SELF-INSURERS

Supplemental or Final Report on Occupational Injury or Disease

Check appropriate box:
Supplemental [X] Final [ ]
Reopening [ ]

Aluminum Company of America
Box 221
Wenatchee, WA 98801

Claim Number S598522 552

Firm Number 700,002-01-9

Soc. Sec. No. 534-28-6412

Form must be filed at the following times on all claims:

a. On the date the first time loss compensation is paid.

b. On the date the time loss compensation is terminated or the rate thereof changed.

c. On the date a determination is requested.

d. On extended claims at least every 180 days.

A medical report need not be submitted with your request for determination on non-compensable claims (medical only).

PLEASE ANSWER ALL QUESTIONS

Workman: DONALD L. CONRAD

Present Address: Spouse-Almeda Conrad 4773 Saturday Ave. Malaga, WA 98828

Date of Injury: Sept. 1953 - Sept. 1973

Date first compensation paid: _____

Marital status: [X] Married [ ] Single [ ] Divorced [ ] Widowed

No. Dependent Children Under Age 18: 0
(and/or under 21 if enrolled in accredited school)

Compensation paid from: _____ through: _____

Use (a) or (b)

(a) Temporary Total Disability at the rate of $ _____ per day for _____ days totaling $ _____.

(b) Temporary Total Disability at the rate of $ _____ per month for _____ months and _____ days totaling $ _____
(For any Temporary Partial Disability paid during this period, show dates and amounts paid and method of calculation based on claimant's earnings in the "Remarks" section below.)

PLAINTIFF'S EXHIBIT
AL-1960

Date physician approved workman's return to work: Deceased - 05-13-83

Date returned to work: _____

Will the claimant be able to return to his former occupation? [ ] Yes [ ] No [ ] Undetermined

Has medical treatment been completed? [ ] Yes [ ] No

Is condition medically fixed? [ ] Yes [ ] No

Is there any permanent impairment? [X] Yes [ ] No [ ] Undetermined

Medical report [X] attached [ ] previously submitted [ ] X-Rays

Determination requested? [ ] Yes [ ] No

Names of treating physicians:

Thomas W. Malpass, M.D.
820 N. Chelan
Wenatchee, WA 98801

Remarks: Death certificate included. - Carcinoma of Unknown Primary

x Elaine C. Doyle
SIGNATURE OF AUTHORIZED REPRESENTATIVE

Workers Comp. Adm.
Title

Date 83-11-10

If this is a FINAL REPORT requesting determination, submit one copy to workman, one copy to Department of Labor & Industries.
If this is a SUPPLEMENTAL REPORT only, submit one copy to the Department of Labor & Industries.
If this is a SUPPLEMENTAL REPORT showing termination of compensation or change in the rate thereof, submit one copy to the workman and one copy to the Department of Labor & Industries.

WENS 013482

11-10-83 - Per June Van Auken - Dept of Ind

Send copy of file to:

Pension Adjudicator
State Fund

Along with SIF #5 and speed note stating - Carrying out an investigation with the possible intent to deny.

Claim being filed for Widows Pension
Don't pay any benefits until settled.

WENS 013483

Labor & Industries, Attention: Accident Report, Claims Section, Olympia, WA 98504. Detach the Physician's Copy (3rd Copy) for your files and promptly mail the balance of the form to the employer (this includes the bottom portion of the Original and all of the 2nd copy).

portion of page submitted by employer.

EMPLOYER'S COPY

DEPT. OF LABOR & INDUSTRIES
CLAIMS SECTION
OLYMPIA, WASHINGTON 98504

TYPE OR PRINT IN INK — REPORT WILL BE MICROFILMED.

ACCIDENT REPORT

NOT CLAIM NUMBER	NON-COMPENSABLE ADJ #	NON-COMPENSABLE STATUS	DATE	SEX	COMPENSABLE ADJ #	COMPENSABLE STATUS	DATE	SEX	CLAIM NUMBER	ROUTING	EMP ACCT
R 539754									S 598522		

EDITOR	UNIT	SERVICE LOCATION	SIGNATURE CLAIM EXAMINER	FIRM #	CK DIGIT	CLASS	ALLOWED	CONT	NON CONT

ALL QUESTIONS BELOW MUST BE ANSWERED OR THERE MAY BE A DELAY IN PAYMENT OF BENEFITS.

INJURED WORKER: PLEASE ANSWER ALL QUESTIONS IN THIS SECTION

NAME OF INJURED EMPLOYEE (TYPE OR PRINT IN INK) — FIRST: Donald — MIDDLE: L — LAST: Conrad

TELEPHONE NUMBER: 663-6694

MAILING ADDRESS: 4773 Saturday Ave — CITY & STATE: Malaga Wa — ZIP CODE: 98808

SOCIAL SECURITY NUMBER: 534-28-6[illegible]

RESIDENCE ADDRESS IF DIFFERENT THAN ABOVE — CITY & STATE — ZIP CODE

DATE OF ACCIDENT: Sept 1953-7 Sept 1978

HOUR ACCIDENT OCCURRED (A.M. / P.M.)	SHIFT HOURS	YOUR JOB TITLE WHEN INJURED	SEX	DATE OF BIRTH	HEIGHT	WEIGHT	GIVE DATE LAST WORKED
		Furnace Caster	M	July 23-29	6'1"	220	Dec 14/98[illegible]

GIVE DATE RETURNED TO WORK, IF SO	WERE YOU DOING YOUR REGULAR WORK AT TIME OF ACCIDENT? YES / NO	WHERE DID ACCIDENT OCCUR? EMPLOYER'S PREMISES / JOB SITE / OTHER	HOW MANY CO-WORKERS WERE HURT? IF ANY	HOW LONG HAVE YOU WORKED FOR THIS EMPLOYER?
Death	NO	EMPLOYER'S PREMISES	None	30 Yr

EMPLOYER'S BUSINESS NAME ONLY: ALCOA - Wenachee Works — STREET ADDRESS: Malaga ALCOA Hwy — CITY: Wenatchee — ZIP: 98801 — PHONE NUMBER: 663-5111

EMPLOYER'S BUSINESS (START TYPE OR NATURE OF): Aluminum Makers — ADDRESS OR LOCATION WHERE ACCIDENT OCCURRED: (P.O. Box 221 Wenatchee, Wa. 98801) — COUNTY: Chelan

WAS THE ACCIDENT IN YOUR OPINION CAUSED IN ANY WAY BY SOMEONE NOT EMPLOYED BY YOUR EMPLOYER? YES / NO	DATE YOU REPORTED ACCIDENT TO YOUR EMPLOYER	TO WHOM REPORTED: (NAME & TITLE)
NO	Oct 1982	Dave Newman - Foreman

IF EMPLOYER WAS NOT NOTIFIED THE SAME DATE AS THE ACCIDENT-GIVE REASON

ENTER YOUR RATE OF PAY IN ONLY ONE BOX BELOW. DO NOT INCLUDE OVERTIME.

PER HOUR	PER DAY	PER WEEK	PER MONTH	WILL YOU RECEIVE FULL SALARY FROM YOUR EMPLOYER?
			2,697.53	

DESCRIBE ACCIDENT FULLY, STATING IF YOU FELL OR WERE STRUCK. IF MACHINERY WAS INVOLVED, NAME MACHINE AND DESCRIBE ITS FUNCTION. WERE YOU LIFTING, PULLING, PUSHING OR CARRYING? FALLS SHOULD BE DESCRIBED AS INDOORS OR OUTDOORS AND LAST OBJECT STRUCK BE NAMED. NAME CHEMICAL INVOLVED, IF APPROPRIATE.

Don worked with Asbestos for 19 years and died of Asbestos Cancer on May 13 1983

IF SEASONAL EMPLOYMENT-DO YOU WORK MORE THAN 40 HOURS PER WEEK? IF YES, GIVE TOTAL HRS. PER WEEK.

GIVE NAME AND BIRTH DATES OF YOUR CHILDREN UNDER 18 SUPPORTED BY YOU.

TODAY'S DATE: 9-22-83

NAME	RELATIONSHIP	BIRTHDATE	NAME	RELATIONSHIP	BIRTHDATE

IF DIVORCED AND YOU HAVE MINOR CHILDREN SUBMIT A COPY OF THE COURT ORDER SHOWING LEGAL CUSTODIAN OF SUCH CHILDREN. ALSO GIVE PRESENT ADDRESS OF SUCH CUSTODIAN.

MEDICAL RELEASE AUTHORIZATION: I HEREBY AUTHORIZE MY PHYSICIAN, HOSPITAL, AGENCY OR ORGANIZATION TO DISCLOSE TO THE DEPARTMENT OF LABOR AND INDUSTRIES, ANY MEDICAL RECORDS OR OTHER INFORMATION REGARDING TREATMENT WHICH HAS PREVIOUSLY BEEN FURNISHED TO ME. (WORKER'S SIGNATURE)

FULL NAME OF SPOUSE AT TIME OF INJURY: Almeda Conrad — IF DIVORCED, GIVE FINAL DECREE DATE

I HAVE READ LEGAL WARNING ON REVERSE SIDE OF ORIGINAL COPY (WORKER'S SIGNATURE): Don Conrad by Rhonda Conrad

PHYSICIAN'S REPORT

DATE OF FIRST TREATMENT: 12-28-83

HISTORY & SUBJECTIVE FINDINGS: He is a 53yo man who has never smoked cigarettes or drunk alcohol, had some asbestos exposure over many years in the past but not in the past 15 years, who has been found to have

OBJECTIVE FINDINGS (IF EXTREMITIES INVOLVED, GIVE RIGHT OR LEFT): diffuse abdominal carcinomatosis with gross ascites, seeding peritoneal surfaces, mesenteric implantation, exteinsic bowel lesions withtou anything intrinsic.

SEE ATTACHED DICTATION

HAD EMPLOYEE EVER BEEN TREATED BY ANYONE FOR SAME OR SIMILAR CONDITION? YES / NO — IF YES ATTACH REPORT

IS THERE ANY RECORDED PRE-EXISTING IMPAIRMENT OF THE AREA INJURED? YES / NO

ARE ANSWERS TO THESE QUESTIONS SATISFACTORY? WILL THIS OR ANY OTHER PRE-EXISTING CONDITION COMPLICATE TREATMENT OR RETARD RECOVERY? YES / NO

IS THE CONDITION DIAGNOSED THE RESULT OF THE INCIDENT DESCRIBED? YES / PROBABLY / POSSIBLY / NO

X-RAY & LAB FINDINGS

WILL THIS EMPLOYEE BE OFF WORK DUE TO THIS INJURY? YES / NO

PROVISIONAL DIAGNOSIS (USE BOTH STANDARD DESCRIPTION AND ICDA CODE)

Adenocarcinoma, unclear primary, metastatic diffusely within abdomen, with negative workup for metastatic tumor from upper GI tract

SEE ATTACHED DICTATION

ESTIMATED TIME LOSS DUE TO INJURY: Patient decease

ATT PHYSICIAN TELEPHONE NUMBER: 663-8711

IF CASE REFERRED TO ANOTHER DOCTOR, GIVE FULL NAME AND ADDRESS:

T. Malpass MD — 820 N. Chelan — WEnatchee, WA — 98801

REFERRED PHYSICIAN PHONE NO.: Same

L&I USE ONLY

IF HOSPITALIZED IN PATIENT	OUT PATIENT	NAME OF HOSPITAL	CITY	HOSPITAL TELEPHONE NUMBER
X		Central Washington Hospital	WEnatchee	663-1511

ATTENDING PHYSICIAN: (PLEASE PRINT OR TYPE YOUR NAME AND ADDRESS.) — ADDRESS — ZIP CODE

D. Notter MD — 820 N. Chelan — WEnatchee, WA — 98801

LICENSED PHYSICIAN MUST SIGN BEFORE REPORT IS ACCEPTED	SIGNATURE	DATE	PAYEE ACCOUNT NUMBER
	[signature]	9-30-83	30773

(USE DEPT. PAYEE ACCOUNT NUMBER STAMP)

DOCTOR: TEAR ALONG PERFORATION AFTER COMPLETING IN FULL AND SUBMIT TO DEPARTMENT OF LABOR & INDUSTRIES, ATTENTION: ACCIDENT REPORT CLAIMS, OLYMPIA, WA. 98504.

WENS 013484