FILE NAME: Garlock (GAR)

DATE: 1958-1960

DOC#: GAR027

DOCUMENT DESCRIPTION: Workmen's Compensation Case Report

ALBANY 4 — 1949 North Broadway
BINGHAMTO — 221 Washington St.
BUFFALO 2 — 210 Franklin St.
NEW YORK 13 — 80 Centre St.
CHESTER 14 — 100 Main St. W.
SYRACUSE 2 — 214 So. Warren St.

WORKMEN'S COMPENSATION BOARD
STATE OF NEW YORK

NOTICE OF AWARD IN DEATH CASES IN WHICH THERE ARE NO PERSONS ENTITLED TO COMPENSATION

1. W.C.B. CASE NO.	2 CARRIER'S CASE NO. AND CODE NO.	3. DATE OF ACCIDENT
75905294	91	11-2-58
4. NAME OF DECEASED		5. DATE OF DEATH
Grace Baylord		11-2-58
6. DATE OF HEARING	7 DATE OF RESERVED DECISION	8. DATE OF THIS NOTICE
	4-28-60	5-4-60 my

EMPLOYER Garlock Packing Co. ✓
Palmyra, N.Y.

CARRIER Employers Mutual Liab.
10 Gibbs St.
Rochester, N.Y.

ADMINISTRATIVE FINANCE OFFICER
WORKMEN'S COMPENSATION BOARD
80 CENTRE STREET - NEW YORK 13, N.Y.
cc: S. A. Corrao
cc: E. D. Igoe

a memorandum
YOU ARE HEREBY NOTIFIED that ~~xxxxxxxxxx~~ on date stated above a Decision and Award was made and duly filed this day as follows:

THE EMPLOYER AND/OR HIS INSURANCE CARRIER IS DIRECTED TO PAY AT ONCE TO:

Robert Byers ✓ (Name) — R. D. #1, Palmyra, N.Y. (Address)

the sum of $400.00 ✓ for funeral expenses:

THE CHAIRMAN, WORKMEN'S COMPENSATION BOARD, "VOCATIONAL REHABILITATION FUND"

the sum of $500.00 in accordance with Sec. 15, subd. 9 of the Workmen's Compensation Law;

THE CHAIRMAN, WORKMEN'S COMPENSATION BOARD, "FUND FOR REOPENED CASES"

the sum of $1500.00 ✓ in accordance with Sec. 25A of the Workmen's Compensation Law. *

* Forward checks payable to CHAIRMAN, WORKMEN'S COMPENSATION BOARD, to the Attention: FINANCE UNIT, 80 Centre Street, New York 13, N.Y.

DECISION: closed. Finding of no dependents. Memo attached.

Angelo R. Parisi
Chairman

M E M O R A N D U M

Re: 7590529½ Estate of Grace Baylord vs. Garlock Packing Co. Emp. Mu

- -

Finding of no dependents. Allow $400.00 funeral expenses payable to Robert Byers, a son of the deceased, who paid the funeral bill. Carrier to pay the usual sums required under Section 15-9 and Section 25-A to the Special Funds. Case is closed.

DFK/rt
4/28/60

DONALD F. KELLY

REFEREE

ALBANY 4 | BINGHAMTON | BUFFALO 2 | NEW YORK 7 | ROCHESTER 14 | SYRACUSE 1
1949 North Broadway | 221 Washington St. | 210 Franklin St. | 80 Park Place | 186 Main St. W. | State Office Bldg., East Washington

STATE OF NEW YORK

WORKMEN'S COMPENSATION BOARD

NOTICE OF DECISION IN DEATH CASE

W. C. B. Case No.	Carrier Case No.	Name of Decedent
75905294	91	GRACE BAYLORD

Claimant:
ESTATE OF GRACE BAYLORD
R.D. #1
PALMYRA, N. Y.

Employer:
GARLOCK PACKING CO.
PALMYRA, N. Y.

ROBERT BYERS
R.D. #1
EAST PALMYRA, N. Y.

You are hereby notified that at a hearing held before the Workmen's Compensation Board on 10-2-59 a decision and award of compensation was made in the above case as follows:

Name	Address	Relationship	Date of Birth	Percentage	Rate per Week
ACCIDENT NOTICE AND CAUSAL RELATION ESTABLISHED FOR CAUSALLY RELATED DEATH. CONTINUED.					

and the employer and insurance carrier are hereby directed in accordance with the provisions of the Workmen's Compensation Law, to pay such award to the following persons:

To ..... (Name) ..... (Address)

..... (Name) ..... (Address)

and funeral expenses $..... to ..... (Name) ..... (Address)

Employer and carrier are directed to pay at once $..... for .....weeks at $.....
from date of death .....to .....19....., direct to the
.....and thereafter ($.....bi-weekly).

Balance of the award is ordered paid into the Aggregate Trust Fund as provided under Section 27 of the law. Present value of the award as ordered paid into the Aggregate Trust Fund as of .....
..... is $..... Present value does not include funeral benefits.
Check to be drawn to the order of "State Insurance Fund — Aggregate Trust Fund Account." The Aggregate Trust Fund is to make bi-weekly payments at the rate of $..... beginning with
..... to the.....

Death benefits to surviving widow shall be increased to 40% of decedent's average weekly wage base upon termination of death benefits to children.

The above copy of the decision and award is sent you pursuant to law. TAKE NOTICE that the above award or decision was duly filed in the office of the Workmen's Compensation Board on the SEVENTH day of OCTOBER 19 59

Dated 10-7-59 19.....

By .....

Solomon E Senior
Chairman

C
67 (1-59)

Copy for hospital file 10/9/59

C-23 (5-57)

ALBANY 4 — 1949 North Broadway
BINGHAMTON — 221 Washington St.
BUFFALO 2 — 210 Franklin St.
NEW YORK 13 — 80 Centre St.
ROCHESTER 14 — 155 Main St. W.
SYRACUSE 2 — State Office Building, East Washington St.

WORKMEN'S COMPENSATION BOARD

STATE OF NEW YORK

NOTICE OF DECISION

1. W.C.B. CASE NO.	2. CARRIER CASE NO. AND CODE NO.		3. DATE OF ACCIDENT OR INJURY
7570694	A40 22779	91	???
4. DATE OF HEARING	5. DATE OF RESERVED DECISION		6. DATE OF THIS NOTICE
12-10-58			12-15-58 my

CLAIMANT

Grace Baylord Estate
R. F. D. #1
Palmyra, N.Y.

EMPLOYER

Garlock Packing Co.
Palmyra, N.Y.

TO THE CLAIMANT:

1. Any compensation due will be sent to you by check by the employer or his insurance carrier.
2. Keep a careful record of the payments received in order that you may have evidence of payment or non-payment in case of dispute.
3. Do not pay money to anyone representing you. The fee, if any, for such representation is determined by the Board or Referee and will be deducted from your award and paid by the employer or his insurance carrier to your representative or attorney.
4. In workmen's compensation cases, no compensation shall be allowed for the first seven days of disability. However, if the injury results in disability of more than thirty-five days, compensation shall be allowed from the first day of disability.

COPY TO:

After hearing on date stated above the following decision and Award was made and duly filed this day under the

☒ Workmen's Compensation Law ☐ Volunteer Firemen's Benefit Law*

AWARD: THE EMPLOYER AND/OR THE INSURANCE CARRIER ARE DIRECTED TO PAY AT ONCE

for disability over a period of weeks	from	to	at rate per Week	the sum of	TO:
21	6-9-58	11-2-58	$36.00	$756.00	CLAIMANT less payments made covering this period.
as lien on award payable by separate check by carrier to CLAIMANT'S REPRESENTATIVE OR ATTORNEY					
fee to DOCTOR for attendance at hearing					

DECISION: Case was claimant died on 11-2-58.

If case was "continued" and continuing payment was directed, it shall be made at the above rate for the period stated and shall be continued thereafter until the employer or carrier has medical or payroll evidence of a change of condition and gives notice thereof to the Chairman, Workmen's Compensation Board, unless otherwise provided in the decision. A further hearing will be held in a "continued" case to determine the extent of further disability, if any.

* In Volunteer Firemen's Benefit cases, the liable political subdivision is deemed to be the "EMPLOYER" of the volunteer fireman.

Angela R. Farini
Chairman

C-23 C-23 C-23 C-23 C-23

EMPLOYERS (UAL LIABILITY INSURANCE COMPANY OF W INSIN
EMPLOYERS MUTUAL FIRE INSURANCE COMPANY
HOME OFFICE: WAUSAU, WISCONSIN

Address Reply To
EMPLOYERS MUTUALS OF WAUSAU
10 DIEHL STREET
ROCHESTER 4, NEW YORK
PHONE HAMILTON 6-8998

The Garlock Packing Company
Palmyra, New York

November 17, 1958

Attention: Personnel Department

re: Grace Baylord -
~~AWC~~-22779

Gentlemen:

There is not much question but what the Compensation Board will erect a death case on the above claim. We would like to make a preliminary check on any known dependents of Mrs. Baylord. In the initial report which our adjuster secured from her, we find she is widowed, and apparently has children over the age of 21. Unless she was partially or wholly supporting aged parents, there probably will be no dependency established. We would appreciate anything from your personnel files which you may have in regard to the dependency factor, we further suggest you forward us a photocopy of the W-4 form from your files.

Yours very truly,

CWBollman

CWBollman - RC 1

Claim Manager

11-24-58 - Item received by J. Wahlin - requested information supplied by Heim. SJW.

Copy made for Mr. Pierris file. SJ.

COPY

WORKMEN'S COMPENSATION BOARD

State of New York

ATTENDING PHYSICIAN'S REPORT

TO ATTENDING PHYSICIAN: Reports on this form should be filed within 48 hours after you first render treatment in a workmen's compensation case or a volunteer firemen's benefit case, again within 15 days after first treatment, and as Progress Reports at intervals of 22 days or less during continuing treatment. As soon as treatment is terminated FINAL REPORT on this form must be filed regardless of the filing of any previous reports. If treatment is completed within 48 hours, file one report and mark it FINAL.

File the signed original of each report directly with (1) CHAIRMAN, WORKMEN'S COMPENSATION BOARD at the office of the district in which the accident occurred and file a signed copy with (2) the INSURANCE CARRIER, if known, or the EMPLOYER.

Enter "X" to show type of report ☐ 48-HOUR PRELIMINARY REPORT ☐ 15-DAY REPORT [X] PROGRESS REPORT [X] FINAL REPORT

1. W.C.B. Case Number (If known)	2. Carrier Case Number and Code (If known)	3. Date of Accident or Injury and Time	4. Address Where Accident or Injury Occurred
			Garlock Packing Co.

	Name	Address	
5. INJURED PERSON *	Grace Baylord	R. D. #1 Palmyra, New York	Age 52
6. EMPLOYER	Garlock Packing Company	Palmyra, New York	
7. INSURANCE CARRIER	EMPLOYERS MUTUAL LIABILITY INSURANCE COMPANY OF WISCONSIN	10 GIBBS STREET • ROCHESTER 4, NEW YORK	
8. HOSPITAL (If any)	F. F. Thompson Mem'l Hosp.	Canandaigua, New York	

MEMO *If patient claims that injury occurred while performing assigned firemanic duty as a Volunteer Firemen, show as EMPLOYER the city, town, village or district against which claim is made for Volunteer Firemen's Benefits and enter "X" here: Vol. F.B.

9. Present condition (Include diagnosis, objective findings, subjective complaints and any change of condition since last report)

Patient's condition dete iorated rapidly. Emergency hospitalization 11-2-58.

Patient deceased suddenly 11-2-58 at 8:50 PM See #16

(a) Is there now any disability or physical defect? yes If so, is such disability or defect a result of the present injury or disease? yes

(b) Will injury result in permanent facial or head disfigurement or other permanent defect? yes If so, describe death

10. Nature of treatment terminated

(a) When did you (1) first treat patient? 5-16-57 (2) last treat patient? 11-2-58

(b) Has patient been discharged from treatment? yes If so, give date 11-2-58 If not, estimate duration of treatment Hospital? Home? Office?

(c) Is future operation, hospital, or rehabilitation treatment advised? no If so, state nature of such treatment

11. Date you think patient was or will be able to (a) resume his usual work? never (b) do any other work? never

(c) Is patient working? no (d) Specify work limitations, if any

COMPLETE ITEMS 12-15 OR ENTER ON THIS LINE DATE OF PREVIOUS REPORT WHICH GAVE THIS INFORMATION: 11-14-57

12. State in patient's own words how accident or injury occurred

13. Describe nature and extent of injury and specify all parts of body involved

(a) Were X-rays taken? (b) Was patient unconscious? If so, for how long?

(c) If claim is for a disease, give (1) Approximate date of onset of related symptoms

(2) Date disability began (3) Patient's occupational history

(d) Is there any history or evidence present of pre-existing injury or disease? If so, describe

14. In your opinion was accident or injury described above the competent producing cause of condition sustained?

15. Was patient previously under the care of another physician? (a) If so, give name and address of preceding physician

(b) Reason for transfer

(c) Did you obtain history and medical data from preceding physician? If not, attach statement of reason.

16. Have here additional information or remarks Autopsy findings: Pulmonary embolism from thrombus of right atrium due to stasis from cor pulmonale secondary to severe pulmonary fibrosis.

I state that the findings and opinions given in the foregoing medical report are full and true to the best of my knowledge, information and belief, and made with full knowledge of the provisions of Sec. 114 of the Workmen's Compensation Law and Sec. 38 of the Volunteer Firemen's Benefit Law. I state that I am a physician duly licensed to practice medicine in the State of New York.

W.C.B. Rating Code X (Signed) William J. Brasil, M.D.
(Written signature of Attending Physician)

W.C.B. Authorization Number 205201 Address 218 East Charlotte Ave.,

Dated November 4, 1958 Palmyra, New York

1905-5110 9-57

C-4 C-4 C-4 C-4 C-4

11-14-58 Hosp. Copy - Varifax of orig. to Mr. Pierce. SJW

C-11 (5-53)

WORKMEN'S COMPENSATION BOARD
STATE OF NEW YORK

EMPLOYER'S REPORT OF INJURED EMPLOYEE'S CHANGE IN EMPLOYMENT STATUS RESULTING FROM INJURY

This report is to be filed directly with the Chairman, Workmen's Compensation Board at address shown on reverse side as soon as the employment status of an injured employee, as reported on Form C-2.5, Form C-2, or on a previous Form C-11, is changed. Change in employment status includes return to work, discontinuance of work, increase or decrease of regular hours of work and increase or reduction of wages.

Copy also should be sent to your insurance carrier.

W.C.B. Case No.	Carrier's Case No. and Code No.	Date of Accident

	Name	Address
1. Employer	THE GARLOCK PACKING COMPANY	PALMYRA, NEW YORK
2. Insurance Carrier	Employers Mutual Liability Insurance Company of Wisconsin 10 Gibbs Street	Rochester 4, New York
3. Injured Person	MRS. GRACE BAYLORD #8-638	R. D. #1, PALMYRA, NEW YORK

4. Date of most recent Employer's Report filed: (Check "x" form and give date filed.) Worked 8-4:30 shift
   ☐ C-2.5 _____ ☒ C-2 11-27-57 ☒ C-11 6-11-58
5. Date Disability Began: 6-8-58 Hour of Day: 8:00 A.M. P.M.
6. Nature of Injury: Claim of pulmonary fibrosis of lungs with shortness of breath.
7. Date of first return to work following injury: _____
8. (a) Change of employment status resulting from above injury:

Employment Status	Hours per Day	Days per Week	Earnings	Occupation
Prior to Injury				
Changed to				

   (b) Date of this change in employment status: _____
   (c) Remarks: _____
9. Loss of time resulting from above injury since first return to work:

From (Mo., Day, Year)	To (Mo., Day, Year)	Reason

10. Is injured still under the care of a physician? _____ If so, give name of physician: _____
11. Has injured died? Yes If so, state date of death: 11-2-58
    Name and address of nearest relative known: Robert E. Byers (son) R. D. #1 Palmyra, N.Y.

Date of this Report November 3, 1958 Firm Name THE GARLOCK PACKING COMPANY

Signed by _____

D. F. FRASER, VICE PRESIDENT
Official Title

C-11 C-11 C-11 C-11 C-11

1303-3117

GORDON D. CURRIE, M.D.

797 Elmwood Avenue
Rochester, 20, New York

August 18, 1958

Employers Mutuals of Wausau
10 Gibbs Street
Rochester 4, New York

Attention: Mr. C. W. Bollman

Re: Grace Baylord
vs: Garlock Packing Co.
#A40-22779

Gentlemen:

This is a report of the examination made on the above-named claimant on July 29, 1958 at your request in my office.

As you are aware, this claimant has a history of working on a machine which makes asbestos yarn. For over 20 years she has been employed by Garlock Packing Company in this capacity. A diagnosis of asbestosis has been established on this patient, and, as I understand it from your letter, this diagnosis is not disputed.

Following the establishment of asbestosis, the claimant returned to work at Garlock Packing Company but was put in a department which was apparently free from dust. In June of this year, she developed an upper respiratory tract infection and was under the care of Dr. William Braell of Palmyra, New York. Associated with this, she became very short of breath and had cough. Following the respiratory infection, she continued to suffer from extreme dyspnea, wheezing, and an inability to perform any exercise without the most marked respriatory difficulty.

PAST HISTORY: TheClaimant has had no serious illnesses other than the present difficulty, and no operations. A complete review of systmes was carried out and was essentially negative in all respects.

The family history was non-contributory.

OCCUPATIONAL HISTORY: As mentioned above, she has worked for Garlock Packing Company for over 20 years.

PHYSICAL EXAMINATION: Temperature 98°
Pulse 120
Respirations 36
Blood pressure 140/90
Height 5'4¼"
Weight 147½ pounds

The claimant is an obviously sick white woman in respiratory distress. Her respirations are rapid and wheezing in character; on the slightest exertion she becomes extremely dyspneic.

Skin: Slight cyanosis of the nail beds.
Head: Normocephalic. No sinus tenderness.

9-12-58 Hosp. Copies .. orig. copy to Mr. Pierce [illegible]

PHYSICAL EXAMINATION (continued):

Eyes: Pupils equal, react to light and accommodation. EOM normal. Fundoscopic examination negative.
Ears, nose, throat: Negative.
Mouth: Edentulous
Neck: Supple. Trachea in the midline. Thyroid not enlarged. Some cervical vein engorgement in the recumbent position.
Thorax: Shows some slight increase in the AP diameter.
Breasts: Negative
Lungs: There was dullness at both bases on percussion. On auscultation there were bronchovesicular breath sounds at the apices: further down both lung fields, the breath sounds became bronchial in character; at the base of both lungs, extending half way up, coarse rales were audible bilaterally.

Heart: Appeared not to be enlarged. The rate was rapid. Sounds were of good quality. There were no murmurs.
Adbomen: Soft. The liver and spleen were not felt. No masses, tenderness or rigidity.
Pelvic & rectal examinations: Not performed.
Spine: Negative.
Extremities: Showed th presence of finger clubbing bilaterally. There was no pitting edema.
Neurological examination: Negative.

LABATORY DATA:
Urine showed a trace of albumin, no sugar; microscopic examination showed no white cells or red cells.
Sedimentation rate elevated, 40mm. per hour.
Hematocrit slightly elevated, 46.
Fluoroscopy and x-ray of the chest were obtained at the office of Dr. Ide and associates. Their report follows:

"chest examination. Fluoroscopy and film examination of the chest reveals prominence of both hilar regions, fullness of the soft tissues in the right upper mediastinum and diffuse linear and fine nodular change throughout the lung parenchyma bilaterally extending from the above downward. In the bases there is some softer superimposed patchy density bilaterally and some obliteration of the pleural costophrenic angles. The heart is mildly enlarged in its transverse diameter. No specific chamber enlargement is noted.

Conclusion: There is radiographic evidence of a fairly diffuse and rather extensive nodular fibrosis throughout the lungs. There is some superimposed subacute to chronic inflammatory change in the bases. The heart is mildly enlarged and there are some mild congestive changes in the hilar regions. I suspect that there is a right upper mediastinal lymph node producing the enlargement

LABORATORY DATA (continued):

x-ray of the chest(continued):

"of the sahdow here. With the clinical history of exposure, I would accept this as a penumoconiesis if fairly specific type."

(Signed) Charles E. Sherwood, M.D.

The x-rays from Mount Morris Tuberculosis hospital were received and were reviewed.

Electrocardiogram showed a rate of 120, a PR interval normal, QRS compleses were all normal. All the waves were essentially within normal limits. The tracing showed only a sinus tachycardia.

OPINION: It is my opinion that this 52 year old claimant is suffering from severe pulmonary asbestosis with marked lowering of her pulmonary reserve as a consequence of her disease. Secondary to the pulmonary difficulty, I believe that she is beginning to show evidence of cor pulmonale and, indeed, is probably in a early cardiac failure at this time.

The claimant is at this time totally disabled and it would be my opinion that she would probably remain so, unless some benefit could be achieved by means of theuse of digitalis and diuretics. With the use of these drugs, the element of cardiac failure may be removed and some of the congestive changes noted in the x-ray may disappear.

If, however, after treatment of her cardiac failure, the claimant still remains as dyspneic as she is at present, then her disability will probably be permanent. So far as the pulmonary disease is concerned, all one can do is administer bronchodilators and expectorants. The relief obtained from these drugs, however, is purely symptomatic and down not prevent progress of the chronic pulmonary disease.

Yours very truly,

(signed) GORDON D. CURRIE, M.D.
SJ 205463

CDC:ee
Orig. to MCB
3cc envl.
cc Dr.Braell
encl.

Garolck Packing Company
Palmyra, New York

Miss Grace Bayàord
R. F. D. #1
Palmyra, New York

July 2, 1958

Re: Garlock Packing Co.
A40-22779

Dear Madam:

At Dr. Braell's suggestion, we are pleased to advise that we have made arrangements for you to be examined by one of our consultant's here in Rochester. We regret, however, that we have been unable to make an appointment until [illegible] four weeks away.

Will you kindly report to the office of Dr. Gordon Currie, 797 Elmwood Avenue, Rochester, New York, at 3:15 P.M. July 29. This is on a Tuesday.

We will reimburse you for your travel expense on this trip, should this date conflict with any other plans, kindly advise promptly in order that a new appointment can be made.

Yours very truly,

CWBollman - RCl

Claim Manager

7-7-58 Sent copy of original to The Firm.

2 pages

A40-2-2-9

4(4-57)

WORKMEN'S COMPENSATION BOARD

State of New York

ATTENDING PHYSICIAN'S REPORT

O ATTENDING PHYSICIANS Reports on this form should be filed within 48 hours after you first render treatment in a workmen's compensation case or a volunteer fireman's benefit case, again within 15 days after first treatment, and as Progress Reports at intervals of 22 days or less during continuing treatment. As soon as treatment is terminated FINAL REPORT on this form must be filed regardless of the filing of any previous reports. If treatment is completed within 48 hours, file one report and mark it FINAL.

File the signed original of each report directly with (1) CHAIRMAN, WORKMEN'S COMPENSATION BOARD at the office of the district in which the accident occurred and file a signed copy with (2) the INSURANCE CARRIER, if known, or the EMPLOYER.

Enter "X" to show type of report: ☐ 48-HOUR PRELIMINARY REPORT ☐ 15-DAY REPORT ☒ PROGRESS REPORT ☐ FINAL REPORT

1. W.C.B. Case Number (If known)	2. Carrier Case Number and Code (If known)	3. Date of Accident or Injury and Time	4. Address Where Accident or Injury Occurred
			Garlock Packing Co.

	Name	Address	
5. INJURED PERSON *	Grace Baylord	R.D. #1, Palmyra, New York	Age 52
6. EMPLOYER	Garlock Packing Company	Palmyra, New York	
7. INSURANCE CARRIER	Emp. Mut. Lia. Ins. Co.	10 Gibbs Street Rochester, 4, New York	
8. HOSPITAL (If any)			

*If patient claims that injury occurred while performing assigned firemanic duty as a Volunteer Fireman, show as EMPLOYER the city, town, village or district against which claim is made for Volunteer Firemen's Benefits and enter "X" here: ☐ Vol. F.B.

9. Present condition (Include diagnosis, objective findings, subjective complaints and any change of condition since last report)

~~Pulmonary fibrosis due to pneumoconiosis from asbestos. Increasing~~ dyspnea and upper respiratory infection.

(a) Is there now any disability or physical defect? yes ... If so, is such disability or defect a result of the present injury or disease? yes

(b) May injury result in permanent facial or head disfigurement or other permanent defect? yes ... If so, describe

Pulmonary impairment

10. Nature of treatment rest

(a) When did you (1) first treat patient? 5/16/57 (2) last treat patient? 6/12/58

(b) Has patient been discharged from treatment? no If so, give date: If not, estimate duration of treatment: unknown Hospital? Home? Office?

(c) Is future operation, hospital, or rehabilitation treatment advised? no If so, state nature of such treatment:

11. Do you think patient was or will be able to (a) resume his usual work? undetermined (b) do any other work?

(c) Is patient working? no (d) Specify work limitations, if any:

COMPLETE ITEMS 12-15 OR ENTER ON THIS LINE DATE OF PREVIOUS REPORT WHICH GAVE THIS INFORMATION: 11/12/57

12. State in patient's own words how accident or injury occurred:

13. Describe nature and extent of injury and specify all parts of body involved:

(a) Were X-rays taken? (b) Was patient unconscious? If so, for how long?

(c) If claim is for a disease, give: (1) Approximate date of onset of related symptoms:

(2) Date disability began (3) Patient's occupational history:

14. Is there any history or evidence present of preceding injury or disease? If so, describe:

15. In your opinion was anything or injury described above the competent producing cause of condition appearing?

16. Was patient previously under the care of another physician? (a) If so, give name and address of preceding physician:

(b) Reason for transfer:

(c) Did you obtain history and medical data from preceding physician? If not, attach statement of reason.

16. Enter here additional information or remarks:

I state that the findings and opinions given in the foregoing medical report are full and true to the best of my knowledge, information and belief, and made with full knowledge of the provisions of Sec. 114 of the Workmen's Compensation Law and Sec. 55 of the Volunteer Firemen's Benefit Law. I state that I am a physician duly licensed to practice medicine in the State of New York.

W.C.B. Rating Code X

W.C.B. Authorization Number 205201

William J Beall M.D.
(Written signature of Attending Physician)

Address WILLIAM J. BEALL, M. D.
216 E. CHARLOTTE AVENUE
PALMYRA, NEW YORK

Dated 6/26/58 M.D. Please Confirm Rec'd

C-4 C-4 C-4 C-4 C-4

11-27-57

COPY

C-4 (4-57)

WORKMEN'S COMPENSATION BOARD

State of New York

ATTENDING PHYSICIAN'S REPORT

TO ATTENDING PHYSICIAN: Reports on this form should be filed within 48 hours after you first render treatment in a workmen's compensation case or a volunteer firemen's benefit case, again within 15 days after first treatment, and as Progress Reports at intervals of 22 days or less during continuing treatment. As soon as treatment is terminated FINAL REPORT on this form must be filed regardless of the filing of any previous reports. If treatment is completed within 48 hours, file one report and mark it FINAL.

File the signed original of each report directly with (1) CHAIRMAN, WORKMEN'S COMPENSATION BOARD at the office of the district in which the accident occurred and file a signed copy with (2) the INSURANCE CARRIER, if known, or the EMPLOYER.

Enter "X" to show type of report: ☐ 48-HOUR PRELIMINARY REPORT ☐ 15-DAY REPORT ☒ PROGRESS REPORT ☐ FINAL REPORT

1. W.C.B. Case Number (If known)	2. Carrier Case Number and Code (If known)	3. Date of Accident or Injury and Time	4. Address Where Accident or Injury Occurred
			Garlock Packing Co.

	Name	Address	Age
5. INJURED PERSON *	Grace Baylord	R.D. #1 PALMYRA, NEW YORK	52
6. EMPLOYER	Garlock Packing Company	Palmyra, New York	
7. INSURANCE CARRIER	EMPLOYERS MUTUAL LIABILITY INSURANCE COMPANY OF WISCONSIN	10 GIBBS STREET - ROCHESTER 4, NEW YORK	
8. HOSPITAL (If any)			

*If patient claims that injury occurred while performing assigned firemanic duty as a Volunteer Fireman, show as EMPLOYER the city, town, village or district against which claim is made for Volunteer Firemen's Benefit and enter "X" here: ☐ Vol. F.B.

9. Present condition: (Include diagnosis, objective findings, subjective complaints and any change of condition since last report)
Pulmonary fibrosis due to pneumoconiomis from asbestos. Increasing dyspnea and upper respiratory infaction.

(a) Is there now any disability or physical defect? Yes If so, is such disability or defect a result of the present injury or disease? Yes

(b) May injury result in permanent facial or head disfigurement or other permanent defect? Yes If so, describe: Pulmonary impairment

10. Nature of treatment: rest

(a) When did you (1) first treat patient? 5/16/57 (2) last treat patient? 6/12/58

(b) Has patient been discharged from treatment? no If so, give date: If not, estimate duration of treatment: Unknown Hospital? Home? Office?

(c) Is future operation, hospital, or rehabilitation treatment advised? no If so, state nature of such treatment:

11. Date you think patient was or will be able to (a) resume his usual work? undetermined (b) do any other work?

(c) Is patient working? no (d) Specify work limitations, if any:

COMPLETE ITEMS 12-15 OR ENTER ON THIS LINE DATE OF PREVIOUS REPORT WHICH GAVE THIS INFORMATION: 11/14/57

12. State, in patient's own words how accident or injury occurred:

13. Describe nature and extent of injury and specify all parts of body involved:

(a) Were X-rays taken? (b) Was patient unconscious? If so, for how long?

(c) If claim is for a disease, give: (1) Approximate date of onset of related symptoms:

(2) Date disability began: (3) Patient's occupational history:

(d) Is there any history or evidence present of pre-existing injury or disease? If so, describe:

14. In your opinion was accident or injury described above the competent producing cause of condition sustained?

15. Was patient previously under the care of another physician? (a) If so, give name and address of preceding physician:

(b) Reason for transfer:

(c) Did you obtain history and medical data from preceding physician? If not, attach statement of reason.

16. Enter here additional information or remarks:

I state that the findings and opinions given in the foregoing medical report are full and true to the best of my knowledge, information and belief, and made with full knowledge of the provisions of Sec. 114 of the Workmen's Compensation Law and Sec. 56 of the Volunteer Firemen's Benefit Law. I state that I am a physician duly licensed to practice medicine in the State of New York.

W.C.B. Rating Code: (Signed) William J. Brasil, M.D.
(Written signature of Attending Physician)

W.C.B. Authorization Number: 205201 Address: 216 E. Charlotte Ave.

Palmyra, New York

Dated

C-4 C-4 C-4 C-4 C-4

6026058 Hosp. Copy - Verifax of orig. to Mr. Pierce SJW

Cape

C-4 (4-57)

WORKMEN'S COMPENSATION BOARD

State of New York

ATTENDING PHYSICIAN'S REPORT

TO ATTENDING PHYSICIAN: Reports on this form should be filed within 48 hours after you first render treatment in a workmen's compensation case or a volunteer firemen's benefit case, again within 15 days after first treatment, and as Progress Reports at intervals of 22 days or less during continuing treatment. As soon as treatment is terminated FINAL REPORT on this form must be filed regardless of the filing of any previous reports. If treatment is completed within 48 hours, file one report and mark it FINAL.

File the signed original of each report directly with (1) CHAIRMAN, WORKMEN'S COMPENSATION BOARD at the office of the district in which the accident occurred and file a signed copy with (2) the INSURANCE CARRIER, if known, or the EMPLOYER.

Enter "X" to show type of report ☐ 48-HOUR PRELIMINARY REPORT ☐ 15-DAY REPORT ☒ PROGRESS REPORT ☐ FINAL REPORT

1. W.C.B. Case Number (If known)	2. Carrier Case Number and Code (If known)	3. Date of Accident or Injury and Time	4. Address Where Accident or Injury Occurred
			Garlock Packing Company

	Name	Address	
5. INJURED PERSON *	Grace Bayford	R D #1, Palmyra, N.Y.	Age 52
6. EMPLOYER	Garlock Packing Company	Palmyra, N.Y.	
7. INSURANCE CARRIER	EMPLOYERS MUTUAL LIABILITY INSURANCE COMPANY OF WISCONSIN	10 GIBBS STREET - ROCHESTER 4, NEW YORK	
8. HOSPITAL (If any)			

*If patient claims that injury occurred while performing assigned firemanic duty as a Volunteer Firemen, show as EMPLOYER the city, town, village or district against which claim is made for Volunteer Firemen's Benefits and enter "X" here: Vol. F.B.

9. Present condition (Include diagnosis, objective findings, subjective complaints and any change of condition since last report)

C.H.R.I. has improved but patient is still markedly dyspneic even on mild exertion.

(Pulmonary fibrosis due to pneumoconiosis from asbestos.)

(a) Is there now any disability or physical defect? Yes If so, is such disability or defect a result of the present injury or disease? Yes

(b) May injury result in permanent facial or head disfigurement or other permanent defect? Yes If so, describe Permanent impairment of pulmonary function.

10. Nature of treatment Rest

(a) When did you (1) first treat patient? 5-16-57 (2) last treat patient? 6-28-58

(b) Has patient been discharged from treatment? No If so, give date If not, estimate duration of treatment Undetermined Hospital? Home? Office?

(c) Is future operative, hospital, or rehabilitative treatment advised? No If so, state nature of such treatment 2-3-58 KMO

11. Date you think patient was or will be able to (a) resume his usual work Undetermined (b) do any other work?

(c) Is patient working? No (d) Specify work limitations, if any. Total at present

COMPLETE ITEMS 12-15 OR ENTER ON THIS LINE DATE OF PREVIOUS REPORT WHICH GAVE THIS INFORMATION: 11-14-57

12. State in patient's own words how accident or injury occurred

13. Describe nature and extent of injury and specify all parts of body involved

(a) Were X-rays taken? (b) Was patient unconscious? If so, for how long?

(c) If claim is for a disease, give (1) Approximate date of onset of related symptoms

(2) Date disability began (3) Patient's occupational history

(d) Is there any history or evidence present of pre-existing injury or disease? If so, describe

14. In your opinion was accident or injury described above the competent producing cause of condition sustained?

15. Was patient previously under the care of another physician? (a) If so, give name and address of preceding physician

(b) Reason for transfer

(c) Did you obtain history and medical data from preceding physician? If not, attach statement of reason.

16. Enter here additional information or remarks

I state that the findings and opinions given in the foregoing medical report are full and true to the best of my knowledge, information and belief, and made with full knowledge of the provisions of Sec. 114 of the Workmen's Compensation Law and Sec. 55 of the Volunteer Firemen's Benefit Law. I state that I am a physician duly licensed to practice medicine in the State of New York.

W.C.B. Rating Code X (signed) William J. Braell, MD
(Written signature of Attending Physician)

W.C.B. Authorization Number 205201 Address 216 E. Charlotte Avenue

Dated 6-20-58 Palmyra, New York

130-3110 9-57

C-4 C-4 C-4 C-4 C-4

Have file. 9-15-58 Copy sent to Pittsburgh

Physical Examination of Employees

Date	March 17, 1950.		
Name	Grace La Plant Saylord	Proposed Job	Twister Oper #2
Age	43		Textile Dept
Weight	139		Permanent - Rehired
Height	5 ft 3 in		
Previous Occupation	Previously worked at G P Co., Textile Dept., Left in 1940.		
Medical History	Usual children's diseases. 1931 One child.		
Surgical History	None		

Condition of:			
Brain and Nervous System		Good	
Heart		Normal	
Lungs		Clear	
Gastro-Intestinal		Good	M. D.
Kidney	No sugar	No albumin	Prod. Mgr.
Nose		Clear	Personnel Mgr. 12/11/56
Throat		Good	

Ears	Clear
Eyes	Rt 20/20 Lt 20/20 As corrected by glasses
Blood Pressure	130/82
Hernia	No
Other Defects	Has upper plate

Physical Rating	A	B	C	Mental Rating	A	B	C
	1	1	1		1	1	1
	2✓	2	2		2	2✓	2
3/13	3	3	3		3	3	3

11-3-52 Checked after absence from Oct. 6, 1952, due to home accident, injured rt shoulder. OK to return to work today. Dr. Nesbitt.

3-25-53 Checked after absence from 3-13-53 due to grippe. OK to return to work today 6 AM. Dr. Nesbitt.

12-30-53 Checked after absence from 8-21-53 due to nervous breakdown. OK'd to return to work Jan 4th by Dr. Dikler and Dr. Nesbitt. Dr. Nesbitt.

2-14-55 Checked after absence from 2-7-55 due to infected rt 3rd finger, Comp. Case, G P Co. Ok'd by Dr. Nesbitt to return to work today 8 AM. Dr. Nesbitt.

11-30-56 Checked after absence from 10-8-56 due to non-occ dis. due to nervous condition OK'd by Dr. Dikler to return to work 6 AM 11-19-56 and OK'd by Dr. Brämer to return to usual work. Dr. B

10-8-56

GPCO. 1951

MEDICAL RECORD

Name GRACE BYERS LA PLANT BAYLORD Address

DATE	INJURY OR ILLNESS
5-3-39	Cold - Lame wrist
8-4-39	Headache
11-8-39	Earache - Headache - Laxative
1-11-40	Lameness
6-11-41	Physical Examination
7-11-41	Laxative - Headacje
11-6-41	Lame left foot--Headache--Laxative
11-19-41	Headache
12-15-41	Cut left index finger at home
3-11-42	Cold--Laxative
3-17-50	Physical Examination
6-5-50	Physical Examination (Textile)
9-28-50	lameness left hip, laxative MM
12-6-50	Cough and constipated MM
1-17-51	Cold LM

DATE	INJURY OR ILLNESS
4-5-51	Headache and laxative MM
8-15-51	Wax in left ear DrN
8-17-51	Retreated left ear DrN
10-15-52	Per.Dep.Rep. 10-15-52 Non-occ dis. began 10-6-52 injured shoulde
11-3-52	Checked after absence from10-16-52 due to home accidant, injured rt s shoulder OK'd to return to work today DrN
11-6-52	Per.Dep.Rep. 11-4-52 Returned to work from non-occ dis. 11-3-52
3-24-53	Per.Dep.Rep. 3-23-53 Non-occ dis began 3-13-53
3-25-53	Checked after absence from 3-13-5 OK'd to work returned 6 AM today
4-1-53	Per.Dep.Rep. 3-30-53 Non-occ dis ended 3-25-53 DrN
9-3-53	Non-occ disability began 8-21-53 Nervous etc. Per. Dep. Rep. 9-1-53

DATE	INJURY OR ILLNESS
12-30-53	Checked after absence from 8-21-5
	nervous breakdown OK'd Dr. Dikler
	and DrN return to work 1-4-54
9-27-54	Cold
11-15-54	Cold and general lameness rt.shoulder.
1-4-55	Several abestose corns both hands.
1-21-55	Checked ash corns both hands-general lameness DrN C-2 made 2-9-55
2-4-55	Infection rad. side rt.3 finger.DrN
2-4-55	redressed right 3 finger.
2-4-55	Trimmed corns on hands,lameness DrN
2-14-55	Returneddto work todaym edressed rt. 3 finger,gneral lameness DrN
2-21-55	Trimmed abbestos corns both hands
2-28-55	redressed right 3rd finger. DrN Redressed right 3 finger.DrN
3-25-55	Trimmed asb. corns rt 3rd fin. DrN
4-15-55	Asbestos corns both hands DrN
5-25-55	Asbestos corns rt handDrN
6-17-55	Corn left index finger.DrN
7-28-55	Trimmed abs.corns both hands-DrN

DATE	INJURY OR ILLNESS
8-24-55	Lameness
10-17-55	Callous rt 3rd finger.
10-26-55	" rt 3rd,left index,cough,lame DrN
1-6-56	Dry skin both hands,
10-24-56	Per.Dep.Rep.10-23-56 Non-occ dis began 10-8-56
11-20-56	Checked after absence 10-8-56 duet non-occ dis.nervous condition,OK D to return to work 11-19-56,under car DrDikler.
11-20-56	Ind Rel dep rep 11-20-56 Non-occ dis ended 11-19-56,6AM
1-11-57	Tex phy.
2-5-57	Chest x-ray DrB
10/30/57	Dry skin, slao cough.
11/14/57	Absent from work for 3 days due to C+H cough and shortness of breath. Under care of Dr. Braell. OK'd by him to return to work 11/14/57. Temp: 98.
11/27/57	Probable asbestosis of lungs.
	C-4 by Dr. Braell dated 11/14/57.
	Negative C-2 dated 11/27/57.

#3 Rpt C-2 dated 11-27-57

MEDICAL RECORD

Name GRACE BAYLORD Address

DATE	INJURY OR ILLNESS	DATE	INJURY OR ILLNESS
12/18/57	Talked with Dr. B. re: frequent absences due to chest congestion. Dr. B. tlaked with Harry Beach, Ray Austin and E. Van Holder about same matter. Also. Employee re-assured.	11-3-58	Expired 11-2-58 9:15 P.M. C-11 dated 11-3-58.
5-19-58	Was Sft. car		
5-20-58	Sft. car agraged - Dr B		
5-21-58	" " " "		
5-22-58	" " " " - advised to see E.N.T. Dr. Ahrocn		
6-3-58	Checked in dept. draining left ear - saw Dr. Brull		
6-12-58	Reported to E. Henderson at his home (+ Harvey Beach Monday A.M.) loosing time beginning 6-9-58 due to Illness of heart - Comp Case C-2 dated 11-27-57.		

ALBANY 4 | BINGHAMTON | BUFFALO 2 | NEW YORK 13 | ROCHESTER | SYRACUSE 2

1949 North Broadway | 221 Washington St. | 210 Franklin St. | [illegible] Cedar St. | 65 Main St. W. | [illegible] Washington St.

WORKMEN'S COMPENSATION BOARD

STATE OF NEW YORK

NOTICE OF DECISION

1 W.C.B. Case No.	2 Carrier Case No. and Code No.	3 Date of Accident
7570964	A40 22779 91	??
4 Date of Hearing	5 Date of Decisive Decision	6 Date of this Notice
3-10-58		3-14-58 ny

CLAIMANT

Grace Baylord
R. F. D. #1
Palmyra, N.Y.

EMPLOYER

Garlock Packing Co.
Palmyra, N.Y.

TO THE CLAIMANT:

1. Any compensation due will be sent promptly by check to the employer's insurance carrier.
2. Keep a careful record of the payments received in order that you may have evidence of payment or non-payment in case of dispute.
3. Do not pay anyone for services pertaining to this fee. If any fee for such services is determined by the Board or Referee and will be deducted from your award and paid to the employer or his insurance carrier or your representative or attorney.
4. In workmen's compensation cases, no compensation shall be allowed for the first seven days of disability. However, if the injury results in disability of more than thirty-five days, compensation shall be allowed from the first day of disability.

COPY TO

After hearing on date stated above the following Decision and Award was made and duly filed this day under the:

☒ Workmen's Compensation Law ☐ Volunteer Firemen's Benefit Law*

AWARD: THE EMPLOYER AND/OR THE INSURANCE CARRIER ARE DIRECTED TO PAY AT ONCE

for disability over a period of / weeks	from	to	at rate per Week	the sum of	TO
			$	$	CLAIMANT
					less payments made covering this period.
as lien on award payable by separate check by carrier to CLAIMANT'S REPRESENTATIVE OR ATTORNEY					
fee to DOCTOR for attendance at hearing					

DECISION: Case was ..... closed on the basis of these findings: Occupational condition noticed and caused relation for asbestosis of the lungs. Disability does not exceed the 7 days waiting period.

If case was "continued" and continuing payment was directed, it shall be made at the above rate for the period stated and shall be continued thereafter until the employer or carrier has medical or other evidence of a change of condition and gives notice thereof to the Chairman, Workmen's Compensation Board, unless otherwise provided in the decision. A further hearing will be held in a "continued" case to determine the extent of further disability, if any.

* In Volunteer Firemen's Benefit cases, the liable political subdivision is deemed to be the "EMPLOYER" of the volunteer fireman.

Angela R. Parisi
Chairman

C-23 C-23 C-23 C-23 C-23

C-2 (5-53)

WORKMEN'S COMPENSATION BOARD
STATE OF NEW YORK

EMPLOYER'S REPORT OF INJURY

Send this notice directly to Chairman, Workmen's Compensation Board at address shown on reverse side within ten (10) days after accident occurs. Copy also should be sent to your insurance carrier.

W.C.B. CASE NO.	CARRIER'S CASE NO. AND	CODE NO.	DATE OF ACCIDENT

(The spaces above not to be filled in by employer)

	NAME	ADDRESS
1. EMPLOYER	THE GARLOCK PACKING COMPANY	PALMYRA, NEW YORK
2. INSURANCE CARRIER	EMPLOYERS MUTUAL LIABILITY INSURANCE COMPANY OF WISCONSIN	EMPLOYEE'S S. S. ACCT. NO. 080 - 01 - 4560
3. INJURED PERSON	MRS. GRACE B. LORD (First Name) (Middle Initial) #8-628 (Last Name)	R. D. #1 PALMYRA, NEW YORK (Home Address) Works 6-5 shift

EMPLOYER

4. Nature of business: (State principal products manufactured or sold or services rendered) Mechanical Packings

ACCIDENT

5. Place where accident occurred: No accident
6. Date of accident: Claim made 11-27-57 19__ Day of Week _____ Hour of Day _____ A. M. _____ P. M.
7. (a) Date disability began: None 19__, Hour of Day _____ A. M. _____ P. M.
   (b) Was injured paid in full for this day? _____
8. Name of foreman Harry Beach - Ring Dept. Elwood Houghton - Textile
9. When did you or foreman first know of injury? 11-27-57
10. Names and addresses of witnesses: _____

INJURED PERSON

11. (a) Marital status: Widow (b) Sex Female
12. Age: 52 13. Did you have on file employment certificate or permit? _____
14. Occupation: (a) Job title for which employed: Borter & Wrapper
    (b) Occupation when injured: _____
15. (a) How long employed by you? Rehired 7 yrs. ago (b) Piece or time worker? Time
    (c) Hours per day: 8 (d) Days per week: 5
16. Earnings in your employ: (a) Rate per: Hour $ 1.60 Day $ 12.80 Week $ 64.00 Month $ _____
    (b) Total earnings paid during year prior to date of accident: (include bonuses paid, value of board lodging, etc.) $ _____ Average per week: $ _____
    (c) Bonuses or premiums paid and included in item 16(b) above: $ _____ (d) Estimated valu of board, lodging, or other advantages in addition to wages: (included in item 16(b) above $ _____
    (e) Calendar weeks in past 52 in same kind of work as at time of injury:

NATURE OF INJURY OR OCCUPATIONAL DISEASE

17. State nature of injury and part or parts of body affected: (as "Injury to Chest," etc.) Complains of shortness of breath
18. Did you provide medical care? _____ If so, when? Consulted own physician 5-16
19. Name and address of physician: Wm. J. Brecll, M.D., Palmyra, New York
20. Name and address of hospital: _____
21. Probable length of disability: None
22. (a) Has employee returned to work? _____ (b) If so, give date: _____
    (c) At what occupation? _____ (d) At what weekly wage? _____

NOTE: Form C-11 must be filed each time there is any change in the employment status as reported i item 22 above.

FATAL CASES

23. Has injured died? _____ (a) If so, give date of death: _____
    (b) Name and address of nearest relative: _____

CAUSE OF ACCIDENT OR OCCUPATIONAL DISEASE

24. (a) What was employee doing when accident occurred? (Describe briefly as "loading truck," "oper ating press," "shoveling dirt," "painting with spray gun," "walking downstairs," etc.) No accident - Employee worked in Textile Dept. as machine operator for several yrs.
    (b) Where did accident occur? (Specify whether in street, factory yard, on loading platform, in fac tory, etc.) No Accident -
25. How was accident or occupational disease sustained? (Describe fully, stating whether injured perso slipped, fell, was struck, etc., and what factors led up to or contributed to accident. Use addition sheets, if necessary.) Employee alleges has shortness of breath which she believes is due to working in Textile Dept. over a period of years.
26. (a) What specific machine, tool, appliance, gas, liquid, or other substance or object was most close connected with this accident or occupational disease? _____
    (b) If mechanical apparatus or vehicle, what part of it? (State if gears, pulley, motor, etc.) _____
27. Were mechanical guards or other safeguards (such as goggles) provided? _____ (a) Were th in use at time of accident? _____ (b) Was machine, tool, or object defective? _____ If s in what way? _____

	Enter "X" in this box if accident was reported on Form C-2.1
	Enter "X" in this box if accident was previously reported on Form C-2.5

FIRM NAME: THE GARLOCK PACKING COMPANY

SIGNED BY: _____ Official

DATE OF THIS REPORT: November 27, 1957

D. F. FRASER, VICE PRESIDENT

C-2 1303-0107 12-53 C-2 C-2 C-2 C-

State of New York

ATTENDING PHYSICIAN'S REPORT

TO ATTENDING PHYSICIAN: Reports on this form should be filed within 48 hours after you first render treatment in a workmen's compensation case or a volunteer firemen's benefit case, again within 15 days after first treatment, and as Progress Reports at intervals of 22 days or less during continuing treatment. As soon as treatment is terminated FINAL REPORT on this form must be filed regardless of the filing of any previous reports. If treatment is completed within 48 hours, file one report and mark it FINAL.

File the signed original of each report directly with (1) CHAIRMAN, WORKMEN'S COMPENSATION BOARD at the office of the district in which the accident occurred and file a signed copy with (2) the INSURANCE CARRIER, if known, or the EMPLOYER.

Enter "X" to show type of report: [X] 48-HOUR PRELIMINARY REPORT [ ] 15-DAY REPORT [ ] PROGRESS REPORT [ ] FINAL REPORT

1. W.C.B. Case Number (If known)	2. Carrier Case Number and Code (If known)	3. Date of Accident or Injury and Time	4. Address Where Accident or Injury Occurred
			Garlock Packing Company

	Name	Address	
5. INJURED PERSON *	Grace Braylord	R. F. D. #1 Palmyra, New York	Age: 52
6. EMPLOYER	Garlock Packing Company	Palmyra, New York	
7. INSURANCE CARRIER	EMPLOYERS MUTUAL LIABILITY INSURANCE COMPANY OF WISCONSIN	10 GIBBS STREET - ROCHESTER 4, NEW YORK	
8. HOSPITAL (if any)			

*If patient claims that injury occurred while performing assigned firemanic duty as a Volunteer Fireman, show as EMPLOYER the city, town, village or district against which claim is made for Volunteer Firemen's Benefit and enter "X" here: [ ] Vol. F.B.

9. Present condition: (Include diagnosis, objective findings, subjective complaints and any change of condition since last report)

probable asbestosis of lungs. XRay findings of pulmonary fibrosis.

Complaint is of dysmea on exertion.

(a) Is there now any disability or physical defect? yes If so, is such disability or defect a result of the present injury or disease? yes

(b) May injury result in permanent facial or head disfigurement or other permanent defect? yes If so, describe: Pulmonary fibrosis. There is probability of progression

10. Nature of treatment: Broncho dilators.

(a) When did you (1) first treat patient? 5/16/57 (2) last treat patient?

(b) Has patient been discharged from treatment? no If so, give date: If not, estimate duration of treatment: Hospital? Home? Office?

(c) Is future operation, hospital, or rehabilitation treatment advised? not at present If so, state nature of such treatment:

11. Date you think patient was or will be able to (a) resume his usual work? has been (b) do any other work?

(c) Is patient working? yes (d) Specify work limitations, if any: avoid dust exposure

COMPLETE ITEMS 12-15 OR ENTER ON THIS LINE DATE OF PREVIOUS REPORT WHICH GAVE THIS INFORMATION:

12. State in patient's own words how accident or injury occurred: "Short of breath. Twenty years - exposure to asbestos dust at work"

13. Describe nature and extent of injury and specify all parts of body involved: Pneumoconiosis, probable etiology is asbestos disease of lung.

(a) Were X-rays taken? yes (b) Was patient unconscious? no If so, for how long?

(c) If claim is for a disease, give: (1) Approximate date of onset of related symptoms: Two years ago

(2) Date disability began: (3) Patient's occupational history: Worked for 22 yrs in Textile Dept. exposed to asbestos dust.

(d) Is there any history or evidence present of pre-existing injury or disease? no If so, describe:

14. In your opinion was accident or injury described above the competent producing cause of condition examined? in all probability

15. Was patient previously under the care of another physician? no (c) If so, give name and address of preceding physician:

(b) Reason for transfer:

(c) Did you obtain history and medical data from preceding physician? If not, attach statement of reason.

16. Enter here additional information or remarks: This report is submitted at request of the patient to establish compensability if her pulmonary fibrosis.

I state that the findings and opinions given in the foregoing medical report are full and true to the best of my knowledge, information and belief, and made with full knowledge of the provisions of Sec. 114 of the Workmen's Compensation Law and Sec. 55 of the Volunteer Firemen's Benefit Law. I state that I am a physician duly licensed to practice medicine in the State of New York.

W.C.B. Rating Code 205201 (Signed) William J. Brazil, M.D.
(Written signature of Attending Physician)

W.C.B. Authorization Number X Address 216 East Charlotte Avenue

Dated 11/14/57 Palmyra, New York

C-4 C-4 C-4 C-4 C-4

11/27/57 Atty. copy

C O P Y

C-4 (4-57)

WORKMEN'S COMPENSATION BOARD

State of New York

ATTENDING PHYSICIAN'S REPORT

TO ATTENDING PHYSICIAN: Reports on this form should be filed within 48 hours after you first render treatment in a workmen's compensation case or a volunteer firemen's benefit case, again within 15 days after first treatment, and as Progress Reports at intervals of 22 days or less during continuing treatment. As soon as treatment is terminated FINAL REPORT on this form must be filed regardless of the filing of any previous reports. If treatment is completed within 48 hours, fill out one report and mark it FINAL.

File the signed original of each report directly with (1) CHAIRMAN, WORKMEN'S COMPENSATION BOARD at the office of the district in which the accident occurred and file a signed copy with (2) the INSURANCE CARRIER, if known, or the EMPLOYER.

Enter "X" to show type of report: [X] 48-HOUR PRELIMINARY REPORT [ ] 15-DAY REPORT [ ] PROGRESS REPORT [ ] FINAL REPORT

1. W.C.B. Case Number (If known)	2. Carrier Case Number and Code (If known)	3. Date of Accident or Injury and Time	4. Address Where Accident or Injury Occurred
			Garlock Packing Company

	Name	Address	
5. INJURED PERSON *	Grace Braylord	R. F. D. #1 Palmyra, New York	Age 52
6. EMPLOYER	Garlock Packing Company	Palmyra, New York	
7. INSURANCE CARRIER	EMPLOYERS MUTUAL LIABILITY INSURANCE COMPANY OF WISCONSIN	10 GIBBS STREET • ROCHESTER 4, NEW YORK	
8. HOSPITAL (If any)			

*If patient claims that injury occurred while performing assigned firemanic duty as a Volunteer Fireman, show as EMPLOYER the city, town, village or district against which claim is made for Volunteer Firemen's benefits and enter "X" here: [ ] Vol. F.B.

9. Present condition (Include diagnosis, objective findings, subjective complaints and any change of condition since last report)

probable asbestosis of lungs. XOray findings of pulmonary fibrosis,

Complaint is of dyspnea on exertion.

(a) Is there now any disability or physical defect? yes If so, is such disability or defect a result of the present injury or disease? yes

(b) May injury result in permanent facial or head disfigurement or other permanent defect? yes If so, describe: Pulmonary Fibrosis. There is probability of progression

10. Nature of treatment: Broncho dilators.

(a) When did you (1) first treat patient? 5/16/57 (2) last treat patient?

(b) Has patient been discharged from treatment? no If so, give date: If not, estimate duration of treatment: Hospital? Home? Office?

(c) Is future operative, hospital, or rehabilitation treatment advised? not at present. If so, state nature of such treatment:

11. Date you think patient was or will be able to (a) resume his usual work? has been (b) do any other work?

(c) Is patient working? yes (d) Specify work limitations, if any: avoid dust exposure

COMPLETE ITEMS 12-15 OR ENTER ON THIS LINE DATE OF PREVIOUS REPORT WHICH GAVE THIS INFORMATION:

12. State in patient's own words how accident or injury occurred: "Short of breath. Twenty years exposure to asbestos dust at work"

13. Describe nature and extent of injury and specify all parts of body involved: Pneumoconiosis, probable etiology is asbestosis disease of lung.

(a) Were X-rays taken? yes (b) Was patient unconscious? no If so, for how long?

(c) If claim is for a disease, give: (1) Approximate date of onset of related symptoms: Two years ago (2) Date disability began: (3) Patient's occupational history: Worked for 22 yrs in Textile Dept. exposed to asbestos dust.

(d) Is there any history or evidence present of pre-existing injury or disease? no If so, describe:

14. In your opinion was accident or injury described above the competent producing cause of condition sustained? in all probability

15. Was patient previously under the care of another physician? no (c) If so, give name and address of present physician:

(b) Reason for transfer:

(c) Did you obtain history and medical data from preceding physician? If not, attach statement of reason

16. Enter here additional information or remarks: This report is submitted at request of the patient to establish compensability if her pulmonary fibrosis.

I state that the findings and opinions given in the foregoing medical report are full and true to the best of my knowledge, information and belief, and made with full knowledge of the provisions of Sec. 114 of the Workmen's Compensation Law and Sec. 55 of the Volunteer Firemen's Benefit Law. I state that I am a physician duly licensed to practice medicine in the State of New York.

W.C.B. Rating Code: 205201

(Signed) William J. Brazill, M.D.
(Written signature of Attending Physician)

W.C.B. Authorization Number: X

Address: 216 East Charlotte Avenue
Palmyra, New York

Dated: 11/14/57

1303-3110 9-57

C-4 C-4 C-4 C-4 C-4

11/21/57 Hosp. Copy

C-11 (5-53)

WORKMEN'S COMPENSATION BOARD
STATE OF NEW YORK

EMPLOYER'S REPORT OF INJURED EMPLOYEE'S CHANGE IN EMPLOYMENT STATUS RESULTING FROM INJURY

This report is to be filed directly with the Chairman, Workmen's Compensation Board at address shown on reverse side as soon as the employment status of an injured employee, as reported on Form C-2.5, Form C-2, or on a previous Form C-11, is changed. Change in employment status includes return to work, discontinuance of work, increase or decrease of regular hours of work and increase or reduction of wages.

Copy also should be sent to your insurance carrier.

W.C.B. Case No.	Carrier's Case No. and Code No.		Date of Accident

	Name	Address
1. Employer	THE GARLOCK PACKING COMPANY	PALMYRA, NEW YORK
2. Insurance Carrier	Employers Mutual Liability Insurance Company of Wisconsin 10 Gibbs Street	Rochester 4, New York
3. Injured Person	MRS. GRACE BAYLORD #8-638	R. D. #1 PALMYRA, NEW YORK

4. Date of most recent Employer's Report filed: (Check "x" form and give date filed.) Works 8-4:30 shift
   ☐ C-2.5_____ ☒ C-2 11-27-57 ☐ C-11_____
5. Date Disability Began: 6-9-58 Hour of Day: _____ A.M. _____ P.M.
6. Nature of Injury: Claim of pulmonary fibrosis of lungs with shortness of breath.
7. Date of first return to work following injury: _____
8. (a) Change of employment status resulting from above injury:

Employment Status	Hours per Day	Days per Week	Earnings	Occupation
Prior to Injury				
Changed to				

   (b) Date of this change in employment status: _____
   (c) Remarks: _____
9. Loss of time resulting from above injury since first return to work:

From (Mo., Day, Year)	To (Mo., Day, Year)	Reason

10. Is injured still under the care of a physician? Yes If so, give name of physician: Dr. Wm. J. Bruell, Palmyra, New York
11. Has injured died? _____ If so, state date of death: _____
    Name and address of nearest relative known: _____

Date of this Report June 11, 1958 Firm Name THE GARLOCK PACKING COMPANY

Signed by _____

D. F. FRASER, VICE PRESIDENT
Official Title

C-11 C-11 C-11 C-11 C-11

1014-2177