

PUBLIC HEALTH REPORTS

VOL. 49

APRIL 13, 1934

NO. 15

CURRENT PREVALENCE OF COMMUNICABLE DISEASES IN THE UNITED STATES¹

February 25–March 24, 1934

The prevalence of certain important communicable diseases, as indicated by weekly telegraphic reports from State health departments to the United States Public Health Service, is summarized in this report. The underlying statistical data are published weekly in the Public Health Reports, under the section entitled "Prevalence of Disease."

Measles.—The number of cases of measles rose from 94,984 for the preceding 4-week period to 129,505 for the 4 weeks ended March 24. All sections of the country contributed to the increase. This is the highest incidence for this period in the recent years for which records are available.

While for the country as a whole the current incidence was only about twice that for the corresponding period last year, the increases in certain geographic areas were much larger. In the South Atlantic group of States the number of cases reported (34,322) was 6 times last year's figure for the same period; in the West South Central area the number (13,866) was 3.4 times last year's figure, and in the Mountain area the number (4,700) was 5.6 times that of last year. While the increases were not so large in other areas, practically all reported a little higher incidence than has occurred in recent years.

Meningococcus meningitis.—For the current period there were 225 cases of meningococcus meningitis reported, about 57 percent of the number for the same period last year. For this period in 1932, 1931, and 1930 the numbers of cases were 296, 682, and 1,211, respectively. The only region showing an increase over last year was the South Atlantic. Of the 29 cases in that group of States, Virginia reported 17 cases for the current period as against 8 last year.

Smallpox.—Smallpox maintained the relatively low level of the preceding 4-week periods of the current year. For the entire reporting area there were 622 cases, as compared with 810, 1,413, and 3,750 for

¹ From the Office of Statistical Investigations, U.S. Public Health Service. The numbers of States included for the various diseases are as follows: Typhoid fever, 48; poliomyelitis, 48; meningococcus meningitis, 48; smallpox, 48; measles, 47; diphtheria, 48; scarlet fever, 48; influenza, 43 States and New York City. The District of Columbia is counted as a State in these reports. These summaries include only the 8 important communicable diseases for which the Public Health Service receives regular weekly reports from the State health officers.

the corresponding period in the years 1933, 1932, and 1931, respectively. For this period in 1930 the number of cases was 6,520. The East North Central and South Central areas reported practically the same number of cases as for this period last year, but, as in all other areas, the incidence was considerably below that of the preceding years.

Typhoid fever.—Typhoid fever was about normal for the current period—508 cases, as compared with 545 for the corresponding period last year, 693 for 1932, and 475 for 1931. The South Central area reported a 10 percent increase over last year's figure, but the incidence in other areas closely approximated that of last year.

Scarlet fever.—The incidence of scarlet fever during the 4 weeks ended March 24 was also approximately normal—26,522 cases, as compared with 26,549 for the corresponding period last year and 25,427 in 1932. The New England and Middle Atlantic groups reported a 25 percent increase over last year's figure, but in all other areas the incidence was practically the same as that for the same period last year.

Poliomyelitis.—For the current 4-week period 73 cases of poliomyelitis were reported, which was about 45 percent higher than the figure for the corresponding period last year and 10 percent in excess of that in 1932. In all areas except the West North Central and Pacific the current incidence was on a level with that of last year. In the West North Central section, while the number of cases (8) was not large, it was 3 times that reported for the same period last year, and in the Pacific area the number of cases (24) was 3.4 times that of last year. California reported 19 out of the 24 cases.

Influenza.—For the 4 weeks ended March 24 there were reported 11,259 cases of influenza, as compared with 10,329, 36,383, and 25,635 for the corresponding period in the years 1933, 1932, and 1931, respectively. With the exception of Missouri in the West North Central and Texas in the West South Central area, where there were considerable increases over last year, the influenza incidence has maintained a very satisfactory level in all parts of the country. The current incidence is very close to the average for years which have been free from epidemics.

Diphtheria.—The incidence of diphtheria, which has continually declined in recent years, is now maintaining the level of last year. The number of cases (2,845) for this period was approximately the same as for the corresponding period last year, as was the case in the preceding 4-week period. There were 3,971, 4,035, and 5,350 cases reported in the corresponding period of the years 1932, 1931, and 1930, respectively. The diphtheria situation was favorable in all sections of the country. The South Atlantic and West South Central regions showed some increases, but they were very insignificant.

Mortality, all causes.—The average mortality rate from all causes in large cities for the 4 weeks ended March 24, as reported by the Bureau of the Census, was 12.8 per 1,000 inhabitants (annual basis). For this period in 1933, 1932, and 1931 the rates were 11.8, 13.5, and 13.7, respectively.

HEALTH SERVICES OF TOMORROW¹

By THOMAS PARRAN, Jr., M.D., *New York State Commissioner of Health*

It is not my purpose in this discussion either to attack or to defend current public health practice; nor have I any criticism whatever for the attitude of physicians concerning it. I feel that we have had enough of controversy; that in order to obtain a perspective of our several problems, we need to detach them, at least momentarily, from the exigencies of personal opinions and desires. It would seem to me that through a greater objectivity we may arrive at a clearer understanding of the past developments and present status of public health service. On the basis of that understanding, we should be able to analyze the trends of such service and to project the line of probable action. In the last analysis, each man must think this through for himself. He may find, as I have found in my effort to arrive at an objective interpretation, that his judgment of what is probable conflicts from time to time with his personal philosophy. Under such circumstances his acceptance of or opposition to the course of events must be predicated upon his intellectual honesty.

In the nation at large there is more than the usual need for open-mindedness, for respect for the point of view unlike our own, as well as a courageous tenacity in adhering to what is truly valuable in established methods. That widely divergent views are held by many, physicians and laymen alike, concerning various public aspects of medicine, no one can deny. Today's forum serves to crystallize these views and should give all of us a broader concept.

On both sides of the controversy we can assume for the most part a sincere desire for medical progress; for better and more complete health services to all the people. Where disagreement exists, it concerns the methods and procedures which will contribute to this progress so ardently desired by all of us. Incomplete information and misinformation fan the flame. Extremists, whether reactionary or radical, do not contribute to progress. The usual result of their labors is to impede it.

It is well to bear in mind that our individual or collective views as doctors have had little weight in the past. Unless we improve the technique of making our views felt, they will have little weight in the

¹ Read before the Joint Conference of the American Academy of Political and Social Science and the College of Physicians of Philadelphia, Philadelphia, Pa., Feb. 7, 1934.

future determination of the structure, scope, or content of public health. The people of each day and generation place an increasingly higher value on medical service. It would seem, however, that they consider themselves, as patients, as important a factor of medical service as we are. In consequence the medical profession conforms to the social system of which it is a part. Sigerist, expressing this point of view, recently said:

There is one lesson that can be derived from history. It is this: that the physician's position in society is never determined by the physician himself, but by the society he is serving. We can oppose the development; we can retard it; but we will be unable to stop it.

From this there is apparent not only the futility of obstructing change but also of championing reforms which go beyond the current concepts of social responsibility. It is time that men should look to physicians themselves for guidance upon medical matters of public concern as well as those of private urgency. Nevertheless, the direction and distance we can lead toward a specific type of health service for tomorrow is limited sharply by the framework of tomorrow's social concepts.

Today's official health services reflect rather accurately our character as a nation.

Their diversity of form is in keeping with a similar diversity of political and social organization among the States, and even within a State.

Their incompleteness parallels the lack of concern for human rights and lack of confidence in government as an instrument for protecting human rights, which until recently characterized the popular mind.

Their individualistic idiosyncrasies show, both in their weakness and in their strength, precisely the lack of regimentation which is to be expected from a nation of individualists.

Their sectional differences represent a difference in problems. Industrialization has brought the need for compensation and safety laws, unavoidable incursions into the health field. The transition from an agrarian to an industrial civilization brings a greater need for health service. Exotic diseases have given an impetus to public health work in the South. Many of the Western States, free from the yellow fever and the hookworm of the South, have been until recently too preoccupied with frontier problems to organize more than a perfunctory health service.

Tradition, too, has left its mark. The town meeting of early New England is reflected in the multiplicity of local health officers now found in these and adjacent States. Custom, also, helps to determine the quality and kind of service rendered. In many States and cities a change of administration entails a clean sweep in health department officials and major employees. Services periodically are disrupted and

no long-range programs undertaken. In other States (New York is an example) it has become the custom to consider the health problem nonpartisan. The State health department has passed through many successive administrations without political changes in personnel or policy. Where partisan politics control the health department, there is the same control of other community services.

The lack of real professional leadership among those rendering health service probably is analogous to that in the medical profession as a whole; which, in turn, may be due to the low standards of professional education which prevailed until recent years among the rank and file.

If we add to these factors the difficulties of scientific appraisal inherent in many aspects of health service, as in many phases of medical practice, the gap between the present and the ideal in this country is easily understood.

Public health, too, is founded upon scientific discoveries which are comparatively recent. There is an inevitable cultural lag between the acquisition of knowledge and its application to the community; and, although the desire for life and health is a basic human emotion, the absence of disease, the prevention of an epidemic, the saving of life generally are rated as negative accomplishments. They are not dramatized in the public consciousness.

For a long time statesmen have expressed the thought that the care of the public health is a primary responsibility of government. Blackstone interpreted the legalistic aspect when he said: "The right to the enjoyment of health is a subdivision of the right of personal liberty, one of the absolute rights of persons."

These concepts mean that the community collectively should perform for its citizens (1) those services which are so important to the social organism that they cannot safely be left to the initiative of the individual uneducated or indifferent as to their importance and (2) those services which, because of their nature, the individual cannot provide for himself. So far, however, the performance of such services is more theory than fact. Public health has not been a major issue of our Government in the past. At the present time, when all human issues are coming to the fore, economic pressure—the necessity of providing a world fit to live in—has continued to shunt aside from public consciousness the present needless sacrifice of human life and efficiency by our inadequate use of scientific medicine. Current measures to restore minimum standards of living, however, are doing more to preserve the mental and physical health of the Nation than a frontal attack on disease alone.

Unfortunately, we have inaction and retrogression even in functions, such as control of communicable disease, which are generally accepted as appropriate spheres for governmental action; and in the

line of private health protection, citizens have become increasingly unable to provide necessary medical service for themselves.

The distribution of present health and medical expenditures is distinctly inequitable, only 3 percent of the total being made for preventive services, public and private. Out of a total per capita expenditure each year of \$30 for all medical care, only \$1 is spent for prevention. Quacks, nostrums, and patent medicines collect too large a part of the remainder.

Public health has not generally attracted the best of medical graduates. It has not in the past offered a satisfactory career because the financial rewards were modest and the openings not influenced by partisan politics were few. Before we can realize a completely sound health plan for tomorrow, we must raise up a new generation, not only of leaders but of well-trained men in the ranks.

Funds for the work have been scanty. Three fourths of our rural population have not even the elements of a public health service. Between 1931 and 1932 health budgets in cities and States, already inadequate for the proper conduct of minimum activities, declined, on the average, 17 percent. In Alabama the cut was 50 percent; in Mississippi and North Dakota, 75 percent.

It is true that remarkable accomplishments have been made in the prevention of disease during the past 2 decades; but it is likewise true that these accomplishments are less than half of what is easily possible if all communities would provide for their citizens the health protective facilities now provided by a few communities.

A further increase in the life span by another 10 years is entirely possible. Of even greater economic importance are the disease and disability which can be prevented. Typhoid fever and diphtheria can be reduced to lower minima, the infant mortality rate can still be cut in half, two thirds of the present 13,000 maternal deaths can be prevented, the increasing incidence of the venereal diseases can be changed to a decreasing progression, the tuberculosis battle is only half won, and cancer can be better controlled.

The medical profession, as at present constituted, is increasingly unable to provide for all the people the minimum essentials of medical care without adding unbearably to the load of poorly paid and unpaid work it now carries. Three factors have contributed to this situation: First, although many human ailments can be treated satisfactorily with limited equipment, scientific advances have increased constantly the complexity and the cost of medical service. Second, the lowered income of a large part of the population has put medical care beyond the reach of an increasing number. As a result, many physicians, and dentists and nurses as well, find themselves today almost destitute. Third, people who are not ill and not confronted by a threat of illness

are unwilling or uneducated to pay out of pocket for a preventive service.

Few will deny that our health system falls woefully short of results; yet there are those who would limit public health service to sanitation, quarantine, and the care of the insane and of other indigent sick. To accept this view is to ignore not only the inherent responsibility of government but the scientific factors and our considerable experience in public medical care. The quality of such service compares favorably with private treatment for the same class of patients in tuberculosis sanatoria, mental disease hospitals, venereal disease clinics, public general hospitals, and immunization clinics.

It is no longer easy to secure applause by damning the Government because of its interference, without presenting valid evidence that alone and unaided by Government we can do a better job.

We may consider the potential scope of public health service as the application of biologic knowledge for the prevention and cure of disease and the promotion of health. In forecasting the health services of tomorrow, we need to determine what functions the Government can exercise better than other agencies to serve the health needs of the people. Society as a whole is indifferent to the squabble between public health officialdom and the medical hierarchy concerning the prerogatives of each. What happens to our present public health system or to the private practice of medicine, as we know them both today, will not be determined by the resolutions of medical societies nor by the recommendations of health officers.

It seems generally agreed that the current social and economic revolution cannot stop where it is. Are we to go forward during the coming years, veer left or right? We will not go back. We must assume that in any event we have faith in our capacity to adjust governmental forms to serve the people better than in the immediate past.

First, it is possible that the speedy return of economic prosperity may be accompanied by a revolt of trade and industry against onerous governmental control. As a result we may emerge with many of the forms and much of the formlessness of yesterday, the chief social residue of the recent tragic era being a somewhat better conception of individual rights and some means of preventing the more flagrant abuses and exploitations of those rights.

There is a second contingency—that we may continue our present trend toward a regulated capitalism with trade associations and cartels operating the economic system of the country under Government regulation and control. In such a system cooperative effort will be the dominant factor.

It must also be considered that we may show an incapacity for cooperative capitalistic effort. We may revolt against rigid regula-

tion which fails to bring high profits in its wake. Recently, in an informal discussion of the subject, I heard a business man of major rank intimate that business as a whole may prove itself too dishonest to function under the regulations of an industrially controlled system. What then? Perhaps chaos as an interlude, but ultimately and possibly soon, a socialistic state.

Whatever the path we take, regardless of how earnestly as doctors we may fight for it or against it, the health service of tomorrow inevitably will conform to the governmental framework, whatever it may be.

If the political philosophy of yesterday again prevails, we shall, of course, continue the traditional forms of medicine and public health. The State will perform more completely, and better, I hope, the services which it now undertakes. New tasks will be added as the developing body of scientific knowledge and the needs of the people determine.

An essential part of this system, in my opinion, is the tools for better work which can be placed in the hands of the practicing physician. Among the aids which the most individualistic of doctors, in large numbers, have approved and used are the following: County general hospitals, managed by local medical boards and open to all citizens at a cost within their means; diagnostic laboratories, for clinical as well as communicable disease diagnosis; free biologic products and arsphenamines; community nursing; plus case finding and consultation service.

Such accessories to care as X-ray, laboratory, nursing, and hospital costs often outweigh the actual medical charges. If these accessories are furnished by the community, the medical bill frequently can be paid, the personal relationship of physician and patient retained, and the quality of medical service promoted. For it must be remembered that a patient may be able and willing to pay for an office call or for attendance at childbirth, yet be unable to negotiate for a cancer operation or the rehabilitation of a crippled child. For this reason it may prove very serviceable to the general practitioner for tax levies to supplement inadequate private subscriptions for the support of hospital and dispensary service; and for facilities now provided for the care of the insane, the aged, the tuberculous, and the venereally infected to be extended to other chronic and, therefore, expensive diseases.

But even under an economic system restored to familiar patterns there is an uncertain medical factor. During past months there have been some 5,000,000 families—about 18 percent of the population—receiving from public funds all the necessities of life, including medical care. Under the happiest of conditions their restoration to self-support will be gradual. Having accepted free and, in about one third of the States, moderately adequate medical care—in many

instances more freely available than in their whole previous experience, and of better quality than provided by the quacks and other questionable practitioners so often patronized by those in the lower income classes—will they, having experienced such care, continue to insist upon it? The history of benefits to veterans gives us food for serious thought on this subject.

Under the traditional system the problem will grow more acute as to how both preventive and treatment needs will be met for the lower income classes. Medical societies will continue to advocate payment of fees from taxes to physicians for these purposes. The bogey of "State medicine" has been removed by acceptance of this principle. All of us now agree that public—that is, tax-supported—action is necessary. Witness the enthusiasm with which the Detroit plan has received medical approbation.

With acceptance of this principle there remain only three relatively minor issues as to method: First, should a particular service be rendered in the home and the doctor's office by any qualified physician on a fee basis paid by the public, or should it be rendered by part-time or full-time physicians? This issue will be resolved very simply. The taxpayer will choose the method which gives a satisfactory service at the lowest cost. This will vary; but, in general, experience has shown that preventive services now rendered by health departments can be done reasonably well and least expensively by organized clinics. In rural areas, on the other hand, the fee for service basis may prove best for certain disease conditions. We have not arrived at our present situation fortuitously.

It is agreed that individual attention, whether preventive or curative, by a skilled and interested physician is the best type of medical care. We should each of us prefer it, just as we should prefer a special nurse and a private hospital room, if we can afford it, when we ourselves are ill. Yet if we cannot pay for anything better, there is nothing inherently vicious about the general nursing service, the ward room, or preventive care and treatment in the clinic when otherwise the community and the individual would suffer from no service at all. In fact, provable progress against disease prevalence has been made thereby. Further, we can find skilled and interested physicians in the public service who treat patients as well as problems; we can find unskillful, uninterested physicians in private service to whom the patient is but a means for filling the pocketbook. The quality of any service depends upon the integrity and ability of its personnel. Neither public nor private medical service is all good or all bad.

The second issue in public medical care is at what income level shall we draw the line of eligibility? In measures to control a communicable disease the primary purpose is to protect the community. Hence, ability to pay for the treatment of smallpox or bubonic plague

is purely a secondary consideration. Also, "ability to pay" for general medical care varies with the nature of the condition and therefore the cost of treatment.

A third issue is whether needed public medical service should be administered by a department of social welfare or by a department of health. I hold very strongly to the view that all public medical and health work should be done by the health department. Here we have the medical foundation which is lacking among social workers. Counterbalancing this, however, the social workers make out a good case for unifying medical relief with other relief and social reconstruction measures. This argument, plus the continued barrage of some medical groups to make prevention and not cure the objective of health service, may reduce health departments to the status of sanitary police, while the major health-promoting functions of the community are carried on by non-medical welfare agencies.

It is an interesting anomaly that if we move ahead and to the right, politically, the current of traditional medicine seems to carry the private practitioner farther and farther away from responsibility for preventive medicine in general and for treatment of disease which, if neglected, would be harmful to the community either because of its infectious nature or because the untreated individual or his family might become a public charge. The reason is simple. The doctor, of his own volition, has rendered long and valiant service for the poor and needy. Yet bound down as he is by the competitive system, we cannot expect him to assume the load of preventive services—nor do we find him volunteering to do it—when he finds it difficult to obtain reasonable compensation for what he does. Neither can the doctor's benevolence absorb the vast strata of those victims of technological maladministration whose sole asset is an uncertain wage at or below the bleakest living requirement.

If tax funds are available for the treatment of these cases, it is probable that the taxpayers' insistence on economy will result in the expenditure of these funds largely through the organized clinic rather than in the doctor's office, and for salaried physicians rather than fees for service.

If, on the other hand, the current economic revolution leads ahead, and left to a regulated capitalism, with industrial cooperation under Government control, then we almost certainly shall see various schemes of social insurance—old age, unemployment, and sickness.

The contest in this case will be over the nature and extent of supervision of the service, the extent of tax support, the freedom of choice and compensation of the physician, the restrictions on specialization, the voluntary or compulsory nature of the system, and the inclusion of cash as well as medical benefits.

Where most successful, sickness insurance requires the general practitioner as the keystone in providing a preventive and general medical service to the family as a unit, with reasonable and assured compensation. The work of health departments would be proportionately minimized in the treatment field as these services, paid for in advance, are available from the family physician.

In fact, is it not possible that the medical profession itself will be the prime advocate of sickness insurance as the least objectionable way of preserving the general practitioner and of attaining economic security? Here, then, is the paradox: As we move ahead along traditional lines, private medical practice is forced away from its preventive and many of its treatment functions by an expanding public health service. As we move to the left by abandoning traditional forms, private medical practice regains its traditional inclusive responsibility for both prevention and treatment, with a corresponding reduction in the scope of health-department functions.

The program of the British Medical Association entitled "A Medical Service for the Nation" deserves consideration if we anticipate this state of society.

If, through evolution or revolution we find ourselves to the extreme left and part of a socialist state tomorrow, then we doctors, too, will be socialists. Or, if we are not, our successors will be. State medicine will exist in the sense that the State will operate medical and health services in a manner comparable to our present system of public education. The medical recommendations contained in the platform of the British Labor Party give at least a rough idea of what this would be like. Or, if we recognize obvious differences in the level of medicine here and in Russia at the beginning of the World War, we may find some suggestions in the medical organization of that country.

What, then, is a doctor to do in a changing world? Is he to fight all suggested innovations as encroachments upon his livelihood? Will he have a voice in his own salvation, or is he but dust upon the wheel of circumstance?

You will notice that I said "doctor", not "private doctor", or "public health doctor." Good or bad, we are cut from the same cloth. We face transition of status and opportunity that will be far-reaching for each of us; but, as I said in the beginning, every man must think out for himself what lies ahead and what his personal attitude toward it will be. To my mind, these are the attitudes of an honest, earnest, well-trained doctor of today:

He is unafraid. The doctor's job, whether his present concern is private practice or public health, is of paramount importance in the Nation's welfare. Whatever the political framework of tomorrow, there will be a place for him and a place in the sun.

He continues to learn. He feels a maladjustment in the society he serves, and he seeks to understand it in the whole as well as in part. He considers with an open mind at least two sides of a suggestion—his own and the patient's. He is eager for new information; he faces facts.

He participates. If he is a practicing physician he is active in obtaining and maintaining a first-class health department for his community. If it is partisan-ridden, he helps to turn the rascals out and to change the rules so that a good job is possible. If he is a health officer, he keeps close to clinical medicine and medical research. He takes counsel with private physicians; he is familiar with their problems.

He plays fair. He is not petty himself nor will he tolerate the factional bitterness which has made so many a medical organization the synonym for strife.

And last, he looks ahead, in terms of the community and the Nation, as well as of himself and his profession. He is a good citizen.

You may think I have discussed a tomorrow that is too far away. Time alone can determine.

What I have attempted to do is to consider alternate political systems of which we will be a part, and to suggest different types of medical and health services within the framework which society places around us.

I have said that as doctors—as guild members—we have not in the past influenced the social structure in which we find ourselves; nor are our resolutions or recommendations likely to mold it tomorrow. When we speak as doctors alone, we have been suspected of self-interest. Yet as citizens we have full voice in the new order of things, and as doctors it is possible for us to implant in every citizen a respect for scientific medicine, for its potentialities, and for its practitioners, which will make easy the adjustments of tomorrow.

What we need is more evangelism in medicine, more concern for the citizen unserved, or poorly served. What we have had is a virulent sectarianism, a concern lest he be served by others who receive the reward.

Let us, then, study the needs of the people for health, consider the service which science has made possible, and interpret to the people the best ways of applying science to health promotion. In doing this let us keep in mind two principles:

1. Progress made through evolution rests on a sounder basis than when the change is revolutionary.
2. The form of a program is not so important as the spirit. Drawn today, it may need to be modified tomorrow; but the ideals of that program, the spirit which conceived it, must be as unchanging as the tides.

COURT DECISION ON PUBLIC HEALTH

Ordinance prohibiting slaughter of chickens for sale in city held unconstitutional.—(Ohio Court of Appeals; *Simon v. City of Cleveland Heights*, 188 N.E. 308; decided Oct. 23, 1933.) An ordinance of the city of Cleveland Heights, among other things, provided that "no such animal or fowl [including chickens] shall be slaughtered for sale in the city." The plaintiff in error was convicted of violating this provision of the ordinance and he appealed to the court of appeals. The evidence established that his place of business, located within one of the business districts, was conducted in a clean and sanitary manner in a modern establishment for the slaughter of chickens and that there were no odors outside the said place of business. The evidence did not even suggest that any of the neighbors or inhabitants were annoyed by noises or odors in connection with the place, and the counsel for the city conceded that it was not a nuisance per se. The appellate court stated that, where others were not materially injured or annoyed by the conduct of a lawful business, an ordinance prohibiting that business could well be said to infringe upon the rights of property guaranteed by the State and Federal constitutions and existing in the individual. Proceeding, the court said:

Where a business by reason of its inherent character is a nuisance per se, such business may be prohibited by the exercise of the police power with a view to suppressing the same. If, however, it is not a nuisance per se, but may become a nuisance by reason of its method or manner of conducting such business, then the police power may be invoked to regulate such business.

In the case at bar, the last clause of that portion of the ordinance above quoted, under which the conviction was obtained, does not attempt to regulate the business as to the location or method of operation, but it in fact expressly prohibits the conduct of a lawful business. It is not a regulatory measure, but a complete prohibition. Insofar as this ordinance undertakes to prohibit the slaughtering of chickens in the city of Cleveland Heights for sale, we think that it is an unreasonable exercise of the police power and is unconstitutional.

The conviction was set aside and the plaintiff in error discharged.

DEATHS DURING WEEK ENDED MARCH 24, 1934

[From the Weekly Health Index, issued by the Bureau of the Census, Department of Commerce]

	Week ended Mar. 24, 1934	Correspond- ing week, 1933
Data from 86 large cities of the United States:		
Total deaths.....	8,974	8,404
Deaths per 1,000 population, annual basis.....	12.5	11.7
Deaths under 1 year of age.....	619	611
Deaths under 1 year of age per 1,000 estimated live births.....	58	53
Deaths per 1,000 population, annual basis, first 12 weeks of year.....	12.7	12.3
Data from industrial insurance companies:		
Policies in force.....	67,654,813	68,730,271
Number of deaths claims.....	14,905	14,138
Death claims per 1,000 policies in force, annual rate.....	11.5	10.7
Death claims per 1,000 policies, first 12 weeks of year, annual rate.....	11.1	11.2

*Data for 81 cities.

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 Weeks Ended Mar. 31, 1934, and Apr. 1, 1933

Cases of certain communicable diseases reported by telegraph by State health officers for weeks ended Mar. 31, 1934, and Apr. 1, 1933

Division and State	Diphtheria		Influenza		Measles		Meningococcus meningitis	
	Week ended Mar. 31, 1934	Week ended Apr. 1, 1933	Week ended Mar. 31, 1934	Week ended Apr. 1, 1933	Week ended Mar. 31, 1934	Week ended Apr. 1, 1933	Week ended Mar. 31, 1934	Week ended Apr. 1, 1933
New England States:								
Maine	5			4	13		0	0
New Hampshire					125		0	0
Vermont	1				72	14	0	0
Massachusetts	15	15		6	2,223	307	2	1
Rhode Island	3	3		2	2		0	0
Connecticut	6	10	1	11	34	214	0	0
Middle Atlantic States:								
New York	37	67	1 24	1 37	1,179	4,317	6	3
New Jersey	22	22	9	20	429	1,882	0	4
Pennsylvania ¹	41	52			3,059	1,818	0	7
East North Central States:								
Ohio	52	45	137	194	1,294	821	6	3
Indiana	19	18	28	43	855	134	1	7
Illinois	22	43	26	80	1,869	575	15	17
Michigan	22	19	9	3	146	1,256	1	2
Wisconsin	1	3	48	59	1,813	387	4	3
West North Central States:								
Minnesota	5	13	3	3	232	1,187	1	0
Iowa ¹	6	4	17		151	11	5	2
Missouri	45	25	63	8	699	233	4	0
North Dakota				2		85	14	0
South Dakota	3		6		498		7	6
Nebraska	3	8	1		221	24	0	1
Kansas	4	5	7		411	316	1	1
South Atlantic States:								
Delaware	2	4			131	13	0	0
Maryland	10	9	18	18	1,102	53	0	1
District of Columbia	9	4	1	1	596	4	1	0
Virginia	21	11			976	380	4	2
West Virginia	4	13	74	33	104	117	4	1
North Carolina	16	12	81	23	2,886	600	1	1
South Carolina	18	8	603	434	902	269	0	0
Georgia ¹	14	11			96	1,444	81	3
Florida	6	12	6	12	476	53	0	0

See footnotes at end of table.

Cases of certain communicable diseases reported by telegraph by State health officers for weeks ended Mar. 31, 1934, and Apr. 1, 1933—Continued

Division and State	Diphtheria		Influenza		Measles		Meningococcus meningitis	
	Week ended Mar. 31, 1934	Week ended Apr. 1, 1933	Week ended Mar. 31, 1934	Week ended Apr. 1, 1933	Week ended Mar. 31, 1934	Week ended Apr. 1, 1933	Week ended Mar. 31, 1934	Week ended Apr. 1, 1933
East South Central States:								
Kentucky	16	12	47	24	691	99	0	2
Tennessee	8	12	74	156	1,314	80	1	4
Alabama ¹	25	8	82	37	765	66	0	0
Mississippi	6	6					0	0
West South Central States:								
Arkansas	3	7	57	39	388	144	0	1
Louisiana	18	7	3	11	223	104	0	1
Oklahoma ¹	13	7	66	78	680	88	1	3
Texas ¹	91	104	389	290	1,372	1,209	2	3
Mountain States:								
Montana	2	1		9	24	33	0	1
Idaho	1				109	20	1	0
Wyoming ⁵					112	2	0	0
Colorado	9	5		31	367	12	0	1
New Mexico	11	2	11	16	201	4	6	1
Arizona		5	12		18	41	0	0
Utah ¹		6	6		768	1	0	1
Pacific States:								
Washington	1	8	2		173	64	0	1
Oregon ⁶	1	1	48	31	52	72	0	0
California ³	45	39	39	52	798	1,272	2	5
Total	656	672	2,090	1,861	32,082	18,398	64	89

Division and State	Poliomyelitis		Scarlet fever		Smallpox		Typhoid fever	
	Week ended Mar. 31, 1934	Week ended Apr. 1, 1933	Week ended Mar. 31, 1934	Week ended Apr. 1, 1933	Week ended Mar. 31, 1934	Week ended Apr. 1, 1933	Week ended Mar. 31, 1934	Week ended Apr. 1, 1933
New England States:								
Maine	0	0	11	26	0	0	28	1
New Hampshire	1	0	18	19	0	0	0	0
Vermont	0	0	10	11	0	1	0	3
Massachusetts	1	0	266	53	0	0	0	0
Rhode Island	0	0	14	37	0	0	0	2
Connecticut	0	0	65	167	0	1	0	0
Middle Atlantic States:								
New York	0	0	862	1,120	0	0	10	3
New Jersey	0	0	185	377	0	1	0	3
Pennsylvania ²	0	1	622	1,000	0	0	4	5
East North Central States:								
Ohio	1	1	1,204	1,538	0	29	6	2
Indiana	0	1	274	265	3	1	1	3
Illinois	2	0	612	565	3	15	4	4
Michigan	0	0	805	673	0	1	3	4
Wisconsin	1	0	234	124	28	17	7	1
West North Central States:								
Minnesota	1	0	57	107	1	0	0	2
Iowa ²	0	1	62	31	6	22	1	0
Missouri	1	0	126	87	6	0	4	1
North Dakota	0	1	52	11	0	0	0	0
South Dakota	0	0	29	6	5	0	1	4
Nebraska	0	0	39	20	9	0	0	0
Kansas	0	1	58	67	1	0	0	1
South Atlantic States:								
Delaware	0	0	7	12	0	0	2	0
Maryland	0	0	90	117	0	0	2	4
District of Columbia	0	0	16	17	0	0	0	0
Virginia	1	0	42	43	1	0	3	3
West Virginia	0	0	101	39	0	0	2	3
North Carolina	1	0	22	53	0	1	4	3
South Carolina	0	0	5	3	3	1	4	6
Georgia ³	0	0	19	8	1	4	6	8
Florida	0	0	2	15	0	0	3	22

See footnotes at end of table.

Cases of certain communicable diseases reported by telegraph by State health officers for weeks ended Mar. 31, 1934, and Apr. 1, 1933—Continued

Division and State	Poliomyelitis		Scarlet fever		Smallpox		Typhoid fever	
	Week ended Mar. 31, 1934	Week ended Apr. 1, 1933	Week ended Mar. 31, 1934	Week ended Apr. 1, 1933	Week ended Mar. 31, 1934	Week ended Apr. 1, 1933	Week ended Mar. 31, 1934	Week ended Apr. 1, 1933
East South Central States:								
Kentucky	1	0	79	70	0	1	2	7
Tennessee	1	0	27	39	0	0	6	4
Alabama ¹	1	0	9	14	0	1	0	5
Mississippi	0	0	11	2	2	0	4	7
West South Central States:								
Arkansas	0	0	5	8	0	3	1	2
Louisiana	0	0	15	13	1	1	6	21
Oklahoma ²	0	1	26	18	2	2	4	5
Texas ³	1	0	117	86	27	39	17	16
Mountain States:								
Montana	0	1	4	10	0	0	0	0
Idaho	0	0	6	1	13	4	0	3
Wyoming ⁴	0	0	14	14	2	0	0	3
Colorado	0	0	23	68	13	6	0	2
New Mexico	1	0	31	8	4	0	1	5
Arizona	0	0	17	21	1	0	1	2
Utah ⁵	0	0	12	6	0	0	0	0
Pacific States:								
Washington	1	1	53	53	12	2	2	0
Oregon ⁶	0	0	22	21	16	10	1	2
California ⁷	3	2	159	167	1	50	8	2
Total	19	11	6,539	7,320	161	213	148	174

¹ New York City only.² Week ended earlier than Saturday.³ Typhus fever, week ended Mar. 31, 1934, 7 cases, as follows: Georgia, 2; Alabama, 1; Texas, 3; California 1.⁴ Exclusive of Oklahoma City and Tulsa.⁵ Rocky Mountain spotted fever, week ended Mar. 31, 1934, 12 cases, as follows: Wyoming, 4; Oregon, 8.

SUMMARY OF MONTHLY REPORTS FROM STATES

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

State	Menin- gococ- cus menin- gitis	Diph- theria	Influ- enza	Malaria	Meas- sles	Pel- lagra	Polio- mye- litis	Scarlet fever	Small- pox	Ty- phoid fever
<i>January 1934</i>										
New Hampshire		2	4				0	76	0	0
<i>February 1934</i>										
Kansas	9	62	22	1	506		0	400	13	5
Nevada		1	20		60		0	25	0	1
Oklahoma ¹	8	66	631	12	1,985	2	0	85	21	13
Puerto Rico		76	61	2,157	63		0		0	81
Virginia	10	103	842	1	3,385	6	2	257	1	14
Wisconsin	12	28	422		4,165		0	897	153	7

¹ Exclusive of Oklahoma City and Tulsa.

February 1934		Leprosy:	Cases	Tetanus:	Cases
Actinomycosis:		Puerto Rico	2	Kansas	1
Kansas	1	Lethargic encephalitis:		Puerto Rico	12
Chicken pox:		Kansas	5	Tetanus, infantile:	
Kansas	535	Virginia	5	Puerto Rico	5
Nevada	13	Wisconsin	2	Trachoma:	
Oklahoma	103	Kansas	66	Oklahoma	2
Puerto Rico	204	Nevada	8	Puerto Rico	43
Virginia	393	Oklahoma	80	Tularaemia:	
Wisconsin	1,916	Puerto Rico	5	Virginia	3
Diarrhea and dysentery:		Virginia	170	Undulant fever:	
Virginia	52	Wisconsin	138	Kansas	2
Dysentery:		Ophthalmia neonatorum:		Oklahoma	2
Kansas (amoebic)	1	Oklahoma	1	Virginia	2
Puerto Rico	98	Puerto Rico	7	Wisconsin	1
Filariasis:		Virginia	4	Vincent's infection:	
Puerto Rico	4	Wisconsin	2	Kansas	5
German measles:		Paratyphoid fever:		Oklahoma	1
Kansas	66	Puerto Rico	5	Virginia	6
Wisconsin	237	Virginia	2	Whooping cough:	
Hookworm disease:		Puerperal septicemia:		Kansas	440
Oklahoma	1	Puerto Rico	11	Nevada	104
Impetigo contagiosa:		Scabies:		Oklahoma	77
Kansas	3	Oklahoma	25	Puerto Rico	417
		Septic sore throat:		Virginia	362
		Virginia	7	Wisconsin	1,458

¹ Exclusive of Oklahoma City and Tulsa.

WEEKLY REPORTS FROM CITIES

City reports for week ended Mar. 24, 1934

[This table summarizes the reports received regularly from a selected list of 121 cities for the purpose of showing a cross section of the current urban incidence of the communicable diseases listed in the table. Weekly reports are received from about 700 cities, from which the data are tabulated and filed for reference]

State and city	Diph- theria cases	Influenza		Meas- sles cases	Pneu- monia deaths	Scar- let fever cases	Small- pox cases	Tuber- culosis deaths	Ty- phoid fever cases	Whoop- ing cough cases	Deaths, all causes
		Cases	Deaths								
Maine:											
Portland	0	0	0	6	1	0	0	0	1	8	26
New Hampshire:											
Concord	0	0	84	1	0	0	0	0	0	2	14
Nashua	0	0	2	0	5	0	0	0	0	0	-----
Vermont:											
Barre	0	0	0	0	0	0	0	0	0	0	2
Burlington	0	0	0	5	0	0	0	0	1	19	16
Massachusetts:											
Boston	2	2	455	25	53	0	9	0	0	69	226
Fall River	2	0	2	2	3	0	0	0	0	3	20
Springfield	1	0	9	0	3	0	0	2	0	15	43
Worcester	1	0	7	11	14	0	0	0	0	14	50
Rhode Island:											
Pawtucket	0	0	0	0	2	0	0	0	0	0	15
Providence	1	0	3	6	7	0	3	0	0	21	55
Connecticut:											
Bridgeport	0	0	4	2	18	0	1	0	0	1	30
Hartford	1	0	0	5	13	0	2	0	0	0	60
New Haven	1	0	0	3	4	0	0	0	0	1	41
New York:											
Buffalo	3	2	193	13	19	0	8	0	0	0	166
New York	41	19	14	118	356	0	92	4	160	1,649	-----
Rochester	3	0	2	6	67	0	2	0	0	8	73
Syracuse	0	0	11	3	6	0	0	0	0	60	51
New Jersey:											
Camden	1	1	2	107	4	14	0	0	0	3	28
Newark	1	3	0	7	18	29	0	6	0	39	115
Trenton	0	2	0	111	5	22	0	3	0	5	47
Pennsylvania:											
Philadelphia	5	11	7	1,248	47	107	0	33	1	75	533
Pittsburgh	8	8	5	174	21	27	0	6	0	32	159
Reading	0	0	0	5	1	5	0	0	0	11	15
Scranton	0	0	0	0	0	6	0	0	0	16	-----
Ohio:											
Cincinnati	4	2	76	12	31	0	8	0	0	28	129
Cleveland	7	50	5	65	23	174	0	15	1	161	228
Columbus	2	0	0	17	4	68	0	0	0	25	74
Toledo	2	4	3	81	10	22	0	2	0	82	90

City reports for week ended Mar. 24, 1934—Continued

State and city	Diphtheria cases	Influenza		Measles cases	Pneumonia deaths	Scarlet fever cases	Small-pox cases	Tuberculosis deaths	Typhoid fever cases	Whooping cough cases	Deaths, all causes
		Cases	Deaths								
Indiana:											
Fort Wayne	2		1	16	3	16	0	1	1	1	24
Indianapolis	2		0	450	15	14	0	2	2	50	
South Bend	0		0	0	2	7	0	0	0	0	17
Terre Haute	0		0	1	1	0	0	0	0	0	20
Illinois:											
Chicago	6	5	9	233	61	325	0	45	0	230	758
Cicero	0		0	0	0	0	0	0	0	0	5
Springfield	0	3	0	266	3	1	0	0	0	14	25
Michigan:											
Detroit	13	8	3	88	30	202	0	6	1	121	267
Flint	1		2	16	6	119	0	2	0	16	37
Grand Rapids	0		2	8	3	41	0	1	1	4	35
Wisconsin:											
Kenosha	0		0	4	0	20	0	0	0	4	6
Madison	0			4		2	0	0	0	0	16
Milwaukee	3	1	1	9	5	129	0	2	0	0	90
Racine	1		0	0	0	22	4	1	0	4	11
Superior	0		0	0	2	1	0	0	0	0	8
Minnesota:											
Duluth	0		0	0	2	0	0	2	0	1	19
Minneapolis	4		4	12	11	26	0	1	0	24	101
St. Paul	0		0	3	3	7	0	4	0	0	64
Iowa:											
Des Moines	0		1			5	0		0	0	43
Sioux City	0		22			0	0		0	4	
Waterloo	0		0			0	0		0	23	
Missouri:											
Kansas City	4		2	6	8	23	0	6	0	21	119
St. Joseph	1		0	17	6	3	0	0	0	0	19
St. Louis	26		118	13	31	2	15	1	1	94	254
North Dakota:											
Fargo	0		0	69	1	0	0	0	0	4	8
Grand Forks	0		0	0	0	0	0	0	0	0	
South Dakota:											
Aberdeen	0		0	1	0	0	0	0	0	1	
Sioux Falls	0		0	6	0	0	0	0	0	0	8
Nebraska:											
Omaha	2		0	134	9	6	2	2	0	12	57
Kansas:											
Topeka	0		0	1	2	4	0	0	0	23	17
Wichita	0		0	14	8	0	0	1	0	22	29
Delaware:											
Wilmington	0		0	78	7	3	0	0	0	1	30
Maryland:											
Baltimore	2	9	2	793	23	38	0	8	0	225	216
Cumberland	0		0	1	2	3	0	0	0	8	11
Frederick	0		0	7	0	2	0	0	0	0	2
District of Columbia:											
Washington	9	1	1	711	21	15	0	22	0	56	195
Virginia:											
Lynchburg	2		0	1	2	3	0	0	0	2	17
Norfolk	0	4	0	124	8	2	1	2	0	2	45
Richmond	0	2	1	246	8	4	0	5	0	0	64
Roanoke	0		2	0	0	3	0	0	0	2	20
West Virginia:											
Charleston	0		0	0	2	2	0	1	0	3	9
Huntington	1		0	0	0	23	0	0	0	0	
Wheeling	0		1	7	2	26	0	0	0	9	13
North Carolina:											
Raleigh	0		0	2	2	1	0	0	0	6	10
Wilmington	0	1	0	59	2	2	0	0	0	0	14
Winston-Salem	0	1	0	59	2	2	0	0	0	0	
South Carolina:											
Charleston	1	34	1	22	4	0	0	3	2	3	25
Columbia	0		0	0	0	0	0	0	0	0	0
Greenville	0		0	3	2	1	0	1	0	8	12
Georgia:											
Atlanta	4	20	2	133	10	1	0	6	0	0	89
Brunswick	0		0	54	0	0	0	1	0	0	2
Savannah	0	83	1	76	3	4	0	5	0	1	45
Florida:											
Miami	1	1	0	38	0	1	0	1	0	13	17
Tampa	1	1	1	27	2	2	0	2	0	0	24
Kentucky:											
Ashland	0			15		1	0		0	6	
Lexington	0		0	13	3	1	0	0	0	3	
Louisville	1	6	0	1	10	24	0	0	0	41	82

City reports for week ended Mar. 24, 1934—Continued

State and city	Diph- theria cases	Influenza		Meas- sles cases	Pneu- monia deaths	Scar- let fever cases	Small- pox cases	Tuber- culosis deaths	Ty- phoid fever cases	Whoop- ing cough cases	Deaths, all causes
		Cases	Deaths								
Tennessee:											
Memphis	3		1	280	18	4	0	5	4	2	104
Nashville	0		1	34	4	5	0	0	0	12	53
Alabama:											
Birmingham	1	3	2	70	5	0	0	4	0	1	64
Mobile	1	1	3	10	3	0	0	2	0	0	30
Montgomery	2	1		53		1	0		0	6	
Arkansas:											
Fort Smith	0			9		1	0		0	1	
Little Rock	1	1	1	106	6	1	0	4	0	0	12
Louisiana:											
New Orleans	19	5	3	47	10	24	0	10	3	0	142
Shreveport	0		1	10	5	3	0	2	0	2	45
Oklahoma:											
Oklahoma City	3		0	15	17	3	2	1	0	0	50
Texas:											
Dallas	5	1	1	6	11	12	0	4	0	7	75
Fort Worth	6		3	2	9	5	0	4	2	0	52
Galveston	4		0	1	3	9	0	1	0	0	13
Houston	2		1	1	14	3	3	11	0	0	92
San Antonio	3		0	7	11	1	0	12	0	0	80
Montana:											
Billings	0		0	0	0	0	0	0	0	0	13
Great Falls	0		0	3	4	0	0	0	0	0	12
Helena	0		0	0	0	0	0	0	0	0	1
Missoula	0		0	1	1	0	0	0	0	3	9
Idaho:											
Boise											
Colorado:											
Denver	2	49	2	106	11	12	1	4	0	89	83
Pueblo	0		0	21	2	3	0	0	0	38	11
New Mexico:											
Albuquerque	1	1	1	10	1	0	0	5	0	1	13
Utah:											
Salt Lake City	1		0	236	1	6	0	1	0	52	26
Nevada:											
Reno	0		0	4	0	0	0	0	0	0	4
Washington:											
Seattle	0		1	1	6	23	1	6	0	78	122
Spokane	0	1	1	25	6	6	1	1	0	16	40
Tacoma	0		0	49	2	0	0	0	0	28	20
Oregon:											
Salem	0	1	0	0	0	0	0	0	0	0	
California:											
Los Angeles	22	21	2	70	23	46	0	23	0	43	315
Sacramento	0		0	3	6	3	0	5	0	2	38
San Francisco	6	3	0	118	3	8	0	17	4	11	159

State and city	Meningococcus meningitis		Polio- myel- itis cases	State and city	Meningococcus meningitis		Polio- myel- itis cases
	Cases	Deaths			Cases	Deaths	
New Hampshire:				Iowa:			
Concord	0	0	1	Des Moines	1	0	0
Massachusetts:				Sioux City	2	2	0
Boston	2	1	1	Missouri:			
New York:				St. Joseph	1	1	0
New York	4	2	0	St. Louis	2	0	0
Syracuse	1	0	0	North Dakota:			
Pennsylvania:				Fargo	0	1	0
Philadelphia	0	0	1	Nebraska:			
Ohio:				Omaha	1	1	0
Cleveland	1	0	0	Maryland:			
Indiana:				Baltimore	1	0	1
Indianapolis	1	0	0	Washington:			
Terre Haute	1	1	0	Spokane	1	0	0
Illinois:				California:			
Chicago	11	4	0	Los Angeles	0	2	4
Springfield	1	0	0	Sacramento	1	0	0
Wisconsin:				San Francisco	0	1	0
Milwaukee	2	0	0				
Minnesota:							
Duluth	1	0	0				

Pellagra.—Cases: Philadelphia, 1; Baltimore, 1; Charleston, S.C., 2; Atlanta, 1; Savannah, 1; Nashville, 1; Birmingham, 2; Montgomery, 1.

Lethargic encephalitis.—Cases: New York, 2; Cleveland, 1; Detroit, 1; Houston, 1; San Francisco, 1.

¹ Nonresident.

FOREIGN AND INSULAR

AUSTRALIA

Notifiable diseases—Year 1933.—During the year 1933, cases of certain notifiable diseases were reported in the Commonwealth of Australia, as follows:

Disease	Cases	Disease	Cases
Anthrax	1	Leprosy	31
Beriberi	2	Malaria	45
Cerebrospinal meningitis	54	Measles	13,709
Chicken pox	1,065	Mumps	452
Dengue	45	Poliomyelitis	62
Diphtheria	14,825	Puerperal fever	43*
Dysentery	37	Scarlet fever	8,80
Erysipelas	130	Tetanus	28
Filariasis	2	Tuberculosis	3,534
Hookworm disease	166	Typhoid fever	501
Hydatid	9	Typhus fever	62
Influenza	897	Whooping cough	987
Lethargic encephalitis	34		

NOTE.—The population of the Commonwealth of Australia, estimated as of June 30, 1933, was 6,630,600.

CUBA

Provinces—Notifiable diseases—5 weeks ended December 30, 1933.—During the 5 weeks ended December 30, 1933, cases of certain notifiable diseases were reported in the Provinces of Cuba, as follows:

Disease	Pinar del Rio	Habana	Matanzas	Santa Clara	Cama- guey	Oriente	Total
Cancer		1		6		1	8
Chicken pox		3		2		2	5
Diphtheria		7	3	8	2	5	23
Leprosy							5
Malaria	528	64	608	3,108	163	1,285	5,756
Measles		3	1	1			5
Scarlet fever		2		1			3
Tuberculosis	10	6	22	119	15	34	206
Typhoid fever	8	4	18	111	16	27	184

Habana—Communicable diseases—4 weeks ended March 24, 1934.—During the 4 weeks ended March 24, 1934, certain communicable diseases were reported in Habana, Cuba, as follows:

Disease	Cases	Deaths	Disease	Cases	Deaths
Diphtheria	10	1	Scarlet fever	2	
Malaria	35		Tuberculosis	46	1
Measles	10		Typhoid fever	35	5

GREAT BRITAIN

England and Wales—Vital statistics—October—December 1933.—During the fourth quarter of the year 1933, 129,925 live births and 122,097 deaths were registered in England and Wales. The following statistics are taken from the Quarterly Return of Births, Deaths, and Marriages, issued by the Registrar-General of England and Wales. The figures are provisional.

Birth and death rates in England and Wales, October—December 1933

Annual rates per 1,000 population:

Live births.....	12.80
Stillbirths.....	.57
Deaths, all causes.....	12.00
Deaths from:	
Diphtheria.....	.09
Influenza.....	.14
Measles.....	.04
Scarlet fever.....	.03

Annual rates per 1,000 population—Continued.

Deaths from—Continued.	
Typhoid fever and paratyphoid fever.....	.01
Violence.....	.53
Whooping cough.....	.03
Deaths per 1,000 live births:	
Diarrhea and enteritis (under 2 years).....	9.10
Deaths under 1 year.....	69.00

England and Wales—Infectious diseases—13 weeks ended December 30, 1933.—During the 13 weeks ended December 30, 1933, cases of certain infectious diseases were reported in England and Wales, as follows:

Disease	Cases	Disease	Cases
Diphtheria.....	16,654	Puerperal pyrexia.....	1,368
Ophthalmia neonatorum.....	902	Scarlet fever.....	51,653
Pneumonia.....	13,132	Smallpox.....	46
Puerperal fever.....	542	Typhoid fever.....	419

ITALY

Communicable diseases—4 weeks ended October 15, 1933.—During the 4 weeks ended October 15, 1933, cases of certain communicable diseases were reported in Italy, as follows:

Disease	Sept. 18-24		Sept. 25-Oct. 1		Oct. 2-8		Oct. 9-15	
	Cases	Com- munes affec- ted	Cases	Com- munes affec- ted	Cases	Com- munes affec- ted	Cases	Com- munes affec- ted
Anthrax.....	77	50	43	32	56	38	40	34
Cerebrospinal meningitis.....	9	9	5	5	4	4	3	3
Chicken pox.....	79	53	109	60	72	51	81	51
Diphtheria and croup.....	487	274	453	242	534	289	604	311
Dysentery.....	28	21	32	21	15	10	11	10
Lethargic encephalitis.....	2	2	3	3	2	2	1	1
Measles.....	582	132	394	118	661	162	558	127
Poliomyelitis.....	15	14	10	9	8	8	12	9
Scarlet fever.....	285	132	354	156	392	184	369	186
Typhoid fever.....	1,251	591	948	475	888	451	713	386

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

(NOTE.—A table giving current information of the world prevalence of quarantinable diseases appeared in the PUBLIC HEALTH REPORTS for Mar. 30, 1934, pp. 438-450. A similar cumulative table will appear in the PUBLIC HEALTH REPORTS to be issued Apr. 27, 1934, and thereafter, at least for the time being, in the issue published on the last Friday of each month.)

Cholera

Philippine Islands.—During the week ended March 31, 1934, cholera was reported in the Philippine Islands as follows: Bohol Province—Tubigon, 3 cases, 4 deaths. Cebu Province—Pinamungajan, 1 case, 1 death. Occidental Negros Province—Escalante, 6 cases, 5 deaths; San Carlos, 6 cases, 6 deaths. Oriental Negros Province—Guianangan, 1 case, 1 death.

Plague

Portuguese India—Colem.—During the week ended February 3, 1934, 2 cases of plague with 2 deaths were reported in Colem, Portuguese India.

Smallpox

Eritrea—Asmara.—During the week ended March 17, 1934, one imported case of smallpox was reported in Asmara, Eritrea.