



# THE BLACK VAULT

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- (a) The widow who is either totally or dependent for support upon the deceased employee at the time of his death.
- (b) The child or children of the deceased employee who are dependent upon him at the time of his death.
- (c) The unmarried child under 18, and those over 18 who are incapable of self-support.
- (d) Parents partially or totally dependent upon the deceased employee for support.
- (e) Unmarried brothers, sisters, or grand-children under 18 years of age, and those over 18 who are incapable of self-support, and who were wholly or partially dependent upon the deceased employee.
- (f) Grandparents wholly or partially dependent upon the deceased employee.

Under the law, the term "child" includes stepchildren, adopted children, and posthumous children, but does not include married children. The terms "brother" and "sister" include stepbrothers and stepsisters, half brothers and half sisters, and others and sisters by adoption, but do not include married brothers or sisters. All of the above terms and the term "grandchild" include only persons who at the time of the death of the deceased employee are under 18 years of age or over that age and incapable of self-support. The term "parent" includes step-parents and parents by adoption. The term "widow" includes by the decedent's wife living with or dependent for support upon him at the time of his death. The term "widower" includes by the decedent's husband dependent for support upon her at the time of her death. The terms "adopted" and "adoption" used in this law include only legal adoption prior to the time of the injury.

The claim should be signed by the person making the claim or his duly authorized representative. There should be given names and addresses of all persons who may be entitled to compensation on account of death, together with the address of person making the claim, which should be sworn to by the person entitled to compensation, or by the person authorized to act on his behalf.

Oaths of claimants residing in foreign countries should be made before a United States consular officer or secretary of legation or before a local official, a certificate of such United States consular official or secretary of legation showing the authority of local official to administer oaths should be annexed.

A certified copy of the death certificate should accompany this claim. If, for any reason, it cannot be secured, give full explanation at the bottom of this sheet.

If the relationship to the decedent of any person entitled to claim compensation is that of adoption, a certified copy of the order of adoption should accompany this claim.

Itemized bill in duplicate covering the medical and burial expenses should be submitted with the claim.

Full name of deceased employee Frank Rudolph Olson  
 Age 43 3. Sex M 4. Occupation Supervisory Picochemist  
 Was deceased able to speak English? Yes 6. If not, what language? \_\_\_\_\_  
 Time of injury: (a) November; (b) 23 (c) 1953 (d) 2:30 a.m.  
 Place where injury occurred Hotel Statler, New York City, New York  
 Nature and extent of injury Multiple fractures, shock, and hemorrhage resulting in death.

Date of death 28 November 1953  
 Place where death occurred Statler Hotel, New York City, New York

Rate of pay of deceased employee at time of injury which resulted in death, \$ 2200.00 per annum and subsistence valued at \$ \_\_\_\_\_ per \_\_\_\_\_

Relationship to the deceased of the person claiming to be entitled to compensation Wife  
 Did deceased leave any other relatives entitled to compensation? No If so, give names, addresses, ages, and relationship below.

(See instructions at top of form for names of persons entitled to compensation)

Name	Address	Age	Relationship
<u>Eric Wicks Olson</u>	<u>R.F.D.#5, Frederick, Md.</u>	<u>9</u>	<u>Son</u>
<u>Lisa Wicks Olson</u>	<u>R.F.D.#5, Frederick, Md.</u>	<u>7</u>	<u>Daughter</u>
<u>Hils Wicks Olson</u>	<u>R.F.D.#5, Frederick, Md.</u>	<u>5</u>	<u>Son</u>
_____	_____	_____	_____
_____	_____	_____	_____

SWORN BY CERTIFY that each and every statement set forth above is true to the best of my knowledge and belief.

Name: Alice Wicks Olson  
 Address: R.F.D. 75  
Frederick Maryland

1. CLAIMANT'S CERTIFICATE

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Name of deceased employee \_\_\_\_\_

Address of employee immediately prior to death \_\_\_\_\_

Date of employee's death \_\_\_\_\_, 19 \_\_\_\_\_

Direct cause of death \_\_\_\_\_

Contributory cause of death \_\_\_\_\_

History of injury given in this case? \_\_\_\_\_ If so, state it briefly \_\_\_\_\_

In your opinion, was the death of the employee due to such injury? \_\_\_\_\_

Remarks: \_\_\_\_\_

I HEREBY CERTIFY that the answers to the above questions are true to the best of my knowledge and belief.

\_\_\_\_\_  
(Signature of certifying physician)

Address: \_\_\_\_\_  
(Street and number)

\_\_\_\_\_  
(City) (State)

This certificate, \_\_\_\_\_, 19 \_\_\_\_\_

It is important that above certificate be furnished, but if for any cause it cannot be secured, give full explanation below and submit such other proof of death as may be obtainable.

CERTIFICATE OF OFFICIAL SUPERIOR

If report of death on Form No. C.A. 3 has not been forwarded to the Bureau, such report should be made and accompany this claim for compensation.

I HEREBY CERTIFY that the person on account of whose death the foregoing claim is made was employed by the United States Government when injured and official report of death was made on \_\_\_\_\_

28 November 1955

(Date)

When circumstances have arisen which after the certificate stated in the official report of death, or if the certifying physician disagrees with any of the statements made on the certificate or on this report, it is recommended that a full explanatory report be made as follows:

Remarks: \_\_\_\_\_

1. Department NY 2. Bureau or office Clinical Service  
(City, State, etc.) (Department, Section, etc.)

3. Place of employment Casey's Residence Home  
(Name, No., St., City, etc.) (City, State, etc.) (City, State, etc.)

4. Full name of injured employee .....

5. Time of injury ..... 19.....  
(Date.) (Day of week.) (Hour, a. m. or p. m.)

6. Time employee stopped work ..... 19.....  
(Date.) (Day of week.) (Hour, a. m. or p. m.)

7. Time employee's pay stopped ..... 19.....  
(Date.) (Day of week.) (Hour, a. m. or p. m.)

8. First day employee was able to resume work ..... 19.....  
(Date.) (Day of week.) (Hour, a. m. or p. m.)

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9. Did employee return to the same work and at same rate of pay after termination of disability? .....

If so, when? ..... If not, state character of work performed upon return to duty and rate paid employee for such work .....

10. Actual time disabled (including Sundays and holidays) ..... days.

11. Number of days for which employee would have received pay had he not been disabled ..... days.

12. If employee was receiving subsistence as part of his wages, was such subsistence furnished during entire period of disability? ..... If not, give dates on which subsistence was not furnished .....

13. Has employee been paid for any portion of above absence on account of—

(a) Annual leave? .....  
(Give exact dates.)

(b) Sick leave? .....  
(Give exact dates.)

(c) Any other reason .....

14. Nature of injury .....

15. Remarks .....

[The following information is to be furnished only in case of death resulting from an injury sustained while in the performance of duty. If death results immediately, or if no report of injury has previously been submitted, such report, on Form C. A. 2, should be forwarded herewith.]

### REPORT OF DEATH

1. Full name of deceased employee Frank R. Olson

2. Time of death 23 November, 1953 .....  
(Date.) (Day of week.) (Hour, a. m. or p. m.)

3. Time employee's pay stopped 24 November, 1953 .....  
(Date.) (Day of week.) (Hour, a. m. or p. m.)

4. Place of death Statler Hotel New York City, New York  
(Name of hospital, establishment, etc.) (City or town, and State.)

5. Immediate cause of death Multiple fractures, shock, and hemorrhage resulting from fall from tenth floor of hotel

6. Widow of deceased employee Alice U. Olson R. F. Dyer Frederick Maryland  
(Give full name.) (Name.) (City, State.)

7. Children of deceased employee under 18 years of age, or those over 18 who are incapable of self-support:

Name	Age
<u>Erica Marie Olson</u>	<u>8</u>
<u>Erica Marie Olson</u>	<u>7</u>
<u>Hills Marie Olson</u>	<u>5</u>

8. Names, relationship, and addresses of all other persons known to be dependent, in any degree, upon decedent at time of death:

Name	Relationship	Address
<u>None</u>		

File of employee

The injured employee

be injury

1. Department Police 2. District Central

3. Place of employment Washington, D.C.

4. Reporting date 23 November 1955

5. Name of supervisor or foreman in charge when injury occurred Col. V. L. Street

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6. Name of injured employee Frank Rudolph Olson 7. Age 35 8. Sex M 9. Race W

10. Home address R.F.D. 25 Frederick Maryland

11. Occupation and division Supervisor, 50 Maintenance Was employee doing his regular work? Yes If not, what work?

13. Total length of service with the Government as a civilian? 8 1/2 years

14. How long at present work in this establishment? 8 1/2 years

15. Dates of other injuries 19 November 1953 is date of injury causing death on 23 Nov. 55

16. Rate of pay on date of injury, \$ 9300.00 per annum { and subsistence valued at \$ \_\_\_\_\_ per \_\_\_\_\_ and quarters valued at \$ \_\_\_\_\_ per \_\_\_\_\_

17. Employee begins work at 7:45 a.m. m. 18. Regular day work ends 4:30 p.m. m.

19. Hours worked per day 8 20. Days paid per week 5

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21. Place where injury occurred (death) Statler Hotel, New York City, N. Y.

22. Date of injury (death) 23 November 1955; day of week Saturday; hour of day 2:30 a.m.

23. Date employee stopped work 27 November 1955; day of week Friday; hour of day 4:00 p.m.

24. Date employee's pay stopped 27 November 1955; day of week Friday; hour of day 4:30 p.m.

25. Has employee returned to work? No

26. Will employee receive pay for any portion of above absence on account of:

(a) Annual leave No

(b) Sick leave No

(c) Any other reason No

27. Describe in full how injury occurred Jump or fall from tenth floor of hotel

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28. State part of body injured and nature and extent of injury Multiple fractures, shock, and hemorrhage resulting in death

29. Did injury cause loss of any member or part of member? No If so, describe exactly

30. Was employee injured while in performance of duty? Yes If not, give detailed statement Death resulted from circumstances arising out of his official duties

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31. Was injury caused by:

(a) Willful misconduct of the employee? No (b) Intentional employee to bring about injury or death of himself or another? No Full information recorded in appropriate official files.

(c) Employee's intoxication? No

(If any answers to these questions are affirmative, the report must contain a detailed statement giving the reason for the conclusion.)

32. Was written notice of injury given within 48 hours? Yes If not, did immediate superior have actual knowledge of injury? Yes (Answer to question 3, Form C. A. 1, must be made if notice was not given within 48 hours)

33. Names and addresses of witnesses to injury Dr. Robert W. Johnson  
1855 New Hampshire N.W.  
Washington, D.C.

34. Was injury caused by a third party other than a Government employee or agency? No If so, has employee been instructed in procedure under the Bureau's regulations?

17 1955

NOTICE — Read carefully instructions on the back before executing this affidavit.

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Frederick, Maryland  
(State or Territory where executed)

ss:

I, Alice Smith Wicks Olson, being duly sworn, on oath say that I am resident of RFD #5, city of Frederick, county of Frederick, State of Maryland; that on the 28th day of November, 1951

Husband Frank Rudolph Olson had personal domicile in and was a resident of Frederick, county of Frederick, and State of Maryland.

on said day died intestate; that burial expenses amounting to Six-hundred and ninety-three dollars and fifty cents (\$693.50) were incurred, as per original itemized bills herewith; that the amount of None dollars (\$          ) has been paid on such burial expenses

from funds belonging to            that there is a balance of Six-hundred and ninety-three dollars and fifty cents (\$693.50) being unpaid.

(Here the affiant must state specific facts as indicated by instructions on back of this form.)

Surviving dependents are:

Widow — Alice Smith Wicks Olson

Son — Eric Wicks Olson

Son — Wils Wicks Olson

Daughters — Lisa Wicks Olson

ed served in the military or naval forces of the United States as follows: ASN O-309341  
March 20, 1942 - April 13, 1944, inclusive. Chemical Warfare Service  
(If none, so state; otherwise give organization, period of service, and Army serial number, if known)

Will Not be made to the Veterans' Administration for burial expenses; that at the time of            (Will or will not)  
case compensation was due said decedent from the Bureau of Employees' Compensation, and            (Was or was not)  
there has been no administration, and if any amounts payable under the Employees' Compensation Act be paid,             
administration will be required.

Alice Smith Wicks Olson  
(Signature must be in ink or indelible pencil. A signature by proxy must be witnessed by two persons.)  
Alice Smith Wicks Olson

ORN to by said            before me, and subscribed in my presence on this day, at my office in said city. And I certify that said affiant is personally well known to me to be the