Commission Exhibit No. 392

PARKLAND MEMORIAL HOSPITAL

OPERATIVE RECORD

R 3220 STATUS: Pvt

NAME: John Connally

UNIT #: 25 36 99

DATE: 11-22-63 Emergency Surg

AGE: RACE: W/M

PRE-OPERATIVE DIAGNOSIS: Gunshot wound of the chest with comminuted fracture of the 5th rib

POST-OPERATIVE DIAGNOSIS: Same with laceration right middle lobe, hematoma lower lobe of lung

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

ANESTHETIC: General BEGAN: 1300 ANESTHESIOLOGIST: Giesecke

SURGEON: Robert Shaw, M.D DRAINS:

ASSISTANTS: Doc Foland and Duke APPLIANCES:

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

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

2ND Correct 1-500 cc whole blood
1-1000cc D-5-R

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 middle yet had passed through the latyssmus dorsi muscle shattered approximately [illegible] 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 parallel 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 latter part of the operation. An elliptical incision was made around the wound of exit removing 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 fragmented 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.

CE:SL (continued)

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Commission Exhibit No. 392

PARKLAND MEMORIAL HOSPITAL

OPERATIVE RECORD

John Connally
25 35 59

DESCRIPTION OF OPERATION (Continued): The ragged ends of the damaged fifth rib were cleaned out with the rongeur. The pleura had been torn open by the secondary missiles created by the fragmented fifth rib. The wound was open widely and exposure was obtained with a self retaining retractor. The right pleural cavity was then carefully inspected approximately 500 cc of clot and liquid blood was removed from the pleural cavity. The middle lobe had a linear tear starting at the peripheral edge going down towards it hilum separating the lobe into two segments. There was an open bronchus in the depth of this wound. Since the blood supply and the bronchial connections to the lobe were intact it was decided to re-[illegible] lobe rather than to remove it. The repair was accomplished with a running suture of 000 chromic gut on atraumatic needle closing both pleural surfaces as well as two mattress sutures approximating the tissue of the central portion of the lobe. This almost completely sealed off the air leaks which were evident in the torn portion of the lobe. The lower lobe was then examined and found to be engorged with blood and at one point a laceration at allowed the oozing of blood. This laceration had undoubtedly been caused by a rib fragment. This laceration was closed with a single suture of 00-0 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 undamaged. There was no evidence of injury of the mediastinum and its contents. Hemostasis had been accomplished within the pleural cavity with the repair of the middle lobe and the suturing of the laceration in the lower lobe. The upper lobe was found to be undamaged. The drains 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 incorporated with two additional openings. 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 anterior surface was then closed with several interrupted sutures of #0 chromic gut. Pre-[illegible]-tissue-was-[illegible] 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 near the angle of the scapula. A 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 interrupted #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 fascia of the muscle. Before closing this incision the palpation with the index finger the Penrose drain 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.

[illegible]

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. Tom Shires.

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Commission Exhibit No. 392

PARKLAND MEMORIAL HOSPITAL

OPERATIVE RECORD

DATE: 11-22-63 Ortho

R# : 223 STATUS: Pvt.

NAME: Governor John Connally

UNIT # 25 35 99

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: 1600 ENDED: 1650

ANESTHETIC: General BEGAN: 1300 ANESTHESIOLOGIST: Giesecke

SURGEON: Dr. Charles Gregory DRAINS:

ASSISTANTS: Dr. Osborne and Perdue APPLIANCES:

SCRUB NURSE: Underwood CIRC. NURSE: Sebastian CASTS/SPLINTS:

SPONGE COUNTS: 1ST 2ND DRUGS I.V. FLUIDS AND BLOOD

COMPLICATIONS: None

CONDITION OF PATIENT: Fair

Clinical Evaluation:

While still under general anesthesia and following a thoracotomy and repair of the chest injury by Dr. Robert Shaw, the right upper extremity was thoroughly prepped in the routine fashion after shaving. He was draped in the routine fashion using sterilette, 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] the radial 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 portion which lay free in the wound and had no soft tissue connections, another much smaller fragment 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 arm small fine bits of cloth consistent with fine bits of fabric. It is our understanding that the patient was wearing a fabric suit at the time of the injury and this accounts for the deposition of such cloth material within the wound. After as careful and complete a debridement as could be carried [illegible] with an apparent integrity of the [illegible] and the median nerve in the volar [illegible], and after thorough irrigation the [illegible] of the skin on the volar surface of the wrist was closed primarily with wire sutures; [illegible] the wound of entrance on the radial side of the forearm was only partially closed, [illegible] for the purpose of drainage should any make [illegible] appearance.

Charles Gregory, M.D.

(continued)

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PARKLAND MEMORIAL HOSPITAL

OPERATIVE RECORD

Governor John Connally
35 36 39

11-22-63 .Ortho

DESCRIPTION OF OPERATION (Continued): This is advisedness to the presence of hematoma and the material 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 that 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 and 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 skin traction, rubber band variety, attached to the thumb at index finger of the right hand. Elevation in attitude of flexion was created at the right elbow, and post operatively the limbus suspended from an overhead frame using tape 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:bl

Commission Exhibit No. 392

PARKLAND MEMORIAL HOSPITAL

OPERATIVE RECORD

DATE: Nov. 22, 1963

A #: 220 STATUS: Pvt.

NAME: Connally, John

UNIT #: 253599
A 924842

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 (*See below) BEGAN: 15:00 ENDED: 15:20

ANESTHETIC: General BEGAN: 13:00 ANESTHESIOLOGIST: Gaissaka

SURGEON: Dr. Shires DRAINS:

ASSISTANTS: Drs. McClelland, Baxter and Perman APPLIANCES:

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

SPONGE COUNTS: 1ST Correct PS DRUGS LV. 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 Allen #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.

Ss

Tom Shires, M.D.

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Commission Exhibit No. 392

PARKLAND MEMORIAL HOSPITAL

OPERATIVE RECORD

ROOM: [illegible] STATUS: E

NAME: Connally, John Bowden

UNIT #: [illegible]

AGE: 24 Yrs. RACE: W/M

DATE: 11/22/63 Surg.

PRE-OPERATIVE DIAGNOSIS: [illegible] gunshot wound of chest with massive blood loss

POST-OPERATIVE DIAGNOSIS: Gunshot injury to thorax and chest

Hemothorax, hemopericardium, chest

OPERATION: Re-suture chest BEGAN: 1210 ENDED: 1307

Dr. Carl Rehn

ANESTHETIC: General BEGAN: 1210 ANESTHESIOLOGIST:

SURGEON: Dr. Tom Shires DRAINS:

ASSISTANTS: Dr. Perry, Dr. [illegible] APPLIANCES:

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

Controlled oxygen rubber tube by closed chest catheter

SPONGE COUNTS: 1ST [illegible] [illegible]

2ND [illegible] [illegible]

COMPLICATIONS:

CONDITION OF PATIENT: Expired at 1307

DRUGS

Ca chloride = 3 vials

[illegible] = 10

Cardiac tonicard

Digoxin = 2½

Aminophylline solution = 3

I.V. FLUIDS AND BLOOD

[illegible] cc. Plasma

[illegible] cc. Ringer's solution

[illegible] cc. Whole blood

[illegible] cc. 5% Dextrose in Balanced Ringer's solution

[illegible] = Urine out

Clinical Evaluation: [illegible] on admission trend over the last hour toward shock type, and an acute hemothorax by subcutaneous palpation of the bullet over the mid lower lateral chest origin. At this time he was seen preoperatively by me without blood pressure, heart beat [illegible] at about tachycardia at 120 beats per minute, and operative timely had endotracheal tube placed and was receiving oxygen by anesthesia

Operative Findings: At this time he was moved to the operating room.

Description of Operation: Under endotracheal oxygen anesthesia, a long mid-line abdominal incision was made. Bleeding vessels and fascia were clamped or tied. Upon entering the peritoneal cavity, approximately 2 to 3 liters of blood, both liquid and clot, were encountered. These were removed. The bullet pathway was then followed as having destroyed the upper anterior portion of the spleen, then entered the [illegible] retroperitoneal area where there was a large retroperitoneal hematoma in the [illegible] and upper retroperitoneal area. Following this, bleeding was seen to be coming from the right [illegible] and upon inspection there was seen to be an exit to the right through the [illegible] with care, either through the superior pole of the right kidney, the lower [illegible] of the right lobe of the liver, and into the right lateral body wall. [illegible] of the right lobe of the liver, and into the right lateral body wall. [illegible] kidney, which was bleeding, was identified, dissected free, [illegible] [illegible] body, and the injuries were controlled with a vascular [illegible] of the [illegible] type. Following this examination, packing accomplished the [illegible] of the right kidney. Attention was then turned to the liver, as bleeding [illegible] from the right kidney. Inspection of the retroperitoneal area revealed [illegible] below the bullet exit. The inspection of the retroperitoneal area revealed

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M.D.

Tom Shires, M.D.

[illegible], Lee Harvey
[illegible]
Page 2

A large hematoma in the mid-line. The spleen was then mobilized, as was the left colon, and the retroperitoneum, approach was made to the mid-line structures. The pancreas was seen to be shattered in its mid portion, bleeding was seen to be coming from the aorta. This was dissected free. Bleeding was controlled with finger pressure by Dr. Malcolm O. Perry. Upon identification of this injury, the superior mesenteric artery had been blown off of the aorta, there was [illegible] bleeding from the superior mesenteric artery. This was cross-clamped with a [illegible] curved DeBakey clamp. The aorta was then occluded with a straight DeBakey clamp above and a Potts clamp below. At this point all major bleeding was controlled, blood pressure was reported to be in the neighborhood of 100 systolic. Shortly thereafter, however, the pulse rate, which had been in the 80 to 90 range, was found to be 40 and a few seconds later found to be zero. No pulse was felt in the aorta at this time. Consequently the left chest was opened through an anterolateral incision in approximately the fourth intercostal space. A pericardiotomy was incised, the heart was seen to be flabby and was [illegible] at all. There was no hemopericardium. There was a hole in the diaphragm but no hemothorax. A left closed chest tube had been introduced in the emergency room prior to surgery, so that there was no significant pneumothorax on the left side. The pericardium was opened, cardiac massage was started, and a pulse was obtainable with massage. The heart was flabby, consequently calcium chloride followed by epinephrine-Xylocaine were injected into the left ventricle without success. However, the myocardium was converted to [illegible]. Following this, defibrillation was done, using 240, 360, 500, and 750 volts [illegible] successful defibrillation was accomplished. However, no effective heart beat could be instituted. A pacemaker was then inserted into the wall of the right ventricle and grounded on skin, and pacing was started. A very feeble, small, localized muscular response was obtained with the pacemaker but still no effective beat. At this time it was decided by Dr. Jenkins that there were no signs of life in that the pupils were fixed and dilated, there was no retinal blood flow, no respiratory effort, and no effective pulse could be maintained even with cardiac massage. The patient was pronounced dead at 1:07 P.M. Anesthesia consisted entirely of oxygen. No anesthetic agents as such were administered. The patient was never conscious from the time of his arrival in the Emergency Room until his death at 1:07 P.M. The subcutaneous bullet was excised from the right side during the attempts at defibrillation, which were [illegible] among the surgeons. The cardiac massage and defibrillation attempts were carried out by Dr. Robert N. McClelland, Dr. Malcolm O. Perry, Dr. Ronald Jones. Assistance was obtained from the cardiologist, Dr. Fouad Bashour.

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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 gloves, 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 Bhat, 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 begun. 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. Foad Dashour, 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:aa

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

Commission Exhibit No. 392

PARKLAND MEMORIAL HOSPITAL — DALLAS, TEXAS

ADMISSION NOTE

J. F. Kennedy

DATE AND HOUR: 11/22/63 — 1630 — DOCTOR: Carrico

Commission Exhibit No. 392

ADMISSION NOTE:

Commission Exhibit No. 392

PARKLAND MEMORIAL HOSPITAL, DALLAS, TEXAS

ADMISSION NOTE

TF Kennedy

22 Nov 1963 DOCTOR PERRY

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Mission Exhibit No. 332

ADMISSION NOTE:

[illegible] Bomb Electrocardiograph
[illegible] [illegible] [illegible] [illegible]
[illegible] [illegible] [illegible] [illegible]
[illegible] [illegible] [illegible] [illegible]
[illegible] [illegible] [illegible] [illegible]
[illegible] [illegible] [illegible] [illegible]

Malcolm O. Bing, M.D.
1630 h. 22 Nov 1963

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DOCTOR.

11.22.1963

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Commission Exhibit No. 392

PARKLAND MEMORIAL HOSPITAL

ADMISSION NOTE

DATE AND HOUR Nov 22, 1963 4:45 P.M. DOCTOR Robert N. McClelland

Statement Regarding Assassination of President Kennedy

At approximately 12:45 PM on the above date I was called from the second floor of Parkland Hospital and went immediately to the Emergency Operating Room. When I arrived I found the President was being attended by Drs. Malcolm Perry, Charles Baxter, James Carrico and Ronald Jones. The President was at that time comatose from a massive gunshot wound of the head with a fragment wound of the trachea. An endotracheal tube and assisted respiration was started immediately by Dr. Carrico on duty in E.R. when the President arrived. Drs. Perry, Baxter and I then performed a tracheostomy for respiratory distress and tracheal injury and Drs. Jones and Paul Peters inserted bilateral chest tubes for pneumothorax secondary to tracheomediastinal injury. Simultaneously Dr. Jenkins had started 3 cutdowns giving blood and fluids immediately. [illegible] [illegible] [illegible]

Commission Exhibit No. 392

ADMISSION NOTE:

Case of Lt. Lee H. Oswald
and the missing Jan. 4 portion of the
F. B. I. report on the assassination of Pres.
J. F. Kennedy. Original EKG entered into
evidence as Exhibit [illegible]

Asst. Prof. of Surgery
Southwestern Med.
School of Univ. of Tex.
Dallas, Texas

Commission Exhibit No. 392

ADMISSION NOTE

DATE: Nov 22 1963 4:45 PM DOCTOR: Baxter

Patient Regarding Examination with the President of the U.S. Presidential Limousine

At 12:30 PM was called from the OR by Parkland Hospital and told that Presidential Limousine had driven to the emergency room by Parkland. When I arrived, Mr. Kellerman had an injured, gunshot head wound. The patient showed a complete decerebrate. The President was dead on arrival at 1:00 PM.

J. Baxter MD

Special Duties of Medical Director Dallas Texas

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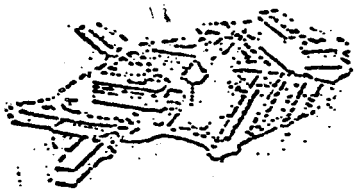
Commission Exhibit No. 392

THE UNIVERSITY OF TEXAS
SOUTHWESTERN MEDICAL SCHOOL
Dallas



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 most alarm that this distinguished patient was being brought to the emergency room at Parkland Memorial Hospital, I dispatched Doctors A. H. 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 Giesecke 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. H. Giesecke assisted with the respiratory problems incident to changing from the orotracheal tube to a tracheostomy tube, and Doctors Akin and Giesecke connected a cardioscope to determine cardiac activity.

During the progress of these activities, the emergency room cart was elevated at the foot in order 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 activity.

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Mr. G. P. 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 fragmentation 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,

M. G. Jenkins, M.D.

/s

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