

CLINICAL RECORD COVER SHEET

1. ADMISSION NOTES	2. WARD <i>111</i>	3. TYPE OF CASE <input type="checkbox"/> DIS <input type="checkbox"/> INJ <input type="checkbox"/> BC			4. LAST NAME — FIRST NAME — MIDDLE INITIAL <i>Lofton Aaron F.</i>							
	5. SEX <i>M</i>	6. RELIGION <i>R</i>	7. PREV. ADM. <input type="checkbox"/> YES <input type="checkbox"/> NO		8. REGISTER NO.		9. SERVICE NO.		10. GRADE <i>PFC</i>			
	11. RATING OR DESIG.		12. DEPARTMENT <i>Army</i>		13. ORGANIZATION AND BRANCH OF SERVICE <i>107th AB (1-16)</i>			14. FLYING STATUS				
	15. NAME AND ADDRESS OF EMERGENCY ADDRESSEE <i>Aaron Lofton (F) Post Office #64 Grenada, Miss</i>				16. AGE <i>21</i>	17. RACE <i>W</i>	18. LENGTH OF SERVICE <i>1 yr</i>	19. DATE OF ADMISSION				
	21. ADMITTING OFFICER				22. CONTINUATION OF ITEMS 13 AND 20. NOTE: Enter flying Status for AF Military Personnel only. For Civilians, etc., show type (Dep, of EM, etc.) in space 13.							
23. DIAGNOSES (See instructions for recording as shown on reverse side, Include all required related data)												
24. OPERATIONS AND SPECIAL THERAPEUTIC PROCEDURES (Show date for each; show anesthetic for each operation)												
25. SELECTED ADMINISTRATIVE DATA (Show nature of and dates for board proceedings; show fact of and dates for leave, AWOL, subsisting elsewhere, detached service, etc.)												
26. PHYSICAL PROFILE												
TYPE	SERIAL						SUFFIX					<input type="checkbox"/> PROFILE IS UNCHANGED
	P	U	L	H	E	S	R	T	D	O	N	
	PREVIOUS											
REVISED												
27. DAYS DURATION THIS FACILITY ALL _____ IN HOSPITAL OR INFIRMARY _____ SUBSISTING ELSEWHERE _____ QUARTERS OR DISPENSARY _____ LEAVE _____ OTHER _____												
28. NATURE OF DISPOSITION										29. DATE OF DISPOSITION		
30. SIGNATURE OF ATTENDING PHYSICIAN						31. SIGNATURE OF REGISTRAR OR MEDICAL RECORDS OFFICER						
32. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY										33. REGISTER NUMBER		

DD FORM 481
1 MAY 51

Replaces WD AGO Form 8-33, 1 Apr 45, which is obsolete.

16-64559-2

34. ADDITIONAL REMARKS (Show item number to which extended entry applies. Group all continuations of a particular item.)

INSTRUCTIONS FOR ITEM 23: Enter primary cause of admission first, followed by additional diagnoses present in order of importance; then by later diagnoses in chronological order preceded by dates made. Number diagnoses in order. Record fully—including causative agent, how, when, where, doing what, for injuries—in accordance with separate directives. For all diagnoses established by pathological findings, so state. Each chronic condition must be indicated as either "PR" (*previously recorded*) or "Not PR." Similarly, any other condition which has been recorded in a previous admission will be so indicated, showing the previous diagnosis. In all cases designated as previously recorded, show place, date, and register number of previous admission. Every condition that existed prior to service will be indicated as "EPTS." Diagnoses of venereal disease and malaria will be characterized either as "EPTS" or as "Not EPTS." In the case of diagnosis from which recovery occurs prior to disposition of the case, a date will be shown, thus: "Recovered 11 May 1951." For each diagnosis line-of-duty status must be shown in accordance with separate directives, thus "LD, No, EPTS," "LD, No, Misconduct," "LD, Yes, EPTS, Aggravated by Service," etc.

35. CAUSE OF DEATH	THIS DOES NOT MEAN THE MODE OF DYING, SUCH AS HEART FAILURE, ASTHENIA, ETC., IT MEANS THE <i>DISEASE, INJURY, or COMPLICATIONS</i> WHICH CAUSED DEATH.	Ia. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
(Do not enter more than one cause per line for items Ia, b and c)	ANTECEDENT CAUSES	b. DUE TO (Or as the consequence of)	
	MORBID CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (Item Ia) STATING THE UNDERLYING CAUSE LAST.	c. DUE TO (Or as the consequence of)	
	THIS MEANS CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITIONS CAUSING DEATH.	II. OTHER SIGNIFICANT CONDITIONS	
36. AUTOPSY PERFORMED (If "YES," indicate date and place)	37. HOUR AND DATE OF DEATH		
38. EXACT PLACE OF DEATH	39. SIGNATURE OF PHYSICIAN		

CLINICAL RECORD COVER SHEET

1. ADMISSION NOTES 1540H No. 011 of A or N		2. WARD		3. TYPE OF CASE <input type="checkbox"/> DIS <input type="checkbox"/> INJ <input type="checkbox"/> BC		4. LAST NAME—FIRST NAME—MIDDLE INITIAL [REDACTED]			
		5. SEX M	6. RELIGION P	7. PREV. ADM. <input type="checkbox"/> YES <input type="checkbox"/> NO		8. REGISTER NO. 77045	9. SERVICE NO. [REDACTED]	10. GRADE [REDACTED]	
		11. RATING OR DSGN		12. DEPARTMENT Army		13. ORGANIZATION AND BRANCH OF SERVICE Army (7032)		14. FLYING STATUS	
		15. NAME AND ADDRESS OF EMERGENCY ADDRESSEE Afton Lofton (P) Box 6 Smith, Mississippi				16. AGE 27	17. RACE C	18. LENGTH OF SERVICE 1 6/12	19. DATE OF ADMISSION 6-27-56
20. SOURCE OF ADMISSION [REDACTED]				NOTE: Enter flying status for AF Military Personnel only. For Civilians, etc., show type (Dep of EM, etc.) in space 13.					
21. ADMITTING OFFICER DR. [REDACTED] 6/27/56				22. CONTINUATION OF ITEMS 13 AND 20 (7032) [REDACTED] 100 056.12					

23. DIAGNOSES (See instructions for recording as shown on reverse side. Include all required related data)

Bg.1 (7032) Observation medical for Histoplasmosis. No Disease found.
IOD Yes.

24. OPERATIONS AND SPECIAL THERAPEUTIC PROCEDURES (Show date for each; show anesthetic for each operation)

25. SELECTED ADMINISTRATIVE DATA (Show nature of and dates for board proceedings; show fact of and dates for leave, AWOL, subsisting elsewhere, detached service, etc.)

26. PHYSICAL PROFILE

TYPE	SERIAL						SUFFIX					<input type="checkbox"/> PROFILE IS UNCHANGED
	P	U	L	H	E	S	R	T	D	O	N	
PREVIOUS												
REVISED												

27. DAYS DURATION THIS FACILITY

ALL 7 IN HOSPITAL OR INFIRMARY 7 SUBSISTING ELSEWHERE 7 QUARTERS OR DISPENSARY 7 LEAVE 7 OTHER 7

28. NATURE OF DISPOSITION

Entry

29. DATE OF DISPOSITION

13 Aug 56

30. SIGNATURE OF ATTENDING PHYSICIAN

31. SIGNATURE OF REGISTRAR OR MEDICAL RECORDS OFFICER

32. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY

US ARMY DISPENSARY FORT ROBBE, CANAL ZONE

33. REGISTER NUMBER

11045

DD FORM 1 MAY 51 481-3 (4 PART)

09-10-71200-1

4

34. ADDITIONAL REMARKS (Show item number to which extended entry applies. Group all continuations of a particular item)

INSTRUCTIONS FOR ITEM 23: Enter primary cause of admission first, followed by additional diagnoses present in order of importance; then by later diagnoses in chronological order preceded by dates made. Number diagnoses in order. Record fully—including causative agent, how, when, where, doing what, for injuries—in accordance with separate directives. For all diagnoses established by pathological findings, so state. Each chronic condition must be indicated as either "PR" (previously recorded) or "Not PR." Similarly, any other condition which has been recorded in a previous admission will be so indicated, showing the previous diagnosis. In all cases designated as previously recorded, show place, date, and register number of previous admission. Every condition that existed prior to service will be indicated as "EPTS." Diagnoses of venereal disease and malaria will be characterized either as "EPTS" or as "Not EPTS." In the case of diagnosis from which recovery occurs prior to disposition of the case, a date will be shown, thus: "Recovered, 11 May 1951." For each diagnosis line of duty status must be shown in accordance with separate directives, thus: "LD, No, EPTS," "LD, No, Misconduct," "LD, Yes, EPTS, Aggravated by Service," etc.

35. CAUSE OF DEATH	THIS DOES NOT MEAN THE MODE OF DYING, SUCH AS HEART FAILURE, ASTHMA, ETC. IT MEANS THE DISEASE, INJURY or COMPLICATIONS WHICH CAUSED DEATH.	Ia. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH.	INTERVAL BETWEEN ONSET AND DEATH
(Do not enter more than one cause per line for items Ia, b, and c)	ANTECEDENT CAUSES	b. DUE TO (Or as the consequence of)	
	MORBID CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (Item Ia) STATING THE UNDERLYING CAUSE LAST.	c. DUE TO (Or as the consequence of)	
	THIS MEANS CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITIONS CAUSING DEATH.	II. OTHER SIGNIFICANT CONDITIONS	
36. AUTOPSY PERFORMED (If "Yes" indicate date and place)	37. HOUR AND DATE OF DEATH		
38. EXACT PLACE OF DEATH	39. SIGNATURE OF PHYSICIAN		

CLINICAL RECORD COVER SHEET

1. ADMISSION NOTES 1540R No Evid of A or N LD-Yes Dg 1: (1342) Histoplasmosis 84 2132		2. WARD 30		3. TYPE OF CASE <input checked="" type="checkbox"/> DYS <input type="checkbox"/> INJ <input type="checkbox"/> BC			4. LAST NAME — FIRST NAME — MIDDLE INITIAL LOFTON, Aaron I							
		5. SEX M	6. RELIGION P	7. PREV. ADM. <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		8. REGISTER NO. 691035		9. SERVICE NO. [REDACTED]		10. GRADE PVT2				
		11. RATING OR DESIG. —		12. DEPARTMENT Army		13. ORGANIZATION AND BRANCH OF SERVICE ASA (8616)			14. FLYING STATUS —					
		15. NAME AND ADDRESS OF EMERGENCY ADDRESSEE Aaron Lofton (F) Box 64 Summit, Mississippi					16. AGE 21	17. RACE Cau	18. LENGTH OF SERVICE 1 6/12		19. DATE OF ADMISSION 6 Aug 1956			
		20. SOURCE OF ADMISSION To be recorded by USA Disp Ft Kobbe, CZ <small>NOTE: Enter flying Status for AF Military Personnel only. For Civilians, etc., show type (Dep. of EM, etc.) in space 13.</small>					21. ADMITTING OFFICER F Hinam CAPT/ng					22. CONTINUATION OF ITEMS 13 AND 20 (13)USARCARIB Ft Kobbe, CZ 056.10		
23. DIAGNOSES (See instructions for recording as shown on reverse side. Include all required related data)														
24. OPERATIONS AND SPECIAL THERAPEUTIC PROCEDURES (Show date for each; show anesthetic for each operation)														
25. SELECTED ADMINISTRATIVE DATA (Show nature of and dates for board proceedings; show fact of and dates for leave, AWOL, subsisting elsewhere, detached service, etc.)														
26. PHYSICAL PROFILE														
TYPE PREVIOUS REVISED		SERIAL					SUFFIX					<input type="checkbox"/> PROFILE IS UNCHANGED		
		P	U	L	H	E	S	R	T	D	O		N	
[Empty grid for physical profile data]														
27. DAYS DURATION THIS FACILITY ALL _____ IN HOSPITAL OR INFIRMARY _____ SUBSISTING ELSEWHERE _____ QUARTERS OR DISPENSARY _____ LEAVE _____ OTHER _____														
28. NATURE OF DISPOSITION										29. DATE OF DISPOSITION				
30. SIGNATURE OF ATTENDING PHYSICIAN						31. SIGNATURE OF REGISTRAR OR MEDICAL RECORDS OFFICER								
32. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY										33. REGISTER NUMBER				

CLINICAL RECORD		NARRATIVE SUMMARY
DATE OF ADMISSION August 6, 1956	DATE OF DISCHARGE August 13, 1956	NUMBER OF DAYS HOSPITALIZED

(Sign and date at end of narrative)

X-Ray No. 220-375

Chart No. 695035

History: This 21 year old army private complained of slight chest pain on very deep breathing in the middle of the chest, of one day's duration. In May of 1956, though feeling well, he had had a survey film taken. He was advised to have a large one made and this showed prominence of the right hilum.

Past History: Revealed occasional wheezing with URI's long ago and occasional hay fever.-

Physical Examination: This was normal except for a slight rib depression in the right anterior axillary line.

Laboratory: Routine hematology was normal; ESR was 19 mm.; urinalysis and stool examination were normal. Serum calcium was 10.0 mgs. %; A/G ratio was 4.54/2.14. Routine serology and heterophile agglutinins were negative. An EKG. was within normal limits. Chest x-rays showed hilar adenopathy on the right. X-Rays of the hands were normal.-

Course in the Hospital: Patient was completely afebrile. The chest pain disappeared during the first day. Histoplasmin and PPD #2 were positive.

Impression: Observation pulmonary lesion. 300-001
This work up failed to reveal the etiology of the hilar adenopathy.

Disposition: 1) Return to duty.
2) Return to the Chest clinic in 4 weeks.-
3) Obtain chest films taken in Jackson, Miss. in 1955.-

W. Strauss M.D.

Walter G. Strauss, M. D.
Chest Service
Gorgas Hospital

(Use additional sheets of this form (Standard Form 502) if more space is required)

SIGNATURE OF PHYSICIAN WALTER G. STRAUSS, M. D.		DATE 8/21/56	IDENTIFICATION NO. RA24919772	ORGANIZATION US ARMY
PATIENT'S LAST NAME—FIRST NAME—MIDDLE NAME LOFTON AARON I.			REGISTER NO. 695035	WARD NO. 30

GORGAS

(NAME OF HOSPITAL OR OTHER MEDICAL FACILITY)

NARRATIVE SUMMARY
Standard Form 502

34. ADDITIONAL REMARKS (Show item number to which extended entry applies. Group all continuations of a particular item.)

INSTRUCTIONS FOR ITEM 23: Enter primary cause of admission first, followed by additional diagnoses present in order of importance; then by later diagnoses in chronological order preceded by dates made. Number diagnoses in order. Record fully—including causative agent, how, when, where, doing what, for injuries—in accordance with separate directives. For all diagnoses established by pathological findings, so state. Each chronic condition must be indicated as either "PR" (*previously recorded*) or "Not PR." Similarly, any other condition which has been recorded in a previous admission will be so indicated, showing the previous diagnosis. In all cases designated as previously recorded, show place, date, and register number of previous admission. Every condition that existed prior to service will be indicated as "EPTS." Diagnoses of venereal disease and malaria will be characterized either as "EPTS" or as "Not EPTS." In the case of diagnosis from which recovery occurs prior to disposition of the case, a date will be shown, thus: "Recovered 11 May 1951." For each diagnosis line-of-duty status must be shown in accordance with separate directives, thus "LD, No, EPTS," "LD, No, Misconduct," "LD, Yes, EPTS, Aggravated by Service," etc.

35. CAUSE OF DEATH	THIS DOES NOT MEAN THE MODE OF DYING, SUCH AS HEART FAILURE, ASTHENIA, ETC., IT MEANS THE <i>DISEASE, INJURY, or COMPLICATIONS</i> WHICH CAUSED DEATH.	1a. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
(Do not enter more than one cause per line for items 1a, b and c)	ANTECEDENT CAUSES	b. DUE TO (Or as the consequence of)	
	MORBID CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (Item 1a) STATING THE UNDERLYING CAUSE LAST.	c. DUE TO (Or as the consequence of)	
	THIS MEANS CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITIONS CAUSING DEATH.	11. OTHER SIGNIFICANT CONDITIONS	
36. AUTOPSY PERFORMED (If "YES," indicate date and place)	37. HOUR AND DATE OF DEATH		
38. EXACT PLACE OF DEATH	39. SIGNATURE OF PHYSICIAN		

CLINICAL RECORD COVER SHEET

1. ADMISSION NOTES 1540R No. evid of A or N		2. WARD		3. TYPE OF CASE <input type="checkbox"/> DIS <input type="checkbox"/> INJ <input type="checkbox"/> BC		4. LAST NAME—FIRST NAME—MIDDLE INITIAL Lofton Aaron I							
5. SEX M		6. RELIGION P		7. PREV. ADM. <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		8. REGISTER NO. 11045		9. SERVICE NO. [REDACTED]		10. GRADE DWM			
11. RATING OR DSGN		12. DEPARTMENT Army		13. ORGANIZATION AND BRANCH OF SERVICE ASA (8616th)				14. FLYING STATUS					
15. NAME AND ADDRESS OF EMERGENCY ADDRESSEE Aaron Lofton (F) Box 64 Sumit, Mississippi						16. AGE 21		17. RACE CAU		18. LENGTH OF SERVICE 1 6/12		19. DATE OF ADMISSION 6 Aug 56	
						20. SOURCE OF ADMISSION Direct Abs SK (Home) Hosp, AZ NOTE: Enter flying status for AF Military Personnel only. For Civilians, etc., show type (Dep of EM, etc.) in space 13.							
21. ADMITTING OFFICER ME. Hinnan, Capt/MC						22. CONTINUATION OF ITEMS 13 AND 20 (13) USARC.MIB NOS 056.10							

23. DIAGNOSES (See instructions for recording as shown on reverse side. Include all required related data)

Dg.1 (7932) Observation medical for Histoplasmosis. No Disease found.
LOD Yes.

24. OPERATIONS AND SPECIAL THERAPEUTIC PROCEDURES (Show date for each; show anesthetic for each operation)

25. SELECTED ADMINISTRATIVE DATA (Show nature of and dates for board proceedings; show fact of and dates for leave, AWOL, subsisting elsewhere, detached service, etc.)

26. PHYSICAL PROFILE												
TYPE	SERIAL						SUFFIX					<input checked="" type="checkbox"/> PROFILE IS UNCHANGED
	P	U	L	H	E	S	R	T	D	O	N	
PREVIOUS												
REVISED												

27. DAYS DURATION THIS FACILITY
ALL 7 IN HOSPITAL OR INFIRMARY 7 SUBSISTING ELSEWHERE _____ QUARTERS OR DISPENSARY _____ LEAVE _____ OTHER _____

28. NATURE OF DISPOSITION
Duty

29. DATE OF DISPOSITION
13 Aug 56

30. SIGNATURE OF ATTENDING PHYSICIAN
W. P. Hinnan, Capt/MC

31. SIGNATURE OF REGISTRAR OR MEDICAL RECORDS OFFICER
Tom Hinnan

32. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY
US ARMY DISPENSARY FORT KOBBE, CANAL ZONE

33. REGISTER NUMBER
11045

DD FORM 1 MAY 51 481-3 (4 PART)

69-10-71200-1

1

CERTIFICATE OF CLEARANCE AND/OR SECURITY DETERMINATION UNDER EO 10450

(SR 380-160-1, SR 380-160-10 or SR 620-220-1)

PART I BASIC INFORMATION

FROM: (Originating headquarters) Hq., The ASA Tng Cen, 8622 DU, Ft Devens, Mass.		DATE 12 May 1955	DOSSIER NUMBER E 3006127
LAST NAME - FIRST NAME - MIDDLE INITIAL LOFTON, Aaron I.		MILITARY OR CIVILIAN GRADE Pvt	SERVICE OR SOCIAL SECURITY NUMBER [REDACTED]
DATE OF BIRTH (Day, Month, Year) [REDACTED]	PLACE OF BIRTH (City, county, state, country) Lincoln County, Mississippi	CIVILIAN JOB TITLE (If any) none	

PART II SECURITY CLEARANCE

DATE INVESTIGATION COMPLETED (Day, Month, Year) 22 April 1955	TYPE OF INVESTIGATION CONDUCTED Background	AGENCY OR COMMAND WHICH CONDUCTED INVESTIGATION Third Army
HIGHEST CLASSIFICATION OR TYPE OF INFORMATION TO WHICH ACCESS IS AUTHORIZED (Top Secret, Secret, Confidential, or Cryptologic duties) TOP SECRET	DATE INTERIM CLEARANCE GRANTED (Day, Month, Year) -----	DATE FINAL CLEARANCE GRANTED (Day, Month, Year) 12 May 1955

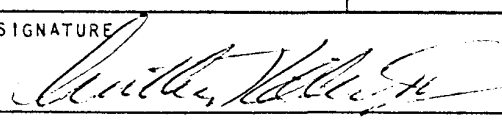
THIS IS TO CERTIFY THAT THE ABOVE NAMED INDIVIDUAL HAS BEEN CLEARED ~~TOP SECRET~~ UNDER THE PROVISIONS OF SR 380-160-1 FOR ACCESS TO CLASSIFIED INFORMATION AS INDICATED ABOVE; ☐ UNDER THE PROVISIONS OF SR 380-160-10 FOR ASSIGNMENT TO CRYPTOLOGIC DUTIES. REQUIRED SECURITY OATH FOR PERSONNEL UNDER THE JURISDICTION OF THE ARMY ESTABLISHMENT IS ATTACHED AS INCLOSURE ONE.

PART III SECURITY DETERMINATION UNDER EO 10450 - (CIVILIAN EMPLOYEES ONLY)

DATE INVESTIGATION COMPLETED (Day, Month, Year)	TYPE OF INVESTIGATION CONDUCTED	AGENCY OR COMMAND WHICH CONDUCTED INVESTIGATION
SENSITIVE POSITION <input type="checkbox"/> CHECK AND COMPLETE PARTS I, II AND V NON-SENSITIVE POSITION <input type="checkbox"/> CHECK AND COMPLETE PARTS I, III, AND V		

PART IV REMARKS

PART V OFFICIAL MAKING CERTIFICATION

ORGANIZATION Hq., The ASA Tng Cen, 8622 DU	PLACE Ft Devens, Mass.	DATE 12 May 1955
TYPED NAME, GRADE AND SERVICE NUMBER LUTHER KELLER II, Lt Col, [REDACTED]		SIGNATURE 
DISTRIBUTION: (SR 380-160-1, SR 380-160-10 or SR 620-220-1 as appropriate) 1 Copy 201 1 Copy GAS-22, CRF 1 Copy TAG		

RECORDS OF INTERIM CLEARANCE WILL NOT BE FORWARDED TO DEPARTMENT OF THE ARMY; SEE SR 380-160-1

REPLACES EDITION OF 1 JAN 53, WHICH IS OBSOLETE

DA FORM 273

MEASUREMENTS AND OTHER FINDINGS											
51. HEIGHT 5' 11"		52. WEIGHT 143		53. COLOR HAIR Brown		54. COLOR EYES Green		55. BUILD: SLENDER <input type="checkbox"/> MEDIUM <input checked="" type="checkbox"/> HEAVY <input type="checkbox"/> OBESE <input type="checkbox"/>		56. TEMP. 98.6	
57. BLOOD PRESSURE (Arm at heart level)						58. PULSE (Arm at heart level)					
SITTING	SYS. 110 DIAS. 70	RECUM. BENT	SYS. DIAS.	STANDING (3 min.)	SYS. DIAS.	SITTING	72	AFTER EXERCISE	2 MIN. AFTER	RECUMBENT	AFTER STANDING 3 MIN.
59. DISTANT VISION				60. REFRACTION				61. NEAR VISION			
RIGHT 20/ 20-2 CORR. TO 20/				BY S. CX				J-1 CORR. TO BY			
LEFT 20/ 20-1 CORR. TO 20/				BY S. CX				J-1 CORR. TO BY			
62. HETEROPHORIA: (Specify distance) ES° EX° R. H. L. H. PRISM DIV. PRISM CONV. PC PD NSA											
63. ACCOMMODATION RIGHT Normal LEFT Normal			64. COLOR VISION (Test used and result) Normal-Pseudo-Ischo			65. DEPTH PERCEPTION (Test used and score)			UNCORRECTED		
									CORRECTED		
66. FIELD OF VISION Normal			67. NIGHT VISION (Test used and score)			68. RED LENS			69. INTRAOCULAR TENSION Normal		
70. HEARING			71. AUDIOMETER						72. PSYCHOLOGICAL AND PSYCHOMOTOR (Tests used and score)		
				250 250	500 512	1000 1024	2000 2048	3000 3096	4000 4096	8000 8192	
RIGHT WV /15 SV /15			RIGHT	5	5	10	10		55	45	8
LEFT WV /15 SV /15			LEFT	0	5	20	15		60	80	13

73. NOTES (Continued) AND SIGNIFICANT OR INTERVAL HISTORY

Hospitalized WRAH.

(Use additional sheets of plain paper if necessary)

74. SUMMARY OF DEFECTS AND DIAGNOSES (List diagnoses with item numbers)

71 Deafness, perceptive type, bilateral, very mild, possibly due to acoustic trauma.
Hearing: Average Loss: AS: 13db; AD: 8db. Speech reception score: AS: 10 db; AD: 5 db;
AU: 5 db. Discrimination: AS: 92%; AD: 92%. Unchanged. LOD: YES

75. RECOMMENDATIONS—FURTHER SPECIALIST EXAMINATIONS INDICATED (Specify)

None

77. EXAMINEE (Check)

☒ IS

QUALIFIED FOR

Separation

☐ IS NOT

78. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER

76. PHYSICAL PROFILE

P	U	L	H	E	S
1	1	1	3	1	1

PHYSICAL CATEGORY

A	B	C	E
		X	

79. TYPED OR PRINTED NAME OF PHYSICIAN

M. HOWARD SKOLNICK, MD

SIGNATURE

M. Howard Skolnick MD

80. TYPED OR PRINTED NAME OF PHYSICIAN

SIGNATURE

81. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN (Indicate which)

FREDERICK A. HELIG, LT. COL., DC

SIGNATURE

Frederick A. Helig Lt Col DC

82. TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY

SIGNATURE

NUMBER OF ATTACHED SHEETS

REPORT OF MEDICAL EXAMINATION

1. LAST NAME—FIRST NAME—MIDDLE NAME Lofton, Aaron I.			2. GRADE AND COMPONENT OR POSITION Sp3		3. IDENTIFICATION NO. [REDACTED]
4. HOME ADDRESS (Number, street or RFD, city or town, zone and State) PO Box 64, Summit, Miss.			5. PURPOSE OF EXAMINATION Separation		6. DATE OF EXAMINATION 29 Oct 57
7. SEX Male	8. RACE Cau	9. TOTAL YRS. GOVT. SERVICE MILITARY 3 CIVILIAN	10. DEPARTMENT, AGENCY, OR SERVICE Army		11. ORGANIZATION UNIT MHD-WRAH
12. DATE OF BIRTH [REDACTED]		13. PLACE OF BIRTH Lincoln Co., Miss.	14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN Aaron I. Lofton, Father, Same as # 4		
15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS Walter Reed Army Hospital, Wash. 12, D.C.			16. OTHER INFORMATION		

17. RATING OR SPECIALTY	TIME IN THIS CAPACITY: TOTAL	LAST SIX MONTHS
CLINICAL EVALUATION		
NOTES.—Describe every abnormality in detail. (Enter pertinent item number before each comment; continue in item 73 and use additional sheets if necessary.)		

NORMAL	ABNOR- MAL	(Check each item in appropriate column; enter "N.E." if not evaluated)
X		18. HEAD, FACE, NECK, AND SCALP
X		19. NOSE
X		20. SINUSES
X		21. MOUTH AND THROAT
	X	22. EARS—GENERAL (Int. & ext. canals) (Auditory acuity under items 70 and 71)
X		23. DRUMS (Perforation)
X		24. EYES—GENERAL (Visual acuity and refraction under items 59, 60, and 61)
X		25. OPHTHALMOSCOPIC
X		26. PUPILS (Equality and reaction)
X		27. OCULAR MOTILITY (Associated parallel movements, nystagmus)
X		28. LUNGS AND CHEST (Include breasts)
X		29. HEART (Thrust, size, rhythm, sounds)
X		30. VASCULAR SYSTEM (Varicosities, etc.)
X		31. ABDOMEN AND VISCERA (Include hernia)
X		32. ANUS AND RECTUM (Hemorrhoids, fistulae) (Prostate if indicated)
X		33. ENDOCRINE SYSTEM
X		34. G-U SYSTEM
X		35. UPPER EXTREMITIES (Strength, range of motion)
X		36. FEET
X		37. LOWER EXTREMITIES (Except feet) (Strength, range of motion)
X		38. SPINE, OTHER MUSCULOSKELETAL
X		39. IDENTIFYING BODY MARKS, SCARS, TATTOOS
X		40. SKIN, LYMPHATICS
X		41. NEUROLOGIC (Equilibrium tests under item 72)
X		42. PSYCHIATRIC (Specify any personality deviation)
Females only		(Check how done)
		43. PELVIC <input type="checkbox"/> VAGINAL <input type="checkbox"/> RECTAL

22. Partial loss of hearing, bilateral; Hospital Diagnosis, H3.

(Continue in item 73)

44. DENTAL (Place appropriate symbols above or below number of upper and lower teeth, respectively) O.—Restorable teeth X.—Missing teeth (6 X 8).—Fixed bridge, brackets to include abutments /.—Nonrestorable teeth XXX.—Replaced by dentures																REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES Class 2	
R	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	L
I	X	X	X	29	28	27	26	25	24	23	22	21	20	19	18	17	E

LABORATORY FINDINGS			
45. URINALYSIS: SP. GR. 1.017 ALBUMIN SUGAR MICROSCOPIC Neg Neg Essen. Negative		46. CHEST X-RAY (Place, date, film number, result) WRAH, 29 Oct 57 Normal	47. SEROLOGY (Specify test used and result) Cardiolipin Flocculation Negative
48. EKG		49. BLOOD TYPE AND RH FACTOR	50. OTHER TESTS

YES	NO	CHECK EACH ITEM YES OR NO. EVERY ITEM CHECKED "YES" MUST BE FULLY EXPLAINED IN BLANK SPACE ON RIGHT
	<input checked="" type="checkbox"/>	27. HAVE YOU BEEN UNABLE TO HOLD A JOB BECAUSE OF: A. SENSITIVITY TO CHEMICALS, DUST, SUNLIGHT, ETC.
	<input checked="" type="checkbox"/>	B. INABILITY TO PERFORM CERTAIN MOTIONS
	<input checked="" type="checkbox"/>	C. INABILITY TO ASSUME CERTAIN POSITIONS
	<input checked="" type="checkbox"/>	D. OTHER MEDICAL REASONS (If yes, give reasons)
	<input checked="" type="checkbox"/>	28. HAVE YOU EVER WORKED WITH RADIOACTIVE SUBSTANCE?
	<input checked="" type="checkbox"/>	29. DID YOU HAVE DIFFICULTY WITH SCHOOL STUDIES OR TEACHERS? (If yes, give details)
	<input checked="" type="checkbox"/>	30. HAVE YOU EVER BEEN REFUSED EMPLOYMENT BECAUSE OF YOUR HEALTH? (If yes, state reason and give details)
	<input checked="" type="checkbox"/>	31. HAVE YOU EVER BEEN DENIED LIFE INSURANCE? (If yes, state reason and give details)
	<input checked="" type="checkbox"/>	32. HAVE YOU HAD, OR HAVE YOU BEEN ADVISED TO HAVE, ANY OPERATIONS? (If yes, describe and give age at which occurred)
	<input checked="" type="checkbox"/>	33. HAVE YOU EVER BEEN A PATIENT (committed or voluntary) IN A MENTAL HOSPITAL OR SANATORIUM? (If yes, specify when, where, why, and name of doctor, and complete address of hospital or clinic)
	<input checked="" type="checkbox"/>	34. HAVE YOU EVER HAD ANY ILLNESS OR INJURY OTHER THAN THOSE ALREADY NOTED? (If yes, specify when, where, and give details)
<input checked="" type="checkbox"/>		35. HAVE YOU CONSULTED OR BEEN TREATED BY CLINICS, PHYSICIANS, HEALERS, OR OTHER PRACTITIONERS WITHIN THE PAST 5 YEARS? (If yes, give complete address of doctor, hospital, clinic, and details) <i>Chest Clinic Gorgas Hospital ANCON, CANAL ZONE</i>
	<input checked="" type="checkbox"/>	36. HAVE YOU TREATED YOURSELF FOR ILLNESSES OTHER THAN MINOR COLDS? (If yes, which illnesses)
	<input checked="" type="checkbox"/>	37. HAVE YOU EVER BEEN REJECTED FOR MILITARY SERVICE BECAUSE OF PHYSICAL, MENTAL, OR OTHER REASONS? (If yes, give date and reason for rejection)
	<input checked="" type="checkbox"/>	38. HAVE YOU EVER BEEN DISCHARGED FROM MILITARY SERVICE BECAUSE OF PHYSICAL, MENTAL, OR OTHER REASONS? (If yes, give date, reason, and type of discharge: whether honorable, other than honorable, for unfitness or unsuitability)
<input checked="" type="checkbox"/>		39. HAVE YOU EVER RECEIVED, IS THERE PENDING, HAVE YOU APPLIED FOR, OR DO YOU INTEND TO APPLY FOR PENSION OR COMPENSATION FOR EXISTING DISABILITY? (If yes, specify what kind, granted by whom, and what amount, when, why) <i>Pending on condition of hearing at a later date</i>

I CERTIFY THAT I HAVE REVIEWED THE FOREGOING INFORMATION SUPPLIED BY ME AND THAT IT IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.
I AUTHORIZE ANY OF THE DOCTORS, HOSPITALS, OR CLINICS MENTIONED ABOVE TO FURNISH THE GOVERNMENT A COMPLETE TRANSCRIPT OF MY MEDICAL RECORD FOR PURPOSES OF PROCESSING MY APPLICATION FOR THIS EMPLOYMENT OR SERVICE.

TYPED OR PRINTED NAME OF EXAMINEE <i>ADAM J. LOTTON</i>	SIGNATURE <i>Adam J. Lottan</i>
--	------------------------------------

40. PHYSICIAN'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA (Physician shall comment on all positive answers in items 20 thru 39)

Partial loss of hearing, hospitalized
Whooping cough, childhood- no sequela
Asthma, hay fever, EPTS, mild
ENT, running ears, fungus, treated and cured
Indigestion, mild, improved.

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER <i>V. M. AND SKELICK, MD</i>	DATE <i>29 Oct 57</i>	SIGNATURE	NUMBER OF ATTACHED SHEETS
--	--------------------------	-----------	---------------------------

REPORT OF MEDICAL HISTORY

THIS INFORMATION IS FOR OFFICIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS

1. LAST NAME—FIRST NAME—MIDDLE NAME <u>Lofton, Aaron I.</u>			2. GRADE AND COMPONENT OR POSITION <u>SP-3</u>		3. IDENTIFICATION NO. <u></u>	
4. HOME ADDRESS (Number, street or RFD, city or town, zone and State) <u>D.O. Box 64, Summit, Miss.</u>			5. PURPOSE OF EXAMINATION <u>Examination</u>		6. DATE OF EXAMINATION <u>29 OCT 57</u>	
7. SEX <u>M</u>	8. RACE <u>Cauc</u>	9. TOTAL YRS. GOVT. SERVICE MILITARY <u>5 yrs</u> CIVILIAN	10. DEPARTMENT, AGENCY, OR SERVICE <u>Army</u>		11. ORGANIZATION UNIT <u>9301</u>	
12. DATE OF BIRTH <u></u>		13. PLACE OF BIRTH <u>Lincoln Co., Miss.</u>		14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN <u>Aaron I. Lofton—Father—Box 64 Summit, Miss.</u>		
15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS <u></u>			16. OTHER INFORMATION <u></u>			

17. STATEMENT OF EXAMINEE'S PRESENT HEALTH IN OWN WORDS. (Follow by description of past history, if complaint exists)

18. FAMILY HISTORY					19. HAS ANY BLOOD RELATION (Parent, brother, sister, other) OR HUSBAND OR WIFE:			
RELATION	AGE	STATE OF HEALTH	IF DEAD, CAUSE OF DEATH	AGE AT DEATH	YES	NO	(Check each item)	RELATION(S)
FATHER	<u>40</u>	<u>Good</u>				<input checked="" type="checkbox"/>	HAD TUBERCULOSIS	
MOTHER	<u>47</u>	<u>Good</u>				<input checked="" type="checkbox"/>	HAD SYPHILIS	
SPOUSE					<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	HAD DIABETES	<u>Cousin</u>
BROTHERS	<u>20</u>	<u>Good</u>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	HAD CANCER	
AND					<input checked="" type="checkbox"/>		HAD KIDNEY TROUBLE	<u>Brother</u>
SISTERS					<input checked="" type="checkbox"/>		HAD HEART TROUBLE	<u>Cousin</u>
					<input checked="" type="checkbox"/>		HAD STOMACH TROUBLE	<u>Father, Brother</u>
CHILDREN					<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	HAD RHEUMATISM (Arthritis)	
					<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	HAD ASTHMA, HAY FEVER, HIVES	<u>Father, Mother</u>
					<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	HAD EPILEPSY (Fits)	
					<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	COMMITTED SUICIDE	
					<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	BEEN INSANE	

20. HAVE YOU EVER HAD OR HAVE YOU NOW (Place check at left of each item)

YES	NO	(Check each item)	YES	NO	(Check each item)	YES	NO	(Check each item)	YES	NO	(Check each item)
<input checked="" type="checkbox"/>		SCARLET FEVER, ERYSIPELAS	<input checked="" type="checkbox"/>		GOITER	<input checked="" type="checkbox"/>		TUMOR, GROWTH, CYST, CANCER	<input checked="" type="checkbox"/>		"TRICK" OR LOCKED KNEE
<input checked="" type="checkbox"/>		DIPHTHERIA	<input checked="" type="checkbox"/>		TUBERCULOSIS	<input checked="" type="checkbox"/>		RUPTURE	<input checked="" type="checkbox"/>		FOOT TROUBLE
<input checked="" type="checkbox"/>		RHEUMATIC FEVER	<input checked="" type="checkbox"/>		SOAKING SWEATS (Night sweats)	<input checked="" type="checkbox"/>		APPENDICITIS	<input checked="" type="checkbox"/>		NEURITIS
<input checked="" type="checkbox"/>		SWOLLEN OR PAINFUL JOINTS	<input checked="" type="checkbox"/>		ASTHMA	<input checked="" type="checkbox"/>		PILES OR RECTAL DISEASE	<input checked="" type="checkbox"/>		PARALYSIS (Inc. infantile)
<input checked="" type="checkbox"/>		MUMPS	<input checked="" type="checkbox"/>		SHORTNESS OF BREATH	<input checked="" type="checkbox"/>		FREQUENT OR PAINFUL URINATION	<input checked="" type="checkbox"/>		EPILEPSY OR FITS
<input checked="" type="checkbox"/>		WHOOPING COUGH	<input checked="" type="checkbox"/>		PAIN OR PRESSURE IN CHEST	<input checked="" type="checkbox"/>		KIDNEY STONE OR BLOOD IN URINE	<input checked="" type="checkbox"/>		CAR, TRAIN, SEA, OR AIR SICKNESS
<input checked="" type="checkbox"/>		FREQUENT OR SEVERE HEADACHE	<input checked="" type="checkbox"/>		CHRONIC COUGH	<input checked="" type="checkbox"/>		SUGAR OR ALBUMIN IN URINE	<input checked="" type="checkbox"/>		FREQUENT TROUBLE SLEEPING
<input checked="" type="checkbox"/>		DIZZINESS OR FAINTING SPELLS	<input checked="" type="checkbox"/>		PALPITATION OR POUNDING HEART	<input checked="" type="checkbox"/>		BOILS	<input checked="" type="checkbox"/>		FREQUENT OR TERRIFYING NIGHTMARES
<input checked="" type="checkbox"/>		EYE TROUBLE	<input checked="" type="checkbox"/>		HIGH OR LOW BLOOD PRESSURE	<input checked="" type="checkbox"/>		VENEREAL DISEASE	<input checked="" type="checkbox"/>		DEPRESSION OR EXCESSIVE WORRY
<input checked="" type="checkbox"/>		EAR, NOSE OR THROAT TROUBLE	<input checked="" type="checkbox"/>		CRAMPS IN YOUR LEGS	<input checked="" type="checkbox"/>		RECENT GAIN OR LOSS OF WEIGHT	<input checked="" type="checkbox"/>		LOSS OF MEMORY OR AMNESIA
<input checked="" type="checkbox"/>		RUNNING EARS	<input checked="" type="checkbox"/>		FREQUENT INDIGESTION	<input checked="" type="checkbox"/>		ARTHRITIS OR RHEUMATISM	<input checked="" type="checkbox"/>		BED WETTING
<input checked="" type="checkbox"/>		CHRONIC OR FREQUENT COLDS	<input checked="" type="checkbox"/>		STOMACH, LIVER OR INTESTINAL TROUBLE	<input checked="" type="checkbox"/>		BONE, JOINT, OR OTHER DEFORMITY	<input checked="" type="checkbox"/>		NERVOUS TROUBLE OF ANY SORT
<input checked="" type="checkbox"/>		SEVERE TOOTH OR GUM TROUBLE	<input checked="" type="checkbox"/>		GALL BLADDER TROUBLE OR GALL STONES	<input checked="" type="checkbox"/>		LAMENESS	<input checked="" type="checkbox"/>		ANY DRUG OR NARCOTIC HABIT
<input checked="" type="checkbox"/>		SINUSITIS	<input checked="" type="checkbox"/>		JAUNDICE	<input checked="" type="checkbox"/>		LOSS OF ARM, LEG, FINGER, OR TOE	<input checked="" type="checkbox"/>		EXCESSIVE DRINKING HABIT
<input checked="" type="checkbox"/>		HAY FEVER	<input checked="" type="checkbox"/>		ANY REACTION TO SERUM, DRUG OR MEDICINE	<input checked="" type="checkbox"/>		PAINFUL OR "TRICK" SHOULDER OR ELBOW	<input checked="" type="checkbox"/>		HOMOSEXUAL TENDENCIES

21. HAVE YOU EVER (Check each item)

<input checked="" type="checkbox"/>	WORN GLASSES	<input checked="" type="checkbox"/>	ATTEMPTED SUICIDE
<input checked="" type="checkbox"/>	WORN AN ARTIFICIAL EYE	<input checked="" type="checkbox"/>	BEEN A SLEEP WALKER
<input checked="" type="checkbox"/>	WORN HEARING AIDS	<input checked="" type="checkbox"/>	LIVED WITH ANYONE WHO HAD TUBERCULOSIS
<input checked="" type="checkbox"/>	STUTTERED OR STAMMERED	<input checked="" type="checkbox"/>	COUGHED UP BLOOD
<input checked="" type="checkbox"/>	WORN A BRACE OR BACK SUPPORT	<input checked="" type="checkbox"/>	bled excessively after injury or TOOTH EXTRACTION

22. FEMALES ONLY: A. HAVE YOU EVER—

<input checked="" type="checkbox"/>	BEEN PREGNANT
<input checked="" type="checkbox"/>	HAD A VAGINAL DISCHARGE
<input checked="" type="checkbox"/>	BEEN TREATED FOR A FEMALE DISORDER
<input checked="" type="checkbox"/>	HAD PAINFUL MENSTRUATION
<input checked="" type="checkbox"/>	HAD IRREGULAR MENSTRUATION

B. COMPLETE THE FOLLOWING:

AGE AT ONSET OF MENSTRUATION
INTERVAL BETWEEN PERIODS
DURATION OF PERIODS
DATE OF LAST PERIOD
QUANTITY: <input checked="" type="checkbox"/> NORMAL <input type="checkbox"/> EXCESSIVE <input type="checkbox"/> SCANTY

23. HOW MANY JOBS HAVE YOU HAD IN THE PAST THREE YEARS?

1

24. WHAT IS THE LONGEST PERIOD YOU HELD ANY OF THESE JOBS?

MONTHS 2 1/2 yrs

25. WHAT IS YOUR USUAL OCCUPATION?

Interior Decorator

26. ARE YOU (Check one)

☒ RIGHT HANDED ☐ LEFT HANDED

WALTER REED ARMY MEDICAL CENTER
Washington 12, D. C.

DEPENDENTS RECEIVING MEDICAL CARE

S T A T E M E N T

1. Reference: AR 40-121, Dependent Medical Care

2. I, Aaron I. Lofton SP3 RA 24 919 772
(Name) (Rank) (SN)

having been (~~discharged~~) (~~separated~~) (~~retired~~) from active service on
1 November 1957, ~~xxxxx~~ (do not) have a dependent receiving
(Date)

medical care in a (military) (civilian) medical facility.

3. a. Name and address of dependent(s):

b. Name and address of (military) (civilian) medical facility or
physician:

4. Forwarding address after release from active duty.

Aaron I. Lofton
(Signature)

* Para (3) must be completed if a dependent is receiving medical care.

DOCTOR'S ORDERS (Date and sign all orders)

[illegible]

CLINICAL RECORD

ABBREVIATED CLINICAL RECORD

PERTINENT HISTORY, CHIEF COMPLAINT, AND CONDITION ON ADMISSION (Enter date of admission)

Bilateral inguinal hernias bilateral testicular atrophy on
right for approx one year. Cause unknown.

COMPLETE PHYSICAL EXAMINATION IS ESSENTIALLY NEGATIVE EXCEPT FOR THE FOLLOWING:

moderately & hearing bilaterally. Hears average
speaking well.

PROGRESS (Enter date of discharge and final diagnosis)

SIGNATURE OF PHYSICIAN <i>Ed. K. ...</i>	DATE 10-15-57	IDENTIFICATION NO.	ORGANIZATION
PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility) Lecton, Aaron I.		REGISTER NO.	WARD NO. 141

U.S. NAVAL HOSPITAL
CHARLESTON, S.C.

ABBREVIATED CLINICAL RECORD
Standard Form 539

CLINICAL CHART COVER
6ND-HOSP-NB-42 (Rev. 12/52)

U. S. NAVAL HOSPITAL
U. S. NAVAL BASE
CHARLESTON, S.C.

HOSPITAL REGISTER NO.

118332

FOR ADMISSION ROOM USE

WARD:

H-1

NAME: (Last) (First) (Middle) (Service No.) (Rank/Rate/Status)
LOFTON AARON ISAAC SP3/USA

ADMISSION DIAGNOSIS: DEAFNESS NEC
DIAGNOSIS NUMBER: 3999

ADMITTED: (Time) (Date) ☒ AMBULATORY ☐ STRETCHER
2230 10/16/57 RELIGION: PROT SEX: MALE

NEXT OF KIN: (Name) (Relationship) (Address)

DISCIPLINARY STATUS: (For Service Active Duty Patients Only)

☐ NO DISCIPLINARY ACTION PENDING

☐ IS A COURT MARTIAL PRISONER

☐ DISCIPLINARY ACTION PENDING AT DUTY STATION

☐ NO INFORMATION RECEIVED WITH RECORDS. WHEN RECEIVED WILL BE FURNISHED TO WARD BY PERSONNEL-RECORDS DIVISION BY MEANS OF DAILY REPORT OF DISCIPLINARY STATUS OF STAFF AND PATIENT PERSONNEL.

FOR WARD USE

TEMPERATURE 98.6 PULSE 64 RESPIRATION 16 BLOOD PRESSURE 110/80 WEIGHT 140 HIT 6' AGE 22

CROSS RECORD SUMMARY (For cross indexing purposes)
(To be completed by Ward Medical Officer)

DIAGNOSIS AND NUMBER

SPECIAL STUDY (Check One)

☐ NO SPECIAL STUDY
☐ BLINDNESS
☐ DEAFNESS
☐ AMPUTATION
☐ CORD BLADDER
☐ DEATH AFTER 72 HOURS
☐ PENICILLIN RX FOR SYPHILIS
☐ RETROCECAL
☐ ESCHINOPHELLIA (over 5%)
☐ BOARD CASE DR.
☐ BURN AND BODY SURFACES
☐ SYSTOLIC B/P UNDER 90mm.

OTHER (Anesthesia or Surgery)

CHANGES IN DISCIPLINARY STATUS SUBSEQUENT TO ADMISSION

Enter date and check mark if Daily Report of Disciplinary Status of Staff and Patient Personnel effects this patient.

DISCIPLINARY ACTION PENDING AT DUTY STATION
(Date)

☐ YES ☐ NO

☐ DISCIPLINARY ACTION PENDING THIS HOSPITAL

AWARDED COURT MARTIAL
(Date)

☐ NO FURTHER DISCIPLINARY ACTION PENDING. (Punishment and/or sentence completed)

SERIOUS/CRITICAL

Personnel-Records Office notified to obtain services of spiritual advisor

(Time) (Date)

DISPOSITION

WARD USE

TRANSFERRED TO WARD (Date)

TRANSFERRED TO WARD (Date)

TRANSFERRED TO WARD (Date)

RECORD OFFICE USE

REPORT OF DENTAL SURVEY																															
UPPER TEETH*																															
RIGHT						LEFT						RIGHT						LEFT													
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8	8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
X	0	0													X	X	0	0												X	
LOWER TEETH*																															
RIGHT						LEFT						RIGHT						LEFT													
16	15	14	13	12	11	10	9	9	10	11	12	13	14	15	16	16	15	14	13	12	11	10	9	9	10	11	12	13	14	15	16
X	X	X													X	X	X	X											X		
OCCLUSION <i>E</i> PERIODONTOCLASIA <i>✓</i> DENTAL FOCI SUSPECTED <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO OTHER CONDITIONS												CLASS <i>2</i> CALCULUS: SLIGHT, MEDIUM, HEAVY <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																			
DATE 4 FEB 1955												SIGNATURE OF DENTAL OFFICER <i>H. A. [Signature]</i>																			
*RESTORABLE CARIOUS TEETH BY O NONRESTORABLE CARIOUS TEETH BY / MISSING NATURAL TEETH BY X																															
TEETH REPLACED BY DENTURE (Horizontal line)																															
TEETH REPLACED BY FIXED BRIDGE (Oval to include abutments)																															

DA FORM 8-116
15 MAR 45
(Formerly WD AGO)

This form supersedes WD AGO Form 8-116, 31 May 1944 (formerly WD MD Form 79) which will not be used upon receipt of this revision.

16-20622-4 GPO

REPORT OF DENTAL SURVEY																															
UPPER TEETH*																															
RIGHT						LEFT						RIGHT						LEFT													
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8	8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
X	0	0													X	X	0	0											X		
LOWER TEETH*																															
RIGHT						LEFT						RIGHT						LEFT													
16	15	14	13	12	11	10	9	9	10	11	12	13	14	15	16	16	15	14	13	12	11	10	9	9	10	11	12	13	14	15	16
X	X	X													X	X	X	X											X		
OCCLUSION <i>Good</i> PERIODONTOCLASIA <i>none</i> DENTAL FOCI SUSPECTED <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO OTHER CONDITIONS												CLASS <i>2</i> CALCULUS: SLIGHT, MEDIUM, HEAVY <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																			
DATE 50 JSS												SIGNATURE OF DENTAL OFFICER <i>Capt. R. J. [Signature]</i>																			
*RESTORABLE CARIOUS TEETH BY O NONRESTORABLE CARIOUS TEETH BY / MISSING NATURAL TEETH BY X																															
TEETH REPLACED BY DENTURE (Horizontal line)																															
TEETH REPLACED BY FIXED BRIDGE (Oval to include abutments)																															

DA FORM 8-116
15 MAR 45
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16-20622-4 GPO

1. LAST NAME, FIRST NAME, MIDDLE INITIAL Lofton, Aaron, I				REGISTER OF DENTAL PATIENTS			
2. REGISTER NO.	3. ARMY SERIAL NO. RA24919772	4. GRADE Pvt-1					
5. ORGANIZATION AND ARM OR SERVICE Co. B 49th ABN ENGR BN							
6. AGE 20	7. RACE Cau	8. LENGTH OF SERV. 2 wks	9. DATE OF ADM. FEB 4 1955				
10. SOURCE OF ADMISSION * DENTAL EXAMINING STATION FORT JACKSON, S. C.							
*Required only when stencil procedure is used.							
				11. DISEASE OR INJURY WITH LOCATION, COMPLICATIONS, SEQUELAE, ETC.			
				12. DATES AND NATURE OF TREATMENTS AND OPERATIONS			
				13. RESULTS AND REMARKS			
SIGNATURE OF DENTAL OFFICER							
16-20622-3							

1. LAST NAME, FIRST NAME, MIDDLE INITIAL LOFTON, AARON I.				REGISTER OF DENTAL PATIENTS			
2. REGISTER NO.	3. ARMY SERIAL NO. RA 24919772	4. GRADE					
5. ORGANIZATION AND ARM OR SERVICE							
6. AGE 20	7. RACE Cau	8. LENGTH OF SERV. 2 wks	9. DATE OF ADM. FEB 4 1955				
10. SOURCE OF ADMISSION * DENTAL EXAMINING STATION FORT JACKSON, S. C.							
*Required only when stencil procedure is used.							
				11. DISEASE OR INJURY WITH LOCATION, COMPLICATIONS, SEQUELAE, ETC.			
				12. DATES AND NATURE OF TREATMENTS AND OPERATIONS			
				13. RESULTS AND REMARKS			
SIGNATURE OF DENTAL OFFICER							
16-20622-3							

REPORT OF DENTAL SURVEY																																																																	
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p style="text-align: center;">UPPER TEETH*</p> <p style="text-align: center;">RIGHT LEFT</p> <table border="1" style="width: 100%; text-align: center; border-collapse: collapse;"> <tr><td>8</td><td>7</td><td>6</td><td>5</td><td>4</td><td>3</td><td>2</td><td>1</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td></tr> <tr><td colspan="16"></td></tr> </table> </div> <div style="width: 45%;"> <p style="text-align: center;">LOWER TEETH*</p> <p style="text-align: center;">RIGHT LEFT</p> <table border="1" style="width: 100%; text-align: center; border-collapse: collapse;"> <tr><td>16</td><td>15</td><td>14</td><td>13</td><td>12</td><td>11</td><td>10</td><td>9</td><td>9</td><td>10</td><td>11</td><td>12</td><td>13</td><td>14</td><td>15</td><td>16</td></tr> <tr><td colspan="16"></td></tr> </table> </div> </div>	8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8																	16	15	14	13	12	11	10	9	9	10	11	12	13	14	15	16																	<p>CLASS</p> <p>OCCUSION <u>11</u></p> <p>PERIODONTICLASIA <u>11</u></p> <p>DENTAL FOCI SUSPECTED <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>OTHER CONDITIONS <u>BD</u></p> <p>CALCULUS: SLIGHT, MEDIUM, HEAVY</p>
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8																																																		
16	15	14	13	12	11	10	9	9	10	11	12	13	14	15	16																																																		
<p>DATE <u>12 Dec 50</u> SIGNATURE OF DENTAL OFFICER <u>[Signature]</u></p>																																																																	
<p>* RESTORABLE CARIOUS TEETH BY O</p> <p>NON-RESTORABLE CARIOUS TEETH BY /</p> <p>MISSING NATURAL TEETH BY X</p> <p>TEETH REPLACED BY DENTURE (Horizontal line)</p> <p>TEETH REPLACED BY FIXED BRIDGE (Oval to include abutments)</p>																																																																	

WD AGO FORM 8-116
15 MAR 1945

This form superseded WD AGO Form 8-116, 31 May 1944 (formerly WD MD Form 79) which will not be used upon receipt of this revision.

16-20622-2 ☆ GPO

CHECK OUT

WARD _____

DATE _____

You are hereby directed to proceed immediately and check out in numerical order at the activities indicated below. This is to take care of all necessary matters in connection with your discharge from the U. S. Naval Hospital.

Read and understood _____ (Patient)

(No. in order of check-out.)

(Initial)

1. WARD
- RECORD OFFICE (incl. PERS. ACCTG.)
- POST OFFICE
- LIBRARY
- DISBURSING OFFICE
- AGENT CASHIER
- CIVIL READJUSTMENT OFFICE (SEPARATEE)
- WELFARE AND RECREATION OFFICE
- RED CROSS OFFICE
- VETERANS OFFICE (VAB ONLY)
- MAINTENANCE/ELECTRICAL SHOP
- BAG ROOM
- MASTER-AT-ARMS

DISPOSITION OF RECORDS

HR/DR _____

SR _____

PR _____

305 _____

CSC _____

(Post No. of S.T.O. to indicate disposition.)

OFFICER OF THE DAY (Info. clerk to note change) _____

This check out must be completed before allowing departure from the hospital, and a responsible officer will sign this form at the bottom as indication of proper clearance. This slip should be filed with patient's case record.

REGISTER OF DENTAL PATIENTS				11. DISEASE OR INJURY WITH LOCATION, COMPLICATIONS, SEQUELAE, ETC.	12. DATES AND NATURE OF TREATMENTS AND OPERATIONS	13. RESULTS AND REMARKS
1. LAST NAME, FIRST NAME, MIDDLE INITIAL LOFTON, Aaron				Adm R	Exam XP# 12 Dec 56	
2. REGISTER NO. 3. ARMY SERIAL NO. 4. GRADE [REDACTED] PFC				Car R-1 D	OS	
5. ORGANIZATION AND ARM OR SERVICE Hqs Det ASA 8616th Ft Kobbe				Car R-2 M	OS 12 Dec 56	ARK Cl-1
6. AGE 7. RACE 8. LENGTH OF SERV. 9. DATE OF ADM. 22 Can 1 11/12 12 Dec 56						
10. SOURCE OF ADMISSION*						

*Required only when stencil procedure is used.

SIGNATURE OF DENTAL OFFICER

16-20022-3

NAME (LAST)		(FIRST)		(MIDDLE)		HOSP. REGISTER NO.	PREV. ADM. DATE	U. S. NAVAL HOSP.	WARD
LOFTON AARON		ISAAC				118332		CHAS. S.C.	DET
DUTY STATUS	AV. STATUS	RACE	RELIG.	MAR. STATUS	(STATE) BIRTH (DATE) (AGE)	PRES. ENLISTM	TE	EXPIR. (VAB DISCH) DATE	TOTAL SERVICE YRS. NOS.
ACT		C	P	S	MESS	22	1/24/55	1/23/58	2/9
(TIME) ADMISSION (DATE)		F R M		GORGAS HOSP. ANCON CANAL ZONE				A LTR. () PHONE () P-10 () U T H. RON	
2230		10/16/57							
RECORDS REC'D MARK 'I' IF REQUESTED POST DATE ACT. NOTIF. - EMER. HOW PATIENT ARRIVED (AMBULANCE NAME, ADDRESS, ETC. FOR CLAIMS)									
HR	SR	PR	305/ CSC	'G'	ORD.	DISC. LTR.	BAG	OTHER	
OFFICER'S PR LOCATION (OR OCCUPATION, IF VAB)						GOVT. INS. (AMT)		DEPENDENTS	
NEXT OF KIN (OR DEPENDENT OF) (NAME IN FULL) (RATE)						PRESENT ADDRESS		TELEPHONE	
LOFTON AARON BOX 64 SUMMIT MISS								FATHER	
MOTHER'S MAIDEN NAME (IN FULL)						BIRTHPLACE		MISC. (1) PLACE OF ENLIST.	
MUMFERY AGNES LOU (LV)						MISS		(2.) SOCIAL SECURITY NO.	
FATHER'S NAME (IN FULL)						BIRTHPLACE		(3.) VETERAN'S ORGANIZATION, ETC.	
LOFTON AARON ALTON (LV)						MISS			
PATIENT'S LEGAL RESIDENCE-TIME (OR IN CASE OF EMERGENCY NOTIFY: NAME, ADDRESS, TELEPHONE)									
SAME AS NOK									
ADMISSION DIAGNOSIS				NUMBER		DISCHARGE DIAGNOSIS			
DEAFNESS NEC				3999					
DISP.	DATE	TO WHERE				MISC. (SICK DAYS)		DATE S. L. BEGAN	
NAME (LAST)		(FIRST)		(MIDDLE)		S.	C.	RATE (INCL. VAB.)	CLASS/BRANCH
LOFTON AARON		ISAAC						SP3	USA
								SERVICE OR VAB 'C' NO.	WARD
									H-1

REPORT OF DENTAL SURVEY																																		
<p>UPPER TEETH</p> <div style="display: flex; justify-content: space-between; align-items: center;"> <div style="text-align: right;"> <p>RIGHT</p> <p>8 6 5 4 3 2 1</p> </div> <div style="text-align: left;"> <p>LEFT</p> <p>2 3 4 5 6 7 8</p> </div> </div> <div style="display: flex; justify-content: space-between; align-items: center; margin-top: 10px;"> <table border="1" style="border-collapse: collapse; text-align: center;"> <tr> <td>X</td><td>0</td><td>0</td><td>X</td><td></td><td></td><td></td><td></td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>X</td> </tr> </table> </div> <p style="text-align: center; margin-top: 10px;">LOWER TEETH</p> <div style="display: flex; justify-content: space-between; align-items: center;"> <div style="text-align: right;"> <p>RIGHT</p> <p>16 15 14 13 12 11 10 9 8 7 6 5 4 3 2 1</p> </div> <div style="text-align: left;"> <p>LEFT</p> <p>16 15 14 13 12 11 10 9 8 7 6 5 4 3 2 1</p> </div> </div> <div style="display: flex; justify-content: space-between; align-items: center; margin-top: 10px;"> <table border="1" style="border-collapse: collapse; text-align: center;"> <tr> <td>X</td><td>X</td><td>X</td><td>1</td><td></td><td></td><td></td><td></td><td>0</td><td>0</td><td>0</td><td></td><td></td><td></td><td>0</td><td>X</td><td>0</td><td>0</td> </tr> </table> </div>		X	0	0	X					0	0	0	0	0	0	X	X	X	X	1					0	0	0				0	X	0	0
X	0	0	X					0	0	0	0	0	0	X																				
X	X	X	1					0	0	0				0	X	0	0																	
<p>OCCLUSION <input checked="" type="checkbox"/> N</p> <p>PERIODONTOCLASIA <input checked="" type="checkbox"/> N</p> <p>DENTAL FOCI SUSPECTED <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>OTHER CONDITIONS</p>	<p>CLASS <u>2</u></p> <p>CALCULUS: SLIGHT, MEDIUM, HEAVY</p>																																	
<p>DATE</p>	<p>SIGNATURE OF DENTAL OFFICER</p>																																	
<p>*RESTORABLE CARIOUS TEETH BY 0</p> <p>NONRESTORABLE CARIOUS TEETH BY 1</p> <p>MISSING NATURAL TEETH BY X</p>																																		
<p>TEETH REPLACED BY DENTURE (Horizontal line)</p>																																		
<p>TEETH REPLACED BY FIXED BRIDGE (Oval to include abutments)</p>																																		

This form supersedes WD AGO Form 8-116, 31 May 1944 (formerly WD MD Form 79) which will not be used upon receipt of this revision.

18-20622-4 CPC

REPORT OF DENTAL SURVEY

UPPER TEETH

RIGHT

LEFT

8 7 6 5 4 3 2 1 16 15 14 13 12 11 10 9 8 7 6 5 4 3 2 1

LOWER TEETH

RIGHT

LEFT

16 15 14 13 12 11 10 9 8 7 6 5 4 3 2 1

CLASS 350

CALCULUS: SLIGHT, MEDIUM, HEAVY

PERIODONTICLASIA

OCCUSION

DENTAL FOCI SUSPECTED

OTHER CONDITIONS

YES ☐ NO ☒

DATE

SIGNATURE OF DENTAL OFFICER

RESTORABLE CARIOUS TEETH BY O

NONRESTORABLE CARIOUS TEETH BY I

MISSING NATURAL TEETH BY X

TEETH REPLACED BY DENTURE

(Horizontal line)

TEETH REPLACED BY FIXED BRIDGE

(Oval to include abutments)

1. LAST NAME, FIRST NAME, MIDDLE INITIAL LOFTON, AARON I				<div>2/</div> <div>REGISTER OF DENTAL PATIENTS</div>		
2. REGISTER NO.		3. ARMY SERIAL NO.			4. GRADE Pvt	
5. ORGANIZATION AND ARM OR SERVICE Co B - Proc Bn ASA						
6. AGE 20	7. RACE Cau	8. LENGTH OF SERV. 4/12	9. DATE OF ADM. 26 Apr 55			
10. SOURCE OF ADMISSION DENTAL CLINIC #1						
*Required only when stencil procedure is used						
11. DISEASE OR INJURY WITH LOCATION, COMPLICATIONS, SEQUELAE, ETC.		12. DATES AND NATURE OF TREATMENTS AND OPERATIONS		13. RESULTS AND REMARKS		
Adm R		Exam "2"		26 Apr 55	2	MNG
PBW		XR #3202			2	GN
Car L-1 do		Consult		7 Jul 55	2	HFS
" L-5 o		"				
" L-6 o		"				
" L-7 o		" anes		7 Jul 55	2	RS
Car R-13 o		OA Agno3 Anes				
Car L-15 do		OA Agno3 Anes		21 Jul 55	2	GH
Car L-1 dlm		OS				
Car L-2 d		OS				
Car L-2 m		OS				
Car L-9 d		OS				
Car R-9 m		OS				
Car R-10 m		OS				
Car L-15 o		OA				
Car R-5 mo		OA				
Car R-7 o		OA				
Car L-13 do		OA		5 Oct 55	20-1	JTS
SIGNATURE OF DENTAL OFFICER					<div>Harry C Ramsey</div> <div>D.C.</div>	

[illegible]



2025 RELEASE UNDER E.O. 14176

Name: BILLY RAY KING
Sex: Male
Race: White
Date of Birth:
Place of Birth: St. Joseph, Louisiana
Height: 6' 1"
Weight: 185 lbs.
Hair: Dark Brown (curly)
Eyes: Blue
Complexion: Medium to Ruddy
Residence: 102 Arlington, Lake Providence, Louisiana
Occupation: Deck hand -Tow Boat
Education: 7th Grade
Marital Status: Single
Employer: KGW Towing Company, Greenville, Mississippi

ME 44-1987-1A-93



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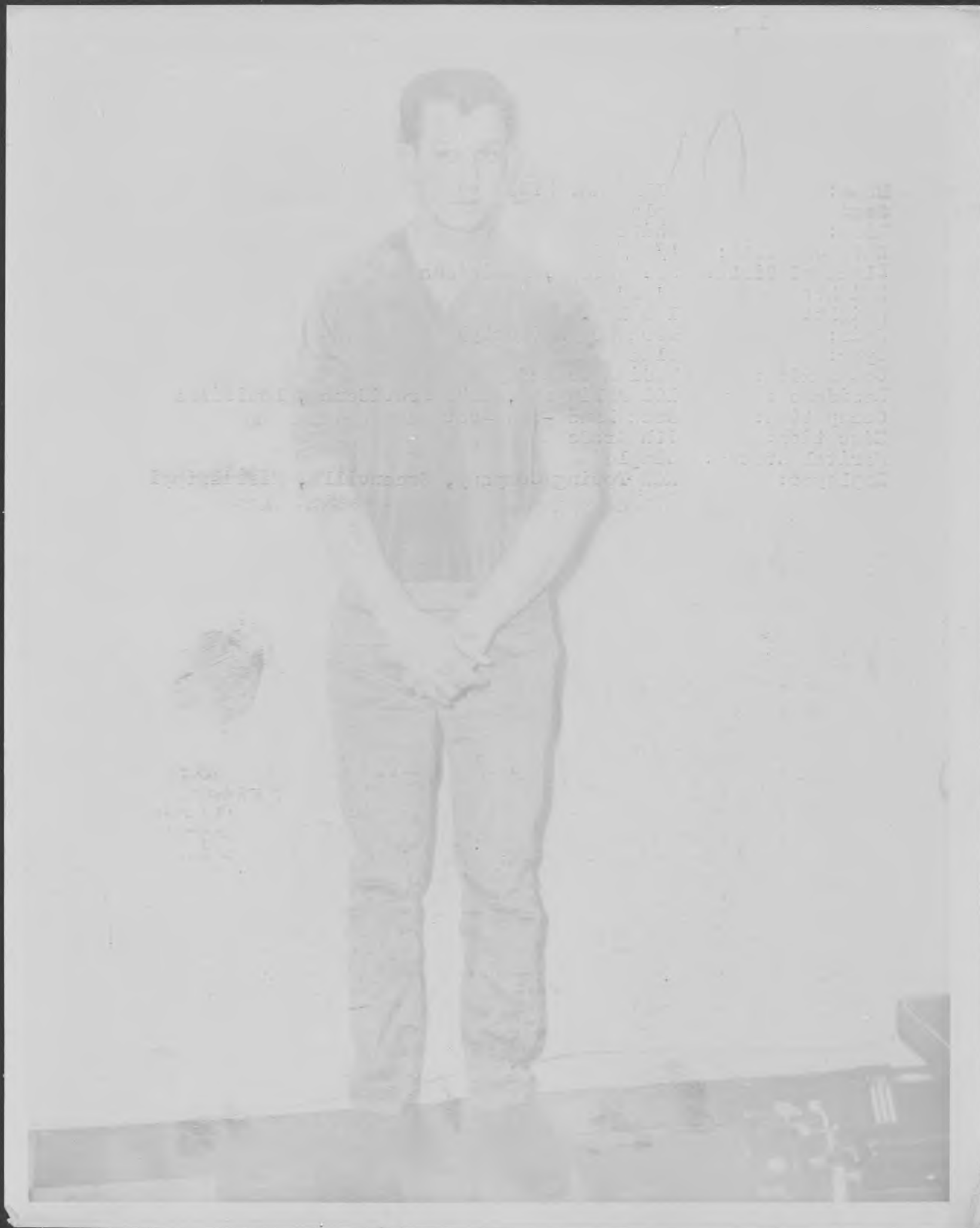
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