Nutrition for Scouts

Milk in Many Ways

Meeting Vitamin C Requirements

Diet List for Blood Donors

Aids to Appetite

Foods are Important (Diet during pregnancy)

3000 copies of this folder were sent to physicians in the state upon request and copy enclosed with each EMIC authorization.

Nutrition movies were shown to 1850 persons.

Diets and menu suggestions for nursing mothers were prepared for hospitals and maternity homes, old people's homes, crippled children's clinics at the request of the State Welfare Board. Menus and diet suggestions were also prepared for a crippled children's home.

Several nutrition exhibits were constructed for nurses meetings, Crippled Childrens Clinics, State Dental Auxiliary Meeting, North Dakota Public Health Association and Teachers Institutes.

Special activities included the chairmanship of Social Welfare and Public Health for the North Dakota Home Economics Association; presence at the conference of nutritionists in conjunction with meeting of the American Dietetics Association; assistance in Famine Emergency Campaign; consultant service to individuals in response to requests; talks to clubs and other groups and news releases on timely subjects.

PUBLIC HEALTH NURSING

PUBLIC HEALTH NURSING

The Public Health Nursing program, although a generalized service, had to meet many every day challenges during the war years and make plans for future services. While the Public Health Nursing services were reduced and curtailed as might be expected, there are evidences of improved quality of service during this two year period.

The problem of maintaining sufficient staff for minimum service of good quality has been of great concern. There was constant encouragement in the use of volunteers and in the employment of War Emergency Nurses to meet certain community needs. The majority of these nurses were married women without public health experience but with other types of experience as well as an interest and willingness to serve their community for the duration.

To meet emergency problems, professional personnel in the Division of Public Health Nursing were assigned to these areas not having public health nursing services to assist with needed preventive health programs. Public health nurses on the home front deserve much praise for the courageous way in which they carried on during the war period.

PERSONNEL—CONSULTANT SERVICE

At the end of the biennium, the Division of Public Health Nursing was fortunate in having a full staff composed of the Director, two Assistant Directors, Consultant in Tuberculosis Nursing and two Staff Nurses. One Staff Nurse was assigned for tuberculosis follow-up service in counties not having public health nursing services. December 1, 1945 a second Public Health Nurse was added to the Division of Public Health Nursing staff. She was assigned to work with the Mobile X-Ray Unit.

Much of the work of the Division of Public Health Nursing is carried on through direct consultant service to personnel of local health departments and public health nurses employed by the departments.

PUBLIC HEALTH NURSES IN NORTH DAKOTA

On June 30, 1946 there were 44 public health nurses in North Dakota. There were 13 vacancies at the end of the same period. Public Health Nurses were distributed as follows:

State Department of Heatlh—6	
Director	1
Assistant Director	2
TB Nursing Consultant	1
TB Staff Nurse	2
District Health Units	
First District Health Unit	7
2 Vacancies	
Supervisor	0
Burke	1
McLean	1
Renville	1
Ward	2
Minot City	2
Southwestern District Health Unit	2
5 vacancies	
Supervisor	1
Adams	0
Billings	0
Bowman	1
Golden Valley	0
Hettinger	0
Slope	0
City Health Departments	16
3 vacancies	
Fargo	7
Valley City	1
Bismarck	3
Devils Lake	0
Jamestown	1
Grand Forks	2
Mandan	1
Williston	1
County Nursing Services	13
3 vacancies	
Barnes	1
Fort Totten	1
Cass	2
Dunn	1
Eddy	0
Grand Forks	1
Pierce	1
LaMoure	0
Oliver	0
Ransom	1
Richland	1
Stutsman	1
Traill	1
Walsh	1
Williams	1
Pembina	0

While many nurses, who had no public health post graduate education, were employed, the State Department of Health recommended that a nurse have a minimum of six months of theory in public health nursing. Twenty-four of the 44 employed had nine months or more post graduate education in public health nursing while two had at least three months of theory. Thirteen have had no post graduate education to prepare them for their work.

PUBLIC HEALTH NURSING SERVICES

Communicable Disease Control

The function of the public health nurse in communicable disease control is to assist in the prevention of the spread of disease in instructions in isolation and in immunization. She assists in securing medical care for those cases needing care. Her work is of direct aid in obtaining complete reporting of communicable diseases, and the information she secures in the home is of great value to the epidemiologist in determining the source of infection.

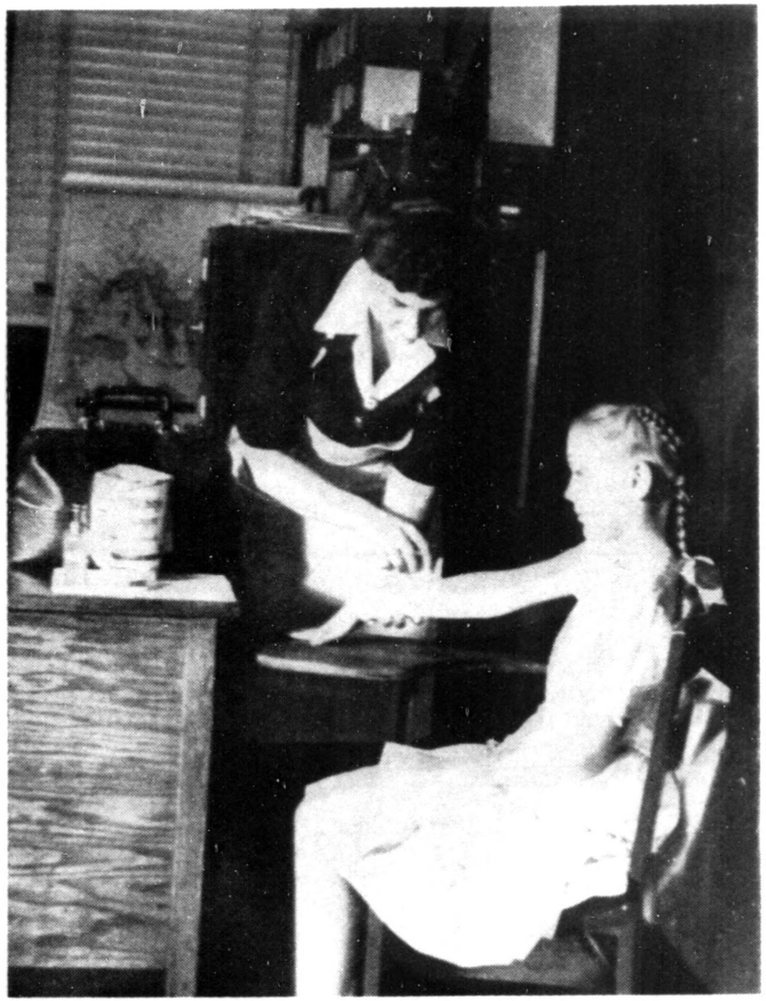
Tabulation of public health nursing visits in the communicable disease control program:

	Total	1945-46	1944-45
Communicable Disease	9804	3410	6394
Venereal Disease	320	113	207

The public health nurses advise parents to have their children vaccinated against smallpox during the first year and have first immuni-

Figure 8
DISTRIBUTION OF PUBLIC HEALTH NURSING SERVICES
NORTH DAKOTA JULY 1, 1944—JUNE 30, 1945

Figure 9
DISTRIBUTION OF PUBLIC HEALTH NURSING SERVICES
NORTH DAKOTA JULY 1, 1945—JUNE 30, 1946



Health of school children is protected through effective service.

zation as a protection against diphtheria when the baby is nine months old. Parents are referred to their family physician for this service. Parents are also encouraged to have their babies vaccinated against whooping cough.

In cooperation with local physicians, Homemaker's Clubs, P.T.A., American Legion Auxiliary's and other organizations, the local health

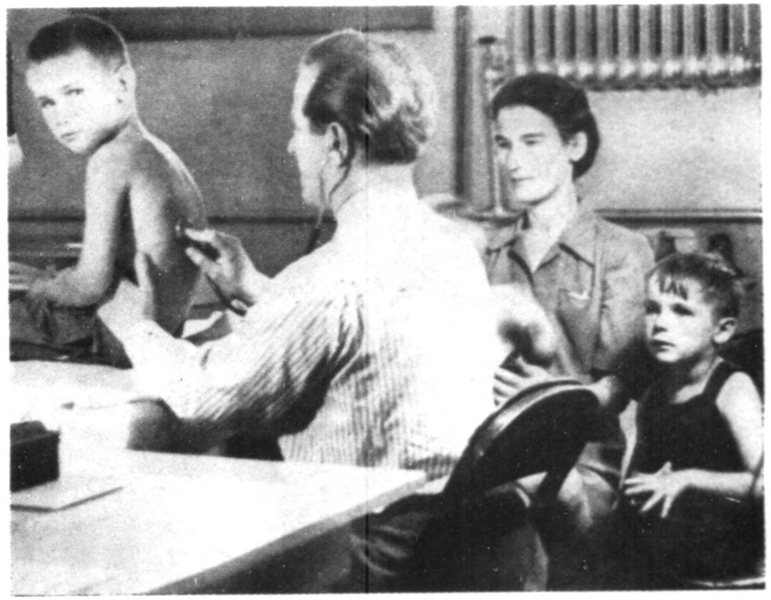
officer and the public health nurse arranged for and conducted immunization clinics for children of the community who were not protected against these diseases. Special immunization clinics were held in communities where cases of preventable diseases occurred. The following report covers these clinics for the biennium:

Immunizations	Total	1945-46	1944-45
Number of clinics	711	343	368
Diphtheria	12974	5597	7377
Smallpox	13624	6923	6701
Whooping cough	4729	1985	2744
Typhoid Fever	152	107	45

4516 children received one or more injections as a protection against diphtheria but did not receive complete immunization.

2465 children did not complete the immunization series as a protection against whooping cough.

The follow-up of active arrested and suspected cases of tuberculosis and their contacts is an important function of the public health nursing program. During the biennium special emphasis was placed on the follow-up of young men rejected from military service on diagnosed cases, suspects and contacts of both. In addition increased emphasis was



Children are carefully examined at the well-child conference.

The public health nurse is a link between home and school.

placed on tuberculin testing of children in the first and high school grades.

Tabulation of tuberculosis nursing visits:

	Total	1945-46	1944-45
Tuberculosis	4802	2457	2345
Tuberculin Tests Applied	23672	13622	10050
Positive Reactions	1993	1393	600
Negative Reactions	21679	12229	9450

CHILD HEALTH CONFERENCES

The public health nurses urge regular supervision of the well child by the family physician or at one of the well child conferences conducted by local physicians or, when available, physicians employed by the State Department of Health.

The public health nurse in cooperation with the local health officer and Women's Clubs organized and arranged for child health conferences. Club members give volunteer services at the conferences. The following is a report of the number conferences conducted and the total attendance for the biennium:

Child Health Conferences	Total	1945-46	1944-45
Conferences	619	279	340
Attendance	6807	3363	3444

TABULATION OF PUBLIC HEALTH NURSING VISITS TO OTHER SERVICES:

	Total	1945-46	1944-45
Maternity	2306	1018	1288
Morbidity	7917	3703	4214
Crippled Children	3244	1882	1362
School Health	11272	5154	6118

Infant health is carefully checked at the conference.

Parent education benefits the entire family.

MERIT SYSTEM

The Classification and Compensation Plan for Public Health Nursing positions in North Dakota was revised. A copy of the revised plan was sent to city and/or county health departments and commissioners employing public health nurses.

PUBLIC HEALTH NURSING AFFILIATION FOR SENIOR CADET NURSES

In cooperation with the School of Nursing and the State Board of Nurse Examiners, the Division of Public Health Nursing planned and arranged for public health nursing experience for Senior Cadet nurses. The first affiliation began May 1, 1944. Twelve Senior Nurses had three months public health nursing experience, three had four months, and one had six months. The program was financed by the State Department of Health.

MANUAL FOR PUBLIC HEALTH NURSES

The Division prepared and issued a manual to the public health nurses. These are kept revised and up-to-date.

EDUCATIONAL ACTIVITIES

In service educational programs are arranged to keep the public health nurses, as nurses and teachers of health, informed of the newer

scientific development in preventive medicine, nursing, and of social sciences.

The following institutes were arranged and/or attended by the public health nurses:

October, 1944	Two day institute. "Principles of Public Health Nursing" conducted by Miss Ruth Freeman, Director, Course of Public Health Nursing, School of Public Health, University of Minnesota.
October, November, 1944	Six, one day regional meetings on "Records, Reports and the Use of the Manual"—Division of Public Health Nursing staff.
February, 1945	One day institute "Introduction to New and Revised Records" conducted by the Division of Public Health Nursing staff.
May, 1945	Three day institute "Tuberculosis Nursing" conducted by Miss Margaret Taylor, Consultant, Tuberculosis Nursing, United States Public Health Service.
October, 1945	One day meeting "The Rehabilitation Program in North Dakota," Mr. Allegrezza, Assistant Director of the State Division of Vocational Rehabilitation. "Nursing the Child with Rheumatic Fever," Jane Nicholson, Consultant, U. S. Children's Bureau.
April, 1946	A North Dakota League of Nursing Education arranged a two day institute on the "Principles of Teaching and Ward Teaching." This institute was conducted by Mrs. Margaret Randall, Instructor of School of Nursing, University of Minnesota.
May, 1946	North Dakota Public Health Association meeting.

To develop better understanding of the problems of nursing, schools of nursing, hospitals and institutional nurses, the public health nurses are encouraged to attend the annual meeting of the State Nurses Association, and meetings arranged by the North Dakota League of Nursing Education.

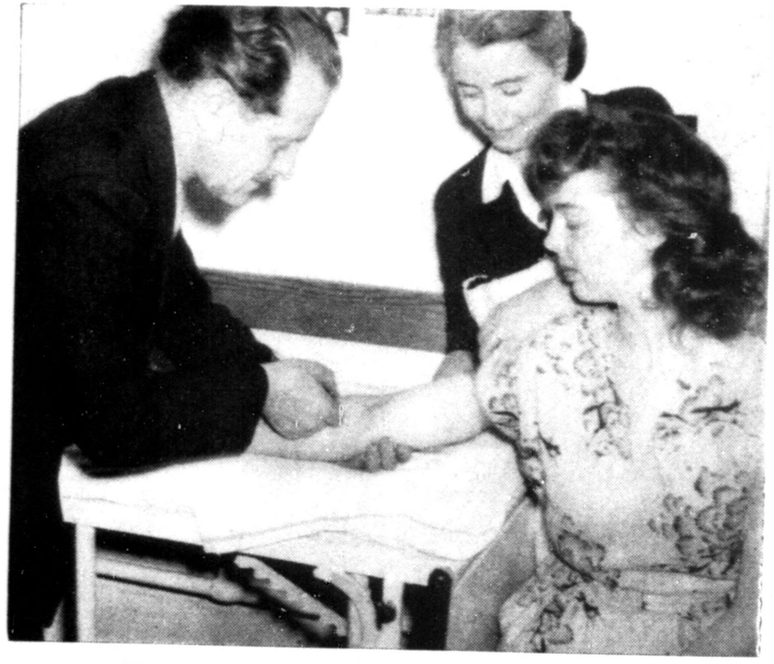
POST GRADUATE EDUCATION

Fellowships and Social Security funds were granted for nurses during the biennium. One completed nine month post graduate education in public health while three completed six months. One nurse left the University before completing the first semester of work. At least six nurses returning from military service have expressed an interest in public health and are planning on post-graduate education beginning October, 1946.

To keep the public health nurse abreast of the present trends in the care of the premature infants, two Assistant Directors were granted a stipend for a months intensive post graduate course in the "Care of the Premature", Presbyterian Hospital, New York City. They will conduct an institute for public health and institutional nurses on "Care of the Premature."

Two nurses attended the annual meeting of the National Tuberculosis Association.

DIVISION OF PREVENTABLE DISEASES



Premarital tests are a part of the total program.

High school and college students take part in a TB Control Program.

DIVISION OF PREVENTABLE DISEASES

General functions of the Division of Preventable Diseases are the prevention and control of communicable diseases and the formation of broad administrative policies. These policies are carried out in cooperation with local health departments.

The division was handicapped during this period by loss of a director. Routine activities were carried out under the supervision of the State Health Officer.

During this period the Bureau of Tuberculosis was organized. This Bureau was necessary to supervise the operation of the X-ray Unit. A portable X-ray was purchased and operations were begun on April 15, 1946 at the State Capitol Building. The colleges in the State followed and were completed before the end of the school year.

TABLE 14

X-Ray Unit Survey of Capitol and Colleges

Survey	Negative	Referred to Physicians	Total X-Rayed
State Capitol	806	80	886
Bismarck Junior College	396	25	421
Dickinson Teachers College	242	37	279
Ellendale Teachers College	104	12	116
N. Dak. Agricultural College, Fargo	1018	58	1076
The University, Grand Forks	1515	169	1684
Jamestown College	273	24	297
Minot Teachers College	859	69	928
Valley City Teachers College	517	37	554
Wahpeton School of Science	315	33	348

The most frequently reported diseases in 1944 were measles with 3,807 cases, pneumonia with 1,914 cases and scarlet fever with 1,049. In 1945 the scene changed somewhat and influenza headed the list with 4,492 cases followed by pneumonia with 1,336 and chickenpox with 859. Whooping cough dropped from 413 in 1944 to 110 in 1945. This is probably due in part to the increase in immunizations during the past few years.

During 1944 there were five deaths due to scarlet fever, 34 from measles, 11 from whooping cough, 213 pneumonia deaths and 83 due to tuberculosis. In 1945 there were 180 pneumonia deaths, 2 whooping cough, 113 tuberculosis and one scarlet fever death.

VENEREAL DISEASES

There were 423 cases of syphilis and 834 of gonorrhea reported during the biennium. This represents an increase of 222 gonorrhea cases over the previous biennum and a decrease of 244 syphilis cases.

Two venereal disease investigators were employed to assist in the investigations made necessary by the demobilization of the Armed Forces. A total of 75 veterans was referred to the department as having had syphilis while in the Forces. While not in the infectious stage of the disease they should be placed under the care of a civilian doctor for observation to avoid relapse. One hundred and seventy-five veterans were referred to this division by the Armed Forces as having either a doubtful or positive serology at the time of their discharge. In addition to the veteran investigations the investigators follow-up contacts named by other states and information received within the State as to a source of either of the veneral diseases.

TUBERCULOSIS

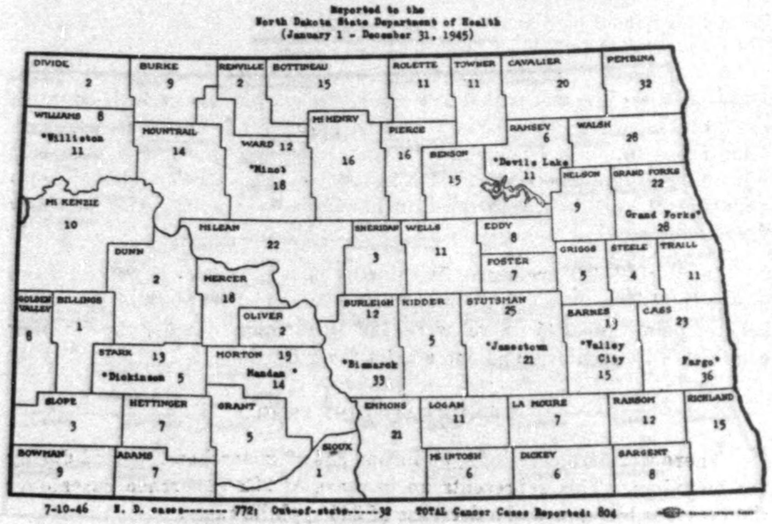
The intensive case finding program which has been in progress in North Dakota for several years continues. Cases reported were 298 in 1944 and 225 in 1945. There were 83 deaths during 1944 and 113 during 1945.

CANCER

In 1944 cancer was made a reportable disease in North Dakota. Figure 10 below shows the number of cases and their distribution during 1945.

Figure 10

CANCER CASES



Portable Tuberculosis Units Service the State

SPECIAL INVESTIGATIONS

An outbreak of infant diarrhea occurred in the city of Fargo during November, 1945. There were fourteen cases resulting in five deaths. The State Health Officer accompanied by a sanitary engineer from the department made several trips to Fargo during this outbreak to work with local authorities.

In February, 1946, a series of uncontrollable epistaxis occurred in the city of LaMoure. There were seven cases of severe epistaxis of unknown origin in this city of 1,600 people during a period of fourteen days. An investigation was made by the division director and recommendations made to the county health officer for the control of this outbreak.

TABLE 15

Reported Cases of Communicable Diseases 1944 and 1945

Disease	1944	1945
Actinomycosis	2	....
Anthrax	....	1
Chickenpox	694	859
Conjunctivitis	3	9
Infant Diarrhea	....	15
Diphtheria	165	132
Dysentery	25	2
Encephalitis	52	16
Erysipelas	26	10
Gonorrhea	284	550
Impetigo	46	6
Influenza	1416	4492
Measles	3807	119
Meningitis	55	24
Malaria	....	1
Pneumonia	1914	1336
Poliomyelitis	53	17
Psittacosis	....	1
Rheumatic Fever	20	27
Rocky Mountain Spotted Fever	2	....
Scabies	188	32
Scarlet Fever	1049	807
Septic Sore Troat	11	20
Smallpox	9	10
Syphilis	226	197
Tetanus	1	1
Trachoma	63	24
Tuberculosis	298	225
Tularemia	1	....
Typhoid Fever	7	21
Paratyphoid Fever	1	1
Undulant Fever	11	26
Vincent's Infection	203	110
Whooping Cough	413	96

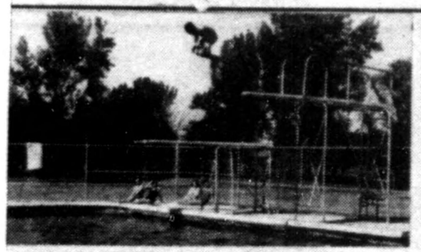
DIVISION OF SANITARY ENGINEERING

MILK SANITATION

ALL CITIES SHOULD ADOPT AND ENFORCE THE "MILK ORDINANCE AND CODE" RECOMMENDED BY THE UNITED STATES PUBLIC HEALTH SERVICE.

SCHOOL SANITATION

NORTH DAKOTA CHILDREN DESERVE THE BEST.



SWIMMING POOLS

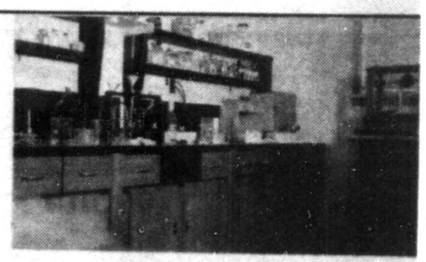
THE POOL WATER SHOULD BE FILTERED AND CHLORINATED WITH WARM WATER AVAILABLE FOR THE SHOWERS.

SEWAGE DISPOSAL

AS NORTH DAKOTA GROWS PROPER SEWAGE DISPOSAL BECOMES INCREASINGLY IMPORTANT.

STREAM POLLUTION

THE VIRUS OF POLIOMYELITIS (INFANTILE PARALYSIS) HAS BEEN ISOLATED FROM SEWAGE CONTAMINATED STREAMS.



CHEMICAL LABORATORY

MOST NORTH DAKOTA GROUND WATER IS HIGHLY MINERALIZED.

DIVISION OF SANITARY ENGINEERING

It is the intent of this report to not only review the activities of the Engineering Division during the biennium, but also to outline in general the over-all problems confronting the Division. A shortage of engineers and many changes in the personnel resulted in considerable difficulty in carrying on many of the various sanitation programs. Not until the last few months of the period did sufficient personnel return from the Service to provide a well organized engineering staff.

WATER SUPPLIES AND SEWERAGE

The inspection of water supplies and sewerage systems was limited largely to requests for such services in connection with proposed changes or improvements to the facilities. An established policy for the majority of North Dakota cities is to submit water samples for bacteriological anaylsis at least once a month. When such samples indicate unsatisfactory conditions, a follow-up is made immediately and, when necessary, one of the Department's emergency chlorinators provides the necessary public health safeguard until such a time that other means of protection are substituted.

North Dakota railroads obtain drinking water for their coaches at over thirty different watering points in the State. In order to assure safe supplies and methods of watering, the U. S. Public Health Service has delegated the authority of inspection to the State Department of Health. These watering points are checked annually and recommendations for the improvement of water handling methods made, if indicated. In some instances it has been necessary to prohibit the railroads from using a certain point either because of the method used, or the insanitary nature of the water supply itself. Considerable improvement in the sanitation at these watering points was noted during the biennium.

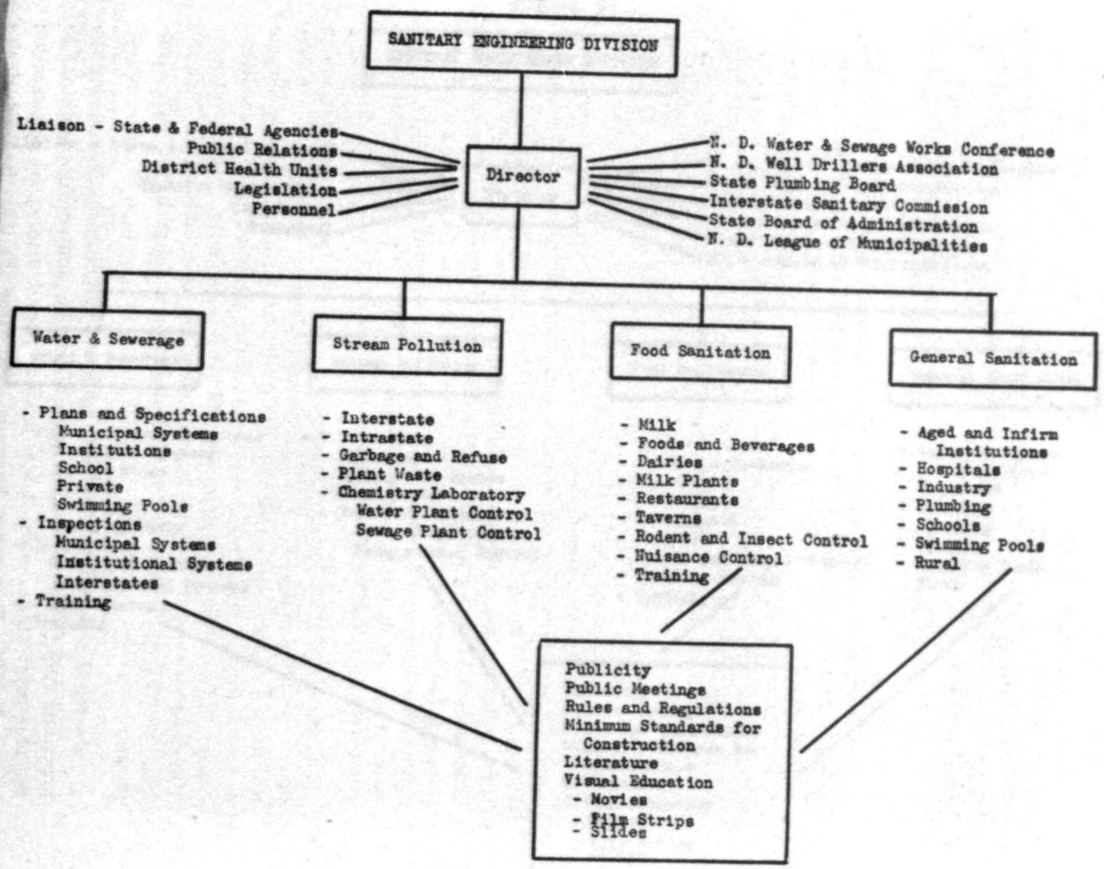
A survey of the sanitation needs of the Country was conducted under the supervision of the U. S. Public Health Service during the last few months of this period. The Engineering Division was called upon to cover a cross section of the State, checking on water supplies, sewage facilities, garbage disposal for municipalities, and rural community sanitation needs. The compiled results of this survey were not available as of June 30, 1946, but the total needs in North Dakota, on a dollar basis, were staggering.

During the war an attempt was made to have municipalities bring the plans and specifications of their proposed water and sewage additions to the blue-print stage, since it was a slack period insofar as construction was concerned. It was not, however, until after the war that a majority of the cities were able to secure the services of consulting engineers and accomplish their planning. During the last few months of this biennium, 51 sets of plans and specifications were received by the Division for

TABLE 15

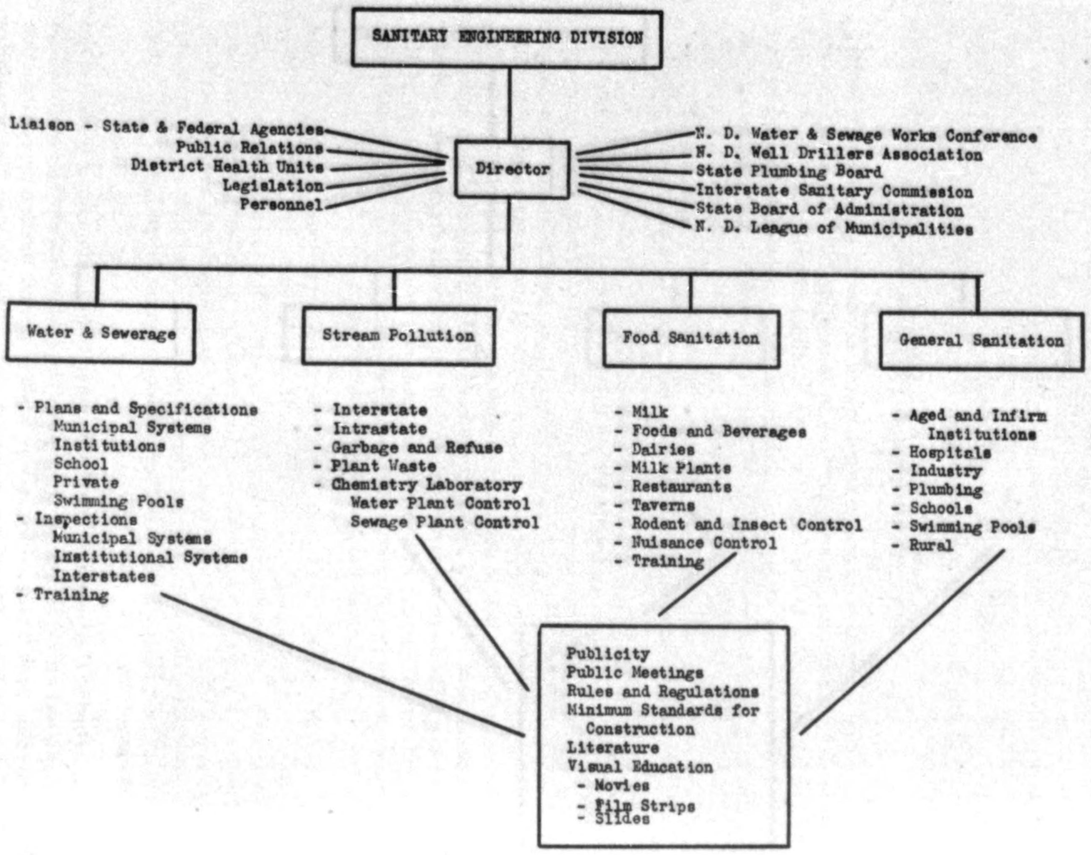
Reported Cases of Communicable Diseases 1944 and 1945

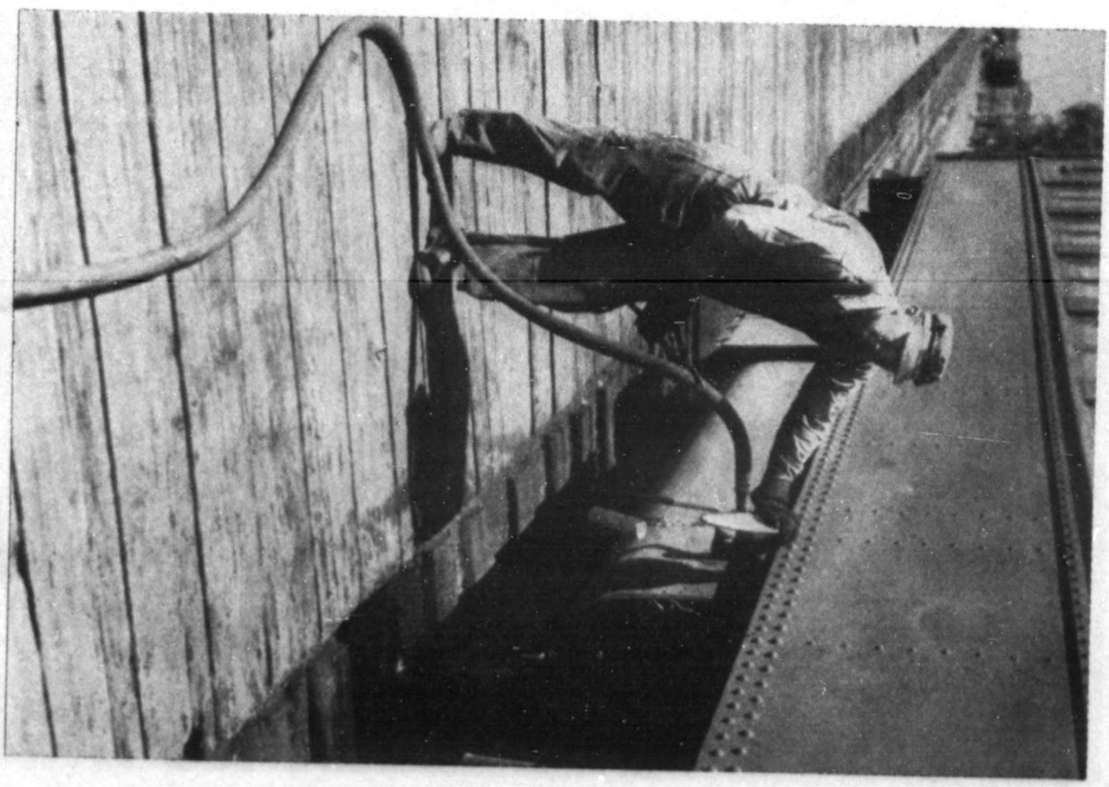
Figure 11



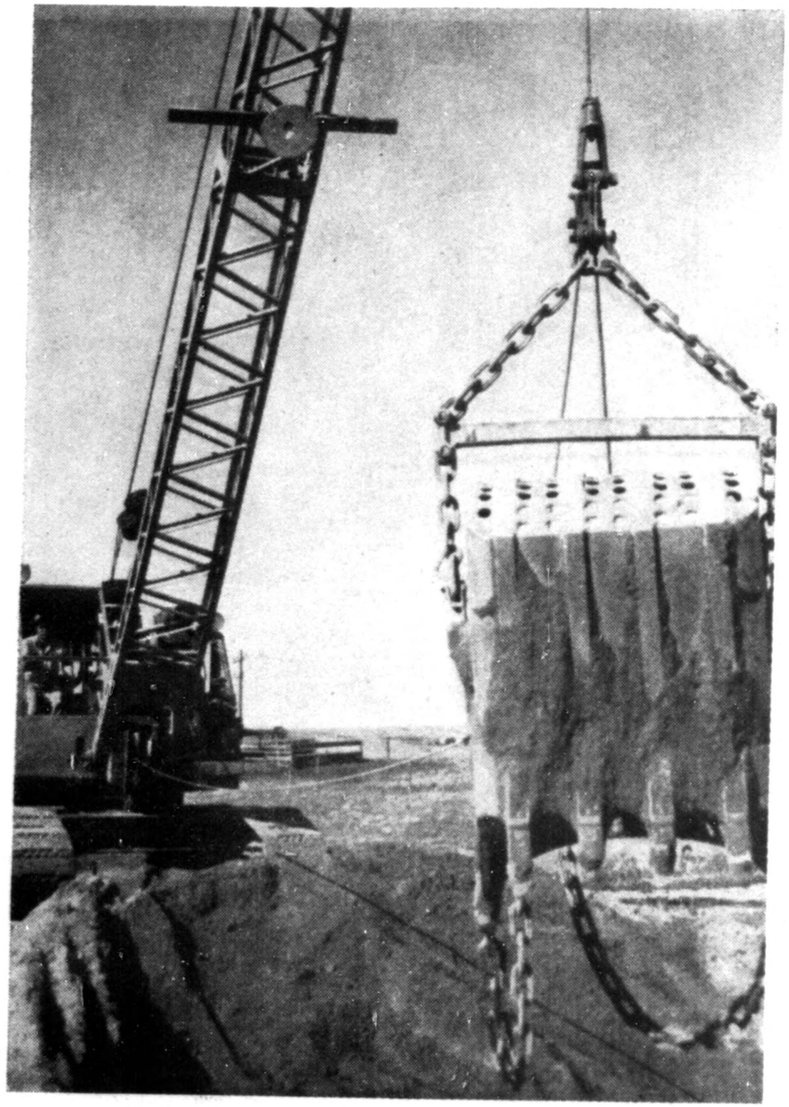
Filling the drinking water tanks of one of the big transcontinental trains. Guarding this supply is an important function at the Division of Sanitary Engineering.

Figure 11





Filling the drinking water tanks of one of the big transcontinental trains. Guarding this supply is an important function at the Division of Sanitary Engineering.

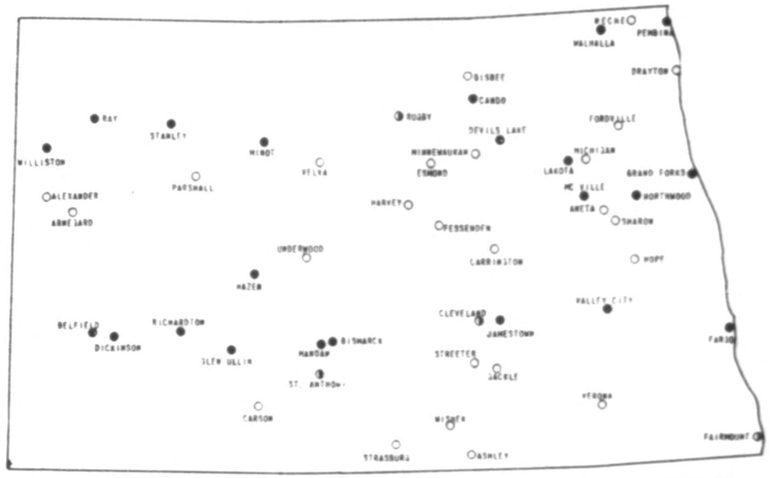


Digging a Sewer Outfall With a Drag Line

The Division of Sanitary Engineering must approve all plans for public water and sewage systems before construction can proceed.

Figure 12

PLANS AND SPECIFICATIONS FOR SANITARY FACILITIES
Reviewed by State Department of Health

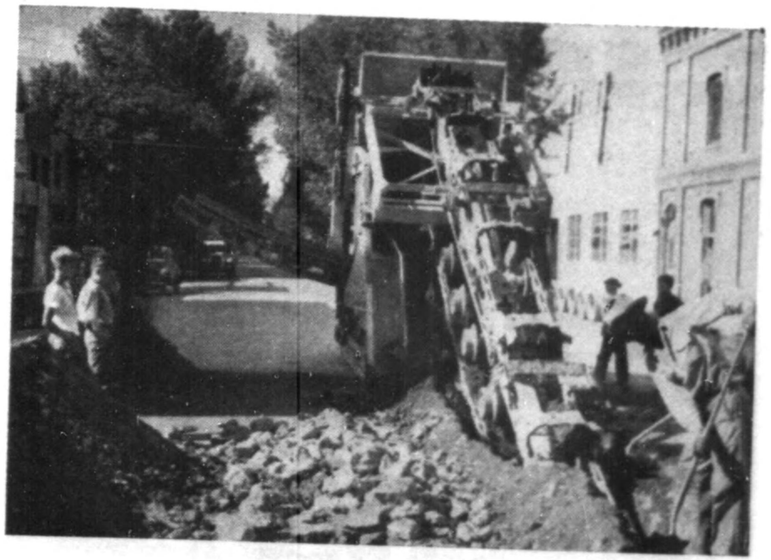


review and approval. Many of these sets included complete water and sewerage systems for a municipality. Some included a water or sewerage system alone, while others were additions to an existing utility.

Army hearings on flood control and water conservation projects were held involving stream pollution and industrial waste problems. Assurance is desired by the Army from the State agencies having control of water resources that the diverted and controlled waters will not be unduly polluted as the result of inadequate treatment by municipalities and industries. The Interstate Sanitation Committee, comprised of Health and Water Conservation personnel in North Dakota, South Dakota, and Minnesota, continued to function in regard to problems of pollution in the Red River Basin. Through the efforts of this Committee, uniform standards of treatment for municipal and industrial wastes are being established which call for the same degree of treatment whether it be in North Dakota or Minnesota.

In order to assist municipalities with their water supply and water treatment problems, a chemist was obtained and the chemical laboratory reopened during the latter part of the biennium. This also provides facilities for the Engineering Division to again conduct stream pollution surveys which are necessary for the proper recommendations for sewage treatment to municipalities and industry.

New water tower being erected at Wishek.



Power Machinery Excavating a Sewer Trench in Mandan

SCHOOL SANITATION

The sanitation of the more than 2300 schools in North Dakota is a major problem in the over-all public health picture of this State. It is a phase of work that the Division has not been able to carry out during the biennium in the manner commensurate with its importance.

In a survey of one county, conducted by the First District Health Unit at Minot, 80 out of 106 schools had no water supply. Of 21 schools which had their own wells, 15 were found to be insanitary. In 83 rural schools, 62 had insanitary privies. Of these same rural schools, 72 had inadequate or no hand washing facilities. Seventy-five percent of the schools in the county had from fair to poor lighting conditions, and 84 percent of the rural schools had inadequate ventilation. Certainly, opportunities for transmission of childhood diseases are better at such population concentration points as schools, when little or no recognition of the importance of proper sanitation or housing is evidenced.

A concerted effort is necessary to bring these facts home to the school boards and parents. Too often the fact is overlooked that the whole child goes to school and not just his academic mind. The child must be provided with an environment that is conducive to good health if he is to grow up consicious of the importance of sanitation and be sound in body and mind.

Swimming pools should provide health recreation for young people.

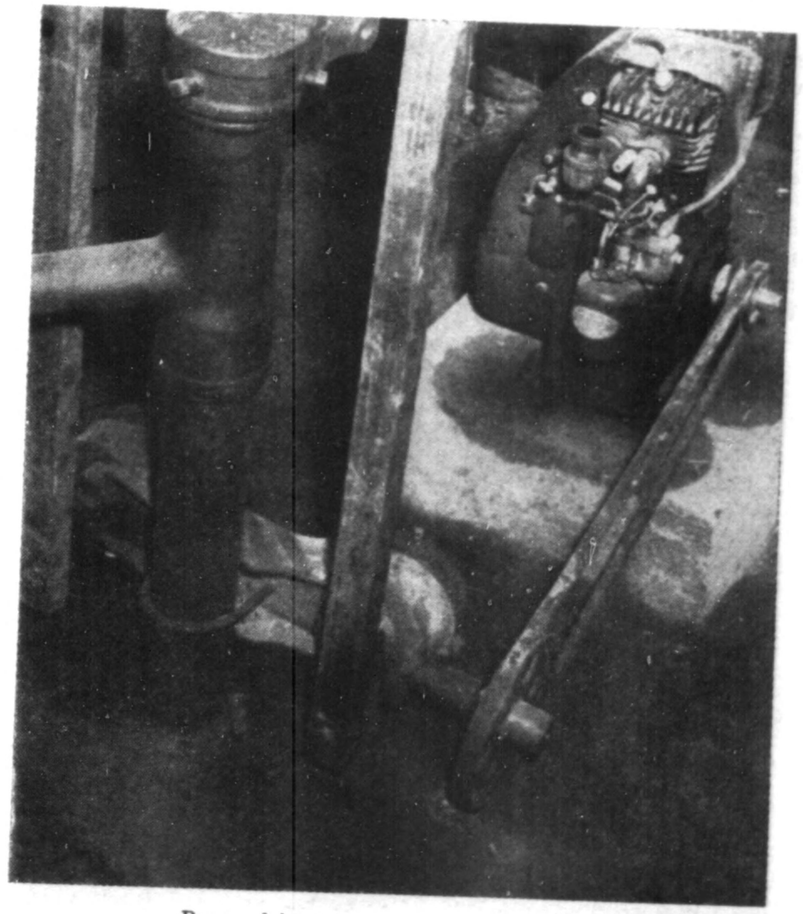
SWIMMING POOL SANITATION

Eighteen swimming pool inspections were made, as compared to eleven during the previous biennium. Swimming pools are considered a possible medium for the spread of various infections. To guard against the transmission of disease, water must be recirculated, treated and chlorinated in a properly constructed and operated pool. The Division does not recommend the construction by a city of a pool which does not have treatment facilities that will continuously produce a water that is bacteriologically safe. The Division's policy of annual inspections has brought about much improvement in the operation of many of North Dakota's swimming pools. In addition, the service rendered by the Division in reviewing plans and specifications for new pools resulted in good public health practice in recent contemplated designs.

RURAL AND FARM SANITATION

As a service to individuals, the Laboratory and Sanitary Engineering Divisions analyze and report out bacteriological analyses on samples submitted from private wells throughout the State. In analyzing some over 1500 samples, during the two-year period, approximately 50 percent were found to be unfit for drinking purposes. Of those unfit for drinking, in practically all cases, the samples were contaminated because the wells were improperly constructed or located.

Many farmers and rural residents have requested information on improving their water supply and the construction of safe and satisfac-



Power driven pump on modern farm.
Notice the concrete platform around the pump.

tory sewage disposal systems. In order to assist them and thus improve their general health, the Division published a 50-page booklet with illustrations entitled, "Sanitation for Health and Convenience." These have been distributed widely to farm agencies and are available to all interested in improving rural sanitation.

MILK PROGRAM

The milk sanitation program under the Health Department is carried on at a local level, inasmuch as the State Dairy Department functions on a state level. Under the Health Department program cities adopt the U.S.P.H.S. Milk Ordinance and cooperate in hiring a qualified milk sanitarian for full time inspection service. These sanitarians are trained and supervised by the State Health Department to insure full compliance with the standard milk ordinance and it's interpretations.

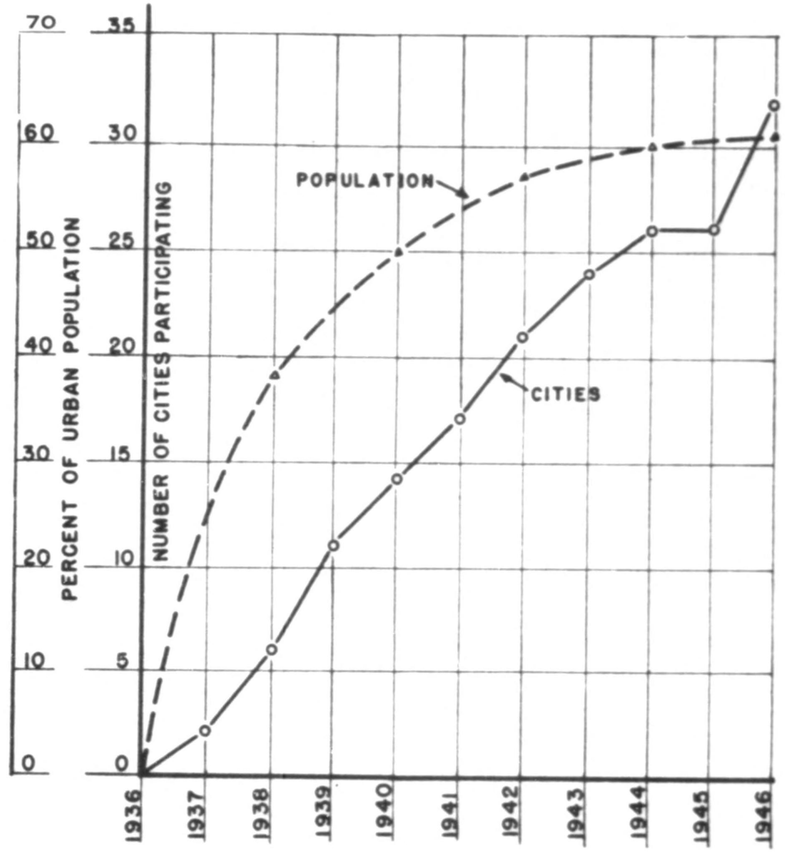
At present, 32 cities are operating under these cooperative agreements which represent an increase of 19% in the number of participating cities. These cities represent 61% of the urban population living in cities of over 300 population. The present program is operating under optimum conditions as the 61% of the population is being served with a minimum number of sanitarians. The remaining 39% constitute a larger number of smaller cities and to serve them will require expenditures and personnel at a higher ratio than with the present group.

Your Child's Health Depends on a Safe Milk Supply

Figure 13

MILK SANITATION PROGRAM

Relationship of Number of Cities and Percentage of Urban Population Served

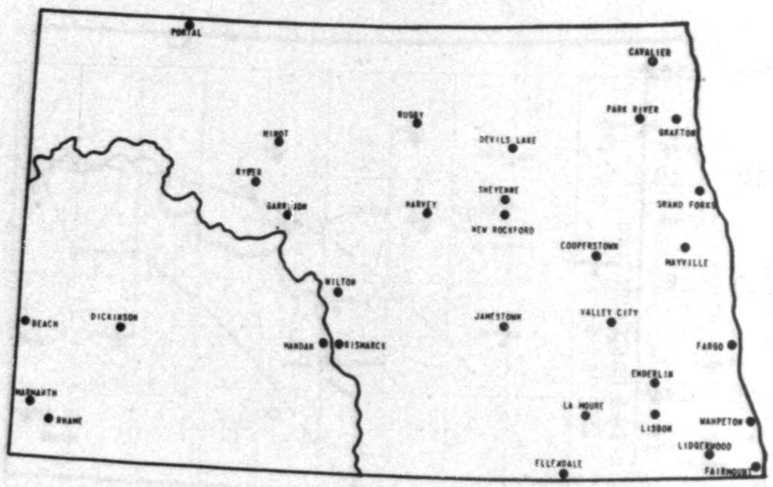


The milk programs on a local level have proven very satisfactory. The majority of the expense is carried by the cities and they feel that they are operating their own program rather than being dictated to by the State.

Figure 14

CITIES WITH U. S. P. H. S. MILK ORDINANCE PROVIDING INSPECTION SERVICE

Under Supervision of State Department of Health



RESTAURANT SANITATION

The restaurant sanitation program carried on by the State Health Department is on the same basis as the milk program, that is through local control. Control on a state level is a function of the state laboratories department.

To date 15 cities have adopted the U.S.P.H.S. Ordinance regulating eating and drinking establishments and are providing adequate enforcement. The sanitarians serving these cities have not only the duty of enforcing the ordinance but also carrying on an educational program for food handlers. During the past two years, 19 schools for food handlers have been conducted with over 2,000 persons attending. These schools bring out the need for sanitation and how to achieve it, thereby making compliance with the ordinance much easier.

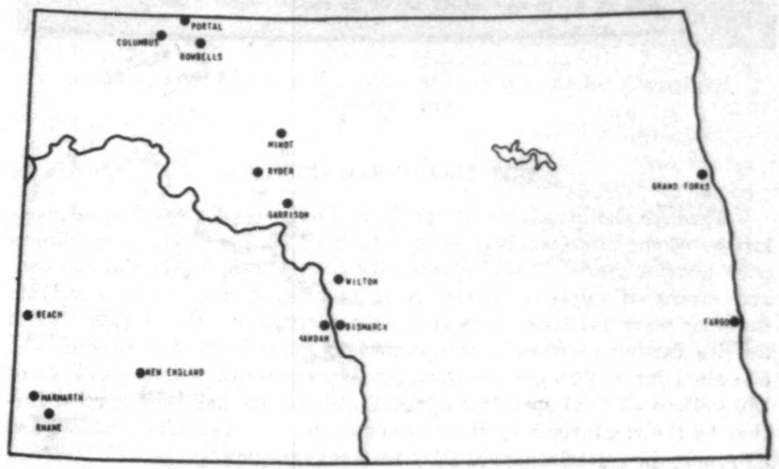
Local control of restaurant sanitation has proven satisfactory as excellent results are obtained. The city pays the majority of the costs, and they feel that they are solving their own problems.

Sanitarian Giving a Restaurant Operator a "Grade A" Sign
Many cities are adopting the Standard Restaurant Ordinance recommended by the Health Department.

Figure 15

CITIES WITH U. S. P. H. S. FOOD ORDINANCE PROVIDING INSPECTION SERVICE

Under Supervision of State Department of Health



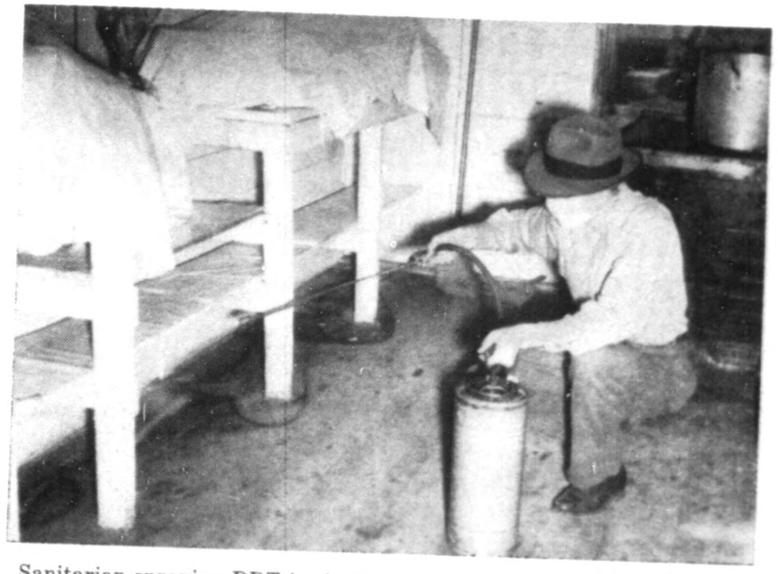
NORTH DAKOTA WATER AND SEWAGE WORKS CONFERENCE

This organization composed of water and sewage works operators and officials continued its program on a very active basis during the biennium. Annual conventions are held with an attendance of 125 to 150 members, at which the latest developments in the water and sewage works field are discussed. "Official Bulletin," the organization's own magazine, has continued to be published monthly by the Engineering Division and serves as an excellent medium for transmitting information to the men in the field.

Registration desk at the North Dakota Water and Sewage Works Conference.

DDT DEMONSTRATIONS

Through the assistance of the U. S. Public Health Service, all sanitarians of the State working in conjunction with the Health Department were given a short course, including demonstrations, on the various uses and means of applying DDT. A restaurant, a dairy, and a private dwelling were actually sprayed by the instructor. The Public Health Service further assisted in this regard by furnishing each sanitarian a 55-gallon drum of 35 percent DDT concentrate, which is the equivalent of 380 gallons of final spraying mixture. This work has been carried further by the sanitarians by their demonstrating to restaurant owners and dairymen the effectiveness of DDT residual spraying.



Sanitarian spraying DDT in the kitchen of Chan Owapi Scout Lodge.

HOMES FOR THE AGED

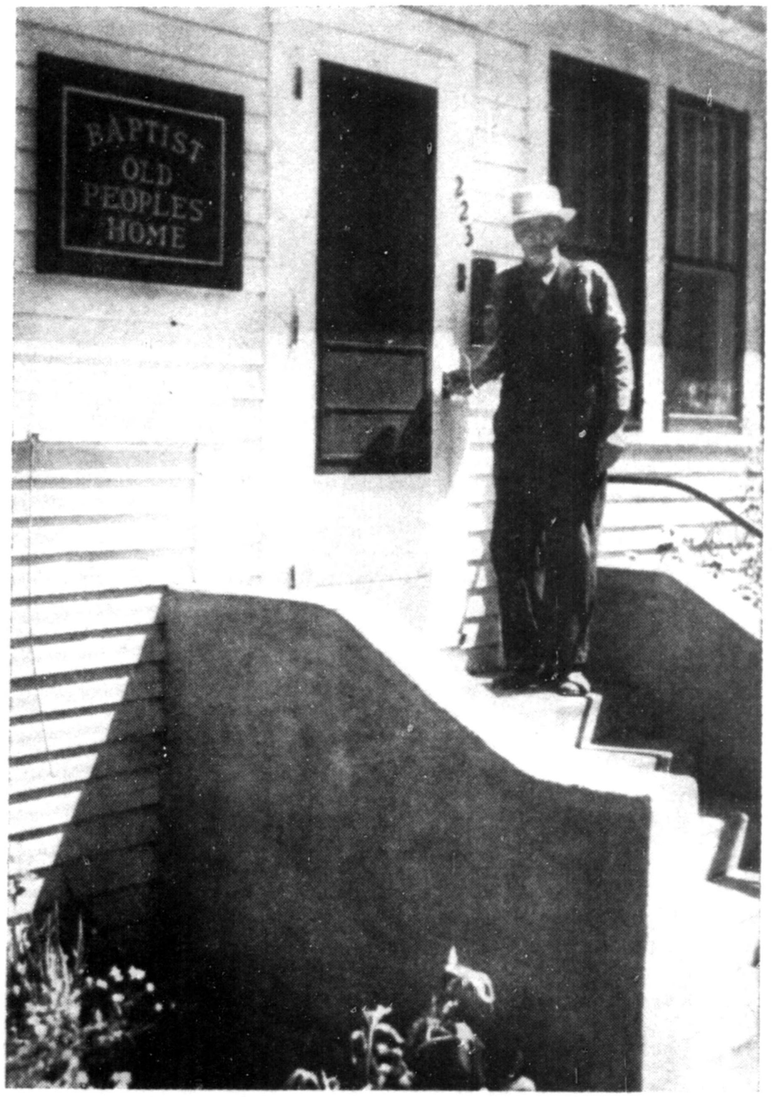
Legislation passed during the biennium requires the licensing of homes for the aged by the State Welfare Board. At the Welfare Board's request, the Engineering Division has made inspections of the homes from a sanitation standpoint, recommending improvements to water supplies, sewage disposal, kitchen operations, plumbing and general cleanliness. Seventy-five homes for the aged were inspected and reports submitted. Although some homes were operating under relatively fair conditions, a majority needed considerable improvement.

GARRISON DAM

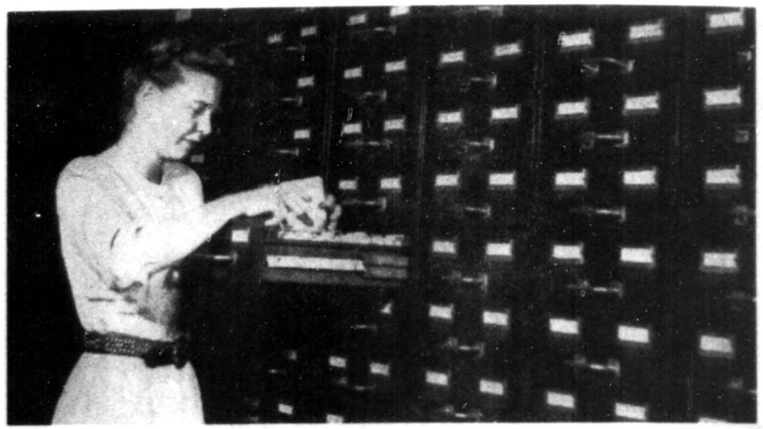
Plans are under consideration for providing sanitation personnel for the Garrison Dam area. Provision should be made in the budget for an engineer and sanitarians to insure proper sanitary conditions in the "Boom Towns" and work camps already springing up. The present personnel of the First District Health Unit will be unable to cope with this problem alone and must be assisted by the State Department of Health.

PUBLICATIONS

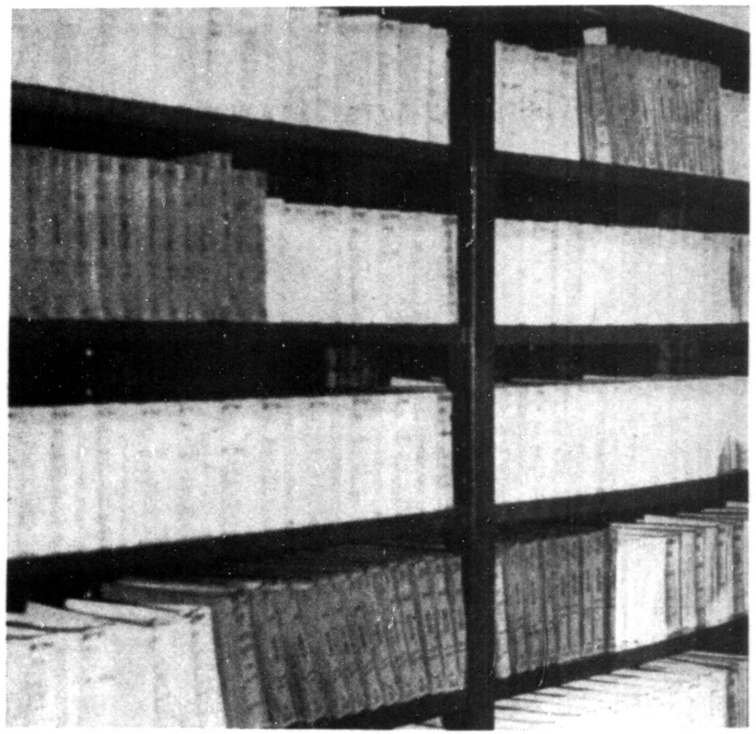
"Take a Tip" (Restaurant Sanitation)
"Destroy Him" (Rat Control)
"Sanitation for Health and Convenience"
"Clean-up Bulletin"
"Milk Posters" (for dairymen)



A sanitary engineer checked each home for the aged in North Dakota.



A master card index lists births and deaths on file with the Department.



Bound volumes of birth and death certificates are filed in a fireproof vault.

DIVISION OF VITAL STATISTICS

The Division of Vital Statistics of the North Dakota State Department of Health has the duty and responsibility of registering births and deaths, issuing certified copies thereof, tabulating statistics, compiling various reports required by federal agencies and numerous other routine tasks related to securing complete and proper current registration, and filing delayed cetificates of birth for those whose births were not recorded at the time the event occurred and who must now have proof of date and place of birth.

The funeral director, or person acting as such, is responsible for securing and filing the death certificate with the local registrar and securing a burial-removal permit. The attending physician, or other person in charge at the time of birth, is required to file the birth certificate with the local registrar. The local registrar forwards these certificates monthly to the Division of Vital Statistics where they are placed in county and chronological order. Records are carefully examined for inaccuracies and omissions, coded, and a statistical punch card is made for each certificate for use in the preparation of statistical data. At the end of the year the certificates are numbered serially, indexed, and bound into volumes for permanent preservation.

On July 1, 1945, a change was made in the method of notifying the mother of the registration of her child's birth. The printed form entitled "Notification of Birth Registration" furnished to the various states by the Bureau of the Census, Department of Commerce, Washington, D. C., was discontinued. After many years experience with the form, its two bad features were obvious. First, and most important, in too many instances the notification was mistaken for a certified copy. Many persons carefully preserved it thinking they had a certified copy, or what is generally known as a "Birth Certificate," and it was even erroneously accepted by some government agencies, as well as by defense plants. This was a particularly bad feature since the form carried neither an original signature nor a raised seal. Second, many people thought the birth was on file in Washington, D. C., as well as in the state of birth because of the heading on the form.

The present system consists of sending the parents an uncertified photocopy of the original record, clearly stamped "uncertified copy" together with a query sheet and a postage-free envelope for reply. This gives the parents an opportunity to examine carefully the pictures of the birth certificate for errors in spelling of names, date of birth, and other items, and to indicate that the certificate is correct, or to have such items corrected before the certificate is actually needed for legal purposes.

During the two year period, the division has placed on file approximately 27,200 birth certificates, 10,200 death certificates, 10,700 delayed certificates of birth, 540 stillbirth records, and 4,680 copies of marriage certificates.

Compilation of statistics for public use is a continuous process.

Over one thousand certified copies of birth records are still being issued each month by the Division of Vital Statistics, compared to the nearly two thousand per month during the first part of the biennial period. Free certified copies of records are furnished to veterans or their dependents when used in connection with applications for benefits provided by State and Federal laws. The monthly average of free certified copies of births during the early part of the biennium was about 25 certified copies per month. In June, 1946, 155 free certified copies of birth records were issued. There has been a slight increase in the number of certified death records issued. Approximately 10 free certified death records were issued monthly in the early part of the biennium as compared to 35 free copies issued in June, 1946.

In June, 1943, the division had the largest payroll in its history, employing nearly 60 people with some part-time employees. The staff on June 30, 1946, consisted of 10 clerks and stenographers, one statistician and the director, which is approximately the normal size of staff required to handle the work of the division efficiently.

Legislation during the past biennium included (1) a statute providing for one certificate in registering a stillborn child instead of the use of

both a birth and a death certificate. (2) A law requiring embalmers, undertakers and others selling caskets to keep a permanent record showing the name of the purchaser, postoffice address, name of deceased, date of death and place of death, and to report certain information monthly to the State Registrar of Vital Statistics. (3) A provision for filing with the Division of Vital Statistics a record of the death of a veteran upon receipt of the original notice of death furnished by the War Department, or a copy of such notice certified by the Veteran's Service Commissioner or the Veterans Administration. From February 4, 1945, to June 30, 1946, 177 such records have been placed on file in the Division.

THE CHANGING PICTURE

A survey of North Dakota death rates for past years shows that the total or crude death rate has been increasing slightly for many years, with a greater than usual increase for 1943, 1944 and 1945. These recent rates are based upon deaths that occur in North Dakota and do not include deaths of North Dakota residents who have been in the armed forces and stationed in other states or overseas. The birth rate, which was declining before, showed a spurt during the war years and is still abnormally high. The marriage rate, likewise rose markedly during these years. Infant and maternal mortality continued a downward trend. The percentage of births attended by physicians and occurring in hospitals has steadily increased. Deaths from specific causes during the biennium follow established trends: upward for heart diseases, cancer, apoplexy, diabetes, and nephritis; downward for pneumonia and influenza and tuberculosis. Only diphtheria and whooping cough, among the diseases of children, show a consistent decline.

Interesting changes have occurred in the relative importance of the ten leading causes of death in the past 22 years, 1924 to 1945. Heart disease has been the leading cause of death in North Dakota from 1930 to the present. Before that time it ranked second to pneumonia and influenza. The latter cause of death has dropped from first to fourth or fifth. Cancer, which ranked third for many years has ranked second from 1938 to the present. Nephritis has held fifth place with some consistency. Diabetes ranked ninth or tenth in the earlier years, seventh more recently. Tuberculosis ranked fifth from 1924 to 1927, seventh from 1929 to 1939, dropped out of the ten leading causes in 1944, and appeared again in ninth place in 1945. Diarrhea and enteritis, which ranked eighth to tenth previously, has not appeared on the list since 1936. Appendicitis, which appeared intermittently among the lower ranks in earlier years has not been among the leading ten since 1940. Motor vehicle accidents first appeared among leading causes in 1933. Encephalitis was among the leading causes for only one year, 1941. Accidental injury by fall or crushing, senility, and congenital malformations are recent additions to the list, and arteriosclerosis appeared for the first time in 1945.

A punch machine helps in tabulating statistics.

The following tables show the detailed statistical tabulations for the past biennium, and in many cases for earlier years. The most useful of the tabulations published in the past are continued to provide continuous data for reference purposes. At the same time, some tabulations are modified to conform with the United States Census Bureau arrangements in order to make possible comparisons among states. Additional or more detailed tabulations may be had upon request.

Three guides for the interpretation of death rates follow: First, small changes in rates from year to year are usually chance variation. Even the large drop in the tuberculosis death rate in 1944 is within the limits of chance variation, and is probably to be so interpreted in view of the rise in rate the following year.

Second, the changing age composition of the state affects the death rates for diseases of old age. The death rate for diseases of the heart increased 112 percent from 1930 to 1940. However, if the population had remained the same age, the rate would have increased only 66 percent.

Third, both the age distribution and color of the population favor North Dakota when comparisons are made between state and national

rates. At the last census the median ages of the population in North Dakota and in the United States were 25.7 and 29.0, respectively; the percentages of non-white population were 1.6 and 10, respectively.

Rates by county are omitted from the following statistical tabulations because of the lack of suitable population figures. The estimated county populations present in Table 16 are computed as follows: the total state population is taken from published estimates by the Census Bureau. The county populations are estimated by us, using the same proportions of the state population as prevailed in 1943, the latest county estimates published by the Census Bureau. It is known that rural populations throughout the country have decreased while urban populations have gained. If this is the case in North Dakota, the city populations published here are underestimated, and probably also the county populations in which the larger cities are located.

The latest census figures for age are for 1940—but this age distribution has almost certainly been seriously disturbed by war and other consequent conditions which have prevailed since that time. Hence, specific rates by age are also omitted from the tables.

TABLE 16

Estimated Population of North Dakota by Counties and Ten Largest Cities, July 1, 1944 and 1945

County and City	1944	1945
State	528,200	520,935
Adams	4,084	4,027
Barnes	14,306	14,109
Rural	9,554	9,423
Valley City	4,752	4,686
Benson	9,969	9,832
Billings	1,682	1,659
Bottineau	10,718	10,571
Bowman	3,192	3,148
Burke	6,342	6,255
Burleigh	19,000	18,739
Rural	6,050	5,967
Bismarck	12,950	12,772
Cass	44,860	44,243
Rural	17,205	16,969
Fargo	27,655	27,274
Cavalier	11,647	11,487
Dickey	7,942	7,833
Divide	5,494	5,418
Dunn	6,572	6,481
Eddy	4,474	4,413
Emmons	9,164	9,038
Foster	4,625	4,562
Golden Valley	2,948	2,908
Grand Forks	29,163	28,762
Rural	12,073	11,907
Grand Forks	17,090	16,855
Grant	6,267	6,180
Griggs	4,624	4,561
Hettinger	6,577	6,486
Kidder	5,512	5,436
LaMoure	8,658	8,539
Logan	6,204	6,119
McHenry	11,893	11,729
McIntosh	7,519	7,416
McKenzie	6,356	6,268
McLean	13,494	13,308
Mercer	7,895	7,786

TABLE 16

Estimated Population of North Dakota by Counties and Ten Largest Cities, July 1, 1944 and 1945—(Continued)

County and City	1944	1945
Morton	17,240	17,003
Rural	11,530	11,372
Mandan	5,710	5,631
Mountrail	8,790	8,669
Nelson	7,432	7,330
Oliver	3,151	3,108
Pembina	12,564	12,391
Pierce	7,659	7,554
Ramsey	12,743	12,568
Rural	7,684	7,578
Devils Lake	5,059	4,990
Ransom	8,064	7,953
Renville	5,212	5,140
Richland	16,731	16,501
Rolette	9,150	9,024
Sargent	7,004	6,908
Sheridan	5,032	4,962
Sioux	3,105	3,063
Slope	2,318	2,286
Stark	13,245	13,062
Rural	8,228	8,114
Dickinson	5,017	4,948
Steele	4,181	4,124
Stutsman	20,080	19,804
Rural	12,568	12,395
Jamestown	7,512	7,409
Towner	5,730	5,651
Traill	10,927	10,777
Walsh	17,092	16,857
Ward	26,705	26,337
Rural	12,863	12,685
Minot	13,842	13,652
Wells	9,614	9,482
Williams	13,250	13,068
Rural	8,548	8,430
Williston	4,702	4,638

State populations are estimated by the United States Census Bureau. County and city estimates are based on the assumption that the same proportions prevail as in earlier Census Bureau estimates.

TABLE 17

Marriages by County Where License Was Granted, Compiled from Records On File in the Division of Vital Statistics, North Dakota, 1938-1945

County	1938	1939	1940	1941	1942	1943	1944	1945
State Total	4,669	4,221	4,224	4,206	3,102	3,028	3,044	3,633
Adams	11	23	29	33	13	17	15	11
Barnes	120	112	130	120	100	95	90	115
Benson	74	84	78	79	76	66	48	56
Billings	7	19	15	7	5	3	4	7
Bottineau	116	93	100	86	69	58	72	77
Bowman	24	22	17	21	14	8	6	13
Burke	93	70	37	32	29	25	19	18
Burleigh	182	162	168	183	152	95	126	156
Cass	316	287	300	311	222	214	184	277
Cavalier	108	83	85	91	79	66	79	71
Dickey	47	43	87	67	54	45	30	50
Divide	85	41	29	24	9	16	19	23
Dunn	52	49	52	34	22	31	37	33
Eddy	43	34	42	51	52	29	22	26
Emmons	75	64	53	86	53	63	77	101
Foster	48	43	43	39	37	28	30	35
Golden Valley	21	9	7	9	3	10	7	10
Grand Forks	294	249	225	225	237	241	182	243
Grant	37	50	46	42	24	42	48	40
Griggs	44	41	40	44	37	33	31	35
Hettinger	45	47	41	52	29	25	43	33
Kidder	59	50	64	50	46	31	38	56
LaMoure	59	52	53	64	61	37	51	50
Logan	53	47	58	83	27	45	54	47
McHenry	119	74	72	81	55	43	67	66
McIntosh	78	65	75	85	41	70	50	73
McKenzie	44	43	30	12	7	8	15	16
McLean	112	118	109	106	80	71	77	79
Mercer	75	85	56	74	50	69	67	58
Morton	140	196	179	173	116	134	139	186
Mountrail	87	71	48	47	35	32	28	47
Nelson	69	54	57	56	48	45	38	41
Oliver	25	27	33	28	21	26	22	29
Pembina	101	111	97	87	61	47	67	57
Pierce	71	76	96	85	46	67	61	62

TABLE 17

Marriages by County Where License Was Granted, Compiled from Records On File in the Division of Vital Statistics, North Dakota, 1938-1945—(Continued)

County	1938	1939	1940	1941	1942	1943	1944	1945
Ramsey	160	123	116	112	103	79	101	110
Ransom	57	57	54	46	52	36	41	42
Renville	51	38	37	37	24	23	31	35
Richland	114	102	141	106	88	84	94	83
Rolette	117	147	109	115	74	50	55	83
Sargent	40	36	36	43	17	32	26	28
Sheridan	73	54	59	49	32	50	44	44
Sioux	31	37	29	30	19	18	16	19
Slope	3	10	13	12	15	7	5	9
Stark	130	117	142	139	88	114	91	104
Steele	41	38	36	34	28	21	21	27
Stutsman	155	133	154	180	131	163	147	171
Towner	58	54	58	65	58	44	37	50
Traill	62	56	51	41	51	45	35	51
Walsh	142	124	144	141	101	93	93	126
Ward	321	258	255	237	141	165	156	243
Wells	89	77	85	105	51	33	54	57
Williams	91	66	54	47	24	36	54	54

TABLE 18

Births, Deaths, Infant Deaths, Maternal Deaths, by Place of Occurrence, North Dakota, 1944

County and City	Births	Deaths	Infant Deaths	Maternal Deaths
TOTAL	13,681	5,057	505	24
Adams	93	27	4	....
Barnes	407	154	8	....
Rural	17	54	....	....
Valley City	390	100	8	....
Benson	119	63	3	....
Billings	....	5	....	....
Bottineau	290	101	11	....
Bowman	91	30	2	....
Burke	73	35	5	1
Burleigh	960	352	45	1
Rural	6	14	1	....
Bismarck	954	338	44	1
Cass	1,543	614	46	3
Rural	44	106	....	....
Fargo	1,499	508	46	3
Cavalier	330	99	18	1
Dickey	200	69	5	1
Divide	144	55	2	....
Dunn	77	18	5	1
Eddy	152	41	6	....
Emmons	228	40	6	....
Foster	97	39	1	....
Golden Valley	98	27	3	....
Grand Forks	1,041	389	36	1
Rural	118	100	3	....
Grand Forks	923	289	33	1
Grant	199	36	9	1
Griggs	81	35	2	....
Hettinger	165	32	2	1
Kidder	81	25	6	....
LaMoure	163	54	6	....
Logan	85	23	5	....
McHenry	45	42	2	....
McIntosh	88	41	10	....
McKenzie	32	24	3	....
McLean	203	55	6	1
Mercer	212	52	7	....

TABLE 18

Births, Deaths, Infant Deaths, Maternal Deaths, by Place of Occurrence, North Dakota, 1944—(Continued)

County and City	Births	Deaths	Infant Deaths	Maternal Deaths
Morton	393	172	23	1
Rural	118	74	11	....
Mandan	275	98	12	1
Mountrail	87	44	4	....
Nelson	122	65	5	....
Oliver	4	10	1	....
Pembina	141	84	3	....
Pierce	347	75	8	2
Ramsey	417	165	18	2
Rural	16	32	2	....
Devils Lake	401	133	16	2
Ransom	89	57	3	....
Renville	9	26	2	....
Richland	190	109	7	....
Rolette	328	128	20	....
Sargent	37	41	2	1
Sheridan	32	18	6	....
Sioux	73	31	5	1
Slope	15	8	....	....
Stark	583	164	24	1
Rural	148	43	4	....
Dickinson	435	121	20	1
Steele	86	48	5	....
Stutsman	562	313	16	2
Rural	106	172	4	....
Jamestown	456	141	12	2
Towner	90	31	....	....
Traill	165	76	3	....
Walsh	489	172	18	1
Ward	1,249	413	48	1
Rural	187	74	9	....
Minot	1,062	339	39	1
Wells	320	73	8	....
Williams	556	157	12	....
Rural	6	40	....	....
Williston	550	117	12	....

TABLE 19

Births, Deaths, Infant Deaths, Maternal Deaths, by Place of Residence, North Dakota, 1944

County and City	Births	Deaths	Infant Deaths	Maternal Deaths
TOTAL	13,681	5,057	505	24
Adams	90	37	4	....
Barnes	326	154	7	....
Rural	220	83	4	....
Valley City	106	71	3	....
Benson	232	110	10	....
Billings	48	15	1	....
Bottineau	305	102	12	....
Bowman	71	34	3	....
Burke	152	55	6	1
Burleigh	517	159	20	....
Rural	150	38	4	....
Bismarck	367	121	16	....
Cass	1,023	429	27	....
Rural	334	141	2	....
Fargo	689	288	25	....
Cavalier	321	109	20	1
Dickey	157	62	4	1
Divide	133	52	3	....
Dunn	203	44	10	1
Eddy	107	37	5	....
Emmons	272	57	10	....
Foster	104	35	1	....
Golden Valley	93	19	4	....
Grand Forks	700	329	28	....
Rural	237	133	6	....
Grand Forks	463	196	22	....
Grant	236	44	10	1
Griggs	133	52	7	....
Hettinger	156	52	4	....
Kidder	161	50	8	....
LaMoure	231	73	7	1
Logan	158	46	7	....
McHenry	271	78	6	1
McIntosh	137	50	10	....
McKenzie	153	49	5	1
McLean	361	99	11	1
Mercer	200	66	9	....

TABLE 19

Births, Deaths, Infant Deaths, Maternal Deaths, by Place of Residence, North Dakota, 1944—(Continued)

County and City	Births	Deaths	Infant Deaths	Maternal Deaths
Morton	449	196	28	1
Rural	311	120	20	....
Mandan	138	76	8	1
Mountrail	211	75	8	1
Nelson	138	90	6	....
Oliver	75	16	2	....
Pembina	284	116	15	....
Pierce	231	63	9	1
Ramsey	312	129	9	1
Rural	179	66	7	1
Devils Lake	133	63	2	....
Ransom	155	76	5	....
Renville	122	54	4	....
Richland	206	113	6	....
Rolette	369	103	21	....
Sargent	119	52	3	1
Sheridan	147	49	8	....
Sioux	85	36	3	1
Slope	50	9	....	....
Stark	386	115	14	1
Rural	247	63	7	1
Dickinson	139	52	7	....
Steele	113	44	4	....
Stutsman	446	189	15	1
Rural	280	112	10	1
Jamestown	166	77	5	....
Towner	136	45	1	1
Traill	223	99	4	....
Walsh	371	155	10	1
Ward	637	270	25	....
Rural	282	115	13	....
Minot	355	156	12	....
Wells	252	77	7	....
Williams	339	123	10	....
Rural	183	75	4	....
Williston	156	48	6	....
Out of state and unknown	774	265	29	5

Place of residence figures include only events which occurred in North Dakota, not events which occurred in other states to residents of North Dakota.

TABLE 20

Births, Deaths, Infant Deaths, Maternal Deaths, by Place of Occurrence, North Dakota, 1945

County and City	Births	Deaths	Infant Deaths	Maternal Deaths
TOTAL	13,497	5,111	414	15
Adams	102	20	1	....
Barnes	430	152	8	....
Rural	6	41	2	....
Valley City	424	111	6	....
Benson	110	64	4	1
Billings	1	6	....	....
Bottineau	278	99	9	1
Bowman	63	22	4	....
Burke	76	44	....	1
Burleigh	980	334	26	....
Rural	....	14	....	....
Bismarck	980	320	26	....
Cass	1,571	621	52	3
Rural	28	90	2	....
Fargo	1,543	531	50	3
Cavalier	320	113	15	....
Dickey	174	46	5	....
Divide	125	50	4	....
Dunn	49	27	3	....
Eddy	158	51	4	....
Emmons	233	46	4	....
Foster	104	32	1	....
Golden Valley	96	27	2	....
Grand Forks	1,034	392	26	1
Rural	136	108	8	....
Grand Forks	898	284	18	1
Grant	223	36	5	....
Griggs	85	27	1	....
Hettinger	121	35	4	....
Kidder	53	11	....	....
LaMoure	156	63	3	....
Logan	67	26	1	....
McHenry	25	34	1	....
McIntosh	86	27	5	....
McKenzie	35	37	2	....
McLean	178	71	5	....
Mercer	213	52	8	....

TABLE 20

Births, Deaths, Infant Deaths, Maternal Deaths, by Place of Occurrence, North Dakota, 1945—(Continued)

County and City	Births	Deaths	Infant Deaths	Maternal Deaths
Morton	367	134	20	....
Rural	85	50	7	....
Mandan	282	84	13	....
Mountrail	82	57	7	....
Nelson	77	86	2	....
Oliver	4	5	....	....
Pembina	112	86	2	1
Pierce	357	94	9	....
Ramsey	450	168	12	1
Rural	14	23	....	....
Devils Lake	438	145	12	1
Ransom	88	51	2	....
Renville	9	16	1	....
Richland	192	92	1	1
Rolette	340	139	17	....
Sargent	23	40	1	....
Sheridan	36	16	1	....
Sioux	66	37	4	1
Slope	10	7	1	....
Stark	575	170	15	....
Rural	124	36	5	....
Dickinson	451	134	10	....
Steele	83	38	2	....
Stutsman	541	361	14	....
Rural	52	173	2	....
Jamestown	489	188	12	....
Towner	85	27	....	....
Traill	129	66	5	....
Walsh	465	186	22	1
Ward	1,391	433	48	2
Rural	159	61	6	....
Minot	1,232	372	42	2
Wells	299	73	6	....
Williams	568	164	19	1
Rural	8	32	....	....
Williston	560	132	19	1

TABLE 21

Births, Deaths, Infant Deaths, Maternal Deaths, by Place of Residence, North Dakota, 1945

County and City	Births	Deaths	Infant Deaths	Maternal Deaths
TOTAL	13,497	5,111	414	15
Adams	83	31	2	....
Barnes	359	139	7	....
Rural	249	81	4	....
Valley City	109	58	3	....
Benson	233	99	6	....
Billings	41	9	....	....
Bottineau	297	101	10	1
Bowman	52	27	2	....
Burke	153	64	1	1
Burleigh	498	160	14	....
Rural	146	40	2	....
Bismarck	352	120	12	....
Cass	985	438	36	....
Rural	349	124	6	....
Fargo	636	314	30	....
Cavalier	317	118	17	....
Dickey	137	49	4	....
Divide	122	48	2	....
Dunn	191	57	6	....
Eddy	121	45	4	....
Emmons	242	67	3	....
Foster	115	41	2	....
Golden Valley	72	24	1	....
Grand Forks	710	307	21	1
Rural	267	126	10	....
Grand Forks	443	181	11	1
Grant	196	47	3	....
Griggs	114	41	1	....
Hettinger	184	57	6	....
Kidder	131	35	2	....
LaMoure	219	97	6	....
Logan	177	40	3	....
McHenry	318	92	3	....
McIntosh	137	36	5	....
McKenzie	134	66	3	....
McLean	388	114	8	....
Mercer	232	66	8	....

TABLE 21

Births, Deaths, Infant Deaths, Maternal Deaths, by Place of Residence, North Dakota, 1945—(Continued)

County and City	Births	Deaths	Infant Deaths	Maternal Deaths
Morton	457	145	20	....
Rural	333	90	17	....
Mandan	124	55	3	....
Mountrail	210	86	8	....
Nelson	150	85	7	....
Oliver	71	11	....	....
Pembina	276	112	4	1
Pierce	220	66	10	....
Ramsey	330	124	7	1
Rural	178	56	....	1
Devils Lake	152	68	7	....
Ransom	167	82	8	....
Renville	114	44	6	....
Richland	210	102	1	....
Rolette	338	100	18	....
Sargent	83	48	2	1
Sheridan	149	43	4	....
Sioux	84	32	6	....
Slope	37	12	1	....
Stark	337	125	10	....
Rural	204	57	7	....
Dickinson	133	68	3	....
Steele	118	38	1	1
Stutsman	412	193	10	....
Rural	251	105	3	....
Jamestown	161	88	7	....
Towner	140	53	2	....
Traill	177	98	5	....
Walsh	347	154	18	1
Ward	680	294	31	2
Rural	319	107	15	....
Minot	361	187	16	2
Wells	237	73	4	....
Williams	355	127	17	1
Rural	209	64	5	1
Williston	146	63	12	....
Out of state and unknown	841	349	28	4

Place of residence figures include only events which occurred in North Dakota, not events which occurred in other states to residents of North Dakota.

TABLE 22

Leading Causes of Deaths Under One Year of Age, by Age, Sex, and Race
North Dakota, 1944

International List Number	Cause	Number Infant Deaths							Rate per 1,000 Live Births					
			Age		Sex		Race			Sex		Race		
		Total	Neo-natal	Later Infancy	M	F	W	C	Total	M	F	W	C	Per Cent of Total
	All causes	505	342	163	298	207	471	34	36.9	42.9	30.7	35.4	94.7	100.0
159	Premature birth	172	171	1	103	69	167	5	12.6	14.8	10.2	12.6	13.9	34.1
157	Congenital malformations	73	53	20	33	40	73	....	5.3	4.8	5.9	5.5	0	14.5
33,107-109	Influenza and pneumonia	64	9	55	37	27	52	12	4.7	5.3	4.0	3.9	33.4	12.7
160	Injury at birth	62	61	1	44	18	61	1	4.5	6.3	2.7	4.6	2.8	12.3
161	Other diseases peculiar to first year of life	26	23	3	15	11	23	3	1.9	2.2	1.6	1.7	8.4	5.1
119	Diarrhea, enteritis	23	7	16	15	8	21	2	1.7	2.2	1.2	1.6	5.6	4.6
199-200	Ill-defined and unknown causes	12	7	5	4	8	11	1	0.9	0.6	1.2	0.8	2.8	2.4
169-195	Accidents	11	3	8	9	2	11	....	0.8	1.3	0.3	0.8	0	2.2
35	Measles	10	....	10	6	4	7	3	0.7	0.9	0.6	0.5	8.4	2.0
9	Whooping cough	8	....	8	4	4	8	....	0.6	0.6	0.6	0.6	0	1.6
122	Hernia and intestinal obstruction	7	1	6	6	1	7	....	0.5	0.9	0.1	0.5	0	1.4
86	Convulsions	6	1	5	3	3	6	....	0.4	0.4	0.4	0.5	0	1.2
	Other causes	31	6	24	19	12	24	7	2.3	2.7	1.8	1.8	19.5	6.1

TABLE 23

Leading Causes of Deaths Under One Year of Age, by Age, Sex, and Race
North Dakota, 1945

International List Number	Cause	Number Infant Deaths							Rate per 1,000 Live Births					
			Age		Sex		Race			Sex		Race		
		Total	Neo-natal	Later Infancy	M	F	W	C	Total	M	F	W	C	Per Cent of Total
	All causes	414	279	135	254	160	398	16	30.7	37.2	24.0	30.3	45.5	100.0
159	Premature birth	129	128	1	83	46	128	1	9.6	12.2	6.9	9.7	2.8	31.2
157	Congenital malformations	65	42	23	38	27	65	....	4.8	5.6	4.0	4.9	0	15.7
33,107-109	Influenza and pnuemonia	47	8	39	24	23	41	6	3.5	3.5	3.4	3.1	17.0	11.4
160	Injury at birth	43	43	....	28	15	43	....	3.2	4.1	2.2	3.3	0	10.4
119	Diarrhea, enteritis	35	11	24	20	15	33	2	2.6	2.9	2.2	2.5	5.7	8.5
161	Other disease peculiar to first year of life	29	27	2	14	15	29	....	2.1	2.1	2.2	2.2	0	7.0
169-195	Accidents	10	....	10	6	4								

199-200	Ill-defined and unknown causes	12	7	5	4	8	11	1	0.9	0.6	1.2	0.8	2.8	2.4
169-195	Accidents	11	3	8	9	2	11	....	0.8	1.3	0.3	0.8	0	2.2
35	Measles	10	....	10	6	4	7	3	0.7	0.9	0.6	0.5	8.4	2.0
9	Whooping cough	8	....	8	4	4	8	....	0.6	0.6	0.6	0.6	0	1.6
122	Hernia and intestinal obstruction	7	1	6	6	1	7	....	0.5	0.9	0.1	0.5	0	1.4
86	Convulsions	6	1	5	3	3	6	....	0.4	0.4	0.4	0.5	0	1.2
	Other causes	31	6	24	19	12	24	7	2.3	2.7	1.8	1.8	19.5	6.1

TABLE 23

Leading Causes of Deaths Under One Year of Age, by Age, Sex, and Race
North Dakota, 1945

International List Number	Cause	Number Infant Deaths							Rate per 1,000 Live Births					Per Cent of Total
		Total	Age: Neonatal	Age: Later Infancy	Sex: M	Sex: F	Race: W	Race: C	Total	Sex: M	Sex: F	Race: W	Race: C	
	All causes	414	279	135	254	160	398	16	30.7	37.2	24.0	30.3	45.5	100.0
159	Premature birth	129	128	1	83	46	128	1	9.6	12.2	6.9	9.7	2.8	31.2
157	Congenital malformations	65	42	23	38	27	65	....	4.8	5.6	4.0	4.9	0	15.7
33,107-109	Influenza and pneumonia	47	8	39	24	23	41	6	3.5	3.5	3.4	3.1	17.0	11.4
160	Injury at birth	43	43	....	28	15	43	....	3.2	4.1	2.2	3.3	0	10.4
119	Diarrhea, enteritis	35	11	24	20	15	33	2	2.6	2.9	2.2	2.5	5.7	8.5
161	Other disease peculiar to first year of life	29	27	2	14	15	29	....	2.1	2.1	2.2	2.2	0	7.0
169-195	Accidents	10	....	10	6	4	8	2	0.7	0.9	0.6	0.6	5.7	2.4
86	Convulsions	6	2	4	5	1	6	....	0.4	0.7	0.1	0.5	0	1.4
122	Hernia and intestinal obstruction	6	....	6	4	2	5	1	0.4	0.6	0.3	0.4	2.8	1.4
199-200	Ill-defined and unknown causes	6	3	3	4	2	3	3	0.4	0.6	0.3	0.2	8.5	1.4
	Other causes	38	15	23	28	10	37	1	2.8	4.1	1.5	2.8	2.8	9.2

TABLE 24

Cause of Maternal Deaths by Age and Race, and Rates by Race, North Dakota, 1944

International List Number	Cause	Number of Deaths									Rate per 1,000 Live Births		
			Age						Race			Race	
		Total	20-24	25-29	30-34	35-39	40-44	45-49	W	C	Total	W	C
	All causes	24	2	2	8	6	5	1	22	2	1.8	1.7	4.2
140b	Abortion (spontaneous, therapeutic, or of unspecified origin) with mention of other infection	1	....	....	....	....	1	....	1	....	0.1	0.1	0
140c	Self induced abortion with mention of infection	1	....	....	1	....	....	....	1	....	0.1	0.1	0
144d	Other toxemias of pregnancy (death before delivery)	1	....	....	....	1	....	....	1	....	0.1	0.1	0
146a	Placenta praevia (with childbirth)	2	....	....	....	1	....	1	2	....	0.1	0.2	0
146b	Premature separation of placenta (with childbirth)	1	1	....	....	....	....	....	1	....	0.1	0.1	0
146c	Other and unspecified hemorrhages of childbirth and the puerperium	3	....	....	2	....	1	....	3	....	0.2	0.2	0
147b	General or local puerperal infection (except pyelitis)	2	....	....	....	2	....	....	1	1	0.1	0.1	2.1
147d	Puerperal embolism and sudden death	4	1	....	2	1	....	....	4	....	0.3	0.3	0
148a	Puerperal eclampsia (excluding death before delivery)	3	....	1	....	1	1	....	3	....	0.2	0.2	0
148b	Puerperal albuminuria and nephritis (excluding death before delivery)	1	....	1	....	....	....	....	1	....	0.1	0.1	0
148d	Other puerperal toxemias (excluding death before delivery)	1	....	....	....	....	1	....	....	1	0.1	0	2.1
149a	Laceration, rupture, or other trauma of pelvic organs and tissue	1	....	....	1	....	....	....	1	....	0.1	0.1	0
149b	Other specified conditions of childbirth	3	....	....	2	....	1	....	3	....	0.2	0.2	0

TABLE 25

Cause of Maternal Deaths by Age and Race, and Rates by Race, North Dakota, 1945

International List Number	Cause	Number of Deaths									Rate per 1,000 Live Births		
			Age						Race			Race	
		Total	20-24	25-29	30-34	35-39	40-44	Unk.	W	C	Total	W	C
	All causes	15	2	1	1	8	2	1	14	1	1.1	1.1	2.8
142b	Ectopic gestation without mention of infection	2	....	....	....	1	1	....	2	....	0.15	0.15	0
144a	Eclampsia of pregnancy (death before delivery)	2	....	1	....	1	....	....	2	....	0.15	0.15	0

146b	Premature separation of placenta (with childbirth)	1	1	....	....	....	....	....	1	....	0.1	0.1	0
146c	Other and unspecified hemorrhages of childbirth and the puerperium	3	....	....	2	....	1	....	3	....	0.2	0.2	0
147b	General or local puerperal infection (except pyelitis)	2	....	....	....	2	....	....	1	1	0.1	0.1	2.1
147d	Puerperal embolism and sudden death	4	1	....	2	1	....	....	4	....	0.3	0.3	0
148a	Puerperal eclampsia (excluding death before delivery)	3	....	1	....	1	1	....	3	....	0.2	0.2	0
148b	Puerperal albuminuria and nephritis (excluding death before delivery)	1	....	1	....	....	....	....	1	....	0.1	0.1	0
148d	Other puerperal toxemias (excluding death before delivery)	1	....	....	....	....	1	....	....	1	0.1	0	2.1
149a	Laceration, rupture, or other trauma of pelvic organs and tissue	1	....	....	1	....	....	....	1	....	0.1	0.1	0
149b	Other specified conditions of childbirth	3	....	....	2	....	1	....	3	....	0.2	0.2	0

TABLE 25

Cause of Maternal Deaths by Age and Race, and Rates by Race, North Dakota, 1945

International List Number	Cause	Number of Deaths									Rate per 1,000 Live Births		
		Age							Race		Race		
		Total	20-24	25-29	30-34	35-39	40-44	Unk.	W	C	Total	W	C
	All causes	15	2	1	1	8	2	1	14	1	1.1	1.1	2.8
142b	Ectopic gestation without mention of infection	2	....	....	....	1	1	....	2	....	0.15	0.15	0
144a	Eclampsia of pregnancy (death before delivery)	2	....	1	....	1	....	....	2	....	0.15	0.15	0
144b	Albuminuria and nephritis of pregnancy (death before delivery)	1	1	....	....	....	....	....	1	....	0.07	0.08	0
146a	Placenta praevia (with childbirth)	1	....	....	....	1	....	....	1	....	0.07	0.08	0
146b	Premature separation of placenta (with childbirth)	2	....	....	....	1	....	1	1	1	0.15	0.08	284
147b	General and local puerperal infection (except pyelitis)	1	1	....	....	....	....	....	1	....	0.07	0.08	0
148a	Puerperal eclampsia (excluding death before delivery)	3	....	....	1	2	....	....	3	....	0.22	0.23	0
148b	Puerperal albuminuria and nephritis (excluding death before delivery)	2	....	....	....	1	1	....	2	....	0.15	0.15	0
149b	Other specified conditions of childbirth	1	....	....	....	1	....	....	1	....	0.07	0.08	0

TABLE 26

Ten Leading Causes of Death with Rates per 100,000 Population and Proportional Mortality, 1944-1945

International List Number	Cause	1944		1945	
		Rate per 100,000 Pop.	Proportional Mortality	Rate per 100,000 Pop.	Proportional Mortality
90-95	Heart disease (all forms)	261.1	27.3	274.3	28.0
45-55	Cancer (all forms)	116.8	12.2	119.0	12.1
83	Intracranial lesions of vascular origin	92.0	9.6	97.1	9.9
33,107-9	Pneumonia and influenza	51.7	5.4	41.1	4.2
130-132	Nephritis (all forms)	50.9	5.3	47.0	4.8
159	Premature birth	32.6	3.4	24.8	2.5
61	Diabetes mellitus	27.1	2.8	29.2	3.0
162	Senility	18.2	1.9	17.7	1.8
157	Congenital malformations	16.3	1.7	.....	.....
170	Motor vehicle accidents	16.3	1.7	.....	.....
13-22	Tuberculosis (all forms)	.....	.....	21.7	2.2
97	Arteriosclerosis	.....	.....	18.0	1.8

TABLE 27

Number of Births, Deaths, Maternal Deaths, Infant Deaths, and Rates, North Dakota 1930-1945

YEAR	Population Estimate	Number				Rate per 1,000 Population		Rate per 1,000 Live Births	
		Births	Deaths	Maternal Deaths	Infant Deaths	Birth	Death	Maternal Death	Infant Death
1945	520,935	13,497	5,111	15	414	25.9	9.8	1.1	30.7
1944	528,200	13,681	5,057	24	505	25.9	9.6	1.8	36.9
1943	542,753	13,647	5,139	40	473	25.1	9.5	2.9	34.7
1942	585,005	13,634	4,866	34	497	23.3	8.3	2.5	36.4
1941									

33,107-9	Pneumonia and influenza	51.7	5.4	41.1	4.2
130-132	Nephritis (all forms)	50.9	5.3	47.0	4.8
159	Premature birth	32.6	3.4	24.8	2.5
61	Diabetes mellitus	27.1	2.8	29.2	3.0
162	Senility	18.2	1.9	17.7	1.8
157	Congenital malformations	16.3	1.7	.....	.....
170	Motor vehicle accidents	16.3	1.7	.....	.....
13-22	Tuberculosis (all forms)	.....	.....	21.7	2.2
97	Arteriosclerosis	.....	.....	18.0	1.8

TABLE 27

Number of Births, Deaths, Maternal Deaths, Infant Deaths, and Rates, North Dakota
1930-1945

YEAR	Population Estimate	Number				Rate per 1,000 Population		Rate per 1,000 Live Births	
		Births	Deaths	Maternal Deaths	Infant Deaths	Birth	Death	Maternal Death	Infant Death
1945	520,935	13,497	5,111	15	414	25.9	9.8	1.1	30.7
1944	528,200	13,681	5,057	24	505	25.9	9.6	1.8	36.9
1943	542,753	13,647	5,139	40	473	25.1	9.5	2.9	34.7
1942	585,005	13,634	4,866	34	497	23.3	8.3	2.5	36.4
1941	620,667	13,577	5,398	35	526	21.9	8.7	2.6	38.7
1940	640,624	13,515	5,267	23	610	21.1	8.2	1.7	45.1
1939	640,381	13,374	5,437	32	650	20.9	8.5	2.5	48.6
1938	640,064	13,120	5,212	30	648	20.5	8.1	2.3	49.4
1937	644,348	13,005	5,463	61	665	20.2	8.5	4.7	51.1
1936	651,616	13,770	5,667	60	676	21.1	8.7	4.4	49.1
1935	657,293	13,819	5,863	71	816	21.0	8.9	5.1	59.1
1934	660,094	14,613	5,861	70	836	22.1	8.9	4.8	57.2
1933	662,705	13,324	5,436	68	782	20.1	8.2	5.1	58.7
1932	667,226	13,858	5,112	71	770	20.8	7.7	5.1	55.6
1931	674,886	14,232	5,112	69	837	21.1	7.6	4.9	58.8
1930	680,062	14,639	5,331	90	905	21.5	7.8	6.2	61.8

TABLE 28
Number of Deaths From Selected Causes, 1935-1945

International List Number	Cause of Death	1935	1936	1937	1938	1939	1940	1941	1942	1943	1944	1945
	All Causes	5,863	5,667	5,463	5,212	5,437	5,267	5,398	4,866	5,139	5,057	5,111
1, 2	Typhoid and paratyphoid fever	9	4	3	3	4	4	1	1	1	---	1
6	Cerebrospinal (meningococcus) meningistis	8	7	13	8	3	3	3	2	10	5	7
8	Scarlet fever	34	33	9	18	8	4	2	2	---	5	1
9	Whooping cough	39	4	14	60	13	16	14	13	5	11	2
10	Diphtheria	20	15	3	6	5	11	5	4	8	7	10
13-22	Tuberculosis	169	172	180	139	143	122	121	121	125	83	113
27	Dysentery	1	8	3	7	2	5	---	3	2	2	1
28	Malaria	---	---	---	---	---	---	---	---	1	---	---
30	Syphilis	21	27	20	21	24	23	37	23	20	22	25
35	Measles	53	3	---	21	19	2	3	9	17	34	---
36	Poliomyelitis and polioencephalitis (acute)	4	1	---	---	2	3	1	2	2	3	3
37	Acute infectious encephalitis	6	5	4	28	12	11	139	12	13	12	11
45-55	Cancer	561	590	554	621	648	610	622	623	634	617	620
58	Acute rheumatic fever	41	25	20	17	10	16	10	8	8	9	11
61	Diabetes mellitus	107	116	120	137	143	167	131	136	152	143	152
63b	Exophthalmic goiter	11	6	12	9	10	17	13	11	9	7	8
77	Alcoholism	18	19	20	11	4	4	7	8	7	8	15
83	Intracranial lesions of vascular origin	501	504	485	461	492	478	477	493	486	486	506
80-82, 84-88	Other diseases of nervous system, etc	107	84	79	70	80	87	77	61	67	87	96
89, 104, 115	Diseases of ear, nose, and throat	76	56	42	27	37	42	24	31	17	21	21
90-95	Diseases of heart	980	1,097	1,126	1,066	1,332	1,335	1,345	1,195	1,365	1,379	1,429
33,107-109	Pneumonia and influenza	812	503	646	434	465	354	321	264	306	273	214
117	Ulcer of stomach or duodenum	36	33	32	27	31	47	48	26	33	32	20
119, 120	Diarrhea, enteritis, etc.	114	122	81	60	57	56	32	45	25	37	45

TABLE 28—(Continued)
Number of Deaths From Selected Causes, 1935-1945

International List Number	Cause of Death	1935	1936	1937	1938	1939	1940	1941	1942	1943	1944	1945
	All Causes	5,863	5,667	5,463	5,212	5,437	5,267	5,398	4,866	5,139	5,057	5,111
121	Appendicitis	129	107	91	77	82	71	50	43	31	31	30
122	Hernia and intestinal obstruction	53	75	64	58	54	48	56	50	52	42	60
124	Cirrhosis of liver	16	24	31	30	35	21	34	27	35	35	36
126, 127	Biliary calculi, etc.	46	58	48	54	48	39	53	39	42	38	42
130-132	Nephritis	319	291	236	291	266	305	309	280	297	269	245
137	Diseases of prostate	51	40	45	54	45	38	52	49	52	37	50
140-150	Diseases of pregnancy, childbirth, etc.	71	60	61	30	32	23	35	34	40	24	15
157	Congenital malformations	65	72	78	81	74	54	62	64	63	85	77

37	Acute infectious encephalitis	6	5	4	28	12	11	139	12	13	12	11
45-55	Cancer	561	590	554	621	648	610	622	623	634	617	620
58	Acute rheumatic fever	41	25	20	17	10	16	10	8	8	9	11
61	Diabetes mellitus	107	116	120	137	143	167	131	136	152	143	152
63b	Exophthalmic goiter	11	6	12	9	10	17	13	11	9	7	8
77	Alcoholism	18	19	20	11	4	4	7	8	7	8	15
83	Intracranial lesions of vascular origin	501	504	485	461	492	478	477	493	486	486	506
80-82, 84-88	Other diseases of nervous system, etc	107	84	79	70	80	87	77	61	67	87	96
89, 104, 115	Diseases of ear, nose, and throat	76	56	42	27	37	42	24	31	17	21	21
90-95	Diseases of heart	980	1,097	1,126	1,066	1,332	1,335	1,345	1,195	1,365	1,379	1,429
33,107-109	Pneumonia and influenza	812	503	646	434	465	354	321	264	306	273	214
117	Ulcer of stomach or duodenum	36	33	32	27	31	47	48	26	33	32	20
119, 120	Diarrhea, enteritis, etc.	114	122	81	60	57	56	32	45	25	37	45

TABLE 28—(Continued)
Number of Deaths From Selected Causes, 1935-1945

International List Number	Cause of Death	1935	1936	1937	1938	1939	1940	1941	1942	1943	1944	1945
	All Causes	5,863	5,667	5,463	5,212	5,437	5,267	5,398	4,866	5,139	5,057	5,111
121	Appendicitis	129	107	91	77	82	71	50	43	31	31	30
122	Hernia and intestinal obstruction	53	75	64	58	54	48	56	50	52	42	60
124	Cirrhosis of liver	16	24	31	30	35	21	34	27	35	35	36
126, 127	Biliary calculi, etc.	46	58	48	54	48	39	53	39	42	38	42
130-132	Nephritis	319	291	236	291	266	305	309	280	297	269	245
137	Diseases of prostate	51	40	45	54	45	38	52	49	52	37	50
140-150	Diseases of pregnancy, childbirth, etc.	71	60	61	30	32	23	35	34	40	24	15
157	Congenital malformations	65	72	78	81	74	54	62	64	63	86	77
159	Premature birth	196	183	202	225	221	223	185	183	178	172	129
163, 164	Suicide	75	72	65	73	68	62	57	70	60	38	56
165-168	Homicide	16	12	10	16	7	8	18	6	2	5	6
170	Motor vehicle accidents	118	140	125	125	102	122	129	103	77	86	80
169, 171-195	Other accidents	266	384	290	248	238	263	334	250	280	277	294

TABLE 29
Death Rates per 100,000 Population for Selected Causes, 1935-1945

International List Number	Cause of Death	1935	1936	1937	1938	1939	1940	1941	1942	1943	1944	1945
	Total Death Rate	892.0	869.7	847.8	814.3	849.0	822.2	869.7	832.3	947.0	957.4	981.1
1, 2	Typhoid and paratyphoid fever	1.4	0.6	0.5	0.5	0.6	0.6	0.2	0.2	0.2	0	0.2
6	Cerebrospinal (meningococcus) meningitis	1.2	1.1	2.0	1.2	0.5	0.5	0.5	0.3	1.8	0.9	1.3
8	Scarlet fever	5.2	5.1	1.4	2.8	1.2	0.6	0.3	0.3	0	0.9	0.2
9	Whooping cough	5.9	0.6	2.2	9.4	2.0	2.5	2.3	2.2	0.9	2.1	0.4
10	Diphtheria	3.0	1.8	0.5	0.9	0.8	1.7	0.8	0.7	1.5	1.3	1.9
13-22	Tuberculosis	25.7	26.4	27.9	21.7	22.3	19.0	19.5	20.7	23.0	15.7	21.7
27	Dysentery	0.2	1.2	0.5	1.1	0.3	0.8	0	0.5	0.4	0.4	0.2
28	Malaria	0	0	0	0	0	0	0	0	0.2	0	0
30	Syphilis	3.2	4.1	3.1	3.3	3.7	3.6	6.0	3.9	3.7	4.2	4.8
35	Measles	8.1	0.5	0	3.3	3.0	0.3	0.5	1.5	3.1	6.4	0
36	Poliomyelitis and polioencephalitis (acute)	0.6	0.1	0	0	0.3	0.5	0.2	0.3	0.4	0.6	0.6
37	Acute infectious encephalitis	0.9	0.8	0.6	4.4	1.9	1.7	22.4	2.1	2.4	2.3	2.1
45-55	Cancer	85.3	90.5	86.0	97.0	101.2	95.2	100.2	106.6	116.8	116.8	119.0
58	Acute rheumatic fever	6.2	3.8	3.1	2.7	1.6	2.5	1.6	1.4	1.5	1.7	2.1
61	Diabetes mellitus	16.3	17.8	18.6	21.4	22.3	26.1	21.1	23.3	28.0	27.1	29.2
63b	Exophthalmic goiter	1.7	0.9	1.9	1.4	1.6	2.7	2.1	1.9	1.7	1.3	1.5
77	Alcoholism	2.7	2.9	3.1	1.7	0.6	0.6	1.1	1.4	1.3	1.5	2.9
83	Intracranial lesions of vascular origin	76.2	77.3	75.3	72.0	76.8	74.6	76.9	84.3	89.6	92.0	97.1
80-82, 84-88	Other diseases of nervous system, etc	16.3	12.9	12.3	10.9	12.5	13.6	12.4	10.4	12.3	16.5	18.4
89, 104, 115	Diseases of ear, nose, and throat	11.6	8.6	6.5	4.2	5.8	6.6	3.9	5.3	3.1	4.0	4.0
90-95	Diseases of heart	149.1	168.3	174.7	166.5	208.0	208.4	216.7	204.4	251.5	261.1	274.3
33,107-109	Pneumonia and influenza	123.5	77.2	100.3	67.8	72.6	55.3	51.7	45.2	56.4	51.7	41.1
117	Ulcer of stomach or duodenum	5.5	5.1	5.0	4.2	4.8	7.3	7.7	4.5	6.1	6.1	3.8
119, 120	Diarrhea, enteritis, etc.	17.3	18.7	12.6	9.4	8.9	8.7	5.2	7.7	4.6	7.0	8.6

TABLE 29—(Continued)
Death Rates per 100,000 Population for Selected Causes, 1935-1945

International List Number	Cause of Death	1935	1936	1937	1938	1939	1940	1941	1942	1943	1944	1945
	Total Death Rate	892.0	869.7	847.8	814.3	849.0	822.2	869.7	832.3	947.0	957.4	981.1
121	Appendicitis	19.6	16.4	14.1	12.0	12.8	11.1	8.1	7.4	5.7	5.9	5.8
122	Hernia and intestinal obstruction	8.1	11.5	9.9	9.1	8.4	7.5	9.0	8.9	9.6	8.0	11.5
124	Cirrhosis of liver	2.4	3.7	4.8	4.7	5.5	3.3	5.5	4.6	6.4	6.6	6.9
126, 127	Biliary calculi, etc.	7.0	8.9	7.5	8.4	7.5	6.1	8.5	6.7	7.7	7.2	8.1
130-132	Nephritis	48.5	44.7	36.6	45.5	41.5	47.6	49.8	47.9	54.7	50.9	47.0
137	Diseases of prostate	7.8	6.1	7.0	8.4	7.0	5.9	8.4	8.4	9.6	7.0	9.6

TABLE 29—(Continued)
Death Rates per 100,000 Population for Selected Causes, 1935-1945

International List Number	Cause of Death	1935	1936	1937	1938	1939	1940	1941	1942	1943	1944	1945
	Total Death Rate	892.0	869.7	847.8	814.3	849.0	822.2	869.7	832.3	947.0	957.4	981.1
121	Appendicitis	19.6	16.4	14.1	12.0	12.8	11.1	8.1	7.4	5.7	5.9	5.8
122	Hernia and intestinal obstruction	8.1	11.5	9.9	9.1	8.4	7.5	9.0	8.6	9.6	8.0	11.5
124	Cirrhosis of liver	2.4	3.7	4.8	4.7	5.5	3.3	5.5	4.6	6.4	6.6	6.9
126, 127	Biliary calculi, etc.	7.0	8.9	7.5	8.4	7.5	6.1	8.5	6.7	7.7	7.2	8.1
130-132	Nephritis	48.5	44.7	36.6	45.5	41.5	47.6	49.8	47.9	54.7	50.9	47.0
137	Diseases of prostate	7.8	6.1	7.0	8.4	7.0	5.9	8.4	8.4	9.6	7.0	9.6
140-150	Diseases of pregnancy, childbirth, etc.	10.8	9.2	9.5	4.7	5.0	3.6	5.6	5.8	7.4	4.5	2.9
157	Congenital malformations	9.9	11.0	12.1	12.6	11.6	8.4	10.0	11.0	11.6	16.3	14.8
159	Premature birth	29.8	28.1	31.3	35.1	34.5	34.8	29.8	31.3	32.8	32.6	24.8
163, 164	Suicide	11.4	11.0	10.1	11.4	10.6	9.7	9.2	12.0	11.1	7.2	10.7
165-168	Homicide	2.4	1.8	1.6	2.5	1.1	1.3	2.9	1.0	0.4	0.9	1.2
170	Motor vehicle accidents	17.9	21.5	19.4	19.5	15.9	19.0	20.8	17.6	14.2	16.3	15.4
169, 171-195	Other accidents	40.5	58.9	45.0	38.7	37.2	41.1	53.8	42.8	51.6	52.4	56.4

TABLE 30

Number of Death From Selected Causes, by Age, North Dakota, 1944

International List Number	Cause of Death	Tot. D'ths	Un. 1	1-4	5-9	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85-89	90+	Unk.
	All Causes	5,057	505	122	61	42	84	55	60	75	104	113	163	234	367	421	524	617	595	516	269	120	10
1, 2	Typhoid and paratyhoid fever	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
6	Cerebrospinal (meningococcus) meningitis	5	1	1	—	1	1	—	—	—	1	—	—	—	—	—	—	—	—	—	—	—	—
8	Scarlet fever	5	—	1	1	2	—	—	—	—	1	—	—	—	—	—	—	—	—	—	—	—	—
9	Whooping cough	11	8	3	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
10	Diphtheria	7	—	3	4	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
13-22	Tuberculosis	83	2	2	1	—	3	10	10	7	4	8	4	8	8	2	5	4	4	—	—	—	1
27	Dysentery	2	2	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
28	Malaria	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
30	Syphilis	22	1	1	—	—	—	1	—	1	1	—	2	1	5	5	1	2	1	—	—	—	—
35	Measles	34	10	9	6	2	3	1	2	1	—	—	—	—	—	—	—	—	—	—	—	—	—
36	Poliomyelitis and polioencephalitis (acute)	3	—	1	—	—	2	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
37	Acute infectious encephalitis	12	1	—	—	1	—	—	1	—	1	1	—	2	1	—	1	1	2	—	—	—	—
45-55	Cancer	617	1	1	—	1	2	2	3	6	12	16	28	43	68	79	93	101	73	50	31	7	—
58	Acute rheumatic fever	9	—	—	—	4	1	—	—	—	2	—	—	—	—	—	—	1	1	—	—	—	—
61	Diabetes mellitus	143	—	—	—	—	1	1	—	2	5	2	1	9	15	21	19	29	23	12	1	1	1
63b	Exophthalmic goiter	7	—	—	—	—	1	—	—	—	—	—	—	—	4	1	—	1	—	—	—	—	—
77	Alcoholism	8	—	—	—	—	—	—	—	1	—	—	—	—	1	3	2	—	1	—	—	—	—
83	Intracranial lesions of vascular origin	486	1	1	—	—	—	1	—	1	2	5	11	21	29	51	75	89	79	78	30	12	—
80-82, 84-88	Other diseases of nervous system, etc.	87	9	10	3	2	8	2	1	5	4	2	6	3	3	5	7	6	6	4	1	—	—
89, 104, 115	Diseases of ear, nose, and throat	21	5	3	3	1	1	—	1	—	4	—	—	2	1	—	—	—	—	—	—	—	—
90-95	Diseases of heart	1,375	—	2	3	2	4	2	9	13	22	31	38	62	110	135	184	228	211	181	90	49	3
33, 107-109	Pneumonia and influenza	273	64	19	3	2	8	2	4	3	5	5	2	6	13	13	18	21	32	31	13	9	—
117	Ulcer of stomach or duodenum	32	—	—	—	—	—	—	—	1	1	—	5	3	6	5	4	3	3	1	—	—	—
119, 120	Diarrhea, enteritis, etc.	37	23	4	—	—	—	1	—	1	—	1	—	—	1	—	1	—	1	2	2	—	—
121	Appendicitis	31	—	6	4	4	2	1	—	2	—	—	2	4	2	3	—	—	1	—	—	—	—
122	Hernia and intestinal obstruction	42	7	1	—	—	2	—	1	—	2	1	—	1	1	7	3	5	2	2	4	3	—
124	Cirrhosis of liver	35	—	—	—	—	—	—	1	1	1	—	1	7	5	6	2	4	6	1	—	—	—

TABLE 30—(Continued)
Number of Deaths From Selected Causes, by Age, North Dakota, 1944

International List Number	Cause of Death	Tot. D'ths	Un. 1	1-4	5-9	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85-89	90+	Unk.
	All Causes	5,057	505	122	61	42	84	55	60	75	104	113	163	234	367	421	524	617	595	516	269	120	10
126, 127	Biliary calculi, etc.	38	—	—	—	—	—	—	—	1	—	—	1	2	4	5	7	7	6	4	—	1	—
130-132	Nephritis	269	2	—	3	1	—	3	4	2	3	6	13	15	17	24	34	36	49	34	18	5	—
137	Diseases of prostate	37	—	—	—	—	—	—	—	—	—	—	—	—	3	1	4	5	10	9	5	—	—
140-150	Diseases of pregnancy, childbirth, etc.	24	—	—	—	—	—	2	2	8	6	5	1	—	—	—	—	—	—	—	—	—	—
157	Congenital malformations	86	73	5	1	1	2	2	—	—	2	—	—	—	—	—	—	—	—	—	—	—	—
159	Premature birth	172	172	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
163, 164	Suicide	38	—	—	—	—	—	1	4	—	4	3	6	5	6	2	4	1	—	2	—	—	—
165-168	Homicide	5	—	1	—	—	—	—	—	—	1	1	1	—	1	—	—	—	—	—	—	—	—
170	Motor vehicle accidents	86	—	5	4	—	14	7	5	7	4	2	6	6	7	6	5	5	3	—	—	—	—
169, 171-195	Other accidents	277	11	22	20	13	22	9	10	7	7	11	17	4	22	14	18	18	14	17	11	8	2

TABLE 31
Number of Deaths From Selected Causes, by Age, North Dakota, 1945

International List Number	Cause of Death	Tot. D'ths	Un. 1	1-4	5-9	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85-89	90+	Unk.
	All Causes	5,111	414	102	65	54	71	58	76	80	116	147	196	231	367	447	543	599	607	469	299	141	29
1, 2	Typhoid and paratyhoid fever	1	—	—	—	—	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
6	Cerebrospinal (meningococcus) meningitis	7	—	1	2	—	—	1	—	1	—	1	—	—	1	—	—	—	—	—	—	—	—
8	Scarlet fever	1	—	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
9	Whooping cough	2	2	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
10	Diphtheria	10	—	3	2	2	—	—	—	—	1	—	1	—	—	—	—	1	—	—	—	—	—
13-22	Tuberculosis	113	1	8	2	4	12	7	11	7	8	9	5	7	9	9	3	3	3	3	1	1	—
27	Dysentery	1	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
28	Malaria	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
30	Syphilis	25	1	1	—	—	—	—	—	1	2	3	1	1	3	3	3	3	2	1	—	—	—
35	Measles	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
36	Poliomyelitis and polioencephalitis (acute)	3	—	1	—	1	—	—	—	—	—	—	1	—	—	—	—	—	—	—	—	—	—
37	Acute infectious encephalitis	11	1	—	1	—	—	—	1	—	1	1	1	1	2	—	—	1	1	—	—	—	—
45-55	Cancer	620	—	1	2	2	1	3	3	8	11	23	31	45	77	67	101	77	85	54	20	8	1
58	Acute rheumatic fever	11	—	—	—	3	3	—	3	—	1	—	—	—	—	—	1	—	—	—	—	—	—
61	Diabetes mellitus	152	1	1	—	1	1	1	5	—	—	1	5	9	20	19	24	26	14	15	8	1	—
63b	Exophthalmic goiter	8	—	—	—	—	1	—	—	—	—	—	1	2	—	2	—	1	1	—	—	—	—
77	Alcoholism	15	—	—	—	—	—	—	1	—	1	3	1	2	3	2	1	—	—	—	—	—	1
83	Intracranial lesions of vascular origin	506	—	—	—	1	1	2	—	1	3	5	13	19	24	49	72	78	98	73	52	14	1
80-82, 84-88	Other diseases of nervous system, etc.	96	11	7	5	2	4	8	6	6	5	4	4	1	10	3	9	6	5	—	—	—	—
89, 104, 115	Diseases of ear, nose, and throat	21	4	5	3	1	—	—	2	1	—	1	—	—	1	—	1	—	2	—	—	—	—
90-95	Diseases of heart	1,429	1	2	4	3	3	4	10	9	22	31	60	66	106	158	192	235	225	159	93	41	5
33, 107-109	Pneumonia and influenza	214	47	10	6	7	4	1	1	1	4	5	8	9	9	15	10	16	19	19	11	11	1
117	Ulcer of stomach or duodenum	20	—	—	—	—	—	—	2	—	—	—	1	2	3	3	5	—	1	1	1	1	—
119, 120	Diarrhea, enteritis, etc.	45	35	1	1	—	—	—	1	2	—	—	—	—	2	—	—	—	—	1	1	1	—
121	Appendicitis	30	—	1	1	4	1	—	1	2	1	2	2	1	2	2	1	2	6	—	1	—	—
122	Hernia and intestinal obstruction	60	6	1	2	—	—	—	—	2	2	3	1	4	5	9	7	3	7	4	3	1	—
124	Cirrhosis of liver	36	—	—	—	—	—	1	—	2	—	3	2	5	2	3	7	4	5	1	1	—	—

TABLE 31—(Continued)
Number of Deaths From Selected Causes, by Age, North Dakota, 1945

International List Number	Cause of Death	Tot. D'ths	Un. 1	1-4	5-9	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85-89	90+	Unk.
	All Causes	5,111	414	102	65	54	71	58	76	80	116	147	196	231	367	447	543	599	607	469	299	141	29
126, 127	Biliary calculi, etc.	42	—	—	—	—	—	—	—	2	2	—	2	—	4	7	10	5	3	6	1	—	—
130-132	Nephritis	245	—	1	6	1	3	3	6	3	6	10	10	3	21	24	29	34	34	30	15	6	—
137	Diseases of prostate	50	—	—	—	—	—	—	—	—	—	—	—	1	—	2	4	14	13	11	5	—	—
140-150	Diseases of pregnancy, childbirth, etc.	15						2	1	1	8	2	—	—	—	—	—	—	—	—	—	—	1
157	Congenital malformations	77	65	6	4	—	2	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	
159	Premature birth	129	129	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
163, 164	Suicide	56	—	—	—	—	2	—	1	3	4	7	5	6	8	6	4	3	3	1	—	—	3
[illegible]	Homicide	6	—	—	—	—	—	—	—	—	1	3	—	1	—	—	—	—	—	1	—	—	—
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	6	9	6	6	8	6	6	4	4	4	4	3	3	—	3	—	—	—
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	15	15	18	15	20	12	7	12

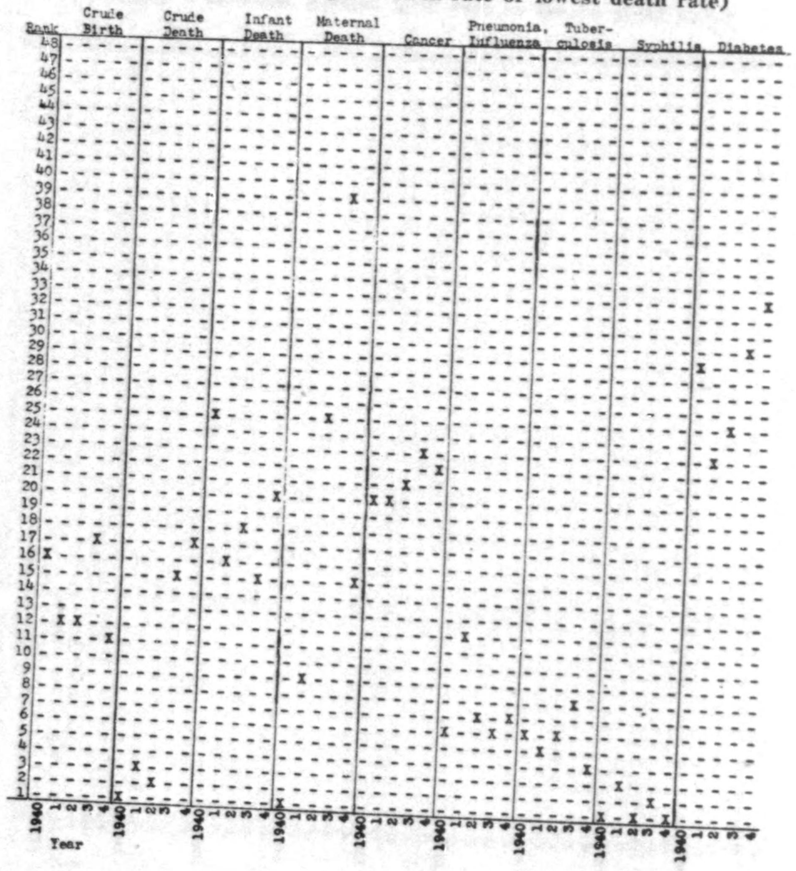
TABLE 31—(Continued)
Number of Deaths From Selected Causes, by Age, North Dakota, 1945

International List Number	Cause of Death	Tot. D'ths	Un. 1	1-4	5-9	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85-89	90+	Unk.
	All Causes	5,111	414	102	65	54	71	58	76	80	116	147	196	231	367	447	543	599	607	469	299	141	29
126, 127	Biliary calculi, etc.	42	—	—	—	—	—	—	—	2	2	—	2	—	4	7	10	5	3	6	1	—	—
130-132	Nephritis	245	—	1	6	1	3	3	6	3	6	10	10	3	21	24	29	34	34	30	15	6	—
137	Diseases of prostate	50	—	—	—	—	—	—	—	—	—	—	—	1	—	2	4	14	13	11	5	—	—
140-150	Diseases of pregnancy, childbirth, etc.	15	—	—	—	—	—	2	1	1	8	2	—	—	—	—	—	—	—	—	—	—	1
157	Congenital malformations	77	65	6	4	—	2	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
159	Premature birth	129	129	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
163, 164	Suicide	56	—	—	—	—	2	—	1	3	4	7	5	6	8	6	4	3	3	1	—	—	3
165-168	Homicide	6	—	—	—	—	—	—	—	—	1	3	—	1	—	—	—	—	—	1	—	—	—
170	Motor vehicle accidents	80	—	6	2	6	9	6	6	8	6	6	4	4	4	4	3	3	—	3	—	—	—
169, 171-195	Other accidents	294	10	31	12	11	15	17	7	12	15	8	9	14	19	15	15	18	15	20	12	7	12

TABLE 32

Rank of North Dakota Among States, Crude Birth and Death Rates, Infant and Maternal Death Rates, and Death Rates from Specific Causes 1940-1944

(Rank 1 indicates highest birth rate or lowest death rate)



APPENDIX A

AUTHORIZED CITY HEALTH OFFICERS

City	Physician
Bathgate	F. N. Burrows
Beach	C. A. Bush
Beulah	Ralph Vinje
Bismarck	P. L. Owens
Bottineau	L. F. Nelson
Bowman	
Buxton	O. A. Knutson
Cando	D. W. Palmer
Carrington	E. L. Goss
Casselton	H. W. Miller
Cavalier	G. W. Waldren
Cooperstown	L. Almklov
Crosby	George Moffatt
Devils Lake	G. J. McIntosh
Dickinson	S. Chernausek
Edgeley	V. D. Fergusson
Edinburg	A. N. Flaten
Ellendale	Roy Lynde
Enderlin	G. Hendrickson
Fargo	E. M. Watson
Finley	O. D. Dekker
Flasher	O. M. DeMoully
Fordville	C. E. Lommen
Garrison	R. H. Ray
Glen Ullen	
Grafton	
Grand Forks	Louis B. Silverman
Hankinson	E. J. Beithon
Harvey	A. F. Hammargren
Hatton	A A. Kjelland
Hazen	E. J. Vinje
Hebron	P. J. Weyrens
Hettinger	
Hillsboro	Syver Vinje
Hunter	E. H. Richter
Jamestown	W. A. Gerrish
Kenmare	R. T. Gammel
Lakota	J. A. D. Engesather
LaMoure	A. M. Limburg
Langdon	V. A. Mulligan
Larimore	C. O Haugen
Lawton	E. G. Nicholson
Leeds	A. B. Lund
Lidgerwood	V. S. Irvine
Linton	H. J. Bertheau
Lisbon	H. Bakke
McClusky	C. E. McReynolds
Maddock	G. N. Vigeland
Mandan	Geo. Spielman
Mayville	H. N. LaFleur
Minot	R. G. White
Minto	N. S. Hardy
Mohall	E. S. Fitzmaurice
Mott	
Neche	
New England	Mary Soules
New Rockford	E. J. Schwing-hamer
New Salem	O. C. Gaebe
Nome	W. H. Gilsdorf
Noonan	
Northwood	M. T. Savre
Oakes	R. W. Van Houten
Park River	F. E. Weed
Pembina	H. M. Waldren
Portland	
Rolette	H. E. Neve
Rolla	B. J. Hughes
Rugby	O. W. Johnson
Sharon	H. G. Cleary
Stanley	M. G. Flath
Starkweather	
Steele	DeWitt Baer
Strasburg	
Towner	O. S. Craise
Valley City	A. C. MacDonald
Velva	Mark I. H. Kaufmann
Wahpeton	Clarence Bateman
Watford City	P. O. C. Johnson
Williston	E. J. Hagen
Wilton	
Wishek	J. H. Barrette
Walhalla	

AUTHORIZED COUNTY HEALTH OFFICERS

County	Physician	Address
Adams		
Barnes	J. Van Houten	Valley City
Benson	J. G. Vigeland	Brinsmade
Billings		
Bottineau	E. E. Greene	Westhope
Bowman		
Burke		
Burleigh	A. C. Orr	Bismarck
Cass	E. M. Watson	Fargo
Cavalier	V. A. Mulligan	Langdon
Dickey	Roy Lynde	Ellendale
Divide		
Dunn	Oscar Smith	Killdeer
Eddy	E. J. Schwinghamer	New Rockford
Emmons	Felix F. Vonnegut	Linton
Foster	E. L. Goss	Carrington
Golden Valley		
Grand Forks	T. Q. Benson	Grand Forks
Grant		
Griggs	L. Almklov	Cooperstown
Hettinger		
Kidder	DeWitt Baer	Steele
LaMoure	V. D. Fergusson	Edgeley
Logan	John Simon	Napoleon
McHenry	O. S. Craise	Towner
McIntosh	C. C. Campbell	Ashley
McKenzie	P. O. C. Johnson	Watford City
McLean	R. G. White	Minot
Mercer	Ralph Vinje	Beulah
Morton	F. E. Bunting	Mandan
Mountrail	M. G. Flath	Stanley
Nelson	L. G. Gerber	Lakota
Oliver	G. H. Spielman	Mandan
Pembina	G. R. Waldren	Cavalier
Pierce	William Fox	Rugby
Ramsey	G. J. McIntosh	Devils Lake
Ransom	T. C. Patterson	Lisbon
Renville		
Richland	I. W. Keilogg	Fairmount
Rolette		
Sargent	F. G. Hubbard	Forman
Sheridan	C. E. McReynolds	McClusky
Sioux		
Slope		
Stark	A. J. Gumper	Dickinson
Steele	Omar D. Dekker	Finley
Stutsman	P. G. Arzt	Jamestown
Towner	J. A. MacDonald	Cando
Traill	R. C. Little	Mayville
Walsh		
Ward	R. G. White	Minot
Wells	D. W. Matthaei	Fessenden
Williams	H. T. Skovholt	Williston

APPENDIX B

STATE DEPARTMENT OF HEALTH

Personnel as of June 30, 1944

HEALTH OFFICERS:
G. F. Campana, A.B., M.D., M.P.H. — State Health Officer
R. G. White, A.B., M.D., M.S.P.H. — District Health Officer, First District Health Unit
Mary Soules, M.D., M.P.H. — District Health Officer, Southwestern District Health Unit
A. A. Nichols, M.D. — Acting Fargo City Health Officer

MATERNAL AND CHILD HYGIENE:
Ethel Heising, B.S. — Nutritionist

SANITARY ENGINEERING:
Jerome H. Svore, B.S., M.S. — Director
Gilbert Groff, B.S., M.S. — Assistant Director
William Gahr, B.S. — Associate Sanitary Engineer
Arthur Williamson, B.S., M.S. — Associate Sanitary Engineer
Earl Arnold, B.S. — Associate Sanitary Engineer
Kenneth Piper — Associate Sanitary Engineer Emergency Appointee
A. L. Bavone, B.S., M.P.H. — Senior Sanitary Engineer, First District Health Unit
Everett Lobb — Associate Sanitary Engineer, Fargo City Health Department

LABORATORIES:
Melvin E. Koones, B.S., M.Sc., M.P.H. — Director, Division of Laboratories
William A. Dunlap, B.S., M.Sc. — Assistant Director
Nora Fluevog, B.A., B.S., M.T. — Bacteriologist-Serologist
Vera Goodrich, B.S. — Bacteriologist-Serologist
C. Pat Steele, B.S. — Bacteriologist-Serologist
Lois Peterson, B.S. — Bacteriologist-Serologist
Arthur A. Gustafson, B.S. — Bacteriologist-Serologist
Caroline Atkinson, B.S. — Bacteriologist
Eleanor Simmons, B.S. — Bacteriologist-Serologist

VITAL STATISTICS:
Margaret L. Watts, B.S. — Director
Mary Agnes Gordon, Ph.D. — Statistician

PUBLIC HEALTH NURSING:
Irene M. Donovan, R.N., B.S. — Director
Virginia R. Field, B.S., M.A., R.N. — Assistant Director
Charlotte Kleiss, B.S. — Assistant Director
Orpha M. LaCroix, B.A., R.N. — Consultant
Freda Thuner, R.N. — Public Health Nurse

HEALTH EDUCATION:
Bernardine Cervinski, B.A., M.P.H. — Director

ADMINISTRATION:
Jeanne Setser — Chief Clerk

PREVENTABLE DISEASES:
William M. Smith, M.D., M.P.H. — Director
Tuberculosis Control (Bureau)
Gerald Pauls — X-Ray Technician
Andrew Sands — X-Ray Technician
Venereal Disease Control (Bureau)
Richard Ludemann — Investigator
Halbert D. Neugebauer — Investigator

APPENDIX C

FINANCIAL STATEMENT FOR THE NORTH DAKOTA STATE DEPARTMENT OF HEALTH FOR THE FISCAL YEARS ENDING JUNE 30, 1945 AND JUNE 30, 1946

	1945 Fiscal Year			1946 Fiscal Year		
	Appropriations and Credits	Expended	Unexpended Balance	Appropriations and Credits	Expended	Unexpended Balance
STATE FUNDS						
Public Health	$ 79,864.28	$ 56,958.13	$ 22,906.15*	$139,920.00	$ 60,046.08	$79,873.92
Child Hygiene	27,466.09	16,683.42	10,782.67*	43,648.00	17,465.88	26,182.12
Laboratories	25,656.35	21,168.77	4,487.58*	48,840.00	23,988.43	24,851.57
Blood Plasma Program	6,000.00	5,993.95	6.05*	8,000.00	3,343.42	4,656.58
SPECIAL FUNDS						
Maternal and Child Health Services	65,504.94	51,273.30	14,231.64	68,035.62	48,886.23	19,149.39
Administration (USPHS)	78,691.56	74,183.49	4,508.07	67,562.07	66,934.68	627.39
Venereal Disease Control	41,821.09	32,826.39	8,994.70	33,256.70	30,398.60	2,858.10
EMIC Program	176,773.99	141,202.91	35,571.08**	155,534.65	116,389.64	39,145.01**
Tuberculosis Control	22,275.00	71.76	22,203.24	83,962.24	72,567.51	11,394.73

*Prior Account Balance
**All Encumbered

A34

HEALTH SERVICE IN MARYLAND

Maryland State Department of Health
Baltimore 18, Maryland

1946

Health Service in Maryland

In Maryland the earliest legislative enactment placing authority in matters of sanitation and public health in governmental hands was passed by the General Assembly in 1865. The State Department of Health was established by law in 1874. This was, therefore, one of the first States to organize a health department of State-wide scope.

For more than seventy years this Department has been responsible for administering the sanitary and health laws of this State. These laws and the work of the State Department of Health have been revised and expanded in accordance with progress in the ever-growing field of public health. Activities are directed toward preventing disease and promoting health and well-being among residents of Maryland, particularly those living in the counties.

The Baltimore City Health Department, with offices in the Municipal Building, is responsible for the health program carried on for residents of Baltimore City. Its work, regulated by State and City laws, is under the direction of the Commissioner of Health of Baltimore City.

State Board of Health

The law makes the State Board of Health responsible for the public health services carried on in the counties of Maryland. The Board consists of eight members, six appointed by the Governor and two ex-officio members, the Director of Health and the Commissioner of Health of Baltimore City. The Governor's appointees must include three physicians, one civil engineer, one certified pharmacist and one experienced doctor of dental surgery. This Board has executive, legislative and judicial authority.

State Department of Health

Activities approved by the State Board of Health and rules and regulations passed by that body are put into effect by the State Department of Health. The Department is the executive branch of the State's health organization.

Director of Health

The Director of Health is appointed by the State Board of Health to be its chairman and also the executive officer in charge of the administration of the State Department of Health. The law requires that the Director be an experienced physician skilled in public health and hygiene. He holds office as long as he performs his duties in a competent manner.

Deputy State Health Officers

A Deputy State Health Officer, who is also the County Health Officer, represents the Director of Health in each of the twenty-

three counties of Maryland. They are all physicians, with special training and experience in public health, who render full-time service as health officers and give no part of their time to the private practice of medicine. They are appointed by the County Commissioners of the counties concerned after they have met the qualifications set forth by the State Employment Commissioner. The Director of Health supervises all public health activities in the counties through these Deputy State and County Health Officers.

County Health Departments

In addition to the health officer the minimum personnel of each county health department should include at least two public health nurses, a secretary and a sanitary inspector. Many of the larger and more densely populated counties have much larger staffs, including assistant health officers and supervising nurses.

Every county has had a full-time health department since 1934. The Law of 1914 provided for the establishment of ten Sanitary Districts, each consisting of two or three counties in charge of a full-time Deputy State Health Officer residing in the district. As the functions increased it gradually became necessary to reduce the territory covered, and a permissive law enacted in 1922 made it possible to establish full-time health departments in individual counties. Allegany County has a compulsory law requiring the establishment of such a health department. In 1931 the number of Sanitary Districts was increased to twenty-three, each corresponding with a county, and the law sanctioned full-time health service in each county. By the end of 1934 a public health program, usually with headquarters in the County Seat, was functioning on a full-time basis in each county in Maryland.

The Board of County Commissioners, which is also the Local Board of Health, appoints the County Health Officer. Their appointee must be a qualified doctor and must be approved by the State Board of Health. The Director of Health, or his representative, administers the oath of office to the health officers, and they work in close cooperation with the central office. They send daily reports concerning notifiable diseases occurring in their counties to the Bureau of Communicable Diseases.

Executive Office

The Executive Office—or the office of the Director of Health—is the main administrative office of the Department. Chiefs of the bureaus and divisions and Deputy State Health Officers are responsible to the Director.

Nutrition services are carried on under the Executive Office. The Chief Nutritionist and Nutritionists conduct a program that includes educational activities and consultation service in county schools, clinics, day care centers and children's institutions. In-

creased attention has been directed toward this important phase of public health in recent years. The need for adequate and well-balanced diet to promote the normal growth and development of children and to maintain health at all ages is recognized and nutrition services are a definite part of the health department program.

Public health education is also under the immediate supervision of the Director. It has not been considered advisable to organize an entire bureau or division to carry on this work, for each county has its own health department to plan local educational activities and residents of Maryland in general are sufficiently well-informed concerning personal and community health to avail themselves of provided services. However, the Public Relations Assistant prepares press releases, a monthly bulletin, the Director's report of each year's activities and other printed and mimeographed materials, often cooperating with bureaus or divisions. Requests for information are answered as completely and promptly as possible. County health departments and the various bureaus and divisions provide talks, exhibits, motion pictures and other educational services.

Bureaus and Divisions

There are eight bureaus and five divisions, each of which is responsible for some phase of the public health program carried on by the State Department of Health. The distinction between bureaus and divisions is largely a legal one, for bureaus are created by laws enacted by the General Assembly and divisions by authority of the State Board of Health.

Bureau of Vital Statistics

Birth and death registration by the State Department of Health began in 1898. Registration was, however, relatively incomplete in the early years, particularly before the separate Bureau of Vital Statistics was organized in 1910.

Certificates of births and deaths are collected by local registrars of vital statistics and are transmitted by them to the central bureau, which reviews, completes and indexes the records. Copies of these records are also transmitted to the County Health Officers.

The bureau also files copies of marriage and divorce records received from Clerks of Circuit Courts.

To increase the completeness and accuracy of birth records periodic surveys have been made to discover and register the births of previously unregistered children. The bureau also reviews evidence for filing or amending birth records for adopted, legitimated and incorrectly registered persons of all ages. Upon payment of a fifty cent fee certified copies of birth and death records are issued to persons entitled to receive them.

Preparation and analysis of many types of vital statistics concerning births, deaths, marriages, divorces and population must also be mentioned among the bureau's major activities. An increasing amount of statistical service is being provided to other bureaus of the Department at their request.

Bureau of Communicable Diseases

Communicable disease control was provided by laws enacted in 1890, 1896 and 1904, and the bureau was established in 1910. This bureau, which exercises administrative control over communicable diseases, receives daily reports from health officers on the incidence of such diseases. It investigates outbreaks of disease and directs measures for their control. Laws concerning notification of reportable diseases and the smallpox vaccination law are enforced.

The Bureau of Communicable Diseases keeps all records on the incidence of the reportable diseases and makes monthly, annual and special reports to the Director. Separate and confidential records are kept of all known cases of tuberculosis and venereal diseases.

Epidemiological investigations are made to determine the occurrence and distribution of communicable diseases in individuals and communities in the counties of Maryland and suitable control measures are instituted. Sources and routes of infection are studied and private physicians and health officers assisted in the diagnosis of communicable diseases and in the discovery of unrecognized or unreported cases. Advice is given as to preferred methods of collecting laboratory specimens. The bureau also assists in diphtheria, typhoid fever and smallpox immunizations when they cannot be given by local physicians or health officers.

Through its Pasteur Division the bureau gives treatment for the prevention of rabies (hydrophobia) to persons unable to pay for the service.

The school health program was formerly under the joint direction of the Bureau of Communicable Diseases, the Executive Office of this Department and the State Department of Education. It has recently been transferred to the Bureau of Child Hygiene.

Venereal Disease Control is in charge of a Deputy State Health Officer assigned to the bureau. Clinics are operated by this Department in cooperation with county health departments and other organizations. The program includes education for the prevention of syphilis and gonorrhea.

A Tuberculosis Control Program is also carried on through this bureau. Clinics are held in cooperation with the Maryland Tuberculosis Association and the county health departments.

Attention is directed toward lowering the State's tuberculosis death rate by early diagnosis—largely by means of x-rays and skin tests, sanitorium care and epidemiological investigation of contacts.

Services for Crippled Children

The administrative functions of Services for Crippled Children are conducted from the central office of the Maryland State Department of Health, Bureau of Communicable Diseases.

The clinics afford treatment, diagnostic and consultation services and are conducted by competent orthopedic surgeons assisted by the orthopedic nurses, physiotherapists and public health nurses.

Any person under twenty-one years of age suffering from a crippling condition is eligible for service. In addition to the clinic service, hospitalization, convalescent and foster home care, all medical and surgical care, follow-up services by orthopedic nurses and physiotherapy, and transportation of patients are provided; the purchase of shoes, braces and appliances and repairs are furnished.

Special clinics are held for cleft palate and cleft lip, club feet and other congenital deformities. A special clinic is conducted for children suffering from birth injuries. These clinics are held on regular schedule throughout the State.

A special rheumatic-cardiac clinic is conducted in Anne Arundel County for the care of rheumatic fever patients under 21 years of age. This service provides medical treatment, hospitalization, convalescent care and after care.

A special program for the prevention of deafness is conducted in Washington County. Patients at this clinic receive an audiometer test, complete ear, nose and throat diagnostic examinations and provisions are made at hospitals for special treatment.

Bureau of Bacteriology

An act of the 1898 legislature provided for the services of a bacteriologist and provision for a bureau was made by the 1910 legislature. This bureau was operated, however, as part of a similar bureau in the Baltimore City Health Department until 1920, when it was separately organized in the State Department of Health.

The work of the Bureau of Bacteriology has grown both in volume and scope of activities since its organization. The primary function has been to assist in the prevention, diagnosis and control of infectious diseases by the examination of specimens from suspected cases or carriers and by the examination of samples of water, sewage, milk and other foods to determine their hygienic quality or freedom from fecal contamination.

The 1939 legislature granted authority to the State Board of Health, to be exercised through this bureau, to control all laboratory work done in the counties of Maryland in connection with the diagnosis and control of human illness. The bureau sets standards for such work and qualifications tor those doing it. Further legislative authority to approve hospital laboratories was granted to this bureau by the hospital licensure law of 1945.

The bureau consists of a central laboratory in the main office of the State Department of Health in Baltimore and eleven branch laboratories in the counties. Branches are located in Annapolis, Cambridge, Cumberland, Easton, Elkton, Frederick, Hagerstown, La Plata, Prince Frederick, Rockville and Salisbury.

Bureau of Chemistry

As early as 1887 an analyst was provided by the State Board of Health. Legislation concerning chemical work by the Department was passed in 1908 and the Bureau of Chemistry was authorized by law in 1910. Chemical examinations of foods, drugs, water, sewage, trade wastes and samples of substances affecting industrial health are made by this bureau. The chemists also develop new analytical methods for testing these materials.

Analyses by the chemists of this bureau contribute to the effectiveness of the public health program in a number of ways. The tests made determine the sanitary quality of waters, milk and dairy products, fruits, vegetables, meats and all types of food substances offered for sale to the public and yield data needed to prevent adulteration and misbranding. They determine the purity, potency and legality of all official drug products and other pharmaceutical, medicinal and proprietary preparations intended for human consumption. Tests of water and sewage help to indicate the efficiency of operations to purify water or treat sewage, while examinations of trade wastes and other contaminants assist in the control of stream pollution. In addition, the bureau cooperates with health officers in the preparation of clinical and diagnostic reagents.

Bureau of Food and Drugs

The Bureau of Food and Drugs was established under laws enacted between 1890 and 1910. Organization as a separate bureau was authorized in the latter year. The office of State Food and Drug Commissioner was created in 1910 and that of Deputy Drug Commissioner in 1922.

Inspectors of this bureau investigate food and drug products manufactured or sold in Maryland to determine their purity, honesty of labeling and compliance with laws governing the manufacture, handling and distribution of food, drugs and milk. They inspect dairies, canneries, pharmacies, restaurants, stores, markets, seafood establishments, slaughter houses and other places where foods or drugs are manufactured, produced or stored. Specimens are collected and submitted to the laboratories of the Department for examination, and hearings are held when violations of the law become apparent. The bureau cooperates closely with Federal and State agencies for more effective control.

Law enforcement is an important function of the Bureau of Food and Drugs. It enforces food laws, drug and narcotic laws and those relating to the conduct of drug stores and the sale of poisons. Since 1941 the Bureau has also been responsible for the administration of the Milk Law enacted in that year. It grants annual licenses to bottling plants, canneries and cold storage plants.

Bureau of Sanitary Engineering

The Bureau of Sanitary Engineering was authorized by law in 1910 but was not organized until 1912. Since that time it has been concerned with problems of water supply, sewerage and stream sanitation.

This bureau supervises the sanitary quality of public water supplies throughout the State. It examines all water supply, sewerage, refuse disposal and industrial waste treatment projects and either approves or amends them. Through this bureau the Department has authority to require installation of water systems, sewerage systems or industrial waste treatment plants and to order changes in the construction or operation of existing works. Supervision is also exercised over stream pollution from sewage or industrial wastes and over aerial pollution. The Sanitary Engineers prepare plans and specifications and supervise the construction and operation of water and sewerage works at State institutions. The bureau also conducts research concerning the maintenance of sanitary systems and the treatment of water, sewage and trade wastes and promotes the installation of sanitary works in communities of Maryland.

Bureau of Child Hygiene

The Bureau of Child Hygiene, authorized by law and organized in 1922, carries on a maternity and child hygiene program for mothers and children residing in the counties.

In cooperation with county health officers and with the approval of local physicians the Bureau of Child Hygiene organizes prenatal clinics and child health conferences and provides pediatric and obstetrical consultation service. In a number of counties the bureau maintains nurse-midwife service for women unable to pay for delivery by a private physician. Assistance is offered physicians in obtaining the advice of specialists and providing hospital accommodations for women and children from low income groups.

Health education is a major activity of the Bureau of Child Hygiene. Information on prenatal care and the needs of infants and preschool children is disseminated by means of printed materials, lectures—often illustrated with slides, and motion pictures. Contacts of nurses and physicians with patients in clinics and conferences afford many opportunities for informal health instruction.

The training of midwives is supervised by the bureau. It furnishes instructions to licensed midwives and to women applying for licenses to practice midwifery.

The school health program, formerly an activity of the Executive Office and the Bureau of Communicable Diseases, was recently transferred to the Bureau of Child Hygiene. This work is carried on jointly by the State Departments of Health and Education. The program consists largely of medical examinations, some diphtheria immunizations, inspections in connection with communicable disease control and home visits by public health nurses.

Bureau of Medical Services

The Bureau of Medical Services was authorized by law and organized in 1945, primarily for the purpose of administering a medical care program for the indigent and medically indigent. The law provides for a Council on Medical Care—composed of representatives of the medical, dental, nursing and pharmaceutical professions, hospitals and welfare agencies—which furnishes consultation and advice to the bureau. The law authorizes the bureau to provide services of physicians, dentists, nurses and hospitals to indigent and medically indigent persons.

In addition, the Bureau of Medical Services is responsible for the licensing of hospitals under the Law of 1945, and its work includes administration of three chronic disease hospitals to be built in various sections of the State during the postwar period. For the duration of the war and for eighteen months thereafter the Emergency Maternity and Infant Care Program to supply medical, nursing and hospital care for the wives and infants of service men of the four lowest pay grades is also the responsibility of this bureau.

Division of Personnel and Accounts

In 1910 the State Board of Health organized the first division of the Department, the Division of Personnel and Accounts. Its function is that of a business office.

The Chief of this division is the Recording Secretary of the State Board of Health and the official property custodian, responsible to the Board for all property and supplies owned by the State Department of Health, as well as all funds placed at its disposal. He is also concerned with financial arrangements for the operation of county health departments and cooperates with county and town officials in preparing joint budgets.

Money accounting and property accounting are the duties of this division, which purchases all supplies, materials and equipment for the bureaus and divisions of the Department and directs the distribution of supplies. The Division of Personnel and Accounts

also exercises general supervision over all employees, keeps records of their absence from duty or lateness and makes up the payroll. It does the mimeographing and most of the printing required by the Department. Maintenance of the State cars used by employees and operation of the garage are also under the direction of the division.

Division of Legal Administration

The Division of Legal Administration was organized by the State Board of Health in 1924. It investigates and prosecutes violations of health laws and rules and regulations. Particular attention is directed toward enforcement of laws relating to the manufacture and sale of bedding and upholstered furniture. Manufacturers of such products for sale in this State are required to affix to each article a cloth tag describing the filling material and an inspection stamp issued by the State Department of Health through this division.

Division of Oral Hygiene

The State Board of Health established the Division of Oral Hygiene in 1929. Its activities include the organization and supervision of school dental clinics in the counties. The educational program includes dental health information for children and the general public as well as undergraduate instruction of dental students and nurses and teacher training. The division cooperates with the Bureau of Medical Services in the dental aspects of the medical care program.

Division of Industrial Health

The Division of Industrial Health was organized by the State Board of Health in 1942, at a time when wartime acceleration of industry was intensifying health problems of workers. Its work consists of detecting health hazards in industry, recommending control measures and helping industries to determine health hazards of new processes and materials before using them. The division investigates occupational disease reports and promotes well-balanced health programs in industrial plants.

Division of Public Health Nursing

In 1945 the State Board of Health created the Division of Public Health Nursing[a] to develop the public health nursing phases of the health program. It provides direction and guidance to public health nurses in the counties. Consultation is provided by public health nurses specially prepared in the fields of maternity, pediatrics, tuberculosis, venereal diseases and orthopedics. Recruitment of personnel to fill nursing vacancies and new positions is another function of this division. In addition, effort is made to correlate

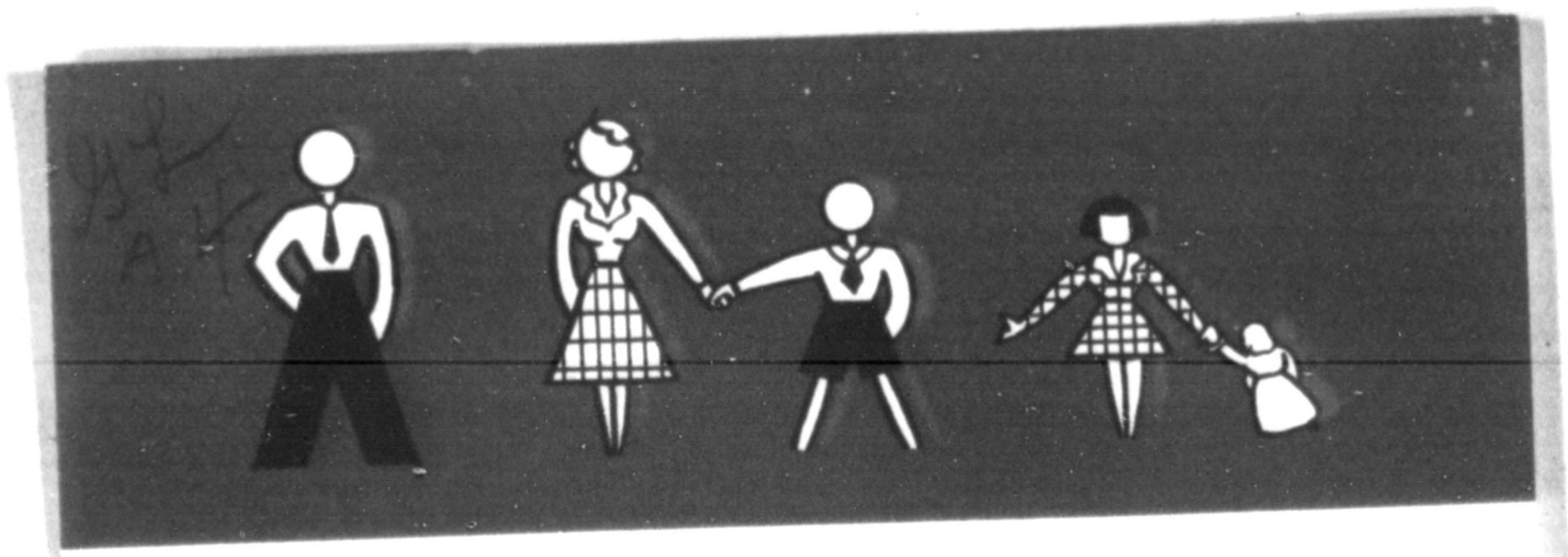
[a] Under the Executive Office

the nursing program of the State Department of Health with public health nursing services of other agencies operating in Maryland communities.

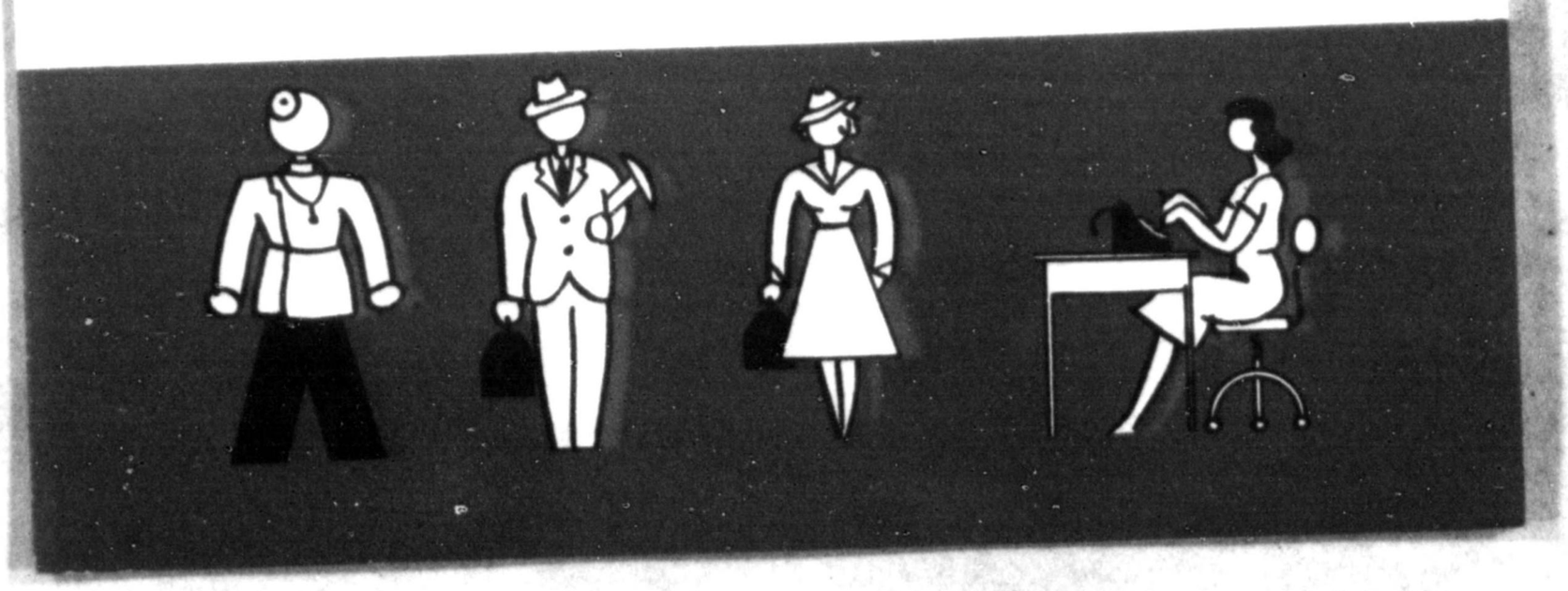
Public Health for All

The State Department of Health carries on this public health program for all residents of Maryland, regardless of age, race or financial status. Its resources—including personnel, equipment and funds—are devoted to preventing disease and promoting health among the people of this State. Many receive direct health services and all share the benefits of sanitation and disease control. In return the Department asks for interest and cooperation in the administration of the Health Laws of Maryland.

For additional information concerning the activities of this Department, inquiries should be addressed to the State Department of Health, Baltimore 18, Maryland. All requests for information are answered as promptly and as completely as possible.



How A FULL TIME HEALTH DEPARTMENT Serves You



A PREVENTABLE DISEASE CONTROL PROGRAM PROTECTS YOU by

Immunization against diphtheria, smallpox, typhoid fever, and whooping cough

Investigating cases of communicable disease for sources of infection and supervision of these cases

Advising families how to prevent the spread of disease

Collecting body specimens for laboratory diagnosis

Special prevention and treatment measures in combatting venereal diseases, tuberculosis, malaria, pellagra, and hookworm disease

Public education through such services as conferences, clinics, home visits, meetings, pamphlets, films

VITAL STATISTICS ARE IMPORTANT TO YOU because

A birth certificate is necessary to prove age for entering army, navy, and marines; to verify your American citizenship for war and government employment; to show age for entering school, voting, marrying; for your protection in legal matters; and in many other ways

Death records point out the leading killers

Marriage and divorce records are your proof of marriage or divorce and are of value in keeping your family's history

THE LABORATORY IS YOUR FBI AGAINST DISEASE GERMS through

Testing the purity of city, school and private water supplies

Determining the sanitary quality of milk

Examining body specimens including feces, blood, urine, and sputum to locate typhoid fever, tuberculosis, syphilis, gonorrhea, malaria, and other diseases

FULL-TIME COUNTY HEALTH DEPART

A SANITATION PROGRAM SAFEGUARDS YOU through

Supervision of foodhandling establishments, dairy farms, pasteurizing plants, creameries, milk stations, ice cream plants, and slaughter houses

Control of insect-borne diseases through such measures as drainage and screening

Public health services to food and milk handlers

Supervisory assistance in securing proper disposal of body wastes and protected water supplies for both public and private premises

Sanitary supervision of public buildings in the county including schools, jails, courthouses, barbershops, hotels and tourist camps, of swimming pools, and water supplies both public and private

Advice as to the proper methods to meet state sanitary regulations aimed to protect the public

MOTHERS ARE SERVED BY THE FULL-TIME COUNTY HEALTH DEPARTMENT by

Medical examination where not otherwise available

Advice to expectant mothers regarding diet, rest, and exercise

Referring those in need of immediate medical or dental care to private physicians or dentists for advice and treatment

Midwife supervision

Home visits of public health nurses to expectant mothers and new mothers

BABIES AND TODDLERS ARE PROTECTED BY THE FULL-TIME HEALTH DEPARTMENT through

Complete physical and dental examinations

Immunization against diphtheria, whooping cough, smallpox, and typhoid fever

Help in the correction of physical defects through civic organizations for those children whose parents are not able to pay for glasses, dental work, removing tonsils, and the like

Home visits by public health nurses to parents about the care of young children

MENTS SAVE HEALTH AND MONEY

SCHOOL BOYS AND GIRLS ARE SERVED BY THE FULL-TIME COUNTY HEALTH DEPARTMENT through

Guidance and instruction in healthful living

Medical examinations at intervals during school life

Improved lunches and lunchrooms and nutrition teaching

Dental inspections

Immunization against typhoid fever, smallpox, and diphtheria

Obtaining help of clubs and civic organizations to correct physical defects of those children whose parents are not able otherwise to get teeth filled, buy glasses, have adenoids removed, and the like

HEALTH EDUCATION OFFERS YOU HELP AND ADVICE through

Special work with parents, teachers, community leaders, and school children

Personal guidance in conferences, clinics, and home visits

Newspaper, radio, pamphlets, exhibits, films, and meetings

All services of a county health department are given without charge. Services are paid for from a budget supported by the county, cities, and the State Board of Health.

MISSISSIPPI STATE BOARD OF HEALTH
FELIX J. UNDERWOOD, M. D.
Executive Officer
Jackson, Mississippi

ENDORSEMENTS OF THE MEDICAL CARE COMMISSION'S GOOD HEALTH PLAN

HARRY B. CALDWELL

EXECUTIVE SECRETARY
N. C. GOOD HEALTH ASSOCIATION

GREENSBORO, N. C.

The Medical Care Commission Plan for making North Carolina the Number One Health State has the endorsement of prominent leaders throughout North Carolina. The objective has been endorsed by both political parties. In fact, the health program is one of the most carefully studied and generally approved recommendations ever presented to the Legislature of North Carolina. A few endorsements of the Plan are presented on the following pages.

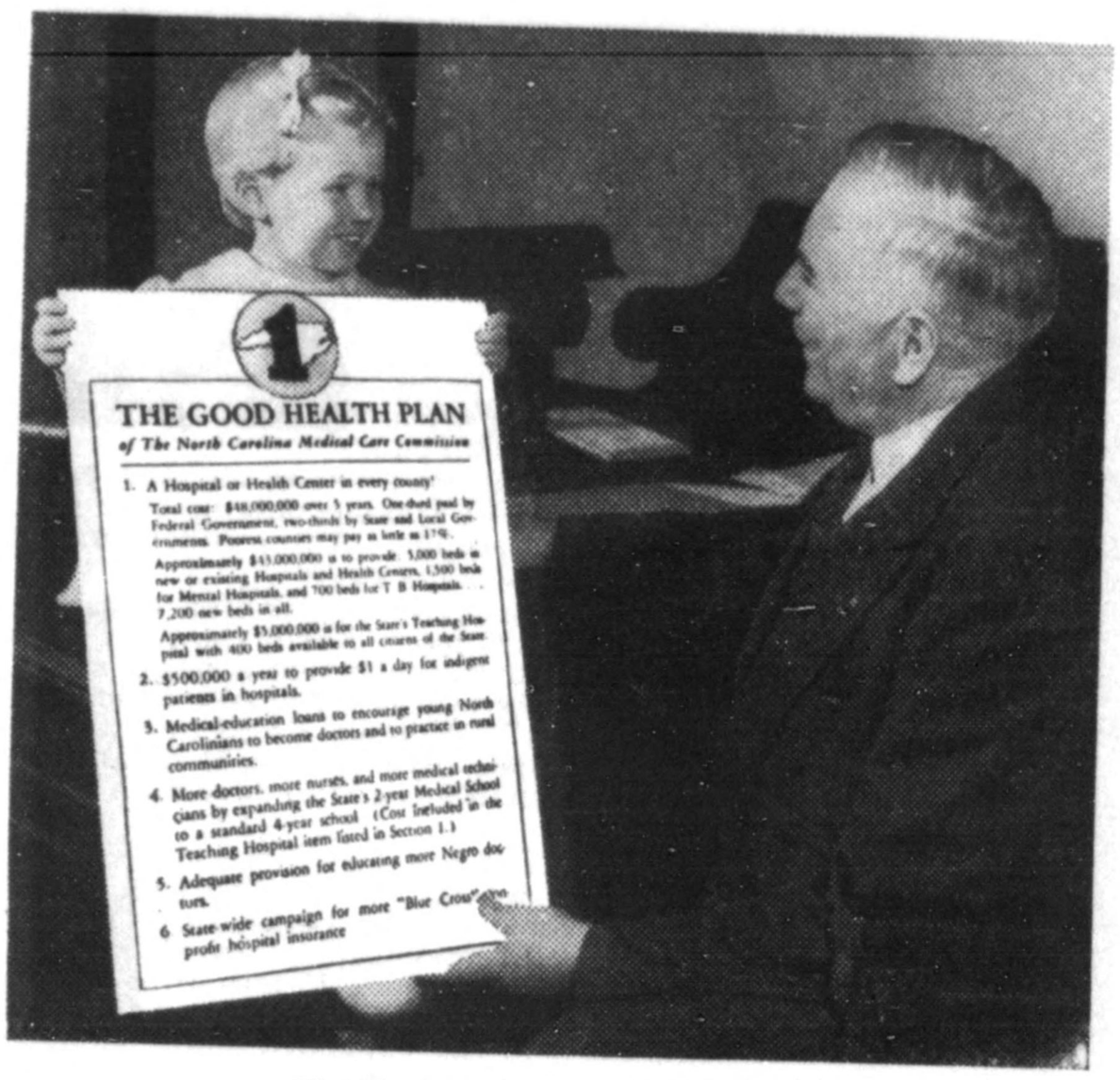
The movement for Good Health in North Carolina began in 1943, when it was discovered that so many North Carolina boys were physically unfit for military service and that a tragic shortage of both doctors and hospital beds was especially serious in most all rural counties. Governor J. Melville Broughton named Dr. Clarence Poe Chairman of a State Hospital and Medical Care Commission to study our health conditions and to develop a statewide program or plan.

The Poe Commission made its final report to Governor R. Gregg Cherry and the General Assembly in January 1945. Governor Cherry, in a special message to the Legislature, recommended the adoption of a hospital and medical care program. The Legislature of 1945 adopted the "Good Health Plan." All parts of the Plan are in operation except the Hospital and Health Center Construction Program, and the expanded State Medical School for more doctors, nurses, technicians, and other medical personnel.

Governor R. Gregg Cherry did much to insure the success of the whole program by the able commission he named to carry it out as follows: James H. Clark, Clarence Poe, J. W. Bean, Paul B. Bissette, Franklin J. Blythe, William M. Coppridge, Don S. Elias, Sample B. Forbus, Fred C. Hubbard, B. Everett Jordan, G. Fred Hale, W. S. Rankin, Carl V. Reynolds, Elizabeth D. Reynolds, William M. Rich, William B. Rodman, C. E. Rozzelle, Miss Flora Wakefield, Paul F. Whitaker, and Ellen B. Winston.

The Medical Care Commission is recommending that the State complete the Program by providing (1) one-third of the estimated cost of constructing 4,600 hospital beds in approved hospitals and health centers so that every county may have either a hospital or health center, and (2) an appropriation to construct the 400 bed teaching hospital and medical center as a part of the expanded University Medical School. Their program recognizes the need for both facilities and personnel. Its adoption will round out the "Good Health Plan" inaugurated by the Legislature of 1945.

We have the opportunity now to make North Carolina the nation's Number One Good Health State by making hospital and medical care services available for all of our people . . . rich and poor . . . town people and farm people!



HON. R. GREGG CHERRY

GOVERNOR OF THE STATE OF NORTH CAROLINA

RALEIGH, N. C.

The 1945 General Assembly authorized the establishment of a Medical Care Commission, pursuant to which an efficient and highly capable group of North Carolina citizens have been struggling to map out a Health Program that would produce the desired results. The Report and findings of this Commission will be submitted to the General Assembly with appropriate Bills to carry out the findings of this Commission. It is recommended by the Commission that the State undertake this new new State-wide Service, including a four-year school of Medicine at Chapel Hill, together with a Teaching Hospital, also to be located at Chapel Hill. The Report also calls for hospitals and medical centers in several of the Counties of the State. It is pointed out that the need for this Program is more doctors and more hospitals to bring our State up to the National Average in this respect.

Several million dollars are requested for each purpose by the Committee in its Report. The funds, if provided by you, would be supplemented by Federal Funds under the Hill-Burton Act of Congress. I pass on to you for your respectful consideration the recommendations of the Majority Group of the Medical Care Commission, *with my approval.* Good health is a problem which concerns every person in North Carolina, and I am sure the General Assembly will give it careful consideration. It should be remembered that what we do for the white race, in justice and fairness, we must do for the colored race, for it is here we find the greatest problems in health.

JAMES H. CLARK

CHAIRMAN OF THE NORTH CAROLINA MEDICAL CARE COMMISSION

ELIZABETHTOWN, N. C.

I favor adoption of the Medical Care Commission plan in its entirety because North Carolina no longer can afford to ignore its most precious asset—the health of its three and a half million citizens. This great State, which is making progress on all other fronts, must take definite steps now to correct unsatisfactory conditions in the field of health and medical care.

We must act now to eliminate forever the conditions which gave North Carolina the highest percentage of draft rejections in the nation during the recent war. Over 49 per cent of white draftees and 71 per cent of Negro draftees were turned down as physically unfit for military service.

We must act now to provide more hospitals and health centers for the thousands of North Carolinians to whom these facilities are not accessible, and we must train many more doctors to serve our people, particularly in the rural area. Forty-four states have more doctors per 100,000 of population than North Carolina; 41 states have more hospital beds per 1,000 of population; there are 33 North Carolina counties that have no hospital beds at all.

It is not surprising, therefore, that a recent State-wide examination of North Carolina schoolboys showed that 85 per cent had defective teeth, 16 per cent had defective vision, 16 per cent were underweight and 14 per cent had defective tonsils.

With the Federal and State appropriations now anticipated, North Carolina will be in a position to improve these exceedingly unsatisfactory conditions and take a long step forward in making the people of our State among the healthiest in the nation.

The need is imperative; we cannot afford to permit further delay!

The North Carolina Medical Care Commission has completed a survey of its hospital resources and is formulating plans for a five year, $48,000,000 hospital construction program. If funds are made available, and conditions for building are satisfactory, it is hoped that actual construction can be started in 1947.

The North Carolina Medical Care Commission was among the first in the nation to win Federal approval for the administering of funds authorized in the Hill-Burton Act. This Act authorized Federal assistance in making surveys and building hospitals, and the North Carolina share is expected to be about $17,500,000 over the five year period.

The State's part in this eminently worth-while five year program would be about $20,000,000, and the contribution from counties and communities would be about $10,500,000, some of which has already been provided for.

Our goal is to put adequate medical and hospital services within an hour's ride of every family in North Carolina. We want to make it possible for more young North Carolinians to

study to become doctors and to practice in rural communities. We want to encourage the training of more dentists, pharmacists, and nurses.

If our plan is put into effect, not only the health but the whole economy of our people would be vastly improved. There would be higher annual earnings among our workers through reduction in the loss of time from illness. Their efficiency would be increased, thereby reducing production costs. Savings will result by reducing sickness. Farmers would increase production.

In short, the program of the Medical Care Commission will give to the people of North Carolina not only a higher standard of health and well-being, but it also will return to them in dollars and cents far more than the program will cost.

Speaking for myself and the splendid people working with me on the Medical Care Commission, I want to see this plan adopted in its entirety without any crippling amendments. If the Medical Program is made subservient to all other needs of the State, or divided into portions that do not cover all of the present medical and hospital needs of the State, it cannot accomplish its full and high purpose.

We must go forward now with full stride.

Dr. John A. Ferrell, left, executive secretary of the North Carolina Medical Care Commission, and James H. Clark, chairman of the Commission, study a chart showing the estimated cost of permanent improvements called for in the proposed five-year Good Health Plan.

CARL V. REYNOLDS, M.D.

SECRETARY AND STATE HEALTH OFFICER

RALEIGH, N. C.

I favor the adoption of the Medical Care Commission plan in its entirety because:

It is an undisputed fact that North Carolina needs expanded medical and preventive care and hospital facilities. These can be insured only through the use of graduates of a four-year medical school.

Rural hospitals, training and public health centers in rural communities, will accomplish an expanded public health program only through the establishment of the essential parts of the program combined and adopted in its entirety.

As one whose professional life has been devoted largely to preventive medicine, it is natural that I favor the expansion of our already existing School of Public Health, but this can be done only after we have enough trained personnel—doctors, nurses, technicians, radiologists, etc.

The School of Public Health is for post-graduate work, but we cannot have post-graduates until we have graduates.

In this important fight, we must forego our personal and selfish ambitions for the sake of a complete program, calling for expanded hospital facilities, medical center, and a four-year medical school to provide adequate personnel. We are planning not only for service to those of the present age, but for generations yet unborn.

R. MAYNE ALBRIGHT

EXECUTIVE DIRECTOR, WORLD FEDERALISTS OF NORTH CAROLINA

RALEIGH, N. C.

I favor adoption of the Medical Care Commission Plan in its entirety because—the plan, in its entirety, is the thoughtful answer of North Carolinians and others who have studied every phase of the State's health problem for over three years. We can afford the program in its entirety now. We cannot afford to delay any part of it when our most valuable asset—the health of the people—is involved. With a surplus in the General Fund now, how can we think of further delay when even with immediate action it will take years to bring us up to the average of the other states.

W. W. ANDREWS

CHAIRMAN, EXECUTIVE COMMITTEE
N. C. STATE GRANGE

GOLDSBORO, N. C.

I favor adoption of the Medical Care Commission Plan in its entirety because:

Studies made by experts show that 42% of the hospital beds are located in six of the large urban counties, while 33 of our rural counties do not have a single hospital bed available. These studies also show that 73% of our citizens live in rural communities and have only 31% of the doctors. Thousands of our rural people cannot get the medical attention needed as a result of these conditions. The time has come when we must take steps to improve health conditions for all the people of the state.

The North Carolina Medical Care Commission is recommending that the State of North Carolina help the counties and localities build the hospitals and health centers so that there will be facilities available within an area of from one to 25 miles for every family in the state. They are likewise recommending that the state expand its present two-year medical school into a standard four-year school so that there will be more doctors, nurses, and medical personnel available for practice in these facilities, especially in the rural areas of North Carolina. We must have hospitals in the rural areas to attract doctors, nurses, and medical workers into those sections and we must have trained workers available to use the facilities if we are to have an overall Good Health Program in North Carolina.

The adoption of this program will give us more hospitals, more doctors, nurses, and medical personnel and will contribute much to making North Carolina the Number One Good Health State.

C. W. ARMSTRONG, M.D.

HEALTH OFFICER

SALISBURY, N. C.

I favor adoption of the Medical Care Commission Plan in its entirety because:

1. By putting into effect all phases of this program it will be well-rounded and complete. It must be evident to anyone who has taken the trouble to inform himself that the adoption of this program is simply one of saving lives and conserving our one real asset; to wit, the health of our people.

2. For twenty-eight years I have been health officer of a typical North Carolina county. This work has given me an unusual opportunity to observe the acute need for better medical care.

There has not been one single working day during those years when this need has not been forcibly impressed upon me.

3. I am convinced that the people of North Carolina will demand better medical care and an opportunity to protect themselves against disease by utilizing the many measures which medical science has made available. Many of our people think that this can be accomplished by socialized medicine. I am in a position to know that the socialization of medicine will improve neither the quantity nor the quality of medical care. This plan of the Medical Care Commission offers a positive means of combating this threatened evil.

4. It is complete and practical, since it emphasizes both the curative and the preventive side of medicine.

5. We have the opportunity to benefit by the funds which are available through the Federal Government.

6. Our system of progress in North Carolina has for many years been top-heavy, and the all-important question of health has not received the attention and the support which it deserves.

"HE WHO HAS HEALTH HAS HOPE; HE WHO HAS HOPE HAS EVERYTHING."

MISS MABEL L. BACON

PRESIDENT, NORTH CAROLINA FEDERATION OF BUSINESS AND PROFESSIONAL WOMEN'S CLUBS

CHARLOTTE, N. C.

I favor the adoption of the Medical Care Commission Plan in its entirety because good health is North Carolina's greatest need. This plan is sound as it has been developed from the results of many independent studies, the findings of which have been used as bases for the recommendations it contains.

Our youth cannot have equal chances for success in our highly competitive postwar world when their many health defects go unremedied because of inadequate health facilities. The 50,000 children who yearly fail to make their normal grade progress because of such defects accept and bear the cross of such neglect. They fail, not because of their lack of effort, but ours. The glory in the achievements of our men in the armed forces, vanishes when we are forced to accept the shame and humiliation for producing the highest percentage of draft rejections in the nation. They bear this blighting sense of defeat, often throughout life, because we failed them.

Shall we continue to force them to bear the brunt of our negligence? No, let's practice true economy by seeking to develop healthy citizens—the State's greatest resources by successfully putting over our Good Health Program.

HYMAN L. BATTLE

ROCKY MOUNT MILLS

ROCKY MOUNT, N. C.

I favor the adoption of the Medical Care Commission Plan in its entirety because aside from the humanitarian phase, I believe that the State could make no finer investment. I am convinced that the industrial workers of this State by reason of poor health are losing a minimum of $15,000,000 annually in pay for days lost through sickness over and above the national average.

MRS. THOMAS W. BIRD

PRESIDENT, AMERICAN LEGION AUXILIARY

CHARLOTTE, N. C.

I heartily endorse the splendid and comprehensive health program developed by Medical Care Commission. I feel sure the General Assembly of North Carolina will do all in its power to make adequate provisions for the care and treatment of the sick in our State.

MRS. KARL BISHOPRIC

PRESIDENT, THE NORTH CAROLINA FEDERATION OF WOMEN'S CLUBS

SPRAY, N. C.

I favor the adoption of the Medical Care Commission Plan in its entirety because:

A careful survey of conditions and a study of the facts disclosed show North Carolina's needs.

A concerted effort in all three fields—

Training more doctors, nurses and technicians who will practice in North Carolina,

Securing more hospitals and Health Centers at which they may work,

Making Health Insurance more easily available, more widely appreciated, and more cheaply purchased—will multiply the fa-

vorable effects of any kind of piecemeal job in relation to the results achieved for time and money invested.

North Carolina has in this century pulled itself out of mental darkness by building schools; out of the mud by building roads. Let's get it into the sunshine of Better Health where its climate and citizenry deserve to be.

If the job should be done, now is the time, assuming especially that the heavy cost of the first five years—plant erection, equipment, etc.—will be shared by the Federal Government through the Hill-Burton Bill, by which North Carolina would receive nearly 3½ million each year for five years.

DR. F. D. BLUFORD

PRESIDENT, A. AND T. COLLEGE

GREENSBORO, N. C.

I favor the adoption of the full program of the North Carolina Medical Care Commission, as there is a great need for the improvement of the health of both races in this State.

According to the report of the Draft Boards, the health of the young men of draft age of both races in North Carolina was the lowest to be found in any state in the nation. If this is true, the State of North Carolina should do everything that it can to correct this deficiency.

It seems to me that if the State adopts the recommendation of the Medical Care Commission it will be making a long step forward in the improvement of the health of all the people of the State.

MRS. W. T. BOST

ADVISORY COMMITTEE, STATE LEGISLATIVE COUNCIL

RALEIGH, N. C.

I favor adoption of the Medical Care Commission Plan in its entirety as the most effective means of making the needed hospital and medical care services available to all the people of the state. The various phases of the plan are interdependent and should therefore be advanced as a total unit in order to obtain the best results.

J. MELVILLE BROUGHTON

ATTORNEY AT LAW

RALEIGH, N. C.

I have followed with great interest the activities of the North Carolina Medical Care Commission appointed under the act of the General Assembly of 1945 and have read with care the plan presented and recommended by this Commission. It is my opinion that the plan so presented is constructive and sound and I hope very much that it will be adopted in its entirety.

As a member of the Federal Hospital Council I have been privileged to study the health programs in most of the states and have been impressed with the fact that North Carolina is well in advance of most states in its planning and preparation for a constructive health program. Thus the State once more is in position to assume and maintain leadership in this important field.

MRS. L. E. BROWN

PRESIDENT, N. C. WOMEN'S CHRISTIAN TEMPERANCE UNION

CHARLOTTE, N. C.

Personally, I favor adoption of the Medical Care Commission Plan in its entirety because:

1. I have great confidence in the judgment of President I. G. Greer and Exec. Sec. Harry B. Caldwell and others of the "Who's Who" group, who, after careful study, formulated the recommendations;

2. Our State ranked so high in percentage of boys who were physically unfit for military service, when they were definitely needed in the World War;

3. There is such a great shortage of hospital beds, doctors and nurses; (having served as a nurses' aide during the war, and even, today, I realize this fact);

4. Our maternal and infant mortality rate is far above the average, as compared with other states;

5. The failures of many of our school children are due to defects that may be corrected by means of this proposed Good Health Program;

6. We who accept the Fatherhood of God must acknowledge the Brotherhood of Man and assume the responsibilities connected therewith.

JAMES W. BUTLER

GOVERNOR, DISTRICT 188, ROTARY INTERNATIONAL

GOLDSBORO, N. C.

Valuable things of life are not always measured in terms of material possessions. The ideal of service in practice may bring rewards in tangible and visible tokens, but the ethical and moral values contribute to the enrichment of life.

Good health can not be measured by a financial rating; it is priceless in value. By whatever standards we may use in evaluating the health of our citizens, there is no substitute for good health, either physical, moral, or spiritual. North Carolina citizens have been moved to a public consciousness of their responsibility to provide an adequate program of medical care for all the people of the state. It not only means the saving of lives, but it is promoting a better standard of moral and spiritual relationshiips. In putting the Good Health Program in full-scale operation, we become Good Samaritans to our own people; we begin the practice of the Good Neighbor policy within our own state, each citizen proclaiming: "What is mine is thine, I'll share it."

Along with the benefits coming from hospitals, medical centers, clinics and better trained physicians, there are the intangible values—the abiding qualities and ideals—which move me to add my endorsement to the program of the Good Health Association and the Medical Care Commission and work for early fulfillment.

MRS. HARRY B. CALDWELL

MASTER, NORTH CAROLINA STATE GRANGE

GREENSBORO, N. C.

I favor adoption of the Medical Care Commission Plan because studies reveal that our poor health in North Carolina is due in a large measure to the lack of doctors, hospitals, and medical personnel. The need is much more acute in the rural sections of the state as shown by the fact that (1) forty-two per cent of our hospitals are located in six large urban counties, while 33 of our rural counties are without hospital facilities of any kind; and (2) seventy-three per cent of our citizens live in rural communities and have only 31% of the doctors.

Thousands of our farm people are in need of medical attention. Hundreds of them die prematurely young from conditions that could be corrected if hospitals and doctors were only avail-

able. Poor health not only brings suffering and death but it results in school failures, inefficient work, and tends to keep the income of our people at low levels. The Medical Care Commission has very wisely recognized that some counties need more assistance than others in constructing hospitals and health centers. They, therefore, recommended that hospital construction be helped by the state in variable amounts ranging from 10 per cent of the cost of approved hospital building in the richest counties to 50 per cent of the cost in the poorest counties. This contribution by the State together with the Federal funds available will enable our poorer rural counties to get the facilities needed by paying as little as 17 per cent of the construction cost.

We must have hospitals and health centers in the rural areas or well trained doctors will not locate in those sections for practice; and we must have doctors, nurses, and technicians available or the facilities will be useless.

Y. Z. CANNON

SECRETARY, ASSOCIATED MASTER BARBERS OF NORTH CAROLINA

CHAPEL HILL, N. C.

The Associated Master Barbers of North Carolina favor the Medical Care Program in its entirety because any one part of it left out will be the same as a missing link of a chain.

Without the health centers called for in the program, a great many of our citizens in the rural areas will be without the type of modern hospital service necessary in the treatment of disease. It is also obvious that erection of these health centers will make rural practice more attractive to the medical profession. One can hardly blame a doctor for not wishing to practice where he has no equipment to work with.

The other great need is the Medical School. Without the Medical School to train doctors and technicians, these health centers would be the same as barber shops without barbers. This would mean that the health centers would be little more than monuments to a magnificent program for the people that failed on account of the shortsightedness of a few individuals.

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Winston-Salem Sentinel: "It is anticipated that several million dollars of Federal funds will soon be available to assist states and local communities in providing more adequate medical care. Whether or not such funds become available, North Carolina can and must wage and win this battle for good health among its people. This fight must not be lost through disputes and controversies over the detailed means or methods of achieving the great and vital objectives involved. It must not be sacrificed to the ambitions or jealousies of individuals, groups or institutions."

IRVING CARLYLE

ATTORNEY AT LAW

MEMBER, STATE ADVISORY BUDGET COMMISSION

WINSTON-SALEM, N. C.

I favor adoption of the Medical Care Commission Plan in its entirety because it will provide better health for all the people of North Carolina. The most valuable asset of our State is not our splendid highway system, not our great public school system, not our productive soil and thriving industries; but the State's chief asset is its people. If our citizens are to produce their maximum capacity of crops, goods and services, they must first of all have good health.

We have done much to conserve our soil and other natural resources; we have done entirely too little to conserve the health and physical well-being of the people. The economic waste resulting from this neglect must be reduced. To bring about this result, we must have more doctors, more hospitals and health centers, and more and better trained health technicians, nurses, and other medical education and research must be fostered by the State.

In order to discharge its full duty to the people, the State should adopt the program being advocated by the Medical Care Commission. In the creation of that program, expert opinion and the best thought of many of the State's leaders were obtained. It is both sound and constructive.

JOHN W. CLARK

MANUFACTURER

FRANKLINVILLE, N. C.

I favor Legislative support of the four-year medical school at Chapel Hill and the entire medical program as I appreciate the need for it and feel that no agency less than the state itself is capable of doing the job.

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Greensboro Daily News: "The amounts requested for health services are not small but our needs are critical and it must be remembered that state appropriations are to be supplemented by federal funds and local funds. The program is an integrated one, a three-pronged attack on a state-wide threat, and it should be put over now while the time is ripe."

BENJAMIN CONE

MANUFACTURER

GREENSBORO, N. C.

I have favored the adoption of the entire program of the Medical Care Commission, and have been active in the N. C. Good Health Association which is fostering the program for the General Assembly at its present session.

I favor the program in its entirety because I feel that it is an integrated program for the benefit of practically every citizen of our State, whatever his financial status happens to be. I believe if adopted in its entirety it will come closer to touching the lives of the average citizen than ever does our State supported public school system. If we can raise the level of the health in the State, we not only assist the business man, but we also save for the industrial worker and the farmer a large part of the fruits of his labor which will enable him to live a fuller, happier and longer life. In the matter of absenteeism in industry, if the rate at our own plants here in Greensboro could be cut in half by reason of raising the general health level of our employees, it would make untold savings and lower costs to the company and at the same time guarantee to the worker a larger annual income.

I believe that now is the time to adopt the program for I feel that eventually the State will have to undertake a lot of it piece meal, and we may not have available to us in the future the provisions of the Hill-Burton Bill.

I realize the question of the expansion of the Medical School at Chapel Hill is controversial. The reason I favor the expansion of the University Medical School is to provide the hospitals and health centers with doctors, nurses and technicians to man the hospitals and health centers in scattered points on a state-wide basis. I believe the four year Medical School and teaching hospital would develop the type of folks who would want to remain at home and work in their own communities for the betterment of the State as a whole.

WM. M. COPPRIDGE, M.D.

PRESIDENT, MEDICAL SOCIETY OF THE STATE OF NORTH CAROLINA

DURHAM, N. C.

I am in favor of the whole program of the North Carolina Medical Care Commission because:

After three years of investigation and study by prominent citizens of the state, a group which includes those in all walks of life—business, labor, medicine, agriculture, ministry, and others—and in which all of our races and creeds are represented, a plan has evolved that

seems logical and necessary to meet our health needs. It brings before the people the necessity for action at the state level if we are to successfully deal with so intricate a problem as the equitable distribution of better medical care. It has been conceived and developed upon the principle that sickness is a matter of concern to the community and the state, as well as to the individual, his family, and friends. It calls for the use of public funds for a purpose than which there can be no more worthy use—the promotion of better health for its citizens. The proposals envision health institutions within easy access to all, and a program to provide encouragement and opportunity to the youth of the state to be trained in the arts and sciences of medicine. It fosters the furtherance of insurance against the financial burdens of illness.

It is distinctly an earnest effort of the people to solve a great humanitarian problem that will affect our welfare for generations to come.

E. B. CRAWFORD

EXECUTIVE VICE-PRESIDENT, HOSPITAL SAVING ASSOCIATION OF N. C., INC.

CHAPEL HILL, N. C.

I favor adoption of the Medical Care Commission plan in its entirety because:

1. The good health of the people of any state is a vital factor in the over-all success of that state and in its standing among other states.

2. Complete health facilities, strategically located with personnel to handle them efficiently, will be a great inducement for our own people to remain in North Carolina to build businesses and become better citizens, as well as attract outsiders for expanding industry in communities all over the State.

3. Our State University, supported by the people of the State, will be given the chance to have an excellent four year school with teaching facilities. We should be anxious and determined to have an outstanding medical school as part of the University just as we want our University to have a fine school of law, agriculture, commerce, engineering, pharmacy, and other special departments of cultural and scientific education. Such a medical school will augment, not interfere with, the work of the present medical schools in the State, and the studies by experts have shown there is a vital need for this particular part of the program.

4. The rural areas in North Carolina need better facilities and the Medical Care Commission plan, with a proper system of hospitals and clinics, and the State-owned medical school seem the most expeditious manner in which the heretofore unattractive areas can be made more attractive for present and future graduates of medicine.

5. It seems that the present surplus in the State Treasury can

well afford the complete program, and the cost in the future, spread properly, will be inconsequential compared to the results.

6. Good health facilities, which include all phases of the proposed program, i.e., more doctors, more hospitals beds and personnel, and more opportunity for prepayment by the people for protection against illness, are all jointly needed for real success. All of these factors are too closely allied to be separated. A missing link would cause a weakness that could be dangerous. But when the people, the doctors, and the hospitals of the community all join hands with the help of a prepayment plan, EVERYBODY WINS.

7. This program, in its entirety, guided by an unbiased, intelligent, and fairminded commission will place North Carolina in the position of being a national leader in the development of a complete health program for its people.

8. Having been personally associated with state-wide health service for the past seven years, I have seen a tremendous interest on the part of the people to protect themselves against catastrophic illness. The net growth of our own Blue Cross Hospital Saving Association during each succeeding year has been progressively greater with 1946 showing the greatest net gain since its organization. Over 50,000 new participants were added in 1946, bringing the total to over 310,000, nearly one out of ten North Carolinians. Nationally, Blue Cross is protecting one out of every six people in the United States, 26,000,000, which in itself is complete evidence of the desire of the mass of people to protect themselves.

The fulfillment of the desire of the people for better health, indicated by this unmistakable evidence, can only be accomplished by a well-rounded, long range program that will provide and maintain adequate facilities.

E. C. DANIEL

PRESIDENT, NORTH CAROLINA PHARMACEUTICAL ASSOCIATION

ZEBULON, N. C.

I favor adoption of the Medical Care Commission Plan in its entirety because of the great shortage of doctors, nurses, technicians, and hospital beds, and for the general better health of the people of the State.

We need 1,300 more doctors to provide one doctor for each 1,000 people of the state.

We are 6,000 Hospital beds below the national average of four beds per thousands population.

Forty-two per cent of our Hospital beds are located in six large urban counties, while 33 rural counties are without hospital facilities of any kind.

That while seventy-three per cent of our people live in rural communities, they have only 31 per cent of the doctors or have one doctor for each 3,600 people.

The average person would have a better chance to get in a hospital in 41 other states and a better chance to get a doctor in 44 other states, when needed, than they would in North Carolina.

North Carolina is 41st in Maternal Mortality, 38th in Infant Mortality, and 38th in death rate per thousand population when adjusted to the age distribution of the total United States population.

A recent state-wide examination of North Carolina schoolboys was cited as showing that 85 per cent had defective teeth; 16 per cent defective vision, 16 per cent were under weight, and 14 per cent had defective tonsils.

About 100,000 school children fail their grade each year in North Carolina. Dr. Carl Reynolds, State Health Officer estimates that one-half or 50,000 of these repeaters are due to physical defects that could be corrected.

Our Tuberculosis and Mental Hospitals are also badly overcrowded.

The State of North Carolina is in excellent financial condition and with the help of the United States Government can well afford to appropriate the necessary funds to carry on such a program for the benefit of the people of our State.

We as Pharmacists are in position to see and know the need of the sick and needy of our State and we are one hundred per cent behind the program.

MRS. CHARLES G. DOAK

EXECUTIVE SECRETARY, N. C. FEDERATION OF WOMEN'S CLUBS

RALEIGH, N. C.

I favor adoption of the Medical Care Commission Plan in its entirety because it calls for the minimum of action that would begin to correct our State's present very bad plight with reference to health. Having established the indisputable facts, the Commission also points out in the plan the sources from which necessary funds may be obtained, and reliable authorities in business and finance give assurance that the funds may be spent without endangering the financial stability of the State.

The organization of 12,000 women which I serve as executive secretary, and I as an individual, have always favored the spending of the **people's** money available in the State's treasury in timely, safe and sane appropriations for the education, health and public welfare of our people.

When Aycock was advocating the building of school houses as a first duty of the State, he said: "I know the people of North Carolina well enough to know that if we build school houses the people will find a way to get their children to them." Schools were built. Twenty years later citizens who had attended those schools voted millions of dollars to build good roads. Then came

consolidated schools. The educational process bore fruit. Aycock further predicted that if the State would provide educational opportunity for her children she would see undreamed of millions flow into the State's treasury from the earnings of all her people. This has come true.

The time is ripe for the State to again reap the benefits of the educational process and for a "government of cultivated minds" to wisely spend the accumulated funds for the greatest present need, namely, health centers, hospitals, doctors, nurses, and schools.

W. W. EAGLES

PRESIDENT, N. C. FARM BUREAU

MACCLESFIELD, N. C.

I favor the adoption of the Medical Care Commission Plan. All of us know the necessity for improvement of the health of our people. Our rural people want the plan put in operation in the country first because we have fewer hospitals, fewer doctors and fewer clinics than the city people. I hope the Legislature can make an appropriation that will give us a good start on this plan.

JAMES S. FICKLEN

TOBACCONIST

GREENVILLE, N. C.

I favor the Medical Care Commission Program in its entirety because the time has come when we must make medical care available for all of our people. We can not afford to ignore the appeal of the sick and suffering throughout North Carolina. I am satisfied that the industrial workers of this state are losing a substantial sum of money each year because of poor health. The adoption of the plan in its entirety will make hospital beds available in hospitals and health centers in every section of the state, thus assuring a better distribution of medical care and it will assure the training of additional doctors, nurses, technicians, dieticians, and other medical personnel needed in the operation of these facilities. I believe that the state of North Carolina can afford this program and I heartily recommend its adoption.

C. A. FINK

PRESIDENT, NORTH CAROLINA FEDERATION OF LABOR

SPENCER, N. C.

I favor the adoption of the Medical Care Commission Plan in its entirety because:

The first and greatest asset of North Carolina is its Citizens, and the greatest asset of the Citizens, as individuals, is good health. If the individual has good health, then the State as a whole will be healthy. This we know is impossible unless the facilities are provided for the promotion, and maintenance of good health. Therefore, as President of the State Federation of Labor of North Carolina, it is of special privilege to me to wholeheartedly recommend and urge the adoption of this most worthy of all programs our great State may adopt.

It took catastrophe in the form of war to focus public attention on the deplorable condition of health our young manhood was in. It stands to reason if this segment of our citizenship was, and is so desperate, the rest of our population must be even more deplorable. Therefore, to me, our first need, our foremost need, and our greatest need, is good health, and in order that we may have this calls for the united support of all our citizens. . . . No State, County, or City, can give its best if it is sick, and in need of medical and hospital care that cannot be had. . . . Thus it becomes our primary duty, above and beyond the usual call of duty, to do all in our power to remove this great liability as speedily as possible.

I. G. GREER

SUPERINTENDENT, THOMASVILLE BAPTIST ORPHANAGE

PRESIDENT OF N. C. GOOD HEALTH ASSOCIATION, INC.

THOMASVILLE, N. C.

I favor the adoption of the North Carolina Good Health Plan as recommended by the Medical Care Commission. The plan, if put into effect in its entirety, will mean a healthier and a more abundant life for all of our people. As I have said before, North Carolina is too poor to permit bad health. Better health for our people would mean increased production in the factories and on the farm; and thereby, greater savings to industry, and, to individual employees, the guarantee of larger annual incomes. It would mean healthier school children and fewer "repeaters" in the elementary grades which would represent a great saving in state funds.

The funds for this entire program are available. The dividends would be realized in the improved health of children and citizens

who otherwise might be defeated. Money has value in terms of its relationship to life. I have been assigned major responsibilities in an institution where every dollar that comes into our treasury is jealously safeguarded. But no matter from what source the money may come, we have never considered the money more sacred than the health or life of a child. Joseph A. Choate, in speaking to a group of Harvard men once said: "Gentlemen, if you would enjoy your own immortality, do something for people who are in need today in order that they might live more abundantly tomorrow."

The Legislature now assembled in Raleigh is presented a challenge. The manner in which they meet this challenge will determine whether many children of tomorrow will be shackled and defeated by disease, or will be permitted to live healthy, normal and successful lives.

I have faith to believe that this group of legislators will manifest the same courage and foresight shown by leaders in other days with reference to schools and roads. This can be done by effecting legislation that will make it possible to carry out the full program as recommended by the Medical Care Commission.

CLAUDE T. HALL

FARMER AND MEMBER OF STATE BOARD OF AGRICULTURE

ROXBORO, N. C.

I am in favor of a Good Health Program because, next to religion, it is the greatest asset an individual or any people can possess, and because I believe it is our greatest need today. No individual, no state, no nation, is or can hope to be stronger than its health. The strength of all three is good health, nor can either of the three long exist, enjoy prosperity, or render the most valuable service to God or man unless the people have strong minds and bodies.

We spend millions in North Carolina every year for good roads, for alcoholic beverages, for education, for pleasures of various kinds, and yet we spend a very small amount to improve our health so that we can better enjoy the above mentioned things.

It is only after it is too late that we start to giving much thought or spending much money toward building our health or preserving that which we have. The majority of the human race spends the best part of life in the neglect and destruction of health; then, oftentimes too late, spends the remainder of their days and fortunes trying to repair that which should have been preserved in their younger days.

I think it is most significant and encouraging that the pioneers of the Good Health Program caught a vision of the needs of such a program for North Carolina at a time when they are most able to launch such a program.

I wonder if it would not be the part of wisdom, while we are spending millions for health and life insurance which will be en-

joyed by some beneficiary, we should not make a large investment toward building and preserving the health of our present and future citizens.

North Carolina was never in a better position to start a sound health program, so that, along with leadership in various other lines, she should gain first place in building and maintaining a good health program for her citizens.

I believe when our people see and learn the truth about our health conditions, the truth will make us strong and free.

EDNA L. HEINZERLING, R.N.

PRESIDENT, N. C. STATE NURSES' ASSOCIATION

WINSTON-SALEM, N. C.

The members of the N. C. State Nurses' Association recognize the lack of personnel and facilities for better health for all citizens and we are whole-heartedly in favor of adequate maternal care, correction of physical defects in school children, hospitalization of the mentally ill, and the early recognition of the two most insidious diseases—tuberculosis and cancer. The most urgent need now is for more hospital beds in rural areas, additional personnel to staff hospitals and health centers, and the willingness of skilled people to work in out-lying districts. Not until we provide adequate equipment and better living conditions can we expect doctors and nurses to locate in isolated sections of the State. Every citizen claims the right to good health, and the results pay big dividends, such as mental happiness and contentment, greater productivity of much needed equipment and a longer span of life. We are ready and anxious to work for the benefit of all who are ill, and to cooperate in any way we can with the plans of the Medical Care Commission.

GEORGE WATTS HILL

BANKER-DAIRYMAN

DURHAM, N. C.

I am in favor of the North Carolina Medical Care Commission six-point Good Health Plan, because I think it is good, sound, hard-headed business.

I have, therefore, contributed my personal funds and much of my time the past six months to the Good Health Educational Program, in the belief that the improvement

of our health facilities is so immediate a problem that it cannot be postponed.

The Medical Care Commission Program has received careful study by experts and laymen. The taxpayers of North Carolina, large and small, can afford it.

Federal funds, under the Hill-Burton Bill, are paying one-third, the State one-third, and local communities one-third. I do not believe that the local cities and counties will allow the opportunity to slip through their fingers to obtain the needed medical facilities, at a cost to them of only one-third.

There will never be a better time, financially speaking, as the State has the necessary cash in hand.

The program must be carried out in its entirety—hospitals are of no value unless we have the trained personnel to man them. Construction of local hospitals, and the teaching of specialists must be done concurrently.

North Carolina must increase its per capita income. Safeguarding and improving the health of its citizens is the best way to increase their productivity and therefore, the cash income of all the people.

E. L. HILLMAN

PRESIDENT, NORTH CAROLINA COUNCIL OF CHURCHES

ROCKY MOUNT, N. C.

I favor the adoption of the Medical Care Commission Plan in its entirety because it provides medical facilities for every citizen of the state in need of such. Every person deserves to have these available if and when he becomes ill.

Because it provides for all persons in the state regardless of color or creed. There is no discrimination.

Because the plan is held to be reasonable of attainment without sacrificing any essential service in the state—this according to those in the responsible places of leadership in the affairs of state.

Because the plan is in line with good religion, good common sense and good business. More good health will mean more success and more happiness for all the people in our state.

I sincerely hope the General Assembly will deem it wise to implement this plan of the Medical Care Commission as soon as possible.

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Charlotte Observer: "Public Health—A Public Duty—Public health has reached that point at which neither private means, local governments, nor the State can assume the whole burden. All must cooperate with Federal aid to spread the load equally. When this is done, we shall see the average health of our State equal the average in the orphanages."

CLYDE R. HOEY

SENIOR SENATOR FROM NORTH CAROLINA

SHELBY, N. C.

There are two questions of paramount importance in North Carolina today. One relates to providing increased compensation for our school teachers and increased efficiency for our public school system. The other is the absolute necessity of providing increased medical care and attention and making it available for all of the people of North Carolina.

I find myself in hearty accord with the Medical Care Commission plan and hope to see this put into effect as rapidly as the resources of the State will permit.

It is absolutely essential to provide additional hospital and clinic facilities for the various Counties throughout the State, and I thoroughly endorse the idea of State and Federal co-operation with the local units of government in providing these health and medical facilities.

I supported the Bill providing Federal Aid to hospitals passed by the last Congress, and I shall insist upon the necessary appropriations being made by this Congress to aid the State and local units of Government in this work.

I am not in favor of socialized medicine and the best way to prevent the adoption of that policy is for the State and local Governments, with Federal assistance, to provide in their own way to meet the needs of medical care and hospitalization for the people in every section of our State.

J. M. HITCH, M.D.

SECRETARY-TREASURER

WAKE COUNTY MEDICAL SOCIETY

RALEIGH, N. C.

Concerning the "Good Health Program," the Wake County Medical Society, in its regular monthly meeting on January 9, 1947, adopted a motion as follows:

"That the Wake County Medical Society does endorse the complete program of the Medical Care Commission and that the Secretary be instructed to communicate this fact to the State Legislators representing Wake County."

This action was passed by a majority vote.

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Asheville Citizen: "More hospital beds are nedeed in rural areas. More doctors must be found to serve rural people in well-equipped clinics or small rural hospitals."

J. R. HOLLIS

CHAIRMAN, LEGISLATIVE COMMITTEE, N. C. ASSOCIATION OF PUBLIC WELFARE SUPERINTENDENTS

WILMINGTON, N. C.

The North Carolina Association of County Superintendents of Public Welfare approved the program of the North Carolina Medical Care Commission at the time of its inception. We are still of the opinion that all parts of the plan should be adopted and put into effect as soon as possible.

We were forcibly impressed with the inadequate medical care available in North Carolina when we were working with Selective Service during the war and saw the tremendous number of young men rejected as unfit for military service. We felt that had these young men been given proper medical attention in early youth, the majority of them would have been perfectly fit for the armed services or for any adequate vocation. We also have for a long time realized that infant mortality and maternal mortality are entirely too high in North Carolina. Both of the latter items are constantly coming to our attention in our work as Superintendents of Public Welfare, and any action that will relieve the situation is much to be desired.

The Superintendents' Association heartily endorses this program and hopes for an early passage of the needed legislation and adequate provision made to put this plan into operation in North Carolina.

MRS. GURNEY P. HOOD

PRESIDENT, WOMAN'S SOCIETY OF CHRISTIAN SERVICE METHODIST CHURCH

RALEIGH, N. C.

I favor adoption of the Medical Care Commission Plan in its entirety because, to date, it offers the best answer in affording the necessary doctors, nurses, and hospitalization for the people of the State, and N. C. can afford it financially.

West Jefferson Skyland Post: "The 1945 legislature started the ball rolling. It is up to the incoming session to activate these plans. North Carolina has made a record for progress for both schools and roads. A state as progressive as ours cannot fail to solve its number one problem of today, better health for all good citizens."

W. E. HORNER

NEWSPAPER PUBLISHER

SANFORD, N. C.

I favor the Medical Care Commission Plan because good health—better health—is essential to the building of the kind of North Carolina we want it to be. More hospital beds, more doctors, nurses and technicians; more facilities to train these people; and more ample provision to enable the residents of the less wealthy counties of our state to avail themselves of the means of good health—all these are needed and can be provided through adoption of the Medical Care Commission Plan.

MRS. E. N. HOWELL

PRESIDENT, NORTH CAROLINA CONGRESS OF PARENTS AND TEACHERS

SWANNANOA, N. C.

I favor the adoption of the Medical Care Commission Plan in its entirety because:

First, the recommendations of the Commission are based on a detailed and comprehensive study of North Carolina's health needs;

Second, it makes possible the establishment and improvement of facilities in rural communities so necessary if good health is to be within reach of the majority of our citizens;

Third, it provides for some financial aid for the care of indigent patients;

Fourth, loans are made available to student nurses and doctors on a basis which will guarantee more service to rural areas;

Fifth, recent experiences have taught North Carolina's citizens that we must have more doctors and nurses which means an expanded training program;

Sixth, the program seems particularly feasible at this time when federal funds are available on the basis of local and state participation.

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Salisbury Sunday Post: "The *Post*, long ago, expressed itself wholeheartedly in favor of the total of the state medical program, and especially in favor of a state medical center of major proportions where doctors, nurses, and technicians could be trained to fill the crying needs of better health on a state-wide scale."

M. A. HUGGINS

GENERAL SECRETARY, BAPTIST STATE CONVENTION OF NORTH CAROLINA

RALEIGH, N. C.

I favor adoption of the Medical Care Commission Plan in its entirety because the need of a well rounded health program in North Carolina is so obvious that it appears to need little argument in its support. In the second place, it seems to me the Medical Care Commission has made a careful survey of the needs, and has available the best expert advice for the meeting of these needs. In the third place, I favor the program because through its well rounded program hospital service will be provided for people in every section of the State without the necessity of traveling so far in order to get treatment. Then, of course, it is quite apparent that the hospitals and medical centers would be useless without trained personnel. It appears further that the facilities now available for such training are quite inadequate.

MRS. ERNEST B. HUNTER

CHARLOTTE, N. C.

I favor the adoption of the Medical Care Commission Plan in its entirety because I know that our state's material blessings are of little value to her citizens unless their health is good enough to permit them to profit from the many advantages that North Carolina has to offer.

J. FRANK JARMAN

PRESIDENT, THE NORTH CAROLINA ASSOCIATION OF BROADCASTERS

DURHAM, N. C.

After a careful study of the Medical Care Commission Plan I am thoroughly convinced that it should be adopted in its entirety.

The need for hospitals, doctors and nurses is appalling and the great State of North Carolina must not allow the existing conditions to continue.

The Commission's thorough study leaves us but one course to follow. We must get in line so that our boys and girls, our future citizens, can be assured of every possible facility for developing physically. By the same token the adults of our State must have the medical care they deserve in order that they might pursue their daily activities without hindrance from physical worries. The very fact that many of our youngsters were deprived of adequate medical care in the years gone by, makes today's report on adult health needs dreadful.

Nothing is closer to us than our health. We must guard it from birth and our medical plan for prevention and remedy must be second to none. North Carolina must be the nation's Number One Good Health State.

CHARLES R. JONAS

PRESIDENT, NORTH CAROLINA BAR ASSOCIATION

LINCOLNTON, N. C.

I favor adopting the Medical Care Commission plan in its entirety because it is a well balanced program designed to benefit all the people of North Carolina. This plan is perhaps the more carefully thought out program that has ever been presented in this state. It is the result of more than three years of study, investigation and debate by two separate commissions appointed by Governors Broughton and Cherry. It has the approval or endorsement of the North Carolina Medical Society, both political parties, and many professional, civic, religious, business, labor and agricultural organizations in the state. It is significant that every official commission, committee or agency of the state which has considered it has approved the plan in its entirety.

There are those who say they favor the plan as a long range objective but that we can't afford it now. That argument does not appeal to me. If we need the program at all, and if we ever expect to undertake it, we simply cannot afford to delay its adoption. There are several reasons why time is of the essence in this matter. One very sound reason is that the federal funds we expect from the Hill-Burton program will not accumulate to our credit but must be used as they become available. Another and perhaps more important reason is that whenever health is involved, delays are usually costly and always dangerous. If your child is sick, you don't first sit down and calculate the cost of medical attention; you call a doctor or hospital immediately and hope and pray that you will find one able to look after the child, let it cost what it may. And the third reason is that we are today more fortunately situated with respect to finances than ever before. We have a large surplus of funds in the state treasury and I believe we are amply able to inaugurate this plan in its entirety without sacrificing any of the essential services we have come to expect from the state.

Then there are some who say they favor part of the program

but cannot support all of it. This does not seem to me to be a sound position. The program proposed is a well-rounded, balanced program. We don't need hospitals, or doctors, or health insurance; we need MORE HOSPITALS, MORE DOCTORS AND MORE HEALTH INSURANCE. Why build hospitals and health centers all over the state if there are not enough doctors, nurses and technicians to staff them? In my judgment, it is just as essential to create more doctors, nurses and technicians as it is to build more hospitals and health centers and, if we are not going to be able to staff the hospitals and health centers that we propose to build, there does not seem to be much reason to build them.

Some critics of the plan argue that the provision to expand the present two-year Medical School of the University is not necessary because there are already two four-year Medical Schools operating in the state. That argument is like saying we don't need a State University because we have Duke, Wake Forest, Davidson, Catawba, High Point, Elon, Guilford, Lenoir-Rhyne and other great educational institutions. It is like saying we don't need the Wilkinson Boulevard because there already is a road connecting Charlotte and Gastonia. The fact is that the present two-year Medical Schools in the state are not producing enough doctors, nurses and technicians to meet the requirements of the people of North Carolina. Then what is more logical and more reasonable than to say we will expand the present two-year Medical School of the State University into a standard four-year Medical School in order to produce for the people of the state the needed personnel to staff the hospitals and health centers we propose to build?

I do not favor wasting the peoples' substance on wild-eyed schemes. I do not believe it is a mark of progressivism or liberalism to be profligate with public funds. I try to be careful and prudent with my own money and I expect my representatives in the General Assembly to be equally careful and prudent with my tax money. But I also believe an ounce of prevention is worth many pounds of cure. If there is any choice about it, I would much prefer to be extravagant in seeking to preserve my good health than to have to expend my substances seeking to regain my health once I have lost it.

North Carolina is first or near the top of the list of states in so many fields that it is intolerable that we should remain last or near the bottom of the list in so many phases of public health. Today we have an opportunity to inaugurate a dynamic program which will lift us from that unenviable position to our rightful place in the forefront of the states of the Union. And the fine part about it is that if we will but act NOW, the Federal Government will provide one-third of the cost of the program. Instead of saying that North Carolina cannot afford the good health plan, I say that we cannot afford to fail to adopt it in its entirety.

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Wilmington Morning Star: "As long as the national government stands ready to make the broad objectives of the Good Health program attainable, and in view of the fact that North Carolina has long been below par in public health, there can be no sound reason for the legislature to be niggardly."

KAY KYSER

ROCKY MOUNT, N. C.

I am for the adoption of the Medical Care Commission's Good Health Plan in its entirety for many reasons. In the first place, every part of the Plan has been recommended by the Commission only after exhaustive study, extensive survey, and much deliberation. They feel that each individual part of the Plan is vital to the Plan's overall success—that those parts are so interwoven that eliminating any one of them would weaken the entire good health plan. Their opinion is corroborated by . . . The *5-to-2 majority* of the National Committee for Medical School Survey . . . The *unanimous verdict* of the committee of Past Presidents of the State Medical Society . . . *The specific pledge* of the Democratic State platform . . . and The *emphatic endorsement* of this program by some of the foremost medical authorities in the nation. That's good enough for me!

Our ultimate goal is for North Carolina to become the No. 1 health state. To achieve this goal, it will be necessary to do many things *not* included in the Good Health Plan such as strengthening our sanitation laws, enlarging the personnel and facilities of our Public Health Department; we must have compulsory blood and chest examination laws, compulsory physical examination for all school children and most of all, an extensive program of health for adults as well as children. However, I believe all of these things are predicated upon our having places to take our people, medical personnel to care for them and the financial means whereby our people can receive medical care. These are what the Good Health Plan calls for.

The Medical Care Commission and all others who have studied our health problems believe that the elimination of any part of the Good Health Plan will so cripple the other parts that they would not be effective and therefore, I am for adopting the Medical Care Commission's Good Health Plan in its entirety—all of it—and now!

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Progressive Farmer: "Talking about which feature of the North Carolina health and hospital program we might do without is very much like trying to decide which finger you could best do without. We need them all and should insist on keeping them all."

———o———

Charlotte News: "The people of North Carolina understand the nature of the crises in health and are willing to sacrifice to meet it."

W. T. MATTOX

PRESIDENT, ASSOCIATION OF COUNTY SUPERINTENDENTS OF PUBLIC WELFARE

HILLSBORO, N. C.

I favor adoption of the Medical Care Commission Plan in its entirety because each phase of the plan is an essential factor in obtaining the desired health conditions for the state of North Carolina. The object of the Commission, as I understand it, is to bring medical treatment within the reach, both physically and economically, of all the people of North Carolina.

To fulfill this purpose it is essential that the state provide funds to help the indigent patients to meet their medical expense. It is also essential that medical centers and hospitals be made available in the rural districts and within the reach of patients who have not the money or the inclination to travel long distances for hospital treatment. Medical centers and hospitals must have adequate personnel—nurses, doctors, etc., in order to be of service to society. Therefore, I deem it essential that the Commission's recommendation for a four-year medical school at Chapel Hill be established in order to help provide the necessary personnel.

MRS. P. P. McCAIN

SANATORIUM, N. C.

I favor the adoption of the Medical Care Commission Plan because it is a unified whole. We can't have the advantages of any one part without the others. Why have Hospitals and Health Centers without a medical staff? Why have medical staff and Hospitals Beds without some aid to the indigent and without encouraging the people (especially the great middle class which is usually hit hardest by the cost of illness) to have Blue Cross Insurance? Why have Doctors and Nurses and money to pay with and no Hospital Beds?

The greatest opposition comes to making the University of North Carolina Medical School into a Four-Year School. *The real question* however, is *NO MEDICAL SCHOOL OR A FOUR-YEAR SCHOOL*. There are only four two-year medical schools in the country now with two of these in the process of being changed to four-year schools. One has only to look at the statistics to see that our State will be in a terrible plight if our *State* Medical School is closed. Is that what some of the opponents want?

We have had one child to finish the two years at the University Medical School (and we have another to enter in 1948) and we know how hard it is to get from Chapel Hill to Watts Hospital in Durham for the clinical work. We know, too, the anxieties and uncertainties about transferring for the third and fourth years. We have first-hand knowledge also of how difficult it is to get and keep good teachers in a two-year school. We've had as well prepared students in the past as could be found because we had men like Dr. Manning, Dr. MacNider, Dr. Bullitt, Dr. Berryhill and many others who stayed at the Medical School because they loved it, but few younger men have that love. Younger men want a four-year school so as to have more facilities along their specialties—then they want *SECURITY* which they don't have in a two-year school and which may soon close completely. Who knows but that if we decide to leave the University Medical School a two-year school those men in Chicago won't tell us they won't recognize us? They did just that to us a few years ago and with the help of Wake Forest (then also a two-year school) we were able to stave off the closing day. Yes, we need the four-year school to train doctors for North Carolina.

We need to continue the loan fund for white and Negro medical students. We need to continue to pay *AS THE STATE HAS FOR SEVERAL YEARS* for the medical training for Negroes (the approximate cost for students at Chapel Hill) until such time as the number of Negro students will be great enough for *the State* to have a medical school for Negroes. It will be years for obvious reasons before there will be many Negro medical students, but we should seek to eliminate these reasons as fast as possible.

We need to educate our people along health and sanitary lines —most positively—but no amount of education can remedy the defects in the 50,000 "repeaters" now in our State schools who could be normal if these defects were corrected. It will take Hospital Beds, doctors, nurses, and other personnel, and the other proposals of the Commission to make these North Carolina children normal.

We are proud of North Carolina's record in its eradication of disease in cattle—thanks to funds appropriated by previous legislatures—and we are confident that this Legislature will do as well in treating the citizens of our State so we can sing with a new and greater zest "Hurrah, Hurrah, The Good Old North State."

JAMES G. K. McCLURE

PRESIDENT, FARMERS FEDERATION

ASHEVILLE, N. C.

North Carolina has carried through two great movements during the past three decades. One of these movements is for good roads, the second is for good schools, and now North Carolina is arousing herself to carry through a movement for good health for all the people of the state.

The plan worked out by the Medical Care Commission is de-

signed to offer the opportunity of good health to all the people of the State of North Carolina. Everyone realizes what a drain sickness and ill health can be, not only on the individual, but on the entire state. If a man is not given proper hospital or medical care when some disaster overtakes him, he may thereafter become a permanent invalid and be a permanent burden on his family and on the state. He is not only a drain on the state, but it deprives the state of the constructive contribution which this citizen would have made. The plan of the Medical Care Commission spreads the opportunity for good health to all parts of the state.

As a worker in the rural areas of the mountain counties of North Carolina, I recognize the tremendous importance of this plan for a better civilization in our rural districts. Local hospitals and rural health centers should work miracles in checking causes of ill health before ill health becomes chronic and in maintaining the health of the men and women who make the homes and raise the children in the rural districts of North Carolina.

L. P. McLENDON

ATTORNEY-AT-LAW

GREENSBORO, N. C.

I favor the adoption of the Medical Care Commission's Plan in its entirety, because it is an entire and complete plan to provide medical care and hospitalization for all the people of North Carolina; each part of the Plan is largely dependent upon the other parts, and it provides both the facilities and the personnel to make it work and produce the result sought, namely, better health for all our people.

ERBIE M. MEDLIN

PRESIDENT, NORTH CAROLINA DENTAL SOCIETY

ABERDEEN, N. C.

I personally think there is a great deal of virtue in the recommendations of North Carolina Medical Care Commission and I am favorable toward them providing the state of North Carolina can afford it without jeopardizing any other essential functions of the state government.

J. VIRGINIA MILES, R.N., M.N.

EDUCATIONAL DIRECTOR FOR SCHOOLS OF NURSING IN NORTH CAROLINA
COUNSELOR, N.C.S.N.A.

RALEIGH, N. C.

I favor adoption of the Medical Care Commission Plan in its entirety because North Carolina is lacking in both facilities and personnel for adequate medical care of its citizens.

In the nursing profession alone, we have a great deficit in every phase of our work—qualified nurse administrators, qualified nurse educators, staff nurses in our hospitals, public health nurses and students in our schools of nursing. Although this situation is national in scope, we do know that potential nurse leaders and educators are leaving North Carolina to seek the necessary educational facilities in other states and that they are not returning to our hospitals, health centers and schools of nursing. It is also true that students do not enter the nursing schools of our state but go to schools in which they are able to obtain a college degree.

One look at our over-worked and over-crowded health facilities of today will convince us that more hospitals and health centers are needed, but without more adequately prepared doctors, nurses, and technicians, it will be futile to plan for expanded health facilities.

CLYDE A. MILNER

PRESIDENT, NORTH CAROLINA COLLEGE CONFERENCE

GUILFORD COLLEGE, N. C.

I favor adoption of the Medical Care Commission Plan in its entirety because the improvement of health in our state is one of the paramount needs today. Poor health and inadequate medical care are basic causes of other problems—educational, economic, and social.

At the annual meeting of the North Carolina College Conference, a brief statement concerning the health needs of North Carolina and the program of the North Carolina Good Health Association were presented. The Conference went on record as approving and supporting this program in every possible way. I am certain that the educational leaders of North Carolina are eager to see this project promoted and implemented by this legislature.

V. G. MOSER

PRESIDENT, N. C. ASSOCIATION OF PLUMBING AND HEATING CONTRACTORS, INC.

ASHEVILLE, N. C.

I favor the adoption of the Medical Care Commission plan in its entirety because it is, without a doubt, the most urgent need of the people of our State; because the health of our people and especially of our children, is a matter that vitally affects every one of us. No matter how many material possessions we may have; no matter how fine our homes, our schools, our roads, or other things, if we do not have healthy bodies and minds, we cannot enjoy those things.

Speaking as a representative of the Plumbing industry in our State, I wish to emphasize the fact that we realize very keenly the close relationship between good Plumbing and good health. We know that much sickness and disease may be spread by impure water connections and by the careless and improper installation of sewer lines and sewage disposal systems. We, of the Plumbing industry, gladly pledge our whole-hearted support to the splendid program offered by the North Carolina Medical Care Commission, both for the passage of the necessary legislation, and for the execution of the various projects outlined in that program, after they have been authorized. We furthermore pledge our cooperation and our best efforts to provide for the people of our State, absolutely safe and modern sanitary systems, in order that the spread of sickness and disease from such sources may be entirely abolished.

MRS. MARIE B. NOELL, R.N.

EXECUTIVE SECRETARY, NORTH CAROLINA STATE NURSES' ASSOCIATION

RALEIGH, N. C.

I favor adoption of the Medical Care Commission Plan in its entirety because the studies of the temporary and permanent Commissions over a three-year period reveal that many additional hospitals, health centers, physicians, nurses, technicians and much health education are needed in North Carolina if our citizens are to have adequate assistance to stay well and healthy and skilled care when they are ill.

There is a great shortage of nurses now—we need approximately one thousand additional nurses in North Carolina today—but with additional hospitals and health centers many, many more nurses will be needed to staff them. A four hundred bed teaching

hospital and medical center as a part of the proposed expanded University Medical School will provide nursing education on the basic and graduate levels; and such an institution will within a short time furnish many additional graduate nurses who will be equipped to give all types of nursing care and provide an adequate number of well prepared teachers for the forty-six schools of nursing in this state.

ETHEL PARKER

FARMER AND MEMBER STATE BOARD OF AGRICULTURE

GATESVILLE, N. C.

I favor the adoption of the Medical Care Commission Plan in its entirety not only because we need it as shown by statistics compiled by able men and women, with the advice of experts: not only because we feel so keenly that neglect brought about the great number of draft rejections in the war: but also because our state has never been more able to put every citizen within the safe reach of medical care.

I believe the Legislature of 1947 in making the appropriation for the Medical Care Program will be making its best investment in well and happy humanity.

HERBERT PEELE

PRESIDENT, N. C. PRESS ASSOCIATION

ELIZABETH CITY, N. C.

The North Carolina Press Association favors adoption of the six-point Medical Care Commission Plan in its entirety because the present health conditions in North Carolina must not be allowed to continue. Forced to admit to such facts as "highest percentage of draft rejections in the nation," "33 counties without a hospital bed," and "45th state in the number of doctors per 1,000 population," there is no doubt as to North Carolina's immediate need for overall improvements. Existing conditions are alarming—action is imperative.

Our state faces no more alarming status than that revealing the health deficiencies of its people, and the scarcity of facilities for medical care.

By adopting the Good Health Program now, we will provide doctors, hospitals, and health centers to thousands of citizens not having access to them at the present time.

The North Carolina Press Association voted last September to write every member newspaper asking fullest possible cooperation in publicizing the emphasis of the Good Health Association. The Association also appointed a three-man committee to serve as councillors to the North Carolina Good Health Association in its current campaign in matters relating to publicity.

The Association believes the Good Health Plan of the Medical Care Commission is the best solution to our state's health hazards. We shall continue to support it in every way possible.

C. W. PHILLIPS

PRESIDENT, THE NORTH CAROLINA EDUCATION ASSOCIATION

GREENSBORO, N. C.

I favor the adoption of the Medical Care Commission plan because I think it impossible to separate the health program of our state from education. They go hand in hand and must be planned and promoted together if we are to continue to develop and become a greater state.

JACOB M. PICKLER

PRESIDENT, N. C. FARM AND FARM WOMEN'S CONVENTION

NEW LONDON, N. C.

I favor adoption of the Medical Care Commission Plan because health conditions in North Carolina are far below the average of many other states. To correct this condition we must build hospitals and health centers in counties where no hospital facilities are available and improve many now existing.

According to a statement made by the Poe Commission 33 rural counties have no hospital facilities of any kind. Since 73 per cent of our poeple live in rural communities and have one doctor for each 3,600 people, many more doctors, nurses and technicians must be trained to take care of this great need. In order to provide doctors, nurses and technicians for these hospitals and health centers, facilities must be made available for training them. Therefore, I heartily endorse the recommendation of the Medical Care Commission in the erection of adequate hospital and health center facilities and the expansion of the Medical School.

CLARENCE POE

EDITOR, PROGRESSIVE FARMER

I favor the adoption of the Medical Care Commission plan in its entirety because there seems to be no question about the soundness of any feature of it except location and need for the Medical School—and with respect to it, there is this evidence:

1. The Legislature itself said that a jury of nationally known experts should recommend location. We not only asked the experts to advise us as to location but also as to need.

2. By a vote of 7 to 2 (better than 3 to 1) these experts said, "There is need—and Chapel Hill is the place"—and the chairman of the experts was President of the Medical College of Virginia whose own college would have benefited by a different decision.

3. Going even further than the Legislature suggested, the Medical Care Commission next referred the matter to five past presidents of the State Medical Society. They unanimously also said, "There is need and Chapel Hill is the place."

4. The question was next fully debated before Medical Care Commission members and by a vote of 13 to 4 (better than 4 to 1) they said, "There is need—and Chapel Hill is the place."

5. The 1946 Democratic State Convention unanimously (2,000 to 0) said:

"We endorse the progressive action of the 1947 General Assembly in setting up the machinery providing for a statewide medical care and hospital program for the people of North Carolina, which includes—expansion of the two-year Medical School of the University of North Carolina into a standard four-year Medical School with adequate hospital facilities . . . THIS PROGRAM MUST BE SUPPORTED AND DEVELOPED."

As a Democrat myself I cannot believe a Democratic Legislature will violate this solemn Democratic pledge unanimously approved by their own state convention, followed by a 5-to-2 vote by the jury selected by a Democratic Legislature and a 13-to-4 vote by the Medical Care Commission named by a Democratic governor.

RALPH C. PRICE

PRESIDENT, JEFFERSON STANDARD LIFE INSURANCE COMPANY

GREENSBORO, N. C.

It goes without saying that I am in favor of good health, as that is the bedrock foundation of our citizenship. We cannot utilize the full advantage of our total population unless they are in good health.

I think the program outlined by the Medical Care Commission is very comprehensive, and one that deserves careful at-

tention by our State Legislature. I feel sure they are going to do a good job in this respect, and I think we, as citizens, should let them know that we are behind them 100% so that they can approach the subject in an unbiased manner. They must act as they see fit, and we must have confidence in our Legislature, not only in this matter but in all other matters.

I have been impressed with the time and attention that Kay Kyser has given this matter, and I think we owe him a vote of thanks. I have listened to his records on several occasions, and I think it is remarkable what he has done in this respect.

BISHOP CLARE PURCELL

THE METHODIST CHURCH

CHARLOTTE, N. C.

GOOD HEALTH FOR NORTH CAROLINIANS

After many months of study and planning the North Carolina Medical Care Commission has presented to the Legislature a statesmanlike report which will embody the necessary action by which North Carolina's number one problem, good health, will be solved. The State was greatly shocked when the Broughton Commission brought to light the real conditions in North Carolina. When it became known that North Carolina had the largest percentage of all the states of rejection for service in the Army and Navy, our people resolved to do something about it. The present Legislature has an opportunity for service to North Carolinians such as few former Legislatures have had. No better investment can be made of surplus funds now in the treasury. To improve the health of human beings is a very effective way of increasing the wealth of human beings. Long has North Carolina held leadership among Southern states in the matter of highways, education, and industrial development. Now it has opportunity to take leadership in the field of health. The people will applaud hearty approval by the Legislature.

E. L. SANDEFUR

C.I.O. STATE REPRESENTATIVE

WINSTON-SALEM, N. C.

I favor the adoption of the Medical Care Commission Plan in its entirety because:

1. It is a carefully-thought-out plan, sincerely proposed by citizens of North Carolina who understand our needs and whose experience in varied fields convinces them that this plan offers the most practical and satisfactory solution to our health problem.
2. The several recommendations of the Medical Care Com-