

FILE NAME: Contract Unit Workers Comp Claims (WCC)

DATE: 1966

DOC#: WCC057

DOCUMENT DESCRIPTION: Workers Comp File - Taylor, Lawrence J

File Name **Contract Unit Claim File: Lawrence J. Taylor Sr.**

Scanned ? **yes**

Source **JMA: NS-JM**

Start Year **1966**

Stop Year **1966**

Contents **claim**

Notes

**WORKMEN'S COMPENSATION DEPARTMENT
LANSING, MICHIGAN**

EMPLOYER'S BASIC REPORT OF COMPENSABLE INJURY

(COPY SHALL BE GIVEN IMMEDIATELY TO INJURED EMPLOYEE AND INSURANCE CARRIER)

Employers must report immediately to the Department on Form 100 all injuries, including diseases, which arise out of and in the course of the employment and cause: 1. An aggregate of seven () or more days of disability not including Sundays or the day of injury. 2. Death. 3. Specific Losses. In case of **DEATH** also file immediately an additional report on Form 106. See Additional Instructions on Reverse Side, The Travelers Insurance Company

EMPLOYER Johnsville Sales Corporation 14
Assumed name, if any
832 Fisher Bldg. Detroit 2, Michigan **M. E. & C. Number**
Address—Street and Number (City) (State)

TYPE OF BUSINESS Industrial Insulation

INSURANCE CARRIER THE TRAVELLERS INSURANCE COMPANY 719 Griswold Street, Detroit 26, Mich.

INJURED EMPLOYEE Laurence J. Taylor Sr. **Soc. Sec. No.** 374-01-6553
(First name) (Middle initial) (Last name)
16854 Beaverland Detroit, Michigan **Marital status** M.
(Street and number) (City) (State)
Age 60 **Sex** M
If under 18, Occupational Approval No. Wking. Permit No.

Number of injured employee's children under age 16, living with injured. _____
If injured is a married man, is wife living with him? Yes
Number of other family members or relatives at least 50% supported by injured. _____

DATE OF INJURY 6-10-66 **Last day worked** 6-13-66
Describe injury or disease Collapsed Lung.

If specific loss, give date of loss 6-13-66
How did injury or disease happen? after moving a load of material this man had to sit down because he was all out of wind.

Where? City Romulus **State** Michigan
Foreman Laurence Taylor **Witnesses** _____
Physician _____ **Hospital** New Grace Hospital
Address _____ (Street and number) (City) (State)

Occupation of injured employee _____

Straight Time Earnings:	Hourly rate _____	Hours per week _____	Total \$ _____
Overtime Earnings:	Hourly rate _____	Hours per week _____	Total \$ _____
If board, room furnished give value _____			Total \$ _____
			Combined weekly earnings \$ _____

If on piece work or commission, explain fully _____

Estimated length of disability _____

HAS A COPY OF THIS REPORT BEEN GIVEN TO EMPLOYEE? Yes No

Laurence Taylor
Signature (in ink) EMPLOYER or Representative (Not Insurance Carrier)

Date of Report _____

9-6613 REV. 7-66 printed in U.S.A.

(LEAVE BLANK)

DO NOT WRITE
IN THIS COLUMN

CASE NO.

EMPLOYER NO.

INSURANCE

PLACE OF INJURY

DATE OF INJURY

NATURE

LOCATION

DISABILITY

AGE

OCCUPATION

CONJUG COND & SEX

DEPENDENTS

WEEKLY WAGE

AGENCY

INJURY TYPE

CODED BY

SUPERVISOR'S INVESTIGATION REPORT

The unsafe acts of persons and the unsafe conditions that cause accidents can be corrected only when they are known specifically. It is your responsibility to find them and cause them and to state the remedy for them in this report.

COMPANY Johns-Manville Sales Corporation		BRANCH OR SUBSIDIARY St. Louis
LOCATION OF ACCIDENT (The name or number of building, store, dept., floor, etc.) Metro Airport		DATE AND HOUR OF ACCIDENT 1-20-66
NAME OF INJURED PERSON Lawrence J. Taylor Sr.	INJURED'S DEPT. OR DIVISION Ind.	INJURED'S JOB OR POSITION Foreman
DESCRIBE THE INJURY Collapsed Lung		

DESCRIBE THE ACCIDENT (State what the injured was doing and the circumstances leading to the accident)

After moving a load of insulation material this man was struggling to get his breath, about that time I happened on the job and saw him, I asked what was wrong and he told me he was having trouble getting his breath, this was on Friday he worked the following Monday still having a little trouble but on Tuesday morning he came in and had to go back home. He went to the doctor and the doctor put him in the hospital.

UNSAFE CONDITION (Describe as oily floor, poor light, lack of guards on belts and gears, broken steps, etc.)

None

UNSAFE ACT - UNSAFE WORK PROCEDURE (Describe as removed guard, adjusted moving machine, or a specific item of unsafe procedure, lack of planned safety, etc.)

None

REMARKS (As a supervisor, what action have you taken or do you propose taking to prevent a repeat accident?)

None

SUPERVISOR L. Berardi	REVIEWED AND APPROVED BY J. M. Williams	DATE REPORT PREPARED 6-20-66
---------------------------------	---	--

30 DAY DUE 10-18

100

Person
NAME OF ACCIDENT (Name, Dept., or Firm) AND (No., Street, and City)
Rambling Michigan
DATE OF ACCIDENT OR DELAY (As reported)
What, became winded after moving load of material.
DEGREE OF INJURY OR DAMAGE (As reported)
 collapsed 22 lungs

REC-4475 01
 JA:bes 7-25-66

[illegible]

- 4 numbered images