FILE NAME: Mundet Cork (MCK)

DATE: 1977

DOC#: MCK102

DOCUMENT DESCRIPTION: WC Claim of Cuthbertson, Pt. 1

PLAINTIFF EXHIBIT

CCS 5142

PLAINTIFF EXHIBIT #69 10-8-61

EMPLOYER'S REPORT OF INDUSTRIAL INJURY

#69

10-81 (C.E.)

TO

STATE OF CALIFORNIA

DEPARTMENT OF INDUSTRIAL RELATIONS

DIVISION OF LABOR STATISTICS AND RESEARCH

Claim Department

THE TRAVELERS INSURANCE COMPANY

315 Montgomery St., San Francisco 4, Calif.

Every question must be answered fully to avoid further correspondence. FAILURE TO FILE IS A MISDEMEANOR SUBJECT TO MAXIMUM FINE OF $100. (Labor Code, Sections 6407-6413)

11-15-54 received mail

Workmen's Comp. claim

Please make this report in DUPLICATE so that we can file copies with Division of Labor Statistics and Research in your behalf. Every work injury to an employee which causes disability lasting longer than the day of the injury or which requires medical service other than first aid treatment must be reported within five days after the injury. If the injury results in death, a report must be made by telephone or telegraph direct to the Division of Labor Statistics and Research not later than 24 hours after death.

DO NOT WRITE IN THIS COLUMN

Case No.

Employer No.

Industry

Age

Sex and Marital Status

Weekly Wage

County

Accident Date

Occupation

Accident Type

Agency

Agency Part

Mach. Defect

Unsafe Act

Personal Defect

Nature of Injury

Location

Extent of Injury

Insurance Carrier

EMPLOYER

1. Name (Give name under which concern does business) Armstrong Cork Co.
2. Office address (No. and Street) 1355 Market St (City or Town) San Francisco, Calif.
3. Nature of business (Manufacturing shoes, retailing men's clothes, trucking for hire, etc.) Industrial Insulation

INJURED EMPLOYEE

4. Name Jack Cuthbertson Soc. Sec. No. 572-24-8568
5. Address (No. and Street) 2284 Holbrook Drive (City and State) Concord, Calif.
6. Age 26 7. Sex? Check (✓) Male X Female 8. Check (✓) Married X Single
9. Number of hours worked per day 8 per week 40 Number of days worked per week 5
10. Wages $ 3.175 per hour, or $ 25.40 per day, or $ 127.00 per week. (If earnings at irregular rates, such as piece work or on commission basis, enter actual average weekly earnings for convenient period not to exceed one year.)
11. If board, lodging, or other advantages furnished in addition to wages, give estimated value $ Varied per day, or $ per week

ACCIDENT

12. Place of accident (No. and Street) Unknown (City or Town) (County)
13. On employer's premises (Yes or No)? 14. Department
15. Date of accident 16. Hour of day A.M./P.M. 17. Did injury result in disability beyond day of accident? (Yes or No) 18. If yes, give date last worked 19. Was injured paid in full for this day? (Yes or No) 20. If injured in a mine, check (✓) accident location: Surface Mill Underground Shaft

USE OF ACCIDENT

21. Occupation (Job title) Asbestos Worker 22. How long employed by you at this occupation? Check (✓) Less than 6 months; 6 months to 2 years; over 2 years X 23. What was employee doing when accident occurred? (Describe briefly, such as: loading truck, operating drill press, shoveling dirt, walking down stairs, etc.) Insulating Pipes, Ducts, and Equipment

24. How did the accident happen? (Describe fully, stating whether the injured person fell, was struck, etc.; give all factors contributing to accident. Use other side of report for additional space) Allegedly caused "Asbestosis" due to working with insulation material. Employee voluntarily quit on 7-11-51 for similar type of work with another employer.

25. What machine, tool, substance, or object was most closely connected with the accident? (Name the specific machine, tool, appliance, gas, liquid, etc., involved)
26. If mechanical apparatus or vehicle, what part of it? (State if power puller, motor, etc.)
27. Were mechanical guards, or other safeguards provided? (Yes or No) 28. Was injured using them? (Yes or No)
29. What do you recommend for preventing this type of accident? (State the specific preventive measures that can be taken by employer and workmen. Do not say, "By being more careful." Specify what should or should not be done.)

NATURE OF INJURY AND PART OF BODY AFFECTED

30. (Describe in detail the nature of the injury and the part of the body affected. For example: amputation of right index finger at second joint, fracture of ribs, lead poisoning, dermatitis of left hand, etc.) Unknown
31. Name and address of physician
32. Name and address of hospital
33. Has employee returned to work? (Yes or No) 34. If yes, give date 35. At what wage? $ per
36. Did injury result in death? (Yes or No) 37. If yes, give date
38. In case of death, give name and address of nearest relative
39. Names and addresses of witnesses

Injured related to Employer? No If so, how?

Date of this report 11-10-54

Signed by [signature] Official position Construction Supt.

Signature

EXHIBIT

EMPLOYER'S REPORT OF INDUSTRIAL INJURY

TO

STATE OF CALIFORNIA

DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF LABOR STATISTICS AND RESEARCH

Claim Department
THE TRAVELERS INSURANCE COMPANY
315 Montgomery St., San Francisco 4, Calif.

315
ET 70
3-10-81 (C.F.)

PLAINTIFF'S EXHIBIT #70
12-2-5

Every question must be answered fully to avoid further correspondence. FAILURE TO FILE IS A MISDEMEANOR SUBJECT TO MAXIMUM FINE OF $100.
(Labor Code, Sections 6407-6413)

Please make this report in DUPLICATE so that we can file copies with Division of Labor Statistics and Research in your behalf.
Every work injury to an employee which causes disability lasting longer than the day of the injury or which requires medical services other than first aid treatment must be reported within five days after the injury. If the injury results in death, a report must be made by telephone or telegraph direct to the Division of Labor Statistics and Research not later than 24 hours after death.

DO NOT WRITE IN THIS COLUMN

Case No.
Employer No.
Industry
Age
Sex and Marital Status
Weekly Wage
County
Learned Date
Occupation
Accident Type
Agency
Agency Part
Mach. Defect
Unsafe Act
Personal Defect
Nature of Injury
Location
Extent of Injury
Insurance Carrier
Report Log

EMPLOYER

1. Name (Give name under which concern does business) Armstrong Cork Co
2. Office address (No. and Street) 1355 Market Street (City or Town) San Francisco, Calif
3. Nature of business (Manufacturing cloths, retailing men's clothes, trucking for hire, etc.) Industrial Insulation

INJURED EMPLOYEE

4. Name Jack Cuthbertson Soc. Sec. No. 572-24-2558
5. Address (No. and Street) 2284 Hollenbeck Drive (City and State) Concord, Calif
6. Age 26 7. Sex Check (√) Male √ Female 8. Check (√) Married √ Single
9. Number of hours worked per day 8 per week 40 Number of days worked per week 5
10. Wages: $ 3.175 per hour, or $ 25.40 per day, or $ 127.00 per week. (If earnings at irregular rate, such as piece work or on commission basis, enter actual average weekly earnings for convenient period not to exceed one year.)
11. If board, lodging, or other advantages furnished in addition to wages, give estimated value $ VARIES per day, or $ ..... per week

ACCIDENT

12. Place of accident (No. and Street) UNKNOWN (City or Town) ..... (County) .....
13. On employer's premises (Yes or No) ..... 14. Department .....
15. Date of accident ..... 16. Hour of day ..... A.M./P.M. 17. Did injury result in disability beyond day of accident? (Yes or No) ..... 18. If yes, give date last worked ..... 19. Was injured paid in full for this day? (Yes or No) ..... 20. If injured in a mine, check (√) accident location: Surface ..... Mill ..... Underground ..... Shaft .....

CAUSE OF ACCIDENT

21. Occupation (job title) ASBESTOS WORKER 22. How long employed by you at this occupation? Check (√) Less than 6 months ....., 6 months to 1 year ....., over 1 year √ 23. What was employee doing when accident occurred? (Describe briefly, such as: loading truck, operating drill press, shoveling dirt, walking down stairs, etc.) INSULATING PIPES, DUCTS AND EQUIPMENT
24. How did the accident happen? (Describe fully, stating whether the injured person fell, was struck, etc.; give all factors contributing to accident. Use other side of report for additional space) ALLEGEDLY CAUSED "ASBESTOSIS" DUE TO WORKING WITH INSULATION MATERIAL. EMPLOYEE VOLUNTARILY QUIT ON 7-14-54 FOR SIMILAR TYPE OF WORK WITH ANOTHER EMPLOYER
25. What machine, tool, substance, or object was most closely connected with the accident? (Name the specific machine, tool, appliance, gas, liquid, etc., involved) .....
26. If mechanical apparatus or vehicle, what part of it? (State if gears, pulley, motor, etc.) .....
27. Were mechanical guards, or other safeguards provided? (Yes or No) ..... 28. Was injured using them? (Yes or No) .....
29. What do you recommend for preventing this type of accident? (State the specific preventive measures that can be taken by employer and workers. Do not say, "By being more careful." Specify what should or should not be done)

NATURE OF INJURY AND PART OF BODY AFFECTED

30. (Describe in detail the nature of the injury and the part of the body affected. For example: amputation of right index finger at second joint, fracture of ribs, lead poisoning, dermatitis of left hand, etc.) UNKNOWN
31. Name and address of physician .....
32. Name and address of hospital .....
33. Has employee returned to work? (Yes or No) ..... 34. If yes, give date ..... 35. At what wage? $ ..... per .....
36. Did injury result in death? (Yes or No) ..... 37. If yes, give date .....
38. In case of death, give name and address of nearest relative .....
39. Names and addresses of witnesses .....
40. Is injured related to Employer? No If so, how? .....

Date of this report 11-10-54

Signed by John E. Murphy (Signature) Official position Claims Examiner

Filing of this report is not an admission of liability. "... No report of injury required to be filed by an employer or an insurer by this chapter shall be admissible as evidence in any adversary ..."

PLAINTIFF'S

3-10-81 C.F.

COMMISSION OFFICES:
FOR NORTHERN CALIFORNIA (EXCEPT SACRAMENTO COUNTY)
525 Mission Street
San Francisco 5
FOR SACRAMENTO COUNTY ONLY
Room 200, 631 J Street
Sacramento
FOR SOUTHERN CALIFORNIA (EXCEPT SAN DIEGO COUNTY)
301 State Building
Los Angeles 12
FOR SAN DIEGO COUNTY ONLY
1521 Fourth Avenue
San Diego 1

STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
INDUSTRIAL ACCIDENT COMMISSION

APPLICATION FOR HEARING

AMENDED

Case No. 55[illegible] 161-870
Filed March 1, 1955

DO NOT WRITE IN THIS SPACE

ENTERED IN DOCKET
BY _____

FILED
MAR 1 1955
INDUSTRIAL ACCIDENT COMMISSION
SAN FRANCISCO

Employee's Name [illegible]

Employee's Address [illegible] Concord, California
STREET AND NUMBER — TOWN OR CITY — COUNTY — STATE

Social Security No. [illegible]

Name of Employer [illegible]

Employer's Address [illegible]
STREET AND NUMBER — TOWN OR CITY — COUNTY — STATE

Name of Insurance Carrier [illegible]

Insurance Carrier's Address [illegible]
STREET AND NUMBER — CITY — COUNTY — STATE

Employee's name [illegible]

Employee's date of birth [illegible]

Date of your injury 1944-1954

Employee's occupation at time of injury asbestos worker

Place where injury occurred San Francisco, Calif.
CITY AND STATE

When did you leave work as a result of this injury September 30, 1953. October 10, 1954

How did injury occur breathing asbestos dust in course of work thereof to chest & lungs.

What part or parts of your body were injured lungs

When did you return to work still disabled

Full or part time work and at what wage

Your wages or salary (before deductions) $ [illegible] per hour or $ _____ per week or $ _____ per month.

If paid on hourly rate, how many hours did you work per week _____

Did you receive any of the following: Board? Yes ☐ No ☐; Lodging? Yes ☐ No ☐; Tips? Yes ☐ No ☐; Other advantages? Yes ☐ No ☐

State their weekly value $ _____

Have you been paid any compensation? Yes ☐ No ☒ How much $ _____ (TOTAL AMOUNT) Weekly rate of payments $ _____

Date when last payment was made _____, 19__

Has the employer or the insurance carrier furnished you with any medical treatment? Yes ☐ No ☒

Date when last treatment was given _____, 19__

List names of all doctors who have treated you and who were furnished by the employer or insurance carrier. University of California

Have you obtained any medical treatment at your own expense? Yes ☒ No ☐.

List names of all doctors who have treated you at your own expense _____

Are you claiming any of the following benefits (Answer Yes or No):

(a) Temporary disability payments yes (b) Permanent disability payment _____

(c) Further medical treatment yes (d) Cost of your medical expense yes

(e) List other benefits claimed and not mentioned above _____

Have you ever before filed a claim with this Commission? Yes ☐ No ☒. If so, when was it filed _____ (DATE)

[illegible]
SIGNATURE OF ATTORNEY FOR APPLICANT

Financial Center Bldg., Oakland
ADDRESS

Glencourt 2 2000
TELEPHONE NUMBER

/s/ [illegible]
SIGNATURE OF APPLICANT

Date March 4, 1955

NOTICE—HEARINGS: After this application has been filed with the Industrial Accident Commission the parties will be notified in writing of the time and place of hearing. Either party may be represented by person, by attorney, or other agent.

ANSWER: The defendant is required to file an answer within 10 days after service of a copy of this application, using the form furnished for this purpose. If a defendant employer is insured and the insurance carrier is properly named in the application, an answer need be filed by the employer, or that will be done by the carrier; but if the insurance carrier is not named, then the employer should notify the carrier immediately so the proper answer can be filed.

DATE OF SERVICE _____ SERVED ON _____

EXHIBIT

3-10-81 (C.F.)

PLAINTIFF'S EXHIBIT #29 5-27-81

Re; JACK CUTHBERTSON IAC # 161-870 List of Employers

Plant Rubber & Asbestos Works,
5309 Horton St.,
Emeryville, Calif.

Western Asbestos Co.,
675 Townsend St., San Francisco, Calif.

J. T. Thorpe & Son,
Emeryville, Calif.

Mundet Cork Corp.,
440 Brannan St.,
San Francisco, Calif.

Cork Insulation Co.,
San Francisco, Calif.

Armstrong Cork Co.,
1355 Market St.,
San Francisco, Calif.

Plant Asbestos Co.,
5309 Horton St.,
Emeryville, Calif.

LIST OF INSURANCE COMPANIES

Travelers Insurance Co.,
Latham Square Bldg.,
Oakland, Calif.

Industrial Indemnity Co.,
350 Sansome St.,
San Francisco, Calif.

State Compensation Ins. Fund
630 McAllister St., San Francisco, Calif.

Pacific Employers Insurance Co.,
3770 Piedmont Ave., Oakland, Calif.

California Compensation Insurance Co.,
24 Geary St.,

(C.F.)

F/c with pertinent claim.

STATE OF CALIFORNIA

INDUSTRIAL ACCIDENT COMMISSION

900 Mission Street, San Francisco 3
416 Rolm Building, Fresno 21
Room 200, 801 J Street, Sacramento

State Building, Los Angeles 12
Room 514, 100 E. Ocean Blvd., Long Beach 2
1521 4th Avenue, San Diego 1

JACK CUTHBERTSON,

Applicant.

vs.

PLANT RUBBER AND ASBESTOS WORKS, ARMSTRONG CORK COMPANY, ARMSTRONG CORK CORPORATION, PLANT ASBESTOS COMPANY, WESTERN ASBESTOS COMPANY, J. T. THORPE AND SON, and TRAVELERS INSURANCE COMPANY, INDUSTRIAL INDEMNITY COMPANY, et al,

Defendants.

Claim No. Stockton 161-870

NOTICE OF HEARING OF APPLICATION FOR ADJUSTMENT OF CLAIM

PLAINTIFF EXHIBIT #76 5-27-

You are hereby notified that an application to adjust a claim for compensation (a copy of which is attached hereto) has been filed with the Industrial Accident Commission of the State of California. You are further notified that said application has been set for hearing at

Rm. 206, 1531 Webster St., Oakland, California, on the

23rd day of May, 1955, at 1:30 o'clock p.m. All p.m.

and that at said time and place the Industrial Accident Commission of the State of California will proceed to hear and dispose of the said application in the manner prescribed by law.

NOTE: The parties are expected to submit all issues in controversy for decision at this hearing; therefore, all necessary witnesses, evidence, documentary, medical reports, payrolls, and other essential proof must be available and ready for submission at the hearing.

Dated: April 25, 1955

INDUSTRIAL ACCIDENT COMMISSION

By EDMUND J. THOR..., Jr.

Assistant Secretary

The undersigned certifies that as an employee of the Industrial Accident Commission she served the foregoing notice on the parties hereinafter mentioned, at the time set opposite their respective names, by depositing a copy of said notice attached to a copy of the application therein mentioned, in a sealed envelope in the United States mail on said day, at San Francisco, California, with the postage thereon fully prepaid, and addressed to the said parties at their last known places of business or residence, as follows, to wit:

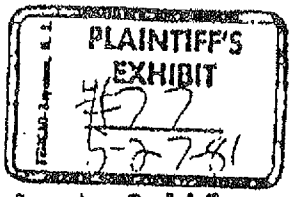
NAMES OF PARTIES SERVED	DATE OF SERVICE
see attached sheet	

[SIGNATURE] .....

EXHIBIT

3-10-81

(C.F.)



Dept. of Employ., P.O. Box 1657, Oakland, Calif. 4/25/55
Occidental Life Ins. Co., 300 Montgomery St., S.F., Calif. "
Jack Cuthbertson, 2264 Holbrook Dr., Concord, Calif. "
Smith & Parrish, Fin. Center Bldg., Oakland, Calif. "
Plant Rubber & Asbestos Works, 5309 Horton St., Emeryville, Cal. "
Armstrong Cork Co., 1355 Market St., S.F., Calif. "
Mundet Cork Corp., 440 Brannan St., S.F., Calif. "
Plant Asbestos Co., 5309 Horton St., 5309 Horton St., Emeryville, "
Western Asbestos Co., 675 Townsend St., S.F., Calif. "
J. T. Thorpe & Son, Emeryville, Calif. "
Travelers Ins. Co., Latham Square Bldg., Oakland, Calif. "
Indus. Indem. Co., 350 Sansome St., S.F., Calif. "
State Comp. Ins. Fund, Personal Service "
Pacific Employ. Ins. Co., 3770 Piedmont Ave., Oakland, Calif. "
Calif. Compensation Ins. Co., 26 Geary St., S.F., Calif. "

vux

COPY