FILE NAME: WR Grace (WRG)

DATE: March 9, 1966

DOC#: WRG135

DOCUMENT DESCRIPTION: 1966 Correspondence from Claims Examiner to California Zonolite Company regarding workmens compensation claim

Argonaut Insurance Companies
1001 WILSHIRE BOULEVARD • LOS ANGELES, CALIFORNIA 90017

March 9, 1966

California Zonolite Company
5440 San Fernando Road
Los Angeles, California

File No :: 02X-197974
Employee : William A. Locke
Employer : California Zonolite Company
Inj.Date : 8/30/63 approx.

Gentlemen :

Mr. William A. Locke has filed an application before the Industrial Accident Commission in which he alleges an apparent lung condition resulting from employment with your concern, between October of 1956 and March 3, 1965.

This application was originally filed against your current carrier, Aetna Casualty & Surety Company and this firm has now been joined in that application.

All records indicate that we apparently had coverage for your concern from 1953 through 9/1/63 and thus we would appreciate receiving certain information from you so that a proper defense may be made in this matter. Would you please advise the exact periods of time that Mr. Locke worked for you, a complete description of his job duties and his rate of pay.

We would also appreciate your advising the circumstances surrounding his injury of 3/3/65. Any other information that you may have would be greatly appreciated.

Yours very truly,

R. B. WINDLING
CLAIMS EXAMINER

m
cc: Mr. John Granger

04210809

EMPLOYER'S REPORT OF INDUSTRIAL INJURY

STATE OF CALIFORNIA
Department of Industrial Relations
Division of Labor Statistics and Research

Complete in Triplicate and send immediately to
The Ætna Casualty and Surety Company

LOS ANGELES 2404 Wilshire Blvd. | SAN DIEGO 1400 Fifth Ave.
SANTA ANA 2215 No. Broadway | SAN BERNARDINO 157 West 5th Street
SAN FERNANDO VALLEY 8155 Van Nuys Blvd. | INGLEWOOD 2930 West Imperial

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 6407-6411)

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 directly to the Division of Labor Statistics and Research, San Francisco, not later than 24 hours after death.

EMPLOYER

1. Name (Give name under which concern does business) California Zonolite Co. Policy No. 33-C84171
2. Office address (No. and Street) 758 Colorado Blvd. (City or Town) Los Angeles
3. Nature of business (Manufacturing shoes, retailing men's clothes, trucking for hire, etc.) Processor of Vermiculite

INJURED EMPLOYEE

4. Name Wm. Locke Social Security No. 163-10-0679
5. Address (No. and Street) 4701 Lowell Avenue (City or Town) La Crescenta
6. Age 60 7. Sex: Check (V) Male X Female 8. Check (V) Married X Single
9. Number of hours worked per day 8; per week 40 Number of days worked per week 5
10. Wages: $2.73 per hour, or $ per day, or $ 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 $ per day, or $ per week

ACCIDENT

12. Place of accident (No. and Street) (City or Town) (County)
13. On employer's premises (Yes or No) 14. Department
15. Date of accident No 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 4-1-65 19. Was injured paid in full for this day? (Yes or No) 20. If injured in a mine, check (V) accident location: Surface Mill Underground Shaft

CAUSE OF ACCIDENT

21. Occupation (job title) Warehouseman 22. How long employed by you at this occupation? Check (V) 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.)
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)
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. In what way was the machine, tool, or object defective?
30. 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

31. (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.)
32. Name and address of physician Dr. Melvin J. Schilling-1369 Foothill-La Canada
33. Name and address of hospital (Phone No. 790-5314)
34. Has employee returned to work? (Yes or No) No 35. If yes, give date 36. At what wage? $ per
37. Did injury result in death? (Yes or No) 38. If yes, give date
39. In case of death, give name and address of nearest relative
40. Is injured employee related to employer? No.

Signed by Signature Official position Date of this report 5-25-65

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 | Mech. Defect | Unsafe Act | Personal Defect | Nature of Injury | Location | Extent of Injury | Insurance Carrier | Report Lag | Coded by

C 1219 A

Filing of this report is not an admission of liability.

DOCTOR'S FIRST REPORT OF WORK INJURY

STATE OF CALIFORNIA 04210810
DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF LABOR STATISTICS AND RESEARCH
P. O. Box 965, San Francisco 1

Immediately after first examination mail one copy directly to the Division of Labor Statistics and Research. Failure to file a report wit the Division is a misdemeanor. (Labor Code, Sections 6407-6413.) Answer all questions fully.

A. INSURANCE CARRIER: Aetna Life & Casualty

Do not write in this space

1. EMPLOYER: California Zonolite Company
2. Address (No., St. & City): 5440 San Fernando Road West Los Angeles 39
3. Business (Manufacturing dept., building construction, retailing men's clothing, etc.): Insulation Mfg.

4. EMPLOYEE (First name, middle initial, Last name): [redacted]
5. Address (No., St. & City): 4311 Lowell, La Crescenta Calif.
6. Occupation: Furnace Operator Age: 60 Sex: M
7. Date injured: ~~Monday~~ 3/7/65 Hour: M. Date last worked: 3/11/65
8. Injured at (No., St. & City): 5440 San Fernando Road West County: Los Angeles
9. Date of your first examination: 3/11/65 Hour: 9 A.M. Who engaged your services? Patient
10. Name other doctors who treated employee for this injury: None I. Holt Robison Internist 4/15/65 3153 Los Feliz, L.A.

11. ACCIDENT OR EXPOSURE: Did employee notify employer of this injury? Yes Employee's statement of cause of injury or illness: Patient did not know cause

12. NATURE AND EXTENT OF INJURY OR DISEASE (Include all objective findings, subjective complaints, and diagnosis. occupational disease state date of onset, occupational history, and exposure.) Onset - 3/7/65

Diag: Pneumoconiosis due to inhalation of a combination of duponol and/or/ sodium nitrate and/or titanium and/or asbestos and/or vermiculite and/or C9.

Degree of exposure: 7 years of blending acoustical materials-furnace running 2 years to 4/1/65 giving exposure to vermiculite, C9 and asbestos.

13. X-rays: By whom taken? (Date if done): Drs. Office - PA of Chest (4)-3/17, 4/1, 4/15, 5/12
Findings: Peribronchial fibrosis and evidence of Pneumoconiosis

14. Treatment: Expectorants; bronchial dilators; Heteril IM
Avoidance of above irritants (item 12)

15. Kind of case (Office, home or hospital): Office If hospitalized, date: Estimated stay:
Name and address of hospital:
16. Further treatment: (Continuing treatment and duration): Weekly-Predicated on no further exposure to irritant
17. Estimated period of disability: For Regular work: Permanent for further exposure to above materials. Modified work: inhalants approx. 2-3 mos
18. Describe any permanent disability or disfigurement expected (Date if done): Still guarded As above
19. If death ensued, date:
20. REMARKS (Note any pre-existing injuries or diseases, need for special examination or laboratory tests, other pertinent information.)

Lab: Histoplasmin and coccidiordin skin tests. Sputum culture, antibiotic sensitivity. Definitive papanicolaou smear.

Off work from 3/11/65 to present-See above (17.)

Name: Melvin J. Schilling (Type or print) Degree: M.D. [PERSONAL SIGNATURE OF DOCTOR] Melvin J Schilling MD

Date of report: 6/4/65 Address (No., St. & City): 1369 Foothill Blvd. La Canada

FORM B021 *Use reverse side if more space required* B3000-807 10-64 80M E OSP

04210811

Argonaut Ins. 1001 Wilshire Blvd.

STATE OF CALIFORNIA

DOCTOR'S FIRST REPORT OF WORK INJURY

STATE COMPENSATION INSURANCE FUND

600 SOUTH LAFAYETTE PARK PLACE, LOS ANGELES 54

FILL OUT AND FORWARD 1 COPY IMMEDIATELY AFTER FIRST SEEING PATIENT

ALSO, immediately after first examination mail one copy directly to the Division of Labor Statistics and Research, P. O. Box 965, San Francisco 1.
Failure to file a report with the Division is a misdemeanor. (Labor Code, Sections 6407-6413.)
Answer all questions fully.

CASE NO.

Do not write in this space

1. EMPLOYER Calif. Zonolite
2. Address (No., St. & City) 5140 San Fernando Rd., West, L. A. 39
3. Business (Manufacturing shoes, building construction, retailing men's clothes, etc.) Insulation Mfg.

4. EMPLOYEE (First name, middle initial, last name) [redacted]
5. Address (No., St. & City) 8721 Lowell, La Crescenta, Calif.
6. Occupation Furnace Opr. Age 36 Sex M.
7. Date injured 4-13-59 Hour 2P. M Date last worked 4-13-59
8. Injured at (No., St. & City) 5140 San Fernando Rd., West, L. A. 39 County L. A.
9. Date of your first examination 4-14-59 Hour 9:00A M Who engaged your services? Patient
10. Name other doctors who treated employee for this injury

11. ACCIDENT OR EXPOSURE: Did employee notify employer of this injury? Yes. Employee's statement of cause of injury or illness:
Lifting asbestos 100 lb. sack, threw off balance, and injured my low back in middle.

12. NATURE AND EXTENT OF INJURY OR DISEASE (Include all objective findings, subjective complaints, and diagnoses. If occupational disease state date of onset, occupational history, and exposure.)
Moderate-severe muscle-ligamentous strain of the lumbo sacral area of the spine.

13. X-rays: By whom taken? (State if none) None
Findings:

14. Treatment: Physio-therapy, adhesive strapping.

15. Kind of case (Office, home, or hospital) Office. If hospitalized, date Estimated stay
Name and address of hospital
16. Further treatment (Estimated frequency and duration) 3-4 weeks, 3 times weekly
17. Estimated period of disability for: Regular work 7-10 days Modified work 3-5 days.
18. Describe any permanent disability or disfigurement expected (State if none) None expected.
19. If death ensued, give date

20. REMARKS (Note any pre-existing injuries or diseases, need for special examination or laboratory tests, other pertinent information.)
Injured back on fall several weeks ago; recovered o.k.

1.—ONLY UNDER EXCEPTIONAL CIRCUMSTANCES WILL A HERNIA BE CONSIDERED DISABLING PRIOR TO OPERATION.
...E INJURED SHOULD BE ADVISED TO CONTINUE WORK, IF POSSIBLE, UNTIL NOTIFIED THAT HIS CLAIM IS ACCEPTED.

Name Melvin J. Schilling Degree D.O. (Type or print) PERSONAL SIGNATURE OF DOCTOR Melvin J. Schilling

Date of report 4-20-59 Address (No., St. & City) 1369 Foothill Blvd., La Canada, Calif.

FORM 10-LA

Use reverse side if more space required

04210812

DOCTOR'S FIRST REPORT OF WORK INJURY

STATE OF CALIFORNIA
STATE COMPENSATION INSURANCE FUND
600 SOUTH LAFAYETTE PARK PLACE, LOS ANGELES 54

FILL OUT AND FORWARD 1 COPY IMMEDIATELY AFTER FIRST SEEING PATIENT

ALSO, immediately after first examination mail one copy directly to the Division of Labor Statistics and Research, P. O. Box 965, San Francisco 1. Failure to file a report with the Division is a misdemeanor. (Labor Code, Sections 6407-6413.)

Answer all questions fully. Argonaut Ins. Co. 1001 Wilshire, L.A. CASE NO. ______

Do not write in this space

1. EMPLOYER Calif. Zonolite Co.
2. Address (No., St. & City) [illegible] San Fernando Rd., West... L. A. 39
3. Business (Manufacturing shoes, building construction, retailing men's clothes, etc.) Insulation Mfg.

4. EMPLOYEE (First name, middle initial) [redacted]
5. Address (No., St. & City) 4701 Lowell, La Crescenta, Calif.
6. Occupation Furnace Operator Age [illegible] Sex M.
7. Date injured 2-11, 3 P.M., 2-20-59 Hour 11 A. M Date last worked 2-25-59
8. Injured at (No., St. & City) [illegible] San Fernando Rd., W. L. A. 39 County L.A.
9. Date of your first examination 2-25-59 Hour 8:30 PM Who engaged your services? Patient
10. Name other doctors who treated employee for this injury No

11. ACCIDENT OR EXPOSURE: Did employee notify employer of this injury? Yes. Employee's statement of cause of injury or illness: "On 2-11-59 slipped on wet floor, hit back of head, and since then neck hurts constantly. On 2-20-59 the same thing occurred again, slipped on wet floor, hit back of head again and neck is still sore".

12. NATURE AND EXTENT OF INJURY OR DISEASE (Include all objective findings, subjective complaints, and diagnoses. If occupational disease state date of onset, occupational history, and exposures.)
Moderate-severe musculo-ligamentous sprain, cervical spine.

13. X-rays: By whom taken? (State if none) 5 vws. Cervical spine, Dr. M.J. Schilling, D.O.
Findings: Negative for fracture, Positive for old healed fracture of body of 3rd cervical, moderate-severe osteoarthritis of cervical spine.

14. Treatment: Physio-therapy as diathermy, intermittent traction.

15. Kind of case (Office, home or hospital) Office. If hospitalized, date ______ Estimated stay ______
Name and address of hospital ______
16. Further treatment (Estimated frequency and duration) 4-6 weeks Twice to once weekly.
17. Estimated period of disability for: Regular work No Modified work No
18. Describe any permanent disability or disfigurement expected (State if none) None expected.

19. If death ensued, give date ______
20. REMARKS (Note any pre-existing injuries or diseases, need for special examination or laboratory tests, other pertinent information.)
Probable old injury. (See above X-ray report)

—ONLY UNDER EXCEPTIONAL CIRCUMSTANCES WILL A HERNIA BE CONSIDERED DISABLING PRIOR TO OPERATION. THE INJURED SHOULD BE ADVISED TO CONTINUE WORK, IF POSSIBLE, UNTIL NOTIFIED THAT HIS CLAIM IS ACCEPTED.

Name Melvin J. Schilling, D.O. Degree ______ PERSONAL SIGNATURE OF DOCTOR Melvin J. Schilling
(Type or print)

Date of report 3-4-59 Address (No., St. & City) 1369 Foothill Blvd., La Canada, Calif.

FORM 10-LA

Use reverse side if more space required

S. AUSTIN JONES, M.D. AND ASSOCIATES
660 WEST BROADWAY, GLENDALE 4, CALIF.
CITRUS 2-4166 CHAPMAN 5-2812

04210813

DOCTOR'S FIRST REPORT OF WORK INJURY

Immediately after first examination mail one copy directly to the Division of Labor Statistics and Research, P. O. Box 965 San Francisco. Failure to file a report with the Division is a misdemeanor. (Labor Code, Sections 6407-6413.) Answer all questions fully.

A. INSURANCE CARRIER Aetna Insurance Company

Do not write in this space

1. EMPLOYER Californiaelite Company
2. Address (No., St. & City) 5440 San Fernando Rd. Glendale Phone
3. Business (Manufacturing shoes, building construction, retailing men's clothes, etc.)

4. EMPLOYEE (First name, middle initial, last name) [redacted]
5. Address (No., St. & City) 4708 Lowell Ave. La Crescenta Phone Ch 82626
6. Occupation Furnace Operator Age 52 Sex M
7. Date Injured 12-1-56 Hour M Date last worked
8. Injured at (No., St. & City) 5440 San Fernando Rd. Glendale County Los Angeles
9. Date of your first examination 3-12-57 Hour 8:00 A.M. Who Engaged your services? Employer
10. Name other doctors who treated employee for this injury Dr. Schilling Foothill Blvd. La Canada

11. ACCIDENT OR EXPOSURE: Did employee notify employer of this injury? Employee's statement of cause of injury or illness:

"Last December I noticed a breaking out on my HANDS, before this I had worked in a filling station where I had the same trouble from an allergy to gasoline."

12. NATURE AND EXTENT OF INJURY OR DISEASE (Include all objective findings, subjective complaints, and diagnoses. If occupational disease state date of onset, occupational history, and exposures.)

There is an erythematous exfoliating eruption of both hands and forearms suggesting a contact allergic dermatitis.

13. X-rays: By whom taken? (State if none) None
Findings:

14. Treatment: To be tested for contacts.

15. Kind of case (Office, home, or hospital) office If hospitalized, date Estimated stay
Name and address of hospital
16. Further treatment (Estimated frequency and duration) depends on tests
17. Estimated period of disability for: Regular work Modified Work
18. Describe any permanent disability or disfigurement expected (State if none)
19. If death ensued, give date
20. REMARKS (Note any pre-existing injuries or diseases, need for special examination or laboratory tests, other pertinent information.)

S. AUSTIN JONES, M.D. AND ASSOCIATES

DATE 3-12-57 19 By M

© C-7836

EMPLOYER'S COPY

04210794

Argonaut Insurance Companies

1001 WILSHIRE BOULEVARD • LOS ANGELES, CALIFORNIA 90017

March 9, 1966

California Zonolite Company
5440 San Fernando Road
Los Angeles, California

File No :: 02X-197974
Employee : William A. Locke
Employer : California Zonolite Company
Inj.Date : 8/30/63 approx.

Gentlemen :

Mr. William A. Locke has filed an application before the Industrial Accident Commission in which he alleges an apparent lung condition resulting from employment with your concern, between October of 1956 and March 3, 1965.

This application was originally filed against your current carrier, Aetna Casualty & Surety Company and this firm has now been joined in that application.

All records indicate that we apparently had coverage for your concern from 1953 through 9/1/63 and thus we would appreciate receiving certain information from you so that a proper defense may be made in this matter. Would you please advise the exact periods of time that Mr. Locke worked for you, a complete description of his job duties and his rate of pay.

We would also appreciate your advising the circumstances surrounding his injury of 3/3/65. Any other information that you may have would be greatly appreciated.

Yours very truly,

R. B. WINDLING
CLAIMS EXAMINER

m
cc: Mr. John Granger

40071354

04210735

DOCTOR'S FIRST REPORT OF WORK INJURY

STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF LABOR STATISTICS AND RESEARCH
P. O. Box 965, San Francisco 1

Immediately after first [illegible] mail one copy directly to the Division of Labor Statistics and Research. Failure to file a report wit the Division is a misdemeanor (Labor Code, Sections 6407-6413.) Answer all questions fully.

A. INSURANCE CARRIER: Aetna Life & Casualty

Do not write in this space

1. EMPLOYER: [redacted] Company
2. Address (No. & St. & City): 9441 San Fernando Road West Los Angeles 39
3. Business (Manufacturing, selling, what kind of service, etc.): Insulation Mfg.

4. EMPLOYEE: [redacted] Louis
5. Address (No. & St. & City): [redacted] La Crescenta Calif.
6. Occupation: Furnace Operator Age 60 Sex M
7. Date injured: 3/7/65 Hour [blank] M. Date last worked 3/11/65
8. Injured at (No. & St. & City): 9441 San Fernando Road West County Los Angeles
9. Date of your first examination: 3/17/65 Hour 9 A.M. Who engaged your services? Patient
10. Name other doctors who treated employee for this injury: George J. Holt Robison Internist 4/15/65 3153 Los Feliz, L.A.

11. ACCIDENT OR EXPOSURE: Did employee notify employer of this injury? Yes Employee's statement of cause of injury or illness: Patient did not know cause

12. NATURE AND EXTENT OF INJURY OR DISEASE (Include all objective findings, subjective complaints, and diagnoses. If occupational disease state date of onset, occupational history, and exposures.) Onset – 3/7/65

Diag: Pneumoconiosis due to inhalation of a combination of duponol and/or/ sodium nitrate and/or titanium and/or asbestos and/or vermiculite and/or C9.

Degree of exposure: 7 years of blending acoustical materials-furnace running 2 years to 4/1/65 giving exposure to vermiculite, C9 and asbestos.

13. X-rays: By whom taken? (Date if done) Drs. Office - PA of Chest (4)-3/17, 4/1, 4/15, 5/12
Findings: Peribronchial fibrosis and evidence of Pneumoconiosis

14. Treatment: Expectorants; bronchial dilators; Heteril IM
Avoidance of above irritants (item 12)

15. Kind of case (Office, home or hospital): Office If hospitalized, date [blank] Estimated stay [blank]
Name and address of hospital [blank]
16. Further treatment (Institutional treatment and duration): Weekly-Predicated on no further exposure to irritant
17. Estimated period of disability for: Regular work Permanent for further Modified work inhalants approx. 2-3 mos
18. Describe any permanent disability or disfigurement expected (Date if done): exposure to above materials. Still quizzed
As above
19. If death ensued, give date [blank]

20. REMARKS (Note any pre-existing injuries or diseases, need for special examination or laboratory tests, other pertinent information.)

Lab: Histoplasmin and coccidiordin skin tests. Sputum culture, antibiotic sensitivity. Definitive papanicolaou smear.

Off work from 3/11/65 to present.-See above (17.)

Name Melvin J. Schilling (Type or print) Degree M.D. [PERSONAL SIGNATURE OF DOCTOR] Melvin J Schilling MD

Date of report 5/4/65 Address (No. & St. & City) 1369 Foothill Blvd. La Canada

40071355

FORM 5021 *Use reverse side if more space required*

WORK INJURY

P. O. Box 963, San Francisco 1

Immediately after first examination mail one copy directly to the Division of Labor Statistics and Research. Failure to file a report wit the Division is a misdemeanor. (Labor Code, Sections 6409-6413.) Answer all questions fully.

A. INSURANCE CARRIER: Aetna Life & Casualty

1. EMPLOYER: [illegible] Conolite Company
2. Address (No. & St. & City): 8440 San Fernando Road West Los Angeles 39
3. Business (Manufacturing, retailing, what kind of goods): Insulation Mfg.

4. EMPLOYEE (Full name): William Locke
5. Address (No. & St. & City): [illegible] Dalewell, La Crescenta Calif.
6. Occupation: Furnace Operator — Age: 60 — Sex: M
7. Date injured: [illegible] 3/11/65 — Hour: ___ M. — Date last worked: 3/11/65
8. Injured at (No. & St. & City): 8440 San Fernando Road West — County: Los Angeles
9. Date of your first examination: 3/11/65 — Hour: 9 A.M. — Who engaged your services? Patient
10. Name other doctors who treated employee for this injury: Glenn L. Holt Robison Internist 4/15/65 3153 Los Feliz, L.A.

11. ACCIDENT OR EXPOSURE: Did employee notify employer of this injury? Yes — Employee's statement of cause of injury or illness: Patient did not know cause

12. NATURE AND EXTENT OF INJURY OR DISEASE (Include all objective findings, subjective complaints, and diagnosis. If occupational disease state date of onset, occupational history, and exposure.) Onset - 3/7/65

Diag: Pneumoconiosis due to inhalation of a combination of duponol and/or/ sodium nitrate and/or titanium and/or asbestos and/or vermiculite and/or C9.

Degree of exposure: 7 years of blending acoustical materials-furnace running 2 years to 4/1/65 giving exposure to vermiculite, C9 and asbestos.

13. X-rays: By whom taken? (Date if same): Drs. Office - PA of Chest (4)-3/17, 4/1, 4/15, 5/12
Findings: Perbronchial fibrosis and evidence of Pneumoconiosis

14. Treatment: Expectorants; bronchial dilators; Heteril IM
Avoidance of above irritants (item 12)

15. Kind of case (Office, home or hospital): Office — If hospitalized, date: ___ — Estimated stay: ___
Name and address of hospital: ___
16. Further treatment (Indicate frequency and duration): Weekly-Predicated on no further exposure to irritant
17. Estimated period of disability for regular work: Permanent for further exposure to above materials. — Probable duration of disability for modified work: inhalants approx. 2-3 mos
18. Describe any permanent disability or disfigurement expected (Date if same): As above — Still employed
19. If death ensued, [illegible]

20. REMARKS (Note any pre-existing injuries or diseases, need for special examination or laboratory tests, other pertinent information.)

Lab: Histoplasmin and coccidiordin skin tests. Sputum culture, antibiotic sensitivity. Definitive papanicolaou smear.

Off work from 3/11/65 to present-See above (17.)

Name: Melvin J. Schilling (Type or print) — Degree: M.D. — [PERSONAL SIGNATURE OF DOCTOR] Melvin J Schilling MD

Date of report: 5/4/65 — Address (No. & St. & City): 1360 Foothill Blvd. La Canada

FORM 5021 — *Use reverse side if more space required*

0421080S

ZONOLITE

CONSTRUCTION PRODUCTS DIVISION

04210773

SEP 7 1982

INTER-OFFICE CORRESPONDENCE

TO: Richard Jung

DATE: September 2, 1982

FROM: T. E. Winkel

SUBJECT: Employee Files

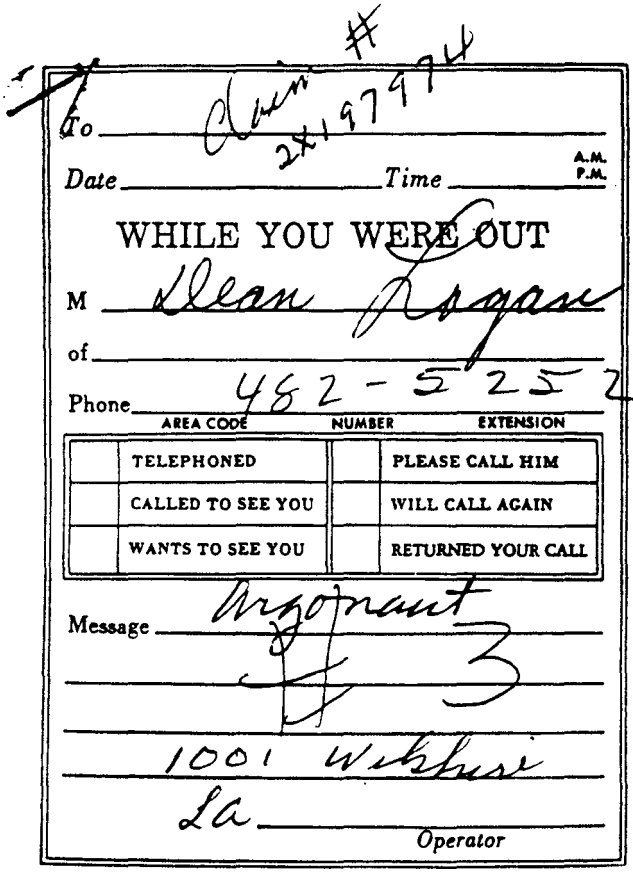
cc: M. M. McDaniel
W. R. Wright
P. B. Rief

Find enclosed the personnel files for Williams Locke and Frank Alverdrez (Los Angeles plant employees) which you requested. The file for Bill Moody (Sacramento plant) can not be located. Please return these files to the attention of Milt McDaniel upon completion of your need.

TEW/jdy

Thomas Elwinkel

04210774



To Clem # 2x1979

Date _____ Time _____ A.M. P.M.

WHILE YOU WERE OUT

M Dean Regan

of _____

Phone 482-5252
AREA CODE NUMBER EXTENSION

	TELEPHONED		PLEASE CALL HIM
	CALLED TO SEE YOU		WILL CALL AGAIN
	WANTS TO SEE YOU		RETURNED YOUR CALL

Message Argonaut

4 3

1001 Wilshire

La _____
Operator

328 P