Form 45-
A. D. WILES CO., Indianapolis
W. C. Forms for All States

STATE OF ILLINOIS

INDUSTRIAL COMMISSION
160 No. LaSalle St., Chicago 1, Ill.

EMPLOYER'S REPORT OF COMPENSABLE INJURY

(Copy should be sent immediately to Insurance Carrier)

Accident Number _____

Employers must report to the Commission on Form 45 between the 15th and 25th of EACH MONTH all compensable injuries. In case of DEATH report IMMEDIATELY.

EMPLOYER:

1. Name American Cyanamid Company
2. Doing business under the name of: American Cyanamid Company Successor to MacGregor Lead
3. Address, Street and No. 4500 West 15th Street City Chicago
4. Nature of Business: Lead Chemical Manufacturer
5. Name of compensation insurance carrier:

INJURED EMPLOYEE:

1. Name: Robert Coburn
2. Address, Street and No.: 4149 West 21st Place City Chicago
3. Sex: Male
4. Marital Status Married
5. Age: 53 years
6. Occupation Ball Mill Operator
7. Average Weekly Earnings: 143.20
8. No. of Children under 18 years of age: ~~XXXXX~~ Five

INJURY:

1. Date of injury: June 7, 1971
2. Hour:
3. How did injury happen: Lead Absorption with Pending Lead Intoxication
4. What was employee doing when accident occurred? Operating Ball Mill
   (Describe briefly, such as loading truck, operating drill press, shoveling sand, etc.)
5. Name of machine, tool, substance, or object most closely connected with the accident: Ball Mill
   (Name the machine, tool, appliance, gas, liquid, etc., involved)
6. If machine or vehicle, what part of it?
   (State if gears, pulley, point of operation, etc.)
7. Where: Street and No. 4500 West 15th St., City Chicago, State Illinois
8. Describe injury (if specific loss, give date of loss) Lead Absorption with Pending Lead Intoxication
9. Length of disability (if undetermined give estimate) 7 weeks

COMPENSATION IN NON-FATAL CASES:

1. Is compensation being paid? No
2. To whom?
3. Rate of compensation: Date of First Payment:
4. Intervals of payment:
5. Are medical and hospital services being furnished? Yes
6. By whom? Clearing Industrial Clinic & American Cyanamid Company

COMPENSATION IN FATAL CASES:

1. Has compensation been paid?
2. To whom?
3. State relationship to deceased:
4. Rate of compensation: Date of First Payment:
5. Intervals of payment:
6. Length of disability prior to death:
7. Have funeral and burial expenses been paid?
8. By whom?
9. Date of this report: 8/30/71
10. Signed: R. I. Bell
11. Position: Manager/MacGregor Products

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Accident Number _____

Employers must report to the Commission on Form 45 between the 15th and 25th of EACH MONTH all compensable injuries. In case of DEATH report IMMEDIATELY.

EMPLOYER:

1. Name AMERICAN CYANAMID COMPANY
2. Doing business under the name of: American cyanamid Company Successor to MacGregor Lead
3. Address, Street and No. 4500 West 15th Street City Chicago
4. Nature of Business: Lead Chemical Manufacturer
5. Name of compensation insurance carrier: _____

INJURED EMPLOYEE:

1. Name: Robert Coburn
2. Address, Street and No.: 4149 West 21st Place City Chicago
3. Sex: Male 4. Marital Status Married
5. Age: 53 years 6. Occupation Ball Mill Operator
7. Average Weekly Earnings: 143.20
8. No. of Children under 18 years of age: Five

INJURY:

1. Date of injury: December 21 1971 2. Hour: 11:15 am
3. How did injury happen: While walking in the area of the north elevator, W. Lee was climbing ladder when a wrench dropped from his pocket and hit Robert Coburn on the head .
4. What was employee doing when accident occurred? Walking from one area to another
   (Describe briefly, such as loading truck, operating drill press, shoveling sand, etc.)
5. Name of machine, tool, substance, or object most closely connected with the accident: A wrench
   (Name the machine, tool, appliance, gas, liquid, etc., involved)
6. If machine or vehicle, what part of it? _____
   (State if gears, pulley, point of operation, etc.)
7. Where: Street and No. 4500 W. 15th Street, City Chicago, State Ill.
8. Describe injury (if specific loss, give date of loss) Bump on the head
9. Length of disability (if undetermined give estimate) _____

COMPENSATION IN NON-FATAL CASES:

1. Is compensation being paid? No
2. To whom? _____
3. Rate of compensation: _____ Date of First Payment: _____
4. Intervals of payment: _____
5. Are medical and hospital services being furnished? _____
6. By whom? _____

COMPENSATION IN FATAL CASES:

1. Has compensation been paid? _____
2. To whom? _____
3. State relationship to deceased: _____
4. Rate of compensation: _____ Date of First Payment: _____
5. Intervals of payment: _____
6. Length of disability prior to death: _____
7. Have funeral and burial expenses been paid? _____
8. By whom? _____
9. Date of this report: _____ 10. Signed: R K Foster
11. Position: _____

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