[illegible]

the [illegible] named officers and enlisted men of Headquarters Company, 12[illegible] [illegible] authorized to wear the wound chevron [illegible] account of [illegible] received in [illegible] with the enemy, while serving with Headquarters Company, 12[illegible] Infantry, at places and on dates indicated:

[illegible] & No.	Rank	Place	Date
Grone[illegible] [illegible]man, [illegible] 273783.	Pvt.	Near Dravegny	Aug 2, 1918.

By order of Colonel LANGDON:

[illegible] ANDERSON,
Captain, 12[illegible] Inf., USA
Adjutant.

DISCHARGE

TO ALL WHOM IT MAY CONCERN:

This is to Certify, that [illegible] Evanowski [illegible]

† Private 1st Cl. Hq. Co. 127th 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

Said [illegible]

in Milwaukee, in the

When enlisted he was 22 11/12 years

He had Blue eyes, Do

was 5 feet 11 inches

Given under my hand at

18th day of May, one th

[illegible] Victory Button

has been issued

J. C. Creighton

Form No. 525, A. G. O.
Oct. 2-IX.

*Insert name, Christian name first; a
†Insert Army serial number, grade,
Company A, 1st Infantry
‡If discharged prior to expiration of

8—1155

ENLISTM

Name Roman Gron

Enlist or Inducted, June

Serving First

enlistment period at date of

Noncommissioned officer:

Marksmanship, gunner qualification or rating: Not Qual

Horsemanship: Not R

Battles, engagements, skirmishes, expeditions:

- Aisne-Marne Off. July

- Aug 24/18 to Sept 6/18

Knowledge of: Machin

Character:

Remarks:

9R4/20.

22409

Dear sir.

Iwould like to know ifyous could help me get composation Iam and Ex. Service man and am out of work on account of my health which I [illegible] while [illegible] service I have been G[illegible] and shell shocked and I am in pretty bad health and I cant stand hard work I would like to know if yous could send me Transportation so I could come up and see [illegible] people [illegible] head way and I have [illegible] Mother & Father [illegible] that is why I [illegible] asking your help [illegible] would [illegible] I have been [illegible] I cant get [illegible] please [illegible] I would [illegible] cant get [illegible] send me Transportation.

[illegible]

I remain yours truly,

[illegible] G[illegible]

[illegible]

[illegible] W[illegible]

[illegible]

G. MISCELLANEOUS INFORMATION

42. Did you make an allotment of your pay while in the service? No

43. If so, to whom? _____

44. Give number of any other compensation claim filed on account of this disability and place where filed _____

45. Did you ever apply for War Risk Insurance? no (a) When? _____

(b) Where? _____ (c) Amount? _____

46. Name of beneficiary in application for insurance _____

47. Have you since changed the beneficiary to some other person? _____

(a) If so, to whom? _____

48. Have you ever previously applied for vocational training? Yes

Give facts briefly Through Milwaukee Red Cross. but dident hear from them about it

49. Do you wish vocational training? Yes.

I make the foregoing statements as a part of this application with full knowledge of the penalty provided for making a false statement as to a material fact in a claim for compensation, insurance, or vocational training.

Roman Gronowski
(Signature of claimant.)

Subscribed and sworn to before me this 4th day of May 192?, by Roman Gronowski, claimant, to whom the statements herein were fully made known and explained.

[SEAL]

Edward H Finn
Notary Public.

We, the undersigned, severally solemnly swear that we have known the claimant whose name is subscribed above 8 years, and that we have read the statements made by him, and the facts stated are true to the best of our knowledge and belief.

Alexander Pehlke
(Signature of witness.)

805 Grove St
(Address of witness.)

Joe Klesch
(Signature of witness.)

673-1st Ave.
(Address of witness.)

Subscribed and sworn to before me this 4th day of May 192?.

[SEAL.]

Edward H Finn
Notary Public.

(If no dependents over 18 years of age are claimed the following supporting affidavit should not be executed)

SUPPORTING AFFIDAVIT

STATE OF Wisconsin
COUNTY OF Milwaukee } ss:

We, the undersigned dependents over 18 years of age, do solemnly swear, for himself and herself individually, that we have read, or had read to us, the foregoing questions and answers; that we understand the same; that we are the persons named in said answers as dependents; and that the statements contained therein as to relationship and dependency of each of us toward said applicant are true.

Mrs Julia Gronowski X
(Signature of affiant.)

(Signature of affiant.)

Mr John Gronowski X
(Signature of affiant.)

(Signature of affiant.)

SUBSCRIBED and sworn to before me this 4th day of May 192?.

[SEAL]

Edward H Finn
Notary Public.

F. AMILY OBLIGATIONS AND DEPENDENCY C..IMS.

28. Are you single, married, widowed, or divorced? Single
29. Times married..... Date and place of last marriage.....
30. Times present wife has been married.....
31. Do you live together? ..... (a) If not, state why you are not living together, and your wife's present address.....
32. Give below the information required concerning each dependent child under 18 years of age and unmarried.

Name of Child	Date of Birth			Name and Address of Person with Whom Child Lives
	Day	Month	Year	

33. If any child mentioned in question 32 is an adopted child, give name of such child and date of adoption..... If a stepchild, give name and date such child became a member of your household.....
34. Have you a child of any age who is insane, idiotic, or otherwise permanently helpless? ..... If so, give name and age.....
35. Give name and address of each parent living Mrs. John Gronowski
Mrs. John Gronowski 805 Grove St Milwaukee Wis
36. Age of mother 62 years.
37. Age of father 72 years.
38. (a) Is your mother now dependent on you for support? Yes
(b) Is your father now dependent on you for support? Yes
39. If compensation is claimed on behalf of either parent, or both, answer the following questions:
(a) Are they living together? Yes (b) Widowed or divorced? .....
(c) Are they incapable of self support? (Yes or no) Yes
(d) If so, how is each incapacitated? Mother Mother cant see well
Father Hands are in bad condition
(e) The average monthly contribution you gave to your mother, $ None; your father, $ None
(f) Value of all property owned by your mother, $.....; your father, $ 3000 00
(g) What is the monthly amount of money received by your mother from all sources, $ 50 00; your father $ None
40. If you claim disability of father, a physician's certificate must be attached hereto showing to just what extent he is incapacitated. he had no fasician he just was advised what to use for her hands.
41. Give the following information concerning all of your brothers and sisters. If you have none, write "None" in blank space below.

Name	Age.	Residence	Married.	Occupation	Annual Income.
Blanch	36	1188 4th Ave City	Yes		
Cathrine	28	332 W Algoma St Oshkosh Wis	Yes		
Tillie	32	805 Grove St	Yes		
Constantans	29	805 Grove St	No	Helper.	He pays board $10 00 per week.

APPLICAT[illegible] FOR COMPENSATION AND VOCATIONAL [illegible]AINING

A. PERSONAL HISTORY.

1. Full name Gronowski (Last Name.) Roman (First Name.) (Middle Name.)
2. Address 805 (Number.) Grove St (Street.) Milwaukee (City or Town.) Wis (State.)
3. Under what name did you serve? Gronowski Roman
4. Color White Date of birth Aug 11 1894 Place of birth Milwaukee Wis

B. MILITARY EXPERIENCE AND RELATED INFORMATION.

5. Make a cross (X) after branches of service you served in:
   General Service..... Limited Service..... Army X Navy..... Marine Corps.....
   Coast Guard..... (a) Give Serial No. 2732783
6. Date you last entered service June 26 1916
   Place of entry Milwaukee Wis
7. Date of last discharge May 18 1919 Place of discharge Camp Grant Ill
8. Company and regiment or organization, vessel on which, or station in which, you *last* served Headquarter Co 127th Inf
9. Rank or rating at time of discharge Private 1st class
10. Nature of discharge: Honorable X; Ordinary.....; Dishonorable.....; Bad conduct.....; S. C. D. .....
11. Nature of disability claimed Gun & Shell shocked Degree of disability.....
12. Date disability began August 2 1918
13. Cause of disability Gun & Shell shocked
14. Where received Near Bray sur Somme France
15. Did you receive treatment at an Army or Navy Hospital, or any other hospital? Base Hospital #7
    (a) If so, state name and location of the hospital and dates of treatment in France was the only hospital I can remember from Aug 2 1918 Dec 24 1918
16. If the injury was caused through the fault of some person other than the United States or the enemy, state whether suit has been commenced against, or settlement made with such person on account of such injury: ..... If settlement has been made or damages recovered state which, and the amount: .....

C. OCCUPATIONAL EXPERIENCE.

17. What was your principal occupation or trade before entering the service?
    Machinest Helper $72.00 (Occupation.) (Monthly wages.) (Date.)
18. Give any other occupation or trade in which you were engaged:
    Truck Driver $80.00 (Occupation.) (Monthly wages.) (Dates.)
    ~~Foreman Billings Co~~ $100.00 (Occupation.) (Monthly wages.) (Dates.)
19. Last two employers before entering the service:
    Hoffman & Billings Clinton & Becker St. 1915 (Employer's name.) (Address.) (Time employed.)
    Excelsior Hosiery Co 10th & Winnebago St. 1916 (Employer's name.) (Address.) (Time employed.)
20. Occupations since discharge, dates of each, and wages received. If less than before, why? .....
    Excelsior Hosiery Co May 24 1919 Aug 14 1919 $80.00 (Occupation.) (Commencing date.) (Ending date.) (Monthly wages.)
    Chair Belt Co Sept 6, 1919 Feb 26 1921 $110.00 (Occupation.) (Commencing date.) (Ending date.) (Monthly wages.)
21. Present employer Out of Work at Present (Full name.) (Address.)

D. EDUCATIONAL HISTORY.

22. How far did you go in grade school? 7 Grade In high school? None
23. What other schooling have you had, such as college, Army or Navy school, night school, correspondence school, etc. (Answer fully.) None

E. MEDICAL DATA.

24. Name and address of physicians who have since discharge attended you for your disability None
25. Are you confined to bed? No Do you require constant nursing or attendant? no
26. Name and address of nurse or attendant.....
27. Are you willing to accept medical or surgical treatment if furnished? Yes

62—8766

FORM NO. 624

CHAIN BELT COMPANY

MANUFACTURERS OF REX CHAIN – REX CONCRETE MIXERS
REX SPROCKETS – REX TRAVELING WATER SCREENS
REX ELEVATORS AND REX CONVEYORS, ESTABLISHED 1891

MILWAUKEE, WIS.

May. 18th. 1922.

To whom it may concern.

This is to certify that Mr. Roman Gronowski, 805 Grove Street was employed by us from September 1919 until February 1921 but had to leave our employment at that time owing to the condition of his health.

Chain Belt Company.
G. P. Longet
Employment Manager.

RATING SHEET

INCREASE

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
GRONOWSKI, Roman	1 181 732	8-31-56
ADDRESS	SERVICE SERIAL NO.	DATE OF LAST EXAMINATION
		7-9-56
CITY / STATE	DATE OF CLAIM / TYPE WAR	OCCUPATIONAL DETERMINATION (*If required*)
TYPE DISCH. / BR. SERVICE	ACTIVE DUTY DATE / DATE R. A. D.	
	7-15-17 5-18-19	
DATE OF BIRTH / PLACE OF BIRTH	RANK / RACE / SEX	
8-11-94		

RATINGS

Jurisdiction: Reopened claim, 8-527 filed 5-21-56.

Issue: PT PT III.

Facts: Veteran worked as a general maintenance man for the city of Oshkosh, Wisconsin, until 6-2-56 when he was granted a leave of absence due to ill health. He last worked on 4-25-56. He has not returned to work and his doctor has advised him not to resume employment.

Examination reveals a severe exertional dyspnea due to emphysema. X-ray showed almost complete loss of the pulmonary markings of both lung fields. There is also flattening and irregularity of both leaves of the diaphragm and blunting of both costophrenic angles. Chest measurements are: expiration, 38 inches, inspiration, 39 inches.

8. Not service incurred or aggravated WW I

I, BERNICE L. FULLER, REGISTER OF DEEDS, in and for the County of Winnebago and State of Wisconsin, do hereby certify that the instrument hereto annexed is a true and correct transcript recorded in the office of the Register of Deeds, in and for said county, on the 7th day of April 1930, at ..... M., in volume 33 on page 276.

IN TESTIMONY WHEREOF, I have hereunto set my hand and affixed my official seal this 18th day of June, A.D., 1956.

Register of Deeds in and for
Winnebago County, Wisconsin

By .....
Deputy

COPY OF ORIGINAL

STATE OF WISCONSIN
Department of Health—Bureau of Vital Statistics

Register No.

CERTIFICATE OF MARRIAGE

Place of Marriage: County of Winnebago; Township of or Village of or City of Oshkosh

I James C. Hogan hereby certify that on the 31 day of March A. D. 19 30 at Oshkosh in the County of Winnebago State of Wisconsin, Roman Gronowski of the State of Wisconsin and Ann C. Frocknow of Oshkosh state of Wisconsin were by me united in marriage as authorized by a Marriage License issued for that purpose by the County Clerk of County and State of Wisconsin, numbered 68 and dated the 26 day of March A. D. 19 30

We, the undersigned, were present at the Marriage of Roman Gronowski and Ann C. Frocknow as set forth in the foregoing certificate, at their request, and heard their declarations that they took each other for husband and wife.

Two Witnesses: George Frocknow; Rosamand Frocknow

Signature of person officiating and P. O. Address: Name James C. Hogan. P. O. Address Oshkosh, Wis.

	Groom	Bride
Name	Roman Gronowski	Ann C. Frocknow
Residence	805. Grove. St. Oshkosh. Wis.	704. West Algoma. St. Oshkosh. Wis.
Age	32	19
Color	White	White
Single / Widower / Divorced	No. of Marriages None	No. of Marriages None
Birthplace	Milwaukee. Wis.	Oshkosh. Wis.
Nationality	American	American
Relationship	None	None
Occupation	Greens Keeper	Stenographer
Name of Father, Guardian or Curator	John Gronowski	George Frocknow
Maiden name of Mother	Julia Burczoh	Rosamond Freda
If Previously Married: Date of Marriage		
To whom Married		
Date of Death / Date of Divorce		
Where Divorced		
By What Court Divorced		
To whom Divorce granted		
Maiden name of Bride if previously Married		

Was a special dispensation issued? Yes

Date of Issue March, 26, 19 30. Geo. W. Mansel. County Clerk

Filed March, 31, 19 30. E.J.Campbell. Local Registrar

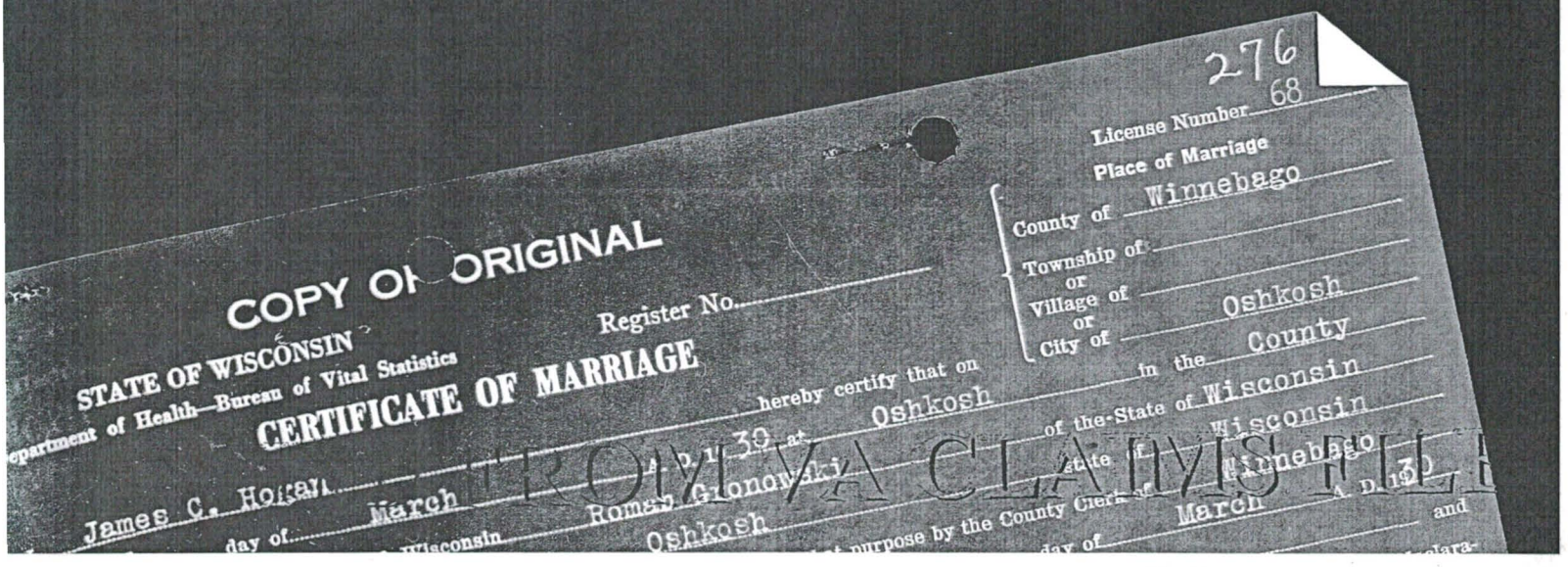
STATE OF WISCONSIN }
WINNEBAGO COUNTY } ss.

I, BERNICE L. FULLER, REGISTER OF DEEDS, in and for the County of Winnebago and State of Wisconsin, do hereby certify that the instrument hereto annexed is a true and correct transcript recorded in the office of the Register of Deeds, in and for said county, on the 7th day of April 1930, at ____ M., in volume 33 on page 276.

IN TESTIMONY WHEREOF, I have hereunto set my hand and affixed my official seal this 18th day of June, A.D., 1956.

Bernice L. Fuller
Register of Deeds in and for
Winnebago County, Wisconsin

By _____
Deputy



HARVEY MONDAY, M. D.
OSHKOSH CLINIC BUILDING
19 JEFFERSON AVENUE
OSHKOSH, WISCONISN

May 10, 1956

Veterans Administration
Oshkosh
Wisconsin

Re: Mr. R. Gronowski

Dear Sir:

Mr. Roman Gronowski has been under my care for the past twenty-four months, and during this time I have had occassion to observe him closely for symptoms regarding his cardio respiratory system.

Mr. Gronowski states he has had a chronic cough for many years dating the onset to World War I during which he was a casualty of chlorine gas. He further states he was hospitalized in France for three weeks.

During the past twenty-four months Mr. Gronowski has had progressively more severe symptoms. The dyspnea now occurs at rest and even slight exertion brings on attacks. It has been necessary for him to leave his employment.

In February 1956, Mr. Gronowski was hospitalized for evaluation to determine the extent of pulmonary damage. The degree of pulmonary fibrosis is such that Mr. Gronowski cannot resume his employment and advised to retire.

The diagnosis regarding this patient is Pulmonary Fibrosis, moderately severe with early Corpulmonale.

Sincerely yours,

H. Monday, M. D./lw

HM/lw

H. Monday, M.D.

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*)	2. CLAIM NO.
GRONOWSKI, Roman nmi	c-1 181 732
3. SOCIAL SECURITY NO.	**4. DATE YOU BECAME TOTALLY DISABLED**
398-10-4280	April 25, 1956

5A. WHAT IS THE MOST YOU EVER EARNED IN ANY ONE YEAR?	5B. WHAT YEAR?	5C. OCCUPATION DURING THAT YEAR
$3,702.60	1955	Laborer

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
City of Oshkosh-Park System City Hall Oshkosh, Wisc.	Laborer	Twelve ~~Eleven~~	Ten days	$3,702.60

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	9. IF YOU ARE STILL SELF-EMPLOYED, DESCRIBE THE WORK YOU DO NOW

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*) After working for a short spell, I find it very hard to breathe and have to rest.

11. IF YOU ARE NOT NOW EMPLOYED OR SELF-EMPLOYED, ON WHAT DATE DID YOU LAST WORK?	12. IF YOU ARE NOW EMPLOYED OR SELF-EMPLOYED, HOW LONG DO YOU WORK?
April 25, 1956	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

14. WHY DO YOU CONSIDER YOURSELF TOTALLY DISABLED?

Because of breathing difficulty at least exertion.

15A. TOTAL EARNINGS FROM WORK FOR PAST 12 MONTHS	15B. TOTAL EARNINGS FROM WORK FOR PAST 3 MONTHS
$ 3,702.60	$ 924.00

16. WHAT ASSISTANCE DO YOU RECEIVE TOWARD YOUR LIVING EXPENSES OTHER THAN YOUR EARNINGS FROM WORK?

none

VA FORM 8-527 DEC 1953 SUPERSEDES VA FORM 8-527, NOV 1950, WHICH WILL NOT BE USED. 16-60862-3

17. EDUCATION (*Enter highest year completed*)			18. NATURE OF AND TIME SPENT IN OTHER EDUCATION OR TRAINING
GRADE SCHOOL	HIGH SCHOOL	COLLEGE	
8th grade	none	none	none

19A. DURING THE PAST 12 MONTHS WERE YOU (*Check applicable box or boxes*)
[X] UNDER DOCTOR'S CARE [ ] ILL IN BED AT HOME [X] ILL IN HOSPITAL

19B. DATES OF ILLNESS X-rays 12-54; 1-56 2-56; Card. 2-56 (2); became ill 12-55 Hosp. 2-27-56/3-2-56.

19C. NATURE OF ILLNESS
Pulmonary Fibrosis, moderately severe with eary Corpulmonale. (as taken from Doctor's report).

19D. NAME AND ADDRESS OF DOCTOR (*If any*)	19E. NAME AND ADDRESS OF HOSPITAL (*If any*)
Dr. Harvey Monday Clinic Bldg., Oshkosh, Wisc.	Mercy Hospital Oshkosh, Wisc.

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

20. KIND OF FARM OR BUSINESS YOU OPERATE	21. DO YOU OWN THE FARM OR BUSINESS?
	[ ] YES [ ] NO

22. DO YOU LIVE ON THE FARM OR BUSINESS PREMISES?	23. HOW MUCH OF YOUR FOOD COMES FROM FARM, STOCK OR PRODUCT?
[ ] YES [ ] NO	[ ] NEARLY ALL [ ] ABOUT HALF [ ] LITTLE [ ] NONE

FARM INFORMATION		BUSINESS INFORMATION
24A. NUMBER OF ACRES	24B. ACRES IN CULTIVATION	25A. GROSS BUSINESS RECEIPTS LAST YEAR $
24C. GROSS RECEIPTS LAST YEAR $	24D. PRINCIPAL CASH CROP	25B. PRINCIPAL KIND OF GOODS OR SERVICES SOLD

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

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

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?	AMOUNT	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
▶	$ 1,181.40	▶	$ none

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
377 W. Algoma St.	May 17, '56	Roman Gronowski

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.

16—69862-1

Confirmed

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
GRONOWSKI, Roman	1 181 732	1-10-56
ADDRESS	SERVICE SERIAL NO.	DATE OF LAST EXAMINATION
		2-24-32
CITY / STATE	DATE OF CLAIM / TYPE WAR	OCCUPATIONAL DETERMINATION (*If required*)
TYPE DISCH. / BR. SERVICE	ACTIVE DUTY DATE: 6-21-16 / DATE R. A. D.: 5-18-19	
DATE OF BIRTH / PLACE OF BIRTH / RANK / RACE / SEX		

RATINGS

Jurisdiction: Reopened claim.

Issue: Service connection for lung condition.

Facts: Veteran's claim of treatment in service for gassing which he believes is the cause of his present lung condition is not substantiated by records. He was hospitalized in 1918 for concussion neurosis from which he apparently recovered. Residuals were not found at separation or examination made in 1932. Statement from Dr. H.Monday has been noted.

Claim for Pt III is not treated as veteran's income exceeds regulation.

8. Not service incurred or aggravated WW I
PULMONARY EMPHYSEMA WITH PULMONARY FIBROSIS, MILD
HERNIA INGUINAL LEFT

35. Not found on last examination 2-24-32, N.P. disability.

ABSTRACT

VETERANS ADMINISTRATION
REGIONAL OFFICE
342 NORTH WATER STREET
MILWAUKEE 2, WISCONSIN

January 16, 1956 YOUR FILE REFERENCE:

IN REPLY REFER TO: 30R/8D

Mr. Roman Cronowski
377 West Algoma Street
Oshkosh, Wisconsin

C- 1 181 732

Dear Sir:

It has been necessary to deny monetary benefits in connection with your claim for disability compensation.

Before compensation payments can be authorized, it is necessary that the evidence on file show a disease or injury incurred in or aggravated by service in line of duty and disabling to a degree of 10% or more. The official records and all other evidence on file in your case at this time fail to establish that these requirements have been met.

It has been found that: There is no record that you received treatment during service for gassing. Your present chest condition is not considered to be related to any condition for which you were treated in service. Therefore, service connection is denied for your chest condition. Regulations provide that a veteran is eligible for pension if he has disabilities which prevent him from working. It must also be shown that his income is under $2700 if the veteran is married. Records show that you are presently employed and earn more than $2700 per year. Accordingly, you are not eligible for pension benefits at this time.

If you have no further evidence to submit but have substantial reason to believe that the decision is not in accordance with the law and the facts in your case, you may appeal to the Administrator of Veterans Affairs at any time within 1 year from the date of this letter. If you wish to appeal, you should so inform this office, and you will be furnished with VA Form 1-9 for that purpose. A copy of this letter has been forwarded to your service organization, the American Legion.

Very truly yours,

J. E. MULIEN
Adjudication Officer

CC to American Legion

FKC/bp

FL VB 8-1
Apr 1955(R)

An inquiry by or concerning an ex-service man or woman should, if possible, give veteran's name and file number, whether C, XC, K, N, V, H, RH, RS, or loan number. If such number is unknown, service or serial number should be given.

VA MED. STK. 1-2345

I, GRONOWSKI (Last name—Print clearly) ROMAN (First name) nmi (Middle name)

Home address 377 W. ALGOMA (Number) STREET (Street) OSHKOSH (City or town) WISCONSIN (State)

hereby make application for compensation or pension based on military or naval service.

1. (a) Place of birth MILWAUKEE, WIS. (b) Date of birth AUGUST 11, 1894

2. Description of applicant as of date of last enlistment:
Sex MALE Race WHITE Weight 145 pounds. Height 71 inches.
Color of hair DK BROWN Color of eyes BLUE Complexion FAIR

3. (a) Make a cross (×) after branches of service in which you served:
Army X Navy ____ Marine Corps ____ Coast Guard ____ Nurse Corps ____
(b) Did you register under the Selective Service Acts? NO (Yes or No)
(1) Address of local draft board with which you registered ---
(2) Your home address at the time of registration ---

4. Give the following information about your active service:

Enlisted		Serial No.	Discharged		Rank and Organization	Character of Discharge
Date	Place		Date	Place		
6-26-1916	Milwaukee	273783	5-18-1919	Camp Grant, Illinois	PFC Hqs. Co. 127th Inf.	Honorable

Note.—(a) If you served under a name other than the one used in this application, indicate the name under which you served and the period of service ____

Note.—(b) If reservist, give the periods of active duty and branch of service ____

5. (a) Have you ever applied for any of the following benefits?

	Yes or No.	Place of Application	Date	Claim No.	Are you now receiving or have you received? (Yes or No)
Disability compensation	no				
Disability allowance	yes	Oshkosh, Wis.	11-7-31	C-1181732	Yes
Active service retirement pay	no				
Emergency officers' retirement pay	no				
Retainer pay	no				
Insurance benefits	no				
Pension	no				
Hospitalization	no				
Domiciliary care	no				
Last period of hospitalization	no				
United States employees' compensation	no				
Civil Service retirement annuity	no				

(b) Have you ever been physically examined for (1) The Veterans Administration? no
(2) The Civil Service Commission? no (3) The former Pension Bureau? yes
(4) The Enlisted Reserve Corps? no (5) The Officers' Reserve Corps? no
(6) The United States Employees Compensation Commission? no
(c) Give date and place of each examination AT WOOD HOSPITAL, WOOD, WIS. IN 1930 or 1931

6. Nature of disease or injury on account of which claim is made and the date each began LUNG INJURY OF LONG STANDING BELIEVED DUE TO BEING GASSED IN WORLD WAR I

7. (a) If you received any treatment while in the service, give the name, number, or location of the hospital, first-aid station, dressing station, or infirmary, or the organization to which it was attached, the dates of treatment, and the nature of sickness, disease, or injury GAS & SHELL SHOCKED--AUG. 2, 1918--DRAVIGNY FIELD HOSPITAL--ATTACHED TO 32nd DIV. ABOUT ONE MONTH HOSPITALIZATION

25% allowance discontinued by T' Economy Act of 1933.

(*b*) Names and addresses of all civilian physicians who have treated you for any sickness, disease, or injury prior to, during, or since your service:

NAME	PRESENT ADDRESS	DISABILITY	DATE
Dr. Wm. Clark	Oshkosh, Wis.	Ulcer Operation	7-27-49
Dr. Harvey Monday	Oshkosh, Wis.	Lung injury of long standing	12-1-54

(*c*) Names and addresses of all 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	ADDRESS	DISABILITY	DATE
Ann Gronowski	377 W. Algoma St.	Double Hernia	Operation in 1934 at V.A. Hospital, Wood, Wis

8. (*a*) If you served in World War I or II, give the names and addresses of employers, and your monthly earnings for the 24 months preceding your entrance into the active military or naval service. If self-employed, so state.

EMPLOYER	ADDRESS	OCCUPATION AND EARNINGS	DUTIES PERFORMED	DATES

(*b*) If you served in World War II, give the following: Highest grade completed: Grammar School _____ High School _____ College _____ University _____ Kind and length of any special study (such as business, trade, professional, academic) _____
Where _____
Length of course _____ Years completed _____
Did you (graduate? _____) (Complete course? _____)

9. What is your trade or vocation? Laborer--limited to light outdoor work.
(*a*) Are you employed? Yes If so, by whom? City of Oshkosh--Park System
(*b*) What is your entire income per month, $_____ From what sources? City of Osh.
$1.65 per hr., 44 hrs per week, six months
$1.65 per hr., 40 hrs per week, six months

(*c*) Names and addresses of former employers for last 12 months:

NAME AND ADDRESS OF EMPLOYER	DATES OF EMPLOYMENT		EARNINGS		TIME LOST
	Beginning	Ending	Weekly	Monthly	
(1)					
(2)					
(3)					

(*d*) Are you being furnished hospitalization or institutional or domiciliary care by the United

16—36390-1

States or any political subdivision thereof? NO What institution and where? ---

10. (a) Are you single, married, widowed, or divorced? MARRIED
(b) Times married ONCE
(c) Date, place, and name of spouse of each marriage MARCH 31, 1930 to ANN C. PROCKNOW
(d) Date and place of dissolution of your marriage ---
11. (a) Times present wife has been married ONCE
(b) Maiden name ANN C. PROCKNOW
(c) Date, place, and name of spouse of each marriage ---
(d) Date and place of dissolution of wife's former marriage ---
12. Do you live together? YES If not, state reason, and your wife's present address ---
13. Have you any child or children living under 18 years of age and unmarried, or any child of any age who is insane, idiotic, or otherwise permanently helpless? NO If so, give the following particulars about each child:

Full Name of Child	Date of Birth			Place of Birth	Name and Address of Person With Whom Child Lives
	Day	Month	Year		

14. (a) What is your father's name? JOHN GRONOWSKI
(b) Date and place of birth? 1850 in GERMANY
(c) Is he now dependent on you for support? NO--DECEASED
15. (a) What is your mother's name? JULIA
(b) Date and place of birth? 1852 in GERMANY
(c) Is she now dependent on you for support? NO--DECEASED
16. Give full name and complete address of nearest relative at date this claim is filed ANN C. GRONOWSKI--WIFE

I HEREBY CERTIFY that I * (have read) (~~have had read to me~~) all questions and answers thereto embodied in this application; that answers to all above questions are true and complete to the best of my knowledge and belief; that I have submitted all available information and evidence in support of this application, and that the foregoing statements are made as a part thereof with full knowledge of the penalty provided for making a false statement as to a material fact in such application.

Roman Gronowski
(Signature of claimant)

SUBSCRIBED AND SWORN to before me this 29th day of December, 1955 by Roman Gronowski, claimant, to whom the statements herein were fully made known and explained. I certify that the questions and answers thereto have, in my presence, been * (~~read to~~) (read by) the claimant.

[SEAL]

Earl Stalley
Notary Public.

MY COMMISSION EXPIRES JAN. 4, 1959

*Delete inapplicable words.

16—36390-1

TO BE COMPLETED BY VETERAN

Date Dec 29 1955 Number ---
(Veterans Administration will enter)

I, Gronowski (Last name) Roman (First name) ---- (Middle name)

hereby make formal application for compensation or pension based on military or naval service. I have not* previously made application for this benefit.

*If you have made previous application either by letter or form, cross out the word "not."

Roman Gronowski
(Full name)
Pfc Hq. Co 127 Inf.
(Rank and organization at discharge)
377 West Elsmere Ave
(Home address)
(Present post office address if different from above)

U. S. GOVERNMENT PRINTING OFFICE 754-36390-1

I, GRONOWSK, ROMAN
(Last name) (Print clearly) (First name) (Middle name)

Address 377 WEST ALGOMA OSHKOSH WISCONSIN
(Number) (Street) (City or town) (State)

hereby make application for pension under the act of March 20, 1933, as the result of disease or injury due to service.

1. (a) Place of birth MILWAUKEE WIS. (b) Date of birth AUGUST 11 1894

2. Description of applicant as of date of this application:
Sex MALE Race WHITE Weight 143 pounds. Height 5' 11" inches.
Color of hair DARK Color of eyes BLUE Complexion FAIR

3. Make a cross (X) after branches of service you served in:
Army X, Navy ____, Marine Corps ____, Coast Guard ____

4. (a) Give following information about your active service and forward a certified copy of each certificate of discharge received:

Enlisted		Serial No.	Discharged		Rank and Organization	Character of Discharge
Date	Place		Date	Place		
JUNE 26 1916	MILWAUKEE	273783	MAY 18 1919	CAMP GRANT ILL	PRIVATE, 1ST CL HQ & CO 127, INF	Excellent

(b) Have you ever been other than honorably discharged from any period of service in any branch of the military or naval service? NO (Yes or No) If answer is "Yes", state rank and organization at time of discharge, and the date and kind of such discharge ____

NOTE.—If during any of the above periods you served under a name other than the one used in this application, indicate the name under which you served and the period of service ____

5. (a) Have you ever applied for any of the following benefits:

	Yes or No	Place of Application	Date	Claim Number
Disability compensation				
Disability allowance	Yes	Oshkosh wis.		
Retirement pay				
Retainer pay				
Insurance benefits				
Pension				
Hospitalization				
Domiciliary care				

(b) Have you ever been physically examined for (1) The Veterans Administration? Yes (2) The former United States Veterans Bureau? ____ (3) The former Pension Bureau? ____ Give date and place of last examination Milwaukee wis on or about November 7 1931

6. Nature of disability, on account of which disability pension is claimed Gassed and Shell Shocked

7. Give full name and complete address of nearest relative Mrs. John Gronowski 2333 South 17th Street Milwaukee Wis.

8. (a) If you received treatment while in the service, give the name, number, or location of the hospital, first-aid station, dressing station, or infirmary, or the organization to which it was attached, the dates of treatment, and the nature of sickness, disease, or injury At a field Hospital at Chaverigny for Shell shock and gas, I was confined to a hospital near Paris

15—637

(b) Names and addresses of all civilian physicians who have treated you for any sickness, disease, or injury since the beginning of your service:

Name	Present Address	Disability	Date

(c) Names and addresses of all persons other than physicians who know any facts about any sickness, disease, or injury which you have had in active service or since discharge from the service:

Name	Address	Disability	Date
Frank Hettkaff	2031 South 5th St	Gas and Shell shock	Aug 2, 1918.
Leo Rusolinski	2320 West Rogers St. Milwaukee Wis		

9. What is your trade or vocation? Labor

(a) Are you employed? Yes If so, by whom? City of Ashland

(b) I receive pension, retirement pay, Government insurance pay, in the amount of $_____ per month from the Veterans Administration Facility at _____, and I have other income averaging $ $70.00 per month from the following sources: working as labor.

(c) Names and addresses of former employers for last 12 months:

Name and Address of Employer	Dates of Employment		Earnings		Time Lost
	Beginning	Ending	Weekly	Monthly	
(1) City of Ashland	March	October	$17.60	$70.00	from october to march.
(2)					
(3)					

(d) Are you now holding any office or position, appointive or elective, under the United States Government, or the municipal government of the District of Columbia or under any corporation, the majority of stock of which is owned by the United States Government? No

If so, give details _____

(e) Are you being furnished hospitalization or institutional or domiciliary care by the United States or any political subdivision thereof? No What institution and where? _____

15—637

10. Are you single, married, widowed, or divorced? Married

11. Times married Once Date and place of last marriage? March 31 1930

12. Times present wife has been married Once Maiden name Ann C. Prockow

13. Do you live together? Yes (a) If not, state reason, and your wife's present address

14. Have you any legitimate or adopted child or children living under 16 years of age and unmarried, or any child of any age who is insane, idiotic, or otherwise permanently helpless? No If so, give the following particulars about each child:

Full Name of Child	Date of Birth			Name and Address of Person With Whom Child Lives
	Day	Month	Year	
Barbara Helen	28	September	1930	Lives with us.

15. (a) Is your mother now dependent on you for support? No

(b) Is your father now dependent on you for support? ~~Not living~~ Head.

I HEREBY CERTIFY that answers to all questions are true and complete to the best of my knowledge and belief; that I have submitted all available information and evidence in support of this application, and that the foregoing statements are made as a part thereof with full knowledge of the penalty provided for making a false statement as to a material fact in such application. (Note sections of law printed on front page.)

Roman Gronowski
(Signature of claimant)

SUBSCRIBED AND SWORN to before me this 23rd day of October, 1933, by Roman Gronowski, claimant, to whom the statements herein were fully made known and explained.

[SEAL]

Emma E. Miller
Winnebago, County, Wis. Notary Public.
My Commission expires Feb. 7, '37.

REGISTERED OCT 24 AM 8 VETERANS ADMINISTRATION

(TO BE COMPLETED BY VETERAN)

Number
(Veterans Administration will enter)

Date October 23, 1933

I, GRONOWSKI (Last name) ROMAN (First name) (Middle name)
hereby make formal application for pension under the act of March 20, 1933, as the result of disease or injury due to service. I have ~~not~~* previously made application for the benefits.

Gronowski Roman
(Full name)
Private 1st Hqs Co. 127 Inf.
(Rank and organization at discharge)
377 W. Algoma St Oshkosh Wis.
(Present post-office address)

*If you have made previous application, either by letter or form, cross out the word "not."

U. S. GOVERNMENT PRINTING OFFICE, 1933 15—637

28. Was guardsman accepted on physical examination for Federal Service? If so, what defects were noted? Yes; See #5.

29. Effective date, amount of insurance and premiums

30. Insurance increased to $..... on ..... 19....., from $.....

31. Insurance canceled ..... Reinstated .....

32. Insurance reduced to $..... on ..... 19....., from $.....

33. Occupation at time of enlistment machinist

34. ..... Statement of service from ....., 19....., to ....., 19.....

Camp or station	*Organization*	*Period served in particular organization*
.....	.....	From ....., 19....., to ....., 19.....

2—9732

No record found of prior service.

Mustered into Federal Service--June 30, 1916; mustered out Jan. 19, 1917.
Physical examination at muster in shows: Moderate flat feet.
Physical examination at musterout shows: no defects.

13. Gassed August 2, 1918; in the line of duty; no disability.

14. Aug. 4--Aug. 14, 1918; Concussion neurosis due to HE shell "O" in action, Aug. 8, 1918; in line of duty; Base Hosp. #11, Nantes, AEF.

Aug. 29--Oct. 9, 1918; Psychoneurosis, concussion neurosis; Aug. 30--Exhaustion from shell shock; Aug. 31/18--Hysteria; in line of duty; Camp Hosp. #4, Evac. Hosp. #5, and Base Hosp. #117.

Dec. 7--Dec. 17, 1918; Psychoneurosis, concussion neurosis; in line of duty; Base Hosp. #117, AEF.

Photostatic copies of all clinical records found on file attached herewith.

James P. McKinley,
Major General,
The Adjutant General.
by: 2/6/34.

VETERANS ADMINISTRATION
Form 3101
Revised July, 1929

PUBLIC NO. 2, 73d CONGRESS.

Supplementary request 2/1/34
Copy of previous report attached.

REQUEST FOR ARMY INFORMATION

FOR USE OF—Milwaukee, Wisconsin.

January 22, 1934

DIVISION Adjudication SUBDIVISION ____ SECTION ____ UNIT ____

It is requested that information be given on the subject checked and this sheet returned to the **Veterans Administration.**

Name GRONOWSKI Roman
(Last.) (First.) (Middle.)

Rank and organization Pvt.1/c Hdq.Co.127th Inf.

Date ____ Camp ____

Date of enlistment June 21, 1916

Date of discharge or death May 18, 1919

ue address 377 West Algoma St.,
Oshkosh, Wisconsin.

Army Serial No.: S 273,783

Allotment No.: A ____

Compensation Claim No.: C 1,181,732

Converted Insurance No.: K ____

Term Insurance No.: T ____

Allotment deductions, Class A ____ Class B ____

From ____, 19____, to ____, 19____

Made subsequent to ____, 19____

Premium deductions:
From ____, 19____, to ____, 19____

Status of allotment through Z. F. O. ____

Has final settlement been made? ____

Certified copies of Forms 1-B ____

Additional information Kindly furnish new AGO report, with clinical records of all treatment administered in service.

Alleged disability ____ incurred at ____

Treated at ____ Hospital No. ____ at ____ from ____, 19____, to ____, 19____

Treated at ____ Hospital No. ____ at ____ from ____, 19____, to ____, 19____

Treated at ____ Hospital No. ____ at ____ from ____, 19____, to ____, 19____

Treated at ____ Hospital No. ____ at ____ from ____, 19____, to ____, 19____

ADW*dvm

By David E. Jude
DAVID E. JUDE, Adjudication Officer.

Name Gronowski, Roman
(Last.) (First.) (Middle.)

2. Army Serial No. 273,783
3. Rank and organization at discharge Pvt. 1/cl. Hdq. Co. 127th Inf.
4. Date of enlistment June 21, 1916
5. Physical defects at enlistment none noted
6. Was he medically examined and accepted at camp? Yes
7. Date and hour of induction by draft board ____
8. Defects noted by draft board not inducted
9. General or limited service general
10. Date of discharge May 18, 1919
11. Character of discharge Hon.
12. Date of indefinite furlough ____
13. Physical defects at discharge over
14. Complete medical history over
15. Future address ____
16. Date of reenlistment (new army) ____
17. Present rank, organization, and location ____
18. Date and cause of death ____
19. Death in line of duty? ____ Death due to own misconduct? ____
20. Emergency address ____
21. Date of birth ____
22. Date and rank of retirement ____
23. Dates and history of desertion or absences with court-martial findings ____

REG'D WORLD WAR DIV.
2 JAN 26 1934

Report below on National Guardsmen only.

24. Date of President's call (World War) Jul. 3/17
25. Date answered President's call Jul. 15, 1917
26. Date mustered into Federal Service ____
27. Date of physical examination for Federal Service (World War) Jul. 30/17.

U. S. GOVERNMENT PRINTING OFFICE: 1931

(SEE REVERSE SIDE)

2—0732

FORM NO. VS-13
200M-REV.-1-68

STATE OF WISCONSIN
DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF HEALTH

LOCAL FILE NUMBER

CERTIFICATE OF DEATH

DECEASED

1. DECEASED—NAME: First: Roman; Middle: ; Last: Gronowski
2. SEX: male
3. DATE OF DEATH: Month Day Year: Jan 5, 1973
4. RACE—White, Negro, American Indian, Etc.: caucasian (Specify)
5a. Age Last Birthday Years: 78
5b. Under One Year: Months: ; Days:
5c. Under One Day: Hours: ; Minutes:
6. DATE OF BIRTH: Month Day Year: Aug 11, 1894
7a. COUNTY OF DEATH: Winnebago
7b. NAME OF CITY, VILLAGE (Location of Death) (If Neither, Name Township): Oshkosh
7c. Inside City or Village Limits: ☒ Yes ☐ No
7d. HOSPITAL OR OTHER INSTITUTION—NAME (If Not in Either Give Street and Number or Location): Mercy Medical Center
8. STATE OF BIRTH (If Not in U.S.A., Name Country): Wisconsin
9. CITIZEN of What Country: USA
10. ☒ Married ☐ Never Married ☐ Widowed ☐ Divorced
11. SURVIVING SPOUSE (If Wife, Give Maiden Name): Anne Gronwoski (Frocknow)
12. SOCIAL SECURITY NO.: 398-10-4280 A
13a. USUAL OCCUPATION Give Kind of Work During Most of Working Life Even if Retired: Ret. Grounds Keeper
13b. KIND OF BUSINESS OR INDUSTRY: Golf Course
14a. RESIDENCE: STATE: Wisconsin
14b. COUNTY: Winnebago
14c. NAME OF CITY, VILLAGE (If Neither, Name Township): Oshkosh
14d. Inside City or Village Limits: ☒ Yes ☐ No
14e. MAILING ADDRESS (Home Address at Time of Death): 257 A. W. 15th Ave.

PARENTS

15. FATHER—NAME: First: John; Middle: ; Last: Gronwoski
16. MOTHER—MAIDEN NAME: First: Julia; Middle: ; Last: Barcan
17a. INFORMANT—NAME: Anne Gronowski
17b. MAILING ADDRESS Street or R.F.D. No. City or Village State Zip: 257 A. W. 15th Ave. Oshkosh, Wis. 54901
17c. WAS DECEASED EVER IN U.S. ARMED FORCES? (If Yes, Give War or Dates of Service): ☒ Yes ☐ No ☐ Unknown WW I

CAUSE

18. PART I DEATH WAS CAUSED BY — Enter Only One Cause Per Line For (A), (B), and (C)

Conditions, If Any, Which Gave Rise to Immediate Cause (A) Stating the Under-Lying Cause Last.

A. Immediate Cause: Cardiac arrest
B. Due to, or as a Consequence of: Advanced emphesema with pulmonary fibrosis
C. Due to, or as a Consequence of: Gen'l arteriosclerosis with arteriosclerotic heart disease

Approximate Interval Between Onset and Death:

PART II OTHER SIGNIFICANT CONDITIONS: Conditions Contributing to Death but not Related to Cause Given in Part I (A)

19a. AUTOPSY (Specify) ☐ Yes ☒ No
19b. WERE FINDINGS CONSIDERED IN DETERMINING CAUSE OF DEATH? ☐ Yes ☐ No

ACCIDENT

20a. ☐ ACCIDENT ☐ SUICIDE ☐ HOMICIDE
20b. DATE OF INJURY Month Day Year:
20c. Hour: M.
20d. HOW INJURY Ooccurred (Enter Nature of Injury in Part I or Part II, Item 18)
20e. INJURY AT WORK ☐ Yes ☐ No
20f. PLACE OF INJURY (Home, Farm, Street, Factory, Etc.) (Specify)
20g. LOCATION Street or R.F.D. No. City or Village State Zip

CERTIFICATION

21a. CERTIFICATION—Month Day Year PHYSICIAN I Attended The Deceased From: Dec 31, 1972
21b. To: Jan 5, 1973
21c. AND LAST SAW HIM/HER ALIVE ON Month Day Year: Jan 4, 1973
21d. DID YOU VIEW THE BODY AFTER DEATH ☒ Yes ☐ No
21e. DEATH OCCURRED (Hour): 3:55 A. M.

At The Place, on The Date, and, To The Best of My Knowledge, Due To The Cause(s) Stated.

22a. CERTIFICATION—MEDICAL EXAMINER OR CORONER: On The Basis of The Examination of The Body and/or The Investigation, In My Opinion, Death Occurred on The Date and Due To The Cause(s) Stated. HOUR OF DEATH: 3:55 A. M.
22b. THE DECEDENT WAS PRONOUNCED DEAD Month Day Year Hour: Jan 5, 1973 4:10 A. M.
23a. CERTIFIER—NAME (Type or Print): Harvey Monday
23b. SIGNATURE—CERTIFIER Title: H. Monday, M. D.
23c. DATE SIGNED Month Day Year: Jan 6, 1973
23d. MAILING ADDRESS—CERTIFIER Street or R.F.D. No. City or Village State Zip: 400 Ceape Ave. Oshkosh, Wis. 54901

BURIAL

24a. ☒ BURIAL ☐ CREMATION ☐ REMOVAL
24b. CEMETERY OR CREMATORY—NAME: Riverside Cemetery
24c. LOCATION City State: Oshkosh, Wis.
24d. BURIAL—DATE Month Day Year: Jan 8, 1973
25a. FUNERAL HOME—NAME AND ADDRESS Street or R.F.D. No. City or Village State Zip: Fiss & Bills, 130 Church Ave. Oshkosh, Wis. 54901
25b. FUNERAL DIRECTOR—SIGNATURE: Victor F. Thiex
26a. REGISTRAR—SIGNATURE: Victor Rossing
26b. DATE RECEIVED By Local Registrar Month Day Year: 1/8/73

Form approved.
Budget Bureau No. 76-R129.2.

VETERANS ADMINISTRATION

APPOINTMENT OF SERVICE ORGANIZATION AS CLAIMANT'S REPRESENTATIVE

1. CLAIM NO.

C-1 181 732

INSTRUCTIONS.—Type or print all entries.

2. NAME OF CLAIMANT *(Veteran, guardian, beneficiary, dependent, or next of kin)*

GRONOWSKI, ROMAN (nmi)

3. ADDRESS OF CLAIMANT *(Street, city, zone, and State)*

377 W. ALGOMA

4. LAST NAME—FIRST NAME—MIDDLE NAME OF VETERAN

AKKY GRONOWSKI, ROMAN (nmi)

5. SERVICE NO.

273783

6. BRANCH OF SERVICE

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

7A. HAS CLAIMANT EVER FILED A CLAIM FOR DISABILITY INSURANCE BENEFITS?

☐ YES ☒ NO *(If "Yes," answer questions 7b, 7c, and 7d.)*

7B. CLAIM FOR DISABILITY INSURANCE BENEFITS MADE UNDER

☐ NSLI ☐ USGLI ☐ BOTH USGLI AND NSLI

7C. POLICY NO(S). *(Include letter prefix)*

7D. GIVE LOCATION OF VA OFFICE WHERE CLAIM FOR DISABILITY INSURANCE BENEFITS HAS BEEN FILED

8. NAME OF SERVICE ORGANIZATION RECOGNIZED BY THE VETERANS ADMINISTRATION

THE AMERICAN LEGION

I hereby appoint the above-named service organization as my attorney to present my claim before the Veterans Administration for all benefits to which I may be entitled or become entitled by virtue of the service of the above-named veteran under the laws administered by the Veterans Administration and to receive any information from the Veterans Administration in connection therewith.

The accredited representative (*check one*) ☒ is ☐ is not authorized to disclose information necessary in the development of my claim to the local organization named below.

9. NAME OF ORGANIZATION, CHAPTER, POST, OR UNIT

COOK-FULLER POST NO. 70

10. LOCATION

OSHKOSH, WISCONSIN

It is understood that no fee or compensation of whatsoever nature will be charged me for service rendered pursuant to this power of attorney and that this power of attorney may be canceled by me, or by the service organization named, on written notice to the Veterans Administration.

11. SIGNATURE OF CLAIMANT

Roman Gronowski

12. RELATIONSHIP *(If other than veteran)*

13. DATE OF SIGNATURE

Jan 4 1956

NOTE.—So long as this appointment is in effect the organization named herein will be recognized as the sole agent for the presentation of your claim before the Veterans Administration and no other organization or person, except yourself will be recognized by the Veterans Administration in connection with your claim or any paper filed thereof.

(THIS POWER OF ATTORNEY DOES NOT REQUIRE EXECUTION BEFORE A NOTARY PUBLIC)

R03030-MILWAUKEE, WIS.
Acknowledged 1-18-56
DIST 3-3781 G.I.
DIST
OTHER

VA FORM MAR 1952 2-22 EXISTING STOCKS OF VA FORM 2-P-22, DEC. 1951, MAY BE USED 16-64046-2 U.S. GOVERNMENT PRINTING OFFICE: 1954 O - 30

DELETED FROM VA CLAIMS FILE

COPY

VETERANS ADMINISTRATION
Form 3101
Revised July, 1929

Files 3/8/34 LBL

REQUEST FOR ARMY INFORMATION
FOR USE OF—

May 13, 1922

DIVISION ..... SUBDIVISION ..... SECTION ..... UNIT .....

It is requested that information be given on the subject checked and this sheet returned to the **Veterans Administration.**

Name ..... (Last.) (First.) (Middle.)
Rank and organization .....
..... Date ..... Camp .....
Date of enlistment .....
Date of discharge or death .....
ıe address .....
.....
.....
.....
Status of allotment through Z. F. O. .....
Has final settlement been made? .....
Certified copies of Forms 1–B .....

Army Serial No.: S.....
Allotment No.: A.....
Compensation Claim No.: C. 1,181,732
Converted Insurance No.: K.....
Term Insurance No.: T.....
Allotment deductions, Class A ..... Class B .....
From ....., 19....., to ....., 19.....
Made subsequent to ....., 19.....
Premium deductions:
From ....., 19....., to ....., 19.....
Additional information .....
.....
.....

Alleged disability ..... incurred at .....
Treated at ..... Hospital No. ..... at ..... from ....., 19....., to ....., 19.....
Treated at ..... Hospital No. ..... at ..... from ....., 19....., to ....., 19.....
Treated at ..... Hospital No. ..... at ..... from ....., 19....., to ....., 19.....
Treated at ..... Hospital No. ..... at ..... from ....., 19....., to ....., 19.....

By .....

Name GRONOWSKI Roman
(Last.) (First.) (Middle.)

2. Army Serial No. 273,783
3. Rank and organization at discharge Pvt.1/c Hdq. Co. 127 Inf.
4. Date of enlistment June 21, 1916
5. Physical defects at enlistment none
6. Was he medically examined and accepted at camp? yes
7. Date and hour of induction by draft board .....
8. Defects noted by draft board .....
9. General or limited service General
10. Date of discharge May 18, 1919
11. Character of discharge Honorable
12. Date of indefinite furlough Not of record
13. Physical defects at discharge The records of this (over)
14. Complete medical history .....
15. Future address .....
16. Date of reenlistment (new army) .....
17. Present rank, organization, and location .....
18. Date and cause of death .....
19. Death in line of duty? ..... Death due to own misconduct? .....
20. Emergency address .....
21. Date of birth .....
22. Date and rank of retirement .....
23. Dates and history of desertion or absences with court-martial findings .....

Report below on National Guardsmen only.

24. Date of President's call (World War) July 3, 1917
25. Date answered President's call .....
26. Date mustered into Federal Service Not mustered in
27. Date of physical examination for Federal Service (World War) July 30, 1917

U. S. GOVERNMENT PRINTING OFFICE: 1931

(SEE REVERSE SIDE)

2—9732

28. Was guardsman accepted on physical examination for Federal Service? If so, what defects were noted? .....

.....

.....

29. Effective date, amount of insurance and premiums .....

.....

30. Insurance increased to $..... on .....
19....., from $.....

31. Insurance canceled .....
Reinstated .....

32. Insurance reduced to $..... on .....
19....., from $.....

33. Occupation at time of enlistment .....

34. ..... Statement of service from ....., 19....., to ....., 19.....

Camp or station	*Organization*	*Period served in particular organization*
.....	.....	From ....., 19....., to ....., 19.....

2—9732

12. No lung findings.

13. Medical records show him treated as follows: B.H.#11, Aug. 4, 1918 to Aug. 14, 1918. Concussion neurosis due to high explosive shell, Slight, In action. Aug. 3, 1918. In line of duty.
B.H.#117 - Aug. 29, 1918 to Oct. 9, 1918. Psychoneurosis, concussion neurosis. In line of duty.
B.H.#117 - Dec. 7, 1918 to Dec. 17, 1918. Psychoneurosis, concussion neurosis. In line of duty.

No additional medical record found.

1364

Form 55a
MEDICAL DEPARTMENT, U. S. ARMY
(Authorized Jan. 17, 1916.)

CLINICAL RECORD
BRIEF

Hospital Base Hosp 117

Register No. 273783 Ward C5

Name Gronowski Roman

Rank Pvt. Co Hd. Regt. or Staff Corps 127 Inf

Age (years) 25 Race W Service (years) 2 3/4

Birthplace Wis.

Station 127 Inf

Date of admission Sept. 10 - 18

Source of admission Evac. Hosp 4

Religion Cath.

Home address 805 Grove St Milwaukee, Wis

Name and address of nearest relative Mother - Mrs Julia Gronowski same

Initials of admitting officer

(To be filled in by ward surgeon when case is completed.)

Disposition Class B 2

Date

Final diagnosis Psychoneurosis Concussion neurosis Line of duty

Condition on completion of case Improved

Ward Surgeon

Ed. Apr. 10-17—2,500,000.

Form 55b
MEDICAL DEPARTMENT, U. S. ARMY
(Authorized Jan. 17, 1916.)

CLINICAL RECORD
FAMILY AND PERSONAL HISTORY

Occupation: Machine operator

Tropical service: Mexican Border only

Habits as to alcohol: v. occas. Beer.

Family history: F.M. L.W. 2S - 3 B.L.W. No neuropathic hist.

Previous personal history: Small pox at 9. Tonsillitis — Always well & strong. Never nervous or easily upset

Gunshot wounds or other casualties: None.

Venereal history: Denied

SURNAME OF PATIENT Gronowski CHRISTIAN NAME Roman

Form 55c
MEDICAL DEPARTMENT, U. S. ARMY
(Authorized Jan. 17, 1916.)

CLINICAL RECORD
HISTORY OF PRESENT DISEASE

(Date and mode of onset; probable cause; evolution and course to admission.)

Enlisted June 21. 1916 - Border till Dec. 17
France. Nov. 4 1918
Front. June - Alsace.
Ch. Th. Aug 1-2
Not apprehensive nervous or shaky
Aug 12. Shell hit house in wh. he was
knocked him silly but not unconscious
no after effects.
Aug. 28. Knocked down by
shell explosion. Did not hear
it coming. Unconscious 5-6
min. Dizzy. Shook all over.
Bilateral supra orbital headache
Shaking lasted c. 1 1/2 days.
Headache ~~better~~ better now
only at night. Sleep broken
by battle dreams. Still
gets nervous at times. Used
to be nervous at times in
Civilian life.

SURNAME OF PATIENT Gronowski CHRISTIAN NAME Roman

Ed. Oct. 17-17—2,500,000.

... well tired out. Carrying ... tried to front when he ... that out.

4

Form 55d
MEDICAL DEPARTMENT, U. S. ARMY
(Authorized Jan. 17, 1916.)

CLINICAL RECORD
SUBJECTIVE SYMPTOMS

Condition on admission:

1. Dull throbbing over both eyes.
2. Occas. feeling of dizziness and blurring before eyes.
3. Sleep pretty good now, much better. Eats well. Stomach O.K.
4. Still jumps at sudden noises.

Is able to sit down and read for hour or so.

Face expresses a good deal of anxiety tho' pat. admits nothing — when asked what he wants to do in hosp. says "anything" and says ... Says eyes water a good deal at times.

SURNAME OF PATIENT: Grabowski
CHRISTIAN NAME: Roman

Form 55e
MEDICAL DEPARTMENT, U. S. ARMY
(Authorized Jan. 17, 1916.)

CLINICAL RECORD
OBJECTIVE SYMPTOMS

Condition on admission: Ambulatory

Weight: Normal ; Present

General condition: W.D.W.N.

Special senses: Neg.

Skin and mucous membranes: Neg.

Glandular system: Neg.

Vascular system:

Blood pressure:

Heart: ... rate 76.

Lungs: Neg.

Genito-urinary system: Neg.

SURNAME OF PATIENT: Grabowski
CHRISTIAN NAME: Roman

... Aug. 27-17—2,000,000.

Base Hospital No.117. Am.E.F.
October 7th,1918.

Pvt Roman GRONOWSKI.
Hd. Co. 127th Infantry.
Age 25: Race White: Service 2-3/12.
#273 783.
Admitted Sept 10th,1918.

SUMMARY OF CASE RECORD.

Enlisted June'16. (Mexican Boarder.) France Mar4th, 1918. Front June'18. (Place) Chat Thierry in Aug. Aug 12th, concussed as after effects. Aug 28th knocked down by shell explosion unconscious 5-6 minutes. Dizzy,Shaking. On entrance occational headaches, and battle dreams. (Nervous at times in civilian life.) Dull throbbing of eyes. Sensative to sudden noises. Looks anxious, but denies anxiety. Inclined to weep. Pulse 96. Oct 7th still looks anxious. Becomes dizzy when he bends over. Cannot do full days work at present.

DIAGNOSIS: Psychoneurosis, concussion neurosis, in line of duty.

Class B-2.

W. Overholser
W. Overholser,
1st Lieut. M.C.

CLAIMS FILE

9

Form 55g
Medical Department, U. S. Army
(Authorized Jan. 17, 1916.)

CLINICAL RECORD
PROGRESS

(All complications, and all changes in diagnosis, with the date in each case, should be entered on this sheet.)

Oct 7. Headaches, esp. at night. Dreams, worrying about anything, but looks anxious. No tremors. Easily dizzy if bends over. ... Concussion B2

Surname of patient: Gronowski
Christian name: Roman

Form 55f
Medical Department, U. S. Army
(Authorized Jan. 17, 1916.)

CLINICAL RECORD
OBJECTIVE SYMPTOMS—CONTINUED

Abdomen:
Liver,
Spleen, neg.
Tenderness,
Masses,
Nervous system: P.R. K.K. ... neg.
Osseous system: neg.
Muscles and joints: neg.
Diagnosis on transfer card:
Diagnosis of ward surgeon:

Surname of patient
Christian name

C-1,181,732 377 N. Algoma St
Oshkosh
Wis.

RECEIVED
1933 AUG - 3 - AM 10:58
VETERANS
ADMINISTRATION
MILWAUKEE, WIS.

Mr. Chas. M. Pearsall
manager
Milwaukee Wis

Aug. 1, 1933,

Gentleman

My disability allowance No. C-1,181,732 was discontinued on June 30, 1933 and Congressman M. K. Reilly advised me to correspond with the Regional manager.

Please give me what ever advice you can and send me application blank for benifits under the Economy Act.

Thank you

Yours Truly

Roman Gronowski
377 N. Algoma St
Oshkosh Wis

August 25, 1933.

C-25

Mr. Roman Gronowski,
377 N. Algoma St.,
Oshkosh, Wisconsin.

C-1,181,758.

Dear Sir:

In reply to your letter of August 1, 1933, please be informed that all disability allowance claims have been cut off by law.

The last examination on you conducted in this office failed to show that you have any service connected disability which is compensable, therefore it would appear that you are not entitled to pension. However, if you feel that you have a disability which is compensable and service connected, kindly fill out the enclosed Form P-1 and return same to this office at your earliest convenience and it will be given the proper consideration.

By direction,

DAVID E. JUDE,
Adjudication Officer,
Milwaukee, Wisconsin.

Encl-1.

GHM/hr

Milwaukee, Wisconsin.

February 24, 1932.

GRONOWSKI, Roman
C-1,181,732

Examination by Dr. B. Erps:

Complaints: Claimant complains of bitemporal headaches, coming on 2 times a week. He has a sort of a drawing sensation. Also complains of shortness of breath. When he exerts himself, either walking or by working, he has to stop because of shortness of breath. Has no further complaints. No other pains anywhere, has no fainting spells. Not unduly exciteable or irritable. Has a good appetite and he sleeps well. Gets along well with everybody. Has no enemies.

History: Age 39; is married and has one child, 18 months old. For the past 7 years, claimant has been employed by the City of Oshkosh, during the summer, running a tractor and taking care of the golf grounds. In the winter time he works at odd jobs and at times he is employed by the City, depending on the weather, taking care of the ice skating rink. For a year prior to his army service he worked for the Everwear Hosiery Company in Milwaukee, running an elevator, earning $17.00 a week. Enlisted in army June 26, 1916; discharged May 18, 1919. Was on the Mexican border and he was in France. States he was gassed and shell shocked while in the army. Was not otherwise injured. Was in hospital for about 2 months. See A.G.O. report.

Past Illnesses: Denies venereal disease or the use of alcohol to excess. Has never had any serious ailments or operations. No accidents otherwise.

Mental: Claimant is alert, answers questions readily and coherently. No delusions or hallucinations. No disturbance of volition or emotional tone. Appears of the average intelligence. General information is good. School knowledge is good. No evidence of any psychosis.

Neurological Examination: Well developed; fairly well nourished white male. Present weight 156 lbs., stripped to the waist. ~~Present~~ Best weight in his clothes 146 lbs. Pupils are equal and regular and react to light and accommodation. No Nystagmus, no Strabismus. Facial muscles are normally inervated. Thyroid is not enlarged. Tongue is somewhat coated but not tremulous. Protrudes in the center. Extended fingers are not tremulous. All the deep reflexes, as well as the superficial reflexes react normally. No parasthesia or anesthesia or hyperasthenia. No Rhomberg. Pulse 80 sitting. After 50 hops pulse is 116; after 2 minutes rest 88. No cardio respiratory embarrassment.

Diagnosis: No N.P. Disability.

11-25-31
Clb.

Milwaukee, Wis.,
November 24, 1931

M-1

Dr. J. M. Conley,
Oshkosh,
Wisconsin.

GRONOWSKI, Roman
C-1161 732

Dear Doctor:

The above named veteran has been instructed to report to you for examination for Disability Allowance (pension claim).

The disability as stated on his application is as follows:

Gassed and shell shocked

When this claimant reports, he should be carefully examined in compliance withe the procedure as outlined in the instructions relative to the examination of veterans for Disability Allowance, copy of which has been furnished you. Report should be submitted on form 2545, Report of Physical Examination, hereto attached. The instructions as set out in the form should be followed. Necessary authority to cover the examination is also enclosed herewith.

The claimant, in order to be entitled to benefits on claim for Disability Allowance (pension claim), has to have a permanent disability, and under the World War Veterans' Act as amended July 3, 1930, a disability will be considered permanent which results from an injury or disease which is reasonably certain to continue unimproved for an indefinite period. You will also, in the examination report, indicate the extent of the claimant's disability, that is, whether it is mild, moderate or severe.

As soon as report has been completed, it should be forwarded to this office together with your bill in duplicate, and duplicate copy of the authority. If you will put the following certification on your bill, and sign it, voucher will not have to be sent to you for signature: "I hereby certify that the above bill is correct and just and payment therefor has not been received".

By direction,

W. C. LIEFERT,
Chief, Out-patient Service,
Milwaukee, Wisconsin.

Signed & Mailed
Date 11-25-31
Medical Section

UNITED STATES VETERANS BUREAU
Form 526-c

APPLICATION OF VETERAN FOR DISABILITY ALLOWANCE UNDER SECTION 200, WORLD WAR VETERANS' ACT, 1924, AS AMENDED JULY 3, 1930.

Name GRONOWSKI ROMAN
(Print clearly) (Last Name) (First Name) (Middle name in full)

Address 377 WEST ALGOMA OSHKOSH WISCONSIN
(Number) (Street) (City or town) (State)

I hereby apply for disability allowance under the provisions of Section 200 of the World War Veterans' Act, 1924, as amended July 3, 1930, and submit the following facts as evidence that I am eligible for that allowance.

1. Place of birth MILWAUKEE WIS.

Date of birth AUGUST. 11. 1893

2. Description of applicant as of date of this application:

Sex MALE Race WHITE Weight 142 pounds. Height 5'10 inches.

Color of hair DARK Color of eyes BLUE Complexion FAIR

3. Give dates of enlistment and discharge for any period or periods of ser during the World War, commencing prior to November 11, 1918.

Date Enlisted JUNE 26 Date Discharged MAY. 18, 1919 Serial No. 273783

Place Enlisted MILWAUKEE, WIS Place Discharged CAMP GRANT ILL.

Nature of Discharge: Honorable; ordinary__; Dishonorable__; Bad conduct__; S.C.D.__

Organization at Discharge HQS. Co - 127 INF.

Rank or Rating at time of Discharge PRIVATE 1ST CLASS

Note:- If during any of these enlistments you served under a name other than the one used in this application, state the name under which you served, the period of the enlistment, and full explanation.

4. (a) Have you ever applied for disability compensation? YES

If so, when and where was application filed? RED CROSS AT MILWAUKEE WIS

What is your Compensation Claim Number? ~~DO~~ CANNOT REMEMBER

(b) Have you ever been physically examined for the United States Veterans' Bureau? NO

If so, give date and place of last examination _____

5. (a) Are you in receipt of retirement pay? NO

(b) Are you in receipt of reduced retirement pay? NO

(c) Are you in receipt of retainer pay? NO

(d) Are you in receipt of a pension? NO

(e) Are you in receipt of disability compensation? NO

(f) Are you in receipt of insurance benefits? NO

6. Nature of disease or injury on account of which disability allowance is claimed GASSED + SHELL SHOCKED

7. Give full name and complete address of nearest relative

MRS. JOHN GRONOWSKI 2031 So. 5th ST. MILWAUKEE WIS

8. Have you ever been dishonorably discharged from any period of service in any branch of the military or naval service? NO (Yes or No) If answer is "Yes" state rank and organization at time of dishonorable discharge, and the date of the dishonorable discharge _____

9. Are you employed? NOT AT PRESENT TIME

(a) What is your regular trade or vocation? GREENSKEEPER HELPER

10. Did you file a Federal income tax return for the last calendar year? NO

(A) Where? _____

(B) Were you exempted from payment of a Federal income tax? _____

(C) If so, why? I DO NOT MAKE ENOUGHT TO FILE ONE

Milwaukee Wis
June 6, 1922

JUN 7 1922

claim #C-4,181,732

Dear Sir

I received your letter in which you told me that the statements are not acceptable because they are not properly acknowledged well if you will send them back to me I will have them made over by a Notary Republic you see I dont know much about this thing so I let it take

All the advice I get and as far a Physical statements I havent any to get for I never was treated by Doctors for I spend most of my time in summer homes for my health but if it necery I will go to some doctor get a Physical examanation and have a statement made

Yours Truly

Roman Gonoush

S-1181732

RECEIVED
MAY 22 1922
HDQ. DIST. #8
U.S. VETERAN'S BUREAU

Milwaukee Wis
May 20 1922

Dear Sir

I received your letter and was very glad to hear so soon I am sending you 2 affadivets I dident have no doctors I was just taking advice I was in the country and I dident bother with Doctors but if you want more statements I will be willing to get more

I remain your Truley
Roman Gronowski