FROM: Industrial Accident Board
200 East Riverside Drive
First Floor
Austin, Texas 78704
Phone: 512-475-2251

TO Jimmy Newell

cc Donald R. Bryant
P. O. Box 326
Kemah, Texas 77565

DATE 1-28-83

BOARD NO. 81-162311-E1

CLAIMANT Donald R. Bryant

EMPLOYER Monsanto

INS. CO. Teia

INS. CO. NO. Unknown

DATE OF INJURY 7-31-81

COUNTY OF INJURY Galveston

COUNTY OF RESIDENCE "

Attorneys must file copy of their Power of Attorney or Contract of Employment signed by both parties.

This acknowledges receipt of Notice of Injury and Claim for Compensation [illegible]

PLAINTIFF'S EXHIBIT
MON-2680

PLEASE FILE THE FOLLOWING (X'd below)
(Applicable to Insurance Company Only)

X Employer's First Report of Injury

___ Employer's Supplemental Report of Injury (Please list all intermittent periods of lost time, if any)

___ Wage Statement (If employee was not employed for one year, submit wage statement of a similar employee)

X A-1 (Report of Initial Payment of Compensation)

___ A-2 (Report of Suspension)

___ A-4 (Resume Compensation)

X Medical Report - Current

___ Medical Report - Final

___ Disability Rating Report

___ Hand or Foot Chart

___ Color Photos of Injured Area

M. A. RIDDLE
FEB 11 1983

LAM012083

SC 10863

Remarks:

Thank you,

JANNETTE MOUNTZOURIS
Resident Reviewer

PHD-25 (Rev. 1-82) Austin

RD

STANDARD FOI

EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS

A. Send ORIGINAL to
INDUSTRIAL ACCIDENT BOARD, P. O. Box 12757, Austin, Texas, 78711 if employee is absent from work more than one day.

B. Upon termination of incapacity to employee or if incapacity extends beyond sixty day period, make supplemental report.

C. Penalty of $1,000 may be assessed for failure to comply with these instructions (Sec. 7, Article 8307, V.A.T.S. amended August 27, 1979).

Copy to _____

State's Number	Board Number
	File
	Carrier
For:	Employer
Carrier's File No.	OSHA File No
(The spaces above are not to be completed by the Employer)	

EMPLOYER

1 Name of Employer Monsanto Company Telephone # 945-4431

2 Office address No and St 201 So Bay street City or Town Texas City State Texas Zip Code 77590

3 Insured by Texas Employers' Insurance Association Policy No. 76771

4 Give nature of business (or article manufactured) Petrochemical Processing

TIME and PLACE

5 (a) Location of plant or place where accident occurred, # and Street 201 So Bay Street City Texas City
Did accident occur on employer's premises? ☐ Yes ☐ No County Galveston State Texas Zip Code 77590
Department where injured unknown Department regularly employed in Dept. 14

(b) If injured in a mine, did accident occur on surface, underground, shaft, drift or mill?

(c) Was employee hired, or if a Texas resident, recruited in Texas? ☐ Yes ☐ No

(d) If injury occurred out of Texas, on what date was employee transferred out of State?

6 Date of injury none 19 Day of Week Hour of Day A M P M

7 First day unable to labor none 19 A M P M 8. Was injured paid in full for this day?

9 When did you or foreman first know of injury? 10 Name of foreman

INJURED PERSON

Full First Name	Middle Initial	Last Name
Donald	R.	Bryant

11 Name of injured Social Security No. 527-22-2662

12 Address No and St P.O. Box 326 City or town Kemah State Texas Zip Code 77565

13 Telephone No Telephone No. Friend or Relative Speak English ☒ Yes ☐ No

14. (a) Age 5/25 (b) Sex male (c) Marital Status (d) Minor Children

15 (a) Occupation when injured operator (b) Was this his or her regular occupation? yes

(c) Under what classification code is employee's payroll reported to insurance carrier?

16. (a) How long employed by you 3/54 (b) Piece or time worker (c) Wages per hour $ 12.31

17 (a) No. hours per day 8 (b) Wages per day $ 98.48 (c) No. days worked per week 5 (d) Average weekly earnings $ 492.40

(e) If board, lodging, fuel or other advantages were furnished in addition to wages, give estimated market value per day, week or month

18 Was injured employee officer, director, partner, or owner? no

CAUSE of INJURY

19 Machine tool or thing causing injury UNKNOWN 20. Kind of power (hand, foot, electrical, steam, etc.)

21 Part of machine on which accident occurred UNKNOWN

22. (a) Name the safety appliance or regulation provided UNKNOWN (b) Was it in use at time?

23. Was accident caused by injured's failure to use or observe safety appliance or regulation?

24 Describe fully how accident occurred, and state what employee was doing when injured
UNKNOWN

SC 10864

25. Names and addresses of witnesses UNKNOWN

NATURE of INJURY

26 Describe the injury or illness in detail and indicate the part of body affected UNKNOWN

27 Probable length of disability 28. Has injured returned to work?
If so, date and hour At what wage $

29 At what occupation?

30 (a) Name and address of physician (if known) UNKNOWN LAM012084
(b) Name and address of hospital (if known)

FATAL CASES

31 Has injured died? If so, give date of death

Date of this report 2/11/83 Firm Name Monsanto Company-Mark Riddle

Signed by Mark Riddle Official Title Safety Engineer

INDUSTRIAL ACCIDENT BOARD REQUIRES COMPLETION OF ALL APPLICABLE ITEMS ON THIS FORM

TEXAS
INDUSTRIAL ACCIDENT BOARD

H. S. HARRIS, JR.
CHAIRMAN
512-475-3126

BOBBY J. BARNES
MEMBER
512-475-3719

TRUMAN F. GRAHAM
MEMBER
512-475-4797

200 EAST RIVERSIDE DRIVE-FIRST FLOOR
AUSTIN, TEXAS 78704
512-475-2251

WILLIAM TREACY
EXECUTIVE DIRECTOR
512-475-4538

INEZ (TIPPY) FOSTER
ASSISTANT EXECUTIVE DIRECTOR
512-475-4156

01/28/83

BOARD NUMBER 81162311-E1

EMPLOYEE DONALD R. BRYANT

EMPLOYER NUMBER 069431-000

DATE OF ACCIDENT 07/31/81

COUNTY GALVESTON

INS. CO. NUMBER

MONSANTO COMPANY
P. O Box 1311
Texas City, TX 77590

Gentlemen:

Notice has been received that the above named employee was injured while in your employ. We are unable to locate the report indicated below.

This report has been filed giving the employee's name or date of injury different from that shown in the above section, please furnish copy of original report with this letter.

EMPLOYER'S FIRST REPORT OF INJURY. (SEE REVERSE SIDE).

M. A. RIDDLE

FEB 4 1983

INS CO PLEASE FILE CURRENT MEDICAL

SECTION 7, ARTICLE 8307, PART II OF THE TEXAS WORKERS' COMPENSATION LAW STATES:

"Every subscriber shall hereafter keep a record of all injuries, fatal or otherwise, sustained by his employees in the course of their employment. After the occurrence of an accident resulting in an injury to an employee, causing his absence from work for more than one (1) day, or after the employee notifies the employer of a definite manifestation of an occupational disease, a written report thereof shall be made within eight (8) days following said absence from work and notice thereof to the employer or notice of manifestation of an occupational disease to the Board on blanks to be procured from the Board for that purpose. Upon the termination of the incapacity of the injured employee, or if such incapacity extends beyond a period of sixty (60) days, the subscriber shall make a supplemental report upon blanks to be procured for that purpose. The said report shall contain the name and nature of the business of the employer, the location of the establishment, the name, age, sex and occupation of the injured employee, and the character of work in which he was engaged at the time of the injury, and shall state the date and hour of receiving such injury or of the definite manifestation of the occupational disease, and the nature and cause of the injury, and such other information as the Board may require. Any employer wilfully failing or refusing to make any such report within the time herein provided, or wilfully failing or refusing to give said Board any information demanded by said Board relating to any injury to any employee, which information is in the possession of or can be ascertained by the employer by the use of reasonable diligence, shall be liable for and shall pay to the State of Texas a penalty of not more than One Thousand ($1,000.00) Dollars for each and every offense, the same to be recovered in a suit to be instituted and prosecuted in Travis County by the Attorney General or by the district or county attorney, under his direction, in a District Court thereof."

PLEASE PLACE THE BOARD NUMBER IN THE UPPER RIGHT HAND CORNER. PLEASE REPLY WITHIN TEN DAYS.

TEXAS EMPLOYERS INSURANCE ASSOCIATION
350 LITTLEFIELD BUILDING
AUSTIN, TX 78701

IAB 14-A (REV 12-79)

SC 10865

LAM012085

SPEEDIMEMO

MONSANTO COMPANY
P. O. BOX 1311 TEXAS CITY, TEXAS 7759

TO	DEPT.-LOCATION
DON GHOLSON	CLAIM DEPT.
FROM	**DEPT.-LOCATION**
DICK WERNER	L.P.+S

SUBJECT

DATE 2/11/83

MESSAGE

DON -
WE ARE SENDING THIS ALONG FOR YOUR INFORMATION. THERE IS NO RECORD OF INJURY AND THIS EMPLOYEE RETIRED ON 8-1-81

REGARDS,
DICK

ORIGINATOR-DO NOT WRITE BELOW THIS LINE SIGNED

REPLY

DEPT.-LOCATION SIGNED DATE / /

WRITER'S COPY

Rediform ® 4S 470
Poly Pak (50 Sets) 4P 473

DETACH AND FILE FOR FOLLOW-UP

SC 10866

LAM012086

A STANDARD FC

EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS

1. Send ORIGINAL to INDUSTRIAL ACCIDENT BOARD, P. O. Box 12757, Austin, Texas, 78711 if employee is absent from work more than one day.
B. Upon termination of incapacity to employee or if incapacity extends beyond sixty day period, make supplemental report.
C. Penalty of $1,000 may be assessed for failure to comply with these instructions (Sec. 7, Article 8307, V.A.T.S. amended August 27, 1979).

Copy to

State's Number	Board Number / File / Carrier / Employer
For	

Carrier's File No

OSHA File No

(The spaces above are not to be completed by the Employer)

EMPLOYER

1. Name of Employer Monsanto Company Telephone # 945-4431
2. Office address: No. and St. 201 So Bay street City or Town Texas City State Texas Zip Code 77590
3. Insured by Texas Employers' Insurance Association Policy No. 76771
4. Give nature of business (or article manufactured) Petrochemical Processing

TIME and PLACE

5. (a) Location of plant or place where accident occurred, # and Street 201 So Bay Street City Texas City
(b) Did accident occur on employer's premises? ☐ Yes ☐ No. County Galveston State Texas Zip Code 77590
(c) Department where injured Unknown Department regularly employed in Dept. 14
(b) If injured in a mine, did accident occur on surface, underground, shaft, drift or mill?
(c) Was employee hired, or if a Texas resident, recruited in Texas? ☐ Yes ☐ No
(d) If injury occurred out of Texas, on what date was employee transferred out of State?
6. Date of injury none 19 Day of Week Hour of Day A.M P.M
7. First day unable to labor none 19 A.M P.M. 8 Was injured paid in full for this day?
9. When did you or foreman first know of injury? 10 Name of foreman

INJURED PERSON

11. Name of injured — Full First Name Donald Middle Initial R. Last Name Bryant Social Security No 527-22-2662
12. Address: No. and St. P.O. Box 326 City or town Kemah State Texas Zip Code 77565
13. Telephone No. Telephone No. Friend or Relative Speak English ☒ Yes ☐ No
14. (a) Age 5/25 (b) Sex male (c) Marital Status (d) Minor Children
15. (a) Occupation when injured operator (b) Was this his or her regular occupation? yes
(c) Under what classification code is employee's payroll reported to insurance carrier?
16. (a) How long employed by you 3/54 (b) Piece or time worker (c) Wages per hour $ 12.31
17. (a) No. hours per day 8 (b) Wages per day $ 98.48 (c) No. days worked per week 5 (d) Average weekly earnings $ 492.40
(e) If board, lodging, fuel or other advantages were furnished in addition to wages give estimated market value per day, week or month
18 Was injured employee officer, director, partner, or owner? no

CAUSE of INJURY

19. Machine, tool or thing causing injury UNKNOWN 20 Kind of power (hand, foot, electrical, steam, etc.)
21 Part of machine on which accident occurred UNKNOWN
22. (a) Name the safety appliance or regulation provided UNKNOWN (b) Was it in use at time of injury?
23. Was accident caused by injured's failure to use or observe safety appliance or regulation?
24. Describe fully how accident occurred, and state what employee was doing when injured UNKNOWN
25. Names and addresses of witnesses UNKNOWN

RECEIVED
APR 7 1983
MONSANTO CO.
LOSS PREVENTION DEPT.

NATURE of INJURY

26 Describe the injury or illness in detail and indicate the part of body affected UNKNOWN LAM012087
27. Probable length of disability 28 Has injured returned to work?
If so, date and hour At what wage $
29 At what occupation?
30. (a) Name and address of physician (if known) UNKNOWN
(b) Name and address of hospital (if known) SC 10867

FATAL CASES

31. Has injured died? If so give date of death

Date of this report 2/11/83 Firm Name Monsanto Company-Mark Riddle

Signed by Mark Riddle Official Title Safety Engineer

THE INDUSTRIAL ACCIDENT BOARD REQUIRES COMPLETION OF ALL APPLICABLE ITEMS ON THIS FORM