

27

Peter		Eeka		4	W	5 T 26	Alien
(Surname)		(Given name)		(Age)	(Race)	(Sex)	(Class of beneficiary)
Admitted							
(Date)		(Hour)		(Authority)		(Source: Vessel or establishment)	

History: (If injury, state date, hour, place, and how it occurred.)

8-16-42: Blister on ankle.

Physical: (Include X-ray, laboratory reports, etc.)

(Patient's signature)

Diagnosis: 1. No. 8-16-42	Name Blister - leg.
2. No. 8-25 (43)	Name Insect - Stung on left foot
3. No.	Name

Other diseases or injuries

OUTPATIENT CARD (Station)

Surgeon, U. S. P. H. S.

NOTE: USE SEPARATE CARD FOR EACH ADMISSION

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If injury, state period of disability in final note:

16-11909

Peters *Rudolf* | 33 | W | T25 A | *Alien*
(Surname) (Given name) (Age) (Race) (Class of beneficiary)
Admitted _____
(Date) (Hour) (Authority) (Source: Vessel or establishment)

History: (If injury, state date, hour, place, and how it occurred.)

7-9-43: Since 2-3 year had had a small swelling behind
rt. ear; since 2-3 weeks painful

Physical: (Include X-ray, laboratory reports, etc.)

(Patient's signature)

Diagnosis: 1. No. _____ Name *inflamed atheroma (rt ear region)*
2. No. _____ Name _____
3. No. _____ Name _____

Other diseases or injuries _____

OUTPATIENT CARD _____

(Station)

Surgeon, U. S. P. H. S.

NOTE: USE SEPARATE CARD FOR EACH ADMISSION

[illegible]

Able to do light work as _____ on _____
Able to return to usual occupation _____ on _____

Peters *Ingelborg* *24* *✓* *S. 45 26* *Alien*
(Surname) (Given name) (Age) (Race) (Address) (Class of beneficiary)
Admitted _____
(Date) (Hour) (Authority) (Source: Vessel or establishment)

History: (If injury, state date, hour, place, and how it occurred.)
Illness acquired prior to admission to camp.

Physical: (Include X-ray, laboratory reports, etc.)

(Patient's signature)

Diagnosis: 1. No. _____ Name *Whooping Cough.*
2. No. _____ Name _____
3. No. _____ Name _____

Other diseases or injuries _____

OUTPATIENT CARD _____
(Station)

S. F. Oliver Surgeon, U. S. P. H. S.

NOTE: USE SEPARATE CARD FOR EACH ADMISSION

- Peters Ingrid 1 1/2 W 115 Alison
(Surname) (Given name) (Age) (Race) (Weight) (Class of beneficiary)

Admitted _____
(Date) (Hour) (Authority) (Source: Vessel or establishment)

History: (If injury, state date, hour, place, and how it occurred.)

Illness acquired prior to admission to camp.

Physical: (Include X-ray, laboratory reports, etc.)

(Patient's signature)

Diagnosis: 1. No. _____ Name Whooping Cough.
2. No. _____ Name _____
3. No. _____ Name _____

Other diseases or injuries _____

OUTPATIENT CARD _____
(Station)

S.F. Oliver Surgeon, U. S. P. H. S.

NOTE: USE SEPARATE CARD FOR EACH ADMISSION

Date:	Weight:	Height:
11/5/43	29 lbs	34"

T. 26 4

U. S. DEPARTMENT OF JUSTICE
IMMIGRATION AND NATURALIZATION SERVICE
Alien Internment Camp
Crystal City, Texas

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DATE: June 7, 1943

NAME: Peters, Ingrid

DATE OF BIRTH: Sept. 25 1941

WEIGHT: 27 HEIGHT: 30

TEETH: normal

SKIN:

normal

PHYSIQUE:

strong

HISTORY:

NUTRITIONAL STATE:

good

IMMUNIZATION: Di Tet 8/25-10/25-43
Smallpox 6/15/43 neg 8/10/43 neg

MUCOSAE:

normal

SUGGESTIONS:

REMARKS:

1

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If injury, state period of disability in final note:

Able to do light work as _____ on _____

Able to return to usual occupation _____ on _____

RECORD OF TREATMENT

DATE	SUBSEQUENT COMPLAINTS, EXAMINATIONS, AND DIAGNOSES	Adminis-tered by (Initials)
2-13-43	whooping cough Cough by 35.64h	S.F.O
2-15-43	Aspirin 400 2 1/2 - 4 hr. 1 c.c Pertussis Vaccine given in Deltoid	S.F.O
11-18-43	Control.	S.F.
22	Pertussis Vaccine 1 c.c. given in deltoid muscle (20,000 u)	S.F.O
1-11-43	Pertussis vaccine 1 c.c.	S.F.
3-43	Discharged	S.F.O
May 8	Cold. Better House call	K
23	Discharged	K
6-7-43	Pertussis 1 c.c.	mtc
June 15	measles vac	K
6-24-43	measles neg.	K
7-17-43	discharged	H.A.
8-10-43	measles vac.	K
8-11-43	feces examination: normal cal	PS
Aug 20	caecum lotion	K
8-20-43	measles vac. neg.	K
8-25-43	Diphtheria / Tetanus Ig.	K
9-7-43	discharged	H.A.
10-25-43	Diphtheria / Tetanus Ig.	K
11-27-43	discharged	HA
2-4-44	measles vac	K
Feb. 7	" " neg.	K.
	Repatriated 2/11/44	

If injury, state period of disability in final note:

Able to do light work as _____ on _____

Able to return to usual occupation _____ on _____