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AN ORGANIZATION FOR PROMOTING MENTAL HOSPITAL SERVICES IN THE UNITED STATES AND CANADA

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INTRODUCTION

Perhaps every age has felt that great historic change impends in the life and enterprise of the time. Some national emergencies of the past, which for the time being seem to blacken the skies and threaten a permanent eclipse of national genius, have been no more than the gray hours before a social sunrise. The emergencies through which the world has been passing in recent years may have the ultimate effect of illuminating American social life and American civilization.

In the past we have taken great pride in our achievements as a people, but with these achievements have gone many secret things which we have too long delayed to scrutinize with candid, fearless eyes. Readjustments have been necessary from time to time in any civilization, for evils creep in with the good, the debased and decadent affect the sound and vital, and spots of corrosion appear here and there that demand attention and removal.

Aside from the countries of the North American continent, there is perhaps no other place in the world where men and women generally and individually have exhibited in more striking form that sympathy and helpfulness for rectifying wrong, alleviating suffering, and setting the weak in the way of strength and hope. Despite this altruistic and democratic attitude of our people, it is not generally appreciated that mental illness constitutes one of the large and important medical, social, economic, and health problems of our civilization. Its solution rests in part upon a more equal distribution of measures and facilities that will provide adequate and early treatment and care for adverse mental situations.

A greater knowledge of the nature and causes of mental ill health is the foundation upon which the whole superstructure for the prevention of mental illness and the conservation of mental health must be built. It is hardly necessary, therefore, to justify the responsibility for mental health or mental hygiene in its broader aspects as being a special or particular challenge to the medical profession.

NEED FOR MEDICAL LEADERSHIP

The recognition, treatment, and care of mental illness require a knowledge of these diseases. Moreover, the present status of medical knowledge in this field makes possible an interpretation of the needs and requirements of these unfortunate people. That knowledge, however, does not always enter into the formulation and administration of public policies toward the mentally ill wards of communities or political jurisdictions. In those jurisdictions where the public policies for treating or ameliorating adverse mental situations are planned, directed, and administered by medically trained persons the facilities and measures for meeting the needs of this form of illness stand far ahead of those where domiciliary facilities alone represent the assumed total of a community's obligation and responsibility.

Future responsibilities in this field do not involve clinging to tradition and custom or to cultivating change merely for change's sake. Tradition and change are not alternatives but are two indispensable elements of any civilization and must be kept in their proper relationship. It is obvious that there has always been a lag between the swiftly changing circumstances of life and the slowly changing outlook of a people. It is right that there should be some lag for it is unsafe to chase down the street after every Pied Piper who has snared a new notion from the cloudland of theory. Most ideas surviving the stresses and storms of centuries are right—that is, the ideas that have survived with living vitality, not those that have merely stayed on as cadavers to poison the intellectual atmosphere.

Changing situations in the scope of modern medical knowledge make it possible for the medical profession of today to assume leadership in shaping and directing public policies that seek a more uniform distribution of adequate facilities for the early recognition and treatment or amelioration of mental illness. Concerted medical leadership is required for the solution of this problem, a leadership and mutual participation of all those national and local medical agencies whose interests and responsibilities are directly concerned with any or all of the many diversified phases of the problem.

PARTICIPATING AGENCIES

In an effort to coordinate the various national medical interests concerned, a committee has been organized, the membership [1] consisting of representatives of the American Psychiatric Association, the

[1] The members of the committee are as follows: Walter L. Treadway, M. D., chairman, Washington, D. C.; S. Spafford Ackerly, M. D., Louisville, Ky.; L. Casamajor, M. D., New York City; Ross McC. Chapman, M. D., Towson, Md.; Franklin G. Ebaugh, M. D., Denver, Colo., C. M. Hincks, M. D., Toronto, Ontario, Canada; J. Allen Jackson, M. D., Danville, Pa.; Bernard T. McGhie, M. D., Toronto, Ontario, Canada; Arthur P. Noyes, M. D., Howard, R. I.; Winfred Overholser, M. D., Boston, Mass.; Frederick W. Parsons, M. D., Albany, N. Y.; Arthur H. Ruggles, M. D., Providence, R. I.; William L. Russell, M. D., White Plains, N. Y.; H. Douglas Singer, M. D., Chicago, Ill.

American Neurological Association, the American Medical Association, the American Board of Psychiatry and Neurology, the National Committee for Mental Hygiene, the United States Public Health Service, the Canadian National Committee for Mental Hygiene, and the Canadian Medical Association. This committee met in New York City on June 29, 1936, to discuss plans and policies for a survey of mental hospital services in the United States. Its ultimate purpose is to bring about a more equal and uniform distribution of adequate measures and facilities for the early recognition and treatment or amelioration of adverse mental conditions and to insure a wider distribution of adequate teaching facilities in psychiatry and neurology. Dr. Samuel W. Hamilton was elected medical director of the committee, with Dr. Grover A. Kempf of the Public Health Service as associate medical director, the latter having been assigned by the Surgeon General to cooperate in the studies.

OBJECTIVES

The evolution of public facilities and measures for meeting the needs of the mentally ill in the United States has been characterized by piecemeal growth and development, which have taken place to a considerable extent without due regard to basic medical facts or medical guidance. In consequence, some community needs have been fulfilled while others have been neglected. Institutional facilities alone, while important, are insufficient to meet the needs of the mentally ill. Changing conditions in our social order have imposed broader obligations upon communities which involve more expert medical service and more satisfactory measures and facilities for fulfilling the needs of the mentally sick.

It has long been apparent that no legislature, in terms of appropriations, has kept pace with the needs of the mentally ill. In some jurisdictions, responsibilities for the care of these persons have been assumed to a greater degree than in others. In jurisdictions where these responsibilities have been recognized, there are often varying standards when two or more similar services are compared. The differences are due to a wide variety of factors, not the least of which is the personal equation of local professional leadership.

RESPONSIBILITIES OF THE MEDICAL PROFESSION

The personal equation, however, is only one consideration, for it is known that many public mental hospitals are restricted in their ability to render adequate services because of the limited funds available. Public appropriations tend to reflect the communities' conception and understanding of the needs. An enlightened understanding of the functions of a public mental hospital would certainly

contribute eventually to more nearly adequate financial support. This can be accomplished best through concerted medical leadership. The creation of such an understanding is not only of concern to the committee and the specialized professional groups who are devoting their lives to the problems of mental illness, but it concerns the entire medical profession.

INTERESTS OF THE PARTICIPATING AGENCIES

American Psychiatric Association.—The membership of the organization now known as the American Psychiatric Association has always stood for progress in the solution of the problems of mental illness and has made tremendous contributions to this field. The annual addresses of the various presidents of the American Psychiatric Association have for almost a century touched upon the care of patients in public mental hospitals and the functions which these institutions should perform. No small part of the annual programs of this association has been devoted to these subjects.

The interest of the association was furthered in this direction by the publication "The Institutional Care of the Insane in the United States and Canada," by the late Dr. Henry M. Hurd, Dr. William F. Drury, Dr. Richard Dewey, and others. The membership of the association contributed toward the publication of this work, which was issued in four volumes by the Johns Hopkins Press in 1916.

At the 1924 meeting of the association, resolutions were adopted directing the committee on standards and policies to report the following year a schedule of the minimum standards which it was thought hospitals for mental diseases might be "reasonably expected to establish and maintain." The 19 points recommended by that committee under the able leadership of Dr. William L. Russell are familiar to the members of the association. At an annual meeting held in Washington, D. C., in 1935, a resolution was proposed by Dr. C. Charles Burlingame that the council of that association authorize its executive committee to proceed with the classification and grading of the public mental hospitals of the United States and Canada.

American Neurological Association.—Other agencies besides the American Psychiatric Association have been interested in this problem. The membership of the American Neurological Association has always stood for improved standards for the recognition, care, and treatment of neurological diseases. The neurological clinical material found in wards of public mental hospitals offers opportunity for study and investigation and should serve for training young men who are to engage in the specialties of psychiatry and neurology. There is a dearth of facilities in the United States for training in organic neurology.

It is apparent from a practical point of view that men who are to engage in the field of psychiatry must necessarily have some under-

standing of neurological diseases and that those who are to engage in the practice of neurology should have some knowledge of mental diseases. It is hoped by many that young men entering the fields of psychiatry and neurology may be trained in both specialties so that this somewhat artificial division may be dissolved. For this accomplishment more centers will have to be established for the training of organic neurologists.

The diversified clinical material in practically every public mental hospital of the country makes it desirable to develop such institutions with the objective of affording some training in organic neurology. In this way every State would have some facilities for teaching undergraduates and graduates in these two allied fields instead of the widely scattered centers which exist at the present time.

American Board of Psychiatry and Neurology.—Not only has the American Neurological Association been interested in these matters, but the newly created American Board of Psychiatry and Neurology was confronted with the necessity of being cognizant of the facilities available in connection with public mental hospitals for instruction in the two specialties involved.

National Committee for Mental Hygiene.—The National Committee for Mental Hygiene for almost three decades has been interested in bringing about improved standards in the public care of mental diseases. It had its beginning with this objective in mind. The recent development of the Division of Mental Hospital Services in the national committee makes possible the utilization of that machinery in connection with the proposed activities of the committee.

American Medical Association.—The American Medical Association has long been concerned with the adequacy of facilities for hospital interneships and residencies not only in the field of general medical education but in the specialist's field as well. In the past three decades its Council on Medical Education has revolutionized medical education in this country. Dr. William D. Cutter, executive officer of the council, officially attended the meeting of the committee on June 29, 1936, taking part in the discussion and explaining the aims and objectives of the council. His willingness to cooperate with the committee and the opportunity mutually to exchange viewpoints in this particular field, articulated as it must be with the broader aspects of medical education, was gratifying and helpful to the several members of the committee.

The American Medical Association, while not directly concerned with the administration of mental hospitals or in methods of diagnosis and treatment of mental cases, such features belonging in the field of the specialist, is, nevertheless, interested in the general problems of hospital administration and the general functions of hospitals. Through its Council on Medical Education and Hospitals it has long

been interested and concerned with medical education in its broader aspects, including both graduate and undergraduate instruction in psychiatry and neurology. In this connection, it is logical to assume that the American Medical Association is aware of the need that the medical profession as a whole should be informed of facts which heretofore were restricted mainly to the specialist.

The medical profession.—An analogy has been drawn between the present situation affecting psychiatry today and aseptic surgery of 30 or more years ago. Thus, aseptic surgery solved the problem of removing an offending appendix. Until the general medical practitioner learned to make the diagnosis before it was too late, the general public did not reap the benefits of this improved technique. Similarly, the general practitioner of today must be alert to recognize the earliest symptoms and contributing factors in mental disease, if the fruits of progress in psychiatry are to be made generally available. He must also know what constitutes adequate care of the mentally ill of the community. The medical profession generally, and specialists, in particular, cannot stand aloof from these obligations, for the standards and policies toward the mentally ill of a community or political jurisdiction reflect favorably or adversely upon professional standards generally. The entire medical profession, including public health agencies, must join hands in an endeavor to solve the problems of mental illness.

Public health agencies.—During the past half century public health measures have been applied intensively to the prevention of deaths from communicable diseases and to the lessening of mortality in infancy. With progress in the prevention of needless deaths, attention of public health workers is being awakened to the basic fact that the health of communities depends not only on the survival of the individual but also on the amount and character of sickness in a population. It is a fact that diseases most frequently resulting in death are not necessarily those causing the most illness and incapacity, and that death rates alone cannot be regarded as an accurate index of the health and vitality of the people. In the development of a modern health program it is not deaths and longevity alone that should serve as health criteria, but the incidence and records of sickness and disability must also be taken into account.

The significance of the need for broadening the scope and outlook of public health measures will be better appreciated when it is realized that the future and security of a nation depend a great deal on the health of its citizens. This cannot be left wholly to individual endeavor, since measures and policies must be adopted eventually for more closely integrating individual medical services with those concerned with the prevention of disease and ill health. The time has arrived when national and local health agencies must take cognizance of the need for greater uniformity and more equal distribution

of facilities and measures for the treatment or amelioration of mental ill health.

FINANCIAL SUPPORT

The ferment which leavened the revolution in medical education is responsible in part for financing the work of the Mental Hospital Survey Committee. The Rockefeller Foundation has made a grant in aid to the National Committee for Mental Hygiene in the amount of $16,000 annually in connection with the committee's activities. Dr. Alan Gregg, of the Foundation, attended the committee meeting and took part in the discussion. As always, his comments were constructive and helpful. The American Psychiatric Association has contributed an appropriation of $5,000 for this purpose, to be administered through the executive committee of the council of that organization. The Public Health Service is contributing in terms of personal services, traveling expenses, and other miscellaneous costs, which amounted to $13,027 for the fiscal year ending June 30, 1936.

ORGANIZATION AND AIMS

At a meeting held in New York City on June 29, 1936, the committee, after discussing the scope of its activities, decided that, for the time being at least, it would be necessary, largely because of financial reasons and the dearth of personnel, to confine the survey to public mental hospitals caring for the insane, the feeble-minded, and the epileptic, including privately endowed institutions of this character.

It was also the consensus of opinion of the committee that an approach to the survey of public mental hospitals should be through evaluating the adequacy of professional, subprofessional, and technical personnel engaged in the care and treatment of mental illness; a determination of the present status of the administrative organizations existing in various political jurisdictions, and the functions which such organizations actually perform; a determination of the availability and suitability of records necessary for evaluating and comparing the omissions and commissions of a given public policy; providing a comparative analysis of the economic problems involved in connection with making provisions for the care of the mentally ill; the evaluation of the adequacy or suitability of institutional structures and equipment; a study of the measures and facilities for the conduct of research; and consideration of the adequacy of facilities and policies concerning graduate and under-graduate instruction in neurology and psychiatry. It is apparent that the scope of these interests is so broad that any surveys undertaken must necessarily be made in piecemeal fashion, selecting certain phases for priority in approach. It is also obvious that a survey of such scope cannot be accomplished in a short time.

ADMINISTRATION

The committee also gave consideration to its internal organization necessary for effectively and economically fulfilling its purpose. The chairman was authorized to appoint an executive committee, having in mind the need for representation from each of the participating agencies and also the economic problems involved in connection with travel. The executive committee was subsequently appointed, consisting of Dr. Walter L. Treadway, chairman ex-officio, of Washington, D. C.; Dr. Winfred Overholser, of Boston, Mass.; Dr. Louis Casamajor, of New York City; and Dr. J. Allen Jackson, of Danville, Pa. The question of appointing subcommittees for special purposes was briefly discussed.

The medical director, Dr. Samuel W. Hamilton, and the associate medical director, Dr. Grover A. Kempf, have, since September 1, 1936, been conducting some brief experimental surveys for the purpose of determining a feasible and practicable method of approach.

The executive committee met in New York on the afternoon of September 27, 1936, for the purpose of considering certain administrative problems confronting the survey committee.

It was agreed that, for the present, the committee's interest should be concentrated on an orientation of the problem, first, by an analysis of the adequacy of the professional personnel engaged in the care and treatment of mental diseases; second, by an analysis for determining the present status of the administrative organizations existing in the several political jurisdictions and the functions which such organizations actually perform; and third, by an evaluation of the adequacy of institutional facilities and personnel for the intensive treatment of newly admitted persons to mental hospitals, with special reference to services rendered during the first year of residence.

It is anticipated that the survey of the personnel situation and the functions of the administrative organizations will be undertaken immediately and that studies of the measures for meeting the needs of early cases, which are much broader in scope, will be carried on synchronously with the above. Further consideration was given to the possibility of the appointment of a subcommittee to deal with questions of medical education in psychiatry and neurology, with special reference to the matter of approving institutions for interneships and residence, the subcommittee to cooperate with the Council on Medical Education and Hospitals of the American Medical Association. The chairman was instructed to appoint such a committee.

The executive committee was approached as to the feasibility or desirability of extending an invitation to the Canadian National Committee for Mental Hygiene and the Canadian Medical Association to become members of the participating agencies of the hospital survey.

The executive committee approved such a proposal with the understanding that any expenses involved in connection with special studies in the Dominion of Canada would be defrayed by the Canadian National Committee for Mental Hygiene.

The executive committee is of the opinion that it should lend moral support to improving the standards of care of mental diseases in the Dominion of Canada if such could be done without depleting the financial resources already available to the committee. As a result of these deliberations, the Canadian National Committee for Mental Hygiene and the Canadian Medical Association were invited to become participating bodies on the committee and were requested to appoint one or more representatives to serve on the committee.

A NEW PROBLEM IN SANITATION

The increasing popularity of the auto trailer, with the accompanying increase in the number of highway nomads, is causing many public health officials just concern. Quite aside from the medico-social problems created by the presence of increasing numbers of all-year automobile tourists, there have arisen a number of specific problems. Foremost among these may be mentioned the matter of safe milk and water and the sanitary disposal of human waste. Fortunately safe water is available along the highways in some States; and safe supplies are so well marked, supervised, and located that there is seldom an excuse for using a questionable supply.

With regard to safe milk the situation is not quite as favorable, though by no means generally dangerous. The wise trailer tourist will, of course, purchase pasteurized milk in a city or town through which he passes, keeping it cool, until it is consumed, in the small ice chest which is a feature of many of the new trailers. When pasteurized milk is not obtainable, he should protect himself by applying the knowledge that heating milk to a temperature of 142°–145° F. for 30 minutes will insure a margin of safety.

However, the chief source of concern is the unsafe or uncertain disposal of human excreta by trailer travelers, which may become a nuisance or a health menace.

As trailer accommodations have improved, provisions have been made for small toilet compartments in which excreta is deposited in cans containing chemical solutions reported to render the waste innocuous. This provision is, of course, highly commendable and constitutes a marked sanitary advance over earlier days when human waste was deposited rather promiscuously by the roadsides.

But a new complication now arises from the use of the can privies on trailers, for no extensive or satisfactory provisions have been made for the disposal of the wastes and the cleansing of the cans. Usually

it is not practicable to dispose of the wastes in tourist-camp privies, in the toilets of gasoline filling stations, or in the public comfort stations available in cities. To throw the excreta on the ground in the open country with the potential danger of contaminating a water supply or creating a nuisance is reprehensible.

It is felt that serious consideration must now be given to providing roadside facilities for the sanitary disposal of human waste from auto trailers. Possibly State or county departments of health could construct disposal systems near roads frequented by auto trailers. Here could be located a combined comfort station and place for the disposal of excreta. The location of such places could be made known by appropriate road signs. Not only would such facilities be greatly appreciated by the occupants of trailers but the opportunities for the creation of nuisances would be materially lessened and potential menaces to the public health would be definitely removed.

The matter is believed to be of sufficient importance to warrant the earnest attention of health officials, automobile associations, and trailer passengers themselves.

USE OF THE VISCEROTOME TO OBTAIN MATERIAL FOR DIAGNOSIS OF PLAGUE

For the benefit of those who have not used this comparatively new device, it may be said that the viscerotome is an instrument designed by Dr. E. R. Rickard, of the Rockefeller Foundation, while working in Pernambuco, Brazil, for the purpose of obtaining small pieces of liver for microscopic section and study in the case of persons dying of a disease suspected to be yellow fever.

The instrument consists of a holder or shield and a flexible cutting and grasping blade. Through a very small aperture in the skin the point of the instrument is inserted into the liver and by a very simple manipulation a small portion of the organ is snipped out and removed. Portions of the spleen or glands may be removed in the same way.

Recently, Dr. Henry Hanson, a representative of the Pan American Sanitary Bureau, working in the Republic of Ecuador, reported that the health authorities of that country are employing this instrument successfully in obtaining material for diagnosis in deaths from suspected bubonic plague.

An illustration of the viscerotome appeared in the *Pan American Sanitary Bulletin* (*Boletín de la Oficina Sanitaria Panamericana*), for April 1934, page 375.

COURT DECISION ON PUBLIC HEALTH

City held liable for improper sewage disposal.—(Oklahoma Supreme Court; *Oklahoma City* v. *Eylar*. 61 P. (2d) 649; decided October 13, 1936.) The plaintiff was the owner of some land adjacent to the river into which the defendant city emptied its sewage. On account of negligent operation of the sewer system, or by improper treatment of the sewage, there were created foul and noxious odors which diminished the right of the plaintiff and his family to enjoy the premises as their home. This was an action instituted by the plaintiff to recover damages. A judgment for $1,000 was rendered in favor of the plaintiff, and from that judgment the defendant appealed.

In sustaining the judgment in favor of the plaintiff the supreme court made two points of interest, which, as contained in the syllabus by the court, are as follows:

The manner of maintenance by a city of a sewer may constitute a nuisance, and, where it does so, immunity from damages does not ensue under the theory that the city is engaged in a governmental function.

The personal inconvenience, annoyance, and discomfort to the occupant of real estate caused by the maintenance by another of a temporary nuisance in the immediate vicinity of said real estate is a separate and distinct element of damage from that of the depreciation of the usable or rental value of the real estate occupied; the measure of such damages being reasonable compensation for the injury.

For similar cases see *Oklahoma City* v. *Myers* (1936) 61 P. (2d) 653; *Town of Sentinel* v. *Boggs* (1936) 61 P. (2d) 654; *Oklahoma City* v. *Dyer* (1936) 61 P. (2d) 660. In the last mentioned case the court stated the measure of damages in such cases to be "the depreciation of the rental value of the property caused by the nuisance."

DEATHS DURING WEEK ENDED DECEMBER 5, 1936

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

	Week ended Dec. 5, 1936	Corresponding week 1935
Data from 86 large cities of the United States:		
Total deaths	8,742	8,731
Deaths per 1,000 population, annual basis	12.2	12.2
Deaths under 1 year of age	527	525
Deaths under 1 year of age per 1,000 estimated live births	48	48
Deaths per 1,000 population, annual basis, 49 weeks of year	12.0	11.3
Data from industrial insurance companies:		
Policies in force	68,816,785	67,820,109
Number of death claims	11,873	12,549
Death claims per 1,000 policies in force, annual rate	9.0	9.6
Death claims per 1,000 policies, 49 weeks of year, annual rate	9.7	9.5

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 December 12, 1936, and December 14, 1935

Cases of certain communicable diseases reported by telegraph by State health officers for weeks ended Dec. 12, 1936, and Dec. 14, 1935

Division and State	Diphtheria		Influenza		Measles		Meningococcus meningitis	
	Week ended Dec. 12, 1936	Week ended Dec. 14, 1935	Week ended Dec. 12, 1936	Week ended Dec. 14, 1935	Week ended Dec. 12, 1936	Week ended Dec. 14, 1935	Week ended Dec. 12, 1936	Week ended Dec. 14, 1935
New England States:								
Maine	1	2		2	37	179	1	1
New Hampshire		1			15	1	0	0
Vermont		1				118	0	0
Massachusetts	3	15			316	125	5	2
Rhode Island		1			12	79	0	0
Connecticut	2	5	2	5	93	134	0	0
Middle Atlantic States:								
New York	37	54	[1] 14	[1] 19	203	662	9	5
New Jersey	22	24	30	13	86	21	3	1
Pennsylvania	35	46			49	198	7	5
East North Central States:								
Ohio	24	67	25	78	20	129	11	5
Indiana	33	43	34	35	11	12	3	4
Illinois	33	76	45	35	15	29	2	10
Michigan	14	30		5	34	42	1	3
Wisconsin	6	2	25	79	17	68	1	1
West North Central States:								
Minnesota	6	5			41	47	0	0
Iowa	3	18	2	1	3	12	2	2
Missouri	15	51	55	95	1	5	1	4
North Dakota	2	5		10	1	2	0	0
South Dakota		4				5	0	0
Nebraska	2	9			1	17	0	2
Kansas	12	24	3		6	6	5	2
South Atlantic States:								
Delaware					21	50	1	0
Maryland [2]	15	15	10	9	111	43	5	4
District of Columbia	5	33			1	3	1	3
Virginia	33	44			32	15	2	2
West Virginia	25	37	77	52	16	13	11	2
North Carolina [3]	76	51	6	9	18	15	5	0
South Carolina [4]	14	9	410	235	30	6	1	2
Georgia [4]	36	20		113			4	0
Florida	7	9	6	4	6		1	0
East South Central States:								
Kentucky	29	36	29	24	10	14	8	3
Tennessee	23	31	93	72	4	1	2	3
Alabama [4]	36	26	189	88	2	10	1	3
Mississippi [2] [4]	17	13					2	1
West South Central States:								
Arkansas	6	6	47	43	2	3	1	5
Louisiana	14	19	9	25	2	13	1	2
Oklahoma [5]	5	17	51	48	4	3	2	35
Texas [4]	78	111	556	202	61	16	1	11

See footnotes at end of table.

Cases of certain communicable diseases reported by telegraph by State health officers for weeks ended Dec. 12, 1936, and Dec. 14, 1935—Continued

Division and State	Diphtheria		Influenza		Measles		Meningococcus meningitis	
	Week ended Dec. 12, 1936	Week ended Dec. 14, 1935	Week ended Dec. 12, 1936	Week ended Dec. 14, 1935	Week ended Dec. 12, 1936	Week ended Dec. 14, 1935	Week ended Dec. 12, 1936	Week ended Dec. 14, 1935
Mountain States:								
Montana	2	1	18	17		15	0	0
Idaho	1		11	2	133	23	1	0
Wyoming						4	0	0
Colorado	8	8			6	11	0	1
New Mexico	1	6	3		54	3	1	0
Arizona	7	3	46	56	70	3	0	0
Utah [2]					4	4	0	1
Pacific States:								
Washington	8		4	3	17	259	0	1
Oregon	1		44	17	8	408	2	2
California [3]	52	43	127	29	13	253	2	7
Total	749	1,021	1,971	1,425	1,586	3,079	106	135
50 weeks of year	27,490	36,393	153,510	115,554	281,071	716,637	7,203	5,378

Division and State	Poliomyelitis		Scarlet fever		Smallpox		Typhoid fever	
	Week ended Dec. 12, 1936	Week ended Dec. 14, 1935	Week ended Dec. 12, 1936	Week ended Dec. 14, 1935	Week ended Dec. 12, 1936	Week ended Dec. 14, 1935	Week ended Dec. 12, 1936	Week ended Dec. 14, 1935
New England States:								
Maine	1	3	29	29	0	0	1	0
New Hampshire	0	0	11	16	0	0	1	1
Vermont	0	0	2	16	0	0	0	1
Massachusetts	0	6	158	217	0	0	2	3
Rhode Island	0	0	11	22	0	0	1	0
Connecticut	0	1	44	59	0	0	2	2
Middle Atlantic States:								
New York	0	8	453	623	8	1	9	19
New Jersey	0	3	84	163	0	0	2	2
Pennsylvania	1	4	364	555	0	0	27	27
East North Central States:								
Ohio	7	1	320	485	1	1	3	4
Indiana	0	1	152	190	3	1	3	7
Illinois	4	4	381	622	0	8	1	6
Michigan	2	6	370	320	2	0	11	10
Wisconsin	0	1	247	424	17	4	0	0
West North Central States:								
Minnesota	1	0	144	376	8	1	0	1
Iowa	1	1	94	180	11	1	1	1
Missouri	2	1	145	140	1	0	2	1
North Dakota	0	0	88	62	5	4	0	0
South Dakota	0	0	44	66	15	15	0	2
Nebraska	0	0	63	256	1	45	1	0
Kansas	5	0	214	186	13	2	9	5
South Atlantic States:								
Delaware	0	0	16	11	0	0	3	1
Maryland [2]	1	0	62	76	0	0	5	7
District of Columbia	0	0	10	19	0	0	1	6
Virginia	0	0	55	75	0	0	14	5
West Virginia	0	0	55	74	0	1	4	5
North Carolina [3]	0	4	65	68	0	0	9	6
South Carolina [4]	0	1	8	3	0	0	3	1
Georgia [4]	4	0	55	33	0	0	6	9
Florida	0	0	5	11	0	0	3	4
East South Central States:								
Kentucky	1	2	68	71	0	0	9	19
Tennessee	3	1	54	72	0	1	14	6
Alabama [4]	1	0	27	14	0	0	3	2
Mississippi [2] [4]	2	0	11	17	0	0	1	7
West South Central States:								
Arkansas	4	0	5	12	0	0	5	5
Louisiana	1	0	8	23	0	1	4	13
Oklahoma [5]	3	0	23	25	0	1	7	9
Texas [4]	4	0	130	134	0	0	14	14

See footnotes at end of table.

Cases of certain communicable diseases reported by telegraph by State health officers for weeks ended Dec. 12, 1936, and Dec. 14, 1935—Continued

Division and State	Poliomyelitis		Scarlet fever		Smallpox		Typhoid fever	
	Week ended Dec. 12, 1936	Week ended Dec. 14, 1935	Week ended Dec. 12, 1936	Week ended Dec. 14, 1935	Week ended Dec. 12, 1936	Week ended Dec. 14, 1935	Week ended Dec. 12, 1936	Week ended Dec. 14, 1935
Mountain States:								
Montana	0	0	68	143	18	22	3	0
Idaho	0	0	52	60	2	1	2	0
Wyoming	0	0	8	98	5	2	2	0
Colorado	2	1	66	94	4	0	0	1
New Mexico	3	1	15	28	0	1	13	5
Arizona	1	1	13	25	0	0	4	0
Utah [2]	0	0	18	108	0	0	0	0
Pacific States:								
Washington	0	3	57	69	9	23	1	1
Oregon	0	5	34	59	52	1	2	3
California [3]	13	7	252	337	0	3	8	16
Total	67	66	4,658	6,766	175	140	216	237
50 weeks of year	4,427	10,640	225,440	240,108	7,116	7,134	14,353	17,201

[1] New York City only.
[2] Week ended earlier than Saturday.
[3] Rocky Mountain spotted fever, week ended Dec. 12, 1936, 2 cases, as follows: North Carolina, 1; California, 1.
[4] Typhus fever, week ended Dec. 12, 1936, 40 cases, as follows: South Carolina, 1; Georgia, 15; Alabama, 10; Mississippi, 1; Texas, 13.
[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	Meningococcus meningitis	Diphtheria	Influenza	Malaria	Measles	Pellagra	Poliomyelitis	Scarlet fever	Smallpox	Typhoid fever
October 1936										
Hawaii Territory	1	9	423	-------	67	-------	0	1	0	1
November 1936										
California	19	247	171	7	114	7	38	964	9	48
Colorado	11	32	1	-------	16	-------	15	139	9	2
Georgia	5	207	290	1,221	20	16	25	154	0	39
Maine	1	13	10	-------	52	-------	2	61	0	4
New Jersey	4	53	57	1	167	-------	3	241	0	12
New Mexico	1	18	6	-------	64	-------	2	89	1	26
North Carolina	12	510	35	-------	102	27	2	374	0	35
South Carolina	-------	327	381	122	24	5	1	6	0	5
West Virginia	13	103	123	-------	38	-------	3	253	0	36

October 1936

Hawaii Territory:	Cases
Chicken pox	16
Conjunctivitis, epidemic	1
Dysentery (amoebic)	1
Hookworm disease	14
Impetigo contagiosa	22
Jaundice, acute infectious	16
Leprosy	7
Mumps	64
Tetanus	1
Trachoma	61
Typhus fever	11
Whooping cough	15

November 1936

Actinomycosis:	
California	2
Georgia	1
Anthrax:	
Georgia	4
Chicken pox:	
California	1,308
Colorado	173
Georgia	32
Maine	210
New Jersey	844
New Mexico	64
North Carolina	182
South Carolina	10
West Virginia	128
Conjunctivitis:	
Georgia	14
New Mexico	1
Dengue:	
Georgia	14
Diarrhea:	
South Carolina	46
Dysentery:	
California (amoebic)	9
California (bacillary)	23
Georgia (amoebic)	9
Georgia (bacillary)	9
New Jersey (amoebic)	1
New Jersey (bacillary)	1
New Mexico (amoebic)	2
New Mexico (bacillary)	3

November 1936—Continued

Dysentery—Continued.	Cases
New Mexico (unspecified)	13
West Virginia	2
Encephalitis, epidemic or lethargic:	
California	2
New Jersey	3
Food poisoning:	
California	23
German measles:	
California	57
Maine	20
New Jersey	155
New Mexico	2
North Carolina	10
South Carolina	1
Granuloma, coccidioidal:	
California	3
Hookworm disease:	
Georgia	1,174
South Carolina	14
Impetigo contagiosa:	
Colorado	2
Lead poisoning:	
New Jersey	1
Milk sickness:	
New Mexico	1
Mumps:	
California	1,613
Colorado	16
Georgia	65
Maine	319
New Jersey	385
New Mexico	61
South Carolina	7
West Virginia	47
Ophthalmia neonatorum:	
California	2
New Jersey	10
North Carolina	1
South Carolina	1
Paratyphoid fever:	
California	3
Colorado	1
North Carolina	3
West Virginia	2
Puerperal septicemia:	
New Mexico	1

November 1936—Continued

Rabies in animals:	Cases
California	83
Maine	4
New Jersey	2
New Mexico	2
South Carolina	31
Rocky Mountain spotted fever:	
North Carolina	2
Scabies:	
Colorado	8
Septic sore throat:	
California	7
Georgia	27
New Mexico	2
North Carolina	15
Tetanus:	
California	3
South Carolina	1
Trachoma:	
California	12
Trichinosis:	
California	2
Tularaemia:	
Georgia	4
South Carolina	1
Typhus fever:	
Georgia	68
North Carolina	1
South Carolina	2
Undulant fever:	
California	12
Georgia	2
New Jersey	2
North Carolina	3
South Carolina	1
Vincent's infection:	
Maine	11
Whooping cough:	
California	929
Colorado	155
Georgia	32
Maine	163
New Jersey	599
New Mexico	27
North Carolina	169
South Carolina	9
West Virginia	72

CASES OF VENEREAL DISEASES REPORTED FOR OCTOBER 1936

These reports are published monthly for the information of health officers in order to furnish current data as to the prevalence of the venereal diseases. The figures are taken from reports received from State and city health officers. They are preliminary and are therefore subject to correction. It is hoped that the publication of these reports will stimulate more complete reporting of these diseases.

Reports from States

	Syphilis		Gonorrhea	
	Cases reported during month	Monthly case rates per 10,000 population	Cases reported during month	Monthly case rates per 10,000 population
Alabama	1,454	5.13	355	1.25
Arizona [1]				
Arkansas [2]	170	.85	73	.37
California	1,299	2.29	1,339	2.37
Colorado	21	.20	35	.33
Connecticut	222	1.29	151	.88
Delaware [1]	144	5.63	57	2.23
District of Columbia [1]				
Florida	315	1.95	81	.50
Georgia	1,311	3.92	931	2.78
Idaho	54	1.13	57	1.19
Illinois	1,554	1.99	1,114	1.43
Indiana	163	.48	134	.39
Iowa [2]	120	.47	148	.58
Kansas	63	.34	66	.36
Kentucky	284	1.00	321	1.13
Louisiana	242	1.14	159	.75
Maine [2]	24	.28	62	.73
Maryland	853	5.29	290	1.74
Massachusetts	466	1.07	567	1.30
Michigan	434	.93	589	1.26

notes at end of table.

Reports from States—Continued

	Syphilis		Gonorrhea	
	Cases reported during month	Monthly case rates per 10,000 population	Cases reported during month	Monthly case rates per 10,000 population
Minnesota	345	1.31	346	1.32
Mississippi	1,668	8.51	2,119	10.81
Missouri	752	1.92	342	.87
Montana [2]	44	.83	76	1.43
Nebraska	38	.28	106	.78
Nevada [3]				
New Hampshire	17	.34	16	.32
New Jersey	708	1.65	358	.83
New Mexico	64	1.59	49	1.22
New York	7,611	5.91	2,306	1.79
North Carolina	1,370	4.01	523	1.53
North Dakota	14	.20	100	1.43
Ohio [2]	1,021	1.52	434	.65
Oklahoma [2]	197	.79	174	.69
Oregon	36	.36	151	1.50
Pennsylvania [4]	332	.33	173	.17
Rhode Island	93	1.37	73	1.07
South Carolina [2]	341	1.69	255	2.26
South Dakota	13	.19	22	.33
Tennessee [2]	669	2.30	354	1.22
Texas	684	1.13	321	.53
Utah [3]				
Vermont [1]				
Virginia	515	1.95	307	1.16
Washington	144	.88	260	1.59
West Virginia	250	1.38	118	.65
Wisconsin [5]	26	.09	155	.53
Wyoming [3]				
Total	26,165	2.09	15,865	1.27

Reports from cities of 200,000 population or over

Akron, Ohio	25	0.92	9	0.33
Atlanta, Ga. [6]				
Baltimore, Md	453	5.49	150	1.82
Birmingham, Ala	155	5.49	88	3.12
Boston, Mass	181	2.29	203	2.57
Buffalo, N. Y	278	4.70	112	1.89
Chicago, Ill	927	2.60	763	2.14
Cincinnati, Ohio [6]				
Cleveland, Ohio	194	2.09	118	1.27
Columbus, Ohio	73	2.39	63	2.06
Dallas, Tex. [6]				
Dayton, Ohio [6]				
Denver, Colo	34	1.15	35	1.18
Detroit, Mich	219	1.27	298	1.72
Houston, Tex. [7]	207	6.18	52	1.55
Indianapolis, Ind	30	.80	37	.98
Jersey City, N. J. [6]				
Kansas City, Mo	62	1.47	6	.14
Los Angeles, Calif. [6]				
Louisville, Ky	127	3.92	26	.80
Memphis, Tenn	230	8.61	73	2.73
Milwaukee, Wis. [6]				
Minneapolis, Minn	99	2.03	94	1.93
Newark, N. J	247	5.33	122	2.63
New Orleans, La. [6]				
New York, N. Y	6,253	8.56	1,443	1.98
Oakland, Calif	33	1.09	47	1.55
Omaha, Nebr	8	.36	14	.64
Philadelphia, Pa	215	1.08	42	.21
Pittsburgh, Pa	69	1.01	38	.56
Portland, Oreg. [6]				
Providence, R. I	48	1.85	43	1.66
Rochester, N. Y	50	1.48	59	1.75
St. Louis, Mo	149	1.78	74	.89
St. Paul, Minn	42	1.49	54	1.91
San Antonio, Tex. [6]				
San Francisco, Calif	150	2.24	148	2.21
Seattle, Wash	93	2.45	143	3.77
Syracuse, N. Y	67	3.07	47	2.16
Toledo, Ohio	38	1.25	28	.92
Washington, D. C. [6]				

[1] Has been reporting regularly but no report received for current month. [2] Incomplete. [3] Not reporting.
[4] Includes only those cases that enter the clinics conducted by the State department of health.
[5] Only cases of syphilis in the infectious stage are reported.
[6] No report for current month.
[7] Reported by Jefferson Davis Hospital; physicians are not required to report venereal diseases.

WEEKLY REPORTS FROM CITIES

City reports for week ended Dec. 5, 1936

This table summarizes the reports received weekly from a selected list of 140 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	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								
Maine:											
Portland	0	------	0	0	6	0	0	1	0	3	33
New Hampshire:											
Concord	0	------	1	0	0	0	0	0	0	0	12
Nashua	0	------	--------	0	-------	0	0	-------	0	0	--------
Vermont:											
Barre	0	------	0	0	2	0	0	1	0	2	8
Burlington	0	------	0	0	0	1	0	0	0	0	7
Rutland	0	------	0	0	2	1	0	0	0	0	7
Massachusetts:											
Boston	0	------	1	3	20	38	0	6	0	180	259
Fall River	1	------	0	1	0	1	0	0	0	0	28
Springfield	0	------	0	1	3	1	0	0	0	8	31
Worcester	0	------	0	31	8	6	0	2	0	40	53
Rhode Island:											
Pawtucket	0	------	0	0	0	0	0	0	0	0	21
Providence	1	------	0	9	7	20	0	5	2	18	80
Connecticut:											
Bridgeport	0	------	1	8	3	0	0	0	0	2	40
Hartford	0	------	0	0	2	8	0	1	0	6	53
New Haven	0	------	2	0	1	1	0	1	0	6	70
New York:											
Buffalo	0	------	0	25	11	31	0	5	1	12	136
New York	27	7	3	39	95	99	0	89	5	94	1,455
Rochester	0	------	0	0	6	2	0	0	0	8	66
Syracuse	1	------	0	0	5	7	0	1	1	14	46
New Jersey:											
Camden	1	3	2	0	2	4	0	2	0	8	39
Newark	0	2	1	7	7	8	0	9	0	24	90
Trenton	0	------	0	0	3	2	0	3	0	5	44
Pennsylvania:											
Philadelphia	9	5	4	6	41	63	0	32	1	100	518
Pittsburgh	3	6	5	1	23	28	0	7	1	16	204
Reading	0	------	0	0	5	1	0	2	0	31	30
Scranton	0	------	--------	0	-------	2	0	-------	0	0	--------
Ohio:											
Cincinnati	3	------	3	1	18	5	0	8	0	2	174
Cleveland	2	10	1	2	15	44	0	11	1	31	199
Columbus	4	3	3	1	6	3	0	4	0	6	96
Toledo	1	------	0	3	5	3	0	3	0	19	64
Indiana:											
Anderson	0	------	0	2	0	6	0	0	0	0	8
Fort Wayne	0	------	0	0	0	8	0	0	0	1	31
Indianapolis	0	------	0	2	7	16	0	4	0	11	122
Muncie	1	------	0	0	0	2	0	1	0	0	6
South Bend	0	------	0	0	0	1	0	0	0	2	14
Terre Haute	0	------	0	0	0	4	0	0	0	0	20
Illinois:											
Alton	0	------	0	0	0	6	0	1	0	0	11
Chicago	6	9	0	13	45	152	0	28	0	69	667
Elgin	1	------	0	0	0	0	0	0	0	18	10
Moline	0	------	0	0	1	1	0	1	0	4	7
Springfield	0	1	0	0	4	3	0	0	1	10	19
Michigan:											
Detroit	9	------	1	9	28	119	0	13	1	99	280
Flint	1	------	0	1	4	20	0	0	0	14	19
Grand Rapids	0	------	0	3	0	16	0	0	0	19	41
Wisconsin:											
Kenosha	0	------	0	0	1	4	0	0	0	0	--------
Madison	0	------	0	2	0	7	0	0	0	1	9
Milwaukee	0	------	0	1	5	28	1	7	1	43	81
Racine	0	------	0	1	0	16	0	0	0	1	6
Superior	0	------	0	0	0	2	0	0	0	0	4
Minnesota:											
Duluth	0	------	0	0	0	18	0	1	0	9	27
Minneapolis	4	------	1	4	3	18	0	0	0	15	112
St. Paul	0	------	0	2	11	18	0	2	0	18	56
Iowa:											
Cedar Rapids	0	------	--------	0	-------	0	0	-------	0	0	--------
Davenport	0	------	--------	0	-------	0	0	-------	0	0	--------
Des Moines	0	------	--------	0	-------	9	0	-------	0	0	33
Sioux City	0	------	--------	0	-------	7	2	-------	0	2	--------
Waterloo	1	------	--------	0	-------	5	0	-------	0	6	--------

City reports for week ended Dec. 5, 1936—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								
Missouri:											
Kansas City	2	------	0	2	10	32	0	6	0	17	97
St. Joseph	3	------	0	0	4	6	0	1	0	0	20
St. Louis	11	2	0	1	13	34	0	6	0	20	212
North Dakota:											
Fargo	2	------	0	0	1	2	1	0	0	0	10
Grand Forks	0	------	0	0	------	0	0	------	0	0	------
Minot	0	------	0	0	0	0	0	0	0	0	5
South Dakota:											
Aberdeen	0	------	------	0	------	1	0	------	0	0	------
Sioux Falls	0	------	0	0	0	1	0	0	0	0	8
Nebraska:											
Omaha	1	------	0	0	10	10	0	0	0	5	56
Kansas:											
Lawrence	0	------	0	0	0	0	0	0	0	0	1
Topeka	0	------	0	2	0	5	0	0	0	4	12
Wichita	1	------	0	0	10	5	0	0	0	1	44
Delaware:											
Wilmington	0	------	0	6	6	1	0	0	0	0	23
Maryland:											
Baltimore	7	11	1	69	19	19	0	15	0	84	241
Cumberland	0	------	0	0	2	0	0	0	1	0	14
Frederick	0	------	0	0	0	0	0	0	0	0	2
District of Columbia:											
Washington	13	2	1	7	18	20	0	11	6	24	183
Virginia:											
Lynchburg	1	------	0	0	2	0	0	0	0	5	13
Norfolk	0	------	0	0	2	2	0	1	0	0	26
Richmond	0	------	2	2	3	8	0	3	0	0	65
Roanoke	0	------	0	0	2	2	0	0	0	2	29
West Virginia:											
Charleston	1	------	0	0	5	0	0	0	1	0	31
Huntington	2	------	------	0	------	1	0	0	------	0	------
Wheeling	0	------	0	0	4	0	0	0	0	1	15
North Carolina:											
Gastonia	0	------	0	0	0	0	0	0	0	0	------
Raleigh	0	------	0	0	0	1	0	0	0	0	19
Wilmington	0	------	0	0	2	2	0	1	0	0	12
Winston-Salem	2	------	0	1	6	0	0	0	0	0	15
South Carolina:											
Charleston	0	48	0	0	3	2	0	2	2	0	35
Columbia	0	------	0	0	6	0	0	0	0	0	14
Florence	0	------	0	0	0	0	0	0	0	0	0
Greenville	2	------	0	0	2	0	0	1	0	0	35
Georgia:											
Atlanta	8	20	2	0	12	9	0	3	0	0	------
Brunswick	0	------	0	0	1	0	0	0	0	0	6
Savannah	0	10	0	0	4	4	0	2	1	1	32
Florida:											
Tampa	0	1	1	0	1	2	0	1	0	7	24
Kentucky:											
Ashland	0	------	------	0	2	1	0	------	0	0	18
Covington	0	------	0	0	5	2	0	1	0	0	15
Lexington	0	3	0	2	2	0	0	2	0	0	20
Louisville	0	3	0	1	11	15	0	3	0	15	61
Tennessee:											
Knoxville	1	------	0	0	5	2	0	1	0	0	39
Memphis	2	------	1	0	5	12	0	3	1	7	77
Nashville	1	------	0	0	6	1	0	1	1	0	63
Alabama:											
Birmingham	4	------	0	0	9	1	0	4	0	0	67
Mobile	1	------	0	2	1	4	0	0	0	0	24
Montgomery	1	1	------	0	------	4	0	------	0	0	------
Arkansas:											
Fort Smith	0	------	------	0	------	2	0	------	0	1	1
Little Rock	0	------	0	0	4	1	0	4	0	0	9
Louisiana:											
Lake Charles	0	------	0	0	2	0	0	0	0	0	10
New Orleans	16	------	5	0	17	0	0	11	1	0	196
Shreveport	0	------	0	0	8	0	0	4	0	0	41
Oklahoma:											
Oklahoma City	2	------	0	0	8	2	0	1	0	0	41
Texas:											
Dallas	7	2	2	1	11	20	0	3	0	4	77
Fort Worth	1	------	1	28	10	26	0	3	0	0	56
Galveston	2	------	0	0	3	0	0	0	1	0	23
Houston	9	------	0	0	16	3	0	5	1	0	104
San Antonio	3	------	3	0	9	2	0	10	0	0	84

City reports for week ended Dec. 5, 1936—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								
Montana:											
Billings	1	------	0	1	0	1	0	0	0	0	5
Great Falls	0	------	0	0	1	3	1	0	0	2	4
Helena	0	------	0	2	2	3	0	0	0	0	5
Missoula	0	------	0	0	0	0	0	0	0	0	5
Idaho:											
Boise	0	------	1	0	5	4	0	0	1	0	12
Colorado:											
Colorado Springs	0	------	0	1	1	2	0	2	0	0	9
Denver	6	------	1	2	7	14	0	8	0	46	91
Pueblo	3	------	1	0	1	4	0	0	0	0	13
New Mexico:											
Albuquerque	0	1	0	0	1	0	0	3	1	0	11
Utah:											
Salt Lake City	0	------	1	0	5	10	0	0	0	0	34
Nevada:											
Reno	------	------	------	------	------	------	------	------	------	------	------
Washington:											
Seattle	1	------	1	2	11	7	0	5	1	0	115
Spokane	1	0	0	0	4	6	0	1	0	0	33
Tacoma	0	------	0	0	5	7	0	0	0	0	40
Oregon:											
Portland	1	------	0	1	6	13	0	3	0	4	74
Salem	0	------	------	0	------	0	0	------	0	0	------
California:											
Los Angeles	13	15	1	8	26	27	1	19	0	45	300
Sacramento	2	------	0	0	6	6	0	2	0	2	38
San Francisco	2	------	0	2	9	18	0	5	1	19	163

State and city	Meningococcus meningitis		Poliomyelitis cases
	Cases	Deaths	
Maine:			
Portland	0	0	1
Massachusetts:			
Boston	1	0	0
Fall River	0	1	0
Rhode Island:			
Providence	1	0	0
New York:			
New York	4	1	1
New Jersey:			
Trenton	1	0	0
Pennsylvania:			
Philadelphia	1	0	0
Ohio:			
Cincinnati	2	2	0
Cleveland	3	1	0
Columbus	0	0	1
Toledo	0	0	1
Indiana:			
Fort Wayne	1	0	0
Indianapolis	2	3	0
Illinois:			
Chicago	1	0	2
Michigan:			
Detroit	1	0	1
Wisconsin:			
Racine	1	0	0
Iowa:			
Des Moines	1	0	0
Missouri:			
Kansas City	2	2	0
Nebraska:			
Omaha	1	0	0
Kansas:			
Wichita	1	1	0
Maryland:			
Baltimore	1	0	0
District of Columbia:			
Washington	2	1	0

State and city	Meningococcus meningitis		Poliomyelitis cases
	Cases	Deaths	
Virginia:			
Norfolk	1	0	0
West Virginia:			
Charleston	1	1	0
Wheeling	1	0	0
South Carolina:			
Charleston	1	0	0
Georgia:			
Atlanta	1	1	1
Kentucky:			
Ashland	0	1	0
Covington	0	1	0
Tennessee:			
Knoxville	0	0	1
Memphis	2	0	0
Alabama:			
Birmingham	1	0	0
Arkansas:			
Fort Smith	0	0	2
Louisiana:			
New Orleans	0	0	2
Shreveport	0	2	0
Oklahoma:			
Oklahoma City	1	0	1
Texas:			
Galveston	0	0	1
Houston	0	1	0
San Antonio	0	1	0
Montana:			
Missoula	1	1	0
Idaho:			
Boise	1	1	0
Colorado:			
Colorado Springs	0	1	0
Utah:			
Salt Lake City	1	1	0
California:			
Los Angeles	1	0	1

Encephalitis, epidemic or lethargic.—Cases: New York, 1; Newark, 1; Pittsburgh, 1; Nashville, 1.
Rabies in man.—Deaths: Philadelphia, 1.
Typhus fever.—Cases. Charleston, S. C., 2; Atlanta, 1; Tampa, 1; Montgomery, 2; Forth Worth, 1.

FOREIGN AND INSULAR

CANADA

Provinces—Communicable diseases—2 weeks ended November 28, 1936.—During the 2 weeks ended November 28, 1936, cases of certain communicable diseases were reported by the Department of Pensions and National Health of Canada as follows:

Disease	Prince Edward Island	Nova Scotia	New Brunswick	Quebec	Ontario	Manitoba	Saskatchewan	Alberta	British Columbia	Total
Cerebrospinal meningitis			1	1	3		1			6
Chicken pox		13	1	682	825	183	245	45	189	2,183
Diphtheria	1	9		64	19	6	2		2	103
Dysentery				1	2					3
Erysipelas		1		9	6	5	3	2	10	36
Influenza		17			15	6			10	48
Lethargic encephalitis						1				1
Measles		3	11	436	373	72	740	224	774	2,633
Mumps		1	47		294	8	28	55	142	575
Paratyphoid fever					1					1
Pneumonia	7	4			47		6		12	76
Poliomyelitis				5	3	15	14		2	44
Scarlet fever		43	27	202	404	156	50	182	63	1,127
Smallpox								3		3
Trachoma							1			1
Tuberculosis	5	10	13	106	77	39	2	3	25	280
Typhoid fever		2	4	21	9	3	2	2	7	50
Undulant fever				3	5				1	9
Whooping cough		76	5	226	342	48	50	18	93	858

GERMANY

Vital statistics—Second quarter 1936.—Following are vital statistics for Germany for the second quarter of 1936:

Number of marriages	171,304	Total deaths	196,103
Number of live births	330,274	Deaths per 1,000 population	11.6
Number of live births per 1,000 population	19.6	Deaths under 1 year of age	23,060
Number of stillbirths	8,327	Deaths under 1 year of age per 100 live births	7.1

JAMAICA

Communicable diseases—4 weeks ended November 28, 1936.—During the 4 weeks ended November 28, 1936, cases of certain communicable diseases were reported in Kingston, Jamaica, and in the island outside of Kingston, as follows:

Disease	Kingston	Other localities	Disease	Kingston	Other localities
Cerebrospinal meningitis		1	Leprosy	1	1
Chicken pox	1	16	Poliomyelitis		1
Diphtheria	1	5	Scarlet fever		1
Dysentery	8	14	Tuberculosis	33	105
Erysipelas		1	Typhoid fever	14	51

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

From medical officers of the Public Health Service, American consuls, International Office of Public Health, Pan American Sanitary Bureau, health section of the League of Nations, and other sources. The reports contained in the following table must not be considered as complete or final as regards either the list of countries included or the figures for the particular countries for which reports are given.

CHOLERA

[C indicates cases; D, deaths; P, present]

Place		Apr. 26–May 30, 1936	May 31–June 27, 1936	June 28–July 25, 1936	July 26–Aug. 29, 1936	Week ended— September 1936				October 1936					November 1936			
						5	12	19	26	3	10	17	24	31	7	14	21	28
Afghanistan	C										P							
Ceylon: Batticaloa	C										3							
India	C	21,278	15,291	17,917	25,973	5,675	5,296	4,729	4,183	4,172	4,358	3,569	3,761					
	D	10,634	7,672	8,500	12,681	2,810	2,555	2,367	2,053	1,965	1,998	1,680	1,755					
Assam	C	569	262	151	293	87	76	82	44	89	59	109	62	49	174	176	187	173
	D	292	152	75	180	46	47	30	35	38	38	59	29	20	88	82	79	69
Bassein	C	9	12	1	1													
Bombay Presidency	C	365	592	1,923	3,597	693	841	751	685	752	897	913	809	910	465			
	D	123	224	795	1,500	345	395	325	313	327	357	429	356	106	254			
Bombay	C		[1] 1	[1] 1			[1] 1				[2] 1							
Calcutta	C	1,012	580	154	103	14	16	13	11	13	11	10	9	30	14	13	19	15
Central Provinces and Berar	C	715	971	1,349	5,730	1,584		1,683	1,096	1,174	1,101	918	677	369	333	228	182	179
Chittagong	C	6	13	5	3	1	4		1			1	1			1		15
Madras Presidency	C	1,556	2,074	3,654	5,478	1,341	1,111	1,145	1,010	1,062	1,007	967	1,413					
	D	787	902	1,621	2,587	678	560	604	494	536	510	487	713					
Madras	C	2		6		4	2	1	1	1	8	3	9		6	6	17	28
	D			1	1			1			1	2	3		1	1	5	5
Moulmein	C	3	1															
Negapatam	C		13	15	24	3	1	4	1									
	D		9	7	10	1	1	1	2									
Northwest Frontier Province	C															2	5	77
Orissa Province	C																	155
Punjab	C	61	231	418	652	91	47	18	13	10	1		7				7	
Rangoon	C		2	3	3						1		1	2	1	1	1	1
Sind State	C				20	19	19											
Tuticorin	C			29												5	4	3
India (French):																		
Chandernagor Territory	C	2	7	8														
Karikal Province	C		8	117	98			25		45		24						
Pondichery Province	C	16	4	1	1			4										

[1] Suspected.
[2] Imported.

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

CHOLERA—Continued

C indicates cases; D, deaths; P, present]

Place		Apr. 26–May 30, 1936	May 31–June 27, 1936	June 28–July 25, 1936	July 26–Aug. 29, 1936	Week ended— September 1936				October 1936					November 1936			
						5	12	19	26	3	10	17	24	31	7	14	21	28
Indochina (see also table below):																		
Bentre	C	1																
Pnom-Penh	C	1																
Siam:																		
Bangkok	C	52	36	22	1													
Provinces	C	288	34	66	117	20	7	16	14	8		6	3	1				
On vessels:																		
S. S. *Karagola* at Penang from Calcutta	C	1																
S. S. *Ekma* at Rangoon from Calcutta	C		1															
S. S. *Chakdina* at Calcutta from Chittagong	C			1														

Place		June 1936			July 1936			August 1936			September 1936			October 1-10, 1936
		1–10	11–20	21–30	1–10	11–20	21–31	1–10	11–20	21–31	1–10	11–20	21–31	
Indochina (French) (see also table above):														
Cambodia [3]	C	1		1		2					2	2		
	D	1		1		2					2	1		
Cochinchina [3]	C		4	1	3	3	1				1			1
	D		4		3	3	1				1			1

[3] Reports incomplete.

PLAGUE[1]

Place		Apr. 26–May 30, 1936	May 31–June 27, 1936	June 28–July 25, 1936	July 26–Aug. 29, 1936	Week ended September 1936				October 1936					November 1936			
						5	12	19	26	3	10	17	24	31	7	14	21	28
Algeria:																		
Oran Department	C				[2] 1	[2] 1		[2] 1										
Philippeville	C				[2] 1													
Argentina. (See table below.)																		
Azores. (See table below.)																		
Belgian Congo	C	1											[2] 2					
Brazil (see also table below):																		
Santos	C				4													
	D				1													
Sao Paulo.[3]																		
British East Africa:																		
Kenya	C	42	39	13	25	7	1	4	2	5	3	4	3	1	4	3		
Tanganyika	C	3																
Uganda	C	153	76	96	97	18	17	33	19	15	21	17	11	17	18			
	D	148	73	93	91	17	17	26	18	15	21	17	11	15	15			
Ceylon:																		
Colombo	C	3	3	3	1				1				1	2		2	2	
	D	3	3	3					1					1		2	1	
Plague-infected rats		8	2	2	1	1				2		1	3	1		5		
Hatton	C	3																
Maskiliya	C			1														
Southern Province	C				1													
China: Manchuria.[4]																		
Dutch East Indies: West Java	C	553	363	318	410	89												
	D	550	362	317	408	89												
Ecuador:																		
Alausi	C						1											
Babahoyo	C																5	
Plague-infected rats																	6	
Bajada del Morro	C											[5] 3				4		
Guayaquil	C				4	1			1				2	3	1	6	9	5
	D				1	1		1	1				1		2	5	2	5
Plague-infected rats			3	5	4	1	4	1		1		1	1	1	2	1	4	

[1] Including plague in the United States and its possessions.
[2] Suspected.
[3] A report dated July 29, 1936, states that 23 cases of pneumonic plague with 18 deaths were reported in Sao Paulo, Brazil.
[4] A report dated Aug. 20, 1936, states that 5 cases of plague were reported at Kirin Province, Manchuria, China.
[5] For 3 weeks.

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

PLAGUE—Continued

Place		Apr. 26–May 30, 1936	May 31–June 27, 1936	June 28–July 25, 1936	July 26–Aug. 29, 1936	Week ended September 1936				October 1936					November 1936			
						5	12	19	26	3	10	17	24	31	7	14	21	28
Egypt:																		
Alexandria: Plague-infected rats		P	P	P	P	P		P		P		P		P		P		
Asyut Province	C	2	2				3		1					[6] 3	1			
Beheira Province	C									1								
Girga Province	C	1												1		1		
Minya Province	C	1																
Suez	C		1															
France: **Marseille** [7]	C				1	1	1											
Hawaii Territory: Plague-infected rats:																		
Hawaii Island—Hamakua district:[8]																		
Hamakua Mill sector											1			1				
Paauhau sector [8]		2		3	6		7	10	5	6	1		3	2	1			2
Maui Island—Wailuku District—Keahua region													1					
India	C	626	139	294	900	298	259	229	386	486	469	326	438					
	D	406	92	186	531	143	106	82	99	141	151	115	114					
Bassein	C	5	2	9	5													1
Plague-infected rats					1		1						1					
Bombay Presidency	C	11	4	3	10	4	14	29	25	17	12	36	11	33	11			
	D	6	2	2	6	2	6	17	20	17	6	15	11	17	5			
Bombay	C		1															
Calcutta	C			[9] 1														
Central Provinces and Berar	C	52		9	147	104	139	29	256	359	324	120	297	345	317	167	368	524
Madras Presidency	C	6		41	154	32	21	10		7	7	11	7	10	6			
	D	2		24	86	26	19	10		7	2	7	1	3	1			
Punjab	C	72																
	D	47																
Rangoon	C	5	2	2	3							1						
Plague-infected rats		1		1	4			1	2									
Indochina (see also table below):																		
Longxuyen	C		1															
Pnom-Penh	C	1			4													
Tanghai	C	4																
Iraq: Baghdad Province	C													1				
Madagascar. (See table below.)																		
Malta	C	1	3		4			1	2	[9] 2			1		1	3	1	1
Peru. (See table below.)			1		1													

Senegal. (See table below.)																	
South-West Africa. (See table below.)																	
Tunisia: Tunis C				2					2	2	1				1		
Plague-infected rats		1	1	2													
Union of South Africa (see also table below) C	6	32	[9] 1	4		6						3		[9] 3			
United States:																	
California:																	
Eldorado County — Plague-infected chipmunk										1							
Lassen County — Plague-infected squirrels		5	1														
Modoc County [10] — Plague-infected squirrels		13	4	10													
Monterey County [10] C		1															
Placer County [10] C			1														
San Bernardino County.[16]																	
Santa Cruz County [10]—Plague-infected squirrels		50	11														
Ventura County — Plague-infected squirrels		P															
Idaho: Bonneville County—Plague-infected squirrels		7															
Montana: Beaverhead County.[11]																	
Nevada: Elko County—Plague-infected squirrels	P																
Utah:																	
Beaver County C			1														
Plague-infected marmots				2													
Plague-infected squirrels			1														
Garfield County [12]—Plague-infected prairie dogs				2													
Sevier County. [12]																	
On vessels:																	
S. S. *Ipanema* at Marseille from Bone and Philippeville C				1													
S. S. *Delambre* at Liverpool from Montevideo, Buenos Aires, Rosario, Santos, and Las Palmas—Plague-infected rats					2												

[5] Suspected.
[6] Includes 1 case of pneumonic plague.
[7] A report dated Sept. 3, 1936, states that 2 plague-infected rats were reported in Marseille, France.
[8] Plague-infected rats have been reported in Hawaii Territory, Hawaii Island, Hamakua District, as follows: No location, week ended Aug. 8, 2 plague-infected rats; Paauhau sector, week ended Dec. 5, 1 plague-infected rat, and week ended Dec. 12, 3 plague-infected rats.
[9] For 2 weeks.
[10] Plague-infected fleas have been reported in California as follows: Week ended June 27, 1936, 3 lots in Modoc County, and 7 lots in Santa Cruz County; Aug. 18–21, 104 plague-infected fleas collected from ground squirrels in San Bernardino County, and according to information dated Nov. 10, 31 fleas taken from 24 Fisher squirrels shot in Holcomb Valley, also in San Bernardino County have been proved positive for plague. A report dated Oct. 13, 1936, states that fleas taken from ground squirrels in Monterey County and from chipmunks and ground squirrels in Placer County have been proved plague infected.
[11] During the week ended July 25, 1936, 153 fleas and 26 lice taken from 7 marmots (ground hogs) shot at the head of Small Horn Canyon, Beaverhead County, Mont., were reported plague infected.
[12] Plague-infected fleas in Utah have also been reported as follows: Aug. 24, 45 fleas taken from 23 prairie dogs in Garfield County, and July 28, 1936, 315 fleas taken from 11 ground squirrels in Clear Creek Canyon, Sevier County.

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

PLAGUE—Continued

[C indicates cases; D, deaths; P, present]

Place		May 1936	June 1936	July 1936	August 1936	September 1936	October 1936
Argentina:							
Buenos Aires—							
Plague-infected rats							4
Catamarca Province	C						1
Salta Province	C			4			
Santiago del Estero Province	C					[6] 2	
Tucuman Province	C			1		[13] 6	
Azores	C	2					
Brazil (see also table above):							
Bahia State	C				[14] 46		
Ceara State	C				[14] 106		
Pernambuco State	C				[14] 45		
Piauhy State	C				[14] 4		
Indochina (see also table above):							
Cambodia	C	1		4	8		
Cochinchina	C	1	1	6	1		
Madagascar (central region)	C	48	38	26	83	104	
	D	47	36	26	81	95	
Peru	C	5	2	4	6	8	
Lambayeque Department	C					3	
Libertad Department	C	4	1	3	1	1	
Lima Department	C	1		1	2	2	
Callao	C		1				
	D		1				
Plague-infected rats					P	P	
Piura Department	C				3	2	
Senegal:							
Dakar [15]	C		2	1			
	D		2	1			
Thies [15]	C	2	1				
Tivaouane [15]	C	5	4	8	4		
South-West Africa: Ovamboland	C	23					
Union of South Africa (see also table above)	C					21	

SMALLPOX

Place		Apr. 26–May 30, 1936	May 31–June 27, 1936	June 28–July 25, 1936	July 26–Aug. 29, 1936	Week ended— September 1936				October 1936					November 1936			
						5	12	19	26	3	10	17	24	31	7	14	21	28
Algeria:																		
Constantine Department	C		2	1														
Oran Department	C		6	2														
Philippeville	C				1													
Angola. (See table below.)																		
Argentina. (See table below.)																		
Belgian Congo. (See table below.)																		
Bolivia. (See table below.)																		

Brazil:																			
Bahia	C			2	43	21	23	31	24	30	20								
Porto Alegre (alsastrim)	D				2				1			1	2						
Recife (alastrim)	C													3	1				
British East Africa: Tanganyika	C	73	7	106	94		73		1	100	15	9		[1] 329					
British Somaliland	C	10	19		2														
Canada:																			
Alberta	C	2	[2] 2		[2] 1											[2] 1			
Saskatchewan	C			[2] 2	[2] 1														
Ceylon: Colombo	C				1						1								
China (see also table below):																			
Amoy	C		3	3															
Dairen	C	10	9	2	2														
Foochow	C	P	P	P	P	P										P			
Hangchow	C	6	4	1			1												
Hankow	C	1	1																
Hong Kong	C	5	2	2					1										
Nanking	C	75	16	5															
Shanghai	C	49	17	14	9							4	1	2	3	1	4	16	
Tientsin	C	1	3	1															
Chosen. (See table below.)																			
Colombia (see also table below)	C	60			126			[3] 76		[2] 50	22								
Barranquilla	D				6		1			1					3				
Ecuador: Guayaquil	C				1				1	3						[2] 3	5		
Egypt:																			
Alexandria	C															[4] 1			
Provinces	C		2																
Ethiopia	C															13			
Finland	C			6	8														
France. (See table below.)																			
Gambia (Upper)	C			38															
Gold Coast	C			[5] 12															
Great Britain: England and Wales—London and Great Towns	C	4																	
Greece: Salonika	C	37	34	13							10	10	10	10	10				
Guatemala. (See table below.)																			
India	C	36,861	16,397	10,011	5,419	935	934	734	810	687	533	279	317						
	D	9,916	4,696	2,955	1,478	239	262	199	186	166	135	81	73						
Assam	C	270	95	54	79	24	19	17	10	13	24	11	4	12	4	4	16	12	
Bombay Presidency	C	2,747	962	647	510	68	71	78	41	52	62	28	22	19	10				
	D	501	192	128	100	8	14	14	10	11	14	9	6	1	3				
Bombay	C	237	99	46	39	2	2	9	4		6	3	1	1		1	1	1	
	D	155	68	28	28	2	2	7	3		4	1		1		1	1	1	
Calcutta	C	567	275	46	45	4		2		2	6		1	3	2		4	2	
	D	466	168	38	39	4	1	3		2	4		1				1	1	
Central Provinces and Berar	C	3,043	1,100	477	187	42		15	13	13	6	3	17	7	9	2	9	18	
Chittagong	D		3	11						[4] 1			2					[4] 2	
Cochin	C						2												
Karachi	C	19	5	2											[4] 1				

[1] Delayed reports.
[2] For 2 weeks.
[3] For 3 weeks.
[4] Imported.
[5] For 4 weeks.
[6] Includes 1 case of pneumonic plague.
[13] Pneumonic plague.
[14] From Jan. to Aug. 31.
[15] Reports incomplete.

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

SMALLPOX—Continued

[C indicates cases; D, deaths; P, present]

Place		Apr. 26–May 30, 1936	May 31–June 27, 1936	June 28–July 25, 1936	July 26–Aug. 29, 1936	Week ended— September 1936				October 1936					November 1936			
						5	12	19	26	3	10	17	24	31	7	14	21	28
India—Continued.																		
Madras Presidency	C	1,225	796	752	1,122	134	141	92	75	106	93	102	80	20	32			
	D	215	137	160	205	22	31	26	17	19	23	22	21	3	6			
Madras	C	5			2		1	2					1				2	1
Moulmein	C	35	21	18	10	4	7	1			2	1			2	1	4	5
Negapatam	C	1																
Northwest Frontier Province	C	11	16	15	7		7	15		4	1	1	5	3	4	5	4	2
Punjab	C	377	320	113	52	19	3	3	40	9	4		18	46	86	86	36	
Rangoon	C	4	7	1	5				1	2	2		5	1	2	4	4	
Sind State	C	249	194	54	31	19	19	5	8	1	7	7	6		2			50
Vizagapatam	C	5	2		2					1								
India (French):																		
Chandernagor Territory	C	10	8															
Pondichery Province	C	2		6	1													
	D	1		2														
India (Portuguese)	C									7								
Indochina (see also table below):																		
Pnom-Penh	C		1	1	1	1		5	1		2	1	1		2	1	1	1
Tourane	C	1																
Iran	C		7	1	6	5	4					2						
Teheran	C			1	3	1		3			2	1		1				
Iraq	C	11	1		1					3						3	3	
Baghdad	C	1			1													
Japan:																		
Osaka	C	1	1	2	11	8	4	4	5	2	1	1		12				
Yokohama	C	1																
Mexico (see also table below):																		
Chihuahua	C	2	2															
Guadalajara	D	21	6	3	2		1											
Mexico, D. F	C	23	15	7	7							1						
Torreon	C			3				2	1	8	1	1	1	2	1		1	
Morocco. (See table below.)																		
Nigeria	C	427	1,028	[5] 512	84					[3] 75	23							
Lagos	C				1				1	1								
Northern Rhodesia	C														76			
Nyasaland. (See table below.)																		
Peru. (See table below.)																		

Portugal (see also table below):																			
Lisbon	C	1		2	2				1										
Oporto	C		1		1			1											
Salvador. (See table below.)																			
Saudi Arabia	C	6																	
Sierra Leone	C	9	25	9	3				[3] 38										
Freetown	C	2																	
Spain	C	12	23																
Straits Settlements: Singapore	C		[4] 1																
Sudan (Anglo-Egyptian)	C	17	5	1	13	4		[6] 100	1	30	6	17		43			56	57
Turkey. (See table below.)																			
Union of South Africa	C			1	P														
Uruguay. (See table below.)																			

[3] For 2 weeks. [4] Imported. [5] For 4 weeks. [6] For 5 weeks.

On vessels:

- S. S. *Kasagi Maru* at Moji from Shanghai — 1 case — May 4, 1936
- S. S. *Awaji Maru* at Nagasaki from Dairen — 1 case — May 8, 1936
- S. S. *Bhutan* at Kobe from Shanghai — 8 cases — May 13, 1936
- S. S. *Jinkai Maru* at Moji from Hongay — 1 case — June 1, 1936

On vessels—Continued.

- S. S. *Rohna* at Penang from Madras — 1 case — June 11, 1936
- S. S. *Maya Maru* at Moji from Shanghai — 2 cases — June 18, 1936
- S. S. *Tulamba* at Rangoon from Calcutta — 1 case — Aug. 11, 1936

Place		May 1936	June 1936	July 1936	August 1936	September 1936	October 1936
Angola	C		7				
Argentina:							
Buenos Aires Province	C	12					
Chaco Territory	C				1		
Corrientes Province	C		4		6	3	1
Entre Rios Province	C						154
Jujuy Province	C	3	9	6	1		
Los Andes Territory	C						12
Salta Province	C		120				31
Santa Fe Province	C					2	
Belgian Congo	C	75	188	98	88	105	
Bolivia	C	31	8	29	12		
China: Manchuria—Harbin	C	7					
Chosen	C	183	84	21	10	3	
Colombia (see also table above):							
Barranquilla	D		1				
France	C			36	2		
Guatemala	C	1	3	5	13	1	1
Indochina (see also table above)	C	142	78	93	119	87	39
	D	19	10	8	21	8	12
Mexico (see also table above):							
Aguascalientes State—Aguascalientes	C	2	1				

Place		May 1936	June 1936	July 1936	August 1936	September 1936	October 1936
Mexico—Continued.							
Chihuahua State—Chihuahua	C				1	1	
Jalisco State—Guadalajara	C	37	7		3	3	
	D	26	7		1	1	
Lower California	C	1					
Mexico State	C	4	2				
Mexico, D. F.	C		18	12	5	1	
Mexico City	C	26					
Nayarit State	D		1				
Puebla State—Puebla	C	2	3			2	
Queretaro State	C			1			
San Luis Potosi State—San Luis Potosi	C		1				
Morocco	C	6	3	3	2	1	
Nyasaland	C		4				
Peru	C	10	15	7	74	23	
Portugal (see also table above)	C	24	39		43	83	
	D	2	3		3	4	
Salvador	C	48					
Turkey	C	16		16			
Uruguay	C					1	

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

TYPHUS FEVER

[C indicates cases; D, deaths; P, present]

Place		Apr. 26–May 30, 1936	May 31–June 27, 1936	June 28–July 25, 1936	Week ended— August 1936					September 1936				October 1936					November 1936	
					1	8	15	22	29	5	12	19	26	3	10	17	24	31	7	14
Algeria:																				
Algiers Department	C	80	85	73	2	4	10	8									2	1		
Algiers	C	4	3	1		1										1				
Constantine Department	C	61	24	44	30		2	8	2			1		1	1			8	6	
Bone	C	1																		
Constantine	C	2	1	2				2					1						1	
Philippeville	C		1																	
Oran Department	C	12	8	1			1	1								1				
Australia: Sydney	C	1																		
Basutoland	C	18		5						[1] 7										
Bolivia. (See table below.)																				
Bulgaria	C							1												
Ceylon: Colombo	C														1					
Chile	C	199	248		[2] 265			[2] 243		[4] 213			[3] 330							
Santiago	C							[2] 87		[4] 83										
Valparaiso	C	2	4	3			1	1	1	1				1	1		3	1		
China:																				
Hankow	C	2	5	1																
Nanking	C			1																
Shanghai	C	3	7								2						2			
Tientsin	C	4	4	6	1										1					
Tsingtao	C	1		1				1	1											
Chosen. (See table below.)																				
Czechoslovakia. (See table below.)																				
Egypt:																				
Alexandria	C	1		2			1	1							2					
Aswan Province	C											1								
Asyut Province	C	2		2		3	1											1		
Beheira Province	C	28	35	8		1														
Cairo	C	8	1	3		1								1	1	2			1	
Dakahliya Province	C	15	9	1																
Faiyum Province	C			1																
Gharbiya Province	C	32	27	5		3												2		
Girga Province	C			1			2													
Minufiya Province	C	2	2	1		2														
Port Said	C	1																		

Qena Province	C	1																		
Sharkiya Province	C	2		7		3	1													
Suez	C		1			1														
Provinces	C	521	336	135	8	14	5	2	1		3	1	1	2	3	1	1	5	3	3
Finland. (See table below.)																				
Greece (see also table below): **Salonika**	C	5	4	1		1	1	1	1	1	1	1	1	1	1	1	1	1	1	
Guatemala. (See table below.)																				
Hawaii Territory: **Honolulu**	C	1		3		1		1	1	4		2	1	4	2	4		2		2
Hungary	C	1								1										
Iran	C	21	17	8	4					2		6	3			3				
Teheran	C			1									2							
Iraq	C		1																	
Irish Free State:																				
Galway County:																				
Bothar Buidhe	C		1	1																
Oughterard	C			2																
Kerry County—Dingle	C								2	1	2				2					
Mayo County	C	1																		
Lithuania	C	4	11																	
Mexico (see also table below):																				
Durango	D					1														
Mexico, D. F.	C	33	13	14	4	1	7	6	2	6	7	6	4		4	2	6			
Saltillo	D															1				
San Luis Potosi	D		1	1																
Torreon	C		1	1							1						2			
Morocco (see also table below)	C	28	7	6		1														
Palestine:																				
Haifa	C	8	13	6	4	1	3	2	3	1	4	5	6		3	2	2	3	2	3
Jaffa	C			5			5	2	6	5	3	7	8	4	3	3	2		6	1
Panama Canal Zone. (See table below.)																				
Paraguay: Asuncion	D				1	1		1		1										
Peru. (See table below.)																				
Poland	C	587	252	136	22	10	3	5	9	6	11	4	26	16	9	13	6	19	15	34
	D	35	15	11									3							
Portugal. (See table below.)																				
Rumania. (See table below.)																				
Spain: Catalonia	C			1																
Straits Settlements: **Singapore**	C			3							2		1							
Tunisia:																				
Tunis	C	3	3	2		1				2						1		1		
Provinces	C	114	49	40	7	11			3	10	3		6	7	12	3	5		6	2
Turkey. (See table below.)																				
Union of South Africa. (See table below.)																				
Yugoslavia. (See table below.)																				
On vessel: At Rotterdam from Algiers	C	1																		

[1] For 6 weeks. [2] For 5 weeks. [3] For 3 weeks. [4] For 2 weeks.

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

TYPHUS FEVER—Continued

[C indicates cases; D, deaths; P, present]

Place		May 1936	June 1936	July 1936	August 1936	September 1936	October 1936
Bolivia	C	33	46	47	29		
China: Manchuria—Harbin	C	33	29	15	3	4	
Chosen	C	225		80	20	24	
Czechoslovakia	C	49	23	4	1		
Finland	C	10			1	1	
Greece (see also table above)	C	3	4	3	10	9	11
Guatemala	C	116	59	30	30	38	17
Mexico (see also table above):							
Aguascalientes State: Aguascalientes	C	5	1		3	1	
Chihuahua State	C					1	
Durango State	D				1		
Guanajuato State	C				7		
Jalisco State: Guadalajara	C		1	1	1	1	
Mexico State	C	6		3	10	4	
	D	2	1	2	2		
Mexico, D. F	C		23	23	19	21	
Mexico City	C	26					
	D	15				8	
Mexico—Continued.							
Oaxaca State	C		1		4	2	
Puebla State: Puebla	C	3	3		10	6	
Queretaro State	C	1	1		1	1	
San Luis Potosi State: San Luis Potosi	C	3	3	3	4	1	
Sinaloa State	D			1			
Morocco (see also table above)	C	26	9	6	2		
Panama Canal Zone	C		2				
Peru	C	81	47	268	67	48	
Portugal	C		1		1	2	
Rumania	C	1,143	427	168	32	25	
Turkey	C	39	25	39	15	27	
Istanbul	C	1	1	2	1	1	
Union of South Africa:							
Cape Province	C	71	60	58	113	43	
Natal	C	2	1				
Orange Free State	C	10	24	2	15	14	
Transvaal	C		1			1	
Yugoslavia	C	125	78	53	16	6	

YELLOW FEVER

Place		Apr. 26–May 30, 1936	May 31–June 27, 1936	June 28–July 25, 1936	Week ended— August 1936					September 1936				October 1936					November 1936		
					1	8	15	22	29	5	12	19	26	3	10	17	24	31	7	14	21
Bolivia: Santa Cruz Department.[1]																					
Brazil: [2]																					
Amazonas State	C	3																			
Maranhão State	C	1																			
Matto Grosso State	C		1																		
Minas Geraes State	C	5	1																		
	D	5	1																		
São Paulo State [3]	C	16	6																		

Colombia [3]	D							2	1			3										
Boyaca Department.[3]																						
Cundinamarca Department	D			2	1																	
Intendencia of Meta—																						
Acacias	D																			1		
Restrepo [3]	D			2		1	1				1						1					
Villavicencio [3]	D											1										
Santander Department [3]	D			2	1	3																
Dahomey	C			[4] 1								[4] 1	1							[4] 1		
French Guinea—Macenta	C										1	[4] 1			1							
Nigeria:																						
Aba	C											[4] 1										
Calabar	C																			[4] 1		
Ilorin Province	D												[4] 1									
Kano	C							[4] 1														
Maiduguri	D																		1			
Senegal:																						
Bambey	C																					1
Khombole	C																	1				
Thiès	C		1															[4] 1				
Tivaouane	C		2								1											
Sierra Leone	C												[4] 1			1						
Freetown	C																					[4] 1
Sudan (French):																						
Katibougou	C														1							
Kayes	C			[4] 1																		
Koulikoro	C											1			2							
Segou	C																	1				

[1] Yellow fever has been reported in Santa Cruz Department, Bolivia, as follows: For the months of April, 1 case; May, 1 case; June, 2 cases.
[2] Yellow fever has also been reported in Brazil as follows: São Paulo State, no date given, 3 cases and 4 deaths. Mar. 24–31, 1936, 2 cases, 2 deaths.
[3] Yellow fever has also been reported in Colombia as follows: Boyaca Department, Jan. 4 to May 15, 9 deaths; Restrepo, June 4 to July 30, 7 deaths; Villavicencio, January, June, and July, 6 deaths; Santander Department, June and July, 6 deaths.
[4] Suspected.

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