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THE ROLE, ORGANIZATION, AND FUNCTION OF PSYCHIATRIC SERVICE IN A CORRECTIONAL INSTITUTION¹

By R. P. HAGERMAN, *Passed Assistant Surgeon (R)*, WILSON K. DYER, *Acting Assistant Surgeon*, and C. C. LIMBURG, *Assistant Psychologist, United States Public Health Service*

In an era of increasing complexity of social life, the problem of crime has become so acute, that, in our present decade, the matter of dealing with crime is becoming more and more a scientific field of endeavor. With the development of scientific methods applied to the study of human and social phenomena, it has been possible to evolve an eclectic science of criminology, and, more particularly, there is in process of evolution a hybrid field of professional activity which deals with the treatment of convicted criminals. The new profession, that of penology, has attracted to its personnel men trained in various other professions, among which the techniques of psychiatry, psychology, sociology, and education have found a place. This paper concerns itself with the orientation and function of what is here termed psychiatric service in the field of penology as it is applied in a correctional institution.

In order to formulate opinions as to the role of psychiatric service in a correctional institution it is necessary to consider the nature of a correctional institution and the nature of crime. All too often the professional worker is recruited into the service of a particular institution with only a vague conception of what that institution is trying to do, and, as a consequence, engages himself with the routine practice of professional duties with little or no success in adapting his knowledge or training to the objectives of the institution.

The writers conceive of a correctional institution as fundamentally a penal institution to which individuals may be committed subsequent to juridical action relating to the commission of an act forbidden and punishable by law. We recognize the historical attitude that penal institutions were originally designated as places of punishment. We adhere to the proposition that they should serve as deterrants to the further commission of crime. We are sympathetic with the ideal

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that they should be so organized as materially to contribute to the rehabilitation of the individual offender so as to make him able to assume, as nearly as possible, a normal adjustment in society. A penal institution becomes a correctional institution only insofar as it succeeds in returning its inmates to a normal position in society.

A crime is not an independent and separable fact, and cannot be studied or treated without reference to predisposing and motivating causes. Scientific data, while incomplete, are sufficiently conclusive to indicate that crime and criminality can logically be viewed as natural phenomena highly ramified and related to other natural phenomena. Predisposing susceptibility to crime consists of a multiplicity of interacting factors both sociogenic and idiogenic in nature. Motivating causes are often observable as overt behavioristic reactions and may frequently be traced to covert impelling forces and emotional drives. Back of each crime committed there will be found an individual or group of individuals; and in its every aspect, the treatment of crime depends no less upon insight into the problems of the individual offender than upon efficient sociolegal supports. Without underestimating the role of the agencies of legal enforcement, crime must be viewed as a challenging field for the scientific investigation of the interplay of human behavior. The method of approach must first concern itself with tracing specific causes before treatment may be prescribed, just as medical science first traces the sources of bodily disorders before appropriate treatment can be administered. The study of the causes of crime, with the purpose of supplying proper corrective and preventive treatment, is the province of the scientific and professional personnel in a correctional institution.

The employment of scientific diagnostic and therapeutic techniques in the field of penology involves an application of the principle of individual differences. This principle, in spite of what may be said about men being free and equal, is merely a recognition of the fact that one of the most characteristic things about human nature is its variability, the extent to which one individual differs from another. Some men are born into homes of poverty, disease, and ignorance, while others are born into homes of luxury, health, and culture. Some few men are born feeble-minded, while others are endowed with average or superior intelligence. Some men are born susceptible to insanity and temperamental defects, while others live from the beginning to the end of life practically free from such abnormalities. Whether men are convicted of crime or not, they show individual differences of heredity, environmental background, physical well-being, mental ability, personality, and character. Such individual differences are of paramount importance in the field of penology when they prove to be associated with crime and criminality in a causal way, and, in the individual case, are vital in a program of specific

treatment directed toward the readjustment of the individual offender. In each and every case adequate correctional treatment can be most effectively administered by considering each offender first of all as an individual.

The technique of finding and presenting the facts relating to individual differences is that of case-work procedure; and while no two criminals may be found to be entirely alike, individualized treatment may be administratively simplified by classification and segregation with respect to important individual differences in the type of problem presented. The aim of such scientific classification is, first of all, the adequate description of the subject matter with which it deals. The criterion of adequacy may vary with situational facilities, but it is usually that of prediction and control. Thus we make the patent observation that the ultimate aim of case work and classification as applied to criminals is the behavioristic prediction and control of the individual criminal.

All too frequently the scientific study of criminals has been concentrated upon classification and segregation alone. The results have been to limit the work mainly to the detection of deviates popularly regarded as incurable and to exaggerate the incidence of such deviations. The point of emphasis needs to be changed to that of treatment rather than study. That most criminals are, from classification standpoints, normal rather than abnormal is not sufficiently recognized. In the scientific literature the abnormal have been selected for special investigation; but it is the normal, or those who are nearly so, that best repay scientific study and treatment.

The foregoing discussion is presented as an orientation toward a program of rehabilitation in a correctional institution. There are naturally difficulties to overcome in applying such a program in terms of practical measures. That such a program is possible, at least in part, we wish to illustrate by a description of the psychiatric service as it has developed in the United States Industrial Reformatory.

The United States Industrial Reformatory was opened by the Federal Department of Justice in January 1926, in the wooden cantonment buildings of Camp Sherman, at Chillicothe, Ohio. The construction of a permanent institution dedicated to the progressive ideals of individualized study and treatment was planned and new quarters were occupied in March 1933, with several units still under construction. Federal first offenders are admitted, with some further selection being made by the Department of Justice. The average daily inmate population for the fiscal year 1934 was 933, and the number of men admitted 940. The average age of the inmate population is approximately 25 years. When all contemplated buildings shall have been completed, this institution will be well equipped to carry out definite plans of rehabilitation.

The psychiatric service, a component part of the medical service, was organized in February 1931, when the medical service was assumed by the United States Public Health Service. The personnel of the psychiatric service has always been a psychiatrist, a psychologist, and such inmate clerical assistance as has been necessary to carry on the work of the department. The psychiatrist and psychologist make separate examinations of each inmate, but collaborate in submitting a joint report of examination findings as well as in carrying on a program of treatment. A broad outline of functions performed would include individual diagnosis of each newly admitted inmate, individual treatment by means of psychological and psychiatric techniques, and advisory relations with the institution personnel. The scope of the service rendered has broadened with increasing institutional facilities and is, at the present time, highly integrated with other departments which are briefly described.

The Department of Justice provides for a social service unit, an educational department, and an institutional parole department, which perform duties relating to their respective departments. The social service unit investigates the antecedents, background, developmental history, and work record of each inmate, and assists the superintendent of the institution in carrying out a program of individualized treatment based upon case material derived from all of the departments. Personal service, relating to individual and family welfare, is also carried on by the social service unit. The educational program consists of coordinated units of academic and occupational training whose objectives are similar to like programs of civilian adult education. Inmates educationally retarded on the basis of ability are required to attend day school up to the fifth grade level and a night school organized upon concepts of socialized education up to the eighth grade level. Advanced education is optional in the night school. Occupational training attempts to teach men what they should know and be able to do successfully in order to maintain self support at such work when they are released from the institution. Library facilities, athletics, music, and entertainment programs are considered as educational projects. The parole officer supervises the preparation of applications for parole to be heard by the parole board, assists each inmate in preparing a plan under which he will live when released from the institution, and performs administrative functions relating to each inmate's release.

The psychiatric service at this institution is, and should be, highly integrated with the administrative, custodial, and the above-mentioned professional departments of the institution. The work of the psychiatric department naturally overlaps with these departments in case work procedure, in classification, and in the integrated program of the institution. Effective analysis and treatment requires the clos-

est cooperation among the several departments, and it has been our pleasure to enjoy such relationship at the United States Industrial Reformatory. Evidence of this cooperative relationship should become apparent from the discussion of institutional routine which follows.

Inmates received at the institution are placed in quarantine and held there for a period of 30 days before being assigned to other quarters and given an institutional work assignment. They are not allowed to mingle with the older residents, but may work on detail segregated from the older population. The quarantine period is considered advisable not only as a health measure but as a period during which the various departments can perform the examinations and investigations necessary to the proper understanding of each inmate. Immediately indicated treatment is completed during this period insofar as it is possible.

The officers in charge of quarantine are specially selected and assist the administrative and professional personnel by observing the newly admitted inmate's reactions and behavior as well as by developing rapport between the inmate and the institution through friendly contact, instruction, and advice. The quarantine officer submits individual reports of his observations directly to the psychiatrist, who makes frequent visits to quarantine so that any suspected maladjustment may be given immediate attention. Through this controlled early contact much valuable information is obtained and desirable effects upon individual morale are achieved.

Initial psychological and psychiatric examinations are completed for each inmate during his quarantine period prior to his hearing before the classification and assignment board. It is our plan to present examination facts along with progress notes in a clear-cut and understandable manner so that members of the lay personnel may assist in remedial treatment by a proper regime of custody, discipline, vocational guidance, academic education, occupational training, and mental hygiene. Reexaminations are frequently made in special cases relating to disciplinary, emotional, educational, and parole problems. Such studies may be written up in considerable detail if the problem presented merits such consideration, and may be requested by any member of the personnel having contact with such problem cases. While a detailed critical discussion of examination techniques is beyond the scope of this paper, it is thought appropriate to refer to a variety of such techniques which have been found applicable to the problems presented at this institution.

In formulating a program of mental testing, the psychologist will naturally select a battery of tests which will meet the requirements presented by the institution in which he works. That such tests will be valid, reliable, and based upon adequate norms must be left to the technological research and judgment of the trained psychologist. The nature of the tests will largely depend upon the scope of the testing program but may well include tests which measure intellectual capacity, special abilities, temperament and character, and interests. Better to understand the testing program herein described, brief mention is made of the type of men examined.

Men admitted to the United States Industrial Reformatory, are, by and large, relatively young men drawn from widely separated sections of the country, and as a group, closely approximate the Army draft with respect to intellectual ability. Social records very frequently reveal histories of poor environmental background, educational maladjustment, limited occupational opportunity, and emotionally unstable behavior. Less than half of the men have done other than irregular manual labor, and it is only infrequently that an inmate of skilled occupational training is encountered. We find that these men possess skilled occupational aptitude from research testing studies and progress reports from observation at work during the course of their confinement. The men usually react favorably to educational and occupational guidance and thus make excellent subjects for an examiner interested in an analysis of individual differences relating to such guidance. Active interest of the psychologist in a program of occupational guidance is considered advantageous from the standpoint of promoting occupational efficiency within the institution and as a therapeutic method in the treatment of occupationally maladjusted individuals. While there are a number of ways in which psychological analysis may be employed in furthering the objectives of promoting individual adjustment and occupational efficiency, the first approach in a correctional institution takes the form of rendering scientific information in work assignment after an evaluation of the work to be done and the man who is to do it. Since trade work is supervised by the director of education, it is advisable that the psychologist cooperate with this official and possibly, as has been done at this institution, hold interviews with each inmate in conjunction with the director of education.

Under the present program at the United States Industrial Reformatory the initial psychological examination requires a minimum of about 5 hours of each inmate's time, and, because of the relatively high number of men admitted, utilizes group methods of testing wherever possible. Preliminary tests given to every newly admitted inmate include the Army Beta, Army Alpha, the Stenquist Mechanical Aptitude Test, the Minnesota Paper Formboard, and a Test of Copying

Designs. The educational department administers the New Stanford Achievement Test, primary and advanced forms, to all inmates, and makes these test results available to this department for use. Verification letters secured by the social service department relating to educational history, occupational records and opportunity, and general social adjustment are available. With all of the above-mentioned material in hand, each inmate is called in for an interview, at which time individual tests may be administered if they are so indicated. A clinical interpretation is formulated from the total material available. A classification is made and presented, along with further descriptive material, in an examination report.

The psychiatric examination consists of an inquiry into all diseases suggested during infancy, childhood, and adolescence, with particular attention to and further investigation in those conditions suggesting an hereditary endowment. Each inmate is interrogated for information relative to disturbances of consciousness, convulsions, disorders of sleep, and other symptoms of adjustmental difficulty. His emotional equipment and attitude are investigated, and his work habits and his ability to adjust in society are discussed. Retention, orientation, and memory are explored. Mood and early adjustment to institutional life are determined by personal contacts and reports of the officers in charge during his residence in quarantine. Inquiries are directed toward eliciting hallucinatory or delusional experiences. He is questioned concerning drug and alcoholic addiction. Where there is evidence of a psychosis, a complete report of the case is submitted. In neurological cases a special report of findings is submitted.

Daily visits are made by the psychiatrist to those confined in isolation for punishment and to those confined for observation for mental disease. The treatment of all cases of insanity is under the direct charge of the psychiatrist.

The classification and assignment board was instituted at this institution during June 1933 at the suggestion of the Honorable Sanford Bates, Director of the Bureau of Prisons. In its original organization this board consisted of representatives from the administrative, medical, educational, and social service departments, and utilized separate reports supplied by the social service and medical departments. The social service department supplied an initial social interview and such verification material as had been received up to that time. The medical department supplied a summary report which included sections covering the major headings of physical condition, emotional and social stability, and intellectual and occupational competency. This board was recently reorganized as advised by Dr. F. Lovell Bixby, Assistant Director of the Bureau of Prisons, and now is composed of the superintendent, assistant superintendent, educational director, psychiatrist, psychologist, parole officer, chaplain, physical director,

and social service representative. A member of the social service acts as secretary of the board and supervises the preparation of integrated reports made up from the contributions of the various departments. Findings and recommendations of each department are reproduced unedited and classified under the following headings: (1) Previous Record, (2) Deputy's Report, (3) Social, (4) Medical, (5) Neuro-psychiatric, (6) Educational, (7) Employment, (8) Religious, and (9) Recreational.

The neuro-psychiatric section of the admission summary includes examination reports by the psychologist and the psychiatrist. The psychologist presents a representative index of mental ability and a clinical analysis of social competency, mental aptitudes, probable development, and occupational level. The psychiatrist gives a condensed statement of his examination findings, and in neurological cases the examination findings are also recorded. Recommendations under the neuro-psychiatric section include those referring to transfer from the institution, custody, treatment, and occupational guidance.

In older penal and correctional institutions the treatment of disciplinary infractions has always been held to be the prerogative of the executive officer. The punishment was ordered to fit the offense, with no consideration of the underlying personality make-up of the individual.

In a forward-looking program, directed toward the ultimate rehabilitation of the inmate, this procedure seems antiquated. The disciplinary board was organized as a means of coordinating the punishment for the offense with the inmate's mental ability and personality make-up.

This board was organized in February 1934 by Mr. Joseph W. Sanford, superintendent, in collaboration with the medical department. Its personnel consists of the superintendent, the assistant superintendent, and the psychiatrist. The psychologist acts as alternate in the absence of the psychiatrist. This board meets the problems of institutional discipline by an analysis of the emotional make-up of the inmate and an understanding of each inmate's mental ability and reactions. It fits the punishment to the individual rather than to the breach of discipline involved.

The procedure of the board is as follows: The inmate is called in, the charge is read to him, and his defense is heard. He is then dismissed until his case is discussed from a custodial, administrative, and mental hygiene viewpoint; then he is recalled and advised of the findings of the board and given advice, based upon the combined investigation of the members, relative to his future adjustment.

Once each week this board hears all requests for interviews relating to adjustment problems of the inmate. These problems are often

personal, and friendly advice is given. At this time certain inmates showing evidence of faulty adjustment either in their work or social contacts are brought in and advised. Then follow-up interviews are held in chronic disciplinary problem cases. When it comes to the attention of any member of the board that there may be some lack of knowledge of the rules, maladjustment, or lack of interest exhibited by the inmate in his corrective vocational project, he is interviewed and his problem corrected by advice and direction. In extreme disciplinary problems, the director of prisons has ordered that three officers shall sit as a board in all cases where the loss of good time is considered as a punitive measure. The psychiatrist is appointed a member of this board by the superintendent. He brings before the board information regarding the mental ability and personality make-up of the individual, and makes his recommendations in accordance with these views.

Where the restoration of good time lost through misconduct is considered, the psychiatric department furnishes the superintendent with a complete summary of the original psychological and psychiatric findings, together with the progress notes in the case and a prognosis as to probable social adjustment.

Psychological and psychiatric information regarding each inmate has, since the institution of the psychiatric department, been supplied to the parole officer, who assembles material for the use of the board of parole. It has been necessary in the past to prepare a special summary for each applicant for parole, making such corrections and additions to the original examination findings as were warranted by further observation and treatment during the inmate's stay in the institution. Under the present integrated program it is necessary to make progress notes only, since the parole officer is supplied with the initial findings shortly after each inmate is admitted. This information, in addition to being used by the parole officer in the institution, is submitted to the probation officer for his guidance in dealing with the inmate after his release from the institution.

A consultation service is maintained by this department. General problems relating to administration, contemplated changes, and individual problems are referred for comment by the various departments. Psychological and psychiatric surveys are made for the information and guidance of the officers concerned.

Each inmate is advised and accorded the privilege of making full use of the consultation service of this department. The custodial officers are instructed to refer all cases of nervous or mental maladjustment promptly and directly for necessary examination and treatment. In cases where further treatment is indicated, a follow-up system is employed and the inmate is called out at regular intervals. The treatment consists in psychological, psychiatric, or neurological

techniques. Many inmates request such consultations of their own accord and receive confidential professional guidance and treatment in accord with the program of the institution.

SUMMARY AND CONCLUSIONS

1. The role of the psychiatric service at the United States Industrial Reformatory is one of advisory service to the institution as a corrective agency and of personal service to the individual inmates representing problems of maladjustment. While services rendered to the institution as a correctional agency take precedence over those rendered the individual offender, both are directed toward the single objective of the readjustment of the individual offender in society.

2. The organization of the psychiatric service as a component part of the United States Public Health Service frequently serves the purpose of emphasizing to the individual inmate that this unit is an agency of treatment to which he can bring his individual difficulties. A possible disadvantage in this service being assigned to a parallel department from that including other professional services engaged in case work procedure may be the inadequate integration of the psychiatric service with the total program of the institution and with other professional departments. The authors have endeavored to point out during the course of this paper that such a disadvantage need not be real and may be overcome by a close cooperation and integration with the program and departments of the institution.

3. Methods employed by the psychiatric service include both psychological and psychiatric techniques utilized for diagnostic, therapeutic, and prognostic purposes. The results of such techniques are made available to every department dealing with the custody, discipline, and corrective treatment of individual inmates and become an integrated part of the institutional program through consolidated reports and consultations with various members of the institution personnel. Representation of the psychologist and psychiatrist upon the classification and disciplinary boards serves to facilitate the use of services supplied and frequently allows the psychologist and psychiatrist to clarify, augment, and point out practical applications of indicated custody, discipline, and corrective treatment.

4. Specific functions of the psychiatric service may be listed as follows:

(a) The diagnosis, partial segregation, and temporary treatment of psychotic inmates prior to their transfer to a specialized institution.

(b) The diagnosis, partial segregation, and temporary treatment of drug addicts prior to their transfer to a specialized institution.

(c) The diagnosis, partial segregation, and recommended treatment of feeble-minded inmates.

(d) The diagnosis, partial segregation, and corrective treatment of borderline psychopathic individuals who are not sufficiently abnormal to be admitted to an institution for the insane.

(e) The diagnosis and corrective treatment of psychoneurotic inmates.

(f) The diagnosis and recommended transfer or segregation of hardened habitual criminals from the general population.

(g) The diagnosis and treatment of the emotionally unstable.

(h) The analysis and classification of each inmate's mental ability, aptitudes, proficiencies, and interests for purposes of vocational guidance and occupational placement within the institution.

(i) The analysis, recommended treatment, and direct supervision of disciplinary problem cases within the institution.

(j) The preparation of a diagnostic summary and statement of anticipated adjustment for use of the parole board and supervision officers subsequent to each inmate's release.

5. The value of the psychiatric service is reflected in contributions to individual and group morale, improved adjustment of the individual inmate within the institution, the corrective treatment of specific defects, more efficient institutional management brought about by intimate knowledge of each inmate's personality, and by readjustment of the individual inmate to society.

6. The value of the psychiatric service at this institution can be extended and improved with the further development of the institutional program as increasing facilities become available. The segregation units of this institution at the present time are of large capacity and do not lend themselves to an adequate classification program of personality types. Suggestions along this line are as follows:

(a) Provisions should be made for the transfer of feeble-minded inmates to an institution specially constructed for their care and treatment or facilities be made available within the present institution for more adequate segregation. A segregation unit would preferably be a separate building, which would be provided with recognized training facilities for this type of individual.

(b) The treatment of borderland mental deviates, such as those of psychopathic personality, is a very difficult problem in an institution of this character, unless quarters for strict segregation and individualized treatment are provided. The construction of a special unit for the treatment of these cases would prove effective from the administrative, custodial, and correctional viewpoints and would provide for a more individualized grouping of the entire population. Intensive psychiatric treatment could be administered until the inmate demonstrated his fitness to adjust in the general population. Such a unit would combine the features segregation, isolation, hydrotherapy, physiotherapy, and occupational therapy with graduated occupational

training. Dietary and medical treatment would also be included. A psychiatrist should be in charge and direct the treatment.

7. The continued personal contact of the psychiatrist and psychologist with individual inmates is limited by the heavy case load. It is advisable, therefore, that all officers have a working knowledge of the principles of mental hygiene and lend sympathetic assistance in the treatment of each case. Officers in charge of quarantine have been very helpful in this respect when instructed in the handling of various types of personality. This instruction should be extended to the entire lay personnel so as to further the work of the classifications and assignment board in the individualized study and treatment of each inmate.

In conclusion, the authors wish to express appreciation for the assistance and full cooperation of the United States Bureau of Prisons, and particularly to the officers at the United States Industrial Reformatory, without whose sympathetic aid the psychiatric service could not have been developed to the point described in this paper.

THE SOCIAL VIEWPOINT OF PSYCHIATRIC SERVICE IN A CORRECTIONAL INSTITUTION *

By AMY N. STANNARD, M.D., *United States Board of Parole, Washington, D.C.*

William Hodson¹ defines social service as "that form of persistent and deliberate effort that helps the individual (or family group) to make a satisfactory adjustment to his environment." He then proceeds to give a very inclusive outline of the various ramifications of social work, among them the entire fields of public health, correction, and mental hygiene; and so I feel that the viewpoint I am invited to bring into the afternoon's discussion has really staggering possibilities. However, one needs to go no further than his topical definition to focus quite clearly on the same objective which Dr. Dyer and Mr. Limburg name for a truly correctional institution, viz, returning its charges to a normal or satisfactory position in society. Also, Hodson's statement that social service is a "persistent and deliberate effort" toward this goal prompts the comment that the director of the Federal penal and correctional system has led and encouraged just such persistent and deliberate efforts in his few years of developing and administering the system. In my recurrent visits to the various institutions over the past 4 years I have found an increasing orientation toward this goal, so that a very great contrast exists between the impressions, say, of July 1930 and July 1934.

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¹ Hodson, William. *Encycl. Brit.*, 14th ed., vol. 20, p. 902.

At first, contacts of staff members with inmates seemed (with a few exceptions) to be of the "lick and a promise" variety. As the specialized services were organized, the foundations were laid for really constructive steps in bringing the inmate and society into mutually agreeable relationship. But there was a serious lack of knitting together of the efforts made by the various departments. As shown in the present paper, organization has now progressed toward the stage of having an integrated staff attitude toward the individual inmate and his ultimate fate. From the social viewpoint I think the important contribution in this paper is the report that a *group* of informed people are thinking together and working together toward a common objective.

Most offenders are emotionally childish in some degree; but there are many persons equally immature from the emotional standpoint who do not come into conflict with the law. The difference, generally speaking, lies in the value which they place upon *group approval*. In the development of the individual, as with the development of the race, identification with the group comes at a higher level of adjustment than identification with another individual. What might be called the tutorial attempt at rehabilitation is based upon a personal relationship tending to throw the balance toward individual identification. It has two possible dangers. One is in permitting the inmate to continue dependence upon another person who will tell him what to do and say in order to save him from being in trouble in his immediate environment. On his release from confinement this prop is removed and a substitute is not so readily found in the more complex life of the outside world. The other danger works from the opposite side of the equation, so to speak, and is the pitfall of the staff member's identification with the prisoner to the extent of impairing his own perspective. The staff member unconsciously adopts the inmate's self-excusing attitude and becomes a protagonist for him in seeking compensation for the real or fancied wrongs society has visited upon him. He thus fails to help the inmate raise his level of adjustment toward the *group ideal*.

I hope not to be understood as minimizing the value of direct contacts between personnel and inmates. What I am trying to emphasize is the fallacy of relying exclusively upon them for ultimate readjustment, and to say that their usefulness is enhanced and their dangers are avoided by the collective attitude of the conference or board. By and large the inmate has to measure higher to meet the goals held up to him by the collective planning of the classification and assignment board. Such practice should stand him in good stead in meeting group demands when he leaves the institution.

A classic example has often been cited of the need for medical social service in the case of the man with heart disease, who, after

courses of rest and digitalis, was repeatedly discharged from the hospital. The staff always confidently expected him to return, since that had been the experience of the past. Finally it became known that, by occupation, the patient was a piano mover, and that explained nearly everything except why he hadn't died long ago. Some adjustments in his mode of living and working postponed his next attack for a long time.

Granted that the offender has been diagnosed, treated, and made able to assume a normal social adjustment, will he continue to be able? As with the discharged heart case, the offender may, and usually does, carry potential inadequacies away with him. We must face the possibility that he may "decompensate" unless a "persistent and deliberate effort" is made to help him avoid the stresses and vicissitudes which are most likely in his particular case to contribute to further delinquency.

A verified social history is indispensable in the adequate study of how the individual offender came to be what he is. Furthermore, knowledge of his social background and current contact with his family or family substitute must be a part of any attempt to help him actually re-form thinking habits, emotional attitudes, and behavior. The gap between intramural and extramural living is so great that the possible supports for the bridging of it must be evaluated and adopted with much care, and in accordance with their practical promise to function in giving the particular inmate a sure footing. While the inmate is still in the institution, contacts which the staff members have with him individually and in conference can be directed toward helping him see (and not just telling him) how and why his antisocial conduct developed. If he develops a practical insight he will welcome efforts to help him (and his family also) avoid those attitudes and circumstances which are known to have brought him and them to grief. Contacts with his family or close friends, made either through tactful direct correspondence or the medium of a social agency in the field, or both, can in many cases foster an understanding attitude in the prospective associates and a willingness on their part to cooperate with the plan for his changed adjustment in the community. When indicated, arrangements for future handling of the case under psychiatric guidance should be made in advance of release. Success in this will depend in part upon the facilities available and in part upon the inmate's disposition to cooperate.

There will be some cases which, from the social viewpoint, will have to be classified as "inoperable", just as the surgeon must now and then admit that the techniques and facilities known or available to him are incapable of affording relief in a given situation. In dealing with this class of cases it is particularly valuable to have an opinion that is the result of consultation. Let us say that the com-

mittee in a candid survey of the whole case decides and records that, the inmate being what he is, and the social situation being what it is, a workable, constructive plan cannot be made with the means available; then there should be no chagrin attached to accepting the fact and turning the energies of personnel into more productive channels. Thus, for some individuals, prolonged (and perhaps permanent) separation from the free-living community will have to be looked upon as their place in society as society is so far developed. Palliative treatment for them will have to be orientated toward the goal of good citizenship within the institution community only.

As can be concluded from the paper under discussion, the social value of psychiatric studies is proportionate to the degree in which they go beyond the selection of a diagnostic label and point to something in the way of (a) treatment in cases susceptible to treatment, and (b) advice as to control, whether intramural or extramural. The paper under discussion reflects a highly commendable practice in this respect, and on behalf of the Board of Parole I wish to testify to our very satisfactory experience in depending upon this type of study as it is found at Chillicothe and other institutions.

MORTALITY FROM CERTAIN CAUSES DURING THE FIRST HALF OF 1934¹

This report covers mortality in 28 States for the first half of 1934, with comparative data for the first half of the 4 preceding years. In addition to the death rate from all causes, rates are shown for 4 groups of diseases and 17 specific causes, some of which are included in the groups. Infant and maternal mortality rates per 1,000 live births are also shown.

The rates are computed from current and generally preliminary reports furnished by State departments of health. Because of some lack of uniformity in the method of classifying deaths according to cause, some delayed death certificates, and various other reasons, these preliminary rates cannot be expected to agree in all instances with final rates published by the Bureau of the Census, which are based on a complete review and retabulation of the individual death certificates from each State. The preliminary rates given in the accompanying table are intended to serve only as a current index of mortality until final figures are issued by the Bureau of the Census.

In general, the mortality situation was somewhat less favorable in the first half of 1934 than in the corresponding half of 1933 or 1932. The death rate from all causes in the group of 24 States² was 11.5

¹ From the Office of Statistical Investigations, U. S. Public Health Service.

² States with data for every cause group included in the table for each of the years 1931, 1932, 1933, and 1934.

per 1,000 as compared with 11.1, 11.4, and 11.8 in the first half of 1933, 1932, and 1931, respectively. In both the first and second quarters of 1934 the rate was above the corresponding rate for 1933, and in the second quarter it was above both 1933 and 1932 and equal to the 1931 rate. The slightly higher mortality rates really began in the latter part of 1933, as the last quarter of that year was above the last quarter of 1931; the last quarter of 1932 included a part of an influenza epidemic, and so was higher than 1933. The winter of 1933-34 was relatively free from influenza; the high general death rate for the first half of 1934 was due to a small but persisting excess in the rate. Of the 28 States with data for both years, 22 showed an increase in the death rate from all causes in 1934 over 1933, 2 remained the same, and 4 decreased.

Infant mortality was 62 per 1,000 live births in the first half of 1934 as compared with 59 and 58 in 1933 and 1932, respectively. Of 26 States with data for both years, 14 increased in 1934 over 1933, 5 remained the same, and 7 decreased.

Tuberculosis declined from 60.3 per 100,000 in the first half of 1933 to 57.8 in the first half of 1934. The decline in 1934 of 4.1 percent from the 1933 rate was somewhat less than that of 8.1 percent in 1933 from the 1932 rate and 6.0 percent in 1932 from the 1931 rate. The 1934 decrease was quite general, 24 of the 28 States having lower rates in 1934 than in 1933 and only 4 increasing.

As already noted, 1934 has been relatively free from influenza; the rate was little more than half what it was in the corresponding half of each of the 3 preceding years. Every one of the 28 States had a lower influenza death rate in the first half of 1934 than in that of 1933. An analysis now in progress of weekly excess death rates from influenza and pneumonia in 95 cities in the several geographic areas reveals no periods in which influenza could be said to be epidemic. Nevertheless, the pneumonia death rate was higher during the first half of 1934 than in any year since 1931, showing an increase from 84.5 per 100,000 in 1933 to 99.8 in 1934, amounting to 18.1 percent. Of the 28 States with data for both years, 24 had higher pneumonia rates in the first half of 1934 than in that of 1933.

Since the influenza rates are low, the explanation of the high pneumonia rates must be found elsewhere. In this connection, the death rates from measles and whooping cough are of interest; the 1934 measles death rate was about 2.3 times the 1933 and 1932 rates and was 56 percent in excess of the 1931 rate. The whooping cough death rate in 1934 was 73 percent above that of 1933 and was also well above both the 1932 and 1931 rates. As both of these diseases are frequently complicated by pneumonia, it is quite probable that some of the deaths credited to pneumonia may have been preceded by these or other communicable diseases of childhood but

the facts have been omitted from the death certificate, thus increasing the pneumonia rate. In 1934, the measles death rate increased over 1933 in 19 of the 28 States, and the whooping cough rate increased in 24 of the 28 States. Although the death rates from communicable diseases of children may be expected to fluctuate from year to year, increases for both measles and whooping cough in the same year in such a large proportion of the States is not what would normally be expected, because the high and low periods of incidence do not usually coincide in different sections of the country.

Typhoid fever was low during the first quarter of 1934 but was up to the 1931 level during the second quarter. For the half year as a whole there was a decline from the 1933 rate in 14 of the 28 States with data for both years. The rate for diarrhea and enteritis was higher than in 1933 and 1932 but less than in 1931. In 15 of the 28 States there was an increase over 1933, in 11 a decrease, and in 2 States the rate was the same.

Heart diseases, nephritis, cerebral hemorrhage, cancer, and diabetes all increased in 1934 over 1933. The majority of these degenerative diseases have for many years been either increasing or maintaining approximately the same level, but the increases this year over last were generally somewhat more than the usual annual increase. The change was particularly marked in heart diseases, which showed an increase of 10.3 percent over the 1933 rate as compared with increases of 1.3 and 1.5 percent in 1933 and 1932, respectively.

Of the 25 disease groups included in the table, 19 showed increases in 1934 over 1933 and 6 showed decreases; however, some of the groups include others, so they are not all independent cause classes. Increases were rather general in the various disease groups.

It is not possible to assign reasons for the increased death rates. Decreases in mortality have occurred for many years and the low record of 1933 may stand for some time. Some of the increase in 1934 may be associated with increased industrial activity and its attendant exposure of workers to accidents and other hazards. On the other hand, the severe weather of the first half of 1934, occurring when many of the unemployed were ill-equipped with clothing and shelter to withstand the exposure, may have contributed to the high pneumonia and certain other death rates. Possible lowered resistance to disease in this element of the population may also have played its part.

Although the 1934 death rate represents some increase over 1933 and 1932, it is not above the 1931 level and is still low as compared with earlier years.

Connecticut:	10.9	55	10.1	4	7	46.8	122.0	28.6	()	()	()	240.4	()	88.7	()	3.9	94.9
1964	11.1	52	1.2	5	5	54.0	150.0	25.3	()	()	()	216.0	()	85.1	()	4.5	97.0
1963	10.8	58	1.0	7	1.0	56.7	114.1	24.9	()	()	()	226.4	()	84.8	()	3.9	94.6
1962	10.9	59	1.1	2	1.7	56.7	111.1	24.9	()	()	()	210.4	()	84.8	()	3.9	94.9
1961	11.8	68	1.3	1.6	1.6	60.9	115.8	20.4	()	()	()	201.4	()	128.5	()	3.0	81.0
District of Columbia:	17.5	64	1.2	8	129.6	148.2	37.7	150.2	112.4	487.1	428.4	185.1	163.2	95.4	10.1	134.0	
1964	16.5	64	2.9	135.3	153.2	37.7	167.0	127.1	428.6	353.6	149.9	131.6	107.1	9.4	128.7		
1963	17.0	69	4.0	182.4	168.3	29.9	165.6	117.5	402.2	344.1	184.6	162.3	94.5	7.8	158.7		
1962	16.8	70	9.0	118.2	136.2	31.1	171.0	113.7	387.4	321.9	222.1	194.3	94.5	7.4	155.4		
1961	15.8	68	2.1	127.7	136.4	28.3	143.8	103.7	399.6	346.9	170.3	145.5	92.6	6.6	174.2		
1960	12.9	70	3	62.1	81.6	17.1	130.8	99.0	255.8	236.3	104.5	90.6	94.7	14.3	124.9		
1964	12.0	71	8	66.1	82.1	15.9	121.3	89.0	236.8	219.4	78.9	61.5	61.5	16.2	122.2		
1963	11.5	65	1.8	62.2	85.8	17.0	122.0	104.7	204.2	205.6	73.1	62.6	62.6	14.3	106.4		
1962	12.7	60	1.1	71.1	70.2	14.1	134.0	112.1	221.8	205.6	86.6	70.9	86.9	10.4	124.8		
1961	12.9	69	1.5	71.9	73.8	16.2	133.5	111.7	214.6	187.1	92.2	72.5	92.7	18.1	127.5		
1960	11.9	56	7	60.0	83.9	12.9	113.4	74.4	180.7	165.9	139.5	128.5	74.2	17.2	104.5		
1964	10.0	72	1.1	57.8	61.3	11.6	101.1	71.0	130.7	121.3	94.2	86.1	61.5	12.5	106.0		
1963	10.7	70	1.2	67.7	48.8	11.9	118.4	81.6	148.7	132.2	110.4	101.1	62.6	10.6	111.9		
1962	11.5	76	2.0	75.7	50.6	10.4	119.6	81.6	151.7	137.7	120.1	110.8	64.1	12.8	110.4		
1961	12.2	53	4	77.9	49.5	11.9	131.7	81.6	166.1	141.1	126.0	113.5	80.2	20.4	142.4		
1960	10.1	88	1.6	89.3	69.9	19.3	60.6	39.7	120.7	107.6	190.2	171.9	89.3	37.6	64.8		
1964	10.1	79	4.8	101.6	70.4	14.8	72.6	51.9	125.6	113.9	113.9	97.9	108.6	47.7	82.7		
1963	10.4	82	2.2	107.9	47.9	14.7	61.4	9.1	62.7	116.3	103.2	91.5	120.0	117.9	60.8		
1962	10.4	77	6.8	107.0	61.4	14.1	61.4	47.9	61.4	116.3	103.2	91.5	120.0	117.9	60.8		
1961	11.5	86	1.1	111.3	75.3	11.2	113.6	82.6	209.7	178.3	142.4	127.6	64.2	2.7	46.9		
1960	10.8	50	3.1	35.9	73.7	11.2	113.6	82.6	209.7	178.3	142.4	127.6	64.2	2.7	46.9		
1964	10.0	52	1.1	30.2	87.3	11.2	113.4	71.0	209.3	176.6	95.4	78.8	59.0	4.9	80.0		
1963	9.6	66	3.1	33.7	62.8	12.6	119.4	90.2	205.6	166.1	96.8	87.1	57.0	2.2	47.1		
1962	10.3	61	7.7	29.3	65.9	10.8	137.6	112.8	197.1	174.1	111.4	102.9	56.8	3.3	37.0		
1961	10.0	58	8.6	36.2	60.1	7.7	106.7	68.7	200.2	174.6	142.9	122.5	52.4	.9	41.6		
1960	11.4	54	2.1	54.2	123.0	29.7	102.2	73.5	264.5	262.1	161.0	90.0	70.1	4.6	106.2		
1964	11.0	58	4.6	66.8	116.9	27.9	106.9	80.6	300.3	261.4	89.0	76.4	66.9	4.9	115.2		
1963	10.9	58	2.4	68.6	112.5	27.2	102.2	73.5	267.0	238.0	94.0	80.0	69.9	()	()		
1962	()	()	()	63.6	()	()	()	()	()	()	()	102.5	()	()	()		
1961	()	()	3.4	64.0	64.0	()	()	()	()	()	()	81.9	()	()	()		
1960	12.8	57	2.0	55.4	111.2	19.2	126.4	()	126.4	()	274.4	()	97.2	()	3.9	81.7	
1964	11.6	57	3.3	57.7	106.7	16.3	112.9	()	112.9	()	187.3	()	80.5	()	5.8	79.6	
1963	11.8	59	2.9	63.5	106.1	16.9	114.0	()	114.0	()	180.6	()	103.6	()	6.9	71.8	
1962	12.4	63	7.0	60.8	105.8	16.4	114.4	()	114.4	()	182.3	()	108.8	()	5.4	80.3	
1961	12.4	63	8.2	73.7	104.6	17.9	117.4	()	117.4	()	202.6	()	106.9	()	7.3	91.0	
1960	12.5	57	12.8	73.7	104.6	17.9	117.4	()	117.4	()	202.6	()	106.9	()	7.3	91.0	

* States included are Alabama, Connecticut, District of Columbia, Georgia, Idaho, Iowa, Kansas, Louisiana, Maryland, Michigan, Minnesota, Montana, Nebraska, New Jersey, New York, Ohio, Pennsylvania, Rhode Island, Tennessee, Virginia, West Virginia, and Wisconsin.

† Data not available.

‡ No deaths.

Mortality from certain causes in the first 6 months of 1934, with comparative data for the corresponding period in preceding years—Continued

State and period	Death rate per 100,000 population (annual basis)																								
	Rate per 1,000 live births		Typhoid fever (1, 2)	Measles (7)	Scarlet fever (8)	Whooping cough (9)	Diphtheria (10)	Influenza (11)	Polymyositis (16)	Lethargic encephalitis (17)	Meningococcus meningitis (18)	Tuberculosis, all forms (23-32)	Cancer (45-53)	Diabetes (59)	Diseases of the nervous system (73-89)	Cerebral hemorrhage, apoplexy (82a, b)	Diseases of the circulatory system (90-103)	Diseases of the heart (90-95)	Diseases of the respiratory system (104-114)	Pneumonias, all forms (107-108)	Diseases of the digestive system (115-129)	Diarrheas and enteritis, under 2 years (119)	Nephritis (130-132)		
	Total infant mortality	All except maternal and early infancy																						Maternal mortality	
All causes, rate per 1,000 population (annual basis)																									
JANUARY TO JUNE—contd.																									
Iowa:																									
1934	11.0	56	0.1	3.9	2.8	4.4	1.9	26.9	0.1	0.9	1.3	25.6	122.9	24.9	153.3	120.4	249.7	217.0	113.0	98.2	59.6	0	0	67.3	
1933	10.8	55	0.1	3.3	2.3	2.3	1.2	56.4	1.1	1.1	2.0	26.6	123.4	21.3	143.8	116.8	258.0	201.4	113.0	91.5	59.6	1.5	0	45.8	
1932	10.6	51	1.1	2.8	2.0	1.9	1.6	39.8	1.1	1.1	1.1	20.1	112.0	16.5	145.4	115.1	280.7	213.2	117.2	83.8	57.3	2.0	0	49.1	
1931	11.2	60	1.1	3.3	2.8	2.8	1.5	43.6	1.1	2.8	4.0	20.3	119.0	23.3	142.3	112.7	233.2	224.5	105.2	91.6	69.3	4.4	0	43.1	
1930	11.0	60	1.1	3.9	2.8	4.6	2.1	35.5	1.1	2.8	3.8	34.3	108.6	23.2	140.9	97.0	281.2	210.4	111.3	101.8	60.2	3.0	0	44.3	
Kansas:																									
1934	10.3	50	0.1	3.2	2.6	6.8	2.0	26.9	1.1	1.4	1.5	28.4	105.1	25.3	117.2	93.2	236.7	209.8	82.9	73.4	70.6	4.0	0	97.4	
1933	11.3	62	0.8	3.1	3.1	3.1	2.3	80.2	0.1	1.4	1.6	33.9	104.6	35.8	134.9	111.7	222.9	202.1	88.1	76.5	66.7	6.0	0	100.8	
1932	10.2	46	0.1	2.4	1.8	2.4	3.5	46.0	0.2	0.6	2.0	34.6	104.6	24.4	124.7	102.5	203.1	182.3	63.4	59.8	62.0	5.0	0	104.5	
1931	10.4	66	0.8	3.1	1.6	1.9	4.6	1.9	1.4	1.4	1.6	38.6	94.7	24.2	128.1	101.9	218.1	152.2	83.0	73.1	67.0	6.1	0	104.2	
1930	10.8	57	0.5	3.1	4.9	3.9	4.3	4.4	1.4	1.4	3.5	38.9	95.0	23.6	132.1	100.6	211.1	183.1	83.7	73.2	66.9	7.6	0	100.6	
Louisiana:																									
1934	10.5	78	0.1	11.2	1.1	12.0	4.7	27.7	3.3	2.2	8.7	71.5	72.8	13.2	83.0	56.3	213.5	193.2	94.5	81.6	70.2	20.6	0	104.9	
1933	10.5	77	0.4	5.3	4.4	5.3	4.8	20.4	3.3	4.4	1.7	64.1	70.3	12.4	64.1	62.2	203.2	185.3	81.4	71.3	70.7	20.6	0	100.8	
1932	10.1	67	0.3	5.0	5.0	4.8	20.4	3.3	3.3	4.4	1.5	77.2	59.0	11.6	70.1	60.4	195.5	180.3	87.2	73.4	68.7	13.2	0	96.5	
1931	11.5	73	0.4	4.8	4.3	7.2	0	15.7	1.3	1.3	3.6	67.0	14.4	83.4	58.0	47.7	217.8	190.3	118.2	106.8	78.7	19.6	0	110.4	
1930	12.4	94	0.1	10.9	6.7	4.5	52.7	1.3	1.3	5.2	94.6	65.6	14.7	96.7	64.9	260.4	212.6	125.4	112.6	88.8	24.0	7.6	0	120.4	
Maryland:																									
1934	13.3	69	0.2	16.1	2.9	9.4	1.2	11.2	4.4	8.1	81.3	124.2	25.5	134.9	108.8	318.1	299.8	144.6	139.2	67.2	67.2	6.9	0	132.9	
1933	12.9	62	0.2	11.1	2.4	11.1	26.5	1.1	1.0	1.0	1.0	87.3	118.3	27.2	132.6	103.0	376.8	136.9	111.4	71.5	61.9	6.9	0	126.2	
1932	13.3	70	0.3	7.8	4.0	20.0	4.3	15.7	2.4	1.9	1.1	116.4	116.4	27.8	145.2	111.9	304.4	276.3	140.2	111.4	71.5	13.2	0	126.2	
1931	13.3	76	0.4	6.4	5.4	2.3	36.4	1.1	1.9	1.9	1.9	102.7	113.4	24.6	153.0	121.7	315.6	248.3	182.2	177.2	67.2	12.3	0	126.2	
1930	13.7	64	0.3	5.6	5.4	3.1	15.7	1.1	1.9	2.2	111.3	110.7	23.7	148.5	110.7	299.3	204.4	168.0	151.2	112.6	67.2	12.3	0	126.2	
Michigan:																									
1934	10.7	57	0.2	5.7	3.7	1.0	16.5	2.1	2.4	2.4	46.0	101.4	28.6	119.3	91.2	278.0	252.7	104.5	92.7	67.4	67.4	5.0	0	64.5	
1933	10.2	52	0.1	4.6	3.7	2.6	28.1	1.1	1.1	1.1	6.8	97.2	268.4	28.4	114.3	86.1	266.4	240.9	71.8	63.8	63.8	4.9	0	61.1	
1932	10.3	57	0.2	5.8	3.0	4.3	26.5	1.1	1.1	1.1	2.0	52.0	92.4	28.4	115.9	88.4	244.0	220.9	61.9	57.6	63.8	4.9	0	61.1	
1931	10.6	62	0.3	3.6	4.3	3.8	28.2	1.1	1.1	1.1	3.4	68.1	91.6	19.8	122.8	90.4	248.3	221.1	97.2	50.4	67.4	3.6	0	63.6	
1930	11.4	66	0.4	1.2	3.8	3.8	7.9	17.2	1.2	1.2	12.4	66.1	89.7	19.0	127.8	90.4	246.8	218.0	114.2	52.3	75.1	3.6	0	63.6	

Mortality from certain causes in the first 6 months of 1934, with comparative data for the corresponding period in preceding years—Continued

State and period	Death rate per 100,000 population (annual basis)																								
	All causes, rate per 1,000 population (annual basis)	Rates per 1,000 live births																							
		Total infant mortality	All except malformations and early infancy	Maternal mortality	Typhoid fever (1, 2)	Measles (7)	Scarlet fever (8)	Whooping cough (9)	Diphtheria (10)	Influenza (11)	Polymyelitis (16)	Lethargic encephalitis (17)	Meningococcal meningitis (18)	Tuberculosis, all forms (23-32)	Cancer, (45-53)	Diabetes (59)	Diseases of the nervous system (78-89)	Cerebral hemorrhage, apoplexy (82a, b)	Diseases of the circulatory system (90-103)	Diseases of the heart (90-95)	Diseases of the respiratory system (104-114)	Pneumonia, all forms (107-109)	Diseases of the digestive system (115-129)	Diphtheria and enteritis under 2 years (119)	Nephritis (130-132)
JANUARY TO JUNE—CON.																									
Pennsylvania:																									
1934	11.9	47.9	5.9	4.8	4.9	4.1	4.1	2.7	2.0	0.2	0.9	0.7	53.0	105.0	30.8	114.7	88.7	322.4	280.8	123.5	108.0	61.2	7.0	100.6	
1933	11.8	57.2	5.4	5.1	4.7	4.1	4.1	2.7	2.0	0.2	0.9	0.7	53.5	103.4	30.8	111.9	88.5	262.8	267.7	123.5	107.7	61.2	7.0	101.3	
1932	11.7	62.0	6.5	1.1	4.0	3.7	4.0	2.7	2.0	0.4	1.2	1.0	57.3	102.6	26.9	118.7	89.0	268.5	268.1	113.7	107.7	62.9	8.2	101.0	
1931	12.4	73.40	6.5	1.6	7.6	3.4	5.1	3.1	2.4	0.3	1.2	0.8	61.8	97.0	27.0	118.5	86.3	268.2	274.8	136.4	122.1	67.5	10.2	100.0	
1930	12.2	62.3	4.3	1.3	3.6	2.7	4.7	3.0	2.7	0.3	1.0	0.8	67.0	96.9	23.0	120.6	89.7	282.9	252.4	136.3	122.3	67.5	12.3	100.2	
Rhode Island:																									
1934	12.0	60.2	6.1	9.0	0.0	4.3	0.0	0.0	10.9	3.0	0.8	0.6	46.0	136.2	33.4	124.3	100.3	354.5	320.2	112.5	100.5	61.7	4.6	120.5	
1933	12.0	60.4	5.0	3.0	0.0	2.0	0.0	0.0	11.6	0.0	0.0	0.0	54.3	135.6	36.5	125.8	102.6	317.4	282.4	103.7	94.8	66.9	4.6	127.0	
1932	12.7	63.9	5.2	0.0	11.8	6.6	7.7	6.9	18.2	0.0	0.0	0.0	58.9	143.9	37.0	131.0	108.3	311.4	286.6	145.8	130.9	66.3	4.6	126.1	
1931	14.3	86.2	0.2	0.6	0.9	2.3	2.9	3.2	26.7	0.0	0.0	0.0	68.9	123.0	33.1	133.5	100.9	269.9	268.8	145.3	134.5	68.3	3.2	120.6	
Tennessee:																									
1934	10.9	77.47	6.6	3.0	30.1	1.5	4.4	3.1	47.6	1.1	1.4	1.4	88.8	62.4	11.6	100.6	80.0	162.2	150.0	130.8	109.2	73.4	14.9	64.1	
1933	10.2	73.47	6.0	4.3	2.3	1.1	4.7	3.1	69.0	1.1	1.8	1.8	86.7	66.7	10.7	86.7	69.3	116.1	199.2	95.0	86.2	72.3	14.4	68.9	
1932	10.6	70.43	7.0	5.2	2.2	2.6	7.5	3.1	63.3	1.7	1.8	1.8	93.8	64.1	10.7	89.8	61.5	113.2	103.5	104.0	95.1	70.7	14.2	68.9	
1931	10.8	73.48	8.3	3.2	7.0	2.4	3.7	3.6	63.6	0.6	0.6	0.6	110.3	64.7	10.4	93.4	61.8	116.9	126.5	116.4	61.7	61.7	9.0	67.4	
1930	11.6	70.48	9.2	4.2	7.7	1.5	4.3	3.4	47.9	0.8	1.0	1.0	122.4	64.6	10.7	104.2	61.5	137.3	121.8	122.1	110.6	80.0	16.6	81.7	
Virginia:																									
1934	12.3	72.0	7.0	2.1	9.9	1.4	7.5	3.9	38.2	0.5	1.6	1.6	81.0	73.3	19.4	127.5	100.2	268.0	239.9	116.1	102.1	54.2	9.4	97.8	
1933	11.5	70.0	6.0	2.5	3.6	1.1	7.7	2.4	33.1	0.2	0.5	1.2	84.0	73.1	15.4	130.5	104.1	217.9	199.8	93.1	82.6	56.0	12.9	92.8	
1932	11.5	70.0	6.0	2.7	3.6	1.2	7.3	2.4	49.8	0.2	0.7	1.0	90.4	67.8	13.7	117.5	94.0	207.0	191.9	96.9	85.3	60.1	11.7	98.7	
1931	12.7	70.0	6.0	2.6	5.6	1.7	3.3	3.1	34.0	0.3	0.7	2.7	94.8	62.8	16.9	134.4	107.7	234.2	216.5	126.4	113.2	57.4	8.9	112.3	
1930	12.3	73.0	7.0	2.0	6.6	1.4	14.0	4.7	41.8	0.8	1.2	3.2	91.3	62.9	16.7	132.1	100.4	217.9	197.2	119.6	104.2	72.3	18.1	112.9	
West Virginia:																									
1934	9.7	69.30	6.3	1.8	3.4	3.8	10.6	4.5	38.1	0.6	0.5	1.8	54.3	64.5	10.6	102.9	82.4	147.1	128.1	110.3	99.1	47.1	7.8	64.5	
1933	9.2	69.0	5.2	3.3	4.1	1.6	8.2	4.0	35.8	1.3	0.2	1.1	60.0	66.7	10.6	103.6	72.6	126.4	116.0	84.1	73.0	41.5	16.7	80.1	
1932	9.6	69.0	5.2	4.1	16.8	2.4	13.7	3.6	32.3	0.7	0.4	1.3	56.0	61.9	13.2	109.1	80.5	122.3	109.7	100.0	88.9	54.6	18.6	63.9	
1931	9.6	69.0	5.2	4.7	7.9	2.4	17.6	3.1	38.7	0.5	0.7	1.0	59.2	69.8	10.7	97.3	70.0	138.9	114.6	122.3	113.0	64.2	12.8	61.4	
1930	10.0	69.0	6.4	5.2	7.1	2.6	16.3	4.1	36.3	0.8	0.3	1.1	71.1	55.3	12.7	90.4	88.6	154.1	130.8	112.5	108.6	63.6	20.1	98.3	

COURT DECISION ON PUBLIC HEALTH

Recovery allowed for personal injuries caused by dust in employment.— (U. S. Circuit Court of Appeals, 8th Circuit; *St. Joseph Lead Co. v. Jones*, 70 F. (2d) 475; decided Apr. 9, 1934.) An action to recover for personal injuries was brought against a company by a former employee. The plaintiff alleged that the company had been negligent in failing to furnish a safe place to work and in failing to observe the Missouri statutory provisions requiring employers to provide protection against industrial or occupational diseases. The plaintiff worked on putting powdered lime, sulphate of iron, and soda ash into tanks of water for the purpose of softening the water for use in the boilers of the company's plant. Dust resulted from this operation, and the court of appeals said that there was substantial evidence to the effect that the dust inhaled was noxious, harmful, and injurious to health and potentially and actually productive of the condition suffered by the plaintiff. The defendant challenged the constitutionality of the statutory provisions concerning protection against industrial diseases, but the appellate court took the view that such provisions were constitutional, saying in part:

In *John Boll v. Condie-Bray Glass & Paint Co.* (321 Mo. 92, 11 S. W. (2d) 48), the corresponding sections of R. S. Mo. 1919 are held to be a reasonable exercise of the police power and constitutional. Without further elaboration, we think this holding is in harmony with the overwhelming weight of authority. * * *

The judgment of the lower court in favor of the plaintiff was affirmed by the court of appeals, a portion of the latter's opinion reading:

* * * However, the claim of Jones that he had not been warned of the danger nor furnished with a respirator stands practically uncontradicted, and is corroborated by the testimony of other witnesses. There was ample evidence from which the jury could have reached the verdict it did, and appellant's requested peremptory instruction to return a verdict for the defendant was properly overruled. It is conceded that neither warnings were given nor notices posted as required by law and by the exercise of due care for the safety of this employee.

DEATHS DURING WEEK ENDED OCT. 20, 1934

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

	Week ended Oct. 20, 1934	Correspond- ing week, 1933
Data from 86 large cities of the United States:		
Total deaths.....	7,839	7,679
Deaths per 1,000 population, annual basis.....	10.9	10.7
Deaths under 1 year of age.....	599	536
Deaths under 1 year of age per 1,000 estimated live births.....	56	46
Deaths per 1,000 population, annual basis, first 42 weeks of year.....	11.3	10.8
Data from industrial insurance companies:		
Policies in force.....	67,015,611	67,550,341
Number of death claims.....	12,803	13,202
Death claims per 1,000 policies in force, annual rate.....	10.0	10.2
Death claims per 1,000 policies, first 42 weeks of year, annual rate.....	9.9	9.8

¹ 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 Oct. 27, 1934, and Oct. 28, 1933

Cases of certain communicable diseases reported by telegraph by State health officers for weeks ended Oct. 27, 1934, and Oct. 28, 1933

Division and State	Diphtheria		Influenza		Measles		Meningococcus meningitis	
	Week ended Oct. 27, 1934	Week ended Oct. 28, 1933	Week ended Oct. 27, 1934	Week ended Oct. 28, 1933	Week ended Oct. 27, 1934	Week ended Oct. 28, 1933	Week ended Oct. 27, 1934	Week ended Oct. 28, 1933
New England States:								
Maine.....	2	2	1	18	4	1	0	0
New Hampshire.....					1	1	0	0
Vermont.....		1			2	2	0	0
Massachusetts.....	17	19			27	68	1	0
Rhode Island.....	3						0	0
Connecticut.....	3		1	3	51	5	0	1
Middle Atlantic States:								
New York.....	46	45	110	115	122	170	3	1
New Jersey.....	10	20	12	9	19	16	0	0
Pennsylvania.....	70	88			256	8	2	4
East North Central States:								
Ohio.....	111	124	45	83	104	14	0	0
Indiana.....	100	66	28	49	65	11	1	0
Illinois.....	118	41	8	13	132	19	3	4
Michigan.....	16	22	2	3	37	11	2	1
Wisconsin.....	8	13	6	34	117	51	2	0
West North Central States:								
Minnesota.....	10	11	1	1	60	11	0	0
Iowa.....	18	25			11	2	2	1
Missouri.....	87	109	17	1	72	3	1	1
North Dakota.....	4	11			33	1	0	0
South Dakota.....		5			4	20	0	0
Nebraska.....	16	6			1	3	0	0
Kansas.....	3	21	2		50	7	0	0
South Atlantic States:								
Delaware.....	4	2	1				0	0
Maryland.....	9	29	16	6	9	3	2	1
District of Columbia.....	8	12		1	2	2	0	0
Virginia.....	164	141			118	6	1	0
West Virginia.....	92	121	18	36	46	6	0	2
North Carolina.....	138	195	8	15	30	75	1	1
South Carolina.....		40		270	2	26	0	0
Georgia.....	71	67				30	0	1
Florida.....	14	9		3	2	2	0	0
East South Central States:								
Kentucky.....	78	140	11	38	4		2	6
Tennessee.....	80	73	18	78	43	73	0	2
Alabama.....	62	95	17	79	26	9	0	1
Mississippi.....	27	36					0	0
West South Central States:								
Arkansas.....	23	52	4	24		18	2	0
Louisiana.....	38	47	3	5	11	1	2	1
Oklahoma.....	19	79	28	38	1	10	3	0
Texas.....	75	275	129	104	39	10	3	6

See footnotes at end of table.

Cases of certain communicable diseases reported by telegraph by State health officers for weeks ended Oct. 27, 1934, and Oct. 28, 1933—Continued

Division and State	Diphtheria		Influenza		Measles		Meningococcus meningitis	
	Week ended Oct. 27, 1934	Week ended Oct. 28, 1933	Week ended Oct. 27, 1934	Week ended Oct. 28, 1933	Week ended Oct. 27, 1934	Week ended Oct. 28, 1933	Week ended Oct. 27, 1934	Week ended Oct. 28, 1933
Mountain States:								
Montana.....	4	2	4	4	47		0	0
Idaho.....	10		3			1	1	0
Wyoming.....					3	1	0	0
Colorado.....	11	11			48	3	2	0
New Mexico.....	3	12	4		19	15	0	0
Arizona.....	1	3	5	3	20		0	0
Utah ¹					5	51	0	1
Pacific States:								
Washington.....	2	6			106	12	0	1
Oregon.....		2	23	25	7	23	0	0
California.....	42	50	19	18	156	193	2	2
Total.....	1,617	2,129	444	976	1912	993	38	26
Division and State	Poliomyelitis		Scarlet fever		Smallpox		Typhoid fever	
	Week ended Oct. 27, 1934	Week ended Oct. 28, 1933	Week ended Oct. 27, 1934	Week ended Oct. 28, 1933	Week ended Oct. 27, 1934	Week ended Oct. 28, 1933	Week ended Oct. 27, 1934	Week ended Oct. 28, 1933
New England States:								
Maine.....	2	4	15	4	0	0	9	9
New Hampshire.....	0	1	9	16	0	0	0	2
Vermont.....	0	2	9	6	0	0	1	1
Massachusetts.....	2	2	122	121	0	0	2	6
Rhode Island.....	0	1	8	7	0	0	1	1
Connecticut.....	0	1	25	39	0	0	2	1
Middle Atlantic States:								
New York.....	7	29	251	244	0	0	26	13
New Jersey.....	0	5	91	84	0	0	5	9
Pennsylvania.....	4	10	338	348	0	0	17	31
East North Central States:								
Ohio.....	6	21	368	397	0	9	36	19
Indiana.....	3	1	121	172	2	2	12	15
Illinois.....	15	5	343	278	6	0	32	12
Michigan.....	5	4	196	217	1	0	16	22
Wisconsin.....	17	1	365	98	7	18	10	2
West North Central States:								
Minnesota.....	1	11	57	38	16	4	1	3
Iowa ²	1	1	50	70	3	0	10	2
Missouri.....	0	1	70	124	0	5	17	5
North Dakota.....	0	4	30	19	0	0	4	2
South Dakota.....	1	1	9	13	0	0	0	3
Nebraska.....	0	3	21	34	3	1	0	4
Kansas.....	4	2	47	119	3	0	4	5
South Atlantic States:								
Delaware.....	0	0	11	5	0	0	4	1
Maryland ²	0	2	106	86	0	0	9	14
District of Columbia.....	0	0	18	9	0	0	3	2
Virginia ⁴	4	2	127	143	2	0	22	28
West Virginia.....	2	5	155	160	0	0	25	32
North Carolina ³	0	1	151	171	1	0	6	15
South Carolina ³	0	0	15	28	0	0	12	13
Georgia ³	1	0	33	33	0	0	7	11
Florida.....	0	0	4	6	0	0	3	1
East South Central States:								
Kentucky.....	3	0	76	144	0	1	19	39
Tennessee.....	1	2	93	161	0	2	26	30
Alabama ²	3	1	32	55	0	0	14	16
Mississippi.....	0	0	27	31	1	0	6	9
West South Central States:								
Arkansas.....	0	0	8	33	1	0	13	11
Louisiana.....	1	0	16	24	1	1	31	27
Oklahoma ²	0	0	12	26	0	1	22	27
Texas ²	7	1	37	94	1	4	35	54

Footnotes at end of table.

Cases of certain communicable diseases reported by telegraph by State health officers for weeks ended Oct. 27, 1934, and Oct. 28, 1933—Continued

Division and State	Pollomyelitis		Scarlet fever		Smallpox		Typhoid fever	
	Week ended Oct. 27, 1934	Week ended Oct. 28, 1933	Week ended Oct. 27, 1934	Week ended Oct. 28, 1933	Week ended Oct. 27, 1934	Week ended Oct. 28, 1933	Week ended Oct. 27, 1934	Week ended Oct. 28, 1933
Mountain States:								
Montana.....	12	0	38	5	0	0	3	2
Idaho.....	3	0	2	4	1	2	2	0
Wyoming.....	0	0	1	5	1	0	0	0
Colorado.....	0	0	99	34	0	5	4	9
New Mexico.....	0	0	15	26	0	1	26	33
Arizona.....	0	0	14	12	0	0	2	3
Utah ¹	0	0	17	1	0	0	2	0
Pacific States:								
Washington.....	25	3	46	37	17	1	7	2
Oregon.....	2	1	75	38	0	3	2	4
California.....	31	5	196	171	0	10	13	13
Total.....	163	133	3,991	3,990	67	70	523	563

¹ New York City only.

² Week ended earlier than Saturday.

³ Typhus fever, week ended Oct. 27, 1934, 36 cases as follows: Maryland, 1; North Carolina, 1; South Carolina, 2; Georgia, 17; Alabama, 7; Texas, 8.

⁴ Rocky Mountain spotted fever week ended Oct. 27, 1934, Virginia, 1 case.

⁵ Exclusive of Oklahoma City and Tulsa.

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- menin- gitis	Diph- theria	Influ- enza	Malaria	Measles	Pel- lagra	Pollo- mye- litis	Scarlet fever	Small- pox	Ty- phoid fever
<i>August 1934</i>										
Missouri.....	4	73	24	310	58	2	4	70	2	296
New Hampshire.....		1				0	0	14	0	1
<i>September 1934</i>										
Alabama.....	2	275	45	1,367	112	21	10	106	0	101
Idaho.....		5	5		4	0	21	13	0	69
Kansas.....	2	40	3	4	33	0	14	125	1	30
Missouri.....	13	187	203	280	96	1	7	174	1	246
Montana.....	1	5	38		65	0	87	29	1	27
Nevada.....			3		1	0	1	6	1	1
New Hampshire.....						0	0	28	0	1
Oklahoma ¹	3	34	110	85	5	6	5	52	0	82
Oregon.....	1	3	93	7	18	0	23	96	0	24
Rhode Island.....	1	5	7		15	0	0	18	0	4
West Virginia.....	6	201	55	1	67	0	22	323	0	163
Wisconsin.....	10	12	41		268	0	42	401	9	29

¹ Exclusive of Oklahoma City and Tulsa.

² Includes 1 case not reported in July.

³ Delayed reports for August.

August 1934		September 1934—Contd.		September 1934—Contd.	
	Cases		Cases		Cases
Missouri:		Lethargic encephalitis:		Septic sore throat—Con.	
Chicken pox.....	6	Alabama.....	3	West Virginia.....	10
Dysentery.....	193	Idaho.....	1	Wisconsin.....	4
Lethargic encephalitis.....	10	Kansas.....	8	Tetanus:	
Mumps.....	18	Missouri.....	14	Alabama.....	6
Rabies in animals.....	8	Wisconsin.....	6	Kansas.....	2
Septic sore throat.....	45	Mumps:		Oklahoma ¹	1
Undulant fever.....	7	Alabama.....	12	Rhode Island.....	1
Whooping cough.....	254	Kansas.....	47	Trachoma:	
		Missouri.....	26	Kansas.....	1
September 1934		Montana.....	10	Montana.....	88
Actinomycosis:		Nevada.....	1	Oklahoma ¹	4
Montana.....	1	Oklahoma ¹	8	Wisconsin.....	1
Chicken pox:		Oregon.....	52	Tularaemia:	
Alabama.....	7	Rhode Island.....	2	Kansas.....	1
Idaho.....	10	West Virginia.....	2	Missouri.....	6
Kansas.....	30	Wisconsin.....	109	Montana.....	1
Missouri.....	35	Ophthalmia neonatorum:		Oregon.....	1
Montana.....	24	Alabama.....	2	Wisconsin.....	3
Nevada.....	4	Montana.....	1	Typhus fever:	
Oregon.....	13	Oklahoma ¹	1	Alabama.....	26
Rhode Island.....	4	Paratyphoid fever:		Alabama.....	8
West Virginia.....	18	Oregon.....	1	Missouri.....	6
Wisconsin.....	218	Rhode Island.....	1	Oregon.....	1
Dengue:		Rabies in animals:		Rhode Island.....	1
Alabama.....	234	Alabama.....	75	Wisconsin.....	4
Dysentery:		Kansas.....	4	Vincent's infection:	
Alabama (amoebic).....	12	Missouri.....	10	Idaho.....	2
Missouri.....	115	Rabies in man:		Kansas.....	1
Montana.....	10	Kansas.....	1	Montana.....	20
Oklahoma ¹	18	Ringworm:		Oklahoma ¹	3
Oregon (amoebic).....	2	Montana.....	3	Oregon.....	14
Oregon (bacillary).....	22	Rocky Mountain spotted fever:		Whooping cough:	
West Virginia.....	1	Alabama.....	1	Alabama.....	115
Favus:		Idaho.....	1	Idaho.....	24
Montana.....	1	Scabies:		Kansas.....	73
German measles:		Montana.....	4	Missouri.....	223
Kansas.....	11	Oregon.....	38	Montana.....	74
Montana.....	5	Septic sore throat:		Nevada.....	8
Wisconsin.....	83	Kansas.....	1	Oklahoma ¹	12
Impetigo contagiosa:		Missouri.....	55	Oregon.....	52
Kansas.....	7	Montana.....	3	Rhode Island.....	98
Montana.....	23	Oklahoma ¹	18	West Virginia.....	181
Oklahoma ¹	3	Oregon.....	1	Wisconsin.....	683
Oregon.....	46				

¹ Exclusive of Oklahoma City and Tulsa.

DENGUE IN SOUTHEASTERN STATES

During the week ended October 27, 1934, 80 cases of dengue were reported in the State of Georgia.

A telegram dated October 26, from Miami, Fla., stated that there were approximately 100 cases of dengue in the city, with very few new cases. The following table shows the number of cases of dengue reported in Florida for the week ended October 27, 1934:

Locality	County	Number of cases	Locality	County	Number of cases
Lake City.....	Columbia.....	1	Pensacola.....	Escambia.....	3
Miami.....	Dade.....	13	Tampa.....	Hillsborough.....	15
Orlando.....	Orange.....	1	West Palm Beach.....	Palm Beach.....	2
Palm Harbor.....	Pinellas.....	1			

WEEKLY REPORTS FROM CITIES

City reports for week ended Oct. 20, 1934

State and city	Diph- theria cases	Influenza		Mea- 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	3	2	0	0	1	6	28
New Hampshire:											
Concord	0		0	1	3	1	0	0	0	0	10
Nashua	1		0	0	0	0	0	0	0	0	
Vermont:											
Barre	0		0	0	0	0	0	0	0	0	2
Burlington	0		0	0	0	0	0	0	0	1	5
Massachusetts:											
Boston	6		0	1	21	18	0	6	4	16	216
Fall River	11		0	7	1	0	0	1	0	4	30
Springfield	0		0	4	1	8	0	0	0	2	32
Worcester	0		0	0	2	28	0	4	0	17	44
Rhode Island:											
Pawtucket	0		0	0	0	0	0	0	0	0	17
Providence	2		0	2	3	4	0	3	0	6	50
Connecticut:											
Bridgeport	0		0	0	2	3	0	0	0	2	24
Hartford	0		0	44	0	2	0	0	0	0	36
New Haven	0		1	0	2	2	0	1	0	0	45
New York:											
Buffalo	0		0	6	19	15	0	11	0	15	126
New York	21	3	4	8	90	52	0	87	17	218	1,459
Rochester	0		0	12	1	8	0	2	0	11	74
Syracuse	0		0	0	2	4	0	1	0	15	54
New Jersey:											
Camden	0	1	0	1	2	2	0	0	3	4	23
Newark	1	2	0	1	6	10	0	5	0	14	99
Trenton	0		0	0	2	10	0	2	0	0	35
Pennsylvania:											
Philadelphia	7		0	4	16	46	0	26	8	162	470
Pittsburgh	8	1	1	8	15	37	0	13	0	4	128
Reading	2		0	0	1	2	0	0	0	16	24
Scranton	0			6		2	0		0	10	
Ohio:											
Cincinnati	14	0	1	0	5	28	0	3	0	5	127
Cleveland	5	20	1	0	4	27	0	13	3	30	193
Columbus	11		0	1	6	26	0	7	1	8	99
Toledo	0		0	2	1	11	0	5	0	5	59
Indiana:											
Fort Wayne	0		0	0	2	4	0	0	0	0	27
Indianapolis	13		0	2	10	21	1	0	0	8	
South Bend	1		0	20		1	0		0	1	
Terre Haute	3		0	0	0	0	0	1	0	0	15
Illinois:											
Chicago	12		3	12	30	144	0	37	3	54	637
Springfield	0		2	0	1	0	0	0	0	0	15
Michigan:											
Detroit	7	2	0	5	12	70	0	14	3	42	191
Flint	1		0	1	1	5	0	1	0	23	19
Grand Rapids	0		0	2	0	15	0	1	0	2	25
Wisconsin:											
Kenosha	0		0	1	0	11	0	0	0	5	8
Milwaukee	0	1	1	5	3	303	0	3	0	56	87
Racine	0		0	0	0	6	0	0	0	2	15
Superior	0		0	1	1	1	0	0	0	0	5
Minnesota:											
Duluth	0		0	13	0	1	0	1	0	3	23
Minneapolis	3		2	35	7	14	0	1	0	15	92
St. Paul	0	1	1	0	7	3	1	1	0	11	50
Iowa:											
Davenport	0			0		4	0		0	0	
Des Moines	0			0		14	0		0	0	30
Sioux City	2			0		2	0		0	3	
Waterloo	2			0		4	0		0	2	
Missouri:											
Kansas City	1		0	0	11	10	0	2	0	1	104
St. Joseph	3		2	0	3	1	0	3	0	0	25
St. Louis	27		0	3	4	16	0	6	0	9	150
North Dakota:											
Fargo	1		0	0	1	1	0	0	0	15	15
Grand Forks	0			0		7	0		0	0	
South Dakota:											
Aberdeen	0			6		2	0		0	3	
Sioux Falls	0			0		0	0		0	0	6

City reports for week ended Oct. 30, 1934—Continued

State and city	Diph- theria cases	Influenza		Mea- 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								
Nebraska:											
Omaha.....	11		0	2	1	9	1	5	0	0	33
Kansas:											
Topeka.....	0		0	0	2	4	0	0	0	1	7
Wichita.....	1		0	0	2	1	0	1	2	0	29
Delaware:											
Wilmington.....	1		0	0	0	0	0	0	0	0	35
Maryland:											
Baltimore.....	0	2	0	1	10	31	0	14	2	21	244
Cumberland.....	0	1	0	0	1	2	0	0	0	0	11
Frederick.....	0		0	0	0	0	0	0	0	0	2
District of Col.:											
Washington.....	7		0	2	10	31	0	7	0	9	156
Virginia:											
Lynchburg.....	18		0	0	1	5	0	0	1	3	7
Norfolk.....	0		0	0	2	8	0	1	0	0	27
Richmond.....	3		0	0	4	4	0	3	0	0	45
Roanoke.....	5		0	1	1	4	0	0	0	0	13
West Virginia:											
Charleston.....	0		0	0	1	7	0	0	0	3	12
Huntington.....	5		0	0		12	0	0	0	0	
Wheeling.....	0		0	0	2	16	0	0	0	6	20
North Carolina:											
Raleigh.....	1		0	0	0	0	0	1	1	2	16
Wilmington.....	0		0	1	0	0	0	0	0	0	8
Winston-Salem.....	7	1	1	0	0	6	0	1	0	4	10
South Carolina:											
Charleston.....	0	7	0	0	5	1	0	0	2	0	24
Columbia.....	0		0	0	4	0	0	0	0	0	25
Greenville.....	0		0	0	0	2	0	0	0	0	3
Georgia:											
Atlanta.....	15	26	3	0	0	12	0	6	1	9	76
Brunswick.....	0		0	0	0	0	0	0	0	0	2
Savannah.....	0	4	0	0	2	0	0	2	1	0	31
Florida:											
Miami.....	1		0	0	2	0	0	2	0	0	27
Tampa.....	2		0	0	1	0	0	1	1	0	20
Kentucky:											
Ashland.....	0		0	0		1	0		2	2	
Lexington.....	2		0	0	1	2	0	1	0	0	22
Louisville.....	26		0	0	8	11	0	3	4	3	70
Tennessee:											
Memphis.....	11		0	0	5	8	0	3	0	11	61
Nashville.....	3		0	0	2	10	0	1	1	5	50
Alabama:											
Birmingham.....	7		1	0	1	7	0	3	0	0	43
Mobile.....	5		0	0	1	0	0	1	0	0	20
Montgomery.....	2		0	0	0	1	0	0	0	1	
Arkansas:											
Little Rock.....	1		1	0	2	2	0	4	0	0	9
Louisiana:											
New Orleans.....	19	2	4	0	5	9	0	13	3	0	130
Shreveport.....	0		0	0	0	2	0	0	0	1	20
Oklahoma:											
Oklahoma City.....	3	6	1	0	4	2	0	1	0	0	40
Texas:											
Dallas.....	2		0	0	2	9	0	1	1	2	55
Fort Worth.....	5		0	0		2	0		3	0	
Galveston.....	1		0	0	2	0	0	0	0	0	16
Houston.....	12		0	0	3	2	0	6	0	0	67
San Antonio.....	0		2	0	0	1	0	5	0	0	52
Montana:											
Billings.....	0		0	2	0	0	0	0	0	0	4
Great Falls.....	0		0	0	0	0	0	0	0	0	7
Helena.....	0		0	0	0	0	0	0	0	0	2
Missoula.....	0		0	0	2	1	0	1	C	0	10
Idaho:											
Boise.....	0		0	0	0	0	0	0	0	0	10
Colorado:											
Denver.....	0	34	0	15	9	57	0	6	0	8	87
Pueblo.....	3		1	1	1	2	0	0	0	0	6
New Mexico:											
Albuquerque.....	0		0	0	1	4	0	4	1	0	12
Utah:											
Salt Lake City.....	0		0	5	1	22	0	1	1	12	43

City reports for week ended Oct. 20, 1934—Continued

State and city	Diphtheria cases	Influenza		Measles cases	Pneumonia deaths	Scarlet fever cases	Smallpox cases	Tuberculosis deaths	Typhoid fever cases	Whooping cough cases	Deaths, all causes
		Cases	Deaths								
Nevada:											
Reno.....	0		0	0	0	0	0	0	0	0	5
Washington:											
Seattle.....	0		0	2	6	2	9	4	2	7	74
Spokane.....	0		0	0	2	3	0	2	0	1	31
Tacoma.....	0			0		1	6		0	1	31
Oregon:											
Portland.....	6		0	0	5	10	0	4	0	1	58
Salem.....	0	4		0		2	0		0	0	
California:											
Los Angeles.....	13	7	0	3	12	39	0	23	0	4	333
Sacramento.....	0		0	0	4	6	0	2	5	0	25
San Francisco.....	2		0	3	8	13	0	4	0	17	150

State and city	Meningococcus meningitis		Polio-myelitis cases	State and city	Meningococcus meningitis		Polio-myelitis cases
	Cases	Deaths			Cases	Deaths	
Massachusetts:				Virginia:			
Boston.....	1	1	1	Roanoke.....	0	0	1
Rhode Island:				North Carolina:			
Providence.....	0	1	0	Raleigh.....	0	0	1
New York:				Kentucky:			
Buffalo.....	0	0	1	Lexington.....	0	0	1
New York.....	1	0	1	Louisville.....	0	1	1
New Jersey:				Tennessee:			
Trenton.....	1	0	0	Memphis.....	0	0	1
Pennsylvania:				Oklahoma:			
Philadelphia.....	1	0	0	Oklahoma City.....	1	0	0
Ohio:				Colorado:			
Cleveland.....	0	0	3	Denver.....	1	1	2
Illinois:				Utah:			
Chicago.....	6	1	2	Salt Lake City.....	0	0	1
Springfield.....	0	0	1	Washington:			
Michigan:				Seattle.....	0	0	4
Detroit.....	2	2	2	Spokane.....	0	0	3
Wisconsin:				Tacoma.....	0	0	3
Milwaukee.....	0	0	2	Oregon:			
Minnesota:				Portland.....	0	0	1
Minneapolis.....	0	1	0	California:			
Iowa:				Los Angeles.....	1	1	6
Des Moines.....	2	0	0	Sacramento.....	0	0	1
Missouri:							
Kansas City.....	1	0	0				
St. Louis.....	1	0	0				

Lethargic encephalitis.—Cases: New York, 1; Newark, 1; Cincinnati, 1; Toledo, 1; Indianapolis, 2.

Dengue.—Cases: Atlanta, 43; Brunswick, 1; Savannah, 48; Miami, 15; Tampa, 76; Montgomery, 1.

Pellagra.—Cases: Worcester, 1; Philadelphia, 1; Winston-Salem, 1; Charleston, S. C., 2; Atlanta, 1; New Orleans, 1.

Typhus fever.—Cases: Wilmington, N. C., 1; Charleston, S. C., 1; Atlanta, 2; Tampa, 2; Birmingham, 1; Montgomery, 1; Dallas, 1.

FOREIGN AND INSULAR

CANADA

Provinces—Communicable diseases—2 weeks ended October 6, 1934.—During the 2 weeks ended October 6, 1934, cases of certain communicable diseases were reported by the Department of Pensions and National Health of Canada, for eight Provinces, as follows:

Disease	Prince Edward Island	Nova Scotia	New Brunswick	Ontario	Manitoba	Saskatchewan	Alberta	British Columbia	Total
Cerebrospinal meningitis								1	1
Chicken pox		3		251	40	84	48	31	457
Diphtheria		2	21	11	8	9	3	2	56
Dysentery								6	6
Erysipelas				1	1	1	1	3	7
Influenza		2		3	9			29	43
Measles		8		36	56	9	7	3	119
Mumps				62	6	5	1	36	110
Paratyphoid fever				2					2
Pneumonia				11		1		5	17
Poliomyelitis		3	1	41		2	1	8	56
Scarlet fever		7	9	141	40	10	12	99	318
Smallpox						1			1
Trachoma								5	5
Tuberculosis	2	3	15	74	39	6	2	47	188
Typhoid fever			4	24	5	5	9	8	55
Undulant fever				2					2
Whooping cough		6	1	145	14	43	2	66	277

NOTE.—No report was received from the Province of Quebec for the above period.

Quebec Province—Communicable diseases—2 weeks ended October 6, 1934.—The Bureau of Health of the Province of Quebec, Canada, reports cases of certain communicable diseases for the 2 weeks ended October 6, 1934, as follows:

Disease	Cases	Disease	Cases
Cerebrospinal meningitis	2	Ophthalmia neonatorum	1
Chicken pox	69	Poliomyelitis	13
Diphtheria	35	Scarlet fever	144
Dysentery	2	Trachoma	1
Erysipelas	7	Tuberculosis	96
German measles	2	Typhoid fever	89
Lethargic encephalitis	1	Whooping cough	382
Measles	114		

CUBA

Provinces—Notifiable diseases—4 weeks ended September 22, 1934.—During the 4 weeks ended September 22, 1934, cases of certain notifiable diseases were reported in the Provinces of Cuba, as follows:

Disease	Pinar del Rio	Habana	Matanzas	Santa Clara	Camaguey	Oriente	Total
Cancer	1			4		2	7
Chicken pox			3	1	2		6
Diphtheria			4	3	3	1	11
Hookworm disease	2			1			3
Leprosy			1	2		7	10
Malaria	764		62	927	542	1,663	3,958
Measles	3	7	1	7			18
Poliomyelitis	3	3	3				9
Scarlet fever	1			1			2
Tetanus, infantile			1				1
Tuberculosis	2	7	22	63	3	57	154
Typhoid fever	10	15	30	68	44	15	182

CZECHOSLOVAKIA

Communicable diseases—August 1934.—During the month of August 1934, certain communicable diseases were reported in Czechoslovakia, as follows:

Disease	Cases	Deaths	Disease	Cases	Deaths
Anthrax	11		Malaria	481	
Cerebrospinal meningitis	3		Paratyphoid fever	34	4
Chicken pox	35		Poliomyelitis	6	
Diphtheria	2,029	151	Puerperal fever	43	17
Dysentery	122	18	Scarlet fever	1,755	28
Influenza	11	2	Trachoma	112	
Lethargic encephalitis	1	1	Typhoid fever	683	41

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 Oct. 26, 1934, pp. 1236-1299. A similar cumulative table will appear in the PUBLIC HEALTH REPORTS to be issued Nov. 30, 1934, and thereafter, at least for the time being, in the issue published on the last Friday of each month.)

Plague

Hawaii Territory—Hawaii Island—Hamakua district—Paauhau.—On October 20, 1934, 1 plague-infected rat was reported in Paauhau, Hamakua district, Island of Hawaii, Hawaii Territory.

Typhus fever

Chile.—According to a report dated October 10, 1934, there were 8,200 cases of typhus fever in Chile during the first week of October, and nearly 2,000 deaths had occurred since January 1, 1934. Santiago continues to be the focal point of typhus fever, 622 cases being registered in local hospitals on October 10. The increase in the number of cases and deaths over the corresponding period of 1933 is attributed to the large crowds which were permitted to gather during the 5-day national holiday in September.

Cuba—Correction.—The report of 2 cases of typhus fever in Oriente Province, Cuba, for the week ended July 14, 1934, published in the PUBLIC HEALTH REPORTS of October 19, 1934, page 1259, and October 26, 1934, page 1296, is an error. No case of typhus fever occurred in Cuba.