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## PLANNING FOR HEALTH EDUCATION IN THE WAR AND POST-WAR PERIODS—THE STATE PROGRAM<sup>1</sup>

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The State is specifically charged by law with the responsibility for the health and welfare of all of the people within its borders. As long ago as 1879 North Carolina recognized this responsibility and commissioned the State Board of Health to "take cognizance of the health interests of the people of the State; make sanitary investigations and inquiries in respect to the people, employing experts when necessary; investigate the causes of diseases dangerous to the public health, especially epidemics, the sources of mortality, the effects of location, employments, and conditions upon the public health." It continues with a farsighted charge explicitly directed toward health education, that is, that the State Board of Health "shall gather such information upon these matters for distribution among the people with the especial purpose of informing them about preventable diseases."

Thus, the North Carolina State Board of Health is commissioned by law with the grave and enormous task of "taking cognizance of the health interests of the people of the State." "Health interest" is a comprehensive term and, interpreted broadly, may include not only the familiar phases of public health concerned with control and prevention, but also may well reach out to embrace that more recent vision of public health which is called by some "constructive medicine" and whose goal is that type of optimal physical fitness imagined by William James when he said "Merely to live, move and breathe is a delight!" This concept of public health is all-inclusive, involving certain aspects of the social and economic realms which heretofore have not been generally considered a field for public health activities; therefore, it is dependent upon personal security and the four freedoms.

This broad concept of the duties of the State health department is fundamental in planning for the post-war period, not only for recon-

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<sup>1</sup> Read before the Public Health Education and Health Officers' Sections, American Public Health Association meeting, New York City, Oct. 12, 1943.

struction and rehabilitation but also for the kind of America and Americans envisioned by our best democratic leaders.

Education is the pipe-line system for the distribution of information to all people. Through education in its many phases, and especially through health education that provides stimulation, knowledge, and experience essential to physical and emotional well-being, will we strive to reach those comprehensive and farsighted goals set up for modern public health.

May I again emphasize the phrase "all the people." The State health department is specifically charged by law to be cognizant of the health interests of "all the people." The pipe line of health education must necessarily reach them. This physical and emotional well-being that we envision in post-war America is for everybody. The health department is the one State department that is responsible for all the people. The schools deal with specific age groups, welfare with specific economic groups, but the health department must reach everyone, regardless of age or economic level. The development of such a program, which would include all, may require certain fundamental changes in existing health education programs.

While no clear-cut, accepted pattern has been designed for State health education programs or for essential health education personnel up to this time, State programs may be said to have fallen into two general types. In the first, the State departments of health, State departments of education, and institutions of higher learning assume a joint responsibility for developing health education programs. In the second, the State department of health provides an advisory service in health education to local communities through trained personnel employed by the department (1).

In Oregon and Tennessee, the State department of health, the State department of education, and institutions of higher learning have pioneered in working together on the health education needs of their States and in planning action programs. Local communities have been stimulated to adopt these programs (1). In North Carolina the State Board of Health and the State Department of Education have been working together for some time trying to solve school health problems. There are, however, few all-inclusive State programs in health education which recognize that there are many groups, both official and nonofficial, that have responsibility for certain phases of health education.

In many States the health education division of the State department of health, in addition to its advisory function, is also responsible for the preparation of health bulletins, news releases, lectures, exhibits, posters, radio talks, and popular leaflets. In others, library service, staff education, teacher training, and refresher courses for

various professional and lay groups are an additional function of such a division.

When the basic health education services on the State level are purely advisory, the State health educators necessarily must function through other people in local health and school departments and through professional and lay groups closely allied to public health. One State director of health education (2), in describing this function, says that materials are sent to public health officers, public health nurses, and superintendents of schools with the hope that they will be used. Too often State departments send out materials and directives that fail to result in definite action. Sometimes these materials are thrown immediately into the overflowing local waste-paper baskets. When health education on the local level is everybody's task it is nobody's specific responsibility. Consequently, great reserves of lay ability are never tapped. Today, when problems are mounting on the home front in rapid succession and health department personnel is as rapidly being depleted, there never was a greater need for the carefully organized and guided utilization of lay individuals and lay groups.

Recently a health educator in a North Carolina county health department, who had previously worked in a State health department, remarked upon the great satisfaction derived from actually doing the job. She had written hundreds of suggestions for health officers, school superintendents, public health nurses, P. T. A. presidents, and civic leaders, but now she plans programs with those local leaders, programs that are suited to specific community needs. Through neighborhood and block study groups she feels that she is reaching out to all the people in a manner never possible on the State level. The awakening of lay responsibility for community health and welfare has truly been a novel and satisfying experience for this health educator.

During the past decade there has been a steady trend toward placing the emphasis of a State health education program at the local level. One State director of health education has said, "Increasing emphasis is being placed on the States' health education activities at the local level." Strong local lay committees are developed to stimulate year-round lay participation in community activities for health promotion on the local level. Doubtless this trend will be given added impetus by the stimulation created in the establishment of those demonstrations in community health education which are now being sponsored by the United States Public Health Service in cooperation with the North Carolina State Board of Health, South Carolina State Board of Health, and Oklahoma State Department of Health.

Health educators of the United States Public Health Service, although assigned to regional and State offices, go directly to county health departments chosen by the State health officer and work there as members of the local staff. Here are utilized all available local, State, and Federal resources, and a county-wide community health education program is developed, based upon lay interest and participation. The usual duties of the health educator in a community program are carried on as a part of the broader public health program, which is built upon the interest of both professional and lay citizens; thus, the program truly becomes one of the vital activities of the community.

In North Carolina five health educators were assigned to the State Board of Health by the United States Public Health Service. Early in the program a training course for health educators was established in the School of Public Health at the University of North Carolina. Health educators trained on North Carolina State Board of Health scholarships are now replacing all the workers assigned by the Public Health Service, and eight others have just begun their training at the University.

A health educator in every local health department is the goal of the North Carolina State Board of Health, with three district supervisors and a State director of health education in the central office. In addition, we feel that a special section of visual aids on the State level is necessary. This materials production unit should include an artist, a photographer, two writers, a carpenter, and a librarian to produce and distribute the "tools of the trade" that will be used by local health departments. A supervisor of films and two technical assistants, together with the required clerical assistants, are necessary for an efficiently managed program of visual aids.

The idea for a health museum for each State health department seems reasonable. If the museum were portable, perhaps of a trailer type, it could better serve the local health departments, and, consequently, the people.

The experience gained in North Carolina indicates that the sound State program for health education is based, first, upon sound local programs carried on by trained health educators under the direction of the local health officer. Such local health education programs provide the State director and district supervisors of health education with straight, vital channels to the people. Then, when techniques and materials are developed on the State level, they are sure to be wisely adapted to local needs and therefore become far more useful. Specific health programs concerned with other agencies and groups can be guided and facilitated in each community by this person well trained in human relationships. When health education programs

function on the local level, the duties of coordination and evaluation of these programs become paramount on the State level, and on the local level the task of the health educator is the practical, everyday application of the democratic process, attempting always to inspire, instruct, and lead to action. The accomplishment of this task is a challenge to the ingenuity of the health educator; however, such a project cannot succeed, even with a health educator in every health department and consultants on the State level, unless adequate educational tools for health instruction are the responsibility of departments of education. Colleges and universities, therefore, should recognize and accept their responsibility for providing teacher training, which in turn will prepare teachers to instruct students effectively in matters pertaining to health.

It should be emphasized that a plan for a State program for health education, based on sound local programs, cannot be established and maintained on the usual minimum budget customarily earmarked for health education. In the modern health department, health education serves in a capacity comparable in importance to older established services. Indications are that in the future even greater emphasis will be placed upon preventive programs in public health, and consequently, greater emphasis upon health education. Surely the time has come to make adequate appropriation for this essential service.

"Creative powers of the people are at the grass roots," says Emory S. Bogardus in *Democracy by Discussion*. In North Carolina capable leadership of local community health education programs has been formed in all groups without regard for social, economic, or racial backgrounds. People have realized, some of them for the first time, that they have a real responsibility for the health and welfare of their neighbors. They have realized, too, that their own apathy and indifference have allowed certain social and economic conditions to exist that they now know must be changed. The democratic spirit that is so greatly needed in the world today is exemplified by this type of program. People think together, study together, and then act together. Many of the people formerly thought that the exclusive duty of the health department was to care for Negroes and poor whites. Now, a new concept of the scope and caliber of health department service and capabilities is slowly spreading. The composite essential parts of the total health program of tomorrow promise to be: communicable disease control, sanitation, maternal and infant care, school health programs, nutrition, dental health, mental hygiene, housing, social and economic welfare, and certain aspects of medical care. The responsibility of the State is to all the people, and, through democratic health education, the departments

of public health can best attempt to bridge the gap between knowledge and skill, and thus discharge this serious obligation entrusted to them by law.

#### REFERENCES

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- (2) 24th Annual Report of the Department of Public Health, State of Illinois, July 1, 1940—June 30, 1941, p. 2.

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### PLANNING FOR HEALTH EDUCATION IN THE WAR AND POST-WAR PERIODS—THE LOCAL PROGRAM<sup>1</sup>

By HUGH B. ROBINS, *Director, Calhoun County Health Department, Marshall, Michigan*

The title, "Planning for Health Education in the War and Post-war Periods," is somewhat misleading, because in public health practice there is no program of public health education, but rather an attempt is made to apply the principles of education to all public health programs.

The past decade has seen an enormous increase in the application of the principles of public health education by those concerned with the public health. When the war began these principles were already being tried out in most public health programs. What changes, if any, must be made in health education plans for the war and post-war periods? It would seem that the change in problems will decide the changes in planning.

The war has brought great changes in the health problems of all communities. It has also reshuffled their relative importance. Many problems, such as the employment of large numbers of women in industry, are entirely new to us. Some old problems, such as the dangers from some of the communicable diseases, have been increased. It is hard to think of an old problem that has been lessened.

Resources to meet these problems have been drastically cut; all communities have lost professional personnel such as physicians, dentists, nurses, teachers, veterinarians, and technicians; the modernizing or building of new houses has been restricted; sanitary supplies are limited; and even travel is curtailed. This brings us to the conclusion that each individual, family, and group must do more for themselves. How can they do this in the face of shrinking resources?

It is pertinent here to ask "Why, about what, who, and how" do we plan for health education in the community health program. It would seem obvious that the answers to these questions are not

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<sup>1</sup> Read at the first session of the Public Health Education Section of the American Public Health Association, New York City, Oct. 12, 1943.

necessarily the same for any two individuals, groups, or communities, or for two different periods of time. The factors influencing health are changing with unusual speed.

The purpose of health education, broadly speaking, is to assist the people in defining their health problems and in utilizing to the utmost the resources in planning and in doing something about these problems to the end that they live in such a manner as to promote the optimum of health.

What should be included in our health education? Here it is expedient to fall back upon the arbitrary divisions of public health—maternal and child health, adult health, environmental sanitation, communicable disease control, industrial health, mental health, nutrition, accident prevention, disease prevention such as cancer control, and general medical care, including medical, dental, nursing, and hospital care. Because of the tremendous scope presented by the foregoing, it is necessary to make some sort of an evaluation so that the most important problems be given proper emphasis. The evaluation schedule of the American Public Health Association is the best tool available for this purpose.

Once the health problems are cataloged and placed in relative order of importance, the next question is "Who is to be educated?" Since health problems are not static, and new information is being accumulated constantly from human experience, it is necessary, first, to design an "in-service" program for the health department staff. Constant study and attempt at self-improvement are the price which must be paid if we aspire to leadership in promoting the community health program. Next, we turn to our professional colleagues, the doctors, dentists, teachers, nurses, veterinarians, etc. Then we consider other official and nonofficial agencies, lay groups, and finally, the parents and individuals.

In considering how to plan health education, the staff must have certain operating policies, such as group teaching wherever possible, promotion of local leadership, working with and through existing organizations whenever practical, and learning by doing. These suggest a pattern for community organization.

Three illustrations showing how the nurse, engineer, and health officer have used this method in Calhoun County follow:

A young physician living in a small village, located in one of the nursing districts, was interested in obstetrics, and he did a good job of prenatal care for his patients. The public health nurse supplemented his care and there was good team work. In 1942 the physician decided to join the Army. His patients would have to be scattered among the physicians of surrounding villages, which were at considerable distances. The nurse asked the physician if he thought it worth

while to try to develop prenatal group conferences. He thought it was a fine idea and a series of conferences was planned. The health officer took these plans to the Public Health Committee of the County Medical Society and they made some suggestions. The physicians in the surrounding villages were approached, and they also made suggestions. Calls were made on a few of the prenatal patients, who liked the idea, and said they would attend. A church and then a library and a school were tried out as places of meeting. The physician's wife became interested in the plan and reopened his office for the meetings. The local library maintained a shelf of reference material. Conferences were held regularly each month and the supplemental work went on.

This program has been continued and, as a result, some of the people have begun to consider the advisability of having conferences on child growth and development.

The engineer of the health department became concerned because about one-third of the market milk was distributed unpasteurized, and it was noted that undulant fever was on the increase. He called a meeting of the pasteurizing plant operators and offered them the opportunity of playing the leading role in a campaign for clean, safe milk. They hesitated because they knew this meant making considerable improvement in their own plants. The health officer and the engineer then conferred with the professional groups to discuss the problem. The county medical society, the dental society, the Schoolmasters' Club, and the veterinarians endorsed the pasteurization of all market milk. Consumer demand was developed, the press was utilized, the county extension agent and 4-H Club leaders were enlisted, and discussions were held with the teachers who were operating hot-lunch programs. Through the county school commissioner the school boards learned of their responsibility in milk-borne epidemics. The engineer designed a chart explaining the method of pasteurizing milk at home, and these were distributed to the homes by the rural school children. The pressure increased and the consumption of raw milk began to decrease. The raw milk distributors, one by one, either equipped their plants for pasteurization, sold their supply to a pasteurization plant, or went out of business.

When the milk supply of a village or city became largely pasteurized, an ordinance was suggested to the council. It was pointed out that the law was not intended as a club over the industry, but as a protection both to the consumer and to those plants that had increased their investment by providing cleaner, safer milk. A striking change in attitude toward the engineer has developed among those in the milk industry. He is no longer looked upon as a police officer, but as a friendly technical adviser. This change has come about through education and not by law.



As a third illustration, let us consider the tuberculosis program. The plan here is the same: What is the problem, what resources are available, and how can they be used most effectively?

From reports of cases and deaths in Calhoun County over a period of years, it was learned that tuberculosis was concentrated in the industrial areas, and was most prevalent among the Negroes and foreign-born whites. A review of the facilities at hand revealed a county medical society, a county tuberculosis hospital, a county tuberculosis society, local hospitals, organized industrial groups, schools, and a State Bureau of Tuberculosis Control. The time-honored "pick and hunt" method of following up contacts to known cases had been used. In 1942, only 17 percent of the cases reported were in the incipient stage of the disease.

After discussions with resource groups, it was decided that a chest X-ray was needed as a part of the industrial pre-employment examination, but talks with personnel managers and labor leaders brought no results. It was then agreed that mass-surveying with a mobile X-ray unit was the next best thing. Areas of responsibility were set up in the group. The county medical society endorsed the plan and requested the use of the State Department's mobile X-ray unit. The county tuberculosis society conferred with labor and management, and set up a calendar for the unit. Labor unions held meetings and voted to cooperate. All original films taken by the mobile unit were read at the State Department of Health. All suspicious small (4" x 5") films were rechecked on 14" x 17" film at local hospitals. The local hospitals offered a special rate for this work and sent the films to the county hospital for reading. The tuberculosis society and the county health department divided the cost of these rechecks. Notifications for rechecks were carried out jointly by the personnel of the county health department, the county tuberculosis society, and the county hospital. The family physicians were given copies of the reports of findings on the large X-rays, and, together with the director of the county hospital, made a decision as to necessary hospitalization of active cases found. The follow-up work was done by the public health nurses. In all, 13,000 persons were examined and 45 cases were found; of these 20 were minimal, 18 moderately advanced, and 7 far advanced.

While arranging for the mobile X-ray unit to invade the industrial area, the health department staff assisted with a general education program of lectures, movies, posters, and school programs, sponsored by the health department and the tuberculosis society in these areas.

Further discussions with the part-time physicians working with industry have resulted in their arranging for five plants to include an X-ray in the pre-employment examination. This idea has been worked out by the physicians with the local hospitals of which they

are staff members. At last one of our long-range objectives is being reached.

Incidentally, the Christmas tuberculosis seal sale this year netted a little over \$10,000, or 10 cents per capita, including gifts of \$400 each from two unions, and \$500 from one industry. The 1941 seal sale netted approximately \$5,000.

These illustrations suffice to make clear that the health department staff does not try to "run" the health programs in Calhoun County. Rather, we feel that the department is one of the many resources available to the people, particularly fitted to act as the coordinating agency. In fact, it has been a definite policy of the health department to minimize its own importance and attempt to strengthen other groups, such as the Schoolmasters' Club, 4-H Clubs, Parent-Teacher Association, etc.

In the past it has been the good fortune of the health department to have unusual resources in consultants on health education, such as Dr. Henry Otto, formerly of the W. K. Kellogg Foundation, who was available for all educational programs, and Miss Vivian Drenckhahn, of the University of Michigan, who worked intensively with the teachers in the county. These persons are no longer available. Assistance from the State Department of Health and Department of Public Instruction cannot provide such intensive help as we would like. We now feel that there should be a health educator on our own staff, who would be available to the entire community in planning the health program.

In conclusion, we should not be unmindful that in public health we still have the privilege of applying democratic principles in the conduct of our work.

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## **TUBERCULOSIS MORTALITY AMONG RESIDENTS OF THE 92 CITIES OF 100,000 OR MORE POPULATION: UNITED STATES, 1939-41 <sup>1</sup>**

By DOROTHY J. LIVERIGHT, *Junior Statistician, United States Public Health Service*

The tuberculosis problem is relatively greater in cities than in rural areas. One out of every 3 persons who died from tuberculosis in the 3-year period 1939-41 was a resident of a city of 100,000 or more population. The death rate from tuberculosis per 100,000 population was 55.4 in these large cities, 43.5 in places of 2,500 to 100,000 population, and 41.1 in rural areas.

The rate of 55.4 is obviously an average figure relating to the combined populations for all the large cities. Of more practical value

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<sup>1</sup> From the Tuberculosis Control Section, States Relations Division.

are the rates for individual cities. These vary from the very low rate of 15.6 to the very high rate of 151.7. Whatever the reasons for such wide variability may be, the first requisite for a control program is the determination of the magnitude of the problem. The death rate for an individual city becomes more meaningful as an index and as a guide to administrative action when it is compared with the rates in other cities of its size. From such a comparison it becomes possible to institute more searching analysis of the factors responsible for the high rates in some cities, and, in turn, a theoretically attainable goal emerges from investigation of the low rates in others.

It is the object of this paper to assemble the tuberculosis mortality rates for all the cities of 100,000 or more population in the United States and to rank them according to their tuberculosis death rate in several ways.

For a number of years, Drolet, of the New York Tuberculosis and Health Association, has compiled annual tabulations of tuberculosis mortality in large American cities. Recently the National Tuberculosis Association has continued this useful work for 42 of the 43 cities of 200,000 or more population.<sup>2</sup> The data for these tabulations were obtained from the individual cities. The present tabulations are based on data from the United States Bureau of the Census and cover the 3-year period 1939-41, centering around the census year of 1940. They therefore have the benefit of the more accurate population data which are available at a census year, and the advantage of uniformity resulting from central tabulation. The rates are also more stable since they cover a 3-year period, and may therefore be used as a base line for the evaluation of future annual tabulations.

Among the factors known to be closely related to tuberculosis are race, age, and sex. The nonwhite rate is more than three times as high as the white. The tabulations are therefore presented separately for whites and nonwhites whenever data are available. Information for individual cities which is sufficient for complete standardization by age and sex is not published by the Bureau of the Census, and consequently the rates have not been corrected for differences in these factors. However, it is felt that such rate standardization would not materially alter the ranking of the cities, and that the crude rates are sufficient for the purposes of this paper.

Tabulations are presented which rank all the 92 cities of 100,000 or more population according to their tuberculosis mortality rate, starting with the city having the lowest rate, which is ranked first, up to the city with the highest rate, which is ranked ninety-second. The ranking is also done separately by color for those cities for which such

<sup>2</sup> Tuberculosis Mortality Among Residents of Large American Cities, National Tuberculosis Association, 1941.

data are available. Rankings of the cities are also presented in 4 size-of-city groups, as follows:

- Cities of 100,000 to 200,000 population.
- Cities of 200,000 to 500,000 population.
- Cities of 500,000 to 1,000,000 population.
- Cities of 1,000,000 and over.

In addition, the cities are ranked within 5 broad geographic divisions.

From these tabulations, it becomes possible for each city to determine its position relative to all the 92 large cities, or in relation to a narrower group which more nearly approximates it in size or in geographic location. It should be noted that from the ranking of the 92 cities it also is possible for each city to determine its position in relation to any other subgrouping of the cities which may be desired. It is merely necessary to select all the cities in the subgrouping and renumber the ranking orders.

Since it is difficult to find a given city in the tables, an appendix table (table 10) is presented for easy reference. This table presents the cities in alphabetical order, and shows for each city its position among all 92 as well as its rank within the size-of-city group and geographic division in which it falls.

#### THE RELATIVE POSITION OF EACH OF THE 92 CITIES

Table 1 presents the 92 cities of 100,000 or more population ranked according to their mortality rate from tuberculosis (all forms) for all races combined. The table presents, in addition to the tuberculosis death rate, the enumerated population of each city, the number of deaths from tuberculosis in the 3-year period 1939-41, and the percentage of the population and of the tuberculosis deaths that were nonwhite.

TABLE 1.—*Mortality from tuberculosis (all forms) in the 92 cities of over 100,000 population: United States, 1939-41 (all races)*

[Cities are ranked according to tuberculosis death rate]

Rank	City	Rate	Popula- tion—1940	Total deaths from tuber- culosis— 1939-41	Percent nonwhite population	Percent <sup>1</sup> nonwhite deaths
1	Grand Rapids, Mich.....	15.6	164,292	77	1.7	-----
2	Salt Lake City, Utah.....	19.3	149,934	87	.8	-----
3	Minneapolis, Minn.....	20.9	492,370	308	1.1	-----
4	Des Moines, Iowa.....	22.7	159,819	109	4.0	-----
5	Spokane, Wash.....	23.8	122,001	87	.9	-----
6	Akron, Ohio.....	25.1	244,791	184	5.0	-----
7	Duluth, Minn.....	25.1	101,065	76	.4	-----
8	Flint, Mich.....	25.5	151,543	116	4.4	-----
9	Wichita, Kans.....	26.4	114,966	91	5.0	-----
10	Long Beach, Calif.....	26.6	164,271	131	1.0	-----
11	St. Paul, Minn.....	26.8	287,736	231	1.5	-----
12	Peoria, Ill.....	27.0	105,087	85	2.7	-----
13	Springfield, Mass.....	27.2	149,554	122	2.1	-----
14	Somerville, Mass.....	27.7	102,177	85	.3	-----
15	Utica, N. Y.....	30.8	100,518	93	.5	-----
16	Rochester, N. Y.....	31.5	324,975	307	1.1	-----
17	Portland, Oreg.....	31.9	305,394	292	1.9	-----
18	Syracuse, N. Y.....	32.0	205,967	198	1.1	-----
19	Paterson, N. J.....	32.2	139,656	135	2.1	-----

TABLE 1.—*Mortality from tuberculosis (all forms) in the 98 cities of over 100,000 population: United States, 1939-41 (all races)*—Continued

Rank	City	Rate	Popula- tion—1940	Total deaths from tuberculosis 1939-41	Percent nonwhite population	Percent <sup>1</sup> nonwhite deaths
20	New Haven, Conn.	33.0	160,005	189	3.9	-----
21	Omaha, Nebr.	34.9	223,844	234	5.5	-----
22	Lowell, Mass.	35.2	101,389	107	1	-----
23	Worcester, Mass.	35.6	193,694	207	7	-----
24	Hartford, Conn.	36.1	166,267	180	4.3	-----
25	Erie, Pa.	36.5	116,955	128	1.2	-----
26	South Bend, Ind.	36.9	101,268	112	3.6	-----
27	Yonkers, N. Y.	37.6	142,598	161	2.9	-----
28	Bridgeport, Conn.	38.5	147,121	170	2.6	-----
29	Oklahoma City, Okla.	39.0	204,424	239	9.6	-----
30	Milwaukee, Wis.	39.3	587,472	693	1.6	-----
31	Providence, R. I.	39.5	253,504	300	2.6	-----
32	Youngstown, Ohio.	39.6	167,720	199	8.7	-----
33	Scranton, Pa.	39.7	140,404	167	5	-----
34	Elizabeth, N. J.	40.0	109,912	132	4.6	-----
35	Tacoma, Wash.	40.2	109,408	132	1.6	-----
36	Oakland, Calif.	40.5	302,163	367	4.7	-----
37	Fort Wayne, Ind.	40.5	118,410	144	2.1	-----
38	Canton, Ohio.	40.6	108,401	132	3.8	-----
39	Kansas City, Kans.	43.6	121,458	159	17.3	43.4
40	Charlotte, N. C.	45.6	100,899	138	31.1	73.2
41	Albany, N. Y.	45.7	130,577	179	2.3	-----
42	San Diego, Calif.	46.9	203,341	286	3.1	-----
43	Fort Worth, Tex.	47.8	177,662	255	14.3	30.6
44	Buffalo, N. Y.	48.0	575,901	830	3.2	-----
45	Cambridge, Mass.	48.4	110,879	161	4.5	-----
46	Seattle, Wash.	48.8	368,302	539	3.9	-----
47	New Bedford, Mass.	50.1	110,341	166	4.0	-----
48	Reading, Pa.	50.4	110,568	167	1.7	-----
49	Wilmington, Del.	50.7	112,504	171	12.7	37.4
50	Detroit, Mich.	50.7	1,623,452	2,468	9.3	34.6
51	Fall River, Mass.	50.8	115,428	176	4	-----
52	Kansas City, Mo.	51.4	399,178	616	10.5	36.5
53	New York, N. Y.	51.5	7,454,995	11,507	6.4	26.5
54	Camden, N. J.	51.9	117,536	183	10.7	32.8
55	Pittsburgh, Pa.	52.3	671,659	1,053	9.3	32.5
56	Louisville, Ky.	53.4	319,077	511	14.8	44.4
57	Denver, Colo.	54.7	322,412	529	2.7	-----
58	Indianapolis, Ind.	54.9	386,972	637	13.2	40.5
59	Los Angeles, Calif.	55.6	1,504,277	2,507	6.5	16.1
60	St. Louis, Mo.	55.6	816,048	1,362	13.4	42.4
61	Columbus, Ohio.	55.8	306,087	512	11.7	39.5
62	Jersey City, N. J.	56.8	301,173	513	4.5	-----
63	Miami, Fla.	57.5	172,172	297	21.5	60.6
64	Dallas, Tex.	57.6	294,734	509	17.1	34.8
65	Tampa, Fla.	59.7	108,391	194	21.5	54.6
66	Boston, Mass.	60.3	770,816	1,394	3.3	11.8
67	Cleveland, Ohio.	60.8	878,336	1,601	9.7	37.4
68	Knoxville, Tenn.	62.1	111,580	208	14.4	40.4
69	Chicago, Ill.	62.4	3,396,808	6,357	8.3	33.3
70	Philadelphia, Pa.	65.1	1,931,334	3,773	13.1	40.9
71	Newark, N. J.	65.2	429,760	841	10.8	45.4
72	Toledo, Ohio	66.1	282,349	560	5.2	-----
73	Gary, Ind.	66.2	111,719	222	18.3	50.0
74	Tulsa, Okla.	67.1	142,187	286	11.1	38.8
75	Cincinnati, Ohio.	67.2	455,610	919	12.2	44.3
76	San Francisco, Calif.	67.4	634,536	1,282	5.0	14.0
77	Trenton, N. J.	67.4	124,697	252	7.5	-----
78	Dayton, Ohio.	67.4	210,718	426	9.6	-----
79	Richmond, Va.	67.5	193,042	391	31.8	63.7
80	Houston, Tex.	74.4	384,514	858	22.5	40.7
81	Nashville, Tenn.	79.3	167,402	398	28.3	54.8
82	Norfolk, Va.	80.6	144,332	349	31.9	71.3
83	New Orleans, La.	81.0	494,537	1,201	30.3	53.0
84	Baltimore, Md.	82.1	859,100	2,116	19.4	54.1
85	Washington, D. C.	82.7	663,091	1,645	28.5	66.9
86	Birmingham, Ala.	83.7	267,583	672	40.7	75.4
87	Atlanta, Ga.	86.5	302,288	784	34.6	75.4
88	Memphis, Tenn.	89.1	292,942	783	41.5	73.9
89	Jacksonville, Fla.	89.4	173,065	464	35.7	79.3
90	Sacramento, Calif.	97.5	105,958	310	5.8	-----
91	Chattanooga, Tenn.	113.7	128,163	437	28.4	61.1
92	San Antonio, Tex.	151.7	253,854	1,155	7.5	-----

<sup>1</sup> Figures available only for cities with more than 20,000 nonwhites, or more than 10 percent nonwhite population.

<sup>2</sup> The nonwhite population of Dayton, Ohio, satisfied the conditions for inclusion at 1940 Census, but was less than 20,000 before that year, and consequently the tabulations on tuberculosis mortality by race are not available.

The enormous variability in the rate is immediately apparent. The highest rate (San Antonio) is nearly ten times as high as the lowest (Grand Rapids). Even excepting the cities having abnormally high rates, the rates in the remaining cities show a gradual variation over the very wide range of 20 to 90. Half of the cities have rates of more than 50, one-quarter have rates of less than 36, and a like number exceed 65.

A comparison of the last two columns in table 1 yields a picture of the magnitude of the tuberculosis problem among the nonwhite population. The proportions of tuberculosis deaths that were nonwhite are approximately three times as great as the percentages which the nonwhites formed of the populations of the different cities. Although in no city are the nonwhites more than 42 percent of the total population, the nonwhite tuberculosis deaths account for almost 80 percent of all the tuberculosis deaths in one city.

The very high rates in such cities as San Antonio and Sacramento may be due to their large Mexican populations. Mexicans are enumerated among the whites, and it is consequently not possible to show separate rates for the North Americans and Latin Americans in these cities.

Table 2 ranks the 92 cities according to their tuberculosis mortality rate among whites. Data for cities in which the nonwhite population is less than 10 percent of the total, or which contain fewer than 20,000 nonwhites, are not tabulated by race in the Bureau of the Census publications. For such cities, the total rate (all races) is also used in the ranking of the white rate. While table 1 presents a picture of the cities in respect to the total tuberculosis problem, the ranking shown in table 2 affords a comparison between the cities without the complicating factor arising from differences in the proportions of the nonwhite population. Thus, it will be noted by a comparison of the two tables that many of the southern cities which have high ranking numbers in table 1 attain relatively low rates in table 2. For example, Charlotte, N. C., which ranked fortieth in the rate for all races combined, stands in second place when only the rate for whites is considered. Similar reductions in ranking order are attained by Jacksonville, Miami, Atlanta, Birmingham, and most of the other southern cities. Conversely, many of the northern cities whose ranks were low according to the rate for all races have relatively high rankings when the rate among whites is used as the yardstick.

In table 3 the 39 cities which satisfy the requirements of the Bureau of the Census for tabulation by race, that is, which have a greater than 10 percent nonwhite population or more than 20,000 nonwhites, are ranked according to their tuberculosis rate among nonwhites. It is striking that the lowest rate in any of the cities is above 100, and that the rate goes up as high as 275 per 100,000 population.

TABLE 2.—*Mortality from tuberculosis (all forms) in the 92 cities of over 100,000 population: United States, 1939-41 (white)*<sup>1</sup>

[Cities are ranked according to tuberculosis death rate]

Rank	City	Rate	Rank	City	Rate
1	Grand Rapids, Mich.	15.6	47	Pittsburgh, Pa.	38.9
2	Charlotte, N. C.	17.8	48	Oklahoma City, Okla.	39.0
3	Salt Lake City, Utah	19.3	49	Camden, N. J.	39.1
4	Minneapolis, Minn.	20.9	50	Milwaukee, Wis.	39.3
5	Des Moines, Iowa	22.7	51	Providence, R. I.	39.5
6	Spokane, Wash.	23.8	52	Youngstown, Ohio	39.6
7	Akron, Ohio	25.1	53	Memphis, Tenn.	39.7
8	Duluth, Minn.	25.1	54	Scranton, Pa.	39.7
9	Flint, Mich.	25.5	55	Newark, N. J.	39.9
10	Wichita, Kans.	26.4	56	Elizabeth, N. J.	40.0
11	Long Beach, Calif.	26.6	57	Tacoma, Wash.	40.2
12	St. Paul, Minn.	26.8	58	New York, N. Y.	40.4
13	Peoria, Ill.	27.0	59	Gary, Ind.	40.5
14	Springfield, Ill.	27.2	60	Fort Wayne, Ind.	40.5
15	Somerville, Mass.	27.7	61	Oakland, Calif.	40.5
16	Jacksonville, Fla.	28.8	62	Canton, Ohio	40.6
17	Miami, Fla.	28.9	63	Cleveland, Ohio	42.1
18	Kansas City, Kans.	29.9	64	Cincinnati, Ohio	42.7
19	Utica, N. Y.	30.8	65	Knoxville, Tenn.	43.3
20	Rochester, N. Y.	31.5	66	Philadelphia, Pa.	44.3
21	Portland, Oreg.	31.9	67	Dallas, Tex.	45.3
22	Syracuse, N. Y.	32.0	68	Chicago, Ill.	45.4
23	Paterson, N. J.	32.2	69	Albany, N. Y.	45.7
24	Atlanta, Ga.	32.5	70	Tulsa, Okla.	46.2
25	New Haven, Conn.	33.0	71	Baltimore, Md.	46.8
26	Norfolk, Va.	33.9	72	San Diego, Calif.	46.9
27	Tampa, Fla.	34.5	73	Buffalo, N. Y.	48.0
28	Birmingham, Ala.	34.7	74	Cambridge, Mass.	48.4
29	Louisville, Ky.	34.8	75	Seattle, Wash.	48.8
30	Omaha, Nebr.	34.9	76	Los Angeles, Calif.	49.7
31	Lowell, Mass.	35.2	77	Nashville, Tenn.	50.0
32	Worcester, Mass.	35.6	78	New Bedford, Mass.	50.1
33	Richmond, Va.	35.9	79	Reading, Pa.	50.4
34	Hartford, Conn.	36.1	80	Fall River, Mass.	50.8
35	Wilmington, Del.	36.3	81	New Orleans, La.	54.6
36	Detroit, Mich.	36.5	82	Denver, Colo.	54.7
37	Erie, Pa.	36.5	83	Boston, Mass.	55.0
38	Kansas City, Mo.	36.5	84	Jersey City, N. J.	56.8
39	South Bend, Ind.	36.9	85	Houston, Tex.	56.9
40	St. Louis, Mo.	37.0	86	San Francisco, Calif.	61.0
41	Yonkers, N. Y.	37.6	87	Chattanooga, Tenn.	61.8
42	Indianapolis, Ind.	37.6	88	Toledo, Ohio	66.1
43	Columbus, Ohio	38.2	89	Dayton, Ohio	67.4
44	Washington, D. C.	38.3	90	Trenton, N. J.	67.5
45	Bridgeport, Conn.	38.5	91	Sacramento, Calif.	97.5
46	Fort Worth, Tex.	38.7	92	San Antonio, Tex.	151.7

<sup>1</sup> For cities having small nonwhite populations, the rate for "all races" is used.

<sup>2</sup> The nonwhite population of Dayton, Ohio, satisfied the conditions for inclusion at 1940 Census, but was less than 20,000 before that year, and consequently the tabulations on tuberculosis mortality by race are not available.

TABLE 3.—*Mortality from tuberculosis (all forms) in 39<sup>1</sup> cities of over 100,000 population: United States, 1939-41 (nonwhite)*

[Cities are ranked according to tuberculosis death rate]

Rank	City	Rate	Rank	City	Rate
1	Fort Worth, Tex.	102.7	21	Norfolk, Va.	180.1
2	Charlotte, N. C.	107.2	22	Gary, Ind.	180.7
3	Kansas City, Kans.	109.2	23	Pittsburgh, Pa.	182.6
4	Dallas, Tex.	116.9	24	Columbus, Ohio	187.5
5	Houston, Tex.	134.4	25	Atlanta, Ga.	188.3
6	Richmond, Va.	135.3	26	San Francisco, Calif.	188.5
7	Los Angeles, Calif.	137.3	27	Detroit, Mich.	189.0
8	New Orleans, La.	141.6	28	Washington, D. C.	194.3
9	Wilmington, Del.	148.9	29	Jacksonville, Fla.	198.4
10	Tampa, Fla.	151.3	30	Philadelphia, Pa.	203.5
11	Nashville, Tenn.	153.5	31	New York, N. Y.	213.0
12	Birmingham, Ala.	155.1	32	Boston, Mass.	215.7
13	Memphis, Tenn.	158.8	33	Baltimore, Md.	229.2
14	Camden, N. J.	159.5	34	Tulsa, Okla.	234.1
15	Louisville, Ky.	160.3	35	Cleveland, Ohio	235.1
16	Miami, Fla.	162.3	36	Cincinnati, Ohio	243.3
17	Indianapolis, Ind.	167.9	37	Chattanooga, Tenn.	244.4
18	Knoxville, Tenn.	173.9	38	Chicago, Ill.	250.1
19	St. Louis, Mo.	176.0	39	Newark, N. J.	275.5
20	Kansas City, Mo.	179.3			

<sup>1</sup> Cities included in this table are those with more than 20,000 nonwhites, or more than 10 percent nonwhite population.

# RELATIVE POSITION OF THE CITIES WHEN CLASSIFIED BY SIZE-OF-CITY GROUPS

Although no striking difference in average rate is noted when the 92 cities are classified into narrower population size groups, it is nevertheless desirable to bring together the cities which are more comparable as to size. It may be of interest to review briefly the variation in the tuberculosis mortality rate according to size of city. Table 4 presents the mortality rate for each of the 4 size-of-city groups by race, in

TABLE 4.—Mortality from tuberculosis (all forms) among residents of cities of over 100,000 population classified by size of city and by race: United States, 1939-41

Size of city	Number of cities	Average annual tuberculosis death rate	Population 1940	Number of deaths from tuberculosis, 1939-41	Percent nonwhite population	Percent nonwhite deaths
ALL RACES						
All cities.....	92	55.4	37,987,989	63,086	8.7	30.0
100,000-200,000.....	49	46.1	6,499,565	8,987	7.2	25.8
200,000-500,000.....	29	56.7	9,120,599	15,511	9.9	29.3
500,000-1,000,000.....	9	61.8	6,456,959	11,976	10.4	34.3
1,000,000 and over.....	5	55.8	15,910,866	26,612	7.9	29.9
WHITE						
All cities.....	92	42.4	34,687,522	44,155	-----	-----
100,000-200,000.....	49	36.9	6,029,221	6,672	-----	-----
200,000-500,000.....	29	44.5	8,220,549	10,971	-----	-----
500,000-1,000,000.....	9	45.3	5,788,018	7,870	-----	-----
1,000,000 and over.....	5	42.4	14,649,734	18,642	-----	-----
NONWHITE						
All cities.....	39	191.2	3,300,467	18,931	-----	-----
100,000-200,000.....	15	164.1	470,344	2,315	-----	-----
200,000-500,000.....	12	168.1	900,050	4,540	-----	-----
500,000-1,000,000.....	7	204.7	668,941	4,106	-----	-----
1,000,000 and over.....	5	210.7	1,261,132	7,970	-----	-----

addition to the percentages of the population and of the tuberculosis deaths which are nonwhite. The rates for all races and for whites do not vary consistently with size of city. The highest rate in both cases is found for cities of 500,000 to 1,000,000 population, and the lowest rate is recorded for cities of 100,000 to 200,000 population. The nonwhite rates, on the other hand, follow the size-of-city trend exactly, with the largest cities showing the highest rate.

The ranking of the individual cities in these narrower groups is presented for whites in table 5 and for nonwhites in table 6. In order to find the position of any city in these tables, reference to table 10, which gives its size-of-city group and rank, will be found helpful.



TABLE 5.—Mortality from tuberculosis (all forms) in the 92 cities of over 100,000 population grouped according to size of city: United States, 1939-41 (white)<sup>1</sup>

[Cities are ranked according to tuberculosis death rate]

Rank	City	Rate	Rank	City	Rate
<i>Cities of 100,000 to 200,000</i>			<i>Cities of 200,000 to 500,000</i>		
1	Grand Rapids, Mich.	15.6	1	Minneapolis, Minn.	20.9
2	Charlotte, N. C.	17.8	2	Akron, Ohio.	25.1
3	Salt Lake City, Utah	19.3	3	St. Paul, Minn.	26.8
4	Des Moines, Iowa.	22.7	4	Rochester, N. Y.	31.5
5	Spokane, Wash.	23.8	5	Portland, Oreg.	31.9
6	Duluth, Minn.	25.1	6	Syracuse, N. Y.	32.0
7	Flint, Mich.	25.5	7	Atlanta, Ga.	32.5
8	Wichita, Kans.	26.4	8	Birmingham, Ala.	34.7
9	Long Beach, Calif.	26.6	9	Louisville, Ky.	34.8
10	Peoria, Ill.	27.0	10	Omaha, Nebr.	34.9
11	Springfield, Mass.	27.2	11	Kansas City, Mo.	36.5
12	Somerville, Mass.	27.7	12	Indianapolis, Ind.	37.6
13	Jacksonville, Fla.	28.8	13	Columbus, Ohio.	38.2
14	Miami, Fla.	28.9	14	Oklahoma City, Okla.	39.0
15	Kansas City, Kans.	29.9	15	Providence, R. I.	39.5
16	Utica, N. Y.	30.8	16	Memphis, Tenn.	39.7
17	Paterson, N. J.	32.2	17	Newark, N. J.	39.9
18	New Haven, Conn.	33.0	18	Oakland, Calif.	40.5
19	Norfolk, Va.	33.9	19	Cincinnati, Ohio	42.7
20	Tampa, Fla.	34.5	20	Dallas, Tex.	45.3
21	Lowell, Mass.	35.2	21	San Diego, Calif.	46.9
22	Worcester, Mass.	35.6	22	Seattle, Wash.	48.8
23	Richmond, Va.	35.9	23	New Orleans, La.	54.6
24	Hartford, Conn.	36.1	24	Denver, Colo.	54.7
25	Wilmington, Del.	36.3	25	Jersey City, N. J.	56.8
26	Erie, Pa.	36.5	26	Houston, Texas.	56.9
27	South Bend, Ind.	36.9	27	Toledo, Ohio.	66.1
28	Yonkers, N. Y.	37.6	28	Dayton, Ohio.	67.4
29	Bridgeport, Conn.	38.5	29	San Antonio, Tex.	151.7
30	Fort Worth, Tex.	38.7			
31	Camden, N. J.	39.1	<i>Cities of 500,000 to 1,000,000</i>		
32	Youngstown, Ohio.	39.6			
33	Scranton, Pa.	39.7	1	St. Louis, Mo.	37.0
34	Elizabeth, N. J.	40.0	2	Washington, D. C.	38.3
35	Tacoma, Wash.	40.2	3	Pittsburgh, Pa.	38.9
36	Gary, Ind.	40.5	4	Milwaukee, Wis.	39.3
37	Fort Wayne, Ind.	40.5	5	Cleveland, Ohio.	42.1
38	Canton, Ohio.	40.6	6	Baltimore, Md.	46.8
39	Knoxville, Tenn.	43.3	7	Buffalo, N. Y.	48.0
40	Albany, N. Y.	45.7	8	Boston, Mass.	55.0
41	Tulsa, Okla.	46.2	9	San Francisco, Calif.	61.0
42	Cambridge, Mass.	48.4			
43	Nashville, Tenn.	50.0	<i>Cities of 1,000,000 and over</i>		
44	New Bedford, Mass.	50.1			
45	Reading, Pa.	50.4	1	Detroit, Mich.	36.5
46	Fall River, Mass.	50.8	2	New York, N. Y.	40.4
47	Chattanooga, Tenn.	61.8	3	Philadelphia, Pa.	44.3
48	Trenton, N. J.	67.4	4	Chicago, Ill.	45.4
49	Sacramento, Calif.	97.5	5	Los Angeles, Calif.	49.7

<sup>1</sup> For cities having small nonwhite populations, the rate for "all races" is used.

## RELATIVE POSITION OF CITIES WHEN GROUPED ACCORDING TO GEOGRAPHIC DIVISIONS

In order to observe the variation in tuberculosis rates in communities located in different parts of the country, the cities have been classified into 5 broad geographic divisions, as follows: New England and Atlantic, North Central, South Central, Mountain, and Pacific. Table 7 shows the rate for each of these groups by race, and the percent of its population which is nonwhite. The total tuberculosis rate (all races) is highest in the South Central areas, and lowest in the Mountain cities. The picture of tuberculosis mortality among whites, when considered geographically, is almost a complete reversal of that found

TABLE 6.—*Mortality from tuberculosis (all forms) in 39<sup>1</sup> cities of over 100,000 population grouped according to size of city: United States, 1939-41 (non-white)*

[Cities are ranked according to tuberculosis death rate]

Rank	City	Rate	Rank	City	Rate
<i>Cities of 100,000 to 200,000</i>			<i>Cities of 200,000 to 500,000—Con.</i>		
1	Fort Worth, Tex	102.7	7	Indianapolis, Ind	167.9
2	Charlotte, N. C	107.2	8	Kansas City, Mo.	179.3
3	Kansas City, Kans.	109.2	9	Columbus, Ohio	187.5
4	Richmond, Va.	135.3	10	Atlanta, Ga.	188.3
5	Wilmington, Del.	148.9	11	Cincinnati, Ohio	243.3
6	Tampa, Fla.	151.3	12	Newark, N. J.	275.5
7	Nashville, Tenn.	153.5			
8	Camden, N. J.	159.5	<i>Cities of 500,000 to 1,000,000</i>		
9	Miami, Fla.	162.3	1	St. Louis, Mo.	176.0
10	Knoxville, Tenn.	173.9	2	Pittsburgh, Pa.	182.6
11	Norfolk, Va.	180.1	3	San Francisco, Calif.	188.5
12	Gary, Ind.	180.7	4	Washington, D. C.	194.3
13	Jacksonville, Fla.	198.4	5	Boston, Mass.	215.7
14	Tulsa, Okla.	234.1	6	Baltimore, Md.	229.2
15	Chattanooga, Tenn.	244.4	7	Cleveland, Ohio	235.1
<i>Cities of 200,000 to 500,000</i>			<i>Cities of 1,000,000 and over</i>		
1	Dallas, Tex.	116.9	1	Los Angeles, Calif.	137.3
2	Houston, Tex.	134.4	2	Detroit, Mich.	189.0
3	New Orleans, La.	141.6	3	Philadelphia, Pa.	203.5
4	Birmingham, Ala.	155.1	4	New York, N. Y.	213.0
5	Memphis, Tenn.	158.8	5	Chicago, Ill.	250.1
6	Louisville, Ky.	160.3			

<sup>1</sup> Cities included in this table are those with more than 20,000 nonwhites, or more than 10 percent nonwhite population.

TABLE 7.—*Mortality from tuberculosis (all forms) among residents of cities of over 100,000 population classified by broad geographic divisions and by race: United States, 1939-41*

Geographic division	Number of cities	Average annual tuberculosis death rate	Population 1940	Number of deaths from tuberculosis, 1939-41	Percent nonwhite population	Percent nonwhite deaths
<b>ALL RACES</b>						
All cities.....	92	55.4	37,987,969	63,086	8.7	30.0
New England and Atlantic.....	40	55.2	18,339,844	30,395	8.8	31.9
North Central.....	27	51.2	12,117,519	18,630	7.0	29.1
South Central.....	13	77.3	3,238,629	7,512	21.8	43.0
Mountain.....	2	43.4	472,346	616		
Pacific.....	10	51.8	3,819,651	5,933	3.4	9.8
<b>WHITE</b>						
All cities.....	92	42.4	34,687,522	44,155		
New England and Atlantic.....	40	41.2	16,728,008	20,701		
North Central.....	27	39.1	11,264,061	13,209		
South Central.....	13	56.3	2,533,138	4,279		
Mountain.....	2	43.4	472,346	616		
Pacific.....	10	48.3	3,689,969	5,350		
<b>NONWHITE</b>						
All cities.....	39	191.2	3,300,467	18,931		
New England and Atlantic.....	16	200.5	1,611,836	9,694		
North Central.....	10	211.7	853,458	5,421		
South Central.....	11	152.8	705,491	3,233		
Mountain.....						
Pacific.....	2	149.6	129,682	583		

among nonwhites. The rates are most favorable to the whites in the sections which in general comprise the Northeast (North Central and New England and Atlantic) and are highest in the Southwest (South Central and Pacific). The nonwhite rates, on the other hand, are at a minimum in the Southwest and are highest in the Northeast.

The ranking of the individual cities within their geographic divisions is presented for whites in table 8 and for nonwhites in table 9.

TABLE 8.—*Mortality from tuberculosis (all forms) in the 92 cities of over 100,000 population grouped by broad geographic divisions: United States, 1939-41 (white)*<sup>1</sup>

[Cities are ranked according to tuberculosis death rate]

Rank	City	Rate	Rank	City	Rate
<i>New England and Atlantic cities</i>			<i>North Central cities—Continued</i>		
1	Charlotte, N. C.	17.8	10	Kansas City, Kans.	29.9
2	Springfield, Mass.	27.2	11	Omaha, Nebr.	34.9
3	Somerville, Mass.	27.7	12	Detroit, Mich.	36.5
4	Jacksonville, Fla.	28.8	13	Kansas City, Mo.	36.5
5	Miami, Fla.	28.9	14	South Bend, Ind.	36.9
6	Utica, N. Y.	30.8	15	St. Louis, Mo.	37.0
7	Rochester, N. Y.	31.5	16	Indianapolis, Ind.	37.6
8	Syracuse, N. Y.	32.0	17	Columbus, Ohio	38.2
9	Paterson, N. J.	32.2	18	Milwaukee, Wis.	39.3
10	Atlanta, Ga.	32.5	19	Youngstown, Ohio	39.6
11	New Haven, Conn.	33.0	20	Fort Wayne, Ind.	40.5
12	Norfolk, Va.	33.9	21	Gary, Ind.	40.5
13	Tampa, Fla.	34.5	22	Canton, Ohio	40.6
14	Lowell, Mass.	35.2	23	Cleveland, Ohio	42.1
15	Worcester, Mass.	35.6	24	Cincinnati, Ohio	42.7
16	Richmond, Va.	35.9	25	Chicago, Ill.	45.4
17	Hartford, Conn.	36.1	26	Toledo, Ohio	66.1
18	Wilmington, Del.	36.3	27	Dayton, Ohio	67.4
19	Erie, Pa.	36.5	<i>South Central cities</i>		
20	Yonkers, N. Y.	37.6	1	Birmingham, Ala.	34.7
21	Washington, D. C.	38.3	2	Louisville, Ky.	34.8
22	Bridgeport, Conn.	38.5	3	Fort Worth, Tex.	38.7
23	Pittsburgh, Pa.	38.9	4	Oklahoma City, Okla.	39.0
24	Camden, N. J.	39.1	5	Memphis, Tenn.	39.7
25	Providence, R. I.	39.5	6	Knoxville, Tenn.	43.3
26	Scranton, Pa.	39.7	7	Dallas, Tex.	45.3
27	Newark, N. J.	39.9	8	Tulsa, Okla.	46.2
28	Elizabeth, N. J.	40.0	9	Nashville, Tenn.	50.0
29	New York, N. Y.	40.4	10	New Orleans, La.	54.6
30	Philadelphia, Pa.	44.3	11	Houston, Tex.	56.9
31	Albany, N. Y.	45.7	12	Chattanooga, Tenn.	61.8
32	Baltimore, Md.	46.8	13	San Antonio, Tex.	151.7
33	Buffalo, N. Y.	48.0	<i>Mountain cities</i>		
34	Cambridge, Mass.	48.4	1	Salt Lake City, Utah	19.3
35	New Bedford, Mass.	50.1	2	Denver, Colo.	54.7
36	Reading, Pa.	50.4	<i>Pacific cities</i>		
37	Fall River, Mass.	50.8	1	Spokane, Wash.	23.8
38	Boston, Mass.	55.0	2	Long Beach, Calif.	26.6
39	Jersey City, N. J.	56.8	3	Portland, Oreg.	31.9
40	Trenton, N. J.	67.4	4	Tacoma, Wash.	40.2
<i>North Central cities</i>			5	Oakland, Calif.	40.5
1	Grand Rapids, Mich.	15.6	6	San Diego, Calif.	46.9
2	Minneapolis, Minn.	20.9	7	Seattle, Wash.	48.8
3	Des Moines, Iowa	22.7	8	Los Angeles, Calif.	55.6
4	Akron, Ohio	25.1	9	San Francisco, Calif.	61.0
5	Duluth, Minn.	25.1	10	Sacramento, Calif.	97.5
6	Flint, Mich.	25.5			
7	Wichita, Kans.	26.4			
8	St. Paul, Minn.	26.8			
9	Peoria, Ill.	27.0			

<sup>1</sup> For cities having small nonwhite populations, the rate for "all races" is used.

TABLE 9.—*Mortality from tuberculosis (all forms) in 39<sup>1</sup> cities of over 100,000 population grouped by broad geographic divisions: United States, 1939-41 (non-white)*

[Cities are ranked according to tuberculosis death rate]

Rank	City	Rate	Rank	City	Rate
<i>New England and Atlantic cities</i>			<i>North Central cities—Continued</i>		
1	Charlotte, N. C.....	107.2	6	Columbus, Ohio.....	187.5
2	Richmond, Va.....	135.3	7	Detroit, Mich.....	189.0
3	Wilmington, Del.....	148.9	8	Cleveland, Ohio.....	235.1
4	Tampa, Fla.....	151.3	9	Cincinnati, Ohio.....	243.3
5	Camden, N. J.....	159.5	10	Chicago, Ill.....	250.1
6	Miami, Fla.....	162.3	<i>South Central cities</i>		
7	Norfolk, Va.....	180.1	1	Fort Worth, Tex.....	102.7
8	Pittsburgh, Pa.....	182.6	2	Dallas, Tex.....	116.9
9	Atlanta, Ga.....	188.3	3	Houston, Tex.....	134.4
10	Washington, D. C.....	194.3	4	New Orleans, La.....	141.6
11	Jacksonville, Fla.....	198.4	5	Nashville, Tenn.....	153.5
12	Philadelphia, Pa.....	203.5	6	Birmingham, Ala.....	155.1
13	New York, N. Y.....	213.0	7	Memphis, Tenn.....	158.8
14	Boston, Mass.....	215.7	8	Louisville, Ky.....	160.3
15	Baltimore, Md.....	229.2	9	Knoxville, Tenn.....	173.9
16	Newark, N. J.....	275.5	10	Tulsa, Okla.....	234.1
<i>North Central cities</i>			11	Chattanooga, Tenn.....	244.4
1	Kansas City, Kans.....	109.2	<i>Pacific cities</i>		
2	Indianapolis, Ind.....	167.9	1	Los Angeles, Calif.....	137.3
3	St. Louis, Mo.....	176.0	2	San Francisco, Calif.....	188.5
4	Kansas City, Mo.....	179.3			
5	Gary, Ind.....	180.7			

<sup>1</sup> Cities included in this table are those with more than 20,000 nonwhites, or more than 10 percent non-white population.

## Appendix

TABLE 10.—Alphabetical listing of the 92 cities of 100,000 or more population with their respective ranking numbers as found in tables 1 through 9

No.	City	Population size group	Geographic division	Rank among 92 cities			Rank within its population size group		Rank within its geographic division	
				All races	White	Non-white	White	Non-white	White	Non-white
1	Akron, Ohio	200,000-500,000	North Central	6	7	—	2	—	4	—
2	Albany, N. Y.	100,000-200,000	Northeastern and Atlantic	41	69	—	40	—	31	—
3	Atlanta, Ga.	200,000-500,000	Northeastern and Atlantic	87	24	25	7	10	10	9
4	Baltimore, Md.	500,000-1,000,000	Northeastern and Atlantic	84	71	33	6	6	32	15
5	Birmingham, Ala.	200,000-500,000	South Central	86	28	12	8	4	1	6
6	Boston, Mass.	500,000-1,000,000	Northeastern and Atlantic	66	83	32	8	5	38	14
7	Bridgeport, Conn.	100,000-200,000	Northeastern and Atlantic	28	45	—	29	—	22	—
8	Buffalo, N. Y.	500,000-1,000,000	Northeastern and Atlantic	44	73	—	7	—	33	—
9	Cambridge, Mass.	100,000-200,000	Northeastern and Atlantic	45	74	—	42	—	34	—
10	Camden, N. J.	100,000-200,000	Northeastern and Atlantic	54	49	14	31	8	24	6
11	Canton, Ohio	100,000-200,000	North Central	38	62	—	38	—	22	—
12	Charlotte, N. C.	100,000-200,000	Northeastern and Atlantic	40	2	2	2	2	1	1
13	Chattanooga, Tenn.	100,000-200,000	South Central	91	87	37	47	15	12	11
14	Chicago, Ill.	1,000,000 and over	North Central	69	68	38	4	4	25	10
15	Cincinnati, Ohio	200,000-500,000	North Central	75	64	36	19	11	24	9
16	Cleveland, Ohio	500,000-1,000,000	North Central	67	63	35	5	5	23	8
17	Columbus, Ohio	200,000-500,000	North Central	61	43	24	13	9	17	6
18	Dallas, Tex.	200,000-500,000	South Central	64	67	—	20	1	7	2
19	Dayton, Ohio	200,000-500,000	North Central	78	89	—	28	—	27	—
20	Denver, Colo.	200,000-500,000	Mountain	57	82	—	24	—	2	—
21	Des Moines, Iowa	100,000-200,000	North Central	50	5	—	4	—	2	—
22	Detroit, Mich.	1,000,000 and over	North Central	7	36	27	1	2	12	7
23	Duluth, Minn.	100,000-200,000	North Central	7	8	—	6	—	3	—
24	Elizabeth, N. J.	100,000-200,000	Northeastern and Atlantic	34	56	—	34	—	28	—
25	Erie, Pa.	100,000-200,000	Northeastern and Atlantic	25	37	—	26	—	19	—
26	Fall River, Mass.	100,000-200,000	Northeastern and Atlantic	51	89	—	46	—	37	—
27	Flint, Mich.	100,000-200,000	North Central	8	9	—	7	—	6	—
28	Fort Wayne, Ind.	100,000-200,000	North Central	37	60	—	37	—	20	—
29	Fort Worth, Tex.	100,000-200,000	South Central	43	46	1	30	1	3	5
30	Gary, Ind.	100,000-200,000	North Central	73	59	22	36	12	21	—
31	Grand Rapids, Mich.	100,000-200,000	North Central	1	34	—	1	—	17	—
32	Hartford, Conn.	100,000-200,000	Northeastern and Atlantic	24	34	—	24	—	17	—
33	Houston, Tex.	200,000-500,000	South Central	80	85	6	26	2	11	3
34	Indianapolis, Ind.	200,000-500,000	North Central	88	42	17	12	7	16	2
35	Jacksonville, Fla.	100,000-200,000	North Central	89	16	29	13	13	39	11
36	Jersey City, N. J.	200,000-500,000	Northeastern and Atlantic	62	84	—	25	—	39	—
37	Kansas City, Mo.	200,000-500,000	North Central	39	18	3	15	3	10	1
38	Kansas City, Mo.	200,000-500,000	North Central	52	38	20	11	8	13	4

TABLE 10.—Alphabetical listing of the 92 cities of 100,000 or more population with their respective ranking numbers as found in tables 1 through 9—Continued

No.	City	Population size group	Geographic division	Rank among 92 cities			Rank within its population size group		Rank within its geographic division
				All races	White	Non-white	White	Non-white	
39	Knoxville, Tenn.	100,000-200,000	South Central	68	65	18	39	10	6
40	Long Beach, Calif.	100,000-200,000	Pacific	10	11	9	9	9	2
41	Los Angeles, Calif.	1,000,000 and over	Pacific	59	76	7	5	1	8
42	Louisville, Ky.	200,000-500,000	South Central	56	29	15	6	6	2
43	Lowell, Mass.	100,000-200,000	Northeastern and Atlantic	22	31	21	21	14	14
44	Memphis, Tenn.	200,000-500,000	South Central	88	53	13	16	5	7
45	Miami, Fla.	100,000-200,000	Northeastern and Atlantic	63	17	16	14	9	5
46	Milwaukee, Wis.	500,000-1,000,000	North Central	30	50	4	4	18	6
47	Minneapolis, Minn.	500,000-1,000,000	North Central	3	4	—	1	—	2
48	Nashville, Tenn.	200,000-500,000	South Central	81	77	11	43	7	9
49	Newark, N. J.	200,000-500,000	Northeastern and Atlantic	71	55	39	17	12	16
50	New Bedford, Mass.	100,000-200,000	Northeastern and Atlantic	47	78	7	17	35	11
51	New Haven, Conn.	100,000-200,000	Northeastern and Atlantic	20	25	—	18	—	35
52	New Orleans, La.	200,000-500,000	South Central	83	81	8	23	3	10
53	New York, N. Y.	200,000-500,000	Northeastern and Atlantic	53	58	31	19	4	29
54	Norfolk, Va.	100,000-200,000	Northeastern and Atlantic	82	26	21	11	11	12
55	Oakland, Calif.	200,000-500,000	Pacific	36	61	—	18	5	7
56	Oklahoma City, Okla.	200,000-500,000	South Central	29	48	—	14	—	5
57	Omaha, Neb.	200,000-500,000	North Central	21	20	—	10	—	11
58	Peoria, Ill.	100,000-200,000	Northeastern and Atlantic	19	32	—	17	—	9
59	Philadelphia, Pa.	1,000,000 and over	North Central	12	13	—	10	—	9
60	Pittsburgh, Pa.	500,000-1,000,000	Northeastern and Atlantic	70	66	30	3	3	30
61	Portland, Ore.	200,000-500,000	Pacific	55	47	23	3	2	23
62	Portland, R. I.	200,000-500,000	Northeastern and Atlantic	17	21	—	5	—	3
63	Reading, Pa.	100,000-200,000	Northeastern and Atlantic	31	51	—	15	—	25
64	Richmond, Va.	100,000-200,000	Northeastern and Atlantic	48	79	—	45	—	36
65	Rochester, N. Y.	200,000-500,000	Northeastern and Atlantic	79	33	6	23	4	16
66	Rochester, N. Y.	200,000-500,000	Northeastern and Atlantic	16	20	—	7	—	2
67	Sacramento, Calif.	100,000-200,000	Pacific	90	91	—	49	—	10
68	St. Louis, Mo.	500,000-1,000,000	North Central	60	40	19	1	1	15
69	St. Paul, Minn.	200,000-500,000	North Central	11	12	—	3	—	8
70	Salt Lake City, Utah	100,000-200,000	Mountain	2	3	—	3	—	1
71	San Antonio, Tex.	200,000-500,000	South Central	92	92	—	29	—	13
72	San Diego, Calif.	200,000-500,000	Pacific	42	72	—	21	—	6
73	San Francisco, Calif.	500,000-1,000,000	Pacific	76	86	26	9	3	9
74	Scranton, Pa.	100,000-200,000	Northeastern and Atlantic	33	54	—	33	—	26
75	Seattle, Wash.	200,000-500,000	Pacific	46	75	—	22	—	7
76	Somerville, Mass.	100,000-200,000	Northeastern and Atlantic	14	15	—	12	—	3
77	South Bend, Ind.	100,000-200,000	North Central	26	39	—	27	—	14

78	Spokane, Wash.	100,000-200,000	Pacific	5	6	1
79	Springfield, Mass.	100,000-200,000	Northeastern and Atlantic	13	14	2
80	Syracuse, N. Y.	200,000-500,000	Northeastern and Atlantic	18	22	8
81	Tacoma, Wash.	100,000-200,000	Pacific	35	57	4
82	Tampa, Fla.	100,000-200,000	Northeastern and Atlantic	65	27	13
83	Toledo, Ohio	200,000-500,000	North Central	72	88	26
84	Trenton, N. J.	100,000-200,000	Northeastern and Atlantic	77	90	40
85	Tulsa, Okla.	100,000-200,000	South Central	74	41	8
86	Utica, N. Y.	100,000-200,000	Northeastern and Atlantic	15	16	6
87	Washington, D. C.	500,000-1,000,000	Northeastern and Atlantic	85	44	10
88	White, Kans.	100,000-200,000	North Central	9	2	7
89	Wilmington, Del.	100,000-200,000	Northeastern and Atlantic	49	25	13
90	Worcester, Mass.	100,000-200,000	Northeastern and Atlantic	23	32	15
91	Yonkers, N. Y.	100,000-200,000	Northeastern and Atlantic	27	41	20
92	Youngstown, Ohio	100,000-200,000	North Central	32	52	19

# 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

### REPORTS FROM STATES FOR WEEK ENDED JULY 15, 1944

#### Summary

Of a total of 462 cases of poliomyelitis reported for the week ended June 15, 400 cases, or 87 percent, were reported in the South Atlantic, Middle Atlantic, East South Central, and East North Central areas (listed in decreasing order of reported cases). Of the increase over last week's total of 290 cases, 90 percent occurred in the Middle Atlantic, East South Central, and East North Central States, principally in New York, Kentucky, and Virginia. Thirteen States reporting 10 or more cases each, all except North Carolina showing increases (last week's figures in parentheses), are as follows: New York 93 (34), Pennsylvania 31 (26), Ohio 16 (7), Indiana 13 (6), Illinois 16 (6), Michigan 10 (1), Virginia 39 (14), North Carolina 63 (94), Kentucky 66 (28), Mississippi 10 (2), Louisiana 11 (9), Texas 13 (5), California 12 (8).

The largest number of cases previously reported for the country as a whole for any corresponding week for which comparable records are available (since 1927) was 297 cases for the same week last year. Prior to June 24, 1944, the weekly cumulative incidence was continuously below that of 1943. For the 3 weeks since that date, 974 cases have been reported, as compared with 732 for the corresponding 3 weeks last year. The total to date this year is 1,756 cases, as compared with 1,626 for the same period last year.

A total of 205 cases of meningococcus meningitis was reported, as compared with 188 for the preceding week, a 5-year median of 35, and 264 for the corresponding week last year. States reporting the largest numbers are New York 25, Pennsylvania and Illinois 15 each, California 17, and Missouri and Virginia 10 each. The cumulative total to date is 12,232, as compared with 12,542 for the same period last year and a 5-year median of 1,276.

Of a total of 148 cases of typhoid fever, as compared with 207 for the week last year and a 5-year median of 239, 17 occurred in Louisiana, 14 in Texas, 8 in Alabama, and 7 each in New York, Indiana, North Carolina, and Kentucky. The total to date is 2,401, as compared with 2,160 for the period last year and a 5-year median of 2,969.

Deaths registered for the week in 93 large cities of the United States totaled 8,845, as compared with 7,838 last week and a 3-year (1941-43) average of 7,849. The total to date is 264,129, as compared with 269,954 for the same period last year.



*Telegraphic morbidity reports from State health officers for the week ended July 15, 1944, and comparison with corresponding week of 1943 and 5-year median*

In these tables a zero indicates definite report, while leaders imply that, although none was reported, cases may have occurred.

Division and State	Diphtheria			Influenza			Measles			Meningitis, meningococcus		
	Week ended		Medi- an 1939- 43	Week ended		Medi- an 1939- 43	Week ended		Medi- an 1939- 43	Week ended		Medi- an 1939- 43
	July 15, 1944	July 17, 1943		July 15, 1944	July 17, 1943		July 15, 1944	July 17, 1943		July 15, 1944	July 17, 1943	
NEW ENGLAND												
Maine.....	0	1	1	1	-----	-----	14	87	87	1	4	0
New Hampshire.....	0	0	0	-----	-----	-----	2	4	4	0	0	0
Vermont.....	0	1	0	-----	-----	-----	11	37	47	0	0	0
Massachusetts.....	5	1	3	-----	-----	-----	227	328	410	8	20	2
Rhode Island.....	0	0	1	7	-----	-----	7	38	41	1	1	0
Connecticut.....	1	1	0	2	1	1	52	66	75	2	5	0
MIDDLE ATLANTIC												
New York.....	7	6	14	(1)	14	13	485	951	840	25	33	8
New Jersey.....	3	3	6	-----	1	1	167	760	500	9	8	2
Pennsylvania.....	9	10	10	-----	-----	-----	111	211	211	15	21	4
EAST NORTH CENTRAL												
Ohio.....	5	7	6	2	2	6	38	154	77	7	17	1
Indiana.....	3	2	2	13	4	4	4	49	16	4	2	1
Illinois.....	6	7	14	-----	6	6	60	342	228	15	10	1
Michigan <sup>1</sup> .....	7	3	3	-----	2	1	146	653	370	9	8	1
Wisconsin.....	2	7	1	3	10	10	235	593	593	8	4	1
WEST NORTH CENTRAL												
Minnesota.....	1	1	1	-----	1	1	52	180	29	2	3	0
Iowa.....	2	1	1	-----	-----	1	14	39	45	2	6	0
Missouri.....	2	1	1	-----	-----	-----	14	37	31	10	8	1
North Dakota.....	4	3	2	1	-----	-----	2	82	9	0	3	0
South Dakota.....	0	2	1	-----	-----	-----	33	24	8	0	0	0
Nebraska.....	1	1	1	3	-----	-----	14	12	12	3	0	0
Kansas.....	1	2	2	-----	-----	-----	27	55	53	1	4	1
SOUTH ATLANTIC												
Delaware.....	0	1	0	-----	-----	-----	0	6	1	1	1	0
Maryland <sup>2</sup> .....	1	1	1	-----	-----	1	31	64	40	7	9	1
District of Columbia.....	0	1	2	-----	-----	-----	24	33	33	2	2	0
Virginia.....	0	1	4	44	42	36	57	74	74	10	8	2
West Virginia.....	0	3	2	-----	-----	2	19	27	23	3	1	1
North Carolina.....	4	12	4	1	5	-----	69	61	61	4	10	1
South Carolina.....	1	0	6	68	121	105	33	10	8	4	7	1
Georgia.....	5	3	3	4	16	16	4	23	20	0	4	0
Florida.....	7	4	2	-----	18	7	41	13	16	3	5	1
EAST SOUTH CENTRAL												
Kentucky.....	1	6	1	-----	3	-----	16	10	10	4	6	3
Tennessee.....	3	5	2	8	4	12	11	38	25	2	2	1
Alabama.....	5	5	5	5	7	7	6	30	30	5	2	2
Mississippi <sup>2</sup> .....	4	2	3	-----	-----	-----	-----	-----	-----	4	5	1
WEST SOUTH CENTRAL												
Arkansas.....	4	3	3	18	10	2	38	11	16	2	1	1
Louisiana.....	2	3	3	2	9	9	9	11	11	3	3	1
Oklahoma.....	1	5	3	5	7	7	15	10	10	0	0	0
Texas.....	24	23	13	203	300	106	237	118	85	4	11	1
MOUNTAIN												
Montana.....	1	0	0	-----	-----	-----	4	45	29	1	0	0
Idaho.....	0	0	1	-----	-----	-----	2	3	3	1	0	0
Wyoming.....	0	0	0	-----	4	-----	9	17	17	0	2	0
Colorado.....	4	4	4	4	-----	-----	27	33	32	3	0	0
New Mexico.....	0	0	0	-----	1	-----	4	2	4	0	0	0
Arizona.....	3	3	0	16	42	24	9	15	37	0	1	0
Utah <sup>2</sup> .....	0	0	0	1	-----	-----	21	20	24	0	2	0
Nevada.....	0	0	0	-----	-----	-----	5	26	5	0	0	0
PACIFIC												
Washington.....	0	8	0	1	-----	-----	49	74	74	2	8	0
Oregon.....	0	10	2	2	4	6	36	58	43	1	4	0
California.....	22	19	12	7	19	19	641	324	324	17	13	0
Total.....	151	182	152	421	643	459	3,132	5,858	4,840	205	264	35
28 weeks.....	5,844	6,446	6,826	336,447	78,893	150,230	583,980	523,593	458,652	12,232	12,542	1,276

<sup>1</sup> New York City only.

<sup>2</sup> Period ended earlier than Saturday.

<sup>3</sup> Corrected reports.—Meningococcus meningitis: Week ended June 24—North Carolina 8 cases, Florida 4 cases; week ended July 1—Florida 3 cases.

Telegraphic morbidity reports from State health officers for the week ended July 15, 1944, and comparison with corresponding week of 1943 and 5-year median—Con.

Division and State	Poliomyelitis			Scarlet fever			Smallpox			Typhoid and paratyphoid fever <sup>1</sup>		
	Week ended		Median 1939-43	Week ended		Median 1939-43	Week ended		Median 1939-43	Week ended		Median 1939-43
	July 15, 1944	July 17, 1943		July 15, 1944	July 17, 1943		July 15, 1944	July 17, 1943		July 15, 1944	July 17, 1943	
NEW ENGLAND												
Maine.....	1	2	0	10	9	3	0	0	0	0	1	1
New Hampshire.....	3	0	0	0	3	1	0	0	0	0	0	0
Vermont.....	0	0	0	3	0	2	0	0	0	0	0	0
Massachusetts.....	2	0	0	84	92	66	0	0	0	3	5	3
Rhode Island.....	0	1	0	2	5	2	0	0	0	0	1	1
Connecticut.....	2	3	0	12	21	13	0	0	0	0	0	3
MIDDLE ATLANTIC												
New York.....	93	11	3	116	89	103	0	0	0	7	6	8
New Jersey.....	1	0	0	36	22	31	0	0	0	2	2	2
Pennsylvania.....	31	3	0	73	44	92	0	0	0	5	9	9
EAST NORTH CENTRAL												
Ohio.....	16	0	3	64	57	57	1	0	0	3	12	9
Indiana.....	13	0	1	14	17	17	0	0	1	7	7	7
Illinois.....	16	2	5	49	53	71	0	0	1	2	5	9
Michigan <sup>2</sup> .....	10	2	4	46	33	74	2	0	1	4	5	5
Wisconsin.....	3	0	0	31	43	42	0	0	0	1	3	1
WEST NORTH CENTRAL												
Minnesota.....	1	2	2	17	16	20	0	0	0	1	0	0
Iowa.....	2	2	2	9	10	10	0	0	2	2	1	1
Missouri.....	1	4	1	6	11	11	0	0	0	4	7	6
North Dakota.....	1	0	0	5	2	2	0	0	0	0	0	1
South Dakota.....	0	0	0	7	5	4	0	0	4	0	0	0
Nebraska.....	0	0	0	3	2	5	0	0	1	0	1	0
Kansas.....	3	7	1	13	14	19	0	0	0	1	2	1
SOUTH ATLANTIC												
Delaware.....	0	0	0	1	1	3	0	0	0	0	0	0
Maryland <sup>1</sup> .....	0	1	0	30	17	14	0	0	0	3	0	4
District of Columbia.....	0	0	0	12	4	4	0	0	0	2	2	1
Virginia.....	39	1	1	5	11	10	0	0	0	6	6	8
West Virginia.....	3	0	0	15	3	12	0	0	0	2	8	8
North Carolina.....	63	1	1	17	22	9	0	0	0	7	5	7
South Carolina.....	5	0	3	2	2	2	0	0	0	6	8	10
Georgia.....	9	1	2	7	0	1	0	0	0	6	8	19
Florida.....	7	2	2	3	1	2	0	0	0	4	2	4
EAST SOUTH CENTRAL												
Kentucky.....	66	0	3	7	7	14	0	0	0	7	11	11
Tennessee.....	7	0	2	12	17	15	0	0	0	6	14	14
Alabama.....	8	3	3	2	8	10	0	0	0	8	7	7
Mississippi <sup>2</sup> .....	10	2	0	2	3	2	0	0	0	1	8	8
WEST SOUTH CENTRAL												
Arkansas.....	1	7	2	1	6	3	0	0	0	6	15	14
Louisiana.....	11	0	1	3	4	5	0	0	0	17	5	12
Oklahoma.....	1	39	1	1	3	5	1	0	0	3	10	10
Texas.....	13	102	7	25	26	14	0	0	0	14	25	27
MOUNTAIN												
Montana.....	0	0	0	7	8	8	0	0	0	0	0	0
Idaho.....	0	0	0	6	2	2	0	0	0	0	1	1
Wyoming.....	0	0	0	4	15	5	0	0	0	0	1	0
Colorado.....	2	1	0	21	25	9	0	0	0	0	0	2
New Mexico.....	0	1	1	12	3	3	0	0	0	3	0	1
Arizona.....	0	3	0	3	9	1	0	0	0	0	1	2
Utah <sup>1</sup> .....	0	2	1	7	7	4	0	0	0	0	0	0
Nevada.....	0	2	0	1	1	0	0	0	0	0	0	0
PACIFIC												
Washington.....	2	0	0	41	13	13	1	1	1	0	0	2
Oregon.....	4	0	0	14	11	5	0	0	1	1	0	0
California.....	12	90	27	114	69	58	0	0	0	4	3	4
Total.....	462	297	143	975	846	884	5	1	16	148	207	239
28 weeks.....	4,756	1,626	974	143,757	93,978	93,978	278	584	1,146	2,401	2,160	2,969

<sup>1</sup>Period ended earlier than Saturday.

<sup>2</sup>Corrected report. Week ended June 24: Poliomyelitis, North Carolina, 41 cases.

<sup>3</sup>Including paratyphoid fever cases reported separately, as follows: Massachusetts, 2, New York 1, Michigan 1, South Carolina 1, Georgia 3, Florida 1, Kentucky 1, Arkansas 2, Louisiana 1, Texas 2, California 3.

*Telegraphic morbidity reports from State health officers for the week ended July 15, 1944, and comparison with corresponding week of 1943 and 5-year median—Con.*

Division and State	Whooping cough			Week ended July 15, 1944								
	Week ended		Median 1939-43	An- thrax	Dysentery			En- ceph- alitis, infec- tious	Lep- rosy	Rocky Mt. spot- ted fever	Tula- remia	Ty- phus fever
	July 15, 1944	July 17, 1943			Ame- bic	Bacil- lary	Un- spec- ified					
NEW ENGLAND												
Maine.....	30	20	21	0	0	0	0	0	9	0	0	0
New Hampshire.....	0	7	1	0	0	0	0	0	0	0	0	0
Vermont.....	51	9	16	0	0	0	0	0	0	0	0	0
Massachusetts.....	73	75	116	0	0	0	0	0	0	0	0	1
Rhode Island.....	5	19	12	0	0	0	0	0	0	0	0	0
Connecticut.....	49	16	53	0	0	0	0	0	0	0	0	0
MIDDLE ATLANTIC												
New York.....	136	236	301	0	4	9	0	0	0	1	0	0
New Jersey.....	65	221	221	0	0	0	0	0	0	2	0	0
Pennsylvania.....	90	265	293	0	1	0	0	0	0	1	0	0
EAST NORTH CENTRAL												
Ohio.....	136	223	267	0	0	0	0	0	0	0	0	0
Indiana.....	21	68	51	0	0	0	0	0	0	4	1	0
Illinois.....	88	207	207	0	1	0	0	2	0	0	0	0
Michigan <sup>1</sup> .....	90	250	250	0	0	3	0	1	0	0	0	0
Wisconsin.....	88	262	208	0	0	0	0	0	0	0	0	0
WEST NORTH CENTRAL												
Minnesota.....	20	64	64	0	1	0	0	0	0	0	0	0
Iowa.....	7	53	44	0	0	0	0	0	0	0	0	0
Missouri.....	29	53	36	0	0	0	0	0	0	0	0	0
North Dakota.....	16	25	20	0	0	0	0	3	0	0	1	0
South Dakota.....	22	12	3	0	0	0	0	0	0	0	0	0
Nebraska.....	27	24	24	0	0	0	0	0	0	0	0	0
Kansas.....	48	92	63	0	0	0	0	0	0	0	0	0
SOUTH ATLANTIC												
Delaware.....	0	2	7	0	0	0	0	0	0	0	0	0
Maryland <sup>2</sup> .....	98	102	65	0	0	0	1	0	0	6	0	0
District of Columbia.....	5	32	15	0	0	0	0	0	0	0	0	0
Virginia.....	50	148	58	0	1	0	331	0	0	6	2	0
West Virginia.....	10	109	38	0	0	0	0	0	0	2	0	0
North Carolina.....	213	226	226	0	0	3	0	0	0	1	0	3
South Carolina.....	88	101	42	0	3	122	0	0	0	0	0	1
Georgia.....	15	79	34	0	0	9	0	0	0	2	0	33
Florida.....	31	13	13	0	2	0	0	0	0	0	0	24
EAST SOUTH CENTRAL												
Kentucky.....	17	25	64	0	0	2	0	0	0	0	0	0
Tennessee.....	37	55	55	0	0	0	12	0	0	1	2	0
Alabama.....	31	96	26	0	1	0	0	1	0	3	0	16
Mississippi <sup>2</sup> .....				0	0	0	0	0	0	0	2	3
WEST SOUTH CENTRAL												
Arkansas.....	20	25	25	0	0	31	0	0	0	0	5	0
Louisiana.....	0	5	27	0	1	5	0	0	0	0	0	8
Oklahoma.....	12	28	19	0	0	0	0	0	0	0	0	0
Texas.....	253	411	203	0	7	797	0	4	0	0	0	51
MOUNTAIN												
Montana.....	5	25	10	0	0	0	0	0	0	0	0	0
Idaho.....	4	0	14	0	0	0	0	0	0	1	0	0
Wyoming.....	4	0	4	0	0	0	0	0	0	0	0	0
Colorado.....	23	35	38	0	0	0	0	0	0	0	0	1
New Mexico.....	2	10	18	0	0	1	0	0	0	0	0	0
Arizona.....	14	30	14	0	0	0	14	0	0	0	0	0
Utah <sup>2</sup> .....	60	95	79	0	0	0	0	0	0	1	2	0
Nevada.....	0	0	0	0	0	0	0	0	0	0	0	0
PACIFIC												
Washington.....	17	83	65	0	0	0	0	0	0	0	0	0
Oregon.....	9	54	27	0	0	0	0	0	0	1	0	0
California.....	94	195	195	0	3	19	0	0	0	0	0	0
Total.....	2,203	4,185	4,078	0	25	1,001	358	11	0	32	15	141
Same week 1943.....	4,185			2	53	599	437	17	1	19	19	123
Same week 1942.....	3,699			6	17	356	411	13	0	17	27	58
28 weeks 1944.....	51,879			28	851	10,633	3,670	308	15	237	330	1,643
28 weeks 1943.....	113,876			37	1,048	7,509	2,612	323	16	221	518	1,507
28 weeks 1942.....	105,735		109,334	50	550	4,039	2,668	246	32	244	553	799

<sup>1</sup> Period ended earlier than Saturday.

<sup>2</sup> Corrected reports.—Week ended June 24: Rocky Mountain spotted fever, North Carolina, 8 cases; typhus fever, North Carolina, 1 case; Florida, 5 cases.

<sup>3</sup> Five-year median, 1939-43.

## WEEKLY REPORTS FROM CITIES

City reports for week ended July 1, 1944

This table lists the reports from 87 cities of more than 10,000 population distributed throughout the United States and represents a cross section of the current urban incidence of the diseases included in the table.

	Diphtheria cases	Erysipellitis, infectious, cases	Influenza		Measles cases	Meningitis, meningococ- cus, cases	Pneumonia deaths	Poliomyelitis cases	Scarlet fever cases	Smallpox cases	Typhoid and paratyphoid fever cases	Whooping cough cases
			Cases	Deaths								
<b>NEW ENGLAND</b>												
Maine:												
Portland.....	0	0		0	6	0	1	0	0	0	0	0
New Hampshire:												
Concord.....	0	0		0	7	0	0	0	0	0	0	0
Vermont:												
Barre.....	0	0		0	0	0	0	0	0	0	0	0
Massachusetts:												
Boston.....	0	0		0	85	4	3	0	40	0	0	3
Fall River.....	0	0		0	4	0	0	0	1	0	0	0
Springfield.....	0	0		0	11	0	0	0	7	0	0	8
Worcester.....	0	0		0	0	0	4	0	15	0	0	4
Rhode Island:												
Providence.....	0	0		0	20	0	1	0	1	0	0	10
Connecticut:												
Bridgeport.....	0	0		0	0	1	0	0	0	0	0	1
New Haven.....	0	0		0	12	1	1	0	1	0	0	1
<b>MIDDLE ATLANTIC</b>												
New York:												
Buffalo.....	0	0		0	6	1	1	6	6	0	0	0
New York.....	6	0	3	1	116	18	44	0	99	0	2	55
Rochester.....	0	0		0	71	0	2	0	6	0	0	3
Syracuse.....	0	0		0	1	1	0	1	2	0	0	3
New Jersey:												
Camden.....	0	0		0	3	1	0	0	2	0	0	0
Newark.....	0	0		0	44	0	0	0	8	0	0	6
Trenton.....	0	0		0	0	0	1	0	0	0	0	1
Pennsylvania:												
Philadelphia.....	0	0		0	25	0	16	0	26	0	1	8
Pittsburgh.....	0	0		0	4	6	8	6	10	0	0	7
Reading.....	0	0		0	1	0	2	1	0	0	0	0
<b>EAST NORTH CENTRAL</b>												
Ohio:												
Cincinnati.....	2	0	1	0	5	1	2	1	12	0	1	3
Cleveland.....	3	0		0	3	4	6	1	13	0	1	17
Columbus.....	0	0		0	1	1	0	0	5	0	0	26
Indiana:												
Fort Wayne.....	0	0		0	0	0	2	0	0	0	0	0
Indianapolis.....	0	0		0	13	0	2	0	13	0	0	14
South Bend.....	0	0		0	0	0	0	0	1	0	0	0
Terre Haute.....	0	0		0	0	0	1	0	0	0	0	1
Illinois:												
Chicago.....	1	0	1	2	0	7	12	2	26	0	0	29
Springfield.....	0	0		0	0	0	4	0	0	0	0	0
Michigan:												
Detroit.....	4	1		0	80	3	9	1	13	0	1	64
Flint.....	0	0		0	0	0	1	0	0	0	0	0
Grand Rapids.....	0	0		0	5	0	0	0	3	0	0	0
Wisconsin:												
Kenosha.....	0	0		0	0	1	0	0	0	0	0	11
Milwaukee.....	1	0		0	103	2	2	0	15	0	1	23
Racine.....	0	0		0	108	0	0	0	1	0	0	2
Superior.....	0	0		0	1	0	0	0	2	0	0	0
<b>WEST NORTH CENTRAL</b>												
Minnesota:												
Duluth.....	0	0		0	44	1	0	1	7	0	0	2
Minneapolis.....	6	1		0	6	3	1	1	13	0	0	1
St. Paul.....	1	0		0	4	1	3	1	4	0	0	4
Missouri:												
Kansas City.....	2	0		2	4	1	6	1	3	0	0	0
St. Joseph.....	0	0		0	1	0	0	0	2	0	0	0
St. Louis.....	0	0	1	0	6	1	12	1	6	0	0	14

## City reports for week ended July 1, 1944—Continued

	Diphtheria cases	Encephalitis, infectious, cases	Influenza		Measles cases	Meningitis, meningococ- cus, cases	Pneumonia deaths	Polionyelitis cases	Scarlet fever cases	Smallpox cases	Typhoid and paratyphoid fever cases	Whooping cough cases
			Cases	Deaths								
WEST NORTH CENTRAL— continued												
North Dakota:												
Fargo.....	0	0	-----	0	0	0	0	0	0	0	0	
Nebraska:												
Omaha.....	0	0	-----	0	9	0	6	0	3	0	0	0
Kansas:												
Topeka.....	0	0	-----	1	8	0	0	2	0	0	0	4
Wichita.....	0	0	-----	0	1	4	0	1	0	0	0	5
SOUTH ATLANTIC												
Delaware:												
Wilmington.....	0	0	-----	0	0	1	0	0	0	0	0	1
Maryland:												
Baltimore.....	4	0	-----	0	20	4	4	1	10	0	1	73
Cumberland.....	0	0	-----	0	0	1	0	0	2	0	0	0
Frederick.....	0	0	-----	0	0	0	0	0	0	0	0	0
District of Columbia:												
Washington.....	0	0	-----	0	30	0	1	0	17	0	0	3
Virginia:												
Lynchburg.....	0	0	-----	0	0	0	0	0	1	0	0	1
Richmond.....	0	0	-----	0	1	1	0	0	2	0	0	0
Roanoke.....	0	0	-----	0	3	0	0	1	0	0	0	14
West Virginia:												
Wheeling.....	0	0	-----	0	0	0	0	0	0	0	0	0
North Carolina:												
Raleigh.....	0	0	-----	0	3	0	0	0	0	0	0	2
Wilmington.....	0	0	-----	0	1	0	2	0	0	0	0	11
Winston-Salem.....	0	0	-----	0	1	0	1	0	0	0	0	2
South Carolina:												
Charleston.....	1	0	-----	0	0	0	2	1	0	0	0	0
Georgia:												
Atlanta.....	0	0	-----	1	0	2	0	7	1	2	0	1
Brunswick.....	0	0	-----	0	2	0	0	0	0	0	0	0
Savannah.....	0	0	-----	0	4	0	2	0	0	0	0	0
Florida:												
Tampa.....	0	0	-----	1	1	0	2	0	1	0	0	0
EAST SOUTH CENTRAL												
Tennessee:												
Memphis.....	0	0	-----	0	0	1	6	1	0	0	0	5
Nashville.....	0	0	-----	0	5	0	1	0	1	0	0	0
Alabama:												
Birmingham.....	0	0	-----	0	1	0	3	1	0	0	0	0
Mobile.....	0	0	-----	0	1	0	1	1	0	0	1	1
WEST SOUTH CENTRAL												
Arkansas:												
Little Rock.....	0	0	-----	0	0	0	1	0	0	0	0	3
Louisiana:												
New Orleans.....	3	0	-----	2	5	1	7	2	1	0	0	0
Shreveport.....	0	0	-----	0	1	0	6	0	1	0	2	0
Texas:												
Dallas.....	0	0	-----	0	10	2	1	0	0	0	0	9
Galveston.....	0	0	-----	0	0	0	3	0	0	0	0	0
Houston.....	0	0	-----	0	3	1	7	1	1	0	1	0
San Antonio.....	1	0	-----	1	0	1	4	0	3	0	0	0
MOUNTAIN												
Montana:												
Billings.....	1	0	-----	0	0	0	1	0	1	0	0	0
Great Falls.....	0	0	-----	0	0	0	1	0	4	0	0	0
Helena.....	0	0	-----	0	0	0	0	0	0	0	0	0
Missoula.....	1	0	-----	0	1	0	1	0	1	0	0	1
Colorado:												
Denver.....	0	0	-----	0	10	0	3	0	3	0	0	9
Pueblo.....	0	0	-----	0	0	0	0	0	0	0	1	0
Utah:												
Salt Lake City.....	0	0	-----	0	21	0	2	0	8	0	0	7

## City reports for week ended July 1, 1944—Continued

	Diphtheria cases	Encephalitis, infectious, cases	Influenza		Measles cases	Meningitis, meningococ- cus, cases	Pneumonia deaths	Pollomyelitis cases	Scarlet fever cases	Smallpox cases	Typhoid and paratyphoid fever cases	Whooping cough cases
			Cases	Deaths								
PACIFIC												
Washington:												
Seattle.....	1	0	-----	0	31	0	7	0	7	0	0	2
Spokane.....	0	0	-----	0	16	0	0	0	5	0	0	0
Tacoma.....	0	0	-----	0	14	1	2	0	5	0	0	1
California:												
Los Angeles.....	13	0	1	0	125	1	7	1	30	0	1	8
Sacramento.....	0	1	-----	0	32	0	5	0	16	0	0	2
San Francisco.....	0	0	-----	0	116	1	4	0	21	0	0	4
Total.....	51	3	12	6	1,278	79	247	38	509	0	13	491
Corresponding week, 1943.....	48	-----	43	17	3,482	-----	332	-----	403	0	22	1,263
Average, 1939-43.....	54	-----	32	11	2,621	-----	256	-----	513	1	26	1,216

<sup>1</sup> 3-year average, 1941-43.<sup>2</sup> 5-year median.

Anthrax.—Cases: New York, 1; Camden 1.

Dysentery, amebic.—Cases: New York, 1; St. Louis, 1; New Orleans, 1; San Francisco, 1.

Dysentery, bacillary.—Cases: Chicago, 1; Detroit, 2; Richmond, 2; Charleston, S. C., 6; Atlanta, 1; Shreveport, 1; Los Angeles, 7.

Dysentery, unspecified.—Cases: Baltimore, 2; Shreveport, 2; San Antonio, 21.

Typhus fever, endemic.—Cases: New York, 1; Savannah, 1; Tampa, 1; Shreveport, 1; Houston, 4.

## Rates (annual basis) per 100,000 population, by geographic groups, for the 87 cities in the preceding table (estimated population, 1943, 34,118,200)

	Diphtheria case rates	Encephalitis, infectious, case rates	Influenza		Measles case rates	Meningitis, meningococ- cus, case rates	Pneumonia death rates	Pollomyelitis case rates	Scarlet fever case rates	Smallpox case rates	Typhoid and paratyphoid fever case rates	Whooping cough case rates
			Case rates	Death rates								
New England.....	0.0	0.0	0.0	0.0	415	17.2	28.6	0.0	186	0.0	0.0	77
Middle Atlantic.....	2.8	0.0	1.4	0.5	125	12.6	34.3	6.5	74	0.0	1.4	38
East North Central.....	6.7	0.6	1.2	1.2	194	11.6	24.9	3.0	63	0.0	2.4	116
West North Central.....	17.9	2.0	2.0	6.0	165	21.9	55.7	15.9	76	0.0	0.0	62
South Atlantic.....	8.4	0.0	3.3	0.0	114	11.7	35.2	6.7	59	0.0	1.7	181
East South Central.....	0.0	0.0	0.0	0.0	41	5.9	64.9	17.7	6	0.0	5.9	35
West South Central.....	11.5	0.0	8.6	0.0	55	14.3	83.2	8.6	17	0.0	8.6	34
Mountain.....	16.5	0.0	0.0	0.0	264	0.0	66.1	0.0	140	0.0	8.3	140
Pacific.....	22.1	1.6	1.6	0.0	528	4.7	39.5	1.6	133	0.0	0.0	27
Total.....	7.8	0.5	1.8	0.9	196	12.1	37.9	5.8	78	0.0	2.0	76

## HUMAN CASE OF PNEUMONIC PLAGUE (LABORATORY INFECTION) IN SAN FRANCISCO, CALIF.

A case of primary pneumonic plague, in which the infection was acquired in the laboratory, has been reported in San Francisco, Calif. The case occurred in a Public Health Service officer, who was engaged at the time in plague work at the plague laboratory in San Francisco. The patient became ill on May 30 and was admitted to the United States Marine Hospital on June 1. He is reported to have recovered. Precautionary measures were promptly adopted, and no secondary cases have occurred.

## TERRITORIES AND POSSESSIONS

## Hawaii Territory

*Honolulu—Dengue fever.*—For the period June 1–15, 1944, only 2 cases of dengue fever were reported in Honolulu, T. H., bringing the total number of cases reported since the beginning of the outbreak to date to 1,495. These 2 cases represent the lowest semi-monthly incidence of the disease since the beginning of the control program.

\* \* \*

## DEATHS DURING WEEK ENDED JULY 8, 1944

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

	Week ended July 8, 1944	Correspond- ing week, 1943
<b>Data for 93 large cities of the United States:</b>		
Total deaths.....	7,835	7,901
Average for 3 prior years.....	7,919	
Total deaths, first 27 weeks of year.....	255,281	261,803
Deaths under 1 year of age.....	516	624
Average for 3 prior years.....	596	
Deaths under 1 year of age, first 27 weeks of year.....	16,768	18,304
<b>Data from industrial insurance companies:</b>		
Policies in force.....	66,653,120	65,598,856
Number of death claims.....	10,036	10,039
Death claims per 1,000 policies in force, annual rate.....	7.9	8.0
Death claims per 1,000 policies, first 27 weeks of year, annual rate.....	10.4	10.2

## FOREIGN REPORTS

### CANADA

*Provinces—Communicable diseases—Week ended June 17, 1944.*—During the week ended June 17, 1944, cases of certain communicable diseases were reported by the Dominion Bureau of Statistics of Canada as follows:

Disease	Prince Edward Island	Nova Scotia	New Brunswick	Quebec	Ontario	Manitoba	Saskatchewan	Alberta	British Columbia	Total
Chickenpox.....		25		85	336	62	20	79	138	745
Diphtheria.....	2	7	1	21	1	13		1		46
German measles.....		1		60	39		38	18	77	233
Influenza.....					3	1			2	6
Measles.....		33	7	439	493	159	53	86	44	1,314
Meningitis, meningococcus.....					1	2				3
Mumps.....		3	1	137	144	10	14	97	49	455
Poliomyelitis.....					3	1			1	5
Scarlet fever.....		6	2	35	132	25	9	47	72	328
Tuberculosis (all forms).....		6	8	289	61	23		9	44	440
Typhoid and paratyphoid fever.....				6	3					9
Undulant fever.....				1	1				2	4
Whooping cough.....		26	1	66	21	3	12	2	30	161

### CUBA

*Provinces—Notifiable diseases—4 weeks ended June 17, 1944.*—During the 4 weeks ended June 17, 1944, cases of certain notifiable diseases were reported in the Provinces of Cuba as follows:

Disease	Pinar del Rio	Habana <sup>1</sup>	Matanzas	Santa Clara	Camaguey	Oriente	Total
Cancer.....		2	3	3		7	15
Cerebrospinal meningitis.....	1						1
Chickenpox.....	1	1					2
Diphtheria.....	2	29	1				32
Leprosy.....		1		1			2
Malaria.....	6	5	4	1	2	232	250
Measles.....	5	15		4			24
Poliomyelitis.....		6			2		8
Scarlet fever.....		1					1
Tetanus, infantile.....			1				1
Tuberculosis.....	6	30	16	16	3	44	115
Typhoid fever.....	16	60	11	24	9	30	150
Whooping cough.....			1				1
Yaws.....						3	3

<sup>1</sup> Includes the city of Habana.



### Plague

*French West Africa—Dakar.*—For the period June 4–28, 1944, 25 cases of plague with 23 deaths were reported in Dakar, French West Africa.

*Palestine—Haifa.*—For the week ended July 1, 1944, 1 case of plague was reported in Haifa, Palestine. Several plague-infected rats were also reported for the preceding two weeks.

### Smallpox

*Bolivia.*—For the month of May 1944, 75 cases of smallpox with 20 deaths were reported in Bolivia, including 18 cases of smallpox with 6 deaths reported in La Paz city and 27 cases with 6 deaths reported in Potosi.

*Greece—Hevros Department.*—For the period March 21–31, 1944, 13 cases of smallpox were reported in Hevros Department, Greece.

*Nigeria.*—For the week ended June 10, 1944, 105 cases of smallpox with 11 deaths were reported in Nigeria.

### Typhus Fever

*Greece.*—Typhus fever has been reported in Greece as follows: March 1–31, 1944, 57 cases; April 1–30, 1944, 41 cases.

*Guatemala.*—For the month of May 1944, 198 cases of typhus fever with 47 deaths were reported in Guatemala.

*Hungary.*—For the 3 weeks ended June 17, 1944, 405 cases of typhus fever (including 190 cases in Subcarpathia) were reported in Hungary.

*Irish Free State—Galway County—Oughterard.*—For the week ended June 24, 1944, 1 case of typhus fever was reported in Oughterard, Galway County, Irish Free State.

*Slovakia.*—For the period May 14–June 3, 1944, 28 cases of typhus fever were reported in Slovakia.

*Tunisia.*—Typhus fever has been reported in Tunisia as follows: June 1–10, 1944, 18 cases; June 11–20, 1944, 38 cases.

*Yugoslavia.*—For the period April 15 to May 7, 1944, 1,212 cases of typhus fever were reported in Yugoslavia.

### REPORTS OF CHOLERA, PLAGUE, SMALLPOX, TYPHUS FEVER, AND YELLOW FEVER RECEIVED DURING THE CURRENT WEEK

NOTE.—Except in cases of unusual incidence, only those places are included which had not previously reported any of the above-mentioned diseases, except yellow fever, during the current year. All reports of yellow fever are published currently.

A table showing the accumulated figures for these diseases for the year to date is published in the PUBLIC HEALTH REPORTS for the last Friday in each month.

(Few reports are available from the invaded countries of Europe and other nations in war zones.)

## Yellow Fever

*Belgian Congo—Bondo.*—The death from yellow fever in Bondo as published on page 793 of the Public Health Reports of June 16, 1944, occurred on April 29, 1944, and not for the week ended June 3, 1944, as published.

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## COURT DECISION ON PUBLIC HEALTH

*Venereal disease—examination of persons suspected of being infected.*—(Illinois Supreme Court; *People ex rel. Baker et al. v. Strautz, Chief of Police*, 54 N.E.2d 441; decided March 21, 1944, rehearing denied May 11, 1944.) In a habeas corpus proceeding in the Supreme Court of Illinois it appeared that the petitioners were arrested in East St. Louis and placed in the city jail. The next morning complaints were filed before a justice of the peace charging that each “wilfully and unlawfully solicited to prostitution” and “wilfully and unlawfully was a lewd and lascivious person in speech and character.” The justice of the peace entered an order holding the petitioners for the clinic because it appeared that they might be suffering from a communicable venereal disease. No bond was fixed. The petitioners refused to be medically examined and sought a writ of habeas corpus, first in the city court of East St. Louis and next in the county circuit court, but both courts denied the writ. An original habeas corpus proceeding was then instituted in the State supreme court and the petition was allowed and a return made thereon. Bail was fixed by the court and given by the petitioners and they were thereby released from custody.

The statute under which the petitioners were ordered held for the clinic provided as follows: “When it appears to any judge or justice of the peace from the evidence or otherwise that any person coming before him on any criminal charge may be suffering from any communicable venereal disease, it shall be the duty of such judge or justice of the peace to refer such person to the director of such hospital, sanitarium or clinic, or to such other officer as shall be selected or appointed, for the purpose of examining the accused person, and if such person be found to be suffering from any communicable venereal disease, he or she may by order of the court be sent for treatment to a hospital, sanitarium or clinic if any be available and if necessary to be segregated for such term as the court may impose at such hospital, sanitarium or clinic.”

For the purpose of the case the petitioners agreed that the arrests, complaints, and warrants were legal and proper but contended that (1) the above-quoted statute was unconstitutional and void in that (a) it deprived them of their liberty without due process of law, (b) it

contained subjects not expressed in the act's title, (c) it denied them bail when they were not charged with a capital offense, and (d) it denied them the right to be heard in answer to the criminal charges and defend in person and to demand the nature and cause of the accusation and denied them the right to a speedy and public trial; (2) if the said statute was valid, then the order of the justice of the peace was void for the reasons stated under (1); and (3) they had been and were being illegally held in custody in violation of Federal and State constitutional provisions.

The supreme court stated that the power to detain a person suspected of having a contagious disease rested in the police power of the State and that when a State employed its police power to safeguard the public health it could act in a summary manner even though the result was to deprive a citizen of his liberty. That the statute in the instant case was a measure enacted within the State's police power was, according to the court, unquestioned.

After reviewing certain decisions in other jurisdictions the supreme court turned its attention to the provision of the statute relative to a justice of the peace detaining a person suspected of having a venereal disease when it appeared from the evidence "or otherwise" that such person might be suffering from such disease. The statute, said the court, did not mean that the justice had any authority outside of the evidence appearing before him. The power to compel any person arrested on any criminal charge to submit to a medical examination "is limited to a criminal case in which evidence is produced or circumstances develop tending to indicate that the person charged may reasonably be suspected of being afflicted with a communicable venereal disease and must, from its very nature, present sufficient evidence upon which the justice of the peace may issue the order referring the party to some medical officer for such examination." The words authorizing the justice to refer the accused person to "such other officer as shall be selected" meant that the party had to be "sent to some hospital, sanitarium, clinic, or to some recognized medical officer who will properly represent both the accused person and the municipality."

The court said that it could be pointed out that a venereal disease most often exists within the veil of secrecy. "Certainly one who is charged with soliciting to prostitution and one of lewd and lascivious character is one who may first be suspected of carrying such dreadful affliction." It was most reasonable, according to the court, to suspect that the petitioners, if carrying on the practice of prostitution, were indiscriminate and promiscuous in their bodily contacts and were natural subjects and carriers of venereal disease. "\* \* \* it was therefore logical and natural that suspicion immediately be cast upon them and necessity dictate a physical examination of their persons.

The citizens of East St. Louis, the war workers and soldiers in its vicinity are entitled to protection against social diseases. Petitioners furthermore have agreed, for the purpose of this suit, that their arrest was legal and proper, that the complaints later filed and the warrants issued likewise are legal and proper. Such being the case, their detention for examination by the clinic as suspects carrying venereal diseases is likewise reasonable and proper."

The contention that the statute violated the Federal and State constitutions was held by the court not to be supported by authority and the title of the act was held to properly describe the subjects contained in the act. It was also concluded that the statutory provision in question did not violate the criminal code since it was based upon the State's police power and did not fall within the provisions of the criminal code. "This likewise answers the contention that the petitioners were held without bail, since quarantine under the police provisions naturally implies such a detention and demands it."

The petition for discharge under the writ of habeas corpus was denied and the petitioners were remanded to the custody of the chief of police of East St. Louis until they submitted to an examination under the provisions of the statute.

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