FOR STATE OF ILLINOIS USE ONLY

DATE RECEIVED

U C EMPLOYER NO.

FILE NO. (OSHA)

STATE OF ILLINOIS
INDUSTRIAL COMMISSION
160 N. LA SALLE ST., CHICAGO, ILLINOIS 60601

EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS

(COPY SHOULD BE SENT TO INSURANCE CARRIER IMMEDIATELY)

ALL EMPLOYERS ARE REQUIRED TO SUBMIT THIS REPORT TO THE ILLINOIS INDUSTRIAL COMMISSION UNDER ILL. PUB. ACTS 77-1900, 77-1901 and 77-1902

EMPLOYER

1	DATE OF REPORT: 7/23/73	ILL. UNEMPLOYMENT COMPENSATION NO.	SIC CODE	REPORT DATE / SIC
2	EMPLOYER'S NAME: American Cyanamid Company			
3	DOING BUSINESS UNDER THE NAME OF: MacGregor Lead Plant			
4	MAILING ADDRESS NO. STREET: 4500 W. 15th St.			
5	CITY: Chicago, Ill. / STATE / ZIP CODE: 60623	COUNTY: Cook	ZIP: 60623	
6	PLANT LOCATION IF DIFFERENT THAN MAILING ADDRESS — STREET / CITY / STATE / ZIP CODE		COUNTY	
7	EMPLOYER'S PHONE NO. (AREA CODE): 312-522-2200	IS EMPLOYER: ☐ INDIVIDUAL ☐ PARTNERSHIP ☒ CORP.	IF MORE THAN ONE PLANT, EMPLOYER NO. OR LOCATOR FOR PLANT: 097	PHONE ( )- / TYPE
8	NATURE OF BUSINESS OR SERVICE (MFG, TRANSPORT, ETC): lead stabilizer manufacturer	SPECIFIC PRODUCT OR SERVICE: lead stabilizers		INS. CO. NO.
9	NAME OF WORKMEN'S COMP. INS. CO. OR, IF SELF-INSURED SPECIFIC OR AGGREGATE CARRIERS: INA	POLICY NO.	SELF INSURED: YES ☐ NO ☐	POLICY NO. / SELF
10	NUMBER OF EMPLOYEES: 30	(1) TOTAL NO. LAST REPORTED FOR UNEMPLOYMENT COMPENSATION PURPOSES: 30	(2) IF MORE THAN ONE PLANT, NO. AT LOCATION WHERE INJURY OR ILLNESS OCCURRED	NO. EMPL. / NO. EMPL.

EMPLOYEE

11	NAME LAST: Moore / FIRST: Leroy / MIDDLE	SOCIAL SECURITY NO.: 347-46-4145	SEX: M ☒ F ☐	STATUS: ☒ SINGLE ☐ MARRIED ☐ DIVORCED	SOC. SEC. NO. / SEX / STATUS
12	MAILING ADDRESS STREET: 4101 S. Federal / CITY: Chicago, Ill. / STATE / ZIP CODE: 60609				
13	DATE OF BIRTH: 7/24/53 / AGE: 19	IS EMPLOYEE UNDER 18 YEARS? YES ☐ NO ☒	NAME OF DEPT. NORMALLY ASSIGNED: general factory	LENGTH OF TIME WITH FIRM: 7 mo	BIRTH DATE / AGE / MINOR
14	JOB TITLE OR OCCUPATION: general factory	WAS EMPLOYEE TEMPORARILY WORKING IN ANOTHER DEPT. OR JOB AT TIME OF INJURY OR ILLNESS? YES ☐ NO ☒	HOW LONG HAS EMPLOYEE WORKED AT JOB AT WHICH INJURY OR ILLNESS OCCURRED? 7 mos.		OCC. CODE / TEMP / TIME
15	AVERAGE WEEKLY EARNINGS: $	NUMBER OF CHILDREN UNDER 18 AT TIME OF INJURY OR ILLNESS	DID EMPLOYEE DIE AS A RESULT OF INJURY OR ILLNESS? YES ☐ NO ☒		EARNINGS / CHILDREN / DIED
16	IF EMPLOYEE DIED:	(1) DATE OF DEATH	(2) GIVE NAME, ADDRESS, AGE AND RELATIONSHIP OF DEPENDENTS		DATE OF DEATH
17					
18					

INJURY / ILLNESS

19	DATE OF INJURY OR OF DIAGNOSIS ILLNESS:	WHAT SHIFT WAS EMPLOYEE WORKING? 2 ☐	TIME: 1:30 AM ☐ PM ☒	WAS INJURY OR EXPOSURE ON EMPLOYER'S PREMISES? YES ☒	REPORT OF: INJURY ☒	INJURY DATE / TIME / A OR P
20	PLACE OF INJURY OR EXPOSURE: MacGregor Lead Plant	ESTABLISHMENT NO. STREET: 4500 W. 15th St.				PREM. / IN OR ILL / REPORT LAG
21	CITY: Chicago, Ill. / STATE / ZIP CODE: 60623	COUNTY: Cook				COUNTY / ZIP
22	WHAT WAS EMPLOYEE DOING WHEN INJURY/ ILLNESS OCCURRED? turning electric hand truck around	WHAT MACHINE OR TOOL?	WHAT OPERATION?			CAUSE OR SOURCE
23						
24	HOW DID INJURY / ILLNESS OCCUR? TELL ALL OBJECTS AND SUBSTANCES INVOLVED IN INJURY / ILLNESS: truck ran over his foot					ACCIDENT TYPE
25						
26						

28		PART OF BODY AFFECTED: left instep	DID INJURY / ILLNESS OCCUR DURING AND IN THE COURSE OF EMPLOYMENT? YES XXX NO	ANY PRIOR PHYSICAL DEFECTS? YES XXX NO IF SO, WHAT? congenital deformity		PART	EMPL DEFECT
29	INJURY / ILLNESS	NATURE AND EXTENT OF INJURY / ILLNESS (BE SPECIFIC): contusion, dorsum of left foot				KIND	NATURE
30							
31		LAST DAY WORKED: 7/18/73	DATE RETURNED TO WORK: 7/19/73	IF DID NOT RETURN, DATE EXPECTED BACK: no lost time		LAST DAY	RETURNED
32		DID INJURY / ILLNESS OCCUR BECAUSE OF: UNSAFE CONDITION XXX / FAILURE TO USE SAFETY DEVICES XXX / FAILURE TO OBEY RULES XXX / UNSAFE XXX / USE OF XXX / XXX XXX / OTHER XXX				LAST DAY TO RETURN LAG	OCCURRED
33		IF EMPLOYEE TREATED, WHO? WHERE? NO. STREET CITY STATE ZIP CODE: Clearing Clinic, 5548 W. 65th St., Chicago, Ill. 60638				CASE CODE STATUS	
34		IF HOSPITALIZED, HOSPITAL NAME, ADDRESS NO. STREET CITY STATE ZIP CODE				NUMBER LOST DAYS	
35	COMPENSATION NONFATAL	IS COMPENSATION BEING PAID? YES XXX NO	RATE OF COMPENSATION: $ /WEEK	DATE FIRST PAYMENT	TO WHOM?	COMP	RATE $	DATE
36		ARE MEDICAL AND/OR HOSPITAL SERVICES BEING FURNISHED? YES NO	BY WHOM?			SERVICES		
37	FATAL	HAS COMPENSATION BEEN PAID? YES NO	TO WHOM? RELATIONSHIP	RATE OF COMPENSATION $ /WEEK	DATE FIRST PAYMENT	COMP	RATE $	DATE
38		LENGTH OF DISABILITY BEFORE DEATH (DAYS)	HAVE FUNERAL AND BURIAL EXPENSES BEEN PAID? YES NO	BY WHOM?		LENGTH	BURIAL	
39	REPORT PREPARED BY:	NAME: R. K. Felter	SIGNATURE: R K Felter	TITLE: Plant Manager	DATE: 7/23/73			

A FILING OF THIS REPORT IS NOT AN ADMISSION OF LIABILITY—ONLY A REPORT OF THE ALLEGED ACCIDENT OR OCCUPATIONAL DISEASE

NOTE: Every employer subject to the Illinois Workmen's Compensation and Occupational Diseases Acts shall file with the Illinois Industrial Commission a report, in writing, of all occupational injuries, illnesses and diseases arising out of, and in the course of the employment and resulting in death, disablement, or illness resulting in the loss of more than one scheduled work day or the inability of an employee to continue in his regular job. In case of death such report shall be made no later than 2 working days following the occupational death. In all other cases such report shall be made between the 15th and 25th of each month unless required to be made sooner by rule of the Illinois Industrial Commission. Failure to file with the Illinois Industrial Commission any of the reports required by law is a misdemeanor punishable by a fine of not less than $100 nor greater than $200. All reports filed hereinunder shall be confidential and any person having access to such records filed with the Illinois Industrial Commission as herein required, who shall release any information therein contained including the names or otherwise identify any persons sustaining injuries or disabilities, or give access to such information to any unauthorized person, shall be subject to discipline or discharge, and in addition shall, upon conviction, be punished by a fine of not more than $1,000 or by imprisonment for not more than 6 months, or both.

NOTE CAREFULLY: Any changes in status of case, including the commencement or stoppage of compensation payment, must be reported on Employer's Supplementary or Final Report of Injury or Illness (Form I.C. 85).

CY 0005358