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

STATE OF ILLINOIS

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

EMPLOYER'S REPORT OF COMPENSABLE INJURY

(Copy should be sent immediately to Insurance Carrier)

Accident Number _____

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

EMPLOYER:

1. Name AMERICAN CYANAMID Co.
2. Doing business under the name of: _____
3. Address, Street and No. 1500 So KILBOURN AVE City CHICAGO ILL.
4. Nature of Business: LEAD MFR.
5. Name of compensation insurance carrier: _____

INJURED EMPLOYEE:

1. Name: ROBERT COBURN
2. Address, Street and No.: 4149 W. 21ST PL. City CHICAGO ILL.
3. Sex: MALE
4. Marital Status MARRIED
5. Age: 53
6. Occupation OPERATOR OF BALL MILL.
7. Average Weekly Earnings: _____
8. No. of Children under 18 years of age: 5 CHILDREN

INJURY:

1. Date of injury: JUNE 7, 1971
2. Hour: WHEN TO DOCTOR BEFORE WORK
3. How did injury happen: LEAD POISONING OVER 4 YEARS
   LEAD ABSORPTION WITH PENDING LEAD INTOXICATION
4. What was employee doing when accident occurred? OPERATOR OF BALL MILL.
   (Describe briefly, such as loading truck, operating drill press, shoveling sand, etc.)
5. Name of machine, tool, substance, or object most closely connected with the accident: BALL MACHINE
   (Name the machine, tool, appliance, gas, liquid, etc., involved)
6. If machine or vehicle, what part of it? CRUSHER
   (State if gears, pulley, point of operation, etc.)
7. Where: Street and No. 1500 So KILBOURN AVE, City CHICAGO, State ILL.
8. Describe injury (if specific loss, give date of loss) LEAD SUBSTANCE IN BLOOD SYSTEM
9. Length of disability (if undetermined give estimate) 3 MONTHS

COMPENSATION IN NON-FATAL CASES:

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

COMPENSATION IN FATAL CASES:

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

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