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tem presented no abnormalities except for the clubbing of the fingers previously noted.

X-ray examination of the chest was made by Dr. Hillyer Rudisill, who reported as follows: "First examination, Jan. 12, 1934: There is a generalized fibrosis throughout both lungs, particularly in the bases. There is generalized increased density in the right base probably caused by pleural thickening. In addition I believe there are bronchiectatic areas through the lower halves of both lungs.

"Impression: Pulmonary fibrosis, pleural thickening (particularly right base), and bronchiectasis, probably the results of inhalation of some irritant material."

FIG. 2. ASBESTO-SILICOSIS WITH CARCINOMA OF LOWER LOBE

The tuberculin (Mantoux), and Wassermann tests were negative. No tubercle bacilli were found in the sputum on numerous examinations. Asbestosis bodies were present in unconcentrated viscid, tough mucopus. Tests for fungi were negative. The urinary findings were normal. Blood counts were as follows: Jan. 11, 1934: hemoglobin 80 per cent (Dare), leukocytes 15,525, small and large lymphocytes 11, large mononuclears 3, neutrophils 86; Feb. 20, 1934: hemoglobin 72 per cent (Dare), leukocytes 13,250, small lymphocytes 18, large mononuclears 4, neutrophils 76, eosinophils 2.

The admission diagnosis was pulmonary fibrosis and pleurisy with effusion. The final diagnosis was asbestosis and chronic indurative pneumonia.

Autopsy (B.G.) No. 20514–34–58, March 17, 1934: Summary of pathological diagnoses: Fibrosis of lungs; pulmonary asbestosis; epider-