FILE NAME: Ford (FD)

DATE: 1977-1983

DOC#: FD046

DOCUMENT DESCRIPTION: Workmen's Comp Claim with Medical Records

Form C.D.-1

INSTRUCTIONS: In accordance with Section 1441.99 of THE OHIO WORKMEN'S COMPENSATION ACT, every employer shall keep a record of ALL injuries received by his employees in the course of their employment and report these injuries to The Industrial Commission on forms provided for that purpose. THIS IS AN APPLICATION FOR PAYMENT OF COMPENSATION AND MEDICAL EXPENSES. Use this Form when disease causes disability of more than seven days. Part I of this form must be completed and signed by the disabled employee. Part II of this form must be executed by the employer by whom applicant was employed when his disability began, or his authorized agent. Part III of this form must be executed by the attending physician. Applications for compensation for occupational disease are forever barred unless filed with The Industrial Commission of Ohio within SIX MONTHS after disability due to the disease began, EXCEPT in cases of claims for disability from SILICOSIS or DISEASES of the RESPIRATORY TRACT resulting from injurious exposure to dusts in which cases applications are forever barred unless filed within ONE YEAR after total disability began.

Do not write in this column

Age

Sex & c. c.

Dependents

Location (Occ.)

Date Report Filed

Date of Disab.

Report Lag

Hearing Lag

Payment Lag

Occupation

Experience

Agency (Disease)

Agency Part.

Type of Disease

Nature of Disab.

Part of Body

Full Wage

Average Wage

Treatment

Complications

Degree of Disab.

Days Lost

Manual No.

3081

WORKMEN'S COMPENSATION
THE INDUSTRIAL COMMISSION OF OHIO

Claim No.

O. D.

PART I. **Claimant's Report of Occupational Disease**

WOODIE THOMPSON

1. CLAIMANT'S NAME (First) (Middle Initial) (Last)

2. Home Address 12518 Emery Road (Number) (Street) (City) (County) (State)

3. Age Social Security No. 416 30 0413 Employer: FORD MOTOR CO

Occupation: Welder (Welder, etc.) No. and relationship of dependents:

4. From what disease are you suffering? Asbestosis

5. What parts of the body are affected? lungs

Give date your symptoms first appeared: 3, 1977 Name of employer when symptoms appeared: FORD MOTOR

How long in employ of this employer before symptoms first appeared?

6. Location of plant where you worked, when disability began: Cuyahoga Brookpark, Ohio (County) (City)

7. When were symptoms first reported to employer? March, 1975

8. Describe exactly how you were exposed to the substance, which, in your opinion caused your disease: I was welding engine blocks. We used abestos to keep the heat off. The abestos would turn into dust and I inhaled it.

9. Give name and address of physician who first diagnosed your disease as being occupational, and date diagnosis made: Dr. Grove Cleveland Clinic 9500 Euclid Ave Cleve.

10. Have you previously suffered from the disease for which this application is made, or any other occupational disease? 3, 197 If so, give details (dates of attacks, name and address of physician)

11. Date quit work: has not returned For what reason? Unable to work

12. Date returned to work: Type of work:

13. Occupation when disability began: Welder Type of work you were doing when disability began: Welder Length of time in this type of work (a) immediately prior to onset of symptoms: 23 yrs

(b) During lifetime: Same

14. Were you exposed to dust in your work? Type of dust: Abestos

Describe briefly how you were exposed: Abestos sheets covered the hot blocks The sheets turned to dust and I inhaled the dust.

Over what periods were you exposed in your employment? 23 years

Date of last exposure to dust: 2, 1977

15. If you were exposed to the substance which allegedly caused this disease in other employments, give the names and addresses of the other employers, and dates of employments:

16. Have you filed a previous application concerning this or any other occupational disease?

If so, give claim number:

By signing this application I expressly waive, on behalf of myself and of any person who shall have any interest in this claim, all provisions of law forbidding any physician or other person who has heretofore attended or examined me, or who hereafter attend or examine me, from disclosing any knowledge or information which they thereby acquired. I have read all the statements contained herein and know the same to be true and correct. I hereby authorize the Industrial Commission to pay any amounts which may be awarded direct to the persons rendering services pursuant to this application for payment out of the State Occupational Disease Fund.

(If applicant signs by mark two witnesses must sign here.) (Signature of applicant. If unable to sign, mark must be made.) Woodie Thompson

Street Address 12518 Emory Ave

Date report sent to employer City or Town Cleveland, Ohio 44135

PART II. **Employer's Report of Occupational Disease**

1. Name of employer: Ford Motor Company (Name as shown on Insurance Certificate)

2. Office address:

3. Nature of business: (Farming, coal mining, etc.) Type of organization: (Corp., partnership.)

4. The earnings of the injured employee for services rendered at time of occupational disease are being reported on

payroll reports of Risk No. Manual No.

8007 0449

STATE OF OHIO
BUREAU OF WORKERS' COMPENSATION
AND
THE INDUSTRIAL COMMISSION OF OHIO

ORIGINAL RECORD OF PROCEEDINGS

Claimant _____ Claim No. _____

Street and No. _____

City _____ (State) _____

Employer _____ Date of Injury _____

Street and No. _____

City _____ (State) _____

Findings of Facts and Minutes

Present for Claimant _____

Present for Employer _____

On this day this claim was heard and findings and orders were made as follows:

[illegible] of the Hearing Officer that the claim has been denied by the claimant's [illegible] to hereby ordered to comply with the findings and order made [illegible] from this order may be filed within 10 days of the receipt of this order.

Dated at _____, this _____ day of _____, 19__

Industrial Commission of Ohio

Bureau of Workers' Compensation

Administrator

Secretary

8007 0450

[illegible] MEDICAL HISTORY

[illegible] the examining physician is not for treatment as a patient and is not privileged. I [illegible] statements are full, true, correctly recorded and that this record may be retained in the files of the Ford [illegible]

[illegible] any of the following diseases or conditions:

[illegible] No Epilepsy No Skin Disease No Operations No Arthritis No
[illegible] No Diabetes No Accidents No Tuberculosis No
[illegible] No Fainting Spells No Back Ailments No

Remarks: Scar on right hand - cut machine - H.S.H.J.

Name: Kenneth Kroupa
Address: Sault Ste. Marie New Hire ✓ Rehire Reinstate
Date: 7-21-51 Interviewer

PRE-EMPLOYMENT PHYSICAL EXAMINATION

Height 6 ft. Inches. Weight 179 Lbs. Age 24 Sex ✓ M F X-Ray
Blood Pressure 120 80 Development: Good ✓ Fair Poor
Vision: Rt. 20/20 20/20 With Glasses Near Vision Cals 20/20 - 6"
Lt. 20/20 20/20 With Glasses
Chest—Inspection Normal Auscultation Normal
Heart—Murmurs Normal Rhythm Normal
Abdomen—(Note scars, tenderness, tension, tumors, etc.) [illegible]

Inguinal Region—(Note Glands, Condition of rings, hernia, size and type, etc.) Rings full

Extremities and Trunk—(Note any deformities, limitations of motion or amputations.) good development & well built

Varicocele None
Females: D.L.M. Periods Regular Scanty Heavy Painful Disabling
Urine: Blood Serology Skin
Compensated Injuries—(Describe and give per cent disability if any.) None - 4 F.

None

Remarks:

7-11-51 Safety program explained

Work Classification: A B C D

Examined By [signature] M.D.

3007 3451 PQ

8007 0452

PQ

[illegible], ROBERT

12324 HIRST AVE.
CLEVELAND 11, OHIO

R .91
L 1.37

OR1-9540

PLANT [illegible] DATE	FORD UNIT	FORD SEN. DATE	BIRTH DATE	U.S. CIT. YES	NO	MALE	FEMALE	SINGLE	MARRIED	TRADE SCHOOL
7-22-52			5-10-28	X		X		X		

SUGGESTIONS: DATE / AMT. / DATE / AMT.

	DATE OF ACTION	DEPT.	RATE	DATE RATE EFFECTIVE	OCCUPATION CODE & GROUP NO.	OCCUPATION
[illegible]	[illegible]-52	89	1.435	7-22-52	23-0-077	Labourer
			.23	6-1-52		
[illegible]	8-4-52	88	1.555	8-11-52	78-0-112	Grinder - Rough
[illegible]		88		8-11-52	To Body 88-511	
CL			.26	9-1-52		
[illegible]	[illegible]-52		1.605	9-1-52		
[illegible]	9-26-52		1.655	9-29-52		
[illegible]			.25	12-1-52		
O	[illegible]-9-53		1.705	4-13-53	04-0-038	Checker
CL			.24	4-13-53		
LP	7-11-53			7-30-53		
GI			1.945	6-1-53		
CL			.05	6-1-53		
CL			.06	9-7-53		
O	[illegible]-29-53		1.945	8-3-53	54-0-017	Welder-Arc & [illegible]
[illegible]	[illegible]-31-53		1.995	8-31-53	9-1	
LP	9-10-53	9-14		9-18-53		
[illegible]	[illegible]-30-53		2.045	9-28-53		
O	[illegible]-25-53	10-1	2.045	9-28-53	54-0-017	Welder-Arc + Gas
[illegible]	[illegible]-23-53		2.045	11-30-53	54-0-059	Welder Furnace
[illegible]			2.095	12-21-53		
[illegible]			2.145	1-18-54		
O	1-15-54		2.145	1-18-54	54-0-059 4A(1)	Welder Furnace
CL			.08	12-7-53		
CL			.07	3-1-54		

[illegible] REINSTATE, I—INCREASE
GI—GENERAL INCREASE, D—DECREASE, TR—TRANSFER, O—OCCUPATION CHANGE
OS—OCCUPATION SURVEY, LP—LEAVE OF ABSENCE PERS., LM—LEAVE OF ABSENCE MED., LO—LAID OFF
[illegible], T—TERMINATION, DA—DISCIPLINARY ACTION, A—APPRENTICE

-[illegible]!

1	2	3	4	5	6	7	8
	A		B		C		

	DATE OF ACTION	DEPT.	RATE	DATE RATE EFFECTIVE	OCCUPATION CODE & GROUP NO.	OCCUPATION
28	IP 2-25-54			3-1-54		
29	C		2.175	6-1-54		
30	C L 7-51 06C			7-12-54		
31	C L 9-6-54 07C					
32	11		2.255	6-1-55		
33	C		.08	12-6-54 6-5-55		
34	C L 9-5-55 07C					
35	C 12-5-55 07C					
36	L 1-56 06C					
37	BJ		2.215	6-1-56		
38	C L 6-4-57 07C			3-1-57		
39	C L 9-3-58 11C					
40						

				2.375	6-1-57		
	C.L. 5-3-57						
	O	7-24-57		2.425	8-5-57	54-0-054-9 4A(1)	Weldon Spring Site
	C.L. 12-2-57 10¢						
	C.L. 3-3-58 10¢						
	O	3-15-58	4568	2.375	3-24-58	54-0-059 4A(1)	Weldon Spring
	O	5-16-58		2.425	6-2-58	54-0-059-9 4A(1)	Weldon Spring Site
	TO	7-14-58			7-21-58		
	C.L. 9-1-58 10¢			2.635	G.I. 7-1-58	69 C.O.L. (15¢)	
	C.L. 12-1-58 10¢						
	C.L. 3-2-59 10¢						
	TO	5-27-59			6-2-59		
	C.L. 6-1-59 10¢						
	TO			2.10	8-1-59		
	C.L. 9-7-59 12¢						
	C.L. 12-7-59 13¢						
	TO			2.77	9-1-60		

H—HIRE
S—SEPARATE
R—REINSTATE
I—INCREASE

GI—GENERAL INCREASE
D—DECREASE
TR—TRANSFER
O—OCCUPATION CHANGE

OS—OCCUPATION SURVEY
LP—LEAVE OF ABSENCE PERM.
LW—LEAVE OF ABSENCE MED.
LO—LAID OFF

3037 0453

P89 0413

SOC SEC NO. 416 30 0413

NAME THOMPSON, Woodie

ADDRESS 12014 Hirst Avenue, Cleveland 11, Ohio

BNO [illegible] P89-851

NAME CHANGES

ADDRESS CHANGES 12518 Emery Ave (35) 28 — PHONE NO. [illegible]

PLANT UNIT	PLANT SEN. DATE	FORD UNIT	FORD SERV. DATE	BIRTH DATE	U.S. CIT. YES	NO	MALE	FEMALE	SINGLE	MARRIED
	7-22-52		7-22-52	5-10-2?	x		x		x	

ACTION CODE	DATE OF ACTION	DEPT.	RATE	DATE RATE EFFECTIVE	OCCUPATION CODE & GROUP NO.		OCCUPATION
			2.77		~~54-0-059-9~~	~~4A(1)~~	~~WELDER FURNACE UTILITY~~
1 O	4-10-61	4589	2.715	4-17-61	54-0-059	4A(1)	WELDER FURNACE
2			2885	IE 9-4-61	OL [illegible] 10-2-61		
3 O	6-27-62	4788	2.94	7-2-62	54-0-059-9	4A(1)	WELDER FURNACE-UTILITY
4 GI			3015	9-3-62			
5 O	9-17-62	4789	2.955	9-24-62	54-0-059	4A(1)	WELDER FURNACE
6 GI			3.03	9-2-63			

FOLD ALONG DOTTED LINE

7							
8							
9			3.20	[illegible] 9-6-65			
10 LL	10-31-65			11-8-65			
11 EA	1-17-66	4789			Badge P89-851		
12 TR	1-17-66	4789	3.20	1-24-66	54-0-059	4A1	Welder Furnace
13 GI			3.31	9-5-66			
14 GI	20 Cec? 18		3.69	10-25-67			
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							

FORD MOTOR COMPANY HOURLY STATUS CARD — Previous editions may be used

ACTION CODES: H—HIRE; RH—REHIRE; RI—REINSTATE; I—AUTO. INCREASE; GI—GENERAL INCREASE; D—DECREASE; TR—TRANSFER; O—OCCUPATION CHANGE; M—MERIT INCREASE; OS—OCCUPATION SURETY; LA—LEAVE OF ABSENCE; LL—LEAVE OF ABSENCE; LO—LAID OFF

8007 0454

	SOCIAL SECURITY NO.	LAST NAME	FIRST NAME
	4[illegible]-30-[illegible]613	THOMPSON	[illegible]

NUMBER AND STREET	CITY	ZONE	STATE	ZIP CODE	PHONE
12519 ENDEAN AVE	CLEVELAND	35	OHIO	44135	252-[illegible]110

UNION CD.	UNION INIT FEE	UNION DEDUCT	UNION SUP	FED. EX	ST. CODE	STATE EX	CITY CODE	CITY EX.	BONDS AMOUNT	BONDS CD	UNITED FUND	COMM. HEALTH
33		0.00	0	02	39	000	29	000	00.00	0	0.25	Y 716
				M01								
				M33	OH	M33	033	000	R			

PLT. UNIT	PLANT SEN DATE	BASIC UNIT	FORD SERV DATE	MED. CODE	DATE OF ENTRY	OCCUPATION CODE	DATE OF ENTRY OCCUPATION TITLE
082	07-22-52	082	07-22-52				

HOURLY EMPLOYEE STATUS POSTING CARD

TRAN. CODE	DATE OF ACTION	DATE RATE EFFECTIVE	PLANT LOC	AREA CODE	RATE	OCCUPATION CODE	SAL. GP	GRADE NO.	SPECIAL RATE
99	03-06-68	FORM 47	1223	2-4789-A	3.690	54-0-059-0		04A1	
	OCCUPATION TITLE		WELDER FURNACE						
GI		11-25-68		2-4789-A	3.800	54-0-059-0		04A1	
	OCCUPATION TITLE								
GI		11-24-69		-4789-	3.915	54-0-059-0		04A1	
	OCCUPATION TITLE								
GI		11-02-70		-4789-	4.580	54-0-059-0		04A1	
	OCCUPATION TITLE								
GI		11-22-71		-4789-	4.715	54-0-059-0		04A1	
	OCCUPATION TITLE								
	OCCUPATION TITLE	11-20-72			4.855				
	OCCUPATION TITLE		COL 11-19-73 35¢		5.490				
	OCCUPATION TITLE	9-23-74			5.635				
	OCCUPATION TITLE	9-22-75			5.845				
	OCCUPATION TITLE								
	OCCUPATION TITLE								
30	12-08-75	12-22-75	1221	-4789-	5.050	54-0-017-0		04A2	
	OCCUPATION TITLE								
	and COLA trans 10-10-76 OCCUPATION TITLE				7.110				
CR	06-04-77	03-03-77	1223	-4789-	7.110	54-0-017-0		03D3	
	OCCUPATION TITLE		N FULL 90 P/E 06-19-77						

3007 0455

CLEVELAND CLINIC HOSPITAL

THOMPSON, Mr. Woody Age 48 Case No. 1-426-475

Bronchoscopy; left thoracotomy; biopsy Date 04-05-77

Anesthetic General Room

Surgeon Dr. L. K. Groves Assistants Dr. M. Peter-Mr. Filsky

PREOPERATIVE DIAGNOSIS: Left sided pleural effusion, etiology undetermined.

POSTOPERATIVE DIAGNOSIS: Mesothelioma.

PATHOLOGICAL DIAGNOSIS:

OPERATIVE FINDINGS:

HISTORY: The patient is a 46-year old black male who has had progressive shortness of breath on the left side with pleural effusion on chest x-ray. This was tapped and 2000 cc. of fluid was removed from there. This was chocolate colored and cytology was negative. Bronchoscopy was unremarkable. When the chest was opened, about 2500 cc. of chocolate colored fluid escaped and there was diffuse infiltration of fibrosis all over the pleural surface. The left lung was contracted and small in size. A biopsy showed on frozen section mesothelioma.

PROCEUDRE: Under general anesthesia, bronchoscopy was performed using a rigid bronchoscope. This was unremarkable.

The patient was intubated, positioned for a thoracotomy on the lateral side with the left side up. Routine thoracotomy incision was made and the chest was entered in the fifth interspace. On opening the pleura, about 2500 cc. of chocolate fluid escaped. This was aspirated. The left lung appeared small in size and had diffuse fibrosis around it. The entire pleural surface was found to be studded with multiple infiltrative lesions. Three of these lesions were biopsied and frozen section showed mesothelioma. Two chest tubes were placed for drainage purposes and the chest wound then closed in routine fashion. The patient tolerated the procedure well and was transferred to the Intensive Care Unit in good condition.

Dictated: Dr. M. Peter for Dr. L. K. Groves/04-05-77
Typed: 04-08-77/mal
I.D. 04-05-77/001

MAR 9 1978

8007 0456

[illegible] CLINIC HOSPITAL
PATHOLOGICAL REPORT

Name THOMPSON, Woodie Clinic No. 1-426-475-2 Path. No. [illegible]

Age 49 Room No. Service Dr. Hewlett Date 12-20-77

PATHOLOGICAL DIAGNOSIS:

FINAL PATHOLOGIC DIAGNOSES

550-8772A

370-8772A
420-8772A
275-8772A
060-8772A
659-8772A
657-8772A
MESOTHELIOMA EXTENSIVELY INVOLVING MEDIASTINUM, PLEURA, PERICARDIUM, DIAPHRAGM, AND PERITONEUM, WITH SEROSAL COATING OF ABDOMINAL VISCERA. METASTASIS TO PARA-ESOPHAGEAL AND LEFT SUPRACLAVICULAR LYMPH NODES AND EPISTERNAL SUBCUTANEOUS TISSUE. LUNG BIOPSY April 1977, Surgical Path. #77-5123.

350-4971
INTRA-PULMONARY ASBESTOS BODIES.

410-43x
410-900.6
CARDIOMEGALY (580 gm.) WITH LEFT VENTRICULAR HYPERTROPHY (2.0 cm.).
Dilatation of right ventricle, right atrium, and left atrium.
Congestion of liver (1550 gm.), kidneys, spleen, and lungs.
Edema, right lung (660 gm.).
Atelectasis, right lower lobe.
Cerebral edema (1780 gm.).

Arterial and arteriolar nephrosclerosis.

Cortical nodular hyperplasia, adrenal glands, mild.

Diverticulosis, sigmoid colon.

Hydroceles, bilateral.

Hyalinized granuloma (1 cm.), liver.

HSL

KP/ Howard S. Levin, M.D.

MAR 9 '78

6007 0457

CLEVELAND CLINIC HOSPITAL
PATHOLOGICAL REPORT

Name THOMPSON, Woodie Clinic No. 1-426-475-2 Path. No. A-10985

Age 49 Room No. Service Dr. Hewlett Date 12-20-77

PATHOLOGICAL DIAGNOSIS:

Date and time of death:	12-20-77 at 1:35 a.m.
Date and time of autopsy:	12-20-77 at 11:00 a.m.
Restrictions:	None
Performed by:	K. Pontius, M.D.

CLINICAL DIAGNOSES

Mesothelioma, respiratory failure, and metabolic acidosis

GROSS EXAMINATION

EXTERNAL EXAMINATION: The body is that of a 49-year-old, black male, weighing approximately 160 pounds and measuring 66 inches in length. The body appears wasted, except for a protuberant abdomen. the hair is black and shows a male balding pattern. The conjunctivae are clear but show marked edema. The irides are brown; the pupils are unremarkable. The ears, nose, and mouth show no abnormalities. The teeth are natural and in fair repair. The neck is of normal configuration and there is a palpable node within the left supraclavicular fossa. The thorax is symmetrical and normal in configuration. There is a well-healed thoracotomy scar running around the left thorax and measuring 30.0 cm. in length. Inferior to this are two well-healed scars, one measuring 1.0 cm. and one measuring 2.0 cm., apparently representing tubal orifices. The breasts are of normal configuration and there are no palpable masses. The abdomen is markedly protuberant and a fluid wave is present. There is a 3.0 cm. ecchymosis located inferior to the umbilicus in the midline. The external genitalia are of normal conformation, and there are no external lesions. The extremities appear normal, and the joints are not deformed. There is a trace of pedal edema. The skin is of normal pliability and texture and shows some depigmentation across the upper extremities in that there are patches of lighter colored skin fronting on the darker pigmented skin. There is no icterus. Other than the described supraclavicular node, there is no palpable lymphadenopathy. There are numerous ecchymoses present in both antecubital fossae and on the radial aspects of both wrists.

INTERNAL EXAMINATION: Pleural Cavities: Upon removing the sternal plate, there is noted to be numerous nodules of gritty white neoplasm present both beneath the sternum and external to the sternum. The tumor likewise encases the ribs. The right pleural cavity contains approximately 1500 cc. of a slightly cloudy serosanguineous fluid. The right lung is matted to the apex and vertebral side of the pleural cavity. There are numerous small tumor nodules studding the lower lobe of the right lung as well as studding the parietal pleura in the lower aspect of the pleural cavity. The left lung is not observed due to encasement by tumor. This is filling the pleural space from apex to base and adhering to the pericardium.

Mediastinum: Numerous tumor nodules are present within the mediastinum and adherent to the sternum, as previously described.

Peritoneal Cavity: There is an accumulation of approximately 5000 cc. of slightly red-tinged serous ascites. The peritoneum

3007 0453

[illegible] CLINIC
PATHOLOGICAL REPORT

Name THOMSON, Woodie Clinic No. 1-426-476-2 Path. No.

Age 69 Room No. Service Dr. Hewlett Date

PATHOLOGICAL DIAGNOSIS: Gross Examination - Page two

as well as the omentum, mesentery, and serosal surfaces of all abdominal viscera are studded by nodules of tumor. The abdominal viscera occupy their normal anatomical positions. The diaphragmatic leafs are elevated. The margin of the liver is in proper relationship to the costal margin and the margin of the spleen is nondetectable due to encasement by tumor.

CARDIOVASCULAR SYSTEM: Heart: Weight 580 grams. The coronary arteries have a normal anatomic distribution and multiple cross sections show no significant narrowing of lumina and no evidence of thrombosis.

The epicardium shows numerous adhesions to the pericardium and, in fact, the pericardial space is obliterated by these adhesions. There is no tumor present on the epicardial surface. There is a normal amount of subepicardial fat and its distribution is normal. The myocardium is of normal consistency and appearance. The right atrium, right ventricle, and the left atrium show marked dilatation. The left ventricle shows a normal configuration, although the left ventricular wall is markedly hypertrophied. The great vessels enter and leave the heart in a normal manner. The septa are intact, and there are no congenital abnormalities. The left and right ventricles are 2.0 cm. and 0.3 cm. thick, respectively. The heart valves are thin, pliable and delicate, and free of deformity. Valvular measurements are as follows: aortic 7.5 cm., mitral 13.0 cm., pulmonic 10.0 cm., and tricuspid 14.5 cm.

Aorta and Its Major Branches: The aorta and its principal branches are patent throughout. There are no thrombi, areas of erosion, or zones of significant narrowing present.

Venae Cavae and Their Major Tributaries: The superior and inferior venae cavae and their major tributaries are patent throughout. No significant areas of extrinsic or intrinsic stenosis are present.

RESPIRATORY TRACT: Larynx: The laryngeal airway is unobstructed. No destructive lesions are present.

Trachea and Major Bronchi: The trachea and major bronchi are free of obstruction. They have a normal caliber.

Lungs: Right 660 grams. The left lung has not been weighed due to an fluoroscopic procedure. The right lung is adherent to the left pleural cavity, as previously described. The visceral pleura shows numerous adhesions in the apical area and is studded with tumor nodules in this area. There is no crepitance present. There are no subpleural emphysematous bullae. The parenchyma of the right lung shows a frothy fluid from the upper lobe. The lower lobe is markedly hypostatic and atelectatic. The pulmonary arteries of the right lung are free of emboli and thrombi. The left lung will be described at a later date following fixation.

HEMATOLYMPHOID SYSTEM: Spleen: The spleen which is 0.3 cm. capsule of tumor weighs 70 grams. The tumor is firmly adherent to the capsule of the spleen. On section, the splenic pulp is of normal consistence and appearance.

Lymph Nodes: A 2.0 cm. lymph node is present from the supraclavicular area and on cut surface appears to be replaced by neoplasm. At the cardioesophageal junction, a lymph node measuring 1.5 cm. is

3007 0459 PQ

Name THOMPSON, Woodie Clinic No. 1-426-475-2 Path. No. A-10[illegible]

Age 49 Room No. Service Dr. Hewlett Date 12-20-77

PATHOLOGICAL DIAGNOSIS: Gross Examination - Page three

present and on cut surface shows part of the parenchyma to be replaced by firm white tissue.

Bone Marrow: The vertebral bone marrow presents a normal appearance.

GASTROINTESTINAL TRACT: The esophagus is free of lesions. The stomach has a normal configuration and the serosa of the stomach is coated by tumor nodules. The mucosa is thrown into rugal folds. There are no areas of ulceration. The retroperitoneal portion of the duodenum shows no involvement by tumor; however, the peritoneal extension of the duodenum shows serosal coating by tumor nodules. The jejunum, ileum, and colon show marked coating of their serosal surfaces by tumor. Numerous diverticula are present within the sigmoid colon. The appendix likewise shows marked serosal wrapping by tumor. The anus is normal.

LIVER: Weight 1550 grams. The capsule is studded with tumor nodules, the largest measuring 0.5 cm. The liver configuration is normal. Multiple cross sections reveal a hyperemic cut surface but no accentuation of the lobular architecture. The inferior surface of the liver shows a thick tumor coat.

The gallbladder is of normal size and configuration. The wall is thin and the mucosa is bile-stained. The viscus contains a normal amount of green-black bile. The cystic duct, the right and left hepatic ducts, and the common duct are patent and free of calculi and other intrinsic lesions.

PANCREAS: The pancreas is soft and mushy and on cut surface the lobulated pattern is present but the parenchyma appears yellow and soft with areas of hemorrhagic discoloration. There is no evidence of fat necrosis. The ducts are patent.

GENITOURINARY SYSTEM: Kidneys: Right 140 grams. Left 150 grams. The right and left kidneys are similar. The capsules strip with moderate difficulty to reveal finely granular subcapsular surfaces. There is a 1.0 cm. depressed wedge-shaped scar in the cortex of the left kidney. The renal arteries and veins are patent and free of stenosing lesions. On section, the renal cortices are of normal thickness and the cortico-medullary demarcations are distinct. The cut surface of the kidneys shows marked hyperemia of the parenchyma. The pelvo-calyceal systems are normal in appearance. The ureters are unremarkable.

Bladder: The bladder is of normal configuration. The pelvic fat surrounding the bladder is studded with nodules of tumor. The mucosa is intact and free of ulceration. There is a small submucosal hemorrhage present in the posterior wall of the bladder.

Prostate and Seminal Vesicles: A portion of the prostate is examined and sections of this reveal rubbery, firm, gray-white parenchyma, free of unusual characteristics.

Testes: There are bilateral hydroceles present but otherwise no abnormalities.

ENDOCRINE SYSTEM: Adrenals: Right 10.0 grams. Left 15.0 grams. The adrenal cortices show marked convolution and nodularity. They are bright yellow in color. The medullae are unremarkable.

Thyroid: Weight 23.0 grams. Multiple cross sections of the lateral lobes and isthmus reveal no parenchymatous nodules or

MAR 9 197[illegible]

0046

PATHOLOGICAL REPORT

[illegible] Clinic No. 1-426-475-2 Path. No. [illegible]

Age [illegible] Room No. Service Dr. Hewlett Date 12-20-77

PATHOLOGICAL DIAGNOSIS: Gross Examination - Page four

[illegible] lesions.

Parathyroids: Two parathyroid glands are identified, which are grossly unremarkable.

Pituitary: The pituitary is unremarkable.

CENTRAL NERVOUS SYSTEM: Brain: Weight 1700 grams. There is marked flattening of the gyri. There is no uncal notching but the right cerebellar tonsil is somewhat softened.

The major cerebral arteries show no significant atherosclerosis or congenital anomalies.

Spinal Cord: The spinal cord and its coverings are unremarkable.

MUSCULOSKELETAL SYSTEM: The axial and appendicular skeleton show no abnormalities. The exposed musculature is unremarkable.

ADDENDUM: Left Lung: The left lung is removed from the pleural cavity with great difficulty due to an encasement by neoplasm. The lung is formalin insufflated for three days prior to sectioning. Cross sections through the entire lung show a 0.5 to 2.0 cm. coating by gritty white neoplasm. The tumor has also encased the pericardium and the diaphragm. The entire pleural surface of the lung is covered by tumor, and tumor nodules extend into the subpleural parenchyma at several areas. In one of these areas there is a rim of compressed lung parenchyma which is quite firm as compared to the surrounding lung tissue. The lung parenchyma away from the tumor shows uniform air spaces without evidence of subpleural bullae. The bronchi are pulmonary arteries show no significant abnormality. Several peribronchial lymph nodes are present at the bifurcation of the main stem bronchus and on cut surface show significant anthracotic pigmentation. Sections of the lung are submitted for microscopic study.

KF:eat

8007 0461 PQ

CLEVELAND CLINIC HOSPITAL
PATHOLOGICAL REPORT

Name THOMPSON, Woodie Clinic No. 1-426-475-2 Path. No. A-1[illegible]3

Age 49 Room No. Service Dr. Hewlett Date 12-20-[illegible]

PATHOLOGICAL DIAGNOSIS:

MICROSCOPIC DESCRIPTION

CARDIOVASCULAR: Sections of the left ventricular wall and interventricular septum show hypertrophy of the muscle bundles manifested by an increased amount of cytoplasm and enlarged nuclei. The epicardial surface shows fibrous scar.

RESPIRATORY: A section of trachea shows it to be wrapped by mesothelioma which is characterized by dense fibrous tissue containing malignant cells with vesicular nuclei and basophilic cytoplasm, which are arranged in papillary structures and tubular structures. Special stains for hyaluronic acid show that the major secretory component of the tissue is indeed hyaluronic acid.

A section of diaphragm shows neoplasm to be coating both its pleural and peritoneal surfaces.

Sections of left lung reveal the pleural surface to be replaced by neoplasm which superficially invades the lung parenchyma. Sections of the left lung taken away from the tumor show severe congestion of the alveolar septal capillaries and edema fluid in the alveolar spaces. There are frequent asbestos bodies present. These stain positively with an iron stain.

Sections of the right lung show similar severe congestion and edema as well as organizing intra-alveolar exudate and areas of hyaline membrane formation. The parenchyma of the right lung likewise shows frequent asbestos bodies. There is no evidence of interstitial fibrosis, however.

LYMPH NODES: A paraesophageal lymph node and left supraclavicular lymph node show metastatic mesothelioma.

LIVER: Sections of hepatic parenchyma show centrilobular congestion without necrosis. The capsular surface of the liver shows studding with tumor nodules. These do not penetrate the capsule into the parenchyma. In addition, there is a hyalinized granuloma present in a subcapsular location.

SPLEEN: The capsular surface of the splenic sections is coated with mesothelioma. The parenchyma of the spleen shows severe congestion.

PANCREAS: Sections of pancreatic parenchyma show autolytic changes.

ADRENAL: Sections of adrenal gland show a nodular cortical hyperplasia characterized by small nodules of adrenocortical cells studding the adrenal cortex.

GASTROINTESTINAL SYSTEM: A section of peritoneum shows its surface to be entirely replaced by mesothelioma. A section of jejunum shows serosal mesothelioma. A section of appendix likewise shows it to be entirely enveloped by mesothelioma.

GENITOURINARY SYSTEM: Sections of the right and left kidneys show numerous cortical scars and hyaline sclerosis of the renal arteries and arterioles. There is moderate congestion of the glomerular capillary loops.

MAR 9 1978

CLEVELAND CLINIC HOSPITAL
PATHOLOGICAL REPORT

Name THOMPSON, Woodie Clinic No. 1-426-475-2 Path. No. A-10985

Age 49 Room No. Service Dr. Hewlett Date 12-20-77

PATHOLOGICAL DIAGNOSIS: Microscopic Description - Page two

BONE MARROW: A section of vertebral body bone marrow is normocellular with a slight erythroid hyperplasia.

SKIN: A section of subcutaneous tissue taken from the episternal area shows nodules of mesothelioma.

BRAIN: Routine sections of rectus gyrus, basal ganglia, hippocampus, mammillary bodies, midbrain, cerebellum, pons, medulla, and spinal cord show no significant changes.

KP:eat

MAR 9 1978

3007 0463

CLEVELAND CLINIC HOSPITAL
PATHOLOGICAL REPORT

Name THOMPSON, Woodie Clinic No. 1-426-475-2 Path. No. A-109021

Age 49 Room No. Service Dr. Hewlett Date 12-20-77

PATHOLOGICAL DIAGNOSIS:

BRAIN AFTER FIXATION: The dura shows no lesions, and the sagittal sinus is patent. The leptomeninges show some thickening and clouding over the frontal and temporal aspects of the brain. They are not thickened, however, at the base of the brain. The convolutional pattern shows some flattening of the gyri. There is no evidence of subfalcial, uncal, or cerebellar tonsillar herniation present. The major cerebral arteries show mild segmental atherosclerosis and appear to be patent throughout. Serial coronal sections through the cerebral hemispheres show poor fixation of the brain but a grossly normal cortical ribbon and underlying white matter. The basal ganglia and diencephalon show no gross abnormalities. Serial cross sections through the brain stem and sagittal sections through the cerebellum fail to show any gross lesions or abnormalities. The ventricular system is symmetric and of normal size and configuration.

SPINAL CORD: Serial 1.0 cm. cross sections through the spinal cord and the cauda equina show no gross abnormalities.

KP:eat

MAR 9

8007 0464

DEGREE— NONE PARTIAL COMPLETE

DATES— FROM TO

MOVED HOSPITAL TRANSFER SKILLED NURSING FACILITY DEATH AUTOPSY

FELLOW ATTENDING

(IF PATIENT DIED OR WAS HOSPITALIZED FOR 48 HOURS OR LONGER COMPLETE REVERSE OR DICTATE DISCHARGE SUMMARY)

ADMISSION MASTER RECORD

PATIENT'S NAME	ROOM-BED	PATIENT NUMBER	SOCIAL SECURITY NO.	SEX	BIRTHDATE	AGE
THOMPSON WOODIE MR.	5021					

HEIGHT WEIGHT ADMITTED SERVICE PHYSICIAN NO.

PHYSICIAN ADMITTED NAME IF DIFFERENT MONTHLY SERVICE

ADMITTING DIAGNOSIS

PROPOSED SURGICAL DATE P.C. PAY TYPE PAY CAT. STAT. BLOOD

PATIENT'S EMPLOYER

EMERGENCY NOTIFICATION

RESPONSIBLE PARTY PAID

REG. BY A.T.

VETERAN

FATHER

MOTHER

BIRTHPLACE

RELIGION

CLEVELAND CLINIC FOUNDATION

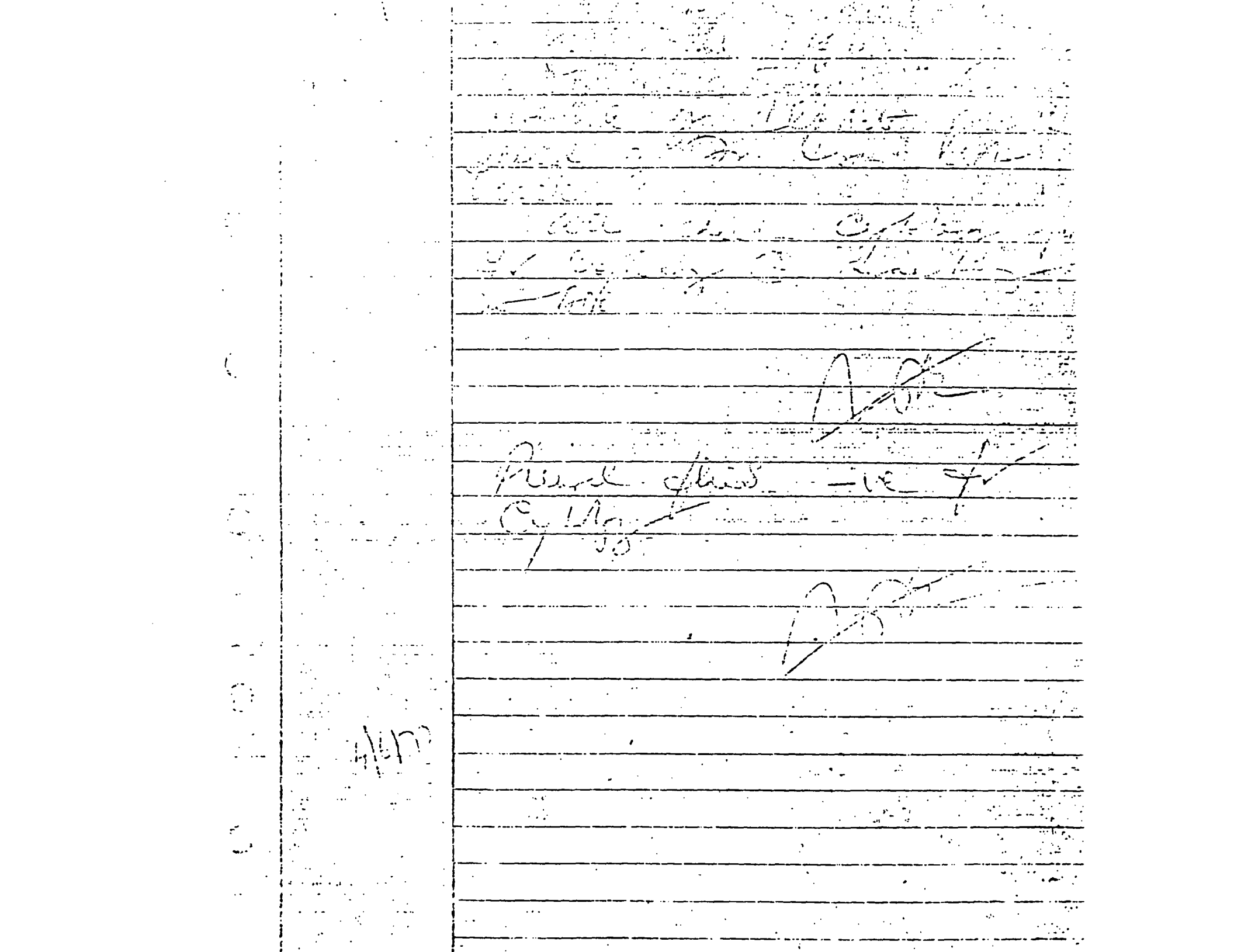
ADMISSION – DISCHARGE RECORD

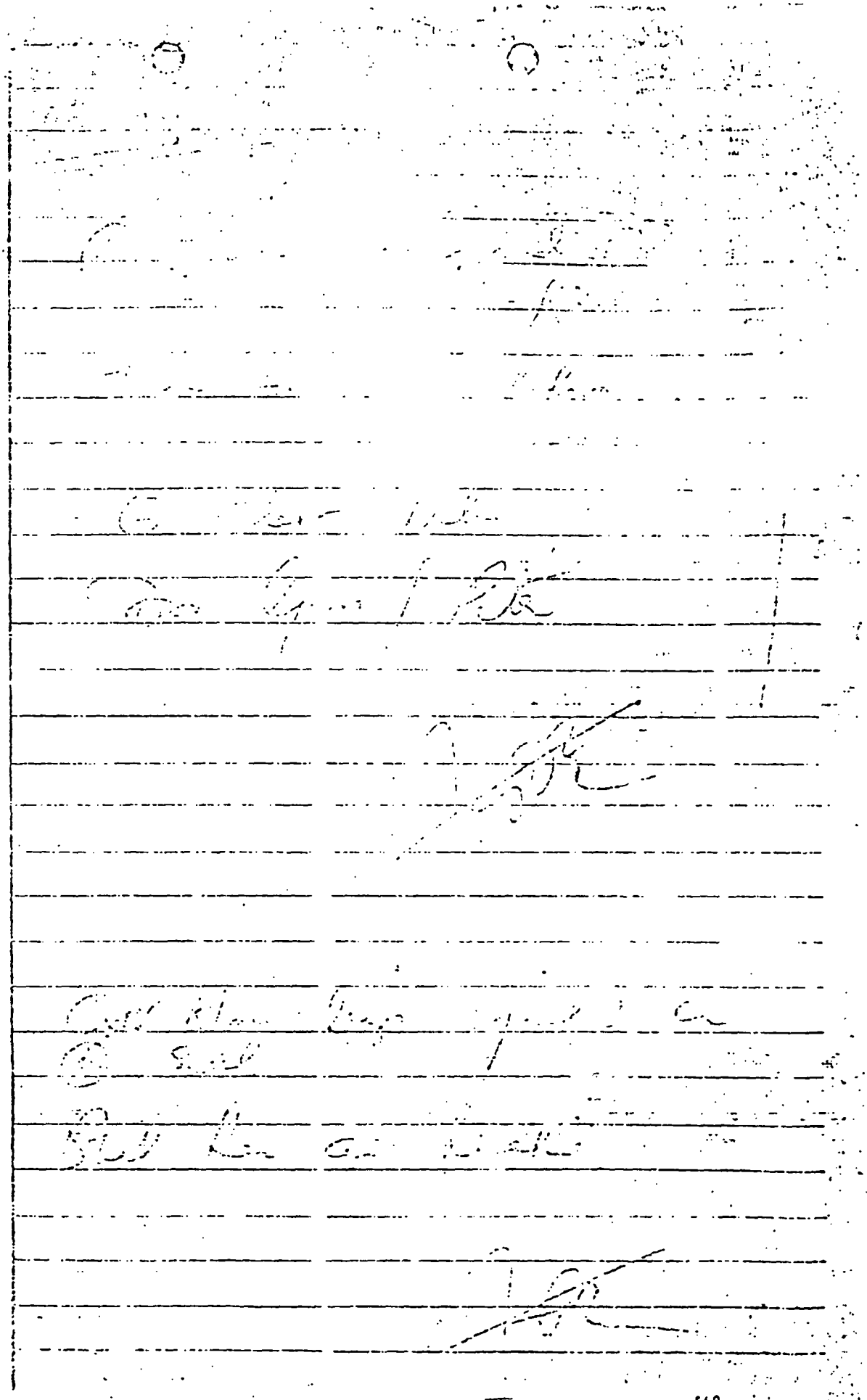
PATIENT NO.

8007 0465

PQ

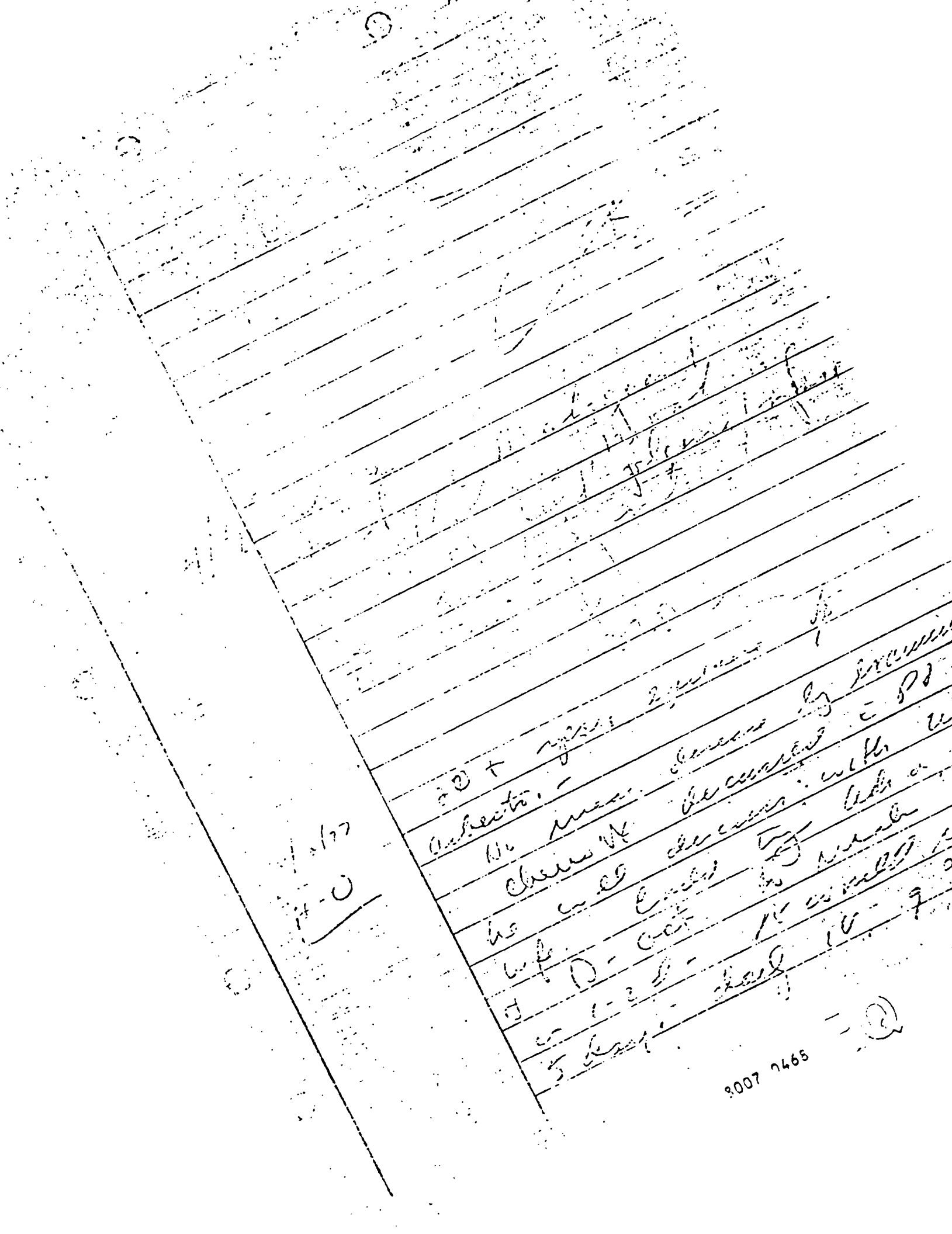
MAR 9 1976



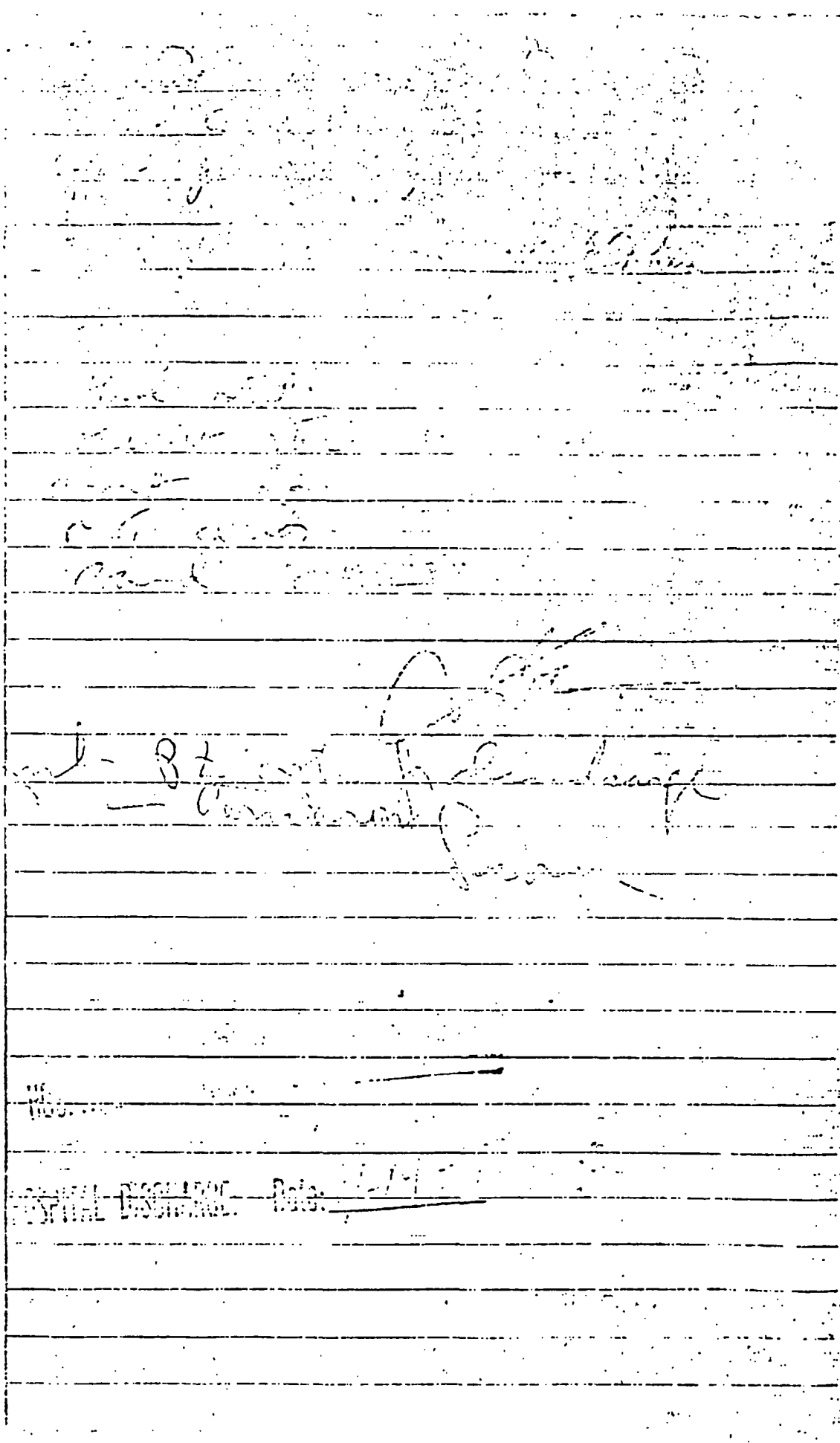


5007 0467

MAR 9 1978



8007 0465



8007 0469 PQ MAR 9 1978

JAMES D. WISMAR, M.D.
8001 OLD OAK BOULEVARD, SUITE 8H
MIDDLEBURG HEIGHTS, OHIO 44130
Telephone 826-2777

February 10, 1978

Robert M. Hisnay
Supervisor, Ins. Relations Dept.
Cleveland, Ohio 44142

Re: Mr. Woodie Thompson

Dear Mr. Hisnay:

Enclosed please find copies of Mr. Thompson's admitting history and physical exam, hospital discharge summary and letters from the Cleveland Clinic relative to his care at that institution. My last contact with him was on March 19, 1977.

Sincerely yours,

James D. Wismar, M. D.

JDW/ktl

FEB 14 1978

3007 0470

CLEVELAND CLINIC

THE CLINIC CENTER • 9500 EUCLID AVENUE, CLEVELAND, OH 44106, U.S.A. • 216/444-2200 • CABLE, CLEVCLIN

DEPARTMENT OF HEMATOLOGY
AND MEDICAL ONCOLOGY

DIVISION OF HEMATOLOGY AND ONCOLOGY

LABORATORY HEMATOLOGY

January 9, 1978

James D. Wismar, M.D.
7225 Old Oak Boulevard
Middleburg Hts., OH 44130

RE: Mr. Woodie Thompson
CLINIC #1-426-476-2

Dear Doctor Wismar:

I regret to inform you that your patient, Mr. Woodie Thompson, with the malignant mesothelioma was admitted to the Cleveland Clinic Hospital through the Emergency Room on December 17, 1977 in a preterminal condition. He was given supportive care but expired on December 20, 1977. Permission for an autopsy was granted. We regret that there was nothing we could do for Mr. Thompson at this late stage of his disease.

Sincerely yours,

James S. Hewlett, M.D.

JSH/ha/M-6395

FEB 14 1978

8007 0471 PQ

[illegible], WOODIE J. 114-2 1So
77-01032-3
Admitted 3/4/77

Dr. Wismar

43 year old Black male admitted to the hospital because of left pleural effusion.

HISTORY OF PRESENT ILLNESS: He states that he was well until approximately a week prior to admission to the hospital when he began to experience cough and exertional dyspnea. These symptoms increased, were not associated with any chills or fever and prompted him to be seen in the E.R. on 2/26/77. At that time, it was felt that his problem was tracheobronchitis. He was started on antibiotics and cough expectorants. He was seen by the undersigned on the day prior to admission to the hospital with no significant improvement. At that time, clinical signs were consistent with left pleural effusion and x-ray examination showed massive density of the left hemithorax with shift of the mediastinum to the right. It was felt he should be hospitalized for further investigation and treatment.

PAST HISTORY: is significant in that the patient has had known hypertension for a period of 6 -7 years. He was additionally treated with antihypertensive therapy and has not taken any medication in the past six months. In 1973, he was hospitalized at SWGH for a "checkup". At that time, he was told that he had a mild diabetes and was treated with diet, but did not follow-up any further medical care for this problem and has not had any symptoms suggestive of polyuria, polydipsia or unexplained weight loss. His health has otherwise been good. No allergies. No injuries.

HABITS: DOes not use tobacco. Drinks alcohol only socially and currently his only medications include Erythromycin and cough expectorant from the emergency room physician.

FAMILY HISTORY: His father died in his 60s from complications of hypertension. Mother is living at 65 yrs. in good health. He has 3 male and 1 female sibling all of whom are well. Patient is married has 3 children, all of whom are in good health. The patient works as a welder for Ford Motor foundry.

SYSTEM REVIEW: HEENT- does relate some diminished vision especially in the right eye recently, but no other symptomatology. C-R- his only distress has been slight right sided pleuritis like chest pain, cough has been productive of only scant amount of mucoid sputum. GI - negative. GU- not remarkable. MS- not remarkable.

8007 0472 PQ

3/4/77

Wiamar

Well developed, well nourished, alert, cooperative Negro male in no acute distress. Vital signs - B/P 200/130 in both arms; pulse rate 88 regular respirations 16 but not labored at rest.

SKIN: No remarkable findings.

EYES: Bilaterally responsive pupils. Arcus senilis was present. Funduscopic examination showed copper wiring with marked tortuosity and AV crossing defects and scattered waxy exddates, but no microaneurysms or nemorrnages. No papilledema.

E.N.T.- nothing remarkable.

NECK: Supple, no thyromegaly or adenopathy present. Supraclavicular pulsations were absent on the left side, present on the right.

CHEST: Expansion appeared to be somewhat limited with definite diminished breath sounds and dullness over the left hemithorax with markedly reduced whispered egophonate and E to A change. No rales or rhonchi were audible.

HEART: Difficult to assess, mediastinum was definitely shifted to the right and the heard sounds were more pronounced on the right than on the left. There is no manifest enlargment. First and second heart sounds appeared to be normal. S2 was more pronounced over the pulmonic region. S3 S4 were absent and no murmurs were present.

ABDOMEN: Showed slight tenderness to deep palpation in the right upper quadrant. No definite organs, masses were felt. Bowel sounds appeared to be normoactive.
External genitalia not remarkable.

EXTREMITIES- peripheral vascular examination was within normal limits.

RECTAL: No remarkable findings.

IMPRESSION:
1. Left pleural effusion, etiology unknown. R/O underlying tuberculosis, malignancy with metastatic disease, empyema etc. associated with bronchopnaumonia.
2. Hypertensive cardiovascular disease.
3. Diabetes mellitus, historical.
4. Hypertensive retinopathy.

3/5/3/5/77 8007 0473 PQ J. Wiamar, M.D.

3007 0474

1. Left pleural effusion, etiology unknown
2. Hypertensive vascular disease
3. Diabetes mellitus, noninsulin dependent
4. Leukopenia, mild, possibly related to Dx. #1

Medical and surgical including repeated thoracentesis, diagnostic workup

The patient is a 48 year old black male admitted to the hospital on 3-4-77 and discharged on 3-19-77. He was admitted because of chest pain and exertional dyspnea. History and physical examination are as dictated.

Laboratory data are as follows: Chest x-ray showed a massive left pleural effusion with shift in the mediastinal structures to the right. Intravenous pyelograms including laminography, oral cholecystogram, upper GI series, Barium enema and liver scan were all within the normal range and chest x-ray following adequate thoracentesis revealed no significant new findings and no expansion of the left chest was noted. EKG was within normal limits. Examination of the pleural fluid showed no evidence of any malignancy. The LDH was 532 units and amylase was 126. Hematocrit of the pleural fluid was 2.2%. Cultures were nonreactive. A tuberculin test was negative. Hemograms showed persistent mild leukopenia with a white count of 3700. Hemoglobin was normal and differential showed no abnormal cells with the exception of the third hemogram which showed a 10% eosinophil count on differential. Electrolyte pattern showed nothing remarkable. SMA-12 showed creatinine to be 1.5, all other parameters were essentially within range. Serum amylase was 84. Serology was nonreactive. Rheumatoid factor was negative. Urinalysis showed nothing significant.

Hospital Course: The patient was tapped on two occasions with 600 and 1200 cc's of fluid removed and sent for studies. The fluid was a dark, reddish, mahogany appearing color. The patient tolerated the procedure well. With a negative workup otherwise, it was felt that thoracotomy with exploration was indicated and arrangement were made and he was seen in consultation by Dr.

(CONTINUED)

[illegible]erberg to do this procedure, however, the patient refused to [illegible] the operation done on the day of its schedule. Accordingly he will be transferred at his request to the Cleveland Clinic for probable exploration and further diagnostic workup as indicated. The liklihood of this [illegible] lymphoma appears to be quite high.

Condition on Discharge - Unchanged.

Discharge medications include HydroDIURIL 50 mg. bid for control of hypertension.

3-21/4-1d-77

J. D. Wismar, M. D.

0007 0475 PQ

Casting Division
Ford Motor Company

Cleveland Casting Plant
5600 Engle Road
Brook Park, Ohio
Mailing Address
P.O. Box 9900
Cleveland, Ohio 44142

February 4, 1978

J. E. Slingluff, M.D.
2223 Fulton Road, N. W.
Canton, Ohio 44709

Re: Woodie Thompson
S.S. #416-30-0413
12518 Emory Avenue
Cleveland, Ohio 4135

Dear Doctor Slingluff:

Prior to his demise, our employe, Woodie Thompson, was seeking lost time and other benefits from us for a physical problem which he was experiencing. We understand he had been under your care for this problem.

In order to properly evaluate his claim, it would be very helpful if you would provide us with a report of your findings, including Mr. Thompson's history.

Enclosed is a waiver signed by Mr. Thompson authorizing release of this information. Please enclose your fee bill for the compiling of this information along with your report and it will have our prompt attention.

Very truly yours,

FORD MOTOR COMPANY

Robert M. Hisnay
Industrial Relations Department
Cleveland Casting & Engine Plants

RMH:pr
Enc.

MAR 7 1978

3007 0476

ACC NO	NAME	DATE RECEIVED	DATE RETURNED
	[illegible] THOMPSON	11/08/77	11/08/77

TEST	RESULTS		NORMAL RANGE OR COMMENT
[illegible] SERUM	96	L MEQ/L	98- 108 ME
[illegible]	TO FOLLOW		
[illegible]	136	MEQ/L	135- 145 ME
POTASSIUM	3.7	MEQ/L	3.5- 5.0 ME
ELECTROLYTE RAT.	60		
HEMOPHILE	SEE ATTACHMENT		
SEPT	13	IU	00- 25 IU
TRIGLYCERIDE	119	MG/DL	10- 190 MG
DIFFERENTIAL	SEE ATTACHMENT		
CO 2	28	MMOL/L	21- 31 MM
SGOT	167	IU/L	
SGOT		NORM.M 17-55	F 13-45
IND BILIRUBIN	.80	H MG/DL	0.00-0.60 MG
DIRECT BILIRUBIN	.20	MG/DL	0.00-0.40 MG
UR CHARACTER	CLDY		
UR COLOR	ORNGE		-YEL

AUTOMATED MEDICAL SERVICES OF OHIO, INC.
Box 615 Mansfield, Ohio 44901

J E SLINGLUFF,DO
2223 FULYON AVE.N.W
CANTON OH
44720

ACCT. NO. 5204127
PAGE NO.

R.J. THABET, M.D., F.C.A.P., F.A.S.C.P
MEDICAL DIRECTOR

ACC NO	NAME	DATE RECEIVED	DATE RETURNED
548984	HOODIE THOMPSON	11/08/77	11/08/77

TEST	RESULTS	NORMAL RANGE OR COMMENT
UR SP. GRAV.	1.010	.015-.030
UR PH	5.0	- 6.0
UR ALBUMIN	NEG	-NEG
UR SUGAR	NEG	-NEG
UR ACETONE	NEG	-NEG
UR BILE	NEG	-NEG
UR OCCULT BLD	NEG	-NEG
UR WBC	NEG	0- 1
UR RBC	NEG	0- 1
UR EPITH	NEG	0- 1
UR BACTERIA	1+	-NEG
UR AMORPH	4+	-NEG
UR CRYSTALS	NEG	-NEG
UR CASTS	NEG	-NEG
UR MUCOUS	NEG	-NEG
UR MISC.	NEG	

AUTOMATED MEDICAL SERVICES OF OHIO, INC.
Box 615 Mansfield, Ohio 44901

J E SLINGLUFF,DO
2223 FULYON AVE.N.W
CANTON OH
44720

ACCT. NO 5204127
PAGE NO

R.J. THABET, M.D., F.C.A.P., F.A.S.C.P
MEDICAL DIRECTOR

ACC NO	NAME	DATE RECEIVED	DATE RETURNED
548984	HOODIE THOMPSON	11/08/77	11/08/77

TEST	RESULTS		NORMAL RANGE OR COMMENT
UR MISC.	NEG		
BUN/CREAT RAT.	TO FOLLOW		
CALCIUM SERUM	9.4	MG/DL	8.5-10.5 MG
PHOSPHORUS	3.9	MG/DL	2.5- 4.5 MG
GLUCOSE	129	H MG/DL	65- 110 MG
BUN	13	MG/DL	10- 20 MG
URIC ACID	7.3	MG/DL	2.5- 8.0 MG
CHOLESTEROL	171	MG/DL	150- 300 MG
TOT PROT	6.6	GM/DL	6.0- 8.0 GM
ALBUMIN	3.13	L GM/DL	3.50-5.00 GM
BILIRUBIN TOTAL	1.0	MG/DL	0.2- 1.0 MG
ALK PHOS	213	H MU/ML	30- 115 MU
LDH	284	H MU/ML	90- 200 MU
SGOT	21	MU/ML	10- 50 MU
GLOBULIN	3.5	H GM/DL	1.3- 3.2 GM
AG RATIO	0.9-1		

AUTOMATED MEDICAL SERVICES OF OHIO, INC.
Box 615 Mansfield, Ohio 44901

J E SLINGLUFF,DO
2223 FULYON AVE.N.W
CANTON OH
44720

ACCT. NO. 5204127
PAGE NO.

R.J. THABET, M.D., F.C.A.P., F.A.S.C.P
MEDICAL DIRECTOR

9007 0477

DOCTORS HOSPITAL
MASSILLON, OHIO
X-RAY REPORT

Examination of NAME					
Thompson, Woodie			Chest, Abdomen		
X-RAY NO.	DATE	HOSPITAL NO.	ROOM NO.	O.P.D.	DR.
77-13403	11/26/77	119865	160-2		Slingluff

Report:

Chest: in two projections revealed the presence of an increased density noted within the left lower lung field. Infiltrate was noted throughout the left lung field. On the lateral projection, the suggestion of a left pleural effusion was noted. A left lateral decubitus projection is recommended for further evaluation. Discoid streaking was noted within the right mid lung field.

Adomen: in supine projection revealed the presence of homogenous density noted throughout the entire abdomen. This may represent evidence of peritoneal fluid. An absence of gas was noted within the left mid abdomen. This may represent the presence of a mass in this area and an IVP is recommended for further evaluation. Hypoplastic 12th ribs were noted bilaterally. Other variation not identified.

RPL/gp

MAR 7 1978

Signature of Roentgenologist

0007 0473

DOCTOR'S HOSPITAL OF STARK COUNTY, MASSILLON, OHIO

CYTO PATHOLOGY REPORT

Chart No. 119865

Name Thompson, Woodie Room No. 160-02 SP Lab. No. 77-P-113301

Surgeon, Dr. Slingluff Age 49 Sex M Race N Date 11-26-77

Resident, Dr. Intern, Dr.

Pre-Operative Diagnosis (Clinical)

Operation

Post-Operative Diagnosis (Clinical)

Tissue Removed Paracentesis fluid

MICROSCOPIC:

We identify numerous histiocytes together with erythrocytes and small cell clusters with somewhat indistinct nuclei. Others of these cells appear having a vacuolated-type cytoplasm and the nuclei appear displaced to the peripheral margin. Some of the cells also appear to have prominen nucleoli. Inflammatory cells are also seen, being part of the background.

The large clusters of cells described appear most consistent with adenocarcinoma, mucus-producing type cell.

IMPRESSION:

PARACENTESIS FLUID, POSITIVE CYTOLOGY. (2Y60-8143)

M. R. Durishin, D. O.
Pathologist
11-29-77
lk

MAR 7 1978

8007 0479

DOCTOR'S HOSPITAL
MASSILLON, OHIO
X-RAY REPORT

Examination of NAME					
Thompson, Maddie			Chest, ABdomen		
X-RAY NO.	DATE	HOSPITAL NO.	ROOM NO.	O.P.D.	DR.
77-13403	12/12/77	120260	142-1		Slingluff

Report:

Chest: in AP projection utilizing the portable apparatus:

Comparison made to previous examination on 11/30/77. The left lung was unchanged as compared to previous examination. Pleural effusion with left lower lobe infiltrate was again noted. Right lung field revealed marked increase in infiltrative changes throughout the portion of the lung as compared to previous examination. Consolidated infiltrate was noted within the right base extending up toward the apex. this was most likely secondary to pneumonitis or pulmonary infarction. The cardiomediastinal silhouette was unchanged.

Abdomen: in supine projection revealed a generalized haziness noted throughout the abdomen. Psoas margins were not noted. The liver border or splenic border could not be visualized. We could not visualize the renal contours. These findings suggest peritoneal fluid. No evidence of gaseous distention was noted. Other variation not identified.

RFL/gp

MAR 7 1978

Signature of Roentgenologist

5007 0490

NUCLEAR MEDICINE

NAME			
[illegible], Neadie			Lung scan; Liver/spleen scan
77-1[illegible]	12/14/77	129269	142-1 Slingluff

Lung scan:

Right lung:

1. Diminished perfusion seen in right upper lung field and inright base. There is infiltration and effusion in these areas on the chest x-ray and differential diagnosis would exist between tumor versus infarction versus pneumonitis.

Left lung:

1. Decreased perfusion is seen throughout lower portion of left lung field. There is effusion and infiltration present on chest x-ray and these findings again present differential diagnosis exists between pneumonia versus infarction. Clinical correlation is suggested.

Liver/Spleen Scan:

1. Some areas of increased uptake are seen in left lobe of liver. This is sometimes seen with obstruction of the superior vena cava. A study of the superior vena cava utilizing Technetium is recommended for further evluation. Liver is otherwise unremarkable.

2. Spleen appears to be within normal limits.

RJr/gp

MAR 1978

PHYSICIAN'S COPY

0007 0431

ADMITTING DIAGNOSIS: 1. Carcinoma of liver and lungs.

FINAL DIAGNOSIS: 1. Carcinomatosis with hepatic lesions, primary site lung.

The patient was admitted because of abdominal distention with shortness of breath. Ascites was believed to be the primary difficulty. He was seen on consult by Dr. Thomas Halter who recommended a paracentesis.

His 2 hour postprandial blood sugar was 110. BUN was 19. Electrolytes showed sodium at 144, potassium at 4.4, chlorides at 104, CO2 at 26. VDRL was nonreactive. The urine was slightly hazy, pH of 5, specific gravity 1.030. Protein 1+. White blood cells occasional. Casts showed 20 hyaline casts with eosinophils occasional and 1+ uric acid. The calcium was 8.9, phosphorus was 4.7. Total protein was 8.0. The albumin was 2.9. Globulin was 5.1, A to G ratio was 0.6. Cholesterol was 166. Uric acid was 8.3. Total bilirubin 0.2, SGOT was 18. LDH was 144. Alkaline phosphatase was 99. CBC showed 5.5 thousand white cells, 4.2 million red cells, 10.0 grams of hemoglobin, 31% hematocrit. 74 MCV, 23.3 MCH wich is very low, 31.4 MCHC with 73 segs, 2 bands, 21 lymphocytes, 4 monocytes. 1 nucleated red blood cell per 100 white cell Adequate platelets. 1+ hypochromia. 2+ anisocytosis, 2+ poikilocytosis, 2+ microcytosis, wit slight stippling. Repeat studies were essentially unchanged. Paracentesis was accomplished. The patient had had a previous paracentesis which was positive for malignant cells on his previous admission to this hospital. Chest x-rays were taken and were essentially unchanged as far as the left lung was concerned and question of pleural effusion of the lower left lung was noted with an infiltrate and ascites was suspected. A lung scan was taken, showed diminished profusion of the right lung upper field and right base. Left lung showed decreased profusion throughout the lower portion of the left lung. The liver-spleen scan showed increased uptaken in the left lobe of the liver. Question of obstruction of the superior vena cava.

The patient's course was one of continued difficulty with this ascites and complications of his malignancy. He was transferred to Cleveland Clinic for further work up and continued evaluation.

J.E. Slingluff, D.O.

d: 1-7-78
t: 1-11-78
JES/gl

MAR 7 1978

NOTES MUST BE SIGNED BY PHYSICIAN

9007 0482 PQ

Date of Admission: 11-25-77
Date of Discharge: 12-6-77

This patient was admitted with obvious ascites. History of carcinoma of the lung. Gave hist of having had a thoracotomy at Cleveland Clinic. Was seen on consult by Dr. Halter who felt that a paracentesis was indicated, as the ascites was probably secondary to metastasis to liver.

The Urine was yellow and clear with pH of 5. Specific gravity 1.018. Protein negative, sugar negative, acetone negative, blood negative, bilirubin negative, urobilinogen negative. The urine was loaded with uric acid.The serum sodium was 142, potassium 3.7, chloride 99. CO2 was 28. The glucose was 83. The BUN was 18, calcium was 8.7, phosphorus 3.3, total protein 6.1. Albumin low at 2.3, globulin high at 3.8, A to G ratio was 0.6, also abnormal. Choleste 171, uric acid was 8.3, which is elevated. Total bilirubin was 0.4. SGOT was 12, LDH was 13 alkaline phosphatase was 80. Triglycerides were 153. CBC showed 8,100 white cells per high powered field, 4.16 million red cells per high powered field. 9.9 grams of hemoglobin. 30.2 hematocrit, 72 MCV, 23.9 MCH, 32.8 MCHC with 73 neutrophils, 21 lymphocytes, 2 monocytes and 4 cosinophils showing hypochromia poikilocytosis, microcytosis and anisocytosis. A protein electrophoretic study was abnormal showing total protein low at 5.7, albumins low at 2.49, globulins showed slight elevation of the alpha 1 at 0.45, normal alpha 2 at 0.82, normal bet at 1.05, normal gamma at 0.99. A to G ratio abnormal at 0.7. T3 was 30.4, T4 was 7.7, T7 was 7.8. Repeat study showed continuous low albumin. He was supplemented with IV albumin which improved until the time of discharge. Chest x-ray showed increase density noted within the left lower lung field. Infiltrate was noted throughout the left lung field and discoid streaking was noted in the right lung. The abdomen was suggestive of ascites. Repeat chest x-rays showed the cardiomegaly to be evident. Some tortuosity of the thoracic aorta. Suggest of effusion was noted. Lung scans were taken showing almost no uptake in the left lung field Decrease uptake in the right lung field suggestive of pleural effusion. EKG showed an abnorm EKG with generalized nonspecific ST-T wave changes consistent with ischemia and/or electrolyte imbalance. Paracentesis was accomplished twice by Dr. Halter and the paracentesis fluid showed a positive cytology consistent with adenocarcinoma of the mucous producing type.

The patient's course was some improvement with relief of some of the symptoms following remo of fluid. He was discharged to be followed as an out patient.

J.E. Slingluff, D.O.

d: 12-23-77
t: 12-28-77
JES/gl

MAR 7 1978

8007 0483

NOTES MUST BE SIGNED BY PHYSICIAN

Inter Office

Personnel and
Organization Staff

Mr. Paul E. Toth

April 28, 1978

Subject: Asbestos Exposure-Cleveland Casting Plant

An investigation of Mr. Woody Thompson's death was conducted at the Cleveland Casting Center on April 25, 1978. Short meetings were held with D. Simmons, D.O., Messrs. G. Short, Security Supervisor, R. Hisnay, Supervisor Worker's Compensation, R. Finnessy, Worker's Compensation Administrator/also former floor supervisor in Mr. Thompson's department, and R. McDaniel, Floor Supervisor, Department 4789.

In general, the operation of concern was a two-shift operation consisting of repair welding on cast parts. This operation was initiated in 1951 and was terminated in November of 1976. (The job was free effort and no production standards existed for it.) Approximately 35 to 45 people were employed on this job at a time. A total number of employes holding this classification was not obtained. An attempt was made to determine if all employes formerly employed in this operation could be identified. This question could not be fully answered but it appears that identification will be somewhat difficult requiring review of individual records.

An attempt was made to define conditions of the operation (furnace welding) which would influence employe asbestos exposure. A plant layout of the cleaning room is attached with the position of employes doing repair welding shown in red.

Mr. Thompson's job was repair welding on heads or blocks. These parts were preheated in a furnace to facilitate welding (maintain welding temperature and stress relief of parts). To provide radiant heat shielding while performing the operation sections of asbestos millboard was used. The sections of boards would vary in size and shape due to the type of repairs being made. The asbestos board would have been shaped by the employe to expose minimal surface area of the part.

Information concerning medical responsibilities in this case was received from Dr. Simmons. A review of the record indicated that on May 6, 1977, Cleveland Casting Plant medical department was informed of the diagnosis of Mr. Thompson's mesothelioma.

Mr. Thompson's medical jacket contains five chest x-rays, the most recent being 1974. It was normal procedure to give yearly x-rays to employes in this area. It would seem that procedural problems (difficulty with scheduling, noncompliance by production personnel with medical requests) precluded getting x-rays for every year of Mr. Thompson's exposure.

I was informed that medical records of other employes in the area should contain the same type of data.

Dr. Simmons also checked the OSHA log during our interview and found that Mr. Thompson's death was not reported or recorded. This case was not considered recordable.

Discussions with Mr. Hisnay revealed that no other cases are pending on asbestos related disease from this or any other area of the plant. However, it was reported that two other deaths of former department 4789 employes have occurred. These do not appear to be asbestos related. Death certificates are enclosed.

Discussions with Mr. W. Kosicky, Material Control Clerk, revealed that the material used was asbestos millboard, 42" x 48" x $\frac{1}{4}$", supplied by Allan Packing Company. The current manufacturer is Philip Carey.

Allan Packing Company has been the supplier for the years of production use except for an approximate three-week interuption of supply.

Mr. Kosicky's estimate of usage was 50 sheets per month during the production welding operation.

Keith Lee

Keith Lee

lb
Attachments

Attachment

The shaping of the board was done by simply scoring the asbestos millboard with a sharp object and breaking it. It was stated by both Messrs. McDaniel and Finnessy that no grinding, sawing, or power cutting of any type was performed on the boards.

Mr. Finnessy and Mr. McDaniel both stated:

a. The area was clean relative to other areas in the plant

b. Employes did not wear respirators. However, welding faceshields or goggles were worn by the welders

c. Housekeeping in the area was above average

d. No training in the hazards of asbestos was conducted for the employes

e. Employes were supplied with Company issued coveralls and those may have been taken home

f. Little abuse of the asbestos boards occurred, except to write names of messages on them with the acetylene gas (this left a black residue on the boards)

g. The boards were not used as bumpers or parts stops

h. Some employes, as personal preference, ate or smoked at their job location

i. Each employe did his own shaping of the asbestos boards. In some instances, the set-up man might prepare a few boards for the welders but generally each man made his own

j. No air blowoffs were remembered

k. The area was well supplied with air-supply ventilation to provide air for cooling. There was no exhaust ventilation

l. Neither man could remember any habit unique to Mr. Woody Thompson which would have increased his exposure greater than other employes in the area

m. The asbestos was disposed of with any regular rubbish generated in the department, no special provisions were made for it

n. Furnaces used in the area were not lined or insulated with asbestos

o. Material was delivered to the area in 42" x 48" x $\frac{1}{4}$" sheets

R. Pupillo
10-C-...

Reg Dist No 18 — Primary Reg Dist No 1877

OHIO DEPARTMENT OF HEALTH
DIVISION OF VITAL STATISTICS
CERTIFICATE OF DEATH

State File No. — Registrar's No. 902W

1341

TYPE OR PRINT IN PERMANENT INK

1 DECEASED—NAME (First) Grover	(Middle) -	(Last) GRAVES	2 SEX Male	3 DATE OF DEATH (Month, Day, Year) April 25, 1977	
4 RACE (White, negro, american indian, etc.) (Specify) Black	5a AGE—(Last birthday) (years) 60	5b UNDER 1 YEAR (Mos. Days)	5c UNDER 1 DAY (Hours Min.)	6 DATE OF BIRTH (Month, Day, Year) June 28, 1916	7a COUNTY OF DEATH Cuyahoga
7b CITY, VILLAGE, OR LOCATION OF DEATH Middleburg Heights	7c INSIDE CITY LIMITS (Specify yes or no) Yes	7d HOSPITAL OR OTHER INSTITUTION—NAME (If not in either, give street and number) Southwest General Hospital			
8 STATE OF BIRTH (If not in U.S.A., name country) North Carolina	9 CITIZEN OF WHAT COUNTRY USA	10 MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	11 SURVIVING SPOUSE (If wife, give maiden name) Sophronia K. (Wesley)		
12a SOCIAL SECURITY NUMBER 236-42-2895	12b WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	(If yes, give dates of service) Apr. 21, 1942 to Oct. 25, 1945			
13a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder	13b KIND OF BUSINESS OR INDUSTRY Ford Motor Co.				
14a RESIDENCE—STATE Ohio	14b COUNTY Cuyahoga	14c CITY, VILLAGE OR LOCATION Berea	14d INSIDE CITY LIMITS (Specify yes or no) Yes	14e STREET AND NUMBER 724 Shelley Parkway	
15 FATHER—NAME (First) Morris	(Middle) -	(Last) Graves	16 MOTHER—MAIDEN NAME (First) Roseline	(Middle) -	(Last) Simpson
17a INFORMANT—NAME Mrs. Sophronia K. Graves	17b MAILING ADDRESS (Street or R.F.D. no., city or village, state, zip) 724 Shelley Parkway Berea, Ohio 44017				

PART I DEATH WAS CAUSED BY: (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c).)

18 IMMEDIATE CAUSE (a) Cardio. respiratory arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF: (b) Ruptured dissection of heart

DUE TO, OR AS A CONSEQUENCE OF: (c) Liver + K. failure + gastrointestinal

PART II. OTHER SIGNIFICANT CONDITIONS (Conditions contributing to death but not related to cause given in part I(a)) — 19a AUTOPSY (Yes or no) — 19b IF YES were findings considered in determining cause of death

Arteriosclerosis

20a ACCIDENT, SUICIDE, HOMICIDE, OR UNDETERMINED (Specify)	20b DATE OF INJURY (Month, Day, Year)	21 HOUR	HOW INJURY OCCURRED (Enter nature of injury in part I or part II, item (a))
20c INJURY AT WORK (Specify yes or no)	20d PLACE OF INJURY (At home, farm, street, factory, office bldg., etc. (Specify))	20e LOCATION (Street or R.F.D. no., city or village, state, zip)	

PHYSICIAN CERTIFIER

CERTIFICATION—PHYSICIAN: I ATTENDED THE DECEASED FROM (Month Day Year) 4-17-77 TO (Month Day Year) 4-25-77

21c AND LAST SAW HIM/HER ALIVE ON (Month Day Year) 4-24-77 — 21d DID/DID NOT VIEW THE BODY AFTER DEATH — 21e DEATH OCCURRED (HOUR) 3:20 AM — To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) stated.

CORONER CERTIFIER

22a CERTIFICATION—CORONER (On the basis of the examination of the body and/or the investigation, in my opinion, death occurred on the date and due to the cause(s) stated.) Hour of death — M.

22b The decedent was pronounced dead (Month Day Year) Hour — M.

23a CERTIFIER—NAME (Type or print) John A. Pupillo, M. D.	23b SIGNATURE	Degree or title M.D.	23c DATE SIGNED 4/27/77
23d MAILING ADDRESS—CERTIFIER (STREET OR R.F.D. NO.) 4732 Pearl Rd.,	(CITY OR VILLAGE) Cleveland,	(STATE) Ohio	(ZIP) 44109

BURIAL

24a BURIAL, CREMATION (Specify) Burial	24b DATE Apr. 28, 1977	24c NAME OF CEMETERY OR CREMATORY Woodvale	24d LOCATION (City, village, or county) (State) Middleburg Heights, Ohio
25 NAME OF EMBALMER Richard A. Baker	(LIC. NO.) 5840-A	26 FUNERAL DIRECTOR'S SIGNATURE Richard A. Baker	(LIC. NO.) 4771
27 FUNERAL FIRM AND ADDRESS (STREET NO.) Baker Funeral Home 206 Front Street	(CITY) Berea,	(STATE) Ohio	(ZIP) 44017

28 DATE REC'D BY REGISTRAR APR 28 1977	REGISTRAR'S SIGNATURE	30 DATE PERMIT ISSUED 11/27/77	31 SIGNATURE OF PERSON ISSUING PERMIT	DIST. NO. 1512

APR 29 1977

WITNESS MY HAND AND SEAL OF THE BOARD OF HEALTH

LOCAL REGISTRAR OF VITAL STATISTICS

3007 0487

PO

S.S.U. 3152.08 Rev. 8/73

OHIO DEPARTMENT OF HEALTH
DIVISION OF VITAL STATISTICS
CERTIFICATE OF DEATH

Reg. Dist. No. 18 | Primary Reg. Dist. No. 1835 | State File No. | Registrar's No. 141-77

DECEASED

1 DECEASED—NAME (First / Middle / Last)	2 SEX	3 DATE OF DEATH (Month, Day, Year)
JOSEPH / FERGUSON	MALE	JANUARY 13, 1977

4 RACE (White, negro, american indian, etc. (Specify))	5a AGE—Last birthday (years)	5b UNDER 1 YEAR: Mos. / Days	5c UNDER 1 DAY: Hours / Min.	6 DATE OF BIRTH (Month, Day, Year)	7a COUNTY OF DEATH
NEGRO	48			3-28-1928	CUYAHOGA

7b CITY, VILLAGE, OR LOCATION OF DEATH	7c INSIDE CITY LIMITS (Specify yes or no)	7d HOSPITAL OR OTHER INSTITUTION—NAME (If not in either, give street and number)
WARRENSVILLE	YES	SUBURBAN COMMUNITY HOSPITAL

8 STATE OF BIRTH (If not in U.S.A., name country)	9 CITIZEN OF WHAT COUNTRY	10 MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	11 SURVIVING SPOUSE (If wife, give maiden name)
GEORGIA	USA	MARRIED	MARY FANNING

12a SOCIAL SECURITY NUMBER	12b WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give dates of service)
255-36-1067	NO

USUAL RESIDENCE WHERE DECEASED LIVED IF DEATH OCCURRED IN INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION.

13a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	13b KIND OF BUSINESS OR INDUSTRY
WELDER	AUTO INDUSTRY

14a RESIDENCE—STATE	14b COUNTY	14c CITY, VILLAGE OR LOCATION	14d INSIDE CITY LIMITS (Specify yes or no)	14e STREET AND NUMBER
OHIO	CUYAHOGA	CLEVELAND	YES	16409 WALDEN AVE.

PARENTS

15 FATHER—NAME (First / Middle / Last)	16 MOTHER—MAIDEN NAME (First / Middle / Last)
UNKNOWN	MARY FERGUSON

17a INFORMANT—NAME	17b MAILING ADDRESS (Street or R.F.D. no., city or village, state, zip)
MARY FERGUSON	16409 WALDEN AVE. CLEVELAND, OHIO 44128

CAUSE

PART I **DEATH WAS CAUSED BY:** ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c).

18		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last)	(a) Congestive Heart Failure	Hours
	DUE TO, OR AS A CONSEQUENCE OF: (b) Congestive Cardiomyopathy	1973
	DUE TO, OR AS A CONSEQUENCE OF: (c)	

PART II OTHER SIGNIFICANT CONDITIONS (Conditions contributing to death but not related to cause given in part I (a)): Hypertension

19a AUTOPSY (Yes or no)	19b IF YES were findings considered in determining cause of death

20a ACCIDENT, SUICIDE, HOMICIDE, OR UNDETERMINED (Specify)	20b DATE OF INJURY (Month, Day, Year)	20c HOUR	20d HOW INJURY OCCURRED (Enter nature of injury in part I or part II, item 18)

20e INJURY AT WORK (Specify yes or no)	20f PLACE OF INJURY (At home, farm, street, factory, office bldg., etc. (Specify))	20g LOCATION (Street or R.F.D. no., city or village, state, zip)

PHYSICIAN CERTIFIER

21a CERTIFICATION—PHYSICIAN I ATTENDED THE DECEASED FROM (Month, Day, Year)	21b (Month, Day, Year)	21c AND LAST SAW HIM/HER ALIVE ON (Month, Day, Year)	21d I DID/DID NOT VIEW THE BODY AFTER DEATH.	21e DEATH OCCURRED (HOUR)	At the place, on the date, and, to the best of my knowledge, due to the cause(s) stated.
7/1968	1/13/77	12 17 76			

CORONER CERTIFIER

CERTIFICATION—CORONER On the basis of the examination of the body and/or the investigation, in my opinion, death occurred on the date and due to the cause(s) stated.

22a Hour of death	22b The decedent was pronounced dead (Month, Day, Year, Hour)

23a CERTIFIER—NAME (Type or print)	23b SIGNATURE	Degree or title	23c DATE SIGNED
N. E. Wills, MD	N. E. Wills, M.D.		1/21/77

23d MAILING ADDRESS—CERTIFIER	STREET OR R.F.D. NO.	CITY OR VILLAGE	STATE	ZIP
16604	Harvard Avenue	Cleveland,	Ohio	44128

BURIAL

24a BURIAL CREMATION (Specify)	24b DATE	24c NAME OF CEMETERY OR CREMATORY	24d LOCATION (City, village, or township) (State)
BURIAL	1-18-77	HIGHLAND PARK CEMETERY	CELEVELAND OHIO

25 NAME OF EMBALMER	(LIC. NO.)	26 FUNERAL DIRECTOR'S SIGNATURE	(LIC. NO.)
EDWARD E. STROWDER	5645 A	Edward E. Strowder	4640

27 FUNERAL FIRM AND ADDRESS	(STREET NO.)	(CITY)	(STATE)	(ZIP)
STROWDER FUNERAL CHAPEL	818 EAST 105th STREET	CLEVELAND	OHIO	44108

DATE REC'D BY LOCAL REG.	29 REGISTRAR'S SIGNATURE	30 DATE PERMIT ISSUED	31 SIGNATURE OF PERSON ISSUING PERMIT	DIST. NO.
JAN 24 1977	E. A. Zuercher	JAN 24 1977		

5152.08 Rev. 8/73

THERE IS CERTIFY THAT THIS IS AN EXACT COPY OF THE ORIGINAL RECORD

No N. C.

JAN 24 1977

FEB 3 1977

8007 0433

WITNESS MY HAND AND SEAL AS CHIEF OF BUREAU OF VITAL STATISTICS

file

Inter Office

Personnel and Organization Staff

25 July 1983

Mr. D. Schultz
Safety Engineer
Cleveland Casting Plant

Subject: Material Analysis

A sample of material that you submitted was analyzed by the Industrial Hygiene Laboratory. You expressed concern that it contained asbestos.

The material is comprised of a red fibrous matrix which included a granular gritty material. The fibers appear to be organic which was confirmed upon ignition above a Bunsen Burner. Approximately one-third of the material ignited leaving no ash or residue. A course granular material remained which was examined microscopically. The particles had the appearance of sand which was subsequently confirmed by your office to be core sand. Asbestos fibers were not demonstrated microscopically. Since asbestos is non-ignitable, the fibrous portion of the sample is assumed to be a material similar to wool, cotton, or wood. No fiberglass was indicated.

Roger Wabeke

Roger Wabeke, Supervisor
Industrial Hygiene Services
Employee Health Services

jb

8007 C489

FORD MOTOR COMPANY INDUSTRIAL HYGIENE LABORATORY
SAMPLE IDENTIFICATION, ANALYSIS REQUEST & RESULTS REPORT.

By Whom taken: Dave Schultz 216-676-7241 Date taken: 7/15 Date submitted to lab: 7/19 Name of Plant: Cleveland Casting

RETRIEVAL No.	SAMPLING TECHNIQUE	ANALYSIS REQUIRED	RESULTS	PROCEDURE	LABORATORY No.
RLW 821	Grab	Qual on suspected asbestos	Neg		83-1250
		Material was fibrous and red in color. Ignition showed it to be mainly organic with a sand residue and a small amt of fiberglass like material est < 0.1% by wt. (sand is from casting operations)			

Date reported from lab: 7/22/83 Analyst(s) RLW + TFS Concur:

Remarks: