bronchitis Care Fluids & Cold Sponges as Directed by Doctor. Diet Chicken Soup & Milk.
9	98	80	18	99	84	20	S.S. enema given
				100	88	20	
10	98	80	20	99	88	20	Cas. & Tan Aid 7 pm.
				100	86	20	
11	98	76	20				
	99	78	18	99	80	20	
12	98	80	20	99	76	20	
				100	88	18	S.S. enema given
14	98	88	20	99	92	20	Mineral Oil & Cascara
				99	80	20	
15	98	92	20	99	76	20	Mineral Oil & Cascara
				99	86	20	
16	98	80	20	99	88	20	Some Care & Diet
				99	78	18	
17	98	84	16	99	88	20	S.S. enema given
				99	80	20	
18	98	92	20	99	76	18	
				99	76	20	
19	98	78	20	99	80	20	Some Care.
20	97	86	20	99	84	18	
21	99	84	18	99	80	20	S.S. enema
22	99	88	20	99	80	20	
				100	90	20	
23	99	90	18	99	76	20	

Name Harbin Rank CWO Ward 11
Hosp. Lab.
Color Light Character Heavy Reaction Alk.
Sp. G. 1.022 Albumen Neg. Sugar Neg.
Acetone Diacetic acid Bile
Blood Indican Volume (24-hr.)
Microscopic W
Remarks

Form 88 L-8 Medical Department, U. S. Army (Revised May 31, 1939)	URINALYSIS	Date M.C.
Form 88 L-8 Medical Department, U. S. Army (Revised May 31, 1939)	URINALYSIS	Date 6-14-42 M.C.
Form 88 L-8 Medical Department, U. S. Army (Revised May 31, 1939)	URINALYSIS	Date June 7 1942
Form 88 L-8 Medical Department, U. S. Army (Revised May 31, 1939)	URINALYSIS	Date 6/14/42 M.C.
Form 88 L-8 Medical Department, U. S. Army (Revised May 31, 1939)	BLOOD	Date
Form 88 L-8 Medical Department, U. S. Army (Revised May 31, 1939)	URINALYSIS	Date 3-20-42 M.C.
Form 88 L-8 Medical Department, U. S. Army (Revised May 31, 1939)	BLOOD	Date 3-21-42
Form 88 L-8 Medical Department, U. S. Army (Revised May 31, 1939)	BLOOD	Date 3-23-42
Form 88 L-8 Medical Department, U. S. Army (Revised May 31, 1939)	BLOOD	Date 3-24-42
Form 88 L-8 Medical Department, U. S. Army (Revised May 31, 1939)	URINALYSIS	Date 3-24-42
Form 88 L-8 Medical Department, U. S. Army (Revised May 31, 1939)	BLOOD	Date 3-27-42
Form 88 L-8 Medical Department, U. S. Army (Revised May 31, 1939)	URINALYSIS	Date 3-27-42 M.C.
Form 88 L-8 Medical Department, U. S. Army (Revised May 31, 1939)	URINALYSIS	Date 3-31-42 M.C.
Form 88 L-8 Medical Department, U. S. Army (Revised May 31, 1939)	BLOOD	Date 3-30-42

H. B. C. Reading Mod. Aden
Remarks Malaria Smear

Form 88 L-8 Medical Department, U. S. Army (Revised May 31, 1939)	BLOOD	Date 6-16-42

12 – I

Form 88 A
Revised May 31, 1920

CLINICAL RECORD
BRIEF

FIELD MEDICAL RECORD

Register No. [redacted] Hospital St. Petersburg, Fla.
Name [redacted], Ralph G. Serial No. 12045229
Grade Pvt. Co. "M" Regt. and Arm or Service Inf. QM
Age 22 Race W Nativity Florida
Service Enl.
Source of admission Transfer Date of admission April 29, 1942
Station St. Petersburg, Fla.
Ward 10
Religion Catholic Previous admission
Name and address of nearest relative Mother [redacted], Johnson, Iowa Address same

Disposition Deceased Date 4-29, 1942

Final diagnosis:

Burn. 3rd Degree. Location. Entire body. Co.
Soldier was in line of duty when enemy shell caused explosion of gasoline truck causing burned body. 4-29-42 at 9 A.M. Roberts Hill in front of Search Light Engine gasoline tank.

Additional diagnoses (Complications, special treatment and operations):

Line of duty Yes. Wilful yes
Condition on admission of case
Transfer diagnosis confirmed or not confirmed —
Autopsy None

W.S. Murdock
Capt M.C.

13

Progress notes

Hist[ory]: Soldier was at post of duty near search light Engine on top of Roberts Hill when gasoline tank exploded from Enemy artillery shell causing burns of soldiers Entire body.

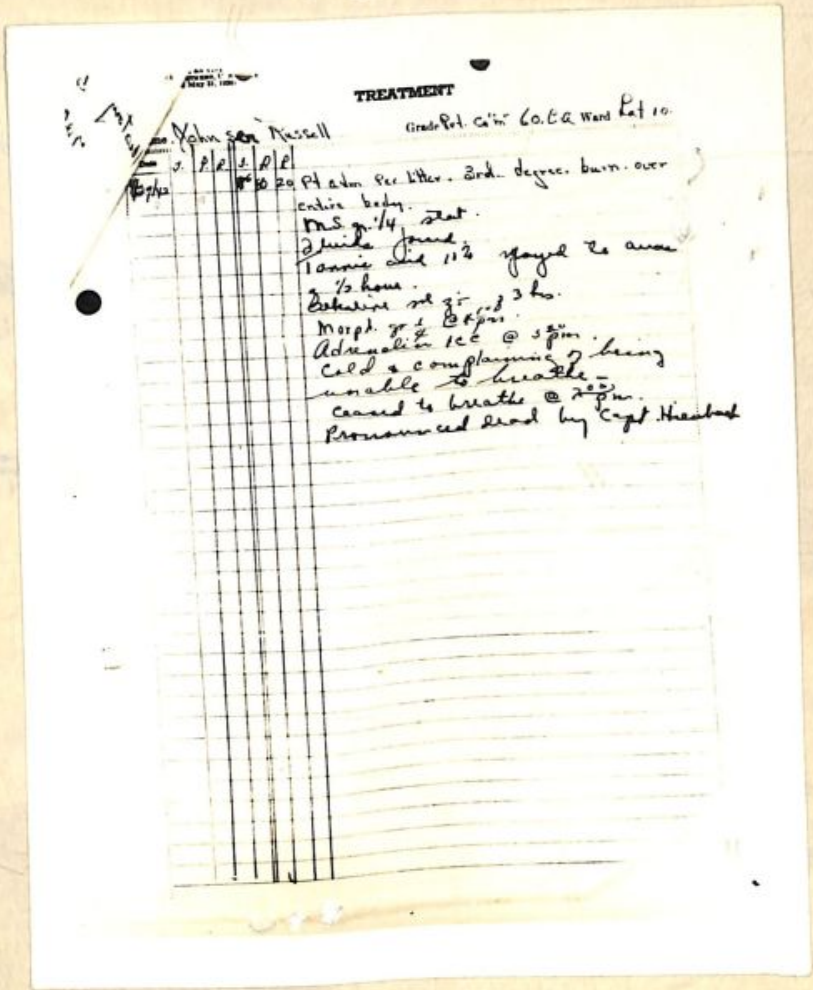
Diagnosis. 3rd degree burns of Entire body

Progress notes.

4-29-42 Patient in extreme shock given 500 cc of Blood & Serum Saline condition very grave. Cardiac tone and pulse poor. Not relieved by adrenalin. 9 PM Patient pronounced dead. 1.05 P.M. 4-29-42 by

W.S. Murdock
Capt M.C

12



TREATMENT

Johnson Russell — Grade Pvt. Co. "M" Co. C.A.C. Ward Pat 10

T.	P.	R.	I.	O	E
8/12			98	30	20

Pt adm. Rec'd Liter. 3rd. degree burn over entire body.
M.S. gr. 1/4 stat.
Shock found
Tonnic died 11⅔ gravel to anus
2 ½ hours.
Belladonna ml gr 1/150 3 hr.
Morph. gr ¼ @ 4 p.m.
Adrenalin 1cc @ 5 p.m.
Cold & complaining of being unable to breathe.
Ceased to breathe @ 20 p.m.
Pronounced dead by Capt Hamblet

13-A

CLINICAL RECORD
BRIEF

Register No. PNR
Name MINGUS, Gail W.
Grade Pvt. 1cl. Co. "F"
Age 21 Race W.
Service
Source of admission Command
Station Fort Mills, P.I.
Ward #3
Religion Prot.

Hospital Station Hospital, Fort Mills, P.I.
Regt. and Arm or Service 60th CA (AA) Serial No. 18300756
Nativity Colo.
Date of admission 5-6-42 @ 7:40 A.M. 19
Previous admission
Home address Center, Colo.
Name and address of nearest relative (Mother) Mrs. Stella Phillips Same address.

Disposition Death
Date May 7-1942 19
Final diagnosis

Wounds machine gun bullet perforating abdomen & small bowel & perforating spinal canal; from enemy firing on Ft. Mills, P.I. 5/6/42

Additional diagnoses. Complications. operations and dates of operations

Closure of intestinal perforations - gas ether anesthesia 5-6-42.

Line of duty
Condition on completion of treatment Died 12 10 am
Transfer diagnosis confirmed or not confirmed
Autopsy

M C

Mingus, Gail W. Pfc. E 60th CA(AA) wd. 3

5/6/42. Wounds gunshot - bullet thru abd. & bowel & spinal cord - Pt. cannot move legs - Closure of intestinal perforations under ether anesthesia. GS.

5/7/42 Expired

14

Name Mingus, Gall W. Grade Pfc D. 60 CA(AA) Ward 3

Date	AM T	AM P	AM R	PM T	PM P	PM R	
1942							
5/6	99	126	28	102	100	22	Adm. per litter @ 7:30 am from O.R.
				101	96	20	unconscious – Pulse weak + rapid. Perforating gsl. bullet of abd + special c… 1st Stomach Ileum. Restless & talkative early evening M.S. Gr 1/4 (H) 8 pm.
					120	26	Can't & talk at random – 10 pm taking H_2O in sips. 11 pm dozing
					136	28	12 pm Restless & talkative – Skin cold & moist – Pulse weak – Good amt. drainage from wound – 12:30 am M.S. Gr 1/4 (H) for restlessness – Can't & talk at random. Pupils dilating. Pulse weak & thready – 12:40 am. Expired – pronounced dead by OD Maj Wilson

NAME AND ARMY SERIAL NUMBER

GRADE	COMPANY	REGIMENT & ARM OR SERVICE				
DIVISION	CORPS	ARMY	AGE	RACE	NATIVITY	SERVICE YEARS
STATION WHERE ADMITTED:					DATE	HOUR

DIAGNOSIS: IF INJURY, STATE HOW, WHEN, WHERE INCURRED
Perforating wound – belly ... [illegible]
LINE OF DUTY
TREATMENT:
[illegible]

ANTITETANIC SERUM: DOSE TIME
MORPHINE: DOSE 1/4 gr TIME 5 am
DISPOSITION: DATE HOUR
[illegible] 5/6/42
SIGNATURE WITH RANK AND ORGANIZATION:
[illegible]
FORM 52b–MEDICAL DEPARTMENT, U. S. A.

Form 66 Cr-2
War Department, U. S. Army
(Revised May 31, 1920)

OPERATION REPORT

Name Maale, Ransom Grade Cio Ward 8

Date May 4 1942 Age

Postoperative diagnosis: Amputation, traumatic, left thigh Mid third, Gram + Shell fragment
(2) Compound Comminuted fracture ischiorum Femur & Lt Elbow joint

Operation: 1, Amputation of leg #2, Debridement of Lt Arm & Splint.

Remarks: Blood Plasma
Blood Transfusion

Operation began 11 Ended 11:45

Operator Maj Altman

Assistants Capt. Hesselt

Anesthesia used Ether Amount

Anesthetist Lt. Meader

Specimens forwarded to laboratory for examination:

(Corps) M. C.

Form 66 A
Medical Department, U. S. Army
(Revised May 31, 1920)

CLINICAL RECORD
BRIEF

Register No. Hospital

Name Serial No.

Grade Co. Regt. and Arm or Service

Age Race Nativity

Service Date of admission 19

Source of admission

Station

Ward Previous admission

Religion Home address

Name and address of nearest relative

(Name) (Title and arm of admitting officer)

Disposition Expired 1:10 A.M. Date 5/5/42 19

Final diagnosis:
①. Traumatic amputation left leg and comp. comm. fracture left elbow from shell fragments during bombardment of Ft. Mills shortly before admission.

Additional diagnoses (Complications, special treatment, and operations):
Reamputation and debridement of elbow.

Line of duty Not applicable
Condition on completion of case Expired

Transfer diagnosis confirmed or not confirmed
Autopsy

Edwin R. Nelson
Lt. U.S.N. M.C.

16

OPERATION REPORT

Ward 8

5/5/42 1:05 A.M. Called to see patient.
5/5/42 4:10 A.M.

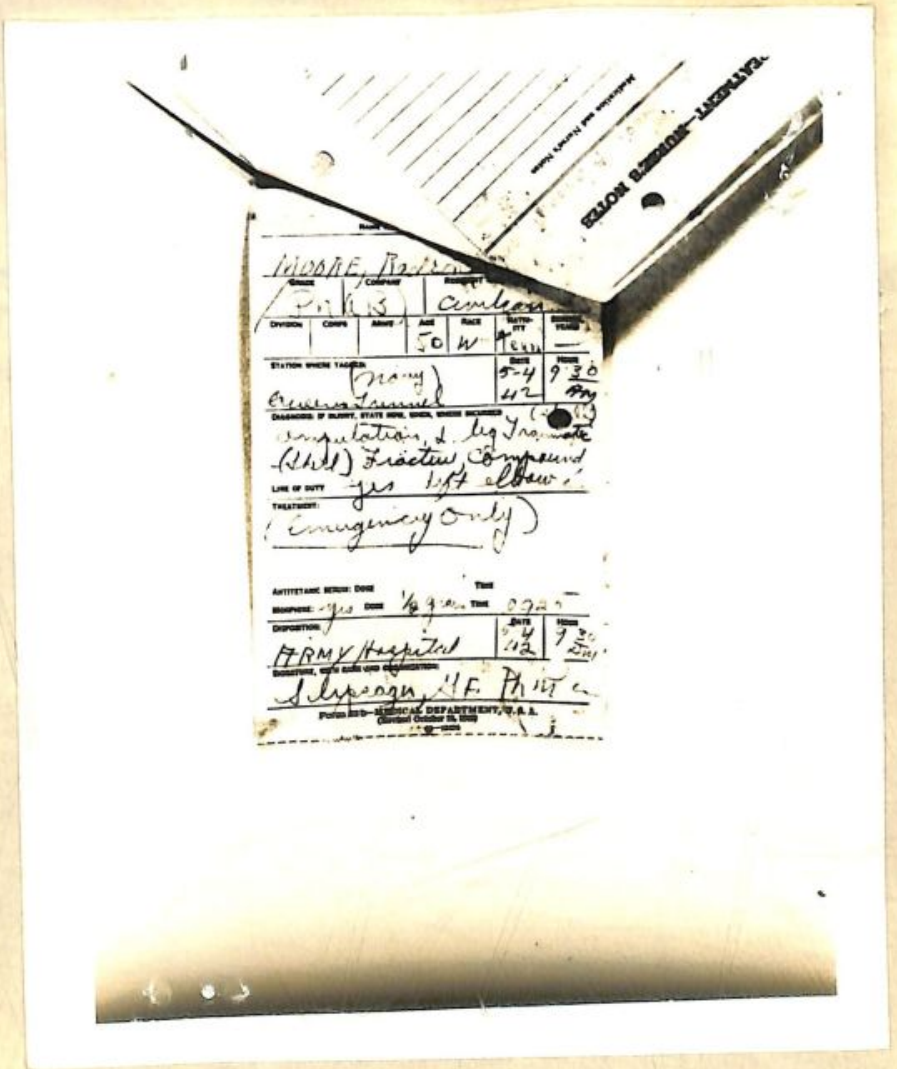
TEMPERATURE—TREATMENT—NURSE'S NOTES

Name Moore Ransom H. Grade Pvt Ward 8

Date 5/4 96 22 98

Self leg amputation + Rt arm
Taken from Operating Room
@ 11:20 500cc of Blood
IV Condition poor
Injected as Tetanus
Elevate left arm on pillows
ATS 1500 units given
Gas Bacillus antitoxin given
Morphine ¼ gr given
Blood Plasma given in surgery
Vomiting Water @ 10:30 Very pain
Resp normal — 98 — 24
Temp @ 2:00 P.M. 98 — 110 ×
Resp ceased @ 1:20 P.M.

15-A



15-B

Form 55 A
Medical Department, U. S. Army
(Revised May 21, 1936)

CLINICAL RECORD
BRIEF

Register No. FMR Hospital Station Hospital, Fort Mills, P.I.
Name Darling, Lester E Serial No. ———
Grade Civilian Co. Empl. CPNAB Regt. and Arm or Service
Age 41 Race W Nativity Washington
Service Date of admission 4/9/42 19
Source of admission Command
Station Fort Mills, P.I.
Ward 8 Previous admission
Religion Protestant Home address 1069 Adams St., Olympia, Washington.
Name and address of nearest relative Mother: Mrs. A.W. Darling, same address.

EEM
EEM/fmr
(Initials of admitting officer)

Disposition Died [illegible] Date April [illegible], 42 19

Final diagnosis:
1. Cholelithiasis, chronic, type and cause undetermined.

Additional diagnoses (Complications, special treatment and operations):
1. Cholecystectomy under spinal anesthesia April 18, 1942.
2. Pneumonia, unclassified, right lower chest, as of April 20, 1942. Sulfathiazole gms 12 given 4-21 to 4/23/1942.

Line of duty Does not apply
Condition on completion of case Died

Transfer diagnosis confirmed or not confirmed
Autopsy Not done

Emil E Merkel
M.C.

16

Form 55 F
Medical Department, U. S. Army
(Revised May 21, 1936)

PROGRESS NOTES

Name Darling, L.H. Grade Civ. of C.P.N.A.B. Ward 8

(Complications and changes in diagnosis, with date in each case, should be entered on this sheet)

April 9, 1942.
[illegible] with a history of [illegible] pain [illegible] fatty foods, loss of [illegible]
[illegible]

[illegible] daily and [illegible].

Progress notes:
April 17, 1942.
Has improved under treatment somewhat however still has flare ups of pain, staff has decided to operate in the morning.
April 18, 1942.
Operation this A.M. revealed a stone in the cystic duct of the gall bladder with distention of gall bladder. Post Op. condition satisfactory.
April 20, 1942.
Has taken fluids well and seems to be getting along well.

April 21, 1942.
[illegible] A.M. patient has taken a turn for the worse, is [illegible] [illegible] cyanotic. Placed in oxygen tent.
April 22, 1942.
Condition remains the same, no improvement thus far.

April 24, 1942.
Condition [illegible]
[illegible]

Emil E Merkel

(For further notes, use [illegible] of this sheet)

16

Form 88 (In)
Medical Department, U. S. Army
(Revised May 31, 1943)

OPERATION REPORT

Name Darling, Lester K. Grade Civ Emp Ward

Date 4-18 1942 Age

Preoperative diagnosis Chalecystitis Chronic, Cholelithiasis
Appendicitis

Operation Cholecystectomy & Appendectomy

Remarks: Blood Transfusion on 2 R.C.
Blood 500 cc
Saline 500 cc

Operation began 8:35 A.M. Ended 9:05 A.M.

Operator Col. Adams, Comm Hayes, Capt Herbst

Assistants

Anesthetic used Spinal

Anesthetist Col. Adams (R.M.) Amount Novocaine 100 mgm

Specimens forwarded to laboratory for examination:

Bureau

16-A

Form 88 (In)
Medical Department, U. S. Army
(Revised May 31, 1943)

TEMPERATURE—TREATMENT—NURSE'S NOTES

3

Name Darling, S H Grade Civ C.P.N.A.B. Ward 8

Date | A.M. 1 2 3 4 5 6 7 8 9 10 11 12 | P.M. 1 2 3 4 5 6 7 8 9 10 11 12 | M.

Medication and Nurse's Notes

4-10 98° 50 20 102 [illegible]
Serve medication & diet

4-11 [illegible]
100 80 20 104 [illegible]
C.B.C. - Blood typing for transfusion - feces to lab for culture - urine to lab for culture - Put Foley in. Gastric sedative gr ¼ M.S. 3 p.m. & 10 p.m.
Blood typed: Kriger-no agglutination. Mag. Sulph. 2 oz c.c. @ 10 A.M.

4-12 99° 98° 58 22 98 78 16
Gastric sedation 3 ii 6 PM - 7 PM + 7 PM 2 oz.
Sulfathiazole gm i 8-12-4-8
Gastric Sedation 8 c.c. ½ hr ac.
Edema

4-14 95° 78 18 77 76 16
4-15 98° 80 16 98° 78 18 98° 80 20
Continue sulfathiazole
Nothing by mouth after 6 am
Prepared for O.R.
Morphine gr ¼ stat ½ hr before 8 am
10 A.M. 01 8:10 - Adl.
Foley cath. at 9:20 A.M.
Anes: Spinal
Operation: Cholecystectomy
Condition: Good B.P. 100-80
Pulse 84. Had Blood 500 cc
Saline 500 cc I.V. Stay
on Foley Bladder 12 hrs
Morphine gr ¼ H @ 10 am
BP 84 H- Pulse [illegible]
11 am BP [illegible] Pulse
3 P.M. BP [illegible] 78 Pulse

TEMPERATURE—TREATMENT—NURSE'S NOTES

Name Darling Lester Grade Civ Ward 8

Date	A.M. T	P	R	P.M. T	P	R	N	Wt	Medication and Nurse's Notes
1943									
9/20									Fluids & medicine
									Oxygen tent count
									Unable to give Sulfathiazole
									Digalen 1/2 gr.
									Bath & mouth care
									1600 Cc. Solution
									Urine - 10 #0 @ 10 pm
									[illegible]
									[illegible]
									Morphine gr ¼ H.C. 1150 pm
									Oxygen tent Continued
									Fruit juice & Water 8: 2 hrs
									Sodium Sulfathiazole gm i
									mixed in water - 8: 2 hrs. daycare RL
									7th Intake 3000 - Output - Bed 1 to Bay
									Oxygen tent Continued
									Sulfathiazole gm i (Sol 10cc)
									intravenously at 8 12 4
									1000 cc 10% glucose ivn
									Nsalem [illegible]
									11:30 pm Oxygen at 2 [illegible]
									Urine [illegible]
4-22	101	96	24	108	132 pm				Subject [illegible] involuntary [illegible]
	101	100	24		6				Bath & mouth care
									Pt. Care. Intake & Output
									Dressing changed large
									amount of drainage
									Spec Care to Dr.
									Rubber ring to bed
									Sulfathiazole gm i 4 H hrs
									Oxygen off @ 4 am pt ?
									7th Intake 1315 cc Output [illegible]
									Bath & mouth care. Dressing [illegible]

(Over)

TEMPERATURE—TREATMENT—NURSE'S NOTES

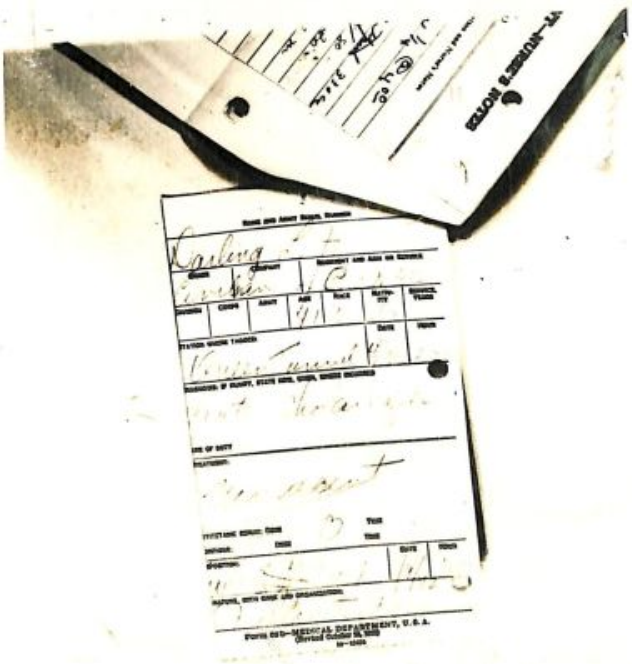
Darling Lester Civ

Date	A.M. T	P	R	P.M. T	P	R	N	Wt	Medication and Nurse's Notes
									Morphine syr ¼ @ 4 pm
									Urine [illegible]
									7th 770 cc - Output 330 cc
									T.P.R. at 11:30 pm 11/50
									TPR 12 20 A m 99 100 20
									Morphine gr ¼ H 12 20 A m
									Tolerated [illegible]
									12hr Intake 1440
									1-hr Output
4-19	99	88	22	99	100	20			Bath + Mouth care
				99	88	20			Fluids freely taken, Urine
									Resting well
									Temp at 12 m 1.02 pm
									Morphine gr ¼ 12 20 am
									Rash noted
9-20	101	104	20	104	150	24			12 hr Intake 1608 Output 1500
				101					Saline 200 cc & glucose 10%
									@ 11 am
									Turn Patient from side to
									side frequently
									Intake & Output
									Sulfathiazole gm i q 4 hrs
									day & night
									Strophine gr 1/200 + Digalen 1 cc
									@ 12 m. Turn by Col Adams
									Morphine gr ¼ H. @ 12 20 pm
									Pitressin ½ cc @ 12 m
									Oxygen 100 lb started 12 20 m
									Flow Rate Remains ill
									Negative [illegible]
									M. Saline Specs & 12 m glucose wl
									intravenously 4 to 8 pm
									Sleeping [illegible] Intake & Output

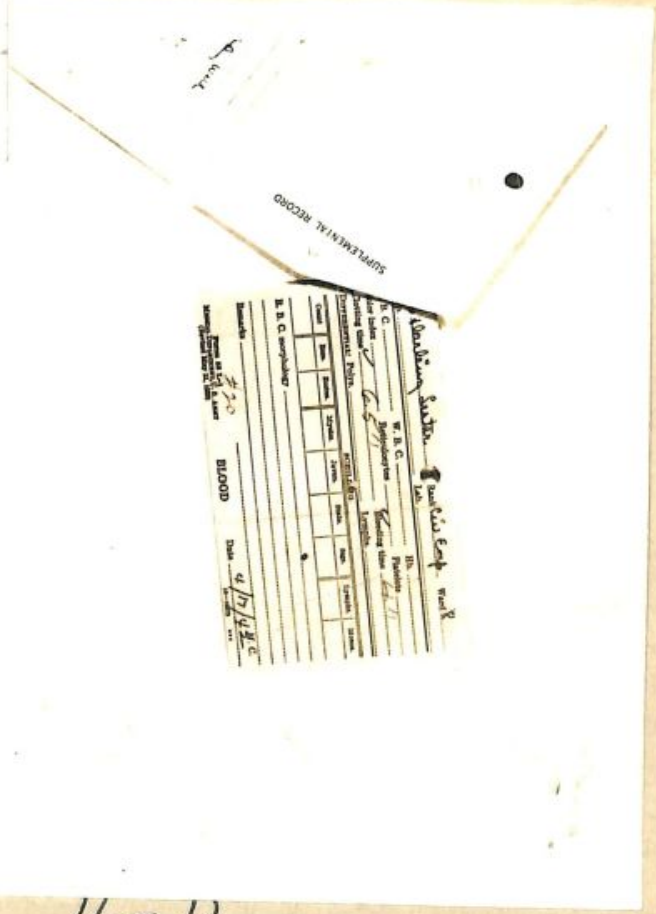
TEMPERATURE—TREATMENT—NURSE'S NOTES

Darling Sister

Date	A.M. T	A.M. P	A.M. R	P.M. T	P.M. P	P.M. R	W	Wt	Medication and Nurse's Notes
7/22									Sulfathiazole gm 1 q 4 hrs. Oxygen Resp. Vapo. Mixture Adlpat Sy Cervical incision C&D
4-23	103	120	30	104	140	34			Bath & wet sheet cool to 101
				104	140	38			Unable to swallow this am
				102	140	36			Continue Oxygen Mist
									Ice cloth & wine sponges
									Saline 1000 Plasma 1000
									@ 11:45 am
									Pulse much weaker
									This pm
									unable to swallow
									Gradually becoming weaker
									Died @ 6:42



16-C



16-D


Name Darling, J.H. Rank Civ CPHM Ward Ward 8-Bed 80
Hosp [illegible] Lab.
R. B. C. W. B. C. Hb.
Color Index Reticulocytes Platelets
Clotting time Bleeding time
Lymphs
DIFFERENTIAL: Poly.

Count	Bas.	Eosno.	Myelo.	Juven.	Stabs.	Segs.	Lymphs.	Mono.

Signing for transfusion Knights
Remarks no agglutination
BLO
Date April 11, 194


Name Darling J.H. Rank Civ CPHM Ward 8-Bed 80
Hosp [illegible] Lab.
Character
Color L. BROWN
Occult blood
Mucus
Fat
Parasites or ova
Reaction
Bile
Pus
Undigested food
POS.
Remarks
Date April 11, 1944

16-E

THE BILIBID HOSPITAL
FOR MILITARY PRISON CAMPS OF P. I.

August 9, 1944.

REPORT OF AUTOPSY IN CASE OF HAWKINS, Walter Christopher, Cpl., U.S. Army, Div. 1580, August 9, 1944. Autopsy performed 1400, August 9, 1944.

The body is that of an emaciated white male, 30 years of age. The estimated weight of body is 100 pounds, the estimated height 70 inches. There is a decubitus ulcer 5 cm. in diameter over the sacrum. There is no rigidity or edema present. There is a sub-icteric tinge to skins. The right pupil measures 1 cm. in diameter. The left pupil 6 mm. The body is devoid of subcutaneous fat.

On opening the abdomen there are flecks of fibrin scattered over the liver and in the pelvis. The omentum is adherent to the spleen. The epiploic foramen is open. The inguinal rings are present. The diaphragm arch recedes to the 5th rib on both sides. There is no free fluid present.

On opening the thorax, there is no fluid present on either side. There are no adhesions. On opening the pericardium, there is 120 c.c. of pale yellow fluid and fibrin.

THE HEART appears pale. Its estimated weight is 370 grams. The pericardium is normal. The walls and septum are fibrous, Myocardium brown. The mitral valve is thickened and congested. Attached to the posterior valve, there is a large vegetation measuring 3 cm. in diameter. It is pinkish grey and friable, irregular in shape and calcified at the base. There are streaks of recent thrombi on the outer surface. The aortic valve is shortened and thickened. The other valves appear normal. The aorta shows atheromatous sclerosis with calcification grade 2. The coronary arteries show sclerosis grade 2.

LUNGS - Both lower lobes show early consolidated areas measuring 2 cm. in diameter and there is one recent abscess in the center of the right lower lobe measuring 3 cm. in diameter.

LIVER - Estimated weight 1500 grams. The capsule is slightly thickened and covered with flecks of fibrin. The capsule cuts with increased resistance, grade 1. The cut surface appears normal.

GALL BLADDER - Contains 10 c.c. black bile. It appears grossly normal.

SPLEEN - Its estimated weight is 350 grams. The hilus is completely covered with fibrin. The hilar artery is replaced by pinkish grey fibrous tissue which projects 1 cm. above the surface. It measures 4 cm. in diameter by 4 cm. thick. Other areas are reddish grey and of softer consistency.

THE KIDNEYS [illegible] appears grossly normal.

THE PANCREAS [illegible] grossly normal.

THE ADRENALS appear grossly normal.

-lo-

16a

THE BILIBID HOSPITAL
FOR MILITARY PRISON CAMPS OF P.I.

November 13, 1944.

MEMORANDUM:

SUBJECT: INFORMATION FOR TRANSPORTATION REPORT.

TO : ALL WARD SURGEONS, MEDICAL OFFICER BUILDING 18, AND ATTENDING SURGEON BUILDING 7.

It is requested that a classification of all individuals in your Ward or Building, in the following categories, be submitted to the Personnel Office on November 15, 1944, together with the Night Report. Submit numbers only, names are not necessary.

(a) Litter patients.
(b) Riding patients.
(c) Walk without baggage.
(d) Walk with baggage.

This report pertains to sick in hospital patients, sick in Quarters patients, wall cripples and well personnel. All well personnel should come under the "walk with baggage" category.

Admissions and discharges that take place prior to the time the evening report is submitted, will be carefully checked to ascertain that all such changes are shown.

JAMES O. HEIDS,
Captain, M.C., U.S. Army.
Adjutant.

Please initial:

Capt. Bertram		Maj. White	
Capt. Brennan		Maj. Jacobs	
Capt. Wallace		Capt. Shaw	
Capt. Winship		Comdr. Welch	
Lt. Pohlman		Maj. Peters	
Lt. Garvold		Capt. Ashton	
Dr. Gilliphant			
Dr. Dwyer			

16-F

Form 88 A
Medical Department, U. S. Army
(Revised May 31, 1920)

CLINICAL RECORD
BRIEF

Register No. F2R Hospital FORT MILLS PI
Name Zaiah, George J. Serial No. 16034723
Grade Pvt Co. G M C. Regt. and Arm or Service U. S. Army
Age Race White Nativity
Service Date of admission 5-14-42 2.00 p.m. 19
Source of admission Command
Station Fort Mills, P.I.
Ward — Previous admission
Religion Home address
Name and address of nearest relative

KIA/In
(Initials of admitting officer)

Disposition Dead upon admission Date 5-14-42 19

Final diagnosis

Additional diagnoses (Complications, special treatment and operations):

Line of duty
Condition on completion of case
Transfer diagnosis confirmed or not confirmed
Autopsy

M. C.

17

17

Form 88 A
Medical Department, U. S. Army
(Revised May 31, 1928)

CLINICAL RECORD
BRIEF

Register No. 7928 Hospital Station Hospital Fort Mills,P.I.
Name TOMB, Virgil I. Serial No. 6652661
Grade T-Sgt Co. 92nd Bty Regt. and Arm or Service 60th CA
Age 39 Race W Nativity Ill.
Service 9-11/12 Date of admission 5/7/42 @ 8:10,AM, 19
Source of admission Command
Station Fort Mills,P.I
Ward 12-Surgical (WIA)
Religion Protestant Home address North High St., Corington, Ohio
Name and address of nearest relative UNCLE, Mr. Ira C. Roseman
Same
DrSmith/jlb
(Initials of admitting officer)

Disposition Death Date 5-15-42, 19

Final diagnosis:

Shrapnel wound - l. l. abdomen - penetrating? - shelling.
Shrapnel wound - rt. chest - anterior - superficial.

Additional diagnoses (Complications, special treatment and operations):
B. Coli Peritonitis, Septicemia.

Line of duty Yes
Condition on completion of case Death

Transfer [illegible] confirmed or not confirmed
Autopsy None

W. C. Sawyer Capt. M.C.

18

TEMPERATURE—TREATMENT—NURSE'S NOTES

Name Young, Virgil J. Grade Sgt Co C 192 Wpn Ward

Date	A.M. T	A.M. P	A.M. R	P.M. T	P.M. P	P.M. R	M	Wt	Medication and Nurse's Notes
									2 Cent Distilled 1 t. s. p.m.
									Temp 102 99 - 20
6-8th									Wound [illegible] abdomen. & shoulder. CARING [illegible]
7	99	84	20						
10	100	76	18						Mercurochrome ointment
	103	88	24	102	92	22			Codeine sulph gr ½ @ 4 hrs prn.
11	102	78	18	103	84	20			Surgical consultation ordered.
	104	96	18	103	84	20			Morphine ½ gr [illegible] at [illegible]
9	103	80	24	104	[illegible]	[illegible]			[illegible]
	103	92	24	103					
									[illegible]
									[illegible]
									White cell count 16,800
									Ft. dilutions chi a.m.
									Gyomic therapy [illegible]
									Enema p.r.
10	102	92	24	103					
	[illegible]	[illegible]	[illegible]	103					Morph. sulph. ½ gr.
11	98	82	22	103	96	24			White cell count.
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]			M.S. gr ¼ q 4 hrs
									[illegible]
									Sulfathiazole gr. XXX & gr. XV
									q 4 hrs.
									Sulfathiazole gr [illegible] q [illegible]
									Morphine [illegible]
									Placed on Laterally Ill list
									6 cc fluid Ringer's Lactate
									[illegible]
15	N.R.								½ cc Neosynephrine

(Over)

18-A

TEMPERATURE—TREATMENT—NURSE'S NOTES

Date	A.M. T	A.M. P	A.M. R	P.M. T	P.M. P	P.M. R	Bk	Wt	Medication and Nurse's Notes
									Dsch 1:26 #4

Name Young, Virgil J. Rank Pvt Ward 12
Temp
B. B. C. W. B. C. 7,200 Hb.
Color index Reticulocytes Platelets
Clotting time Bleeding time
Differential: Polys 74 Lymphs 19

Basos	Eosins	Myelos	Juxtas	Stabs	Segs	Lymphs	Monos

R. B. C. morphology

Remarks

(#2)

Form 55 L-1 Medical Department U. S. Army (Revised May 31, 1939) BLOOD Date 5/12 M C

Name Young, Virgil J. Rank Pvt Ward 12
Temp 1
B. B. C. W. B. C. 12,200 Hb.
Color index Reticulocytes Platelets
Clotting time Bleeding time
Differential: Polys 53 Lymphs 45

Basos	Eosins	Myelos	Juxtas	Stabs	Segs	Lymphs	Monos

R. B. C. morphology

Remarks

#4

Form 55 L-1 Medical Department U. S. Army (Revised March, 1939) BLOOD Date 5/14 M C

Form 8BD—MEDICAL DEPARTMENT, U. S. A. (Revised October 15, 1940)

18-B

5-12-42 Persistent temperature averages around 104. Blood culture negative. Urine sp. gr. 1.020 not remarkable. Sulfa may be due to malaria. Patient = pernicious anemia.

5-13-42 Urine sufficient for reduction of temperature. Wound draining profusely. Drainage thin, watery, gray in color and has strong fecal odor. Patient is peaceful. No abdominal rigidity. Surgical peritonitis should be considered.

5-14-42 Drainage profuse and foul. Went into coma this morning.

5-15-42 Respiration stopped 7:16 AM.

Form 88 A
Medical Department, U. S. A.
(Revised May 11, 1920)

CLINICAL RECORD
BRIEF

Register No. 7181 Hospital Station Hospital, Fort Mills, P.I.
Name WITT, William T. 698th Ordnance Regt. and Arm or Service Serial No. 6271497
Grade Prt. 1cl. Co. Nativity Tex.
Age 29 Race W. Date of admission 5-6-42 @ 12:30 A.M.
Service EXPEDN 5-6/12
Source of admission Command
Station Fort Mills, P.I.
Ward S Previous admission
Religion Prot. Home address 2817 S. 1st St., Abilene, Tex.
Name and address of nearest relative Cousin-Mrs. C.H. Martin Same address.
RTA/cwb
(Initials of admitting officer)

Disposition Died Date 5 May 19 42

Final diagnosis: Wound (shrapnel), multiple,
Extreme

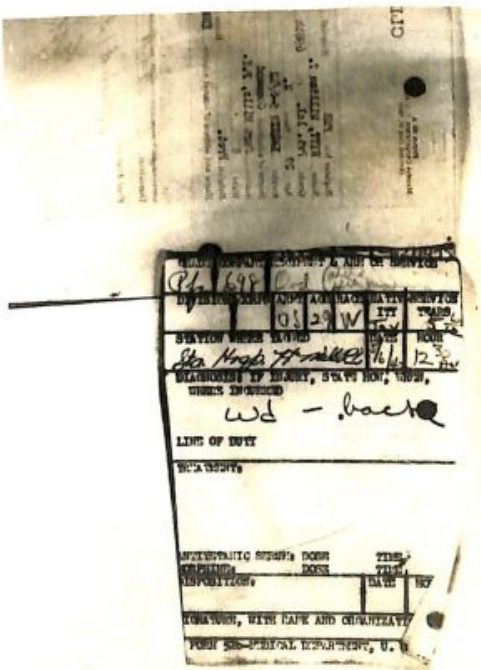
W. A.D.

Additional diagnosis (Complications, special treatment and operations):

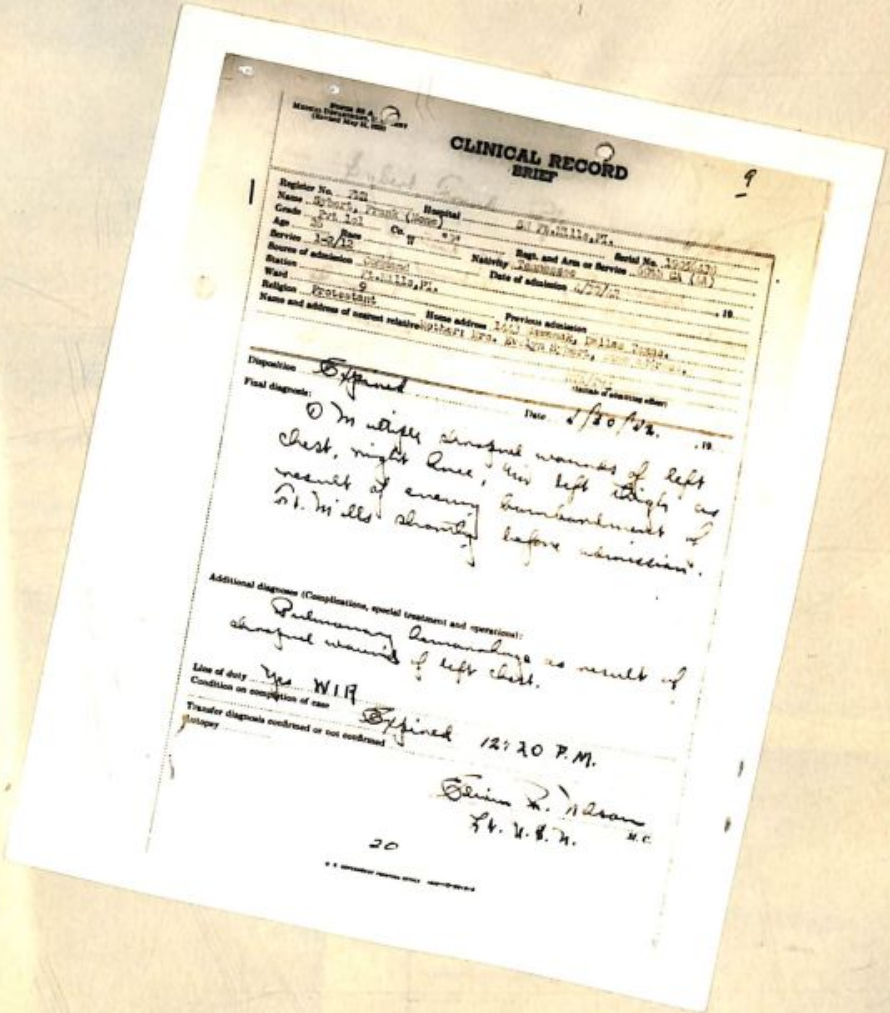
Line of duty Yes Died 6 May 42
Condition on completion of case
Transfer diagnosis confirmed or not confirmed
Autopsy

M. C.

19



19



CLINICAL RECORD
BRIEF

9

Register No. 320
Name Roberts, Frank (Negro)
Grade Pvt 1cl
Age 20
Service 3-9-42
Station Cleveland
Ward Psychiatric
Religion Protestant
Name and address of nearest relative Robert Roberts, Mr. Ruth St. Toledo, Ohio

Hospital U.S. Marine Hospital
Co. H
Race
Nativity Pennsylvania
Date of admission 4/20/42
Previous admission
Home address 1603 Jefferson Avenue Toledo, Ohio

Serial No. 1627[illegible]
Regt. and Arm or Service [illegible]

Disposition Efficient
Final diagnosis:
1) Multiple shrapnel wounds of left chest, right knee, left thigh as result of enemy bombardment of Ft. Mills shortly before admission.

Additional diagnoses (Complications, special treatment and operations):
Pulmonary hemorrhage as result of shrapnel wounds of left chest.

Line of duty Yes WIR
Condition on completion of case Efficient 12:20 P.M.
Transfer diagnosis confirmed or not confirmed
Autopsy

Edwin R. Adson
Lt. M.C. U.S.N.

20

20

CLINICAL RECORD
BRIEF

Register No. [illegible] Hospital Station Hospital, Fort Mills, P.I.
Name [illegible] Serial No. 13041100
Grade Pvt 1 Co. H Regt. and Arm or Service 54 CA
Age [illegible] Race W Nativity [illegible]
Service [illegible] Date of admission 5-May-42 @ 2100 P.M., 19
Source of admission Command
Station Fort Mills, P.I.
Ward 10
Religion Prot. Previous admission
Name and address of nearest relative [illegible] Home address 4813 Park Place Blvd., Houston, Tex.
[illegible]

Disposition Deceased. Date 5-4-, 19[illegible]

Final diagnosis:

(1) 710 Contu. Skull, basal. cran. Soldier was injured by exploding enemy shell, causing along Beaumont Road Officers Quarters. 5-2-42 at 1[illegible] P.M.

(2) Wound, laceration, moderate scalp occipital area, Cause same as 710 C

Additional diagnoses (Complications, special treatment and operations):

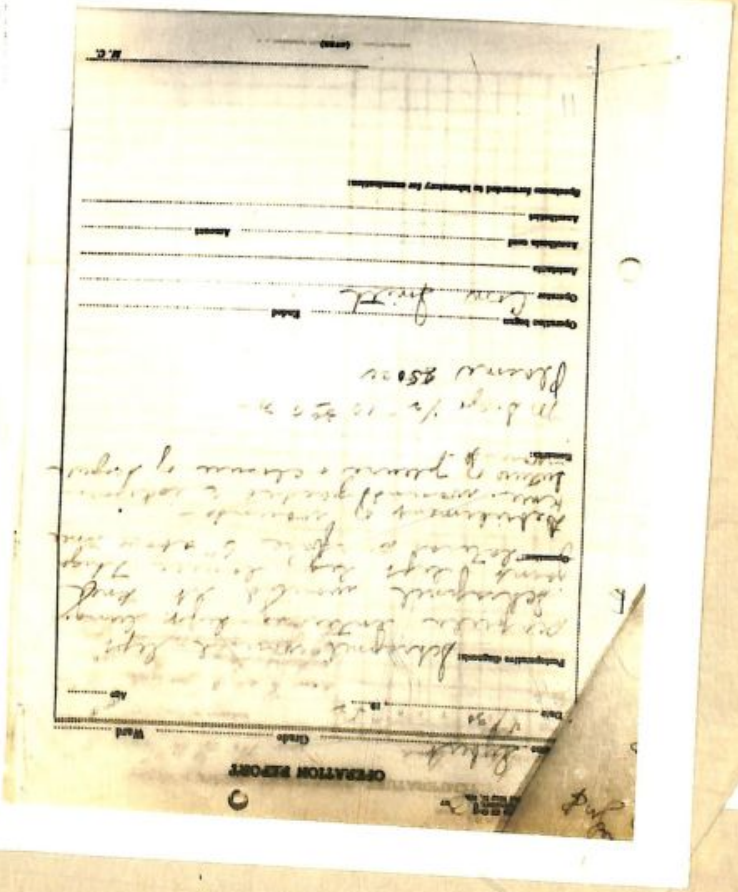
Special Rep. 4-2-42, and 4-3-42.

Line of duty Yes. W.I.A. - Yes
Condition on completion of case Dead.

Transfer diagnosis confirmed or not confirmed [illegible]
Autopsy Yes A.

[illegible] M.C.
[illegible] M.C.

21



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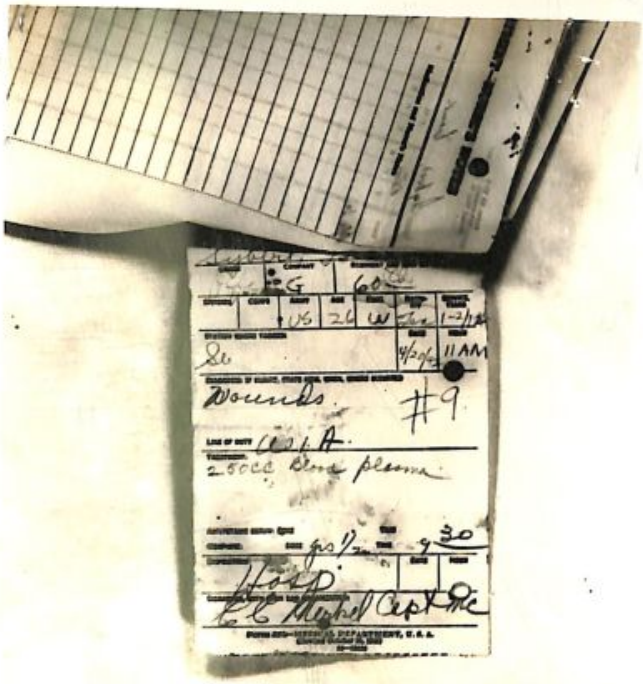
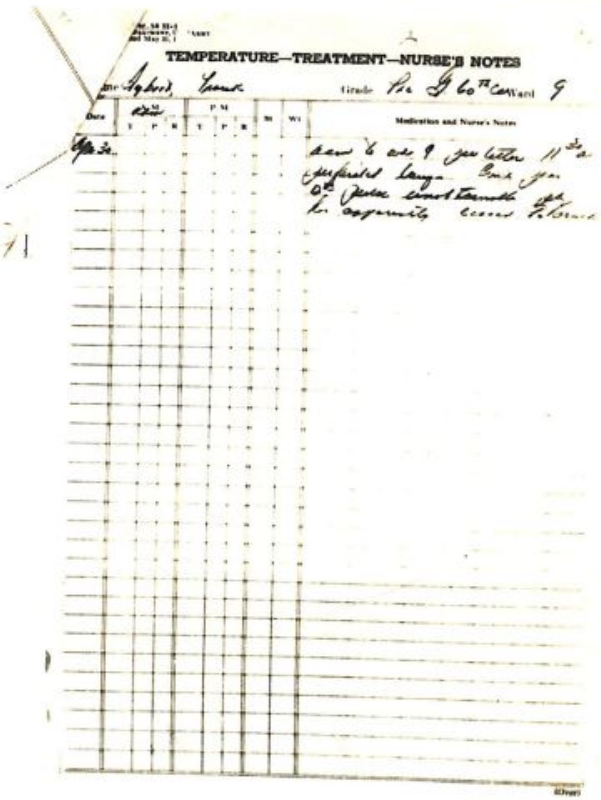




221-A

OPERATION REPORT

Name 30 Grade ..... Ward .....

Date 5 - 2 1942 Age .....

Postoperative diagnosis: Fracture skull base.

Operation: Debridement of scalp. Acquisition. Sponsel top.

Remarks:

Operation began 3 30 P.M. Ended 8.40 P.M.

Operator Lt Col Adams.

Assistants Capt. Hambath.

Anesthesia used Nitrous Amount

Anesthetist —

Specimens forwarded to laboratory for examination:

W.J. Hambath
Capt M C
(over)

OPERATION REPORT

Name 30

Date 5 - 2 1942

History: Patient was at part of daily mess. Shows [illegible] unless acutely ill. Developed beginning patient. X-Ray Skull. Nov. 2d-42.

Diagnosis #1 Fracture. skull. basal.
1" Nasal. Scalp. lacerated. left
" occipital area.

Treatment: Sponsel Top. Bloody fluid
5-2-42. Patient remained quiet and well on O.D.
Bleeding ceased after Sponsel Top. 10 cc. removed.
Sponsel Top. removed.
Operation. Patient temperature morning
gave 100 cc Nembutal & then administered
P.M. Patient was taken post.

5/4/42 Pt expired at 6:00 AM. JPP

Name 30

Date 5 - 2 1942

Operation began 3 30 P.M. Ended 8.40 P.M.

Operator Lt Col Adams

Assistants Capt. Hambath

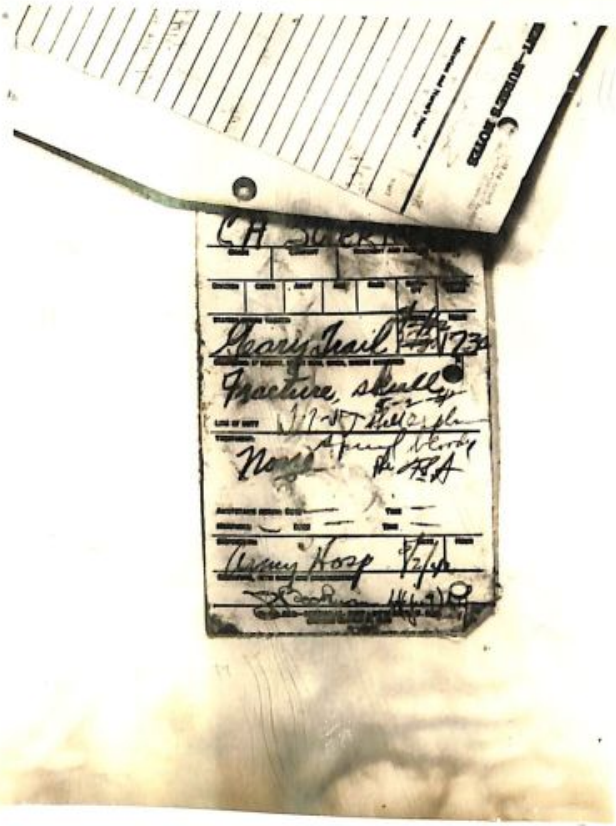
Anesthesia used Nitrous

Anesthetist

Specimens forwarded to laboratory for examination:

W.J. Hambath
Capt M C

#21-



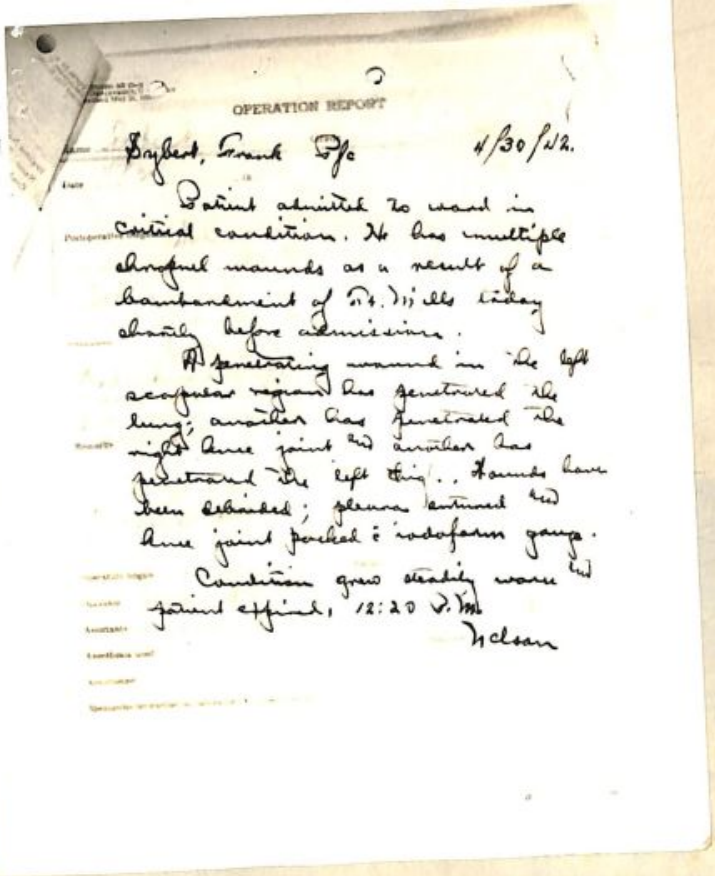
#30

TEMPERATURE—TREATMENT—NURSE'S NOTES

Name Sulver C 11 Grade ... Ward 10

Date	A.M. T	P	R	P.M. T	P	R	In	Wt	Medication and Nurse's Notes
5/2/52									Pt adm to Ward 10 — fractured skull — 102-104-82 Sodium Luminal amp I.M. Special Corpsman on Pt. Talks — Pt quiet & much dyspnea present Spinal puncture pain Chest warm & dry Ice cap to head Pupils slightly [illegible] Pt appears [illegible] Cond. Grave - [illegible] Resp. [illegible] labored. Soln 2c saline I.M. @ 6 PM 106° - 148 - 38 @ 1730 Ice cap to head Respiration becoming [illegible] Expired @ 2300
5/3	105	104	38						
	104	50 cc		104	116	34			
				105	144	30			

#21-C



OPERATION REPORT

Bryhert, Frank Pfc 4/30/42.

Patient admitted to ward in critical condition. He has multiple shrapnel wounds as a result of a bombardment of Ft. Wills today shortly before admission.

A penetrating wound in the left occipular region has penetrated the lung; another has penetrated the right knee joint and another has penetrated the left thigh. Wounds have been debrided; pleura sutured and knee joint packed & iodoform gauze.

Condition grave steadily worse and patient expired, 12:20 P.M.

Nelson

21D

TEMPERATURE—TREATMENT—NURSE'S NOTES

Williams, Hank Pvt 6 A "2/20/42.

Medication and Nurse's Notes

Patient admitted to ward direct from surgery in stretcher. Condition. Pt. is fully [illegible] following difficulty getting responding to [illegible] stimulants As has been given in the O.R.

Pt. has a penetrating wound of the lower left thorax region that involved the chest and abdominal cavities. Pt. is result of enemy bombardment of U.S. Mills shortly before admission.

Pints of blood were replaced in surgery.

No response to stimuli. Patient expired 2:05 P.M.

Nelson

CLINICAL RECORD

Register No. 758 Hospital Ft. Phillips, Pr.
Name Stevens, Harry Serial No. 6738472
Grade Pvt. Co. Regt. and Arm or Service 60th CA (AA)
Age 25 Race W Nativity Michigan
Service 3 years Date of admission 2/20/42
Source of admission Command
Station Phillips, Pr.
Ward 9 Previous admission
Religion Catholic Home address Lawrence, Michigan.
Name and address of nearest relative Mother Mrs. Agnes Pudlok, same address.

Disposition Expired 2:05 P.M. Date 2/20/42

Final diagnosis:
1) Penetrating shrapnel wound of left thorax and abdomen as result of enemy bombardment of U.S. Mills shortly before admission.

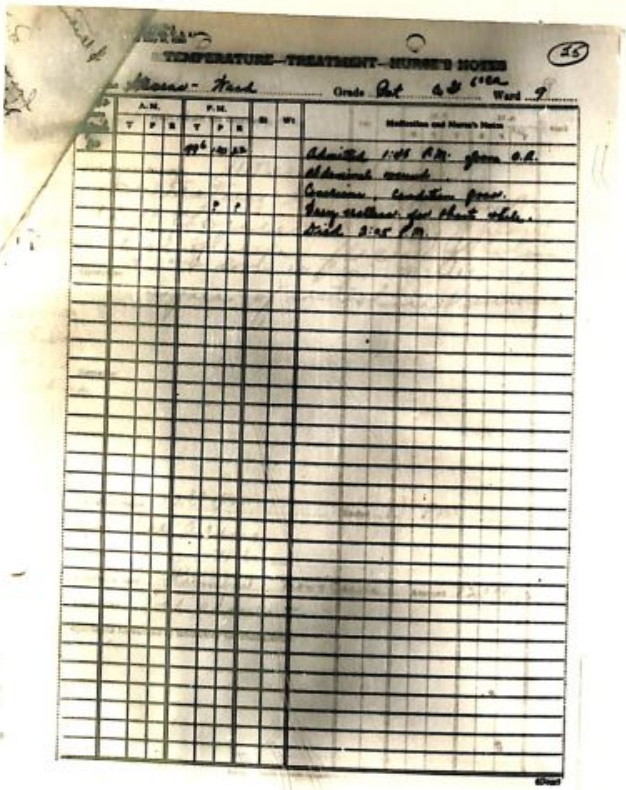
Additional diagnosis (Complications, special treatment and operations):
Pulmonary hemorrhage
Perforating wounds of large and small bowel.

Line of duty Yes WIP
Condition on completion of case Expired
Transfer diagnosis confirmed or not confirmed
Autopsy

Edwin P. Nelson
1st Lt. M.C.

22

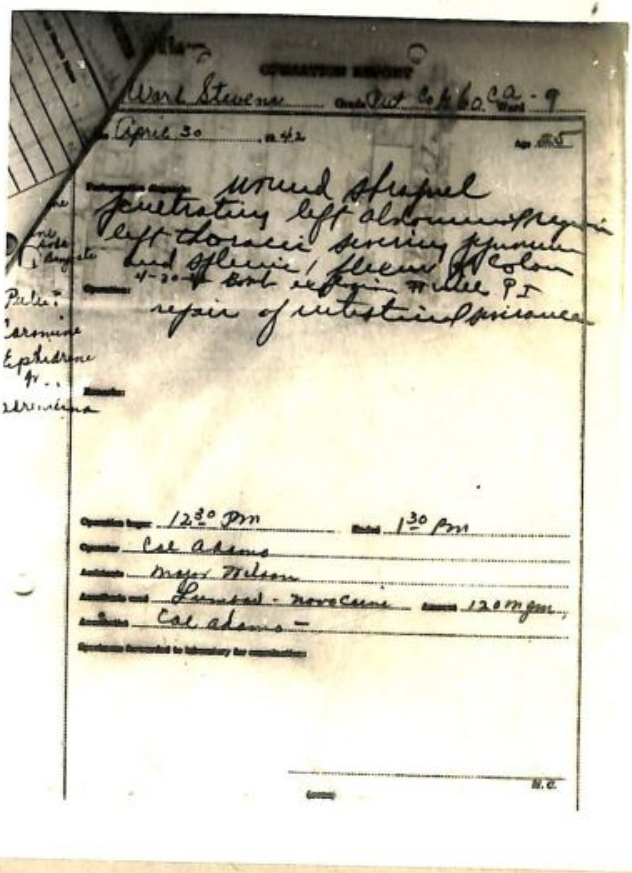
22



TEMPERATURE—TREATMENT—NURSE'S NOTES

Stevens - Ward ... Grade Pvt ... Ward 9

A.M. T	A.M. P	A.M. R	P.M. T	P.M. P	P.M. R	Bl.	Wt.	Medication and Nurse's Notes
			99.6	140	32			Admitted 1:45 P.M. from O.R. Abdominal wound. Continue condition good. Very restless for short while. Sleeping 3:05 P.M.



OPERATION REPORT

Ward Stevens ... Grade Pvt Co K 60 C.A. Ward 9

April 30 ... M 42 ... Age 25

Diagnosis: Wound Gunshot penetrating left abdomen, thoracic, ... left thoracic ... Colon

Operation: ... repair of intestinal perforation

Surgeon: ... Assistants: ...

Anesthetic and ... Amount ... 120 M gm.

Operation began 12:30 PM ... Ended 1:30 PM

Operator Col Adams

Assistants Major Nelson

Anesthetic and Duration - Novocaine ... Amount 120 M gm.

Assistants Col Adams —

Specimens forwarded to laboratory for examination:

M.C.

22 - A

NAME AND ARMY SERIAL NUMBER
Stanton, Wendell 6718471
GRADE, ORGANIZATION, BRANCH & ARM OF SERVICE
Pvt G 2 60 CA
DIVISION | CORPS | ARMY | ZONE | SECTION | NATIVE, RESIDENT OR ENEMY ALIEN | TRANS
US | 25 | W | | | S
STATION WHERE WOUNDED | DATE | HOUR
Sta Hosp, Ft Mills, PI | 9/Nov | 10?a
DIAGNOSIS OF INJURY, GUNSHOT, SHELL, BOMB, INJURY INCURRED
GSW left chest + evisceration of wound causing left abdomen - Shock
KIND OF DUTY When WIA
CIRCUMSTANCES
Repair of intestinal Lesion #9
ANTITETANIC SERUM: DOSE | TIME
VACCINATION: DOSE | TIME
INOCULATION: Admission | DATE | HOUR
VACCINATED WITH SCAR AND CHARACTERISTIC
Melvin H. Stone
OF MEDICAL DEPARTMENT,

22-C

CLINICAL RECORD
BRIEF

Register No. [illegible] Hospital Station Hospital Ft. [illegible], P.I.
Name [illegible], John J. Serial No. 6960747
Grade [illegible] Co. Hdq. Regt. and Arm or Service [illegible] C.A.
Age [illegible] Race W Nativity [illegible]
Service [illegible] Date of admission 4/21/42 @ 10:30PM, 19
Source of admission Command
Station Fort Mills (P.I.)
Ward [illegible] (Med.) Previous admission [illegible]
Religion Catholic Civilian address Dushnoy, Pa. [illegible]
Name and address of nearest relative Mrs. [illegible] Mary [illegible]
[illegible] Jno. Wilcox
RFA/11b
(Outside of admitting office)

Disposition Died Date 4/25/42, 19

Final diagnosis: ① Wound Asp. Perforating Severe back and abdomen Incurred during Shell fire on this post about 9:30 Am 4/24/42
② Shock Surgical Type Severe secondary to ① above.
N.D.A. Yes.

Additional diagnoses (Complications, special treatments and operations):
None

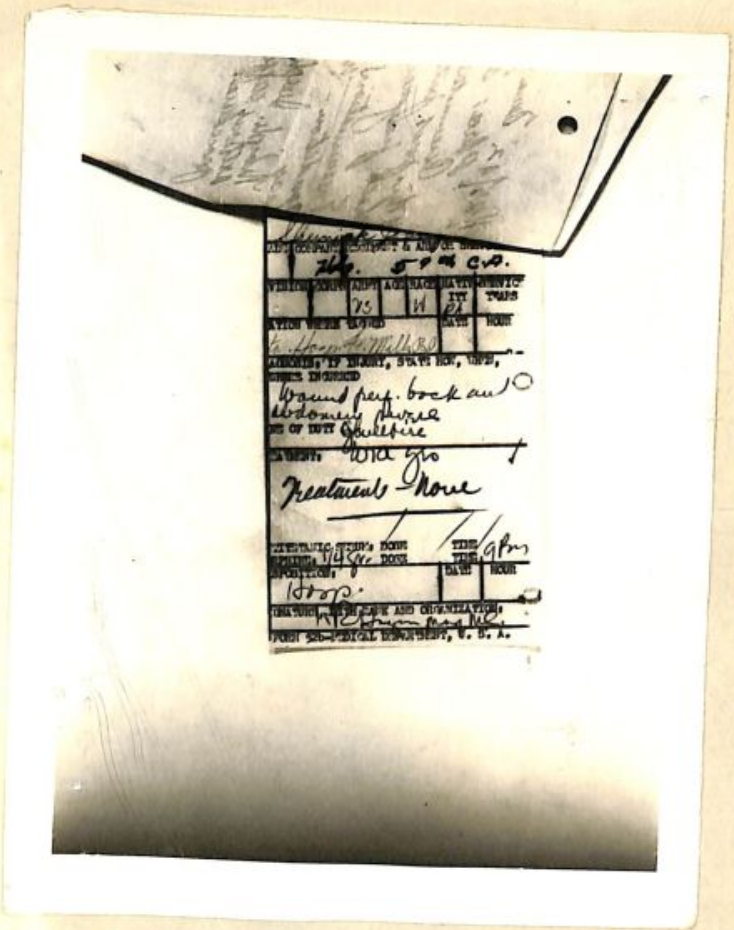
Line of duty Yes
Condition on completion of case Died
Transfer Wounds confirmed or non-confirmed
Autopsy None

[illegible] M.C.

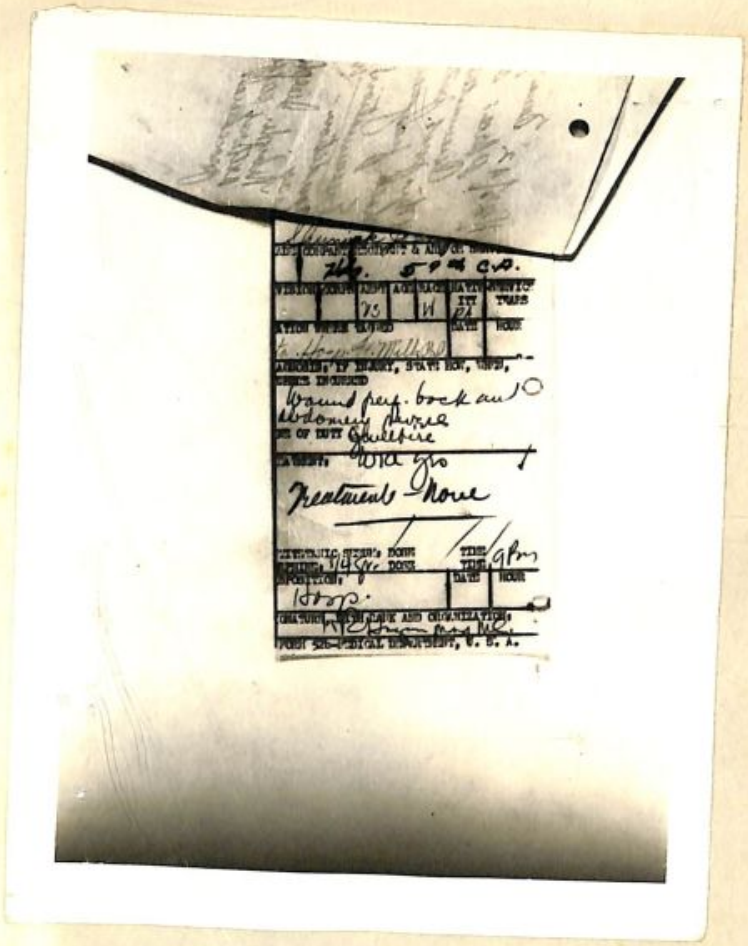
23

4/25/42. Adm: Appr. 9:30 Pm. 4/25/42
Obser. Sh. Shock P.T.
Circumstances: Hearing shelling
this post patient was attack by
shell fragments in back and abdomen
Examination: Patient is severely wounded
condition - Wound perforating abdomen and
back.
Treatment: Morph. Sulph. gr ¼ (M) Plasma Diet as accepts.
Will have surgical consult. Ready for surgical
procedure.
[illegible]

23



23-A



23-A

CLINICAL RECORD

Register No. [illegible] Hospital [illegible]
Name [illegible] Serial No. [illegible]
Grade Pfc. Co. [illegible] Regt. and Arm or Service [illegible]
Age 19 Race W Nativity Wisconsin
Service 1-1/12 Date of admission 4/20/42 19..
Source of admission Command
Station Ft. Mills, P.I.
Ward 19 Previous admission
Religion [illegible] Home address Princeton, Wisconsin
Name and address of nearest relative Mother Mrs. Martha Moslowski, same address.
[illegible]
(Address of informing officer)

Disposition Deceased Date 4-29 19 42

Final diagnosis:

Burn - 3rd degree involving entire surfaces of head, upper extremities and upper half of body.
Cause: Explosion of [illegible] of dump on Malinta Hill when enemy shell exploded gasoline storage tank on Malinta Hill. Subject was at [illegible] of dump at time of explosion. Taken to ophthalmic service for burns of head and upper half of body. 4-29-42 at Malinta Hill Hospital, Malinta, P.I.

Additional diagnoses (Complications, special treatment and operations):

W.M.D. yes

Line of duty Yes.
Condition on completion of case Dead.

Transfer diagnosis confirmed or not confirmed
Autopsy Yes

H. D. Newlands
Capt. M.C. M.C.

24

Register No. [illegible] Hospital [illegible]
Name [illegible] Serial No. [illegible]
Grade Pfc. Co. [illegible] Regt. and Arm or Service [illegible]
Age 19 Race W Nativity Wisconsin
Service 1-1/12 Date of admission 4/20/42 19..
Source of admission Command
Station Ft. Mills, P.I.
Ward 19 Previous admission
Religion [illegible] Home address Princeton, Wisconsin
Name and address of nearest relative Mother Mrs. Martha Moslowski, same address.
[illegible]
(Address of informing officer)

Disposition Deceased Date 4-29 19 42

Final diagnosis:

Burn - 3rd degree involving entire surfaces of head, upper extremities and upper half of body.
Cause: Explosion of [illegible] of dump on Malinta Hill when enemy shell exploded gasoline storage tank on Malinta Hill. Subject was at [illegible] of dump at time of explosion. Taken to ophthalmic service for burns of head and upper half of body. 4-29-42 at Malinta Hill Hospital, Malinta, P.I.

Additional diagnoses (Complications, special treatment and operations):

W.M.D. yes

Line of duty Yes.
Condition on completion of case Dead.

Transfer diagnosis confirmed or not confirmed
Autopsy Yes

H. D. Newlands
Capt. M.C. M.C.

24

Progress notes. #16

Pfc. [illegible] Co. [illegible] Hat. 16

4-29-42. Patient was struck on top of Malinta Hill when enemy shell exploded gasoline storage tank on hill.

Physical Examination - Glassy burns of face, head and upper half of body anterior and posterior surfaces.

Diagnosis - Burns 3rd degree burns of head, face and upper half of body. M.D.N.

Instrument and Surgical

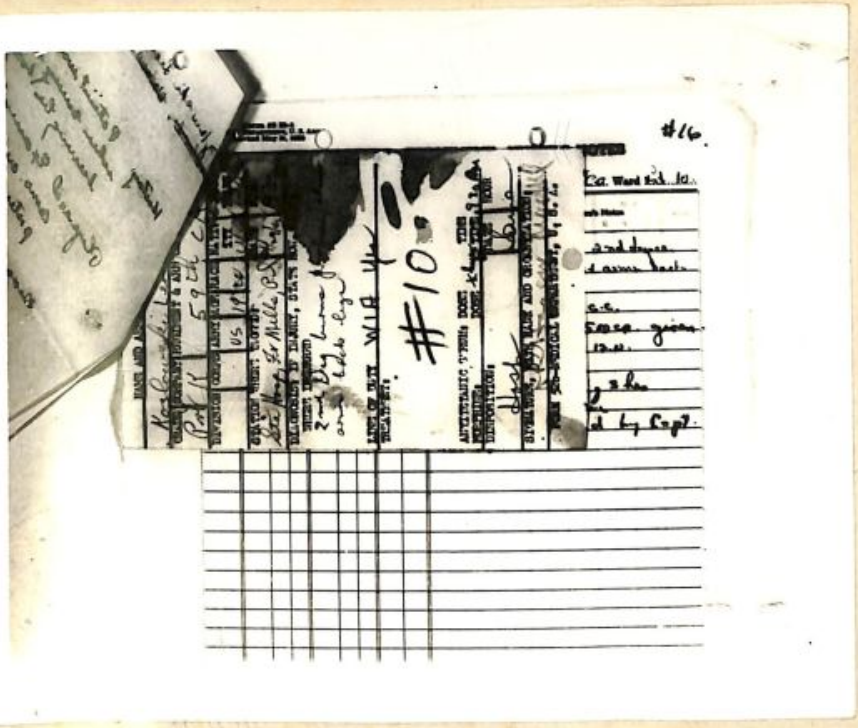
4-29-42. Patient admitted via ambulance stretcher. Severe flame entanglement. Severe third degree burns of head, face & body. Admitted 10 a.m.

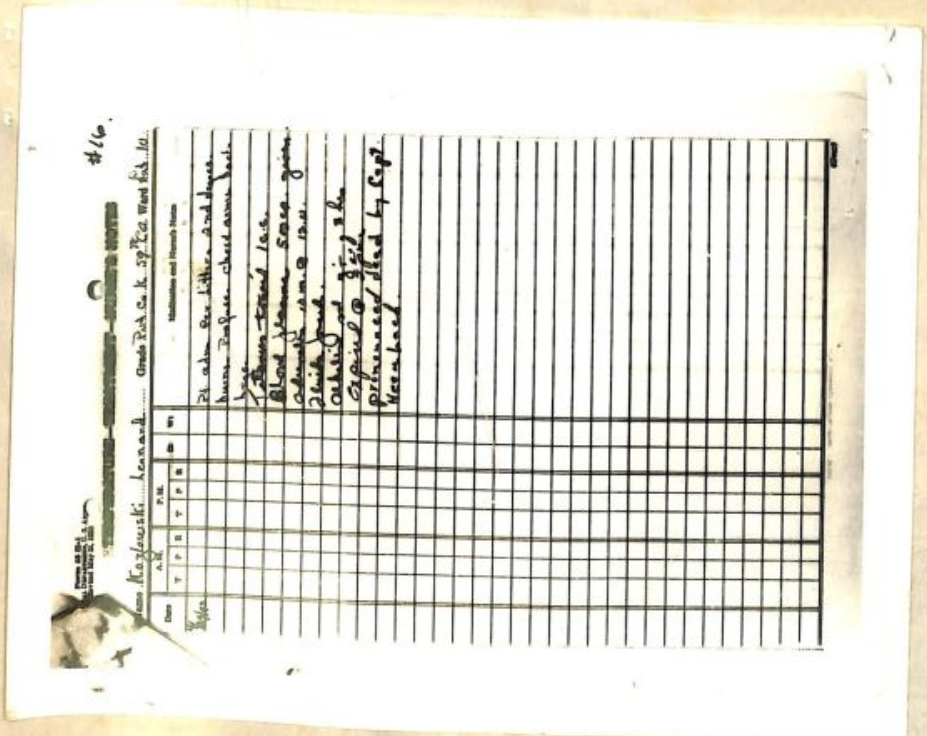
Patient having respiratory failure to gather with pulmonary edema. Pulse weak. 4:20 P.M.

Patient pronounced dead at 5:P.M. 4-29-42 by Ward Surgeon H.D. Newlands. Capt M.C.

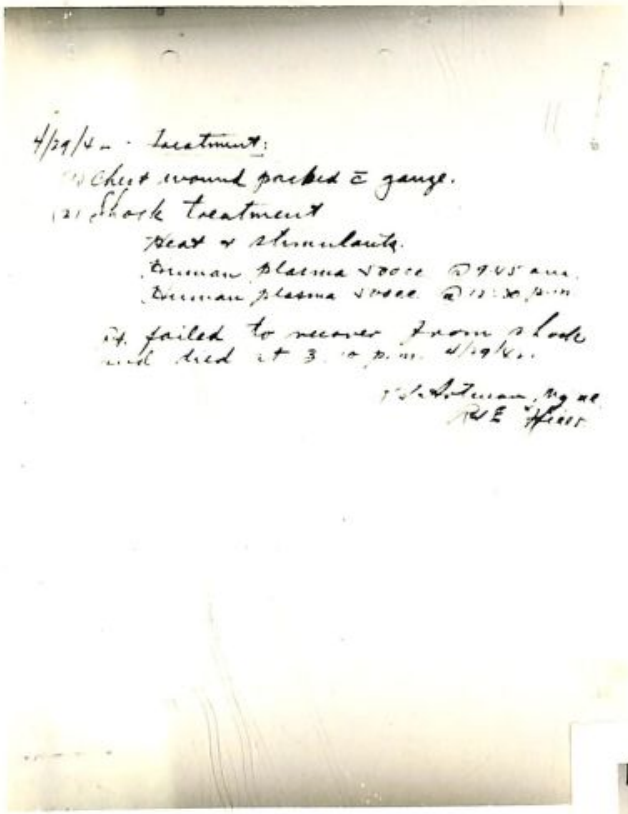
H.D. Newlands
Capt. M.C.

24



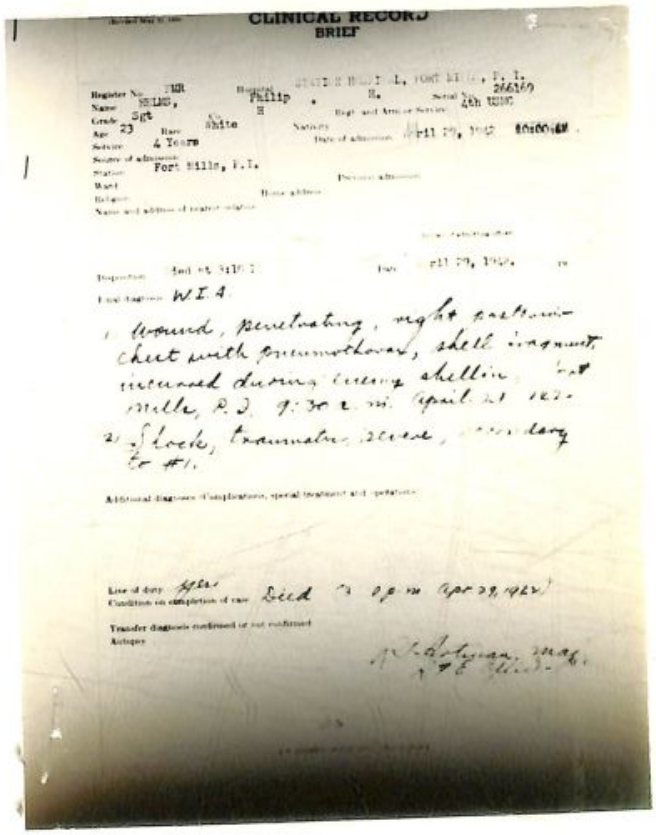


24-A



4/29/42 - Treatment:
(1) Chest wound packed & gauze.
(2) Shock treatment
Heat + stimulants.
Human plasma 1000cc @ 9:45 a.m.
Human plasma 1000cc @ 11:30 p.m.
(3) failed to recover from shock and died at 3:10 p.m. 4/29/42.

J. L. Hoffman, Maj MC
CO 121st Field Hosp



CLINICAL RECORD
BRIEF

Register No. [illegible] Hospital [illegible], FORT [illegible], P. I.
Name [illegible], Philip H. Serial No. 266369
Grade Sgt Co. H Regt. and Arm or Service 24th Inf
Age 23 Race White Nativity [illegible] Date of admission April 29, 1942
Service 4 Years
Source of admission Fort Mills, P.I.
Station Present station
Ward Home address
Religion
Name and address of nearest relative

Disposition Died Date April 29, 1942
Final diagnosis W.I.A.

1. Wound, penetrating, right posterior chest with pneumothorax, shell fragment, incurred during enemy shelling at Mile, R.D. 9:30 a.m. April 29 1942.
2. Shock, traumatic severe, [illegible] day prior to #1.

Additional diagnoses, complications, special treatment and operations

Line of duty yes
Condition on completion of case Died 3:10 p.m. Apr 29, 1942
Transfer diagnosis confirmed or not confirmed
Autopsy

J. L. Hoffman, Maj.
CO 121st Field Hosp

25

Name Evins Ld Wilson
Ft. Hills, Fla.

Diagnosis: Shell wound penetrating R. right parietal w/ chest with pneumothorax. (Fragment of exploding shell in Battery Point.)

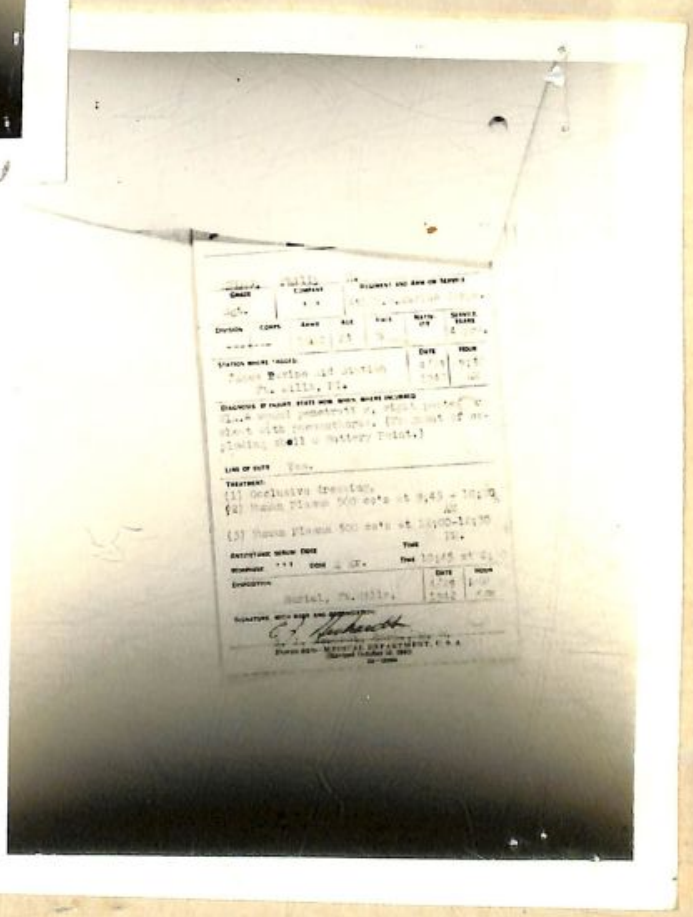
Line of Duty Yes.

Treatment:
(1) Occlusive dressing.
(2) Human Plasma 500 cc's at 9:45 - 10:00 AM
(3) Human Plasma 500 cc's at 10:00-10:30 PM.

Ambulance Serum Date Time
Morphine ... Dose ½ GR. Time 10:45 at 21

Disposition: Buried, Ft. Hills, Date 6/19/1918 Hour 1:00 PM

E. J. Huckstadt
Medical Department, U.S.A.



Name Evins Ld Wilson
Ft. Hills, Fla.

Diagnosis: Shell wound penetrating R. right parietal w/ chest with pneumothorax. (Fragment of exploding shell in Battery Point.)

Line of Duty Yes.

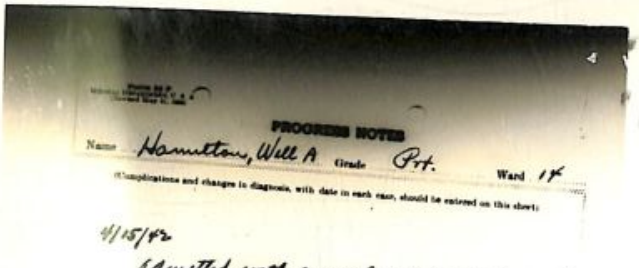
Treatment:
(1) Occlusive dressing.
(2) Human Plasma 500 cc's at 9:45 - 10:00 AM
(3) Human Plasma 500 cc's at 10:00-10:30 PM.

Ambulance Serum Date Time
Morphine ... Dose ½ GR. Time 10:45 at 21

Disposition: Buried, Ft. Hills, Date 6/19/1918 Hour 1:00 PM

E. J. Huckstadt
Medical Department, U.S.A.

25-A



PROGRESS NOTES

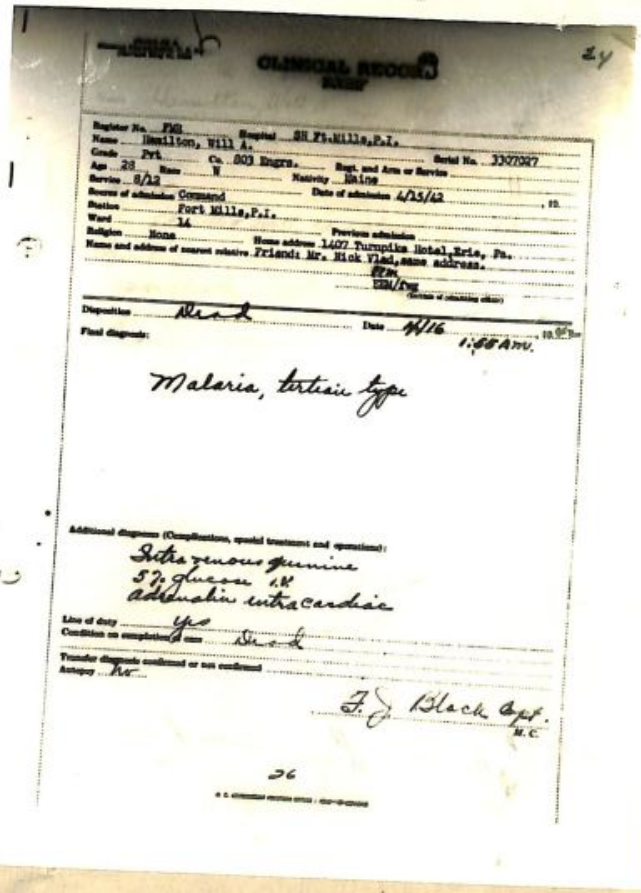
Name Hamilton, Will A Grade Pvt. Ward 14

(Complications and changes in diagnosis, with date in each case, should be entered on this sheet)

4/15/42

Admitted with complaint of weakness. Ambulant TPR 99.4-116-20 - examination essentially negative - no history of chills, fever, or diarrhea. Placed on liquid diet - temperature of 101 on admission.

J.J.B.



CLINICAL RECORD

24

Register No. PMG Hospital SH Ft.Mills,P.I.

Name Hamilton, Will A.

Grade Pvt. Co. 809 Engrs. Regt. and Arm or Service Serial No. 3307097

Age 28 Race W Nativity Maine

Service 8/12 Date of admission 4/15/42

Source of admission Command

Station Fort Mills,P.I.

Ward 14

Religion None Previous admission

Home address 1407 Turnpike Hotel,Erie, Pa.

Name and address of nearest relative Friend: Mr. Nick Vlad,same address.

Disposition Died Date 4/16 1:55 Am.

Final diagnosis:

Malaria, tertian type

Additional diagnoses (Complications, special treatment and operations):

Intravenous quinine
5% glucose i.V.
adrenalin intracardiac

Line of duty Yes

Condition on completion of case Died

Transfer diagnosis confirmed or not confirmed

Autopsy No

F. J. Black Capt. M.C.

26

26

PROGRESS NOTES

Name Hamilton, Will A. Grade Pvt. Ward 14

(Completations and changes in diagnosis, with date in each case, should be entered on this sheet)

4/15/42

Pt seen at 11:45 p. Respirations difficult, shallow. Temp. 104°. Pulse 140, good volume. Tenderness and sli. rigidity upper abdomen. Cyanotic. W.B.C. 3,500. Malaria smear positive for plasmodium vivax & many ring forms and some gametocytes.

Treatment:

10 c.c. Quinine dihydrochloride I.V.
Morph. Sulph. Gr. ¼
1000 c.c. 5% Glucose started.

Pt's condition was rapidly growing worse in spite of above treatment plus adrenaline, stimulants, etc. and he expired at 1:55 a. m. 4/16/42

R. D. Stutman
Maj. MC.
Officer of the Day

(If on both sides of this sheet)

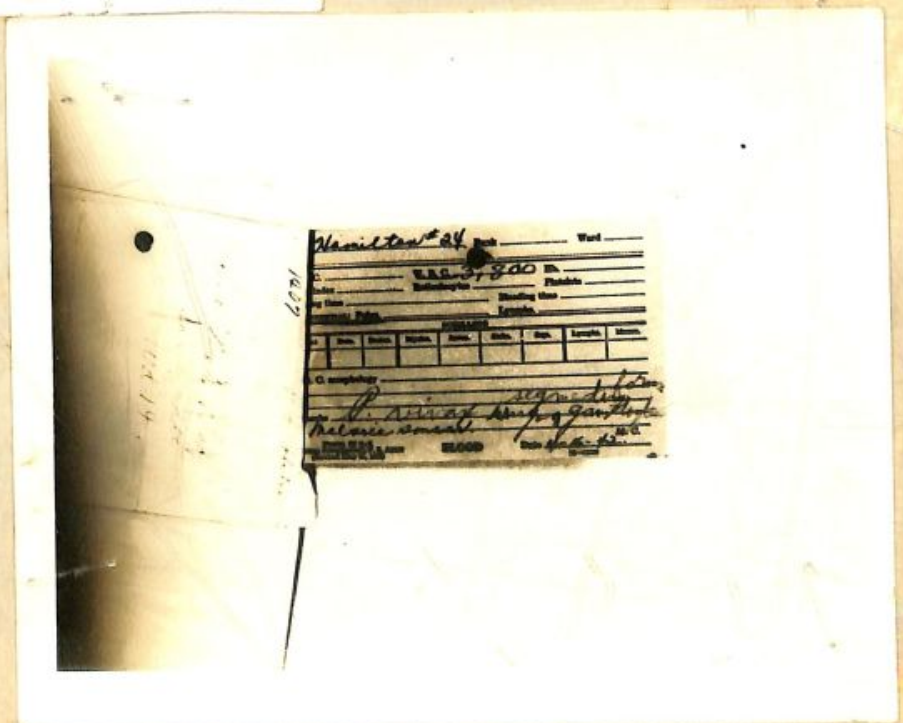
34

Name Hamilton, Will Grade Pvt. 7-18 Engr. Ward 19

Date	A.M. B	P.M. T	P	R	Remarks and Name Nurse
					Pt. was ordered out of bed on ward walking.
					Pt. went [illegible] and had to be carried back to bed.
11:45					Pt seems very weak, but otherwise all right.
12:00					T 104 P 140 R 36 - Seems to have labored respirations. G.D. Called
					Seen by O.D. WBC - Diff and Malaria smear taken.
1:30 p.m.					Quinine Dihydrochloride amp II given I.V.
1:30 p.m.					I.V. of 1000 cc 5% glucose started about 250 cc given.
1:35 p.m.					MS gr ¼ H.C. Pulse poor.
1:45					Adrenalin 3 cc. given directly into heart muscle by Maj. Cutman. Cheyne - Stokes Respirations - Unable to feel pulse.
1:55 p.m.					Respirations ceased Pronounced by Maj Cutman

(over)

26-A



26-C

FILE: 999-1-16 pc I

TITLE: Death Reports

ORIGIN: Miscellaneous

DATES: 1942-1945 CLASSIFICATION: None

AUTHENTICITY: Originals, some signed, Carbon copies some signed

SOURCE: Unknown

Extracted by Yes Date _____ Microfilmed Yes Date _____

SCREENED (NO PA.P.)

X X XX X X X X X X X X X X X X

ARCHIVES FILE NUMBER 999-1-16

TITLE DEATH REPORTS

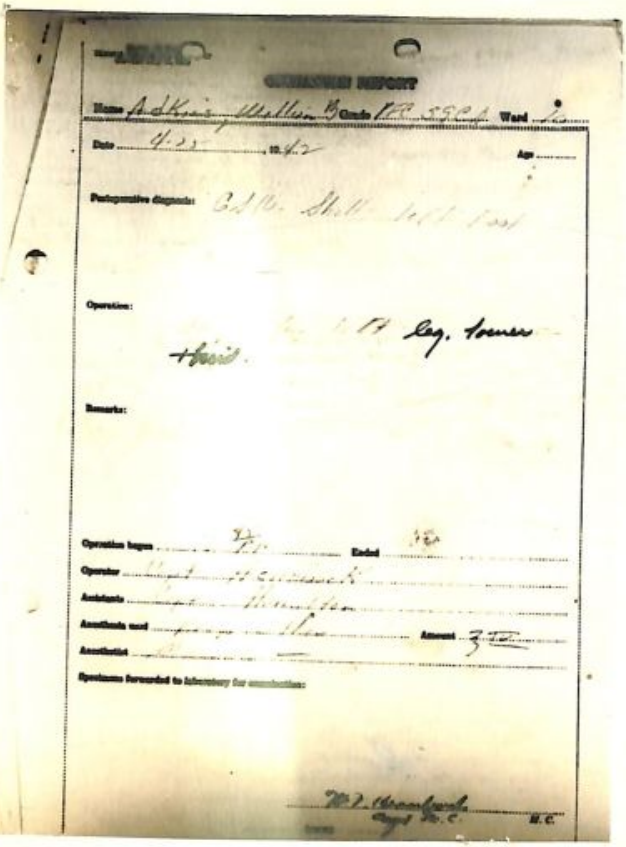
ORIGIN MISCELLANEOUS

DATES 1942-1945

AUTHENTICITY ORIGINALS. SOME SIGNED CARBON COPIES SOME SIGNED

SOURCE UNKNOWN

X X X X X X X X X X X X X X X X X X



OPERATIVE REPORT

Name Adkins, Wallace B Grade Pvt 35901 Ward 2

Date 4-22- 1945 Age

Preoperative diagnosis: GSW. Shell frag. [illegible]

Operation:

[illegible] Leg, lower

+Hemi.

Remarks:

Operation began 7 PM Ended 10

Operator [illegible]

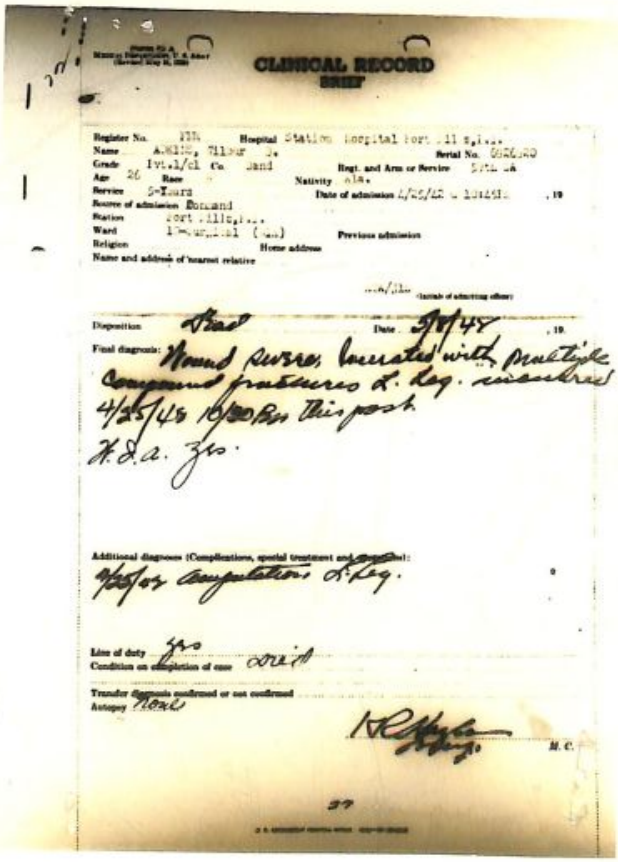
Assistants [illegible]

Anesthetic used [illegible] Amount 3

Anesthetist [illegible]

Specimens forwarded to laboratory for examination:

[illegible] Chaplain M.C.



CLINICAL RECORD
BRIEF

Register No. 1114 Hospital Station: Hospital Port [illegible]

Name Adkins, Wallace B. Serial No. 35901,820

Grade Pvt.1/cl Co. Band Regt. and Arm or Service Inf. 26

Age 26 Race [illegible] Nativity Ala.

Service 3-Years Date of admission 4/25/45 [illegible] 19

Source of admission Command

Station Port [illegible]

Ward [illegible] Previous admission

Religion Home address

Name and address of nearest relative

[illegible] (Include of admitting officer)

Disposition Dead Date 5/1/45 19

Final diagnosis: Wound gunshot, lacerated with multiple compound fractures L. leg. extremities 4/25/45 15:00 Hrs this post. W.D.A. 3yo.

Additional diagnoses (Complications, special treatment and [illegible]):

4/25/45 Amputation L. leg.

Line of duty Yes

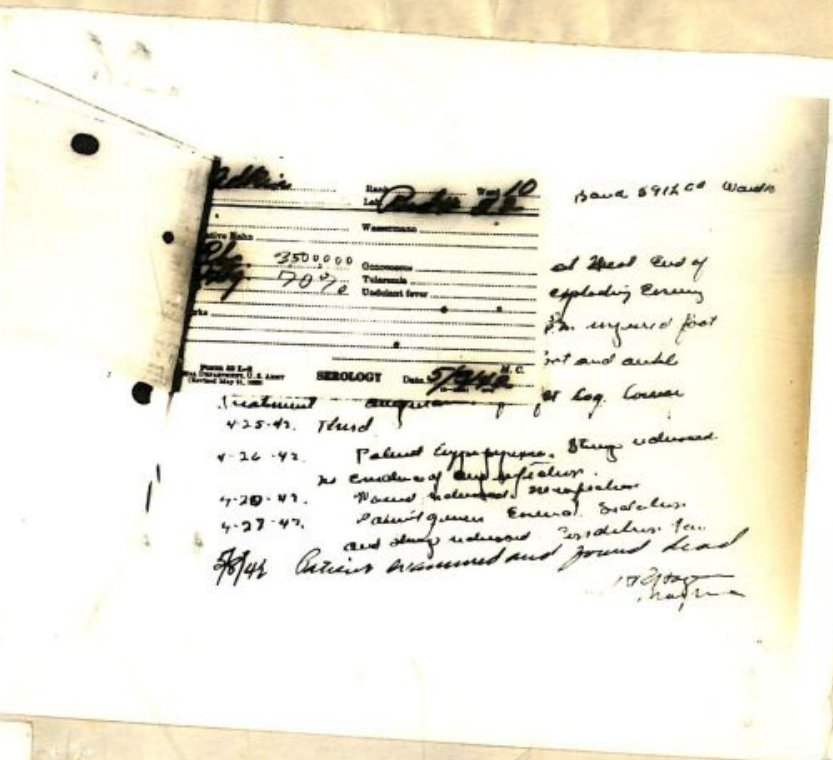
Condition on completion of case Dead

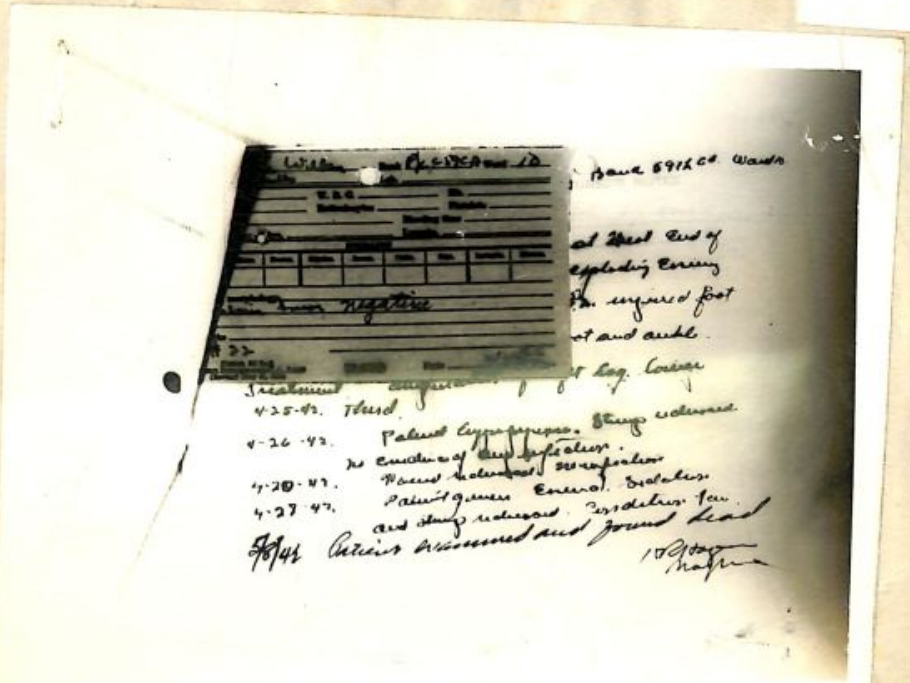
Transfer diagnosis confirmed or not confirmed

Autopsy None

[illegible] Major M.C.

37





Adams William Pvt. Age 26. Band 691 Co Ward 10

History Patient was standing at West End of Malinta Tunnel when exploding Enemy Shell. At 4.25.42 10:15 a.m. injured foot

Diagnosis Lacerations of left foot and ankle

Treatment Amputation of left leg. Closure 4-25-42. Thigh.

4-26-42. Patient hypotensive. Stump redressed. No evidence of hemorrhage.

4-28-42. Wound redressed. Wound clean

4-29-42. Patient quiet. General. Sedation and stump redressed. Condition fair.

5/1/42 Patient discharged and found dead

10 Gage Major

4/28/99 102 24
98 70 16 99 120 20
Malaria smear requested.
Decentrinol 5 Gr. 6 hr. Iemide

TEMPERATURE—TREATMENT—NURSE'S NOTES

Name Il Santiago fC 59 Ward 10

Date	A.M. T	P	R	P.M. T	P	R	Ht	Wt	Medication and Nurse's Notes
4/25/42									Pt admitted to Ward 10
									Amp left foot
	100.1	08	At						Plasmoquin 1/48 gr (Iter)
									Thiamine Hydrochloride 1/66
									Liter of
4/26/42	101	76	28	101	120	28			Liquid diet
	101	120	28	104	120	28			Bleeding from wound
									Morphine Sulf 1/4 gr IM
									Sulfaguanidine gr XV q 4 h
	104	120	36						Tylenol rect.
									Morphine gr 1/4 @ 1130
									Liquid diet
									Slept well
4/27/42									
	103	160	24	104	120	20			Fluids forced
	102	120	24	102	120	20			Sup ait
									Liquid gr XX 8-12-4
									Ss Enema given
									Bowels passed after the noted
									pulse drops to 80
									Decitalis discont
									Sulfonine Routine Regm
									Sulfaguanidine Contd
									Milk toasts 20 ounces
									Regm after 1000 cc IV
									Proper IV
									Temp 104 - 178 - 70
									" 102 - 130 - 32
									Morphine gr 1/4 @ 20
4/28/99	102	24							Malaria smear requested.
	98	70	16	99	120	20			Decentrinol 5 Gr. 6 hr. Iemide

27-B

TEMPERATURE—TREATMENT—NURSE'S NOTES

Date	A.M. T	P	R	P.M. T	P	R	Bl	Wt	Medication and Nurse's Notes
4/29	99	96	24	101	96	20			Active treatment
	100	78	18	100	100	20			
4/30	98	70	18						
	100	84	18	100	88	24			Quinine gr X T.i.D
				100	90	24			Sod Salicylat gr 15
									Sod Iodothiol gr 5
									Sol. 40% @ 3 pm
5/1	99	90	24						Sig. Type Hyd. & Calcium Gluc.
				103	92	28			Cal. Mur. Gluc. 20% I.V. B.i.D
				103	94	27			Caucara Sag. M.D.
5/2	103	94	22						M 3 gr 1/4 @ 10 30
									Sod. Salicylat gr 15 at 4 pm
				104	96	24			Sulfathiazole T.i.D
				104	102	26			Caucara Sag. M.D. @ 12
									Phenobarbital gr 1/2 3 p.m.
5/3	102	98	22						Sulfa. guanidine T.i.D
	102	30		103	102	20			
5/4	101	94	20	101	98	26			Phenobarbital gr 1/2
				104	112	24			
5/5	101	94	20	103	102	28			
				104	98	26			Coramine 15 m
				104	100	24			Sulfa. gr 30 at 2 p.m.
5/6	103	102	28	104	96	28			
				103	100	26			
				103	104	24			I.V. 1000 cc normal saline at 3 P.m. Chill following I.V.
									Chills
									10

TREATMENT

Name Robert [illegible] Grade Pfc 396 Ward 10

Date	A.M. T	P	R	P.M. T	P	R	
5/2	104	128	28	104	104	28	malaria smear
				104	30	30	Quinine gr X T.i.D
				104	12	26	Resp very rapid
	10 Sag						Sulphadiazine
	106	24					TM-3 gr 1/4 @ 2 30
							Condition same
							Pulse irregular
5/8	105	136	32	105	128	26	Morphine gr 1/4 @ 10
				106	134	28	Coramine to breathe 6 10 P.m.

27-C

Form No. A
Revised May 15, 1942

CLINICAL RECORD
BRIEF

Register No. [redacted] Hospital [redacted]
Name [redacted] Serial No. [redacted]
Grade [redacted] Co. [redacted] Regt. and Arm or Service [redacted]
Age [redacted] Race [redacted] Nativity [redacted]
Service [redacted] Date of admission [redacted], 19
Address of admission [redacted]
Station [redacted]
Ward [redacted] Previous admission
Religion [redacted] Home address [redacted]
Name and address of nearest relative [redacted]

Disposition Expired 9:25 P.M. Date 5/2/42, 19

Final diagnosis:
① Traumatic amputation of left leg mid calf region, fracture of right tibia from large steel fragments as a result of an enemy bombardment of St. Nicholas Jan 28/42.

Additional diagnoses (Complications, special treatment and operations):
Bilateral amputation of left leg mid thigh, debridement of right leg ② operation. Has gangrene of stumps of left leg

Line of duty Yes WIA
Condition on completion of case Expired

Transfer diagnosis confirmed or not confirmed
Autopsy

Edwin A. Adams
1st Lt. M.C. U.S.A.

28

Form No. [illegible]
Revised May 15, 1942

OPERATION REPORT

Name Cobb, James J. Grade Cpl 60th C.A. Ward [redacted]
Date April 28 1942 Age 25 yrs M.

Preoperative diagnosis Multiple wounds of both legs - Traumatic amputation of left leg at mid calf level. Compound comminuted fracture of upper right tibia

Operation Mid thigh Guillotine, left leg. Debridement and Acetabutamine ② [illegible] packing and splinting of right leg.

Remarks Transfusion of 500 c.c. Citrated Blood 250 c.c. Blood Plasma given 1000 c.c. Normal Saline Solution I.V.

Operation began 1:25 P.M. Ended 2:10 P.M.
Operator Lt. Nelson
Assistants Commander Hayes
Anesthesia used Procaine (Spinal) Amount 150 mgm.
Anesthetist 1st Lt. Adams
Specimens forwarded to laboratory for examination

M.C.

28

Gable, Jesse J. Cpl. 4/20/42.

Patient received traumatic amputation of the left leg at the knee and a comp. comminuted fracture of the upper right tibia from large shell fragments during an enemy bombardment of Ft. Mills Corregidor before admission. His condition is critical.

A guillotine amputation of the left leg at mid thigh was done but the open wound of the right leg was debrided, cleaned and covered in the O.R., then placed in a Cabot splint. His condition has improved but slightly since surgery. To have another transfusion this P.M.

Nelson

4/21/42. Patient very restless this P.M. Pulse is rapid and strong. He appears febrile.

Nelson

4/22/42. Patient definitely worse. Temp. very restless this A.M. Pulse is respirations are the marked aspect of the chart, the fever and unrest is uncertain and the cause is circumstantial of gas infection. A multiple stimuli.

Nelson

5/1/42. Aboard the same this A.M. & like today's this restless. Patient became quiet and is now sleeping after 40,000 U of antitoxin in 1000 cc N. saline IV.

Nelson

TREATMENT

Name Gable, Jesse J. Grade Cpl. 66th C.A. Ward 6

1942	T	P	R	T	P	R	
4/21					108		Adm. to W2 & PAR. Litter Pan. O.R. Coun. Shk. in Shock. Amp. Left Leg. Frac. Rt. Leg. Shock Blocks to Foot of Bed. Blood Plasma 250cc 250cc. Citrated Blood. 100cc. N.S.S. IV. in O.R. - B.P. on adm. to ward 70
4/22	101.4 / 101.8	126 / 132	40 / 32	101 / 101.8	122 / 120	32 / 26	pulse volume rapid but very irregular. Seen by Comm. Surg. Shock Blocks applied. Cpl. Nelson to see pt. Pulse has improved. Pt. is quite restless. Morph. gr ¼ @ 12 noon per orders Maj. Morgan. Trans. To Ward 9
5/1	101 / 102	120 / 108	20 / 28	101 / 103	120 / 118	24	At rest hrs. Dressing soaked Rpeated & cd. Seen but nothing done. Cond. Take pulse. kept on morning. Morphine gr ¼ "H" given 2:00 Am packed. No vomiting Dressing on very foul. Ft. Shock by Miss Smith. Ft. husband - Walter Thomas Spring — Shearing Charge. To Rec Ceretaker time for Dressing

28-A

TREATMENT

Bible #30

Date	T	P	R	T	P	R	
							1st 100000 u/s i.v. c 40,000 u. on admission i.v.
							2nd 20,000
30				103°	130	28	3rd 10,000 u. ⓒ for catheter 5 cc plain M.S. in 10 grams
5-1-43	80	180	36	103	120	32	Infusion 1000 cc D/W
							Given 2 Cee gangrene antitoxin 8cc
				105	136	28	Infusion 1000 cc D/W i.v.
							Given 2 Cee Gangrene antitoxin 4cc
5-2	80	120	32	102	130	29	Very weak throughout all night
				103	118	32	Failed weak
		4		103	118	32	Saline - 1000 cc - Blood transfusion 1000 cc - 10,000 u. Cee gangrene antitoxin - 5 cc m.
							M.M. 4 cc
							Tubes plasma very poor
							10,000 units Cee Gangrene antitoxin I.M.
							1000 cc D/W Solution i.v. 7 cc
5-2-43							Expired 9:05 P.M.
							Permission deal by Dr. Nelson

J. Espinosa

TREATMENT

Name Bible, Jim J. Grade Cpl. Ward 9

5/2

Massive doses of antitoxin (60,000-80,000 units IV) Pulse failed to response the ordering of the gas infection. Stains expired 9:05 P.M.

Nelson

28-B

Form 88 A
Memo, Surgeon's Office, U. S. Army
(Revised May 31, 1943)

CLINICAL RECORD
BRIEF

Register No. [illegible] Hospital Station Hospital Fort Riley, Kans.
Name [illegible], William T. Serial No. 19013383
Grade Co Pfc Arm or Service Inf Regt and Arm or Service [illegible]
Age [illegible] Race [illegible] Nativity [illegible]
Service [illegible] Date of admission April 9, 1942 @ 4:45 PM, 19
Source of admission [illegible]
Station [illegible]
Ward [illegible]
Religion [illegible] Previous admission [illegible]
Name and address of nearest relative [illegible]

Disposition died 6 pm. Date April 9, 19 42
Final diagnosis: W.I.A.

1. Fracture, skull, Compound, Comminuted, caused by enemy shell fragments, April 9, 1942 about 4:30 P.M. at Ft Riley, Kans.
2. Wound, lacerated, brain, severe, cause as #1.

Additional diagnoses (Complications, special treatment and operations):

Line of duty
Condition on completion of case Pt died

Transfer diagnosis confirmed or not confirmed
Autopsy — None

[signature] M.C.

39.

Form 88 A
Memo, Surgeon's Office, U. S. Army
(Revised May 31, 1943)

PROGRESS NOTES

Name [illegible], William T Grade [illegible] Ward 5

(Complications and changes in diagnosis, with date in each case, should be entered on this sheet)

4/9/42. 6 pm. Pt. expired — comp'd comminuted fracture of skull & lacerated brain. Moribund on arrival to hospital.

[signature]

(For both sides of this sheet)

39

TEMPERATURE—TREATMENT—NURSE'S NOTES

Name Brewer, Wm J. Jr. Grade ____ Ward 5

Date	A.M. T	P	R	P.M. T	P	R	Wt	Medication and Nurse's Notes
11/7								
4/9								Admitted at 10 a.m. - sisters
				1.30				sisters. Shellgunfire
								Under week and water
								syphilis
								Medications started.
								Ordered at 6 p.m.
								Pronounced dead by Maj
								Brees

TREATMENT—NURSE'S NOTES

29-A

1

CLINICAL RECORD
BRIEF

Register No. 7581 Hospital Ft. Sill, Okla.
Name Dahmer, Hamilton (Home) Serial No. 6393554
Grade Pvt 1cl Co. Dept. and Arm or Service 89th AF Co.
Age Race Nativity Oklahoma
Service Date of admission 4/22/42 @ 10:00 PM, 19
Source of admission Command
Station Ft. Sill, Okla.
Ward 10-Surgical Previous admission
Religion Protestant Home address Route 1, Sperry, Oklahoma
Name and address of nearest relative Orlie Stewart, same address

Disposition Returned Date 4-28, 1942

Final diagnosis:

(1) Laceration, scalp, scalp. Left temporal-occipital area.
(2) Fracture, comminuted, Head, temporo-occipital, left side.
(3) Hemorrhage, subdural, traumatic, Head, temporal occipital area, left side, secondary to No(2)

Patient was struck by flying debris caused by exploding enemy shell, sustained left side of head. Received 3 P.M. on 4-22-42. Admitted to Ward 10 at 4:30 P.M.

Additional diagnosis (Complications, special treatment and operations):
Concussion, Debridement of scalp wound, Sutured.

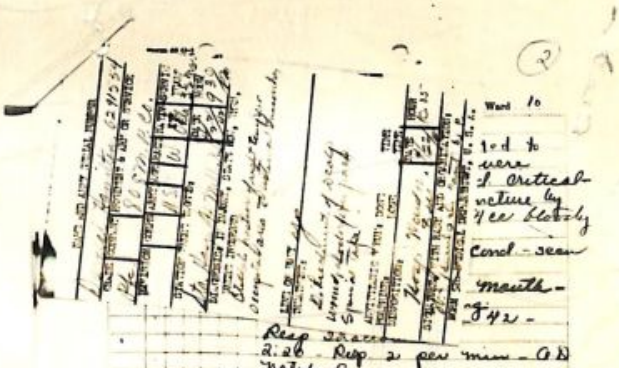
Line of duty Yes
Condition on completion of case Cured
Transfer diagnosis confirmed or not confirmed None
Autopsy None

W. F. Crawford
Capt M.C. M.C.

3

NR

(2)



Ward 10
1-d to
were
L Orticeal-
ucture by
4 ee Hotsky
Cond - sear
mouth -
-42 -
Resp
2.26 Resp 2 per min - OD
Notified
2 So Patient expired - OD present

20

TREATMENT

Name Jarnal, Hamilton Grade Pfc Ward 10

Date	
4/22	10 30 p m patient admitted to Ward 10 per litter - severe head injury - and critical.
	11:15 pm - Spinal puncture by Capt. Hirschback - Mod bloody fluid obtained.
	11:00 No change in cond - seen by Chaplain.
	12:00 Bleeding from Mouth - head wound oozing.
	2:00 Pulse Strong - 142 - Resp shallow
	2:20 Resp 2 per min - O.D notified
	2 30 Patient expired - O.D present

Jarnal Hamilton Pvt Inf Ward 10

History

Patient was struck on left side of head by flying debris caused by exploding enemy shell, in East end leading to Makata Tunnel

Examination

Extensive scalp wound, with exposed fracture of temporal area. Left Ear Bleeding. Hemorrhage also in Nostrils. Patient admitted to Emergency Ward 10 - 4-22-42

Diagnosis

1) Laceration of scalp
2) Fracture Comminuted left temporal area
3) Hemorrhage, subdural, traumatic left cerebral.

Treatment

4-22-42 Debridement of scalp wound with removal of bone fragments. Bloody fluid, spinal column removed therefrom. Patient shows signs of Profuse bleeding. Patient expired - Death at 2.30 AM.

4-23-42. Autopsy performed by O.D.

Wm Hemsley
Capt MC.

30-A

1

CLINICAL RECORD
BRIEF

Disposition died

Date

Final diagnosis:

1. Wound, contused, lacerated, multiple, perforating, left. knee, by bomb fragment H.E. 7.7. mills R.D. 4/30/42

2. Fracture, compound, comminuted, tibia, middle third, lower, by bomb fragment H.E. 7.7. mills R.D. 4/30/42

W.I.A.

Additional diagnosis (Complications, special treatment and operations):

None

Line of duty Yes

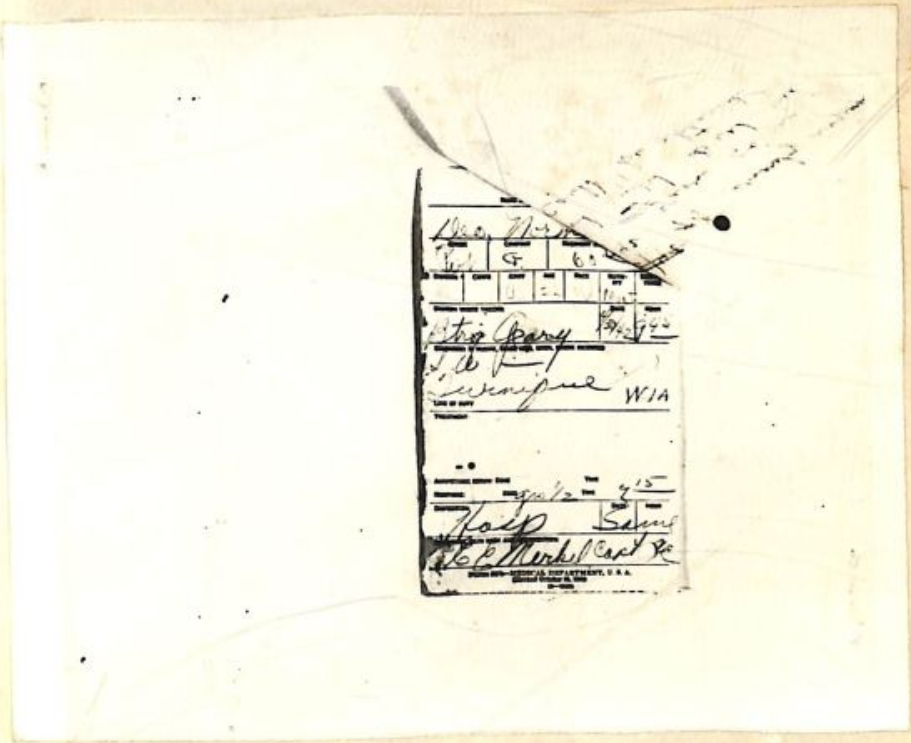
Condition on completion of case Died

Warren A. Wilson
Maj. M.C.

31

42 ~~###~~ 42 severely injured
Given 20 cc citrated plasma
and died before blood donor
could be obtained.

31



31-A

Recruit, Eulalio, Serial No. 1st. 4th Marines.

History: [illegible] 4/14/42 During the enemy shelling of this post the patient was struck in the jaw by a fragment of shell. There was no loss of consciousness.

Past History; Essentially Negative.
Examination; No abnormal findings.
Special examination; The central portion of the mandible and lip are missing. The suprahyoid muscles partially missing and fragments of the mandible in the cavity left by the missing muscles. The central incisors are missing. The floor of the mouth and the mucosae of the tongue is split in the midline deeply into the muscle tissue.

Operation; Closure of the muscle planes with Chromic 0 suture and lower portion of the tissues of the tongue. The ends of the mandible were covered with mucosa, and wired to the maxillae. The lower lip was repaired plastically and a drain was inserted in the lower angle of the wound.
Anes; 1% Procaine infiltration. Operator; Maj. Hagen
Asst. Maj. Richardson.
Tetanus Toxoid; 1cc.

4/15/42 Dressing. Coad. Speech is good. Swallowing without difficulty. No respiratory difficulty. [illegible]

4/17/42 Some bleeding from stab drains. Rubber drains and clots removed. Packed & Iodoform gauze. No further bleeding. [illegible]

4/17/42 10 PM Patient is said to have got out of bed and was delirious. Nurse states that there was no temperature.

CLINICAL RECORD
BRIEF

Register No. 922 Hospital Station Hospital Fort Mills, P.I.
Name RECUNDO, Eulalio (None) Serial No.
Grade Pvt 1st Cl. Regt. and Arm or Service 4th Marines
Age Race F Nativity P.I.
Source of admission Command Date of admission April 14, 1942 @ 5:30 P.M.
Station Fort Mills, P.I.
Ward Surgical (MIA) Previous admission
Religion Catholic Home address
Name and address of nearest relative

MMD/lib

Disposition Died Date 4/17/42
Final diagnosis (1) Fracture Compound Communited Mandible with loss of substance; Central multiple Injuries Incurred during Enemy Shelling of this post 4/14/42. 4 PM.
(2) Cerebral Concussion Severe
and Contusions of skin and superficial musculature incurred Concurrently with (1)
Line of duty Yes
Condition on separation or death Died
Autopsy None

[signature] M.C.

32

32

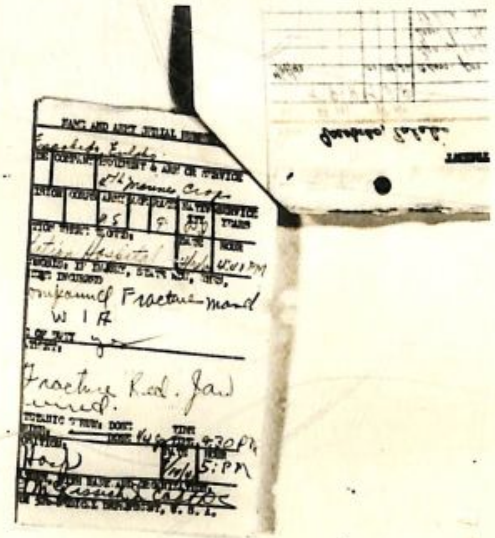
story apparently Private McCann and folded died. W. Clayton Hayne

TREATMENT

Name Goodbody Zalaba Grade Mast 1st Cl Co Ward

Date	T	P	R	T	P	R	
3/16/03							adm. per Litter at 7 PM. Jan case
							Dressing last given
							Seen by Chaplain Carberry
							Blood M.S. & CT on OK
15	99	104	28				M.S. gr 1/4 @ 10 pm. + 2 am. Aconite Jar 30 Ind.
	101	102	24				Fomentation
							Wet MS gr 1/4
16	98	104	28				Expectorate Cave. + Mixt. Ext & neon.
	101	104	28				Ind. Catharsis 4 m. I.V.
							30 cc Con gr 1/4 (morphia)
17	98	104	20				Hemorrhage from chest wound @ 12 P.M.
	99	100	22				to dress Dressing. Expectorate
							Temp. T. w/d 6. Mabchell Cl Co.
							C&C + morphia 3 drops Expectorated.
							Swallowed 9 AM & PM
							Mixt. 02 1/2 oz 3 PM per Katheter
							Respirations.
							Rectus.
							Pulse - fair volume. Respiration
							somewhat labored.
							Cocaine gr 1/4
							Aspirin gr X @ 9 PM
							Put out of bed @ 9 PM
							Put back to bed. Gasping
							Caffeine & Sod Benzoate Comp #
							Major Hayne. Notified
							Respiration ceased, pronounced
							dead by Major Hayne.

32-A



32-B

SUPPLEMENTAL RECORD

CLINICAL RECORD
BRIEF

Register No. F58
Hospital Station Hospital, Fort Mills, P.I.
Name Sagay, Cornelio (none)
Grade Civilian Co. Engl Serial No. ——
Age 53 Race F Regt. and Arm or Service Engr. Dept.
Service 35 years Nativity P.I.
Source of admission Command Date of admission 3/22/42, 19..
Station Fort Frank, Cavite, P.I.
Ward 70
Religion Catholic Previous admission No
Home address Ft. Frank, Cavite, P.I.
Name and address of nearest relative Wife: Mrs. R. Sagay, Calumpan, Ft. Frank, Cavite, P.I.

Disposition *Died* Date *4/7/42*, 19..

Final diagnosis: WIA
#1: Shrapnel wound, lateral aspect of left foot, with compound fracture of the OS Calcis
#2: Shrapnel wound, slight, with compound, comminuted fracture proximal end of the right tibia
#1&2 accidentally incurred while on duty at Fort Frank, P.I. March 21, 1942, when he was struck by fragments from a Japanese shell.

Additional diagnoses (Complications, special treatment and operations) Operation. March 22, 1942
Spinal anesthesia: Radical debridement of all wounds, shrapnel fragment removed from the body of the left Os Calcis, packed open with sulfanilamid and vaseline gauze, boot cast. Fracture of right tibia, reduced by traction and manipulation, wound packed as above boot cast applied.

Line of duty Not applicable Surgeon: Capt. T.H.Hewlett
Condition on completion of case *Dead.*
Transfer diagnosis confirmed or not confirmed
Autopsy

Cause of death: Same as final diagnosis

NK

Thomas H. Hewlett
Thomas H. Hewlett, Capt. M.C.

38

PROGRESS NOTES

Name Sagay, Contlio Grade Lt. [illegible] Ward Ortho.

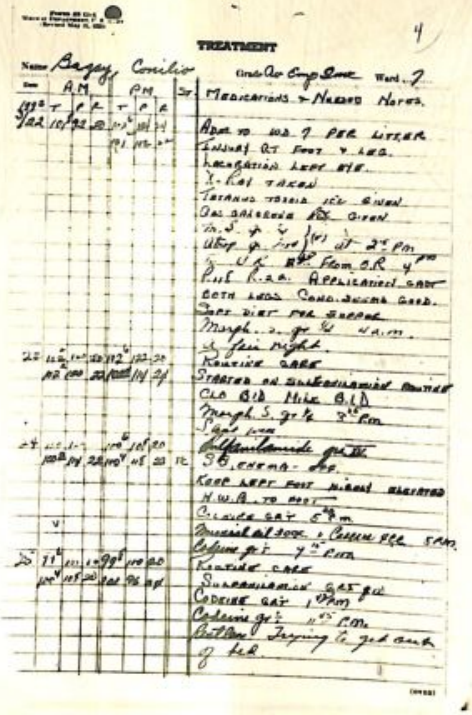
Complications and changes in diagnosis, with date in each case, should be entered on this sheet.

March 22, 1942: Shrapnel wounds of both legs, debrided and treated by modified Orr technic, boot casts applied to both legs, spinal anesthesia, patient returned to bed in good condition.
T.H.Hewlett

3/24/42 Progress satisfactory no complaints, mental attitude suggestive of senility. T.H.H

[illegible] ... noted, ... rational. ... examination ... findings are not consistent with a diagnosis ... present time. ... above 99.

4/7/42 Patient seems slightly improved early in A.M. but developed gradually temp to 105.4 axillary at 3:40 P.M. difficult respiration no response to stimulants dead at 3:45 P.M.
Thos H Hewlett

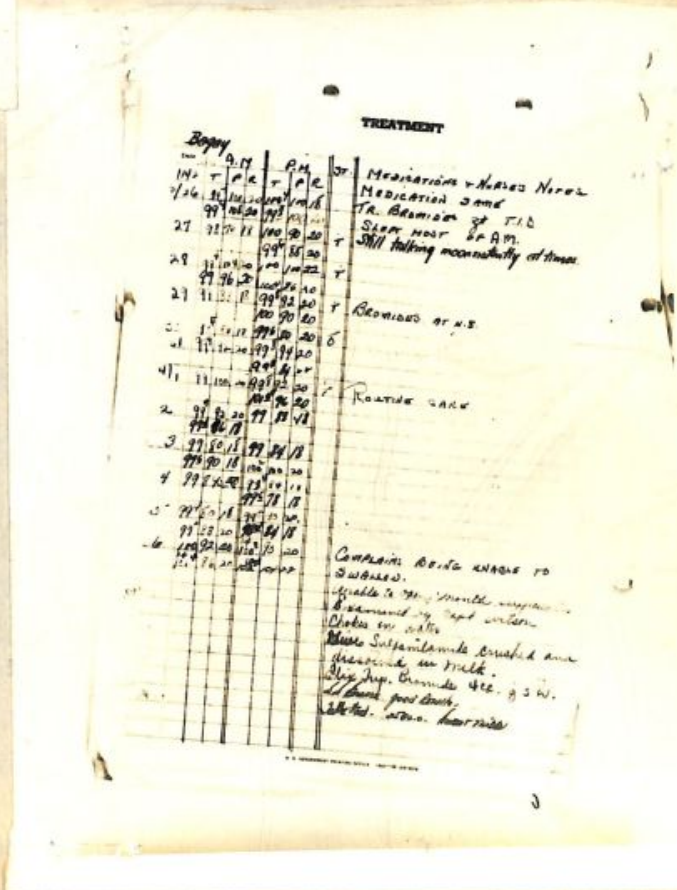


TREATMENT

Name Baggy Conklin Ward 7

Circle One: Comp Quar

Date	AM T	AM P	AM R	PM T	PM P	PM R	Dr	Medications + Nursed Notes.
11/30 9/22	10[2]	92	20	101	104	24		Adm to 102 7 PER LITER.
				99[1]	102	24		Lavage Rt foot + leg.
								Immersion Left Rib.
								X-Ray taken
								Tetanus toxoid ice given
								Gas Gangrene Rx Given
								Dr. S. + V. (#1 at 2:00 PM
								Ultra + Rx (#2 at 2:00 PM
								+ U.V. Rx from O.R. 4:00
								Pulse R.A.D. Application Cast
								both legs Cond. Seems Good.
								Soft Diet per Surgeon
								Morph. 2 gr ½ 4 A.M.
								to flexi night.
23	112[2]	120	20	112[2]	122	20		Routine Care
	98[2]	100	22	100[2]	104	24		Started on Sulfadiazine mixture
								Clo Bib Mix B.I.D.
								Morph. S. gr ½ 2:00 PM
								Pupils even
24	102[2]	104	20	100	108	20		Sulfamelamide gm III
	100[2]	PM 22	100[2]	108	23	12		S.B. enema - Sup.
								Keep kept foot higher elevated
								H.W.B. to foot
	V							Glucose 5% 6:00 PM
								Mineral oil 30cc + Castor Oil 5 PM.
								Codeine gr ½ 7:00 PM
25	99[2]	102	20	98[2]	100	20		Routine Care
	100[2]	108	20	100	98	20		Sulfadiazine gm III
								Codeine gr ½ 1 PM
								Codeine gr ½ 11:45 PM
								Bilbow + Jumping to get out of B



TREATMENT

Baggy

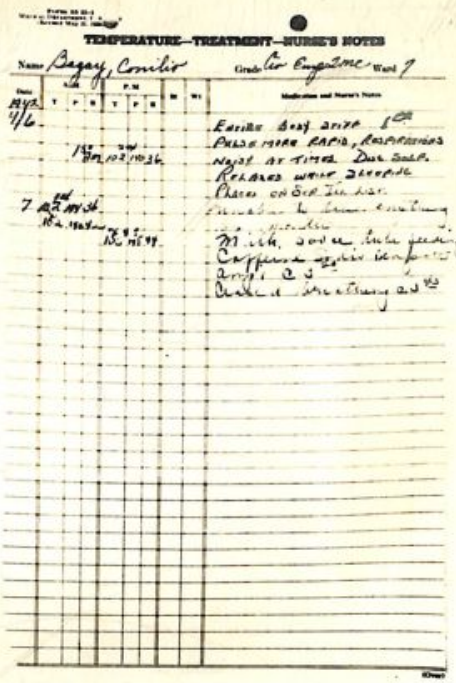
Date	AM T	AM P	AM R	PM T	PM P	PM R	Dr	Medications + Nursed Notes
11/30 9/26	10[2]	92	20	101	104	18		Medication 3 and
	99[2]	98	20	99[2]	100	20		T.R. Bromides gr T.I.D.
27	98[2]	98	18	100	98	20	T	Slept most of A.M.
				99[4]	98	20		Still talking incoherently at times
28	98[2]	100	20	100	98	20		
	99	96	20	99[4]	98	20	T	
29	98[2]	98	18	100	98	20	T	Bromides gr X.S.
	98[2]	98	20	99[6]	98	20		
30	98[2]	98	20	99	98	20		
	98[2]	98	20	99	98	20		
41/1	98[2]	100	20	99[2]	98	20	T	Routine Care
				99[2]	98	20		
2	98[2]	98	20	99	98	18		
	98[2]	98	18					
3	98[2]	98	18	99	98	18		
	98[2]	98	18	100	98	20		
4	98[2]	98	18	99	98	18		
				99[2]	98	18		
5	98[2]	98	18	99	98	18		
	98[2]	98	20	99[2]	98	18		
6	98[2]	98	20	100	98	20		Complains bowels unable to
								Swallowed.
								Unable to [illegible]
								Examined by Capt Watson
								Chokes on water
								Adm Sulfamelamide crushed and
								dissolved in Milk
								Skin Inj. Cremide 4cc. q 3 H.
								Allowed food Orally
								Started. Adm. heart mixture

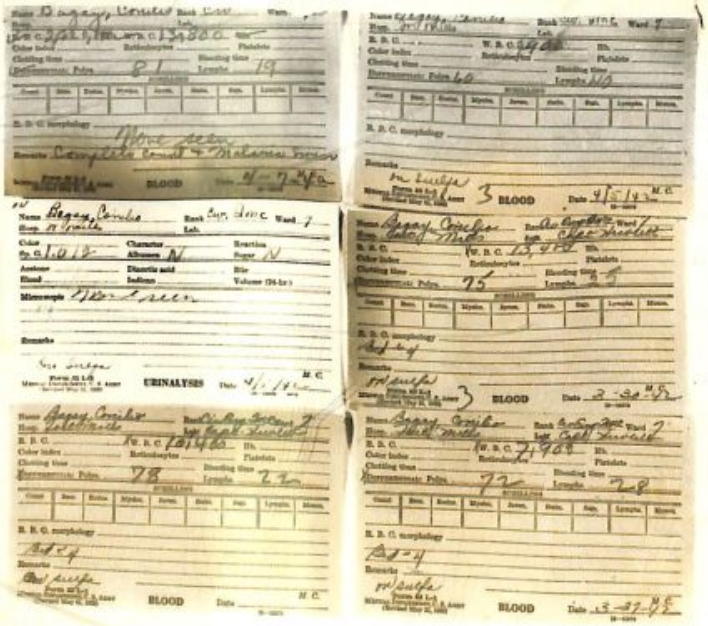
J

24 33-A

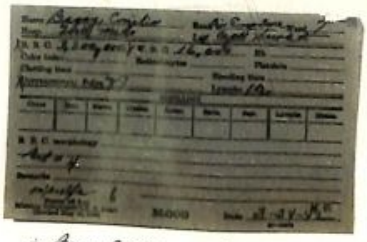
TEMPERATURE—TREATMENT—NURSE'S NOTES

Name Bagay, Conchir Ward 7





33-B



Name Baggy Combs Ward 7
Hosp Fort Smith 4th Cavalry Div
Color
Sp. G. 1.07 Character Reaction
Albumen 4+ Sugar 1+
Acetone Diacetic acid Bile
Blood Indican Volume (24-hr.)
Microscopic Normal

Remarks

Ord Sulfa

URINALYSIS Date 2-2-43 M.C.

Name Baggy Combs Ward 7
Hosp Fort Smith 4th Cavalry Div
Color
Sp. G. 1.07 Character Reaction
Albumen 4+ Sugar 1+
Acetone Diacetic acid Bile
Blood Indican Volume (24-hr.)
Microscopic

Remarks

Ord Sulfa

URINALYSIS Date 2-27-43 M.C.

Name Baggy Combs Ward 7
Hosp Fort Smith 4th Cavalry Div
Color
Sp. G. 1.07 Character Reaction
Albumen 4+ Sugar 1+
Acetone Diacetic acid Bile
Blood Indican Volume (24-hr.)
Microscopic

Remarks

Ord Sulfa

URINALYSIS Date 3-30 M.C.

Name Baggy Combs Ward 7
Hosp Fort Smith 4th Cavalry Div
Color
Sp. G. 1.016 Character Reaction
Albumen Trace Sugar 1+
Acetone Diacetic acid Bile
Blood Indican Volume (24-hr.)
Microscopic

Remarks

Normal

33-C

Form 88 A
Revised May 31, 1935

CLINICAL RECORD
BRIEF

Register No. 252 Hospital Station Hospital Fort Mills, P.I.
Name De [illegible], Lorenzo (Last) Serial No. [illegible]
Grade Private Co. Philippine QM Regt. and Arm or Service Engr. Dept.
Age 26 Rate — Nativity P.I.
Service [illegible] Date of admission 4/30/42 a 0300 , 19
Source of admission P.S.H. (Tfr. fr. CO-504)
Station Fort Mills, P.I.
Ward [illegible] Previous admission —
Religion [illegible] Home address [illegible], Bataan, P.I.
Name and address of nearest relative [illegible] Cruz, Silverio Cruz
[illegible] P.I.
(Wife)
(Include if attending officer)

Disposition died 8:15 am Date May 7, 1942

Final diagnosis:
1. Wound, perforating, severe, mid-epigastric, abdomen by shrapnel from enemy shell 4/30/42, Fort Mills, P.I. W.I.A.
2. Wound, perforating, of thoracic colon, mod. severe; cause undetermined.

Additional diagnoses (Complications, special treatment and operations):
Suture of perforated transverse colon + wound of abdominal wall (150 mgs. sy. penicillin) 4/30/42.

Line of duty YES
Condition on completion of case died

Transfer diagnosis confirmed or not confirmed —
Autopsy —

[signature] M.C.

34

5-1-42. Abdom. Surg. - High M vertical incision. Penetrating wounds of transverse colon (2) closed by purse string and interrupted Lembert sutures of [illegible]. Omentum ligated. Foreign body (shell) removed from wall of gut. Abdomen closed in layers. 500 cc 5% glucose and 500 cc saline by vein.

5/2/42. Magnesium sulfate started & stopped - bowel hyperactive. Colace ordered. 2000 cc N saline given & stopped for respiratory difficulty (moist rales)

5/3/42. Bowels moved twice before 9 a.m. O.B. Magnesium removed - stopping continued - Castor oil given for abdominal cramps

5/6/42. Condition bad. Pulmonary edema present B

5/7/42. Pt. died 5/7/42 8:15 a.m.

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TEMPERATURE—TREATMENT—NURSE'S NOTES

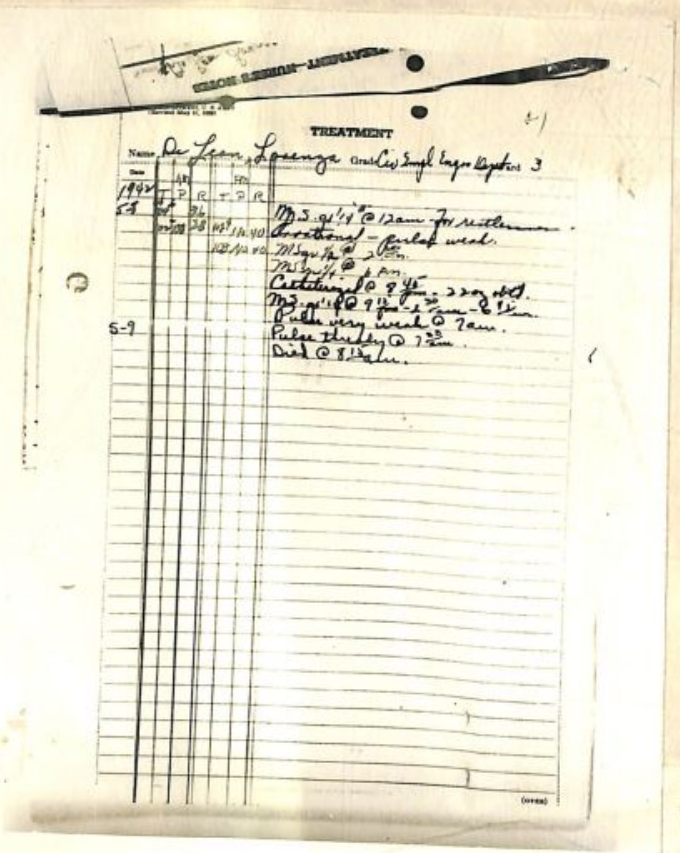
Name Pte Leon Lorenzo Grade Cav Engl Regt or Dept 3

Date	A.M. T	P	R	P.M. T	P	R	W	Wt	Medications and Nurse's Notes
5/4/42									Admitted about 10 P.M. Treated for symptoms of abd Smallpox. Pale Yellow Complexion. Temp and Pulse normal.
6/4/42									T. 101.0 R. 1st 2 a.m. Delirious at 1st a.m. Semi Comatose at 2nd a.m.
									(1) 2 pills by mouth 12 hr
									(2) abundant diet
									(3) Sponge Forehead — 8 a.m.
									(4) M.S. gr. ¼ & Atrop. gr. 1/150
									(5) 3000 Units parenterally 4 hrly
									(6) 1000 cc S.T.A. Glucose 10% Saline
5/4/42	102	24	108	102	24	96			mother & boy married
				103	28	96			A.T.S. 1/4 cc at 11 a.m.
									Glucose Saline & Soda Bicarb
									Enemas of Soda Bicarb
									Magnesium sulphate 1/2 oz
									4 hrs by Capt Nelson Pulse & T
									Water ad lib
									Atropine gr 1/150 @ 2 hrly
									Atrop. 1/100 & Morphine 1/6 Sol Jr
									by Mouth P 138 - 36
									M.S. gr 1/4 & Atropine 1/150
									Pulse 144 & "A" fib (Atropine gr 1/100) 3:45
									Pulse Air Equity Respirations laboured & short Mucus rales in throat Profuse diaphoresis
									Concentrated Oxygen for 15 minutes 9.20 P.M.
									Continuous Saline & Magnesia Injections approx. 9 P.M. Clark fluid ingested from
									Small mouth. Mucus Rales & Delirium
									Patient expired at 12 P.M.
5/4/42	104	124	52	106	84	44			1/4 gr. M.S. & Atropine gr 1/100
	104	130	48						Magnesium working continuously

TEMPERATURE—TREATMENT—NURSE'S NOTES

Date	A.M. T	P	R	P.M. T	P	R	W	Wt	Medications and Nurse's Notes
6/4/42									Magnesium Oz ss. 2nd
May 2									Magnesium reinserted @ 3 P.M.
									Temp. Normal Delirious
									Pulse Irregularity Mucus rales in throat Diffused Cyanosis
									M.S. gr ¼ & Atropine gr 1/150 at 11 P.M.
5/4/42	103	120	50	101	32	90			Magnesium sulphate 1/2 oz
	101	132	46	103	28	90			1000 cc Glucose 5% & Saline Bicarb
									8 P.M. M.S. gr ¼ & Atropine gr 1/150 Patient Constantly getting wet water Fatty Restless & delirious shallow & rapid P. is weak & rapid. Mucus rales more evident. Semi Comatose.
6/4/42	102	120	28	103	124	90			Pleural Intake.
	102	128	24	103	120	90			1000 cc Glucose & Saline
									11 P.M. M.S. gr ¼ & Atropine gr 1/150
									5 a.m. Patient getting worse rapidly Mucus rales & Cyanosis increasing.
				101	128	22			M.S. gr ¼ & ½ & ¾ & 1 gr at 9 a.m. & 1 p.m. & 5 p.m. Magnesium working continuously
5/5	104	124	32	102	120	28			Cyanosis increasing. Mucus rales increasing.
	101	132	28	100	112	28			Cream & boiled cereal 2 T.
6/6	100	120	26	101	120	30			Hot Gruel 2 T.
	100	120	28	102	120	4			M.S. ¼ & ½ 8 9 10 a.m.
									Tested Q. 3 hours Not up & started to be restless again.
									Cool & cold cards Weight & Temperature at 10 a.m.
5/7	101	124	32	100	104	32			Magnesium.
	101	120	24	104	100	32			

34-A



TREATMENT

Name De Leon, Lorenza Grade Co Engl Engr Regt'l 3

Date

1945 5-8 P R + P R

MS 9 1/4 @ 12am for sutterance. Overtone - Relief week.
MS 9 1/4 @ 2 Pm.
Catheter #0 @ 8 Pm.
MS 9 1/4 @ 9 1/2 Pm - 2 Pm - 8 1/2 Pm.
Pulse very weak @ 7am.
5-9 Pulse thready @ 7 25 am.
Died @ 8 15 am.

GRADE | COMPANY | REGIMENT & ARM OR SERVICE
Co Engr Engr

DIVISION | CORPS | ARMY AIR FORCE | RACE | NATIONALITY | SERVICE (ARMY)

STATION WHERE WOUNDED | DATE | HOUR

DIAGNOSIS: IF INJURY, STATE NATURE, WHERE AND HOW INCURRED
Wound Abdominal

LIST OF ITEMS TRANSFERRED
Plasma, Sulfa Ointment + Dressing

ANTITOXIC SERUM: DOSE | TIME
TETANUS: DOSE | TIME
DISPOSITION: | DATE | HOUR
Died

SIGNATURE, WARD, RANK AND ORGANIZATION OF ATTENDING OFFICER

FORM 52—Medical Department, U. S. A.

34-B

CLINICAL RECORD
BRIEF

Register No. [illegible] Hospital Ft. Mills, P.I.
Name [illegible] Alla (Miss) Serial No. 2290663[illegible]
Grade Pvt. Co. C Regt. and Arm or Service Hist. CA (PS)
Age 59 Race F Nativity P.I. Date of admission 5/21/42 @ 4:30PM, 19..
Service
Source of admission Quarters #1
Station Fort Mills, P.I.
Ward 12-13 Hist
Previous admission
Religion Catholic Home address Kafadon, Manila, P.I.
Name and address of nearest relative Mrs. Nenita, Alcantara
Same

Disposition Died 7:45 PM. June 2 19 42

Final diagnosis:
Bronchopneumonia

Additional diagnoses (Complications, special treatment and operations):
Cerebral Arteriosclerosis

Line of duty Yes Died
Condition on completion of case
Transfer diagnosis confirmed or not confirmed
Autopsy

E Skagy
MAJOR M.C.

35

5-22-42 Temperature still high, cough and pain in chest persistent. Many subcrepitant rales are heard in the bases of both lungs. This may be a bronchopneumonia. Sulfapyridine started today.

5-25-42 Patient unco-operative, refuses to take medicine and does for himself. He is incontinent both of bowels and urine. Seems to have retired mentally within himself. Do most probably uncheerful.

5-26-42 Mental status about same. No improvement seen. Patient a difficult nursing problem. To be transferred for further care.

5-28-42 General condition much improved. He is still quite a nursing problem, but temperature very well. He is swiftly a lonely old man who is puzzled by his situation.

6/2 Course downhill - pt. is seriously ill & - afebrile

Moribund

6/3/42 Patient pronounced dead by me at 7:45 PM

E Skagy
Maj. MC

35

#1

TREATMENT

Name Ricarte Prm. ... Rm. ... Grade ... Ward 12

Date	T.	P.	R.	T.	P. R.	
5-21-42			108			Admitted, at 4 P.M. ambulatory
						Marked oedema face
						Legs and left arm flame
						Cough Mass ++ 7 4 6 +
						Codeine gr ½ 4 p.m.
22	102	48	28	99		Cough Mass ++ 12-3
	101	20	36	100	28	Marked Edema
						Surface redness gone IV - 8-12-4
						Face & Chest dark ground
						Face Edema subsiding
						Cough Mass + 8-12-4
23						
	100	28	20	98	24	
24	97	60	32	99		Surface redness gone IV - 8-12-4
						Edema subsiding gone 2:30 2:30 & 8 p.m.
25	96	100	24	97		Cough Mass - 8 p.m.
						Surface redness discontinued.
26	A.F.W.					Cough Mass @ 8 p.m. - 4 Cc.
						T. [illegible]
	99	4	10	26		
5/27	99	112	34	98	24	
28	98	80	30	98	24	Betapen Tab 7 P.D
29	98	80	30	98	24	
30	98			98	20	
31	98			98		
June 1	98	84	20	99	22	restless & noisy - slept very
6-2			98	20	20	little condition poor
			98	32	20	Disoriented - quiet. Is very weak
						Has No cough.
						very noisy & condition poor.
6-3	Coma	98	134	56		Phenobarb. Tab gr 1½ @ 5 p.m.
		98	10	46	24	Placed in serious list
						Much weaker.
						Found dead at 7:45 P.M.

Ricarte

Name Ricarte, Rank ... Ward 10
Hosp. ... Lab. # 4
Vol. C. 3,500,000 W. B. C. ... Ver. 70%
Color Index ... Reticulocytes ... Platelets ...
Clotting time ... Bleeding time ...
Differential: Polys. ... Lymphs. ...

Cranial	Horm.	Endocr.	Hepatic	Pancr.	Skeletal	Resp.	Lymphatic	Miscell.

R. B. C. morphology ...
Remarks ...
Form 88 B-2 4 BLOOD Date ... M. C.

35-A

35-B

EAR, NOSE, AND THROAT EXAMINATION

Name Jessie Summers Grade Pvt Ward 6

Date 3-23-42 Admitted 3-19

Diagnosis Influenza, acute. Simple follicular tonsillitis, acute, R

Examination is requested as checked below:

Sig B
M. C., Ward Officer

Symptoms referable to E. N. T.:

Examination:

Nose:

Fissures, transillumination, frontals: R. L. Antra: R. L.

Pharynx:

Larynx:

Ears:

Hearing: Low conversational voice Watch Audiometer

A. D.

A. S.

Diagnosis:

Treatment and recommendations:

M. C.

(over)

TEMPERATURE—TREATMENT—NURSE'S NOTES

Name Summers, Jessie Grade Pvt. 3rd Co. 60th C.A. Ward 6

Date	A.M. T	P	R	P.M. T	P	R	BP	Wt	Medication and Nurse's Notes
3-19	100	96	20	99					Admitted To ward 6 at 10 [illegible]
									Acute Concussion syndrome
									Regimen Diet
14	98	72	18	98	74	16			Temperature
15	98	76	18	98	80	20			Urinalysis
16	98	60	18	98	74	18			Urinalysis
17	98	76	18	98	74	18			[illegible]
18	98	80	18	98	78	18			[illegible]
19	97	62	18	[illegible]					[illegible]
20	98	84	18	98	78	18			[illegible]
21	98	80	18	98	74	18			Wet dressings to right arm Continuously
22	98	62	18	99	68	18			[illegible]
23	98	62	18	[illegible]					Urinalysis Bath [illegible]
24	97	70	18	98	66	18			[illegible]
25	98	70	18	[illegible]					Regimen Diet
26	98	80	20	[illegible]					Temperature
27	98	66	16	[illegible]					Regimen Diet
28	98	70	20	[illegible]					Urinalysis
29	98	70	18	98	72	18			To Dental Consultation
30	97	70	18	98	72	18			Regimen Diet - Supervision
31	98	84	18	98	[illegible]				[illegible]
4-1	98	72	[illegible]	[illegible]					[illegible]
4	98	72	20	98	72	18			Urinalysis
4-3	98	70	[illegible]	98	74	18			Bright, [illegible]
4	99	72	[illegible]	[illegible]					[illegible]
5	98	72	[illegible]	[illegible]					[illegible]

35-C

FMR

CLINICAL RECORD
BRIEF

Register No. [illegible] Hospital Station Hospital, Fort Mills, P.I.
Name Romero, Jesus
Grade Pvt. Co. [illegible] Serial No. [illegible]
Age 24 Race B Nativity Philippine
Service [illegible] Date of admission 7/30/40
Source of admission Duty
Station Fort Mills, P.I.
Ward
Religion Protestant Previous admission
Name and address of nearest relative [illegible]

Disposition Died Date April 9, 1942

Final diagnosis:
Nephritis, acute, subsiding
Nephritis, retinopathy
Anemia, secondary
Cause of death - Uremia

W8A - mc

Additional diagnoses (Complications, special treatment and operations):

Line of duty
Condition on completion of case Improved.
Transfer diagnosis confirmed or not confirmed
Autopsy

W. A. Rose
1st M.C.

36

NR

Disposition Died Date April 9, 1942

Final diagnosis:
Nephritis, acute, subsiding
Nephritis, retinopathy
Anemia, secondary
Cause of death - Uremia

W8A - mc

Additional diagnoses (Complications, special treatment and operations):

Line of duty
Condition on completion of case Improved.
Transfer diagnosis confirmed or not confirmed
Autopsy

W. A. Rose
1st M.C.

36

NR

Romero, Jesus
Pvt. E 4 QCAA
19 M 1941
Philippine Scouts
Pond Pvt - Concussion
Improved.
March 13, 1943

36

PROGRESS NOTES

Name Summers, Jessie Grade Pvt 760TH Ward 6

(Complications and changes in diagnosis, with date in each case, should be entered on this sheet)

Pt. admitted Infirmary in Division, since marked ill nights, for about 2 weeks. About one week ago while in ground, he fell off a [illegible], about 15 feet & struck the head + the R. parietal region. He was dazed, but not rendered unconscious. Since then he has had occasional headache in that region.

Past history: Mumps, only childhood illness recalled. Vaccination 2 years 3 months ago - no sick take off & pain. Tuberculin 3 months ago for about 3 months, he made swelling.

Entry: Pale, well developed man aided boy of 19. Not acutely ill. Uremic odor + breath.

Head - no evidence of trauma.

Eyes: pupils equal + react to light. Eyes normal.

Fundi - bilateral papilledema of two degrees, + marked tortuosity of arteries. Marked thinning of retina. No hemorrhages + exudates seen. (Pupils not dilated - Urea)

Vision OD 20/30; OS 20/20-2.

Ears, Nose + Throat normal. Mouth normal.

Neck - no abnormal nodes.

Chest - well formed. Resp. Sys. - clear.

Heart - noticeably enlarged, apex 1" to left of nipple in 5th ICS.

Blood sounds muffled, Rhythm normal - no apex

P2 > P1 and accentuated. Rate 82/min. Rhythm regular.

Abdomen normal.

Pelvis - normal. No edema.

Nerves - normal power, coordination, reflexes + sensation.

Skin - few shallow ulcerated abscess on right arm.

Diagnosis: 1. Uremia, due to Chronic Glomerulonephritis

2. Hypertensive Heart disease, compensated.

3. Nephritis Retinopathy.

4. Secondary Anemia, due to C.

(Use both sides of this sheet)

Emil Horn
Capt. MC

PROGRESS NOTES—Continued

2/15/42 Ophthalmological consultation

Fundi - media - clear

Disc margins hazy especially nasal on R.

Retinal edema as manifested by absence of vessel stamp. Vessels found below disc.

Veins: arteries :: 2:1

(No A-V compressions)

tortuosity; marked peripheral capillary

[illegible] neuro-retinopathy secondary to renal lesion

W. A. Wilson
Capt. MC

2/18/42. Pt. feels much improved since admn. Temp. normal. Fundi - some subsidence of papilledema esp. at left. BP 132/92. Uremia is probably acute nephritis within three months. Hematuria gone. Edema gone.

2/19. Urine shows continued improvement.

2/23. Pt. has recurrence of headaches in past 2 days + complains of a cold.

Exam. Nose - nasal mucosa reddened & pt. mucoid secretion in pharynx middle meatus on Right.

Nasopharynx - small adenoidal mass, not grossly inflamed.

Pharynx - small buried tonsils, not grossly inflamed.

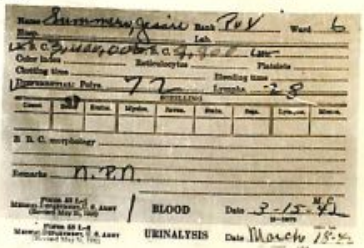
Tracheobronchial - clear small fremitus, clear auscultation.

36-A

Color
Sp. G. 1009
Acetone
Blood 1010
Albumin
Diacetic acid
Indican
Microscopic
Remarks Tr. fluids after 24 hrs. intake
URINALYSIS
Date Spring 4, 1942

Patient has shown gradual improvement. BP has dropped to 130/80 & vision has become progressively better. To be discharged to Boston for further convalescence.
Prognosis: Acute Nephritis

4/4/42. Concentration test - No fluids after 9 pm urine collected @ 7 am & sp gr. tested 1 hr later another spec. collected. Sp Gr 1009 & 1010 showing considerable impairment of concentration. No ABC or casts. No headaches but in past 3 days has coughed & has appetite & nausea



Name Summerlin, Jessie Ward 6
Bed No. Lab. No.
Color Index Reticulocytes Platelets
Clotting time Bleeding time
Hemoglobin: Palm 77 Females -28
Count Diff. Stabs Myelos. Juvens. Staffs. Segs. Lymphs. Monos.
R. B. C. morphology
Remarks N.P.N.
BLOOD Date 3-15-42
URINALYSIS Date March 18-42

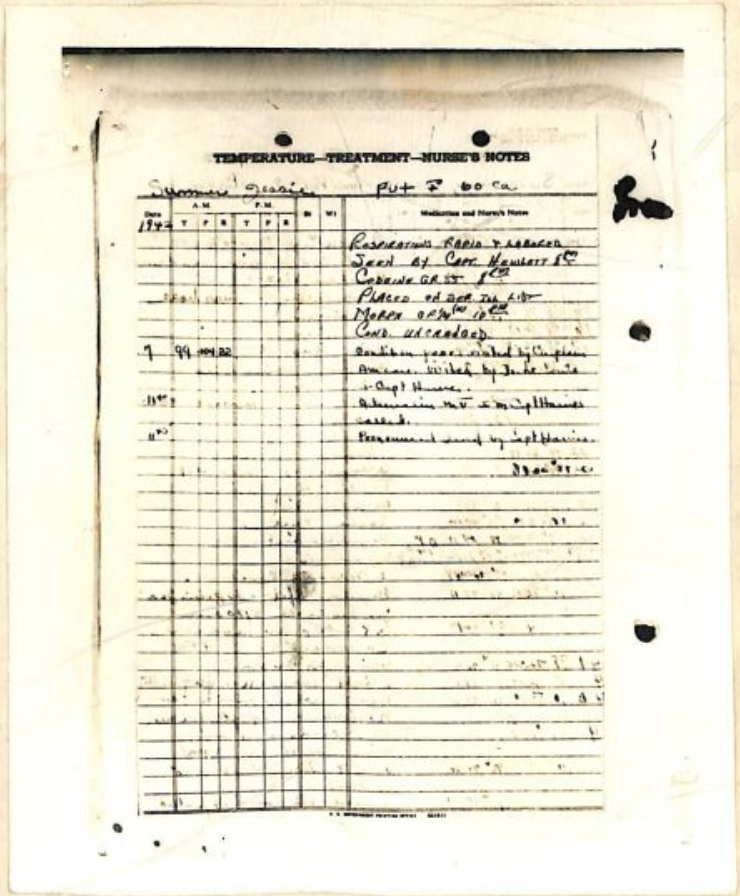
PROGRESS NOTES—Continued

4/5/42. Feeling well but has developed boils on rt forearm & rt axilla. Both incised & dressed. Hot Soln compresses & elevation to reduce swelling of hand. Eye grounds unchanged. Marked hypertension.
USR

Impression
In view of above course, poor functioning of kidney & bilirubin this patient is now in the chronic stage of glomerulo nephritis

4/6/42 Patient in uremic coma
10:00 PM BP 180/120 - dyspnoea and semi comatose. F. W. Kinsler

36-B



TEMPERATURE—TREATMENT—NURSE'S NOTES

Summers Jessie — Put F 60 Co.

Date 1942	A.M. T	A.M. P	A.M. R	P.M. T	P.M. P	P.M. R	Bl	Wt	Medication and Nurse's Notes
									Respirations Rapid & labored
									Sent by Capt Hewlett Co
									Capsule Gr XX
									Placed on Dr Th List
									Morph Sulph 1/4 Gr
									Cond. Ultraviolet
7	99	104	32						Sanitary report noted by Captain Amerine. Noted by Lt. Lewis & Capt Hunter.
11th									Admission M.U. & M. Sgt Hannes noted.
12th									Assessment noted by Capt Harris.
									Dec 31 - 42

36-C

Form 88 A
Medical Department, U. S. Army
(Revised May 31, 1943)

CLINICAL RECORD
BRIEF

Register No. [illegible] Hospital [illegible]
Name Gaither, Valeriano Serial No. [illegible]
Grade Pvt 3/c Co. Regt. and Arm or Service Inf. Co. (PS)
Age 22 Race [illegible] Nativity Texas
Service [illegible] Date of admission 4/12/44, 19..
Source of admission Ambulance
Station [illegible]
Ward [illegible] Previous admission
Religion Catholic Home address [illegible]
Name and address of nearest relative
[illegible]
[illegible]

Disposition Dead Date 4/12/44, 19..

Final diagnosis:
① Wounds, severe, perforating lego, severe, incurred during shelling by enemy, of this post at 9 AM 4/12/44
② Shock, severe, secondary to ① above. N. D. A. - Yes.

Additional diagnosis (Complications, special treatment and operations):
None

Line of duty Yes.
Condition on completion of case Dead
Transfer diagnosis confirmed or not confirmed Confirmed
Autopsy None

I. M. Hogan M.C.
Maj.

37

Form 88 (R)
Medical Department, U. S. Army
(Revised May 31, 1943)

TEMPERATURE—TREATMENT—NURSE'S NOTES

Name Sanchez, Valeriano Grade Pfc 995 Co. Ward 7

Date	A.M. T	A.M. P	A.M. R	P.M. T	P.M. P	P.M. R	M	Wt	Medication and Nurse's Notes
4-12	99+	120	M	98	120	28			Admitted To W 7 c 10 PM
									Surgery to L Thy Legs
									Saline Infusion rapid
									Adrenaline Ice c 11
				IN 7 PM					Shock Blocks
									Dilaudid Gr 1/200 IM.
									Adrenaline Ice c 11 PM
									Sulfadiazine Gm 2
				98°	100	24			Sulfadiazine Gm 1 c 11 PM
									Body roll - alcohol all Pr.
									Compound solution 1 hr applied
									Pressure started but supplies
									have not arrived. Complains of
									abdominal pain
									PLACED ON DEATH
									LIST BY PRIEST
					8	24			Extreme Unction
									Not under Oxygen Tent
									Very restless
									Morphine Sulph - gr ¼ @ 12 c.m.
									Adrenaline 1 cc + 5 Inj. Sol @ 5 c.m.
									Plasma 250 cc @ 5 c.m.
					10	24			Morphine Sulph gr ¼ @ 10 c.m.
									[redacted]
									Oxygen [illegible]
					10	28			Very restless, quite comfortable
									Pt's condition seems worse. 2 hr.
									Sulfadiazine gr ¼ @ 3 c.m.
					3	16			Morphine 1 amp @ 3 c.m.
					3				Caffein 1 cc @ 4 c.m.
					0				Strychnine Sulph. applied
									O.A. adm. @ 4 c.m.
									Strychnine Sulph @ 4:15 c.m.
									Pronounced Dead by
									Major Hogan

(Over)

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4/13/42 Patient examined and found dead 4:30 am
I S Ridgeway
Surgeon

Form 88 A
Medical Department U. S. A.
(Revised May 31, 1920)

CLINICAL RECORD
BRIEF

Register No. 7838 Hospital 5th Hosp Ft Mills, P.I.
Name DEALE, Lorenzo Serial No. 3498353
Grade Pfc Co. D Bty Regt. and Arm or Service 91st CA
Age 34 Race F Nativity P.I.
Service 23 yrs. Date of admission April 25, 1945 Ft. 19
Source of admission Command
Station Ft Mills, P.I.
Ward 7-Surg Previous admission
Religion Home address
Name and address of nearest relative

Diagnosis: [redacted]
Final [redacted]

① G.S.W. perforating of left lumbar region as result of enemy bombardment of this post about 10:30 AM. on 4/24/45.

Additional diagnosis (Complications, special treatment and operations):
Multiple perforations of large & small bowel as result of ① & ② with fecal contamination of peritoneal cavity.
Operation: Closure of perforations & drainage of retroperitoneal abscess.
Line of duty Yes: W.I.A.
Condition on completion of case Expired
Transfer diagnosis confirmed or not confirmed
Autopsy

Elmer K. Nelson M.C.
1st Lt. U.S.A.

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Form 88 A
Medical Department U. S. A.
(Revised May 31, 1920)

TREATMENT

Name Deale, Lorenzo Grade Pfc D 91st Ward

Date	Hour	Temperature	Pulse	Respiration
4-24-45	10	98	120	

Medication
1. Lab. operating - 10m.
2. Transfusion - Type O, Sub Group
3. Shock treatment
M. S. gr. 1/4(H) for pain q 4 hrs p.r.n.
4. M.S. 2½ g.m. in A.R.
5. Castor oil when ordered

Condition poor this time
Morphine sulphate gr 1/4 at 8 am
Patient some easier but pulse
Quality poor and respirations
labored. Foot of bed lowered.
Castor oil was attempted
but unsuccessful.
Respirations more embarrassed
Placed in Fowlers
Pronounced dead by
Dr. Nelson at 10:45 pm

38

LICHFIELD

OPERATION REPORT

Name Crate, Lorenzo Grade Pfc 91 CO Ward 9

Date April 25 1943 Age

Postoperative diagnosis Schrapnel wounds of Back penetrating Abdominal Cavity resulting in multiple perforated wounds of large & small intestines and splenic & Retroperitoneal hemorrhage on Lt side

Operation Closure of multiple opening of Jejunum & large intestines. Closure of opening of Parietal peritoneum. Closure of incision wound to Left rubber drainage one in peritoneum & Lt side of wound of Back. Number drain in Retro peritoneal space

Operation began 1 AM Ended 2:30 AM

Operator Com Smith

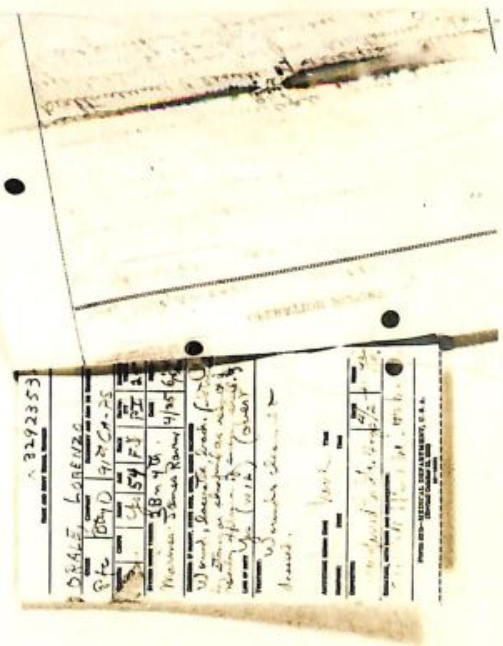
Assistants H. E. Nelson

Anesthesia used Spinne

Anesthetist Amount 100 c.c. novocaine

Specimens forwarded to laboratory for examination

Grade M.C.



38-A

MAY 7,1942

ADMITTED AMBULATORY WITH DX: MALARIA. TEMP, 104°. MALARIAL REGIME QUININE GRS X T.I.D. SEGUN.

Capt MC

MAY 8,1942

7:30 PM. TEMP. 106°. PATIENT NOT RESPONDING AS YET TO QUININE THERAPY. ALCOHOL SPONGE BATHS FOR RELIEF.

MAY 9,1942

PATIENT BECAME INCREASINGLY RESTLESS AND COMATOSE DESPITE ATOTAL DOSAGE OF 70 GRS. QUININE SIMS CNERI AND EXPIRED AT 1:00 AM.

FINAL DX:

FUO

(MALARIA, CEREBRAL, MALIGNANT TYPE, PROBABLE)

Capt M.C.

Form 88 A.
Revised May 15, 1941

CLINICAL RECORD
BRIEF

Register No. 7SR Hospital Station Hospital, Fort Mills, P.I.
Name MOSANAS, Cirilo, Serial No. 661011
Grade Pfc. Co. Regt. and Arm or Service 12th. Medical Bn.
Age 45 Race Filipino Nativity P.I.
Service 23 Years Date of admission 5-7-42
Source of admission Command
Station Fort Mills, P.I. Previous admission
Ward 18/ Medical
Religion Catholic Home address San Juan, Quezon City,
Name and address of nearest relative (Father) Antonio Marsana
Same Address (Same Juan, Quezon City.)
H/Shr.

Disposition DECEASED Date MAY 9, 1942
Final diagnosis FUO
(MALARIA)

Additional diagnoses (Complications, special treatment and operations):

Line of duty YES
Condition on completion of case DECEASED
Transfer diagnosis confirmed or not confirmed —
Autopsy —

Capt. M.C.

37

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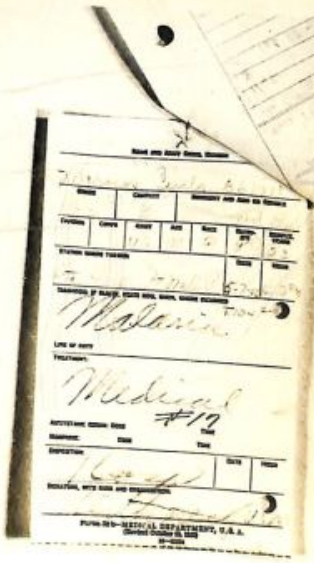
TREATMENT

Name Maranan, Jesus Grade Pfc. B/12 Pld Bn Ward 18

Date	Am	Pm	
7/3/42			Adm Pm ambulatory c. moderate fever. Mx 22 T 103.8 P 120 R 24 B.P. 130/70 Dx Malaria 3 days. Alcohol sponge prn Temp c 102° F. Sponge until temp 99° F. Quinine sulph 0.3 gm stat & 0.2 gm q 6 hrs p.o. Very restless - M.S. gr ½ stat. Quinine - Alcohol sponge. Cont. alcohol sponge. D.O. to have Qt. Cold sponge, Quinine + alcohol sponge. Diet Mat - Ward to Pt. Resting quietly. Temp - 100° F. Consult Surgeon to Ward Pt.
10:05			
11pm			
12mn 1 a.m.	7/4/42		



39-A

Progress Notes

5-20-42 Admitted to ward 14 with severe chill. Bronchopneumonia. Condition serious. Put on chemotherapy and given routine supportive care.

5-21-42 Condition appears worse & with marked increase dyspnea. Continues on chemotherapy and all around WHA

5-22-42 2 P.M. Patient's condition becoming increasingly worse. Dyspnea. Restless. Continue morphine and give strophin gr 1/100. Steward condition extremely serious. WHA

7:45 P.M. Patient expired. Respiratory failure. WHA

(15)

CLINICAL RECORD
BRIEF

Register No. 19 Hospital Ft. Mills, P.I.
Name CALBIO, Oscar (Nurse) Serial No.
Grade Civilian Co. P.I. Regt. and Arm of Service
Age 45 Race F Nativity P.I.
Service Date of admission 5/20/42 @ 11 30PM, 19
Source of admission Command
Station Fort Mills, P.I.
Ward 14-Medical (D) Previous admission
Religion Catholic Home address Capangan, P.I.
Name and address of nearest relative PAT. Wife. Cirisco Deleso
Date (Signature of admitting officer)

Disposition Civ Date May 22 19 42

Final diagnosis:
Bronchopneumonia.

Additional diagnoses (Complications, special treatment and operations):

Line of duty Civ.
Condition on completion of case Expired May 22 - 7:45 P.M.
Transfer diagnosis confirmed or not confirmed
Autopsy

W.F. Bond, Capt MC
M.C.

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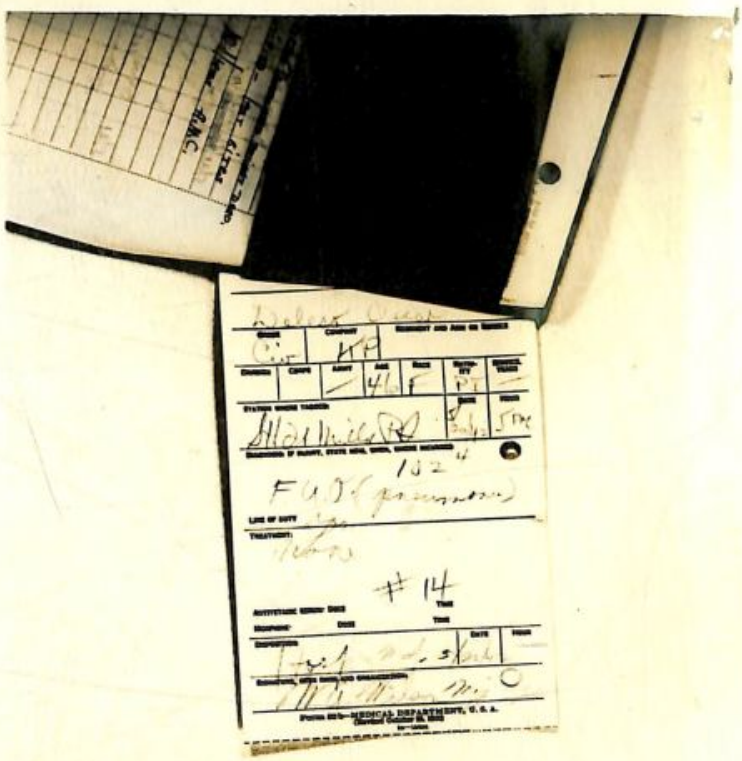
TREATMENT

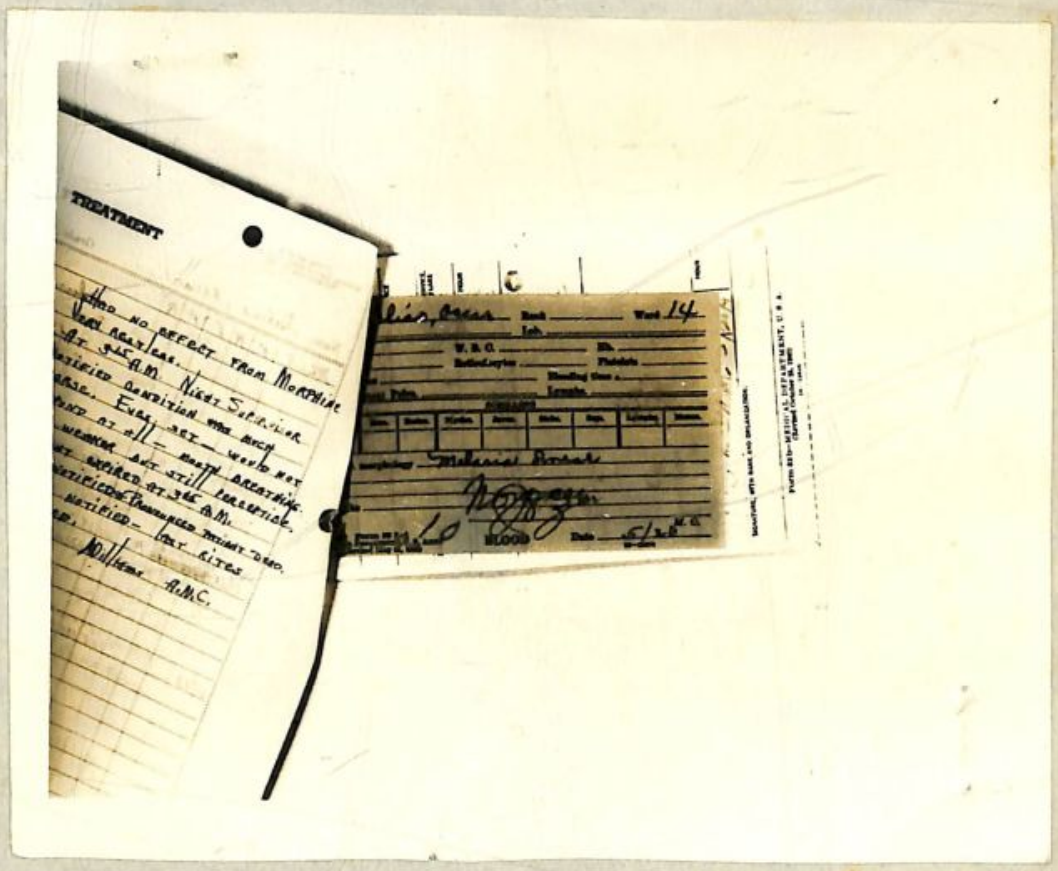
Name Delos, Oscar Grade Civ Ward 14

Date	T	P	R	T	P	R
5/20				101.4	92	20

adm. amb. 6 7.40 Pneu.
Reg. Diet
Sulfathiazole gm. I g.i.d.
Ephedrine gr. ¾ once in night
Cough Mixt. prn
Morphine Sulph gr. ¼ prn
5/20 Sulfathiazole Gm. I 2-12-4
Expec. Sulfa gr. ¾ & Terpinhydrate Codeine gr. 1/2
Alc. Sponge. PATIENT VERY DYSPNEIC
Cough FREQ.
5/21 101 132 28 102 24 28 moved to C 24
100 120 20 102 132 32 Absolute bed patient
By decision III 1:57
S.S. Enema 2 quarts. 4pill 1 pint. "Sulfa Letter." Morph. Sulph gr. ¼(H) 6 a.m.
5/21 105 138 42 PATIENT VERY RESTLESS
ATTEMPTED TO GET OUT OF BED SEVERAL TIMES.
ABDOMEN VERY HARD & DISTENDED
Normal Saline Enema Given - Ret'd Light Colored - NO FECES — MUCH FLATUS.
Expelled PART OF ENEMA BY SIPHON.
Good Results — ABDOMEN MUCH SOFTER.
FLUIDS FORCED.
Had Sulfathiazole Gm. I & Terpinhydrate gr. V tid AT 8 P.M. & 12 M.
Had Morph. Sulph. gr. ¼(H) AT 9:30 P.M. FOR RESTLESSNESS.
Quieted PATIENT FOR SHORT while. THEN BECAME MORE RESTLESS - CHEYNE-STOKES.
5/22 107 140 56 MARKED DYSPNEA — Lg. AMT. OF MUCUS IN TRACHEA
NIGHT SUPERVISOR & O.D. NOTIFIED.
O.D. ORDERED Atrop. Sulph. gr. 1/200(H) AT 2 A.M.
MORPH. SULPH. gr. ¼ AT 2 A.M.



40-A



40-B

Form 88 A
Medical Department, U. S. Army
Changed May 31, 1943

CLINICAL RECORD
BRIEF

Register No. [illegible] Hospital [illegible]
Name [illegible] Serial No. [illegible]
Grade [illegible] Co. [illegible] Regt. and Arm or Service [illegible]
Age [illegible] Race [illegible] Nativity [illegible]
Service [illegible] Date of admission 5/7/42, 19
Source of admission [illegible]
Station [illegible]
Ward [illegible] Previous admission [illegible]
Religion [illegible] Home address [illegible]
Name and address of nearest relative [illegible]

(Initials of admitting officer)

Disposition Died 12 30 Date 5/7/42, 19

Final diagnosis:

1 Wound, shell H.E., with D. chest, penetrating with injury to lung - Sev
WIA

Additional diagnoses (Complications, special treatment and operations):

Line of duty Yes
Condition on completion of case Died
Transfer diagnosis confirmed or not confirmed
Autopsy

Howard F. Wilson
Maj. M.C.

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U. S. GOVERNMENT PRINTING OFFICE : [illegible]

Form 88 Hyd
Changed May 31, 1943

TEMPERATURE—TREATMENT—NURSE'S NOTES

Name Caballero, Gabriel Grade Civ. Kp "C" Co 59th Ward 8

Date	A.M. T	A.M. P	A.M. R	P.M. T	P.M. P	P.M. R	Wt	Medication and Nurse's Notes
5/7/42				99	120	24		Serious wound Abdo. in Left [illegible] 1" to R. m. Lt. Lat. Chest + scapula. Slumped. Irregular breath. M.O. gr 1/4 q 4 + H.R. given at 3 P.M.
				99	118	28		
				99	[illegible]	[illegible]		
5-8	102	96	24	102	140	36		Sulfadiazine 0.5 gm q 4 hr. Terminal gr 1/150 at 4 P.M. Very restless.
				[illegible]	[illegible]	[illegible]		
5/6	100	92	22	102	140	24		Sulfathiazole gm II stat gm I q 4 hr.
	99	84	20	D	140	36		Decedrine gr I @ 10 00 hrs
5/7								Restless and Resp Cleared @ 15 30

DECLASSIFIED
Authority 883078

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Photo 88 A
Memoranda Division, U. S. A.
(Revised May 31, 1920)

CLINICAL RECORD
BRIEF

Register No. 7231 Hospital Station Hospital, Fort Mills, P.I.
Name MEAD, Vincent (Home.) Serial No.
Grade Civilian Co. Unit, Fld. Arty. Regt. and Arm or Service (Scout Ranger)
Age 45 Race P. Nativity Penn.
Service
Source of admission Ground. Date of admission 5-5-42 @ 9:25 P.M. 19
Station Fort Mills, P.I.
Ward 9 Previous admission
Religion Home address
Name and address of nearest relative

RCR/dcb
(Initials of admitting officer)

Disposition died Date May 5 1942.

Final diagnosis
W.I.A.
Wound, shell fragment abdomen penetrating ileum, cecum, mesoappendix, transverse colon, sigmoid, received from enemy artillery shelling 5-5-42 Fort Mill, P.I. 6.25 p.m.

Additional diagnoses (Complications, special treatment and operations)
Laparotomy, with closure of intestinal perforations 5/5/42 (completed 10 p.m. 5th)
Blood plasma 750 cc
500 c.c. citrated blood.

Line of duty YES
Condition on completion of case died

Transfer diagnosis confirmed or not confirmed
Autopsy

P Bressler Major M C

12

NR

5/5/42 - Pt. sustained numerous intestinal perforation from shell fragment 5/5/42 - 6:25 p.m. Operation performed (closure of perforations. Blood plasma & citrated blood given. Pt. died 8:15 p.m. - 1½ hr. after operation.

BB

OPERATION REPORT

Name Bress, Vincent Grade Cpl. U.S. Engr. Ward 3

Date May 5, 1944 Age

Preoperative diagnosis: Wound, shell fragment, abdomen, perforating, involving ileum, cecum, mesentery, transverse colon, and diaphragm

Operation: Exploration perforations sutured with silk, abdominal wall closed in layers with interrupted silk and silkworm gut. Lt. thigh

Remarks: P.S.W.

Blood Plasma 35 c.c. @ 6:50 P.M.
Spinal anesthesia: 7:10 P.M.
Blood 500 c.c.
Saline 1000 c.c. intravenously

Operation began 7:25 Ended 8:45 P.M.

Operator Lt. Col. Adams M.C.

Assistant Maj. Wilson M.C.

Anesthesia used Procaine (Spinal) & Ether 240 c.c. Amount 150 mgs.

Anesthetist Col. Adams.

Specimens forwarded to laboratory for examination:

(over) M.C.

TREATMENT

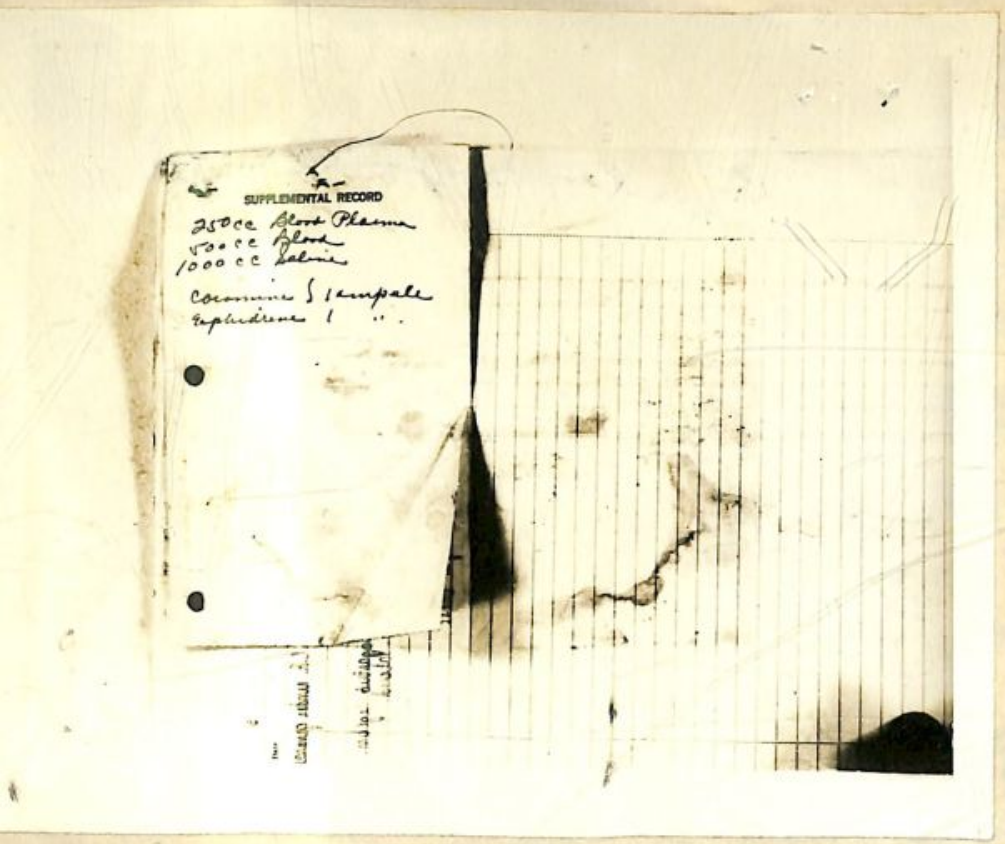
Name Bress, Vincent Grade Pvt. U.S.A. Ward 9

Date	Hour	Arm T	Arm P	Arm R	Arm	Leg T	Leg P	Leg R	Leg

Admitted post operative from O.R. under general anesthesia.
Shock blocks
Penetrating wound of hypogastric region.
Pulse rapid. Respirations labored.
Expired @ 9:15 p.m.
Pronounced by Lt Bress

DECLASSIFIED
Authority 883078

42-A



42-B

Form 88 A
Medical Department, U. S. Army
(Revised May 31, 1939)

CLINICAL RECORD
BRIEF

Register No. [illegible] Hospital Station Hospital Fort Mills, P.I.
Name FERNANDO, Mariano Serial No. [illegible]
Grade Sgt. Co. Regt. and Arm or Service [illegible]
Age [illegible] Race F Nativity P.I.
Service [illegible] Date of admission 5/7/42 11:00PM, 19
Source of admission Command
Station Fort Mills, P.I.
Ward 12-Surgical (D)
Religion [illegible] Previous admission [illegible]
Name and address of nearest relative [illegible] Home address [illegible]

Comm. Smt thf 41b
(Initials or admitting officer)

Disposition [illegible] Date [illegible], 19

Final diagnosis:

Cerebral Concussion - shelling
Laceration - abrasion - neck

Additional diagnoses (Complications, special treatment and operations):

Line of duty
Condition on completion of case Exploration wound - 11:00PM
Transfer diagnosis confirmed or not confirmed
Autopsy

M. C.

43

Form 88 H-1
Medical Department, U. S. Army
(Revised May 31, 1939)

TEMPERATURE—TREATMENT—NURSE'S NOTES

Name Fernando Mariano Grade [illegible] Ward 12

Date	A.M. T	A.M. P	A.M. R	P.M. T	P.M. P	P.M. R	M	Wt	Medication and Nurse's Notes
5/7 42	101	98	24	103	120	24			Cyclon. per Little. Unconscious Pulse strong. Wound on back. Seen by capt Albinby. Injured diet. Morph gr ¼ at 4:30 p.m.
8	105	98	24	104	120	24			Pulse strong, always staying Sponge bath given Temperature mostly inconstant Keeps most of time unable to swallow 6 P.M. Temp - 106 - 98 - 24. Sponge bath & alcohol rub given. Same condition. Closely watched At 8:00 p.m. seen by the Ward phys. Resp. wound at 11:00 p.m.

(Over)

43

43-A

Form 88 A.
Medical Department, U. S. Army
(Revised May 31, 1920)

CLINICAL RECORD
BRIEF

Register No. FHR Hospital SH Ft.Mills,PI
Name Saul, Teodoro S. Serial No. 10305595
Grade Prt Co. "C" 92nd CA Regt. and Arm or Service (PS)
Age 22 Race F Nativity PI
Service 10/12 Date of admission 4/15/42, 19
Source of admission Command
Station Fort Mills,PI.
Ward 9 Previous admission
Religion Catholic Home address 1426 Int.Leveriza St.,Malate,Manila,PI
Name and address of nearest relative Mother:Mrs. Luisiana Siantong,same address.
(Wife, husband, father, mother, brother, sister, friend, guardian, or other)

Disposition Expired Date 4/15/42, 19

Final diagnosis:

① G.S.W. abdominal wound right lower abdomen.

② Comp. comm. fractures of both legs as result of abdominal wounds.

Additional diagnoses (Complications, special treatment and operations):

A Abdominal hemorrhage from ①

Line of duty Yes K.I.A.
Condition on completion of case Expired
Transfer diagnosis confirmed or not confirmed
Autopsy

Edwin R. Nelson M.C.
1st Lt. M.C.

Form 88 H
Medical Department, U. S. Army
(Revised May 31, 1920)

TEMPERATURE—TREATMENT—NURSE'S NOTES

Name Saul Teodoro S. Grade Pvt C 92 CA (PS) Ward 9 # 27

Date	A.M. T	A.M. P	A.M. R	P.M. T	P.M. P	P.M. R	Wt	Wt	Medication and Nurse's Notes
4/15/42	adm								Admitted 9 SH Abdomen & both legs. Has had Morphine Sulphate gr ¼ No Tetanus injection Ice fluids by Mouth. Intravenous Saline started by Dr Nelson 500 cc given B.P. 0 3 P.M. 90/50 P 116 R 48 To O R at 3:30 P.M. Expired at 8 P.M. in O R.

(Over)

43 - B

Form 66 C-6
War Department, U. S. Army
(Revised May 31, 1943)

OPERATION REPORT

Name Sauls Teodoro S. Grade Pvt C&C. 92 Cn Ward 7

Date April 15, 19 42 Age

Preoperative diagnosis: #1 Shrapnel wound of abdomen. Entrance Rt lower quadrant. Perforation of cecum. #2. Fract Compound tibia and fibia both legs. Posterior splint Rt & Left leg.

Operation: Closure of wound.

Remarks:

Pt Expired at 3 45 pm

Operation began 3:20 PM Ended 3 45 Expired

Operator Col Adams

Assistants Capt Nelson

Anesthesia used Novocaine Amount 10 comps

Anesthetist Col Adams.

Specimens forwarded to laboratory for examination:

(over) M. C.

Form 66 C-6
War Department, U. S. Army
(Revised May 31, 1943)

OPERATION REPORT 92nd C.A

Name Sauls, Teodoro S Grade Pvt C&C Ward

Date 4-16, 19 42 Age

Preoperative diagnosis: 1) G. S. W. Abdomen Lower right side -
2) Fractures - Compound. Tibia & Fibia Both legs

Operation:
1) Posterior Splint to Left leg
2)
3)

Remarks:

Operation began 12 15 Ended

Operator Comander Smith. Comander Hayes

Assistants

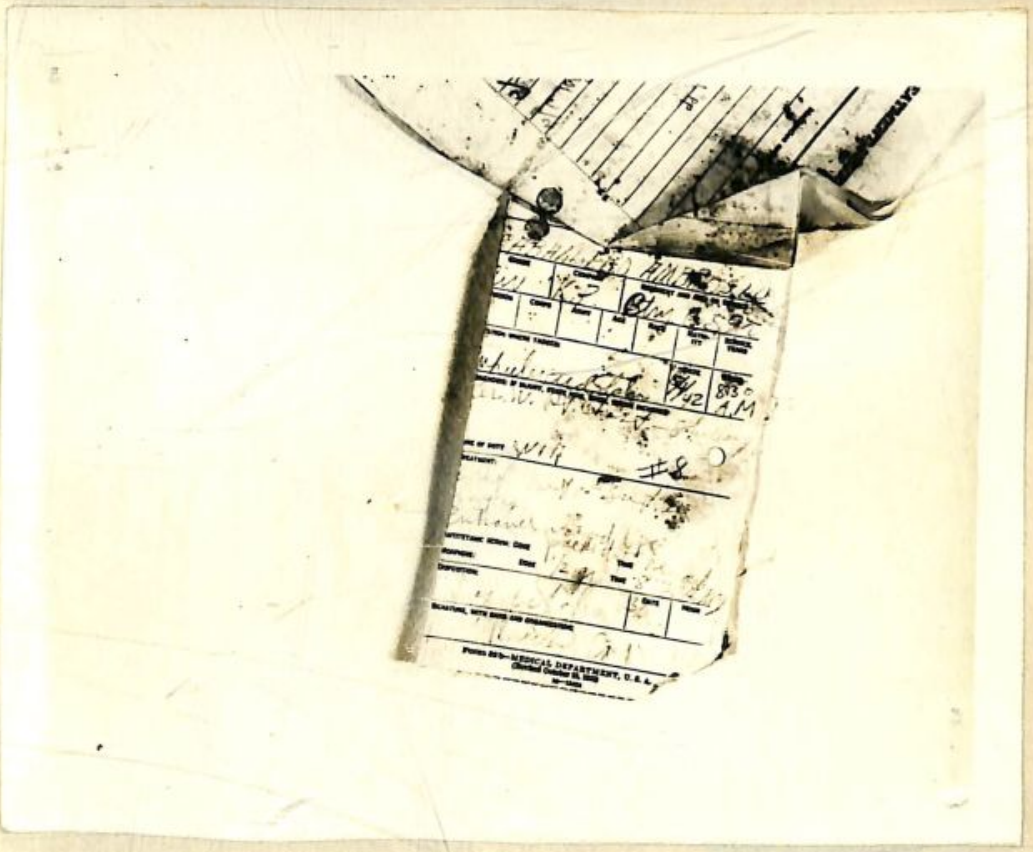
Anesthesia used Amount

Anesthetist

Specimens forwarded to laboratory for examination:

(over) M. C.

43-C



41-A

PROGRESS NOTES

Name Paul, Frederic E. Grade Pvt. Ward 9

(Complications and changes in diagnosis, with date in each case, should be entered on this sheet)

Patient admitted directly from E.R. in critical condition.

He has multiple shrapnel wounds of both legs resulting in comp. comm. fractures of the legs and a wound of the RLQ of the abdomen from which several inches of intestines protruded. These have been replaced. He was wounded shortly before admission during a bombardment of 81 m.m. Mills.

Patient was given 1000 cc IV fluids and he responded sufficiently to be taken to surgery. He expired on the table while repairing intestinal perforations.

Edwin R. Nelson
Lt. M.C.

(Use both sides of this sheet)

NAME AND ARMY SERIAL NUMBER

Paul Frederic E 10305975

GRADE	COMPANY, REGIMENT OR ARM OR SERVICE
Pvt	C 92nd CA(PS)

DIVISION	SQUAD	AGE	RACE	NATIVITY	SERVICE
		23	W	U.S.C.	YEARS 10/12

STATION WHERE INJURED: Station Hosp. DATE: 11/5/42 HOUR: 11:50 A.M.

CIRCUMSTANCES BY WHOM, STATE HOW, WHEN, WHERE INCURRED: GSW - Abdomen, Both Legs

LINE OF DUTY: Yes WIA

TREATMENT: Emergency Care

ANTITETANIC SERUM: DOSE ____ TIME ____
INNOCULATED: DOSE ____ TIME ____

DISPOSITION: Morgue DATE ____ HOUR ____

SIGNATURE WITH RANK AND ORGANIZATION: [illegible] MAC 42 11

FORM 268—MEDICAL DEPARTMENT, U. S. A.

4 D

Form 55 A
Medical Department, US Army

CLINICAL RECORD
brief

Register No. [illegible] Hospital Station Hospital, Fort Mills, P.I.
Name MILAN, Meranda R. Serial No. R-912121
Grade 1st Sgt. Co. "H" Regt. & Arm or Service 92nd CA (PS)
Age 47 Race F. Nativity P.I.
Service 21-9/12 Date of admission 5-29-42 @ 8:40 AM. ,1942.
Source of admission Command
Station Fort Mills, P.I.
Ward 16 Previous admission
Religion Cath. Home address Balamban, Cebu, P.I.
Name and address of nearest relative (Wife) Mrs. Fausta Milan
Camp address.
JCM/bk
(Initials of admitting officer)

Disposition Died Date June 4 1942.
Bronchio-pneumonia, Malaria

Additional diagnoses (Complications, special treatment and operations):
None

*Line of duty Yes
Condition on completion of case Died 11:45 P.M. 6-4-42
Transfer diagnosis confirmed or not confirmed
Autopsy

W. T. Boone
Capt M. C.

5-29-42 admitted 2 T. 1020 Diag. Malaria. Put on atabrine. Condition recvd fair. WT#15

6-1-42 T 1020. complains pain in chest and some difficulty breathing. Exam reveals coarse ronchi. both lung fields R.R.R. 12 ovc. P78 L22 Tr. Sulfathiazole gr. [illegible] stat. and q [illegible] 9-4-42. WT#15

6-3-42 Condition same. Tonsils swollen. WT#15.

6-4-42 Suddenly expired 11:45 A.M. WT#15

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(36)

TREATMENT

Name: Milan [illegible] L. Grade: 1st Sgt [illegible] Ward: 44

Date	T	P	R	T	P	R	
5/29							Adm. [illegible] [illegible]
							[illegible] [illegible] [illegible]
5/30							Alcohol Rub - Slept well
							Atabrine tab. iii t.i.d. 1st Day
							Aspirin } 5 grs given for [illegible]
							Phenacetin } 2 tiny.
							Alcohol back rub given
							Quinine [illegible]
							Aspirin, Phenacetin [illegible] [illegible]
5/31							Soft Diet.
							Atabrine tab. iii t.i.d. 2nd Day
							W.B.C., Diff. + Malarial [illegible]
6/1							Complaining of pain in region of
							spleen - Alcohol Backrub
							Atabrine tab. iii t.i.d. 3rd Day.
6/2							Complaining of severe pain in chest - [illegible]
							Breathing - Elevated on pillows - [illegible]
							[illegible] [illegible] - Coughing frequently
							Slept fairly well
							Atabrine tab. [illegible] 4th day
							Aspirin + Phenacetin gr. [illegible]
							Alcohol rub
6/3							Slept fairly well - Seems to have difficulty
							breathing
							[illegible] + [illegible]
							Atabrine tab. [illegible] 5th day
							Codeine gr. [illegible] for cough.
							Aspirin + Phenacetin [illegible]
							Sulfathiazole gr. [illegible] stat (7:30)
							Sulfathiazole [illegible] q 4 hrs. day + night.
							Morph. [illegible] if needed at H.S. and [illegible]
							Phenobarbital gr. [illegible] for [illegible]
							Alcohol Backrub

(over)

TREATMENT

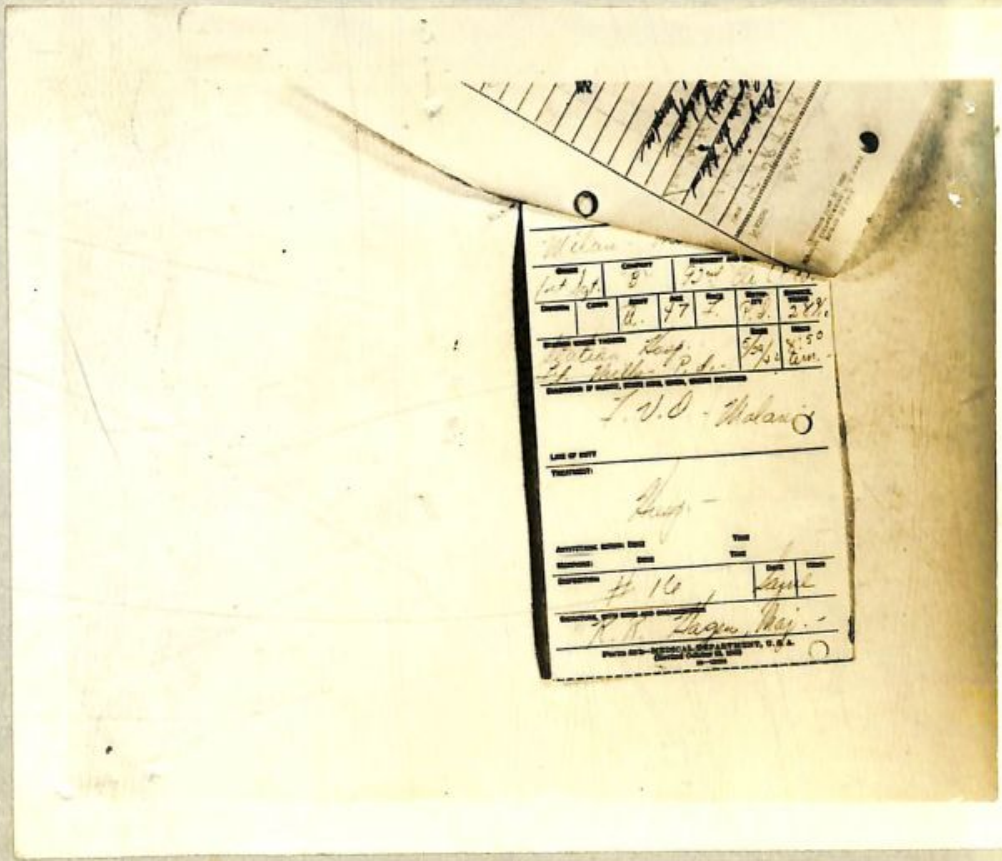
Date	T	P	R	T	P	R	
6/4							Pt condition [illegible] - Breathing
							[illegible] - Coughing - [illegible]
							[illegible] [illegible] (by [illegible])
							[illegible] [illegible] @ 8[illegible] for dyspnea
							[illegible] [illegible] - [illegible] [illegible] [illegible]
							[illegible]
							Patient died @ [illegible] a.m. -
							Pronounced dead by Capt [illegible]

44-A

TREATMENT

	T	P.	R.	
9/2	104.2	122	40	Nacl 1000 c.c. I.V.
	104	120	36	
	104.4	110	30	
	103	106	26	nacl 1000 cc Im @ 6 PM
				M.S. qu 1/4 @
				Mineral Oil Ounce to eyes
5/2	105	124	32	Sulfa @ 11 AM 105.6 oz - 124 - 32
5/3	104.6	124	42	" @ 3 PM 106.2 oz - 130 - 41
	100.4	140	40	

Cond. Critical
Sulfathiazole gr ½ @ 9 PM Alcohol sponge
Ordered @ 1 PM pronounced
Dead by Capt Shattuck.



44-B

6

CLINICAL RECORD
BRIEF

Register No. 1131 Hospital Station Hospital Fort Mills, P.I.
Name Alli-Alli, Juan (None) Serial No. 6611631
Grade Private Co. Hqs Str'f Regt. and Arm or Service 91st CA (PS)
Age Race F Nativity P.I.
Service Date of admission 4/26/42 @ 5:00AM, 19
Source of admission Command
Station Fort Frank, P.I.
Ward Surgical (F.H.) Previous admission
Religion Catholic Home address Zebubin, Bataan, P.I.
Name and address of nearest relative Wife: Mrs. Trinidad, Delero
Same address
(Include all admitting offices)

Disposition Died Date April 26, 1942

Final diagnosis (1) Hemorrhage subdural traumatic right cerebral hemisphere severe
(2) Fracture Comminuted simple Complete Skull right occipital and basal right incurred at Ft Frank P.I. on April 25, 1942 when struck on head by shovel wielded by another worker by name of Castillo

Additional diagnoses (Complications, special treatment and operations):

Line of duty Questionable (Line of duty board)
Condition on admission of case Died 4-26-42

Transfer diagnosis confirmed or not confirmed
Autopsy

F. X. Adams
1st Lt M.C.

45

4-26-42

Soldier was brought from Ft. Frank in a stuporous condition suggestive of skull fracture Spinal puncture revealed increase cerebrospinal pressure with markedly bloody fluid and due to cerebral hemorrhage. Withdrawal of 10 c.c. relieved his pressure and stupor. This was often and soon again followed by signs of increase intracranial pressure, and sterterous breathing and finally died, at

F.X.A.

45

Form 44-11-1
Medical Department, U. S. Army
(Revised May 31, 1943)

TEMPERATURE—TREATMENT—NURSE'S NOTES

Name Alinalina Juans Grade Pvt Hq 91 Cd Ward 8

Date	A.M. T	A.M. P	A.M. R	P.M. T	P.M. P	P.M. R	Bl	Wt	Medication and Nurse's Notes
4/26/42									Pt adm to Wd 8 - skull fx — spinal to Malium tpressure.
	96.20								Ice bag to head
									head of bed elevated
									B.P. 112/70 Pulse 68
									Urotropin X gr tid
									Phenobarbital for restlessness
									Liquids as tolerated
									Ice Soda Sup.
									Orpheed @ 10:20 Am 4/26/42

(Over)

45-A

Form 88 (3-1)
Medical Department, U. S. Army
(Revised May 31, 1920)

#5

TREATMENT

1942

Name De La Cruz Mariano Grade Pfc Ward 14

Date	Sick	Off	
May 12		1030	Admitted at SPDA via litter
			Diagnosis Pneumonia
			MS gr ½ (4) @ 5:30 PM
			Self-expedient gr XXX @ 5:30 PM
			Elevate head of bed
			Force fluids
			Liquid diet.
			9:30 - M.S. gr. ½ s.c. for restlessness. R.
			Causing much respiratory embarrassment.
			Seen by O.D. @ 10 P.M. - Ordered into
			O_2 tent - Transf. to ward 10.
			Oxygen (mask) started @ 11 P.M.
			Morphine gr ½ S.C. 12:30 AM 4 AM
5/19	1030	5/19/42	Expd. Critical
			Morphine Gr 1/150 @ 9:45 AM
			Respirations Ceased. 10:15 AM
			Pronounced dead by Capt Heimbach.

(over)

Patient admitted S-18-42 S.P.A. from the field. Unable to elicit history that can be obtained other than has been done all in one day.

Examination remain. Bilateral consolidation of lung. Chest not much cyanosis. Lips heavily coated.

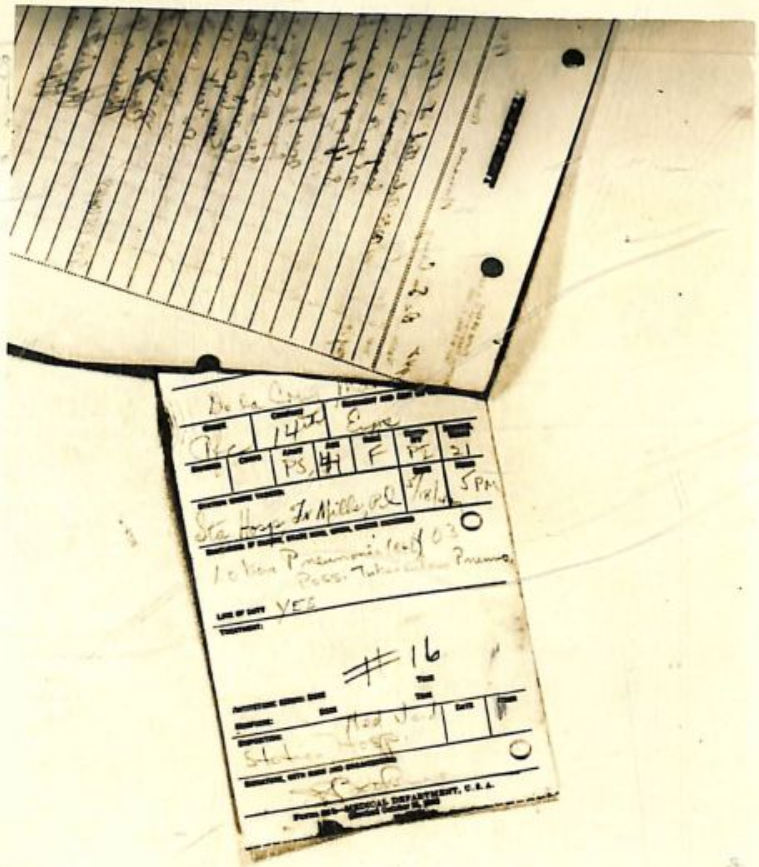
Treatment and progress note.

5-18-42. Patient admitted semi comatose dyspneic with signs and symptoms of pneumonia, bilateral. B.P. 70 gravis oppos. Does not respond.

5-19-42. Patient semi conscious, fairly regular pulmonary edema. Pronounced dead at 10:15 a.m.

M.D.

H.J. Heimbach
Capt M.C.



46-A

Form 88 A
Medical Department, U. S. Army
(Revised May 31, 1940)

CLINICAL RECORD
BRIEF

Register No. 787 Hospital 8H Ft. Mills, P.I.
Name Bordeos, Anastacio Serial No. 6732904
Grade Cpl. Co. "A" Regt. and Arm or Service 92nd CA (PS)
Age ... Race ... Nativity P.I.
Service ... Date of admission 4/12/42 19...
Source of admission Command
Station Fort Mills, P.I.
Ward 9 Previous admission ...
Religion Catholic Home address Lariyales, Bataan, P.I.
Name and address of nearest relative Mother: Rosaria Bordearia, same address.

Disposition Expired 1SP Date 4/12/42 19...

Final diagnosis:
① Penetrating shrapnel wound of lower right chest.
② Multiple shrapnel wounds of both lower extremities.

Additional diagnoses (Complications, special treatment and operations):
Abdominal hemorrhage as result of ① above from wounds of liver, gall bladder and stomach.

Line of duty Yes
Condition on completion of case Expired
Transfer diagnosis confirmed or not confirmed ...
Autopsy No

Edwin P. Nelson M.C.
Lt. U.S.N.

Seen by Pitts Rec

Form 88 B
Medical Department, U. S. Army
(Revised May 31, 1940)

PROGRESS NOTES

Name Bordeos, Anastacio Grade Cpl. Ward 9

(Complications and changes in diagnosis, with date in each case, should be entered on this sheet)

Patient admitted suffering from multiple shrapnel wounds - one in lower right chest wall severed in both legs. First aid given in receiving office.
Given shock treatment and intravenous coff and benzedrine.
Patient responded and complains of abdominal pain. Abdomen is rigid and tender in both upper quadrants.
To surgery for dep.
Edwin P. Nelson, M.C.
Lt U.S.N.

Returned from surgery in poor condition - pulseless and dyspneic.
Expired 1:15 P.M.
Edwin P. Nelson

(Use both sides of this sheet)

47

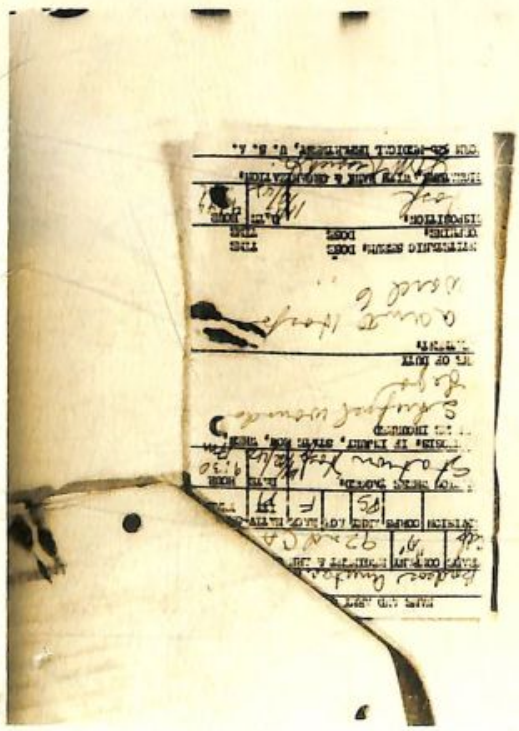
TREATMENT

4738904

Name Bordeos Anastacio Grade Ward 9th 3

Date							
4/4/42	8th	12					

Admn per letter from Dressing Room 9th Does not response. Pulse imperceptible Caffeine Sodii Benzoatis gr VIII (0.5) 9:55 Respirations poor. Injected R. Leg. & Chest Intravenously of Saline started. Hot Water Bottles & Extra Blankets Foot of Bed elevated 10th Complaining of pain in Abdomen seen by Surgical Staff. To OR for Surgery 11:00. Returned 12:3 Semi Conscious Condition fair. Abdominal Bandage strong B. S. W. Liver; L.A. Stomach Fresh Bloody drainage on Wounds of L. Leg Very restless. No Water by Mouth Expired 1 P.M.



DECLASSIFIED
Authority 883078

47-A

Form 55 A
Medical Department, US Army

CLINICAL RECORD
brief

Register No. [illegible] Hospital Station Hospital, Fort Mills, P.I.
Name Zaragosa, Vicente ---- Serial No. ---------
Grade Civilian Co. Engl.Const.& Utils Regt. & Arm or Service QMC
Age 80 Race F Nativity P.I.
Service 22 years Date of admission 4/1/42 ,1942.
Source of admission Command
Station Fort Mills,P.I.
Ward 9 Previous admission Yes
Religion Catholic Home address Corregidor,Cavite,P.I.
Name and address of nearest relative Son in law Sgt.Legado,Hq.91st CA (PS)

(Initials of admitting officer)

Disposition Died Date 3.15 P.M. April 12th 1942.

Diagnosis: Cerebral apoplexy result of generalized, senile arteriosclerosis.

Additional diagnoses (Complications, special treatment and operations):

•Line of duty yes
Condition on completion of case Died

Transfer diagnosis confirmed or not confirmed
Autopsy

48 John F. Bresnahan
Major, M. C.

Zaragosa, Vicente - Cir Surg. QMC 7

Cachectic elderly Filipino male. Bedridden, helpless + weakness. Unable to talk. Practically moribund. Transferred from 2 Ward 14, 1 mile ago where he had H.F.U.O. Adm to Ward 6

4/1/42: No evidence of hemiplegia. Marked cachexia + asthenia. Able to take only little nourishment. WDR.

4/5/42 · Condition unchanged. Very weak Cardiac tones very faint WDR

4/12/42 Condition progressively worse. Patient expired at 3:15 P.M. this date. Burial arrangements made with Harbor Defense Quartermaster. John F Bresnahan Major M.C. Ward Surgeon #6

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TEMPERATURE—TREATMENT—NURSE'S NOTES

Name Zaragosa, Vicente Grade Cir. Ward 14

1942

Date	A.M. T	P	R	P.M. T	P	R	Bl	Wt	Medication and Nurse's Notes
10/2				96	56	16			Adm to Wd by litter 1 30 PM. Pt's Condition very poor. Pulse weak. respirations poor. Cath. Priest notified. Caff. Sod benzoate 7½ gns IM @ 1 45 PM. Unable to swallow black coffee. Diag: apoplexy acute cause unded. Seen by Cath. Priest. Voided in bed Unable to swallow anything. Comatose.
4-2	97	64	16	97	66	22			Condition the same. Bath & Gen care given - took 1 glass coffee by tea-spoon this AM. Trans to Wd 6.
4-2	97	56	16	98	70	18			100 cc's fruit juice swallowed very restless, unable to keep covered. Pineapple juice 100 cc's taken & retained. Bath & bed Care. Voided. 200 cc's. Almost 100 cc's fruit juice not retained.
4	96	60	18	98	70	18			Pineapple juice 1200 cc's retained. Voided 1800 cc's.
5	97	56	18	98	68	18			Soup 700 cc's retained. Weaker and swallows anything thickened.
6	98	65	18	98	64	18			Bowel movement involuntary Reported. Soup & Noon
7	98	58	18	97	5	20			
8	98	54	15						Quite Restless to day
9	98	58	18						
10									
11	97			98					Last Nourishment Administered by Mouth - Barley Water (Orders) 7:15

TEMPERATURE—TREATMENT—NURSE'S NOTES

Date	A.M. T	P	R	P.M. T	P	R	Bl	Wt	Medication and Nurse's Note
							8 00		Pulse Poor. Pt very Restless. M.S. gr 1/6 2 cc
							2 30		Pt quiet Pulse poor Unable to count
							7 30		Pt quiet during a Pulse 2 1/2 Poor Cond Sterts Death.
4-12 10	1	28	1	00					Pt becomes stertorous -
4-13 10	1	24							Expired 3 10 P.M.

48-A

48-B

Form 88 A
Medical Department, U. S. Army
(Revised May 31, 1943)

CLINICAL RECORD
BRIEF

Register No. FHS Hospital Station Hospital Fort Mills, P.I.
Name VELASCO, Hugo L. Serial No. ----
Grade Civilian Co. Employee by Regt. and Arm or Service Army Trans. Serv.
Age 22 Race F Nativity P.I.
Service ---------- Date of admission 4/29/42 @ 8:15PM 19
Source of admission Par.6,b, (2) h AR 40-990
Station Fort Mills, P.I.
Ward Surgical (WL) Previous admission
Religion Catholic Home address Lucan Cavite, P.I.
Name and address of nearest relative Mr. Mrs. Guillermo Ramoren
Same Address

MTA/jlb
(Initials of admitting officer)

Disposition Expired 6:44AM. Date 5/5/42. 19

Final diagnosis:

W.I.A.
Wounds, extensive lacerating, of mediastinum & anterior thoracic regio; inflicted from enemy shelling 4/29/42, Fort Mills, P.I.

Additional diagnoses (Complications, special treatment and operations):

Line of duty Yes applicable
Condition on completion of case Expired
Transfer diagnosis confirmed or not confirmed
Autopsy

Edwin R. Hansen
1st Lt. M.C.

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U. S. GOVERNMENT PRINTING OFFICE 1942-O-631918

OPERATION REPORT

Velasco, Hugo Grade Civ. Employee Ward 3

Date ---------- 19---- Age ----

Preliminative diagnosis: Wound Shrapnel
Mediastinum & Left
Chest 4-29-42

Operation: Cleaning debridement
sutures & packing

Remarks:

Operation began ---------- Ended ----------
Operation Hansen
Assistants ----------
Anesthesia used None Amount ----------
Anesthetist ----------
Specimens forwarded to laboratory for examination:

M.C.

(over)

DECLASSIFIED
Authority 883078

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PROGRESS NOTES

Name Velasco, Hugo Grade Civ Empl 8TS Ward 3

Considerations and changes in diagnosis, with date in each case, should be entered on this sheet.

4/20/42 Pt. was admitted last night for extensive shrapnel wounds of neck & back (thoracic) region. These were debrided, sutured & packed.

5/4/42. Condition of pt. deteriorating. Old wound from 72; wound extensive; has been semi-comatose for past few days.

5/5/42. 7:00 A.M. Called to see patient. He had been dead about 45 minutes.

(Use both sides of this sheet)

TEMPERATURE—TREATMENT—NURSE'S NOTES

Name Velasco, Hugo J. Grade Civ Empl. 8TS Ward 3

Date	A.M. T	P	R	P.M. T	P	R	M	Wt	Medication and Nurse's Notes
4/20/42					84	20			adm. per Amb. to Ward 3 @ Noon. Wounds, Shrapnel, neck + shoulder. Restless + disoriented. Considerable bleeding from shoulder wd. Pulse good quality.
4/21/42									Morphine ½, gr. ¼ H 8 P.M.
4/21/42	9 AM 100	64	18	100	80	20			Pt dead on Ward. Still bleeding.
	100	98	20	102	84	20			Tetanus Antitoxin 1500 U. @ 10 A.M.
				104	78	20			Pulse very weak - Cafe. and Benzoate Amp I given @ 10 P.M.
									M.S. gr ¼ @ 12 Noon.
									MS gr ¼ @ 3 P.M.
									Very restless + violent 10 P.M. - 5 A.M.
									Morph. Sul. ¼ 10 P.M. - 6 A.M.
5/1/42	9 AM 101	80	20	100	80	20			Condition poor.
				104	84	24			MS gr ¼ @ 2 P.M.
									M.S. gr. ¼ 9 P.M. — 3 A.M.
5/2/42	4 AM 98	28	28	4 PM 100	84	24			Pulse very weak thready
	102	24	24	10 P.M.					M.S. gr ¼ @ 8 P.M.
									Coramine 10 cc's I.V.
									MS gr ¼ @ 7 A.M.
					118	32			M.S. gr. ¼ 11 P.M. - Extremely restless
5/3/42					92				Pulse irregular weak. Respirations normal. Condition
									M.S. gr. ¼ 3 A.M.
5/3/42	8 AM 102	24	22	101	80	20			Pulse weak.
	100	24	20	101	80	20			MS gr ¼ @ 3:30 P.M.
					92	24			M.S. gr. ¼ @ 11 P.M. + 3 A.M. Condition good.
5/4/42	4 AM 100	110	28	101	80	18			Quieter today.
	101	96	24	101	76	18			MS gr ¼ @ 2 P.M.
					82	20			Pulse poor quality. Semi-comatose at intervals.
									M.S. gr ¼ 1 A.M.
									Respirations slow + labored at 5 A.M.
									Coramine gr. 10 M. pulse poor

(Over)

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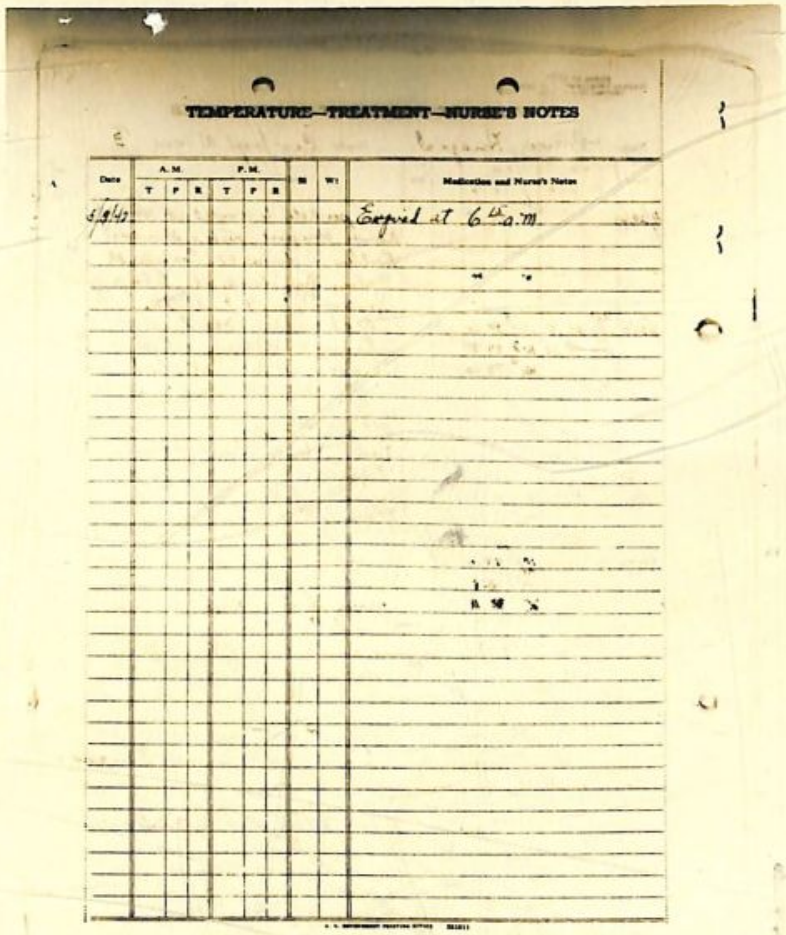

TEMPERATURE—TREATMENT—NURSE'S NOTES

Date	A.M. T	A.M. P	A.M. R	P.M. T	P.M. P	P.M. R	H	Wt	Medication and Nurse's Notes
5/9/42									Expired at 6 a.m.