Construction Products Division
W.R. Grace & Co.
Whittemore Avenue, Cambridge, Mass. 02140
6-18-80

GRACE

PLEASE REMIT
WITH COPY OF INVOICE TO:
W.R. GRACE & CO.
P.O. BOX 93130
CHICAGO, ILLINOIS 60693

D-U-N-S 04-827-2637

INVOICE DATE	INVOICE NO	LOCATION	PLANT	U.S.	TERRITORY	YOUR ORDER NUMBER	CUST. ORD.
6-23-80	01-009	1-034-035	721	730	732	01-2240	21606

SHIPPED VIA	CUSTOMER NO	SHIPPED FROM	CAR NUMBER	BILL OF LAD	
Southwest No. 669	04018	Travelers Rest		129371	2

SOLD TO
Brighton By Products
P.O. Box 23
New Brighton, Pa. 15066

SHIP TO
Otto's Greenhouse
18706 Miles Ave.
Cleveland, Ohio 44128

QUANTITY ORDERED	QUANTITY SHIPPED	DESCRIPTION	UNIT PRICE	AMOUNT
350	350	Bags Metro Mix #300 (41-12-53-7-04)	$4.50/Bag	$ 1575.00
		$0.85/Bag Freight		297.50
				$1872.50

185675

02008831

X 15.75 7-3-80

PLEASE RETURN THIS COPY WITH REMITTANCE TO ASSURE PROPER CREDIT

[illegible]

Use of the above goods shall be an acceptance of the conditions of sale on the reverse side hereof as the only conditions applying to the sale of said goods.

ZB9-A (11-78)

WRG00289434
ED_005351_00000355-00001

BRIGHTON BY-PRODUCTS CO., INC.
P. O. BOX 23
NEW BRIGHTON, PENNSYLVANIA 15066

NEW BRIGHTON PA. JUL - 2 '80
U.S. POSTAGE .15
PB METER P.B. 942970

W. R. Grace & Co.
P. O. Box 96160
Chicago, IL 60693

02008832

CARL BREHOB & SON
3821 BREHOB ROAD
INDIANAPOLIS, IND. 46217

14696

14

02008835

7-03 1980 20-5/740

PAY TO THE ORDER OF W. R. Grace $3221.22

THREE THOUSAND TWO HUNDRED TWENTY-ONE AND 22/100 DOLLARS

CARL BREHOB & SON

The Indiana National Bank
Indianapolis, Indiana 46266

FOR 01-033

⑈014696⑈ ⑆074000052⑆ 16⑈028 880⑈

5

CONTINENTAL BANK
JUL 9 1980

WRG00289436
ED_005351_00000355-00003

Construction Products Division
W.R. Grace & Co.
Whittemore Avenue, Cambridge, Mass. 02140
6/26/80

GRACE

PLEASE REMIT
WITH COPY OF INVOICE TO:
W.R. GRACE & CO.
P.O. BOX 93130
CHICAGO, ILLINOIS 60693

D-U-N-S 04-827-2637

INVOICE DATE	INVOICE NO	LOCATION					CUST ORDER NO AND DATE
6/27/80	01-033	1-013-017	721	750	753	01-2301	

SHIPPED VIA	CUSTOMER	SHIPPED FROM	BILL OF LADING NO	CHECK
Customer Pick Up	03934	Travelers Rest	129401	3

SOLD TO
Carl Brehob & Sons
3821 Brehob Road
Indianapolis, Indiana 46217

SHIP TO
R & R Greenhouse
R. R. 3
Logansport, Indiana

QUANTITY ORDERED	QUANTITY SHIPPED	DESCRIPTION	UNIT PRICE	AMOUNT
685	685	Bags Metro Mix # 300 (41-12-53-7-04)	$4.75	$3253.75

322122

02008836

PLEASE RETURN THIS COPY WITH REMITTANCE
TO ASSURE PROPER CREDIT

X 32.53 7/7/80

Use of the above goods shall be an acceptance of the conditions of sale on the reverse side hereof as the only conditions applying to the sale of said goods.

ZB9-A (11-78)

CARL BREHOB & SON

3821 BREHOB ROAD
INDIANAPOLIS, INDIANA 46217

INDIANAPOLIS, IN 462
PM
3 JUL
1980

USA 15c
THE HOME OF THE BRAVE

W. R. Grace
P.O. Box 96160
Chicago Ill 60693

02C08837

GEORGIA GOLF & GARDEN SUPPLY CO., INC.
200-C PIEDMONT COURT
DORAVILLE, GEORGIA 30340

7076

36 02008846 19 80 64-1/610

PAY TO THE ORDER OF W. R. GRACE & Co. $ 7328 90/xx

Seven Thousand Three Hundred Twenty Eight & 90/100 DOLLARS

FIRSTATLANTA
The First National Bank of Atlanta
Atlanta, Georgia

FOR

⑆061000010⑆ 12 233 204⑈

CONTINENTAL BANK
ATLANTA
JUL 6 1980

WRG00289439
ED_005351_00000355-00006

TERRA-LITE®
Horticultural & Agricultural Products

W.R. Grace & Co.
4-14-80 Wilmemore Avenue, Cambridge, Mass. 02140

GRACE

PLEASE REMIT WITH COPY OF INVOICE TO:
P.O. BOX 96160
CHICAGO, ILLINOIS 60693

PLEASE RETURN THIS COPY WITH YOUR REMITTANCE

INVOICE DATE	INVOICE NO.	LOC.	PLANT	DIST.	TERRITORY	OUR ORDER NUMBER	CUST. ORDER NO. AND DATE
4-15-80	01-075	1-010-089	721	740	471	01-2084	7278

SHIPPED VIA	CUST.	SHIPPED FROM	CAR NUMBER	BILL OF LADING NO.	CHECKED
TR TRK B/L 129106	11131	Travelers Rest		000262	1

D-U-N-S 04-827-2637

SOLD TO
Georgia Golf & Garden
200-C Piedmont Court
Doraville, Ga. 30340

SHIPPED TO
Same

QUANTITY ORDERED	QUANTITY SHIPPED	DESCRIPTION	PRODUCT CODE	UNIT PRICE	AMOUNT	QUANTITY ORDERED	QUANTITY SHIPPED	DESCRIPTION	PRODUCT CODE	UNIT PRICE	AMOUNT
		Vermiculite 6 Cu. Ft., No. 2 Bag	39-12-18-1-01					African Violet Soil 2 Qts., 24 Per Baler	41-12-20-4-10		
		[illegible]	39-12-01-1-01					[illegible]	41-12-21-4-09		
		Vermiculite 4 Cu. Ft., No. 2 Bag	39-12-17-1-02					Terranova Soil 2 Qts., 2 Per Baler	41-12-19-4-10		
		[illegible]	39-12-19-1-02					[illegible]	41-12-31-4-10		
		Vermiculite 16 Qts. Per Baler	39-12-01-4-44					Planting Mix 32 Qts. Bag	41-12-69-4-45		
1	1	[illegible]	39-12-01-4-09	5.50	5.50			[illegible] 16 Qts. [illegible]	41-12-69-4-44		
		Perlite-Coarse 6 Cu. Ft., Bag	39-12-27-1-01					Planting Mix [illegible] Qts., 1[illegible] Per Baler	41-12-69-4-09		
100	100	[illegible]	39-12-27-1-02	3.85	385.00			[illegible]	41-12-69-4-10		
		Perlite 16 Qts. 6 Per Baler	39-12-27-4-44					[illegible] Pot. Soil Display 36 4 Qts., Per Box	41-12-17-4-43		
10	10	[illegible] 12 Per Bal.	39-12-27-4-09	6.35	63.50			[illegible]	41-12-21-4-43		
25	25	Red-Earth Potting Soil 4 Cu. Ft. Bag	41-12-17-1-02	5.50	137.50	100	100	4 CF Terra-Lite #3 39-12-01-1-02		3.35	335.00
25	25	[illegible]	41-12-16-1-05	3.70	92.50	150	150	Metro Mix #200 41-12-52-7-04		4.55	682.50
		Red-Earth Potting Soil 3 Pk. 6 Per Bale	41-12-16-4-55			20	20	8 Qt. Metro Mix #300 41-12-82-4-95		8.05	161.00
		[illegible]	41-12-16-4-44			10	10	Mag Amp 95-15-40-0-19		16.70	167.00
		Red-Earth Potting Soil 4 Qts., 12 Per Baler	41-12-16-4-09			2	2	3 Pk. Tomato Soil 41-12-29-4-55		11.60	23.20
		[illegible]	41-12-50-1-05			375	375	Metro Mix #300 41-12-53-7-04		4.55	1706.25
		Tomato Veg. Soil 3 Pk. 6 Per Baler	41-12-29-4-46								
		[illegible]	41-12-30-4-55								

02008847

7328.40

NO CASH DISCOUNT – NET 30 DAYS

TAX

FREIGHT 202.50

$ 37.59 CASH DISCOUNT ALLOWED IF PAID BY 4-25-80

TOTAL $3961.45

WRG00289440
ED_005351_00000355-00007

TERRA-LITE®
Horticultural & Agricultural Products

W.R. Grace & Co.
3-25-80
Whitemore Avenue, Cambridge, Mass. 02140

GRACE

PLEASE REMIT WITH COPY OF INVOICE TO:
P.O. BOX 96160
CHICAGO, ILLINOIS 60693

PLEASE RETURN THIS COPY WITH YOUR REMITTANCE

INVOICE DATE	INVOICE NO.	LOCATION	PLANT	DIST.	TERRITORY	OUR ORDER NUMBER	CUST. ORDER NO. AND DATE
3-28-80	01-022	1-010-089	721	740	471	01-2016	7209

SHIPPED	CUST NO.	SHIPPED	CAR NUMBER	BILL OF LADING NO.	CHECKED
TR TRK B/L/ 129027	11131	Travelers Rest		000262	1

D-U-N-S 04-827-2637

SOLD TO
Georgia Golf & Garden
200-C Piedmont Court
Doraville, Ga. 30340

SHIP TO
Same

QUANTITY ORDERED	QUANTITY SHIPPED	DESCRIPTION	PRODUCT CODE	UNIT PRICE	AMOUNT
		Vermiculite 6 Cu. Ft., No. 2 Bag	39-12-18-1-01		
		Vermiculite	39-12-01-1-01		
		Vermiculite 4 Cu. Ft., No. 2 Bag	39-12-17-1-02		
		Vermiculite	39-12-19-1-02		
		Vermiculite 16 Qts. Per Baler	39-12-01-4-44		
		Vermiculite	39-12-01-4-09		
		Perlite Coarse 3 Cu. Ft., Bag	39-12-27-1-01		
200	200		39-12-27-1-02	3.85	770.00
25	25	Perlite Coarse 6 Per Baler	39-12-27-4-44	6.15	153.75
		Perlite 4 Qts. 12 Per Baler	39-12-27-4-09		
		Redi-Earth Potting Soil 4 Cu. Ft. Bag	41-12-17-1-02		
		Potting Soil 2 Cu. Ft.	41-12-16-1-05		
		Redi-Earth Potting Soil 3 Peds, 6 Per Baler	41-12-16-4-55		
		Potting Soil	41-12-16-4-44		
		Redi-Earth Potting Soil 4 Qts., 12 Per Baler	41-12-16-4-09		
		Potting Soil	41-12-50-1-05		
		Tomato Veg. Soil 3 Peds, 6 Per Baler	41-12-29-4-46		
		Potting Soil	41-12-30-4-55		

QUANTITY ORDERED	QUANTITY SHIPPED	DESCRIPTION	PRODUCT CODE	UNIT PRICE	AMOUNT
		African Violet Soil 2 Qts., 24 Per Baler	41-12-20-4-10		
		Seedling Potting Soil	41-12-21-4-09		
		Terrarium Soil 2 Qts., 24 Per Baler	41-12-19-4-10		
		Cactus & Succulent Soil	41-12-31-4-10		
		Planting Mix 32 Qts. Bag	41-12-69-4-45		
		Planting Mix	41-12-69-4-44		
		Planting Mix 4 Qts., 12 Per Baler	41-12-69-4-09		
			41-12-69-4-10		
		Potting Soil Display 36-4 Qts., Per Box	41-12-17-4-43		
		Seed Starting Soil 2 Qts., 6 Per Box	41-12-21-4-43		
200	200	4 CF Terra-Lite #3 39-12-01-1-02		3.35	670.00
8	8	Metro Mix ~~#XX~~ 350 41-12-70-7-04		4.35	34.80
2	2	Metro Mix #500 41-12-75-7-04		3.80	7.60
336	336	Metro Mix #300 41-12-53-7-04		4.55	1528.80

☐ NO CASH DISCOUNT – NET 30 DAYS

02008848

GAST# 044-99-21671

$ 31.65 CASH DISCOUNT ALLOWED IF PAID BY 4-4-7-80

TAX

FREIGHT 202.50

TOTAL $3367.45

Each of the above goods shall be at acceptance subject to the conditions of sale on the reverse side hereof or the only conditions applying to the sale of said goods

WRG00289441
ED_005351_00000355-00008

Dead storage Box #9
Box C 331
Zono Cash Remittance
7-1-80 to 7-18-80
Box 294

indexed

NO.#
02008584 to 02008877

BUSCH BROTHERS
936 BOONE AVE. N.
MINNEAPOLIS, MINN. 55427

3009

July 1 1980 17-110/910

PAY TO THE ORDER OF W. R. Grace Co $378.61

THE SUM 3 7 3 DOLS 6 1 CTS DOLLARS

First Bank Produce
Member First Bank System
100 North Seventh St.
Minneapolis, MN 55403

020088838 William A. Busch

FOR

⑆091001102⑆ ⑈310 3517 649⑈

CONTINENTAL BANK

Construction Products Division
W.R. Grace & Co.
Whittemore Avenue, Cambridge, Mass. 02140
6/26/80

GRACE

PLEASE REMIT
WITH COPY OF INVOICE TO:
W.R. GRACE & CO.
P.O. BOX 96180
CHICAGO, ILLINOIS 60693

D-U-N-S 04-827-2637

INVOICE DATE	INVOICE NO	LOCATION	PLANT	DIST	TERRITORY	OUR ORDER NUMBER	CUST ORDER NO AND DATE
6/27/80	61-011	1-022-053	661	750	755		6/13/80

SHIPPED VIA	CUSTOMER NO	SHIPPED FROM	CAR NUMBER	BILL OF LADING NO	TRUCK
PICK UP	04642	MPLS.			3

SOLD TO
BUSCH BROS. GREENHOUSES
936 BOONE AVENUE NORTH
GOLDEN VALLEY, MINNESOTA

SHIP TO
SAME

QUANTITY ORDERED	QUANTITY SHIPPED	DESCRIPTION	UNIT PRICE	AMOUNT
100	75	39-12-27-1-02 BAGS PERL GRO COARSE 4 CU. FT.	5.10	382.50
		TAX 9681221 02008839		378.41
		XX 3.83		7/7/80

PLEASE RETURN THIS COPY WITH REMITTANCE
TO ASSURE PROPER CREDIT

TO AVOID DELAY [illegible] GARDING THIS SHIPMENT [illegible] BRANCH SERVICE [illegible]

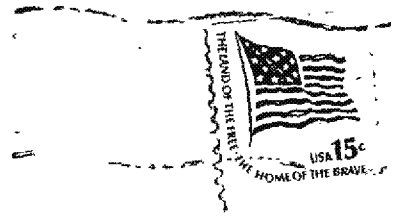
Use of the above goods shall be an acceptance of the conditions of sale on the reverse side hereof as the only conditions applying to the sale of said goods.

Z89-A (11-78)

WRG00289444
ED_005351_00000355-00011

BUSCH BROTHERS
GREENHOUSES
936 BOONE AVE. NO.
MINNEAPOLIS, MINN. 55427

MINNEAPOLIS, MINN.
PM
2 JUL
1980



W.R.Grace Co.
P.O.Box ~~2630096~~ 96160
Chicago Ill.60693

02008840

Dead storage Box #9
Box C 331
Zono Cash Remittance
7-1-80 to 7-18-80
Box 294

indexed

Not
02008584 to 02008877

MR. OR MRS. W. P. BIGGERS JR. 1
648 NORTH INDIAN CREEK LANE
CLARKSTON, GEORGIA 30021

1517

June 20 1980

02008819

PAY TO THE ORDER OF Trace Co. $ 108 15/100

One Hundred Eight & 15/100 DOLLARS

National Bank of Georgia Atlanta, Georgia

FOR 292-8276

W.P. Biggers Jr.

⑆061000256⑆ 0 05 600 6⑈ 1517

5

CONTINENTAL BANK

MACH JUL 6 1980

Construction Products Division
W.R. Grace & Co.
Whittemore Avenue, Cambridge, Mass. 02140

6/20/80

GRACE

PLEASE REMIT
WITH COPY OF INVOICE .
W.R. GRACE & CO.
P.O. BOX 93160
CHICAGO, ILLINOIS 60693

D-U-N-S 04-827-2637

INVOICE DATE	INVOICE NO.	LOCATION	PLANT	DIST	DIVISION	OUR ORDER NUMBER	CUST ORDER NO. AND DATE
6/25/80	11-023	6-010-135	611	611	112	11-2340	

SHIPPED VIA	CUSTOMER NO.	SHIPPED FROM	CARRIER	BILL OF LADING NO.	CHECKED
PICK UP	35011	ATLANTA			3

SOLD TO . W. P. BIGGERS JR.
648 NORTH INDIAN CREEK LANB
CLARKSTON, GA. 30021

CASH SALE

SHIP TO

02008818

QUANTITY ORDERED	QUANTITY SHIPPED	DESCRIPTION	UNIT PRICE	AMOUNT
35	35	BAGS ATTIC INSULATION (39-01-51-1-04)	3.00	$ 105.00
		3% SALES TAX		3.15
				$ 108.15
		PAID CHECK # 1517 6/20/80		

PLEASE RETURN THIS COPY WITH REMITTANCE
TO ASSURE PROPER CREDIT

TO AVOID DELAY, REFER ALL MATTERS REGARDING [illegible] SHIPMENT, OTH[illegible]

Use of the above goods shall be an acceptance of the conditions of sale on the reverse side hereof as the only conditions applying to the sale of said goods.

Dead storage Box #9
Box C 331
Zono Cash Remittance
7-1-80 to 7-18-80
Box 294

indexed

NO.#
02008584 to 02008877

TERRA-LITE®
Horticultural & Agricultural Products

W.R. Grace & Co.
Whittemore Avenue, Cambridge, Mass. 02140

02008814 **GRACE**

PLEASE REMIT WITH COPY OF INVOICE TO:
P.O. BOX 96160
CHICAGO, ILLINOIS 60693

6/18/80 PLEASE RETURN THIS COPY WITH YOUR REMITTANCE

INVOICE DATE	INVOICE NO.		PLANT	DIST.	TERRITORY	OUR ORDER NUMBER	DATE
6/20/80	03-004	1-009-031	723	740	472	03-0380	33679

		SHIPPED FROM	CAR NUMBER	BILL OF LADING NO.	PACKED
P/U	01921	Jax.			3

D-U-N-S 04-827-2637

SOLD TO: Asgrow Florida Company
P.O. Box Drawer D.
Plant City, Fl 33566

SHIPPED TO: SAME AS "SOLD TO" UNLESS OTHERWISE SPECIFIED BELOW
Pick-Up

DESCRIPTION	PRODUCT CODE	UNIT PRICE	AMOUNT	QUANTITY ORDERED	QUANTITY SHIPPED	DESCRIPTION	PRODUCT CODE	UNIT PRICE	AMOUNT
Vermiculite 6 Cu. Ft. No. 2 Bag	39-12-18-1-01					Rose Bush Planting Soil 3 Pecks-6 Per Baler	41-12-30-4-55		
[illegible]	39-12-01-1-01					[illegible]	41-12-20-4-10		
Vermiculite 4 Cu. Ft. No. 2 Bag	39-12-17-1-02					Seed Starter Soil Qt.-12 Per Baler	41-12-21-4-09		
[illegible]	39-12-19-1-02					Terrarium [illegible]	41-12-19-4-10		
Vermiculite 4 Cu. Ft. No. 4 Bag	39-12-51-1-02					Cactus & Succulent Soil 2 Qt. 24 Per Baler	41-12-31-4-10		
[illegible] Qt.-6 Per Baler	39-12-01-4-44					Planting Mix 32 Qt. Bag	41-12-69-4-45		
Vermiculite 4 Qt.-12 Per Baler	39-12-01-4-09					Planting Mix 16 Qt.-6 Per Baler	41-12-69-4-44		
Perlite-Coarse [illegible] Bag	39-12-27-1-01					Planting Mix 4 Qt. [illegible] Per Baler	41-12-69-4-09		
Perlite-Coarse 4 Cu. Ft. Bag	39-12-27-1-02					Planting Mix 2 Qt.-24 Per Baler	41-12-69-4-10		
[illegible] 16 Qt.-6 Per Baler	39-12-27-4-44					Redi-earth Potting Soil Display 4 Qt.-36 Per Box	41-12-17-4-43		
Perlite 4 Qt.-12 Per Baler	39-12-27-4-09					Seed Starter Soil Display 4 Qt.-36 Per Box	41-12-21-4-43		
[illegible] Potting Soil	41-12-17-1-02			100	54	Bags Metro #220 (41-12-77-7-04)		4.55	245.70
Redi-earth Potting Soil 2½ Cu. Ft. Bag	41-12-16-1-05			100	100	Bags Metro #350 (41-12-70-7-04)		4.35	435.00
[illegible]	41-12-16-4-55			~~300~~	~~300~~	Bags Metro #500 (41-12-75-7-04)		3.80	1140.00
Redi-earth Potting Soil 16 Qt.-6 Per Baler	41-12-16-4-44			~~246xxx246~~		~~BagxMixxx~~			
Redi-earth [illegible] Fertilizer	41-12-16-4-09			246	246	Bags Veg. Plug Mix (41-12-78-1-02)		4.20	1033.20
Tomato & Veg. Soil 2½ Cu. Ft. Bag	41-12-50-1-05								
Potting Soil 3 Pecks-6 Per Baler	41-12-29-4-55								

TE# 39-12-02970-17

☐ NO CASH DISCOUNT — NET 30 DAYS

$ 28.54 CASH DISCOUNT ALLOWED IF PAID BY 7/1/80

TAX
FREIGHT
TOTAL $2,853.90

Use of the above goods shall be an acceptance of the conditions of sale on the reverse side hereof as the only conditions applying to the sale of said goods

ZTL-1 (6-77)

WRG00289450
ED_005351_00000355-00017

Asgrow Florida Company

VENDOR NUMBER	INVOICE NUMBER	INVOICE TOTAL	DISCOUNT	NET TOTAL	
3060	03-004	2.853.90	28.54	2.825.36	METRO

02008815

Asgrow Florida Company
subsidiary of The Upjohn Company
GENERAL OFFICES, PLANT CITY, FLORIDA

No. 029005

74-42
724

THE FIRST NATIONAL BANK
AND TRUST COMPANY OF MICHIGAN
KALAMAZOO, MICHIGAN MEMBER FDIC

3

DATE
7/02/80

02008816

AMOUNT
$****2,825.36

PAY
TO THE
ORDER OF

W.R. GRACE & CO.
P.O. BOX 95160
CHICAGO, ILL 60693

Asgrow Florida Company

BY _____
AUTHORIZED SIGNATURE

⑈029005⑈ ⑆072400421⑆ 023 04512 5⑈

CONTINENTAL BANK
MICHIGAN JUL 6 1980

WRG00289452
ED_005351_00000355-00019

Asgrow Florida Company
subsidiary of The Upjohn Company
P. O. Drawer D, Plant City, Florida 33566

02008817

PLANT CITY
JUL - 2'80
FLA.
U.S. POSTAGE
15
P.B. METER 616523

WRG00289453

ED_005351_00000355-00020

Dead storage Box #9
Box C 331
Zono Cash Remittance
7-1-80 to 7-18-80
Box 294

indexed

NO.#
02008584 to 02008877

SALINAS TRANSPLANTS CO.
200 OLD STAGE ROAD
BOX 276 • SALINAS, CA 93902

02008806 № 3574

11-35
1210

DATE	CHECK NO	AMOUNT
6-27-80	3574	2,204.62

REGISTERED $2204 dols 62 cts

TO THE ORDER OF

10

W. R. Grace & Co.
P.O. Box 96160
Chicago, Illinois 60693

SALINAS TRANSPLANTS CO

BY [signature]

SALINAS MAIN OFFICE, BANK OF AMERICA, SALINAS, CALIFORNIA

⑈003574⑈ ⑆121000358⑆ 00721⑈05436⑈

CONTINENTAL BANK
CONTINENTAL ILLINOIS NATIONAL BANK AND TRUST COMPANY (CHICAGO)
MACH 2 JUL 3 1980

WRG00289455
ED_005351_00000355-00022

DATE 6-27-80 REF. ATTACHED OR AS FOLLOWS:	GROSS AMOUNT	DISCOUNT	NET AMOUNT	REMARKS
#: 76-232	2,227.50	<22.88>	2,204.62	02008807

SALINAS TRANSPLANTS CO.
200 OLD STAGE ROAD
BOX 276 • SALINAS, CA 93902

DETACH AND RETAIN THIS STATEMENT

№ 3574

Construction Products Division
W.R. Grace & Co. #20
2500 South Garnsey St., Santa Ana, CA 92707 (714) 979-4900
6-11-80

GRACE

PLEASE REMIT
WITH COPY OF INVOICE TO:
W.R. GRACE & CO.
P.O. BOX 96160
CHICAGO, ILLINOIS 60693

D-U-N-S 04-827-2637

INVOICE DATE	INVOICE NO.	LOCATION	PLANT	DIST.	TERRITORY	OUR ORDER NUMBER	CUST. ORD.	DUE
6-12-80	76-232	3-004-053	676	772	703	762268	1816	5-28-80

SHIPPED VIA	CUSTOMER NO.	FLIGHT	CAR NUMBER	
WILL CALL	25096	Santa Ana	6-11-80	3

SOLD TO
SALINAS TRANSPLANTS INC
P.O. Box 276
Salinas, CA 93901

SHIP TO
SAME

QUANTITY ORDERED	QUANTITY SHIPPED	DESCRIPTION	UNIT PRICE	AMOUNT
700	594	Bags TERRA LITE #2 (39-12-04-1-02)	3.75	2227.50
		SRC HA 26-600690		

02008808

PLEASE RETURN THIS COPY WITH REMITTANCE
TO ASSURE PROPER CREDIT

XX 22.88 6-22-80

TO AVOID DELAY, REFER ALL MATTERS REGARDING [illegible] THAN PAYMENTS, TO THE [illegible]

Use of the above goods shall be an acceptance of the conditions of sale on the reverse side hereof as the only conditions applying to the sale of said goods.

ZB9-A (CAL) 4-79

WRG00289457
ED_005351_00000355-00024

Construction Products Division
W.R. Grace & Co. #20
2500 South Garnsey St., Santa Ana, CA 92707 (714) 979-4900
6-11-80

GRACE

PLEASE REMIT
WITH COPY OF INVOICE TO:
W.R. GRACE & CO.
P.O. BOX 96160
CHICAGO, ILLINOIS 60693

D-U-N-S 04-827-2637

INVOICE DATE	INVOICE NO.	LOCATION	PLANT	DIST.	TERRITORY	OUR ORDER NUMBER	CUST. ORDER NO. AND DATE
6-12-80	76-232	3-004-053	676	772	703	762268	1816 5-28-80

SHIPPED VIA	CUSTOMER NO.	SHIPPED FROM	CAR NUMBER	BILL OF LADING NO.	CHECKED
WILL CALL	25096	Santa Ana	6-11-80		3

SOLD TO
SALINAS TRANSPLANTS INC
P.O. Box 276
Salinas, CA 93901

SHIP TO
SAME

QUANTITY ORDERED	QUANTITY SHIPPED	DESCRIPTION	UNIT PRICE	AMOUNT
700	594	Bags TERRA LITE #2 (39-12-04-1-02)	3.75	2227.50
		SRC HA 26-500690		

02008808

PLEASE RETURN THIS COPY WITH REMITTANCE TO ASSURE PROPER CREDIT

XX 22.88 6-22-80

TO AVOID DELAY, REFER ALL MATTERS REGARDING THIS SHIPMENT, "OTHER THAN PAYMENTS," TO THE SALES BRANCH SERVING YOU.

Use of the above goods shall be an acceptance of the conditions of sale on the reverse side hereof as the only conditions applying to the sale of said goods.

ZB9-A (CAL) 4-79

Fresh as Tomorrow.
BUD
OF CALIFORNIA

BUD ANTLE, INC. P.O. BOX 1759, SALINAS, CALIFORNIA 93902

SALINAS, CA 93902
PM
29 JUN 1980
SALINAS
JUN 28 '80
CALIF.
PB METER
991223

02008809

WRG00289459

Dead storage Box #9
Box C 331
Zono Cash Remittance
7-1-80 to 7-18-80
Box 294

indexed

NO.#
02008584 to 02008877

ANDERSON PEAT - MICHIGAN
ROUTE 1
IMLAY CITY MI 48444

DATE	CHECK NO.
06/29/80	36805 00036805

9

PAY TO THE ORDER OF
W. R. GRACE CO.
62 WHITTEMORE AVE.
CAMBRIDGE MA 02140

02008802

CHECK AMOUNT
$**1843.78

EXACTLY *****1843 DOLLARS AND 78 CENTS

INDIANA BANK & TRUST CO.
OF FORT WAYNE, INDIANA
71-34
74

AUTHORIZED SIGNATURE

⑈36805⑈ ⑆074900343⑆ 47⑈3 097 604⑈

CONTINENTAL BANK
NATIONAL BANK AND TRUST COMPANY OF CHICAGO
JUL 3 1980

WRG00289461
ED_005351_00000355-00028

Construction Products Division

W.R. Grace & Co.
Whittemore Avenue, Cambridge, Mass. 02140

GRACE

PLEASE REMIT
WITH COPY OF INVOICE TO:
W.R. GRACE & CO.
P.O. BOX 96160
CHICAGO, ILLINOIS 60693

INVOICE DATE	INVOICE NO	LOCATION	PLANT	DIST	TERRITORY	OUR ORDER NUMBER	CUST. ORDER NO. AND DATE
6-06-80	51-081	1-021-163	651	750	753		

SHIPPED VIA	CUST. VEN NO.	SHIPPED FROM	CAR NUMBER	BILL OF LADING NO	CHECKED
DEARBORN PICK UP	01392	DEARBORN	PICK UP		3

D-U-N-S 04-827-2637

SOLD TO

ANDERSON PEAT
322 GRAHAM ROAD
IMLAY CITY, MI 48444

SHIP TO PICK UP

QUANTITY ORDERED	QUANTITY SHIPPED	DESCRIPTION	UNIT PRICE	AMOUNT
T/L	384	BAGS TERRA LITE #3 6CF 39-12-01-1-01	4.85	1862.40
				0200880.
		TE		

PLEASE RETURN THIS COPY WITH REMITTANCE
TO ASSURE PROPER CREDIT

XX 18.62 7-10-80

TO AVOID DELAY, REFER ALL MATTERS REGARDING THIS SHIPMENT TO THE [illegible]

Use of the above goods shall be an acceptance of the conditions of sale on the reverse side hereof as the only conditions applying to the sale of said goods.

ANDERSON PEAT - MICHIGAN IMLAY CITY MI 48444

VOUCHER NO. 36805

DATE 06/29/80

PAGE 1 PAID TO: W. R. GRACE CO. ACCOUNT NO. 62104 00036805

RECORD DATE	RECORD NUMBER	GROSS AMOUNT	DISCOUNT	NET AMOUNT	BRANCH	DEPT.	ACCOUNT NO.
06/06/80	1051081	1862.40	18.62	1843.78	00	000	00000635
							02008804
	TOTALS	1862.40	18.62	1843.78			

mail to Chicago

WRG00289463

ED_005351_00000355-00030

OLD FORT INDUSTRIES, INC.
FORT WAYNE, INDIANA 46801

FORT WAYNE
JUL - 1 '80
IND.

U.S. POSTAGE
0.15

02008805

W R Grace Co.
P O Box 96160
Chicago Illinois 60693

Dead storage Box #9
Box C 331
Zono Cash Remittance
7-1-80 to 7-18-80
Box 294

indexed

No. #
02008584 to 02008877

LOS ANGELES SEED CO., INC. 26992
736 MERCHANT ST. 623-1060
LOS ANGELES, CALIF. 90021

16

June 26 19 80 16-77/101 1220

PAY TO THE ORDER OF Zonolite Company $ 870.00

870 DOLS 00 CTS 02008628 DOLLARS

TOTAL
DISCOUNT
AMOUNT OF CHECK

California Mart Office
UNION BANK
900 S. Main St., Los Angeles, Ca. 90015

⑈026992⑈ ⑆122000771⑆ 10186⑈1415⑈

02008628

CONTINENTAL BANK
JUL 8 1980

WRG00289466
ED_005351_00000355-00033

Construction Products Division
W.R. Grace & Co. #02
Whittemore Avenue, Cambridge, Mass. 02140

GRACE

PLEASE REMIT
WITH COPY OF INVOICE TO:
W.R. GRACE & CO.
P.O. BOX 95150
CHICAGO, ILL. 60693

02008629

5-15-80

D-U-N-S 04-827-2637

INVOICE DATE	INVOICE NO	LOCATION	PLANT	DIST	TERRITORY	OUR ORDER NUMBER	CUST ORDER NO AND DATE
5-16-80	76-020	1-004-037	676	771	705	762102	Verbal 5-12-80

SHIPPED VIA	CUSTOMER NO	SHIPPED FROM	CAR NUMBER	BILL OF LADING NO	SHEET
WILL CALL	17150	Santa Ana	5-14-80		3

SOLD TO

L A SEED CO.
736 Merchant St.
Los Angeles, CA 90021

SHIP TO

SAME

QUANTITY ORDERED	QUANTITY SHIPPED	DESCRIPTION	UNIT PRICE	AMOUNT
150	150	Bags TERRA LITE #3 (39-12-05-1-02)	3.00	450.00
150	150	Bags TERRA LITE #4 (39-12-03-1-02)	2.80	420.00
				870.00
		Release No. C 05024		
		AA-494		

PLEASE RETURN THIS COPY WITH REMITTANCE TO ASSURE PROPER CREDIT

XX 8.70

5-26-80

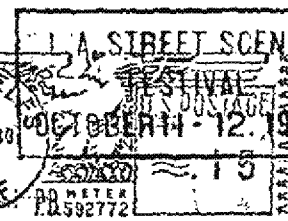
TO AVOID DELAY, REFER ALL MATTERS REGARDING THIS SHIPMENT, "OTHER THAN PAYMENTS," TO [illegible]

Use of the above goods shall be an acceptance of the conditions of sale on the reverse side hereof as the only conditions applying to the sale of said goods.

ZB9-A (11-78)

Quality Seeds since 1912

LOS ANGELES SEED CO., INC.
736 MERCHANT STREET
LOS ANGELES, CALIFORNIA 90021



02008630

Zonolite Company
P. O. Box 96160
Chicago, Illinois 60693

WRG00289468

Dead Storage Box #9
Box C 331
Zono Cash Remittance
7-1-80 to 7-18-80
Box 294

indexed

NO.#
02008584 to 02008877

Denver Wholesale Florists Co.

DWF

4800 DAHLIA ST. | P.O. BOX 1138 | DENVER, CO 80201 | (303) 395-0970

23-1
1020

02008666 NO 101580

DATE		AMOUNT
07 01 80	PAY: THE SUM OF ****460 DOLLARS AND 35 CENTS	$****460.35

TO THE ORDER OF

16

W.R. GRACE & COMPANY
P. O. BOX 96160
CHICAGO, IL 60693

DENVER WHOLESALE FLORISTS CO.

Douglas R. Gordon

THE FIRST NATIONAL BANK OF DENVER
DENVER, COLORADO

⑈101580⑈ ⑆107000018⑆ 11-00134⑈

CONTINENTAL BANK
MARCH 4 JUL 10 1980
WAYNE

WRG00289470
ED_005351_00000355-00037

DENVER WHOLESALE FLORISTS CO. DENVER, COLORADO 80201

DATE	DESCRIPTION	INVOICE NO.	GROSS	DEDUCTIONS	NET AMOUNT
06 17 80		62090	465.00	4.65	460.35
			02008667		
			465.00	4.65	460.35

TERRA-LITE®
Horticultural & Agricultural Products

WR Grace & Co.
Whittemore Avenue, Cambridge, Mass. 02140

GRACE

PLEASE REMIT WITH COPY OF INVOICE TO:
P.O. BOX 96160
CHICAGO, ILLINOIS 60693

PLEASE RETURN THIS COPY WITH YOUR REMITTANCE

SHIPPED VIA	INVOICE NO.	LOCATION	CUST. NO.	PLANT	HISTORY	OUR ORDER NUMBER	CAR NUMBER	BILL OF LADING NO.	CHECKED
6/17/80	62- 090	1-005-031		662	750	755	T01932	A000563	5/29/80

PICKUP 08173 DENVER D-U-N-S 04-827-2637 3

SOLD TO: DENVER WHOLESALE FLORISTS
P. O. BOX 1138
DENVER, CO 80201

SHIPPED TO: SAME

QUANTITY ORDERED	QUANTITY SHIPPED	DESCRIPTION	PRODUCT CODE	UNIT PRICE	AMOUNT
		Vermiculite 6 Cu. Ft., No. 2 Bag	39-12-18-1-01		
100	100	[illegible]	39-12-01-1-01	4.65	465.00
		Vermiculite 4 Cu. Ft., No. 2 Bag	39-12-17-1-02		
		[illegible]	39-12-19-1-02		
		Vermiculite 16 Qts. Per Baler	39-12-01-4-44		
		[illegible]	39-12-01-4-09		
		Perlite Coarse 3 Cu. Ft., Bag	39-12-27-1-01		
		[illegible]	39-12-27-1-02		
		Perlite Coarse 6 Per Baler	39-12-27-4-44		
		[illegible]	39-12-27-4-09		
		Redi Earth Potting Soil [illegible]	41-12-17-1-02		
		[illegible]	41-12-16-1-05		
		Redi Earth Potting Soil 3 Qts. 3 Per Baler	41-12-16-4-55		
		[illegible]	41-12-16-4-44		
		Redi Earth Potting Soil 4 Qts., 12 Per Baler	41-12-16-4-09		
		[illegible]	41-12-50-1-05		
		Tomato & Veg. Soil 3 Pkgs. 3 Per Baler	41-12-29-4-46		
		[illegible]	41-12-30-4-55		

QUANTITY ORDERED	QUANTITY SHIPPED	DESCRIPTION	PRODUCT CODE	UNIT PRICE	AMOUNT
		African Violet Soil 2 Qts., 24 Per Baler	41-12-20-4-10		
		Seed [illegible]	41-12-21-4-09		
		Geranium Soil 2 Qts., 24 Per Baler	41-12-19-4-10		
		[illegible]	41-12-31-4-10		
		Planting Mix 32 Qts. Bag	41-12-69-4-45		
		[illegible]	41-12-69-4-44		
		Planting Mix [illegible] Per Baler	41-12-69-4-09		
		[illegible]	41-12-69-4-10		
		[illegible] Potting Soil Display 36 4 Qts., Per Box	41-12-17-4-43		
		[illegible] Display 36 4 Qts. Per Box	41-12-21-4-43		

"PRICE PROTECTED"

02008668

☐ NO CASH DISCOUNT – NET 30 DAYS ST#01-09667

$ 4.65 CASH DISCOUNT ALLOWED IF PAID BY 6/27/80

TAX -0-
FREIGHT -0-
TOTAL $465.00

[illegible]

WRG00289472
ED_005351_00000355-00039

HIGH ALTITUDE FLOWERS FOR HIGHER QUALITY

Denver Wholesale Florists Co.

4800 Dahlia • P.O. Box 1138 • Denver, Colorado 80201

DENVER JUL-8'80 COLO.

U.S. POSTAGE .15

PB METER P.O. 902751

02008669

DWF

Dead storage Box #9
Box C331
Zono Cash Remittance
7-1-80 to 7-18-80
Box 294

indexed

NO.#
02008584 to 02008877

KINNEY BONDED WAREHOUSE, INC.
102 N. 13TH 512-464-4491
DONNA, TEXAS 78537

88-1918
1149

4677

6/30/80 19

PAY TO THE ORDER OF W. R. GRACE 02008798 $ 4645.66

The sum of $4645 and 66 cts DOLLARS

ALAMO BANK OF TEXAS P.O. Box 548 Alamo, Texas 78516

KINNEY BONDED WAREHOUSE, INC.

Beverly M. Kinney

⑈114919184⑈ 00 0081 70⑈

INV. 91-010
91-011

STAMFORD LOWDON CO. FORM 8

CONTINENTAL BANK
CONTINENTAL ILLINOIS NATIONAL BANK AND TRUST CO. OF CHICAGO

MARCH 4 JUL 3 1980

WRG00289475
ED_005351_00000355-00042

Construction Products Division
W.R. Grace & Co.
Whittemore Avenue, Cambridge, Mass. 02140

GRACE

PLEASE REMIT
WITH COPY OF INVOICE TO:
W.R. GRACE & CO.
P.O. BOX 96160
CHICAGO, ILLINOIS 60693

516-80

D-U-N-S 04-827-2637

INVOICE DATE	REFERENCE	LOCATION				OUR ORDER NUMBER	CUST ORDER NO. AND DATE
5-20-80	91-011	1-042-113	691	790	792 XXX	91-7540	

SHIPPED VIA	CUSTOMER NO.	SHIPPED FROM	CARRIER	BILL OF LADING NO.	CHECKED
COMMON CARRIER CENTRAL	15788	XXXXX, DALLAS, TX		106788	3

SOLD TO

KINNEY BONDED WAREHOUSE
102 NORTH 13TH
DONNA, TEXAS 78537

SHIP TO

QUANTITY ORDERED	QUANTITY SHIPPED	DESCRIPTION	UNIT PRICE	AMOUNT
25	25	BXX G.P. 20-20-20 5# 41-14-49-1-50	29.10	~~727.50~~ 727.50
			Less	7.28
				720.22
		02008799		4645.66
		TAX# 1-74-1989281-0		
		X 7.28		7-10-80

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Use of the above goods shall be an acceptance of the conditions of sale on the reverse side hereof as the only conditions applying to the sale of said goods.

Z89-A (11-78)

TERRA-LITE®
Horticultural & Agricultural Products

WR Grace & Co.
Whitemore Avenue, Cambridge, Mass. 02140

5-16-80

GRACE

PLEASE REMIT WITH COPY OF INVOICE TO:
P.O. BOX 96160
CHICAGO, ILLINOIS 60693

PLEASE RETURN THIS COPY WITH YOUR REMITTANCE

[illegible]	[illegible]	LOCATION	PLANT	DIST.	TERRITORY	OUR ORDER NUMBER	CUST. ORDER NO. AND DATE
5-20-80	91-010	1-042-113	691	790	792	91-7544	381

[illegible]	SHIPPED FROM	CAR NUMBER	BILL OF LADING NO.	CHECKED
A.T.S. CALDWELL SP MERITO SID 15788 ING TRACK 0403 SPOT #3	DALLAS, TEXAS	ATSF 48827	106786	3

D-U-N-S 04-827-2637

SOLD TO:
KINNEY BONDED WAREHOUSE
102 NORTH 13TH ST.
DONNA, TEX 78537

SHIPPED TO
SAME AS "SOLD TO" UNLESS OTHERWISE SPECIFIED BELOW
GRIFFIN & BRAND
MERITO ~~XXX~~ SIDING
MERITO, TEX

QUANTITY ORDERED	QUANTITY SHIPPED	DESCRIPTION	PRODUCT CODE	UNIT PRICE	[illegible]	QUANTITY ORDERED	QUANTITY SHIPPED	DESCRIPTION	PRODUCT CODE	UNIT PRICE	AMOUNT
870	870	Vermiculite 6 Cu Ft No 2 Bag	39-12-18-1-01	4.80	4176.00			Rose Bush Planting Soil 3 Pecks-6 Per Baler	41-12-30-4-55		
		Vermiculite [illegible]	39-12-01-1-01					[illegible]	41-12-20-4-10		
		Vermiculite 4 Cu Ft No 2 Bag	39-12-17-1-02					Seed Starter Soil [illegible] Qt 12 Per Baler	41-12-21-4-09		02008800
		[illegible]	39-12-19-1-02					Terrantum 2 Qt -24 [illegible]	41-12-19-4-10		
		Vermiculite 4 Cu Ft No 4 Bag	39-12-51-1-02					Cactus & Succulent Soil 2 Qt -24 Per Baler	41-12-31-4-10		
		[illegible]	39-12-01-4-44					Planting Mix 32 Qt Bag	41-12-69-4-45		
		Vermiculite [illegible] Qt -12 Per Baler	39-12-01-4-09					Planting Mix 15 Qt [illegible] Per Baler	41-12-69-4-44		
		[illegible] Coarse [illegible] Cu Ft Bag	39-12-27-1-01					[illegible] 4 Qt [illegible]	41-12-69-4-09		
		Perlite Coarse 4 Cu Ft Bag	39-12-27-1-02					Planting Mix 2 Qt -24 Per Baler	41-12-69-4-10		
		[illegible] 16 Qt -6 Per Baler	39-12-27-4-44					Redi-earth [illegible] Display 4 Qt [illegible]	41-12-17-4-43		
		Perlite [illegible] Qt -12 Per Baler	39-12-27-4-09					Seed Starter Soil Display 4 Qt -3[illegible] Per Bag	41-12-21-4-43		
		[illegible] Potting Soil [illegible] Cu Ft Bag	41-12-17-1-02								
		Redi-earth Potting Soil 2[illegible] Cu Ft Bag	41-12-16-1-05			LESS	5% CARLOAD ALLOWANCE				
		[illegible]	41-12-16-4-55				X6-790-59-005				(208.80)
		Redi-earth Potting Soil 16 Qt 6 Per Baler	41-12-16-4-44								
		[illegible]	41-12-16-4-09								
		Tomato & Veg Soil 2 Cu Ft Bag	41-12-50-1-05								
		Tomato & Veg Soil [illegible] Pecks-6 Per Baler	41-12-29-4-55								

TAX# 1-74-1939281-0

TAX

FREIGHT

NO CASH DISCOUNT – NET 30 DAYS

$ 41.76 CASH DISCOUNT ALLOWED IF PAID BY 7-10-80

TOTAL 3967.20

Less 41.76

[illegible]

Use of the above goods shall be an acceptance of the conditions of sale on the reverse side hereof as the only conditions applying to the sale of said goods

ZTL-1 (6-77)

3925.44

WRG00289437

ED_005351_00000355-00044

KINNEY BONDED WAREHOUSE, INC.
102 NORTH 13TH • DONNA, TEXAS 78537 • 512-464-4491

MC ALLEN, TX
PM
30 JUN
1980

ALWAYS
ZIP CODE
USA 15

02008801

W. R. Grace

P.O. Box 96160

Chicago, Ill. 60693

Construction Products Division
W.R. Grace & Co.
Whittemore Avenue, Cambridge, Mass. 02140

6-10-80

GRACE

PLEASE REMIT
WITH COPY OF INVOICE TO:
W.R. GRACE & CO.
P.O. BOX 96160
CHICAGO, ILLINOIS 60693

D-U-N-S 04-827-2637

INVOICE DATE	INVOICE NO.	LOCATION	PLANT	DIST	FPR	LRY	OUR ORDER NUMBER	CUST ORDER NO AND DATE
6-17-80	91-235	1-042-113	691	790	794		91-7673	

SHIPPED VIA	CUSTOMER NO.	SHIPPED FROM	CAR NUMBER	BILL OF LADING NO	CHECKED
CUSTOMER PICK UP	21220	DALLAS, TEXAS			3

SOLD TO
NORTEX DISTRIBUTOR CO.
7700 NORTHAVEN RD.
DALLAS, TEXAS 75230

SHIP TO

02008743

QUANTITY ORDERED	QUANTITY SHIPPED	DESCRIPTION	UNIT PRICE	AMOUNT
250	250	METRO MIX 300 41-12-53-7-04	4.90	1225.00
		TAX# 1-75-1244460-9		

PLEASE RETURN THIS COPY WITH REMITTANCE TO ASSURE PROPER CREDIT

X 12.25 7-10-80

TO AVOID DELAY, REFER ALL MATTERS REGARDING THIS SHIPMENT, "OTHER THAN PAYMENT" TO THE SALES BRANCH SERVING YOU.

Use of the above goods shall be an acceptance of the conditions of sale on the reverse side hereof as the only conditions applying to the sale of said goods.

ZB9-A (11-78)

Construction Products Division
W.R. Grace & Co.
Whittemore Avenue, Cambridge, Mass. 02140
5-30-80

GRACE

PLEASE REMIT
WITH COPY OF INVOICE TO:
W.R. GRACE & CO.
P.O. BOX 95160
CHICAGO, ILLINOIS 60693

D-U-N-S 04-827-2637

INVOICE DATE	INVOICE NO	LOCATION	PLANT	DIST	TERRITORY	OUR ORDER NUMBER	CUST ORDER NO. AND DATE
6-3-80	91-118	1-042-113	691	790	794	91-7613	25373

SHIPPED VIA	CUSTOMER NO.	SHIPPED FROM	CAR NUMBER	BILL OF LADING NO	CHECKED
customer pick up	21220	DALLAS, TEXAS			3

SOLD TO

NORTEX DISTRIBUTOR CO.
7700 NORTHAVEN RD.
DALLAS, TEXAS 75230

SHIP TO

02008744

QUANTITY ORDERED	QUANTITY SHIPPED	DESCRIPTION	UNIT PRICE	AMOUNT
49	49	BAGS METRO MIX 300 41-12-53-7-04	4.90	240.10
		TAX# 1-75-1244460-9		
		X 2.40		7-10-80

PLEASE RETURN THIS COPY WITH REMITTANCE TO ASSURE PROPER CREDIT

TO AVOID DELAY, REFER ALL MATTERS REGARDING THIS SHIPMENT, OTHER THAN PAYMENTS, TO THE SALES BRANCH SERVING YOU

Use of the above goods shall be an acceptance of the conditions of sale on the reverse side hereof as the only conditions applying to the sale of said goods.

Z89-A (11-78)

TERRA-LITE®
Horticultural & Agricultural Products

WR Grace & Co.
[redacted] Avenue, Cambridge, Mass. 02140

GRACE

PLEASE REMIT WITH COPY OF INVOICE TO:
P.O. BOX 96160
CHICAGO, ILLINOIS 60693

PLEASE RETURN THIS COPY WITH YOUR REMITTANCE

INVOICE DATE	INVOICE NO.	LOCATION	[redacted]	DIST.	TERRITORY	OUR ORDER NUMBER	[redacted]
5-22-80	91-042	1-042-113	691	790	791	91-7573	

[redacted] VIA	CUST. NO.	SHIPPED FROM	CAR NUMBER	BILL OF LADING [redacted]
CUSTOMER PICK UP	21220	DALLAS, TEXAS		3

D-U-N-S 04-827-2637

SOLD TO: NORTEX DISTRIBUTOR CO.
7700 NORTHAVEN RD.
DALLAS, TEXAS 75230

SHIPPED TO: SAME AS SOLD TO UNLESS OTHERWISE SPECIFIED BELOW

02008745

QUANTITY ORDERED	QUANTITY SHIPPED	DESCRIPTION	PRODUCT CODE	UNIT PRICE	AMOUNT	QUANTITY ORDERED	QUANTITY SHIPPED	DESCRIPTION	PRODUCT CODE	UNIT PRICE	AMOUNT
		Vermiculite 6 Cu. Ft. No. 2 Bag	39-12-18-1-01					Rose Bush Planting Soil 3 Pecks Per Baler	41-12-30-4-55		
15	15	Vermiculite	39-12-01-1-01	4.20	63.00				41-12-20-4-10		
		[illegible] 4 Cu. Ft. No. 3 Bag	39-12-17-1-02					[illegible] Soil [illegible] Per Bale	41-12-21-4-09		
		[illegible]	39-12-19-1-02						41-12-19-4-10		
		[illegible] Cu. Ft. No. 4 Bag	39-12-51-1-02					[illegible] Succulent Soil [illegible] Per Baler	41-12-31-4-10		
			39-12-01-4-44					[illegible]	41-12-69-4-45		
5	5	[illegible]	39-12-01-4-09	5.65	28.25			Planting Mix [illegible] 6 Per Bale	41-12-69-4-44		
125	31		39-12-27-1-01	5.20	161.20			[illegible]	41-12-69-4-09		
		Perlite Coarse 4 Cu. Ft. Bag	39-12-27-1-02					Planting Mix 2 Qt. 21 Per Baler	41-12-69-4-10		
			39-12-27-4-44					[illegible]	41-12-17-4-43		
		Perlite [illegible]	39-12-27-4-09					Seed Starter Soil [illegible]	41-12-21-4-43		
10	10		41-12-17-1-02	5.80	58.00	5	5	P.P.S. 8QT 41-12-70-1-95			N/C
		[illegible] Soil 2 Cu. Ft. Bag	41-12-16-1-05			5	5	P.P.S. 16QT 41-12-70-4-44			N/C
			41-12-16-4-55								
		Begonia [illegible] Soil [illegible] 6 Per Bale	41-12-16-4-44								
			41-12-16-4-09								
		[illegible] 2 Cu. Ft. [illegible]	41-12-50-1-05								
			41-12-29-4-55								

TAX# 1-75-1244460-9

☐ NO CASH DISCOUNT – NET 30 DAYS

$ 3.10 CASH DISCOUNT ALLOWED IF PAID BY 7-10-80

TAX	
FREIGHT	
TOTAL	310.45

[redacted] OTHER THAN PAYMENT [redacted] TIME SALE [redacted]

Use of the above goods shall be an acceptance of the conditions of sale on the reverse side hereof, as the only conditions apply to the sale of said goods.

WRG00289481
ED_005351_00000355-00048

Bunch Wholesale, Inc.

09403

02008712

W R GRACE
P O BOX 96160
CHICAGO IL 60693

BUNCH WHOLESALE INC

Betty Gale Bunch

⑆082900759⑆ ⑈02⑈879⑈7⑈

CONTINENTAL BANK

JUL 16 1980

VENDOR: W R GRACE

DATE 7/09/80

VOUCHER 5552

09403

INVOICE DATE	INVOICE NUMBER	DESCRIPTION	GROSS AMOUNT	DISCOUNT	NET AMOUNT
5/22/80	91-030		980.00	9.80	970.20
5/22/80	91-031		3,280.25	32.80	3,247.45
5/28/80	91-072		2,350.60	23.51	2,327.09
6/13/80	91-208		2,296.50	22.97	2,273.53
5/20/80	91-604		220.00	2.20	217.80

02008713

903607

DETACH BEFORE DEPOSITING

BUNCH WHOLESALE INC TEXARKANA TX 75501

REMITTANCE STATEMENT

_ . Products Division
Grace & Co.
Littlemore Avenue, Cambridge, Mass. 02140

GRACE

PLEASE REMIT
WITH COPY OF INVOICE TO:
W.R. GRACE & CO.
P.O. BOX 96160
CHICAGO, ILLINOIS 60693

2-28-80

D-U-N-S 04-827-2637

INVOICE DATE	INVOICE NO	LOCATION	PLANT		CHARTERY	OUR ORDER NUMBER	CUST ORDER NO. AND DATE
5-20-80	91-604	1-042-037	691	790	791	91-5094	

SHIPPED VIA	CUSTOMER NO	SHIPPED FROM	CAR NUMBER	BILL OF LADING NO	CODE
PICK UP	04511	DALLAS, TEXAS	3819		5

SOLD TO • BUNCH WHOLESALE, INC.
P O BOX 5968
TEXARKANA, TX 75501

SHIP TO

02008714

QUANTITY ORDERED	QUANTITY SHIPPED	DESCRIPTION		UNIT PRICE	AMOUNT
		DEBIT MEMO TO CORRECT PRICING ON LINE ITEM 12 INVOICE #91-103 DATED 3-3-80			
SHOULD READ:	200	BAGS REDI-EARTH 4 CU FT	41-12-17-1-02	5.80	1160.00
DID READ:	200	BAGS REDI-EARTH 4 CU FT	41-12-17-1-02	4.70	940.00
		TOTAL AMOUNT DUE			220.00

PLEASE RETURN THIS COPY WITH REMITTANCE TO ASSURE PROPER CREDIT

X 2.20 7-10-80

TO AVOID DELAY, REFER ALL MATTERS REGARDING THIS SHIPMENT, OTHER THAN PAYMENTS, TO THE SALES BRANCH SERVING YOU.

• Use of the above goods shall be an acceptance of the conditions of sale on the reverse side hereof as the only conditions applying to the sale of said goods.

ZB9-A (11-78)

WRG00289484
ED_005351_00000355-00051

...s Division

...e & Co.

Whittemore Avenue, Cambridge, Mass. 02140

5-16-80

GRACE

PLEASE REMIT WITH COPY OF INVOICE TO:
W.R. ...
P.O. BOX 95150
CHICAGO, ILLINOIS 60693

02008715

D-U-N-S 04-827-2637

INVOICE DATE	INVOICE NO.	LOCATION	PLAN				CUST. ORDER
5-22-80	91-030	1-042-113	691	790	794	91-7542	

SHIPPED VIA	CUSTOMER NO.	SHIP TO	CAR NUMBER	BILL OF LADING NO.
CUSTOMER PICK UP	04511	DALLAS, TEXAS		X3 -

SOLD TO

BUNCH WHOLESALE, INC.
P.O. BOX 5968
TEXARKANA, TEX 75501

SHIP TO

GREAT BIG GREENHOUSE

QUANTITY ORDERED	QUANTITY SHIPPED	DESCRIPTION		UNIT PRICE	AMOUNT
200	200	BAGS METRO MIX 300	41-12-53-7-04	4.90	980.00
			TAX# 1-75-1401278-5		

PLEASE RETURN THIS COPY WITH REMITTANCE TO ASSURE PROPER CREDIT

X 9.80

7-10-80

TO AVOID DELAY REFER ALL MATTERS REGARDING THIS SHIPMENT, ... TO THE SALES BRANCH SERVING YOU.

Use of the above goods shall be an acceptance of the conditions of sale on the reverse side hereof as the only conditions applying to the sale of said goods.

ZB9-A (11-78)

WRG00289485

ED_005351_00000355-00052

a-LITE ®
...cultural & Agricultural Products

WR Grace & Co.
Whitemore Avenue, Cambridge, Mass. 02140

02008716

GRACE

PLEASE REMIT WITH COPY OF INVOICE TO:
P.O. BOX 96160
CHICAGO, ILLINOIS 60693

PLEASE RETURN THIS COPY WITH YOUR REMITTANCE

[illegible]	INVOICE NO.	LOCATION	PLANT	DIST.	TERRITORY	OUR ORDER NUMBER	CUST. ORDER NO. AND DATE
5-22-80	91 031	1-042-113	691	790	791	91-7543	

[illegible]	CUS[illegible]	[illegible]	CAR NUMBER	BILL OF LADING NO.	CHECKED
CUSTOMER PICK UP	04511	DALLAS, TEXAS			3

D-U-N-S 04-827-2637

SOLD TO:
BUNCH WHOLESALE, INC.
P.O. BOX 5968
TEXARKANA, TEX 75501

SHIPPED TO: SAME AS "SOLD TO" UNLESS OTHERWISE SPECIFIED BELOW

QUANTITY	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	QUANTITY	QUANT[illegible]	[illegible]	[illegible]	AMOUNT
150	150	Vermiculite 5 Cu. Ft. No. 2 Bag	39-12-18-1-01	4.80	720.00			Rose Bush Planting Soil 3 Pecks-6 Per Baler	41-12-30-4-55	
BAL	130	[illegible]	39-12-01-1-01	4.20	546.00			[illegible] 2 Qt.-24 [illegible]	41-12-20-4-10	
		Vermiculite 4 Cu. Ft. No. 2 Bag	39-12-17-1-02					Seed Starter Soil [illegible] Qt.-12 Per Baler	41-12-21-4-09	
		[illegible]	39-12-19-1-02					Terra[illegible] 2 Qt.-24 [illegible]	41-12-19-4-10	
		Vermiculite 4 Cu. Ft. No. 4 Bag	39-12-51-1-02					Cactus & Succulent Soil 2 Qt.-24 Per Baler	41-12-31-4-10	
		[illegible]	39-12-01-4-44					Planting Mix 32 Qt. [illegible]	41-12-69-4-45	
		Vermiculite [illegible] Qt.-12 Per Baler	39-12-01-4-09					Planting Mix 16 Qt.-6 Per Baler	41-12-69-4-44	
		[illegible]	39-12-27-1-01					Planting Mix 4 Qt.-12 Per [illegible]	41-12-69-4-09	
		Perlite Coarse 4 Cu. Ft. Bag	39-12-27-1-02					Planting Mix 2 Qt.-24 Per Baler	41-12-69-4-10	
		Perlite [illegible]	39-12-27-4-44					Display 4 Qt.-36 Per Box	41-12-17-4-43	
		Perlite [illegible] Qt.-12 Per Baler	39-12-27-4-09					Seed Starter Soil Display 4 Qt.-36 Per Box	41-12-21-4-43	
25	25	Redi-earth Potting Soil [illegible]	41-12-17-1-02	5.80	145.00	25	25	METRO MIX 16QT 41-12-53-4-44	7.85	196.25
		Redi-earth Potting Soil 2 Cu. Ft. Bag	41-12-16-1-05			100	100	VERM T.L. 4CF#2 39-12-02-1-02	3.50	350.00
		Redi-earth Potting Soil [illegible]	41-12-16-4-55			170	270 ~~170~~	METRO MIX 300 41-12-53-7-04	4.90	1323.00
		Redi-earth Potting Soil 16 Qt. 6 Per Baler	41-12-16-4-44							
		[illegible]	41-12-16-4-09							
		Tomato & Veg. Soil 2 Cu. Ft. Bag	41-12-50-1-05							
		[illegible]	41-12-29-4-55							

☐ NO CASH DISCOUNT — NET 30 DAYS

TAX# 1-75-1401278-5

TAX

FREIGHT

$ 32.80 CASH DISCOUNT ALLOWED IF PAID BY 7-10-80

TOTAL 3280.25

TO AVOID [illegible] THIS REGARDING THIS [illegible] "OTHER THAN PA[illegible] SALES [illegible]

Use of the above goods shall be an acceptance of the conditions of sale on the reverse side hereof as the only conditions applying to the sale of said goods

ZTL-1 (6-77)

WRG00289486
ED_005351_00000355-00053

.al Products

GRACE

PLEASE REMIT
WITH COPY OF INVOICE
TO: P.O. BOX 96760
CHICAGO, ILLINOIS 60693
02008717

...uce & Co.
...re Avenue, Cambridge, Mass 02140

PLEASE RETURN THIS COPY WITH YOUR REMITTANCE

5-22-80

INVOICE DATE	INVOICE NO.		PLANT	TERRITORY	OUR ORDER NUMBER	CUST. ORDER NO. AND DATE
5-28-80	91-072	1-042-113	691	790 791	91-7571	2819

SHIPPED VIA		SHIPPED FROM	CAR NUMBER	BILL OF LADING NO.	CHECKED
CUSTOMER PICK UP	04511	DALLAS, TEXAS	3155		3

D-U-N-S 04-827-2637

SOLD TO: BUNCH WHOLESALE, INC.
P.O. BOX 5968
TEXARKANA, TEXAS 75501

SHIPPED TO: SAME AS SOLD TO UNLESS OTHERWISE SPECIFIED BELOW

BROUGHT BACK TRAILER # 2102

QUANTITY ORDERED	QUANTITY SHIPPED	DESCRIPTION	PRODUCT	UNIT PRICE	AMOUNT	QUANTITY ORDERED	QUANTITY SHIPPED	DESCRIPTION	PRODUCT	UNIT PRICE	AMOUNT
			39-12-18-1-01						41-12-30-4-55		
BAL	393		39-12-01-1-01	4.20	1650.60				41-12-20-4-10		
			39-12-17-1-02						41-12-21-4-09		
			39-12-19-1-02						41-12-19-4-10		
			39-12-51-1-02						41-12-31-4-10		
			39-12-01-4-44						41-12-69-4-45		
			39-12-01-4-09						41-12-69-4-44		
100	100		39-12-27-1-01	5.20	520.00				41-12-69-4-09		
			39-12-27-1-02					2 Qt-24 Per Baler	41-12-69-4-10		
			39-12-27-4-44						41-12-17-4-43		
			39-12-27-4-09						41-12-21-4-43		
			41-12-17-1-02								
			41-12-16-1-05								
			41-12-16-4-55								
		Pothing Sol	41-12-16-4-44								
25	25		41-12-16-4-09	7.20	180.00						
			41-12-50-1-05								
			41-12-29-4-55								

TAX# 1-75-1401278-5

TAX

FREIGHT

TOTAL

☐ NO CASH DISCOUNT — NET 30 DAYS

$ 23.51 CASH DISCOUNT ALLOWED IF PAID BY 7-10-8

Use of the above goods shall be an acceptance of the conditions of sale on the reverse side hereof as the only conditions applying to the sale of said goods

2TL-1 (6-77)

WRG00289487
ED_005351_00000355-00054

-LITE®
[illegible]ltural & Agricultural Products

WR Grace & Co
6-13-80 Whittemore Avenue, Cambridge, Mass. 02140

GRACE

PLEASE REMIT WITH COPY OF INVOICE TO: 02008718
P.O. BOX 96160
CHICAGO, ILLINOIS 60693

PLEASE RETURN THIS COPY WITH YOUR REMITTANCE

[illegible]	[illegible] NO.	LOCATION	PLANT	[illegible]	TERRITORY	OUR ORDER NUMBER	CUST. ORDER NO. AND DATE
6-13-80	91-208	1-042-113	691	790	791	91-7676	2930

[illegible]	CUST. NO.	SHIPP[illegible]	[illegible]	BILL OF LADING NO.	CHECKED
CUSTOMER PICK UP	04511	DALLAS, TEXAS	6369		3

D-U-N-S 04-827-2637

SOLD TO: BUNCH WHOLESALE, INC.
P.O. BOX 5968
TEXARKANA, TEXAS 75501

SHIPPED TO: SAME AS "SOLD TO" UNLESS OTHERWISE SPECIFIED BELOW

#2273 RETURNED

QUANTITY [illegible]	QUANTITY [illegible]	[illegible]	[illegible]	UNIT [illegible]	AMOUNT	QUANTITY ORDERED	QUANTITY SHIPPED	DESCRIPTION	PRODUCT	UNIT [illegible]	AMOUNT
		Vermiculite 3 Cu. Ft. No. 2 Bag	39-12-18-1-01					Rose Bush Planting Soil 3 Pocket 6 Per Bale	41-12-30-4-55		
150	150	[illegible]	39-12-01-1-01	4.20	60.00				41-12-20-4-10		
		[illegible]	39-12-17-1-02					[illegible]	41-12-21-4-09		
			39-12-19-1-02					[illegible]	41-12-19-4-10		
		[illegible]	39-12-51-1-02					[illegible] Succulent Soil 2 Qt. 24 Per Bale	41-12-31-4-10		
20	20		39-12-01-4-44	5.80	116.00			[illegible]	41-12-69-4-45		
		[illegible]	39-12-01-4-09					[illegible] 16 [illegible] Per Bale	41-12-69-4-44		
			39-12-27-1-01					[illegible]	41-12-69-4-09		
BAL	150	Perlite Coarse 4 Cu. Ft. Bag	39-12-27-1-02	3.60	540.00			Plantion Mix 2 Qt. 24 Per Bale	41-12-69-4-10		
		Perlite	39-12-27-4-44					[illegible]	41-12-17-4-43		
		Perlite [illegible]	39-12-27-4-09					Seed Starter Soil Display 4 Qt. [illegible]	41-12-21-4-43		
			41-12-17-1-02			200	200	VERM T.L. 4CF#2 39-12-02-1-02		3.50	700.00
		[illegible] 2 Cu. Ft. Bag	41-12-16-1-05			150	150	METRO MIX 300 41-12-53-7-04		4.90	735.00
			41-12-16-4-55			5	5	G.P. 20-20-20 5# 41-14-49-1-50		29.10	145.50
		Redheart Potting Soil 16 Qt. 8 Per Bale	41-12-16-4-44								
			41-12-16-4-09								
		[illegible] Soil 2 Cu. Ft. [illegible]	41-12-50-1-05								
			41-12-29-4-55								

TAX# 1-75-1401278-5

NO CASH DISCOUNT — NET 30 DAYS

$ 22.97 CASH DISCOUNT ALLOWED IF PAID BY 7-10-80

TAX

FREIGHT

TOTAL 2296.50

[illegible] OTHER THAN [illegible]

Use of the above goods shall be an acceptance of the conditions of sale on the reverse side hereof as the only conditions applying to the sale of said goods

ZTL-1 (6-77)

WRG00289488
ED_005351_00000355-00055

KLEPAC BROS. GREENHOUSES, INC.
P. O. BOX 790
BLANCO, TEXAS 78606

1366

02008680 1980

30-79
1140

PAY TO THE ORDER OF W. R. Grace & Co. $ 2160.08

Two Thousand, One Hundred Sixty and 08/100 DOLLARS

Kelley Field

CONTINENTAL BANK
JUL 10 1980

WRG00289489

ED_005351_00000355-00056

DETACH AND RETAIN THIS STATEMENT
THE ATTACHED CHECK IS IN PAYMENT OF ITEMS DESCRIBED BELOW.
IF NOT CORRECT PLEASE NOTIFY US PROMPTLY. NO RECEIPT DESIRED.

KLEPAC BROS. GREENHOUSES, INC.
BLANCO, TEXAS

DELUXE FORM DVO-3 V-2

DATE	DESCRIPTION			AMOUNT
7-8-80	Invoice 91-198	2181.90	02008681	2160.08
	Discount	21.82		
	W. R. Grace & Co. P. O. Box 96160 Chicago, Illinois 60693			

V-2

TERRA-LITE®
Horticultural & Agricultural Products

W.R. Grace & Co.
6-10-80
Whittemore Avenue, Cambridge, Mass. 02140

GRACE

PLEASE REMIT
WITH COPY OF INVOICE
TO:
P.O. BOX 96160
CHICAGO, ILLINOIS 60693

PLEASE RETURN THIS COPY WITH YOUR REMITTANCE

INVOICE	INVOICE NO.	LOCATION	PLANT	[illegible]	[illegible]	[illegible] NUMBER	CUST. ORDER NO. AND DATE
6-12-80	91-198	1-042-113	691	790	792	91-7661	1801

SHIPPED VIA	CUST. NO.	SHIPPED [illegible]	CAR NUMBER	[illegible]	CHECKED
CUSTOMER PICK UP	15829	DALLAS, TEXAS			3

D-U-N-S 04-827-2637

SOLD TO: KLEPAC GREEN HOUSE
RT 1 BOX 85
BLANCO, TEX 78606

SHIPPED TO: SAME AS "SOLD TO" UNLESS OTHERWISE SPECIFIED BELOW

QUANTITY ORDERED	QUANTITY SHIPPED	DESCRIPTION	PRODUCT CODE	UNIT PRICE	AMOUNT	QUANTITY ORDERED	QUANTITY SHIPPED	DESCRIPTION	PRODUCT CODE	UNIT PRICE	AMOUNT
		[illegible] 5 Cu Ft No 2 Bag	39-12-18-1-01					[illegible] Plantng Soil [illegible] Per Baler	41-12-30-4-55		
			39-12-01-1-01					[illegible] 24 [illegible]	41-12-20-4-10		
		[illegible]	39-12-17-1-02					[illegible] Soil [illegible] Baler	41-12-21-4-09		
			39-12-19-1-02					[illegible]	41-12-19-4-10		
		[illegible] 4 Cu Ft No 1 Bag	39-12-51-1-02					Cactus & Succu[illegible] 2 Qt 24 Per Bale	41-12-31-4-10		
			39-12-01-4-44					[illegible]	41-12-69-4-45		
		[illegible]	39-12-01-4-09					[illegible] Per Baler	41-12-69-4-44		
			39-12-27-1-01						41-12-69-4-09		
300	301	[illegible] 4 C[illegible] Bag	39-12-27-1-02	4.00	1204.00			Planting [illegible] 2 Qt 24 Per Baler	41-12-69-4-10		
			39-12-27-4-44					[illegible]	41-12-17-4-43		
		Farlita [illegible]	39-12-27-4-09					[illegible] Starter Soil [illegible]	41-12-21-4-43		
			41-12-17-1-02			400	254	VERM T.L. 4CF#2 39-12-02-1-02		3.85	977.90
		[illegible] 2 Cu Ft Bag	41-12-16-1-05								
			41-12-16-4-55								
		[illegible] Potting Soil 16 Qt 6 Per Baler	41-12-16-4-44								
			41-12-16-4-09								
		[illegible] Bag Soil 2 Cu Ft Bag	41-12-50-1-05								
			41-12-29-4-55								

TAX# 1-74-1647029-4

TAX

FREIGHT

NO CASH DISCOUNT – NET 30 DAYS

$ 21.82 CASH DISCOUNT ALLOWED IF PAID BY 7-10-80

TOTAL 2181.90

TO AVOID DELAY, [illegible]
"OTHER THAN PAY[illegible]

02008682

Use of the above goods shall be an acceptance of the conditions of sale on the reverse side hereof as the only conditions applying to the sale of said goods

ZTL-1 (6-77)

WRG00289491
ED_005351_00000355-00058

KLEPAC BROTHERS • GREENHOUSES INCORPORATED •

fine pot plants

P.O.Box 790 • Blanco, Texas 78606

BLANCO TEX. JUL -8'80

U.S. POSTAGE 0.15

P.B.METER 1161089

02008683

WRG00289492

ED_005351_00000355-00059

Dead storage Box #9
Box C 331
Zono Cash Remittance
7-1-80 to 7-18-80
Box 294

indexed

NO.#
02008584 to 02008877

BROAD DESOTO OFFICE
NATIONAL AMERICAN BANK
OF NEW ORLEANS
NEW ORLEANS, LOUISIANA

REUTER SEED CO., INC.

SEEDS, BULBS, PLANTS
320 N. CARROLLTON AVE.

Nº 57899 14-60 850

NEW ORLEANS, LA. JUNE 30, 1980 19

PAY $917 and 10 DOLLARS

45

02008769

$ $917.10

REUTER SEED CO., INC.

TO THE ORDER OF
TERRALITE
W. R. GRACE AND COMPANY
POST OFFICE BOX 96160
CHICAGO, ILL. 60693

PRESIDENT

CONTINENTAL BANK
MACH 2 JUL 3 1980

WRG00289494
ED_005351_00000355-00061

DETACH BEFORE DEPOSITING

REUTER SEED CO., INC.
320 N. CARROLLTON AVE.
NEW ORLEANS, LA.

TENDERS THE ATTACHED CHECK IN FULL PAYMENT
OF INVOICES LISTED BELOW

INVOICE DATE	TERMS	DISCOUNT	FREIGHT	OTHER DEDUCTIONS	AMOUNT OF INVOICE	NET AMOUNT	REMARKS

Invoice Number 13-015 ---------- $917.10

02008770

WRG00289495
ED_005351_00000355-00062

TERRA-LITE®
Horticultural & Agricultural Products

W.R. Grace & Co.
4/22/80 Whitemore Avenue, Cambridge, Mass. 02140

GRACE

PLEASE REMIT WITH COPY OF INVOICE TO:
P.O. BOX 96160
CHICAGO, ILLINOIS 60693

PLEASE RETURN THIS COPY WITH YOUR REMITTANCE

[illegible]	INVOICE NO.	LOCATION	DIST.	TERRITORY	ORDER NUMBER	CUST. ORDER NO. AND DATE
4/30/80	13-015	1-017-051	613	740 473		15301

[illegible]	CU[illegible]	SHIPPED FROM	[illegible] NUMBER	[illegible]	CHECKED
Customer Truck	24009	New Orleans			3

D-U-N-S 04-827-2637

SOLD TO:
Reuter Seed Co., Inc.
320 N. Carrollton Avenue
New Orleans, La. 70119

SHIPPED TO: SAME AS "SOLD TO" UNLESS OTHERWISE SPECIFIED BELOW

02008771

QUANTITY ORDERED	QUANTITY SHIPPED	DESCRIPTION		UNIT PRICE	AMOUNT	[illegible]	QUANTITY SHIPPED	DESCRIPTION	PRODUCT CODE	UNIT PRICE	AMOUNT
		Vermiculite 6 Cu. Ft. No. 2 Bag	39-12-18-1-01					Rose Bush Planting Soil 3 Pecks-6 Per Baler	41-12-30-4-55		
		Vermiculite [illegible]	39-12-01-1-01					[illegible]	41-12-20-4-10		
		Vermiculite 4 Cu. Ft. No. 2 Bag	39-12-17-1-02					Seed Starter Soil [illegible] Qt.-12 Per Baler	41-12-21-4-09		
		[illegible]	39-12-19-1-02					[illegible]	41-12-19-4-10		
		Vermiculite 4 Cu. Ft. No. 4 Bag	39-12-51-1-02					Cactus & Succulent Soil 2 Qt.-24 Per Baler	41-12-31-4-10		
	20	[illegible]	39-12-01-4-44	6.15	123.00			[illegible]	41-12-69-4-45		
		Vermiculite [illegible] Qt.-12 Per Baler	39-12-01-4-09					Planting Mix 16 Qt.-6 Per Baler	41-12-69-4-44		
		[illegible]	39-12-27-1-01					[illegible]	41-12-69-4-09		
	100	Perlite Coarse 4 Cu. Ft. Bag	39-12-27-1-02	3.85	385.00			Planting Mix 2 Qt.-24 Per Baler	41-12-69-4-10		
	19	[illegible]	39-12-27-4-44	6.15	116.85			[illegible]	41-12-17-4-43		
		Perlite [illegible] Qt.-12 Per Baler	39-12-27-4-09					Seed Starter Soil Display 4 Qt.-[illegible] Per Box	41-12-21-4-43		
		[illegible] Potting Soil 4 Cu. Ft. Bag	41-12-17-1-02								
		Redi-earth Potting Soil 2 Cu. Ft. Bag	41-12-16-1-05								
		[illegible]	41-12-16-4-55								
		Redi-earth Potting Soil 16 Qt.-6 Per Baler	41-12-16-4-44								
	35	[illegible]	41-12-16-4-09	8.35	292.25						
		Tomato & Veg. Soil 2 Cu. Ft. Bag	41-12-50-1-05								
		[illegible] 3 Pecks 6 Per Baler	41-12-29-4-55								

ST# 360-75-3177

NO CASH DISCOUNT – NET 30 DAYS

$ 9.17 CASH DISCOUNT ALLOWED IF PAID BY 5/10/80

TAX	
FREIGHT	
TOTAL	$ 917.10

TO AVOID DELAY, REFER ALL MATTERS REGARDING THIS SHIPMENT, "OTHER THAN PAYMENTS," TO THE SALES BRANCH SERVING YOU

Use of the above goods shall be an acceptance of the conditions of sale on the reverse side hereof as the only conditions applying to the sale of said goods

ZTL-1 (6-77)

WRG00289496
ED_005351_00000355-00063

REUTER SEED COMPANY
INCORPORATED
320 N. CARROLLTON AVENUE
POST OFFICE BOX 19255 • NEW ORLEANS, LA. 70179

02008772

NEW ORLEANS LA. JUN 30 '80
U.S. POSTAGE .15
P.B. METER 554433

Dead storage Box #9
Box C331
Zono Cash Remittance
7-1-80 to 7-18-80
Box 294

indexed

NO.#
02008584 to 02008877

AGRONOMISTS' RESEARCH CORPORATION
1400 SUCKLE HIGHWAY
PENNSAUKEN, NEW JERSEY 08110

1148

02008786 6/26 19 80 55-85/310 15

PAY TO THE ORDER OF W.R. Grace & Co $ 2021 96/100

Two thousand twenty one 96/100 DOLLARS

HERITAGE BANK

FOR 52-045

Roberta J. Moore

⑆0310⑈0085⑆ 626 783 5⑈

CONTINENTAL BANK
CONTINENTAL ILLINOIS NATIONAL BANK AND TRUST COMPANY OF CHICAGO
MACH 2 JUL 3 1980

WRG00289499
ED_005351_00000355-00066

Construction Products Division
W.R. Grace & Co.
Watertown Avenue, Cambridge, Mass. 02140

GRACE

PLEASE REMIT
WITH COPY OF INVOICE TO:
W.R. GRACE & CO.
P.O. BOX 53120
CHICAGO, ILLINOIS 60653

D-U-N-S 04-827-2637

5-20-80

5-23-80	52-045	3-029-007	652 730 777	045r	Verbal

Trenton Truck	00450	Trenton	000263	1

SOLD TO

Agronomist Research
1432 Union Ave., Off Rte. 130
Pennsauken, NJ 08110

SHIP TO

ORDERED	SHIPPED	DESCRIPTION	UNIT PRICE	OUT
700	698	Bags Agricultural Grade #3(39-13-04-1-02)	2.52 bg	1758.96
		Delivery Charge		263.00
				$2021.96
		NJ Tax Exempt		
		02008787		

PLEASE RETURN THIS COPY WITH REMITTANCE TO ASSURE PROPER CREDIT

xx 17.58 6-3-80

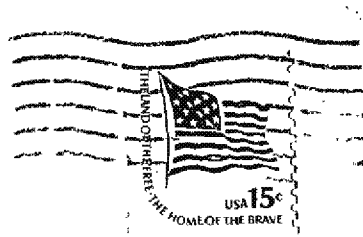
Use of the above goods shall be an acceptance of the conditions of sale on the reverse side hereof as the only conditions applying to the sale of said goods.

-A (11-78)

WRG00289500
ED_005351_00000355-00067

AQUATROLS CORPORATION OF AMERICA, INC.
1432 Union Ave., Pennsauken, New Jersey 08110

SOUTH JERSEY, NJ 080
PM
30 JUN
1980



W.R.Grace & Co.
P.O.Box 96160
Chicago, IL 60693

02008788

Dead storage Box #9
Box C331
Zono Cash Remittance
7-1-80 to 7-18-80
Box 294

indexed

No.#
02008584 to 02008877

TESSMAN SEED & CHEMICAL CO. 304540
3660 KENNEBEC DRIVE
EAGAN MN. 55122

DATE	INVOICE	AMOUNT

12506

29

PAY _____ DOLLARS

DATE	TO THE ORDER OF	CHECK NO	GROSS	DISCOUNT	CHECK AMOUNT
7-3-80	W R Grace	12506	401	14520	5023 60

TESSMAN SEED & CHEMICAL CO.

02008584

RICHFIELD BANK & TRUST CO.
RICHFIELD, MINNESOTA

Clarice N. Hendrickson

⑆091016498⑆ 9⑈24⑈746⑈

CONTINENTAL BANK
MACH 3 JUL 7 1980

WRG00289503
ED_005351_00000355-00070

ERRA-LITE®
Horticultural & Agricultural Products

W.R. Grace & Co.
11-20-79 Acre Avenue, Cambridge, Mass. 02140

02008585

GRACE

PLEASE REMIT WITH COPY OF INVOICE TO:
P.O. BOX 96160
CHICAGO, ILLINOIS 60693

INVOICE DATE	INVOICE NO.	LOCATION	PLANT	DIST.	TERRITORY	OUR ORDER NUMBER	CUST. ORDER NO. AND DATE
5-1-80	02-004	1-022-033	724	750	012		Verbal 10-31-79

SHIPPED VIA	CUST. NO.	SHIPPED FROM	CAR NUMBER	BILL OF LADING NO.	CHECKED
Customer Pick Up	29610	W. Grace.	PB		S

D-U-N-S 04-827-2637

SOLD TO: Tessman Seed & Chemical
3550 Kennedy Drive
Cagan Minnesota 55122

SHIPPED TO: SAME AS "SOLD TO" UNLESS OTHERWISE SPECIFIED BELOW

QUANTITY ORDERED	QUANTITY SHIPPED	DESCRIPTION	PRODUCT CODE	UNIT PRICE	AMOUNT	QUANTITY ORDERED	QUANTITY SHIPPED	DESCRIPTION	PRODUCT CODE	UNIT PRICE	AMOUNT
		Vermiculite 6 Cu. Ft. No. 2 Bag	39-12-18-1-01					Rose Bush-Planting Soil 3 Pecks-6 Per Baler	41-12-30-4-55		
		Vermiculite 6 Cu. Ft. No. 3 Bag	39-12-01-1-01					African Violet Soil 2 Qt.-24 Per Baler	41-12-20-4-10		
		Vermiculite 4 Cu. Ft. No. 2 Bag	39-12-17-1-02			5	5	Seed Starter Soil 4 Qt.-12 Per Baler	41-12-21-4-09	7.30	35.50
		Vermiculite 4 Cu. Ft. No. 3 Bag	39-12-19-1-02					Terrarium Soil 2 Qt.-24 Per Baler	41-12-19-4-10		
		Vermiculite 4 Cu. Ft. No. 4 Bag	39-12-51-1-02					Cactus & Succulent Soil 2 Qt.-24 Per Baler	41-12-31-4-10		
200	200	Vermiculite 16 Qt.-6 Per Baler	39-12-01-4-44	5.20	1040.00			Planting Mix 32 Qt. Bag	41-12-69-4-45		
300	300	Vermiculite 4 Qt.-12 Per Baler	39-12-01-4-09	5.45	1635.00			Planting Mix 16 Qt.-6 Per Baler	41-12-69-4-44		
		Perlite-Coarse 6 Cu. Ft. Bag	39-12-27-1-01					Planting Mix 4 Qt.-12 Per Baler	41-12-69-4-09		
		Perlite-Coarse 4 Cu. Ft. Bag	39-12-27-1-02					Planting Mix 2 Qt.-24 Per Baler	41-12-69-4-10		
		Perlite 16 Qt.-6 Per Baler	39-12-27-4-44					Redi-earth® Potting Soil Display 4 Qt.-36 Per Box	41-12-17-4-43		
		Perlite 4 Qt.-12 Per Baler	39-12-27-4-09					Seed Starter Soil Display 4 Qt.-36 Per Box	41-12-21-4-43		
200	75	Redi-earth® Potting Soil 4 Cu. Ft. Bag	41-12-17-1-02	5.20	234.00	100	25	41-12-52-7-04 Metro Mix 200		4.20	105.00
50	0	Redi-earth® Potting Soil 2½ Cu. Ft. Bag	41-12-16-1-05	3.60	----	50	50	53-15-10-0-19 Dog Crap		19.50	975.00
		Redi-earth® Potting Soil 3 Pecks-6 Per Baler	41-12-16-4-55								
100	100	Redi-earth® Potting Soil 16 Qt.-6 Per Baler	41-12-16-4-44	8.10	810.00						
25	25	Redi-earth® Potting Soil 4 Qt.-12 Per Baler	41-12-16-4-09	7.30	182.50						
		Tomato & Veg. Soil 2½ Cu. Ft. Bag	41-12-50-1-05								
		Tomato & Veg. Soil 3 Pecks-6 Per Baler	41-12-29-4-55								

02008588

Tax 0 000300 Truck loaded to full capacity.
BS Day 10, 1980
Net Day 30, 1980

☐ NO CASH DISCOUNT – NET 30 DAYS

$ 51.00 CASH DISCOUNT ALLOWED IF PAID BY _____

TAX	
FREIGHT	
TOTAL	$5160.00

TO AVOID DELAY, REFER ALL MATTERS REGARDING THIS SHIPMENT, "OTHER THAN PAYMENTS," TO THE SALES BRANCH SERVING YOU

RECEIVED

Use of the above goods shall be an acceptance of the conditions of sale on the reverse side hereof as the only conditions applying to the sale of said goods.

ZEL-1 (6-77)

WRG00289504
ED_005351_00000355-00071

Speed Letter® 44-902 GrayLine® SNAP-A-WAY® FORM

Speed Letter®

To W R Grace
Box 96160
Chicago Ill

From TESSMAN SEED AND CHEMICAL CO.
3660 KENNEBEC DRIVE
EAGAN, MINNESOTA 55122
612 · 452-4050

Subject 04-004 # 516880

—No. 9 & 10 FOLD

MESSAGE

	Credit due
4 cu ft Lidi earth billed 74 rec'd 66	41.60
3 - 50# magamp broken 19.50	58.50
Returned broken contents by customers	
4 bales ½ bu perlite 5 20	20.80
3 bales ½ bu Lidi earth 8 10	24.30
Date 7-3-80 Signed [illegible]	145.20

REPLY

02008586

—No. 9 FOLD

—No. 10 FOLD

Date Signed

Wilson Jones Company
GRAYLINE FORM 44-902 3-PART
© 1978 • PRINTED IN U.S.A.

RECIPIENT—RETAIN WHITE COPY, RETURN PINK COPY

Speed Letter.

From [illegible]

[illegible]

[illegible]

To TESSMAN SEED AND CHEMICAL CO.

3660 KENNEBEC DRIVE

EAGAN, MINNESOTA 55122

612 - 452-4050

Subject 04-004 [illegible]

—No. 9 & 10 FOLD

MESSAGE

		Credit Due
[illegible]	[illegible]	41.60
3 - 50# [illegible]	14.50	58.50
[illegible]		
[illegible]	5.70	[illegible]
[illegible]	8.10	24.30
	Date 7-3-[illegible] Signed [illegible]	145.20

REPLY

02008587

—No. 9 FOLD

—No. 10 FOLD

Date Signed

Wilson Jones Company
GRAYLINE FORM 44-902 3-PART
© 1978 • PRINTED IN U.S.A.

RECIPIENT—RETAIN WHITE COPY, RETURN PINK COPY.
TURN OVER FOR USE WITH WINDOW ENVELOPE.

Terrman Seed & Chemical Company

3660 KENNEBEC DRIVE • EAGAN, MN. 55122

W.R. Grace & Co.
P.O. Box 96160
Chicago, Ill. 60693

02008589

Dead storage Box #9
Box C 331
Zono Cash Remittance
7-1-80 to 7-18-80
Box 294

indexed

NO.#
02008584 to 02008877

BY ENDORSEMENT THIS CHECK WHEN PAID IS ACCEPTED IN FULL PAYMENT OF THE FOLLOWING ACCOUNT

DATE		AMOUNT
Inv # 76-002		
TOTAL OF INVOICES		
LESS ____ % DISCOUNT		
LESS		
TOTAL DEDUCTIONS		
AMOUNT OF CHECK		

GOLDEN FIELD GREENHOUSES, INC.
775 MAHER COURT
WATSONVILLE, CALIF. 95076

2354

02008621

June 30 1980 11-57/718 1210

PAY TO THE ORDER OF W. R. Grace & Co $3180.00

Three Thousand One Hundred Eighty 00/100 DOLLARS

UNITED CALIFORNIA BANK
Salinas Office
456 South Main Street
Salinas, California 93901

George Alexander

Harold A. Kimmi

⑈002354⑈ ⑆121000578⑆718709877⑈ 11

CONTINENTAL BANK
MACH 4 JUL 8 1980

WRG00289509
ED_005351_00000355-00076

Construction Products Division
W.R. Grace & Co. #01
2500 South Garnsey St., Santa Ana, CA 92707 (714) 979-4900
6-18-80

GRACE

PLEASE REMIT
WITH COPY OF INVOICE TO:
W.R. GRACE & CO.
P.O. BOX 93160
CHICAGO, ILLINOIS 60693

D-U-N-S 04-827-2637

INVOICE DATE	INVOICE NO.	LOCATION	PLANT	DIST.	TERRITORY	OUR ORDER NO.	CUST. ORDER NO. AND DATE
6-19-80	76-002	3-004-053	676	772	703	762322	verbal 6-5-80

SHIPPED VIA	CUSTOMER NO.	SHIP FROM	CARRIER	BILL OF LADING NO.	CHECK
L & V - collect	11396	Santa Ana	6-17-80	128873	3

SOLD TO
GOLDEN FIELD GREENHOUSES
P.O. Box 968
11301 Washington
Castroville, CA 95012

SHIP TO
SAME

QUANTITY ORDERED	QUANTITY SHIPPED	DESCRIPTION	UNIT PRICE	AMOUNT
800	800	Bags TERRA LITE #2 (39-12-04-1-02)	3.75	3000.00
		6% state tax		180.00
				3180.00
		Tax Discount		
		1.80		
		XX 30.00		6-29-80

PLEASE RETURN THIS COPY WITH REMITTANCE
TO ASSURE PROPER CREDIT

TO APPLICATION, REFER ALL MATTERS REGARDING THIS SHIPMENT [illegible] PAYMENTS, TO THE SALES BEING DESIRING YOU.

Use of the above goods shall be an acceptance of the conditions of sale on the reverse side hereof as the only conditions applying to the sale of said goods.

ZB9-A (CAL) 4-79

WRG00289510
ED_005351_00000355-00077

GOLDEN FIELD GREENHOUSES, INC.
775 MAHER COURT
WATSONVILLE, CALIF. 95076

OAKLAND, CA 946
PM
3 JUL
1980

02008623

W.R. Grace & Co.
P.O. Box 96160
Chicago, Illinois
60693

NORMAN INDUSTRIES, INC.
11801 E. SLAUSON AVENUE
SANTA FE SPRINGS, CALIFORNIA 90670

HEADQUARTERS BANKING OFFICE
UNION BANK
9TH AND FIGUEROA
LOS ANGELES, CALIF. 90017

16-1302
1222

№ 8788

PAY TO THE ORDER OF

02008700

DATE	CHECK NO	AMOUNT
JUN 30 80	8,788	965.25 T

W. R. GRACE & CO.
P. O. BOX 96160
CHICAGO, ILLINOIS 60693

NORMAN INDUSTRIES, INC

BY [signature]
Elaise Childs

⑆1220⑉1302⑆ 10569⑉1198⑈

CONTINENTAL BANK
JUL 6 1980

WRG00289512
ED_005351_00000355-00079

DATE	REFERENCE	GROSS AMOUNT	DISCOUNT	PREVIOUS BALANCE	BALANCE	REMARKS
JUN 19 80	76,069	975.00 T	9.75		965.25 S	
	02008701					Kindly note we did not receive this invoice until G. as it is addressed incorrectly.

PLEASE DETACH
THIS REMITTANCE ADVICE
BEFORE DEPOSITING CHECK

NORMAN INDUSTRIES, INC.
11801 E. SLAUSON AVENUE
SANTA FE SPRINGS, CA. 90670

THE ATTACHED CHECK
IS IN PAYMENT OF THE
ITEMS LISTED ABOVE

Construction Products Division
W.R. Grace & Co. #06
Whittemore Avenue, Cambridge, Mass. 02140
6-25-80

GRACE

PLEASE REMIT
WITH COPY OF INVOICE TO:
W.R. GRACE & CO.
P.O. BOX 96160
CHICAGO, ILLINOIS 60693

D-U-N-S 04-827-2637

INVOICE DATE	INVOICE NO	LOCATION	PLANT			OLD ORDER NO	ORDER NO	
6-26-80	76-069	3-004-073	676	771	706	762447	2831	6-19-80

WILL CALL	21216	Santa Ana	6-25-80	3

SOLD TO:
NORMAN INDUSTRIES
11801 E. ~~Geween~~ Slauson Ave
Santa Fe Springs, CA 91360

SHIP TO
NORMAN INDUSTRIES
32371 Cory Don Rd
Lake Elsinore, CA 92330

QUANTITY ORDERED	QUANTITY SHIPPED	DESCRIPTION	UNIT PRICE	AMOUNT
250	250	Bags TERRA LITE #3 (39-12-05-1-02)	XXX XXX 3.90	975.00
		02008702		
		SR AD 17-627000		

TERMS: 1% 10 days 9.75 CASH DISCOUNT ALLOWED IF PAID BY 7-6-80

TO AVOID DELAY, REFER ALL MATTERS REGARDING THIS SHIPMENT, OTHER THAN PAYMENTS, TO THE SALES BRANCH SERVING YOU.

Use of the above goods shall be an acceptance of the conditions of sale on the reverse side hereof as the only conditions applying to the sale of said goods.

ZB9 B (5-80)

norman industries inc.

11801 E. SLAUSON AVENUE
SANTA FE SPRINGS, CALIF. 90670

WHITTIER, CA 906
PM
30 JUN
1980

SANTA FE
JUN 30
CALIF.

02008703

AGRI-CHEMICAL PRODUCTS, INC.
5450 NORTH ESTELLE DRIVE
TUCSON, ARIZONA 85718
PHONE 602-888-4383

02008708

1819

91-170
1221

July 11 80

W. R. Grace & Co

14989 60/xx

4981 [illegible] 61 [illegible]

DOLLARS

THE Arizona BANK
NORTH STONE
901 NORTH STONE AVENUE
TUCSON, ARIZONA

Vincent La Mastra

⑈0001819⑈ ⑆122101706⑆ 004⑉242859⑈

CONTINENTAL BANK
MAR JUL 16 1980

Construction Products Division
W.R. Grace & Co. #10
Whittemore Avenue, Cambridge, Mass. 02140

GRACE

PLEASE REMIT
WITH COPY OF INVOICE TO:
W.R. GRACE & CO.
P.O. BOX 98160
CHICAGO, ILLINOIS 60693

7-1-80

D-U-N-S 04-827-2637

INVOICE DATE	INVOICE NO.	LOCATION						
7-2-80	76-118	1-002-019	676	775	712	762487	8758	6-24-80

SHIPPED VIA					
SOUTHERN PACIFIC-COLLECT	00454	Santa Ana	6-27-80	128920	3

SOLD TO:
AGRICHEMICAL PRODUCTS
5450 North Estelle Drive
Tucson, AZ 85718

SHIP TO
EKHEVARRIA ASSOCIATES
C/O: Franks Distributing
Rio Rico Industrial Park
Nogales, AZ

QUANTITY ORDERED	QUANTITY SHIPPED	DESCRIPTION	UNIT PRICE	AMOUNT
1200	1200	Bags TERRA LITE #2 (39-12-04-1-02)	3.43	4116.00
		7626-90025	02008709	

14989.68

TERMS: 1% 10 days, net 30 $41.16 CASH DISCOUNT ALLOWED IF PAID BY 7-12-80

TO AVOID DELAY, REFER ALL MATTERS REGARDING THIS SHIPMENT, "OTHER T[illegible] TO THE SALES BRANCH SERVING YOU

Use of the above goods shall be an acceptance of the conditions of sale on the reverse side hereof as the only conditions applying to the sale of said goods.

ZB9 B (5-80)

WRG00289517
ED_005351_00000355-00084

Construction Products Division
W.R. Grace & Co.
Whittemore Avenue, Cambridge, Mass. 02140

GRACE

PLEASE REMIT
WITH COPY OF INVOICE TO:
W.R. GRACE & CO.
P.O. BOX 98160
CHICAGO, ILLINOIS 60693

D-U-N-S 04-827-2637

INVOICE DATE	INVOICE NO	LOCATION	PLANT				
6/19/80							
6/20/80	75-025	1-211-000	675	775	712	1266	8765

SHIPPED VIA	CUST NO				
Customer	00454	Phoenix			3

SOLD TO: AGRI CHEMICAL PRODUCTS, INC.
5450 No. Estelle Drive
Tucson, Arizona 85718

SHIP TO: ENGEBRETSON
DEMERUTIS

QUANTITY ORDERED	QUANTITY SHIPPED	DESCRIPTION	UNIT PRICE	AMOUNT
1200	1200	REDI-EARTH (41-12-17-1-02)	5.70	6840.00
		02008710		
		#7626-900025		

TERMS: $ 68.40 CASH DISCOUNT ALLOWED IF PAID BY: 6/30/80

TO AVOID DELAY, REFER ALL MATTERS REGARDING THIS SHIPMENT, "OTHER THAN PAYMENTS" TO THE SALES BRANCH

Use of the above goods shall be an acceptance of the conditions of sale on the reverse side hereof as the only conditions applying to the sale of said goods.

ZB9 B (5 80)

Construction Products Division
W.R. Grace & Co. #10
Whittemore Avenue, Cambridge, Mass. 02140

GRACE

PLEASE REMIT
WITH COPY OF INVOICE TO:
W.R. GRACE & CO.
P.O. BOX 96160
CHICAGO, ILLINOIS 60693

7-1-80

D-U-N-S 04-827-2637

INVOICE DATE	INVOICE NO.	LOCATION						
7-2-80	76-119	1-002-019	676	775	712	762489	8758	6-24-80

SHIPPED VIA	CUSTOMER		CAR NO.		
SOUTHER PACIFIC-COLLECT	00454	SantaAna	7--1-80	128921	3

SOLD TO:
AGRI CHEMICAL PRODUCTS
5450 North Estelle Drive
Tucson, AZ 85718

SHIP TO
ECHEVARRIA ASSOCIATES
C/O Frank Distribution Co
Rio Rico Industrial Park
Nogales, AZ

QUANTITY ORDERED	QUANTITY SHIPPED	DESCRIPTION	UNIT PRICE	AMOUNT
1200	1200	Bags TERRA LITE #2 (39-12-04-1-02)	3.43	4116.00
		02008711		
		7626-90025		

TERMS: 1% 10 days, net 30 $41.16 CASH DISCOUNT ALLOWED IF PAID BY 7-12-80

TO AVOID DELAY, REFER ALL MATTERS REGARDING THIS SHIPMENT, "OTHER THAN PAYMENTS," TO THE SALES BRANCH SERVING YOU.

Use of the above goods shall be an acceptance of the conditions of sale on the reverse side hereof as the only conditions applying to the sale of said goods.

ZB9 B (5-80)

WRG00289519
ED_005351_00000355-00086

Dead storage Box #9
Box C 331
Zono Cash Remittance
7-1-80 to 7-18-80
Box 294

indexed

NO.#
02008584 to 02008877

AGRI-CHEMICAL PRODUCTS, INC.
5450 NORTH ESTELLE DRIVE
TUCSON, ARIZONA 85718
PHONE 602-888-4383

02008656

1817

91-170
1221

July 7 19 80

PAY TO THE ORDER OF W R Grace & Co

$ 15628 50/100

15628 DOLS 50 CTS DOLLARS

THE ARIZONA BANK
[illegible] STONE
[illegible] NORTH STONE AVENUE
TUCSON, ARIZONA

Vincent La Mastia

⑈0001817⑈ ⑆122101706⑆ 004⑉242859⑈

CONTINENTAL BANK
MAR 2 JUL 10 1980

WRG00289521
ED_005351_00000355-00088

Construction Products Division
W.R. Grace & Co.
Whittemore Avenue, Cambridge, Mass. 02140

02008657

GRACE

PLEASE REMIT
WITH COPY OF INVOICE TO:
W.R. GRACE & CO.
P.O. BOX 96160
CHICAGO, ILLINOIS 60693

D-U-N-S 04-827-2637

INVOICE DATE	INVOICE NO	LOCATION	PLANT				CUST ORDER NO AND DATE
6/12/80							
6/13/80	75-225	1-002-013	675	775	712	1210	875 8764
Customer		00454	Phoenix				3

SOLD TO:
AGRI CHEMICAL PRODUCTS, INC.
5450 No. Estelle Drive
Tucson, Arizona 85718

SHIP TO
Growers Supply

QUANTITY ORDERED	QUANTITY SHIPPED	DESCRIPTION	UNIT PRICE	AMOUNT
600	600	REDI-EARTH (41-12-17-1-02)	5.70	3420.00
60	60	TERRA-LITE#2 (39-12-04-1-02)	3.85	231.00
				3651.00
		7626-900025		

TERMS: $ 36.51 CASH DISCOUNT ALLOWED IF PAID BY. 6/23/80

TO AVOID DELAY, REFER ALL MATTERS REGARDING THIS SHIPMENT, "OTHER THAN PAYMENTS" TO THE SALES BRANCH SERVING YOU.

Use of the above goods shall be an acceptance of the conditions of sale on the reverse side hereof as the only conditions applying to the sale of said goods.

ZB9 8 (5-80)

Construction Products Division
W.R. Grace & Co.
Whittemore Avenue, Cambridge, Mass. 02140

GRACE

PLEASE REMIT
WITH COPY OF INVOICE TO:
W.R. GRACE & CO.
P.O. BOX 95[illegible]
CHICAGO, ILLINOIS 60693

02005658

D-U-N-S 04-827-2637

6/10/80

INVOICE DATE	INVOICE NO.	LOCATION	PLANT	DIST	[illegible]	[illegible]	[illegible]
6/12/80	75-211	1-211-000	675	775	712	1190	8755

SHIPPED VIA	CUST.	SHIPPED FROM	CAR NUMBER	[illegible]	
So. Pacific -Frt. Collect	00454	Phoenix	SP222243	121346	3

SOLD TO:

AGRI-CHEMICAL PRODUCTS, INC.
5450 No. Estelle Drive
Tucson, Arizona 85718

SHIP TO

C.A.A.D.E.S. Gonzalo Raul Avila
c/o Tomato Country
Nogales, Arizona
Final Destination: Culiacan,
Sinaloa, Mexico

QUANTITY ORDERED	QUANTITY SHIPPED	DESCRIPTION	UNIT PRICE	AMOUNT
900	900	REDI-EARTH (41-12-17-1-02)	5.70	5130.00
150	150	#2 TERRA-LITE (39-12-04-1-02)	3.85	577.50
				5707.50
		7626-900025		

TERMS: $ 57.08 CASH DISCOUNT ALLOWED IF PAID BY: 6/23/80

TO AVOID DELAY, REFER ALL MATTERS REGARDING THIS SHIPMENT, "OTHER THAN PAYMENTS," TO THE SALES BRANCH SERVING YOU.

Use of the above goods shall be an acceptance of the conditions of sale on the reverse side hereof as the only conditions applying to the sale of said goods.

ZB9 B (5-80)

1100	1100	REDI-EARTH (41-12-17-1-02)	5.70	6270.00
		#7626-900025		

TERMS: $ 62.70 CASH DISCOUNT ALLOWED IF PAID BY: 6/23/80

TO AVOID DELAY, REFER ALL MATTERS REGARDING THIS SHIPMENT, "OTHER THAN PAYMENTS," TO THE SALES BRANCH SERVING YOU

Use of the above goods shall be an acceptance of the conditions of sale on the reverse side hereof as the only conditions applying to the sale of said goods.

ZB9 B (5-80)

Construction Products Division
W.R. Grace & Co.
Whittemore Avenue, Cambridge, Mass. 02140

GRACE

PLEASE REMIT
WITH COPY OF INVOICE TO:
W.R. GRACE & CO.
P.O. BOX 06160
CHICAGO, ILLINOIS 60693

020659

6/10/80

D-U-N-S 04-827-2637

			PLANT				
6/12/80	75-210	1-211-000	675	775	712	1189	8758

SHIPPED VIA	CUST. NO.				
So. Pacific - Frt. Collect	00454	Phoenix	SP243976	121345	3

SOLD TO:

AGRI-CHEMICAL PRODUCTS, INC.
5450 No. Estelle Drive
Tucson, Arizona 85718

SHIP TO

C.A.A.D.E.S. Echevarria Assoc.
c/o Frank's Distributing
Nogales, Arizona
Final Destination: Culiacan,
Sinaloa, Mexico

QUANTITY ORDERED	QUANTITY SHIPPED	DESCRIPTION	UNIT PRICE	AMOUNT
1100	1100	REDI-EARTH (41-12-17-1-02)	5.70	6270.00
		#7626-900025		

TERMS: $ 62.70 CASH DISCOUNT ALLOWED IF PAID BY 6/23/80

TO AVOID DELAY, REFER ALL MATTERS REGARDING THIS SHIPMENT, "OTHER THAN PAYMENTS," TO THE SALES BRANCH SERVING YOU.

Use of the above goods shall be an acceptance of the conditions of sale on the reverse side hereof as the only conditions applying to the sale of said goods.

ZB9 B (5-80)

Agri-Chemical Products, Inc.
5450 N. Estelle Drive
TUCSON, ARIZONA 85718

TUCSON, AZ 85
1 PM
7 JUL
1980

THE LAND OF THE FREE
USA 15c
HOME OF THE BRAVE

W R. GRACE & Co.
P O BX 96160
CHICAGO, ILLINOIS
60693

02008660

15628.50

Dead storage Box #9
Box C 331
Zono Cash Remittance
7-1-80 to 7-18-80
Box 294

indexed

No.#
02008584 to 02008877

INV NO	AMOUNT
24152	

FRINK'S GREENHOUSES, INC. 18365
IOWA'S MOST PROGRESSIVE
WHOLESALE GROWERS
CEDAR FALLS, IOWA 50613

07390180 6

7-1 1980

13

PAY TO THE ORDER OF W. R. Grace + Co. $1,499.40

GREENHOUSES I 499 DOLS 40 CTS DOLLARS

02008795

FIRST NATIONAL BANK
CEDAR FALLS, IOWA

FRINK'S GREENHOUSES, INC.

Maurice F. Frink

⑆073901806⑆ 251⑈168⑈1⑈

5

CONTINENTAL BANK
CONTINENTAL ILLINOIS NATIONAL BANK AND TRUST COMPANY OF CHICAGO
MACH 2 JUL 3 1980

Construction Products Division
W.R. Grace & Co.
Whittemore Avenue, Cambridge, Mass. 02140
6-18-80

GRACE

PLEASE REMIT
WITH COPY OF INVOICE TO:
W.R. GRACE & CO.
P.O. BOX 96160
CHICAGO, ILLINOIS 60693

D-U-N-S 04-827-2637

INVOICE DATE	INVOICE NO.	LOCATION	PLANT	DIST.	TERRITORY	OUR ORDER NUMBER	CUST. ORDER NO. AND DATE
6-24-80	04-002	1-014-133	724	750	751	24152	Verbal

SHIPPED VIA	CUSTOMER NO.	SHIPPED FROM	CAR NUMBER	BILL OF LADING NO.	CHECKED
Customer Pick Up	10649	U. Chgo.	PU		3

SOLD TO
Frinks Greenhouse
418 West 13th
Cedar Rapids, IA 50613

SHIP TO

QUANTITY ORDERED	QUANTITY SHIPPED	DESCRIPTION	UNIT PRICE	AMOUNT
300	300	41-12-52-7-04 Bags Metro Mix 220	4.90	1470.00
		Tax	3%	44.10
				$1514.10
				14.70
				1499.40
		02008796		

1% $ 14.70 CASH DISCOUNT ALLOWED IF PAID BY 7-4-80

NO CASH DISCOUNT - NET 30 DAYS

TO AVOID DELAY, REFER ALL MATTERS REGARDING THIS SHIPMENT, "OTHER THAN PAYMENTS," TO THE SALES BRANCH SERVING YOU.

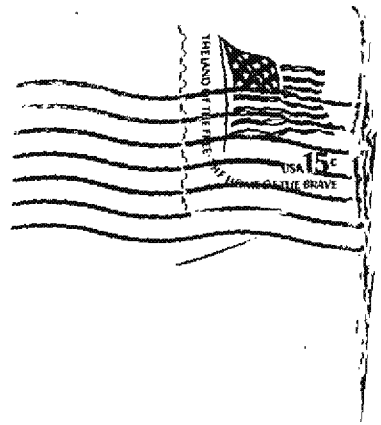
Use of the above goods shall be an acceptance of the conditions of sale on the reverse side hereof as the only conditions applying to the sale of said goods.

ZB9-A (11-78)

WRG00289529
ED_005351_00000355-00096

AFTER FIVE DAYS RETURN TO
FRINK'S GREENHOUSES, INC.
418 WEST 13TH ST.
CEDAR FALLS, IOWA 50613

WATERLOO, IA
JUL 1
PM
1980
50702



02008797

W. R. Grace & Co.
P. O. Box 96160
Chicago, Illinois 60693

Dead storage Box #9
Box C 331
Zono Cash Remittance
7-1-80 to 7-18-80
Box 294

indexed

No.#
02008584 to 02008877

Construction Products Division

W.R. Grace & Co. 6/11/80

Whittemore Avenue, Cambridge, Mass. 02140

GRACE

PLEASE REMIT
WITH COPY OF INVOICE TO:
W.R. GRACE & CO.
P.O. BOX 96160
CHICAGO, ILLINOIS 60693

D-U-N-S 04-827-2637

INVOICE DATE	INVOICE NO.	LOCATION	PLANT	OUR ORDER NUMBER	CUST. ORDER NO. AND DATE
6/12/80	57-097	1-047-033	657 651 512	0415	PHONE 6/10/80

SHIPPED VIA	CUSTOMER P.O.	SHIPPED FROM	CAR NUMBER	BILL OF LADING NO.	CHECKED
NC VERM TRK		NEW CASTLE		000329	1

SOLD TO

CENTRAL SUPPLY CO.
JACKSON ST. & LINDEN AVE.
BOX 968
CLARKSBURG, W. VA. 26301

SHIP TO

SAME 02008723

QUANTITY ORDERED	QUANTITY SHIPPED	DESCRIPTION	UNIT PRICE	AMOUNT
	50	BAGS ATTIC INSULATION 39-01-51-1-04 4.85	$2.88	$ 144.00
3.54	489	BAGS MASONRY FILL 39-04-02-1-02 5.75	3.43	1677.27
4.16	200	BAGS STABILIZED CONC AGG 39-02-11-1-02 6.25	3.75	750.00
		AI FREIGHT CHARGE	.31	15.50
		MF/SCA FREIGHT CHARGE	.39	268.71
		FREIGHT SURCHARGE	7%	17.05
				$2872.53

TAX [illegible]

PLEASE RETURN THIS COPY WITH REMITTANCE
TO ASSURE PROPER CREDIT

X 25.71 7/10/80

TO AVOID DELAY, REFER ALL MATTERS REGARDING ITS SHIPMENT, "OTHER THAN PAYMENTS," TO THE SALES BRANCH SERVING YOU.

Use of the above goods shall be an acceptance of the conditions of sale on the reverse side hereof as the only conditions applying to the sale of said goods.

Z89-A (11-78)

Construction Products Division

W.R. Grace & Co. CREDIT MEMO
Whittemore Avenue, Cambridge, Mass. 02140

INVOICE ~~CREDIT~~

GRACE

PLEASE REMIT WITH COPY OF INVOICE TO: 02008725
P.O. BOX 96160
CHICAGO, ILLINOIS 60693

INVOICE DATE	INVOICE NO.	LOCATION	PLANT	DIV.	TERRITORY	OUR ORDER NUMBER	CUS. ORDER NO. AND DATE
6/16/80	57-802	1-047-033	657	651	512	C/M	RGH 6/13/80

SHIPPED VIA	CUST. NO	SHIPPED FROM	CAR NUMBER	BILL OF LADING NO	CHECKED
NC VERM TRK		NEW CASTLE			4

D-U-N-S 04-827-2637

SOLD TO
CENTRAL SUPPLY CO.
BOX 968 JACKSON ST. & LINDEN AVE.
CLARKSBURG, W. VA. 26301

SHIP TO
SAME

QUANTITY ORDERED	QUANTITY SHIPPED	DESCRIPTION	UNIT PRICE	AMOUNT
		~~CREDIT MEMO~~ TO ADJUST UNIT ~~PRICE~~ ON ITEMS 2 AND 3 ON REFERENCE INVOICE 57-097 DATED 6/12/80:		
DID READ:	489	BAGS MASONRY FILL 39-04-02-1-02	$ 3.43	$1677.27
	200	BAGS STAB CONC AGG 39-02-11-1-02	3.75	750.00
				$2427.27
SHOULD READ:	489	BAGS MASONRY FILL 39-04-02-1-02	$3.22	$1574.58
	200	BAGS STAB CONC AGG 39-02-11-1-02	3.50	700.00
				$2274.58
		CREDIT MEMO		($152.69)
	TAX EXEMPT D-35-0778356178			

CREDIT MEMORANDUM

PLEASE RETURN THIS COPY WITH REMITTANCE TO ASSURE PROPER CREDIT

☐ $ _____ CASH DISCOUNT ALLOWED IF PAID BY _____

☐ NO CASH DISCOUNT - NET 30 DAYS

[illegible]

Use of the above goods shall be an acceptance of the conditions of sale on the reverse side hereof as the only conditions applying to the sale of said goods.

WRG00289535
ED_005351_00000355-00100

THE CENTRAL SUPPLY COMPANY
CLARKSBURG, W. VA.

REMITTANCE VOUCHER
DETACH BEFORE DEPOSITING CHECK

No. 015982

DATE	REFERENCE	INVOICES	DEDUCTIONS	BALANCE
6 12 80	57097	2,872.53		
6 16 80	57802	152.69-		2,719.84*
			02008724	2695.65

WHEN CORRESPONDING WITH US IN REGARD TO THE ITEMS ON THIS REMITTANCE
PLEASE REFER TO THE ABOVE VOUCHER NUMBER

CENTRAL

THE CENTRAL SUPPLY COMPANY

TRANSIT MIXED CONCRETE · BUILDING SU

SINCE 1915

CLARKSBURG, WEST VIRGINIA

69-87
522

02008722

DATE	CHECK NO.	DISCOUNT	AMOUNT
JUL. 10 80	12022	24.19-	$2,695.65*

PAY

CENTRAL SUPPLY 269[illegible] 65 CTS

TO THE ORDER OF

W R GRACE & CO
P.O. BOX 96160
CHICAGO, IL 60693

THE CENTRAL SUPPLY COMPANY

THE LOWNDES BANK · CLARKSBURG, W. VA.

⑆0522⑈0087⑆ 15 205 7⑈

CONTINENTAL BANK

MACH 2 JUL 16 1980

WRG00289537
ED_005351_00000355-00102

Dead storage Box #9
Box C 331
Zono Cash Remittance
7-1-80 to 7-18-80
Box 294

indexed

NO.#
02008584 to 02008877

SALINAS TRANSPLANTS CO.
200 OLD STAGE ROAD
BOX 276 • SALINAS, CA 93902

Nº 3587

DATE	CHECK NO	AMOUNT
7-3-80	3587	2,376.00

9 REGISTERED $2376 dols 00 cts

TO THE ORDER OF

W. R. Grace & Co.
P.O. Box 96160
Chicago, Ill. 60693

SALINAS TRANSPLANTS CO

02008634

BY [signature]

SALINAS MAIN OFFICE, BANK OF AMERICA, SALINAS, CALIFORNIA

⑈003587⑈ ⑆121000358⑆ 00721⑈05436⑈

CONTINENTAL BANK

JUL 8 1980

WRG00289539
ED_005351_00000355-00104

DATE 7-3-80 REF. ATTACHED OR AS FOLLOWS:	GROSS AMOUNT	DISCOUNT	NET AMOUNT	REMARKS
# 76-064	2,400.00	< 24.00 >	2,376.00	02008635

SALINAS TRANSPLANTS CO.
200 OLD STAGE ROAD
BOX 276 • SALINAS, CA 93902

DETACH AND RETAIN THIS STATEMENT

№ 3587

Construction Products Division
W.R. Grace & Co. #06
2500 South Garnsey St., Santa Ana, CA 92707 (714) 979-4900
6-25-80

GRACE

PLEASE REMIT
WITH COPY OF INVOICE TO:
W.R. GRACE & CO.
P.O. BOX 93180
CHICAGO, ILLINOIS 60693

D-U-N-S 04-827-2637

INVOICE DATE	INVOICE NO.	LOCATION				ORDER NUMBER	CUST. ORDER NO. AND DATE
6-26-80	76-064	3-004-053	676	772	703	762270	1817 5-28-80

SHIPPED VIA	CUSTOMER NO.	SHIPPED FROM	CAR NUMBER	BILL OF LADING NO.	CHECKED
WILL CALL	25096	Santa Ana	6-25-80		3

SOLD TO

SALINAS TRANSPLANTS INC
P.O. Bx 276
Salinas, CA 93901

SHIP TO

SAME

QUANTITY ORDERED	QUANTITY SHIPPED	DESCRIPTION	UNIT PRICE	AMOUNT
700	640	Bags TERRA LITE #2 (39-12-04-1-02)	3.75	2400.00
		SRC HA 26-600590		

02008636

XX 24.00 7-6-80

PLEASE RETURN THIS COPY WITH REMITTANCE TO ASSURE PROPER CREDIT

TO AVOID DELAY, REFER ALL MATTERS REGARDING THIS SHIPMENT, "OTHER THAN PAYMENTS," TO THE SALES BRANCH SERVING YOU.

Use of the above goods shall be an acceptance of the conditions of sale on the reverse side hereof as the only conditions applying to the sale of said goods.

ZB9-A (CAL) 4-79

Fresh as Tomorrow

BUD OF CALIFORNIA

BUD ANTLE, INC. P.O. BOX 1759, SALINAS, CALIFORNIA 93902

SALINAS CALIF. JUL-3'80

U.S. POSTAGE .15

PB METER 991223

02008637

WRG00289542

ED_005351_00000355-00107

Dead storage Box #9
Box C 331
Zono Cash Remittance
7-1-80 to 7-18-80
Box 294

indexed

NO.#
02008584 to 02008877

DREAM POOLS
3303 BRUNSWICK PIKE
TRENTON, N.J. 08648

REMITTANCE ADVICE

55-73/312 05

11756

PAY 761 DOLS 20 CTS DOLLARS

DATE	TO THE ORDER OF	GROSS AMOUNT	MISC.	GRAV.	SAND	ESC. ROW	INS.	NET AMOUNT
6-30-80	U.A. Gross & Company	02008638						

DESCRIPTION

VOID AFTER NINETY DAYS

NEW JERSEY NATIONAL BANK
LAWRENCE OFFICE

⑆031200730⑆ 160234 1⑈

CONTINENTAL BANK

MACH 4 JUL 8 1980

WRG00289544
ED_005351_00000355-00109

Construction Products Div.
W.R. Grace & Co.
Whitemore Avenue, Cambridge, Mass. 02140

5-19-80

GRACE

PLEASE CREDIT
WITH COPY OF INVOICE TO:
W.R. GRACE & CO.
P.O. BOX 96150
CHICAGO, ILLINOIS 60693

D-U-N-S 04-827-2637

5-21-80	52-023	1-029-021	652 730 731	- 023r	Verbal	
Trenton Truck		08622	Trenton		000000	1

SOLD TO

Dream Pools
Rte. 1
Trenton, NJ

SHIP TO 02008639

Same

7,611.20

ORDERED	SHIPPED	DESCRIPTION	UNIT PRICE	AMOUNT
700	700	Bags Grace Pool Cushion (39-07-17-1-02)	3.35 bg	2345.00
				$2345.00
		NJ Tax Exempt		

PLEASE RETURN THIS COPY WITH REMITTANCE TO ASSURE PROPER CREDIT

xx 23.45 5-31-80

BILL OF LADING SHIPMENT

Use of the above goods shall be an acceptance of the conditions of sale on the reverse side hereof as the only conditions applying to the sale of said goods.

Z89-A (11-78)

Construction Products Division
W.R. Grace & Co.
Whittemore Avenue, Cambridge, Mass. 02140

GRACE

PLEASE REMIT WITH COPY OF INVOICE TO:
W.R. GRACE & CO.
P.O. BOX 2025
CHICAGO, ILLINOIS 60603

02008640

5-30-80

D-U-N-S 04-827-2837

INVOICE DATE	CUSTOMER NO.	DEALER NO.	PRODUCT	DIST.	TERM	SUPPLY	CUSTOMER
6-2-80	52-105	1-029-021	652	730	731	105r	Verbal

Trenton Truck	08622	Trenton		000000	1

SOLD TO

Dream Pools
Rte. 1
Trenton, NJ 08610

SHIP TO

Same

QUANTITY ORDERED	QUANTITY SHIPPED	DESCRIPTION	UNIT PRICE	
700	672	Bags Pool Cushion (39-07-17-1-02)	3.35 bg	2251.20
				$2251.20
		NJ Tax Exempt		

xx 22.51 6-12-80

PLEASE RETURN THIS COPY WITH REMITTANCE TO ASSURE PROPER CREDIT

Use of the above goods shall be an acceptance of the conditions of sale on the reverse side hereof as the only conditions applying to the sale of said goods

Z89-A (11-78)

Construction Products Division
W.R. Grace & Co.
Wintermore Avenue, Cambridge, Mass. 02140

5-29-80

GRACE

PLEASE REMIT
WITH COPY OF INVOICE TO:
W.R. GRACE & CO.
P.O. BOX 93100
CHICAGO, ILLINOIS 60693

02008641

D-U-N-S 04-827-2637

INVOICE DATE							CUST. ORDER NUMBER	CUST. ORDER NO.	DATE
6-2-80	52-099	1-029-021	652	730	731		099r	Verbal	

SHIPPED BY	CUSTOMER NO.	SHIPPED FROM	CARRIER	BILL OF LADING	WEEK
Pick Up	08622	Trenton		122723	3

SOLD TO

Dream Pools
Rte. 1
Trenton, NJ 08610

SHIP TO

Same

QUANTITY ORDERED	QUANTITY SHIPPED	DESCRIPTION	UNIT PRICE	AMOUNT
200	200	Bags Pool Cushion (39-07-17-1-02)	3.35 bg	670.00
				$670.00
		NJ Tax Exempt		

PLEASE RETURN THIS COPY WITH REMITTANCE TO ASSURE PROPER CREDIT

xx 6.70 6-12-80

Use of the above goods shall be an acceptance of the conditions of sale on the reverse side hereof as the only conditions applying to the sale of said goods.

ZB9-A (11-78)

Construction Products Division
W.R. Grace & Co.
Whitemore Avenue, Cambridge, Mass. 02140
6/9/80

GRACE

PLEASE REMIT
WITH COPY OF INVOICE TO:
W.R. GRACE & CO.
P.O. BOX 06642
CHICAGO, ILLINOIS 60693
D-U-N-S 04-827-2637

6/10/80	52-174	1-029-021	652 730 731	174	

SHIPPED VIA	BILL OF LADING NO.	SHIPPED FROM		
Trenton Truck	0863	Trenton	000000	1

SOLD TO Dream Pools
Rt. 1
Trenton, NJ 08619

SHIP TO Same

QUANTITY ORDERED	QUANTITY SHIPPED	DESCRIPTION	UNIT PRICE	AMOUNT
700	700	Bags Grace Pool Cushion(39-07-17-1-02)	3.35 bag	2345.00
		Sales Tax Exempt		

PLEASE RETURN THIS COPY WITH REMITTANCE
TO ASSURE PROPER CREDIT

X 23.45 6/20/80

Use of the above goods shall be an acceptance of the conditions of sale on the reverse side hereof as the only conditions applying to the sale of said goods.
Z89-A (11-78)

WRG00289548
ED_005351_00000355-00113

PHILADELPHIA, PA
PM
JUL

W. R. Grace and Company
P. O. Box 96160
Chicago, Illinois 60693

02008643

Dream Pools

3303 BRUNSWICK PIKE, U.S. ROUTE 1, P.O. Box 6305 LAWRENCEVILLE, N.J. 08648

TREMOLITE DATA
GENERAL

Oxford PENDAFLEX®
HANGING FOLDERS
U. S. PAT.
CANADIAN
No. 4152 1/5
MADE IN U.S.A.

Tremolite - General 3/77 - 7/78

File Vermiculite

RECEIVED

OCT 19 1977

CONST. PROD. DIV.
ADMIN. DEPT.

GRACE

Construction Products Division

To: D. M. Kirven

Date: October 18, 1977

From: F. W. Eaton

Subject: User Exposure - Early Bird Farm, Ithaca, N. Y.

cc: J. R. Becker
R. C. Ericson
L. G. Feldman
W. R. Hanlon
H. C. Duecker
J. W. Wolter
E. S. Wood

Per your request job site User Exposure Tests were conducted for fiber, total dust, and free silica at Early Bird Farm, September 29, & 30, 1977, on Metro-Mix 350, Redi-Earth, and Libby #3 Terra-lite Vermiculite. Summary of results for total dust and fiber are listed in table 1 and 2 respectfully. Total dust samples were sent to Clayton Laboratories for free silica analysis and results should be available in approximately two weeks. Due to the small amount of dust collected, the free silica analysis may be meaningless as the lowest detectable quantitative value at those levels will be less than 2% free silica.

Filling 4 1/2" square pots with Metro-Mix 350 and Redi-Earth, and 13" X 18" flats with L #3 Terra-lite Vermiculite was done at the east end of Greenhouse #8. Filling pots and flats on a 4 X 8 sheet of plywood was done under normal greenhouse potting procedures. Due to ambient conditions, the overhead door was open during part of the test period and closed the remainder. Greenhouse #8 is the normal mixing and potting location although at times one of the Redi-Mix concrete mixers is positioned adjacent to one of the greenhouses and potting takes place outside. Normal potting procedures at Early Bird Farm is to pot approximately 1,000 pots at a time or approximately one hour's work. CPD's grower TWA timefactor for Metro-Mix and Redi-Earth is 4/8 and the TWA time factor for Early Bird Farm would be 1/8. Filling flats at Early Bird Farm is normally done with a mixed product and filling is semi-automatic. For this test straight L3 Terra-lite Vermiculite was used and filling was done manually in accordance with CPD's grower commercial use of Terra-lite procedure. During each test total dust samples were taken over the mans right shoulder and left shoulder and a fiber sample taken in between. Sampleing time for total dust was 180 minutes and the fiber sampling ranged from 15 to 31 minutes. The following is a summary of tests by product:

Metro-Mix 350

Two 3 cuft. bags of Metro-Mix 350 were used in the filling of 4 1/2" sq. pots at a rate of approximately 1,000 to 1,100 pots per hour. Full pots were removed from the potting area, emptied out, and the material returned to the potting area for re-potting. During the three hour test period, approximately 3,000 pots were filled and the two bags of Metro-Mix 350 were recycled nine times. CPD's grower TWA time factor for Metro-Mix and Redi-Earth is 4/8.

For Early Bird Farm, the TWA time factor is 1/8. Total dust and the fiber exposures listed in table 1 and 2 are adjusted for a 4/8 and 1/8 TWA time factor. Based on my limited knowledge of Metro-Mix 350, this material looked good and was quite damp.

Redi-Earth

Two 30 lb. bags of Redi-Earth were used to fill 4 1/2" sq. pots. The same potting procedure and frequency of potting listed above under Metro-Mix 350 were followed with Redi-Earth. It was not until the test was underway that it was discovered that the two bags of Redi-Earth were different and came from two different plant locations. One bag packaged in a valve bag and assume to be W. Chicago material, contained peat-twigs, perlite, and lumps of brown agglomerated fines assumed to be nutrient. Material in the other bag appeared to be normal and a shipping label on the bag identified the plant location as Jacksonville. Both bags were not as damp as the Metro-Mix 350.

good West Chicago Product

L #3 Terra-lite Vermiculite

Six-6 cuft. bags of Libby #3 Terra-lite Vermiculite were used to fill 13" X 18" flats at a rate of 24 flats per 6 cuft. bag or 12 minutes per bag. This test was done in accordance with CPD's grower commercial use of Terra-lite test procedure except 6-6 cuft. bags were used during the 180 minute sample period and each bag was recycled approximately 3 times.

The Terra-lite Vermiculite was material from Early Bird Farm inventory and was packaged in white bags with green letters with no plant date identification. It is assumed that this material was produced in Weedsport, and processed sometime prior to mill changes and procedural changes at the expanding plant. Per P. R. Reyer, this material was shipped to Early Bird Farm, February 27, 1977 as part of a 450 bag order. Although total dust results are not particularly high it was noted on the sampling sheet that this material appeared to be dustier than recent screened and unbound Libby #3 Attic Fill. As the person emptying the flats outside Greenhouse #8, I was very much aware of the visable dust being generated in the closed greenhouse. With exception of sample #EBF-12-TL, fiber count on recycled material appeared to be somewhat higher than the initial filling cycle. Fiber exposure on the recycled material was taken during the second and third hour of this test. Sample #EBF-12-TL was

scanned by H. A. Eschenbach and he concurred that the results listed were valid.

Summary of Results

Total dust values listed in table 1 for all three products tested, are well below the TLV's. If the Libby 3 Terra-lite Vermiculite had been of recent material, there is a possibility that total dust values might have been somewhat less than listed in table 1. As far as fiber exposure listed in table 2 is concerned there should be no concern on the Metro-Mix 350 and Redi-Earth. The Redi-Earth values should be treated as a composite using both South Carolina and Libby Vermiculite rather than specific values for either source. The Terra-lite fiber exposure values are higher than expected on the present quality of process ore and are very close to the OSHA TLV. The values are above our January 1, 1978 target of 1.0 f/ml., 8 hr. TWA and 5 f/ml. ceiling. I strongly recommend that these values not be used and if possible this test re-scheduled. If the test is re-scheduled, it would be my recommendation that none of the material be recycled during the testing period.

F. W. Eaton

FWE/cc

Attachments

TABLE I

TOTAL DUST (mg/M^3)

PRODUCT	MIN	MAY	AVE	TWA 4/8	TWA 1/8
Metro-Mix 350	0.243	0.590	0.417	0.208	0.052
Redi-Earth	0.382	1.076	0.729	0.365	0.091
L #3 Terra-Lite Vermiculite	2.12	3.44	2.78	1.39	0.348

TABLE II

FIBER COUNT (f/ml)

PRODUCT	MIN	MAY	AVE	TWA 4/8	TWA 1/8
Metro-Mix 350	< 0.14*	0.57	0.101	0.088	0.013
Redi-Earth	< 0.21*	< 0.31*	< 0.253*	< 0.221*	< 0.032*
L #3 Terra-Lite Vermiculite	1.07	5.13	2.162	1.892	0.270

NOTE

< Means no visible fibers seen in counting fields.

* Means no visible fibers seen outside counting fields.

<* Means no visible fibers seen in or outside counting fields - therefore zero fibers although calculations are based on seeing one (1) fiber.

(1)

CR CR

AIR SAMPLING RECORD SHEET

PLANT LOCATION: EARLY BIRD FARM
CONTAMINANT: TOTAL DUST / FREE SILICA
SAMPLING BY: F.W. EATON
DATE: 9/29/77

SAMPLING CONDITIONS:
OUTSIDE: FAIR
INSIDE DRAFT:
VISIBLE DUST:

HOUSEKEEPING:

Sample Number	Employee Name	Job Location and Description	Remarks	Pump Number	Pump Off	Pump On	Sampling Time MIN	Flow Rate	Total Sampled Volume	Lab Evaluation
350-1A	GREG SHELDRAKE	FILLING 4½" SQ POTS	FILLING POTS IN #8 GREEN-	1CG6	955	955	180	1.6		0.590
			HOUSE WHERE ALL POTS &							
			FLATS ARE MIXED & POTTED							
350-2A			USING 2-3cF BAGS OF	1CG-7		955	180	1.6		0.243
			MM-350 PER FILLING CYCLE.							
			EACH CYCLE TAKE APPROX							
			18-20 MIN TO FILL 345-							
			4½" SQ POTS (1000-1100 POTS/HR)							

EARLY BIRD FARM TWA FACTOR WILL BE 1/8

TEST CONDITIONS ARE NORMAL GREENHOUSE PROCEDURES FOR FILLING POTS. POTTING IS AT END OF GREENHOUSE NEXT TO OVERHEAD DOOR. IN SUMMER TIME 4 FT DIA FAN WOULD BE ON.

EARLY BIRD FARM NORMALLY POTS 1000 POT/DAY - APPROX 1 HR WORK

Additional Comments: 350-1A RIGHT SHOULDER
350-2A LEFT "
BOTH BAGS MM-350 FROM SAX.

Laboratory Evaluation By: Nancy Catalde
Date: 10/7/77

WRG00291416
ED_005351_00000355-00121

(5)

CRCE

AIR SAMPLING RECORD SHEET

PLANT LOCATION EARLY BIRD FARM
CONTAMINANT TOTAL DUST / FREE SILICA
SAMPLING BY F. W. EATON
DATE: 9/29/77

SAMPLING CONDITIONS:
OUTSIDE FAIR
INSIDE DRAFT
VISIBLE DUST

HOUSEKEEPING:

Sample Number	Employee Name	Job Location and Description	Remarks	Pump Number	Pump Off	Pump On	Sampling Time MIN	Flow Rate	Total Sampled Volume	Lab Evaluation
RE-3A	GREG SHELDRAKE	FILLING 4½" SQ POTS	FILLING POTS WITH PEDI-	ICG-4	1715	1415	180	1.6		1.076
			EARTH IN #8 GREENHOUSE							
RE-4A			USING 2 - 30LB BAGS OF	ICG-7	1715	1415	180	1.6		0.382
			R.E. 1 FROM W. CHICAGO & 1							
			FROM JAX. NO PLANT LOT	No.						
			REFER TO NM-350 TOTAL							
			DUST SAMPLING SHEET FOR							
			ADDITIONAL SAMPLING CONDITIONS							
			CLOSED DOOR @ 1540							

Additional Comments: NOTE: W. CHICAGO MAIL CONTAINS PERLITE

Laboratory Evaluation By: Nancy Caldo
Date: 10/7/77

WRG00291417
ED_005351_00000355-00122

GR DE

AIR SAMPLING RECORD SHEET

PLANT LOCATION EARLY BIRD FARM
CONTAMINANT TOTAL DUST / FREE SILICA
SAMPLING BY F. W. EATON
DATE: 9/30/77

SAMPLING CONDITIONS:
OUTSIDE FAIR
INSIDE DRAFT
VISIBLE DUST

HOUSEKEEPING:

Sample Number	Employee Name	Job Location and Description	Remarks	Pump Number	Pump Off	Pump On	Sampling Time	Flow Rate	Total Sampled Volume	Lab Evaluation
L-5A	GREG SHELDRAKE		FILLING 10- 13"x18"	1BG-6	1145	0845	180	1.6		2.12
			FLATS W/LIBBY #3 TERRA-							
L-6A			LITE VERMICULITE. THIS	1GS-7	1145	0845	180	1.6		3.44
		24 FLATS/6 CF BAG	MAT'L CAME FROM E.B.F							
		12 MIN/BAG	INVENTORY & IS IN WHITE/GREEN TERRA LITE 6 CF BAGS. THERE							
			IS NO PLANT LOCATION/LOT NO. ON BAG. WEEDSPORT HOWEVER,							
			THIS COULD BE OLD MAT'L. APPEARS TO BE DUSTIER							
			THAN RECENT SCREENED, UNBOUND L#3 ATTIC ESPECIALLY							
			EMPTYING FLATS							
		FOR 1ST 3/4 HR	EMPTYING FLATS AT OPPOSITE END OF #8 GREENHOUSE. REMAINDER							
		OF TEST, FLATS	EMPTIED OUTSIDE.							

Additional Comments: EARLY BIRD FARM DOES NOT USE PLAIN TERRA-LITE VERMICULITE IN SEEDING FLATS - ONLY MIXED MAT'L

Laboratory Evaluation By: Nancy Cataldo
Date: 10/7/77

(2)

AIR SAMPLING RECORD SHEET

PLANT LOCATION: EARLY BIRD FARM
CONTAMINANT: FIBER
SAMPLING BY: F.W. EATON
DATE: 9/29/72

SAMPLING CONDITIONS:
OUTSIDE: FAIR / VAR. CLOUD.
INSIDE DRAFT:
VISIBLE DUST:

HOUSEKEEPING:

Sample Number	Employee Name	Job Location and Description	Remarks	Pump Number	Pump Off	Pump On	Sampling Time MIN	Flow Rate	Total Sampled Volume	Lab Evaluation
EBF-1-350	GREG SHELDRAKE	FILLING 4½" SQ POTS	FILLING POTS WITH MEDIO-	ICG-1			20	1.6	0	<0.21*
			MIX 350 IN #8 GREENHOUSE							
EBF-2-350	GREG		USING 2-3CF BAGS OF MM-350				31	1.6	0	<0.14*
			& FILLING AT A RATE OF							
EBF-3-350			1000-1100 4½" SQ POTS/HR.				19	1.6	0	<0.22*
BF-4-350			REFER TO MM-350				15	1.6	8.55	0.57
			TOTAL DUST SAMPLING SHEET				85		8.55/85 = 0.101	
			FOR ADDITIONAL SAMPLING							
			CONDITIONS.							

Additional Comments: * no visible fiber seen outside the counting fields

Laboratory Evaluation By: Nancy Cataldo
Date: 10/7/72

OSHA

AIR SAMPLING RECORD SHEET

PLANT LOCATION: EARLY BIRD FARM
CONTAMINANT: FIBER
SAMPLING BY: F. W. LIBTOM
DATE: 9/29/77

SAMPLING CONDITIONS:
OUTSIDE
INSIDE DRAFT
VISIBLE DUST

HOUSEKEEPING:

Sample Number	Employee Name	Job Location and Description	Remarks	Pump Number	Pump Off	Pump On	Sampling Time MIN	Flow Rate	Total Sampled Volume	Lab Evaluation
BF-5-RE			10 MIN JAY REDI-EARTH 8 " W.C. " "				18	1.6	4.32	<0.24*
BF-6-RE			W. CHICAGO REDI-EARTH				14	1.6	4.34	<0.31*
BF-7-RE			JAY REDI-EARTH				16	1.6	4.32	<0.27*
BF-8-RE			MIXTURE OF W.C & JAY. MAT'L				20	1.6	4.2	<0.21*
							68		17.18/68 =	<0.253*
		FILLING POTS WITH REDI-EARTH IN #8 GREENHOUSE. USING 2-30LB								
		OF REDI-EARTH 1 FROM W. CHICAGO & 1 FROM JAY.								
		SAME SAMPLING CONDITIONS AS MM-330 (SHEET 1)								

Additional Comments: NOTE: I AM NOT 100% SURE ~~BOTH~~ MAT'L LOCATION ID. IS CORRECT. EMPTYING 1000 POTS/HR IT WAS DIFFICULT KEEPING TRACK OF BAGS & TOWARD THE END OF TEST, THERE WAS A MIXTURE OF BOTH MAT'L. TESTS SHOULD HAVE BEEN CONDUCTED WITH ~~ALL~~ MAT'L FROM ONLY ONE POINT

Laboratory Evaluation By: Nancy Cataldo
Date: 10/7/77

WRG00291420
ED_005351_00000355-00125

(6)

AIR SAMPLING RECORD SHEET

PLANT LOCATION: EARLY BIRD FARM
CONTAMINANT: FIBER
SAMPLING BY: F.W. EATON
DATE: 9/30/77

SAMPLING CONDITIONS:
OUTSIDE: FOIR
INSIDE DRAFT:
VISIBLE DUST:

HOUSEKEEPING:

Sample Number	Employee Name	Job Location and Description	Remarks	Pump Number	Pump Off	Pump On	Sampling Time MIN	Flow Rate	Total Sampled Volume	Lab Evaluation
BF-9-TL			FILLING 10-13"x18" FLATS	ICG-1			24	1.6	25.68	1.07
			W/ LIBBY #3 TERRA-LITE							
BF-10-TL		6-6 LF BAGS 1 HR 15 MIN	VERMICULITE				17	1.6	25.67	1.51
BF-11-TL							15	1.6	21.45	1.43
			REFER TO L#3 TERRA-							
BF-12-TL ←			LITE VERMICULITE TOTAL				15	1.6	76.95	5.13
			DUST SAMPLING SHEET (5)							
BF-13-TL		REUSING SAME MAT'L LISTED ABOVE	FOR MULTIPLE SAMPLING CONDITIONS.				25	1.6	55.5	2.22
BF-14-TL							26	1.6	51.22	1.97
BF-15-TL							19	1.6	55.48	2.92
BF-16-TL			358.95 / 166 = 2.162				25 / 166	1.6	47.0 / 358.95	1.88

Additional Comments:

Laboratory Evaluation By: Nancy Cataldo
Date: 10/7/77

USED IN CALCULATING OF TWA

TIME BY CLOCK. STOP WATCH STARTED IN ERROR. CALCULATE EXPOSURE BUT DO NOT USE IN TWA CALCULATIONS
10/14/77

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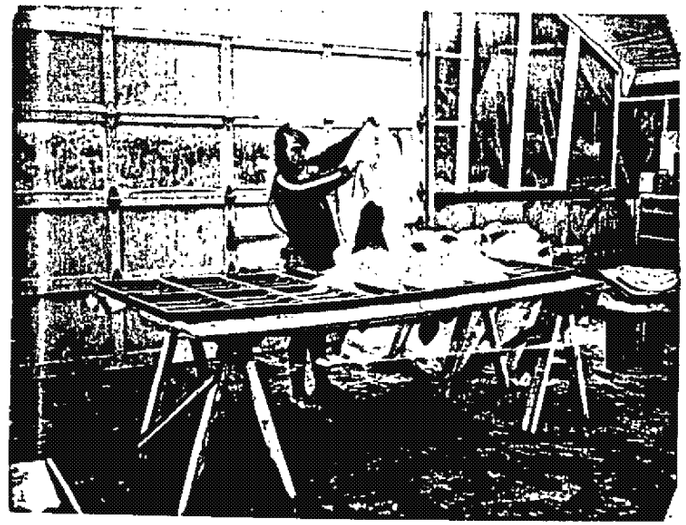
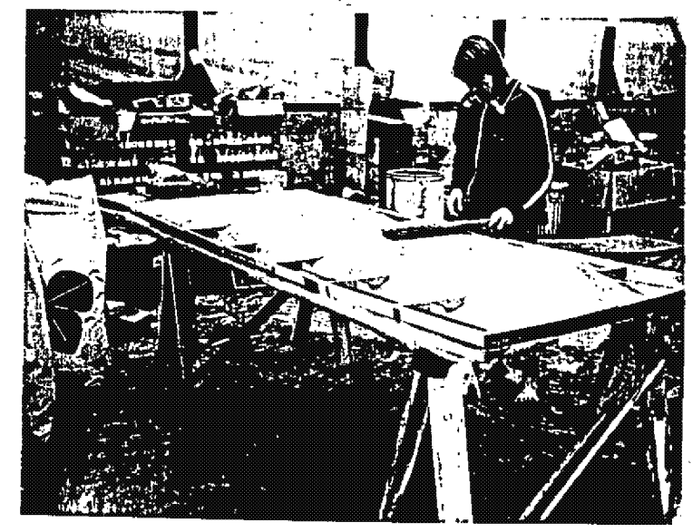
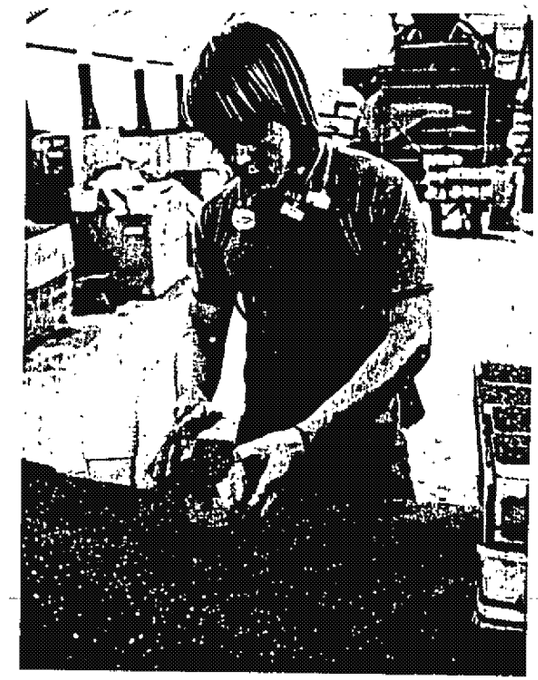
EARLY BIRD FARM, ITHACA, N. Y. GROWER AIR SAMPLING SEPTEMBER 29 & 30, 1977

EARLY BIRD FARM, ITHACA, N. Y. GROWER AIR SAMPLING SEPTEMBER 29 & 30, 1977







Medical
Schnetter, Steve.
(00800015

WRG002990

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Mr. Melcher

ACCIDENT INVESTIGATION REPORT

INDUSTRIAL CHEMICALS GROUP
W. R. Grace & Co.

Plant Libby Lost Time Case ____

Division Construction Products Division Not Lost Time Case ____
(Check one)

- All accidents involving lost time from work or the services of a physician must be investigated and the report completed within 48 hours by the injured employee's supervisor. Forward one copy of report to office of Safety Administrator.

1. Name of injured employee Steven J. Schnetter
2. Department Reseaych Date of Hire 9-5-73
3. Job Title Reseaych Foreman Was he doing regular job? Yes ✓ No ____
4. Date and time of injury May 3rd 1976 11:30 A.M.
5. Date and time injury reported May 3rd 1976 11:30 A.M.
6. Injured employee is: Salaried ____ Hourly ✓ Male ✓ Female ____

   Under 25 years ____ 25 to 34 ✓ 35 to 49 ____ 50 and over ____
7. Describe in detail what employee was doing at time of injury: include reference to any tools, machines and materials involved:

   Cutting with Cutting Torch, Piece or pieces of Slag got under Cutting goggles
8. Describe injury: Burn on Eyelid and Eyeball
9. What medical action was taken? Taken To Doctor
10. What, in your opinion, was the basic cause of this accident?

    Unsafe Act ____ Unsafe Condition ____ Explain Employee was using proper Safety Equipment

C0080016

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11. What were the contributing causes? Failure of Equipment To protect Completely

12. What action have you taken and/or are you planning to take to avoid a recurrence of this accident? Explain To Crew The Importance of goggles. And how serious This could have been without proper safety Equipment

13. Have you counselled your other employees regarding lessons to be learned from this accident?

Yes ✓ No ____ if not, why _____

14. Have you scheduled any maintenance work or planned any disciplinary action with the accident?

Yes ____ No ✓ Comments, if any: _____

(Signed) Edwin L. Erickson (Supervisor) Date 5/3/76 Plant Libby

****

You have now completed answering some very important questions regarding an injury to one of your employees. Take the time to think carefully and ask yourself the following two questions:

a) How long did I take to think out and complete the answers to the questions above?
b) Have I really taken enough time, given enough thought, to a subject which might very well mean the life of one of my employees at some future date?

****

This space reserved for Plant Managers

1. Have you discussed this injury with .....

the supervisor concerned? Yes ____ No ____
all members of your supervisory group? Yes ____ No ____

2. Do you have any comments to add to the statements by the Foreman?

_____

_____

(Plant Manager) _____ (Date) _____

Form 65-25

C0080017

MONTANA DIVISION OF WORKERS' COMPENSATION

Complied with 82—1137 R.C.M.

815 Front Street
Helena, Montana 59601

SEND ORIGINAL TO INSURER

EMPLOYER'S FIRST REPORT
of Occupational Injury or
Occupational Disease
Employee Copy

CASE NUMBER

FIRM NUMBER 2503

INSTRUCTIONS - Every employer in Montana is required by law to complete this form immediately after every accident to an employee which arises out of and in the course of employment, and which causes loss of time from work or requires medical attention. The original of this form must be immediately filed with the employer's insurer or the Division of Workers' Compensation, 815 Front Street, Helena, Montana 59601. All questions must be answered fully. If a question cannot be answered, please explain why. **Please print with a ball point pen or type.**

FEDERAL OSHA REQUIREMENTS - The United States Department of Labor requires employers to maintain, in the employer's office, a record of occupational injuries. For the employer's convenience, this form has been designed to meet such requirements and to provide employers a record copy.

EMPLOYEE

Full Name of INJURED EMPLOYEE: Steven Schnetter
Social Security Number: 517-56-5940
EMPLOYEE'S Home Address (Street or Box): 619 Louisiana Avenue
City: Libby
State: MT
Zip Code: 59923
Occupation: Research Foreman
Sex: M
Age: 28
Marital Status: [X] Married [ ] Single
Length of time in your Employment: since 9-5-73
Department where regularly employed: Research
Date of Birth (mo.) 12 (day) 13 (yr.) 48

WAGES

Employee's Gross Wage Rate is $ 2.415 per [ ] week, or [ ] day, or [X] hour, or [ ] month
Days Worked Per Week: 5
Hours Worked Per Day: 8
If board or room is furnished state value reported per day to Internal Revenue Service $
Check One— [X] Full Time Employee [ ] Part Time Employee
Payroll Classification under which employee's wages were reported
Employee's gross earnings for last four (4) pay periods (Date / Amount) (Date / Amount) (Date / Amount) (Date / Amount)
Employee's pay period [ ] Monthly [X] Semi-monthly [ ] Bi-Weekly [ ] Weekly [ ] Other

ACCIDENT INFORMATION

Describe in full detail how accident happened, and give cause - Explain what employee was doing when injured.
Using a cutting torch to do some work overhead, drop of hot slag got under goggles dropped into right eye--mostly on eyelid.

What specific object or substance caused the injury? hot slag
Nature of the injury? (cut, fracture, etc.) slight burn, right eye
Part of body affected (leg, arm, back, head, etc.) right eye
DATE OF INJURY (month) May (day) 3 (year) 1976 (hour) 11:30 (a.m. or p.m.) a.m.
Names of witnesses to accident 1. 2.
Place where accident occurred (address & city) Our mill area, 12 miles north of Libby (county) Lincoln
Was place of accident on employer's premises? Yes [X] No [ ]
Was employee injured while in your employ? Yes [X] No [ ]
Were you notified, or did you have actual knowledge of the accident? Yes [X] No [ ] If yes, date notified & how 5-3-76, by employee
Do you have any reason to question this accident? [ ] Yes [X] No If yes, please explain fully

MEDICAL

Attending physician name and address: W. T. Matthews, MD 402 Montana Avenue, Libby, MT 59923
If hospitalized, hospital's name and address
Will employee return to work during next scheduled shift? Yes [X] No [ ]
If no, will wage loss exceed 7 days? Yes [ ] No [ ] Not Sure [ ]
Date wage loss began (mo) (day) (yr.)
Date of return, if returned to work (mo.) (day) (yr.)

EMPLOYER

EMPLOYER'S NAME Construction Products Division W. R. Grace & Co.
Commercial Name (doing business as): Same
Employer's mailing address (Street or Box): Box 609 (City) Libby (State) Mt. (Zip Code) 59923
Phone number: 293-4131
Location of operation, if different from mailing address
Nature of business: Mining & Milling
Firm is a: (Check one) [ ] Sole proprietorship [ ] Partnership, or [X] Corporation
Was the Injured employee? (Check if applicable) [ ] A Sole Proprietor, [ ] A working Partner, [ ] A Corporate Officer, or [ ] A member of the employer's (sole proprietor or partner) family, dwelling in the employer's household.
Prepared by: Joan B. Runyan
Authorized Signature X
Official Title Adm. Asst.
Date 5-5-76

DWC USE ONLY: OCCUPATION, SEX, AGE, MARITAL STATUS, COUNTY, LENGTH (YRS) EMPLOYED, WEEKLY EARNINGS, CLASS CODE, ACCIDENT TYPE, SOURCE OF INJURY, PART OF BODY INJURED, OSHA RECORDABLE CODE, DISABILITY TYPE, NATURE OF INJURY, HAZARDOUS CONDITION, UNSAFE ACT

Above - DWC-MIS Form 37-Employer's First Report (Rev. 1-76)

Below - DWC-MIS Form 54A-Claim for Compensation

EMPLOYEE'S CLAIM FOR COMPENSATION

EMPLOYER'S NOTE: For convenience purposes and if the worker is available, the form below has been provided so that an employer may allow an injured worker to file a claim for compensation on this form to avoid having the employee fill out and file a separate detailed form. Separate claim forms are available if the employer does not want the worker to use this form. **Do not delay in submission of this form if employee is not available to sign below.**

INJURED EMPLOYEE'S NOTE: An injured employee may use the form below to make a claim for compensation, or the employee may fill out and submit a separate detailed form that is available from the Division.

I have carefully read the above information as documented by the employer, and (except for any statements I may write below) I concur with the information and I hereby make claim for compensation benefits due me now or in the future under Montana's Workers' Compensation Act.

Signature of injured employee X Address City Date Phone

I DO NOT concur with the following information documented by the employer

C008001B

Filing of this claim is authorization for release of medical records and records of the Social Security Administration

MEDICAL
Schoonmaker, Edward

C00B0019

Industrial Accident Board, Helena, Montana, Form 37 Revised

06063058

Industrial Accident Board

HELENA, MONTANA

DO NOT WRITE IN THIS SPACE

Firm No.

File No.

EMPLOYER'S FIRST REPORT OF INJURY

INSTRUCTIONS—Employer must complete form at once after every accident which causes loss of time from work or requires medical attention and mail it to the Industrial Accident Board, Helena, Montana. Form must be signed in pen and ink. ALL QUESTIONS MUST BE ANSWERED FULLY.

INJURED EMPLOYEE

Full name of injured employee: Edward Schoonmaker Occupation: Construction Worker

Mailing address: Libby, Montana How long has he been in your employ: 4 mos.

Social Security No.: 590-40-3497 Sex: M Age: 34 Married ☒ Single ☐

EARNINGS

Monthly Wage ..... Weekly Wage ..... Daily Wage ..... Hourly Wage: 3.06

Receive board Yes ☐ No ☒ Daily Value ..... Receive room Yes ☐ No ☒ Daily Value .....

Piece Worker Yes ☐ No ☒ If yes, give method of computing earnings .....

Number of hours worked per day: 8 Days worked per week: 5 Employee's pay period?

Monthly ☐ Semi monthly ☒ Weekly ☐ List employee's earnings last 4 pay periods 1: 303.07

2: 370.00 3: 291.20 4: 263.88

Under what payroll classification has employees' wages been reported? ..... (Sawmill - Mechanic - Etc.)

ACCIDENT AND INJURY

Describe in full how accident happened and GIVE CAUSE: While doing some welding in Sheet Metal Shop, received flash burn in eyes.

Part of body injured? Describe fully: eyes

Names of witnesses to accident 1: ?? 2: .....

Date of accident: 6-20-68 19..... Hour: ..... A.M. Was employee injured in course of employment? Yes ☐

Place where accident occured: our shop, 19 miles north of Libby (Address) (City) Lincoln (County)

Did you or employee's supervisor have actual knowledge of accident? Yes ☒ No ☐

Were you notified of accident by injured employee? Yes ☒ No ☐ How: in person Date: 6-24-68

Have you reason to question this accident? Yes ☐ No ☒ If "yes" explain fully .....

SAFETY

Was employee's accident due to unsafe work practices? Yes ☐ No ☒ If "yes", what did he do unsafely? .....

Was a specific device, object or substance involved in accident? Yes ☒ No ☐ If "yes", name specific device, object or substance: welder Was device or object defective? Yes ☐ No ☒

Was employee doing regular work when injured? Yes ☒ No ☐ Was employee trained to do work he was doing when injured? Yes ☒ No ☐ Were adequate safe guards provided? Yes ☒ No ☐ If "yes" were they being used at time of accident? Yes ☒ No ☐ Was wearing helmet

MEDICAL ATTENDANCE

Name of attending physician: Dr. W. T. Matthews Address: Libby, Montana

Was employe hospitalized? Yes ☐ No ☒ Name of hospital ..... Address .....

Was first aid administered by someone other than attending physician? Yes ☐ No ☒

TIME AND WAGE LOSS

Will employe lose time from work due to accident? Yes ☐ No ☒ How long? .....

If injury results in time loss, will employee, while disabled, receive sick leave benefits? Yes ☐ No ☐

Paid vacation? Yes ☐ No ☐

Will employe lose wages? Yes ☐ No ☐ Room? Yes ☐ No ☐ Board? Yes ☐ No ☐

Date wage loss began: NONE Amount of weekly wage loss .....

EMPLOYER

Name of employer: Zonolite Division-W.R.Grace & Co.

Address: Libby, Montana Nature of business: Mining & Milling Vermiculite

IS FIRM A CORPORATION ☒ OR PARTNERSHIP ☐ OR INDIVIDUAL ☐

IF
- Corporation—is injured employee an officer or director of corporation? Yes ☐ No ☒
- Partnership—is injured employee related to any partner? Yes ☐ No ☐ Relationship .....
- Individual—is injured employee related to employer? Yes ☐ No ☐ Relationship .....

Signed, this 28th day of June 19 68

Employer's Name: Zonolite Division-W.R.Grace & Co.

Signed by .....

at Libby Montana

Official Title .....

Carrier

Firm No.

File No.

Major Industry

County

Date of Acc.

Time

Sex & Marital Status

Age

Mont. Code

Acc. Class

Occupation

Type

Agency

Agency Part

Nature of Inj.

Location

Time Loss

Mech. Defect

Unsafe Act

Pers. Factor

Weekly Wage

NOTICE—EMPLOYEE'S CLAIM FOR COMPENSATION, FORM 54, MUST BE FILED WITHIN 12 MONTHS FROM DATE OF ACCIDENT

Form 1-HU-163-ZR

C0080020

WRG00299031

ED_005351_00000355-00134

MEDICAL
Schoonmaker, Edward

C0080019

06063171

0

Industrial Accident Board

HELENA, MONTANA

Firm No.....

File No.....

EMPLOYER'S FIRST REPORT OF INJURY

INSTRUCTIONS—Employer must complete form at once after every accident which causes loss of time from work or requires medical attention and mail it to the Industrial Accident Board, Helena, Montana. Form must be signed in pen and ink. ALL QUESTIONS MUST BE ANSWERED FULLY.

INJURED EMPLOYEE

Full name of injured employee: Edward Schoonmaker Occupation: Construction worker

Mailing address: 619 Minnesota (Street) Libby (City) How long has he been in your employ? 12 yr.

Social Security No.: 550-40-3497 Sex: M Age: 35 Married ☒ Single ☐

EARNINGS

Monthly Wage..... Weekly Wage..... Daily Wage..... Hourly Wage: 3.15

Receive board Yes ☐ No ☒ Daily Value..... Receive room Yes ☐ No ☒ Daily Value.....

Piece Worker Yes ☐ No ☒ If yes, price per unit at piece work..... Hours worked per day: 8

Days worked per week: 6 Employee's pay period? Monthly ☐ Semi-monthly ☒ Weekly ☐ List employee's earnings last 4 pay periods 1. 302.40 2. 355.95 3. 226.80 4. 280.35

List Payroll Classification and Code under which employee's wages were reported..... (Sawmill - Mechanic - Etc.) Code..... (2702, 3506, 8810)

ACCIDENT AND INJURY

Describe in full how accident happened and GIVE CAUSE: While working with construction crew in mine area got vermiculite dust in left eye.

Nature or extent of injury: foreign material (Cut - Fracture) Part of body injured? left eye (Leg - Arm - Back - Head)

Names of witnesses to accident 1..... 2.....

Date of accident: 3-24- 19 69 Hour: 10 A. M. P. M. Was employee injured in course of employment? Yes ☒ No ☐

Place where accident occurred: our mine, 9 miles north of Libby (Address) (City) Lincoln (County)

Did you or employee's supervisor have actual knowledge of accident? Yes ☒ No ☐

Were you notified of accident by injured employee? Yes ☒ No ☐ How: In person Date: 3-24-69

Have you reason to question this accident? Yes ☐ No ☒ If "yes" explain fully.....

SAFETY

Was employee's accident due to unsafe work practice? Yes ☐ No ☒ If "yes", what did he do unsafely?.....

Was a specific device, object or substance involved in accident? Yes ☐ No ☐ If "yes", name specific device, object or substance..... Was device or object defective? Yes ☐ No ☐

Was employee doing regular work when injured? Yes ☒ No ☐ Was employee trained to do work he was doing when injured? Yes ☒ No ☐ Were adequate safeguards provided? Yes ☐ No ☐ If "yes", were they being used at the time of accident? Yes ☐ No ☐

MEDICAL ATTENTION

Name of attending physician: Dr. W. T. Matthews Address: Libby, Montana

Was employee hospitalized? Yes ☐ No ☒ Name of hospital..... Address.....

Was first aid administered by someone other than attending physician? Yes ☐ No ☒

TIME AND WAGE LOSS

Will employee lose time from work due to accident? Yes ☐ No ☒ How long? none If injury results in time loss will employee, while disabled, received sick leave benefits? Yes ☐ No ☐ Paid vacation? Yes ☐ No ☐ Will employee lose wages? Yes ☐ No ☐ Room? Yes ☐ No ☐ Board? Yes ☐ No ☐

Date wage loss began: NONE Amount of weekly wage loss.....

EMPLOYER

Name of employer: Zonolite Division-W.R.Grace & Co.

Address: Libby, Montana Nature of Business: Mining & Milling Vermiculite

IS FIRM A CORPORATION ☒ OR PARTNERSHIP ☐ OR INDIVIDUAL ☐

IF
- Corporation—is injured employee an officer or director of corporation? Yes ☐ No ☒
- Partnership—is injured employee related to any partner? Yes ☐ No ☐ Relationship.....
- Individual—is injured employee related to employer? Yes ☐ No ☐ Relationship.....

Signed, this 5th day of May, 19 69

at Libby, Montana

Employer's Name: Zonolite Division-W.R.Grace & Co.

Signed by.....

Official Title.....

NOTICE—EMPLOYEE'S CLAIM FOR COMPENSATION, FORM 54, MUST BE FILED WITHIN 12 MONTHS FROM DATE OF ACCIDENT.

C0080024

WRG00299037

ED_005351_00000355-00136

MEDICAL
Schoonmaker, Edward

C0080019

06063183

Industrial Accident Board, Helena, Montana, Form 37 Revised

AMERICAN CASUALTY COMPANY OF READING, PENNSYLVANIA

Industrial Accident Board

HELENA, MONTANA

DO NOT WRITE IN THIS SPACE

Firm No.....

File No.....

EMPLOYER'S FIRST REPORT OF INJURY

INSTRUCTIONS—Employer must complete form at once after every accident which causes loss of time from work or requires medical attention and mail it to the Industrial Accident Board, Helena, Montana. Form must be signed in pen and ink. ALL QUESTIONS MUST BE ANSWERED FULLY.

INJURED EMPLOYEE

Full name of injured employee Edward Schoonmaker Occupation Construction Worker

Mailing address 619 Minnesota, Libby How long has he been in your employ 1 year

Social Security No. 590-40-3497 Sex M Age 35 Married ☒ Single ☐

EARNINGS

Monthly Wage..... Weekly Wage..... Daily Wage..... Hourly Wage 3.15

Receive board Yes ☐ No ☒ Daily Value..... Receive room Yes ☐ No ☒ Daily Value.....

Piece Worker Yes ☐ No ☒ If yes, give method of computing earnings.....

Number of hours worked per day 8 Days worked per week 6 Employee's pay period?

Monthly ☐ Semi monthly ☐ Weekly ☒ List employee's earnings last 4 pay periods 1 279.20

2 321.30 3 258.30 4 320.00

Under what payroll classification has employees' wages been reported?..... (Sawmill - Mechanic - Etc.)

ACCIDENT AND INJURY

Describe in full how accident happened and GIVE CAUSE Construction crew was setting poles in ground. Employee was in hole about 8 feet deep and when they cut the reinforcing steel, 1 angle brace weighting about 20 lbs. fell across his back.

Part of body injured? Describe fully ribs and back

Names of witnesses to accident 1..... 2.....

Date of accident 3-27-69 19..... Hour 2 Was employee injured in course of employment? Yes ☒ No ☐

Place where accident occured our mill area, 9 miles north of Libby (Address) (City) Lincoln (County)

Did you or employee's supervisor have actual knowledge of accident? Yes ☒ No ☐

Were you notified of accident by injured employee? Yes ☒ No ☐ How In person Date 3-12-69

Have you reason to question this accident? Yes ☐ No ☒ If "yes" explain fully.....

SAFETY

Was employee's accident due to unsafe work practices? Yes ☐ No ☒ If "yes", what did he do unsafely?

Was a specific device, object or substance involved in accident? Yes ☒ No ☐ If "yes", name specific device, object or substance angle iron Was device or object defective? Yes ☐ No ☒

Was employee doing regular work when injured? Yes ☒ No ☐ Was employee trained to do work he was doing when injured? Yes ☒ No ☐ Were adequate safe guards provided? Yes ☐ No ☐ If "yes" were they being used at time of accident? Yes ☐ No ☐

MEDICAL ATTENDANCE

Name of attending physician Dr. W. T. Matthews Address Libby, Montana

Was employe hospitalized? Yes ☐ No ☒ Name of hospital St. Johns for X-ray Address Libby

Was first aid administered by someone other than attending physician? Yes ☐ No ☒

TIME AND WAGE LOSS

Will employe lose time from work due to accident? Yes ☐ No ☒ How long? None

If injury results in time loss, will employee, while disabled, receive sick leave benefits? Yes ☒ No ☐

Paid vacation? Yes ☐ No ☐

Will employe lose wages? Yes ☐ No ☒ Room? Yes ☐ No ☒ Board? Yes ☐ No ☒

Date wage loss began None Amount of weekly wage loss.....

EMPLOYER

Name of employer Zonolite Division-W.R.Grace & Co.

Address Libby, Montana Nature of business Mining & Milling Vermiculite

IS FIRM A CORPORATION ☒ OR PARTNERSHIP ☐ OR INDIVIDUAL ☐

IF
- Corporation—is injured employee an officer or director of corporation? Yes ☐ No ☒
- Partnership—is injured employee related to any partner? Yes ☐ No ☐ Relationship.....
- Individual—is injured employee related to employer? Yes ☐ No ☐ Relationship.....

Signed, this 17th day of March 19 69

at Libby Montana

Employer's Name Zonolite Division-W.R.Grace & Co.

Signed by.....

Official Title.....

Carrier

Firm No.

File No.

Major Industry

County

Date of Acc.

Time

Sex & Marital Status

Age

Mont. Code

Acc. Class

Occupation

Type

Agency

Agency Part

Nature of Inj.

Location

Time Loss

Mech. Defect

Unsafe Act

Pers. Factor

Weekly Wage

NOTICE—EMPLOYEE'S CLAIM FOR COMPENSATION, FORM 54, MUST BE FILED WITHIN 12 MONTHS FROM DATE OF ACCIDENT

Form 1-HU-163-ZR

C00B0025

WRG00299039

ED_005351_00000355-00138

Medical
Schulke, Earl L.

C00B0026

ACCIDENT INVESTIGATION REPORT

INDUSTRIAL CHEMICALS GROUP
W. R. Grace & Co.

Plant Libby Lost Time Case ____

Division Const. Prod. Div. Not Lost Time Case ✓ (Check one)

All accidents involving lost time from work or the services of a physician must be investigated and the report completed within 48 hours by the injured employee's supervisor. Forward one copy of report to office of Safety Administrator.

1. Name of injured employee EARL L Schulke
2. Department Labor pool Date of Hire 8-8-76
3. Job Title Labor Was he doing regular job? Yes ✓ No ____
4. Date and time of injury 4-13-77 3PM -
5. Date and time injury reported 4-14-77 NOON -
6. Injured employee is: Salaried ____ Hourly ✓ Male ✓ Female ____

   Under 25 years ____ 25 to 34 ____ 35 to 49 ____ 50 and over ✓
7. Describe in detail what employee was doing at time of injury: include reference to any tools, machines and materials involved: Hold ing IRON IN position For the welder to weld (in the sheet metal shop.)
8. Describe injury: welding Flash
9. What medical action was taken? eye drops & pain pills.
10. What, in your opinion, was the basic cause of this accident?

    Unsafe Act ✓ Unsafe Condition ____ Explain didn't Cover the side OF his eye.

C0080027

~~WRG00299041~~

ED_005351_00000355-00140

11. What were the contributing causes? Hurring, and Taking time to cover his eyes properly

12. What action have you taken and/or are you planning to take to avoid a recurrence of this accident? will use in our safety meeting

13. Have you counselled your other employees regarding lessons to be learned from this accident?

Yes ____ No ____ if not, why will at our meeting.

14. Have you scheduled any maintenance work or planned any disciplinary action with the accident?

Yes ____ No ✓ Comments, if any: _____

4-18-77

(Signed) [signature] (Supervisor) Date 4/18/77 Plant Libby

****

You have now completed answering some very important questions regarding an injury to one of your employees. Take the time to think carefully and ask yourself the following two questions:

a) How long did I take to think out and complete the answers to the questions above?
b) Have I really taken enough time, given enough thought, to a subject which might very well mean the life of one of my employees at some future date?

****

This space reserved for Plant Managers

1. Have you discussed this injury with .....

the supervisor concerned? Yes ____ No ____
all members of your supervisory group? Yes ____ No ____

2. Do you have any comments to add to the statements by the Foreman?

_____

_____

(Plant Manager) (Date)

Form 65-25

C0080028

Complied with 82—1137 R.C.M.

MONTANA DIVISION OF WORKERS' COMPENSATION

815 Front Street
Helena, Montana 59601

4-25-77

SEND ORIGINAL TO INSURER

EMPLOYER'S FIRST REPORT of Occupational Injury or Occupational Disease

Employee Copy

CASE NUMBER

FIRM NUMBER 2503

INSTRUCTIONS - Every employer in Montana is required by law to complete this form immediately after every accident to an employee which arises out of and in the course of employment, and which causes loss of time from work or requires medical attention. The original of this form must be immediately filed with the employer's insurer or the Division of Workers' Compensation, 815 Front Street, Helena, Montana 59601. All questions must be answered fully. If a question cannot be answered, please explain why. **Please print with a ball point pen or type.**

FEDERAL OSHA REQUIREMENTS - The United States Department of Labor requires employers to maintain, in the employer's office, a record of occupational injuries. For the employer's convenience, this form has been designed to meet such requirements and to provide employers a record copy.

EMPLOYEE

Full Name of INJURED EMPLOYEE: Earl L. Schulke

Social Security Number: 477-40-8014

EMPLOYEE'S Home Address (Street or Box): Rt. 1

City: Libby

State: Mt.

Zip Code: 59923

Occupation: Laborer

Sex: M

Age: 57

Marital Status: [X] Married [ ] Single

Length of time in your Employment: 8 Months

Department where regularly employed: Labor Pool

Date of Birth (mo.) 3 / (day) 17 / (yr.) 20

WAGES

Employee's Gross Wage Rate is $ 5.465 per [ ] week, or [ ] day or [X] hour, or [ ] month

Days Worked Per Week: 5

Hours Worked Per Day: 8

If board or room is furnished state value reported per day to Internal Revenue Service $

Check One— [X] Full Time Employee [ ] Part Time Employee

Payroll Classification under which employee's wages were reported: Common Labor

Employee's gross earnings for last four (4) pay periods (Date / Amount): 2/20/77 437.20; 3/5/77 505.58; 3/20/77 466.00; 4/5/77 223.24

Employee's pay period: [ ] Monthly [X] Semi-monthly [ ] Bi-Weekly [ ] Weekly [ ] Other

ACCIDENT INFORMATION

Describe in full detail how accident happened, and give cause - Explain what employee was doing when injured.

Employee was holding piece of iron in position for the welder to weld. Received a welding flash in right eye.

What specific object or substance caused the injury? Welder

Nature of the injury? (cut, fracture, etc.) Welding flash in right eye

Part of body affected (leg, arm, back, head, etc.): Right eye

DATE OF INJURY (month) April (day) 13, (year) 1977 (hour) 3:00 (a.m. or p.m.) p.m.

Names of witnesses to accident: 1. Harry Ostheller 2. Richard Hermsmeyer

Place where accident occurred (address & city): 12 Mi. North of Libby, Montana (county) Lincoln

Was place of accident on employer's premises? Yes [X] No [ ]

Was employee injured while in your employ? Yes [X] No [ ]

Were you notified, or did you have actual knowledge of the accident? Yes [X] No [ ]

If yes, date notified & how: 4/13/77, Supervisor

Do you have any reason to question this accident? [ ] Yes [X] No

If yes, please explain fully

MEDICAL

Attending physician name and address: James F. Graham, M.D., Libby, Montana 59923

If hospitalized, hospital's name and address

Will employee return to work during next scheduled shift? Yes [X] No [ ]

If no, will wage loss exceed 7 days? Yes [ ] No [ ] Not Sure [ ]

Date wage loss began (mo) / (day) / (yr.)

Date of return, if returned to work (mo.) / (day) / (yr.)

EMPLOYER

EMPLOYER'S NAME: W. R. Grace & Co.

Commercial Name (doing business as)

Employer's mailing address (Street or Box): Box 609 (City) Libby (State) Montana (Zip Code) 59923

Phone number: 293-4131

Location of operation, if different from mailing address: 12 Miles North of Libby, Montana

Nature of business: Mining

Firm is a: (Check one) [ ] Sole proprietorship [ ] Partnership, or [X] Corporation

Was the Injured employee? (Check if applicable) [ ] A Sole Proprietor, [ ] A working Partner, [ ] A Corporate Officer, or [ ] A member of the employer's (sole proprietor or partner) family, dwelling in the employer's household.

Prepared by: Darlene Myhre

Authorized Signature: X

Official Title: Administrative Assistant

Date: 4/25/77

DWC USE ONLY

OCCUPATION | SEX | AGE | MARITAL STATUS | COUNTY | LENGTH (YRS) EMPLOYED | WEEKLY EARNINGS | CLASS CODE | ACCIDENT TYPE | SOURCE OF INJURY | PART OF BODY INJURED | O S H A RECORDABLE CODE | DISABILITY TYPE | NATURE OF INJURY | HAZARDOUS CONDITION | UNSAFE ACT

Above - DWC-MIS Form 37-Employer's First Report (Rev. 1-76)

Below - DWC-MIS Form 54A-Claim for Compensation

EMPLOYEE'S CLAIM FOR COMPENSATION

EMPLOYER'S NOTE: For convenience purposes and if the worker is available, the form below has been provided so that an employer may allow an injured worker to file a claim for compensation on this form to avoid having the employee fill out and file a separate detailed form. Separate claim forms are available if the employer does not want the worker to use this form. **Do not delay in submission of this form if employee is not available to sign below.**

INJURED EMPLOYEE'S NOTE: An injured employee may use the form below to make a claim for compensation, or the employee may fill out and submit a separate detailed form that is available from the Division.

I have carefully read the above information as documented by the employer, and (except for any statements I may write below) I concur with the information and I hereby make claim for compensation benefits due me now or in the future under Montana's Workers' Compensation Act.

Signature of injured employee X | Address | City | Date | Phone

I DO NOT concur with the following information documented by the employer

C0080029

Filing of this claim is authorization for release of medical records and records of the Social Security Administration

Medical
Schulke, Earl L.

C00B0026

WRG00299044

ED_005351_00000355-00143

ACCIDENT INVESTIGATION REPORT

INDUSTRIAL CHEMICALS GROUP
W. R. Grace & Co.

Plant Libby - Minesite Lost Time Case X

Division Construction Products Division Not Lost Time Case _____
(Check one)

All accidents involving lost time from work or the services of a physician must be investigated and the report completed within 48 hours by the injured employee's supervisor. Forward one copy of report to office of Safety Administrator.

C0080030

1. Name of injured employee Earl Shulke (660)
2. Department Labor Pool - On-Lone to Mine Date of Hire 8-9-76
3. Job Title Laborer Was he doing regular job? Yes X No _____
4. Date and time of injury 12/8/81 Approximately 3:20 PM
5. Date and time injury reported 12/8/81 Approximately 3:35 PM
6. Injured employee is: Salaried _____ Hourly X Male X Female _____

   Under 25 years _____ 25 to 34 _____ 35 to 49 _____ 50 and over X
7. Describe in detail what employee was doing at time of injury: include reference to any tools, machines and materials involved: Earl Shulke was responsible for shoveling stemming material (Pyroxene sand) from the bucket of the BobCat. Ed Nixon was the operator of the Bobcat at the time. When Ed tipped the bucket slightly forward so that Earl could shovel the stemming o the Bobcat become unbalanced and tilted forward. The ed of the bucket hit Earl's left knee cap.
8. Describe injury: The left knee was slightly swollen, no blood was observe at the time of the accident as Earl was wearing long johns.
9. What medical action was taken? Earl said that his knee was sore but that he could continue work. That night the knee swelled and Earl discovered that the skin had been broken
10. What, in your opinion, was the basic cause of this accident?

    Unsafe Act X Unsafe Condition X Explain Earl Shulke sho not have been as close to the bobcat as he was. Ed Nixon had complained that the bobcat should have o

11. What were the contributing causes? See above.

12. What action have you taken and/or are you planning to take to avoid a recurrence of this accident? I have talked to Mike Ray about a counterweight and Ed Nixon is now lowering the Bobcat bucket almost to the ground before tipping it.

13. Have you counselled your other employees regarding lessons to be learned from this accident?

Yes X No ___ if not, why I have talked with everyone on the loading crew.

14. Have you scheduled any maintenance work or planned any disciplinary action with the accident?

Yes ___ No X Comments, if any: I have spoken with Mike Ray about the possibility of adding a counterweight to the bobcat

(Signed) [illegible] (Supervisor) Date 12/9/81 Plant Libby - Mine

****

You have now completed answering some very important questions regarding an injury to one of your employees. Take the time to think carefully and ask yourself the following two questions:

a) How long did I take to think out and complete the answers to the questions above?
b) Have I really taken enough time, given enough thought, to a subject which might very well mean the life of one of my employees at some future date?

12-14-81 [illegible]

****

This space reserved for Plant Managers

1. Have you discussed this injury with .....

the supervisor concerned? Yes ___ No ___
all members of your supervisory group? Yes ___ No ___

2. Do you have any comments to add to the statements by the Foreman?

(Plant Manager) (Date)

Form 65-25

C00B0031
WRG00299046
ED_005351_00000355-00145

MONTANA DIVISION OF WORKERS' COMPENSATION

815 Front Str[redacted] Helena, Montana 59601

EMPLOYER'S FIRST REPORT of Occupational Injury or Occupational Disease

DATE STAMP

SEND ORIGINAL TO INSURER:

CASE NO -

FIRM NO -

Employee Copy

INSTRUCTIONS - Every employer in Montana is required by law to complete this form immediately after every industrial accident to an employee which causes loss of time from work or requires medical attention. The original of this form must be immediately filed with the employer's insurer or the Division of Workers' Compensation, 815 Front Street, Helena, Montana 59601. All questions must be answered fully. If a question cannot be answered, please explain why.
Please print with a ball point pen or type.

FEDERAL OSHA REQUIREMENTS - The United States Department of Labor requires employers to maintain, in the employer's office, a record of occupational injuries. For the employer's convenience, this form has been designed to meet such requirements and to provide employers a record copy.

EMPLOYEE

FULL NAME OF INJURED EMPLOYEE | PHONE | SOCIAL SECURITY NUMBER

EMPLOYEE'S HOME ADDRESS (Street or Box) | CITY | STATE | ZIP CODE

OCCUPATION | SEX | DATE OF BIRTH (Mo / Day / Yr) / / | MARITAL STATUS ☐ Married ☐ Single | LENGTH OF TIME IN YOUR EMPLOYMENT

WAGES

Employee's Gross Wage Rate is $ Per WEEK ☐ DAY ☐ HOUR ☐ MO. ☐ | Days Worked Per Week | Hours Worked Per Day | If board or room is furnished state value reported per day to Internal Revenue Service $

Check one - ☐ Full Time Employee ☐ Part Time Employee | Payroll Classification under which employee's wages were reported | Employee's Pay Period: Monthly, ☐ Semi-monthly, ☐ Bi-weekly, ☐ Weekly, ☐ Other (explain) ☐ | Regular Days Off

Employee's gross earnings for last four (4) pay periods - (Date / Amount) (Date / Amount) (Date / Amount) (Date / Amount)

Will employee return to work during next scheduled shift? Yes ☐ No ☐ | If no, will employee lose more than 5 days wages? Yes ☐ No ☐ Not Sure ☐ | DATE WAGE LOSS BEGAN (Mo / Day / Yr) / / | DATE OF RETURN, if returned to work (Mo / Day / Yr) / /

ACCIDENT INFORMATION

Describe in full detail how accident happened, and give cause - Explain what employee was doing when injured.

DATE OF INJURY (month) 12 (day) (year) (hour) (a.m. or p.m.) | What specific object or substance caused the injury?

Nature of the injury? (cut, fracture, etc.) | Part of body affected (leg, arm, back, head, etc.)

Names of witnesses to accident
1. 2.

Was place of accident on employer's premises? Yes ☐ No ☐ | Place where accident occurred (address & city) (county)

Was employee injured while in your employ? Yes ☐ No ☐ | *Were you notified, or did you have actual knowledge of the accident?* Yes ☐ No ☐ | *If yes, date notified & how*

Do you have any reason to question this accident? ☐ Yes ☐ No | If yes, please explain fully

C0080032

MEDICAL

Attending Physician's Name | PHONE | Address (Street or Box) | (City) | (State) | (Zip Code)

If Hospitalized, Hospital's Name | Address (Street or Box) | (City) | (State) | (Zip Code)

EMPLOYER

EMPLOYER'S NAME | Commercial Name (doing business as)

Employer's mailing address (street or box) | (City) | (State) | (Zip Code) | Phone Number

Location of operation, if different from mailing address | Nature of Business

Firm is a: (Check one) ☐ *Sole proprietorship* ☐ *Partnership, or* ☐ *Corporation* | Was the injured employee? (Check if applicable) ☐ *A Sole Proprietor,* ☐ *A working Partner,* ☐ *A Corporate Officer, or* ☐ *A member of the employer's (sole proprietor or partner) family, dwelling in the employer's household.*

Prepared by: | Authorized Signature | Official Title | Date

ABOVE - DWC - MIS Form 37 - Employer's First Report (Rev. 6-78)

~~BELOW - DWC - MIS Form 54 - Claim for Compensation~~

EMPLOYEE'S CLAIM FOR COMPENSATION

EMPLOYER'S NOTE: For convenience purposes and if the worker is available, the form below has been provided so that an employer may allow an injured worker to file a claim for compensation on this form to avoid having the employee fill out and file a separate detailed form. Separate claim forms are available if the employer does not want the worker to use this form. ***Do not delay in submission of this form if employee is not available to sign below.***

EMPLOYEE'S CLAIM FOR COMPENSATION

INJURED EMPLOYEE'S NOTE: An injured employee may use the form below to make a claim for compensation, or the employee may fill out and submit a separate detailed form that is available from the Division.

List other types of work you have done
1. 2. 3.

Education ☐ Grade School ☐ High School ☐ College ☐ Other _____ | How many members are in your immediate family?

Have you ever had an industrial injury before? Yes ☐ No ☐ | If yes, in what state? | Type of injury

I have carefully read the information as documented by the employer, and (except for any statements I may write below) I concur with the information and I hereby make claim for compensation benefits due me now or in the future under Montana's Workers' Compensation Act.

Signature of injured employee | Address | City | Date | Phone

X

I DO NOT concur with the following information documented by the employer _____

X Filing of this claim is authorization for release of medical records and records of the Social Security Administration

U. S. Department of Labor
Mine Safety and Health Administration

Form Approved, OMB No. 044-R1665, Expires December 1982.

Section A – Identification Data

MSHA ID Number: 2400165
Contractor I.D.:
Report Category: [X] Metal/Nonmetal Mining [ ] Coal Mining
[ ] Check here if report pertains to contractor.
Mine Name: Zonolite
Company Name: W. R. Grace & Co.

Section B – Complete for Each Reportable Accident Immediately Reported to MSHA

1. Accident Code (circle applicable code – see instructions) 01 – Death 02 – Serious Injury 03 – Entrapment 04 – Inundation 05 – Gas or Dust Ignition 06 – Mine Fire 07 – Explosives 08 – Roof Fall 09 – Outburst 10 – Impounding Dam 11 – Hoisting 12 – Offsite Injury
2. Name of Investigator
3. Date Investigation Started: Month / Day / Year
4. Steps Taken to Prevent Recurrence of Accident

Section C – Complete for Each Reportable Accident, Injury or Illness

5. Circle the Codes Which Best Describe Where Accident/Injury/Illness Occurred (see instructions)
(a) Surface Location: 02 Surface at Underground Mine 30 Mill, Preparation Plant, etc. (03 Strip/Open Pit Mine 04 Surface Auger Operation 05 Culm Bank/Refuse Pile 06 Dredge Mining 12 Other Surface Mining 17 Independent Shops (with own MSHA ID) 99 Office Facilities
(b) Underground Location: 01 Vertical Shaft 02 Slope/Inclined Shaft 03 Face 04 Intersection 05 Underground Shop/Office 06 Other
(c) Underground Mining Method: 01 Longwall 02 Shortwall 03 Conventional Stoping 05 Continuous Miner 06 Hand 07 Caving 08 Other

6. Date of Accident: Month 12 / Day 08 / Year 81
7. Time of Accident: 3:00 [ ] am [X] pm
8. Time Shift Started: 8:00 [X] am [ ] pm
9. Describe Fully the Conditions Contributing to the Accident/Injury/Illness, and Quantify the Damage or Impairment

Employee was hoveling sand from bucket of Bobcat to stem blast holes. The Bobcat became unbalanced, tipped forward and hit Schulke in Left Knee cap.

10. Equipment Involved: Bobcat Loader
Type:
Manufacturer: Clark
Model Number: 610
11. Name of Witness to Accident/Injury/Illness: Ed Nixon
12. Number of Reportable Injuries or Illnesses Resulting from This Occurrence: 1
13. Name of Injured/Ill Employee: Earl Schulke
14. Sex: [X] Male [ ] Female
15. Date of Birth: Month 3 / Day 17 / Year 20
16. Last Four Digits of Social Security Number: 8014
17. Regular Job Title: Laborer
[ ] 18. Check if this Injury/Illness resulted in death.
[ ] 19. Check if Injury/Illness resulted in permanent disability (include amputation, loss of use, & permanent total disability).
20. What Directly Inflicted Injury or Illness? Bobcat Loader Bucket
21. Nature of Injury or Illness: Bruise
22. Part of Body Injured or Affected: Left Knee
23. Occupational Illness (circle applicable code – see instructions) 21 Occupational Skin Diseases 22 Dust Diseases of the Lungs 23 Respiratory Conditions (toxic agents) 24 Poisoning (toxic materials) 25 Disorders (physical agents) 26 Disorders (repeated trauma) 29 Other
24. Employee's Work Activity When Injury or Illness Occurred: Stemming Drill Holes

Experience	Years	Weeks
25. Experience in This Job Title	5	13
26. Experience at This Mine	5	13
27. Total Mining Experience		

Section D – Return to Duty Information *Answer 30 & 31 when case is closed*

[ ] 28. Permanently Transferred or Terminated (if checked, complete items 29, 30 & 31)
29. Date Returned to Regular Job at Full Capacity (or item 28): Month 12 / Day 14 / Year 81
30. Number of Days Away from Work (if none, enter 0): 3
31. Number of Days Restricted Work Activity (if none, enter 0): 0

Person Completing Form (name): Earl D. Loyick
Title: Manager of Administration
Date This Report Prepared (month, day, year): 2-09-82
Area Code and Phone Number: 406-293-4131

MSHA Form 7000-1, Feb. 80 (revised)

For Official Use Only
Degree
Accident Type
Accident Class
Scheduled Charge
Keyword

C0080033
WRG00299048

 RETAIN THIS COPY AT THE MINE (OR NEAREST MINE OFFICE) FOR 5 YEARS

Medical
Schulke, Earl L.

C00B0026

WRG00299049
ED_005351_00000355-00148

GRACE

INCIDENT INVESTIGATION REPORT
PERSONAL INJURY/PROPERTY DAMAGE

NUMBER OF DAYS AWAY FROM WORK: 0

NUMBER OF RESTRICTED WORK DAYS: 0

DIVISION/PLANT: CPD/Libby

PLANT LOCATION (City/State): Libby, MT

INJURY NUMBER (From OSHA 200 Log): —

LOCATION OF INCIDENT: Wet Mill - 7th Floor

COMPANY PREMISES: ☒ YES ☐ NO

TIME OF INCIDENT: 2355 AM ☐ PM ☒

DATE OF INCIDENT: 1 | 13 | 83

INJURED OR ILL

NAME (FIRST): EARL (MIDDLE): L. (LAST): Schulke

SOC SEC NO: 477-40-8014

SEX: ☒ MALE ☐ FEMALE

MARITAL STATUS: ☐ MARRIED ☒ SINGLE

DATE OF BIRTH: 3 | 17 | 20

ACCIDENT CATEGORY: ☐ DAYS AWAY FROM WORK ☒ MEDICAL TREATMENT ☐ RESTRICTED WORK ☐ FIRST AID

OCCUPATION: Shift Millwright

LENGTH OF EMPLOYMENT	YEARS	MONTHS	LENGTH OF PRESENT OCC.	YEARS	MONTHS
	6	9		1	2

SHIFT: ☒ REG. ☐ OVERTIME

NATURE OF INJURY/PARTS OF BODY AFFECTED: Bruised Rt. Kidney

DATES OF PREVIOUS INJURIES: 12-8-81

WHAT FIRST AID: None

WHERE GIVEN: N/A

BY WHOM: N/A

WHERE SENT ☐ HOSPITAL (Name and Address) ☐ HOME ☐ OTHER (Specify)

Employee Completed his shift and went to Doctor on 1-14-83

NAME AND ADDRESS OF ATTENDING PHYSICIAN

Dr. Rodgea Bros
Box 630
Libby, MT 59923

PROPERTY DAMAGE (est. dollar value): N/A

LOST PRODUCTION (Hours, days, tons) AND ESTIMATED VALUE: N/A

LOSS TYPE (explosion, fire, wind)/IDENTIFY PROPERTY DAMAGED: N/A

(NEAR MISS) NATURE OF INCIDENT/DOLLAR COST (if applicable): N/A

DESCRIBE EVENTS LEADING TO INCIDENT/WORK IN PROGRESS/STAGE OF PROCESS/ACTUAL ACTS OF INJURED AND FELLOW EMPLOYEES

Injured was walking down short flight of metal steps from platform around 1/4 inch Roll Screens on 7th. floor of wet mill. When he stepped onto the wet concrete floor he slipped and fell, hitting the Rt. side of his back on a flange. This bruised his kidney.

C0080034

73-119(Rev. 6/82)

ACCIDENT INVESTIGATION REPORT

INDUSTRIAL CHEMICALS GROUP
W. R. Grace & Co.

Plant _____ Lost Time Case _____

Division _____ Not Lost Time Case _____
(Check one)

All accidents involving lost time from work or the services of a physician must be investigated and the report completed within 48 hours by the injured employee's supervisor. Forward one copy of report to office of Safety Administrator.

1. Name of injured employee Earl Schulke
2. Department Mill Date of Hire 8/9/76
3. Job Title Mill Mechanic Was he doing regular job? Yes ✓ No ____
4. Date and time of injury 1/13/83 1155 PM
5. Date and time injury reported 1/14/83 · 1200 AM
6. Injured employee is: Salaried ____ Hourly ✓ Male ✓ Female ____

   Under 25 years ____ 25 to 34 ____ 35 to 49 ____ 50 and over ✓
7. Describe in detail what employee was doing at time of injury: include reference to any tools, machines and materials involved:

   Employee was walking down North end of stairs off the 7th floor 1/4" roll screen when he stepped on the concrete floor and slipped and fell. He hit his back on a pipe flange.
8. Describe injury: Right side of back (Kidney area) was struck
9. What medical action was taken? Employee plans to see a doctor following graveyard shift
10. What, in your opinion, was the basic cause of this accident?

    Unsafe Act (✓)? Unsafe Condition ____ Explain The floor was clean and wet as usually. Employee was semi careless.

C00B0036
WRG00299051
ED_005351_00000355-00150

11. What were the contributing causes? Wet floor and a less than careful employee.

12. What action have you taken and/or are you planning to take to avoid a recurrence of this accident? Crew has been advised about slipping hazards

13. Have you counselled your other employees regarding lessons to be learned from this accident?

Yes ____ No ____ if not, why _____

14. Have you scheduled any maintenance work or planned any disciplinary action with the accident?

Yes ____ No ____ Comments, if any: _____

(Signed) J K Mudge (Supervisor) Date 1/14/83 Plant _____

****

You have now completed answering some very important questions regarding an injury to one of your employees. Take the time to think carefully and ask yourself the following two questions:

a) How long did I take to think out and complete the answers to the questions above?
b) Have I really taken enough time, given enough thought, to a subject which might very well mean the life of one of my employees at some future date?

****

This space reserved for Plant Managers

1. Have you discussed this injury with .....

the supervisor concerned? Yes ____ No ____
all members of your supervisory group? Yes ____ No ____

2. Do you have any comments to add to the statements by the Foreman?

_____

_____

(Plant Manager) (Date)

Form 65-25

C00B0037

WRG00299052

ED_005351_00000355-00151

MONTANA DIVISION OF WORKERS' COMPENSATION

815 Front Street, Helena, Montana 59601

EMPLOYER'S FIRST REPORT of Occupational Injury or Occupational Disease

DATE STAMP

SEND ORIGINAL TO INSURER:

CASE NO -

FIRM NO -

Employer Copy

INSTRUCTIONS - Every employer in Montana is required by law to complete this form immediately after every industrial accident to an employee which causes loss of time from work or requires medical attention. The original of this form must be immediately filed with the employer's insurer or the Division of Workers' Compensation, 815 Front Street, Helena, Montana 59601. All questions must be answered fully. If a question cannot be answered, please explain why.
Please print with a ball point pen or type.

FEDERAL OSHA REQUIREMENTS - The United States Department of Labor requires employers to maintain, in the employer's office, a record of occupational injuries. For the employer's convenience, this form has been designed to meet such requirements and to provide employers a record copy.

EMPLOYEE

FULL NAME OF INJURED EMPLOYEE: Earl L. Schulke
PHONE: 293-7005
SOCIAL SECURITY NUMBER: 477-40-8014
EMPLOYEE'S HOME ADDRESS (Street or Box): Star Rt. 1 Box 38
CITY: Libby
STATE: MT
ZIP CODE: 59923
OCCUPATION: Millwright
SEX: M
DATE OF BIRTH (Mo / Day / Yr): 3 / 17 / 20
MARITAL STATUS: [ ] Married [X] Single
LENGTH OF TIME IN YOUR EMPLOYMENT: 6 years

WAGES

Employee's Gross Wage Rate is $ 10.39 Per WEEK [ ] DAY [ ] HOUR [X] MO. [ ]
Days Worked Per Week 5
Hours Worked Per Day 8
If board or room is furnished state value reported per day to Internal Revenue Service $
Check one - [X] Full Time Employee [ ] Part Time Employee
Payroll Classification under which employee's wages were reported
Employee's Pay Period: Monthly, [ ] Semi-monthly, [X] Bi-weekly, [ ] Weekly, [ ] Other (explain) [ ] Regular Days Off
Employee's gross earnings for last four (4) pay periods (Date / Amount) (Date / Amount) (Date / Amount) (Date / Amount)
Will employee return to work during next scheduled shift? Yes [X] No [ ]
If no, will employee lose more than 5 days wages? Yes [ ] No [X] Not Sure [ ]
DATE WAGE LOSS BEGAN (Mo / Day / Yr): 1X / 14 / 83
DATE OF RETURN, if returned to work (Mo / Day / Yr): ~~[illegible]~~

ACCIDENT INFORMATION

Describe in full detail how accident happened, and give cause - Explain what employee was doing when injured.

He was walking off the north side of the 7th floor 1/4" roll screens and his foot hit the cement and he slipped and fell down. When he slipped he hit his right back side kidney on a piece of pipe that was sticking out of the floor about 4 inches.

DATE OF INJURY: (month) 1 (day) 14 (year) 83 (hour) 1:00 (a.m. or p.m.) a.m.
What specific object or substance caused the injury? pipe used for drainage
Nature of the injury? (cut, fracture, etc.) bruised kidney
Part of body affected (leg, arm, back, head, etc.) right kidney
Names of witnesses to accident: 1. Jerry Ledum (did not witness accident) 2. Richard Viereck
Was place of accident on employer's premises? Yes [X] No [ ]
Place where accident occurred (address & city): 12 Miles N.E. of Libby (county) Lincoln
Was employee injured while in your employ? Yes [X] No [ ]
Were you notified, or did you have actual knowledge of the accident? Yes [X] No [ ]
If yes, date notified & how: 1/14/83 called Ed Hendrickson date of injury
Do you have any reason to question this accident? [ ] Yes [X] No
If yes, please explain fully

MEDICAL

Attending Physician's Name: Dr. Brus
PHONE: 293-5945
Address (Street or Box): 111 E. Cedar
(City): Libby
(State): Montana
(Zip Code): 59923
If Hospitalized, Hospital's Name: St. Johns Lutheran Hospital (X-rays only)
Address (Street or Box):
(City): Libby
(State): Montana
(Zip Code): 59923

EMPLOYER

EMPLOYER'S NAME: V. R. Grace & Co.
Commercial Name (doing business as)
Employer's mailing address (street or box): P.O. Box 609
(City): Libby
(State): Montana
(Zip Code): 59923
Phone Number: 293-3746
Location of operation, if different from mailing address: 12 Miles Ne E. Of Libby
Nature of Business: Mining & Milling
Firm is a: (Check one) [ ] Sole proprietorship [ ] Partnership, or [X] Corporation
Was the injured employee? (Check if applicable) [ ] A Sole Proprietor, [ ] A working Partner, [ ] A Corporate Officer, or [ ] A member of the employer's (sole proprietor or partner) family, dwelling in the employer's household.
Prepared by: Alison Leader
Authorized Signature: [signature]
Official Title: Manager of Administration
Date: 1/14/83

ABOVE - DWC - MIS Form 37 - Employer's First Report (Rev.-6-78)
BELOW - DWC - MIS Form 54 - Claim for Compensation

EMPLOYEE'S CLAIM FOR COMPENSATION

EMPLOYER'S NOTE: For convenience purposes and if the worker is available, the form below has been provided so that an employer may allow an injured worker to file a claim for compensation on this form to avoid having the employee fill out and file a separate detailed form. Separate claim forms are available if the employer does not want the worker to use this form. **Do not delay in submission of this form if employee is not available to sign below.**

EMPLOYEE'S CLAIM FOR COMPENSATION

INJURED EMPLOYEE'S NOTE: An injured employee may use the form below to make a claim for compensation, or the employee may fill out and submit a separate detailed form that is available from the Division.

List other types of work you have done: 1. 2. 3.
Education: [ ] Grade School [ ] High School [ ] College [ ] Other
How many members are in your immediate family?
Have you ever had an industrial injury before? Yes [ ] No [ ]
If yes, in what state?
Type of injury

I have carefully read the information as documented by the employer, and (except for any statements I may write below) I concur with the information and I hereby make claim for compensation benefits due me now or in the future under Montana's Workers' Compensation Act.

Signature of injured employee: X [signature] Address City Date Phone

I DO NOT concur with the following information documented by the employer

C0080038

Filing of this claim is authorization for release of medical records and records of the Social Security Administration

Medical
Schulke, Earl L.

C0080026

ACCIDENT INVESTIGATION REPORT

INDUSTRIAL CHEMICALS GROUP
W. R. Grace & Co.

Plant Libby Lost Time Case ____

Division Const. prod. Div. Not Lost Time Case ✓ (Check one)

All accidents involving lost time from work or the services of a physician must be investigated and the report completed within 48 hours by the injured employee's supervisor. Forward one copy of report to office of Safety Administrator.

1. Name of injured employee EARL L Schulke
2. Department Labor pool Date of Hire 8-9-76
3. Job Title Labor Was he doing regular job? Yes ✓ No ____
4. Date and time of injury 4-13-77 3PM
5. Date and time injury reported 4-14-77 NOON
6. Injured employee is: Salaried ____ Hourly ✓ Male ✓ Female ____

   Under 25 years ____ 25 to 34 ____ 35 to 49 ____ 50 and over ✓
7. Describe in detail what employee was doing at time of injury: include reference to any tools, machines and materials involved: Hold ing IRON IN position For the welder to weld (in the sheet metal shop.)
8. Describe injury: welding Flash
9. What medical action was taken? eye drops & pain pills.
10. What, in your opinion, was the basic cause of this accident?

    Unsafe Act ✓ Unsafe Condition ____ Explain didn't Cover the side OF his eye.

C00B0027
WRG00299055
ED_005351_00000355-00154

11. What were the contributing causes? Hurring, and Taking time to cover his eyes properly

12. What action have you taken and/or are you planning to take to avoid a recurrence of this accident? will use in our safety meeting

13. Have you counselled your other employees regarding lessons to be learned from this accident?

Yes ____ No ____ if not, why will at our meeting.

14. Have you scheduled any maintenance work or planned any disciplinary action with the accident?

Yes ____ No ✓ Comments, if any: _____

4-18-77

(Signed) [illegible] (Supervisor) Date 4/18/77 Plant Libby

****

You have now completed answering some very important questions regarding an injury to one of your employees. Take the time to think carefully and ask yourself the following two questions:

a) How long did I take to think out and complete the answers to the questions above?
b) Have I really taken enough time, given enough thought, to a subject which might very well mean the life of one of my employees at some future date?

****

This space reserved for Plant Managers

1. Have you discussed this injury with .....

the supervisor concerned? Yes ____ No ____
all members of your supervisory group? Yes ____ No ____

2. Do you have any comments to add to the statements by the Foreman?

_____

_____

(Plant Manager) (Date)

Form 65-25

C0080028
WRG00299056
ED_005351_00000355-00155

MONTANA DIVISION OF WORKERS' COMPENSATION

Complied with 82—1137 R.C.M.

815 Front Street
Helena, Montana 59601

4-25-77

SEND ORIGINAL TO INSURER

EMPLOYER'S FIRST REPORT
of Occupational Injury or
Occupational Disease
Employee Copy

CASE NUMBER

FIRM NUMBER 2503

INSTRUCTIONS - Every employer in Montana is required by law to complete this form immediately after every accident to an employee which arises out of and in the course of employment, and which causes loss of time from work or requires medical attention. The original of this form must be immediately filed with the employer's insurer or the Division of Workers' Compensation, 815 Front Street, Helena, Montana 59601. All questions must be answered fully. If a question cannot be answered, please explain why.
Please print with a ball point pen or type.

FEDERAL OSHA REQUIREMENTS - The United States Department of Labor requires employers to maintain, in the employer's office, a record of occupational injuries. For the employer's convenience, this form has been designed to meet such requirements and to provide employers a record copy.

EMPLOYEE

Full Name of INJURED EMPLOYEE: Earl L. Schulke
Social Security Number: 477-40-3014

EMPLOYEE'S Home Address (Street or Box): Rt. 1
City: Libby
State: Mt.
Zip Code: 59923

Occupation: Laborer
Sex: M
Age: 57
Marital Status: [X] Married [ ] Single
Length of time in your Employment: 8 Months

Department where regularly employed: Labor Pool
Date of Birth (mo.) 3 / (day) 17 / (yr.) 20

WAGES

Employee's Gross Wage Rate is $ 5.465 per [ ] week, or [ ] day, or [X] hour, or [ ] month
Days Worked Per Week: 5
Hours Worked Per Day: 8

If board or room is furnished state value reported per day to Internal Revenue Service $
Check One— [X] Full Time Employee [ ] Part Time Employee
Payroll Classification under which employee's wages were reported: Common Labor

Employee's gross earnings for last four (4) pay periods (Date / Amount): 2/20/77 437.20; 3/5/77 505.58; 3/20/77 466.00; 4/5/77 223.24

Employee's pay period: [ ] Monthly [X] Semi-monthly [ ] Bi-Weekly [ ] Weekly [ ] Other

ACCIDENT INFORMATION

Describe in full detail how accident happened, and give cause - Explain what employee was doing when injured.
Employee was holding piece of iron in position for the welder to weld. Received a welding flash in right eye.

What specific object or substance caused the injury? Welder
Nature of the injury? (cut, fracture, etc.) Welding flash in right eye

Part of body affected (leg, arm, back, head, etc.): Right eye
DATE OF INJURY (month) April (day) 13, (year) 1977 (hour) 3:00 (a.m. or p.m.) P.M.

Names of witnesses to accident
1. Harry Ostheller
2. Richard Hermsmeyer

Place where accident occurred (address & city): 12 Mi. North of Libby, Montana
(county) Lincoln
Was place of accident on employer's premises? Yes [ ] No [ ]

Was employee injured while in your employ? Yes [X] No [ ]
Were you notified, or did you have actual knowledge of the accident? Yes [X] No [ ]
If yes, date notified & how: 4/13/77, Supervisor

Do you have any reason to question this accident? [ ] Yes [X] No
If yes, please explain fully

MEDICAL

Attending physician name and address: James F. Graham, M.D., Libby, Montana 59923

If hospitalized, hospital's name and address

Will employee return to work during next scheduled shift? Yes [X] No [ ]
If no, will wage loss exceed 7 days? Yes [ ] No [ ] Not Sure [ ]
Date wage loss began (mo) / (day) / (yr.)
Date of return, if returned to work (mo.) / (day) / (yr.)

EMPLOYER

EMPLOYER'S NAME: W. R. Grace & Co.
Commercial Name (doing business as)

Employer's mailing address (Street or Box): Box 609
(City) Libby (State) Montana (Zip Code) 59923
Phone number: 293-4131

Location of operation, if different from mailing address: 12 Miles North of Libby, Montana
Nature of business: Mining

Firm is a: (Check one) [ ] Sole proprietorship [ ] Partnership, or [X] Corporation
Was the injured employee? (Check if applicable) [ ] A Sole Proprietor, [ ] A working Partner, [ ] A Corporate Officer, or [ ] A member of the employer's (sole proprietor or partner) family, dwelling in the employer's household.

Prepared by: Darlene Myhre
Authorized Signature: X
Official Title: Administrative Assistant
Date: 4/25/77

DWC USE ONLY: OCCUPATION, SEX, AGE, MARITAL STATUS, COUNTY, LENGTH (YRS) EMPLOYED, WEEKLY EARNINGS, CLASS CODE, ACCIDENT TYPE, SOURCE OF INJURY, PART OF BODY INJURED, OSHA RECORDABLE CODE, DISABILITY TYPE, NATURE OF INJURY, HAZARDOUS CONDITION, UNSAFE ACT

Above - DWC-MIS Form 37-Employer's First Report (Rev. 1-76)

Below - DWC-MIS Form 54A-Claim for Compensation

EMPLOYEE'S CLAIM FOR COMPENSATION

EMPLOYER'S NOTE: For convenience purposes and if the worker is available, the form below has been provided so that an employer may allow an injured worker to file a claim for compensation on this form to avoid having the employee fill out and file a separate detailed form. Separate claim forms are available if the employer does not want the worker to use this form. **Do not delay in submission of this form if employee is not available to sign below.**

INJURED EMPLOYEE'S NOTE: An injured employee may use the form below to make a claim for compensation, or the employee may fill out and submit a separate detailed form that is available from the Division.

I have carefully read the above information as documented by the employer, and (except for any statements I may write below) I concur with the information and I hereby make claim for compensation benefits due me now or in the future under Montana's Workers' Compensation Act.

Signature of injured employee: X
Address
City
Date
Phone

I DO NOT concur with the following information documented by the employer

C0080029

Filing of this claim is authorization for release of medical records and records of the Social Security Administration

Medical
Schulke, Earl L.

C0080026

ED_005351_00000355-00157

ACCIDENT INVESTIGATION REPORT

INDUSTRIAL CHEMICALS GROUP
W. R. Grace & Co.

Plant Libby - Minesite Lost Time Case X

Division Construction Products Division Not Lost Time Case _____
(Check one)

All accidents involving lost time from work or the services of a physician must be investigated and the report completed within 48 hours by the injured employee's supervisor. Forward one copy of report to office of Safety Administrator.

C0080030

1. Name of injured employee Earl Shulke (660)
2. Department Labor Pool - On Lone to Mine Date of Hire 8-9-76
3. Job Title Laborer Was he doing regular job? Yes X No _____
4. Date and time of injury 12/8/81 Approximatly 3:20 PM
5. Date and time injury reported 12/8/81 Approximatly 3:35 PM
6. Injured employee is: Salaried _____ Hourly X Male X Female _____

   Under 25 years _____ 25 to 34 _____ 35 to 49 _____ 50 and over X
7. Describe in detail what employee was doing at time of injury: include reference to any tools, machines and materials involved: Earl Shulke was responsible for shoveling stemming material (Pyrocon sand) from the bucket of the BobCat. Ed Nixon was the operator of the Bobcat at the time. When Ed tipped the bucket slightly forward so that Earl could shovel the stemming out the Bobcat become unbalanced and tilted forward. The lip of the bucket hit Earl's left knee cap.
8. Describe injury: The left knee was slightly swollen, no blood was observed at the time of the accident as Earl was wearing long johns.
9. What medical action was taken? Earl said that his knee was sore but that he could continue work. That night the knee swelled and Earl discovered that the skin had been broken.
10. What, in your opinion, was the basic cause of this accident?

    Unsafe Act X Unsafe Condition X Explain Earl Shulke should not have been as close to the bobcat as he was. Ed Nixon had complained that the bobcat should have a counterweight to keep it from becoming front heavy. The old Bobcat

WRG00299059

ED_005351_00000355-00158

11. What were the contributing causes? See above.

12. What action have you taken and/or are you planning to take to avoid a recurrence of this accident? I have talked to Mike Ray about a counterweight and Ed Nixon is now lowering the Bobcat bucket almost to the ground before tipping it.

13. Have you counselled your other employees regarding lessons to be learned from this accident?

Yes X No ___ if not, why I have talked with everyone on the loading crew.

14. Have you scheduled any maintenance work or planned any disciplinary action with the accident?

Yes ___ No X Comments, if any: I have spoken with Mike Ray about the possibility of adding a counterweight to the bobcat

(Signed) [illegible] (Supervisor) Date 12/9/81 Plant Libby - Mine

****

You have now completed answering some very important questions regarding an injury to one of your employees. Take the time to think carefully and ask yourself the following two questions:

a) How long did I take to think out and complete the answers to the questions above?
b) Have I really taken enough time, given enough thought, to a subject which might very well mean the life of one of my employees at some future date?

12-14-81 [illegible]

****

This space reserved for Plant Managers

1. Have you discussed this injury with .....

the supervisor concerned? Yes ___ No ___
all members of your supervisory group? Yes ___ No ___

2. Do you have any comments to add to the statements by the Foreman?

(Plant Manager) (Date)

Form 65-25

C00B0031

WRG00299060

ED_005351_00000355-00159

MONTANA DIVISION OF WORKERS' COMPENSATION

815 Front St[illegible] Helena, Montana 59601

DATE STAMP

EMPLOYER'S FIRST REPORT of Occupational Injury or Occupational Disease

SEND ORIGINAL TO INSURER:

CASE NO -

FIRM NO -

Employee Copy

INSTRUCTIONS - Every employer in Montana is required by law to complete this form immediately after every industrial accident to an employee which causes loss of time from work or requires medical attention. The original of this form must be immediately filed with the employer's insurer or the Division of Workers' Compensation, 815 Front Street, Helena, Montana 59601. All questions must be answered fully. If a question cannot be answered, please explain why.
Please print with a ball point pen or type.

FEDERAL OSHA REQUIREMENTS - The United States Department of Labor requires employers to maintain, in the employer's office, a record of occupational injuries. For the employer's convenience, this form has been designed to meet such requirements and to provide employers a record copy.

EMPLOYEE

FULL NAME OF INJURED EMPLOYEE | PHONE | SOCIAL SECURITY NUMBER

EMPLOYEE'S HOME ADDRESS (Street or Box) | CITY | STATE | ZIP CODE

OCCUPATION | SEX | DATE OF BIRTH (Mo / Day / Yr) | MARITAL STATUS ☐ Married ☐ Single | LENGTH OF TIME IN YOUR EMPLOYMENT

WAGES

Employee's Gross Wage Rate is $ Per ☐ WEEK ☐ DAY ☐ HOUR ☐ MO. | Days Worked Per Week | Hours Worked Per Day | If board or room is furnished state value reported per day to Internal Revenue Service $

Check one - ☐ Full Time Employee ☐ Part Time Employee | Payroll Classification under which employee's wages were reported | Employee's Pay Period: ☐ Monthly, ☐ Semi-monthly, ☐ Bi-weekly, ☐ Weekly, ☐ Other (explain) | Regular Days Off

Employee's gross earnings for last four (4) pay periods (Date / Amount) (Date / Amount) (Date / Amount) (Date / Amount)

Will employee return to work during next *scheduled shift?* ☐ Yes ☐ No | If no, will employee lose more than 5 *days wages?* ☐ Yes ☐ No ☐ Not Sure | DATE WAGE LOSS BEGAN (Mo / Day / Yr) | DATE OF RETURN, if returned to work (Mo / Day / Yr)

ACCIDENT INFORMATION

Describe in full detail how accident happened, and give cause - Explain what employee was doing when injured.

DATE OF INJURY (month) 12 (day) (year) (hour) (a.m. or p.m.) | What specific object or substance caused the injury?

Nature of the injury? (cut, fracture, etc.) | Part of body affected (leg, arm, back, head, etc.)

Names of witnesses to accident
1. 2.

Was place of accident on employer's premises? ☐ Yes ☐ No | Place where accident occurred (address & city) (county)

Was employee injured while in your employ? ☐ Yes ☐ No | Were you notified, or did you have actual knowledge of the accident? ☐ Yes ☐ No | If yes, date notified & how

Do you have *any reason* to question this accident? ☐ Yes ☐ No | If yes, please explain fully

C00B0032

MEDICAL

Attending Physician's Name | PHONE | Address (Street or Box) | (City) | (State) | (Zip Code)

If Hospitalized, Hospital's Name | Address (Street or Box) | (City) | (State) | (Zip Code)

EMPLOYER

EMPLOYER'S NAME | Commercial Name (doing business as)

Employer's mailing address (street or box) | (City) | (State) | (Zip Code) | Phone Number

Location of operation, if different from mailing address | Nature of Business

Firm is a: (Check one) ☐ Sole proprietorship ☐ Partnership, or ☐ Corporation | Was the Injured employee? (Check if applicable) ☐ A Sole Proprietor, ☐ A working Partner, ☐ A Corporate Officer, or ☐ A member of the employer's (sole proprietor or partner) family, dwelling in the employer's household.

Prepared by: | Authorized Signature | Official Title | Date

ABOVE - DWC - MIS Form 37 - Employer's First Report (Rev. 6-78)

BELOW - DWC - MIS Form 54 - Claim for Compensation

EMPLOYEE'S CLAIM FOR COMPENSATION

EMPLOYER'S NOTE: For convenience purposes and if the worker is available, the form below has been provided so that an employer may allow an injured worker to file a claim for compensation on this form to avoid having the employee fill out and file a separate detailed form. Separate claim forms are available if the employer does not want the worker to use this form. **Do not delay in submission of this form if employee is not available to *sign below.***

EMPLOYEE'S CLAIM FOR COMPENSATION

INJURED EMPLOYEE'S NOTE: An injured employee may use the form below to make a claim for compensation, or the employee may fill out and submit a separate detailed form that is available from the Division.

List other types of work you have done
1. 2. 3.

Education ☐ Grade School ☐ High School ☐ College ☐ Other _____ | How many members are in your immediate family?

Have you ever had an industrial injury before? ☐ Yes ☐ No | If yes, in what state? | Type of injury

I have carefully read the information as documented by the employer, and (except for any statements I may write below) I concur with the information and I hereby make claim for compensation benefits *due me now or in the future under Montana's Workers' Compensation Act.*

Signature of injured employee | Address | City | Date | Phone

X

I DO NOT concur with the following information documented by the employer _____

Filing of this claim is authorization for release of medical records and records of the Social Security Administration.

U. S. Department of Labor
Mine Safety and Health Administration

Form Approved, OMB No. 044-R1665, Expires December 1982.

Section A – Identification Data

MSHA ID Number: 2400165
Contractor I.D.:
Report Category: [X] Metal/Nonmetal Mining [ ] Coal Mining
[ ] Check here if report pertains to contractor.
Mine Name: Zonolite
Company Name: W. R. Grace & Co.

Section B – Complete for Each Reportable Accident Immediately Reported to MSHA

1. Accident Code (circle applicable code – see instructions) 01 – Death 02 – Serious Injury 03 – Entrapment 04 – Inundation 05 – Gas or Dust Ignition 06 – Mine Fire 07 – Explosives 08 – Roof Fall 09 – Outburst 10 – Impounding Dam 11 – Hoisting 12 – Offsite Injury
2. Name of Investigator
3. Date Investigation Started: Month / Day / Year
4. Steps Taken to Prevent Recurrence of Accident

Section C – Complete for Each Reportable Accident, Injury or Illness

5. Circle the Codes Which Best Describe Where Accident/Injury/Illness Occurred (see instructions)
(a) Surface Location: 02 Surface at Underground Mine 30 Mill, Preparation Plant, etc. (03 Strip/Open Pit Mine 04 Surface Auger Operation 05 Culm Bank/Refuse Pile 06 Dredge Mining 12 Other Surface Mining 17 Independent Shops (with own MSHA ID) 99 Office Facilities
(b) Underground Location: 01 Vertical Shaft 02 Slope/Inclined Shaft 03 Face 04 Intersection 05 Underground Shop/Office 06 Other
(c) Underground Mining Method: 01 Longwall 02 Shortwall 03 Conventional Stoping 05 Continuous Miner 06 Hand 07 Caving 08 Other

6. Date of Accident: Month 12 / Day 08 / Year 81
7. Time of Accident: 3:00 [ ] am [X] pm
8. Time Shift Started: 8:00 [X] am [ ] pm
9. Describe Fully the Conditions Contributing to the Accident/Injury/Illness, and Quantify the Damage or Impairment

Employee was hoveling sand from bucket of Bobcat to stem blast holes. The Bobcat became unbalanced, tipped forward and hit Schulke in Left Knee cap.

10. Equipment Involved: Type: Bobcat Loader; Manufacturer: Clark; Model Number: 610
11. Name of Witness to Accident/Injury/Illness: Ed Nixon
12. Number of Reportable Injuries or Illnesses Resulting from This Occurrence: 1
13. Name of Injured/Ill Employee: Earl Schulke
14. Sex: [X] Male [ ] Female
15. Date of Birth: Month 3 / Day 17 / Year 20
16. Last Four Digits of Social Security Number: 8014
17. Regular Job Title: Laborer
[ ] 18. Check if this Injury/Illness resulted in death.
[ ] 19. Check if Injury/Illness resulted in permanent disability (include amputation, loss of use, & permanent total disability).
20. What Directly Inflicted Injury or Illness? Bobcat Loader Bucket
21. Nature of Injury or Illness: Bruise
22. Part of Body Injured or Affected: Left Knee
23. Occupational Illness (circle applicable code – see instructions) 21 Occupational Skin Diseases 22 Dust Diseases of the Lungs 23 Respiratory Conditions (toxic agents) 24 Poisoning (toxic materials) 25 Disorders (physical agents) 26 Disorders (repeated trauma) 29 Other
24. Employee's Work Activity When Injury or Illness Occurred: Stemming Drill Holes

Experience	Years	Weeks
25. Experience in This Job Title	5	13
26. Experience at This Mine	5	13
27. Total Mining Experience		

Section D – Return to Duty Information *Answer 30 & 31 when case is closed*

[ ] 28. Permanently Transferred or Terminated (if checked, complete items 29, 30 & 31)
29. Date Returned to Regular Job at Full Capacity (or item 28): Month / Day / Year
30. Number of Days Away from Work (if none, enter 0): 3
31. Number of Days Restricted Work Activity (if none, enter 0): 0

Person Completing Form (name): Earl D. Lovick
Title: Manager of Administration
Date This Report Prepared (month, day, year): 2-09-82
Area Code and Phone Number: 406-293-4131

MSHA Form 7000-1, Feb. 80 (revised)

For Official Use Only
Degree
Accident Type
Accident Class
Scheduled Charge
Keyword

 RETAIN THIS COPY AT THE MINE (OR NEAREST MINE OFFICE) FOR 5 YEARS

C0080033
WRG00299062
ED_005351_00000355-00161

Medical
Schulke, Earl L.

C0080026

GRACE

INCIDENT INVESTIGATION REPORT
PERSONAL INJURY/PROPERTY DAMAGE

NUMBER OF DAYS AWAY FROM WORK: 0

NUMBER OF RESTRICTED WORK DAYS: 0

DIVISION/PLANT: CPD/Libby

PLANT LOCATION (City/State): Libby, MT

INJURY NUMBER (From OSHA 200 Log): —

LOCATION OF INCIDENT: Wet Mill - 7th Floor

COMPANY PREMISES: ☒ YES ☐ NO

TIME OF INCIDENT: 2355 AM ☐ PM ☒

DATE OF INCIDENT: 1 | 13 | 83

INJURED OR ILL

NAME (FIRST): EARL (MIDDLE): L. (LAST): Schulke

SOC SEC NO: 477-40-8014

OCCUPATION: Shift Millwright

SEX: ☒ MALE ☐ FEMALE

MARITAL STATUS: ☐ MARRIED ☒ SINGLE

DATE OF BIRTH: 3 | 17 | 20

ACCIDENT CATEGORY: ☐ DAYS AWAY FROM WORK ☒ MEDICAL TREATMENT ☐ RESTRICTED WORK ☐ FIRST AID

LENGTH OF EMPLOYMENT: YEARS 6 MONTHS 9

LENGTH OF PRESENT OCC.: YEARS 1 MONTHS 2

SHIFT: ☒ REG. ☐ OVERTIME

NATURE OF INJURY/PARTS OF BODY AFFECTED: Bruised Rt. Kidney

DATES OF PREVIOUS INJURIES: 12-8-81

WHAT FIRST AID: None

WHERE GIVEN: N/A

BY WHOM: N/A

WHERE SENT ☐ HOSPITAL (Name and Address) ☐ HOME ☐ OTHER (Specify)

Employee Completed his shift and went to Doctor on 1-14-83

NAME AND ADDRESS OF ATTENDING PHYSICIAN

Dr. Rodgen Bros
Box 630
Libby, MT 59923

PROPERTY DAMAGE (est. dollar value): N/A

LOST PRODUCTION (days hours, etc. units) AND ESTIMATED VALUE: N/A

LOSS TYPE (explosion, fire, wind) / IDENTIFY PROPERTY DAMAGED: N/A

(NEAR MISS) NATURE OF INCIDENT / DOLLAR COST (if applicable): N/A

DESCRIBE EVENTS LEADING TO INCIDENT/WORK IN PROGRESS/STAGE OF PROCESS/ACTUAL ACTS OF INJURED AND FELLOW EMPLOYEES

Injured was walking down short flight of metal steps from platform around 1/4 inch Roll Screens on 7th. floor of wet mill. When he stepped onto the wet concrete floor he slipped and fell, hitting the Rt. side of his back on a flange. This bruised his kidney.

C0080034

73-119(Rev. 6/82)

ED_005351_00000355-00163

DESCRIPTION

ANALYSIS AND EVALUATION

IMMEDIATE CAUSE(S): WHAT SPECIFIC ACTS / FAILURE TO ACT OR CONDITIONS CONTRIBUTED DIRECTLY TO THE INCIDENT?

Injured was careless when stepping on wet floor.

Note: due to nature of process floor is usualy wet in this area.

BASIC CAUSE(S): WHAT ARE THE BASIC CAUSES AND WHAT ARE THE REASONS FOR THESE CAUSES TO EXIST?

EVALUATION	SEVERITY POTENTIAL			PROBABLE RECURRENCE RATE		
	☐ MAJOR	☐ SERIOUS	☒ NOT SERIOUS	☐ FREQUENT	☐ OCCASIONAL	☒ RAR

PREVENTION

WHAT CORRECTIVE ACTION HAS BEEN OR WILL BE TAKEN TO PREVENT A RECURRENCE?

Employees on this crew have been Re-advised About slipping hazards.

COMPLETION DATE 1 1 14 83

INVESTIGATED BY	DATE	REVIEWED BY	DATE
J.K. Mudge	1 1 14 83		/ /

REVIEWER'S COMMENTS (IS INVESTIGATION COMPLETE AND CORRECTIVE ACTION ADEQUATE?)

C0080035

IF SERIOUS PROPERTY DAMAGE OR PERSONAL INJURY OCCURS, IMMEDIATELY PHONE THE IC ALTH AND SAFETY DEPARTMENT.

ACCIDENT INVESTIGATION REPORT

INDUSTRIAL CHEMICALS GROUP
W. R. Grace & Co.

Plant _____ Lost Time Case _____

Division _____ Not Lost Time Case _____
(Check one)

All accidents involving lost time from work or the services of a physician must be investigated and the report completed within 48 hours by the injured employee's supervisor. Forward one copy of report to office of Safety Administrator.

1. Name of injured employee Earl Schulke
2. Department Mill Date of Hire 8/9/76
3. Job Title Mill Mechanic Was he doing regular job? Yes ✓ No ____
4. Date and time of injury 1/13/83 1155 PM
5. Date and time injury reported 1/14/83 - 1200 AM
6. Injured employee is: Salaried ____ Hourly ✓ Male ✓ Female ____

   Under 25 years ____ 25 to 34 ____ 35 to 49 ____ 50 and over ✓
7. Describe in detail what employee was doing at time of injury: include reference to any tools, machines and materials involved:

   Employee was walking down North end of stairs off the 7th floor 1/4" roll screen when he stepped on the concrete floor and slipped and fell. He hit his back on a pipe flange.
8. Describe injury: Right side of back (Kidney area) was struck
9. What medical action was taken? Employee plans to see a doctor following graveyard shift
10. What, in your opinion, was the basic cause of this accident?

    Unsafe Act (✓)? Unsafe Condition ____ Explain The floor was clean and wet as usually. Employee was semi careless.

C0080036
WRG00299066
ED_005351_00000355-00165

11. What were the contributing causes? Wet floor and a less than careful employee.

12. What action have you taken and/or are you planning to take to avoid a recurrence of this accident? Crew has been advised about slipping hazards

13. Have you counselled your other employees regarding lessons to be learned from this accident?

Yes ____ No ____ if not, why _____

14. Have you scheduled any maintenance work or planned any disciplinary action with the accident?

Yes ____ No ____ Comments, if any: _____

(Signed) J K Mudge (Supervisor) Date 1/14/83 Plant _____

****

You have now completed answering some very important questions regarding an injury to one of your employees. Take the time to think carefully and ask yourself the following two questions:

a) How long did I take to think out and complete the answers to the questions above?
b) Have I really taken enough time, given enough thought, to a subject which might very well mean the life of one of my employees at some future date?

****

This space reserved for Plant Managers

1. Have you discussed this injury with .....

the supervisor concerned? Yes ____ No ____
all members of your supervisory group? Yes ____ No ____

2. Do you have any comments to add to the statements by the Foreman?

_____

_____

(Plant Manager) _____ (Date) _____

Form 65-25

C0080037
WRG00299067
ED_005351_00000355-00166

MONTANA DIVISION OF WORKERS' COMPENSATION

815 Front Street, Helena, Montana 59601

EMPLOYER'S FIRST REPORT of Occupational Injury or Occupational Disease

DATE STAMP

SEND ORIGINAL TO INSURER:

CASE NO -

FIRM NO -

Employer Copy

INSTRUCTIONS - Every employer in Montana is required by law to complete this form immediately after every industrial accident to an employee which causes loss of time from work or requires medical attention. The original of this form must be immediately filed with the employer's insurer or the Division of Workers' Compensation, 815 Front Street, Helena, Montana 59601. All questions must be answered fully. If a question cannot be answered, please explain why.
Please print with a ball point pen or type.

FEDERAL OSHA REQUIREMENTS - The United States Department of Labor requires employers to maintain, in the employer's office, a record of occupational injuries. For the employer's convenience, this form has been designed to meet such requirements and to provide employers a record copy.

EMPLOYEE

FULL NAME OF INJURED EMPLOYEE	PHONE	SOCIAL SECURITY NUMBER
Earl L. Schulke	293-7005	477-40-8014

EMPLOYEE'S HOME ADDRESS (Street or Box)	CITY	STATE	ZIP CODE
Star Rt. 1 Box 38	Libby	MT	59923

OCCUPATION	SEX	DATE OF BIRTH (Mo / Day / Yr)	MARITAL STATUS	LENGTH OF TIME IN YOUR EMPLOYMENT
Millwright	M	3 / 17 / 20	☐ Married ☒ Single	6 years

WAGES

Employee's Gross Wage Rate is $ 10.33 Per WEEK ☐ DAY ☐ HOUR ☒ MO. ☐ — Days Worked Per Week 5 — Hours Worked Per Day 8 — If board or room is furnished state value reported per day to Internal Revenue Service $

Check one - ☒ Full Time Employee ☐ Part Time Employee — Payroll Classification under which employee's wages were reported — Employee's Pay Period: Monthly ☐ Semi-monthly ☒ Bi-weekly ☐ Weekly ☐ Other (explain) ☐ — Regular Days Off

Employee's gross earnings for last four (4) pay periods (Date / Amount) (Date / Amount) (Date / Amount) (Date / Amount)

Will employee return to work during next scheduled shift? Yes ☒ No ☐ — If no, will employee lose more than 5 days wages? Yes ☐ No ☒ Not Sure ☐ — DATE WAGE LOSS BEGAN (Mo / Day / Yr) 12 / 14 / 83 — DATE OF RETURN, if returned to work (Mo / Day / Yr) ~~12 / 21 / 83~~

ACCIDENT INFORMATION

Describe in full detail how accident happened, and give cause - Explain what employee was doing when injured.

He was walking off the north side of the 7th floor 1/4" roll screens and his foot hit the cement and he slipped and fell down. When he slipped he hit his right back side kidney on a piece of pipe that was sticking out of the floor about 4 inches.

DATE OF INJURY	(month)	(day)	(year)	(hour)	(a.m. or p.m.)	What specific object or substance caused the injury?
	1	14	83	1:00	a.m.	pipe used for drainage

Nature of the injury? (cut, fracture, etc.) bruised kidney — Part of body affected (leg, arm, back, head, etc.) right kidney

Names of witnesses to accident
1. Jerry Ledum (did not witness accident) 2. Richard Viereck

Was place of accident on employer's premises? Yes ☒ No ☐ — Place where accident occurred (address & city) 12 Miles N.E. of Libby — (county) Lincoln

Was employee injured while in your employ? Yes ☒ No ☐ — Were you notified, or did you have actual knowledge of the accident? Yes ☒ No ☐ — If yes, date notified & how 1/14/83 called Ed Hendrickson date of injury

Do you have any reason to question this accident? ☐ Yes ☒ No — If yes, please explain fully

MEDICAL

Attending Physician's Name	PHONE	Address (Street or Box)	(City)	(State)	(Zip Code)
Dr. Brus	293-5945	111 E. Cedar	Libby	Montana	59923

If Hospitalized, Hospital's Name	Address (Street or Box)	(City)	(State)	(Zip Code)
St. Johns Lutheran Hospital (X-rays only)		Libby	Montana	59923

EMPLOYER

EMPLOYER'S NAME: W. R. Grace & Co. — Commercial Name (doing business as)

Employer's mailing address (street or box)	(City)	(State)	(Zip Code)	Phone Number
P.O. Box 609	Libby	Montana	59923	293-3746

Location of operation, if different from mailing address: 12 Miles Ne E. Of Libby — Nature of Business: Mining & Milling

Firm is a: (Check one) ☐ Sole proprietorship ☐ Partnership, or ☒ Corporation — Was the Injured employee? (Check if applicable) ☐ A Sole Proprietor, ☐ A working Partner, ☐ A Corporate Officer, or ☐ A member of the employer's (sole proprietor or partner) family, dwelling in the employer's household.

Prepared by:	Authorized Signature	Official Title	Date
Alison Leader	[signature]	Manager of Administration	1/14/83

ABOVE - DWC - MIS Form 37 - Employer's First Report (Rev.-6-78)
BELOW - DWC - MIS Form 54 - Claim for Compensation

EMPLOYEE'S CLAIM FOR COMPENSATION

EMPLOYER'S NOTE: For convenience purposes and if the worker is available, the form below has been provided so that an employer may allow an injured worker to file a claim for compensation on this form to avoid having the employee fill out and file a separate detailed form. Separate claim forms are available if the employer does not want the worker to use this form. **Do not delay in submission of this form if employee is not available to sign below.**

EMPLOYEE'S CLAIM FOR COMPENSATION

INJURED EMPLOYEE'S NOTE: *An injured employee may use the form below to make a claim for compensation, or the employee may fill out and submit a separate detailed form that is available from the Division.*

List other types of work you have done: 1. 2. 3.

Education: ☐ Grade School ☐ High School ☐ College ☐ Other — How many members are in your immediate family?

Have you ever had an industrial injury before? Yes ☐ No ☐ — If yes, in what state? — Type of injury

I have carefully read the information as documented by the employer, and (except for any statements I may write below) I concur with the information and I hereby make claim for compensation benefits due me now or in the future under Montana's Workers' Compensation Act.

Signature of injured employee: X [signature] — Address — City — Date — Phone

I DO NOT concur with the following information documented by the employer

C0080038

Filing of this claim is authorization for release of medical records and records of the Social Security Administration

Medical
Schulke, Earl L.

C0080026

INCIDENT

[redacted] INVESTIGATION REPORT

INDUSTRIAL CHEMICALS GROUP
W. R. Grace & Co.

Plant LIBBY, MONTANA Lost Time Case XX

Division CONSTRUCTION PRODUCTS DIVISION Not Lost Time Case _____
(Check one)

All accidents involving lost time from work or the services of a physician must be investigated and the report completed within 48 hours by the injured employee's supervisor. Forward one copy of report to office of Safety Administrator.

1. Name of injured employee Earl Schulke
2. Department Mine (Labor Pool) Date of Hire 08-09-76
3. Job Title Euclid Driver Was he doing regular job? Yes X No _____
4. Date and time of ~~injury~~ Incident - 8/11/81 - 2115
5. Date and time injury reported 8/11/81 - 2116
6. Injured employee is: Salaried _____ Hourly X Male X Female _____

   Under 25 years _____ 25 to 34 _____ 35 to 49 _____ 50 and over X
7. Describe in detail what employee was doing at time of injury: include reference to any tools, machines and materials involved: After dumping an oversize load from Transfer Point at the 18th level dump, Earl got out of the truck to relieve himself. When he got back in the truck he failed to lower the box. As he headed back to the loader he pulled down power lines to the 18th level dump.
8. Describe injury: None
9. What medical action was taken? No
10. What, in your opinion, was the basic cause of this accident?

    Unsafe Act XX Unsafe Condition _____ Explain Inattention to the job.

C0080039

WRG00299070

ED_005351_00000355-00169

11. What were the contributing causes? None [redacted]

12. What action have you taken and/or are you planning to take to avoid a recurrence of this accident? We placed a power line marker on the lines.

13. Have you counselled your other employees regarding lessons to be learned from this accident?

Yes X No ____ if not, why _____

14. Have you scheduled any maintenance work or planned any disciplinary action with the accident?

Yes X No ____ Comments, if any: _____

(Signed) E.W. Snoreau (Supervisor) Date 8/13/81 Plant Libby, MT.

****

8-14-81 cfm

You have now completed answering some very important questions regarding an injury to one of your employees. Take the time to think carefully and ask yourself the following two questions:

a) How long did I take to think out and complete the answers to the questions above?
b) Have I really taken enough time, given enough thought, to a subject which might very well mean the life of one of my employees at some future date?

****

This space reserved for Plant Managers

1. Have you discussed this injury with .....

the supervisor concerned? Yes ____ No ____
all members of your supervisory group? Yes ____ No ____

2. Do you have any comments to add to the statements by the Foreman?

_____

_____

_____ (Plant Manager) _____ (Date)

Form 65-25

C00B0040

WRG00299071

ED_005351_00000355-00170

Zonolite
Construction Products Division

GRACE

TO: E. W. Moreau
FROM: W. D. Fields

DATE: 8/11/81
SUBJECT: Earl Schulke - Knocking down Power Line.

On 8/11/81 at 2115 Earl Schulke hauled a load of Transfer Point oversize to the 18th level dump.

After dumping the load Earl got out of the truck to relieve himself. When he got back in the truck he did not lower the box. He headed back to the loader but when he went under the power line to the 18th level dump lights his box broke the wires and pulled the west pole off, knocking down lights and transformer.

We blocked off the area until we were sure the fuses were out. Doug Reynolds checked and called Hughes for his o.k. before we let traffic go through.

C0080041

WRG00299072
ED_005351_00000355-00171

W. R. GRACE &CCO.
CONSTRUCTION PRODUCTS DIVISION

C0080042

REPRIMAND

Name: Earl Schulke Date: 8/11/81

The employee noted above was (reprimanded) (commended) for the following action:

FULL EXPLANATION

You are reprimanded for obvious inattention to your job, i.e., driving with your truck box up, thus creating a hazardous situation for yourself and your fellow employees by knocking down the 2400 volt power feeder line.

Any additional incidents of this nature or magnitude will result in severe disciplinary action.

Original to Person Named
Duplicate to Personnel Dept.
Triplicate to Originating Dept.
Quadriplicate to Union

Foreman W. D. Fields

Department Mine (Labor Pool)

Reviewed & Approved E. W. Moreau (Supervisor)

Reviewed by: _____ (Industrial Relations Dept.)

MEDICAL
Schull, Billie Joe

C0080043

06063048

Industrial Accident Board, Helena, Montana, Form 37 Revised

Industrial Accident Board

HELENA, MONTANA

DO NOT WRITE IN THIS SPACE

Firm No.

File No.

EMPLOYER'S FIRST REPORT OF INJURY

INSTRUCTIONS—Employer must complete form at once after every accident which causes loss of time from work or requires medical attention and mail it to the Industrial Accident Board, Helena, Montana. Form must be signed in pen and ink. ALL QUESTIONS MUST BE ANSWERED FULLY.

INJURED EMPLOYEE

Full name of injured employee: Billie Joe Schell Occupation: Euclid Driver

Mailing address: #14 Mill Road, Libby How long has he been in your employ: 1 year

Social Security No. 514-38-6734 Sex: M Age: 29 Married ☐ Single ☒

EARNINGS

Monthly Wage ..... Weekly Wage ..... Daily Wage ..... Hourly Wage: 3.06

Receive board Yes ☐ No ☒ Daily Value ..... Receive room Yes ☐ No ☒ Daily Value .....

Piece Worker Yes ☐ No ☒ If yes, give method of computing earnings .....

Number of hours worked per day: 8 Days worked per week: 5 Employee's pay period?

Monthly ☐ Semi monthly ☒ Weekly ☐ List employee's earnings last 4 pay periods 1. 259.36 2. 349.10 3. 377.00 4. 346.56

Under what payroll classification has employees' wages been reported? (Sawmill - Mechanic - Etc.)

ACCIDENT AND INJURY

Describe in full how accident happened and GIVE CAUSE: The mine crew was moving a new shovel up the road to the mine. They had wooden blocking in the road, and when employee picked up piece of blocking, he lacerated his right hand on a nail protruding from piece of wood.

Part of body injured? Describe fully: right hand

Names of witnesses to accident 1. Day shift 2. .....

Date of accident: 6-28 19 68 Hour ..... A.M. Was employee injured in course of employment? Yes ☐ No ☐

Place where accident occured: ourmine, 3 miles north of Libby (Address) (City) Lincoln (County)

Did you or employee's supervisor have actual knowledge of accident? Yes ☒ No ☐

Were you notified of accident by injured employee? Yes ☒ No ☐ How: in person Date: 6-28-68

Have you reason to question this accident? Yes ☐ No ☒ If "yes" explain fully .....

SAFETY

Was employee's accident due to unsafe work practices? Yes ☐ No ☒ If "yes", what did he do unsafely?

Was a specific device, object or substance involved in accident? Yes ☒ No ☐ If "yes", name specific device, object or substance: board with nail Was device or object defective? Yes ☐ No ☐

Was employee doing regular work when injured? Yes ☒ No ☐ Was employee trained to do work he was doing when injured? Yes ☒ No ☐ Were adequate safe guards provided? Yes ☐ No ☐ If "yes" were they being used at time of accident? Yes ☐ No ☐

MEDICAL ATTENDANCE

Name of attending physician: Paul J. Seifert, MD Address: Libby, Montana

Was employe hospitalized? Yes ☐ No ☒ Name of hospital ..... Address .....

Was first aid administered by someone other than attending physician? Yes ☐ No ☒

TIME AND WAGE LOSS

Will employe lose time from work due to accident? Yes ☐ No ☒ How long? .....

If injury results in time loss, will employee, while disabled, receive sick leave benefits? Yes ☐ No ☐

Paid vacation? Yes ☐ No ☐

Will employe lose wages? Yes ☐ No ☐ Room? Yes ☐ No ☐ Board? Yes ☐ No ☐

Date wage loss began: NONE Amount of weekly wage loss .....

EMPLOYER

Name of employer: Zonolite Division-W.R.Grace & Co.

Address: Libby, Montana Nature of business: Mining & Milling Vermiculite

IS FIRM A CORPORATION ☒ OR PARTNERSHIP ☐ OR INDIVIDUAL ☐

IF
- Corporation—is injured employee an officer or director of corporation? Yes ☐ No ☒
- Partnership—is injured employee related to any partner? Yes ☐ No ☐ Relationship .....
- Individual—is injured employee related to employer? Yes ☐ No ☐ Relationship .....

Signed, this 9th day of August, 19 68

Employer's Name: Zonolite Division-W.R.Grace & Co.

Signed by .....

at Libby Montana

Official Title .....

NOTICE—EMPLOYEE'S CLAIM FOR COMPENSATION, FORM 54, MUST BE FILED WITHIN 12 MONTHS FROM DATE OF ACCIDENT

Form 1-HU-163-ZR

Carrier | Firm No. | File No. | Major Industry | County | Date of Acc. | Time | Sex & Marital Status | Age | Mont. Code | Acc. Class | Occupation | Type | Agency | Agency Part | Nature of Inj. | Location | Time Loss | Mech. Defect | Unsafe Act | Pers. Factor | Weekly Wage

C0080044
WRG00299075
ED_005351_00000355-00174

06063045

August 2, 1968

American Adjustment Co.
P. O. Box 2625
Great Falls, Montana 59401

Re: Bill Schull
D/A 6-28-68
03 WCM 34 024973

Gentlemen:

Mr. Schull has left our employ, and did so before he reported the above industrial accident to us. The safety supervisor at our mine was on vacation at the time of the accident, otherwise we would have details as to what happened. We are wondering if you could advise us as to what doctor attended Mr. Schull.

There was no lost-time involved, according to our time records. However, we would like to complete the Employer's First Report and submit it to you.

Very truly yours

ZONOLITE DIVISION
W. R. GRACE & CO.

By:

Joan B. Greenup

C0080045

WRG00299076

ED_005351_00000355-00175

AREA CODE 406/293-4131 - CABLE ADDRESS "ZONOCO" CHICAGO, ILLINOIS

GRACE

06063046

ZONOLITE

DIVISION W. R. GRACE & CO.

LIBBY, MONTANA

MINERS AND MANUFACTURERS OF VERMICULITE PRODUCTS

August 2, 1968

American Adjustment Co.
P. O. Box 2625
Great Falls, Montana 59401

Re: Bill Schull
D/A 6-28-68
03 WCM 34 024973

Gentlemen:

Mr. Schull has left our employ, and did so before he reported the above industrial accident to us. The safety supervisor at our mine was on vacation at the time of the accident, otherwise we would have details as to what happened. We are wondering if you could advise us as to what doctor attended Mr. Schull.

There was no lost-time involved, according to our time records. However, we would like to complete the Employer's First Report and submit it to you.

Very truly yours

ZONOLITE DIVISION
W. R. GRACE & CO.
By: Joan B. Greenup

Joan B. Greenup

I am enclosing the doctor's report form for your use as it appears that this is an industrial accident.

C0080046

Industrial Accident Board, Helena, Montana, Form 37 Revised

06063047

Industrial Accident Board

HELENA, MONTANA

Firm No.

File No.

EMPLOYER'S FIRST REPORT OF INJURY

DO NOT WRITE IN THIS SPACE

INSTRUCTIONS—Employer must complete form at once after every accident which causes loss of time from work or requires medical attention and mail it to the Industrial Accident Board, Helena, Montana. Form must be signed in pen and ink. ALL QUESTIONS MUST BE ANSWERED FULLY.

INJURED EMPLOYEE

Full name of injured employee: Billie Joe Schull Occupation: Euclid Driver

Mailing address: #14 Mill Row, Libby How long has he been in your employ: 1 year

Social Security No. 514-38-6734 Sex: M Age: 29 Married ☐ Single ☒

EARNINGS

Monthly Wage: Weekly Wage: Daily Wage: Hourly Wage: 3.06

Receive board Yes ☐ No ☒ Daily Value: Receive room Yes ☐ No ☒ Daily Value:

Piece Worker Yes ☐ No ☒ If yes, give method of computing earnings:

Number of hours worked per day: 8 Days worked per week: 5 Employee's pay period?

Monthly ☐ Semi monthly ☒ Weekly ☐ List employee's earnings last 4 pay periods 1. 259.96 2. 349.10 3. 377.00 4. 346.56

Under what payroll classification has employees' wages been reported? (Sawmill - Machanic - Etc.)

ACCIDENT AND INJURY

Describe in full how accident happened and GIVE CAUSE: The mine crew was moving a new shovel up the road to the mine. They had wooden blocking in the road, and when employee picked up piece of blocking, he lacerated his right hand on a nail protruding from piece of wood.

Part of body injured? Describe fully: right hand

Names of witnesses to accident 1. Day shift 2.

Date of accident: 6-28- 1968 Hour: P.M. A.M. Was employee injured in course of employment? Yes ☐ No ☐

Place where accident occured: ourmine, 9 miles north of Libby (Address) (City) Lincoln (County)

Did you or employee's supervisor have actual knowledge of accident? Yes ☒ No ☐

Were you notified of accident by injured employee? Yes ☒ No ☐ How: In person Date: 6-28-68

Have you reason to question this accident? Yes ☐ No ☒ If "yes" explain fully:

SAFETY

Was employee's accident due to unsafe work practices? Yes ☐ No ☒ If "yes", what did he do unsafely?

Was a specific device, object or substance involved in accident? Yes ☒ No ☐ If "yes", name specific device, object or substance: board with nail Was device or object defective? Yes ☐ No ☐

Was employee doing regular work when injured? Yes ☒ No ☐ Was employee trained to do work he was doing when injured? Yes ☒ No ☐ Were adequate safe guards provided? Yes ☐ No ☐ If "yes" were they being used at time of accident? Yes ☐ No ☐

MEDICAL ATTENDANCE

Name of attending physician: Paul J. Seifert, MD Address: Libby, Montana

Was employe hospitalized? Yes ☐ No ☒ Name of hospital: Address:

Was first aid administered by someone other than attending physician? Yes ☐ No ☒

TIME AND WAGE LOSS

Will employe lose time from work due to accident? Yes ☐ No ☒ How long?

If injury results in time loss, will employee, while disabled, receive sick leave benefits? Yes ☐ No ☐

Paid vacation? Yes ☐ No ☐

Will employe lose wages? Yes ☐ No ☐ Room? Yes ☐ No ☐ Board? Yes ☐ No ☐

Date wage loss began: NONE Amount of weekly wage loss:

EMPLOYER

Name of employer: Zonolite Division-W.R.Grace & Co.

Address: Libby, Montana Nature of business: Mining & Milling Vermiculite

IS FIRM A CORPORATION ☒ OR PARTNERSHIP ☐ OR INDIVIDUAL ☐

IF
- Corporation—is injured employee an officer or director of corporation? Yes ☐ No ☒
- Partnership—is injured employee related to any partner? Yes ☐ No ☐ Relationship
- Individual—is injured employee related to employer? Yes ☐ No ☐ Relationship

Signed, this 9th day of August, 19 68

at Libby Montana

Employer's Name: Zonolite Division-W.R.Grace & Co.

Signed by: [signature]

Official Title:

NOTICE—EMPLOYEE'S CLAIM FOR COMPENSATION, FORM 54, MUST BE FILED WITHIN 12 MONTHS FROM DATE OF ACCIDENT

Form 1-HU-163-ZR

Carrier | Firm No. | File No. | Major Industry | County | Date of Acc. | Time | Sex & Marital Status | Age | Mont. Code | Acc. Class | Occupation | Type | Agency | Agency Part | Nature of Inj. | Location | Time Loss | Mech. Defect | Unsafe Act | Pers. Factor | Weekly Wage

00080047
WRG00299078
ED_005351_00000355-00177

MEDICAL
Schultz, Robert L.

C0080048

G00299079

ED_005351_00000355-00178

STRIAL ACCIDENT BOARD, HELENA, MONTANA. FORM 37 REVISED. 2M 5-59 18933

Industrial Accident Board

HELENA, MONTANA

Claim Department

m No. _____
im No. 1 1 1 1
ident No. _____
(DO NOT FILL IN)

EMPLOYER'S FIRST REPORT OF INJURY

DO NOT WRITE IN THIS SPACE

INSTRUCTIONS—The employer must fill out this form and return same to Industrial Accident Board, Helena, ntana, at once after every accident which causes any loss of work or requires medical attention. In filling out form use pen or typewriter.

MPLOYER, LACE AND TIME

Employer's name: Zonolite Company
Office address: Libby, Montana (Street and number, city or town)
Nature of business: Mining and Milling Vermiculite (Type of construction, manufacturing, etc.)
Did accident occur on work for a public corporation? No
Location of plant or place of work where accident occurred: Same (Street and Number)
In what city or village? Libby County? Lincoln
Date of accident: September 20, 19 59; hour of day: 9:30 A.M. P.M.
Did accident happen on premises? Yes
If away from the plant, state where?
Was employee injured in the course of employment? yes

THE INJURED MPLOYEE

Give full name of injured workman: Robert Schultz
Mailing address: Box 789, Libby, Montana (Street and number, city or town and county)
Sex: M Age: 19 Speak English? Yes If not, what language?
Occupation when injured? Euclid Operator Married or single? Single
Was injured employee on duty at time of accident? Yes (See Form 87-a) If not, state fully on back hereof
How long was injured person in your employment? 5 months

CAUSE OF INJURY

Described in full how the accident occurred (DO NOT FAIL TO DO THIS): While driving away from shovel in pit, became stuck in mud. While looking backward out door of cab to see where he was backing, left outside dual tire blew out, throwing mud and gravel into face and eyes.

THE INJURY

State nature and extent of injury according to your own information. (We do not need the doctor's report here): Foreign matter in eyes, and bruise on forehead.
WILL EMPLOYEE LOSE TIME? YES N.A. NO
DATE WAGE LOSS BEGAN? PROBABLE DURATION OF WAGE LOSS? 1/2 day (Give your best estimate)

MEDICAL TENDANCE

Name and address of physician attending injured employee: Dr. Paul Seifert, Libby, Montana
To what hospital was employee sent? St. Johns Lutheran
If not sent to hospital, where is he? no
Are you still providing medical attendance? Have you a hospital contract? no

WAGES

Monthly wage (If paid by month) Weekly wage 9 (If paid by week) Daily wage (If paid by day) Rate per hour 2.925 (If paid by hour)
Number of hours per day Number of working days per week 7 5
If employee receives board in addition to money wage, state how many meals per day none
Does he receive room in addition to money wage? No

AGE LOSS

How much money wage will employee lose per day because of accident? none
How much board? Will he lose room? no

OTICE OF INJURY

Were you notified by the injured employee of his injury? yes If so, how and when? by employee (Write on back of this form if necessary)
Did you or your managing superintendent in charge of work of injured employee at time of injury have actual knowledge of such accident and injury? yes If so, explain how by employee (Write on back of this form if necessary)

ed, this 14th day of October, 19 59
Libby, Montana

Employer's Name: Zonolite Company
Signed by: C0080049
Official Title: Secretary

TICE—Employer should have injured workmen fill out Form 37-A and return same to Board with Employer's First Report of Injury.

Firm No.
Acc. No.
Major Industry
County
Date of Acc.
Time
Sex & Marital Status
Age
Mont. Code
Acc. Class
Occupation
Type
Agency
Agency Part
Nature of Inj.
Location
Ext. of Dis.
Mech. Defect
Unsafe Act
Pers. Factor
Weekly Wage
Report Lag
Carrier

MEDICAL
Schultz, Robert L.

C0080049

INDUSTRIAL ACCIDENT BOARD, HELENA, MONTANA. FORM 37 REVISED. 2M 8-59 19933

Industrial Accident Board

06062242

HELENA, MONTANA

Claim Department

Firm No.
Claim No.
Accident No.
DO NOT FILL IN

EMPLOYER'S FIRST REPORT OF INJURY

DO NOT WRITE IN THIS SPACE

INSTRUCTIONS—The employer must fill out this form and return same to Industrial Accident Board, Helena, Montana, at once after every accident which causes any loss of work or requires medical attention. In filling out this form use pen or typewriter.

EMPLOYER, PLACE AND TIME

Employer's name: Zonolite Com pany
Office address: Libby, Montana (Street and number, city or town)
Nature of business: Mining and Milling Vermiculite (Type of construction, manufacturing, etc.)
Did accident occur on work for a public corporation? No
Location of plant or place of work where accident occurred: Same (Street and Number)
In what city or village? Libby County? Lincoln
Date of accident: September 20, 19 59; hour of day: 9:30 A.M. P.M.
Did accident happen on premises? Yes
If away from the plant, state where?
Was employee injured in the course of employment? yes

THE INJURED EMPLOYEE

Give full name of injured workman: Robert Schultz
Mailing address: Box 789, Libby, Montana (Street and number, city or town and county)
Sex: M Age: 19 Speak English? Yes If not, what language?
Occupation when injured? Euclid Operator Married or single? Single
Was injured employee on duty at time of accident? Yes (See Form 87-a) If not, state fully on back hereof
How long was injured person in your employment? 5 months

CAUSE OF INJURY

Described in full how the accident occurred (DO NOT FAIL TO DO THIS)
While driving away from shovel in pit, became stuck in muck. While looking backward out door of cab to see where he was backing, left outside dual tire blew out, throwing mud and gravel into face and eyes.

THE INJURY

State nature and extent of injury according to your own information. (We do not need the doctor's report here) Foreign matter in eyes, and bruise on forehead.
WILL EMPLOYEE LOSE TIME? YES NO
DATE WAGE LOSS BEGAN? PROBABLE DURATION OF WAGE LOSS? 1/2 day (Give your best estimate)

MEDICAL ATTENDANCE

Name and address of physician attending injured employee: Dr. Paul Seifert, Libby, Montana
To what hospital was employee sent? St. Johns Lutheran
If not sent to hospital, where is he?
Are you still providing medical attendance? no Have you a hospital contract? no

WAGES

Monthly wage (If paid by month) Weekly wage (If paid by week) Daily wage (If paid by day) Rate per hour 2.325 (If paid by hour)
Number of hours per day: 8 How many working days per week: 7
If employee receives board in addition to money wage, state how many meals per day: none
Does he receive room in addition to money wage? no

WAGE LOSS

How much money wage will employee lose per day because of accident? none
How much board? Will he lose room? no

NOTICE OF INJURY

Were you notified by the injured employee of his injury? yes If so, how and when? by employee (Write on back of this form if necessary)
Did you or your managing superintendent in charge of work of injured employee at time of injury have actual knowledge of such accident and injury? yes If so, explain how by employee (Write on back of this form if necessary)

Signed, this 14th day of October, 19 59
at Libby, Montana
Employer's Name: Zonolite Company
Signed by
Official Title: Secretary

NOTICE—Employer should have injured workmen fill out Form 37-A and return same to Board with Employer's First Report of Injury.

Firm No. | Acc. No. | Major Industry | County | Date of Acc. | Time | Sex & Marital Status | Age | Mont. Code | Acc. Class | Occupation | Type | Agency | Agency Part | Nature of Inj. | Location | Ext. of Dis. | Mech. Defect | Unsafe Act | Pers. Factor | Weekly Wage | Report Leg | Carrier

C0080051
WRG00299082
ED_005351_00000355-00181

MEDICAL
Schultz, Robert L.

C0080048

STANDARD FORM FOR EMPLOYER'S FIRST REPORT OF INJURY

Approved by I. A. I. A. B. C.

☞ Complete and send immediately to CLAIMS DEPARTMENT

State's Number For:	File : ..... Carrier : ..... Employer: .....
Carrier's File No.	
(The spaces above not to be filled in by Employer)	

POLICY NUMBER .....

Employer

1. Name of Employer: Zonolite Company
2. Office address: No. and St. P. O. Box 607, City or Town: Libby State: Montana
3. Insured by Name of Company: Royal Indemnity Co.
4. Give nature of business (or article manufactured): Mining & Milling Vermiculite

Time and Place

5. (a) Location of plant or place where accident occurred: Same
   Mine Department ..... State if employer's premises: Yes
   (b) If injured in a mine, did accident occur on surface, underground, shaft, drift or mill: Surface
6. Date of Injury: 9-20- 19 61 Day of week: Wed. Hour of day: A.M. 10:30 P.M.
7. Date disability began: no disability 19 ..... A.M. ..... P.M. 8. Was injured paid in full for this day: yes
9. When did you or foreman first know of injury: 9-20-61
10. Name of foreman: Orville M. Thorn

Injured Person

11. Name of Injured: Robert (First Name) L. (Middle Initial) Schultz (Last Name)
12. Address: No. and St. Box 789 City or Town: Libby State: Montana
13. Check (√) Married....., Single....X, Widowed....., Widower....., Divorced.....; Male....X, Female.....; White....X, Colored.....
14. Nationality: American Speak English: Yes
15. Age: 21 Did you have on file employment certificate or permit .....
16. (a) Occupation when injured: Transfer Point Operator (b) Was this his or her regular occupation: No
    (If not, state in what department or branch of work regularly employed) Euclid driver
17. (a) How long employed by you: 2-1/2 yrs (b) Piece or time worker: Time (c) Wages per hour $: 2.44
18. (a) No. hours worked per day: 8 (b) Wages per day $: 19.52
    (c) No. days worked per week: 5 (d) Average weekly earnings $: 97.60
    (e) If board, lodging, fuel or other advantages were furnished in addition to wages, give estimated value per day, week or month .....

Cause of Injury

19. Machine, tool or thing causing injury ..... 20. Kind of power (hand, foot, electrical, steam, etc.) ..... 21. Part of machine on which accident occurred .....
22. (a) Was safety appliance or regulation provided ..... (b) Was it in use at time .....
23. Was accident caused by injured's failure to use or observe safety appliance or regulation .....
24. Describe fully how accident occurred, and state what employee was doing when injured:
    While operating transfer point, received ore dust in eyes.
25. Names and addresses of witnesses .....

Nature of Injury

26. Nature and location of injury (describe fully exact location of amputations or fractures, right or left):
    foreign matter in eyes.
27. Probable length of disability: none 28. Has injured returned to work: yes
    If so, date and hour: 9-21-61 At what wage $: same
29. At what occupation: same
30. (a) Name and address of physician: Dr. Paul J. Seifert, Jr., Libby, Montana
    (b) Name and address of hospital: St. Johns Lutheran

Disposition of Injured

31. Has injured died ..... If so, give date of death .....

Date of this report: October 13, 1961 Firm name: ZONOLITE COMPANY

Signed by ..... Official Title .....

24861A - SOM-11-56
(Formerly CH-1 S.F.No.1)

C0080050

TRIAL ACCIDENT BOARD, HELENA, MONTANA. FORM 37 REVISED. 2M 6-57 84530

Industrial Accident Board

HELENA, MONTANA

Claim Department

n No.
m No.
dent No.

DO NOT FILL IN

EMPLOYER'S FIRST REPORT OF INJURY

DO NOT WRITE IN THIS SPACE

INSTRUCTIONS—The employer must fill out this form and return same to Industrial Accident Board, Helena, tana, at once after every accident which causes any loss of work or requires medical attention. In filling out form use pen or typewriter.

MPLOYER, LACE AND TIME

Employer's name: Zonolite Company
Office address: Libby, Montana (Street and number, city or town)
Nature of business: Mining & Milling Vermiculite (Type of construction, manufacturing, etc.)
Did accident occur on work for a public corporation? No
Location of plant or place of work where accident occurred: Libby (Street and Number)
In what city or village? Libby County? Lincoln
Date of accident: September 20, 1961; hour of day 10:30 ~~a.m.~~ P.M.
Did accident happen on premises? yes
If away from the plant, state where?
Was employee injured in the course of employment? yes

THE NJURED MPLOYEE

Give full name of injured workman: Robert L. Schultz
Mailing address: Box 789, Libby, Montana (Street and number, city or town and county)
Sex: M Age: 21 Speak English? Yes If not, what language?
Occupation when injured? Euclid Driver Married or single? Single (See Form 87-a)
Was injured employee on duty at time of accident? Yes If not, state fully on back hereof
How long was injured person in your employment? 2-1/2 yrs.

AUSE OF INJURY

Described in full how the accident occurred (DO NOT FAIL TO DO THIS)
While operating transfer point, received foreign matter in ~~factor~~ left eye.

THE INJURY

State nature and extent of injury according to your own information. (We do not need the doctor's report here) Foreign matter in left eye.
WILL EMPLOYEE LOSE TIME? YES NO XX
DATE WAGE LOSS BEGAN? none PROBABLE DURATION OF WAGE LOSS? none (Give your best estimate)

MEDICAL TENDANCE

Name and address of physician attending injured employee: Dr. Seifert, Libby, Montana
To what hospital was employee sent? St. Johns Lutheran
If not sent to hospital, where is he?
Are you still providing medical attendance? No Have you a hospital contract? No

WAGES

Monthly wage (If paid by month) Weekly wage (If paid by week) Daily wage (If paid by day) Rate per hour 2.44 (If paid by hour)
Number of hours per day 8 How many working days per week 5
If employee receives board in addition to money wage, state how many meals per day none
Does he receive room in addition to money wage? no

AGE LOSS

How much money wage will employee lose per day because of accident? none
How much board? none Will he lose room? no

OTICE OF INJURY

Were you notified by the injured employee of his injury? yes If so, how and when by employee (Write on back of this form if necessary)
Did you or your managing superintendent in charge of work of injured employee at time of injury have actual knowledge of such accident and injury? yes If so, explain how by employee (Write on back of this form if necessary)

ed, this 11th day October, 1961

Employer's Name Zonolite Company
Signed by
Official Title Secretary

Libby, Montana

C0080052

TICE—Employer should have injured workmen fill out Form 37-A and return same to Board with Employer's First Report of Injury.

DO NOT WRITE IN THIS SPACE: Firm No. / Acc. No. / Major Industry / County / Date of Acc. / Time / Sex & Marital Status / Age / Mont. Code / Acc. Class / Occupation / Type / Agency / Agency Part / Nature of Inj. / Location / Ext. of Dis. / Mech. Defect / Unsafe Act / Pers. Factor / Weekly Wage / Report Lag / Carrier

MEDICAL
Schultz, Robert L.

C0080048

WRG00299086

ED_005351_00000355-00185

06062435

STANDARD FORM FOR EMPLOYER'S FIRST REPORT OF INJURY

Approved by I. A. I. A. B. C.

☞ Complete and send immediately to CLAIMS DEPARTMENT

State's Number For:	File : ..... Carrier : ..... Employer: .....
Carrier's File No.	

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

POLICY NUMBER .....

Employer

1. Name of Employer: Zonolite Company
2. Office address: No. and St. P.O. Box 607, City or Town: Libby State: Montana
3. Insured by Name of Company: Royal Indemnity Co.
4. Give nature of business (or article manufactured): Mining & Milling Vermiculite

Time and Place

5. (a) Location of plant or place where accident occurred: Same
   Mine Department State if employer's premises: Yes
   (b) If injured in a mine, did accident occur on surface, underground, shaft, drift or mill: Surface
6. Date of Injury: 9-20- 19 61 Day of week: Wed. Hour of day: A.M. 10:30 P.M.
7. Date disability began: no disability 19 A.M. P.M. 8. Was injured paid in full for this day: yes
9. When did you or foreman first know of injury: 9-20-61
10. Name of foreman: Orville M. Thorn

Injured Person

11. Name of Injured: Robert (First Name) L. (Middle Initial) Schultz (Last Name)
12. Address: No. and St. Box 789 City or Town: Libby State: Montana
13. Check (√) Married ....., Single X, Widowed ....., Widower ....., Divorced .....; Male X, Female .....; White X, Colored .....
14. Nationality: American Speak English: Yes
15. Age: 21 Did you have on file employment certificate or permit .....
16. (a) Occupation when injured: Transfer Point Operator (b) Was this his or her regular occupation: No
    (If not, state in what department or branch of work regularly employed) Euclid driver
17. (a) How long employed by you: 2-1/2 yrs (b) Piece or time worker: Time (c) Wages per hour $: 2.44
18. (a) No. hours worked per day: 8 (b) Wages per day $: 19.52
    (c) No. days worked per week: 5 (d) Average weekly earnings $: 97.60
    (e) If board, lodging, fuel or other advantages were furnished in addition to wages, give estimated value per day, week or month .....

Cause of Injury

19. Machine, tool or thing causing injury ..... 20. Kind of power (hand, foot, electrical, steam, etc.) ..... 21. Part of machine on which accident occurred .....
22. (a) Was safety appliance or regulation provided ..... (b) Was it in use at time .....
23. Was accident caused by injured's failure to use or observe safety appliance or regulation .....
24. Describe fully how accident occurred, and state what employee was doing when injured:
    While operating transfer point, received ore dust in eyes.
25. Names and addresses of witnesses .....

Nature of Injury

26. Nature and location of injury (describe fully exact location of amputations or fractures, right or left): foreign matter in eyes.
27. Probable length of disability: none 28. Has injured returned to work: yes
    If so, date and hour: 9-21-61 At what wage $: same
29. At what occupation: same
30. (a) Name and address of physician: Dr. Paul J. Seifert, Jr., Libby, Montana
    (b) Name and address of hospital: St. Johns Lutheran

Cases Fatal

31. Has injured died ..... If so, give date of death C0080053

Date of this report: October 13, 1961 Firm name: ZONOLITE COMPANY

Signed by ..... Official Title .....

CH 24861A - 50M-11-56 ☞
Formerly CH43

WRG00299087

ED_005351_00000355-00186

INDUSTRIAL ACCIDENT BOARD, HELENA, MONTANA. FORM 37 REVISED. 2M 6-57 84530

06062426

Industrial Accident Board

HELENA, MONTANA

Claim Department

Firm No.

Claim No.

Accident No.

DO NOT FILL IN

EMPLOYER'S FIRST REPORT OF INJURY

DO NOT WRITE IN THIS SPACE

INSTRUCTIONS—The employer must fill out this form and return same to Industrial Accident Board, Helena, Montana, at once after every accident which causes any loss of work or requires medical attention. In filling out this form use pen or typewriter.

EMPLOYER, PLACE AND TIME

Employer's name: Zonolite Company

Office address: Libby, Montana (Street and number, city or town)

Nature of business: Mining & Milling Vermiculite (Type of construction, manufacturing, etc.)

Did accident occur on work for a public corporation? No

Location of plant or place of work where accident occurred: Libby (Street and Number)

In what city or village? Libby County? Lincoln

Date of accident: September 20, 1961; hour of day: 10:30 ~~A.M.~~ P.M.

Did accident happen on premises? yes

If away from the plant, state where?

Was employee injured in the course of employment? yes

THE INJURED EMPLOYEE

Give full name of injured workman: Robert L. Schultz

Mailing address: Box 789, Libby, Montana (Street and number, city or town and county)

Sex: M Age: 21 Speak English? Yes If not, what language?

Occupation when injured? Euclid Driver Married or single? Single (See Form 37-a)

Was injured employee on duty at time of accident? Yes If not, state fully on back hereof

How long was injured person in your employment? 2-1/2 yrs.

CAUSE OF INJURY

Described in full how the accident occurred (DO NOT FAIL TO DO THIS)

While operating transfer point, received foreign matter in ~~both~~ left eye.

THE INJURY

State nature and extent of injury according to your own information. (We do not need the doctor's report here) Foreign matter in left eye.

WILL EMPLOYEE LOSE TIME? YES ____ NO XX

DATE WAGE LOSS BEGAN? none PROBABLE DURATION OF WAGE LOSS? none (Give your best estimate)

MEDICAL ATTENDANCE

Name and address of physician attending injured employee: Dr. Seifert, Libby, Montana

To what hospital was employee sent? St. Johns Lutheran

If not sent to hospital, where is he?

Are you still providing medical attendance? No Have you a hospital contract? No

WAGES

Monthly wage (If paid by month) ____ Weekly wage (If paid by week) ____ Daily wage (If paid by day) ____ Rate per hour (If paid by hour) 2.44

Number of hours per day: 8 How many working days per week: 5

If employee receives board in addition to money wage, state how many meals per day: none

Does he receive room in addition to money wage? no

WAGE LOSS

How much money wage will employee lose per day because of accident? none

How much board? none Will he lose room? no

NOTICE OF INJURY

Were you notified by the injured employee of his injury? yes If so, how and when: by employee (Write on back of this form if necessary)

Did you or your managing superintendent in charge of work of injured employee at time of injury have actual knowledge of such accident and injury? yes If so, explain how: by employee (Write on back of this form if necessary)

Signed, this 11th day October, 1961

Employer's Name: Zonolite Company

Signed by

at Libby, Montana

Official Title: Secretary

NOTICE—Employer should have injured workmen fill out Form 37-A and return same to Board with Employer's First Report of Injury.

Firm No. | Acc. No. | Major Industry | County | Date of Acc. | Time | Sex & Marital Status | Age | Mont. Code | Acc. Class | Occupation | Type | Agency | Agency Part | Nature of Inj. | Location | Ext. of Dis. | Mech. Defect | Unsafe Act | Pers. Factor | Weekly Wage | Report Lag | Carrier

C0080054 WRG00299088

ED_005351_00000355-00187

MEDICAL
Schroeder, Charles

C0080055

Industrial Accident Board

06063353

HELENA, MONTANA

Firm No. 2503

File No.

EMPLOYER'S FIRST REPORT OF INJURY

INSTRUCTIONS—Employer must complete form at once after every accident which causes loss of time from work or requires medical attention and mail it to the Industrial Accident Board, Helena, Montana. Form must be signed in pen and ink. ALL QUESTIONS MUST BE ANSWERED FULLY.

INJURED EMPLOYEE

Full name of injured employee: Charles Schroeder Occupation: Engineer

Mailing address: Route 3 Box 1004A, Libby, Montana (Street, City) How long has he been in your employ? 11 mos.

Social Security No. 530-32-3205 Sex: M Age: 25 Married [X] Single [ ]

EARNINGS

Monthly Wage ____ Weekly Wage ____ Daily Wage ____ Hourly Wage ____

Receive board Yes [ ] No [X] Daily Value ____ Receive room Yes [ ] No [X] Daily Value ____

Piece Worker Yes [ ] No [X] If yes, price per unit at piece work ____ Hours worked per day 8

Days worked per week 6 Employee's pay period? Monthly [X] Semi-monthly [ ] Weekly [ ] List employee's earnings last 4 pay periods 1 ____ 2 ____ 3 ____ 4 ____

List Payroll Classification and Code under which employee's wages were reported ____ (Sawmill - Mechanic - Etc.) Code ____ (2702, 5506, 8810)

ACCIDENT AND INJURY

Describe in full how accident happened and GIVE CAUSE: Was loosening a bolt on a feeder box in the mill with a crescent wrench and pliers, bolt broke loose suddenly, right index finger struck piece of metal on feeder box, laceration resulted.

Nature or extent of injury: laceration (Cut - Fracture) Part of body injured? right index finger (Leg - Arm - Back - Head)

Names of witnesses to accident 1 ____ 2 ____

Date of accident: 5-21-71 19__ Hour ____ A.M. P.M. Was employee injured in course of employment? Yes [X] No [ ]

Place where accident occurred: our mill, 9 miles north of Libby (Address, City) Lincoln (County)

Did you or employee's supervisor have actual knowledge of accident? Yes [X] No [ ]

Were you notified of accident by injured employee? Yes [X] No [ ] How: In person Date: 6-10-71

Have you reason to question this accident? Yes [ ] No [X] If "yes" explain fully ____

SAFETY

Was employee's accident due to unsafe work practice? Yes [ ] No [X] If "yes", what did he do unsafely? ____

Was a specific device, object or substance involved in accident? Yes [ ] No [X] If "yes", name specific device, object or substance ____ Was device or object defective? Yes [ ] No [ ]

Was employee doing regular work when injured? Yes [X] No [ ] Was employee trained to do work he was doing when injured? Yes [X] No [ ] Were adequate safeguards provided? Yes [ ] No [ ] If "yes", were they being used at the time of accident? Yes [ ] No [ ]

MEDICAL ATTENTION

Name of attending physician: Paul J. Seifert, Jr. M.D. Address: Libby, Montana

Was employee hospitalized? Yes [ ] No [X] Name of hospital ____ Address ____

Was first aid administered by someone other than attending physician? Yes [ ] No [X]

TIME AND WAGE LOSS

Will employee lose time from work due to accident? Yes [ ] No [X] How long? NONE If injury results in time loss will employee, while disabled, received sick leave benefits? Yes [ ] No [ ] Paid vacation? Yes [ ] No [ ] Will employee lose wages? Yes [ ] No [ ] Room? Yes [ ] No [ ] Board? Yes [ ] No [ ]

Date wage loss began: NONE Amount of weekly wage loss ____

EMPLOYER

Name of employer: Construction Products Division-W.R.Grace & Co.

Address: Libby, Montana Nature of Business: Mining & Milling Vermiculite

IS FIRM A CORPORATION [X] OR PARTNERSHIP [ ] OR INDIVIDUAL [ ]

IF
- Corporation—is injured employee an officer or director of corporation? Yes [ ] No [X]
- Partnership—is injured employee related to any partner? Yes [ ] No [ ] Relationship ____
- Individual—is injured employee related to employer? Yes [ ] No [ ] Relationship ____

Signed, this 15th day of June, 19 71

at Libby, Montana

Employer's Name: Construction Products Division W. R. Grace & Co.

Signed by: E. D. Goode

Official Title: Mgr

NOTICE—EMPLOYEE'S CLAIM FOR COMPENSATION, FORM 54, MUST BE FILED WITHIN 12 MONTHS FROM DATE OF ACCIDENT.

C0080056

MEDICAL
Sterrick, Enoch

C0080057

INDUSTRIAL ACCIDENT BOARD, HELENA, MONTANA. FORM 37 REVISED. 2M 5-59 19953

Industrial Accident Board

06062260

HELENA, MONTANA

Claim Department

Firm No.

Claim No.

Accident No.

DO NOT FILL IN

EMPLOYER'S FIRST REPORT OF INJURY

DO NOT WRITE IN THIS SPACE

INSTRUCTIONS—The employer must fill out this form and return same to Industrial Accident Board, Helena, Montana, at once after every accident which causes any loss of work or requires medical attention. In filling out this form use pen or typewriter.

EMPLOYER, PLACE AND TIME

Employer's name: Zonolite Company

Office address: ~~XXX~~ Libby, Montana (Street and number, city or town)

Nature of business: Mining and Milling (Type of construction, manufacturing, etc.)

Did accident occur on work for a public corporation? no

Location of plant or place of work where accident occurred: Libby (Street and Number)

In what city or village? Libby County? Lincoln

Date of accident 10-24-, 19 59; hour of day 2:50 ~~A.M.~~ P.M.

Did accident happen on premises? Yes

If away from the plant, state where?

Was employee injured in the course of employment? yes

THE INJURED EMPLOYEE

Give full name of injured workman: Enoch R. Shairrick

Mailing address: Box 751, Libby, Montana (Street and number, city or town and county)

Sex M Age 47 Speak English? Yes If not, what language?

Occupation when injured? Tester Married or single? Married (See Form 37-a)

Was injured employee on duty at time of accident? yes If not, state fully on back hereof

How long was injured person in your employment? 8 months

CAUSE OF INJURY

Described in full how the accident occurred (DO NOT FAIL TO DO THIS)

While on way from spiral section of mill to laboratory, slipped on metal grating-type step which was wet and slippery. Missed one step and landed with jolt on concrete floor.

THE INJURY

State nature and extent of injury according to your own information. (We do not need the doctor's report here) Strained shoulder and neck muscle

WILL EMPLOYEE LOSE TIME? YES ____ NO XX

DATE WAGE LOSS BEGAN? ____ PROBABLE DURATION OF WAGE LOSS? ____ (Give your best estimate)

MEDICAL ATTENDANCE

Name and address of physician attending injured employee: Dr. H. H. Anderson, Libby, Montana

To what hospital was employee sent? none

If not sent to hospital, where is he? working

Are you still providing medical attendance? no Have you a hospital contract? no

WAGES

Monthly wage ____ (If paid by month) Weekly wage ____ (If paid by week) Daily wage ____ (If paid by day) Rate per hour 3.20 (If paid by hour)

Number of hours per day 8 How many working days per week 5 6

If employee receives board in addition to money wage, state how many meals per day none

Does he receive room in addition to money wage? no

WAGE LOSS

How much money wage will employee lose per day because of accident? none

How much board? ____ Will he lose room? no

NOTICE OF INJURY

Were you notified by the injured employee of his injury? yes If so, how and when? by employee (Write on back of this form if necessary)

Did you or your managing superintendent in charge of work of injured employee at time of injury have actual knowledge of such accident and injury? yes If so, explain how ____ (Write on back of this form if necessary)

Signed, this 27th day of October, 19 59

Employer's Name: Zonolite Company

Signed by: ____

Official Title: Secretary

at Libby, Montana

NOTICE—Employer should have injured workmen fill out Form 37-A and return same to Board with Employer's First Report of Injury.

Firm No. | Acc. No. | Major Industry | County | Date of Acc. | Time | Sex & Marital Status | Age | Mont. Code | Acc. Class | Occupation | Type | Agency | Agency Part | Nature of Inj. | Location | Ext. of Dis. | Mech. Defect | Unsafe Act | Pers. Factor | Weekly Wage | Report Lag | Carrier

C0080059

WRG00299094

MEDICAL
Shearer, Ra | ph

C0080061

06062355

JARDINE, STEPHENSON, BLEWETT & WEAVER
ATTORNEYS AT LAW
FIRST NATIONAL BANK BUILDING
GREAT FALLS, MONTANA

ART JARDINE
JOHN D. STEPHENSON
ALEX BLEWETT, JR.
JOHN H. WEAVER
JOSEPH G. MUDD

WILLIAM L. BAILLIE
L. MORRIS ORMSETH
GEORGE N. MCCABE

PHONE
GLENDALE 3-0391

November 28, 1960

Zonolite Company
Libby, Montana

Re: Ralph Shearer
D/A: October 17, 1960

Gentlemen:

We are enclosing Employee's Claim forms for completing by Mr. Shearer in connection with the above captioned case. We have previously forwarded these forms to Mr. Shearer in Libby, but we have not received them. It appears from the file that Mr. Shearer would be entitled to two days compensation if he wishes to present a claim.

We will keep our file open for a short time and if we do not receive the claim forms in the next few days, we will assume he does not wish to present a claim for the small amount of compensation to which he may be entitled.

Very truly yours,

JARDINE, STEPHENSON, BLEWETT & WEAVER

By William L. Baillie

WLB:ew

CC: Mr. Ralph Shearer
Route 1, Box 117
Libby, Montana

Enc. - Employee's Claim Forms

C0080067
WRG00299098
ED_005351_00000355-00193

06062356

Industrial Accident Board, Helena, Montana. Form No. 54—500 7-57 85247 Plan No.

Industrial Accident Board

HELENA, MONTANA

CLAIM DEPARTMENT

Firm No.

Claim No.

Accident No.

DO NOT FILL IN

Employee's Claim for Compensation in Case of Injury

INSTRUCTIONS—To facilitate prompt payment of compensation the injured employee, or someone for him, should write carefully (using ink or typewriter) answers to the following questions, and mail the same directly to the Board, within 30 days after date of injury.

I hereby make claim for compensation for an injury resulting in disability, due to an accident occurring 17th day of October, 19 60, arising out of and in the course of my employment by Zonolite Company of Libby, Montana

My claim is: providing—Total Disabled

From, what date October 17, 19 60

Are you now disabled? No If not, on what date were you able to return to work? October 27, 1960

(for light work only)

, 19 . If still disabled, how long do you estimate disability to continue?

IF PARTIALLY DISABLED: From what date? October 27, 19 60 Are you still partially disabled? Yes If not, on what date did disability cease? , 19

If still partially disabled, how long do you estimate disability will continue? Unknown

By how much have your daily earnings been reduced by this injury? $1.20

Have you contributed to Hospital Fund? no

In proof of such claim I make the following statements under oath:

Place Of Accident

Location of plant where accident occurred Libby, Montana

In what city or village? Libby, County? Lincoln

If away from employer's premises or plant, state where accident happened

The Injured Employee

Full name of injured employee Ralph H. Shearer

Address where mail should be sent Route 1, Box 117, Libby, Montana

(Street and number, city or village and county.)

Sex? M Age? 24 Do you speak English? Yes

If not, what language? Are you married or single? Married

Where were you born? Missoula, Montana

State occupation when injured? Euclid Driver

How long have you worked at this occupation? 5 weeks

How long have you worked for present employer? 11 months (at time of accident)

Were you doing your regular work when injured? Yes--

Piece or time worker? Time How many days per week? 5

Describe how accident occurred? While taking euclid down to shop, it jumped out of gear, brakes failed, and vehicle ran into bank. I rode the vehicle out and when it rolled over the battery cover came loose and fell across my back, injuring my back and breaking one (right) shoulder blade.

(OVER) TRIBUNE PRINTING & SUPPLY CO., GREAT FALLS, MONTANA

C00B006B

WRG00299099

ED_005351_00000355-00194

INDUSTRIAL ACCIDENT BOARD, HELENA, MONT. FORM NO. 43-IN 1-57 81907 TRIBUNE PRINTING & SUPPLY CO., GREAT FALLS, MONTANA

06062358

Plan No.....

Industrial Accident Board

HELENA, MONTANA

Claim Department

Firm No.....

Claim No.....

Accident No.....

Employee No.....

DO NOT FILL IN

Employer's Supplemental Report Of Injury

This notice to be filled out by employer and sent to the Industrial Accident Board, at Helena, Montana, immediately upon employee's returning to work fully recovered if within two weeks—or upon his death or at the expiration of two weeks from date of injury.

Name of injured employee **Ralph H. Shearer**

Address **Route 1, Box 117, Libby, Montana**

Injured **October 17**, 19 **60**

If worked after accident, last date worked?.....

Is injured employee fully recovered? **Yes** On what date? **October 27, 1960**

Has he/she returned to work for you? **Yes** On what date? **October 27, 1960** **(for light work only)**

Has he/she accepted other employment? On what date?.....

If so, where now employed?.....

Has he/she died? If so, when?.....

Signed: **Zonolite Company**

Address **Libby, Montana**

Dated **November 9**, 19 **60**

C0080070

06062359

STANDARD FORM FOR EMPLOYER'S FIRST REPORT OF INJURY

Approved by I. A. I. A. B. C.

Complete and send immediately to CLAIMS DEPARTMENT

State's Number For:	File: ..... Carrier: ..... Employer: .....
Carrier's File No.	

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

POLICY NUMBER .....

Employer

1. Name of Employer: Zonolite Company
2. Office address: No. and St. P. O. Box 607 City or Town Libby State Montana
3. Insured by Name of Company: Royal Indemnity Co.
4. Give nature of business (or article manufactured): Mining and Milling Vermiculite

Time and Place

5. (a) Location of plant or place where accident occurred: Libby, Montana
   Mining Department State if employer's premises: Yes
   (b) If injured in a mine, did accident occur on surface, underground, shaft, drift or mill: Surface
6. Date of Injury: 10-17- 19 60 Day of week: Monday Hour of day: A.M. 6:00 P.M.
7. Date disability began: 10-17-60 19 A.M. 6:09 M. 8. Was injured paid in full for this day: yes
9. When did you or foreman first know of injury: Immediately
10. Name of foreman: Orville M. Thorn

Injured Person

11. Name of Injured: Ralph (First Name) H. (Middle Initial) Shearer (Last Name)
12. Address: No. and St. Route 1, Box 117 City or Town Libby State Montana
13. Check (√) Married X, Single ....., Widowed ....., Widower ....., Divorced .....; Male X, Female .....; White X, Colored .....
14. Nationality: American Speak English: Yes
15. Age: 24 Did you have on file employment certificate or permit .....
16. (a) Occupation when injured: Euclid Driver (b) Was this his or her regular occupation: No
    (If not, state in what department or branch of work regularly employed) Dumpman at mine
17. (a) How long employed by you: 11 months (b) Piece or time worker: Time (c) Wages per hour $: 2.375
18. (a) No. hours worked per day: 8 (b) Wages per day $: 19.00
    (c) No. days worked per week: 5 (d) Average weekly earnings $: 95.00
    (e) If board, lodging, fuel or other advantages were furnished in addition to wages, give estimated value per day, week or month .....

Cause of Injury

19. Machine, tool or thing causing injury ..... 20. Kind of power (hand, foot, electrical, steam, etc.) ..... 21. Part of machine on which accident occurred .....
22. (a) Was safety appliance or regulation provided ..... (b) Was it in use at time .....
23. Was accident caused by injured's failure to use or observe safety appliance or regulation .....
24. Describe fully how accident occurred, and state what employee was doing when injured:
    While taking Euclid down to the shop, jumped out of gear, brakes failed and vehicle ran into bank.
    C00B0071
25. Names and addresses of witnesses .....

Nature of Injury

26. Nature and location of injury (describe fully exact location of amputations or fractures, right or left):
    Broken shoulder blade, scratches & bruises
27. Probable length of disability: 2 weeks 28. Has injured returned to work: Yes - light duty only
    If so, date and hour: 10-31-60 At what wage $: 2.225
29. At what occupation: Dumpman
30. (a) Name and address of physician: Dr. W. T. Matthews, Libby, Montana
    (b) Name and address of hospital: St. Johns Lutheran Hospital, Libby, Montana

Cases Fatal

31. Has injured died ..... If so, give date of death .....

Date of this report: November 2 Firm name: Zonolite Company

CH 24861A - 50M-11-56 Formerly CH42 (B.P. No. 1)

Signed by ..... Official Title .....

WRG00299101

ED_005351_00000355-00196

INDUSTRIAL ACCIDENT BOARD, HELENA, MONTANA. FORM 37 REVISED. 2M 5-59 19933

06062360

Industrial Accident Board

HELENA, MONTANA

Claim Department

Firm No.
Claim No.
Accident No.
DO NOT FILL IN

EMPLOYER'S FIRST REPORT OF INJURY

DO NOT WRITE IN THIS SPACE

INSTRUCTIONS—The employer must fill out this form and return same to Industrial Accident Board, Helena, Montana, at once after every accident which causes any loss of work or requires medical attention. In filling out this form use pen or typewriter.

EMPLOYER, PLACE AND TIME

Employer's name: Zonolite Company
Office address: Libby, Montana (Street and number, city or town)
Nature of business: Mining and milling (Type of construction, manufacturing, etc.)
Did accident occur on work for a public corporation? No
Location of plant or place of work where accident occurred: Same (Street and Number)
In what city or village? Libby County? Lincoln
Date of accident: October 17, 1960; hour of day: 5:00 A.M. P.M.
Did accident happen on premises? Yes
If away from the plant, state where?
Was employee injured in the course of employment? Yes

THE INJURED EMPLOYEE

Give full name of injured workman: Ralph Shearer
Mailing address: Route 1, Box 17, Libby, Montana (Street and number, city or town and county)
Sex: M Age: 24 Speak English? Yes If not, what language?
Occupation when injured: Muckin driver Married or single? Married (See Form 87-a)
Was injured employee on duty at time of accident? Yes If not, state fully on back hereof
How long was injured person in your employment? 11 months

CAUSE OF INJURY

Described in full how the accident occurred (DO NOT FAIL TO DO THIS): [illegible] fell and vehicle ran into back.

THE INJURY

State nature and extent of injury according to your own information. (We do not need the doctor's report here): Broken shoulder blade, [illegible] scratches & bruises
WILL EMPLOYEE LOSE TIME? YES NO
DATE WAGE LOSS BEGAN? 10-19-60 PROBABLE DURATION OF WAGE LOSS? 2 weeks (Give your best estimate)

MEDICAL ATTENDANCE

Name and address of physician attending injured employee: Dr. [illegible], Libby, Montana
To what hospital was employee sent? St. John's [illegible] for emergency care
If not sent to hospital, where is he?
Are you still providing medical attendance? yes Have you a hospital contract? No

WAGES

Monthly wage (If paid by month) Weekly wage (If paid by week) Daily wage (If paid by day) Rate per hour (If paid by hour) [illegible]
Number of hours per day: 8 How many working days per week: 5
If employee receives board in addition to money wage, state how many meals per day
Does he receive room in addition to money wage? No

WAGE LOSS

How much money wage will employee lose per day because of accident? $13.00
How much board? None Will he lose room? No

NOTICE OF INJURY

Were you notified by the injured employee of his injury? Yes If so, how and when? [illegible] (Write on back of this form if necessary)
Did you or your managing superintendent in charge of work of injured employee at time of injury have actual knowledge of such accident and injury? yes If so, explain how [illegible] (Write on back of this form if necessary)

Signed, this 20 day of November, 1960
at Libby, Montana

Employer's Name: Zonolite Company
Signed by
Official Title: Secretary

NOTICE—Employer should have injured workmen fill out Form 37-A and return same to Board with Employer's First Report of Injury.

Firm No.
Acc. No.
Major Industry
County
Date of Acc.
Time
Sex & Marital Status
Age
Mont. Code
Acc. Class
Occupation
Type
Agency
Agency Part
Nature of Inj.
Location
Ext. of Dis.
Mech. Defect
Unsafe Act
Pers. Factor
Weekly Wage
Report Lag
Carrier

C0080072
WRG00299102
ED_005351_00000355-00197

Medical
Shelley, Dennis

C0080076

06063609

Return to: Hugo Dobler Adjuster, Inc. Box 233 – Helena, Mt. 59601

WORKMEN'S COMPENSATION DIVISION

Department of Labor and Industry
815 Front Street
Helena, Montana 59601

CASE No. _____

Firm No. 2503

EMPLOYER'S FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE

INSTRUCTIONS—Employer must complete form at once after every accident or occupational disease which causes loss of time from work or requires medical attention and mail to Workmen's Compensation Division, Helena, Montana. Form must be signed in pen and ink. ALL QUESTIONS MUST BE ANSWERED FULLY. This form contains all items requested on OSHA Form No. 101, "Supplementary Record of Occupational Injuries and Illnesses."

INJURED EMPLOYEE

Full name of injured employee Dennis J. Shelley Occupation Euc. Driver
Home address Rt. 1 - Box 903C, Libby, MT (Street, City) How long has he been in your employ? 9 months
Social Security No. 516-66-1221 Sex M Age 20 Married ☒ Single ☐
Department Construction (Enter name of department or division in which the injured person is regularly employed, even though he may have been temporarily working in another department at the time of injury.)

EARNINGS

Monthly Wage _____, or Weekly Wage _____, or Daily Wage _____, or Hourly Wage 4.46
Receive board? Yes ☐ No ☒ Receive room? Yes ☐ No ☒ Days worked per week 5 Hours worked per week 40 Employee's pay period? Monthly ☐, Semi-monthly ☒, Weekly ☐. List employee's gross earnings and date of last 4 pay periods
1 _____ Date/Amount 2 _____ Date/Amount 3 _____ Date/Amount 4 _____ Date/Amount
List Payroll Classification Code under which employee's wages were reported _____

ACCIDENT AND INJURY

Describe in full how accident happened and GIVE CAUSE—Tell what employee was doing when injured:
Employee slipped on muddy step and fell four feet to cement.
Struck left elbow.

Nature or extent of injury or illness _____ (Cut-Fracture) Part of body affected Arm (Leg-Arm-Back-Head)
Did employee die? Yes ☐ No ☒
Name of witnesses to accident 1 _____ 2 _____
Date of injury or initial diagnosis of occupational illness Mo. 5 Day 7 Year 74 Hour 11:40 A.M. XXXX
Was employee injured in course of employment? Yes ☒ No ☐
Place where accident occurred
our mill, 12 miles north of Libby (Address) Libby (City) Lincoln (County)
Was place of accident or exposure on employer's premises? Yes ☒ No ☐
Were you notified of accident? Yes ☒ No ☐ How _____ Date _____
Have you reason to question this accident? Yes ☐ No ☒ If "yes," explain fully _____

SAFETY

1. Was the accident caused by an unsafe act on the part of the injured? Yes ☒ No ☐
2. Was the accident caused by an unsafe condition? Yes ☒ No ☐
3. What specific device, object or substance caused the injury? muddy pavement

MEDICAL ATTENTION

Name of attending physician W. T. Matthews, M. D.
Address 402 Montana Ave., Libby, Montana 59923
Was employee hospitalized? Yes ☐ No ☒ Name of hospital St. John's Lutheran - X-rays only
Address Libby, Montana 59923

TIME AND WAGE LOSS

1. Will the employee return to work before or during his next scheduled shift? Yes ☒ No ☐
2. Will employee lose wages? Yes ☐ No ☒
3. Date wage loss began _____ Amount of weekly wage loss _____

EMPLOYER

Name of employer Construction Products Division, W. R. Grace & Co.
D.B.A. _____
Address Box 609, Libby, Montana Nature of business Mining & Milling Vermiculit
Location, if different from mail address _____
Check one: Individual ☐ Partnership ☐ Corporation ☒

Signed, this 14th day of May, 19 74
at Libby, Montana

Prepared by [signature]
Signed by [signature]
Official Title [signature]

NOTICE—EMPLOYEE'S CLAIM FOR COMPENSATION, FORM 54, MUST BE FILED WITHIN 12 MONTHS FROM DATE OF ACCIDENT

FORM 57-2

C0080078
WRG00299107
ED_005351_00000355-00199

Medical
Shelley, Dennis

C00B0076

GRACE SPECIALTY CHEMICALS CO.

INCIDENT INVESTIGATION REPORT

(1) CASE NO._____ (2) Lost Time_____ First Aid_____ Recordable_____ Fatality_____

REPORT QUALTIY SCORE

INCIDENT

DIVISION/PLANT	CITY/STATE	DEPARTMENT	LOCATION OF INCIDENT
(3) Zonolite C.P.D.	(4) Libby MT	(5) 21-79	(6) 10th Floor Mill

COMPANY PREMISES:	DATE OF INCIDENT	TIME OF INCIDENT	DATE INCIDENT REPORTED
(7) ☒ YES ☐ NO	(8) 3-12-91	(9) 2:00 ☐ AM ☐ PM	(10) 3-12-91

15

EVENT

EMPLOYEE NAME:	DATE OF BIRTH	SEX	EMPLOYEE NO.	DATE OF HIRE
(11) FIRST Dennis MI J LAST Shelley	(12)	(13) ☒ M ☐ F	(14) 470	(15) 9-10-73

OCCUPATION	MOS./YRS. IN CURRENT JOB	SUPERVISOR IN CHARGE OF ACTIVITY AT TIME OF INCIDENT
(16) Const Worker	(17) 7 Months	(18) Robert Kraus

NATURE OF INJURY/ILLNESS: PARTS OF BODY AFFECTED
(19) NONE

MEDICAL TREATMENT/FIRST AID
(20) NONE

10

DESCRIPTION

DESCRIBE INCIDENT: How did incident occur? What emergency actions were taken? (21)

Dennis was cutting distributor on 10th Floor with torch when the rubber lining caught Fire. Dennis tried to put fire out with fire ext. But fire was too big to put out so we let it burn itself out.

"No damage was done"

15

CAUSE ANALYSIS

IMMEDIATE CAUSE: What unsafe act or condition caused the incident? (22)

BASIC CAUSE: What specific personnel or job factor resulted in the immediate cause? (23)

20

C0080079

(FORM GSC-01-89) **ATTACH ADDITIONAL FORMS/SHEETS AS NEEDED TO EXPAND ON ANY ITEM.**

ACTION PLAN

CORRECTIVE ACTION: (24) Estimated completion date._____ 25

LOSS

ACTUAL LOSS: (25)

☐ Major ☐ Serious ☐ Minor

POTENTIAL: (26) 10

☐ Major ☐ Serious ☐ Minor

PREPARED BY: (27)	DATE:	REVIEWED BY: (28)	DATE:	REVIEWED BY: (29)	DATE:	5
				APPROVED BY: (30)	DATE:	

INSTRUCTIONS

Complete all blocks. Where additional space is required, attach separate forms/sheets. Unless otherwise indicated, all blocks are self explanatory. Numbers below refer to numbers in the blocks.

1. Case No. – A unique sequential number preferably tied to the calendar year, e.g., 89-01, 89-02, 89-03, etc.

2. Check all that apply.

INCIDENT

All information refers to the location of the incident except item 5 which is the department to which individual is assigned.

6. Be specific, e.g., shipping, production line #2.

EVENT

16. Job title at time of incident, e.g., apprentice electrician, clerk/typist, forklift operator.

17. Refers to title in block 16.

18. Name and title, e.g., Line Supervisor – Mary Jones, Warehouse Foreman – John Smith.

19. e.g., fracture left big toe, chemical burns to both eyes, 3 inch cut right upper arm.

20. Be specific. For example: XRay, cast, prescription pain reliever, Dr. L. Brooks, County Hospital; cleansed wound, bandage, Ms. Owen – Plant first aid room.

DESCRIPTION

21. Describe Incident – Give a precise narrative explanation of facts and events leading to the incident. Describe the operation or process occurring at the time and what emergency steps were taken to limit further injury or property damage.

CAUSE ANALYSIS

22. Immediate Cause(s) – Identify the unsafe acts or conditions contributing to the incident, e.g., Unsafe act – operating without authority, making safety devices inoperable, using equipment improperly, improper lifting, etc. Unsafe conditions – inadequate guards or protection, inadequate housekeeping, defective tools, defective equipment, etc.

23. Basic Cause(s) – After analysis of the incident and evaluation of the immediate cause(s) (see 22.), what were the basic causes and what are the significant factors for these cause(s) to exist.

Personnel factors – lack of knowledge or skill, improper motivation, physical or mental problems, etc.

Job factors – inadequate work standards, inadequate design or maintenance, inadequate purchasing standards, abnormal usage, inadequate training, etc. (Be specific.)

ACTION PLAN

24. Corrective Action – What specific corrective action has been (or will be) taken to prevent a recurrence? If future action is proposed, state what action is to be taken until permanent correction is provided. Include date(s) for review of progress and estimated completion date.

LOSS

25. & 26. Based upon your investigation and analysis, what is the actual and potential loss resulting from this incident?

MAJOR: Severe injury or death, major property damage (≥$25,000), and/or interruption of operation for greater than 24 hours.

SERIOUS: Lost time injury but no permanent disability, moderate property damage (≥$1,000/<$25,000), but minimum interruption of operation.

MINOR: Minor medical aid, minimal property damage (<$1,000), and no interruption of operation.

27. Prepared by – The person conducting the investigation and completing the report signs in the space provided. This should be the person directly supervising the injured employee or responsible for the area in which the incident occurred.

28. Reviewed by – Preparer's immediate supervisor.

29. Reviewed by – The facility safety professional or designated individual should provide appropriate comments, in the appropriate block or by attached memo, concerning accuracy and completeness of the report.

30. Approved by – The plant manager, or other appropriate individual, who can address the support necessary to complete corrective action in a timely manner and whether further action is required by higher authority.

Medical
Shelley, Dennis

C0080076

TE	DOCTOR	REFILL TIMES	PRESCRIPTION NUMBER	PATIENT	AMOUNT
4/21	Tenhen	(N)	279932	Dennis	9.00
4/21		(N)	279933	Shelley	8.00

RETAIN THIS RECEIPT FOR PROOF OF MEDICAL EXPENSE

LIBBY Rexall PHARMACY

"YOUR PROFESSIONAL STORE"

LIBBY, MONTANA

PHONE 293-5741

LOST 4 DAYS

...EN'S COMPENSATION

...BOR AND INDUSTRY

...nt Street

...ntana 59601

Hugo Dobler Agency Inc
Box 293 — Helena, Mont. 59601

EMPLOYER'S FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE

...nt or occupational disease which causes loss of time from work or requires ...15 Front Street, Helena, Montana. Form must be signed in pen and ink. ...ns requested on OSHA Form No. 101, "Supplementary Record of Occupational Injuries and Illnesses."

...MAINTAIN A COMPLETE RECORD OF ALL

INJURED EMPLOYEE

Full name of injured employee Dennis J. Shelley Occupation Construction Worker
Home Address Route 1 Box 903C, Libby, MT (Street, City) How long has he been in your employ? 2½ years
Social Security No. 516-66-1221 Sex M Age 22 Married [X] Single [ ]
Department where regularly employed Labor Pool
Department where employed at time of injury Labor Pool
Would employment be classified as: (Check appropriate description)
(1) Household employment [ ]
(2) Casual employment [ ]
(3) Employment of members of an employer's family dwelling in employer's household [ ]
(4) Employment of sole proprietors or working members of a partnership [ ]
(5) Employment for which a rule of liability for injury, occupational disease, or death is provided under the laws of the United States [X]
(6) Any person performing services in return for aid or sustenance only. (Board & Room) [ ]
Scheduled days off

EMPLOYEE'S EARNINGS

Monthly wage ..., or Weekly wage ..., or Daily wage ..., or Hourly wage 5.29
Received board? Yes [ ] No [X] Received room? Yes [ ] No [X] Days worked per week 5
Hours worked per day 8 Employee's pay period: Monthly [ ] Semi-monthly [X] Weekly [ ]
Bi-weekly [ ] List employee's gross earnings and date for last 4 pay periods:
(1) ... Date/Amount (2) ... Date/Amount (3) ... Date/Amount (4) ... Date/Amount
List payroll classification under which employee's wages were reported

ACCIDENT AND INJURY

Describe in full how accident happened and GIVE CAUSE—Tell what employee was doing when injured:
Digging post holes at the screen plant in extremely rocky ground. Using pry bar to remove a large boulder, the boulder gave a little, he lost balance and dislocated back.
Nature or extent of injury or illness dislocation (Cut-Fracture) Part of body affected back (Leg-Arm-Back-Head)
Did employee die? Yes [ ] No [X]
Name or witnesses to accident 1 ... 2 ...
Date of injury or initial diagnosis of occupational illness. Mo. 4 Day 21 Yr 76 Hour 3:30 A.M. P.M.
Was employee injured in course of employment? Yes [X] No [ ]
Place where accident occurred our screen plant, approx. 5 miles from Libby Lincoln (Address, City, County)
Was place of accident or exposure on employer's premises? Yes [X] No [ ]
Have you reason to question this accident? Yes [ ] No [X] If "yes" explain fully

NOTICE

Were you notified of the accident? Yes [X] No [ ] How by employee 4-22-76

SAFETY

1. Was the accident caused by an unsafe act on the part of the injured? Yes [ ] No [X]
2. Was the accident caused by an unsafe condition? Yes [ ] No [X]
3. What specific device, object, or substance caused the injury?

MEDICAL ATTENTION

Name of attending physician James F. Graham, MD
Address 401 Louisiana Avenue, Libby, MT
Was employee hospitalized? Yes [ ] No [X] Name of hospital
Address

TIME AND WAGE LOSS

1. Will the employee return to work before or during his next scheduled shift? Yes [ ] No [X]
2. Will employee lose wages? Yes [X] No [ ] Will wage loss exceed 7 days? Yes [ ] No [ ]
3. Date wage loss began 4-22-76 Amount of weekly wage loss 211.60 not known at this time

EMPLOYER

Name of employer Construction Products Division-W.R.Grace & Co. Phone 293-4131
Firm name
Address Box 609, Libby, MT Nature of business Mining & Milling Vermiculite
Location, if different from mail address
Check one: Individual [ ] Partnership [ ] Corporation [X]

Signed, this 22nd day of April, 19 76
at Libby, Montana

Prepared by Joan B. Runyan
Signed by
Official title Administrative Assistant

NOTICE—EMPLOYEE'S CLAIM FOR COMPENSATION, FORM 54, SHOULD BE FILED WITHIN 12 MONTHS FROM DATE OF ACCIDENT

FORM 37-2 REVISED

C0080081

Medical
Shelley, Dennis

C00B0076

ACCIDENT INVESTIGATION REPORT

INDUSTRIAL CHEMICALS GROUP
W. R. Grace & Co.

Plant Libby Lost Time Case ____

Division Const Prod Div Not Lost Time Case ✓
(Check one)

All accidents involving lost time from work or the services of a physician must be investigated and the report completed within 48 hours by the injured employee's supervisor. Forward one copy of report to office of Safety Administrator.

1. Name of injured employee Dennis J Shelley
2. Department Const Date of Hire 9-10-73
3. Job Title Const 1st class Was he doing regular job? Yes ✓ No ____
4. Date and time of injury 1 PM 5-28-76
5. Date and time injury reported 1 PM 5-28-76
6. Injured employee is: Salaried ____ Hourly ✓ Male ✓ Female ____

   Under 25 years ✓ 25 to 34 ____ 35 to 49 ____ 50 and over ____
7. Describe in detail what employee was doing at time of injury: include reference to any tools, machines and materials involved:

   Dennis was punching holes in some small pieces of angle iron with iron worker machine. The machine punches & returns each stroke automatically. He punched a hole and caught his thumb between of piece of angle iron and the machine
8. Describe injury: Smashed the end of his thumb and cut a small piece of it out.
9. What medical action was taken? Wraped it with a splint.
10. What, in your opinion, was the basic cause of this accident?

    Unsafe Act ✓ Unsafe Condition ____ Explain ~~[illegible]~~ [illegible] in to much of a hurry. Not watching for Dangers

C0080082
WRG00299114
ED_005351_00000355-00206

11. What were the contributing causes? INEXPERIANCE WITH MACHINE

12. What action have you taken and/or are you planning to take to avoid a recurrence of this accident? CAUTIONED EMPLOY about SUCH JOBS. WE ARE THINKING of LETTING only EXPERIENCED MAN USE THIS MACH.

13. Have you counselled your other employees regarding lessons to be learned from this accident?

Yes ✓ No ____ if not, why _____

14. Have you scheduled any maintenance work or planned any disciplinary action with the accident?

Yes ____ No ✓ Comments, if any: _____

(Signed) Don Riley (Supervisor) Date 6-1-76 Plant Libby

****

You have now completed answering some very important questions regarding an injury to one of your employees. Take the time to think carefully and ask yourself the following two questions:

a) How long did I take to think out and complete the answers to the questions above?
b) Have I really taken enough time, given enough thought, to a subject which might very well mean the life of one of my employees at some future date?

****

This space reserved for Plant Managers

1. Have you discussed this injury with .....

the supervisor concerned? Yes ____ No ____
all members of your supervisory group? Yes ____ Yes ____ No ____

2. Do you have any comments to add to the statements by the Foreman?

_____

(Plant Manager) 6/9/76 (Date)

Form 65-25

C0080083

WRG00299115
ED_005351_00000355-00207

MONTANA DIVISION OF WORKERS' COMPENSATION

Complied with 82-1137 R.C.M.

815 Front Street
Helena, Montana 59601

SEND ORIGINAL TO INSURER

EMPLOYER'S FIRST REPORT
of Occupational Injury or
Occupational Disease
Employee Copy

CASE NUMBER

FIRM NUMBER 2503

INSTRUCTIONS - Every employer in Montana is required by law to complete this form immediately after every accident to an employee which arises out of and in the course of employment, and which causes loss of time from work or requires medical attention. The original of this form must be immediately filed with the employer's insurer or the Division of Workers' Compensation, 815 Front Street, Helena, Montana 59601. All questions must be answered fully. If a question cannot be answered, please explain why. **Please print with a ball point pen or type.**

FEDERAL OSHA REQUIREMENTS - The United States Department of Labor requires employers to maintain, in the employer's office, a record of occupational injuries. For the employer's convenience, this form has been designed to meet such requirements and to provide employers a record copy.

EMPLOYEE

Full Name of INJURED EMPLOYEE: Dennis Shelley
Social Security Number: 516-66-1221
EMPLOYEE'S Home Address (Street or Box): Route 1 Box 903C
City: Libby
State: MT
Zip Code: 59923
Occupation: Construction Worker
Sex: M
Age: 23
Marital Status: [X] Married [ ] Single
Length of time in your Employment: 9-10-73
Department where regularly employed: Construction Crew
Date of Birth (mo.) 10 / (day) 2 / (yr.) 5

WAGES

Employee's Gross Wage Rate is $ 5.29 per [ ] week, or [ ] day, or [X] hour, or [ ] month
Days Worked Per Week: 5
Hours Worked Per Day: 8
If board or room is furnished state value reported per day to Internal Revenue Service: $
Check One— [X] Full Time Employee [ ] Part Time Employee
Payroll Classification under which employee's wages were reported
Employee's gross earnings for last four (4) pay periods: (Date / Amount) (Date / Amount) (Date / Amount) (Date / Amount)
Employee's pay period: [ ] Monthly [ ] Semi-monthly [ ] Bi-Weekly [ ] Weekly [ ] Other

ACCIDENT INFORMATION

Describe in full detail how accident happened, and give cause - Explain what employee was doing when injured.
Helping in sheet metal shop punching holes in sheet metal. The material being punched hung up in the punch and as the machine raised the material up, employee caught right thumb between sheet metal and the frame of the machine.

What specific object or substance caused the injury? punching machine
Nature of the injury? (cut, fracture, etc.) contusion
Part of body affected (leg, arm, back, head, etc.): right thumb
DATE OF INJURY (month) May (day) 28 (year) 1976 (hour) 1 (a.m. or p.m.) p.m.
Names of witnesses to accident: 1. Ed Andersen 2.
Place where accident occurred (address & city): our mill, 12 miles north of Libby
(county) Lincoln
Was place of accident on employer's premises? Yes [X] No [ ]
Was employee injured while in your employ? Yes [X] No [ ]
Were you notified, or did you have actual knowledge of the accident? Yes [X] No [ ]
If yes, date notified & how: by employee, 5-28-76
Do you have any reason to question this accident? [ ] Yes [X] No
If yes, please explain fully

MEDICAL

Attending physician name and address: Paul J. Seifert, Jr. MD, 402 Montana Avenue, Libby, MT 59923
If hospitalized, hospital's name and address: St. Johns Lutheran Hospital, 350 Louisiana Avenue, Libby, MT (emergency room)
Will employee return to work during next scheduled shift? Yes [X] No [ ]
If no, will wage loss exceed 7 days? Yes [ ] No [ ] Not Sure [ ]
Date wage loss began (mo) (day) (yr.)
Date of return, if returned to work (mo.) (day) (yr.)

EMPLOYER

EMPLOYER'S NAME: W. R. Grace & Co. Construction Products Division
Commercial Name (doing business as): Same
Employer's mailing address (Street or Box): Box 609
(City) Libby
(State) MT
(Zip Code) 59923
Phone number: 293-4131
Location of operation, if different from mailing address: 12 miles north of Libby
Nature of business: Mining & Milling Vermiculite
Firm is a: (Check one) [ ] Sole proprietorship [ ] Partnership, or [y] Corporation
Was the Injured employee? (Check if applicable) [ ] A Sole Proprietor, [ ] A working Partner, [ ] A Corporate Officer, or [ ] A member of the employer's (sole proprietor or partner) family, dwelling in the employer's household.
Prepared by: Joan B Runyan
Authorized Signature: X
Official Title
Date

DWC USE ONLY

OCCUPATION
SEX
AGE
MARITAL STATUS
COUNTY
LENGTH (YRS) EMPLOYED
WEEKLY EARNINGS
CLASS CODE
ACCIDENT TYPE
SOURCE OF INJURY
PART OF BODY INJURED
OSHA RECORDABLE CODE
DISABILITY TYPE
NATURE OF INJURY
HAZARDOUS CONDITION
UNSAFE ACT

Above - DWC-MIS Form 37-Employer's First Report (Rev. 1-76)

Below - DWC-MIS Form 54A-Claim for Compensation

EMPLOYEE'S CLAIM FOR COMPENSATION

EMPLOYER'S NOTE: For convenience purposes and if the worker is available, the form below has been provided so that an employer may allow an injured worker to file a claim for compensation on this form to avoid having the employee fill out and file a separate detailed form. Separate claim forms are available if the employer does not want the worker to use this form. **Do not delay in submission of this form if employee is not available to sign below.**

INJURED EMPLOYEE'S NOTE: An injured employee may use the form below to make a claim for compensation, or the employee may fill out and submit a separate detailed form that is available from the Division.

I have carefully read the above information as documented by the employer, and (except for any statements I may write below) I concur with the information and I hereby make claim for compensation benefits due me now or in the future under Montana's Workers' Compensation Act.

Signature of Injured employee: X
Address
City
Date
Phone

I DO NOT concur with the following information documented by the employer

C0080084

Filing of this claim is authorization for release of medical records and records of the Social Security Administration

Medical
Shelley, Dennis

C0080076

MONTANA DIVISION OF WORKERS' COMPENSATION

Complied with 82—1137 R.C.M.

815 Front Street
Helena, Montana 59601

SEND ORIGINAL TO INSURER

EMPLOYER'S FIRST REPORT
of Occupational Injury or
Occupational Disease
Employee Copy

CASE NUMBER

FIRM NUMBER 2503

INSTRUCTIONS - *Every employer in Montana is required by law to complete this form immediately after every accident to an employee which arises out of and in the course of employment, and which causes loss of time from work or requires medical attention. The original of this form must be immediately filed with the employer's insurer or the Division of Workers' Compensation, 815 Front Street, Helena, Montana 59601.* All questions must be answered fully. If a question cannot be answered, please explain why.
Please print with a ball point pen or type.

FEDERAL OSHA REQUIREMENTS - The United States Department of Labor requires employers to maintain, *in the employer's office, a record of occupational injuries.* For the employer's convenience, this form has been designed to meet such requirements and to provide employers a record copy.

EMPLOYEE

Full Name of INJURED EMPLOYEE: Dennis J. Shelley
Social Security Number: 516-66-1221
EMPLOYEE'S Home Address (Street or Box): Route 2 Box 903,
City: Libby
State: MT
Zip Code: 59923
Occupation: Construction Worker
Sex: M
Age: 23
Marital Status: [X] Married [ ] Single
Length of time in your Employment: 3 years
Department where regularly employed: Construction Crew
Date of Birth (mo.) 10 / (day) 2 / (yr.) 53

WAGES

Employee's Gross Wage Rate is $ 5.75 per [ ] week, or [ ] day or [X] hour, or [ ] month
Days Worked Per Week: 5
Hours Worked Per Day: 8
If board or room is furnished state value reported per day to Internal Revenue Service $
Check One— [X] Full Time Employee [ ] Part Time Employee
Payroll Classification under which employee's wages were reported
Employee's gross earnings for last four (4) pay periods (Date / Amount) (Date / Amount) (Date / Amount) (Date / Amount)
Employee's pay period: [ ] Monthly [X] Semi-monthly [ ] Bi-Weekly [ ] Weekly [ ] Other

ACCIDENT INFORMATION

Describe in full detail how accident happened, and give cause - Explain what employee was doing when injured.
Using piece of pipe to help tighten chain binder on load on truck, hand slipped, pipe struck right side of face and jaw.

What specific object or substance caused the injury? Pipe
Nature of the injury? (cut, fracture, etc.) laceration
Part of body affected (leg, arm, back, head, etc.) right lower jaw
DATE OF INJURY (month) 10 (day) 20 (year) 76 (hour) 3 pm (a.m. or p.m.)
Names of witnesses to accident: 1. 2.
Place where accident occurred (address & city): our mill area, 12 miles north of Libby
(county) Lincoln
Was place of accident on employer's premises? Yes [X] No [ ]
Was employee injured while in your employ? Yes [X] No [ ]
Were you notified, or did you have actual knowledge of the accident? Yes [X] No [ ]
If yes, date notified & how: by employee, 10-20-76
Do you have any reason to question this accident? [ ] Yes [X] No
If yes, please explain fully

MEDICAL

Attending physician name and address: W. T. Matathews, MD, 402 Montana Avenue, Libby, MT 59923
If hospitalized, hospital's name and address: St. Johns for Emergency room care only
Will employee return to work during next scheduled shift? Yes [X] No [ ]
If no, will wage loss exceed 7 days? Yes [ ] No [ ] Not Sure [ ]
Date wage loss began (mo) / (day) / (yr.)
Date of return, if returned to work (mo.) / (day) / (yr.)

EMPLOYER

EMPLOYER'S NAME: W. R. Grace & Co. Construction Products Division
Commercial Name (doing business as): Same
Employer's mailing address (Street or Box): Box 609
(City) Libby
(State) MT
(Zip Code) 59923
Phone number: 293-4131
Location of operation, if different from mailing address: 12 miles north of Libby
Nature of business: Mining & Milling
Firm is a: (Check one) [ ] Sole proprietorship [ ] Partnership, or [X] Corporation
Was the injured employee? (Check if applicable) [ ] A Sole Proprietor, [ ] A working Partner, [ ] A Corporate Officer, or [ ] A member of the employer's (sole proprietor or partner) family, dwelling in the employer's household.
Prepared by: Joan B. Runyan
Authorized Signature: X
Official Title: Administrative Assistant
Date: 10-28-76

DWC USE ONLY

OCCUPATION
SEX
AGE
MARITAL STATUS
COUNTY
LENGTH (YRS) EMPLOYED
WEEKLY EARNINGS
CLASS CODE
ACCIDENT TYPE
SOURCE OF INJURY
PART OF BODY INJURED
OSHA RECORDABLE CODE
DISABILITY TYPE
NATURE OF INJURY
HAZARDOUS CONDITION
UNSAFE ACT

Above - DWC-MIS Form 37-Employer's First Report (Rev. 1-76)

Below - DWC-MIS Form 54A-Claim for Compensation

EMPLOYEE'S CLAIM FOR COMPENSATION

EMPLOYER'S NOTE: For convenience purposes and if the worker is available, the form below has been provided so that an employer may allow an injured worker to file a claim for compensation on this form to avoid having the employee fill out and file a separate detailed form. Separate claim forms are available if the employer does not want the worker to use this form. **Do not delay in submission of this form if employee is not available to sign below.**

INJURED EMPLOYEE'S NOTE: An injured employee may use the form below to make a claim for compensation, or the employee may fill out and submit a separate detailed form that is available from the Division.

I have carefully read the above information as documented by the employer, and (except for any statements I may write below) I concur with the information and I hereby make claim for compensation benefits due me now or in the future under Montana's Workers' Compensation Act.

Signature of injured employee: X
Address
City
Date
Phone

I DO NOT concur with the following information documented by the employer

C00B0085

Filing of this claim is authorization for release of medical records and records of the Social Security Administration

Medical
Shelley, Dennis

C0080076

ZONOLITE
CONSTRUCTION PRODUCTS DIVISION

TO File

DATE June 15, 1977

FROM W. J. McCaig

SUBJECT Incident Investigation Report
Dennis Shelley -- 6-14-77

CC: T. DeShazer, W. J. Melcher, R. L. Oliverio, D. Riley

Dennis was driving the Construction Freight Truck, hauling from the Tails Pile across the Mud Dam to a crew placing fill in the spillway area. He was repeating his trip sequence (driving along the Tails Pile, getting loaded by 931, backing out loaded, along the toe of the Tailing Pile to the Dam, all the way across the Dam, dump). This sequence was used with knowledge and approval of supervision. The sequence was established because of the close quarters at both ends and the direction of desired dumping.

1. Loaded, he started backing along the toe of the Tail Pile approaching the Dam. He was changing gears and got too close to the shoulder. The edge caved under the rear wheels, tipping the truck on its side.

   The width of good surface on the road is 20 feet.

   There was no demarcation between the road surface and the shoulder.

   Approximately 300 trips had been made prior to the incident.

This accident could have been prevented had someone been more alert to the hazard presented by the unusual sequence for the truck and flagged or barricaded the soft shoulder.

HOME OFFICE

GRACE

C0080086

Medical
Shelley, Dennis

C0080076

WRG00299121
ED_005351_00000355-00213

INCIDENT

~~ACCIDENT~~ INVESTIGATION REPORT

INDUSTRIAL CHEMICALS GROUP
W. R. Grace & Co.

Plant LIBBY Lost Time Case _____

Division CONSTRUCTION PRODUCTS DIVISION Not Lost Time Case XX
(Check one)

All accidents involving lost time from work or the services of a physician must be investigated and the report completed within 48 hours by the injured employee's supervisor. Forward one copy of report to office of Safety Administrator.

1. Name of injured employee Dennis Shelley
2. Department Construction Date of Hire 09-10-73
3. Job Title Const. Truck Driver Was he doing regular job? Yes ____ No XX
4. Date and time of injury 11-02-78 at approximately 11:00 A.M.
5. Date and time injury reported Same
6. Injured employee is: Salaried ____ Hourly XX Male XX Female ____

   Under 25 years ____ 25 to 34 XX 35 to 49 ____ 50 and over ____
7. Describe in detail what employee was doing at time of injury: include reference to any tools, machines and materials involved: Driving haul truck between Lower C Bins & Screen Plant. Motor Grader had left a berm in the road such that only on lane was passable. Shelley had to drive in the left lane -- he came upon a pick coming up the hill. Because of steep grade, Shelley couldn't stop so he straddl the berm and hit a rock hidden in the berm which damaged the engine oil pan and transmission oil pan.
8. Describe injury: _____
9. What medical action was taken? _____
10. What, in your opinion, was the basic cause of this accident?

    Unsafe Act ____ Unsafe Condition XX Explain The berm allowed only on passable lane for the haul truck and consisted of large rocks.

C00B0087
WRG00299122
ED_005351_00000355-00214

11. What were the contributing causes? Motor grader pulled rock from ditch and left it in berm on road.

12. What action have you taken and/or are you planning to take to avoid a recurrence of this accident? Stop haul when Motor Grader has road passable in only one lane (usually once in the fall and once in the spring).

13. Have you counselled your other employees regarding lessons to be learned from this accident?

Yes XX No ____ if not, why _____

14. Have you scheduled any maintenance work or planned any disciplinary action with the accident?

Yes ____ No XX Comments, if any: _____

(Signed) Jerry Harrington (Supervisor) Date 11-02-78 Plant _____

****

You have now completed answering some very important questions regarding an injury to one of your employees. Take the time to think carefully and ask yourself the following two questions:

a) How long did I take to think out and complete the answers to the questions above?
b) Have I really taken enough time, given enough thought, to a subject which might very well mean the life of one of my employees at some future date?

****

This space reserved for Plant Managers

1. Have you discussed this injury with .....

the supervisor concerned? Yes ____ No ____
all members of your supervisory group? Yes ____ No ____

2. Do you have any comments to add to the statements by the Foreman?

_____

_____

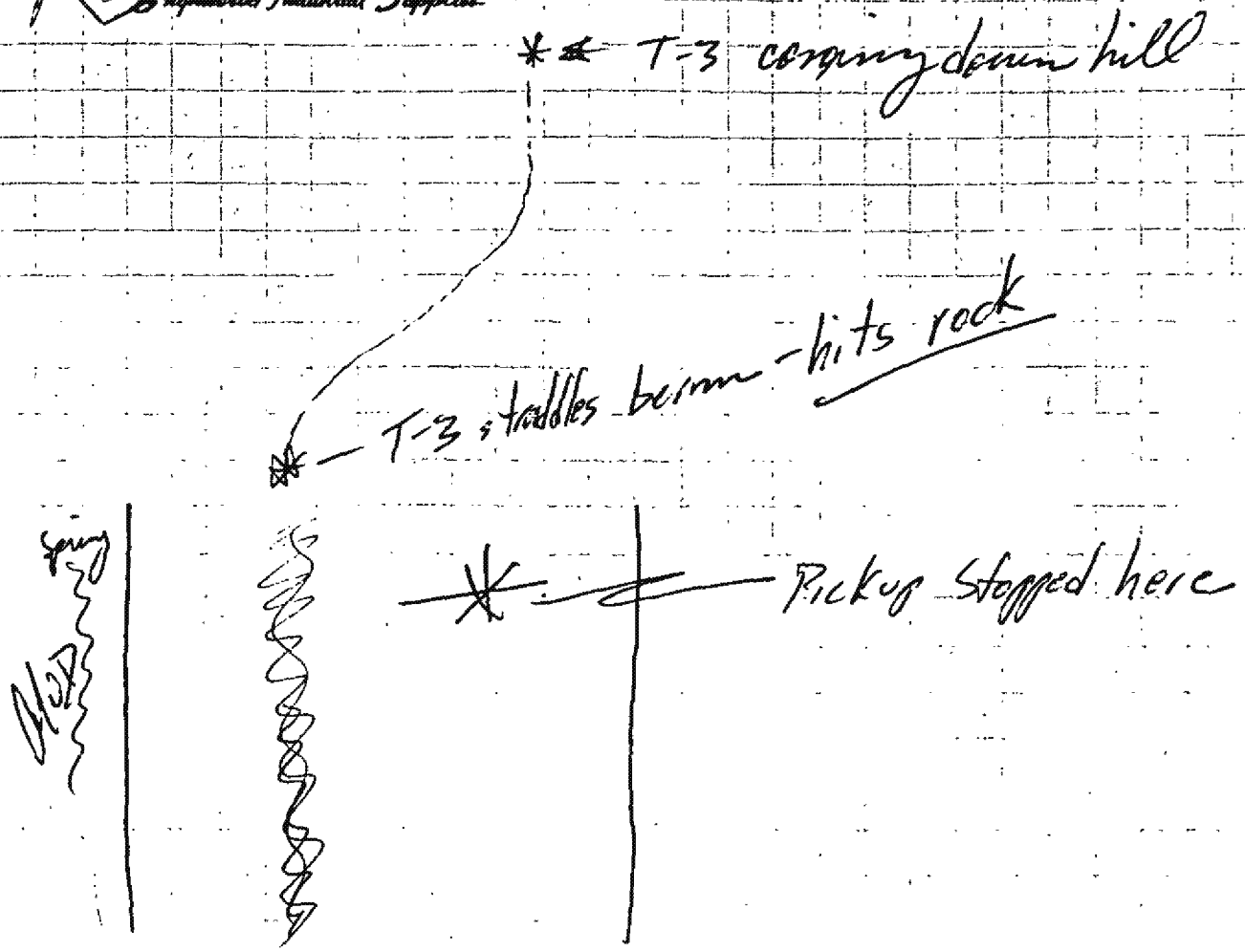
(Plant Manager) (Date)

Form 65-25

THE ARCHIBALD CO.
Application Engineers
Engineered Industrial Supplies

Butte, Montana
406/723-8075

Pocatello, Idaho
208/237-2763



C0080089

MEDICAL
Shelley, Trevert

C0080090

06062578

Industrial Accident Board, Helena, Montana, Form 37 Revised—YM - U - WU

STATE PUBLISHING CO., HELENA, MONT.

Industrial Accident Board

HELENA, MONTANA

Firm No.....

File No.....

EMPLOYER'S FIRST REPORT OF INJURY

INSTRUCTIONS—Employer must complete form at once after every accident which causes loss of time from work or requires medical attention and mail it to the Industrial Accident Board, Helena, Montana. Form must be signed in pen and ink. ALL QUESTIONS MUST BE ANSWERED FULLY.

INJURED EMPLOYEE

Full name of injured employee: Trevert L. Shelley Occupation: Mill Worker

Mailing address: Box 1001 (Street) Libby (City) How long has he been in your employ: 6 months

Social Security No.: 516-46-9994 Sex: M Age: 22 Married ☒ Single ☐

EARNINGS

Monthly Wage..... Weekly Wage..... Daily Wage..... Hourly Wage: 2.43

Receive board Yes ☐ No ☒ Daily Value..... Receive room Yes ☐ No ☒ Daily Value.....

Piece Worker Yes ☐ No ☒ If yes, price per unit at piece work..... Hours worked per day: 8

Days worked per week: 5 Employee's pay period? Monthly ☐ Semi-monthly ☒ Weekly ☐ List employee's earnings last 4 pay periods 1. 223.56 2. 165.24 3. 243.00 4. 233.28

List Payroll Classification and Code under which employee's wages were reported..... (Sawmill - Mechanic - Etc.) Code..... (2702, 5506, 8810)

ACCIDENT AND INJURY

Describe in full how accident happened and GIVE CAUSE: Slipped on wet ore on floor of mill, fell into jig table, struck head on table.

Nature or extent of injury: Skinned forehead (Cut - Fracture) Part of body injured? Forehead (Leg - Arm - Back - Head)

Names of witnesses to accident 1. none 2.

Date of accident: 12-30 19 63 Hour: 12:45 P.M. Was employee injured in course of employment? Yes ☒ No ☐

Place where accident occurred: our mill, 9 miles north of Libby (Address) Lincoln (County)

Did you or employee's supervisor have actual knowledge of accident? Yes ☒ No ☐

Were you notified of accident by injured employee? Yes ☒ No ☐ *How* by employee *Date* 12-30-63

Have you reason to question this accident? Yes ☐ No ☒ If "yes" explain fully.....

SAFETY

Was employee's accident due to unsafe work practice? Yes ☐ No ☒ If "yes", what did he do unsafely?.....

Was a specific device, object or substance involved in accident? Yes ☐ No ☐ If "yes," name specific device, object or substance..... Was device or object defective? Yes ☐ No ☐

Was employee doing regular work when injured? Yes ☒ No ☐ Was employee trained to do work he was doing when injured? Yes ☒ No ☐ Were adequate safeguards provided? Yes ☐ No ☐ If "yes," were they being used at the time of accident? Yes ☐ No ☐

MEDICAL ATTENTION

Name of attending physician: Dr. W. T. Matthews Address: Libby, Montana

Was employee hospitalized? Yes ☐ No ☒ Name of hospital..... Address.....

Was first aid administered by someone other than attending physician? Yes ☐ No ☒

TIME AND WAGE LOSS

Will employee lose time from work due to accident? Yes ☐ No ☒ How long?..... If injury *results in time loss will employee, while disabled, receive sick leave benefits?* Yes ☐ No ☐ *Paid vacation?* Yes ☐ No ☐ Will employee lose wages? Yes ☐ No ☐ Room? Yes ☐ No ☐ Board? Yes ☐ No ☐

Date wage loss began..... Amount of weekly wage loss.....

EMPLOYER

Name of employer: Zonolite Division - W. R. Grace & Co.

Address: Libby, Montana *Nature of business:* Mining & Milling Vermiculite

IS FIRM A CORPORATION ☒ OR PARTNERSHIP ☐ OR INDIVIDUAL ☐

IF
- Corporation—is injured employee an officer or director of corporation? Yes ☐ No ☒
- Partnership—is injured employee related to any partner? Yes ☐ No ☐ Relationship.....
- Individual—is injured employee related to employer? Yes ☐ No ☐ Relationship.....

Signed, this 3rd day of January, 19 64

at Libby, Montana

Employer's Name: Zonolite Division-W.R.Grace & Co.

Signed by.....

Official Title: Secretary

NOTICE—EMPLOYEE'S CLAIM FOR COMPENSATION, FORM 54, MUST BE FILED WITHIN 12 MONTHS FROM DATE OF ACCIDENT.

C00B0091

WRG00299126

ED_005351_00000355-00218

MEDICAL
Shelley, Trevert

C0080030

INDUSTRIAL ACCIDENT BOARD, HELENA, MONTANA. FORM 37 REVISED—2M 3-61 32492

Industrial Accident Board

HELENA, MONTANA

06062641

Claim Department

Firm No.

Claim No.

Accident No.

DO NOT FILL IN

EMPLOYER'S FIRST REPORT OF INJURY

DO NOT WRITE IN THIS SPACE

INSTRUCTIONS—*The employer must fill out this form and return same to Industrial Accident Board, Helena, Montana, at once after every accident which causes any loss of work or requires medical attention. In filling out this form use pen or typewriter.*

EMPLOYER, PLACE AND TIME

Employer's name: Zonolite Division-W.R.Grace & Co.

Office address: Libby, Montana (Street and number, city or town)

Nature of business: Mining & Milling Vermiculite (Type of construction, manufacturing, etc.)

Did accident occur on work for a public corporation? No

Location of plant or place of work where accident occurred: Same (Street and Number)

In what city or village? Libby County? Lincoln

Date of accident 7-8-63, 19..; hour of day 4:15 p.m. A.M. P.M.

Did accident happen on premises? ~~XXXX~~ Yes

If away from the plant, state where?

Was employee injured in the course of employment? Yes

THE INJURED EMPLOYEE

Give full name of injured workman: Trevert Shelley

Mailing address: Box 1081, Libby, Montana, Lincoln County (Street and number, city or town and county)

Sex M Age 22 Speak English? Yes If not, what language?

Occupation when injured? Construction worker Married or single? Married (See Form 87-a)

Was *injured employee on duty at time of accident?* Yes *If not, state fully on back hereof*

How long was injured person in your employment? 1 week

CAUSE OF INJURY

Described in full how the accident occurred (DO NOT FAIL TO DO THIS)

While clearing brush, chopped left leg, below knee, with axe.

THE INJURY

State *nature and extent of injury according to your own information. (We do not need the doctor's* report here) Laceration of left leg below knee, required 1 suture

WILL EMPLOYEE LOSE TIME? YES ..... NO XX

DATE WAGE LOSS BEGAN? ..... PROBABLE DURATION OF WAGE LOSS? ..... (Give your best estimate)

MEDICAL ATTENDANCE

Name and address of physician attending injured employee: Dr. Paul J. Seifert, Jr. Libby, Montana

To what hospital was employee sent? none

If not sent to hospital, where is he? working

Are you still providing medical attendance? yes Have you a hospital contract? no

WAGES

Monthly wage ..... (If paid by month) Weekly wage ..... (If paid by week) Daily wage ..... (If paid by day) Rate per hour 2.125 (If paid by hour)

Number of hours per day 8 How many working days per week 5

If employee receives board in addition to money wage, state how many meals per day none

Does he receive room in addition to money wage? no

WAGE LOSS

How much money wage will employee lose per day because of accident?

How much board? ..... Will he lose room?

NOTICE OF INJURY

Were you notified by the injured employee of his injury? yes If so, how and when? by employee (Write on back of this form if necessary)

Did you or your managing superintendent in charge of work of injured employee at time of injury have actual knowledge of such accident and injury? yes If so, explain how by employee (Write on back of this form if necessary)

Signed, this 8th day of July, 19 63

Employer's Name Zonolite Division W. R. Grace & Co.

Signed by

at Libby, Montana

Official Title Secretary

NOTICE—Employer should have injured workmen fill out Form 37-A and return same to Board with Employer's *First Report of Injury.*

Firm No. | Acc. No. | Major Industry | County | Date of Acc. | Time | Sex & Marital Status | Age | Mont. Code | Acc. Class | Occupation | Type | Agency | Agency Part | Nature of Inj. | Location | Ext. of Dis. | Mech. Defect | Unsafe Act | Pers. Factor | Weekly Wage | Report Lag | Carrier

C00B0092

WRG00299128

ED_005351_00000355-00220

Medical
Shelmerdine, Ronald D.

C0080093

Return to:
Hugo Dobler Adjuster, Inc.
Box 233 — Helena, Mt. 59601

DIVISION OF WORKMEN'S COMPENSATION

DEPARTMENT OF LABOR AND INDUSTRY
815 Front Street
Helena, Montana 59601

CASE NO. .....

Firm No. 2503

EMPLOYER'S FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE

INSTRUCTIONS—Employer must complete form at once after every accident or occupational disease which causes loss of time from work or requires medical attention and mail to the Division of Workmen's Compensation, 815 Front Street, Helena, Montana. Form must be signed in pen and ink. ALL QUESTIONS MUST BE ANSWERED FULLY. This form contains all items requested on OSHA Form No. 101, "Supplementary Record of Occupational Injuries and Illnesses."

INJURED EMPLOYEE

Full name of injured employee Ronald D. Shelmerdine Occupation Construction Worker
Home Address Box 259, Libby, MT (Street, City) How long has he been in your employ? 3 months
Social Security No. 517-50-4416 Sex M Age 29 Married [X] Single [ ]
Department where regularly employed Construction
Department where employed at time of injury Same
Would employment be classified as: (Check appropriate description)
(1) Household employment [ ]
(2) Casual employment [ ]
(3) Employment of members of an employer's family dwelling in employer's household [ ]
(4) Employment of sole proprietors or working members of a partnership [ ]
(5) Employment for which a rule of liability for injury, occupational disease, or death is provided under the laws of the United States [X]
(6) Any person performing services in return for aid or sustenance only. (Board & Room). [ ]
Scheduled days off .....

EMPLOYEE'S EARNINGS

Monthly wage ....., or Weekly wage ....., or Daily wage ....., or Hourly wage 5.005
Received board? Yes [ ] No [X] Received room? Yes [ ] No [X] Days worked per week 5
Hours worked per day 8 Employee's pay period: Monthly [ ] Semi-monthly [X] Weekly [ ]
Bi-weekly [ ] List employee's gross earnings and date for last 4 pay periods:
(1) ..... (2) ..... (3) ..... (4) .....
Date/Amount Date/Amount Date/Amount Date/Amount
List payroll classification under which employee's wages were reported .....

ACCIDENT AND INJURY

Describe in full how accident happened and GIVE CAUSE—Tell what employee was doing when injured:
Suffered allergic reaction (skin rash) from exposure to diesel fuel.

Nature or extent of injury or illness skin rash (Cut-Fracture) Part of body affected entire body (Leg-Arm-Back-Head)
Did employee die? Yes [ ] No [X]
Name or witnesses to accident 1 ..... 2 .....
Date of injury or initial diagnosis of occupational illness. Mo. 10 Day 24 Yr 75 Hour .....A.M. .....P.M.
Was employee injured in course of employment? Yes [X] No [ ]
Place where accident occurred our mill area, 12 miles north of Libby Lincoln (Address, City, County)
Was place of accident or exposure on employer's premises? Yes [X] No [ ]
Have you reason to question this accident? Yes [ ] No [X] If "yes" explain fully .....

NOTICE Were you notified of the accident? Yes [X] No [ ] How by employee

SAFETY

1. Was the accident caused by an unsafe act on the part of the injured? Yes [ ] No [X]
2. Was the accident caused by an unsafe condition? Yes [ ] No [X]
3. What specific device, object, or substance caused the injury? Diesel fuel

MEDICAL ATTENTION

Name of attending physician Paul J. Seifert, Jr., MD
Address 402 Montana Avenue, Libby, MT
Was employee hospitalized? Yes [ ] No [X] Name of hospital .....
Address .....

TIME-AND-WAGE LOSS

1. Will the employee return to work before or during his next scheduled shift? Yes [X] No [ ]
2. Will employee lose wages? Yes [ ] No [X] Will wage loss exceed 7 days? Yes [ ] No [ ]
3. Date wage loss began none Amount of weekly wage loss .....

EMPLOYER

Name of employer Construction Products Division-W.R.Grace & Co. Phone 293-4131
Firm name .....
Address Box 609, Libby, MT 59923 Nature of business Mining & Milling Vermiculit
Location, if different from mail address .....
Check one: Individual [ ] Partnership [ ] Corporation [X]

C00B0094

Signed, this 10th day of December, 19 75
at Libby, Montana

Prepared by Joan B. Runyan
Signed by .....
Official title Administrative Assistant

NOTICE—EMPLOYEE'S CLAIM FOR COMPENSATION, FORM 54, SHOULD BE FILED WITHIN 12 MONTHS FROM DATE OF ACCIDENT

FORM 37-2 REVISED

Medical
Short, James R.

C0080095

WRG00299131
ED_005351_00000355-00223

WORKMEN'S COMPENSATION DIVISIC
Department of Labor and Industry
815 Front Street
Helena, Montana 59601

CASE No.

Firm No. 2503

EMPLOYER'S FIRST REPORT
OF OCCUPATIONAL INJURY OR DISEASE

INSTRUCTIONS—Employer must complete form at once after every accident or occupational disease which causes loss of time from work or requires medical attention and mail to Workmen's Compensation Division, Helena, Montana. Form must be signed in pen and ink. ALL QUESTIONS MUST BE ANSWERED FULLY. This form contains all items requested on OSHA Form No. 101, "Supplementary Record of Occupational Injuries and Illnesses."

INJURED EMPLOYEE

Full name of injured employee James R. Short Occupation Construction Worker
Home address Route 1 Box 1290, Libby (Street, City) How long has he been in your employ? 3 years
Social Security No. 516-42-4539 Sex M Age 36 Married [X] Single [ ]
Department Construction Labor Pool (Enter name of department or division in which the injured person is regularly employed, even though he may have been temporarily working in another department at the time of injury.)

EARNINGS

Monthly Wage ____, or Weekly Wage ____, or Daily Wage ____, or Hourly Wage 5.005
Receive board? Yes [ ] No [X] Receive Room? Yes [ ] No [X] Days worked per week 5 Employee's pay period? Monthly [ ], Semi-monthly [X], Weekly [ ]. List employee's earnings and date of last 4 pay periods
1 ____ (Date/Amount) 2 ____ (Date/Amount) 3 ____ (Date/Amount) 4 ____ (Date/Amount)
List Payroll Classification and Code under which employee's wages were reported ____ Code ____

ACCIDENT AND INJURY

Describe in full how accident happened and GIVE CAUSE—Tell what employee was doing when injured: Welding along side another man with a shield between them, but they were so close that whenever Short raised his hood he got a welding flash from the other man's equipment. Welding in confined area in OS&B building. + inside of shield painted
Nature or extent of injury or illness Welding flash (Cut-Fracture) Part of body affected eyes (Leg-Arm-Back-Head)
Did employee die? Yes [ ] No [X]
Name of witnesses to accident 1 ____ 2 ____
Date of injury or initial diagnosis of occupational illness 8-25-75 Hour ____ A.M. 3:00 P.M.
Was employee injured in course of employment? Yes [X] No [ ]
Place where accident occurred
Ore storage & blending building, 12 miles north of Libby (Address, City) Lincoln (County)
Was place of accident or exposure on employer's premises? Yes [X] No [ ]
Were you notified of accident? Yes [X] No [ ] How by employee Date 8-26-75
Have you reason to question this accident? Yes [ ] No [X] If "yes," explain fully ____

SAFETY

1. Was the accident caused by an unsafe act? Yes [ ] No [X]
2. Was the accident caused by an unsafe condition? Yes [ ] No [X] Should not be that close
3. What specific device, object or substance caused the injury? welding flash

MEDICAL ATTENTION

Name of attending physician W. T. Matthews, M.D.
Address 402 Montana Avenue Libby, Montana
Was employee hospitalized? Yes [ ] No [X] Name of hospital ____
Address ____

TIME AND WAGE LOSS

1. Will the employee return to work before or during his next scheduled shift? Yes [X] No [ ]
2. Will employee lose wages? Yes [ ] No [X]
3. Date wage loss began none Amount of weekly wage loss ____

EMPLOYER

Name of employer Construction Products Division-W.R.Grace & Co.
D.B.A. ____
Address Box 609, Libby, Montana Nature of business Mining & Milling Vermiculite
Location, if different from mail address ____

Signed, this 29th day of August, 1975
at Libby, Montana

Prepared by Joan B. Runyan
Signed by ____
Official Title Administrative Assistant

NOTICE—EMPLOYEE'S CLAIM FOR COMPENSATION, FORM 54, MUST BE FILED WITHIN 12 MONTHS FROM DATE OF ACCIDENT

FORM 27

C0080096

Medical
Short, James R.

C0080095

WRG00299133
ED_005351_00000355-00225

WORKMEN'S COMPENSATION DIVISION

Department of Labor and Industry
815 Front Street
Helena, Montana 59601

CASE No. _____

Firm No. 2503

EMPLOYER'S FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE

INSTRUCTIONS—Employer must complete form at once after every accident or occupational disease which causes loss of time from work or requires medical attention and mail to Workmen's Compensation Division, Helena, Montana. Form must be signed in pen and ink. ALL QUESTIONS MUST BE ANSWERED FULLY. This form contains all items requested on OSHA Form No. 101, "Supplementary Record of Occupational Injuries and Illnesses."

INJURED EMPLOYEE

Full name of injured employee James R. Short Occupation Construction Worker
Home address ~~Route 1 Box 1290, Libby~~ (Street, City) How long has he been in your employ? 3 years
Social Security No. 516-42-4539 Sex M Age 36 Married [X] Single [ ]
Department Construction (Enter name of department or division in which the injured person is regularly employed, even though he may have been temporarily working in another department at the time of injury.)

EARNINGS

Monthly Wage _____, or Weekly Wage _____, or Daily Wage _____, or Hourly Wage 5.005
Receive board? Yes [ ] No [X] Receive Room? Yes [ ] No [X] Days worked per week 5 Employee's pay period? Monthly [ ], Semi-monthly [X], Weekly [ ]. List employee's earnings and date of last 4 pay periods
1 _____ (Date/Amount) 2 _____ (Date/Amount) 3 _____ (Date/Amount) 4 _____ (Date/Amount)
List Payroll Classification and Code under which employee's wages were reported _____ Code _____

ACCIDENT AND INJURY

Describe in full how accident happened and GIVE CAUSE—Tell what employee was doing when injured: Was working outside near other employees who were welding. Was not wearing protective equipment as he was not welding. Got welding flash in both eyes from others equipment.

Nature or extent of injury or illness Welding Flash (Cut-Fracture) Part of body affected both eyes (Leg-Arm-Back-Head)
Did employee die? Yes [ ] No [X]
Name of witnesses to accident 1 Ed Yankey 2 _____
Date of injury or initial diagnosis of occupational illness 1-6-76 Hour _____ A.M. _____ P.M.
Was employee injured in course of employment? Yes [X] ~~No [ ]~~
Place where accident occurred
our mill area, 12 miles north of Libby (Address, City) Lincoln (County)
Was place of accident or exposure on employer's premises? Yes [X] No [ ]
Were you notified of accident? Yes [X] No [ ] How ~~by employee~~ Date 1-9-76
Have you reason to question this accident? Yes [ ] No [X] If "yes," explain fully _____

SAFETY

1. Was the accident caused by an unsafe act? Yes [ ] No [X]
2. Was the accident caused by an unsafe condition? Yes [ ] No [X]
3. What specific device, object or substance caused the injury? welding equipment

MEDICAL ATTENTION

Name of attending physician W. T. Matthews, MD
Address 402 MontanaAvenue, Libby, MT 59923
Was employee hospitalized? Yes [ ] No [X] Name of hospital _____
Address _____

TIME AND WAGE LOSS

1. ~~Will the employee return to work before or during his next scheduled shift? Yes [X] No [ ]~~
2. Will employee lose wages? Yes [ ] No [X]
3. Date wage loss began none Amount of weekly wage loss _____

EMPLOYER

Name of employer Construction Products Division-W.R.Grace & Co.
D.B.A. _____
Address Box 609, Libby, MT Nature of business Mining & Milling Vermiculite
Location, if different from mail address _____

Signed, this 13th day of January, 19 76 Prepared by Joan B. Runyan
at Libby, Montana Signed by _____ Official Title Administrative Assistant

NOTICE—EMPLOYEE'S CLAIM FOR COMPENSATION, FORM 54, MUST BE FILED WITHIN 12 MONTHS FROM DATE OF ACCIDENT

FORM 37 3

C0080097

MEDICAL
Siefke, Kenneth

C0080123

06063279

Industrial Accident Board

HELENA, MONTANA

Film No.

File No.

EMPLOYER'S FIRST REPORT OF INJURY

INSTRUCTIONS—*Employer must complete form at once after every accident which causes loss of time from work or requires medical attention and mail it to the Industrial Accident Board, Helena, Montana. Form must be signed in pen and ink.* **ALL QUESTIONS MUST BE ANSWERED FULLY.**

INJURED EMPLOYEE

Full name of injured employee: Kenneth Slefke Occupation: Construction Worke

Mailing address: Box 54, Troy, Montana (Street, City) How long has he been in your employ? 10-mos.

Social Security No. 728-07-8621 Sex: M Age: 31 Married ☒ Single ☐

EARNINGS

Monthly Wage ____ Weekly Wage ____ Daily Wage ____ Hourly Wage 3.35

Receive board Yes ☐ No ☒ Daily Value ____ Receive room Yes ☐ No ☒ Daily Value ____

Piece Worker Yes ☐ No ☒ If yes, price per unit at piece work ____ Hours worked per day 8

Days worked per week 6 Employee's pay period? Monthly ☐ Semi-monthly ☒ Weekly ☐ List employee's earnings last 4 pay periods 1. 321.60 2. 214.40 3. 402.00 4. 348.40

List Payroll Classification and Code under which employee's wages were reported ____ (Sawmill - Mechanic - Etc.) Code ____ (2702, 5506, 8810)

ACCIDENT AND INJURY

Describe in full how accident happened and GIVE CAUSE: While chipping slag from a weld, got piece of steel in right eye.

Nature or extent of injury: foreign object--eye (Cut - Fracture) Part of body injured? right eye (Leg - Arm - Back - Head)

Names of witnesses to accident 1. ____ 2. ____

Date of accident 3-30-70 19__ Hour ____ A.M. P.M. Was employee injured in course of employment? Yes ☒ No ☐

Place where accident occurred: our shop, 9 miles north of Libby, Montana (Address) Libby (City) Lincoln (County)

Did you or employee's supervisor have actual knowledge of accident? Yes ☒ No ☐

Were you notified of accident by injured employee? Yes ☒ No ☐ How: In person Date: 4-3-70

Have you reason to question this accident? Yes ☐ No ☒ If "yes" explain fully ____

SAFETY

Was employee's accident due to unsafe work practice? Yes ☐ No ☒ If "yes", what did he do unsafely? ____

Was a specific device, object or substance involved in accident? Yes ☐ No ☐ If "yes", name specific device, object or substance ____ Was device or object defective? Yes ☐ No ☐

Was employee doing regular work when injured? Yes ☒ No ☐ Was employee trained to do work he was doing when injured? Yes ☒ No ☐ Were adequate safeguards provided? Yes ☐ No ☐ If "yes", were they being used at the time of accident? Yes ☐ No ☐

MEDICAL ATTENTION

Name of attending physician: W. T. Matthews, M.D Address: Libby, Montana

Was employee hospitalized? Yes ☐ No ☒ Name of hospital ____ Address ____

Was first aid administered by someone other than attending physician? Yes ☐ No ☒

TIME AND WAGE LOSS

Will employee lose time from work due to accident? Yes ☐ No ☒ How long? NONE If injury results in time loss will employee, while disabled, received sick leave benefits? Yes ☐ No ☐ Paid vacation? Yes ☐ No ☐ Will employee lose wages? Yes ☐ No ☐ Room? Yes ☐ No ☐ Board? Yes ☐ No ☐

Date wage loss began: NONE Amount of weekly wage loss ____

EMPLOYER

Name of employer: Construction Products Division-W.R.Grace & Co.

Address: Libby, Montana Nature of Business: Mining & Milling Vermiculite

IS FIRM A CORPORATION ☒ OR PARTNERSHIP ☐ OR INDIVIDUAL ☐

IF
- Corporation—is injured employee an officer or director of corporation? Yes ☐ No ☒
- Partnership—is injured employee related to any partner? Yes ☐ No ☐ Relationship ____
- Individual—is injured employee related to employer? Yes ☐ No ☐ Relationship ____

Signed, this 6th day of April, 19 70

at Libby, Montana

Employer's Name: Construction Products Division W. R. Grace & Co.

Signed by ____

Official Title ____

NOTICE—EMPLOYEE'S CLAIM FOR COMPENSATION, FORM 54, MUST BE FILED WITHIN 12 MONTHS FROM DATE OF ACCIDENT.

C0080124

MEDICAL
Siefke, Kenneth

C0080123

06063416

Industrial Accident Board

HELENA, MONTANA

Firm No. 2503

File No.

EMPLOYER'S FIRST REPORT OF INJURY

INSTRUCTIONS—Employer must complete form at once after every accident which causes loss of time from work or requires medical attention and mail it to the Industrial Accident Board, Helena, Montana. Form must be signed in pen and ink. ALL QUESTIONS MUST BE ANSWERED FULLY.

INJURED EMPLOYEE

Full name of injured employee Kenneth A. Siefke Occupation Mechanic

Mailing address Box 54 (Street) Troy (City) How long has he been in your employ? 3 yrs.

Social Security No. 728-07-8621 Sex M Age 34 Married ☒ Single ☐

EARNINGS

Monthly Wage ..... Weekly Wage ..... Daily Wage ..... Hourly Wage .....

Receive board Yes ☐ No ☒ Daily Value ..... Receive room Yes ☐ No ☒ Daily Value .....

Piece Worker Yes ☐ No ☒ If yes, price per unit at piece work ..... Hours worked per day 8

Days worked per week 5 Employee's pay period? Monthly ☐ Semi-monthly ☒ Weekly ☐ List employee's earnings last 4 pay periods 1 269.84 2 204.64 3 214.60 4 249.79

List Payroll Classification and Code under which employee's wages were reported ..... (Sawmill - Mechanic - Etc.) Code ..... (2702, 5506, 8810)

ACCIDENT AND INJURY

Describe in full how accident happened and GIVE CAUSE He was working on RC-30 drill cabl on 8-23-72, he did not notice that his eye (right) was inflamed until he got home that night. Cause unknown.

Nature or extent of injury inflamed eye (Cut - Fracture) Part of body injured? right eye (Leg - Arm - Back - Head)

Names of witnesses to accident 1 ..... 2 .....

Date of accident 8-29- 19 72 Hour ..... A. M. P. M. Was employee injured in course of employment? Yes ☒ No ☐

Place where accident occurred our mine 12 miles north of Libby (Address) Lincoln (County)

Did you or employee's supervisor have actual knowledge of accident? Yes ☒ No ☐

Were you notified of accident by injured employee? Yes ☒ No ☐ How, 8x38- in person Date 8-30-72

Have you reason to question this accident? Yes ☐ No ☒ If "yes" explain fully .....

SAFETY

Was employee's accident due to unsafe work practice? Yes ☐ No ☒ If "yes", what did he do unsafely? .....

Was a specific device, object or substance involved in accident? Yes ☐ No ☐ If "yes", name specific device, object or substance ..... Was device or object defective? Yes ☐ No ☐

Was employee doing regular work when injured? Yes ☒ No ☐ Was employee trained to do work he was doing when injured? Yes ☒ No ☐ Were adequate safeguards provided? Yes ☐ No ☐ If "yes", were they being used at the time of accident? Yes ☐ No ☐

MEDICAL ATTENTION

Name of attending physician W. T. Matthews, M.D. Address Libby

Was employee hospitalized? Yes ☐ No ☒ Name of hospital St. Johns Lutheran Address Libby

Dr. looked at eye

Was first aid administered by someone other than attending physician? Yes ☐ No ☐

TIME AND WAGE LOSS

Will employee lose time from work due to accident? Yes ☐ No ☒ How long? NONE If injury results in time loss will employee, while disabled, received sick leave benefits? Yes ☐ No ☐ Paid vacation? Yes ☐ No ☐ Will employee lose wages? Yes ☐ No ☐ Room? Yes ☐ No ☐ Board? Yes ☐ No ☐

Date wage loss began NONE Amount of weekly wage loss .....

EMPLOYER

Name of employer Construction Products Division - W. R. Grace & Co.

Address Libby, Montana Nature of Business Mining&Milling Vermiculi

IS FIRM A CORPORATION ☒ OR PARTNERSHIP ☐ OR INDIVIDUAL ☐

IF
- Corporation—is injured employee an officer or director of corporation? Yes ☐ No ☒
- Partnership—is injured employee related to any partner? Yes ☐ No ☐ Relationship .....
- Individual—is injured employee related to employer? Yes ☐ No ☐ Relationship .....

Signed, this 1st day of September, 19 72

at Libby, Montana

Employer's Name Construction Products Division W. R. Grace & Co.

Signed by [signature]

Official Title Pers Mgr

NOTICE—EMPLOYEE'S CLAIM FOR COMPENSATION, FORM 54, MUST BE FILED WITHIN 12 MONTHS FROM DATE OF ACCIDENT.

C0080125

MEDICAL
Siefke, Kenneth

C0080123

WRG00299141
ED_005351_00000355-00231

06063310

Industrial Accident Board

HELENA, MONTANA

Firm No. 2503

File No.

EMPLOYER'S FIRST REPORT OF INJURY

INSTRUCTIONS—Employer must complete form at once after every accident which causes loss of time from work or requires medical attention and mail it to the Industrial Accident Board, Helena, Montana. Form must be signed in pen and ink. ALL QUESTIONS MUST BE ANSWERED FULLY.

INJURED EMPLOYEE

Full name of injured employee Kenneth Siefke Occupation Construction Worker

Mailing address Box 54, Troy, Montana (Street, City) How long has he been in your employ? 2½ years

Social Security No. 728-07-8621 Sex M Age 33 Married ☒ Single ☐

EARNINGS

Monthly Wage Weekly Wage Daily Wage Hourly Wage 3.725

Receive board Yes ☐ No ☒ Daily Value Receive room Yes ☐ No ☒ Daily Value

Piece Worker Yes ☐ No ☒ If yes, price per unit at piece work Hours worked per day 8

Days worked per week 6 Employee's pay period? Monthly ☐ Semi-monthly ☒ Weekly ☐ List employee's earnings last 4 pay periods 1. 302.20 2. 353.38 3. 357.60 4. 302.45

List Payroll Classification and Code under which employee's wages were reported (Sawmill - Mechanic - Etc.) Code (2702, 5506, 8810)

ACCIDENT AND INJURY

Describe in full how accident happened and GIVE CAUSE Was breaking up old cement floor in the garage with jackhammer, slipped, injured lower back.

Nature or extent of injury Strain (Cut - Fracture) Part of body injured? lower back (Leg - Arm - Back - Head)

Names of witnesses to accident 1. 2.

Date of accident 12-21 19 71 Hour A.M. P.M. Was employee injured in course of employment? Yes ☒ No ☐

Place where accident occurred our shop, 9 miles north of Libby (Address, City) Lincoln (County)

Did you or employee's supervisor have actual knowledge of accident? Yes ☒ No ☐

Were you notified of accident by injured employee? Yes ☒ No ☐ How in person Date 12-27-71

Have you reason to question this accident? Yes ☐ No ☒ If "yes" explain fully

SAFETY

Was employee's accident due to unsafe work practice? Yes ☐ No ☒ If "yes", what did he do unsafely?

Was a specific device, object or substance involved in accident? Yes ☐ No ☒ If "yes", name specific device, object or substance Was device or object defective? Yes ☐ No ☐

Was employee doing regular work when injured? Yes ☒ No ☐ Was employee trained to do work he was doing when injured? Yes ☒ No ☐ Were adequate safeguards provided? Yes ☐ No ☐ If "yes", were they being used at the time of accident? Yes ☐ No ☐

MEDICAL ATTENTION

Name of attending physician W. T. Matthews, M.D. Address Libby, Montana

Was employee hospitalized? Yes ☐ No ☒ Name of hospital Address

Was first aid administered by someone other than attending physician? Yes ☐ No ☒

TIME AND WAGE LOSS

Will employee lose time from work due to accident? Yes ☐ No ☒ How long? none If injury results in time loss will employee, while disabled, received sick leave benefits? Yes ☐ No ☐ Paid vacation? Yes ☐ No ☐ Will employee lose wages? Yes ☐ No ☐ Room? Yes ☐ No ☐ Board? Yes ☐ No ☐

Date wage loss began none Amount of weekly wage loss

EMPLOYER

Name of employer Construction Products Division-W.R.Grace & Co.

Address Libby, Montana Nature of Business Mining & Milling Vermiculite

IS FIRM A CORPORATION ☒ OR PARTNERSHIP ☐ OR INDIVIDUAL ☐

IF
- Corporation—is injured employee an officer or director of corporation? Yes ☐ No ☒
- Partnership—is injured employee related to any partner? Yes ☐ No ☐ Relationship
- Individual—is injured employee related to employer? Yes ☐ No ☐ Relationship

Signed, this 30th day of December, 19 71

at Libby, Montana

Employer's Name Construction Products Division W. R. Grace & Co.

Signed by [signature]

Official Title [signature]

NOTICE—EMPLOYEE'S CLAIM FOR COMPENSATION, FORM 54, MUST BE FILED WITHIN 12 MONTHS FROM DATE OF ACCIDENT.

C0080127

Medical
Skip Shack

C0080167

GRACE

INCIDENT INVESTIGATION REPORT

~~PERSONAL INJURY~~/PROPERTY DAMAGE

NUMBER OF DAYS AWAY FROM WORK

NUMBER OF RESTRICTED WORK DAYS

DIVISION/PLANT	PLANT LOCATION (City/State)	INJURY NUMBER (From OSHA 200 Log)
Const Prod Div Libby	Libby Mont	

LOCATION OF INCIDENT	COMPANY PREMISES	TIME OF INCIDENT	DATE OF INCIDENT
SKIP Bin AREA	☒ YES ☐ NO	11:00 AM ☒ PM ☐	5 / 1 / 86

PERSONNEL

INJURED OR ILL

NAME (FIRST) (MIDDLE) (LAST)

SOC. SEC. NO. #

OCCUPATION

SEX ☐ MALE ☐ FEMALE

MARITAL STATUS ☐ MARRIED ☐ SINGLE

DATE OF BIRTH

ACCIDENT CATEGORY

☐ DAYS AWAY FROM WORK ☐ MEDICAL TREATMENT

☐ RESTRICTED WORK ☐ FIRST AID

NA

LENGTH OF EMPLOYMENT	YEARS	MONTHS	LENGTH OF PRESENT OCC.	YEARS	MONTHS	SHIFT
						☒ REG. ☐ OVERTIME

NATURE OF INJURY/PARTS OF BODY AFFECTED

DATES OF PREVIOUS INJURIES

WHAT FIRST AID

WHERE GIVEN

BY WHOM

WHERE SENT ☐ HOSPITAL (Name and Address) ☐ HOME ☐ OTHER (Specify)

NAME AND ADDRESS OF ATTENDING PHYSICIAN

PROPERTY

PROPERTY DAMAGE (est. dollar value)

None

LOST PRODUCTION (i.e., days, hours, lbs., tons) AND ESTIMATED VALUE

30 minutes Power outage To service shops.

LOSS TYPE (explosion, fire, wind) / IDENTIFY PROPERTY DAMAGED

OTHER

(NEAR MISS) NATURE OF INCIDENT / DOLLAR COST (if applicable)

C0080168

DESCRIPTION

DESCRIBE EVENTS LEADING TO INCIDENT/WORK IN PROGRESS/STAGE OF PROCESS/ACTUAL ACTS OF INJURED AND FELLOW EMPLOYEES

We were setting up the 65 ton P&H crane to install a C.B. Radio antena on top of the building. We THREAded THE Boom up Through several Low voltage insulated elect wires To Reach THE location.

SET UP LOCATION WAS ALTERNATE BECAUSE SAFEST SETUP SPOT WAS BLOCKED w/ 40 YDS OF GRAVEL FOR SKIP.

after setting up the crane with THE Boom in Place THE operator Dismounted THE machine. THE main Hoist Line became engaged in THE Down position. THE main Block & Hook (on)

73-119 (Rev. 6/82)

WRG00299144

ED_005351_00000355-00234

DESCRIPTION

CONTINUE DESCRIPTION Layed on and Became Tangled in the Power Lines.
We Then Had To Shut The Power off To clear The Lines

ANALYSIS AND EVALUATION

IMMEDIATE CAUSE(S): WHAT SPECIFIC ACTS / FAILURE TO ACT OR CONDITIONS CONTRIBUTED DIRECTLY TO THE INCIDENT?

Unsafe conditions A. The Hoist Lever on The crane is Designed in such a manner That The quick Release Hoses Tend To pull The lever into The Down position.
B. We left The crane Running without the operator in it.

BASIC CAUSE(S): WHAT ARE THE BASIC CAUSES AND WHAT ARE THE REASONS FOR THESE CAUSES TO EXIST?

We knew The lever condition Existed and we Had attemped to fix it but our first try didn't work.
We also leave the crane Running to Keep the oil up to operating temperature so as to make it Run smoothly and Properly.

DID NOT RESPECT THE LOW VOLTAGE LINE.

EVALUATION	SEVERITY POTENTIAL			PROBABLE RECURRENCE RATE		
	☐ MAJOR	☐ SERIOUS	☒ NOT SERIOUS	☐ FREQUENT	☐ OCCASIONAL	☒ RARE

PREVENTION

WHAT CORRECTIVE ACTION HAS BEEN OR WILL BE TAKEN TO PREVENT A RECURRENCE?

We installed a spring on the lever to Prevent its accidental movement
We would also like to install Heaters in the oil system so the crane would not have to be left Running.
The crane will be shut Down when without an operator in control of it

COMPLETION DATE 5 | 7 | 86

INVESTIGATED BY	DATE	REVIEWED BY	DATE
Don Riley	5 | 7 | 86	Mike Ray	5 | 7 | 86

REVIEWER'S COMMENTS (IS INVESTIGATION COMPLETE AND CORRECTIVE ACTION ADEQUATE?)

W. R. GRACE
Terry J. Jacobs
SAFETY DIRECTOR
Jake
Date 5/7/86

C00B0169

IF SERIOUS PROPERTY DAMAGE OR PERSONAL INJURY OCCURS, IMMEDIATELY PHONE THE ICG HEALTH AND SAFETY DEPARTMENT.

Medical
Slauson Dick

C00B0170

WRG00299146

ED_005351_00000355-00236

MONTANA DIVISION OF WORKERS' COMPENSATION

Complied with 82—1137 R.C.M.

815 Front Street
Helena, Montana 59601

SEND ORIGINAL TO INSURER

EMPLOYER'S FIRST REPORT
of Occupational Injury or
Occupational Disease
Employee Copy

CASE NUMBER

FIRM NUMBER

INSTRUCTIONS - Every employer in Montana is required by law to complete this form immediately after every accident to an employee which arises out of and in the course of employment, and which causes loss of time from work or requires medical attention. The original of this form must be immediately filed with the employer's insurer or the Division of Workers' Compensation, 815 Front Street, Helena, Montana 59601. All questions must be answered fully. If a question cannot be answered, please explain why. **Please print with a ball point pen or type.**

FEDERAL OSHA REQUIREMENTS - The United States Department of Labor requires employers to maintain, in the employer's office, a record of occupational injuries. For the employer's convenience, this form has been designed to meet such requirements and to provide employers a record copy.

EMPLOYEE

Full Name of INJURED EMPLOYEE: Richard H. Slauson
Social Security Number: 516-26-8474
EMPLOYEE'S Home Address (Street or Box): 401 W 2nd
City: Libby
State: Mt
Zip Code: 59923
Occupation: Labor Pool
Sex: M
Age: 53
Marital Status: [X] Married [ ] Single
Length of time in your Employment: 3 weeks
Department where regularly employed: Labor Pool
Date of Birth (mo.) (day) (yr.): 5-X / 29 / 26

WAGES

Employee's Gross Wage Rate is $ 7.725 per [ ] week, or [ ] day, or [X] hour, or [ ] month
Days Worked Per Week: 5
Hours Worked Per Day: 8
If board or room is furnished state value reported per day to Internal Revenue Service $
Check One— [X] Full Time Employee [ ] Part Time Employee
Payroll Classification under which employee's wages were reported
Employee's gross earnings for last four (4) pay periods (Date / Amount) (Date / Amount) (Date / Amount) (Date / Amount)
Employee's pay period: [ ] Monthly [ ] Semi-monthly [X] Bi-Weekly [ ] Weekly [ ] Other

ACCIDENT INFORMATION

Describe in full detail how accident happened, and give cause - Explain what employee was doing when injured.
Caught fingers of right hand in Wet Mill Elevator Door

What specific object or substance caused the injury? Elevator Door
Nature of the injury? (cut, fracture, etc.) Bruised right Middle & Index Fingers
Part of body affected (leg, arm, back, head, etc.): Right Hand
DATE OF INJURY (month) (day) (year) (hour) (a.m. or p.m.): November 1 1979 10:00 a.m.
Names of witnesses to accident: 1. 2.
Place where accident occurred (address & city): 12 miles N.E. Libby Mt. (county) Lincoln
Was place of accident on employer's premises? Yes [X] No [ ]
Was employee injured while in your employ? Yes [X] No [ ]
Were you notified, or did you have actual knowledge of the accident? Yes [X] No [ ] If yes, date notified & how: Don Riley 11/2/79
Do you have any reason to question this accident? [ ] Yes [X] No If yes, please explain fully

MEDICAL

Attending physician name and address: Dr Roger H. Brus, 111 E Cedar, Libby, Mt. 59923
If hospitalized, hospital's name and address
Will employee return to work during next scheduled shift? Yes [X] No [ ]
If no, will wage loss exceed 7 days? Yes [ ] No [ ] Not Sure [ ]
Date wage loss began (mo) (day) (yr.)
Date of return, if returned to work (mo.) (day) (yr.)

EMPLOYER

EMPLOYER'S NAME: W. R. Grace & Co.
Commercial Name (doing business as)
Employer's mailing address (Street or Box) (City) (State) (Zip Code): P O Box 609 Libby, Mt. 59923
Phone number: (406) 293-4131
Location of operation, if different from mailing address: 12 Miles N.E. Libby, Mt.
Nature of business: Mining & Milling
Firm is a: (Check one) [ ] Sole proprietorship [ ] Partnership [X] Corporation
Was the Injured employee? (Check if applicable) [ ] A Sole Proprietor, [ ] A working Partner, [ ] A Corporate Officer, or [ ] A member of the employer's (sole proprietor or partner) family, dwelling in the employer's household.
Prepared by: B Woodard
Authorized Signature: X [signature] Official Title: Manager of Administration Date: 11/6/79

DWC USE ONLY

OCCUPATION
SEX
AGE
MARITAL STATUS
COUNTY
LENGTH (YRS) EMPLOYED
WEEKLY EARNINGS
CLASS CODE
ACCIDENT TYPE
SOURCE OF INJURY
PART OF BODY INJURED
OSHA RECORDABLE CODE
DISABILITY TYPE
NATURE OF INJURY
HAZARDOUS CONDITION
UNSAFE ACT

Above - DWC-MIS Form 37-Employer's First Report (Rev. 1-76)

Below - DWC-MIS Form 54A-Claim for Compensation

EMPLOYEE'S CLAIM FOR COMPENSATION

EMPLOYER'S NOTE: For convenience purposes and if the worker is available, the form below has been provided so that an employer may allow an injured worker to file a claim for compensation on this form to avoid having the employee fill out and file a separate detailed form. Separate claim forms are available if the employer does not want the worker to use this form. **Do not delay in submission of this form if employee is not available to sign below.**

INJURED EMPLOYEE'S NOTE: An injured employee may use the form below to make a claim for compensation, or the employee may fill out and submit a separate detailed form that is available from the Division.

I have carefully read the above information as documented by the employer, and (except for any statements I may write below) I concur with the information and I hereby make claim for compensation benefits due me now or in the future under Montana's Workers' Compensation Act.

Signature of injured employee: X [signature] Address: 401 W. 2nd City: Libby, Date: 11/6/79 Phone: 293-5237

I DO NOT concur with the following information documented by the employer

C0080171

Filing of this claim is authorization for release of medical records and records of the Social Security Administration

MEDICAL
Smerker, Dennis

C0080172

06062979

Industrial Accident Board, Helena, Montana, Form 37 Revised—YM - U - WU

Industrial Accident Board

HELENA, MONTANA

Firm No.

File No.

EMPLOYER'S FIRST REPORT OF INJURY

INSTRUCTIONS—Employer must complete form at once after every accident which causes loss of time from work or requires medical attention and mail it to the Industrial Accident Board, Helena, Montana. Form must be signed in pen and ink. ALL QUESTIONS MUST BE ANSWERED FULLY.

INJURED EMPLOYEE

Full name of injured employee Dennis Smerker Occupation Construction Wor

Mailing address Box 805, Libby, Montana (City) How long has he been in your employ 6 months

Social Security No. 517-48-1030 Sex M Age 28 Married ☒ Single ☐

EARNINGS

Monthly Wage Weekly Wage Daily Wage Hourly Wage 2.58

Receive board Yes ☐ No ☒ Daily Value Receive room Yes ☐ No ☒ Daily Value

Piece Worker Yes ☐ No ☒ If yes, price per unit at piece work Hours worked per day 8

Days worked per week 5 Employee's pay period? Monthly ☐ Semi-monthly ☒ Weekly ☐ List employee's earnings last 4 pay periods 1 319.92 2 288.96 3 288.96 4 199.26

List Payroll Classification and Code under which employee's wages were reported (Sawmill - Mechanic - Etc.) Code (2702, 5506, 8810)

ACCIDENT AND INJURY

Describe in full how accident happened and GIVE CAUSE Was loading some 3 x 12's onto a truck along with 2 other workers. Pulled muscle in upper back.

Nature or extent of injury Muscle strain (Cut - Fracture) Part of body injured? Upper back (Leg - Arm - Back - Head)

Names of witnesses to accident 1 Kenneth Fredricks 2 Ronald Doubek

Date of accident 5-2-67 19 Hour 8:30 A.M. P.M. Was employee injured in course of employment? Yes ☒ No ☐

Place where accident occurred our mill, 3 miles north of Libby (Address, City) Lincoln (County)

Did you or employee's supervisor have actual knowledge of accident? Yes ☒ No ☐

Were you notified of accident by injured employee? Yes ☒ No ☐ How by employee Date 5-2-67

Have you reason to question this accident? Yes ☐ No ☒ If "yes" explain fully

SAFETY

Was employee's accident due to unsafe work practice? Yes ☐ No ☒ If "yes", what did he do unsafely?

Was a specific device, object or substance involved in accident? Yes ☐ No ☐ If "yes," name specific device, object or substance Was device or object defective? Yes ☐ No ☐

Was employee doing regular work when injured? Yes ☒ No ☐ Was employee trained to do work he was doing when injured? Yes ☒ No ☐ Were adequate safeguards provided? Yes ☐ No ☐ If "yes," were they being used at the time of accident? Yes ☐ No ☐

MEDICAL ATTENTION

Name of attending physician Dr. W. T. Matthews Address Libby, Montana

Was employee hospitalized? Yes ☐ No ☒ Name of hospital Address

Was first aid administered by someone other than attending physician? Yes ☐ No ☒

TIME AND WAGE LOSS

Will employee lose time from work due to accident? Yes ☐ No ☒ How long? If injury results in time loss will employee, while disabled, receive sick leave benefits? Yes ☐ No ☐ Paid vacation? Yes ☐ No ☐ Will employee lose wages? Yes ☐ No ☐ Room? Yes ☐ No ☐ Board? Yes ☐ No ☐

Date wage loss began NONE Amount of weekly wage loss

EMPLOYER

Name of employer Zonolite Division-W. R. Grace & Co.

Address Libby, Montana Nature of business Mining & Milling Vermiculite

IS FIRM A CORPORATION ☒ OR PARTNERSHIP ☐ OR INDIVIDUAL ☐

IF
- Corporation—is injured employee an officer or director of corporation? Yes ☐ No ☒
- Partnership—is injured employee related to any partner? Yes ☐ No ☐ Relationship
- Individual—is injured employee related to employer? Yes ☐ No ☐ Relationship

Signed, this 3rd day of May, 19 67

at Libby, Montana

Employer's Name Zonolite Division-W.R.Grace & Co.

Signed by

Official Title

NOTICE—EMPLOYEE'S CLAIM FOR COMPENSATION, FORM 54, MUST BE FILED WITHIN 12 MONTHS FROM DATE OF ACCIDENT.

Δ

C0080173

WRG00299149

ED_005351_00000355-00239

MEDICAL
Smerker, Dennis

C0080172

WRG00200150
ED_005351_00000355-00240

Industrial Accident Board, Helena, Montana, Form 37 Revised

06062950

Industrial Accident Board

HELENA, MONTANA

DO NOT WRITE IN THIS SPACE

Firm No.....

File No.....

EMPLOYER'S FIRST REPORT OF INJURY

INSTRUCTIONS—Employer must complete form at once after every accident which causes loss of time from work or requires medical attention and mail it to the Industrial Accident Board, Helena, Montana. Form must be signed in pen and ink. ALL QUESTIONS MUST BE ANSWERED FULLY.

INJURED EMPLOYEE

Full name of injured employee: Dennis Saerker Occupation: Euclid Driver

Mailing address: Box 861, Libby How long has he been in your employ: 1 yr.

Social Security No.: 517-48-1038 Sex: M Age: 29 Married ☒ Single ☐

EARNINGS

Monthly Wage..... Weekly Wage..... Daily Wage..... Hourly Wage: 2.96

Receive board Yes ☐ No ☒ Daily Value..... Receive room Yes ☐ No ☒ Daily Value.....

Piece Worker Yes ☐ No ☒ If yes, give method of computing earnings.....

Number of hours worked per day: 8 Days worked per week: 5 Employee's pay period?

Monthly ☐ Semi monthly ☐ Weekly ☐ List employee's earnings last 4 pay periods 1. 276.51

2. 253.50 3. 320.88 4. 274.24

Under what payroll classification has employees' wages been reported?..... (Sawmill - Mechanic - Etc.)

ACCIDENT AND INJURY

Describe in full how accident happened and GIVE CAUSE: Slipped and fell

Part of body injured? Describe fully: right elbow

Names of witnesses to accident 1. Orville Thorn 2.....

Date of accident: 12-29 19 67 Hour: 8.m. A.M. P.M. Was employee injured in course of employment? Yes ☒ No ☐

Place where accident occured: our pit, 9 miles north of Libby (Address) (City) (County)

Did you or employee's supervisor have actual knowledge of accident? Yes ☒ No ☐

Were you notified of accident by injured employee? Yes ☒ No ☐ How: by employee Date: 12-28-67

Have you reason to question this accident? Yes ☐ No ☒ If "yes" explain fully.....

SAFETY

Was employee's accident due to unsafe work practices? Yes ☐ No ☒ If "yes", what did he do unsafely?

Was a specific device, object or substance involved in accident? Yes ☐ No ☐ If "yes", name specific device, object or substance..... Was device or object defective? Yes ☐ No ☐

Was employee doing regular work when injured? Yes ☒ No ☐ Was employee trained to do work he was doing when injured? Yes ☒ No ☐ Were adequate safe guards provided? Yes ☐ No ☐ If "yes" were they being used at time of accident? Yes ☐ No ☐

MEDICAL ATTENDANCE

Name of attending physician: Dr. Matthews Address: Libby, Montana

Was employe hospitalized? Yes ☐ No ☒ Name of hospital: St. Johns for X-Rays only

Was first aid administered by someone other than attending physician? Yes ☐ No ☒

TIME AND WAGE LOSS

Will employe lose time from work due to accident? Yes ☐ No ☒ How long?.....

If injury results in time loss, will employee, while disabled, receive sick leave benefits? Yes ☐ No ☐

Paid vacation? Yes ☐ No ☐

Will employe lose wages? Yes ☐ No ☐ Room? Yes ☐ No ☐ Board? Yes ☐ No ☐

Date wage loss began: NONE Amount of weekly wage loss.....

EMPLOYER

Name of employer: Zonolite Division-W.R.Grace & Co.

Address: Libby, Montana Nature of business.....

IS FIRM A CORPORATION ☒ OR PARTNERSHIP ☐ OR INDIVIDUAL ☐

IF
- Corporation—is injured employee an officer or director of corporation? Yes ☐ No ☒
- Partnership—is injured employee related to any partner? Yes ☐ No ☐ Relationship.....
- Individual—is injured employee related to employer? Yes ☐ No ☐ Relationship.....

Carrier | Firm No. | File No. | Major Industry | County | Date of Acc. | Time | Sex & Marital Status | Age | Mont. Code | Acc. Class | Occupation | Type | Agency | Agency Part | Nature of Inj. | Location | Time Loss | Mech. Defect | Unsafe Act | Pers. Factor | Weekly Wage

Signed, this 29th day of Dec., 19 67

Employer's Name: Zonolite Division-W.R.Grace & Co.

Signed by.....

at Libby Montana

Official Title.....

NOTICE—EMPLOYEE'S CLAIM FOR COMPENSATION, FORM 54, MUST BE FILED WITHIN 12 MONTHS FROM DATE OF ACCIDEN

Form 1-HU-163-ZR

C0080174

WRG0029915T

ED_005351_00000355-00241

DUPLICATE OF FORM FILED 12-29-67

06062949

Industrial Accident Board, Helena, Montana, Form 37 Revised—YM - U - WU

Industrial Accident Board

HELENA, MONTANA

Firm No.....

File No.....

EMPLOYER'S FIRST REPORT OF INJURY

INSTRUCTIONS—Employer must complete form at once after every accident which causes loss of time from work or requires medical attention and mail it to the Industrial Accident Board, Helena, Montana. Form must be signed in pen and ink. ALL QUESTIONS MUST BE ANSWERED FULLY.

INJURED EMPLOYEE

Full name of injured employee Dennis Scarcher Occupation Euclid Driver

Mailing address Box 861, Libby, Montana (Street, City) How long has he been in your employ 1 year

Social Security No. 517-40-1030 Sex M Age 29 Married ☒ Single ☐

EARNINGS

Monthly Wage..... Weekly Wage..... Daily Wage..... Hourly Wage 2.96

Receive board Yes ☐ No ☒ Daily Value..... Receive room Yes ☐ No ☒ Daily Value.....

Piece Worker Yes ☐ No ☒ *If yes, price per unit at piece work*..... Hours worked per day 8

Days worked per week 5 Employee's pay period? Monthly ☐ Semi-monthly ☒ Weekly ☐ List employee's earnings last 4 pay periods 1 276.51 2 253.50 3 320.88 4 274.24

List Payroll Classification and Code under which employee's wages were reported..... (Sawmill - Mechanic - Etc.) *Code*..... (2702, 5506, 8810)

ACCIDENT AND INJURY

Describe in full how accident happened and GIVE CAUSE Slipped & fell

Nature or extent of injury contusion right elbow (Cut - Fracture) Part of body injured? right elbow (Leg - Arm - Back - Head)

Names of witnesses to accident 1 Orville Thorn 2.....

Date of accident 12-9- 1967 Hour..... A. M. XXXX Was employee injured in course of employment? Yes ☒ No ☐

Place where accident occurred our pit, 9 miles north of Libby (Address, City) Lincoln (County)

Did you or employee's supervisor have actual knowledge of accident? Yes ☒ No ☐

Were you notified of accident by injured employee? Yes ☒ No ☐ How By employee Date 12-28-67

Have you reason to question this accident? Yes ☐ No ☒ If "yes" explain fully.....

SAFETY

Was employee's accident due to unsafe work practice? Yes ☐ No ☒ *If "yes", what did he do unsafely?*.....

Was a specific device, object or substance involved in accident? Yes ☐ No ☐ If "yes," name specific device, object or *substance*..... *Was device or object defective?* Yes ☐ No ☐

Was employee doing regular work when injured? Yes ☒ No ☐ Was employee trained to do work he was doing when injured? Yes ☐ No ☐ Were adequate safeguards provided? Yes ☐ No ☐ If "yes," were they being used at the time of accident? Yes ☐ No ☐

MEDICAL ATTENTION

Name of attending physician Dr. W. T. Matthews Address Libby, Montana

Was employee hospitalized? Yes ☐ No ☒ *Name of hospital* St. Johns for X-rays only Address.....

Was first aid administered by someone other than attending physician? Yes ☐ No ☒

TIME AND WAGE LOSS

Will employee lose time from work due to accident? Yes ☐ No ☒ How long?..... If injury results in time loss will employee, while disabled, receive sick leave benefits? Yes ☐ No ☐ Paid vacation? Yes ☐ No ☐ Will employee lose wages? Yes ☐ No ☐ Room? Yes ☐ No ☐ Board? Yes ☐ No ☐

Date wage loss began NONE Amount of weekly wage loss.....

EMPLOYER

Name of employer Zonolite Division-W.R.Grace & Co.

Address Libby, Montana Nature of business Mining & Milling Vermiculite

IS FIRM A CORPORATION ☒ OR PARTNERSHIP ☐ OR INDIVIDUAL ☐

IF
- Corporation—is injured employee an officer or director of corporation? Yes ☐ No ☒
- Partnership—is injured employee related to any partner? Yes ☐ No ☐ Relationship.....
- Individual—is injured employee related to employer? Yes ☐ No ☐ Relationship.....

Signed, this 29th day of December, 19 67

at Libby, Montana

Employer's Name Zonolite Division-W.R.Grace & Co.

Signed by.....

Official Title.....

NOTICE—EMPLOYEE'S CLAIM FOR COMPENSATION, FORM 54, MUST BE FILED WITHIN 12 MONTHS FROM DATE OF ACCIDENT.

DUPLICATE DUPLICATE DUPLICATE

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C0080175

WRG00299152

ED_005351_00000355-00242

Medical Smith, James (IRR) Ex22

06063425

Industrial Accident Board

HELENA, MONTANA

Firm No. 2503

File No.

EMPLOYER'S FIRST REPORT OF INJURY

INSTRUCTIONS—Employer must complete form at once after every accident which causes loss of time from work or requires medical attention and mail it to the Industrial Accident Board, Helena, Montana. Form must be signed in pen and ink. ALL QUESTIONS MUST BE ANSWERED FULLY.

INJURED EMPLOYEE

Full name of injured employee: James Smith Occupation: Equip Driver

Mailing address: Box 47, Libby, Montana (Street, City) How long has he been in your employ? 1½ yrs.

Social Security No. 517-62-4232 Sex M Age 21 Married ☒ Single ☐

EARNINGS

Monthly Wage ____ Weekly Wage ____ Daily Wage ____ Hourly Wage 4.165

Receive board Yes ☐ No ☒ Daily Value ____ Receive room Yes ☐ No ☒ Daily Value ____

Piece Worker Yes ☐ No ☒ If yes, price per unit at piece work ____ Hours worked per day 8

Days worked per week 5 Employee's pay period? Monthly ☐ Semi-monthly ☒ Weekly ☐ List employee's earnings last 4 pay periods 1 336.60 2 348.96 3 156.00n 4 353.40

List Payroll Classification and Code under which employee's wages were reported ____ (Sawmill - Mechanic - Etc.) Code ____ (2702, 5506, 8810)

ACCIDENT AND INJURY

Describe in full how accident happened and GIVE CAUSE: Standing beside truck at transfer point ~~was~~ while dumping, rock jumped out of chute, bounced off truck, struck left hand, third finger.

Nature or extent of injury: bruises (Cut - Fracture) Part of body injured? third finger left hand (Leg - Arm - Back - Head)

Names of witnesses to accident 1 ____ 2 ____

Date of accident 6-8 1972 Hour 11:30 ~~A.M.~~ P.M. Was employee injured in course of employment? Yes ☒ No ☐

Place where accident occurred: our mine, 9 miles north of Libby (Address, City) Lincoln (County)

Did you or employee's supervisor have actual knowledge of accident? Yes ☒ No ☐

Were you notified of accident by injured employee? Yes ☒ No ☐ How: in person Date 6-9-72

Have you reason to question this accident? Yes ☐ No ☒ If "yes" explain fully ____

SAFETY

Was employee's accident due to unsafe work practice? Yes ☐ No ☒ If "yes", what did he do unsafely? ____

Was a specific device, object or substance involved in accident? Yes ☐ No ☒ If "yes", name specific device, object or substance ____ Was device or object defective? Yes ☐ No ☐

Was employee doing regular work when injured? Yes ☒ No ☐ *Was employee trained to do work he was doing when injured?* Yes ☒ No ☐ Were adequate safeguards provided? Yes ☐ No ☐ If "yes", were they being used at the time of accident? Yes ☐ No ☐

MEDICAL ATTENTION

Name of attending physician: R. D. MacKenzie, M.D. Address: Libby, Montana

Was employee hospitalized? Yes ☐ No ☒ Name of hospital: St. Johns Lutheran Address: for X-rays only

Was first aid administered by someone other than attending physician? Yes ☐ No ☒

TIME AND WAGE LOSS

Will employee lose time from work due to accident? Yes ☒ No ☐ How long? one day If injury results in time loss will employee, while disabled, received sick leave benefits? Yes ☐ No ☐ Paid vacation? Yes ☐ No ☐ Will employee lose wages? Yes ☐ No ☐ Room? Yes ☐ No ☐ Board? Yes ☐ No ☐

Date wage loss began 6-9-72 Amount of weekly wage loss 166.60

EMPLOYER

Name of employer: Construction Products Division-W.R.Grace & Co.

Address: Libby, Montana Nature of Business: Mining & Milling Vermiculite

IS FIRM A CORPORATION ☒ OR PARTNERSHIP ☐ OR INDIVIDUAL ☐

IF
- Corporation—is injured employee an officer or director of corporation? Yes ☐ No ☒
- Partnership—is injured employee related to any partner? Yes ☐ No ☐ Relationship ____
- Individual—is injured employee related to employer? Yes ☐ No ☐ Relationship ____

Signed, this 12th day of June, 19 72

at Libby, Montana

Employer's Name: Construction Products Division W. R. Grace & Co.

Signed by: [signature]

Official Title: Ass't

NOTICE—EMPLOYEE'S CLAIM FOR COMPENSATION, FORM 54, MUST BE FILED WITHIN 12 MONTHS FROM DATE OF ACCIDENT.

C0080212

~~WRG00299154~~

ED_005351_00000355-00244

Medical Smith, James (IRR) Ex22

06063375

Industrial Accident Board

HELENA, MONTANA

Firm No. 2503

File No.

EMPLOYER'S FIRST REPORT OF INJURY

INSTRUCTIONS—Employer must complete form at once after every accident which causes loss of time from work or requires medical attention and mail it to the Industrial Accident Board, Helena, Montana. Form must be signed in pen and ink. ALL QUESTIONS MUST BE ANSWERED FULLY.

INJURED EMPLOYEE

Full name of injured employee: James E. Smith Occupation: Mill Worker

Mailing address: Box 129 (Street) Libby (City) How long has he been in your employ? 1 month

Social Security No. 517-62-4232 Sex: M Age: 19 Married ☐ Single XX

EARNINGS

Monthly Wage ____ Weekly Wage ____ Daily Wage ____ Hourly Wage ____

Receive board Yes ☐ No X Daily Value ____ Receive room Yes ☐ No X Daily Value ____

Piece Worker Yes ☐ No X If yes, price per unit at piece work ____ Hours worked per day 8

Days worked per week 5 Employee's pay period? Monthly ☐ Semi-monthly XX Weekly ☐ List employee's earnings last 4 pay periods 1. 386.40 2. 234.60 3. ____ 4. ____

List Payroll Classification and Code under which employee's wages were reported ____ (Sawmill - Mechanic - Etc.) Code ____ (2702, 5506, 8810)

ACCIDENT AND INJURY

Describe in full how accident happened and GIVE CAUSE: While working at the tables some Caustic splashed down into his ~~leg~~ left eye

Nature or extent of injury ____ (Cut - Fracture) *Part of body injured?* left eye (Leg - Arm - Back - Head)

Names of witnesses to accident 1. ____ 2. ____

Date of accident 2-11 19 71 Hour 10 A.M. XX P.M. Was employee injured in course of employment? Yes X No ☐

Place where accident occurred: out mill 9 miles north of Libby (Address) Lincoln (County)

Did you or employee's supervisor have actual knowledge of accident? Yes X No ☐

Were you notified of accident by injured employee? Yes XX No ☐ How: In person Date: 2-11-71

Have you reason to question this accident? Yes ☐ No ☐ If "yes" explain fully ____

SAFETY

Was employee's accident due to unsafe work practice? Yes ☐ No ☐ If "yes", what did he do unsafely? ____

Was a specific device, object or substance involved in accident? Yes X No ☐ If "yes", name specific device, object or substance: Caustic Was device or object defective? Yes ☐ No X

Was employee doing regular work when injured? Yes XX No ☐ Was employee trained to do work he was doing when injured? Yes XX No ☐ Were adequate safeguards provided? Yes ☐ No ☐ If "yes", were they being used at the time of accident? Yes ☐ No ☐

MEDICAL ATTENTION

Name of attending physician: William T. Matthews, M.D. Address: Libby

Was employee hospitalized? Yes ☐ No X Name of hospital ____ Address ____

Was first aid administered by someone other than attending physician? Yes ☐ No ☐

TIME AND WAGE LOSS

Will employee lose time from work due to accident? Yes ☐ No XX How long? ____ If injury results in time loss will employee, while disabled, received sick leave benefits? Yes ☐ No ☐ Paid vacation? Yes ☐ No ☐ Will employee lose wages? Yes ☐ No ☐ Room? Yes ☐ No ☐ Board? Yes ☐ No ☐

Date wage loss began: NONE Amount of weekly wage loss ____

EMPLOYER

Name of employer: Construction Products Divison - W. R. Grace & Co.

Address: Libby, Montana Nature of Business: Mining & Milling Vemiculite

IS FIRM A CORPORATION X OR PARTNERSHIP ☐ OR INDIVIDUAL ☐

IF
- Corporation—is injured employee an officer or director of corporation? Yes ☐ No XX
- Partnership—is injured employee related to any partner? Yes ☐ No ☐ Relationship ____
- Individual—is injured employee related to employer? Yes ☐ No ☐ Relationship ____

Signed, this 19th day of February, 19 71

at Libby, Montana

Employer's Name: Construction Products Division W. R. Grace & Co.

Signed by: [signature]

Official Title: [signature]

NOTICE—EMPLOYEE'S CLAIM FOR COMPENSATION, FORM 54, MUST BE FILED WITHIN 12 MONTHS FROM DATE OF ACCIDENT.

C0080213

PATCH II

W.R. Grace Fall 2000 Document Production Target Sheet

- [ ] Notice
  - [ ] Testing
  - [ ] Agency
- [ ] Libby Ore/Operations
- [x] Libby All Other
- [ ] Expanding Plant (see below)
- [ ] Non-Grace Expanding Plant
- [ ] Attic Insulation
- [ ] Agricultural/ Horticultural Products
- [ ] Other Consumer Products
- [ ] Workers Comp
- [ ] Medical Records and Other Personal Confidental
- [ ] Privilege
- [ ] Trade Secret

- [ ] All
- [ ] Invoices

- [ ] Albany, N.Y.
- [ ] Atlanta, Georgia
- [ ] Birmingham, Alabama
- [ ] Boca Raton, Florida
- [ ] Chicago, Illinois (Blue Island)
- [ ] Dallas, Texas
- [ ] Dearborn, Michigan
- [ ] Denver, Colorado
- [ ] Easthampton, Mass.
- [ ] Ellwood City, Penn.
- [ ] Enoree, S. Carolina
- [ ] Hialeah, Florida
- [ ] High Point, N. Carolina
- [ ] Irondale, Alabama
- [ ] Jacksonville, Florida
- [ ] Kansas City, Missouri
- [ ] Kearny, S. Carolina
- [ ] Kenilworth Ave, Washington D.C.
- [ ] Los Angeles, Calif.
- [ ] Milwaukee, Wisconsin
- [ ] Minneapolis, Minn. (Western Min. Prod.)
- [ ] Muirkirk, Maryland (Beltsville)
- [ ] Nashville, Tennessee
- [ ] Newark, California
- [ ] New Castle, Pennsylvania
- [ ] New Orleans, Louisiana
- [ ] North Billerica, Mass.
- [ ] North Little Rock, Ark.
- [ ] Oklahoma City, Oklahoma
- [ ] Omaha, Nebraska (Western Min. Prod.)
- [ ] Phoenix, Arizona (Glendale)
- [ ] Pompano Beach, Florida
- [ ] Portland, Oregon
- [ ] Rio Piedras, Puerto Rico
- [ ] Sacramento, Calif.
- [ ] San Antonio, Texas
- [ ] Santa Ana, California
- [ ] Savannah, Georgia
- [ ] Sharpsburg, Penn.
- [ ] Spokane, Washington
- [ ] St. Louis, Missouri
- [ ] Tampa, Florida
- [ ] Travelers Rest, S. Carolina
- [ ] Trenton, New Jersey (East Trenton)
- [ ] Utica, New York
- [ ] Weedsport, N. Y. (Brutus)
- [ ] West Chicago, Illinois
- [ ] Wilder, Kentucky (Newport)

- [ ] Canadian Expanding plants

F18

Medical Smith, James (IRR) Ex 22

WRG00299159

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06063394

Industrial Accident Board

HELENA, MONTANA

Firm No. 2503

File No.

EMPLOYER'S FIRST REPORT OF INJURY

INSTRUCTIONS—Employer must complete form at once after every accident which causes loss of time from work or requires medical attention and mail it to the Industrial Accident Board, Helena, Montana. Form must be signed in pen and ink. ALL QUESTIONS MUST BE ANSWERED FULLY.

INJURED EMPLOYEE

Full name of injured employee: James E. Smith Occupation: Mill Worker

Mailing address: Box 47, Libby, Montana (Street, City) How long has he been in your employ? 1 week

Social Security No. ~~XXX~~ 517-62-4232 Sex: M Age: 19 Married ☐ Single ☒

EARNINGS

Monthly Wage ..... Weekly Wage ..... Daily Wage ..... Hourly Wage 3.45

Receive board Yes ☐ No ☒ Daily Value ..... Receive room Yes ☐ No ☒ Daily Value .....

Piece Worker Yes ☐ No ☒ If yes, price per unit at piece work ..... Hours worked per day 8

Days worked per week 6 Employee's pay period? Monthly ☐ Semi-monthly ☒ Weekly ☐ List employee's earnings last 4 pay periods 1. HADN'T WORKED LONG ENOUGH TO HAVE A PAYDAY

List Payroll Classification and Code under which employee's wages were reported ..... (Sawmill - Mechanic - Etc.) Code ..... (2702, 5306, 8810)

ACCIDENT AND INJURY

Describe in full how accident happened and GIVE CAUSE: While working in the wet mill by the manlift, on first floor, a piece of steel girder fell from above, striking him in chest.

Nature or extent of injury: bruise (Cut - Fracture) Part of body injured? chest (Leg - Arm - Back - Head)

Names of witnesses to accident 1. Billy Jo Fellenberg 2. .....

Date of accident: 1-13-71 19.. Hour ..... A. M. P. M. Was employee injured in course of employment? Yes ☒ No ☐

Place where accident occurred: our mill (Address) Libby (City) Lincoln (County)

Did you or employee's supervisor have actual knowledge of accident? Yes ☒ No ☐

Were you notified of accident by injured employee? Yes ☒ No ☐ How: in person Date .....

Have you reason to question this accident? Yes ☐ No ☒ If "yes" explain fully .....

SAFETY

Was employee's accident due to unsafe work practice? Yes ☐ No ☒ If "yes", what did he do unsafely? .....

Was a specific device, object or substance involved in accident? Yes ☐ No ☒ If "yes", name specific device, object or substance ..... Was device or object defective? Yes ☐ No ☐

Was employee doing regular work when injured? Yes ☒ No ☐ Was employee trained to do work he was doing when injured? Yes ☒ No ☐ Were adequate safeguards provided? Yes ☐ No ☐ If "yes", were they being used at the time of accident? Yes ☐ No ☐

MEDICAL ATTENTION

Name of attending physician: Paul J. Seifert, Jr. M.D. Address: Libby, Montana

Was employee hospitalized? Yes ☐ No ☒ Name of hospital ..... Address .....

Was first aid administered by someone other than attending physician? Yes ☐ No ☒

TIME AND WAGE LOSS

Will employee lose time from work due to accident? Yes ☐ No ☒ How long? ..... If injury results in time loss will employee, while disabled, received sick leave benefits? Yes ☐ No ☐ Paid vacation? Yes ☐ No ☐ Will employee lose wages? Yes ☐ No ☐ Room? Yes ☐ No ☐ Board? Yes ☐ No ☐

Date wage loss began: NONE Amount of weekly wage loss .....

EMPLOYER

Name of employer: Construction Products Division-W.R.Grace & Co.

Address: Libby, Montana Nature of Business: Mining & Milling Vermiculite

IS FIRM A CORPORATION ☒ OR PARTNERSHIP ☐ OR INDIVIDUAL ☐

IF
- Corporation—is injured employee an officer or director of corporation? Yes ☐ No ☒
- Partnership—is injured employee related to any partner? Yes ☐ No ☐ Relationship .....
- Individual—is injured employee related to employer? Yes ☐ No ☐ Relationship .....

Signed, this 31st day of March, 19 71

at Libby, Montana

Employer's Name: Construction Products Division W. R. Grace & Co.

Signed by .....

Official Title .....

NOTICE—EMPLOYEE'S CLAIM FOR COMPENSATION, FORM 54, MUST BE FILED WITHIN 12 MONTHS FROM DATE OF ACCIDENT.

C0080214

WRG00299160

ED_005351_00000355-00250

Medical Smith, James (IRR) Ex 22

06062756

Industrial Accident Board, Helena, Montana, Form 37 Revised—YM - U - WU

Industrial Accident Board

HELENA, MONTANA

Firm No.....

File No.....

EMPLOYER'S FIRST REPORT OF INJURY

INSTRUCTIONS—Employer must complete form at once after every accident which causes loss of time from work or requires medical attention and mail it to the Industrial Accident Board, Helena, Montana. Form must be signed in pen and ink. ALL QUESTIONS MUST BE ANSWERED FULLY.

INJURED EMPLOYEE

Full name of injured employee James D. Smith Occupation Welder

Mailing address Box 596, Libby, Montana (Street, City) How long has he been in your employ 12 years

Social Security No. 564-22-4424 Sex M Age 38 Married ☒ Single ☐

EARNINGS

Monthly Wage..... Weekly Wage..... Daily Wage..... Hourly Wage 2.47

Receive board Yes ☐ No ☒ Daily Value..... Receive room Yes ☐ No ☒ Daily Value.....

Piece Worker Yes ☐ No ☒ If yes, price per unit at piece work..... Hours worked per day 8

Days worked per week 5 Employee's pay period? Monthly ☐ Semi-monthly ☒ Weekly ☐ List employee's earnings last 4 pay periods 1. 296.40 2. 247.01 3. 247.00 4. 268.00

List Payroll Classification and Code under which employee's wages were reported..... (Sawmill - Mechanic - Etc.) Code..... (2702, 5506, 8810)

ACCIDENT AND INJURY

Describe in full how accident happened and GIVE CAUSE While on duty in welding shop, removed goggles, received arc flash from another welder's equipment.

Nature or extent of injury arc flash (Cut - Fracture) Part of body injured? both eyes (Leg - Arm - Back - Head)

Names of witnesses to accident 1..... 2.....

Date of accident 12-27 19 63 Hour..... A. M. P. M. Was employee injured in course of employment? Yes ☒ No ☐

Place where accident occurred Our shop, 9 miles north of Libby (Address, City) Lincoln (County)

Did you or employee's supervisor have actual knowledge of accident? Yes ☒ No ☐

Were you notified of accident by injured employee? Yes ☒ No ☐ How by employee Date 2-3-64

Have you reason to question this accident? Yes ☐ No ☒ If "yes" explain fully.....

SAFETY

Was employee's accident due to unsafe work practice? Yes ☐ No ☐ If "yes", what did he do unsafely?.....

Was a specific device, object or substance involved in accident? Yes ☐ No ☐ If "yes," name specific device, object or substance..... Was device or object defective? Yes ☐ No ☐

Was employee doing regular work when injured? Yes ☐ No ☐ Was employee trained to do work he was doing when injured? Yes ☐ No ☐ Were adequate safeguards provided? Yes ☐ No ☐ If "yes," were they being used at the time of accident? Yes ☐ No ☐

MEDICAL ATTENTION

Name of attending physician Dr. Woodrow Nelson Address Libby, Montana

Was employee hospitalized? Yes ☐ No ☒ Name of hospital..... Address.....

Was first aid administered by someone other than attending physician? Yes ☐ No ☒

TIME AND WAGE LOSS

Will employee lose time from work due to accident? Yes ☐ No ☒ How long?..... If injury results in time loss will employee, while disabled, receive sick leave benefits? Yes ☐ No ☐ Paid vacation? Yes ☐ No ☐ Will employee lose wages? Yes ☐ No ☐ Room? Yes ☐ No ☐ Board? Yes ☐ No ☐

Date wage loss began..... Amount of weekly wage loss.....

EMPLOYER

Name of employer Zonolite Division-W.R.Grace & Co.

Address Libby, Montana Nature of business Mining & Milling Vermiculite

IS FIRM A CORPORATION ☒ OR PARTNERSHIP ☐ OR INDIVIDUAL ☐

IF
- Corporation—is injured employee an officer or director of corporation? Yes ☐ No ☒
- Partnership—is injured employee related to any partner? Yes ☐ No ☐ Relationship.....
- Individual—is injured employee related to employer? Yes ☐ No ☐ Relationship.....

Signed, this 7th day of February, 19 64

at Libby, Montana

Employer's Name Zonolite Division-W.R.Grace & Co.

Signed by.....

Official Title Secretary

NOTICE—EMPLOYEE'S CLAIM FOR COMPENSATION, FORM 54, MUST BE FILED WITHIN 12 MONTHS FROM DATE OF ACCIDENT.

C0080216

WRG00299162

ED_005351_00000355-00252

Medical Smith, James (IRR) Ex 22

INDUSTRIAL ACCIDENT BOARD, HELENA, MONT. FORM NO. 43-1M 1-57 81907 TRIBUNE PRINTING & SUPPLY CO., GREAT FALLS, MONTANA

Plan No. 06062695

Industrial Accident Board

HELENA, MONTANA

Claim Department

Firm No.
Claim No.
Accident No.
Employee No.

DO NOT FILL IN

Employer's Supplemental Report Of Injury

This notice to be filled out by employer and sent to the Industrial Accident Board, at Helena, Montana, immediately upon employee's returning to work fully recovered if within two weeks—or upon his death or at the expiration of two weeks from date of injury.

Name of injured employee James D. Smith

Address Box 596, Libby, Montana

Injured 10-5- , 19 64

If worked after accident, last date worked?

Is injured employee fully recovered? Yes On what date? 11-16-64

Has he/she returned to work for you? Yes On what date? 11-16-64

Has he/she accepted other employment? On what date?

If so, where now employed?

Has he/she died? If so, when?

Signed: Zonolite Division-W.R.Grace & Co.

Address Libby, Montana

Dated November 18 , 19 64

C0080217

WRG00299164

ED_005351_00000355-00254

06062696

Industrial Accident Board, Helena, Montana. Form No. 64—2M—11—46. Plan No.

Industrial Accident Board

HELENA, MONTANA

CLAIM DEPARTMENT

Firm No.

Claim No.

Accident No.

DO NOT FILL IN

Employee's Claim for Compensation in Case of Injury

INSTRUCTIONS—To facilitate prompt payment of compensation the injured employee, or someone for him, should write carefully (using ink or typewriter) answers to the following questions, and mail same directly to the Board within 30 days after date of injury.

I hereby make claim for compensation for an injury resulting in disability, due to an accident occurring 5th day of October, 1964, arising out of and in the course of my employment by Zonolite Division-W.R.Grace & Co. of Libby, Montana

My claim is; providing—Total Disability

From, date October 6, 1964

Are you now disabled? Yes If not, on what date were you able to return to work?

, 19 If still disabled, how long do you estimate disability to continue? Unknown at this time.

IF PARTIALLY DISABLED: From what date?, 19 Are you still partially disabled? If not, on what date did disability cease?, 19

If still partially disabled, how long do you estimate disability will continue?

By how much have your daily earnings been reduced by this injury? $20.72

Have you contributed to Hospital Fund? no

Place Of Accident

In proof of such claim I make the following statements under oath:

Location of plant where accident occurred 9 miles north of Libby, Montana

In what city or village? County? Lincoln

If away from employer's premises or plant, state where accident happened

The Injured Employee

Full name of employee James D. Smith

Address where mail should be sent Box 596, Libby, Montana Lincoln
(Street and number, city or village and county.)

Sex? Male Age? 39 Do you speak English? Yes

If not, what language? Are you married or single? Married

Where were you born? Wright City, Oklahoma

State occupation when injured? Freight truck driver

How long have you worked at this occupation? 8 months

How long have you worked for present employer? 13 years 2 months

Were you doing your regular work when injured? Yes

Piece or time worker? Time How many days per week? 5

Describe how accident occurred? While unloading empty barrels from truck, picked up barrel, turned wrong, ruptured self

(Over)

MONTANA RECORD PUBLISHING CO. HELENA, MONTANA

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WRG00299165
ED_005351_00000355-00255

Industrial Accident Board, Helena, Montana, Form 37 Revised—YM - U - WU

06062698

Industrial Accident Board

HELENA, MONTANA

Firm No.....

File No.....

EMPLOYER'S FIRST REPORT OF INJURY

INSTRUCTIONS—Employer must complete form at once after every accident which causes loss of time from work or requires medical attention and mail it to the Industrial Accident Board, Helena, Montana. Form must be signed in pen and ink. ALL QUESTIONS MUST BE ANSWERED FULLY.

INJURED EMPLOYEE

Full name of injured employee James D. Smith Occupation Freight Truck Driver

Mailing address Box 596, Libby, Montana (Street, City) How long has he been in your employ 13 yrs.

Social Security No. 564-22-4424 Sex M Age 39 Married [X] Single [ ]

EARNINGS

Monthly Wage..... Weekly Wage..... Daily Wage..... Hourly Wage 2.59

Receive board Yes [ ] No [X] Daily Value..... Receive room Yes [ ] No [X] Daily Value.....

Piece Worker Yes [ ] No [X] If yes, price per unit at piece work..... Hours worked per day 8

Days worked per week 5 Employee's pay period? Monthly [ ] Semi-monthly [X] Weekly [ ] List employee's earnings last 4 pay periods 1 290.08 2 290.08 3 293.97 4 269.36

List Payroll Classification and Code under which employee's wages were reported..... (Sawmill - Mechanic - Etc.) Code..... (2702, 5506, 8810)

ACCIDENT AND INJURY

Describe in full how accident happened and GIVE CAUSE While unloading empty barrels from truck, picked up barrel, turned wrong, resulted in hernia, right side

Nature or extent of injury hernia (Cut - Fracture) Part of body injured? right side (Leg - Arm - Back - Head)

Names of witnesses to accident 1..... 2.....

Date of accident 10-5- 19 64 Hour 2 A.M. P.M. Was employee injured in course of employment? Yes [X] No [ ]

Place where accident occurred mux our mine, 2 miles north of Libby, Lincoln (Address, City, County)

Did you or employee's supervisor have actual knowledge of accident? Yes [X] No [ ]

Were you notified of accident by injured employee? Yes [X] No [ ] How by employee Date 10-6-64

Have you reason to question this accident? Yes [ ] No [X] If "yes" explain fully.....

SAFETY

Was employee's accident due to unsafe work practice? Yes [ ] No [X] If "yes", what did he do unsafely?.....

Was a specific device, object or substance involved in accident? Yes [ ] No [ ] If "yes," name specific device, object or substance..... Was device or object defective? Yes [ ] No [ ]

Was employee doing regular work when injured? Yes [X] No [ ] Was employee trained to do work he was doing when injured? Yes [ ] No [ ] Were adequate safeguards provided? Yes [ ] No [ ] If "yes," were they being used at the time of accident? Yes [ ] No [ ]

MEDICAL ATTENTION

Name of attending physician Dr. Paul J. Seifert, Jr. Address Libby, Montana

Was employee hospitalized? Yes [X] No [ ] Name of hospital St. Johns Lutheran Address Libby, Montana

Was first aid administered by someone other than attending physician? Yes [ ] No [X]

TIME AND WAGE LOSS

Will employee lose time from work due to accident? Yes [X] No [ ] How long? not known If injury results in time loss will employee, while disabled, receive sick leave benefits? Yes [X] No [ ] Paid vacation? Yes [X] No [ ] Will employee lose wages? Yes [ ] No [ ] Room? Yes [ ] No [ ] Board? Yes [ ] No [ ]

Date wage loss began 10-6-64 Amount of weekly wage loss $103.60

EMPLOYER

Name of employer Zonolite Division-W.R.Grace & Co.

Address Libby, Montana Nature of business Mining & Milling Vermiculite

IS FIRM A CORPORATION [X] OR PARTNERSHIP [ ] OR INDIVIDUAL [ ]

IF
- Corporation—is injured employee an officer or director of corporation? Yes [ ] No [X]
- Partnership—is injured employee related to any partner? Yes [ ] No [ ] Relationship.....
- Individual—is injured employee related to employer? Yes [ ] No [ ] Relationship.....

Signed, this 19th day of October, 19 64

at Libby, Montana

Employer's Name Zonolite Division-W.R.Grace & Co.

Signed by.....

Official Title Secretary

NOTICE—EMPLOYEE'S CLAIM FOR COMPENSATION, FORM 54, MUST BE FILED WITHIN 12 MONTHS FROM DATE OF ACCIDENT.

C0080220

WRG00299166

ED_005351_00000355-00256

IBR Ex22

Medical
Siefke, Lyle

WRG00299

06062993

Industrial Accident Board, Helena, Montana, Form 37 Revised—YM - U - WU

Industrial Accident Board

HELENA, MONTANA

Firm No.

File No.

EMPLOYER'S FIRST REPORT OF INJURY

INSTRUCTIONS—Employer must complete form at once after every accident which causes loss of time from work or requires medical attention and mail it to the Industrial Accident Board, Helena, Montana. Form must be signed in pen and ink. ALL QUESTIONS MUST BE ANSWERED FULLY.

INJURED EMPLOYEE

Full name of injured employee Lyle Siefke Occupation Construction Work

Mailing address Route 1, Box 825-1, Libby, Montana (Street, City) How long has he been in your employ 4 years

Social Security No. 725-14-1074 Sex M Age 33 Married ☒ Single ☐

EARNINGS

Monthly Wage ..... Weekly Wage ..... Daily Wage ..... Hourly Wage 2.56

Receive board Yes ☐ No ☒ Daily Value ..... Receive room Yes ☐ No ☒ Daily Value .....

Piece Worker Yes ☐ No ☒ If yes, price per unit at piece work ..... Hours worked per day 8

Days worked per week 6 Employee's pay period? Monthly ☐ Semi-monthly ☒ Weekly ☐ List employee's earnings last 4 pay periods 1 272.32 2 310.06 3 337.48 4 280.00

List Payroll Classification and Code under which employee's wages were reported ..... (Sawmill - Mechanic - Etc.) Code ..... (2702, 5506, 8810)

ACCIDENT AND INJURY

Describe in full how accident happened and GIVE CAUSE While loading a car of ore, got vermiculite particle in left eye.

Nature or extent of injury foreign material (Cut - Fracture) Part of body injured? left eye. (Leg - Arm - Back - Head)

Names of witnesses to accident 1 ..... 2 .....

Date of accident 7-18- 1967 Hour ..... P. M. Was employee injured in course of employment? Yes ☒ No ☐

Place where accident occurred our rail siding, in Libby (Address, City) Lincoln (County)

Did you or employee's supervisor have actual knowledge of accident? Yes ☒ No ☐

Were you notified of accident by injured employee? Yes ☒ No ☐ How in person Date 7-19-67

Have you reason to question this accident? Yes ☐ No ☒ If "yes" explain fully .....

SAFETY

Was employee's accident due to unsafe work practice? Yes ☐ No ☒ If "yes", what did he do unsafely? .....

Was a specific device, object or substance involved in accident? Yes ☐ No ☒ If "yes," name specific device, object or substance ..... Was device or object defective? Yes ☐ No ☐

Was employee doing regular work when injured? Yes ☒ No ☐ Was employee trained to do work he was doing when injured? Yes ☒ No ☐ Were adequate safeguards provided? Yes ☐ No ☐ If "yes," were they being used at the time of accident? Yes ☐ No ☐

MEDICAL ATTENTION

Name of attending physician Dr. W. T. Matthews Address Libby, Montana

Was employee hospitalized? Yes ☐ No ☒ Name of hospital ..... Address .....

Was first aid administered by someone other than attending physician? Yes ☐ No ☒

TIME AND WAGE LOSS

Will employee lose time from work due to accident? Yes ☐ No ☒ How long? ..... If injury results in time loss will employee, while disabled, receive sick leave benefits? Yes ☐ No ☐ Paid vacation? Yes ☐ No ☐ Will employee lose wages? Yes ☐ No ☐ Room? Yes ☐ No ☐ Board? Yes ☐ No ☐

Date wage loss began NONE Amount of weekly wage loss .....

EMPLOYER

Name of employer Zonolite Division W.R.Grace & Co.

Address Libby, Montana Nature of business Mining & Milling Vermiculite

IS FIRM A CORPORATION ☒ OR PARTNERSHIP ☐ OR INDIVIDUAL ☐

IF
- Corporation—is injured employee an officer or director of corporation? Yes ☐ No ☒
- Partnership—is injured employee related to any partner? Yes ☐ No ☐ Relationship .....
- Individual—is injured employee related to employer? Yes ☐ No ☐ Relationship .....

Signed, this 20th day of July, 1967

at Libby, Montana

Employer's Name Zonolite Division W.R.Grace & Co.

Signed by .....

Official Title .....

NOTICE—EMPLOYEE'S CLAIM FOR COMPENSATION, FORM 54, MUST BE FILED WITHIN 12 MONTHS FROM DATE OF ACCIDENT.

Δ

C0080129

WRG00299168

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IBR Ex 22

Medical
Siefke, Lyle

Industrial Accident Board, Helena, Montana, Form 37 Revised

06062942

Industrial Accident Board

HELENA, MONTANA

DO NOT WRITE IN THIS SPACE

Firm No.....

File No.....

EMPLOYER'S FIRST REPORT OF INJURY

INSTRUCTIONS—Employer must complete form at once after every accident which causes loss of time from work or requires medical attention and mail it to the Industrial Accident Board, Helena, Montana. Form must be signed in pen and ink. ALL QUESTIONS MUST BE ANSWERED FULLY.

INJURED EMPLOYEE

Full name of injured employee: Lyle Siefke Occupation: Truck Driver

Mailing address: Route 1, Box 885-1, Libby How long has he been in your employ: 4 yrs.

Social Security No.: 725-14-1074 Sex: M Age: 31 Married ☒ Single ☐

EARNINGS

Monthly Wage..... Weekly Wage..... Daily Wage..... Hourly Wage: 2.96

Receive board Yes ☐ No ☒ Daily Value..... Receive room Yes ☐ No ☒ Daily Value.....

Piece Worker Yes ☐ No ☒ If yes, give method of computing earnings.....

Number of hours worked per day: 8 Days worked per week: 5 Employee's pay period?

Monthly ☐ Semi monthly ☐ Weekly ☐ List employee's earnings last 4 pay periods 1. 355.94

2. 288.60 3. ~~XXX~~ 340.40 4. ~~XXX~~ 288.60

Under what payroll classification has employees' wages been reported?..... (Sawmill - Machanic - Etc.)

ACCIDENT AND INJURY

Describe in full how accident happened and GIVE CAUSE: While washing the truck on 11-24-67 at the pumphouse, lacerated end of middle finger right hand and skin between third and fourth fingers on rough metal on hood. These became infected.

Part of body injured? Describe fully: 2 fingers on right hand.

Names of witnesses to accident 1..... 2.....

Date of accident: 11 24 1967 Hour: ~~XXX~~ A.M. P.M. Was employee injured in course of employment? Yes ☒ No ☐

Place where accident occured: pumphouse (Address) - about 5 miles from Libby (City) Lincoln (County)

Did you or employee's supervisor have actual knowledge of accident? Yes ☒ No ☐

Were you notified of accident by injured employee? Yes ☒ No ☐ How: by employee Date: 11-27-67

Have you reason to question this accident? Yes ☐ No ☒ If "yes" explain fully.....

SAFETY

Was employee's accident due to unsafe work practices? Yes ☐ No ☒ If "yes", what did he do unsafely?

Was a specific device, object or substance involved in accident? Yes ☒ No ☐ If "yes", name specific device, object or substance: hood of truck Was device or object defective? Yes ☐ No ☐

Was employee doing regular work when injured? Yes ☒ No ☐ Was employee trained to do work he was doing when injured? Yes ☒ No ☐ Were adequate safe guards provided? Yes ☒ No ☐ If "yes" were they being used at time of accident? Yes ~~XX~~ No ☐

MEDICAL ATTENDANCE

Name of attending physician: Dr. James F. Graham Address: Libby, Montana

Was employe hospitalized? Yes ☐ No ☒ Name of hospital..... Address.....

Was first aid administered by someone other than attending physician? Yes ☐ No ☒

TIME AND WAGE LOSS

Will employe lose time from work due to accident? Yes ☐ No ☒ How long?.....

If injury results in time loss, will employee, while disabled, receive sick leave benefits? Yes ☐ No ☐

Paid vacation? Yes ☐ No ☐

Will employe lose wages? Yes ☐ No ☐ Room? Yes ☐ No ☐ Board? Yes ☐ No ☐

Date wage loss began: NONE Amount of weekly wage loss.....

EMPLOYER

Name of employer: Zonolite Division of W.R. Grace & Co.

Address: Libby, Montana Nature of business: Mining & Milling Vermiculite Ore

IS FIRM A CORPORATION ☒ OR PARTNERSHIP ☐ OR INDIVIDUAL ☐

IF
- Corporation—is injured employee an officer or director of corporation? Yes ☐ No ☒
- Partnership—is injured employee related to any partner? Yes ☐ No ☐ Relationship.....
- Individual—is injured employee related to employer? Yes ☐ No ☐ Relationship.....

Signed, this 27th day of November, 19 67

Employer's Name: Zonolite Division-W.R.Grace & Co.

Signed by.....

at Libby Montana.....

Official Title.....

NOTICE—EMPLOYEE'S CLAIM FOR COMPENSATION, FORM 54, MUST BE FILED WITHIN 12 MONTHS FROM DATE OF ACCIDENT

Form 1-HU-163-ZR

Carrier | Firm No. | File No. | Major Industry | County | Date of Acc. | Time | Sex & Marital Status | Age | Mont. Code | Acc. Class | Occupation | Type | Agency | Agency Part | Nature of Inj. | Location | Time Loss | Mech. Defect | Unsafe Act | Pers. Factor | Weekly Wage

C0080130

WRG00299170

ED_005351_00000355-00260

IBR Ex 22

Medical
Sieffke, Lyle

06063471

Return to:
Hugo Dobler Adjuster, Inc.
Box 233 – Helena, Mt. 59601

DIVISION OF WORKMEN'S COMPENSATION

DEPARTMENT OF LABOR AND INDUSTRY
815 Front Street
Helena, Montana 59601

Case No. .....

Firm No. .....

Handicapped Certificate No. .....

CLAIM FOR COMPENSATION

INSTRUCTIONS—This form must be filled out by the injured person or someone for him. Answer all questions. Return claim immediately.

INJURED EMPLOYEE

I hereby claim the benefits of the Workmen's Compensation Act for an accident that occurred (Date) July 11, 19 73
Employee's name LYLE E. SIEFKE Date of Birth Sept 9 1934 Sex MALE
Mailing address KC (City) Box 941 (State) Occupation MILL WRIGHT
Other types of work you have done: 1. TRUCK DRIVER 2. LABORER
3. LIFT TRUCK DRIVER 4. ..... Education: Grade School ☐ High School ☒ College ☐ Other ..... Social Security No. [illegible]
Married ☒ Single ☐ How many members in your immediate family? 2 kids

EMPLOYEE'S EARNINGS

Monthly wage ..... or weekly wage ..... or daily wage ..... or hourly wage 4.46
Receive board? Yes ☐ No ☒ Receive room? Yes ☐ No ☒ Days worked per week 6 days
Hours worked per day 8 Employee's pay period: Monthly ☐ Semi-monthly ☒ Weekly ☐
Bi-weekly ☒ List gross earnings and date for last 4 pay periods:
1. 9/8/73 $662.89 (Date/Amount) 2. 9/25/73 $614.37 (Date/Amount) 3. 10/9/73 $700.64 (Date/Amount) 4. Oct 24 1973 $594.30 (Date/Amount)

IF PARTIAL WAGE LOSS NOTE DATES AND AMOUNT ON REVERSE SIDE

ACCIDENT AND INJURY

Did you notify your employer of the accident? Yes How? Told Foreman Date 8-30-73 Reported to town off
Describe accident fully I was getting into elevator of Loggedand fell on my left knee & well all my weight
Extent of injury Severe bruises Part of body Leg (Leg-Arm-Back-Head)
Witnesses: 1. ..... 2. .....
Have you ever had an industrial injury before? Yes ☒ No ☐
In what state? Montana Type of injury Broken right thumb

SAFETY

Was the accident caused by an unsafe condition? Yes ☐ No ☒
If yes, please explain .....

Was accident caused by equipment not owned by your employer, or by a person not employed by your employer? Yes ☐ No ☒ If yes, state details .....

MEDICAL ATTENTION

Name of your doctor Dr. William T. Matthews, M.D.
Address 402 Montana Ave. Libby, Montana
Were you hospitalized? Yes ☐ No ☒ Name of hospital St. Johns Lutheran for X-Rays

TIME AND WAGE LOSS

Did you return to work before or during your next scheduled shift? Yes ☒ No ☐
Did you lose wages? Yes ☒ No ☐ (If partial wage loss note dates and amount on reverse side)
Date wage loss began 11-9-73, 19..... Released by doctor? Yes ☒ No ☐
Date returned to work ....., 19..... (Tentative for 11-19-73)

EMPLOYER

Name of employer W.R. GRACE & CO. Nature of business Lumber Products
Address 317 Mineral Ave. (Street) Libby (City) Montana (State)
Place of accident Libby (City) Lincoln (County) Montana (State)
If away from employer's premises, where did accident happen? .....

Filing of this claim is authorization for release of medical information and records of the Social Security Administration.

Dated 11-12, 19 73

I certify that the information above is correct and just in all respect.

Your signature Lyle E. Siefke
Street address KC Box 941
Phone number 293-4567
(If rural area, please give directions on reverse side)

THIS CLAIM SHOULD BE FILED WITHIN 12 MONTHS FROM DATE OF ACCIDENT

C0080131

WRG00299172

ED_005351_00000355-00262

Return to:
Hugo Dobler Adjuster, Inc.
Box 233 — Helena, Mt. 59601

DIVISION OF WORKMEN'S COMPENSATION

DEPARTMENT OF LABOR AND INDUSTRY
815 Front Street
Helena, Montana 59601

060634472

CASE NO. .....

Firm No. 2503

EMPLOYER'S FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE

INSTRUCTIONS—Employer must complete form at once after every accident or occupational disease which causes loss of time from work or requires medical attention and mail to the Division of Workmen's Compensation, 815 Front Street, Helena, Montana. Form must be signed in pen and ink. ALL QUESTIONS MUST BE ANSWERED FULLY. This form contains all items requested on OSHA Form No. 101, "Supplementary Record of Occupational Injuries and Illnesses."

INJURED EMPLOYEE

Full name of injured employee: Lyle E. Siefke Occupation Millwright
Home Address Box 941, Libby, Montana (Street, City) How long has he been in your employ? 10 years
Social Security No. 725-14-1074 Sex M Age 39 Married [X] Single [ ]
Department where regularly employed Millwright Crew
Department where employed at time of injury Millwright Crew
Would employment be classified as: (Check appropriate description)
(1) Household employment [ ]
(2) Casual employment [ ]
(3) Employment of members of an employer's family dwelling in employer's household [ ]
(4) Employment of sole proprietors or working members of a partnership [ ]
(5) Employment for which a rule of liability for injury, occupational disease, or death is provided under the laws of the United States [X]
(6) Any person performing services in return for aid or sustenance only. (Board & Room) [ ]
Scheduled days off .....

EMPLOYEE'S EARNINGS

Monthly wage ....., or Weekly wage ....., or Daily wage ....., or Hourly wage 4.46
Received board? Yes [ ] No [X] Received room? Yes [ ] No [X] Days worked per week 5
Hours worked per day 8 Employee's pay period: Monthly [ ] Semi-monthly [X] Weekly [ ]
Bi-weekly [ ] List employee's gross earnings and date for last 4 pay periods:
(1) ..... (2) ..... (3) ..... (4) .....
Date/Amount Date/Amount Date/Amount Date/Amount
List payroll classification under which employee's wages were reported .....

ACCIDENT AND INJURY

Describe in full how accident happened and GIVE CAUSE—Tell what employee was doing when injured:
While getting into the elevator, tripped over door sill, fell on left knee. Sustained bruises and water on knee.

Nature or extent of injury or illness Bruises (Cut-Fracture) Part of body affected Left Knee (Leg-Arm-Back-Head)
Did employee die? Yes [ ] No [X]
Name or witnesses to accident 1 ..... 2 .....
Date of injury or initial diagnosis of occupational illness. Mo. 7 Day 11 Yr 73 Hour ....A.M. ....P.M.
Was employee injured in course of employment? Yes [X] No [ ]
Place where accident occurred our mill, 12 miles north of Libby (Address) Lincoln (City) (County)
Was place of accident or exposure on employer's premises? Yes [X] No [ ]
Have you reason to question this accident? Yes [ ] No [X] If "yes" explain fully .....

NOTICE

Were you notified of the accident? Yes [X] No [ ] How by employee

SAFETY

1. Was the accident caused by an unsafe act on the part of the injured? Yes [ ] No [X]
2. Was the accident caused by an unsafe condition? Yes [ ] No [XX]
3. What specific device, object, or substance caused the injury? door sill on elevator

MEDICAL ATTENTION

Name of attending physician W. T. Matthews, M.D.
Address 402 Montana Avenue, Libby, Montana 59923
Was employee hospitalized? Yes [ ] No [X] Name of hospital St. Johns Lutheran for X-rays
Address 350 Louisiana Avenue, Libby, Montana 59923

TIME AND WAGE LOSS

1. Will the employee return to work before or during his next scheduled shift? Yes [X] No [ ]
2. Will employee lose wages? Yes [ ] No [X] Will wage loss exceed 7 days? Yes [ ] No [ ]
3. Date wage loss began none Amount of weekly wage loss .....

EMPLOYER

Name of employer W. R. Grace & Co. Construction Products Division Phone 293-4131
Firm name Same
Address Box 609, Libby, Montana 59923 Nature of business Mining & Milling Vermiculite
Location, if different from mail address .....
Check one: Individual [ ] Partnership [ ] Corporation [X]

Signed, this 30th day of August, 19 73
at Libby, Montana

Prepared by Joan B. Runyan
Signed by .....
Official title Administrative Assistant

NOTICE—EMPLOYEE'S CLAIM FOR COMPENSATION, FORM 54, SHOULD BE FILED WITHIN 12 MONTHS FROM DATE OF ACCIDENT

FORM 37-2 REVISED

C0080132

WRG00299173

ED_005351_00000355-00263

Medical

Sieffie, Lyle

IBR

Ex 22

06062771

Industrial Accident Board, Helena, Montana, Form 37 Revised—YM - U - WU

Industrial Accident Board

HELENA, MONTANA

Firm No.

File No.

EMPLOYER'S FIRST REPORT OF INJURY

INSTRUCTIONS—Employer must complete form at once after every accident which causes loss of time from work or requires medical attention and mail it to the Industrial Accident Board, Helena, Montana. Form must be signed in pen and ink. ALL QUESTIONS MUST BE ANSWERED FULLY.

INJURED EMPLOYEE

Full name of injured employee Lyle Sleike Occupation Construction work

Mailing address Route 1, Box 131A, Libby, Montana (Street, City) How long has he been in your employ 2 yrs.

Social Security No. 725-14-1074 Sex M Age 31 Married ☒ Single ☐

EARNINGS

Monthly Wage Weekly Wage Daily Wage Hourly Wage 2.53

Receive board Yes ☐ No ☒ Daily Value Receive room Yes ☐ No ☒ Daily Value

Piece Worker Yes ☐ No ☐ If yes, price per unit at piece work Hours worked per day 8

Days worked per week 5 Employee's pay period? Monthly ☐ Semi-monthly ☒ Weekly ☐ List employee's earnings last 4 pay periods 1 232.76 2 303.60 3 202.40 4 222.64

List Payroll Classification and Code under which employee's wages were reported (Sawmill - Mechanic - Etc.) Code (2702, 5506, 8810)

ACCIDENT AND INJURY

Describe in full how accident happened and GIVE CAUSE While working at expanding plant, struck right knee on metal edge of ore hopper.

Nature or extent of injury Bruise (Cut - Fracture) Part of body injured? right knee (Leg - Arm - Back - Head)

Names of witnesses to accident 1 2

Date of accident 12-16 1965 Hour 1:30 A.M. P.M. Was employee injured in course of employment? Yes ☒ No ☐

Place where accident occurred our expanding plant (Address) Libby (City) Lincoln (County)

Did you or employee's supervisor have actual knowledge of accident? Yes ☒ No ☐

Were you notified of accident by injured employee? Yes ☒ No ☐ How 12-15 by employee 12-16-65

Have you reason to question this accident? Yes ☐ No ☒ If "yes" explain fully

SAFETY

Was employee's accident due to unsafe work practice? Yes ☐ No ☒ If "yes", what did he do unsafely?

Was a specific device, object or substance involved in accident? Yes ☐ No ☐ If "yes," name specific device, object or substance Was device or object defective? Yes ☐ No ☐

Was employee doing regular work when injured? Yes ☐ No ☐ Was employee trained to do work he was doing when injured? Yes ☐ No ☐ Were adequate safeguards provided? Yes ☐ No ☐ If "yes," were they being used at the time of accident? Yes ☐ No ☐

MEDICAL ATTENTION

Name of attending physician Dr. L. Boldt Address Libby, Montana

Was employee hospitalized? Yes ☐ No ☒ Name of hospital Address

Was first aid administered by someone other than attending physician? Yes ☐ No ☒

TIME AND WAGE LOSS

Will employee lose time from work due to accident? Yes ☒ No ☐ How long? 4 days If injury results in time loss will employee, while disabled, receive sick leave benefits? Yes ☒ No ☐ Paid vacation? Yes ☐ No ☐ Will employee lose wages? Yes ☐ No ☐ Room? Yes ☐ No ☐ Board? Yes ☐ No ☐

Date wage loss began 12-17-65 Amount of weekly wage loss $101.20

EMPLOYER

Name of employer Zonolite Division-W.R.Grace & Co.

Address Libby, Montana Nature of business Mining & Milling Vermiculite

IS FIRM A CORPORATION ☒ OR PARTNERSHIP ☐ OR INDIVIDUAL ☐

IF
- Corporation—is injured employee an officer or director of corporation? Yes ☐ No ☒
- Partnership—is injured employee related to any partner? Yes ☐ No ☐ Relationship
- Individual—is injured employee related to employer? Yes ☐ No ☐ Relationship

Signed, this 20th day of December, 1965

at Libby, Montana

Employer's Name Zonolite Division-W.R.Grace & Co.

Signed by

Official Title

NOTICE—EMPLOYEE'S CLAIM FOR COMPENSATION, FORM 54, MUST BE FILED WITHIN 12 MONTHS FROM DATE OF ACCIDENT.

Δ

C0080133

WRG00299175

ED_005351_00000355-00265

IBR Ex22

Medical
Siefke, Lyle

06062686

December 17, 1964

Mr. David G. Hendricks
Maryland Casualty Company
P. O. Box 1499
Great Falls, Montana 49401

Re: Lyle Siefke, D/A: 11-18-64

Dear Mr. Hendricks:

We are not returning the "Employee's Claim for Compensation" forms which you sent to Mr. Siefke inasmuch as he lost only six (6) days work because of his injury.

He was injured at approximately 2:45 p.m. on Wednesday, November 18, so he was paid for a full day's work. He missed work on Thursday, November 19, Friday, November 20 and Saturday, November 21 of that week. The company operated only Monday, Tuesday and Wednesday of the following week due to the Thanksgiving holiday, and Mr. Siefke was released to return to work on light duty on Monday, November 30, which he did.

If you have any questions, please contact us.

Very truly yours

ZONOLITE DIVISION
W. R. GRACE & CO.

By:

Joan B. Greenup

C0080136

WRG00299177

ED_005351_00000355-00267

Stock Form — State Publishing Company, Helena, Montana
Industrial Accident Board — Form No. 43 YM-T-YZ

06062687

Plan No.....

Industrial Accident Board

HELENA, MONTANA

CLAIM DEPARTMENT

Firm No.....
Claim No.....
Accident No.....
Employe No.....

DO NOT FILL IN

Employer's Supplemental Report of Injury

This notice to be filled out by employer and sent to the Industrial Accident Board, at Helena, Montana, immediately upon employe's returning to work fully recovered if within 2 weeks—or upon his death or at the expiration of two weeks from date of injury.

Name of injured employe Lyle Siefke

Address 1207½ Dakota Avenue, Libby, Mon tana

Injured November 18, 19 64

Is injured employe fully recovered? XXX No On what date?

Has he/she returned to work for you? Yes On what date? 11-30-64 for light duty

Has he/she accepted other employment? No On what date?

If so, where now employed?

Has he/she died? If so, when?

Signed: Zonolite Division-W.R.Grace & Co.

Address Libby, Montana

Dated December 17th, 19 64

C0080137

WRG00299178

ED_005351_00000355-00268

06062688

Industrial Accident Board, Helena, Montana, Form 37 Revised—YM - U - WU

Industrial Accident Board

HELENA, MONTANA

Firm No.....

File No.....

EMPLOYER'S FIRST REPORT OF INJURY

INSTRUCTIONS—Employer must complete form at once after every accident which causes loss of time from work or requires medical attention and mail it to the Industrial Accident Board, Helena, Montana. Form must be signed in pen and ink. ALL QUESTIONS MUST BE ANSWERED FULLY.

INJURED EMPLOYEE

Full name of injured employee: Lyle Siefke Occupation: Dock Worker

Mailing address: 1207½ Dakota Avenue (Street) Libby (City) How long has he been in your employ: 1 yr. 2 mos.

Social Security No.: 72[illegible]-14-1074 Sex: ..... Age: 30 Married ☒ Single ☐

EARNINGS

Monthly Wage..... Weekly Wage..... Daily Wage..... Hourly Wage: 2.48

Receive board Yes ☐ No ☒ Daily Value..... Receive room Yes ☐ No ☒ Daily Value.....

Piece Worker Yes ☐ No ☒ If yes, price per unit at piece work..... Hours worked per day: 8

Days worked per week: 5 Employee's pay period? Monthly ☐ Semi-monthly ☒ Weekly ☐ List employee's earnings last 4 pay periods 1. 218.24 2. 284.48 3. 303.80 4. 272.62

List Payroll Classification and Code under which employee's wages were reported..... (Sawmill - Mechanic - Etc.) Code..... (2702, 5506, 8810)

ACCIDENT AND INJURY

Describe in full how accident happened and GIVE CAUSE: While pulling boxcar into position at loading dock with motorized car puller, cable came loose from box car. Siefke went out to box car to connect cable, and as he did so another worker automated car puller, crushed Siefke's right hand between cable and brace on box car.

Nature or extent of injury: broken bone (Cut - Fracture) Part of body injured? right hand (Leg - Arm - Back - Head)

Names of witnesses to accident 1. William Hostetler 2.

Date of accident: 11-13 1964 Hour: 2:45 P.M. Was employee injured in course of employment? Yes ☒ No ☐

Place where accident occurred: our loading dock, in town, (Libby) (Address, City) Lincoln (County)

Did you or employee's supervisor have actual knowledge of accident? Yes ☒ No ☐

Were you notified of accident by injured employee? Yes ☒ No ☐ How: by employee Date: 11-13-64

Have you reason to question this accident? Yes ☐ No ☒ If "yes" explain fully.....

SAFETY

Was employee's accident due to unsafe work practice? Yes ☐ No ☒ If "yes", what did he do unsafely?.....

Was a specific device, object or substance involved in accident? Yes ☒ No ☐ If "yes," name specific device, object or substance: Car puller Was device or object defective? Yes ☐ No ☒

Was employee doing regular work when injured? Yes ☒ No ☐ Was employee trained to do work he was doing when injured? Yes ☒ No ☐ Were adequate safeguards provided? Yes ☒ No ☐ If "yes," were they being used at the time of accident? Yes ☒ No ☐

MEDICAL ATTENTION

Name of attending physician: Dr. W. T. Hattlows Address: Libby, Montana

Was employee hospitalized? Yes ☐ No ☒ Name of hospital..... Address.....

Was first aid administered by someone other than attending physician? Yes ☐ No ☒

TIME AND WAGE LOSS

Will employee lose time from work due to accident? Yes ☒ No ☐ How long? approx. 6 weeks If injury results in time loss will employee, while disabled, receive sick leave benefits? Yes ☒ No ☐ Paid vacation? Yes ☐ No ☐ Will employee lose wages? Yes ☐ No ☐ Room? Yes ☐ No ☐ Board? Yes ☐ No ☐

Date wage loss began: 11-13-64 Amount of weekly wage loss: $99.20

EMPLOYER

Name of employer: Zonolite Division-W.R.Grace & Co.

Address: Libby, Montana Nature of business: Mining & Milling Vermiculite

IS FIRM A CORPORATION ☒ OR PARTNERSHIP ☐ OR INDIVIDUAL ☐

IF
- Corporation—is injured employee an officer or director of corporation? Yes ☐ No ☒
- Partnership—is injured employee related to any partner? Yes ☐ No ☐ Relationship.....
- Individual—is injured employee related to employer? Yes ☐ No ☐ Relationship.....

Signed, this 18th day of November, 19 64

at Libby, Montana

Employer's Name: Zonolite Division-W.R.Grace & Co.

Signed by: Ed D. Cook

Official Title: Assistant Manager

NOTICE—EMPLOYEE'S CLAIM FOR COMPENSATION, FORM 54, MUST BE FILED WITHIN 12 MONTHS FROM DATE OF ACCIDENT.

C0080138

WRG00299179

ED_005351_00000355-00269

Medical IBR Ex 22
Siefke, Lyle

INDUSTRIAL ACCIDENT BOARD, HELENA, MONTANA. FORM 37 REVISED—2M 3-61 32493

Industrial Accident Board

HELENA, MONTANA

06062625

Claim Department

Firm No.

Claim No.

Accident No.

DO NOT FILL IN

EMPLOYER'S FIRST REPORT OF INJURY

DO NOT WRITE IN THIS SPACE

INSTRUCTIONS—The employer must fill out this form and return same to Industrial Accident Board, Helena, Montana, at once after every accident which causes any loss of work or requires medical attention. In filling out this form use pen or typewriter.

EMPLOYER, PLACE AND TIME

Employer's name: Zonolite Division - W. R. Grace & Co.

Office address: Libby, Montana, Lincoln County (Street and number, city or town)

Nature of business: Mining & Milling Vermiculite (Type of construction, manufacturing, etc.)

Did accident occur on work for a public corporation? No

Location of plant or place of work where accident occurred (Street and Number)

In what city or village? Libby County? Lincoln

Date of accident 9-18, 19 63; hour of day 3:00 ~~A.M.~~ P.M.

Did accident happen on premises? Yes

If away from the plant, state where?

Was employee injured in the course of employment? Yes

THE INJURED EMPLOYEE

Give full name of injured workman: Lyle Siefkes

Mailing address: 516 Poplar Street, Libby, Montana, Lincoln (Street and number, city or town and county)

Sex M Age 29 Speak English? Yes If not, what language?

Occupation when injured? Construction worker Married or single? Single (See Form 87-a)

Was injured employee on duty at time of accident? Yes If not, state fully on back hereof

How long was injured person in your employment? 2½ months

CAUSE OF INJURY

Described in full how the accident occurred (DO NOT FAIL TO DO THIS)

While loading bags of ore into box car, pulled ~~xxxxxxxx~~ muscle in right side of back

THE INJURY

State nature and extent of injury according to your own information. (We do not need the doctor's report here) pulled muscle

WILL EMPLOYEE LOSE TIME? YES XX NO

DATE WAGE LOSS BEGAN? 9-19-63 PROBABLE DURATION OF WAGE LOSS? 2days (Give your best estimate)

MEDICAL ATTENDANCE

Name and address of physician attending injured employee: Dr. Paul J. Seifert, 402 Montana Avenue, Libby, Montana

To what hospital was employee sent? none

If not sent to hospital, where is he? working

Are you still providing medical attendance? no Have you a hospital contract? no

WAGES

Monthly wage (If paid by month) Weekly wage (If paid by week) Daily wage (If paid by day) Rate per hour 2.20 (If paid by hour)

Number of hours per day 8 How many working days per week 5

If employee receives board in addition to money wage, state how many meals per day none

Does he receive room in addition to money wage? no

WAGE LOSS

How much money wage will employee lose per day because of accident? $17.60

How much board? none Will he lose room? no

NOTICE OF INJURY

Were you notified by the injured employee of his injury? yes If so, how and when? by employee (Write on back of this form if necessary)

Did you or your managing superintendent in charge of work of injured employee at time of injury have actual knowledge of such accident and injury? yes If so, explain how by employee (Write on back of this form if necessary)

Signed, this 2nd day of October, 19 63

Employer's Name Zonolite Division W. R. Grace & Co.

Signed by

at

Official Title

NOTICE—Employer should have injured workmen fill out Form 37-A and return same to Board with Employer's First Report of Injury.

Firm No. | Acc. No. | Major Industry | County | Date of Acc. | Time | Sex & Marital Status | Age | Mont. Code | Acc. Class | Occupation | Type | Agency | Agency Part | Nature of Inj. | Location | Ext. of Dis. | Mech. Defect | Unsafe Act | Pers. Factor | Weekly Wage | Report Lag | Carrier

C0080139

WRG00299181

ED_005351_00000355-00271

IBR Ex22

Medical
Siefke, Lyle

MONTANA DIVISION OF WORKERS' COMPENSATION

Complied with 82—1137 R.C.M.

815 Front Street
Helena, Montana 59601

SEND ORIGINAL TO INSURER

EMPLOYER'S FIRST REPORT
of Occupational Injury or
Occupational Disease
Employee Copy

CASE NUMBER

FIRM NUMBER

INSTRUCTIONS - Every employer in Montana is required by law to complete this form immediately after every accident to an employee which arises out of and in the course of employment, and which causes loss of time from work or requires medical attention. The original of this form must be immediately filed with the employer's insurer or the Division of Workers' Compensation, 815 Front Street, Helena, Montana 59601. All questions must be answered fully. If a question cannot be answered, please explain why.
Please print with a ball point pen or type.

FEDERAL OSHA REQUIREMENTS - The United States Department of Labor requires employers to maintain, in the employer's office, a record of occupational injuries. For the employer's convenience, this form has been designed to meet such requirements and to provide employers a record copy.

EMPLOYEE

Full Name of INJURED EMPLOYEE: Lyle E. Siefke
Social Security Number: 725-14-1074
EMPLOYEE'S Home Address (Street or Box): P O BOX 941
City: Libby,
State: MT
Zip Code: 59923
Occupation: Export Operator
Sex: M
Age: 45
Marital Status: [X] Married [ ] Single
Length of time in your Employment: 16 yrs.
Department where regularly employed: Construction
Date of Birth (mo.) 9 / (day) 7 / (yr.) 33

WAGES

Employee's Gross Wage Rate is $ 8.305 per [ ] week, or [ ] day, or [X] hour, or [ ] month
Days Worked Per Week: 5
Hours Worked Per Day: 8
If board or room is furnished state value reported per day to Internal Revenue Service $
Check One— [X] Full Time Employee [ ] Part Time Employee
Payroll Classification under which employee's wages were reported
Employee's gross earnings for last four (4) pay periods (Date / Amount) (Date / Amount) (Date / Amount) (Date / Amount)
Employee's pay period: [ ] Monthly [ ] Semi-monthly [X] Bi-Weekly [ ] Weekly [ ] Other

ACCIDENT INFORMATION

Describe in full detail how accident happened, and give cause - Explain what employee was doing when injured.
Loading Car at Export (100 pd Bags) he went to put bag in car and while turning pulled muscle in lower back & hip area.

What specific object or substance caused the injury? 100 pd bag
Nature of the injury? (cut, fracture, etc.) Hurt lower back
Part of body affected (leg, arm, back, head, etc.) Back
DATE OF INJURY (month) September (day) 26, (year) 1979 (hour) 2:00 (a.m. or p.m.) p.m.
Names of witnesses to accident: 1. Dale Vinson 2.
Place where accident occurred (address & city) Old Loading Dock, Libby Mt. (county) Lincoln
Was place of accident on employer's premises? Yes [ ] No [ ]
Was employee injured while in your employ? Yes [X] No [ ]
Were you notified, or did you have actual knowledge of the accident? Yes [X] No [ ] If yes, date notified & how Dale Vinson 9/26/79
Do you have any reason to question this accident? [ ] Yes [X] No If yes, please explain fully

MEDICAL

Attending physician name and address: R.E. Combs
If hospitalized, hospital's name and address
Will employee return to work during next scheduled shift? Yes [ ] No [X]
If no, will wage loss exceed 7 days? Yes [ ] No [X] Not Sure [ ]
Date wage loss began (mo) / (day) / (yr.)
Date of return, if returned to work (mo.) / (day) / (yr.)

EMPLOYER

EMPLOYER'S NAME: W. R. GRACE & CO.
Commercial Name (doing business as)
Employer's mailing address (Street or Box) P O BOX 609 (City) Libby, (State) Mt. (Zip Code) 59923
Phone number 293-4131
Location of operation, if different from mailing address
Nature of business: Milling & Mining
Firm is a: (Check one) [ ] Sole proprietorship [ ] Partnership, or [X] Corporation
Was the Injured employee? (Check if applicable) [ ] A Sole Proprietor, [ ] A working Partner, [ ] A Corporate Officer, or [ ] A member of the employer's (sole proprietor or partner) family, dwelling in the employer's household.
Prepared by: D. Woodward
Authorized Signature: X
Official Title: Manager of Administration
Date: 9/28/79

DWC USE ONLY

OCCUPATION
SEX
AGE
MARITAL STATUS
COUNTY
LENGTH (YRS) EMPLOYED
WEEKLY EARNINGS
CLASS CODE
ACCIDENT TYPE
SOURCE OF INJURY
PART OF BODY INJURED
OSHA RECORDABLE CODE
DISABILITY TYPE
NATURE OF INJURY
HAZARDOUS CONDITION
UNSAFE ACT

Above - DWC-MIS Form 37-Employer's First Report (Rev. 1-76)

Below - DWC-MIS Form 54A-Claim for Compensation

EMPLOYEE'S CLAIM FOR COMPENSATION

EMPLOYER'S NOTE: For convenience purposes and if the worker is available, the form below has been provided so that an employer may allow an injured worker to file a claim for compensation on this form to avoid having the employee fill out and file a separate detailed form. Separate claim forms are available if the employer does not want the worker to use this form. **Do not delay in submission of this form if employee is not available to sign below.**

INJURED EMPLOYEE'S NOTE: An injured employee may use the form below to make a claim for compensation, or the employee may fill out and submit a separate detailed form that is available from the Division.

I have carefully read the above information as documented by the employer, and (except for any statements I may write below) I concur with the information and I hereby make claim for compensation benefits due me now or in the future under Montana's Workers' Compensation Act.

Signature of injured employee: X
Address: Box 941
City: Libby
Date: 9/28/79
Phone: 293-4567

I DO NOT concur with the following information documented by the employer

Filing of this claim is authorization for release of medical records and records of the Social Security Administration

C0080142

Medical IBR Ex22
Siefke, Lyle

ACCIDENT INVESTIGATION REPORT

INDUSTRIAL CHEMICALS GROUP
W. R. Grace & Co.

Plant Libby Mont Lost Time Case Yes

Division Const Prod Div Not Lost Time Case _____
(Check one)

All accidents involving lost time from work or the services of a physician must be investigated and the report completed within 48 hours by the injured employee's supervisor. Forward one copy of report to office of Safety Administrator.

1. Name of injured employee Lyle Sirfke
2. Department Const Date of Hire 7-1-63
3. Job Title Const semi skill Was he doing regular job? Yes ✓ No _____
4. Date and time of injury 10-11-80-11Am
5. Date and time injury reported 10-11-80-11Am
6. Injured employee is: Salaried _____ Hourly ✓ Male ✓ Female _____

   Under 25 years _____ 25 to 34 _____ 35 to 49 ✓ 50 and over _____
7. Describe in detail what employee was doing at time of injury: include reference to any tools, machines and materials involved:

   Guiding a Piece of Pipe into a tight Place with another Person help. the other Employee Pushed the Pipe toward Lyle and he caught his finger between to pieces of Pipe
8. Describe injury: smashed the small finger
9. What medical action was taken? Doctor X RAYed on 10-13-80

C0080143

10. What, in your opinion, was the basic cause of this accident?

    Unsafe Act ✓ Unsafe Condition _____ Explain Man was not Paying attention to the fact his hand was between the Pipes and they were being moved together when in fact he was helping move it

WRG00299188
ED_005351_00000355-00275

11. What were the contributing causes? People were working with a person who doesn't normally do this type of work

12. What action have you taken and/or are you planning to take to avoid a recurrence of this accident? still under investigation at this time

13. Have you counselled your other employees regarding lessons to be learned from this accident?

Yes ✓ No ____ if not, why _____

14. Have you scheduled any maintenance work or planned any disciplinary action with the accident?

Yes ____ No ____ Comments, if any: _____

(Signed) [illegible] (Supervisor) Date 10-16-80 Plant [illegible]

****

You have now completed answering some very important questions regarding an injury to one of your employees. Take the time to think carefully and ask yourself the following two questions:

10-30-80

a) How long did I take to think out and complete the answers to the questions above?
b) Have I really taken enough time, given enough thought, to a subject which might very well mean the life of one of my employees at some future date?

****

This space reserved for Plant Managers

1. Have you discussed this injury with .....

the supervisor concerned? Yes ____ No ____
all members of your supervisory group? Yes ____ No ____

2. Do you have any comments to add to the statements by the Foreman?

_____

_____

(Plant Manager) (Date)

Form 65-25

C0080144
WRG00299189
ED_005351_00000355-00276

MONTANA DIVISION OF WORKERS' COMPENSATION

815 Front Street / Helena, Montana 59601

DATE STAMP

EMPLOYER'S FIRST REPORT of Occupational Injury or Occupational Disease

SEND ORIGINAL TO INSURER:

CASE NO

FIRM NO

Employee Copy

INSTRUCTIONS - Every employer in Montana is required by law to complete this form immediately after every industrial accident to an employee which causes loss of time from work or requires medical attention. The original of this form must be immediately filed with the employer's insurer or the Division of Workers' Compensation, 815 Front Street, Helena, Montana 59601. All questions must be answered fully. If a question cannot be answered, please explain why.
Please print with a ball point pen or type.

FEDERAL OSHA REQUIREMENTS - The United States Department of Labor requires employers to maintain, in the employer's office, a record of occupational injuries. For the employer's convenience, this form has been designed to meet such requirements and to provide employers a record copy.

EMPLOYEE

FULL NAME OF INJURED EMPLOYEE: LYLE E. SIEFKE

SOCIAL SECURITY NUMBER: 725-14-1074

EMPLOYEE'S HOME ADDRESS (Street or Box): P O Box 941

CITY: Libby

STATE: MT

ZIP CODE: 59923

OCCUPATION: Const. Semi Skilled

SEX: M

DATE OF BIRTH (Mo / Day / Yr): 2 / 9 / 34

MARITAL STATUS: [X] Married [ ] Single

LENGTH OF TIME IN YOUR EMPLOYMENT: 17 yrs.

WAGES

Employee's Gross Wage Rate is $ 8.950 Per WEEK [ ] DAY [ ] HOUR [X] MO. [ ]

Days Worked Per Week 5

Hours Worked Per Day 8

If board or room is furnished state value reported per day to Internal Revenue Service $

Check one - [X] Full Time Employee [ ] Part Time Employee

Payroll Classification under which employee's wages were reported

Employee's Pay Period: Monthly [ ] Semi-monthly [X] Bi-weekly [ ] Weekly [ ] Other (explain) [ ]

Employee's gross earnings for last four (4) pay periods (Date / Amount) (Date / Amount) (Date / Amount) (Date / Amount)

Will employee return to work during next scheduled shift? Yes [ ] No [X]

If no, will wage loss exceed 7 days? Yes [ ] No [X] Not Sure [ ]

DATE WAGE LOSS BEGAN (Mo / Day / Yr): 10 / 13 / 80

DATE OF RETURN, if returned to work (Mo / Day / Yr): 10 / 14 / 80

ACCIDENT INFORMATION

Describe in full detail how accident happened, and give cause - Explain what employee was doing when injured.

Was replacing pipe on overflow tank and his right little finger was caught between 2 - 12" pipe smashing it.

DATE OF INJURY (month) October (day) 11 (year) 1980 (hour) 2 (a.m. or p.m.) p.m.

What specific object or substance caused the injury? Pipe

Nature of the injury? (cut, fracture, etc.) Smashed right little finger

Part of body affected (leg, arm, back, head, etc.) Right hand

Names of witnesses to accident: 1. Don Riley 2. Kenneth Fredricks

Was place of accident on employer's premises? Yes [X] No [ ]

Place where accident occurred (address & city): 12 Miles N.E. Libby, Mt. (county) Lincoln

Was employee injured while in your employ? Yes [X] No [ ]

Were you notified, or did you have actual knowledge of the accident? Yes [X] No [ ]

If yes, date notified & how: Don Riley

Do you have any reason to question this accident? [ ] Yes [X] No

If yes, please explain fully

MEDICAL

Attending Physician's Name: Dr. W. T. Matthews

Address (Street or Box): 402 Montana Ave

(City): Libby (State): MT (Zip Code): 59923

If Hospitalized, Hospital's Name

Address (Street or Box) (City) (State) (Zip Code)

EMPLOYER

EMPLOYER'S NAME: W. R. Grace & Co.

Commercial Name (doing business as)

Employer's mailing address (street or box): P O Box 609

(City): Libby, (State): Mt. (Zip Code): 59923

Phone Number: 406-293-4131

Location of operation, if different from mailing address: 12 Miles N.E. Libby, MT

Nature of Business: Mining & Milling

Firm is a: (Check one) [ ] Sole proprietorship [ ] Partnership, or [X] Corporation

Was the injured employee? (Check if applicable) [ ] A Sole Proprietor, [ ] A working Partner, [ ] A Corporate Officer, or [ ] A member of the employer's (sole proprietor or partner) family, dwelling in the employer's household.

Prepared by: Darlene Woodward

Authorized Signature: [illegible]

Official Title: Manager of Administration

Date: 1/27/81

ABOVE - DWC - MIS Form 37 - Employer's First Report (Rev. 6-78)

BELOW - DWC - MIS Form 54 - Claim for Compensation

EMPLOYEE'S CLAIM FOR COMPENSATION

EMPLOYER'S NOTE: For convenience purposes and if the worker is available, the form below has been provided so that an employer may allow an injured worker to file a claim for compensation on this form to avoid having the employee fill out and file a separate detailed form. Separate claim forms are available if the employer does not want the worker to use this form. **Do not delay in submission of this form if employee is not available to sign below.**

EMPLOYEE'S CLAIM FOR COMPENSATION

INJURED EMPLOYEE'S NOTE: An injured employee may use the form below to make a claim for compensation, or the employee may fill out and submit a separate detailed form that is available from the Division.

List other types of work you have done: 1. 2. 3.

Education: [ ] Grade School [ ] High School [ ] College [ ] Other

How many members are in your immediate family?

Have you ever had an industrial injury before? Yes [ ] No [ ]

If yes, in what state?

Type of injury

I have carefully read the information as documented by the employer, and (except for any statements I may write below) I concur with the information and I hereby make claim for compensation benefits due me now or in the future under Montana's Workers' Compensation Act.

Signature of injured employee: X [illegible]

Address: P O Box [illegible]

City: Libby, Mt

Date: 1/27/81

Phone: 293-[illegible]

C0080145

I DO NOT concur with the following information documented by the employer

Filing of this claim is authorization for release of medical records and records of the Social Security Administration

IAR Ex 22

Medical
Sieffke, Lyle

WRG00

ACCIDENT INVESTIGATION REPORT

INDUSTRIAL CHEMICALS GROUP
W. R. Grace & Co.

Plant Libby Lost Time Case ____

Division C.P.D. Not Lost Time Case ✓
(Check one)

All accidents involving lost time from work or the services of a physician must be investigated and the report completed within 48 hours by the injured employee's supervisor. Forward one copy of report to office of Safety Administrator.

1. Name of injured employee Lyle F Siefke
2. Department Const. Date of Hire 7-1-63
3. Job Title Steam Eng. Trainee Was he doing regular job? Yes ✓ No ____
4. Date and time of injury 11-30-81 ; Apx. 11:00 AM
5. Date and time injury reported 12-1-81
6. Injured employee is: Salaried ____ Hourly ✓ Male ✓ Female ____

   Under 25 years ____ 25 to 34 ____ 35 to 49 ✓ 50 and over ____
7. Describe in detail what employee was doing at time of injury: include reference to any tools, machines and materials involved: Removing burner Section from #1 boiler, while adjusting wooden stand to support burner got a splinter of wood in right little finger
8. Describe injury: wood splinter in right little finger apx. ½" long
9. What medical action was taken? Removed by Doctor
10. What, in your opinion, was the basic cause of this accident?

    Unsafe Act ✓ Unsafe Condition ____ Explain Not wearing gloves

C0080146

MONTANA DIVISION OF WORKERS' COMPENSATION

815 Front Street, Helena, Montana 59601

DATE STAMP

EMPLOYER'S FIRST REPORT of Occupational Injury or Occupational Disease

SEND ORIGINAL TO INSURER:

CASE NO

FIRM NO

Employee Copy

INSTRUCTIONS - Every employer in Montana is required by law to complete this form immediately after every industrial accident to an employee which causes loss of time from work or requires medical attention. The original of this form must be immediately filed with the employer's insurer or the Division of Workers' Compensation, 815 Front Street, Helena, Montana 59601. All questions must be answered fully. If a question cannot be answered, please explain why.
Please print with a ball point pen or type.

FEDERAL OSHA REQUIREMENTS - The United States Department of Labor requires employers to maintain, in the employer's office, a record of occupational injuries. For the employer's convenience, this form has been designed to meet such requirements and to provide employers a record copy.

EMPLOYEE

FULL NAME OF INJURED EMPLOYEE: LYLE SIEFKE

SOCIAL SECURITY NUMBER: 725-[illegible]

EMPLOYEE'S HOME ADDRESS (Street or Box): P. O. BOX 541

CITY: LIBBY

STATE: MT.

ZIP CODE: [illegible]

OCCUPATION: STEAM FIRE TRAINER

SEX: M

DATE OF BIRTH (Mo / Day / Yr): 9 / 9 / 34

MARITAL STATUS: [X] Married [ ] Single

LENGTH OF TIME IN YOUR EMPLOYMENT: 11 YEARS

WAGES

Employee's Gross Wage Rate is $ Per: WEEK [ ] DAY [ ] HOUR [ ] MO. [ ]

Days Worked Per Week: 5

Hours Worked Per Day: [illegible]

If board or room is furnished state value reported per day to Internal Revenue Service $

Check one - [ ] Full Time Employee [ ] Part Time Employee

Payroll Classification under which employee's wages were reported

Employee's Pay Period: Monthly [ ] Semi-monthly [ ] Bi-weekly [X] Weekly [ ] Other (explain) [ ]

Employee's gross earnings for last four (4) pay periods (Date / Amount) (Date / Amount) (Date / Amount) (Date / Amount)

Will employee return to work during next scheduled shift? Yes [ ] No [ ]

If no, will wage loss exceed 7 days? Yes [ ] No [ ] Not Sure [ ]

DATE WAGE LOSS BEGAN (Mo / Day / Yr): NONE

DATE OF RETURN, if returned to work (Mo / Day / Yr):

ACCIDENT INFORMATION

Describe in full detail how accident happened, and give cause - Explain what employee was doing when injured.

MOVING A STOOL WHILE WORKING ON FURNACE AND PUT A SLIVER OF WOOD [illegible]

FINGER

DATE OF INJURY (month) (day) (year) (hour) (a.m. or p.m.): [illegible] / 2 / 81

What specific object or substance caused the injury? STEAM FIRE [illegible]

Nature of the injury? (cut, fracture, etc.) SLIVER OF WOOD IN FINGER

Part of body affected (leg, arm, back, head, etc.) FINGER

Names of witnesses to accident: 1. BILL [illegible] 2.

Was place of accident on employer's premises? Yes [X] No [ ]

Place where accident occurred (address & city) (county): BOILER HOUSE - 12 MILES N.E. OF LIBBY, MT.

Was employee injured while in your employ? Yes [X] No [ ]

Were you notified, or did you have actual knowledge of the accident? Yes [X] No [ ]

If yes, date notified & how: 12/1/81

Do you have any reason to question this accident? [ ] Yes [ ] No

If yes, please explain fully

MEDICAL

Attending Physician's Name: DR. [illegible] MATTHEWS

Address (Street or Box): 402 [illegible] AVE

(City): LIBBY

(State): MT

(Zip Code):

If Hospitalized, Hospital's Name

Address (Street or Box) (City) (State) (Zip Code)

EMPLOYER

EMPLOYER'S NAME: W. R. GRACE & CO.

Commercial Name (doing business as)

Employer's mailing address (street or box): P. O. BOX 639

(City): LIBBY

(State)

(Zip Code): [illegible]

Phone Number

Location of operation, if different from mailing address: 12 MILES N.E. OF LIBBY, MT.

Nature of Business: MT [illegible]

Firm is a: (Check one) [ ] Sole proprietorship [ ] Partnership, or [ ] Corporation

Was the Injured employee? (Check if applicable) [ ] A Sole Proprietor, [ ] A working Partner, [ ] A Corporate Officer, or [ ] A member of the employer's (sole proprietor or partner) family, dwelling in the employer's household.

Prepared by: [illegible]

Authorized Signature

Official Title

Date

ABOVE - DWC - MIS Form 37 - Employer's First Report (Rev. 6-78)

BELOW - DWC - MIS Form 54 - Claim for Compensation

EMPLOYEE'S CLAIM FOR COMPENSATION

EMPLOYER'S NOTE: For convenience purposes and if the worker is available, the form below has been provided so that an employer may allow an injured worker to file a claim for compensation on this form to avoid having the employee fill out and file a separate detailed form. Separate claim forms are available if the employer does not want the worker to use this form. **Do not delay in submission of this form if employee is not available to sign below.**

EMPLOYEE'S CLAIM FOR COMPENSATION

INJURED EMPLOYEE'S NOTE: An injured employee may use the form below to make a claim for compensation, or the employee may fill out and submit a separate detailed form that is available from the Division.

List other types of work you have done: 1. 2. 3.

Education: [ ] Grade School [ ] High School [ ] College [ ] Other

How many members are in your immediate family?

Have you ever had an industrial injury before? Yes [ ] No [ ]

If yes, in what state?

Type of injury

I have carefully read the information as documented by the employer, and (except for any statements I may write below) I concur with the information and I hereby make claim for compensation benefits due me now or in the future under Montana's Workers' Compensation Act.

Signature of injured employee: X

Address

City

Date

Phone

I DO NOT concur with the following information documented by the employer

X

C0080148

Filing of this claim is authorization for release of medical records and records of the Social Security Administration

IAR Ex 22

Medical
Siefke, Lyle

ACCIDENT INVESTIGATION REPORT

INDUSTRIAL CHEMICALS GROUP
W. R. Grace & Co.

Plant Libby

Division CPD

Lost Time Case ✓

Not Lost Time Case _____
(Check one)

All accidents involving lost time from work or the services of a physician must be investigated and the report completed within 48 hours by the injured employee's supervisor. Forward one copy of report to office of Safety Administrator.

1. Name of injured employee Lyle E. Siefke
2. Department Const Date of Hire 7-1-63
3. Job Title Steam Engineer Was he doing regular job? Yes ✓ No _____
4. Date and time of injury 1-20-82 1:30 PM
5. Date and time injury reported 1-20-82 1:45 PM
6. Injured employee is: Salaried _____ Hourly ✓ Male ✓ Female _____

   Under 25 years _____ 25 to 34 _____ 35 to 49 ✓ 50 and over _____
7. Describe in detail what employee was doing at time of injury: include reference to any tools, machines and materials involved: Was removing a 50Lb bag of salt from storage shed & tripped on board attached to plastic cover of shed that was covered by snow, fell striking right leg
8. Describe injury: Pulled muscle in Right calf of leg
9. What medical action was taken? Went to Doctor who prescribed Medication
10. What, in your opinion, was the basic cause of this accident?

    Unsafe Act ✓ Unsafe Condition _____ Explain Walking Area Not kept Clear

C0080149

11. What were the contributing causes? Ice + Torn Plastic Cover

12. What action have you taken and/or are you planning to take to avoid a recurrence of this accident? See 14

13. Have you counselled your other employees regarding lessons to be learned from this accident?

Yes ✓ No ____ if not, why ____

14. Have you scheduled any maintenance work or planned any disciplinary action with the accident?

Yes ✓ No ____ Comments, if any: Have Shed moved back to original location. + improve curtin

(Signed) RP Hughes (Supervisor) Date 1-22-82 Plant Libby

****

You have now completed answering some very important questions regarding an injury to one of your employees. Take the time to think carefully and ask yourself the following two questions:

a) How long did I take to think out and complete the answers to the questions above?
b) Have I really taken enough time, given enough thought, to a subject which might very well mean the life of one of my employees at some future date?

1-26-82
1-26-82

****

This space reserved for Plant Managers

1. Have you discussed this injury with .....

the supervisor concerned? Yes ____ No ____
all members of your supervisory group? Yes ____ No ____

2. Do you have any comments to add to the statements by the Foreman?

(Plant Manager) (Date)

Form 65-25

C0080150

WRG00299196
ED_005351_00000355-00283

GRACE

Zonolite
Construction Products Division

TO: Pete Hughes

DATE: February 3, 1982

FROM: Mike Ray

SUBJECT: Lyle Siefke's Accident

cc: Luis Vazquez, Bob Stainbrook, Bill Melcher, Don Riley

On Friday, January 22, 1982, you called and asked me about the salt storage bin and its location and condition that were circumstantial to Lyle Siefke's accident. Because the matter was safety related, I looked into it as soon as I could. The result of that investigation was very interesting and possibly raised more questions than it answered.

Lyle Siefke's accident occurred on Wednesday, January 20th. On Monday or Tuesday of that week he had approached Francis Landis about the condition of the temporary cover that had been put on the salt storage bin by construction. He told Francis Landis that one corner of the visquine that was used as a temporary cover had come loose and that it was hanging down. Francis answered him that he was capable of picking up a hammer and fixing the problem himself and that is what he should do.

I believe that Francis was correct in telling him that it would not be fixed by Construction and that he should do it himself because the reason, as I recall, that we now have two people in the boiler house was to insure that the boiler system and the fire system and its associated equipment were in top condition. I don't believe that their workload at that time was such that he could not have handled it himself.

I have a question as to why the salt storage shed has to be covered at all. To the best recollection of the people that have been here much longer than myself, the salt storage bin has never been covered. When we painted the boiler house we pulled the shed away from the boiler house and repaired the numerous holes in it. We decided as long as we had it pulled away from the building and were rebuilding it that we would just place it over by the hill where it presently sits. As I explained when you called Friday, this was done simply to open up the driveway between Research and the boiler house and to facilitate snow removal.

Putting the question of location aside, it must be asked why the snow was not kept away from the front of the storage shed in the first place. If, as you say, two 50 lb. sacks of salt are carried into the boiler house each day, I would think that a priority would be to keep the walkway between the storage shed and the boiler house clear, no matter where it is. The sheet metal shop is able to keep the snow clear from in front of their own shop and the boiler house operators are certainly not short of salt in order to keep the ice buildup down.

GRACE

Zonite
Construction Products Division

TO: Pete Hughes
DATE: February 3, 1982

Finally, I believe that on the accident report form that this accident should be termed "An Unsafe Act". In addition, I believe that Lyle Siefke should be given a reprimand for seeing a hazard, recognizing it as such, and not correcting it immediately. As of Monday morning when I was reviewing this accident, the visquine cover was still hanging loose off of the salt storage shed just as it was when he was injured. I find it hard to believe that he didn't either remove or repair the visquine cover even after he himself had been injured.

M.D.Ray:ch

MONTANA DIVISION OF WORKERS' COMPENSATION

815 Front Street, Helena, Montana 59601

EMPLOYER'S FIRST REPORT of Occupational Injury or Occupational Disease

DATE STAMP

SEND ORIGINAL TO INSURER:

CASE NO -

FIRM NO -

Employer Copy

INSTRUCTIONS - Every employer in Montana is required by law to complete this form immediately after every industrial accident to an employee which causes loss of time from work or requires medical attention. The original of this form must be immediately filed with the employer's insurer or the Division of Workers' Compensation, 815 Front Street, Helena, Montana 59601. All questions must be answered fully. If a question cannot be answered, please explain why.
Please print with a ball point pen or type.

FEDERAL OSHA REQUIREMENTS - The United States Department of Labor requires employers to maintain, in the employer's office, a record of occupational injuries. For the employer's convenience, this form has been designed to meet such requirements and to provide employers a record copy.

EMPLOYEE

FULL NAME OF INJURED EMPLOYEE	PHONE	SOCIAL SECURITY NUMBER
Lyle E. Siefke	293-8594	725-14-1074

EMPLOYEE'S HOME ADDRESS (Street or Box)	CITY	STATE	ZIP CODE
P O Box 941	Libby	MT	59923

OCCUPATION	SEX	DATE OF BIRTH (Mo / Day / Yr)	MARITAL STATUS	LENGTH OF TIME IN YOUR EMPLOYMENT
Steam Engineer	M	9 / 9 / 24	[x] Married [ ] Single	18 years

WAGES

Employee's Gross Wage Rate is $ 10.15 Per [ ] WEEK [ ] DAY [x] HOUR [ ] MO. Days Worked Per Week 5 Hours Worked Per Day 8 If board or room is furnished state value reported per day to Internal Revenue Service $

Check one - [x] Full Time Employee [ ] Part Time Employee. Payroll Classification under which employee's wages were reported. Employee's Pay Period: [ ] Monthly, [x] Semi-monthly, [ ] Bi-weekly, [ ] Weekly, [ ] Other (explain) Regular Days Off

Employee's gross earnings for last four (4) pay periods (Date / Amount) (Date / Amount) (Date / Amount) (Date / Amount)

Will employee return to work during next scheduled shift? Yes [ ] No [X] If no, will employee lose more than 5 days wages? Yes [ ] No [X] Not Sure [ ] DATE WAGE LOSS BEGAN (Mo / Day / Yr) / / DATE OF RETURN, if returned to work (Mo / Day / Yr) / /

ACCIDENT INFORMATION

Describe in full detail how accident happened, and give cause - Explain what employee was doing when injured.
Getting salt out of salt storage and they have a piece of visqueen with a board on it to keep snow out and it was burled under the snow and he tripped over it falling foreward straining right calf muscles.

DATE OF INJURY (month) January (day) 20 (year) 1982 (hour) 1:30 (a.m. or p.m.) p.m. What specific object or substance caused the injury? tripped on board/stick

Nature of the injury? (cut, fracture, etc.) strained calf muscles- right let Part of body affected (leg, arm, back, head, etc.) right leg

Names of witnesses to accident 1. Bill Crill 2.

Was place of accident on employer's premises? Yes [x] No [ ] Place where accident occurred (address & city) 12 miles N.E. Libby, MT (county) Lincoln

Was employee injured while in your employ? Yes [x] No [ ] Were you notified, or did you have actual knowledge of the accident? Yes [ ] No [ ] If yes, date notified & how

Do you have any reason to question this accident? [ ] Yes [X] No If yes, please explain fully

MEDICAL

Attending Physician's Name	PHONE	Address (Street or Box)	(City)	(State)	(Zip Code)
Dr. W. T. Matthews	293-4181	402 Montana Ave	Libby	MT	59923

If Hospitalized, Hospital's Name — Address (Street or Box) — (City) — (State) — (Zip Code)

EMPLOYER

EMPLOYER'S NAME: W. R. Grace & Co. Commercial Name (doing business as)

Employer's mailing address (street or box)	(City)	(State)	(Zip Code)	Phone Number
P O BOX 609	Libby	MT	59923	406-293-4131

Location of operation, if different from mailing address: 12 Miles N.E. Libby, Montana Nature of Business: mining & milling

Firm is a: (Check one) [ ] Sole proprietorship [ ] Partnership, or [x] Corporation. Was the Injured employee? (Check if applicable) [x] A Sole Proprietor, [ ] A working Partner, [ ] A Corporate Officer, or [ ] A member of the employer's (sole proprietor or partner) family, dwelling in the employer's household.

Prepared by: Darlene Woddward Authorized Signature [signature] Official Title Manager of Adminstration Date 1-21-82

ABOVE - DWC - MIS Form 37 - Employer's First Report (Rev. 6-78)
BELOW - DWC - MIS Form 54 - Claim for Compensation

EMPLOYEE'S CLAIM FOR COMPENSATION

EMPLOYER'S NOTE: For convenience purposes and if the worker is available, the form below has been provided so that an employer may allow an injured worker to file a claim for compensation on this form to avoid having the employee fill out and file a separate detailed form. Separate claim forms are available if the employer does not want the worker to use this form. **Do not delay in submission of this form if employee is not available to sign below.**

EMPLOYEE'S CLAIM FOR COMPENSATION

INJURED EMPLOYEE'S NOTE: An injured employee may use the form below to make a claim for compensation, or the employee may fill out and submit a separate detailed form that is available from the Division.

List other types of work you have done 1. 2. 3.

Education [ ] Grade School [ ] High School [ ] College [ ] Other _____ How many members are in your immediate family?

Have you ever had an industrial injury before? Yes [ ] No [ ] If yes, in what state? Type of injury

I have carefully read the information as documented by the employer, and (except for any statements I may write below) I concur with the information and I hereby make claim for compensation benefits due me now or in the future under Montana's Workers' Compensation Act.

Signature of injured employee	Address	City	Date	Phone
X Lyle E. Siefke	P O Box 941	Libby	1-21-82	293-8594

I DO NOT concur with the following information documented by the employer _____

C0080153

Filing of this claim is authorization for release of medical records and records of the Social Security Administration

Medical IBR Ex 22
Siefke, Lyle

ACCIDENT INVESTIGATION REPORT

INDUSTRIAL CHEMICALS GROUP
W. R. Grace & Co.

Plant Libby Lost Time Case ✓

Division CPD Not Lost Time Case _____
(Check one)

All accidents involving lost time from work or the services of a physician must be investigated and the report completed within 48 hours by the injured employee's supervisor. Forward one copy of report to office of Safety Administrator.

1. Name of injured employee Lyle E. Siefke
2. Department Construction Date of Hire 7-1-63
3. Job Title Steam Engineer Was he doing regular job? Yes ✓ No _____
4. Date and time of injury 11-2-82; 1:30 P.M.
5. Date and time injury reported 11-2-82; 1:45 P.M.
6. Injured employee is: Salaried _____ Hourly ✓ Male ✓ Female _____

   Under 25 years _____ 25 to 34 _____ 35 to 49 ✓ 50 and over _____
7. Describe in detail what employee was doing at time of injury: include reference to any tools, machines and materials involved: Was visually following a steam line on the 2½ deck of Old Wet Mill when he fell thru a 2'x3' hole in floor grating. He fell apx. 10' down to 2nd floor on old steel pipe that was being stored there, landing on his back
8. Describe injury: Hand was severely bruised, both arms cut + bruised. bad bruise on lower back legs scratched + bruised
9. What medical action was taken? Taken to Emergency Room of Hospital
10. What, in your opinion, was the basic cause of this accident?

    Unsafe Act ✓ Unsafe Condition _____ Explain failure to watch where he was walking

C0080154
WRG00299201
ED_005351_00000355-00288

11. What were the contributing causes? Unsafe Conditions: equipment had been removed and floor penetrations not covered or roped off

12. What action have you taken and/or are you planning to take to avoid a recurrence of this accident? have holes covered, area roped off until repairs made

13. Have you counselled your other employees regarding lessons to be learned from this accident?

Yes ✓ No ____ if not, why _____

14. Have you scheduled any maintenance work or planned any disciplinary action with the accident?

Yes ✓ No ____ Comments, if any: _____

(Signed) RP Hughes (Supervisor) Date 11-8-82 Plant Libby

****

You have now completed answering some very important questions regarding an injury to one of your employees. Take the time to think carefully and ask yourself the following two questions:

a) How long did I take to think out and complete the answers to the questions above?
b) Have I really taken enough time, given enough thought, to a subject which might very well mean the life of one of my employees at some future date?

****

11-9-82 wfy

This space reserved for Plant Managers

1. Have you discussed this injury with .....

the supervisor concerned? Yes ____ No ____
all members of your supervisory group? Yes ____ No ____

2. Do you have any comments to add to the statements by the Foreman?

_____

(Plant Manager) (Date)

Form 65-25

C0080155

MONTANA DIVISION OF WORKERS' COMPENSATION

815 Front Street / Helena, Montana 59604

EMPLOYER'S FIRST REPORT of Occupational Injury or Occupational Disease

DATE STAMP

SEND ORIGINAL TO INSURER:

CASE NO

FIRM NO

EMPLOYEE COPY

INSTRUCTIONS - Every employer in Montana is required by law to complete this form immediately after every industrial accident to an employee which causes loss of time from work or requires medical attention. The original of this form must be immediately filed with the employer's insurer or the Division of Workers' Compensation, 815 Front Street, Helena, Montana 59601. All questions must be answered fully. If a question cannot be answered, please explain why.
Please print with a ball point pen or type.

FEDERAL OSHA REQUIREMENTS - The United States Department of Labor requires employers to maintain, in the employer's office, a record of occupational injuries. For the employer's convenience, this form has been designed to meet such requirements and to provide employers a record copy.

EMPLOYEE

FULL NAME OF INJURED EMPLOYEE: Lyle Edward Siefke

SOCIAL SECURITY NUMBER: 725-14-1074

EMPLOYEE'S HOME ADDRESS (Street or Box): P.O. Box 941

CITY: Libby

STATE: MT

ZIP CODE: 59923

OCCUPATION: Steam Engineer

SEX: M

DATE OF BIRTH (Mo / Day / Yr): 9 / 09 / 34

MARITAL STATUS: [X] Married [ ] Single

LENGTH OF TIME IN YOUR EMPLOYMENT: 19

WAGES

Employee's Gross Wage Rate is $ 10.89 Per WEEK [ ] DAY [ ] HOUR [X] MO. [ ]

Days Worked Per Week 5

Hours Worked Per Day 8

If board or room is furnished state value reported per day to Internal Revenue Service $

Check one - [X] Full Time Employee [ ] Part Time Employee

Payroll Classification under which employee's wages were reported

Employee's Pay Period: Monthly [ ] Semi-monthly [X] Bi-weekly [ ] Weekly [ ] Other (explain) [ ]

Employee's gross earnings for last four (4) pay periods (Date / Amount) (Date / Amount) (Date / Amount) (Date / Amount)

Will employee return to work during next scheduled shift? Yes [ ] No [X]

If no, will wage loss exceed 5 work days? Yes [X] No [ ] Not Sure [ ]

REG. DAYS OFF

DATE WAGE LOSS BEGAN (Mo / Day / Yr): 11 / 03 / 82

DATE OF RETURN, if returned to work (Mo / Day / Yr)

ACCIDENT INFORMATION

Describe in full detail how accident happened, and give cause. Explain what employee was doing when injured

Checking the steam lines in the old mill. He was looking up at the lines and he stepped into a hole in the floor and fell 9'8".

DATE OF INJURY: (month) 11 (day) 02 (year) 82 (hour) 1:30 (a.m. or p.m.) p.m.

What specific object or substance caused the injury? Hole in floor

Nature of the injury? (cut, fracture, etc.) Bruised back, hips, hands, behind

Part of body affected (leg, arm, back, head, etc.) hips, back, hands, legs etc.

Names of witnesses to accident:
1. Dennis Day — Did NOT see happen.

Was place of accident on employer's premises? Yes [X] No [ ]

Place where accident occurred (address & city): 12 Miles N.E. of Libby, Montana (county) Lincoln

Was employee injured while in your employ? Yes [X] No [ ]

Were you notified, or did you have actual knowledge of the accident? Yes [X] No [ ]

If yes, date notified & how

Do you have any reason to question this accident? [ ] Yes [X] No

If yes, please explain fully

MEDICAL

Attending Physician's Name: Dr. Matthews

Address (Street or Box): 402 Montana Ave.

(City): Libby (State): MT (Zip Code): 59923

If Hospitalized, Hospital's Name

Address (Street or Box) (City) (State) (Zip Code)

EMPLOYER

EMPLOYER'S NAME: W. R. Grace & Co.

Commercial Name (doing business as)

Employer's mailing address (street or box): Box 609

(City): Libby (State): MT (Zip Code): 59923

Phone Number: 406-293-3746

Location of operation, if different from mailing address: 12 Miles N.E. of Libby, Montana

Nature of Business: Mining & Milling

Firm is a: (Check one) [ ] Sole proprietorship [ ] Partnership, or [X] Corporation

Was the Injured employee? (Check if applicable) [ ] A Sole Proprietor, [ ] A working Partner, [ ] A Corporate Officer, or [ ] A member of the employer's (sole proprietor or partner) family, dwelling in the employer's household.

Prepared by: Alison Leader

Authorized Signature

Official Title: Manager of Administration

Date: 11-15-82

ABOVE - DWC - MIS Form 37 - Employer's First Report (Rev. 6-78)

BELOW - DWC MIS Form 54 - Claim for Compensation

EMPLOYEE'S CLAIM FOR COMPENSATION

EMPLOYER'S NOTE: For convenience purposes and if the worker is available, the form below has been provided so that an employer may allow an injured worker to file a claim for compensation on this form to avoid having the employee fill out and file a separate detailed form. Separate claim forms are available if the employer does not want the worker to use this form. **Do not delay in submission of this form if employee is not available to sign below.**

EMPLOYEE'S CLAIM FOR COMPENSATION

INJURED EMPLOYEE'S NOTE. An injured employee may use the form below to make a claim for compensation, or the employee may fill out and submit a separate detailed form that is available from the Division.

List other types of work you have done:
1. 2. 3.

Education: [ ] Grade School [ ] High School [ ] College [ ] Other

How many members are in your immediate family?

Have you ever had an industrial injury before? Yes [ ] No [ ]

If yes, in what state?

Type of injury

I have carefully read the information as documented by the employer, and (except for any statements I may write below) I concur with the information and I hereby make claim for compensation benefits due me now or in the future under Montana's Workers' Compensation Act.

Signature of injured employee: X Lyle E. Siefke

Address: P.O. Box 941

City: Libby

Date: 11-08-82

Phone: 406-293-8594 (unlisted)

I DO NOT concur with the following information documented by the employer

C0080156

Filing of this claim is authorization for release of medical records and records of the Social Security Administration

ARTCRAFT PRINTERS OF MISSOULA

Medical IBR Ex 22
Siefke, Lyle

MONTANA DIVISION OF WORKERS' COMPENSATION

815 Front Street / Helena, Montana 59604

EMPLOYER'S FIRST REPORT of Occupational Injury or Occupational Disease

DATE STAMP: Jacobs

SEND ORIGINAL TO INSURER: Compensation Adjusters Inc. Box 2999 Missoula, Montana 59801

CASE NO.

FIRM NO. 2503

INSURER COPY

INSTRUCTIONS - Every employer in Montana is required by law to complete this form immediately after every industrial accident to an employee which causes loss of time from work or requires medical attention. The original of this form must be immediately filed with the employer's insurer or the Division of Workers' Compensation, 815 Front Street, Helena, Montana 59601. All questions must be answered fully. If a question cannot be answered, please explain why.
Please print with a ball point pen or type.

FEDERAL OSHA REQUIREMENTS - The United States Department of Labor requires employers to maintain, in the employer's office, a record of occupational injuries. For the employer's convenience, this form has been designed to meet such requirements and to provide employers a record copy.

EMPLOYEE

FULL NAME OF INJURED EMPLOYEE: Lyle Edward Siefke
SOCIAL SECURITY NUMBER: 725-14-1074
EMPLOYEE'S HOME ADDRESS (Street or Box): P O Box 941
CITY: Libby
STATE: MT
ZIP CODE: 59923
OCCUPATION: Service Mechanic
SEX: M
DATE OF BIRTH (Mo / Day / Yr): 9 / 09 / 34
MARITAL STATUS: [X] Married [ ] Single
LENGTH OF TIME IN YOUR EMPLOYMENT: since 7-1-63

WAGES

Employee's Gross Wage Rate is $ 13.150 Per: WEEK [ ] DAY [ ] HOUR [X] MO. [ ]
Days Worked Per Week: 5
Hours Worked Per Day: 8
If board or room is furnished state value reported per day to Internal Revenue Service $
Check one: [X] Full Time Employee [ ] Part Time Employee
Payroll Classification under which employee's wages were reported
Employee's Pay Period: Monthly [ ] Semi-monthly [X] Bi-weekly [ ] Weekly [ ] Other (explain) [ ]
Employee's gross earnings for last four (4) pay periods: (Date / Amount) (Date / Amount) (Date / Amount) (Date / Amount)
Will employee return to work during next scheduled shift? Yes [X] No [ ]
If no, will wage loss exceed 5 work days? Yes [ ] No [ ] Not Sure [ ]
REG. DAYS OFF: Sat/Sun
DATE WAGE LOSS BEGAN (Mo / Day / Yr):
DATE OF RETURN, if returned to work (Mo / Day / Yr):

ACCIDENT INFORMATION

Describe in full detail how accident happened, and give cause. Explain what employee was doing when injured.
Uncertain the date of accident. May be related to accident of 11-~~16~~ 02-82
(see attached).

DATE OF INJURY (month) (day) (year) (hour) (a.m. or p.m.): see above
What specific object or substance caused the injury? see 11-~~16~~ 02-82 report
Nature of the injury? (cut, fracture, etc.): left hand
Part of body affected (leg, arm, back, head, etc.): right hand finger and hip bothering him - believed from 11-~~16~~ 02-82 injury
Names of witnesses to accident: 1. see attached 2.
Was place of accident on employer's premises? 11-16-82 Yes [X] No [ ]
Place where accident occurred (address & city) (county): 12 miles NE of Libby at our mill area
Was employee injured while in your employ? 11-16-82 Yes [X] No [ ]
Were you notified, or did you have actual knowledge of the accident? Yes [X] No [ ]
If yes, date notified & how: In office on 7-25-86 by Lyle Siefke
Do you have any reason to question this accident? [ ] Yes [X] No
If yes, please explain fully

MEDICAL

Attending Physician's Name: ~~Hopefully~~ to be: on 8-29-86 @ 9:30 a.m. (Address - Street or Box) (City) (State) (Zip Code)
W. R. Leachman, M.D., Spokane Orthopaedic Clinic, N 5901 Lidgerwood, #224, Spokane, WA 99207
If Hospitalized, Hospital's Name: Address (Street or Box) (City) (State) (Zip Code)

EMPLOYER

EMPLOYER'S NAME: W R Grace & Co
Commercial Name (doing business as):
Employer's mailing address (street or box): P O BOx 609
(City) (State) (Zip Code): Libby, MT 59923
Phone Number: 406-293-3746
Location of operation, if different from mailing address: Office: 317 Mineral Avenue, Libby, Montana 59923
Nature of Business: mining & milling vermiculi
Firm is a: (Check one) [ ] Sole proprietorship [ ] Partnership, or [X] Corporation
Was the injured employee? (Check if applicable) [ ] A Sole Proprietor, [ ] A working Partner, [ ] A Corporate Officer, or [ ] A member of the employer's (sole proprietor or partner) family, dwelling in the employer's household.
Prepared by: Sue Whitmarsh
Authorized Signature: Robert C. Marozzo
Official Title: Administrative Manager
Date: 8-5-86

ABOVE - DWC - MIS Form 37 - Employer's First Report (Rev. 6-78)
BELOW - DWC - MIS Form 54 - Claim for Compensation

EMPLOYEE'S CLAIM FOR COMPENSATION

EMPLOYER'S NOTE: For convenience purposes and if the worker is available, the form below has been provided so that an employer may allow an injured worker to file a claim for compensation on this form to avoid having the employee fill out and file a separate detailed form. Separate claim forms are available if the employer does not want the worker to use this form. Do not delay in submission of this form if employee is not available to sign below.

EMPLOYEE'S CLAIM FOR COMPENSATION
INJURED EMPLOYEE'S NOTE: An injured employee may use the form below to make a claim for compensation, or the employee may fill out and submit a separate detailed form that is available from the Division.

List other types of work you have done: 1. 2. 3.
Education: [ ] Grade School [ ] High School [ ] College [ ] Other
How many members are in your immediate family?
Have you ever had an industrial injury before? Yes [X] No [ ]
If yes, in what state? Montana
Type of injury

I have carefully read the information as documented by the employer, and (except for any statements I may write below) I concur with the information and I hereby make claim for compensation benefits due me now or in the future under Montana's Workers' Compensation Act.

Signature of injured employee: X Lyle Siefke
Address: P O Box 941, Libby, MT 59923
City
Date: 8/6/86
Phone: 293-8594

I DO NOT concur with the following information documented by the employer

C0080157

Filing of this claim is authorization for release of medical records and records of the Social Security Administration

DWC-MIS FORM 37 — State Publishing Co., Helena, Mont.

MONTANA DIVISION OF WORKERS' COMPENSATION

815 Front S[illegible] / Helena, Montana 59604

DATE STAMP

EMPLOYER'S FIRST REPORT of Occupational Injury or Occupational Disease

SEND ORIGINAL TO INSURER:

CASE NO [redacted]

FIRM N[redacted] 2503

EMPLOYER COPY

INSTRUCTIONS - Every employer in Montana is required by law to complete this form immediately after every industrial accident to an employee which causes loss of time from work or requires medical attention. The original of this form must be immediately filed with the employer's insurer or the Division of Workers' Compensation, 815 Front Street, Helena, Montana 59601. All questions must be answered fully. If a question cannot be answered, please explain why.
Please print with a ball point pen or type.

FEDERAL OSHA REQUIREMENTS - The United States Department of Labor requires employers to maintain, in the employer's office, a record of occupational injuries. For the employer's convenience, this form has been designed to meet such requirements and to provide employers a record copy.

EMPLOYEE

FULL NAME OF INJURED EMPLOYEE: Lyle Edward Siefke

SOCIAL SECURITY NUMBER: 725-14-1074

EMPLOYEE'S HOME ADDRESS (Street or Box): P.O. Box 941

CITY: Libby

STATE: MT

ZIP CODE: 59923

OCCUPATION: Steam Engineer

SEX: M

DATE OF BIRTH (Mo / Day / Yr): 9 / 09 / 34

MARITAL STATUS: [X] Married [ ] Single

LENGTH OF TIME IN YOUR EMPLOYMENT: 10

WAGES

Employee's Gross Wage Rate is $ 10.89 Per: WEEK [ ] DAY [ ] HOUR [X] MO. [ ]

Days Worked Per Week: 5

Hours Worked Per Day: 8

If board or room is furnished state value reported per day to Internal Revenue Service $

Check one: [X] Full Time Employee [ ] Part Time Employee

Payroll Classification under which employee's wages were reported:

Employee's Pay Period: Monthly [ ] Semi-monthly [ ] Bi-weekly [ ] Weekly [ ] Other (explain) [ ]

Employee's gross earnings for last four (4) pay periods: (Date / Amount) (Date / Amount) (Date / Amount) (Date / Amount)

Will employee return to work during next scheduled shift? Yes [ ] No [X]

If no, will wage loss exceed 5 work days? Yes [X] No [ ] Not Sure [ ]

REG. DAYS OFF:

DATE WAGE LOSS BEGAN (Mo / Day / Yr): 11 / 03 / 82

DATE OF RETURN, if returned to work (Mo / Day / Yr):

ACCIDENT INFORMATION

Describe in full detail how accident happened, and give cause. Explain what employee was doing when injured.

Checking the steam lines in the old mill. He was looking up at the lines and he stepped into a hole in the floor and fell 9'8".

DATE OF INJURY: (month) 11 (day) 02 (year) 82 (hour) 1:30 (a.m. or p.m.) p.m.

What specific object or substance caused the injury? Hole in floor

Nature of the injury? (cut, fracture, etc.) Bruised back, hips, hands, behind

Part of body affected (leg, arm, back, head, etc.) hips, back, hands, legs etc.

Names of witnesses to accident: 1. Dennis Day 2.

Was place of accident on employer's premises? Yes [X] No [ ]

Place where accident occurred (address & city): 12 Miles N.E. of Libby, Montana (county) Lincoln

Was employee injured while in your employ? Yes [X] No [ ]

Were you notified, or did you have actual knowledge of the accident? Yes [X] No [ ]

If yes, date notified & how

Do you have any reason to question this accident? Yes [ ] No [X]

If yes, please explain fully

MEDICAL

Attending Physician's Name: Dr. Matthews

Address (Street or Box): [redacted] 402 Montana Ave. (City) Libby (State) MT (Zip Code) 59923

If Hospitalized, Hospital's Name: Address (Street or Box): (City): (State): (Zip Code):

EMPLOYER

EMPLOYER'S NAME: W. R. Grace & Co.

Commercial Name (doing business as):

Employer's mailing address (street or box): Box 609 (City) Libby (State) MT (Zip Code) 59923

Phone Number: 406-293-3746

Location of operation, if different from mailing address: 12 Miles N.E. of Libby, Montana

Nature of Business: Mining & Milling

Firm is a: (Check one) [ ] Sole proprietorship [ ] Partnership, or [X] Corporation

Was the injured employee: (Check if applicable) [ ] A sole proprietor, [ ] A working Partner, [ ] A Corporate Officer, or [ ] A member of the employer's (sole proprietor or partner) family, dwelling in the employer's household.

Prepared by: Alison Leader

Authorized Signature: [signature]

Official Title: Manager of Administration

Date: 11-15-82

ABOVE - DWC - MIS Form 37 - Employer's First Report (Rev. 8-78)

BELOW - DWC - MIS Form 54 - Claim for Compensation

EMPLOYEE'S CLAIM FOR COMPENSATION

EMPLOYER'S NOTE: For convenience purposes and if the worker is available, the form below has been provided so that an employer may allow an injured worker to file a claim for compensation on this form to avoid having the employee fill out and file a separate detailed form. Separate claim forms are available if the employer does not want the worker to use this form. Do not delay in submission of this form if employee is not available to sign below.

EMPLOYEE'S CLAIM FOR COMPENSATION

INJURED EMPLOYEE'S NOTE: An injured employee may use the form below to make claim for compensation, or the employee may fill out and submit a separate detailed form that is available from the Division.

List other types of work you have done: 1. 2. 3.

Education: [ ] Grade School [ ] High School [ ] College [ ] Other

How many members are in your immediate family?

Have you ever had an industrial injury before? Yes [ ] No [ ]

If yes, in what state?

Type of Injury

I have carefully read the information as documented by the employer, and (except for any statements I may write below) I concur with the information and I hereby make claim for compensation benefits due me now or in the future under Montana's Workers' Compensation Act.

Signature of injured employee: X Lyle E. Siefke

Address: P.O. Box 941 City: Libby Date: 11-08-82 Phone: 406-293-85[illegible] (Unlisted)

I DO NOT concur with the following information documented by the employer:

Filing of this claim is authorization for release of medical records and records of the Social Security Administration

C0080158

Medical IBR Ex22
Siefkie, Lyle

Zonolite
Construction Products Division

GRACE

TO: File

DATE: March 28, 1983

FROM: W.J. Melcher

SUBJECT: Bus-Propane Tanker Accident of January 31, 1983

CC: E.D. Lovick

At approximately 1530 the Mill Shift Bus left our property via the main gate with the following occupants:

1.	Dick Gostnell	Driver
2.	Jerry Ledum	Front seat, R. side
3.	Richard Viereck	2nd seat from rear, R. side
4.	Lucille Fields	Front seat, L. side
5.	Dale Moen	Back seat, L. side
6.	Lyle Siefke	3rd seat from front, R. side
7.	Ray Hartley	2nd seat from rear, L. side
8.	Monte Bennett	Back seat, L. side
9.	Rod Mitchell	2nd seat from front, L. side
10.	Orville Johnson	2nd seat from front, R. side

All of the occupants are employees of W. R. Grace & Co. and were on their way home after completing the day shift (0730-1530) except employee #9 & #10.

Passenger #9, Rod Mitchell is one of the bus owners who had just driven the bus from town.

Passenger #10, Orville Johnson is a day shift guard for Burns Guard Service. He had also just completed his shift at our main gate.

The road from W. R. Grace & Co. Libby Operations to Montana Highway 37 is gravel built and maintained by W. R. Grace & Co. At the time of the accident the road surface was very muddy with a frozen surface under the mud. This condition had existed for many days prior to the accident.

At about 1545, _____ miles from our main gate (4.6 miles from Montana Highway 37) the bus met a tractor tanker trailer unit; hauling propane from Libby to our property. The tanker was on a curve to the right going downhill and at this point the bus slid across the center of the road, striking the left front of the tractor unit.

The initial impact appreared to be at about the center of the left front wheel, from that point the impact continued down the side of the unit ending at the rear end of the left saddle tank. At that point the bus bounced back across the road and into the right hand (going downhill) ditch. Damage to the bus was confined to the left front area wheel and fender.

At approximately 1638 I came upon the accident on my way home. At that time the bus had been pulled from the ditch and the propane tanker was being towed up the hill by our motor grader. Mr. W.J. McCaig asked that I call the Montana Highway Patrol which I did.

Montana Highway Patrolman G. Criner (242) arrived at the accident scene at 1708, and began an investigation in which I assisted.

The driving surface at the apparent point of contact (both vehicles had been moved) was twenty-nine feet wide. The propane tanker occupied the outer twelve feet of the roadway. This left seventeen feet of roadway for the bus. The Montana Highway Patrol cited the bus driver for a basic rule violation (crossing the centerline). Rod Mitchell, the bus owner, who was a passenger on the bus agreed that his driver was going to fast for the road conditions.

As all of the bus occupants except Rod Mitchell had gone home. We did not interview any of them until the following day when they returned to work. All but one of the occupants of the bus agreed that the tanker was on the proper side of the road and that the bus was going too fast.

Lucille Fields told the investigating officer that the tanker was on the wrong side of the road. (This did not appear in the officer's final report.) Lucille Fields claimed some vague injury to her neck, but only after the officer explained that no future claim would be allowed if she did not have an injury in his report. She went to her doctor (Dr. W. T. Matthews) that evening which was over 24 hours after the accident. She returned to work the next day with a neck brace.

Jerry Ledum, who was holding the pipe stanchion at the right front seat, was pivoted around the stanchion and ended up sitting on the floor in the front doorway. He was not injured.

There were no other injuries or incidents reported.

The bus was as follows:

1976 Dodge - License No. MT 56T-B611

Driver - Dick Gostnell who is employed
by Mitchell Bus Co.

Insurance - USF&G Policy No. BAP373819

The tractor was as follows:

1980 White Freightliner - License No. WY 1452

Driver - Ron A. Kaski
P.O. Box 483
Lakeside, MT

Employer - Cal Gas Corp. out of Kalispell, MT.

Owner - Cal Gas Corp.

Insurance - Aetna Policy No. 05AL189534SCA

The Montana Highway Patrol filed a complete accident report as the roadway is a Forest Service access road even though we built and maintain it.

WJM/al

C0080161

WRG00299210
ED_005351_00000355-00297

IAR Ex 22

Medical
Siefke, Lyle

WRG00299211

ED_005351_00000355-00298

06063085

Industrial Accident Board, Helena, Montana, Form 37 Revised

Industrial Accident Board

HELENA, MONTANA

Firm No.....

File No.....

EMPLOYER'S FIRST REPORT OF INJURY

DO NOT WRITE IN THIS SPACE

INSTRUCTIONS—Employer must complete form at once after every accident which causes loss of time from work or requires medical attention and mail it to the Industrial Accident Board, Helena, Montana. Form must be signed in pen and ink. ALL QUESTIONS MUST BE ANSWERED FULLY.

INJURED EMPLOYEE

Full name of injured employee: Lyle Siefke Occupation: Construction Worker

Mailing address: Route 1 Box 885-1 Libby How long has he been in your employ: 4½ yrs.

Social Security No. 725-14-1074 Sex: M Age: 33 Married ☐ Single ☒

EARNINGS

Monthly Wage..... Weekly Wage..... Daily Wage..... Hourly Wage: 2.96

Receive board Yes ☐ No ☒ Daily Value..... Receive room Yes ☐ No ☒ Daily Value.....

Piece Worker Yes ☐ No ☐ If yes, give method of computing earnings.....

Number of hours worked per day: 8 Days worked per week: 5 Employee's pay period?

Monthly ☐ Semi monthly ☒ Weekly ☐ List employee's earnings last 4 pay periods 1: 296.74

2: 296.00 3: 296.00 4: 189.44

Under what payroll classification has employees' wages been reported?..... (Sawmill - Mechanic - Etc.)

ACCIDENT AND INJURY

Describe in full how accident happened and GIVE CAUSE: While loading a box car at the export dock, wrenched right shoulder.

Part of body injured? Describe fully: right shoulder

Names of witnesses to accident 1: Bill Harris 2.....

Date of accident: 2-7- 19 68 Hour..... A.M. Was employee injured in course of employment? Yes ☒ No ☐

Place where accident occured: our export dock, (Address) Libby (City) Lincoln (County)

Did you or employee's supervisor have actual knowledge of accident? Yes ☒ No ☐

Were you notified of accident by injured employee? Yes ☒ No ☐ How: in person Date: 2-8-68

Have you reason to question this accident? Yes ☐ No ☒ If "yes" explain fully.....

SAFETY

Was employee's accident due to unsafe work practices? Yes ☐ No ☒ If "yes", what did he do unsafely?

Was a specific device, object or substance involved in accident? Yes ☐ No ☒ If "yes", name specific device, object or substance..... Was device or object defective? Yes ☐ No ☐

Was employee doing regular work when injured? Yes ☒ No ☐ Was employee trained to do work he was doing when injured? Yes ☒ No ☐ Were adequate safe guards provided? Yes ☐ No ☐ If "yes" were they being used at time of accident? Yes ☐ No ☐

MEDICAL ATTENDANCE

Name of attending physician: Dr. James F. Graham Address: Libby, Montana

Was employe hospitalized? Yes ☐ No ☒ Name of hospital: St. Johns for Address: X-rays

Was first aid administered by someone other than attending physician? Yes ☐ No ☒

TIME AND WAGE LOSS

Will employe lose time from work due to accident? Yes ☐ No ☒ How long?.....

If injury results in time loss, will employee, while disabled, receive sick leave benefits? Yes ☐ No ☐

Paid vacation? Yes ☐ No ☐

Will employe lose wages? Yes ☐ No ☐ Room? Yes ☐ No ☐ Board? Yes ☐ No ☐

Date wage loss began: NONE Amount of weekly wage loss.....

EMPLOYER

Name of employer: Zonolite Division-W.R.Grace & Co.

Address: Libby, Montana Nature of business: Mining & Milling Vermiculite

IS FIRM A CORPORATION ☒ OR PARTNERSHIP ☐ OR INDIVIDUAL ☐

IF
- Corporation—is injured employee an officer or director of corporation? Yes ☐ No ☒
- Partnership—is injured employee related to any partner? Yes ☐ No ☐ Relationship.....
- Individual—is injured employee related to employer? Yes ☐ No ☐ Relationship.....

Signed, this 29th day of February 19 68

Employer's Name: Zonolite Division-W.R.Grace & Co.

Signed by.....

at: Libby Montana

Official Title.....

NOTICE—EMPLOYEE'S CLAIM FOR COMPENSATION, FORM 54, MUST BE FILED WITHIN 12 MONTHS FROM DATE OF ACCIDENT

Form 1-HU-163-ZR

Firm No. | File No. | Major Industry | County | Date of Acc. | Time | Sex & Marital Status | Age | Mont. Code | Acc. Class | Occupation | Type | Agency | Agency Part | Nature of Inj. | Location | Time Loss | Mech. Defect | Unsafe Act | Pers. Factor | Weekly Wage

C0080162

WRG00299212

ED_005351_00000355-00299

PATCH II

W.R. Grace Fall 2000 Document Production Target Sheet

- [ ] Notice
  - [ ] Testing
  - [ ] Agency
- [ ] Libby Ore/Operations
- [x] Libby All Other
- [ ] Expanding Plant (see below)
- [ ] Non-Grace Expanding Plant
- [ ] Attic Insulation
- [ ] Agricultural/ Horticultural Products
- [ ] Other Consumer Products
- [ ] Workers Comp
- [ ] Medical Records and Other Personal Confidental
- [ ] Privilege
- [ ] Trade Secret

- [ ] All
- [ ] Invoices

- [ ] Albany, N.Y.
- [ ] Atlanta, Georgia
- [ ] Birmingham, Alabama
- [ ] Boca Raton, Florida
- [ ] Chicago, Illinois (Blue Island)
- [ ] Dallas, Texas
- [ ] Dearborn, Michigan
- [ ] Denver, Colorado
- [ ] Easthampton, Mass.
- [ ] Ellwood City, Penn.
- [ ] Enoree, S. Carolina
- [ ] Hialeah, Florida
- [ ] High Point, N. Carolina
- [ ] Irondale, Alabama
- [ ] Jacksonville, Florida
- [ ] Kansas City, Missouri
- [ ] Kearny, S. Carolina
- [ ] Kenilworth Ave. Washington D.C.
- [ ] Los Angeles, Calif.
- [ ] Milwaukee, Wisconsin
- [ ] Minneapolis, Minn. (Western Min. Prod.)
- [ ] Muirkirk, Maryland (Beltsville)
- [ ] Nashville, Tennessee
- [ ] Newark, California
- [ ] New Castle, Pennsylvania
- [ ] New Orleans, Louisiana
- [ ] North Billerica, Mass.
- [ ] North Little Rock, Ark.
- [ ] Oklahoma City, Oklahoma
- [ ] Omaha, Nebraska (Western Min. Prod.)
- [ ] Phoenix, Arizona (Glendale)
- [ ] Pompano Beach, Florida
- [ ] Portland, Oregon
- [ ] Rio Piedras, Puerto Rico
- [ ] Sacramento, Calif.
- [ ] San Antonio, Texas
- [ ] Santa Ana, California
- [ ] Savannah, Georgia
- [ ] Sharpsburg, Penn.
- [ ] Spokane, Washington
- [ ] St. Louis, Missouri
- [ ] Tampa, Florida
- [ ] Travelers Rest, S. Carolina
- [ ] Trenton, New Jersey (East Trenton)
- [ ] Utica, New York
- [ ] Weedsport, N. Y. (Brutus)
- [ ] West Chicago, Illinois
- [ ] Wilder, Kentucky (Newport)

- [ ] Canadian Expanding plants

F19

IAR Ex22

Medical
Siefke, Lyle

06063370

Industrial Accident Board

HELENA, MONTANA

Firm No. 2503

File No.

EMPLOYER'S FIRST REPORT OF INJURY

INSTRUCTIONS—Employer must complete form at once after every accident which causes loss of time from work or requires medical attention and mail it to the Industrial Accident Board, Helena, Montana. Form must be signed in pen and ink. ALL QUESTIONS MUST BE ANSWERED FULLY.

INJURED EMPLOYEE

Full name of injured employee: Lyle ~~XXXX~~ Siefke Occupation: Mill Worker

Mailing address: Route 1 Box 885-1, Libby, Montana (Street, City) How long has he been in your employ? 7 years

Social Security No. 725-14-1074 Sex: M Age: 36 Married ☒ Single ☐

EARNINGS

Monthly Wage ____ Weekly Wage ____ Daily Wage ____ Hourly Wage 3.65

Receive board Yes ☐ No ☒ Daily Value ____ Receive room Yes ☐ No ☒ Daily Value ____

Piece Worker Yes ☐ No ☒ If yes, price per unit at piece work ____ Hours worked per day 8

Days worked per week 6 Employee's pay period? Monthly ☐ Semi-monthly ☒ Weekly ☐ List employee's earnings last 4 pay periods 1. 343.16 2. 375.40 3. 427.00 4. 420.16

List Payroll Classification and Code under which employee's wages were reported ____ (Sawmill - Mechanic - Etc.) Code ____ (2702, 5506, 8810)

ACCIDENT AND INJURY

Describe in full how accident happened and GIVE CAUSE: Had been working on 6th floor of mill, was coming down stairs to 5th floor, got something in left eye. (Vermiculite dust).

Nature or extent of injury: foreign material in (Cut - Fracture) Part of body injured? left eye (Leg - Arm - Back - Head)

Names of witnesses to accident 1. Welcie Maynard 2. ____

Date of accident 3-12-71 19____ Hour 11:15 ~~A.M.~~ P.M. Was employee injured in course of employment? Yes ☒ No ☐

Place where accident occurred: our mill (Address) Libby (City) Lincoln (County)

Did you or employee's supervisor have actual knowledge of accident? Yes ☒ No ☐

Were you notified of accident by injured employee? Yes ☒ No ☐ How: in person Date: 3-15-71

Have you reason to question this accident? Yes ☐ No ☒ If "yes" explain fully ____

SAFETY

Was employee's accident due to unsafe work practice? Yes ☐ No ☒ If "yes", what did he do unsafely? ____

Was a specific device, object or substance involved in accident? Yes ☐ No ☒ If "yes", name specific device, object or substance ____ Was device or object defective? Yes ☐ No ☐

Was employee doing regular work when injured? Yes ☒ No ☐ Was employee trained to do work he was doing when injured? Yes ☒ No ☐ Were adequate safeguards provided? Yes ☐ No ☐ If "yes", were they being used at the time of accident? Yes ☐ No ☐

MEDICAL ATTENTION

Name of attending physician: W. T. Matthews, M.D. Address: Libby, Montana

Was employee hospitalized? Yes ☐ No ☒ Name of hospital ____ Address ____

Was first aid administered by someone other than attending physician? Yes ☐ No ☒

TIME AND WAGE LOSS

Will employee lose time from work due to accident? Yes ☐ No ☒ How long? ____ If injury results in time loss will employee, while disabled, received sick leave benefits? Yes ☐ No ☐ Paid vacation? Yes ☐ No ☐ Will employee lose wages? Yes ☐ No ☐ Room? Yes ☐ No ☐ Board? Yes ☐ No ☐

Date wage loss began: NONE Amount of weekly wage loss ____

EMPLOYER

Name of employer: Construction Products Division-W.R. Grace & Co.

Address: Libby, Montana ~~XX~~ Nature of Business: Mining & Milling Vermiculite

IS FIRM A CORPORATION ☒ OR PARTNERSHIP ☐ OR INDIVIDUAL ☐

IF
- Corporation—is injured employee an officer or director of corporation? Yes ☐ No ☒
- Partnership—is injured employee related to any partner? Yes ☐ No ☐ Relationship ____
- Individual—is injured employee related to employer? Yes ☐ No ☐ Relationship ____

Signed, this 31st day of March, 19 71

at Libby, Montana

Employer's Name: Construction Products Division W. R. Grace & Co.

Signed by ____

Official Title ____

NOTICE—EMPLOYEE'S CLAIM FOR COMPENSATION, FORM 54, MUST BE FILED WITHIN 12 MONTHS FROM DATE OF ACCIDENT.

C0080164

WRG00299216

ED_005351_00000355-00303

Medical IBR Ex 22
Siefke, Lyle

GRACE

Zonolite
Construction Products Division

TO: Lyle Siefke DATE: January 27, 1989

FROM: Mary Jo Zwang

cc: Terry Jacobs, Alan Stringer, J B Henderson (Lexington)

Previously you were told that your hearing shows a standard threshold shift. In order to verify this shift Dr. Oehrtman was going to conduct an on-site exam. This will not be possible since neither W. R. Grace nor St. John's Lutheran Hospital have the appropriate equipment. Therefore, please set up an appointment before June 1, 1989 with Dr. Karl Oehrtman's audiologist in Kalispell (752-4141). Please notify me of your appointment date so that I can ensure Dr. Oehrtman's office receives a copy of your hearing file.

Please note that only the doctor's fee will be covered by W. R. Grace. If you choose to have no further testing the attached waiver form must be completed and returned to me.

As always, we strongly recommend that you wear hearing protection when around loud noise either at work or at home to protect your ears from damage.

Mary Jo Zwang

C0080165

Medical

Shrewsberry, Harold IRR Exig

DUPLICATE DUPLICATE

trial Accident Board, Helena, Montana, Form 37 Revised—YM - U - WU STATE PUBLISHING CO., HELENA, MONT. 3

Industrial Accident Board

HELENA, MONTANA

No.....

No.....

EMPLOYER'S FIRST REPORT OF INJURY

INSTRUCTIONS—Employer must complete form at once after every accident which causes loss of time from work or requires medical attention and mail it to the Industrial Accident Board, Helena, Montana. Form must be signed in pen and ink. ALL QUESTIONS MUST BE ANSWERED FULLY.

INJURED EMPLOYEE

Full name of injured employee Harold Shrewsberry Occupation Sheet Metal Worker

Mailing address Box 1013 (Street) Libby (City) How long has he been in your employ 10 yrs.

Social Security No. 236-05-7271 Sex M Age 42 Married ☒ Single ☐

EARNINGS

Monthly Wage..... Weekly Wage..... Daily Wage..... Hourly Wage 2.465

Receive board Yes ☐ No ☒ Daily Value..... Receive room Yes ☐ No ☒ Daily Value.....

Piece Worker Yes ☐ No ☐ If yes, price per unit at piece work..... Hours worked per day 8

Days worked per week 5 Employee's pay period? Monthly ☐ Semi-monthly ☒ Weekly ☐ List employee's earnings last 4 pay periods 1 266.22 2 256.36 3 226.78 4 236.64

List Payroll Classification and Code under which employee's wages were reported..... (Sawmill - Mechanic - Etc.) Code..... (2702, 5506, 8810)

ACCIDENT AND INJURY

Describe in full how accident happened and GIVE CAUSE

While carrying 12 ft. piece of steel in sheet metal shop, strained muscles in back.

Nature or extent of injury strained muscle (Cut - Fracture) Part of body injured? right side of back (Leg - Arm - Back - Head)

Names of witnesses to accident 1..... 2.....

Date of accident 8-6-62 19..... Hour 3:00 ~~A.M.~~ P.M. Was employee injured in course of employment? Yes ☒ No ☐

Place where accident occurred..... Libby (Address) Lincoln (City) (County)

Did you or employee's supervisor have actual knowledge of accident? Yes ☒ No ☐

Were you notified of accident by injured employee? Yes ☒ No ☐ How by employee Date 8-9-62

Have you reason to question this accident? Yes ☐ No ☒ If "yes" explain fully.....

SAFETY

Was employee's accident due to unsafe work practice? Yes ☐ No ☒ If "yes", what did he do unsafely?.....

Was a specific device, object or substance involved in accident? Yes ☐ No ☒ If "yes," name specific device, object or substance..... Was device or object defective? Yes ☐ No ☐

Was employee doing regular work when injured? Yes ☒ No ☐ Was employee trained to do work he was doing when injured? Yes ☒ No ☐ Were adequate safeguards provided? Yes ☒ No ☐ If "yes," were they being used at the time of accident? Yes ☒ No ☐

MEDICAL ATTENTION

Name of attending physician Dr. R. D. MacKenzie Address Libby, Montana

Was employee hospitalized? Yes ☐ No ☒ Name of hospital..... Address.....

Was first aid administered by someone other than attending physician? Yes ☐ No ☐

TIME AND WAGE LOSS

~~Will employee lose time from work due to accident? Yes ☐ No ☒ How long?~~ If injury results in time loss will employee, while disabled, receive sick leave benefits? Yes ☐ No ☐ Paid vacation? Yes ☐ No ☐ Will employee lose wages? Yes ☐ No ☐ Room? Yes ☐ No ☐ Board? Yes ☐ No ☐

Date wage loss began none Amount of weekly wage loss.....

EMPLOYER

Name of employer Zonolite Company

Address Libby, Montana Nature of business Mining & Milling Vermic

IS FIRM A CORPORATION ☒ OR PARTNERSHIP ☐ OR INDIVIDUAL ☐

IF
- Corporation—is injured employee an officer or director of corporation? Yes ☐ No ☒
- Partnership—is injured employee related to any partner? Yes ☐ No ☐ Relationship.....
- Individual—is injured employee related to employer? Yes ☐ No ☐ Relationship.....

ed. this 19th day of September, 19 62

Libby, Montana

Employer's Name Zonolite Company

Signed by.....

Official Title Secretary

NOTICE—EMPLOYEE'S CLAIM FOR COMPENSATION, FORM 54, MUST BE FILED WITHIN 12 MONTHS FROM DATE OF ACCIDENT.

C0080099

Medical
Shrewsberry, Harold IRR Ex 22

INDUSTRIAL ACCIDENT BOARD, HELENA, MONT. FORM NO. 43—IM 1-57 81907 TRIBUNE PRINTING & SUPPLY CO., GREAT FALLS, MONTANA

Plan No.....

Industrial Accident Board

HELENA, MONTANA

Claim Department

Firm No.....
Claim No.....
Accident No.....
Employee No.....
DO NOT FILL IN

Employer's Supplemental Report Of Injury

This notice to be filled out by employer and sent to the Industrial Accident Board, at Helena, Montana, immediately upon employee's returning to work fully recovered if within two weeks—or upon his death or at the expiration of two weeks from date of injury.

Name of injured employee: Harold Shrewsberry

Address: Box 1013, Libby, Montana

Injured: March 21, 19 60

If worked after accident, last date worked? Worked on through to March 28, took day off to see doctor that date.

Is injured employee fully recovered? yes On what date? March 31, 1960

Has he/she returned to work for you? yes On what date? March 29, 1960

Has he/she accepted other employment? On what date?

If so, where now employed?

Has he/she died? If so, when?

Signed: Zonolite Company

Address: Libby, Montana

Dated: April 4, 19 60

C0080100

STRIAL ACCIDENT BOARD, HELENA, MONTANA. FORM 37 REVISED. 2M 5-59 19933

Industrial Accident Board

HELENA, MONTANA

Claim Department

n No. _____

m No. _____

ident No. _____

DO NOT FILL IN

EMPLOYER'S FIRST REPORT OF INJURY

DO NOT WRITE IN THIS SPACE

INSTRUCTIONS—The employer must fill out this form and return same to Industrial Accident Board, Helena, atana, at once after every accident which causes any loss of work or requires medical attention. In filling out form use pen or typewriter.

MPLOYER, LACE AND TIME

Employer's name: Zonolite Company

Office address: Libby, Montana (Street and number, city or town)

Nature of business: Mining and Milling (Type of construction, manufacturing, etc.)

Did accident occur on work for a public corporation? No

Location of plant or place of work where accident occurred: Same (Street and Number)

In what city or village? Libby County? Lincoln

Date of accident: March 21, 1960; hour of day: 2:00 ~~A.M.~~ P.M.

Did accident happen on premises? Yes

If away from the plant, state where?

Was employee injured in the course of employment? Yes

THE INJURED MPLOYEE

Give full name of injured workman: Harold Shrewsberry

Mailing address: Box 1013, Libby, Montana (Street and number, city or town and county)

Sex: M Age: 39 Speak English? Yes If not, what language?

Occupation when injured? Millwright Married or single? Married

Was injured employee on duty at time of accident? yes If not, state fully on back hereof (See Form 87-a)

How long was injured person in your employment? 8 years

AUSE OF INJURY

Described in full how the accident occurred (DO NOT FAIL TO DO THIS): While installing new separating tables, and working around acid ~~tank~~ barrels, which were overhead, there was a leak in one of the barrels, and acid splashed onto table, and into eyes of employes.

THE INJURY

State nature and extent of injury according to your own information. (We do not need the doctor's report here) Foreign matter (acid) in eyes.

WILL EMPLOYEE LOSE TIME? YES ~~XX~~ NO

DATE WAGE LOSS BEGAN? 3-29-60 PROBABLE DURATION OF WAGE LOSS? unknown (Give your best estimate)

MEDICAL TENDANCE

Name and address of physician attending injured employee: Dr. R. D. MacKenzie, Libby, Montana

To what hospital was employee sent? none

If not sent to hospital, where is he? home

Are you still providing medical attendance? yes Have you a hospital contract? no

WAGES

Monthly wage (If paid by month) _____ Weekly wage (If paid by week) _____ Daily wage (If paid by day) _____ Rate per hour (If paid by hour) 2.325

Number of hours per day 8 How many working days per week 5

If employee receives board in addition to money wage, state how many meals per day none

Does he receive room in addition to money wage? no

AGE LOSS

How much money wage will employee lose per day because of accident? $18.60

How much board? none Will he lose room? no

OTICE OF INJURY

Were you notified by the injured employee of his injury? yes If so, how and when? by employee (Write on back of this form if necessary)

Did you or your managing superintendent in charge of work of injured employee at time of injury have actual knowledge of such accident and injury? yes If so, explain how by employee (Write on back of this form if necessary)

ed. this 29th day of March, 19 60

Employer's Name: Zonolite Company

Signed by: _____

Libby, Montana

Official Title: Secretary

C00B0101

Firm No.

Acc. No.

Major Industry

County

Date of Acc.

Time

Sex & Marital Status

Age

Mont. Code

Acc. Class

Occupation

Type

Agency

Agency Part

Nature of Inj.

Location

Ext. of Dis.

Mech. Defect

Unsafe Act

Pers. Factor

Weekly Wage

Report Lag

Carrier

TICE—Employer should have injured workmen fill out Form 37-A and return same to Board with Employer's First Report of Injury.

Medical
Shrewsberry, Harold IRR Ex 22

STRIAL ACCIDENT BOARD, HELENA, MONTANA. FORM 37 REVISED. 2M 6-59 18933

Industrial Accident Board

HELENA, MONTANA

Claim Department

m No.
m No.
ident No.

DO NOT FILL IN

EMPLOYER'S FIRST REPORT OF INJURY

DO NOT WRITE IN THIS SPACE

INSTRUCTIONS—The employer must fill out this form and return same to Industrial Accident Board, Helena, ntana, at once after every accident which causes any loss of work or requires medical attention. In filling out form use pen or typewriter.

MPLOYER, LACE AND TIME

Employer's name: Zonolite Company

Office address: Libb , Montana (Street and number, city or town)

Nature of business: Mining and Milling (Type of construction, manufacturing, etc.)

Did accident occur on work for a public corporation? No

Location of plant or place of work where accident occurred: Same (Street and Number)

In what city or village? Libby County? Lincoln

Date of accident: April 5, 160; hour of day: 9:30 A.M. P.M.

Did accident happen on premises? Yes

If away from the plant, state where?

Was employee injured in the course of employment? Yes

THE INJURED MPLOYEE

Give full name of injured workman: Harold Shrewsberry

Mailing address: Box 1013, Libby, Montana (Street and number, city or town and county)

Sex: M Age: 39 Speak English? Yes If not, what language?

Occupation when injured? Millwright Married or single? Married

Was injured employee on duty at time of accident? Yes If not, state fully on back hereof (See Form 87-a)

How long was injured person in your employment? 8 years

CAUSE OF INJURY

Described in full how the accident occurred (DO NOT FAIL TO DO THIS)

While driving steel punch, end shattered, slivers of steel became imbedded in left hand.

THE INJURY

State nature and extent of injury according to your own information. (We do not need the doctor's report here) Foreign object in hand.

WILL EMPLOYEE LOSE TIME? YES NO XX

DATE WAGE LOSS BEGAN? PROBABLE DURATION OF WAGE LOSS? (Give your best estimate)

MEDICAL TENDANCE

Name and address of physician attending injured employee: Dr. R. D. MacKenzie Libby, Montana

To what hospital was employee sent? none

If not sent to hospital, where is he? working

Are you still providing medical attendance? yes Have you a hospital contract? no

WAGES

Monthly wage (If paid by month) Weekly wage (If paid by week) Daily wage (If paid by day) Rate per hour (If paid by hour) 2.325

Number of hours per day: 8 How many working days per week: 5

If employee receives board in addi to money wage, state how many meals per day: none

Does he receive room in addition to ey wage? no

AGE LOSS

How much money wage will employee l per day because of accident? none

How much board? none Will he lose room? no

OTICE OF INJURY

Were you notified by the injured employee of is injury? yes If so, how and when? by employee (Write on back of this form if necessary)

Did you or your managing superintendent in ch of work of injured employee at time of injury have actual knowledge of such accident and inj yes If so, explain how by employee (Write on back of this form if necessary)

ed, this 5th day of April, 19 60

Employer's Name: Zonolite Company

Signed by

Libby, Montana

Official Title: Secretary

C0080102

TICE—Employer should have injured workmen fill out Form 37-A and return sam to Board with Employer's First Report of Injury.

Firm No.
Acc. No.
Major Industry
County
Date of Acc.
Time
Sex & Marital Status
Age
Mont. Code
Acc. Class
Occupation
Type
Agency
Agency Part
Nature of Inj.
Location
Ext. of Dis.
Mech. Defect
Unsafe Act
Pers. Factor
Weekly Wage
Report Lag
Carrier

Medical

Shrewsberry, Harold IRR Ex 22

Industrial Accident Board, Helena, Montana. Form No. 54—500 7-57 85247

Plan No._____

Industrial Accident Board

HELENA, MONTANA

CLAIM DEPARTMENT

Firm No._____

Claim No._____

Accident No._____

DO NOT FILL IN

Employee's Claim for Compensation in Case of Injury

INSTRUCTIONS—To facilitate prompt payment of compensation the injured employee, or someone for him, should write carefully (using ink or typewriter) answers to the following questions, and mail the same directly to the Board, within 30 days after date of injury.

I hereby make claim for compensation for an injury resulting in disability, due to an accident occurring 5th day of December, 19 58, arising out of and in the course of my employment by Zonolite Company of Libby, Montana

My claim is: providing—Total Disabled

From, what date December 5, 19 58

Are you now disabled? No If not, on what date were you able to return to work? December 15, 19 58. If still disabled, how long do you estimate disability to continue?_____

IF PARTIALLY DISABLED: From what date?_____, 19____ Are you still partially disabled?_____ If not, on what date did disability cease?_____, 19____

If still partially disabled, how long do you estimate disability will continue?_____

By how much have your daily earnings been reduced by this injury? $18.00

Have you contributed to Hospital Fund? No

Place Of Accident

In proof of such claim I make the following statements under oath:

Location of plant where accident occurred Libby, Montana

In what city or village? Libby, County? Lincoln

If away from employer's premises or plant, state where accident happened_____

The Injured Employee

Full name of injured employee Harold O. Shrewsberry

Address where mail should be sent Box 1013, Libby, Montana
(Street and number, city or village and county.)

Sex? M Age? 38 Do you speak English? Yes

If not, what language?_____ Are you married or single? Married

Where were you born? BNX Gloustor, Ohio

State occupation when injured? Millwright

How long have you worked at this occupation? 4 years

How long have you worked for present employer? 6-1/2 years

Were you doing your regular work when injured? Yes

Piece or time worker? Time How many days per week? 5

Describe how accident occurred? While trying to reach light switch in darkened area of mill, slipped and fell into ore hopper.

(OVER) TRIBUNE PRINTING & SUPPLY CO., GREAT FALLS, MONTANA

C0080103

INDUSTRIAL ACCIDENT BOARD, HELENA, MONT. FORM NO. 43—IN 1-57 81907 TRIBUNE PRINTING & SUPPLY CO., GREAT FALLS, MONTANA

Plan No.....

Industrial Accident Board

HELENA, MONTANA

Claim Department

Firm No.....
Claim No.....
Accident No.....
Employee No.....
DO NOT FILL IN

Employer's Supplemental Report Of Injury

This notice to be filled out by employer and sent to the Industrial Accident Board, at Helena, Montana, immediately upon employee's returning to work fully recovered if within two weeks—or upon his death or at the expiration of two weeks from date of injury.

Name of injured employee Harold Shrewsberry

Address XX Box 1013, Libby, Montana

Injured December 5, 19 58

If worked after accident, last date worked?

Is injured employee fully recovered? Yes On what date? December 15, 1958

Has he/she returned to work for you? Yes On what date? December 15, 1958

Has he/she accepted other employment? On what date?

If so, where now employed?

Has he/she died? If so, when?

Signed: Zonolite Company
By:

Address Libby, Montana

Dated December 22, X 19 58

C0080104

INDUSTRIAL ACCIDENT BOARD, HELENA, MONTANA. FORM 37 REVISED. 28 8-57 84820

Industrial Accident Board

HELENA, MONTANA

Claim Department

Claim No.

Case No.

Accident No.

EMPLOYER'S FIRST REPORT OF INJURY

INSTRUCTIONS—The employer must fill out this form and return same to Industrial Accident Board, Helena, Montana, at once after every accident which causes any loss of work or requires medical attention. In filling out this form use pen or typewriter.

EMPLOYER, PLACE AND TIME

Employer's name: Zonolite Company

Office address: Libby, Montana (Street and number, city or town)

Nature of business: Mining and Milling Vermiculite (Type of construction, manufacturing, etc.)

Did accident occur on work for a public corporation? No

Location of plant or place of work where accident occurred: Libby (Street and Number)

In what city or village? Libby County? Lincoln

Date of accident: 12-5- , 19 58 ; hour of day: 8:00 A.M. P.M.

Did accident happen on premises? Yes

If away from the plant, state where?

Was employee injured in the course of employment? Yes

THE INJURED EMPLOYEE

Give full name of injured workman: Harold Shrewsbarry

Mailing address: Box 1013, Libby, Montana (Street and number, city or town and county)

Sex: M Age: 38 Speak English? Yes If not, what language?

Occupation when injured? Millwright Married or single? Married (See Form 37-a)

Was injured employee on duty at time of accident? Yes If not, state fully on back hereof

How long was injured person in your employment? 6 years

CAUSE OF INJURY

Described in full how the accident occurred (DO NOT FAIL TO DO THIS)

While trying to reach light switch in darkened area of mill, slipped and fell into raw ore hopper.

THE INJURY

State nature and extent of injury according to your own information. (We do not need the doctor's report here) Torn ligaments in left knee.

WILL EMPLOYEE LOSE TIME? YES XX NO

DATE WAGE LOSS BEGAN? 12-5-58 PROBABLE DURATION OF WAGE LOSS? one week (Give your best estimate)

MEDICAL ATTENDANCE

Name and address of physician attending injured employee: Dr. Paul Seifert, Libby, Montana

To what hospital was employee sent? None

If not sent to hospital, where is he? home

Are you still providing medical attendance? NO Have you a hospital contract? NO

WAGES

Monthly wage (If paid by month) Weekly wage (If paid by week) Daily wage (If paid by day) Rate per hour 2.25 (If paid by hour)

Number of hours per day 8 How many working days per week 5

If employee [illegible] money wage, state how many meals per day none

How [illegible] money wage? xxx no

WAGE LOSS

How much money wage will employee lose per day because of accident? $18.00

How much board? none Will he lose room? no

NOTICE OF INJURY

Were you notified by the injured employee of his injury? yes If so, how and when? by employee (Write on back of this form if necessary)

Did you or your managing superintendent, in charge of work of injured employee at time of injury have actual knowledge of such accident and injury? Yes If so, explain how by employee (Write on back of this form if necessary)

Signed this 12th day of December, 19 58

Employer's Name: Zonolite Company

Signed by

Official Title: Secretary

Libby, Montana

NOTICE—Employer should have injured workman [illegible] return same to Board with Employer's First Report of Injury.

C0080105

Claim No. | Case No. | Employer | Occupation | Type | Agency | Agency Part | Nature of Inj. | Injured | Dist. of Inj. | Mach. Defect | Comp. Act | Form. Factor | Weekly Wage | Support Leg | Carrier | Acc. Class | Mard. Code | Age | Sex & Marital Status | Time | Date of Acc. | County | Mailing Address | Name

IRR Ex 22

Medical Shrewsberry, Harold

06062231

Industrial Accident Board, Helena, Montana. Form No. 54—500 7-57 85247 Plan No.

Industrial Accident Board

HELENA, MONTANA

CLAIM DEPARTMENT

Firm No.

Claim No.

Accident No.

DO NOT FILL IN

Employee's Claim for Compensation in Case of Injury

INSTRUCTIONS—To facilitate prompt payment of compensation the injured employee, or someone for him, should write carefully (using ink or typewriter) answers to the following questions, and mail the same directly to the Board, within 30 days after date of injury.

I hereby make claim for compensation for an injury resulting in disability, due to an accident occurring 5th day of December, 19 58, arising out of and in the course of my employment by Zonolite Company of Libby, Montana

My claim is: providing—Total Disabled

From, what date December 5, 19 58

Are you now disabled? No If not, on what date were you able to return to work? December 15, 19 58. If still disabled, how long do you estimate disability to continue?

IF PARTIALLY DISABLED: From what date?, 19 Are you still partially disabled? If not, on what date did disability cease?, 19

If still partially disabled, how long do you estimate disability will continue?

By how much have your daily earnings been reduced by this injury? $18.00

Have you contributed to Hospital Fund? No

In proof of such claim I make the following statements under oath:

Place Of Accident

Location of plant where accident occurred Libby, Montana

In what city or village? Libby, County? Lincoln

If away from employer's premises or plant, state where accident happened

The Injured Employee

Full name of injured employee Harold O. Shrewsberry

Address where mail should be sent Box 1013, Libby, Montana
(Street and number, city or village and county.)

Sex? M Age? 38 Do you speak English? Yes

If not, what language? Are you married or single? Married

Where were you born? EBX Glouster, Ohio

State occupation when injured? Millwright

How long have you worked at this occupation? 4 years

How long have you worked for present employer? 6-1/2 years

Were you doing your regular work when injured? Yes

Piece or time worker? Time How many days per week? 5

Describe how accident occurred? While trying to reach light switch in darkened area of mill, slipped and fell into ore hopper.

(OVER)

TRIBUNE PRINTING & SUPPLY CO., GREAT FALLS, MONTANA

C0080106

WRG00299233

ED_005351_00000355-00318

INDUSTRIAL ACCIDENT BOARD, HELENA, MONT. FORM NO. 43-IM 1-57 61907 TRIBUNE PRINTING & SUPPLY CO., GREAT FALLS, MONTANA

06062232

Plan No.....

Industrial Accident Board

HELENA, MONTANA

Claim Department

Firm No.....

Claim No.....

Accident No.....

Employee No.....

DO NOT FILL IN

Employer's Supplemental Report Of Injury

This notice to be filled out by employer and sent to the Industrial Accident Board, at Helena, Montana, immediately upon employee's returning to work fully recovered if within two weeks—or upon his death or at the expiration of two weeks from date of injury.

Name of injured employee **Harold Shrewsberry**

Address **XX Box 1013, Libby, Montana**

Injured **December 5**, 19 **58**

If worked after accident, last date worked?.....

Is injured employee fully recovered? **Yes** On what date? **December 15, 1958**

Has he/she returned to work for you? **Yes** On what date? **December 15, 1958**

Has he/she accepted other employment? ..... On what date? .....

If so, where now employed? .....

Has he/she died? ..... If so, when? .....

Signed: **Zonolite Company**

By:

Address **Libby, Montana**

Dated **December 22, K**, 19 **58**

C0080107

Industrial Accident Board, Helena, Montana, Form 37 Revised. 10-8-57 84830

Industrial Accident Board

HELENA, MONTANA

06062233

Claim Department

Firm No. _____

Claim No. _____

Accident No. _____

DO NOT FILL IN

EMPLOYER'S FIRST REPORT OF INJURY

INSTRUCTIONS—The employer must fill out this form and return same to Industrial Accident Board, Helena, Montana, at once after every accident which causes any loss of work or requires medical attention. In filling out this form use pen or typewriter.

EMPLOYER, PLACE AND TIME

Employer's name: Zonolite Company

Office address: Libby, Montana (Street and number, city or town)

Nature of business: Mining and Milling Vermiculite (Type of construction, manufacturing, etc.)

Did accident occur on work for a public corporation? No

Location of plant or place of work where accident occurred: Libby (Street and Number)

In what city or village? Libby County? Lincoln

Date of accident: 12-5-, 1958; hour of day: 8:00 A.M. ~~P.M.~~

Did accident happen on premises? Yes

If away from the plant, state where? _____

Was employee injured in the course of employment? Yes

THE INJURED EMPLOYEE

Give full name of injured workman: Harold Shrewsberry

Mailing address: Box 1013, Libby, Montana (Street and number, city or town and county)

Sex: M Age: 38 Speak English? Yes If not, what language? _____

Occupation when injured? Millwright Married or single? Married (See Form 57-a)

Was injured employee on duty at time of accident? Yes If not, state fully on back hereof

How long was injured person in your employment? 6 years

CAUSE OF INJURY

Described in full how the accident occurred (DO NOT FAIL TO DO THIS)

While trying to reach light switch in darkened area of mill, slipped and fell into one ore hopper.

THE INJURY

State nature and extent of injury according to your own information. (We do not need the doctor's report here) Torn ligaments in left knee.

WILL EMPLOYEE LOSE TIME? YES XX NO _____

DATE WAGE LOSS BEGAN? 12-5-58 PROBABLE DURATION OF WAGE LOSS? one week (Give your best estimate)

MEDICAL ATTENDANCE

Name and address of physician attending injured employee: Dr. Paul Seifert, Libby, Montana

To what hospital was employee sent? None

If not sent to hospital, where is he? home

Are you still providing medical attendance? no Have you a hospital contract? no

WAGES

Monthly wage (If paid by month) _____ Weekly wage (If paid by week) _____ Daily wage (If paid by day) _____ Rate per hour (If paid by hour) 2.25

Number of hours per day: 8 How many working days per week: 5

If employee [illegible] money wage, state how many meals per day: none

[illegible] wage? yes no

WAGE LOSS

How much money wage will employee lose per day because of accident? $18.00

How much board? none Will he lose room? no

NOTICE OF INJURY

Were you notified by the injured employee of his injury? yes. If so, how and when? by employee (Write on back of this form if necessary)

Did you or your managing superintendent [illegible] of work of injured employee at time of injury have actual knowledge of such accident [illegible] If so, explain how by employee (Write on back of this form if necessary)

Signed, this 12th day of December 1958 Employer's Name: Zonolite Company

Signed by _____

at Libby, Montana Official Title: Secretary

NOTICE—Employer should have injured workman [illegible] return same to Board with Employer's First Report of Injury.

Firm No. | Acc. No. | Major Industry | County | Date of Acc. | Time | Sex & Married Status | Age | Mont. Code | Acc. Class | Occupation | Type | Agency | Agency Part | Nature of Inj. | Location | Ext. of Dis. | Mech. Defect | Unsafe Act | Pers. Factor | Weekly Wage | Support Leg | Carrier

C0080108

WRG00299235

ED_005351_00000355-00320

Medical
Shrewsberry, Harold IRR Ex JJ

INDUSTRIAL ACCIDENT BOARD, HELENA, MONT. FORM NO. 43—1M 1-57 81907 TRIBUNE PRINTING & SUPPLY CO., GREAT FALLS, MONTANA

Plan No. 06062289

Industrial Accident Board

HELENA, MONTANA

Claim Department

Firm No.....
Claim No.....
Accident No.....
Employee No.....

DO NOT FILL IN

Employer's Supplemental Report Of Injury

This notice to be filled out by employer and sent to the Industrial Accident Board, at Helena, Montana, immediately upon employee's returning to work fully recovered if within two weeks—or upon his death or at the expiration of two weeks from date of injury.

Name of injured employee: Harold Shrewsberry

Address: Box 1013, Libby, Montana

Injured: March 21, 19 60

If worked after accident, last date worked? Worked on through to March 29, took day off to see doctor that date.

Is injured employee fully recovered? yes On what date? March 31, 1960

Has he/she returned to work for you? yes On what date? March 29, 1960

Has he/she accepted other employment? ..... On what date? .....

If so, where now employed? .....

Has he/she died? ..... If so, when? .....

Signed: Zonolite Company

Address: Libby, Montana

Dated: April 4, 19 60

C00B0109

WRG00299237

ED_005351_00000355-00322

INDUSTRIAL ACCIDENT BOARD, HELENA, MONTANA. FORM 37 REVISED. 2M 5-59 19933

Industrial Accident Board

HELENA, MONTANA

06062290

Claim Department

Firm No.

Claim No.

Accident No.

DO NOT FILL IN

EMPLOYER'S FIRST REPORT OF INJURY

DO NOT WRITE IN THIS SPACE

INSTRUCTIONS—The employer must fill out this form and return same to Industrial Accident Board, Helena, Montana, at once after every accident which causes any loss of work or requires medical attention. In filling out this form use pen or typewriter.

EMPLOYER, PLACE AND TIME

Employer's name: Zonolite Company

Office address: Libby, Montana (Street and number, city or town)

Nature of business: Mining and Milling (Type of construction, manufacturing, etc.)

Did accident occur on work for a public corporation? No

Location of plant or place of work where accident occurred: Same (Street and Number)

In what city or village? Libby County? Lincoln

Date of accident: March 21, 1960; hour of day: 2:00 ~~A.M.~~ P.M.

Did accident happen on premises? Yes

If away from the plant, state where?

Was employee injured in the course of employment? Yes

THE INJURED EMPLOYEE

Give full name of injured workman: Harold Chrewsberry

Mailing address: Box 1013, Libby, Montana (Street and number, city or town and county)

Sex: M Age: 39 Speak English? Yes If not, what language?

Occupation when injured? Millwright Married or single? Married

Was injured employee on duty at time of accident? yes If not, state fully on back hereof (See Form 87-a)

How long was injured person in your employment? 8 years

CAUSE OF INJURY

Described in full how the accident occurred (DO NOT FAIL TO DO THIS)

While installing new separating tables, and working around acid ~~tank~~ barrels, which were overhead, there was a leak in one of the barrels, and acid splashed onto table, and into eyes of employee.

THE INJURY

State nature and extent of injury according to your own information. (We do not need the doctor's report here) Foreign matter (acid) in eyes.

WILL EMPLOYEE LOSE TIME? YES ~~NO~~ NO ✓

DATE WAGE LOSS BEGAN? 3-29-60 PROBABLE DURATION OF WAGE LOSS? unknown (Give your best estimate)

MEDICAL ATTENDANCE

Name and address of physician attending injured employee: Dr. E. D. McKenzie, Libby, Montana

To what hospital was employee sent? none

If not sent to hospital, where is he? home

Are you still providing medical attendance? yes Have you a hospital contract? no

WAGES

Monthly wage (If paid by month) Weekly wage (If paid by week) Daily wage (If paid by day) Rate per hour (If paid by hour) 2.325

Number of hours per day: 8 How many working days per week: 5

If employee receives board in addition to money wage, state how many meals per day: none

Does he receive room in addition to money wage? no

WAGE LOSS

How much money wage will employee lose per day because of accident? $18.60

How much board? none Will he lose room? no

NOTICE OF INJURY

Were you notified by the injured employee of his injury? yes If so, how and when? by employee (Write on back of this form if necessary)

Did you or your managing superintendent in charge of work of injured employee at time of injury have actual knowledge of such accident and injury? yes If so, explain how by employee (Write on back of this form if necessary)

Signed, this 29th day of March, 19 60

Employer's Name: Zonolite Company

Signed by

at Libby, Montana

Official Title: Secretary

NOTICE—Employer should have injured workmen fill out Form 37-A and return same to Board with Employer's First Report of Injury.

Firm No. | Acc. No. | Major Industry | County | Date of Acc. | Time | Sex & Marital Status | Age | Mont. Code | Acc. Class | Occupation | Type | Agency | Agency Part | Nature of Inj. | Location | Ext. of Dis. | Mech. Defect | Unsafe Act | Pers. Factor | Weekly Wage | Report Lag | Carrier

C0080110

WRG00299238

ED_005351_00000355-00323

Medical

Shrewsberry, Harold IRR Ex 12

INDUSTRIAL ACCIDENT BOARD, HELENA, MONTANA. FORM 37 REVISED—2M 3-61 32492

Industrial Accident Board

HELENA, MONTANA

Claim Department

06062476

DO NOT WRITE IN THIS SPACE

Firm No.

Claim No.

Accident No.

DO NOT FILL IN

EMPLOYER'S FIRST REPORT OF INJURY

INSTRUCTIONS—The employer must fill out this form and return same to Industrial Accident Board, Helena, Montana, at once after every accident which causes any loss of work or requires medical attention. In filling out this form use pen or typewriter.

EMPLOYER, PLACE AND TIME

Employer's name: Zonolite Company

Office address: Libby, Montana (Street and number, city or town)

Nature of business: Mining & Milling Vermiculite (Type of construction, manufacturing, etc.)

Did accident occur on work for a public corporation? No

Location of plant or place of work where accident occurred: Same (Street and Number)

In what city or village? Libby County? Lincoln

Date of accident August 6, 19 62; hour of day 3:00 A.M. P.M.

Did accident happen on premises? yes

If away from the plant, state where?

Was employee injured in the course of employment? yes

THE INJURED EMPLOYEE

Give full name of injured workman: Harold Shrewsberry

Mailing address: Box 1013, Libby, Montana Lincoln County (Street and number, city or town and county)

Sex M Age 42 Speak English? yes If not, what language?

Occupation when injured? Sheet Metal Shop worker Married or single? Married (See Form 87-a)

Was injured employee on duty at time of accident? yes If not, state fully on back hereof

How long was injured person in your employment? 10 years

CAUSE OF INJURY

Described in full how the accident occurred (DO NOT FAIL TO DO THIS): [illegible] strained muscles in back.

THE INJURY

State nature and extent of injury according to your own information. (We do not need the doctor's report here) Strained muscles, right side of back.

WILL EMPLOYEE LOSE TIME? YES NO

DATE WAGE LOSS BEGAN? PROBABLE DURATION OF WAGE LOSS? (Give your best estimate)

MEDICAL ATTENDANCE

Name and address of physician attending injured employee: Dr. R. D. MacKenzie Libby, Montana

To what hospital was employee sent? none

If not sent to hospital, where is he? working

Are you still providing medical attendance? yes Have you a hospital contract? no

WAGES

Monthly wage (If paid by month) Weekly wage (If paid by week) Daily wage (If paid by day) Rate per hour 2.65 (If paid by hour)

Number of hours per day 8 How many working days per week 5

If employee receives board in addition to money wage, state how many meals per day none

Does he receive room in addition to money wage?

WAGE LOSS

How much money wage will employee lose per day because of accident?

How much board? Will he lose room?

NOTICE OF INJURY

Were you notified by the injured employee of his injury? yes If so, how and when? by employee (Write on back of this form if necessary)

Did you or your managing superintendent in charge of work of injured employee at time of injury have actual knowledge of such accident and injury? yes If so, explain how by employee (Write on back of this form if necessary)

Signed, this 9th day of August, 19 62

Employer's Name: Zonolite Company

Signed by

at Libby, Montana

Official Title: Secretary

NOTICE—Employer should have injured workmen fill out Form 37-A and return same to Board with Employer's First Report of Injury.

Firm No. | Acc. No. | Major Industry | County | Date of Acc. | Time | Sex & Marital Status | Age | Mont. Code | Acc. Class | Occupation | Type | Agency | Agency Part | Nature of Inj. | Location | Ext. of Dis. | Mech. Defect | Unsafe Act | Pers. Factor | Weekly Wage | Report Lag | Carrier

Medical
Shrewsberry, Harold IRR Ex 22

DUPLICATE DUPLICATE 06062475

Industrial Accident Board, Helena, Montana, Form 37 Revised—YM - U - WU

STATE PUBLISHING CO., HELENA, MONT.

Industrial Accident Board

HELENA, MONTANA

Firm No.....

File No.....

EMPLOYER'S FIRST REPORT OF INJURY

INSTRUCTIONS—Employer must complete form at once after every accident which causes loss of time from work or requires medical attention and mail it to the Industrial Accident Board, Helena, Montana. Form must be signed in pen and ink. ALL QUESTIONS MUST BE ANSWERED FULLY.

INJURED EMPLOYEE

Full name of injured employee: Harold Shrewsberry Occupation: Sheet Metal Worker

Mailing address: Box 1013 (Street) Libby (City) How long has he been in your employ: 10 yrs.

Social Security No.: 236-05-7271 Sex: M Age: 42 Married ☒ Single ☐

EARNINGS

Monthly Wage..... Weekly Wage..... Daily Wage..... Hourly Wage: 2.465

Receive board Yes ☐ No ☒ Daily Value..... Receive room Yes ☐ No ☒ Daily Value.....

Piece Worker Yes ☐ No ☐ If yes, price per unit at piece work..... Hours worked per day: 8

Days worked per week: 5 Employee's pay period? Monthly ☐ Semi-monthly ☒ Weekly ☐ List employee's earnings last 4 pay periods 1. 266.22 2. 256.36 3. 226.78 4. 236.64

List Payroll Classification and Code under which employee's wages were reported..... (Sawmill - Mechanic - Etc.) Code..... (2702, 5506, 8810)

ACCIDENT AND INJURY

Describe in full how accident happened and GIVE CAUSE: While carrying 12 ft. piece of steel in sheet metal shop, strained muscles in back.

Nature or extent of injury: strained muscle (Cut - Fracture) Part of body injured? right side of back (Leg - Arm - Back - Head)

Names of witnesses to accident 1..... 2.....

Date of accident: 8-6-62 19..... Hour: 3:00 ~~A.M.~~ P.M. Was employee injured in course of employment? Yes ☒ No ☐

Place where accident occurred..... (Address) Libby (City) Lincoln (County)

Did you or employee's supervisor have actual knowledge of accident? Yes ☒ No ☐

Were you notified of accident by injured employee? Yes ☒ No ☐ How: by employee Date: 8-9-62

Have you reason to question this accident? Yes ☐ No ☒ If "yes" explain fully.....

SAFETY

Was employee's accident due to unsafe work practice? Yes ☐ No ☒ If "yes", what did he do unsafely?.....

Was a specific device, object or substance involved in accident? Yes ☐ No ☒ If "yes," name specific device, object or substance..... Was device or object defective? Yes ☐ No ☐

Was employee doing regular work when injured? Yes ☒ No ☐ Was employee trained to do work he was doing when injured? Yes ☒ No ☐ Were adequate safeguards provided? Yes ☒ No ☐ If "yes," were they being used at the time of accident? Yes ☒ No ☐

MEDICAL ATTENTION

Name of attending physician: Dr. R. D. MacKenzie Address: Libby, Montana

Was employee hospitalized? Yes ☐ No ☒ Name of hospital..... Address.....

Was first aid administered by someone other than attending physician? Yes ☐ No ☐

TIME AND WAGE LOSS

Will employee lose time from work due to accident? Yes ☐ No ☒ How long?..... If injury results in time loss will employee, while disabled, receive sick leave benefits? Yes ☐ No ☐ Paid vacation? Yes ☐ No ☐ Will employee lose wages? Yes ☐ No ☐ Room? Yes ☐ No ☐ Board? Yes ☐ No ☐

Date wage loss began: none Amount of weekly wage loss.....

EMPLOYER

Name of employer: Zonolite Company

Address: Libby, Montana Nature of business: Mining & Milling Vermic

IS FIRM A CORPORATION ☒ OR PARTNERSHIP ☐ OR INDIVIDUAL ☐

IF
- Corporation—is injured employee an officer or director of corporation? Yes ☐ No ☒
- Partnership—is injured employee related to any partner? Yes ☐ No ☐ Relationship.....
- Individual—is injured employee related to employer? Yes ☐ No ☐ Relationship.....

Signed, this 19th day of September, 19 62

at Libby, Montana

Employer's Name: Zonolite Company

Signed by.....

Official Title: Secretary

NOTICE—EMPLOYEE'S CLAIM FOR COMPENSATION, FORM 54, MUST BE FILED WITHIN 12 MONTHS FROM DATE OF ACCIDENT.

C0080112
WRG00299242
ED_005351_00000355-00327

Medical

Shrewsberry, Harold IRR Ex 12

06063180

Industrial Accident Board

HELENA, MONTANA

Firm No.....

File No.....

EMPLOYER'S FIRST REPORT OF INJURY

INSTRUCTIONS—Employer must complete form at once after every accident which causes loss of time from work or requires medical attention and mail it to the Industrial Accident Board, Helena, Montana. Form must be signed in pen and ink. ALL QUESTIONS MUST BE ANSWERED FULLY.

INJURED EMPLOYEE

Full name of injured employee Harold G. Shrewsberry Occupation Welder

Mailing address Route 2 Box 552 (Street) Libby (City) How long has he been in your employ? 17 Yrs.

Social Security No. 236-05-7271 Sex M Age 48 Married ☒ Single ☐

EARNINGS

Monthly Wage..... Weekly Wage..... Daily Wage..... Hourly Wage.....

Receive board Yes ☐ No ☒ Daily Value..... Receive room Yes ☐ No ☒ Daily Value.....

Piece Worker Yes ☐ No ☒ If yes, price per unit at piece work..... Hours worked per day 8

Days worked per week 5 Employee's pay period? Monthly ☐ Semi-monthly ☒ Weekly ☐ List employee's earnings last 4 pay periods 1 316.32 2 378.93 3 413.32 4 362.45

List Payroll Classification and Code under which employee's wages were reported..... (Sawmill - Mechanic - Etc.) Code..... (2702, 5506, 8810)

ACCIDENT AND INJURY

Describe in full how accident happened and GIVE CAUSE At the transfer point installing side plate in hopper, hammer wedged under plate, hammer slipped and hit left little toe

Nature or extent of injury..... (Cut - Fracture) Part of body injured? Left little toe (Leg - Arm - Back - Head)

Names of witnesses to accident 1..... 2.....

Date of accident 3-23-69 19..... Hour..... A. M. P. M. Was employee injured in course of employment? Yes ☒ No ☐

Place where accident occurred Our pit 9 miles North of Libby (Address) Lincoln (City) (County)

Did you or employee's supervisor have actual knowledge of accident? Yes ☒ No ☐

Were you notified of accident by injured employee? Yes ☒ No ☐ How In Person Date 3-27-69

Have you reason to question this accident? Yes ☐ No ☐ If "yes" explain fully.....

SAFETY

Was employee's accident due to unsafe work practice? Yes ☐ No ☒ If "yes", what did he do unsafely?.....

Was a specific device, object or substance involved in accident? Yes ☒ No ☐ If "yes", name specific device, object or substance Hammer Was device or object defective? Yes ☐ No ☐

Was employee doing regular work when injured? Yes ☒ No ☐ Was employee trained to do work he was doing when injured? Yes ☒ No ☐ Were adequate safeguards provided? Yes ☐ No ☐ If "yes", were they being used at the time of accident? Yes ☐ No ☐

MEDICAL ATTENTION

Name of attending physician Dr. W. T. Matthews Address Libby

Was employee hospitalized? Yes ☐ No ☒ Name of hospital X-rays at doctors office Address.....

Was first aid administered by someone other than attending physician? Yes ☐ No ☐

TIME AND WAGE LOSS

Will employee lose time from work due to accident? Yes ☐ No ☒ How long? NONE If injury results in time loss will employee, while disabled, received sick leave benefits? Yes ☒ No ☐ Paid vacation? Yes ☐ No ☐ Will employee lose wages? Yes ☐ No ☐ Room? Yes ☐ No ☐ Board? Yes ☐ No ☐

Date wage loss began..... Amount of weekly wage loss NONE

EMPLOYER

Name of employer Zonolite Division - W. R. Grace & Co.

Address Libby, Montana Nature of Business Mining&Milling Vermiculite

IS FIRM A CORPORATION ☒ OR PARTNERSHIP ☐ OR INDIVIDUAL ☐

IF
- Corporation—is injured employee an officer or director of corporation? Yes ☐ No ☒
- Partnership—is injured employee related to any partner? Yes ☐ No ☐ Relationship.....
- Individual—is injured employee related to employer? Yes ☐ No ☐ Relationship.....

Signed, this 28th day of March, 19 69

at Libby, Montana

Employer's Name Zonolite Division-W.R.Grace & Co.

Signed by.....

Official Title.....

NOTICE—EMPLOYEE'S CLAIM FOR COMPENSATION, FORM 54, MUST BE FILED WITHIN 12 MONTHS FROM DATE OF ACCIDENT.

C0080113

WRG00299244

ED_005351_00000355-00329

Medical

Shrewsberry, Harold IRR Ex 22

06062836

August 31, 1966

Maryland Casualty Company
Claim Department
1415 S.E. Ankeny Street
Portland, Oregon

Re: Harold Shrewsberry
Date of Loss: 10-11-65

Gentlemen:

This is in answer to your letter of August 12, 1966, to St. John's Lutheran Hospital with a copy to us.

Your confusion on this is understandable, and I have contributed to this confusion for I wrote the letter stating that he was not working on October 11, 1965. This was correct.

However, in checking further into this matter, this X-ray was prescribed to check on a condition caused by an industrial accident incurred November 21, 1964. The diagnosis at that time was "a pulled tendon" when a steel beam slipped and fell across his right foot.

At that time, the doctors expected a quick recovery with no lasting effects. However, his ankle continued to bother him, and in the early part of 1965 he was examined by an orthopedic specialist in Spokane, who did not advise surgery. However, he stated the condition could continue to bother him, and it should be watched and periodically checked.

This has continued to bother Mr. Shrewsberry and it still does. The X-ray billed for was for one of the periodic checks.

The claim, it seems to us, is a legitimate one, and results from the injury incurred November 21, 1964.

I hope this has shed some light on the situation, and if there is anything further that we can furnish, we will be happy to do so.

Very truly yours

ZONOLITE DIVISION
W. R. GRACE & CO.

By:

E. D. Lovick

EDL/jbg

c.c. St. John's Lutheran Hospital

C0080115

July 15, 1966

Maryland Casualty Company
1415 S. E. Ankeny Street
Portland, Oregon 97214

Attention: Mr. B. R. Rome

Re: Harold Shrewsberry
October 11, 1965

Gentlemen:

We are unable to furnish a first report of injury for above date as requested in your letter of July 12.

Mr. Shrewsberry was not working on this date, but was recovering from a hernia operation, which he had in September, and was not industrially caused.

We feel there is some mix-up which we cannot explain.

Very truly yours

ZONOLITE DIVISION
W. R. GRACE & CO.

By:

E. D. Lovick

EDL/jbg

C0080116

MARYLAND CASUALTY COMPANY
CLAIM DIVISION
1415 S. E. Ankeny St
Portland, Oregon

06062837

August 12, 1966

St. John's Lutheran Hospital
Libby, Montana

Employee - Harold Shrewsberry
D/Loss - October 11, 1965

Gentlemen:

Recently we received form 73A with charges indicated for an xray of the right ankle, in the sum of $12.50, for your patient, Harold Shrewsberry. On the form it indicated that this was an injury that occurred while he was employed by W. R. Grace & Co., Libby Montana, on October 11, 1965.

As compensation carriers for the above assured, W. R. Grace & Co., we have checked our files to determine if this loss was reported to us prior to receipt of your billing, and find that no record of this loss date was made by the employee or employer to this company. Our assured now informs us that Mr. Shrewsberry was not working on October 11, 1965, for their company, but was recovering from a hernia operation which had no relation to the injury sustained while employed by them.

In order for this company to further consider the billing submitted, we must determine that it occurred during his employment, and on what date the accident took place, as the date October 11, 1965, appears to be an error.

Your prompt response to the above would be appreciated.

Very truly yours,

Claralee Lockhart
Office Adjuster

CL:jh

cc: W. R. Grace & Co.
Zonolite Division
Libby, Montana

C00B0117

WRG00299248
ED_005351_00000355-00333

06062838

Industrial Accident Board, Helena, Montana, Form 37 Revised—YM - U - WU

Industrial Accident Board

HELENA, MONTANA

Firm No.....

File No.....

EMPLOYER'S FIRST REPORT OF INJURY

INSTRUCTIONS—Employer must complete form at once after every accident which causes loss of time from work or requires medical attention and mail it to the Industrial Accident Board, Helena, Montana. Form must be signed in pen and ink. ALL QUESTIONS MUST BE ANSWERED FULLY.

INJURED EMPLOYEE

Full name of injured employee: Harold Shrewsberry Occupation: Welder

Mailing address: Box 1013 (Street, City) How long has he been in your employ: 12 years

Social Security No.: 236-05-7271 Sex: M Age: 44 Married [X] Single [ ]

EARNINGS

Monthly Wage..... Weekly Wage..... Daily Wage..... Hourly Wage: 2.65

Receive board Yes [ ] No [X] Daily Value..... Receive room Yes [ ] No [X] Daily Value.....

Piece Worker Yes [ ] No [X] If yes, price per unit at piece work..... Hours worked per day: 8

Days worked per week: 5 Employee's pay period? Monthly [ ] Semi-monthly [X] Weekly [ ] List employee's earnings last 4 pay periods 1. 243.80 2. 265.00 3. 233.20 4. 304.75

List Payroll Classification and Code under which employee's wages were reported..... (Sawmill - Mechanic - Etc.) Code..... (2702, 5506, 8810)

ACCIDENT AND INJURY

Describe in full how accident happened and GIVE CAUSE: while jacking up a beam at the transfer point in order to get at some machinery to weld, hydraulic jack slipped and fell over on right foot.

Nature or extent of injury: pulled tendon (Cut - Fracture) Part of body injured?: right foot (Leg - Arm - Back - Head)

Names of witnesses to accident 1..... 2.....

Date of accident: 11-21 19 64 Hour: ✓ A.M. P.M. Was employee injured in course of employment? Yes [X] No [ ]

Place where accident occurred: our mine, 9 miles north of Libby (Address, City) Lincoln (County)

Did you or employee's supervisor have actual knowledge of accident? Yes [X] No [ ]

Were you notified of accident by injured employee? Yes [X] No [ ] How: by employee Date: 12-1-64

Have you reason to question this accident? Yes [ ] No [X] If "yes" explain fully.....

SAFETY

Was employee's accident due to unsafe work practice? Yes [ ] No [X] If "yes", what did he do unsafely?.....

Was a specific device, object or substance involved in accident? Yes [X] No [ ] If "yes," name specific device, object or substance: hydraulic jack Was device or object defective? Yes [ ] No [X]

Was employee doing regular work when injured? Yes [X] No [ ] Was employee trained to do work he was doing when injured? Yes [X] No [ ] Were adequate safeguards provided? Yes [X] No [ ] If "yes," were they being used at the time of accident? Yes [X] No [ ] Was wearing steel-toed shoes or would have been injured more severely.

MEDICAL ATTENTION

Name of attending physician: Dr. R. D. MacKenzie Address: Libby, Montana

Was employee hospitalized? Yes [ ] No [X] Name of hospital: X Address.....

Was first aid administered by someone other than attending physician? Yes [ ] No [ ]

TIME AND WAGE LOSS

Will employee lose time from work due to accident? Yes [ ] No [X] How long?: X If injury results in time loss will employee, while disabled, receive sick leave benefits? Yes [X] No [ ] Paid vacation? Yes [ ] No [ ] Will employee lose wages? Yes [ ] No [ ] Room? Yes [ ] No [ ] Board? Yes [ ] No [ ]

Date wage loss began..... Amount of weekly wage loss.....

EMPLOYER

Name of employer: Zonolite Division-W.R.Grace & Co. Milling & Milling

Address: Libby, Montana Nature of business.....

IS FIRM A CORPORATION [X] OR PARTNERSHIP [ ] OR INDIVIDUAL [ ]

IF
- Corporation—is injured employee an officer or director of corporation? Yes [ ] No [X]
- Partnership—is injured employee related to any partner? Yes [ ] No [ ] Relationship.....
- Individual—is injured employee related to employer? Yes [ ] No [ ] Relationship.....

Signed, this 2nd day of December, 19 64

at Libby, Montana

Employer's Name: Zonolite Division-W.R.Grace & Co.

Signed by.....

Official Title.....

NOTICE—EMPLOYEE'S CLAIM FOR COMPENSATION, FORM 54, MUST BE FILED WITHIN 12 MONTHS FROM DATE OF ACCIDENT.

C0080118 WRG00299249

ED_005351_00000355-00334

Medical
Shrewsberry, Harold IRR Ex 12

06062911

MARYLAND CASUALTY COMPANY

H. ELLSWORTH MILLER, PRESIDENT

JOHN S. HOPKINS
MANAGER

PORTLAND CLAIM DIVISION
1415 S. E. Ankeny Street PORTLAND, OREGON 97214
Phone 234-9901

April 26, 1966

W. R. Grace & Company
Zonolite Division
Libby, Montana

Re: Employee: Harold Shrewsberry
Loss Date: 4-7-66

Gentlemen:

We have received an Attending Physician's Statement from Dr. R. H. Brus as well as a billing of $5.00 from St. John's Lutheran Hospital regarding an injury sustained while employed by your firm.

We are attaching Employer's First Report of Injury forms in triplicate and request that you return all three copies direct to this office, unless you have already made out the proper forms and have sent them to the American Adjustment Company in Great Falls, Montana. By carbon copy of this letter we are requesting that the American Adjustment Company remit to us these forms if they have same.

Very truly yours,

Claralee Lockhart, Office Adjuster

CC: American Adjustment Company
P. O. Box 2625
Great Falls, Montana

THE MARYLAND AMERICAN GENERAL GROUP

MARYLAND CASUALTY COMPANY - AMERICAN GENERAL LIFE INSURANCE COMPANY - AMERICAN GENERAL INSURANCE CO. - AMERICAN GENERAL LIFE INSURANCE CO. OF DEL. - AMERICAN GENERAL LIFE INSURANCE CO. OF OKLA. - ASSURANCE COMPANY OF AMERICA - AUTOPLAN INSURANCE COMPANY - HAWAIIAN LIFE INSURANCE CO., LTD. - MAINE BONDING AND CASUALTY CO. - MARYLAND AMERICAN GENERAL INSURANCE CO. - NATIONAL STANDARD INSURANCE CO. - NORTHERN INSURANCE CO. OF N. Y. - NORTH PACIFIC INSURANCE COMPANY - OREGON AUTOMOBILE INSURANCE CO.

06062912

Industrial Accident Board, Helena, Montana, Form 37 Revised—YM - U - WU

Industrial Accident Board

HELENA, MONTANA

Firm No.

File No.

EMPLOYER'S FIRST REPORT OF INJURY

INSTRUCTIONS—Employer must complete form at once after every accident which causes loss of time from work or requires medical attention and mail it to the Industrial Accident Board, Helena, Montana. Form must be signed in pen and ink. ALL QUESTIONS MUST BE ANSWERED FULLY.

INJURED EMPLOYEE

Full name of injured employee Harold Shrewsberry Occupation Welder

Mailing address Box 1013, Libby, Montana (Street, City) How long has he been in your employ 14 years

Social Security No. 236-05-7271 Sex M Age 45 Married ☒ Single ☐

EARNINGS

Monthly Wage ..... Weekly Wage ..... Daily Wage ..... Hourly Wage 2.70

Receive board Yes ☐ No ☒ Daily Value ..... Receive room Yes ☐ No ☒ Daily Value .....

Piece Worker Yes ☐ No ☒ If yes, price per unit at piece work ..... Hours worked per day 8

Days worked per week 5 Employee's pay period? Monthly ☐ Semi-monthly ☒ Weekly ☐ List employee's earnings last 4 pay periods 1 324.00 2 302.40 3 226.80 4 270.00

List Payroll Classification and Code under which employee's wages were reported ..... (Sawmill - Mechanic - Etc.) Code ..... (2702, 5506, 8810)

ACCIDENT AND INJURY

Describe in full how accident happened and GIVE CAUSE

While welding on piece of equipment, got slag in left eye.

Nature or extent of injury foreign material in eye (Cut - Fracture) Part of body injured? left eye (Leg - Arm - Back - Head)

Names of witnesses to accident 1 ..... 2 .....

Date of accident April 6 19 66 Hour 10:00 A.M. Was employee injured in course of employment? Yes ☒ No ☐

Place where accident occurred Cut Shop, 3 Miles North of Libby (Address, City) Lincoln (County)

Did you or employee's supervisor have actual knowledge of accident? Yes ☐ No ☐

Were you notified of accident by injured employee? Yes ☒ No ☐ How by employee Date April 8, 1966

Have you reason to question this accident? Yes ☐ No ☒ If "yes" explain fully .....

SAFETY

Was employee's accident due to unsafe work practice? Yes ☐ No ☒ If "yes", what did he do unsafely? .....

Was a specific device, object or substance involved in accident? Yes ☐ No ☐ If "yes," name specific device, object or substance ..... Was device or object defective? Yes ☐ No ☐

Was employee doing regular work when injured? Yes ☒ No ☐ Was employee trained to do work he was doing when injured? Yes ☒ No ☐ Were adequate safeguards provided? Yes ☐ No ☐ If "yes," were they being used at the time of accident? Yes ☐ No ☐

MEDICAL ATTENTION

Name of attending physician Dr. Roger Brus Address Libby

Was employee hospitalized? Yes ☐ No ☒ Name of hospital Dr. Dedrickson, Optometrist St. Johns for emergency Address Libby

Was first aid administered by someone other than attending physician? Yes ☐ No ☐ by Dedrickson & Brus both--

TIME AND WAGE LOSS

Will employee lose time from work due to accident? Yes ☒ No ☐ How long? 1 day If injury results in time loss will employee, while disabled, receive sick leave benefits? Yes ☒ No ☐ Paid vacation? Yes ☐ No ☐ Will employee lose wages? Yes ☐ No ☐ Room? Yes ☐ No ☐ Board? Yes ☐ No ☐

Date wage loss began April 8, 1966 Amount of weekly wage loss $100.00

EMPLOYER

Name of employer Zonolite Division-W.R.Grace & Co.

Address Libby, Montana Nature of business Mining & Milling Vermiculite

IS FIRM A CORPORATION ☒ OR PARTNERSHIP ☐ OR INDIVIDUAL ☐

IF
- Corporation—is injured employee an officer or director of corporation? Yes ☐ No ☒
- Partnership—is injured employee related to any partner? Yes ☐ No ☐ Relationship .....
- Individual—is injured employee related to employer? Yes ☐ No ☐ Relationship .....

Signed, this 9th day of April, 19 66

at Libby, Montana

Employer's Name Zonolite Division-W.R.Grace & Co.

Signed by .....

Official Title .....

NOTICE—EMPLOYEE'S CLAIM FOR COMPENSATION, FORM 54, MUST BE FILED WITHIN 12 MONTHS FROM DATE OF ACCIDENT.

Δ

WRG00299252

ED_005351_00000355-00337

Medical
Shrewsberry, Harold IRR Ex 22

Industrial Accident Board, Helena, Montana, Form 37 Revised—YM - U - WU

Industrial Accident Board

HELENA, MONTANA

Firm No.....

File No.....

EMPLOYER'S FIRST REPORT OF INJURY

INSTRUCTIONS—Employer must complete form at once after every accident which causes loss of time from work or requires medical attention and mail it to the Industrial Accident Board, Helena, Montana. Form must be signed in pen and ink. ALL QUESTIONS MUST BE ANSWERED FULLY.

INJURED EMPLOYEE

Full name of injured employee Harold Shrewsberry Occupation Welder

Mailing address Box 1013, Libby, Montana (Street, City) How long has he been in your employ 15 years

Social Security No. 236-05-7271 Sex M Age 47 Married ☒ Single ☐

EARNINGS

Monthly Wage..... Weekly Wage..... Daily Wage..... Hourly Wage 3.105

Receive board Yes ☐ No ☒ Daily Value..... Receive room Yes ☐ No ☒ Daily Value.....

Piece Worker Yes ☐ No ☒ If yes, price per unit at piece work..... Hours worked per day 8

Days worked per week 6 Employee's pay period? Monthly ☐ Semi-monthly ☒ Weekly ☐ List employee's earnings last 4 pay periods 1. 354.06 2. 328.72 3. 328.72 4. 328.72

List Payroll Classification and Code under which employee's wages were reported..... (Sawmill - Mechanic - Etc.) Code..... (2702, 3506, 8810)

ACCIDENT AND INJURY

Describe in full how accident happened and GIVE CAUSE While welding at transfer point, pinched left hand between two pieces of steel which were being moved.

Nature or extent of injury severe bruise (Cut - Fracture) Part of body injured? left hand (Leg - Arm - Back - Head)

Names of witnesses to accident 1..... 2.....

Date of accident 6-17 19 67 Hour..... A. M. P. M. Was employee injured in course of employment? Yes ☒ No ☐

Place where accident occurred Our mine, 5 miles north of Libby (Address, City) Lincoln (County)

Did you or employee's supervisor have actual knowledge of accident? Yes ☒ No ☐

Were you notified of accident by injured employee? Yes ☒ No ☐ How by employee Date 6-19-67

Have you reason to question this accident? Yes ☐ No ☒ If "yes" explain fully.....

SAFETY

Was employee's accident due to unsafe work practice? Yes ☐ No ☒ If "yes", what did he do unsafely?.....

Was a specific device, object or substance involved in accident? Yes ☐ No ☐ If "yes," name specific device, object or substance..... Was device or object defective? Yes ☐ No ☐

Was employee doing regular work when injured? Yes ☒ No ☐ Was employee trained to do work he was doing when injured? Yes ☒ No ☐ Were adequate safeguards provided? Yes ☒ No ☐ If "yes," were they being used at the time of accident? Yes ☒ No ☐

MEDICAL ATTENTION

Name of attending physician Dr. James F. Graham Address Libby

Was employee hospitalized? Yes ☐ No ☒ Name of hospital..... Address.....

Was first aid administered by someone other than attending physician? Yes ☐ No ☒

TIME AND WAGE LOSS

Will employee lose time from work due to accident? Yes ☐ No ☒ How long?..... If injury results in time loss will employee, while disabled, receive sick leave benefits? Yes ☐ No ☐ Paid vacation? Yes ☐ No ☐ Will employee lose wages? Yes ☐ No ☐ Room? Yes ☐ No ☐ Board? Yes ☐ No ☐

Date wage loss began NONE Amount of weekly wage loss.....

EMPLOYER

Name of employer Zonolite Division-W.R.Grace & Co.

Address Libby, Montana Nature of business Mining & Milling Vermiculite

IS FIRM A CORPORATION ☒ OR PARTNERSHIP ☐ OR INDIVIDUAL ☐

IF
- Corporation—is injured employee an officer or director of corporation? Yes ☐ No ☒
- Partnership—is injured employee related to any partner? Yes ☐ No ☐ Relationship.....
- Individual—is injured employee related to employer? Yes ☐ No ☐ Relationship.....

Signed, this 20th day of June, 19 67

at Libby, Montana

Employer's Name Zonolite Division-W.R.Grace & Co.

Signed by.....

Official Title.....

NOTICE—EMPLOYEE'S CLAIM FOR COMPENSATION, FORM 54, MUST BE FILED WITHIN 12 MONTHS FROM DATE OF ACCIDENT.

Δ

Medical
Shrewsberry, Harold IRR Ex 22

06063078

Industrial Accident Board, Helena, Montana, Form 37 Revised—YM - U - WU

Industrial Accident Board

HELENA, MONTANA

Firm No.....

File No.....

EMPLOYER'S FIRST REPORT OF INJURY

INSTRUCTIONS—Employer must complete form at once after every accident which causes loss of time from work or requires medical attention and mail it to the Industrial Accident Board, Helena, Montana. Form must be signed in pen and ink. ALL QUESTIONS MUST BE ANSWERED FULLY.

INJURED EMPLOYEE

Full name of injured employee: Harold Shrewsberry Occupation: Welder

Mailing address: Route 2 Box 552 (Street) (City) How long has he been in your employ: 16 years

Social Security No.: 236-05-7271 Sex: M Age: 48 Married ☒ Single ☐

EARNINGS

Monthly Wage..... Weekly Wage..... Daily Wage..... Hourly Wage: 3.105

Receive board Yes ☐ No ☒ Daily Value..... Receive room Yes ☐ No ☒ Daily Value.....

Piece Worker Yes ☐ No ☒ If yes, price per unit at piece work..... Hours worked per day: 8

Days worked per week: 5 Employee's pay period? Monthly ☐ Semi-monthly ☒ Weekly ☐ List employee's earnings last 4 pay periods 1. 347.76 2. 322.92 3. 572.60 4. 397.44

List Payroll Classification and Code under which employee's wages were reported..... (Sawmill - Mechanic - Etc.) Code..... (2702, 5506, 8810)

ACCIDENT AND INJURY

Describe in full how accident happened and GIVE CAUSE

Employee was welding on a burner and a piece of hot slag popped up and hit him in eye. A piece of steel was taken out of left eye.

Nature or extent of injury: Cut (Cut - Fracture) Part of body injured? Left Eye (Leg - Arm - Back - Head)

Names of witnesses to accident 1..... 2.....

Date of accident: April 2 19 68 Hour..... A. M. P. M. Was employee injured in course of employment? Yes ☒ No ☐

Place where accident occurred: Our sheet metal shop 9 miles from Libby, Montana (Address) (City) (County)

Did you or employee's supervisor have actual knowledge of accident? Yes ☒ No ☐

Were you notified of accident by injured employee? Yes ☒ No ☐ How..... Date.....

Have you reason to question this accident? Yes ☐ No ☒ If "yes" explain fully.....

SAFETY

Was employee's accident due to unsafe work practice? Yes ☐ No ☒ If "yes", what did he do unsafely?.....

Was a specific device, object or substance involved in accident? Yes ☐ No ☐ If "yes," name specific device, object or substance..... Was device or object defective? Yes ☐ No ☐

Was employee doing regular work when injured? Yes ☒ No ☐ Was employee trained to do work he was doing when injured? Yes ☒ No ☐ Were adequate safeguards provided? Yes ☒ No ☐ If "yes," were they being used at the time of accident? Yes ☒ No ☐

MEDICAL ATTENTION

Name of attending physician: Dr. Roger Brus Address: Libby, Montana

Was employee hospitalized? Yes ☐ No ☒ Name of hospital..... Address.....

Was first aid administered by someone other than attending physician? Yes ☐ No ☒

TIME AND WAGE LOSS

Will employee lose time from work due to accident? Yes ☐ No ☒ How long?..... If injury results in time loss will employee, while disabled, receive sick leave benefits? Yes ☐ No ☐ Paid vacation? Yes ☐ No ☐ Will employee lose wages? Yes ☐ No ☒ Room? Yes ☐ No ☐ Board? Yes ☐ No ☐

Date wage loss began..... Amount of weekly wage loss.....

EMPLOYER

Name of employer: Zonolite Division - W. R. Grace & Co.

Address: Libby, Montana Nature of business: Mining & Milling Vermiculite

IS FIRM A CORPORATION ☒ OR PARTNERSHIP ☐ OR INDIVIDUAL ☐

IF
- Corporation—is injured employee an officer or director of corporation? Yes ☐ No ☐
- Partnership—is injured employee related to any partner? Yes ☐ No ☐ Relationship.....
- Individual—is injured employee related to employer? Yes ☐ No ☐ Relationship.....

Signed, this 5 day of April, 19 68

at Libby, Montana

Employer's Name: Zonolite Division - W. R. Grace & Co.

Signed by.....

Official Title.....

NOTICE—EMPLOYEE'S CLAIM FOR COMPENSATION, FORM 54, MUST BE FILED WITHIN 12 MONTHS FROM DATE OF ACCIDENT.

MEDICAL
Smerker, Ray

C0080176

MONTANA DIVISION OF WORKERS' COMPENSATION

Complied with 82—1137 R.C.M.

815 Front Street
Helena, Montana 59601

SEND ORIGINAL TO INSURER

EMPLOYER'S FIRST REPORT of Occupational Injury or Occupational Disease
Insurer's or Division Copy

CASE NUMBER

FIRM NUMBER

INSTRUCTIONS - Every employer in Montana is required by law to complete this form immediately after every accident to an employee which arises out of and in the course of employment, and which causes loss of time from work or requires medical attention. The original of this form must be immediately filed with the employer's insurer or the Division of Workers' Compensation, 815 Front Street, Helena, Montana 59601. All questions must be answered fully. If a question cannot be answered, please explain why.
Please print with a ball point pen or type.

FEDERAL OSHA REQUIREMENTS - The United States Department of Labor requires employers to maintain, in the employer's office, a record of occupational injuries. For the employer's convenience, this form has been designed to meet such requirements and to provide employers a record copy.

DWC USE ONLY: OCCUPATION | SEX | AGE | MARITAL STATUS | COUNTY | LENGTH (YRS EMPLOYED) | WEEKLY EARNINGS | CLASS CODE | ACCIDENT TYPE | SOURCE OF INJURY | PART OF BODY INJURED | OSHA RECORDABLE CODE | DISABILITY TYPE | NATURE OF INJURY | HAZARDOUS CONDITION | UNSAFE ACT

EMPLOYEE

Full Name of INJURED EMPLOYEE: Raymond A. Smerker
Social Security Number: 517-66-5369
EMPLOYEE'S Home Address (Street or Box): Box 89
City: Libby
State: Mt.
Zip Code: 59923
Occupation: Drill Operator
Sex: M
Age: 23
Marital Status: [X] Married [ ] Single
Length of time in your Employment: 4 Yr 4 Mo.
Department where regularly employed: Mine
Date of Birth (mo.) (day) (yr.)

WAGES

Employee's Gross Wage Rate is $ 6.78 per [ ] week, or [ ] day, or [X] hour, or [ ] month
Days Worked Per Week: 5
Hours Worked Per Day: 8
If board or room is furnished state value reported per day to Internal Revenue Service $
Check One: [X] Full Time Employee [ ] Part Time Employee
Payroll Classification under which employee's wages were reported: Drill Operator
Employee's gross earnings for last four (4) pay periods (Date / Amount) (Date / Amount) (Date / Amount) (Date / Amount)
Employee's pay period: [ ] Monthly [X] Semi-monthly [ ] Bi-Weekly [ ] Weekly [ ] Other

ACCIDENT INFORMATION

Describe in full detail how accident happened, and give cause - Explain what employee was doing when injured.
Employee was helping start an end loader by spraying starting fluid on the filter. He jumped off the counter of the end loader and slipped and fell on the ice and snow, injuring ribs.

What specific object or substance caused the injury? fall on ice and snow
Nature of the injury? (cut, fracture, etc.) Injured ribs (ribs pulled apart)
Part of body affected (leg, arm, back, head, etc.) lower ribs on right side
DATE OF INJURY (month) 11 (day) 28 (year) 77 (hour) 6:15 (a.m. or p.m.) p.m.
Names of witnesses to accident: 1. Willis Fields 2. Jerry Fincher
Place where accident occurred (address & city): 12 Mi. N.E. Libby, Mt. (county) Lincoln
Was place of accident on employer's premises? Yes [X] No [ ]
Was employee injured while in your employ? Yes [X] No [ ]
Were you notified, or did you have actual knowledge of the accident? Yes [X] No [ ] If yes, date notified & how By employee 1-17-78
Do you have any reason to question this accident? [X] Yes [ ] No
If yes, please explain fully: Employee was in automobile accident 1-6-78. Following the above claimed industrial accident, he denied any injury on several occasions when questioned by his supervisors

MEDICAL

Attending physician name and address: Paul Siefert, M.D. Libby, Mt. 1-10-78
If hospitalized, hospital's name and address
Will employee return to work during next scheduled shift? Yes [X] No [ ]
If no, will wage loss exceed 7 days? Yes [ ] No [ ] Not Sure [ ]
Date wage loss began (mo.) (day) (yr.)
Date of return, if returned to work (mo.) (day) (yr.)

EMPLOYER

EMPLOYER'S NAME: W. R. Grace & Co.
Commercial Name (doing business as)
Employer's mailing address (Street or Box): Box 609
(City): Libby
(State): Mt.
(Zip Code): 59923
Phone number: 293-4131
Location of operation, if different from mailing address: xx 12 Mi. N.E. Libby, Mt.
Nature of business: Mining & Milling
Firm is a: (Check one) [ ] Sole proprietorship [ ] Partnership, or [X] Corporation
Was the injured employee? (Check if applicable) [ ] A Sole Proprietor, [ ] A working Partner, [ ] A Corporate Officer, or [ ] A member of the employer's (sole proprietor or partner) family, dwelling in the employer's household.
Prepared by: Darlene Myhre
Authorized Signature: X
Official Title: Administrative Assistant
Date

Above - DWC-MIS Form 37-Employer's First Report (Rev. 1-74)

Below - DWC-MIS Form 54A-Claim for Compensation

EMPLOYEE'S CLAIM FOR COMPENSATION

EMPLOYER'S NOTE: For convenience purposes and if the worker is available, the form below has been provided so that an employer may allow an injured worker to file a claim for compensation on this form to avoid having the employee fill out and file a separate detailed form. Separate claim forms are available if the employer does not want the worker to use this form. Do not delay in submission of this form if employee is not available to sign below.

INJURED EMPLOYEE'S NOTE: An injured employee may use the form below to make a claim for compensation, or the employee may fill out and submit a separate detailed form that is available from the Division.

I have carefully read the above information as documented by the employer, and (except for any statements I may write below) I concur with the information and I hereby make claim for compensation benefits due me now or in the future under Montana's Workers' Compensation Act.

Signature of Injured employee: X Raymond Smerker
Address: Box 89
City: Libby
Date: 1/17/78
Phone: 29

I DO NOT concur with the following information documented by the employer:

C0080177

Filing of this claim is authorization for release of medical records and records of the Social Security Administration

FROM THE DESK OF
Earl D. Lovick

Talked to Smoker 1/20/78.
He is not claiming an
Ind Acc.
Talked to Dr Seifert. told
him we are not
acknowledging an Ind. Acc.

EL

C0080178

WRG00299259

ED_005351_00000355-00344

ERANCE NEEDED—It takes a lot of patience and the right kind of bait to pull trout ozen lake. Allen Benau of Kalispell waits on Loon Lake in southern Lincoln County r another fish to add to those on the ice already caught by Benau and Bill McClain.

ow, Bad Roads Cause sh of Auto Accidents

hazardous driving kept city police, ers, and highway busy last week as he usual number of curred.

patrolman Bill igated an accident e golf course road bby. According to d A. Haines, 17, riving onto the golf d from a private e saw a car driven mith 59, of Libby. idded across the the Smith vehicle, bler, on the left were no injuries, was moderate oth vehicles.

at afternoon high- man Jerry Criner an accident that hen Bradley A. ibby, drove a 1969 Impala from a e without cleaning geared down, losing control of his 1968 Chevrolet station wagon, going over an embankment and striking a tree.

Craig was accompanied by his sons, Kelly, 4, Shannon, 11, and Scott, 10, but there were no injuries. There was minor damage to the vehicle.

Highway partolman Dick Chase investigated an accident that occurred Jan. 4 at 12:05 p.m. According to Chase, the accident happened 4½ miles south of Libby on Highway 2, and involved a 1955 Chevrolet pickup driven by Steve Allen Becker, 20, Libby, and a 1977 Peterbilt truck driven by Duane Arthur Skranak, 23, also of Libby.

Chase said that Becker was attempting to make a left turn into a private drive when he was struck by the logging truck which was attempting to pass. Both vehicles were knocked out of control. Becker came to Wenholz vehicle by the snow berm in the center of the road. There was minor damage to both vehicles, but there were no injuries and no citiations.

On Friday, Cady investigated another accident that occurred in nearly the same place. Cady said that Raymond Smerker, 23, of Libby, was driving a 1976 Ford four wheel drive pickup, was heading east, and was about to make a left turn into a trailer court across from Dinny's Grocery when he struck a 1977 Chevrolet Vega station wagon driven by Robin Dennis Wilke, 27 of Libby.

Damage was extensive to the Wilke vehicle and moderate to the Smerker pickup. Cady cited Smerker for careless driving, and Wilke complained of minor cuts and bruises.

City policeman Daryl Anderson investigated an accident that happened Saturday

The Western News,
Libby, Mont.,
Thurs., Jan. 12, 1978—2

Rites Held Monday for Mrs. Swanoski

Daphne B. Swanoski, 75, died Wednesday at St. John's Lutheran Hospital.

Born Dec. 13, 1902 in Sandstone Village, Minn., she was raised in Superior, Wis., where she received her education.

She married Andrew J. Swanoski Nov. 4, 1939 in Carlton, Minn. They moved to Winslow, Ariz. in 1945 and to Phoenix in 1961, remaining there until coming to Libby in May of 1976. Her husband preceded her in death on June 20, 1977. She had been a member of the Libby Senior Citizens Center.

Survivors include one son, Sam Stewart of Libby, one daughter, Jeanne Anderson of Phoenix, Ariz., one brother, Charles Conner of Superior, Wis., five grandchildren, Linda Bishop, Terry Anderson, Ruth, Andrea, Jennifer Stewart, all of Libby, and one great grandchild, Alyson Bishop.

Graveside services were conducted Monday at 2 p.m. at the City of Libby Cemetery with Father Charles Strom of St. Joseph Catholic Church officiating.

Pallbearers were Greg Roberts, Ralph Roberts, Steve Loveless, Larry Loveless, Niles Nelson, and Albert Urdahl.

U.
JAYC

C0080179

WR 00299260

ED_005351_00000355-00345

Medical
Smith, Arnold L.

C0080180

WRG00299261
ED_005351_00000355-00346

INDUSTRIAL ACCIDENT BOARD, HELENA, MONTANA. FORM 37 REVISED. 2M 5-59 19933

Industrial Accident Board

HELENA, MONTANA

06062243

Claim Department

Firm No.

Claim No.

Accident No.

DO NOT FILL IN

EMPLOYER'S FIRST REPORT OF INJURY

DO NOT WRITE IN THIS SPACE

INSTRUCTIONS—The employer must fill out this form and return same to Industrial Accident Board, Helena, Montana, at once after every accident which causes any loss of work or requires medical attention. In filling out this form use pen or typewriter.

EMPLOYER, PLACE AND TIME

Employer's name: Zonolite Company

Office address: Libby, Montana (Street and number, city or town)

Nature of business: Mining and Milling Vermiculite (Type of construction, manufacturing, etc.)

Did accident occur on work for a public corporation? No

Location of plant or place of work where accident occurred: Same (Street and Number)

In what city or village? Libby County? Lincoln

Date of accident: September 25, 1959; hour of day 8:15 A.M.

Did accident happen on premises? Yes

If away from the plant, state where?

Was employee injured in the course of employment? Yes

THE INJURED EMPLOYEE

Give full name of injured workman: Arnold M L. Smith

Mailing address: Box 724, Libby, Montana (Street and number, city or town and county)

Sex M Age 41 Speak English? Yes If not, what language?

Occupation when injured? Shovel Oiler Married or single? Married (See Form 87-a)

Was injured employee on duty at time of accident? Yes If not, state fully on back hereof

How long was injured person in your employment? 9-1/2 years

CAUSE OF INJURY

Described in full how the accident occurred (DO NOT FAIL TO DO THIS)

While oiling on shovel, bolt in hoist broke allowing hoist brake to release, striking right leg.

THE INJURY

State nature and extent of injury according to your own information. (We do not need the doctor's report here) Badly bruised right leg.

WILL EMPLOYEE LOSE TIME? YES [illegible] NO

DATE WAGE LOSS BEGAN? 9-26-59 PROBABLE DURATION OF WAGE LOSS? 2 days (Give your best estimate)

MEDICAL ATTENDANCE

Name and address of physician attending injured employee: Dr. Paul J. Seifert, Libby, Montana

To what hospital was employee sent? St. Johns Lutheran

If not sent to hospital, where is he? working

Are you still providing medical attendance? no Have you a hospital contract? no

WAGES

Monthly wage (If paid by month) Weekly wage (If paid by week) Daily wage (If paid by day) Rate per hour 2.30 (If paid by hour)

Number of hours per day 8 How many working days per week 5

If employee receives board in addition to money wage, state how many meals per day none

Does he receive room in addition to money wage? no

WAGE LOSS

How much money wage will employee lose per day because of accident? $18.40

How much board? none Will he lose room? no

NOTICE OF INJURY

Were you notified by the injured employee of his injury? yes If so, how and when? by employee (Write on back of this form if necessary)

Did you or your managing superintendent in charge of work of injured employee at time of injury have actual knowledge of such accident and injury? yes If so, explain how by employee (Write on back of this form if necessary)

Signed, this 29th day of Sept., 1959

Employer's Name Zonolite Company

Signed by

at Libby, Montana

Official Title Secretary

NOTICE—Employer should have injured workmen fill out Form 37-A and return same to Board with Employer's First Report of Injury.

Firm No. | Acc. No. | Major Industry | County | Date of Acc. | Time | Sex & Marital Status | Age | Mont. Code | Acc. Class | Occupation | Type | Agency | Agency Part | Nature of Inj. | Location | Ext. of Dis. | Mech. Defect | Unsafe Act | Pers. Factor | Weekly Wage | Report Lag | Carrier

C00801B1
WRG00299262
ED_005351_00000355-00347

Medical
Smith, Arnold L.

C0080180

WRG00299263
ED_005351_00000355-00348

TRIAL ACCIDENT BOARD, HELENA, MONTANA. FORM 37 REVISED. 2M 5-59 10933

Industrial Accident Board

HELENA, MONTANA

Claim Department

m No.
im No.
ident No.

DO NOT FILL IN

EMPLOYER'S FIRST REPORT OF INJURY

DO NOT WRITE IN THIS SPACE

INSTRUCTIONS—The employer must fill out this form and return same to Industrial Accident Board, Helena, ntana, at once after every accident which causes any loss of work or requires medical attention. In filling out form use pen or typewriter.

MPLOYER, LACE AND TIME

Employer's name: Zonolite Company

Office address: Libby, Montana (Street and number, city or town)

Nature of business: Mining and Milling Vermiculite (Type of construction, manufacturing, etc.)

Did accident occur on work for a public corporation? No

Location of plant or place of work where accident occurred: Same (Street and Number)

In what city or village? Libby County? Lincoln

Date of accident: September 25, 1954; hour of day 8:15 A.M. ~~P.M.~~

Did accident happen on premises? Yes

If away from the plant, state where?

Was employee injured in the course of employment? Yes

THE INJURED MPLOYEE

Give full name of injured workman: Arnold ~~E~~ L. Smith

Mailing address: Box 724, Libby, Montana (Street and number, city or town and county)

Sex: M Age: 41 Speak English? Yes If not, what language?

Occupation when injured? Shovel Oiler Married or single? Married (See Form 87-a)

Was injured employee on duty at time of accident? Yes If not, state fully on back hereof

How long was injured person in your employment? 9-1/2 years

CAUSE OF INJURY

Described in full how the accident occurred (DO NOT FAIL TO DO THIS)

While oiling on shovel, bolt in hoist broke allowing hoist brake to release, striking right leg.

THE INJURY

State nature and extent of injury according to your own information. (We do not need the doctor's report here) Badly bruised right leg.

WILL EMPLOYEE LOSE TIME? YES XX NO

DATE WAGE LOSS BEGAN? 9-26-54 PROBABLE DURATION OF WAGE LOSS? 2 days (Give your best estimate)

MEDICAL TENDANCE

Name and address of physician attending injured employee: Dr. Paul J. Seifert, Libby, Montana

To what hospital was employee sent? St. Johns Lutheran

If not sent to hospital, where is he? working

Are you still providing medical attendance? no Have you a hospital contract? no

WAGES

Monthly wage (If paid by month) Weekly wage (If paid by week) Daily wage (If paid by day) Rate per hour (If paid by hour) 2.30

Number of hours per day 8 ~~How many working days per week~~ 5

If employee receives board in addition to money wage, state how many meals per day none

Does he receive room in addition to money wage? no

Firm No.
Acc. No.
Major Industry
County
Date of Acc.
Time
Sex & Marital Status
Age
Mont. Code
Acc. Class
Occupation
Type
Agency
Agency Part
Nature of Inj.
Location
Ext. of Dis.
Mech. Defect
Unsafe Act

WRG00299264
ED_005351_00000355-00349

PATCH II

W.R. Grace Fall 2000 Document Production Target Sheet

- [ ] Notice
  - [ ] Testing
  - [ ] Agency
- [ ] Libby Ore/Operations
- [x] Libby All Other
- [ ] Expanding Plant (see below)
- [ ] Non-Grace Expanding Plant
- [ ] Attic Insulation
- [ ] Agricultural/ Horticultural Products
- [ ] Other Consumer Products
- [x] Workers Comp
- [ ] Medical Records and Other Personal Confidental
- [ ] Privilege
- [ ] Trade Secret

- [ ] All
- [ ] Invoices

- [ ] Albany, N.Y.
- [ ] Atlanta, Georgia
- [ ] Birmingham, Alabama
- [ ] Boca Raton, Florida
- [ ] Chicago, Illinois (Blue Island)
- [ ] Dallas, Texas
- [ ] Dearborn, Michigan
- [ ] Denver, Colorado
- [ ] Easthampton, Mass.
- [ ] Ellwood City, Penn.
- [ ] Enoree, S. Carolina
- [ ] Hialeah, Florida
- [ ] High Point, N. Carolina
- [ ] Irondale, Alabama
- [ ] Jacksonville, Florida
- [ ] Kansas City, Missouri
- [ ] Kearny, S. Carolina
- [ ] Kenilworth Ave, Washington D.C.
- [ ] Los Angeles, Calif.
- [ ] Milwaukee, Wisconsin
- [ ] Minneapolis, Minn. (Western Min. Prod.)
- [ ] Muirkirk, Maryland (Beltsville)
- [ ] Nashville, Tennessee
- [ ] Newark, California
- [ ] New Castle, Pennsylvania
- [ ] New Orleans, Louisiana
- [ ] North Billerica, Mass.
- [ ] North Little Rock, Ark.
- [ ] Oklahoma City, Oklahoma
- [ ] Omaha, Nebraska (Western Min. Prod.)
- [ ] Phoenix, Arizona (Glendale)
- [ ] Pompano Beach, Florida
- [ ] Portland, Oregon
- [ ] Rio Piedras, Puerto Rico
- [ ] Sacramento, Calif.
- [ ] San Antonio, Texas
- [ ] Santa Ana, California
- [ ] Savannah, Georgia
- [ ] Sharpsburg, Penn.
- [ ] Spokane, Washington
- [ ] St. Louis, Missouri
- [ ] Tampa, Florida
- [ ] Travelers Rest, S. Carolina
- [ ] Trenton, New Jersey (East Trenton)
- [ ] Utica, New York
- [ ] Weedsport, N. Y. (Brutus)
- [ ] West Chicago, Illinois
- [ ] Wilder, Kentucky (Newport)

- [ ] Canadian Expanding plants

F22

Medical
Smith, Arnold L.

C0080180

J Melchar

ACCIDENT INVESTIGATION REPORT

INDUSTRIAL CHEMICALS GROUP
W. R. Grace & Co.

Plant Zonolite Lost Time Case

Division Construction Products Division Not Lost Time Case ✓
(Check one)

All accidents involving lost time from work or the services of a physician must be investigated and the report completed within 48 hours by the injured employee's supervisor. Forward one copy of report to office of Safety Administrator.

1. Name of injured employee Arnold L. Smith
2. Department Loading Dock - Hauling Date of Hire 4-11-50
3. Job Title Ore Hauler Was he doing regular job? Yes ✓ No
4. Date and time of injury 1:45 PM Oct. 5, 1976
5. Date and time injury reported 2:00 PM Oct. 5, 1976
6. Injured employee is: Salaried Hourly ✓ Male ✓ Female
   Under 25 years 25 to 34 35 to 49 50 and over ✓
7. Describe in detail what employee was doing at time of injury: include reference to any tools, machines and materials involved: Coming down the 14% grade with load of ore when he hit a slick spot on the oiled road. It had just started to rain. The Truck spun around Backwards and into Bank and Turn over on its side. Had made 16 Trips Before Accident.
8. Describe injury: None
9. What medical action was taken? Doctor checked out man and found nothing wrong. was given a Release To come Back.
10. What, in your opinion, was the basic cause of this accident?
    Unsafe Act Unsafe Condition ✓ Explain Road surface Needs some other type oil or have it graded more often.

C0080183 WRG00299268

ED_005351_00000355-00353

11. What were the contributing causes? Rain and Slick oil also Three tires Badly worn.

12. What action have you taken and/or are you planning to take to avoid a recurrence of this accident? Call mine and Have grader Sent Down

13. Have you counselled your other employees regarding lessons to be learned from this accident?

Yes ✓ No ____ if not, why ____

14. Have you scheduled any maintenance work or planned any disciplinary action with the accident?

Yes ____ No ✓ Comments, if any: Road has Been graded

(Signed) M. H. Kain (Supervisor) Date Oct. 6, 1976 Plant Mill Dept.

****

You have now completed answering some very important questions regarding an injury to one of your employees. Take the time to think carefully and ask yourself the following two questions:

a) How long did I take to think out and complete the answers to the questions above?

b) Have I really taken enough time, given enough thought, to a subject which might very well mean the life of one of my employees at some future date?

****

This space reserved for Plant Managers

1. Have you discussed this injury with .....

the supervisor concerned? Yes ____ No ____
all members of your supervisory group? Yes ____ No ____

2. Do you have any comments to add to the statements by the Foreman?

(Plant Manager) (Date) 10/5/76

Form 65-25

C0080184
WRG00299269
ED_005351_00000355-00354

MONTANA DIVISION OF WORKERS' COMPENSATION

Complied with 82—1137 R.C.M.

815 Front Street
Helena, Montana 59601

SEND ORIGINAL TO INSURER

EMPLOYER'S FIRST REPORT
of Occupational Injury or
Occupational Disease
Employee Copy

CASE NUMBER

FIRM NUMBER 2503

INSTRUCTIONS - Every employer in Montana is required by law to complete this form immediately after every accident to an employee which arises out of and in the course of employment, and which causes loss of time from work or requires medical attention. The original of this form must be immediately filed with the employer's insurer or the Division of Workers' Compensation, 815 Front Street, Helena, Montana 59601. All questions must be answered fully. If a question cannot be answered, please explain why. **Please print with a ball point pen or type.**

FEDERAL OSHA REQUIREMENTS - The United States Department of Labor requires employers to maintain, in the employer's office, a record of occupational injuries. For the employer's convenience, this form has been designed to meet such requirements and to provide employers a record copy.

EMPLOYEE

Full Name of INJURED EMPLOYEE: Arnold L. Smith
Social Security Number: 558-14-8840
EMPLOYEE'S Home Address (Street or Box): Box 129
City: Libby
State: MT
Zip Code: 59923
Occupation: Kenworth Driver
Sex: M
Age: 58
Marital Status: [X] Married [ ] Single
Length of time in your Employment: 26 yrs.
Department ~~where regularly employed~~: Loading Dock Hauling Dept.
Date of Birth: 2 (mo.) / 18 (day) / 18 (yr.)

WAGES

Employee's Gross Wage Rate is $ 6.17 per [ ] week, or [ ] day, or [X] hour, or [ ] month
Days Worked Per Week: 5
Hours Worked Per Day: 8
If board or room is furnished state value reported per day to Internal Revenue Service $
Check One— [X] Full Time Employee [ ] Part Time Employee
Payroll Classification under which employee's wages were reported
Employee's gross earnings for last four (4) pay periods (Date / Amount) (Date / Amount) (Date / Amount) (Date / Amount)
Employee's pay period: [ ] Monthly [X] Semi-monthly [ ] Bi-Weekly [ ] Weekly [ ] Other

ACCIDENT INFORMATION

Describe in full detail how accident happened, and give cause - Explain what employee was doing when injured.
Hauling ore on lower concentrate haul road, hit oil slick, swung out to miss it, truck turned over on side.

What specific object or substance caused the injury? oil slick in road
Nature of the injury? (cut, fracture, etc.) none
Part of body affected (leg, arm, back, head, etc.): none
DATE OF INJURY (month) 10 (day) 5 (year) 76 (hour) 1:45 (a.m. or p.m.) pm
Names of witnesses to accident: 1. 2.
Place where accident occurred (address & city): lower concentrate haul road near Libby
(county) Lincoln
Was place of accident on employer's premises? Yes [X] No [ ]
Was employee injured while in your employ? Yes [ ] No [ ]
Were you notified, or did you have actual knowledge of the accident? Yes [X] No [ ]
If yes, date notified & how: by employee 10-26-76
Do you have any reason to question this accident? [ ] Yes [X] No
If yes, please explain fully

MEDICAL

Attending physician name and address: W. T. Matthews, MD, 402 Montana Avenue, Libby, MT 59923
If hospitalized, hospital's name and address: none
Will employee return to work during next scheduled shift? Yes [X] No [ ]
If no, will wage loss exceed 7 days? Yes [ ] No [ ] Not Sure [ ]
Date wage loss began (mo) (day) (yr.)
Date of return, if returned to work (mo.) (day) (yr.)

EMPLOYER

EMPLOYER'S NAME: W. R. Grace & Co. Construction Products Division
Commercial Name (doing business as): Same
Employer's mailing address (Street or Box): Box 609
(City) Libby (State) MT (Zip Code) 59923
Phone number: 293-4131
Location of operation, if different from mailing address: 12 miles north of Libby
Nature of business: Mining & Milling
Firm is a: (Check one) [ ] Sole proprietorship [ ] Partnership, or [X] Corporation
Was the Injured employee? (Check if applicable) [ ] A Sole Proprietor, [ ] A working Partner, [ ] A Corporate Officer, or [ ] A member of the employer's (sole proprietor or partner) family, dwelling in the employer's household.
Prepared by: Joan B. Runyan
Authorized Signature: X
Official Title: Administrative Assistant
Date: 10-26-76

DWC USE ONLY

OCCUPATION
SEX
AGE
MARITAL STATUS
COUNTY
LENGTH (YRS) EMPLOYED
WEEKLY EARNINGS
CLASS CODE
ACCIDENT TYPE
SOURCE OF INJURY
PART OF BODY INJURED
OSHA RECORDABLE CODE
DISABILITY TYPE
NATURE OF INJURY
HAZARDOUS CONDITION
UNSAFE ACT

Above - DWC-MIS Form 37-Employer's First Report (Rev. 1-76)

Below - DWC-MIS Form 54A-Claim for Compensation

EMPLOYEE'S CLAIM FOR COMPENSATION

EMPLOYER'S NOTE: For convenience purposes and if the worker is available, the form below has been provided so that an employer may allow an injured worker to file a claim for compensation on this form to avoid having the employee fill out and file a separate detailed form. Separate claim forms are available if the employer does not want the worker to use this form. **Do not delay in submission of this form if employee is not available to sign below.**

INJURED EMPLOYEE'S NOTE: An injured employee may use the form below to make a claim for compensation, or the employee may fill out and submit a separate detailed form that is available from the Division.

I have carefully read the above information as documented by the employer, and (except for any statements I may write below) I concur with the information and I hereby make claim for compensation benefits due me now or in the future under Montana's Workers' Compensation Act.

Signature of injured employee X | Address | City | Date | Phone

I DO NOT concur with the following information documented by the employer

C0080185

Filing of this claim is authorization for release of medical records and records of the Social Security Administration.

Medical
Smith, Don

C0080186

Industrial Accident Board, Helena, Montana, Form 37 Revised

06063094

Industrial Accident Board

HELENA, MONTANA

Firm No.....

File No.....

EMPLOYER'S FIRST REPORT OF INJURY

DO NOT WRITE IN THIS SPACE

INSTRUCTIONS—Employer must complete form at once after every accident which causes loss of time from work or requires medical attention and mail it to the Industrial Accident Board, Helena, Montana. Form must be signed in pen and ink. ALL QUESTIONS MUST BE ANSWERED FULLY.

INJURED EMPLOYEE

Full name of injured employee: Ronald R. Smith Occupation.....

Mailing address: Route 2, Box 1424, Libby How long has he been in your employ: 17 yrs.

Social Security No.: 538-20-5086 Sex: M Age: 40 Married ☒ Single ☐

EARNINGS

Monthly Wage..... Weekly Wage..... Daily Wage..... Hourly Wage: 2.83

Receive board Yes ☐ No ☒ Daily Value..... Receive room Yes ☐ No ☒ Daily Value.....

Piece Worker Yes ☐ No ☒ If yes, give method of computing earnings.....

Number of hours worked per day: 8 Days worked per week: 5 Employee's pay period?

Monthly ☐ Semi monthly ☐ Weekly ☐ List employee's earnings last 4 pay periods: 1. 351.24 2. 328.28 3. 350.32 4. 316.96

Under what payroll classification has employees' wages been reported?..... (Sawmill - Mechanic - Etc.)

ACCIDENT AND INJURY

Describe in full how accident happened and GIVE CAUSE: While moving ~~XXXXXXXXXX~~ piece of steel from one shelf to another in the warehouse, caught right index finger between ~~XXXX~~ piece of steel and shelf.

Part of body injured? Describe fully: right index finger, lacerated, lost nail

Names of witnesses to accident 1..... 2.....

Date of accident: 1-18 1968 Hour: 10:15 A.M. Was employee injured in course of employment? Yes ☒ No ☐

Place where accident occured: our warehouse, 9 miles north of Libby Lincoln (Address) (City) (County)

Did you or employee's supervisor have actual knowledge of accident? Yes ☒ No ☐

Were you notified of accident by injured employee? Yes ☒ No ☐ How: by employee Date: 1-18-68

Have you reason to question this accident? Yes ☐ No ☒ If "yes" explain fully.....

SAFETY

Was employee's accident due to unsafe work practices? Yes ☐ No ☐ If "yes", what did he do unsafely?

Was a specific device, object or substance involved in accident? Yes ☒ No ☐ If "yes", name specific device, object or substance: piece of steel Was device or object defective? Yes ☐ No ☒

Was employee doing regular work when injured? Yes ☒ No ☐ Was employee trained to do work he was doing when injured? Yes ☒ No ☐ Were adequate safe guards provided? Yes ☐ No ☐ If "yes" were they being used at time of accident? Yes ☐ No ☐

MEDICAL ATTENDANCE

Name of attending physician: Dr. Lyle O. Boldt Address: Libby, Montana

Was employe hospitalized? Yes ☐ No ☒ Name of hospital..... Address.....

Was first aid administered by someone other than attending physician? Yes ☐ No ☒

TIME AND WAGE LOSS

Will employe lose time from work due to accident? Yes ☐ No ☒ How long?.....

If injury results in time loss, will employee, while disabled, receive sick leave benefits? Yes ☐ No ☐

Paid vacation? Yes ☐ No ☐

Will employe lose wages? Yes ☐ No ☐ Room? Yes ☐ No ☐ Board? Yes ☐ No ☐

Date wage loss began: None Amount of weekly wage loss.....

EMPLOYER

Name of employer: Zonolite Division-W.R.Grace & Co.

Address: Libby, Montana Nature of business: Mining & Milling Vermiculite

IS FIRM A CORPORATION ☒ OR PARTNERSHIP ☐ OR INDIVIDUAL ☐

IF
- Corporation—is injured employee an officer or director of corporation? Yes ☐ No ☒
- Partnership—is injured employee related to any partner? Yes ☐ No ☐ Relationship.....
- Individual—is injured employee related to employer? Yes ☐ No ☐ Relationship.....

Signed, this 20th day of January 19 68

at K Libby Montana

Employer's Name: Zonolite Division-W.R.Grace & Co.

Signed by.....

Official Title.....

Carrier | Firm No. | File No. | Major Industry | County | Date of Acc. | Time | Sex & Marital Status | Age | Mont. Code | Acc. Class | Occupation | Type | Agency | Agency Part | Nature of Inj. | Location | Time Loss | Mech. Defect | Unsafe Act | Pers. Factor | Weekly Wage

NOTICE—EMPLOYEE'S CLAIM FOR COMPENSATION, FORM 54, MUST BE FILED WITHIN 12 MONTHS FROM DATE OF ACCIDENT

Form 1-HU-163-ZR

C0080188

Medical
Smith, Don

C0080186

INDUSTRIAL ACCIDENT BOARD, HELENA, MONT. FORM NO. 43—IM 1-57 81907 TRIBUNE PRINTING & SUPPLY CO., GREAT FALLS, MONTANA

Plan No.....

Industrial Accident Board

HELENA, MONTANA

Claim Department

Firm No.....
Claim No.....
Accident No.....
Employee No.....
DO NOT FILL IN

Employer's Supplemental Report Of Injury

This notice to be filled out by employer and sent to the Industrial Accident Board, at Helena, Montana, immediately upon employee's returning to work fully recovered if within two weeks—or upon his death or at the expiration of two weeks from date of injury.

Name of injured employee: Donald R. Smith

Address: Route 1, Box 180, Libby, Montana

Injured 7-7- 19 60

If worked after accident, last date worked? July 11, 1960

Is injured employee fully recovered? Yes On what date? July 11, 1960

Has he/she returned to work for you? Yes On what date? July 11, 1960

Has he/she accepted other employment? ..... On what date? .....

If so, where now employed? .....

Has he/she died? ..... If so, when? .....

Signed: Zonolite Company

Address: Libby, Montana

Dated July 22, 19 60

C00B0189

STANDARD FORM FOR EMPLOYER'S FIRST REPORT OF INJURY

Approved by I. A. I. A. B. C.

☞ Complete and send immediately to CLAIMS DEPARTMENT

State's Number For:	File: ..... Carrier: ..... Employer: .....
Carrier's File No.	

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

POLICY NUMBER .....

Employer

1. Name of Employer: Zonolite Company
2. Office address: No. and St. ..... City or Town: Libby State: Montana
3. Insured by Name of Company: Royal Indemnity Company
4. Give nature of business (or article manufactured): Mining and Milling Vermiculite Ore

Time and Place

5. (a) Location of plant or place where accident occurred: Libby, Montana Department: Mine State if employer's premises: Yes
   (b) If injured in a mine, did accident occur on surface, underground, shaft, drift or mill: Surface
6. Date of Injury: July ~~June~~ 6 1960 Day of week: Wed. Hour of day: 10:00 A.M. P.M.
7. Date disability began: July 7 1960 A.M. 8:00 ~~P.M.~~ 8. Was injured paid in full for this day: yes
9. When did you or foreman first know of injury: July 7, 1960, 11:45 a.m.
10. Name of foreman: Orville Thorn

Injured Person

11. Name of Injured: Donald (First Name) R. (Middle Initial) Smith (Last Name)
12. Address: No. and St.: Route 1, Box 180 City or Town: Libby State: Montana
13. Check (√) Married: X, Single: ....., Widowed: ....., Widower: ....., Divorced: .....; Male: X, Female: .....; White: X, Colored: .....
14. Nationality: American Speak English: Yes
15. Age: 33 Did you have on file employment certificate or permit: .....
16. (a) Occupation when injured: Shovel Operator (b) Was this his or her regular occupation: Yes
    (If not, state in what department or branch of work regularly employed) .....
17. (a) How long employed by you: 9 yrs (b) Piece or time worker: time (c) Wages per hour $: 2.625
18. (a) No. hours worked per day: 8 (b) Wages per day $: 21.00
    (c) No. days worked per week: 5 (d) Average weekly earnings $: 105.00
    (e) If board, lodging, fuel or other advantages were furnished in addition to wages, give estimated value per day, week or month .....

Cause of Injury

19. Machine, tool or thing causing injury: ..... 20. Kind of power (hand, foot, electrical, steam, etc.): ..... 21. Part of machine on which accident occurred: .....
22. (a) Was safety appliance or regulation provided: ..... (b) Was it in use at time: .....
23. Was accident caused by injured's failure to use or observe safety appliance or regulation: .....
24. Describe fully how accident occurred, and state what employee was doing when injured:
    While replacing haulback cable on drum, on shovel, cable slipped.
25. Names and addresses of witnesses: .....

Nature of Injury

26. Nature and location of injury (describe fully exact location of amputations or fractures, right or left): Sprained left wrist.
27. Probable length of disability: Unknown 28. Has injured returned to work: no
    If so, date and hour: ..... At what wage $: .....
29. At what occupation: .....
30. (a) Name and address of physician: Paul I. Seifert, Jr., Libby, Montana
    (b) Name and address of hospital: None

Disposition of Injured

31. Has injured died: No If so, give date of death: .....

Date of this report: July 7, 1960 Employer's name: Zonolite Company

24861A - 50M-11-56 Signed by: ..... Official Title: .....

Formerly CH-41 (I.F.No.1)

C0080190

Industrial Accident Board

HELENA, MONTANA

Claim Department

m No.
im No.
ident No.

DO NOT FILL IN

EMPLOYER'S FIRST REPORT OF INJURY

DO NOT WRITE IN THIS SPACE

INSTRUCTIONS—The employer must fill out this form and return same to Industrial Accident Board, Helena, ntana, at once after every accident which causes any loss of work or requires medical attention. In filling out form use pen or typewriter.

MPLOYER, LACE AND TIME

Employer's name: Zonolite Company
Office address: Libby, Montana (Street and number, city or town)
Nature of business: Mining and Milling (Type of construction, manufacturing, etc.)
Did accident occur on work for a public corporation? No
Location of plant or place of work where accident occurred: Same (Street and Number)
In what city or village? Libby County? Lincoln
Date of accident: July 6, 19 60; hour of day: 10:00 A.M. ~~P.M.~~
Did accident happen on premises? Yes
If away from the plant, state where?
Was employee injured in the course of employment? Yes

THE INJURED MPLOYEE

Give full name of injured workman: Donald R. Smith
Mailing address: Route 1, Box 160, Libby, Montana (Street and number, city or town and county)
Sex: M Age: 33 Speak English? Yes If not, what language?
Occupation when injured? Shovel Operator Married or single? Married
Was injured employee on duty at time of accident? Yes If not, state fully on back hereof (See Form 87-a)
How long was injured person in your employment? 9 years

AUSE OF INJURY

Described in full how the accident occurred (DO NOT FAIL TO DO THIS)
While replacing haulback cable on drum on shovel, sprained wrist.

THE INJURY

State nature and extent of injury according to your own information. (We do not need the doctor's report here) Sprained left wrist.
WILL EMPLOYEE LOSE TIME? YES X NO
DATE WAGE LOSS BEGAN? 7-7-60 PROBABLE DURATION OF WAGE LOSS? unknown (Give your best estimate)

MEDICAL TENDANCE

Name and address of physician attending injured employee: Dr. Paul Seifert, Jr. Libby, M ntana
To what hospital was employee sent? none
If not sent to hospital, where is he? home
Are you still providing medical attendance? yes Have you a hospital contract? no

WAGES

Monthly wage (If paid by month) Weekly wage (If paid by week) Daily wage (If paid by day) Rate per hour 2.625 (If paid by hour)
Number of hours per day 8 How many working days per week 5
If employee receives board in addition to money wage, state how many meals per day none
Does he receive room in addition to money wage? no

AGE LOSS

How much money wage will employee lose per day because of accident? $21.00
How much board? none Will he lose room? no

OTICE OF INJURY

Were you notified by the injured employee of his injury? yes If so, how and when? by employee (Write on back of this form if necessary)
Did you or your managing superintendent in charge of work of injured employee at time of injury have actual knowledge of such accident and injury? yes If so, explain how by employee (Write on back of this form if necessary)

ned. this 7th day of July, 19 60

Employer's Name: Zonolite Company

Signed by

Libby, Montana

Official Title: Secretary

C0080191

TICE—Employer should have injured workmen fill out Form 37-A and return same to Board with Employer's First Report of Injury.

Firm No.
Acc. No.
Major Industry
County
Date of Acc.
Time
Sex & Marital Status
Age
Mont. Code
Acc. Class
Occupation
Type
Agency
Agency Part
Nature of Inj.
Location
Ext. of Dis.
Mech. Defect
Unsafe Act
Pers. Factor
Weekly Wage
Report Lag
Carrier

Medical
Smith, Don

C0080186

WRG00299277
ED_005351_00000355-00362

STANDARD FORM FOR EMPLOYER'S FIRST REPORT OF INJURY

Approved by I. A. I. A. B. C.

Complete and send immediately to CLAIMS DEPARTMENT

POLICY NUMBER.....

State's Number For:	File : ..... Carrier : ..... Employer: .....
Carrier's File No.	

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

Employer

1. Name of Employer: Zonolite Company
2. Office address: No. and St. Box 607 City or Town Libby State Montana
3. Insured by Name of Company Royal Indemnity
4. Give nature of business (or article manufactured) Mining & Milling Vermiculite

Time and Place

5. (a) Location of plant or place where accident occurred Libby
   Mine Department State if employer's premises Yes
   (b) If injured in a mine, did accident occur on surface, underground, shaft, drift or mill Surface
6. Date of Injury 7-11-62 19 Day of week Wed. Hour of day A.M. X 4:00 P.M.
7. Date disability began none 19 A.M. P.M. 8. Was injured paid in full for this day
9. When did you or foreman first know of injury July 18, 1962
10. Name of foreman Orville Thorn

Injured Person

11. Name of Injured Donald (First Name) R. (Middle Initial) Smith (Last Name)
12. Address: No. and St. Route 1, Box 180 City or Town Libby State Montana
13. Check (√) Married X, Single, Widowed, Widower, Divorced; Male X, Female; White X, Colored
14. Nationality American Speak English Yes
15. Age 35 Did you have on file employment certificate or permit
16. (a) Occupation when injured Shovel Operator (b) Was this his or her regular occupation Yes
    (If not, state in what department or branch of work regularly employed)
17. (a) How long employed by you 12 years (b) Piece or time worker Time (c) Wages per hour $ 2.725
18. (a) No. hours worked per day 8 (b) Wages per day $ 21.80
    (c) No. days worked per week 5 (d) Average weekly earnings $ 109.00
    (e) If board, lodging, fuel or other advantages were furnished in addition to wages, give estimated value per day, week or month

Cause of Injury

19. Machine, tool or thing causing injury 20. Kind of power (hand, foot, electrical, steam, etc.) 21. Part of machine on which accident occurred
22. (a) Was safety appliance or regulation provided (b) Was it in use at time
23. Was accident caused by injured's failure to use or observe safety appliance or regulation
24. Describe fully how accident occurred, and state what employee was doing when injured
    While working in pit under dusty conditions, received foreign material (vermiculite) in right eye.
25. Names and addresses of witnesses

Nature of Injury

26. Nature and location of injury (describe fully exact location of amputations or fractures, right or left)
    Foreign material in right eye.
27. Probable length of disability none 28. Has injured returned to work yes
    If so, date and hour July 12, 1962 At what wage $ same
29. At what occupation same
30. (a) Name and address of physician Dr. Paul J. Seifert, Jr., Libby
    (b) Name and address of hospital none

Cause Fatal

31. Has injured died If so, give date of death

Date of this report October 12, 1962 Firm name Zonolite Company

H 24861A - 50M (Formerly CH-1 S.F.No.1)

Signed by ..... Official Title .....

C0080192

trial Accident Board, Helena, Montana, Form 37 Revised—YM - U - WU

STATE PUBLISHING CO., HELENA, MONT. 3

Industrial Accident Board

HELENA, MONTANA

1 No.....

No.....

EMPLOYER'S FIRST REPORT OF INJURY

INSTRUCTIONS—Employer must complete form at once after every accident which causes loss of time from work or requires medical attention and mail it to the Industrial Accident Board, Helena, Montana. Form must be signed in pen and ink. ALL QUESTIONS MUST BE ANSWERED FULLY.

INJURED EMPLOYEE

Full name of injured employee Donald R. Smith Occupation Shovel Operator

Mailing address Route 1, Box 180, Libby. (Street, City) How long has he been in your employ 12 yrs.

Social Security No. 538-20-5086 Sex M Age 35 Married ☒ Single ☐

EARNINGS

Monthly Wage..... Weekly Wage..... Daily Wage..... Hourly Wage 2.725

Receive board Yes ☐ No ☒ Daily Value..... Receive room Yes ☐ No ☒ Daily Value.....

Piece Worker Yes ☐ No ☒ If yes, price per unit at piece work..... Hours worked per day 8

Days worked per week 5 Employee's pay period? Monthly ☐ Semi-monthly ☒ Weekly ☐ List employee's earnings last 4 pay periods 1..... 2..... 3..... 4.....

List Payroll Classification and Code under which employee's wages were reported..... (Sawmill - Mechanic - Etc.) Code..... (2702, 5506, 8810)

ACCIDENT AND INJURY

Describe in full how accident happened and GIVE CAUSE

While working in pit under dusty conditions, received foreign material (vermiculite) in right eye.

Nature or extent of injury Foreign material in (Cut - Fracture) Part of body injured? right eye. (Leg - Arm - Back - Head)

Names of witnesses to accident 1..... 2.....

Date of accident July 11 19 62 Hour 4:00 P.M. Was employee injured in course of employment? Yes ☒ No ☐

Place where accident occurred..... (Address) Libby (City) Montana (County) Lincoln

Did you or employee's supervisor have actual knowledge of accident? Yes ☒ No ☐

Were you notified of accident by injured employee? Yes ☒ No ☐ How by employee Date 7-18-62

Have you reason to question this accident? Yes ☐ No ☒ If "yes" explain fully.....

SAFETY

Was employee's accident due to unsafe work practice? Yes ☐ No ☐ If "yes", what did he do unsafely?.....

Was a specific device, object or substance involved in accident? Yes ☐ No ☐ If "yes," name specific device, object or substance..... Was device or object defective? Yes ☐ No ☐

Was employee doing regular work when injured? Yes ☐ No ☐ Was employee trained to do work he was doing when injured? Yes ☐ No ☐ Were adequate safeguards provided? Yes ☐ No ☐ If "yes," were they being used at the time of accident? Yes ☐ No ☐

MEDICAL ATTENTION

Name of attending physician Dr. Paul Seifert Address Libby, Montana

Was employee hospitalized? Yes ☐ No ☒ Name of hospital..... Address.....

Was first aid administered by someone other than attending physician? Yes ☐ No ☒

TIME AND WAGE LOSS

Will employee lose time from work due to accident? Yes ☐ No ☒ How long?..... If injury results in time loss will employee, while disabled, receive sick leave benefits? Yes ☐ No ☐ Paid vacation? Yes ☐ No ☐ Will employee lose wages? Yes ☐ No ☐ Room? Yes ☐ No ☐ Board? Yes ☐ No ☐

Date wage loss began..... Amount of weekly wage loss.....

EMPLOYER

Name of employer Zonolite Company

Address Libby Montana Nature of business Mining & Milling Vermiculite

IS FIRM A CORPORATION ☒ OR PARTNERSHIP ☐ OR INDIVIDUAL ☐

IF
- Corporation—is injured employee an officer or director of corporation? Yes ☐ No ☒
- Partnership—is injured employee related to any partner? Yes ☐ No ☐ Relationship.....
- Individual—is injured employee related to employer? Yes ☐ No ☐ Relationship.....

Signed, this 18th day of July, 19 62

Libby, Montana

Employer's Name Zonolite Company

Signed by.....

Official Title Secretary

NOTICE—EMPLOYEE'S CLAIM FOR COMPENSATION, FORM 54, MUST BE FILED WITHIN 12 MONTHS FROM DATE OF ACCIDENT.

C0080193

Medical
Smith, Don

C0080186

WRG00299280
ED_005351_00000355-00365

INDUSTRIAL ACCIDENT BOARD, HELENA, MONT. FORM NO. 43—IM 1-57 81907 TRIBUNE PRINTING & SUPPLY CO., GREAT FALLS, MONTANA

06062313 Plan No.

Industrial Accident Board

HELENA, MONTANA

Claim Department

Firm No.
Claim No.
Accident No.
Employee No.

DO NOT FILL IN

Employer's Supplemental Report Of Injury

This notice to be filled out by employer and sent to the Industrial Accident Board, at Helena, Montana, immediately upon employee's returning to work fully recovered if within two weeks—or upon his death or at the expiration of two weeks from date of injury.

Name of injured employee: Donald R. Smith

Address: Route 1, Box 190, Libby, Montana

Injured 7-7- , 19 60

If worked after accident, last date worked? July 11, 1960

Is injured employee fully recovered? Yes On what date? July 11, 1960

Has he/she returned to work for you? Yes On what date? July 11, 1960

Has he/she accepted other employment? On what date?

If so, where now employed?

Has he/she died? If so, when?

Signed: Zonolite Company

Address: Libby, Montana

Dated July 22, 19 60

C0080194

06062314

STANDARD FORM FOR EMPLOYER'S FIRST REPORT OF INJURY

Approved by I. A. I. A. B. C.

☞ Complete and send immediately to
CLAIMS DEPARTMENT

State's Number For:	File : ..... Carrier : ..... Employer: .....
Carrier's File No.	

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

POLICY NUMBER .....

Employer

1. Name of Employer: Zonolite Company
2. Office address: No. and St. ..... City or Town: Libby State: Montana
3. Insured by Name of Company: Royal Indemnity Company
4. Give nature of business (or article manufactured): Mining and Milling Vermiculite Ore

Time and Place

5. (a) Location of plant or place where accident occurred: Libby, Montana
   Department: Mine State if employer's premises: Yes
   (b) If injured in a mine, did accident occur on surface, underground, shaft, drift or mill: Surface
6. Date of Injury: July ~~June~~ 6 19 60 Day of week: Wed. Hour of day: 10:00 A.M. P.M.
7. Date disability began: July 7 19 60 A.M. 8:00 ~~P.M.~~ 8. Was injured paid in full for this day: yes
9. When did you or foreman first know of injury: July 7, 1960, 11:45 a.m.
10. Name of foreman: Orville Thorn

Injured Person

11. Name of Injured: Donald (First Name) R. (Middle Initial) Smith (Last Name)
12. Address: No. and St. Route 1, Box 180 City or Town: Libby State: Montana
13. Check (√) Married X, Single ....., Widowed ....., Widower ....., Divorced .....; Male X, Female .....; White X, Colored .....
14. Nationality: American Speak English: Yes
15. Age: 33 Did you have on file employment certificate or permit: .....
16. (a) Occupation when injured: Shovel Operator (b) Was this his or her regular occupation: Yes
    (If not, state in what department or branch of work regularly employed) .....
17. (a) How long employed by you: 9 yrs (b) Piece or time worker: time (c) Wages per hour $: 2.625
18. (a) No. hours worked per day: 8 (b) Wages per day $: 21.00
    (c) No. days worked per week: 5 (d) Average weekly earnings $: 105.00
    (e) If board, lodging, fuel or other advantages were furnished in addition to wages, give estimated value per day, week or month .....

Cause of Injury

19. Machine, tool or thing causing injury ..... 20. Kind of power (hand, foot, electrical, steam, etc.) ..... 21. Part of machine on which accident occurred .....
22. (a) Was safety appliance or regulation provided ..... (b) Was it in use at time .....
23. Was accident caused by injured's failure to use or observe safety appliance or regulation .....
24. Describe fully how accident occurred, and state what employee was doing when injured:
    While replacing haulback cable on drum, on shovel, cable slipped.
25. Names and addresses of witnesses .....

Nature of Injury

26. Nature and location of injury (describe fully exact location of amputations or fractures, right or left): Sprained left wrist.
27. Probable length of disability: unknown 28. Has injured returned to work: no
    If so, date and hour ..... At what wage $ .....
29. At what occupation .....
30. (a) Name and address of physician: Dr. Paul J. Seifert, Jr., Libby, Montana
    (b) Name and address of hospital: None

Cases Fatal

31. Has injured died: No If so, give date of death: .....

C0080195

Date of this report: July 7, 1960 Firm name: Zonolite Company

CH 24861A - 50M-11-56
Formerly CH-2 (S.F.No.1)

Signed by ..... Official Title .....

WRG00299282

ED_005351_00000355-00367

INDUSTRIAL ACCIDENT BOARD, HELENA, MONTANA. FORM 37 REVISED. 2M 8-59 19933

06062315

Industrial Accident Board

HELENA, MONTANA

Claim Department

Firm No.

Claim No.

Accident No.

DO NOT FILL IN

EMPLOYER'S FIRST REPORT OF INJURY

DO NOT WRITE IN THIS SPACE

INSTRUCTIONS—The employer must fill out this form and return same to Industrial Accident Board, Helena, Montana, at once after every accident which causes any loss of work or requires medical attention. In filling out this form use pen or typewriter.

EMPLOYER, PLACE AND TIME

Employer's name: Zonolite Company

Office address: Libby, Montana (Street and number, city or town)

Nature of business: Mining and Milling (Type of construction, manufacturing, etc.)

Did accident occur on work for a public corporation? No

Location of plant or place of work where accident occurred: Same (Street and Number)

In what city or village? Libby County? Lincoln

Date of accident: July 6, 19 60; hour of day: 10:00 A.M.

Did accident happen on premises? Yes

If away from the plant, state where?

Was employee injured in the course of employment? Yes

THE INJURED EMPLOYEE

Give full name of injured workman: Donald R. Smith

Mailing address: Route 1, Box 180, Libby, Montana (Street and number, city or town and county)

Sex: M Age: 33 Speak English? Yes If not, what language?

Occupation when injured? Shovel Operator Married or single? Married

Was injured employee on duty at time of accident? Yes (See Form 37-a) If not, state fully on back hereof

How long was injured person in your employment? 9 years

CAUSE OF INJURY

Described in full how the accident occurred (DO NOT FAIL TO DO THIS)

While replacing haulback cable on drum on shovel, sprained wrist.

THE INJURY

State nature and extent of injury according to your own information. (We do not need the doctor's report here) Sprained left wrist.

WILL EMPLOYEE LOSE TIME? YES X NO

DATE WAGE LOSS BEGAN? 7-7-60 PROBABLE DURATION OF WAGE LOSS? unknown (Give your best estimate)

MEDICAL ATTENDANCE

Name and address of physician attending injured employee: Dr. Paul Seifert, Jr. Libby, Montana

To what hospital was employee sent? none

If not sent to hospital, where is he? home

Are you still providing medical attendance? yes Have you a hospital contract? no

WAGES

Monthly wage (If paid by month) Weekly wage (If paid by week) Daily wage (If paid by day) Rate per hour 2.625 (If paid by hour)

Number of hours per day 8 How many working days per week 5

If employee receives board in addition to money wage, state how many meals per day none

Does he receive room in addition to money wage? no

WAGE LOSS

How much money wage will employee lose per day because of accident? $21.00

How much board? none Will he lose room? no

NOTICE OF INJURY

Were you notified by the injured employee of his injury? yes If so, how and when? by employee (Write on back of this form if necessary)

Did you or your managing superintendent in charge of work of injured employee at time of injury have actual knowledge of such accident and injury? yes If so, explain how by employee (Write on back of this form if necessary)

Signed, this 7th day of July, 19 60

Employer's Name: Zonolite Company

Signed by

at Libby, Montana

Official Title: Secretary

NOTICE—Employer should have injured workmen fill out Form 37-A and return same to Board with Employer's First Report of Injury.

Firm No. | Acc. No. | Major Industry | County | Date of Acc. | Time | Sex & Marital Status | Age | Mont. Code | Acc. Class | Occupation | Type | Agency | Agency Part | Nature of Inj. | Location | Ext. of Dis. | Mech. Defect | Unsafe Act | Pers. Factor | Weekly Wage | Report Lag | Carrier

C0080196

WRG00299283

ED_005351_00000355-00368

Medical
Smith, Don

C0080186

WRG00299284
ED_005351_00000355-00369

06062872

Industrial Accident Board, Helena, Montana, Form 37 Revised—YM - U - WU

Industrial Accident Board

HELENA, MONTANA

Firm No.....

File No.....

EMPLOYER'S FIRST REPORT OF INJURY

INSTRUCTIONS—Employer must complete form at once after every accident which causes loss of time from work or requires medical attention and mail it to the Industrial Accident Board, Helena, Montana. Form must be signed in pen and ink. ALL QUESTIONS MUST BE ANSWERED FULLY.

INJURED EMPLOYEE

Full name of injured employee: Donald R. Smith Occupation: Shovel Operator

Mailing address: Route #1 2, Box 1424, Libby (Street, City) How long has he been in your employ: 15 yrs.

Social Security No.: 538-20-5086 Sex: M Age: 33 Married ☒ Single ☐

EARNINGS

Monthly Wage ..... Weekly Wage ..... Daily Wage ..... Hourly Wage: 3.06

Receive board Yes ☐ No ☒ Daily Value ..... Receive room Yes ☐ No ☒ Daily Value .....

Piece Worker Yes ☐ No ☒ If yes, price per unit at piece work ..... Hours worked per day: 8

Days worked per week: 6 Employee's pay period? Monthly ☐ Semi-monthly ☒ Weekly ☐ List employee's earnings last 4 pay periods 1. 309.00 2. 336.16 3. 347.22 4. 355.56

List Payroll Classification and Code under which employee's wages were reported ..... Code ..... (Sawmill - Mechanic - Etc.) (2702, 3506, 8810)

ACCIDENT AND INJURY

Describe in full how accident happened and GIVE CAUSE

While operating shovel in the pit, got vermiculite dust in L left eye.

Nature or extent of injury: foreign material in (Cut - Fracture) Part of body injured?: left eye. (Leg - Arm - Back - Head)

Names of witnesses to accident 1. ..... 2. .....

Date of accident: 9-28 19 66 Hour: 10.00 A.M. P.M. Was employee injured in course of employment? Yes ☒ No ☐

Place where accident occurred: our pit, 9 miles north of Libby (Address, City) Lincoln (County)

Did you or employee's supervisor have actual knowledge of accident? Yes ☐ No ☐

Were you notified of accident by injured employee? Yes ☒ No ☐ How: by employee Date: 9-29-66

Have you reason to question this accident? Yes ☐ No ☒ If "yes" explain fully .....

SAFETY

Was employee's accident due to unsafe work practice? Yes ☐ No ☒ If "yes", what did he do unsafely? .....

Was a specific device, object or substance involved in accident? Yes ☐ No ☐ If "yes," name specific device, object or substance ..... Was device or object defective? Yes ☐ No ☐

Was employee doing regular work when injured? Yes ☐ No ☐ Was employee trained to do work he was doing when injured? Yes ☐ No ☐ Were adequate safeguards provided? Yes ☐ No ☐ If "yes," were they being used at the time of accident? Yes ☐ No ☐

MEDICAL ATTENTION

Name of attending physician: Dr. Paul J. Seifert, Jr. Address: Libby, Montana

Was employee hospitalized? Yes ☐ No ☒ Name of hospital: Saw doctor at St. Johns Emergency Room Libby, Montana

Was first aid administered by someone other than attending physician? Yes ☐ No ☒

TIME AND WAGE LOSS

Will employee lose time from work due to accident? Yes ☐ No ☒ How long? ..... If injury results in time loss will employee, while disabled, receive sick leave benefits? Yes ☐ No ☐ Paid vacation? Yes ☐ No ☐ Will employee lose wages? Yes ☐ No ☐ Room? Yes ☐ No ☐ Board? Yes ☐ No ☐

Date wage loss began: NONE Amount of weekly wage loss .....

EMPLOYER

Name of employer: Zonolite Division-W.R.Grace & Co.

Address: Libby, Montana Nature of business: Mining & Milling Vermiculite

IS FIRM A CORPORATION ☒ OR PARTNERSHIP ☐ OR INDIVIDUAL ☐

IF
- Corporation—is injured employee an officer or director of corporation? Yes ☐ No ☒
- Partnership—is injured employee related to any partner? Yes ☐ No ☐ Relationship .....
- Individual—is injured employee related to employer? Yes ☐ No ☐ Relationship .....

Signed, this 29th day of September, 19 66

at Libby, Montana

Employer's Name: Zonolite Division-W.R.Grace & Co.

Signed by .....

Official Title .....

NOTICE—EMPLOYEE'S CLAIM FOR COMPENSATION, FORM 54, MUST BE FILED WITHIN 12 MONTHS FROM DATE OF ACCIDENT.

Δ

Medical
Smith, Don

C0080186

WRG00299286
ED_005351_00000355-00371

06062588

STANDARD FORM FOR EMPLOYER'S FIRST REPORT OF INJURY

Approved by I. A. I. A. B. C.

Complete and send immediately to CLAIMS DEPARTMENT

State's Number For:	File : ..... Carrier : ..... Employer: .....
Carrier's File No.	

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

POLICY NUMBER .....

Employer

1. Name of Employer: Zonolite Company
2. Office address: No. and St. Box 607 City or Town Libby State Montana
3. Insured by Name of Company Royal Indemnity
4. Give nature of business (or article manufactured) Mining & Milling Vermiculite

Time and Place

5. (a) Location of plant or place where accident occurred Libby
   Mine Department State if employer's premises Yes
   (b) If injured in a mine, did accident occur on surface, underground, shaft, drift or mill Surface
6. Date of Injury 7-11-62 19 Day of week Wed. Hour of day A.M. X 4:00 P.M.
7. Date disability began none 19 A.M. P.M. 8. Was injured paid in full for this day
9. When did you or foreman first know of injury July 18, 1962
10. Name of foreman Orville Thorn

Injured Person

11. Name of Injured Donald (First Name) R. (Middle Initial) Smith (Last Name)
12. Address: No. and St. Route 1, Box 180 City or Town Libby State Montana
13. Check (√) Married X, Single ....., Widowed ....., Widower ....., Divorced ....., Male X, Female ....., White X, Colored .....
14. Nationality American Speak English Yes
15. Age 35 Did you have on file employment certificate or permit
16. (a) Occupation when injured Shovel Operator (b) Was this his or her regular occupation Yes
    (If not, state in what department or branch of work regularly employed)
17. (a) How long employed by you 12 years (b) Piece or time worker Time (c) Wages per hour $ 2.725
18. (a) No. hours worked per day 8 (b) Wages per day $ 21.80
    (c) No. days worked per week 5 (d) Average weekly earnings $ 109.00
    (e) If board, lodging, fuel or other advantages were furnished in addition to wages, give estimated value per day, week or month

Cause of Injury

19. Machine, tool or thing causing injury 20. Kind of power (hand, foot, electrical, steam, etc.) 21. Part of machine on which accident occurred
22. (a) Was safety appliance or regulation provided (b) Was it in use at time
23. Was accident caused by injured's failure to use or observe safety appliance or regulation
24. Describe fully how accident occurred, and state what employee was doing when injured
    While working in pit under dusty conditions, received foreign material (vermiculite) in right eye.
25. Names and addresses of witnesses

Nature of Injury

26. Nature and location of injury (describe fully exact location of amputations or fractures, right or left)
    Foreign material in right eye.
27. Probable length of disability none 28. Has injured returned to work yes
    If so, date and hour July 12, 1962 At what wage $ same
29. At what occupation same
30. (a) Name and address of physician Dr. Paul J. Seifert, Jr., Libby
    (b) Name and address of hospital none

Cases Fatal

31. Has injured died ..... If so, give date of death .....

C0080198

Date of this report October 12, 1962 Firm name Zonolite Company

Signed by ..... Official Title .....

CH 24861A - 50M
Formerly CH42

WRG00299287

ED_005351_00000355-00372

06062489

Industrial Accident Board, Helena, Montana, Form 37 Revised—YM - U - WU

STATE PUBLISHING CO., HELENA, MONT.

Industrial Accident Board

HELENA, MONTANA

Firm No.....

File No.....

EMPLOYER'S FIRST REPORT OF INJURY

INSTRUCTIONS—Employer must complete form at once after every accident which causes loss of time from work or requires medical attention and mail it to the Industrial Accident Board, Helena, Montana. Form must be signed in pen and ink. ALL QUESTIONS MUST BE ANSWERED FULLY.

INJURED EMPLOYEE

Full name of injured employee: Donald R. Smith Occupation: Shovel Operator

Mailing address: Route 1, Box 180, Libby. (Street, City) How long has he been in your employ: 12 yrs.

Social Security No.: 538-20-8086 Sex: M Age: 38 Married ☒ Single ☐

EARNINGS

Monthly Wage..... Weekly Wage..... Daily Wage..... Hourly Wage: 2.72$

Receive board Yes ☐ No ☒ Daily Value..... Receive room Yes ☐ No ☒ Daily Value.....

Piece Worker Yes ☐ No ☒ If yes, price per unit at piece work..... Hours worked per day: 8

Days worked per week: 5 Employee's pay period? Monthly ☐ Semi-monthly ☒ Weekly ☐ List employee's earnings last 4 pay periods 1..... 2..... 3..... 4.....

List Payroll Classification and Code under which employee's wages were reported..... Code..... (Sawmill - Mechanic - Etc.) (2702, 5506, 8810)

ACCIDENT AND INJURY

Describe in full how accident happened and GIVE CAUSE: While working in pit under dusty conditions, received foreign material (vermiculit in right eye.

Nature or extent of injury: Foreign material in (Cut - Fracture) Part of body injured? right eye. (Leg - Arm - Back - Head)

Names of witnesses to accident 1..... 2.....

Date of accident: July 11 19 62 Hour: 4:00 P.M. Was employee injured in course of employment? Yes ☒ No ☐

Place where accident occurred..... (Address) Libby (City) Montana (County) Lincoln

Did you or employee's supervisor have actual knowledge of accident? Yes ☒ No ☐

Were you notified of accident by injured employee? Yes ☒ No ☐ How: by employee Date: 7-18-62

Have you reason to question this accident? Yes ☐ No ☒ If "yes" explain fully.....

SAFETY

Was employee's accident due to unsafe work practice? Yes ☐ No ☐ If "yes", what did he do unsafely?.....

Was a specific device, object or substance involved in accident? Yes ☐ No ☐ If "yes," name specific device, object or substance..... Was device or object defective? Yes ☐ No ☐

Was employee doing regular work when injured? Yes ☐ No ☐ Was employee trained to do work he was doing when injured? Yes ☐ No ☐ Were adequate safeguards provided? Yes ☐ No ☐ If "yes," were they being used at the time of accident? Yes ☐ No ☐

MEDICAL ATTENTION

Name of attending physician: Dr. Paul Seifert Address: Libby, Montana

Was employee hospitalized? Yes ☐ No ☒ Name of hospital..... Address.....

Was first aid administered by someone other than attending physician? Yes ☐ No ☒

TIME AND WAGE LOSS

Will employee lose time from work due to accident? Yes ☐ No ☒ How long?..... If injury results in time loss will employee, while disabled, receive sick leave benefits? Yes ☐ No ☐ Paid vacation? Yes ☐ No ☐ Will employee lose wages? Yes ☐ No ☐ Room? Yes ☐ No ☐ Board? Yes ☐ No ☐

Date wage loss began..... Amount of weekly wage loss.....

EMPLOYER

Name of employer: Zonolite Company

Address: Libbymx Montana Nature of business: Mining & Milling Vermic

IS FIRM A CORPORATION ☒ OR PARTNERSHIP ☐ OR INDIVIDUAL ☐

IF
- Corporation—is injured employee an officer or director of corporation? Yes ☐ No ☒
- Partnership—is injured employee related to any partner? Yes ☐ No ☐ Relationship.....
- Individual—is injured employee related to employer? Yes ☐ No ☐ Relationship.....

Signed, this 18th day of July, 19 62

at Libby, Montana

Employer's Name: Zonolite Company

Signed by.....

Official Title: Secretary

NOTICE—EMPLOYEE'S CLAIM FOR COMPENSATION, FORM 54, MUST BE FILED WITHIN 12 MONTHS FROM DATE OF ACCIDENT.

C0080199

~~WRG00299288~~

ED_005351_00000355-00373

Medical
Smith, Don

C0080186

WKG00299289
ED_005351_00000355-00374

Crawford
RISK MANAGEMENT SERVICES

CLAIMS SERVICES
HEALTH AND REHABILITATION
INFORMATION SYSTEMS
RISK CONTROL
EDUCATION
RISK SCIENCES GROUP

JOHN J. GREGORY
BRANCH MANAGER
CLAIMS SERVICES

February 9, 1987

W.R. Grace
P. O. Box 609
Libby, MT 59923

Injured Employee: Don R. Smith

Employer: W.R. Grace

Date of Injury: 1-30-87

Kind of Injury: cut right hand

YOUR ASSISTANCE IS NEEDED in order for us to comply on your behalf with the requirements of the Workers' Compensation Law.

A report of work injury concerning this employee has been received. However, we have not received your Employer's Report of Industrial Injury to confirm this injury and provide us with information necessary to properly handle this claim.

We have enclosed an Employer's Report of Injury form for your convenience. If you have already submitted your report, please send a copy. If, in your opinion, this injury is not work-related, we will need the facts upon which you have based your opinion.

Please attach this letter to your reply.

Sincerely,

CRAWFORD & COMPANY

L. Block

Linda Block

C00B0200

Medical
Smith, Don

C0080186

GRACE

INCIDENT INVESTIGATION REPORT
PERSONAL INJURY/PROPERTY DAMAGE

87-A2

NUMBER OF DAYS AWAY FROM WORK

NUMBER OF RESTRICTED WORK DAYS

DIVISION/PLANT: CONSTRUCTION PRODUCTS - W.R. GRACE

PLANT LOCATION (City/State): LIBBY, MONT

INJURY NUMBER (From OSHA 200 Log):

LOCATION OF INCIDENT: 10TH FLOOR MILL

COMPANY PREMISES: ☒ YES ☐ NO

TIME OF INCIDENT: 1:40 AM ☐ PM ☒

DATE OF INCIDENT: JAN | 30 | 87

PERSONNEL

INJURED OR ILL

NAME (FIRST): DONALD (MIDDLE): R. (LAST): SMITH

SOC SEC NO #: 538-20-5086

OCCUPATION: #2 OPERATOR

SEX: ☒ MALE ☐ FEMALE

MARITAL STATUS: ☒ MARRIED ☐ SINGLE

DATE OF BIRTH: 4 | 12 | 27

ACCIDENT CATEGORY: ☐ DAYS AWAY FROM WORK ☐ MEDICAL TREATMENT ☐ RESTRICTED WORK ☐ FIRST AID

LENGTH OF EMPLOYMENT: YEARS 25 MONTHS 9

LENGTH OF PRESENT OCC.: YEARS 8 MONTHS 6

SHIFT: ☒ REG. ☐ OVERTIME

NATURE OF INJURY/PARTS OF BODY AFFECTED: 3 LACERATIONS ON HAND - POSSIBLE FRACTURE

DATES OF PREVIOUS INJURIES:

WHAT FIRST AID: HAND WRAPPED

WHERE GIVEN: CONTROL ROOM

BY WHOM: B. CHAPPEL - L. THOM

WHERE SENT: ☒ HOSPITAL (Name and Address) ☐ HOME ☐ OTHER (Specify)

ST. JOHNS LUTHERN HOSPITAL - E. ROOM

NAME AND ADDRESS OF ATTENDING PHYSICIAN:

PROPERTY

PROPERTY DAMAGE (est. dollar value): 0

LOST PRODUCTION (# days hours lost) AND ESTIMATED VALUE: 0

LOSS TYPE (explosion, fire, wind) / IDENTIFY PROPERTY DAMAGED: 0

OTHER

(NEAR MISS) NATURE OF INCIDENT / DOLLAR COST (if applicable):

DESCRIPTION

DESCRIBE EVENTS LEADING TO INCIDENT/WORK IN PROGRESS/STAGE OF PROCESS/ACTUAL ACTS OF INJURED AND FELLOW EMPLOYEES

IN The process of cleaning Clarkson Feeder. Slipped + dropped feeder. Tried to catch it + ~~it~~ Feeder banged his hand into floor, lacerating hand in 3 places + possibly fracturing knuckle.

C00B0201

73-119(Rev. 6/82)

DESCRIPTION

CONTINUE DESCRIPTION

ANALYSIS AND EVALUATION

IMMEDIATE CAUSE(S): WHAT SPECIFIC ACTS / FAILURE TO ACT OR CONDITIONS CONTRIBUTED DIRECTLY TO THE INCIDENT?

BASIC CAUSE(S): WHAT ARE THE BASIC CAUSES AND WHAT ARE THE REASONS FOR THESE CAUSES TO EXIST?

EVALUATION	SEVERITY POTENTIAL			PROBABLE RECURRENCE RATE		
	☐ MAJOR	☐ SERIOUS	☐ NOT SERIOUS	☐ FREQUENT	☐ OCCASIONAL	☐ RARE

PREVENTION

WHAT CORRECTIVE ACTION HAS BEEN OR WILL BE TAKEN TO PREVENT A RECURRENCE?

COMPLETION DATE

INVESTIGATED BY	DATE	REVIEWED BY	DATE

REVIEWER'S COMMENTS (IS INVESTIGATION COMPLETE AND CORRECTIVE ACTION ADEQUATE?)

C0080202

IF SERIOUS PROPERTY DAMAGE OR PERSONAL INJURY OCCURS, IMMEDIATELY PHONE THE ICG HEALTH AND SAFETY DEPARTMENT.

DIVISION OF WORKERS' COMPENSATION

MONTANA DIVISION OF WORKERS' COMPENSATION

5 South Last Chance Gulch - Helena, Montana 59601

EMPLOYER'S FIRST REPORT OF NOTICE of Occupational Injury or Occupational Disease

DATE STAMP

SEND ORIGINAL TO INSURER
Crawford Risk Management
P O Box 2397
Kalispell, MT 59903-2397

CASE NO. 87-2A

FIRM NO. 2503

DEPT. CODE

EMPLOYEE COPY

INSTRUCTIONS: Every employer in Montana is required by law to complete this form immediately after notice of every industrial accident to an employee which causes loss of time from work or requires medical attention, regardless of whether the employer believes the injury to be compensable. The original of this form must be immediately filed with the employer's insurer or the Division of Workers' Compensation, 5 South Last Chance Gulch, Helena, Montana 59601. All questions must be answered fully. If a question cannot be answered please explain why. **Please print with a ball point pen or type.**

FEDERAL OSHA REQUIREMENTS. The United States Department of Labor requires employers to maintain, in the employer's office, a record of occupational injuries. For the employer's convenience, this form has been designed to meet such requirements and to provide employers a record copy.

EMPLOYER'S REPORT OF NOTICE

Employee

FULL NAME OF INJURED EMPLOYEE: Donald R Smith
SOCIAL SECURITY NUMBER: 538-20-5086
EMPLOYEE'S HOME ADDRESS (Street or Box): 134 Ski Road
CITY: Libby
STATE: MT
ZIP CODE: 59923
OCCUPATION: #2 Mill Operator
SEX: M
DATE OF BIRTH (Mo./Day/Yr.): 04/ 12 /27
MARITAL STATUS: [X] Married [ ] Single
LENGTH OF TIME WITH THIS EMPLOYER: since 05-03-51

Wages

Employee's Gross Wage Rate is $ 13.15 Per [ ] WEEK [ ] DAY [X] HOUR [ ] MO.
Days Worked Per Week: 5
Hours Worked Per Day: 8
If board or room is furnished, state value reported per day to Internal Revenue Service. $
Check one: [X] Full Time Employee [ ] Part Time Employee
Payroll Classification under which employee's wages were reported:
Employee's Pay Period: [ ] Monthly [X] Semi-monthly [ ] Bi-weekly [ ] Weekly [ ] Other (explain)
Employee's gross earnings for last four (4) pay periods: (Date / Amount) (Date / Amount) (Date / Amount) (Date / Amount)
Will employee return to work during next scheduled shift? [X] Yes [ ] No
If no, will wage loss exceed 5 work days? [ ] Yes [ ] No [ ] Not Sure
REG. DAYS OFF: Sat/Sun
DATE WAGE LOSS BEGAN (Mo/Day/Yr): n/a / /
DATE OF RETURN, if returned to work (Mo/Day/Yr): / /
Do the pay periods show usual wages? [ ] Yes [ ] No
Do the wages include overtime pay? [ ] Yes [ ] No
Are other forms of payment, besides wages, customary? [ ] Yes [ ] No

Accident Information

If you have knowledge of the accident, describe in full detail how accident happened, and give cause. Explain what employee was doing when injured.
IN THE PROCESS OF CLEANING the CLARKSON Feeder, employee slipped & dropped feeder. Employee tryed to catch it & feeder banged his hand into floor, LACERATING hand in 3 places WITH POSSIBLE FRACTURE
DATE OF INJURY (month) (day) (year): 1-30-87 (hour) (a.m. or p.m.): 1340 pm
What specific object or substance caused the injury? CLARKSON feeder.
Nature of the injury? (cut, fracture, etc.) LACERATION
Part of body affected (leg, arm, back, head, etc.) Right HAND
Names of witnesses to accident: 1. 2.
Was place of accident on employer's premises? [X] Yes [ ] No
Place where accident occurred (address & city): 12 miles NE of Libby @ minesite (county) Lincoln
Was employee injured while in your employ? [X] Yes [ ] No
Were you notified, or did you have actual knowledge of the accident? [X] Yes [ ] No
If yes, date notified & how: by x-ray billing 2-10-87
Do you have any reason to question this accident? [ ] Yes [X] No
If yes, please explain fully:

Medical

Attending Physician's Name: ROGER BRUS ~~Robert Patton, MD.~~
Address (Street or Box): ~~418 Main Ave.~~ 114 E. Cedar
(City): Libby, MT
(State)
(Zip Code): 59923
If Hospitalized, Hospital's Name
Address (Street or Box)
(City)
(State)
(Zip Code)

Employer

Employer's Name: W R Grace & Co
Commercial Name (doing business as)
Employer's mailing address (Street or Box): P O Box 609
(City): Libby, MT
(State)
(Zip Code): 59923
Phone Number: 293-3746
Location of operation, if different from mailing address: Office: 317 Mineral Ave, Libby, MT 59923
Nature of business: mine & mill vermiculite
Firm is a (check one): [ ] Sole proprietorship [ ] Partnership, or [X] Corporation
Was the injured employee? (Check if applicable) [ ] A Sole Proprietor [ ] A working Partner [ ] A Corporate Officer, or [ ] A member of the employer's (sole proprietor or partner) family dwelling in the employer's household.
Prepared By: Sue Whitmarsh
Authorized Signature:
Official Title: Administrative Mgr
Date:

ABOVE - DWC - MIS Form PF937 - Employer's First Report (Rev. 10/85)
BELOW - DWC - MIS Form PF954 - Claim for Compensation

EMPLOYEE'S CLAIM FOR COMPENSATION

EMPLOYER'S NOTE: For convenience purposes and if the worker is available, the form below has been provided so that an employer may allow an injured worker to file a claim for compensation on this form to avoid having the employee fill out and file a separate detailed form. Separate claim forms are available if the employer does not want the worker to use this form. **DO NOT DELAY IN SUBMISSION OF THIS FORM IF EMPLOYEE IS NOT AVAILABLE TO SIGN BELOW.**

INJURED EMPLOYEE'S NOTE: An injured employee may use the form below to make a claim for compensation, or the employee may fill out and submit a separate detailed form that is available from the Division. If the employer is unavailable or refuses to complete and submit this form, contact the Division of Workers' Compensation for a separate Claim for Compensation form.

List other types of work you have done: 1. 2. 3.
Education: [ ] Grade School [ ] High School [ ] College [ ] Other
How many members are in your immediate family?
Have you ever had an industrial injury before? [ ] Yes [ ] No
If yes, in what state?
Type of injury:

I have carefully read the information as documented by the employer, and (except for any statements I may write below) I concur with the information and I hereby make claim for compensation benefits due me now or in the future under Montana Workers' Compensation or Occupational Disease Acts.

Signature of injured employee: X [signature]
Address: 134 Ski Road
City: Libby
Date: 2-11-87
Phone: 293-4651

I DO NOT concur with the following information documented by the employer:

Filing of this claim is authorization for release of medical records, rehabilitation records and records of the Social Security Administration

DWC-MIS PF937 (Rev. 10/85) Replaces Forms 37 and 37F

C0080203

DS 269/270

GRACE

Zonolite
Construction Products Division

W.R. Grace & Co.
P.O. Box 609
Libby, MT 59923-0609

(406) 293-3746

Ambulance Copy
AMBULANCE COMPANY: W.R. GRACE DATE: 01 30 87 (Mo. Day Year)
Check One: ☑ Ground Transport ☐ Air Transport
Patient's Name: DON SMITH
Address:

AGE: 59 ☑ Years ☐ Months SEX: ☑ Male ☐ Female

TIMES (24-Hour):

Call Received	13:43
Ambulance En-Route	13:44
Arrived At Scene	13:45
En-route to Destin.	13:51
Arrived at Destin.	14:12
Available for Service (Optional)	14:40

DISPATCHED BY:
☐ 911
☐ Law Enforcement
☐ Medical Facility
☐ Fire Dept.
☐ Private Agency
☑ Other: CONTROL ROOM

NATURE OF CALL:
☐ Emergent
☐ Urgent
☑ Elective
☐ Transfer (Scheduled)
☐ Inter-Hospital Transfer
☐ Pronounced Dead
☐ Dry Run/False Alarm

NATURE OF SERVICE:
☑ Treated & Transported
☐ Transported Only
☐ Call Cancelled En-Route/At Scene
☐ Treated, Not Transported
☐ Treatment Refused, Not Transp.
☐ Unable to Locate

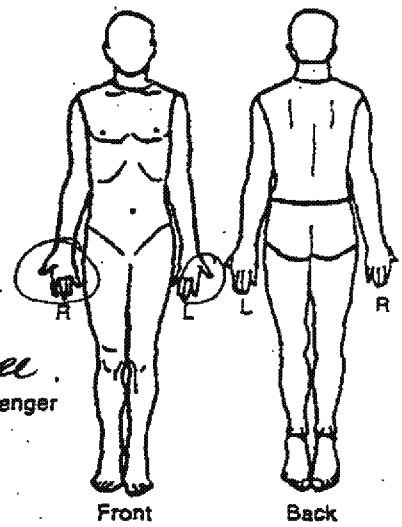
PATIENT TAKEN FROM: ZONOLITE MINE (MILL) TO ST. JOHNS HOSPITAL LIBBY.
Delays Encountered At Scene/En-Route:

PATIENT'S CONDITION AT SCENE:
Level of Consciousness
☑ Alert/Oriented
☐ Confused/Disoriented
☐ Unresponsive
☐ D.O.A. At Scene

CHECK IF PRESENT:
☐ Breathing Difficulties
☐ Total Obstructed Airway
☐ Respiratory Arrest
☐ Cyanosis
☐ Nausea/Vomiting
☐ Convulsions
☐ Shock
☐ Other:

SIGNS AND SYMPTOMS SUGGEST:
☐ Major Trauma
☐ Spinal Injury
☐ Head Injury
☐ Minor Trauma
☐ Cardiac Condition
☐ High Risk Infant
☐ Alcohol Abuse
☐ Drug Abuse/Overdose
☐ Poisoning
☐ CVA (Stroke)
☐ Psychiatric Problem
☐ Burn: ___ % of Body
☐ Other — Details Below

MAJOR INJURY/PROBABLY FRACTURE, FOLLOWING LOCATION (Please "X"):



1352 : 1400 Time ___ : ___
B.P.
74 70 P.
20 20 R.
☑ Equal ☐ Unequal Pupils ☐ Equal ☐ Unequal

SUSPECTED INJURY/ILLNESS: Laceration L & R HANDS POSSIBLE 2ND Phalange FRACTURE

SUSPECTED CAUSE: ☐ M.V. Accident: ☐ Driver ☐ Passenger
☑ Industrial Accident ☐ Other Accident ☐ Drowning
☐ Fall ☐ Other:

CHANGES IN CONDITION:

At Scene		En-Route
☐	Improved	☐
☑	Unchanged	☑
☐	Worsened	☐
☐	Cardiac Arrest	☐

EMERGENCY CARE RENDERED: ☐ Transported Only

At Scene	En Route		At Scene	En Route	
☐	☐	Airway Cleared/Maintained	☐	☐	Burn Treated
☐	☐	Oropharyngeal Airway Used	☑	☑	Bleeding Controlled
☐	☐	Oxygen Administered	☐	☐	Neck/Spine Immobilization
		___ Liters/minute	☐	☐	Extremity Splints/Traction
☐	☐	Artificial Respiration	☐	☐	MAST Trousers
☐	☐	CPR Initiated	☐	☐	IV Fluids Maintained
			☐	☐	Psychological Aid
			☐	☐	Other:

___ : ___ Time

COMMUNICATIONS:

At Scene	En Route	
☑	☐	Radio Communication Established Hospital: 1350
☐	☐	Communication Problems (Please Specify Nature Below)

NOTES/MEDICAL HISTORY: LEROY thom / WILLIAM Chappell

ATTENDANT'S LEVEL OF TRAINING:
☐ M.D. ☐ L.P.N. ☐ E.M.T.-A
☐ R.N. ☐ Adv. E.M.T. ☑ Adv. First Aid

DRIVER'S EMT NO: ___ ATTENDANT'S EMT NO: ___ ATTENDANT'S EMT NO: ___ ATTENDANT'S EMT NO: ___

C0080204
WRG00299295
ED_005351_00000355-00380

Medical
Smith, Don

C0080186

GRACE

INCIDENT INVESTIGATION REPORT

~~PERSONAL INJURY~~/PROPERTY DAMAGE

NUMBER OF DAYS AWAY FROM WORK

NUMBER OF RESTRICTED WORK DAYS

DIVISION/PLANT	PLANT LOCATION (City/State)	INJURY NUMBER (From OSHA 200 Log)
CPD/Libby Operations	Libby, MT 59923	N/A

LOCATION OF INCIDENT	COMPANY PREMISES	TIME OF INCIDENT	DATE OF INCIDENT
10th Floor Mill	XX YES ☐ NO	: AM ☐ PM ☐	

PERSONNEL

INJURED OR ILL

NAME (FIRST) Donald (MIDDLE) (LAST) Smith

SOC. SEC NO. # 538-20-5086

OCCUPATION: No. 2 Mill Operator

SEX: ☒ MALE ☐ FEMALE

MARITAL STATUS: ☒ MARRIED ☐ SINGLE

DATE OF BIRTH: 04 | 12 | 27

ACCIDENT CATEGORY: ☐ DAYS AWAY FROM WORK ☐ MEDICAL TREATMENT ☐ RESTRICTED WORK ☐ FIRST AID

LENGTH OF EMPLOYMENT	YEARS	MONTHS	LENGTH OF PRESENT OCC.	YEARS	MONTHS	SHIFT
	35	0		7	6	☒ REG. ☐ OVERTIME

NATURE OF INJURY/PARTS OF BODY AFFECTED: Banged head on overhead pipe

DATES OF PREVIOUS INJURIES: n/a

WHAT FIRST AID	WHERE GIVEN	BY WHOM
N/A	N/A	N/A

WHERE SENT ☐ HOSPITAL (Name and Address) ☐ HOME ☐ OTHER (Specify): N/A

NAME AND ADDRESS OF ATTENDING PHYSICIAN: N/A

PROPERTY

PROPERTY DAMAGE (est. dollar value): N/A

LOST PRODUCTION (i.e., days, hours, lbs., tons) AND ESTIMATED VALUE: N/A

LOSS TYPE (explosion, fire, wind)/IDENTIFY PROPERTY DAMAGED: N/A

OTHER

(NEAR MISS) NATURE OF INCIDENT/DOLLAR COST (if applicable)

Hitting head on overhead pipe on tenth floor, possible head/neck injury.

DESCRIPTION

DESCRIBE EVENTS LEADING TO INCIDENT/WORK IN PROGRESS/STAGE OF PROCESS/ACTUAL ACTS OF INJURED AND FELLOW EMPLOYEES

Climbing up stairs, employee banged head on overhead pipe 10th floor Mill. Possible head injury or neck injury. Recommendation is to move stairs to other side or realign pipe

* EMPLOYEE WAS WEARING HARD HAT.

C0080205

73-119(Rev 6/82)

DESCRIPTION

CONTINUE DESCRIPTION

ANALYSIS AND EVALUATION

IMMEDIATE CAUSE(S): WHAT SPECIFIC ACTS / FAILURE TO ACT OR CONDITIONS CONTRIBUTED DIRECTLY TO THE INCIDENT?

Overhead pipe above stair and landing distance from stair step to pipe =

Rod Mill Line: Landing Top = 42"
1st Step from Landing = 50"
2nd Step from Landing = 58"
3rd Step from Landing = 67"

With the average height in the US for malessat 69" there is probable cause for concern in regards to a future accident/incident.

PICTURES TAKEN 5/14/86 (ATTACHED - Jake)

BASIC CAUSE(S): WHAT ARE THE BASIC CAUSES AND WHAT ARE THE REASONS FOR THESE CAUSES TO EXIST?

EVALUATION	SEVERITY POTENTIAL			PROBABLE RECURRENCE RATE		
	☐ MAJOR	☒ SERIOUS	☐ NOT SERIOUS	☐ FREQUENT	☐ OCCASIONAL	☒ RARE

PREVENTION

WHAT CORRECTIVE ACTION HAS BEEN OR WILL BE TAKEN TO PREVENT A RECURRENCE?

Millwrights are looking into moving stairway to another location to avoid coming into contact with the pipe.

Until this corrective action is carried out, suggestion is to paint pipe above with Fluorescent Orange Paint for warning

COMPLETION DATE 05 | 13 | 86

INVESTIGATED BY	DATE	REVIEWED BY	DATE
Terry J. Jacobs Jake	05 | 13 | 86		| |

REVIEWER'S COMMENTS (IS INVESTIGATION COMPLETE AND CORRECTIVE ACTION ADEQUATE?)

C0080206

IF SERIOUS PROPERTY DAMAGE OR PERSONAL INJURY OCCURS, IMMEDIATELY PHONE THE ICG HEALTH AND SAFETY DEPARTMENT.

Medical
Smith, Don

C0080186

99299

ED_005351_00000355-00384

06062613

Industrial Accident Board, Helena, Montana, Form 37 Revised—YM - U - WU

STATE PUBLISHING CO., HELENA, MONT.

Industrial Accident Board

HELENA, MONTANA

Firm No.....

File No.....

EMPLOYER'S FIRST REPORT OF INJURY

INSTRUCTIONS—Employer must complete form at once after every accident which causes loss of time from work or requires medical attention and mail it to the Industrial Accident Board, Helena, Montana. Form must be signed in pen and ink. ALL QUESTIONS MUST BE ANSWERED FULLY.

INJURED EMPLOYEE

Full name of injured employee: Donald R. Smith Occupation: Shovel Operator

Mailing address: Route 1, Box 180, Libby (Street, City) How long has he been in your employ: 12 year

Social Security No.....Sex: M Age: 36 Married [X] Single [ ]

EARNINGS

Monthly Wage..... Weekly Wage..... Daily Wage..... Hourly Wage: 2.80

Receive board Yes [ ] No [X] Daily Value..... Receive room Yes [ ] No [X] Daily Value.....

Piece Worker Yes [ ] No [ ] If yes, price per unit at piece work..... Hours worked per day: 8

Days worked per week: 5 Employee's pay period? Monthly [ ] Semi-monthly [X] Weekly [ ] List employee' earnings last 4 pay periods 1..... 2..... 3..... 4.....

List Payroll Classification and Code under which employee's wages were reported..... (Sawmill - Mechanic - Etc.) Code..... (2702, 5306, 8810

ACCIDENT AND INJURY

Describe in full how accident happened and GIVE CAUSE: While operating shovel, operator was having trouble with hoist cable, crawled out front window of shovel cab, striking top of head on top of window frame.

Nature or extent of injury: Severe laceration (Cut - Fracture) Part of body injured? left side of top of hea (Leg - Arm - Back - Head)

Names of witnesses to accident 1..... 2.....

Date of accident: 10 - 9 19 63 Hour: 1:00 A.M. P.M. Was employee injured in course of employment? Yes [X] No [ ]

Place where accident occurred: our pit, 9 miles north of Libby, (Address, City) Lincoln (County)

Did you or employee's supervisor have actual knowledge of accident? Yes [X] No [ ]

Were you notified of accident by injured employee? Yes [X] No [ ] How: by employee Date: 10-15-63

Have you reason to question this accident? Yes [ ] No [X] If "yes" explain fully.....

SAFETY

Was employee's accident due to unsafe work practice? Yes [X] No [ ] If "yes", what did he do unsafely? should not have crawled out window--should have used steps provided.

Was a specific device, object or substance involved in accident? Yes [ ] No [ ] If "yes," name specific device, object o substance.....Was device or object defective? Yes [ ] No [ ]

Was employee doing regular work when injured? Yes [X] No [ ] Was employee trained to do work he was doing whe injured? Yes [X] No [ ] Were adequate safeguards provided? Yes [ ] No [ ] If "yes," were they being used at th time of accident? Yes [ ] No [ ]

MEDICAL ATTENTION

Name of attending physician: Dr. Paul J. Seifert, Jr. Address: Libby, Montana

Was employee hospitalized? Yes [ ] No [X] Name of hospital: St. Johns Lutheran for emergency only Address.....

Was first aid administered by someone other than attending physician? Yes [X] No [ ]

TIME AND WAGE LOSS

Will employee lose time from work due to accident? Yes [X] No [ ] How long? Lost one day If injur results in time loss will employee, while disabled, receive sick leave benefits? Yes [X] No [ ] Paid vacation? Yes [ ] No [ ] Will employee lose wages? Yes [ ] No [ ] Room? Yes [ ] No [ ] Board? Yes [ ] No [ ]

Date wage loss began: 10-10-63 Amount of weekly wage loss.....

EMPLOYER

Name of employer: Zonolite Division-W.R.Grace & Co.

Address: Libby, Montana Nature of business: Mining & Milling Vermicull

IS FIRM A CORPORATION [X] OR PARTNERSHIP [ ] OR INDIVIDUAL [ ]

IF
- Corporation—is injured employee an officer or director of corporation? Yes [ ] No [X]
- Partnership—is injured employee related to any partner? Yes [ ] No [ ] Relationship.....
- Individual—is injured employee related to employer? Yes [ ] No [ ] Relationship.....

Signed, this 15th day of October, 19 63

at Libby, Montana

Employer's Name: Zonolite Division-W.R.Grace & Co.

Signed by.....

Official Title: Secretary

NOTICE—EMPLOYEE'S CLAIM FOR COMPENSATION, FORM 54, MUST BE FILED WITHIN 12 MONTHS FROM DATE OF ACCIDENT.

C0080207

WRG00299300

ED_005351_00000355-00385

MEDICAL
Smith, Harry R.

C0080208

• INDUSTRIAL ACCIDENT BOARD, HELENA, MONT. FORM NO. 43-1M 1-57 81907 TRIBUNE PRINTING & SUPPLY CO., GREAT FALLS, MONTANA

Plan No. 06062764

Industrial Accident Board

HELENA, MONTANA

Claim Department

Firm No.
Claim No.
Accident No.
Employee No.

DO NOT FILL IN

Employer's Supplemental Report Of Injury

This notice to be filled out by employer and sent to the Industrial Accident Board, at Helena, Montana, immediately upon employee's returning to work fully recovered if within two weeks—or upon his death or at the expiration of two weeks from date of injury.

Name of injured employee: Harry R. Smith

Address: 514 East 8th, Libby, Montana

Injured: January 17, 19 64

If worked after accident, last date worked?

Is injured employee fully recovered? yes On what date? January 20, 1964

Has he/she returned to work for you? yes On what date? January 20, 1964

Has he/she accepted other employment? On what date?

If so, where now employed?

Has he/she died? If so, when?

Signed: Zonolite Division-W.R.Grace & Co.

Address: Libby, Montana

Dated: January 22, 19 64

C0080209

06062765

Industrial Accident Board, Helena, Montana, Form 37 Revised—YM - U - WU

STATE PUBLISHING CO., HELENA, MONT.

Industrial Accident Board

HELENA, MONTANA

Firm No.....

File No.....

EMPLOYER'S FIRST REPORT OF INJURY

INSTRUCTIONS—Employer must complete form at once after every accident which causes loss of time from work or requires medical attention and mail it to the Industrial Accident Board, Helena, Montana. Form must be signed in pen and ink. ALL QUESTIONS MUST BE ANSWERED FULLY.

1

INJURED EMPLOYEE

Full name of injured employee: Harry R. Smith Occupation: Freight Truck Driver

Mailing address: 514 East 8th, (Street) Libby (City) How long has he been in your employ: 1½ yrs.

Social Security No.: 517-20-1000 Sex: M Age: 42 Married ☒ Single ☐

EARNINGS

Monthly Wage..... Weekly Wage..... Daily Wage..... Hourly Wage: 2.54

Receive board Yes ☐ No ☒ Daily Value..... Receive room Yes ☐ No ☒ Daily Value.....

Piece Worker Yes ☐ No ☒ If yes, price per unit at piece work..... Hours worked per day: 8

Days worked per week: 5 Employee's pay period? Monthly ☐ Semi-monthly ☒ Weekly ☐ List employee's earnings last 4 pay periods 1. 288.29 2. 272.16 3. 258.88 4. 258.88

List Payroll Classification and Code under which employee's wages were reported..... (Sawmill - Mechanic - Etc.) Code..... (2702, 5506, 8810)

ACCIDENT AND INJURY

Describe in full how accident happened and GIVE CAUSE: While loading oxygen cylinders onto freight truck at Cox Machine Shop, strained muscle in lower back.

Nature or extent of injury: ~~sm~~ strained muscle (Cut - Fracture) Part of body injured? lower back (Leg - Arm - Back - Head)

Names of witnesses to accident 1. Delbert Cox, Cox Machine Shop

Date of accident: 1-17-64 19..... Hour: 10:00 A.M. ~~P.M.~~ Was employee injured in course of employment? Yes ☒ No ☐

Place where accident occurred: Cox Machine Shop (Address), Libby (City), Lincoln (County)

Did you or employee's supervisor have actual knowledge of accident? Yes ☒ No ☐

Were you notified of accident by injured employee? Yes ☒ No ☐ How: by employee Date: 1-17-64

Have you reason to question this accident? Yes ☐ No ☒ If "yes" explain fully.....

SAFETY

Was employee's accident due to unsafe work practice? Yes ☐ No ☒ If "yes", what did he do unsafely?.....

Was a specific device, object or substance involved in accident? Yes ☐ No ☐ If "yes," name specific device, object or substance..... Was device or object defective? Yes ☐ No ☐

Was employee doing regular work when injured? Yes ☐ No ☐ Was employee trained to do work he was doing when injured? Yes ☐ No ☐ Were adequate safeguards provided? Yes ☐ No ☐ If "yes," were they being used at the time of accident? Yes ☐ No ☐

MEDICAL ATTENTION

Name of attending physician: Dr. H. H. Anderson Address: Libby, Montana

Was employee hospitalized? Yes ☐ No ☒ Name of hospital..... Address.....

Was first aid administered by someone other than attending physician? Yes ☐ No ☒

TIME AND WAGE LOSS

Will employee lose time from work due to accident? Yes ☒ No ☐ How long? 1 day If injury results in time loss will employee, while disabled, receive sick leave benefits? Yes ☒ No ☐ Paid vacation? Yes ☐ No ☐ Will employee lose wages? Yes ☐ No ☐ Room? Yes ☐ No ☐ Board? Yes ☐ No ☐

Date wage loss began: 1-18-64 Amount of weekly wage loss: $101.60

EMPLOYER

Name of employer: Zonolite Division - W. R. Grace & Co.

Address: Libby, Montana Nature of business: Mining & Milling Vermiculite

IS FIRM A CORPORATION ☒ OR PARTNERSHIP ☐ OR INDIVIDUAL ☐

IF
- Corporation—is injured employee an officer or director of corporation? Yes ☐ No ☒
- Partnership—is injured employee related to any partner? Yes ☐ No ☐ Relationship.....
- Individual—is injured employee related to employer? Yes ☐ No ☐ Relationship.....

Signed, this 22nd day of January, 19 64

at Libby, Montana

Employer's Name: Zonolite Division-W.R.Grace & Co.

Signed by.....

Official Title: Secretary

NOTICE—EMPLOYEE'S CLAIM FOR COMPENSATION, FORM 54, MUST BE FILED WITHIN 12 MONTHS FROM DATE OF ACCIDENT.

Medical
Smith, Michael

C0080221

ACCIDENT INVESTIGATION REPORT

INDUSTRIAL CHEMICALS GROUP
W. R. Grace & Co.

Plant W. R. Grace Lost Time Case ____

Division Libby, Mont. Not Lost Time Case ✓
(Check one)

All accidents involving lost time from work or the services of a physician must be investigated and the report completed within 48 hours by the injured employee's supervisor. Forward one copy of report to office of Safety Administrator.

1. Name of injured employee Mike Smith
2. Department Labor Pool Date of Hire 05-17-74
3. Job Title Laborer Was he doing regular job? Yes ✓ No ____
4. Date and time of injury 12-30-77 9:00 AM.
5. Date and time injury reported 12-30-77 12:30 same day
6. Injured employee is: Salaried ____ Hourly ✓ Male ✓ Female ____

   Under 25 years ____ 25 to 34 ✓ 35 to 49 ____ 50 and over ____
7. Describe in detail what employee was doing at time of injury: include reference to any tools, machines and materials involved: Shoveling skip track with crew of men.
8. Describe injury: slipped and fell down and hurt lower part of back
9. What medical action was taken? ____
10. What, in your opinion, was the basic cause of this accident?

    Unsafe Act ____ Unsafe Condition ✓ Explain Employee was wearing ice grips but side of mountain is very slick

C0080222
WRG00299307
ED_005351_00000355-00390

11. What were the contributing causes? SNOW & ICE - ICE GRIPS DO not solve ALL PROBLEMS in THIS AREA

12. What action have you taken and/or are you planning to take to avoid a recurrence of this accident? I will look for BETTER ICE GRIPS & COUNCEL ALL employees AS TO THIS HAZZARD

13. Have you counselled your other employees regarding lessons to be learned from this accident?

Yes ____ No ____ if not, why ~~[illegible]~~ THIS will BE DONE AT our next SAFTY meeting

14. Have you scheduled any maintenance work or planned any disciplinary action with the accident?

Yes ____ No ✓ Comments, if any: _____

(Signed) Don Riley (Supervisor) Date 12-30-77 Plant _____

****

You have now completed answering some very important questions regarding an injury to one of your employees. Take the time to think carefully and ask yourself the following two questions:

a) How long did I take to think out and complete the answers to the questions above?
b) Have I really taken enough time, given enough thought, to a subject which might very well mean the life of one of my employees at some future date?

****

This space reserved for Plant Managers

1. Have you discussed this injury with .....

the supervisor concerned? Yes ____ No ____
all members of your supervisory group? Yes ____ No ____

2. Do you have any comments to add to the statements by the Foreman?

_____

_____

(Plant Manager) _____ (Date) _____

Form 65-25

C0080223

WRG00299308
ED_005351_00000355-00391

MONTANA DIVISION OF WORKERS' COMPENSATION

Complied with 62—1137 R.C.M.

815 Front Street
Helena, Montana 59601

SEND ORIGINAL TO INSURER

EMPLOYER'S FIRST REPORT
of Occupational Injury or
Occupational Disease
Employee Copy

CASE NUMBER

FIRM NUMBER

INSTRUCTIONS - Every employer in Montana is required by law to complete this form immediately after every accident to an employee which arises out of and in the course of *employment, and which causes loss of time from work or requires medical attention. The original of this form must be immediately filed with the employer's insurer or the* Division of Workers' Compensation, 815 Front Street, Helena, Montana 59601. All questions must be answered fully. If a question cannot be answered, please explain why. ***Please print with a ball point pen or type.***

FEDERAL OSHA REQUIREMENTS - The United States Department of Labor requires employers to maintain, in the employer's office, a record of occupational injuries. For the employer's convenience, this form has been designed to meet such requirements and to provide employers a record copy.

EMPLOYEE

Full Name of INJURED EMPLOYEE: Michael Smith
Social Security Number: 517-60-7401
EMPLOYEE'S Home Address (Street or Box): Route 2, Box 8660
City: Libby
State: Mt.
Zip Code:
Occupation: Laborer
Sex: M
Age: 26
Marital Status: [X] Married [ ] Single
Length of time in your Employment: 3 Yr. 7 Mo.
Department where regularly employed: Labor Pool
Date of Birth: 9 (mo.) / 2 (day) / (yr.)

WAGES

Employee's Gross Wage Rate is $ 5.925 per [ ] week, or [ ] day, or [X] hour, or [ ] month
Days Worked Per Week: 5
Hours Worked Per Day:
If board or room is furnished state value reported per day to Internal Revenue Service $
Check One— [X] Full Time Employee [ ] Part Time Employee
Payroll Classification under which employee's wages were reported: Common Labor
Employee's gross earnings for last four (4) pay periods (Date / Amount) (Date / Amount) (Date / Amount) (Date / Amount)
Employee's pay period: [ ] Monthly [X] Semi-monthly [ ] Bi-Weekly [ ] Weekly [ ] Other

ACCIDENT INFORMATION

Describe in full detail how accident happened, and give cause - Explain what employee was doing when injured.
While employee was shoveling the skip track, he slipped and fell on the snow and ice, twisting the lower part of his back

What specific object or substance caused the injury? Snow & Ice
Nature of the injury? (cut, fracture, etc.) strained back
Part of body affected (leg, arm, back, head, etc.): Lower back
DATE OF INJURY (month) 12 (day) 30 (year) 77 (hour) 12:30 (a.m. or p.m.) p.m.
Names of witnesses to accident: 1. None 2.
Place where accident occurred (address & city): 12 Mi. N.E. Libby, Mt.
(county) Lincoln
Was place of accident on employer's premises? Yes [X] No [ ]
Was employee injured while in your employ? Yes [X] No [ ]
Were you notified, or did you have actual knowledge of the accident? Yes [ ] No [ ]
If yes, date notified & how
Do you have any reason to question this accident? [ ] Yes [X] No
If yes, please explain fully

MEDICAL

Attending physician name and address: Dr. Henke, Libby, Mt.
If hospitalized, hospital's name and address
Will employee return to work during next scheduled shift? Yes [X] No [ ]
If no, will wage loss exceed 7 days? Yes [ ] No [ ] Not Sure [ ]
Date wage loss began (mo) / (day) / (yr.)
Date of return, if returned to work (mo.) / (day) / (yr.)

EMPLOYER

EMPLOYER'S NAME: W. R. Grace & Co.
Commercial Name (doing business as)
Employer's mailing address (Street or Box): Box 609
(City) Libby (State) Mt. (Zip Code) 59923
Phone number: 293-4131
Location of operation, if different from mailing address: 12 Mi. N.E. Libby, Mt.
Nature of business: Mining & Milling
Firm is a: (Check one) [ ] Sole proprietorship [ ] Partnership, or [X] Corporation
Was the Injured employee? (Check if applicable) [ ] A Sole Proprietor, [ ] A working Partner, [ ] A Corporate Officer, or [ ] A member of the employer's (sole proprietor or partner) family, dwelling in the employer's household.
Prepared by: Darlene G. Myhre
Authorized Signature: X
Official Title: Administrative Assistant
Date

DWC USE ONLY

OCCUPATION
SEX
AGE
MARITAL STATUS
COUNTY
LENGTH (YRS) EMPLOYED
WEEKLY EARNINGS
CLASS CODE
ACCIDENT TYPE
SOURCE OF INJURY
PART OF BODY INJURED
OSHA RECORDABLE CODE
DISABILITY TYPE
NATURE OF INJURY
HAZARDOUS CONDITION
UNSAFE ACT

Above - DWC-MIS Form 37-Employer's First Report (Rev. 1-76)

Below - DWC-MIS Form 54A-Claim for Compensation

EMPLOYEE'S CLAIM FOR COMPENSATION

EMPLOYER'S NOTE: For convenience purposes and if the worker is available, the form below has been provided so that an employer may allow an injured worker to file a claim for compensation on this form to avoid having the employee fill out and file a separate detailed form. Separate claim forms are available if the employer does not want the worker to use this form. ***Do not delay in submission of this form if employee is not available to sign below.***

INJURED EMPLOYEE'S NOTE: An injured employee may use the form below to make a claim for compensation, or the employee may fill out and submit a separate detailed form that is available from the Division.

I have carefully read the above information as documented by the employer, and (except for any statements I may write below) I concur with the information and I hereby make claim for compensation benefits due me now or in the future under Montana's Workers' Compensation Act.

Signature of injured employee: X
Address: Route 2, Box 8660
City: Libby, Mt.
Date: 1/10/77
Phone:

I DO NOT concur with the following information documented by the employer

C00B0224

Filing of this claim is authorization for release of medical records and records of the Social Security Administration

Medical
Smith, Michael

C0080221

ACCIDENT INVESTIGATION REPORT

INDUSTRIAL CHEMICALS GROUP
W. R. Grace & Co.

Plant Libby Lost Time Case ✓

Division Const Prod div Not Lost Time Case _____
(Check one)

All accidents involving lost time from work or the services of a physician must be investigated and the report completed within 48 hours by the injured employee's supervisor. Forward one copy of report to office of Safety Administrator.

1. Name of injured employee Mike Snell
2. Department Const Date of Hire 5-17-74
3. Job Title Const 1st class Was he doing regular job? Yes ✓ No _____
4. Date and time of injury 11-6-79
5. Date and time injury reported 1-6-79 12 noon
6. Injured employee is: Salaried _____ Hourly ✓ Male ✓ Female _____

   Under 25 years _____ 25 to 34 ✓ 35 to 49 _____ 50 and over _____
7. Describe in detail what employee was doing at time of injury: include reference to any tools, machines and materials involved: Carrying a piece of steel
8. Describe injury: Pulled & strained lower back muscles
9. What medical action was taken? told to use heat & pills given by Doctor
10. What, in your opinion, was the basic cause of this accident?

    Unsafe Act ✓ Unsafe Condition _____ Explain using unsafe method (Hands instead of equipment)

C0080225

11. What were the contributing causes? Improper attitude - Moving to much weight by Hand Instead of using Hoist Ect.

12. What action have you taken and/or are you planning to take to avoid a recurrence of this accident? The Employee involved was told to use equipment when needed to move this type material

13. Have you counselled your other employees regarding lessons to be learned from this accident?

Yes ✓ No ____ if not, why _____

14. Have you scheduled any maintenance work or planned any disciplinary action with the accident?

Yes ____ No ✓ Comments, if any: _____

(Signed) [illegible] (Supervisor) Date 12-10-79 Plant Lisbon

****

WHL 12-10-79

You have now completed answering some very important questions regarding an injury to one of your employees. Take the time to think carefully and ask yourself the following two questions:

a) How long did I take to think out and complete the answers to the questions above?
b) Have I really taken enough time, given enough thought, to a subject which might very well mean the life of one of my employees at some future date?

****

This space reserved for Plant Managers

1. Have you discussed this injury with .....

the supervisor concerned? Yes ____ No ____
all members of your supervisory group? Yes ____ No ____

2. Do you have any comments to add to the statements by the Foreman?

_____

_____

(Plant Manager) (Date)

Form 65-25

C0080226

MONTANA DIVISION OF WORKERS' COMPENSATION

815 Front Street / Helena, Montana 59601

DATE STAMP

EMPLOYER'S FIRST REPORT of Occupational Injury or Occupational Disease

SEND ORIGINAL TO INSURER:

CASE NO

FIRM NO

Employee Copy

INSTRUCTIONS - Every employer in Montana is required by law to complete this form immediately after every industrial accident to an employee which causes loss of time from work or requires medical attention. The original of this form must be immediately filed with the employer's insurer or the Division of Workers' Compensation, 815 Front Street, Helena, Montana 59601. All questions must be answered fully. If a question cannot be answered, please explain why.
Please print with a ball point pen or type.

FEDERAL OSHA REQUIREMENTS - The United States Department of Labor requires employers to maintain, in the employer's office, a record of occupational injuries. For the employer's convenience, this form has been designed to meet such requirements and to provide employers a record copy.

EMPLOYEE

FULL NAME OF INJURED EMPLOYEE: Michael R. Smith

SOCIAL SECURITY NUMBER: 517-60-7401

EMPLOYEE'S HOME ADDRESS (Street or Box): Rt 3, Box 9901

CITY: Libby, Mt

STATE: Mt

ZIP CODE: 59923

OCCUPATION: Const. 1st Class

SEX: M

DATE OF BIRTH (Mo / Day / Yr): 9 / 2 / 51

MARITAL STATUS: [ ] Married [X] Single

LENGTH OF TIME IN YOUR EMPLOYMENT: 5 yrs.

WAGES

Employee's Gross Wage Rate is $ 8.010 Per WEEK [ ] DAY [ ] HOUR [X] MO. [ ]

Days Worked Per Week: 5

Hours Worked Per Day: 8

If board or room is furnished state value reported per day to Internal Revenue Service $

Check one - [X] Full Time Employee [ ] Part Time Employee

Payroll Classification under which employee's wages were reported

Employee's Pay Period: Monthly [ ] Semi-monthly [ ] Bi-weekly [ ] Weekly [ ] Other (explain) [ ]

Employee's gross earnings for last four (4) pay periods (Date / Amount) (Date / Amount) (Date / Amount) (Date / Amount)

Will employee return to work during next scheduled shift? Yes [ ] No [X]

If no, will wage loss exceed 7 days? Yes [ ] No [ ] Not Sure [X]

DATE WAGE LOSS BEGAN (Mo / Day / Yr) / /

DATE OF RETURN, if returned to work (Mo / Day / Yr) / /

ACCIDENT INFORMATION

Describe in full detail how accident happened, and give cause - Explain what employee was doing when injured.

Had been moving some steel (Channel Iron) and having set it down stoodup and felt pain in lower back.

DATE OF INJURY: (month) November (day) 6 (year) 1979 (hour) 9:00 (a.m. or p.m.) a.m.

What specific object or substance *caused the injury?* Steel

Nature of the injury? (cut, fracture, etc.) Pain in lower back

Part of body affected (leg, arm, back, head, etc.) Back (lower)

Names of witnesses to accident 1. 2.

Was place of accident on employer's premises? Yes [X] No [ ]

Place where accident occurred (address & city) (county)

Was employee injured while in your employ? Yes [ ] No [ ]

Were you notified, or did you have actual knowledge of the accident? Yes [X] No [ ]

If yes, date notified & how: Don Riley 11/ /79

Do you have any reason to question this accident? [ ] Yes [X] No

If yes, please explain fully

MEDICAL

Attending Physician's Name: Dr. James F. Graham, Address (Street or Box): 401 Louisiana, (City): Libby, (State): Mt. (Zip Code): 59923

If Hospitalized, Hospital's Name Address (Street or Box) (City) (State) (Zip Code)

EMPLOYER

EMPLOYER'S NAME: W. R. Grace & Co.

Commercial Name (doing business as)

Employer's mailing address (street or box): P O Box 609 (City): K Libby (State): Mt. (Zip Code): 59923

Phone Number: (406) 293-4131

Location of operation, if different from mailing address: 12 Miles N.E. Libby, Mt.

Nature of Business: Mining & Milling

Firm is a: (Check one) [ ] Sole proprietorship [ ] Partnership, or [X] Corporation

Was the Injured employee? (Check if applicable) [ ] A Sole Proprietor, [ ] A working Partner, [ ] A Corporate Officer, or [ ] A member of the employer's (sole proprietor or partner) family, dwelling in the employer's household.

Prepared by: D. Woodward

Authorized Signature: [signature]

Official Title: Manager of Administration

Date: 11/9/79

ABOVE - DWC - MIS Form 37 - Employer's First Report (Rev. 6-78)

BELOW - DWC - MIS Form 54 - Claim for Compensation

EMPLOYEE'S CLAIM FOR COMPENSATION

EMPLOYER'S NOTE: For convenience purposes and if the worker is available, the form below has been provided so that an employer may allow an injured worker to file a claim for compensation on this form to avoid having the employee fill out and file a separate detailed form. Separate claim forms are available if the employer does not want the worker to use this form. **Do not delay in submission of this form if employee is not available to sign below.**

EMPLOYEE'S CLAIM FOR COMPENSATION

INJURED EMPLOYEE'S NOTE: An injured employee may use the form below to make a claim for compensation, or the employee may fill out and submit a separate detailed form that is available from the Division.

List other types of work you have done 1. 2. 3.

Education [ ] Grade School [ ] High School [ ] College [ ] Other

How many members are in your immediate family?

Have you ever had an industrial injury before? Yes [ ] No [ ]

If yes, in what state?

Type of injury

I have carefully read the information as documented by the employer, and (except for any statements I may write below) I concur with the information and I hereby make claim for compensation benefits due me now or in the future under Montana's Workers' Compensation Act.

Signature of injured employee: X [signature] Address: Rt 3, Box 990 L City: LIBLy, Mt. 59923 Date: 11/9/79 Phone: 293-7244

I DO NOT concur with the following information documented by the employer

C0080227

Filing of this claim is authorization for release of medical records and records of the Social Security Administration

Medical
Smith, Michael

C0080221

W. J. Melchar

ACCIDENT INVESTIGATION REPORT

INDUSTRIAL CHEMICALS GROUP
W. R. Grace & Co.

Plant LIBBY — Lost Time Case ✓

Division C.P.D. (ZONOLITE) — Not Lost Time Case ____ (Check one)

All accidents involving lost time from work or the services of a physician must be investigated and the report completed within 48 hours by the injured employee's supervisor. Forward one copy of report to office of Safety Administrator.

1. Name of injured employee MICHAEL R. SMITH
2. Department SHEET METAL — Date of Hire 5-17-74
3. Job Title WELDER & LAYOUT MAN — Was he doing regular job? Yes ✓ No ____
   SEE NOTES ON EXTRA SHEET
4. Date and time of injury AUG. 4-81 SCRATCH AUG. 12-81 BURN
   REPORTED TO DOWNTOWN OFFICE AUG. 21-81
5. Date and time injury reported REPORTED IN DETAIL TO ME SEPT. 1-81
6. Injured employee is: Salaried ____ Hourly ✓ Male ✓ Female ____

   Under 25 years ____ 25 to 34 ✓ 35 to 49 ____ 50 and over ____
7. Describe in detail what employee was doing at time of injury: include reference to any tools, machines and materials involved: MIKE SAYS "HE THINKS HE WAS GETTING READY TO SHEAR A PIECE OF 16 GAUGE METAL AND BRUSHED AGAINST IT WITH HIS ELBOW. BUT HE IS NOT SURE.
8. Describe injury: MIKE CLAIMS THAT HE HAD A SCRATCH ABOUT 6" LONG SKIN DEEP ON HIS RIGHT ELBOW. ALSO THAT HE GOT A SMALL BURN FROM A SPARK WHILE WELDING ON A ENCLID BOX. THAT THE SPARK BURNED HIS SHIRT SLEEVE
9. What medical aid was taken
10. What, in your opinion, was the basic cause of this accident?

    Unsafe Act ____ Unsafe Condition ____ Explain UNKNOWN

X

C0080228
WRG00299315
ED_005351_00000355-00398

11. What were the contributing causes? UNKNOWN

12. What action have you taken and/or are you planning to take to avoid a recurrence of this accident? PLAN ON TALKING TO CREW, ABOUT HAZARDS OF HANDELING METAL AND WELDING BURNS AND REPORTING ACCIDENTS

13. Have you counselled your other employees regarding lessons to be learned from this accident?

Yes ____ No ✓ if not, why WILL DO SO

14. Have you scheduled any maintenance work or planned any disciplinary action with the accident?

Yes ____ No ✓ Comments, if any: TALKED TO SMITH ABOUT GETTING INCIDENTS OR ACCIDENTS ON RECORD AS SOON AS POSSIBLE AFTER THE FACT,

(Signed) H. Shrewsberry (Supervisor) Date 9-1-81 Plant LIBBY (ZONOLITE)

****

You have now completed answering some very important questions regarding an injury to one of your employees. Take the time to think carefully and ask yourself the following two questions:

a) How long did I take to think out and complete the answers to the questions above?
b) Have I really taken enough time, given enough thought, to a subject which might very well mean the life of one of my employees at some future date?

****

This space reserved for Plant Managers

1. Have you discussed this injury with .....

the supervisor concerned? Yes ____ No ____
all members of your supervisory group? Yes ____ No ____

2. Do you have any comments to add to the statements by the Foreman?

(Plant Manager) (Date)

Form 65-25

C00B0229

9-1-81

SUPPLEMENT TO MICHAEL R. SMITH ACCIDENT REPORT.

ON MON, AUG. 10 1981 SMITH REPORTED FOR WORK ON SWING SHIFT. THIS WAS AN EXTREMLY HOT DAY AND SMITH DID NOT HAVE A SHIRT ON, JUST A TEE SHIRT. I NOTICED THAT HE HAD A BANDAGE ON HIS EXBOW. I ASKED WHAT WAS WRONG AND HE SAID "OH I JUST GOT A SMALL SCRATC OR BUMP SOMEWHERE" I SAID WAS IT ON THE JOB AND HE SAID "I DON'T KNOW" BUT IT'S ALL TAKEN CARE OF, NO PROBLEM!

SINCE I DIDN'T SEE SMITH WITH HIS SHIRT OFF OR HIS ELBOW BANDAGED AFTER THAT AND HE MADE NO FURTHER COMPLAINT I DIDN'T THINK ANY MORE OF THE INCIDENT UNTIL AUG. 20, 81 AT WHCH TIME HE LEFT A MESSAGE AT MY OFFICE THAT HE WAS SICK.

I CALLED HIM BY PHONE AUG 21-81 AND ASKED WHAT WAS WRONG AND HE SAID "HE HAD BLOOD POISONING IN HIS ARM". I ASKED IF THIS WAS AN INDUSTRIAL ACCIDENT. "HE SAID I DON'T KNOW. I HAVE TO TALK TO MY DR. FIRST AND THEN I'LL LET YOU KNOW".

SMITH REPORTED THAT HIS PROBLEM WAS ON THE JOB INJURY TO THE DOWN ~~[illegible]~~ TOWN OFFICE ON AUG 24, 81 SMITH REPORTED BACK TO WORK ON SEPT 1, 81 AT WHCH TIME I QUESTIONED HIM AGAIN. HE SAYS THAT HIS PROBLEM WAS JOB RELATED, BUT DOES'NT SEEM TO BE EXACTLY SURE OF HOW OR WHEN.

SMITH PRESENTED A DR'S STATEMEN THAT HE WAS OFF AND THAT HE WAS RELEASED TO RETURN TO WORK.

HE WAS OFF FROM 8-20-81 TO 8-31 81 — 8 DAYS LOST TIME

H. Strawberry

C0080230
WRG00299317
ED_005351_00000355-00400

Date: 8-31-81

TO: CONSTRUCTION PRODUCTS DIVISION - W. R. GRACE & CO

This is to certify that your employee Michael Smith

has been under my care and has received treatment from me for Cellulitis, Rarm from 8-20-81 to 8-31-81

This is to certify that this employee may return to work on 9-1-81

Signed: [signature]

Attending Physician

C0080231

MONTANA DIVISION OF WORKERS' COMPENSATION

815 Front Street, Helena, Montana 59601

EMPLOYER'S FIRST REPORT of Occupational Injury or Occupational Disease

DATE STAMP

SEND ORIGINAL TO INSURER:

CASE NO -

FIRM NO -

Employee Copy

INSTRUCTIONS - Every employer in Montana is required by law to complete this form immediately after every industrial accident to an employee which causes loss of time from work or requires medical attention. The original of this form must be immediately filed with the employer's insurer or the Division of Workers' Compensation, 815 Front Street, Helena, Montana 59601. All questions must be answered fully. If a question cannot be answered, please explain why.
Please print with a ball point pen or type.

FEDERAL OSHA REQUIREMENTS - The United States Department of Labor requires employers to maintain, in the employer's office, a record of occupational injuries. For the employer's convenience, this form has been designed to meet such requirements and to provide employers a record copy.

EMPLOYEE

FULL NAME OF INJURED EMPLOYEE: Michael R. Smith
PHONE: 293-7244
SOCIAL SECURITY NUMBER: 517-60-7401

EMPLOYEE'S HOME ADDRESS (Street or Box): Rt 3, Box 915
CITY: Libby
STATE: MT
ZIP CODE: 59923

OCCUPATION: Welder I/o man
SEX: M
DATE OF BIRTH (Mo / Day / Yr): 9 / 2 / 51
MARITAL STATUS: ☐ Married ☐ Single
LENGTH OF TIME IN YOUR EMPLOYMENT: 7 yrs.

WAGES

Employee's Gross Wage Rate is $ 10.08 Per WEEK ☐ DAY ☐ HOUR ☒ MO. ☐
Days Worked Per Week: 5
Hours Worked Per Day: 8
If board or room is furnished state value reported per day to Internal Revenue Service $

Check one - ☒ Full Time Employee ☐ Part Time Employee
Payroll Classification under which employee's wages were reported
Employee's Pay Period: Monthly ☐ Semi-monthly ☒ Bi-weekly ☐ Weekly ☐ Other (explain) ☐ Regular Days Off

Employee's gross earnings for last four (4) pay periods (Date / Amount) (Date / Amount) (Date / Amount) (Date / Amount)

Will employee return to work during next scheduled shift? Yes ☐ No ☒
If no, will employee lose more than 5 days wages? Yes ☐ No ☐ Not Sure ☐
DATE WAGE LOSS BEGAN (Mo / Day / Yr) / /
DATE OF RETURN, if returned to work (Mo / Day / Yr) / /

ACCIDENT INFORMATION

Describe in full detail how accident happened, and give cause - Explain what employee was doing when injured.
Welding burn on Agust 12, 1981 with a combination of scratch on arm (non-Industrial)
which occuned on August 4, 1981

DATE OF INJURY (month) 8-12-81 (day) (year) (hour) (a.m. or p.m.) 7:00 p.m.
What specific object or substance caused the injury? Welder

Nature of the injury? (cut, fracture, etc.) Welding burn
Part of body affected (leg, arm, back, head, etc.) right arm

Names of witnesses to accident
1. 2.

Was place of accident on employer's premises? Yes ☒ No ☐
Place where accident occurred (address & city) 12 miles N.E. Libby, MT Lincoln (county)

Was employee injured while in your employ? Yes ☒ No ☐
Were you notified, or did you have actual knowledge of the accident? Yes ☐ No ☒
If yes, date notified & how

Do you have any reason to question this accident? ☒ Yes ☐ No
If yes, please explain fully
Burn not reported - Prick wound may responsible

MEDICAL

Attending Physician's Name: Dr. James F. Graham M.D. PHONE: 293-4119 Address (Street or Box): 401 Louisiana AVe (City): Libby (State): MT (Zip Code): 59923

If Hospitalized, Hospital's Name Address (Street or Box) (City) (State) (Zip Code)

EMPLOYER

EMPLOYER'S NAME: W. R. Grace & Co
Commercial Name (doing business as): Mining & Milling

Employer's mailing address (street or box): p o Box 609, Libby, MT (City) (State) (Zip Code) 1
Phone Number: 400 293-4[illegible]

Location of operation, if different from mailing address: 12 miles N.E. Libby, MT
Nature of Business: Mining [illegible]

Firm is a: (Check one) ☐ Sole proprietorship ☐ Partnership, or ☒ Corporation
Was the Injured employee? (Check if applicable) ☐ A Sole Proprietor, ☐ A working Partner, ☐ A Corporate Officer, or ☐ A member of the employer's (sole proprietor or partner) family, dwelling in the employer's household.

Prepared by: Darlene Woodward
Authorized Signature: [signature]
Official Title: Manager of Administration
Date: 8-24-81

ABOVE - DWC - MIS Form 37 - Employer's First Report (Rev. 6-78)
BELOW - DWC - MIS Form 54 - Claim for Compensation

ON

EMPLOYER'S NOTE: For convenience purposes and if the worker is available, the form below has been provided so that an employer may allow an injured worker to file a claim for compensation on this form to avoid having the employee fill out and file a separate detailed form. Separate claim forms are available if the employer does not

EMPLOYEE'S CLAIM FOR COMPENSATION
INJURED EMPLOYEE'S NOTE: An injured [illegible]

WRG00299319

ED_005351_00000355-00402

Medical
Smith, Michael

C0080221

Copy me Town

C0080233

ACCIDENT INVESTIGATION REPORT

INDUSTRIAL CHEMICALS GROUP
W. R. Grace & Co.

Plant G. P. D. Lost Time Case ✓

Division W.R. Grace Not Lost Time Case _____
(Check one)

All accidents involving lost time from work or the services of a physician must be investigated and the report completed within 48 hours by the injured employee's supervisor. Forward one copy of report to office of Safety Administrator.

1. Name of injured employee Michael Smith
2. Department Labor Pool Date of Hire 05-17-74
3. Job Title Labor Pool Was he doing regular job? Yes ✓ No ✓
4. Date and time of injury 8-22-83
5. Date and time injury reported 8-22-83 3:00 A.M.
6. Injured employee is: Salaried _____ Hourly ✓ Male ✓ Female _____

   Under 25 years _____ 25 to 34 ✓ 35 to 49 _____ 50 and over _____
7. Describe in detail what employee was doing at time of injury: include reference to any tools, machines and materials involved:

   Mike went in Skip Bag house to ck for Plug up as part of norm. Job. Turned Twisted left ankle he dosent know if happened to step on something or not. There was a wash hose on Floor. Mike was alone.
8. Describe injury: Twisted ankle
9. What medical action was taken? went to Dr. next day Dr. Bordo
10. What, in your opinion, was the basic cause of this accident?

    Unsafe Act ✓ Unsafe Condition _____ Explain Area was clean and well lit

C0080234

WRG00299321

ED_005351_00000355-00404

U. S. Department of Labor
Mine Safety and Health Administration

Form Approved, OMB No. 044-R1665, Expires December 1982.

Section A – Identification Data

MSHA ID Number: 2400165 | Contractor I.D. | Report Category: ☐ Metal/Nonmetal Mining ☐ Coal Mining | ☐ Check here if report pertains to contractor.

Mine Name: X | Company Name

Complete – Complete for Each Reportable Accident Immediately Reported to MSHA

1. Accident Code (circle applicable code – see instructions) 01 – Death 02 – Serious Injury 03 – Entrapment 04 – Inundation 05 – Gas or Dust Ignition 06 – Mine Fire 07 – Explosives 08 – Roof Fall 09 – Outburst 10 – Impounding Dam 11 – Hoisting 12 – Offsite Injury

2. Name of Investigator | 3. Date Investigation Started (Month / Day / Year) | 4. Steps Taken to Prevent Recurrence of Accident

Section C – Complete for Each Reportable Accident, Injury or Illness

5. Circle the Codes Which Best Describe Where Accident/Injury/Illness Occurred (see instructions)

(a) Surface Location: 02 Surface at Underground Mine 30 Mill, Preparation Plant, etc. 03 Strip/Open Pit Mine 04 Surface Auger Operation 05 Culm Bank/Refuse Pile 06 Dredge Mining 12 Other Surface Mining 17 Independent Shops (with own MSHA ID) 99 Office Facilities

(b) Underground Location: 01 Vertical Shaft 02 Slope/Inclined Shaft 03 Face 04 Intersection 05 Underground Shop/Office 06 Other

(c) Underground Mining Method: 01 Longwall 02 Shortwall 03 Conventional Stoping 05 Continuous Miner 06 Hand 07 Caving 08 Other

6. Date of Accident: Month 8, Day 12, Year 81 | 7. Time of Accident: ☐ am ☐ pm 7:00 X | 8. Time Shift Started: ☐ am ☐ pm 6:00 X

9. Describe Fully the Conditions Contributing to the Accident/Injury/Illness, and Qualify the Damage or Impairment

Employee burned arm while welding. The burn wound became infected.

10. Equipment Involved | Type | Manufacturer | Model Number

11. Name of Witness to Accident/Injury/Illness | 12. Number of Reportable Injuries or Illnesses Resulting from This Occurrence

13. Name of [illegible] | 14. Sex: ☐ Male ☒ Female | 15. Date of Birth: Month 9, Day 02, Year 51

16. Last Four Digits of Social Security Number: Michael Galth | 17. Regular Job Title | ☐ 18. Check if this Injury/Illness resulted in death. | ☐ 19. Check if Injury/Illness resulted in permanent disability (include amputation, loss of use, & permanent total disability).

20. What Directly Inflicted Injury or Illness? 7401 Welder & Layout Man | 21. Nature of Injury or Illness

22. Part of Body Injured or Affected: Welding burn | 23. Occupational Illness (circle applicable code – see instructions) Infection 21 Occupational Skin Diseases 22 Dust Diseases of the Lungs 23 Respiratory Conditions (toxic agents) 24 Poisoning (toxic materials) 25 Disorders (physical agents) 26 Disorders (repeated trauma) 29 Other

24. Right Forearm Employee's Work Activity When Injury or Illness Occurred: Welding

Experience	Years	Weeks
25. Experience in This Job Title		
26. Experience at This Mine	1	35
27. Total Mining Experience	7	4

Section D – Return to Duty Information — *Answer 30 & 31 when case is closed*

☐ 28. Permanently Transferred or Terminated (if checked, complete items 29, 30 & 31)

29. Date Returned to Regular Job at Full Capacity (or item 28) Month	Day	Year	30. Number of Days Away from Work (if none, enter 0)	31. Number of Days Restricted Work Activity (if none, enter 0)
8	31	82	8	0

Person Completing Form (name): Earl D. Lovick | Title: Manager of Administration

Date This Report Prepared (month, day, year): 8-09-82 | Area Code and Phone Number: 406-293-4131

MSHA Form 7000-4, Feb. 80 (revised)

For Official Use Only
Degree
Accident Type
Accident Class
Scheduled Charge
Keyword

PAGE 4 RETAIN THIS COPY AT THE MINE (OR NEAREST MINE OFFICE) FOR 5 YEARS

C00B0237
WRG00299322
ED_005351_00000355-00405

MONTANA DIVISION OF WORKERS' COMPENSATION

815 Front Street, Helena, Montana 59601

DATE STAMP

EMPLOYER'S FIRST REPORT of Occupational Injury or Occupational Disease

SEND ORIGINAL TO INSURER

CASE NO

FIRM NO

Employee Copy

INSTRUCTIONS - Every employer in Montana is required by law to complete this form immediately after every industrial accident to an employee which causes loss of time from work or requires medical attention. The original of this form must be immediately filed with the employer's insurer or the Division of Workers' Compensation, 815 Front Street, Helena, Montana 59601. All questions must be answered fully. If a question cannot be answered, please explain why.
Please print with a ball point pen or type.

FEDERAL OSHA REQUIREMENTS - The United States Department of Labor requires employers to maintain, in the employer's office, a record of occupational injuries. For the employer's convenience, this form has been designed to meet such requirements and to provide employers a record copy.

EMPLOYEE

FULL NAME OF INJURED EMPLOYEE: Michael [illegible]

SOCIAL SECURITY NUMBER: 517-60-7401

EMPLOYEE'S HOME ADDRESS (Street or Box): Route 3 Box 915

CITY: Libby

STATE: Montana

ZIP CODE: 59923

OCCUPATION: Laborer

SEX: M

DATE OF BIRTH (Mo / Day / Yr): 9 / 02 / 51

MARITAL STATUS: [X] Married [ ] Single

LENGTH OF TIME IN YOUR EMPLOYMENT: 9 Years

WAGES

Employee's Gross Wage Rate is $ 10.75 Per: WEEK [ ] DAY [ ] HOUR [X] MO. [ ]

Days Worked Per Week: 5

Hours Worked Per Day: 8

If board or room is furnished state value reported per day to Internal Revenue Service $

Check one: [X] Full Time Employee [ ] Part Time Employee

Payroll Classification under which employee's wages were reported

Employee's Pay Period: Monthly [ ] Semi-monthly [X] Bi-weekly [ ] Weekly [ ] Other (explain) [ ]

Employee's gross earnings for last four (4) pay periods: (Date / Amount) (Date / Amount) (Date / Amount) (Date / Amount)

Will employee return to work during next scheduled shift? Yes [ ] No [X]

If no, will wage loss exceed 7 days? Yes [ ] No [X] Not Sure [ ]

DATE WAGE LOSS BEGAN (Mo / Day / Yr): 8 / 23 / 83

DATE OF RETURN, if returned to work (Mo / Day / Yr): 3 / 25 / 83

ACCIDENT INFORMATION

Describe in full detail how accident happened, and give cause - Explain what employee was doing when injured.

Walked down one step in the baghouse by the skip. Stepped on a hose and twisted ankle

DATE OF INJURY (month) (day) (year) (hour) (a.m. or p.m.) a.m.

What specific object or substance caused the injury? Hose

Nature of the injury? (cut, fracture, etc.) Ankle Sprained

Part of body affected (leg, arm, back, head, etc.) Ankle

Names of witnesses to accident: 1. None 2.

Was place of accident on employer's premises? Yes [X] No [ ]

Place where accident occurred (address & city): 12 Miles Northeast of Libby, Montana (county) Lincoln

Was employee injured while in your employ? Yes [X] No [ ]

Were you notified, or did you have actual knowledge of the accident? Yes [X] No [ ]

If yes, date notified & how: 3/25/83 - Employee came into office.

Do you have any reason to question this accident? [ ] Yes [X] No

If yes, please explain fully

MEDICAL

Attending Physician's Name: Mark R. [illegible] M.D. Address (Street or Box): 401 Louisiana (City): Libby (State): Montana (Zip Code): 59923

If Hospitalized, Hospital's Name: Address (Street or Box): (City): (State): (Zip Code):

EMPLOYER

EMPLOYER'S NAME: W. R. Grace & Co.

Commercial Name (doing business as):

Employer's mailing address (street or box): P. O. Box 609 (City): Libby (State): Montana (Zip Code): 59923

Phone Number: 293-3745

Location of operation, if different from mailing address: 12 miles northeast of Libby, Montana

Nature of Business: Mining & Milling Vermiculite

Firm is a: (Check one) [ ] Sole proprietorship [ ] Partnership, or [X] Corporation

Was the Injured employee? (Check if applicable) [ ] A Sole Proprietor, [ ] A working Partner, [ ] A Corporate Officer, or [ ] A member of the employer's (sole proprietor or partner) family, dwelling in the employer's household.

Prepared by: Ravetta Morrison

Authorized Signature: [signature]

Official Title:

Date: 3/23/83

ABOVE - DWC - MIS Form 37 - Employer's First Report (Rev. 6-78)
BELOW - DWC - MIS Form 54 - Claim for Compensation

EMPLOYEE'S CLAIM FOR COMPENSATION

EMPLOYER'S NOTE: For convenience purposes and if the worker is available, the form below has been provided so that an employer may allow an injured worker to file a claim for compensation on this form to avoid having the employee fill out and file a separate detailed form. Separate claim forms are available if the employer does not want the worker to use this form. **Do not delay in submission of this form if employee is not available to sign below.**

EMPLOYEE'S CLAIM FOR COMPENSATION

INJURED EMPLOYEE'S NOTE: An injured employee may use the form below to make a claim for compensation, or the employee may fill out and submit a separate detailed form that is available from the Division.

List other types of work you have done: 1. 2. 3.

Education: [ ] Grade School [ ] High School [ ] College [ ] Other

How many members are in your immediate family?

Have you ever had an industrial injury before? Yes [ ] No [ ]

If yes, in what state?

Type of injury

I have carefully read the information as documented by the employer, and (except for any statements I may write below) I concur with the information and I hereby make claim for compensation benefits due me now or in the future under Montana's Workers' Compensation Act.

Signature of injured employee: X [signature] Address: Route 3 Box 915 City: Libby Date: 3/23/83 Phone:

I DO NOT concur with the following information documented by the employer

C00B0236

Filing of this claim is authorization for release of medical records and records of the Social Security Administration

MEDICAL
Smith, Ronald

C0080238

06062723

Industrial Accident Board, Helena, Montana, Form 37 Revised—YM - U - WU

Industrial Accident Board

HELENA, MONTANA

Firm No.....

File No.....

EMPLOYER'S FIRST REPORT OF INJURY

INSTRUCTIONS—Employer must complete form at once after every accident which causes loss of time from work or requires medical attention and mail it to the Industrial Accident Board, Helena, Montana. Form must be signed in pen and ink. ALL QUESTIONS MUST BE ANSWERED FULLY.

INJURED EMPLOYEE

Full name of injured employee: Ronald Smith Occupation: Pumpman

Mailing address: Box 724 (Street) Libby (City) How long has he been in your employ: 10 months

Social Security No. 482-18-5739 Sex: M Age: 19 Married ☐ Single ☒

EARNINGS

Monthly Wage..... Weekly Wage..... Daily Wage..... Hourly Wage: 2.37

Receive board Yes ☐ No ☒ Daily Value..... Receive room Yes ☐ No ☒ Daily Value.....

Piece Worker Yes ☐ No ☒ If yes, price per unit at piece work..... Hours worked per day: 8

Days worked per week: 5 Employee's pay period? Monthly ☐ Semi-monthly ☒ Weekly ☐ List employee's earnings last 4 pay periods 1. 218.48 2. 178.91 3. 150.80 4. 195.68

List Payroll Classification and Code under which employee's wages were reported..... (Sawmill - Mechanic - Etc.) Code..... (2702, 5506, 8810)

ACCIDENT AND INJURY

Describe in full how accident happened and GIVE CAUSE: Cleaning windows on Bus - slipped on oil spill on step - struck right knee on step while falling

Nature or extent of injury: Bone Bruise (Cut - Fracture) Part of body injured? Right Knee (Leg - Arm - Back - Head)

Names of witnesses to accident 1..... 2.....

Date of accident: 5/21 19 64 Hour: 9 P.M. Was employee injured in course of employment? Yes ☒ No ☐

Place where accident occurred: Our Mine - 9 miles north of Libby (Address) (City) (County)

Did you or employee's supervisor have actual knowledge of accident? Yes ☒ No ☐

Were you notified of accident by injured employee? Yes ☒ No ☐ How: employee Date: 5/22/64

Have you reason to question this accident? No ☒ If "yes" explain fully.....

SAFETY

Was employee's accident due to unsafe work practice? Yes ☐ No ☒ If "yes", what did he do unsafely?.....

Was a specific device, object or substance involved in accident? Yes ☒ No ☐ If "yes," name specific device, object or substance: Oil Spill on step Was device or object defective? Yes ☐ No ☒

Was employee doing regular work when injured? Yes ☒ No ☐ Was employee trained to do work he was doing when injured? Yes ☒ No ☐ Were adequate safeguards provided? Yes ☒ No ☐ If "yes," were they being used at the time of accident? Yes ☒ No ☐

MEDICAL ATTENTION

Name of attending physician: Dr. Mackenzie Address: Libby, Montana

Was employee hospitalized? Yes ☐ No ☒ Name of hospital..... Address.....

Was first aid administered by someone other than attending physician? Yes ☐ No ☒

TIME AND WAGE LOSS

Will employee lose time from work due to accident? Yes ☒ No ☐ How long? unknown If injury results in time loss will employee, while disabled, receive sick leave benefits? Yes ☒ No ☐ Paid vacation? Yes ☐ No ☐ Will employee lose wages? Yes ☒ No ☐ Room? Yes ☐ No ☒ Board? Yes ☐ No ☒

Date wage loss began: May 22, 1964 Amount of weekly wage loss: 94.80

EMPLOYER

Name of employer: Zonolite Division - W. R. Grace & Co.

Address: Libby, Montana Nature of business: Milling & Mining Vermiculite

IS FIRM A CORPORATION ☒ OR PARTNERSHIP ☐ OR INDIVIDUAL ☐

IF
- Corporation—is injured employee an officer or director of corporation? Yes ☐ No ☒
- Partnership—is injured employee related to any partner? Yes ☐ No ☐ Relationship.....
- Individual—is injured employee related to employer? Yes ☐ No ☐ Relationship.....

Signed, this 22 day of May, 19 64

at Libby, Montana

Employer's Name: Zonolite Division-W. R. Grace & Co.

Signed by.....

Official Title: Secretary

NOTICE—EMPLOYEE'S CLAIM FOR COMPENSATION, FORM 54, MUST BE FILED WITHIN 12 MONTHS FROM DATE OF ACCIDENT.

C0080239

WRG00299325

ED_005351_00000355-00408

MEDICAL
Smith, Terry L.

C0080244

06063427

Industrial Accident Board

HELENA, MONTANA

Firm No. 2503

File No.

EMPLOYER'S FIRST REPORT OF INJURY

INSTRUCTIONS—Employer must complete form at once after every accident which causes loss of time from work or requires medical attention and mail it to the Industrial Accident Board, Helena, Montana. Form must be signed in pen and ink. ALL QUESTIONS MUST BE ANSWERED FULLY.

INJURED EMPLOYEE

Full name of injured employee Terry L. Smith Occupation Dump Dozerman

Mailing address Box 129, Libby, Montana (Street, City) How long has he been in your employ? 2½ years

Social Security No. 516-52-2537 Sex M Age 26 Married ☒ Single ☐

EARNINGS

Monthly Wage ..... Weekly Wage ..... Daily Wage ..... Hourly Wage 4.00

Receive board Yes ☐ No ☒ Daily Value ..... Receive room Yes ☐ No ☒ Daily Value .....

Piece Worker Yes ☐ No ☒ If yes, price per unit at piece work ..... Hours worked per day 8

Days worked per week 5 Employee's pay period? Monthly ☐ Semi-monthly ☒ Weekly ☐ List employee's earnings last 4 pay periods 1 516.40 2 290.56 3 326.55 4 374.20

List Payroll Classification and Code under which employee's wages were reported ..... (Sawmill - Mechanic - Etc.) Code ..... (2702, 5506, 8810)

ACCIDENT AND INJURY

Describe in full how accident happened and GIVE CAUSE While getting into a pickuptruck struck side of head on top of door jamb, pulled muscle in neck, twisted neck.

Nature or extent of injury sprain (Cut - Fracture) Part of body injured? neck (Leg - Arm - Back - Head)

Names of witnesses to accident 1 ..... 2 .....

Date of accident 5-22-72 19 ..... Hour 1 ~~A.M.~~ P.M. Was employee injured in course of employment? Yes ☒ No ☐

Place where accident occurred our pit, 9 miles north of Libby (Address, City) Lincoln (County)

Did you or employee's supervisor have actual knowledge of accident? Yes ☒ No ☐

Were you notified of accident by injured employee? Yes ☒ No ☐ How in person Date 5-23-72

Have you reason to question this accident? Yes ☐ No ☒ If "yes" explain fully .....

SAFETY

Was employee's accident due to unsafe work practice? Yes ☐ No ☒ If "yes", what did he do unsafely? .....

Was a specific device, object or substance involved in accident? Yes ☐ No ☒ If "yes", name specific device, object or substance ..... Was device or object defective? Yes ☐ No ☐

Was employee doing regular work when injured? Yes ☒ No ☐ Was employee trained to do work he was doing when injured? Yes ☒ No ☐ Were adequate safeguards provided? Yes ☐ No ☐ If "yes", were they being used at the time of accident? Yes ☐ No ☐

MEDICAL ATTENTION

Name of attending physician W. T. Matthews, M.D. Address Libby, Montana

Was employee hospitalized? Yes ☐ No ☒ Name of hospital ..... Address .....

Was first aid administered by someone other than attending physician? Yes ☐ No ☒

TIME AND WAGE LOSS

Will employee lose time from work due to accident? Yes ☒ No ☐ How long? not known this time If injury results in time loss will employee, while disabled, received sick leave benefits? Yes ☐ No ☐ Paid vacation? Yes ☐ No ☐ Will employee lose wages? Yes ☐ No ☐ Room? Yes ☐ No ☐ Board? Yes ☐ No ☐

Date wage loss began 5-23-72 Amount of weekly wage loss $160.00

EMPLOYER

Name of employer Construction Products Division-W.R.Grace & Co.

Address Libby, Montana Nature of Business Mining & Milling Vermiculite

IS FIRM A CORPORATION ☒ OR PARTNERSHIP ☐ OR INDIVIDUAL ☐

IF
- Corporation—is injured employee an officer or director of corporation? Yes ☐ No ☒
- Partnership—is injured employee related to any partner? Yes ☐ No ☐ Relationship .....
- Individual—is injured employee related to employer? Yes ☐ No ☐ Relationship .....

Signed, this 24th day of May, 1972

at Libby, Montana

Employer's Name ~~Construction Products Division~~ W. R. Grace & Co.

Signed by [signature]

Official Title Ad. Asst.

NOTICE—EMPLOYEE'S CLAIM FOR COMPENSATION, FORM 54, MUST BE FILED WITHIN 12 MONTHS FROM DATE OF ACCIDENT.

C0080245

WRG00299327

ED_005351_00000355-00410

MEDICAL
Solum, Harris J.

C0080246

WRG00299328
ED_005351_00000355-00411

STANDARD FORM FOR EMPLOYER'S FIRST REPORT OF INJURY

Approved by I. A. I. A. B. C.

Complete and send immediately to CLAIMS DEPARTMENT

State's Number For:	File: ..... Carrier: ..... Employer: .....
Carrier's File No.	

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

POLICY NUMBER .....

Employer

1. Name of Employer: Zonolite Company
2. Office address: No. and St. ..... City or Town: Libby State: Montana
3. Insured by Name of Company: Royal Indemnity Company
4. Give nature of business (or article manufactured): Mining and Milling Vermiculite

Time and Place

5. (a) Location of plant or place where accident occurred: Libby, Montana
   Construction Department ..... State if employer's premises: Yes
   (b) If injured in a mine, did accident occur on surface, underground, shaft, drift or mill .....
6. Date of Injury: August 16 19 60 Day of week: Monday Hour of day: unknown A.M. ..... P.M.
7. Date disability began: no disability 19 ..... A.M. ..... P.M. 8. Was injured paid in full for this day: yes
9. When did you or foreman first know of injury: August 19, 1960
10. Name of foreman: Thomas DeShazer

Injured Person

11. Name of Injured: Harris (First Name) J. (Middle Initial) Solum (Last Name)
12. Address: No. and St.: Box 945 City or Town: Libby State: Montana
13. Check (√) Married: X, Single: ....., Widowed: ....., Widower: ....., Divorced: .....; Male: X, Female: .....; White: X, Colored: .....
14. Nationality: American Speak English: Yes
15. Age: 38 Did you have on file employment certificate or permit .....
16. (a) Occupation when injured: Construction worker (b) Was this his or her regular occupation: Yes
    (If not, state in what department or branch of work regularly employed) .....
17. (a) How long employed by you: 2-1/2 mos. (b) Piece or time worker: Time (c) Wages per hour $: 2.005
18. (a) No. hours worked per day: 8 (b) Wages per day $: 16.04
    (c) No. days worked per week: 5 (d) Average weekly earnings $: 80.20
    (e) If board, lodging, fuel or other advantages were furnished in addition to wages, give estimated value per day, week or month: none

Cause of Injury

19. Machine, tool or thing causing injury ..... 20. Kind of power (hand, foot, electrical, steam, etc.) ..... 21. Part of machine on which accident occurred .....
22. (a) Was safety appliance or regulation provided ..... (b) Was it in use at time .....
23. Was accident caused by injured's failure to use or observe safety appliance or regulation .....
24. Describe fully how accident occurred, and state what employee was doing when injured:
    While working in culvert which had been plugged with rocks, rock rolled out causing strained back.
25. Names and addresses of witnesses .....

Nature of Injury

26. Nature and location of injury (describe fully exact location of amputations or fractures, right or left): Sprained back.
27. Probable length of disability: none 28. Has injured returned to work: yes
    If so, date and hour: no disability--no lost time At what wage $: same
29. At what occupation: same
30. (a) Name and address of physician: Dr. H. H. Anderson, Libby, Montana
    (b) Name and address of hospital: None

Cases Fatal

31. Has injured died ..... If so, give date of death .....

Date of this report: September 8, 1960 Firm name: Zonolite Company

Signed by

124861A - 50M - 11-56

WRG00299329

ED_005351_00000355-00412

STRIAL ACCIDENT BOARD, HELENA, MONTANA. FORM 37 REVISED. 2M 5-59 19933

Industrial Accident Board

HELENA, MONTANA

Claim Department

n No.

m No.

dent No.

DO NOT FILL IN

EMPLOYER'S FIRST REPORT OF INJURY

DO NOT WRITE IN THIS SPACE

INSTRUCTIONS—The employer must fill out this form and return same to Industrial Accident Board, Helena, ntana, at once after every accident which causes any loss of work or requires medical attention. In filling out form use pen or typewriter.

MPLOYER, LACE AND TIME

Employer's name: Zonolite Company

Office address: Libby, M ntana (Street and number, city or town)

Nature of business: Mining and Milling (Type of construction, manufacturing, etc.)

Did accident occur on work for a public corporation? No

Location of plant or place of work where accident occurred: Same (Street and Number)

In what city or village? Libby County? Lincoln

Date of accident: August 16, 19 60; hour of day: unknown A.M. P.M.

Did accident happen on premises? Yes

If away from the plant, state where?

Was employee injured in the course of employment? yes

THE INJURED MPLOYEE

Give full name of injured workman: Harris J. Solum

Mailing address: Box 945, Libby, Montana (Street and number, city or town and county)

Sex: M Age: 38 Speak English? Yes If not, what language?

Occupation when injured? Construction Worker Married or single? Married (See Form 87-a)

Was injured employee on duty at time of accident? Yes If not, state fully on back hereof

How long was injured person in your employment? 2-1/2 months

AUSE OF INJURY

Described in full how the accident occurred (DO NOT FAIL TO DO THIS)

While working in culvert, opening culvert which had been plugged with rocks, rolled rocks out of culvert, strained back.

THE INJURY

State nature and extent of injury according to your own information. (We do not need the doctor's report here) sprained back

WILL EMPLOYEE LOSE TIME? YES NO XX

DATE WAGE LOSS BEGAN? PROBABLE DURATION OF WAGE LOSS? (Give your best estimate)

MEDICAL TENDANCE

Name and address of physician attending injured employee: Dr. H. H. Anderson, Libby, Montana

To what hospital was employee sent? none

If not sent to hospital, where is he? working

Are you still providing medical attendance? yes Have you a hospital contract? no

WAGES

Monthly wage (If paid by month) Weekly wage (If paid by week) Daily wage (If paid by day) Rate per hour 2.005 (If paid by hour)

Number of hours per day 8 How many working days per week 5

If employee receives board in addition to money wage, state how many meals per day none

Does he receive room in addition to money wage? no

Firm No.

Acc. No.

Major Industry

County

Date of Acc.

Time

Sex & Marital Status

Age

Mont. Code

Acc. Class

Occupation

Type

Agency

Agency Part

Nature of Inj.

Location

Ext. of Dis.

Mech. Defect

Unsafe Act

WRG00299330
ED_005351_00000355-00413

06062361

STANDARD FORM FOR EMPLOYER'S FIRST REPORT OF INJURY

Approved by I. A. I. A. B. C.

Complete and send immediately to
CLAIMS DEPARTMENT

State's Number For:	File: ..... Carrier: ..... Employer: .....
Carrier's File No.	

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

POLICY NUMBER .....

Employer

1. Name of Employer: Zonolite Company
2. Office address: No. and St. ..... City or Town: Libby State: Montana
3. Insured by Name of Company: Royal Indemnity Company
4. Give nature of business (or article manufactured): Mining and Milling Vermiculite

Time and Place

5. (a) Location of plant or place where accident occurred: Libby, Montana
   Construction Department ..... State if employer's premises: Yes
   (b) If injured in a mine, did accident occur on surface, underground, shaft, drift or mill .....
6. Date of Injury: August 16 19 60 Day of week: Monday Hour of day: unknown A.M. P.M.
7. Date disability began: no disability 19 ..... A.M. P.M. 8. Was injured paid in full for this day: yes
9. When did you or foreman first know of injury: August 19, 1960
10. Name of foreman: Thomas DeShazer

Injured Person

11. Name of Injured: Harris (First Name) J. (Middle Initial) Solum (Last Name)
12. Address: No. and St. Box 945 City or Town: Libby State: Montana
13. Check (√) Married X, Single ....., Widowed ....., Widower ....., Divorced .....; Male X, Female .....; White X, Colored .....
14. Nationality: American Speak English: Yes
15. Age: 38 Did you have on file employment certificate or permit .....
16. (a) Occupation when injured: Construction worker (b) Was this his or her regular occupation: Yes
    (If not, state in what department or branch of work regularly employed) .....
17. (a) How long employed by you: 2-1/2 mos. (b) Piece or time worker: Time (c) Wages per hour $: 2.005
18. (a) No. hours worked per day: 8 (b) Wages per day $: 16.04
    (c) No. days worked per week: 5 (d) Average weekly earnings $: 80.20
    (e) If board, lodging, fuel or other advantages were furnished in addition to wages, give estimated value per day, week or month: none

Cause of Injury

19. Machine, tool or thing causing injury ..... 20. Kind of power (hand, foot, electrical, steam, etc.) ..... 21. Part of machine on which accident occurred .....
22. (a) Was safety appliance or regulation provided ..... (b) Was it in use at time .....
23. Was accident caused by injured's failure to use or observe safety appliance or regulation .....
24. Describe fully how accident occurred, and state what employee was doing when injured:
    While working in culvert which had been plugged with rocks, rock rolled out causing strained back.
25. Names and addresses of witnesses .....

Nature of Injury

26. Nature and location of injury (describe fully exact location of amputations or fractures, right or left):
    Sprained back.
27. Probable length of disability: none 28. Has injured returned to work: yes
    If so, date and hour: no disability--no lost time At what wage $: same
29. At what occupation: same
30. (a) Name and address of physician: Dr. H. H. Anderson, Libby, Montana
    (b) Name and address of hospital: None

Cases Fatal

31. Has injured died ..... If so, give date of death C0080249

Date of this report: September 8, 1960 Firm name: Zonolite Company

CH 24861A - 50M - 11-56
Formerly CH 41

Signed by ..... Official Title WRG00299331

ED_005351_00000355-00414

INDUSTRIAL ACCIDENT BOARD, HELENA, MONTANA. FORM 37 REVISED. 2M 5-59 19933

Industrial Accident Board

06062362

HELENA, MONTANA

Claim Department

Firm No.

Claim No.

Accident No.

DO NOT FILL IN

EMPLOYER'S FIRST REPORT OF INJURY

DO NOT WRITE IN THIS SPACE

INSTRUCTIONS—The employer must fill out this form and return same to Industrial Accident Board, Helena, Montana, at once after every accident which causes any loss of work or requires medical attention. In filling out this form use pen or typewriter.

EMPLOYER, PLACE AND TIME

Employer's name: Zonolite Company

Office address: Libby, M ntana (Street and number, city or town)

Nature of business: Mining and Milling (Type of construction, manufacturing, etc.)

Did accident occur on work for a public corporation? No

Location of plant or place of work where accident occurred: Same (Street and Number)

In what city or village? Libby County? Lincoln

Date of accident: August 16, 19 60; hour of day: unknown A.M. P.M.

Did accident happen on premises? Yes

If away from the plant, state where?

Was employee injured in the course of employment? yes

THE INJURED EMPLOYEE

Give full name of injured workman: Harris J. Solum

Mailing address: Box 945, Libby, Montana (Street and number, city or town and county)

Sex: M Age: 38 Speak English? Yes If not, what language?

Occupation when injured? Construction Worker Married or single? Married (See Form 37-a)

Was injured employee on duty at time of accident? Yes If not, state fully on back hereof

How long was injured person in your employment? 2-1/2 months

CAUSE OF INJURY

Described in full how the accident occurred (DO NOT FAIL TO DO THIS)

While working in culvert, opening culvert which had been plugged with rocks, rolled rocks out of culvert, strained back.

THE INJURY

State nature and extent of injury according to your own information. (We do not need the doctor's report here) sprained back

WILL EMPLOYEE LOSE TIME? YES NO XX

DATE WAGE LOSS BEGAN? PROBABLE DURATION OF WAGE LOSS? (Give your best estimate)

MEDICAL ATTENDANCE

Name and address of physician attending injured employee: Dr. H. H. Anderson, Libby, Montana

To what hospital was employee sent? none

If not sent to hospital, where is he? working

Are you still providing medical attendance? yes Have you a hospital contract? no

WAGES

Monthly wage (If paid by month) Weekly wage (If paid by week) Daily wage (If paid by day) Rate per hour 2.005 (If paid by hour)

Number of hours per day 8 How many working days per week 5

If employee receives board in addition to money wage, state how many meals per day none

Does he receive room in addition to money wage? no

WAGE LOSS

How much money wage will employee lose per day because of accident?

How much board? Will he lose room?

NOTICE OF INJURY

Were you notified by the injured employee of his injury? yes If so, how and when? by employee (Write on back of this form if necessary)

Did you or your managing superintendent in charge of work of injured employee at time of injury have actual knowledge of such accident and injury? yes If so, explain how by employee (Write on back of this form if necessary)

Signed, this 19th day of August, 19 60

Employer's Name: Zonolite Company

Signed by

at Libby, Montana

Official Title

NOTICE—Employer should have injured workmen fill out Form 37-A and return same to Board with Employer's First Report of Injury.

Firm No. | Acc. No. | Major Industry | County | Date of Acc. | Time | Sex & Marital Status | Age | Mont. Code | Acc. Class | Occupation | Type | Agency | Agency Part | Nature of Inj. | Location | Ext. of Dis. | Mech. Defect | Unsafe Act | Pers. Factor | Weekly Wage | Report Lag | Carrier

MEDICAL
Moeller, Douglas

C0079220

STRIAL ACCIDENT BOARD, HELENA, MONTANA. FORM 37 REVISED. 2M 2-56 75524

Industrial Accident Board

HELENA, MONTANA

Claim Department

m No.
m No.
ident No.

DO NOT FILL IN

EMPLOYER'S FIRST REPORT OF INJURY

DO NOT WRITE IN THIS SPACE

INSTRUCTIONS—The employer must fill out this form and return same to Industrial Accident Board, Helena, ntana, at once after every accident which causes any loss of work or requires medical attention. In filling out form use pen or typewriter.

MPLOYER, LACE AND TIME

Employer's name: Zonolite Company
Office address: Libby, Montana (Street and number, city or town)
Nature of business: Mining and Milling vermiculite (Type of construction, manufacturing, etc.)
Did accident occur on work for a public corporation? no
Location of plant or place of work where accident occurred: Same (Street and Number)
In what city or village? Libby County? Lincoln
Date of accident 2-25, 19 57; hour of day 2:15 A.M. P.M.
Did accident happen on premises? Yes
If away from the plant, state where?
Was employee injured in the course of employment? Yes

THE INJURED MPLOYEE

Give full name of injured workman: Douglas Moeller
Mailing address: Route #1, Libby, Montana (Street and number, city or town and county)
Sex M Age 20 Speak English? Yes If not, what language?
Occupation when injured? Mill Tester Married or single? Married
Was injured employee on duty at time of accident? Yes If not, state fully on back hereof (See Form 87-a)
How long was injured person in your employment? 3 months

AUSE OF INJURY

Described in full how the accident occurred (DO NOT FAIL TO DO THIS)
Slipped on wet stairway and fell, catching arm on protruding piece of iron support post, gashing wrist, right arm.

THE INJURY

State nature and extent of injury according to your own information. (We do not need the doctor's report here) Gash on right wrist.
WILL EMPLOYEE LOSE TIME? YES X NO
DATE WAGE LOSS BEGAN? 2/26 PROBABLE DURATION OF WAGE LOSS? 1 da (Give your best estimate)

MEDICAL TENDANCE

Name and address of physician attending injured employee: Dr. Nelson, Libby, Montana
To what hospital was employee sent? none
If not sent to hospital, where is he? home
Are you still providing medical attendance? yes Have you a hospital contract?

WAGES

Monthly wage (If paid by month) Weekly wage (If paid by week) Daily wage (If paid by day) Rate per hour 2.07 1/2 (If paid by hour)
Number of hours per day 8 How many working days per week 5
If employee receives board in addition to money wage, state how many meals per day none
Does he receive room in addition to money wage? no

AGE LOSS

How much money wage will employee lose per day because of accident? $16.60
How much board? none Will he lose room? no

OTICE OF INJURY

Were you notified by the injured employee of his injury? Yes If so, how and when? by employee (Write on back of this form if necessary)
Did you or your managing superintendent in charge of work of injured employee at time of injury have actual knowledge of such accident and injury? yes If so, explain how by employee (Write on back of this form if necessary)

ned, this 26th day of February, 19 57

Employer's Name: ZONOLITE COMPANY

Signed by: Secretary

Official Title:

Libby, Montana

C0079222

TICE—Employer should have injured workmen fill out Form 37-A and return same to Board with Employer's First Report of Injury.

Firm No.
Acc. No.
Major Industry
County
Date of Acc.
Time
Sex & Marital Status
Age
Mont. Code
Acc. Class
Occupation
Type
Agency
Agency Part
Nature of Inj.
Location
Ext. of Dis.
Mech. Defect
Unsafe Act
Pers. Factor
Weekly Wage
Report Lag
Carrier

MEDICAL
Moeller, Douglas

C0079220

ITRIAL ACCIDENT BOARD, HELENA, MONTANA. FORM 37 REVISED. 2M 6-57 84530

Industrial Accident Board

HELENA, MONTANA

Claim Department

n No.
m No.
ident No.
DO NOT FILL IN

EMPLOYER'S FIRST REPORT OF INJURY

DO NOT WRITE IN THIS SPACE

INSTRUCTIONS—The employer must fill out this form and return same to Industrial Accident Board, Helena, ntana, at once after every accident which causes any loss of work or requires medical attention. In filling out form use pen or typewriter.

MPLOYER, LACE AND TIME

Employer's name: Zonolite Company
Office address: Libby, Montana (Street and number, city or town)
Nature of business: Mining and Milling (Type of construction, manufacturing, etc.)
Did accident occur on work for a public corporation? No
Location of plant or place of work where accident occurred: Libby (Street and Number)
In what city or village? Libby County? Lincoln
Date of accident: November 1, 1957; hour of day: 10:30 A.M. ~~P.M.~~
Did accident happen on premises? No.
If away from the plant, state where? On county road
Was employee injured in the course of employment? Yes

THE INJURED MPLOYEE

Give full name of injured workman: Douglas Moeller
Mailing address: Route 1, Libby, Montana (Street and number, city or town and county)
Sex: M Age: 21 Speak English? Yes If not, what language?
Occupation when injured? Truck Driver Married or single? Married (See Form 87-a)
Was injured employee on duty at time of accident? Yes If not, state fully on back hereof
How long was injured person in your employment? 11 months

AUSE OF INJURY

Described in full how the accident occurred (DO NOT FAIL TO DO THIS)
While hauling concentrate from lower ore bins to river loading dock, left front tire on truck blew out, causing truck to veer into ditch on left side of road and to tip over on left side.

THE INJURY

State nature and extent of injury according to your own information. (We do not need the doctor's report here) None
WILL EMPLOYEE LOSE TIME? YES ____ NO XX
DATE WAGE LOSS BEGAN? ____ PROBABLE DURATION OF WAGE LOSS? ____ (Give your best estimate)

EDICAL TENDANCE

Name and address of physician attending injured employee: Dr. Paul J. Seifert, Jr. Libby, Montana
To what hospital was employee sent? none
If not sent to hospital, where is he? working
Are you still providing medical attendance? No Have you a hospital contract? No

WAGES

~~Monthly wage~~ (If paid by month) ____ Weekly wage (If paid by week) ____ Daily wage (If paid by day) ____ Rate per hour (If paid by hour) 2.25
Number of hours per day: 8 How many working days per week: 5
If employee receives board in addition to money wage, state how many meals per day: none
Does he receive room in addition to money wage? no

AGE LOSS

How much money wage will employee lose per day because of accident? none
How much board? none Will he lose room? no

OTICE OF INJURY

Were you notified by the injured employee of his injury? Yes If so, how and when? by employee (Write on back of this form if necessary)
Did you or your managing superintendent in charge of work of injured employee at time of injury have actual knowledge of such accident and injury? yes If so, explain how by employee (Write on back of this form if necessary)

ed, this 1st day of November, 1957 Employer's Name: Zonolite Company

Signed by: C0079223

Libby, Montana Official Title: Secretary

TICE—Employer should have injured workmen fill out Form 37-A and ret same to Board with Employer's First Report of Injury.

Firm No.
Acc. No.
Major Industry
County
Date of Acc.
Time
Sex & Marital Status
Age
Mont. Code
Acc. Class
Occupation
Type
Agency
Agency Part
Nature of Inj.
Location
Ext. of Dis.
Mech. Defect
Unsafe Act
Pers. Factor
Weekly Wage
Report Lag
Carrier

MEDICAL
Moen, Norman

C0079236

Stock Form — State Publishing Company, Helena, Montana
Industrial Accident Board — Form No. 43 YM-T-YZ

06063556

Plan No.

Industrial Accident Board

HELENA, MONTANA

CLAIM DEPARTMENT

Firm No. 2503

Claim No.

Accident No.

Employe No.

DO NOT FILL IN

Employer's Supplemental Report of Injury

This notice to be filled out by employer and sent to the Industrial Accident Board, at Helena, Montana, immediately upon employe's returning to work fully recovered if within 2 weeks—or upon his death or at the expiration of two weeks from date of injury.

Name of injured employe Norman Moen

Address Route 1 Box 992, Libby, Montana 59923

Injured 10-10-74, 19

Is injured employe fully recovered? Yes On what date? 10-12-74

Has he/she returned to work for you? Yes 10-12-74 On what date? 10-12-74

Has he/she accepted other employment? On what date?

If so, where now employed?

Has he/she died? If so, when?

Signed: Construction Products Division
W. R. Grace & Co.
Joan B. Kerrigan

Address Box 609, Libby, Montana

Dated 10-31-74, 19

C0079237

WRG00299340
ED_005351_00000355-00421

06063557

Return to:
Hugo Dobler Adjuster, Inc.
Box 233 — Helena, Mt. 59601

DIVISION OF WORKMEN'S COMPENSATION
DEPARTMENT OF LABOR AND INDUSTRY
815 Front Street
Helena, Montana 59601

CASE NO. .....

Firm No. 2503

EMPLOYER'S FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE

INSTRUCTIONS—Employer must complete form at once after every accident or occupational disease which causes loss of time from work or requires medical attention and mail to the Division of Workmen's Compensation, 815 Front Street, Helena, Montana. Form must be signed in pen and ink. ALL QUESTIONS MUST BE ANSWERED FULLY. This form contains all items requested on OSHA Form No. 101, "Supplementary Record of Occupational Injuries and Illnesses."

INJURED EMPLOYEE

Full name of injured employee Norman Moen Occupation Construction Worker
Home Address Rate 1 Box 992, Libby, Mont (Street, City) How long has he been in your employ? 6 years
Social Security No. 476-01-8187 Sex M Age 59 Married ☒ Single ☐
Department where regularly employed Construction
Department where employed at time of injury Same
Would employment be classified as: (Check appropriate description)
(1) Household employment ☐
(2) Casual employment ☐
(3) Employment of members of an employer's family dwelling in employer's household ☐
(4) Employment of sole proprietors or working members of a partnership ☐
(5) Employment for which a rule of liability for injury, occupational disease, or death is provided under the laws of the United States ☒
(6) Any person performing services in return for aid or sustenance only. (Board & Room) ☐
Scheduled days off .....

EMPLOYEE'S EARNINGS

Monthly wage ....., or Weekly wage ....., or Daily wage ....., or Hourly wage 4.96
Received board? Yes ☐ No ☒ Received room? Yes ☐ No ☒ Days worked per week 5
Hours worked per day 8 Employee's pay period: Monthly ☐ Semi-monthly ☒ Weekly ☐
Bi-weekly ☐ List employee's gross earnings and date for last 4 pay periods:
(1) ..... (Date/Amount) (2) ..... (Date/Amount) (3) ..... (Date/Amount) (4) ..... (Date/Amount)
List payroll classification under which employee's wages were reported .....

ACCIDENT AND INJURY

Describe in full how accident happened and GIVE CAUSE—Tell what employee was doing when injured:
Removing table in old wet mill with a Skil saw, table gave way, employee fell face first onto some channel iron.

Nature or extent of injury or illness bruises, loss of 6 teeth (Cut-Fracture) Part of body affected mouth (Leg-Arm-Back-Head)
Did employee die? Yes ☐ No ☒
Name or witnesses to accident 1 Patrick Byrnes 2 .....
Date of injury or initial diagnosis of occupational illness, Mo. 10 Day 10 Yr 74 Hour 1:30 ~~A.M.~~ P.M.
Was employee injured in course of employment? Yes ☒ No ☐
Place where accident occurred our mill, 12 miles north of Libby (Address, City) Lincoln (County)
Was place of accident or exposure on employer's premises? Yes ☒ No ☐
Have you reason to question this accident? Yes ☐ No ☒ If "yes" explain fully .....

NOTICE

Were you notified of the accident? Yes ☒ No ☐ How by employee

SAFETY

1. Was the accident caused by an unsafe act on the part of the injured? Yes ☐ No ☒
2. Was the accident caused by an unsafe condition? Yes ☐ No ☒
3. What specific device, object, or substance caused the injury? .....

MEDICAL ATTENTION

Name of attending physician T. F. Pacheco, D.D.S.
Address Box 709, Libby, Montana
Was employee hospitalized? Yes ☐ No ☒ Name of hospital .....
Address .....

TIME AND WAGE LOSS

1. Will the employee return to work before or during his next scheduled shift? Yes ☐ No ☒
2. Will employee lose wages? Yes ☒ No ☐ Will wage loss exceed 7 days? Yes ☐ No ☒
3. Date wage loss began 10-11-74 Amount of weekly wage loss 198.40

EMPLOYER

Name of employer Construction Products Division-W.R.Grace & Co. Phone 293-4131
Firm name .....
Address Box 609, Libby, Montana 59923 Nature of business Mining & Milling Vermiculite
Location, if different from mail address .....
Check one: Individual ☐ Partnership ☐ Corporation ☒

Signed, this 15th day of October, 1974
at Libby, Montana

Prepared by Joan B. Runyan
Signed by .....
Official title Adm. Asst.

NOTICE—EMPLOYEE'S CLAIM FOR COMPENSATION, FORM 54, SHOULD BE FILED WITHIN 12 MONTHS FROM DATE OF ACCIDENT

FORM 37-2 REVISED

MEDICAL
Moen, Norman

C0079236

WRG00299342

ED_005351_00000355-00423

06063275

Industrial Accident Board

HELENA, MONTANA

Firm No.....

File No.....

EMPLOYER'S FIRST REPORT OF INJURY

INSTRUCTIONS—Employer must complete form at once after every accident which causes loss of time from work or requires medical attention and mail it to the Industrial Accident Board, Helena, Montana. Form must be signed in pen and ink. ALL QUESTIONS MUST BE ANSWERED FULLY.

INJURED EMPLOYEE

Full name of injured employee Norman Hoen Occupation Const. Worker

Mailing address Route 1 Box 952, Libby, Montana (Street, City) How long has he been in your employ? 1½ yr.

Social Security No. 476-01-8187 Sex M Age 55 Married ☒ Single ☐

EARNINGS

Monthly Wage..... Weekly Wage..... Daily Wage..... Hourly Wage 3.45

Receive board Yes ☐ No ☒ Daily Value..... Receive room Yes ☐ No ☒ Daily Value.....

Piece Worker Yes ☐ No ☐ If yes, price per unit at piece work..... Hours worked per day 8

Days worked per week 6 Employee's pay period? Monthly ☐ Semi-monthly ☒ Weekly ☐ List employee's earnings last 4 pay periods 1. 331.70 2. 386.40 3. 414.00 4. 353.63

List Payroll Classification and Code under which employee's wages were reported..... (Sawmill - Mechanic - Etc.) Code..... (2702, 3506, 8810)

ACCIDENT AND INJURY

Describe in full how accident happened and GIVE CAUSE Was working outside on a construction project, wind was blowing very hard, got piece of steel in left eye.

Nature or extent of injury foreign object in eye (Cut - Fracture) Part of body injured? left eye (Leg - Arm - Back - Head)

Names of witnesses to accident 1..... 2.....

Date of accident 4-6 19 70 Hour 3 ~~A.M.~~ P.M. Was employee injured in course of employment? Yes ☒ No ☐

Place where accident occurred our pit, 9 miles north of Libby (Address, City) Lincoln (County)

Did you or employee's supervisor have actual knowledge of accident? Yes ☒ No ☐

Were you notified of accident by injured employee? Yes ☒ No ☐ How in person Date 4-8-70

Have you reason to question this accident? Yes ☐ No ☒ If "yes" explain fully.....

SAFETY

Was employee's accident due to unsafe work practice? Yes ☐ No ☒ If "yes", what did he do unsafely?.....

Was a specific device, object or substance involved in accident? Yes ☐ No ☐ If "yes", name specific device, object or substance..... Was device or object defective? Yes ☐ No ☐

Was employee doing regular work when injured? Yes ☒ No ☐ Was employee trained to do work he was doing when injured? Yes ☒ No ☐ Were adequate safeguards provided? Yes ☐ No ☐ If "yes", were they being used at the time of accident? Yes ☐ No ☐

MEDICAL ATTENTION

Name of attending physician A. T. Matheson, M.D. Address Libby, Montana

Was employee hospitalized? Yes ☐ No ☒ Name of hospital..... Address.....

Was first aid administered by someone other than attending physician? Yes ☐ No ☒

TIME AND WAGE LOSS

Will employee lose time from work due to accident? Yes ☐ No ☒ How long? NONE If injury results in time loss will employee, while disabled, received sick leave benefits? Yes ☐ No ☐ Paid vacation? Yes ☐ No ☐ Will employee lose wages? Yes ☐ No ☐ Room? Yes ☐ No ☐ Board? Yes ☐ No ☐

Date wage loss began None Amount of weekly wage loss.....

EMPLOYER

Name of employer Construction Products Division-W.R.Grace & Co.

Address Libby, Montana Nature of Business Mining & Milling Vermiculite

IS FIRM A CORPORATION ☒ OR PARTNERSHIP ☐ OR INDIVIDUAL ☐

IF
- Corporation—is injured employee an officer or director of corporation? Yes ☐ No ☒
- Partnership—is injured employee related to any partner? Yes ☐ No ☐ Relationship.....
- Individual—is injured employee related to employer? Yes ☐ No ☐ Relationship.....

Signed, this 8th day of April, 19 70

at Libby, Montana

Employer's Name Construction Products Division W. R. Grace & Co.

Signed by.....

Official Title.....

NOTICE—EMPLOYEE'S CLAIM FOR COMPENSATION, FORM 54, MUST BE FILED WITHIN 12 MONTHS FROM DATE OF ACCIDENT.

C0079239

MEDICAL
Moen, Norman

C0079236

#2503

Industrial Accident Board

HELENA, MONTANA

06063292

Firm No.....

File No.....

EMPLOYER'S FIRST REPORT OF INJURY

INSTRUCTIONS—Employer must complete form at once after every accident which causes loss of time from work or requires medical attention and mail it to the Industrial Accident Board, Helena, Montana. Form must be signed in pen and ink. ALL QUESTIONS MUST BE ANSWERED FULLY.

INJURED EMPLOYEE

Full name of injured employee: Norman Moen Occupation: Construction Worker 1 ye

Mailing address: Route 1 Box 992, Libby (Street, City) How long has he been in your employ?

Social Security No.: 476-01-8187 Sex: M Age: 54 Married ☒ Single ☐

EARNINGS

Monthly Wage..... Weekly Wage..... Daily Wage..... Hourly Wage: 3.45

Receive board Yes ☐ No ☒ Daily Value..... Receive room Yes ☐ No ☒ Daily Value.....

Piece Worker Yes ☐ No ☒ If yes, price per unit at piece work..... Hours worked per day: 8

Days worked per week: 6 Employee's pay period? Monthly ☐ Semi-monthly ☒ Weekly ☐ List employee's earnings last 4 pay periods 1..... 2..... 3..... 4.....

List Payroll Classification and Code under which employee's wages were reported..... (Sawmill - Mechanic - Etc.) Code..... (2702, 5506, 8810)

ACCIDENT AND INJURY

Describe in full how accident happened and GIVE CAUSE: Was moving some channel iron, slipped on snowy wet floor, dropped piece of iron on big toe, right foot.

Nature or extent of injury: smashed toe (Cut - Fracture) Part of body injured? big toe, right foot (Leg - Arm - Back - Head)

Names of witnesses to accident 1..... 2.....

Date of accident: 1-5- 1970 Hour..... A. M. P. M. Was employee injured in course of employment? Yes ☒ No ☐

Place where accident occurred: our mill, 9 miles north of Libby (Address, City) Lincoln (County)

Did you or employee's supervisor have actual knowledge of accident? Yes ☒ No ☐

Were you notified of accident by injured employee? Yes ☒ No ☐ How: in person Date: 1-9-70

Have you reason to question this accident? Yes ☐ No ☒ If "yes" explain fully.....

SAFETY

Was employee's accident due to unsafe work practice? Yes ☐ No ☒ If "yes", what did he do unsafely?.....

Was a specific device, object or substance involved in accident? Yes ☐ No ☐ If "yes", name specific device, object or substance..... Was device or object defective? Yes ☐ No ☐

Was employee doing regular work when injured? Yes ☒ No ☐ Was employee trained to do work he was doing when injured? Yes ☒ No ☐ Were adequate safeguards provided? Yes ☐ No ☐ If "yes", were they being used at the time of accident? Yes ☐ No ☐

MEDICAL ATTENTION

Name of attending physician: Dr. W. T. Matthews Address: Libby, Montana

Was employee hospitalized? Yes ☐ No ☒ Name of hospital..... Address.....

Was first aid administered by someone other than attending physician? Yes ☐ No ☒

TIME AND WAGE LOSS

Will employee lose time from work due to accident? Yes ☒ No ☐ How long? 3 days If injury results in time loss will employee, while disabled, received sick leave benefits? Yes ☒ No ☐ Paid vacation? Yes ☐ No ☐ Will employee lose wages? Yes ☐ No ☐ Room? Yes ☐ No ☐ Board? Yes ☐ No ☐

Date wage loss began: 1-6-70 Amount of weekly wage loss: $138.00

EMPLOYER

Name of employer: Zonolite Division-W.R.Grace & Co.

Address: Libby, Montana Nature of Business: Mining & Milling Vermiculite

IS FIRM A CORPORATION ☒ OR PARTNERSHIP ☐ OR INDIVIDUAL ☐

IF
- Corporation—is injured employee an officer or director of corporation? Yes ☐ No ☒
- Partnership—is injured employee related to any partner? Yes ☐ No ☐ Relationship.....
- Individual—is injured employee related to employer? Yes ☐ No ☐ Relationship.....

Signed, this 16th day of January, 19 70

at Libby, Montana

Employer's Name: Zonolite Division-W.R.Grace & Co.

Signed by.....

Official Title.....

NOTICE—EMPLOYEE'S CLAIM FOR COMPENSATION, FORM 54, MUST BE FILED WITHIN 12 MONTHS FROM DATE OF ACCIDENT.

C0079240
WRG00299345
ED_005351_00000355-00426

Medical
Moen, Dale Exp

ACCIDENT INVESTIGATION REPORT

INDUSTRIAL CHEMICALS GROUP
W. R. Grace & Co.

Plant Libby operations Lost Time Case ____

Division Construction Products Not Lost Time Case ✓
(Check one)

All accidents involving lost time from work or the services of a physician must be investigated and the report completed within 48 hours by the injured employee's supervisor. Forward one copy of report to office of Safety Administrator.

1. Name of injured employee DALE MOEN
2. Department MILL Date of Hire July 23 - 79
3. Job Title Millwright Was he doing regular job? Yes ✓ No ____
4. Date and time of injury 6 MAY 81 9:00 pm (SWING)
5. Date and time injury reported 6 MAY 81 9:45 pm (SWING)
6. Injured employee is: Salaried ____ Hourly ✓ Male ✓ Female ____

   Under 25 years ✓ 25 to 34 ____ 35 to 49 ____ 50 and over ____
7. Describe in detail what employee was doing at time of injury: include reference to any tools, machines and materials involved:

   finger got pinched on the Hand winch over at the Skip the gear back up on him. Employee was helping shorten cable on skip.

   -8-81

8. Describe injury: Pinched tip of finger (left hand Ring finger) tore-up finger Nail
9. What medical action was taken? Went to docta to Band-aid-up finger & give him A Shot.
10. What, in your opinion, was the basic cause of this accident?

    Unsafe Act ✓ Unsafe Condition ____ Explain ____

    Employee was in hurry

C0079230

WRG00299347

ED_005351_00000355-00428

11. What were the contributing causes? Employee was in hurry & lack of absolute way to tie skigoup, while shortening cable.

12. What action have you taken and/or are you planning to take to avoid a recurrence of this accident?

Employee was counselled about accident.

13. Have you counselled your other employees regarding lessons to be learned from this accident?

Yes ✓ No ____ if not, why _____

14. Have you scheduled any maintenance work or planned any disciplinary action with the accident?

Yes ____ No ✓ Comments, if any: _____

(Signed) JEVAN Vort (Supervisor) Date 2 MAY 81 Plant Libby operations

****

You have now completed answering some very important questions regarding an injury to one of your employees. Take the time to think carefully and ask yourself the following two questions:

a) How long did I take to think out and complete the answers to the questions above?
b) Have I really taken enough time, given enough thought, to a subject which might very well mean the life of one of my employees at some future date?

****

This space reserved for Plant Managers

1. Have you discussed this injury with J. E. Van Vort, W. Melcher

the supervisor concerned? Yes ✓ No ____
all members of your supervisory group? Yes ____ No ✓

2. Do you have any comments to add to the statements by the Foreman?

(Plant Manager) 5/20/81 (Date)

Form 65-25

C0079231
WRG00299348
ED_005351_00000355-00429

MONTANA DIVISION OF WORKERS' COMPENSATION

815 Front Street / Helena, Montana 59601

DATE STAMP

EMPLOYER'S FIRST REPORT of Occupational Injury or Occupational Disease

SEND ORIGINAL TO INSURER:

CASE NO -

FIRM NO -

Employee Copy

INSTRUCTIONS - Every employer in Montana is required by law to complete this form immediately after every industrial accident to an employee which causes loss of time from work or requires medical attention. The original of this form must be immediately filed with the employer's insurer or the Division of Workers' Compensation, 815 Front Street, Helena, Montana 59601. All questions must be answered fully. If a question cannot be answered, please explain why.
Please print with a ball point pen or type.

FEDERAL OSHA REQUIREMENTS - The United States Department of Labor requires employers to maintain, in the employer's office, a record of occupational injuries. *For the employer's convenience, this form has been designed to meet such requirements and to provide employers a record copy.*

EMPLOYEE

FULL NAME OF INJURED EMPLOYEE: DALE MOEN
PHONE: 293-3278
SOCIAL SECURITY NUMBER: 517-70-9590
EMPLOYEE'S HOME ADDRESS (Street or Box): P O BOX 1096
CITY: LIBBY
STATE: MS
ZIP CODE: 59923
OCCUPATION: MILLWRIGHT
SEX: M
DATE OF BIRTH (Mo / Day / Yr): 8 / 14 / 57
MARITAL STATUS: [X] Married [ ] Single
LENGTH OF TIME IN YOUR EMPLOYMENT: 2 YRS.

WAGES

Employee's Gross Wage Rate is $ 9.065 Per WEEK [ ] DAY [ ] HOUR [X] MO. [ ]
Days Worked Per Week: 5
Hours Worked Per Day: 8
If board or room is furnished state value reported per day to Internal Revenue Service $
Check one: [X] Full Time Employee [ ] Part Time Employee
Payroll Classification under which employee's wages were reported
Employee's Pay Period: Monthly [ ] Semi-monthly [X] Bi-weekly [ ] Weekly [ ] Other (explain) [ ]
Regular Days Off
Employee's gross earnings for last four (4) pay periods (Date / Amount) (Date / Amount) (Date / Amount) (Date / Amount)
Will employee return to work during next scheduled shift? Yes [X] No [ ]
If no, will employee lose more than 5 days wages? Yes [ ] No [ ] Not Sure [ ]
DATE WAGE LOSS BEGAN (Mo / Day / Yr) / /
DATE OF RETURN, if returned to work (Mo / Day / Yr) / /

ACCIDENT INFORMATION

Describe in full detail how accident happened, and give cause - Explain what employee was doing when injured.
WORKING ON SKIP AND HE GOT HIS LEFT RIBG FINGER PINCHED BETWEEN TWO GEARS.

DATE OF INJURY (month) MAY (day) 6, (year) 1981 (hour) 9:45 (a.m. or p.m.) A.M.
What specific object or substance caused the injury? HAND WINCH
Nature of the injury? (cut, fracture, etc.) PINCHED LEFT RING FINGER
Part of body affected (leg, arm, back, head, etc.) LEFT HAND
Names of witnesses to accident: 1. JOHN VANVORST 2. DICK GOSTNELL
Was place of accident on employer's premises? Yes [X] No [ ]
Place where accident occurred (address & city) (county)
Was employee injured while in your employ? Yes [X] No [ ]
Were you notified, or did you have actual knowledge of the accident? Yes [ ] No [ ]
If yes, date notified & how
Do you have any reason to question this accident? [ ] Yes [X] No
If yes, please explain fully

MEDICAL

Attending Physician's Name: DR. PAUL SEIFERT
PHONE: 293-4181
Address (Street or Box): 402 MONTANA AVE
(City): LIBBY
(State): MT
(Zip Code): 59923
If Hospitalized, Hospital's Name
Address (Street or Box)
(City)
(State)
(Zip Code)

EMPLOYER

EMPLOYER'S NAME: W. R. GRACE & CO.
Commercial Name (doing business as)
Employer's mailing address (street or box): P O BOX 609
(City): LIBBY
(State): MS
(Zip Code): 59923
Phone Number: 406-293-4131
Location of operation, if different from mailing address: 12 MILES NE LIBBY MT
Nature of Business: MINING & MILLING
Firm is a: (Check one) [ ] Sole proprietorship [ ] Partnership, or [X] Corporation
Was the injured employee? (Check if applicable) [X] A Sole Proprietor, [ ] A working Partner, [ ] A Corporate Officer, or [ ] A member of the employer's (sole proprietor or partner) family, dwelling in the employer's household.
Prepared by: DARLENE WOODWARD
Authorized Signature
Official Title: MANAGER OF ADMINISTRATION
Date: 5-8-81

ABOVE - DWC - MIS Form 37 - Employer's First Report (Rev. 6-78)
BELOW - DWC - MIS Form 54 - Claim for Compensation

EMPLOYEE'S CLAIM FOR COMPENSATION

EMPLOYER'S NOTE: For convenience purposes and if the worker is available, the form below has been provided so that an employer may allow an injured worker to file a claim for compensation on this form to avoid having the employee fill out and file a separate detailed form. Separate claim forms are available if the employer does not want the worker to use this form. **Do not delay in submission of this form if employee is not available to sign below.**

EMPLOYEE'S CLAIM FOR COMPENSATION

INJURED EMPLOYEE'S NOTE: An injured employee may use the form below to make a *claim for compensation, or the employee may fill out and submit a separate detailed form that is* available from the Division.

List other types of work you have done: 1. 2. 3.
Education: [ ] Grade School [ ] High School [ ] College [ ] Other
How many members are in your immediate family?
Have you ever had an industrial injury before? Yes [ ] No [ ]
If yes, in what state?
Type of injury

I have carefully read the information as documented by the employer, and (except for any statements I may write below) I concur with the information and I hereby make claim for compensation benefits due me now or in the future under Montana's Workers' Compensation Act.

Signature of injured employee: X [signature]
Address: P O BOX 1096
City: LIBBY, MT
Date: 5-8-81
Phone: 293-3278

I DO NOT concur with the following information documented by the employer

C0079232

Filing of this claim is authorization for release of medical records and records of the Social Security Administration

Medical
Moen, Dale Exp

Zonolite
Construction Products Division

GRACE

TO: File

DATE: March 28, 1983

FROM: W.J. Melcher

SUBJECT: Bus-Propane Tanker Accident of January 31, 1983

CC: E.D. Lovick

At approximately 1530 the Mill Shift Bus left our property via the main gate with the following occupants:

1.	Dick Gostnell	Driver
2.	Jerry Ledum	Front seat, R. side
3.	Richard Viereck	2nd seat from rear, R. side
4.	Lucille Fields	Front seat, L. side
5.	Dale Moen	Back seat, L. side
6.	Lyle Siefke	3rd seat from front, R. side
7.	Ray Hartley	2nd seat from rear, L. side
8.	Monte Bennett	Back seat, L. side
9.	Rod Mitchell	2nd seat from front, L. side
10.	Orville Johnson	2nd seat from front, R. side

All of the occupants are employees of W. R. Grace & Co. and were on their way home after completing the day shift (0730-1530) except employee #9 & #10.

Passenger #9, Rod Mitchell is one of the bus owners who had just driven the bus from town.

Passenger #10, Orville Johnson is a day shift guard for Burns Guard Service. He had also just completed his shift at our main gate.

The road from W. R. Grace & Co. Libby Operations to Montana Highway 37 is gravel built and maintained by W. R. Grace & Co. At the time of the accident the road surface was very muddy with a frozen surface under the mud. This condition had existed for many days prior to the accident.

At about 1545, _____ miles from our main gate (4.6 miles from Montana Highway 37) the bus met a tractor tanker trailer unit; hauling propane from Libby to our property. The tanker was on a curve to the right going downhill and at this point the bus slid across the center of the road, striking the left front of the tractor unit.

C0079233

The initial impact appreared to be at about the center of the left front wheel, from that point the impact continued down the side of the unit ending at the rear end of the left saddle tank. At that point the bus bounced back across the road and into the right hand (going downhill) ditch. Damage to the bus was confined to the left front area wheel and fender.

At approximately 1638 I came upon the accident on my way home. At that time the bus had been pulled from the ditch and the propane tanker was being towed up the hill by our motor grader. Mr. W.J. McCaig asked that I call the Montana Highway Patrol which I did.

Montana Highway Patrolman G. Criner (242) arrived at the accident scene at 1708, and began an investigation in which I assisted.

The driving surface at the apparent point of contact (both vehicles had been moved) was twenty-nine feet wide. The propane tanker occupied the outer twelve feet of the roadway. This left seventeen feet of roadway for the bus. The Montana Highway Patrol cited the bus driver for a basic rule violation (crossing the centerline). Rod Mitchell, the bus owner, who was a passenger on the bus agreed that his driver was going to fast for the road conditions.

As all of the bus occupants except Rod Mitchell had gone home. We did not interview any of them until the following day when they returned to work. All but one of the occupants of the bus agreed that the tanker was on the proper side of the road and that the bus was going too fast.

Lucille Fields told the investigating officer that the tanker was on the wrong side of the road. (This did not appear in the officer's final report.) Lucille Fields claimed some vague injury to her neck, but only after the officer explained that no future claim would be allowed if she did not have an injury in his report. She went to her doctor (Dr. W. T. Matthews) that evening which was over 24 hours after the accident. She returned to work the next day with a neck brace.

Jerry Ledum, who was holding the pipe stanchion at the right front seat, was pivoted around the stanchion and ended up sitting on the floor in the front doorway. He was not injured.

There were no other injuries or incidents reported.

C0079234

The bus was as follows:

1976 Dodge - License No. MT 56T-B611

Driver - Dick Gostnell who is employed
by Mitchell Bus Co.

Insurance - USF&G Policy No. BAP373819

The tractor was as follows:

1980 White Freightliner - License No. WY 1452

Driver - Ron A. Kaski
P.O. Box 483
Lakeside, MT

Employer - Cal Gas Corp. out of Kalispell, MT.

Owner - Cal Gas Corp.

Insurance - Aetna Policy No. 05AL189534SCA

The Montana Highway Patrol filed a complete accident report as [illegible] the roadway is a Forest Service access road even though we built and [illegible] maintain it.

WJM/al

C0079235

Medical, IRR Ex 3f
Monroe, Duane

06063033

Industrial Accident Board, Helena, Montana, Form 37 Revised

Industrial Accident Board

HELENA, MONTANA

Firm No.....

File No.....

EMPLOYER'S FIRST REPORT OF INJURY

DO NOT WRITE IN THIS SPACE

Carrier
Firm No.
File No.
Major Industry
County
Date of Acc.
Time
Sex & Marital Status
Age
Mont. Code
Acc. Class
Occupation
Type
Agency
Agency Part
Nature of Inj.
Location
Time Loss
Mech. Defect
Unsafe Act
Pers. Factor
Weekly Wage

INSTRUCTIONS—Employer must complete form at once after every accident which causes loss of time from work or requires medical attention and mail it to the Industrial Accident Board, Helena, Montana. Form must be signed in pen and ink. ALL QUESTIONS MUST BE ANSWERED FULLY.

INJURED EMPLOYEE

Full name of injured employee Duane Monroe Occupation Mine Tester

Mailing address Box 505 Libby How long has he been in your employ 1yr

Social Security No. 516-40-5416 Sex M Age 29 Married ☒ Single ☐

EARNINGS

Monthly Wage..... Weekly Wage..... Daily Wage..... Hourly Wage.....

Receive board Yes ☐ No ☒ Daily Value..... Receive room Yes ☐ No ☒ Daily Value.....

Piece Worker Yes ☐ No ☒ If yes, give method of computing earnings.....

Number of hours worked per day 8 Days worked per week 5 Employee's pay period?

Monthly ☐ Semi monthly ☐ Weekly ☐ List employee's earnings last 4 pay periods 1. 345.47 2. 366.20 3. 317.72 4. 344.67

Under what payroll classification has employees' wages been reported?..... (Sawmill - Mechanic - Etc.)

ACCIDENT AND INJURY

Describe in full how accident happened and GIVE CAUSE Stepped out of the mobil lab on to a pile of dirt and sprained his ankle

Part of body injured? Describe fully Right Ankle

Names of witnesses to accident 1..... 2.....

Date of accident 10-9 19 68 Hour 11 A.M. Was employee injured in course of employment? Yes ☒ No ☐

Place where accident occured Our pit 5 miles North of Libby Lincoln (Address) (City) (County)

Did you or employee's supervisor have actual knowledge of accident? Yes ☒ No ☐

Were you notified of accident by injured employee? Yes ☒ No ☐ How In person Date 10-16-68

Have you reason to question this accident? Yes ☐ No ☐ If "yes" explain fully.....

SAFETY

Was employee's accident due to unsafe work practices? Yes ☐ No ☒ If "yes", what did he do unsafely?

Was a specific device, object or substance involved in accident? Yes ☒ No ☐ If "yes", name specific device, object or substance pile of dirt Was device or object defective? Yes ☐ No ☐

Was employee doing regular work when injured? Yes ☒ No ☐ Was employee trained to do work he was doing when injured? Yes ☒ No ☐ Were adequate safe guards provided? Yes ☐ No ☐ If "yes" were they being used at time of accident? Yes ☐ No ☐

MEDICAL ATTENDANCE

Name of attending physician Dr. Paul J. Seifert Address Libby

Was employe hospitalized? Yes ☐ No ☒ Name of hospital..... Address.....

Was first aid administered by someone other than attending physician? Yes ☐ No ☐

TIME AND WAGE LOSS

Will employe lose time from work due to accident? Yes ☐ No ☒ How long?.....

If injury results in time loss, will employee, while disabled, receive sick leave benefits? Yes ☐ No ☐

Paid vacation? Yes ☐ No ☐

Will employe lose wages? Yes ☐ No ☐ Room? Yes ☐ No ☐ Board? Yes ☐ No ☐

Date wage loss began NONE Amount of weekly wage loss.....

EMPLOYER

Name of employer Zonolite Division-W. R. Grace & Co.

Address Libby, Montana Nature of business Mining&MillingVermiculite

IS FIRM A CORPORATION ☒ OR PARTNERSHIP ☐ OR INDIVIDUAL ☐

IF
- Corporation—is injured employee an officer or director of corporation? Yes ☐ No ☐
- Partnership—is injured employee related to any partner? Yes ☐ No ☐ Relationship.....
- Individual—is injured employee related to employer? Yes ☐ No ☐ Relationship.....

Signed, this 17th day of October 19 68

Employer's Name Zonolite Division-W.R.Grace&Co.

Signed by.....

at Libby Montana

Official Title.....

NOTICE—EMPLOYEE'S CLAIM FOR COMPENSATION, FORM 54, MUST BE FILED WITHIN 12 MONTHS FROM DATE OF ACCIDENT

Form 1-HU-163-ZR

C0079248

WRG00299357

ED_005351_00000355-00436

Medical, IRR Ex 2J
Monroe, Dwane

06063322

Industrial Accident Board

HELENA, MONTANA

Firm No. 2503

File No.

EMPLOYER'S FIRST REPORT OF INJURY

INSTRUCTIONS—Employer must complete form at once after every accident which causes loss of time from work or requires medical attention and mail it to the Industrial Accident Board, Helena, Montana. Form must be signed in pen and ink. ALL QUESTIONS MUST BE ANSWERED FULLY.

INJURED EMPLOYEE

Full name of injured employee Dwane Monroe Occupation Mill Wright

Mailing address Route 1 Box 505 (Street) Libby (City) How long has he been in your employ? 4½ yrs.

Social Security No. 516-40-5416 Sex M Age 33 Married XX Single ☐

EARNINGS

Monthly Wage ..... Weekly Wage ..... Daily Wage ..... Hourly Wage .....

Receive board Yes ☐ No XX Daily Value ..... Receive room Yes ☐ No ☒ Daily Value .....

Piece Worker Yes ☐ No ☒ If yes, price per unit at piece work ..... Hours worked per day 8

Days worked per week 5 Employee's pay period? Monthly ☐ Semi-monthly XX Weekly ☐ List employee's earnings last 4 pay periods 1 467.61 2 454.22 3 455.70 4 447.43

List Payroll Classification and Code under which employee's wages were reported ..... (Sawmill - Mechanic - Etc.) Code ..... (2702, 5506, 8810)

ACCIDENT AND INJURY

Describe in full how accident happened and GIVE CAUSE loading long section of pipe. Pipe caught in bottom of pickup box, caught left hand between pipe and pickup box. Index, middle, 4th and little finger skinned.

Nature or extent of injury contusion (Cut - Fracture) Part of body injured? left hand (Leg - Arm - Back - Head)

Names of witnesses to accident 1 ..... 2 .....

Date of accident 10-15-71 19 Hour 11:30 AM. XX Was employee injured in course of employment? Yes XX No ☐

Place where accident occurred our mill 9 miles north of Libby (Address) (City) Lincoln (County)

Did you or employee's supervisor have actual knowledge of accident? Yes ☒ No ☐

Were you notified of accident by injured employee? Yes XX No ☐ How in person Date 11-16-71

Have you reason to question this accident? Yes ☐ No ☐ If "yes" explain fully .....

SAFETY

Was employee's accident due to unsafe work practice? Yes ☐ No ☒ *If "yes", what did he do unsafely?* .....

Was a specific device, object or substance involved in accident? Yes ☐ No ☐ If "yes", name specific device, object or substance ..... Was device or object defective? Yes ☐ No ☐

Was employee doing regular work when injured? Yes XX No ☐ Was employee trained to do work he was doing when injured? Yes XX No ☐ *Were adequate safeguards provided?* Yes ☐ No ☐ *If "yes", were they being used at the time of accident?* Yes ☐ No ☐

MEDICAL ATTENTION

Name of attending physician Dr. P. J. Seifert Address Libby, Montana

Was employee hospitalized? Yes ☐ No XX Name of hospital St. Johns Lutheran X-rays only Address Libby

Was first aid administered by someone other than attending physician? Yes ☐ No ☐

TIME AND WAGE LOSS

Will employee lose time from work due to accident? Yes ☐ No ☒ How long? NONE If injury results in time loss will employee, while disabled, received sick leave benefits? Yes ☐ No ☐ Paid vacation? Yes ☐ No ☐ *Will employee lose wages?* Yes ☐ No ☐ *Room?* Yes ☐ No ☐ *Board?* Yes ☐ No ☐

Date wage loss began None Amount of weekly wage loss .....

EMPLOYER

Name of employer Construction Products Division-W. R. Grace & Co.

Address Libby, Montana Nature of Business Mining & Milling Vermicul

IS FIRM A CORPORATION XX OR PARTNERSHIP ☐ OR INDIVIDUAL ☐

IF
- Corporation—is injured employee an officer or director of corporation? Yes ☐ No ☒
- Partnership—is injured employee related to any partner? Yes ☐ No ☐ Relationship .....
- Individual—is injured employee related to employer? Yes ☐ No ☐ Relationship .....

Signed, this 17th day of November, 19 71

at Libby, Montana

Employer's Name Construction Products Division W. R. Grace & Co.

Signed by [signature]

Official Title Asst

NOTICE—EMPLOYEE'S CLAIM FOR COMPENSATION, FORM 54, MUST BE FILED WITHIN 12 MONTHS FROM DATE OF ACCIDENT.

C0079249

~~WRG00299359~~

ED_005351_00000355-00438

PATCH II

W.R. Grace Fall 2000 Document Production Target Sheet

- [ ] Notice
  - [ ] Testing
  - [ ] Agency
- [ ] Libby Ore/Operations
- [x] Libby All Other
- [ ] Expanding Plant (see below)
- [ ] Non-Grace Expanding Plant
- [ ] Attic Insulation
- [ ] Agricultural/ Horticultural Products
- [ ] Other Consumer Products
- [ ] Workers Comp
- [ ] Medical Records and Other Personal Confidental
- [ ] Privilege
- [ ] Trade Secret

- [ ] All
- [ ] Invoices

- [ ] Albany, N Y.
- [ ] Atlanta, Georgia
- [ ] Birmingham, Alabama
- [ ] Boca Raton, Florida
- [ ] Chicago, Illinois (Blue Island)
- [ ] Dallas, Texas
- [ ] Dearborn, Michigan
- [ ] Denver, Colorado
- [ ] Easthampton, Mass.
- [ ] Ellwood City, Penn.
- [ ] Enoree, S. Carolina
- [ ] Hialeah, Florida
- [ ] High Point, N. Carolina
- [ ] Irondale, Alabama
- [ ] Jacksonville, Florida
- [ ] Kansas City, Missouri
- [ ] Kearny, S. Carolina
- [ ] Kenilworth Ave. Washington D.C.
- [ ] Los Angeles, Calif.
- [ ] Milwaukee, Wisconsin
- [ ] Minneapolis, Minn. (Western Min. Prod.)
- [ ] Muirkirk, Maryland (Beltsville)
- [ ] Nashville, Tennessee
- [ ] Newark, California
- [ ] New Castle, Pennsylvania
- [ ] New Orleans, Louisiana
- [ ] North Billerica, Mass.
- [ ] North Little Rock, Ark.
- [ ] Oklahoma City, Oklahoma
- [ ] Omaha, Nebraska (Western Min. Prod.)
- [ ] Phoenix, Arizona (Glendale)
- [ ] Pompano Beach, Florida
- [ ] Portland, Oregon
- [ ] Rio Piedras, Puerto Rico
- [ ] Sacramento, Calif.
- [ ] San Antonio, Texas
- [ ] Santa Ana, California
- [ ] Savannah, Georgia
- [ ] Sharpsburg, Penn.
- [ ] Spokane, Washington
- [ ] St. Louis, Missouri
- [ ] Tampa, Florida
- [ ] Travelers Rest, S. Carolina
- [ ] Trenton, New Jersey (East Trenton)
- [ ] Utica, New York
- [ ] Weedsport, N. Y. (Brutus)
- [ ] West Chicago, Illinois
- [ ] Wilder, Kentucky (Newport)

- [ ] Canadian Expanding plants

F34

Medical,
Monroe, Dwone

IRR

Ex 22

Industrial Accident Board, Helena, Montana, Form 37 Revised—YM - U - WU

06063062

Industrial Accident Board

HELENA, MONTANA

Firm No.....

File No.....

EMPLOYER'S FIRST REPORT OF INJURY

INSTRUCTIONS—Employer must complete form at once after every accident which causes loss of time from work or requires medical attention and mail it to the Industrial Accident Board, Helena, Montana. Form must be signed in pen and ink. ALL QUESTIONS MUST BE ANSWERED FULLY.

INJURED EMPLOYEE

Full name of injured employee: Duane Monroe Occupation: Mine Tester

Mailing address: Box 247, Libby, Montana (Street, City) How long has he been in your employ: 1 year

Social Security No.: 516-40-5416 Sex: M Age: 30 Married ☐ Single ☒

EARNINGS

Monthly Wage..... Weekly Wage..... Daily Wage..... Hourly Wage: 2.93

Receive board Yes ☐ No ☒ Daily Value..... Receive room Yes ☐ No ☒ Daily Value.....

Piece Worker Yes ☐ No ☒ If yes, price per unit at piece work..... Hours worked per day: 8

Days worked per week: 5 Employee's pay period? Monthly ☐ Semi-monthly ☒ Weekly ☐ List employee's earnings last 4 pay periods 1. 340.48 2. 325.51 3. 306.12 4. 343.48

List Payroll Classification and Code under which employee's wages were reported..... (Sawmill - Mechanic - Etc.) Code..... (2702, 5506, 8810)

ACCIDENT AND INJURY

Describe in full how accident happened and GIVE CAUSE: While sliding seat ahead in Mine Tester's pickup truck at beginning of day shift, caught right hand between seat and rail--

Nature or extent of injury: severe bruises (Cut - Fracture) Part of body injured? right hand (Leg - Arm - Back - Head)

Names of witnesses to accident 1..... 2.....

Date of accident: 6-14 1968 Hour: 8:00 A.M. ☒ P.M. ☐ Was employee injured in course of employment? Yes ☒ No ☐

Place where accident occurred: our mine office, 2 miles north of Libby (Address, City) Lincoln (County)

Did you or employee's supervisor have actual knowledge of accident? Yes ☒ No ☐

Were you notified of accident by injured employee? Yes ☒ No ☐ How: by employee Date: 6-14-68

Have you reason to question this accident? Yes ☐ No ☒ If "yes" explain fully.....

SAFETY

Was employee's accident due to unsafe work practice? Yes ☐ No ☒ If "yes", what did he do unsafely?.....

Was a specific device, object or substance involved in accident? Yes ☐ No ☐ If "yes," name specific device, object or substance..... Was device or object defective? Yes ☐ No ☐

Was employee doing regular work when injured? Yes ☒ No ☐ Was employee trained to do work he was doing when injured? Yes ☐ No ☐ Were adequate safeguards provided? Yes ☐ No ☐ If "yes," were they being used at the time of accident? Yes ☐ No ☐

MEDICAL ATTENTION

Name of attending physician: Dr. Paul J. Seifert, Jr. Address: Libby, Montana

Was employee hospitalized? Yes ☐ No ☒ Name of hospital..... Address.....

Was first aid administered by someone other than attending physician? Yes ☐ No ☒

TIME AND WAGE LOSS

Will employee lose time from work due to accident? Yes ☐ No ☒ How long?..... If injury results in time loss will employee, while disabled, receive sick leave benefits? Yes ☒ No ☐ Paid vacation? Yes ☐ No ☐ Will employee lose wages? Yes ☐ No ☐ Room? Yes ☐ No ☐ Board? Yes ☐ No ☐

Date wage loss began: NONE Amount of weekly wage loss.....

EMPLOYER

Name of employer: Zonolite Division-W.R.Grace & Co.

Address: Libby, Montana Nature of business: Mining & Milling Vermiculite

IS FIRM A CORPORATION ☒ OR PARTNERSHIP ☐ OR INDIVIDUAL ☐

IF
- Corporation—is injured employee an officer or director of corporation? Yes ☐ No ☒
- Partnership—is injured employee related to any partner? Yes ☐ No ☐ Relationship.....
- Individual—is injured employee related to employer? Yes ☐ No ☐ Relationship.....

Signed, this 17th day of June, 1968

at Libby, Montana

Employer's Name: Zonolite Division-W.R.Grace & Co.

Signed by.....

Official Title.....

NOTICE—EMPLOYEE'S CLAIM FOR COMPENSATION, FORM 54, MUST BE FILED WITHIN 12 MONTHS FROM DATE OF ACCIDENT.

Δ

C0079250

WRG00299363

ED_005351_00000355-00442

Medical, IRR Ex 22
Monroe, Dwane

Industrial Accident Board

06063396

HELENA, MONTANA

Firm No. 2503

File No.

EMPLOYER'S FIRST REPORT OF INJURY

INSTRUCTIONS—Employer must complete form at once after every accident which causes loss of time from work or requires medical attention and mail it to the Industrial Accident Board, Helena, Montana. Form must be signed in pen and ink. *ALL QUESTIONS MUST BE ANSWERED FULLY.*

INJURED EMPLOYEE

Full name of injured employee: Dwane Monroe Occupation: Mill Worker

Mailing address: Route 1 Box 505 (Street) Libby (City) How long has he been in your employ? 2½ yrs.

Social Security No. 516-40-5416 Sex: M Age: 32 Married XX Single ☐

EARNINGS

Monthly Wage ____ Weekly Wage ____ Daily Wage ____ Hourly Wage ____

Receive board Yes ☐ No XX Daily Value ____ Receive room Yes ☐ No XX Daily Value ____

Piece Worker Yes ☐ No XX If yes, price per unit at piece work ____ Hours worked per day 8

Days worked per week 5 Employee's pay period? Monthly ☐ Semi-monthly ☒ Weekly ☐ List employee's earnings last 4 pay periods 1. 352.88 2. 398.32 3. 439.16 4. 400.08

List Payroll Classification and Code under which employee's wages were reported ____ (Sawmill - Mechanic - Etc.) Code ____ (2702, 5506, 8810)

ACCIDENT AND INJURY

Describe in full how accident happened and GIVE CAUSE: While working on the sizers in the wet mill he fell off a ladder, hooked his left arm in the ladder & pulled the muscles & tendons.

Nature or extent of injury: Sprain (Cut - Fracture) Part of body injured? Left Arm (Leg - Arm - Back - Head)

Names of witnesses to accident 1. ____ 2. ____

Date of accident: 1-7-71 Hour: 9 XX A.M. P.M. Was employee injured in course of employment? Yes XX No ☐

Place where accident occurred: our mill 9 miles north of Libby (Address) Lincoln (City) (County)

Did you or employee's supervisor have actual knowledge of accident? Yes ☒ No ☐

Were you notified of accident by injured employee? Yes ☒ No ☐ How: in person Date: 1-8-71

Have you reason to question this accident? Yes ☐ No ☐ If "yes" explain fully ____

SAFETY

Was employee's accident due to unsafe work practice? Yes ☐ No XX If "yes", what did he do unsafely? ____

Was a specific device, object or substance involved in accident? Yes ☐ No XX If "yes", name specific device, object or substance ____ Was device or object defective? Yes ☐ No ☐

Was employee doing regular work when injured? Yes ☒ No ☐ Was employee trained to do work he was doing when injured? Yes ☒ No ☐ Were adequate safeguards provided? Yes ☐ No ☐ If "yes", were they being used at the time of accident? Yes ☐ No ☐

MEDICAL ATTENTION

Name of attending physician: Paul J. Selfert, Jr., MD Address: Libby

Was employee hospitalized? Yes ☐ No XX Name of hospital ____ Address ____

Was first aid administered by someone other than attending physician? Yes ☐ No ☐

TIME AND WAGE LOSS

Will employee lose time from work due to accident? ~~Yes~~ No ☒ How long? ~~[illegible]~~ None If injury results in time loss will employee, while disabled, received sick leave benefits? Yes XX No ☐ Paid vacation? Yes ☐ No ☐ Will employee lose wages? Yes ☐ No ☐ Room? Yes ☐ No ☐ Board? Yes ☐ No ☐

Date wage loss began: 1-8-71 Amount of weekly wage loss: 142.00

EMPLOYER

Name of employer: Construction Products Division-W. R. Grace & Co.

Address: Libby, Montana Nature of Business: Mining&MillingVermiculite

IS FIRM A CORPORATION XX OR PARTNERSHIP ☐ OR INDIVIDUAL ☐

IF
- Corporation—is injured employee an officer or director of corporation? Yes ☐ No XX
- Partnership—is injured employee related to any partner? Yes ☐ No ☐ Relationship ____
- Individual—is injured employee related to employer? Yes ☐ No ☐ Relationship ____

Signed, this 20th day of January, 19 71

at Libby, Montana

Employer's Name: Construction Products Division W. R. Grace & Co.

Signed by: [signature]

Official Title: [signature]

NOTICE—EMPLOYEE'S CLAIM FOR COMPENSATION, FORM 54, MUST BE FILED WITHIN 12 MONTHS FROM DATE OF ACCIDENT.

C0079251

WRG00299365

ED_005351_00000355-00444

Medical, IRR Ex 3J
Monroe, Duane

06063282

Industrial Accident Board

HELENA, MONTANA

Firm No. 2503

File No.

EMPLOYER'S FIRST REPORT OF INJURY

INSTRUCTIONS—Employer must complete form at once after every accident which causes loss of time from work or requires medical attention and mail it to the Industrial Accident Board, Helena, Montana. Form must be signed in pen and ink. ALL QUESTIONS MUST BE ANSWERED FULLY.

INJURED EMPLOYEE

Full name of injured employee: Dwane Monroe Occupation: Mill Worker

Mailing address: Route 1 Box 505, Libby, Montana (Street, City) How long has he been in your employ? 3½ years

Social Security No. 516-40-5416 Sex: M Age: 31 Married ☐ Single ☐

EARNINGS

Monthly Wage: Weekly Wage: Daily Wage: Hourly Wage: 3.35

Receive board Yes ☐ No ☒ Daily Value: Receive room Yes ☐ No ☒ Daily Value:

Piece Worker Yes ☐ No ☒ If yes, price per unit at piece work: Hours worked per day: 8

Days worked per week: 5 Employee's pay period? Monthly ☐ Semi-monthly ☒ Weekly ☐ List employee's earnings last 4 pay periods 1. 333.00 2. 384.16 3. 456.83 4. 356.72

List Payroll Classification and Code under which employee's wages were reported: (Sawmill - Mechanic - Etc.) Code: (2702, 5506, 8810)

ACCIDENT AND INJURY

Describe in full how accident happened and GIVE CAUSE: First day on this particular phase of job, was watching another employee mix amine, this slopped up and struck him in the face, particularly right eye.

Nature or extent of injury: foreign material (acid) (Cut - Fracture) Part of body injured? right eye (Leg - Arm - Back - Head)

Names of witnesses to accident 1. 2.

Date of accident: 3-6- 1970 Hour: A.M. ~~P.M.~~ Was employee injured in course of employment? Yes ☒ No ☐

Place where accident occurred: our mill, 9 miles north of Libby (Address, City) Lincoln (County)

Did you or employee's supervisor have actual knowledge of accident? Yes ☒ No ☐

Were you notified of accident by injured employee? Yes ☒ No ☐ How: in person Date: 3-6-70

Have you reason to question this accident? Yes ☐ No ☒ If "yes" explain fully:

SAFETY

Was employee's accident due to unsafe work practice? Yes ☒ No ☐ If "yes", what did he do unsafely? should have been wearing safety goggles

Was a specific device, object or substance involved in accident? Yes ☒ No ☐ If "yes", name specific device, object or substance: amine acid Was device or object defective? Yes ☐ No ☒

Was employee doing regular work when injured? Yes ☒ No ☐ Was employee trained to do work he was doing when injured? Yes ☐ No ☒ Were adequate safeguards provided? Yes ☐ No ☒ If "yes", were they being used at the time of accident? Yes ☐ No ☐

MEDICAL ATTENTION

Name of attending physician: James F. Graham, M.D. Address: Libby

Was employee hospitalized? Yes ☐ No ☒ Name of hospital: St. Johns for Emergency room (Address) Libby

Was first aid administered by someone other than attending physician? Yes ☐ No ☒

TIME AND WAGE LOSS

Will employee lose time from work due to accident? Yes ☒ No ☐ How long? lost one day If injury results in time loss will employee, while disabled, received sick leave benefits? Yes ☒ No ☐ Paid vacation? Yes ☐ No ☐ Will employee lose wages? Yes ☐ No ☐ Room? Yes ☐ No ☐ Board? Yes ☐ No ☐

Date wage loss began: 3-7-70 Amount of weekly wage loss: 134.00

EMPLOYER

Name of employer: Construction Products Division-W.R.Grace & Co.

Address: Libby, Montana Nature of Business: Mining & Milling Vermiculite

IS FIRM A CORPORATION ☒ OR PARTNERSHIP ☐ OR INDIVIDUAL ☐

IF
- Corporation—is injured employee an officer or director of corporation? Yes ☐ No ☒
- Partnership—is injured employee related to any partner? Yes ☐ No ☐ Relationship:
- Individual—is injured employee related to employer? Yes ☐ No ☐ Relationship:

Signed, this 19th day of March, 1970 at Libby, Montana

Employer's Name: Construction Products Division W. R. Grace & Co.

Signed by:

Official Title:

NOTICE—EMPLOYEE'S CLAIM FOR COMPENSATION, FORM 54, MUST BE FILED WITHIN 12 MONTHS FROM DATE OF ACCIDENT.

C0079252

Medical, IRR Ex 3f
Monroe, Dwone

GRACE

INCIDENT INVESTIGATION REPORT

PERSONAL INJURY/PROPERTY DAMAGE

NUMBER OF DAYS AWAY FROM WORK _____

NUMBER OF RESTRICTED WORK DAYS _____

PERSONNEL

DIVISION/PLANT: CPD/Libby OPS

PLANT LOCATION (City/State): Libby, Montana

INJURY NUMBER (From OSHA 200 Log):

LOCATION OF INCIDENT: Emplyees Home

COMPANY PREMISES: ☐ YES ☒ NO

TIME OF INCIDENT: : AM ☐ PM ☐

DATE OF INCIDENT: 08 | 22 | 88

INJURED OR ILL

NAME (FIRST) Dwane (MIDDLE) D. (LAST) Monroe

SOC. SEC. NO # 516-40-5416

OCCUPATION: Mill Shifter

SEX: ☒ MALE ☐ FEMALE

MARITAL STATUS: ☒ MARRIED ☐ SINGLE

DATE OF BIRTH: 10 | 29 | 38

ACCIDENT CATEGORY

☐ DAYS AWAY FROM WORK ☐ MEDICAL TREATMENT

☐ RESTRICTED WORK ☐ FIRST AID

LENGTH OF EMPLOYMENT	YEARS	MONTHS	LENGTH OF PRESENT OCC.	YEARS	MONTHS	SHIFT
						☐ REG. ☐ OVERTIME

NATURE OF INJURY/PARTS OF BODY AFFECTED

DATES OF PREVIOUS INJURIES

WHAT FIRST AID

WHERE GIVEN

BY WHOM

WHERE SENT ☐ HOSPITAL (Name and Address) ☐ HOME ☐ OTHER (Specify)

NAME AND ADDRESS OF ATTENDING PHYSICIAN

PROPERTY

PROPERTY DAMAGE (est. dollar value): Pickup #183 Stains Left Side

LOST PRODUCTION (i.e., days, hours, lbs., tons) AND ESTIMATED VALUE: $13.00

LOSS TYPE (explosion, fire, wind)/IDENTIFY PROPERTY DAMAGED

OTHER

(NEAR MISS) NATURE OF INCIDENT/DOLLAR COST (if applicable)

DESCRIPTION

DESCRIBE EVENTS LEADING TO INCIDENT/WORK IN PROGRESS/STAGE OF PROCESS/ACTUAL ACTS OF INJURED AND FELLOW EMPLOYEES

12 year old boy sprayed left side of Grace pickup #183. Material was removed on 8/23/88 at Gene's Auto Body. Parents of boy payed the bill.

73-119(Rev. 6/82)

No 1755

GENE'S BODY SHOP
115 E. 2ND STREET
LIBBY, MT 59923
406-293-4544

Pickup # 187

PAGE ____ OF ____ PAGES

ESTIMATE

NAME: Dust W.R. GRACE		PHONE: Duayne Monroe	DATE: 8/23/88
STREET:		CITY: Libby	
YEAR: 1981	MAKE: GMC	MODEL: Pickup 2wd.	COLOR:
MOTOR NO.:	LICENSE NO.:		
ESTIMATED BY:	SERIAL NO.:	REGISTRATION NO.:	MILEAGE:
INSURANCE CO.:		ADJUSTOR:	

REPLACE	REPAIR	QTY.	PART NO. AND DESCRIPTION	PARTS	LABOR	REFINISH	SUBLET
			Remove stains from left side of truck		.4		
			materials	3.00			
			TOTALS	3.00	.4		

C0079255

PARTS PRICES ARE BASED ON STANDARD CATALOG PROCUREMENT PRICE LISTS AND ARE SUBJECT TO CHANGE WITHOUT NOTICE. PROCUREMENT AND DELIVERY CHARGES MAY BE ADDED FOR SPECIAL SERVICE ON ITEMS NOT AVAILABLE LOCALLY.

PARTS REMOVED FROM CARS WILL BE JUNKED UNLESS OTHERWISE REQUESTED IN WRITING.

THE ABOVE IS AN ESTIMATE BASED ON OUR INSPECTION AND DOES NOT COVER ADDITIONAL PARTS OR LABOR POSSIBLY REQUIRED AFTER THE WORK HAS STARTED. OCCASIONALLY WORN OR DAMAGED PARTS ARE DISCOVERED WHICH MAY NOT BE EVIDENT ON THE FIRST INSPECTION. THEREFORE, THE ABOVE PRICES ARE NOT GUARANTEED.

TOTAL PARTS	3.00
TOTAL LABOR	10.00
TOTAL REFINISH	
TAX	
TOTAL SUBLET	
TOTAL	$13.00

AUTHORIZATION FOR REPAIRS. I HEREBY AUTHORIZE YOU TO MAKE THE ABOVE LISTED REPAIRS.

SIGNATURE ____ DATE ____

© 1983 J. WILLIAM COMPANY, INC.

DUPLICATE

FORM NO. 1903 J. WILLIAM CO.
CALL: 1-800-241-0854, IN GA CALL: 1-800-532-0178

Medical, IRR Ex 33
Monroe, Dwone

Jacobs

DIVISION OF WORKERS' COMPENSATION

MONTANA DIVISION OF WORKERS' COMPENSATION

5 South Last Chance Gulch · Helena, Montana 59601

EMPLOYER'S FIRST REPORT OF NOTICE of Occupational Injury or Occupational Disease

DATE STAMP

SEND ORIGINAL TO INSURER
Jim Putman, Adjuster
Crawford Risk Management
P O Box 2397, Kalispell, MT 59903

CLAIM NO.

FIRM NO. 2503

DEPT. CODE

EMPLOYER COPY

INSTRUCTIONS: Every employer in Montana is required to complete this form within 6 days after notice of every industrial accident to an employee which causes loss of time from work or requires medical attention, regardless of whether the employer believes the injury to be compensable. The original of this form must be immediately filed with the employer's insurer or the Division of Workers' Compensation, 5 South Last Chance Gulch, Helena, Montana 59601. All questions must be answered fully. If a question cannot be answered please explain why. Please print with a ball point pen or type.

FEDERAL OSHA REQUIREMENTS. The United States Department of Labor requires employers to maintain, in the employer's office, a record of occupational injuries. For the employer's convenience, this form has been designed to meet such requirements and to provide employers a record copy.

EMPLOYER'S REPORT OF NOTICE

Employee

FULL NAME OF INJURED EMPLOYEE: Dwane D Monroe

SOCIAL SECURITY NUMBER: 516405416

EMPLOYEE'S HOME ADDRESS (Street or Box): 308 Parmenter

CITY: Libby

STATE: MT

ZIP CODE: 59923

OCCUPATION: Mill Shift Foreman

SEX: M

DATE OF BIRTH (Mo./Day/Yr.): 10/29/38

MARITAL STATUS: ☒ MARRIED ☐ SINGLE

LENGTH OF TIME WITH THIS EMPLOYER: since 6-1-67

IS THE EMPLOYEE CERTIFIED BY THE SUBSEQUENT INJURY FUND? ☐ YES ☐ NO

Wages

Employee's gross earnings for four (4) pay periods preceding the injury: **CONFIDENTIAL** (Date/Amount) (Date/Amount) (Date/Amount) (Date/Amount)

Employee's Gross Wage Rate is $ Per ☐ WEEK ☐ DAY ☐ HOUR ☐ MO.

Days Worked Per Week

Hours Worked Per Day

Payroll Classification under which employee's wages were reported.

Employee's Pay Period: ☐ Monthly ☐ Semi-monthly ☐ Bi-weekly ☐ Weekly ☐ Other (explain)

Check one: ☐ Full Time Employee ☐ Part Time Employee

Did employee return to work during next scheduled shift? ☐ Yes ☐ No

If no, will wage loss exceed 6 work days? ☐ Yes ☐ No ☐ Not Sure

REG. DAYS OFF

DATE WAGE LOSS BEGAN (Mo/Day/Yr) / /

DATE OF RETURN, if returned to work (Mo/Day/Yr) / /

Do the gross wages above include any of the following? Check those which apply.
☐ Board & Room ☐ Overtime ☐ Bonus ☐ Commissions ☐ Other (Explain)

Do you pay anything in addition to the above wages? Check those which apply.
☐ Board & Room ☐ Bonus ☐ Commissions ☐ Other (Explain)

Did the employee receive sick leave pay after the date of accident? ☐ Yes ☐ No

Accident Information

Describe in full detail how the accident happened, and give the cause. Explain what the employee was doing when injured. Be specific. Give full details on all factors which led or contributed to the accident. Use a separate sheet if you need additional space.

Employee claims hearing loss due to noise exposure over period of employment.

AT: 114 NOI: 130 SOI: 115 PBA: 270

DATE OF INJURY (month) (day) (year) (hour) (a.m. or p.m.)

What specific object or substance caused the injury? noise exposure

Nature of the injury? (cut, fracture, etc.) hearing loss

Part of body affected (leg, arm, back, head, etc.) right ear

Names of witnesses to accident:
1. 2.

Was place of accident on employer's premises? ☒ Yes ☐ No

Place where accident occurred (address & city): Mill area 12 miles NE of Libby, MT (county) Lincoln

Was employee injured while in your employ? ☒ Yes ☐ No

Were you notified, or did you have actual knowledge of the accident? ☒ Yes ☐ No

If yes, date notified & how: By employee 3-3-89 after hearing tests

Do you have any reason to question this accident? ☐ Yes ☒ No

If yes, please explain fully. Use a separate sheet if you need additional space.

Medical

Attending Physician's Name: Medical Arts Hearing Services

Address (Street or Box): 210 Sunnyview Lane, Suite 101, Kalispell

If Hospitalized, Hospital's Name: Melia C Biedscheid, CCC-A, Audiologist

Address (Street or Box) (City) (State) (Zip Code): MT 59901

Employer

Commercial Name (doing business as): W R Grace & Co-Conn

Employer's Name

Mailing address (Street or Box): P O Box 609

(City) (State) (Zip Code): Libby, MT 59923

Phone Number: 293-3746

Location of operation, if different from mailing address: Vermiculite Mountain 12 miles NE of Libby, MT

Nature of business: mine & mill vermiculite

Firm is a (check one): ☐ Sole proprietorship ☐ Partnership, or ☒ Corporation

Was the injured employee? (Check if applicable) ☐ A Sole Proprietor ☐ A working Partner ☐ A Corporate Officer, or ☐ A member of the employer's (sole proprietor or partner) family dwelling in the employer's household.

Prepared By:

Authorized Signature:

Official Title:

WR0299372

ED_005351_00000355-00451

Medical
Moles, Steven D.

C0079241

WRG00299373
ED_005351_00000355-00452

06063460

Return to:
Hugo Dobler Adjuster, I
Box 233 — Helena, Mt. 5

DIVISION OF WORKMEN'S COMPENSATION

DEPARTMENT OF LABOR AND INDUSTRY
815 Front Street
Helena, Montana 59601

CASE NO. .....

Firm No. 2503

EMPLOYER'S FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE

INSTRUCTIONS—Employer must complete form at once after every accident or occupational disease which causes loss of time from work or requires medical attention and mail to the Division of Workmen's Compensation, 815 Front Street, Helena, Montana. Form must be signed in pen and ink. ALL QUESTIONS MUST BE ANSWERED FULLY. This form contains all items requested on OSHA Form No. 101, "Supplementary Record of Occupational Injuries and Illnesses."

INJURED EMPLOYEE

Full name of injured employee Steven Moles Occupation Laborer
Home Address (Street) Route 3 Box 1570, Libby, Montana (City) How long has he been in your employ? 6 wks.
Social Security No. 517-58-2986 Sex M Age 24 Married [X] Single [ ]
Department where regularly employed Construction Labor Pool
Department where employed at time of injury Construction Labor Pool
Would employment be classified as: (Check appropriate description)
(1) Household employment [ ]
(2) Casual employment [ ]
(3) Employment of members of an employer's family dwelling in employer's household [ ]
(4) Employment of sole proprietors or working members of a partnership [ ]
(5) Employment for which a rule of liability for injury, occupational disease, or death is provided under the laws of the United States [X]
(6) Any person performing services in return for aid or sustenance only. (Board & Room) [ ]
Scheduled days off .....

EMPLOYEE'S EARNINGS

Monthly wage ....., or Weekly wage ....., or Daily wage ....., or Hourly wage 3.86
Received board? Yes [ ] No [X] Received room? Yes [ ] No [X] Days worked per week 5
Hours worked per day 8 Employee's pay period: Monthly [ ] Semi-monthly [X] Weekly [ ]
Bi-weekly [ ] List employee's gross earnings and date for last 4 pay periods:
(1) ..... (Date/Amount) (2) ..... (Date/Amount) (3) ..... (Date/Amount) (4) ..... (Date/Amount)
List payroll classification under which employee's wages were reported .....

ACCIDENT AND INJURY

Describe in full how accident happened and GIVE CAUSE—Tell what employee was doing when injured:
While working with crew installing new cell in wet mill, pulled muscle in back.

Nature or extent of injury or illness strained muscle (Cut-Fracture) Part of body affected back (Leg-Arm-Back-Head)
Did employee die? Yes [ ] No [XX]
Name or witnesses to accident 1 ..... 2 .....
Date of injury or initial diagnosis of occupational illness. Mo. 10 Day 16 Yr 73 Hour ..... A.M. ..... P.M.
Was employee injured in course of employment? Yes [X] No [ ]
Place where accident occurred our mill, 12 miles north of Libby (Address) Lincoln (County)
Was place of accident or exposure on employer's premises? Yes [X] No [ ]
Have you reason to question this accident? Yes [ ] No [X] If "yes" explain fully .....

NOTICE

Were you notified of the accident? Yes [X] No [ ] How by employee

SAFETY

1. Was the accident caused by an unsafe act on the part of the injured? Yes [ ] No [X]
2. Was the accident caused by an unsafe condition? Yes [ ] No [X]
3. What specific device, object, or substance caused the injury? none

MEDICAL ATTENTION

Name of attending physician Philip W. Wallestad, M.D.
Address 703 Louisiana Avenue, Libby, Montana 59923
Was employee hospitalized? Yes [ ] No [X] Name of hospital .....
Address .....

TIME AND WAGE LOSS

1. Will the employee return to work before or during his next scheduled shift? Yes [X] No [ ]
2. Will employee lose wages? Yes [ ] No [X] Will wage loss exceed 7 days? Yes [ ] No [X]
3. Date wage loss began ~~10-16-73 (1 day)~~ Amount of weekly wage loss .....

EMPLOYER

Name of employer Construction Products Division-W.R.Grace & Co. Phone 293-4131
Firm name .....
Address Box 609, Libby, Montana Nature of business Mining & Milling Vermicul
Location, if different from mail address .....
Check one: Individual [ ] Partnership [ ] Corporation [X]

Signed, this 2nd day of November, 19 73
at Libby, Montana

Prepared by Joan B. Runyan
Signed by .....
Official title Adm. Asst.

NOTICE—EMPLOYEE'S CLAIM FOR COMPENSATION, FORM 54, SHOULD BE FILED WITHIN 12 MONTHS FROM DATE OF ACCIDENT

FORM 37-2 REVISED

C0079242
WRG00299374
ED_005351_00000355-00453

Medical
Moles, Steven D.

C0079241

WRG00299379

ED_005351_00000355-00454

DIVISION OF WORKMEN'S COMPENSATION

DEPARTMENT OF LABOR AND INDUSTRY
815 Front Street
Helena, Montana 59601

Return to: Hugo Dobler Adjuster, Inc. Box 233 — Helena, Mt. 59601

CASE NO. .....

Firm No. .....2503.....

EMPLOYER'S FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE

INSTRUCTIONS—Employer must complete form at once after every accident or occupational disease which causes loss of time from work or requires medical attention and mail to the Division of Workmen's Compensation, 815 Front Street, Helena, Montana. Form must be signed in pen and ink. *ALL QUESTIONS MUST BE ANSWERED FULLY.* This form contains all items requested on OSHA Form No. 101, "Supplementary Record of Occupational Injuries and Illnesses."

INJURED EMPLOYEE

Full name of injured employee Steven D. Moles Occupation Construction Worker
Home Address 416 Main Avenue, Libby, Mt. (Street, City) How long has he been in your employ? 1 mo.
Social Security No. 517-58-2986 Sex M Age 26 Married [X] Single [ ]
Department where regularly employed Construction
Department where employed at time of injury Construction
Would employment be classified as: (Check appropriate description)
(1) Household employment [ ]
(2) Casual employment [ ]
(3) Employment of members of an employer's family dwelling in employer's household [ ]
(4) *Employment of sole proprietors or working members of a partnership* [ ]
(5) Employment for which a rule of liability for injury, occupational disease, or death is provided under the laws of the United States [X]
(6) *Any person performing services in return for aid or sustenance only. (Board & Room)* [ ]
Scheduled days off .....

EMPLOYEE'S EARNINGS

Monthly wage ....., or Weekly wage ....., or Daily wage ....., or Hourly wage 5.005
Received board? Yes [ ] No [X] Received room? Yes [ ] No [X] Days worked per week 5
Hours worked per day 8 Employee's pay period: Monthly [ ] Semi-monthly [X] Weekly [ ]
Bi-weekly [ ] List employee's gross earnings and date for last 4 pay periods:
(1) ..... Date/Amount (2) ..... Date/Amount (3) ..... Date/Amount (4) ..... Date/Amount
List payroll classification under which employee's wages were reported .....

ACCIDENT AND INJURY

Describe in full how accident happened and GIVE CAUSE—Tell what employee was doing when injured:
While walking across the driveway at the garage while working as mechanic helper, stepped on rock, twisted left ankle.

Nature or extent of injury or illness sprained ankle (Cut-Fracture) Part of body affected left ankle (Leg-Arm-Back-Head)
Did employee die? Yes [ ] No [X]
Name or witnesses to accident 1 Steven Munyan 2 .....
Date of injury or initial diagnosis of occupational illness. Mo. 9 Day 11 Yr 75 Hour 10:30 A.M. P.M.
Was employee injured in course of employment? Yes [ ] No [X]
Place where accident occurred our shop area, 12 miles north of Libby (Address, City) Lincoln (County)
Was place of accident or exposure on employer's premises? Yes [X] No [ ]
Have you reason to question this accident? Yes [ ] No [X] *If "yes" explain fully* .....

NOTICE

Were you notified of the accident? Yes [X] No [ ] How by employee

SAFETY

1. Was the accident caused by an unsafe act on the part of the injured? Yes [ ] No [X]
2. Was the accident caused by an unsafe condition? Yes [ ] No [X]
3. What specific device, object, or substance caused the injury? rock in driveway

MEDICAL ATTENTION

Name of attending physician James F. Graham, M.D.
Address 402 Louisiana Avenue, Libby, Montana 59923
Was employee hospitalized? Yes [ ] No [X] Name of hospital .....
Address .....

TIME AND WAGE LOSS

1. Will the employee return to work before or during his next scheduled shift? Yes [ ] No [X]
2. Will employee lose wages? Yes [X] No [ ] Will wage loss exceed 7 days? Yes [ ] No [X]
3. Date wage loss began lost 9-15-75 only Amount of weekly wage loss .....

EMPLOYER

Name of employer Construction Products Division-W.R.Grace & Co. Phone 293-4131
Firm name .....
Address Box 609, Libby, Montana Nature of business Mining & Milling Vermiculite
Location, if different from mail address .....
Check one: Individual [ ] Partnership [ ] Corporation [X]

Signed, this 19th day of September, 19 75
at Libby, Montana

Prepared by Joan B. Runyan
Signed by .....
Official title Administrative Assistant

NOTICE—EMPLOYEE'S CLAIM FOR COMPENSATION, FORM 54, SHOULD BE FILED WITHIN 12 MONTHS FROM DATE OF ACCIDENT

FORM 37-2 REVISED

C0079243

Medical
Moreau, Wally

C0079260

06062590

Industrial Accident Board, Helena, Montana, Form 37 Revised—YM - U - WU

STATE PUBLISHING CO., HELENA, MONT.

Industrial Accident Board

HELENA, MONTANA

Firm No.....

File No.....

EMPLOYER'S FIRST REPORT OF INJURY

INSTRUCTIONS—Employer must complete form at once after every accident which causes loss of time from work or requires medical attention and mail it to the Industrial Accident Board, Helena, Montana. Form must be signed in pen and ink. ALL QUESTIONS MUST BE ANSWERED FULLY.

INJURED EMPLOYEE

Full name of injured employee E. Wallace Moreau Occupation Mine Research

Mailing address 114 West Oak (Street) Libby (City) How long has he been in your employ 3½ months

Social Security No. 011-30-2710 Sex M Age 24 Married ☒ Single ☐

EARNINGS

Monthly Wage..... Weekly Wage..... Daily Wage..... Hourly Wage 2.47

Receive board Yes ☐ No ☒ Daily Value..... Receive room Yes ☐ No ☒ Daily Value.....

Piece Worker Yes ☐ No ☐ If yes, price per unit at piece work..... Hours worked per day 8

Days worked per week 5 Employee's pay period? Monthly ☐ Semi-monthly ☒ Weekly ☐ List employee's earnings last 4 pay periods 1 293.70 2 282.24 3 279.64 4 211.18

List Payroll Classification and Code under which employee's wages were reported..... (Sawmill - Mechanic - Etc.) Code..... (2702, 5506, 8810)

ACCIDENT AND INJURY

Describe in full how accident happened and GIVE CAUSE while collecting test samples in lab (expanded samples—very light & abrasive material) received particle of vermiculite in right eye.

Nature or extent of injury foreign material in eye (Cut - Fracture) Part of body injured? right eye (Leg - Arm - Back - Head)

Names of witnesses to accident 1..... 2.....

Date of accident 11-25-63 19..... Hour 7 ~~A.M.~~ P. M. Was employee injured in course of employment? Yes ☒ No ☐

Place where accident occurred our laboratory, 9 miles north of Libby, (Address) Lincoln (City) (County)

Did you or employee's supervisor have actual knowledge of accident? Yes ☒ No ☐

Were you notified of accident by injured employee? Yes ☒ No ☐ How by employee Date 11-26-63

Have you reason to question this accident? Yes ☐ No ☒ If "yes" explain fully.....

SAFETY

Was employee's accident due to unsafe work practice? Yes ☐ No ☐ If "yes", what did he do unsafely?.....

Was a specific device, object or substance involved in accident? Yes ☐ No ☐ If "yes," name specific device, object or substance..... Was device or object defective? Yes ☐ No ☐

Was employee doing regular work when injured? Yes ☒ No ☐ Was employee trained to do work he was doing when injured? Yes ☒ No ☐ Were adequate safeguards provided? Yes ☐ No ☐ If "yes," were they being used at the time of accident? Yes ☐ No ☐

MEDICAL ATTENTION

Name of attending physician Dr. J. M. Cairns Address Libby, Montana

Was employee hospitalized? Yes ☐ No ☒ Name of hospital St. Johns Lutheran for emergency care only

Was first aid administered by someone other than attending physician? Yes ☐ No ☒

TIME AND WAGE LOSS

Will employee lose time from work due to accident? Yes ☐ No ☒ How long?..... If injury results in time loss will employee, while disabled, receive sick leave benefits? Yes ☐ No ☐ Paid vacation? Yes ☐ No ☐ Will employee lose wages? Yes ☐ No ☐ Room? Yes ☐ No ☐ Board? Yes ☐ No ☐

Date wage loss began..... Amount of weekly wage loss.....

EMPLOYER

Name of employer Zonolite Division - W. R. Grace & Co., Libby, Montana

Address..... Nature of business Mining & Milling Vermiculite

IS FIRM A CORPORATION ☒ OR PARTNERSHIP ☐ OR INDIVIDUAL ☐

IF
- Corporation—is injured employee an officer or director of corporation? Yes ☐ No ☒
- Partnership—is injured employee related to any partner? Yes ☐ No ☐ Relationship.....
- Individual—is injured employee related to employer? Yes ☐ No ☐ Relationship.....

Signed, this 27th day of November, 19 63

at Libby, Montana

Employer's Name Zonolite Division-W.R.Grace & Co.

Signed by.....

Official Title Secretary

NOTICE—EMPLOYEE'S CLAIM FOR COMPENSATION, FORM 54, MUST BE FILED WITHIN 12 MONTHS FROM DATE OF ACCIDENT.

C0079261

Medical
Moreau, Wally

C0079260

GRACE

Zonolite
Construction Products Division

TO: Wally Moreau DATE: January 27, 1989

FROM: Mary Jo Zwang

cc: Terry Jacobs, Alan Stringer, J B Henderson (Lexington)

Previously you were told that your hearing shows a standard threshold shift. In order to verify this shift Dr. Oehrtman was going to conduct an on-site exam. This will not be possible since neither W. R. Grace nor St. John's Lutheran Hospital have the appropriate equipment. Therefore, please set up an appointment before June 1, 1989 with Dr. Karl Oehrtman's audiologist in Kalispell (752-4141). Please notify me of your appointment date so that I can ensure Dr. Oehrtman's office receives a copy of your hearing file.

Please note that only the doctor's fee will be covered by W. R. Grace. If you choose to have no further testing the attached waiver form must be completed and returned to me.

As always, we strongly recommend that you wear hearing protection when around loud noise either at work or at home to protect your ears from damage.

Mary Jo Zwang

C0079266

WRG00299380

ED_005351_00000355-00459

GRACE

Zonolite
Construction Products Division

TO: Wally Moreau DATE: November 4, 1988

FROM: Mary Jo Zwang

cc: Terry Jacobs, Alan Stringer, Robert Marion (Lexington)

Based on your two audiograms of 7-26-88 and 11-2-88, your hearing shows a standard threshold shift. In order to verify this shift and determine its cause, we will have Dr. Oehrtman conduct on-site exams periodically. You will be notified of your appointment date and time.

This referral visit will be paid by W. R. Grace. If you choose to have no further testing, please complete and return the attached waiver form.

As always, we strongly recommend that you wear hearing protection when around loud noise either at work or at home to protect your ears from damage.

Mary Jo Zwang
Mary Jo Zwang

Attachment

W. R. GRACE
Terry J. Jacobs
SAFETY DIRECTOR

Date 11-8-88

C0079267

MEDICAL
Morin, Richard

C0079268

06063628

DIVISION OF WORKMEN'S COMPENSATION

DEPARTMENT OF LABOR AND INDUSTRY
815 Front Street
Helena, Montana 59601

Return to: Hugo Dobler Adjuster, Inc. Box 233 – Helena

CASE NO. .....

Firm No. 2503

EMPLOYER'S FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE

INSTRUCTIONS—Employer must complete form at once after every accident or occupational disease which causes loss of time from work or requires medical attention and mail to the Division of Workmen's Compensation, 815 Front Street, Helena, Montana. Form must be signed in pen and ink. ALL QUESTIONS MUST BE ANSWERED FULLY. This form contains all items requested on OSHA Form No. 101, "Supplementary Record of Occupational Injuries and Illnesses."

INJURED EMPLOYEE

Full name of injured employee Richard Morin Occupation Construction Worker
Home Address Route 2 Box 720, Libby (Street, City) How long has he been in your employ? 3 weeks
Social Security No. 517-70-8914 Sex M Age 38 Married ☒ Single ☐
Department where regularly employed Construction Crew
Department where employed at time of injury Construction Crew
Would employment be classified as: (Check appropriate description)
(1) Household employment ☐
(2) Casual employment ☐
(3) Employment of members of an employer's family dwelling in employer's household ☐
(4) Employment of sole proprietors or working members of a partnership ☐
(5) Employment for which a rule of liability for injury, occupational disease, or death is provided under the laws of the United States ☒
(6) Any person performing services in return for aid or sustenance only. (Board & Room) ☐
Scheduled days off .....

EMPLOYEE'S EARNINGS

Monthly wage ....., or Weekly wage ....., or Daily wage ....., or Hourly wage 3.86
Received board? Yes ☐ No ☒ Received room? Yes ☐ No ☒ Days worked per week 5
Hours worked per day 8, Employee's pay period: Monthly ☐ Semi-monthly ☒ Weekly ☐
Bi-weekly ☐ List employee's gross earnings and date for last 4 pay periods:
(1) ..... (Date/Amount) (2) ..... (Date/Amount) (3) ..... (Date/Amount) (4) ..... (Date/Amount)
List payroll classification under which employee's wages were reported .....

ACCIDENT AND INJURY

Describe in full how accident happened and GIVE CAUSE—Tell what employee was doing when injured: Helping one of the millwrights when he caught the middle finger of left hand on a piece of steel, sliced down side of finger nail and into flesh of finger. This later became infected.
Nature or extent of injury or illness ☒ Infection (Cut-Fracture) Part of body affected finger (Leg-Arm-Back-Head)
Did employee die? Yes ☐ No ☒
Name or witnesses to accident 1 ..... 2 .....
Date of injury or initial diagnosis of occupational illness, Mo. 3 Day 10 Yr 74 Hour ..... A.M. P.M.
Was employee injured in course of employment? Yes ☒ No ☐
Place where accident occurred our mill area, 12 miles north of Libby (Address, City) Lincoln (County)
Was place of accident or exposure on employer's premises? Yes ☒ No ☐
Have you reason to question this accident? Yes ☐ No ☒ If "yes" explain fully .....

NOTICE

Were you notified of the accident? Yes ☒ No ☐ How by employee

SAFETY

1. Was the accident caused by an unsafe act on the part of the injured? Yes ☐ No ☒
2. Was the accident caused by an unsafe condition? Yes ☐ No ☒
3. What specific device, object, or substance caused the injury? piece of steel

MEDICAL ATTENTION

Name of attending physician Paul J. Seifert, Jr. M.D.
Address 402 Montana Avenue, Libby, Montana 59923
Was employee hospitalized? Yes ☐ No ☒ Name of hospital .....
Address .....

TIME AND WAGE LOSS

1. Will the employee return to work before or during his next scheduled shift? Yes ☒ No ☐
2. Will employee lose wages? Yes ☒ No ☐ Will wage loss exceed 7 days? Yes ☐ No ☒
3. Date wage loss began 3-19-74 (lost 1 day). Amount of weekly wage loss .....

EMPLOYER

Name of employer Construction Products Division-W.R.Grace & Co. Phone 293-4131
Firm name .....
Address Box 609, Libby, Montaa 59923 Nature of business Mining & Milling Vermicull
Location, if different from mail address .....
Check one: Individual ☐ Partnership ☐ Corporation ☒

Signed, this 21st day of March, 1974
at Libby, Montana

Prepared by Joan B. Runyan
Signed by .....
Official title Payroll Clerk

NOTICE—EMPLOYEE'S CLAIM FOR COMPENSATION, FORM 34, SHOULD BE FILED WITHIN 12 MONTHS FROM DATE OF ACCIDENT

C0079269

WRG00299383

ED_005351_00000355-00462

MEDICAL
Morton, Stanley

MEDICAL
Morton, Stanley

C0079271

Industrial Accident Board, Helena, Montana, Form 37 Revised

06063095

Industrial Accident Board

HELENA, MONTANA

DO NOT WRITE IN THIS SPACE

Firm No.

File No.

EMPLOYER'S FIRST REPORT OF INJURY

INSTRUCTIONS—Employer must complete form at once after every accident which causes loss of time from work or requires medical attention and mail it to the Industrial Accident Board, Helena, Montana. Form must be signed in pen and ink. ALL QUESTIONS MUST BE ANSWERED FULLY.

INJURED EMPLOYEE

Full name of injured employee: Stanley Morton Occupation: Euclid Driver

Mailing address: 101 Mineral Ave. Libby How long has he been in your employ: 7 months

Social Security No. 519-10-4651 Sex: M Age: 48 Married [X] Single [ ]

EARNINGS

Monthly Wage ..... Weekly Wage ..... Daily Wage ..... Hourly Wage 2.96

Receive board Yes [ ] No [X] Daily Value ..... Receive room Yes [ ] No [X] Daily Value .....

Piece Worker Yes [ ] No [X] If yes, give method of computing earnings .....

Number of hours worked per day 8 Days worked per week 5 Employee's pay period?

Monthly [ ] Semi monthly [X] Weekly [ ] List employee's earnings last 4 pay periods 1. 224.96

2. 221.89 3. 310.44 4. 338.24

Under what payroll classification has employees' wages been reported? .....
(Sawmill - Mechanic - Etc.)

ACCIDENT AND INJURY

Describe in full how accident happened and GIVE CAUSE: While backing under shovel, [redacted] front wheels struck a rock, spinning steering wheel out of driver's hands, he lost balance and struck back on side of cab.

Part of body injured? Describe fully: lower left ribs & back, dislocated vertebra

Names of witnesses to accident 1. ..... 2. .....

Date of accident 1-10 19 68 Hour 3 A.M. P.M. Was employee injured in course of employment? Yes [X] No [ ]

Place where accident occured: our pit, 9 miles north of Libby (Address) Lincoln (County)

Did you or employee's supervisor have actual knowledge of accident? Yes [X] No [ ]

Were you notified of accident by injured employee? Yes [X] No [ ] How: by employee Date: 1-16

Have you reason to question this accident? Yes [ ] No [X] If "yes" explain fully .....

SAFETY

Was employee's accident due to unsafe work practices? Yes [ ] No [X] If "yes", what did he do unsafely? .....

Was a specific device, object or substance involved in accident? Yes [X] No [ ] If "yes", name specific device, object or substance: rock under wheel Was device or object defective? Yes [ ] No [X]

Was employee doing regular work when injured? Yes [X] No [ ] Was employee trained to do work he was doing when injured? Yes [X] No [ ] Were adequate safe guards provided? Yes [ ] No [ ] If "yes" were they being used at time of accident? Yes [ ] No [ ]

MEDICAL ATTENDANCE

Name of attending physician: Dr. Sam Border Address: Libby, Montana

Was employe hospitalized? Yes [ ] No [X] Name of hospital ..... Address .....

Was first aid administered by someone other than attending physician? Yes [ ] No [X]

TIME AND WAGE LOSS

Will employe lose time from work due to accident? Yes [ ] No [X] How long? NONE

If injury results in time loss, will employee, while disabled, receive sick leave benefits? Yes [ ] No [ ]

Paid vacation? Yes [ ] No [ ]

Will employe lose wages? Yes [ ] No [ ] Room? Yes [ ] No [ ] Board? Yes [ ] No [ ]

Date wage loss began: NONE Amount of weekly wage loss: NONE

EMPLOYER

Name of employer: Zonolite Division-W.R.Grace & Co.

Address: Libby, Montana Nature of business: Mining & Milling Vermiculite

IS FIRM A CORPORATION [X] OR PARTNERSHIP [ ] OR INDIVIDUAL [ ]

IF
- Corporation—is injured employee an officer or director of corporation? Yes [ ] No [X]
- Partnership—is injured employee related to any partner? Yes [ ] No [ ] Relationship .....
- Individual—is injured employee related to employer? Yes [ ] No [ ] Relationship .....

Signed, this 17th day of January, 19 68

Employer's Name: Zonolite Division-W.R.Grace & Co.

Signed by .....

at Libby Montana

Official Title .....

NOTICE—EMPLOYEE'S CLAIM FOR COMPENSATION, FORM 54, MUST BE FILED WITHIN 12 MONTHS FROM DATE OF ACCIDENT

Form 1-HU-163-ZR

Carrier

Firm No.

File No.

Major Industry

County

Date of Acc.

Time

Sex & Marital Status

Age

Mont. Code

Acc. Class

Occupation

Type

Agency

Agency Part

Nature of Inj.

Location

Time Loss

Mech. Defect

Unsafe Act

Pers. Factor

Weekly Wage

60078272
WRG00299385
ED_005351_00000355-00464

MEDICAL
Moss, Kenneth

C0079273

DIVISION OF WORKMEN'S COMPENSATION

DEPARTMENT OF LABOR AND INDUSTRY
815 Front Street
Helena, Montana 59601

Return to: Hugo Dobler Adjuster, Inc. Box 233 – Helena, Mt. 59601

06063562

CASE NO. .....

Firm No. .....2503.....

EMPLOYER'S FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE

INSTRUCTIONS—Employer must complete form at once after every accident or occupational disease which causes loss of time from work or requires medical attention and mail to the Division of Workmen's Compensation, 815 Front Street, Helena, Montana. Form must be signed in pen and ink. ALL QUESTIONS MUST BE ANSWERED FULLY. This form contains all items requested on OSHA Form No. 101, "Supplementary Record of Occupational Injuries and Illnesses."

INJURED EMPLOYEE

Full name of injured employee .....Kenneth Moss..... Occupation .....Construction Worker
Home Address .....1317 Montana Ave. Libby..... How long has he been in your employ? ~~517-62-4996~~
Street City
Social Security No. .....~~XXX~~ 517-62-4996..... Sex ..... Age ..... Married ☐ Single ☐
Department where regularly employed .....
Department where employed at time of injury .....
Would employment be classified as: (Check appropriate description)
(1) Household employment ☐
(2) Casual employment ☐
(3) Employment of members of an employer's family dwelling in employer's household ☐
(4) Employment of sole proprietors or working members of a partnership ☐
(5) Employment for which a rule of liability for injury, occupational disease, or death is provided under the laws of the United States ☒
(6) Any person performing services in return for aid or sustenance only. (Board & Room) ☐
Scheduled days off .....

EMPLOYEE'S EARNINGS

Monthly wage ....., or Weekly wage ....., or Daily wage ....., or Hourly wage 4.105
Received board? Yes ☐ No ☒ Received room? Yes ☐ No ☒ Days worked per week ....5.....
Hours worked per day ....8..... Employee's pay period: Monthly ☐ Semi-monthly ☒ Weekly ☐
Bi-weekly ☐ List employee's gross earnings and date for last 4 pay periods:
(1) ..... (2) ..... (3) ..... (4) .....
Date/Amount Date/Amount Date/Amount Date/Amount
List payroll classification under which employee's wages were reported .....

ACCIDENT AND INJURY

Describe in full how accident happened and GIVE CAUSE—Tell what employee was doing when injured:
While working on the thickeners, struck left knee cap on piece of angle iron.

Nature or extent of injury or illness .....severe bruises..... Part of body affected .....knee bone.....
(Cut-Fracture) (Leg-Arm-Back-Head)
Did employee die? Yes ☐ No ☒
Name or witnesses to accident 1 .....Tim Grotjohn..... 2 .....
Date of injury or initial diagnosis of occupational illness. Mo. 9 ....~~8~~ Day 24 ..... Yr 74 ..... Hour 9 ....A.M.
Was employee injured in course of employment? Yes ☒ No ☐ .....~~XXX~~M.
Place where accident occurred .....our mill area, 12 miles north of Libby..... Lincoln.....
Address City County
Was place of accident or exposure on employer's premises? Yes ☒ No ☐
Have you reason to question this accident? Yes ☐ No ☒ If "yes" explain fully .....

NOTICE

Were you notified of the accident? Yes ☒ No ☐ How .....by employee.....

SAFETY

1. Was the accident caused by an unsafe act on the part of the injured? Yes ☐ No ☒
2. Was the accident caused by an unsafe condition? Yes ☐ No ☒
3. What specific device, object, or substance caused the injury? piece of angle iron.....

MEDICAL ATTENTION

Name of attending physician R. D. MacKenzie, M.D.
Address ....711 California Avenue, Libby, Montana 59923.....
Was employee hospitalized? Yes ☐ No ☒ Name of hospital St. Johns Lutheran (for X-rays)
Address .....~~XXXXXXXXXX~~..... 350 Louisiana Avenue, Libby, Montana 59923.....

TIME AND WAGE LOSS

1. Will the employee return to work before or during his next scheduled shift? Yes ☒ No ☐
2. Will employee lose wages? Yes ☐ No ☒ Will wage loss exceed 7 days? Yes ☐ No ☐
3. Date wage loss began .....none..... Amount of weekly wage loss .....

EMPLOYER

Name of employer Construction Products Division-W.R.Grace & Co. Phone .....293-4131.....
Firm name .....same.....
Address Box 609, Libby, Montana 59923..... Nature of business Mining & Milling Vermiculite
Location, if different from mail address .....
Check one: Individual ☐ Partnership ☐ Corporation ☒

Signed, this ....1st.... day of ....October....., 19 74.....
at .....Libby....., Montana

Prepared by .....Joan B. Runyan.....
Signed by .....
Official title .....Adm. Asst.....

NOTICE—EMPLOYEE'S CLAIM FOR COMPENSATION, FORM 54, SHOULD BE FILED WITHIN 12 MONTHS FROM DATE OF ACCIDENT

FORM 37-2 REVISED

C0079274
WRG00299387
ED_005351_00000355-00466

MEDICAL
Moss, Kenneth

C0079273

06063507

WORKMEN'S COMPENSATION DIVISION

Department of Labor and Industry
815 Front Street
Helena, Montana 59601

CASE No. _____

Firm No. 2503

EMPLOYER'S FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE

INSTRUCTIONS—Employer must complete form at once after every accident or occupational disease which causes loss of time from work or requires medical attention and mail to Workmen's Compensation Division, Helena, Montana. Form must be signed in pen and ink. ALL QUESTIONS MUST BE ANSWERED FULLY. This form contains all items requested on OSHA Form No. 101, "Supplementary Record of Occupational Injuries and Illnesses."

INJURED EMPLOYEE

Full name of injured employee: Kenneth Moss Occupation: Const. Worker
Home address: 1317 Montana, Libby (Street, City) How long has he been in your employ? 1 day
Social Security No. 517-62-4996 Sex: M Age: 18 Married ☐ Single ☒
Department: Construction (Enter name of department or division in which the injured person is regularly employed, even though he may have been temporarily working in another department at the time of injury.)

EARNINGS

Monthly Wage _____, or Weekly Wage _____, or Daily Wage _____, or Hourly Wage 3.605
Receive board? Yes ☐ No ☒ Receive Room? Yes ☐ No ☒ Days worked per week 5 Employee's pay period? Monthly ☐, Semi-monthly ☒, Weekly ☐. List employee's earnings and date of last 4 pay periods
1 _____ (Date/Amount) 2 _____ (Date/Amount) 3 _____ (Date/Amount) 4 _____ (Date/Amount)
List Payroll Classification and Code under which employee's wages were reported _____ Code _____

ACCIDENT AND INJURY

Describe in full how accident happened and GIVE CAUSE—Tell what employee was doing when injured:
Was loading sample barrels and old screens onto the crane, one fell striking right leg below knee.

Nature or extent of injury or illness: Bruises, abrasions (Cut-Fracture) Part of body affected: right lower le- (Leg-Arm-Back-Head)
Did employee die? Yes ☐ No ☒
Name of witnesses to accident 1 _____ 2 _____
Date of injury or initial diagnosis of occupational illness: 6-1-72 Hour _____ A.M _____ P.M
Was employee injured in course of employment? Yes ☒ No ☐
Place where accident occurred: our mill area, 12 miles north of Libby (Address, City) Lincoln (County)
Was place of accident or exposure on employer's premises? Yes ☒ No ☐
Were you notified of accident? Yes ☒ No ☐ How: by employee Date: 6-1-72
Have you reason to question this accident? Yes ☐ No ☒ If "yes," explain fully _____

SAFETY

1. Was the accident caused by an unsafe act? Yes ☐ No ☒
2. Was the accident caused by an unsafe condition? Yes ☐ No ☒
3. What specific device, object or substance caused the injury? _____

MEDICAL ATTENTION

Name of attending physician: Paul J. Seifert, Jr., M.D.
Address: 402 Montana Avenue, Libby, Montana
Was employee hospitalized? Yes ☐ No ☒ Name of hospital: St. Johns Lutheran (X-rays only)
Address: 350 Louisiana Avenue, Libby, Montana

TIME AND WAGE LOSS

1. Will the employee return to work before or during his next scheduled shift? Yes ☒ No ☐
2. Will employee lose wages? Yes ☐ No ☒
3. Date wage loss began: NONE Amount of weekly wage loss _____

EMPLOYER

Name of employer: Construction Products Division - W. R. Grace & Co.
D.B.A. _____
Address: Box 609, Libby, Montana Nature of business: Mining & Milling Vermicul
Location, if different from mail address _____

Signed, this 4th day of June, 19 73 at Libby, Montana

Prepared by: Joan B. Runyan
Signed by _____
Official Title: Adm. Asst.

NOTICE—EMPLOYEE'S CLAIM FOR COMPENSATION, FORM 54, MUST BE FILED WITHIN 12 MONTHS FROM DATE OF ACCIDENT

FORM 57

C0079275
WRG00299389
ED_005351_00000355-00468

MEDICAL
Munro, Henery J.

C0079276

WRG00299390

ED_005351_00000355-00469

From: Jardine, Stephenson, Blewett & Weaver
First National Bank Building
Great Falls, Montana

To:

Date: November 16, 1962

Re: Zonolite Company
Henry J. Munro
D/A: 9-28-62

Zonolite Company
Libby,
Montana

Although your supplemental report form shows this man did not return to work until October 8, 1962, Dr. Seifert released this man as being able to work on October 1, 1962. We are, therefore, not accepting this case as being compensable. We are paying the doctor bill and retiring our file.

rp

INDUSTRIAL ACCIDENT BOARD, HELENA, MONT. FORM NO. 43—1M 1-57 81907 TRIBUNE PRINTING & SUPPLY CO., GREAT FALLS, MONTANA

Plan No.....

Industrial Accident Board

HELENA, MONTANA

Claim Department

Firm No.....

Claim No.....

Accident No.....

Employee No.....

DO NOT FILL IN

Employer's Supplemental Report Of Injury

This notice to be filled out by employer and sent to the Industrial Accident Board, at Helena, Montana, immediately upon employee's returning to work fully recovered if within two weeks—or upon his death or at the expiration of two weeks from date of injury.

Name of injured employee Henry J. Munro

Address Box 543, Libby, Montana

Injured September 28, 19 62

If worked after accident, last date worked?.....

Is injured employee fully recovered? yes On what date? October 8, 1962

Has he/she returned to work for you? yes On what date? October 8, 1962

Has he/she accepted other employment? ..... On what date? .....

If so, where now employed? .....

Has he/she died? ..... If so, when? .....

Signed: ZONOLITE COMPANY

Address Libby, Montana

Dated October 24, 19 62

STRIAL ACCIDENT BOARD, HELENA, MONTANA. FORM 37 REVISED—2M 3-61 32482

Industrial Accident Board

HELENA, MONTANA

Claim Department

m No. _____

im No. _____

ident No. _____

DO NOT FILL IN

EMPLOYER'S FIRST REPORT OF INJURY

DO NOT WRITE IN THIS SPACE

INSTRUCTIONS—The employer must fill out this form and return same to Industrial Accident Board, Helena, ntana, at once after every accident which causes any loss of work or requires medical attention. In filling out s form use pen or typewriter.

MPLOYER, LACE AND TIME

Employer's name: Zonolite Company

Office address: Libby, Montana (Street and number, city or town)

Nature of business: Mining & Milling Vermiculite (Type of construction, manufacturing, etc.)

Did accident occur on work for a public corporation? No

Location of plant or place of work where accident occurred: Same (Street and Number)

In what city or village? Libby County? Lincoln

Date of accident: September 28, 19 62; hour of day: 2:00 A.M.

Did accident happen on premises? Yes

If away from the plant, state where?

Was employee injured in the course of employment? Yes

THE INJURED MPLOYEE

Give full name of injured workman: Henry J. Munro

Mailing address: Box 543, Libby, Montana, Lincoln County (Street and number, city or town and county)

Sex: M Age: 39 Speak English? Yes If not, what language?

Occupation when injured? Construction worker Married or single? Married (See Form 87-a)

Was injured employee on duty at time of accident? Yes If not, state fully on back hereof

How long was injured person in your employment? 2 years

CAUSE OF INJURY

Described in full how the accident occurred (DO NOT FAIL TO DO THIS): left While lifting a large rock out of the hopper at the tails mill, foot slipped, sprained left side of back.

THE INJURY

State nature and extent of injury according to your own information. (We do not need the doctor's report here): Sprained back

WILL EMPLOYEE LOSE TIME? YES XX NO _____ 2 days.

DATE WAGE LOSS BEGAN? 10-1-62 PROBABLE DURATION OF WAGE LOSS? ~~1 week~~ (Give your best estimate)

MEDICAL TENDANCE

Name and address of physician attending injured employee: Dr. Paul J. Seifert 402 Montana Avenue, Libby, Montana

To what hospital was employee sent? none

If not sent to hospital, where is he? home

Are you still providing medical attendance? yes Have you a hospital contract? no

WAGES

Monthly wage _____ (If paid by month) Weekly wage _____ (If paid by week) Daily wage _____ (If paid by day) Rate per hour 2.465 (If paid by hour)

Number of hours per day: 8 How many working days per week: 5

If employee receives board in addition to money wage, state how many meals per day: none

Does he receive room in addition to money wage? no

AGE LOSS

How much money wage will employee lose per day because of accident? 19.72

How much board? none Will he lose room? no

OTICE OF INJURY

Were you notified by the injured employee of his injury? yes If so, how and when? by employee (Write on back of this form if necessary)

Did you or your managing superintendent in charge of work of injured employee at time of injury have actual knowledge of such accident and injury? yes If so, explain how: by employee (Write on back of this form if necessary)

ned, this 24th day of October 19 62

Employer's Name: Zonolite Company

Signed by _____

Official Title: Secretary

Libby, Montana

C0079279

TICE—Employer should have injured workmen fill out Form 37-A and retu same to Board with Employer's First Report of Injury.

Firm No. | Acc. No. | Major Industry | County | Date of Acc. | Time | Sex & Marital Status | Age | Mont. Code | Acc. Class | Occupation | Type | Agency | Agency Part | Nature of Inj. | Location | Ext. of Dis. | Mech. Defect | Unsafe Act | Pers. Factor | Weekly Wage | Report Lag | Carrier

MEDICAL
Munro, Henery J.

C0079276

VRG00299394

ED_005351_00000355-00473

INDUSTRIAL ACCIDENT BOARD, HELENA, MONTANA. FORM 37 REVISED—2M 3-61 32492

Industrial Accident Board

HELENA, MONTANA

Claim Department

Firm No. _____
Claim No. _____
Accident No. _____
(DO NOT FILL IN)

EMPLOYER'S FIRST REPORT OF INJURY

DO NOT WRITE IN THIS SPACE

INSTRUCTIONS—The employer must fill out this form and return same to Industrial Accident Board, Helena, Montana, at once after every accident which causes any loss of work or requires medical attention. In filling out this form use pen or typewriter.

EMPLOYER, PLACE AND TIME

Employer's name: Zonolite Company
Office address: Libby, Montana (Street and number, city or town)
Nature of business: Mining & Milling Vermiculite (Type of construction, manufacturing, etc.)
Did accident occur on work for a public corporation? No
Location of plant or place of work where accident occurred: Same (Street and Number)
In what city or village? Libby County? Lincoln
Date of accident 12-17-62, 19__; hour of day forenoon A.M. P.M.
Did accident happen on premises? Yes
If away from the plant, state where?
Was employee injured in the course of employment? Yes

THE INJURED EMPLOYEE

Give full name of injured workman: Henry J. Munro
Mailing address: Box ~~XX~~ 543, Libby, Montana, Lincoln County (Street and number, city or town and county)
Sex M Age 40 Speak English? Yes If not, what language?
Occupation when injured? Construction Worker Married or single? Married
Was injured employee on duty at time of accident? Yes If not, state fully on back hereof (See Form 87-a)
How long was injured person in your employment? 2 years

CAUSE OF INJURY

Described in full how the accident occurred (DO NOT FAIL TO DO THIS)
While unloading barrels from freight truck, strained muscle in left hand.

(Note: Although this man missed six (6) days of work, it was not recommended by the doctor that he do so. The muscle strain was not severe enough to warrant losing any time.)

THE INJURY

State nature and extent of injury according to your own information. (We do not need the doctor's report here) strained muscle, left hand.
WILL EMPLOYEE LOSE TIME? YES ~~XX~~ NO None
DATE WAGE LOSS BEGAN? 12-20-62 PROBABLE DURATION OF WAGE LOSS? (Give your best estimate)

MEDICAL ATTENDANCE

Name and address of physician attending injured employee: Dr. W. T. Matthews, 402 Montana Avenue, Libby, Montana
To what hospital was employee sent? none
If not sent to hospital, where is he? back to work on January 2, 1963
Are you still providing medical attendance? no Have you a hospital contract? no

WAGES

Monthly wage (If paid by month) ____ Weekly wage (If paid by week) ____ Daily wage (If paid by day) ____ Rate per hour 2.465 (If paid by hour)
Number of hours per day 8 How many working days per week 5
If employee receives board in addition to money wage, state how many meals per day none
Does he receive room in addition to money wage? no

WAGE LOSS

How much money wage will employee lose per day because of accident? none
How much board? none Will he lose room? no

NOTICE OF INJURY

Were you notified by the injured employee of his injury? yes If so, how and when? by employee (Write on back of this form if necessary)
Did you or your managing superintendent in charge of work of injured employee at time of injury have actual knowledge of such accident and injury? yes If so, explain how by employee (Write on back of this form if necessary)

Signed, this 8th day of January, 19 63
at Libby, Montana

Employer's Name Zonolite Company
Signed by
Official Title Secretary

NOTICE—Employer should have injured workmen fill out Form 37-A and return same to Board with Employer's First Report of Injury.

Firm No. | Acc. No. | Major Industry | County | Date of Acc. | Time | Sex & Marital Status | Age | Mont. Code | Acc. Class | Occupation | Type | Agency | Agency Part | Nature of Inj. | Location | Ext. of Dis. | Mech. Defect | Unsafe Act | Pers. Factor | Weekly Wage | Report Lag | Carrier

C0079280

MEDICAL
Munro, Henery J.

C0079276

MSDS: 0569

MATERIAL SAFETY DATA SHEET

NPCA 1-82

FOR COATINGS, RESINS AND RELATED MATERIALS

(Approved by U.S. Department of Labor "Essentially Similar" to Form OSHA-20)

Section I

MANUFACTURER'S NAME Cargill Refined Oils

DATE OF PREP 10/85

STREET ADDRESS P.O. Box 9300

CITY, STATE, AND ZIP CODE Minneapolis, MN 55440

EMERGENCY TELEPHONE NO. 612/825-8643 (5pm-8am)

INFORMATION TELEPHONE NO. 800/328-3534

PRODUCT CLASS Refined, Bleached, Deodorized Soybean Oil

MANUFACTURERS CODE IDENTIFICATION 100500

TRADE NAME Cargill Clearsoy

Section II—HAZARDOUS INGREDIENTS

INGREDIENT	PERCENT	OCCUPATIONAL EXPOSURE LIMITS	VAPOR PRESSURE	TOXICITY DATA
This material is not hazardous under Labor Department regulations.				

W. R. GRACE
Terry J. Jacobs
SAFETY DIRECTOR
TJAKE
Date 2/24/86

Section III—PHYSICAL DATA

BOILING RANGE Greater than 300°C

VAPOR DENSITY ☒ HEAVIER ☐ LIGHTER THAN AIR

EVAPORATION RATE ☐ FASTER ☒ SLOWER THAN ETHER

PERCENT VOLATILE BY VOLUME 0%

WEIGHT PER GALLON 7.55-7.65

Section IV—FIRE AND EXPLOSION HAZARD DATA

FLAMMABILITY CLASSIFICATION OSHA _____ DOT _____

FLASH POINT over 200°C

LEL

EXTINGUISHING MEDIA

☒ FOAM ☐ "ALCOHOL" FOAM ☒ CO_2 ☒ DRY CHEMICAL ☐ WATER FOG ☐ OTHER

UNUSUAL FIRE AND EXPLOSION HAZARDS

Rags and other materials containing this material may heat and spontaneously ignite if exposed to air. Store wiping rags and similar material in metal cans with tight fitting lids. Avoid use of water in extinguishing fires.

C0079281

WRG00299397

ED_005351_00000355-00476

Section V—HEALTH HAZARD DATA

EFFECTS OF OVEREXPOSURE No adverse health affects.

EMERGENCY AND FIRST AID PROCEDURES

Section VI—REACTIVITY DATA

STABILITY ☐ UNSTABLE ☒ STABLE CONDITIONS TO AVOID

INCOMPATABILITY (Materials to avoid)

HAZARDOUS DECOMPOSITION PRODUCTS

HAZARDOUS POLYMERIZATION ☐ MAY OCCUR ☒ WILL NOT OCCUR

Section VII—SPILL OR LEAK PROCEDURES

STEPS TO BE TAKEN IN CASE MATERIAL IS RELEASED OR SPILLED

Small spill: Add solid adsorbent, shovel into disposable container and hose down area.
Large spill: Squegee or pump into holding container.

WASTE DISPOSAL METHOD

Dispose in accordance with local, state and Federal regulations.

Section VIII—SPECIAL PROTECTION INFORMATION

RESPIRATORY PROTECTION

VENTILATION

In the presence of any vegetable oil mist proper respiratory protection should be worn. Vegetable oil mists are classified as a respiratory "nuisance particulate" (no health effects) by the American Conference of Governmental Industrial Hygienists.

PROTECTIVE GLOVES

OTHER PROTECTIVE EQUIPMENT

EYE PROTECTION

Section IX—SPECIAL PRECAUTIONS

PRECAUTIONS TO BE TAKEN IN HANDLING AND STORING

Hazardous Material Identification System Ratings.
Health - 0 (minimal hazard)
Flammability - (flash point over 200°F)
Reactivity - (normally stable)

OTHER PRECAUTIONS

Personal Protection - No special equipment required

MEDICAL
Munro, Henery J.

C0079276

WRG00299399

ED_005351_00000355-00478

INDUSTRIAL ACCIDENT BOARD, HELENA, MONTANA. FORM 37 REVISED-2M 3-61 32492

Industrial Accident Board 06062448

HELENA, MONTANA

Claim Department

Firm No. _____

Claim No. _____

Accident No. _____

DO NOT FILL IN

EMPLOYER'S FIRST REPORT OF INJURY

DO NOT WRITE IN THIS SPACE

INSTRUCTIONS—The employer must fill out this form and return same to Industrial Accident Board, Helena, Montana, at once after every accident which causes any loss of work or requires medical attention. In filling out this form use pen or typewriter.

EMPLOYER, PLACE AND TIME

Employer's name: Zonolite Company

Office address: Libby, Montana (Street and number, city or town)

Nature of business: Mining & Milling Vermiculite (Type of construction, manufacturing, etc.)

Did accident occur on work for a public corporation? No

Location of plant or place of work where accident occurred: Same (Street and Number)

In what city or village? Libby County? Lincoln

Date of accident 12-17-62, 19..; hour of day forenoon A.M. P.M.

Did accident happen on premises? Yes

If away from the plant, state where?

Was employee injured in the course of employment? Yes

THE INJURED EMPLOYEE

Give full name of injured workman: Henry J. Munro

Mailing address: Box ~~XX~~ 543, Libby, Montana, Lincoln County (Street and number, city or town and county)

Sex M Age 40 Speak English? Yes If not, what language?

Occupation when injured? Construction Worker Married or single? Married (See Form 87-a)

Was injured employee on duty at time of accident? Yes If not, state fully on back hereof

How long was injured person in your employment? 2 years

CAUSE OF INJURY

Described in full how the accident occurred (DO NOT FAIL TO DO THIS): While unloading barrels from freight truck, strained muscle in left hand.

(Note: Although this man missed six (6) days of work, it was not recommended by the doctor that he do so. The muscle strain was not severe enough to warrant losing any time.)

THE INJURY

State nature and extent of injury according to your own information. (We do not need the doctor's report here) strained muscle, left hand.

WILL EMPLOYEE LOSE TIME? YES ~~XXX~~ NO None

DATE WAGE LOSS BEGAN? 12-20-62 PROBABLE DURATION OF WAGE LOSS? (Give your best estimate)

MEDICAL ATTENDANCE

Name and address of physician attending injured employee: Dr. W. T. Matthews, 402 Montana Avenue, Libby, Montana

To what hospital was employee sent? none

If not sent to hospital, where is he? back to work on January 2, 1963

Are you still providing medical attendance? no Have you a hospital contract? no

WAGES

Monthly wage (If paid by month) ..... Weekly wage (If paid by week) ..... Daily wage (If paid by day) ..... Rate per hour 2.465 (If paid by hour)

Number of hours per day 8 How many working days per week 5

If employee receives board in addition to money wage, state how many meals per day none

Does he receive room in addition to money wage? no

WAGE LOSS

How much money wage will employee lose per day because of accident? none

How much board? none Will he lose room? no

NOTICE OF INJURY

Were you notified by the injured employee of his injury? yes If so, how and when? by employee (Write on back of this form if necessary)

Did you or your managing superintendent in charge of work of injured employee at time of injury have actual knowledge of such accident and injury? yes If so, explain how by employee (Write on back of this form if necessary)

Signed, this 8th day of January, 19 63

Employer's Name Zonolite Company

Signed by

at Libby, Montana

Official Title Secretary

NOTICE—Employer should have injured workmen fill out Form 37-A and return same to Board with Employer's First Report of Injury.

Firm No. | Acc. No. | Major Industry | County | Date of Acc. | Time | Sex & Marital Status | Age | Mont. Code | Acc. Class | Occupation | Type | Agency | Agency Part | Nature of Inj. | Location | Ext. of Dis. | Mech. Defect | Unsafe Act | Pers. Factor | Weekly Wage | Report Lag | Carrier

C0078283 WRG00299400

ED_005351_00000355-00479

PATCH II

W.R. Grace Fall 2000 Document Production Target Sheet

- [ ] Notice
  - [ ] Testing
  - [ ] Agency
- [ ] Libby Ore/Operations
- [x] Libby All Other
- [ ] Expanding Plant (see below)
- [ ] Non-Grace Expanding Plant
- [ ] Attic Insulation
- [ ] Agricultural/ Horticultural Products
- [ ] Other Consumer Products
- [ ] Workers Comp
- [ ] Medical Records and Other Personal Confidental
- [ ] Privilege
- [ ] Trade Secret

- [ ] All
- [ ] Invoices

- [ ] Albany, N.Y.
- [ ] Atlanta, Georgia
- [ ] Birmingham, Alabama
- [ ] Boca Raton, Florida
- [ ] Chicago, Illinois (Blue Island)
- [ ] Dallas, Texas
- [ ] Dearborn, Michigan
- [ ] Denver, Colorado
- [ ] Easthampton, Mass.
- [ ] Ellwood City, Penn.
- [ ] Enoree, S. Carolina
- [ ] Hialeah, Florida
- [ ] High Point, N. Carolina
- [ ] Irondale, Alabama
- [ ] Jacksonville, Florida
- [ ] Kansas City, Missouri
- [ ] Kearny, S. Carolina
- [ ] Kenilworth Ave. Washington D.C.
- [ ] Los Angeles, Calif.
- [ ] Milwaukee, Wisconsin
- [ ] Minneapolis, Minn. (Western Min. Prod.)
- [ ] Muirkirk, Maryland (Beltsville)
- [ ] Nashville, Tennessee
- [ ] Newark, California
- [ ] New Castle, Pennsylvania
- [ ] New Orleans, Louisiana
- [ ] North Billerica, Mass.
- [ ] North Little Rock, Ark.
- [ ] Oklahoma City, Oklahoma
- [ ] Omaha, Nebraska (Western Min. Prod.)
- [ ] Phoenix, Arizona (Glendale)
- [ ] Pompano Beach, Florida
- [ ] Portland, Oregon
- [ ] Rio Piedras, Puerto Rico
- [ ] Sacramento, Calif.
- [ ] San Antonio, Texas
- [ ] Santa Ana, California
- [ ] Savannah, Georgia
- [ ] Sharpsburg, Penn.
- [ ] Spokane, Washington
- [ ] St. Louis, Missouri
- [ ] Tampa, Florida
- [ ] Travelers Rest, S. Carolina
- [ ] Trenton, New Jersey (East Trenton)
- [ ] Utica, New York
- [ ] Weedsport, N. Y. (Brutus)
- [ ] West Chicago, Illinois
- [ ] Wilder, Kentucky (Newport)

- [ ] Canadian Expanding plants

F 40

MEDICAL
Munro, Henery J.

C0079276

06062738

Industrial Accident Board, Helena, Montana, Form 37 Revised—YM - U - WU

Industrial Accident Board

HELENA, MONTANA

Firm No.....

File No.....

EMPLOYER'S FIRST REPORT OF INJURY

INSTRUCTIONS—Employer must complete form at once after every accident which causes loss of time from work or requires medical attention and mail it to the Industrial Accident Board, Helena, Montana. Form must be signed in pen and ink. ALL QUESTIONS MUST BE ANSWERED FULLY.

INJURED EMPLOYEE

Full name of injured employee: Henry J. Munro Occupation: Construction worker

Mailing address: Box 543, Libby, Montana (Street, City) How long has he been in your employ: 4 yrs.

Social Security No.: 516-22-9655 Sex: M Age: 41 Married [XX] Single [ ]

EARNINGS

Monthly Wage..... Weekly Wage..... Daily Wage..... Hourly Wage: 2.54

Receive board Yes [ ] No [X] Daily Value..... Receive room Yes [ ] No [XX] Daily Value.....

Piece Worker Yes [ ] No [X] If yes, price per unit at piece work..... Hours worked per day: 8

Days worked per week: 5 Employee's pay period? Monthly [ ] Semi-monthly [X] Weekly [ ] List employee's earnings last 4 pay periods 1. 254.16 2. 101.60 3. 102.88 4. 335.28

List Payroll Classification and Code under which employee's wages were reported..... (Sawmill - Mechanic - Etc.) Code..... (2702, 5506, 8810)

ACCIDENT AND INJURY

Describe in full how accident happened and GIVE CAUSE: While loading boxes at expanding plant, reached down to pick one up from floor, got wooden sliver in joint of middle finger, left hand.

Nature or extent of injury: large sliver (Cut - Fracture) Part of body injured?: middle finger, left hand (Leg - Arm - Back - Head)

Names of witnesses to accident 1. Robert Cohenour 2.....

Date of accident: 3-24-64 19..... Hour: 3 ~~A.M.~~ P.M. Was employee injured in course of employment? Yes [XX] No [ ]

Place where accident occurred: our expanding plant, in Libby (Address, City) Lincoln (County)

Did you or employee's supervisor have actual knowledge of accident? Yes [XX] No [ ]

Were you notified of accident by injured employee? Yes [XX] No [ ] How: by employee Date: 3-25-64

Have you reason to question this accident? Yes [ ] No [XX] If "yes" explain fully.....

SAFETY

Was employee's accident due to unsafe work practice? Yes [ ] No [X] If "yes", what did he do unsafely?.....

Was a specific device, object or substance involved in accident? Yes [ ] No [ ] If "yes," name specific device, object or substance..... Was device or object defective? Yes [ ] No [ ]

Was employee doing regular work when injured? Yes [X] No [ ] Was employee trained to do work he was doing when injured? Yes [ ] No [ ] Were adequate safeguards provided? Yes [ ] No [ ] If "yes," were they being used at the time of accident? Yes [ ] No [ ]

MEDICAL ATTENTION

Name of attending physician: Dr. W. T. Matthews Address: Libby, Montana

Was employee hospitalized? Yes [ ] No [X] Name of hospital..... Address.....

Was first aid administered by someone other than attending physician? Yes [ ] No [XX]

TIME AND WAGE LOSS

Will employee lose time from work due to accident? Yes [ ] No [X] How long?..... If injury results in time loss will employee, while disabled, receive sick leave benefits? Yes [ ] No [ ] Paid vacation? Yes [ ] No [ ] Will employee lose wages? Yes [ ] No [ ] Room? Yes [ ] No [ ] Board? Yes [ ] No [ ]

Date wage loss began..... Amount of weekly wage loss.....

EMPLOYER

Name of employer: Zonolite Division, W. R. Grace & Co.,

Address: Libby, Montana Nature of business: Mining & Milling Vermiculite

IS FIRM A CORPORATION [XX] OR PARTNERSHIP [ ] OR INDIVIDUAL [ ]

IF
- Corporation—is injured employee an officer or director of corporation? Yes [ ] No [XX]
- Partnership—is injured employee related to any partner? Yes [ ] No [ ] Relationship.....
- Individual—is injured employee related to employer? Yes [ ] No [ ] Relationship.....

Signed, this: 26th day of: March, 19: 64

at: Libby, Montana

Employer's Name: Zonolite Division-W.R.Grace & Co

Signed by.....

Official Title: Secretary

NOTICE—EMPLOYEE'S CLAIM FOR COMPENSATION, FORM 54, MUST BE FILED WITHIN 12 MONTHS FROM DATE OF ACCIDENT.

C0079287

WRG00299404

ED_005351_00000355-00483

MEDICAL
Munts, Calvin

C0079288

WKG00299405
ED_005351_00000355-00484

06063316

Industrial Accident Board

HELENA, MONTANA

Firm No. 2503

File No.

EMPLOYER'S FIRST REPORT OF INJURY

INSTRUCTIONS—Employer must complete form at once after every accident which causes loss of time from work or requires medical attention and mail it to the Industrial Accident Board, Helena, Montana. Form must be signed in pen and ink. ALL QUESTIONS MUST BE ANSWERED FULLY.

INJURED EMPLOYEE

Full name of injured employee: Calvin Munts Occupation: Mill Worker

Mailing address: Box 710, Libby, Montana (Street, City) How long has he been in your employ? 5 years

Social Security No. 517-42-7811 Sex: M Age: 34 Married ☒ Single ☐

EARNINGS

Monthly Wage ____ Weekly Wage ____ Daily Wage ____ Hourly Wage 3.725

Receive board Yes ☐ No ☒ Daily Value ____ Receive room Yes ☐ No ☒ Daily Value ____

Piece Worker Yes ☐ No ☒ If yes, price per unit at piece work ____ Hours worked per day 8

Days worked per week 6 Employee's pay period? Monthly ☐ Semi-monthly ☒ Weekly ☐ List employee's earnings last 4 pay periods 1 430.24 2 379.95 3 503.80 4 ____

List Payroll Classification and Code under which employee's wages were reported ____ (Sawmill - Mechanic - Etc.) Code ____ (2702, 5506, 8810)

ACCIDENT AND INJURY

Describe in full how accident happened and GIVE CAUSE: Was carrying a garbage-can type bucket, bucket slipped out of hands, fell on little toe of left foot.

Nature or extent of injury: dislocated toe (Cut - Fracture) Part of body injured? little toe, left foot (Leg - Arm - Back - Head)

Names of witnesses to accident 1 ____ 2 ____

Date of accident 10-29 19 71 Hour 10:30 A.M. P.M. Was employee injured in course of employment? Yes ☒ No ☐

Place where accident occurred: our mill, 9 miles north of Libby (Address, City) Lincoln (County)

Did you or employee's supervisor have actual knowledge of accident? Yes ☒ No ☐

Were you notified of accident by injured employee? Yes ☒ No ☐ How: In person Date: 11-12-71

Have you reason to question this accident? Yes ☐ No ☒ If "yes" explain fully ____

SAFETY

Was employee's accident due to unsafe work practice? Yes ☐ No ☒ If "yes", what did he do unsafely? ____

Was a specific device, object or substance involved in accident? Yes ☐ No ☒ If "yes", name specific device, object or substance ____ Was device or object defective? Yes ☐ No ☐

Was employee doing regular work when injured? Yes ☒ No ☐ Was employee trained to do work he was doing when injured? Yes ☒ No ☐ Were adequate safeguards provided? Yes ☐ No ☐ If "yes", were they being used at the time of accident? Yes ☐ No ☐

MEDICAL ATTENTION

Name of attending physician: Dr. M. G. Pozar, Address: Libby, Montana

Was employee hospitalized? Yes ☐ No ☒ Name of hospital ____ Address ____

Was first aid administered by someone other than attending physician? Yes ☐ No ☒

TIME AND WAGE LOSS

Will employee lose time from work due to accident? Yes ☐ No ☒ How long? NONE If injury results in time loss will employee, while disabled, received sick leave benefits? Yes ☐ No ☐ Paid vacation? Yes ☐ No ☐ Will employee lose wages? Yes ☐ No ☐ Room? Yes ☐ No ☐ Board? Yes ☐ No ☐

Date wage loss began: NONE Amount of weekly wage loss ____

EMPLOYER

Name of employer: Construction Products Division-W.R.Grace & Co.

Address: Libby, Montana Nature of Business: Mining & Milling Vermiculite

IS FIRM A CORPORATION ☒ OR PARTNERSHIP ☐ OR INDIVIDUAL ☐

IF
- Corporation—is injured employee an officer or director of corporation? Yes ☐ No ☒
- Partnership—is injured employee related to any partner? Yes ☐ No ☐ Relationship ____
- Individual—is injured employee related to employer? Yes ☐ No ☐ Relationship ____

Signed, this 12th day of November, 19 71

at Libby, Montana

Employer's Name: Construction Products Division W. R. Grace & Co.

Signed by: [signature]

Official Title: Pers Dept

NOTICE—EMPLOYEE'S CLAIM FOR COMPENSATION, FORM 54, MUST BE FILED WITHIN 12 MONTHS FROM DATE OF ACCIDENT.

C0079289

WRG00299406

ED_005351_00000355-00485

MEDICAL
Munts, Calvin

C0079288

06062984

Stock Form — State Publishing Company, Helena, Montana
Industrial Accident Board — Form No. 43 YM-T-YZ

Plan No.....

Industrial Accident Board

HELENA, MONTANA

CLAIM DEPARTMENT

Firm No.....
Claim No.....
Accident No.....
Employe No.....

DO NOT FILL IN

Employer's Supplemental Report of Injury

This notice to be filled out by employer and sent to the Industrial Accident Board, at Helena, Montana, immediately upon employe's returning to work fully recovered if within 2 weeks—or upon his death or at the expiration of two weeks from date of injury.

Name of injured employe Calvin Munts

Address Box 606, Libby, Montana

..... Injured 5-24-67, 19.....

Is injured employe fully recovered? Yes On what date? 5-31-67

Has he/she returned to work for you? Yes On what date? 5-31-67

Has he/she accepted other employment? ..... On what date? .....

If so, where now employed? .....

Has he/she died? ..... If so, when? .....

Signed: Zonolite Division-W.R.Grace & Co.

Address Libby, Montana

Dated June 1, 19 67

△

C0079290

WRG00299408

ED_005351_00000355-00487

06062985

Industrial Accident Board, Helena, Montana. Form 37 Revised—YM - U - WU

Industrial Accident Board

HELENA, MONTANA

Firm No.....

File No.....

EMPLOYER'S FIRST REPORT OF INJURY

INSTRUCTIONS—Employer must complete form at once after every accident which causes loss of time from work or requires medical attention and mail it to the Industrial Accident Board, Helena, Montana. Form must be signed in pen and ink. ALL QUESTIONS MUST BE ANSWERED FULLY.

INJURED EMPLOYEE

Full name of injured employee: Calvin Phetts Occupation: Skip Operator

Mailing address: Box 606, Libby, Montana (Street, City) How long has he been in your employ: 2 months

Social Security No. 317-42-7011 Sex: M Age: 30 Married ☐ Single ☒

EARNINGS

Monthly Wage..... Weekly Wage..... Daily Wage..... Hourly Wage: 2.605

Receive board Yes ☐ No ☒ Daily Value..... Receive room Yes ☐ No ☒ Daily Value.....

Piece Worker Yes ☐ No ☒ If yes, price per unit at piece work..... Hours worked per day: 8

Days worked per week: 5 Employee's pay period? Monthly ☐ Semi-monthly ☒ Weekly ☐ List employee's earnings last 4 pay periods 1. 240.12 2. 305.28 3. 248.79 4. 235.19

List Payroll Classification and Code under which employee's wages were reported..... (Sawmill - Mechanic - Etc.) Code..... (2702, 5506, 8810)

ACCIDENT AND INJURY

Describe in full how accident happened and GIVE CAUSE: Was going down steps &, foot slipped on edge of step, twisted ankle.

Nature or extent of injury: Severe sprain (Cut - Fracture) Part of body injured? left ankle (Leg - Arm - Back - Head)

Names of witnesses to accident 1..... 2.....

Date of accident: 5-24-57 19..... Hour: 2:30XXXX A.M. P.M. Was employee injured in course of employment? Yes ☒ No ☐

Place where accident occurred: saw mill, 3 miles north of Libby (Address, City) Lincoln (County)

Did you or employee's supervisor have actual knowledge of accident? Yes ☒ No ☐

Were you notified of accident by injured employee? Yes ☒ No ☐ How: by employee Date: 5-25-57

Have you reason to question this accident? Yes ☐ No ☒ If "yes" explain fully.....

SAFETY

Was employee's accident due to unsafe work practice? Yes ☐ No ☒ If "yes", what did he do unsafely?.....

Was a specific device, object or substance involved in accident? Yes ☐ No ☐ If "yes," name specific device, object or substance..... Was device or object defective? Yes ☐ No ☐

Was employee doing regular work when injured? Yes ☒ No ☐ Was employee trained to do work he was doing when injured? Yes ☒ No ☐ Were adequate safeguards provided? Yes ☐ No ☐ If "yes," were they being used at the time of accident? Yes ☐ No ☐

MEDICAL ATTENTION

Name of attending physician: Dr. H. Pozer Address: Libby, Montana

Was employee hospitalized? Yes ☐ No ☒ Name of hospital..... Address.....

Was first aid administered by someone other than attending physician? Yes ☐ No ☒

TIME AND WAGE LOSS

Will employee lose time from work due to accident? Yes ☒ No ☐ How long? not known at this time. If injury results in time loss will employee, while disabled, receive sick leave benefits? Yes ☒ No ☐ Paid vacation? Yes ☐ No ☐ Will employee lose wages? Yes ☐ No ☐ Room? Yes ☐ No ☒ Board? Yes ☐ No ☒

Date wage loss began: 5-25-57 Amount of weekly wage loss: $106.60

EMPLOYER

Name of employer: Zonolite Division-W.R.Grace & Co.

Address: Libby, Montana Nature of business: Mining & Milling Vermiculite

IS FIRM A CORPORATION ☒ OR PARTNERSHIP ☐ OR INDIVIDUAL ☐

IF
- Corporation—is injured employee an officer or director of corporation? Yes ☐ No ☒
- Partnership—is injured employee related to any partner? Yes ☐ No ☐ Relationship.....
- Individual—is injured employee related to employer? Yes ☐ No ☐ Relationship.....

Signed, this 27th day of May, 19 57

at Libby, Montana

Employer's Name: Zonolite Division-W.R.Grace & Co.

Signed by.....

Official Title.....

NOTICE—EMPLOYEE'S CLAIM FOR COMPENSATION, FORM 54, MUST BE FILED WITHIN 12 MONTHS FROM DATE OF ACCIDENT.

Δ

C0079291

WRG00299409

ED_005351_00000355-00488

Medical
Munyan, Steve

C0079292

WRG00299410

ED_005351_00000355-00489

ACCIDENT INVESTIGATION REPORT

INDUSTRIAL CHEMICALS GROUP
W. R. Grace & Co.

Plant Libby, Montana Lost Time Case ✓

Division Construction Products Division Not Lost Time Case _____
(Check one)

All accidents involving lost time from work or the services of a physician must be investigated and the report completed within 48 hours by the injured employee's supervisor. Forward one copy of report to office of Safety Administrator.

1. Name of injured employee Steven Munyan
2. Department Garage Date of Hire 6-29-71
3. Job Title Ass't Foreman Was he doing regular job? Yes ✓ No _____
4. Date and time of injury 7-8-76 10:00 pm
5. Date and time injury reported 7-9-76 9:00 am
6. Injured employee is: Salaried _____ Hourly ✓ Male ✓ Female _____

   Under 25 years _____ 25 to 34 ✓ 35 to 49 _____ 50 and over _____
7. Describe in detail what employee was doing at time of injury: include reference to any tools, machines and materials involved:

   Removed rear dual wheels on a tandem axle Ford truck - equip. no. T-4. Employee was pulling on wheels at the time of injury. His left foot slipped on some oil on the floor.
8. Describe injury: Pulled muscles in small of back.
9. What medical action was taken? Medication and therapist.
10. What, in your opinion, was the basic cause of this accident?

    Unsafe Act _____ Unsafe Condition ✓ Explain Floor dry was applied to oil on floor before he slipped.

C0079293

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11. What were the contributing causes? _____

12. What action have you taken and/or are you planning to take to avoid a recurrence of this accident? We should possibly be using sawdust instead of floor-dry as floor-dry will roll.

13. Have you counselled your other employees regarding lessons to be learned from this accident?

Yes ✓ No ____ if not, why We cannot do this because of MESA regulations

14. Have you scheduled any maintenance work or planned any disciplinary action with the accident?

Yes ____ No ✓ Comments, if any: _____

(Signed) R. Dennis Kosny (Supervisor) Date 7-28-76 Plant Libby, Mt.

****

You have now completed answering some very important questions regarding an injury to one of your employees. Take the time to think carefully and ask yourself the following two questions:

a) How long did I take to think out and complete the answers to the questions above?
b) Have I really taken enough time, given enough thought, to a subject which might very well mean the life of one of my employees at some future date?

****

This space reserved for Plant Managers

1. Have you discussed this injury with .....

the supervisor concerned? Yes ____ No ____
all members of your supervisory group? Yes ____ No ____

2. Do you have any comments to add to the statements by the Foreman?

(Plant Manager) 8/4/76 (Date)

Form 65-25

C0079294

WRG00299412

ED_005351_00000355-00491

MONTANA DIVISION OF WORKERS' COMPENSATION

Complied with 82-1137, R.C.M.

815 Front Street
Helena, Montana 59601

SEND ORIGINAL TO INSURER

EMPLOYER'S FIRST REPORT
of Occupational Injury or Occupational Disease
Employee Copy

CASE NUMBER

FIRM NUMBER 2503

INSTRUCTIONS - Every employer in Montana is required by law to complete this form immediately after every accident to an employee which arises out of and in the course of employment, and which causes loss of time from work or requires medical attention. The original of this form must be immediately filed with the employer's insurer or the Division of Workers' Compensation, 815 Front Street, Helena, Montana 59601. All questions must be answered fully. If a question cannot be answered, please explain why. ***Please print with a ball point pen or type.***

FEDERAL OSHA REQUIREMENTS -- The United States Department of Labor requires employers to maintain, in the employer's office, a record of occupational injuries. For the employer's convenience, this form has been designed to meet such requirements and to provide employers a record copy.

EMPLOYEE

Full Name of INJURED EMPLOYEE: Steven Munyan
Social Security Number: 516-54-5621
EMPLOYEE'S Home Address (Street or Box): 10099California Avenue
City: Libby
State: MT
Zip Code: 59923
Occupation: Mechanic
Sex: M
Age: 26
Marital Status: [X] Married [ ] Single
Length of time in your Employment: 6-29-71
Department where regularly employed: Garage
Date of Birth (mo.) 8 (day) 2 (yr.) 45

WAGES

Employee's Gross Wage Rate is $ 6.56 per [ ] week, or [ ] day, or [X] hour, or [ ] month
Days Worked Per Week: 5
Hours Worked Per Day: 8
If board or room is furnished state value reported per day to Internal Revenue Service $
Check One— [X] Full Time Employee [ ] Part Time Employee
Payroll Classification under which employee's wages were reported
Employee's gross earnings for last four (4) pay periods (Date / Amount) (Date / Amount) (Date / Amount) (Date / Amount)
Employee's pay period: [ ] Monthly [X] Semi-monthly [ ] Bi-Weekly [ ] Weekly [ ] Other

ACCIDENT INFORMATION

Describe in full detail how accident happened, and give cause - Explain what employee was doing when injured.
Pulling wheel off truck, cement garage floor was slippery, lost balance, strained muscle in back.

What specific object or substance caused the injury?
Nature of the injury? (cut, fracture, etc.) pulled muscle
Part of body affected (leg, arm, back, head, etc.): back
DATE OF INJURY (month) July (day) 8 (year) 1976 (hour) 10 (a.m. or p.m.) p.m.
Names of witnesses to accident: 1. 2.
Place where accident occurred (address & city): our garage, 12 miles north of Libby
(county) Lincoln
Was place of accident on employer's premises? Yes [X] No [ ]
Was employee injured while in your employ? Yes [X] No [ ]
Were you notified, or did you have actual knowledge of the accident? Yes [X] No [ ]
If yes, date notified & how: by employee, 7-12-76
Do you have any reason to question this accident? [ ] Yes [X] No
If yes, please explain fully

MEDICAL

Attending physician name and address: R. D. MacKenzie, M.D. 709 California Avenue, Libby, MT. Leo Beck, PT, Libby
If hospitalized, hospital's name and address: none
Will employee return to work during next scheduled shift? Yes [ ] No [X]
If no, will wage loss exceed 7 days? Yes [ ] No [X] Not Sure [ ]
Date wage loss began (mo.) 7 (day) 9 (yr.) 76
Date of return, if returned to work (mo.) / (day) 10 (yr.) 76

EMPLOYER

EMPLOYER'S NAME: W. R. Grace & Co. Construction Products Division
Commercial Name (doing business as): Same
Employer's mailing address (Street or Box): Box 609,
(City) Libby
(State) MT
(Zip Code) 59923
Phone number: 293-4131
Location of operation, if different from mailing address: 12 miles north of Libby
Nature of business: Mining & Milling
Firm is a: (Check one) [ ] Sole proprietorship [ ] Partnership, or [X] Corporation
Was the Injured employee? (Check if applicable) [ ] A Sole Proprietor, [ ] A working Partner, [ ] A Corporate Officer, or [ ] A member of the employer's (sole proprietor or partner) family, dwelling in the employer's household.
Prepared by: Joan B. Runyan
Authorized Signature: X
Official Title: Administrative Asst.
Date: 7-23-76

DWC USE ONLY

OCCUPATION
SEX
AGE
MARITAL STATUS
COUNTY
LENGTH (YRS) EMPLOYED
WEEKLY EARNINGS
CLASS CODE
ACCIDENT TYPE
SOURCE OF INJURY
PART OF BODY INJURED
OSHA RECORDABLE CODE
DISABILITY TYPE
NATURE OF INJURY
HAZARDOUS CONDITION
UNSAFE ACT

Above - DWC-MIS Form 37-Employer's First Report (Rev. 1-76)

Below - DWC-MIS Form 54A-Claim for Compensation

EMPLOYEE'S CLAIM FOR COMPENSATION

EMPLOYER'S NOTE: For convenience purposes and if the worker is available, the form below has been provided so that an employer may allow an injured worker to file a claim for compensation on this form to avoid having the employee fill out and file a separate detailed form. Separate claim forms are available if the employer does not want the worker to use this form. **Do not delay in submission of this form if employee is not available to sign below.**

INJURED EMPLOYEE'S NOTE: An injured employee may use the form below to make a claim for compensation, or the employee may fill out and submit a separate detailed form that is available from the Division.

I have carefully read the above information as documented by the employer, and (except for any statements I may write below) I concur with the information and I hereby make claim for compensation benefits due me now or in the future under Montana's Workers' Compensation Act.

Signature of injured employee: X
Address
City
Date
Phone

I DO NOT concur with the following information documented by the employer

Filing of this claim is authorization for release of medical records and records of the Social Security Administration

C0079295

Medical
Munyan, Steve

C0079292

ZONOLITE

CONSTRUCTION PRODUCTS DIVISION

W. R. GRACE & CO. P.O. BOX 609 LIBBY, MONTANA 59923 406-293-4131

August 30, 1974

Mr. Thomas Mazurek
Hugo Dobler Adjuster, Inc.
P. O. Box 233
Helena, Montana 59601

Dear Tom:

We are returning the check you sent to Steven R. Munyan for disability payment for the period July 9 through July 16, 1974.

Mr. Munyan was injured July 8 and did not return to work until July 17th, because of his injury. However, for this period we paid him sick leave, in accordance with our union contract, for six days pay. He should not be paid double for this loss of time.

Will you please adjust this. Thank you.

Very truly yours

CONSTRUCTION PRODUCTS DIVISION
W. R. GRACE & CO.

By:
Earl D. Lovick
Administrative Assistant

EDL/jbr

enc.

9/3/74
Earl, I enclose a new draft - Thanks
Tom Mazurek

SEP 2 1974
HUGO DOBLER ADJUSTERS
HELENA MONTANA

GRACE

C0079296

WRG00299415

ED_005351_00000355-00494

06063590

WORKMEN'S COMPENSATION DIVISION

Department of Labor and Industry
815 Front Street
Helena, Montana 59601

Return to:
Hugo Dobler Adjuster, Inc.
Helena, Mt. 59601

CASE No. _____

Firm No. 2503

EMPLOYER'S FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE

INSTRUCTIONS—Employer must complete form at once after every accident or occupational disease which causes loss of time from work or requires medical attention and mail to Workmen's Compensation Division, Helena, Montana. Form must be signed in pen and ink. ALL QUESTIONS MUST BE ANSWERED FULLY. This form contains all items requested on OSHA Form No. 101, "Supplementary Record of Occupational Injuries and Illnesses."

INJURED EMPLOYEE

Full name of injured employee Steven R. Munyan Occupation Mechanic
Home address 1009 California Ave. Libby (Street, City) *How long has he been in your employ?* 3 years
Social Security No. 516-54-5621 Sex M Age 24 Married [X] Single [ ]
Department R&M (Enter name of department or division in which the injured person is regularly employed, even though he may have been temporarily working in another department at the time of injury.)

EARNINGS

Monthly Wage _____, or Weekly Wage _____, or Daily Wage _____, or Hourly Wage 4.81
Receive board? Yes [ ] No [X] Receive room? Yes [ ] No [X] Days worked per week 5 Hours worked per week 40 Employee's pay period? Monthly [ ], Semi-monthly [X], Weekly [ ]. List employee's gross earnings and date of last 4 pay periods
1 _____ (Date/Amount) 2 _____ (Date/Amount) 3 _____ (Date/Amount) 4 _____ (Date/Amount)
List Payroll Classification Code under which employee's wages were reported _____

ACCIDENT AND INJURY

Describe in full how accident happened and GIVE CAUSE—Tell what employee was doing when injured:
Was servicing new Caterpillar 992 end loader, stepped down to ground, sprained left ankle

Nature or extent of injury or illness severe sprain (Cut-Fracture) Part of body affected left ankle (Leg-Arm-Back-Head)
Did employee die? Yes [ ] No [X]
Name of witnesses to accident 1 _____ 2 _____
Date of injury or initial diagnosis of occupational illness Mo. 7 Day 8 Year 74 Hour 8 A.M. XXXXX
Was employee injured in course of employment? Yes [X] No [ ]
Place where accident occurred
our pit area, 12 miles north of Libby (Address, City) Lincoln (County)
Was place of accident or exposure on employer's premises? Yes [X] No [ ]
Were you notified of accident? Yes [X] No [ ] How by employee Date 7-8-74
Have you reason to question this accident? Yes [ ] No [X] If "yes," explain fully _____

SAFETY

1. Was the accident caused by an unsafe act on the part of the injured? Yes [ ] No [X]
2. Was the accident caused by an unsafe condition? Yes [ ] No [X]
3. What specific device, object or substance caused the injury? _____

MEDICAL ATTENTION

Name of attending physician James F. Graham, M.D.
Address 401nLouisiana Avenue, Libby, Montana
Was employee hospitalized? Yes [ ] No [X] Name of hospital St. Johns for X-rays
Address 350 Louisiana Avenue, Libby, Montana 59923

TIME AND WAGE LOSS

1. Will the employee return to work before or during his next scheduled shift? Yes [ ] No [X]
2. Will employee lose wages? Yes [X] No [ ]
3. Date wage loss began 7-9-74 Amount of weekly wage loss $192.40

EMPLOYER

Name of employer Construction Products Division-W.R.Grace & Co.
D.B.A. _____
Address Box 609, Libby, Montana 59923 Nature of business Mining & Milling Vermiculit
Location, if different from mail address _____
Check one: Individual [ ] Partnership [ ] Corporation [X]

Signed, this 10th day of July, 19 74 Prepared by Joan B. Runyan
Signed by _____
at Libby, Montana Official Title Administrative Assistant

NOTICE—EMPLOYEE'S CLAIM FOR COMPENSATION, FORM 54, MUST BE FILED WITHIN 12 MONTHS FROM DATE OF ACCIDENT

FORM 37-2

C0079297

~~WRG00299416~~

ED_005351_00000355-00495

Hugh Dobler Adjuster, ...
Box 233 — Helena, Mt. 59601

DIVISION OF WORKMEN'S COMPENSATION

DEPARTMENT OF LABOR AND INDUSTRY
815 Front Street
Helena, Montana 59601

06063644

CASE NO. .....

Firm No. 2503

EMPLOYER'S FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE

INSTRUCTIONS—Employer must complete form at once after every accident or occupational disease which causes loss of time from work or requires medical attention and mail to the Division of Workmen's Compensation, 815 Front Street, Helena, Montana. Form must be signed in pen and ink. ALL QUESTIONS MUST BE ANSWERED FULLY. This form contains all items requested on *OSHA Form No. 101, "Supplementary Record of Occupational Injuries and Illnesses."*

INJURED EMPLOYEE

Full name of injured employee Steven R. Munyan Occupation Mechanic
Home Address 1009 California Ave. Libby (Street, City) How long has he been in your employ? 2½ years
Social Security No. 516-54-5621 Sex M Age 24 Married ☒ Single ☐
Department where regularly employed Repair & Maintenance
Department where employed at time of injury Repair & Maintenance
Would employment be classified as: (Check appropriate description)
(1) Household employment ☐
(2) Casual employment ☐
(3) Employment of members of an employer's family dwelling in employer's household ☐
(4) Employment of sole proprietors or working members of a partnership ☐
(5) Employment for which a rule of liability for injury, occupational disease, or death is provided under the laws of the United States ☒
(6) *Any person performing services in return for aid or sustenance only.* (Board & Room) ☐
Scheduled days off .....

EMPLOYEE'S EARNINGS

Monthly wage ....., or Weekly wage ....., or Daily wage ....., or Hourly wage 4.52
Received board? Yes ☐ No ☒ Received room? Yes ☐ No ☒ Days worked per week 5
Hours worked per day 8 Employee's pay period: Monthly ☐ Semi-monthly ☒ Weekly ☐
Bi-weekly ☐ List employee's gross earnings and date for last 4 pay periods:
(1) ..... (Date/Amount) (2) ..... (Date/Amount) (3) ..... (Date/Amount) (4) ..... (Date/Amount)
List payroll classification under which employee's wages were reported .....

ACCIDENT AND INJURY

Describe in full how accident happened and GIVE CAUSE—Tell what employee was doing when injured:
While getting down from dozer after doing some work on it, he slipped, reached back and grabbed at something to keep from falling, pulled muscle in stomach.

Nature or extent of injury or illness pulled muscle (Cut-Fracture) Part of body affected stomach (Leg-Arm-Back-Head)
Did employee die? Yes ☐ No ☒
Name or witnesses to accident 1 ..... 2 .....
Date of injury or initial diagnosis of occupational illness. Mo. 1 Day 24 Yr 74 Hour ..... A.M. ..... P.M.
Was employee injured in course of employment? Yes ☒ No ☐
Place where accident occurred our pit, 12 miles north of Libby (Address, City) Lincoln (County)
Was place of accident or exposure on employer's premises? Yes ☒ No ☐
Have you reason to question this accident? Yes ☐ No ☒ If "yes" explain fully .....

NOTICE

Were you notified of the accident? Yes ☒ No ☐ How by employee

SAFETY

1. Was the accident caused by an unsafe act on the part of the injured? Yes ☐ No ☒
2. Was the accident caused by an unsafe condition? Yes ☐ No ☒
3. What specific device, object, or substance caused the injury? .....

MEDICAL ATTENTION

Name of attending physician James F. Graham, M.D.
Address 401 Louisiana Avenue, Libby, Montana
Was employee hospitalized? Yes ☐ No ☒ Name of hospital .....
Address .....

TIME AND WAGE LOSS

1. Will the employee return to work before or during his next scheduled shift? Yes ☐ No ☒
2. Will employee lose wages? Yes ☒ No ☐ Will wage loss exceed 7 days? Yes ☐ No ☒
3. Date wage loss began 1-25-74 Amount of weekly wage loss .....

EMPLOYER

Name of employer Construction Products Division-W.R.Grace & Co. Phone 293-4131
Firm name Same
Address Box 609, Libby, Montana 59923 Nature of business Mining & Milling Vermicu
Location, if different from mail address .....
Check one: Individual ☐ Partnership ☐ Corporation ☒

Signed, this 4th day of February, 19 74
at Libby, Montana

Prepared by Joan B. Runyan
Signed by .....
Official title Administrative Asst.

C0079298

WRG00299417

ED_005351_00000355-00496

Medical
Munyan, Steve

C0079292

06063309

Industrial Accident Board

HELENA, MONTANA

Firm No. 2503

File No.

EMPLOYER'S FIRST REPORT OF INJURY

INSTRUCTIONS—Employer must complete form at once after every accident which causes loss of time from work or requires medical attention and mail it to the Industrial Accident Board, Helena, Montana. Form must be signed in pen and ink. ALL QUESTIONS MUST BE ANSWERED FULLY.

INJURED EMPLOYEE

Full name of injured employee Steven R. Munyan Occupation Construction Worker

Mailing address Box 561, Libby, Montana (Street, City) How long has he been in your employ? 6-29-71

Social Security No. 516-54-5621 Sex M Age 22 Married ☐ Single ☒

EARNINGS

Monthly Wage ..... Weekly Wage ..... Daily Wage ..... Hourly Wage 3.55

Receive board Yes ☐ No ☒ Daily Value ..... Receive room Yes ☐ No ☒ Daily Value .....

Piece Worker Yes ☐ No ☒ If yes, price per unit at piece work ..... Hours worked per day 8

Days worked per week 6 Employee's pay period? Monthly ☐ Semi-monthly ☒ Weekly ☐ List employee's earnings last 4 pay periods 1 381.58 2 350.52 3 400.92 4 297.42

List Payroll Classification and Code under which employee's wages were reported ..... (Sawmill - Mechanic - Etc.) Code ..... (2702, 5506, 8810)

ACCIDENT AND INJURY

Describe in full how accident happened and GIVE CAUSE Working with mechanics in the garage, pulling pin from cat track. A piece of steel chipped off the driving pin, struck left knee.

Nature or extent of injury laceration (Cut - Fracture) Part of body injured? left knee (Leg - Arm - Back - Head)

Names of witnesses to accident 1 ..... 2 .....

Date of accident 12-28 19 71 Hour 2 ~~AM~~ P M. Was employee injured in course of employment? Yes ☒ No ☐

Place where accident occurred our shop, 9 miles north of Libby (Address, City) Lincoln (County)

Did you or employee's supervisor have actual knowledge of accident? Yes ☒ No ☐

Were you notified of accident by injured employee? Yes ☒ No ☐ How in person Date 12-29-71

Have you reason to question this accident? Yes ☐ No ☒ If "yes" explain fully .....

SAFETY

Was employee's accident due to unsafe work practice? Yes ☐ No ☒ If "yes", what did he do unsafely? .....

Was a specific device, object or substance involved in accident? Yes ☐ No ☒ If "yes", name specific device, object or substance ..... Was device or object defective? Yes ☐ No ☐

Was employee doing regular work when injured? Yes ☒ No ☐ Was employee trained to do work he was doing when injured? Yes ☒ No ☐ Were adequate safeguards provided? Yes ☐ No ☐ If "yes", were they being used at the time of accident? Yes ☐ No ☐

MEDICAL ATTENTION

Name of attending physician R. D. MacKenzie, M.D. Address Libby

Was employee hospitalized? Yes ☐ No ☒ Name of hospital ..... Address .....

Was first aid administered by someone other than attending physician? Yes ☐ No ☒

TIME AND WAGE LOSS

Will employee lose time from work due to accident? Yes ☐ No ☒ How long? none If injury results in time loss will employee, while disabled, received sick leave benefits? Yes ☐ No ☐ Paid vacation? Yes ☐ No ☐ Will employee lose wages? Yes ☐ No ☐ Room? Yes ☐ No ☐ Board? Yes ☐ No ☐

Date wage loss began none Amount of weekly wage loss .....

EMPLOYER

Name of employer Construction Products Division-W.R.Grace & Co.

Address Libby, Montana Nature of Business Mining & Milling Vermiculite

IS FIRM A CORPORATION ☒ OR PARTNERSHIP ☐ OR INDIVIDUAL ☐

IF
- Corporation—is injured employee an officer or director of corporation? Yes ☐ No ☒
- Partnership—is injured employee related to any partner? Yes ☐ No ☐ Relationship .....
- Individual—is injured employee related to employer? Yes ☐ No ☐ Relationship .....

Signed, this 30th day of December, 19 71

at Libby, Montana

Employer's Name Construction Products Division W. R. Grace & Co.

Signed by [signature]

Official Title Ad. Asst

NOTICE—EMPLOYEE'S CLAIM FOR COMPENSATION, FORM 54, MUST BE FILED WITHIN 12 MONTHS *FROM DATE OF ACCIDENT.*

C0079299

WRG00299419

ED_005351_00000355-00498

Medical
Munyan, Steve

C0079292

06063412

Industrial Accident Board

HELENA, MONTANA

Firm No. 2503

File No.

EMPLOYER'S FIRST REPORT OF INJURY

INSTRUCTIONS—Employer must complete form at once after every accident which causes loss of time from work or requires medical attention and mail it to the Industrial Accident Board, Helena, Montana. Form must be signed in pen and ink. ALL QUESTIONS MUST BE ANSWERED FULLY.

INJURED EMPLOYEE

Full name of injured employee: Steven R. Munyan Occupation: Service Mechanic

Mailing address: Box 561, Libby, Montana (Street, City) How long has he been in your employ? 1 years

Social Security No. 516-54-5621 Sex: M Age: 23 Married ☐ Single ☒

EARNINGS

Monthly Wage ____ Weekly Wage ____ Daily Wage ____ Hourly Wage 4.01

Receive board Yes ☐ No ☒ Daily Value ____ Receive room Yes ☐ No ☒ Daily Value ____

Piece Worker Yes ☐ No ☒ If yes, price per unit at piece work ____ Hours worked per day 8

Days worked per week 5 Employee's pay period? Monthly ☐ Semi-monthly ☒ Weekly ☐ List employee's earnings last 4 pay periods 1 ____ 2 ____ 3 ____ 4 ____

List Payroll Classification and Code under which employee's wages were reported ____ (Sawmill - Mechanic - Etc.) Code ____ (2702, 5506, 8810)

ACCIDENT AND INJURY

Describe in full how accident happened and GIVE CAUSE: Working under Euclid truck, while servicing it, got foreign body in ~~xxx~~ right eye.

Nature or extent of injury: foreign body (Cut - Fracture) Part of body injured? in right eye (Leg - Arm - Back - Head)

Names of witnesses to accident 1 ____ 2 ____

Date of accident: 9-21 19 72 Hour: 8:50 ~~A.M.~~ P.M. Was employee injured in course of employment? Yes ☒ No ☐

Place where accident occurred: our shop, 9 miles north of Libby (Address, City) Lincoln County

Did you or employee's supervisor have actual knowledge of accident? Yes ☒ No ☐

Were you notified of accident by injured employee? Yes ☒ No ☐ How: in person Date: 9-22-72

Have you reason to question this accident? Yes ☐ No ☒ If "yes" explain fully ____

SAFETY

Was employee's accident due to unsafe work practice? Yes ☐ No ☒ If "yes", what did he do unsafely? ____

Was a specific device, object or substance involved in accident? Yes ☐ No ☒ If "yes", name specific device, object or substance ____ Was device or object defective? Yes ☐ No ☐

Was employee doing regular work when injured? Yes ☒ No ☐ Was employee trained to do work he was doing when injured? Yes ☐ No ☐ Were adequate safeguards provided? Yes ☐ No ☐ If "yes", were they being used at the time of accident? Yes ☐ No ☐

MEDICAL ATTENTION

Name of attending physician: R. D. MacKenzie, M.D. Address: Libby, Montana

Was employee hospitalized? Yes ☐ No ☒ Name of hospital: St. Johns Emergency Room Address: Libby

Was first aid administered by someone other than attending physician? Yes ☐ No ☒

TIME AND WAGE LOSS

Will employee lose time from work due to accident? Yes ☐ No ☒ How long? ____ If injury results in time loss will employee, while disabled, received sick leave benefits? Yes ☐ No ☐ Paid vacation? Yes ☐ No ☐ Will employee lose wages? Yes ☐ No ☐ Room? Yes ☐ No ☐ Board? Yes ☐ No ☐

Date wage loss began: none Amount of weekly wage loss ____

EMPLOYER

Name of employer: Construction Products Division W. R. Grace & Co.

Address: Libby, Montana Nature of Business: Mining & Milling Vermiculite

IS FIRM A CORPORATION ☒ OR PARTNERSHIP ☐ OR INDIVIDUAL ☐

IF
- Corporation—is injured employee an officer or director of corporation? Yes ☐ No ☒
- Partnership—is injured employee related to any partner? Yes ☐ No ☐ Relationship ____
- Individual—is injured employee related to employer? Yes ☐ No ☐ Relationship ____

Signed, this 25th day of September, 19 72

at Libby, Montana

Employer's Name: Construction Products Division W. R. Grace & Co.

Signed by ____

Official Title ____

NOTICE—EMPLOYEE'S CLAIM FOR COMPENSATION, FORM 54, MUST BE FILED WITHIN 12 MONTHS FROM DATE OF ACCIDENT.

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