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Public Health Reports

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Public Health Reports

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PLANNING FOR HEALTH EDUCATION IN THE WAR AND POST-WAR PERIODS—THE NATIONAL PROGRAM [1]

By E. R. Coffey, *Medical Director, United States Public Health Service*

Health education is evolving into a specialized method by means of which it is possible to advance other public health endeavors. The Public Health Service is now shaping its educational activities in that direction, through a broad, coordinated program designed to give impetus to national thought and action in this field.

Health education is not a new function; it is as old as health work itself. In fact, it would be almost impossible to render a health service of any type if it were stripped of educational substance. Through the years public health workers have come to realize that they were using education to implement their services, and that the more effective their educational work, the more quickly people sought health for themselves and supported community health measures.

Until very recent years, however, health authorities in general at local, State, and Federal levels were guilty of acknowledging the worth of health education while they neglected to use this ally for all it is worth. Few health department budgets provided funds specifically for health education. The health department that boasted a health educator was rare indeed. The Public Health Service was in the same position.

To be sure, members of the staff made talks or showed motion pictures when organizations requested them. Pamphlets were distributed haphazardly; news items appeared when the reporter came around for a story, or when the health officer had time to write one. But organized and coordinated programs with clearly defined objectives and responsibilities were extremely rare.

These early activities stemmed from the old concept that the educational function of public health agencies was to tell people

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people learn only when they are interested and when they realize that they have a problem. Today, the approach is democratic—"We have a problem; what can we do to solve it?"

The objectives and responsibilities in health education thus have become more clearly defined. Evidence of this progress may be seen in the recent delineation of the functions in health education by the Committee on Professional Education of this Association.[2] Here the emphasis is placed on assisting people to recognize their own individual and community health problems, to learn the scientific facts necessary to solve these problems, and then to translate their solutions into action. Materials and methods of health education, which have absorbed so much of our discussion in the past, are still important tools. But the real objective now is to give the people an opportunity, in their own communities, mutually to study their problems and mutually to solve them. This, in the language of the educator, means "to provide learning situations."

Viewed in this light, the responsibility of health education is universal. It must encompass everyone—young and old, rich and poor, all races—for each person must become intelligently aware of his own health problems and those of his community and his nation, and share in their solution.

Along with the clarification of objective, there has emerged an increasing recognition of the importance of health education as a significant part of the total public health program. States are augmenting their budget allotments for health education. In the fiscal year 1943, $1,200,000, from all sources, was budgeted by the States for health education. In the fiscal year 1942, the amount budgeted was around $900,000.

The most significant and far-reaching evidence of the new trend in health education is the awakening interest of local health authorities, for it is at the community level that the needs of the people are met. Already local health officers are planning to have full-time health educators on their permanent staffs. In fact, it has now become apparent that every full-time health unit, as defined by the Committee on Local Health Units, of this Association should have at least one qualified full-time health educator.

While these changes have been going on, the Public Health Service has coordinated the various health education activities carried on by several of our divisions. It has long been the policy of the Public Health Service to stimulate and support leadership in community and State. In health education the function of the national agency,

A primary responsibility of the Federal agency is to lead the way in defining national problems, in focusing the Nation's attention upon them, and in attacking those problems. More than a quarter of a century ago, the Federal government used the facts of maternal and infant mortality as opening guns in the drive to secure health services for mothers and children. Today maternal and child health services are Nation-wide. Very little could be done toward eliminating the venereal diseases so long as the prejudice against talking of these diseases prevailed and kept the people from hearing or speaking of this national health problem. The Federal government broke the long silence on this subject in 1936. Since then, the whole Nation has become vocal against the venereal diseases. More important still, the Nation has increased by 300 percent the clinics where these diseases are diagnosed and treated. In many other fields the Federal government has led the way by telling the facts and by supporting the attack.

An equally mandatory responsibility of the national agency is to give consultation and practical assistance to State and local health departments in the planning and conduct of effective health education programs. To this end, the Public Health Service has recruited eight qualified health educators and has broadened their experience by putting them to work in a few local health departments. Here they become regular members of the staff, and, under the supervision of the health officer, they organize and operate a community health education program.

These programs have not dealt with new problems in public health or raised controversial issues. In every case the program has been focused upon old problems of public health, the solution of which is a part of our enormous wartime responsibility. Venereal disease and prostitution, tuberculosis, food sanitation, rat control—even garbage disposal—are all problems with which health officers are struggling. But their solution depends upon community participation. And our health education programs have been the community's meeting-ground for understanding and action against these menaces to health and welfare.

In one community, the health officer had been blocked for years from obtaining hospital facilities for the long waiting list of tuberculosis patients in the county. The barrier was the resistance of uninformed citizens who feared that the proximity of a tuberculosis hospital would expose them to a dangerous disease. When all of the

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In another community, restaurant owners had been apathetic to the idea of food sanitation and the training of food handlers. When the subject of sanitation was studied in the community health education program, the need for improvement was recognized by the citizens. Within the month of study devoted to sanitation, the restaurant owners in a body were begging the health department to provide instruction for their employees.

And in yet another town, a once casual interest in typhus and its presence in a nearby State grew into a community demand for rat control. Many of the housewives who joined in the program had never associated typhus with rats, nor were they aware of the heavy infestation of rodents, not only in the dumps and alleys, but in the market areas of their own town.

These typical accomplishments are evidence that the programs developed by our health educators are effective. Even more significant is the acceptance of this type of program by health officials in the States where our staff has been in action. North Carolina has employed five health educators to take over the programs initiated by Public Health Service workers and has placed five others in training to increase the number of local health departments having this new type of program. Complete information on other States is not available, but we do know that Oklahoma, Illinois, Indiana, California, and South Carolina are training one or more health educators.

As our staff of health educators has grown and has been through the test of doing the job themselves, the Public Health Service is building a foundation for further expansion of public health education in the States through the provision of consultant services at the District level.

An emergency resource for community health education has been utilized in our malaria control program. For the past two summers, local school teachers have been employed in the malarious areas of the South to carry on educational programs. The teachers were given an intensive 2-week course on malaria control and on methods of community health education. They then returned to work as regular employees of their county health departments for the remainder of the vacation period. Although this has been an emergency program, it has had values beyond the immediate results. The teachers have become more interested in community health problems and their solution. They have carried their new-found knowledge and enthusiasm into the classroom, the faculty meeting, and the community after their summer jobs as malaria educators were over. And the program

they propose to issue. Although health education materials prepared by national organizations, both official and nonofficial, have been used widely by local health departments, many communities would prefer to prepare their own materials.

The preparation of effective materials, however, requires special skills which many State and local health departments cannot afford. By using consultant services, health departments can improve the quality of local materials. The Public Health Service cannot yet give as much assistance of this type as it would like to give. We do have a staff of specialists in the production of health education materials—pamphlets, popular talks, press releases, posters, film strips, movies, radio plays, and exhibits. Within the limits of staff, we shall be glad to consult with State and local health departments on the preparation of their materials.

The Service has a further duty—to hold high the standards of training for health educators, and in doing so to make sure that they are well grounded in the fundamental principles of preventive medicine and public health, and that they understand the learning process. The first requirement is to make them missionaries for scientific medicine, and the second is to make them competent guides to learning rather than didactic instructors. Our initial efforts have been materially aided by two grants from the W. K. Kellogg Foundation for fellowships in health education. These grants were made to meet the growing need for trained personnel in war areas and to stimulate schools of public health to include more training in community organization for health education.

Thirty-six students are in training at the University of North Carolina, University of Michigan, and Yale University, on Fellowships established by Kellogg grants, for their master's degree in public health with a major in public health education. Another group of about the same number are taking similar training on stipends paid by State health departments. Health educators of the Public Health Service are available to the schools to describe the programs the Service has developed.

After 9 months of academic training the students are required to take 3 months of field training. This field experience is acquired in those health departments where our educators are operating demonstration programs.

In the future, participation of the Public Health Service in the training of health educators will be concentrated on recruiting train-

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finding resources available to the Service in the fields of medicine, hygiene, and other interrelated sciences are not likely to be duplicated at the State or local level. Both professional and lay groups have constant need for reference to authoritative source materials. A few years ago, the machinery was set up to provide service of this type. Reference materials useful in public health education, especially pamphlets and reprinted publications, were collected. Current literature was covered systematically. Thus, a pool of source materials on many special topics of interest to professional and nonprofessional groups was established. Later, a special collection of pamphlets for lay consumption was made, including the materials issued by 115 official and nonofficial health agencies. A start was made on establishing a catalog of motion picture films.

In order to make some of these references more readily available, the Service proposes to make up loan packets containing pamphlet materials from a variety of agencies. The packets will be devoted to health problems of national importance in wartime. The purpose of these packets is to help health departments in selecting pamphlet materials or in developing their own publications. If the circulation of the first group of loan packets is sufficient to warrant it, it may be possible to expand the service.

Pooling source information is only one of the many functions the Public Health Service can profitably perform as a clearing house, but present resources limit its performance. For example, more bibliographies should be compiled, especially in relation to public health work during the war and to post-war health problems. A select catalog of motion-picture films, which have been reviewed for accuracy and effectiveness, together with a brief comment on each film would be enormously useful. Analysis of the news—that is, classification and appraisal of news stories and editorial comment on health matters—is a service which should be available to health authorities in order that they may be informed on trends in public interest.

In connection with these information services, the national agency has a further important function, namely, that of reviewing and abstracting the current literature of scientific research and public health administration. It is a truism that the ever-growing body of knowledge in the health fields is beyond the powers of any individual to encompass, hence the need for consistent and concerted effort to summarize the significant contributions as they appear. The Public Health Service has met this responsibility only in a limited area, that

needed in public health education. Obviously, the national agency should confine its efforts in this field to problems of national importance and to new problems not yet fully recognized. It is particularly important that we continue to strive for materials of high quality, since in making health education materials available the Public Health Service should present accurate information and demonstrate modern approaches and techniques. That our production has been small is due both to limited appropriations and to the universal war problem of maintaining sufficient personnel. However, the materials produced by the Public Health Service in recent years have exercised a considerable influence on the quality of health education materials. The wide circulation of our illustrated folders, posters, workers' health series, and films also has attested their value.

No health agency can escape the responsibility of answering personal inquiries from the general public. Of the thousands of letters directed to the Public Health Service, a large proportion could perhaps be answered better by a State or local organization. This is especially true when the writer has some personal or family health problem about which he desires authoritative information or practical help. We have often debated whether we should redirect such inquiries to the State health officer. But, since the Service is a governmental agency from which the public has a right to expect an answer, we must continue to reply to these requests. The Service has, however, adopted the policy of referring correspondence of certain classifications directly to the State health department. These include complaints about State or local health conditions, requests for birth certificates and for information on State or local vital statistics. However, we believe that people should learn more and more to turn to their State health authorities. Better public information regarding the services and organization of the official agency at the State level would greatly advance public awareness.

Perhaps the most essential function of a national agency, particularly at the present stage of development, is research and evaluation. Results must be measured in order to ascertain the degree to which the many procedures now in use do change knowledge, attitude, and behavior. The various media and the ways in which they are used must also be evaluated, and we must know how to make the most effective use of radio, posters, exhibits, pamphlets, and motion pictures. Data as to which types of material are most useful among groups at different economic and educational levels are also needed. A small beginning on some of these problems has been made through: (1) a

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Further studies have been discontinued, but the Service expects to resume these activities after the war.

In summary, the objective of health education during the war and in the post-war period is to stimulate and assist individuals to recognize, study, and solve their own health problems, both individual and community. The particular responsibilities of the Public Health Service may be defined as:

(1) To focus attention on health problems of national scope as they arise.
(2) To give consultation service and assistance in program planning and execution, and in the preparation of materials when such assistance is requested.
(3) To stimulate the training of personnel and hold high the standards for their training and accomplishment.
(4) To serve as a clearing house for new ideas, methods, and materials.
(5) To summarize new developments in science and show its applicability to the subject matter of health education.
(6) To prepare high quality materials that have national application.
(7) To conduct an information service for the many inquiries received.
(8) To conduct research on methods and materials of health education, and evaluate programs with the purpose of making all our efforts more effective.

Mutual action by Federal, State, and local agencies is necessary in the operation of a national health education program. It is hoped that the discussions here today will facilitate all our efforts to educate the people so that they will know what steps to take to maintain health and will be willing to take them.

PLANNING FOR HEALTH EDUCATION IN THE WAR AND POST-WAR PERIODS—THE SCHOOL PROGRAM [1]

By JOHN W. STUDEBAKER, *United States Commissioner of Education*

The topic, "National Planning for Health Education in the War and Post-war Periods," is a very formidable assignment even when it is limited to a discussion of the part to be played by the organized educational system of the Nation in making and effectuating such plans.

In a democracy planning is both desirable and inevitable. Man is an animal endowed with foresight and the ability to look ahead, to project future goals. Individual and social planning can no more be avoided than can eating or breathing. Planning in a democracy is largely educational in character, both in the projection of goals and in the choice of means for achieving them; democracy must depend upon an engineering of human consent based on understanding. In a democratic society the role of government [illegible]

Now let us turn to the particular topic of health education. The ultimate health goal of the school is to help each student to attain the best possible physical development and condition for his particular age and biological endowment. Be it noted at once that the public health service, the home, the family doctor, and others share this objective with the school. The primary concern of the school as an educational agency is with the development by the individual student of good health knowledge functioning through good health habits. The attainment of optimum individual health depends upon a nexus of factors or influences, many of which do not appear to be primarily educational in character. It depends, for example, upon the income of parents, upon the home dietary standards, upon community provisions for sanitation, medical care, and recreation. It depends upon all of these factors as well as upon community provisions for the health education of students in schools. All of these factors are involved in a complete consideration of the means by which the ideal of positive health for each individual in the Nation may be attained.

The special responsibility of the schools is not only to help to develop personal ideals of health but also to give students a proper knowledge of the means, both individual and social, by which those ideals may be attained. Or, to put the matter otherwise, the development of a personal health consciousness and of a social conscience regarding the health of others is a primary educational goal. The school effort to assist the student in the development of personal health consciousness and of a social conscience regarding the health of others ordinarily goes by the name of health instruction. It is designed to communicate a knowledge of sound principles of hygiene, both physical and mental, a knowledge of how to deal with emergencies, of when to utilize the services of health experts, of the possibilities of preventive medicine, of how to combat the spread of disease, and of the principles of good nutrition. The controlling objective of all such health instruction is not merely knowledge or understanding as such, but knowledge which can be made to function in daily living, knowledge which is put into practice and made a part of the habit system of the individual.

How far short we, as a Nation, are of attaining the goal of positive physical and mental health for all citizens is a matter into which I have neither the time nor the ability to go in any exhaustive way. Suffice it to say that this war has disclosed again, as did the First World War

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of the Nation must bear their fair share of blame for this condition since an effective program for the identification of remediable physical defects in school children and youth has not been universally operative during the past 25 years.

Following the First World War some 34 States passed laws making physical education mandatory in the schools. Many of these laws were more honored in the breach than in their effective observance. Nevertheless, some States and school systems did inaugurate fairly efficient systems of physical education. With respect to the medical examination of school children, however, the record is not so good. Only 1 State, New York, has by law a State director of medical inspection; in perhaps 5 other States some official in the State department of education or of health serves in this capacity. Examinations are required annually in 19 States; every 2 years in 2 States; every 3 years in 1. In a large majority of the States, however, no medical examination is required by law or by regulation, and it is frequently true that in those States in which such an examination is required it is limited and cursory in character.

Many of the larger cities of the Nation, it must be noted, do provide a rather thorough medical examination of students as they enter and again before they graduate from high school. But even in these larger cities, enrolling about half of the Nation's youth of high school age, much more thorough and universal examination of students is in order. This has been brought home to the United States Office of Education with especial force in the past year in connection with the efforts made to stimulate and guide the development of physical fitness programs in the high schools.

In the summer of 1942 it became apparent that, in view of the national emergency, there was need for a readjustment of the secondary school curriculum. To meet this need, the Office of Education, with the assistance of a committee of prominent educators, promulgated the High School Victory Corps as a wartime pattern of student organization and curricular readjustment. Participation in a physical fitness program was made a prominent feature of the Corps. This was in recognition of the fact that one of the most important things the schools could do for young people was to give them a better physical preparation for the exigencies of wartime. More strenuous physical activity, harder muscular work, toughening of physical fibre, physical stamina to endure—these cannot be attained unless there are sustained and vigorous physical activity programs.

Under the auspices of the Office of Education and with the coopera-

for the schools of the Nation. Their recommendations are embodied in detail in two publications: Physical Fitness Through Physical Education for the High School Victory Corps and Physical Fitness Through Health Education for the High School Victory Corps.

Without going into detail as to the recommendations contained in those two bulletins, it may suffice to say that physical fitness is meant to connote good nutrition, muscular strength, endurance, motor skills, mental health, and morale. Physical conditioning of boys is to be achieved in the school program by combative sports, by games stressing individual competition, by games that develop team play and the team spirit of "all for one and one for all." It was recognized that it is not enough to herd youths together and exercise them vigorously. A constructive physical-fitness program must include the rationale of the activities so that youth may learn how to conduct themselves in a physical regimen and through hygienic living under varying circumstances. Health instruction was therefore given a prominent place in the recommended physical-fitness program. The achievement of physical fitness takes time, and another major recommendation for the schools' program for physical fitness in wartime was for an increase from the usual two or three periods a week to one period daily for physical and health education, plus 2 hours daily of extracurricular physical activity.

With the purpose of implementing the High School Victory Corps program for the preinduction training of high school students for war service, legislation has been introduced in the Senate which, if passed, would authorize appropriations to assist the States to make available rather thorough medical examinations for at least one-third of the students enrolled in secondary schools, and to provide local district teacher-training services for teachers of physical fitness in the high schools. This legislation has the active backing of the American Association of Health, Physical Education, and Recreation, of the armed forces, and of the National Education Association. For if there is one thing concerning which educators are in substantial agreement at the present time it is that the preliminary physical conditioning of high school youth for the rigors of military life and for the strain of wartime living is a job which the high schools must and can be expected to accomplish.

It is recognized, of course, that there have been a few critics of this program, just as there have always been critics of any effort to modify the time-honored high school

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can be made to serve the ends of evil tyrants or it can be made to contribute to the overthrow of these same tyrants. If we must choose between the development of a knowledge of Shakespeare and the development by youth of strong and vigorous bodies, Shakespeare will have to wait in wartime. Of course, even in wartime one is not confronted with the necessity for any such choice. Many high schools are doing both—continuing to provide opportunity for the liberal humanizing studies and at the same time putting greater emphasis upon health and physical education for high school youth.

The second part of my assigned topic, namely, planning for health education in the post-war period, is more difficult than the first. Not only does post-war planning for health education look to a more distant and to some degree unpredictable future, but the subject is further complicated by the fact that, as far as can be ascertained, no representative educational body has yet made any definite and detailed pronouncement on post-war health education in the schools. Consequently, if I am to discuss the matter at all, I must ask you to pardon me for my seeming personal presumption in proposing—rather dogmatically perhaps—some planks in a platform of health education for the post-war period.

First, there is need for a more adequate and properly graded program of health instruction in every school in the land. There is particular need for greater stress on this subject matter in the high schools, where students have sufficient maturity to understand the physiologic and scientific background information for healthful living.

The second plank in a platform for post-war health education has to do with the physical accommodations of the school. Every child and youth in America ought to go to a school which is well built, comfortable, sanitary, properly lighted, and provided with sufficient gymnasium and playground facilities to permit a well-rounded program of physical activities, games, sports, etc.

Third, there should be school provisions for the annual medical examination of school children and youth, with a follow-up to acquaint parents with the results of the school examination; and to encourage, and if necessary assist in securing, such reparative or remedial work as may be indicated. I realize that in this matter of health and medical service as distinguished from health instruction there are differing viewpoints and opinions. Personally, I have been of the opinion for many years that it is not only a legitimate province but a duty of the schools to provide for medical examinations of students

most particularly of the parents of the children themselves. There should be proper coordination of the health services of the schools with those of other community agencies to the end that the needs of the children and youth are definitely met. If we keep our eyes on the same goal, we should find ourselves marching side by side in the provision of adequate health services for all of America's children and youth.

A fourth plank in my platform for post-war health education in and through the schools concerns education for the physically handicapped. At first thought this may seem to be somewhat outside the field of health education. Yet, if health education is concerned with mental as well as physical well-being, it is important that essential justice be done to the physically handicapped by providing them with opportunities for a completely rounded-out program of developmental activities, suited to their individual capacities and needs. In this program of developmental activities, the physical development of handicapped children has an important place. There are tens of thousands of these children in America—the lame, the deaf, the semisighted, the undernourished—who should be enabled to get to school and to be given a well-balanced program of instruction, rest, exercise, and nutrition which will help them in so far as possible to overcome or to compensate for their handicaps. Beginnings have already been made in a number of the States in assisting local communities to meet the additional cost of transportation or of educational and health services for the handicapped out of State tax resources. I believe that it is a proper function of the Federal government to stimulate the extension of such pioneer efforts in other States until every handicapped child in the Nation is assured of equity with respect to educational opportunity.

Fifth, I propose as a plank in the platform of post-war health education that the schools undertake to provide opportunities for older children and youth to experience for at least a month out of each year the health-building activities of a well-conducted camp. This again is not exclusively a health-education proposal, although its major benefit would be the building of health and physical vigor. As things stand now the opportunity to experience the benefits of summer camping is limited largely to children from homes of comfortable economic circumstances, and to a very limited extent to children from economically underprivileged homes. I believe that it is a proper project of

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proposal. We have had a great deal of experience in the past 20 years with school-lunch programs, supported in part in recent years by surplus commodities or by Federal funds.

In connection with the provision of school lunches, as with all of the other planks in this proposed platform for post-war health education, it is apparent that the crucial questions have to do with the means by which such more or less ideal measures may be made actual and real. In the last analysis all of these things have an economic tag attached to them—they will cost money, and the question of means becomes finally a question of how much money they will cost and how this money is to be provided. Sufficient to say, it is my opinion that the provision of the funds necessary to implement any such program of improved health services and activities as I have outlined is a joint responsibility of the local communities, of the States, and finally, of the Nation. We have learned in this war that the results of malnutrition, of physical handicap and underdevelopment are not a concern solely of the localities, or even of the States. The children and youth reared in one locality or one State become youthful or adult citizens of other localities and other States. In time of national peril when our national resources of manpower as well as matériel must be mobilized we become acutely conscious of the national interest in measures of health and education. It is to be hoped that this national interest will be matched by a national sense of responsibility and by appropriate national action.

I believe firmly in the necessity of safeguarding the rights of self-determination, of freedom of choice and of decision, which are the very essence of democratic government—whether in the individual, the small group of neighbors, the community, the State, or the Nation. I believe, in other words, in the necessity for decentralization of the controls of education in our communities, keeping these controls of education close to the parents of the children and youth to be educated. On the other hand, the units for the administration and the support of education must not be so small and weak that a minimum defensible program of education cannot be provided for the children and youth concerned.

Furthermore we have in the principle of grants-in-aid a workable compromise between decentralized support, administration, and control and some measure of coordination and regulation by the larger and wider community of State and Nation, which are also parties-

crepancies and inequalities in educational opportunity in America we shall then find it relatively easy to plan for the removal of these same discrepancies in that part of the educational program which is concerned with the optimum development of the health of all American youth.

PLAGUE INFECTION REPORTED IN THE UNITED STATES DURING 1943[1]

IN HUMAN BEINGS

One case of plague in a human being and one death from the disease were reported in the United States during the calendar year 1943, both of which occurred in Siskiyou County, Calif.

The fatal case is of especial interest in that the death occurred 2 months after the onset of the disease. The case was in a child between 2 and 3 years of age, who was taken ill on November 8 or 9, 1942,[2] and terminated fatally on January 10, 1943.[3] The patient was erroneously reported to have recovered.[4] According to information furnished by Dr. Wilton L. Halverson, Director of Public Health in California, the diagnosis established at autopsy was "bubonic plague and chronic plague encephalitis."

A case of plague was reported in the same county during the week of August 28, 1943, occurring in a boy 11 years of age residing on an Indian reservation in Quartz Valley. The infection was believed to have been contracted on a hunting trip near Fort Jones.

Two fatal cases of plague were reported in Siskiyou County in 1941, both in children. One case was in a 10-year-old boy living near Montague and one in a 5-year-old boy living 1 mile northeast of Mount Shasta City, about 50 miles from the locality in which the other case occurred. Subsequently, plague infection has been found in ground squirrels and fleas from ground squirrels taken in scattered localities in the county.

A suspected case of plague was reported in Harney County, Ore., during the year, occurring in a sheepherder 60 years of age. According to Dr. H. M. Graning, of the Public Health Service, who investigated the case on June 17, a bubo appeared in the left groin of the patient about May 12. The patient had been working in a

[1] A consolidation of reports received from the Plague Laboratory of the U. S. Public Health Service in San Francisco, Calif., and published currently in the Public Health Reports. Previous reports on plague infection in the United States are as follows:

Plague in the United States (1900–1939). Pub. Health Rep., 55: 1143–1158 (June 28, 1940).

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locality in which plague infection had previously been found. On the basis of physical examination, clinical history, and possible exposure in an infected area, Dr. Graning was of the opinion that it was a case of plague. While the laboratory examination and tests of material secured from the bubo did not reveal *B. pestis*, the infection had been in process for more than 30 days before the examination. In view of the fact that the diagnosis was not confirmed bacteriologically, and the case was not reported as plague by Dr. Stricker, State health officer of Oregon, it has not been so recorded by the Public Health Service.

IN RODENTS AND ECTOPARASITES

As in previous years, field surveys to determine the location and extent of endemic areas were conducted by mobile units operated by the Public Health Service and by several western States. The Public Health Service plague laboratory in San Francisco continued to examine the animal tissues and ectoparasites collected by these field units and to aid in identifying the species of animals and infected insects. During 1943, plague infection was proved in rats (*Rattus* sp.) in Oakland, Calif., and Tacoma, Wash., and in wild rodents or ectoparasites in California, Colorado, Montana, New Mexico, Oregon, and Wyoming. During the year plague infection was reported for the first time in the following named localities: *California*—Inyo and Kings Counties; *Colorado*—Huerfano, Larimer, and Las Animas Counties; *Montana*—Custer County; *New Mexico*—Lincoln, Quay, Sandoval, Torrance, and Union Counties; *Wyoming*—Carbon and Johnson Counties. Infection was found during the year in the following-named animals and parasites: *Rodents*—rats (*Rattus* sp.), ground squirrels, chipmunks, wood rats, meadow mice, harvest mice, white-footed mice, grasshopper mice, and prairie dogs; *ectoparasites*—fleas, lice, and ticks.

The proved area of plague infection in wild rodents was extended farther east during the year by the finding of infected fleas from grasshopper mice (*Onychomys leucogaster*) taken 12 miles south of Clayton, Union County, N. Mex. This is slightly east of any area in which sylvatic plague had previously been reported, that is, Quay County, N. Mex., in 1943; in Divide County, N. Dak., in 1941; and Larimer County, Colo., in 1943. The accompanying table lists the areas and the species of rodent or ectoparasite in which plague infection was found and reported to the Public Health Service in 1943.

It should not be informed that these and previous reports give the

periods favorable for conducting the surveys are limited. Although necessarily restricted more or less to a sampling procedure, the surveys demonstrate the continuance of a wide biological and geographic distribution of plague infection in western United States and will serve to give a warning if the areas of sylvatic infection approach localities of sufficient biological densities of susceptible rodent species and human populations to constitute a dangerous situation.

The presence of plague infection in specimens of animal tissues and ectoparasites was demonstrated in each instance by laboratory examination, inoculation of laboratory animals, or mass inoculation with emulsions of parasites.

Plague infection in rats, wild rodents, and their ectoparasites reported to the Public Health Service during 1943

State and county	Date [1]	Infection found in—
California:		
Alameda County	Mar. 10	Spleen from a rat (*Rattus norvegicus.*) taken in Oakland.
Do	Mar. 17	A pool of organs from 5 rats (*R. norvegicus.*) taken in Oakland.
Contra Costa County	Mar. 12	Organs from 18 Norway rats taken in Richmond.
Eldorado County	Aug. 27	5 pools of fleas from 8 ground squirrels, (*C. beecheyi*), 6 golden mantled ground squirrels, and 22 chipmunks taken from locations near Lake Tahoe.
Do	Sept. 1	Tissue from 1 ground squirrel (*C. beecheyi*) taken at Tallac, Lake Tahoe.
Do	Sept. 20	Pools of fleas from 23 golden mantled ground squirrels and 2 Tamarack squirrels (*Sciurus douglasii albolimbatus*) taken at Tallac.
Inyo County	Sept. 22	Pool of fleas from 38 ground squirrels (*C. beldingi*) takenat South Lake Resort, 14 miles west of Big Pine.
Kern County	June 28	Pool of 2 collections of fleas from 12 ground squirrels (*C. beecheyi*) taken approximately 3 miles northwest of Tehachapi.
Do	June 9	Pools of fleas and lice from 48 ground squirrels (*C. beecheyi*) taken 6 miles north of California Institution for Women.
Do	June 12	Pool of fleas from 7 ground squirrels (*C. beecheyi*) taken 1 mile west of Cummings Valley School.
Do	June 15	Pool of fleas from 6 ground squirrels (*C. beecheyi*) taken 7 miles northwest of Tehachapi.
Do	Nov. 8	Pool of fleas from 22 ground squirrels (*C. beecheyi*) taken 2 miles northwest of Lebec.
Kings County	June 25	Pool of fleas from 10 ground squirrels (*C. beecheyi*) taken approximately 7 miles southeast of Hanford.
Mono County	June 12	Pool of fleas from 18 golden mantled ground squirrels.
Do	July 14	Pool of fleas from 18 ground squirrels (*C. beldingi*).
Do	July 19	Pool of tissue from 9 chipmunks.
Do	July 31	2 pools of fleas from 64 (2 lots) golden mantled ground squirrels.
Do	Aug. 12	Pool of fleas from 21 chipmunks. All specimens collected at or within 5 miles east and 4 miles south of June Lake.
Monterey County—(Camp Hunter Ligget Military Reservation, Jolon).	Mar. 30	Tissue from 1 wood rat and from 2 pools of wood rats (*Neotoma fuscipes*), tissue from 1 and pools of fleas from 55 meadow mice (*Microtus californicus*).
Do	Mar. 30-31	Pool of fleas from 76 wood rats (*N. fuscipes*) and a pool of fleas from 32 harvest mice (*Reithrodontomys* sp.).
Do	Mar. 31	2 pools of fleas, respectively, from 87 and 108 meadow mice (*M. californicus*); a pool of fleas from 3 species of mice (*Peromyscus* sp.).
San Antonio River	Aug. 3-4	Pool of fleas from 46 wood rats (*Neotoma* sp.).
Fort Ord Military	Mar. 15	Pool of fleas from 3 ground squirrels (*C. beecheyi*).

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Plague infection in rats, wild rodents, and their ectoparasites reported to the Public Health Service during 1943—Continued

State and county	Date	Infection found in—
California—Continued.		
Monterey County—Continued.		
Fort Ord Military Reservation (12 miles southwest of Salinas).	Mar. 20	Pool of fleas from 24 mice, (*Microtus* sp.) (22) and (*Peromyscus* sp.) (2).
Do	Mar. 23	Pool of fleas from 9 meadow mice (*Microtus* sp.).
Do	Mar. 24	Pool of fleas from 40 and a pool of organs from 10 meadow mice (*Microtus* sp.).
Do	Mar. 26	Pool of fleas from 47 and a pool of organs from 10 meadow mice (*Microtus* sp.).
Do	Mar. 27	Pool of fleas from 46 mice (*Microtus* sp.).
Do	Mar. 29	Pool of fleas from 47 mice (*Microtus* sp.).
In areas designated—		
Area C 2	Apr. 9	Organs from 20 meadow mice (*Microtus* sp.).
Do	Apr. 10	Organs from 10 meadow mice (*Microtus* sp.).
Area D	Apr. 9	Pool of fleas from 23 mice (*Peromyscus* sp.).
Do	Apr. 14	Pool of fleas from 19 mice (*Peromyscus* sp.).
Do	Apr. 19	Organs from 9 mice (*Peromyscus* sp.).
Do	Apr. 22	Pool of fleas from 2 ground squirrels (*C. beecheyi*).
Area E	Apr. 18	Organs from 44 mice (*Microtus* sp.).
Do	Apr. 18–19	Organs from 19 mice (*Microtus* sp.) and 2 ground squirrels (*C. beecheyi*).
Do	Apr. 19	Organs from 36 mice (*Microtus* sp.).
Do	Apr. 20	Organs from 2 ground squirrels (*C. beecheyi*).
Location 12 miles south and 12 miles east of Monterey.	July 9	Tissue from 1 ground squirrel (*C. beecheyi*) and 5 pools of fleas from 33 ground squirrels, same species.
Do	July 12	Pool of tissue from 10 ground squirrels (*C. beecheyi*) and 5 pools of fleas from 27 ground squirrels, same species.
Location 12 miles south and 18 miles east of Monterey.	July 22	Pool of tissue from 9 ground squirrels (*C. beecheyi*), a pool of fleas from 19, and a pool of ticks from 19 ground squirrels, same species.
Do	July 31	Pool of fleas from 19 ground squirrels (*C. beecheyi*).
Location 10 miles south and 14 miles east of Monterey.	July 1	6 pools of fleas, each from 35 ground squirrels (*C. beecheyi*), and 1 pool of ticks from 39 ground squirrels, same species.
Do	July 2	Pool of fleas and a pool of ticks, each from 29 ground squirrels (*C. beecheyi*).
Do	July 13	4 pools of fleas, each from 16 ground squirrels (*C. beecheyi*).
Do	July 15	Pool of fleas from 16 ground squirrels (*C. beecheyi*).
Location 13 miles south and 20 miles east of Monterey.	July 14	Pool of tissue from 10 ground squirrels (*C. beecheyi*) and a pool of fleas from 33 ground squirrels, same species.
Do	July 19	Pool of ticks from 33 and a pool of ticks from 12 ground squirrels (*C. beecheyi*).
Location 11 miles south and 12 miles east of Monterey.	July 20	Pool of fleas from 14 ground squirrels (*C. beecheyi*).
Location 11 miles east of Bradley.	Aug. 5	Pool of tissue from 6 ground squirrels (*C. beecheyi*).
Location 9 miles south and 3 miles west of King City.	Aug. 20	2 pools of fleas, each from 16 ground squirrels (*C. beecheyi*).
Nevada County	July 5	Pool of fleas from 18 ground squirrels (*C. beecheyi*).
Placer County	Sept. 24	Pool of fleas from 1 ground squirrel (*C. beecheyi*) taken at Carnelian Bay, Lake Tahoe.
San Diego County	Mar. 15	Pool of fleas from 27 ground squirrels (*C. fisheri*) taken 1½ miles southwest of Bonsell.
Do	Mar. 18	Pool of fleas from 52 ground squirrels (*C. beecheyi*) taken 1½ miles southeast of Delmar.
Do	Aug. 27	Pools of fleas from ground squirrels (*C. fisheri*) as follows: 15 ground squirrels taken at Lake Henshaw, 20 ground squirrels taken at Cuyamaca State Park, 20 ground squirrels taken 31 miles south of Julian; 44 ground squirrels taken approximately 3 miles southeast of Julian.
Santa Clara County	Aug. 31	2 pools of fleas from lots, respectively, of 7 and 5 ground squirrels (*C. beecheyi*) taken near military reservation.
Siskiyou County	July 13	Pool of fleas from 14 ground squirrels (*C. douglasii*) taken approximately 8 miles northeast of Etna.
Do	Sept. 27	Pool of fleas from 5 ground squirrels (*C. douglasii*) taken

Plague infection in rats, wild rodents, and their ectoparasites reported to the Public Health Service during 1943—Continued

State and county	Date	Infection found in—
Colorado:		
Huerfano County	Aug. 16	Pool of fleas from 97 prairie dogs (*Cynomys gunnisoni*) taken 15 miles northwest of Walsenburg, Highway No. 69.
Larimer County	June 21	Pool of fleas from 38 black-tailed prairie dogs (*Cynomys ludovicianus*) taken 5 miles northwest of Wellington.
Las Animas County	July 23	Pool of fleas and ticks from 127 prairie dogs (*C. ludovicianus*) taken 30 miles northwest of Springfield.
Montana:		
Custer County	Sept. 3	Pool of fleas from 28 prairie dogs (*C. ludovicianus*) taken 20 miles southeast of Miles City.
Do	Sept. 4	Pool of fleas from 30 prairie dogs (*C. ludovicianus*) taken 27 miles southeast of Miles City.
Do	Sept. 13	Pool of fleas from 41 prairie dogs (*C. ludovicianus*) taken 13 miles southeast of Miles City.
Do	Sept. 22	Pool of fleas from 20 prairie dogs (*C. ludovicianus*) taken 21 miles south of Miles City.
Garfield County	Apr. 4	Pool of fleas from 80 prairie dogs (*C. ludovicianus*) taken 12 miles west of Jordan.
Do	Apr. 5	Pool of fleas from 83 prairie dogs (*C. ludovicianus*) taken 12 miles west of Jordan.
Do	Aug. 9	Pool of fleas from 18 prairie dogs (*C. ludovicianus*) taken 7 miles west of Jordan.
Do	Aug. 10	Pool of fleas from 82 prairie dogs (*C. ludovicianus*) taken 35 miles south of Jordan.
Do	Aug. 11	Pool of fleas from 89 prairie dogs (*C. ludovicianus*) taken 13 miles west of Jordan.
New Mexico:		
Lincoln County	Apr. 22	Pool of fleas from 9 prairie dogs (*C. ludovicianus*) taken 1½ miles south of Corona.
Do	Apr. 27	Pool of fleas from 3 grasshopper mice (*Onychomys torridus*) taken 8 miles south of Carrizozo.
Quay County	May 22 [2]	Pool of fleas from 23 grasshopper mice (*Onychomys leucogaster*) taken 19 miles east of Tucumcari.
Do	May 24 [2]	Tissue from 1 grasshopper mouse (*O. leucogaster*) taken 19 miles east of Tucumcari; 2 pools of fleas from lots of 18 and 23 wood rats (*Neotoma albigula*) taken, respectively, 15 and 20 miles east of Tucumcari.
Sandoval County	May 24 [2]	Pool of fleas from 30 grasshopper mice (*Onychomys* sp.) taken 2 miles west of Bernalillo.
Torrence County	May 8	Pool of fleas from 2 thirteen-striped ground squirrels (*Citellus tridecemlineatus*) taken 2 miles south of Moriarty.
Union County	June 1	Pool of fleas from 11 grasshopper mice (*O. leucogaster*) taken 9 miles south of Clayton.
Do	June 11	Pool of fleas from 9 grasshopper mice (*O. leucogaster*) taken 12 miles south of Clayton.
Oregon:		
Grant County	June 20	Tissue from 1 ground squirrel (*C. oregonus*) taken south of Seneca on Highway No. 70.
Do	June 24	Pool of fleas and lice from 63 ground squirrels (*C. oregonus*) taken 6 miles east of Long Creek.
Malheur County	June 22	Pool of fleas from 21 ground squirrels (*C. oregonus*) taken 6 to 11 miles west of Jordan Valley.
Union County	June 5	Pool of 187 fleas and 15 lice from 93 ground squirrels (*C. oregonus*) taken 1 to 5 miles west of North Powder.
Washington:		
Pierce County, Tacoma.	Jan. 2 to May 4	15 pools of tissue and 24 pools of fleas from rats (*R. norvegicus* taken in industrial, commercial, and residential sections of the city of Tacoma.
Wyoming:		
Carbon County	July 21	Pool of fleas from 35 ground squirrels (*C. richardsoni*) taken 20 miles north of Rawlins.
Johnson County	Sept. 21	Pool of fleas from 50 prairie dogs (*C. ludovicianus*) taken 17 miles south of Arvada and a pool of fleas from 25 prairie dogs (same sp.) taken 12 miles south of Arvada.
Do	Sept. 22	Pool of fleas from 75 prairie dogs (*C. ludovicianus*) taken 13 miles south of Arvada.

[2] Date infection proved.

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PUBLIC HEALTH SERVICE ACT, 1944

The Public Health Service Act, signed by President Roosevelt on July 3, 1944, is another milestone in the 146-year history of the United States Public Health Service.

The act brings together in compact and orderly arrangement substantially all existing law affecting the Service. It eliminates many outmoded regulations and, in a series of revisions dictated by operating experience, streamlines the administration of the Public Health Service.

In several respects the act broadens the scope of previously established Public Health Service functions. It provides authority to make grants-in-aid to research institutions for study of any disease—in the same way the National Cancer Act of 1937 provides for cancer research. It authorizes expansion of the Federal-State cooperative public health programs, and calls for the establishment of a national tuberculosis control program, patterned after the venereal disease control program.

The final act presented to the President for approval is the result of two years' work and study under the leadership of Representative Alfred L. Bulwinkle, of North Carolina. It is due to the interest and close attention of Mr. Bulwinkle, Senator Elbert Thomas, of Utah, and their colleagues that this essential streamlining of the Nation's public health law has been brought to a successful conclusion.

The new law retains all the important duties which Congress has laid upon the Service in previous legislation enacted over the last half century. Basic responsibilities still include medical and hospital care of American Merchant Marine seamen, the United States Coast Guard, and other Federal beneficiaries; the National Quarantine Service; scientific research; control of biologic products; and care of lepers and narcotic drug addicts. Assistance to State and Territorial health departments also will continue.

In recent years, the trend of public health work has been toward tackling public health problems individually and directing all available resources to the eradication of widely prevalent diseases which place an unnecessary burden upon the health and economy of the Nation. The new law, which authorizes establishment of a tuberculosis control program, makes it possible to extend this type of direct attack. The program follows the pattern of the national venereal disease control program, authorized by the Congress in 1938. It places upon the Public Health Service the responsibility of administering [illegible]

annually (as provided under title VI of the Social Security Act) to $20,000,000. It empowers the Service to use a limited portion of these funds for the training of public health personnel and for special demonstrations in the solution of particular community health problems.

Provision also is made for the strengthening of the commissioned corps of the United States Public Health Service and for the commissioning of specialists in scientific fields relating to public health—such as entomology, chemistry, and zoology. Under the new law, nurses may now be commissioned in the Service. Other sections of the act carry over previous legislation giving the commissioned personnel of the Public Health Service in wartime substantially the same benefits and privileges afforded officers of the Army and Navy.

Fundamental reorganization laws expanding Public Health Service functions and strengthening its administration have been enacted through the years. Acts of Congress in 1878, 1890, 1893, and 1906 authorized the Service to prevent the introduction of epidemic diseases into this country from abroad and to prevent the interstate spread of communicable diseases. In 1889, the Service was organized along military lines and provision made for the establishment of a corps of commissioned officers with grades, ranks, and rates of pay similar to those of the Army and Navy Medical Corps.

The organization of the Service now includes four major administrative units—the Office of the Surgeon General, the National Institute of Health, the Bureau of State Services, and the Bureau of Medical Services. The staff of the Surgeon General is made up of a Deputy Surgeon General and three Assistant Surgeons General in charge of the three bureaus. In addition, staff officers with the rank of Assistant Surgeon General are assigned to the administration of dental and sanitary engineering activities. The Medical Director of the United States Coast Guard has the rank of Assistant Surgeon General on the staff of the Surgeon General of the Public Health Service.

The significance of the Public Health Service Act is far reaching. From a legislative point of view, the codification of laws of a Service which came into being in 1798 is of direct benefit, not only to the Service itself, but to the various governmental and State agencies that have to deal with public health. It might well serve as model legislation for all Federal services and bureaus.

TUBERCULOSIS CONTROL DIVISION ESTABLISHED IN

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a Tuberculosis Control Division in the Bureau of State Services of the United States Public Health Service. Federal Security Administrator Paul V. McNutt on the same day approved the organization of the new division.

Establishment of this administrative unit is the first step leading to the implementation of the Federal-State cooperative program for tuberculosis control authorized in Section 314, subsection *b*, of the Public Health Service Act. The subsection was introduced in the Senate as an amendment by Senator Elbert Thomas of Utah, after the passage of the act in the House; the House concurred without a dissenting vote.

Grants and services to States authorized in this subsection include the provisions embodied in a tuberculosis control bill backed by the National Tuberculosis Association and sponsored in the House by Mr. Alfred Bulwinkle and in the Senate by Mr. Thomas. When it became apparent that passage of the Public Health Service Act would precede passage of the bill, the sponsors of the legislation moved to incorporate the same tuberculosis control provisions in the Public Health Service Act. Subsection *b* reads:

> To enable the Surgeon General to carry out the purposes of section 301 with respect to developing more effective measures for the prevention, treatment, and control of tuberculosis, and to assist, through grants and as otherwise provided in this section, States, counties, health districts, and other political subdivisions of the States in establishing and maintaining adequate measures for the prevention, treatment, and control of such disease, including the provision of appropriate facilities for care and treatment and including the training of personnel for State and local health work, and to enable him to prevent and control the spread of tuberculosis in interstate traffic, and to meet the cost of pay, allowances, and traveling expenses of commissioned officers and other personnel of the Service detailed to assist in carrying out the purposes of this section with respect to tuberculosis, and to administer this section with respect to such disease, there is hereby authorized to be appropriated for the fiscal year ending June 30, 1945, the sum of $10,000,000, and for each fiscal year thereafter a sum sufficient to carry out the purposes of this subsection.

Senior Surgeon Herman E. Hilleboe, who has been in charge of the Public Health Service emergency tuberculosis control program since 1942, has been appointed chief of the new Division, with the rank of Medical Director. The first activity undertaken by the Tuberculosis Control Division, according to Dr. Hilleboe, is the preparation of a budget for submission to Congress at an early date in order to obtain the funds authorized for the Nation-wide program.

The Surgeon General's order establishing the Division follows:

FEDERAL SECURITY AGENCY

U. S. PUBLIC HEALTH SERVICE

Washington 14

WASHINGTON, *July 6, 1944.*

Public Health Service Reorganization Order No. 2.
Subject: Organization of Tuberculosis Control Division.

Pursuant to the authority contained in section 202 of the Public Health Service Act, Public Law 410, 78th Congress, approved July 3, 1944, the following order is promulgated:

There is hereby established within the Bureau of State Services the Tuberculosis Control Division. This Division will perform all functions authorized by section 314 (*b*) of the Public Health Service Act to be performed with respect to (1) developing more effective measures for the prevention, treatment, and control of tuberculosis, (2) assisting States, counties, health districts, and other political subdivisions of the States in establishing and maintaining adequate measures for the prevention, treatment and control of such disease, and (3) preventing and controlling the spread of tuberculosis in interstate traffic, and any other activities with respect to the prevention, treatment, and control of tuberculosis, which may be authorized to be performed by the Public Health Service.

The administrative functions of the Division with respect to the tuberculosis prevention and control program will be comparable to those of the Venereal Disease Division with respect to the venereal disease program and subject to the provisions of Reorganization Order No. 1, dated December 30, 1943.

Approved:

PAUL V. MCNUTT, *Administrator.*

THOMAS PARRAN, *Surgeon General.*

JULY 6, 1944.

FELLOWSHIPS IN HEALTH EDUCATION FOR MEN

The United States Public Health Service, through the cooperation of the National Foundation for Infantile Paralysis and the W. K. Kellogg Foundation, has announced that fellowships in health education are now available for qualified men of certain Selective Service classifications. The fellowships have been made available for the fall term of college, 1944. The requirements for men are the same as those previously announced for women (Public Health Reports, May 26, 1944) with the exception that the men must be 30 years of age and over or must have a Selective Service classification of 4 F or 1 AL. The qualifications are: A bachelor of science degree from a recognized college, skill in the use of the English language, courses in the physical, biological, and social sciences, education, and [illegible]

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9 months of academic work in public health education and 3 months of supervised field experience; $100 a month will be paid for all 12 months, plus full tuition and travel.

Application forms may be obtained from the Surgeon General, United States Public Health Service, Washington 14, D. C. Applications must be in the office of the Surgeon General not later than August 15, 1944, accompanied by a transcript of college credits and a small photograph.

DEATHS DURING WEEK ENDED JULY 1, 1944

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

	Week ended July 1, 1944	Corresponding week, 1943
Data for 93 large cities of the United States:		
Total deaths	8,473	9,428
Average for 3 prior years	8,353	
Total deaths, first 26 weeks of year	247,443	253,902
Deaths under 1 year of age	599	680
Average for 3 prior years	560	
Deaths under 1 year of age, first 26 weeks of year	16,252	17,681
Data from industrial insurance companies:		
Policies in force	66,643,086	65,581,183
Number of death claims	11,441	12,017
Death claims per 1,000 policies in force, annual rate	9.0	9.6
Death claims per 1,000 policies, first 26 weeks of year, annual rate	10.5	10.3

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 8, 1944

Summary

With the exception of the Pacific area, increased incidence of poliomyelitis was reported in all of the 9 geographic sections of the country. The largest numerical increases occurred in the South Atlantic, Middle Atlantic, and East North Central areas. A total of 290 cases was reported for the country as a whole, as compared with 222 last week, 84 for a 5-year (1939–43) median, and 245 for the corresponding week last year. The next largest number for a corresponding week in the past 6 years was 86, reported in 1941. Of the current total, 196 cases, or 68 percent, occurred in 5 States, as follows (last week's figures in parentheses): North Carolina 94 (84), New York 34 (25), Kentucky 28 (29), Pennsylvania 26 (6), Virginia 14 (6). A total of 1,295 cases has been reported to date this year, as compared with 1,329 for the same period last year and a 5-year median of 847. The unusually high incidence at this time last year was confined chiefly to the Pacific and West South Central areas, while this year the largest numbers of cases are being reported in the South Altantic, East South Central, and Middle Atlantic States.

A total of 188 cases of meningococcus meningitis was reported, as compared with 180 last week, 267 for the same week last year, and a 5-year median of 32. The current increase, noted in the Middle Atlantic, South Atlantic, East South Central and Pacific Areas, is mostly accounted for by the increase in Pennsylvania from 6 to 21, and California, from 22 to 32 cases, respectively. New York reported 18 cases, New Jersey 11, and Maryland 12. The total to date is 12,029, as compared with 12,278 last year and a 5-year median of 1,241.

Of a total of 138 cases of typhoid fever, as compared with 111 last week and a 5-year median of 215, Texas reported 24, Georgia 11, South Carolina 9, Louisiana 8, and Ohio, Kentucky, and Tennessee 7 each. The cumulative figure to date is 2,253, as compared with 1,953 for the same period last year and a 5-year median of 2,730.

A total of 33 cases of Rocky Mountain Spotted Fever was reported, of which 23 occurred in the South Atlantic and East South Central

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Telegraphic morbidity reports from State health officers for the week ended July 8, 1944, and comparison with corresponding week of 1943 and 5-year median

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

Division and State	Diphtheria			Influenza			Measles			Meningitis, meningococcus		
	Week ended—		Median 1939–43	Week ended—		Median 1939–43	Week ended—		Median 1939–43	Week ended—		Median 1939–43
	July 8, 1944	July 10, 1943		July 8, 1944	July 10, 1943		July 8, 1944	July 10, 1943		July 8, 1944	July 10, 1943	
New England:												
Maine	0	0	0	------	------	------	32	23	38	1	4	0
New Hampshire	0	0	0	------	------	------	31	11	9	0	3	0
Vermont	0	0	0	------	------	------	10	91	74	0	0	0
Massachusetts	2	0	0	------	------	------	347	480	480	5	19	2
Rhode Island	1	0	0	6	------	------	13	106	53	0	0	0
Connecticut	0	1	1	------	------	------	66	124	145	1	7	1
Middle Atlantic:												
New York	2	14	10	[1] 1	[1] 1	[1] 1	328	1,292	738	18	28	4
New Jersey	1	1	1	------	2	1	262	967	285	11	9	0
Pennsylvania	5	7	7	------	------	------	133	226	226	21	18	4
East North Central:												
Ohio	6	3	3	3	2	5	68	216	62	0	9	1
Indiana	4	2	2	1	1	2	14	108	22	2	3	0
Illinois	4	10	10	13	5	4	72	548	150	8	14	1
Michigan [2]	3	3	1	1	2	------	296	883	230	8	5	1
Wisconsin	2	2	0	2	7	8	461	942	643	5	2	0
West North Central:												
Minnesota	3	4	2	------	------	1	72	131	31	1	1	0
Iowa	3	1	1	------	1	1	16	52	69	1	2	0
Missouri	4	1	1	------	1	------	19	58	38	8	9	0
North Dakota	0	2	0	1	1	1	7	96	12	1	1	1
South Dakota	2	1	2	------	------	------	3	159	10	0	1	0
Nebraska	2	3	1	------	------	------	23	55	16	1	2	0
Kansas	3	4	3	------	4	2	51	67	60	2	0	1
South Atlantic:												
Delaware [2]	0	1	0	------	------	------	3	5	4	1	1	0
Maryland [2]	4	0	3	3	3	2	59	85	31	12	7	5
District of Columbia	0	0	1	1	------	------	28	39	39	2	5	0
Virginia	0	3	3	37	32	25	82	102	102	6	15	1
West Virginia	3	3	3	1	------	1	53	8	8	1	4	0
North Carolina	4	2	3	------	19	1	99	41	41	1	13	1
South Carolina	2	1	4	100	160	111	31	38	38	4	9	1
Georgia	2	2	3	5	8	5	35	8	15	1	5	1
Florida	3	2	1	5	9	3	34	18	13	[3] 1	5	1
East South Central:												
Kentucky	1	1	1	4	2	1	28	12	12	3	5	2
Tennessee	7	1	3	16	6	11	25	18	27	5	2	2
Alabama	4	2	2	15	12	4	9	30	30	5	1	1
Mississippi [2]	7	6	6	------	------	------	0	------	------	2	2	1
West South Central:												
Arkansas	1	2	2	11	12	6	24	16	16	0	2	0
Louisiana	0	6	4	------	11	9	19	15	11	2	0	1
Oklahoma	0	3	3	1	5	5	31	4	12	4	4	0
Texas	23	16	14	236	295	122	277	118	118	7	7	2
Mountain:												
Montana	1	0	1	------	1	------	8	69	44	1	2	0
Idaho	0	0	0	4	3	------	17	3	7	0	0	0
Wyoming	0	0	0	------	9	------	9	12	14	0	0	0
Colorado	5	5	5	------	11	11	20	32	32	1	0	0
New Mexico	2	0	0	------	------	------	4	1	10	0	1	0
Arizona	3	1	1	22	30	27	19	20	20	1	3	0
Utah [2]	0	0	0	------	------	------	30	70	70	0	2	0
Nevada	0	0	0	1	------	------	42	2	2	0	0	0
Pacific:												
Washington	1	10	3	------	------	------	121	93	93	1	5	0
Oregon	3	2	2	1	------	1	27	46	46	1	7	0
California	15	10	16	12	13	17	841	366	366	32	23	2

Telegraphic morbidity reports from State health officers for the week ended July 8, 1944, and comparison with corresponding week of 1943 and 5-year median—Con.

Division and State	Poliomyelitis			Scarlet fever			Smallpox			Typhoid and paratyphoid fever [4]		
	Week ended—		Median 1939–43	Week ended—		Median 1939–43	Week ended—		Median 1939–43	Week ended—		Median 1939–43
	July 8, 1944	July 10, 1943		July 8, 1944	July 10, 1943		July 8, 1944	July 10, 1943		July 8, 1944	July 10, 1943	
New England:												
Maine	0	0	0	14	2	3	0	0	0	1	1	1
New Hampshire	0	0	0	6	2	1	0	0	0	0	1	0
Vermont	1	0	0	11	5	0	0	0	0	1	0	0
Massachusetts	0	0	0	74	132	65	0	0	0	3	8	5
Rhode Island	1	0	0	4	4	4	0	0	0	0	0	0
Connectucut	2	1	0	19	25	14	0	0	0	0	1	0
Middle Atlantic:												
New York	34	5	3	111	87	110	0	0	0	6	3	5
New Jersey	2	1	1	33	23	34	0	0	0	1	0	2
Pennsylvania	26	0	1	88	38	76	0	0	0	0	4	6
East North Central:												
Ohio	7	3	1	258	74	74	2	0	0	7	14	7
Indiana	6	0	0	20	12	12	0	0	1	2	2	2
Illinois	6	5	2	44	38	65	0	1	3	2	5	5
Michigan	1	0	0	80	34	67	2	0	0	1	3	3
Wisconsin	1	0	0	46	88	50	0	0	1	0	1	1
West North Central:												
Minnesota	2	2	1	44	21	21	0	0	1	0	0	0
Iowa	2	1	1	9	19	15	0	0	0	1	0	3
Missouri	1	0	0	12	24	12	0	0	0	1	1	5
North Dakota	1	1	0	5	1	4	0	0	0	1	0	0
South Dakota	0	0	0	14	4	4	0	5	4	0	0	0
Nebraska	1	0	0	5	14	7	0	0	0	0	0	0
Kansas	2	5	0	15	10	16	0	0	0	2	0	1
South Atlantic:												
Delaware	0	0	0	2	1	2	0	0	0	0	0	0
Maryland	0	0	0	37	9	11	0	0	0	4	2	2
District of Columbia	0	0	0	2	9	9	0	0	0	0	0	0
Virginia	14	1	1	18	13	10	0	0	0	1	10	10
West Virginia	0	0	0	19	16	12	1	0	0	4	8	6
North Carolina	94	0	1	11	11	11	0	0	0	3	3	4
South Carolina	4	0	0	2	2	1	0	0	0	9	2	6
Georgia	4	0	4	6	11	8	0	0	0	11	11	20
Florida	7	0	2	2	6	1	0	0	0	5	4	4
East South Central:												
Kentucky	28	2	2	6	5	8	0	0	0	7	9	11
Tennessee	2	3	2	12	6	14	0	0	0	7	8	10
Alabama	5	1	2	5	7	7	0	0	0	4	1	5
Mississippi	2	0	1	2	6	2	0	1	0	6	7	8
West South Central:												
Arkansas	1	3	0	2	1	2	0	0	0	3	5	8
Louisiana	9	0	0	5	4	4	0	0	0	8	6	12
Oklahoma	2	44	3	1	7	7	0	0	1	4	3	9
Texas	5	90	4	40	25	17	0	0	0	24	17	37
Mountain:												
Montana	0	0	0	8	3	6	1	0	0	1	0	0
Idaho	2	0	0	7	1	1	0	0	0	0	0	0
Wyoming	0	0	0	3	11	3	0	0	0	0	0	0
Colorado	3	1	0	10	25	8	0	0	0	2	0	0
New Mexico	0	0	0	0	1	1	0	0	0	0	1	2
Arizona	1	0	0	14	3	2	0	0	0	0	2	1
Utah	0	0	0	15	14	6	0	0	0	0	0	0
Nevada	0	1	0	0	0	0	0	0	0	0	0	0
Pacific:												
Washington	1	0	0	65	10	10	0	0	0	0	0	1
Oregon	2	0	0	22	10	5	0	0	0	1	0	1
California	8	75	14	161	90	53	0	0	0	5	3	4
Total	290	245	84	1,389	964	921	6	7	19	138	146	215
27 weeks	[5] 1,295	1,329	847	142,782	93,132	93,132	273	583	1,130	2,253	1,953	2,730

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Telegraphic morbidity reports from State health officers for the week ended July 8, 1944, and comparison with corresponding week of 1943 and 5-year median—Con.

Division and State	Whooping cough: Week ended July 8, 1944	Whooping cough: Week ended July 10, 1943	Whooping cough: Median 1939–43	Week ended July 8, 1944: Anthrax	Dysentery: Amebic	Dysentery: Bacillary	Dysentery: Unspecified	Encephalitis, infectious	Leprosy	Rocky Mt. spotted fever	Tularemia	Typhus fever
New England:												
Maine	11	15	22	0	0	0	0	0	0	0	0	0
New Hampshire	0	0	1	0	0	0	0	0	0	0	0	0
Vermont	30	13	14	0	0	0	0	0	0	0	0	0
Massachusetts	48	53	84	0	0	0	0	0	0	0	0	0
Rhode Island	2	18	18	0	0	0	0	0	0	0	0	0
Connecticut	24	19	38	0	0	0	0	1	0	0	0	0
Middle Atlantic:												
New York	83	247	247	0	1	6	0	1	0	1	0	0
New Jersey	47	160	160	0	0	0	0	1	0	2	0	0
Pennsylvania	76	199	238	0	0	0	0	1	0	0	0	0
East North Central:												
Ohio	196	211	211	0	1	0	0	2	0	0	0	0
Indiana	20	79	62	0	0	0	0	0	0	0	0	0
Illinois	78	139	139	0	3	0	0	0	0	0	0	0
Michigan	43	190	167	0	0	0	0	1	0	0	0	0
Wisconsin	67	283	223	0	0	0	0	1	0	0	0	0
West North Central:												
Minnesota	14	80	41	0	2	0	0	0	0	0	0	0
Iowa	10	58	47	0	0	0	0	0	0	1	0	0
Missouri	31	46	17	0	0	0	1	0	0	0	0	0
North Dakota	14	20	15	0	0	0	0	1	0	0	0	0
South Dakota	55	1	1	0	0	0	0	1	0	0	0	0
Nebraska	17	14	14	0	0	0	0	0	0	0	0	0
Kansas	70	83	69	0	0	0	0	0	0	0	1	0
South Atlantic:												
Delaware	4	6	4	0	0	0	0	0	0	0	0	0
Maryland	91	86	84	0	0	0	2	1	0	2	0	0
District of Columbia	1	38	22	0	0	0	0	0	0	0	0	0
Virginia	55	144	112	0	0	0	286	0	0	2	1	0
West Virginia	34	74	36	0	0	0	0	0	0	1	0	0
North Carolina	144	176	123	0	0	0	0	0	0	5	0	1
South Carolina	124	144	90	0	0	64	0	0	0	1	0	1
Georgia	22	39	37	0	0	4	0	0	0	0	0	29
Florida	21	7	8	0	3	0	0	0	0	0	0	6
East South Central:												
Kentucky	156	29	45	0	0	0	0	0	0	3	0	0
Tennessee	69	54	54	0	0	0	8	0	0	7	2	0
Alabama	47	39	39	0	49	0	0	0	0	2	0	18
Mississippi	------	------	------	0	0	0	0	0	0	0	0	3
West South Central:												
Arkansas	11	46	22	0	0	36	0	0	0	1	1	0
Louisiana	1	22	12	0	4	27	0	0	0	0	1	6
Oklahoma	15	40	17	0	0	0	0	0	0	2	0	0
Texas	267	316	234	0	6	626	0	1	0	0	3	27
Mountain:												
Montana	4	31	14	0	0	0	0	0	0	0	0	0
Idaho	3	2	7	0	0	0	0	0	0	0	0	0
Wyoming	8	0	3	0	0	0	0	0	0	0	6	0
Colorado	15	33	33	0	0	0	0	0	0	0	0	0
New Mexico	0	8	22	0	0	0	0	0	0	0	0	0
Arizona	17	24	8	0	0	0	48	0	0	0	0	0
Utah	62	93	55	0	0	0	0	0	0	3	0	0
Nevada	0	0	0	0	0	0	0	1	0	0	0	0
Pacific:												
Washington	13	49	29	0	0	0	0	0	0	0	0	0
Oregon	5	32	26	0	0	0	0	0	0	0	0	0
California	47	216	222	0	2	13	0	0	0	0	0	1
Total	2,172	3,676	3,431	0	71	776	345	13	0	33	15	92
Same week, 1943	3,676	------	------	0	34	566	449	18	1	18	21	98
Same week, 1942	3,522	------	------	2	20	482	394	9	0	24	25	65

WEEKLY REPORTS FROM CITIES

City reports for week ended June 24, 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	Encephalitis, infectious, cases	Influenza: Cases	Influenza: Deaths	Measles cases	Meningitis, meningococcus, cases	Pneumonia deaths	Poliomyelitis cases	Scarlet fever cases	Smallpox cases	Typhoid and Paratyphoid fever cases	Whooping cough cases
NEW ENGLAND												
Maine:												
Portland	0	0	------	0	10	0	1	0	4	0	0	0
Vermont:												
Barre	0	0	------	0	0	0	0	0	0	0	0	0
Massachusetts:												
Boston	1	0	------	0	106	4	10	0	41	0	2	17
Fall River	0	0	------	0	13	1	2	0	------	0	0	6
Springfield	0	0	------	0	17	1	------	0	12	0	0	5
Worcester	0	0	------	0	2	0	6	0	10	0	0	14
Rhode Island:												
Providence	0	0	------	0	4	1	2	0	3	0	0	3
Connecticut:												
Bridgeport	0	0	------	0	1	1	0	0	1	0	1	1
Hartford	1	0	------	0	8	0	1	0	9	0	0	4
New Haven	0	0	------	0	11	0	3	0	2	0	0	2
MIDDLE ATLANTIC												
New York:												
Buffalo	0	0	------	0	4	1	4	2	4	0	0	0
New York	14	2	------	0	148	13	31	5	108	0	2	28
Rochester	0	0	------	0	68	0	3	1	6	0	1	1
Syracuse	0	0	------	0	1	0	0	0	1	0	0	14
New Jersey:												
Camden	0	0	------	0	3	1	0	0	6	0	0	0
Newark	0	0	------	0	57	4	6	0	11	0	0	11
Trenton	0	0	------	0	0	0	3	0	0	0	0	1
Pennsylvania:												
Philadelphia	5	0	1	1	20	5	17	0	39	0	1	2
Pittsburgh	0	0	------	0	4	3	5	3	10	0	0	14
Reading	1	0	------	0	2	0	1	1	0	0	0	0
EAST NORTH CENTRAL												
Ohio:												
Cincinnati	2	0	------	0	9	2	1	0	15	0	0	14
Cleveland	0	0	1	1	2	4	3	1	18	0	0	14
Columbus	0	0	------	0	3	0	1	0	2	0	0	15
Indiana:												
Fort Wayne	0	0	------	0	0	0	1	0	0	0	0	0
Indianapolis	0	0	------	1	11	1	5	0	9	0	0	8
South Bend	0	0	------	0	0	0	0	0	1	0	0	0
Terre Haute	0	0	------	0	3	0	2	0	0	0	0	0
Illinois:												
Chicago	3	1	------	0	78	9	17	0	38	0	1	32
Michigan:												
Detroit	6	0	1	2	89	6	7	0	32	0	0	43
Flint	0	0	------	0	0	0	1	0	1	0	0	0
Grand Rapids	0	0	------	0	1	0	0	0	4	0	0	0
Wisconsin:												
Kenosha	0	0	------	0	47	0	0	0	0	0	0	10
Milwaukee	0	0	------	0	120	1	1	0	16	0	0	17
Racine	1	0	------	0	109	0	0	0	0	0	0	5
Superior	0	0	------	0	1	0	0	0	2	0	0	0
WEST NORTH CENTRAL												
Minnesota:												
Duluth	0	0	------	0	78	0	0	0	3	0	0	1
Minneapolis	[illegible]	[illegible]		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]			

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City reports for week ended June 24, 1944—Continued

	Diphtheria cases	Encephalitis, infectious, cases	Influenza		Measles cases	Meningitis, meningococcus, cases	Pneumonia deaths	Poliomyelitis cases	Scarlet fever cases	Smallpox cases	Typhoid and paratyphoid fever cases	Whooping cough cases
			Cases	Deaths								
WEST NORTH CENTRAL—continued												
Nebraska:												
Omaha	3	0	------	0	5	0	2	0	3	0	0	0
Kansas:												
Topeka	0	0	------	0	19	0	0	0	0	0	0	1
Wichita	0	0	------	0	1	0	4	0	0	0	0	2
SOUTH ATLANTIC												
Delaware:												
Wilmington	0	0	------	0	1	0	0	0	0	0	0	0
Maryland:												
Baltimore	3	0	------	0	20	0	7	0	12	0	1	80
Cumberland	0	0	------	0	0	0	0	0	0	0	0	0
Frederick	0	0	------	0	0	0	0	0	1	0	0	0
District of Columbia:												
Washington	0	0	------	0	46	3	6	0	17	0	0	1
Virginia:												
Lynchburg	0	0	------	0	2	0	0	1	0	0	0	1
Richmond	0	0	------	0	2	0	3	0	1	0	0	3
Roanoke	0	0	------	0	0	0	0	0	0	0	0	4
West Virginia:												
Charleston	0	0	------	0	0	0	0	0	0	0	0	0
Wheeling	0	0	------	0	0	0	1	0	0	0	0	0
North Carolina:												
Raleigh	0	0	------	0	3	0	4	0	0	0	0	2
Wilmington	0	0	------	0	4	0	2	0	0	0	0	16
Winston-Salem	0	0	------	0	0	0	2	0	0	0	0	4
South Carolina:												
Charleston	0	0	------	0	2	0	1	1	2	0	0	0
Georgia:												
Atlanta	0	0	2	0	0	0	1	0	3	0	2	0
Brunswick	0	0	------	0	0	0	0	0	1	0	0	0
Savannah	0	0	------	0	1	0	1	0	0	0	0	0
Florida:												
Tampa	2	0	------	0	2	0	3	0	1	0	0	0
EAST SOUTH CENTRAL												
Tennessee:												
Memphis	0	0	------	0	2	2	1	0	3	0	0	18
Nashville	0	0	------	0	5	0	4	0	1	0	0	0
Alabama:												
Birmingham	0	0	------	0	0	1	2	0	0	0	0	5
Mobile	0	0	------	0	0	2	2	0	0	0	0	0
WEST SOUTH CENTRAL												
Arkansas:												
Little Rock	0	0	------	0	0	0	1	0	0	0	0	1
Louisiana:												
New Orleans	2	0	1	1	13	3	7	6	3	0	2	0
Texas:												
Dallas	0	0	------	1	16	0	1	0	0	0	0	7
Galveston	0	0	------	0	1	0	1	0	0	0	1	0
Houston	4	0	------	0	5	0	7	0	1	0	1	1
San Antonio	1	1	1	0	1	1	3	0	1	0	0	0
MOUNTAIN												
Montana:												
Billings	0	0	------	0	1	0	0	0	1	0	0	0
Great Falls	0	0	------	0	0	1	2	0	0	0	0	0
Helena	0	0	------	0	0	0	0	0	0	0	0	0
Missoula	0	0	------	0	10	0	0	0	1	0	0	0
Idaho:												
Boise	0	0		0	0	0	1	0	0	0	0	0

City reports for week ended June 24, 1944—Continued

	Diphtheria cases	Encephalitis, infectious, cases	Influenza		Measles cases	Meningitis, meningococcus, cases	Pneumonia deaths	Poliomyelitis cases	Scarlet fever cases	Smallpox cases	Typhoid and paratyphoid fever cases	Whooping cough cases
			Cases	Deaths								
PACIFIC												
Washington:												
Seattle	0	0	------	0	41	1	3	0	12	0	0	0
Spokane	1	0	1	1	12	0	0	0	5	0	0	0
Tacoma	0	0	------	0	11	0	2	0	13	0	0	0
California:												
Los Angeles	5	0	2	0	213	1	1	3	25	0	4	4
Sacramento	0	0	------	0	32	0	1	0	18	0	0	1
San Francisco	3	0	1	0	110	2	4	0	16	0	0	0
Total	64	4	11	8	1,679	81	235	29	618	0	20	482
Corresponding week, 1943	67	2	42	11	4,150	130	301	39	595	0	15	1,284
Average, 1939–43	57	------	32	[1] 11	[2] 3,163	------	[1] 257	------	638	2	25	1,188

[1] 3-year average, 1941–43.
[2] 5-year average, 1939–43.

Dysentery, amebic.—Cases: Philadelphia, 1; Detroit, 1; Houston, 1; Los Angeles, 1; San Francisco, 3.
Dysentery, bacillary.—Cases: Providence, 1; St. Louis, 1; Baltimore, 1; Richmond, 2; Atlanta, 1; Nashville, 1; Houston, 1; Los Angeles, 9.
Dysentery, unspecified.—Cases: Richmond, 1; Houston, 1; San Antonio, 16.
Rocky Mountain spotted fever.—Cases: Philadelphia, 1; St. Louis, 2; Baltimore, 1; Richmond, 1; Winston-Salem, 1.
Typhus fever.—Cases: New York 2; Savannah, 3; Tampa, 2; New Orleans, 2; Houston, 4; Galveston, 1.

Rates (annual basis) per 100,000 population, by geographic groups, for the 87 cities in the preceding table (estimated population, 1943, 34,209,000)

	Diphtheria case rates	Encephalitis, infectious, case rates	Influenza		Measles case rates	Meningitis, meningococcus, case rates	Pneumonia death rates	Poliomyelitis 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	5.3	0.0	0.0	0.0	455	21.1	66.1	0.0	217	0.0	7.9	137
Middle Atlantic	9.3	0.9	0.5	0.5	142	12.5	32.4	5.6	86	0.0	1.9	33
East North Central	7.4	0.6	1.2	2.5	290	14.1	24.0	0.6	85	0.0	0.6	97
West North Central	11.9	0.0	0.0	0.0	263	8.0	37.8	8.0	107	0.0	2.0	64
South Atlantic	8.2	0.0	3.3	0.0	136	4.9	50.7	3.3	62	0.0	4.9	181
East South Central	0.0	0.0	0.0	0.0	41	29.5	53.1	0.0	24	0.0	0.0	136
West South Central	21.1	3.0	6.0	6.0	109	12.1	60.4	18.1	15	0.0	12.1	27
Mountain	23.8	0.0	0.0	0.0	397	23.8	87.4	7.9	183	0.0	0.0	167
Pacific	14.2	0.0	6.3	1.6	663	6.3	17.4	4.7	141	0.0	6.3	8
Total	9.8	0.6	1.7	1.2	257	12.4	36.0	4.4	94	0.0	3.1	74

PLAGUE INFECTION IN CIMARRON COUNTY, OKLA.

Plague infection has been reported in ectoparasites collected on June 8, 20 miles southwest of Boise City, Cimarron County, Okla.,

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infection in ectoparasites or wild rodents has been reported in the United States. Cimarron County borders on Union County, N. Mex., where infected fleas from grasshopper mice, *Onychomys leucogaster*, were found in May 1944 and June 1943, in localities 18–23 miles and 9–12 miles, respectively, south of Clayton. These localities, and Divide County, N. Dak. (1941), were the farthest east in which sylvatic plague infection had previously been found in the United States.

FOREIGN REPORTS

ANGOLA

Notifiable diseases—January–March 1944.—During the months of January, February, and March 1944, certain notifiable diseases were reported in Angola, as follows:

Disease	January		February		March	
	Cases	Deaths	Cases	Deaths	Cases	Deaths
Beriberi	16	3	5		7	1
Cerebrospinal meningitis	1		2	1		
Chickenpox	52		143		85	
Diphtheria	1		4	1		
Dysentery (amebic)	132	3	153	1	118	3
Dysentery (bacillary)			8		5	
Gonorrhea	227		220		207	
Hookworm disease	419	10	335	6	374	4
Influenza	741	16	600	11	994	5
Leprosy	9	1	8		5	
Measles	40		20		14	
Mumps	12		3		3	
Pneumonia (all forms)	164	21	115	9	151	23
Poliomyelitis	1		1			
Relapsing fever	14		20		14	
Sleeping sickness	84	11	114	6	210	13
Smallpox	18		2		2	
Syphilis	469	1	432		418	3
Tetanus	12	6	4	3	2	2
Trachoma	1		3			
Tuberculosis (respiratory)	52	5	53	3	50	7
Typhoid and paratyphoid fever	10	3	14		29	6
Whooping cough	193	2	118	2	145	5
Yaws	914		794	1	864	2

CANADA

Provinces—Communicable diseases—Week ended June 10, 1944.—During the week ended June 10, 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		27		149	339	55	25	66	146	807
Diphtheria	2	3	1	14	5	3	1	1		30
Dysentery (bacillary)				7		1				8
German measles		11		142	90	4	47	2	42	338
Influenza		13			7	3			1	24
Measles		36	3	596	602	168	79	72	37	1,593
Meningitis, meningococcus				1	5	1			2	9
Mumps		6		138	191	[illegible]	6	[illegible]	[illegible]	[illegible]

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Morocco (French).—For the month of May 1944, 448 cases of typhus fever were reported in French Morocco.

Palestine.—For the month of May 1944, 80 cases of typhus fever with 12 deaths were reported in Palestine.

Peru.—For the month of April 1944, 104 cases of typhus fever including 13 cases in Arequipa Department, 17 cases in Huanuco Department, and 29 cases in Junin Department, were reported in Peru.

Spain.—For the week ended April 29, 1944, 16 cases of typhus fever were reported in Spain.

Yellow Fever

Bolivia.—For the month of May 1944, 4 cases of yellow fever were reported in Bolivia, including 1 case in the Department of La Paz and 3 cases in the Department of Santa Cruz.

Colombia.—For the months of January and February 1944, yellow fever was reported in Colombia as follows: Boyaca Department, 1 case, 1 death; Cundinamarca Department, 1 case, 1 death; Santander Department, 2 cases, 2 deaths.

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FEDERAL SECURITY AGENCY

UNITED STATES PUBLIC HEALTH SERVICE

THOMAS PARRAN, *Surgeon General*

DIVISION OF PUBLIC HEALTH METHODS

G. ST. J. PERROTT, *Chief of Division*

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