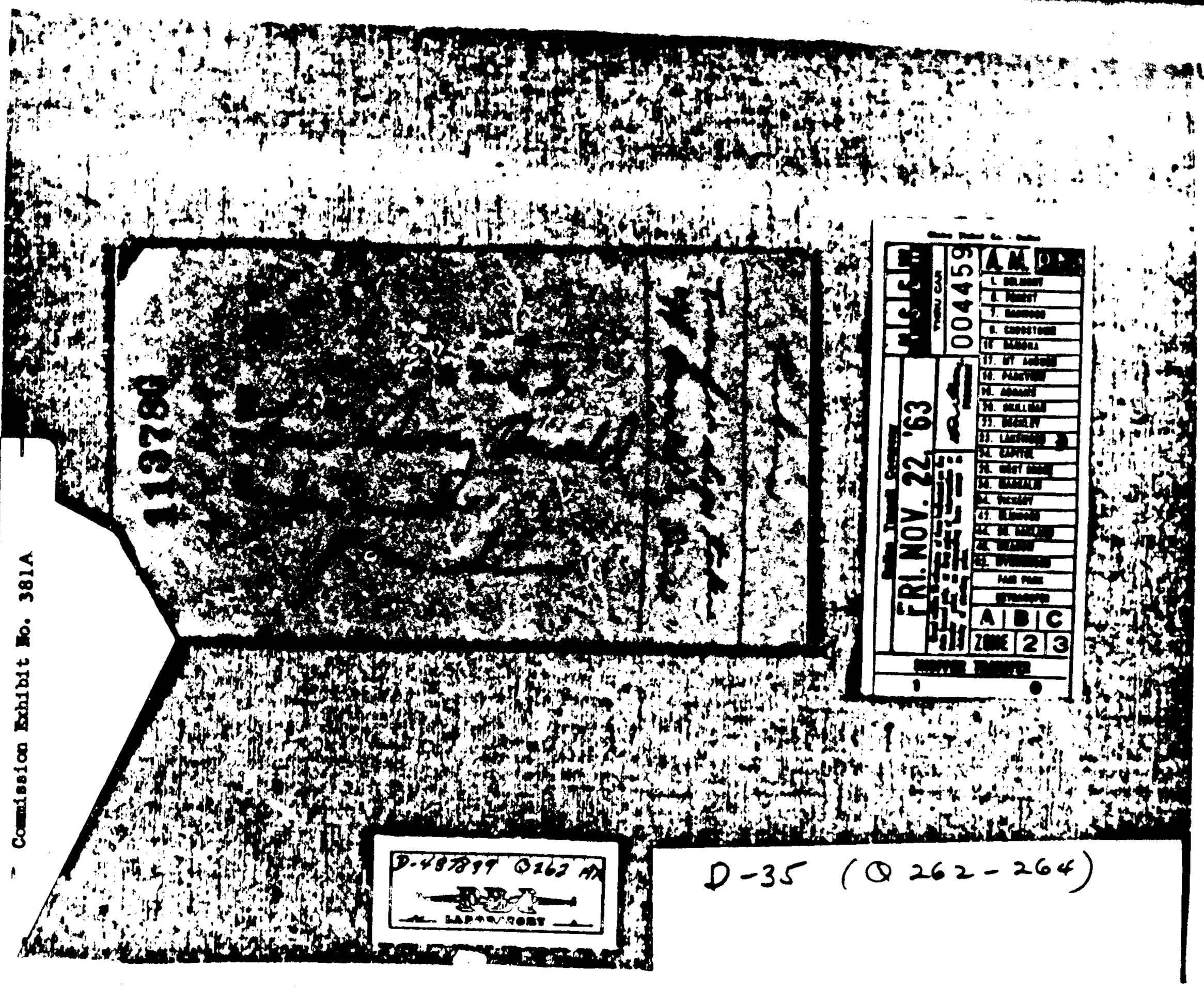
Commission Exhibit No. 381A



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COMMISSION EXHIBIT
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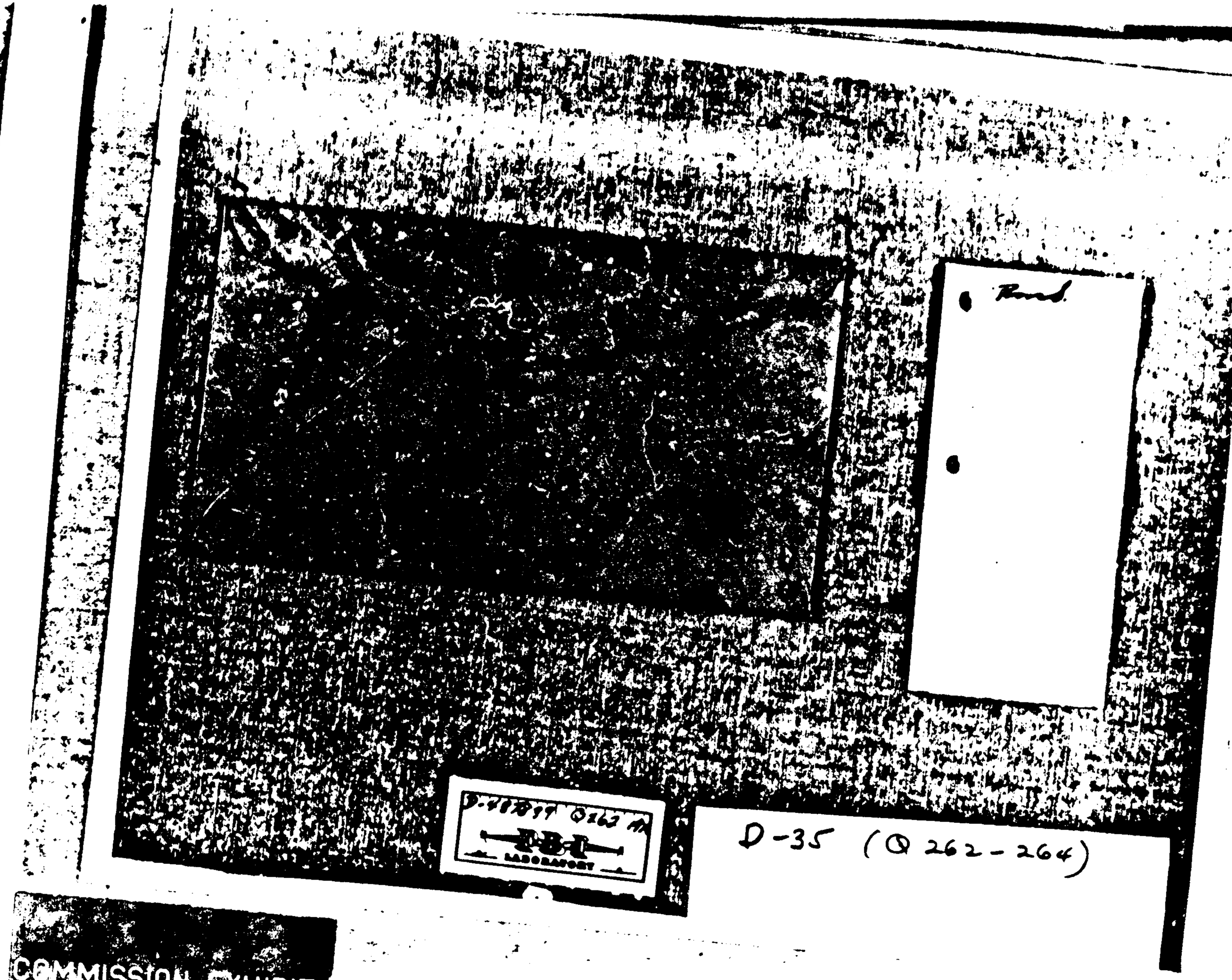
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COMMISSION EXHIBIT
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SAFETY FIRST — OBEY ALL TRAFFIC LAWS — GIVE PROPER SIGNALS — AVOID SUDDEN STARTS AND STOPS.

Driver W. W. Whaley

Shift SHORT DAY

Date Nov 22 5 05 AM '63

Car No. 3611

	Trips	Units	Paid Miles	Total Miles	Dead Miles
In	3591	8308	1698	60111	
Out	3570	8151	11636	59020	
Diff.	21	157	62	109	
+					
−					
Totals					

METER READING

Subtract Trips or Units if OK'd

MILES IN 80350

MILES OUT 80235

TOTAL MILES

Use Only If Two Cars Are Driven or Meter Changed

Add Second Meter Readings

Office Verification By

Call or Pickup	No.	FROM	TO	Meter	Flat Rate	Charge	No. Pass.	Time Out	Time In	Miles Out	Miles In
C	1	4934 Belmont	Airport	1.75			4	600	620		44
C	2	10697 Marsh	4126 Walnut Hill	.85			1	630	700	44	54
P	3	Walnut Hill &	2804 Fairmount	.75			1	700	715	54	58
C	4	5623 Abrams	Stemmons	2.05			1	730	750	58	70
C	5	3214 Knight	3403 Hall	.85			2	810	820	70	71
P	6	3403 Hall	3214 Knight	1.75			1	820	845	71	77
C	7	3807 Hawthorne	5317 Finley	1.05			1	900	915	77	84
C	8	Mckinney &	Olive & Hall	1.25			1	915	940	84	92
C	9	Lemmon & Inwood	Lemmon & Inwood	.25			1	1030	1050	92	99
C	10	Lemmon & Inwood	3528 Ashbury	.85			1	1100	1115	99	05
C	11	2918 N. Haskell	Elm & St Paul	1.15			2	1115	1130	05	09
C	12	Travis Hotel	#16	.55			3	1200	215	09	11
P	13	#16	Greyhound	.55			1	1215	1230	11	12
P	14	Greyhound	508 N. Buckley	.95			1	1230	1245	12	15
P	15	Stations	Greyhound	.55			1	100	115	15	16
P	16	Greyhound	1809 So Lamar	.75			1	115	130	16	19
C	17	Travis	#16	.55			1	130	145	19	20
P	18	#16	Dallas Sta	3.45			1	145	230	20	32
C	19	Stanleigh	Airport	1.55			2	245	310	32	42
C	20	3605 Routh	#16	.95			1	315	330	42	45
P	21	#16	605 Conn	1.05			1	330	345	45	49
	22										

AVOID ERRORS

Trips	21	9.45
Units	157	15.70
P.R.		
TOTAL $		25.15
Less: Charges		
Net Cash		
Gas	51x	
Oil		
Pick Ups	8	
Calls	13	
Passengers	29	

25.15 11 15MAY22

25.15 CA 11 15MAY22

COURTEOUS, ALERT DRIVERS ARE SELDOM INVOLVED IN ACCIDENTS

KEEP A SAFE DISTANCE BEHIND THE CAR AHEAD

COMMISSION EXHIBIT

SAFETY FIRST — OBEY ALL TRAFFIC LAWS — GIVE PROPER SIGNALS — AVOID SUDDEN STARTS AND STOPS.

COURTEOUS, ALERT DRIVERS ARE SELDOM INVOLVED IN ACCIDENTS

KEEP A SAFE DISTANCE BEHIND THE CAR AHEAD

Driver W. W. Whaley

Shift SHORT DAY

Date Nov 22 5 05 AM '63

Car No. 316

METER READING	Trips	Units	Paid Miles	Total Miles	Dead Miles
In	3591	8308	1698	6011	
Out	3570	8151	1636	5902	
Diff.	21	157	62	109	
+					
−					
Totals					

Subtract Trips or Units if OK'ed

MILES IN 80350

MILES OUT 80235

TOTAL MILES

Use Only if Two Cars Are Driven or Meter Changed

Add Second Meter Readings

Office Verification By

Call In	No.	FROM	TO	Meter	Flat Rate	Charge	No. Pass.	Time Out	Time In	Miles Out	Miles In
C	1	4924 Belmont	Airport	1.75			4	600	620		44
C	2	10607 Marsh	4126 Walnut St.	.85			1	630	700	44	54
P	3	Walnut Hill Ct.	2804 Lombardy	.75			1	700	715	54	58
C	4	5623 Ashworth	Stanleigh	2.05			1	730	750	58	70
C	5	3210 Knight	3403 Hall	.85			2	810	820	70	71
P	6	3403 Hall	3210 Knight	1.75			1	820	845	71	77
C	7	3807 Hawthorne	5317 Hinkle	1.05			1	900	915	77	84
C	8	Melrose	Alba Hall	1.35			1	915	940	84	92
C	9	Lyon Winton	Lyon Winton	.25			1	1030	1050	92	99
P	10	Lena Hotel	2528 Ashbury	.85			1	1100	1115	99	05
C	11	2918 No Henthorn	Elm & St Paul	1.15			2	1115	1130	05	09
C	12	Travis Hotel	#16	.55			3	1200	1215	09	11
P	13	#16	Greyhound	.55			1	1215	1230	11	12
P	14	Greyhound	508 No. Buckley	.95			1	1230	1245	12	15
P	15	Station	Greyhound	.55			1	100	115	15	16
P	16	Greyhound	1809 So Lamar	.75			1	115	130	16	19
P	17	Travis	#16	.55			1	130	145	19	20
P	18	#16	Dal Hi Sta	3.45			1	145	230	20	32
C	19	Stanleigh	Airport	1.55			2	245	[illegible]	32	42
P	20	3605 Roberts	#16	.95			1	215	230	42	45
P	21	#16	Hall Assn	1.05			1	330	345	45	49
	22										

AVOID ERRORS

Trips	21	9.45
Units	157	15.70
F.S.		
TOTAL $		25.15

Less: Charges

Net Cash

Gas 5½

Oil

Pick Ups 8

Calls 13

Passengers 29

ISSUED 25.15

ISSUED 23.50

COMMISSION EXHIBIT

Commission Exhibit No. 3031

262-2(4)

COMMISSION EXHIBIT

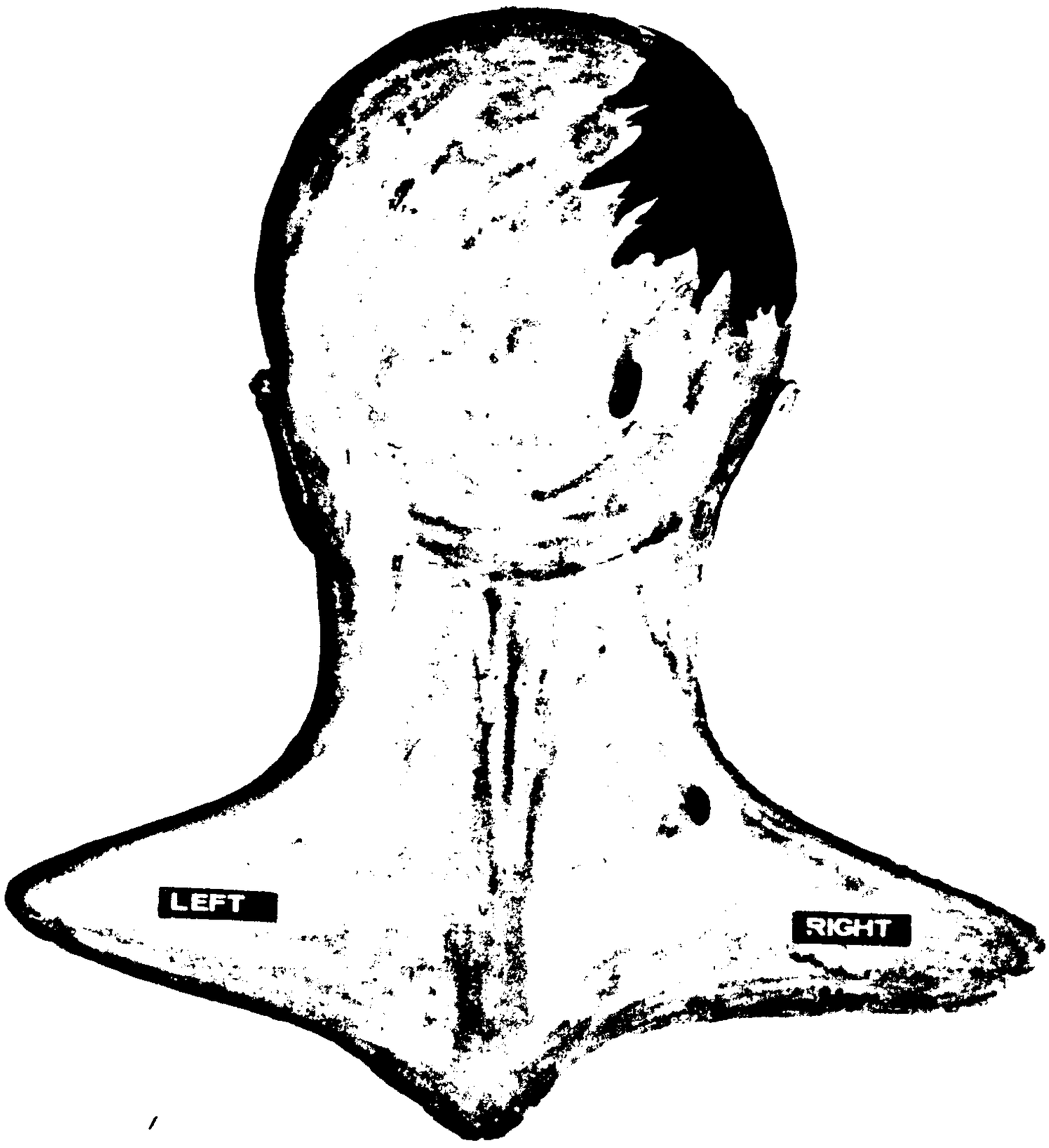
Commission Exhibit No. 384

June 19, 1962

"To Whom It May Concern

"This is to certify that Mr. Lee Harvey Oswald has a good knowledge of the Russian language. He acquired this knowledge during his three-year residence in the Soviet Union. In my opinion, he is capable of being an interpreter and perhaps a translator."

COMMISSION EXHIBIT
385



COMMISSION EXHIBIT
386

Commission Exhibit No. 387

CLINICAL RECORD

AUTOPSY PROTOCOL A63-272 (JJE:ec)

DATE AND HOUR DIED	DATE AND HOUR AUTOPSY PERFORMED	CHECK ONE		
		FULL AUTOPSY	HEAD ONLY	TRUNK ONLY
22 November 1963 1300(CST)	22 November 1963 2000(EST)			
ASSISTANT (497831)	ASSISTANT (439370)			
CDR J. L. HUMES, MC, USN	CDR "J" THORNTON BOSWELL, MC, USN	X		
	LCOL PIERRE A. FINCK, MC, USA (04 043 322)			

Ht. - 72½ inches
Wt. - 170 pounds
Eyes - blue
Hair - Reddish brown

PATHOLOGICAL DIAGNOSES

CAUSE OF DEATH: Gunshot wound, head.

(APPROVED SIGNATURE)

MILITARY ORGANIZATION (If any reported)	AGE	SEX	RACE	IDENTIFICATION NO.	AUTOPSY NO.
J. J. HUMES, CDR, MC, USN					A63-272
PRESIDENT, UNITED STATES	46	Male	Cauc.		
PATIENT'S IDENTIFICATION (For typed or written entries give Name—last, first, middle, grade, class, designation or unit(s))				REGISTER NO.	WARD NO.

KENNEDY, JOHN F.
NAVAL MEDICAL SCHOOL

AUTOPSY PROTOCOL
Standard Form 506

Commission Exhibit No. 357

PATHOLOGICAL EXAMINATION REPORT A63-272

CLINICAL SUMMARY: According to available information the deceased, President John F. Kennedy, was riding in an open car in a motorcade during an official visit to Dallas, Texas on 22 November 1963. The President was sitting in the right rear seat with Mrs. Kennedy seated on the same seat to his left. Sitting directly in front of the President was Governor John B. Connolly of Texas and directly in front of Mrs. Kennedy sat Mrs. Connolly. The vehicle was moving at a slow rate of speed down an incline into an underpass that leads to a freeway route to the Dallas Trade Mart where the President was to deliver an address.

Three shots were heard and the President fell forward bleeding from the head. (Governor Connolly was seriously wounded by the same gunfire.) According to newspaper reports ("Washington Post" November 23, 1963) Bob Jackson, a Dallas "Times Herald" Photographer, said he looked around as he heard the shots and saw a rifle barrel disappearing into a window on an upper floor of the nearby Texas School Book Depository Building.

Shortly following the wounding of the two men the car was driven to Parkland Hospital in Dallas. In the emergency room of that hospital the President was attended by Dr. Malcolm Perry. Telephone communication with Dr. Perry on November 23, 1963 develops the following information relative to the observations made by Dr. Perry and procedures performed there prior to death.

Dr. Perry noted the massive wound of the head and a second much smaller wound of the low anterior neck in approximately the midline. A tracheostomy was performed by extending the latter wound. At this point bloody air was noted bubbling from the wound and an injury to the right lateral wall of the trachea was observed. Incisions were made in the upper anterior chest wall bilaterally to combat possible subcutaneous emphysema. Intravenous infusions of blood and saline were begun and oxygen was administered. Despite these measures cardiac arrest occurred and closed chest cardiac massage failed to re-establish cardiac action. The President was pronounced dead approximately thirty to forty minutes after receiving his wounds.

The remains were transported via the Presidential plane to Washington, D.C. and subsequently to the Naval Medical School, National Naval Medical Center, Bethesda, Maryland for postmortem examination.

GENERAL DESCRIPTION OF BODY: The body is that of a muscular, well-developed and well nourished adult Caucasian male measuring 72½ inches and weighing approximately 170 pounds. There is beginning rigor mortis, minimal dependent livor mortis of the dorsum, and early algor mortis. The hair is reddish brown and abundant, the eyes are blue, the right pupil measuring 8 mm. in diameter, the left 4 mm. There is edema and ecchymosis of the inner canthus region of the left eyelid measuring approximately 1.5 cm. in greatest diameter. There is edema and ecchymosis diffusely over the right supra-orbital ridge with abnormal mobility of the underlying bone. (The remainder of the scalp will be described with the skull.)

Commission Exhibit No. 367

There is clotted blood on the external ears but otherwise the ears, nares, and mouth are essentially unremarkable. The teeth are in excellent repair and there is some pallor of the oral mucous membrane.

Situated on the upper right posterior thorax just above the upper border of the scapula there is a 7 x 4 millimeter oval wound. This wound is measured to be 14 cm. from the tip of the right acromion process and 14 cm. below the tip of the right mastoid process.

Situated in the low anterior neck at approximately the level of the third and fourth tracheal rings is a 6.5 cm. long transverse wound with widely gaping irregular edges. (The depth and character of these wounds will be further described below.)

Situated on the anterior chest wall in the nipple line are bilateral 2 cm. long recent transverse surgical incisions into the subcutaneous tissue. The one on the left is situated 11 cm. cephalad to the nipple and the one on the right 8 cm. cephalad to the nipple. There is no hemorrhage or ecchymosis associated with these wounds. A similar clean wound measuring 2 cm. in length is situated on the antero-lateral aspect of the left mid arm. Situated on the antero-lateral aspect of each ankle is a recent 2 cm. transverse incision into the subcutaneous tissue.

There is an old well healed 8 cm. McBurney abdominal incision. Over the lumbar spine in the midline is an old, well healed 15 cm. scar. Situated on the upper antero-lateral aspect of the right thigh is an old, well healed 8 cm. scar.

MISSILE WOUNDS:

1. There is a large irregular defect of the scalp and skull on the right involving chiefly the parietal bone but extending somewhat into the temporal and occipital regions. In this region there is an actual absence of scalp and bone producing a defect which measures approximately 13 cm. in greatest diameter.

From the irregular margins of the above scalp defect tears extend in stellate fashion into the more or less intact scalp as follows:

a. From the right inferior temporo-parietal margin anterior to the right ear to a point slightly above the tragus.

b. From the anterior parietal margin anteriorly on the forehead to approximately 4 cm. above the right orbital ridge.

c. From the left margin of the main defect across the midline antero-laterally for a distance of approximately 8 cm.

d. From the same starting point as c. 10 cm. postero-laterally.

Situated in the posterior scalp approximately 2.5 cm. laterally to the right and slightly above the external occipital protuberance is a lacerated wound measuring 15 x 7 mm. In the underlying bone is a corresponding wound through the skull which exhibits beveling of the margins of the bone when viewed from the inner aspect of the skull.

Clearly visible in the above described large skull defect and exuding from it is lacerated brain tissue which on close inspection proves to represent the major portion of the right cerebral hemisphere. At this point it is noted that the falx cerebri is extensively lacerated with disruption of the superior saggital sinus.

Upon reflecting the scalp multiple complete fracture lines are seen to radiate from both the large defect at the vertex and the smaller wound at the occiput. These vary greatly in length and direction, the longest measuring approximately 19 cm. These result in the production of numerous fragments which vary in size from a few millimeters to 10 cm. in greatest diameter.

The complexity of these fractures and the fragments thus produced tax satisfactory verbal description and are better appreciated in photographs and roentgenograms which are prepared.

The brain is removed and preserved for further study following formalin fixation.

Received as separate specimens from Dallas, Texas are three fragments of skull bone which in aggregate roughly approximate the dimensions of the large defect described above. At one angle of the largest of these fragments is a portion of the perimeter of a roughly circular wound presumably of exit which exhibits beveling of the outer aspect of the bone and is estimated to measure approximately 2.5 to 3.0 cm. in diameter. Roentgenograms of this fragment reveal minute particles of metal in the bone at this margin. Roentgenograms of the skull reveal multiple minute metallic fragments along a line corresponding with a line joining the above described small occipital wound and the right supra-orbital ridge. From the surface of the disrupted right cerebral cortex two small irregularly shaped fragments of metal are recovered. These measure 7 x 2 mm. and 3 x 1 mm. These are placed in the custody of Agents Francis X. O'Neill, Jr. and James W. Sibert, of the Federal Bureau of Investigation, who executed a receipt therefor (attached).

2. The second wound presumably of entry is that described above in the upper right posterior thorax. Beneath the skin there is ecchymosis of subcutaneous tissue and musculature. The missile path through the fascia and musculature cannot be easily probed. The wound presumably of exit was that described by Dr. Malcolm Perry of Dallas in the low anterior cervical region. When observed by Dr. Perry the wound measured "a few millimeters in diameter", however it was extended as a tracheostomy incision and thus its character is distorted at the time of autopsy. However, there is considerable ecchymosis of the strap muscles of the right side of the neck and of the fascia about the trachea adjacent to the line of the tracheostomy wound. The third point of reference in connecting

These two wounds is in the apex (supra-clavicular portion) of the right pleural cavity. In this region there is contusion of the parietal pleura and of the extreme apical portion of the right upper lobe of the lung. In both instances the diameter of contusion and ecchymosis at the point of maximal involvement measures 5 cm. Both the visceral and parietal pleura are intact overlying these areas of trauma.

INCISIONS: The scalp wounds are extended in the coronal plane to examine the cranial content and the thoracotomy (Y) shaped incision is used to examine the body cavities.

THORACIC CAVITY: The bony cage is unremarkable. The thoracic organs are in their normal positions and relationships and there is no increase in free pleural fluid. The above described area of contusion in the apical portion of the right pleural cavity is noted.

LUNGS: The lungs are of essentially similar appearance the right weighing 320 Gm., the left 290 Gm. The lungs are well aerated with smooth glistening pleural surfaces and gray-pink color. A 5 cm. diameter area of purplish red discoloration and increased firmness to palpation is situated in the apical portion of the right upper lobe. This corresponds to the similar area described in the overlying parietal pleura. Incision in this region reveals recent hemorrhage into pulmonary parenchyma.

HEART: The pericardial cavity is smooth walled and contains approximately 10 cc. of straw-colored fluid. The heart is of essentially normal external contour and weighs 350 Gm. The pulmonary artery is opened in situ and no abnormalities are noted. The cardiac chambers contain moderate amounts of postmortem clotted blood. There are no gross abnormalities of the leaflets of any of the cardiac valves. The following are the circumferences of the cardiac valves: aortic 7.5 cm., pulmonic 7 cm., tricuspid 12 cm., mitral 11 cm. The myocardium is firm and reddish brown. The left ventricular myocardium averages 1.2 cm. in thickness, the right ventricular myocardium 0.4 cm. The coronary arteries are dissected and are of normal distribution and smooth walled and elastic throughout.

ABDOMINAL CAVITY: The abdominal organs are in their normal positions and relationships and there is no increase in free peritoneal fluid. The vermiform appendix is surgically absent and there are a few adhesions joining the region of the cecum to the ventral abdominal wall at the above described old abdominal incisional scar.

SKELETAL SYSTEM: Aside from the above described skull wounds there are no significant gross skeletal abnormalities.

PHOTOGRAPHY: Black and white and color photographs depicting significant findings are exposed but not developed. These photographs were placed in the custody of Agent Roy H. Kellerman of the U. S. Secret Service, who executed a receipt therefore (attached).

ROENTGENOGRAMS: Roentgenograms are made of the entire body and of the separately submitted three fragments of skull bone. These are developed and were placed in the custody of Agent Roy H. Kellerman of the U. S. Secret Service, who executed a receipt therefor (attached).

SUMMARY: Based on the above observations it is our opinion that the deceased died as a result of two perforating gunshot wounds inflicted by high velocity projectiles fired by a person or persons unknown. The projectiles were fired from a point behind and somewhat above the level of the deceased. The observations and available information do not permit a satisfactory estimate as to the sequence of the two wounds.

The fatal missile entered the skull above and to the right of the external occipital protuberance. A portion of the projectile traversed the cranial cavity in a posterior-anterior direction (see lateral skull roentgenograms) depositing minute particles along its path. A portion of the projectile made its exit through the parietal bone on the right carrying with it portions of cerebrum, skull and scalp. The two wounds of the skull combined with the force of the missile produced extensive fragmentation of the skull, laceration of the superior saggital sinus, and of the right cerebral hemisphere.

The other missile entered the right superior posterior thorax above the scapula and traversed the soft tissues of the supra-scapular and the supra-clavicular portions of the base of the right side of the neck. This missile produced contusions of the right apical parietal pleura and of the apical portion of the right upper lobe of the lung. The missile contused the strap muscles of the right side of the neck, damaged the trachea and made its exit through the anterior surface of the neck. As far as can be ascertained this missile struck no bony structures in its path through the body.

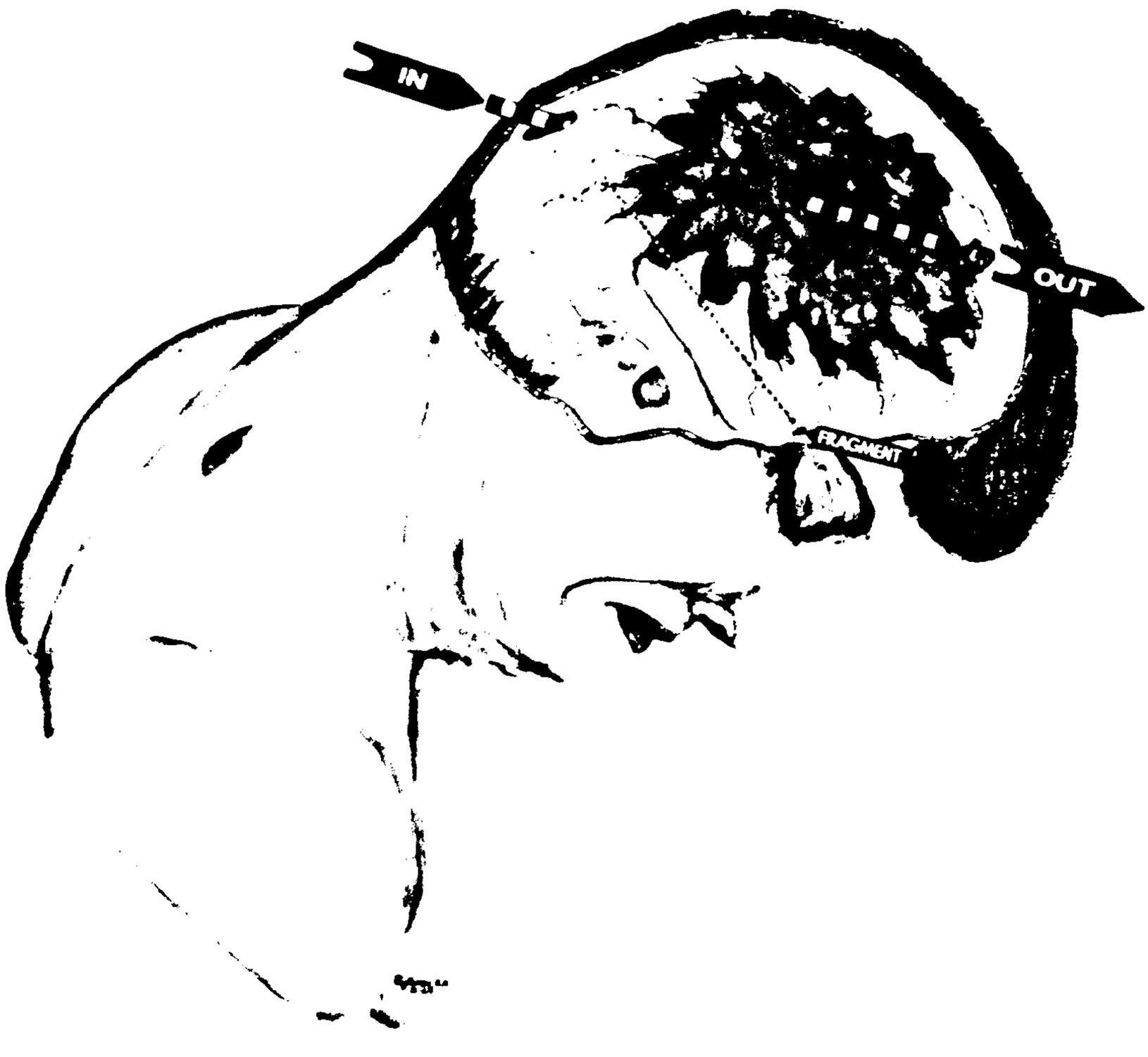
In addition, it is our opinion that the wound of the skull produced such extensive damage to the brain as to preclude the possibility of the deceased surviving this injury.

A supplementary report will be submitted following more detailed examination of the brain and of microscopic sections. However, it is not anticipated that these examinations will materially alter the findings.

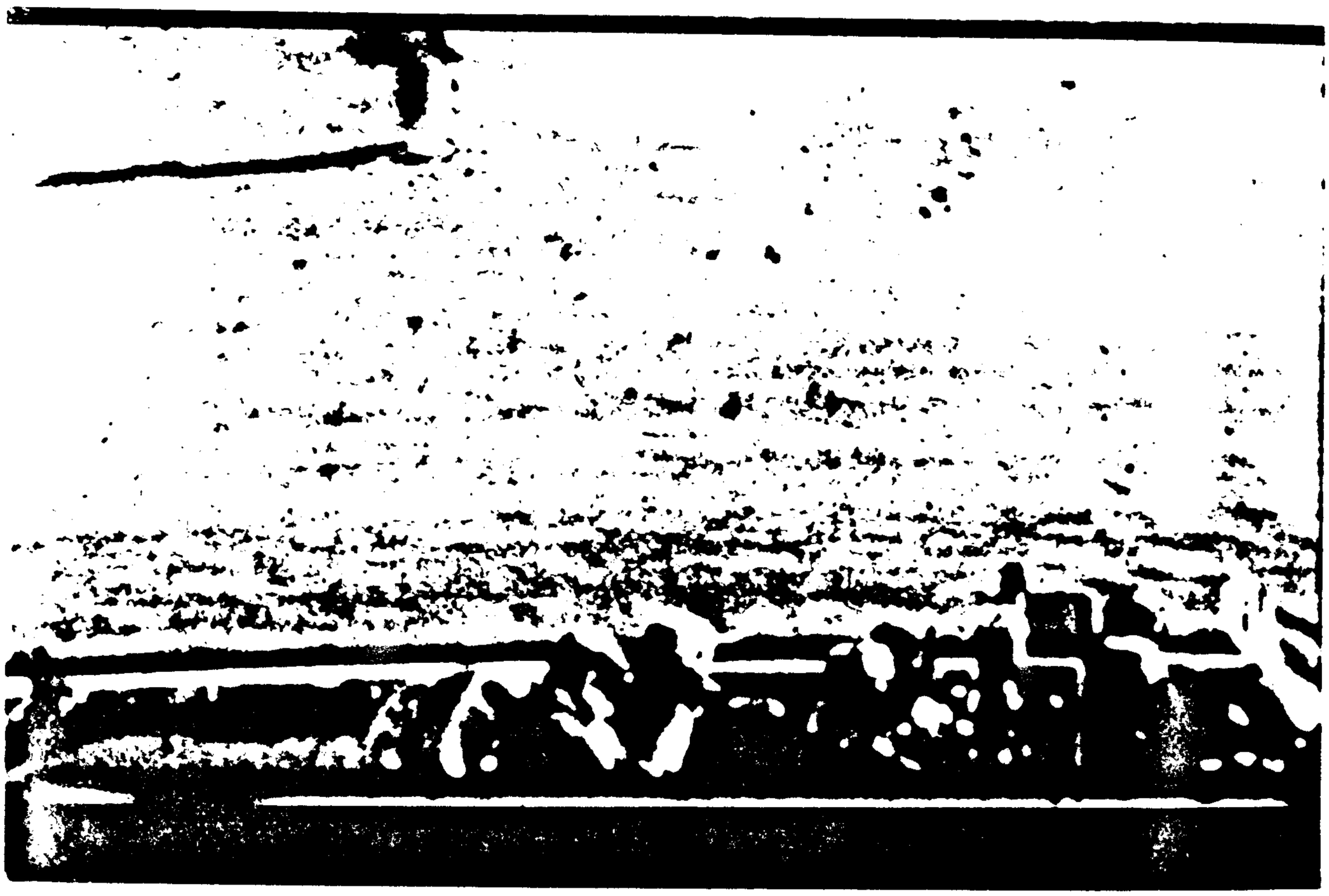
J. J. HUMES
CDR, MC, USN (497831)

THORNTON BOSWELL
CDR, MC, USN (489878)

PIERRE A. FINCK
LT COL, MC, USA
(04-043-322)



COMMISSION EXHIBIT
388



COMMISSION EXHIBIT
#389

COMMISSION EXHIBIT
#390

Commission Exhibit No. 391

11/6/63

SUPPLEMENTARY REPORT OF AUTOPSY NUMBER A63-272
PRESIDENT JOHN F. KENNEDY

EXAMINATION REPORT

DESCRIPTION OF BRAIN: Following formalin fixation the brain weighs 1500 gms. The right cerebral hemisphere is found to be markedly disrupted. There is a longitudinal laceration of the right hemisphere which is para-sagittal in position approximately 2.5 cm. to the right of the of the midline which extends from the tip of the occipital lobe posteriorly to the tip of the frontal lobe anteriorly. The base of the laceration is situated approximately 4.5 cm. below the vertex in the white matter. There is considerable loss of cortical substance above the base of the laceration, particularly in the parietal lobe. The margins of this laceration are at all points jagged and irregular, with additional lacerations extending in varying directions and for varying distances from the main laceration. In addition, there is a laceration of the corpus callosum extending from the genu to the tail. Exposed in this latter laceration are the interiors of the right lateral and third ventricles.

When viewed from the vertex the left cerebral hemisphere is intact. There is marked engorgement of meningeal blood vessels of the left temporal and frontal regions with considerable associated sub-arachnoid hemorrhage. The gyri and sulci over the left hemisphere are of essentially normal size and distribution. Those on the right are too fragmented and distorted for satisfactory description.

When viewed from the basilar aspect the disruption of the right cortex is again obvious. There is a longitudinal laceration of the mid-brain through the floor of the third ventricle just behind the optic chiasm and the mammillary bodies. This laceration partially communicates with an oblique 1.5 cm. tear through the left cerebral peduncle. There are irregular superficial lacerations over the basilar aspects of the left temporal and frontal lobes.

In the interest of preserving the specimen coronal sections are not made. The following sections are taken for microscopic examination:

a. From the margin of the laceration in the right parietal lobe.

b. From the margin of the laceration in the corpus callosum.

c. From the anterior portion of the laceration in the right frontal lobe.

d. From the contused left fronto-parietal cortex.

e. From the line of transection of the spinal cord.

f. From the right cerebellar cortex.

g. From the superficial laceration of the basilar aspect of the left temporal lobe.

1221

Commission Exhibit No. 391

During the course of this examination seven (7) black and white and six (6) color 4x5 inch negatives are exposed but not developed (the cassettes containing those negatives have been delivered by hand to Rear Admiral George G. Burkley, MC, USN, White House Physician).

MICROSCOPIC EXAMINATION:

BRAIN: Multiple sections from representative areas as noted above are examined. All sections are essentially similar and show extensive disruption of brain tissue with associated hemorrhage. In none of the sections examined are there significant abnormalities other than those directly related to the recent trauma.

HEART: Sections show a moderate amount of subepicardial fat. The coronary arteries, myocardial fibers, and endocardium are unremarkable.

LUNGS: Sections through the grossly described area of contusion in the right upper lobe exhibit disruption of alveolar walls and recent hemorrhage into alveoli. Sections are otherwise essentially unremarkable.

LIVER: Sections show the normal hepatic architecture to be well preserved. The parenchymal cells exhibit markedly granular cytoplasm indicating high glycogen content which is characteristic of the "liver biopsy pattern" of sudden death.

SPLEEN: Sections show no significant abnormalities.

KIDNEYS: Sections show no significant abnormalities aside from dilatation and engorgement of blood vessels of all calibers.

SKIN WOUNDS: Sections through the wounds in the occipital and upper right posterior thoracic regions are essentially similar. In each there is loss of continuity of the epidermis with coagulation necrosis of the tissues at the wound margins. The scalp wound exhibits several small fragments of bone at its margins in the subcutaneous tissue.

FINAL SUMMARY: This supplementary report covers in more detail the extensive degree of cerebral trauma in this case. However neither this portion of the examination nor the microscopic examinations alter the previously submitted report or add significant details to the cause of death.

J. J. Humes
J. J. HUMES
CDR, MC, USN, 497831

1221

Commission Exhibit No. 391

1221

6 December 1963

From: Commanding Officer, U. S. Naval Medical School
To: The White House Physician
Via: Commanding Officer, National Naval Medical Center

Subj: Supplementary report of Naval Medical School autopsy No. A63-272, John F. Kennedy; forwarding of

1. All copies of the above subject final supplementary report are forwarded herewith.

J. H. STOVER, JR.

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6 December 1963

FIRST ENDORSEMENT

From: Commanding Officer, National Naval Medical Center
To: The White House Physician

1. Forwarded.

C. B. GALLOWAY

1221

Commission Exhibit No. 392

PARKLAND MEMORIAL HOSPITAL

OPERATIVE RECORD

R 3220 STATUS Pvt

NAME: John Connally

UNIT # 25 36 99

DATE: 11-22-63 Thoracic Surg

AGE: RACE: W/M

PREOPERATIVE DIAGNOSIS: Gunshot wound of the chest with comminuted fracture of the 5th rib

POSTOPERATIVE DIAGNOSIS: Same with laceration right middle lobe, laceration lower lobe of lung

OPERATION: Thoracotomy, removal of foreign body, debridement of wound BEGAN: 1305 ENDED: 1500

ANESTHETIC: General BEGAN: 1300 ANESTHESIOLOGIST: Giesecke

SURGEON: Robert Shaw, M.D DRAINS:

ASSISTANTS: Doctors Colard and Duke APPLIANCES:

SCRUB NURSE: Mrs. Henderson CIRC. NURSE: Johnson CASTS/SPLINTS:

SPONGE COUNTS: 1ST Correct DRUGS I.V. FLUIDS AND BLOOD

2ND Correct 11-500 cc whole blood
11-1000cc D-5-L

COMPLICATIONS

None

CONDITION OF PATIENT: Satisfactory

Clinical Evaluation: The patient was brought to the OR from the ER. In the ER a sucking wound of the right chest was partially controlled by an occlusive dressing supported by manual pressure. A tube had been placed through the second interspace in the mid-clavicular line connected to a waterseal bottle to evacuate the right pneumothorax and hemothorax. An IV infusion of RL solution had already been started. As soon as the patient was positioned on the OR table the anesthesia was induced by Dr. Giesecke and an endotracheal tube was in place. As soon as it was possible to control respiration with positive pressure the occlusive dressing was taken from the right chest and the extent of the wound more carefully determined. It was found that the wound of entrance was just lateral to the right scapula about the angle yet had passed through the latyssmus dorsi muscle shattered approximately 10 cm of the lateral and anterior portion of the right fifth rib and emerged below the right nipple. The wound of entrance was approximately three cm in its longest diameter and the wound of exit was a ragged wound approximately five cm in its greatest diameter. The skin and subcutaneous tissue over the path of the missile moved in a pendulous manner with respiration indicating softening of the chest. The skin of the whole area was carefully cleansed with Phisohex and Iodine. The entire area including the wound of entrance and wound of exit was draped partially excluding the wound of entrance for the first part of the operation. An elliptical incision was made around the wound of exit excising the torn edges of the skin and the damaged subcutaneous tissue. The incision was then carried in a downward curve up toward the right axilla so as to not have the skin incision over the actual path of the missile but through the chest wall. This incision was carried down through the subcutaneous tissue to expose the Serratus anterior muscle and the anterior border of the latissimus dorsi muscle. The ragmented and damaged portions of the Serratus anterior muscle were excised. Small rib fragments that were adhering to periosteal tags were carefully removed preserving as much periosteum as possible. The fourth intercostal muscle bundle and fifth intercostal muscle bundle were not appreciably damaged.

Dr. Robert Shaw M.D. 551

(continued)

Commission Exhibit No. 392

PARKLAND MEMORIAL HOSPITAL

OPERATIVE RECORD

John Connally
25 35 99

DESCRIPTION OF OPERATION (Continued): The ragged ends of the damaged ninth rib were cleaned out with the rongeur. The pleura had been torn open by the secondary missiles created by the fragmented ninth rib. The wound was open widely and exposure was obtained with a self retaining retractor. The right pleural cavity was then carefully inspected approximately 100 cc of clot and liquid blood was removed from the pleural cavity. The middle lobe had a lacerated wound starting at the peripheral edge going down towards it hilum separating the middle from the segments. There was an open bronchus in the depth of this wound. Since the vascular supply and the bronchial connections to the lobe were intact it was decided to resect this lobe rather than to salvage it. The resection was accomplished with a running suture of #00 chromic gut on atraumatic needle closing both pleural surfaces as well as the muscle sutures approximating the tissue at the central portion of the lobe. This almost completely occluded all the air leaks which were evident in the main portion of the lobe. The lower lobe was examined and found to be engorged with blood and at one point a laceration at the hilum was found to be oozing blood. This laceration had undoubtedly been caused by a rib fragment. The laceration was closed with a single suture of #3-0 chromic gut on atraumatic needle. The right pleural cavity was now carefully examined and small rib fragments were removed, the diaphragm was found to be unlacerated there was no evidence of injury of the mediastinum and the pericardium. Hemostasis had been accomplished within the pleural cavity with the resection of the middle lobe and the suturing of the laceration in the lower lobe. The upper lobe was found to be uninjured. The drain which had previously been placed in the second interspace in the midclavicular line was found to be longer than necessary so approximately ten cm of it was cut away and the remaining portion was decontaminated with two additional sponges. An additional drain was placed through a stab wound in the eighth interspace in the posterior axillary line. Both these drains were then connected to a water seal bottle. The fourth and fifth intercostal muscles were then approximated with interrupted sutures of #0 chromic gut. The remaining portion of the Serratus anterior muscle was then approximated across the closure of the intercostal muscle. The laceration of the latissimus dorsi muscle on the internal surface was then closed with several interrupted sutures of #0 chromic gut. The subcutaneous tissue was then closed. Before closing the subcutaneous tissue one million units of Penicillin and one gram of Streptomycin in 100 cc normal saline was instilled into the wound. The stab wound was then made in the most dependent portion of the wound coming out under the angle of the scapula. Large Penrose drain was drawn out through this stab wound to allow drainage of the wound of the chest wall. The subcutaneous tissues then approximated with #0 chromic gut inverting the knots. Skin closed with interrupted vertical sutures of black silk. Attention was next turned to the wound of entrance. It was excised with an elliptical incision. It was found that the latissimus dorsi muscle although lacerated was not badly damaged so that the opening was closed with sutures of #0 chromic gut in the depth of the muscle. Before closing this incision the palpation with the index finger the bullet fragment could be felt immediately below in the space beneath the latissimus dorsi muscle. The skin closed with interrupted vertical mattress sutures of black silk. Drainage tubes were secured with safety pins and adhesive tape and dressings applied. As soon as the operation on the chest had been concluded Dr. Gregory and Dr. Shires started the surgery that was necessary for the wounds of the right wrist and left thigh.

Dr. Robert Shaw

There was also a comminuted fracture of the [illegible] radius secondary to the same missile and in addition a small flesh wound of the left thigh. The operative notes concerning the management of the right arm and left thigh will be dictated by Dr. Charles and Dr. Ron Shires.

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Commission Exhibit No. 392

PARKLAND MEMORIAL HOSPITAL

OPERATIVE RECORD

DATE: 11-22-63 Dallas

RM # 223 STATUS: Pvt.

NAME: Governor John Connally

UNIT # 25 35 59

AGE: w/m RACE:

PRE-OPERATIVE DIAGNOSIS: Comminuted fracture of the right distal radius, open secondary to gunshot wound

POST-OPERATIVE DIAGNOSIS: Same

OPERATION: Debridement of gunshot wound of right wrist, reduction of fracture of the radius BEGAN: 1300 ENDED: 1530

ANESTHETIC: General BEGAN 1300 ANESTHESIOLOGIST: Giordano

SURGEON: Dr. Charles Gregory DRAINS:

ASSISTANTS: Dr. Gilbert and Parkes APPLIANCES:

SCRUB NURSE: Richardson CIRC. NURSE: Coleman CASTS/SPLINTS:

SPONGE COUNTS: 1ST

2ND

DRUGS

I.V. FLUIDS AND BLOOD

COMPLICATIONS:

None

CONDITION OF PATIENT: Fair

Clinical Procedure:

While still under general anesthesia and following a thorough scrub of the chest injury by Dr. Robert Shaw, the right upper extremity was thoroughly prepped in the routine fashion after shaving. It was draped in the routine fashion using stockinette, the only addition was the use of a debridement pan. The wound of entry on the [illegible] aspect of the right wrist over the junction of the distal fourth of the radius and [illegible] was approximately two cm in length and rather oblique with the loss of tissue with some considerable contusion at the margins of it. There was a wound of exit along the volar surface of the wrist about two cm above the flexion crease of the wrist and in the midline. The wound of entrance was carefully excised and developed through the muscles and tendons [illegible] side of that bone to the bone itself where the fracture was encountered. [illegible] that the tendon of the abductor pollicis brevis was transected, only two small fragments of bone was removed, one approximately one cm in length and consisted of lateral [illegible] which lay free in the wound and had no soft tissue connections, another much smaller [illegible] perhaps 3 mm in length was subsequently removed. Small bits of metal were encountered at various levels throughout the wound and these were wherever they were identified and could be picked up were picked up and have been submitted to the Pathology department for identification and examination. Throughout the wound it was not and especially in the superficial layers and to some extent in the tendon and tendon sheaths on the radial side of the ... small fine bits of cloth consistent with fine bits of fabric. It is [illegible] understanding that the patient was wearing a fabric suit at the time of the injury and this accounts for the deposition of such organic material within the wound. After as careful and complete a debridement as could be carried out with an apparent integrity of the [illegible] tendons and the radial nerve in the volar area, and after thorough irrigation the [illegible] of exit on the volar surface of the wrist was closed primarily with wire sutures. [illegible] wound of entrance on the radial side of the forearm was only partially closed, [illegible] for the purpose of drainage should any take [illegible].

(continued)

Charles Gregory, M.D.

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Commission Exhibit No. 392

PARKLAND MEMORIAL HOSPITAL

OPERATIVE RECORD

Governor John Connally
25 36 59

11-22-63 Ortho

DESCRIPTION OF OPERATION (Continued): This is [illegible] to the presence of debris and [illegible] carried deep into the wound which is prone to produce tissue reactions and to encourage infection and this precaution of not closing the wound was taken in correspondence with our experience in this regard.

In view of the urgency of the Governor's original chest injury it was impossible to definitely ascertain the status of the circulation into the nerve supply to the hand and wrist on the right side. Accordingly, it was determined as best we could at the time of operation that the radial artery was found to be intact and pulsating normally. The integrity of the median nerve and the ulnar nerve is not clearly established but it is presumed to be present. Following closure of the volar wound and partial closure of the radial wound, dry sterile dressings were applied and a long arm cast was then applied with slight wrist extension, rubber band variety, attached to the thumb at index finger of the right hand. Traction in attitude of flexion was created at the right elbow, and post operatively the limbs supported from an overhead frame with gauze traction. The post operative diagnosis for the right forearm remains the same and again I suggest that you incorporate this particular dictation together with other dictations which will be given to you by the surgeons concerned with this patient.

Charles Gregory, M.D.

CG:el

Admission Exhibit No. 392

PARKLAND MEMORIAL HOSPITAL

OPERATIVE RECORD

DATE: Nov. 22, 1963

A #: 220 STATUS: Pvt.

NAME: Connally, John

UNIT #: 253599
A 024842

AGE: RACE: W/M

PREOPERATIVE DIAGNOSIS: Gunshot Wound, Right Chest, Right Wrist, Left Thigh

POSTOPERATIVE DIAGNOSIS: Same

OPERATION: Exploration and Debridement of Gunshot Wound of Left Thigh (Pass below) BEGAN: 15:00 ENDED: 15:20

ANESTHETIC: General BEGAN: 13:00 ANESTHESIOLOGIST: Gaissacks

SURGEON: Dr. Shires DRAINS:

ASSISTANTS: Drs. McClelland, Baxter and Perry APPLIANCES:

SCRUB NURSE: Oliver CIRC. NURSE: Deming and Schrader CASTS/SPLINTS:

SPONGE COUNTS: 1ST Correct PS DRUGS I.V. FLUIDS AND BLOOD

2ND

COMPLICATIONS: *This portion of the operation is involved only with the operation on the left thigh. The chest injury has been dictated by Dr. Shaw, the orthopedic injury to the arm by Dr. Gregory.

CONDITION OF PATIENT:

Clinical Evaluation: There was a 1 cm. punctate missile wound over the juncture of the middle and lower third, medial aspect, of the left thigh. X-rays of the thigh and leg revealed a bullet fragment which was imbedded in the body of the femur in the distal third. The leg was prepared with Phisohex and I.O. Prep and was draped in the usual fashion.

Operative Findings: Following this the missile wound was excised and the bullet tract was explored. The missile wound was seen to course through the subcutaneous fat and into the vastus medialis. The necrotic fat and muscle were debrided down to the region of the femur. The direction of the missile wound was judged not to be in the course of

Description of Operation: the femoral vessel, since the wound was distal and anterior to Hunter's canal. Following complete debridement of the wound and irrigation with saline, the wound was felt to be adequately debrided enough so that three simple through-and-through, stainless steel Alby #28 wire sutures were used encompassing skin, subcutaneous tissue, and muscle fascia on both sides. Following this a sterile dressing was applied. The dorsalis pedis and posterior tibial pulses in both legs were quite good. The thoracic procedure had been completed at this time, the debridement of the compound fracture in the arm was still in progress at the time this soft tissue injury repair was completed.

Tom Shires, M.D.

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Commission Exhibit No. 392

PARKLAND MEMORIAL HOSPITAL

OPERATIVE RECORD

NUM: ——— STATUS: S

NAME: [redacted]

UNIT #: [redacted]

DATE: [redacted] SURG. [redacted]

AGE: [redacted] RACE: W/C

PRE-OPERATIVE DIAGNOSIS: [redacted]

POST-OPERATIVE DIAGNOSIS: [redacted]

OPERATION: [redacted] BEGAN: [redacted] ENDED: [redacted]

ANESTHETIC: [redacted] BEGAN: [redacted] ANESTHESIOLOGIST: [redacted]

SURGEON: [redacted] DRAINS: [redacted]

ASSISTANTS: [redacted] APPLIANCES: [redacted]

SCRUB NURSE: [redacted] CIRC. NURSE: [redacted] CASTS/SPLINTS: [redacted]

SPONGE COUNTS: 1ST [redacted] [redacted]

2ND [redacted] [redacted]

COMPLICATIONS:

CONDITION OF PATIENT: [redacted]

DRUGS

[redacted]

I.V. FLUIDS AND BLOOD

[redacted]

Clinical Evolution: [redacted]

Operative Findings: [redacted]

Description of Operation: [redacted]

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Tom Shires, M.D.

1670

Commission Exhibit No. 392

The President arrived in the Emergency Room at exactly 12:43 p.m. in his limousine. He was in the back seat, Gov. Connally was in the front seat of the same car, Gov. Connally was brought out first and was put in room two. President was brought out next and put in room one. Dr. Clark pronounced the President dead at 1 p.m. exactly. All of the President's belongings except his watch were given to the Secret Service. His watch was given to Mr. O. P. Wright. He left the Emergency Room, the President, at about 2 p.m. in an O'Neal ambulance. He was put in a bronze colored plastic casket after being wrapped in a blanket and was taken out of the hospital. He was removed from the hospital,. The Gov. was taken from the Emergency Room to the Operating Room.

The President's wife refused to take off her bloody gown, clothes. She did take a towel and wipe her face. She took her wedding ring off and placed it on one of the President's fingers.

SUMMARY

The President arrived at the Emergency Room at 12:40 P.M., the 22nd of November, 1963. He was in the back seat of his limousine. Governor Connally of Texas was also in this car. The first physician to see the President was Dr. James Carrico, a Resident in General Surgery.

Dr. Carrico noted the President to have slow, agonal respiratory efforts. He could hear a heartbeat but found no pulse or blood pressure to be present. Two external wounds, one in the lower third of the anterior neck, the other in the occipital region of the skull, were noted. Through the head wound, blood and brain were extruding. Dr. Carrico inserted a cuffed endotracheal tube. While doing so, he noted a ragged wound of the trachea immediately below the larynx.

At this time, Dr. Malcolm Perry, Attending Surgeon, Dr. Charles Baxter, Attending Surgeon, and Dr. Ronald Jones, another Resident in General Surgery, arrived. Immediately thereafter, Dr. M. T. Jenkins, Director of the Department of Anesthesia, and Doctors Giesecke and Rhat, two other Staff Anesthesiologists, arrived. The endotracheal tube had been connected to a Bennett respirator to assist the President's breathing. An Anesthesia machine was substituted for this by Dr. Jenkins. Only 100% oxygen was administered.

A cutdown was performed in the right ankle, and a polyethylene catheter inserted in the vein. An infusion of lactated Ringer's solution was begun. Blood was drawn for type and crossmatch, but unmatched type "O" RH negative blood was immediately obtained and began. Hydrocortisone 300 mgms was added to the intravenous fluids.

Dr. Robert McClelland, Attending Surgeon, arrived to help in the President's care. Doctors Perry, Baxter, and McClelland began a tracheostomy, as considerable quantities of blood were present from the President's oral pharynx. At this time, Dr. Paul Peters, Attending Urological Surgeon, and Dr. Kemp Clark, Director of Neurological Surgery, arrived. Because of the lacerated

trachea, anterior chest tubes were placed in both pleural spaces. These were connected to sealed underwater drainage.

Neurological examination revealed the President's pupils to be widely dilated and fixed to light. His eyes were divergent, being deviated outward; a skew deviation from the horizontal was present. No deep tendon reflexes or spontaneous movements were found.

There was a large wound in the right occipito-parietal region, from which profuse bleeding was occurring. 1500 cc. of blood were estimated on the drapes and floor of the Emergency Operating Room. There was considerable loss of scalp and bone tissue. Both cerebral and cerebellar tissue were extruding from the wound.

Further examination was not possible as cardiac arrest occurred at this point. Closed chest cardiac massage was begun by Dr. Clark. A pulse palpable in both the carotid and femoral arteries was obtained. Dr. Perry relieved on the cardiac massage while a cardiotachioscope was connected. Dr. Fouad Bashour, Attending Physician, arrived as this was being connected. There was electrical silence of the President's heart.

President Kennedy was pronounced dead at 1300 hours by Dr. Clark.

Kemp Clark, M.D.
Director
Service of Neurological Surgery

KC:ca

cc to Dean's Office, Southwestern Medical School
cc to Medical Records, Parkland Memorial Hospital

Commission Exhibit No. 392

J. R. Kenwody

DATE AND HOUR: 11/22/63 -- 1130 -- DOCTOR: Carrico

ADMISSION NOTE:

551

RECORD NUMBER HOSPITAL

ADMISSION NOTE

TO Parkland

DATE 22 Nov 1963 DOCTOR PERRY

CC: Wife shot.

HPI: This 35 y/o white male was riding in the motorcade in the Presidential limousine in the front seat on the right side. He was sitting next to the President and he thinks he was shot at approximately 12:30 PM. He was sitting in the front seat on the right side of the car and was facing forward. He heard a loud noise and felt a sharp pain in the back of his neck. He then noticed blood on his clothes and realized he had been shot. He was then taken to Parkland Hospital by ambulance.

PMH: He has had no serious illnesses in the past. He has had no operations. He has had no blood transfusions. He has had no injuries to the head or neck.

MEDICATIONS: He is not taking any medications.

ALLERGIES: He has no known allergies.

SOCIAL HISTORY: He is married and has two children. He is employed by the Texas School Book Depository as a stock clerk.

REVIEW OF SYSTEMS: He has had no recent illnesses. He has had no chest pain, shortness of breath, abdominal pain, nausea, vomiting, diarrhea, dysuria, hematuria, or rectal bleeding.

PHYSICAL EXAMINATION: He is a well developed, well nourished white male in no acute distress. He is lying supine on the stretcher. His vital signs are stable. He is afebrile.

HEENT: Pupils are equal, round, and reactive to light and accommodation. Extraocular movements are intact. Sclerae are anicteric. Conjunctivae are clear. There is a 2 cm laceration in the right occipital region of the scalp. There is brisk bleeding from the wound. There is no active bleeding from the nose or ears. There is no malocclusion. There is no drainage from the nose or ears. There is no battle's sign.

(CVIII)

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Mission Exhibit No. 392

ADMISSION NOTE:

[illegible] Hospital Electrocardiographic
[illegible] Laboratory Report on [illegible]
[illegible] Medical Witness Testimony [illegible]
[illegible] Testimony [illegible] Admitted [illegible]
[illegible] Hospital Records [illegible]
[illegible] Court Reporter

Malcolm O. Bruyn M.D.
1630 h. 22 IV 1963

DEC 55

Commission Exhibit No. 392

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[illegible] MEMORIAL HOSPITAL [illegible]

ADMISSION NOTE

J. F. Kennedy -

Admitted 22 Nov 63 DOCTOR

[illegible] 13 [illegible] -

Called by Page while standing in line [illegible]
[illegible] it. Was told that the President had
been shot. I arrived in the ER at 12:30-12:35
[illegible] The President was bleeding profusely
from the back of the head. There was a large
[illegible] fragment of [illegible] tissue present
at the wound. There was a small amount of
cerebellar tissue present also.

A tracheostomy was being performed
Drs. Perry, Baxter, and McClellan
[illegible] the President showed that an
endotracheal tube was in place and respiratory
[illegible] was being given by Dr. Akin &
[illegible] His pupils were dilated, fixed to
[illegible] and the eyes were deviated
[illegible] and the right was downward and
[illegible]

The trach was completed and I
[illegible] the endotracheal tube a little
[illegible] blood was present in the mouth -
[illegible] suction was used to remove the
[illegible] tube was [illegible] with the [illegible]
the [illegible]

OVER

Commission Exhibit No. 392

[illegible] HOSPITAL [illegible] NO. [illegible]

ADMISSION NOTE

[illegible] Nov 22, 1963 4:45 PM DOCTOR Platt M McClelland

[illegible] Regarding Assassination of

President Kennedy

[illegible]

561

EVCD

Commission Exhibit No. 392

ADMISSION NOTE:

Case of 11-17 was admitted to the Parkland Memorial Hospital on 11-22-63 at 1:30 PM. He was transferred to the Southwestern Medical School of the University of Texas Dallas, Texas

DOCTOR —

561

THE UNIVERSITY OF TEXAS
SOUTHWESTERN MEDICAL SCHOOL
DALLAS

M. T. Jenkins, M.D.
Professor and Chairman
Department of Anesthesiology

Clinical Departments of Anesthesia
PARKLAND MEMORIAL HOSPITAL
SOUTHWESTERN MEDICAL CENTER

November 22, 1963
1630

To: Mr. C. J. Price, Administrator
Parkland Memorial Hospital

From: M. T. Jenkins, M.D., Professor and Chairman
Department of Anesthesiology

Subject: Statement concerning resuscitative efforts for President John F. Kennedy

Upon receiving a last alarm that this distinguished patient was being brought to the emergency room at Parkland Memorial Hospital, I dispatched Doctors A. E. Giesecke and Jerrie H. Hunt with an anesthesia machine and resuscitative equipment to the major surgical emergency room area, and I ran down the stairs. On my arrival in the emergency operating room at approximately 1230 I found that Doctors Curtis and/or Delaney had begun resuscitative efforts by introducing an orotracheal tube, connecting it for controlled ventilation to a Bennett intermittent positive pressure breathing apparatus. Doctors Charles Baxter, Malcolm Perry, and Robert McClelland arrived at the same time and began a tracheostomy and started the insertion of a right chest tube, since there was also obvious tracheal and chest damage. Doctors Paul Peters and Kemp Clark arrived simultaneously and immediately thereafter assisted respectively with the insertion of the right chest tube and with manual closed chest cardiac compression to assure circulation.

For better control of artificial ventilation, I exchanged the intermittent positive pressure breathing apparatus for an anesthesia machine and continued artificial ventilation. Doctors Gene Akin and A. E. Giesecke assisted with the respiratory problems incident to changing from the orotracheal tube to a tracheostomy tube, and Doctors Hunt and Giesecke connected a cardioscope to determine cardiac activity.

During the progress of these activities, the emergency room cart was elevated at the foot of the stretcher to provide a Trendelenburg position, a venous cutdown was performed on the right saphenous vein, and additional fluids were begun in a vein in the left forearm while blood was ordered from the blood bank. All of these activities were completed by approximately 1245, at which time external cardiac massage was still being carried out effectively by Doctor Clark as judged by a palpable peripheral pulse. Despite these measures there was no electrocardiographic evidence of cardiac

Mrs. G. H. Price, Administrator
November 22, 1963
Page 2 - Statement concerning resuscitative
efforts for President John F. Kennedy

These described resuscitative activities were indicated as of first importance, and after they were carried out attention was turned to all other evidences of injury. There was a great laceration on the right side of the head (temporal and occipital), causing a great defect in the skull plate so that there was lacerations and laceration of great amount of the brain, even to the extent that the cerebellum had protruded from the wound. There were also fragmented sections of brain on the drapes of the emergency room cart. With the institution of adequate cardiac compression, there was a great flow of blood from the cranial cavity, indicating that there was much vascular damage as well as brain tissue damage.

It is my personal feeling that all methods of resuscitation were instituted expeditiously and efficiently. However, this cranial and intracranial damage was of such magnitude as to cause the irreversible damage. President Kennedy was pronounced dead at 1300.

Sincerely,

[signature]

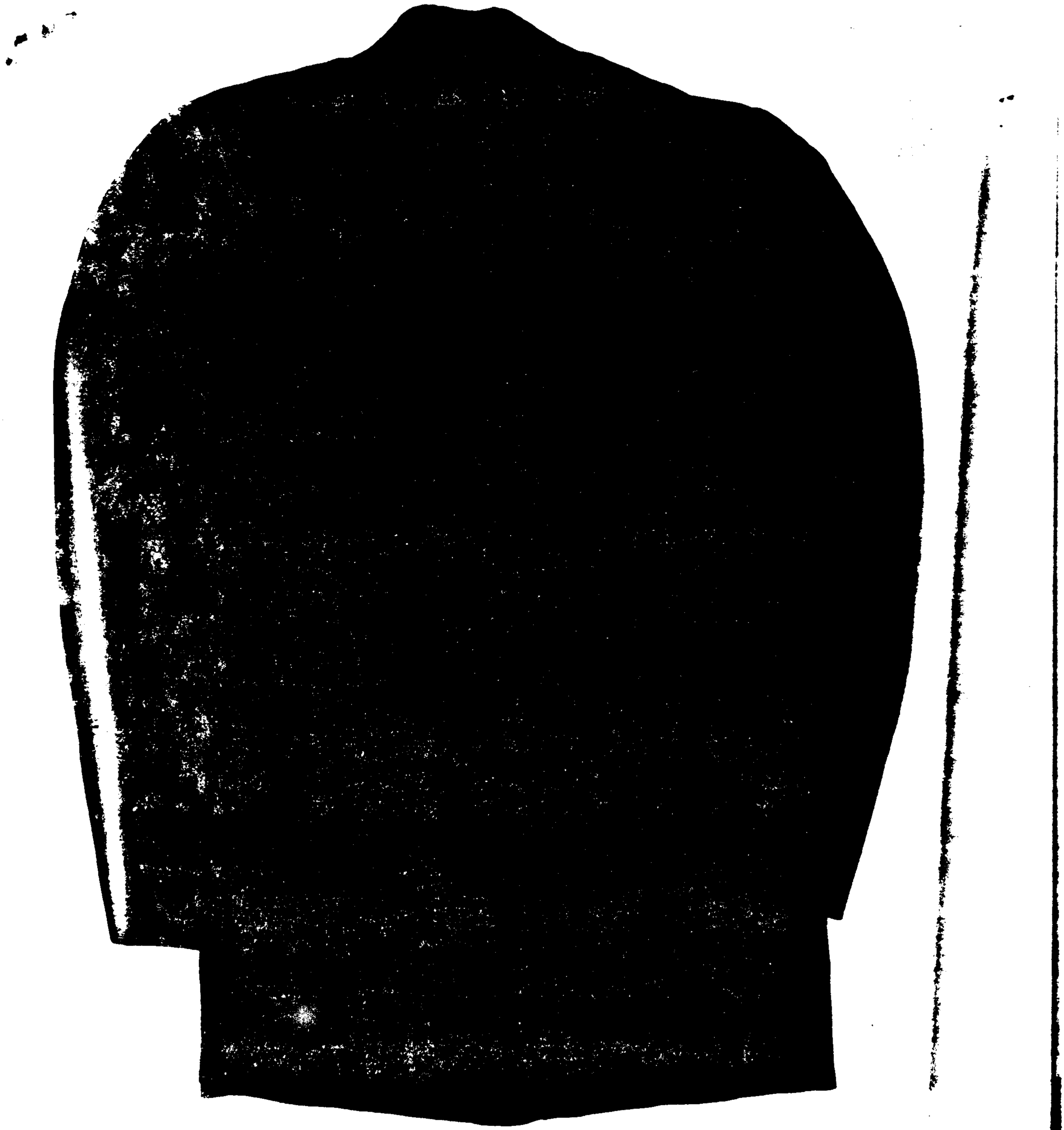
M. G. Perkins, M.D.

jr

551

561

C 29
COMMISSION EXHIBIT
393



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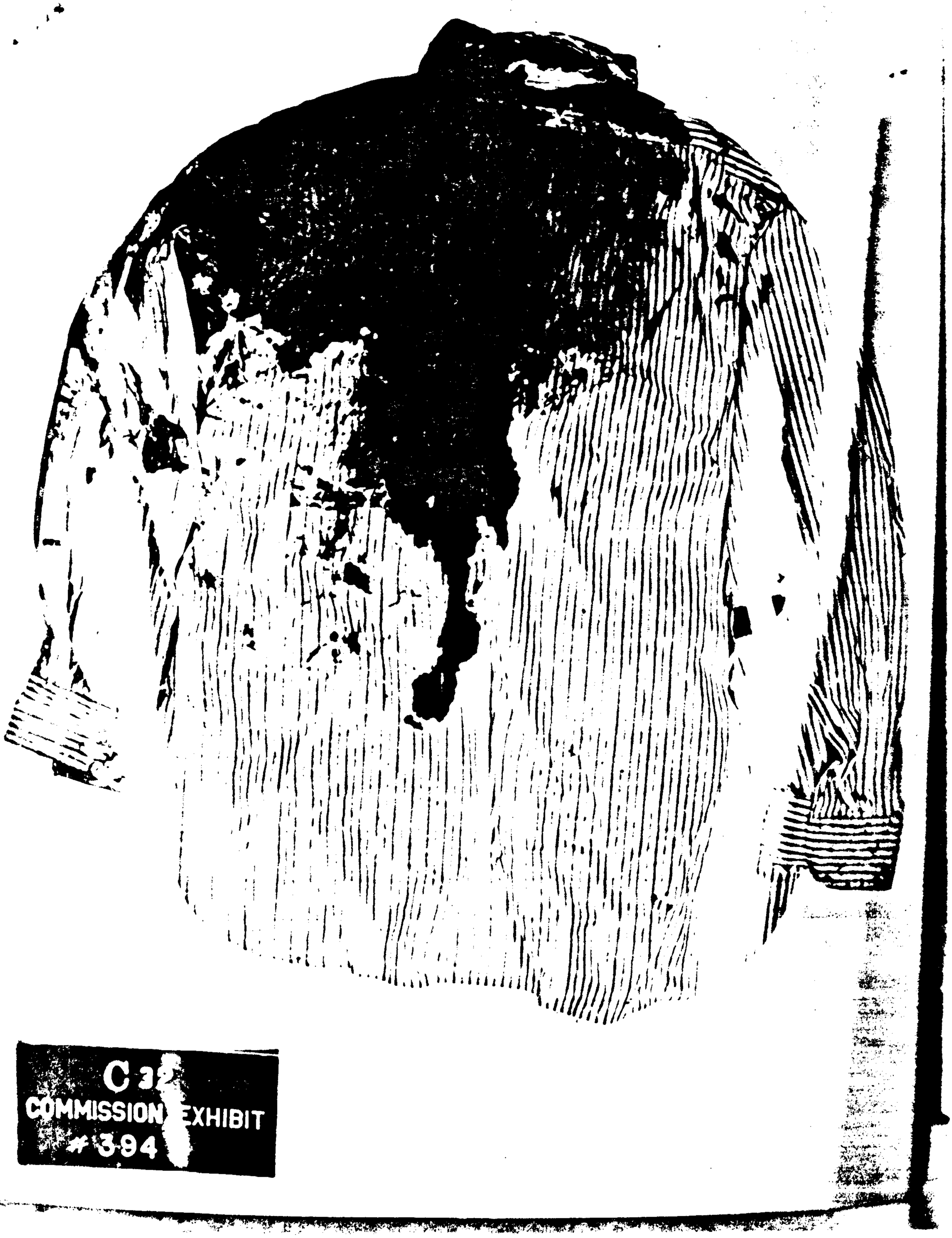
COMMISSION EXHIBIT
393



C 32
COMMISSION EXHIBIT
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COMMISSION EXHIBIT
#396

Wound entrance 2 cm. Right
Bleeding air via
upper mediastinum

Only a few mm in
size 3-5 mm.

Ingress at Col.
wall of the trachea -
no missile in the wound.

Dep. Melrose 1-5050
4115 Park Lane
Dallas 20, Tex.
FL 2-5548
Home

Off in Med. School
Dept. of Surgery
Tom
Dr. Shires
Dr. Mal Perry at Hume

Commission Exhibit No. 397

A63.237 Kennedy, John F.

Date of birth — — 1917
Date of death 11/22/63
Hour of death 1:00 pm CST Dallas, Tex.
Hour of autopsy 8:00 pm EST Bethesda, Md.

Clinical Summary

According to available information the deceased, President John F. Kennedy, was riding in an open car in a motorcade during an official visit to Dallas, Texas on 22 Nov. 1963. The president was sitting in the right rear seat with Mrs. Kennedy seated on the same seat to his left. Sitting directly in front of the president was Gov. John B. Connally of Texas and directly in front of Mrs. Kennedy sat Mrs. Connally. The vehicle was moving at a slow rate of speed ~~as it proceeded~~ down an incline into an underpass that leads to a freeway route to the Dallas Trade Mart where the president was to deliver an address. Three shots were heard and the president fell forward ~~to the floor of the vehicle~~