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ORGANIZATION OF THE HEALTH PROGRAM OF A UNIVERSITY

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Just as in the whole field of education, so in the special field of health education, there has been in recent years a marked change in the objectives. Health has been redefined as "the quality of life that renders the individual fit to live most and to serve best," [1] and the aims of health education in the primary and secondary schools have been stated in the following terms: [2]

1. To instruct children and youth so that they may conserve and improve their own health.
2. To establish in them the habits and principles of living which, throughout their school life and in later years, will assure that abundant vigor and vitality which provide the basis for the greatest possible happiness and service in personal, family, and community life.
3. To influence parents and other adults, through the health education program for children, to better habits and attitudes, so that the school may become an effective agency for the promotion of the social aspects of health education in the family and community as well as in the school itself.
4. To improve the individual and community life of the future; to insure a better second generation, and a still better third generation, a healthier and fitter nation and race.

A health-educational program is in operation in most of our urban schools, and even at this early date results are becoming quite evident.[3] The next step in the development of the health-educational program is undoubtedly to be taken in the colleges and universities of the country. A preliminary survey of existing conditions has already been made and is shortly to be published,[4] and on the basis of those facts a comprehensive program is to be launched. The urgent question of the next few years in our college and university health circles is to be: How can we best organize our institution for health purposes? As a contribution to the solution of that trying problem I am herewith presenting suggestions based largely on Cornell University's experience in the field of health education.

[1] J. F. Williams: Personal Hygiene Applied. W. B. Saunders, Philadelphia, 1922.
[2] Report of Joint Committee on Health Problems in Education. By T. D. Wood, New York City, 1924.
[3] For the last 3 years each entering class at Cornell University has shown progressively fewer physical defects and faulty health habits than the preceding class.
[4] Report of President's Committee of Fifty on College Hygiene. By Thomas A. Storey, College of the City of New York, New York City.

I. AN ANALYSIS OF THE HEALTH NEEDS OF THE AVERAGE COLLEGE STUDENT

1. Healthful living conditions.
   - Good food at reasonable prices.
   - Sanitary water and milk supply.
   - Clean dining rooms and food handlers.
   - Healthful study rooms and classrooms.
2. Adequate health service.
   - Health advice.
   - Infirmary services.
   - Medical examination service and laboratory service.
   - Communicable-disease control.
3. Well-adjusted activities.
   - Congenial studies.
   - Suitable physical exercise.
   - Wholesome recreation and sociability.
   - Thoughtful religious study and discussion.
4. Effective health instruction.
   - General biology.
   - Human anatomy.
   - Human physiology.
   - General bacteriology.
   - Personal hygiene.
   - Sanitation.
   - Public health.

II. RESPONSIBILITIES OF VARIOUS DEPARTMENTS FOR MEETING THE HEALTH NEEDS OF THE STUDENT

The health needs of the student are found to involve not only the university health service but the department of physical education, the departments of biology, bacteriology, anatomy, physiology, sanitary chemistry, dairy industry, sanitary engineering, the department of administration, the University Christian Association, the University Union or Social Center, and the various college orientation courses. And if we consider the ramification of one small part of the field of hygiene, i. e., sex hygiene, we find the following possibilities suggested by the American Social Hygiene Association and the Interfraternity Council:[5]

> Sex and reproduction and their impulses and implications are not, as we have allowed ourselves to conceive them, isolated and distinct phases of life. They are normal and integral parts of complete life, and furthermore, they irradiate into and profoundly modify all the rest of life that is worth while. For these reasons the educational treatment of these factors should not be unnecessarily

[5] An appeal for the greatest personal and social health for students. Report of the Committee on Social Hygiene of the Interfraternity Conference, 120 Broadway, New York City, 1922.

separate from other phases of education, but wherever possible should be imbedded quite naturally and for the most part inconspicuously in all the physical, intellectual, emotional, esthetic, social, and moral education and training the youth receives.

For similar reasons sex education should not be partial—that is, exclusively physical or emotional or religious—but it should represent a fair synthesis of all the interests and points of view which contribute vitally to ideas, motives, and conduct in respect to sex. This synthesis must include the facts of the underlying sciences, as biology, physiology, psychology, hygiene, and pathology, and, no less, the idealism of the esthetic, social, and religious cultures, and equally the practical training and inspiration of everyday conduct and relations. A sound or workable philosophy and practice of sex life can not be had if it ignores any one of these aspects.

As a corollary of the above, the general program of the effective educational institution must be on an adequate hygienic basis throughout—in administration, in curriculum, in "activities," and in its social life.

Apparently, then, the health-educational responsibilities are widespread throughout the departments of the university.

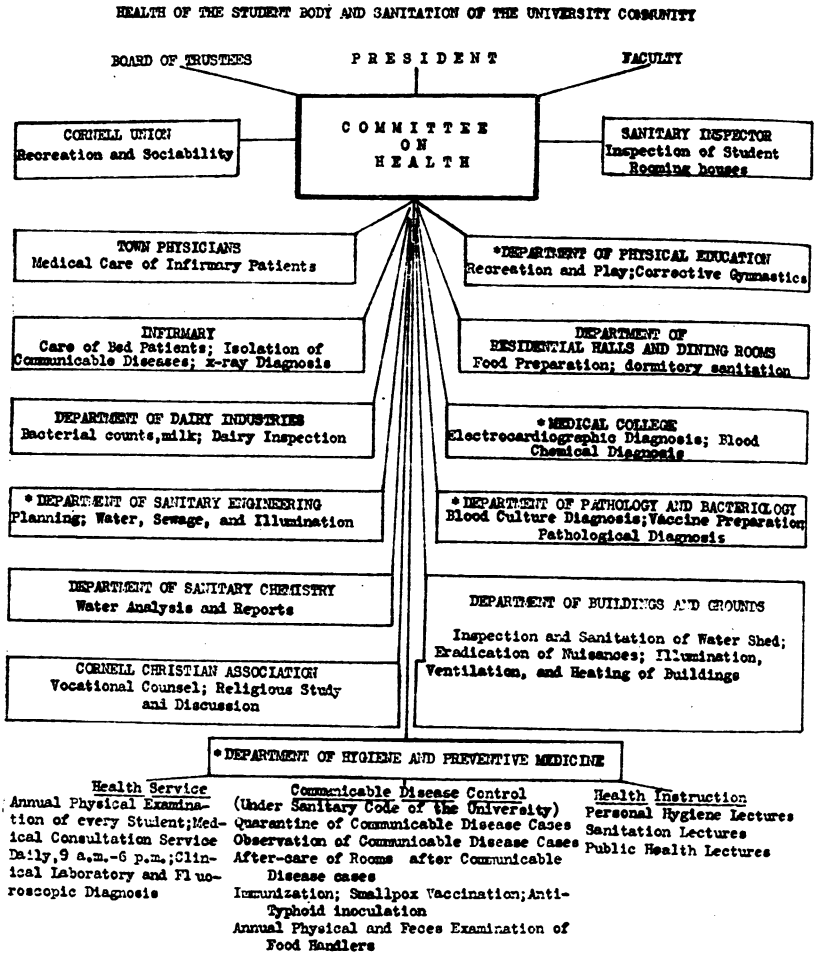
III. THE ORGANIZATION OF THE UNIVERSITY TO MEET ITS HEALTH EDUCATIONAL RESPONSIBILITIES

In the recent beginnings of health education in the universities of the country we have had examples of health education combined with physiology,[6] with biology, with physical education,[7] with bacteriology—largely as a matter of expediency and for the purpose of utilizing for the new health work the preexisting machinery most suited to the task. In many instances the scheme has been so effective as to result in a permanent organization. In some quarters, however, the organization problem has been attacked from the opposite point of view; an attempt has been made to magnify the health interests and centralize under one head all of the health educational activities. Thus we have departments of student health representing the combined fields of health service, hygiene teaching, environmental sanitation, physical education, and intercollegiate athletics.[8] But even in the most pretentious departments of health there are some of the student's health needs still to be ministered to outside the realm of that department, and this raises the general question of whether it is worth while disrupting any of the old schemes of organization and subordinating any of the older departments for the purpose of attempting the impossible, i. e., having *all* of the health educational work centralized under one head in a university department of health.

When the opportunity for health educational expansion came, through the Interdepartmental Social Hygiene Board support at Cornell in 1919, it seemed wiser to charge one department, that of

[6] Vassar.
[7] Princeton, McGill, Smith, Rochester.
[8] University of Michigan, Stanford University.

the medical adviser (which had been responsible for physical examinations, health advice, and communicable disease control since 1911), with the added responsibility of hygiene instruction,[9] and then seek the cooperation of related departments through the organization of a faculty committee on health and a faculty committee on instruction in hygiene and preventive medicine, rather than through the actual consolidation of departments.

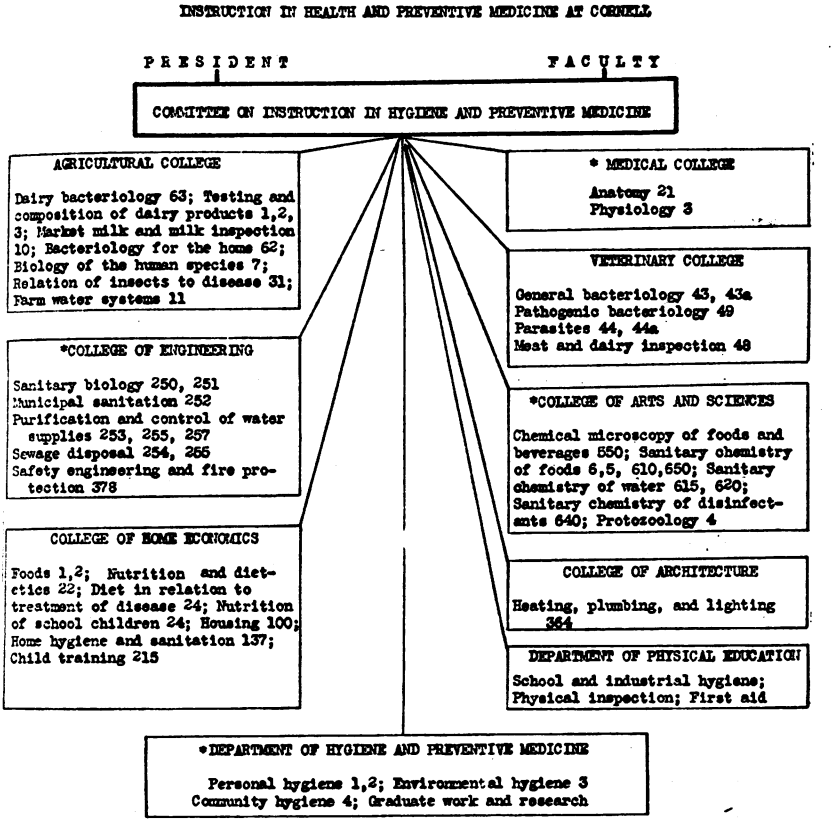


IV. THE CORRELATION OF VARIOUS DEPARTMENTS FOR HEALTH EDUCATION

Under this scheme the president of the university appoints each year from the various departments related to health five members of the committee on health, which committee constitutes the central

[9] Though this was first done in 1919, hygiene had been taught at Cornell either in the department of zoology or in the department of physical education since the founding of the university in 1868.

authority in health matters and acts on all questions of policy in health affairs.[10] This insures that the various departments represented on the committee become conversant with the health problems facing the whole university. It also insures to the university the advantage of the consensus of opinion on important health questions of the departments concerned. The executive officer of this committee is the university health officer, in whom is vested the committee's authority for the purpose of administering the university



*Department or college represented on Committee on Instruction in Hygiene and Preventive Medicine

sanitary code. The chart on page 2634 shows the scheme for correlation of health activities through this committee.

The committee on instruction in hygiene and preventive medicine is composed of four faculty members appointed by the president from departments related, always, however, including the dean of the university faculty. This insures faculty interest and cooperation in health education throughout the university without any reorgan-

[10] This faculty committee is usually identical with the trustee's committee on health, and it therefore carries the authority of the faculty and board of trustees.

ization or subordination of departments already existing. It also administers the university requirement for four terms of hygiene instruction for each student. The scheme for correlation through this committee is shown in the chart on page 2635.

Under such a system the health educational work of a university can be markedly developed and expanded; each aspect of the work, however, being developed in the department peculiarly adapted to that purpose, and the department of health itself remaining free from any suspicion of being desirous of dominating other fields, such as physiology, bacteriology, physical education, or organized athletics, with the health interest. To be sure it is extremely important that the health interest be developed and stressed in the work of these related departments, but it is not entirely clear that in such departments health interests should supersede vocational or scientific investigative interests, or that health values should be more sought in physical education and athletics than such moral values as courage, fairness, etc.

V. THE DEVELOPMENT OF THE HEALTH EDUCATIONAL PROGRAM IN THE CORNELL UNIVERSITY DEPARTMENT OF HEALTH

The development of the health educational program in the university department of health we have found at Cornell to be almost entirely a job for physicians, not nurses—for young physicians, not retired practitioners—for physicians interested in health education and preventive medicine rather than specialists or those interested primarily in therapy. We have found that full-time physicians are preferable to part time, that men physicians are preferable for men and women physicians for women, that regular professorial ratings in terms of instructorships, assistant professorships, and professorships are preferable to other ratings, and that a schedule permitting each man to distribute his energy over the five fields of physical examination, medical consultation, communicable-disease control, instruction in hygiene and preventive medicine, and research, was preferable to directing his energy to any one field alone. Our salary range for graduate physicians has been from $2,250 to $4,000 per nine-month school year, and there is no doubt that this level will have to be raised if we are going to continue to attract and hold the type of worker demanded. The hours of routine work have been six a day, leaving some time for research work or special follow-up work on the cases found in our examinations. On this basis we have found that we need at least one physician to every 500 students; and if the mental hygiene problems of the student body are to receive adequate attention, the proportion of doctors must of necessity in the future be considerably increased.

The work of the department of hygiene can be conveniently divided and described under the five headings—health examination, medical consultation, communicable-disease control, health education, research.

Health examinations.—Every undergraduate and every entering graduate student is required to have an annual physical examination. The examination which we have adopted as our standard procedure takes about 40 minutes for entering students and 30 minutes for old students, and is completed entirely, with the exception of the urine examination, by one physician. For statistical accuracy the group method of examination is far preferable, but we have found that an examination has much more health value if the history, record of health habits, and physical findings are all at once in the mind of the examiner and he is able to devote his entire attention to the health problems of that one individual for half an hour and attempt to convince him of the importance of rectifying the remediable defects or faulty health habits found. With such a system we, of course, make no attempt to complete our examinations during one period in the fall, but simply schedule our examinations one per office hour per doctor right through the year and thus complete the examination of the 4,800 undergraduates and entering graduates between the 1st of October and the 1st of June. The appointments for these examinations are made at the beginning of the first term by all entering students and sophomores, at the beginning of the second term by all juniors and seniors. Athletes are examined first of all and given their athletic number or rejected from athletics early in the fall. No athlete is permitted to represent the university on an athletic team without having qualified for and procured an athletic number from the medical adviser's office. Recruits for the university reserve officers' training corps are accepted or rejected according to Army regulations at the time of their regularly appointed health examination. We therefore duplicate no examinations and give no special examinations of any kind—our only examination being our regular annual physical examination.

This plan is open to the objection that an entering student might go on undetected until almost midyear with communicable disease, but as a matter of fact we are more troubled by the acute infectious diseases occurring after Christmas and Easter vacations than by those occurring after the summer vacation, and it is questionable whether it would ever be worth while to examine the whole student body for communicable disease immediately after each vacation or to rush the examination of all students in the fall in order to pick up a little earlier the occasional case of tuberculosis or syphilis present in the entering class. A full-time force also demands a full-time examining schedule.

Inspection of the examination and history forms as found below (the forms for women students differ slightly) reveals certain inadequacies in the routine examination made necessary by the short time provided for examination; but provision can usually be made for a rectal, blood, eye ground or fluoroscopic examination if the history or physical findings indicate the necessity of such special examination. Serious organic disorders like chronic cardiac valvular disease, nephritis, or tuberculosis are found in a very small number of students—rarely more than 2 per cent; the majority of our findings are defects in posture, defects in vision, nasal obstruction, acne, malnutrition, infected tonsils, faulty habits of sleep, exercise, use of stimulants, etc. Our entering students have averaged 2½ of these remediable defects or faulty health habits per student for the past five years (though each succeeding entering class appears to have remedied slightly more of its defects before college entrance, and the urban group appear to have remedied their defects somewhat more than the rural group).[11]

Follow-up studies on the 150 to 200 albuminuria cases, 60 to 100 glycosuria cases, 50 to 100 chronic chest cases, etc., are made by calling in the student at intervals by letter. Among these cases we rarely find more than 2 actual cases of nephritis, 2 cases of true diabetes, 25 cases of definite tuberculosis (out of which, perhaps, 3 to 5 are active and forced to leave school and seek sanitarium treatment), and 50 actual cases of chronic cardiac valvular disease.

In our physical examinations we plan on devoting about two-thirds of our time to detecting defects and faulty health habits and one-third to convincing the student as to the necessity of remedying the condition found; thus one-third of the physical examination time is devoted to pointed personal health instruction. This also gives an opportunity for discussion of sex-hygiene topics, though we raise this question ourselves only in the examination of freshmen. The encouraging fact in this whole field is that more than 94 per cent of the abnormal conditions found can be remedied or improved.

Medical consultation service.—We have found that, in health as well as in other fields, "a stitch in time saves nine." Our medical offices are open daily from 9 a. m. to 6 p. m., not to set fractures, nor to refract eyes, nor to give time-consuming treatments, but to give medical advice for any physical condition deviating even ever so slightly from the normal. This advice may be in the form of a suggestion that a specialist be consulted, or that diet or habits of life be somewhat altered, or that certain lines of simple medication be followed, or that the student go to the infirmary for bed care; but in each consultation the final consideration is, How can we

[11] D. F. Smiley: Health Inventory of Rural and Urban Students. The Nation's Health, Vol. VIII, No. 1, January, 1926.

prevent a recurrence of the disabling condition? That this service is appreciated is evidenced by the fact that we carry on about 25,000 of these voluntary consultations per year, an average of 5 for each student in the university. Of these consultations, about 4,000 are for "colds" or their complications, about 750 for digestive disorder, about 650 for eyestrain, about 550 for indefinite headache or fatigue, about 250 for constipation, about 250 for furuncle, about 250 for dysmenorrhea; no other illness provides more than 200 cases a year. The fact that such large numbers of cases of digestive disorder, eyestrain, constipation, and furuncle occur year by year is a challenge to our health educative forces; the fact that "colds" and dysmenorrhea are still so common is a challenge to our health research forces.

The free use of the university infirmary in the case of any student needing bed care is one of the most valuable preventive factors in our health program. It is simply assumed that, since each student has paid his $5 infirmary fee each term, he is entitled to infirmary care whenever he is sick enough to be in bed. The only check needed against abuse of the privilege of infirmary care is the provision that, while there, each student must be under the daily care of his private physician, whom he chooses from the practicing physicians of the city. The efficacy of this system is to some degree attested by the fact that, of the 658 cases of influenza occurring during the past month of March, practically all were seen early, put to bed immediately in the infirmary, and permitted to leave only when they were safely convalescent. This meant sometimes caring for 140 to 150 patients a day in the infirmary; but it unquestionably aided in keeping the complications with pneumonia down to six cases—a figure less than 1 per cent of the total influenza cases.

Recommendations for excuse from class because of illness are recognized by the various college administrative offices only as they come from the medical adviser's office. Recommendations from town physicians and out of town physicians are brought to the medical adviser's office and filed and official recommendations issued. No official recommendation for excuse from classes is issued by the medical advisers at a period later than 48 hours after the resumption of classes, and no recommendation is made unless the student presents definite signs of illness or a certificate of illness from a physician. Thus we maintain a fairly complete morbidity record for the student body and prevent students from staying at home ill and returning to classes while still infectious. During the past year 1.28 per cent of the 4,570,533 school hours available to the 4,897 undergraduate students was lost as the result of illness. The lost time of instruction hours among the 1,173 women students was 1.8 per cent, and among the 3,724 men students was 1.1 per cent.

Communicable disease control.—The control of communicable disease in a college community is somewhat simpler than in a primary or secondary school because of the larger number of immunes. As a rule, for instance, we find that 90 per cent of our entering students have had measles and about 50 per cent have had mumps, whooping cough, and chickenpox. Therefore, in the construction of our university sanitary code we felt it safe to waive isolation of all contacts and substituted instead (in the case of the nonimmunes) a system of observation at the medical adviser's office at one or two day intervals throughout the incubation period of the disease in question. Immediate isolation of the patient in the contagious ward of the infirmary for a period extending from a week in case of measles to a month in scarlet fever is of course demanded. A satisfactory certificate of vaccination against smallpox is a requirement for matriculation. Such a certificate is deemed satisfactory only as it records a positive reaction (vaccinia, vaccinoid, or immune reaction) within five years, or three unsuccessful attempts within the same period. Tuberculosis cases showing tubercle bacilli in the sputum are not permitted to attend classes unless they furnish the medical adviser (who is also the university health officer) with satisfactory evidence that their care of secretions and their mode of life are such as to preclude danger of spread to others. Cases of gonorrhea (rarely more than eight a year) are not permitted to attend classes until treatment has been instituted and until they have a permit to return from the medical adviser. Cases of syphilis (rarely more than three to five a year) are not permitted to attend classes until treatment has been instituted and there are no open lesions on skin or mucous membrane and until they have a permit to return from the medical adviser.

Synopses of this code are posted in all university buildings and dormitories and distributed to the various fraternities and rooming houses, and cordial cooperation of the student body is the general rule. As a result, we rarely see more than 40 cases a year of any one of these reportable diseases, though each year we expect an outcropping of one or several of these diseases after the Easter and Christmas recesses. The amount of time put into this system of control by the medical staff is rather large; we often call in and observe 700 to 800 contacts of various diseases in the course of the year. But among that group of contacts we will usually detect 10 to 20 secondary cases, and we therefore feel that the time spent in observing contacts is well spent, provided the contacts are carefully selected.

Though this system never entirely prevents the occurrence of these infectious diseases of childhood, it enables us (judging by the experience of the past six years) to keep them in hand, the number of cases rarely exceeding 75 a year. In regard to influenza, "colds," and conjunctivitis, however, we feel very much less optimistic.

Health instruction.—Just what a college student should know about health is a question which, Dr. Livingston Farrand, president of the university, attempted to summarize in the following terms: [12]

1. He should have a knowledge of the physiological basis for sound health habits, such as regular and sufficient hours of sleep, right posture, suitable exercise, and proper elimination.

2. He should know the types, amounts, and proportions of the various food elements essential to the proper nurture of his body.

3. He should have an acquaintance with the principles of normal mental action and the conditions underlying the more common variations from normal state of mind.

4. He should have a general understanding of the sex instinct—its stages of development, its normal expression, and the values and penalties attaching to it.

5. He should have a knowledge of the factors determining infection and resistance and the principles of artificial immunization in the case of certain of the common infectious diseases.

6. He should have enough knowledge of the causes and prevention of the degenerative diseases to offer a prospect of passing through middle life without a breakdown.

7. He should know, and therefore be armed against, health hazards lurking in the environment, such as polluted water and milk supply, congestion in housing, poisonous dusts of certain industries, infected soil, etc.

8. He should appreciate the necessity for frequent medical and dental examination.

9. He should have an intelligent basis for choosing wisely his medical and dental advisers, and for realizing that the modern practice of medicine is grounded on science and not on mystery, fancy, and tradition.

10. He should have a knowledge of the important health problems facing the community, of the methods of attacking those problems, and of the results to be expected from intelligent community action in the public health field.

Cornell, at its founding in 1868, required a 30-lecture course in hygiene for every student in his first year. This requirement continued until 1904, when it was abolished and a course in hygiene was offered but not required. This scheme continued until the fall of 1919, when hygiene again became a required subject, this time a 60-lecture course. These lectures are given by the physicians of the medical adviser's office to the freshmen and sophomore class divided into groups averaging 135 members each and meeting once a week. The lectures are 50 minutes in length and are supplemented by considerable demonstration material and by charts. A notebook and a

[12] Report of meeting of American Public Health Association, Atlantic City, May 18, 1926, New York Times, May 19, 1926.

preliminary examination are required each of the four terms. The final examination is waived where the term's average in notebook, preliminary examination, and attendance is 85 per cent or better. The "hygiene requirement" is administered by the dean of the university faculty and the Faculty Committee on Instruction in Hygiene and Preventive Medicine. No credit is given, but the satisfactory completion of four terms' work in hygiene is a university requirement for graduation. Following is the schedule of lecture topics of the past year (1925–26):[13]

OUTLINE OF LECTURE SCHEDULE

HYGIENE I—PERSONAL HYGIENE

1. The health program at Cornell University—Factors that influence health.
2. Bacteria and disease—The development of the germ theory.
3. Infection and resistance.
4. Immunity.
5. The hygiene of the nose and throat—Nasal obstruction; tonsils and adenoids; ear trouble.
7. "Colds"—Are they preventable?
8. The personal prevention of tuberculosis.
9. The preventable causes of mental disease.
10. The causes and prevention of nervousness.
11. The importance of positive health to the individual and to the community.
12. The structure and physiology of the genital system.
13. The mechanism of reproduction—The development of the sex instinct—Hygiene of sex.
14. The venereal diseases.

HYGIENE II—PERSONAL HYGIENE

1. Foods—Types and amounts needed.
2. The mechanism of digestion, absorption, storage, and utilization—The prevention of indigestion and constipation.
3. The hygiene of vision.
4. The functions and care of the skin.
5. The hygiene of growth.
6. Teeth and their care.
7. Posture and health.
8. The hygiene of the circulatory system and kidneys.
9. The muscles and exercise—The benefits of exercise.
10. Safeguarding athletics—Exercise facilities at Cornell.
11. Heredity and health.
12. The emergency treatment of unconsciousness—Artificial respiration.
13. The emergency treatment of wounds.
14. Why an annual physical examination?—Results of examination of freshman class.

HYGIENE III—HYGIENE OF ENVIRONMENT

1. Man the most frequent source of infection for man—Epidemiology—Carriers.
2. Animals as sources of infection for man.
3. Air and disease—Climate and disease.
4. Ventilation.

[13] The sex-hygiene content of these lectures has been published in Health Education Program, Cornell University, by D. F. Smiley: Social Pathology, Vol. 1, No. 5. United States Public Health Service.

5. Soil and disease.
6. Water and disease.
7. The provision of a safe water supply.
8. Sanitary housing—Sanitary disposal of wastes.
9. Food deficiencies, poisons, infections, adulterations.
10. Milk and meat—Their proper production and handling.
11. Alcohol, tobacco, coffee, and the narcotic drugs.
12. Nostrums and quackery.
13. Insects and disease.
14. Occupational health hazards.

HYGIENE IV—PUBLIC HEALTH

1. The development of public health and preventive medicine.
2. Community problems in mental hygiene—Mental disease, mental deficiency, delinquency, drug addiction.
3. Community problems in sex hygiene—Venereal disease, illegitimacy, prostitution, divorce.
4. Tuberculosis and the community.
5. The problem of the diseases of middle life—The degenerative diseases and cancer.
6. The community's interest in maternity and infancy.
7. Safeguarding the health of school children.
8. The health of the industrial workers.
9. Military hygiene.
10. The place of the voluntary health organizations in public health work.
11. Official health agencies.
12. Physicians versus quacks—The problem of providing good medical care.
13. Nurses and hospitals—The problem of providing good hospital and nursing service.
14. The cost versus the results of public health work.

Research.—Some of the most striking opportunities for research, peculiar to the field of health education in colleges and universities, are, we believe, along the following lines, though the numerous possibilities make choice difficult: Statistical study of morbidity rates for such minor disorders as "colds" and "grippe"; study of the effects of exercise upon the heart, kidneys, and blood vessels; study of albuminuria and glycosuria to determine type and cause; statistical study of afterlife of persons showing minor abnormalities such as slight hypertension or albuminuria or glycosuria or recurrent jaundice while in college; statistical study by questionnaire method to determine what constitutes the normal condition in regard to frequency of bowel movement, frequency of headaches, frequency of vomiting attacks, and any possible relationship to health habits; study of the results of vaccine therapy in cases of recurrent "colds," acne, furunculosis; study of the results of desensitizing treatment for hay fever; statistical study of the results of health educational work in the university.

Along all these lines we have been working and have attained some rather encouraging results. We hope that time will bring forth results in greater measure; but even in the absence of remarkable

findings the stimulation which accompanies research is a factor to be reckoned with throughout all the work of the department. A university department of health which does not provide time and incentive and some facilities for research can not hope, we believe, to maintain a high standard either of work or of workers.

VI. MEASURING THE RESULTS OF THE HEALTH EDUCATIONAL PROGRAM

Most of the results of a health educational program are not measurable; most of the results are to be seen in the future rather than in the present. Yet measurable results of our work are continuously being sought, and, after a fashion, we can begin to estimate roughly our successes and failures.

In 1919–20 Dr. Haven Emerson [14] found that, at Cornell University, 1.6 per cent of the school days available to the student body during the year were lost as the result of illness, 2.4 per cent being lost by the women, and 1.5 per cent being lost by the men. During the past year (1925–26), and in spite of a heavy March influenza epidemic, the undergraduate student body lost only 1.28 per cent of the school days available, the women 1.8 per cent, the men 1.1 per cent. We believe that Cornell students are losing less school time as the result of illness than they did five years ago.

Another method of measuring our results is to be tried during the coming year, 1926–27. Using the table of defects and faulty health habits appended, we will mark each student at the time of the annual physical examination, deducting 5 per cent for every faulty health habit and every remediable defect found and marking on the basis of 100 per cent. We will thus rate each individual upon his health upkeep, and not penalize him for his health inheritance, or irremediable health deficit. An average health upkeep rating of about 85 per cent is what we think we have in our present entering class; an average health upkeep rating of 100 per cent is what we can aim to get in that same class at graduation. Certain it is that if health knowledge *can* prevent disease and foster health it ought to do so to a measurable degree in a period of four years among a group of college students.

HEALTH UPKEEP GRADING TABLE [15]

Each group is valued at 5 per cent. Even 1 defect in a group subtracts the 5 per cent of the whole group.

1. *Nutrition:*
   - More than 10 per cent underweight.
   - More than 10 per cent overweight.
2. *Posture:*
   - C or D grade of postural abnormality—
     - Stoop neck.
     - Round hollow back.
     - Drop shoulder.

[14] Education in Health at Cornell University. By Haven Emerson et al. American Journal of Public Health, April, 1921.

[15] Slight modifications have been made in this table to adapt it to use for the women students.

3. *Vaccination:*
   No vaccination mark and no history of smallpox.
4. *Eyes:*
   Vision 20/24 or less and not properly corrected by glasses.
   Vision 20/13 or more and not properly corrected by glasses.
5. *Ears:*
   Discharging ear, not under treatment.
   Impacted cerumen plugging entire canal.
   Deafness, uninvestigated by specialist.
6. *Nose:*
   Defects causing symptoms, yet uninvestigated by specialist.
7. *Sinuses:*
   Chronic sinus infection, not under treatment.
8. *Teeth:*
   Uncorrected dental caries.
   Abscessed teeth.
   Marked tartar deposit.
   Dead tooth not examined by X ray within two years.
   Pyorrhea, not under treatment.
9. *Tonsils:*
   Tonsils judged chronically infected from history and appearance.
10. *Hernia.*
11. *Veins:*
   Hemorrhoids or varicose veins (operable).
12. *Genitals:*
   Phimosis.
   Large varicocele threatening atrophy of testes or causing pain.
   Hydrocele.
13. *Feet:*
   Improper posture of feet, grade C or D.
14. *Stimulants:*
   Using more than—10 cigarettes a day, or
   5 pipefuls a day, or
   2 cigars a day, or
   2 cups of coffee a day, or
   2 cups of tea a day.
15. *Bathing:*
   Bathing less than twice a week.
16. *Eating habits:*
   Indigestion and hurried meals.
   Indigestion and eating irregularly.
   Indigestion and improper diet.
17. *Evacuation habits:*
   Bowels constipated, and not given chance to move at regular time at least once a day.
18. *Exercise habits:*
   Exercising less than—
   One hour a day walking.
   Two hours a week vigorous exercise.
19. *Sleep habits:*
   Less than 8 hours sleep, with fatigue symptoms.
20. *Recreational habits:*
   One hour a day through the week.
   One-half day on Saturday or Sunday, in addition to exercise time.

Department of Hygiene and Preventive Medicine, Cornell University

Year expect to graduate ..... Name ..... College .....

Examination date .....

HISTORY

	First year	Second year	Third year	Fourth year
Ithaca address				
Age..... Years..... Months				
Date of birth				
Place of birth				
Derivation of student:				
English				
French				
German				
Jewish				
American				
or				
Name of member of family having—				
Pulmonary tuberculosis				
Cancer				
Diabetes				
Nephritis				
Epilepsy				
Insanity				
Heart disease				
Apoplexy				
Give age and cause of death:				
Father				
Mother				
Brother				
Sister				
Have you had (give date)—				
Measles				
German measles				
Mumps				
Whooping cough				
Scarlet fever				
Chickenpox				
Diphtheria				
Pneumonia				
Malaria				
Mastoiditis				
Influenza				
Meningitis				
Smallpox				
Poliomyelitis				
Otitis media				

	First year	Second year	Third year	Fourth year
Have you had (give date)—				
Tonsillitis				
Pleurisy				
Gonorrhea				
Syphilis				
Tuberculosis				
Chronic bronchitis				
Chorea				
Epilepsy				
Neurasthenia				
Asthma				
Hay fever				
Nephritis				
Valvular heart disease				
Diabetes				
Rheumatism				
Fracture				
Dislocation				
Wounds				
Gassed				
Typhoid fever				
Nervous breakdown				
Do the effects of such illness persist?				
If so, what				
What operations have you had?				
Nasal				
Tonsils				
Adenoids				
Appendix				
Hernia				
Mastoid				
Circumcision				
or				
Have you had injury with loss of consciousness?				
Nature..... Date				
Vaccination:				
Smallpox..... Date				
Typhoid..... Date				
Diphtheria..... Date				
Schick test..... Date				

Examination date _____

	First year	Second year	Third year	Fourth year
Did you have any of the following last year?				
Indigestion				
Constipation				
Headache				
Backache				
Nervousness				
Fainting				
Dizziness				
Coughs				
Expectoration				
Spitting of blood				
Nausea				
Vomiting				
Palpitation				
Deafness				
Night sweats				
Poor appetite				
Diarrhea				
Nosebleeds				
Hoarseness				
Chills or fevers				
Shortness of breath				
Swelling of feet or ankles				
Jaundice				
Sleeplessness				
Frequent urination nights				
Discharging ear				
Piles				
Convulsions				
Fits				
Painful feet				
Poor vision				
Speech defect				

	First year	Second year	Third year	Fourth year
How many colds did you have last year in your—				
Nose				
Throat				
Lungs				
Do you use tobacco?				
Form Amount				
Do you use tea or coffee?				
Cups per day				
How often do you bathe—				
Summer Winter				
When do you brush your teeth?				
Do your gums bleed easily?				
How many times did you go to a dentist last year?				
How much time do you spend at a meal?				
Are meals regular?				
Do you chew your food well?				
Do your bowels move regularly once a day?				
What exercise do you take and hours per day—				
Walks				
Games				
Gymnasium				
Track				
Etc				
Do you sleep well?				
Hours per night				
Are your windows open?				
Previous occupation				
Are you self-supporting?				
Whole Part				
Hours work per day				

Department of hygiene and preventive medicine, Cornell University

MEDICAL EXAMINATION

No. ..... Classification.

Name ..... College ..... Class .....

Date				
Weight ..... Height	Weight ..... Height	Weight ..... Height	Weight ..... Height .....
(1) Maturity	(1)	(1)	(1)
(2) Development	(2)	(2)	(2)
(3) Nourishment	(3)	(3)	(3)
Posture			
Skin:			
Scars			
Acute or chronic diseases			
Hair and scalp			
Mucous membranes			
Eyes:			
Vision R ..... L	R ..... L	R ..... L	R ..... L .....
Astigmatism R ..... L	R ..... L	R ..... L	R ..... L .....
Corrected R ..... L	R ..... L	R ..... L	R ..... L .....
Astigmatism R ..... L	R ..... L	R ..... L	R ..... L .....
Color vision			
Ocular movements			
Exophthalmos			
Eyelids			
Sclera			
Pupils			
Size			
Conjunctiva			
Ears:			
Discharge			
Tympanum			
Cerumen			
Hearing R ..... L	R ..... L	R ..... L	R ..... L .....
Nose:			
Obstruction			
Discharge			
Sinuses			
Teeth:			
Caries ..... Dead			
Notched incisors			
Misplaced			
Gums: Pyorrhea			
Tonsils:			
Large ..... Small			
Prominent ..... Buried			
Removed ..... Remnants			
Infected ..... Acute			
Chronic			

Pharynx			
Neck:			
(1) Thyroid	(1)	(1)	(1)
(2) Pulsations	(2)	(2)	(1)
Chest:			
(1) Shape	(1)	(1)	(2)
(2) Movements	(2)	(2)	(2)
Measurements:			
Inspir. Expir. Expan.	Inspir. Expir. Expan.	Inspir. Expir. Expan.	Inspir. Expir. Expan.
Lungs:			
Palpation			
Percussion			
Auscultation			
Heart:			
Apex beat—			
(1) Char			
(2) Location			
Thrill			
Area of dullness			
Murmurs			
Functional test			
Pulse:			
Rate			
Rhythm			
Blood pressure (recumbent):			
S. D.	S. D.	S. D.	S. D.
Spine:			
Organic Functional			
Abdomen			
Hernia			
Hemorrhoids			
Genitals Foreskin			
Tests Varicocele			
Hydrocele			
Lymph nodes Cerv			
Ax Ing			
Nervous system:			
Speech defect Tremor			
Coordination Knee jerks			
Upper extremity			
Lower extremity			
Varicose veins			
Feet			
Urinalysis			
Recommendations			

Some Federal Safeguards of the Manufacture and Distribution of Diphtheria Toxin-Antitoxin Mixture

Diphtheria toxin-antitoxin mixture has in the last few years come into such general use in the prevention of diphtheria as to occupy a place of importance in the preventive immunization against disease probably second only to smallpox vaccine. Every year thousands of children are immunized, and the effect of this excellent prophylactic measure is being reflected in the lowered diphtheria rate which is evident in localities where much work has been done along this line. This result in the control of a dreaded disease of early childhood is all the more gratifying in that immunization is accomplished with practically no local or general reactions in the inoculated children. Very young children unquestionably take toxin-antitoxin mixture better even than those of school age, the ideal age for producing immunity being around the end of the first year of life. By this time the child will have lost the immunity acquired from the mother and will soon begin to come more generally into contact with other children, with the increase in danger of acquiring diphtheria. Heaviest mortality rates from diphtheria are encountered in children below the school age, and it is probably safe to say that the immunization of one child of this group will equal the immunization of five school children in effect on the diphtheria death rate. Some means of reaching this very important group of children is very much needed.

Toxin-antitoxin mixture is prepared only in establishments holding license issued by the Secretary of the Treasury, upon recommendation of the Public Health Service. The service, through the hygienic laboratory, insures that the establishment is properly equipped with both physical apparatus and properly trained personnel to carry out the careful technique of manufacture and testing before recommending a license. This information is obtained always by means of a careful personal inspection by an officer of the Public Health Service.

The product is prepared, as the name indicates, from diphtheria toxin and diphtheria antitoxin, mixed in such proportions that the former, a poison derived from the diphtheria bacillus, is almost, but not quite, neutralized by the antitoxin, which is obtained from the blood of a highly immunized horse. Very careful, accurate testing is always done on each lot.

The toxin is usually prepared in the establishment and allowed to age for at least one year. By this time the first rapid deterioration will have taken place. The strength is next accurately determined by inoculation in guinea pigs weighing 250 grams (8–9 ounces). One drop of a good toxin is sufficient to prepare three doses, or one course of immunizing treatments of toxin-antitoxin mixture.

The antitoxin is a specially selected, highly concentrated product, as it is derived from the serum of the horse and it is desired to keep the dose as low as possible. One drop of a good antitoxin is sufficient to prepare 2,000 doses of toxin-antitoxin mixture. The antitoxin is also aged to make stable, and then very carefully tested to determine the exact strength expressed in units per cubic centimeter. Guinea pigs are also used for this test.

These two products are next diluted with sterile phenolized salt solution and mixed in such proportions that five human doses will kill a 250-gram guinea pig in from 6 to 20 days, while one human dose will cause a local reaction in the guinea pig, but will only cause paralysis in from 15 to 30 days. It is thus seen that the amount which shows no acute symptoms in the very susceptible guinea pig weighing one-half pound, could not possibly harm a child weighing from 20 to 80 pounds. This exact degree of toxicity is difficult to obtain, and can only be secured by careful measurements of ingredients, the strengths of which are accurately known. Frequent adjustments and re-tests are usually required.

After the mixture is completed and adjustments of toxicity are made the entire lot is filtered to sterilize, and final toxicity and sterility tests are applied by the manufacturer. If these tests are satisfactory and the manufacturer considers the mixture suitable for the market, samples of each lot are sent to the Hygienic Laboratory, where sterility and guinea-pig tests are also made. No lot is released for distribution until tests at the Hygienic Laboratory are satisfactorily completed.

Owing to the tendency of diphtheria toxin to deteriorate, and particularly when diluted, this product is allowed to remain on the market for only six months, and precautions should be taken to keep in a cold place but not allow it to freeze. Freezing causes a slight turbidity to appear and renders the product inactive.

With the present type of mixture which is in universal use, the original toxin content is one-thirtieth that of the older mixtures, the product is water clear, and with the great care in manufacture, with check testing by different laboratories, the public is assured a safe and effective product which may be employed with confidence.

SPECIAL COURSES FOR PHYSICIANS IN TREATMENT OF VENEREAL DISEASE

Surgeon General Hugh S. Cumming has announced that the United States Public Health Service, as a part of its cooperative work with State health departments in the control of venereal diseases, will give special courses of training to physicians, clinicians, and health officers at its venereal disease clinic, Hot Springs, Ark.

This clinic, which is operated by the Public Health Service in a new building belonging to the Department of the Interior, offers exceptional opportunities for the study of the venereal diseases, especially in clinical and laboratory diagnosis, treatment methods, and clinic management. Here studies of the many practical and scientific problems connected with venereal-disease control are carried on. Last year 3,570 indigent persons were examined at the clinic, and 3,064 cases of syphilis and gonorrhea were diagnosed and given a total of 32,315 treatments.

Surgeon General Cumming states that the instruction courses which now are offered will consist of a series of lectures by the director and the consulting specialists attached to the clinic, demonstrations in laboratory and treatment methods, and practical experience in the diagnosis and treatment of syphilis and gonorrhea in various stages through participation in the routine work of the clinic. New classes of not more than 10 physicians will form on the 1st of each month and the course will continue for a minimum of 30 days. Engraved certificates will be presented by the Public Health Service to those who satisfactorily complete the 30-day course.

Fees are not charged for this course of instruction. The individual physician, however, will necessarily provide his own travel expense to and from Hot Springs and his living expenses while there.

Interested physicians should write to the local State health officer or to the Surgeon General, United States Public Health Service, Washington, D. C., for information or application blanks. Applications should be indorsed by the State health department in which the applicant resides before being submitted to the United States Public Health Service.

THE "DEADLINESS" OF A DISEASE

The following is quoted from the Vital Statistics Bulletin of the Pennsylvania Department of Health for October, 1926:

"When you say a disease is 'deadly,' just what do you mean? Thus, during the first seven months of this year, measles killed six times as many people as did typhoid fever. On the other hand, measles killed only one out of every hundred people it attacked, whereas typhoid killed one out of every five patients. Which, then, is the more 'deadly' disease? If you are a physician, typhoid is of course the more deadly; that is, it offers the most unfavorable prognosis. If you are a health official, measles is the most deadly, in that it kills off more people in your jurisdiction.

"Vital statistics should answer both sides of the question, and we present herewith, as a supplement to the 'Mortality Rates' routinely published, 'Case Fatality Rates' for the first seven months of 1926 for the State as a whole. These represent the number of deaths reported for each hundred cases of the particular disease.

Diphtheria	10. 5
Measles	1. 1
Scarlet fever	1. 3
Typhoid	18. 5
Whooping cough	5. 8

"These rates are all, of course, a little too high, due to the present incompleteness of case reporting. They are, however, of value in that they show the relative seriousness of these diseases from the patient's or attending physician's viewpoint.

"OUTSTANDING RESULTS

"The chart presented with this issue impressively tells the story of the subjection in Pennsylvania of two dread diseases, tuberculosis and typhoid. It is seen that during the period the State department of health has been in existence the death rate from tuberculosis has been reduced 48 per cent while that from typhoid has been reduced 91 per cent. What better argument can be presented for the effectiveness of pure water, pure milk, better sanitation, and better health habits?"

The chart shows that tuberculosis deaths were reduced approximately from 150 to 77 per 100,000 and typhoid fever from 56 to 4.8 per 100,000 during the period 1906 to 1925.

PUBLIC HEALTH ENGINEERING ABSTRACTS

City Authorities Held Responsible for Typhoid. Anon. *Canadian Engineer*, vol. 50, No. 26, June 29, 1926, pp. 697–698 and 716. (Abstract by Rudolph E. Thompson.)

The full text is given of Justice Logie's judgment in case in which the city of Owen Sound, Ontario, the public utilities commission, and the local board of health were sued for damages by a girl who contracted typhoid during an epidemic in September, 1925. The plaintiff was awarded damages of $2,000 with costs. Justice Logie stated that the evidence presented was fully convincing that the typhoid was water-borne, and he severely rebuked the civic authorities for gross negligence in disregarding repeated warnings that the water supply was of dangerous quality. Despite instructions from the provincial board of health that steps be taken to insure the safety of the supply and reports from the local representative of the provincial board that the quality of the water was unsatisfactory, chlorination was postponed until it was too late. It was brought out in evidence, brief extracts from which are included, that some time previous to the epidemic an old reservoir was put into service which had been closed on the recommendation of the provincial board of health in 1916, when there was typhoid among the troops quartered in Owen Sound. When this connection between the reservoir and the city supply was closed, the epidemic abated.

Survey shows Relation of Goiter to Drinking Water. Anon. *The Nation's Health*, vol. 8, No. 8, August, 1926, pp. 557–559. (Abstract by H. N. Old.)

The city of Saginaw, Mich., is taken for this survey of goiter prevalence in school children and the relationship of drinking water. In this city examinations of the deep-well water supplies used indicated an average iodine content of 0.31 milligram per gallon, varying from 0.024 to 1.4, while absent in shallow wells.

Tables are given showing the analyses of the deep-well waters, and also tables showing the prevalence by schools, and by grades at one school, of thyroid enlargement among the children.

The conclusion is reached that this enlargement does not occur among children who use deep-well water regularly, and the evidence seems to indicate quite clearly that (1) there is a definite relation between the incidence of goiter and the kind of drinking water used; (2) those who have used water from deep wells regularly have benefited by its use in both the prevention and decrease of thyroid enlargement; (3) we are led to believe that even the minutest quantity of iodine in drinking water (0.024 milligram per gallon) if regularly used is sufficient to prevent thyroid enlargement.

Chlorination in Relation to Factors of Safety for Water Filtration Processes. H. W. Streeter, Sanitary Engineer, United States Public Health Service. *Water Works*, vol. 65, No. 9, September, 1926, pp. 439–442. (Abstract by E. A. Reinke.)

This paper is a memorandum based on a survey of 17 water filtration plants on the Ohio River submitted as an appendix to the committee report presented at the conference of State sanitary engineers at Buffalo, N. Y., June, 1926. Tables and charts show the relation between *B. coli* index and frequency with which on individual days it exceeded specified limits; the relation between *B. coli* index of raw water and unchlorinated effluent; and assumed factors of safety attributed to chlorination necessary to give a specified chlorinated effluent for certain *B. coli* indices in unchlorinated effluent.

Mr. Streeter suggests as a basis for compromise between those who would demand an unchlorinated effluent conforming to the Treasury Department standard and those who are satisfied with chlorinated effluents meeting the standard, "that instead of taking chlorination as the factor of safety, a definite numerical factor be assigned such that the average *B. coli* index of the chlorinated effluent shall be some specified fraction of the maximum limit prescribed by a given standard of quality, as, for example, the revised Treasury Department standard. Thus, if the factor of safety be five, the required average *B. coli* index of the chlorinated filtered effluent would be not greater than 0.2 per 100 cubic centimeters." After discussing several possible conditions,

Mr. Streeter suggests as a basis for working factors of safety the following table:

Class	Factor of safety	Limiting yearly average B. coli index per 100 c. c.	
		Chlorinated filter effluent	Unchlorinated filter effluent
A	10	0.10	3.2
B	5	.20	4.6
C	3	.33	5.7

Raw waters would be put in class A, B, or C, depending on the difficulty experienced in treating them.

Water Purification in Relation to Stream Pollution.—*Waterworks*, volume 65, No. 9, September, 1926, pp. 447–449. (Abstract by E. A. Reinke.)

The paper is the progress report of committee on water supply and purification presented at the conference of State sanitary engineers, Buffalo, N. Y., June, 1926.

A survey of 17 municipal water filtration plants "has indicated that the average fully equipped plant of modern design operated efficiently under skilled supervision and treating a water similar in its general character to that of the Ohio River, should be able to produce a chlorinated filter effluent showing an average conformance to the revised Treasury Department *B. Coli* standard when the mean *B. coli* index of the raw water does not exceed approximately 5,000 per 100 cubic centimeters." Modern tendencies may be to rely too much on chlorination, using filtration merely for clarifying water. Efficiency of bacterial removal is not greatly effected by raw water turbidity or changes in season. Most probable numbers of *B. coli* is most satisfactory measurement of bacterial relationships. A more precise and more highly standardized method of enumerating B. coli should be adopted. A definite specification should be made as to the maximum permissible bacterial or *B. coli* content of unchlorinated or chlorinated water, and this will depend upon extent to which chlorination is considered a "factor of safety."

Zoning on Trial Before the United States Supreme Court.—James Metzenbaum. *American City*, volume 35, No. 1, July, 1926, pp. 74–76. (Abstract by George N. McDaniel, jr.)

A zoning ordinance passed by the village of Euclid, Ohio, has been assailed by the Ambler Realty Co. charging that such an ordinance is unconstitutional. The question as to the reasonableness of the Euclid ordinance is, in itself, of negligible importance, but a ruling concurring with the realty company would affect zoning ordinances

all over the country. Several State supreme courts have passed on the validity of zoning ordinances, and at the present their opinions are equally divided. The Euclid case will be reargued before the United States Supreme Court this fall.

An Investigation Concerning the Incidence of Lead Poisoning in Motor-Car Painters.—C. Badham (Studies in Industrial Hygiene, No. 6), Report Director General of Public Health, New South Wales for 1924; 90–100 (19 refs.) (Abstracted by E. L. Collis.) From *Bulletin of Hygiene*, volume 1, No. 8, August, 1926, page 643. (Abstract by Arthur P. Miller.)

"An investigation, during which 100 men exposed to risk of lead poisoning in the motor-car painting trade were examined, is made the text for an unusually interesting discussion of our present knowledge with regard to plumbism. The incidence of lead poisoning was found to be grave; 14 men were classed as clear cases of lead poisoning, 12 as slight cases, and 17 as suspicious, while 11 had other nonoccupational disabilities. The prohibition of lead compounds in the paints used is indicated. A blue line on the gums is not confined to lead exposure, as it has been found in 25 per cent of men receiving injections of bismuth at a venereal-disease clinic, but when due to lead it is a danger signal. Like lead in the urine, it indicates active transportation of lead in the system. The term 'lead absorption' is objected to as a mere euphemism for minor poisoning. Punctate basophilia was found in 18 of the motor-car painters, but was entirely absent among 25 painters using nonlead paints on bedsteads and among men receiving bismuth injections. Thirteen of the 100 had granular casts in their urine, an unusually high proportion; but the group as a whole showed no evidence of blood pressure being unusually high or low. Detailed information is given in tabular form of each examination made."

Relation of Health Departments to Industrial Hygiene.—C. T. Graham-Rogers, M. D. *American Journal of Public Health*, volume 16, No. 2, February, 1926, pages 117–120. (Abstract by A. L. Dopmeyer.)

The first accomplishment desired in industrial hygiene work is coordination with the work of the various agencies in the State and cooperation between State and local authorities. Factors within and without the industry responsible for accidents and health hazards, and remedial measures, are discussed.

Methods for satisfactory cooperation between various agencies are suggested, and a plea is made for better observance of the laws and simplification of inspection work by elimination of duplication.

DEATHS DURING WEEK ENDED OCTOBER 30, 1926

Summary of information received by telegraph from industrial insurance companies for week ended October 30, 1926, and corresponding week of 1925. (From the Weekly Health Index, November 3, 1926, issued by the Bureau of the Census, Department of Commerce)

	Week ended Oct. 30, 1926	Corresponding week, 1925
Policies in force	65, 729, 006	61, 864, 119
Number of death claims	11, 573	10, 672
Death claims per 1,000 policies in force, annual rate	9. 2	9. 0

Deaths from all causes in certain large cities of the United States during the week ended October 30, 1926, infant mortality, annual death rate, and comparison with corresponding week of 1925. (From the Weekly Health Index, November 3, 1926, issued by the Bureau of the Census, Department of Commerce)

City	Week ended Oct. 30, 1926		Annual death rate per 1,000 corresponding week, 1925	Deaths under 1 year		Infant mortality rate, week ended Oct. 30, 1926 [2]
	Total deaths	Death rate [1]		Week ended Oct. 30, 1926	Corresponding week, 1925	
Total (65 cities)	6, 759	12. 2	12. 5	802	741	[3] 65
Akron	30			5	2	54
Albany [4]	41	18. 0	13. 3	6	2	124
Atlanta	85			9	11	
White	41			3	5	
Colored	44	(5)		6	6	
Baltimore [4]	190	12. 3	13. 6	13	25	40
White	142			10	17	38
Colored	48	(5)		3	8	48
Birmingham	70	17. 3	18. 8	15	10	
White	34			4	5	
Colored	36	(5)		11	5	
Boston	222	14. 7	13. 9	43	25	120
Bridgeport	41			6	3	102
Buffalo	148	14. 2	11. 4	7	21	29
Cambridge	25	10. 7	8. 7	2	3	36
Camden	21	8. 4	15. 0	3	3	50
Canton	24	11. 4	8. 3	3	3	66
Chicago [4]	639	10. 9	11. 3	57	67	50
Cincinnati	119	15. 1	17. 6	14	9	87
Cleveland	202	11. 0	10. 2	26	20	68
Columbus	80	14. 6	13. 6	9	12	84
Dallas	47	12. 3	14. 3	6	12	
White	37			6	11	
Colored	10	(5)		0	1	
Dayton	43	12. 7	12. 1	10	4	164
Denver	77	14. 1	11. 5	9	6	
Des Moines	26	9. 3	14. 0	5	4	84
Detroit	269	10. 9	10. 2	42	35	68
Duluth	18	8. 3	11. 3	2	1	46
El Paso	27	12. 9	13. 4	9	3	
Erie	35			3	1	59
Fall River [4]	32	12. 7	10. 5	7	3	110
Flint	26	9. 9	8. 8	4	1	68
Fort Worth	16	5. 2	6. 8	3	3	
White	14			3	2	
Colored	2	(5)		0	1	
Grand Rapids	35	11. 7	16. 6	7	7	100
Houston	42			6	10	
White	25			3	6	
Colored	17	(5)		3	4	
Indianapolis	103	14. 6	15. 3	10	4	76
White	85			7		61
Colored	18	(5)		3		172
Jersey City	71	11. 6	10. 8	10	11	76
Kansas City, Kans	22	9. 8	14. 8	7	2	136
White	19			7	2	156
Colored	3	(5)		0	0	0
Kansas City, Mo	99	13. 8	12. 9	9	15	
Los Angeles	210			32	19	89

(Footnotes at end of table)

Deaths from all causes in certain large cities of the United States during the week ended October 30, 1926, infant mortality, annual death rate, and comparison with corresponding week of 1925—Continued.

City	Week ended Oct. 30, 1926		Annual death rate per 1,000 corresponding week, 1925	Deaths under 1 year		Infant mortality rate, week ended Oct. 30, 1926 [2]
	Total deaths	Death rate [1]		Week ended Oct. 30, 1926	Corresponding week, 1925	
Louisville	75	12.6	13.3	9	6	77
White	59			9	5	87
Colored	16	(3)		0	1	0
Lowell	30			4	1	77
Lynn	14	7.0	10.1	2	1	53
Memphis	63	18.6	18.5	11	8	
White	26			1	4	
Colored	37	(3)		10	4	
Milwaukee	87	8.8	11.3	11	19	52
Minneapolis	82	9.9	11.8	4	7	22
Nashville [4]	49	18.6	20.7	7	2	
White	32			6	1	
Colored	17	(3)		1	1	
New Bedford	20			4	8	69
New Haven	41	11.7	11.1	5	5	68
New Orleans	143	17.8	14.6	26	16	
White	84			16	8	
Colored	59	(3)		10	8	
New York	1,296	11.4	12.4	157	143	64
Bronx Borough	167	9.7	10.3	14	14	47
Brooklyn Borough	441	10.3	10.5	61	51	62
Manhattan Borough	536	14.9	16.6	64	67	71
Queens Borough	104	6.7	8.9	12	9	55
Richmond Borough	48	17.5	13.6	6	2	105
Newark, N. J	83	9.4	12.0	14	14	67
Norfolk	33	9.9	11.7	5	7	101
White	15			1	3	33
Colored	18	(3)		4	4	212
Oakland	59	11.8	9.9	3	8	35
Oklahoma City	23			4	6	
Omaha	53	12.8	11.8	4	6	42
Paterson	25	9.1	11.0	0	3	0
Philadelphia	496	12.9	13.7	62	51	83
Pittsburgh	156	12.8	14.4	19	27	63
Portland, Oreg	60			4	4	40
Providence	68	12.9	12.3	9	5	75
Richmond	43	11.9	12.3	12	6	149
White	19			7	4	136
Colored	24	(3)		5	2	173
Rochester	68	11.0	10.5	5	13	40
St. Louis	220	13.8	13.6	22	9	
St. Paul	58	12.2	12.9	4	4	35
Salt Lake City [4]	40	15.7	12.7	5	2	76
San Antonio	45	11.4	14.0	9	10	
San Diego	48	22.8	13.8	2	1	42
San Francisco	160	14.7	11.3	9	3	54
Schenectady	21	11.8	10.1	0	1	0
Seattle	72			5	2	48
Somerville	25	13.0	16.8	1	2	28
Spokane	26	12.4	13.9	0	3	0
Springfield, Mass	38	13.7	12.5	4	4	62
Syracuse	49	13.9	14.6	6	6	76
Toledo	73	12.9	9.4	11	5	106
Trenton	30	11.7	13.8	3	3	51
Utica	38	19.2	14.9	1	0	23
Washington, D. C	135	13.3	13.7	10	15	57
White	77			5	9	42
Colored	58	(3)		5	6	91
Waterbury	16			1	6	24
Wilmington, Del	30	12.6	11.5	2	2	44
Worcester	43	11.6	16.7	6	8	72
Yonkers	28	12.6	8.7	1	2	23
Youngstown	26	8.2	8.8	3	3	38

[1] Annual rate per 1,000 population.
[2] Deaths under 1 year per 1,000 births. Cities left blank are not in registration area for births.
[3] Data for 63 cities.
[4] Deaths for week ended Friday, Oct. 29, 1926.
[5] In the cities for which deaths are shown by color, the colored population in 1920 constituted the following percentages of the total population: Atlanta, 31; Baltimore, 15; Birmingham, 39; Dallas, 15; Fort Worth, 14; Houston, 25; Indianapolis, 11; Kansas City, Kans., 14; Louisville, 17; Memphis, 38; Nashville, 30; New Orleans, 26; Norfolk, 38; Richmond, 32; and Washington, D. C., 25.

DEATHS DURING WEEK ENDED NOVEMBER 6, 1926

Summary of information received by telegraph from industrial insurance companies for week ended November 6, 1926, and corresponding week of 1925. (From the Weekly Health Index, November 10, 1926, issued by the Bureau of the Census, Department of Commerce)

	Week ended Nov. 6, 1926	Corresponding week, 1925
Policies in force	64, 674, 006	61, 998, 918
Number of death claims	10, 599	10, 005
Death claims per 1,000 policies in force, annual rate	8. 5	8. 4

Deaths from all causes in certain large cities of the United States during the week ended November 6, 1926, infant mortality, annual death rate, and comparison with corresponding week of 1925. (From the Weekly Health Index, November 10, 1926, issued by the Bureau of the Census, Department of Commerce)

City	Week ended Nov. 6, 1926		Annual death rate per 1,000 corresponding week, 1925	Deaths under 1 year		Infant mortality rate, week ended Nov. 6, 1926 [2]
	Total deaths	Death rate [1]		Week ended Nov. 6, 1926	Corresponding week, 1925	
Total (66 cities)	6, 566	11. 8	12. 8	712	732	[3] 57
Akron	36			7	3	75
Albany [4]	45	19. 7	15. 9	1	2	21
Atlanta	73			7	16	
White	37			2	10	
Colored	36	[5]		5	6	
Baltimore [4]	193	12. 5	15. 0	23	20	70
White	143			17	12	64
Colored	50	[5]		6	8	96
Birmingham	47	11. 6	19. 5	7	10	
White	29			5	5	
Colored	18	[5]		2	5	
Boston	185	12. 3	14. 3	22	20	61
Bridgeport	26			2	2	34
Buffalo	143	13. 7	16. 4	17	30	71
Cambridge	27	11. 5	12. 6	2	2	36
Camden	35	13. 9	15. 0	4	6	67
Canton	21	10. 0	11. 3	2	3	44
Chicago [4]	601	10. 3	11. 4	62	62	54
Cincinnati	128	16. 2	17. 2	11	9	69
Cleveland	190	10. 3	9. 7	18	23	47
Columbus	79	14. 5	13. 4	8	5	75
Dallas	46	12. 0	16. 7	7	8	
White	35			6	6	
Colored	11	[5]		1	2	
Dayton	36	10. 6	8. 7	2	1	33
Denver	79	14. 5	14. 3	6	3	
Des Moines	20	7. 1	11. 1	2	2	33
Detroit	283	11. 4	11. 3	46	37	75
Duluth	24	11. 1	7. 1	2	2	46
El Paso	28	13. 4	12. 9	7	4	
Erie	28			4	4	78
Fall River [4]	28	11. 1	10. 1	4	6	63
Flint	24	9. 1	6. 8	7	3	119
Fort Worth	35	11. 5	9. 9	5	1	
White	27			5	1	
Colored	8	[5]		0	0	
Grand Rapids	34	11. 4	8. 5	4	2	57
Houston	48			6	6	
White	37			6	3	
Colored	11	[5]		0	3	
Indianapolis	87	12. 4	14. 0	10	8	76
White	73			9		78
Colored	14	[5]		1		57
Jersey City	59	9. 7	11. 2	7	7	53
Kansas City, Kans	35	15. 6	20. 2	2	6	39
White	27			1	4	22
Colored	8	[5]		1	2	152
Kansas City, Mo	92	12. 8	14. 3	9	6	
Los Angeles	225			23	19	64

(Footnotes at end of table)

Deaths from all causes in certain large cities of the United States during the week ended November 6, 1926, infant mortality, annual death rate, and comparison with corresponding week of 1925—Continued.

City	Week ended Nov. 6, 1926		Annual death rate per 1,000 corresponding week, 1925	Deaths under 1 year		Infant mortality rate week ended Nov. 6, 1926 [2]
	Total deaths	Death rate [1]		Week ended Nov. 6, 1926	Corresponding week, 1925	
Louisville	75	12.6	15.7	6	10	51
White	56			5	9	49
Colored	19	(3)		1	1	70
Lowell	25			1	8	19
Lynn	22	11.0	10.6	0	1	0
Memphis	59	17.4	22.7	8	8	
White	28			4	5	
Colored	31	(3)		4	3	
Milwaukee	100	10.1	11.2	14	9	66
Minneapolis	83	10.0	12.0	4	11	22
Nashville [4]	65	24.7	16.5	14	7	
White	44			10	5	
Colored	21	(3)		4	2	
New Bedford	26			1	1	
New Haven	38	10.9	9.9	4	3	17
New Orleans	153	19.0	18.6	18	15	55
White	90			10	9	
Colored	63	(3)		8	6	
New York	1,260	11.1	12.1	109	151	44
Bronx boro	140	8.1	8.3	16	11	53
Brooklyn boro	456	10.6	11.1	42	57	43
Manhattan boro	514	14.3	15.8	43	67	48
Queens boro	113	7.7	8.5	5	13	23
Richmond boro	37	13.5	17.0	3	3	33
Newark, N. J	91	10.3	10.3	8	6	38
Norfolk	36	10.8	10.5	6	3	121
White	20			3	0	98
Colored	16	(3)		3	3	150
Oakland	55	11.0	9.2	6	3	70
Oklahoma City	32			5	4	
Omaha	43	10.4	12.6	5	5	53
Paterson	34	12.4	9.6	2	0	34
Philadelphia	478	13.4	11.4	45	45	60
Pittsburgh	125	10.2	16.5	22	29	73
Portland, Oreg	66			4	3	40
Providence	55	10.4	15.2	6	8	59
Richmond	68	18.8	15.9	9	10	112
White	41			4	4	78
Colored	27	(3)		5	6	173
Rochester	64	10.4	11.5	13	9	105
St Louis	206	12.9	16.0	25	13	
St. Paul	60	12.6	10.6	5	1	43
Salt Lake City [4]	33	12.9	11.5	7	5	106
San Antonio	44	11.2	12.9	6	10	
San Diego	30	14.2	16.2	0	0	0
San Francisco	115	10.6	13.3	7	15	42
Schenectady	11	6.2	10.7	3	1	87
Seattle	73			3	1	29
Somerville	33	17.2	12.6	5	2	141
Spokane	29	13.9	12.4	2	1	46
Springfield, Mass	26	9.3	13.6	4	4	62
Syracuse	41	11.6	10.9	6	7	76
Tacoma	24	11.8	15.5	4	3	95
Toledo	89	15.8	12.7	10	6	96
Trenton	40	15.6	18.6	6	6	102
Utica	27	13.7	19.5	3	1	68
Washington, D. C	131	12.9	15.5	11	17	63
White	95			8	11	67
Colored	36	(3)		3	6	55
Waterbury	13			1	3	24
Wilmington, Del	26	10.9	13.7	1	6	22
Worcester	41	11.1	12.6	8	6	96
Yonkers	16	7.2	11.5	1	0	23
Youngstown	36	11.4	13.7	2	7	25

[1] Annual rate per 1,000 population.
[2] Deaths under 1 year per 1,000 births. Cities left blank are not in registration area for births.
[3] Data for 64 cities.
[4] Deaths for week ended Friday, Nov. 5, 1926.
[5] In the cities for which deaths are shown by color, the colored population in 1920 constituted the following percentages of the total population: Atlanta, 31; Baltimore, 15; Birmingham, 39; Dallas, 15; Fort Worth, 14; Houston, 25; Indianapolis, 11; Kansas City, Kans., 14; Louisville, 17; Memphis, 38; Nashville, 30; New Orleans, 26; Norfolk, 38; Richmond, 32; and Washington, D. C., 25.

PREVALENCE OF DISEASE

No health department, State or local, can effectively prevent or control disease without knowledge of when, where, and under what conditions cases are occurring

UNITED STATES

CURRENT WEEKLY STATE REPORTS

These reports are preliminary, and the figures are subject to change when later returns are received by the State health officers

Reports for Week Ended November 13, 1926

ALABAMA

	Cases
Chicken pox	13
Dengue	2
Diphtheria	66
Influenza	64
Malaria	76
Measles	6
Mumps	8
Pellagra	6
Pneumonia	48
Scarlet fever	27
Smallpox	4
Tuberculosis	20
Typhoid fever	22
Whooping cough	22

ARIZONA

Chicken pox	2
Diphtheria	7
Measles	37
Mumps	25
Scarlet fever	18
Trachoma	1
Tuberculosis	35
Typhoid fever	1
Whooping cough	10

ARKANSAS

Chicken pox	16
Diphtheria	12
Hookworm disease	1
Influenza	117
Malaria	155
Measles	4
Mumps	2
Ophthalmia neonatorum	1
Paratyphoid fever	2
Pellagra	10
Poliomyelitis	1
Scarlet fever	17
Smallpox	2
Trachoma	1
Tuberculosis	16
Typhoid fever	18
Whooping cough	46

CALIFORNIA

	Cases
Cerebrospinal meningitis—Oakland	1
Chicken pox	244
Diphtheria	156
Influenza	21
Jaundice (epidemic)	2
Measles	644
Mumps	133
Poliomyelitis:	
Orange	1
Redondo	1
Scarlet fever	259
Smallpox:	
Mendocino County	32
Scattering	10
Tuberculosis	140
Typhoid fever	17
Whooping cough	77

COLORADO

Chicken pox	16
Diphtheria	22
German measles	1
Hookworm disease	1
Impetigo contagiosa	1
Measles	12
Mumps	6
Pneumonia	2
Scarlet fever	76
Smallpox	39
Tuberculosis	19
Typhoid fever	8
Vincent's angina	1
Whooping cough	2

CONNECTICUT

Chicken pox	118
Conjunctivitis (infectious)	1
Diphtheria	24
German measles	1
Influenza	2
Measles	9
Mumps	3
Pneumonia (broncho)	12

CONNECTICUT—continued

	Cases
Pneumonia (lobar)	26
Scarlet fever	65
Tuberculosis (all forms)	27
Typhoid fever	4
Whooping cough	52

DELAWARE

Chicken pox	2
Diphtheria	4
Measles	1
Pneumonia	1
Scarlet fever	24
Tuberculosis	2
Typhoid fever	3
Whooping cough	6

FLORIDA

Chicken pox	2
Diphtheria	87
Hookworm disease	33
Influenza	2
Malaria	4
Measles	1
Pneumonia	3
Scarlet fever	13
Smallpox	3
Tetanus	1
Tuberculosis	14
Typhoid fever	15
Whooping cough	2

GEORGIA

Chicken pox	2
Conjunctivitis (infectious)	1
Diphtheria	128
Dysentery	3
Hookworm disease	5
Influenza	83
Malaria	42
Measles	3
Mumps	2
Paratyphoid fever	1
Pellagra	1
Pneumonia	36
Poliomyelitis	4
Scarlet fever	22
Septic sore throat	9
Smallpox	9
Tuberculosis	12
Tularaemia	1
Typhoid fever	28
Whooping cough	16

IDAHO

Chicken pox	6
Diphtheria	3
Measles	32
Scarlet fever	43
Typhoid fever	1

ILLINOIS

Cerebrospinal meningitis:	
Cook County	2
Kane County	1
Chicken pox	408
Diphtheria	143
Influenza	14

ILLINOIS—continued

	Cases
Measles	306
Mumps	45
Pneumonia	183
Poliomyelitis:	
Macon County	2
Madison County	1
McHenry County	1
Scarlet fever	273
Smallpox	5
Tuberculosis	324
Typhoid fever	40
Whooping cough	220

INDIANA

Anthrax—Gary	2
Chicken pox	139
Diphtheria	107
Influenza	20
Measles	28
Pneumonia	11
Scarlet fever	185
Smallpox	72
Tuberculosis	44
Typhoid fever	21
Whooping cough	129

IOWA

Cerebrospinal meningitis	1
Chicken pox	62
Diphtheria	23
Measles	12
Mumps	9
Pneumonia	5
Scarlet fever	42
Smallpox	8
Trachoma	1
Tuberculosis	10
Typhoid fever	5
Whooping cough	3

KANSAS

Chicken pox	122
Diphtheria	29
German measles	1
Influenza	4
Measles	126
Mumps	27
Pneumonia	25
Poliomyelitis—Ash Grove	1
Scarlet fever	76
Smallpox	5
Tuberculosis	29
Typhoid fever	16
Whooping cough	38

LOUISIANA

Cerebrospinal meningitis	2
Diphtheria	53
Hookworm disease	7
Influenza	14
Malaria	20
Pneumonia	23
Scarlet fever	17
Smallpox	2
Tuberculosis	66
Typhoid fever	16

MAINE

	Cases
Chicken pox	92
Diphtheria	3
German measles	1
Measles	107
Mumps	3
Pneumonia	9
Poliomyelitis	3
Scarlet fever	42
Tuberculosis	10
Typhoid fever	3
Whooping cough	13

MARYLAND [1]

Cerebrospinal meningitis	2
Chicken pox	62
Diphtheria	54
Dysentery	6
German measles	1
Influenza	13
Lethargic encephalitis	4
Measles	19
Mumps	13
Paratyphoid fever	1
Pneumonia (broncho)	32
Pneumonia (lobar)	28
Scarlet fever	52
Septic sore throat	2
Tuberculosis	57
Typhoid fever	24
Whooping cough	74

MASSACHUSETTS

Chicken pox	289
Conjunctivitis (suppurative)	9
Diphtheria	107
German measles	9
Influenza	15
Malaria	1
Measles	29
Mumps	139
Ophthalmia neonatorum	28
Pneumonia (lobar)	57
Poliomyelitis	7
Scarlet fever	251
Septic sore throat	2
Trachoma	2
Trichinosis	1
Tuberculosis (pulmonary)	91
Tuberculosis (other forms)	21
Typhoid fever	8
Whooping cough	104

MICHIGAN

Diphtheria	151
Measles	53
Pneumonia	78
Scarlet fever	207
Smallpox	33
Tuberculosis	31
Typhoid fever	25
Whooping cough	128

MINNESOTA

Actinomycosis	1
Chicken pox	222
Diphtheria	88

MINNESOTA—continued

	Cases
Dysentery	1
Influenza	2
Measles	119
Pneumonia	8
Scarlet fever	224
Smallpox	2
Tuberculosis	41
Typhoid fever	3
Whooping cough	27

MISSISSIPPI

Diphtheria	41
Scarlet fever	17
Smallpox	1
Typhoid fever	16

MISSOURI
(Exclusive of Kansas City)

Cerebrospinal meningitis	1
Chicken pox	35
Diphtheria	63
Epidemic sore throat	3
Influenza	10
Measles	19
Mumps	1
Ophthalmia neonatorum	1
Pneumonia	1
Scarlet fever	100
Smallpox	1
Trachoma	2
Tuberculosis	34
Typhoid fever	38
Whooping cugh	22

MONTANA

Chicken pox	40
Diphtheria	[illegible]
Measles	12[illegible]
Scarlet fever	9[illegible]
Smallpox	[illegible]
Typhoid fever	[illegible]
Whooping cough	4

NEBRASKA

Chicken pox	70
Diphtheria	8
Measles	4
Mumps	11
Poliomyelitis	1
Scarlet fever	25
Smallpox	7
Tuberculosis	1
Typhoid fever	2
Whooping cough	16

NEW JERSEY

Cerebrospinal meningitis	2
Chicken pox	130
Diphtheria	125
Influenza	10
Malaria	1
Measles	32
Paratyphoid fever	1
Pneumonia	107
Poliomyelitis	2
Scarlet fever	144
Typhoid fever	20
Whooping cough	124

[1] Week ended Friday.

NEW MEXICO

	Cases
Chicken pox	4
Diphtheria	1
Pellagra	1
Pneumonia	2
Scarlet fever	28
Tuberculosis	21
Typhoid fever	4
Whooping cough	3

NEW YORK

(Exclusive of New York City)

Cerebrospinal meningitis	1
Chicken pox	419
Diphtheria	78
Dysentery	1
German measles	48
Influenza	3
Malaria	2
Measles	592
Mumps	171
Paratyphoid fever	1
Pneumonia	205
Poliomyelitis	11
Scarlet fever	136
Septic sore throat	1
Smallpox	44
Typhoid fever	46
Vincent's angina	22
Whooping cough	256

NORTH CAROLINA

Chicken pox	50
Diphtheria	184
German measles	3
Malaria	4
Measles	6
Poliomyelitis	2
Scarlet fever	104
Septic sore throat	1
Smallpox	22
Typhoid fever	20
Whooping cough	259

OREGON

Chicken pox	38
Diphtheria	9
Influenza	19
Measles	10
Pneumonia	[2] 11
Scarlet fever	58
Smallpox:	
Josephine County	10
Scattering	8
Tuberculosis	24
Typhoid fever	5
Whooping cough	4

PENNSYLVANIA

Cerebrospinal meningitis—Philadelphia	1
Chicken pox	569
Diphtheria	226
German measles	9
Impetigo contagiosa	20
Lethargic encephalitis—Philadelphia	1

[2] Deaths.

PENNSYLVANIA—continued

	Cases
Measles	561
Mumps	62
Opthalmia neonatorum—Philadelphia	2
Pellagra—Philadelphia	1
Pneumonia	31
Poliomyelitis:	
Baden	1
Clearfield County	1
Rabies—Pittsburgh	1
Scabies	8
Scarlet fever	412
Trachoma—Pittsburgh	1
Tuberculosis	113
Typhoid fever	54
Whooping cough	277

RHODE ISLAND

Chicken pox	2
Diphtheria	10
Mumps	1
Ophthalmia neonatorum	2
Pneumonia	1
Scarlet fever	17
Tuberculosis	8
Whooping cough	2

SOUTH DAKOTA

Chicken pox	16
Diphtheria	4
Measles	31
Mumps	8
Pneumonia	3
Poliomyelitis	1
Scarlet fever	35
Smallpox	1
Tuberculosis	3
Typhoid fever	2
Whooping cough	7

TENNESSEE

Cerebrospinal meningitis—Memphis	1
Chicken pox	15
Diphtheria	109
Dysentery	6
Influenza	29
Malaria	7
Measles	19
Ophthalmia neonatorum	1
Paratyphoid fever	1
Pellagra	6
Pneumonia	31
Rabies	3
Scarlet fever	82
Smallpox	2
Tetanus	1
Tuberculosis	35
Typhoid fever	81
Whooping cough	50

TEXAS

Cerebrospinal meningitis	1
Chicken pox	4
Dengue	10
Diphtheria	48

TEXAS—continued

	Cases
Dysentery	10
Mumps	3
Pellagra	5
Pneumonia	1
Scarlet fever	34
Smallpox	3
Tuberculosis	14
Typhoid fever	9
Whooping cough	5

UTAH

	Cases
Chicken pox	41
Diphtheria	13
German measles	1
Influenza	4
Measles	221
Mumps	2
Pneumonia	9
Scarlet fever	24
Trachoma—Eureka	1
Typhoid fever	1
Whooping cough	7

VERMONT

	Cases
Chicken pox	33
Diphtheria	1
Measles	124
Mumps	10
Scarlet fever	2
Whooping cough	47

VIRGINIA

	Cases
Cerebrospinal meningitis—Prince Edward County	1

WASHINGTON

	Cases
Chicken pox	77
Diphtheria	28
German measles	5
Measles	42
Mumps	22
Pneumonia	2
Scarlet fever	64
Smallpox	8
Tuberculosis	2
Typhoid fever	10
Whooping cough	8

WEST VIRGINIA

	Cases
Chicken pox	76
Diphtheria	41
Influenza	11
Measles	7
Scarlet fever	63
Smallpox	1
Tuberculosis	16
Typhoid fever	28
Whooping cough	72

WISCONSIN

	Cases
Milwaukee:	
Chicken pox	99
Diphtheria	13
German measles	1
Measles	6
Mumps	38
Pneumonia	15
Scarlet fever	13
Tuberculosis	15
Typhoid fever	2
Whooping cough	60
Scattering:	
Cerebrospinal meningitis	1
Chicken pox	171
Diphtheria	31
German measles	2
Influenza	27
Measles	238
Mumps	18
Pneumonia	9
Poliomyelitis	3
Scarlet fever	114
Smallpox	4
Tuberculosis	19
Typhoid fever	6
Whooping cough	162

WYOMING

	Cases
Chicken pox	6
Diphtheria	1
Measles	14
Poliomyelitis—Hot Springs County	1
Scarlet fever	13
Smallpox	1
Typhoid fever	1
Whooping cough	5

Reports for Week Ended November 6, 1926

DISTRICT OF COLUMBIA

	Cases
Cerebrospinal meningitis	1
Chicken pox	5
Diphtheria	36
Measles	1
Pellagra	1
Pneumonia	18
Poliomyelitis	1
Scarlet fever	6
Tuberculosis	21
Typhoid fever	2
Whooping cough	1

NORTH DAKOTA

	Cases
Chicken pox	21
Diphtheria	11
Measles	44
Mumps	5
Pneumonia	1
Scarlet fever	62
Smallpox	9
Trachoma	2
Tuberculosis	2
Typhoid fever	1
Whooping cough	4

SOUTH CAROLINA	Cases
Chicken pox	25
Dengue	10
Diphtheria	123
Hookworm disease	29
Influenza	524
Malaria	461
Measles	2
Paratyphoid fever	2

SOUTH CAROLINA—continued	Cases
Pellagra	43
Poliomyelitis	2
Scarlet fever	26
Smallpox	4
Tuberculosis	48
Typhoid fever	51
Whooping cough	27

SUMMARY OF MONTHLY REPORTS FROM STATES

The following summary of monthly State reports is published weekly and covers only those States from which reports are received during the current week.

State	Cerebrospinal meningitis	Diphtheria	Influenza	Malaria	Measles	Pellagra	Poliomyelitis	Scarlet fever	Smallpox	Typhoid fever [1]
September, 1926										
Delaware	0	8	1	3			3	19	0	10
Oregon	1	34	39	5	27		4	87	33	42
Virginia	4	280	513	259	138	15	10	185	8	294
October, 1926										
Arizona	1	14	0		72		0	35	0	11
Connecticut	3	108	13	2	62		9	139	0	20
Georgia		393	214	502	15	13	1	92	30	305
Vermont	0	9	0		386		1	12	0	6

[1] Including paratyphoid fever.

GENERAL CURRENT SUMMARY AND WEEKLY REPORTS FROM CITIES

Diphtheria.—For the week ended October 30, 1926, 37 States reported 2,290 cases of diphtheria. For the week ended October 31, 1925, the same States reported 1,904 cases of this disease. Ninety-nine cities, situated in all parts of the country and having an aggregate population of more than 29,800,000, reported 1,221 cases of diphtheria for the week ended October 30, 1926. Last year for the corresponding week they reported 984 cases. The estimated expectancy for these cities was 1,256 cases. The estimated expectancy is based on the experience of the last nine years, excluding epidemics.

Measles.—Thirty-six States reported 2,119 cases of measles for the week ended October 30, 1926, and 1,312 cases of this disease for the week ended October 31, 1925. Ninety-nine cities reported 352 cases of measles for the week this year, and 583 cases last year.

Poliomyelitis.—The health officers of 37 States reported 60 cases of poliomyelitis for the week ended October 30, 1926. The same States reported 113 cases for the week ended October 31, 1925.

Scarlet fever.—Scarlet fever was reported for the week as follows: Thirty-seven States—this year, 2,543 cases; last year, 2,163 cases; 99 cities—this year, 966 cases; last year, 869 cases; estimated expectancy, 757 cases.

Smallpox.—For the week ended October 30, 1926, 37 States reported 197 cases of smallpox. Last year for the corresponding week they reported 208 cases. Ninety-nine cities reported smallpox for the week as follows: 1926, 17 cases; 1925, 56 cases; estimated expectancy, 36 cases. No deaths from smallpox were reported by these cities for the week this year.

Typhoid fever.—Seven hundred and seventy-seven cases of typhoid fever were reported for the week ended October 30, 1926, by 37 States. For the corresponding week of 1925, the same States reported 831 cases of this disease. Ninety-nine cities reported 159 cases of typhoid fever for the week this year and 140 cases for the corresponding week last year. The estimated expectancy for these cities was 136 cases.

Influenza and pneumonia.—Deaths from influenza and pneumonia were reported for the week by 93 cities, with a population of more than 29,150,000, as follows: 1926, 598 deaths; 1925, 691 deaths.

City reports for week ended October 30, 1926

The "estimated expectancy" given for diphtheria, poliomyelitis, scarlet fever, smallpox, and typhoid fever is the result of an attempt to ascertain from previous occurrence how many cases of the disease under consideration may be expected to occur during a certain week in the absence of epidemics. It is based on reports to the Public Health Service during the past nine years. It is in most instances the median number of cases reported in the corresponding week of the preceding years. When the reports include several epidemics or when for other reasons the median is unsatisfactory, the epidemic periods are excluded and the estimated expectancy is the mean number of cases reported for the week during nonepidemic years.

If reports have not been received for the full nine years, data are used for as many years as possible, but no year earlier than 1917 is included. In obtaining the estimated expectancy the figures are smoothed when necessary to avoid abrupt deviations from the usual trend. For some of the diseases given in the table the available data were not sufficient to make it practicable to compute the estimated expectancy.

Division, State, and city	Population July 1, 1925, estimated	Chicken pox, cases reported	Diphtheria		Influenza		Measles, cases reported	Mumps, cases, reported	Pneumonia, deaths reported
			Cases, estimated expectancy	Cases reported	Cases reported	Deaths reported			
NEW ENGLAND									
Maine:									
Portland	75,333	5	2	0	0	0	0	0	1
New Hampshire:									
Concord	22,546	0	1	0	0	0	0	0	0
Manchester	83,097	0	4	0	0	0	0	0	4
Vermont:									
Barre	10,008	3	0	1	0	0	0	0	2
Burlington	24,089	1	0	0	0	0	0	0	1
Massachusetts:									
Boston	779,620	27	58	17	3	1	6	25	18
Fall River	128,993	1	4	4	0	0	0	2	4
Springfield	142,065	1	4	2	0	0	0	0	1
Worcester	190,757	24	7	4	0	1	0	0	1
Rhode Island:									
Pawtucket	69,760	4	1	0	0	0	0	0	0
Providence	267,918	0	7	12	0	1	1	0	5
Connecticut:									
Bridgeport	(1)	0	10	4	1	0	2	1	3
Hartford	160,197	1	8	1	0	0	0	2	0
New Haven	178,927	16	3	0	0	0	1	0	7

[1] No estimate made.

City reports for week ended October 30, 1926—Continued

Division, State, and city	Population July 1, 1925, estimated	Chicken pox, cases reported	Diphtheria		Influenza		Measles, cases reported	Mumps, cases, reported	Pneumonia, deaths reported
			Cases, estimated expectancy	Cases reported	Cases reported	Deaths reported			
MIDDLE ATLANTIC									
New York:									
Buffalo	538,016	33	24	16	2	0	2	1	11
New York	5,873,356	67	161	163	52	7	13	27	113
Rochester	316,786	3	13	4	-------	0	0	0	5
Syracuse	182,003	0	11	0	-------	0	2	2	3
New Jersey:									
Camden	128,642	2	8	13	1	1	0	0	1
Newark	452,513	13	15	8	0	0	2	5	2
Trenton	132,020	1	5	1	0	0	0	0	2
Pennsylvania:									
Philadelphia	1,979,364	54	73	50	-------	4	5	4	44
Pittsburgh	631,563	43	36	22	-------	4	2	3	21
Reading	112,707	10	5	0	-------	0	1	0	1
Scranton	142,266	2	5	4	-------	0	1	0	2
EAST NORTH CENTRAL									
Ohio:									
Cincinnati	409,333	4	21	11	0	4	2	5	7
Cleveland	936,485	23	47	81	0	2	6	0	23
Columbus	279,836	3	6	24	0	0	0	0	6
Toledo	287,380	79	14	6	0	1	1	0	4
Indiana:									
Fort Wayne	97,846	1	3	4	0	0	0	0	1
Indianapolis	358,819	40	14	31	0	0	1	1	13
South Bend	80,091	2	3	1	0	0	1	0	0
Terre Haute	71,071	4	3	2	0	0	0	0	0
Illinois:									
Chicago	2,995,239	73	149	63	6	7	69	17	38
Peoria	81,564	3	2	0	0	0	71	3	1
Springfield	63,923	3	3	4	1	1	8	0	3
Michigan:									
Detroit	1,245,824	42	67	107	4	6	4	1	19
Flint	130,316	17	13	3	0	0	1	0	4
Grand Rapids	153,698	7	8	1	0	0	0	0	1
Wisconsin:									
Kenosha	50,891	0	2	0	0	0	0	1	0
Madison	46,385	7	1	0	0	0	0	1	0
Milwaukee	509,192	-------	30	-------	-------	-------	-------	-------	-------
Racine	67,707	16	3	2	0	0	2	1	1
Superior	39,671	0	1	0	0	0	0	0	1
WEST NORTH CENTRAL									
Minnesota:									
Duluth	110,502	5	4	3	0	0	29	0	0
Minneapolis	425,435	89	31	42	0	0	1	0	6
St. Paul	246,001	19	21	9	0	1	6	0	7
Iowa:									
Davenport	52,469	0	2	1	0	-------	2	0	-------
Sioux City	76,411	3	2	5	0	-------	1	1	-------
Waterloo	36,771	43	1	0	0	-------	0	0	-------
Missouri:									
Kansas City	367,481	14	16	8	0	0	0	4	10
St. Joseph	78,342	0	4	0	0	0	0	0	2
St. Louis	821,543	19	53	49	0	0	2	0	-------
North Dakota:									
Fargo	26,403	11	0	1	0	0	0	2	0
South Dakota:									
Aberdeen	15,036	2	0	1	0	-------	1	0	-------
Sioux Falls	30,127	1	1	0	0	-------	0	0	-------
Nebraska:									
Omaha	211,768	3	11	13	0	0	1	1	4
Kansas:									
Topeka	55,411	12	2	0	0	0	0	0	0
Wichita	88,367	0	6	1	0	0	2	0	1

City reports for week ended October 30, 1926—Continued

Division, State, and city	Population July 1, 1925, estimated	Chicken pox, cases reported	Diphtheria		Influenza		Measles, cases reported	Mumps, cases reported	Pneumonia, deaths reported
			Cases, estimated expectancy	Cases reported	Cases reported	Deaths reported			
SOUTH ATLANTIC									
Delaware:									
Wilmington	122,049	1	4	5	0	0	0	0	3
Maryland:									
Baltimore	796,296	22	29	17	3	2	1	4	11
Cumberland	33,741	1	1	5	0	1	1	0	0
Frederick	12,035	0	0	2	0	0	0	0	0
District of Columbia:									
Washington	497,906	3	18	41	2	3	0	0	12
Virginia:									
Lynchburg	30,395	1	3	5	0	0	1	0	1
Norfolk	(1)	6	4	3	0	0	0	2	5
Richmond	186,403	4	22	47	1	3	0	0	2
Roanoke	58,208	0	5	6	0	1	0	0	3
West Virginia:									
Charleston	49,019	0	4	2	1	0	0	0	0
Huntington	63,485	0	4	7	0		0	0	
Wheeling	56,208	7	3	3	0	0	0	0	1
North Carolina:									
Raleigh	30,371	0	4	1	0	0	0	0	1
Wilmington	37,061	6	1	2	0	0	0	0	2
Winston-Salem	69,031	0	4	5	0	0	1	0	1
South Carolina:									
Charleston	73,125	0	2	2	20	0	0	0	2
Columbia	41,225	0	3	4	0	0	0	0	0
Greenville	27,311	0	1	2	0	0	0	0	0
Georgia:									
Atlanta	(1)	4	11	25	13	0	0	0	8
Brunswick	16,809	0	1	0	0	0	0	2	1
Savannah	93,134	0	4	0	9	1	1	0	4
Florida:									
Miami	69,754	0		8	0	0	0	0	1
St. Petersburg	26,847		0			0			0
Tampa	94,743	2	1	3	0	0	0	0	0
EAST SOUTH CENTRAL									
Kentucky:									
Covington	58,309	2	3	28	0	0	0	0	1
Louisville	305,935	3	13	7	1	0	0	0	11
Tennessee:									
Memphis	174,533	4	15	8	0	1	0	0	7
Nashville	136,220	0	4	18	0	1	1	0	0
Alabama:									
Birmingham	205,670	0	7	3	4	0	3	1	6
Mobile	65,955	0	2	3	0	0	0	0	1
Montgomery	46,481	0	3	7	2	0	0	0	0
WEST SOUTH CENTRAL									
Arkansas:									
Fort Smith	31,643	0	1	1	0		0	0	
Little Rock	74,216	0	3	0	0	1	0	0	3
Louisiana:									
New Orleans	414,493	0	11	11	1	1	0	0	8
Shreveport	57,857	0	1	10	0	0	0	0	2
Oklahoma:									
Oklahoma City	(1)	0	4	3	0	1	0	0	2
Texas:									
Dallas	194,450	0	12	41	5	3	0	0	2
Galveston	48,375	0	1	1	0	0	0	0	0
Houston	164,954	0	5	6	0	1	0	0	4
San Antonio	198,069	0	2	7	0	0	0	0	1
MOUNTAIN									
Montana:									
Billings	17,971	0	0	0	0	0	0	0	1
Great Falls	29,883	55	1	0	0	0	0	0	2
Helena	12,037	0	0	0	0	0	0	0	0
Missoula	12,668	3	1	0	0	0	0	1	0
Idaho:									
Boise	23,042	0	0	0	0	0	0	0	0

[1] No estimate made.

City reports for week ended October 30, 1926—Continued

Division, State, and city	Population July 1, 1925, estimated	Chicken pox, cases reported	Diphtheria		Influenza		Measles, cases reported	Mumps, cases reported	Pneumonia, deaths reported
			Cases, estimated expectancy	Cases reported	Cases reported	Deaths reported			
MOUNTAIN—continued									
Colorado:									
Denver	260,911	7	15	13	-------	0	1	1	5
Pueblo	43,787	6	6	0	0	1	0	0	2
New Mexico:									
Albuquerque	21,000	0	1	0	0	0	0	0	1
Arizona:									
Phoenix	38,669	0	0	0	0	0	0	0	2
Utah:									
Salt Lake City	130,948	24	4	4	0	0	42	0	9
Nevada:									
Reno	12,665	0	0	0	0	0	0	0	1
PACIFIC									
Washington:									
Seattle	(1)	28	7	11	0	-------	3	21	-------
Spokane	108,897	29	4	1	0	-------	26	0	-------
Tacoma	104,455	8	3	10	0	0	0	2	2
Oregon:									
Portland	282,383	9	10	9	1	0	14	0	6
California:									
Los Angeles	(1)	14	37	40	7	1	5	1	18
Sacramento	72,260	2	2	3	0	0	10	3	1
San Francisco	557,530	31	19	11	1	1	83	13	4

Division, State, and city	Scarlet fever		Smallpox			Tuberculosis, deaths reported	Typhoid fever			Whooping cough, cases reported	Deaths, all causes
	Cases, estimated expectancy	Cases reported	Cases, estimated expectancy	Cases reported	Deaths reported		Cases, estimated expectancy	Cases reported	Deaths reported		
NEW ENGLAND											
Maine:											
Portland	0	0	0	0	0	0	1	1	0	0	26
New Hampshire:											
Concord	0	1	0	0	0	0	0	0	0	0	13
Manchester	1	0	0	0	0	0	0	0	0	0	12
Vermont:											
Barre	0	0	0	0	0	1	0	0	0	1	4
Burlington	1	0	0	0	0	0	0	0	0	5	6
Massachusetts:											
Boston	31	63	0	0	0	16	3	1	2	17	222
Fall River	2	4	0	0	0	3	0	0	0	6	32
Springfield	6	2	0	0	0	2	0	1	1	0	39
Worcester	9	18	0	0	0	2	0	0	0	5	-------
Rhode Island:											
Pawtucket	0	0	0	0	0	0	0	0	0	0	9
Providence	4	6	0	0	0	2	1	1	0	3	68
Connecticut:											
Bridgeport	5	4	0	0	0	1	1	0	0	0	41
Hartford	4	5	0	0	0	1	0	1	1	5	41
New Haven	5	1	0	0	0	3	2	0	0	0	41
MIDDLE ATLANTIC											
New York:											
Buffalo	16	17	1	0	0	9	2	6	0	5	143
New York	69	94	0	0	0	[2] 94	22	2	3	39	1,296
Rochester	6	3	0	0	0	2	2	0	0	0	65
Syracuse	9	1	0	0	0	0	1	1	0	16	49
New Jersey:											
Camden	2	9	0	0	0	1	0	0	0	3	21
Newark	10	6	0	0	0	5	3	0	1	26	79
Trenton	1	1	0	0	0	3	1	1	1	4	30

[1] No estimate made.

[2] Pulmonary tuberculosis only.

City reports for week ended October 30, 1926—Continued

Division, State, and city	Scarlet fever		Smallpox			Tuberculosis, deaths reported	Typhoid fever			Whooping cough, cases reported	Deaths, all causes
	Cases, estimated expectancy	Cases reported	Cases, estimated expectancy	Cases reported	Deaths reported		Cases, estimated expectancy	Cases reported	Deaths reported		
MIDDLE ATLANTIC—continued											
Pennsylvania:											
Philadelphia	50	29	0	0	0	33	9	18	0	52	496
Pittsburgh	34	22	0	0	0	5	2	1	2	10	156
Reading	1	3	0	0	0	0	0	0	0	5	22
Scranton	2	4	0	0	0	2	0	0	0	2	41
EAST NORTH CENTRAL											
Ohio:											
Cincinnati	10	12	1	0	0	11	2	4	0	1	119
Cleveland	21	25	1	0	0	11	3	1	1	25	202
Columbus	9	6	1	0	0	4	2	3	0	5	80
Toledo	10	10	1	0	0	5	2	2	1	15	73
Indiana:											
Fort Wayne	1	0	0	0	0	1	0	1	1	0	23
Indianapolis	8	22	1	0	0	6	1	2	2	15	103
South Bend	3	0	0	0	0	0	0	0	0	0	10
Terre Haute	2	6	0	0	0	1	1	0	0	0	17
Illinois:											
Chicago	90	66	1	0	0	43	8	11	1	45	639
Peoria	9	2	0	0	0	1	1	0	0	0	29
Springfield	2	4	0	0	0	1	1	0	0	8	24
Michigan:											
Detroit	60	53	2	2	0	21	4	3	0	50	269
Flint	8	4	1	0	0	1	0	0	0	1	26
Grand Rapids	8	7	0	0	0	0	0	0	0	1	35
Wisconsin:											
Kenosha	2	2	1	0	0	0	0	0	0	5	16
Madison	1	2	1	0	0	0	0	0	0	2	----
Milwaukee	20	----	2	----	----	----	1	----	----	----	----
Racine	4	2	0	0	0	0	1	0	0	5	9
Superior	2	3	1	0	0	0	0	0	0	0	3
WEST NORTH CENTRAL											
Minnesota:											
Duluth	6	11	1	0	0	0	1	0	0	0	18
Minneapolis	35	74	1	0	0	2	1	2	1	4	82
St. Paul	14	27	4	0	0	5	1	0	0	13	66
Iowa:											
Davenport	0	4	0	0	----	----	0	0	----	1	----
Sioux City	3	2	1	0	----	----	0	1	----	6	----
Waterloo	2	2	0	0	----	----	0	0	----	3	----
Missouri:											
Kansas City	10	7	0	0	0	8	2	5	0	7	99
St. Joseph	3	3	0	0	0	0	0	0	0	0	24
St. Louis	33	32	0	0	0	7	3	3	0	12	220
North Dakota:											
Fargo	2	10	0	0	0	1	0	0	0	0	13
South Dakota:											
Aberdeen	0	6	0	0	----	----	0	0	----	4	----
Sioux Falls	1	5	0	0	0	0	0	0	0	0	----
Nebraska:											
Omaha	4	4	1	1	0	2	1	0	0	0	53
Kansas:											
Topeka	3	1	1	0	0	3	1	0	0	5	9
Wichita	2	3	1	0	0	1	0	1	0	1	30
SOUTH ATLANTIC											
Delaware:											
Wilmington	3	13	0	0	0	0	1	0	0	0	30
Maryland:											
Baltimore	12	12	0	0	0	11	6	12	2	26	190
Cumberland	0	0	0	0	0	1	1	0	0	2	9
Frederick	1	2	0	0	0	0	0	1	0	2	2
District of Columbia:											
Washington	14	11	1	0	0	16	3	4	0	9	135

City reports for week ended October 30, 1926—Continued

Division, State, and city	Scarlet fever		Smallpox			Tuberculosis, deaths reported	Typhoid fever			Whooping cough, cases reported	Deaths, all causes
	Cases, estimated expectancy	Cases reported	Cases, estimated expectancy	Cases reported	Deaths reported		Cases, estimated expectancy	Cases reported	Deaths reported		
SOUTH ATLANTIC—continued											
Virginia:											
Lynchburg	1	2	0	0	0	0	1	2	0	2	4
Norfolk	1	5	0	0	0	3	1	1	1	2	----
Richmond	8	5	0	0	0	2	2	0	0	0	45
Roanoke	2	4	0	0	0	0	1	3	1	2	24
West Virginia:											
Charleston	1	3	0	0	0	1	0	2	0	0	13
Huntington	1	3	0	0	----	----	0	0	----	0	----
Wheeling	3	1	0	0	0	0	0	0	0	0	12
North Carolina:											
Raleigh	2	1	0	0	0	0	1	1	0	7	13
Wilmington	1	0	0	0	0	0	0	0	0	3	12
Winston-Salem	2	2	1	0	0	1	0	2	0	7	11
South Carolina:											
Charleston	0	1	0	0	0	0	1	3	1	0	24
Columbia	0	2	0	0	0	0	0	1	0	0	----
Greenville	0	0	0	1	0	0	0	1	0	0	6
Georgia:											
Atlanta	6	7	1	0	0	6	1	5	4	0	85
Brunswick	0	0	0	0	0	0	0	0	0	0	7
Savannah	1	0	0	0	0	2	1	2	0	0	39
Florida:											
Miami	----	2	----	0	0	2	----	0	0	3	40
St. Petersburg	0	----	0	----	0	1	0	----	0	----	8
Tampa	0	0	0	2	0	2	0	0	0	0	18
EAST SOUTH CENTRAL											
Kentucky:											
Covington	2	3	0	0	0	0	0	0	0	0	17
Louisville	4	17	0	0	0	3	2	1	0	1	75
Tennessee:											
Memphis	4	13	0	1	0	5	2	0	0	10	63
Nashville	4	15	0	0	0	3	3	15	6	6	49
Alabama:											
Birmingham	4	13	0	0	0	4	2	11	1	1	70
Mobile	1	1	0	0	0	1	0	0	0	0	25
Montgomery	1	2	0	0	0	0	0	0	0	0	27
WEST SOUTH CENTRAL											
Arkansas:											
Fort Smith	1	0	0	0	----	----	1	0	----	0	----
Little Rock	2	1	0	0	0	1	2	1	1	0	----
Louisiana:											
New Orleans	4	5	0	0	0	11	4	3	0	0	143
Shreveport	1	0	0	0	0	1	1	0	0	0	25
Oklahoma:											
Oklahoma City	2	1	0	0	0	2	0	0	0	2	23
Texas:											
Dallas	4	16	0	0	0	2	2	3	0	0	47
Galveston	0	1	0	0	0	2	0	0	0	0	14
Houston	2	2	0	1	0	1	0	0	0	0	42
San Antonio	0	1	0	0	0	6	0	2	1	0	45
MOUNTAIN											
Montana:											
Billings	1	0	0	0	0	0	0	0	0	0	7
Great Falls	2	1	1	0	0	0	0	0	0	0	7
Helena	0	0	0	0	0	0	0	0	0	0	4
Missoula	0	9	1	0	0	0	1	1	0	0	4
Idaho:											
Boise	1	0	0	1	0	0	1	0	0	0	5
Colorado:											
Denver	7	27	2	0	0	6	2	0	0	0	77
Pueblo	1	0	0	0	0	1	0	1	0	0	----
New Mexico:											
Albuquerque	0	2	0	0	0	9	1	1	0	0	15

City reports for week ended October 30, 1926—Continued

Division, State, and city	Scarlet fever		Smallpox			Tuberculosis, deaths reported	Typhoid fever			Whooping cough, cases reported	Deaths all causes
	Cases, estimated expectancy	Cases reported	Cases, estimated expectancy	Cases reported	Deaths reported		Cases, estimated expectancy	Cases reported	Deaths reported		
MOUNTAIN—con.											
Arizona:											
Phoenix	2	1	0	0	0	4	0	0	0	0	15
Utah:											
Salt Lake City	2	3	0	0	0	1	2	3	0	5	40
Nevada:											
Reno	1	0	1	0	0	0	0	0	0	0	4
PACIFIC											
Washington:											
Seattle	8	15	2	1			1	1		0	
Spokane	7	16	1	0			1	0		3	
Tacoma	2	4	1	7	0	0	0	0	0	0	23
Oregon:											
Portland	7	21	3	3	0	3	1	1	1	0	60
California:											
Los Angeles	15	37	3	0	0	20	3	1	1	4	210
Sacramento	1	4	0	0	0	1	1	0	0	0	20
San Francisco	7	12	0	0	0	9	2	5	0	15	154

Division, State, and city	Cerebrospinal meningitis		Lethargic encephalitis		Pellagra		Poliomyelitis (infantile paralysis)		
	Cases	Deaths	Cases	Deaths	Cases	Deaths	Cases, estimated expectancy	Cases	Deaths
NEW ENGLAND									
Massachusetts:									
Boston	0	0	0	1	0	0	1	0	0
Rhode Island:									
Providence	0	0	0	0	0	0	0	1	0
Connecticut:									
Hartford	0	0	0	0	0	0	0	1	0
MIDDLE ATLANTIC									
New York:									
Buffalo	0	1	0	0	0	0	1	3	0
New York	1	1	4	2	0	0	9	2	0
Rochester	0	0	0	0	0	0	0	1	0
Pennsylvania:									
Philadelphia	0	0	0	0	0	0	1	2	0
EAST NORTH CENTRAL									
Ohio:									
Cleveland	0	0	1	0	0	0	1	3	0
Illinois:									
Chicago	1	1	1	2	0	0	3	2	0
Michigan:									
Detroit	1	0	1	0	0	0	1	1	0
Grand Rapids	0	0	0	0	0	0	0	1	1
WEST NORTH CENTRAL									
Minnesota:									
Minneapolis	0	0	0	0	0	0	0	1	0
SOUTH ATLANTIC									
Maryland:									
Baltimore	0	0	1	1	1	0	1	0	0
Virginia:									
Richmond	0	0	0	1	0	0	0	1	0
Roanoke	0	0	0	1	0	0	0	0	0

City reports for week ended October 30, 1926—Continued

Division, State, and city	Cerebrospinal meningitis		Lethargic encephalitis		Pellagra		Poliomyelitis (infantile paralysis)		
	Cases	Deaths	Cases	Deaths	Cases	Deaths	Cases, estimated expectancy	Cases	Deaths
SOUTH ATLANTIC—continued									
South Carolina:									
Charleston [1]	0	0	0	0	4	1	0	0	0
Columbia	0	0	0	0	0	0	0	1	0
EAST SOUTH CENTRAL									
Tennessee:									
Memphis	0	0	0	0	1	1	0	0	0
Nashville	1	1	0	0	0	0	0	0	0
Alabama:									
Birmingham	0	0	0	0	1	1	0	0	0
Mobile	0	0	0	0	0	1	0	0	0
WEST SOUTH CENTRAL [2]									
Arkansas:									
Little Rock	0	0	0	0	0	2	0	0	0
Louisiana: [3]									
Shreveport	0	0	0	0	0	1	0	0	0
Texas:									
Dallas	0	0	0	0	1	1	0	1	1
San Antonio	0	0	0	0	0	2	0	0	0
MOUNTAIN									
Colorado:									
Denver	1	1	0	0	0	0	0	0	0
PACIFIC									
Washington:									
Spokane	1	0	0	0	0	0	0	0	0
Oregon:									
Portland	1	0	0	0	0	0	1	1	0
California:									
Los Angeles	1	1	0	0	0	0	0	1	0
Sacramento	1	1	0	0	0	0	0	0	0
San Francisco	0	1	2	2	0	0	0	0	0

[1] Dengue; 1 case at Charleston, S. C.
[2] Typhus fever; 1 case at Oklahoma City, Okla.
[3] Plague (imported); 2 cases and 1 death at New Orleans, La.

The following table gives the rates per 100,000 population for 101 cities for the five-week period ended October 30, 1926, compared with those for a like period ended October 31, 1925. The population figures used in computing the rates are approximate estimates as of July 1, 1925, and 1926, respectively, authoritative figures for many of the cities not being available. The 101 cities reporting cases had an estimated aggregate population of nearly 30,000,000 in 1925 and nearly 30,500,000 in 1926. The 95 cities reporting deaths had more than 29,200,000 estimated population in 1925 and more than 29,730,000 in 1926. The number of cities included in each group and the estimated aggregate populations are shown in a separate table below.

Summary of weekly reports from cities, September 26 to October 30, 1926—Annual rates per 100,000 population, compared with rates for the corresponding period of 1925 [1]

DIPHTHERIA CASE RATES

	Week ended—									
	Oct. 3, 1925	Oct. 2, 1926	Oct. 10, 1925	Oct. 9, 1926	Oct. 17, 1925	Oct. 16, 1926	Oct. 24, 1925	Oct. 23, 1926	Oct. 31, 1925	Oct. 30, 1926
101 cities	[2] 115	128	134	159	150	165	[3] 163	203	[4] 176	[5] 213
New England	74	66	96	66	120	85	[6] 94	85	132	106
Middle Atlantic	84	81	114	118	129	100	128	122	148	138
East North Central	[2] 130	136	153	188	166	219	180	261	186	[5] 244
West North Central	192	143	198	177	233	209	256	240	278	264
South Atlantic	207	163	179	216	209	218	[7] 252	302	213	357
East South Central	63	270	89	254	89	270	100	400	89	384
West South Central	62	211	79	176	88	219	101	280	251	331
Mountain	129	291	194	173	157	164	361	255	[4] 170	155
Pacific	102	175	102	200	105	175	135	191	149	205

MEASLES CASE RATES

101 cities	[2] 39	36	53	31	67	43	[3] 91	49	[4] 102	[5] 61
New England	242	21	371	33	431	26	[6] 578	26	582	24
Middle Atlantic	35	10	47	11	65	9	87	12	110	13
East North Central	[2] 24	24	24	29	24	36	45	47	54	[5] 69
West North Central	6	10	6	26	10	44	10	42	12	85
South Atlantic	23	13	15	15	52	21	[7] 37	26	56	9
East South Central	11	5	11	5	5	0	37	21	16	21
West South Central	0	0	0	0	0	13	13	4	4	0
Mountain	9	109	37	109	18	237	28	337	[4] 19	391
Pacific	3	329	11	181	28	291	11	278	14	342

SCARLET FEVER CASE RATES

101 cities	[2] 86	100	92	111	121	130	[3] 127	152	[4] 155	[5] 168
New England	86	104	105	144	127	144	[6] 125	194	194	246
Middle Atlantic	62	51	65	57	75	62	96	51	106	92
East North Central	[2] 96	99	109	121	143	132	135	155	185	[5] 155
West North Central	176	197	119	215	256	318	284	373	292	354
South Atlantic	67	111	92	100	129	126	[7] 126	163	180	133
East South Central	74	99	121	145	142	145	121	223	74	332
West South Central	48	69	62	69	53	86	40	95	40	112
Mountain	176	319	148	300	46	264	111	446	[4] 189	364
Pacific	88	175	102	159	135	205	127	235	141	237

SMALLPOX CASE RATES

101 cities	[2] 2	1	5	3	8	4	[3] 7	3	[4] 10	[5] 3
New England	0	0	0	0	0	0	[6] 7	0	0	0
Middle Atlantic	0	0	0	0	0	0	0	0	0	0
East North Central	[2] 0	0	1	1	8	3	4	3	16	[5] 1
West North Central	2	2	10	2	0	6	4	0	25	2
South Atlantic	0	4	6	0	6	4	[7] 0	9	6	6
East South Central	0	0	16	10	42	0	5	10	5	5
West South Central	0	0	0	4	0	4	0	0	0	4
Mountain	9	9	9	9	28	9	9	0	[4] 9	9
Pacific	25	5	44	19	55	32	75	16	44	22

[1] The figures given in this table are rates per 100,000 population, annual basis, and not the number of cases reported. Populations used are estimated as of July 1, 1925 and 1926, respectively.
[2] Superior, Wis., not included.
[3] Barre, Vt., and Winston-Salem, N. C., not included.
[4] Helena, Mont., not included.
[5] Milwaukee, Wis., not included.
[6] Barre, Vt., not included.
[7] Winston-Salem, N. C., not included.

Summary of weekly reports from cities, September 26 to October 30, 1926—Annual rates per 100,000 population, compared with rates for the corresponding period of 1925—Continued

TYPHOID FEVER CASE RATES

	Week ended—									
	Oct. 3, 1925	Oct. 2, 1926	Oct. 10, 1925	Oct. 9, 1926	Oct. 17, 1925	Oct. 16, 1926	Oct. 24, 1925	Oct. 23, 1926	Oct. 31, 1925	Oct. 30, 1926
101 cities	[2] 39	42	36	33	35	32	[3] 32	26	[4] 25	[5] 28
New England	46	17	26	17	24	57	[6] 14	19	17	12
Middle Atlantic	32	28	31	27	28	26	25	20	21	14
East North Central	[2] 20	33	21	23	31	15	9	13	15	[5] 18
West North Central	35	40	33	22	20	14	33	22	18	24
South Atlantic	50	115	52	77	65	66	[7] 73	77	25	75
East South Central	131	130	163	145	121	140	147	99	100	140
West South Central	92	47	57	22	44	26	79	22	79	39
Mountain	111	82	120	64	46	46	65	27	[4] 85	46
Pacific	28	19	8	22	19	16	30	13	19	19

INFLUENZA DEATH RATES

95 cities	[2] 5	6	3	4	6	6	[3] 8	7	[4] 10	[5] 11
New England	0	2	0	0	0	5	[6] 2	7	12	7
Middle Atlantic	3	2	3	3	5	4	8	8	10	8
East North Central	[2] 6	5	3	2	8	2	9	5	7	[5] 15
West North Central	6	0	4	6	6	11	6	2	11	2
South Atlantic	4	9	2	6	2	8	[7] 2	8	6	21
East South Central	16	10	0	5	16	16	5	10	26	10
West South Central	19	38	15	14	10	14	19	14	34	24
Mountain	0	18	9	18	0	27	37	27	[4] 9	9
Pacific	0	7	0	0	11	11	4	0	4	7

PNEUMONIA DEATH RATES

95 cities	[2] 61	69	63	64	90	77	[3] 88	85	[4] 117	[5] 96
New England	31	87	58	33	93	76	[6] 87	83	108	99
Middle Atlantic	68	71	63	76	94	88	89	104	136	101
East North Central	[2] 44	59	61	54	89	63	79	60	114	[5] 86
West North Central	36	70	45	63	58	53	60	49	97	63
South Atlantic	81	66	71	60	121	88	[7] 116	113	129	107
East South Central	100	109	110	83	95	52	121	99	105	135
West South Central	63	71	63	94	53	104	111	57	116	80
Mountain	139	155	92	55	120	118	111	127	[4] 76	182
Pacific	87	28	51	53	80	82	76	99	47	89

[2] Superior, Wis., not included.
[3] Barre, Vt., and Winston-Salem, N. C., not included.
[4] Helena, Mont., not included.
[5] Milwaukee, Wis., not included.
[6] Barre, Vt., not included.
[7] Winston-Salem, N. C., not included.

Number of cities included in summary of weekly reports, and aggregate population of cities in each group, approximated as of July 1, 1925 and 1926, respectively

Group of cities	Number of cities reporting cases	Number of cities reporting deaths	Aggregate population of cities reporting cases		Aggregate population of cities reporting deaths	
			1925	1926	1925	1926
Total	101	95	29,900,058	30,427,598	29,221,531	29,733,613
New England	12	12	2,176,124	2,206,124	2,176,124	2,206,124
Middle Atlantic	10	10	10,346,970	10,476,970	10,346,970	10,476,970
East North Central	16	16	7,481,656	7,655,436	7,481,656	7,655,436
West North Central	12	10	2,550,024	2,589,131	2,431,253	2,468,448
South Atlantic	21	21	2,716,070	2,776,070	2,716,070	2,776,070
East South Central	7	7	993,103	1,004,953	993,103	1,004,953
West South Central	8	6	1,184,057	1,212,057	1,078,198	1,103,695
Mountain	9	9	563,912	572,773	563,912	572,773
Pacific	6	4	1,888,142	1,934,084	1,434,245	1,469,144

FOREIGN AND INSULAR

THE FAR EAST

Report for week ended October 23, 1926.—The following report for the week ended October 23, 1926, was transmitted by the Far Eastern Bureau of the Secretariat of the Health Section of the League of Nations, located at Singapore, to the headquarters at Geneva:

Maritime towns	Plague		Cholera		Smallpox	
	Cases	Deaths	Cases	Deaths	Cases	Deaths
Egypt: Alexandria	0	0	0	0	2	1
Mauritius: Port Louis	----	2	0	0	0	0
Madagascar: Tamatave	1	0	0	0	0	0
British India:						
Calcutta	----	0	----	15	4	2
Bombay	----	0	----	0	7	5
Madras	----	0	----	0	2	1
Rangoon	----	1	----	0	----	1
Dutch East Indies:						
Batavia	0	0	0	0	1	0
Padang	0	0	0	0	4	----
Siam: Bangkok	0	0	1	0	2	1
China:						
Amoy	0	0	5	----	0	0
Shanghai	0	0	3	1	0	0
U. S. S. R.: Vladivostok	0	0	0	0	3	----

Telegraphic reports from the following maritime towns indicated that no case of plague, cholera, or smallpox was reported during the week:

ASIA

Arabia.—Aden, Jeddah, Kamaran, Perim.

Iraq.—Basrah.

Persia.—Mohammerah, Bender-Abbas, Bushire.

British India.—Karachi, Chittagong, Cochin, Vizagapatam, Tuticorin, Negapatam.

Ceylon.—Colombo.

Federated Malay States.—Port Swettenham.

Straits Settlements.—Singapore, Penang.

Dutch East Indies.—Cheribon, Surabaya, Samarang, Belawan-Deli Sabang, Makassar, Banjermasin, Tarakan, Palembang, Menado, Samarinda, Pontianak.

Sarawak.—Kuching.

British North Borneo.—Sandakan, Jesselton, Kudat, Tawao.

Portuguese Timor.—Dilly.

French Indo-China.—Saigon and Cholon, Turane, Haiphong.

China.—Hong-Kong.

Formosa.—Keelung

Japan.—Yokohama, Osaka, Nagasaki, Moji, Kobe, Niigata, Tsuruga, Hakodate, Shimonoseki.

Korea.—Chemulpo, Fusan.

Manchuria.—Mukden, Changchun, Harbin, Antung.

Kwantung.—Port Arthur, Dairen.

AUSTRALASIA AND OCEANIA

Australia.—Adelaide, Melbourne, Sydney, Brisbane, Rockhampton, Townsville, Port Darwin, Broome, Fremantle, Carnarvon, Thursday Island.

New Guinea.—Port Moresby,

New Britain Mandated Territory.—Rabaul.

New Zealand.—Auckland, Wellington, Christchurch, Invercargill, Dunedin.

New Caledonia.—Noumea.

Fiji.—Suva.

Hawaii.—Honolulu.

Society Islands.—Papeete.

AFRICA

Egypt.—Port Said, Suez.

Anglo-Egyptian Sudan.—Port Sudan, Suakin.

Eritrea.—Massaua.

French Somaliland.—Jibuti.

British Somaliland.—Berbera.

Italian Somaliland.—Mogadiscio.

Kenya.—Mombasa.

Zanzibar.—Zanzibar.

Tanganyika.—Dar-es-Salaam.

Seychelles.—Victoria.

Portuguese East Africa.—Mozambique, Beira, Lorenco Marques.

Madagascar.—Majunga.

Union of South Africa.—Durban, East London, Port Elizabeth, Cape Town.

Reports had not been received in time for distribution from—

Dutch East Indies.—Balik-Papan.

Philippine Islands.—Manila, Iloilo, Jolo, Cebu, Zamboanga.

CANADA

Communicable diseases—Quebec—August, 1926.—Births and deaths in the Province of Quebec for the month of August, 1926, have been reported as follows:

Estimated population	2,570,000
Births	6,592
Birth rate per 1,000 population	30.77
Deaths (all causes)	2,890
Death rate per 1,000 population	13.49
Deaths under 1 year	1,176
Infant mortality rate	178.39
Deaths from—	
Cancer	123
Cerebrospinal meningitis	8
Diabetes	22
Diphtheria	20
Deaths from—Continued.	
Heart disease	316
Influenza	16
Measles	12
Poliomyelitis (infantile paralysis)	3
Scarlet fever	10
Syphilis	7
Tuberculosis (pulmonary)	177
Tuberculosis (all other forms)	50
Typhoid fever	11
Whooping cough	53

CUBA

Communicable diseases—Habana—October, 1926.—During the month of October, 1926, communicable diseases were reported at Habana, Cuba, as follows:

Disease	New cases	Deaths	Remaining under treatment Oct. 31, 1926	Disease	New cases	Deaths	Remaining under treatment Oct. 31, 1926
Chicken pox	3		2	Measles	3		
Diphtheria	5	1	1	Scarlet fever	4		3
Leprosy	3		10	Typhoid fever [1]	93	12	71
Malaria [1]	135	2	31				

[1] Many of these cases from the interior.

FINLAND

Communicable diseases—August, 1926.—During the month of August, 1926, communicable diseases were reported in the Republic of Finland as follows:

Disease	Cases	Disease	Cases
Diphtheria	73	Poliomyelitis	1
Dysentery	5	Scarlet fever	50
Paratyphoid fever	129	Typhoid fever	78

MADAGASCAR

Plague—Tananarive Province—August 16–31, 1926.—During the 16 days ended August 31, 1926, 79 cases of plague with 78 deaths were reported in the Province of Tananarive, Madagascar. Of these, 17 cases, 1 bubonic and 16 pneumonic, occurred in the interior town of Tananarive. Of the remaining cases, 9 with 8 deaths were bubonic, 15 cases with 15 deaths pneumonic, and 38 cases with 38 deaths septicemic.

SALVADOR

Mortality from communicable diseases—San Salvador—August, 1926.—During the month of August, 1926, there were reported 61 deaths from communicable diseases at San Salvador, Republic of Salvador, of which 1 death was caused by diphtheria, and 1 by typhoid fever. There were reported 38 deaths from gastroenteritis and 21 from tuberculosis. Population, 85,000.

Mortality—Republic of Salvador—Disease prevalence.—During the period under report 3,665 deaths from all causes were reported for the Republic of Salvador. Population, 1,600,000. Malarial and other tropical fevers were stated to be the most prevalent diseases.

CHOLERA, PLAGUE, SMALLPOX, TYPHUS FEVER, AND YELLOW FEVER

The reports contained in the following tables must not be considered as complete or final as regards either the lists of countries included or the figures for the particular countries for which reports are given

Reports Received During Week Ended November 19, 1926[1]

CHOLERA

Place	Date	Cases	Deaths	Remarks
China:				
Foochow	Sept. 19–Oct. 2			Present. One death in foreign population.
Nanking	do			Present.
Shanghai	do	2	24	Cases, native. Deaths, in foreign and natives, international settlements.
Swatow	Sept 26–Oct. 2			Sporadic. Slight increase reported.
French Settlements in India	June 27–July 24	42	36	
India				Sept. 5–18, 1926: Cases, 4,053; deaths, 2,586.
Calcutta	Sept. 19–25	9	7	
Philippine Islands:				
Manila	Oct. 2	1		
Siam				Sept. 19–25, 1926: Cases, 39; deaths, 35. Apr. 1–Sept. 25, 1926: Cases, 7,643; deaths, 5,023.
Bangkok	Sept. 19–25	3		

PLAGUE

France:				
Paris	Oct. 18	1		
India				Sept. 5–18, 1926: Cases, 2,268; deaths, 1,237.
Madras Presidency	Sept. 12–18	56	27	
Rangoon	Sept. 26–Oct. 2	3	3	
Java:				
Batavia	do	6	6	
Cheribon	Sept. 12–18	1	1	
Madagascar:				
Tananarive Province				Aug. 16–31, 1926: Cases, 79; deaths, 78. Bubonic, pneumonic, and septicemic.
Tananarive Town	Aug. 16–31	17	17	Bubonic, 1; pneumonic, 16.
Other localities	do	62	61	Bubonic, 9; pneumonic, 15; septicemic, 38.
Nigeria	May 1–June 30	76	71	
Senegal	Mar. 1–Apr. 30	21	6	Later reports.
Do	May 1–31	129	71	
Siam				Apr. 1–Sept. 25, 1926: Cases, 15; deaths, 10.
Tunisia	July 21–Aug. 20	1		

[1] From medical officers of the Public Health Service, American consuls, and other sources.

CHOLERA, PLAGUE, SMALLPOX, TYPHUS FEVER, AND YELLOW FEVER—Continued

Reports Received During Week Ended November 19, 1926—Continued

SMALLPOX

Place	Date	Cases	Deaths	Remarks
Algeria	July 21-Aug. 20	87		
Brazil:				
Bahia	Sept. 25-Oct. 2	3	1	
Pernambuco	Sept. 12-25	51	4	
Rio de Janeiro	Oct. 3-16	196	113	Jan. 1-Oct. 16, 1926: Cases, 3,601; deaths, 1,895.
Sao Paulo	June 27-Aug. 22		5	
Canada:				
Ontario—				
Toronto	Oct. 17-23	1		
Ceylon:				
Colombo	Sept. 19-Oct. 2	6		
China:				
Changchun	Sept. 5-11	1		
Foochow	Sept. 19-Oct. 2			Present
Fushun	Sept. 12-18	1		
Penhsihu	Aug. 8-22	2		
Ssupingkai	Aug. 1-7	1		Manchurian Railway.
Wa-feng-tien	do	1		Do.
Chosen	June 1-30	119	25	
Egypt:				
Alexandria	Aug. 24-Oct. 7	2	1	
France	July 1-31	17		
Paris	Oct. 1-10	22	4	
St. Etienne	Sept. 16-30	2	1	
French Settlements in India	June 27-July 31	37	37	
Gold Coast	June 1-30	9		
Great Britain:				
England and Wales	Oct. 3-16	253		
Hull	Oct. 17-23	1		
London	Oct. 10-16	1		
India				Sept. 5-18, 1926: Cases, 3,831; deaths, 851.
Calcutta	Sept. 19-Oct. 2	7	5	
Madras	Oct. 3-9	11	1	
Italy	July 11-31	8		
Japan	June 20-26	17		
Do	June 27-July 17	40		
Java:				
Batavia	Sept. 19-25	1		Province.
Surabaya	Sept. 5-11	10	1	
Mexico	May 1-31		297	
Nigeria	May 1-June 30	117	16	
Portugal:				
Lisbon	Oct. 3-23	4		
Russia	Apr. 1-30	426		
Siam				Sept. 19-25, 1926: Cases, 7; deaths, 4. Apr. 1-Sept. 25, 1926: Cases, 583; deaths, 230.
Bangkok	Sept. 19-25	7	4	
Spain:				
Valencia	Oct. 17-23	1		
Tripolitania	May 1-June 30	1		
Tunisia	June 21-30	1		
Do	July 1-Aug. 20	15		
Union of South Africa:				
Transvaal—				
Johannesburg	Sept. 19-25	2		

TYPHUS FEVER

Algeria	July 21-Aug. 20	18	1	
Chosen	June 1-30	118	21	
Egypt:				
Alexandria	Oct. 1-7	1	1	
Port Said	do	1		
Hungary	May 1-June 30	3		
Ireland (Irish Free State):				
Cork County	Oct. 17-23	1		
Lithuania	July 1-31	17		
Mexico	May 1-31		45	
Mexico City	Oct. 10-23	13		Including municipalities in the Federal district.
Morocco	July 1-31	10		
Palestine				Oct. 5-11, 1926: Cases, 7.
Petah Tokvah	Oct. 5-11	3		
Poland	July 25-Aug. 14	64	4	
Russia	Apr. 1-30	3,833		

CHOLERA, PLAGUE, SMALLPOX, TYPHUS FEVER, AND YELLOW FEVER—Continued

Reports Received During Week Ended November 19, 1926—Continued

TYPHUS FEVER—Continued

Place	Date	Cases	Deaths	Remarks
Tunisia	June 21-30	6		
Do	July 1-Aug. 20	58		
Union of South Africa:				
Natal—				
Durban	Sept. 11-18	1		

YELLOW FEVER

Gold Coast	June 1-30	2	1	
Nigeria	do	1	1	

Reports Received from June 26 to November 12, 1926 [1]

CHOLERA

Place	Date	Cases	Deaths	Remarks
Ceylon				Apr. 18-May 29, 1926: Cases, 31; deaths, 29.
China:				
Amoy	Aug. 8-Oct. 2	235		Stated to be present in epidemic form.
Canton	June 1-30	38	14	
Do	July 15-31	54	28	
Foochow	Aug. 15-Sept. 18			Present.
Kulangsu	Sept. 12-18		2	
Manchuria—				
Dairen	Aug. 23-29	1	1	
Nanking	July 25-Aug. 7			Do.
Shanghai	Reported July 20	35	8	
Do	July 25-Sept. 18	36	385	Cases, foreign; deaths, native and foreign.
Swatow	July 11-Sept. 25	36	63	
Tsingtao	July 11-Aug. 30	4	4	Japanese settlements, 10 deaths; Chinese, 30 to 40 deaths daily; estimated.
Chosen:				
North Hcian Province	Sept 3-16	70	30	Deaths estimated.
Shingishu	Sept. 13	19		Including places in vicinity.
French Settlements in India				Mar. 7-June 26, 1926: Cases, 31; deaths, 30.
India				Apr. 25-June 26, 1926: Cases, 18,526; deaths, 11,531. June 27-Sept. 4, 1926: Cases, 20,991; deaths, 13,391.
Bombay	May 30-June 5	1	1	
Do	July 18-Aug. 28	3	3	
Calcutta	Apr. 4-May 29	478	418	
Do	June 13-26	73	69	
Do	June 27-Sept. 18	295	265	
Madras	May 16-June 5	2	1	
Do	Aug. 1-Sept. 25	7	6	
Rangoon	May 9-June 26	67	44	
Do	June 27-Sept. 4	31	29	
Indo-China:				
Saigon	May 2-15	52	48	
Do	May 22-June 26	42	32	
Do	June 27-Aug. 14	31	17	
Japan				To Sept. 10, 1926: Cases, 35.
Ken (Prefecture)—				
Hiroshima	To Sept. 10	1		
Hyogo	do	7		
Kagakawa	do	8		
Kanagawa	do	3		Including Yokohama.
Kochi	do	1		
Ookayama	do	7		
Osaka	do	6		
Taihoku	Sept. 1-10	2		
Wakayama	To Sept. 10	2		

[1] From medical officers of the Public Health Service, American consuls, and other sources.

CHOLERA, PLAGUE, SMALLPOX, TYPHUS FEVER, AND YELLOW FEVER—Continued

Reports Received from June 26 to November 12, 1926—Continued

CHOLERA—Continued

Place	Date	Cases	Deaths	Remarks
Philippine Islands:				
Manila	May 18–24	2	2	
Do	June 27–Sept. 11	13	3	
Provinces—				
Albay	Apr. 18–24	1	1	
Davao	May 23–29	1		
Mindoro	Feb. 21–Mar. 6	3	3	
Pampanga	July 25–31	1	1	
Rizal	July 18–24	1		
Romblon	Dec. 14–31	42	43	
Do	Jan. 2–Mar. 27	41	35	
Siam				Apr. 1–Sept. 18, 1926: Cases, 7,604; deaths, 4,988.
Bangkok	May 2–June 12	1,325	736	
Do	June 20–26	56	26	
Do	June 27–Sept. 18	91	33	
Straits Settlements:				
Singapore	July 4–17	2	1	
On vessel:				
Steamship Macedonia	Aug. 5	7		At Yokohama, Japan. Vessel sailed from Singapore, July 18, 1926.

PLAGUE

Algeria:				
Algiers	June 21–30	1		Under date of July 16, 2 cases reported.
Do	July 1–20	1		
Do	Sept. 23	1		
Bona	Aug. 14	1		
Oran	Sept. 21–Oct. 10	9	4	
Philippeville	Sept. 7	1		
Azores:				
Fayal Island—				
Horta	Aug. 2–29	2	2	
St. Michaels Island	May 9–June 26	4	1	
Do	June 27–July 10	3	1	
Brazil:				
Paranagua	Oct. 8			Present.
British East Africa:				
Kisumu	May 16–22	1	1	
Do	Aug. 17–Sept. 11	3	2	
Uganda	Mar. 1–June 30	732	574	
Canary Islands:				
Teneriffe	Aug. 2	2		
Ceylon:				
Colombo	May 29–June 5	1	1	
Chile:				
Iquique	June 20–26		1	
China:				
Amoy	Apr. 18–June 26	40	30	
Do	June 27–Aug. 7	28		
Foochow	June 6–July 31			Several cases. Not epidemic.
Nanking	May 9–Sept. 18			Prevalent.
Swatow	July 25–31	14		
Ecuador				January–June, 1926: Cases, 385; deaths, 154.
Chimborazo	January–June	9	2	Rats, taken, 766.
Guayaquil	May 16–June 30	6		Rats taken, 30,914; found infected, 31.
Do	July 1–Sept. 30	16	3	Rats taken, 62,544; found infected, 89.
Leon	January–June	43	19	Localities, 2.
Loja	do	176	75	Cantons, 2.
Tungurahua	do	83	29	At Ambato, Huachi, and Picayhua. Rats taken, 1,542.
Egypt				Jan. 1–Sept. 9, 1926: Cases, 128.
City—				
Alexandria	July 27–Aug. 12	4	1	
Suez	May 21–July 1	9	5	
Do	July 29	2		
Provinces—				
Behera	July 23–Aug. 15	4	1	
Beni-Suef	May 23–June 8	8	2	
Charkieh	July 27	1	1	
Gharbieh	June 2	1	1	
Minieh	July 24	1	1	
Sidi Barani	Sept. 30–Oct. 12	19	3	In western desert.

CHOLERA, PLAGUE, SMALLPOX, TYPHUS FEVER, AND YELLOW FEVER—Continued

Reports Received from June 26 to November 12, 1926—Continued

PLAGUE—Continued

Place	Date	Cases	Deaths	Remarks
France:				
Marseille	July 8	1	1	Reported July 24.
St. Denis	Reported Aug. 2	1		Vicinity of Paris.
St. Ouen	Aug. 14	2		Suburb of Paris.
Great Britain:				
Liverpool	Aug. 29–Sept. 4	2	1	
Greece:				
Athens	Apr. 1–May 31	16	4	Including Piræus.
Do	Aug. 1–Sept. 30	20	5	Do.
Patras	May 27–June 12	4	1	
Do	July 25–Oct. 2	8	4	
Zante	May 17	1		
Hawaii:				
Hamakua	June 9			1 plague rodent trapped near Hamakua Mill.
Paauhau	July 18–24			Plague-infected rat trapped.
India				Apr. 25–June 16, 1926: Cases, 53,001; deaths, 41,576. June 27–Sept. 4, 1926: Cases, 3,471; deaths, 2,038.
Bombay	May 2–June 26	16	15	
Do	July 18–Sept. 18	9	8	
Karachi	May 23–June 26	15	13	
Do	July 11–17	1	1	
Madras Presidency	Apr. 25–June 26	162	93	
Do	July 4–Sept. 11	599	291	
Rangoon	May 9–June 26	20	15	
Do	June 27–Sept. 25	80	69	
Indo-China:				
Saigon	May 23–June 26	8	3	
Do	July 18–Aug. 7	2	1	
Iraq:				
Baghdad	Apr. 18–June 12	161	108	
Do	July 18–Sept. 11	4	4	
Japan:				
Yokohama	July 2–Aug. 10	9	80	
Java:				
Batavia	Apr. 24–June 19	65	65	
Do	June 26–Sept. 11	64	62	
Cheribon	Apr. 11–24	3	3	
East Java and Madura	June 13–19	1	1	
Do	July 25–31	1	1	
Surabaya	Aug. 22–28	17	2	
Madagascar:				
Ambositra Province	May 1–15	4	4	Septicemic.
Antisirabi Province	June 16–30	4	4	
Itasy Province	do	17	10	
Majunga Province	do	10	6	
Mananjary Province	do	1	1	
Moramanga Province	Apr. 1–15	2	2	Do.
Tananarive Province				Apr. 1–June 30, 1926: Cases, 130; deaths, 120. July 1–Aug. 15, 1926: Cases, 47; deaths, 41.
Towns—				
Majunga	Aug. 1–15	14	10	
Tamatave (Port)	May 16–31	1	1	
Do	July 1–Aug. 15	6	5	
Tananarive	Apr. 1–June 30	7	7	
Do	July–Aug. 15	7	7	
Mauritius:				
Port Louis	July 31	1	1	
Nigeria				Feb. 1–Apr. 30, 1926: Cases, 115; deaths, 92.
Peru				May–June, 1926: Cases, 57; deaths, 16. July 1–Sept. 30, 1926: Cases, 89; deaths, 52.
Departments—				
Ancash	May 1–31			Present.
Do	July 1–Sept. 30	2		
Cajamarca	May 1–June 30	10	4	
Do	Aug. 1–Sept. 30	1		
Ica	May 1–31	1		
Do	July 1–31	1		
Junin	Sept. 1–30	21	20	
Lambayeque	do	1		
Libertad	May 1–31	4		
Do	Sept. 1–30	3	1	
Lima	May 1–June 30	29	12	
Do	July 1–Sept. 30	60	31	
Piura	June 1–30	13		
Russia				Jan. 1–Mar. 31, 1926: Cases, 37.

CHOLERA, PLAGUE, SMALLPOX, TYPHUS FEVER, AND YELLOW FEVER—Continued

Reports Received from June 26 to November 12, 1926—Continued

PLAGUE—Continued

Place	Date	Cases	Deaths	Remarks
Senegal				Nov. 1–30, 1925: Cases, 3; deaths, 2. Mar. 1–Apr. 30, 1926: Cases, 15; deaths, 4.
Siam				Apr. 1–Sept. 11, 1926: Cases, 15; deaths, 10.
Bangkok	May 23–June 26	2	2	
Do	July 18–24	1	1	
Straits Settlements:				
Singapore	May 2–8	1	1	
Do	July 4–17	1	1	
Syria:				
Beirut	July 1–Aug. 10	2		
Do	Oct. 15			Present.
Tunisia	May 11–June 30	174		
Do	July 1–20	12		
Kairouan	June 9	3		9 cases 30 miles south of Kairouan.
Turkey:				
Constantinople	Aug. 1–Sept. 25	7	4	
Union of South Africa:				
Cape Province	May 16–22	5	3	
Calvinia District	June 13–26	12	6	
Do	June 27–Aug. 21	3	3	
Williston District	June 13–26	2		
Do	June 27–July 3	1		
Orange Free State—				
Hoopstad District	Aug. 15–21	1		
Protestpan	May 9–22	3	3	
On vessel:				
Steamship Zaria	September, 1926	2	2	At Liverpool, England, from Lagos, Nigeria, West Africa; 29 plague-infected rats found on board.

SMALLPOX

Algeria:				
Algiers	May 21–June 20	14		
Do	July 1–Aug. 31	3		
Arabia:				
Aden	Oct. 3–9	1		Imported.
Belgium:				
Antwerp	Aug. 1–7	1	1	
Bolivia:				
La Paz	May 1–June 30	14	7	
Do	July 1–Aug. 31	16	8	
Brazil:				
Bahia	June 20–26	1		
Do	June 27–Sept. 18	68	38	
Manaos	Apr. 1–30		5	
Para	May 16–June 26	26	25	
Do	June 27–Sept. 25	29	19	
Pernambuco	July 11–Sept. 11	115	18	
Porto Alegre	Aug. 10–31	2		
Rio de Janeiro	May 2–June 19	132	91	
Do	July 4–Sept. 25	2,534	1,338	
Santos	Mar. 1–7		1	
British East Africa:				
Mombasa	July 5–11	5	4	
Tanganyika	May 1–31	252	46	
Uganda	Mar. 1–May 31	3		
British South Africa:				
Northern Rhodesia	May 18–24	17	6	Natives.
Do	June 8–14	5		
Do	Sept. 11–17	1		
Canada				May 30–June 12, 1926: Cases, 46.
Alberta				May 30–June 12, 1926: Cases, 3.
Calgary	Sept. 5–Oct. 16	21		June 27–Oct. 16, 1926: Cases, 53.
British Columbia—				
Vancouver	Aug. 16–Sept. 12	3		
Manitoba				May 30–June 26, 1926: Cases, 15.
Winnipeg	June 6–12	5		June 27–Sept. 25, 1926: Cases, 19.
Do	July 4–Sept. 4	12		

CHOLERA, PLAGUE, SMALLPOX, TYPHUS FEVER, AND YELLOW FEVER—Continued

Reports Received from June 26 to November 12, 1926—Continued

SMALLPOX—Continued

Place	Date	Cases	Deaths	Remarks
Canada—Continued.				
New Brunswick—				
Northumberland County.	Oct. 11-23	1		
Ontario				May 30-June 26, 1926: Cases, 33. June 27-Oct. 23: Cases, 87.
Fort William	July 25-Aug. 7	2		
Kingston	May 23-June 26	5		
Do	July 11-17	2		
Kitchener	Apr. 26-May 29	3	1	
North Bay	May 2-22	5		
Do	July 25-31	2		
Orillia	Apr. 26-May 29	7		
Ottawa	July 18-24	1		
Packenham	do	10		
Peterboro	Sept. 1-30	10		
Toronto	July 18-Oct. 9	11		
Waterloo	July 18-24	6		
Saskatchewan				May 30-June 26, 1926: Cases, 16; June 27-Oct. 23: Cases, 89.
Regina	July 4-Sept. 25	3		
Ceylon				Mar. 14-May 29, 1926: Cases, 44; deaths, 3. Sept. 12-18, 1926: Cases, 2.
Chile:				
Antofagasta	June 6-12	1		
China:				
Amoy	May 1-June 26	4	8	
Do	July 4-10	1		
Antung	May 17-June 19	5		
Do	July 4-18	2		
Canton	May 1-31	4	2	
Changsha	Aug. 8-14	1		
Chungking	May 2-Sept. 18			Present.
Foochow	May 2-Sept. 11			Do.
Hongkong	May 2-June 26	19	10	
Do	June 27-July 3	1	1	
Manchuria	July 4-31	18		Railway stations.
An-shan	May 16-June 12	5		South Manchurian Railway.
Antung	May 16-June 19	5		
Changchun	May 16-June 26	6		Do.
Do	June 27-July 3	1		Do.
Dairen	Apr. 26-June 20	69	16	
Do	June 28-Aug. 8	5	3	
Fushun	May 16-June 5	4		Do.
Harbin	May 14-June 30	21		Do.
Do	July 1-28	12		
Kai-yuan	May 16-June 30	10		Do.
Kungchuling	June 13-19	1		Do.
Liaoyang	May 16-June 30	4		Do.
Mukden	do	4		Do.
Penhsihu	May 16-June 19	4		Do.
Ssupingkai	May 16-June 30	2		Do.
Teshihchiao	do	2		Do.
Wa-feng-tien	do	3		Do.
Nanking	May 8-Sept. 18			Present.
Shanghai	May 2-June 26	10	25	Cases, foreign: Deaths, population of international concession, foreign and native.
Do	June 27-July 24	3	3	
Swatow	May 9-Sept. 25			Sporadic.
Tientsin	June 2-26		1	Reported by British municipality.
Wanshien	May 1			Prevalent.
Chosen				Mar. 1-May 31, 1926: Cases, 548; deaths, 121.
Fusan	May 1-31	1		
Seishun	do	2	1	
Egypt:				
Alexandria	May 15-July 1	18	3	
Do	July 23-Aug. 19	11	5	
Cairo	Jan. 29-May 13	39	8	
Esthonia				May 1-June 30, 1926: Cases, 3.
France				Mar. 1-June 30, 1926: Cases, 141.
Paris	Sept. 1-20	21	5	
St. Etienne	Apr. 18-June 15	7	3	
French Settlements in India	Mar. 7-June 26	282	282	
Gold Coast	Mar. 1-May 31	662	13	

CHOLERA, PLAGUE, SMALLPOX, TYPHUS FEVER, AND YELLOW FEVER—Continued

Reports Received from June 26 to November 12, 1926—Continued

SMALLPOX—Continued

Place	Date	Cases	Deaths	Remarks
Great Britain:				
England and Wales				May 23–June 26, 1926: Cases, 933. June 27–Oct 2, 1926: Cases, 1,385.
Birmingham	Sept. 26–Oct. 2	1		
Bradford	May 23–29	1		
Do	Aug. 29–Sept. 4	1		
London	Sept. 26–Oct. 2	2		
Newcastle-on-Tyne	June 6–12	1		
Do	July 11–Oct. 9	4		St. Gateshead, several cases reported.
Nottingham	May 2–June 5	7		
Do	July 18–24	1		
Sheffield	June 13–19	1		
Do	July 4–Oct. 2	9		
South Shields	Oct. 3–9	1		
Greece:				
Athens	July 1–31	71	6	Including Piræus.
Saloniki	June 1–14		3	
Guatemala:				
Guatemala City	June 1–30		2	
India				Apr. 25–June 26, 1926: Cases, 54,851; deaths, 14,771. June 27–Sept. 4, 1926: Cases, 22,163; deaths, 7,099.
Bombay	May 2–June 26	220	134	
Do	June 27–Sept. 18	112	61	
Calcutta	Apr. 4–May 20	171	152	
Do	June 13–26	24	18	
Do	June 27–Sept. 18	38	37	
Karachi	May 16–June 26	44	18	
Do	June 27–Oct. 2	14	7	
Madras	May 16–June 26	7	4	
Do	June 27–Oct. 2	60	18	
Rangoon	May 9–June 26	10	5	
Do	July 4–Sept. 11	21	4	
Indo-China:				
Saigon	May 9–June 26	2		
Iraq:				
Baghdad	do	8	3	
Do	July 4–Sept. 11	3	1	
Basra	Apr. 18–June 22	34	25	
Do	Aug. 15–21	1		
Italy				Mar. 28–June 26, 1926: Cases, 34. June 27–July 10, 1926: Cases, 3.
Catania	Aug. 9–15	2		Entire consular district, including island of Sardinia.
Rome	June 14–20	4		
Jamaica				Apr. 25–June 26, 1926: Cases, 201. (Reported as alastrim.)
Do				June 27–Sept. 25, 1926: Cases, 238. (Reported as alastrim.)
Japan				Apr. 11–June 19, 1926: Cases, 641.
Kobe	May 30–June 5	1		
Nagoya	May 16–June 22		1	
Do	July 4–10	1		
Taiwan Island	May 11–20	24		
Do	June 1–20	23		
Do	July 11–Aug. 10	2		
Tokyo	June 26–July 17	3		
Yokohama	May 2–8	2		
Java:				
Batavia	May 15–June 25	2		Province.
Do	July 24–Sept. 18	9		Do.
East Java and Madura	Apr. 11–July 3	100	6	
Do	July 4–Aug. 7	43	1	
Malang	Apr. 4–10	6	1	Interior.
Surabaya	May 16–22	14	1	
Do	July 18–Sept. 4	87	6	
Latvia				Apr. 1–June 30, 1926: Cases, 5.
Mexico				Feb. 1–Apr. 30, 1926: Deaths, 982.
Aguascalientes	June 13–26		5	
Guadalajara	June 8–14		2	
Do	June 29–Sept. 27		8	
Mexico City	May 16–June 5	3		Including municipalities in Federal District.
Do	July 25–Sept. 25	6		Do.
Saltillo	July 18–24		1	
San Antonio de Arenales	Jan. 1–June 30			Present: 100 miles from Chihuahua.
San Luis Potosi	June 13–26		7	
Do	July 4–Oct. 23		19	
Tampico	June 1–10		2	
Torreon	May 1–June 30		17	
Do	July 1–Sept. 30		13	

CHOLERA, PLAGUE, SMALLPOX, TYPHUS FEVER, AND YELLOW FEVER—Continued

Reports Received from June 26 to November 12, 1926—Continued

SMALLPOX—Continued

Place	Date	Cases	Deaths	Remarks
Netherlands:				
Amsterdam	July 18-24		9	
Nigeria				Feb. 1-Apr. 30, 1926: Cases, 404; deaths, 33.
Persia:				
Teheran	Apr. 21-July 23		10	
Peru:				
Arequipa	June 1-30		1	
Poland				Mar. 28-May 1, 1926: Cases, 12; deaths, 1. June 27-July 24, 1926: Cases, 2; deaths, 1.
Portugal:				
Lisbon	Apr. 26-June 19	10	3	
Do	July 11-Sept. 25	22	6	
Oporto	May 23-June 5	4		
Do	July 11-24	2		
Russia				Jan. 1-Mar. 31, 1926: Cases, 2,103.
Siam				Apr. 1-Sept. 18, 1926: Cases, 576; deaths, 226.
Bangkok	May 2-June 12	23	20	
Do	July 4-Sept. 18	67	51	
Spain:				
Valencia	Aug. 22-Sept. 25	2		
Straits Settlements:				
Singapore	Apr. 25-May 1	1		
Do	July 11-17	1		
Sumatra:				
Medan	Aug. 22-28			One case varioloid.
Switzerland:				
Lucerne Canton	June 1-30	1		
Do	July 1-31	2		
Tripolitania	Apr. 1-30	11		
Tunisia				Apr. 1-June 30, 1926: Cases, 17.
Tunis	Aug. 11-30	2		
Union of South Africa	June 1-30	8	1	
Cape Province	June 20-26			Outbreaks.
Do	Aug. 15-21			Do.
Idutya district	May 23-29			Do.
Natal	May 30-June 5			Do.
Orange Free State	June 20-Aug. 28			Do.
Transvaal				June 6-12, 1926: Outbreaks in Pietersburg and Rustenburg districts.
Do	Aug. 29-Sept. 4	1		Native.
Johannesburg	May 9-June 12	5		
Do	July 11-Sept. 4	2		
Yugoslavia				Apr. 15-30, 1926: Cases, 2; deaths, 1.
Zagreb	Aug. 9-15	2		
On vessels:				
S. S. Karapara				At Zanzibar, June 7, 1926: One case of smallpox landed. At Durban, Union of South Africa June 16, 1926: One suspect case landed.
Steamship	July 2	1		Vessel from Glasgow, Scotland, for Canada. Patient from Glasgow; removed at quarantine on outward voyage.

TYPHUS FEVER

Algeria:				
Algiers	May 21-June 30	7	1	
Do	July 21-Aug. 31	3		
Argentina:				
Rosario	Feb. 1-28	2		
Bolivia:				
La Paz	June 1-30		1	
Do	Aug. 1-31	9	1	
Bulgaria				Mar. 1-June 30, 1926: Cases, 87; deaths, 14.

CHOLERA, PLAGUE, SMALLPOX, TYPHUS FEVER, AND YELLOW FEVER—Continued

Reports Received from June 26 to November 12, 1926—Continued

TYPHUS FEVER—Continued

Place	Date	Cases	Deaths	Remarks
Chile:				
Antofagasta	May 23–June 26	4		
Do	June 27–July 3	1		
Concepcion	June 1–7		1	
Valparaiso	Apr. 29–May 5		1	
Do	Aug. 14–Sept. 18	7		
China:				
Antung	June 14–27	7	1	
Do	June 28–Oct. 10	37	1	
Canton	May 1–31	1		
Chunking	Aug. 29–Sept. 4			Present.
Ichang			1	Reported May 1, 1926. Occurring among troops.
Wanshien				Present among troops, May 1, 1926. Locality in Chingking consular district.
Chosen				Feb. 1–May 31, 1926: Cases, 887; deaths, 91.
Chemulpo	May 1–June 30	38	2	
Do	July 1–31	7	2	
Gensan	June 1–30	1		
Seoul	do	8	3	
Do	July 1–Aug. 31	8		
Czechoslovakia				Jan. 1–June 30, 1926: Cases, 156; deaths, 6.
Egypt:				
Alexandria	July 16–Aug. 19	3		
Cairo	Jan. 29–May 13	89	27	
Do	July 23–Aug. 5	1		
Port Said	June 4–24	4	1	
Do	July 9–Aug. 19	4	1	
Great Britain:				
Scotland—				
Glasgow	July 30–Aug. 21	9	1	
Greece:				
Athens	Sept. 1–30		17	Including Piræus.
Ireland (Irish Free State):				
Cobh (Queenstown)	May 30–June 5	1		
Do	June 27–July 3	1	1	
Cork	June 5	1		
Kerr County—				
Dingle	June 27–July 3	1		
Italy				Mar. 28–May 8, 1926: Cases, 3.
Palermo	Sept. 12–18	1		
Japan				Mar. 28–May 29, 1926: Cases, 37.
Latvia				May 1–June 30, 1926: Cases, 19.
Lithuania				Mar. 1–June 30, 1926: Cases, 199; deaths, 22.
Mexico				Feb. 1–Apr. 30, 1926: Deaths, 110.
Durango	July 1–31		1	
Mexico City	May 16–June 5	20		Including municipalities in Federal District.
Do	June 13–19	9		Do.
Do	July 25–31	3		Do.
Do	Aug. 15–Oct. 9	46		Do.
San Luis Potosi	June 13–26			Present, city and country.
Morocco				Mar. 1–June 30, 1926: Cases, 426.
Norway:				
Stavanger	Sept. 6–12	1		
Palestine				Mar. 1–June 30, 1926: Cases, 14; deaths, 1. Aug. 10–Sept. 13, 1926: Cases, 5.
Gaza	July 6–12	1		
Haifa	July 13–Aug. 30	5		
Halalal	Aug. 17–23	1		
Jaffa district	June 15–28	5		
Do	Sept. 28–Oct. 4	1		
Jerusalem	Sept. 14–27	2		
Majdal district	July 13–Aug. 2	2		
Nazareth district	do	3		
Tiberias	Aug. 3–9	1		
Yavneil	Aug. 17–23	1		
Persia:				
Teheran	May 23–June 22		1	
Peru:				
Arequipa	Jan. 1–31		2	

CHOLERA, PLAGUE, SMALLPOX, TYPHUS FEVER, AND YELLOW FEVER—Continued

Reports Received from June 26 to November 12, 1926—Continued

TYPHUS FEVER—Continued

Place	Date	Cases	Deaths	Remarks
Poland				Mar. 28–June 26, 1926: Cases, 1,272; deaths, 85. June 27–July 24, 1926: Cases 147; deaths, 11.
Rumania				Mar. 1–May 31, 1926: Cases, 711; deaths, 69.
Russia				Jan. 1–Mar. 31, 1926: Cases, 14,814.
Tunisia				Apr. 1–June 30, 1926: Cases, 110.
Tunis	June 11–30	3		
Turkey:				
Constantinople	June 16–22	1		
Union of South Africa				Apr. 1–May 31, 1926: Cases, 153; deaths, 19.
Do				July 1–31, 1926: Cases, 90; deaths, 17.
Cape Province				Apr. 1–June 30, 1926: Cases, 202; deaths, 24, native. July 1–31, 1926: Cases, 58; deaths, 15.
Glengray district	June 27–July 3			Outbreaks.
Grahamstown	do	1		
Natal				Apr. 1–June 30, 1926: Cases, 28. July 1–31, 1926: Cases, 23
Durban	July 25–Aug. 14	10	1	deaths, 2.
Orange Free State				Apr. 1–June 30, 1926: Cases, 24; deaths, 4. July 1–31, 1926; Cases, 7.
Transvaal				Apr. 1–June 30, 1926: Cases, 10; deaths, 5. July 1–31, 1926: Cases, 2. Aug. 15–21, 1926:
Johannesburg	Aug. 29–Sept. 4	1		Outbreaks.
Walkkerstroom district	June 20–26			Outbreaks.
Wolmaransstad district	do			Do.
Yugoslavia				Apr. 15–June 30, 1926: Cases, 48;
Zagreb	May 15–21	1		deaths, 7. July 1–Aug. 31, 1926; Cases, 3; deaths, 1.

YELLOW FEVER

Brazil	Reported June 26			Present in interior of Bahia, Pirapora, and Minas.
Bahia	May 9–June 26	10	7	
Do	July 4–10	1		
Gold Coast	Apr. 1–May 31	6	3	