Veterans Administration

Post Office Box 8079
Philadelphia PA 19101

N/R 5-20-85

April 22, 1985

IN REPLY REFER TO: 21/24

AMELIA L ERB
1555 BROOKSIDE RD
ALLENTOWN PA 18106

FILE NUMBER:
19-884-206 10
D ERB

The last VA check to AMELIA L ERB has been returned.

Please furnish the information requested below and return this letter to us. Your prompt reply will be appreciated.

If payee died show date and place of death:

Your relationship to payee:

Amelia L Erb - Died - Dec. 31, 1984 around 12:02 P.M.

Place of Death: 1555 Brookside Rd. Allentown, Pa. 18106

towards expenses of funeral - (she had that one before she died)
One - or first Check was given to Undertaker - Kulick - Emmaus

Two other checks were returned directly to Veterans administration, you should have received two uncashed checks -

I am the daughter of Amelia L Erb - who took care of her in her sickness - My name is: Ellenore M. Bartholomew - 1555 Brookside Rd. Allentown Pa. 18104, and I also was responsible for her burial. -

Yours truly
Ellenore M. Bartholomew -

Veterans Administration

VA FORM
AUG 1979 21-8332-1

AWARD OR DISALLOWANCE OF DISABILITY OR DEATH CLAIM WORKSHEET

TYPE OF LETTER

DISABILITY CLAIMS

- ☐ FL 21-822 NOTIFICATION OF AWARD
- ☐ FL 21-81 NOTICE TO VETERAN S/C ESTAB., MONETARY BENEFITS DENIED
- ☐ FL 21-138 NOTICE OF DISALLOWANCE OF CLAIM FOR DISABILITY PENSION

DEATH CLAIMS

- ☐ FL 21-822 NOTIFICATION OF AWARD
- ☐ FL 21-39 NOTICE OF DISALLOWANCE OF PARENTS CLAIM FOR D.I.C.
- ☐ FL 21-98 NOTICE OF DISALLOWANCE OF CLAIM FOR D.I.C. OR PENSION
- ☒ FL 21-144 NOTICE OF DISALLOWANCE OF D.I.C. AND REQ. FOR EVLD.

ATTACHMENTS

DISABILITY CLAIMS

- ☐ 21-6750 ADJUSTED COMPEN. BY REASON OF HOSPITALIZATION
- ☐ 21-6754 INCREASED DISABILITY COMPENSATION
- ☐ 21-6755 INCREASED AWARD OF DISABILITY COMPENSATION BECAUSE OF DEPENDENTS
- ☐ 21-6756 ACTIVE DUTY AND DRILL PAY ADJUSTMENT
- ☐ 21-6758 FIDUCIARY FOR DISABILITY COMPENSATION OR PENSION
- ☐ 21-6759 DISABILITY PENSION AWARD
- ☐ 21-6761 INFORMATION REGARDING PAYMENT OF BENEFITS DURING HOSP.
- ☐ 21-6763 REDUCED DISABILITY COMPENSATION
- ☐ 21-6766 INFORMATION ON GRADUATED RATING FOR RESP. CONDITION
- ☐ 21-6767 RESTORATION OF AWARD PENDING EXAMINATION
- ☐ 21-6768 INCREASED AWARD FOR AID AND ATTENDANCE
- ☐ 21-6769 APPORTIONED AWARD DURING HOSPITALIZATION
- ☐ 21-6773 APPORTIONED AWARD TO AN ESTRANGED WIFE
- ☐ 21-6776 INSTITUTIONAL AWARD
- ☐ 21-6782 ORIGINAL DISABILITY COMPENSATION
- ☐ 21-6791 AWARD APPOR. WITHHELD WHERE VET. & WIFE ESTRANGED

DEATH CLAIMS

- ☐ 21-6753 ORIGINAL OR AMENDED D.I.C. AWARD
- ☐ 21-6757 DEATH PENSION AWARD
- ☒ 21-6771 DEATH COMPENSATION AWARD — encls - 21-4100

SERVICE CONNECTION

ALLOWED FOR:	DEGREE	EFFECTIVE DATE

DENIED FOR:	DISALLOWANCE	PARAGRAPH

REMARKS

JL-144 — Cause of death — Heart disease

X Block 11 — complete enclosed VA Form 21-4100 showing your actual & expected gross income from all sources for 1962 — (This information was not shown on your application)

ENCLOSURES	NO. OF COPIES	COPIES TO:
1	ORIGINAL AND 1 COPIES	☐ AL ☐ AM. VETS. ☐ ARC ☐ DAV ☐ VFW ☐ OTHER (Specify)

SUBMITTED BY:	DATE	COMPLETED BY:	DATE
J	4-22-62		

☆ U.S. GOVERNMENT PRINTING OFFICE : 1961 O —591838

AWARD OR DISALLOWANCE SHEET

Check applicable box and complete Section I or Section II as appropriate.

☑ BURIAL ALLOWANCE ☐ ACCRUED AMOUNT PAYABLE AS REIMBURSEMENT ☐ DISALLOWANCE

NOTE. Do not complete items 4, 5, 6, 11, and 13 except when burial allowance is awarded.

1. STATION NO. 3010

2. LAST NAME—FIRST NAME—MIDDLE NAME OF DECEASED VETERAN: ERB DANIEL

3. CLAIM NO. XC-19884206

4. PERIOD OF ACTIVE SERVICE: 4A. FROM 9/19/17 4B. TO 7/26/19

5. DATE OF DEATH: 3/18/62

6. DID DEATH OCCUR IN VA HOSPITAL: ☐ YES ☑ NO

7. DATE CLAIM FILED: 4/2/62

8. LAST NAME—FIRST NAME—MIDDLE INITIAL OF DECEASED BENEFICIARY

9. RELATIONSHIP TO VETERAN

10. DATE OF BENEFICIARY'S DEATH

11. TYPE OF DECEASED VETERAN'S SERVICE *(Complete only if burial allowance is awarded)*

11A. WARTIME SERVICE *(Check applicable box(es))*

☐ KOREAN CONFLICT ☐ WORLD WAR II ☑ WORLD WAR I ☐ SPANISH-AMERICAN WAR ☐ OTHER *(Specify)*

11B. PEACETIME SERVICE

☐ DISCHARGED FOR DISABILITY INCURRED IN LINE OF DUTY OR WAS IN RECEIPT OF COMPENSATION FOR A SERVICE-CONNECTED DISABILITY AT TIME OF DEATH

SECTION I—AWARD

Payee is entitled to an award under provisions of laws checked in item 12 or 14.

12. BURIAL LAWS *(Check applicable box)*

☑ 38 U.S.C. 902-905 ☐ OTHER *(Specify)*

13. CLASS OF BURIAL AWARD

☑ INITIAL AWARD ☐ SUBSEQUENT AWARD

14. ACCRUED LAWS *(Check applicable box)*

☐ 38 U.S.C. 3021 AND 3022 ☐ OTHER *(Specify)*

15. AMOUNT OF BURIAL OR ACCRUED AWARD PAYEE ENTITLED TO

$ 250.00

(FOR FINANCE USE ONLY)

SUB. VOUCHER NO.

16. REMARKS *(Identify by Item No.)*

DPC APR 1962 MARO 3010

17. NAME AND ADDRESS OF PAYEE *(Or Claimant)*

CLARENCE R RITTER
FUNERAL HOME
36-38 SOUTH FIFTH ST
EMMAUS PA

SECTION II—DISALLOWANCE

Claim considered under applicable laws and disallowed.

19. REASONS FOR DISALLOWANCE *(Check applicable box(es))*

☐ A. DECEASED WAS NOT VETERAN OF ANY WAR
☐ B. NOT DISCHARGED OR RETIRED FROM PEACETIME SERVICE FOR DISABILITY INCURRED IN, OR AGGRAVATED BY, SERVICE IN LINE OF DUTY AND NOT IN RECEIPT OF COMPENSATION FOR SERVICE-CONNECTED DISABILITY
☐ C. CHARACTER OF DISCHARGE IS A BAR
☐ D. DIED IN SERVICE
☐ E. CLAIM NOT FILED WITHIN THE STATUTORY PERIOD
☐ F. EVIDENCE TO COMPLETE CLAIM NOT FURNISHED WITHIN THE STATUTORY PERIOD
☐ G. TOTAL BURIAL EXPENSES PAYABLE FROM BURIAL BENEFIT FROM OUTSIDE SOURCE
☐ H. BURIAL ALLOWANCE AUTHORIZED BY OTHER GOVERNMENT AGENCY
☐ I. NOT THE PROPER CLAIMANT
☐ J. OTHER REASONS *(Explain fully under "Remarks")*

20. DATE SUBMITTED	21. SIGNATURE OF REIMBURSEMENT CLAIMS EXAMINER	22. DATE APPROVED	23. SIGNATURE OF REIMBURSEMENT CLAIMS REVIEWER
4-17-62	Mina S. Freedman	4-17-62	T.H. Norman

24. NAME AND ADDRESS OF PERSONS TO BE NOTIFIED OF ACTION *(Other than Claimant)* FLB-143 (PAYEE)

AMELIA L. ERB.
ROUTE #1, EMMAUS, PA.

VA FORM NOV 1961 **21-4189** EXISTING STOCK OF VA FORM 21-4189, AUG 1959, WILL BE USED.

U.S. GOVERNMENT PRINTING OFFICE : 1961 OF—620461

AWARD OR DISALLOWANCE SHEET

1. R. O. INDENT. NO. 3010

2. TYPE OF AWARD
☒ ORIGINAL AWARD ☐ AMENDED AWARD ☐ INSTITUTIONAL AWARD ☐ DISALLOWANCE

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

LAST NAME — FIRST NAME — MIDDLE NAME: ERB, Daniel
C-NO.: 19 884 206
ADDRESS: Route #1
SERVICE — SERIAL NO.: 735 179
CITY: Emaus, Pa.
STATE
DATE OF CLAIM: 9-10-56
TYPE: 8-526
WAR: I
TYPE DISCHARGE: Hon
ACTIVE DUTY DATE: 9-19-17
DATE R. A. D.: 7-26-19
Army
6-7-86 Penna Cpl X M

3. DEGREE OF DISABILITY: PT Part III

4. CHECK APPLICABLE SERVICE(S)
☐ WAR SERVICE ☐ PEACE SERVICE ☒ NONSERVICE

5. DATE OF RATING: 10-11-56

6. PAYEE IS ENTITLED TO
☐ COMPENSATION ☒ PENSION ☐ RETIREMENT PAY
UNDER PROVISIONS OF ACT OF
PL 2 73rd C as amended,

7. AWARD DATA

A. NAME OF DEPENDENT	RELATIONSHIP	DATE OF BIRTH OR MARRIAGE	DATE OF CLAIM	DATE PROOF RECEIVED
1. Amelia F. Kline	W	6-25-21	Basic	9-10-56
2.				
3.				
4.				
5.				
6.				

B. PAYEE (If other than veteran, show name and address)	TOTAL AWARD	MONTHLY PAYMENTS	COMMENCING DATE	ENDING DATE
1.		78 75	9-10-56	—
2.				
3.				
4.				
5.				
6.				

8. REMARKS: Income not a bar
vet is 65 years of age.

SW

9. DISALLOWANCE DATA

A. BASIS FOR DISALLOWANCE (*Circle number of reasons for disallowance*)
2. NOT A VETERAN OF WARTIME SERVICE.
3. IN RECEIPT OF ACTIVE SERVICE OR RETIREMENT PAY.
4. DISCHARGED UNDER DISHONORABLE CONDITIONS.
5. LESS THAN ☐ 70 ☐ 90 DAYS WARTIME SERVICE.
6. DISABILITY INCURRED NOT IN LINE OF DUTY.
7. CLAIMANT'S FAILURE TO PROSECUTE.
8. RESULT OF OWN WILLFUL MISCONDUCT.
9. DISABILITY NOT INCURRED IN WARTIME SERVICE.
10. DISABILITY NOT INCURRED IN PEACETIME SERVICE.
11. LESS THAN 10 PERCENT OR 0 PERCENT DISABILITY.
12. DISABILITY NOT PERMANENT AND TOTAL.
13. INCOME SUFFICIENT TO BAR ENTITLEMENT.
14. DISABILITY NOT SHOWN AT TIME OF LAST EXAMINATION.
15. DISABILITY NOT SHOWN BY EVIDENCE OF RECORD.
16. CONSTITUTIONAL OR DEVELOPMENTAL ABNORMALITY.
17. OTHER. (*Specify*)

10. SUBMITTED (*Adjudicator*)	11. DATE	12. APPROVED (*Authorization officer*)	13. DATE
Chas H Clarke Jr	10-17-56	Lew Stetson Acting	10-17-56

VA FORM AUG 1950 8-553 EXISTING STOCK VA FORM 8-553, APR. 1947, WILL BE USED.

16—62483-1 U. S. GOVERNMENT PRINTING OFFICE

Form approved.
Budget Bureau No. 76-R355.1

VETERANS ADMINISTRATION

STATEMENT IN SUPPORT OF CLAIM

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

CLAIM NO.

LAST NAME—FIRST NAME—MIDDLE NAME OF VETERAN (*Type or print*)

Erb, Daniel nmi.

XC- 19 884 206

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

With reference to my V. A. Widow's pension claim I wish to inform your office that effective Apr. 1, 1965 I have been granted my Social Security benefits in the amount of $58.60 per month which will amount to $527.40 for 1965. I have been working part time only since Jan. 1, 1965 and my income from part time employment for Jan. was $20.00; Feb. $20.00, and March $20.00 making a total of $60.00 from part time employment. Due to my poor health I will not be able to work any more therefore my total gross income for 1965 will be none other than my Social Secueity - $527.40 and $60.00 from part time work making my total gross income for 1965 - $587.50

If there is any further information needed in regards to my claim please let me know and I will cooperate with your instructions.

RECEIVED
MAY 4 1965
ADJUDICATION
PHILA. PA.

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

DATE SIGNED	SIGNATURE
4/27/1965	SIGN HERE ▶ Amelia L. Erb

ADDRESS

R. F. D. #1, Emmaus, Pa. 18049

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 one year, or both.

VA FORM 21-4138
JAN 1963

GPO: 643 16 - 77965 - 1

VETERANS ADMINISTRATION
REGIONAL OFFICE
128 NORTH BROAD STREET
PHILADELPHIA 2, PENNSYLVANIA

IN REPLY REFER TO:

Mrs. Amelia L. Erb
Route No. 1
Emmaus, Penna.

JUN 1 2 1962

XC 19 884 206
ERB, Daniel
3010/211A

Dear Mrs. Erb:

You have been awarded benefits due and unpaid at the time of death of the payee in this case. A check in payment of the amount due will be mailed to you from the Treasury Department soon.

This check has no bearing on any other VA payments which you may be receiving or for which you may have filed claim.

Very truly yours,

R. J. McCAULEY
Adjudication Officer

FL 21-841
MAY 1960

RJM/jam

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

RATING DECISION

1. TYPE RATING	
2. NO. OF COPIES	
3. RATING PURPOSE	☐ DISAB. ☒ DEATH ☐ MEMO ☐ ACCRUED
4. ADDRESS OF VETERAN (If required on copy)	
5. CLAIM NUMBER	XC 19 884 206
6. STATION NO.	10
7. TYPE RATING	
8. SEX (1—MALE 2—FEMALE)	
9. INITIALS AND SURNAME OF VETERAN	D ERB
10. BR. OF SVC. (1-ARMY 2-NAVY 3-U.S.M.C. 4-U.S.C.G. 5-U.S.P.H.S. 6-AIR FORCE 7-PHIL. ARMY 8-WAAC 9-OTHER)	
11. ACTIVE DUTY DATES (Mo., day, yr.) EOD	9 19 17
RAD	7 26 19
12. COMBAT DISABILITIES (1—NONE 2—COMPENSABLE 3—NONCOMPENSABLE 4—BOTH)	
13. NUMBER OF SERVICE CONNECTED DISABILITIES (0 through 9)	
14. EMPLOYABILITY (1—EMPLOYABLE OR NOT AN ISSUE 2—UNEMPLOYABLE)	
15. DATE OF BIRTH (Month, day, year)	
16. DATE OF FUTURE MEDICAL EXAMINATION (Mo., day, yr. If "None," type "No Exam")	
17. COMPETENCY (1—COMPETENT OR NOT AN ISSUE 2—INCOMPETENT)	
18. DATE OF THIS RATING	5/24/62
19. DATE OF LAST EXAMINATION	
20. DATE OF DEATH	3/18/62

21. DIAG. CODE | % — 22. BODY OF RATING (J—Jurisdiction; I—Issue; F—Facts; D—Discussion)

8 NSC WW I
MYOCARDIAL INFARCTION DUE TO ARTERIOSCLEROTIC H. D.

6 CAUSE OF DEATH: MYOCARDIAL INFARCTION DUE TO ARTERIOSCLEROTIC H. D.
NSC as above

The fatal condition was first shown during 1956.

23. SPECIAL MONTHLY COMPENSATION	PARA. CODE / LOSS USE / ANAT. LOSS / OTHER LOSSES
24. SPECIAL PROV. CODE	1—PAR. 29 2—PAR. 30 3—VAR 1321 4—VAR 1322 5—ANALOGOUS RATING 6—OTHER OR COMB.
25. RATING SPECIALIST (Medical)	EDW. ZUKAUCKAS, MD CHM. ☐
26. RATING SPECIALIST (Legal)	J. L. AARON CHM. ☒
27. RATING SPECIALIST (Occupational)	W. N. BROWNSTEIN ☐
28. RATING BOARD NO.	1
29. CLAIMANT REPRESENTED BY	☐ AL ☐ ARC ☐ AMVETS ☐ DAV ☐ VFW ☐ OTHER (Specify)
30. COPIES TO	☐ CO ☐ MED. ☐ VRE ☐ OTHER (Specify)

de

VA FORM APR 1961 21-6796 EXISTING STOCKS OF VA FORM 21-6796, APR. 1960, WILL BE USED.

U.S. GOVERNMENT PRINTING OFFICE

VETERANS ADMINISTRATION
128 NORTH BROAD STREET
PHILADELPHIA 2, PENNA.

4-44

In Reply Refer To:
XC 19 884 206
ERB, D.
3010/211A

MAY - 1962

Mrs. Amelia L. Erb
Route 1
Emmaus, Pa.

ATTACHED
5-14-62
DATE

Dear Mrs. Erb:

We have carefully considered your claim for dependency and indemnity compensation. For entitlement to this benefit, the evidence must establish that the veteran's death was due to a service-connected disease or injury. You are not entitled to dependency and indemnity compensation because the evidence does not meet this requirement.

Cause of Death: Heart desease

We are now considering your claim for pension for death not due to service. Your attention is invited to the item checked below:

☒ 1. Please submit the following evidence so that further action may be taken. Complete the enclosed VA Form 21-4100 showing your actual and expected gross income from all sources for 1962. (This information was not shown on your application).

☐ 2. Please submit the evidence requested in our letter dated

The evidence requested above must be actually received in the VA within one year from date of letter otherwise no benefits are payable on the basis of this pending claim.

Any new evidence which you believe would justify a different decision should be sent to us promptly. If you have no further evidence but believe this decision is not correct, you may appeal to the Board of Veterans Appeals within one year from the date of this letter; otherwise, this decision becomes final. Should you wish to appeal, let us know so we may send you the proper form.

Very truly yours,

R. J. McCauley

R. J. McCAULEY
Adjudication Officer

RECEIVED
MAY 14 1962
ADJUDICATION
PHILA. 2, PA.

FL 21-144
Jun 1959 (R)

VA-DC-288961

3010/211A

Form Approved
Budget Bureau No. 76-R195.4

VETERANS ADMINISTRATION

STATEMENT OF INCOME AND NET WORTH

1. CLAIM NUMBER: XC- 19 884 206

2. FULL NAME OF PERSON WHOSE INCOME IS REPORTED: Amelia L. Erb

3. FIRST NAME - MIDDLE NAME - LAST NAME OF VETERAN: D. ERB

IMPORTANT - Read instructions on reverse before completing this form. All items must be answered. If your answer to any item is "none," write "none." For additional space, attach a separate sheet of paper indicating item numbers to which answers apply.

4. HAS WIDOW REMARRIED SINCE DEATH OF VETERAN?
☐ YES ☒ NO *(If "Yes," complete item 5)*

5. DATE REMARRIED:

ANNUAL INCOME *(By calendar year)*

6A. SOURCE OF INCOME LAST YEAR	6B. AMOUNT LAST YEAR
Housewife	$ None

7A. SOURCE OF INCOME RECEIVED AND EXPECTED THIS YEAR *(Year in which this form is signed by you)*	7B. AMOUNT RECEIVED AND EXPECTED THIS YEAR
Life Insurance	$ 126.00
No other income	

8A. SOURCE OF EXPECTED INCOME NEXT YEAR *(If unable to state exact amount, give an approximate amount expected)*	8B. AMOUNT EXPECTED NEXT YEAR
None	$ None

NET WORTH *(Value of estate)*				DEBTS	
9A. REAL ESTATE *(Other than your home)*	9B. SAVINGS	9C. STOCKS AND BONDS	9D. OTHER ASSETS	9E. MORTGAGES ON REAL ESTATE OTHER THAN HOME	9F. OTHER DEBTS
$ None	$ None	$ None	$ None	$ None	$ None

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

10. DATE	11. SIGNATURE OF WIDOW, CURRENT NAME
8 May 1962	Amelia L. Erb.

12. ADDRESS *(Street, city, zone and State)*: Route #1, Emmaus, Penna.

RECEIVED
MAY 14 1962
VERIFICATION
[redacted] 2, PA.

WITNESSES

If you sign by mark (X), it must be witnessed by two persons who know you personally and the signature and address of such witnesses must be shown below.

13. SIGNATURE OF FIRST WITNESS	14. ADDRESS *(Street, city, [redacted])*
15. SIGNATURE OF SECOND WITNESS	16. ADDRESS *(Street, city, zone and State)*

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.

V A FORM DEC 1960 **21-4100** EXISTING STOCKS OF VA FORM 21-4100, FEB 1960, WILL BE USED.

5-14 40 0

310

VETERANS ADMINISTRATION

REQUEST FOR INFORMATION

1. TYPE OF CLAIM: Original

2. SEPARATION FORMS ON FILE: [X] YES [ ] NO

3. DATA REQUESTED: [ ] SERVICE [X] MEDICAL [ ] DENTAL [ ] OTHER

4. TO: [X] ARMY 10 [ ] NAVY [ ] AIR FORCE [ ] MARINE CORPS [ ] COAST GUARD [ ] NATIONAL GUARD (Army) [ ] NATIONAL GUARD (Air) [ ] OTHER (Specify)

FROM

5A. NAME AND ADDRESS OF VA REQUESTING OFFICE: VARO, 128 N. Broad Street Philadelphia, Pa.

5B. ORIGINATING UNIT: Adjudication Div.

6. CLAIM NO.: XC 19 884 206

7. INSURANCE NO.:

8. LAST NAME - FIRST NAME - MIDDLE INITIAL (Under which served): ERB, Daniel

9. ALL SERVICE NOS.: 735 179

10. DATE OF BIRTH	11. PLACE OF BIRTH	12. DATE OF DEATH
6-7-86	Pa.	3-18-62

	13. DATE ENTERED ACTIVE DUTY	14. DATE SEPARATED FROM ACTIVE DUTY	15. CHARACTER OF SEPARATION OR DISCHARGE	16. LAST GRADE, RATE OR RANK, AND ORGANIZATION
A.	9-19-17	7-26-19	Hon.	
B.				
C.				

	17. ALLEGED DISEASE OR INJURY	18. DATES OF TREATMENT	19. PLACES OF TREATMENT	20. ORGANIZATION AT TIME DISEASE OR INJURY WAS INCURRED
A.				
B.				
C.				

21. ADDITIONAL INFORMATION REQUESTED

22. DATE: 5-8-62

23. SIGNATURE AND TITLE OF VA OFFICIAL: R. J. Mc CAULEY, Adjudication Officer

MSF:lr

ENDORSEMENT - VERIFICATION BY SERVICE DEPARTMENT (Check applicable box(es))

[ ] AVAILABLE REQUESTED RECORDS FORWARDED [ ] ITEMS 8 & 9, AND 12 THROUGH 15 VERIFIED CORRECT [ ] ITEMS 8 & 9, AND 12 THROUGH 15 VERIFIED CORRECT, EXCEPT:

ATTACHED
5-18-R
DATE INITIAL

No medical records found.

NO. OF ENCLOSURES	ORIG	COPY	NO. ENCLS. (Cont.)	ORIG	COPY
HEALTH RECORDS			CLINICAL RECORDS		
PHYSICAL EXAMINATIONS AT ENTRANCE	X		X-RAYS		
PHYSICAL EXAMINATIONS AT SEPARATION	X		DENTAL RECORDS		
			MEDICAL CARDS		
			OTHER RECORDS	X	

SERVICE INFORMATION — DATE: 5/15/62 — SIGNATURE AND TITLE: [illegible]

MEDICAL RECORDS — DATE — SIGNATURE AND TITLE

Military Personnel Records Center, GSA (Code)
St. Louis 32, Missouri

VA FORM 3101 JUL 1957

SUPERSEDES VA FORM 3101, NOV 1945; VA FORM 3101-1, NOV 1945; AND VA FORM 3102, JAN 1946; WHICH WILL NOT BE USED.

1

RE: Erb, Daniel
XC - 19 884 20

EMMAUS, PA. March 23, 19 62.

Mr. Daniel Erb Funeral Expenses

CLARENCE R. RITTER

FUNERAL HOME

Phone WO 5-2023

36-38 SOUTH FIFTH STREET

Coppertone Finish casket, Sunset Interior and				
Slumber Comfort, Plate engraved with name and				
Professional Services	575	00		
Embalming	35	00		
Hearse	10	00		
Grave and Airseal Vault	140	00		
Funeral Notices - Call & Chronicle	9	00		
Rev. Luther Linn	10	00		
			779	00
April 7/62 Check from Lehigh Co Treasurer			75	00
			704	00
May 1/62 U.S. Treasury Check			250.	00
		Bal.	454	00
May 1/62 Received cash from Mrs Amelia Erb			454.	00
Received Payment in full				
May 1/62 Clarence R. Ritter				

RECEIVED
MAY 14 1962
ADJUDICATION
PHILA. PA.

OPTIONAL FORM NO. 10
5010-103-02

UNITED STATES GOVERNMENT

Memorandum

TO : Unit

DATE: 5-4-62

FROM : ~~Bd~~ #1

SUBJECT: D. ERB XC19884206

Obtain 3101 (MEDICAL)

J. H. Brownstein

A[illegible] NO. 19884706

RO 3010 PHILA., PA.

Form approved.
Budget Bureau No. 76-R049.5.

VETERANS ADMINISTRATION

APPLICATION FOR UNITED STATES FLAG FOR BURIAL PURPOSES

IMPORTANT: Complete Original and Duplicate

SECTION I—APPLICATION (*A flag will not be furnished under any circumstances unless all information requested in this section is given in full.*)

1. NAME—FIRST NAME—MIDDLE NAME OF DECEASED (*Print or type*)

ERB, DANIEL

Erb, Daniel

BRANCH OF SERVICE (*Check*): [x] ARMY [ ] NAVY [ ] AIR FORCE [ ] MARINE CORPS [ ] COAST GUARD

NAME OF WAR (*Check*): [x] WWI [ ] WWII [ ] SPANISH AMERICAN [ ] OTHER (*Specify*)

CHECK THE CONDITION UNDER WHICH DECEASED WAS SEPARATED FROM SERVICE

[x] 1. VETERAN OF A WAR OR THE KOREAN CONFLICT DISCHARGED OR RELEASED FROM ACTIVE DUTY UNDER CONDITIONS OTHER THAN DISHONORABLE.

[ ] 2. DISCHARGED FROM, OR RELEASED FROM ACTIVE DUTY IN U. S. ARMED FORCES UNDER CONDITIONS OTHER THAN DISHONORABLE, AFTER SERVING AT LEAST ONE ENLISTMENT, OR DISCHARGED FOR DISABILITY INCURRED IN LINE OF DUTY.

[ ] 3. BY DEATH IN ACTIVE SERVICE AFTER MAY 27, 1941, AND FLAG NOT FURNISHED BY THE SERVICE DEPARTMENT.

[ ] 4. SEPARATED FROM 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 25, 1951.

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

Mrs. Amelia Erb (wife), Emmaus, R.1, Pa.

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

CLAIM NO.	SERVICE SERIAL NO.	DATE OF ENLISTMENT	DATE OF DISCHARGE	DATE OF BIRTH
C-	735179	9/19/1917	7/26/1919	6/7/1886

DATE OF DEATH	PLACE OF DEATH (*Address*)	PLACE OF BURIAL (*Address*)	DATE OF BURIAL
3/18/62	Emmaus, R.1, Pa.	Old Zionsville, Pa.	3/23/62

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	ADDRESS	RELATIONSHIP TO DECEASED	DATE
SIGN HERE IN INK Amelia Erb	Emmaus Route 1	wife	3/27/62

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 2008 MAR. 1960 EXISTING STOCKS OF VA FORM 2008, MAY 1956, WILL BE USED. 16-68962-7

530 + 134 Rent 4-6-62 ORIGINAL

Form approved.
Budget Bureau No. 76-R191.5.

VETERANS ADMINISTRATION

DISABLED VETERAN'S INCOME QUESTIONNAIRE

1. DATE MAILED

January 1, 1958

INSTRUCTIONS.—*Carefully read the instructions before completing this form.* The information called for below about your income is essential to determine whether you are entitled to continue receiving pension payments. Answer all questions fully, clearly and accurately. If the answer is none, write "NONE." IF YOU DO NOT RETURN THIS FORM TO THE OFFICE SHOWN BELOW WITHIN 30 DAYS FROM DATE SHOWN IN ITEM NO. 1, FURTHER PAYMENTS WILL BE DISCONTINUED.

2. NAME AND ADDRESS OF VETERAN OR FIDUCIARY

TO DANIEL ERB
ROUTE 1
EMMAUS
PA

$78.75*
C-19 884 206

VETERANS ADMINISTRATION
PHILA. REG. OFF.
128 N. BROAD ST.
PHILA. PA.

Please return the completed Form to the Veterans Administration office shown above.

3. PRESENT MARITAL STATUS
[XX] MARRIED [ ] WIDOWED
[ ] NEVER MARRIED [ ] DIVORCED

4A. HAVE YOU A CHILD OR CHILDREN? [ ] YES [XX] NO (*If "Yes," complete 4B*)

4B. DATE OF BIRTH OF YOUNGEST CHILD (*Month—day—year*)

	NAME AND ADDRESS OF EMPLOYER	DATES OF EMPLOYMENT CALENDAR YEAR 1957 (*From—To*)	AMOUNT RECEIVED CALENDAR YEAR 1957 (A)	AMOUNT EXPECTED CALENDAR YEAR 1958 (B)
			(*ANSWER BOTH COLUMNS*)	
5. GROSS WAGES OR SALARY	None RECEIVED JAN 6 1958 ADJUDICATION PHILA. 2, PA	None	$ None	$ None
6. DIVIDENDS, INTEREST			None	None
7. NET RENTAL INCOME (*Use back of sheet—Read Instruction No. 7*)			None	None
8. ANNUITIES, RETIREMENT BENEFITS (*Use back of sheet—Read Instruction No. 8*)			None	None
9. FEDERAL OLD-AGE AND SURVIVORS' INSURANCE (SOCIAL SECURITY BENEFITS)			800.40	800.40
10. NET PROFIT FROM SELF-EMPLOYMENT OR OPERATION OF BUSINESS (*Use back of sheet—Read Instruction No. 10*)			None	None
11. NET PROFIT FROM FARMING (*Use back of sheet—Read Instruction No. 11*)			None	None
12. OTHER SOURCES (*Name sources*)			None	None
13. TOTAL INCOME (*Sum of items 5, 6, 7, 8, 9, 10, 11 and 12*) (*DO NOT INCLUDE DISABILITY PENSION RECEIVED FROM VETERANS ADMINISTRATION*)			$ 800.40	$ 800.40

File 1-8

14. GROSS MONTHLY RATE OF WAGES OR SALARY BEING EARNED AT PRESENT TIME BEFORE ANY DEDUCTIONS	15A. WHEN DID YOU LAST FILE A FEDERAL INCOME TAX RETURN?	15B. LOCATION OF OFFICE OF INTERNAL REVENUE TO WHICH RETURN WAS SENT	16. SOCIAL SECURITY NO.
$ None	1951	Phila., Pa.	198 84 206

I HEREBY CERTIFY that the entries made herein are true and correct to the best of my knowledge and belief.

17. DATE	18. SIGNATURE OF VETERAN	19. ADDRESS (*If different than item 2*)
12/31/1957	SIGN HERE ▶ Daniel Erb	Same as above

PENALTY.—The law provides forfeiture of rights, claims, and benefits of a person who makes any statement of a material fact knowing it to be false. Upon conviction thereof, such person is subject to a fine of not more than $1,000 or imprisonment for not more than one year, or both.

WITNESSES TO SIGNATURE OF VETERAN IF MADE BY "X" MARK—*Signature made by mark must be witnessed by two persons who know the veteran personally and the signatures and addresses of such witnesses must be shown below.*

20A. SIGNATURE OF WITNESS	20B. ADDRESS (*City and State*)
21A. SIGNATURE OF WITNESS	21B. ADDRESS (*City and State*)

VA FORM JUN 1957 **VB 8-59** SUPERSEDES VA FORM VB 8-59 JUN 1956, WHICH WILL NOT BE USED.

Form approved.
Budget Bureau No. 76-R191.5.

VETERANS ADMINISTRATION

DISABLED VETERAN'S INCOME QUESTIONNAIRE

1. DATE MAILED

JAN 9 1957

INSTRUCTIONS.—*Carefully read the instructions before completing this form.* The information called for below about your income is essential to determine whether you are entitled to continue receiving pension payments. Answer all questions fully, clearly and accurately. If the answer is none, write "NONE." IF YOU DO NOT RETURN THIS FORM TO THE OFFICE SHOWN BELOW WITHIN 30 DAYS FROM DATE SHOWN IN ITEM NO. 1, FURTHER PAYMENTS WILL BE DISCONTINUED.

2. NAME AND ADDRESS OF VETERAN OR FIDUCIARY

$78.75*

TO DANIEL ERB

C-19 884 206

ROUTE 1
EMMAUS
PA

VETERANS ADMINISTRATION

PHILA. REG. OFF.
128 N. BROAD ST.
PHILA. 2 PA.

Please return the completed Form to the Veterans Administration office shown above.

3. PRESENT MARITAL STATUS
☒ MARRIED ☐ WIDOWED ☐ NEVER MARRIED ☐ DIVORCED

4A. HAVE YOU A CHILD OR CHILDREN? ☐ YES ☒ NO (*If "Yes," complete 4B*)

4B. DATE OF BIRTH OF YOUNGEST CHILD (*Month—day—year*)

5. GROSS WAGES OR SALARY	NAME AND ADDRESS OF EMPLOYER	DATES OF EMPLOYMENT CALENDAR YEAR 1956 (*From—To*)	AMOUNT RECEIVED CALENDAR YEAR 1956 (A) (*ANSWER BOTH COLUMNS*)	AMOUNT EXPECTED CALENDAR YEAR 1957 (B)
	None	None	$ None	$ None

RECEIVED
JAN 14 1957
ADJUDICATION
PHILA. 2 PA.

6. DIVIDENDS, INTEREST	None	None
7. NET RENTAL INCOME (*Use back of sheet—Read Instruction No. 7*)	None	None
8. ANNUITIES, RETIREMENT BENEFITS (*Use back of sheet—Read Instruction No. 8*)	None	None
9. FEDERAL OLD-AGE AND SURVIVORS' INSURANCE (SOCIAL SECURITY BENEFITS)	800.40	800.40
10. NET PROFIT FROM SELF-EMPLOYMENT OR OPERATION OF BUSINESS (*Use back of sheet—Read Instruction No. 10*)	None	None
11. NET PROFIT FROM FARMING (*Use back of sheet—Read Instruction No. 11*)	None	None
12. OTHER SOURCES (*Name sources*)	None	None
13. TOTAL INCOME (*Sum of items 5, 6, 7, 8, 9, 10, 11 and 12*) (*DO NOT INCLUDE DISABILITY PENSION RECEIVED FROM VETERANS ADMINISTRATION*)	$ 800.40	$ 800.40

14. GROSS MONTHLY RATE OF WAGES OR SALARY BEING EARNED AT PRESENT TIME BEFORE ANY DEDUCTIONS	15A. WHEN DID YOU LAST FILE A FEDERAL INCOME TAX RETURN?	15B. LOCATION OF OFFICE OF INTERNAL REVENUE TO WHICH RETURN WAS SENT	16. SOCIAL SECURITY NO.
$ None	1951	Phila., Pa.	181-05-1367

I HEREBY CERTIFY that the entries made herein are true and correct to the best of my knowledge and belief.

17. DATE	18. SIGNATURE OF VETERAN OR FIDUCIARY	19. ADDRESS (*If different than item 2*)
14 Jan. 57	SIGN HERE ▶ Daniel Erb	

PENALTY.—The law provides forfeiture of rights, claims, and benefits of a person who makes any statement of a material fact knowing it to be false. Upon conviction thereof, such person is subject to a fine of not more than $1,000 or imprisonment for not more than one year, or both.

WITNESSES TO SIGNATURE OF VETERAN IF MADE BY "X" MARK—*Signature made by mark must be witnessed by two persons who know the veteran personally and the signatures and addresses of such witnesses must be shown below.*

20A. SIGNATURE OF WITNESS	20B. ADDRESS (*City and State*)
21A. SIGNATURE OF WITNESS	21B. ADDRESS (*City and State*)

RATING SHEET

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

NAME	C-NO	DATE OF RATING
ERB, Daniel	19 884 206	10/11/56
ADDRESS	SERVICE SERIAL NO	DATE OF LAST EXAMINATION
Route #1	735 179	10/1/56
CITY / STATE	DATE OF CLAIM / TYPE / WAR	OCCUPATIONAL DETERMINATION (If required)
Emmaus, Pa.	9-10-56 / 8-526 / I	
TYPE DISCH / BR SERVICE	ACTIVE DUTY DATE / DATE R A D	
Hon / Army	9-19-17 / 7-26-19	0
DATE OF BIRTH / PLACE OF BIRTH	RANK / RACE / SEX	
6-7-86 / Penna	Cpl / X / M	

RATINGS

Jurisdiction: Original Claim

Issue: P & T, Part III

Facts: This 70 year old veteran claims total unemployability since June 1951. He is in receipt of $66.70 per month social security. VA exam of 10/1/56 reveals veteran has severe sclerosis of brachial and temporal arteries and that he has had marked disability of hands because of spasticity. Veteran has a high albuminuria with hematuria creating a chronic nephritis. The veteran is senile and has many other disabilities. He is believed to be unemployable in fact. In absence of definite work stoppage date award from date of claim.

2. PT WW I from 9/10/56

7005 ARTERIOSCLEROTIC HEART DISEASE (60%)
w/NEPHRITIS & NEUROLOGIC DISABILITY OF HANDS
CATARACT, LEFT (10%)
Combined (60%)

18. Individual Unemployability - 100%

No 8-2507

ABSTRACT

OCT 23 1956

c/c Mand

RATING SPECIALIST (Medical)	RATING SPECIALIST (Claims)	RATING SPECIALIST (Occupational)
S. PAGLIANTE, M.D.	C. MC LAUGHLIN, Chm.	C. K. MORSE
RATING BOARD NO.	VETERANS ADMINISTRATION (Name of station)	
2	3010, Phila. 2, Pa.	hw

VA FORM JUN 1955 VB 8-564 EXISTING STOCKS OF VA FORM 8-564, DEC 1946, WILL BE USED.

U. S. GOVERNMENT PRINTING OFFICE : 1955—O-348780

Form Approved.
Budget Bureau No. 76-R246.1.

VETERANS ADMINISTRATION

REPORT OF MEDICAL EXAMINATION FOR DISABILITY EVALUATION

1. CLAIM NO. C- 19884206

2. INSURANCE FILE NO. (N, V, or H, if 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)	4. PURPOSE OF EXAMINATION	5. DATE OF EXAMINATION
ERB DANIEL	PENSION PURPOSES.	OCT 1 1956

6. HOME ADDRESS (Street or RFD number, city, zone, and State)	7. PLACE OF EXAMINATION
R.F.D. #1 EMMAUS, PA.	VETERANS ADMINISTRATION 128 NORTH BROAD STREET PHILADELPHIA 2, PENNA.

8. BRANCH OF SERVICE	9. DATES OF ACTIVE SERVICE	10. SEX	11. RACE	12. AGE	13. DATE OF BIRTH
11 Infantry Corporal	Served In FRANCE From Apr. 24, 1918 to July 20, 1919	MALE	White	70	JUNE 7, 1886

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

	NAME AND ADDRESS OF EMPLOYER (If unemployed, enter "None")	TYPE OF WORK	MONTHLY WAGES	DATES OF EMPLOYMENT FROM	DATES OF EMPLOYMENT TO	TIME LOST
14A.	~~PHACONOLE FOUNDRY~~	~~LABOR~~	~~About $18~~	~~1940~~	~~1946~~	
14B.	Unemployed					
14C.						

14D. 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)

Five years ago veteran had a "heart attack" from which he never fully recovered and has continued in his present debilitated and incapacitated state. His finger joints appear to be

	NAME AND ADDRESS OF DOCTOR OR HOSPITAL	CONDITION TREATED	FROM	TO
16A.	Frederick Dry	TABULATED Condition		
16B.	Emmaus, Pa.	Treated 5 yrs — to this date.		
16C.		OCT 3 1956		

17. PRESENT COMPLAINT (Symptoms only, not diagnosis)

Heart Condition stiff and cannot be flexed enough to enable him to close his hand. ABSTRACT

Hard of hearing for 2 yrs or more. OCT 8 1956

RECEIVED

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)
OCT 1 1956	Daniel Erb OCT 8 1956

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.

ADJUDICATION PHILA. 2, PA.

VA FORM OCT 1950 10-2545 SUPERSEDES VA FORM 2545, DEC. 1945 WHICH WILL NOT BE USED.

16-63041-2

DATE RECEIVED FOR RATING OCT 4 - 1956

SECTION C—EXAMINATION (*Examinee must be stripped*)

20. HEIGHT	21. WEIGHT	22. MAX. WT. PAST YEAR	23. BUILD AND STATE OF NUTRITION	24. TEMPERATURE
5'2"	121 LBS.	121 LBS.	small - well nourished	

25. CARRIAGE	26. POSTURE	27. GAIT	28. (RIGHT) OR LEFT-HANDED—HOW DETERMINED	
fair	fair	small steps	sets statement	AT AM PM

29. SKIN—INCLUDING APPENDAGES (*Describe type, area, and extent of lesions. Report injuries, including burns, under item 41.*)

Patches of vitiligo on both hands
Acne vulgaris, mild, on back & upper arms.

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

n s a

31. HEAD, FACE, AND NECK Gray and balding.

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

Full d entures - both jaws - but cannot chew on his lower denture.

33A. EARS (*Describe canals, drums, perforations, discharge. Specify tests made for air and bone conduction and attach audiometric test chart, if made*)

n s a on inspection - but has poor hearing bilaterally

33B. HEARING (*In feet*)

	BEFORE CORRECTION	CORRECTED BY AID
R (WV)		
L (WV)		
R (CV)		
L (CV)		

34A. EYES (*Describe external eye, pupil reaction, movements and field of vision*)

senile, advanced, blot. Very poor vision - rt. eye - due to cataract. Wears glasses

34B. DISTANT VISION

R 20/	CORRECTED TO 20/
L 20/	CORRECTED TO 20/

35A. CARDIOVASCULAR SYSTEM (*Describe thrust, size, rhythm, sounds, and condition of peripheral vessels*)

Brachial and temporal arteries show advanced sclerosis.

Heart - normal size, irregular rhythm, soft systolic murmur over apex and base, on g. m. exam. History of myocardial infarction.

	35B. PULSE	35C. BLOOD PRESSURE	35D. RESPIRATION	35E. IF NOT EXERCISED, GIVE REASON
SITTING	92	S 128 D 60	20	
RECUMBENT		S D		
STANDING		S D		
SITTING AFTER EXERCISE		S D		
2 MIN. AFTER EXERCISE		S D		

36A. VARICOSE VEINS (*Describe location, size, extent, ulcers, scars, and competency of deep circulation*)

n s a

36B. ARE ELASTIC STOCKINGS NECESSARY?

36C. IS OPERATION RECOMMENDED?

REPORT OF MEDICAL EXAMINATION
DISABILITY EVALUATION

18—68041-1

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

37A. RESPIRATORY SYSTEM (*Describe cough, expectoration, mobility, palpation, percussion, and auscultation and specify area*)

n s a

37B. SHAPE OF CHEST

normal

37C. EXPIRATION

3u INCHES

37D. INSPIRATION

3 5 INCHES

38. DIGESTIVE SYSTEM (*Describe findings on inspection and palpation, enlargements, masses, tenderness, rigidity, hemorrhoids (internal or external), fissures, stricture, prolapse, etc.*)

32" in girth -

Abdomen - n s a

Rectum - n s a

39. HERNIA (*Describe type, location, size, whether complete, reducible, recurrent, retained by truss, and whether operable*)

n s a

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*)

n s a

41. MUSCULO-SKELETAL SYSTEM

(*A—DISEASES and INJURIES, include effect of gunshot wounds and other injuries on skin and underlying structures.*

B—SCARS, describe location, measurements, depression, type of tissue loss, adherence, disfigurement, and tenderness.

C—FUNCTIONAL EFFECTS, describe location, swelling, atrophy, tenderness, degree of limitation of flexion and extension, angle of fixation, fracture or disease, fibrous or bony residual, and specify mechanical aid used and benefit.

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 limitation in degrees and indicate whether right or left, acquired or congenital.

E—BURNS, degree and area in square inches.)

Hands - marked disability functionally because of spasticity and weakness - associated with this "heart attack" veteran states.

42. ENDOCRINE SYSTEM (*Describe disease of thyroid, pituitary, adrenals, pancreas, gonads, etc.*)

nea

43. NERVOUS SYSTEM

(A—NEUROLOGICAL, describe motor status, coordination, reflexes, sensory status, equilibrium, and give exact 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 (*Cite number of item continued in this space*)

#46-
4- Defective Hearing, severe
5- " " Dentition, mod. severe
6- " " Vision - almost blind in rt. eye (cataract?) + poor vision in left, presbyopia
7- Vitiligo, hands.
8- Acne, back, mod. severe
9- Senility - debilitated and incapacitated
10- Urine (10/1/56) - albuminuria cylindruria and hematuria compatible with nephritis, chronic.

45A. LABORATORY TESTS, X-RAYS, BMR, EKG, ETC.	45B. DATE MADE	45C. URINALYSIS		
		SPECIFIC GRAVITY	ALBUMIN	SUGAR
		MICROSCOPIC		

45D. OTHER TESTS RECOMMENDED, ETC.

46. DIAGNOSIS 1. Arteriosclerosis, brachials & temporal arteries, severe
2. Residuals of myocardial infarction, history
3 Disability, neurologic, hands, severe.

47A. IS EXAMINEE BEDRIDDEN?	47B. IS HOSPITALIZATION NEEDED?	47C. WILL EXAMINEE ACCEPT HOSPITALIZATION?
No	no	
48A. IS EXAMINEE ABLE TO TRAVEL?	**48B. ALONE?**	**48C. WITH ATTENDANT?**

49. SPECIALISTS' EXAMINATIONS RECOMMENDED

ADMINISTRATIVELY ADEQUATE
FOR RATING OCT 3 1956
REFERRED FOR ACTION

50. SIGNATURE OF PHYSICIAN	NAME AND SPECIALTY (*Type or print*)	DATE SIGNED
E. L. Straub, MD	F. L. Straub, M.D. GM	10/1/56
51. SIGNATURE OF PHYSICIAN	**NAME AND SPECIALTY (*Type or print*)**	**DATE SIGNED**
52. SIGNATURE OF PHYSICIAN	**NAME AND SPECIALTY (*Type or print*)**	**DATE SIGNED**
53. SIGNATURE OF REVIEWING OFFICER	**NAME AND TITLE (*Type or print*)**	**DATE SIGNED**

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

U. S. GOVERNMENT PRINTING OFFICE 16-63041-1

Form approved by Comptroller General, U. S. June 10, 1952

VETERANS ADMINISTRATION

AUTHORIZATION TO REPORT—VOUCHER FOR MILEAGE ALLOWANCE

(Beneficiary Travel)

1. DATE ISSUED: SEP 20 1956

AUTHORIZATION TO REPORT

2. NAME, CLAIM NO., AND ADDRESS OF VETERAN

C- 19 884 206

Mr. Daniel Rob
Route #1
Ramona, Penna.

3. NAME AND ADDRESS OF ISSUING OFFICE

Veterans Administration
Regional Office, 3010
128 N. Broad Street
Philadelphia 2, Pa.

4. REPORT TO Cherry St. Entrance

- ☐ Receptionist - 2nd Floor
- ■ Receptionist - 3rd Floor
- ☐ Receptionist - 4th Floor

AND RETURN

5. REASON FOR REPORTING: APPOINTMENT WITH: Pension #13

6. WHEN TO REPORT

■ VETERAN WILL REPORT (Date) TIME: October 1, 1956 2:15 P.M. ☐ DOCTOR WILL NOTIFY VETERAN WHEN TO REPORT ☐ VETERAN WILL CONTACT DOCTOR FOR APPOINTMENT

REMARKS

Should you be unable to keep the above appointment, please contact this office or phone LOcust 8-0400, Extension 303.

8. TRAVEL AT GOVERNMENT EXPENSE

■ IS AUTHORIZED ☐ IS NOT AUTHORIZED

9. AUTHORIZATION PERIOD

10. AUTHORITY: V. A. Reg. 6100

11. SIGNATURE OF AUTHORIZING OFFICIAL

Designate of Chief Medical Officer VA

12. FISCAL SYMBOLS 3870156.001 - 8618.42-0220

13. ESTIMATED COST OF TRAVEL

$

14. TRAVEL AUTHORIZATION (*Show "type" of travel authorized, serial No(s). of Government request form(s), ticket(s), etc.*)

GENERAL INSTRUCTIONS TO VETERAN

Present this authorization when reporting for the purpose indicated above. If you cannot report on the date(s) indicated, or if you have moved to a city or town other than shown above, write new address or reason for inability to report on bottom of other side of this form and return to this office. (If you return this authorization do not report until you are furnished another one.)

INSTRUCTIONS TO VETERAN WHEN AUTHORIZED TO TRAVEL AT GOVERNMENT EXPENSE (See item 8 above)

1. If you are authorized to travel at Government expense, you may choose one of the following:

(a) You may pay your own necessary expenses of travel, and

(1) be paid an allowance of 5 cents per mile for the total mileage involved (round trip) in place of all expenses incurred by you, including meals and lodging. OR

(2) be repaid whatever you spend for actual and necessary expenses. If you choose this option, you must get receipts in duplicate for all expenses on which local or State taxes are paid; for Pullman accommodations; and for each additional item of expense over $3.00. (The Veterans Administration cannot repay you more than $1.25 for any single meal; more than $2.25 for any single lodging; or more than $6.00 for meals and lodging for any 24 hour period). OR

(b) If you do not wish to use your own money for travel expenses, you may return this authorization, stating on the bottom of the other side of this form, the kind of transportation desired, for example, the name of the railroad or bus company. Government request forms, which may be exchanged for tickets and necessary meals and lodging, will then be furnished you. When you travel, the Government transportation request should be presented to the ticket office of the transportation company named. The meal and lodging request should be shown to the waiter or hotel clerk before ordering a meal or registering at a hotel. Any such forms not used must be returned promptly to this office.

2. Claim for reimbursement of travel expenses must be received within 30 days following completion of your travel.

FREDERICK A. DRY. M. D. — Reg. No. 9541 — Phone WO. 5-2622 — 222 Main Street

STANLEY S. STAUFFER, M. D. — Reg. No. 5363 — EMMAUS, PENNSYLVANIA

For .....

℞ Address ..... Date 9-4-56.

To whom it may concern:

Mr. Daniel Erb has been under my care for the past five years. Diagnosis – myocardial infarction with generalized arteriosclerosis.

19 884 206

Sincerely

F. A. Dry M. D.

REFIL UT DICT.
1 ☐ 2 ☐ 3 ☐ 4 ☐ TIMES
P. R. N. ☐ NON. REP. ☐
REFILLED — — — —

Form approved,
Budget Bureau No. 76-R007.2.

VETERANS ADMINISTRATION

VETERAN'S APPLICATION FOR COMPENSATION OR PENSION

Do Not Write in This Space

NOTE.—Disability compensation is paid for disability resulting from service in the armed forces. Disability pension is paid for disability not resulting from service in the armed forces. Pension is paid only to veterans of wartime service or of service on or after June 27, 1950, and the disability must be permanent and total.

While a claimant may employ an attorney or claim agent recognized by the Veterans Administration to assist him in prosecuting his claim, it is not necessary that he do so. Any attorney or agent so employed may not legally charge any fee other than that allowed and paid by the Veterans Administration, and which is deducted from benefits otherwise payable to the claimant.

Instructions.—Answer all pertinent questions fully. Write plainly, print or typewrite. If you need information about the meaning of any question, write the Veterans Administration Regional Office. If additional space is needed for any item, use "Remarks" section on page 4.

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. ADDRESS (*Number and street, city, zone number and State*)
Erb, Daniel nmi.	Route #1, Emmaus, Pa.

3. DATE OF BIRTH	4. PLACE OF BIRTH	5. SEX
7 June 1886	Treichlersville, Pa. Berks County	XX MALE ☐ FEMALE

6. NUMBER AND ADDRESS OF SELECTIVE SERVICE BOARD WITH WHICH YOU REGISTERED (*If none, write "None"*)	7. HOME ADDRESS AT TIME OF REGISTRATION
Does not apply	Does not apply

19884206

SERVICE INFORMATION

LIST EACH PERIOD OF ACTIVE SERVICE, INCLUDING BEGINNING AND ENDING OF RESERVIST OR NATIONAL GUARD STATUS
(*It is important to show all service numbers, particularly the last number assigned—including Reserve or National Guard*)

8. BRANCH OF SERVICE IN WHICH YOU SERVED (*Check which*)

XX ARMY ☐ NAVY ☐ AIR FORCE ☐ MARINE CORPS ☐ COAST GUARD ☐ OTHER (*Specify*)

9. ENTERED SERVICE: DATE	9. ENTERED SERVICE: PLACE	10. SERVICE NO.	11. SEPARATED FROM SERVICE: DATE	11. SEPARATED FROM SERVICE: PLACE	12. GRADE AND ORGANIZATION	13. TYPE OF SEPARATION*
17 Sept. 1917	Allentown, Pa.	735179	26 July 1919	Cpl. Detachment 11th Inf. Regt. Camp Dix., N. J.		Honorable Discharged - Demobilization

* *Enter "Retired (permanent or temporary)," "Discharged" or "Released from active duty."*

14. IF YOU SERVED UNDER ANOTHER NAME, GIVE NAME AND PERIOD DURING WHICH YOU SERVED

Same as above

15. IF RESERVIST OR NATIONAL GUARDSMAN, GIVE BRANCH OF SERVICE AND PERIOD OF ACTIVE OR INACTIVE TRAINING DUTY DURING WHICH DISABILITY OCCURRED

Does not apply

16A. HAVE YOU EVER APPLIED FOR ANY BENEFITS OR MEDICAL TREATMENT FROM THE VETERANS ADMINISTRATION?

☐ YES XX NO (*If "Yes," complete 16B, 16C, 16D, and 16E*)

16B. VETERANS ADMINISTRATION BENEFITS (*Check those applied for*)

☐ HOSPITALIZATION OR DOMICILIARY CARE
☐ OUT-PATIENT TREATMENT
☐ EDUCATION OR TRAINING UNDER PUBLIC LAW 16
☐ COMPENSATION OR PENSION
☐ EDUCATION OR TRAINING UNDER PUBLIC LAW 346
☐ DISABILITY ALLOWANCE
☐ INSURANCE BENEFITS OR WAIVER OF NATIONAL SERVICE LIFE INSURANCE PREMIUMS

(None)

16C. DATE OF APPLICATION	16D. CLAIM NO.	16E. LOCATION OF CLAIMS FOLDER
None	C- None	None

RECEIVED SEP 13 1956 ADJUDICATION PHILA 2, PA.

17A. ARE YOU NOW RECEIVING RETIREMENT OR RETAINER PAY?	17B. BRANCH OF SERVICE	17C. MONTHLY AMOUNT
☐ YES XX NO (*If "Yes," complete 17B and 17C*)		$

18A. HAVE YOU EVER APPLIED FOR OR RECEIVED DISABILITY SEVERANCE PAY?	18B. AMOUNT
☐ YES XX NO (*If "Yes," complete 18B*)	$

19A. HAVE YOU EVER HAD A MEDICAL EXAMINATION FROM ANY U. S. GOVERNMENT CIVILIAN AGENCY?	19B. DATE EXAMINED	19C. NAME AND LOCATION OF AGENCY
☐ YES XX NO (*If "Yes," complete 19B and 19C*)		

20. HAVE YOU EVER FILED A CLAIM FOR COMPENSATION FROM THE U. S. BUREAU OF EMPLOYEES COMPENSATION (*Formerly the U. S. Employees' Compensation Commission*)?	21A. ARE YOU NOW HOSPITALIZED OR RECEIVING DOMICILIARY CARE?	21B. NAME AND ADDRESS OF INSTITUTION
☐ YES ☒ NO	☐ YES ☒ NO (*If "Yes," complete #1B*)	None

22. NATURE OF DISEASES OR INJURIES FOR WHICH CLAIM IS MADE AND DATE EACH BEGAN

Total-Non-service-Connected-Disability

Severe Heart Condition.

Items 23, 24, and 25 should be completed only if disability is claimed to be the result of service in the armed forces. (Veterans of the Indian Wars, Spanish American War, Boxer Rebellion, or Philippine Insurrection need not complete these items.)

23. IF YOU RECEIVED ANY TREATMENT WHILE IN SERVICE, FILL IN THE FOLLOWING INFORMATION

NAME, NUMBER, OR LOCATION OF HOSPITAL, FIRST AID STATION, DRESSING STATION, OR INFIRMARY	DATES OF TREATMENT	NATURE OF SICKNESS, DISEASE, OR INJURY

24. LIST CIVILIAN PHYSICIANS WHO HAVE TREATED YOU FOR ANY SICKNESS, DISEASE OR INJURY PRIOR TO, DURING, OR SINCE YOUR SERVICE

NAME	PRESENT ADDRESS	DISABILITY	DATE

25. LIST PERSONS OTHER THAN PHYSICIANS WHO KNOW ANY FACTS ABOUT ANY SICKNESS, DISEASE OR INJURY WHICH YOU HAD PRIOR TO, DURING, OR SINCE YOUR SERVICE

NAME	PRESENT ADDRESS	DISABILITY	DATE

16—66320-1

26. MARITAL STATUS (Check one)

☐ NEVER MARRIED ☒ MARRIED ☐ WIDOWED ☐ DIVORCED

27. NUMBER OF TIMES YOU HAVE BEEN MARRIED: Once

28. NUMBER OF TIMES YOUR PRESENT SPOUSE HAS BEEN MARRIED: Once

29. FURNISH THE FOLLOWING INFORMATION REGARDING EACH OF YOUR MARRIAGES

DATE AND PLACE OF MARRIAGE	TO WHOM MARRIED	HOW MARRIAGE TERMINATED (Death, divorce)	DATE AND PLACE TERMINATED
June 25, 1921 Emmaus, Pa. License Was taken out in Lehigh County	Amelia L. Kline	Does not apply	

30. FURNISH THE FOLLOWING INFORMATION REGARDING EACH PREVIOUS MARRIAGE OF YOUR PRESENT SPOUSE

DATE AND PLACE OF MARRIAGE	TO WHOM MARRIED	HOW MARRIAGE TERMINATED (Death, divorce)	DATE AND PLACE TERMINATED
June 25, 1921 Emmaus, Pa.	Daniel Erb	Does not apply	

31A. DO YOU LIVE TOGETHER?	31B. REASON FOR SEPARATION	31C. PRESENT ADDRESS OF SPOUSE
☒ YES ☐ NO (If "No," complete 31B and 31C)		

32. LIST EACH LIVING CHILD OF THE VETERAN WHO IS UNDER 18 YEARS OLD AND UNMARRIED, OR OVER 18 AND UNDER 21 AND ATTENDING SCHOOL, OR ANY CHILD OF ANY AGE WHO IS INSANE, IDIOTIC, OR OTHERWISE PERMANENTLY HELPLESS

FULL NAME OF CHILD	DATE OF BIRTH (Month, day, year)	PLACE OF BIRTH	NAME AND ADDRESS OF PERSON HAVING CUSTODY OF CHILD
None			

33A. IS YOUR FATHER DEPENDENT UPON YOU FOR SUPPORT?	33B. NAME AND ADDRESS OF DEPENDENT FATHER
☐ YES ☒ NO (If "Yes," complete 33B)	
34A. IS YOUR MOTHER DEPENDENT UPON YOU FOR SUPPORT?	**34B. NAME AND ADDRESS OF DEPENDENT MOTHER**
☐ YES ☒ NO (If "Yes," complete 34B)	

35. NAME AND PRESENT ADDRESS OF NEAREST RELATIVE	36. DO YOU CLAIM TO BE TOTALLY DISABLED?
Mrs. Amelia L. Erb, wife Route #1, Emmaus, Pa.	☒ YES ☐ NO

Items 37 through 45 should be completed only if you claim to be totally disabled. (Veterans of the Indian Wars, Spanish American War, Boxer Rebellion, or Philippine Insurrection need not complete these items.)

37. DATE YOU BECAME TOTALLY DISABLED	38A. ARE YOU NOW EMPLOYED?	38B. DATE YOU BECAME UNEMPLOYED
June 1951	☐ YES ☒ NO (If "No," complete 38B)	June 1951

39. LIST ALL YOUR EMPLOYMENT, INCLUDING SELF-EMPLOYMENT, FOR 1 YEAR BEFORE YOU BECAME TOTALLY DISABLED

NAME AND ADDRESS OF EMPLOYER	KIND OF WORK	MONTHS WORKED	TIME LOST FROM ILLNESS	TOTAL EARNINGS
Macungie Foundry Macungie, Pa.	Labor	June 1950 June 1951	two months	1500.00

16—66320-1

Social Security No 181-05-1367

40A. WHAT IS THE MOST YOU EVER EARNED IN ANY ONE YEAR	40B. WHAT YEAR	40C. OCCUPATION IN YEAR YOU EARNED THE MOST
$ 2500.00	1944	Moulder

41. LIST ALL YOUR EMPLOYMENT, INCLUDING SELF-EMPLOYMENT, SINCE YOU BECAME TOTALLY DISABLED

NAME AND ADDRESS OF EMPLOYER	KIND OF WORK	MONTHS WORKED	TIME LOST FROM ILLINESS	TOTAL EARNINGS
None				

42. IF YOU WERE SELF-EMPLOYED BEFORE BECOMING DISABLED, JUST WHAT PART OF THE WORK DID YOU DO	43. IF YOU ARE STILL SELF-EMPLOYED, JUST WHAT PART OF THE WORK DO YOU DO NOW
Does not apply	Does not apply

44. EDUCATION (Circle highest year finished)	45. OTHER EDUCATION
1 2 3 4 5 6 (7) 8 (GRADE) 1 2 3 4 (HIGH) 1 2 3 4 (COLLEGE)	None

Items 46 through 49 should be completed only if you are applying for pension. (Veterans of the Indian Wars, Spanish American War, Boxer Rebellion, or Philippine Insurrection need not complete these items.)

46. WHAT ASSISTANCE DO YOU RECEIVE TOWARD YOUR LIVING OTHER THAN YOUR EARNINGS FROM WORK

$66.70 per month from Social Security Benefits.

47A. IS ANY PART OF YOUR INCOME A PUBLIC ASSISTANCE BENEFIT?	47B. AMOUNT	47C. SOURCE
☐ YES ☒ NO (If "Yes," complete 47B and 47C)	$	

48. WHAT INCOME DO YOU EXPECT TO RECEIVE DURING THIS CALENDAR YEAR	49. IF YOU BECAME TOTALLY DISABLED DURING THIS CALENDAR YEAR, WHAT INCOME DO YOU EXPECT TO RECEIVE FROM THAT DATE TO THE END OF CALENDAR YEAR
$ 800.40 From Social Security	$ Does not apply

50. IF CLAIM IS FILED IN BEHALF OF AN INCOMPETENT VETERAN, DOES THE VALUE OF HIS ESTATE EQUAL OR EXCEED $1,500?

☐ YES ☒ NO Does not apply

51. REMARKS (Cite item numbers continued in this space)

Due to my poor health condition I am not able to work at a gainful occupation, also my old age is a great handicap.

RECEIVED SEP 10 1956

CERTIFICATION

I CERTIFY that the foregoing statements are true and complete to the best of my knowledge and belief. I consent that any physician, surgeon, dentist or hospital that has treated me or examined me for any purpose, or that I have consulted professionally, may divulge to the Veterans Administration any information concerning myself and I waive any privilege which renders such information confidential.

52. DATE	53. SIGNATURE OF CLAIMANT
7 Sept. 56	Daniel F. [illegible]

Witnesses to Signature of Claimant If Made by "X" Mark

54A. SIGNATURE OF WITNESS	54B. ADDRESS OF WITNESS
55A. SIGNATURE OF WITNESS	**55B. ADDRESS OF WITNESS**

PENALTY.—The laws of the United States provide severe penalties involving forfeiture of rights, fines and imprisonment for any false statement or fraud knowingly made or submitted in connection with any claim for, or receipt of, compensation or pension.

16—66820-1 U. S. GOVERNMENT PRINTING OFFICE : 1955—O-366215

Form Approved.
Budget Bureau No. 76-R010.8.

VETERANS ADMINISTRATION

APPLICATION FOR DEPENDENCY AND INDEMNITY COMPENSATION OR DEATH PENSION BY WIDOW OR CHILD

(INCLUDING ACCRUED BENEFITS AND DEATH COMPENSATION, WHERE APPLICABLE)

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.*

(DO NO WRITE IN THIS SPACE
VA DATE STAMP)

1. LAST NAME—FIRST NAME—MIDDLE NAME OF DECEASED VETERAN *(Type or print)*
Erb, Daniel Nmi.

2A. FIRST NAME—MIDDLE NAME—LAST NAME OF CLAIMANT *(Type or print)*
Amelia L. Erb

2B. MAILING ADDRESS OF CLAIMANT *(Number and street or rural route, city or P.O., zone number and State)*
Route #1,
Emmaus, Pa.

2C. RELATIONSHIP TO VETERAN *(Check one)*
☒ WIDOW ☐ CHILD

3. IF VETERAN PREVIOUSLY APPLIED TO THE VETERANS ADMINISTRATION FOR ANY BENEFIT, INSERT CLAIM NUMBER IF KNOWN
C- 19 884 206

4. SOCIAL SECURITY ACCOUNT NO. OF VETERAN
181-05-1367

5. RAILROAD RETIREMENT NO.
None

6. VETERANS ADMINISTRATION CLAIM NO.
XC- 19 884 206

PART I—IDENTIFICATION AND SERVICE INFORMATION OF VETERAN

7. DATE OF BIRTH	8. PLACE OF BIRTH	9. DATE OF DEATH	10. PLACE OF DEATH
6/7/1886	Hereford, Pa.	18 Mar. 1962	Route #1, Emmaus, Pa.

11A. CAUSE OF DEATH *(See Instructions, paragraph F)*
Heart Disease

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

SERVICE INFORMATION

NOTE—The following information should be furnished for each period of the veteran's active service 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.

12A. ENTERED ACTIVE SERVICE DATE	12A. ENTERED ACTIVE SERVICE PLACE	12B. SERVICE NO.	12C. SEPARATED FROM ACTIVE SERVICE DATE	12C. SEPARATED FROM ACTIVE SERVICE PLACE	12D. GRADE, RANK OR RATING, ORGANIZATION AND BRANCH OF SERVICE
9/19/1917		735,179	7/26/1919	Cpl.	Co. D. 11th Inf. Regt.
Allentown, Pa.			Camp Dix., N. J.		

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

PART II—INFORMATION RELATING TO MARRIAGE *(See Instructions, paragraph G)*

INFORMATION RELATING TO VETERAN

14. HOW MANY TIMES HAS VETERAN BEEN MARRIED?
Once

15A. MARRIAGE DATE	15A. MARRIAGE PLACE	15B. TO WHOM MARRIED	15C. HOW MARRIAGE ENDED *(Death, divorce, etc.)*	15D. MARRIAGE ENDED DATE	15D. MARRIAGE ENDED PLACE
25 June 1921	Emmaus, Pa.	Amelia L. Kline	Death	18 Mar. 1962	Route #1, Emmaus, Pa.

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

16. HOW MANY TIMES HAS WIDOW BEEN MARRIED?
Once

17A. MARRIAGE DATE	17A. MARRIAGE PLACE	17B. TO WHOM MARRIED	17C. HOW MARRIAGE ENDED *(Death, divorce, etc.)*	17D. MARRIAGE ENDED DATE	17D. MARRIAGE ENDED PLACE
25 June 1921	Emmaus, Pa.	Daniel Erb	Death	18 Mar. 1962	Route #1, Emmaus, Pa.

PART II—INFORMATION RELATING TO MARRIAGE *(Continued)*

NOTE.—If claimant is not the veteran's widow, omit items 18 to 26, inclusive.

18. MAIDEN NAME OF VETERAN'S WIDOW *(First—middle—last)*	19. DATE OF BIRTH
Amelia L. Kline	4/27/1903

20. PLACE OF BIRTH	21. WAS A CHILD BORN OF WIDOW'S MARRIAGE TO VETERAN?	22. DID WIDOW LIVE CONTINUOUSLY WITH THE VETERAN FROM DATE OF MARRIAGE TO DATE OF DEATH?
Vera Cruz, Pa.	XXX YES ☐ NO	XXX YES ☐ NO *(If "No," fill in 23)*

23. CAUSE OF SEPARATION *(Explain fully, giving reason, date of separation, duration, etc. If separation was by court order, attach a certified copy of such order.)*

Does not apply

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24. HAS WIDOW REMARRIED SINCE DEATH OF VETERAN?	25. DATE REMARRIED	26. PLACE REMARRIED
☐ YES XXX NO *(If "Yes," fill in items 25 and 26)*		

PART III—INFORMATION CONCERNING CHILDREN *(See Instructions, Paragraph III)*

APR 10 1962

IDENTIFICATION OF CHILDREN AND INFORMATION RELATIVE TO CUSTODY

NOTE.—List below, the name of each unmarried child of the veteran, including adopted child or stepchild, under 18 years of age (or under 21 years of age if attending school); or of any age if permanently incapable of self-support by reason of mental defect or physical defect. If the birth of a child of the veteran is expected, that fact should be stated.

PHILA. 2, PA.

27A. NAME OF CHILD	27B. DATE OF BIRTH	27C. PLACE OF BIRTH	27D. NAME AND ADDRESS OF PERSON HAVING CUSTODY OF EACH CHILD
None under 18 yrs. of age			

NOTE.—Item 28 to be answered by widow only if any child listed above is not in her custody.

28. DO YOU ALSO DESIRE THIS APPLICATION TO BE CONSIDERED AS A CLAIM FOR THE VETERAN'S CHILDREN LISTED IN ITEM 27A, WHO ARE NOT IN YOUR CUSTODY?

☐ YES XX NO Does not apply

ADDITIONAL INFORMATION RELATING TO CHILDREN LISTED IN ITEM 27A

29. NAME OF LEGALLY ADOPTED CHILD *(If none, write "NONE")*	30. NAME OF HELPLESS CHILD *(If none, write "NONE")*	31. HAS SUCH CHILD EVER MARRIED?
None	None	☐ YES XXXX

32. NAMES OF CHILDREN OF AGE 18, 19, OR 20, WHO ATTEND SCHOOL REGULARLY *(If none, write "NONE")*

None

33. NAME OF ILLEGITIMATE CHILD *(If none, write "NONE")*	34. NAME OF STEPCHILD *(If none, write "NONE")*
None	None

NOTE.—If no children are listed in items 33 and 34, do not fill in item 35.

35. NAMES OF CHILDREN LISTED IN ITEMS 33 AND 34 WHO WERE MEMBERS OF THE VETERAN'S HOUSEHOLD AT TIME OF VETERAN'S DEATH *(If none, write "NONE")*

None

NOTE—If the veteran died while in active service or if he had no service after April 5, 1917, do not fill in Part IV.

PART IV—ANNUAL INCOME OF WIDOW AND/OR CHILD *(By calendar year)*

IMPORTANT—*Read carefully Instructions, paragraph I, before answering questions. All items required to be filled in must be answered FULLY and COMPLETELY.*

NOTE—If part of your income is from Social Security Annuity based on your own employment as distinguished from the employment of your husband complete the following:

36A. BEGINNING DATE	36B. MONTHLY AMOUNT	36C. SOCIAL SECURITY NUMBER
None	$ None	None

NOTE—If part of your income is from any other retirement plan or annuity based upon your employment or purchase complete the following:

37A. BEGINNING DATE	37B. MONTHLY AMOUNT	37C. BY WHOM PAID	37D. AMOUNT YOU PAID INTO PLAN
None	$ None	None	$ None

INCOME DURING CALENDAR YEAR IN WHICH VETERAN DIED

NOTE—Fill in only if application is filed within one year from date of veteran's death.

38A. WIDOW AND/OR CHILD OR CHILDREN	38B. AMOUNT OF INCOME FROM JANUARY 1ST TO DATE OF DEATH	38C. SOURCE OF INCOME
NAME OF WIDOW Amelia L. Erb	$ None	Housewife
NAME OF CHILD	$	
NAME OF CHILD	$	
NAME OF CHILD	$	

39A. WIDOW AND/OR CHILD OR CHILDREN	39B. AMT. OF INCOME RECEIVED AND EXPECTED FROM DATE OF DEATH TO DEC. 31ST OF SAME YEAR	39C. SOURCE OF INCOME
NAME OF WIDOW Amelia L. Erb	$ 126.00	Life Insurance
NAME OF CHILD	$	
NAME OF CHILD	$	
NAME OF CHILD	$	

INCOME RECEIVED AND EXPECTED THIS CALENDAR YEAR *(Year in which this form is signed by you)*

NOTE—Do not fill in if claim is filed in calendar year in which veteran died.

40A. WIDOW AND/OR CHILD OR CHILDREN	40B. AMOUNT OF INCOME	40C. SOURCE OF INCOME
NAME OF WIDOW Does not apply	$	
NAME OF CHILD	$	
NAME OF CHILD	$	
NAME OF CHILD	$	

EXPECTED ANNUAL INCOME FOR NEXT CALENDAR YEAR

NOTE—If unable to state exact amounts, give approximate amounts expected.

41A. WIDOW AND/OR CHILD OR CHILDREN	41B. AMOUNT OF INCOME	41C. SOURCE OF INCOME
NAME OF WIDOW Amelia L. Erb	$ None	None
NAME OF CHILD	$	
NAME OF CHILD	$	
NAME OF CHILD	$	

ANNEXED XC 443 A

Form Approved.
Budget Bureau No. 76-R009.5

VETERANS ADMINISTRATION

APPLICATION FOR BURIAL ALLOWANCE

IMPORTANT—Read Instructions on reverse before filling in form. YOUR COMPLETE COMPLIANCE WITH ALL INSTRUCTIONS WILL EXPEDITE ACTION ON YOUR CLAIM.

1. SOCIAL SECURITY NO. OF VETERAN	2. CLAIM NO.
181-05-1367	XC- 19 884 206

3. LAST NAME—FIRST NAME—MIDDLE NAME OF DECEASED VETERAN	4. LAST NAME—FIRST NAME—MIDDLE NAME OF CLAIMANT
Erb, Daniel nmi.	Ritter, Clarence R. Funeral Director

PART I—INFORMATION REGARDING VETERAN

5. DATE OF BIRTH	6. PLACE OF BIRTH	7. DATE OF DEATH	8. PLACE OF DEATH
6/7/1886	Hereford, Pa.	3/18/1962	Route #1, Emmaus, Pa.

9. DATE OF BURIAL	10. PLACE OF BURIAL	11. LEGAL DOMICILE AT TIME OF DEATH
3/23/1962	Zionsville, Pa.	Route #1, Emmaus, Pa.

12. LIVING RELATIVES (Check): [XX] SPOUSE [ ] MOTHER [ ] FATHER

13. MARITAL STATUS: [ ] NEVER MARRIED [XX] MARRIED [ ] WIDOWED [ ] DIVORCED (If ever married, fill in 14A and 14B)

14A. FULL NAME OF SPOUSE: Amelia (Kline) Erb

14B. ADDRESS OF SPOUSE (If living): Route #1, Emmaus, Pa. ATTACHED 4-9R

15A. FULL NAME OF FATHER

16A. FULL NAME OF MOTHER

DATE INITIAL

15B. ADDRESS OF FATHER (If living): Deceased

16B. ADDRESS OF MOTHER (If living): Deceased

SERVICE INFORMATION— NOTE: The following information should be furnished for the period of the Veteran's active service in the Army, Navy, Air Force, Marine Corps, or Coast Guard of the United States.

17A. ENTERED SERVICE DATE	17A. ENTERED SERVICE PLACE	17B. SERVICE NO.	17C. SEPARATED FROM SERVICE DATE	17C. SEPARATED FROM SERVICE PLACE	17D. GRADE, RANK OR RATING, ORGANIZATION AND BRANCH OF SERVICE
9/19/1917	Allentown, Pa.	735,179	7/26/1919	Camp Dix., N. J.	Cpl. Co. D. 11th Inf. Regt.

18. IF VETERAN SERVED UNDER A NAME OTHER THAN THAT SHOWN IN ITEM 3, GIVE FULL NAME AND SERVICE RENDERED UNDER THAT NAME: Same as above

19A. WAS THE VETERAN AT THE TIME OF DEATH ON ACTIVE OR INACTIVE DUTY AS A MEMBER OF THE RESERVE FORCES OF THE ARMY, NAVY, AIR FORCE, MARINE CORPS, COAST GUARD, OR A MEMBER OF THE NATIONAL GUARD? [ ] YES [XX] NO (If "Yes," fill in 19B and 19C)

19B. TYPE OF DUTY AT TIME OF DEATH: [ ] ACTIVE [ ] INACTIVE

19C. BRANCH OF SERVICE

20. SOURCE FROM WHICH ABOVE INFORMATION WAS SECURED: Honorable Discharge & Widow

PART II—INFORMATION RELATING TO VETERAN'S BURIAL

21. TOTAL EXPENSE OF BURIAL, FUNERAL, AND TRANSPORTATION	22A. HAVE BILLS BEEN PAID IN FULL?	22B. AMOUNT UNPAID
$ 779.00	[ ] YES [XX] NO (If "No," fill in 22B)	$ 779.00

23A. HAS ANY AMOUNT BEEN ALLOWED ON EXPENSES BY STATE OR FEDERAL AGENCY?	23B. AMOUNT	23C. SOURCE	24. WAS THE VETERAN A MEMBER OF A BURIAL ASSOCIATION OR COVERED BY BURIAL INSURANCE?
[XX] YES [ ] NO (If "Yes," fill in 23B and 23C)	$75.00	Lehigh County Comm. Allentown, Pa.	[ ] YES [XX] NO (Before answering, read and comply with Instruction No. 7 on reverse)

NOTE: If claim is made by person who paid the bills, fill in 25A and 25B.

25A. WHOSE FUNDS WERE USED?

25B. HAS PERSON WHOSE FUNDS WERE USED BEEN REIMBURSED? [ ] YES [ ] NO (If "Yes," fill in 25C)

25C. AMOUNT AND SOURCE OF REIMBURSEMENT $

NOTE: Where the claimant is a firm or other unpaid creditor, the following certification must be made 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.

30. SIGNATURE OF PERSON WHO AUTHORIZED SERVICES (If signed by mark, fill in items 34A through 35B on reverse): Amelia L. Erb

31. ADDRESS (Number and street or rural route, city or P.O., zone number and State): Route #1, Emmaus, Pa.

32. DATE: 3-30-1962

33. RELATIONSHIP TO VETERAN: Widow

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.

26. SIGNATURE OF CLAIMANT (If signed by mark, 34A through 35B on reverse should be executed): Clarence R. Ritter

27. SIGNATURE AND CAPACITY OF PERSON SIGNING FOR FIRM

28. ADDRESS (Number and street or rural route, city or P.O., zone number and State): 36-38 S. 5th St., Emmaus, Pa.

29. CREDITOR ~~OR RELATIONSHIP TO DECEASED~~: Creditor

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.

VA FORM FEB 1960 **21-530** EXISTING STOCKS OF VA FORM 21-530, JAN 1959, WILL BE USED.

WARNING: It is illegal to duplicate this copy by photostat or photograph.

MAR 29 1962 — Date

358155 — No.

This is to certify that this is a true copy of the record which is on file in the Pennsylvania Department of Health, in accordance with Act 66, P. L. 304, approved by the General Assembly, June 29, 1953.

Issued Free On Military Status

(Fee for this certification $1.00)

C. L. Wilbar Jr.

C. L. Wilbar, Jr., M. D.
Secretary of Health
Harrisburg, Pennsylvania

Local Reg. No. 19

Primary Dist. No. 31-364

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH
VITAL STATISTICS

CERTIFICATE OF DEATH

File No.

1. PLACE OF DEATH
a. County: Lehigh
b. City, Borough or Township: Emmaus
c. Length of stay in 1b.:
d. FULL NAME (If NOT in hospital, give street address) of HOSPITAL or INSTITUTION: Route 1
e. Is Place of Death Inside Municipality Limits? Yes ☐ No ☒

2. USUAL RESIDENCE (where deceased lived. If institution: residence before admission)
a. State: Pa. b. County: Lehigh
c. City, Borough or Township: Emmaus
d. Street Address or Location: Route 1
e. Is Residence Inside Municipality Limits? Yes ☐ No ☒
f. Is Residence on a Farm? Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): a. (First) DANIEL Daniel b. (Middle) c. (Last) ERB

4. DATE OF DEATH: (Month) March (Day) 18 (Year) 1962

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6/7/1886
9. AGE (In years last birthday): 75 — If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10. FULL NAME OF SPOUSE: Amelia Erb KLINE
11. BIRTHPLACE (Also give state or foreign country): Hereford, Berks Co., Pa.
12. CITIZEN OF WHAT COUNTRY: U. S.

13. FATHER'S NAME: William Erb
14. MOTHER'S MAIDEN NAME: Mary Shade

15. USUAL OCCUPATION (even if retired): Laborer, East Penn Foundry
16. Social Security No.: 181-05-1367
17. INFORMANT: Mrs. Amelia Erb, ADDRESS: Emmaus, R. 1, Pa

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) & (c)]
PART I. Death was caused by:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Myocardial Infarction	3 hrs
Conditions, if any, which gave rise to above cause (a) stating the underlying cause last. DUE TO (b)	Arteriosclerotic Heart Disease	10 yrs
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS [contributing to death but not related to the terminal disease given in Part I (a)]

19. WAS AUTOPSY PERFORMED? Yes ☐ No ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED.
20c. Time of Injury: Hour, m. E.S.T. / Month, Day, Year
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (e.g., home, farm, factory, street, etc.)
20f. CITY, BOROUGH, TOWNSHIP / COUNTY / STATE

21. *I hereby certify that I attended the above named deceased and that death occurred at* 12:15 P m, E. S. T., *from the causes and on the date state above.*

22a. SIGNATURE: F. A. Rau, M.D. or D.O.
22b. ADDRESS: 224 Main St. Emmaus Pa
22c. DATE SIGNED: March 19 1962

23a. BURIAL ☒ CREMATION ☐ REMOVAL ☐
23b. DATE: 3/23/62
23c. NAME OF CEMETERY OR CREMATORY: Zions Lutheran Cemetery
23d. LOCATION (City, Boro., Twp. & County) (State): Old Zionsville, Lehigh, Pa.

24. DATE REC'D BY REG.: 3-22-62
25. REGISTRAR'S SIGNATURE: Catherine A. Weiler
26. SIGNATURE OF FUNERAL DIRECTOR: Clarence R. Ritter
ADDRESS: 38205 4th Emmaus Pa

2M 7-55

ORPHANS' COURT OF LEHIGH COUNTY, PA. — ETHAN A. GEARHART, PRESIDENT JUDGE

COMMONWEALTH OF PENNSYLVANIA
COUNTY OF LEHIGH } ss:

I, RUSSELL F. C. BENFER, Clerk of the Orphans' Court in and for the County aforesaid, **DO HEREBY CERTIFY,** That on the Twenty Fifth day of June in the year of our Lord, one thousand nine hundred and Twenty One Daniel Erb and Amelia F. Kline were united in marriage in accordance with License issued by the Clerk of the Orphans' Court of Lehigh County, Pennsylvania, numbered 38593 at Emmaus, Pa. by Rev David C. Kaufman

Mans age 35 years
Womans age 18 "

IN WITNESS WHEREOF, I have hereunto set my hand and official seal, at Allentown, Pennsylvania, this Seventh day of September A. D., 1956

Russell F. C. Benfer
Clerk of Orphans' Court

Assistant Clerk of Orphans' Court

ASN. 735179

Form approved.
Budget Bureau No. 76-R008.3.

VETERANS ADMINISTRATION

EMPLOYMENT STATEMENT

(In Support of Claim for Total Disability Benefits)

1. LAST NAME—FIRST NAME—MIDDLE NAME OF CLAIMANT (*Type or print*)
Erb, Daniel nmi.

2. CLAIM NO.
C- Pending

3. SOCIAL SECURITY NO.
181-05-1367

4. DATE YOU BECAME TOTALLY DISABLED
June 1951

5A. WHAT IS THE MOST YOU EVER EARNED IN ANY ONE YEAR?
$ 2500.00

5B. WHAT YEAR?
1944

5C. OCCUPATION DURING THAT YEAR
Moulder

6. LIST ALL YOUR EMPLOYMENT, INCLUDING SELF-EMPLOYMENT, FOR 1 YEAR BEFORE YOU BECAME TOTALLY DISABLED

NAME AND ADDRESS OF EMPLOYER	KIND OF WORK	MONTHS WORKED	TIME LOST FROM ILLNESS	TOTAL EARNINGS
Macungie Foundry Macungie, Pa.	Labor	June 1950 June 1951	two months	$1500.00

19884206

7. LIST ALL YOUR EMPLOYMENT, INCLUDING SELF-EMPLOYMENT, SINCE YOU BECAME TOTALLY DISABLED

NAME AND ADDRESS OF EMPLOYER	KIND OF WORK	MONTHS WORKED	TIME LOST FROM ILLNESS	TOTAL EARNINGS
None				

8. IF YOU WERE SELF-EMPLOYED BEFORE BECOMING TOTALLY DISABLED, DESCRIBE THE WORK YOU DID YOURSELF
Does not apply

9. IF YOU ARE STILL SELF-EMPLOYED, DESCRIBE THE WORK YOU DO NOW
Does not apply

10. DID YOU HAVE TO QUIT YOUR LAST JOB OR SELF-EMPLOYMENT ON ACCOUNT OF YOUR PHYSICAL CONDITION?
☒ YES ☐ NO (*If "yes," give the facts*)
Due to my old age and poor health.

11. IF YOU ARE NOT NOW EMPLOYED OR SELF-EMPLOYED, ON WHAT DATE DID YOU LAST WORK?
June 1951

12. IF YOU ARE NOW EMPLOYED OR SELF-EMPLOYED, HOW LONG DO YOU WORK?
Does not apply HOURS A DAY DAYS A WEEK

13. LIST THE EMPLOYMENT YOU HAVE TRIED AND FAILED TO OBTAIN DURING THE PAST YEAR

NAME AND ADDRESS OF EMPLOYER	KIND OF WORK	DATE APPLIED
None other than listed above.		

14. WHY DO YOU CONSIDER YOURSELF TOTALLY DISABLED?
Due to my old age and poor health condition.

15A. TOTAL EARNINGS FROM WORK FOR PAST 12 MONTHS
$ None

15B. TOTAL EARNINGS FROM WORK FOR PAST 3 MONTHS
$ None

16. WHAT ASSISTANCE DO YOU RECEIVE TOWARD YOUR LIVING EXPENSES OTHER THAN YOUR EARNINGS FROM WORK?
$66.70 per month from Social Security Benefits.

VA FORM 8-527 DEC 1953 SUPERSEDES VA FORM 8-527, NOV 1950, WHICH WILL NOT BE USED.

16—60803-1

17. EDUCATION (*Enter highest year completed*)

GRADE SCHOOL	HIGH SCHOOL	COLLEGE
7th	None	None

18. NATURE OF AND TIME SPENT IN OTHER EDUCATION OR TRAINING: None

19A. DURING THE PAST 12 MONTHS WERE YOU (*Check applicable box or boxes*)

[XX] UNDER DOCTOR'S CARE [XX] ILL IN BED AT HOME [ ] ILL IN HOSPITAL

19B. DATES OF ILLNESS: During the past 5 years.

19C. NATURE OF ILLNESS: Severe Heart Condition.

19D. NAME AND ADDRESS OF DOCTOR (*If any*): Dr. Frederick A. Dry

19E. NAME AND ADDRESS OF HOSPITAL (*If any*): 222 Main Street, Emmaus, Pa.

Answer items 20 through 31 if you operate a farm or business.

20. KIND OF FARM OR BUSINESS YOU OPERATE: Does not apply

21. DO YOU OWN THE FARM OR BUSINESS? [ ] YES [ ] NO

22. DO YOU LIVE ON THE FARM OR BUSINESS PREMISES? [ ] YES [ ] NO

23. HOW MUCH OF YOUR FOOD COMES FROM FARM, STOCK OR PRODUCT? [ ] NEARLY ALL [ ] ABOUT HALF [ ] LITTLE [ ] NONE

FARM INFORMATION

24A. NUMBER OF ACRES

24B. ACRES IN CULTIVATION

24C. GROSS RECEIPTS LAST YEAR $

24D. PRINCIPAL CASH CROP

BUSINESS INFORMATION

25A. GROSS BUSINESS RECEIPTS LAST YEAR $

25B. PRINCIPAL KIND OF GOODS OR SERVICES SOLD

26. HAVE YOUR DISABILITIES MADE YOU SELL OR RENT PART OF FARM OR BUSINESS? [ ] YES [ ] NO

27. HAVE YOUR DISABILITIES MADE YOU REDUCE ACREAGE UNDER CULTIVATION OR YOUR VOLUME OF BUSINESS? [ ] YES [ ] NO (*If "yes," explain under item 31*)

28A. HOW OFTEN DID YOU HAVE TO HIRE HELP BEFORE BEING DISABLED? [ ] ALL YEAR [ ] HALF YEAR [ ] SOME [ ] NONE

28B. HOW OFTEN DO YOU HAVE TO HIRE HELP NOW? [ ] ALL YEAR [ ] HALF YEAR [ ] SOME [ ] NONE

29A. NAME OF EMPLOYEE	29B. AGE	29C. RELATIONSHIP TO YOU	29D. DOES HE (SHE) LIVE ON FARM OR BUSINESS PREMISES?
			[ ] YES [ ] NO

COUNTY AGENT OR OTHER PUBLIC OFFICIAL WHO VISITS OR KNOWS MOST ABOUT YOUR FARM

30A. NAME AND TITLE

30B. ADDRESS

RECEIVED SEP 10 1956 MAIL ROOM

31. ADDITIONAL INFORMATION RELATIVE TO CHANGE IN OPERATION OF FARM OR BUSINESS, SINCE YOU BECAME TOTALLY DISABLED

32A. WHAT INCOME DO YOU EXPECT TO RECEIVE DURING THIS CALENDAR YEAR? From Social Security Benefits — AMOUNT $800.40

32B. IF YOU BECAME TOTALLY DISABLED DURING THIS CALENDAR YEAR, WHAT INCOME DO YOU EXPECT TO RECEIVE FROM THAT DATE TO THE END OF THE CALENDAR YEAR? AMOUNT $ Does not apply

CERTIFICATION—I hereby certify that the information I have given above is true and correct to the best of my knowledge and belief.

33A. ADDRESS OF CLAIMANT	33B. DATE	33C. SIGNATURE OF CLAIMANT
Route #1, Emmaus, Pa.	9-7-56	Donald Erb

WITNESSES TO SIGNATURE OF CLAIMANT IF MADE BY "X" MARK

NOTE—Signatures 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.

	SIGNATURE OF WITNESS	ADDRESS OF WITNESS
1		
2		

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.

10—69862-1

Honorable Discharge from The United States Army

TO ALL WHOM IT MAY CONCERN:

This is to Certify, That* Daniel Erb

† 735172 Cpl. Det. 11th Inf

THE UNITED STATES ARMY, as a TESTIMONIAL OF HONEST AND FAITHFUL SERVICE, is hereby HONORABLY DISCHARGED from the military service of the UNITED STATES by reason of‡ Cir 106 W. D. 1918.

Said Daniel Erb was born in Irwinville, in the State of Pennsylvania. When enlisted he was 31 years of age and by occupation a Laborer. He had brown eyes, brown hair, dark complexion, and was 5 feet 2½ inches in height.

Given under my hand at Camp Dix New Jersey this 26th day of July, one thousand nine hundred and nineteen.

Major

Commanding.

301

Form No. 525, A. G. O. Oct. 1918.

3—3164

* Insert name, Christian name first; e. g., "John Doe."

† Insert Army serial number, grade, company and regiment or arm or corps or department; e. g., "1,620,302"; "Corporal, Company A, 1st Infantry"; "Sergeant, Quartermaster Corps"; "Sergeant, First Class, Medical Department."

‡ If discharged prior to expiration of service, give number, date, and source of order or full description of authority therefor.

ENLISTMENT RECORD.

Name: Daniel Erb Grade: Corporal

Enlisted, or Inducted, Sept 19, 1917, at Allentown, Pa.

Serving in first enlistment period at date of discharge.

Prior service:* none

Noncommissioned officer: apptd Cpl. Nov. 16, 1918.

Marksmanship, gunner qualification or rating: † not qualified

Horsemanship: not mounted

Battles, engagements, skirmishes, expeditions. Amonville Sector, June 14 - July 16, 1918
St. Die Sector (Vosges) July 17 to Aug. 23, 1918. Marbache
Sector Sept 12 to Sept 14, 1918
St Mihiel Off. Sept 12 to Sept 16, 1918 Meuse
Argonne Oct 6 to Oct 22, 1918 and Oct 27 to Nov. 11, 1918

Knowledge of any vocation: Laborer

Wounds received in service: none

Physical condition when discharged: good

Typhoid prophylaxis completed Oct. 7, 1917.

Paratyphoid prophylaxis completed Oct. 7, 1917.

Married or single: single

Character: Excellent

Remarks: Served in France with A. E. F. from Sept 24, 1918 to July 20, 1919.

Entitled to travel pay to Emmaus, Pa

Signature of soldier: Daniel Erb

John C. Wemmer
Capt [illegible]
Commanding [illegible]

9825

1470

5783

Form No. 14, P. M. G. O.
Prepared by the Surgeon General of the Army.

DUPLICATE

PHYSICAL EXAMINATION

UNDER THE

SELECTIVE SERVICE ACT OF MAY 18, 1917

(See instructions, page 4)

Erb
Earl (Surname) David (Christian name.)

Serial No. 1401

STATEMENT OF PERSON EXAMINED

Have you found that your health and habits in any way interfere with your success in civil life? If so, give details: No

Do you consider that you are now sound and well? If not, state details .....

ADJUTANT GENERAL'S
RECEIVED
JAN 8 1918

Have you ever been under treatment in a hospital or asylum? If so, for what ailment? No

I certify that the foregoing questions and my answers thereto have been read over to me; that I fully understand the questions and that my answers thereto are correctly recorded and true in all respects.

I further certify that I have been fully informed and know that making or being a party to making any false statement as to my fitness for military service renders me liable to punishment by imprisonment.

David Erb
(Signature of person examined.)

John B. Price M. D.,
Examining Physician.

Place, Camp Home Allentown Pa.

Date, Sept. 10 - 1917

(1)

(4)

Teeth: Serviceable

		Right.								Left.							
Missing Teeth:	Upper,	8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
	Lower,	8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8

(Strike out those that are missing.)

Remarks: .....

I certify that I have carefully examined the person named on the first page hereof and have carefully recorded the results of the examination, and that it is my judgment and belief that he is *physically qualified for military service *~~physically disqualified and not physically qualified for military service~~ by reason of .....

Geo. E. Lewis
Capt. M. R. C.

Place, Camp Meade Md.

Date, Sept. 19 1917.

*Strike out clause not applicable.

INSTRUCTIONS

1. The name of the person examined and the serial (red ink) number of his registration card will be entered in the spaces for that purpose on page 1 exactly as they appear on his registration card.

2. The questions under the heading "Statement of Person Examined" will be asked by the examining physician and the answers recorded by him before the person to be examined has been stripped. Any answer indicating a possible disqualification will be followed up by searching inquiry and examination and the result noted in the examining physician's report.

3. The physical examination will conform strictly to the requirements of this form and all prescribed regulations and instructions governing physical examinations under the Selective Service Act of May 18, 1917.

4. Deviations from normal, though not cause for finding the person examined physically deficient and not physically qualified for military service, will be noted under the proper headings.

5. The space under the Remarks will be used for continuation of an answer if the allotted space is insufficient, and for any further statement that the examining physician may desire to make.

6. In each case in which, after examination by one examining physician, a reexamination by another is required by regulations, an independent report of the reexamination will be made on this form; and the word "Reexamination" will be entered in red ink under the words "Serial Number" on the first page of the report of the reexamination. After completion of the reexamination the report thereof will be permanently attached to the report of the original examination.

3—4468

PHYSICAL EXAMINATION BLANK.

Date JUN 23 1919

Name Erb, (none) Daniel
(Surname) (In.) (Given Name)

Organization Co. D, 11th Infantry

Serial No. 735179

Date of Birth June 7 1886

Date of Enlistment Sept. 19, 1917

	Present Time	Upon Entrance in Service
Height	64	
Weight	126	
Chest Measurements	34	
Expiration	33 1/2	
Inspiration	35	
Expansion	1 1/2	
Degree of Robustness (Exc., very good, good, fair, poor.)	G	

P-1947-T—Printed by G-2-C, 3rd Army—200M—6-2-19

1470 T

REPORT OF PHYSICAL EXAMINATION OF ENLISTED MAN PRIOR TO SEPARATION FROM SERVICE IN THE UNITED STATES ARMY

Est Daniel 735179
(Surname.) (Christian name.) (Army serial number.)

PR (Grade.) (Company and regiment or arm or corps or department.) 2

(Occupation prior to entry into service.) Discharge Unit No.

DECLARATION OF SOLDIER

Question. Have you any reason to believe that at the present time you are suffering from the effects of any wound, injury, or disease, or that you have any disability or impairment of health, whether or not incurred in the military service?

Answer. Yes

Q. If so, describe the disability, stating the nature and location of the wound, injury, or disease.

A.

Q. When was the disability incurred?

A.

Q. Where was the disability incurred?

A.

Q. State the circumstances, if known, under which the disability was incurred.

A.

I declare that the foregoing questions and my answers thereto have been read over to me, and that I fully understand the questions, and that my replies to them are true in every respect and are correctly recorded.

T. Daniel Estes
(Signature of soldier.)

Witness: W G Reed
(Signature of witnessing officer.)

Capt. U.S.A. Discharge Unit No. 2
(Rank and organization.)

Place CAMP DIX, N. J.

Date JUL 22 1919

Form No. 125-3, A. G. O.
Nov. 11, 1918.

53—6895

(1)

REPORT OF BOARD OF REVIEW

(See instruction 2.)

From a careful consideration of the case and a critical examination of the soldier,

WE FIND:

*That he is physically and mentally sound.

*He is physically and mentally sound with the following exceptions:

(Describe the nature and location of the defect, wound, injury, or disease.)

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

The wound, injury, or disease {is / is not} likely to result in death or disability.

In our opinion the wound, injury, or disease {did / did not} originate in the line of duty in the service of the United States.

In view of occupation, he is ..... per cent disabled.

....., M.C., U.S.Army.
(Name.) (Rank.)

....., M.C., U.S.Army.
(Name.) (Rank.)

....., M.C., U.S.Army.
(Name.) (Rank.)

....., 191
(Place and date.)

*Strike out the part of the certificate not applicable to the case.

†Strike out words not applicable.

INSTRUCTIONS.

1. This report will be made out for each soldier, immediately preceding separation from service in The United States Army.

2. If the declaration of the soldier and the certificate of the examining surgeon do not agree, the case will be referred to a board of review, to consist of not less than two medical officers, convened by the camp, post, or regimental commander, which will complete the report on page 4 of this form.

3. When completed the report will be forwarded, with the service record of the soldier, to The Adjutant General of the Army in compliance with instructions prescribed in orders and regulations. 21—6196