

11-16-1972

William P. Averill, 16 November 1972

William P. Averill

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1102 Arthur Circle
Tupelo, Miss, 38801
16 November, 1972

Dear Tish,

It was certainly nice hearing from you and am sorry if there are still some unanswered questions floating around. If I can be of any help just drop me a line. I want to be of assistance but best of all it does my ego a bit of good to be able asked to help.

As to your immediate problem concerning the identity of the man with the General, I am firmly of the opinion that it is Eddie Bloomer for the following reasons:

(1) The General is wearing the uniform of World War II and before, the "Pink and Green". Therefore the picture must have been taken either during or shortly after the war.

(2) Bloomer was the State Director during the war and and was reappointed when the System was recreated in 1948. He did not serve too long as he died in the early 50s.

(3) I do not remember when the "Pinks and Greens" went out but I am quite sure it was before General Fraser came on the scene.

(4) As I remember General Fraser was a man some smaller than the General. The man in the picture is just about the same height as the General, even with his hat on.

(5) General Fraser was rarely seen out of uniform.

(6) If my memory serves me correctly, General Fraser wore a white mustache on his upper lip.

(7) General Fraser did not come to Selective Service until after King Tut retired and that was considerably after we changed into the new uniform.

Tish, for the above reasons I vote that the man in your picture is the late Eddie Bloomer.

We are fast getting settled although it will be some time before we can really say that we are finally through. I signed a contract this morning to add two rooms (over-all 12x20 ft.), a breakfast room for Helen and a workshop for me. It has been a novel experience moving into a new House. I had no idea that there could be so many little things which had to be done or adjusted.

Please give our very best regards to General and Mrs Hershey. Also remember us to Mrs Clatterbuck, Hope Tom is doing O.K.

We send our best to the Dennys individually and collectively.

THE WHITE HOUSE

WASHINGTON

13 November 1972

Dear Colonel Averill:

I certainly am sorry I let you get away from this area before I asked all the questions there are around here.

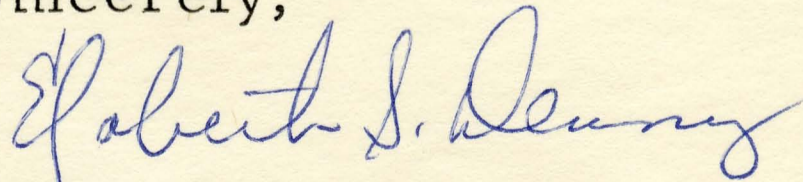
The enclosed picture is a puzzler. It was in the file with a notation on the back "LTC E. N. Bloomer, State Director, New Jersey." John Barber took a look at it and said "That is Frank Fraser of Arizona." For once, the General is of no help - he says it could be either one.

Can you cast a vote? We will ^{let} you be the deciding factor, since I never knew either man I cannot help either.

Thank you, and enclosed is your pin. Do hope things are all settled in Tupelo. Give our best to your girls, and the grandson.

The General heard a rumor that Mrs. Omer had another stroke about a week ago. He was one up on me on that one - I never heard that she had the first one.

Sincerely,



Elizabeth S. Denny
LCDR, USNR

Colonel William P. Averill
1102 Arthur Circle
Tupelo, Mississippi 38801

CLINICAL RECORD

NARRATIVE SUMMARY

DATE OF ADMISSION
April 1969

DATE OF DISCHARGE

NUMBER OF DAYS HOSPITALIZED

(SIGN AND DATE AT END OF NARRATIVE)

MILITARY HISTORY: The patient is an active duty COL with 29 years' active service.

SOCIAL AND FAMILY HISTORY: The patient smoked 2½ packages of cigarettes per day for 44 years and has not smoked since 15 October 1968. He drinks 2-3 highballs per day. At the time of admission, he was taking no medications. The patient's mother is 85 years of age, living and well. His father died at 59 years of age of arteriosclerotic heart disease. A sister died at 60 years of age of carcinoma of the lung. There is no family history of diabetes mellitus.

PAST MEDICAL HISTORY: In 1960, the patient had a herniated nucleus pulposus which was successfully treated conservatively. In 1962, he was hospitalized for one week with a fever of unknown origin, and no definite diagnosis was made. In 1957, he had a hemorrhoidectomy. A "shadow" was noted in the patient's right lung during the hospitalization in 1962. This has been followed since that time without any change noted.

REVIEW OF SYSTEMS: Noncontributory, with exception of a life-long history of intermittent night sweats.

CHIEF COMPLAINT: This 58-year-old Caucasian male, active duty COL, was admitted via the Medical Outpatient Clinic with apparent diabetes mellitus.

HISTORY OF PRESENT ILLNESS: Four months prior to admission, the patient developed fatigue, thirst, polyphagia, polyuria and nocturia. He was seen in the Medical Outpatient Clinic, where fasting blood sugar was found to be 560 mg. per cent. Urine was 4 plus positive for glucose with moderate acetone. A glucose tolerance test was subsequently performed and was grossly abnormal. In the four months prior to admission, the patient had lost 25 pounds. Slight blurring of vision had developed over the same period. There were no neurologic symptoms and the patient was unaware of a family history of diabetes.

PHYSICAL EXAMINATION: Temperature, 98.6; pulse, 110 and regular; blood pressure, 150/70. In general, the patient presented as a well developed, drawn, 58-year-old Caucasian male, who appeared older than his stated age, in no acute distress. HEENT examination revealed moderate arteriolar narrowing of the fundi. The posterior pharynx was erythematous. Tympanic membranes were clear. There was no significant adenopathy. The lungs were clear to percussion and auscultation. The heart examination demonstrated sinus tachycardia; the first and second heart sounds were physiologic. There were no significant murmurs, cardiomegaly, third or fourth heart sounds. The abdomen was soft. The liver was 12 cm. in the

(USE ADDITIONAL SHEETS OF THIS FORM (STANDARD FORM 502) IF MORE SPACE IS REQUIRED)

SIGNATURE OF PHYSICIAN EUGENE P. FLANNERY MAJ MC	DATE	IDENTIFICATION NO. 0 368 748	ORGANIZATION
PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)		REGISTER NO. 8863 023	WARD NO.

AVERILL, William P. COL
ch

WALTER REED GENERAL HOSPITAL

NARRATIVE SUMMARY
Standard Form 502

CLINICAL RECORD

NARRATIVE SUMMARY

DATE OF ADMISSION

7 April 1969

DATE OF DISCHARGE

NUMBER OF DAYS HOSPITALIZED

(SIGN AND DATE AT END OF NARRATIVE)

right rectus line by percussion with a slightly tender edge palpable four finger-breadths below the right costal margin. Bowel sounds were normoactive. The remainder of the physical examination was entirely within normal limits.

LABORATORY AND X-RAY DATA: Please refer to the attached Consolidated Laboratory Report Sheets. Chest x-ray revealed a right hilar prominence which was unchanged on x-rays dating back to 1965.

HOSPITAL COURSE: At the time of admission, the patient exhibited marked fatigue and blood sugars were in the range of 500 mg. per cent. Urines were 4-plus positive for sugar and strongly positive for acetone. Initial diabetic control was obtained with regular insulin, the dosages regulated by fractional urine examinations for sugar and acetone. After satisfactory control had been obtained in this manner, the patient was placed on tolbutamide, 500 mg. three times a day. On this regimen and with full activity, his diabetes was adequately controlled, two-hour postprandial blood sugars being in the range of 110 to 130 mg. per cent. Symptomatically, the patient noted marked improvement as his diabetes came under control and on 15 April 1969, he was begun on a convalescent leave. In May 1969 while on convalescent leave, he had the sudden onset of pain in the back and left buttock. This improved with several days of bed rest, followed by limited activity. However, it has recurred on several subsequent occasions and recent x-rays demonstrated degenerative changes of the lumbosacral spine, hips, cervical and dorsal spines.

CONSULTATIONS: A Pulmonary consultation was obtained for evaluation of the right hilar prominence described above. Further Pulmonary Clinic follow-up is scheduled. An Ophthalmology consultation was obtained for a refraction due to the marked change in the patient's refractive error with control of his diabetes mellitus.

PRESENT CONDITION: The patient's diabetes is well controlled with diet and 500 mg. of tolbutamide three times a day. The above described degenerative joint disease intermittently is responsible for moderately severe back pain. His chronic cough is productive of white phlegm, and he is dyspneic with rapid walking on level ground or climbing one flight of stairs.

DIAGNOSES:

1. Diabetes mellitus, adult onset type, without evidence of target organ involvement, well controlled on diet and hypoglycemic drugs. LOD: Yes.
2. Herniated nucleus pulposus, intermittently symptomatic. LOD: Yes.
3. Bronchopulmonary disease, chronic, obstructive, moderate with emphysema. LOD: Yes.
4. Osteoarthritis involving the hips, cervical spine, dorsal spine and lumbosacral spine. LOD: Yes.

SIGNATURE OF PHYSICIAN

EUGENE P. FLANNERY MAJ MC

DATE

IDENTIFICATION NO.

0 368 748

ORGANIZATION

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)

REGISTER NO.

8863 023

WARD NO.

WVERILL, William P. COL

-2-

WALTER REED GENERAL HOSPITAL

NARRATIVE SUMMARY
Standard Form 502

CLINICAL RECORD

NARRATIVE SUMMARY

DATE OF ADMISSION

DATE OF DISCHARGE

NUMBER OF DAYS HOSPITALIZED

7 April 1969

(SIGN AND DATE AT END OF NARRATIVE)

RECOMMENDATIONS: It is the opinion of the Medical Board that this patient is unfit for further military service under the provisions of paragraphs 3-11d, 3-14a(3), and 3-25(d), AR 40-501. It is therefore recommended that he be referred to a Physical Evaluation Board for consideration of separation from the service.

(USE ADDITIONAL SHEETS OF THIS FORM (STANDARD FORM 502) IF MORE SPACE IS REQUIRED)

SIGNATURE OF PHYSICIAN

DATE

IDENTIFICATION NO.

ORGANIZATION

EUGENE P. FLANNERY MAJ MC

D 368 748

PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)

REGISTER NO.

WARD NO.

8863 023

AVERILL, William P. COL

-3-

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WALTER REED GENERAL HOSPITAL

NARRATIVE SUMMARY
Standard Form 502

DATE	4-1	4-11							
Color-Appearance	S-C	-							
Reaction	5	5							
Specific Gravity	1.032	1.037							
Albumin	Med	TRACE							
Sugar	4+	4+							
Acetone	POS MOD	POS LARGE							
Bile									
casts, Hyal.									
casts, Gran.									
casts, Leuko.									
casts, RBC's									
WBC's									
RBC's									
Epithelial Cells									
Bacteria									
Morphous sed.									
Ureter									

FLOCCULATION (SEROLOGY)

DATE	CARDIOLIPIN SLIDE FLOCCULATION	CARDIOLIPIN COMPLEMENT FIXATION	TREPOMENA (TPI) PALLIDUM IMMOBILIZATION
5-69	N.R.		
1-15-69	N.R.		

OTHER LABORATORY REPORTS

DATE	TEST
8	SERUM Protein P. Elec = Albumin 53.5, α_1 3.5, α_2 10.5, β 14.0, γ 18.4 T.P. 9.7
8	Glucose Tolerance Fast 142 30 min, 60 min, 120 min, 180 min 4+
15	Urea Part F. P. Alb 54.5, α_1 4.3, α_2 11.4, β 11.6, γ 11.2 TP 7.3
8	serum Triglyceride = 33.75 mg/100 ml
15-69	Triglycerides = 4.35 mg/100 ml

NAME
ERILL, William P.

BLOOD CHEMISTRY

DATE	4-11	4-10	4-13	4-14	4-15	4-16	4-23
CO ₂ Combining Power - mEq/l	26.5						
Chlorides - mEq/l	94						
Sodium - mEq/l	136						
Potassium - mEq/l	4.5						
Calcium - mEq/l							
Phosphorus - mg.%							
Uric Acid - mg.%							
Amylase - units							
Urea Nitrogen (BUN) - mg.%	14	237	137	137			
Glucose - mg.%		330	125	141	126	157	111
Cholesterol - mg.%	560						
Esters - mg.%							
Bilirubin (total) - mg.%	0.4						
Bilirubin (direct) - mg.%							
BSP - % in 45 min.							
Thymol Turbidity - units							
Ceph. Floc. - 24 hrs. - 1-4+							
Ceph. Floc. - 48 hrs. - 1-4+							
Protein Total - gm.%							
Albumin - gm.%							
Alkaline Phosphatase (KAU)	120						
Acid Phosphatase - SJR units							
Transaminase (SCOT)	71						
Lactic Dehydrogenase (LDH)							
	500						
	1.0						

URINE CHEMISTRY

DATE							
CO ₂ Combining power - mEq/l							
Chlorides - mEq/l							
Sodium - mEq/l							
Potassium - mEq/l							
Calcium - mEq/l							
Phosphorus - mg.%							
Uric Acid - mg.%							
Amylase - units							
Creatinine - mg.%							
Urea - mg.%							
Volume - cc.							

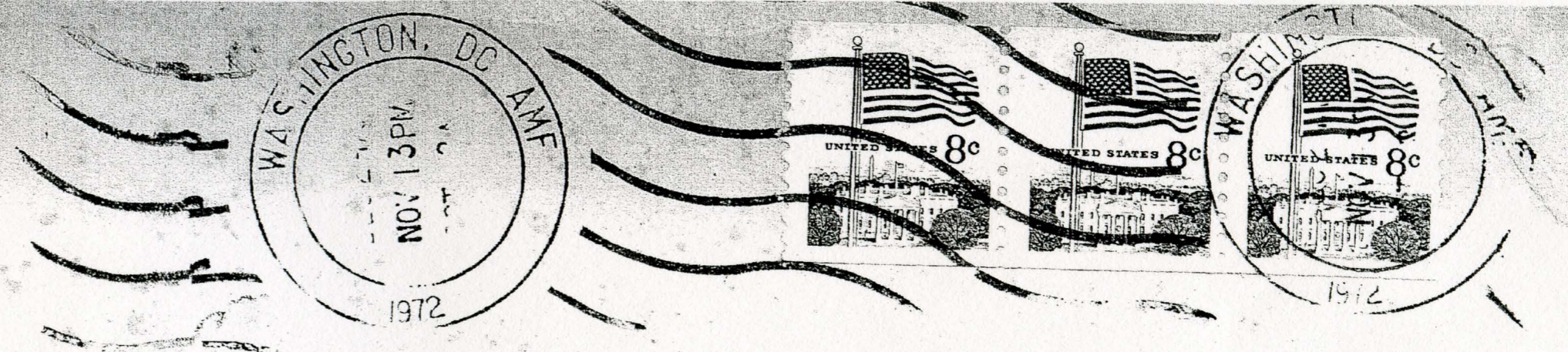
PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)

AVERILL, William P.

DATE: From _____ To _____

THE WHITE HOUSE

Office of General Lewis B. Hershey, USA
Advisor to the President
N. E. O. B. Suite 8230
Washington, D. C. 20500



Air Mail

Colonel William P. Averill
1102 Arthur Circle
Tupelo, Mississippi 38801