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PREVALENCE OF COMMUNICABLE DISEASES IN THE UNITED STATES

June 20–July 17, 1937

The accompanying tables summarize the prevalence of eight important communicable diseases based on weekly telegraphic reports from State Health Departments. The reports from each State are published in the Public Health Reports under the section "Prevalence of Disease." Table 1 gives the number of cases of poliomyelitis reported in recent weeks of 1937 and in corresponding weeks of 1936 and 1935, by geographic regions, and table 2 gives the number of cases of eight important communicable diseases, including poliomyelitis, for the 4-week period ending July 17, the number reported for the corresponding period in 1936, and the median number for the years 1932–36.

DISEASES ABOVE MEDIAN PREVALENCE

The number of reported cases of influenza, meningococcus meningitis, poliomyelitis, and scarlet fever exceeded the median number reported for the corresponding period during the past 5 years.

Poliomyelitis.—The poliomyelitis situation in the South Central region, to which attention has been called in previous summaries, has grown more serious, and the incidence has also risen in other sections of the country. An increase of this disease is to be expected at this time of the year, but the current incidence is considerably higher than the seasonal median for the 5 preceding years.

Slightly more than two-thirds of the total of 771 cases occurring during the 4 weeks ending July 17 were reported from the two South Central regions, but every region except the New England and Middle Atlantic reported an excess over the median incidence.

An examination of the regional distribution in table 1 for 1937, 1936, and 1935 shows that the disease is more prevalent than last year in all regions except New England, where the incidence is about normal. From May 9 to the latest date for which reports had been received at the time this compilation was made (week ending July 24), there had been 486 cases reported from the West South Central region, as compared with 18 and 65 for the corresponding period in the

TABLE 1.—*Poliomyelitis cases reported in recent weeks of 1937, and in corresponding weeks of 1936 and 1935, by geographic regions*

Region and year	Week ending—										
	May 15	May 22	May 29	June 5	June 12	June 19	June 26	July 3	July 10	July 17	July 24
All States: *											
1937	22	18	21	36	38	69	82	158	256	275	324
1936	22	21	22	21	26	20	28	32	61	135	119
1935	29	19	38	50	51	101	146	160	156	191	229
New England:											
1937	0	1	0	1	1	3	1	3	7	4	15
1936	2	1	6	8	4	2	1	0	0	5	10
1935	0	0	2	1	3	1	4	5	3	4	18
Middle Atlantic:											
1937	1	3	1	4	1	4	3	5	7	12	9
1936	4	4	3	2	5	3	1	4	5	5	5
1935	1	1	3	3	5	2	13	14	11	24	23
East North Central:											
1937	4	4	4	3	1	5	5	5	14	32	44
1936	2	4	5	0	8	1	5	5	3	10	5
1935	3	1	1	2	3	5	5	5	6	8	4
West North Central:											
1937	1	0	0	3	2	2	3	4	25	14	28
1936	1	0	0	1	1	2	1	1	1	3	1
1935	2	1	0	2	3	2	0	0	4	1	4
South Atlantic:											
1937	1	1	3	2	5	6	12	14	14	18	16
1936	3	3	1	3	1	5	1	4	6	7	6
1935	4	4	21	31	21	60	78	90	87	103	124
East South Central:											
1937	6	3	7	11	10	30	32	53	42	33	90
1936	0	1	3	1	0	1	9	7	38	95	79
1935	3	1	1	3	1	3	2	7	7	18	11
West South Central:											
1937	5	3	1	5	14	11	17	63	135	141	91
1936	3	1	0	0	1	4	2	3	1	1	2
1935	7	6	3	4	6	7	9	4	6	4	9
Mountain: *											
1937	0	0	0	0	0	0	0	3	4	2	9
1936	3	2	0	1	3	0	1	0	0	0	1
1935	0	0	1	1	0	1	3	1	0	0	0
Pacific:											
1937	4	3	5	7	4	8	9	8	8	19	22
1936	4	5	4	5	3	2	7	8	7	9	16
1935	9	5	6	3	9	20	32	34	32	29	38

* Exclusive of Nevada, for which no reports are received.

years 1936 and 1935, respectively. For this same period the cases in the East South Central region totaled 317, as against 234 in 1936 and 57 in 1935. The highest incidence in this region in the current period was reported from Tennessee and Mississippi. The largest numbers of cases reported from other regions were from widely scattered States—California reported 85 cases; Ohio, 51; Missouri, 47; and North Carolina, 40.

In 1936 an outbreak of poliomyelitis started at about this time in Alabama and later spread into adjoining States in the East South Central region. In 1935 poliomyelitis was unusually prevalent at this time in North Carolina and Virginia, and later spread into States in the North Atlantic regions. In 1934 an epidemic occurred in California and other western States, and the total cases for this period numbered approximately 2,500. With the exception of 1934, the total of 1,299 cases in 1937 during the 11-week period included in the table is the highest incidence for this period in any of the 9 years for which data are available.

TABLE 2.—*Number of reported cases of eight communicable diseases in the United States during the 4-week period June 20–July 17, 1937, the number for the corresponding period in 1936, and the median number of cases reported for the corresponding period, 1932–36* [1]

Region	Current period	1936	5-year median	Current period	1936	5-year median	Current period	1936	5-year median	Current period	1936	5-year median
	Diphtheria			Influenza [2]			Measles [3]			Meningococcus meningitis		
U. S.[1]	1,249	1,232	1,592	1,269	2,691	1,068	22,810	24,029	27,149	296	362	145
N. Eng.	59	32	82	5	3	5	1,661	4,182	3,315	14	8	12
Mid. Atl.	241	294	346	19	36	20	8,422	10,052	8,899	81	72	34
E. N. C.	317	299	320	124	177	194	7,655	1,806	10,438	33	62	79
W. N. C.	53	108	165	322	118	77	341	504	1,166	19	16	13
S. Atl.	160	180	195	220	227	263	1,688	1,094	1,813	53	106	16
E. S. C.	82	84	110	60	109	110	967	149	436	43	46	13
W. S. C.	155	109	257	399	380	237	859	463	463	29	18	11
Mount.	41	32	45	52	74	23	559	504	504	3	9	9
Pac.	111	94	138	68	1,567	140	658	4,675	2,076	21	25	13
	Poliomyelitis			Scarlet fever			Smallpox			Typhoid fever		
U. S.[1]	771	256	256	8,017	9,638	7,531	479	534	482	1,770	1,240	2,132
N. Eng.	15	6	15	652	649	764	0	0	0	14	24	24
Mid. Atl.	27	15	39	2,381	2,858	2,686	0	2	0	132	115	151
E. N. C.	56	23	24	2,932	3,037	3,037	98	116	79	139	100	234
W. N. C.	46	6	11	751	1,244	439	188	220	97	114	78	108
S. Atl.	58	18	18	288	330	330	1	9	9	479	257	571
E. S. C.	160	149	19	105	135	139	5	4	4	345	267	428
W. S. C.	356	7	16	241	122	158	16	7	56	446	240	497
Mount.	9	1	2	217	382	164	101	149	39	48	56	62
Pac.	44	31	31	450	881	584	70	27	107	53	103	60

[1] 48 States. Nevada is excluded and the District of Columbia is counted as a State in these reports.
[2] 44 States and New York City. The median is for the years 1933–36 only; the data for 1932 are not comparable.
[3] 46 States. Mississippi and Georgia are not included.

Scarlet fever.—The scarlet fever incidence was low in relation to the high years of 1936 and 1935, but it was slightly above the median for the years 1932–36. The number of cases reported from the West North Central, West South Central, and Mountain States was somewhat above the seasonal expectancy; in other regions the incidence was relatively low.

Influenza.—The number of cases of influenza was slightly above the average for the four preceding years. The incidence in the West North Central, and West South Central areas, particularly in North Dakota and Texas, was a little above normal for this season of the year; in all other regions the situation was very favorable.

Meningococcus meningitis.—The incidence of meningococcus meningitis dropped considerably below that for the corresponding periods in 1936 and 1935, when the cases totaled 362 and 392, respectively. The number of cases reported for the current period was, however, more than twice the median number of cases for the years 1932–36. Although the incidence in the South Atlantic and South Central regions declined appreciably from that during the preceding 4-week period, the numbers of cases reported from those areas were still

relatively high. New York and Pennsylvania, in the Middle Atlantic region, reported 39 and 36 cases, respectively, for the current period, each figure being a little higher than normal for those States.

DISEASES BELOW MEDIAN PREVALENCE

The numbers of cases of diphtheria, measles, and typhoid fever were considerably below the median for the 5 preceding years, while the incidence of smallpox stood approximately at the median level. The incidence of measles was somewhat above the seasonal expectancy in the South Central regions, and the North Central and Mountain regions continued to report a relatively high incidence of smallpox.

Compared with the corresponding period in 1936, the current incidence of typhoid fever was about 45 percent in excess of last year's figure, and for the first time in recent years the downward trend of diphtheria in the country as a whole was interrupted; the number of cases (1,249) reported for the current period was slightly above that (1,232) for the corresponding period of 1936.

MORTALITY, ALL CAUSES

The average mortality rate for large cities during the 4-week period ended July 17, based on data received from the Bureau of the Census, was 11.0 per 1,000 inhabitants (annual basis). The rates for the separate weeks were 10.6, 10.4, 10.6, and 12.4. The average rate for this 4-week period in the 3 preceding years was 11.4, 11.3, and 11.1, regressively.

The sharp increase in the death rate in the last week of the current period was without doubt due to high temperatures in the New England and Middle Atlantic States. In some cities in those States the number of deaths was approximately twice the number reported during this period in 1936, while for others a 50-percent increase over last year was reported.

STUDIES ON CHRONIC BRUCELLOSIS

I. Introduction

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Surveys have recently been conducted in three widely separated sections of the United States to obtain such information as might be available concerning the prevalence of chronic brucellosis (chronic undulant fever). It is expected to report the results of these surveys in future papers of this series. The present paper gives a brief review

of the literature and presents evidence of the difficulties in diagnosis of the chronic form of brucellosis.

In his monograph on "Undulant Fever", Hughes (1897) mentioned cases in which sciatica continued for over a year and a half. He stated that prolonged cases do not return to their original state of health for 12 to 24 months; in many cases years are required for complete recovery.

A report of cases of chronic brucellosis appeared in the American literature subsequent to the return of the United States Army from the Philippines. Craig (1903, 1906) described three chronic cases, all of which had been treated unsuccessfully for malaria in the Philippines. He reported important observations on the chronic form of the disease. He stated that, in many cases, after the initial attack, a chronic infection results and is characterized by symptoms so slight as to be unrecognizable unless watched for and understood. He noted the low, uncharacteristic temperature curve, and remarked that, instead of being an aid to diagnosis, it is the reverse, and is the chief cause of mistaken diagnoses. He noted the absence of physical signs of disease.

In spite of the recognition of the chronic form of brucellosis in those early classics, the disease has not received the attention which it merits and is seldom considered in cases of chronic disease of obscure origin in the United States. Within recent years, however, it has been discussed by a number of writers.

In 1928 Baker reported a case of intermittent hydrarthrosis and moderate general debility in which the symptoms had continued for 8 months before the patient was hospitalized. *Brucella* were cultured from the blood and from the material obtained by puncture of each knee joint. Agglutination reactions with the homologous and other strains remained negative throughout the first 2 months of hospitalization.

In 1931 Amoss reported two cases of chronic brucellosis. In one case *Brucella* were found localized in the fallopian tube, in the glands of the meso-appendix, in the appendix, and in benign cysts of the ovaries. In the other case, in which symptoms persisted for many years, *Brucella* were cultivated from hemorrhagic ovarian cysts removed at operation, and 3 years later *Brucella* were cultivated from bile obtained by duodenal drainage and from the wall of the gall-bladder removed at operation. In this case there were no abnormalities found on physical examination or by X-ray examinations. The agglutination reaction remained negative throughout the course of the chronic disease.

In 1934 Cameron and Wells reported that, during the 3 preceding years, 46 cases of brucellosis were diagnosed in Washington County,

Md. Ten of the series continued to suffer ill effects of the disease for long periods. Six were confined to bed at more or less irregular intervals for more than 2 years.

In the 1935 literature on brucellosis there are several articles dealing with the chronic form of the disease. Thames stated that *Brucella* infection may commonly result in various disorders of long duration. He reported three cases, in two of which a marked specific intradermal reaction indicated brucellosis. In one of these cases, an agglutination titer of 1:80 offered additional evidence of *Brucella* infection. Marietta reported in detail a prolonged case of brucellosis, with spinal meningitis occurring during one stage of the disease, followed by bone involvement. Angle reported that, among the 100 cases of brucellosis which he had seen, two general types could be recognized—acute and chronic. In the latter, the symptoms persisted for long periods, with neurologic symptoms particularly manifest. Harris reported that he had seen 75 cases within the 2½ preceding years. All but 19 of these cases were chronic. Schoville reported a mild ambulatory case with normal or nearly normal temperature and negative agglutination titers, but markedly positive skin and phagocytic reactions. At various times the diagnoses were neurasthenia, undiscoverable focus of infection, and chronic neutropenic state.

In 1936 Hamman and Wainwright reported the results of their re-examination of 36 patients with long-continued low grade fever. An accurate diagnosis was finally made on 10 of them, among whom were 3 cases of brucellosis. Questionable diagnoses were made on 6 more patients among whom was 1 case of questionable brucellosis. Hamman and Wainwright give a detailed report of one of their cases of chronic brucellosis. The experience of their patient was typical of that of many who have consulted with the writer—prolonged ill health, examinations revealing no organic abnormality, a diagnosis of neurasthenia, and finally a diagnosis of *Brucella* infection.

DeJong reported a case of brucellosis in which prolonged meningoencephalitis developed after the disease had run an uneventful course for many months. *Brucella* were cultivated from the spinal fluid.

Recently McCullagh and Clodfelter reported four cases of encephalitis due to *Brucella* infection. Three of the cases were prolonged. One of them gave an agglutinin titer of 1:160. In the other two cases, the agglutination reaction was negative but intradermal reactions were strong.

From the above review of the literature, the conclusion may be drawn that chronic brucellosis is extremely difficult to diagnose correctly. Physical signs of disease, a significant temperature curve, and positive agglutination reaction may all be lacking throughout years of illness.

In a previous publication, the writer's reasons for thinking that cases of unrecognized chronic brucellosis may be common in this country were discussed. The facts may be summarized as follows:

1. *Brucella* infection is known to occur in domestic and experimental animals which appear to be healthy.
2. Milch animals are known to be commonly infected with *Brucella*, which are excreted in the milk.
3. Milk is consumed raw on farms, in villages, in small towns, and in some cities.
4. Acute *Brucella* infections in man can be diagnosed only by means of laboratory tests.
5. Laboratory tests to detect *Brucella* infection are made as a rule only in cases of definite fever, rarely in cases of mild chronic disease.
6. The severity of *Brucella* infection in man is known to vary from the acute disease to a form so mild that the subject is unaware of illness.
7. Chronic ill health of undetermined cause is widely prevalent.

Through the writer's own experience with chronic brucellosis which failed to receive the correct diagnosis for many years following an acute attack, and through the similar experiences of many sufferers with the chronic form of the disease with whom contact was made through correspondence or consultation, the conviction grew that *Brucella* infection might be responsible for much ill health in spite of the fact that it is rarely recognized in cases of chronic disease. The file of letters from chronic brucellosis patients revealed that almost invariably before the correct diagnosis of chronic brucellosis was made, the patient had suffered for a long time with mild disease of obscure origin. In about 25 percent of the cases the patients were physicians or members of the family of a physician—that is, they were individuals for whom an unsatisfactory diagnosis would be less likely to be allowed to stand than in the case of the average person. In several cases the lay patient was the first to suggest undulant fever to the doctor, either because the symptoms were recognized as the same in mild form as were suffered at an earlier time during an acute attack, or the idea was obtained through the reading of popular articles about brucellosis.

In one case the patient spent a consecutive period of more than 1 year in three different hospitals, finally receiving the combined attention of the staff of a well-known teaching hospital, and yet diagnosis failed until another malady was discovered necessitating an operation which revealed also the focus from which *Brucella* were cultivated. A similar incident was reported to the writer (personal communication) to have occurred in a teaching hospital in London.

The following résumé of the correspondence in regard to one case is illustrative of many cases:

A woman wrote that her husband, who was in the habit of drinking about 3 quarts of raw milk daily, had been in ill health for about 15 months, but had con-

tinued with his work. He had consulted several physicians, none of whom was able to find any cause for complaint. The patient in some way arrived at a vague conviction that he was being poisoned by the milk he was drinking. His wife, who was a nurse, went to the public library and read everything she could find on diseases caused by drinking raw milk, including an article on brucellosis. Thus she conceived the idea that her husband's trouble might be brucellosis. She wrote asking for suggestions. This patient, who lived near Seattle, Wash., was advised to consult Senior Surgeon G. C. Lake, of the United States Marine Hospital, Seattle, who has had a wide experience with brucellosis in its various forms. On the basis of history, symptoms, and positive agglutination reaction, Dr. Lake made a diagnosis of brucellosis.

In another case, ill health continued for almost 20 years. In 1919 a diagnosis of tuberculosis was made. Six months later, and repeatedly since that time, a diagnosis of chronic nervous exhaustion was made. In 1936 the patient developed a severe attack of typical acute brucellosis, not recognized at the time. Since the acute attack the patient has been confined to bed almost continuously. Finally, in 1937, a culture was obtained from the urine and sent to the National Institute of Health for identification. It proved to be *Brucella melitensis* variety *abortus*. During these 20 years of ill health, brucellosis seems to have been considered only once before, when an agglutination test was made, which was interpreted as negative.

Although there is no test which will give a definite diagnosis, the evidence appeared to demand an investigation to determine to what extent *Brucella* infection may be responsible for the many cases of chronic ill health for which satisfactory diagnoses cannot be made. It seemed worth while to investigate the incidence of the disease in several sections of the country, using such tests as were available. Investigations were therefore conducted by the United States Public Health Service in San Antonio, Tex., Charlotte, N. C., and Kansas City, Kans. These cities were chosen because they represent sections of the United States in which the sources of infection differ according to the different proportions of cattle, hogs, and goats in their respective localities. The percentages of raw milk sold in these cities is as follows: Charlotte, 81 percent; Kansas City, 45 percent; San Antonio, 36 percent.

The investigators began their studies by presenting to the local physicians the plan and purpose of their investigation, requesting an opportunity to cooperate in cases of disease in which the diagnosis was uncertain. In all three cities this cooperation was generously given. In each case in which the cooperation of the investigator was requested, examinations were made for agglutination, opsono-cytophagic and intradermal reactions, as well as for suggestive history and symptoms.

Cultural studies on some of the suggestive cases are now in progress. The data from these studies will be analyzed for the information they

may yield on the prevalence of chronic brucellosis and for the indications they may give on the significance of the specific tests.

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CASE RECORDS AS AN INDEX OF THE PUBLIC HEALTH NURSE'S WORK[1]

By Helen Bean, *Associate Public Health Nursing Analyst*, and Emily Hankla, *United States Public Health Service*

The work of a nurse on the staff of a county health department may be divided into two broad categories—that which she performs in the capacity of an assistant and that which she does largely on her own initiative. The first division of her activities includes attendance at clinics for tuberculosis and venereal disease, at maternity and child health conferences, and participation in school medical inspection. When carrying out these functions the separate identity of the nurse disappears, because her work and techniques are fused with those of the physician. Clinic visits, physical examinations, or similar services are reported with the patient as the central figure. Nurse participa-

[1] From the Division of Public Health Methods, National Institute of Health, in cooperation with the Division of Domestic Quarantine.

tion in such joint enterprises can be expressed chiefly by the amount of time consumed during a report period.

In the performance of activities for which she is primarily responsible, the county health department nurse may render to groups educational services which cannot be readily assigned to the individual beneficiary. Neither can these efforts be rightfully multiplied by the number in attendance. Group and community work on the part of the nurse should therefore be expressed on a basis of time involved, related perhaps to the total number of individuals served.

Insofar as records portray the activities of a nurse, she can be identified most easily when, as a lone worker, she interviews individual patients on matters pertaining to personal health. Such service forms the basis for most accounts of public health nursing. Quite important, therefore, is consideration of the recording policies in different health departments and the extent to which such policies are carried out in actual practice.

During the course of any representative day, a nurse will make professional contact with several individuals. Almost without exception she enters in consecutive order on a form, commonly spoken of as the "daily report", the name and address of each contact together with some classification of the service. Beyond this initial step in record keeping, the practice may vary between health departments, depending in large part on local policy and to some extent on the faithfulness with which the nurses observe instructions.

When a nurse is confronted with a condition that suggests the necessity for a permanent office record or the desirability of further attention, it is common practice to open an individual or case record. After the case record has been opened, an account of each contact with the individual is made on this as well as on the current daily report.

From a local standpoint the system of record keeping just described might be regarded as common sense practice and, if thoroughly understood, should give rise to no complications unless analyses are undertaken which require more data than may be found on the daily report. Occasions for analysis, however, are becoming more frequent. The alert administrator certainly can use more than a gross summary of visits. Even the simple tabulations required for making reports to governmental agencies that contribute to local budgets and for completing various devices used in the appraisal of local health service necessitate some description of the individual and the service. As a

result, instructions [2] commonly specify that credit can be given only for service that is entered in a formal way on case records. It is quite apparent that a measure of the volume of service obtained by summating all activities which were entered on the daily reports of nurses may differ considerably from the amount that would be revealed by a count of only those services that were also recorded on individual case cards.

Certain studies which the United States Public Health Service is making of county health department practice afforded an opportunity for determining the nature and extent of these differences. In each of three counties considered, health service is under the direction of a full-time medical health officer. One county, which will be referred to as county A, employed only a single staff nurse; the others, county B and county C, each had 5 nurses. Additional service, equivalent to the full time of one person, became available in each county by engaging local nurses from unemployment rolls. Throughout the paper, these individuals are referred to as C. W. A. nurses. The population load per nurse was about as follows: County A, 13,265; county B, 10,435; and county C, 6,810.

Basically the nursing service of the three counties operates along similar lines. It is designed to support the commonly accepted activities of a county health department in matters pertaining to the control of acute communicable diseases, and tuberculosis, and to the promotion of hygiene, especially for the maternity and child population. The approach used is one of education with actual nursing care being given only occasionally and then for demonstration purposes.

The record forms under consideration are those used by each nurse to describe the service and to guide her in the future handling of the clients. Records, such as those of clinic and school health work, which may portray joint activity of physician and nurse, and accounts of group activities are excluded. Since forms of the type under consideration were designed primarily for describing home visits, only conditions handled in this manner will be studied in relation to recording practice. No personal-record form had been provided for

[2] Recording of local health work. By W. Frank Walker and Caroline Randolph. The Commonwealth Fund, New York City, 1935.

Appraisal form for city health work, third edition, 1929. The American Public Health Association, New York City.

Appraisal form for rural health work, second edition, 1932, The American Public Health Association, New York City.

Interchamber city health conservation contest—Fact-finding schedule, 1937. United States Chamber of Commerce, Washington, D. C.

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Tabulation of health department services, Public Health Reports, vol. 51, no. 36, Sept. 4, 1936. (Reprint No. 1768.)

miscellaneous work, such as social service and transportation of patients; hence, these activities are excluded.[3]

It may be well to emphasize that nurses in the study counties claimed to be following the methods of record keeping above described. They made a brief entry on the daily report for every individual who was the recipient of a personal service. A case card was also opened when the condition was considered of especial importance to the department, and under other circumstances if a continuing type of service was contemplated.

The analyses which follow are designed primarily to disclose differences between the amounts of service that were entered on the daily reports and on the individual case cards. Variations in findings are studied only to determine the possible influence of factors such as health department policy, condition for which service was rendered, frequency of visits, and the behavior of individual nurses on actual recording practice.

PROPORTION OF TOTAL CLIENTS INCLUDED ON CASE RECORDS

Home services in relation to maternity, tuberculosis, communicable disease, or health supervision were entered on the appropriate case records for 70 percent of the clients in counties A and C and for 60 percent in county B (table 1). Accordingly, if the quantity of home service should be measured by a count of case records alone, the nurses in these counties would receive credit for about two-thirds of their patients. Expressed in another way, services to one-third of the cases seen in the home would be lost if an appraisal or analysis of the work of these health departments were made according to the manner prescribed.[4]

The actual number of cases is, however, only a rough measure of the total volume of the nurse's service, for one case may have represented a temporary condition and have received a single visit, while another may have been seen on several occasions over a long period of time. Further analyses are indicated to elucidate such points as the proportion of services included on the individual case cards, the extent to which conditions of various types were entered on the appropriate records, and possible differences between the cases described on individual cards and those listed only on the daily report.

[3] In one of the counties, home visiting to school children for the correction of physical defects occasionally was recorded on school cards and not on separate case records, hence credit for these few visits is not given.

[4] See footnote 2.

TABLE 1.—*Number of cases visited by the nurses in each of 3 counties during a 12-month period and percentage of these on case records*

County	Total cases served	Percent on case records
County A	1,027	69.9
County B	2,620	60.3
County C	5,862	70.0

MATERNITY RECORDS

Under what contrasting circumstances were maternity records opened or omitted? The outstanding difference lay between cases first carried for antepartum or for postpartum service. In each of the counties case cards were opened for more than 90 percent of all persons receiving antepartum service, whereas this practice was followed for a much smaller percentage of those carried exclusively as postpartum cases (table 2).

TABLE 2.—*Number of antepartum and postpartum maternity cases visited by the nurses in each of 3 counties and percentage of these on case records*

Period of first contact with nurse	Total cases served			Percent on case records		
	County			County		
	A	B	C	A	B	C
Total	79	259	154	96.2	63.3	84.4
Antepartum	62	128	110	96.8	94.5	92.7
Postpartum only	17	131	44	94.1	32.8	63.6

The prenatal cases for which personal records were made differed from those entered only on a daily report principally in that they had more visits. Whereas only one case without a record had a second visit, about a third of the recorded cases in county B, slightly over a third in county A, and 43 percent in county C received as many as three or more visits.

As previously mentioned, the recording practice for maternity cases with postpartum visits only was not as complete or uniform as for cases with antepartum service. The wide variation between the counties in recording postpartum service seems to have been closely related to a difference in the use of the word "postpartum." According to common practice, the postpartum state is limited to a period which does not extend beyond 2 months after confinement; but it seems probable that services of a type which in the other counties would not have been considered as postpartum were so entered on the reports in county B. Most of the postnatal cases in counties A and C were visited within the first few weeks after confinement, while in county B 60 percent were visited during the second month after child-

birth. For persons given the initial visit during the first month after confinement, individual records were made out in equal proportions by counties B and C, while for those first visited during the second month of the postpartum period, case records were kept for nearly five times as many in county C as in county B.

In review, it seems that a study of the maternity records would have given a fair quantitative picture of prenatal service. The few cases which were entered only on the daily report, with a single exception, received only one visit. For maternity patients first visited during the postpartum period, individual records were seldom opened except when several visits were made.

TUBERCULOSIS RECORDS

Services to cases, suspects, contacts, and others visited in relation to tuberculosis were on the whole individually recorded for almost two-thirds of the clients. The percentages with case cards varied from 57 percent in counties B and C to 86 percent in county A. This variation between counties is surprising, since it is generally expected that individual records would have been prepared for all actual cases of tuberculosis, all suspects, and at least those contacts who were clearly associated with diagnosed cases.

With these differences in recording, the following questions arise: What types of individuals were entered on the case records? Was performance consistent in the three counties?

TABLE 3.—*Number of tuberculosis cases, suspects, contacts, and others visited by nurses and percentage of these on case records*

Classification of clients	Total clients served			Percent on case records		
	County			County		
	A	B	C	A	B	C
Total	224	568	131	86.2	57.4	56.5
Case	65	216	34	100.0	95.4	67.6
Suspect	89	70	35	87.6	88.6	51.4
Contact	56	212	53	83.9	27.4	58.5
Nontuberculous	0	39	0	(1)	0.0	(1)
Diagnosis unknown	14	31	9	21.4	0.0	22.2

[1] Indeterminate.

The desirable practice of making an individual record for every case of tuberculosis was followed only in county A. Individual records were opened for over 95 percent of the patients listed as tuberculosis cases by county B nurses. The 10 cases entered only on the daily reports were unaccompanied by any specific information regarding the activities of the nurse. It seemed apparent, however, judging from the brevity of the entries and the lack of return visits, that a continuing type of service was neither given nor planned.

Considerable departure from the usual policy of recording actual cases of tuberculosis occured in county C, where 11, or approximately one-third, of the 34 actual cases served, were entered on the daily report only. According to notations on the report, these individuals were given the following services: Transportation to the tuberculosis clinic, information regarding the availability of sanatorium care, and delivery of messages. In contrast, when case records were opened, a more complete type of service was given.

Less frequently recorded than cases were those clients classed as suspects or contacts of tuberculosis. This was especially true in county B where about one-half of the suspects and contacts had individual records. The nurses in this county often visited homes solely to read tuberculin reactions on contacts. The result of the test may have been entered on the clinical record, but the visit appeared on the daily record only, thus accounting in part at least for the fact that only 27 percent of contacts had individual nursing records.

It seems evident that the nurse was more likely to open an individual case record when contemplating a continuing type of service. The proportion of clients with three or more visits who appeared on case records was larger than the proportion of those with one or even two visits. This statement applies to contacts, suspects, and cases in each of the three counties. Altogether there were 21 actual cases of tuberculosis without case records; and of these, only three received second visits.

Should the quantity of tuberculosis service in the three counties be measured by a count based on the individual case records, about 64 percent of the total persons served in the three counties would be included. In this group would be found more than 90 percent of the diagnosed cases. The proportion of visits included in the count would be higher than the proportion of individuals covered since patients with three or more visits were recorded on case cards with greater frequency than those receiving one or two visits.

COMMUNICABLE DISEASE RECORDS

Individual case records were opened for approximately 85 percent of the clients included in the communicable disease service. The proportions, however, differed widely for the three counties, as 71 percent of the clients in county A, 27 percent in county B, and 93 percent in county C were entered on case records. These percentages refer to all the beneficiaries of the communicable disease service, including actual cases, suspects, and contacts. The proportion of actual cases recorded is greater than the percentage of total clients with individual records, but even among the actual cases, the differences in the recording practices of the counties stand out (table 4).

TABLE 4.—*Number of communicable disease cases, suspects, and contacts visited by nurses and percentage of these on case records*

Classification of clients	Total clients served [1]			Percent on case records		
	County			County		
	A	B	C	A	B	C
Total	234	472	3,508	70.5	26.5	92.7
Case	194	202	3,347	71.6	59.4	97.0
Suspect	19	35	67	89.5	8.6	6.0
Contact	21	221	71	42.9	0.9	0
Unknown	0	14	23	(2)	0	0

[1] Excluding individuals served in the home for 2 or more communicable disease conditions during the year.
[2] Indeterminate.

For suspects and contacts the differences in recording practice are even more accentuated. The nurses of county A kept individual records for a higher percentage of persons suspected of having a communicable disease than for the actual cases. They also opened individual cards for 43 percent of those in contact with actual cases. Practice in the other two counties was decidedly different in that case records were opened for less than 10 percent of the suspects and for virtually none of the contacts.

In order to compensate for possible differences which disproportionate incidence of communicable diseases might make in a picture of recording practice, the cases were placed in four diagnostic categories. These categories were determined by the public health importance of the conditions and by the differences in administrative procedure. Scarlet fever, diphtheria, and typhoid fever were grouped together as diseases of a serious nature. Measles, whooping cough, mumps, and chicken pox were placed in the second group, principally because each health department seemed to have followed essentially the same policy with regard to the four diseases. Scabies, impetigo, ringworm, conjunctivitis, and similar minor infections formed the third group. Diseases rarely visited by the nurses were omitted.

TABLE 5.—*Distribution of cases of communicable disease according to disease classification and percentage in each grouping on case records*

Type of disease	Total cases served [1]			Percent on case records		
	County			County		
	A	B	C	A	B	C
Total	188	176	3,341	70.7	66.5	97.2
Diphtheria, scarlet fever, and typhoid fever cases	21	113	153	38.1	97.3	95.4
Measles, whooping cough, mumps, and chicken pox cases	112	21	3,126	74.1	14.3	99.0
Scabies and other minor infections	55	42	62	76.4	9.5	6.5

[1] Cases of certain diseases which were rarely visited by the nurses are excluded from this total.

It will be seen that communicable disease records were opened for most of the actual cases of the three major diseases registered for nursing service in counties B and C. In county A, however, 13 of the 21 cases visited were merely listed on the daily report as cases. Perhaps this practice reflects the influence of the health department's policy which limited the nurses' service to a maximum of two visits for major communicable diseases. The 7 cases without individual records in county C were visited only for quarantine release. Four were released on the first visit, and 3 had return visits for additional release cultures. In contrast, cases on records were usually quarantined or placarded and must therefore have been brought under the supervision of the nurse sufficiently early in the course of the disease for return visits to have been planned. The cases without individual records in the other counties were merely listed on the daily report with no information concerning services.

The greatest variation in the three nursing units was shown in recording cases of measles, whooping cough, mumps, and chicken pox. Ninety-nine percent of the 3,126 cases of these diseases had individual records in county C. In county A the proportion was also fairly high in that 74 percent of the 112 cases appear on separate cards, but in county B only 3 of 21 cases were handled in this manner.

The high proportion of cases of minor contagion with individual records in county C may be the result of a regulation of the State health department which required placarding and releasing in cases of measles and whooping cough as well as in other communicable diseases. Such regulations were not applied in the other two counties.

One difference between communicable disease clients for whom case records were opened and those listed only on the daily reports was consistent throughout; those with case records had a definitely larger number of visits. This was true for cases, suspects, and contacts in each of the foregoing disease classifications. Individual records were opened for every recipient of three or more visits in county A, for all but 9 in county C, and for all the actual cases in county B. In county A there were only two clients who received return visits for whom there were no case records. These two were diphtheria cases, and the purpose for which they were first visited was to release the family from quarantine.

In summary, approximately 85 percent of all communicable disease clients of the home nursing service had individual records; but there was extreme variation in recording practice of the three counties, both in regard to the type of client and in regard to the type of communicable disease. In one county, for instance, minor skin diseases were entered on individual case cards with greater frequency than were major communicable diseases, and suspects relatively more often than cases.

With such variations in recording practice, any count of the individual case records for communicable disease would include decidedly different types of cases for the several counties and varying proportions of the individuals visited. Consequently, if a comparison of procedures directed toward the control of communicable diseases should be based on a study of case cards alone, the results would be warped by dissimilarities of recording practice.

HEALTH SUPERVISION RECORDS

Health supervision case cards were opened for about half of the persons given home services other than maternity, tuberculosis, or communicable disease. The percentage with case records in each county was 58 for county A, 73 for county B, and 31 for county C (table 6).

TABLE 6.—*Number of cases given health supervision in the home and percentage on case records according to age groups*

Age group	Total number of cases			Percent on case records		
	County			County		
	A	B	C	A	B	C
Total	490	1,321	2,069	58.0	73.0	31.5
Infant	69	458	432	88.4	82.3	76.6
Preschool	89	589	386	60.7	85.7	16.3
School	223	169	966	44.4	35.5	18.2
Adult	109	105	285	64.2	21.0	28.8

The age of the individual seemed to be an important factor in determining whether or not a case record would be opened when a health supervisory visit was made. More than 75 percent of the infants visited in each county were entered on individual records; but for the other age groups the practice within the separate counties was very inconsistent. The percentage of preschool health supervision cases with individual record cards varied from 86 to 16. In county B, where the preschool services were most often recorded, adult hygiene services were least frequently entered on case cards. With such variations in recording, no comparable estimate of the relative amount of service rendered to the several age groups in the separate counties can be obtained from a count of the case cards.

Individual records were opened with greatest frequency, in each of the three counties, when a sustained type of service was contemplated. Those cases with return visits had a higher proportion of individual records than those with only one visit. This increase in individual recording with increase in number of visits occurred irrespective of age.

The recording practice of individual nurses within the specific counties was much more varied for the hygiene services than for the types of service discussed earlier in the paper. For other services the practice between counties differed, but, within the staffs, nurses followed about the same procedure. In relation to health supervision, however, the behavior of separate nurses was sufficiently variable to merit consideration. By referring to table 7 one may note wide individual differences, especially for county B. Even so, the contrast between counties B and C was greater than the contrast between specific members of each nursing staff.

TABLE 7.—*Variation in the recording practice of individual nurses for cases given health supervision in the home*

Nurses	Total number of cases [1]			Percent on case records		
	County			County		
	A	B	C	A	B	C
Health Department nurses:						
One	182	98	377	78.6	60.2	32.4
Two	----------	167	331	----------	65.9	35.3
Three	----------	219	180	----------	44.3	33.9
Four	----------	99	369	----------	43.4	27.6
Five	----------	32	291	----------	78.1	32.0
C. W. A. nurses	210	534	164	31.9	94.4	29.3

[1] Excluding clients served by more than 1 nurse.

In general, visits for health supervision appear on individual record cards less frequently than visits for any other of the services rendered by the nurses, and with less consistency. Approximately one-half of the individuals served had case cards. Services to infants were entered on individual records in slightly over three-fourths of the cases. Less of the preschool and still less of adult and school health supervision was included on the special cards. The individually recorded group included a large proportion of those cases with continued or repeated service, and this was consistently true regardless of other factors. According to these data, a count of the case cards would yield an index of the volume of service rendered infants, for approximately four-fifths of those served had case cards. But for the other ages no such index could be obtained because the recording practice in the three counties was so widely divergent that number of case cards has a different relation to the volume of the service in each.

SUMMARY

A consideration of record keeping for services in relation to maternity, tuberculosis, communicable disease, and health supervision by

the nurses of three representative county health departments showed that from 60 to 70 percent of all recipients of such services in the home were entered on individual case records. Briefly, it might be said that cases included on individual records were those most emphasized by the county health department program and those for whom a continuing type of service was initiated.

A count of case records for the three counties combined would have encompassed over 90 percent of the prenatal patients, about the same percentage of the actual cases of tuberculosis, and approximately 80 percent of the infants who received health supervision from the nurses. Maternity cases first seen in the postpartum period, tuberculosis suspects and contacts, and hygiene cases in the preschool, school, and adult age groups were included in the case records less frequently and in varying degrees—in some instances reaching as low as zero. The extent to which different types of communicable disease services were entered on case records in the separate counties varied widely, apparently being influenced by local policy. When comparisons could be made of recording practice in relation to specific services, the findings indicated that, as a rule, individuals without case records were visited for conditions of a transitory nature or were given services which, though happening on separate occasions, were incidental to the work of the physician, clinic, or hospital.

A considerably greater proportion of visits than of individuals would be included by a count of case records alone, since patients with three or more visits were entered on case cards with greater frequency than those receiving one or two visits.

The recording of various types of services, with the exception of health supervision work, was carried out in a similar manner by the nurses in each health department, thus indicating that the policy of the health department was a more important factor than behavior of the individual nurse in determining recording practice.

Unless the regulations governing reports are changed, nurses now find themselves in a situation where they may select either of two courses: They may, by assuming the risk of presenting only a part of their work, retain a system by which they are granted considerable latitude in choosing the cases and situations for which individual records are to be opened. The other alternative is to open a special record for every individual, irrespective of the necessity for such formality, and thus be assured of full credit for every service regardless of how trivial it may be.

REPORT ON MARKET-MILK SUPPLIES OF CERTAIN URBAN COMMUNITIES

Compliance of the Market-Milk Supplies of Certain Urban Communities With the Grade A Pasteurized and Grade A Raw Milk Requirements of the Public Health Service Milk Ordinance and Code (as Shown by Compliance (not Safety) Ratings of 90 Percent or More Reported by the State Milk-Sanitation Authorities During the Period July 1, 1935, to June 30, 1937)

The accompanying list gives the eighth semiannual revision of the list of certain urban communities in which the pasteurized market milk is both produced and pasteurized in accordance with the Grade A pasteurized milk requirements of the Public Health Service Milk Ordinance and Code, and in which the raw market milk sold to the final consumer is produced in accordance with the Grade A raw milk requirements of said ordinance and code, as shown by ratings of 90 percent or more reported by State milk-sanitation authorities.

These ratings are not a complete measure of safety, but represent the degree of compliance with the Grade A requirements of the Public Health Service Milk Ordinance and Code. Safety estimates should also take into account the percentage of milk pasteurized, which is given in the following tables.

The primary reason for publishing such lists from time to time is to encourage the communities of the United States to attain and maintain a high level of excellence in the public health control of milk supplies.

It is emphasized that the Public Health Service does not intend to imply that all communities not on the list are not provided with high-grade milk supplies. Some communities which have high-grade milk supplies are not included because arrangements have not been made for the determination of their ratings by the State milk-sanitation authority. In other cases the ratings which have been determined are now more than 2 years old and have therefore lapsed. In still other communities with high-grade milk supplies there seems, in the opinion of the community, to be no local necessity nor desire for rating or inclusion in the list, nor any reasonable local benefit to be derived therefrom.

The rules under which a community is included in this list are as follows:

(1) All ratings must have been determined by the State milk-sanitation authority in accordance with the Public Health Service rating method, based upon the Grade A pasteurized-milk and the Grade A raw milk requirements of the Public Health Service Milk Ordinance and Code.

(2) No community will be included in the list unless both its pasteurized milk and its raw milk ratings are 90 percent or more, provided

that communities in which only raw milk is sold will be included if the raw milk ratings are 90 percent or more.

(3) The rating used will be the latest rating submitted to the Public Health Service, but no rating will be used which is more than 2 years old.

(4) Occasional surprise checks will be made of the rating methods used by the State, and discounts will be applied if State ratings are found to be more than 5 percent too high.

Communities are urgently advised to bring their ordinances up to date at least every 5 years, since ratings will be made on the basis of later editions if those adopted locally are more than 5 years old.

Communities which are not now on the list and desire to be rated should request the State milk-sanitation authority to determine their ratings and, if necessary, should improve their status sufficiently to merit inclusion in the list.

Communities which are now on the list should not permit their ratings to lapse, as ratings more than 2 years old cannot be used.

Communities which have not adopted the Public Health Service Milk Ordinance may wish to give thoughtful consideration to the advisability of doing so. It is obviously easier to satisfy the requirements upon which the rating method is based if these are included in the local legislation.

Communities which are enforcing the Public Health Service Milk Ordinance, but which have not yet been admitted to the list, should determine whether this has been the result of failure to enforce the ordinance strictly or failure to bring the ordinance up to date.

State milk sanitation authorities which are not now equipped to determine municipal ratings are urged, in fairness to their communities, to equip themselves as soon as possible. The personnel required is small, as in most States one milk specialist is sufficient for the work.

The inclusion of a community in this list means that the pasteurized milk sold in the community, if any, is of such a degree of excellence that the weighted average of the percentages of compliance with the various items of sanitation required for Grade A pasteurized milk is 90 percent or more and that, similarly, the raw milk sold in the community, if any, so nearly meets the requirements that the weighted average of the percentages of compliance with the various items of sanitation required for Grade A raw milk is 90 percent or more. However, high-grade pasteurized milk is safer than high-grade raw milk, because of the added protection of pasteurization. To secure this added protection, those who are dependent on raw milk can pasteurize the milk at home in the following simple manner: Place the milk in an aluminum vessel on a hot flame and heat to 155° F., stirring constantly; then immediately set the vessel in cold water and continue stirring until cool.

TABLE 1.—*Communities in which all market milk is pasteurized. In these communities market milk complies with the Grade A pasteurized milk requirements of the Public Health Service Milk Ordinance and Code to the extent shown by pasteurized milk ratings of 90 percent or more* [1]

Community	Percentage of milk pasteurized	Date of rating
MINNESOTA		
Winona	100	Oct. 30, 1936
NORTH CAROLINA		
Greenville	100	Dec. 16, 1936
Princeville	100	Nov. 12, 1936
Sanford	100	June 22, 1937
Tarboro	100	Nov. 12, 1936

[1] Note particularly the percentage of milk pasteurized in the various communities listed in these tables. This percentage is an important factor to consider in estimating the safety of a city's milk supply.

TABLE 2.—*Communities in which some market milk is pasteurized. In these communities the pasteurized market milk complies with the Grade A pasteurized milk requirements and the raw market milk complies with the Grade A raw milk requirements of the Public Health Service Milk Ordinance and Code to the extent shown by pasteurized and raw milk ratings, respectively, of 90 percent or more* [1]

[NOTE.—All milk should be pasteurized or boiled, either commercially or at home, before it is consumed, See text for home method.]

Community	Percentage of milk pasteurized	Date of rating
ALABAMA		
Huntsville	82	Dec. 16, 1936.
Montgomery	27	Dec. 4, 1936.
Tuscaloosa	77	Dec. 13, 1935.
ARKANSAS		
Eldorado	32	October 1936.
Fort Smith	28	June 1937.
Jonesboro	29	Do.
Little Rock	33	November 1936.
Pine Bluff	31	June 1937.
Texarkana	39	Do.
FLORIDA		
Coral Gables	89	May 1937.
Fort Lauderdale	64	Do.
Miami	89	Do.
ILLINOIS		
Chicago	99.7	Jan. 22, 1937.
KANSAS		
Junction City	31	June 1936.
Lawrence	48	May 1936.
Topeka	59	Do.
Wichita	58	December 1935.
KENTUCKY		
Ashland	86	June 1936.
Bowling Green	48	April 1937.
Glasgow	67	Do.
Henderson	34	May 1936.
Louisville	96	March 1936.
MINNESOTA		
Albert Lea	97	Oct. 23, 1936.
Little Falls	55	Oct. 23, 1935.
MISSISSIPPI		
Greenville	26	Aug. 29, 1935.
McComb	8	Jan. 9, 1936.
MISSOURI		
Columbia	41	Mar. 3, 1936.
Hannibal	31	May 29, 1936.
Moberly	49	May 1, 1936.
Sedalia	20	Apr. 10, 1936.
NEW MEXICO		
Las Cruces	53	Nov. 13, 1935.
NORTH CAROLINA		
Bryson City	50	Jan. 19, 1937.
Charlotte	34	June 10, 1937.
Clinton	29	Dec. 17, 1936.
Durham	89	Apr. 3, 1937.
Fayetteville	52	Sept. 30, 1936.
Franklin	68	Jan. 20, 1937.
Hope Mills	40	Sept. 30, 1936.
Kinston	16	Apr. 10, 1936.
Morehead City	61	Dec. 3, 1936.
Oxford	7	May 20, 1937.
Rocky Mount	35	Dec. 19, 1936.
OKLAHOMA		
Bartlesville	32	Mar. 20, 1936.
Blackwell	48	June 3, 1936.
Muskogee	59	January 1936.
Oklahoma City	70	December 1935.
Okmulgee	57	June 25, 1937.
Tulsa	72	Apr. 22, 1937.
OREGON		
Astoria	59	June 5, 1937.
Portland	77	October 1936.

[1] Note particularly the percentage of milk pasteurized in the various communities listed in these tables. This percentage is an important factor to consider in estimating the safety of a city's milk supply.

TABLE 2.—*Communities in which some market milk is pasteurized. In these communities the pasteurized market milk complies with the Grade A pasteurized milk requirements and the raw market milk complies with the Grade A raw milk requirements of the Public Health Service Milk Ordinance and Code to the extent shown by pasteurized and raw milk ratings, respectively, of 90 percent or more* [1]—Continued

[NOTE.—All milk should be pasteurized or boiled, either commercially or at home, before it is consumed. See text for home method.]

Community	Percentage of milk pasteurized	Date of rating	Community	Percentage of milk pasteurized	Date of rating
TENNESSEE			**TEXAS—contd.**		
Dyersburg	21	May 13, 1937.	Midland	51	Mar. 23, 1937.
Knoxville	69	Apr. 16, 1937.	Port Arthur	41	June 1937.
Memphis	84	June 3, 1937.	San Angelo	60	Apr. 17, 1937.
Union City	33	May 21, 1936.	San Antonio	70	Apr. 16, 1937.
TEXAS			Seguin	51	June 8, 1937.
			Sweetwater	53	Mar. 18, 1937.
			Texarkana	41	Mar. 24, 1937.
Abilene	77	Mar. 17, 1937.	Tyler	60	January 1936.
Amarillo	62	July 3, 1937.	Victoria	13	February 1936.
Austin	35	Dec. 19, 1935.	Waco	31	Sept. 20, 1935.
Ballinger	50	Mar. 2, 1936.	Wichita Falls	79	May 26, 1936.
Beaumont	52	June 1937.	**VIRGINIA**		
Big Spring	27	Mar. 22, 1937.			
Brownwood	17	June 26, 1936.			
Corsicana	19	Mar. 12, 1937.	Pulaski	39	May 28, 1937.
Dallas	75	May 3, 1937.	**WASHINGTON**		
El Paso	69	Apr. 7, 1937.			
Fort Worth	80	February 1937.			
Gainesville	46	Sept. 6, 1935.	Vancouver	31	Oct. 9, 1936.
Galveston	75	August 1936.	**WEST VIRGINIA**		
Kerrville	72	May 8, 1936.			
Livingston	20	March 1936.			
Lubbock	32	July 10, 1935.	Huntington	43	Aug. 5, 1936.

[1] Note particularly the percentage of milk pasteurized in the various communities listed in these tables. This percentage is an important factor to consider in estimating the safety of a city's milk supply.

TABLE 3.—*Communities in which no market milk is pasteurized, but in which the raw market milk complies with the Grade A raw milk requirements of the Public Health Service Milk Ordinance and Code to the extent shown by raw milk ratings of 90 percent or more* [1]

[NOTE.—All milk should be pasteurized or boiled, either commercially or at home, before it is consumed. See text for home method.]

Community	Date of rating	Community	Date of rating
ALABAMA		**MISSOURI**	
		Ash Grove	July 9, 1936.
Demopolis	Nov. 22, 1935.	**NORTH CAROLINA**	
Scottsboro	Dec. 31, 1935.		
Stevenson	Dec. 31, 1935.		
Sylacauga	Dec. 6, 1935.	Ahoskie	June 25, 1937.
Talladega	Dec. 6, 1935.	Angier	May 18, 1936.
York	Nov. 20, 1935.	Aulander	June 24, 1937.
		Buies Creek	Nov. 9, 1936.
KANSAS		Canton	June 29, 1937.
Horton	Sept. 1, 1936.	Cary	Apr. 23, 1936.
Sabetha	Sept. 25, 1936.	Coats	May 18, 1936.
		Dunn	May 18, 1936.
MISSISSIPPI		Erwin	May 18, 1936.
		Fairmont	May 28, 1936.
Brookhaven	May 31, 1937.	Lillington	Nov. 9, 1936.
Durant	June 9, 1937.	Lumberton	May 28, 1936.
Magnolia	Jan. 10, 1936.	North Wilkesboro	Nov. 11, 1936.
Ocean Springs	Sept. 5, 1935.	Pinehurst	Nov. 7, 1936.
Pascagoula	Sept. 5, 1935.	Raeford	May 29, 1936.
Yazoo City	June 8, 1937.	Red Springs	May 28, 1936.

[1] Note particularly the percentage of milk pasteurized in the various communities listed in these tables. This percentage is an important factor to consider in estimating the safety of a city's milk supply.

TABLE 3.—*Communities in which no market milk is pasteurized, but in which the raw market milk complies with the Grade A raw milk requirements of the Public Health Service Milk Ordinance and Code to the extent shown by raw milk ratings of 90 percent or more* [1]—Continued.

[NOTE.—All milk should be pasteurized or boiled, either commercially or at home, before it is consumed. See text for home method.]

Community	Date of rating	Community	Date of rating
NORTH CAROLINA—continued		TEXAS	
Roanoke Rapids	Apr. 6, 1936.	Brenham	June 11, 1936.
Southern Pines	Nov. 11, 1936.	Bryan	May 1936.
Southport	Oct. 2, 1935.	Canyon	July 15, 1937.
Spindale	June 30, 1937.	Childress	Apr. 17, 1936.
Sylva	June 21, 1937.	Colorado	Mar. 19, 1937.
Washington	Sept. 26, 1935.	Commerce	Mar. 16, 1937.
Whiteville	Dec. 18, 1936.	Crockett	May 1936.
Williamston	Nov. 19, 1936.	Del Rio	June 8, 1937.
Wilkesboro	Nov. 11, 1936.	Jacksonville	Jan. 1936.
Windsor	June 24, 1937.	WASHINGTON	
Winton	June 25, 1937.	Camas	Oct. 9, 1936.
TENNESSEE			
Alcoa	July 3, 1935.		
Jonesboro	June 24, 1937.		
Savannah	June 15, 1937.		

[1] Note particularly the percentage of milk pasteurized in the various communities listed in these tables. This percentage is an important factor to consider in estimating the safety of a city's milk supply.

DEATHS DURING WEEK ENDED JULY 17, 1937

(From the Weekly Health Index, issued by the Bureau of the Census, Department of Commerce)

	Week ended July 17, 1937	Corresponding week, 1936
Data from 86 large cities of the United States:		
Total deaths	8,933	12,183
Average for 3 prior years	7,781	
Total deaths, first 28 weeks of year	258,089	259,038
Deaths under 1 year of age	584	651
Average for 3 prior years	543	
Deaths under 1 year of age, first 28 weeks of year	16,161	16,107
Data from industrial insurance companies:		
Policies in force	70,073,939	68,609,012
Number of death claims	12,283	10,691
Death claims per 1,000 policies in force, annual rate	9.1	8.1
Death claims per 1,000 policies, first 28 weeks of year, annual rate	10.5	10.4

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

Cases of certain communicable diseases reported by telegraph by State health officers for weeks ended July 24, 1937, and July 25, 1936

Division and State	Diphtheria		Influenza		Measles		Meningococcus meningitis	
	Week ended July 24, 1937	Week ended July 25, 1936	Week ended July 24, 1937	Week ended July 25, 1936	Week ended July 24, 1937	Week ended July 25, 1936	Week ended July 24, 1937	Week ended July 25, 1936
New England States:								
Maine	1	1			14	30	0	0
New Hampshire		3	1		3	2	0	0
Vermont	1				7	7	0	0
Massachusetts	9	8			85	272	2	2
Rhode Island	1	2			19	5	0	0
Connecticut	10		1		17	32	0	0
Middle Atlantic States:								
New York	21	27	[1] 6	[1] 2	325	354	5	10
New Jersey	3	7		1	183	165	0	0
Pennsylvania [2]	23	10			787	234	2	6
East North Central States:								
Ohio	6	5	4	7	127	50	6	1
Indiana	2	12	8	15	56	4	0	2
Illinois [2]	28	21	6	3	167	13	0	5
Michigan	14	13			115	19	1	1
Wisconsin	5		1	20	44	52	2	0
West North Central States:								
Minnesota	1	4			8	7	0	0
Iowa [2]	7	4	1		7		1	0
Missouri	5	5	22	6	42	5	1	0
North Dakota			5			4	0	0
South Dakota		1			1	1	0	1
Nebraska	1	1			7	5	1	1
Kansas	4	2	3		8	4	0	0
South Atlantic States:								
Delaware		1			2	2	0	0
Maryland [2 3]	5	9	1	1	13	77	2	5
District of Columbia	8	2		1	20	38	0	1
Virginia [2]	8	4			54	42	6	2
West Virginia	2	5	12		35	4	1	0
North Carolina [2 4]	15	14		1	75	3	4	0
South Carolina [4]		4	38	19	19	2	1	0
Georgia [4]	7	10					1	0
Florida [4]	2	3	1	3			0	4

See footnotes at end of table.

Cases of certain communicable diseases reported by telegraph by State health officers for weeks ended July 24, 1937, and July 25, 1936—Continued

Division and State	Diphtheria		Influenza		Measles		Meningococcus meningitis	
	Week ended July 24, 1937	Week ended July 25, 1936	Week ended July 24, 1937	Week ended July 25, 1936	Week ended July 24, 1937	Week ended July 25, 1936	Week ended July 24, 1937	Week ended July 25, 1936
East South Central States:								
Kentucky	2	4	3	2	58	27	2	10
Tennessee [2 4]	5	11	1	9	99	8	2	0
Alabama [4]	8	7	9	----	6	8	2	2
Mississippi [3]	8	7	----	----	----	----	0	0
West South Central States:								
Arkansas	3	3	3	5	6	----	0	0
Louisiana [4]	7	9	6	5	2	6	1	2
Oklahoma [3]	5	5	5	2	17	1	1	0
Texas [4]	28	17	39	23	104	34	0	0
Mountain States:								
Montana	1	----	----	----	4	5	1	0
Idaho	----	1	6	2	12	10	1	0
Wyoming [6]	----	----	----	----	5	----	0	0
Colorado	2	1	----	----	20	2	1	0
New Mexico	2	5	----	1	100	32	0	1
Arizona	1	3	10	10	7	20	0	2
Utah [3]	----	----	1	----	43	7	0	0
Pacific States:								
Washington	----	1	----	----	24	52	0	1
Oregon	2	----	13	5	7	8	1	0
California	18	26	4	6	47	155	2	8
Total	281	278	210	149	2,801	1,808	50	67
First 29 weeks of year	12,525	13,573	273,534	139,344	235,831	264,233	3,921	5,636

Division and State	Poliomyelitis		Scarlet fever		Smallpox		Typhoid fever	
	Week ended July 24, 1937	Week ended July 25, 1936	Week ended July 24, 1937	Week ended July 25, 1936	Week ended July 24, 1937	Week ended July 25, 1936	Week ended July 24, 1937	Week ended July 25, 1936
New England States:								
Maine	4	1	5	9	0	6	0	0
New Hampshire	1	0	1	----	0	0	1	0
Vermont	0	0	----	5	0	0	0	1
Massachusetts	10	1	38	47	0	0	6	25
Rhode Island	0	0	8	6	0	0	0	2
Connecticut	0	1	7	7	0	0	3	3
Middle Atlantic States:								
New York	8	6	66	120	0	0	9	14
New Jersey	1	1	24	26	0	0	5	2
Pennsylvania [2]	0	3	114	100	0	0	16	10
East North Central States:								
Ohio	20	1	34	44	1	0	18	6
Indiana	7	2	29	31	7	0	4	2
Illinois [3]	11	7	102	80	10	6	22	11
Michigan	4	6	130	76	7	1	2	5
Wisconsin	2	0	56	75	2	5	1	3
West North Central States:								
Minnesota	1	0	21	25	10	3	1	0
Iowa [2]	3	0	31	19	52	28	3	0
Missouri	16	0	38	13	0	5	21	15
North Dakota	0	0	1	3	6	1	5	2
South Dakota	0	0	11	6	1	1	0	0
Nebraska	4	0	2	12	0	0	0	1
Kansas	4	2	17	32	14	0	30	3
South Atlantic States:								
Delaware	0	0	1	2	0	0	1	0
Maryland [2 3]	1	0	8	13	0	0	16	1
District of Columbia	0	0	3	5	0	0	2	2
Virginia [2]	1	0	7	7	0	0	28	18
West Virginia	1	1	11	11	1	0	8	9
North Carolina [2 4]	9	0	8	15	1	0	25	23
South Carolina [4]	1	0	10	----	0	0	11	9
Georgia [4]	3	2	5	5	0	0	43	35
Florida [4]	0	0	1	1	0	0	6	1

See footnotes at end of table.

Cases of certain communicable diseases reported by telegraph by State health officers for weeks ended July 24, 1937, and July 25, 1936—Continued

Division and State	Poliomyelitis		Scarlet fever		Smallpox		Typhoid fever	
	Week ended July 24, 1937	Week ended July 25, 1936	Week ended July 24, 1937	Week ended July 25, 1936	Week ended July 24, 1937	Week ended July 25, 1936	Week ended July 24, 1937	Week ended July 25, 1936
East South Central States:								
Kentucky	18	2	14	13	0	0	47	29
Tennessee [2] [4]	[7] 10	17	12	9	0	0	53	52
Alabama [4]	1	39	2	10	0	0	12	20
Mississippi [3]	13	3	7	3	1	0	23	16
West South Central States:								
Arkansas	48	0	7	3	0	0	50	14
Louisiana [4]	7	1	3	4	0	0	33	37
Oklahoma [5]	53	0	18	3	0	0	30	33
Texas [4]	31	0	37	16	0	0	85	47
Mountain States:								
Montana	1	1	5	13	2	10	1	2
Idaho	0	1	8	3	17	2	0	0
Wyoming [6]	1	0	3	6	0	0	1	0
Colorado	3	0	5	7	1	0	1	6
New Mexico	2	1	9	5	0	0	2	18
Arizona	2	0	1	1	0	0	4	0
Utah [3]	0	0	7	5	0	0	0	1
Pacific States:								
Washington	0	3	8	19	0	2	2	2
Oregon	1	0	10	16	2	0	4	5
California	21	15	57	67	1	0	12	6
Total	324	117	1,002	998	136	64	647	491
First 29 weeks of year	1,670	894	161,216	174,878	7,693	5,767	5,486	5,018

[1] New York City only.
[2] Rocky Mountain spotted fever, week ended July 24, 1937, 14 cases, as follows: Pennsylvania, 1; Illinois, 2; Iowa, 1; Maryland, 2; Virginia, 4; North Carolina, 3; Tennessee, 1.
[3] Week ended earlier than Saturday.
[4] Typhus fever, week ended July 24, 1937, 78 cases, as follows: North Carolina, 2; South Carolina, 2; Georgia, 32; Florida, 2; Tennessee, 3; Alabama, 17; Louisiana, 1; Texas, 19.
[5] Figures for 1936 are exclusive of Oklahoma City and Tulsa.
[6] Colorado tick fever, week ended July 24, 1937, Wyoming, 1 case.
[7] 1 nonparalytic case included.

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
June 1937										
Hawaii Territory	-------	17	49	-------	1,236	-------	0	-------	0	7
Illinois	10	133	65	12	2,072	2	3	1,353	71	34
Indiana	7	29	38	2	2,148	-------	1	320	61	12
Kansas	4	36	5	1	79	1	6	224	24	11
Louisiana	7	54	80	146	25	27	13	39	1	71
Maryland	8	18	3	-------	612	3	0	80	0	31
Massachusetts	13	15	-------	-------	2,356	2	6	725	0	5
Montana	-------	1	142	-------	32	1	0	62	95	9
Nevada	-------	-------	-------	-------	17	-------	1	7	0	0
New York	28	159	-------	12	6,109	-------	9	1,926	0	52
Oklahoma	1	12	35	75	149	21	28	41	8	49
Rhode Island	5	6	-------	-------	274	-------	0	144	0	3
South Dakota	1	6	-------	-------	11	-------	0	71	10	2
Texas	17	132	495	2,579	1,267	226	14	301	16	106
Virginia	25	30	43	24	788	10	6	25	0	37
Washington	4	9	8	-------	290	-------	1	102	6	3

Summary of monthly reports from States—Continued

June 1937

Actinomycosis:	Cases
Illinois	1
Anthrax:	
Massachusetts	2
Texas	1
Chicken pox:	
Hawaii Territory	73
Illinois	1,487
Indiana	139
Kansas	71
Louisiana	1
Maryland	289
Massachusetts	1,512
Montana	85
Nevada	11
New York	3,257
Oklahoma	20
Rhode Island	73
South Dakota	25
Texas	403
Virginia	125
Washington	469
Dengue:	
Texas	13
Diarrhea:	
Kansas	1
Maryland	21
Dysentery:	
Illinois (amoebic)	5
Illinois (amoebic carriers)	13
Illinois (bacillary)	10
Indiana (amoebic)	1
Kansas (amoebic)	2
Kansas (bacillary)	1
Louisiana (amoebic)	14
Louisiana (bacillary)	2
Maryland (bacillary)	21
Massachusetts (bacillary)	1
New York (amoebic)	2
New York (bacillary)	24
Oklahoma (amoebic)	2
Oklahoma (bacillary)	30
Texas (bacillary)	358
Virginia (diarrhea included)	775
Washington (amoebic)	1
Encephalitis, epidemic or lethargic:	
Illinois	5
Kansas	2
Louisiana	1
Maryland	4
Massachusetts	1
New York	6
Texas	6
Washington	4
German measles:	
Illinois	63
Kansas	3
Maryland	22
Massachusetts	153
Montana	3
New York	257
Rhode Island	13
Washington	16
Hookworm disease:	
Hawaii Territory	74
Louisiana	40
Impetigo contagiosa:	
Hawaii Territory	12
Maryland	4
Montana	2
Oklahoma	1
Washington	1
Jaundice, infectious:	
Hawaii Territory	4
Lead poisoning:	
Massachusetts	3
Leprosy:	
Hawaii Territory	2
Illinois	1
Louisiana	1
Mumps:	
Hawaii Territory	46
Illinois	920
Indiana	73
Kansas	289
Louisiana	2
Maryland	220
Massachusetts	463
Montana	97
Oklahoma	23
Rhode Island	4
South Dakota	2
Texas	584
Virginia	229
Washington	396
Ophthalmia neonatorum:	
Illinois	2
Indiana	1
Massachusetts	91
Montana	1
New York [1]	11
Rhode Island	3
Paratyphoid fever:	
Hawaii Territory	3
Illinois	3
Kansas	1
Louisiana	2
Maryland	1
Massachusetts	51
New York	6
Texas	11
Washington	1
Puerperal septicemia:	
Washington	3
Rabies in animals:	
Illinois	31
Indiana	44
Louisiana	19
Massachusetts	19
New York [1]	4
Rhode Island	2
Texas	8
Washington	22
Rabies in man:	
Illinois	1
Relapsing fever:	
Kansas	1
Rocky Mountain spotted fever:	
Maryland	9
Montana	10
Nevada	3
New York	1
Virginia	7
Septic sore throat:	
Illinois	4
Kansas	3
Louisiana	1
Maryland	14
Massachusetts	8
Montana	5
New York	55
Oklahoma	8
Rhode Island	18
Virginia	6
Washington	2
Tetanus:	
Hawaii Territory	2
Illinois	2
Kansas	3
Louisiana	2
Massachusetts	3
New York	3
Oklahoma	4
Washington	1
Trachoma:	
Hawaii Territory	1
Illinois	57
Massachusetts	1
Montana	151
Oklahoma	2
South Dakota	9
Trichinosis:	
Illinois	3
Massachusetts	1
New York	16
Tularaemia:	
Illinois	2
Kansas	1
Louisiana	1
Maryland	1
Montana	1
Texas	1
Virginia	8
Typhus fever:	
Hawaii Territory	1
Indiana	1
Louisiana	1
Maryland	1
New York	4
Texas	44
Undulant fever:	
Illinois	11
Kansas	8
Louisiana	7
Maryland	3
Massachusetts	5
Montana	1
New York	18
Oklahoma	8
Texas	8
Virginia	3
Washington	1
Vincent's infection:	
Illinois	45
Kansas	3
Maryland	10
New York [1]	69
Whooping cough:	
Hawaii Territory	15
Illinois	643
Indiana	297
Kansas	527
Louisiana	80
Maryland	487
Massachusetts	996
Montana	81
Nevada	1
New York	1,745
Oklahoma	86
Rhode Island	214
South Dakota	12
Texas	1,392
Virginia	446
Washington	283

[1] Exclusive of New York City.

WEEKLY REPORT FROM CITIES

City reports for week ended July 17, 1937

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								
Data for 90 cities:											
5-year average	139	42	14	1,666	324	525	8	392	79	1,306	----
Current week [1]	90	31	8	1,331	401	357	4	406	60	1,466	----
Maine:											
Portland	0	----	0	4	3	1	0	0	0	0	27
New Hampshire:											
Concord	0	----	0	0	2	0	0	0	0	0	8
Nashua	1	----	----	0	----	0	0	----	0	0	6
Vermont:											
Barre	0	----	0	0	0	0	0	0	0	0	2
Burlington	0	----	0	0	0	0	0	0	0	0	4
Rutland	0	----	0	0	0	0	0	0	0	0	5
Massachusetts:											
Boston	0	----	0	32	31	13	0	5	0	48	263
Fall River	0	----	0	5	1	5	0	2	0	9	42
Springfield	0	----	0	0	1	3	0	0	1	12	36
Worcester	0	----	0	1	7	0	0	4	0	9	52
Rhode Island:											
Pawtucket	0	----	0	0	0	0	0	0	0	0	17
Providence	0	----	0	6	4	7	0	3	0	18	85
Connecticut:											
Bridgeport	0	----	0	2	2	2	0	0	0	3	34
Hartford	0	----	0	19	3	3	0	1	0	1	48
New Haven	0	----	0	0	1	0	0	1	0	0	29
New York:											
Buffalo	0	----	0	21	4	3	0	3	0	40	97
New York	21	5	2	287	109	34	0	91	6	96	2,038
Rochester	0	----	0	4	1	0	0	1	0	28	70
Syracuse	0	----	0	12	1	6	0	2	0	30	50
New Jersey:											
Camden	0	----	0	2	1	1	0	0	1	2	31
Newark	0	----	0	0	7	1	0	8	16	0	120
Trenton	0	----	0	18	1	3	0	4	0	0	42
Pennsylvania:											
Philadelphia	3	----	0	9	17	20	0	36	7	55	603
Pittsburgh	3	2	1	128	16	5	0	4	0	50	----
Reading	0	----	0	10	3	3	0	0	0	0	29
Ohio:											
Cincinnati	1	----	0	10	7	1	0	9	1	44	126
Cleveland	1	4	0	172	5	24	0	15	0	39	204
Columbus	0	----	0	2	0	0	0	0	0	12	72
Toledo	2	2	1	45	0	2	0	2	0	72	77
Indiana:											
Anderson	0	----	0	4	0	0	0	0	0	6	9
Fort Wayne	0	----	0	0	1	1	0	0	0	0	23
Indianapolis	0	----	0	21	2	2	0	0	0	25	95
Muncie	0	----	0	3	0	1	0	1	0	4	15
South Bend	0	----	0	0	0	0	0	0	0	0	12
Terre Haute	1	----	0	0	0	2	0	0	0	0	11
Illinois:											
Alton	0	----	0	0	0	1	0	0	0	0	10
Chicago	10	2	2	209	18	54	0	42	1	111	658
Elgin	0	----	0	0	0	0	0	0	0	5	6
Moline	0	----	0	0	0	1	0	0	0	16	3
Springfield	0	----	0	5	1	0	0	0	0	2	15
Michigan:											
Detroit	9	----	0	58	9	40	0	26	1	79	244
Flint											
Grand Rapids	0	----	0	15	4	5	0	0	0	19	44
Wisconsin:											
Kenosha	0	----	0	2	0	0	0	0	0	0	8
Madison	0	----	0	2	0	2	0	1	0	5	28
Milwaukee	0	----	0	14	6	14	0	3	1	46	107
Racine	0	----	0	0	0	1	0	0	0	0	11
Superior	0	----	0	0	0	1	0	0	0	0	4

[1] Figures for Flint, Mich., estimated; report not received.

City reports for week ended July 17, 1937—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								
Minnesota:											
Duluth	0	------	0	1	0	3	0	0	0	9	18
Minneapolis	0	------	0	2	3	3	0	1	0	4	93
St. Paul	0	------	0	0	4	1	0	2	0	40	67
Iowa:											
Cedar Rapids	0	------	--------	1	-------	2	0	-------	0	3	-------
Des Moines	1	------	--------	2	-------	5	0	-------	0	0	29
Sioux City	0	------	--------	0	-------	3	0	-------	0	0	-------
Waterloo	0	------	--------	2	-------	0	0	-------	0	2	-------
Missouri:											
Kansas City	1	------	0	1	5	5	1	4	0	6	78
St. Joseph	0	------	0	0	0	0	0	1	0	2	18
St. Louis	9	------	0	27	4	21	0	16	3	25	202
North Dakota:											
Fargo	0	------	0	0	1	0	1	1	0	38	13
Grand Forks	0	------	--------	0	-------	0	0	-------	0	1	-------
Minot	0	------	0	0	0	0	1	0	0	0	6
South Dakota:											
Sioux Falls	0	------	0	0	0	0	0	0	0	0	9
Nebraska:											
Omaha	0	------	0	1	6	3	0	1	0	6	55
Kansas:											
Lawrence	0	0	0	0	0	1	0	0	0	6	-------
Topeka	0	------	0	0	2	3	0	0	0	18	19
Wichita	0	------	0	2	4	0	0	0	0	11	17
Delaware:											
Wilmington	0	------	0	0	1	0	0	1	1	9	29
Maryland:											
Baltimore	1	2	0	22	11	5	0	12	5	96	270
Cumberland	0	------	0	0	0	0	0	0	0	1	14
Frederick	0	------	0	0	0	0	0	0	0	0	4
District of Columbia:											
Washington	2	------	0	33	7	4	0	16	4	14	183
Virginia:											
Lynchburg	1	------	0	0	1	0	0	0	0	17	9
Norfolk	0	------	0	0	3	1	0	0	0	0	35
Richmond	0	------	0	7	2	2	0	0	0	1	48
Roanoke	0	------	0	4	2	0	0	0	3	2	28
West Virginia:											
Charleston	0	------	0	0	3	0	0	1	0	0	33
Huntington	0	------	--------	1	-------	3	0	-------	0	0	-------
Wheeling	0	------	0	2	1	2	0	2	0	5	21
North Carolina:											
Gastonia	0	------	--------	0	-------	0	0	-------	0	0	-------
Raleigh	0	------	0	1	0	0	0	0	1	0	11
Wilmington	1	------	0	0	1	0	0	0	0	9	9
Winston-Salem	0	------	0	1	2	0	0	2	0	0	18
South Carolina:											
Charleston	0	------	0	0	4	0	0	2	0	0	29
Florence	0	------	0	0	0	0	0	0	0	0	15
Greenville	0	------	0	0	0	0	0	0	0	9	2
Gerogia:											
Atlanta	2	------	--------	1	8	4	0	2	2	17	61
Brunswick	0	------	0	0	0	0	0	0	0	1	-------
Savannah	0	------	0	0	1	0	0	3	2	0	29
Florida:											
Miami	0	------	0	1	3	0	0	0	0	0	25
Tampa	1	------	0	5	2	0	0	1	0	8	33
Kentucky:											
Ashland	0	------	--------	11	-------	0	0	-------	0	6	1
Covington	0	------	0	3	0	1	0	0	0	4	13
Lexington	0	------	0	0	0	1	0	2	0	10	19
Louisville	1	------	0	23	9	7	0	7	0	59	93
Tennessee:											
Knoxville	0	2	0	0	0	0	0	0	2	0	35
Memphis	0	------	1	27	4	0	0	8	2	22	80
Nashville	0	------	0	3	2	2	0	0	0	21	56
Alabama:											
Birmingham	0	5	0	10	3	0	0	6	3	6	65
Mobile	0	------	0	0	5	0	0	0	0	2	23
Montgomery	0	1	--------	0	-------	1	0	-------	3	12	-------
Arkansas:											
Fort Smith	0	------	--------	0	-------	0	0	-------	2	0	-------
Little Rock	0	------	0	0	4	1	0	5	1	0	12

City reports for week ended July 17, 1937—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								
Louisiana:											
Lake Charles	0	------	0	0	0	0	0	0	0	0	3
New Orleans	2	4	0	2	2	1	0	9	5	10	129
Shreveport	0	------	0	0	3	0	0	0	0	2	31
Oklahoma:											
Muskogee	0	------	0	0	0	0	0	0	0	0	0
Oklahoma City	0	------	0	0	6	1	0	1	0	0	49
Tulsa	0	------	--------	3	-------	1	0	-------	0	22	--------
Texas:											
Dallas	1	------	0	3	3	1	0	3	1	28	66
Fort Worth	0	------	0	0	1	3	0	1	1	15	42
Galveston	0	------	0	0	1	0	0	1	0	0	21
Houston	3	------	0	1	0	3	0	1	2	3	64
San Antonio	0	------	0	0	2	1	0	7	0	1	58
Montana:											
Billings	0	------	0	0	0	0	0	0	0	1	11
Great Falls	0	------	0	0	0	0	0	0	0	6	6
Helena	0	------	0	1	0	0	2	0	0	0	2
Missoula	0	------	0	0	0	0	0	0	0	0	5
Idaho:											
Boise	0	------	0	0	0	0	0	0	0	2	1
Colorado:											
Colorado Springs	0	------	0	0	1	1	0	0	0	0	9
Denver	0	------	1	33	5	1	0	2	1	14	69
Pueblo	0	------	0	0	0	1	0	1	0	1	11
New Mexico:											
Albuquerque	0	------	0	1	0	0	0	0	0	0	--------
Utah:											
Salt Lake City	0	------	0	30	3	4	0	1	1	7	29
Washington:											
Seattle	3	------	0	9	2	0	0	4	0	48	83
Spokane	1	------	0	18	0	2	0	0	0	21	19
Tacoma	0	------	0	0	1	0	0	1	0	9	22
Oregon:											
Portland	0	------	0	1	6	3	0	1	0	3	97
Salem	0	------	--------	0	-------	0	0	-------	0	1	--------
California:											
Los Angeles	11	6	1	8	11	12	0	18	2	69	270
Sacramento	1	------	0	4	1	2	0	3	1	10	29
San Francisco	0	1	0	3	2	10	0	7	1	46	141

City reports for week ended July 17, 1937—Continued

State and city	Meningococcus meningitis		Poliomyelitis cases
	Cases	Deaths	
Maine:			
Portland	1	0	0
Massachusetts:			
Boston	1	1	1
Fall River	0	0	1
New York:			
Buffalo	1	0	0
New York	6	4	5
Pennsylvania:			
Philadelphia	0	0	1
Pittsburgh	2	1	0
Ohio:			
Cincinnati	1	0	7
Cleveland	1	0	1
Illinois:			
Chicago	2	2	3
Michigan:			
Detroit	0	0	1
Minnesota:			
Minneapolis	0	0	1
Missouri:			
Kansas City	0	0	2
St. Louis	1	0	0
Nebraska:			
Omaha	0	0	4
Maryland:			
Baltimore	2	2	0
West Virginia:			
Huntington	1	0	0
North Carolina:			
Wilmington	1	1	0
Georgia:			
Atlanta	1	0	0
Kentucky:			
Lexington	1	1	0
Louisville	0	0	1
Tennessee:			
Knoxville	0	0	1
Memphis	0	0	1
Arkansas:			
Fort Smith	1	0	0
Little Rock	0	0	10
Louisiana:			
New Orleans	1	0	0
Shreveport	0	0	1
Oklahoma:			
Oklahoma City	0	0	2
Tulsa	0	0	2
Texas:			
Dallas	0	0	2
Fort Worth	0	0	3
Houston	0	0	1
Washington:			
Tacoma	1	1	0
California:			
Los Angeles	1	0	10

Encephalitis, epidemic or lethargic.—Cases: New York, 2; Pittsburgh, 2.
Pellagra.—Cases: Philadelphia, 1; Winston-Salem, 2; Charleston, S. C., 1; Brunswick, 1; Louisville, 1; Fort Smith, 1; New Orleans, 1; Los Angeles, 2.
Typhus fever.—Cases: New York, 1; Baltimore, 1; Wilmington, N. C., 1; Charleston, S. C., 3; Savannah, 2; Birmingham, 1; Mobile, 1; Montgomery, 1; Houston, 3.

FOREIGN AND INSULAR

JAMAICA

Communicable diseases—4 weeks ended July 10, 1937.—During the 4 weeks ended July 10, 1937, cases of certain communicable diseases were reported in Kingston, Jamaica, and in the island outside of Kingston, as follows:

Disease	Kingston	Other localities
Chicken pox	2	39
Diphtheria	1	2
Dysentery	3	4
Erysipelas	1	----------
Leprosy	----------	2
Puerperal septicemia	----------	1
Tuberculosis	25	93
Typhoid fever	11	80

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 July 30, 1937, pages 1054–1068. A similar cumulative table will appear in the PUBLIC HEALTH REPORTS to be issued August 27, 1937, and thereafter, at least for the time being, in the issue published on the last Friday of each month.

Cholera

China.—Information dated July 28, 1937, stated that approximately 30 cases of cholera had been reported in Canton. The number of deaths was not known. During the week ended July 17, 1937, 100 cases of cholera were reported in Hoihow, China.

Plague

Hawaii Territory—Island of Hawaii—Hamakua District—Honokaa Sector.—One plague-infected rat was reported July 23, 1937, in Honokaa Sector, Hamakua District, Island of Hawaii, Hawaii Territory.

Indochina—Cochinchina—Sadec.—During the week ended July 10, 1937, 1 death from plague was reported in Sadec, Cochinchina, Indochina.

Peru.—During the month of July 1937, plague was reported present in Salaverry, Peru. Plague-infected rats were also reported in Peru as follows: May 12, 1 plague-infected rat in Salaverry; 1 plague-infected rat, April 6, and another May 28, in Trujillo, Peru.

Yellow fever

Colombia.—Yellow fever has been reported in Colombia as follows: Boyaca Department—Borbur, May 27–29, 2 deaths; Guadalito, May 26, 1 death; Cundinamarca Department—Yacopi, May 31, 1 death; Intendencia of Meta—Villavicencio, April 24, 1 death; Santander Department—Cuesta Rica, April 9, 1 death, Lebrija, May 7, 1 death, Rio Negro, May 18, 1 death.