

WORKMEN'S COMPENSATION THE INDUSTRIAL COMMISSION OF OHIO

DUPLICATE
Record of Proceedings

Employee: Henry N. Hoerst Claim No. O. D. 107910
Street and No. 10109 Wayne Ave., Woodlawn Date of Disability 11/15/60
City Cincinnati 15, Ohio Manual No. 4233
(State)

Employer: The Philip Carey Mfg. Co. Risk No. 1684
Street and No. Wayne Ave., Lockland
City Cincinnati 15, Ohio
(State)

PREVIOUS AWARDS FOR COMPENSATION, MEDICAL, NURSING AND HOSPITAL SERVICES

Temporary Total to _____ Amount \$ _____
Permanent Total 11-16-60
Temporary Partial to _____ Amount \$ _____
Permanent Partial for loss of _____ Amount \$ _____
Total Medical Services to date _____ Amount \$ 50.00-
74.40

FINDINGS OF FACTS AND MINUTES

On this day this claim was before the Commission. Findings and orders were made for the payment of the items listed below. The Auditor was instructed to issue such warrants as are necessary to pay such items.

MEDICAL SERVICES

Item	Name*	Address	Amount	Warrant No.

COMPENSATION _____ Weeks at Rate of \$ _____

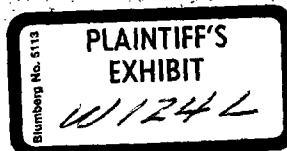
Type	Period	Amount	Warrant No.

* Note to Auditor — In absence of another name, Claimant is Payee.

Present for Claimant _____ Present for Employer _____

This action based upon the following motion made by Mr. Tobin

Heard by Mr. Dickerson, Mr. Tobin and Mr. Marshall, w/Mr. Hickling and Mr. Brockins. This claim coming on to be heard on the employer's Application for Handicapped Reimbursement filed on January 25, 1961, it is the finding of the Commission that the said application be denied for the reason that the claimant's disability, diagnosed as asbestosis was not caused by a cardiac condition, nor has any compensation or medical benefits been paid for an aggravation of the heart condition by the said asbestosis.



That any special finding or order written hereon supersedes any printed matter in conflict therewith.

This motion was seconded by Mr. Dickerson and was voted upon as follows: Mr. Tobin, aye; Mr. Dickerson, aye.

Date March 31, 1961 Secretary [Signature]

INSTRUCTIONS: In accordance with Section 4123-28 of THE OHIO WORKMEN'S COMPENSATION ACT, every employer shall keep a record of all injuries received by his employees in the course of their employment and report same to the Bureau of Workmen's Compensation upon forms provided for that purpose. THIS APPLICATION MUST BE FULLY COMPLETED AND SHOULD BE FILED WITH THE BUREAU PROMPTLY. Part I of this form must be executed by the employer by whom the deceased was employed when his disability began, or his authorized agent; Part II of this form must be completed and signed by the claimant. Mail this report in its completed form to The Bureau of Workmen's Compensation, Claims Section, Columbus, Ohio.

FOR OCCUPATIONAL DISEASE ONLY

Claim No.

O. D. 107910

STATE OF OHIO

BUREAU OF WORKMEN'S COMPENSATION**First Notice of Death and Preliminary Application****EMPLOYER'S REPORT****PART I****EMPLOYER**

1. Name of employer: The Philip Carey Manufacturing Company
(Name as shown on Insurance Certificate)
2. Office Address: 300 S. Wayne Ave. Hamilton Cinti. Ohio
(Number) (Street) (County) (City) (State)
3. Nature of business: Manufacturing Type of Organization: Corporation
(Farming, Coal Miner, Mach. Mfg., etc.) (Partnership, Corp. or Individual owner)

DECEASED EMPLOYEE

4. Name: Henry N. Hoerst
(First) (Middle Initial) (Last)
5. Home Address: 10109 Wayne Ave. Cincinnati 15 Ohio
(Number) (Street) (City) (State)
6. Age: 10-14-99 Male: Male Single, Married, Divorced, Widowed: Married Social Security No. 270-07-0405
7. Number and relationship of dependents: One - Wife
8. Was deceased a partner, member of firm or owner of business? No

OCCUPATIONAL DISEASE (TIME)

9. Where was disease contracted: See record
(City) (County) (State)

10. Date quit work: 11-17-60 Date of death: 10-17-63
11. What was deceased's occupation?
12. Explain fully the kind of work deceased was doing when disability began:
13. How long had deceased been doing this work?
14. Experience of deceased employee in this type of work during life time
15. When did the last period of employment with this employer begin?
16. Name the employers for whom deceased had worked during the three years preceding the beginning of the disability, and give their addresses and business:

17. Decedent's earnings were reported on payroll reports of Risk No

Under Manual No.

By signing below, I do hereby certify that I have authority to execute this Employer's Report and that the answers to the questions given in said report are correct to the best of my information and belief; that the deceased herein named was, on the date shown herein, an employee of the undersigned and at the time of entering into the employment from which the disease is claimed to have resulted (did not) represent himself as not having previously suffered from such disease.

Date report sent to claimant

For

THE PHILIP CAREY MFG. CO.
LOCKHEED PLANT OHIO

Date received from claimant

(Official title of person signing and his department)

SAFETY SUPER.

Date mailed to Bureau

(Name of employer as shown on Insurance Certificate)

Do not write in this column

Age

Sex & c. c.

Dependents

Location (Geo.)

Date Report Filed

Date of Death

Report Lag

Hearing Lag

Payment Lag

Occupation

Experience

Agency (Disease)

Agency Part

Type of Disease

Nature of Disab.

Part of Body

Full Wage

Average Wage

Treatment

Complications

Degree of Injury

Days Lost

Coded by

Manual No.

Risk No.