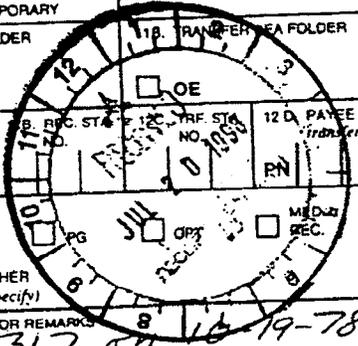


JUL 06 1998

A0872553

REQUEST FOR AND /OR NOTICE OF TRANSFER OF VETERANS RECORDS	
ITEM NO.	1. STATION NAME AND NO. (Include mail routing symbol on temporary transfers only.) ROUTE TO THE FOLLOWING IN ORDER INDICATED
1A	040 Estpoint
1B	345 Phoenix
1C	ACC# 015-79-0001
COR	ENTER STATION NO.
4. NAME (Last, First, Middle - Separate names by commas.) SCHAD EDWARD H 1	
C SS	5A. FILE NO. (Circle C or SS) 05 450 700
SS	5B. (If not file number)
SN	6. SERVICE NO.
	7. BENEFICIARY MASTER RECORD (If not a veteran, enter "1")
	8. TYPE OF TRANSFER <input checked="" type="checkbox"/> PERMANENT <input type="checkbox"/> TEMPORARY
	9. OTHER FILE NO.
10.	11A. TRANSFER CLAIMS FOLDER (C, XC, SS or XSS) NEW <input type="checkbox"/> CL
	11B. TRANSFER IDEA FOLDER <input type="checkbox"/> OE
12A.	DATE OF TRANSFER (Month, day, year)
	12B. REC. STA. NO.
	12C. TRF. STA. NO.
	12D. PAYEE NO. (DEA transfer only.) RN 000 \$
13.	OTHER FOLDER TRANSFER <input type="checkbox"/> R & E <input type="checkbox"/> INS. <input type="checkbox"/> LG <input type="checkbox"/> PG <input type="checkbox"/> OPT <input type="checkbox"/> MEDICAL REC. <input type="checkbox"/> HOSP. CORRESP.
	COUNSELING/ TRAINING SUBFOLDER <input type="checkbox"/> OTHER (Specify)
14.	REASON FOR TRANSFER AND/OR REMARKS retired July 31, 1978 on 16-19-78 PRIVACY ACT REQUEST
15.	ADJUDICATION ACTION PENDING? <input type="checkbox"/> YES <input type="checkbox"/> NO
16.	FROM (Originating office) 345 Phoenix
	17. DATE 6-30-98
*If transfer of C-folder or DEA folder is permanent, complete Item 18.	
18. CHECK WHEN COPY 2 IS SENT TO TELECOM UNIT <input type="checkbox"/> UNIT	

7918



VA FORM 7216a JUN 1992(R)

COPY MADE FROM VETERANS CLAIM FOLDER

**SOCIAL SECURITY ADMINISTRATION
APPLICATION FOR SURVIVORS BENEFITS
(PAYABLE UNDER TITLE II OF THE SOCIAL SECURITY ACT)**
IMPORTANT - Read instructions before filling in form. Detach and retain ONLY the instruction sheet.

(DO NOT WRITE IN THIS SPACE)
RECEIVED
JAN 7 1974
VARO 317
P. O. Box 1437
St. Petersburg, Fla.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

1. FIRST NAME - MIDDLE NAME - LAST NAME OF VETERAN (Type or print) **Edward HAROLD Schad Sr** 2. DATE OF DEATH **7-7-1973**

NOTE: If the veteran's Social Security No. is unknown, fill in Items 4, 5, 6 and 7 about veteran.

3. SOCIAL SECURITY NO. OF VETERAN **134-10-6782** 4. DATE OF BIRTH **AUG 24, 1920** 5. PLACE OF BIRTH **SYRACUSE NY**

6. NAME OF FATHER **John Schad** 7. MAIDEN NAME OF MOTHER **CATHERINE HOUSER**

8. DID THE VETERAN WORK IN THE RAILROAD INDUSTRY AT ANY TIME ON OR AFTER 1-1-37?
 YES NO **worked on RR tracks in 1941-**

NOTE - The following information should be furnished for each period of the veteran's active service after September 7, 1939, in the Army, Navy, Air Force, Marine Corps or Coast Guard of the United States or service as a commissioned officer in the Coast and Geodetic Survey or Public Health Service.

ENTERED ACTIVE SERVICE		9C. SERVICE NO.	SEPARATED FROM ACTIVE SERVICE		9F. GRADE, RANK OR RATING, ORGANIZATION AND BRANCH OF SERVICE
9A. DATE	9B. PLACE		9D. DATE	9E. PLACE	
July 17 1942	Syracuse NY	32378461	Oct 6 1945	AFF Comandant	STAFF SERGEANT US ARMY Plato. Army Branch IN AIR FORCE

10. RELATIONSHIP OF APPLICANT TO VETERAN
 WIDOW CHILD PARENT (Fill in Item 11)

11. DATE OF BIRTH OF APPLICANT **SEPT 2 1919** 12. VETERANS ADMINISTRATION CLAIM NO. **C-5456700**

CHILDREN: Show names of surviving unmarried children (including stepchildren, adopted, and illegitimate children) of the veteran who were (a) Under 18; (b) 18 to 22 and going to school; (c) Age 18 or over if disabled before 18.

13A. _____ 13B. _____
13C. _____ 13D. _____

I certify that the above statements are true, knowing that anyone who makes a false statement or misrepresents in connection with an application for Federal benefits is committing a crime punishable under Federal law.

14. DATE (Month, day, year) **Jan 2 1974** 15. SIGNATURE OF APPLICANT (Write in ink) **Michael C. Schad**

16. MAILING ADDRESS OF APPLICANT (No. and street or rural route, city or P.O., State and ZIP Code) **PO Box 12082 New York 10022** 17. TELEPHONE NO. **633-2349**

18A. SIGNATURE OF WITNESS _____ 18B. ADDRESS OF WITNESS (No. and street, city, State and ZIP Code) _____
19A. SIGNATURE OF WITNESS _____ 19B. ADDRESS OF WITNESS (No. and street, city, State and ZIP Code) _____

ITEMS BELOW TO BE COMPLETED BY THE VETERANS ADMINISTRATION (Use reverse for "Remarks")

20. PROOFS RECEIVED (Check)	21. PROOFS REQUESTED FROM CLAIMANT OR OTHERS (Specify)
<input type="checkbox"/> DEATH <input type="checkbox"/> MARRIAGE	<input type="checkbox"/> DEATH <input type="checkbox"/> MARRIAGE
<input type="checkbox"/> AGE _____ (NAME)	<input type="checkbox"/> AGE _____ (NAME)
_____ (NAME)	_____ (NAME)
_____ (NAME)	_____ (NAME)
<input type="checkbox"/> OTHER (Specify)	<input type="checkbox"/> OTHER (Specify)

22. DATE _____ 23. NAME AND ADDRESS OF TRANSMITTING VA OFFICE _____

VA FORM **OA-C24**
JUN 1971

SUPERSEDES OA-C24, JAN 1969,
WHICH WILL NOT BE USED.

COPY MADE FROM VETERANS CLAIM FOLDER

APPLICATION FOR VETERANS COMPENSATION
(INCLUDING ACCRUED BENEFITS)

WIDOW OR CHILD
APPLICATION, WHERE APPLICABLE

(DO NOT WRITE IN THESE SPACES)
VA DATE STAMP

RECEIVED
JAN 7 1974
VARO 317
P. O. Box 1437
St. Petersburg, Fla.

IMPORTANT - Read instructions before filling in form. Answer all items fully. Detach and retain ONLY the instruction sheet. If more space is required, attach additional sheets and identify each answer by item number.

1. LAST NAME - FIRST NAME - MIDDLE NAME OF DECEASED VETERAN (Type or print)
SHAD, Edward H., Sr.

2A. FIRST NAME - MIDDLE NAME - LAST NAME OF CLAIMANT (Type or print)
MABEL JEANNE Schad

2B. TELEPHONE NO.
632 349

2C. MAILING ADDRESS OF CLAIMANT (Number and street or rural route, city or P.O., State and ZIP Code)
Rt 1 Kuhlville 921 13082

2D. RELATIONSHIP TO VETERAN (Check one)
 WIDOW CHILD

3. IF VETERAN PREVIOUSLY APPLIED TO THE VETERANS ADMINISTRATION FOR ANY BENEFIT, INSERT CLAIM NUMBER, IF KNOWN
05 450 700

4. SOCIAL SECURITY NUMBER OF VETERAN
134-10-6782

5. RAILROAD RETIREMENT NO.

6. VETERANS ADMINISTRATION CLAIM NO.
XC 05 450 700

PART I - IDENTIFICATION AND SERVICE INFORMATION OF VETERAN (See Instructions - paragraphs F & G)

7. DATE OF BIRTH
AUG 24 - 1920

8. PLACE OF BIRTH
SYRACUSE NY

9. DATE OF DEATH
NOV 9 - 1973

10. PLACE OF DEATH
BRIDGEPORT NEW YORK

11A. CAUSE OF DEATH (See Instructions, paragraph F)
HEART ATTACK

11B. ARE YOU CLAIMING THAT THE CAUSE OF DEATH WAS DUE TO SERVICE?
 YES NO

12A. ENTERED ACTIVE SERVICE		12B. SERVICE NO.	12C. SEPARATED FROM ACTIVE SERVICE		12D. GRADE, RANK OR RATING, ORGANIZATION AND BRANCH OF SERVICE
DATE	PLACE		DATE	PLACE	
July 31 1942	SYRACUSE NY	2378461	Oct 6 1945	PLATTSBURG NEW YORK	TECH SARGENT STAFF SERGEANT - AIR FORCE

13. IF VETERAN SERVED UNDER A NAME OTHER THAN THAT SHOWN IN ITEM 1, GIVE FULL NAME AND SERVICE RENDERED UNDER THAT NAME

PART II - INFORMATION RELATING TO MARRIAGE (See Instructions, paragraph H)

INFORMATION RELATING TO VETERAN

14. HOW MANY TIMES WAS VETERAN MARRIED?
one

15A. MARRIAGE		15B. TO WHOM MARRIED	15C. HOW MARRIAGE ENDED (Death, divorce, etc.)	15D. MARRIAGE ENDED	
DATE	PLACE			DATE	PLACE
DEC 13 1941	SYRACUSE NY	Mabel Cole	DEATH	Nov 9 1973	BRIDGEPORT NY

INFORMATION RELATING TO WIDOW OR MOTHER OF THE CHILDREN FOR WHOM THIS CLAIM IS BEING MADE

16. HOW MANY TIMES HAS WIDOW BEEN MARRIED?
one - to Edward H. Schadt

17. HAS WIDOW REMARRIED SINCE DEATH OF VETERAN?
 YES NO (If "Yes," complete Item 18 and 19)

20A. MARRIAGE		20B. TO WHOM MARRIED	20C. HOW MARRIAGE ENDED (Death, divorce, etc.)	20D. MARRIAGE ENDED	
DATE	PLACE			DATE	PLACE

21-534

EXISTING STOCKS OF VA FORM 21-534, JUN 1971, WILL BE USED.

COPY MADE FROM VETERANS CLAIM FOLDER

April 4, 1974

XC 05 450 700
SCHAD, E. H.

Mrs. Mabel J. Schad
RD 1, Kirkville Rd.
Kirkville, NY 13082

Dear Mrs. Schad:

x

x

2,600

Sincerely yours,

M. R. WOODALL

Encl: VAF 21-4100
21-837,SCa, NSCa
sch 4-3-74

COPY MADE FROM
VETERANS CLAIM FOLDER

PART V - DEDUCTIBLE EXPENSES

NOTE - Your income may be reduced by the amount of unreimbursed expenses of the veteran's or his child's last illness and burial and the veteran's just debts which were paid by you after his death. Be sure to include as income in items 37E, 38E and 39E any reimbursement received on these expenses or debts. See Par. "L" of instructions for reporting payments and reimbursements made after filing of your claim.

43A. NAME AND ADDRESS OF PERSON TO WHOM PAID	43B. TOTAL AMT. OF EXPENSE OR DEBT	43C. NATURE OF EXPENSE OR DEBT	43D. DATE PAID	43E. AMOUNT PAID BY YOU
	\$			\$
	\$			\$
	\$			\$

RECEIVED
ADJUDICATION DIVISION
JAN 21 1974
VA REGIONAL OFFICE
VA PETERSBURG, VA

PART VI - NET WORTH OF WIDOW AND/OR CHILD OR CHILDREN (See instructions, para 44, items 44A to 44E incl.)

LINE NO.	SOURCE	AMOUNTS			
		WIDOW	NAME OF CHILD	NAME OF CHILD	NAME OF CHILD
44A	STOCKS, BONDS, BANK DEPOSITS	\$	\$	\$	\$
44B	REAL ESTATE				
44C	OTHER PROPERTY				
44D	TOTAL DEBTS				
44E	NET WORTH	\$	\$	\$	\$

PART VII - MISCELLANEOUS INFORMATION

43A. FULL NAME OF VETERAN'S MOTHER: *Catherine Elizabeth Houser*

43B. FULL NAME OF VETERAN'S FATHER: *John Baden Schoel*

43C. ADDRESS OF VETERAN'S MOTHER, IF LIVING: *1111 1st St. Petersburg, FL 33705*

43D. ADDRESS OF VETERAN'S FATHER, IF LIVING: *1111 1st St. Petersburg, FL 33705*

47. HAS WIDOW OR CHILD FILED CLAIM FOR COMPENSATION FROM UNITED STATES BUREAU OF EMPLOYEES COMPENSATION BECAUSE OF DEATH OF VETERAN ON WHOSE SERVICE THIS CLAIM IS FILED? YES NO

48A. HAS THE WIDOW OR CHILD PREVIOUSLY FILED CLAIM FOR BENEFITS WITH THE VETERANS ADMINISTRATION? YES NO (If "Yes," fill in 48B thru 50, inclusive)

48B. NAME OF PERSON ON WHOSE SERVICE CLAIM WAS MADE

48C. RELATIONSHIP TO CLAIMANT

51. HAS ANY FEE BEEN PAID OR WILL ANY FEE BE PAID TO ANY PERSON FOR ASSISTANCE IN THE PREPARATION OF THIS APPLICATION FORM? YES NO (If "Yes," fill in 52 and 53.)

52. NAME AND ADDRESS OF PERSON ASSISTING

53. AMOUNT OF FEE

54. REMARKS (Use this space for any additional information regarding this claim) *HUSBAND RECEIVED PENSION FROM GOVT FOR THE LAST SIX YRS. WOULD APPRECIATE ANYTHING YOU COULD DO TO SPEED THIS CLAIM THROUGH.*

CERTIFICATION: I CERTIFY THAT the foregoing statements are true and correct to the best of my knowledge and belief.

55. DATE SIGNED: *Jan 5 1974*

56. SIGNATURE OF CLAIMANT: *Mabel C. Schoel*

WITNESS TO SIGNATURE OF CLAIMANT IF MADE BY MARK. Note - Signature made by mark must be witnessed by two persons to whom the person making the statement is personally known, and the signatures and addresses of such witnesses must be shown below.

57A. SIGNATURE OF WITNESS: *Thomas F. Schoel*

57B. ADDRESS OF WITNESS: *379 Village Dr. Sp. 74 1300 B.D.P. Bridgeport Tex. 13030*

58A. SIGNATURE OF WITNESS: *James Schoel*

58B. ADDRESS OF WITNESS: *379 Village Dr. Sp. 74 1300 B.D.P. Bridgeport Tex. 13030*

PENALTY - The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement or evidence of material fact, knowing it to be false, or for the fraudulent acceptance of any payment to which you are not entitled.

PART IV - ANNUAL INCOME OF WIDOW AND/OR CHILD (By calendar years, (Continued))

OTHER INCOME					
LINE NO.	(A) SOURCE	AMOUNT OF INCOME			
		(B) WIDOW	(C) NAME OF CHILD	(D) NAME OF CHILD	(E) NAME OF CHILD
NOTE: INCOME RECEIVED FROM JANUARY 1 TO DATE OF DEATH OF VETERAN or, if claim is filed more than a year after the veteran died, income received from January 1 to date you sign this application.					
37A	EARNINGS FROM ALL EMPLOYMENT	\$ 142 - weekly			
37B	SOCIAL SECURITY			\$	\$
37C	OTHER ANNUITIES OR RETIREMENTS				
37D	DIVIDENDS, INTEREST, ETC.				
37E	ALL OTHER INCOME			\$	\$
37F	TOTAL INCOME	\$	\$	\$	\$
Do NOT complete lines 37G and 37H if you had no income from those sources.					
37G	GROSS INCOME FROM SELF-EMPLOYMENT, FARM OR BUSINESS (Include net income in line 37E)	\$	\$	\$	\$
	GROSS INCOME FROM RENTALS FROM REAL ESTATE (Include net income in line 37E)	\$	\$	\$	\$
NOTE: INCOME EXPECTED FROM DATE OF DEATH OF VETERAN TO DECEMBER 31 THAT YEAR or, if claim is filed more than a year after the veteran died, income expected from the date you sign this application to December 31 of the same year.					
38A	EARNINGS FROM ALL EMPLOYMENT	\$			
38B	SOCIAL SECURITY		\$	\$	\$
38C	OTHER ANNUITIES OR RETIREMENTS				
38D	DIVIDENDS, INTEREST, ETC.				
38E	ALL OTHER INCOME			\$	\$
38F	TOTAL INCOME	\$	\$	\$	\$
Do NOT complete lines 38G and 38H if you had no income from those sources.					
38G	GROSS INCOME FROM SELF-EMPLOYMENT, FARM OR BUSINESS (Include net income in line 38E)	\$	\$	\$	\$
38H	GROSS INCOME FROM RENTALS FROM REAL ESTATE (Include net income in line 38E)	\$	\$	\$	\$
NOTE: INCOME EXPECTED FOR THE NEXT CALENDAR YEAR. If you are unable to state the exact amount, give approximate amounts expected.					
39A	EARNINGS FROM ALL EMPLOYMENT	\$			
	SOCIAL SECURITY		\$	\$	\$
39C	OTHER ANNUITIES OR RETIREMENTS				
39D	DIVIDENDS, INTEREST, ETC.				
39E	ALL OTHER INCOME			\$	\$
39F	TOTAL INCOME	\$	\$	\$	\$
Do NOT complete lines 39G and 39H if you had no income from those sources.					
39G	GROSS INCOME FROM SELF-EMPLOYMENT, FARM OR BUSINESS (Include net income in line 39E)	\$	\$	\$	\$
39H	GROSS INCOME FROM RENTALS FROM REAL ESTATE (Include net income in line 39E)	\$	\$	\$	\$
40A. HAVE YOU APPLIED FOR OR ARE YOU RECEIVING OR ENTITLED TO RECEIVE ANY BENEFITS FROM THE SOCIAL SECURITY ADMINISTRATION?		40B. BEGINNING DATE (Month and year)			
<input type="checkbox"/> YES <input type="checkbox"/> NO (If "Yes," fill-in items 40B thru 40D) <i>I have applied but not received anything up to this date - on my husband's death</i>		<i>13410-6782</i>			
40C. MONTHLY AMOUNT		40D. IS YOUR SOCIAL SECURITY BASED ON YOUR OWN EMPLOYMENT?			
\$		<input type="checkbox"/> YES <input type="checkbox"/> NO (If "Yes," fill-in item 40E)			
If part of your income is from any other retirement plan, annuity, or endowment insurance based upon your employment, fill-in 41A to 42.					
41A. BEGINNING DATE (Month and year)	41B. MONTHLY AMOUNT	42. BY WHOM PAID (Name and address)			

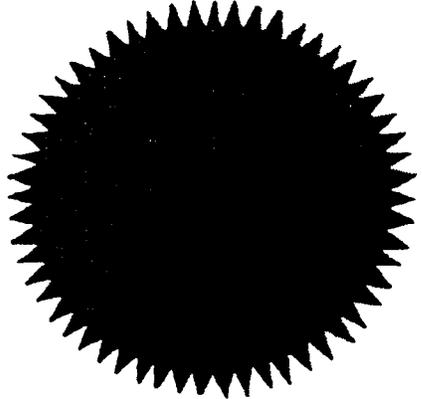
COPY MADE FROM VETERANS CLAIM FOLDER

STATE OF NEW YORK }
MADISON COUNTY } ss.
CITY OF ONEIDA CLERK'S OFFICE }

I Elaine M. Carello, City Clerk of the City of Oneida and Registrar of Vital Statistics, DO HEREBY CERTIFY that I have compared the annexed copy of ..Death Certificate..... and the endorsement thereon with the original thereof remaining on file in this office and that the same is a correct transcript thereof and of the whole of such original.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the seal of the City of Oneida, in the city of Oneida, in said County, this 12. day of NOV..... 19.73.

Elaine M. Carello
Registrar of Vital Statistics
City Clerk



COPY MADE FROM
VETERANS CLAIM FOLDER

DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
CERTIFICATE OF DEATH
TYPE ALL ENTRIES OR PRINT IN PERMANENT BLACK INK.

CENSUS TRACT _____ SUB-DIVISION _____

STATISTICAL DISTRICT _____

USUAL RESIDENCE WHERE DECEASED LIVED, IF DEATH OCCURRED IN INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION.

ATTENTION
AN ERROR IS NOTED IN A CERTIFICATE BEFORE ACCEPTANCE BY REGISTRAR A CORRECTED CERTIFICATE MAY BE SUBSTITUTED.
AN INCORRECT CERTIFICATE HAS BEEN ACCEPTED BY REGISTRAR, FILE AM V.S. 84.

1. NAME: FIRST MIDDLE LAST Edward H. Sched, Sr.			2. SEX MALE <input checked="" type="checkbox"/> FEMALE <input type="checkbox"/>	3A. DATE OF DEATH MONTH DAY YEAR 11 7 73	3B. AGE 60
4. RACE: (WHITE, NEGRO, AMERICAN INDIAN, ETC.) White	5. AGE YRS. 53	6A. VETERAN OF U.S. ARMED FORCES? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNKNOWN <input type="checkbox"/>	6B. IF YES - SPECIFY WAR DATES OF SERVICE WW II		
7A. COUNTY (NYS) Madison	7B. TOWN ONEIDA	7C. CITY OR VILLAGE DOA	7D. LENGTH OF STAY IN TOWN, CITY OR VILLAGE	7E. HOSPITAL OR OTHER INSTITUTION (IF NEITHER, GIVE STREET & NO.) ONEIDA CITY HOSP.	
8. STATE OF BIRTH (COUNTRY, IF NOT USA) N.Y.	9. DECEDENT BORN MONTH DAY YEAR 8 24 20	10. CITIZEN OF WHAT COUNTRY U.S.	11. MARITAL STATUS MARRIED	12. SURVIVING SPOUSE (IF WIFE, MAIDEN NAME) MABEL COLE	
13A. USUAL OCCUPATION (EVEN IF RETIRED) PAINTER		13B. KIND OF BUSINESS OR INDUSTRY OWN BUSINESS		13C. SOCIAL SECURITY NO. 134-10-678	
14A. STATE N.Y.	14B. COUNTY MADISON	14C. TOWN SULLIVAN	14D. CITY OR VILLAGE	14E. WITHIN THE CORPORATE LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	14F. STREET AND NUMBER KIRKVILLE RD
18A. FATHER'S NAME: FIRST MIDDLE LAST John Sched			18B. MOTHER'S MAIDEN NAME: FIRST MIDDLE LAST KATHERINE Houser		
18A. INFORMANT'S NAME: MRS MABEL SCHED			18B. MAILING ADDRESS: (INCLUDE ZIP CODE) RFD 1 KIRKVILLE N.Y.		

PART I. DEATH WAS CAUSED BY ENTER ONLY ONE CAUSE PER LINE FOR (A), (B), AND (C).			APPROXIMATE INTERVAL BETWEEN ONSET & DEATH
17. IMMEDIATE CAUSE (A) VENT. FIRMILLATION DUE TO OR AS A CONSEQUENCE OF (B) Coronary Heart Df DUE TO OR AS A CONSEQUENCE OF (C) Hypertensive Card. vascular Df			
PART II. OTHER SIGNIFICANT CONDITIONS: CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO CAUSE GIVEN IN PART I (A)			18A. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
			18B. IF YES, WERE FINDINGS CONSIDERED IN DETERMINING THE CAUSE OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
19A. ACCIDENT, HOMICIDE, SUICIDE, UNDETERMINED	19B. MONTH DAY YEAR	19C. HOUR	19D. HOW DID INJURY OCCUR? (ENTER NATURE OF INJURIES IN #17 I, OR II.)
19E. INJURY AT WORK? YES <input type="checkbox"/> NO <input type="checkbox"/>	19F. PLACE OF INJURY, HOME, FACTORY, OFFICE BLDG., ETC.		19G. LOCATION (STREET & NO., CITY OR VILLAGE, TOWN, COUNTY, STATE)

20. PART I TO BE COMPLETED BY CERTIFYING PHYSICIAN ONLY		-OR-		20. PART II TO BE COMPLETED BY CORONER OR MEDICAL EXAMINER ONLY	
A. TO THE BEST OF MY KNOWLEDGE, DEATH OCCURRED AT THE TIME, DATE AND PLACE AND DUE TO THE CAUSES STATED SIGNED: <i>[Signature]</i> MONTH DAY YEAR 11 7 73		A. ON THE BASIS OF EXAMINATION AND/OR INVESTIGATION, IN MY OPINION DEATH OCCURRED AT THE TIME, DATE AND PLACE AND DUE TO THE CAUSES STATED. SIGNED: _____ TITLE _____		B. PRONOUNCED DEAD C. HOUR D. DATE SIGNED MONTH DAY YEAR MONTH DAY YEAR MONTH DAY YEAR	
B. THE PHYSICIAN ATTENDED THE DECEASED C. LAST SEEN ALIVE FROM: MONTH DAY YEAR 4 30 71 TO: MONTH DAY YEAR 7 5 72 MONTH DAY YEAR 7 5 72		E. CORONER'S PHYSICIAN, IF OTHER THAN CERTIFIER:			
D. ATTENDING PHYSICIAN: CHARLES C. KALLEY, M.D.		21. NAME AND ADDRESS OF HEALTH CARE FACILITY, MEDICAL EXAMINER, CORONER'S PHYSICIAN, MEDICAL DIRECTOR: BRIDGEPORT MEDICAL CENTER BRIDGEPORT, N. Y. 13030			

22A. BURIAL CREMATION REMOVAL <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	MONTH DAY YEAR 11 10 73	22B. PLACE OF BURIAL, CREMATION OR REMOVAL BRIDGEPORT Cem.	22C. LOCATION (CITY OR TOWN, STATE) BRIDGEPORT, N.Y.
23A. NAME AND ADDRESS OF FUNERAL HOME TRAUB FUNERAL HOME Inc. BRIDGEPORT N.Y.			
24A. NAME OF FUNERAL DIRECTOR GEORGE TRAUB JR.		24B. SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>	24C. REGISTRATION NO. 02789
25A. SIGNATURE OF REGISTRAR <i>[Signature]</i>		25B. DATE FILED MONTH DAY YEAR	25C. BURIAL OR REMOVAL PERMIT ISSUED BY <i>[Signature]</i>
		25D. MONTH DAY YEAR 11 9	

COPY MADE FROM VETERANS CLAIM FOLDER

January 28, 1974

317/21-D427

XG 5 450 700

SCHAD, Edward H., Sr.

Mrs. Mabel C. Schad

RR No. 1

Kirkville, NY 13082

Dear Mrs. Schad:

Receipt from cemetery. Copy has been made and placed in the C folder.

HAROLD P. GREGG
Acting Adjudication Officer

1-30-74
Rm 427

RNYE:mc 1/25/74

COPY MADE FROM
VETERANS CLAIM FOLDER

No. Nov 9 1973

RECEIVED OF Mable Scher

fifty DOLLARS \$ 50.00

for 1/2 of Lot 365 (Boulevard) in Budget

Amt. of Account		
Amt. Paid		
Balance Due		

Cemetery

By Le Roy Stenberg

FORM 78-MR

COPY MADE FROM
VETERANS CLAIM FOLDER

23381 12/13/73



VETERANS ADMINISTRATION
REGIONAL OFFICE
P.O. BOX 1437
ST. PETERSBURG, FLORIDA 33731

Date: January 2, 1974

In Reply
Refer to:

317/21-D406
XC 5 450 700
SCHAD, Edward H., Sr.

Mrs. Mabel C. Schad
RD #1
Kirkville, NY 13032

IMPORTANT
Read the back of this letter

Dear Mrs. Schad:

Please furnish the evidence described below as soon as possible so that further action may be taken on the claim for Veterans Administration plot or interment allowance.

Please provide us a copy of the receipt from the cemetery showing the name of the person or person who paid for the veteran's plot.

Sirs:
This is the only copy I have of this receipt of opening the grave so please make a copy of it and send it back to me. Thank you.
Sincerely,
Mrs Mabel Schad

This evidence should be submitted as soon as possible, preferably within 60 days and in any case it must be received in the Veterans Administration within one year from the date of this letter; otherwise, benefits, if entitlement is established, may not be paid prior to the date of its receipt.

Sincerely yours,

Harold P. Gregg
HAROLD P. GREGG, Acting
Adjudication Officer



FL 21-117
MAY 1971(R)

Show veteran's full name, VA file number, and social security number on all correspondence.

COPY MADE FROM
VETERANS CLAIM FOLDER

January 2, 1974

317/21-D406
XC 5 450 700
SCHAD, Edward H., Sr.

Mrs. Mabel C. Sched
RD #1
Kirkville, NY 13082

Dear Mrs. Sched:

Veterans Administration plot or interment allowance.

Please provide us a copy of the receipt from the cemetery showing the name of the person or person who paid for the veteran's plot.

HAROLD P. GREGG, Acting

cc:
Traub Funeral Home Inc.

FL 21-117
REAMES:kmt 12-20-73

1-2-74
TAS

COPY MADE FROM
VETERANS CLAIM FOLDER

W/R 12/3

P21

VETERANS ADMINISTRATION
APPLICATION FOR BURIAL BENEFITS
 (Under 38, USC, Chapter 23)

1. SOCIAL SECURITY NO. OF VETERAN: **134-10-6782**

2. FILE NO.: **xc- 5 450 700**

IMPORTANT - Read instructions carefully before completing form, YOUR COMPLETE COMPLIANCE WITH ALL INSTRUCTIONS WILL AVOID DELAY.

3. FIRST NAME, MIDDLE NAME, LAST NAME OF DECEASED: **Edward H. Schad, Sr.**

4. FIRST NAME, MIDDLE NAME, LAST NAME OF CLAIMANT: **Traub Funeral Home, Inc.**

PART I - INFORMATION REGARDING VETERAN

5. DATE OF BIRTH: **8/24/20**

6. PLACE OF BIRTH: **Syracuse, NY**

7. DATE OF DEATH: **11/7/73**

8. PLACE OF DEATH: **Oneida, NY**

9. MARITAL STATUS: NEVER MARRIED MARRIED WIDOWED DIVORCED

10. SURVIVING CHILD(REN)? YES NO

11. FIRST NAME, MIDDLE NAME, LAST NAME OF SPOUSE (Complete address, if living): **Mabel Cole Schad R.D.#1 Kirkville, NY**

12. FIRST NAME, MIDDLE NAME, LAST NAME OF FATHER (Complete address, if living): **John Schad**

13. FIRST NAME, MIDDLE NAME, LAST NAME OF MOTHER (Complete address, if living): **Katharine Houser**

SERVICE INFORMATION (The following information should be furnished for the period of the VETERAN'S ACTIVE SERVICE)

14A. ENTERED SERVICE		14B. SERVICE NO.	14C. SEPARATED FROM SERVICE		14D. GRADE, RANK OR RATING ORGANIZATION AND BRANCH, OF SERVICE T/Sgt. Air Corps, AUS, NY 1010th AAF Base Unit
DATE	PLACE		DATE	PLACE	
7/30/42	Syracuse, NY	32-378-461	10/6/45	Plattsburgh, NY	

15. IF VETERAN SERVED UNDER A NAME OTHER THAN THAT SHOWN IN ITEM 3, GIVE FULL NAME AND SERVICE RENDERED UNDER THAT NAME.

PART II - INFORMATION RELATING TO VETERAN'S BURIAL

NOTE - If claiming Plot Allowance Only, do not complete Part II, but complete Part III on reverse.

16. DATE OF BURIAL: **11/10/73**

17. PLACE OF BURIAL: **Bridgport, NY**

18. TOTAL EXPENSE OF BURIAL, FUNERAL, AND TRANSPORTATION: **\$ 1411.00**

19A. HAVE BILLS BEEN PAID IN FULL? YES NO (If "No," fill in 19B)

19B. AMOUNT UNPAID: **\$ 1411.00**

20A. HAS OR WILL ANY AMOUNT BE ALLOWED ON EXPENSES BY STATE OR FEDERAL AGENCY? YES NO (If "Yes," fill in 20B and 20C)

20B. AMOUNT: **\$ 255.00**

20C. SOURCE: **Social Security**

21. WAS THE VETERAN A MEMBER OF A BURIAL ASSOCIATION OR COVERED BY BURIAL INSURANCE? YES NO (Before answering read and comply with instruction No. 9)

NOTE: If claim is made by person who paid the bills fill in 22A and 22B

22A. WHOSE FUNDS WERE USED?

22B. HAS PERSON WHOSE FUNDS WERE USED BEEN REIMBURSED? YES NO (If "Yes," fill in 22C)

22C. AMOUNT AND SOURCE OF REIMBURSEMENT: **\$**

23. WAS BURIAL IN A NATIONAL CEMETERY OR CEMETERY OWNED BY THE FEDERAL GOVERNMENT? YES NO (If "No," complete Item 24.)

24. BURIAL PLOT, MAUSOLEUM, ETC. COST IS: (Check one)
 NONE UNPAID AND DUE CEMETERY OWNER
 PAID BY ANOTHER PERSON OR PERSONS

I CERTIFY THAT the foregoing statements made in connection with this application for burial allowance on account of the above-named veteran are true and correct to the best of my knowledge and belief.

25. SIGNATURE OF CLAIMANT (If signed by mark, complete items 47A thru 48B on reverse): *George Traub, Jr.*

26. FULL NAME OF THE FIRM OR CORPORATION AND OFFICIAL POSITION OR CONNECTION OF THE INDIVIDUAL WHO SIGNS ON ITS BEHALF (See instruction 6): **Traub Funeral Home, Inc. George Traub, Jr., Pres.**

27. ADDRESS (Number and street or rural route, city or P.O., State and ZIP Code): **110 N. Main St. Central Square, NY 13036**

28. CREDITOR OR RELATIONSHIP TO DECEASED: **creditor**

NOTE - Where the claimant is a firm or other unpaid creditor, Items 29 thru 32 MUST be completed by the individual who authorized services.

I CERTIFY THAT the foregoing statements made by the claimant are correct to the best of my knowledge and belief.

29. SIGNATURE OF PERSON WHO AUTHORIZED SERVICES (If signed by mark, complete items 47A thru 48B on reverse.): *Mabel C. Schad*

30. ADDRESS (Number and street or rural route, city or P.O., State and ZIP Code): **R.D.#1, Kirkville, NY 13082**

31. DATE: **11/15/73**

32. RELATIONSHIP TO VETERAN: **wife**

copy made from 1-2-73

COPY MADE FROM VETERANS CLAIM FOLDER

PART III - CLAIM FOR PLOT - INTERMENT ALLOWANCE ONLY

IMPORTANT - Complete only if burial was NOT in a national cemetery or ~~interment~~ provided by the Federal Government.

33. COST OF BURIAL PLOT <i>(Individual Grave Site)</i>		34. DATE OF PURCHASE		35. AMOUNT UNPAID	
\$		CEMETERY GRAVE PURCHASED PRIOR TO DEATH OF VETERAN			
36A. AMOUNT WHICH HAS BEEN PAID		36B. DATE OF PAYMENT		37A. WHOSE FUNDS WERE USED?	
\$		VA REGIONAL OFFICE		37B. HAS PERSON WHOSE FUNDS WERE USED BEEN REIMBURSED? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>(If "Yes," complete 37C)</i>	
37C. AMOUNT AND SOURCE OF REIMBURSEMENT		38A. HAS OR WILL ANY AMOUNT BE ALLOWED ON EXPENSES BY STATE OR FEDERAL AGENCY? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>(Items 38B and 38C)</i>		38B. AMOUNT	
\$				38C. SOURCE	

I CERTIFY THAT the foregoing statements made by the claimant are true and correct to the best of my knowledge and belief.

39. SIGNATURE OF CLAIMANT <i>(If signed by firm, complete Items 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100)</i>		40. FULL NAME OF THE FIRM OR CORPORATION AND OFFICIAL POSITION OR CONNECTION OF THE INDIVIDUAL WHO SIGNS ON ITS BEHALF <i>(See Instructions 4)</i>	
41. ADDRESS <i>(Number and street or rural route, city or P.O., State and ZIP Code)</i>		42. CREDITOR OR RELATIONSHIP TO DECEASED	

NOTE - Where the claimant is a firm or other unpaid creditor, Items 43 thru 46 **MUST** be completed by the individual who authorized services.

I CERTIFY THAT the foregoing statements made by the claimant are correct to the best of my knowledge and belief.

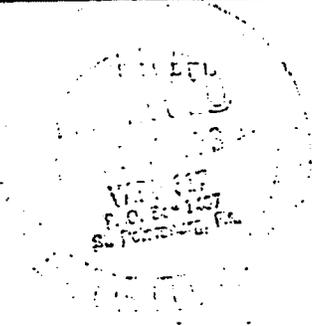
43. SIGNATURE OF PERSON WHO AUTHORIZED SERVICES <i>(If signed by mark, complete Items 47A thru 48B)</i>		44. ADDRESS <i>(Number and street or rural route, city or P.O., State and ZIP Code)</i>	
45. DATE		46. RELATIONSHIP TO VETERAN	

WITNESSES TO SIGNATURE IF MADE BY "X" MARK

NOTE: Signature made by mark must be witnessed by two persons to whom the person making the statement is personally known, and the signatures and addresses of such witnesses must be shown below.

47A. SIGNATURE OF WITNESS		47B. ADDRESS OF WITNESS	
48A. SIGNATURE OF WITNESS		48B. ADDRESS OF WITNESS	

PENALTY - The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement or evidence of a material fact, knowing it to be false.



DISTRICT NO. 2601

Issued Free For Veterans Use Only REGISTERED NO. 212

COPY MADE FROM VETERANS CLAIM FOLDER

1. RECORD NAME

2. FULL NAME, ADDRESS, BIRTH DATE, SEX, RACE, HEIGHT, HAIR, EYES, COMPLEXION

3. TYPE OF SERVICE, BRANCH, GRADE, DATE OF ENTRY, DATE OF DISCHARGE

4. DATE OF BIRTH, PLACE OF BIRTH

5. SOCIAL SECURITY NO.

6. TYPE OF SERVICE, BRANCH, GRADE, DATE OF ENTRY, DATE OF DISCHARGE

7. TYPE OF SERVICE, BRANCH, GRADE, DATE OF ENTRY, DATE OF DISCHARGE

8. TYPE OF SERVICE, BRANCH, GRADE, DATE OF ENTRY, DATE OF DISCHARGE

9. TYPE OF SERVICE, BRANCH, GRADE, DATE OF ENTRY, DATE OF DISCHARGE

10. TYPE OF SERVICE, BRANCH, GRADE, DATE OF ENTRY, DATE OF DISCHARGE

11. TYPE OF SERVICE, BRANCH, GRADE, DATE OF ENTRY, DATE OF DISCHARGE

12. TYPE OF SERVICE, BRANCH, GRADE, DATE OF ENTRY, DATE OF DISCHARGE

13. TYPE OF SERVICE, BRANCH, GRADE, DATE OF ENTRY, DATE OF DISCHARGE

14. TYPE OF SERVICE, BRANCH, GRADE, DATE OF ENTRY, DATE OF DISCHARGE

15. TYPE OF SERVICE, BRANCH, GRADE, DATE OF ENTRY, DATE OF DISCHARGE

16. TYPE OF SERVICE, BRANCH, GRADE, DATE OF ENTRY, DATE OF DISCHARGE

17. TYPE OF SERVICE, BRANCH, GRADE, DATE OF ENTRY, DATE OF DISCHARGE

18. TYPE OF SERVICE, BRANCH, GRADE, DATE OF ENTRY, DATE OF DISCHARGE

19. TYPE OF SERVICE, BRANCH, GRADE, DATE OF ENTRY, DATE OF DISCHARGE

20. TYPE OF SERVICE, BRANCH, GRADE, DATE OF ENTRY, DATE OF DISCHARGE

21. TYPE OF SERVICE, BRANCH, GRADE, DATE OF ENTRY, DATE OF DISCHARGE

22. TYPE OF SERVICE, BRANCH, GRADE, DATE OF ENTRY, DATE OF DISCHARGE

23. TYPE OF SERVICE, BRANCH, GRADE, DATE OF ENTRY, DATE OF DISCHARGE

24. TYPE OF SERVICE, BRANCH, GRADE, DATE OF ENTRY, DATE OF DISCHARGE

25. TYPE OF SERVICE, BRANCH, GRADE, DATE OF ENTRY, DATE OF DISCHARGE

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28. TYPE OF SERVICE, BRANCH, GRADE, DATE OF ENTRY, DATE OF DISCHARGE

29. TYPE OF SERVICE, BRANCH, GRADE, DATE OF ENTRY, DATE OF DISCHARGE

30. TYPE OF SERVICE, BRANCH, GRADE, DATE OF ENTRY, DATE OF DISCHARGE

31. TYPE OF SERVICE, BRANCH, GRADE, DATE OF ENTRY, DATE OF DISCHARGE

32. TYPE OF SERVICE, BRANCH, GRADE, DATE OF ENTRY, DATE OF DISCHARGE

33. TYPE OF SERVICE, BRANCH, GRADE, DATE OF ENTRY, DATE OF DISCHARGE

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35. TYPE OF SERVICE, BRANCH, GRADE, DATE OF ENTRY, DATE OF DISCHARGE

36. TYPE OF SERVICE, BRANCH, GRADE, DATE OF ENTRY, DATE OF DISCHARGE

37. TYPE OF SERVICE, BRANCH, GRADE, DATE OF ENTRY, DATE OF DISCHARGE

38. TYPE OF SERVICE, BRANCH, GRADE, DATE OF ENTRY, DATE OF DISCHARGE

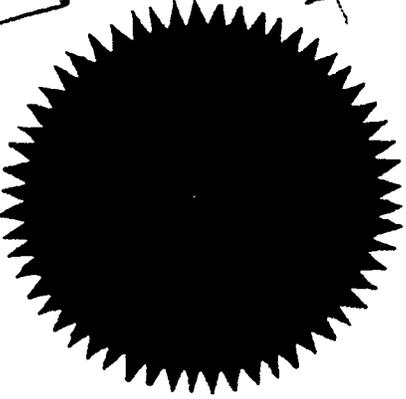
39. TYPE OF SERVICE, BRANCH, GRADE, DATE OF ENTRY, DATE OF DISCHARGE

40. TYPE OF SERVICE, BRANCH, GRADE, DATE OF ENTRY, DATE OF DISCHARGE

41. TYPE OF SERVICE, BRANCH, GRADE, DATE OF ENTRY, DATE OF DISCHARGE

42. TYPE OF SERVICE, BRANCH, GRADE, DATE OF ENTRY, DATE OF DISCHARGE

43. TYPE OF SERVICE, BRANCH, GRADE, DATE OF ENTRY, DATE OF DISCHARGE



STATE OF NEW YORK
MADISON COUNTY
CITY OF ONEIDA CLERK'S OFFICE

I, Elaine M. Garello, Deputy City Clerk of the City of Oneida and Registrar of Vital Statistics, DO HEREBY CERTIFY that I have compared the annexed copy of Death Certificate and the endorsement thereon with the original thereof remaining on file in this office and that the same is a correct transcript thereof and of the whole of such original.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the seal of the City of Oneida, in the city of Oneida, Madison County, this 26th day of Nov. 1973.

Elaine M. Garello
Deputy City Clerk
Registrar of Vital Statistics
City Clerk

62-5450700

TRAUB Funeral Home Inc.

110 N. Main St., CENTRAL SQUARE, NEW YORK, N.Y. 10013 • BERNARDS BLDG., N.Y. 13068 Phone 675-3517
BRIDGEPORT, N.Y. 12030 Phone 633-2311

TYLER-TRAUB Funeral Home - SHUTTENANGO, N.Y. 13027 Phone 687-2011

Register No. 413 FUNERAL SERVICE AGREEMENT

The following is an itemization of the expenditures authorized for the funeral of:

Date 11-9 1973

NAME Edward H. Schaal Sr.

CASH ADVANCES FOR YOUR CONVENIENCE

PLACE OF DEATH Paula City Hosp.

Cemetery: Graves

DATE OF DEATH 11-7-73

Opening \$5.00

CHARGE TO Estate

Equipment \$20.00

ADDRESS Franklin Ave.

ITEMIZED CHARGES

Casket Consolidated Steel \$15.00

Clergy Honorarium \$20.00

Outer Case Amherst Composite \$12.00

Professional Fees \$97.00

Clothing \$25.00

Graveside Expenses \$287.00

Memorial and/or Acknowledgment Cards \$25.00

GRIVE PURCHASE BALANCE

Other \$190.00

PRIOR TO DEATH OF VETERAN

PROFESSIONAL SERVICES

CASH ADVANCES TOTAL \$97.00

Arrangements and Supervision \$10.00

Graveside Expenses \$287.00

Transfer of Decedent \$70.00

Graveside Expenses \$287.00

Embalming \$90.00

Graveside Expenses \$287.00

Other Preparation \$25.00

Graveside Expenses \$287.00

FACILITIES

Graveside Expenses \$287.00

Funeral Home \$190.00

Graveside Expenses \$287.00

Operating of Preparation Room \$25.00

Graveside Expenses \$287.00

MOTOR EQUIPMENT

Graveside Expenses \$287.00

Funeral Coach \$10.00

Graveside Expenses \$287.00

Other Licensed Funeral Coach \$10.00

Graveside Expenses \$287.00

Flower Car \$10.00

Graveside Expenses \$287.00

Passenger Cars & \$ \$10.00

Graveside Expenses \$287.00

TOTAL ITEMIZED CHARGES \$1267.00

Graveside Expenses \$287.00

TO Franklin Ave.
Funeral Director

I hereby agree to pay the above charges for the funeral of the decedent named herein, and I understand that the funeral home is not responsible for the payment of these charges if the decedent is a member of a fraternal organization or a veteran of the United States Army, Navy, Air Force, Marine Corps, or Coast Guard, or if the decedent is a member of a fraternal organization or a veteran of the United States Army, Navy, Air Force, Marine Corps, or Coast Guard, or if the decedent is a member of a fraternal organization or a veteran of the United States Army, Navy, Air Force, Marine Corps, or Coast Guard.

Funeral Director's Signature [Signature]

COPY MADE FROM VETERANS CLAIM FOLDER

December 14, 1973

D406
XC 05 450 700
SHAD, Edward H., Sr.

Mrs. Mabel Shad
RD 1
Kirkville, NY 13082

Dear Mrs. Shad:

x

Sincerely yours,

GUY R. NICHOLS

x

21-15 b1 c, enc 534

Encs:ish 12-14-73

12-14-73
400

COPY MADE FROM
VETERANS CLAIM FOLDER

VA

Form approved.
Budget Bureau No. 76-10487.

**VETERANS ADMINISTRATION
APPLICATION FOR UNITED STATES FLAG FOR BURIAL PURPOSES**

SECTION I—APPLICATION (Postmaster: Be sure to submit both the original and duplicate to the nearest VA Regional Office.)

LAST NAME—FIRST NAME—MIDDLE NAME OF DECEASED (Print or type)

SCHAD EDWARD H. Sr.

DUPLICATE RETURNED IN VA OFFICE

CHECK THE CONDITION UNDER WHICH DECEASED WAS SEPARATED FROM SERVICE

1. VETERAN OF A WAR, MEXICAN BORDER SERVICE, OR OF SERVICE AFTER 1-31-54 DISCHARGED OR RELEASED FROM ACTIVE DUTY UNDER CONDITIONS OTHER THAN DISHONORABLE.

2. DISCHARGED FROM, OR RELEASED FROM ACTIVE DUTY IN U.S. ARMY, AIR FORCE, NAVY, MARINE CORPS, OR COAST GUARD, AFTER SERVING AT LEAST ONE YEAR OF ACTIVE DUTY.

3. BY DEATH IN COMBAT OR WHILE SERVING IN PHILIPPINE MILITARY FORCES, UNDER CONDITIONS OTHER THAN DISHONORABLE, AFTER SERVING UNITED STATES IN SUCH FORCES UNDER PRESIDENT'S ORDER OF JULY 26, 1941, AND DIED ON OR AFTER APRIL 24, 1951.

NAME, ADDRESS, AND RELATIONSHIP BY PERSON ENTITLED TO RECEIVE FLAG (If none, indicate "NONE." See par. 7 of the attached Instructions.)

Mrs. Mabel Schad, R.D.#1, Kirkville, NY 13082

SECTION II—PERSONAL DATA OF DECEASED
(To be filled in if possible)

SERVICE SERIAL NO. **32-378-461**

DATE OF ENLISTMENT **7/17/42**

DATE OF DEATH **11/7/73**

PLACE OF DEATH (Address) **Dundas, NY**

CLAIM NO. **C-**

DATE OF DISCHARGE **10/6/45**

DATE OF BIRTH **8/24/20**

PLACE OF BURIAL (Address) **Bridgport, NY**

SOCIAL SECURITY NO. **134-10-6782**

DATE OF BURIAL **11/10/73**

CERTIFICATION: I CERTIFY THAT, to the best of my knowledge and belief, the statements made above are correct and true; the deceased is eligible in accordance with attached Instructions, for issue of a United States flag for burial purposes, and such flag has not previously been applied for or furnished.

SIGNATURE OF APPLICANT **Scott Trane**

ADDRESS **1000 Broadway**

RELATIONSHIP TO DECEASED **Son**

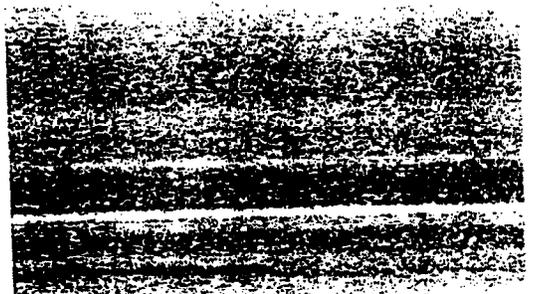
DATE **11-8-73**

PENALTY.—The law provides that whoever makes any statement of a material fact knowing it to be false shall be punished by a fine or by imprisonment or both.

VA FORM 07-2008 SUPPLIES VA FORM 07-2008 MAY 1965 WHICH WILL NOT BE USED.

16-6982-18 ORIGINAL

COPY MADE FROM VETERANS CLAIM FOLDER



SECTION III—ACKNOWLEDGMENT OF RECEIPT OF FLAG

CERTIFICATION

I HEREBY CERTIFY that the flag requested by the applicant will be used to drape the casket of the deceased in whose honor it is issued by the Veterans Administration; and that per. 7 of the attached Instructions will be complied with.

SIGNATURE OF PERSON RECEIVING FLAG

SIGN HERE IN INK *George T. [Signature]*

DATE FLAG RECEIVED
11-8-73

DATE FLAG ISSUED

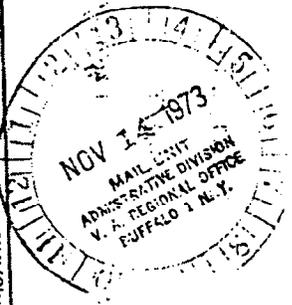
11/8/73

SIGNATURE OF POSTMASTER OR OTHER ISSUING OFFICIAL

SIGN HERE IN INK *E. [Signature]*

ADDRESS

RECEIVED
JUDICATION DIVISION
DEC 11 1973



DATE DUPLICATE IS BEING FORWARDED TO SUPPLY (Date date and in field)

NOV 13 1973

ORIGINAL

11/30/73

121

N/R
R. O. EBERHART

FADDEN AND BRITT, P. C.
ATTORNEYS AT LAW
403-5 TULIP STREET
LIVERPOOL, NEW YORK 13088

457-3500
AREA CODE 315

HENRY C. FADDEN
PHILIP J. BRITT
PETER J. OBERNESSER

November 21, 1973

12/28
Z

Veterans Administration
1021 Main Street
Buffalo, New York 14203

2 3 1 ↓
Re: Edward H. Schad, Sr. Deceased
File No. C-5 450 700 c#
Social Security # 134-10-6782
Date of Death: September 7, 1973

Gentlemen:

Please be advised this office represents the estate of the above decedent who died a resident of Madison County, New York on the 7th day of September, 1973. The surviving spouse has advised us that the decedent received a monthly award at the rate of \$132.00.

Would you be kind enough to advise this office whether the decedent's pension contained any death benefits, and if so, supply the under- signed with the appropriate claim forms.

If you have any questions, please contact me.

Very truly yours,
Philip J. Britt
PHILIP J. BRITT

PJB/cav

COPY MADE FROM
VETERANS CLAIM FOLDER

104

ROUTING: PULL MAIL (231C)

FILE CLERK:

IF FOLDER MARKED XC, DROP FILE.

IF FOLDER NOT MARKED "XC" PULL,
CHARGE TO 231A.

INDEX MESSAGE. JURISDICTION ASSIGNED YOUR OFFICE FOR
SCHAD, EDWARD, H ON WOD ACTION. XC5450700 FOLDER LOCATION
STPETE RO(317). BUFFALO RO(307) WILL SEND WOD MATERIAL TO YOUR
OFFICE.

COPY MADE FROM
VETERANS CLAIM FOLDER

21 St Petersburg
Fla
10/18-71

Mrs Mabel C. Dehad
R.D. # Kerhville, New York 13082
Nov 11, 1971

Mr E.S. Rolader
Veterans Adjudication Officer
Dear Sir:

On June 7, 1971, my husband, Edward Dehad
whose claim number is C.5-450-700 went to the Veterans
hospital for a appointment to be examined by the doctor.
They told him he would hear the results from them in
6 to 8 weeks regarding and we still havnt heard from
them as of yet.

He was examined by Dr Charles Kallet,
Bridgeport Medical Service and was given a full
disability and I sent the papers to you along with
all the information of my marriage certificate and
all the questions I answered regarding my children
along with a copy of my marriage certificate. He
has also received a paid up life insurance from
Prudential Insurance Co because of his disability.

They told me at the Veterans Hospital
in Syracuse that I would hear from the examining
board in six to eight weeks and I have not
heard from no body at all. I am checking to

COPY MADE FROM
VETERANS CLAIM FOLDER

find out if something is wrong or I have to do
if so let me know.

We have been depending on my
pay and I got hurt on my job and I am out on
compensation which I have not received any from
them and I am getting real low on funds and have
no means of support and taking care of us.

Would appreciate any news or
information regarding my husband's claim and
let me know as soon as possible.

Claim Number - C5-450,700

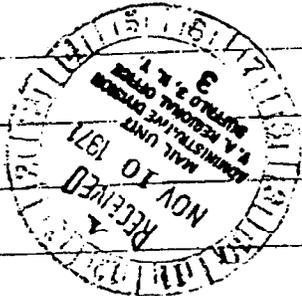
Edward H. Schad Sr

Thank you

Sincerely, Mabel C. Schad

R.D. #1 Kirkville N.Y. Co

13082



November 18, 1971

317/21-2205
C-5 450 700

Mr. Edward H. Schad
P.O. Box 751
Holly Hills, FL 32017

Dear Mr. Schad:

Your disability claim has been reviewed based on all the evidence of record including a Veterans Administration examination.

Increased pension is payable to a veteran if he is in a nursing home or if he is helpless or blind or so nearly so as to require the regular aid and attendance of another person. It must be shown that care or assistance is required on a regular basis to protect the veteran from hazards or dangers incident to his daily environment. The veteran must have a single disability considered permanent which evaluates to 100 percent disabling.

Increased pension because of being housebound is payable to a veteran who is entitled to pension and who is not so disabled as to require aid and attendance. He must have a single or permanent disability rated as 100 percent disabling and an additional disability rated at 60 percent or more, or he must have a single permanent disability rated 100 percent disabling and be permanently housebound by reason of his disabilities.

It has been determined that you do not meet either of the above requirements and, therefore, it is necessary to disallow your claim for increased pension benefits. You will continue to receive disability pension payments at the present rate.

Sincerely yours,

GUY R. NICHOLS
Adjudication Officer

Enclosure
VA Form 21-4107

cc:
VFW

MHostetler:jas 11-17-71

COPY MADE FROM
VETERANS CLAIM FOLDER



VETERANS ADMINISTRATION
REFERENCE SLIP

ROUTE TO		INITIALS-DATE
1.	V.A. REGIONAL OFFICE	
2.	1021 MAIN ST.	
3.	BUFFALO, N.Y. 14203	
4.	C. FILES	
5.	ADJ. PULL MAIL	

REASON FOR REFERENCE

- | | | |
|---------------------------------------|---|---|
| <input type="checkbox"/> APPROVAL | <input type="checkbox"/> CONCURRENCE | <input type="checkbox"/> NOTE AND RETURN |
| <input type="checkbox"/> AS REQUESTED | <input type="checkbox"/> FOR YOUR FILES | <input type="checkbox"/> PER CONVERSATION |
| <input type="checkbox"/> CALL ME | <input type="checkbox"/> INFORMATION | <input type="checkbox"/> RECOMMENDATION |
| <input type="checkbox"/> COMMENTS | <input type="checkbox"/> NECESSARY ACTION | <input type="checkbox"/> SIGNATURE |

PREPARE REPLY FOR SIGNATURE OF

REMARKS

FAILED TO COOPERATE _____

UNDELIVERABLE _____

UNABLE TO KEEP APPT. _____

MOVED TO St. Pete _____

FROM

exam necessary St. Pete.
VA HOSP 670/136A1
IRVING AVE
SYRACUSE, N.Y. 13210

DATE

TEL EX

460

VA FORM
OCT 1968

3230-1

COPY MADE FROM
VETERANS CLAIM FOLDER

NAME Edward H. Chad 10/7/71

SOCIAL SECURITY NUMBER 134-10-6782

I will report for examination at scheduled time and date.

I am unable to report as scheduled.
Please reschedule after 5/5/72

COPY MADE FROM
VETERANS CLAIM FOLDER

NOTE TO REPORT

REPORT TO

2. DATE ISSUED
9/22/71

3. DATE AND TIME TO REPORT
10/7/71 at 1:00 PM

Reception 1st floor
VA Hospital
Irving Ave. & University Pl.
Syracuse, New York 13210

4. TRAVEL AT GOVERNMENT EXPENSE
 IS IS NOT

1. REASON FOR REPORTING
 TREATMENT EXAMINATION
 ADMISSION TO HOSPITAL OR DOMICILIARY

C 5 450 700

AND RETURN

Edward H. Schad
RD 1
Kirbyville, N.Y. 13082

NOTIFY HOSPITAL OR CLINIC IMMEDIATELY IF YOU ARE UNABLE TO KEEP THE SCHEDULED APPOINTMENT - A new appointment will be arranged.
Please complete and mail enclosed card or call 315 476-7461 ext. 421

Please see reverse for instructions.
COLLECT CALLS NOT ACCEPTED

VA FORM 07-3542c
JAN 1969

Sept 29, 1971

COPY MADE FROM
VETERANS CLAIM FOLDER

Sir:

I took a complete physical examination for my pension on June 6, 1971. I am in Florida on advice from Dr to see if I can get some relief from ailments. I cannot be back in New York State until after May 5, 1972.

For some reason I have to take an examination it will have to be here in Florida. Thank you

C. No. 5-750-700
P.O. Box 757
Holly Hills, Florida 32017

S. Lee

UNITED STATES GOVERNMENT

Memorandum

Dr. Newer
10-7-71
100/

TO : Director (170)
VAH, Syracuse, N.Y.

FROM : Acting Adjudication Officer (213)
VARO, Buffalo, N.Y.

SUBJECT: C 5 450 700
SCHAD, Edward H.

DATE: September 7, 1971

W 5 9/21/71

1. VA Form 21-2545, Report of Medical Examination, in the case of the subject veteran, is returned herewith for inclusion of a complete general medical examination, with appropriate tests necessary to furnish a definitive diagnosis with regard to veteran's arthritic condition, described at times as osteoarthritis and at other times as gouty arthritis. Please include history of weight loss, if any, constitutional manifestations, degree of impairment, limitation of motion and other criteria necessary to evaluate.

2. Veteran has a claim pending for special monthly pension for either aid and attendance or housebound benefits.

H. R. LIPSTEIN

Attachment



COPY MADE FROM
VETERANS CLAIM FOLDER



Buy U.S. Savings Bonds Regularly on the Payroll Savings Plan

VETERANS ADMINISTRATION		1A. CLAIM NO.	1B. VETERANS SOCIAL SECURITY NO.		
REPORT OF MEDICAL EXAMINATION FOR DISABILITY EVALUATION		C.	134-10-6782		
		2. INSURANCE FILE NO. (V.H.K. etc., if pertinent)			C
INSTRUCTIONS FOR PREPARING THIS FORM.—This report must be completely executed. Describe the results of a general examination of every system and body part including, but not restricted to, the systems and body parts involved in the history and present complaints. Wherever indicated, specialists' examinations, X-rays, laboratory examinations, etc., should be recommended. If additional space is needed, comments may be continued in item 44 or on separate sheets attached to this form.					
3. LAST NAME—FIRST NAME—MIDDLE NAME OF VETERAN (Type or print)		4. PURPOSE OF EXAMINATION		5. DATE OF EXAMINATION	
SCHAD EDWARD H.					
6. HOME ADDRESS (Street or RFD number, city, State, and ZIP Code)		7. PLACE OF EXAMINATION		8. AGE	
RDI Kirksville N.Y. 13082					
SECTION A—OCCUPATIONAL HISTORY SINCE LATEST DISCHARGE FROM MILITARY SERVICE OR LATEST VA EXAMINATION					
9. NAME AND ADDRESS OF EMPLOYER (If unemployed enter "None".)	10. TYPE OF WORK	11. MONTHLY WAGES	12. DATES OF EMPLOYMENT		14. TIME LOST IN PAST 12 MONTHS
			12. FROM	13. TO	
14B. REASON FOR TIME LOST (If any)					
SECTION B—MEDICAL HISTORY SINCE LATEST VA EXAMINATION AS RELATED BY PERSON EXAMINED					
15. NARRATIVE HISTORY (Include manner and date of origin)					
16A. NAME AND ADDRESS OF DOCTOR OR HOSPITAL		CONDITION TREATED		TO	
16B.					
16C.					
17. PRESENT COMPLAINT (Symptoms only, not diagnosis)		APPROVED G.B. Stevens, M.D. Chief, OE & Adm. Serv. AUG 3 1971			
I HEREBY CERTIFY that the entries under Occupational and Medical History are complete and correct to the best of my knowledge.					
18. DATE SIGNED		19. SIGNATURE OF PERSON EXAMINED (Do not print)			
6/24/71		Edward H. Schad			
PENALTY.—The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement or evidence of a material fact, knowing it to be false, or for the fraudulent acceptance of any payment to which you are not entitled.					

COPY MADE FROM VETERANS CLAIM FOLDER

SECTION C EXAMINATION (Examinee must be stripped)

1. WEIGHT	2. WEIGHT <small>LBS.</small>	3. MAX. WT. PAST YEAR <small>LBS.</small>	4. BUILD AND STATE OF NUTRITION	5. TEMPERATURE
6. CARRIAGE	7. POSTURE	8. GAIT	9. RIGHT- OR LEFT-HANDED—HOW DETERMINED	<small>AT</small> <small>AM</small> <small>PM</small>

10. SKIN—INCLUDING APPENDAGES (Describe type, area, and extent of lesions. Report injuries, including burns, under item 43)

11. LYMPHATIC AND HEMIC SYSTEMS (Describe local or generalized adenopathy, enlargement, tenderness, suppuration, blocking of lymphatic circulation, etc.)

12. HEAD, FACE, AND NECK

13. NOSE, SINUSES, MOUTH, AND THROAT (Include gross dental findings)

13A. EARS (Describe canals, drums, perforations, discharges)	13B. HEARING LOSS NOTED
	<input type="checkbox"/> YES <input type="checkbox"/> NO

14A. EYES (Describe external eye, pupal reaction, movements and field of vision)	14B. DISTANT VISION				
	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%;"><small>R. 20'</small></td> <td style="width:50%;"><small>CORRECTED TO 20'</small></td> </tr> <tr> <td><small>L. 20'</small></td> <td><small>CORRECTED TO 20'</small></td> </tr> </table>	<small>R. 20'</small>	<small>CORRECTED TO 20'</small>	<small>L. 20'</small>	<small>CORRECTED TO 20'</small>
<small>R. 20'</small>	<small>CORRECTED TO 20'</small>				
<small>L. 20'</small>	<small>CORRECTED TO 20'</small>				

15A. CARDIOVASCULAR SYSTEM (Describe thrust, size, rhythm, sounds, and condition of peripheral vessels)

	15B. PULSE	15C. BLOOD PRESSURE	15D. RESPIRATION	15E. IF NOT EXERCISED, GIVE REASON
SITTING		S D		
RECUMBENT		S D		
STANDING		S D		
SITTING AFTER EXERCISE		S D		
2 MIN. AFTER EXERCISE		S D		

16A. VARICOSE VEINS (Describe location, size, extent, ulcers, sores, and competency of deep circulation)	16B. ARE ELASTIC STOCKINGS NECESSARY?
	16C. IS OPERATION RECOMMENDED?

CLINICAL RECORD

6/24/71

Report on NP EXAMINATION

or
Continuation of S. F. _____
(Strike out one line) (Specify type of examination or data)

(Sign and date)

PRESENT COMPLAINT:

Mr. Schad does not offer a present complaint.

HISTORY OF ILLNESS:

This 50-year-old, married, father of four states he's been unemployed for five years. He rambles so much during the interview it is difficult to tell how reliable the material is. He states he is disabled/due to arthritis and nervous condition. He states, "would you hire me," to the interviewer. He states he used to be a painter but he states he's unable to work due to arthritis. He states he was put in Canandaigua VAH about a year ago by his family who were "pushing me around," (approximate quotation). He is very aggressive and uncooperative during the interview. He does not wish to reply to questions but wishes to indulge in a long, irrelevant almost incoherent monologue. He does not wish to be interrupted. At one point he says, "if I could go to Florida everything would be hunky-dory." He states that people bother him. He is too confined. He looks at four walls all the time and listens to snowmobiles, motor boats and lawn mowers outside the house. He states, "when you listen to those all day, "the little putt-putt motors bother you," (approximate quotation). This was approximately what I could glean from his monologue. He states he never took the medication prescribed by Canandaigua. He is not seeing a doctor. He displays a distrustful attitude toward doctors.

NEUROLOGICAL EXAMINATION: Not done.

MENTAL STATUS:

This man is aggressive, evasive and uncooperative. He uses the interview as an uninterrupted monologue which tends to be irrelevant and almost incoherent. It is difficult to make sense out of what he is saying. He would appear to be unemployable. He suffers from arthritis and nervous condition. He gives the above history. Content of thought indicated above. Reference is made to the above paragraph. At one point he states, "would you hire me?" After a long monologue he will then say "is that a good answer to your question?" People bother him. He feels too confined. He feels that snowmobiles, motor boats and lawn mowers are getting on his nerves (approximate quotation). "It's those putt-putt motors," he states. He states he never took the medication prescribed at Canandaigua VAH. "If I could go to Florida everything would be hunky-dory." He gives the date as July 26th. He is disoriented. Affect appears to be restricted. Insight and judgment poor.

DIAGNOSIS: (OVER)

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)

REGISTER NO.

C# 5 450 700

WARD NO.

PENNSION

SCHAD, Edward H. SS# 134 10 6702
VAH OPC SYRACUSE NY 6/29/71 mdeR

REPORT ON _____ or CONTINUATION OF _____
Standard Form 507
507-104

COPY MADE FROM
VETERANS CLAIM FOLDER

DIAGNOSIS:

Schizophrenic reaction, chronic, undifferentiated type.
Organic brain syndrome by history.
Anxiety reaction by history.

It would appear that schizophrenic reaction, chronic, undifferentiated type,
is the correct NP diagnosis.

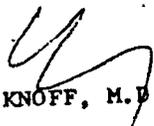
STRESS: Multiple problems.

PERSONALITY: Predisposition not determined.

RESULTANT INCAPECITY: Severe.

COMPETENT.

APPROVED:


W.F. KNOFF, M.D.

EXAMINATION FOR HOUSEBOUND STATUS OR NEED FOR REGULAR AID AND ATTENDANCE

1. LAST NAME - FIRST NAME - MIDDLE NAME SEHAD EDWARD H		2. CLAIM NO. C- 5 450 700	
3. HOME ADDRESS		4. PLACE OF EXAMINATION	5. DATE OF EXAMINATION
6. WAS CLAIMANT ACCOMPANIED TO PLACE OF EXAMINATION? <input type="checkbox"/> YES <input type="checkbox"/> NO (If "Yes," complete Items 7 and 8)		7. NAME OF NURSE OR ATTENDANT	
9. IS CLAIMANT HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO (If "Yes," complete Items 10 & 11)		10. DATE ADMITTED	
		11. NAME AND ADDRESS OF HOSPITAL	

MEDICAL EXAMINER: PLEASE READ CAREFULLY

The purpose of this examination is to record manifestations and findings pertinent to the question of whether the claimant is housebound or in need of the regular aid and attendance of another person. Findings should be recorded to show whether the claimant is blind or bed-ridden. The report should be in sufficient detail to determine whether there is disease or injury producing physical or mental impairment, loss of coordination or enfeeblement affecting ability to dress and undress, to feed himself, to attend to the wants of nature and keep himself ordinarily clean and presentable.

In addition, it is necessary to determine whether the claimant is "housebound", that is, whether he is confined to his home or immediate premises.

In either instance, whether the claimant is claiming housebound or aid and attendance benefits, the report should reflect how well the individual ambulates, where he goes and what he is able to do during a typical day.

12. INDIVIDUAL'S COMPLAINT: <i>(1) Complaint of pain & stiffness hands, elbows & shoulders of both hands. (2) Poor hearing, especially on right side.</i>			
13. AGE 50	14. WEIGHT ACTUAL: 154 LBS. ESTIMATED: _____ LBS.	15. HEIGHT FT: 5 INCHES: 7 1/2	
16. NUTRITION <i>Good</i>		17. GAIT <i>Steady</i>	
18. BLOOD PRESSURE 175/40	19. PULSE RATE 90	20. RESPIRATORY RATE	21. NUMBER OF HOURS IN BED FROM 9 PM TO 9 AM: _____ FROM 9 AM TO 9 PM: _____
22. POSTURE AND GENERAL APPEARANCE <i>Posture good</i>			

EXTREMITIES AND SPINE

23. DESCRIBE RESTRICTIONS OF EACH UPPER EXTREMITY WITH PARTICULAR REFERENCE TO GRIP, FINE MOVEMENTS, AND ABILITY TO FEED HIMSELF, BUTTON CLOTHING, SHAVE AND ATTEND TO THE NEEDS OF NATURE.

He is able to feed self, shave, button & take care of his own needs of nature. Has many trophies on hands, wrists & elbows but he makes a fist without difficulty, good wrist motion, elbows flex normally & raises arms over head's difficulty.

24. DESCRIBE RESTRICTIONS OF EACH LOWER EXTREMITY WITH PARTICULAR REFERENCE TO EXTENT OF LIMITATION OF MOTION, ATROPHY, CONTRACTURES OR OTHER INTERFERENCE. IF INDICATED, COMMENT SPECIFICALLY ON WEIGHT BEARING, BALANCE AND PROPULSION OF EACH LOWER EXTREMITY.

Has many trophies on hands, wrists & elbows but he makes a fist without difficulty, good wrist motion. Was also many trophies of feet. Walks without limp; can stand on one leg. Also knee bends & can walk on toes & heels.

COPY MADE FROM VETERANS CLAIM FOLDER

EXTREMITIES AND SPINE (Continued)

23. DESCRIBE RESTRICTION OF THE SPINE, TRUNK AND NECK

No restriction of neck. Forward bending with finger tips touching the floor.

26. SET FORTH ALL OTHER PATHOLOGY INCLUDING THE EFFECTS OF ADVANCING AGE, SUCH AS DIZZINESS, LOSS OF MEMORY, POOR BALANCE WHICH AFFECTS CLAIMANT'S ABILITY TO PERFORM SELF-CARE, AMBULATE OR TRAVEL BEYOND THE PREMISES OF HIS HOME OR IF HOSPITALIZED BEYOND THE WARD OR CLINICAL AREA. DESCRIBE WHERE HE GOES AND WHAT HE DOES DURING A TYPICAL DAY. (Use additional sheet if necessary)

Does not lose memory, no headaches or dizziness. Can walk several blocks but claims joints pain and become stiff by spells.

METHOD OF AMBULATION

27. IS HE ABLE TO WALK WITHOUT THE ASSISTANCE OF ANOTHER PERSON?

YES NO (If "Yes," give distance) 1 BLOCK 5 OR 6 BLOCKS 1 MILE OTHER (Specify distance)

28. DESCRIBE HOW OFTEN PER DAY OR WEEK AND UNDER WHAT CIRCUMSTANCES HE IS ABLE TO LEAVE HIS HOME OR IMMEDIATE PREMISES

at will.

29. ARE AIDS SUCH AS CANE, BRACES, CRUTCHES OR WALKER REQUIRED FOR LOCOMOTION? (If so, specify and describe effectiveness in terms of distance that can be traveled as in Item 27 above.)

Does not use aids.

30. ADDITIONAL REMARKS

My feeling is that besides the leg his main problem is associated with his nervous or mental difficulty. This was not evaluated today and was not scheduled.

31. DIAGNOSES

- (1) Arthritis - would respect joint.
- (2) Nervous disorder not evaluated.

32. SIGNATURE OF EXAMINING PHYSICIAN

C. J. Hitt (Signature)

33. TITLE

Attach Continuation Sheets, Specialists' Reports, Laboratory Reports, etc., in this space.

<p>37A. RESPIRATORY SYSTEM (Describe cough, expectoration, mobility, palpation, percussion, and auscultation and specify area)</p>	<p>37B. SHAPE OF CHEST</p>
	<p>37C. EXPIRATION</p> <p style="text-align: right;">INCHES</p>
	<p>37D. INSPIRATION</p> <p style="text-align: right;">INCHES</p>
<p>38. DIGESTIVE SYSTEM (Describe findings on inspection and palpation, enlargements, masses, tenderness, rigidity, hemorrhoids (internal or external), fissures, strictures, prostates, etc.)</p>	
<p>39. HERNIA (Describe type, location, size, whether complete, reducible, recurrent, retained by truss, and whether operable)</p>	
<p>40. GENITO-URINARY SYSTEM (Describe kidneys, bladder, prostate, seminal vesicles, testes, cord, penis, and appendages; evidence of past or present venereal disease; in females report pelvic exam., if indicated)</p>	
<p>41. MUSCULO-SKELETAL SYSTEM</p> <p>A—DISEASES and INJURIES. include effect of gunshot wounds and other injuries on skin and underlying structures.</p> <p>B—SCARS. describe location, measurements, depression, type of tissue loss, adherence, displacement, and tenderness.</p> <p>C—FUNCTIONAL EFFECTS. describe location, swelling, atrophy, tenderness, degree of limitation of flexion and extension, angle of fixation, fracture or dislocation, abrasion or bony residual, and specify mechanical aid used and benefit.</p> <p>D—FEET. describe objective evidence of pain at rest and on manipulation, rigidity, spasm, circulatory disturbance, swelling, callus, strength, mobility of ankles, feet, toes, and indicate whether right or left, acquired or congenital.</p> <p>E—BURNS. degree and area in square inches.)</p>	
<p>42. ENDOCRINE SYSTEM (Describe disease of thyroid, pituitary, adrenals, pancreas, gonads, etc.)</p>	

COPY MADE FROM VETERANS CLAIM FOLDER

HEAD SUBJECT RECORD

III. NERVOUS SYSTEM

(A—**NEUROLOGICAL**, describe motor status, coordination, reflexes, sensory status, equilibrium, and give past location.
 B—**PSYCHIATRIC** and **PERSONALITY**, describe behavior, comprehension, coherence of response, emotional reaction, orientation, memory, signs of tension and status as to social and industrial capacity.)

44. REMARKS (Give number of item continued in this space)

43A. LABORATORY TESTS, X-RAYS, BMR, EKG, ETC.	43B. DATE MADE	43C. URINALYSIS		
		SPECIFIC GRAVITY	ALBUMIN	SUGAR
		MICROSCOPIC		

45. OTHER TESTS RECOMMENDED, ETC.

46. DIAGNOSIS

47A. IS EXAMINEE BEDRIDDEN?	47B. IS HOSPITALIZATION NEEDED?	47C. WILL EXAMINEE ACCEPT HOSPITALIZATION?
48A. IS EXAMINEE ABLE TO TRAVEL?	48B. ALONE?	48C. WITH ATTENDANT?

49. SPECIALISTS EXAMINATIONS RECOMMENDED

SIGNATURE OF PHYSICIAN	NAME AND SPECIALTY (Type or print)	DATE SIGNED
SIGNATURE OF REVIEWING OFFICER	NAME AND TITLE (Type or print)	DATE SIGNED

50. ATTACHMENTS MADE A PART OF THIS EXAMINATION (List by number or describe)

REQUEST FOR AND/OR NOTICE OF TRANSFER OF VETERANS RECORDS

ITEM NO.	STATION NAME AND NO. <small>(Include mail routing symbol on temporary transfers only.)</small>	DATE						
1	VARO ST. PETERSBURG FL 317	10/19/71						
2								
3								
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;">4. DATE OF TRANSFER (37-42)</td> <td style="width: 33%;">5. TRF. STA. NO. (44-46)</td> <td style="width: 33%;">6. REC. STA. NO. (48-50)</td> </tr> <tr> <td style="text-align: center;">1 0 1 9 7 1</td> <td style="text-align: center;">3 0 7 3 1 7</td> <td style="background-color: #cccccc;"></td> </tr> </table>			4. DATE OF TRANSFER (37-42)	5. TRF. STA. NO. (44-46)	6. REC. STA. NO. (48-50)	1 0 1 9 7 1	3 0 7 3 1 7	
4. DATE OF TRANSFER (37-42)	5. TRF. STA. NO. (44-46)	6. REC. STA. NO. (48-50)						
1 0 1 9 7 1	3 0 7 3 1 7							
7. NAME OF REC. STA. (52-58)		8. FILE NO. (60-68)						
S T P E T E R		005 450 700						
9A. LAST NAME (71-80)								
SCHAD								
9B. FIRST NAME (69)		9C. MIDDLE NAME (70)						
E		H						
10. TYPE OF FOLDER		11. TYPE TRANSFER						
<input checked="" type="checkbox"/> C-XC <input type="checkbox"/> DE <input type="checkbox"/> R&E <input type="checkbox"/> INS. <input type="checkbox"/> LG <input type="checkbox"/> PG <input type="checkbox"/> OPT <input type="checkbox"/> MED. REC. <input type="checkbox"/> HOSP. CORRES. <input type="checkbox"/> OTHER (Specify)		<input checked="" type="checkbox"/> PERMANENT <input type="checkbox"/> TEMPORARY						
12. REASON FOR TRANSFER								
VET RESIDES EXAM. NECESSARY								
NOTE: If file number is unknown, complete items 13A through 13D.								
13A. DATE OF BIRTH		13B. DATE OF ENLISTMENT						
13C. DATE OF DISCHARGE		13D. SERVICE NO.						
14. REMARKS								
15. ADJUDICATION ACTION PENDING		16. CHAPTER 31						
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> (If checked, remove status card.)						
17. FROM (Originating Office)		18. DATE						
VARO BUFFALO NY 307		10/18/71						

VA FORM 07-7216
JAN 1969

SUPERSEDES VA FORM 23-7216, APR 1966, AND
FL 10-68, JUN 1957, WHICH WILL NOT BE USED.

C-C Posted 10/19/71

COPY MADE FROM VETERANS CLAIM FOLDER

STATUS OF REQUESTS FOR PHYSICAL EXAMINATIONS		DATE 10-4-71
TO Chief Medical Officer VA HOSPITAL SYRACUSE NY	FROM Adjudication Officer VARO BELO NY	
NAME OF VETERAN EDWARD H SCHA D		CLAIM NUMBER C. 5450700
VA FORM 21-2507 REQUESTING EXAMINATION OF VETERAN HAS NOT BEEN RETURNED TO ADJUDICATION DIVISION. KINDLY ADVISE STATUS BY COMPLETING LOWER PORTION OF FORM.		DATE
AT ONCE - INITIAL CLAIM - VA FORM 21-2507 ISSUED		
✓ AT ONCE - VA FORM 21-2507 ISSUED & memo		5-14-71 9-7-71
FUTURE EXAMINATION SCHEDULED FOR		
PREVIOUS FOLLOW-UP BY ADJUDICATION DIVISION		
ADJUDICATION OFFICER Doyle B Stogler		
TO Adjudication Officer		DATE
STATUS OF VA FORM 21-2507 IS AS FOLLOWS:		
INDICATE DATE COMPLETED EXAMINATION WILL BE FORWARDED		SIGNATURE OF CHIEF MEDICAL OFFICER

VA FORM 21-4199
JAN 1966

EXISTING STOCKS OF VA FORM 21-4199,
APR 1962, WILL BE USED.

1220
10-4-71

COPY MADE FROM
VETERANS CLAIM FOLDER

Director (170)
VAH, Syracuse, N.Y.

September 7, 1971

Acting Adjudication Officer (213)
VARO, Buffalo, N.Y.

C 5 450 700
SCHAD, Edward H.

1. VA Form 21-2545, Report of Medical Examination, in the case of the subject veteran, is returned herewith for inclusion of a complete general medical examination, with appropriate tests necessary to furnish a definitive diagnosis with regard to veteran's arthritic condition, described at times as osteoarthritis and at other times as gouty arthritis. Please include history of weight loss, if any, constitutional manifestations, degree of impairment, limitation of motion and other criteria necessary to evaluate.

2. Veteran has a claim pending for special monthly pension for either aid and attendance or housebound benefits.

H. R. LIPSTEIN

Attachment

120P
9-8-71
JLW

ELK

ELKassirer:hc 9-1-71

COPY MADE FROM
VETERAN'S CLAIM FOLDER

2/21

STATUS OF REQUESTS FOR PHYSICAL EXAMINATIONS		DATE
TO	Chief Medical Officer <i>VAH Sgt M W att exam req</i>	Adjudication Officer <i>VARI Gplo W Jy.</i>
NAME OF VETERAN <i>SCHAD EDWARD H</i>		CLAIM NUMBER <i>C- 5450700</i>
VA FORM 21-2507 REQUESTING EXAMINATION OF VETERAN HAS NOT BEEN RETURNED TO ADJUDICATION DIVISION. KINDLY ADVISE STATUS BY COMPLETING LOWER PORTION OF FORM.		DATE
<input type="checkbox"/>	AT ONCE - INITIAL CLAIM - VA FORM 21-2507 ISSUED	
<input checked="" type="checkbox"/>	AT ONCE - VA FORM 21-2507 ISSUED	<i>5-14-71</i>
<input type="checkbox"/>	FUTURE EXAMINATION SCHEDULED FOR	
PREVIOUS FOLLOW-UP BY ADJUDICATION DIVISION		
ADJUDICATION OFFICER <i>R. Hunter</i>		
TO	Adjudication Officer	DATE
STATUS OF VA FORM 21-2507 IS AS FOLLOWS:		
<i>no scheduled for examination 7/15/71</i>		
<i>1208 7-21-71 D.H.</i>		
INDICATE DATE COMPLETED EXAMINATION WILL BE FORWARDED		SIGNATURE OF CHIEF MEDICAL OFFICER
<i>7/15/71</i>		<i>J. S. Korman</i>

VA FORM
JAN 1966

21-4199

EXISTING STOCKS OF VA FORM 21-4199,
APR 1962, WILL BE USED.

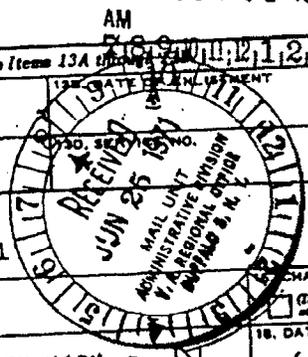
427903

COPY MADE FROM
VETERANS CLAIM FOLDER

*Suspense
6/23/71
St. R. 6/17/71*

REQUEST FOR AND/OR NOTICE OF TRANSFER OF VETERANS RECORDS

ITEM NO.	STATION NAME AND NO. <small>(Include mail routing symbol on temporary transfers only.)</small>	DATE
1	VAB SYRACUSE, NEW YORK	
2	VAB SYRACUSE, NEW YORK	6/23/71
3	VABO BUFFALO, NEW YORK	
4. DATE OF TRANSFER (37-42)		5. TRF. STA. NO. (44-46)
7. NAME OF REC. STA. (52-58)		8. FILE NO. (60-68) 5 450 700
9A. LAST NAME (71-80) SCHAD		
9B. FIRST NAME (69) Edward		9C. MIDDLE NAME (70) H.
10. TYPE OF FOLDER <input checked="" type="checkbox"/> C-XC <input type="checkbox"/> OE <input type="checkbox"/> R&E <input type="checkbox"/> INS. <input type="checkbox"/> LG <input type="checkbox"/> OPT <input type="checkbox"/> MED. REC. <input type="checkbox"/> HOSP. CORRES. <input type="checkbox"/> OTHER (Specify)		11. TYPE TRANSFER <input type="checkbox"/> PERMANENT <input checked="" type="checkbox"/> TEMPORARY V. A. HOSPITAL Syracuse, N. Y.
12. REASON FOR TRANSFER JUN. 24 1971		
NOTE: If file number is unknown, complete items 13A through 13E.		
13A. DATE OF BIRTH		13B. DATE OF ENLISTMENT
13C. DATE OF DISCHARGE		13D. SERVICE NO.
14. REMARKS MEDICAL EXAM. 6/24/71		
15. ADJUDICATION ACTION PENDING <input type="checkbox"/> YES <input type="checkbox"/> NO		16. DATE 6-15-71
17. FROM (Originating Office) 136A4 VAB SYRACUSE, NEW YORK		18. DATE 6-15-71



VA FORM 07-7216
JAN 1966

SUPERSEDES VA FORM 22-216, APR 1966, AND FL 10-66, JUN 1967, WHICH WILL NOY BE USED.

COPY MADE FROM VETERANS CLAIM FOLDER

21



VETERANS ADMINISTRATION
REGIONAL OFFICE
1001 Main Street
Buffalo, New York 14203

Date: April 27, 1971

In Reply
Refer to: 307/214
C-5 450 700

Mr. Edward H. Schad
RD #1, Kirkville Road
Kirkville, NY 13082

IMPORTANT
Read the back of this letter

Please furnish the evidence described below as soon as possible so that further action may be taken on the ~~claim~~ recent letter regarding your disability.

Please furnish us with medical evidence regarding your condition. This may be either a medical report from your family physician or if you were recently hospitalized please have the hospital furnish us with this report.

Here is your report.

*Sincerely,
Mr. Edward H. Schad*

This evidence should be submitted as soon as possible, preferably within 30 days and in any case it must be received in the Veterans Administration within one year from the date of this letter; otherwise, benefits, if entitlement is established, may not be paid prior to the date of its receipt.

R. Huber
R. HUBER
Adjudication Officer

CC:
VFW

126 5-177
[Handwritten signature]
5-14-71

FL 21-117
NOV 1970(R)

COPY MADE FROM
VETERANS CLAIM FOLDER

Show veteran's full name, VA file number, and social security number on all correspondence.

C. C. KALLET, M. D.
BRIDGEPORT MEDICAL CENTER
HOURS: BY APPOINTMENT
BRIDGEPORT, N. Y.
PHONE 833-2812

FOR Edward S. Good DATE 4/30/71

ADDRESS 70 Windward Green

Rx
pt has severe osteoarthritis
of hands + feet + elbows.
He has large masses + nodules
around joints + skin
Soft Tissues - breasts
& very painful.
also joints, arthritis
This patient
is in respiratory trouble.

1	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>	4	<input type="checkbox"/>	Times
P. R. N.	<input type="checkbox"/>	Non. Rep.	<input type="checkbox"/>					
REFILLED								

COPY MADE FROM
VETERANS CLAIM FOLDER

CHARLES C. KALLET, M. D.
BRIDGEPORT MEDICAL CENTER
BRIDGEPORT, NEW YORK 13030
TELEPHONE 633-2812

4/30/71

Re: Mr. Edward Schad.

The above named patient was first seen in this office today. In my opinion he is totally disabled. We have no previous reports. The patient has been seen at the U.A. Hospital in the past and discharged in 1970 with a 40% disability due to his arthritis, Patient states.

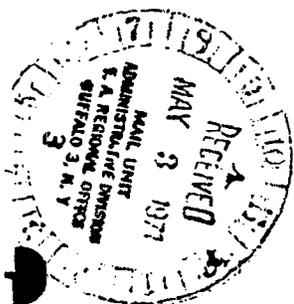
On exam the patient has severe osteo-arthritis of hands feet and elbows. He has large masses and nodules around joints and soft tissue - swelling, restriction and pain. Also Euly arthritis. We question other probable diagnosis due to masses and nodules but could not make a statement on this at this time since

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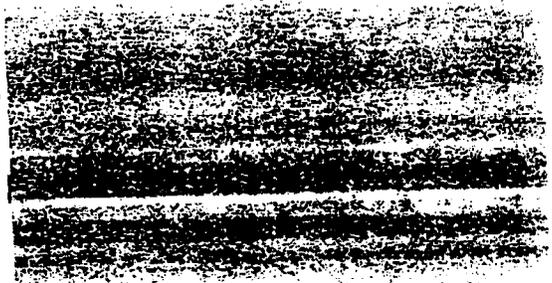
we do not have previous reports and patient is financially unable to continue medical care or have additional studies done. He continues at U.A.
In my opinion this patient is totally disabled.

CHARLES C. KALLET, M.D.
BRIDGEPORT MEDICAL CENTER
BRIDGEPORT, N. Y. 13030

Charles C. Kallet



COPY MADE FROM
VETERANS CLAIM FOLDER



Pension

dy

1. LAST NAME - FIRST NAME - MIDDLE NAME OF VETERAN SCHAD EDWARD H.		7. SEX M	8. CLAIM NO. C-5450700
2. ADDRESS OF VETERAN (Street, City, State and ZIP Code) RD #1, KIRKVILLE Rd KIRKVILLE, NY 13082		9. DATE OF RECEIPT	10. DATE ECHED. OR AUTH.
3. TYPE OF EXAMINATION (Include X-ray and laboratory tests desired) <input checked="" type="checkbox"/> GEN <input type="checkbox"/> OI <input type="checkbox"/> NOSE & THROAT <input type="checkbox"/> EYE <input type="checkbox"/> PV <input type="checkbox"/> CV <input type="checkbox"/> ORTHO <input type="checkbox"/> HEAR-TO-LOGIC <input type="checkbox"/> SKIN <input type="checkbox"/> SUHO <input type="checkbox"/> GU <input type="checkbox"/> NEURO <input type="checkbox"/> EAM <input type="checkbox"/> DENTAL <input type="checkbox"/> OTHER (Specify)		11. PLACE OF EXAMINATION (Check one) <input type="checkbox"/> CLINIC <input type="checkbox"/> FEE STATION <input type="checkbox"/> OTHER STATION	12. NAME OF FEE EXAMINER OR OTHER STATION
4. REMARKS (Include list of service-connected disabilities and in pension cases list extent of disability) <i>Other activities of hands, feet, and elbows from arthrits Scolophanes, middle toes Vet Sec 109 for disability pension</i>		13. EXAMINATION SCHEDULED <input checked="" type="checkbox"/> AT ONCE <input type="checkbox"/> OTHER (Specify date)	14. PURPOSE OF EXAMINATION (Check appropriate boxes) <input type="checkbox"/> TERMINAL <input type="checkbox"/> ORIGINAL <input type="checkbox"/> REOPENED <input type="checkbox"/> FUTURE <input type="checkbox"/> POW <input type="checkbox"/> ORIGINAL (N.S.C.) <input checked="" type="checkbox"/> INCREASE <input type="checkbox"/> OTHER (Specify)
5A. SIGNATURE OF AUTHORIZING OFFICIAL R. Hudson	5B. SIGN. AND BOARD NO.	5C. DATE	15. YEAR OF BIRTH 1920
6A. ORIGINAL OFFICE VHRO Buffalo, NY	6B. DATE 5-14-71	16. PERIOD OF SERVICE EOD (Mo. Yr.) 7 42	17. PERIOD OF SERVICE RAD (Mo. Yr.) 10 45
18. REQUIRE MEDICAL EXAMINATION OF COMPETENCY (NEED FOR AID AND ATTENDANCE AND HOUSEHOLD MAINTENANCE) (See VA Form 21-2800)		19. CLAIMANT REPRESENTED BY <input type="checkbox"/> AL <input checked="" type="checkbox"/> VFW <input type="checkbox"/> DAV <input type="checkbox"/> ANC <input type="checkbox"/> AM-VETS <input type="checkbox"/> OTHER (Specify)	

VETERANS ADMINISTRATION

REGIONAL OFFICE
1221 Main Street
Buffalo, New York 14201



Date: April 27, 1971

In Reply
Refer to:

307/214
C-5 450 700

Mr. Edward H. Sobad
ED #1, Kirkville Road
Kirkville, NY 13082

IMPORTANT

Read the back of this letter

Please furnish the evidence described below as soon as possible so that further action may be taken on the ~~claim~~ recent letter regarding your disability.

Please furnish us with medical evidence regarding your condition. This may be either a medical report from your family physician or if you were recently hospitalized please have the hospital furnish us with this report.

This evidence should be submitted as soon as possible, preferably within 30 days and in any case it must be received in the Veterans Administration within one year from the date of this letter; otherwise, benefits, if entitlement is established, may not be paid prior to the date of its receipt.

R. HUBER
Adjudication Officer

OCJ
YFW

FL 21-117
NOV 1970(R)

Show veteran's full name, VA file number, and social security number on all correspondence.
PZiegelhofer:kg 4-21-71

COPY MADE FROM
VETERANS CLAIM FOLDER

21

Mrs Mabel E. Schad
Rt 1 Kirkville N.Y.
13082

Veterans Administration 5-450-700
1021 Main St
Buffalo New York



Dear Sir -

I am writing this letter to let you know that my husband, Edward H. Schad, File No. 705450700 00307 is in very bad condition and I am going to have to quit my job and stay home and take care of him. He has more bumps coming on his hands & feet & arms and he is always in pain. I would like to know if he will receive more pay as he can't hardly walk & do anything. He is receiving \$132 a month as of 1-01-71. I would appreciate your help as it is hard for me to work & try to care for him at the same

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VETERANS CLAIM FOLDER

time. He has big ~~is~~ bumps on the bottom
of his toes & can hardly get his shoes on
I don't believe he will ever be able to
work again. He is in pain all the
time. I would appreciate it if you
could arrange for him to have more
pay so that I can stay home & take care
of him the right way. He is really in
a very bad way. He is all crippled up.
Please send me any information at all
I would appreciate it.

Thank you
Mrs. Mabel Schaal

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VETERANS CLAIM FOLDER

Mrs. Mabel Schach
P.O. # Kitchell N.Y.
13082

Veterans Administration Regional Office
1021 Main St.
Buffalo, New York.

Dear Sirs:

I have filled in the papers to the best of my knowledge & the amount made for the year of 1970 & 71. I could be laid off tomorrow as work is very slow and then again I may not be. As for my husband he also estimated his profit well I don't believe he will even make that unless he feels better.

Mrs. Mabel or (Mable)
Schach

COPY MADE FROM
VETERANS CLAIM FOLDER

 This Certifies that 

Edward Harold Schach
of Syracuse, N.Y.
and
Mable Jerome Cole
of Syracuse, N.Y.
were by me united in 

Holy Matrimony

 at Syracuse
According to the Ordinance of God
and the laws of New York
on the 13th day of December
in the year of Our Lord 1944. 

Alfred L. Taylor minister
Witnesses

Mrs. Charles Whelton

Mr. John Handenburgh

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VETERANS CLAIM FOLDER

VETERANS ADMINISTRATION DECLARATION OF MARITAL STATUS			1. FILE NO. C-5 450 700
INSTRUCTIONS: This form must be completed and returned to the VA Office shown in Item 3. Inasmuch as documentary evidence of marriage and the birth of any child of the veteran and of step-children and children adopted into or out of the family is necessary to substantiate existing status, it is requested that the claimant obtain and submit such documents as required to complete this form. It will not be necessary to furnish documents previously submitted. Certified copies of public records may usually be obtained free if the county clerk or similar custodian of such records is informed that they are required by the Veterans Administration in determining eligibility for benefits.			
2. NAME AND ADDRESS OF CLAIMANT TO — Mrs. Mabel Schad R. D. #1, Kirkville Road Bridgeport, NY 13082		3. ORIGINATING VA OFFICE (Include symbol) VAO, 1021 Main Street Buffalo, NY 14203	
		4. MARITAL STATUS (Check one) <input type="checkbox"/> NEVER (If so, do not complete 5 MARRIED through 10) <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED	
		5. NUMBER OF TIMES YOU HAVE BEEN MARRIED	6. NUMBER OF TIMES YOUR PRESENT SPOUSE HAS BEEN MARRIED None
NOTE: Furnish the following information about each of your marriages and certified copy of the public or church record of your current marriage.			
7A. DATE AND PLACE OF MARRIAGE	7B. TO WHOM MARRIED	7C. HOW MARRIAGE TERMINATED (Death, divorce)	7D. DATE AND PLACE TERMINATED
12/13/41 Syracuse New York 1941	Edward Harold Schad Sr		
NOTE: Furnish the following information about each previous marriage of your present spouse.			
8A. DATE AND PLACE OF MARRIAGE	8B. TO WHOM MARRIED	8C. HOW MARRIAGE TERMINATED (Death, divorce)	8D. DATE AND PLACE TERMINATED
9A. DO YOU LIVE TOGETHER? (Answer only if married) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO (If "No," fill in 9B and 9C)		9B. REASON FOR SEPARATION	9C. AMOUNT YOU CONTRIBUTE TO YOUR WIFE'S SUPPORT MONTHLY \$
10. ADDRESS OF PRESENT SPOUSE (If different than item 2)			
11. HAVE YOU ANY CHILD OR CHILDREN (Check) <input type="checkbox"/> UNDER 18 YEARS OF AGE AND UNMARRIED? <input type="checkbox"/> OVER 18 AND UNDER 23 UNMARRIED AND ATTENDING SCHOOL? <input type="checkbox"/> OF ANY AGE PERMANENTLY HELPLESS FOR MENTAL OR PHYSICAL REASONS?			
NOTE - If any block in item 11 is checked, furnish the following information for each child and submit a certified copy of (1) public record of birth, or (2) church record of baptism, or (3) court record of adoption, with the form unless such documentary evidence has been submitted previously.			
12A. FULL NAME OF EACH CHILD	12B. DATE OF BIRTH	12C. PLACE OF BIRTH	12D. NAME AND ADDRESS OF PERSON HAVING CUSTODY OF CHILD
CERTIFICATION: I hereby certify that the foregoing statements are true and correct to the best of my knowledge and belief.			
13. DATE June 20/1970	14. SIGNATURE OF CLAIMANT (Do not print) Mrs. Mabel Schad		
PENALTY - The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement or evidence of a material fact, knowing it to be false, or for the fraudulent acceptance of any payment to which you are not entitled.			

VA FORM 21-686c
OCT 1969

EXISTING STOCKS OF VA FORM 21-686c,
MAR 1969, WILL BE USED.

472261

COPY MADE FROM VETERANS CLAIM FOLDER

SUPPALS
 TRANS 5-450-700
 JUN 25 1970

R. C. [Signature]
 9/16

VAH [Signature] 6/16
 Form approved by
 Budget Bureau No. 76-R6481

MILITARY FILES TRANS ADMINISTRATION
STATEMENT OF INCOME AND NET WORTH - DISABILITY

FILE NUMBER
 c-5 450 700
 VETERAN'S SOCIAL SECURITY NUMBER

IMPORTANT: Read instructions on reverse before completing this form. All items should be answered fully.
 For additional space attach a separate sheet of paper indicating part numbers to which items apply.

NAME OF VETERAN (Last, First, Middle)
SCHAD, Edward H., Sr.
 NAME OF VETERAN'S WIFE
Michael Schaad

PART I - INCOME RECEIVED AND EXPECTED

LINE NO.	SOURCE	AMOUNT RECEIVED		AMOUNT RECEIVED AND EXPECTED		AMOUNT EXPECTED NEXT YEAR	
		VETERAN	WIFE	VETERAN	WIFE	VETERAN	WIFE
1	TOTAL WAGES (Report total income and not "take home pay")	1-1 to 2-10-70 \$ None	\$ 727	2-11 to 2-31-70 \$ None	\$ 56877	Est- 1971 \$ 500	Est- \$ 570564
2	SOCIAL SECURITY	None		None	None		
3	OTHER ANNUITIES OR RETIREMENT BENEFITS	None		None	None		
4	DIVIDENDS AND INTEREST	None		None	None		
5	UNEMPLOYMENT COMPENSATION	None		None	None		
6	NET INCOME FROM RENTAL(S)	None		None	None		
7	NET PROFIT FROM SELF-EMPLOYMENT (Business or Farm)	None		None	None		
8	INSURANCE (Other than VA)	None		None	None		
9	OTHER INCOME (Specify source)	None		None	None		
10	TOTAL INCOME (Total of lines 1 thru 9)	\$ None	\$	\$ None	\$	\$ 500	\$ 570564
11	GROSS RENTAL(S) (Before any deductions)						

PART II - NET WORTH (Value of Estate)

LINE NO.	TYPE OF ASSET	AMOUNT	TYPE OF DEBT	AMOUNT
12	MARKET VALUE OF REAL ESTATE (Not your home)	\$ None	SEARS TU SET	500
13	STOCKS AND BONDS	None	MORTGAGES (Other than your home)	\$ None
14	BANK SAVINGS AND LOAN DEPOSITS	740	OTHER DEBTS (Specify)	
15	OTHER (Specify)		Household Bills	
16	TOTAL	\$ 740	TOTAL	\$ 500

CERTIFICATION: I HEREBY CERTIFY that the information I have given above is true and correct to the best of my knowledge and belief.

DATE: **June 20, 1970**
 SIGNATURE OF VETERAN, CUSTODIAN OR GUARDIAN: **Edward H. Schaad Sr.**
 ADDRESS (Street, City, State and ZIP Code): **RDT Kerkrill, N. Y.**

Witnesses - If you sign by (X), it must be witnessed by two persons who know you personally and the signatures and addresses of such witnesses must be shown.

SIGNATURE OF WITNESS
 ADDRESS OF WITNESS

PENALTY - The law provides severe penalties which include fine or imprisonment or both, for the willful submission of any statement or evidence of material fact, knowing it to be false.

COPY MADE FROM VETERANS CLAIM FOLDER



VETERANS ADMINISTRATION
REGIONAL OFFICE
1021 Main Street
Buffalo, New York 14203

June 16, 1970

Mrs. Mabel Schad
R. D. #1, Kirkville Road
Bridgeport, NY 13082

IN REPLY REFER TO:
307(214)
C-5 450 700
SCHAD, Edward H., Sr.

IMPORTANT

Read the back of this letter

Dear Mrs. Schad:

Please furnish the evidence described below as soon as possible so that further action may be taken on the claim for pension benefits for the veteran:

Complete and return the enclosed VA Form 21-6397 setting forth the veteran's income and your income from all sources for the following periods: January 1 to February 10, 1970; February 11 to December 31, 1970 and 1971. Also, show your current net worth. Also submit a copy of your marriage certificate to the veteran.

This evidence should be submitted as soon as possible, preferably within 60 days and in any case it must be received in the Veterans Administration within one year from the date of this letter; otherwise, benefits, if entitlement is established, may not be paid prior to the date of its receipt.

Enclosures:

VA Form 21-6397

VA Form 21-686c

cc:

Veterans of Foreign Wars (2)

Sincerely yours,

E. S. POLADER
Adjudication Officer

FL 21-117
MAR 1969(R)

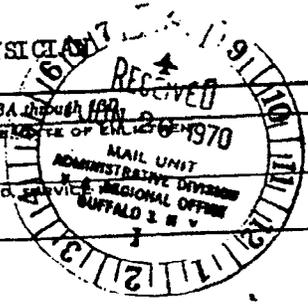
MGGiancarlo/dab 6-15-70
Show veteran's full name and VA file number on all correspondence. If VA number is unknown, show service number.

COPY MADE FROM
VETERANS CLAIM FOLDER

2/D
7/22/70

REQUEST FOR AND/OR NOTICE OF TRANSFER OF VETERANS RECORDS

ITEM NO.	STATION NAME AND NO. <i>(Include mail routing symbol on temporary transfers only.)</i>	DATE
1	From VAH CANANDAIGUA NY	4/22
2	To: VARO BUFFALO NY 307	
4. DATE OF TRANSFER (37-42)	5. TRF. STA. NO. (44-46)	6. REC. STA. NO. (48-50)
7. NAME OF REC. STA. (53-58)	8. FILE NO. (60-68) 05 450 700	
9A. LAST NAME (71-80) SCHAD, JR.		
9B. FIRST NAME (89) Edward		9C. MIDDLE NAME (70) H
10. TYPE OF FOLDER <input checked="" type="checkbox"/> C-XC <input type="checkbox"/> OE <input type="checkbox"/> R&E <input type="checkbox"/> INS. <input type="checkbox"/> LG <input type="checkbox"/> PG <input type="checkbox"/> OPT <input type="checkbox"/> MED. REC. <input type="checkbox"/> HOSP. CORRES. <input type="checkbox"/> OTHER (Specify)		11. TYPE TRANSFER <input type="checkbox"/> PERMANENT <input checked="" type="checkbox"/> TEMPORARY
12. REASON FOR TRANSFER FOR REVIEW BY STAFF PHYSICIAN		
NOTE: If file number is unknown, complete items 13A through 13C.		
13A. DATE OF BIRTH	13B. SERVICE OF ENL. (20-1970)	
13C. DATE OF DISCHARGE	13D. SERVICE REGIONAL OFFICE BUFFALO 3 NY	
14. REMARKS Thank you		
15. ADJUDICATION ACTION PENDING <input type="checkbox"/> YES <input type="checkbox"/> NO		16. CHAPTER 31 <input type="checkbox"/> (If checked, remove status card.)
17 FROM (Originating Office) VAH Edgemo NY VARO BUFFALO NY 307		18. DATE 25- 6-28-70



07-7216

SUPERSEDES VA FORM 23-7216, APR 1966, AND PL 10-86, JUN 1967, WHICH WILL NOT BE USED.

COPY MADE FROM VETERANS CLAIM FOLDER



VETERANS ADMINISTRATION
HOSPITAL
CANANDAIGUA, NEW YORK 14424
June 11, 1970

YOUR FILE REFERENCE:

IN REPLY REFER TO: 532 (136)

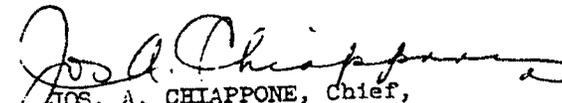
TO: Manager (23)
VA Regional Office
1021 Main St.
Buffalo, N. Y. 14203

SCHAD, Edward H. Sr.
C 5 450 700

SHINEBARGER, Ronald J.
C 18 341 567

SUBJ: Loan of C Folders

1. We are requesting the loan of claims folders in the above named veterans' cases, for review by our staff physician. This is our second request.


JOS. A. CHIAPPONE, Chief,
Medical Administration Division

Include Zip Code in your return address and give veteran's social security number.
Show veteran's full name and VA file number on all correspondence. If VA number is unknown, show service number.

COPY MADE FROM
VETERANS CLAIM FOLDER

VARO BFLO NY

SCHAD, EDWARD SS# 134 10 6782

C# 5 450 700

DOB: 8/24/20

RD#1 Kirkville NY

AF 32378461 4/15/42 - 10/6/45

NAME AND LOCATION OF STATION VA HOSPITAL SYRACUSE NY 670/136A3		FOR CO-RO - RPC USE ONLY	
FILE NO.			
CO	RO		
<input type="checkbox"/> NO RECORD	<input type="checkbox"/> NO RECORD		
INITIALS-DATE	INITIALS-DATE		

PART I - PURPOSE (Check appropriate box and complete)			
1. REPORT (Check one) <input type="checkbox"/> INITIAL <input type="checkbox"/> SUPPLEMENTAL		2. STATUS (Check) <input type="checkbox"/> VA HOSPITAL PATIENT <input type="checkbox"/> NON-VA HOSPITAL PATIENT <input type="checkbox"/> DOMICILIARY MEMBER	
3. PATIENT OR MEMBER (Check) <input type="checkbox"/> IS INCOMPETENT <input type="checkbox"/> WAS ADMITTED OR READMITTED FOLLOWING AN IRREGULAR DISCHARGE		4. IF COMMITTED, ENTER COURT, LOCATION, AND DATE COMMITTED	
5. REQUEST FOR INFORMATION/ADJUDICATIVE ACTION VERIFY MILITARY SERVICE INFORMATION SHOWN ABOVE, SHOW CORRECTIONS IN <input type="checkbox"/> A. FILE NO. <input checked="" type="checkbox"/> B. REMARKS SECTION, PART II <input checked="" type="checkbox"/> C. MONETARY BENEFITS INFORMATION <input checked="" type="checkbox"/> D. SERVICE CONNECTION <input type="checkbox"/> E. DATES AND TYPE OF DISCHARGE FROM MOST RECENT HOSPITAL OR DOMICILIARY CARE			
6. REMARKS ALSO ALL NSC CONDITIONS.			
7. ADJUDICATIVE ACTION (When this is checked include in Item 6, data for determination of service connection; i.e., disease, injury or dental condition; name of hospital, clinic, first aid station where applicant states he received treatment during military service; dates of treatment and condition treated.) <input type="checkbox"/>		8. DECISION ON OTHER THAN HONORABLE DISCHARGE <input type="checkbox"/>	
MILITARY SERVICE INFORMATION VERIFIED <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		ACTIVE RESERVE INACTIVE RESERVE COMPLETELY SEPARATED INITIALS AND DATE JAR 5/5/70	
PART II - EXTRACT FROM CLAIM FOLDER		PART III - REQUEST (Check)	
1. NO MONETARY BENEFITS <input type="checkbox"/>		2. ACTION <input type="checkbox"/> COMPETENT <input type="checkbox"/> INCOMPETENT <input type="checkbox"/> BY VA <input type="checkbox"/> BY COURT	
3. COMPENSATION <i>Award, Susp.</i>	4. PENSION VETERAN	5. RETIREMENT PAY VA: \$ OTHER: \$ NAME AND ADDRESS OF OTHER PAYEE	
6. APPORTIONMENT \$ OTHER PAYEE \$	7. GUARDIAN NAME AND ADDRESS (Check) <input type="checkbox"/> PERSON <input type="checkbox"/> ESTATE		
8. SERVICE-CONNECTED CONDITIONS (Complete when information on monetary benefits is requested, even if only 0%) <i>Anxiety Nervosis 10% - Disfiguring scar right, 10% Zygoma area, Lt. Planus, Left 0%</i>		1. VA FORM 10-7132	
9. REMARKS <i>AD. dat. 7-31-42 to 10-6-45 Hon. non-S.C. disability Deformity of left 5 finger Epidemiomatophytosis left.</i>		2. HOSPITAL SUMMARY	
NAME OF STATION AND NO. <i>Buffalo NY</i>		3. 21 DAY CERTIFICATE EXAMINATION OF CONDITIONS LISTED	
SIGNATURE <i>L. So Rolando</i>		4. IN REMARKS	
DATE <i>5-20-70</i>		5. SPECIAL REPORT (Explain in Remarks)	
		6. COMPETENCY REPORT	
		7. VA FORM 21-2680	
		8. ASSET INFORMATION	
		9. ADMISSION REPORT	
		10. OUTPATIENT TREATMENT REPORT	
		FROM:	
		TO:	

VA FORM 10-7131 MAY 1968

SUPERSEDES VA FORM 10-7131, APR 1965, AND 10-2731, JUN 1965, WHICH WILL NOT BE USED.

EXCHANGE OF BENEFICIARY INFORMATION AND REQUEST FOR ADMINISTRATIVE AND ADJUDICATIVE ACTION

COPY MADE FROM VETERANS CLAIM FOLDER

COPY MADE FROM

4/27/70

21

Approved exception to SF 502

NAME	AGE	SEX	RACE	CLAIM NO.	SOCIAL SECURITY NO.	NAME OF HOSPITAL
Edward R. Sr.	50	M	W	C5 450 700	134 10 6782	VAH, Canandaigua, NY

1. (List and number in order of clinical importance all established diagnoses for which treatment was given. Place the letter to the one diagnosis responsible for the major part of the patient's stay. For discharge to Nursing Care, place letter "N" against diagnosis(es) responsible for Nursing Care placement.)

ICDA CODE

- Schizophrenia, Chronic Undifferentiated Type.
- Acute Bronchitis and Respiratory Infection.

Major diagnoses noted but not treated

OPERATIONS PERFORMED AT THIS HOSPITAL DURING CURRENT ADMISSION

DATE

SUMMARY (Brief statement should include, if applicable, history; pertinent physical findings; course in hospital; treatment given; condition at discharge; date patient is capable of returning to full employment; period of convalescence, if required; recommendations for follow-up treatment; medications furnished at discharge; competency opinion; and name of the Nursing Home, if known.)

Mr. Schad is a 50 year old, married, employable veteran who is 10% SC for "nerves" and he is considered COMPETENT to handle VA funds. Mr. Schad was admitted to VAH, Canandaigua, for the first time on 3/4/70, having been brought to the hospital by police on a Health Officer's Certificate. According to his wife and son, he never showed signs of mental illness until about eight weeks prior to his admission when he began to display very bizarre behavior and delusional thoughts. Apparently, he said that the house was "bugged" and he took apart a vacuum cleaner to show his family the microphone. He was also seen often folding his hands over his ears and "thumbing his nose at his wife." However, Mr. Schad's wife and son both insisted that his mental breakdown was very recent and that he had been a "good husband and father" in past years.

In spite of Mr. Schad's family members' insistence that he was okay until recently, there is evidence to the contrary. He was given a 10% SC rating for nerves when discharged from the service and he admits to a long history of excessive alcoholism. During the staff conference on 4/13/70, he said that although he stopped drinking about three years ago, he used to be a heavy drinker and he described himself as a "drunk."

Mr. Schad also reiterated his intention to sell some property he owns in the business section of Bridgeport, N. Y. "to the state for the betterment of mankind." His family had been very concerned about his intention to sell the property. Apparently, they oppose the sale and do not feel he is showing sound judgment in the matter.

When admitted to this station on 3/4/70, Mr. Schad showed no understanding of his illness. He stated that he was a member of the aerospace program and was being (over)

ADMISSION DATE	DISCHARGE DATE	TYPE OF DISCHARGE	INPATIENT DAYS	ADD DAYS	WARD NO.	SIGNATURE OF PHYSICIAN
3/4/70	4/16/70	MHB			6	

*Till
ending
4/10/70
3-1
4-2*

VA FORM 10-1000 FEB 1969

EXISTING STOCK OF VA FORM 10-1000 FEB 1969 WILL BE USED

HOSPITAL SUMMARY dem

Recd. 4/15; typed 4/21/70

hospitalized for "further treatment." He has adjusted well to hospital routine, however, and at the time of ~~the~~ staff conference, he appeared much improved although he continued to display some vague and illogical thought processes. He appeared alert and well oriented, but he demonstrated no insight into his problems or understanding of his family's concern for him.

Although Mr. Schad continued to show signs of a schizophrenic process at the time of staff conference, it was felt that he had improved to the point where he could be considered for release from in-hospital treatment. Since his wife had also requested his early discharge, it was decided to discharge him MIB with a 30 day supply of medication, Chlorpromazine, 50 mgm. b.i.d. He will be referred to the VA Clinic in Syracuse for OPT.

for B.W. Walsh
THOMAS M. WALSH, Ph.D.
Clinical Psychologist
G.B. Wing
G. B. WING, M.D.
Staff Physician

MAR 27 1970
MAIL UNIT
COMMUNICATIONS DIVISION
V. A. MEDICAL CENTER
Syracuse, N. Y.

SCHAD, Edward H. Sr.
C# 5 450 700 SS# 134 10 6782 DOB: 2/24/20 VAM, Canandaigua, N.Y.

COPY MADE FROM
VETERANS CLAIM FOLDER

NR 100-100000
100A

PTO N.Y. 3/16/70
N.Y.

SCHMIDT EDWARD L. 17. 131 10 87 32 37
E 400 100 100000 100 100 100 100
100 100 100 100 100 100 100 100
R 100 100 100 100 100 100 100 100
S/A 10000
ARMY 100 100 100 100 100 100 100 100
100/100/100
SCHMIDT REACTION

23.
Bo. P. Miller

NAME AND LOCATION OF STATION	FOR CO-RO - RPC USE ONLY	
	FILE NO.	
<small>Station not using electronic register should furnish name, Claim No., date of admission and admission diagnosis. If Claim No. not available, add date of birth, Service No. and last period of service.</small>	CO	NO
	<input type="checkbox"/> NO RECORD	<input type="checkbox"/> NO RECORD
INITIALS-DATE	INITIALS-DATE	

PART I - PURPOSE (Check appropriate box and complete)

ADMISSION NOTICE	1. REPORT (Check one)	2. STATUS (Check)	
	<input checked="" type="checkbox"/> INITIAL <input type="checkbox"/> SUPPLEMENTAL	<input checked="" type="checkbox"/> VA HOSPITAL PATIENT	<input type="checkbox"/> NON-VA HOSPITAL PATIENT <input type="checkbox"/> DOMICILIARY MEMBER
3. PATIENT OR MEMBER (Check)		4. IF COMMITTED, ENTER COURT, LOCATION, AND DATE COMMITTED	
<input type="checkbox"/> IS INCOMPETENT <input type="checkbox"/> WAS ADMITTED OR READMITTED FOLLOWING AN IRREGULAR DISCHARGE			
5. REQUEST FOR INFORMATION/ADJUDICATIVE ACTION			
<input type="checkbox"/> A. FILE NO.	<input checked="" type="checkbox"/> B. REMARKS SECTION, PART II	<input checked="" type="checkbox"/> C. MONETARY BENEFITS	<input checked="" type="checkbox"/> D. SERVICE CONNECTION <input type="checkbox"/> E. CARE
<input type="checkbox"/> ADJUDICATIVE ACTION (When this is checked include in Item 6, date for determination of service connection; i.e., disease, injury or dental condition; name and location of hospital, clinic, first aid station where applicant states he received treatment during military service; dates of treatment and condition treated.)			
<input type="checkbox"/> G. DECISION ON OTHER THAN HONORABLE DISCHARGE			
6. REMARKS			MILITARY SERVICE INFORMATION VERIFIED <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> ACTIVE RESERVE <input type="checkbox"/> INACTIVE RESERVE <input type="checkbox"/> COMPLETELY SEPARATED INITIALS AND DATE

PART II - EXTRACT FROM CLAIM FOLDER

1. NO MONETARY BENEFITS	2. ACTION	
<input type="checkbox"/>	<input type="checkbox"/> COMPETENT <input type="checkbox"/> INCOMPETENT	<input type="checkbox"/> BY VA <input type="checkbox"/> BY COURT
3. COMPENSATION	4. PENSION	5. RETIREMENT PAY
\$ 23.00	\$	VA: \$ OTHER: \$
6. APPORTIONMENT	NAME AND ADDRESS OF OTHER PAYEE	
\$		
7. GUARDIAN	(Check) <input type="checkbox"/> PERSON <input type="checkbox"/> ESTATE	
8. SERVICE-CONNECTED CONDITIONS (Complete when information on monetary benefits is requested, even if only 0%)		
Anxiety Reaction 10%		
9. REMARKS		
<i>20/20 vision diagnosis correct please advise if not in anxiety or report clinical safety</i>		
NAME OF STATION AND NO.	SIGNATURE	DATE
100 BUFFALO	E S Polak	4-23-70

PART III - REQUEST (Check)

<input checked="" type="checkbox"/> 1. VA FORM 10-7132
<input checked="" type="checkbox"/> 2. HOSPITAL SUMMARY
<input type="checkbox"/> 3. 21 DAY CERTIFICATE EXAMINATION OF CONDITIONS LISTED
<input type="checkbox"/> 4. IN REMARKS
<input checked="" type="checkbox"/> 5. SPECIAL REPORT (Explain in Remarks)
<input checked="" type="checkbox"/> 6. COMPETENCY REPORT
<input type="checkbox"/> 7. VA FORM 21-2680
<input type="checkbox"/> 8. ASSET INFORMATION
<input type="checkbox"/> 9. ADMISSION REPORT
<input type="checkbox"/> 10. OUTPATIENT TREATMENT REPORT
FROM:
TO:

VA FORM 10-7131 MAY 1966

SUPERSEDES VA FORM 10-7131, APR 1965, AND 10-2731, JUN 1965, WHICH WILL NOT BE USED.

EXCHANGE OF BENEFICIARY INFORMATION AND REQUEST FOR ADMINISTRATIVE AND ADJUDICATIVE ACTION

COPY MADE FROM VETERANS CLAIM FOLDER



VETERANS ADMINISTRATION
REGIONAL OFFICE
1021 Main Street
Buffalo, New York 14203

May 7, 1970

IN REPLY REFER TO:

307(214)
C-5 450 700
SCHAD, Edward H. Sr.

Mrs. Mabel Schad
RD #1, Kirkville Road
Bridgeport, New York 13082

Dear Mrs. Schad:

Reference is made to **your husband's claim for increased benefits.**

Attention is invited to the paragraph(s) checked below: **IGNORE ANY PARAGRAPH NOT CHECKED.**

1. Further action on your claim awaits evidence or information which we are obtaining from:
- a. Military Records c. (Other)
 b. Hospital Records
2. Arrangements are being made for your physical examination. You will be informed at a later date of the time and place of examination.
3. The evidence requested below should be submitted as soon as possible, preferably within 60 days, and in any case it must be received in the Veterans Administration within one year from the date of this letter; otherwise, benefits, if entitlement is established, may not be paid prior to the date of its receipt.
- a. The enclosed form(s) should be completed and returned promptly to this office so that further action may be taken.
- b. Please furnish two statements from persons who have terminated your employment or refused to employ you because of disability or from disinterested persons who know you are unable to work because of disability. The enclosed VA Forms 21-4138 may be used for this purpose.
- c. Please furnish a report from your personal physician covering a recent physical examination. It should include his findings and diagnoses. The cost of obtaining this medical statement must be borne by the claimant.
- d. Please answer all the questions in part(s) 1, 2, 3, 4 and 5 of the enclosed VA Form 21-527 and return it to this office. The information requested is necessary to determine your entitlement to disability benefits.
- 4.

Enclosure

cc:
Veterans of Foreign Wars (2)
FL 21-96
DEC 1968 (RS)

Sincerely yours,

E. S. ROLADER
Adjudication Officer

CDMurszewski:cdm 5/5/70

Show veteran's full name and VA file number on all correspondence. If VA number is unknown, show service number.

COPY MADE FROM
VETERANS CLAIM FOLDER



VETERANS ADMINISTRATION
Regional Office
1021 Main Street
Buffalo, New York 14203

May 7, 1970

Mrs. Mabel Schad
RD #1, Kirkville Road
Bridgeport, New York 13082

IN REPLY REFER TO:
307 (214)
C-5 450 700
SCHAD, Edward H. Sr.

IMPORTANT
Read the back of this letter

Dear Mrs. Schad:

Please furnish the evidence described below as soon as possible so that further action may be taken on the claim for **benefits**.

1. Certified copy of the public or church record of your marriage.
2. Certified copy of documents (Divorce Decrees, Decrees of Annulment or Death Certificates) terminating all prior marriages for both you and your present wife.
3. Certified copy of public record of birth or a copy of the record of baptism for each of your unmarried children, showing the names of both parents.
4. Complete the enclosed VA Form 21-686c, Declaration of Marital Status.
5. The enclosed VA Form 21-509, Statement of Dependency, completed by your parent or parents.
6. Certified copy of the public record of your birth or the church record of your baptism showing the names of both parents.
7.

This evidence should be submitted as soon as possible, preferably within 60 days and in any case it must be received in the Veterans Administration within one year from the date of this letter; otherwise, benefits, if entitlement is established, may not be paid prior to the date of its receipt. **WRITE YOUR NAME AND C-NUMBER ON ALL DOCUMENTS SUBMITTED.**

Enclosure

Sincerely yours,

cc:
Veterans of Foreign Wars (2)

E. S. BOLADER
Adjudication Officer

FL 21-117a
OCT 1969

CDMurszewski:cdm 5/5/70

Show veteran's full name and VA file number on all correspondence. If VA number is unknown, show service number.

Edm
5/7/70
1209
COPY MADE FROM
VETERANS CLAIM FOLDER

NOTE - SHADDED AREAS TO BE COMPLETED BY INPUT ACTIVITY

1. COPY TO <input type="checkbox"/> INS. <input type="checkbox"/> DE FOLDER <input type="checkbox"/> OTHER (Specify) <input type="checkbox"/> MED <input type="checkbox"/> R & E FOLDER			RATING DECISION			2. FILE NUMBER C-5450700									
3. TRAINING CODE		4. DATE OF ISSUE H.R. 2-10-70 to 3-2-70				5. LAST EXAMINATION		6. DATE OF DEATH		7. INITIALS AND SURNAME OF VETERAN E. H. SCHAD					
8. TYPE OF RATING 2		9. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		10. BRANCH F		11. ACTIVE DUTY (Mo., day, yr.) EOD 7-31-42 B4G 10-6-45		12. ADOTL SVC. 1. WT. 2. LPTS 3. SCDS		13. DATE OF BIRTH (Mo., day, yr.) 8-24-20		14. COMBAT 1. NONE 2. COMP 3. NON COMP 4. BOTH 1		15. EMPLOYABILITY 1. EMPLOYABLE OR NOT AN ISSUE 2. UNEMPLOYABLE 1	
16. COMPETENCY 1. COMPETENT 2. INCOMPETENT 1			17. NO. OF AC. DEAS. TO WHICH APPLICABLE (If 2, specify reasons) 3			18. FUTURE DATE CONTROLS						19. DATE OF THIS RATING 4-24-70			
			PHYSICAL EXAM.			OTHER CONTROL									
			MO. YR. REASON no-exam 01			1. ESTABLISH 2. CANCEL									

20. NARRATIVE

J. Claim for increase, 2-11-70.

I. Increased evaluation for anxiety reaction.

F. Current hospital report shows veteran admitted after developing persecution illusions and threatening his family. Skull X-rays reveal some density increase overlying the left antrum. He was discharged AMA before full testing could be completed and is not considered competent to handle funds. The veteran was rehospitalized on 3-4-70.

9400	1. SC 38 USC 310 (INC WWII) 10% from 10-7-45 ANXIETY REACTION
7805	0% from 6-23-52 DISFIGURING SCAR, RIGHT ZYGOMATIC AREA
5276	0% from 6-23-52 PES PLANUS
9311	8. NSC WWII 100% ORGANIC BRAIN SYNDROME
5227	0% DEFORMITY LEFT 5TH FINGER
7813	0% EPIDERMOPHYTOSIS, FEET

COPY MADE FROM VETERANS CLAIM FOLDER

**CONTINUATION SHEET
RATING DECISION**

NAME OF VETERAN

E. H. SCHAD

CLAIM NUMBER

C- 5450700

PAGE 2 OF RATING DATED: 4-24-70

COMB: 100%

2. PT WWII from 2-11-70

~~33. Incompetent from 2-10-70~~

FORWARDED TO DPC

JUL 23 1970

RD-07

21. SPECIAL PROVISION CODE			22. SPECIAL MONTHLY COMPENSATION				23. OVER
1-PAR 28	3-VAR 12E1	5-ANAL. RATING	A. SMC PAR CODE	B. LOSS OF USE	C. ANAT. LOSS	D. OTHER LOSS	
2-PAR 30	4-VAR 12E2	6-OTHER OR COMB.					
24. CLAIMANT REPRESENTED BY						25. RATING BOARD NO.	26. R.D. NO.
<input type="checkbox"/> AL	<input checked="" type="checkbox"/> ATTORNEY	<input type="checkbox"/> AGENT	<input type="checkbox"/> SURVIVOR	<input type="checkbox"/> OTHER (Specify)	C&P-1		307
27. RATING SPECIALIST (Initials)			28. RATING SPECIALIST (Name - Complete)		29. RATING SPECIALIST (Legal-Occupational)		
V. J. DI MARCO, S.D. - CHM. <input type="checkbox"/>			J. T. D'AMICO CHM. <input checked="" type="checkbox"/>		A. KANTER CHM. <input type="checkbox"/>		

VA FORM 21-6796b MAY 1968

SUPERSEDES VA FORM 21-6796b, AUG 1963, WHICH WILL NOT BE USED.

61:eh

GPO : 1968 O - 348-188

COPY MADE FROM VETERANS CLAIM FOLDER

PATIENT OR MEMBER STATUS CHANGE	REPORT (Check one)	<input checked="" type="checkbox"/> INITIAL
		<input type="checkbox"/> SUPPLEMENTAL

TO VARO, ADJUDICATION DIVISION, BUFFALO, NY FROM VAH, SYRACUSE, NEW YORK

PART I - PERSONAL DATA

1. VETERAN'S NAME SCHAD, EDWARD H., SR.	2. CLAIM NO. c. 5 450 700	3. SOCIAL SECURITY NO. 134 10 6782
---	-------------------------------------	--

4. HOSPITAL, DOMICILIARY OR NURSING HOME (Check one)

A. HOSPITAL PATIENT (Check) <input type="checkbox"/> NON-VA <input checked="" type="checkbox"/> VA	B. DOMICILIARY MEMBER <input type="checkbox"/>	C. NURSING HOME CARE UNIT (Check) <input type="checkbox"/> NON-VA <input type="checkbox"/> VA
---	---	--

PART II - MOVEMENT OR DISPOSITION (Check and indicate date of action)

1. DISCHARGED		DATE
<input type="checkbox"/> MIB	<input type="checkbox"/> MIB-DOMICILIARY	3/2/70
<input type="checkbox"/> MIB/CBOC	<input type="checkbox"/> MIB-NURSING HOME	
<input type="checkbox"/> DIED	<input type="checkbox"/> OTHER (Specify)	
<input checked="" type="checkbox"/> IRREGULAR A.M.A.		

(✓) ACTION	DATE	(✓) ACTION	DATE
2. PLACED ON AUTHORIZED LEAVE OF 30 DAYS		7. RETURNED FROM ELOPEMENT OR UNAUTHORIZED ABSENCE	
3. RETURNED FROM AUTHORIZED LEAVE OF 30 DAYS		8. PLACED ON TRIAL VISIT FROM ELOPEMENT OR UNAUTHORIZED ABSENCE	
4. PLACED ON TRIAL VISIT OR FURLOUGH 30 DAYS OR MORE		9. TRANSFERRED TO:	
5. RETURNED FROM TRIAL VISIT OR FURLOUGH 30 DAYS OR MORE			
6. ELOPED OR PLACED ON UNAUTHORIZED ABSENCE		10. DATE SET FOR DISCHARGE FROM TRIAL VISIT	

PART III - CERTIFICATION OF 21 DAYS CONSECUTIVE HOSPITALIZATION

CURRENT CLINICAL RECORDS SHOW THE VETERAN WAS HOSPITALIZED FOR 21 CONSECUTIVE DAYS _____ (From)

_____ (To) FOR TREATMENT OR OBSERVATION OF (State diagnosis(es))

AND HIS PRESENCE IS STILL REQUIRED IN THE HOSPITAL FOR THESE CONDITIONS.

PART IV - INFORMATION FOR CHIEF ATTORNEY

DESTINATION OF PATIENT (Address)	2. NAME AND ADDRESS OF PERSON AGREEING TO PROVIDE SUPERVISION
3. IS PATIENT COMMITTED? (If "Yes," complete item 4) <input type="checkbox"/> YES <input type="checkbox"/> NO	4. COMMITMENT COURT, LOCATION AND DATE
5. CURRENT BALANCE OF FUNDS ON DEPOSIT IN PROP \$	

PART V - ASSET INFORMATION

FUNDS ON DEPOSIT	AMOUNT	3. LIST OF OTHER ASSETS	4. ASSETS ON VA FORM 10-7131
1. GRATUITOUS	\$		
2. OTHER	\$		
TOTAL			

PART VI - STATEMENT OF PRE-HOSPITALIZATION ACTIVITY/CONVALESCENCE PERIOD

1. IS VETERAN CAPABLE OF RETURNING TO FULL EMPLOYMENT IMMEDIATELY? <input type="checkbox"/> YES <input type="checkbox"/> NO	2. IS A PERIOD OF CONVALESCENCE REQUIRED FOR VETERAN? <input type="checkbox"/> YES <input type="checkbox"/> NO (If "Yes," how long?)
--	---

REMARKS: *PT has been sent to Canandaigua on a Health officers Certificate. See attached Summary*

SIGNATURE: *John M. Elhever* DATE: **4/10/70**

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COPY MADE FROM VETERANS CLAIM FOLDER

21-7132-1000-7131 4/14/70

21

PATIENT OR MEMBER STATUS CHANGE		REPORT (Check one)	INITIAL	
		<input checked="" type="checkbox"/> XX	SUPPLEMENTAL	
TO	VARO BUFFALO, N.Y.		FROM	VAH GDGA, N.Y.
PART I - PERSONAL DATA				
1. VETERAN'S NAME SCHAD, Edward H Sr.		2. CLAIM NO. C- 5 450 700	3. SOCIAL SECURITY NO. 134 10 6782	
4. HOSPITAL, DOMICILIARY OR NURSING HOME (Check one)				
A. HOSPITAL PATIENT (Check)		B. DOMICILIARY MEMBER		
<input type="checkbox"/> NON-VA <input checked="" type="checkbox"/> VA		<input type="checkbox"/> NON-VA <input type="checkbox"/> VA		
PART II - MOVEMENT OR DISPOSITION (Check and indicate date of action)				
1. DISCHARGED			DATE	
<input checked="" type="checkbox"/> MHB <input type="checkbox"/> MHB-DOMICILIARY <input type="checkbox"/> DIED <input type="checkbox"/> OTHER (Specify)			4-16-70	
<input type="checkbox"/> MHB/CBOC <input type="checkbox"/> MHB-NURSING HOME <input type="checkbox"/> IRREGULAR				
(✓)	ACTION	DATE	ACTION	
	2. PLACED ON AUTHORIZED LEAVE OF 30 DAYS		7. RETURNED FROM ELOPEMENT OR UNAUTHORIZED ABSENCE	
	3. RETURNED FROM AUTHORIZED LEAVE OF 30 DAYS		8. PLACED ON TRIAL VISIT FROM ELOPEMENT OR UNAUTHORIZED ABSENCE	
	4. PLACED ON TRIAL VISIT OR FURLOUGH 30 DAYS OR MORE		9. TRANSFERRED TO:	
	5. RETURNED FROM TRIAL VISIT OR FURLOUGH 30 DAYS OR MORE		10. DATE SET FOR DISCHARGE FROM TRIAL VISIT	
	6. ELOPED OR PLACED ON UNAUTHORIZED ABSENCE			
PART III - CERTIFICATION OF 21 DAYS CONSECUTIVE HOSPITALIZATION				
CURRENT CLINICAL RECORDS SHOW THE VETERAN WAS HOSPITALIZED FOR 21 CONSECUTIVE DAYS (From)				
(To) FOR TREATMENT OR OBSERVATION OF (State diagnosis(es))				
AND HIS PRESENCE IS STILL REQUIRED IN THE HOSPITAL FOR THESE CONDITIONS.				
PART IV - INFORMATION FOR CHIEF ATTORNEY				
DESTINATION OF PATIENT (Address)		2. NAME AND ADDRESS OF PERSON AGREEING TO PROVIDE SUPERVISION		
RD #1 Kirkville Rd Bridgeport, N.Y. 13082.				
3. IS PATIENT COMMITTED? (If "Yes," complete item 4)	4. COMMITMENT COURT, LOCATION AND RATE	5. CURRENT BALANCE OF FUNDS ON DEPOSIT IN PPDP		
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		\$ 00		
PART V - ASSET INFORMATION				
FUNDS ON DEPOSIT		AMOUNT	3. LIST OF OTHER ASSETS	
1. GRATUITOUS	\$		4. ASSETS ON VA FORM 10-7131	
2. OTHER	\$			
TOTAL	\$			
PART VI - STATEMENT OF PRE-EMPLOYMENT ACTIVITY/CONVALESCENCE PERIOD				
1. IS VETERAN CAPABLE OF RETURNING TO FULL EMPLOYMENT IMMEDIATELY?		2. IS A PERIOD OF CONVALESCENCE REQUIRED FOR VETERAN?		
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO (If "Yes," how long?)		
REMARKS				
SIGNATURE <i>Jos. A. Chiappone</i> JOS. A. CHIAPPONE, Chief, Med Adm Div.			DATE 4-16-70	

VA FORM 10-7132
MAR 1965

EXISTING STOCK OF VA FORM 10-7132, NOV. 1962, WILL BE USED.

ADJUDICATION DIVISION

COPY MADE FROM VETERANS CLAIM FOLDER

PATIENT NAME	SEX	RACE	CLASS NO.	SOCIAL SEC. NO.	NAME OF HOSPITAL
SCHUB, Edward H. Sr.	M	W	5-340 700	134 10 6782	VAH, SYRACUSE, NY

DIAGNOSES (List and number in order of clinical importance all established diagnoses for which treatment was given. Place the letter "X" before the one diagnosis responsible for the major part of the patient's stay. For discharge to Nursing Care, place letter "N" before diagnosis(s) responsible for Nursing Care placement.)

ICDA CODE

1. Psychosis with organic brain syndrome of unknown etiology (possibly secondary to alcoholism, head trauma and/or vascular disease)

205.9

VAF 10-1004 completed

Major diagnoses noted but not treated

OPERATIONS PERFORMED AT THIS HOSPITAL DURING CURRENT ADMISSION

DATE

APPROVED
 J.B. Stevens, M.D.
 OP & Adm. Svc.

SUMMARY (Brief statement should include, if applicable, history, pertinent physical findings; course in hospital; treatment given; condition at discharge; date patient is capable of returning to full employment; period of convalescence, if required; recommendations for follow-up treatment; medications furnished at discharge; competency opinion; and name of the Nursing Home, if known.)

ADDENDUM TO FINAL SUMMARY

As best we could obtain the history, this first SVAH admission of this 49 year old man is the result of a relatively acute onset of an organic brain syndrome of some sort. He had a 20 year history of heavy drinking, but apparently none in the four years prior to admission. There is a history of minor head trauma at age 3. It is possible that he may have fallen at other times in the recent past (he hurt his back four years ago) but this isn't definite. In late January 1970 he developed illusions of persecution. These were accompanied by fear and his reaction to this was a toxic one; that is, he piled trash on the floor, ripped the phone off the wall, threatened violence to his family and threatened to burn the house down. When he was admitted to the hospital the most notable thing about him apparently was his irritability and insistence on leaving. He went home a couple of times and was with difficulty returned to the hospital, finally leaving on 3-2-70 and refusing to return at all. The workup did not reveal any cause for the presumed organic brain syndrome. Skull films showed normally what might have been a left antral sinusitis (he had no clinical symptoms of this). A brain scan on 2-18-70 did show some decreased flow in the left carotid artery and decreased perfusion in the left hemisphere. An EEG and psych testing were not performed because there wasn't time prior to the patient's leaving. The patient also reported some time during the hospitalization that he was hearing voices. We don't know any more about that. I think that the safest thing to do is to say that this was an episode of an organic brain syndrome with psychosis of undetermined etiology, possibly related to his history of alcoholism, possibly related to unknown head trauma, and possibly on a vascular basis. Since the patient has been sent to Canandaigua on a Health Officer's certificate, I suppose the workup can be continued there.

ADMISSION DATE	DISCHARGE DATE	TYPE OF DISCHARGE	INPATIENT DAYS	ABO DAYS	WARD NO.	SIGNATURE OF PHYSICIAN
2-10-70	3-2-70	AMA	20		7E	JOHN J. DANEHY, M.D.

VA FORM 10-1000 FEB 1965

EXISTING STOCK OF VA FORM 10-1000, NOV 1965, WILL BE USED.

HOSPITAL SUMMARY

Dict 3-31-70

Trans 4-1-70 in

5-450 700

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1. Alcohol paranoid state

This was the first SVAH admission and first psychiatric admission for this 50 year old white married male, who worked as a house painter until three years ago. His family first noted a change in behavior 3 to 4 weeks before admission. He began complaining that the telephone was tapped, that people were watching him through the windows, and that people were following him. At this time there was a change in his behavior. He became bizarre and inappropriate, thumbing his nose at his wife, picking up buttons constantly. He became loud and threatened violence to his family. He threatened to burn the house down. He was finally brought to the hospital by his family, but he refused to stay. He returned a couple more times before he was finally admitted. On the ward he was noted to be impulsive, with frequently changing affect. At times he was hostile and abusive. At first he refused his p.o. medication and was given i.m. medicine. He then agreed to take his medicines orally. On the whole his behavior improved but he still had intermittent periods of hostile or bizarre behavior. Two weeks after admission he went on an evening pass with his wife, who had difficulty in getting him to return to the hospital. He was treated with Thorazine 50 mg. b.i.d. which was increased to 50 mg. q.i.d. He was also given supportive psychotherapy. On the afternoon of March 2nd, the patient eloped from the hospital. The family was notified and they tried unsuccessfully to get the patient to return to this hospital. He began acting out at home and he was finally HOC'd by Dr. West to the Canandaigua VA Hospital on the 3rd of March. Significant past history included these events: The patient suffered minor head trauma at age 3, resulting in a lacerated occiput. At age 8 he had "blood poisoning". He was a prisoner of war for 2 years in Germany and received a 10% disability compensation for a nervous condition, which gradually passed. He was told by a doctor about 15 years ago that he had an ulcer. He has had epigastric pain and distress in the past but no specific therapy. He smokes 2 packs of cigarettes a day. He admitted to a heavy intake of alcohol

2-10-70 3-2-70 AMA

7E WILFRED L. PILETTE, M.D.

Dict 3-24-70

Trans 3-24-70 1h

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VETERANS CLAIM FOLDER

1 COPY MADE FROM

for 20 years, until 4 years ago, and has drunk nothing since. He fell off a ladder about 4 years prior to admission while painting a house and apparently only injured his back. There was no loss of consciousness. The family reported that he may have fallen at other times without reporting it to them. He had no history of dizziness or blackouts. He complained of a headache every day and said it was located frontally. There was no significant family history for medical or mental illness. He has been married for 29 years and has four children. His oldest son is presently in jail and sent him a card recently, but the family feels that this upset him greatly and he had ruminated constantly about this. He was educated through high school. He has spent most of his time in recent years keeping busy around the house. His wife reported no change in sex relations. The couple has continued to have intercourse about two times a week. They both describe their marriage as happy. Physical exam was unremarkable. Lab work which included VDRL, BUN, serum glucose, SGOT, SGPT, serum electrolytes, serum LDH, urinalysis and CBC was all within normal limits. Chest xrays were negative. Skull xray revealed some increase in density overlying the left antrum which could represent increased density in the left antral sinus. It was suggested, if clinically indicated, that a Waters view could be taken. It was interpreted as an essentially negative skull with possible left antral sinusitis. EKG demonstrated minor, nonspecific ST segment abnormalities. The patient left before a brain scan, EEG, or psych testing could be obtained. He was discharged AMA on March 4, 1970.

The patient is not competent to handle funds.



1. *Schad, Edward H.*
 2. *5-450-700*

NAME AND LOCATION OF STATION <i>V.A.R.O.</i> <i>Adj. Dir.</i> <i>Ruffalo, NY</i>	FOR CO-RO - RPC USE ONLY	
	FILE NO.	
	CO	RO
	<input type="checkbox"/> NO RECORD	<input type="checkbox"/> NO RECORD
INITIALS-DATE	INITIALS-DATE	

PART I - PURPOSE (Check appropriate box and complete)

ADMISSION NOTICE <input type="checkbox"/> INITIAL <input type="checkbox"/> SUPPLEMENTAL	1. REPORT (Check one) <input type="checkbox"/> INITIAL <input type="checkbox"/> SUPPLEMENTAL	2. STATUS (Check) <input type="checkbox"/> VA HOSPITAL PATIENT <input type="checkbox"/> NON-VA HOSPITAL PATIENT <input type="checkbox"/> DOMICILIARY MEMBER
	3. PATIENT OR MEMBER (Check) <input type="checkbox"/> IS INCOMPETENT <input type="checkbox"/> WAS ADMITTED OR READMITTED FOLLOWING AN IRREGULAR DISCHARGE	
4. IF COMMITTED, ENTER COURT, LOCATION, AND DATE COMMITTED		5. REQUEST FOR INFORMATION/ADJUDICATIVE ACTION A. FILE NO. <input type="checkbox"/> B. REMARKS SECTION, PART II <input type="checkbox"/> C. MONETARY BENEFITS INFORMATION <input type="checkbox"/> D. SERVICE CONNECTION <input type="checkbox"/> E. DATES AND TYPE OF DISCHARGE FROM MOST RECENT HOSPITAL OR DOMICILIARY CARE
<input type="checkbox"/> ADJUDICATIVE ACTION (When this is checked include in Item 6, data for determination of service connection; i.e., disease, injury or dental condition; name of hospital, clinic, first aid station where applicant states he received treatment during military service; dates of treatment and condition treated.) <input type="checkbox"/> G. DECISION ON OTHER THAN HONORABLE DISCHARGE		
6. REMARKS <i>To U.A. Hosp. Syracuse, NY ✓</i>		MILITARY SERVICE INFORMATION VERIFIED <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> ACTIVE RESERVE <input type="checkbox"/> INACTIVE RESERVE <input type="checkbox"/> COMPLETELY SEPARATED INITIALS AND DATE

PART II - EXTRACT FROM CLAIM FOLDER		PART III - REQUEST (Check)
1. NO MONETARY BENEFITS <input type="checkbox"/>	2. ACTION <input type="checkbox"/> COMPETENT <input type="checkbox"/> INCOMPETENT <input type="checkbox"/> BY VA <input type="checkbox"/> BY COURT	
3. COMPENSATION \$	4. PENSION VETERAN \$ OTHER PAYEE \$	1. VA FORM 10-7132
5. APPORTIONMENT \$	6. RETIREMENT PAY VA: \$ OTHER: \$ NAME AND ADDRESS OF OTHER PAYEE	2. HOSPITAL SUMMARY
7. GUARDIAN NAME AND ADDRESS	<input type="checkbox"/> PERSON <input type="checkbox"/> ESTATE	3. 21 DAY CERTIFICATE EXAMINATION OF CONDITIONS LISTED 4. IN REMARKS 5. SPECIAL REPORT (Explain in Remarks)
8. SERVICE-CONNECTED CONDITIONS (Complete when information on monetary benefits is requested, even if only 0%) <i>SC Anxiety Neurosis</i> <i>(Examiner should review C-file)</i>		6. COMPETENCY REPORT
9. REMARKS <i>Supplement to 10-7131 dated 4-2-70, Veterans SC for anxiety neurosis; current diagnosis paranoid psychosis. Is current diagnosis a continuation of S.C. Anxiety neurosis or a separate element entirely.</i>		7. VA FORM 21-2680 8. ASSET INFORMATION
NAME OF STATION AND NO. <i>Ruffalo, NY</i>	SIGNATURE <i>E. A. Schad</i>	9. ADMISSION REPORT 10. OUTPATIENT TREATMENT REPORT FROM: TO:
DATE <i>4/9/70</i>	EXCHANGE OF BENEFICIARY INFORMATION AND REQUEST FOR ADMINISTRATIVE AND ADJUDICATIVE ACTION	

VA FORM 10-7131 MAY 1966

SUPERSEDES VA FORM 10-7131, APR 1965, AND 10-2731, JUN 1965, WHICH WILL NOT BE USED.

COPY MADE FROM VETERANS CLAIM FOLDER

VETERANS ADMINISTRATION
REFERENCE SLIP

TO (Name or title—Organizational element—Room No. and bldg.)	INITIALS—DATE
1. <i>Adyud Clerk</i>	
2.	
3.	
4.	
5.	

REASON FOR REFERENCE

- | | | |
|---------------------------------------|---|---|
| <input type="checkbox"/> APPROVAL | <input type="checkbox"/> CONCURRENCE | <input type="checkbox"/> NOTE AND RETURN |
| <input type="checkbox"/> AS REQUESTED | <input type="checkbox"/> FOR YOUR FILES | <input type="checkbox"/> PER CONVERSATION |
| <input type="checkbox"/> CALL ME | <input type="checkbox"/> INFORMATION | <input type="checkbox"/> RECOMMENDATION |
| <input type="checkbox"/> COMMENTS | <input type="checkbox"/> NECESSARY ACTION | <input type="checkbox"/> SIGNATURE |

PREPARE REPLY FOR SIGNATURE OF *C# 5 450 700*

REMARKS
*Please compile attached
7131 & forward to
VAH.*

FROM	DATE <i>4-2-77</i>
<i>Cop 1</i>	TEL. EXT.

VA FORM 3230 OCT 1956
EXISTING STOCKS OF VA FORM 3230, NOV 1945, WILL BE USED.

COPY MADE FROM VETERANS CLAIM FOLDER

NR-

SCHAD, EDWARD L. SR 131 10 1722 7E
 # 450 700 6) 24 1942 10 2 10 70
 SOCIAL SECURITY NO. 131 10 1722 7E
 MARIED WIFE 2 21 20
 S.A. 633 5173
 AIR FORCE 02/21/41 7 31 42 10 10 5 45 NO
 SC 21. DENTURES BRDLO, NY
 DX PARANOID PSYCHOISIS

NAME AND LOCATION OF STATION	FOR CO-RO - RPC USE ONLY	
	FILE NO.	
VA HOSPITAL SYRACUSE NY	<input type="checkbox"/> NO RECORD	<input type="checkbox"/> NO RECORD
	INITIALS-DATE	INITIALS-DATE

PART I - PURPOSE (Check appropriate box and complete)

ADMISSION NOTICE

1. REPORT (Check one)
 INITIAL SUPPLEMENTAL

2. STATUS (Check)
 HOSPITAL PATIENT NON-VA HOSPITAL PATIENT DOMICILIARY MEMBER

3. PATIENT OR MEMBER (Check)
 IS INCOMPETENT
 WAS ADMITTED OR READMITTED FOLLOWING AN IRREGULAR DISCHARGE

4. IF COMMITTED, ENTER COURT, LOCATION, AND DATE COMMITTED

5. REQUEST FOR INFORMATION/ADJUDICATIVE ACTION

A. FILE NO. B. REMARKS SECTION, PART II C. INFORMATION D. CONNECTION E. CARE

VERIFY MILITARY SERVICE INFORMATION SHOWN ABOVE. SHOW CONNECTIONS IN MONETARY BENEFITS SERVICE DATES AND TYPE OF DISCHARGE FROM MOST RECENT HOSPITAL OR DOMICILIARY

ADJUDICATIVE ACTION (When this is checked include in item 6, data for determination of service connection; i.e., disease, injury or dental condition; name and location of hospital, clinic, first aid station where applicant states he received treatment during military service; date of treatment and condition treated.)

G. DECISION ON OTHER THAN HONORABLE DISCHARGE

6. REMARKS

MILITARY SERVICE INFORMATION VERIFIED YES NO

ACTIVE RESERVE

INACTIVE RESERVE

COMPLETELY SEPARATED

INITIALS AND DATE
 SKB 2-11-70

PART II - EXTRACT FROM CLAIM FOLDER

1. NO MONETARY BENEFITS

2. ACTION
 COMPETENT INCOMPETENT BY VA BY COURT

3. COMPENSATION \$ 13.⁰⁰

4. PENSION
 VETERAN \$
 OTHER PAYEE \$

5. RETIREMENT PAY
 VA: \$ - OTHER: \$ -
 NAME AND ADDRESS OF OTHER PAYEE

6. APPORTIONMENT

7. GUARDIAN
 NAME AND ADDRESS (Check)
 PERSON ESTATE

8. SERVICE-CONNECTED CONDITIONS (Complete when information on monetary benefits is requested, even if only 0%)
 Conf. Neurosis 10% - Disfiguring scar, slight, rt. leg
 Area, Res. Plane, left eye.

9. REMARKS
 PD dat 7-31-42 to 10-6-45 Hon.

PART III - REQUEST (Check)

1. VA FORM 10-7132

2. HOSPITAL SUMMARY

3. 21 DAY CERTIFICATE EXAMINATION OF CONDITIONS LISTED

4. IN REMARKS

SPECIAL REPORT (Explain 5. in Remarks)

6. COMPETENCY REPORT

7. VA FORM 21-2680

8. ASSET INFORMATION

9. ADMISSION REPORT

10. OUTPATIENT TREATMENT REPORT

FROM:

TO:

NAME OF STATION AND NO. *Buffalo NY* SIGNATURE *E. S. Schader* DATE *4-3-70*

VA FORM 10-7131 MAY 1968

SUPERSEDES VA FORM 10-7131, APR 1965, AND 10-2731, JUN 1963, WHICH WILL NOT BE USED.

EXCHANGE OF BENEFICIARY INFORMATION AND REQUEST FOR ADMINISTRATIVE AND ADJUDICATIVE ACTION

COPY MADE FROM VETERAN'S CLAIM FOLDER

2/21

VETERANS ADMINISTRATION

STATEMENT IN SUPPORT OF CLAIM

CLAIM NO.

NOTE -- If additional space is needed, use reverse.

LAST NAME - FIRST NAME - MIDDLE NAME OF VETERAN (Type or print)

Schub, Edward H. Sr.

C-3453700

The following statement is made in connection with a claim for benefits in the case of the above named veteran:

Please reopen my claim for
increase in my S.C. nerve condition.
I am now a patient at VAH Syracuse for
H.P. treatment.

I am ~~not~~ a self-employed painter and
earned only \$500 in 1969 because
I couldn't work due to my nerves.

I CERTIFY that the foregoing statements are true and correct to the best of my knowledge and belief.

DATE SIGNED

2/11/70

SIGNATURE

SIGN
HERE

Edward H. Schub Sr.

ADDRESS

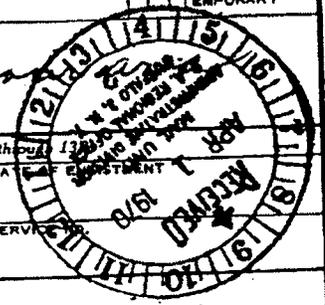
South Rd Bridgeport N.Y. 13030

PENALTY - The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement or evidence of a material fact, knowing it to be false.

COPY MADE FROM
VETERANS CLAIM FOLDER

C1/35

REQUEST FOR AND/OR NOTICE OF TRANSFER OF VETERANS RECORDS		
ITEM NO.	STATION NAME AND NO. <small>(Include mail routing symbol on temporary transfers only.)</small>	DATE
1	VARO, NY NY ³⁰⁷ BFLO	3/18/70
2		
4. DATE OF TRANSFER (37-42) 5. TRF. STA. NO. (44-46) 6. REC. STA. NO. (48-50)		
03 0770344307		
7. NAME OF REC. STA. (52-58)		8. FILE NO. (60-68)
BUFFALO		5-450-700
9A. LAST NAME (71-80)		
SCHAD		
9B. FIRST NAME (69)		9C. MIDDLE NAME (70)
EDWARD		H
10. TYPE OF FOLDER		11. TYPE TRANSFER
<input checked="" type="checkbox"/> C- 1 <input type="checkbox"/> OE <input type="checkbox"/> R & E <input type="checkbox"/> INS. <input type="checkbox"/> LG <input type="checkbox"/> PG <input type="checkbox"/> OPT <input type="checkbox"/> MED. REC. <input type="checkbox"/> HOSP. CORRES. <input type="checkbox"/> OTHER (Specify)		<input checked="" type="checkbox"/> PERMANENT <input type="checkbox"/> TEMPORARY
12. REASON FOR TRANSFER		
<i>Vet. residing year</i>		
NOTE: If file number is unknown, complete items 13A through 13D and attach to file.		
13A. DATE OF BIRTH		13B. DATE OF ENLISTMENT
13C. DATE OF DISCHARGE		13D. SERVICE NO.
14. REMARKS		
<i>4138 pend.</i>		
15. ADJUDICATION ACTION PENDING		16. CHAPTER 31 <small>(If checked, remove status card.)</small>
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/>
17. FROM (Originating Office)		18. DATE
VAROLA 344/211		3-13-70



VA FORM 07-7216
JAN 1969

SUPERSEDES VA FORM 23-7216, APR 1966, AND FL 10-68, JUN 1967, WHICH WILL NOT BE USED. 330

14/1162

COPY MADE FROM VETERANS CLAIM FOLDER

DEFERRED OR CONFIRMED RATING DECISION

DISABILITY DEATH ACCRUED

NAME OF VETERAN (Last—First—Middle) <i>Schad, Edward H</i>		CLAIM NO. <i>C-5450700</i>	DATE OF RATING <i>11/24/59</i>
ACTIVE DUTY DATE <i>7/31/42</i>	DATE OF S.A.D. <i>10/6/45 Hon</i>	DATE OF DEATH	DATE OF LAST EXAM. <i>9/5/52</i>

PART I.—DEFERRED RATING DECISION

RATING DEFERRED PENDING RECEIPT OF DATA INDICATED BELOW

EXAM. REPORT
 HOSP. REPORT
 FIELD EXAM. REPORT
 SUPPL. SERV. RECORDS
 EVID. FROM VETERAN OR OTHERS
 OTHER (Specify)

PART II.—CONFIRMED RATING DECISION

Claim reviewed on the following evidence:

Reviewed Letter D A 12/14/54 01

Which was received subsequent to rating action dated: *11/18/52*

This evidence does not warrant change in service-connected status or evaluation of any disability or contain any new and material evidence relevant to the question at issue which was not on file when the previous decision was made. Such decision is therefore CONFIRMED.

INFORMATION ON EXAMINATION REQUEST 21-2507 (check one or more)

NEW 21-2507 (see attached 21-563b)
 CHANGE DATE OF PRIOR 21-2507 TO:
 NO 21-2507
 21-2507 AS SCHEDULED
 CANCEL ALL PRIOR 21-2507

SIGNATURE OF RATING SPECIALIST (Medical) <i>Joseph Reeves</i>	SIGNATURE OF RATING SPECIALIST (Legal) <i>Frank Hand Bratt</i>	SIGNATURE OF RATING SPECIALIST (Occupational) <i>W. Linder</i>
<input type="checkbox"/> CHAIRMAN	<input type="checkbox"/> CHAIRMAN	<input type="checkbox"/> CHAIRMAN

CLAIMANT REPRESENTED BY: AL VPW DAV ARC AMVETS OTHER (Specify)

RATING BOARD NO. *A1* STATION NO. *3044*

COPY MADE FROM VETERANS CLAIM FOLDER

VETERANS ADMINISTRATION

MAY 8, 1957

FILE

MANAGER

VA REGIONAL OFFICE

ALBANY, NEW YORK

RE: [Illegible] MAY 2, 1957 [Illegible] [Illegible]
[Illegible] [Illegible] [Illegible] [Illegible] [Illegible]
AREA AND HIS PLACES LEFT 10% DISABLING. HOSPITAL BEING CLEAN.

/s/ [Illegible]

CHAPMAN

RECOMMENDED BY:

[Signature]
ADMINISTRATIVE OFFICER

COPY MADE FROM
VETERANS CLAIM FOLDER

COMMUNICATIONS

100 ST. STRACUSE, NY

APR. 1951

101 ST. SGB EDWARD H. SCHAD C-5-A710-7003 0715-1118

45-450-1700

[Handwritten signature]

[Handwritten signature]

RECEIVED
ADJUDICATION DIV.
7. A. RES. OFFICE
LOS ANGELES, CALIF.

MAY 2 PM 2:35

~~1956~~ 19 1956

Veterans Administration

1631 Broadway
Los Angeles, Calif.
Nov. 14, 1956

Edward H. Schad OK

C No - 5 450 700

A. Draft - 32278461

Ready for file 301
3044 - FINANCE
By JA
Date 11-26-56

Sirs -

Am writing in regard to my pension check which have been transferred to your office from Charles Bdd, Syracuse New York, I have not recieved the one for October and would like to know what the delay is. Would appreciate your kindness into looking in the delay.

Sincerely
Edward Harold Schad

Traces sent
11-26-56

COPY MADE FROM
VETERANS CLAIM FOLDER

Regional Office
Chines Building
Syracuse 2, New York

November 25, 1952

3071-8AA
C 5 450 700

Mr. Edward H. Schad
611 Plymouth Avenue
Syracuse 11, New York

Dear Mr. Schad:

Your claim for disability compensation has been reviewed under all applicable laws on the basis of all the evidence of record, including report of your recent physical examination at Syracuse, New York.

It has been determined that your scar, forehead condition, and the condition of your feet were incurred in service in World War II and are 0% disabling from June 23, 1952. If at any time in the future you desire further consideration be given your claim with respect to your scar, forehead condition, and the condition of your feet, not disabling to a compensable degree, you should submit a statement from your physician, setting forth his complete findings and diagnoses relative to these conditions. You are also entitled to treatment for these conditions should such treatment be necessary. This letter will help you to establish entitlement to such treatment and should be presented at the time of your application therefor.

It was further determined that the skin condition of your feet was not incurred in or aggravated by your service in World War II. The determination that your nervous condition was incurred in service in World War II and is 10% disabling remains unchanged. You will continue to receive \$15.75 monthly under your award of disability compensation.

You were represented in this action by the Veterans of Foreign Wars, recognized as your representative before the Veterans Administration.

Very truly yours,

A. C. RYKARSON
Adjudication Officer

Att:
FL 8-73

2 cc: VFW

RH:mpv

RK

COPY MADE FROM
VETERANS CLAIM FOLDER

RATING SHEET

CONFIRMED 11/19
VFW

INSTRUCTIONS.—If stencil is not used to fill in information in caption, then type only those items which are unshaded.

NAME SCHAD, Edward H.	C. NO. 5 450 700	DATE OF RATING 11/18/52
ADDRESS		DATE OF LAST EXAMINATION 9/5/52
CITY	STATE	DATE OF CLAIM
OCCUPATIONAL DETERMINATION (If required)		CODED
TYPE DISCH. Hon.	ACTIVE DUTY DATE 7/31/42	DATE R. A. D. 10/6/45
		JAN 22 1958

RATINGS

Jurisdiction: Claim for Increase.
Medical statement of Dr. Schiffman received 6/23/52.

Issue: Service connection for disfiguring scar; Pes Planus and Skin Condition.

Facts: Medical statement of Dr. Schiffman reveals an injury in the form of an abrasion of the right zygoma area, during a parachute jump over Germany. There is also indication that the veteran injured his left foot when he made a landing as noted above. Service records confirm injury to left foot and abrasion of the zygoma area. Statement of Dr. Schiffman also referred to a skin condition of the feet, not confirmed by service records. Examination of the right zygomatic area shows scarring, considered slightly disfiguring. Examination of the left foot shows localized tenderness over the attachment of the plantar fascia to the os calcis. There is no definite swelling palpable in this region. Dorsalis pedis and posterior tibialis are palpable. There is some flattening of the longitudinal arch. Range of motion is complete. X-ray of the left foot shows no evidence of fracture and no pathology.

Discussion: Future examination unnecessary - static condition.

9F
9105
A. Inc. WW II VR 1(a) Part 1 Par 1 (a)
10% from 10/7/45 to 3/31/46 (1933S)
10% from 4/1/46 (1945S)
ANXIETY NEUROSIS

0% from 6/23/52
DISFIGURING SCAR, SLIGHT, RIGHT ZYGOMA AREA; PES PLANUS, LEFT.

(SEE -PAGE-2)

CODED

NOV 5 1956

COPY MADE FROM VETERANS CLAIM FOLDER

Claimant's name: SCHAD, Edward H.

C- 5 450 700

G. Not service incurred or aggravated WW II
EL DEFORMITY OF LEFT 5 FINGER;
EPIDERMATOPHYTOSIS, FEET. 9

NO 8-2507

COMP COMBAT

NON COMP COMBAT

Represented by: Veterans of Foreign Wars.

CODED

NOV 5 1958

B. S. Harwood
B. S. HARWOOD, MD.
(Chief, Special Medical)

R. J. Keane
R. J. KEANE, M.D.
(Chief, Special Medical)

Rating Board No. 2

Veterans Affairs

COPY MADE FROM
VETERANS CLAIM FOLDER

VETERANS ADMINISTRATION REPORT OF MEDICAL EXAMINATION FOR DISABILITY EVALUATION	1. CLAIM NO. <i>C 5450700</i>
2. INSURANCE FILE NO. (N, V, or H, V pertinent)	

INSTRUCTIONS FOR PREPARING THIS FORM.—This report must be completely executed. Describe the results of a general examination of every system and body part including, but not restricted to, the systems and body parts involved in the history and present complaints. Wherever indicated, specialists' examinations, X-rays, laboratory examinations, etc., should be recommended. If additional space is needed, comments may be continued in item 44 or on separate sheets attached to this form.

3. LAST NAME—FIRST NAME—MIDDLE NAME OF VETERAN (Type or print) <i>SCHAD EDWARD H</i>		4. PURPOSE OF EXAMINATION <i>Comp.</i>	5. DATE OF EXAMINATION <i>9/5/52</i>
6. HOME ADDRESS (Street or RFD number, city, zone, and State) <i>611 Plymouth Ave. Syracuse 11, N.Y.</i>		7. PLACE OF EXAMINATION <i>R.O. Syracuse NY</i>	
8. BRANCH OF SERVICE	9. DATES OF ACTIVE SERVICE	10. SEX <i>M</i>	11. RACE <i>W</i>
		12. AGE <i>32</i>	13. DATE OF BIRTH <i>8/24/20</i>

SECTION A—OCCUPATIONAL HISTORY SINCE LATEST DISCHARGE FROM MILITARY SERVICE OR LATEST VA EXAMINATION

NAME AND ADDRESS OF EMPLOYER <i>(If unemployed, enter "None")</i>	TYPE OF WORK	MONTHLY WAGES	DATES OF EMPLOYMENT		TIME LOST
			FROM	TO	
14A. <i>Halemont Steel, City Shipping Ck.</i>		<i>61.50</i>	<i>Dec 50</i>	<i>Pres 3 months</i>	
14B.					
14C.					

14D. REASON FOR TIME LOST (If any)
sickness

SECTION B—MEDICAL HISTORY SINCE LATEST VA EXAMINATION AS RELATED BY PERSON EXAMINED

15. NARRATIVE HISTORY (Include manner and date of origin)

NAME AND ADDRESS OF DOCTOR OR HOSPITAL	CONDITION TREATED	FROM	TO
16A. <i>Dr. Schifferman Methylol, N.Y.</i>	<i>sickness</i>	<i>postwar</i>	
16B.			
16C.			

17. PRESENT COMPLAINT (Symptoms only, not diagnosis)
swellings

ADEQUATE FOR RATING
 OCT 17 1952
 DESIG. OF C. M. O.

I HEREBY CERTIFY that the entries under Occupational and Medical History are complete and correct to the best of my knowledge.

18. DATE SIGNED <i>9/5/52</i>	19. SIGNATURE OF PERSON EXAMINED (Do not print) <i>Edward H Schad</i>
----------------------------------	--

PENALTY.—The law provides that whoever makes any statement of a material fact, knowing it to be false, shall be punished by a fine of not more than \$1,000 or by imprisonment for not more than 1 year, or both.

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