HOME OFFICE
Bituminous Casualty Corporation
Cleaveland Building
Rock Island, Ill.

STATE OF ILLINOIS

INDUSTRIAL COMMISSION

205 W. WACKER DRIVE, CHICAGO, ILLINOIS

Occupational Disease Number

Report of Disablement From Occupational Disease

FILL OUT COMPLETELY! Occupational disease resulting in death must be reported immediately. All others should be reported within two weeks.

Has this occupational disease resulted in death, (yes or no)? No Ins. Co. File Number

Employer Address

(1) Employer's Name: John R. MacGregor Lead Company
(2) Doing business under name of:
(3) Office address, Street and No.: 4520 W. 15th Street
City: Chicago County: Cook

Insurance and Business

(4) Name of compensation insurance carrier: Bituminous Casualty Corp.
(5) If not insured, what arrangements have you made to cover workmen's compensation payments:

(6) Business (goods produced, kind of work done, kind of trade or transportation): lead manufacturer

Place and Time

(7) Name of plant or place where occupational disease occurred: John R. MacGregor Lead
Street and No.: 4520 W. 15th Street
City: Chicago County: Cook
(8) Date of disablement: April 5, 1960 19
(9) Date injured ceased work: 19

Employee

(10) Employee's Name: Casimir Perz (11) Sex: Male
(12) Address: Street and No.: 1729 N. Sayre City: Chicago
(13) Age (as of last birthday): 43 (14) Birth date (If under 18 yrs. of age):
(15) Number of employment certificate (if injured is under 16):
(16) Date issued (17) Place issued (18) For what job:
(19) Occupation: Foreman (20) Hours per day: per week: days per week:
(21) How long employed? 14 years (22) Piece or Time Worker:
(23) Wages per Hr. $ (24) Day Shift or Night Shift Worker:
(25) Average weekly wages: $ (26) If board, lodging, fuel or other advantages were furnished in addition to wages, give estimated value per day, week or month:
(27) Single, married, widowed, divorced: Married (28) How many children under 16 yrs. of age: None

Cause of Accident

(29) Describe clearly and definitely how occupational disease occurred: On and off had pain in shoulders, elbows and was feeling poorly, nauseated in AM with metallic taste in his mouth
(30) (a) Was safety appliance or regulation provided? yes
(b) Was it in use at time? yes

Nature and Extent of Disease

(31) State exactly the nature of the disablement (silicosis, lead posoning, etc.) pain in elbows and shoulders, nauseated in AM
(32) Was there an amputation: No Mark exact point of amputation or dismemberment on chart on reverse side of report. (38) Attending doctor or hospital name and address:
(33) Has employee returned to work: Yes (34) When (give date):
(35) At what occupation: (36) What wage:

Occupational Disease Resulting in Death

(37) Date of Death: (38) Length of disability before death:
(39) Name of nearest Relative of deceased:
(40) Address; Street and No.: City:

(41) Date of this report: 6/14/60 (42) Signed:
(43) Position: President

Form OD-45