Form O D-2

INSTRUCTIONS: In accordance with Section 4123.28 of THE OHIO WORKMEN'S COMPENSATION ACT every employer shall keep a record of all injuries received by his employes, in the course of their employment and report same to The Bureau of Workmen's Compensation upon forms provided for that purpose. THIS APPLICATION MUST BE FULLY COMPLETED AND FILED WITH THE BUREAU PROMPTLY. Part I of this form must be executed by the employer by whom the deceased was employed when his disability began, or his authorized agent. Part II of this form must be completed and signed by the claimant. Mail this report to the completed form to The Bureau of Workmen's Compensation, Claims Section, Columbus, Ohio.

Do not write in this column
Age
Sex & c. c.
Dependents
Location (Geo.)
Date Report Filed
Date of Death
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 Injury
Days Lost
Coded by
Manual No.
Risk No.

3-4-64 MKG

FOR OCCUPATIONAL DISEASE ONLY

Claim No. O. D. 107910

STATE OF OHIO

BUREAU OF WORKMEN'S COMPENSATION

First Notice of Death and Preliminary Application

EMPLOYER'S REPORT

PART I

EMPLOYER

1. Name of employer: The Philip Carey Manufacturing Company (Name as shown on Insurance Certificate)
2. Office Address: 320 (Number) S. Wayne Ave. (Street) Hamilton (County) Cinti. (City) Ohio (State)
3. Nature of business: Manufacturing (Farming, Coal Miner, Mach. Mfr., etc.) Type of Organization: Corporation (Partnership, Corp. or Individual owner)

DECEASED EMPLOYE

4. Name: Henry (First) H. (Middle Initial) Hoerst (Last)
5. Home Address: 1105 Wayne Ave. (Number) (Street) Cincinnati 15 (City) Ohio (State)
6. Age 10-14-00 Male Female: Male Single, Married, Divorced, Widowed: Married Social Security No. 270-07-0405
7. Number and relationship of dependents: One - Wife
8. Was deceased a partner, member of firm or owner of business? No

OCCUPATIONAL DISEASE (TIME)

9. Where was disease contracted: See record (City) (County) (State)
10. Date quit work: 11-17-60 Date of death: 10-17-63
11. What was deceased's occupation?
12. Explain fully the kind of work deceased was doing when disability began:
13. How long had deceased been doing this work?
14. Experience of deceased employe in this type of work during the three years preceding the beginning of the disability:
15. When did the last period of *employment with this employer begin?*
16. Name the employers for whom deceased had worked during the three years preceding the beginning of the disability, and give their addresses and business:
17. Decedent's earnings were reported on payroll reports of Risk No

Under Manual No.

By signing below, I do hereby certify that I have authority to execute this Employer's Report and that the answers to the questions given in said report are correct to the best of my information and belief; that the deceased herein named was, on the date shown herein, an employe of the undersigned and at the time of entering into the employment from which the disease is claimed to have resulted (did not) represent himself as not having previously suffered from such disease.

Date report sent to claimant For THE PHILIP CAREY MFG. CO. (Name of employer as shown on Insurance Certificate)

Date received from claimant SAFETY SUPVR. (Official title of person signing and his department) 12-26-63

Date mailed to Bureau (Name of employer as shown on Insurance Certificate)

RECEIVED DEC 13 1963

DEC 5 1963

PLAINTIFF'S EXHIBIT 1-24-68