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Temporal Variations in School-Associated Student Homicide and Suicide Events — United States, 1992–1999

Recent, widely reported violent deaths associated with schools have led many adults to believe that a school shooting could occur in their community and many children to express increasing concern about their own safety at school (*1*). CDC, in collaboration with the U.S. Education and Justice departments, has been tracking school-associated violent deaths* since the 1992–1993 school year (*2*). To evaluate whether the risk for school-associated violent death varies during the school year, CDC analyzed monthly counts of school-associated homicide and suicide events that occurred among students in elementary and secondary (middle, junior high, and senior high) schools in the United States. This report summarizes the results of these analyses, which indicate that student homicide event rates are usually highest near the start of the fall and spring semesters, and suicide event rates are highest during the spring semester. These findings can assist school personnel in planning and implementing violence-prevention programs.

For these analyses, a school-associated violent death event was defined as a homicide or suicide of a student in which the fatal injury occurred 1) on the campus of a functioning public or private elementary or secondary school in the United States, 2) while the victim was on the way to or from regular sessions at such a school, or 3) while the victim was attending or traveling to or from an official school-sponsored event. Events resulted in the death of at least one student but may have included the deaths of nonstudents (e.g., faculty, school staff, family members, and community residents). Events were identified through a systematic search of two computerized newspaper and broadcast media databases (Lexis-Nexis and Dialog) (*3,4*). To confirm events, a qualifying interview was conducted with at least one law enforcement or school official familiar with each event.

Student homicide and suicide event rates were analyzed individually for the 10 months that define a typical school year (September–June). Events that involved the homicide of a student followed by the suicide of a student perpetrator were included in each analysis. Event totals for each month were calculated by summing over the 7 school years in the study period. For both homicide and suicide events, the relevant exposure period in each month was based on the total number of school days in that month over the entire 7-year period, estimated by inspection of several school calendars selected from each region of the country. For each event type, the number of events per school day was calculated for each month in the school calendar and plotted to allow visual assessment of trends.

*Any homicide, suicide, legal intervention (victim killed by police officer in the line of duty), or unintentional firearm-related death.

Student Homicide and Suicide Events — Continued

Poisson rate models were used to evaluate the trends over the school year. Each model was restricted to one monthly time-trend variable and one semester transition variable to account for the apparent increase in event rates following the semester/holiday break that usually occurs in late December through early January.

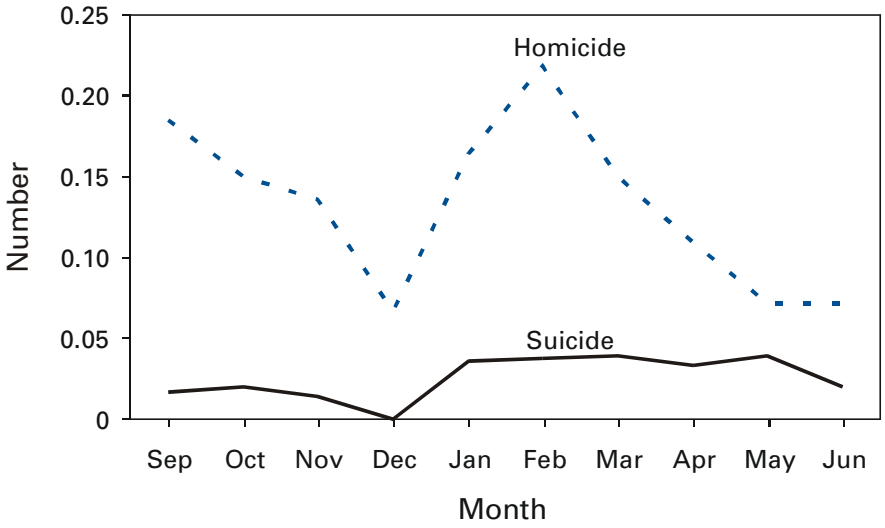
For the 7 school years during September 1, 1992–June 30, 1999, 209 school-associated violent death events occurred that involved either the homicide or suicide of a student. During the 7 school years of the study period, an average of 0.14 school-associated homicide events occurred each school day (one event every 7 school days) (Figure 1). For homicide events, rates decreased during each semester (monthly change in log rate: –0.2; p=0.0002) and increased markedly in association with the transition between the fall and spring semesters (increase in log rate: 0.98; p=0.001). These findings indicate that homicide event rates were relatively high near the beginning of the school year, gradually declined during the fall semester, and exhibited a similar pattern during the spring semester.

For suicides, an average of 0.03 events occurred each school day (one event every 31 school days). The estimated Poisson rate model for suicide events involved a nonsignificant time-trend variable. As a result, this variable was subsequently dropped and the resulting simplified model, which included only the semester transition variable, suggests that the suicide event rate was higher during the spring semester than the fall semester (increase in log rate: 1.0; p=0.0103).

Reported by: Safe and Drug Free Schools Program, US Dept of Education. National Institute of Justice, US Dept of Justice. Div of Violence Prevention and Office of Statistics and Programming, National Center for Injury Prevention and Control, CDC.

Editorial Note: The findings in this report suggest significant systematic temporal variations in school-associated student homicide and suicide events. Student homicide event rates were highest near the start of each semester and then declined over the following months. In comparison, suicide event rates did not show any significant variation within semesters, but the overall rate was significantly higher in the spring semester than in the fall semester.

FIGURE 1. Number of student homicide and suicide events per school day, by month — United States, 1992–1999 school years



Student Homicide and Suicide Events — Continued

Several possible explanations exist for the relatively high rates of school-associated homicide events at the start of each semester. First, conflicts that started either before or during the semester/holiday break may have escalated into lethal violence when students returned to school for the start of a new semester. Second, the start of a new semester represents a time of considerable change and stress for students, requiring them to adapt to new schedules, teachers, and classmates, which may contribute to violent behavior. For these reasons, schools should consider policies and programs to facilitate adjustment of students during this transitional period. Violence prevention strategies could include enhancing the social skills of students through classroom curricula, improving the social climate of the school by training teachers and administrators, and providing a safe environment through use of security measures (*5–8*). Strategies such as these may prevent school-associated homicides by helping students avoid new conflicts and resolve existing conflicts in a nonviolent way.

The findings on suicide are consistent with other studies that have shown increased suicide rates in the general population during the spring (*9*). Programs designed to prevent suicide and suicidal behavior among students should recognize that the spring semester is the period of highest risk. The Surgeon General recommends training teachers to recognize students that show signs of risk for suicide and refer them to a mental health professional for assessment and treatment (*10*). Using schools as access and referral points for mental health services can enhance community-care resources for students at risk for suicide.

The findings in this report are subject to at least two limitations. First, because events were identified from news media reports, any event not reported in the media would not have been included in this study. Most homicide events receive extensive media attention; however, news media coverage of suicides may be limited or discouraged. If underreporting of suicides did occur, coverage probably did not vary by time of year and would not account for the higher rate observed during the spring semester. Second, because the suicide event trend analysis is based on a small number of reported events, results should be interpreted with caution.

Prevention programs can be effective in preventing youth violence (*6*). Effective programs often focus on both individual risk factors and environmental conditions that may predispose young persons toward violent behavior. By describing temporal variations in school-associated student homicide and suicide events, this report provides information that can assist school administrators and faculty in planning the timing and focus of violence prevention programs.

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Effectiveness of a Middle School Vaccination Law — California, 1999–2001

In 1996, the Advisory Committee on Immunization Practices, the American Academy of Pediatrics, the American Association of Family Physicians, and the American Medical Association recommended a routine health-care visit for adolescents aged 11–12 years (*1*). During this visit, adolescents not fully vaccinated should receive up to four recommended vaccines (hepatitis B, a measles-containing vaccine [MCV], varicella, and tetanus-diphtheria) and other preventive services and counseling. Because many adolescents are not up-to-date for all of these vaccines, 43 states have developed middle school entrance requirements or laws for one or more of these vaccines. Since 1997, CDC, in collaboration with the Pre-Teen Health Project in San Diego, California, has evaluated the impact of the state's middle school vaccination law, which requires students entering seventh grade on or after July 1, 1999, to have documented receipt of three doses of hepatitis B and two doses of MCV or to have obtained a written exemption based on personal beliefs or medical grounds. This report summarizes the results of that analysis, which indicate that when school entrance requirements are enforced, high vaccination coverage can be achieved.

During the 1999–2000 school year, the law affected 464,476 seventh-grade students in California, including 38,875 in San Diego County. For this analysis, three different surveys were used to assess the impact of changes in the vaccination law. First, to estimate baseline coverage, a countywide telephone random-digit–dialed vaccination coverage survey of fifth and sixth graders was conducted during April–June 1998 in San Diego County (*2*). Second, to evaluate compliance with state school vaccination requirements, California requires each school to report coverage as of October of each year, based on records obtained for every enrolled student. Finally, health-care officials confirm these results by reviewing vaccination records in randomly selected schools statewide during February–April (*3*). During the 1999–2000 and 2000–2001 school years, 199 and 163 schools, respectively, had their vaccination records validated statewide.

In the 1998 baseline telephone survey of 741 households with adolescents in San Diego County, vaccination history was verified through the parent-held records of 203 fifth and sixth graders (*2*). Of these, 142 (70.0%) had received two doses of MCV, 32 (15.8%) had received three doses of hepatitis B, and 27 (13.3%) had received both vaccines.

During October 1999, data from all 315 San Diego County schools with seventh-grade students (38,875 seventh graders) indicated that 36,005 (92.6%) students had received two doses of MCV, and 26,614 (68.5%) had received three doses of hepatitis B vaccine. Overall, 26,110 (67.2%) students were in compliance with the law by vaccination and 691 (1.8%) by exemption. Of 12,074 adolescents not in compliance,10,814 (89.6%)

Middle School Vaccination Law — Continued

were in the process of completing the three-dose hepatitis B series. Coverage continued to increase through the end of the school year as unvaccinated students completed the three-dose hepatitis B series. Similar coverage levels were achieved statewide during October 1999 and increased by the time of the review during February–April 2000 (Table 1). In October 2000, the beginning of the second year the law was in effect, coverage was higher than in October 1999 (Table 1).

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Editorial Note: As of July 2001, of the 43 states with middle school vaccination laws, 27 required students entering middle school to be fully vaccinated against hepatitis B, and 41 required students to have received two doses of MCV. The findings in this report indicate that school vaccination laws are an important strategy for promoting universal coverage with hepatitis B and MCV among an adolescent population. Although the passage of a vaccination law is an important step in increasing coverage, cooperation by the public health community in enforcing the law is essential for successful implementation (*4*). San Diego County achieved a high level of coverage through monitoring and close cooperation with schools, frequent reminders to parents, and exclusion of students from school when necessary.

The 1991 recommendation for universal infant vaccination with hepatitis B vaccine and state requirements for proof of vaccination at kindergarten entry produced a cohort of children in the United States who are highly vaccinated against hepatitis B. However, in 1998, when only eight states had hepatitis B vaccination coverage laws for middle school students, national coverage for hepatitis B vaccine among persons aged 13–15 years with a vaccination record was an estimated 27.3% (CDC, unpublished data, 2001). Even among adolescents enrolled in prepaid health-care plans, coverage remains low in the absence of a law (*5*).

TABLE 1. Percentage of students in compliance with the California seventh grade vaccination law and antigen-specific coverage with hepatitis B vaccine (HepB) and measles-containing vaccine (MCV) — California, 1999–2000 and 2000–2001 school years

Characteristic	October 1999*	February–April 2000†	October 2000*	February–April 2001†
Compliant with law	66.7%	90.0%	70.9%	89.5%
3 Doses HepB and 2 Doses MCV	65.1%	87.2%	69.5%	87.7%
Exemption	1.6%	2.7%	1.5%	1.8%
Medical	0.2%	0.2%	0.2%	0.2%
Personal	1.4%	2.5%	1.3%	1.6%
Not compliant	33.3%	10.0%	29.1%	10.5%
Individual vaccine coverage				
3 Doses HepB	70.6%	89.9%	73.2%	91.4%
2 Doses MCV	91.4%	96.5%	95.3%	96.4%

*State Mandated Immunization Survey.
† State School Selective Review.

Middle School Vaccination Law — Continued

A statewide evaluation of a middle school vaccination law in Florida indicated that, following implementation of changes to the Florida Administrative Code requiring adolescent vaccinations, 61.8% of students were vaccinated fully with three doses of hepatitis B within 3 months of the start of the 1997 school year (*6*). However, no mechanism was in place in Florida to determine the number of students that had completed the series of three doses before or after that time in the school year.

The success of voluntary hepatitis B vaccination programs does not necessarily predict sustainable large-scale implementation. In a pilot program in San Diego County during 1993–1995, 61% of fourth through ninth graders in 16 schools in San Diego County were vaccinated (*7*). However, by 1998, countywide coverage was only 15.8% among fifth and sixth graders (*2*).

Hepatitis B vaccination is especially important for adolescents because approximately 9% of hepatitis B occurs in adolescents and an additional 45% in persons aged 20–29 years (*8*; CDC, unpublished data, 2001). Adolescents also should be up-to-date with two doses of MCV because interruption of measles transmission in the United States during the 1990s was a result of increased coverage and the administration of a second dose of MCV to children and adolescents (*9*).

The findings in this report are subject to at least three limitations. First, the findings are subject to the effect of confounding because it was not possible to assess changes in coverage among seventh graders that would have occurred in the absence of a law. Second, because three methods were used to assess coverage (random-digit–dialing, school reporting, and on-site record reviews), results may differ from those found if the same method was used at each point in time. Finally, only confirmed vaccination histories were used in the telephone survey, and most parents surveyed could not find their child's vaccination record.

In California and Florida, the two states in which middle school vaccination requirements have been evaluated, the laws resulted in a substantial increase in hepatitis B vaccination coverage and, in California, high second dose MCV coverage (*6*). The effectiveness of the California law is consistent with evaluations of vaccinations required for school entry in other age groups, suggesting that vaccination requirements and laws are an effective means of protecting young persons in all age groups from vaccine preventable diseases (*4*).

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Middle School Vaccination Law — Continued

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Effectiveness of School-Based Programs as a Component of a Statewide Tobacco Control Initiative — Oregon, 1999–2000

With funds available from revenue generated by a voter-initiated ballot measure to increase the state cigarette excise tax (*1*), the Oregon Health Division (OHD) created the Tobacco Prevention and Education Program (TPEP) in 1997. Coalitions in all Oregon counties, a countermarketing campaign, a statewide tobacco cessation quitters' helpline, and competitive grants to community groups, tribal associations, and school districts are supported by TPEP (*2*); 12% of TPEP's $8.5 million annual funding was used to implement CDC's *Guidelines for School Health Programs to Prevent Tobacco Use and Addiction* (*3*) in 23 school districts or consortia of districts. Data from annual school-based surveys conducted to monitor adolescent risk behavior indicated that from 1999 to 2000, 30-day smoking prevalence among eighth grade students declined more in funded schools than in a comparison group of nonfunded schools. The declines were significantly greater among schools with high and medium levels of implementation. These results suggest that comprehensive school-based programs can be an effective component of statewide antitobacco efforts.

Data on smoking behavior among students were collected by OHD from either the Oregon Public School Drug Use Survey (OPSDUS) questionnaire or the Youth Risk Behavior Survey (YRBS) questionnaire. In 1999, 49 (53%) of 93 funded schools and 61 (25%) of 246 nonfunded schools used the YRBS questionnaire. In 2000, 58 funded schools and 47 nonfunded schools used either the OPSDUS or YRBS questionnaires. All analyses were based on data from 38 funded schools and 14 nonfunded schools that participated in both 1999 and 2000. Eighth graders were selected for analysis because TPEP's most intensive interventions targeted middle schools, which meant that eighth graders in 2000, who were seventh graders in 1999, had been exposed to the program for 2 years. Smoking prevalence for 1999 and 2000 was measured in both funded and nonfunded schools, and multivariate logistic regression was used to compare the 2000 difference in prevalence between the two groups of schools. Prevalence in 2000 in schools with high, medium, or low program implementation scores also was compared with 2000 prevalence in nonfunded schools. Among the 52 schools, 1942 (55%) of 3519 eighth graders surveyed attended funded schools in 1999. In 2000, 4089 (74%) of 5556 eighth graders surveyed attended funded schools. Funded schools were required to conduct an eighth grade student census; nonfunded schools participated on a voluntary basis. The number of participating students varied as a result of differences in sampling protocol between the two surveys.

Without knowledge of the school survey results, each funded school district was categorized on cumulative implementation (progress before and during funding) of six areas identified in CDC guidelines (*3*): tobacco-free school policies, family involvement, community involvement, tobacco prevention curriculum instruction, teacher/staff

Tobacco Control Initiative — Continued

training, and student tobacco use cessation support. Tobacco-free school policies were assessed by summing the number of elements completed out of 19 (*3*). Family involvement and student tobacco use cessation support were assessed by summing the total completed out of five criteria in each of two components (*3*). Community involvement was measured by whether the district sent a representative to community tobacco coalition meetings; teacher/staff training was assessed by whether the district had provided training during the survey period; and tobacco prevention curriculum instruction was assessed by the implementation of a CDC-identified curriculum. The quartile score for the first three areas (scored one to four) was added to the dichotomous measures of the latter three areas ("yes" was scored zero and "no" was scored one) for a final score that ranged from three (best score) to 15 (worst score). Based on natural cut-off points in the distribution of scores, the schools then were classified as low (nine–15), medium (six–eight), or high (three–five) on the six areas. Of the 38 participating funded schools, 14 were in low-ranked districts, 15 were ranked medium, and nine were ranked high on implementation criteria.

Both the YRBS and OPSDUS self-report questionnaires were administered anonymously to all students in the participating eighth grade classrooms. The YRBS question used to determine smoking status was "During the past 30 days, on how many days did you smoke cigarettes?" The OPSDUS question was "How frequently have you smoked cigarettes during the past 30 days?" Students who indicated that they had smoked on $\geq$1 days were classified as smokers on each survey.

In 1999, no statistical differences were observed in student or school characteristics, including eighth grade smoking prevalence, in funded versus nonfunded schools. The 30-day smoking prevalence decreased from 16.6% in 1999 to 13.0% in 2000 (p=0.002) in funded schools and from 17.0% in 1999 to 15.7% in 2000 (p=0.47) in nonfunded schools. Stratified by implementation level in 1999 and 2000, changes in prevalence among eighth grade students were larger in schools in districts with high (from 14.2% to 8.2%) or medium (from 17.8% to 13.9%) ratings; changes in smoking prevalence in schools in districts with low ratings (from 17.1% to 15.6%) were almost equal to those in nonfunded schools (from 17.0% to 15.7%) (Figure 1).

Logistic regression was conducted to compare prevalence in funded and nonfunded schools and was adjusted for respondent sex, other substance use (e.g., alcohol, cocaine, marijuana, and inhalants), school size, school geographic location in state, and socioeconomic status of each school. Based on the regression model, students in the funded schools in 2000 were approximately 20% less likely to smoke (odds ratio=0.8; 95% confidence interval [CI]=0.7–1.0*) compared with students in nonfunded schools. School funding status in 1999 was not associated with student smoking prevalence. Based on similar multivariate logistic regression analyses using 2000 results, the odds of an eighth grade student reporting smoking during the past 30 days were lowest among schools in districts with high or medium cumulative implementation (Table 1).

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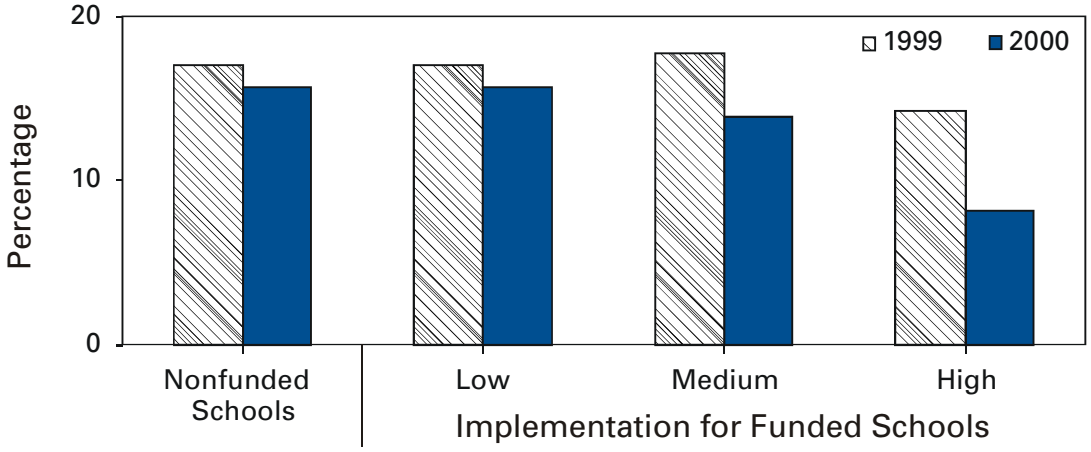
Editorial Note: The findings in this report suggest that a comprehensive school-based tobacco prevention program that includes tobacco-free school policies and community involvement as one component of a statewide tobacco program may contribute to

* Values rounded to one decimal place, but CI did not include 1.0.

Tobacco Control Initiative — Continued

FIGURE 1. Percentage of eighth grade public school students who reported smoking during the past 30 days, by tobacco use prevention program implementation scores — Oregon, 1999 and 2000*



*1999 data from Youth Risk Behavior Survey (YRBS) questionnaire, and 2000 data from either the YRBS or the Oregon Public School Drug Use Survey questionnaire.

TABLE 1. Odds ratios for completeness of program implementation and reduction in smoking prevalence — Oregon, 2000

Completeness	No. schools	No. students	Smoking prevalence (%)*	Odds ratio	(95% CI†)
Unfunded	14	1467	15.7%	ref	—
Lowest ranked	14	1303	15.6%	1.0	(0.8–1.3)
Medium ranked	15	1725	13.9%	0.8	(0.6–1.0)§
Highest ranked	9	1061	8.2%	0.7	(0.5–0.9)

* Past 30 day prevalence of smoking adjusted for sex of respondent; other substance use; size, region, socioeconomic status of school; and school clustering effect.
† Confidence interval.
§ Values rounded to one decimal place, but CI did not include 1.0.

reductions in current smoking among eighth graders (*3*). The significantly greater declines in smoking prevalence in the schools that rated high and medium on implementation criteria emphasize the importance of monitoring activity in funded school programs and the need for ongoing assistance to facilitate implementation of evidence-based recommendations (*3*).

The findings in this report are subject to multiple limitations. Two different student surveys, each with slightly different questions, were used to measure prevalence. Question wording and context in the questionnaires may have affected responses (*4*). Funded districts self-selected to apply for the competitive grants to implement the tobacco prevention program and represented approximately one third of the public school students in Oregon. Among them, only 38 of 93 schools conducted school-based surveys in both 1999 and 2000. The nonfunded schools also represented a self-selected sample, and the 14 nonfunded schools with survey data from both 1999 and 2000 represented only 6% of all nonfunded Oregon schools. The funded and nonfunded schools may have differed in unmeasured characteristics (e.g., the effectiveness of a county coalition's antitobacco activities) that may have influenced 2000 smoking prevalence. In the multivariate

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analyses, sample clustering by school was represented in the analysis; however, variable sampling rates within each school could not be accounted for because information on these rates was unavailable. Student smoking prevalence was based on self-reports, and in schools with stronger programs, students might have underreported smoking because of stronger antismoking norms. No information was available on the student response rate for the schools in this study; however, the average student response rate for Oregon surveys using the YRBS questionnaire has been 78%. Changes in smoking prevalence from 1999 to 2000 were based on comparisons of cross-sectional samples of eighth graders rather than on a longitudinal cohort. Measurements of program implementation were based on coordinator self-reports and, although these reports assessed policies for a range of characteristics, they did not include measures of policy enforcement, and the self-reports could not be validated externally. Finally, the results of this study were based on a comparison of only 2 years of data, and further surveillance is necessary to confirm trends and the impact of this school-based program.

The implementation of a tobacco prevention curriculum alone may be insufficient to prevent cigarette smoking among adolescents (*5*). CDC recommends a combination of tobacco-free school policies and an evidence-based curriculum linked to communitywide programs involving families, peers, and organizations. School-based activities are most effective when integrated with countermarketing campaigns and community-based activities (*6*). Several states, including Oregon, have reported declines in youth smoking rates after implementing multicomponent tobacco prevention and control efforts (*2,7–9*). Consistent with CDC's *Best Practices for Comprehensive Tobacco Control Programs* (*10*), the data in this report suggest that school-based programs can be an effective element of statewide tobacco prevention and education.

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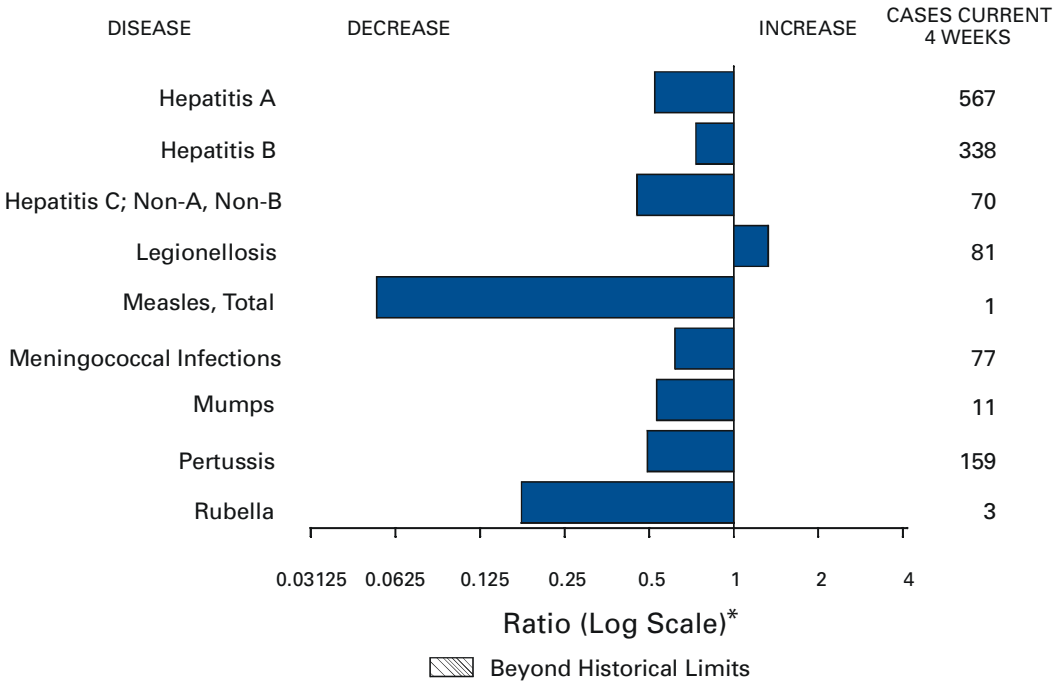
*All *MMWR* references are available on the Internet at <http://www.cdc.gov/mmwr>. Use the search function to find specific articles.

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals ending August 4, 2001, with historical data



* Ratio of current 4-week total to mean of 15 4-week totals (from previous, comparable, and subsequent 4-week periods for the past 5 years). The point where the hatched area begins is based on the mean and two standard deviations of these 4-week totals.

TABLE I. Summary of provisional cases of selected notifiable diseases, United States, cumulative, week ending August 4, 2001 (31st Week)

	Cum. 2001		Cum. 2001
Anthrax	-	Poliomyelitis, paralytic	-
Brucellosis*	39	Psittacosis*	9
Cholera	4	Q fever*	15
Cyclosporiasis*	75	Rabies, human	1
Diphtheria	1	Rocky Mountain spotted fever (RMSF)	243
Ehrlichiosis: human granulocytic (HGE)*	97	Rubella, congenital syndrome	-
human monocytic (HME)*	37	Streptococcal disease, invasive, group A	2,338
Encephalitis: California serogroup viral*	9	Streptococcal toxic-shock syndrome*	36
eastern equine*	2	Syphilis, congenital §	84
St. Louis*	-	Tetanus	15
western equine*	-	Toxic-shock syndrome	77
Hansen disease (leprosy)*	45	Trichinosis	13
Hantavirus pulmonary syndrome*	4	Tularemia*	53
Hemolytic uremic syndrome, postdiarrheal*	61	Typhoid fever	145
HIV infection, pediatric*†	98	Yellow fever	-
Plague	2		

-: No reported cases.
*Not notifiable in all states.
† Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention (NCHSTP). Last update June 26, 2001.
§ Updated from reports to the Division of STD Prevention, NCHSTP.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending August 4, 2001, and August 5, 2000 (31st Week)

Reporting Area	AIDS		Chlamydia†		Cryptosporidiosis		*Escherichia coli* O157:H7*			
							NETSS		PHLIS	
	Cum. 2001§	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000
UNITED STATES	19,145	23,248	392,801	407,197	1,088	1,056	1,166	2,181	888	1,923
NEW ENGLAND	746	1,317	13,112	13,710	48	61	130	219	86	221
Maine	20	20	668	836	6	9	17	14	15	16
N.H.	17	21	757	630	2	7	20	17	17	21
Vt.	10	17	346	319	17	14	8	22	2	23
Mass.	411	837	6,039	5,812	16	20	64	104	28	98
R.I.	53	54	1,659	1,501	3	2	6	11	5	11
Conn.	235	368	3,643	4,612	4	9	15	51	19	52
MID. ATLANTIC	3,974	5,374	45,132	38,723	136	188	91	231	102	167
Upstate N.Y.	322	539	7,920	818	55	50	70	140	66	38
N.Y. City	1,996	2,958	17,748	16,041	54	97	4	15	7	10
N.J.	960	1,065	6,033	7,262	4	7	17	76	29	73
Pa.	696	812	13,431	14,602	23	34	N	N	-	46
E.N. CENTRAL	1,408	2,253	55,665	70,061	333	256	263	500	171	392
Ohio	237	344	7,727	18,320	80	29	75	75	51	90
Ind.	165	214	8,243	7,545	37	13	42	56	25	56
Ill.	665	1,289	15,471	19,770	1	41	59	112	41	89
Mich.	261	297	17,468	14,856	78	38	32	63	27	50
Wis.	80	109	6,756	9,570	137	135	55	194	27	107
W.N. CENTRAL	454	568	20,475	22,804	139	107	196	313	159	326
Minn.	85	101	3,906	4,686	70	21	85	79	69	95
Iowa	47	60	1,858	2,959	34	32	31	81	24	80
Mo.	218	277	7,764	7,828	11	15	25	71	38	64
N. Dak.	1	2	569	529	6	7	9	8	14	15
S. Dak.	18	4	957	1,071	5	9	12	17	8	28
Nebr.	39	38	1,999	2,218	13	20	22	41	-	34
Kans.	46	86	3,422	3,513	-	3	12	16	6	10
S. ATLANTIC	6,167	6,200	75,000	76,042	177	153	106	160	61	170
Del.	116	111	1,697	1,718	2	4	1	1	3	-
Md.	751	705	6,909	7,908	28	8	8	13	1	1
D.C.	465	448	1,764	1,880	9	5	-	-	U	U
Va.	501	395	11,466	9,637	13	4	28	34	20	35
W. Va.	49	37	1,379	1,260	1	3	4	10	1	7
N.C.	402	371	11,072	13,004	18	15	27	30	17	44
S.C.	350	486	6,705	5,114	-	-	3	10	3	12
Ga.	757	704	13,906	16,206	62	73	15	26	9	31
Fla.	2,776	2,943	20,102	19,315	44	41	20	36	7	40
E.S. CENTRAL	977	1,097	28,881	29,010	25	31	50	73	44	61
Ky.	201	127	5,213	4,701	3	4	18	22	24	20
Tenn.	293	438	8,752	8,464	5	7	21	30	18	32
Ala.	224	301	7,984	8,520	9	10	9	5	-	4
Miss.	259	231	6,932	7,325	8	10	2	16	2	5
W.S. CENTRAL	2,058	2,383	60,317	61,854	20	57	36	164	56	200
Ark.	104	111	4,283	3,864	5	5	4	36	-	30
La.	472	366	9,778	11,214	7	10	2	13	24	28
Okla.	107	185	6,201	4,999	6	4	13	9	17	7
Tex.	1,375	1,721	40,055	41,777	2	38	17	106	15	135
MOUNTAIN	714	836	21,605	23,820	69	46	134	205	79	159
Mont.	12	9	1,015	885	6	8	7	22	-	-
Idaho	15	16	956	1,106	8	3	18	24	-	19
Wyo.	1	7	482	465	1	5	7	10	1	6
Colo.	140	200	3,694	7,167	19	13	54	83	44	58
N. Mex.	56	88	3,153	2,885	11	3	9	9	6	9
Ariz.	295	244	8,732	7,613	4	3	16	30	9	26
Utah	63	86	961	1,419	18	8	17	23	18	34
Nev.	132	186	2,612	2,280	2	3	6	4	1	7
PACIFIC	2,647	3,220	72,614	71,173	141	157	160	316	130	227
Wash.	290	291	8,085	7,572	N	U	48	108	31	118
Oreg.	112	107	2,464	4,144	15	10	22	52	17	56
Calif.	2,204	2,727	58,254	55,936	123	147	78	125	79	44
Alaska	13	12	1,620	1,438	-	-	3	22	-	1
Hawaii	28	83	2,191	2,083	3	-	9	9	3	8
Guam	9	13	-	295	-	-	N	N	U	U
P.R.	580	707	1,692	U	-	-	1	5	U	U
V.I.	2	24	53	-	-	-	-	-	U	U
Amer. Samoa	-	-	U	U	U	U	U	U	U	U
C.N.M.I.	-	-	72	U	-	U	-	U	U	U

N: Not notifiable. U: Unavailable. -: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.

* Individual cases can be reported through both the National Electronic Telecommunications System for Surveillance (NETSS) and the Public Health Laboratory Information System (PHLIS).

† Chlamydia refers to genital infections caused by *C. trachomatis*. Totals reported to the Division of STD Prevention, NCHSTP.

§ Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention. Last update June 26, 2001.

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending August 4, 2001, and August 5, 2000 (31st Week)

Reporting Area	Gonorrhea		Hepatitis C; Non-A, Non-B		Legionellosis		Listeriosis	Lyme Disease	
	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2001	Cum. 2000
UNITED STATES	181,058	203,990	2,009	1,989	509	509	249	4,468	8,299
NEW ENGLAND	3,617	3,895	14	16	27	28	29	1,291	2,172
Maine	79	50	-	1	3	2	-	-	-
N.H.	98	65	-	-	6	2	1	78	36
Vt.	43	35	6	3	4	3	1	4	13
Mass.	1,843	1,572	8	8	6	13	15	152	832
R.I.	422	367	-	4	2	3	1	183	211
Conn.	1,132	1,806	-	-	6	5	11	874	1,080
MID. ATLANTIC	22,445	21,926	764	426	90	129	37	2,241	4,637
Upstate N.Y.	4,741	3,983	34	23	31	36	16	1,283	1,524
N.Y. City	7,453	6,791	-	-	6	19	6	1	150
N.J.	3,641	4,368	697	376	5	10	7	85	1,914
Pa.	6,610	6,784	33	27	48	64	8	872	1,049
E.N. CENTRAL	29,873	41,147	113	157	128	134	29	223	572
Ohio	4,537	10,912	7	5	69	50	9	62	39
Ind.	3,413	3,487	1	-	13	23	4	3	14
Ill.	9,593	12,288	11	16	-	19	-	-	30
Mich.	10,052	10,382	94	136	30	22	14	-	18
Wis.	2,278	4,078	-	-	16	20	2	158	471
W.N. CENTRAL	8,703	10,103	444	360	37	35	7	154	109
Minn.	1,268	1,866	3	5	9	3	-	112	48
Iowa	428	663	-	1	6	7	-	19	12
Mo.	4,660	4,956	434	345	12	17	4	14	34
N. Dak.	18	41	-	-	1	-	-	-	-
S. Dak.	144	166	-	-	3	2	-	-	-
Nebr.	687	863	3	3	5	2	1	3	2
Kans.	1,498	1,548	4	6	1	4	2	6	13
S. ATLANTIC	46,911	53,119	64	63	106	85	42	452	670
Del.	959	972	-	2	3	5	-	28	137
Md.	3,821	5,350	10	8	23	27	5	286	392
D.C.	1,558	1,400	-	2	7	-	-	7	2
Va.	6,637	5,975	-	3	14	14	7	85	82
W. Va.	365	387	8	12	N	N	4	8	21
N.C.	9,838	10,522	10	13	5	8	2	19	25
S.C.	4,782	4,887	5	1	4	2	3	2	2
Ga.	7,521	10,199	-	2	6	5	8	-	-
Fla.	11,430	13,427	31	20	44	24	13	17	9
E.S. CENTRAL	18,645	20,905	133	289	36	19	11	19	24
Ky.	2,028	2,031	4	22	8	11	4	9	5
Tenn.	5,839	6,670	43	62	17	5	3	6	15
Ala.	6,232	6,825	2	7	9	2	4	4	2
Miss.	4,546	5,379	84	198	2	1	-	-	2
W.S. CENTRAL	29,318	32,197	161	513	5	20	6	7	50
Ark.	2,646	2,117	3	5	-	-	1	-	5
La.	6,813	7,993	74	275	2	7	-	1	4
Okla.	2,836	2,142	3	5	3	2	2	-	-
Tex.	17,023	19,945	81	228	-	11	3	6	41
MOUNTAIN	5,891	6,146	232	42	36	23	23	8	5
Mont.	53	27	1	2	-	1	-	-	-
Idaho	39	53	1	3	2	4	1	3	1
Wyo.	37	35	190	2	4	-	1	3	2
Colo.	1,840	1,879	13	8	10	7	3	1	-
N. Mex.	503	622	10	11	2	1	6	-	-
Ariz.	2,394	2,534	9	11	11	5	6	-	-
Utah	86	145	2	-	5	5	1	-	-
Nev.	939	851	6	5	2	-	5	1	2
PACIFIC	15,655	14,552	84	123	44	36	65	73	60
Wash.	1,789	1,330	16	19	6	13	4	4	3
Oreg.	362	547	9	21	N	N	1	5	5
Calif.	12,920	12,207	59	81	34	23	57	62	51
Alaska	230	187	-	-	-	-	-	2	1
Hawaii	354	281	-	2	4	-	3	N	N
Guam	-	27	-	2	-	-	-	-	-
P.R.	455	308	1	1	2	1	-	N	N
V.I.	6	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	-	U	U
C.N.M.I.	7	U	-	U	-	U	-	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending August 4, 2001, and August 5, 2000 (31st Week)

Reporting Area	Malaria		Rabies, Animal		Salmonellosis*			
					NETSS		PHLIS	
	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000
UNITED STATES	601	772	3,586	4,031	17,849	20,193	14,104	17,800
NEW ENGLAND	35	40	369	451	1,298	1,260	1,088	1,308
Maine	3	4	42	85	122	85	102	63
N.H.	2	1	7	8	114	79	115	84
Vt.	-	2	37	40	41	69	39	68
Mass.	11	15	138	143	747	743	460	739
R.I.	3	5	33	26	66	65	97	93
Conn.	16	13	112	149	208	219	275	261
MID. ATLANTIC	132	172	653	722	2,263	2,793	2,271	2,887
Upstate N.Y.	38	36	428	450	654	644	622	740
N.Y. City	57	90	13	6	558	718	701	729
N.J.	19	24	100	95	501	678	527	549
Pa.	18	22	112	171	550	753	421	869
E.N. CENTRAL	60	89	54	67	2,508	2,752	1,983	1,767
Ohio	16	13	17	15	773	631	630	655
Ind.	13	5	1	-	285	312	266	351
Ill.	1	46	9	12	634	893	429	1
Mich.	19	18	21	30	438	520	421	552
Wis.	11	7	6	10	378	396	237	208
W.N. CENTRAL	23	37	206	367	1,168	1,323	1,187	1,489
Minn.	6	13	23	55	382	291	383	405
Iowa	3	1	45	52	176	197	168	203
Mo.	8	9	20	30	306	409	423	497
N. Dak.	-	2	24	89	16	34	48	51
S. Dak.	-	-	25	66	74	57	63	61
Nebr.	2	6	4	1	80	122	-	93
Kans.	4	6	65	74	134	213	102	179
S. ATLANTIC	172	167	1,315	1,376	4,419	3,780	2,842	3,203
Del.	1	3	21	20	49	65	43	74
Md.	71	61	178	255	452	437	418	409
D.C.	11	12	-	-	46	33	U	U
Va.	35	32	259	357	804	516	497	530
W. Va.	1	2	80	74	63	87	71	86
N.C.	9	12	344	345	627	513	570	567
S.C.	5	1	78	84	433	360	374	304
Ga.	8	4	223	157	662	637	624	959
Fla.	31	40	132	84	1,283	1,132	245	274
E.S. CENTRAL	18	24	121	112	1,097	1,131	751	908
Ky.	6	8	14	15	183	214	126	162
Tenn.	8	5	76	63	294	281	302	400
Ala.	3	10	31	34	341	304	244	284
Miss.	1	1	-	-	279	332	79	62
W.S. CENTRAL	6	54	506	580	1,285	2,547	1,147	1,548
Ark.	3	2	19	20	307	339	92	282
La.	1	9	-	2	250	435	360	349
Okla.	1	4	45	39	182	204	184	160
Tex.	1	39	442	519	546	1,569	511	757
MOUNTAIN	29	30	144	162	1,166	1,486	778	1,468
Mont.	2	1	21	39	44	62	-	-
Idaho	3	2	10	5	81	82	4	71
Wyo.	-	-	20	39	40	42	22	36
Colo.	15	15	-	-	310	438	276	414
N. Mex.	1	-	7	14	139	134	116	135
Ariz.	3	5	83	60	345	349	216	386
Utah	3	3	2	4	135	219	121	270
Nev.	2	4	1	1	72	160	23	156
PACIFIC	126	159	218	194	2,645	3,121	2,057	3,222
Wash.	4	13	-	-	285	275	358	391
Oreg.	5	26	-	5	131	184	186	239
Calif.	109	112	181	165	1,990	2,502	1,332	2,437
Alaska	1	-	37	24	26	33	2	24
Hawaii	7	8	-	-	213	127	179	131
Guam	-	-	-	-	-	17	U	U
P.R.	3	4	62	50	324	359	U	U
V.I.	-	-	-	-	-	-	U	U
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	8	U	U	U

N: Not notifiable. U: Unavailable. -: No reported cases.
* Individual cases can be reported through both the National Electronic Telecommunications System for Surveillance (NETSS) and the Public Health Laboratory Information System (PHLIS).

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending August 4, 2001, and August 5, 2000 (31st Week)

Reporting Area	Shigellosis* NETSS Cum. 2001	Shigellosis* NETSS Cum. 2000	Shigellosis* PHLIS Cum. 2001	Shigellosis* PHLIS Cum. 2000	Syphilis (Primary & Secondary) Cum. 2001	Syphilis (Primary & Secondary) Cum. 2000	Tuberculosis Cum. 2001	Tuberculosis Cum. 2000
UNITED STATES	8,543	12,302	4,164	6,865	3,197	3,603	6,806	8,205
NEW ENGLAND	128	226	111	214	29	52	245	235
Maine	6	6	2	4	-	1	7	8
N.H.	2	4	2	7	1	1	11	11
Vt.	4	2	2	-	2	-	2	4
Mass.	86	158	63	145	17	35	139	137
R.I.	8	19	18	19	3	4	21	24
Conn.	22	37	24	39	6	11	65	51
MID. ATLANTIC	704	1,694	538	1,063	287	173	1,347	1,342
Upstate N.Y.	343	479	76	172	18	7	185	165
N.Y. City	196	727	240	454	155	72	702	726
N.J.	40	331	157	277	57	40	305	318
Pa.	125	157	65	160	57	54	155	133
E.N. CENTRAL	1,859	2,519	910	752	527	758	703	790
Ohio	1,205	175	605	152	46	47	125	172
Ind.	138	906	25	112	103	233	55	77
Ill.	234	731	143	2	138	263	353	361
Mich.	166	497	118	449	223	181	135	126
Wis.	116	210	19	37	17	34	35	54
W.N. CENTRAL	927	1,298	712	1,080	40	47	258	297
Minn.	286	374	288	415	20	7	138	93
Iowa	277	291	222	224	1	10	18	25
Mo.	165	439	118	309	8	25	70	112
N. Dak.	16	4	12	8	-	-	3	2
S. Dak.	89	4	50	3	-	-	8	11
Nebr.	49	61	-	50	2	2	21	12
Kans.	45	125	22	71	9	3	-	42
S. ATLANTIC	1,281	1,572	380	592	1,149	1,184	1,357	1,681
Del.	5	10	4	10	8	5	9	8
Md.	71	97	37	58	135	172	123	149
D.C.	31	30	U	U	24	21	16	14
Va.	136	256	57	217	70	79	145	166
W. Va.	7	3	7	3	-	2	19	20
N.C.	225	92	112	59	278	327	196	216
S.C.	165	68	72	59	155	129	123	161
Ga.	134	143	72	116	185	225	235	357
Fla.	507	873	19	70	294	224	491	590
E.S. CENTRAL	816	562	349	333	369	525	431	543
Ky.	294	182	155	50	26	57	71	60
Tenn.	60	232	60	257	204	317	159	207
Ala.	155	34	114	23	74	72	149	179
Miss.	307	114	20	3	65	79	52	97
W.S. CENTRAL	1,028	1,988	693	594	413	485	686	1,220
Ark.	388	124	155	43	22	66	85	118
La.	108	182	112	110	82	123	-	94
Okla.	29	67	14	26	41	72	89	93
Tex.	503	1,615	412	415	268	224	512	915
MOUNTAIN	501	557	259	388	134	130	246	291
Mont.	1	5	-	-	-	-	-	6
Idaho	23	37	-	23	-	1	7	4
Wyo.	2	3	-	2	-	1	2	1
Colo.	101	94	80	57	24	5	66	45
N. Mex.	66	62	40	48	10	10	16	28
Ariz.	239	231	99	151	89	108	101	121
Utah	36	37	32	48	7	1	18	27
Nev.	33	88	8	59	4	4	36	59
PACIFIC	1,299	1,886	212	1,849	249	249	1,533	1,806
Wash.	113	329	119	298	34	47	143	148
Oreg.	46	109	65	71	4	9	58	53
Calif.	1,102	1,417	-	1,457	205	192	1,215	1,451
Alaska	4	7	1	3	-	-	27	69
Hawaii	34	24	27	20	6	1	90	85
Guam	-	28	U	U	-	2	-	33
P.R.	6	21	U	U	259	104	54	92
V.I.	-	-	U	U	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	4	U	U	U	-	U	20	U

N: Not notifiable. U: Unavailable. -: No reported cases.

*Individual cases can be reported through both the National Electronic Telecommunications System for Surveillance (NETSS) and the Public Health Laboratory Information System (PHLIS).

TABLE III. Provisional cases of selected notifiable diseases preventable by vaccination, United States, weeks ending August 4, 2001, and August 5, 2000 (31st Week)

Reporting Area	*H. influenzae*, Invasive		Hepatitis (Viral), By Type				Measles (Rubeola)					
			A		B		Indigenous		Imported*		Total	
	Cum. 2001†	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	2001	Cum. 2001	2001	Cum. 2001	Cum. 2001	Cum. 2000
UNITED STATES	834	798	5,467	7,509	3,718	4,133	1	43	-	32	75	61
NEW ENGLAND	46	63	279	230	59	71	-	4	-	1	5	6
Maine	1	1	5	11	5	5	-	-	-	-	-	-
N.H.	-	10	11	17	11	11	-	-	-	-	-	3
Vt.	2	5	8	7	3	6	-	1	-	-	1	3
Mass.	33	31	98	90	2	8	-	2	-	1	3	-
R.I.	2	1	15	15	14	13	-	-	-	-	-	-
Conn.	8	15	142	90	24	28	-	1	-	-	1	-
MID. ATLANTIC	107	152	504	813	566	716	-	2	-	9	11	20
Upstate N.Y.	43	59	161	133	82	77	-	1	-	4	5	9
N.Y. City	27	41	181	294	290	347	-	-	-	-	-	10
N.J.	27	30	70	147	64	118	-	-	-	1	1	-
Pa.	10	22	92	239	130	174	-	1	-	4	5	1
E.N. CENTRAL	112	120	586	976	475	431	-	-	-	10	10	6
Ohio	49	39	147	161	71	72	-	-	-	3	3	2
Ind.	34	17	53	39	26	30	-	-	-	4	4	-
Ill.	10	41	166	431	74	65	-	-	-	3	3	3
Mich.	6	8	182	293	304	242	-	-	-	-	-	1
Wis.	13	15	38	52	-	22	U	-	U	-	-	-
W.N. CENTRAL	41	39	233	490	116	182	-	4	-	-	4	1
Minn.	24	20	16	131	13	21	-	2	-	-	2	1
Iowa	-	-	22	51	14	19	-	-	-	-	-	-
Mo.	11	12	60	216	59	96	-	2	-	-	2	-
N. Dak.	4	2	2	2	-	2	-	-	-	-	-	-
S. Dak.	-	-	1	-	1	-	-	-	-	-	-	-
Nebr.	1	3	27	22	16	28	-	-	-	-	-	-
Kans.	1	2	105	68	13	16	-	-	-	-	-	-
S. ATLANTIC	251	186	1,256	766	769	709	1	4	-	1	5	2
Del.	-	-	-	10	-	9	-	-	-	-	-	-
Md.	59	52	166	97	90	78	-	2	-	1	3	-
D.C.	-	-	29	15	11	19	-	-	-	-	-	-
Va.	18	29	76	92	88	93	1	1	-	-	1	2
W. Va.	9	4	7	47	20	7	-	-	-	-	-	-
N.C.	32	18	92	99	113	154	-	-	-	-	-	-
S.C.	5	7	45	32	19	6	-	-	-	-	-	-
Ga.	64	49	498	126	181	121	-	1	-	-	1	-
Fla.	64	27	343	248	247	222	-	-	-	-	-	-
E.S. CENTRAL	55	36	205	276	255	291	-	2	-	-	2	-
Ky.	2	12	47	32	22	56	-	2	-	-	2	-
Tenn.	27	15	82	97	136	133	-	-	-	-	-	-
Ala.	25	7	63	40	55	33	-	-	-	-	-	-
Miss.	1	2	13	107	42	69	-	-	-	-	-	-
W.S. CENTRAL	31	43	616	1,407	422	623	-	1	-	-	1	-
Ark.	-	1	44	100	57	66	U	-	U	-	-	-
La.	3	12	47	46	28	89	U	-	U	-	-	-
Okla.	28	28	92	168	63	87	-	-	-	-	-	-
Tex.	-	2	433	1,093	274	381	-	1	-	-	1	-
MOUNTAIN	114	79	510	524	344	312	-	-	-	1	1	12
Mont.	-	-	8	3	2	3	-	-	-	-	-	-
Idaho	1	3	48	19	9	5	-	-	-	1	1	-
Wyo.	17	1	22	4	31	-	-	-	-	-	-	-
Colo.	25	16	44	129	71	50	U	-	U	-	-	2
N. Mex.	14	17	22	50	84	100	-	-	-	-	-	-
Ariz.	42	32	270	246	106	112	-	-	-	-	-	-
Utah	6	7	54	33	16	14	-	-	-	-	-	3
Nev.	9	3	42	40	25	28	U	-	U	-	-	7
PACIFIC	77	80	1,278	2,027	712	798	-	26	-	10	36	14
Wash.	2	3	76	178	76	52	-	13	-	2	15	3
Oreg.	17	22	51	132	43	65	-	3	-	-	3	-
Calif.	32	29	1,136	1,694	573	664	-	8	-	4	12	8
Alaska	3	6	14	11	5	8	-	-	-	-	-	1
Hawaii	23	20	1	12	15	9	-	2	-	4	6	2
Guam	-	1	-	1	-	9	U	-	U	-	-	-
P.R.	1	3	58	177	102	168	U	-	U	-	-	2
V.I.	-	-	-	-	-	-	U	-	U	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	20	U	U	-	U	-	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.
*For imported measles, cases include only those resulting from importation from other countries.
† Of 168 cases among children aged <5 years, serotype was reported for 81, and of those, 15 were type b.

TABLE III. (Cont'd) Provisional cases of selected notifiable diseases preventable by vaccination, United States, weeks ending August 4, 2001, and August 5, 2000 (31st Week)

Reporting Area	Meningococcal Disease		Mumps			Pertussis			Rubella		
	Cum. 2001	Cum. 2000	2001	Cum. 2001	Cum. 2000	2001	Cum. 2001	Cum. 2000	2001	Cum. 2001	Cum. 2000
UNITED STATES	1,475	1,468	4	124	221	38	2,574	3,481	-	16	96
NEW ENGLAND	80	86	-	-	3	-	258	921	-	-	11
Maine	1	7	-	-	-	-	-	14	-	-	-
N.H.	10	9	-	-	-	-	25	74	-	-	2
Vt.	4	2	-	-	-	-	24	162	-	-	-
Mass.	46	50	-	-	1	-	193	626	-	-	8
R.I.	2	6	-	-	1	-	2	12	-	-	-
Conn.	17	12	-	-	1	-	14	33	-	-	1
MID. ATLANTIC	150	168	-	11	17	-	202	321	-	4	8
Upstate N.Y.	43	47	-	1	5	-	109	150	-	1	1
N.Y. City	30	35	-	7	5	-	33	49	-	2	7
N.J.	38	30	-	-	3	-	8	24	-	1	-
Pa.	39	56	-	3	4	-	52	98	-	-	-
E.N. CENTRAL	188	252	-	12	17	5	306	394	-	3	1
Ohio	63	57	-	1	7	-	189	193	-	-	-
Ind.	31	31	-	1	-	5	32	40	-	1	-
Ill.	20	64	-	8	5	-	33	36	-	2	1
Mich.	43	73	-	2	4	-	28	46	-	-	-
Wis.	31	27	U	-	1	U	24	79	U	-	-
W.N. CENTRAL	101	100	-	6	12	2	129	185	-	2	1
Minn.	15	14	-	2	-	-	31	88	-	-	-
Iowa	21	21	-	-	5	-	16	26	-	1	-
Mo.	37	48	-	-	4	1	61	37	-	-	-
N. Dak.	5	2	-	-	-	-	-	2	-	-	-
S. Dak.	4	5	-	-	-	-	3	3	-	-	-
Nebr.	10	4	-	1	1	-	4	5	-	-	1
Kans.	9	6	-	3	2	1	14	24	-	1	-
S. ATLANTIC	281	215	2	20	31	4	131	249	-	4	50
Del.	2	-	-	-	-	-	-	7	-	-	-
Md.	34	21	-	4	6	-	17	69	-	1	-
D.C.	-	-	-	-	-	-	1	2	-	-	-
Va.	30	34	2	4	5	2	15	36	-	-	-
W. Va.	10	10	-	-	-	-	1	1	-	-	-
N.C.	57	31	-	1	4	-	46	51	-	-	42
S.C.	28	15	-	1	10	-	23	20	-	2	6
Ga.	36	37	-	7	2	-	7	21	-	-	-
Fla.	84	67	-	3	4	2	21	42	-	1	2
E.S. CENTRAL	100	102	-	3	4	3	62	71	-	1	5
Ky.	18	21	-	1	-	-	11	35	-	-	1
Tenn.	44	41	-	-	2	-	27	21	-	1	1
Ala.	29	29	-	-	2	3	21	12	-	-	3
Miss.	9	11	-	2	-	-	3	3	-	-	-
W.S. CENTRAL	169	154	-	8	24	10	218	178	-	-	6
Ark.	12	10	U	1	1	U	8	29	U	-	1
La.	54	35	U	2	5	U	2	12	U	-	1
Okla.	23	21	-	-	-	-	1	9	-	-	-
Tex.	80	88	-	5	18	10	207	128	-	-	4
MOUNTAIN	74	65	-	7	14	7	927	435	-	1	2
Mont.	3	4	-	-	1	-	14	12	-	-	-
Idaho	7	6	-	-	-	-	164	43	-	-	-
Wyo.	6	-	-	1	1	-	1	2	-	-	-
Colo.	25	21	U	1	-	U	165	242	U	1	1
N. Mex.	11	6	-	2	1	4	68	74	-	-	-
Ariz.	11	19	-	1	3	-	460	41	-	-	1
Utah	7	6	-	1	4	3	46	12	-	-	-
Nev.	4	3	U	1	4	U	9	9	U	-	-
PACIFIC	332	326	2	57	99	7	341	727	-	1	12
Wash.	51	35	-	1	4	6	90	217	-	-	7
Oreg.	25	40	N	N	N	-	30	74	-	-	-
Calif.	245	238	1	29	72	-	193	390	-	-	5
Alaska	2	5	-	1	8	1	3	18	-	-	-
Hawaii	9	8	1	26	15	-	25	28	-	1	-
Guam	-	-	U	-	11	U	-	3	U	-	1
P.R.	3	7	U	-	-	U	2	5	U	-	-
V.I.	-	-	U	-	-	U	-	-	U	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	U	-	U	U	-	U	U	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.

TABLE IV. Deaths in 122 U.S. cities,* week ending August 4, 2001 (31st Week)

Reporting Area	All Causes, By Age (Years)						P&I† Total
	All Ages	≥65	45-64	25-44	1-24	<1	
NEW ENGLAND	342	259	50	22	4	7	26
Boston, Mass.	U	U	U	U	U	U	U
Bridgeport, Conn.	U	U	U	U	U	U	U
Cambridge, Mass.	24	19	5	-	-	-	-
Fall River, Mass.	27	22	5	-	-	-	1
Hartford, Conn.	60	38	12	5	2	3	4
Lowell, Mass.	23	16	3	3	-	1	2
Lynn, Mass.	12	10	1	1	-	-	1
New Bedford, Mass.	28	23	3	2	-	-	3
New Haven, Conn.	37	29	4	2	-	2	3
Providence, R.I.	U	U	U	U	U	U	U
Somerville, Mass.	5	4	-	1	-	-	-
Springfield, Mass.	44	37	4	1	2	-	1
Waterbury, Conn.	26	23	3	-	-	-	2
Worcester, Mass.	56	38	10	7	-	1	9
MID. ATLANTIC	2,041	1,407	419	136	43	36	101
Albany, N.Y.	54	43	8	1	1	1	3
Allentown, Pa.	26	18	8	-	-	-	1
Buffalo, N.Y.	85	60	16	3	1	5	6
Camden, N.J.	23	13	2	4	1	3	2
Elizabeth, N.J.	25	18	7	-	-	-	-
Erie, Pa.§	37	30	5	1	1	-	2
Jersey City, N.J.	44	32	7	4	1	-	-
New York City, N.Y.	1,032	694	226	78	18	16	40
Newark, N.J.	U	U	U	U	U	U	U
Paterson, N.J.	29	15	6	3	1	4	-
Philadelphia, Pa.	303	193	75	23	11	1	15
Pittsburgh, Pa.§	38	24	8	6	-	-	1
Reading, Pa.	18	14	3	-	-	1	3
Rochester, N.Y.	112	78	21	8	3	2	13
Schenectady, N.Y.	23	19	3	-	1	-	2
Scranton, Pa.§	39	34	2	2	1	-	-
Syracuse, N.Y.	97	78	15	-	2	2	10
Trenton, N.J.	32	24	6	1	-	1	2
Utica, N.Y.	24	20	1	2	1	-	1
Yonkers, N.Y.	U	U	U	U	U	U	U
E.N. CENTRAL	1,602	1,080	334	114	27	47	113
Akron, Ohio	40	28	10	-	-	2	3
Canton, Ohio	29	21	3	3	2	-	-
Chicago, Ill.	U	U	U	U	U	U	U
Cincinnati, Ohio	81	53	16	7	1	4	13
Cleveland, Ohio	132	81	34	13	2	2	10
Columbus, Ohio	157	113	32	9	-	3	10
Dayton, Ohio	147	111	23	8	2	3	13
Detroit, Mich.	200	115	48	21	6	10	12
Evansville, Ind.	47	34	10	2	-	1	7
Fort Wayne, Ind.	74	53	13	6	-	2	3
Gary, Ind.	19	9	9	1	-	-	1
Grand Rapids, Mich.	46	33	7	2	3	1	5
Indianapolis, Ind.	182	113	40	18	2	9	10
Lansing, Mich.	26	21	4	-	-	1	-
Milwaukee, Wis.	118	78	31	7	2	-	15
Peoria, Ill.	40	28	5	2	5	-	1
Rockford, Ill.	43	28	10	3	-	2	2
South Bend, Ind.	62	43	13	4	1	1	5
Toledo, Ohio	95	68	18	5	1	3	3
Youngstown, Ohio	64	50	8	3	-	3	-
W.N. CENTRAL	736	490	149	49	23	24	45
Des Moines, Iowa	49	40	6	2	-	1	5
Duluth, Minn.	18	16	-	2	-	-	2
Kansas City, Kans.	24	11	8	2	2	1	2
Kansas City, Mo.	94	63	16	5	3	7	4
Lincoln, Nebr.	36	22	7	6	1	-	4
Minneapolis, Minn.	186	131	37	14	3	1	12
Omaha, Nebr.	93	66	18	2	5	2	8
St. Louis, Mo.	97	43	34	9	6	5	-
St. Paul, Minn.	58	38	10	3	2	4	2
Wichita, Kans.	81	60	13	4	1	3	6
S. ATLANTIC	1,326	801	330	116	41	35	58
Atlanta, Ga.	178	95	53	20	5	5	5
Baltimore, Md.	204	107	65	25	4	2	13
Charlotte, N.C.	89	49	25	8	5	2	8
Jacksonville, Fla.	136	91	31	6	3	5	6
Miami, Fla.	125	88	21	12	3	1	10
Norfolk, Va.	46	24	11	5	1	5	1
Richmond, Va.	55	21	17	9	5	2	3
Savannah, Ga.	50	37	8	-	2	2	3
St. Petersburg, Fla.	51	38	7	4	1	1	3
Tampa, Fla.	163	112	34	12	4	1	2
Washington, D.C.	200	123	45	15	8	9	4
Wilmington, Del.	29	16	13	-	-	-	-
E.S. CENTRAL	778	503	166	57	21	27	72
Birmingham, Ala.	181	115	38	12	6	6	15
Chattanooga, Tenn.	71	44	14	8	1	4	4
Knoxville, Tenn.	82	56	17	6	1	2	7
Lexington, Ky.	59	34	15	4	1	5	3
Memphis, Tenn.	167	110	36	12	6	3	16
Mobile, Ala.	53	39	9	3	1	1	3
Montgomery, Ala.	47	34	7	4	2	-	7
Nashville, Tenn.	118	71	30	8	3	6	17
W.S. CENTRAL	1,294	798	287	119	52	36	79
Austin, Tex.	74	45	20	5	2	2	3
Baton Rouge, La.	U	U	U	U	U	U	U
Corpus Christi, Tex.	52	31	16	3	1	1	1
Dallas, Tex.	217	133	55	20	6	3	23
El Paso, Tex.	45	29	8	3	-	5	1
Ft. Worth, Tex.	119	72	24	6	7	10	2
Houston, Tex.	364	194	83	52	26	9	31
Little Rock, Ark.	53	32	9	6	4	1	-
New Orleans, La.	U	U	U	U	U	U	U
San Antonio, Tex.	230	165	45	14	4	2	7
Shreveport, La.	-	-	-	-	-	-	-
Tulsa, Okla.	139	97	27	10	2	3	11
MOUNTAIN	1,026	683	204	99	24	15	50
Albuquerque, N.M.	104	77	15	10	1	1	6
Boise, Idaho	38	23	9	4	2	-	1
Colo. Springs, Colo.	54	33	15	5	1	-	2
Denver, Colo.	102	63	19	14	1	5	2
Las Vegas, Nev.	264	176	60	20	6	2	7
Ogden, Utah	30	17	8	3	1	1	2
Phoenix, Ariz.	155	84	36	24	6	4	8
Pueblo, Colo.	21	20	1	-	-	-	-
Salt Lake City, Utah	107	70	20	11	5	1	7
Tucson, Ariz.	151	120	21	8	1	1	15
PACIFIC	1,722	1,238	317	100	36	30	122
Berkeley, Calif.	17	10	3	1	-	3	-
Fresno, Calif.	122	88	22	8	4	-	5
Glendale, Calif.	30	26	3	1	-	-	2
Honolulu, Hawaii	66	37	23	2	2	2	4
Long Beach, Calif.	73	48	16	8	-	1	9
Los Angeles, Calif.	541	400	95	33	6	7	40
Pasadena, Calif.	33	29	1	2	-	1	5
Portland, Oreg.	111	85	18	2	4	2	6
Sacramento, Calif.	137	99	26	6	4	2	13
San Diego, Calif.	156	95	40	13	4	4	6
San Francisco, Calif.	U	U	U	U	U	U	U
San Jose, Calif.	164	124	23	11	3	2	15
Santa Cruz, Calif.	27	17	9	-	1	-	4
Seattle, Wash.	125	88	19	8	5	5	-
Spokane, Wash.	36	27	5	2	1	1	5
Tacoma, Wash.	84	65	14	3	2	-	8
TOTAL	10,867¶	7,259	2,256	812	271	257	666

U: Unavailable. -:No reported cases.

*Mortality data in this table are voluntarily reported from 122 cities in the United States, most of which have populations of ≥100,000. A death is reported by the place of its occurrence and by the week that the death certificate was filed. Fetal deaths are not included.

†Pneumonia and influenza.

§Because of changes in reporting methods in this Pennsylvania city, these numbers are partial counts for the current week. Complete counts will be available in 4 to 6 weeks.

¶Total includes unknown ages.

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