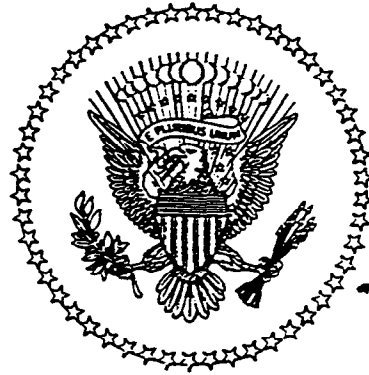


REPORT OF
THE PRESIDENT'S COMMISSION ON THE
ASSASSINATION OF
President John F. Kennedy

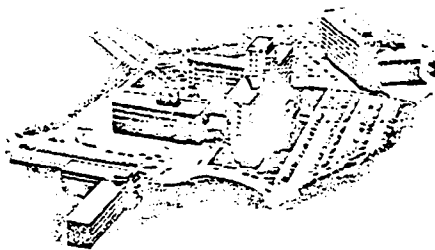


UNITED STATES
GOVERNMENT PRINTING OFFICE
WASHINGTON, D.C.

001041

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
CHILDREN'S 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 stat alarm that this distinguished patient was being brought to the emergency room at Parkland Memorial Hospital, I dispatched Doctors A. E. Giesecke and Jackie 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 Carrico 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 Hunt and Giesecke connected a cardioscope to determine cardiac activity.

During the progress of these activities, the emergency room cart was elevated at the feet 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.

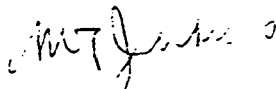
COMMISSION EXHIBIT No. 392—Continued

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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 herniation and laceration of great areas of the brain, even to the extent that the cerebellum had protruded from the wound. There were also fragmented pieces 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. T. Jenkins, M.D.

COMMISSION EXHIBIT No. 392—Continued

001043

INVESTIGATION OF
THE ASSASSINATION OF PRESIDENT JOHN F. KENNEDY

HEARINGS

Before the President's Commission
on the Assassination
of President Kennedy

PURSUANT TO EXECUTIVE ORDER 11130, an Executive order creating a Commission to ascertain, evaluate, and report upon the facts relating to the assassination of the late President John F. Kennedy and the subsequent violent death of the man charged with the assassination and S.J. RES. 137, 88TH CONGRESS, a concurrent resolution conferring upon the Commission the power to administer oaths and affirmations, examine witnesses, receive evidence, and issue subpoenas

Volume

VI

UNITED STATES GOVERNMENT PRINTING OFFICE

WASHINGTON, D.C.

001044

Dr. BAXTER. No.

Mr. SPECTER. Thank you very much for coming, Dr. Baxter.

Dr. BAXTER. Thank you.

Marion T. Jenkins
M. T. Jenkins

TESTIMONY OF DR. MARION THOMAS JENKINS

The testimony of Dr. Marion Thomas Jenkins was taken at 5:30 p.m., on March 25, 1964, at Parkland Memorial Hospital, Dallas, Tex., by Mr. Arlen Specter, assistant counsel of the President's Commission.

Mr. SPECTER. May the record show that Dr. M. T. Jenkins has appeared in response to a letter request in connection with the inquiry of the President's Commission on the Assassination of President Kennedy, to testify concerning his observations and medical treatment performed by him on President Kennedy, and with this preliminary statement of purpose, would you stand up, please, Dr. Jenkins, and raise your right hand.

Do you solemnly swear the testimony you give before the President's Commission in this deposition proceeding, will be the truth, the whole truth, and nothing but the truth, so help you God?

Dr. JENKINS. I do.

Mr. SPECTER. Would you state your full name for the record, please?

Dr. JENKINS. Marion Thomas Jenkins.

Mr. SPECTER. What is your profession, please?

Dr. JENKINS. I'm a physician.

Mr. SPECTER. Are you licensed by the State of Texas to practice medicine?

Dr. JENKINS. Yes.

Mr. SPECTER. And what is your specialty, Dr. Jenkins?

Dr. JENKINS. Anesthesiology.

Mr. SPECTER. Will you outline your educational background for me, please?

Dr. JENKINS. I am a graduate of the University of Texas in 1937. I have a B.A. degree and an M.D. degree from the University of Texas Medical Branch at Galveston in 1940, rotating internship at the University of Kansas Hospital, Kansas City, Kans., 1940-41; Assistant Residency in Internal Medicine, John Sealy Hospital in Galveston, Tex., 1941-42; active duty in the U.S. Navy as a Medical Officer, 1942 to 1946; Resident in Surgery—Parkland Hospital, Dallas, 1946-47; Resident in anesthesiology in the Massachusetts General Hospital, Boston, 1947-48; and Director of the Department of Anesthesiology, Parkland Hospital and Parkland Memorial Hospital, 1948 to the present; Professor and Chairman of the Department of Anesthesiology, University of Texas, Southwestern Medical School—since 1951. Diplomate—other certification, do you want this?

Mr. SPECTER. Yes, what Boards are you certified?

Dr. JENKINS. I am a Diplomate of the American Board of Anesthesiology and also fellow of the American College of Anesthesiologists.

Mr. SPECTER. And what year were you certified by the American Board?

Dr. JENKINS. 1952.

Mr. SPECTER. Did you have occasion to assist in the treatment of President Kennedy on November 22, 1963?

Dr. JENKINS. Yes.

Mr. SPECTER. And will you relate briefly the circumstances surrounding your being called into that case?

Dr. JENKINS. Well, I was in the dining room with other members of the hospital staff when we heard the Chief of Surgery, Dr. Tom Shires, being paged "Stat." This is a rather unusual call, for the Chief of any service to be called "Stat" as this is the emergency call.

Mr. SPECTER. What does that mean, "Stat"?

Dr. JENKINS. "Stat" means emergency, that's just a code word that has been used for years in medical terms. He was paged twice this way, and one of the

surgical residents, Dr. Ronald Jones, answered the phone, thinking something bad must be up and that he would call the Chief of Surgery. I was sitting near the telephone and Dr. Jones immediately came back by with a very anguished look and the color was drained from his face—I'm sure I had that impression, and he said, "The President has been shot and is on his way to the hospital." At the same time we heard the sirens of the ambulance as they turned into the driveway from Harry Hines into the hospital drive, and it was obvious that this was the car coming in because the ambulance sirens usually stop in the street, but these came on clear to the building.

Mr. SPECTER. That's Harry Hines Boulevard right in front of the hospital?

Dr. JENKINS. Yes; I ran up the stairs to the Anesthesia Department, that's on the second floor—one floor above the dining room, where I was, and notified two members of the Department, the first two I saw, my Chief Associate, Dr. A. H. Giesecke, Jr., and Dr. Jackie Hunt, that the President had been shot and was being brought to the emergency room and for them to bring all the resuscitative equipment we have including an anesthesia machine. The emergency room is set up well, but we are used to working with our own equipment and I asked them to bring it down and I ran down the back stairs, two flights down, and I arrived in the emergency room just after or right behind him being wheeled in, I guess.

Mr. SPECTER. At about what time did you arrive at the emergency room?

Dr. JENKINS. Oh, this was around 12:30-12:35 to 12:40. I shouldn't be indefinite about this—in our own specialty practice, we watch the clock closely, and there are many things we have to keep up with, but I didn't get that time exactly, I'll admit.

Mr. SPECTER. Who was present at the time of your arrival in the emergency room, if anyone?

Dr. JENKINS. The hallway was loaded with people.

Mr. SPECTER. What medical personnel were in attendance?

Dr. JENKINS. Including Mrs. Kennedy, I recognized, and Secret Service men, I didn't know whether to block the way or get out of it, as it turned out. Dr. James Carrico and Dr. Dulany—Dick Dulany, I guess you have his name, and several nurses were in the room.

Mr. SPECTER. Could you identify the nurses?

Dr. JENKINS. Well, not really. I could identify them only having later looked around and identified from my own record that I have, the names of all who were there later. Now, whether they are the same ones when I first went there, I don't know. I have all the names in my report, it seemed to me.

Mr. SPECTER. Could you now identify all of the nurses from your later observations of them? *Partially*

Dr. JENKINS. Well, I can identify who was in there at the close of the procedure, that is, the doctors, as well as those who were helping. *Partially*

Mr. SPECTER. Fine, would you do that for us, please?

Dr. JENKINS. These included a Mrs. or Miss Patricia Hutton and Miss Diana Bowron, B-o-w-r-o-n (spelling), and a Miss Hencliffe—I don't know her first name, but I do know it is Hencliffe.

Mr. SPECTER. Margaret?

Dr. JENKINS. Margaret—certainly. Those three—there were probably some student nurses too, whom I didn't recognize. Shall I continue?

Mr. SPECTER. Yes, please. Have you now covered all the people you recollect as being in the room?

Dr. JENKINS. Well, as I came into the room, I saw only the—actually—you know, in the haste of the coming of the President, two doctors whom I recognized, and there were other people and I have identified all I remember.

Mr. SPECTER. What did you observe as to the President's condition when you arrived in the emergency room?

Dr. JENKINS. Well, I was aware of what he was in an agonal state. This is not a too unfamiliar state that we see in the Service, as much trauma as we see, that is, he had the agonal respiratory gasp made up of jerking movements of the mylohyoid group of muscles. These are referred to sometimes as chin jerk, tracheal tug or agonal muscles of respiration. He had this

characteristic of respiration. His eyes were opened and somewhat exophthalmic and color was greatly suffused, cyanotic—a purplish cyanosis.

Still, we have patients in the state, as far as cyanosis and agonal type respiration, who are resuscitatable. Of course, you don't stop at this time and think, "Well, this is a hopeless circumstance,"—because one in this state can often be resuscitated—this represents the activities prior to one's demise sometimes, and if it can be stopped, such as the patient is oxygenated again and circulation reinstated, he can be saved.

Dr. Carrico had just introduced an endotracheal tube, I'm very proud of him for this because it's not as easy as it sounds. At times and under the circumstances—it was harder—he had just completed a 3-month rotation on the anesthesiology service, and I thought this represented good background training for a smart individual, and he told me he had a cuff on the endotracheal tube and he introduced it below the wound.

The reason I said this, of course, this is a reflex—there is a tube, the endotracheal tube, if it is pushed down a little too far it can go into the right main stem of the bronchus impairing respiration from both lungs, or both chests.

There was in the room an intermittent positive pressure breathing apparatus, which can be used to respire for a patient. As I connected this up, however, Dr. Carrico and I connected it up to give oxygen by artificial respiration, Dr. Giesecke and Dr. Hunt arrived on the scene with the anesthesia machine and I connected it up instead with something I am more familiar with—not for anesthesia, I must insist on that—it was for the oxygenation, the ability to control ventilation with 100 percent oxygen.

As I came in there, other people came in also. This is my recollection. Now, by this time I was in familiar surroundings, despite the anguish of the circumstance.

Despite the unusual circumstance, in terms of the distinguished personage who was the patient, I think the people who had gathered or who had congregated were so accustomed to doing resuscitative procedures of this nature that they knew where to fit into the resuscitation team without having a preconceived or predirected plan, because, as obviously—some people were doing things not necessarily in their specialty, but there was the opening and there was the necessity for this being done.

There were three others who came in as I did who recognized at once the neck wound, in fact, where the wound was, would indicate that we would have serious pulmonary problems unless a tracheotomy tube was put in. This is one way of avoiding pushing air out through a fractured trachea and down into each chest cavity, which would cause a pneumothorax or a collapse of the lungs. These were doctors Malcolm Perry, Charley Baxter, and Robert McClelland, who with Dr. Carrico's help, I believe, started the tracheotomy.

About this time Drs. Kemp Clark and Paul Peters came in, and Dr. Peters because of the appearance of the right chest, the obvious physical characteristics of a pneumothorax, put in a closed chest drainage—chest tube. Because I felt no peripheral pulse and was not aware of any pulse, I reported this to Dr. Clark and he started closed chest cardiac massage.

There were other people—one which started an I.V. in a cutdown in the right leg and one a cutdown in the left arm. Two of my department connected up the cardioscope, in which we had electrical silence on the cardioscope as Dr. Clark started closed chest massage. That's the sequence of events as I reconstructed them that day and dictated them on my report, which you have here, I think.

Mr. SPECTER. Speaking of your report, Dr. Jenkins, permit me to show you a group of papers heretofore identified as Commission Exhibit No. 392 which has also been identified by Mr. Price, the hospital Administrator, as being photostatic copies of original reports in his possession and controlled as Custodian of Records, and I show you what purports to be a report from you to Mr. Price, dated November 22, 1963, and ask you if in fact this 2-page report was submitted by you to Mr. Price?

Dr. JENKINS. Yes; it was.

Mr. SPECTER. Now, going back to the wound which you observed in the neck, did you see that wound before the tracheotomy was performed?

Dr. JENKINS. Yes; I did, because I was just connecting up the endotracheal tube to the machine at the time and that's when Dr. Carrico said there was a wound in the neck and I looked at it.

Mr. SPECTER. Would you describe that wound as specifically as you can?

Dr. JENKINS. Well, I'm afraid my description of it would not be as accurate, of course, as that of the surgeons who were doing the tracheotomy, because my look was a quick look before connecting up the endotracheal tube to the apparatus to help in ventilation and respiration for the patient, and I was aware later in the day, as I should have put it in the report, that I thought this was a wound of exit because it was not a clean wound, and by "clean" clearly demarcated, round, punctate wound which is the usual wound of an entrance wound, made by a missile and at some speed. Of course, entrance wounds with a lobbing type missile, can make a jagged wound also, but I was of the impression and I recognized I had the impression it was an exit wound. However, my mental appreciation for a wound—for the wound in the neck, I believe, was sort of—was overshadowed by recognition of the wound in the scalp and skull plate.

Mr. SPECTER. Have you now described the wound in the neck as specifically as you can at this moment?

Dr. JENKINS. I believe so.

Mr. SPECTER. Now, will you now describe the wound which you observed in the head?

Dr. JENKINS. Almost by the time I was—had the time to pay more attention to the wound in the head, all of these other activities were under way. I was busy connecting up an apparatus to respire for the patient, exerting manual pressure on the breathing bag or anesthesia apparatus, trying to feel for a pulse in the neck, and then reaching up and feeling for one in the temporal area, seeing about connecting the cardioscope or directing its being connected, and then turned attention to the wound in the head.

Now, Dr. Clark had begun closed chest cardiac massage at this time and I was aware of the magnitude of the wound, because with each compression of the chest, there was a great rush of blood from the skull wound. Part of the brain was herniated; I really think part of the cerebellum, as I recognized it, was herniated from the wound; there was part of the brain tissue, broken fragments of the brain tissue on the drapes of the cart on which the President lay.

Mr. SPECTER. Did you observe any wounds immediately below the massive loss of skull which you have described?

Dr. JENKINS. On the right side?

Mr. SPECTER. Yes, sir.

Dr. JENKINS. No—I don't know whether this is right or not, but I thought there was a wound on the left temporal area, right in the hairline and right above the zygomatic process.

Mr. SPECTER. The autopsy report discloses no such development, Dr. Jenkins.

Dr. JENKINS. Well, I was feeling for—I was palpating here for a pulse to see whether the closed chest cardiac massage was effective or not and this probably was some blood that had come from the other point and so I thought there was a wound there also.

Mr. SPECTER. At approximately what time was President Kennedy pronounced dead?

Dr. JENKINS. Well, this was pronounced, we know the exact time as 1300, according to my watch, at least, at the time.

Mr. SPECTER. And what, in your opinion, was the cause of death?

Dr. JENKINS. Cerebral injury—brain injury.

Mr. SPECTER. Was President Kennedy ever turned over during the course of this treatment at Parkland?

Dr. JENKINS. No.

Mr. SPECTER. Why was he not turned over, Dr. Jenkins?

Dr. JENKINS. Oh, I think this was beyond our prerogative completely. I think as we pronounced the President dead, those in attendance who were there just sort of melted away, well, I guess "melted" is the wrong word, but we felt like we were intruders and left. I'm sure that this was considerably beyond our prerogative, and the facts were we knew he had a fatal wound, and I think my

own personal feeling was that this was—would have been meddlesome on anybody's part after death to have done any further search.

Mr. SPECTER. Was any examination of his back made before death, to your knowledge?

Dr. JENKINS. No, no; I'm sure there wasn't.

Mr. SPECTER. Did he remain on the stretcher cart at all times while he was being cared for?

Dr. JENKINS. Yes, sir.

Can I say something that isn't in the report here, or not?

Mr. SPECTER. Yes; let's go off the record a minute.

(Discussion off the record between Counsel Specter and the witness, Dr. Jenkins.)

Mr. SPECTER. May the record show that we are back on the record and Dr. Jenkins has made an interesting observation about the time of the declaration of death, and I will ask you, Dr. Jenkins, for you to repeat for the record what you have just said off the record.

Dr. JENKINS. As the resuscitative maneuvers were begun, such as "chest cardiac massage," there was with each compression of the sternum, a gush of blood from the skull wound, which indicated there was massive vascular damage in the skull and the brain, as well as brain tissue damage, and we recognized by this time that the patient was beyond the point of resuscitation, that he was in fact dead, and this was substantiated by getting a silent electrical pattern on the electrocardiogram, the cardioscope that was connected up.

However, for a period of minutes, but I can't now define exactly, since I didn't put this in a report, after we knew he was dead, we continued attempted resuscitative maneuvers.

When we saw the two priests who arrived in the corridor outside the emergency room where this was taking place, I went to the door and asked one of those—after turning over my ventilation, my respiration job to another one of my department—and asked him what is the proper time to declare one dead. That is, I am not a Catholic and I was not sure of the time for the last rites. As I remember now, he said, "The time that the soul leaves the body—is not at exactly the time that medical testimony might say that death was declared." There would be a period of time and so if we wished to declare him dead at that time they would still have the final rites.

Mr. SPECTER. Did they then have the final rites after the time he was declared dead medically?

Dr. JENKINS. Well, just a minute now—I suspect that was hazy to me that day—I'm not sure, it's still hazy. This was a very personal—on the part of the very anguished occasion, and Mrs. Kennedy had come back into the room and most of the people were beginning to leave because they felt like this was such a grief stricken and private affair that they should not be there. It was real intrusion even after they put forth such efforts at resuscitation and I'm not sure now whether the priests came in while I was still doing the resuscitative procedure, respiration at least, and while Dr. Clark was still doing the other. My memory is that we had stopped. I was still present, however, and that's the reason I'm not clear, because I hadn't left the room and I was still there as the rites were performed and a prayer was said.

Mr. SPECTER. Dr. Jenkins, would your observation of the wound and your characterization of it as an exit hole be consistent with a set of facts which I will ask you to assume for purposes of giving me your view or opinion.

Assume, first of all, if you will, that President Kennedy had a wound on the upper right posterior thorax just above the upper border of the scapula, measuring 14 cm. from the tip of the right acromion process and 14 cm. below the tip of the right mastoid process, and that the missile was a 6.5 mm. jacketed bullet fired from a weapon having a muzzle velocity of approximately 2,000 feet per second and approximately 160 to 250 feet from the President, and that after entering the President's body at the point indicated, the missile traveled between two strap muscles and through a fascia plane without violating the pleura cavity, and then struck the right side of the trachea and exited through

the throat, would the throat wound which you observed be consistent with such a wound inflicted in the manner I have just described?

Dr. JENKINS. As far as I know, it wouldn't be inconsistent with it, Mr. Specter.

Mr. SPECTER. What has your experience been with gunshot wounds, that is, to what extent have you had experience with such wounds?

Dr. JENKINS. Well, having been Chief of the Anesthesia Service here for this 16 years, we have a rather large trauma emergency service, and so I see gunshot wounds many times a week. I'm afraid I couldn't hazard a guess at the moment as to how many we see a year, and I'm afraid probably if I knew, I would not like to admit to this number, but I do go further in saying that my main interest is not in the tracks of the wounds. My main interest is what physiological changes that they have caused to the patient that I am to anesthetize or a member of the department is to anesthetize, what has happened to the cardiovascular system, respiratory, and neurological, and so I am aware of the wounds of entrance and exit only by a peripheral part of my knowledge and activities during the time.

Mr. SPECTER. Have you ever had any formal training in ballistics or in exit wounds or entrance wounds—bullet wounds?

Dr. JENKINS. No, I have not.

Mr. SPECTER. Have you talked to any representative of the Federal Government at any time prior to today?

Dr. JENKINS. Oh, there was a man whose name I don't remember now, who showed what looked like the proper credentials from the FBI, who came to ask only whether the report I had submitted to Mr. Price for the hospital record or for Mr. Price's record constituted all the reports I had. That's the only time, and that was the extent of our conversation, I think.

Mr. SPECTER. And is that the only written record you have of your participation in the treatment of the President?

Dr. JENKINS. Oh, I submitted one to the Dean of the Medical School, essentially the same, and a very little more. I don't think you have that. I don't know whether you want it or not.

Mr. SPECTER. Yes, I would like to see it.

Dr. JENKINS. It is essentially the same report—however—can I ask you something off of the record here?

Mr. SPECTER. Sure.

(Discussion between Counsel Specter and the witness, Dr. Jenkins, off the record.)

Mr. SPECTER. The record will show that we have been off the record on a couple of matters which I am going to now put on the record, but I will ask the court reporter to identify this as Dr. Jenkins' Exhibit No. 36.

(Instrument referred to marked by the Reporter as Dr. Jenkins' Exhibit No. 36, for identification.)

Mr. SPECTER. I will ask you, Dr. Jenkins, for the record to identify this as a report which you submitted to Dean Gill.

Dr. JENKINS. Yes, it is.

Mr. SPECTER. And is this in conjunction with the report you submitted to Mr. Price—do these reports constitute all the writings you have on your participation in the treatment of President Kennedy?

Dr. JENKINS. Yes; that's right.

Mr. SPECTER. One of the comments we were just discussing off the record—I would like to put on the record, Dr. Jenkins, is the question as to whether or not the wound in the neck would have been fatal in your opinion, absent the head wound. What would your view of that be?

Dr. JENKINS. Well, from my knowledge of the wound in the neck, this would not have been fatal, except for one thing, and that is—you have not told me whether the wound with its point of entrance and point of exit had contacted the vertebral column in its course?

Mr. SPECTER. It did not.

Dr. JENKINS. In that case I would not expect this wound to have been fatal.

Mr. SPECTER. What is your view, Dr. Jenkins, as to whether the wounds which you observed were caused by one or two bullets?

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Dr. JENKINS. I felt quite sure at the time that there must have been two bullets—two missiles.

Mr. SPECTER. And, Dr. Jenkins, what was your reason for that?

Dr. JENKINS. Because the wound with the exploded area of the scalp, as I interpreted it being exploded, I would interpret it being a wound of exit, and the appearance of the wound in the neck, and I also thought it was a wound of exit.

Mr. SPECTER. Have you ever changed any of your original opinions in connection with the wounds received by President Kennedy?

Dr. JENKINS. I guess so. The first day I had thought because of his pneumothorax, that his wound must have gone—that the one bullet must have traversed his pleura, must have gotten into his lung cavity, his chest cavity, I mean, and from what you say now, I know it did not go that way. I thought it did.

Mr. SPECTER. Aside from that opinion, now, have any of your other opinions about the nature of his wounds or the sources of the wounds been changed in any way?

Dr. JENKINS. No; one other. I asked you a little bit ago if there was a wound in the left temporal area, right above the zygomatic bone in the hairline, because there was blood there and I thought there might have been a wound there (indicating).

Mr. SPECTER. Indicating the left temporal area?

Dr. JENKINS. Yes; the left temporal, which could have been a point of entrance and exit here (indicating), but you have answered that for me. This was my only other question about it.

Mr. SPECTER. So, that those two points are the only ones on which your opinions have been changed since the views you originally formulated?

Dr. JENKINS. Yes, I think so.

Mr. SPECTER. On the President's injuries?

Dr. JENKINS. Yes, I think so.

Mr. SPECTER. Is the conversation you had with that Secret Service Agent the only time you were interviewed by anyone from the Federal Government prior to today about this subject?

Dr. JENKINS. As far as I remember—I don't believe so.

Mr. SPECTER. Now, you say that was the only time you were interviewed?

Dr. JENKINS. Yes, as far as I remember—I have had no formal interviews. I have been asked—there have been some people calling on the phone. As you know, there were many calls from various sources all over the country after that, wanting to know whether we had done this method of treatment or some other method and what principles we followed.

Mr. SPECTER. But the only one you can identify as being from the Federal Government is the one you have already related from the Secret Service?

Dr. JENKINS. Yes.

Mr. SPECTER. And did you and I have a very brief conversation before the deposition started today, when you gave me some of your views which you expounded and expanded upon during the course of the deposition on the record?

Dr. JENKINS. Yes.

Mr. SPECTER. And is there anything which you think of to add that you believe would be of some assistance or any assistance to the President's Commission in its inquiry?

Dr. JENKINS. I believe not, Mr. Specter.

Mr. SPECTER. Well, thank you very much, Dr. Jenkins.

Dr. JENKINS. All right.

~~Ronald Coy Jones~~
Ronald C. Jones

TESTIMONY OF DR. RONALD COY JONES

The testimony of Dr. Ronald Coy Jones was taken at 10:20 a.m., on March 24, 1964, at Parkland Memorial Hospital, Dallas, Tex., by Mr. Arlen Specter, assistant counsel of the President's Commission.

INVESTIGATION OF THE ASSASSINATION OF PRESIDENT JOHN F. KENNEDY

APPENDIX TO HEARINGS

U.S. Congress, House, BEFORE THE
SELECT COMMITTEE ON ASSASSINATIONS,

OF THE

U.S. HOUSE OF REPRESENTATIVES

NINETY-FIFTH CONGRESS

SECOND SESSION

VOLUME VII

MEDICAL AND FIREARMS EVIDENCE

MARCH 1979

Printed for the use of the Select Committee on Assassinations



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Kennedy

INVESTIGATION INTERVIEW SCHEDULE

003974

1. Identifying Information:

Name Dr. Marion T. Jenkins Date 11/10/77
 Address Parkland Hospital Place Parkland Memorial Hospital
 City/State Dallas, Texas Telephone _____
 Date of Birth _____ M or S _____
 Social Security _____ Spouse _____
 Children _____

2. Physical Description:

Height _____ Color Eyes _____ Hair _____
 Weight _____ Special Characteristics _____
 Ethnic Group _____

3. Personal History:

- a. Present Employment: _____
 Address _____
 Telephone _____
- b. Criminal Record
 - 1. Arrests _____
 - 2. Convictions _____

4. Additional Personal Information:

- a. Relative(s): Name _____
 Address _____
- b. Area frequented: _____
- c. Remarks: _____

Investigator Andy Purdy

Date 12/12/77

Form #4-B

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SELECT COMMITTEE ON ASSASSINATIONS *Kennedy*

NAME Dr. Marion T. Jenkins Date 11/10/77 Time 4:50
 Address Parkland Hospital Place Parkland Memorial Hospital
Dallas, Texas

Interview: By: Andy Purdy, Esq.

Dr. Jenkins (anesthesiologist) was one of the first doctors into the Parkland trauma room where the President was. He said the President's thick shock of hair largely covered up the head wound. However, Dr. Jenkins was positioned at the head of the table so he had one of the closest views of the head wound (believes he was " . . . the only one who knew the extent of the head wound.") His location was customary for an anesthesiologist.

Dr. Jenkins said he knew the President was non-resuscitable from his experience with many similar injuries (with the exception of the head injury). He noticed that blood gushed out of the head with each cardiac massage compression.

Dr. Jenkins said he bears the responsibility for the postponement in the determination that the President had expired. Because the President was his patient, he used an artificial respirator inspite of his professional determination that he was non-resuscitable.

Dr. Jenkins said he turned to a priest standing nearby and asked him what the Catholic Church's position is regarding what constitutes death and when the last rites must be adminis-

Interviewer

Andy Purdy
 (Signature)

Andy Purdy

(Name)

Date Transcribed 12/2/77 by LJ
 (Ini)

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tered. He was told they must be given within two hours of a medical determination of death.

Regarding the head wound, Dr. Jenkins said that only one segment of bone was blown out -- it was a segment of occipital or temporal bone. He noted that a portion of the cerebellum (lower rear brain) was hanging out from a hole in the right -- rear of the head.

During the emergency medical procedures, Mrs. Kennedy came in the room and gave Dr. Jenkins a piece of the President's brain. Mrs. Kennedy, the priest, and Dr. Jenkins were the last three people to leave the trauma room.

Dr. Jenkins attempted to explain (on his own initiative) Dr. McClelland's Warren Commission testimony that the President had a wound of the left temple. He said McClelland did not personally see the wound and misinterpreted Dr. Jenkins' feeling the President's left temple for a pulse as indicating there was a wound there.