Form No. S.F.1 STANDARD FORM FOR

EMPLOYER'S FIRST REPORT OF INJURY

Approved by I. A. I. A. B. C.

☞ Complete and send immediately to
CLAIM DEPARTMENT

AMERICAN MUTUAL LIABILITY INSURANCE CO.
76 WESTMINSTER STREET
PROVIDENCE, RHODE ISLAND

State's Number For:	File: Carrier: Employer:
Carrier's File No.	

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

Office Providence, State R. I. ..... Acc. No. ..... Policy No. ..... Mo. and Year of Issue

Employer

1. **Name of Employer** Lonsdale Company, Berkeley Mill
2. Office address: No. and St. 50 So. Main City or Town Prov. State R.I.
3. **Insured by AMERICAN MUTUAL LIABILITY INSURANCE COMPANY**
4. Give nature of business (or article manufactured) Cotton Textiles

Time and Place

5. (a) Location of plant or place where accident occurred Berkeley Mill, Berkeley, R.I.
   Carding Department State if employer's premises Yes
   (b) If injured in a mine, did accident occur on surface, underground, shaft, drill or mill
6. **Date of Injury** May 1, 1942 Day of week Fri. Hour of day A. M. 2:00 P. M.
7. Date disability began May 1, 1942 A. M. 2:00 P. M. 8. Was injured paid in full for this day No
9. When did you or foreman first know of injury May 1, 1942
10. Name of foreman Frank Holden

Injured Person

11. **Name of Injured** Antonio (First Name) Luis (Middle Initial) (Last Name)
12. Address: No. and St. 35 McGirr St., City or Town Valley Falls, State R.I.
13. Check (V) Married x, Single ___, Widowed ___, Widower ___, Divorced ___; Male x, Female ___; White x, Colored ___
14. Nationality Portugese Speak English Yes
15. Age 45 Did you have on file employment certificate or permit
16. (a) Occupation when injured Comber Tender (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 1½ Mo. (b) Piece or time worker Piece (c) Wages per hour $ .4893
18. (a) No. hours worked per day 8 Hrs. (b) Wages per day $ 3.91
    (c) No. days worked per week 6 Days 48 Hrs. (d) Average weekly earnings $ 25.44
    (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 Comber 20. Kind of power, (hand, foot, electrical, steam, etc.) electrical 21. Part of machine on which accident occurred Lap roll
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 appliance or regulation
24. **Describe fully how accident occurred, and state what employee was doing when injured**
    The injured said he was cleaning a comber and caught his finger in the lap roll and top comb arm.
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)
    Cut second finger left hand.
27. Probable length of disability 1 Day 28. **Has injured returned to work** Yes
    If so, date and hour May 4, 1942 At what wage $ Same
29. At what occupation Comber Tender
30. (a) Name and address of physician Dr. Barned Lonsdale, R.I.
    (b) Name and address of hospital

Fatal Cases

31. **Has injured died** If so, give date of death

Date of this report May 4, 1942 Firm name Lonsdale Company, Berkeley Mill

Signed by [signature] Official Title Superintendent

Mo. and Year of Issue ..... Policy No. ..... Acc. No. ..... Office Providence, State R. I.

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Carrier's File No.	

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

Employer

1. **Name of Employer** Berkeley Mill, Lonsdale Company
2. Office address: No. and St. 50 So. Main St., City or Town Prov. State R.I.
3. **Insured by AMERICAN MUTUAL LIABILITY INSURANCE COMPANY**
4. Give nature of business (or article manufactured) Cotton Textiles

Time and Place

5. (a) Location of plant or place where accident occurred Berkeley, R.I.
   #2 Weave Department State if employer's premises Yes
   (b) If injured in a mine, did accident occur on surface, underground, shaft, drill or mill
6. **Date of Injury** April 22, 19 42 Day of week Wed. Hour of day A. M. 2:15 P. M.
7. Date disability began Apr. 22, 1942 A. M. P. M. 8. Was injured paid in full for this day Yes
9. When did you or foreman first know of injury April 22, 1942
10. Name of foreman Albert Maurer

Injured Person

11. **Name of Injured** Antonio (First Name) Lisi (Middle Initial) (Last Name)
12. Address: No. and St. 281 Langdon St., City or Town Providence, State R.I.
13. Check (V) Married X, Single ___, Widowed ___, Widower ___, Divorced ___; Male X, Female ___; White X, Colored ___
14. Nationality Italian Speak English Yes
15. Age 45 Did you have on file employment certificate or permit
16. (a) Occupation when injured Loom Fixer (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 7 Yrs. (b) Piece or time worker Time (c) Wages per hour $ .9784
18. (a) No. hours worked per day 8 Hrs. (b) Wages per day $ 7.83
    (c) No. days worked per week 6 Days-46 Hrs. (d) Average weekly earnings $ 47.94
    (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 appliance or regulation
24. **Describe fully how accident occurred, and state what employee was doing when injured**
    Cut finger on loom.
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)
    Cut fourth finger of left hand.
27. Probable length of disability 28. **Has injured returned to work**
    If so, date and hour At what wage $
29. At what occupation
30. (a) Name and address of physician Dr. Curreri, 825 Charles St., Prov. R.I.
    (b) Name and address of hospital

Fatal Cases

31. **Has injured died** If so, give date of death

Date of this report April 24, 1942 Firm name Lonsdale Co. Berkeley Mill

Signed by D. Burk Official Title Superintendent.

Office Providence, State R. I. ..... Acc. No. ..... Policy No. ..... Mo. and Year of Issue

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Office Providence, State R. I. ..... Acc. No. ..... Policy No. ..... Mo. and Year of Issue

Employer

1. **Name of Employer** Lonsdale Company Berkeley Mill
2. Office address: No. and St. 80 South Main Street City or Town Prov. State R. I.
3. **Insured by AMERICAN MUTUAL LIABILITY INSURANCE COMPANY**
4. Give nature of business (or article manufactured) Cotton Textiles

Time and Place

5. (a) Location of plant or place where accident occurred Berkeley Mill, Berkeley, R.I.
   Spinning Department State if employer's premises Yes
   (b) If injured in a mine, did accident occur on surface, underground, shaft, drill or mill
6. **Date of Injury** 4/16/42 **19** Day of week Thurs. Hour of day A. M. 8:30 P. M.
7. Date disability began 4/16/42 19 A. M. 8:30 P. M. 8. Was injured paid in full for this day
9. When did you or foreman first know of injury Immediately
10. Name of foreman Charles Fuel

Injured Person

11. **Name of Injured** Rosanna (First Name) Laroque (Middle Initial) (Last Name)
12. Address: No. and St. 37 High Street City or Town Central Falls State R.I.
13. Check (V) Married ___, Single ___, Widowed ___, Widower ___, Divorced X; Male ___, Female X; White X, Colored ___
14. Nationality French Speak English Yes
15. Age 44 Did you have on file employment certificate or permit
16. (a) Occupation when injured Twister Tender (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 1 year (b) Piece or time worker Piece (c) Wages per hour $ .5077
18. (a) No. hours worked per day 8 Hrs. (b) Wages per day $ 4.06
    (c) No. days worked per week 6 Days (d) Average weekly earnings $ 24.88
    (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 Fall 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 appliance or regulation
24. **Describe fully how accident occurred, and state what employee was doing when injured** Employee says that she was unexpectedly startled when another employee passed by. She jumped back banging her left elbow on the wall.
25. Names and addresses of witnesses Beatrice Podgurski

Nature of Injury

26. Nature and location of injury (describe fully exact location of amputations or fractures, right or left) Hurt left elbow
27. Probable length of disability 3 Days 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. Albert Barnes, Broad St., Lonsdale, R.I.
    (b) Name and address of hospital

Fatal Cases

31. **Has injured died** If so, give date of death

Date of this report 4/17/42 Firm name Lonsdale Company, Berkeley Mill

Signed by R. Fuel Official Title

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Employer

1. **Name of Employer** Lonsdale Company Berkeley Mill
2. Office address: No. and St. 50 So. Main St., City or Town Prov. State R.I.
3. **Insured by AMERICAN MUTUAL LIABILITY INSURANCE COMPANY**
4. Give nature of business (or article manufactured) Cotton Textiles

Time and Place

5. (a) Location of plant or place where accident occurred Berkeley, R.I.
   Carding Department State if employer's premises Yes
   (b) If injured in a mine, did accident occur on surface, underground, shaft, drill or mill
6. **Date of Injury** January 13, 1942 Day of week Tues. Hour of day 2:30 A. M. P. M.
7. Date disability began Jan. 13, 42 19 A. M 10:30 P. M. 8. Was injured paid in full for this day No
9. When did you or foreman first know of injury Frank Holden Immediately
10. Name of foreman Frank Holden

Injured Person

11. **Name of Injured** Walenty (First Name) Mroz (Middle Initial) (Last Name)
12. Address: No. and St. 445 High Street, City or Town Central Falls State R.I.
13. Check (V) Married x, Single ..., Widowed ..., Widower ..., Divorced ...; Male x, Female ...; White x, Colored ...
14. Nationality Polish Speak English Yes
15. Age 52 Did you have on file employment certificate or permit
16. (a) Occupation when injured Ribbon Tender (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 4 Mo. (b) Piece or time worker Piece (c) Wages per hour $ .3750
18. (a) No. hours worked per day 8 Hrs. (b) Wages per day $ 3.00
    (c) No. days worked per week 6 Days (d) Average weekly earnings $ 19.50
    (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 Doubler 20. Kind of power, (hand, foot, electrical, steam, etc.) electrical 21. Part of machine on which accident occurred Spool
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 appliance or regulation
24. **Describe fully how accident occurred, and state what employee was doing when injured**
    Injured claims he was doffing a doubler and dropped a spool on his finger.
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)
    Hurt lfirst finger left hand
27. Probable length of disability 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. Barnes, Broad St. Lonsdale, R.I.
    (b) Name and address of hospital

Fatal Cases

31. **Has injured died** If so, give date of death

Date of this report January 20, 1942 Firm name Lonsdale Company Berkeley Mill

Signed by R. Hunt Official Title Superintendent

Mo. and Year of Issue ..... Policy No. ..... Acc. No. ..... Office Providence, State R. I.

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Carrier's File No.	

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Office Providence, State R. I. ..... Acc. No. ..... Policy No. ..... Mo. and Year of Issue

Employer

1. **Name of Employer** Lonsdale Company, Berkeley Mill
2. Office address: No. and St. 50 So. Main St., City or Town Prov. State R.I.
3. **Insured by AMERICAN MUTUAL LIABILITY INSURANCE COMPANY**
4. Give nature of business (or article manufactured) Cotton Textiles

Time and Place

5. (a) Location of plant or place where accident occurred Berkeley, R.I.
   Carding Department State if employer's premises Yes
   (b) If injured in a mine, did accident occur on surface, underground, shaft, drill or mill
6. **Date of Injury** April 30, **1942** Day of week Thurs Hour of day 7:30 A. M. P. M.
7. Date disability began May 2, 1942- 8:30 A. M. P. M. 8. Was injured paid in full for this day
9. When did you or foreman first know of injury May 1, 1942
10. Name of foreman Frank Holden

Injured Person

11. **Name of Injured** Marie (First Name) O'Neil (Middle Initial) (Last Name)
12. Address: No. and St. 99 Victory Street, City or Town Berkeley, State R.I.
13. Check (V) Married X, Single ..., Widowed ..., Widower ..., Divorced ...; Male ..., Female X; White X, Colored ...
14. Nationality Canadian Speak English Yes
15. Age 39 Did you have on file employment certificate or permit
16. (a) Occupation when injured Jack Tender (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 Yrs. (b) Piece or time worker Piece (c) Wages per hour $ .5658
18. (a) No. hours worked per day 8 Hrs. (b) Wages per day $ 4.53
    (c) No. days worked per week 6 Days(48 Hrs) (d) Average weekly earnings $ 29.42
    (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 Jack Speeder 20. Kind of power, (hand, foot, electrical, steam, etc.) electrical 21. Part of machine on which accident occurred Bobbin Gear Pin
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 appliance or regulation
24. **Describe fully how accident occurred, and state what employee was doing when injured**
    The injured said she was cleaning the spindles on th doff and cut her thumb on the bobbin gear pin.
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)
    Cut on left thumb.
27. Probable length of disability 28. **Has injured returned to work**
    If so, date and hour At what wage $
29. At what occupation
30. (a) Name and address of physician Dr. Hanley, Pawtucket, R.I.
    (b) Name and address of hospital

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31. **Has injured died** If so, give date of death

Date of this report May 12, 1942 Firm name Lonsdale Company, Berkeley Mill

Signed by A. Reed Official Title Superintendent.

Mo. and Year of Issue ..... Policy No. ..... Acc. No. ..... Office Providence, State R. I.