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WHAT LIES BENEATH;
UNCOVERING THE HEALTH OF MILWAUKEE'S PEOPLE,
1880-1929

by

Brigitte M. Charaus, B.A., M.A.

A Dissertation submitted to the Faculty of the Graduate School,
Marquette University,
in Partial Fulfillment of the Requirements for
the Degree of Doctor of Philosophy

Milwaukee, Wisconsin

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ABSTRACT
WHAT LIES BENEATH; UNCOVERING THE HEALTH OF MILWAUKEE'S
PEOPLE, 1880-1929

Brigitte M. Charaus, B.A., M.A.

Marquette University, 2010

The true measure of a city's health is the health of its people. To truly understand how Milwaukee came to be known as the "healthiest city" in 1930, one must examine the health needs of common Milwaukeeans from 1880 to 1929. This study seeks to complement Judith Leavitt's pioneering work on public health in Milwaukee by presenting a picture, not of the politics of health reform, but of the personal side of health in the city.

Through an extensive examination of records including, but not limited to, coroner's reports, hospital records, personal correspondence, newspapers, cemetery data, and institutional records, a picture of the overall health of the city's population emerges. These records speak of the urban environment and its effects on everyday people. Communicable diseases, tragic accidents, suicides, physical examinations, venereal diseases, housing problems, and occupational hazards are only a portion of the health story that Milwaukee created at the turn of the last century. While political and institutional histories are essential, the story told here focuses on the people of Milwaukee and their experiences.

While the city would dramatically grow and change during the twentieth century, its people remained its most valuable asset. As a city initially defined by German, Polish, and Italian immigrants, today Milwaukee has significant Hispanic and Hmong communities. The immigrant groups have changed but the challenges of living in the urban environment remain the same. The health of the city as a whole, as well as of its everyday citizens, is a strong indicator of its general economic, social, and physical health. Sick citizens create a sick city, both on a biologic level and an economic level. By bettering their individual health, the health of the overall city improves. The lessons and challenges that Milwaukeeans faced in the early twentieth century provide insight and models for Milwaukeeans of the twenty-first century. While breweries will make Milwaukee famous, it is her citizenry that makes the city prosper.

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Brigitte M. Charaus, B.A., M.A.

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Introduction

For the European poor, the United States was the land of promise and hope. As economic and political conditions worsened for countless souls in Europe, the siren song of an industrializing America was too strong to resist. The cliché of promised American prosperity, of streets paved with gold, quickly dissolved into the reality of American urban and industrial life. Parallel with this evolving urban space and the growth of the industrial workplace was a pressing need to deal with health related issues in the city. Communicable diseases, occupational safety, and maternal health as well as concerns over living conditions occupied health officials and the people themselves. While smaller and less densely packed than Chicago, its southern neighbor, Milwaukee fought to maintain both a prosperous economy and a healthy populace.

At the turn of the nineteenth century, Milwaukee struggled through the growing pains of urbanization and industrialization. An absence of building codes, overcrowded conditions, high infant and maternal mortality rates, epidemic disease, dangerous working conditions, and a growing awareness of problems with venereal diseases challenged the city and its populace. These problems were daunting challenges across the socio-economic spectrum, but they impacted the poor and working classes most significantly and most directly. The working class of Milwaukee became the focus of this

study because they were the most vulnerable to the health problems in the city. While examples may appear from across the social spectrum, my concern in studying the health of the city centered around those frequently forgotten. They were, shop owners, grocers, garbage men, wives, mothers, students, alcoholics, and even “deviants.” They were in other words, the common “herd.”¹ While sharing similar health issues, these groups individually were more unique than health department statistics suggest. A closer examination of these groups and their health issues presents a clearer picture of Milwaukee’s overall health during this pivotal time in the city’s history.

The growing industrial workforce and immigrant populace in Milwaukee were subject to difficult challenges as they adjusted to life in the city. In an era before safety devices and OSHA regulations, they were subject to dangerous working conditions. Industries could quickly replace injured or deceased workers since there was no shortage of replacements willing to expose themselves to a host of workplace dangers for the promise of a wage. The perils of substandard housing and the ravages of epidemic diseases that spread through crowded living conditions also created hazards for those living in the city. The city offered the promise of prosperity that was traded for disease, danger, and on occasion, death. In this transaction between the worker and industry and the urban resident and the city, laborers and their families frequently paid the highest price. Whether they were men or women, ethnic or native born, their dreams of American prosperity frequently met with the reality of sickness, injury, and even early death. Understanding how this relationship between the city and its most vulnerable residents

¹ A reference to Jacob Riis and his work *How the Other Half Lives*. While Riis used this term to designate the destitute working poor of New York, I believe it fits well here to describe the everyday citizenry of Milwaukee as well, the people who were frequently treated as a group, not as individuals.

evolved during this period offers a glimpse at the underside of what enabled Milwaukee to become the great “machine shop to the world.”² Success and prosperity frequently came at a high cost for those who made the machine run.

Background

Historically, urban space has been a dynamic area of development, growth, conflict and, most importantly for this study, a place of dialogue. This ideologically and politically charged space has created an arena in which larger discussions about the relationship of the landscape and its inhabitants, the impact of the city on its residents, and the real versus imagined dangers of the urban environment could take place. The American city of the late nineteenth and early twentieth century was an urban space undergoing a tremendous transformation in terms of its physical as well as its social landscape. A dialogue, or a reciprocal relationship, between the city and its inhabitants forms the foundation for this study of Milwaukee at the opening of the twentieth century. While other authors, such as Judith Leavitt, have focused on the impact of *institutions* on the overall health of the city, this work focuses on the *people* who lived within the city’s limits. Official health statistics, health “propaganda,” pamphlets, and even newspaper accounts only tell part of the story. By focusing on the most basic level of records—

² This well-known moniker obviously refers to Milwaukee’s dominance in the manufacturing and machining trades during the twentieth century, but the origins of the term are less clear. While no one person is credited with bestowing the title of “machine shop to the world” on the city, some of the earliest references can be found in advertisements for the Milwaukee School of Engineering during the 1950s. For a broader discussion of Milwaukee’s role as “machine shop to the world,” see John Gurda, *The Making of Milwaukee* (Milwaukee: Milwaukee County Historical Society, 1999), 164. For an example of one of the Milwaukee School of Engineering’s advertisements which used this catch phrase, see *Popular Mechanics* (September 1957): 43.

hospital ledgers, personal letters, diaries, death records, and supplementing them with “official” reports—a clearer picture of the real health of the city can be developed.

Institutional histories, biographies, business histories, and governmental histories all provide insight into the development of the city’s institutions and makeup of its people. Governmental structures can speak to the principles of organization and the power of political ideologies within a particular community. The physical layout and planning efforts within the community may suggest differing conceptions of space by those who overtly design the city and its subsequent development. Spontaneous construction by those who actually lived in the urban arena frequently counteracted more formal planning.³ Subtle undercurrents regarding racial, ethnic, and class relations within the community can be seen in the physical layout of the city. Where and how people lived were key indicators of their status and agency within that society, and their ability to change a situation. Furthermore, a city’s formal institutions communicate through a language of values and priorities. The location of schools, hospitals, religious institutions, and cultural venues provide a map by which to read the cultural and social “temperature” of that particular place and time, creating a gauge to measure the overall biases of greater society toward the poor and working classes. How many hospitals does one find in the

³ There is a wide body of literature discussing this practical divide between planners and city inhabitants. Often there is a stark difference between the city as envisioned and implemented by those planners, and the everyday needs of city residents. Despite the best intentions of planners, city residents frequently have altered the physical landscape and thwarted the best laid planning schemes. For further readings regarding the divide between those who plan and those who live in that space, see James M. Simmie, *Citizens in Conflict: The Sociology of Town Planning* (London: Hutchinson, 1981); Roger Montgomery, “Pruit-Igoe: Policy Failure or Societal?” in *The Metropolitan Midwest: Policy Problems and Prospects for Future Change*, ed. Barry Checkoway and Carl V. Patton (Chicago: University of Illinois Press, 1985), 229-243; Jane Jacobs, *The Death and Life of Great American Cities* (New York: Vintage: 1961); Jack Meltzer, *Metropolis to Metroplex: The Social and Spatial Planning of Cities* (Baltimore: Johns Hopkins Press, 1984); Edward Krupat, *People in Cities* (Cambridge: Cambridge University Press, 1985); and Sylvia Hood Washington, *Packing Them In: An Archaeology of Environmental Racism in Chicago* (Lanham, MD: Lexington Books, 2005).

poorer segments of town? How accessible are various museums, parks, and cultural attractions to the different classes within that society? What sort of languages are the religious services presented in, and do they reflect old or contemporary ethnic compositions of that area? Small subtleties of these socially constructed institutions suggest volumes regarding the importance of various groups within the community. The acceptance of or bias against various groups has a strong correlation with their social status in the community as well as their overall health and wellness.⁴

The last aspect of this map of the city would most certainly be the people themselves. The role of prominent businessmen and boosters in the formation and development of a city is undeniable. Numerous urban historians have delved into the impact of prominent businessmen, officials, and powerbrokers.⁵ In the older tradition of the “urban biography” model of city histories, it was frequently the prominent citizens, businessmen, and politicians who were the focal point in understanding the development and growth of these areas.⁶ However, a shift in urban historiography started to develop by the 1960s, with the second wave of urban historians. The latter focused more narrowly on social history as a new way of understanding urban space. It was no longer the

⁴ Much of this “temperature” argument is grounded in and informed by Theodore Hershberg’s discussion on the rates of acculturation and assimilation of immigrant groups in United States history. For further reading on this topic, see Theodore Hershberg, Stephanie Greenberg, Alan Burnstein, William Yancy and Eugene Ericksen, “A Tale of Three Cities: Blacks, Immigrants, and Opportunity in Philadelphia, 1850-1880, 1930, 1970,” in *Work, Space, Family and Group Experience in the Nineteenth Century*, ed. Theodore Hershberg (New York: Oxford University Press, 1981), 461-91.

⁵ For a small sampling of the impact of boosters in the development of cities, see Carl Abbott, *Boosters and Businessmen: Popular Economic Thought and Urban Growth in the Antebellum Middle West* (Westport, Connecticut: Greenwood Press, 1981); Richard Wade, *The Urban Frontier* (Cambridge: Harvard University Press, 1959); and David Perry and Alfred Watkins, eds., *The Rise of the Sunbelt Cities* (Beverly Hills, CA: Sage Publications, 1977).

⁶ Howard Conrad (1895), William George Bruce (1922) and John Gregory (1931) in their multivolume histories of the city spent considerable time on biographical accounts of the city’s prominent leaders, businessmen, religious leaders, and socialites. Even as late as 1948, Bayrd Still’s *Milwaukee: The History of a City* still focused on history from the top down.

histories of politicians, captains of industry, and bureaucrats, but increasingly the history of the Polish Kashubian fisherman on Jones Island, striking workers at Bay View, or women reformers.⁷ These histories were not simply niche histories but provided new insights into the life of the city. Although logistically we cannot know the history and impact of every single man, woman, or ethnic minority in the city, it is crucial in our analysis of the city to gain an insight into a few of these individuals or even a general understanding of the shared experiences of these groups. While individually they are often not viewed as essential elements to the story of the city, collectively their ideas, attitudes, shared experiences, and perceptions helped shape the industrial city. I would also go further and argue that, even individually, they are necessary to understanding the urban life of Milwaukee or similar urban environments. The individual in the industrial age was frequently seen as a cog in the larger machine of society, but the machine metaphor dehumanizes the individual and trivializes their experiences, their tragedies, and their presence. We can learn as much from individuals in the lowest levels of urban society as we can from institutions, governments, and the upper classes. The experiences of the lower classes, while unique to them, are nevertheless valuable in understanding Milwaukee as a whole. Their lives provide insight into the physical and social adaptation to the urban environment, the impact of the industrial world on individuals and groups, and the formation of class and ethnic stereotypes in an industrial and immigrant based

⁷ For works on these topics, see Ruth Kriehn, *The Fisherfolk of Jones Island* (Milwaukee, WI: County Historical Society, 1988); John Gurda, *Bay View, WI*. (Milwaukee: Milwaukee Humanities Program, 1979) and *The Making of Milwaukee*; Bernard Korn, *The Story of Bay View* (Milwaukee: Milwaukee County Historical Society, 1980); and Diane Long Hoeveler, *Milwaukee Women Yesterday* (Milwaukee: University of Wisconsin Board of Regents, 1979).

society. Additionally, how society perceived them and acted upon them becomes integral to the larger story.

Health and the City

The overall health of a city can be determined through an examination of general populations as well as individuals. Just as a city is made up of individuals, their personal health and wellness contributes to the health of the city as a whole. While mortality rates of an urban population tell part of the story, an examination of morbidity contributes to the overall picture of community health.⁸ Physical health also influences the social and economic well-being of the city. A health assessment of the city's residents can serve as a barometer of the overall state of the city itself. A city with a sick general and individual population may not work effectively or efficiently. Sick workers, epidemic diseases, and environmental health concerns all contribute to a city that does not perform at its economic and social peak. An individual's health when added together with those of others becomes a more accurate measurement for the well being of the city as a whole.

Cities are organic creations with biologic, economic, and social systems. When one part of that system ceases to function or becomes "ill," the overall health of the whole organism starts to falter. Cities are born, grow, die, and even reincarnate in new forms through new economies and new populaces. To understand the city as a living thing as Anthony Orum has suggested,⁹ one needs to look at the general health of its

⁸ Mortality rates are the rates of death within a community, while morbidity rates gauge sickness rates within a set population.

⁹ Anthony Orum, *City Building in America* (Boulder, CO: Westview Press, 1995), 20-22.

components, in this case its citizenry. A city is only as healthy as its citizenry. A city with strong racial and ethnic divides or with problems of significant socio-economic inequality frequently will have higher mortality and morbidity rates among poor and minority groups.¹⁰ Large divides can exist between the general health services the community provides and what is realistically accessible to a particular group. A city, however, which proactively cares for its citizenry with public health measures, an extensive and well-funded medical system, and community outreach and education ultimately produces a healthy workforce, no matter their income or socio-economic status. John P. Koehler, Health Commissioner for Milwaukee from 1924 to 1940, noted in his work, *The Road to Health*, the importance of “national, civic, and personal health.” He went further to question “what is an individual or a nation without health?”¹¹

An examination of the general health of Milwaukee’s citizenry during the late

¹⁰ A larger and growing body of literature in a variety of disciplines serves as a basis for the connection between health, socio-economic status, and larger society. See Michaela Benzeval, Ken Judge, and Sue Shouls, “Understanding the Relationship Between Income and Health,” *Social Policy Administration*, 35 (2001): 376-96; Richard Wilkinson, *Unhealthy Societies: The Affliction of Inequality* (London: Routledge, 1996); Evelyn Kitagawa and Philip Hauser, *Differential Mortality in the United States: A Study in Socioeconomic Epidemiology* (Cambridge: Harvard University Press, 1973); Felicia LeClere and Mah-Jabeen Soobader, “The Effects of Income Inequality on the Health of Selected U.S. Demographic Groups,” *American Journal of Public Health* 90 (2000): 1892-97; Ichiro Kawachi, Bruce Kennedy, and Deborah Protherow-Stith, “Social Capital, Income Inequality, and Mortality,” *American Journal of Public Health*, 87 (1997): 1491-98; Ken Judge, Jo-Ann Mulligan, and Michaela Benzeval, “Income Inequality and Population Health,” *Social Science and Medicine*, 46 (1997): 567-79; Angus Deaton and Darrow Lubotsky, “Mortality, Inequality, and Race in American Cities and States,” *Social Science and Medicine*, 56, no.6 (March 2003): 1139-1153; and Angus Deaton, “Health, Inequality, and Economic Development,” *Journal of Economic Literature*, 41 (March 2003): 113-158.

¹¹ John P. Koehler, *The Road to Health* (Milwaukee, WI: Milwaukee Health Department, 1929), 4. While discussions of community/civic health were often couched in the language of economics and productivity during the early twentieth century, there has been a continued dialogue regarding the importance of maintaining a healthy populace. For further discussion on these issues, see Anthony C. Gatrell, *Geographies of Health* (London: Blackwell Publishers, 2003); Mark Roseland, ed., *Eco City Dimensions: Healthy Communities, Healthy Planet*. (Gabriola Island, BC: New Society Publishers, 1997); Kristine M. Gebbie, “Using the Vision of Healthy People to Build Healthier Communities,” *Nursing Administration Quarterly* 21, no.4 (1997), 83-90; John K. Davies and Michael P. Kelly, eds., *Healthy Cities: Research and Practice* (London: Routledge, 1993); and James Kusher, *Healthy Cities: the Intersection of Urban Planning, Law, and Health*. (Durham, NC: Carolina Academic Press, 2007).

nineteenth and early twentieth centuries helps explain the process by which it came to be, according to Judith Leavitt, "the healthiest city."¹² Leavitt documented the road to a "healthy city" in her study of the relationship among the health department, city government, and the general populace. Leavitt focused on the process of reform and the reaction of several groups within the city to various health crises in the city.¹³ In contrast, this present work aims to supplement the institutional history offered by Leavitt with a focus on the health of individuals. While not an exhaustive personal medical history of each Milwaukee resident during the period of 1880-1929, it is an attempt to understand group as well as individual health concerns that beset the citizenry. What were the particular health needs and concerns of women, children, men, and ethnic and minority groups within the city? The responses by various institutions and political agencies are secondary in this study. While Judith Leavitt has provided a groundbreaking study on the institutional aspect of Milwaukee's health, this current project provides a complement to her own.

As suggested above, this study seeks to examine the health issues of individuals as members of particular groups within the city. Women's issues at the turn of the century often focused on concerns surrounding childbirth and reproductive issues.

Occupational safety and health were frequently the focus of the urban male worker. For children, the issues at the turn of the century were those of communicable diseases.

Ethnic and minority groups within the city not only battled urban illnesses, poverty, and

¹²"The Healthiest City" was an award presented to the city of Milwaukee in 1929 by the Chamber of Commerce of the United States for Milwaukee's first place in the national health conservation contest. The contest measured various aspects of health in the city including infant mortality rates, general mortality rates, general health improvements, and improvements in environmental health. George Dundon, "Health Conservation," *Milwaukee Health Department Bulletin* 20 (1931): 9-11.

¹³ Judith Walzer Leavitt, *The Healthiest City: Milwaukee and the Politics of Health Reform* (Madison: University of Wisconsin Press, 1996), 9.

workplace dangers, but nativist fears that saw a connection between these groups and the growing degradation of the urban space as well as the potential eclipse of “white” American society.¹⁴ This study also seeks to examine the health of Milwaukee’s population during one of the most pivotal time periods in the city’s history, from the ground up. What did these individuals or groups see as their most pressing health concerns? How did the larger community view these medical concerns and issues? How did society react and what measures were taken to manage these urban health issues both for the individual and larger society?

The dynamic period of the late nineteenth century and early twentieth century presented a promising focal point for this study. The confluence of mass immigration, rising industrialization, growing urbanization, and shifts in the medical field provide a series of powerful forces shaping American cities and their peoples. As the country emerged as a global industrial leader, Milwaukee was itself shifting from trading entrepot to industrial center. The promise of new jobs, boundless opportunities, and strong ethnic communities drew European immigrants to the city. The work presented here focuses on the years between 1880 and 1929, for this period comprises the most dramatic demographic shift in Milwaukee’s population, while still maintaining familiar institutions and the city’s legacy as an ethnic enclave. This struggle between change and continuity provided the foundation for the health and wellness struggles that the community

¹⁴While there is a growing body of bibliographic material surrounding nativist sentiments regarding health and wellness during the turn of the last century, a few titles not to be overlooked include Alan M. Kraut, *Silent Travelers: Germs, Genes and the Immigrant Menace* (Baltimore, MD: Johns Hopkins Press, 1995); Nayan Shah, *Contagious Divides: Epidemics and Race in San Francisco’s Chinatown* (Berkeley, CA: University of California Press, 2001); and Roger Daniels, *Guarding the Golden Door* (New York: Hill & Wang, 2004) as well as the Jacob Riis’ period piece *How the Other Half Lives* (New York: Charles Scribner’s Sons, 1890; reprint New York: Dover, 1971).

underwent during this period. Assimilation and acculturation into American, and in this case Milwaukee, society was directly linked to the ability of immigrant newcomers as well as the already marginalized to negotiate the complex world of Progressive Era medicine and related biases. Nativist attitudes during this period openly challenged views of America as a melting pot and safe haven for the “wretched refuse,” and challenged the ability of immigrants and the poor to succeed in this promised land. A starting point of 1880 was chosen for practical reasons because the majority of institutional records for the Milwaukee County Hospital, where most of the poorest in the city found medical care, begin with 1880. While there are records that predate 1880, they become much more complete after this point in time.

Outside of the sociopolitical dynamics of the period, the medical establishment was itself undergoing a significant restructuring. The growing professionalization of the medical industry and the growing reliance on the advice of these “professionals” would come to color patient doctor relationships for the rest of the century.¹⁵ Increasingly individuals were told to respect the advice of “experts” in a particular field, and to distrust those not educated in the American system or validated by American authorities. The rise of the Progressive movement, which reinforced this focus on the importance of “expert” advice, further accentuated the gulf which had been developing between recognized American medical professionals and immigrant and ethnic health care providers, that is, those who were less formally trained but nevertheless provided

¹⁵ Much has been written on this subject, especially in the case of the history of obstetrics. Charlotte G. Borst, *Catching Babies: The Professionalization of Childbirth, 1870-1920* (Harvard: Harvard University Press, 1995) provides a background to this shift in women’s health, as well as Judith Leavitt’s work on the same topic in “Science Enters the Birthing Room: Obstetrics in America Since the 18th century,” *Journal of American History*, Vol. 70, No.2, September 11, 1983, 281-304.

invaluable medical help to the local immigrant communities. The expertise of formal educational training increasingly came to replace real world experiences as a basis for determining the legitimacy of one health professional over another. Gradually more of the decisions regarding medical treatment, care, and “agency” were removed from individual patients and transferred to those who “knew better.” This shift in doctor-patient relationships and authority can be most clearly observed in the health issues of women, immigrants, and minorities. With little influence themselves, these three groups increasingly turned for assistance to those with social or medical power, or at least those deemed by society to have agency and authority. This period of study provides a dynamic focus for the evolving dialogue between patient and physician as well as society and those who needed care.¹⁶

Focusing on the beginning of the twentieth century also touches upon the strong immigrant character of Milwaukee, while at the same time acknowledging the shift that was occurring in the city’s ethnic composition. While the original German population continued to dominate social and economic life in Milwaukee, the “New Immigration” was having a profound impact on how the city viewed itself and its citizenry. Unfamiliar languages, traditions, foods, and even religious practices found their way to Milwaukee’s shores during this period as they did across the United States. Growing numbers of

¹⁶ For further discussion regarding this shift in the doctor-patient relationship, see Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982); Eliot Freidson, *Profession of Medicine* (New York: Dodd Mead, 1970) and *Professional Dominance* (Chicago: Aldine, 1970); Charles Rosenberg, *The Care of Strangers: The Rise of the American Hospital System* (New York: Basic Books, 1987); Edward Shorter, *Doctors and their Patients* (New Brunswick, N.J.: Transaction, 1991); David J. Rothman, *Strangers at the Bedside: A History on How Law and Bioethics Transformed Medical Decision Making* (New York: Basic Books, 1991); Rima Apple, “Constructing Mothers: Scientific Motherhood in the Nineteenth and Twentieth Centuries,” *Social History of Medicine* 8 (1995): 161-178; Eric Cassel, “The Changing Concept of the Ideal Physician,” *Daedalus* 115 (1986): 185-208; and Ronald L. Numbers “The Fall and Rise of the American Medical Profession,” in *The Profession in American History*, ed. Nathan O. Hatch (Notre Dame, IN: University of Notre Dame Press, 1985): 57-67.

Southern and Eastern European immigrants were drawn to Milwaukee's industrial jobs as well as by immigrant communities already established in the city. Milwaukee's Polish, Slavic, Russian Jewish, Serbian, Croatian, and even Greek and Syrian communities blossomed during this period.¹⁷ These groups, while welcomed by businessmen in the city as a steady and willing workforce, were not received quite as warmly by established immigrant groups or native-born inhabitants. Long-settled immigrants found themselves contending for jobs and resources with increasing numbers of groups who they found less than desirable on cultural as well as biologic/genetic levels. Shared experiences seemed hard to find; shared religions were no match for prejudice and eugenic sentiments;¹⁸ and old world prejudices resurfaced here in the New World as well. Therefore, an examination of the living and working conditions as well as the general health of these newly arriving groups provides not only insight into their health experiences but an understanding of the perceptions of others toward these new groups.

Planners and social commentators had long believed the city could make people "sick." The era of industrialization in the United States confirmed suppositions regarding urbanization and sickness. The ideological conflict of the rural and urban space had

¹⁷ For a discussion of immigration during this period as well a survey of Milwaukee history, see both Bayrd Still, *Milwaukee: The History of the City* as well as John Gurda, *The Making of Milwaukee*. Both works, although separated by over fifty years, provide the classic narrative of immigration to Milwaukee at the turn of the twentieth century. For earlier Milwaukee immigration, Kathleen Conzen, *Immigrant Milwaukee* (Cambridge, MA: Harvard University Press, 1976) provides a more focused study of immigration during the early to mid-nineteenth century.

¹⁸ While German and Russian Jewish immigrants will share a common religion, that bond was frequently not enough to create a cohesive community. Minutes from Jewish charity organizations and correspondence from Jewish leaders of the period, all German Jews, were harshly critical about the habits, lifestyle, and the general "worth" of the Russian Jewish immigrants. They saw this newly arriving groups as uncultured, unclean, and even unkosher (in that they had difficulty keeping or following kosher laws). There was a distinct cultural and social divide between the two groups as many in the German Jewish leadership openly voiced concern over the deleterious effects of the newly arriving Russian Jewish immigrants.

existed long before the growth of industrial urban centers of the end of the last century.¹⁹ From Thomas Jefferson's yeoman farmer to the green space planning of Frederick Law Olmsted, thinkers and planners had sought to transform the landscape into something more pastoral, pleasant, "healthy," and "moral." As cities increasingly became a breeding ground for issues of physical, mental, and moral health, a growing body of reformers, politicians, planners, and medical professionals sought to change that relationship and improve the health of individuals within the city. City life, with its noise, pollution, traffic, and disease was a dangerous place for any man, woman, and especially child. Added to these tangible dangers were the social and moral dangers of sin, corruption, and vice which the city also offered and seemingly fostered. Some viewed the city as a place devoid of moral authority, where any innocent soul would be corrupted beyond the hope of redemption. In this negative ideology, the city was a place that weakened the American population. The benefits of industry, commercialism, and progress were secondary to the damaging effects the urban space was having on the psyche of Americans themselves.

While the dangers between rural and urban space might have been exaggerated by

¹⁹ Fear and animosity for the urban space had long existed in American literature. There has been a large body of material in American history which focused on the dangers of the urban environment to humanity on physical, social, and even psychological levels. The growth of the park planning and suburban planning during the nineteenth and early twentieth centuries under the likes of Ebenezer Howard, Frederick Law Olmsted, and even Frank Lloyd Wright focused on an integration of green/garden space into the physical sphere of urban inhabitants. Pastoralism, romanticism, and planning merged to create an ideal mixture of urban conveniences and rural aesthetic. See Ebenezer Howard, *Garden Cities of Tomorrow* (London: Swan Sonnenschein & Co., 1902); Robert Fishman, *Urban Utopias in the Twentieth Century: Ebenezer Howard, Frank Lloyd Wright, and Le Corbusier* (New York: Basic Books, 1977); M. Christine Boyer, *Dreaming the Rational City: the Myth of American City Planning* (Cambridge, MA: MIT Press, 1983); John Reys, *The Making Of Urban America* (New York: Princeton University Press, 1992); Frank Lloyd Wright, *The Disappearing City* (New York: William Farquhar Parson, 1932); Peter Hall, *Cities of Tomorrow: an Intellectual History of Urban Planning and Design in the Twentieth Century* (Cambridge, MA: Blackwell Press, 2002); and Martin Gabriel White and Lucia White, *The Intellectual Versus the City* (Cambridge, MA: Harvard University Press, 1962).

some commentators to feed fears of growing industrialization (and a loss of the rural ideal in American society), reality showed that citizens in urban spaces were indeed subject to different stresses, health hazards, and concerns than their country cousins. While the city was filled with congested housing conditions, runaway infectious disease, and noisy, dangerous streets, Milwaukee could also boast a greater concentrations of hospitals and medical care, increasing health education, and a growing emphasis upon public health measures than the surrounding rural areas. The urban space presented Milwaukee's citizenry with the best and worst of both worlds, but still with an experience that was uniquely urban and uniquely turn of the century.

A belief in the transformative power of the landscape drives this particular work on the city of Milwaukee. While two of the major sources of evidence for this study are county-based, the majority of the patrons served therein were from the city.²⁰ While the borders of the city of Milwaukee were in flux during this period, the research presented stayed as true to the city's boundaries as possible. When able, county or other non-resident individuals, stories, and institutions were excluded. A few, however, have been retained for descriptive and narrative purposes as they illustrate larger points about shifts in health attitudes and social circumstances during this period.

There were numerous ending points to close this particular study of the Milwaukee's health. Nineteen-twenty-nine was chosen as the concluding point of the historical study even though the issues, institutions, and subjects of study live on long after 1929. The start of the Great Depression in 1929 added an entirely new level of

²⁰ The city's population accounted for between 83 and 85 percent of the total county population between 1880 and 1920, with the highest percentage (86.60 percent) in 1890. This percentage would finally dip below the 80 percent mark in 1930 (79.73 percent).

complexity to the discussion of health in the city of Milwaukee. With the reorganization of health care systems in light of the faltering economic situation and the arrival of federal aid, the focus of any discussion would likely have drifted from its intended purpose; hence the end date of the study. While relief and health related issues intertwined long before the financial collapse that led to the Great Depression, the overreaching federal role in those agencies complicated what was already an intricate and complex relationship.²¹

In looking at public health, my methodology started with the larger institutions and agency records as a way of gaining demographic information about the population under study. The Milwaukee County Hospital ledgers and the corresponding Pauper Cemetery Burial Registry provided the first evidentiary material upon which my later research was based. While starting with broader records seemingly contradicts the bottom-up approach, starting with a broader picture of the overall population helped to focus on specific individuals and cases. The coroner's report on Fredrich Reüchert and his tragic story, which is recounted in the men's health chapter, would have been invisible in the countless boxes on file at the Milwaukee County Historical Society had it not been for the appearance of both his name and his daughter's in the pauper cemetery's burial registry. In trying to understand the individual stories that make up the collective experience, one frequently needed to start at a much broader level.

²¹ For a further discussion about the growing complexity of medical and social services with the onset of the Great Depression, see Walter Trattner, *From Poor Law to Welfare State* 6th ed. (New York: Free Press, 1999); George Rosen, *A History of Public Health* (1958; repr., Baltimore: Johns Hopkins Press, 1993); David Kennedy, *Freedom From Fear* (New York: Oxford University Press, 2001); Michael Katz, *In the Shadow of the Poorhouse* (New York: Basic Books, 1996) and *The Undeserving Poor* (New York: Pantheon Books, 1986); and Richard Scott, Martin Reuf, Peter Mendel, and Carol Caronna, *Institutional Change and Health Care Organization: From Professional Dominance to Managed Care* (Chicago: University of Chicago Press, 2000).

The records themselves were disparate in their completeness. A number of the private hospitals and health organizations puzzled at my inquiries regarding their historic institutional records, especially those made regarding records prior to the 1950's or even the 1970's. Apocryphal stories of records kept "in someone's file cabinet" or in boxes under someone's desk were the only evidence regarding the last known resting places of certain institutional records. Even the records of some municipal institutions, such as the Johnston Emergency Hospital, were destroyed because of simple space concerns as one department's records took importance and precedence over others. Records regarding health conditions frequently were seen as less significant and therefore less important for preservation purposes than planning reports, sewage designs, or transportation summaries. Valuable information about one individual, unit, or even period can be fundamentally different as time, agencies, and priorities in a society change. Emergency hospital records were seen as dispensable and non-essential, and were therefore slated for destruction. "Housecleaning" by the Milwaukee Health Department in the late 1990's resulted in the unintentional loss of other health related records. Records deemed significant to one person were simply a pointless waste of valuable shelf space to another.

The history of individuals, especially ordinary people, also presents an especially challenging area of study. Archival collections are subject to the whims and fancies of archivists and decisions of what is "worthy" to retain. Personal accounts, diaries, recollections, and letters retained by archives are heavily weighted toward the prominent and influential, rather than the ordinary and common. Even the former rarely dealt with personal health related issues. Perhaps deemed too inconsequential or personal for everyday correspondence or record keeping, medical events frequently elude modern

researchers. Influenzas come and go every year; why bother writing about one in 1918 when it was of no great consequence the year before? Measles and smallpox were common everyday parts of life; why note them in everyday correspondence? It was more important to record how many tons of iron ore your company shipped that week than how many factory accidents had occurred. Even moral propriety governed the discussion and documentation of diseases. Diseases such as gonorrhea and syphilis, associated with loose living and sinful behavior, were not considered proper topics of polite conversation or public discourse.

Despite these difficulties, there were a few bodies of evidentiary material whereby the story of the common Milwaukeean and frequently the poorest within the community came to light. These records touch upon those whose American dream dissolved into the reality of the urban landscape and the industrial machine. Coroner's reports, Milwaukee County Hospital patient ledgers, and the burial registry of the Milwaukee County Poor Farm provide some of the clearest evidence of the health and wellness (or lack thereof) in the city's population. These institutional records recount the history of those who could not afford the best medical care, who were victims of the industrial machine, and whose golden promise of hope in this new land soon tarnished. Whether from the hospital records, the coroner's reports, or the burial registry for those too poor, disgraced, or unknown to be buried elsewhere, these evidentiary materials speak volumes to the legacy of the urban environment and its effect on everyday citizens. We see within these records the chronic occupational ailments, the freak industrial accidents, the ravages of drug and alcohol abuse, the sad story of the sexually exploited, and of the crushing despair that could come when all hope was lost. Ironically, it was by being the poorest and by having

the most ignominious of illnesses and deaths that so much is known about these people. The healthy, the middle class, and the wealthy were served by private hospitals; these institutional histories were less available to historians. The sick and poverty-stricken had few such shields and ironically provided a richer body of evidence for study. By understanding both the possibilities and limitations of this research, one can paint a more vivid picture of the health concerns and needs of Milwaukee's citizenry during one of its most formative periods.

With the rise of the Progressive movement, Milwaukee's citizens, both ethnic and native-born, found themselves torn between age-old traditions, the advice of professionals, and their own personal fears and frustrations in navigating an increasingly complex world. This conflict can be viewed through the metaphor of translation. Each group saw the late nineteenth and early twentieth centuries in Milwaukee through their own lenses, with their own codes, symbols, and languages. Each group brought to the table their own preconceptions, misconceptions, fears, doubts, and experiences, and utilized those as a way, however faulty, to understand—and—contend with others. Pregnant immigrant women struggled not only with issues of language and culture, but also with the imposition of male medical professionals in what was traditionally a woman's domain. Industrial workers struggled with class as well as ethnicity issues as they strove to make a living in the machine shops, breweries, and rail yards of the city. African Americans struggled with issues of racial discrimination and attitudes that barred them not only from certain occupations and residences, but also excluded them from

medical care and treatment from which others benefited.²² Each group had its own understanding of the world. Only through carefully negotiating these different understandings could one create a cohesive and well functioning society. It is in this dialogue between citizen and society, patient and doctor, immigrant and native-born that the real story of a community and the health or sickness of its population lies.

As previously stated, this work is not an attempt to retell the institutional health history of Milwaukee. Instead, this study seeks to complement Judith Leavitt's earlier work and expand our understanding of the city and its health through an examination of everyday citizens. By making the common Milwaukeean the focus, not the institutions and how they operated, a new perspective on the city's health comes into focus as Milwaukee strove to become the "healthiest" city.

An examination of the everyday Milwaukeean presents the "real" health of the city, whereas official governmental statistics and health department reports only recount part of the story. An iceberg metaphor fits aptly this discussion of Milwaukee's health: the health department reports and official statistics represent the small part of the iceberg that one sees above the surface. They are publicly visible and seem quite substantial in regard to our understanding of the whole. However, the death records, diaries, and hospital ledgers represent the portion of the iceberg below the water line. These records provide a larger body of information and are essential to our understanding of health conditions in the city. They provide a detailed snapshot in order to comprehend the true

²² For a discussion of African American life in Milwaukee, see Joe William Trotter's influential volume, *Black Milwaukee: The Making of an Industrial Proletariat*, 2nd ed. (Chicago: University of Illinois Press, 2006).

magnitude of the larger object before us.²³ The real health of the city can be quite different from the perceived health that official documents and agencies purport, and this study intends to disclose what lies beneath the waterline.

²³ This metaphor in medical sociological circles is referred to as the “iceberg of morbidity.” It stems from the idea that the amount of disease or illness actually reported to health professionals is minute in comparison to the real numbers in society. For more information about the problems of the accurate reporting of morbidity as well as perceptions of illness, see J.M. Last, “The Iceberg ‘completing the clinical picture’ in General Practice,” *The Lancet* 282, no.7297 (6 July 1963): 28-31; D.R. Hannay, *The Symptom Iceberg: A Study in Community Health* (London: Routledge, 1979); E.H. van de Lisdonk, “Perceived and Presented Morbidity in General Practice,” *Scandinavian Journal of Primary Health Care* 7 (1989): 73-8; and S.E. Kooiker, “Exploring the Iceberg of Morbidity: a comparison of different survey methods for assessing the occurrence of everyday illness,” *Social Science and Medicine*, 41, No.3 (1995): 317-32.

Chapter One:

Milwaukee's Women

Introduction

When examining the health of a city, the seemingly logical place to start was with those who were responsible for the health, reproduction,¹ and some might suggest the moral fiber of its community: its women. A woman's place in nineteenth and early twentieth century America was complicated and evolving. While women were supposedly locked within the boundaries of the "sphere of domesticity," they were utilizing those same social stereotypes to gain greater voice within the urban and reform communities of these decades.² Similarly, the field of women's health dynamically shifted during this period, as the control of women's bodies became a point of public contention and debate.

¹ The term "reproduction" here is used in the context of "replication."

² For more information about the attitudes regarding women during the late nineteenth and early twentieth centuries, see Barbara Welter's seminal article "The Cult of True Womanhood: 1820-1860," *American Quarterly* 18, no.2 (1966): 151-74; Carol Smith-Rosenberg, *Disorderly Conduct: Visions of Gender in Victorian America* (Oxford: Oxford University Press, 1985); Marlene Stein Wortman, "Domesticating the Nineteenth-Century American City," *Perspectives* III (1977): 531-72; Margaret Gibbons Wilson, *The American Woman in Transition: The Urban Influence, 1870-1920* (Santa Barbara, CA: Greenwood Press, 1979); Rosalind Rosenberg, *Beyond Separate Spheres: Intellectual Roots of Modern Feminism* (New Haven: Yale University Press, 1982); Judy Giles, *The Parlour and the Suburb: Domestic Identities, Class, Femininity, and Modernity* (Oxford: Berg, 2004); Joan Scott and Debra Keates, ed., *Going Public: Feminism and the Shifting Boundaries of the Private Sphere* (Urbana, IL: University of Illinois Press, 2004); S.J. Kleinberg, *Women in the United States, 1830-1945* (New Brunswick, NJ: Rutgers University Press, 1999); and Betsy Klimasmith, *At Home in the City: Urban Domesticity in American Literature and Culture, 1850-1930* (Lebanon, NH: University Press of New England, 2005).

Medical concerns surrounding pregnancy and childbirth had always been critical issues for women as the greater portion of an adult woman's life could be spent in cycles of pregnancy and childbearing. These familiar subjects, however, were in dramatic flux by the late nineteenth century in light of advances in medicine, the professionalization of the obstetrical field, and the development of the bacteriological theory of disease.

Childbirth moved out of a purely woman's domain as the practice of midwives "catching babies" was soon to be replaced by obstetricians "delivering" women of their children.

Growing pressure for women to be the passive recipients of medical advice and care quickly replaced active agency. Alongside this professionalization of the obstetrical field were growing fears of "race suicide" among native-born populations. Rooted in the fears surrounding the influx of Southern and Eastern European immigrants and their supposed "inferiority," reproductive rights gained a political and racial slant as well.

Milwaukee women, both immigrant and native-born, shared these same health concerns with women in other large urban areas. As women increasingly stepped out of the home and into the workplace and socio-political arena, they challenged as well as reformed issues, surrounding their biology. Reproductive health and venereal disease as well as the link between health and morality would be rethought, reworked, and renegotiated at the turn of the twentieth century, both on the national front as well as in the streets and hospitals of the city of Milwaukee.

Pregnancy and Childbirth

Pregnancy and childbirth issues have been one of the prime concerns for women throughout history since the frequent cycles of pregnancy and childbirth often caused

physical and psychological stress. While some women rejoiced at the thought of motherhood, others were anxious, if not fearful of each succeeding pregnancy. Most women forged ahead with these pregnancies with little knowledge of proper diets, appropriate clothing, or a chance to recuperate either body or mind between their successive pregnancies. Over time, frequent pregnancies, resulting in live, still, or premature births, exacted a severe physical toll on women's bodies as they were constantly under stress. Nutritional deficiencies, prolapsed uteri, and poorly healed lacerations incurred during labor were common conditions physicians saw in women during this period.

Physicians examined women permanently debilitated by childbearing and sought to prevent lifelong disabilities by educating and instructing women on proper prenatal and postnatal care of both themselves and their children. During this period, a growing movement in the medical community began to connect good maternal health with good pediatric health. By ensuring the health of the mother, the health of the child could also be assured. A Milwaukee Health Department pamphlet entitled "The Care of the Baby and Young Child" extorted that "[e]very baby has a right to a healthy mother."³

While local Milwaukee institutions would finally offer pre-natal care and clinics by the 1920's, institutions such as the Milwaukee Maternity Hospital, the Milwaukee Health Department, and the Social Hygiene Society laid the groundwork for "better mothers" and "better babies" through publications, media campaigns, and social work. The utilization of print media proved a key element in reaching a large part of the city's

³ John P. Koehler, *The Care of the Baby and Young Child* (Milwaukee: Milwaukee Health Department, 1935), 1, Mss 2126, Milwaukee Health Department Collection, Milwaukee County Historical Society (hereafter MCHS).

different social, economic and ethnic classes during the early twentieth century and proved to be instrumental in publicizing their message.⁴

This local focus on maternal health paralleled a growing national focus that culminated in 1912 with the creation of the National Children's Bureau. Originally a part of the Department of Commerce, the bureau fell under the power of the Department of Labor in 1913. This bureau was created as the primary government agency working toward the improvement of maternal and infant welfare. It became a strong advocate of comprehensive maternal and infant welfare services. Medical staff at the bureau understood that in order to advance the health of children one had to advance the health of their mothers since sick and unhealthy women frequently produced sick and unhealthy children. Prior to this period, improvements in child mortality rates had focused on immunizations for childhood contagious diseases and sanitary improvements. By supplementing that approach with an emphasis upon the care of the mother, the bureau fundamentally changed the approach of the government and health establishment's approach to combating infant mortality. By working to "educate, monitor and care for pregnant women," they would by default care for the children that these women would bear as well.⁵

Booklets and pamphlets published by the Milwaukee Health Department, among a variety of other social and medical organizations, detailed practical and medical advice for expectant mothers. A Milwaukee General and Maternity Hospital brochure presented

⁴ Kathleen Conzen, *Immigrant Milwaukee* (Cambridge, MA: Harvard University Press, 1976), 183-189; Judith Walzer Leavitt, *The Healthiest City: Milwaukee and the Politics of Health Reform* (Madison: University of Wisconsin Press, 1996), 256-57.

⁵ "Achievements in Public Health, 1900-1999: Healthier Mothers and Babies," *Morbidity and Mortality Weekly*, October 1, 1999, v.48 (38): 848.

advice to the expectant mother through an interesting approach by addressing the woman initially as a bride: “The Bride should be in good health. She should be familiar with the duties of a bride.”⁶ Women were expected to have an understanding, however implied, of their marital responsibilities that would lead them to their highest goal in life, motherhood. Women were expected to bear the burden of frequent pregnancies and numerous children as part of these expectations.

To be fair, the pamphlet also took time to address the husband’s responsibilities towards his wife and child. Husbands were reminded frequently of their moral duties to wife and child, along with their financial and physical duties. Instead of the more practical advice about changing diapers or tending colicky babies that one might find in modern pregnancy and early childhood manuals, fathers in this pamphlet from a century ago were reminded that “the pregnant woman is performing the noblest work of the human family, and she is enduring—gladly and willingly—for him all the pain and suffering which accompanies her ordeal.”⁷ He was reminded to treat her with the respect which this duty deserved in consideration of her great suffering for his and his progeny’s sake. These manuals instilled middle class values and societally correct views on marriage and motherhood. They focused on indoctrinating women and men, especially the poor and immigrant classes, toward “proper” relationships, proper marital expectations, and proper marital goals. These were the fundamental objectives for those concerned with producing a “better” society.

⁶ Milwaukee General and Maternity Hospital, Untitled Brochure, n.d., Milwaukee Manuscript Collection BG, Box 13a, United Community Center, Hospital Council of Milwaukee, 1929-1934, United Community Services of Greater Milwaukee, Records 1903-1969, University of Wisconsin, Milwaukee (hereafter UWM).

⁷ Ibid.

While extolling ideals of motherhood and wifely duties, this three-page pamphlet also acted as an instruction manual for women as they progressed in their pregnancies. The pamphlet suggested that women wear comfortable and loose fitting clothes, specifically avoiding either tight fitting or “pregnancy” corsets that were popular dress for the day. The booklets also advised expectant mothers to sleep at least eight hours a night, preferably with windows opened to allow for fresh air and good circulation in the sleeping quarters. Advice was also handed out regarding the types of foods to avoid (spicy and rich) and consume (soothing and bland) during the pregnancy. A 1932 *Milwaukee Leader* article printed advice from Dr. M.M. Sherwood, Chief of Staff of the Milwaukee Maternity and General Hospital, advising expectant mothers to “drink at least a pint, and preferably a quart of milk every day.”⁸ Substantial quantities of fat, meat and vegetables were recommended by a number of sources as being beneficial to both mother and child.

Finally, the booklets placed a strong emphasis on professional medical care. It was in the publishing institution’s best interest to promote this idea, since hospitals were supported by the growth in professional obstetrics. The pamphlets strongly reinforced the importance of doctors, obstetricians, and hospitals for the pregnant woman’s well being. The woman was to “place her entire faith in her Physician.”⁹ Women were frequently extolled to put their trust and lives in the hands of the growing numbers of obstetricians. Progressive and “modern” women in the twentieth century no longer sought the advice or services of midwives; instead they went to hospitals to be delivered of their children.

⁸ “Advises Milk in Expectant Mothers’ Diet,” *Milwaukee Leader*, January 25, 1932.

⁹ Untitled Brochure, Milwaukee General and Maternity Hospital, n.d., Milwaukee Manuscript Collection BG, Box 13a, United Community Center, Hospital Council of Milwaukee, 1929-1934, United Community Services of Greater Milwaukee, Records 1903-1969, UWM.

Hospitals provided supposedly sanitary conditions and the most modern medical techniques for the benefit of mother and child. The message in these pamphlets was decidedly clear: to be a “good mother” meant putting your trust squarely in the hands of medical professionals and the medical establishment. Anything less would fall short of one’s moral and motherly duties.

The health of the mother could no longer be neglected as a factor in the health of the child. A woman’s nutrition, her encounters with disease, her occupational experiences, and her standard of living all contributed to the health of her child. Nutritionally based diseases, such as marasmus¹⁰ or porotic hyperostosis,¹¹ frequently seen in children, had their start in the mother and her health history. By providing for better care of expectant mothers, doctors hoped to assure healthy children as well. Among doctors and health professionals, there was a growing realization that “if the mother doesn’t get a proper diet during the nine months the child is developing the result will be that the child will grow at the expense of the mother.”¹² Not only would children fail to develop correctly, but the pregnancy itself would physically tax and possibly destroy the health of the mother. Through providing both practical and moral advice, these brochures and the organizations behind them hoped to mold the behavior of pregnant women. By guiding them toward “proper” and “modern” mind-sets, women could be encouraged to provide for better health of their children by providing better care

¹⁰ Marasmus is a form of severe chronic malnutrition in children which can originate in utero with the poor nutrition of the mother. It is caused by a severe deficiency of nutrients, especially protein and calories. Augustus Caillé, *Differential Diagnosis and Treatment of Disease* (New York: Appleton & Co., 1906), 142-43.

¹¹ Porotic Hyperostosis is a disease that causes bone tissue to appear spongy or pitted. The disease had frequently been linked to iron deficiency brought on by malnutrition. The most clear manifestations of this condition is a pitting in the eye orbits of infants and children. For further reading, see Jeffrey H. Schwartz, *Skeleton Keys* (New York: Oxford University Press, 1995), 20-22.

¹² “Advises Milk,” *Milwaukee Leader*.

for themselves. Simply put, child care began first with mother care.

Conflict Between Obstetricians and Midwives

The field of obstetrics is a relatively recent addition to the medical discipline. The term obstetrics was not coined until the early nineteenth century and referred to “the doctrines or practice of midwifery.”¹³ The mid to late nineteenth century saw the first references to obstetricians as medically schooled physicians. Most of the physicians who entered the field of obstetrics were men, due to the limited medical education opportunities available to women during this period. Men had been, since the eighteenth century, attendants or accoucheurs for female midwives as they treated women in their homes. The nineteenth century witnessed the full development of the field of obstetrics, with the transition from home births with attending midwives to hospital births with attending obstetricians. This shift in obstetrics in the nineteenth and early twentieth century showcased the change from midwives “comforting the parturient and waiting” to the male obstetrician’s active intervention in the birthing process.¹⁴ Paralleling this movement was the broadening of care from simple lying-in or confinement care to a focus on prenatal care as women moved from home to hospital care.¹⁵

Midwives had for centuries aided women in childbirth. Female midwives

¹³ Online *Oxford English Dictionary*, “Obstetrics,” www.oed.com, (accessed 03/25/2008).

¹⁴ Judith Walzer Leavitt, *Brought to Bed: Childbearing in America 1750 to 1950* (New York: Oxford University Press, 1986), 37.

¹⁵ For further discussion regarding the evolution of obstetrics in American medicine, see Charlotte Borst, *Catching Babies: The Professionalization of Childbirth, 1850-1920* (Cambridge, MA: Harvard University Press, 1995); and Judith Walzer Leavitt, “The Growth of Medical Authority: Technology and Morals in Turn-of-the-Century Obstetrics,” *Medical Anthropology Quarterly* Vol.1, No.3, (September 1987), 230-255.

provided a female social network for women to aid in all aspects of pregnancy and childbirth. Women also turned to midwives for advice on parenting and terminating unwanted pregnancies. While common with all classes of women in the eighteenth and early nineteenth centuries, upper class women started to “invite” male physicians into the birthing room as “technical experts” to aid in difficult deliveries.¹⁶ These newly invited male medical professionals were skeptical of the medicine midwives practiced. A growing field of obstetricians set out to displace midwives as the primary authority at the foot of the birthing bed. While the women relied on practical experience, the men promoted their expertise with formal education in obstetrical practices. Promoting ideas of science and modernity, obstetricians cast midwives as backwards, unqualified, and downright dangerous for both mother and child. Women were increasingly encouraged to deliver their children in modern, sanitary hospitals, not in their own unhygienic bedrooms.¹⁷

Even prior to the twentieth century’s growth in obstetrics, there were attempts on the part of some medical professionals to regulate midwives. Milwaukee’s Health Commissioner, Isaac H. Stearns, in his 1878 annual report feared that “many women in this community were practicing midwifery without the proper qualifications.”¹⁸ Unlicensed medical practitioners were a common danger to the general population, and he hoped to “set about the difficult and delicate task of sorting the white sheep from the black.”¹⁹ Stearns proposed to check the certifications and qualifications of the midwives as

¹⁶ Leavitt, *Brought to Bed*, 4.

¹⁷ *Ibid.*, 142-195.

¹⁸ Milwaukee Health Department, Annual Report, 1878, Legislative Reference Bureau (hereafter LRB).

¹⁹ *Ibid.*

they came to the city's vital records office to submit death certificates²⁰ of children who had died during delivery.²¹ He directed his records clerks to refuse "to sign any such [death] certificate until the midwife sending it in could substantiate her qualifications to practice her art."²² Pleased with the result of his efforts, the Health Commissioner noted that "many exhibited diplomas, regularly issued by the proper medical authorities of Germany. Others were able to bring the endorsements of respectable physicians in this city . . . [a] few, who had no diploma and could not bring satisfactory recommendations, passed a satisfactory examination in this office."²³ Any midwife who could not meet these qualifications was put on a "rejected" list. The Milwaukee coroner would automatically investigate any death certificate submitted by these non-licensed midwives. This early quality control of medical professionals provided the Health Department with some assurance as to the medical care provided by these midwives who often fell outside the normal medical establishments. Frequently accused by the medical establishment of immoral and illegal activities, they were nevertheless defended by Sterns who noted, "the educated midwives of Milwaukee are, as a class, conscientious, laborious, useful women."²⁴

Others, however, had less favorable opinions of midwives and the trade they

²⁰ A death certificate is the official record of death kept at the Vital Records office of the City of Milwaukee. They can only be signed by doctors, coroners, and certified medical professionals. In the early twentieth century, they recorded the name of the deceased, parents of the deceased, place of death, primary and secondary causations of death, ethnicity/race, and where the deceased would be buried.

²¹ Presently the City of Milwaukee no longer issues death certificates for stillbirths or miscarriages. The logic behind the decision is that a death certificate can only be issued if the person was living, that is, if there was a birth certificate issued. Since the child was never alive, no birth certificate was ever issued and therefore no death certificate can be issued. The city, however, does keep record of stillbirths for statistical purposes.

²² Health Department, Annual Report, 1878.

²³ Ibid.

²⁴ Ibid.

practiced. Clara Hipke, the founder of the Milwaukee Maternity Hospital, had few kind words for the midwives of the city, suggesting that the childbearing in the city was “inefficient and in the hands of self-named midwives whose moral standing was questionable.”²⁵ Outside of their “questionable morals” (which hints at the abortion practices of some midwives), Hipke also focused on one of evils that Progressivism sought to combat: inefficiency. When Hipke established the Milwaukee Maternity Hospital in 1906,²⁶ she sought to fill a “great need in Milwaukee for a place where poor women could be properly cared for before and during child birth, and where babies could be cared for after birth.”²⁷ The efficiency of complete obstetrical services under one roof was the height of progressive thinking for Hipke; it was contrary to logical thinking not to seek the best and most advanced medical practices if they were available. Why use old world European traditions when you lived in the brave new world of America? In 1914, the Maternity Hospital cared for over 327 poor mothers, dealt with sixty-six surgical cases, thirty-one medical cases, and had over 8,954 visits by physicians for women at home and in the hospital.²⁸

Hipke, a physician’s wife, saw a distinctive gap between the need of maternity services and the actual services available for women. She was concerned that women, especially the poor in the community, had nowhere to go for maternity care. The Maternity Hospital was always open for emergency maternity cases, unlike the County Hospital which required admission through the County Poor Office. She lamented: “What

²⁵ “Maternity Hospital Improves the Coming Generation of City,” *Milwaukee Leader*, January 2, 1915, “Milwaukee Features – Hospitals” microfilm, MCHS.

²⁶ “Illness Fatal to Mrs. Hipke,” uncited newspaper, December 2, 1938, Hipke Family Collection Mss 1625, Clara B. Hipke, Activities, 1907-1938, MCHS.

²⁷ “Maternity Hospital Improves the Coming Generation of City,” *Milwaukee Leader*.

²⁸ *Ibid.*

would be done at midnight in an emergency case? The poor office is closed at night.”²⁹

She also had begun, with the creation of the hospital, a battle with the midwives of the city over dominance in the birthing process.

Hipke was only one of a number of health crusaders who moved to exclude midwives from the birthing room in favor of obstetricians trained at medical schools. In 1915, the Maternity Hospital estimated that 4,000 cases each year were attended by midwives who in their eyes had “no scientific education and who know little or nothing about prenatal work and other features in the field of obstetrics.”³⁰ Clara Hipke of the Maternity Hospital and others in the medical establishment believed midwifery care to be decidedly inferior, even dangerous, when compared to obstetrical care and that “if all these cases were properly cared for by physicians . . . great numbers of fatalities and the greater number of injuries would be greatly reduced.”³¹

²⁹ Ibid.

³⁰ Ibid.

³¹ Ibid.

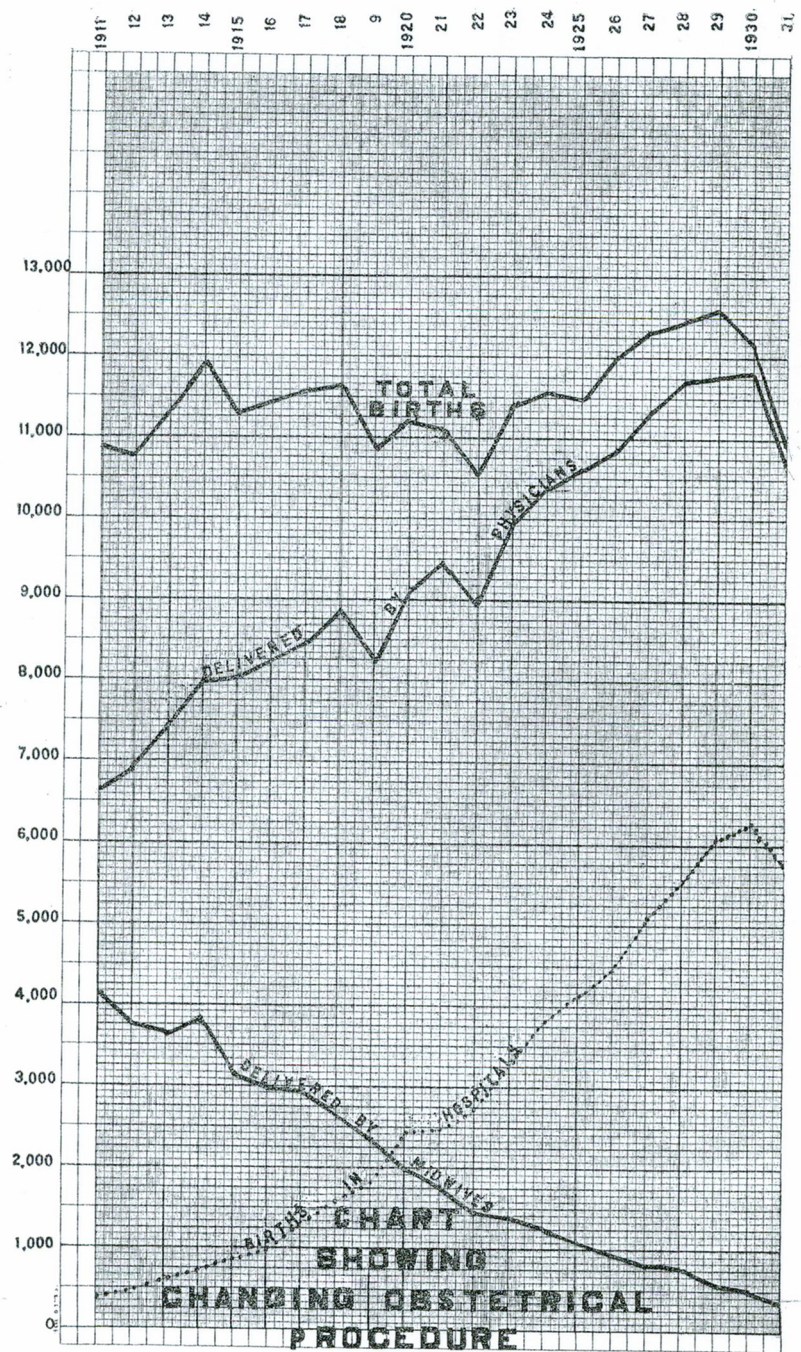


Figure 1: Changes in Obstetrical Procedure in Wisconsin, 1911-1931³²

³² City of Milwaukee, Vital Statistics Office. Data from Vital Statistics Office was not part of any established collection or repository, but located in binders in the main office of the Milwaukee Vital Statistics Office.

By 1941, when Dr. Gerald F. Burghardt surveyed the obstetric picture in Milwaukee, “the proportion of women delivered by midwives has fallen...still have eleven women within the city engaged in obstetrical work.” Burghardt further commented that “[h]ospitals have become almost the accepted place of delivery . . . seventy five percent were hospital cases.”³³ Figure 1 illustrates the shifting tides of obstetrical procedures and clearly demonstrates the growth in hospital and physician assisted births, and the decline in midwife deliveries. Prophetically, Sterns in 1878 would also note his wish to have “the same power to sort male practitioners, to make a white list of useful physicians and a black list of pretenders. If the death work of quacks could be peremptorily passed over to the coroner, not only in obstetrics but also in every department of practice, the community would soon be rid of a great and perilous nuisance.”³⁴ The medical establishment would promote the safety and modernity of obstetrics, especially the importance of hospital deliveries. However, they frequently failed to live up to their progressive promises.

Puerperal Fever & Problems with Delivery

While Hipke and others in the medical establishment were quick to extol the virtues of obstetricians, there were many critics who contended that delivery by doctors was no safer and sometimes even more dangerous than by midwife. The field of obstetrics was avoided by many physicians as a lesser field of medicine governed by

³³ Gerald F. Burghardt, M.D, “Obstetrics in Milwaukee,” *Wisconsin Medical Journal* (May 1941): 1-5.

³⁴ Milwaukee Health Department, Annual Report, 1878.

what were seen to be “poorly trained or untrained medical practitioners,” people who often used “inappropriate and excessive surgical and obstetric interventions (e.g. induction of labor, use of forceps, episiotomy and cesarean deliveries).”³⁵ Governed by laws of Victorian morality and “decency,” obstetricians had only practiced on models of women before being sent to their first real obstetrical case. Being unable to train on real women frequently left male obstetricians embarrassed, confused, and at times completely clueless by the sights and sounds they witnessed in the birthing room.³⁶

Doctors in the emerging field of obstetrics were eager to demonstrate their skill and utilize the newest techniques and procedures being promoted by the medical schools. A 1940 report of the obstetrical situation in Milwaukee noted that the use of instruments, specifically forceps, had become quite a common practice, as had the growing use of cesarean section deliveries.³⁷ Obstetricians were criticized, within and outside of the field, for the frequent and often hasty use of instruments and drugs to accelerate the rate of deliveries. Doctors, either untrained or anxious to move on to the next patient, applied high forceps during the early stages of labor in order to more quickly extract the child. Ergot and opium were also used to help with the birthing process, to both speed up contractions and return the uterus to its pre-birth state after delivery. In tandem with this rapid growth of the profession came a tendency to use the newest, if not necessarily the safest, practices and procedures in the name of progressive medicine.

Prior to the widespread use of antibiotics, cesarean sections were exceedingly dangerous operations since any procedure that opened the abdominal cavity had the

³⁵ “Achievements in Public Health,” *Morbidity and Mortality Weekly*, 849.

³⁶ Leavitt, *Brought to Bed*, 39-43.

³⁷ Burghardt, 2-3.

potential for sepsis. During difficult deliveries, doctors were apt to perform a craniotomy³⁸ rather than a cesarean section, especially for home deliveries where asepsis conditions could not be guaranteed. It was only after the discovery and regular use of antibiotics that cesarean sections became commonplace. In 1940, the County Hospital recorded an “incidence of 3.2 per cent of cesarean sections in a total of 1,290 deliveries.”³⁹ Many obstetricians prioritized the life of the mother over that of the child, preferring to sacrifice the life of the child being born over the possibility of losing both mother and child by doing nothing.

Aseptic conditions in either home or hospital settings, however, were not any more prevalent among medical professionals than midwives prior to the 1920s. In 1847, Ignaz Philipp Semmelweis, a German-Hungarian doctor practicing in the obstetrical ward of Vienna’s General Hospital, made the first connection between the pathological dissections of his colleagues and the epidemic of puerperal fever among women in the lying-in ward. Failing to wash their hands after the dissections, doctors would go straight to the ward to either examine women in labor, to deliver babies, or to examine those recently delivered of children. Noting that those women who fell ill from puerperal fever were seen by those physicians who had come straight from dissections to the ward, Semmelweis instituted a regime which called for doctors to wash their hands in a solution of chloride of lime after the dissections and before examining any further patients. The puerperal infection rate dropped from eighteen to approximately 2.5 percent. His colleagues failed to clearly understand his theory that was further clouded by his

³⁸ The craniotomy process of abortion perforated the skull of the infant which was then compressed and crushed to allow for extraction from the birth canal. This form of abortion was usually only used in life threatening situations during labor and delivery when the child could not be safely extracted.

³⁹ Burghardt, 3.

unwillingness to speak publicly about his ideas, causing fellow doctors to dismiss and ridicule Semmelweis and his notions. Only long after his death, Semmelweis and his revolutionary contribution to medicine were fully recognized for they predated Lister and his asepsis theories by twenty years.⁴⁰

Hospitals in the nineteenth and early twentieth centuries were seen more frequently as places of death, not necessarily of healing. Without antibiotics or asepsis techniques, hospitals could not easily control infections in patients or infectious outbreaks on wards. Women saw lying-in hospitals or lying-in wards of general hospitals as places of disease and possibly death, not places of new life. Women feared the doctors and their wards, knowing that their babies might return home but not themselves.

Women's homes, however, were no more safe from incompetent physicians and puerperal fever. More than one Milwaukee County Corner's report details the outright negligence or inaction of doctors in difficult labors. As noted previously, obstetricians were only one of a group of actors in the birthing room in the nineteenth century. While they were frequently called to assist and provide expertise in difficult births, they also had to contend with midwives, husbands, family members, and the birthing mothers themselves when it came to making decisions about how the birth should proceed. Unfortunately for these doctors, their lack of practical experience left them and the women they cared for in precarious situations. One particular example in 1884 recounts the labor and delivery of a thirty-nine year old married woman. After approximately twelve hours of a difficult and unproductive labor, the midwife finally called a doctor to

⁴⁰ Ironically, Semmelweis died tragically of blood poisoning in a Viennese insane asylum in 1865. For a discussion of Ignác Semmelweis and his work discovering the origins of childbed fever, see Sherwin B. Nuland, *The Doctor's Plague: Germs, Childbed Fever, and the Strange Case Story of Ignác Semmelweis* (New York: W.W. Norton, 2003).

assist and hopefully deliver the baby which was in a breach presentation. Doctor “A” was called and, after two hours of attempting to turn the child manually, he finally attempted a forceps delivery (which had been growing in popularity since the mid-nineteenth century). Failing multiple times to extricate the child (the head kept slipping out of the forceps), he called for a second physician. Upon the second physician’s arrival, they briefly argued about the second’s participation in this increasingly dire case. The second physician finally consented to try his hand, or in this case his forceps, at delivering the child. After an additional three hours of attempting to manually turn the child and trying to deliver the child with forceps, they finally succeeded in delivering the infant, now dead. The mother, unfortunately, was in little better shape.

In one of the attempts to deliver the child with the forceps, the second doctor most likely ruptured the uterine wall and the mother started hemorrhaging quite severely after the child was finally delivered. Arguments between the two doctors ensued even after the delivery, debating as to where blame lay regarding the condition of the mother, and whether or not to prescribe any pain medications. Finally Doctor “A” prescribed opium for the woman, as her case was deemed unrecoverable. She died two days later from a massive septic infection brought on by the botched delivery attempts of the two doctors. While a midwife would not have had the tools to successfully deliver the child, she could have done no worse than the obstetricians who attended this birth—and death.⁴¹

⁴¹ Christine Radtke, Coroner’s Report, August 28, 1884, Mss 306, Milwaukee Coroner’s Reports, MCHS.

Mortality

Pregnancy trauma and childbirth have been significant factors in female mortality rates deep into the twentieth century. A 1999 special report by the Centers for Disease Control estimated that at the beginning of the twentieth century for “every 1,000 live births, six to nine women in the United States died of pregnancy related complications.”⁴² The highest rates of maternal deaths documented by the CDC were recorded from 1900 to 1930. Today’s maternal death rate of less than 0.1% resulted from a decrease of almost 99 percent in less than seventy years.⁴³

Health concerns related to pregnancy were larger and more varied than the dangers of labor and delivery. High blood pressure, eclampsia, and diabetes were problems for pregnant women long before they had medical definitions. Miscarriage and stillbirth rates were also quite high into the twentieth century. This was caused by common nutritional deficiencies and the occupational hazards that women faced. Once the expectant mother made it to the actual labor and delivery, the more tangible dangers of childbirth became apparent. The physical process of labor and delivery, owing to our unique human physiology, is an arduous and difficult task for the mother. Complications with delivery were not uncommon, and without skilled assistance, could result in the loss of mother, child, or both. Breech presentations, cephalopelvic disproportion,⁴⁴ and retained placentas were common and potentially deadly problems, especially for home deliveries.

⁴² “Achievements in Public Health,” *Morbidity and Mortality Weekly*, 849.

⁴³ *Ibid.*

⁴⁴ Condition where the infant’s head is larger than the mother’s pelvic opening.

The way in which women delivered children was in dramatic flux during the opening of the last century as fewer women, especially urban women, delivered their children at home, opting instead to deliver in hospitals. While midwife deliveries did not offer the medical attention of hospitals, especially in high-risk pregnancies, hospitals were no less dangerous. Hospital wards concentrated larger numbers of people, as few turn of the century hospitals had individual rooms. These factors along with the inconsistent sanitary practices made the spread of disease and infection among patients prevalent. While contemporary doctors and the medical establishment touted obstetrics as the modern and progressive technique for delivery, most medical historians would agree that “poor obstetric education and delivery practices were mainly responsible for the high numbers of maternal deaths, most of which were preventable.”⁴⁵ Almost half of maternal deaths were caused by sepsis, broken down evenly between delivery related problems and illegally induced abortions. Figure 2 (below) displays the numbers of women dying each year from puerperal (childbed) fever as recorded by the Department of Vital Statistics. While the numbers may fluctuate year to year, they remain in a relatively small bracket, which attests to the consistent problem of post-partum infections for women into the early twentieth century. The remaining maternal deaths were attributable to hemorrhaging from and during delivery, and toxemia brought about by the pregnancy.⁴⁶

⁴⁵ “Achievements in Public Health,” *Morbidity and Mortality Weekly*, 850.

⁴⁶ *Ibid.*

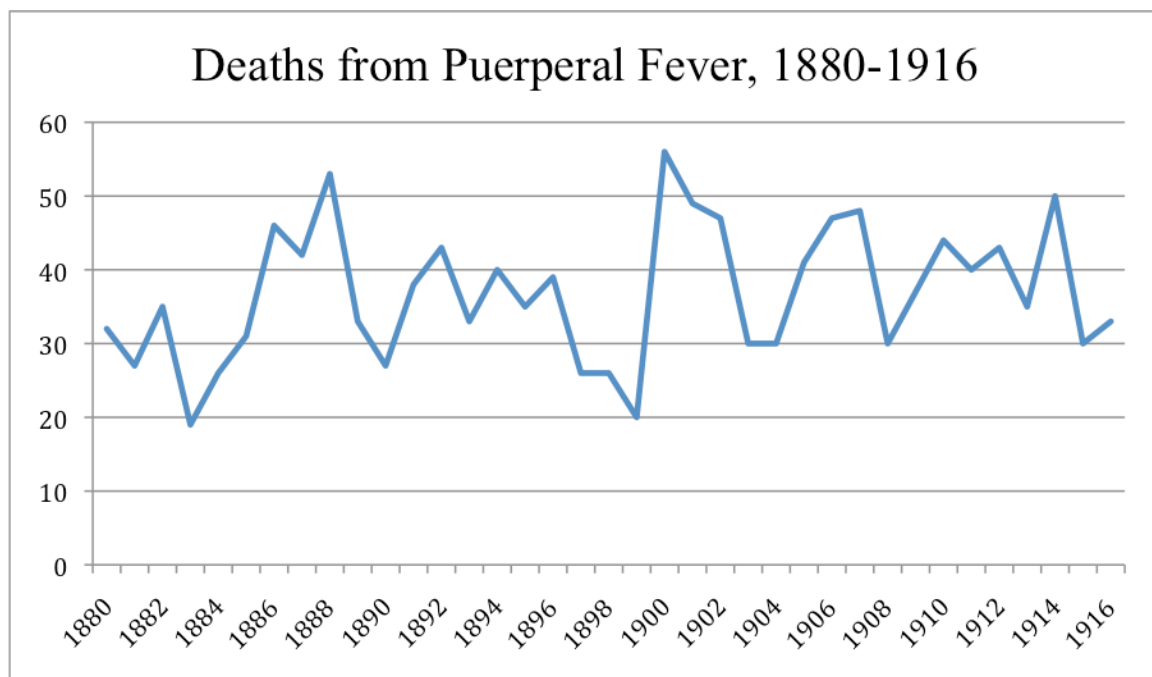


Figure 2: Deaths from Puerperal Fever, 1880-1916⁴⁷

As early as 1915, Milwaukee was noted to have “more than its proportionate share” of blood poisoning. A study by the Milwaukee Maternity Hospital noted that in “other cities more care is given women before and after confinement.” Milwaukee, however, was not alone in this problem. Nationwide in 1915, it was estimated that yearly over 100,000 women acquired blood poisoning through pregnancy and over 20,000 died of their condition. Economic class correlated strongly to these mortality rates. Patients with lower incomes lacked the more extensive medical care afforded those of upper classes. The *Milwaukee Leader* lamented the situation for those lower income patients. Hospitals and private doctors on average charged between twenty and twenty five dollars for in-hospital or at home deliveries. While low-income patients could turn to private and

⁴⁷ City of Milwaukee, Vital Statistics Office.

county physicians in a time of need, they frequently received poorer care as a direct result of their economic status. A physician could justify spending less time “where he is paid . . . \$8 or \$10,” only a fraction of what was usually charged.⁴⁸ Given that they were being paid less, some physicians attempted to hurry along the delivery and used forceps to hasten the birth. Frequently blood poisoning or other complications would follow, resulting in the loss of life for mother, child, or possibly both.⁴⁹

The issue of maternal deaths was still such a pressing problem in 1930 that the American Public Health Association set as one of its objectives, the “Reduction of the maternal mortality rates, so that the United States and Canada will be second to no nation in the safety of motherhood.”⁵⁰ The lack of prenatal care, as simple as it might have been at this time, played a role in maternal deaths since women frequently received little to no medical care prior to their presence in delivery wards of hospitals. Of the 632 women which the Milwaukee Health Department noted had died of “causes related to pregnancy, labor and puerperal period” in 1931, 44 percent had no prenatal care and 20 percent of the women had seen a physician only one or twice during their pregnancy.⁵¹

Concern for the welfare of pregnant women transferred into a concern for the children produced or possibly left behind by a mother’s untimely death. Motherless children were more likely to end up as institutional wards, especially the children of unwed mothers. It followed then that the drive to improve maternal mortality rates received support from agencies devoted to orphaned and dependent children, such as the

⁴⁸ “Maternity Hospital Improves the Coming Generation of City,” *Milwaukee Leader*.

⁴⁹ Leavitt, *Brought to Bed*, 51-55.

⁵⁰ Milwaukee Health Department, *Healthologist*, (February 1931), Milwaukee Health Department, Mss 2126, MCHS.

⁵¹ *Ibid.*

Maternity Hospital and the Infant's Hospital. If you could save more mothers' lives, the thinking went, there would be less strain on the already overburdened system of orphanages and dependent homes. Approximately half of the above-mentioned 632 women who died in childbirth in 1931 left living children to be cared for by other relatives or by the system. This accounted for 1,700 motherless children, a significant burden on the system.⁵²

Contraception

Contraception was one way to limit births and family sizes, but during this period it was unreliable and frequently unsafe. Pessaries, condoms, cervical caps, intrauterine devices, and douches were used by women to control family size and prevent unwanted births. None were wholly reliable forms of birth control, and additionally, none were legal as such.⁵³ The 1873 Comstock Laws deemed "obscene all physical instruments, visual images, and written material pertaining to contraception or abortion."⁵⁴ This legislation, which remained in effect until 1936, severely hampered the birth control movement as well as any medical research surrounding reproductive issues.⁵⁵

To avoid the Comstock stigma, legitimate contraceptives and the less reputable contraceptive devices and concoctions avoided censure through creative marketing. By

⁵² Milwaukee Health Department, *Healthologist* (May 1931), Mss 2621, Milwaukee Health Department, MCHS.

⁵³ Linda Gordon, *The Moral Property of Women: A History of Birth Control Politics in America* (Urbana: University of Chicago Press, 2002):13-14, 18-21.

⁵⁴ Andrea Tone, *Controlling Reproduction: An American History* (Wilmington, DE: Scholarly Resources, 1997), 140.

⁵⁵ Janet Farrell Brodie, *Contraception and Abortion in 19th-Century America* (Ithaca, NY: Cornell University Press, 1994), 281-88.

the end of the nineteenth century, contraception had become a lucrative business. Products advertised to regulate “female hygiene” to “ease fears” and to offer “protection” were frequently found in women’s magazines and geared themselves toward middle class women and their fears of childbirth.⁵⁶

Throughout the nineteenth century, the search was on for safe and effective birth control. Birth control clinics found that women fitted for diaphragms and pessaries by physicians still failed to use them properly as they saw them as embarrassing and messy. Condoms were less commonly employed because they required the willing cooperation of the husband or male partner. Social convention would have left few women comfortable enough to make such a request. These social and personal reservations provided a significant obstacle for early advocates of birth control.⁵⁷

In addition to issues of effectiveness, early contraceptives suffered from an issue of cost. For working class women, birth control was simply beyond their economic grasp. While early forms of pessaries, condoms, and diaphragms were available if one knew who and what to ask for, it was at a price that most of the buying populace could not afford. While the birth control clinics established by Margaret Sanger were targeted at working class and immigrant women, the birth control advertisement of the 1910’s and 1920’s was generally geared at middle class women. Affordable contraception became a rallying cry for progressive reformers such as Margaret Sanger. Female progressive reformers sought to spread the gospel of contraception as a means of freeing women, especially the poor and immigrant, from the burdens of continual childbearing. While Milwaukee was not on the front lines of the birth control debate, the women of this city

⁵⁶ Tone, 65-66; Gordon, 26.

⁵⁷ Brodie, 205-224.

were nonetheless interested in greater access to and information about birth control. As women throughout the country attempted to gain more control over their political lives, they mirrored this process in their reproductive lives. The ability to limit births and the separation of sexual activity from reproduction were concepts that women desired, and desperately needed. Not only did birth control, and even basic reproductive education, offer them autonomy over their own bodies, but was necessary for their own self-preservation. For women who had suffered difficult pregnancies or life-threatening deliveries they now had the tools to their own safety and survival in their hands.⁵⁸

Given the crackdowns on early birth control clinics, poorer women turned in desperation to a wide variety of products—few safe—as means of preventing conception. Syringes and tubing, sold as a douching method, were a common form of contraception. Unfortunately, if used improperly, they could introduce air bubbles in the blood stream and result in a fatal embolism. Antiseptic products, especially Lysol, were also actively marketed as contraceptive devices. Lysol, still a commonly used cleaning product, was directly marketed as a feminine hygiene product through the 1950s (See Figure 4). Not only could it clean floors and bathrooms, but also ensure that any wife was “still the girl he married.”⁵⁹ Unfortunately these and the other folk and herbal remedies that women turned to were less than reliable, and frequently, life-threatening. The County Emergency and General Hospital would see almost two dozen women each year ill enough to require medical attention when contraceptive methods caused physical harm (See Figure 3).

⁵⁸ Brodie, 184-85.

⁵⁹ Lysol Advertisement, 1923, Figure 3. <http://thepill.umwblogs.org/files/2009/03/lysol28.jpg> (accessed 4/10/2009).

While some of these cases might have been accidental poisonings, the compounds represented in Figure 3 represent some of the most common abortifacients available to women during this period. While products such as Lysol were marketed as feminine hygiene products, other compounds were used as contraceptives, even though that was not their intended use. Bichloride of mercury, iodine, potassium permanganate, and carbolic acid (also known as phenol) were all antiseptic solutions that were added into vaginal douches for contraceptive purposes. Cedar oil had been used since ancient times as a spermicide. Oil of tansy, arsenic, and strychnine—all deadly poisons—were frequently part of oral contraceptive solutions. The variety of deadly compounds women opted to use in order to prevent pregnancy reflects the desperation of their situation. They would try any device or “cure” in order to prevent an unwanted pregnancy, even if it was at the expense of their own life. One must supposed, however, that there were hundreds more who were fortunate in their usage and never needed medical attention, or sadly were too ill to ever make it to the hospital.

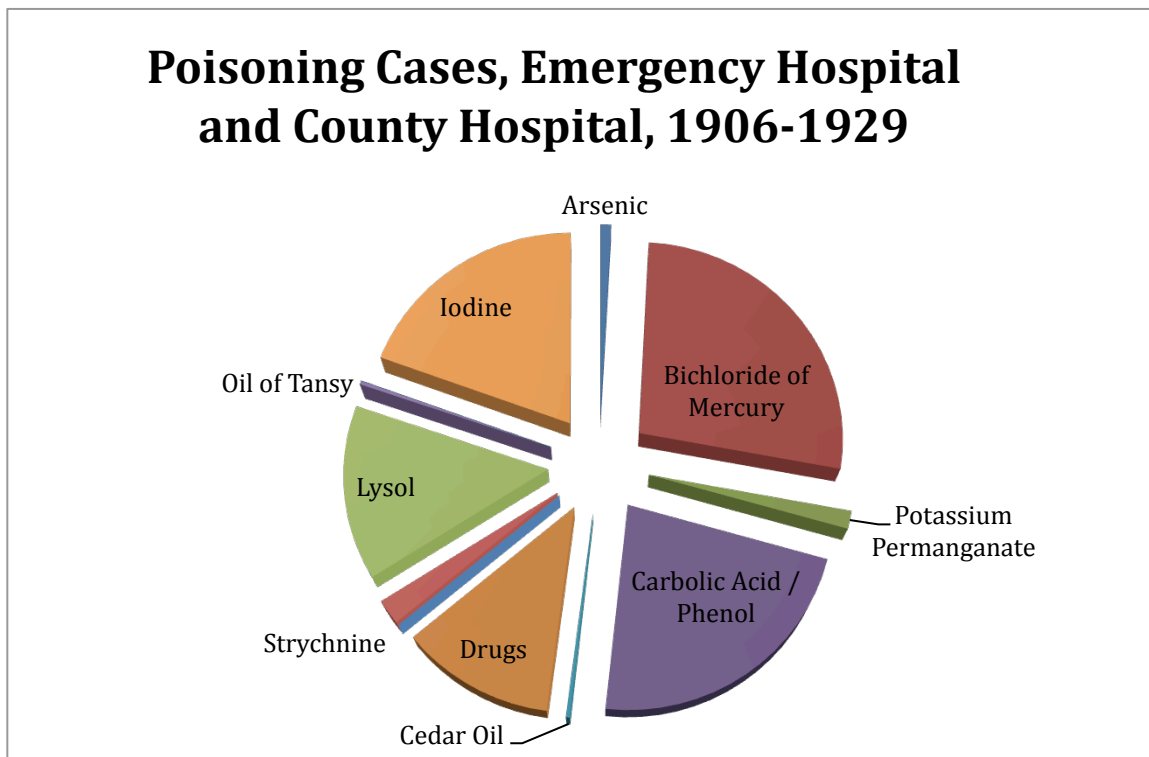


Figure 3: Poisoning Cases, Emergency Hospital and County Hospital 1906-1929⁶⁰

⁶⁰ Milwaukee County Hospital, Annual Reports, 1906-1929; Johnston Emergency Hospital, Annual Reports, 1908-1925, Mss 723, Milwaukee County Institutions and Departments, MCHS.

Lysol

Disinfectant

REG. U. S. PAT. OFF.



Still "the girl he married"

WHEN they were first married, five years ago, they liked to dance together, go motoring together, play golf together. They still like to do those things together today.

She is still the girl he married.

During the years following her marriage, she has protected her zest for living, her health and youthfulness, and "stayed young with him" by the *correct* practice of feminine hygiene.

But feminine hygiene, wrongly practiced, does more harm than good. Using the wrong disinfectant may lead to very serious consequences.

Realizing this, the makers of "Lysol" Disinfectant have prepared a booklet called "The Scientific Side of Health and Youth." It gives the facts about this vital subject. Send the coupon now. The booklet will reach you in a plain envelope. It is free.

In the meantime, take no needless, dangerous chances. Buy a bottle of "Lysol" Disinfectant at your druggist's today. Complete, explicit directions come with every bottle.

Made by Lysol, Incorporated, a division of Lehn & Fink Products Company. Sole distributors, Lehn & Fink, Inc., Bloomfield, N.J. In Canada, Lysol (Canada) Limited. Distributed by Lehn & Fink (Canada) Limited.



"Lysol" Disinfectant is sold at retail only in the brown bottle packed in the yellow carton.

LEHN & FINK, Inc., Sole Distributors, Bloomfield, N.J.
Department 149

Please send me, free, your booklet,
"The Scientific Side of Health and Youth."

Name.....City.....

Street.....State.....

© Lehn & Fink, Inc., 1923

Figure 4: Lysol Advertisement, 1928.

Abortion

Abortion, while not legal in the late nineteenth and early twentieth centuries, was not an unheard of part of the female experience. While the prevalence of abortion is regarded by some as a twentieth century phenomena, it was estimated that as much as one third of Protestant births ended in abortion in 1881.⁶¹ While numbers may have been somewhat exaggerated by anti-abortionists in the late nineteenth century, the statistics illustrate that abortion was neither uncommon nor unknown for women of this time period. This said, abortion was not a practice to be openly advertised or promoted. Abortion was an act left to the shadows.

Initially, one must deal with the actual term “abortion” for it is a decidedly problematic term for any medical historian of this period. The *Oxford English Dictionary* defines *abortion* as “the act of giving untimely birth to offspring, premature delivery, miscarriage; the procuring of premature delivery so as to destroy offspring.”⁶² The dual nature of this definition, meaning both the purposeful attempt to deliver and the body’s spontaneous expulsion of the fetus complicates attempts to accurately assess the prevalence of abortion in turn of the century society. Some medical examiner’s reports list a number of female deaths as due to “criminal” or “self-induced” abortions. Records of the Milwaukee County Hospital make note of “induced” abortions that were most likely procedures performed by hospital staff for either eugenical or therapeutic reasons. Finally, there are numerous ambiguous notations in the records of simply an “abortion”

⁶¹ R. Sauer, “Attitudes to Abortion in America, 1800-1973,” *Population Studies*, 28, No.1 (March 1974): 53-67.

⁶² Online *Oxford English Dictionary*, “abortion,” www.oed.com, (accessed 03/25/2008).

with no further description of the type or causation.⁶³

Trying to understand the actual term “abortion” does not necessarily help to clarify the historic records. The term abortion can be broken down into a number of different categories. First, abortions could be either natural or induced. Natural abortions occurred when some health problem with the fetus or the mother causes the loss of the fetus. Natural abortions are classified as either miscarriages where death occurs before twenty weeks of gestation or stillbirths where the fetus is delivered after that twenty week threshold without any sign of life. Induced abortions involve an intentional intervention to cause the loss of the fetus. Induced abortions can be of three different types: elective, eugenic, or therapeutic. The one which most people are familiar with in today’s abortion debate would be considered elective abortions where the woman voluntarily decides to end the pregnancy, but not because of any health related issues. Eugenic abortions are preformed “to prevent the birth of a child with severe birth defects.”⁶⁴ Finally, therapeutic abortions are performed when there is danger of serious harm or injury to the mother.

In Milwaukee, women who sought abortions were a varied group both in age and economic standing. As early as 1878, the Health Commissioner considered abortion a serious enough subject to dedicate a part of the Health Department’s annual report to this delicate issue. The practice was common enough in Milwaukee even though “the crime is perpetrated in secret, and its helpless victims receive no public burial.”⁶⁵ The coroner went on to note that “our population is largely foreign, largely Catholic, and there is

⁶³ Milwaukee County Hospital, Annual Reports, 1906-1929, Mss 723, Milwaukee County Institutions and Departments, MCHS.

⁶⁴ Louis J. Palmer, *Encyclopedia of Abortion in the United States* (Jefferson, North Carolina: McFarland Company, 2000), 252.

⁶⁵ Annual Report, Health Department, 1878.

probably no city in this country freer from this revolting practice.”⁶⁶ While he acknowledged the presence of abortion in the city, he believed that the demographic makeup of the city, foreign and Catholic, would help to stifle the rate of abortions being performed in the city. The veracity of that statement is debatable, but nevertheless one can suppose that a large Catholic population would not be as inclined toward abortion as women of other faiths. The Health Department did not have an accurate way to record the frequency of abortions within the city, as it was not a reportable medical event. Frequently, the only way in which the city could count the number of abortions being performed was through the women who sought medical care at the local hospitals, the scandals that found their way to the newspaper pages, and those poor unfortunate women who arrived for the Coroner’s examination.

This difficulty in both defining what an abortion is, as well as counting the actual numbers, makes an examination of this topic difficult for this time period. From 1919 to 1926, the Medical Examiner of Milwaukee County recorded fifty-nine confirmed abortions.⁶⁷ The numbers break relatively evenly between “self-induced,” meaning the woman used some method in attempting to abort the child herself, and “criminal” abortions, referring to those abortions performed by a second party, either a doctor or midwife. Other hospital records simply list “abortion” in their patient ledgers while also recording “stillbirths” and “premature births.” This inconsistency in definitions leaves the interpretation up to the reader and history.

⁶⁶ Ibid.

⁶⁷ Milwaukee County Medical Examiner, Annual Reports, 1919, Mss 186, Milwaukee County Medical Examiner, MCHS.

Fifty-nine abortions in seven years might not seem to be a significant number by today's standards but these were only the cases that reached the medical examiner's table through the death of the mother. These cases do not account for the hundreds of other women who survived their attempts at ridding themselves of an unwanted child or those whose deaths were attributed to other causes—the real reason behind their death hidden so as not to shame the family or the women involved. So prevalent were these occurrences that, in 1919, Milwaukee's medical examiner noted that "too long has the woman been looked upon as a breeding machine only . . . There cannot be words strong enough to condemn the act of 'tickling the unborn' but the only cure for it is intelligent instruction of birth control."⁶⁸

The modern conceptions of abortion are quite different from those of the late nineteenth and early twentieth centuries. Municipalities frequently had no legal restrictions against abortions and allowed them up to the time of "quickening."⁶⁹ The basis for setting the legality of abortion at "quickening" was from secular law in England. Until 1854, an abortion was considered permissible through the quickening stage in the United States. Often women did not feel that taking action prior to this point was reprehensible.⁷⁰ Most legal statutes based notions of criminality on the concept of "quickening," allowing abortions prior to quickening and prohibiting them once that time had passed. As abortionists "professionalized" in the late nineteenth century, similar to

⁶⁸ Ibid.

⁶⁹"Quickening" was the term used to describe when the mother first felt the child move.

⁷⁰ Gordon, 26.

other medical professionals, a greater call to crack down on the “imposters” (those without formal medical training) followed.⁷¹

Women throughout this period were quite willing and able to use both mechanical and chemical means to rid themselves of children that they did not want. While a decidedly risky venture in an age which lacked antibiotics and during which medical authorities sought to vilify those who performed them, women still risked their lives and their ability to bear future children to abort unwanted pregnancies.

There were numerous varieties of abortifacients on the market during this period. Mechanically, women could use a variety of objects, including crochet hooks, knitting needles, and button hooks to disrupt and physically break up the pregnancy.⁷² Doctors and midwives favored these physical methods because they were easier than chemical means and produced a quicker result. In addition to the mechanical means, a variety of chemical abortifacients were sold, thinly disguised as “menstrual regulators” for they forced a woman’s menstruation to begin. These mixtures expelled any unwanted pregnancies in the regulation of the woman’s menstrual flow. Compounds such as ergot, root of iris, and bichloride of mercury were used to dilate the cervix and end a pregnancy. Many of these same compounds were also sold to combat or treat venereal diseases. An advertisement in the *Sporting and Club House Guide to Milwaukee* for “Dr. LaVine’s French Tonic” purported that it was able to take “away all that soreness, relieves painful and suppressed menstruation and is positively the best tonic known for ladies.”⁷³ Women

⁷¹ Gordon, 30.

⁷² Gordon, 15.

⁷³ *Sporting and Club House Guide to Milwaukee*, Mss 1384, MCHS.

supposedly could relieve two problems with only one tonic, but frequently these concoctions helped neither situation.

While both doctors and midwives performed abortions or assisted women in self-inducing abortions, the greater share of the blame fell on the midwives. Once again, Health Commissioner Stern came to their aid, protesting in 1878 that “[m]idwives in this city have been falsely accused as especial perpetrators of this crime [abortion] . . . [There is] no information tending to substantiate such a grave charge.”⁷⁴ Doctors, however, could be just as guilty of such crimes. A 1883 coroner’s inquest detailed the death of a young woman who “came to her death at the office of Dr. _____, Number ___ Clinton Street.” The cause of death was determined to be “an abortion performed on her by said _____.” To add a note of irony to the sad story of this young girl, the doctor in question was her fiancé. Their shame of the illegitimate child was revealed to the public because of the sad circumstances of her death and the subsequent manslaughter trial of the young doctor.⁷⁵

The demographics of abortion were also complex. The few statistics that are available from the coroner’s reports and the Milwaukee County Hospital’s female patient ledger suggest that the majority of recorded abortion cases were procured by married women. At least 40 percent of childbirth-related coroner’s cases from 1873 to 1890 involved married women who had tried to abort their fetuses.⁷⁶ Of the 188 women who were treated at the Milwaukee County Hospital between 1880 and 1923 for abortion-

⁷⁴ Milwaukee Health Department, Annual Report, 1878.

⁷⁵ Kittie O’Toole, Coroner’s Report, February 19, 1883, Mss 306, Milwaukee Coroner’s Reports, MCHS.

⁷⁶ Milwaukee Coroner’s Reports, MCHS;

related issues, over 70 percent were married women.⁷⁷ The image of the wife as a ‘breeding machine’ remains as one reads each coroner’s report, testifying to a woman’s unwillingness to bear yet another child. Prior traumatic births, economic hard times, and marital instability led women to risk their lives and their moral standing to seek or to induce abortions.⁷⁸

Morality and Women’s Health

The Progressive Era that came to characterize the political and social worlds of the United States in the early twentieth century sought to “progress” American society forward through a general policy of reform. By cleaning up government corruption or by physically cleaning up the urban environment, reformers hoped to improve the overall well-being of the American people. While Progressivism was interested in improvements in physical space and governmental politics, the movement also sought to improve the morality of the general population. Progressive reformers, as well as public and private institutions, sought to improve the mental and physical health of Milwaukee’s population through betterment of both the physical and social landscape of the city. Improve the physical surroundings and one could improve the moral character of the citizen was the Progressive’s slogan. This concern was especially acute for women since Progressives considered females particularly weak and vulnerable to outside influences and

⁷⁷ Milwaukee County Hospital, Female patient ledger, Mss 723, Milwaukee County Institutions and Departments, MCHS.

⁷⁸ Brodie, 9-37.

seductions.⁷⁹

Reformers tied mental and physical health with environmental and moral conduct. If people led immoral lives, they most likely would be found living in wretched conditions. Poor housing and unsanitary surroundings would most certainly lead to ill health and poor moral constitutions. A 1932 study of delinquent girls in Milwaukee “showed that 83 percent of them had come from bad housing in congested areas.”⁸⁰ For reformers, the earlier the girl was corrected in her moral misdirection, the earlier she could led back onto the right path. An interesting paradox, however, developed for these reformers. While some reformers wished to remove young girls from their detrimental surroundings, others were concerned with girls leaving the house at all and the dangers that could result if she did. Illegitimacy, infanticide, and venereal disease awaited the girl who was lured in by the siren song of the city and its denizens.

The Girl Astray – Illegitimacy & Infanticide

For young women out in the urban world, the dangers of physical violence and sexual exploitation were very real concerns. The city was a place of danger—and vice—which might lead an unsuspecting and naive young girl down the dark path of sexual licentiousness and illegitimate children. Unwanted pregnancies were not uncommon in the late nineteenth and early twentieth centuries. The unreliability of birth control, the

⁷⁹ For further discussion regarding the link between the urban environment, mental health, and physical health, see Hollis Godfrey, *The Health of the City* (Boston: Houghton Mifflin, 1910); Ruth C. Eng, *The Progressive Era's Health Reform Movement: a Historical Dictionary* (Santa Barbara, CA: Greenwood Publishing Group, 2003); and Martha Verbrugge, *Able Bodied Womanhood* (Oxford: Oxford University Press, 1988).

⁸⁰ Edith Elmer Wood, “Slums and Blighted Areas in the United States,” (1935): 64, Mss 546, Box 12, Pamphlets, “Housing,” Daniel W. Hoan Collection, MCHS.

danger of abortion, and a flexible morality (which was attributed to urban areas) all lent themselves to high rates of illegitimate births. And the coroner's inquests abound with accounts of infanticide and "illegal operations."

A review of the Milwaukee County Hospital's female patient ledger from 1880 to 1923⁸¹ attests to the prevalence of single women giving birth, as almost 75 percent of the 2,655 women surveyed fit this criteria. A small number were noted to have been married in the hospital, presumably to the child's father, but the majority seemed to be self-supporting single women. Most of these pregnant single women were between fifteen and twenty-five years of age, a not uncommon pregnancy demographic for the early twentieth century. The majority of the occupations listed for these women fell into the categories of "domestics" or "servants" although there were also factory girls, seamstresses, milliners, and even prostitutes among these numbers (See Figure 5).⁸² The statistics at the county hospital of course are skewed toward the poorest of Milwaukee's population, but present an interesting insight into this more vulnerable population. While the County Hospital provided pregnancy care for poor women, and until 1906 was the only real option for unwed mothers, some young girls took a decidedly different path with their pregnancies.⁸³

⁸¹ 1923 proved to be the cutoff point for my examination of the ledgers because the reasons for treatment were no longer noted after that year.

⁸² Milwaukee County Hospital Female Patient Ledger, MCHS.

⁸³ "Maternity Hospital Improves the Coming Generation of City," *Milwaukee Leader*, January 2, 1915, "Milwaukee Features – Hospitals" microfilm, MCHS.

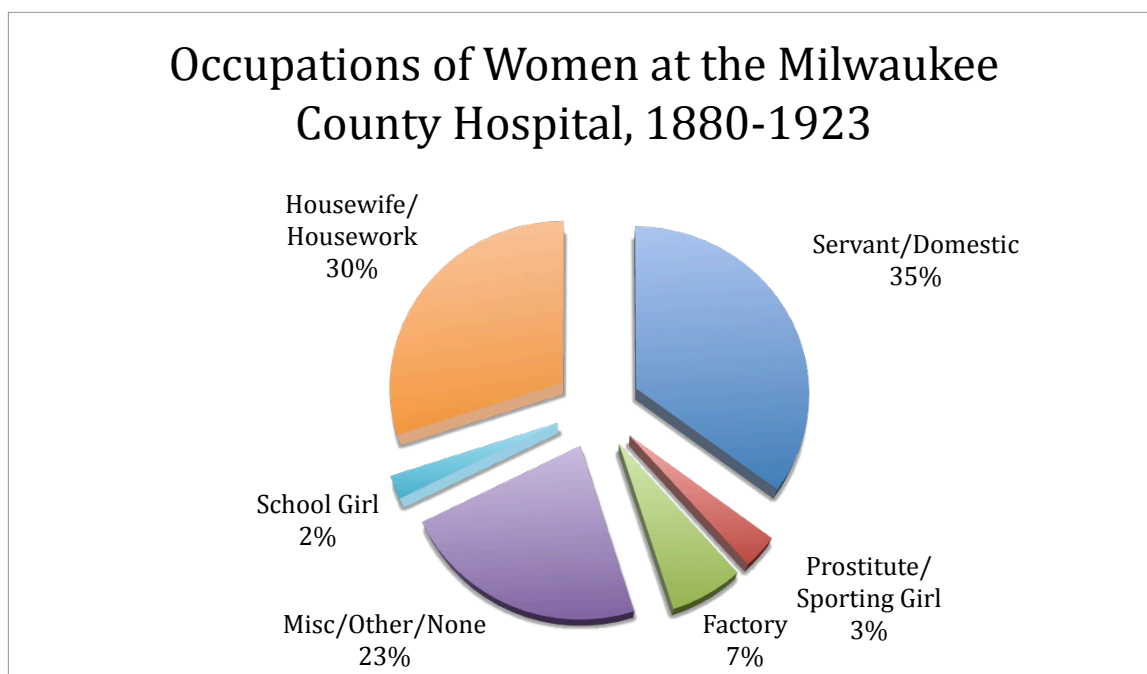


Figure 5: Occupations of Women at the Milwaukee County Hospital, 1880-1923

While married women made up the larger number of *abortions* performed during this period, young single women committed the greater portion of *infanticides*. These young women, who often migrated to Milwaukee alone, worked as shop girls, clerical staffers, or domestic servants. Alone, in the big city, they fell prey to men considerably older than themselves who often abandoned the girl once she was found to be pregnant. Hiding the pregnancy until the birth of the child was the only option for some of these girls. Few could return home to their families after such an indiscretion knowing that they would most likely be rejected as a moral failure by both family and society. Fewer still knew where to procure or could afford an abortion from a midwife or doctor. Giving birth alone in their boarding house rooms, the girls sometimes choose to smother, strangle, or abandon their infants. Illegitimacy, while prevalent in society, was still a shame to be hidden and dealt with in secret. The evidence of this “immorality” was often hidden

among bed linens, stashed in garbage bins, or abandoned on the street. The coroner's reports have countless tales of young shop girls seduced and abandoned by men. In a fit of madness or desperation, they murdered the child to hide their shame. Drownings, smotherings, and abandonments were all employed to quiet the crying baby and erase the shame of seduction.⁸⁴

As the twentieth century progressed, greater attention was paid to the social setting surrounding illegitimate pregnancies. Increasingly, reformers sought to keep infants with their unwed mothers as it was believed to be beneficial for both parties. Instead of being wrenched away at birth, "more children are being kept with their mothers than formerly; separation of mothers and children is coming at a later period."⁸⁵ Women were encouraged to breastfeed their children, bond with them as health officials believed it created healthier and happier babies. There was also a growing movement to hold men accountable as "more effect is being made to establish paternity; more aid is given to the mother so that economic stress does not become the major factor in the decision to place the child."⁸⁶ Social services attempted, if the situation was deemed suitable, to keep the mother permanently with the child and to assure the young, unwed mother that the father of her child would not shirk his paternal duties. They wanted to make sure that economic desperation did not drive women to give up their children and hoped to provide the best starting point for a mother and child in a difficult situation.

One of these institutions designed to provide aid for these "unfortunate" young

⁸⁴ Milwaukee County Coroners Cases, MCHS. These anecdotes are an assembly of many hundred cases that I personally examined while investigating the circumstances of death of those interred at the Milwaukee County Institutional Grounds pauper cemetery.

⁸⁵ "The Salvation Army Women's Home and Maternity Hospital 1922-23," Salvation Army Collection, MCHS.

⁸⁶ Ibid.

women was the Salvation Army Women's Home and Hospital, or as it was later known, the Martha Washington Home and Maternity Hospital, established and incorporated in 1894. Located at 6304 Cedar Street (54th & Cedar after 1920), the home had the ability to care for forty girls and thirty babies at its facilities. The need, however, was much greater than the home could ever manage because "before the workmen were out of the way or the building properly furnished, girls were knocking at the door for admittance, and a dozen wee babes were born under its sheltering roof before the opening day."⁸⁷

The charitable home was founded as a "house of refuge for girls and women who, through misfortune, for which others are usually more to blame than themselves, are without friends or shelter in the most critical time of their lives."⁸⁸ The home largely limited itself to just the medical needs of the women, but also sought to ensure that the women and children could "return to the world, either self-supporting through training or in the care of relatives."⁸⁹ The Home saw itself as having both reformatory (changing a girl's behavior) and industrial (providing her with useful occupational skills) purposes. The women were allowed to stay as long as needed, with most women averaging five months. The hope was that in the time that the women spent at the Home they could be rehabilitated socially, educated for employment, and instructed how to properly care for her child.

Francis Peabody of the Salvation Army extolled the virtues of the caring mission which the Salvation Army undertook. She noted that "there are many who know how to conduct splendid hospitals for the sick, but none like the women of the Salvation Army

⁸⁷ Ibid.

⁸⁸ Ibid.

⁸⁹ Ibid.

have the invaluable art of befriending the fallen girl, gaining her confidence and love, nursing her through her trying ordeal, teaching her the arts of home keeping, motherhood and child training, and inculcating into her life that which will enable her to walk the path of virtue and industry.”⁹⁰ Physical health was only a small part of the overall health of the individual. Healthy women equipped with the skills to support themselves and the confidence to manage the difficulties of life were invaluable in the eye of the Salvation Army as they sought to reproduce a generation like themselves.

While the Salvation Army, as well as the Maternity Hospital, sought to improve the quality of mothers who left their institutions, the debate over “fitness” and “desirability” of a person was a complex issue. Debate raged in the early twentieth century over who was “deserving” of aid and over who was “desirable” in society. As the social and ethnic makeup of the United States was changing at the turn of the twentieth century, Americans struggled with questions of identity. Women as the reproducers of American society found themselves on the frontline of this debate.

Eugenics

The eugenics movement had its roots in England. Frederick Dalton, Charles Darwin’s cousin and an amateur scientist in his own right, coined the name in 1883. Based on a Greek root meaning “good birth,” the movement contended that “selective human breeding could produce ‘a highly gifted race of men’—and that regulating the

⁹⁰ Ibid.

population could prevent the reproduction of people deemed undesirable.”⁹¹ Good health, a pleasing appearance, and the lack of social or psychological problems such as alcoholism, gambling, or illegitimacy were all desirable traits that eugenicists hoped to pass on from one generation to the next.⁹²

This selective breeding was to be achieved through a number of means. Primarily this goal was to be met through the encouragement of breeding by those with superior genes and the discouragement of those whose genes were deemed “inferior.” These superior or inferior traits were mapped out on extensive pedigrees that documented the successful businessmen, moral leaders, and captains of industry on one chart and documenting the feeble-minded, the alcoholics, the sexually deviant and gamblers on an “inferior” chart. Two of the leaders of the eugenics movement, Paul Popenoe and Samuel Hill Johnston, railed against the ideas of mediocrity. These eugenicists and others like them believed that “even if the offspring of mentally diseased and defective individuals may not qualify for the Hall of Fame, many of them will be normal, useful individuals. . . . Is the nation in such desperate need of average, normal individuals as deliberately to encourage their production under these circumstances?”⁹³ Mediocrity and average were not good enough; in the United States, we needed to produce “advanced” peoples.

The second method, and perhaps the most infamous, of the eugenics movement was sterilization of those deemed “unfit.” The mentally ill, the developmentally disabled, and those deemed socially unfit were sterilized throughout the twentieth century.

Eugenics leaders saw themselves as protecting the larger population for “[e]ugenic law is

⁹¹ “ ‘Perfecting Mankind’ Beauty? Brains? Place Your Orders,” *New York Times*, February 16, 2001.

⁹² Wendy Kline, *Building a Better Race* (Berkeley, CA: University of California Press, 2005), 7-31.

⁹³ Paul Popenoe and Roswell Hill Johnson, *Applied Eugenics* (New York: The MacMillan Company, 1935), 157.

one way to make procreation impossible of persons who are unfit to have progeny; it stands for the protection of the innocent, and safeguarding of the health of generations yet unborn.”⁹⁴ The first eugenic sterilization occurred in 1899 in Indiana by Dr. Henry Sharp of the Indiana State reformatory.⁹⁵ Vasectomies were normally performed on men, while hysterectomies or ovariectomies (removal of the ovaries) were performed on women. While the procedures were less invasive for men, on average more women were sterilized than men under the eugenics program.⁹⁶

Clara Hipke and her work with the Maternity Hospital played a large part in the eugenics movement in Wisconsin. The hospital’s administration was instrumental in the passage of Wisconsin’s eugenics law in 1913.⁹⁷ The 1913 statute empowered the state to sterilize inmates of both mental and penal institutions, and required the presentation of a medical certificate when applying for a marriage license.⁹⁸ Not only did the law allow for the forced sterilization of inmates of mental and penal institutions but also allowed for the “feeble minded” and epileptics to be sterilized as well. From 1915 until early 1939, 134 men and 859 women were sterilized in the state of Wisconsin, primarily at the State Home for the Feeble Minded in Chippewa Falls.⁹⁹ The state institution was created and promoted by progressive reformers as a way to care for Wisconsin’s “mental defectives” through a custodial care environment. Monitoring them under supervision, as well as

⁹⁴ Milwaukee Maternity Hospital and Dispensary, “The Eugenic Law,” n.d., Milwaukee Manuscript Collection BG, Records 1903-1969, “Maternity Hospital,” United Community Services of Greater Milwaukee, UWM.

⁹⁵ Popenoe and Roswell, 150.

⁹⁶ *Ibid*, 151.

⁹⁷ “Maternity Hospital Improves the Coming Generation of City,” *Milwaukee Leader*.

⁹⁸ Harry H. Laughlin, *Eugenical Sterilization in the United States* (Chicago: Psychopathic Laboratory of the Municipal Court of Chicago, 1922): 34.

⁹⁹ Sterilization Record, Series 2205, Box 5, Northern Wisconsin Center of the Developmentally Disabled, Chippewa Falls, WI, Wisconsin State Historical Society.

preventing them from reproducing would help to create a more “fit” population.¹⁰⁰ The 1913 eugenics law was preceded by a 1907 law that forbid epileptics, feeble-minded, and the insane from marrying. Wisconsin, similarly to most states, retained its sterilization laws until the 1970s. In later years, it was primarily used in an institutional setting. The great majority of sterilizations occurred during the 1920s and 1930s, during the height of the eugenic and nativist fears of “race suicide.” Eugenic advocates targeted women more often than men. Perceived by society as the more moral of the sexes, deviations from the accepted sexual norms of society could have a woman deemed “feebleminded” and eligible for sterilization.¹⁰¹

One of the dangers in this public policy lay in the vagueness of its terms. “Feeble mindedness” was a broad term that connoted a wide variety of real and imagined ailments. The definition stretched from those with Down’s Syndrome to those men, and especially women, who led sexual lives outside of societal norms. In the minds of some progressive reformers, sexually promiscuous women were as great a danger as any criminal for “the feeble minded female of the type that is committed to state institutions is characteristically a sex delinquent. This is one of the reasons why she is committed. If she had behaved herself she would have been kept at home . . . nine out of every twelve had been sex offenders before commitment.”¹⁰² Remove them from their situations, keep them at home, preferably supervised by those morally competent to guide them, the reformers argued. Women who fell outside of societal norms were caught in the

¹⁰⁰ Wisconsin Department of Health Services. 2007. “History of Northern Wisconsin Center.” <http://dhs.wisconsin.gov/dd_nwc/aboutnwc/history.htm> (accessed 12/15/2009).

¹⁰¹ Julius Paul, *Three Generations of Imbeciles Are Enough: State Eugenic Sterilization Laws in American Thought and Practice* (Washington, D.C.: Walter Reed Army Institute of Research, 1965): 548; Kline, 32-60.

¹⁰² Popenoe and Roswell, 154-55.

middle.¹⁰³

The issue of informed consent loomed large in the issue of sterilization. Sterilization advocates insisted that “the sterilized patients themselves are generally satisfied, often greatly pleased with the results.” They couldn’t help but also note that the “investigators did not seek the opinions of the feeble minded, considering these of little value”¹⁰⁴ Many who were sterilized were never informed of the sterilization procedures, often being told they were being hospitalized for appendectomies. It was only years later, sometimes after unsuccessful attempts to conceive children, when they found out the real truth about what had been done. While the law allowed for a medical superintendent of an institution to order a sterilization operation, the normal procedure was to receive the consent of the nearest relative.¹⁰⁵ Well meaning caregivers and relatives made life-changing decisions for individuals who were never informed of the actual act. Eugenics supporters, however, believed that despite concerns surrounding consent what they had undertaken was in the best interests of the parties involved. The majority of the sterilizations performed in this country in the early part of the twentieth century, proponents maintained, were performed with the “earnest desire, of those most closely affected.”¹⁰⁶

The most zealous of sterilization programs was found in California where between 1909 and 1933 over 8,500 sterilizations were performed.¹⁰⁷ While Wisconsin never reached the rate of California, the almost one thousand people sterilized by 1933

¹⁰³ Kline, 32-60.

¹⁰⁴ Popenoe and Roswell, 152.

¹⁰⁵ Ibid, 151.

¹⁰⁶ Ibid., 160.

¹⁰⁷ Ibid., 150.

were a significant population nevertheless. The Milwaukee County Hospital did not note any procedures that were clearly listed as “eugenical sterilizations” in its records from this period. But starting in 1914, one starts to see notations for currettments (scraping of the uterus), post-operative abortions, salpingectomies (removal of fallopian tubes), and one surgery performed on an “imbecile.” While none of these are definitively eugenical, the particular procedures do not appear in the records prior to the start of the eugenical movement. These numbers are especially disturbing when one realizes the vagueness of the term “unfit.” Most of those sterilized across the country came from the laboring classes, including large numbers of immigrants and African Americans.¹⁰⁸

Eugenicists saw these last two groups as having made a “very slight contribution to the list of genius[es].”¹⁰⁹ Mediocrity was a trait which eugenicists could do without, arguing that “no embryonic Shakespeares or Aristotles are being cut off by modern eugenic sterilization . . . If the burdens imposed on society by the proliferation of defectives can be reduced, it may be possible to bring about an increase of reproduction among intellectually superior people, whence the great men of history have usually arisen.”¹¹⁰ Sterilization was also deemed the most reliable form of birth control and population management during this period. Those most likely to be sterilized were those thought most inadequate to manage personal birth control. Community leaders such as Clara Hipke and Lizzie Kander fought against ideas of mediocrity, extolling virtues of fitness and excellence. Kander noted in her essay “Survival of the Best” that the human race was in the process of “isolating and finally eliminating members of society, who

¹⁰⁸ Paul, 546.

¹⁰⁹ Popenoe and Roswell, 157.

¹¹⁰ Popenoe, 157.

should not be allowed to reproduce their kind.”¹¹¹

Eugenics reformers sought to make it easier for hospitals and institutions to perform the sterilizations, without fear of legal repercussions. Hospitals also used sterilizations in conjunction with therapeutic abortions. Some hospitals refused to “perform an abortion unless they sterilize at the same time.” They did not want women returning year after year for the same procedure with the same excuses; one therapeutic abortion, in their minds, was enough.¹¹² Eugenics also figured strongly into the discussion of venereal disease as the Milwaukee Health Department in 1922 took on a decidedly eugenic tone in its discussion of the benefits of sterilizing those infected by gonorrhea and especially syphilis. Dr. John P. Kohler wrote in the report that “we have every reason to feel that by sterilizing one individual with syphilis, that the incidence of this malady is bound to become less.” The emphasis on prevention was further emphasized in Koehler’s premise that the “keeping of someone from contracting syphilis is greater than curing the one who has it.”¹¹³ Koehler placed greater emphasis in preventing infected individuals from reproducing than in curing them of their illnesses.

The ideals of eugenics and the growing concern over increasing venereal disease rates were of particular interest to a broad spectrum of American business and social interests. Those in the business and political worlds “embraced eugenics as proof of the natural order of the capitalist system, rationalizing wealth and poverty as evidence of the survival of the fittest. At the same time the eugenics movement depended on liberal support, a belief that government should intervene more aggressively in people’s

¹¹¹ “Survival of the Best,” Milwaukee Manuscript Collection, DN, Box 3. Lizzie Black Kander Papers, 1875-1960, UWM.

¹¹² Popenoe and Roswell, 159.

¹¹³ Annual Report, 1922, Mss 2126, Milwaukee Health Department, MCHS.

lives.”¹¹⁴ Growing nativist sentiments and racial tensions in the early twentieth century became legitimized through both federal legislation and a Supreme Court decision. The 1924 Immigration Act (Johnson-Reed Act) enacted strict quotas on Southern and Eastern European immigrants, linking their numbers to population numbers from the 1890 census as well as limiting total immigration numbers to 165,000 per year. The 1937 *Buck v. Bell* decision assured the constitutionality of the sterilizations of the “feeble-minded,” with Oliver Wendell Holmes making his infamous pronouncement that “three generations of imbeciles are enough.”¹¹⁵ The legalization of these nativist fears and prejudices helped to reinforce these attitudes towards any who were deemed “unfit” and “undesirable.”

Venereal Disease

Entwined within the eugenics debate was a growing recognition of venereal disease in early twentieth century America. Concern emerged in the early part of the new century over the numbers of venereal diseases cases found within both American and European populations. Milwaukee Health Commissioner John Koehler noted that the “problem of venereal disease is recognized as one of the most important with which we have to deal today . . . [O]nly since the war [has] this matter . . . been brought into the open and is being approached with the frankness it should have been dealt with long ago.”¹¹⁶ While venereal disease had been a significant health issue since the sixteenth century, advances in the bacteriology allowed health departments and hospitals to detect

¹¹⁴ “Perfecting Mankind” Beauty? Brains? Place Your Orders.” *New York Times*, February 16, 2007.

¹¹⁵ *Buck v. Bell*, 274, U.S. 200 (1927).

¹¹⁶ Letter from George Ruhland to Daniel Hoan, May 14, 1920, Daniel W. Hoan Collection, Mss 546, Box 18, Health Department, 1911-1925, MCHS.

even dormant cases of these diseases, including syphilis and gonorrhea. What health officials found appalled them. Estimates put national levels of these diseases as high as 33 percent of the total national population.¹¹⁷ In Milwaukee, the numbers were a bit lower but health officials still estimated “from five to ten per cent of all individuals have syphilis and that from fifty to seventy five per cent have, or will have, gonorrhea.”¹¹⁸ Along with increased awareness by health officials, a growing prevalence of literature concern the detection and control of venereal disease in American society.¹¹⁹

The diagnosis, treatment, and prevention of venereal diseases (especially syphilis) took on militaristic tones as health departments spoke of campaigns, wars, and treatment regimens. Health officials saw these diseases in no uncertain terms; they had to be stopped for the sake of the white race. Madison Grant’s *The Passing of the Great Race* noted that “what is needed in the community most of all is an increase in the desirable classes, which are of superior type physically, intellectually and morally.”¹²⁰ Bound up in the eugenics movement of the late nineteenth and early twentieth century, the discussion surrounding venereal disease at times became muddled and clouded with racist and

¹¹⁷ Lee Alexander Stone, “Racial Efficiency,” (Madison, WI: Wisconsin State Board of Health, n.d.) Mss 546, Box 12, “Pamphlets-Health,” Daniel W. Hoan Collection, MCHS.

¹¹⁸ John P. Koehler, *The Road to Health* (Milwaukee, WI: Milwaukee Health Department, 1929), 57. Koehler’s assertion about gonorrheal rates for the general population is based on early twentieth century beliefs that gonorrhea, as well as syphilis could be transmitted without sexual contact or immorality. Fears about public drinking cups, toilets, even cloth towel dispensers in restrooms helped to spread the belief that venereal diseases could be contracted by casual contact. This belief in the casual contact transmission model underlies Koehler’s startling statement.

¹¹⁹ For a sampling of these works, see Edward B. Vedder, *Syphilis and Public Health* (Philadelphia: Lea & Febiger, 1918); G. Frank Lydston, *Sex Hygiene for the Male and What to Say to the Boy* (Chicago: Riverton Press, 1912); J.H. Kellogg *Ladies’ Guide in Health and Disease* (Battle Creek, MI: Modern Medicine Publishing Co., 1902); and F.O.S. Fowler, *Sexual Science* (Cambridge: Harvard University Press, 1870).

¹²⁰ Madison Grant, *The Passing of the Great Race* (New York: Charles Scribner’s Sons, 1922), 48. Madison Grant who was an American eugenicist put forward the idea of “Nordic superiority” in his work. He advocated for a strong eugenics program in the United States to preserve that superiority in light of what he saw as an inundation of “lesser” stock and races (Southern and Eastern European immigrants).

prejudicial overtones. Venereal diseases were seen as endemic in “low” populations—immigrants, ethnics, minorities—those of moral questionability.

The Milwaukee Health Department, like other municipalities, set out to meet the need of the growing problem of venereal disease in the city. A separate Division of Venereal Disease was established within the Health Department by 1920. It filled the need for the examination of venereal cases, treatment of those ill, and laboratory testing for venereal diseases. The Division and its clinics experienced an ever growing demand for their medical services. By 1925, it was estimated that approximately 20 percent of the women who came into the Venereal Division’s clinics were infected with some sort of venereal disease.¹²¹ That same year, the Health Department performed over six thousand Wasserman (which detected for syphilis) tests, with almost 14 percent testing positive. These tests were a combination of samples sent from the division clinics, from the county hospital, and from public school examiners as well as the House of Corrections.¹²²

In 1926, the city’s Health Department published a list of specific improvements to stem disease rates in the city by controlling both those who had the disease and those who claimed to be able to cure it. They first recommended that all venereal diseases should become reportable to the local and state health boards, as any other communicable disease would be. Secondly, the Health Department focused on the patient themselves. The suggestion was made to require six months of treatment under a doctor’s care as a way of controlling the person infected. The Health Department also sought the legal ability to commit those who refused treatment or stopped treatment early. Health officials hoped to gain a greater handle on those who were ill and prevent the further spread of the

¹²¹ Annual Report, 1925, Mss 2126, Milwaukee Health Department, Venereal Disease Division, MCHS.

¹²² Ibid.

venereal disease they were carrying. Finally, the Health Department sought to regulate those who claimed to care for such patients as they mandated that only licensed physicians could treat venereal diseases.¹²³ Too often, untrained or quack doctors preying on common fears “treated” patients with nothing more than big promises, fake and sometimes dangerous pharmaceuticals, and disreputable medicine. Milwaukee citizens were warned to be wary of “‘medical institutes’ and advertising quacks. Patent medicines and ‘favorite prescriptions’ are dangerous. Every case need[s] individual attention and the care of an absolutely reliable physician.”¹²⁴

By the early 1930’s, the health department offered “free diagnostic service for venereal disease to all who apply and [assigned] the expense of this service to the tax payers.”¹²⁵ While the Health Department offered free clinics, there was a severe lack of other hospital facilities willing or able to care for venereal disease cases. The City’s Dispensary at Twenty-fifth and Wisconsin had a “very large treatment clinic for venereal disease”¹²⁶ which, however, was all done on an outpatient basis. Marquette University’s Dispensary and Hospital worked with the Maternity Hospital and the Health Department, providing diagnosis for venereal diseases as well as Salvarsan treatments for syphilis, but once again mainly on an outpatient basis. The general work of caring for these cases was “handicapped by the lack of hospital facilities . . . [the] increase has been steady and those urgent cases which needed immediate hospitalization have been referred to

¹²³ Milwaukee Health Department, “Municipal Report,” 1926, Mss 2126, Milwaukee Health Department, MCHS.

¹²⁴ “Manpower,” (Madison, WI: Wisconsin State Board of Health, 1919), 8, Mss 546, Box 12, “Pamphlets-Health,” Daniel W. Hoan Collection, MCHS.

¹²⁵ Letter from John Koehler to Otto Hauser, Secretary to Mayor Daniel W. Hoan, November 30, 1932, Mss 546, Box 18, “Health Department, Dr. John P. Koehler, 1930-1940,” Daniel W. Hoan Collection, MCHS.

¹²⁶ Ibid.

agencies which disposed of them as satisfactorily as possible.”¹²⁷ Few hospitals would admit venereal disease cases; in fact, most had clauses in their charters specifically excluding such cases. The Milwaukee Hospital, Columbia Hospital as well as St. Mary’s hospital refused admittance “if suffering from a venereal disease.”¹²⁸ If a patient was admitted and later found to be infected with any venereal disease, they could be discharged on the spot. The Milwaukee Maternity Hospital was one of the few hospitals to admit women with venereal diseases.¹²⁹ Starting in the late 1920’s, the Health Department frequently called for the establishment of a hospital to specifically treat venereal disease. A petition to the Rockefeller Foundation in the late 1920’s was unsuccessful in securing funds for such an endeavor.

The cure and treatment for venereal disease came from less orthodox sources. The *Sporting and Club House Guide to Milwaukee* has numerous advertisements for Dr. LaVine and his miraculous cures. One advertisement claimed that his tonic was a “positive cure for Syphilis, Gonoerhoea[sic], Gleet, etc. . . . Any case of Syphilis cured in three months. Any case of Gonoerhoea cured in four days.”¹³⁰ Dr. LaVine’s also promoted a prophylactic that would prevent the infection: “Dr. LaVine’s Sure Preventive. . . By using this preventive one cannot possibly catch any of those loathsome disease. Harmless and easy to use. No pain and a positive preventive. One package will last a year.”¹³¹ While the *Sporting Guide* had a high male readership, much of the advertising in fact was directed toward women. The readership might have very well

¹²⁷ 1921 Annual Report, Milwaukee Health Department, 76.

¹²⁸ Milwaukee Hospital, Annual Reports, 1907-1916, Milwaukee Manuscript Collection 109, Box 5, Sinai Samaritan Medical Center, UWM.

¹²⁹ United Community Services of Greater Milwaukee, Records 1903-1969, Milwaukee Manuscript Collection BG, Box 10, “Institutional Care in Milwaukee County,” UWM.

¹³⁰ *Sporting and Club House Guide to Milwaukee*.

¹³¹ *Ibid.*

been the “boarders” who were so gloriously extolled in the publication.¹³² While these advertisements were clearly false, thousands of dollars were spent every year on quick cures and quack medicines. The real danger in many of these patent medicines lay in the fact that they delayed or prevented the real treatment of these conditions. Without the proper medications and prompt treatments, any disease, but especially venereal diseases, only grew worse. Delays in treatment resulted in the development of secondary conditions related to the venereal disease and made any hope for a full recovery unlikely.

Just as in the early days of the AIDS epidemic, there was a concern in the medical community that venereal diseases (such as gonorrhea and syphilis) could be transmitted casually as well as sexually. John P. Kohler, Milwaukee’s Health Commissioner, reminded his readers in 1929 that “it must not be forgotten that venereal diseases can also be contracted without sexual relations and without immorality. Many innocent men, women and children may contract these terrible diseases.”¹³³ While Koehler’s and many other health officials assertions turned out to be incorrect, it still led to a general fear over the spread of venereal diseases and a sense of constant vigilance from both moral and health reformers.

Moral reformers called for sexual self-control and relationships in line with Victorian values as a way of combating venereal disease. Individuals were to be restrained in their sexual relationships, only expending sexual energies for procreative purposes. Any sort of sexual license was to be avoided. Health could be achieved by

¹³² The *Sporting Guide* never overtly referred to the women as prostitutes, working girls, or “sporting girls.” It referred to the brothels as boarding or rooming houses, and the prostitutes therein as “boarders” at these residences. Men were encouraged to look up a particular young “boarder” at one of these brothels for their pleasing personalities, charm, and talents.

¹³³ Koehler, 56.

leading a “life of continence before marriage and to marry only such an individual that gives every evidence of being free from venereal disease. The general idea that sexual intercourse is necessary for physical health is the greatest fallacy.”¹³⁴ Sexuality was confined to the discussion of parenthood. Women were supposed to acknowledge they were sexual creatures only in the capacity of their potential to be mothers. Any sexual expression that deviated from the norm was considered immoral and even dangerous to themselves and anyone they encountered. Many firmly believed that “vigorous recreation, hard work, [and] wholesome companionship are the preventatives of extreme temptations to use the reproductive organs in a dangerous manner.”¹³⁵ With enough fresh air and strenuous exercise, any temptation could be overcome.

For some, increased venereal disease rates had less to do with bacteriology or moral deficiencies. They saw a distinct lack in basic sexual education. Victorian sensibilities coupled with the Comstock laws insured that “the silence surrounding sex has meant hours of needless worry and depression in the lives of millions.”¹³⁶ Health officials believed that “as with most contagious diseases, the way to prevent and reduce venereal diseases is to educate people concerning them.”¹³⁷ Even though “the problem of venereal disease is recognized as one of the most important with which we have to deal today . . . only since the war [has] . . . this matter . . . been brought into the open and is being approached with the frankness it should have been dealt with long ago.”¹³⁸ As societal attitudes shifted following the First World War, a new openness of culture,

¹³⁴ Ibid, 57.

¹³⁵ “Manpower,” MCHS.

¹³⁶ Ibid.

¹³⁷ Ibid.

¹³⁸ Letter from George Ruhland to Daniel W. Hoan, May 14, 1920, Daniel W. Hoan Collection, Mss 546, Box 18, “Health Department, 1911-1925,” MCHS. The war in question here is World War One.

society, and even medical discussion emerged regarding sexuality and venereal disease. While previous social mores and even legislation prevented the discussion and dissemination of such sexual health knowledge, there was a now growing movement to address the issue of sexually transmitted diseases and the culture of silence that contributed much to its spread. Women could more easily be virtuous if men were as well. Proper men were to “respect and honor all women,” and to “demand no more of a woman than he is willing to give in return.”¹³⁹ Moral reformers called for a change in the double sexual standards that existed during the Victorian era and demanded men be held to the same level of moral exactitude that women were held.

Venereal diseases were the root cause of much more than just the primary disease they caused. They not only created “disability, wrecked lives, paralysis and insanity among men, but invalidism and sterility among women, blindness, deformity and idiocy among children.”¹⁴⁰ The threat to the larger population created calls for swift and certain action against those known or suspected to be infected with venereal disease. Syphilitics were seen as a “menace to society and should be forced to take treatment in order that they may not carry their disease to unsuspecting and pure women, who in turn will convey it to their offspring.”¹⁴¹ The fears of many health officials were that not only would they be infecting “innocent” wives but also the children, the future generations, and do both irreparable harm.

¹³⁹ State Board of Health, Madison, WI, “The Moral and Healthy Community: An Appeal to the Clergy of Wisconsin,” (Madison, WI: State Board of Health, n.d.) 6, Mss 546, Pamphlets-Health, Box 12, Daniel W. Hoan Collection, MCHS

¹⁴⁰ “Manpower,” MCHS.

¹⁴¹ Stone, “Racial Efficiency,” 12.

Gonorrhea

Gonorrhea along with syphilis became one of the two great evils fought by both moral and health reformers during the Progressive Era. Gonorrhea was seen by many health officials as even more injurious than syphilis in the long run. Unlike syphilis that would manifest symptoms from two to eight weeks after initial infection, gonorrhea could achieve its destructive handiwork with few outward signs. This silent menace was seen as the greatest threat to the health of women and children and, thereby, to the whole American population.

Gonorrhea is caused by the *Neisseria gonorrhoeae* bacterium. While the most common mode of transmission is through sexual contact, gonorrhea could also be transmitted from mother to child during birth. To nineteenth century doctors, however, gonorrhea was seemingly more easily transmitted than we know it to be today. The medical literature of the time spoke of the “innocent victims” who would contract gonorrhea from toilet seats, dirty bed linens, and casual contact. Modern medicine has proved the casual contact of gonorrhea unfounded. Doctors were frequently confounded with the cases of young girls with gonorrhea, unaware or unwilling to admit the potential for sexual abuse of these children. Hospitals were filled with young girls with very adult problems.

Gonorrhea was “one of the hardest to cure. It sometimes results in complete loss of sex power or even sterility . . . sometimes, when treated wrongly or left too long without treatment, gonorrhea is absolutely incurable . . . self treatment or quack

treatment or quick cures are all dangerous.”¹⁴² For too long, this threat had silently destroyed the ability of women to have children. Too often women were too ashamed to come forward and seek diagnosis and treatment. Too often women were uneducated in sexual matters, unwilling to admit their husband’s infidelities, and unable to remove themselves from their “wifely duties.” Doctors estimated that to treat a new case of gonorrhea “properly takes about four weeks.”¹⁴³ Unfortunately, few cases were properly cared for. Treatments needed for gonorrhea were extensive. For most of its history, the cure for gonorrhea was almost worse than the disease itself. Treatment solutions were based either on silver or zinc compounds. For infants born from mothers with gonorrhea, the solution was the use of silver nitrate drops in their eyes right after delivery. The Maternity Hospital, through Clara Hipke’s efforts, became instrumental in passage legislation requiring the drops for all newborns in the state.¹⁴⁴ Through simple silver nitrate drops, generations of blindness could be avoided.

The key threat of gonorrhea was not its potential to outwardly scar, as syphilis could, but to internally scar. The disease was seen as being responsible for “child sterility . . . that in many cases it is the cause of absolute sterility[,] thus becoming an active cause of the so-called ‘race-suicide.’”¹⁴⁵ Women infected with gonorrhea were frequently left infertile after only one birth as the gonorrhea caused both extensive scarring and damage to her reproductive organs. Race suicide was one of the trigger phrases of the Progressive era. Fears brought on by vast influxes of immigrants from

¹⁴² “Manpower,” MCHS.

¹⁴³ Ibid.

¹⁴⁴ Milwaukee Maternity Hospital, “There is No Excuse for Blindness of Infants,” n.d. United Community Services of Greater Milwaukee, Records 1903-1969, Milwaukee Manuscript Collection BG, Box 13a, United Community Center, Hospital Council of Milwaukee, 1929-1934, UWM.

¹⁴⁵ Milwaukee Maternity Hospital, “The Eugenics Law,” n.d., *ibid.*

Southern and Eastern Europe, and the growing awareness of declining birth rates among more established and “desirable” families combined to create an atmosphere of near hysteria over issues of “proper breeding” and this supposed “race suicide.” The fear over sterility in the white, non-immigrant population was ever present in the minds of eugenic reformers. The damage to women from gonorrhea was not just personal, but “the number of cases of blindness due to gonococcus represents an appalling national loss.”¹⁴⁶ This was more than a private illness. This became a national tragedy.

For women with advanced cases of gonorrhea, hysterectomies were the only option and it is believed that “sixty percent of all women who are operated on for diseases of the pelvic organs are suffering from a gonorrheal infection.”¹⁴⁷ No disease was seen as more dangerous to women than gonorrhea. Outside of causing venereal infection, gonorrhea also caused heart, rheumatic, and arthritic problems.¹⁴⁸

Syphilis

While gonorrhea was seen as a specific menace to women, syphilis was seen as a menace to society as a whole. Syphilis transmitted to women could be easily passed on to any child that she carried. Unfortunately for that child and mother, it was not easily treated with silver nitrate drops in the eyes. The end result of a syphilis infection was not sterility but instead it ranged from insanity to skeletal and soft tissue degeneration. This was a disease feared by the populace and combated by health officials.

¹⁴⁶ Stone, 12.

¹⁴⁷ “The Moral and Healthy Community,” 6, MCHS.

¹⁴⁸ Charles C. Norris, *Gonorrhea in Women* (Philadelphia: W.B. Saunders Company, 1913), 430-31.

There are at least four distinct types of syphilis. Primary syphilis, syphilis in its earliest form takes between two and eight weeks for the first symptoms to appear. Secondary syphilis, whose symptoms manifested themselves from six weeks to three months after first contact, is characterized by “headache, bone pains, fever, sores in the mouth and throat, skin rashes, swelling of the glands, and rapid loss of hair.”¹⁴⁹ The final stage, called tertiary syphilis, was the most serious and the least recoverable. Tertiary syphilis could take from one to twenty years to develop. It was characterized by “locomotor ataxia, certain kinds of paralysis, paresis, some forms of insanity, [and] deformities of bones and joints.”¹⁵⁰ The final type of syphilis, perhaps the most heartbreaking, is congenital syphilis, the form of the disease passed from mother to her unborn child in utero. Children born with congenital syphilis rarely lived into their teens and suffered from a wide variety of ailments including a host of developmental problems in addition to the complications that accompanied the other three forms.¹⁵¹

While the main focus of venereal disease prevention was on male conduct, men were reminded once again that “syphilis, like gonorrhea is usually caught from loose women or whores.”¹⁵² While health officials were certain about the sexually transmittable nature of venereal diseases, they were also convinced that a more casual spread of the disease could also take place. The public was also warned that “it [syphilis] is also transmitted by kissing and sometimes by touching things which may have been

¹⁴⁹ “Manpower,” MCHS.

¹⁵⁰ Ibid.

¹⁵¹ M. Ikeda and H. Jenson, “Evaluation and Treatment of Congenital Syphilis,” *Journal of Pediatrics* 117, no. 6 (1990): 843-852.

¹⁵² Ibid.

used by syphilitic people, such as clothing, cups, pipes, towels, beds, etc.”¹⁵³

Similar to gonorrhea, a variety of patent medicines proved tempting for those infected with syphilis. The medically approved treatments for syphilis seemed no more safe or reasonable than the patent frauds. From the sixteenth century, the standard syphilitic treatment was based in mercury compounds and the nineteenth century was no different. Bichloride of mercury was a popular treatment used by many doctors and hospitals. Outside of the mercury treatments, an emerging treatment using arsenic compounds, under various names, were beginning to be used. The treatments were as bad as the disease at times, with significant long-term side effects including drug induced insanity.¹⁵⁴

The First World War brought new concern over venereal disease and new worries about treatment. A 1915 *Milwaukee Leader* article, while never actually naming the disease as syphilis, worried that the disease was “rapidly spreading in Milwaukee due to a lack of neo-salvarsan, or ‘914,’ as it is commonly known.”¹⁵⁵ The Neo-salvarsan medication was the primary treatment option for those with syphilis prior to the introduction of antibiotics after the First World War, but was in short supply because of wartime shortages. Without a supply of the treatment, the “danger to the public through the exhaustion of the supply of neo-salvarsan also is increased. Those afflicted with the disease will continue to go to public places and leave the germs in towels, table cutlery, dishes, etc.”¹⁵⁶ Once again, the absence of a treatment was just as dangerous as the

¹⁵³ Ibid.

¹⁵⁴ J.G. O’Shea, “‘Two Minutes with Venus, Two Years with Mercury’—Mercury as an antisiphilitic chemotherapeutic agent,” *Journal of the Royal Society of Medicine* 83 (June 1990): 392-395.

¹⁵⁵ “Drugs Lacking, Loathsome Ailment is Spreading,” *Milwaukee Leader*, December 13, 1915.

¹⁵⁶ Ibid.

wrong treatment, leaving the healthy population vulnerable to contact with diseased people and leaving those with syphilis vulnerable to more serious form of the disease.

The most significant discussion of venereal diseases, especially syphilis, focused on the impact for future generations. The infected husband “may transmit it to his wife, and she may transmit it to the body of the child before birth, so that the child will be born dead, or so that, if it is born, it will be crippled in mind and body. Syphilis is transmitted to the offspring in full violence and its inherited effects are appalling.”¹⁵⁷ Syphilis was frequently blamed for filling up state institutions for the mentally insane and feeble minded.¹⁵⁸ By not preventing the spread of syphilis, the cost to future society became greater than the initial costs to diagnosis, treat, or sterilize patients. Syphilis was blamed for at least 25 percent of miscarriages during this period.¹⁵⁹ Syphilis was not only seen as a problem for the current generation, but also for generations to come: “Many men and women today in society, who suffer from mental and physical weaknesses, may trace their troubles directly to a syphilitic ancestor.”¹⁶⁰

Syphilitics were seen “as a menace to society and should be forced to take treatment in order that they may not carry their disease to unsuspecting and pure women, who in turn will convey it to their offspring.”¹⁶¹ Frequently, the discussion of venereal disease centered around reproduction. To knowingly pass on venereal disease was bad enough, but this transmission held larger, more significant consequences in that a mother

¹⁵⁷ “Manpower,” MCHS.

¹⁵⁸ Mary Gough Rose, *An Ecological Study of Feeble-Mindedness in Milwaukee Based on Records of the Two State Training Schools* (Milwaukee: Marquette University, 1942), 44-48.

¹⁵⁹ Milwaukee Maternity Hospital and Dispensary, “The Eugenic Law,” n.d., Milwaukee Manuscript Collection BG, Records 1903-1969, “Maternity Hospital,” United Community Services of Greater Milwaukee, UWM.

¹⁶⁰ “Manpower,” MCHS.

¹⁶¹ Stone, 13.

might then pass it on to her children. A pamphlet distributed by the Milwaukee Maternity Hospital suggested that “syphilis is the cause of more miscarriages than any one other known cause...twenty five per cent or more infants dying during the first two weeks after birth are due to syphilis.”¹⁶² While the pamphlet did not state where those statistics originated, it seemed to be the prevalent popular medical opinion of the time that infant mortality rates could be significantly lessened with more attention paid to venereal diseases. The eugenics movement attempted to provide a solution through its counseling of prospective couples as to their “fitness” to produce offspring. Many states during this period enacted or strengthened laws requiring physical exams prior to issuance of marriage licenses. Finally, many states enacted, starting in 1913, sterilization laws preventing those deemed feeble-minded and insane (as well a variety of other classifications) from having children in the first place.

¹⁶² “The Eugenics Law, ” UWM.

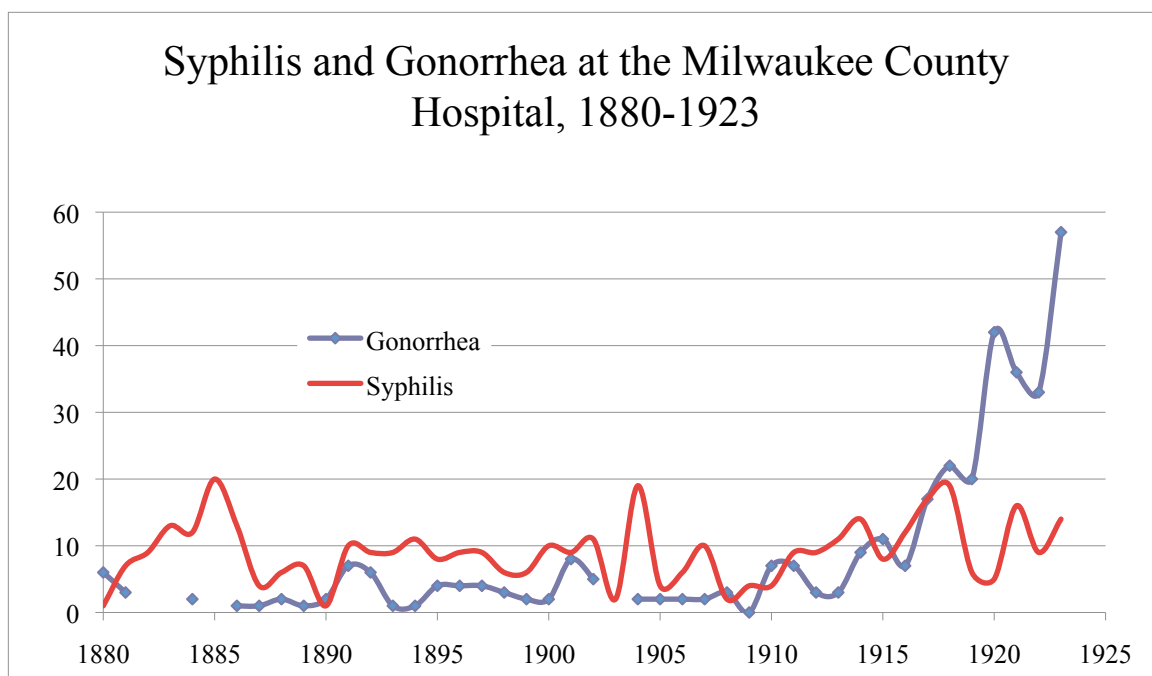


Figure 6: Syphilis and Gonorrhea at the Milwaukee County Hospital, 1880-1923

Figure 6 presents the number of cases of gonorrhea and syphilis in the County Hospital in the period under study. While there were fluctuations from year to year, there was a decidedly upward trend of both diseases by the 1910s, possibly from increased incidence, but also perhaps from more accurate testing. From 1880 to 1923, when the County Hospital patient registry stopped listing reason for entry, 350 cases of gonorrhea and 400 cases of syphilis were recorded in the female registry. This was out of 2,574 pregnancy, venereal, and reproductive related cases. The syphilis and gonorrheal cases alone account for over 29 percent of the female cases in the hospital during these years. While pregnancies account for 43.6 percent of the patients, the venereal cases make up a significant amount of the caseload and resources of the hospital.¹⁶³ As stated earlier,

¹⁶³ Milwaukee County Hospital, Annual Reports, 1906-1929; Milwaukee County Hospital Patient Ledgers, 1880-1923, Mss 723, Milwaukee County Institutions and Departments, MCHS. Breaks in the above chart reflect a lack of reported cases for that year.

most private hospitals would not admit anyone with a venereal disease, even if the reason for their admittance was something other than the venereal disease. Fear of contamination and spread of gonorrhea and syphilis left many women with only one option for treatment: the County Hospital.

The majority of those cases (around 600) are found in women under twenty-five years of age, and nearly ninety were in young women between the ages of ten and fifteen. They were more likely to be women working as domestics, in factories, or simply housewives. While prostitutes comprise eighty-six individuals in the survey, they were not the dominate demographic group. Venereal diseases were not only for the “morally corrupted” members of society, but were part of larger societal issues.¹⁶⁴

The upward trends of both diseases, but especially syphilis numbers suggest a number of possibilities. First, with advanced testing techniques, disease rates will always rise. Better diagnostic tools will generate higher numbers as more cases are diagnosed earlier. Secondly, not only is the testing better, but the early 1910s saw a broader range of people who where being tested for venereal disease. General hospital populations, inmates of institutions (criminal and medical), children at school, and even couples applying for a marriage license were tested. This larger pool most surely identified cases that might have previously remained undiagnosed. Finally, there may have been a true rise in numbers of syphilis cases. Soldiers returning from World War One and the emergence of the “new” woman, politically empowered and sexually liberated, might have had an effect on venereal disease rates in the city. Unfortunately, the real growth, if any, is masked by changes in diagnostic techniques and the growth in the body of those

¹⁶⁴ Allan M. Brandt, *No Magic Bullet* (New York: Oxford University Press, 1987), 7-20.

being tested. This difficulty in discerning between new cases and better testing is a dilemma that still besets modern medical reporting of disease.¹⁶⁵

Prostitution

Of the women who entered the County Hospital between 1880 and 1923 and who lived in the City of Milwaukee, eighty-six out of 2,574 declared their “occupation” as prostitute or “sporting girl.” For many of these women and for many who did not formally declare this as their occupation, prostitution was a economic necessity, but a dangerous one. Subject to abuse by customers, venereal disease, and unwanted pregnancies, these women struggled to eke out a living on the margins of society.

The female patient registry of the Milwaukee County Hospital provided an interesting perspective into the prostitutes of the city. Frequently poor and alone, they had few other places to turn but the County Hospital. Many women simply listed their occupations as “servants” or “domestics,” but their addresses hint at their true profession. A number of women listed as “domestics” or “servant girls” provided addresses on River Street, which was the heart of Milwaukee’s vice district. Women only turned to prostitution when finances were tight or if they had no other means of support. Few women ever entered the lifestyle because they enjoyed what they did.¹⁶⁶

Following World War I, increased attention was paid to venereal disease, especially its connection with the “social evil” of prostitution. A 1919 pamphlet

¹⁶⁵ Brandt, 12-14.

¹⁶⁶ Ruth Rosen, *The Lost Sisterhood: Prostitution in America 1900-1918* (Baltimore: Johns Hopkins Press, 1982), 137-168.

published by the Wisconsin State Board of Health declared: “every prostitute (or whore) has them [venereal diseases] sooner or later.”¹⁶⁷ The pamphlet also warned against the danger of both “professional prostitutes [who] have one or both diseases” and charity girls. “Charity girls” was a term used to describe women who would do sexual favors in exchange for gifts, a night out, or a trip to the movies. While charity girls were never seen in the same light as career prostitutes, men were still advised to be wary for she “may also have caught the disease from the first man who had her.”¹⁶⁸

The mental health and well being of women became a significant focus in health care in the late nineteenth and early twentieth centuries. Population movements toward the cities led to a growing concern over the moral well being of urban populations, especially women. Cities were seen as places with little to no morality, places where the social structures and constraints of the rural or small town setting did not exist. This led many impressionable souls down the wrong path. Women were especially vulnerable in these new settings as they were outside of the social networks that had kept them safe up to that point. Constitutionally, women were also considered more vulnerable as they were viewed as the “weaker” sex, more prone to mental illness, feeble mindedness, and moral coercion. Religious and social reformers during the Victorian era often sought solutions to the city’s apparent lack of morality. These reformers hoped by changing personal behaviors as well as the environment they might change the overall health of the city’s population.¹⁶⁹

While cities offered many economic opportunities for young women, they also

¹⁶⁷ “Manpower,” MCHS.

¹⁶⁸ Ibid.

¹⁶⁹ Paul Boyer, *Urban Masses and Moral Order* (Cambridge, MA: Harvard University Press, 1978), 198-202; Rosen, 28-30.

presented many struggles and temptations for a woman alone. Both immigrant women from Europe and girls from rural areas journeyed to Milwaukee to start a new life and to avail themselves of the new economic options. Unfortunately, while the job market was expanding for women during this period, the wages they would make rarely provided enough to live on. A few women switched from domestic labor to factory labor as wages were slightly higher. Some turned to less reputable ways of paying their rent, including prostitution.

While no survey of Milwaukee's prostitutes exists similar to Chicago's Vice Commission report,¹⁷⁰ distinctive red light districts existed well into the early part of the twentieth century. River Street (now Edison), Martin Street (now East State) and Market Streets were all densely populated with brothels, saloons, and rooming houses in which women plied their trade.

The *Sporting Club Guide* provided a list of brothels in the city with names and descriptions of the "lodgers" at each sporting house. The *Sporting Club Guide* even noted a house in which African American girls served only a white clientele. Women like Lucille Martin who was arrested at her residence on Clybourn Street or "Diamond Minnie" who was accused of running a house of "ill fame," were seen as not only menaces to the social order, but to the health order as well.¹⁷¹

Reformers often did not blame the women for their lives of prostitution, but instead blamed the men who had seduced them. "Many a woman who walks the streets or

¹⁷⁰ In 1911 the city of Chicago commissioned a report that came to be known as *The Social Evil in Chicago*. This 400-page report detailed the extent of prostitution in the city, providing demographic information on 5,000 women engaged in the trade, and offered ideas to reduce the numbers and economic need for prostitution in Chicago.

¹⁷¹ "Church Women Give Officials Vice Warning," March 1, 1891, uncited newspaper, Milwaukee Microfilms Collection, "Women in Milwaukee," MCHS.

lives in a brothel and offers her body for sale was seduced by an unfaithful lover who promised marriage knowing he would never live up to his pledge.”¹⁷² Reformers frequently called for the abandonment of the double standard of sexual behavior between men and women. Women were supposed to be pure, innocent, and sexless creatures. Men, on the other hand, needed sexual gratification to preserve their good health. Once infected, many female prostitutes were seen as “social avengers” who spread “venereal diseases broadcast among those males who seek her.”¹⁷³ Even women who were regularly seen by physicians were not considered “safe.” Individuals who prostituted themselves did so for economic reasons; they needed to work to feed themselves and frequently their families. Even though they might be under a physician’s care, they were still engaging in behavior that could transmit disease.

One place where the city hoped to combat issues of venereal disease was in the jails and prisons. Health officials sought to examine those arrested for venereal disease as a way to curtail new cases. While more men were arrested than women during this period, women composed a significant amount of the examinations performed in the city.¹⁷⁴ By the mid-1920s, a number of cities including St. Louis and New York had begun to forcibly examine individuals arrested under a certain set of charges.¹⁷⁵ Dr. John P. Koehler wrote to Thomas Duncan, Mayor Daniel Hoan’s secretary, in August of 1926 with the hopes “that every effort should be made to have laws passed...[that] make it possible to examine all individuals for venereal disease who have been convicted of

¹⁷² Stone, 4-5.

¹⁷³ Ibid, 5.

¹⁷⁴ Milwaukee Health Department, *Annual Report*, 1925, Mss 2126, Milwaukee Health Department, MCHS.

¹⁷⁵ Letter from J.G. Laubenheimer, Chief of Police of Milwaukee to Thomas Duncan, Secretary to Mayor Daniel Hoan, August 13, 1926, Mss 546, Box 18, “Health Department, 1926-28,” Daniel W. Hoan Collection, MCHS.

fornication, adultery, prostitution, vagrancy, and lewd and lascivious conduct.”¹⁷⁶

However, the Assistant City Attorney, Joseph L. Bednarek, was quite concerned over the legal basis for these forced examinations. Bednarek saw the police as “exposing themselves to liability.”¹⁷⁷ Bednarek believed that “under the present state of the law you would not be warranted in refusing them to bail or in forcibly attempting to examine them.”¹⁷⁸ Informed consent was crucial for Bednarek; the arrested had to be told for what they were being examined. While Milwaukee’s Health Department was anxious that a similar program be instituted in Milwaukee, the Police Department and the City Attorney’s office were less keen on the idea.

Police Chief J.G. Laubenheimer raised the further issue of personnel constraints because “over three thousand persons are arrested annually on the charges mentioned.”¹⁷⁹ It was unreasonable to expect the city’s already overtaxed police forces to examine all of those arrested under these particular charges. For Laubenheimer, the police medical bureau would be completely incapable of meeting the demand for examinations¹⁸⁰ The chief further echoed the city attorney’s concerns over the legality of the examinations and the possible liability which it exposed the police department and city. Finally, the police chief raised an important point of semantics in regard to the charges which formed the basis for the examinations. If the system was implemented as presently written, many more would slip through the cracks as “many hundreds belonging to class in question are

¹⁷⁶ Letter from John P. Koehler to Thomas Duncan, Secretary to Daniel W. Hoan, Mayor, August 26, 1926, Mss 546, Box 18, “Health Department, 1926-29,” Daniel W. Hoan Collection, MCHS.

¹⁷⁷ Letter from Joseph L. Bednarek, Assistant City Attorney to J.G. Laubenheimer, Chief of Police, City of Milwaukee, August 13, 1926, Mss 546, Box 18, “Health 1926-1929,” Daniel W. Hoan Collection, MCHS.

¹⁷⁸ Ibid.

¹⁷⁹ Letter from J.G. Laubenheimer, Chief of Police of Milwaukee to Thomas Duncan, Secretary to Mayor Daniel Hoan, August 13, 1926, Mss 546, Box 18, “Health Department, 1926-28,” Daniel W. Hoan Collection, MCHS.

¹⁸⁰ Ibid.

charged with disorderly conduct, drunk, and drunk and disorderly, none of which offenses are included in the provisions of the rules pertaining to the State Board of Health.”¹⁸¹ Many individuals who would be carriers of a variety of venereal diseases would go undetected as they were not arrested for crimes deemed “examinable” by the State Board of Health.

With the election of Milwaukee’s first Socialist mayor, Emil Seidel, in 1910, a renewed effort to combat and control vice had been undertaken. Unlike their European cousins, Milwaukee’s brand of socialism (“sewer socialism,” as it came to be known) focused on the creation of a clean city and a graft-free government. These were not violent radicals, but community-minded individuals who strove to improve Milwaukee on many levels.¹⁸² Reform-minded women in Milwaukee saw new hope with the government’s pledge for “clean” government. These social leaders protested that “every clause is needed to wage effective war on offenders against the morals, health and welfare of the public.”¹⁸³ These same women sought to fight vice and institutions that supported immoral activities. Under Mayor Rose’s administration, River Street and the surrounding area became the de facto vice district of the city. Rose had supported an “open town” model that advocated tolerance of prostitution, alcohol, and gambling.¹⁸⁴ Rose even travelled to St. Louis to “study the problem of operating a red light district under strict regulations.”¹⁸⁵ Rose’s administration held to a policy of containment, rather than suppression, allowing for the vice to continue as long as it remained geographically

¹⁸¹ Ibid.

¹⁸² Gurda, 213-232.

¹⁸³ “Take Vice to the Legislature” March 16, 1921, uncited newspaper, Milwaukee Microfilms Collections, “Women in Milwaukee,” MCHS.

¹⁸⁴ Still, 426.

¹⁸⁵ Gurda, 200.

localized.¹⁸⁶ Socialist attempts after 1910 to clean up the vice district of the city only succeeded in geographically spreading the problem. Reformers complained that the prostitutes that had been concentrated just east of the Milwaukee River on Martin, River, and Market Streets had now found “lodgings in respectable quarters under assumed identities, plying their occupation in obscure ways in resorts.”¹⁸⁷ The vice problem had not disappeared after Socialists gained control, but had simply moved to other areas within the city.

The city was so concerned over the issue of venereal disease that in 1921 they sought outside funding to help with the battle. Mayor Daniel Hoan wrote to the Rockefeller Foundation asking for funding for a venereal disease hospital because police tactics to stem vice and venereal disease had been unsuccessful. Hoan wrote that the city was “considering treating the question as a health question,” instead of a social problem.¹⁸⁸ While the city sought to more ably care for venereal disease, they also sought to clean up its streets and lead women to a more moral life. They saw the two as intricately linked.

Prostitutes were visible and tangible reminders of the dangers of venereal disease, a physically visible enemy in the battle against gonorrhea and syphilis. Through the limitation of these undesirable elements, the diseases they carried and the culture they bred would also disappear. Health and morality became intricately intertwined in the early twentieth century as reformers sought not only cure disease, but cure social ills as well.

¹⁸⁶ Ibid., 200-201.

¹⁸⁷ Ibid.

¹⁸⁸ Letter from Daniel W. Hoan to the Rockefeller Foundation, February 26, 1921, Mss 546, Box 18, “Health Department, 1911-1925, Daniel W. Hoan Collection, MCHS.

Conclusion

For women in Milwaukee, as in the rest of the country, the late nineteenth century saw dramatic changes in women's health and their relationship to the medical establishment. Milwaukee's women would continue to struggle with the everyday health concerns of pregnancy, childbirth, and reproductive health. As the obstetrical profession grew, women struggled with issues of agency in the delivery room. They lost power and decision making to male doctors with professional degrees. Advances in medicine, the growth of hospitals, and the professionalization of obstetrics and gynecology shifted the focus of women's health from a female to a professional, and predominantly male, world.

Caught between traditional Victorian morals and a new emerging ideal of female sexuality, women struggled to redefine themselves in the early twentieth century. As contraception became more widely available, women had the ability to gain more control over their reproductive lives. That said, women were still willing to go to extraordinary and dangerous lengths for that reproductive control. Often that dangerous choice cost women their lives.

As a new dialog of sexuality and morality emerged, social concerns of the day - - eugenics, vice control, and moral control - - became health concerns as well. The growing prominence of the eugenics movement altered the debates surrounding marriage, procreation, and who were "desirable" members of society. The increasing visibility of sexually transmitted diseases brought issues of sexuality and morality into the public spotlight. Ironically as women gained more political power in the United States, they came under greater control of male physicians, and under greater assault by social and eugenical reformers. Milwaukee's women were caught in this flux of changing roles. As

they tried to negotiate this new social, sexual, and medical order, they blurred the line between the public and private. As pregnancy, sexuality, and morality increasingly became public issues for debate what had been private choices and intimate decisions now came under public and medical scrutiny. For reformers, doctors, and politicians, however, it was crucial to preserve the physical and moral health of the city's women. As women were seen as the moral foundation of society and the biological foundation of future generations, their health and wellness was imperative for the health of the community at large. Endangering their physical or moral health could only have grave consequences for their children and the future.

Chapter Two

Children of Milwaukee

Introduction

While women acted as the deliverers of future generations, the children that they bore *were* the future of the nation. The health of mothers, but also for children, was instrumental for the future of the city and society. Life at the turn of the twentieth century, however, was fraught with dangers and disease. Surviving the first year, let alone the first five, was a daunting task for many children. Figure 7 presents the average age at death during the time period under study. The bottom line represents the average age at death with the mortality of all age groups considered. In 1882, that average was 18.1 years, increasing to forty-nine years by 1930. The top line is the average age at death with deaths of children under five excluded from the tally. One can see that infant and childhood mortality played a significant role in the life expectancy of the city as infant mortality rates were high enough to reduce the average life expectancy up to twenty years at the turn of the century. Communicable diseases, accidents, violence, contaminated food, poor hygiene, and nutrition led to the deaths of up to 30 percent of infants before

their first birthday.¹ Being the most vulnerable of the city’s population, children were unable to actively advocate for their health. They relied on others to both provide better health and living conditions, but also to keep them safe and secure in light of the dangers of the urban environment.

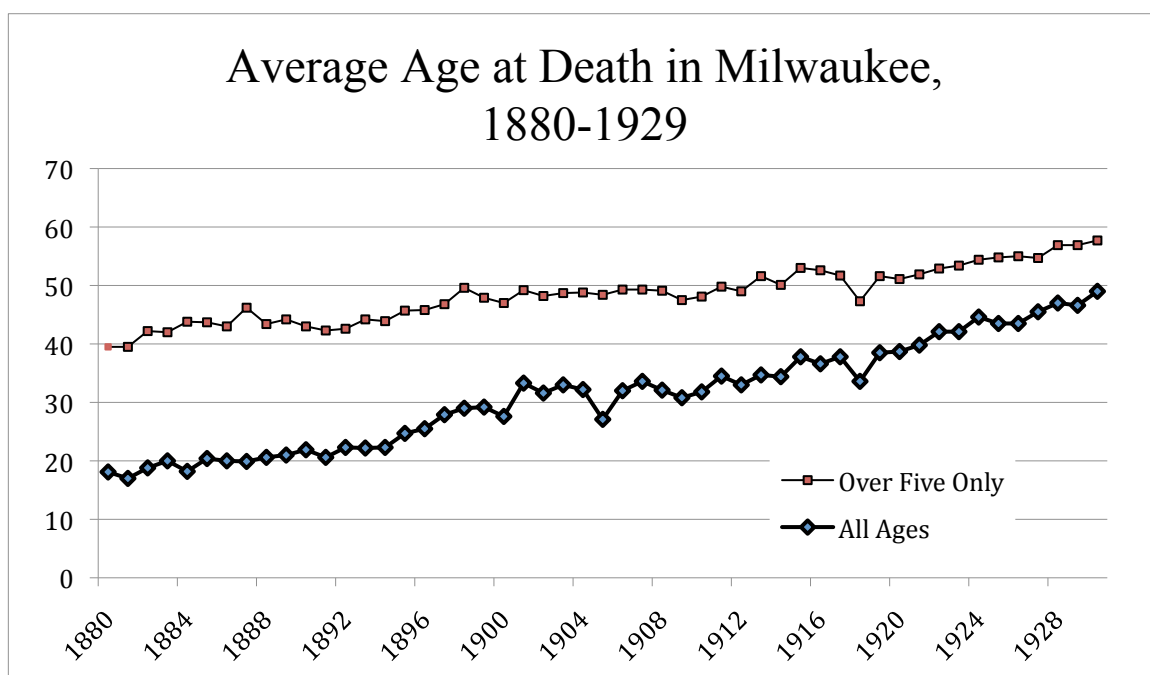


Figure 7: Average Age at Death in Milwaukee, 1880-1929²

In order to create a better city and better health for Milwaukee’s children, reformers and health officials set out to improve not only living conditions in the city, but the children themselves. Reformers sought to instruct mothers on the proper care of their infants and children. Aggressive campaigns for tuberculin testing of milk sought to

¹ “Achievements in Public Health, 1900-1999: Healthier Mothers and Babies,” *Morbidity and Mortality Weekly*, 48, no.38 (October 1, 1999): 838.

² City of Milwaukee Vital Statistics Office, “Average Age at Death,” City of Milwaukee Vital Statistics Office files.

eliminate *M. bovis*³ as a major cause of childhood mortality. Vaccinations programs were implemented to insure that diseases such as smallpox and diphtheria would kill fewer children as they ravaged American cities.⁴

Reformers not only sought to target the cities with their public health campaigns. They also sought to target the children themselves, to create “better babies.” Grounded in the eugenics movement, reformers called for “better babies” and “fitter families” to ensure the progress of the nation’s population. To produce such children, threats to their lives had to be corrected. Not only were the problems of general care, safe food, and epidemic disease addressed, but also the problems of bad genes and bad breeding. Social and medical reformers set out to ensure the health of future generations by ensuring that the present one was free from bad traits as well as inherited diseases.

The confluence of these motivations and movements would fundamentally change the health of children during this period, but would also dramatically alter the experiences of all children from this point forward. The innovations that are instituted in the early twentieth century lowered infant mortality rates, improved the overall health of children, and subsequently raised the overall health of the general population. The children were not only the future of Milwaukee, they were also its impetus to better health. Bettering the health of the city’s children meant a healthier future for the city as a whole. Figure 7 above illustrates the gradual growth in life expectancy during the late nineteenth and early twentieth centuries for both demographic cohorts represented. Life expectancies for all ages moved from eighteen years in 1880 to forty-nine years in 1930.

³ *Mycobacterium bovis* is the bovine form of tuberculosis that can be transmitted to humans from infected cows through unpasteurized milk and dairy products.

⁴ Leavitt, *The Healthiest City*, 44; Evelyn Maxine Hammonds, *Childhood’s Deadly Scourge* (Baltimore: Johns Hopkins University Press, 1999), 211-17.

What the chart also makes quite clear is the distinct difference in life expectancy once a child passed the age of five. If the child survived past this crucial age life expectancy dramatically rose from thirty-nine years in 1880 to fifty-seven years in 1930.

The Dangers of Childhood

Infant Mortality

For many children, the most difficult part of their lives was the opening months. As demonstrated by Figure 8, infant mortality rates contributed heavily to the overall mortality rates of the city and had a significant effect on life expectancy estimations. Demographers and medical professionals defined infancy as the period up to one year of age, so infant mortality rates normally noted deaths of infants one year of age and under. That said, the first five years are, even today, the most risky for young children as it was during this period under study. They are more susceptible to communicable diseases, the effects of malnutrition, and the influences of their physical environment. The child (not infant) mortality rate is considered to be a leading indicator for not only the level of general health in a community, but also the overall development of the community. The children in many respects become a gauge for the community at large.⁵

⁵ “Child Mortality,” www.who.int/healthinfo/statistics/mortchildmortality.en/index.html (accessed 07/01/2009).

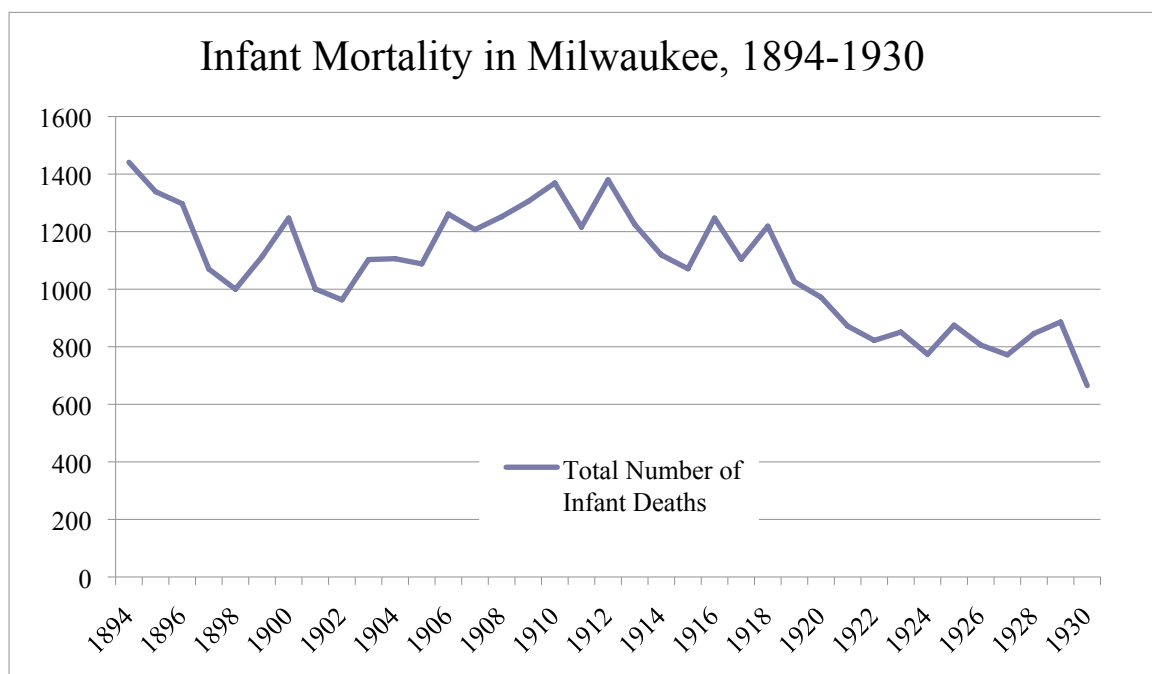


Figure 8: Infant Mortality in Milwaukee, 1894-1930⁶

Figure 8 highlights the steadily dropping numbers of infant deaths in Milwaukee into the early twentieth century, even though births in the city would continue to rise during the same period. This decline in infant deaths is the result of a multi-faceted campaign of improved childcare, vaccination programs, living conditions, as well as a different way of thinking about children and their role in society.

A deadly mix of substandard living conditions, poor sanitation, infectious disease, accidents, and criminal acts contributed to the deaths of many children. While mortality rates in infants and children were higher among lower socioeconomic groups in the city, the ravages of epidemic disease cared little for economic condition or address. One need to look no further than the funeral monument for one of Milwaukee's preeminent families, the Pabst's. Seven gravestones mark the resting places of the Pabst children who

⁶ City of Milwaukee, Vital Statistics.

did not survive birth, sickness, and epidemic disease.⁷

High rates of infant mortality were a cause of concern throughout the nation. In a 1916 national study of infant mortality, Milwaukee ranked thirty-six out of forty-six cities, with centers such as Pittsburgh, Detroit, Washington, D.C., and Baltimore ranking worse.⁸ While Milwaukee's highest infant mortality rate of 199 per 1,000 live births would occur in 1894, by this 1916 study childhood deaths were still significant problem in the city.⁹ A 1921 Milwaukee County Dispensary report noted a concern for the overall health of infants, not only in the city but in the surrounding area as well. The report emphasized that "out of every thousand children born in the City of Milwaukee in 1920, only eighty-nine died, while in Milwaukee County outside of the city . . . [there] were one hundred and nine deaths."¹⁰ This number might strike some as unusual, as one expects to see higher rates of infant mortality in the city with its crowded housing, questionable food, and dangerous conditions. The higher rates in the outer county areas point to problems with access to health care and poor sanitation in some surrounding areas as well as lower rates of vaccinations and preventive medicine among those in outlying communities.

The specifics that fuel these high rates of infant mortality were varied and complex. Numerous factors worked alone in some cases or in conjunction with other health problems to cause the death of a child. For infants (those under one year of age),

⁷ The Pabst/Schandein Family monument can be found in Forest Home Cemetery in what is known as Brewer's Corner, directly across from both the Blatz and Schlitz family monuments.

⁸ Henry H. Hibbs, "Infant Mortality: Its Relation to Social And Industrial Conditions" (New York: Russell Sage Foundation, 1916) in David J. Rothman & Shelia M. Rothman, eds. *Women and Children First* (New York: Garland Publishing Co, 1987), 7.

⁹ City of Milwaukee Vital Statistics Office, "Infant Mortality," City of Milwaukee Vital Statistics Office files.

¹⁰ Milwaukee County Dispensary, Annual Report, 1921, Mss 723, Milwaukee County Institutions and Departments, MCHS.

most were attributed to intestinal complaints such as diarrhea, marasmus, “summer complaint,” and gastro-enteritis. Many of these intestinal problems originated with the growing popularity of artificial feeding among mothers during the early twentieth century, which will be discussed at some length later in this chapter.¹¹ Children had difficulty in digesting these new formulas and therefore developed diarrhea and intestinal problems, some of which eventually led to death. Many of these intestinal issues were also linked to problems with poor sanitation in the city. A young child, especially one who is just starting to explore their world, could easily come into contact with contaminated water, food, and fecal matter. While exploring their new world, many unwittingly came into contact with typhoid, dysentery, and even dreaded cholera.¹²

For children a bit older than one year, growing numbers of them succumbed to communicable and contagious diseases. The Milwaukee Health Department increasingly emphasized the importance of vaccinations, physical exams, and regular check-ups for children as a way to ensure that they were on the proper road to health. (The difficulty in trying to convince Milwaukee’s population of the efficacy and safety of the vaccination system in light of a growing anti-vaccination movement which will be discussed further later on in the chapter.)

Reformers also sought to target the family and living conditions of these children as a way of reducing infant mortality. Studies linked rates of infant mortality with birth order and interval, concluding that the shorter the birth interval the higher the infant

¹¹ Levenstein, Harvey, “‘Best for Babies’ or ‘Preventable Infanticide’? The Controversy over Artificial Feeding of Infants in America, 1850-1920,” *Journal of American History* 70, n.1 (June 1983):84.

¹² For more information regarding infant mortality, see, M. Greenwood and J.W. Brown, “An Examination of Some Factors Influencing the Rate of Infant Mortality,” *Journal of Hygiene* 12, No.1 (May 1912): 5-45.

mortality rate.¹³ Henry Hibbs, Jr. noted in his study that women were continually depleted by constant childbearing and when there was too short a period between pregnancies it “harmfully affect[ed] both the prenatal and postnatal development of subsequent children.”¹⁴ Many women, burdened with too many children, also turned to artificial feeding which subsequently raised infant mortality rates. The conclusion was clear: the greater the number of children, the greater likelihood of high rates of infant mortality among the children born later in the family.¹⁵

Living conditions for many immigrant and poor families also came under close scrutiny. During an 1896 heat wave that killed over sixty children, higher infant death rates were found in the more congested and dilapidated areas of the city. As “frail bodies soon succumbed to the continued heat,” health officials once again called for housing improvements in the poorest areas of the city.¹⁶ According to these experts, poverty led to higher rates of infant mortality in a number of ways. Crowded living conditions, poor nutrition, lack of medical care, and even the employment of mothers were all seen as contributing to the high rates of infant mortality in the city. A national study of poverty and housing noted that 20 percent of reported child mortality cases occurred in blighted and impoverished areas in the United States.¹⁷ A 1915 Health Department study found similar trends in Milwaukee, showing that “the districts in which we recognize a housing problem have furnished...more than twenty-one percent of all deaths for children under

¹³ Henry H. Hibbs Jr., “Mortality and the Size of the Family,” *Publications of the American Statistical Association* 14, Issue III (September 1915): 640.

¹⁴ *Ibid.*

¹⁵ *Ibid.*, 641.

¹⁶ “Death Dealing Heat,” August 8, 1896, *Evening Wisconsin*, “Epidemics,” Milwaukee Features Microfilm, MCHS.

¹⁷ Edith Elmer Wood, *Slums and Blighted Areas in the United States* (Washington, D.C.: U.S. Government Printing Office, 1935), 64, Mss 546, Box 12, “Housing,” Daniel W. Hoan Collection, MCHS.

five years of age.”¹⁸

While the rates of infant mortality would drop 90 percent by 1977, the struggle to achieve those reductions was a long, drawn-out battle.¹⁹ To fight the high infant mortality rates, health officials needed to target what they saw as the contributing causes to these high rates: problems at birth, safety, communicable diseases, living conditions, and venereal disease. “Better babies” were to be shaped, molded, and designed as much as they were to be born.

The Dangers of Birth

The logical place to start with children’s health was at the beginning, at birth. As discussed in the previous chapter, health and social reformers in Milwaukee instituted a campaign to improve maternal health as a route to improving child health. Diet, working habits, and even dress were reevaluated, and more scientifically based “professional” opinions were given. Expectant mothers were instructed to drink at least a pint of milk, and preferably a quart of milk, daily.²⁰ There was concern that if the mother did not receive a proper diet it would directly influence the growth and development of the child.²¹ Women were also instructed to avoid working too late into the pregnancy. There was fear that at “women who work too long or too hard may have weak or sickly

¹⁸ Milwaukee Health Department, Annual Report, 1915, Mss 2126, Milwaukee Health Department Collection, MCHS.

¹⁹ “Achievements in Public Health, 1900-1999: Healthier Mothers and Babies,” *Morbidity and Mortality Weekly* 48, no. 38 (October 1, 1999): 849-858.

²⁰ “Advises Milk in Expectant Mother’s Diet,” January 25, 1932, *Milwaukee Leader*.

²¹ *Ibid.*

babies.”²² This position was grounded both in practical concerns of overwork and strain, but also in middle class conventions about what sort of work women should or should not perform.

Women’s improved prenatal care created a corresponding rise in the health of the babies they bore.²³ A 1926 announcement by the American Child Health Association pointed out that there “should be no child in America that has not been born under proper conditions.”²⁴ As midwives who supposedly knew “little or nothing about pre-natal work” were replaced by obstetricians who contended they knew everything, children were born into a changing world of obstetrics and child care.²⁵

All children faced adversity when they entered the world. For children born out of wedlock, illegitimacy hung heavy over their births at the County Hospital, Misericordia Hospital, the Maternity Hospital as well as the Martha Washington Home. Outwardly the issue of illegitimacy may not seem to be a medical issue, rather a moral one. Many in both medical and social circles saw illegitimacy to be an automatic strike against the health and welfare of the child. Deprived of the social and economic benefits of married parents, subject to possible abuse or infanticide, marred with the title of “bastard,” these children were disadvantaged in numerous ways. Even as late as 1941, Dr. Gerald F. Burgardt writing about the obstetrics situation in Milwaukee commented that many “youngsters get off to a bad start by not being born to legally recognized

²² John P. Koehler, *The Care of the Baby and Young Child* (Milwaukee: Milwaukee Health Department, 1935), 28, Mss 2126, Milwaukee Health Department Collection, MCHS.

²³ “Achievements in Public Health, 1900-1999: Healthier Mothers and Babies.”

²⁴ American Child Health Association, “Announcement – Child Health Day,” May 1, 1926, Mss 546, Box 18, “Health Department, 1926-29,” Daniel W. Hoan Collection, MCHS.

²⁵ “Maternity Hospital Improves the Coming Generation of the City,” January 2, 1915, *Milwaukee Leader*, Milwaukee Features Microfilm, “Hospitals,” MCHS.

parents.”²⁶ Burgardt’s research noted that illegitimate children were born to parents of all types of employment and that age “adds no wisdom” in this situation.²⁷ This was not merely a teenage problem, an immigrant problem, or moral problem; this was a concern for health officials as well.

Data from Milwaukee County Hospital’s Female Patient ledger confirms the presence of illegitimacy as a concern in the city. Of the 2,574 women who were admitted for reproductive related issues, 1,123 were admitted with a diagnosis of “pregnancy.” Of this same sample of 2,574 women, over 1,976 were listed as “single” in their marital status. Figure 9 presents the numbers of children born out of wedlock in Milwaukee from 1908 to 1930, which remained relatively stable throughout the period of study.²⁸ Children born out of wedlock had birth certificates kept in a separate set of binders at the vital statistics office and to this day are considered much more confidential records than the other birth certificates on record.²⁹ Any stigmatization or disadvantage would weigh heavily on children no matter what stage of their lives.

²⁶ Gerald Burgardt, “Obstetrics in Milwaukee,” *Wisconsin Medical Journal*, May 1941.

²⁷ *Ibid.*

²⁸ 1908 is the first year that the Vital Statistics Office officially started tabulating data on out of wedlock births.

²⁹ During research work at the Vital Statistics Office, I had the chance to witness a remarkable, but sad event when an elderly woman came to the office to obtain a copy of her birth certificate for a passport application. What had started out as a simple errand to complete an application became a traumatic day in the woman’s life. When they were unable to initially locate her birth certificate in the regular files, they decided to check the “illegitimate” records, finding her birth certificate therein. Her parents, who had married after her birth, had never told her of the circumstances of her birth or their later marriage. Sadden and a bit traumatized the woman was still clearly affected by the thought of being “illegitimate” even seventy-five years after her birth.

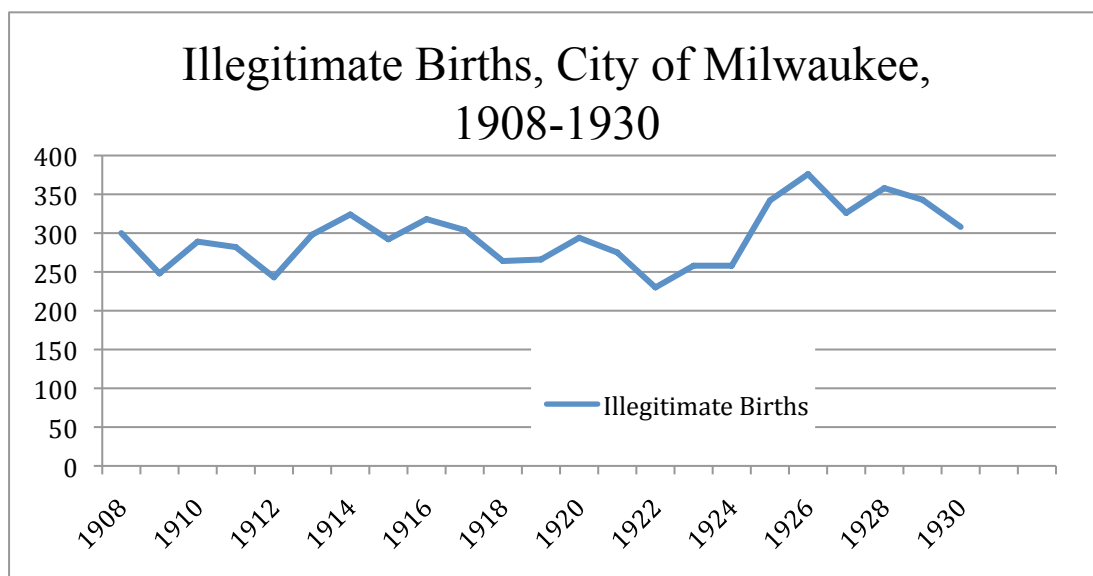


Figure 9: Illegitimate Births, City of Milwaukee, 1908-1930³⁰

Infanticide

In addition to and frequently as a result of illegitimacy, infanticide also came to play a role in turn of the century Milwaukee. Infanticide, the killing of infant children, while uncommon was not unheard of in the city. While a majority of abortion cases involved married women—who, for a variety of reasons, did not or could not carry their child to term—infanticide cases usually involved a different female demographic. The largest number of coroner’s inquests of infanticide cases (not including “unknown” cases) involved young single women. Their stories were usually quite similar. Many came from rural areas of Wisconsin or the outskirts of the city, hoping to find a job in Milwaukee. Seduced by bosses, customers, or acquaintances, these girls, who were frequently without any family or support network, found themselves alone and pregnant.

³⁰ City of Milwaukee, Vital Statistics Office.

While some chose to abort the unplanned pregnancies, many carried the child to term but in secret, fearful of the stigma of illegitimacy and moral disgrace which might accompany such a birth. In the panic and pain of childbirth, some of these young women choose the unthinkable: murder. Smothered in bedclothes, drowned in pails of water, even thrown from train windows, many children's first gasps for breath would also be their last at the hands of their own mothers.³¹

While coroner's reports from the late 1910s and early 1920's only reported five to six infanticides a year, most likely the actual numbers of infanticide were somewhat higher than those seen in the coroner's office. Infants were discovered abandoned throughout the city, simply listed as "unknown babe," or "unknown female" in the Poor Farm Cemetery ledger and coroner's reports.³² While actual figures might be difficult to ascertain, it can be assumed that considering the nature of the offense and the relative ease to conceal the remains of a new born child, many infanticides went undetected and therefore unreported to authorities. Most infanticides took the form of smothering or strangulation. To keep the newborn from crying out (and thereby risking the discovery of the secret pregnancy) or to simply end the life of an unwanted child, many children were simply suffocated with bedclothes or sheets shortly after birth. An unknown female child murdered by strangulation was found at the life saving station at Jones Island. In another instance, Lizzie Krantz, a twenty year-old servant, strangled her infant daughter in 1905 not long after its birth. Lizzie's murder was particularly disturbing as the coroner noted finger marks on the infant's neck. This was no simple smothering, but an act of violence. Exposure was also a common form of infanticide. In 1883, the son of Anna Westesmeir

³¹ Milwaukee County Coroner's Reports, MCHS.

³² Ibid.; Register of Burial, Milwaukee County Poor Farm, personal collection.

was abandoned and in the cold of an early April day. Drownings, strangulations, and physical violence also accounted for a number of infanticide cases. The heinous nature of these incidents became increasingly apparent the more cases were examined. Viola Kung in 1923 threw her infant child to her death out a window. Evelyn Ochbette was killed when her mother scalded her to death. A male infant was found beaten to death in 1923. For many of the “unknown” infants found exposed in vacant lots, garbage heaps, and the Milwaukee River, cause of death was uncertain as they were too decomposed for any certain determination.³³ Not only were children at risk by parental neglect before being born, but also had to fear their parents once they entered this world.

Safety

Once children passed the dangers of infancy, they also were subject to the dangers of the home and street. Residences at the turn of the century lacked many of the modern safety devices that keep children safe in the home. Being scalded by hot water boiling on the stove, accidental poisonings from household chemicals, and a simple fall down a flight of stairs could all have tragic consequences. Outside the home, it was not much safer. The street, where many children played, was a busy thoroughfare of horses, wagons, streetcars, and automobiles. The workplace, if children did work outside the home, could be just as deadly.

An examination of the Health Department’s accident ledgers for 1906 and 1907

³³ Milwaukee Coroner, Coroner’s Reports, Mss 306, Milwaukee Coroner’s Office, MCHS; Register of Burial, Milwaukee County Poor Farm, personal collection.

found over 121 reported childhood accidents.³⁴ While only eight of the cases were fatal, many more were listed as “severe” or “serious.” Given the nature of these latter cases, the mortality rates probably were much higher than those officially reported.³⁵ The range of the childhood accidents varies from a sliver in the hand, a cut playing baseball, being run over by a wagon to being shot during a domestic dispute. While some of these incidents seem to be part of the regular bumps and bruises of childhood (for example, Clarence Borgenhagen who was injured playing “crack the whip”), others speak to the dangers of urban life.³⁶

Joseph Butki, six years old, was burned and suffered fatal lung damage as he accidentally overturned a kerosene lamp. A curious Howard Larson, four years and ten months, received a concussion when he was struck on the head by a beam being in used in the construction of sewers on the south side. And in eerie similarity to cases today, Carl Baumgarten, age seven, shot himself in the hand while handling a revolver. Thomas (Gaetano) Alioto, one year and seven months old, was fatally shot as his mother nursed him during a domestic argument.³⁷ A little four-year-old girl named Rosie was found by her teacher who had gone to check on her after an absence from the Mission Kindergarten. The teacher found Rosie in “great agony from the scalds of hot coffee spilled on her chest and shoulders the day before.”³⁸ The cases in the accident ledger tell a story of childhood which was forced to carefully negotiate the often dangerous urban

³⁴ These were reported to the Milwaukee Health Department since they maintained accident statistics for the city.

³⁵ Milwaukee Health Department, Mss 2126, “Accident Ledgers,” 1905-1907, Milwaukee Health Department, MCHS.

³⁶ Ibid.

³⁷ Milwaukee County Coroner, Annual Reports, Mss 2076, MCHS.

³⁸ Children’s Hospital, Annual Reports, Children’s Hospital Archives, Children’s Hospital of Wisconsin, Milwaukee Campus.

environment.³⁹

Children were especially vulnerable to accidents in the street. Their small size, use of the street as a play area, and the busy traffic patterns left kids vulnerable on the street. Mary Orlalowitz, a child of two, was fatally injured in 1907 when she was struck by an electric streetcar while crossing the street. On a rainy day, twelve-year-old Samuel Lanz attempted to turn a sharp corner on his bicycle when the wheel slipped throwing him under a moving electric streetcar. Christina Buscagai (one year and eight months) and Erma Behrens (four years and eleven months) were both fatally injured when they ran out into the street only to be run over by unsuspecting teamsters. Road safety and the dangers that an increasingly automobile-dominated world presented were a common concern for safety commissions around the country. While children's dying in traffic accidents was frequently linked to the introduction of the automobile, the prevalence of motorized vehicles simply added a new and more dangerous element to the urban child's life. Draft wagons and carriages gave way to automobiles and unforgiving streetcars.

Author, publisher, and civic activist William George Bruce yearly wrote private volumes documenting both personal and public history from the 1910s to the 1940s. These volumes, entitled "Days with Children," present an intimate portrait of family life, as well as his reflections on world events, from one of Milwaukee's more eminent citizens. Even that distinction, however, could not save William George Bruce's grandson from harm.

In 1921 Bruce wrote:

Yesterday Willie on his way home from school hitched onto a Ford truck. After traveling some distance he jumped, fell and received a severe bruise on his

³⁹ Ibid.

forehead...His daddy seeing that the injury was not serious, administered to Master Willie a severe lecture on the conduct of boys in observing traffic safety on the streets and sent him to bed without supper...To be injured by an old truck was humiliating but to be deprived of supper was worse.⁴⁰

Willie survived with only a few minor bruises. Many other children were not as lucky in their encounters with motor vehicles. The accident ledgers record over thirty-one traffic related incidents, six of those being fatal, between 1905 and 1907.

One other area where childhood accidents were especially common was the Fourth of July. In 1906, exploding fireworks injured three boys in three separate incidents. One twelve-year-old boy had a “tablet of dynamite” explode in his hand. Seven-year-old William Krahn was severely burnt by a firework that set his clothes on fire. Six-year-old Irving Scheffler suffered severe burns to his hand and right thigh from a firecracker that exploded in his pocket.⁴¹ The problems of children being injured with explosives was so serious that in 1930 the Health Department, as part of their monthly *Healthologist* publication, released “rules” for a safe, but fun Fourth of July.

1. “Have a good time but don’t get wild with excitement for you will need good judgment more on the Fourth of July than at any other time.
2. Report all injuries to your parents so that they can take you to the doctor for proper treatment
3. Don’t forget that school is out and there is nothing gained by getting hurt this time of year
4. Before crossing the streets first look in every direction for automobiles. Don’t celebrate in the street.
5. Don’t get your face too close to firecrackers and fireworks while lighting them.
6. Don’t throw firecrackers at anybody or anything because it is neither smart nor safe.⁴²

⁴⁰ Bruce, William George. *Days with Children*, 1921, William George Bruce Collection, Mss 161, MCHS, Box , 28-29.

⁴¹ Milwaukee Health Department, Accident Ledgers.

⁴² Milwaukee Health Department, *Healthologist*, (July 1930):7, Mss 2126, Milwaukee Health Department, MCHS.

While the rules come across as those of the scolding teacher or parent, the dangers were real, both for the Fourth of July and for the rest of the year.

Health officials also focused on overcrowded conditions, poor housekeeping practices, poor ventilation, and sewage problems in their war against high infant and child mortality rates. Many infant and childhood deaths were blamed on parents who “could not afford to live anywhere save where bad housing hobnobbed with death.”⁴³ Not only was poor housing seen as having a direct correlation to infant mortality, it was also viewed as a long-term barrier to the future good health and morality of its inhabitants. A 1932 study of delinquent girls in Milwaukee showed that 83 percent of them had come from bad housing in congested areas.⁴⁴ There was obviously a correlation between the two.

A housing survey conducted by Milwaukee’s Health Commissioner in 1916 clearly identified the link between housing problems and infant mortality and morbidity rates. Between 1911 and 1915, 13.5 percent of the 29,986 cases of acute contagious diseases occurred in areas deemed to have poor housing.⁴⁵ These same areas contained over 25 percent of the deaths of children under the age of five.⁴⁶ There was a direct correlation between the concentration of newly arrived immigrants, the poorest housing, and the “appalling infant mortality rates.” Health officials saw a direct correlation between “declining father’s incomes and rising infant mortality.”⁴⁷ Clara Biddle, a social

⁴³ “Poor Housing Perils Health and Morals, is Survey Finding,” 1916, Uncited newspaper, Milwaukee Features Microfilm, “Housing,” MCHS.

⁴⁴ Edith Elmer Wood, “Slums and Blighted Areas in the United States,” (1935), 64, Daniel W. Hoan Collection, Mss 546, Box 12, “Pamphlets – Housing,” MCHS.

⁴⁵ George Ruhland, *Housing Conditions in Milwaukee* (Milwaukee: Milwaukee Health Department, 1916), 6, Mss 2126, Annual Report, 1916, Milwaukee Health Department, MCHS.

⁴⁶ *Ibid.*, 7.

⁴⁷ Levenstein, 90.

worker from the Health Department, noted the “bad physical and moral effect upon the whole family of bad air, bad drainage, and over-crowding of rooms with the resulting lack of privacy which causes familiarity and moral indifference If it were possible to house families in cleaner and more airy quarters, much of our problem of neglect and cruelty to children would disappear.”⁴⁸ She, like many others, linked poor housing to poor behavior and morals. To her, the destitution of the poor urban areas had a real and damaging effect on the people who lived therein. No child could come out of these surroundings unscarred, or at least, unchanged by their environment.

Finally, not only did children have to be concerned with accidents in the home or on the street, but also the neglect and abuse from their parents and guardians. The Children’s Hospital kept detailed patient histories from 1882 to 1885. These social histories of children who entered the hospital are a haunting reminder that those who are supposed to keep children safe frequently did not. John Berringer had been “kept in a closet without light, air, or food, daily for weeks by his parents . . . one eye is closed and swollen from the hit of a boot, face covered with bruises and sores . . . found half naked.”⁴⁹ Fred Noble who came into the hospital approximately five months of age suffered from a young and experienced sixteen-year-old mother. Deserted by her husband she had given the child “laudanum instead of soothing syrup.”⁵⁰ While numerous cases are simple problems of inexperience or poor parents who could not care for their children properly, others are gross examples of the brutality of the home environment. Rosa Liede was covered with bruises and had her front teeth knocked out. Christie Walter had her

⁴⁸George Ruhland, “Housing Conditions in Milwaukee,” (November 20, 1916), 9.

⁴⁹ Children’s Hospital, “Patients Personal and Social History, May 1882 – February 1885,” Children’s Hospital of Wisconsin, Milwaukee Campus.

⁵⁰ Ibid.

“head all pounded out of shape and otherwise bruised.”⁵¹ Remarkably, they also noted that she recovered and became “a nice baby.” At times, however, the cases seemed too extreme, even for the Children’s Hospital to fix. Eddy Boerman, born in 1883 was brought to the hospital in very poor condition. The social worker writing up the case history noted that he was “the worst looking deserted infant in the Home—We have him on our hands until he dies for no one will ever adopt him.”⁵² True to her word Eddy spend the next fifteen months at the hospital until he finally died in April of 1884. While wagons were dangerous and kerosene could burn, the greatest danger for children often lay with their guardians.

Communicable Disease

Accidents were not the only childhood danger to concern the citizens of Milwaukee. A far more deadly issue, for both the children as well as the community at large, were communicable diseases. Even with advent of the bacteriological theory of disease in the late 1880s, the exact vectors or modes of transmission of a variety of communicable diseases eluded the medical community. By 1890, a toxin-antitoxin existed for diphtheria, and by the early 19th century, a vaccine had been produced to combat smallpox. But, for many, these treatments and preventatives came too late or were viewed to be as dangerous as the disease. To control the great communicable diseases of the turn of the century—smallpox, diphtheria, typhoid, and gastro-intestinal disorders—would be a great victory in the battle to save children’s lives and improve the

⁵¹ Ibid.

⁵² Ibid.

overall health of the city.

Smallpox

Smallpox in the nineteenth and early twentieth centuries was probably the most feared of the communicable diseases. Variola major (the most common form) was a viral disease which originally presented with high fevers, general malaise, muscle pain, and vomiting. By the twelfth day of the virus incubation, however, the infamous pustules began to form on the patient's body.⁵³ With fatality rates of approximately 30 percent or more outbreaks of the disease were feared throughout urban areas where the disease could spread quickly through crowded conditions. Not only did this disease ravage urban populations, but it left a stark reminder of its presence—its scars—behind. It is estimated that it permanently scarred 65 to 85 percent of its victims. Along with the permanent scarring smallpox could also cause blindness (from corneal scarring) and limb deformities from arthritic and osteomyelitic complications.⁵⁴ Outbreaks of smallpox also raised other health issues in the community, including the debate over vaccination and the state of the city's isolation hospitals.

Milwaukee had a long contentious relationship with smallpox; a the disease would ravage through the city in 1846, 1868, 1872, 1876, 1894, 1904, 1914, and finally, in 1925. The citizenry and health officials vociferously debated how to handle these

⁵³ Frank Sherman Meara, *The Treatment of Acute Infectious Diseases* (New York: Macmillan Company, 1927), 608-624.

⁵⁴ In small numbers of cases the virus can reach the bones and joints to cause these secondary infections and complications.

outbreaks.⁵⁵ The infamous smallpox riots of 1894, for example, brought the residents of the south side of Milwaukee to blows with the Health Department and Police Department. The riots centered around two main issues, isolation and power. It was common practice in the city to isolate patients with infectious disease in the city's isolation hospital. Few other hospitals would take patients infected with communicable diseases. The safest course of action was to remove them from the general population. Unfortunately, the isolation hospital in the late nineteenth century was seen as a dangerous and deadly place, where patients received poor medical attention. It was not a place of wellness but a place of death.⁵⁶ When health officers tried to forcibly remove a number of children who were infected with smallpox in August of 1894, parents and the surrounding community acted on what they perceived to be a threat to their children. They hid the children from the health officers and when the Health Department officials returned with police backup the next day, they were met with bricks, stones, and an angry populace. There was a proposal around this same time to construct "mothers' cottages" on the grounds of the Isolation Hospital so that children "might be cared for by their mothers in a place that would afford the comforts and security of a home, and at the same time, the security and care of a hospital."⁵⁷

For many, the creation of a new Isolation Hospital at Eighteenth Avenue and Mitchell Streets in 1916 brought small comfort as little ones were whisked away during outbreaks of illnesses. The health officials, however, contended that "highly contagious diseases are best treated, and the best attention given when the patient is removed to the

⁵⁵ Leavitt, *The Healthiest City*, 265-271.

⁵⁶ *Ibid.*, 100-101.

⁵⁷ "Mothers' Cottages," August 3, 1894, *Evening Wisconsin*, "Epidemics," Milwaukee Features Microfilm, MCHS.

South View Hospital.”⁵⁸ Isolation and quarantine were one of the few ways to truly stop the spread of this dread disease.

Along with quarantining and isolating children, vaccination was an important part of the battle against smallpox. Vaccinations during epidemics were frequently offered free of charge by physicians, the Health Department, and the County Dispensary. Many health officials believed that it was the “duty of every good citizen to take advantage of this service.”⁵⁹ There was, however, a strong anti-vaccination movement in the city. Driven by “irregular” physicians,⁶⁰ a large portion of the city’s as well as the nation’s population by the early 1900’s was unvaccinated.⁶¹ The well-structured campaigns of these anti-vaccinations appealed to several elements in their campaign against compulsory vaccination. They attracted individuals who truly believed that vaccinations were not successful in preventing smallpox, those concerned with the side effects of vaccinations, those who were antagonistic toward local health officials, and frequently to immigrants who were uncertain about medical practices and procedures.⁶² Anti-vaccination movements would even draw strength from the sanitary movement, as they tried to promote better sanitation, not in conjunction with but instead of vaccinations.⁶³

By the 1925 outbreak, the situation was not much better in the city, in regards to the vaccination debate. Milwaukee Health Commissioner Koehler noted that “many

⁵⁸ *Rail and Wire*, December 1918, MCHS. The South View Hospital was another name for the city’s Isolation Hospital.

⁵⁹ *Boys Tech Craftsman*, May 1, 1925, Milwaukee Public Library.

⁶⁰ “Irregular” consisted of a large body of physicians including homeopaths, chiropractors, osteopaths, and any that advocated unorthodox medical treatments.

⁶¹ Martin Kaufman, “The American Anti-Vaccinationists and Their Arguments,” *Bulletin of the History of Medicine* 41, no. 5 (September/October, 1967): 464.

⁶² *Ibid*, 467.

⁶³ *Ibid*, 477.

parents believe they can avoid exposure by keeping babies and children at home.”⁶⁴

When the 1925 epidemic hit, the city scrambled to vaccinate thousands in the city. The largest mortality and cases numbers occurred in those children under the age of five who had not been vaccinated.⁶⁵ Of the 376 diagnosed smallpox cases, eighty-seven individuals died and of those, eighty-two had never been vaccinated. Health officials advised that babies should “be vaccinated at the age of six months in order to prevent it from contracting smallpox.”⁶⁶ Approximately 82 percent of mothers who had taken their babies to be examined during the epidemic had neglected their smallpox vaccinations.⁶⁷

Diphtheria

While smallpox might have been the most feared of diseases because of its horrific aftereffects, the most feared because of the rate of childhood deaths was diphtheria. Diphtheria, caused by the *C. diphtheriae* bacteria, is transmitted through the air when infected individuals sneezed, coughed, or spit. The illness was usually concentrated in the throat and lungs. As part of the disease’s progress, the toxin it produces forms a thick false membrane over the windpipe, constricting and eventually cutting off air supply for the infected victim. Infection, fever, rash, and eventually suffocation made diphtheria feared like few other diseases at the turn of the century. Diphtheria, while it could strike anyone who had not been vaccinated, found its largest

⁶⁴ John P. Koehler. *The Care of the Baby and Young Child* (Milwaukee: Milwaukee Health Department) 40, Mss 2126, Milwaukee Health Department Collection, MCHS.

⁶⁵ Ibid.

⁶⁶ Ibid., back cover.

⁶⁷ Milwaukee Health Department, *Healthologist* (November 1930): 11, Mss 2126, Milwaukee Health Department, MCHS.

target among the young, with 50 percent of deaths attributable to diphtheria occurring in children between the ages of one and five.⁶⁸ Figure 10 presents the cases and death from diphtheria in Milwaukee during the period of study. (There is an abrupt start in 1892 in terms of the number of cases because the city only recorded deaths from instances, not cases of diphtheria.)

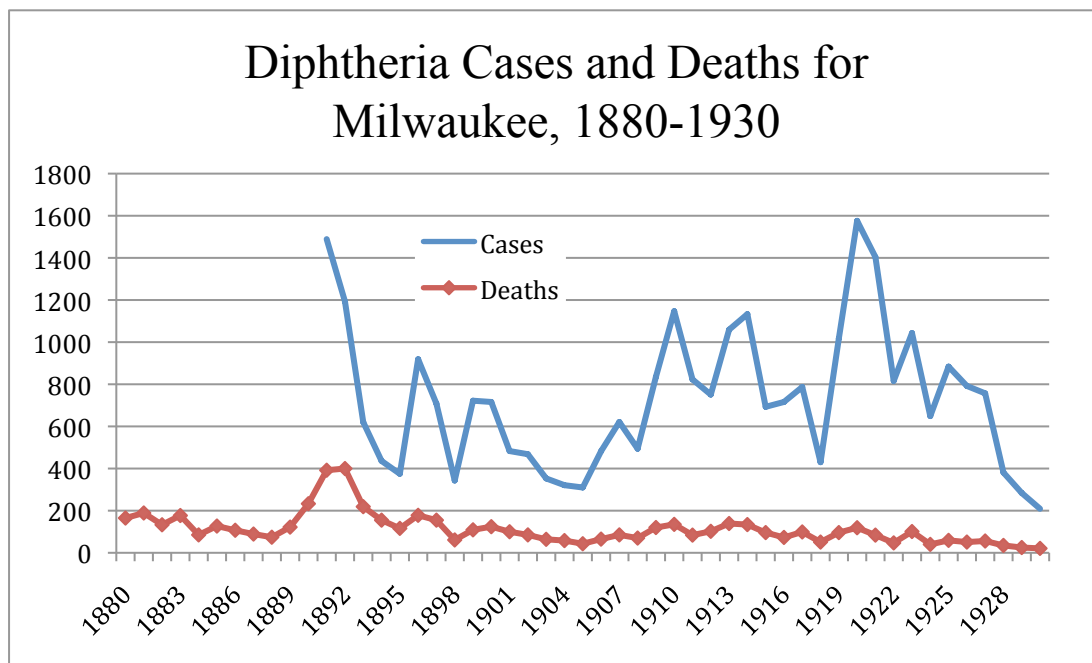


Figure 10: Diphtheria Cases and Deaths for Milwaukee, 1880-1930⁶⁹

Once again William George Bruce's, *Days With Children* provide a glimpse into one of the more potentially deadly encounters in childhood. Another one of his grandchildren, Robert Bruce, contracted diphtheria in the first week of November 1921. Throat specimens taken from Robert by a consulting physician were sent to the Health

⁶⁸ Milwaukee Health Department, "Diphtheria Queries," *Healthologist* August 1931, Mss 2126, Health Department Collection, MCHS.

⁶⁹ City of Milwaukee, Vital Statistics.

Department who “pronounced the illness diphtheria.”⁷⁰ Robert, like many other children, was quickly and strictly quarantined. Those who had contact with the patient were inoculated with toxin-antitoxin⁷¹ in order to prevent their development of the disease. Robert was safely quarantined with a hired nurse in the library of the house, and after a couple weeks of rest and isolation, he made a full recovery.⁷² Many others were not so fortunate.

Diphtheria, like smallpox was also easily preventable, but many ignored the dangers. The same study that demonstrated that mothers had been neglecting their smallpox vaccinations also showed that nearly 70 percent of mothers neglected diphtheria vaccinations as well.⁷³ Parents who did not vaccinate their children for one disease frequently left them vulnerable to others as well. Thankfully for the city and its children, the first supply of serum used in the antitoxin treatment arrived in Milwaukee in December 1894.⁷⁴ Diphtheria was targeted in two ways. Those exposed to the illness were treated with the antitoxin; it gave immediate, but short-term immunity. Toxin-antitoxin was given to others to prevent the illness and although it had slower effects, it did provide a lifelong immunity.⁷⁵ While many parents were neglectful in terms of the vaccinations, others were happy to see any chance to combat this deadly disease. By

⁷⁰ William George Bruce, *Days with Children*, 1921.

⁷¹ Researchers working on a vaccination for diphtheria noted that injections of the toxin which had been *almost* neutralized by the anti-toxin produced the production of anti-toxin in the experimental subject. This way health officials could produce an active immunity with longer lasting effects. For more discussion on the battle against diphtheria see, Evelyn Maxine Hammonds, *Childhood's Deadly Scourge* (Baltimore: Johns Hopkins University Press, 1999).

⁷² Bruce, *Days with Children*, 1921.

⁷³ Letter from Ruhland to Harbach, May 17, 1918, Mss 546, Box 18, Health Department 1918-25, Daniel W. Hoan Collection, MCHS.

⁷⁴ “To Try Antitoxin,” December 3, 1894, *Evening Wisconsin*, “Epidemics,” Milwaukee Features Microfilm, MCHS.

⁷⁵ Milwaukee Health Department, “Diphtheria Queries,” *Healthologist* (August 1931), Mss 2126, Milwaukee Health Department Collection, MCHS.

1931, the deaths attributable to diphtheria had dropped significantly, to only 21 deaths.⁷⁶ Through a vigilant campaign of vaccinations, information, and isolation, the city won the battle against diphtheria and had virtually eliminated the disease by the mid-twentieth century.

Isolation and Examination

Numerous other communicable diseases ravaged Milwaukee's children and would be a constant threat to the health and welfare of the larger community. Measles, whooping cough, infantile paralysis (polio), and scarlet fever each became problems to be solved by health agencies in the city. These illnesses, along with the aforementioned diphtheria and smallpox, also tested the powers of Health Department officials in their attempts to control outbreaks of disease. Through enforcement of isolation policies in tandem with vaccination campaigns, health officials hoped to curb further outbreaks. In addition, the Health Department established program of in-school student inspections to identify and treat any physical problem before it became a more serious issues.

Measles epidemics would visit the city throughout the late nineteenth century, with the largest epidemic occurring in 1929 when 13,198 cases of measles were identified in the city.⁷⁷ Many officials felt that the "seriousness of measles [was] not generally recognized," even though measles had the second highest death rate after diphtheria

⁷⁶ Milwaukee Health Department, *Healthologist*, (April 1931), Milwaukee Health Department, Mss 2126, MCHS.

⁷⁷ City of Milwaukee Vital Statistics Office.

among common contagious diseases.⁷⁸ Schools and teachers were enlisted to help combat any measles outbreak that occurred by carefully inspect students for any sign of illness. The Health Department further recommended exclusion for any suspected cases.⁷⁹ As measles was easily transmitted from person to person, schools were prime incubators for this illness and became the front lines for defense. Figure 11 presents the measles cases, as recorded by the Vital Statistics Office between 1891 and 1930. One can see how measles outbreaks occurred in waves with some years reporting a couple hundred cases, and other years thousands of cases. The measles epidemic of 1929 would have the largest number of cases on record, but gratefully only twenty-five deaths.

⁷⁸ City Club, "Press Release," Milwaukee Manuscript Collection AS, Box 13, "Public Health, 1922-28," City Club of Milwaukee, UWM.

⁷⁹ Ibid.

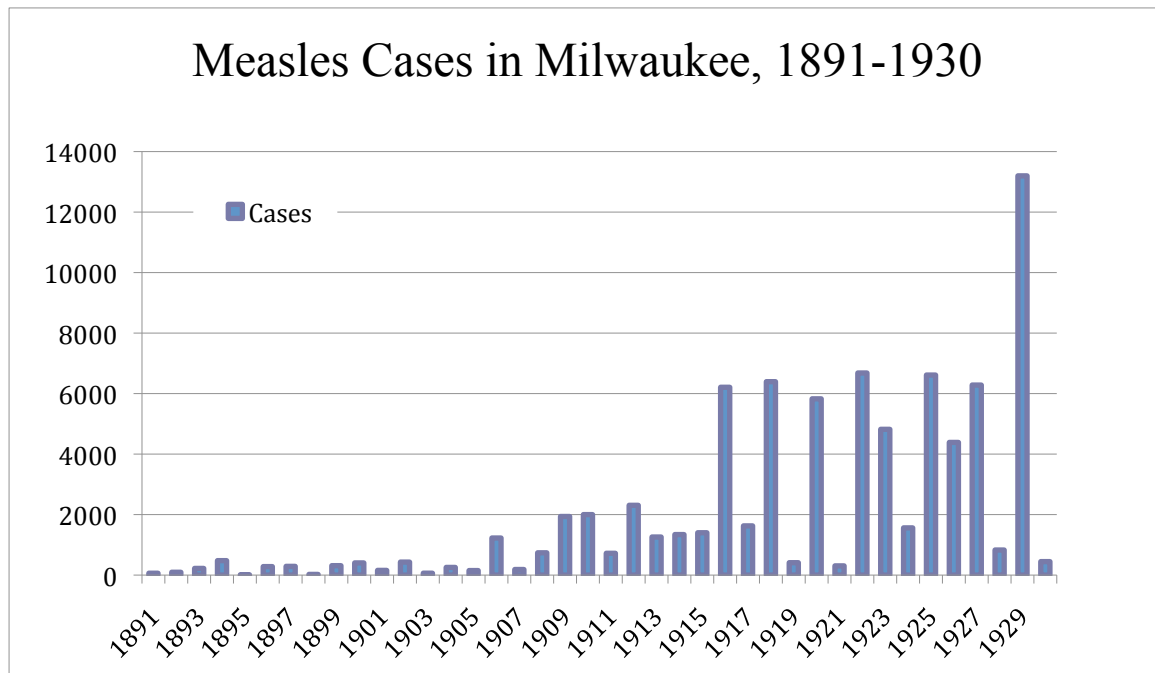


Figure 11: Measles Cases in Milwaukee, 1891-1930⁸⁰

Isolation, similar to what was practiced with smallpox campaigns, became the preferred method of counter attack. Refusing to admit sick children to school, placarding homes, and disinfection campaigns became readily used tools to fight measles. By stopping the disease before it spread further, they hoped to contain it to a few dozen or even hundred cases. In the meantime, officials awaited a hoped-for vaccine to make their jobs even easier. A vaccination for measles, however, would be many years away as the first vaccine would not be widely available until 1963.⁸¹ Up to that point the city relied on pre-emptive exams by health officials, isolation tactics, and public health informational campaigns to help keep the case numbers and incidents of death as few as

⁸⁰ City of Milwaukee, Vital Statistics Office. 1891 is the first year that the Vital Statistics Office started documenting measles cases.

⁸¹ Centers for Disease Control, "Measles" *CDC Update*, 1999, <http://www.cdc.gov/nip/diseases/measles/history.htm> (accessed August 20, 2007).

possible. A flyer circulated by the Milwaukee Health Department in 1922 noted that “[I]n each case the center and focus of infection and spread is **THE SCHOOL!!!**”⁸² The flyer would go further on to say that the key to controlling any spread was “**EXCLUSION UPON SUSPICION.**”⁸³

Scarlet fever also proved to be an excellent case study of the benefits of isolation in helping to prevent the creation of a wider epidemic. A third grandchild of William George Bruce would battle this disease in his “Days With Children” journal of 1919. Bruce vividly recounted the precautions and nursing care that “Frankie” received. Being well to do, the family could afford a private nurse who cared for the child in isolation from the rest of the family. The health authorities quarantined him and his nurse to a portion of the house and labeled it with the red “Scarlet Fever” quarantine sign. “At the end of ten days there were signs of improvement. The rash subsided but one of the glands in the neck showed a bad swelling...after two weeks...the patient was able to sit up today and look out of the second story window.” The isolation would last until Frankie was completely well and had been cleared by health officials. Bruce sympathized with both the sick child and his caregiver for “he is still a prisoner in his sick room. His nurse who is imprisoned with him, owing to the quarantine, is most loyal and self sacrificing...we are all anxious to see him again and take his place with the members of the family...the isolation is of course, ordered to protect the rest of the children.”⁸⁴ While William George Bruce’s account is that of an upper class family, it does provide the ideal

⁸² W.W. Bauer, “Measles,” (Washington, D.C.: U.S. Public Health Service, 1922), Milwaukee Manuscript collection AS, Box 13, “Public Health,” City Club of Milwaukee, UWM. The emphasis is in the original document.

⁸³ Ibid.

⁸⁴ William George Bruce, *Days With Children*, 1919.

behavior that the health department strove to promote: quarantine and followed by a full recovery.

Homes and neighborhoods frequently became points of contention between the sick and the healer, as proven by the smallpox epidemic of 1892. Similarly, Milwaukee's schools evolved into a volatile battleground for the prevention of communicable diseases and the vaccination debate. The health department in conjunction with the Visiting Nurses Association and the public schools initiated vaccination and inspection campaigns to maintain the health of Milwaukee's children. Health inspections in schools became increasingly common, as teachers and health department officials lending a hand to weed out illness, physical defects, and communicable disease.⁸⁵

When the 1925 smallpox outbreak occurred, a goodly number of Milwaukeeans remained unvaccinated. Milwaukee Health Commissioner Koehler noted that "many parents believe they can avoid exposure by keeping babies and children at home."⁸⁶ While isolation was an important element, as noted in the discussion of measles, it was not the only weapon especially in the case of smallpox. The health department advised that babies should be vaccinated as early as six months to prevent contraction of smallpox.⁸⁷ The health officials scrambled to vaccinate thousands in the city who were unprotected. Parents, instead of proactively vaccinating their children, frequently waited until an epidemic was upon the city and flooded health department offices and clinics for the much needed vaccinations. In 1925, the Health Department vaccinated 77,078,

⁸⁵ School inspectors checked children for hearing problems, vision issues, scoliosis, and lameness as well as swollen tonsils and adenoids.

⁸⁶ *The Care of the Baby and Young Child*, 40.

⁸⁷ *Ibid.*, back cover.

children and in the last great smallpox outbreak in 1929, they vaccinated 13,243.⁸⁸ The largest mortality—and cases numbers—occurred in those children under the age of five who had not been vaccinated.⁸⁹ Of the 376 diagnosed smallpox cases in 1925, eighty-two of the eighty-seven deaths were in individuals who had never been vaccinated.

This only reinforced health officials' determination to not only vaccinate, but to improve the overall health of Milwaukee's children. The Health Department also enlisted the aid of auxiliary nursing forces in the form of the Visiting Nurses Association. This organization was formally incorporated in 1907, although there had been a single visiting nurse working in the city the year before. The original mission of the Visiting Nurses Association focused on charitable cases, and they worked for "the benefit of those who are otherwise unable to secure skilled assistance in time of illness, and to promote cleanliness and to teach people care of the sick."⁹⁰

In 1908, the Visiting Nurses Association began systematic inspections for sick children in the Milwaukee public schools, the first service of its kind in the area.⁹¹ They worked in tandem with the Milwaukee Health Department that called for thorough examinations of all school children for visual defects, lice, tuberculosis, physical deformities, and a myriad of other ailments and conditions. To minister to a diverse population, health officials printed health advisory notes in at least five languages (See Figure 13).⁹² There were forms for lice, dental caries (cavities), ringworm, stammering,

⁸⁸ City of Milwaukee, Vital Statistics Office.

⁸⁹ Ibid.

⁹⁰ Ibid. The Visiting Nurses Association also became involved in industrial health, tuberculosis care, post-natal care, physiotherapy, and occupational therapy as well as providing emergency nursing help during epidemics like the 1918 Spanish Influenza pandemic.

⁹¹ "VNA Grows with Milwaukee," 3, Health Collection, Mss 2620, MCHS.

⁹² A form to alert parents of a lice infestation was written in German, Hebrew, English, and Polish, and Italian.

orthopedic problems, and hearing and vision problems among other conditions (See Figure 14 and Figure 15).

Figure 12 presents the numbers of children examined and defects found by the health examiners in Milwaukee's schools. Approximately half of the "defects" found during any given year were "corrected," meaning eyeglasses were prescribed, braces were fitted, tonsils and adenoids were removed, and teeth were cleaned and filled. It was noted in 1921 that "Milwaukee is one of the few cities in the United States in which health supervision is extended to public, private, and parochial schools, both grammar and high, trade schools, and continuation schools."⁹³ In the same 1921 report, it was noted that over 195,000 children fell under the umbrella of these health inspections and that number would only continue to grow.⁹⁴ There were also calls for the program to establish a psychiatric clinic for the "seven percent of children in the grade schools [who] are in a mentally subnormal group."⁹⁵ Overall, these examinations became the first line of defense against the spread of epidemic disease and poor general health.

⁹³ Milwaukee Common Council, *Municipal Government and Activities of the City of Milwaukee* (Milwaukee, WI: The Council, 1921), MPL.

⁹⁴ *Ibid.*

⁹⁵ *Ibid.*

	1921	1922	1925	1926	1927	1928
Morning Inspections	66,000	58,000	65,745	49,327	218,843	285,829
Physical Exams	44,000	45,000	50,168	54,008	67,673	62,011
Defects Found	23,000	16,000	31,503	48,591	58,569	55,976
Diseased Tonsils	5,600	3,600	10,458	12,232	5,719	6,134
Diseased Adenoids	900	569	264			
Tonsils & Adenoids			1,813	1,904	1,987	1,627
Defective Hearing	175	37	396	235		
Defective Vision	3,100	2,631	6,249	5,841	3,997	3,600
Defective Teeth	11,700	8,832	12,691	14,877	7,293	7,004
Orthopedic	82	47	222	117		
Pulmonary	26	81	17	35		
Cardiac	169	130	370	343		
Nervous Diseases	92	81	73	57		
Malnutrition			3,131	2,732		1,142

Figure 12: School Hygiene Examinations, 1921-22, 1925-28⁹⁶

⁹⁶ Milwaukee Common Council, *Municipal Government and Activities of the City of Milwaukee* (Milwaukee, WI: The Council, 1921, 1922, 1925, 1926, 1927, 1928), MPL.

ERSTE NOTIZ Datum _____

Ihr Sohn _____ ist mit Pediculosis (Läusen) be-
 haftet. Lassen sie das Kind von ihrem Hausarzt behandeln, oder behandeln sie es
 selbst nach der folgenden Vorschrift:--

Baumöl (sweet oil) und Petroleum (kerosene) werden zu gleichen Teilen gemischt. Reiben
 Sie den Kopf mit dieser Mischung gründlich ein und unwickeln sie ihn alsdann mit einem Hand-
 tuch. Nachdem der Kopf sechs bis acht Stunden eingehüllt geblieben ist, waschen sie Haupt und
 Haar mit Seife und Wasser in welchem einen Teelöffelvoll Soda aufgelöst ist und kämmen Sie das
 Haar tüchtig mit einem feinen Kamme durch, der in heisem Essig getaucht wird. Diese Behand-
 lung muss an drei aufeinander folgenden Tagen wiederholt werden.
 (Statt der Mischung von Öl und Petroleum kann auch Tincture Larkspur benutzt werden.
 Die Gebrauchsanweisung ist dieselbe.)
 Halten Sie das Kind während der Behandlung von Feuer und Licht fern.

 SCHULARZT.

ZAWIADOMIENIE PIERWSZE. Data _____

Wasz syn _____ dotknięty }
 Wasza córka _____ dotknięta } jest Pedikulosa,

to jest że ma wszy. Polecam łaskawie poradzić się Waszego rodzinnego
 lekarza, aptekarza, albo użycie środka tu podanego:

Wskazówka:—Zmieszaj równe części oliwy (Sweet Oil) i Kerozyny i namocz w
 mieszankę włosy, miej potem głowę owiniętą wielkim ręcznikiem przez sześć do ośm godzin.
 (Zamiast tej mieszanki można użyć "Tincture of Larkspur", które się używa w ten sam sposób).
 Używaj to przez trzy kolejno po sobie następujące dni lub noce. Głową i włosy po każdym
 namoczeniu zmyj doskonale mydłem i wodą, w której rozpuści łyżeczkę (do kawy) sody. Po
 każdym zmyciu wyczesz włosy doskonale matyn grzebiulem i zmoż gorącą octem.
 Podczas tej operacji trzymaj dziecko z dala od ognia lub zapalanej lampy.

 Inspektor-lekarz.

PRIMA NOTIZIA Data, _____

Vostr Figlio _____ e' affetto da Pediculosis (Pidocchi).
 Figlia _____

Per piacere portatelo dal dottore della vostra famiglia, o alla dispensaria; ovvero
 fate le seguenti cure.

DIREZIONI:—Mescolate eguale parte di olio d'oliva e Petrolio, e bagnate i capelli con
 questa mescolanza. Dopo fasciate la testa con una larga tovaglia per sei od otto ore.
 La tintura di Larkspur puo' essere usata invece della mescolanza di olio. Le direzioni sono
 le stesse.
 Ripetete questo per tre giorni e notti consecutivi, lavando testa e capelli dopo ciascun
 trattamento con sapone ed acqua in cui un cucchiaino di soda e' stato sciolto.
 Dopo ciascun lavaggio, pettinate i capelli interamente con un buon pettine, bagnato con
 aceto caldo.
 Mentre si fa la medicatura bisogna stare lontani dal fuoco o dalla lampada accesa.

 Ispettore Medico.

עֲדִשְׁמַע נְאֻמִים.

דאטום _____

אייער זאחן מאכטער _____

איז געפלאגט מיט פעדיקולאסיס (לייז) ברענגט איהם ויא
 צו אייער הויודאקטאר אדער אין דיספענסערי, אדער
 בעהאנדעלט ועלכסט וויא פאקט:

דירעקשאן, מישט צוזאמען א גלייכע קוואנטיטעט
 סוויט־עויל און קעראסין. און מיט דעם בענעצט דיא האר.
 נאכהער וויקעלט איין דעם קאפ מיט א גרויסען האנדטוך
 פאר 6 אדער 8 שטונדען. (אנשטאט דיווען מיקטשור קענט
 איהר אויך קויפען אין דרוג־סטאר טינקטשור אף לארקס-
 פור און בעהאנדלען דיא האר און דעם קאפ אויף דעם
 זעלבן ארט). דאס מוזט איהר טהון 3 טעג אדער 3 נעכט
 הינטעראינאנדער, נאך יעדען טריטמענט מוזט איהר
 וואשען דעם קאפ און דיא האר מיט ווייט־וואסער אריין
 געמישט א טהע־לעפעל סאדע, און נאכהער נאם מאכען
 א קאם אין הייסען עסיג און מיט דעם קעמען דיא האר.
 ביי דיווער בעהאנדלונג זאלט איהר זיך היטען צו צו-
 קומען נאווענט צום פייער אדער נאווענט צו א לאמפ.
 מעריקעל אינספעקטאר _____

FIRST NOTICE Date, _____

Your Son _____ is afflicted with Pediculosis (Lice).
 Your Daughter _____

Kindly take h _____ to your family doctor or dispensary, or treat as follows:

DIRECTIONS: Mix equal parts of Sweet Oil and Kerosene and saturate the hair with
 this mixture. Then wrap the head in a large towel for six or eight hours. (Tincture of Larkspur
 may be used instead of the oil mixture. The directions for use are the same.) Repeat this for
 three successive days or nights, washing the head and hair thoroughly after each treatment with
 soap and water in which a teaspoonful of soda has been dissolved. After each washing, comb the
 hair thoroughly with a fine toothed comb wet with hot vinegar. While under treatment keep
 the child from the fire or lighted lamp.

 MEDICAL INSPECTOR.

Figure 13: Note informing parents of a lice infestation in five languages.⁹⁷

⁹⁷ City of Milwaukee, School Hygiene Activities, 1924-1943, Office of Vital Statistics.

#5

WAUKEE HEALTH DEPT. DIVISION OF SCHOOL HYGIENE
 HEALTH RECORD

Name	Address			
Sex	Birthplace	Date of Birth		
Occupation of Father		Occupation of Mother		
No. in family	No. of children in school			
Measles	Pertussis	Influenza	Mumps	
Pneumonia	Small Pox	Chicken Pox		
Scarlet Fever	Diphtheria	Tonsillitis	Vaccination	
<input type="checkbox"/> DENOTES NO DEFECT PRESENT <input checked="" type="checkbox"/> DENOTES DEFECT PRESENT				
Grade				
No. of years in school				
Date of examination				
Height				
Weight				
Nutrition				
Defective teeth				
Defective vision R. L.				
Abnormal tonsils				
Defective nasal breathing				
Defective hearing				
Orthopedic				
Lungs				
Heart				
Mentally subnormal				
Speech defect				
Nervous				
Other defects				
(over)				

Figure 14: Health record form.⁹⁸

⁹⁸ Ibid.

MILWAUKEE PUBLIC SCHOOLS
Department of School Hygiene

27

re

DEAR SIR OR MADAM:

The method of treatment for stammering varies somewhat according to its cause. Will you therefore answer the following questions fully, so that your child may receive the benefit of a proper form of instruction.

Respectfully,

GEO. P. BARTH, M. D.,
CHIEF INSPECTOR

Full Name of Child _____ Age _____ Sex _____

Date of birth of child _____ Place of birth _____

Name of parents of child—Father _____ Mother _____

Residence of parents—Post office _____ Town _____

County _____ Nearest railroad station _____

Occupation of father _____

Nationality of father _____

At what age did you first notice that the child stuttered? _____

Did it follow an attack of acute illness? _____ If so, what? _____

Did it follow upon some nervous shock? _____ If so, at what age of the child? _____

Did it follow upon some fright which the child experienced? _____

Did the child ever have throat trouble? _____

Was the child's throat ever operated upon? _____

If so, what was the operation? _____

Any other facts of importance? _____

Have attempts been made to remove the defect? _____

Has child been under instruction? _____ What school? _____ How long? _____

Have you any other child that stutters? _____

Did or do any of your relatives stutter, and what is there relationship to the child? _____

Diagnosis (leave blank) _____

Date of admission _____ SCHOOL PHYSICIAN

268 5/15 Stammerer's Diagnosis

Figure 15: Stammering Form.⁹⁹

⁹⁹ Ibid.

Minor medical procedures were performed at the schools in addition to the physical exams. Vaccination campaigns regularly included Milwaukee's schools, although problems did arise as many times children were vaccinated against the wishes of their parents. Usually only after the vaccination had occurred were the parents informed and "attention called to the fact that the parents objected to the vaccination."¹⁰⁰ A bit more invasive, minor surgeries were also performed at schools to help prevent the development of more serious conditions. In the 1910s, a wave of tonsillectomies and adenoidectomies were performed at both the County Hospital as well as in the schools. One account tells of horrified parents rushing to school fearing the worst for their children. Health officials justified these procedures as they believed that enlargement of the tonsils and adenoids was responsible for conditions as varied as snoring to feeble mindedness. If the tonsils and adenoids were not removed in time the child might become "mentally dull" and become part of that worrisome 7 percent.¹⁰¹

Making Better Milwaukeeans—Reform, Eugenics, and Improving the Lives of the Smallest Milwaukeeans

Along with targeting infant mortality and communicable disease, health reformers sought to improve the general health and welfare of children, thereby creating "better babies" and consequently better Milwaukee adults. Progressive reformers targeted areas of general infant care, safer feeding of infants, and venereal disease as a way of

¹⁰⁰ Milwaukee Health Department, *Healthologist*, November 1930, 11.

¹⁰¹ Koehler, "The Care of the Baby and Young Child."

improving the long term health and wellness of the city's population. When the American Association for Study and Prevention of Infant Mortality met in Milwaukee in 1916, they set out a number of goals including the "education of the public on important phases of child welfare; to secure a division of child hygiene in department of health of every state and large city; to secure the passage and enforcement of laws requiring the registration of births and to stimulate local investigations into the causes of infant mortality."¹⁰² By identifying areas in need of improvement, reformers could refocus their attentions in particular areas of interest.

Institutions

The late 1880's saw the start of a specialization in medical care. Health care institutions were increasingly created to serve specific interests and functions. Instead of multifaceted general hospitals, the late nineteenth century saw an explosion of maternity hospitals, tuberculosis sanitariums, mental asylums, and especially for this study, children and infant hospitals. Through the good will of many society ladies and the zeal of the growing field of obstetrics, these institutions became key elements to the health and welfare of Milwaukee's children.

The Children's Free Hospital of Milwaukee, now Children's Hospital of Wisconsin, has maintained the longest history with Milwaukee's children. This facility was opened in June of 1894 by a group of Milwaukee socialites including Mrs. Carol Allis, Mrs. Clara Adler, Mrs. Margaret Falk, Mrs. Eleanor Simpson, Mrs. Laura Catlin,

¹⁰² "Infant Care Students to Meet Oct. 19," October 19, 1916, *Milwaukee Leader*, Milwaukee Microfilm Collection, "Children," MCHS.

Dr. Frances Sercombe and Miss Alice Bradley. These enterprising women “rented a house on Brady St., scrubbed and shellacked its floors themselves and hired a nurse for \$25 per month.”¹⁰³ While in local newspapers some male physicians labeled them as “ill advised women,”¹⁰⁴ their determination to provide an institution to meet the needs of the city’s children cannot to be underestimated. They saw a need for just such a hospital during their charitable work visiting poor families. Many of Milwaukee’s poor and immigrants lacked proper care for their children because they were too poor to pay for private hospitalization or home nursing.¹⁰⁵

Children’s Hospital was established as a general hospital for children from infancy to sixteen years of age. It accepted all income levels, from those who could fully pay for services to those who could only partially pay to those who were strictly charity cases. The facility offered occupational therapy, physical therapy, public school instruction, and clinics in general medicine, general surgery, cardiology, dermatology, diabetes, epilepsy, neurology, orthopedics, otolaryngology, and speech. It even had a convalescent home for children. The only cases not accepted were contagious diseases.¹⁰⁶ Any child with chicken pox, measles, scarlet fever, diphtheria or any contagious disease was sent immediately to the South View Isolation Hospital for quarantine.

These facilities came to be the mainstay for children’s health in Milwaukee and the pre-eminent institution for critically ill young people and for the most difficult cases.

The development of specific child centered hospitals and programs reflected growing

¹⁰³ “Diamond Year Recalls a Sparkling Past,” July 21, 1969, *Milwaukee Journal*, Milwaukee Microfilm Collection, “Charities,” MCHS.

¹⁰⁴ *Ibid.*

¹⁰⁵ Mary Myers, “How Milwaukee Charities Began,” 1931, *Milwaukee Journal*, Milwaukee Microfilm Collection, “Charities,” MCHS.

¹⁰⁶ Joseph W. McGee Papers, 1946-1971, Department of Social and Cultural Sciences, College of Arts & Sciences. C1.16, Series 2, JWMC, Box 1, “Correspondence, 1955,” Marquette University Archives.

focus on children and their needs in turn of century America. Realizing that children's medical needs and problems were more complex than smaller versions of adult problems was the first step toward creating healthy children and healthy citizens. The hospital sought to create a "splendid and healthy citizenship" through better children's health and thereby better health for all.¹⁰⁷

General Care

The first place to start in creating "healthy" citizens was to create "better babies." By targeting the care and nutrition of children early in life, society could insure healthier, better, and fitter citizens. The importance of maternal and infant welfare even caught the attention of the federal government in 1921 with the passage of the Sheppard-Towner Maternity and Infancy Protection Act. While not providing financial aid or medical care directly, the bill provided federally matched grants to states for prenatal and child health clinics. Many states, including Wisconsin, used these funds to provide information on nutrition and hygiene, programs for midwife training, and prenatal and postnatal visits by nurses. Unfortunately the programs supported by the Sheppard Towner Act would not receive federal funds for very long. Many physicians, male politicians, and organizations including the American Medical Association opposed the bill as unpatriotic and even dangerous to the American ideal because a large number of the women from the Children's Bureau who administered the funds were also involved in socialist activities. Opponents of the bill claimed that the women who ran the program were part of a

¹⁰⁷ "Hospital for Children is Opened Sunday," October 27, 1923, Uncited Newspaper, Milwaukee Microfilm Collection, "Hospitals," MCHS.

“Soviet-directed plan to subvert the nation.”¹⁰⁸ For the bill’s opponents, these women offered nothing more than intrusions into the home and the established medical hierarchy. This battle between reformers, many of them women (and mothers themselves), and the medical establishment over the welfare of their children would continue throughout the early twentieth century.

Despite issues of funding, the general health movement of the time still emphasized the importance of prenatal care for the sake of both mother and child. As late as 1935, Milwaukee’s Health Department continued to stress the importance of care for both mother and child. Women were encouraged to apply at the Milwaukee Health Department if they could not afford to have a doctor come to their home or go to the hospital. Increasingly a baby’s health was seen as dependant on its mother for a “mother must be cared for in the right way at this time, or she may be sick a long time and lose the baby. Everything depends on the care that the mother and baby get at this time.”¹⁰⁹ If women were healthy their children would be as well.

Once children were born, the health community provided an abundance of information to help new or immigrant mothers care for their children. While some of the advice may seem obvious, to new mothers or to those who had recently arrived in the country these bits of advice were invaluable. Parents were warned against allowing children to sleep with them. Numerous coroner’s cases attest to children accidentally smothered by their parents. Mothers were cautioned to dress children lightly and loosely,

¹⁰⁸ Kim E. Nielsen, *Un-American Womanhood, Antiradicalism, Antifeminism and the Red Scare*. (Columbus, OH: Ohio State University Press, 2001), 108.

¹⁰⁹ Koehler, “The Care of the Baby and Young Child,” 3.

to keep the “baby warm enough in winter and cool enough in summer.”¹¹⁰ Mothers were cautioned not to bundle their children in scarves for “throat protectors make weak throats.”¹¹¹ The advice books warned against rocking children to sleep, giving them pacifiers, and protecting them from excitement. Coddling children, many feared, would lead to weak, nervous, and sickly adults.¹¹² Children who were coddled physically or emotionally would grow up to have weak constitutions and mental problems. The “strenuous life,” as coined by Theodore Roosevelt, for Milwaukee’s children started young.

Finally, mothers were instructed in ways to prevent communicable diseases from affecting their young charges. Mothers were told never to kiss a baby on the mouth. Feared diseases such as tuberculosis, diphtheria, scarlet fever, measles, whooping cough, and syphilis were “communicated from the diseased adult to the innocent child.”¹¹³ Mothers were also cautioned to never “allow a fly to touch the baby or the baby’s milk.”¹¹⁴ Houseflies in the early twentieth century became demonized as carriers of diseases such as typhoid and polio.¹¹⁵ The Milwaukee Health Department warned that a “fly has a wonderful sense of smell and anything that reeks with foulness attracts the fly, for he loves to wallow in it.”¹¹⁶ This fear of the common household fly, much of it unfounded, became a fundamental part of the advice given to young mothers for protecting their children.

¹¹⁰ Ibid., 8.

¹¹¹ Ibid., 6-7.

¹¹² Ibid., 7.

¹¹³ Ibid.

¹¹⁴ Ibid., 6-7.

¹¹⁵ Naomi Rogers, “Germs with Legs: Flies, Disease and The New Public Health,” *Bulletin of the History of Medicine*, 63, Issue 4 (Winter 1989), 604-610.

¹¹⁶ Milwaukee Health Department, “The Uninvited Guest,” *Healthologist* (May 1930), 8, Mss 2126, Health Department Collection, MCHS.

Authorities cautioned mothers against giving babies “soothing syrups or other patent medicines recommended by kind neighbors.”¹¹⁷ The use of alcohol and narcotics was commonplace in many immigrant households to calm and sooth fussy or fretting babies. Villages in southern and eastern Europe afforded little modern medicine. Mothers turned to the traditional cures and treatments for childhood ailments. Gassy babies were given fennel teas, cupping for stomachaches, alcohol for teething gums, and a bit of poppy juice for fussy babies.¹¹⁸ As well as retaining their language, immigrant communities maintained traditions of child rearing practices and folk medicines. It is no surprise then as immigrant groups acculturated to American ways, along with the strong push of Progressive reforms, that many abandoned traditional ways for “modern” and “American” ways of raising and caring for their children. One way in which many women were pressured to conform was through the food and nutrients they provided to their children.

Better Foods – Breast Milk, Artificial Feeding, and Safe Food

At a time when infant mortality rates were on the minds of health professionals throughout the country, a new solution was proposed: artificial feeding. Pioneers in the field of artificial feeding saw this advancement as a surefire way to prevent infant deaths.

¹¹⁷ Milwaukee Maternity Hospital, “Breast Feeding,” n.d.; United Community Services of Greater Milwaukee Records, 1903-1969, Milwaukee Manuscript Collection BG, Box 13, United Community Center, Hospital Council of Milwaukee, 1929-1934, UWM.

¹¹⁸ Much of this comes from family anecdotes about life back in Yugoslavia and personal experience, outside of the poppy juice. Cupping is a practice of creating a vacuum under a cup or glass applied to the body and using that suctioning motion to treat a variety of illnesses. In my personal experience, the suction was created with a small candle that had been set into a small piece of bread to create a stand for the candle. The candle was lit and then the glass was placed over the candle, using up the oxygen, and thereby creating suction under the glass.

Improper feeding in their minds was akin to infanticide, whether it was by simple ignorance or purposeful neglect.¹¹⁹ To prevent poor feeding was to prevent infanticide.

Both hospitals and health departments placed strong emphasis for new mothers on breast-feeding. Superimposed on the health benefits were the moral duties for a woman to nurse her newborn child. Breastfeeding was seen as the epitome of a woman's motherly duties for it was her "greatest privilege to be a Mother . . . Every mother should consider it a joy and duty to breast feed her baby."¹²⁰ State Board of Health, the State Board of Control, and local boards of health rulings required that mothers breastfeed their babies for at least three months, unless physically unable to do so.¹²¹ Despite the artificial feeding campaign that was being conducted, most health care workers continued to emphasize the importance of breast-feeding as the preeminent food for newborn infants. Outside of providing physical nourishment mothers were also counseled on their diet and demeanor while breast-feeding. Women were encouraged to drink milk, avoid too much coffee or tea, and to "court cheerfulness because grief, anger, fear and worry will spoil her milk."¹²²

The Maternity Hospital put the idea in no uncertain terms. It was insistent on breast-feeding. "[E]very mother in its care **must** breast feed her baby—rich and poor alike. Even physicians bringing their private cases to the hospital are expected to accept this ruling—if they object . . . they are invited to take their cases elsewhere."¹²³ The

¹¹⁹ Harvey Levenstein, "Best for Babies; or 'Preventable Infanticide': The Controversy over Artificial Feeding of Infants in America, 1850-1920," *Journal of American History* 70, No.1 (June 1983): 84.

¹²⁰ Milwaukee Maternity Hospital, "Breast Feeding," MCHS.

¹²¹ "A Community Program for the Unmarried Mother & Her Child," Conference on Illegitimacy in Milwaukee, 1924. United Community Services of Greater Milwaukee, Records, 1903-1969, Milwaukee Manuscript Collection BG, Box 61, "Children's Conference," Central Council of Social Agencies, UWM.

¹²² Milwaukee Maternity Hospital, "Breast Feeding," MCHS.

¹²³ Ibid.

Maternity Hospital boasted of having 100 percent of its babies breast fed, unless medical circumstances prevented the child from being breast fed. Very few mothers were discouraged from breastfeeding—mostly those with infectious or communicable diseases. For example, women with tuberculosis, blood poisoning, and especially any venereal disease were discouraged, if not prohibited, from breast-feeding their newborns.¹²⁴ It was estimated in 1915 that over 400 children were “needlessly deprived of mother’s milk yearly because of fever, pain, poison or debility of the mother.”¹²⁵ For these women, manufactured formula or donated milk was the only option.

Through the 1890s artificial feeding was increasingly perceived as scientific and modern through intensive promotion by manufacturers of condensed milk and baby bottles.¹²⁶ Advertisers and manufacturers sought to win over women through a campaign that included advertisements cloaked as testimonials and handbooks as well as the distribution of free samples of formula to magazine subscribers. By the 1920s, the advertising campaign increasingly targeted not the women themselves, but the field of obstetrics as it gained professional weight in the medical community.¹²⁷ In the end, formula feeding appealed to many women over breast-feeding as artificial feeding came to be associated with an American lifestyle that was modern and scientific; breast-feeding was seen as antiquated and backward.¹²⁸

Artificial feeding had a direct link with Americanization and education. Many immigrants resorted to older, more traditional foods, instead of artificial feeding. They

¹²⁴ Ibid.

¹²⁵ “Maternity Hospital Improves the Coming Generation of City,” January 2, 1915, *Milwaukee Leader*, Milwaukee Features Microfilm, “Hospitals,” MCHS.

¹²⁶ Levenstein, 79.

¹²⁷ Ibid., 77-78.

¹²⁸ Ibid., 83.

used various sorts of animal milk (cow, sheep, goat), mashed bread, farina, chopped meat, sweetened coffee, and cooked potatoes in lieu of milk to feed young children. That started to change, however, as they became more acculturated into American society.¹²⁹ A number of studies found that as the foreign-born increased their mastery of English and subsequently their Americanization they were more apt to use artificial feeding methods for their children. Acculturation meant adopting American norms and practices, even in the feeding and weaning of their children.¹³⁰ For many working class women, poverty would force them to wean their children sooner than recommended so that they could return to work. In an era before maternity leave and on site day care, the certainty of a job and the survival of the family depended on working class women returning to the work force as soon as possible after the birth of their child. That said, foreign mothers regardless of their economic status fed their children formula at lower rates than native-born mothers. In addition to ethnicity, there was also a strong correlation with economic status for as income increased, breastfeeding decreased.¹³¹

Formula feeding¹³² was supported by many medical professionals and driven by the interests of the artificial formula industry. For physicians, the process of precisely mixing formulas was not to be left in the hands of mere mothers. One physician was concerned that “infant feeding could be left in the hands of non-specialists.”¹³³ Formula feeding was precise and scientific, not to be left for “ignorant nurses” and immigrant mothers. While the handbooks for formula feeding explained the chemistry of milk and

¹²⁹ Ibid., 76.

¹³⁰ Ibid., 83-84.

¹³¹ Ibid., 89-90.

¹³² Formula during the early twentieth century consisted of water-diluted cream with sugar in varying percentages depending on the proprietary recipes of the formulas.

¹³³ Levenstein, 81.

feeding in clear manner, the relative sophistication of the language added an aura of scientific authority to the process.¹³⁴ “Percentage feeding,” as formula feeding was also known, was “needlessly elaborate and expensive.” Many saw the main advantage to formula feeding was the cleanliness of the ingredients and the surroundings in which they were prepared (usually hospital or laboratory settings). The Milwaukee Infants Hospital prepared over 55,000 bottles for individual feedings from August 1, 1922 to August 1, 1923.¹³⁵ Unfortunately for many working class and immigrant mothers, the production costs involved kept the formula out of reach for all but the wealthiest of mothers.¹³⁶

Outside of formula feeding, another common breast milk substitute was condensed milk, which was mixed in a twelve to one ratio with water. Mothers found it convenient for unlike regular milk it was shelf stable and did not need to be refrigerated. It was already sweetened and cost much less than regular milk.¹³⁷ But condensed milk—and even many formulas—had serious health consequences for children. In the late nineteenth century, a link was established between the use of condensed milk and high rates of scurvy, which at the time was not fully understood.¹³⁸ Many children who were fed either condensed milk or formula also suffered from gastro-intestinal problems as well as a greater likelihood of colds, laryngitis, bronchitis, and other childhood maladies. While many physicians were impressed by the scientific nature of formula feeding, others

¹³⁴ *Ibid.*, 78.

¹³⁵ Milwaukee Infants Hospital, “Year Book, August 1, 1922-August 1, 1923,” 6, Children’s Hospital of Wisconsin, Milwaukee Campus.

¹³⁶ *Ibid.*, 83.

¹³⁷ *Ibid.*, 78-79.

¹³⁸ A lack of an understanding of the role of vitamins contributed to this ignorance. Levenstein, 85.

realized its negative aspects: “Artificially fed children at times look fat and plump but cannot withstand or resist disease.”¹³⁹

Despite advances in the field of artificial feeding, most medical officials and hospitals believed, in the end, that breast-feeding would produce a healthier, fatter baby and one that was better able to resist the diseases common to childhood. A Maternity Hospital pamphlet cited the statistic that “before the age of one year, nine artificially fed babies die to one breast fed child.”¹⁴⁰ Many contended that there was no perfect substitute for mother’s milk, but others would try to find one.¹⁴¹

The most common natural substitute for breast milk was cow’s milk, although it was seen as too dangerous to give to children. Frequently full of bacteria, cow’s milk was regarded as a “baby killer” to European populations who took to boiling the milk before giving it to their children. Boiling, however, “seemed to do little to reduce the appalling infant-mortality rates” associated with cow’s milk.¹⁴² Americans rarely chose to boil their milk, instead relying on the hopes of a “clean” milk supply. Unfortunately for many in Milwaukee, their milk was tainted with tuberculosis, diphtheria, and diarrheal diseases.¹⁴³ Clean milk supplies were not always to be found. The Health Department issued a series of advisories for farmers who wished to sell milk in Milwaukee, stating that in order to do so they needed to provide proper ventilation in their milk houses, to keep clean, non-

¹³⁹ Milwaukee Maternity Hospital, “Breast Feeding,” MCHS.

¹⁴⁰ Ibid.

¹⁴¹ Ibid.

¹⁴² Levenstein, 76.

¹⁴³ Leavitt, 158.

rusted utensils, have their cattle receive annual tuberculin testing, and maintain barnyards with good drainage and no manure within fifteen feet of the stable.¹⁴⁴

In order to further combat problems with disease ridden milk, the Milwaukee Health department established a set of “milk stations” that “certified” milk from various local farms.¹⁴⁵ Farms had to meet certain sanitary requirements by the Health Department in order for their milk to be sold in the city. While most of the milk that came through the stations was not pasteurized, it bore the seal of approval of the health authorities who had been convinced of the health and safety of not only the milk, but the animals which produced it. By safeguarding milk, reformers hoped—and did—reduce infant mortality rates in the early part of the twentieth century.¹⁴⁶ Milk for infants had to be carefully safeguarded as a lack of disease resistance in infants made them peculiarly susceptible to the diseases which were caused by impure milk.”¹⁴⁷ While the milk station movement peaked around 1912-1914, its focus on improving food safety would continue.

Cow’s milk also faced other problems as a substitute for mother’s milk. The composition of cow’s milk was very different from human milk for it had a higher proportion of fat and protein and a lower proportion of sugar. This difference in proportions made it difficult for babies to digest this milk.¹⁴⁸ The second half the nineteenth century saw attempts to create systems to chemically alter the cow’s milk to make it more similar to human milk and thereby make it easier for babies to digest. The

¹⁴⁴ Health Department, “Milk Advisories,” n.d., City of Milwaukee Health Department, Mss 2126, “Loose Pamphlets,” MCHS.

¹⁴⁵“Achievements in Public Health, 1900-1999.”

¹⁴⁶ “City to Certify Milk for Babes,” August 12, 1907, *Evening Wisconsin*, Milwaukee Features Microfilm, “Children,” MCHS.

¹⁴⁷ Ibid.

¹⁴⁸ Levenstein, 77.

inability to process the cow's milk could lead to a variety of diarrheal conditions, dehydration, and even malnutrition.

“Teething” was one of the more puzzling causes of death encountered when examining the deaths of children at the Milwaukee County Poor Farm Cemetery Ledger. Problems associated with teething were directly linked with badly fed babies. Children given improperly prepared cow's milk, condensed milk, proprietary foods, or prepared milk at too frequent intervals led to digestive problems. These digestive problems led to physical debilitation, rachitis (rickets), and development problems that led children to cut their teeth too late or too many at one time which subsequently led to fevers, convulsions, diarrhea, vomiting and possible death.¹⁴⁹ Gastro enteritis, an inflammation of the stomach and intestines, was a common cause of sickness and death in children under two years of age (See Figure 16). The inflammation caused by the gastro enteritis would leave the child unable to absorb certain proteins (lactose). Moreover, the diarrhea that would accompany it left many children severely dehydrated and even malnourished. Children's developing intestinal tracts were no match for improper feeding techniques and improper foods. As Figure 16 demonstrates, gastro enteritis, one of the leading causes of death for children under the age of two, would prove to be a significant challenge to Milwaukee's attempts to improve infant mortality rates through the 1910s. The disease claimed hundreds of deaths throughout the early twentieth century as the city tried to improve water supplies, food safety, and educate parents on better feeding techniques. For the poor, however, the improper implementation of feeding regimes left their children at even

¹⁴⁹ Koehler, “The Care of the Baby and Young Child,” 17-18.

more at risk for illness and death as children of the poor were “generally smaller and less resistant to disease.”¹⁵⁰

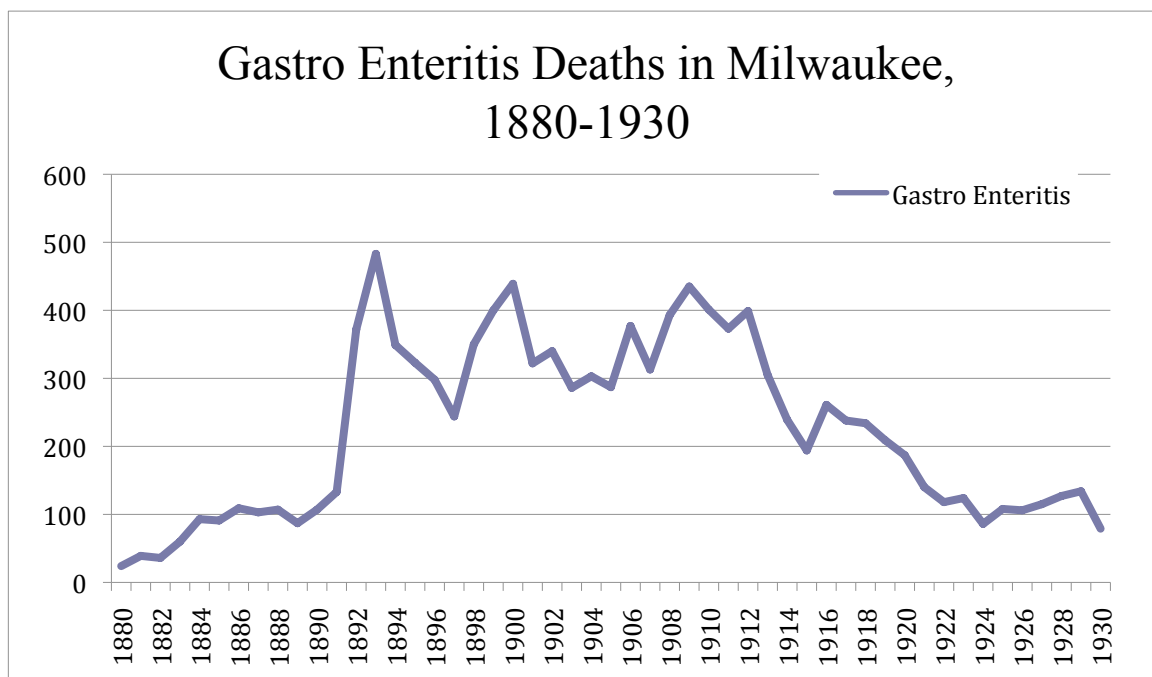


Figure 16: Gastro Enteritis Deaths in Milwaukee 1880-1930¹⁵¹

The final alternative for women who could not breast feed their children was to hire someone to do the job for them. The practice of “farming out babies” as it came to be known was a lucrative business for many of the women who practiced professional wet nursing. Unfortunately for the children involved, their wet nurses and caregivers were frequently more concerned about the money they made than the children under their control. Women could make from five to twelve dollars a month nursing other women’s

¹⁵⁰ Levenstein, 94.

¹⁵¹ City of Milwaukee Vital Statistics Office.

children.¹⁵² Most of the babies at these “baby farms” were from very poor parents who not only needed a wet nurse, but someone to watch the child for a time. These “farms” suffered from problems of low-grade milk, no medical supervision, and no segregation of sick children. It was estimated that infant mortality rates at these establishments ran as high as 25 percent.¹⁵³ Despite all attempts to find alternatives, in the end many health officials contended that the best food for young infants was still breast milk. It made for a healthier child and provided them with a much-needed head start in life.

Beyond the many issues related to infant’s milk, health officials also targeted for scrutiny the solid foods that older children ate. In the late 1920s, the Division of School Hygiene, a department of the Milwaukee Health Department, started to provide nutrition lessons for parents as well as children. A 1921 report by the Milwaukee Common Council noted that at least 10 percent of children brought into their child welfare clinics were considered undernourished. Those children were admitted to the clinics for further monitoring by health officials were given “a graham cracker and half a pint of milk per day.”¹⁵⁴ Physicians prescribed diets to these underweight children and the home conditions of those children deemed “exceptionally undernourished” were investigated.¹⁵⁵ The courts at times even stepped in to advocate for the welfare of children in neglect cases. In 1926, the courts saw seven cases of neglect for children who had become crippled and rachitic by improper feeding and care.¹⁵⁶ By 1928, the division was conducting over 3,500 “nutrition lessons” annually, and by 1929, over 14,000

¹⁵² “Farming Out Babies,” December 28, 1883, uncited newspaper, MKE Features Microfilm, “Charities,” MCHS.

¹⁵³ “Baby Farms are Hit by Expert,” undated, uncited newspaper, City of Milwaukee Vital Statistics Office.

¹⁵⁴ Milwaukee Common Council, *Municipal Government and Activities of the City of Milwaukee*, 1921.

¹⁵⁵ *Ibid.*

¹⁵⁶ *Ibid.*

lessons.¹⁵⁷ Health officials, however, continued to complain that large numbers of school age children “live on a diet of rye bread and coffee. Perhaps potatoes vary this diet once a day, but bread and coffee are the staples on which these children live. This is what inadequate incomes mean in terms of food.”¹⁵⁸

Local Agents of the Eugenics Movement

In order to combat the deleterious effects of the urban environment, health professionals and progressive reformers sought to create fitter, “better” Americans, particularly children. Healthier and thereby “better” babies and children would produce a better society. The science of eugenics sought to create a fitter population through genetic counseling, detailed family genealogies, and even sterilizations. Eugenic counseling, however, was not enough to provide for “better babies.” Along with eugenics, advances in medical science also provided for healthier babies. The advent of artificial feeding, growth in the field of bacteriology, vaccination programs, and a greater emphasis on preventive health provided a grounding for a movement which sought to bolster the health and vitality of the nation’s population. Finally, private and municipal organizations moved children out of the congested cities providing them with “fresh” air and better surroundings in the hopes of bolstering their well being, both physically and morally.

Better babies originated from informed parents. Through the use of eugenic counseling and sterilizations, health reformers sought to control the spread of what they saw as “unfit” individuals. Couples were counseled before marriage to ensure a good

¹⁵⁷City of Milwaukee, School Hygiene Activities, 1924-1943, Office of Vital Statistics.

¹⁵⁸ Ibid.

eugenic match. Those deemed “unfit” were discouraged from having children through counseling or directly prevented through sterilizations. “Feeble-minded” individuals would be sterilized in the tens of thousands to prevent them from passing on their bad genes to a next generation. For those, however, who had children despite counseling and before being caught up in the wave of eugenical sterilizations, their children were usually dealt with in other ways.

Tens of thousands of children were taken from their homes and sent west on what were deemed the “Orphan Trains.” Removed from “unfit” situations and households, these children were relocated with families in the Midwest and West who were to provide them with a morally and economically stable home environment. Some took children for altruistic purposes, some because they needed unpaid labor. But, as a movement, this program hoped to rescue children from the city’s den of vice and corruption, and transplant them to fresh air, hard work, good morals, and sobriety.¹⁵⁹ In Milwaukee, the Milwaukee County Home for Dependent Children acted under similar principles. Milwaukee County’s care for the indigent created a new concern as to how to care for the children of the poor. Normally, children were housed along with their parents in the County Almshouse or Poor Farm. However, the desire to remove children from the “corrupt” influences and examples of older inmates at the almshouse spurred the creation of a separate institution specifically for the care of indigent children.

An 1882 state provision deemed that children over the age of five and under the age of sixteen were no longer to be sent to the Milwaukee County Almshouse. With these

¹⁵⁹ For further reading on the Orphan Trains, see Marilyn Irvin Holt’s *The Orphan Trains: Placing Out in America*. (Omaha: University of Nebraska Press, 1992) and Linda Gordon, *The Great Orphan Abduction* (Cambridge, MA: Harvard University Press, 2001).

accommodations now officially barred to them, the question of where to temporarily house these children until other accommodations could be made came to the forefront. The county attempted to place as many children as possible in temporary housing and with outside organizations. Private institutions, adoptions, and children “placed out” to work were only a partial solution to an ever-growing problem. By the early 1890’s, with increasing number of immigrants and economic hardships, it was becoming increasingly clear that a more permanent solution was needed as the number of indigent children skyrocketed. By February of 1898, the Home for Dependent Children opened its doors. The home became the primary institution for the temporary care of orphaned, abandoned, neglected, and otherwise “dependant” children.¹⁶⁰

The primary focus of this facility was *temporary* care. It was hoped that children would either return to their parents or another responsible relative when circumstances improved. However, the records from the Home for Dependant Children tell a much different story. A 1922 annual report for the Home noted that out of the 878 children who had spent time at the institution during the period from 1898 to 1922, forty-four children had been there longer than two years, fifteen longer than three years, ten longer than four years, thirteen longer than five years, six longer than seven years, and eight children longer than eight years.¹⁶¹ While the average stay for children in 1922 was approximately nine months, for many it could be their entire childhood.¹⁶²

To solve the problem of too many children and too little space, the Home for Dependent children relied on other options. Non-relatives formally adopted hundreds of

¹⁶⁰ Milwaukee County Home for Dependant Children, Annual Report, 1898, Mss 723, Milwaukee County Departments and Institutions, MCHS.

¹⁶¹ Ibid, 1922.

¹⁶² Ibid.

children from the Home during its history. Small candid photographs sent to August Kringle, Superintendent for the Home in the early twentieth century, were marked with two sets of names -- their given and adopted name. These tiny snapshots of first communions, trips to the beach, and rides on new bicycles are poignant reminders that many children started happy new lives after their time at the Home.¹⁶³ Grateful adoptive parents sent photos, postcards, and even letters to Kringle detailing the lives of the children who had once been residents there.

Another option that was available to the institution, and the children, was a practice known as “placing out.” The Home for Dependant Children issued “Indenture” contracts between itself and various individuals and families. Between 1898 and 1922, over 402 children were contracted as part of these “indenture” agreements to various families throughout Wisconsin.¹⁶⁴ “Placing out” as it was more colloquially known could involve a wide variety of tasks. A 1902 letter written to Superintendent Kringle by a young boy in a childish hand told of his daily work milking twenty-five cows, caring for six horses and forty head of cattle. While he did adult work, he poignantly inquired at the end of the letter “would you please let me no [sic] when my birthday is and let me no [sic] how old I am now.”¹⁶⁵ While they performed decidedly adult labor, one cannot forget their true ages or their history as orphans or abandoned children. Older children were often placed in rural areas to help with farm work or with domestic chores until

¹⁶³ A large collection of these photos can be found at the Milwaukee County Historical Society, previously archived under “Children’s Fashion” photos. The real background of these photos was just discerned recently and they now have been correctly re-cataloged under the Home for Dependant Children’s collection.

¹⁶⁴ Milwaukee County Home for Dependant Children, Annual Report, 1922, Mss 723, Milwaukee County Departments and Institutions, MCHS. The legal papers for these contracts were formally titled “Indenture” agreements. While not a term one expects to see after the colonial period of United States history, the children’s labor was being exchanged for room, board, and basic education.

¹⁶⁵ “Children’s Fashion Photographs,” MCHS.

their indenture agreement had expired, usually on their eighteenth birthday. Annual reports noted that under the terms of the indenture children over sixteen were required to be paid for their labor. All indentures involved a thirty-day trial period after which the family could either retain or return the child.

Whether in indentured service or at the Home itself, children were by the Home's mission statement to be well cared for. The children at the Home for Dependant Children were housed, fed, and educated in the basic subjects (reading, writing, arithmetic) as well as in singing, geography, domestic work, and manual training. While the children from most reports were looked after in all aspects of life, they couldn't escape the dangers of institutional life. High morbidity and mortality rates, frequently associated with public institutions, were also present at the Home for Dependant Children. Epidemics of measles, whooping cough, and chicken pox swept through the home. Whereas the 1922 annual report listed twenty-six deaths during the period of 1898 to 1922, the Milwaukee County Institutional Grounds burial ledger for the same period lists 139 deaths. While it might be a simple clerical error perhaps there was also a tendency to under-report numbers of ill and dying children at the County Home. The contagious disease reports from the Board of Health of Wauwatosa listed over 420 cases of communicable diseases at the County Home from the period of 1901-1915, suggesting that the Home, while somewhat isolated in the rural areas of Wauwatosa, could not escape the ravages of childhood disease. High numbers of sick and dying children, while not uncommon in state run institutions, still do not look good on annual reports. Far darker specters also loomed over this young population. Pneumonia, influenza, tuberculosis, and sexually

transmitted diseases plagued this population and accounted for a large portion of the morbidity as well as its mortality rate.¹⁶⁶

For those children deemed incorrigible, seen as mentally or physically deficient, or branded as “feeble minded,” permanent institutionalization and eventual sterilization were common. Some physicians moved to the next level and even counseled parents of newborns with disabilities to simply let their children die. Dr. Harry Haiselden, a Chicago doctor, was one such advocate who through a lack of care let children with congenital disabilities die instead of performing surgeries that might have otherwise saved them.¹⁶⁷ In 1917, a movie entitled *The Black Stork* was released in which Haiselden played himself. Just as in real life, he warned “ill-suited” parents about their “defective” offspring and counseled a number of parents who had sickly children to simply let them die.¹⁶⁸ Haiselden took his cause to the newspapers, having himself photographed with mothers and their dying babies and becoming celebrity for his outspoken views on eugenics. Just as the late twentieth century had its Jack Kevorkian, the early twentieth century had its Harry Haiselden. His spotlight on the question of intervention sparked nationwide attention and debate over the efficacy of prolonging the lives of those deemed to be a “burden” on society. Certain medical professionals and eugenic reformers voiced opinions that it was better to let one sickly child die than to allow that person to grow and become a ward of the state or even worse to have children like themselves.¹⁶⁹

¹⁶⁶ Milwaukee County Home for Dependant Children, Annual Reports, Mss 723, Milwaukee County Departments and Institutions, MCHS.

¹⁶⁷ *Independent*, January 3, 1916.

¹⁶⁸ The name, “black stork” originated from the idea that the white stork brought healthy babies and the black stork sickly and diseased children.

¹⁶⁹ Martin S. Pernik, *The Black Stork: Eugenics and the Death of “Defective” Babies in American Medicine and Motion Pictures since 1915* (Oxford: Oxford University Press, 1999), 133.

Concerns over “defective” children breeding a future race of “defectives” was a real fear for the eugenics movement. Concerns over “race suicide” were fueled by waves of immigrants from Europe and with a perceived lower fertility rate among native whites. (While non-immigrants did have lower fertility rates than newly arrived immigrants, they had more children who survived till adulthood.)¹⁷⁰ These concerns, whether real or unfounded, led to substantive medical and social policies. Even social welfare organizations were particular in the children whom they sent to adoptive families. The Children’s Home and Aid Society in Milwaukee was extremely selective for they had to check “all available records as to heredity, background, direct parentage, health and living conditions [P]hysical examinations are made in order that defects, if any, may be corrected. The mentally and physically unfit are placed in a state or county home.”¹⁷¹

Milwaukee Children’s Hospital noted in 1922 that “Mental defect and neurotic condition” have come to be seen as the “underlying causes of poverty, crime and general failure of individuals to react intelligently to forces around them.” The hospital had seen a growing number of “neurotics” in their clinics and was concerned that they would eventually grow up to be “misfits in the community.”¹⁷²

Frequently, eugenic programs were exemplified in “better baby contests” held at state and county fairs. The national or local eugenical societies sponsored events at fairs which not only chose the “better baby” but also the “fitter family.” In conjunction with these contests were extensive exhibits warning people of the dangers of “improper

¹⁷⁰ Wilbur L. Cressy, “Children of Decedents in Michigan,” *Publications of the American Statistical Association*, 9, No. 72 (December 1905): 355.

¹⁷¹ Mary Myers, “How Milwaukee Charities Began,” *Milwaukee Journal*, 1931, Milwaukee Features Microfilm, “Charities,” MCHS.

¹⁷² Milwaukee Children’s Hospital, Annual Report, 1922, 35, Children’s Hospital of Wisconsin, Milwaukee Campus.

breeding,” and the economic and social burden of those populations on American society.¹⁷³ The Milwaukee Health Department sponsored a child welfare exhibit for the 1915 Wisconsin State Fair that included displays on “feeding and clothing infants, the preparation of food, [and the] prevention of infant diseases.” The department also sponsored a baby scoring contest to rate and evaluate the “fitness” of participants. They were also quick to note that the baby scoring was not competitive, only educational.¹⁷⁴ The City Club of Milwaukee at the beginning of the eugenics craze in 1916 sponsored a lecture by Alexander Johnson, a “leading authority on the problem of feeble-mindedness” and at the time, the Field Secretary of the Nation Committee on Provision for the Feeble Minded. The City Club sought through his lecture to address “one of the most urgent social problems of the day.”¹⁷⁵ If these social and medical associations were not able to control unfit children, he maintained, they would grow into unfit adults and be a menace and economic burden to larger society.¹⁷⁶ One other area that eugenicists targeted was the explosion of childhood venereal disease cases in the city.

Venereal Disease

A growing awareness of venereal disease in children paralleled medicine’s increasing recognition of venereal diseases in adults. Syphilis and gonorrhea posed the greatest threat to children. Congenital syphilis could impede a child’s development and

¹⁷³ Harry Bruinius, *Better For All the World* (New York: Alfred A. Knopf, 2006), 234-242.

¹⁷⁴ “May Have Baby Scoring Feature at State Fair,” August 22, 1915, uncited newspaper, Milwaukee Features Microfilm, “Eugenics,” MCHS.

¹⁷⁵ City Club Collection, Milwaukee Manuscript Collection AS, Box 2, “Programs, 1911-1917,” Box 2, UWM.

¹⁷⁶ *Ibid.*

condemn them to an early grave. Gonorrhea, while making women sterile, could blind children in the simple act of their birth. These “innocent victims” became one of the fronts in the battle against the “social diseases” of the period.

Eugenicists and health officials fought the battle of venereal disease for the sake of future generations and the overall moral health of the community: “[c]ountless numbers of defectives are brought into the world because of the growing rates of venereal disease in the community.”¹⁷⁷ A state board of health survey noted that “we can trace directly in our state penitentiaries and homes for delinquents syphilis as being in some of the cases the cause of delinquency.”¹⁷⁸ The disease came to be responsible for the social behavior of the individuals. Therefore, by treating the physical disease, one can treat the social ill as well as a physical one.

Blindness was a special target for health reformers in their battle with venereal disease, especially gonorrhea. It was estimated that 37 percent of infant blindness was caused by venereal disease.¹⁷⁹ Mrs. Clara Hipke, the founder and head of the Milwaukee Maternity Hospital, was credited with being the primary motivating force behind the Wisconsin Legislature’s legislation requiring mandatory silver nitrate drops in the eyes of newborn infants to prevent blindness caused by maternal gonorrhea.¹⁸⁰ Since 1906, the hospital had been using the silver nitrate drops in the eyes of all children at birth, thus limiting the number of cases of ophthalmia neonatorum.¹⁸¹ It was not, however, until 1913 that Clara Hipke was able to push through state legislation providing free and compulsory

¹⁷⁷ Milwaukee Maternity Hospital, “The Eugenics Law,” MCHS.

¹⁷⁸ “The Moral and Healthy Community,” 6, MCHS.

¹⁷⁹ “The Eugenics Law,” MCHS.

¹⁸⁰ “Clara Hipke is Dead at 70,” *Milwaukee Sentinel*, December 2, 1938, Mss 1625, “Clara B. Hipke, Activities, 1907-1938,” Hipke Family Collection, MCHS.

¹⁸¹ Milwaukee Maternity Hospital, “There is No Excuse for Blindness of Infants,” MCHS.

distribution of silver nitrate statewide by the Wisconsin State Board of Health. What had started out in 1906 at her Maternity Hospital in Milwaukee had by 1913 spread throughout the state.

While gonorrheal infections blinded the young, syphilitic infections of children were systemically more serious. Syphilis was blamed for at least 25 percent of stillbirths and early infant mortality (the first two weeks after birth), so it played a larger role in overall infant mortality rates.¹⁸² Syphilis could also be transmitted to unborn children, but with more serious physical and mental consequences. The disease would start its progress when the child was still in utero. One health official noted that the consequence of sowing ones proverbial “wild oats resulted in “a baby who should have been born into the world clean and free from disease, [but was] born with the marks of syphilis all over its little body.”¹⁸³ Stunted in growth (mentally and physically) and subject to congenital deformities,¹⁸⁴ children born into syphilis rarely reached their teenage years, and were a constant reminder of the sexual immorality of their parents. Moral reformers warned that “[i]f every man were straight, there would be no illegitimate children . . . few children would be born blind . . . there would not be nearly so many babies born dead . . . fewer mentally defective children.” The speaker held that if every individual led a moral life, then the children they produced would not suffer needlessly. The author went on further to say that “luckily, 80% of such children die within a few days or weeks.”¹⁸⁵ In hindsight, luck played no role, outside of perhaps alleviating their suffering. The children

¹⁸² “The Eugenics Law,” MCHS.

¹⁸³ “The Moral and Healthy Community,” 5-6, MCHS.

¹⁸⁴ Children born with congenital syphilis suffered a wide range of physical and mental deformities. They suffered from anemia, enlargement of the liver and spleen, skin rashes, deafness, keratitis (inflammation of the cornea), cranial swelling, saber shin (sharp bowing of the tibia), and Hutchinson’s teeth (notched and peg sized incisors). Charles Clayton Dennie, *Congenital Syphilis* (Philadelphia: Lea & Febiger, 1940).

¹⁸⁵ “The Moral and Healthy Community,” 8, MCHS.

who contracted venereal diseases did so through no fault of their own, but were an ever-present reminder of the dangers lurking among even the youngest of the city's population.

The Milwaukee County Hospital created in 1915 a Department of Social Services whose original intent was to work with unmarried mothers, case follow-ups, and venereal disease.¹⁸⁶ That venereal diseases were listed so prominently in this charter document suggests the extent these diseases were present in Milwaukee's society. It is in this 1915 annual report which introduced the Department of Social Services that one of the most disturbing elements of venereal disease in children came to light. The annual report detailed three cases that exemplified the different foci of the department. One of the reports described a "female child aged four years, suffering with gonorrhoea." Her parents could not account for how she became infected but an "[i]nvestigation of the home conditions disclosed that child slept with [the] father who was infected."¹⁸⁷ It is a statement to make anyone sit up, take notice, and shudder. While gonorrhoea is still today the second most common venereal disease, it cannot be transmitted by casual contact. What the report suggests, but never names, is not only an example of venereal infection in a small child, but likely a case of sexual abuse as well. This report on the child concluded with the note that the "child [was] returned cured and parents were instructed to provide separate bed for child and how to prevent further infection."¹⁸⁸

County Hospital, while not guilty of grossly overlooking sexual abuse, was part of a growing medical trend in the early twentieth century that subscribed to a more

¹⁸⁶ Milwaukee County Hospital, Annual Reports, Mss 723, Milwaukee County Hospital Annual Reports, Milwaukee County Departments and Institutions, MCHS.

¹⁸⁷ Ibid.

¹⁸⁸ Ibid.

“accidental” mode of gonorrheal infection for young girls. Innocent contact with toilet seats, public drinking cups, and soiled bedclothes could presumably infect them with venereal disease.¹⁸⁹ By the late nineteenth century, toilet seats became the prime targets for sanitarians and health reformers because it was “less embarrassing to accuse a toilet seat than a family member.”¹⁹⁰ Even as late as the 1950s, physicians were still trying to find a non-sexual mode of gonorrheal transmission, to no avail.¹⁹¹ While poor and working class girls were seen as more likely to be infected because of the “primitive” nature of their men folk, white middle and upper class daughters were not subject to such moral improprieties. Health officials believed that “men among certain classes, especially ignorant Italians, Chinese, and Negroes’ assault their daughters because they supposedly believed “that, if a man afflicted with an obstinate venereal disease have intercourse with a virgin, the latter will develop the disease and he will be cured.”¹⁹² Doctors, health reformers, and social workers had few doubts that poor and working class girls were subjects to abuse and rape (as they suggested), but had difficult times explaining the numbers/cases in girls of more well-to-do households.¹⁹³ Instead of investigating what they found, doctors simply changed the definitions and revised the description of the disease.¹⁹⁴

Health officials also had a hard time explaining the epidemics of gonorrhea that they found in public institutions. Blamed primarily on the poor hygiene of those

¹⁸⁹ Lynn Sacco, “Sanitized for Your Protection, Medical Discourse and the Denial of Incest, in the United States, 1890-1940,” *Journal of Women’s History* 14, No.3 (2002): 85.

¹⁹⁰ *Ibid.*, 90.

¹⁹¹ *Ibid.*, 92.

¹⁹² Sacco, 84. Ironically this is a belief still held in Africa today and is partly to blame for the high rates of AIDS in areas of sub-Saharan Africa.

¹⁹³ *Ibid.*

¹⁹⁴ *Ibid.*, 81.

institutions, many started to test all girls who were admitted and frequently refused admittance to those testing positive.¹⁹⁵ For the years 1922 through 1923, the Milwaukee Infants Hospital performed over fifty-two vaginal smears and conducted Wasserman blood tests on children that physicians deemed to be suspect cases.¹⁹⁶ As early as 1921, the venereal disease division of the Milwaukee Health Department established a clinic for the examination and treatment of children in conjunction with the Child Hygiene Bureau.¹⁹⁷ In 1925, the Milwaukee County Home for Dependent Children examined over 270 children both for the home itself and for other institutions in the city.¹⁹⁸ By shifting the blame from infected parents to unhygienic institutions, they widened the rift between sexual contact and the venereal disease, thereby also altering the social and moral implications of the illness.¹⁹⁹

Conclusion

A citywide Children's Day was celebrated the second weekend of June in 1894. Traditionally held by churches of the Protestant faith, 1894's celebrations held even more significance as the festivities coincided with the opening of the Milwaukee Children's Hospital. Church services on June 10, 1894 extolled the importance of children to society and reminded all of the importance of childlike faith. A Professor J.J. Blaisdell of Beloit noted during the services at Immanuel Presbyterian Church that children performed a

¹⁹⁵ Ibid., 85.

¹⁹⁶ Milwaukee Infants Hospital Year Book, 1922-23, 13, Children's Hospital Historic Records, Children's Hospital of Milwaukee.

¹⁹⁷ Milwaukee Common Council, *Municipal Government and Activities of the City of Milwaukee* (Milwaukee, WI: The Council, 1921), MPL.

¹⁹⁸ Milwaukee Health Department, Annual Report, 1925, Mss 2126, Milwaukee Health Department, MCHS.

¹⁹⁹ Sacco, 89.

“most important function in society” and they needed to be “properly reared to save us from a deluge of crime.”²⁰⁰ Properly raised and cared for children would in the end become good and proper citizens.²⁰¹

It was not only moral well-being, but physical well being that made children the future good citizens of Milwaukee. The experiences of the children were told through their epidemics, their tragedies, and their growth. While Mrs. Gertrude S. Hasbrough from the State’s Bureau of Child Welfare noted in 1927 that “it was seven times safer to be a soldier in the trenches during the World War [I] than to have been a baby under one year of age in America,” the war against childhood disease and high mortality was being won.²⁰² Infant mortality rates were dropping, safer food and milk were a part of the daily lives of children, and the battle against venereal disease was in full swing. The health and social reformers had waged a war for the future of the city and the future of its people. By ensuring the health of children, they would also ensure the health of Milwaukee.

²⁰⁰ “Day for Children,” *Milwaukee Sentinel*, June 11, 1894.

²⁰¹ Children’s Hospital of Milwaukee, “Children’s Hour,” 3, Mss 1234, File 1, Children’s Hospital Collection, MCHS.

²⁰² “Infant Deaths Outstrip War Killings,” October 5, 1927, uncited newspaper, Milwaukee Features Microfilm, MCHS.

Chapter 3

Milwaukee Men

Introduction

Dealing with men's health issues at the turn of the twentieth century is not as clear cut as detailing the health issues of women, children, or even ethnic and minority groups. Pinpointing specific male health issues at the turn of the last century presents a number of challenges related to the relationship that men had with the medical establishment and to the reasons for which they sought help. Men, both historically and contemporarily, are less likely to seek medical attention outside of the most serious of conditions.¹ An examination of the health concerns of Milwaukee's men presents a significantly skewed image of their health issues, because of this behavior. Therefore one must realize that the picture of male health may only be the tip of the larger health iceberg. Secondly, unlike women's health where a large component of medical care is focused around reproductive issues or children, male health concerns are not targeted around a particular health issue; they are more general and generic. Alcoholism, drug

¹The pioneering work in the study of sex differences regarding the medical profession has been the work of Lois Verbrugge including "Sex Differences in morbidity and mortality in the United States," *Social Biology* 23 (1976): 275-296 and "Sex differentials in health," *Public Health Reports* 97, no.5 (September-October 1982): 417-437.

abuse, chronic illnesses, and ailments such as rheumatism, bronchitis, hernias, carcinomas, and gastro-intestinal problems, while prolific in the male populations studied, are not exclusive to men. But male health issues are intertwined with issues of the dangers of industrial working conditions, the temptations of drugs and alcohol, venereal disease, and the dangers and stresses of city life

Dangers of the Workplace

Industrial Health

Working conditions in the late nineteenth and early twentieth centuries were fraught with danger and risk. As the nation's urban areas rapidly industrialized, workplace conditions for workers deteriorated. Dangerous working conditions were commonplace in a climate dominated by the lure of quick profit and a seemingly unlimited supply of workers. With increased mechanization, faster machines, and assembly line production the workers increasingly were at risk for on-the-job injuries. With the dramatic increase of Southern and Eastern European immigrants in the late nineteenth century, an enormous labor pool was introduced to the United States economy. Wage earners vied for available positions resulting in a high turnover rate of workers in many industrial settings. As a consequence of this large labor pool and the willingness of individuals to work in dangerous conditions, few employers proactively sought to better the working environment. There was little incentive to change working conditions when workers were prepared to labor under any condition and, frequently, for any price. A small but vocal movement began to develop that encouraged workplace safety. It forged

alliances among industry and health agencies. Strong backs and hard workers would long be an easy commodity in industrial Milwaukee, but a healthy, well trained, and loyal workforce was increasingly seen as a wise capital investment.²

As Milwaukee grew as an industrial power, there are constant calls for improvements in the working conditions of the city's workforce. Emil Seidel, Milwaukee's first socialist mayor and someone with an abiding concern over labor conditions in the city, in his inaugural address noted:

The workers of our city are its most valuable asset. The Administration should constantly watch over the conditions prevailing in factories, workshops, and places of employment, with regard to sanitation. In contracts to be let by the city the specifications should provide for hours of labor that are not exhausting, that leave a margin of time for rest and development. Such specifications should also provide for sufficiency of light and ventilation; they should prohibit child labor, properly protect woman labor, and prevent the imposition upon workers of degrading conditions."³

Seidel set out a mandate for the city government as well as the city's industry to follow: fair, safe, and healthy working conditions. To the mayor, these were not simply ideals but rights for every worker in the city. A city and an economy with an unhealthy, injured, and demoralized workforce was a city and an economy on the road to crisis. Working from Seidel's statement, a healthy workforce meant a healthy economy and a healthy Milwaukee. All three were intricately tied together and linked by the delicate thread of health; one could not easily function without the other.

² For further reading on the background of workers and working conditions in the industrial United States, see Thomas Sewall Adams and Helen Sumner, *Labor Problems: A Text Book* (New York: Macmillan, 1905); Paul Frederick Brissenden and Emil Frankel, *Labor Turnover in Industry* (New York: Macmillan, 1922); David Brody, *Workers in Industrial America: Essays on the Twentieth Century Struggle* (Oxford: Oxford University Press, 1980); and S.J. Kleinberg, *The Shadow of the Mills: Working Class Families in Pittsburgh, 1870-1907* (Pittsburgh: University of Pittsburgh, 1989).

³ Emil Seidel, "Inaugural Address," April 19, 1910, "Mayor Seidel in Office" *New York Times*, April 20, 1910, 8.

Four years prior to Seidel's inaugural speech, some of the first efforts to contend with the issue of industrial health were underway. Until the early twentieth century, little existed in the way of industrial health services in the city. Following trends in other metropolitan areas, women in Milwaukee played an instrumental part in the industrial and public health of the city. Sarah Boyd, whose husband ran the Shadbolt-Boyd Iron Company, would send her private nurse to the homes of sick or injured workers. By 1906, she had hired Maude Tompkins to act as Milwaukee's first "visiting nurse."⁴ Boyd saw the growing threats to workers at her husband's iron works and sought, in true Progressive era fashion, to use her "womanly" skills to organize and minister to those in need.⁵ The Visiting Nurses Association was formally incorporated in 1907 with the express mission to aid "those who are otherwise unable to secure skilled assistance in time of illness and to promote cleanliness and to teach proper care of the sick."⁶ While the original purpose of this incorporation was to aid ill and injured workers, the VNA quickly expanded its services to a larger spectrum of the community. But it would be Sarah Boyd's visiting nurses who pioneered industrial health in Milwaukee.

Industrial health care in the city was slow to develop and to be implemented by Milwaukee's industrial leaders. Two years after the Visiting Nurses Association's

⁴ Visiting Nurses Association, *History of the Visiting Nurses Association*, (Milwaukee, WI: VNA, 1950), 4.

⁵ Middle and upper-class women played a strong role in Progressive era social and public health movements. Women entered the public sphere utilizing the social traits and stereotypes which they had been given in the nineteenth century. Their ability to keep house was transformed into ideas of "municipal housekeeping." Their skill at educating children presumably provided them expertise to sit on school boards. Their upstanding moral characters allowed them to be the social and moral voice for the "dangerous" urban spaces. Finally, their nurturing and caring natures made their entry into the nursing fields quite natural. Women were able to utilize their domestic "housekeeping" skills to help manage the larger municipal community. The "home" in this instance was the larger city and the duties of the family home could be easily translated to the larger public sphere. The establishment of the Visiting Nurses Association by Sarah Boyd, while important in the history of health care in Milwaukee and the nation, is part of a larger trend of female involvement in the male public sphere.

⁶ "VNA Grows With Milwaukee" Mss 2620, Health Collection, MCHS.

incorporation in 1907, Pfister and Vogel, one of the largest tanneries in Milwaukee, contracted with the VNA to provide nursing services for the company and its employees.⁷ The VNA provided on site nursing care for Pfister and Vogel's employees, in both emergency accident settings as well as in a general health and welfare role. They instructed employees about communicable diseases, ministered to minor scrapes and injuries, and educated workers on general sanitary practices. The same year, the VNA contracted with Metropolitan Life Insurance Company to "care for all the sick industrial policyholders."⁸

While benevolence was a strong motivator, the economic reality of life insurance policies, disability payments, and a debilitated workforce factored strongly into the motivations of companies working with the Visiting Nurses Association. The VNA would go on to develop partnerships with many more Milwaukee businesses. It would, however, take almost twenty more years for the association to establish long term therapy and occupational treatment programs for the city and its population. Starting in 1928, the VNA initiated a physiotherapy program for the city's employees and the following year established a citywide occupational therapy service to rehabilitate workers following accidents and disabilities.⁹ Simply treating men for a workplace injury was not enough. In order to maintain a strong workforce, there was a need to rehabilitate and reintegrate workers back into the workforce despite injury. Through this therapy service, the VNA hoped to ensure that formerly injured and debilitated workers would not become public

⁷ Ibid.

⁸ Mary Myers, "How Milwaukee's Charities Began," *Milwaukee Journal*, 1931, Milwaukee Features Microfilm, "Charities," MCHS.

⁹ Ibid.

charges and therefore a burden on society. The hope was that they would return to both health and productivity.

For industrial workers, health and safety were unquestionably matters of life and death. Dangerous jobs and hazardous conditions were a reality of life in turn of the century America. In an industrializing nation, production and profit frequently superseded health and safety. Workers were as interchangeable (and in some respects as dispensable) as the mass produced objects that they generated. While the tragic 1911 Triangle Shirtwaist Fire of New York had no parallel in Milwaukee's early industrial history, Rose Schneiderman's words at a post-fire rally of union workers and supporters spoke clearly to the plight of workers, whether in New York or Milwaukee:

The old Inquisition had its rack and its thumbscrews and its instruments of torture with iron teeth. We know what those things are today: the iron teeth are our necessities, the thumbscrews are the high-powered and swift machinery close to which we must work, and the rack is here in the firetrap structures that will destroy us the minute they catch fire... The life of men and women is so cheap, and property is so sacred! There are so many of us for one job, it matters little if one hundred and forty-odd are burned to death.¹⁰

In an age long before the creation of OSHA, there was little regulation of the workplace.

¹¹ When legislation was passed that did affect the workplace, it was frequently aimed at the product being produced, not the means of production. The passage of the Pure Food and Drug Act, as well as the Meat Inspection Act, in 1906, driven in good part by the publication of Upton Sinclair's *The Jungle*, focused on insuring the proper labeling and representation of food products, not on the horrific conditions in which the

¹⁰ Rose Schneiderman, "We Have Found You Wanting" in Leon Stein, *The Triangle Fire* (New York: Carroll & Graf, 1962), 144-145.

¹¹ The Occupational Safety and Health Administration would not be established until 1971 under the Nixon Administration, long after the high point of American manufacturing and industrialization.

slaughterhouse workers toiled. The adulteration of the meat product from the dismembered human finger was of greater concern than how the digit found its way there in the first place. Legislation at the turn of the century was frequently focused on production of safer and cleaner products, not on a safer and cleaner workplace. When workplace legislation was passed in Milwaukee by the early twentieth century, it was aimed at limiting the amount of time children as well as women spent in the factory, not necessarily in making conditions safer there for those left behind.

One of the early concerns in workplace health and safety revolved around the link between the workplace and tuberculosis. For many workers, the pollutants they were exposed to in the workplace environment, such as dust, fumes, smoke, heat, and humidity wreaked havoc on a person's lungs. While none of these irritants directly caused tuberculosis, they could contribute to a weakening of an individual's health and thereby the condition of their lungs. Scarred, injured, and chronically irritated lungs were prone to infection, and therefore were a prime location for the tuberculosis bacilli to lodge itself and became the site for its fateful course of development. Once the immune system and the pleural cavity were compromised, a disease could more easily spread throughout the respiratory system, and if not fatal to the individual, could prove to be a lifelong debility.¹² By 1909, the Federated Jewish Charities in Milwaukee pressed the city and its

¹² For further reading, see Philip Ellman, "Diseases of the Lung in Industry," *British Medical Journal* 1, no. 4090 (May 27, 1939): 1114; Alice Hamilton, *Exploring the Dangerous Trades* (Boston, Little, Brown, 1943); "Workers Compensation for Dust Diseases," *Columbia Law Review* 56, No. 7 (November 1936): 1142-1155; Thomas Oliver, "An Address on Occupational and Other Causes of Pulmonary Fibrosis," *British Medical Journal* 1, No. 3354 (April 11, 1925): 685-687; G. St. J. Perrott and Helen C. Griffin, "An Inventory of the Serious Disabilities of the Urban Relief Population," *Milbank Memorial Fund Quarterly* 14, No. 3 (July 1936): 213-241; and David Rosner and Gerald Markowitz, eds., *Dying for Work: Worker's Safety and Health in Twentieth Century America* (Bloomington, Indiana: Indiana University Press, 1987).

health institutions for improvements in working and living conditions that they saw as a direct correlation to the contraction of tuberculosis.

Those who are engaged in unskilled and underpaid occupations, must by force of necessity, resort to unreasonably long hours of activity; thus, owing to an irregular mode of living and physical over-exertion, and lacking the necessary sustenance where-with to replenish the expended energy, the physical structure becomes devitalized, and if the individual chances to resist an attack of the dreadful white plague, he must eventually succumb to other forms of diseases...he is forced to extreme economy of living in quarters unfit for human beings. Under-feeding, insufficient clothing, improper housing, over-work and lack of health and necessary recreation are the primary causes of tubercular and other diseases.¹³

Workers forced into unreasonable working conditions, forced to live in poor housing, and forced to work beyond their physical limits were prime breeding grounds for disease, especially tuberculosis. What the average worker had to endure in the workplace and in the domestic sphere were not only unbearable, but unhealthy as well. The U.S. Bureau of Labor Statistics estimated that among working men between the ages of twenty-five to forty-four the proportion of deaths from tuberculosis was over 37.4 percent. This significant rate of death from the disease, much of it tied to exposure of “dusts” in industrial conditions, also “coincided with the period of greatest productive efficiency on the part of wage earners.”¹⁴ If measures were not taken, the disease could have a devastating effect on Milwaukee’s workforce and economy.

While tuberculosis was a growing concern throughout the city, a number of programs were established to help care for the rising numbers of workers infected with this dreaded disease. As early as 1908, the Visiting Nurses Association partnered with the South Side

¹³ Federated Jewish Charities, “Annual Report,” 1909, Manuscript Collection 87, Jewish Family and Children’s Services, UWM.

¹⁴ George M. Kober and William C. Hanson, eds., *Diseases of Occupation and Vocational Hygiene* (Philadelphia: P. Blakiston’s Son & Co, 1916), 782.

Free Dispensary to care for tuberculosis in Milwaukee, and by 1912, the VNA had inaugurated tuberculosis work in the city in conjunction with the Milwaukee Health Department. The Social Workers of Milwaukee opened a tuberculosis asylum in 1911 at the intersection of Humbolt and Keefe Avenues to care for incipient and convalescent cases in an attempt to help relieve the burden on other hospitals for tuberculosis care and to provide an alternative to Muirdale, the county tuberculosis sanitarium.¹⁵ Education was the real goal and a key to combating this disease. In 1911, the city presented an “ideal plan” for tuberculosis care which included the reporting and registering of existing cases, home treatment of patients by visiting nurses, and a dispensary for “early detection, advice and instruction.”¹⁶ Health department and VNA nurses instructed workers on ways to prevent the spread the disease, on how not to be an agent of infection to others, and on the promotion of good health in the household and community. A 1913 annual report of the health department praised factory owners in the city for their assistance with tuberculosis prevention. Factory owners reported suspicious cases to the health department and allowed the health department to provide speakers over the lunch hour to speak on tuberculosis to workers at the plants. Mr. Alvin Rees, “a very able speaker [,] gave noon-day talks under our [health department] supervision in about 50 factories.”¹⁷ While little is known about Mr. Rees personally, the noontime talks affected those listening as concerned workers and their family members contacted the health

¹⁵ Central Council of Social Agencies, *Directory*, 1920, 42, Mss 220, Central Council of Social Agencies, MCHS.

¹⁶ “Let City Manage Consumption War,” *Evening Wisconsin*, February 14, 1911, Milwaukee Features Microfilm, “Charities,” MCHS.

¹⁷ Health Department, Annual Reports, 1913, Mss 2126, City of Milwaukee Health Department, MCHS.

department shortly after hearing his speeches on the dangers of tuberculosis.¹⁸ The nurses visiting in the factories were not to be outdone by these presentations as they gave out over 10,000 booklets on tuberculosis printed in various languages.¹⁹ The VNA, similarly to the health department as well as other welfare organizations, realized the importance of reaching out in languages other than English, as many of the factory workers were new immigrants. With greater awareness and greater education, perhaps the disease could be eradicated. However, it was of no great surprise that tuberculosis, one of the great winnowers of the nineteenth and twentieth centuries, did not fall from the top five causes of death in the United States until almost the 1930s.²⁰ While education played a key role in helping to limit the numbers infected, it would take the widespread use of antibiotic medicines to finally control the disease.

Alongside concerns over tuberculosis, there was a growing awareness of the dangers of exposures to common irritants. Dust, soot, smoke, asbestos, silicon, heat, humidity, coal dust, and many other substances easily scarred lung tissue and damaged the sensitive tissue making it more susceptible to diseases such as tuberculosis.²¹ Late in the 1920s, there was an awareness that there was “something present in soot which irritates the skin and leads to cancer”²² and that “inhalation of carbon particles and irritating fumes lower the resistance of the nasal mucous membrane, rendering it susceptible to acute and chronic infections.”²³ The health of workers was in serious jeopardy from the quality of air in the workplace and from the city’s general air quality.

¹⁸ Ibid.

¹⁹ Ibid.

²⁰ National Office of Vital Statistics, www.cdc.gov/nchs/default.htm (accessed 02/25/2008).

²¹ Kober and Hanson, eds., *Diseases of Occupation and Vocational Hygiene*, 427-431, 777-788.

²² Health Department, *Annual Report*, 1931, Mss 2126, City of Milwaukee Health Department, MCHS.

²³ Ibid.

A 1902 *Milwaukee Sentinel* article complained about the “deplorable gloom” which had fallen over Milwaukee as a result of industrial and domestic use of bituminous coal (from a shortage of anthracite coal in the city.)²⁴ The heavy pall of particulate matter from smoke in the air had taken a toll on the city’s air quality and appearance, so much so that the reporter noted that it was difficult to discern the location of the sun in the evenings, and the city—heaven forbid—had begun to “resemble some of Chicago.”²⁵ A 1907 Health department reported on the “dust evil” which befell Milwaukee each spring and fall, and which was a “cause of a great deal of sickness and discomfort.”²⁶ In the 1920s, Milwaukee was constantly combating smoke, noxious odors from gas plants, and soot problems in the city. By the 1920s and 1930s, numerous studies had begun to point to the connection of air pollution and increased risk and complications from tuberculosis. In 1931, a Council of the Academy of Medicine Report noted that “air pollution has a definite effect in increasing the incidence and death rate from tuberculosis.”²⁷ While calls for smoke abatement programs were consistently challenged by industry, a growing awareness of the need to improve air quality developed, both inside and outside of the workplace.

Evidence from Milwaukee hospital records supports the link between occupation and respiratory-related illnesses, and the dominance of tuberculosis during this period. The men who entered the County Hospital with lung problems more frequently had

²⁴ Bituminous is a softer coal which produces more particulate matter when it burns. Anthracite, which was increasingly used by industry because it produced higher temperatures when burned, produced comparatively less soot and particulate matter.

²⁵ “Pall of Smoke In Milwaukee,” *Milwaukee Sentinel*, August 19, 1902, Milwaukee Features Microfilm, “Pollution,” MCHS. There were numerous other articles from the early 1900s that detail the noxious air quality in the city. Not only were workers dealing with noxious fumes, vapors, and particulate matter in their factories, but also these same pollutants affected life outside of the workplace.

²⁶ Health Department, *Annual Report*, 1907, Mss 2126, City of Milwaukee Health Department, MCHS.

²⁷ Health Department, *Annual Report*, 1931, Mss 2126, City of Milwaukee Health Department, MCHS.

occupations in the laboring or industrial trades.²⁸ In a study of the County Hospital's Male Patient Registries for the years 1880, 1890, 1900, 1910, 1920, and 1929 over 5,209 respiratory related cases were treated. Of those cases, 1,481 had a probability to be linked to occupational exposure. One quarter to one third of those thousand cases were found in men who self identified as "laborers." Considering this evidence, one can posit the observation that a significant portion of those cases might be related to occupational exposure and respiratory damage in the workplace. Long term exposure to silicon in glass blowing, mercury in various chemical trades, and asbestos in building and manufacturing trades left indelible scars on many individuals. The scarring, however, was not solely located on the patient's lungs as family life and economic stability were often threatened and destroyed by this disease that could debilitate but not necessarily kill.

Teasing out other occupational health problems from the health records can be a challenge, as many seemingly innocuous diseases or incidents can, upon closer inspection, have their roots in the workplace. Cases of mercurial stomatitis, for example, which are mouth sores caused by chronic mercury poisoning, was a disease common among a number of manufacturing trades. Pneumococonis was a condition produced by the inhalation of various dusts and pollutants, common among stonecutters and needle-makers.²⁹ Probably one of the most exotic occupational hazards involved incidents in the 1921 and 1923 Emergency Hospital reports. Once in 1921 and twice in 1923, individuals

²⁸ Milwaukee County Hospital Male Patient Registry, Mss 723, Milwaukee County Institutions and Departments, MCHS; Johnston Emergency Hospital, Annual Reports, Records, Mss 723, Milwaukee County Institutions and Departments MCHS.

²⁹ Kober and Hanson, 224-229.

reported to the Emergency Hospital with tarantula spider bites.³⁰ On the surface one might wonder how anyone in the early 1920's came across a tarantula in the city of Milwaukee. The solution most likely lies with Italian grocers in the Third Ward. Even today, it is not uncommon for boxes of bananas coming from Central and South America to arrive in grocery stores with small hairy travelers. One can imagine a grocer in 1917 reaching into a box of bananas to put them on display for customers and being shocked by a sharp bite on the hand from an equally frightened spider.

Another of the more exotic, or perhaps unusual, occupational hazards which working men in Milwaukee had to face was Caisson disease or decompression sickness.³¹ Caisson disease started making an appearance in Milwaukee's health statistics as early as 1910 when the Vital Statistics Office of the City of Milwaukee noted three cases.³² The Emergency Hospital saw two cases in 1914, ten cases in 1916, and only one case in 1917. Caisson disease occurred when workers emerged from a pressurized environment. Nitrogen gas, usually dissolved in the body's fluids and tissues, comes out of solution to form nitrogen bubbles in the body as the workers return to normal pressure environments. The bubbles cause disorientation, shortness of breath, severe pain (hence its nickname of "the bends"), and possibly death. The link between a disease commonly associated with

³⁰ Johnston Emergency Hospital, Annual Reports, Mss 723, Milwaukee County Institutions and Departments, MCHS. Sadly all the records we have for the Emergency Hospital are annual reports, which do not provide us with any further demographic data on the patients outside of sex. The more detailed records were destroyed by the Milwaukee Health Department in the mid-1990s as part of their records deaccessioning.

³¹ The disease is named after the caisson workers, in whom this disease was originally identified. They worked in the construction of tunnels in England and United States. These workers worked in compressed air-filled tunnels to keep water and mud out of the construction areas, and needed to be decompressed to sea level upon emerging from the tunnels.

³² Vital Statistics, Statistical Tables, City of Milwaukee Vital Statistics Office. The statistics and data from the City of Milwaukee Vital Statistics Office were kept in binders on the shelves of the department office; they are not part of any cataloged or established collection.

diving and deep sea exploration and early twentieth century Milwaukee was quite puzzling at first. The trail, however, led to the water's edge and a mile out from Milwaukee's shores. The health department noted in its 1916 annual report that their division of sanitation had examined twenty employees of the Sewage Commission for compressed air work, a strong suggestion of some undertaking by the Sewage commission and a possible clue to these cases.³³ While there was not any sort of deep water exploration occurring in Lake Michigan or sport diving in the early 1910's, the city was preoccupied with supplying the city with fresh, clean water. To accomplish this task, the city's sewage commission was involved in constructing a number of water intake tunnels, some over a mile in length, into Lake Michigan.³⁴ The pressurized tunnels, while preventing water from entering the tunnels, also proved to be a hazard for working men. Working for extended periods under highly pressurized conditions or having to emerge from the tunnels too quickly (as in emergency situations) could easily produce the effects of Caisson disease. While these men themselves did not write about their experiences of working in the tunnels, the notations by hospital staff prove to be a valuable insight into not only Milwaukee's growth but also its concern for better health. The water intakes, which proved essential for Milwaukee to achieve a better health standard, came at a cost for those who performed the dangerous task of making that fresh water possible.

Workplace accidents were also a serious concern for city health officials. The health department records from 1905-1907 filled thirteen ledger books with accidents

³³ Milwaukee Health Department, *Annual Report*, 1916, Mss 2126, City of Milwaukee Health Department, MCHS.

³⁴ "City Water Responsible for Typhoid," n.d., Milwaukee Manuscript Collection AS, Box 3, "Public Health Committee, Minutes and Report, 1914-1917, City Club Collection, UWM.

reported in the city limits, including work, traffic, or home-based incidents.³⁵ While the ledgers were only maintained for a few years, a telling portrait of working conditions and workplace mishaps became clear. Workers as young as 14 and as old as their late 60s attempted to dodge flying bottles, boiling tar, runaway train cars, machine punch presses, ill-tempered horses, and molten iron in their day to day life on the job. A sample of over 600 cases from the ledgers demonstrates the hazards of the work environment in the city during these three years.³⁶ Of the 605 cases in the sample, remarkably only nineteen of the cases were listed as fatal accidents. Most likely the actual numbers of fatalities were higher, as a number of those listed as “serious” might have eventually ended up as fatal. Of the nineteen fatalities, eight of those involved workers on the various railroads in the city. The rest of the fatalities are a mix of ship based-fatalities, gas asphyxiation, traffic accidents, and one failed jackscrew that caused a building to collapse.³⁷

As for the rest of the 586 non-fatal cases, they represent a wide range of accidents, levels of severity, and industries. The types of accidents can be classed into a number of general categories: fractures, amputations, burns, contusions, lacerations, and crushing accidents. Many of the non-fatal cases are simply examples of a workplace devoid of safety devices or safeguards. Numerous hands were caught in machine presses, thumbs became caught in saws, and burns resulted from red-hot rivets. These injuries along with crushed and mangled extremities speak volumes to the dangerous jobs workers were willing to undertake for a living wage. Milwaukee’s most prominent

³⁵ Milwaukee Health Department, “Accident Ledgers,” Mss. 2126, Milwaukee Health Department, MCHS.

³⁶ While three years comprised over thirteen volumes, I chose three volumes from each of the years to try to glean some generalized picture of the occupational hazards that faced Milwaukee’s workers during these three years that the ledgers were kept. The ledgers did not have any discernable rhyme or reason, as incidents were not entered chronologically throughout the year, but seemingly in batches from different companies. One also encountered duplicate reports of the same incident.

³⁷ Ibid.

employers were often represented in these accident reports: Pfister and Vogel, Schlitz Brewing Company, Pabst Brewing Company, Allis Chalmers, Bucyrus, and Falk to name a few. While it might suggest that working conditions at some of these companies were not the safest, this must be tempered with the knowledge that not all workers were knowledgeable or skilled at their jobs. Numerous individuals had multiple entries into the ledger, sometimes only days apart with similar injuries.³⁸

In addition to the health department's accident ledgers, the medical examiner regularly kept track of industrial accidents in Milwaukee. From 1921 until 1930, railroad accidents were singled out as a specific category of note. Working in the rail yards was an especially dangerous trade. Brakemen hand-braked train cars; rail workers were constantly in danger of falling between moving cars; and the loading and unloading of cargo meant that a constant vigilance was required around the yards. Brakemen were especially prone to work related fatalities as many an unfortunate worker was crushed in between cars or lost his grip and was crushed beneath moving cars. From 1921 to 1930, the Milwaukee medical examiner reported over sixty-eight deaths of railroad employees, with the peak number of fatalities (12) occurring in 1922.³⁹

Job fatalities were a fact of life for the men who worked in dangerous occupations as well as a constant fear for their families and dependants. Loss of the household breadwinner could be devastating for families, immigrant and native born. But for most, it was a risk they were willing to take in an effort to provide a better life for themselves or for their families. Foundry workers, sailors, teamsters, and especially railroad workers were frequently those for whom the dream of economic opportunity held the greatest

³⁸ Ibid.

³⁹ Milwaukee Medical Examiner, Annual Reports, Mss 186, Milwaukee Medical Examiner, MCHS.

promise, but also the greatest tragedy. Cooperation among city health officials, factory owners, and workers was seemingly the only way to ensure better industrial health in the city. In 1921, James H. Williamson, assistant manager of the Milwaukee Association of Commerce wrote to Thomas Duncan, secretary to Mayor Daniel Hoan, noting of the progress of industrial safety in the city, especially with the growth of “a great inter-shop organization of men interested in safety who have done much to promote the ‘spirit of safety.’” Without that spirit of cooperation, Williamson believed that any progress in Milwaukee’s industrial health was doomed to failure.⁴⁰

While working conditions were certainly difficult, laborers who had a poor grasp of English were dangerous in the workplace. Not understanding commands being given to them or an inability to read safety signs could have tragic results.⁴¹ Likewise, unskilled laborers attempting to do skilled jobs were just as dangerous as they lacked the experience and knowledge to handle what was often dangerous, fast moving equipment. These human elements of the workplace could be as hazardous as any dangerous work environment. Whatever the case, the accident reports are clear evidence that the industrial prosperity of Milwaukee came at a physical cost to many workers.⁴² For many of these men, the promise of economic opportunity, a better life, and the golden “American Dream” was tied to sickness, injury, and tragedy.

⁴⁰ Letter from James H. Williamson to Thomas Duncan, June 29, 1921, Mss 546, Box 30, “Safety Commission, 1916-1921,” Daniel W. Hoan Collection, MCHS.

⁴¹ Gerd Korman, “Americanization at the Factory Gate,” *Industrial and Labor Relations Review* 18 (1965): 396-419.

⁴² Milwaukee Health Department, “Accident Ledgers.”

City Life

Along with occupational health, concerns over the effects of city life dominated health concerns for men in Milwaukee. Male workers in the city, be they clerks in City Hall or tanners at Pfister and Vogel, were vulnerable to the effects of city life on both their physical and moral health. The city was a complex entity, both welcoming and seductive, cold and unfeeling. It could offer the greatest promise and the greatest despair, and few could predict its temperaments. Every citizen, but especially men, were seen as more morally susceptible to the temptations and demons that the city produced: alcohol, drugs, violence, mental illness, and sexual license.⁴³

The city in American history has always held a complex role in the formation of American culture. While Thomas Jefferson would see the American ideal in the yeoman farmer and Frederick Jackson Turner would see the frontier as the defining element in American society, for many others the urban landscape of late nineteenth and early twentieth century America was the real showcase of America's identity.⁴⁴ The city, especially the cross-century city, represented all that was dynamic and progressive in America during this period. Growing skyward, ruled by industry, and dominated by new forms of transportation, the city of the late nineteenth and early twentieth centuries thrived as new peoples flooded America's shores. The great influx of "new immigrants" from Southern and Eastern Europe helped ensure that the cattle were slaughtered, the

⁴³ Rev. J. Watts Lethbridge, *Woman: The Glory of the Man* (London: Thomas Richardson and Son, 1856), 85-86.

⁴⁴ For further reading, see Louis Wirth, "Urbanism as a Way of Life," in Richard Sennett, ed., *Classic Essays on the Culture of Cities* (Englewood Cliffs, NJ: Prentice Hall, 1969); Carl Abbot, "Thinking About Cities: The Central Tradition in U.S. Urban History," *Journal of Urban History* 22 (September 1996): 686-701; and Sam Bass Warner, *The Urban Wilderness, A History of the American City* (New York: Harper and Row, 1972).

machine presses ran smoothly, and the textile industry responded to customer demand. Migrations of African Americans in search of better paying industrial jobs also added to the growing diversity in urban areas, although the largest influx of African Americans into Milwaukee would not occur until after World War II. The economic pull in the Brew City was a strong enough to bring black rural southerners far away from the family, work experiences, and climates with which they were familiar. The pull of the industrialized city was an attractive magnet to many, be they from rural Wisconsin, the rural south, or from across the ocean. The adaptation, or attempted adaptation, to urban life, especially for the many men who would come to work in Milwaukee's expanding industry, would be trying to both body and mind. Milwaukee's promise of prosperity was no different than other industrializing cities of the period: full of the dreams of new immigrants, of the hopes of powerful burgeoning industrialists and the promise of economic potential. Unfortunately the ideal of the city was a promise easily and swiftly broken.

Alcohol, Violence, and Drugs

The siren song of alcohol and drugs figured strongly into the sphere of the urban male. Coupled with these two temptations, the violent aspects of city life were never far behind. Many men who sought out Milwaukee for work came a long way from the normalized and regulated life of the family or old world village. Social and cultural mechanisms that kept various vices such as gambling, drinking, or "loose" women in check in small towns or peasant villages were not present in the city. Milwaukee would at various times during its history try to control vice, but the controls that were implemented were not the same as traditional small town methods of modifying behavior. Some men,

far from what they knew as home and without close contacts or relatives, found themselves sinking into a world of crime filled with violence, drugs, illicit sexual activity, and alcohol.

County Hospital, the Johnston Emergency Hospital, and the House of Corrections as well as the county dispensary saw large numbers of primarily men admitted for treatment with alcohol related problems. Alcoholism, delirium tremens (tremors which afflict detoxing or drying alcoholics), cirrhosis of the liver, and various forms of alcohol poisoning accounted for hundreds of admissions to the hospitals each year; these maladies were also a large treatment concern for the House of Corrections. Figure 17 provides numbers of cases of alcohol related admissions to the County Hospital as well as the Johnston Emergency Hospital. In examining the numbers, there is a growing, albeit unsteady, number of admissions. Alcohol related admissions would form one of the largest single blocks of medical admissions, making up between twenty-five and 30 percent of admissions for any given year. Some of this variability stems from reporting by health officials as well as general variance of people's encounter with alcoholism. Some of the higher numbers in the 1920s are easily attributable to black market alcohol during Prohibition; many of the cases admitted during these years are for alcohol poisoning. The passage of the Eighteenth Amendment that prohibited the sale, manufacturing, or transportation of alcohol did little to slow the numbers seeking help for alcohol related problems. In fact, it only seemed to increase numbers, especially those seeking treatment because of the questionable quality of much of the unregulated alcohol produced during this period.

1906	21
1908	88
1909	23
1910	254
1914	412
1915	502
1916	503
1917	180
1918	228
1919	84
1921	439
1922	492
1923	548
1924	470
1925	532
1926	162
1927	263
1928	385
1929	426

Figure 17: Alcohol Related Cases at the County Hospital and Johnston Emergency Hospital⁴⁵

The chronic alcoholic was a familiar sight in many reports as well as many hospital records. The Milwaukee County Infirmity became in time the old age home for the county. It saw many individuals who were life-long and chronic alcoholics carrying police arrest reports pages long. Many individuals were actually banned from the county facilities for their chronic drunkenness and violent behavior when drinking.⁴⁶ Alcohol, however, offered an outlet and a consolation for many men as they sought some escape

⁴⁵ Johnston Emergency Hospital, Annual Reports, Mss 723, Milwaukee County Institutions and Departments, MCHS; Milwaukee County Hospital, Annual Reports, Mss 723, Milwaukee County Institutions and Departments, MCHS. The figures are the combined totals from both the Milwaukee County Hospital and the Johnston Emergency Hospital. Years missing in the chart reflect a lack of annual reports for those particular years.

⁴⁶ Milwaukee County Almshouse, Patient Records, Mss 723, Milwaukee County Almshouse, Milwaukee County Hospitals and Institutions, As I processed these records for the County Historical Society, I had the privilege of first hand glimpses into the life of chronic alcoholics who became wards of the county.

from the loneliness of city life, the frustrations of home life, or the pain of life in general. The alcohol numbed the senses, warmed the body, and blurred the memories.

James Marten details this alcoholic lifestyle, not among Milwaukee's immigrants, but among her war veterans. In "Nomads in Blue: Disabled Veterans and Alcohol at the National Home," Marten details the struggle which returning war veterans faced with the demon of alcohol and the troubles which the National Home faced in trying to manage these men. The convenience of available drink, the desire to forget the horrors of war, and the physical and social deterioration that came with age made alcohol an easy solution to complex problems. Similar to what is seen in the larger population, the hospital records of the National Home noted that alcohol factored into 14 percent of all cases of disease or injury that occurred. Drinking also exacerbated existing physical and psychological problems, including complications with heart disease, digestive problems, depression, anger issues, and even dementia.⁴⁷ The population at the National Home provides another example of the detrimental impact of alcohol on men who were isolated outside of conventional social settings and relationships.

The alcoholic lifestyle was a dangerous and narrow line for men to walk. Initially one had to worry about the alcohol itself. In an age of adulterated food products, alcohol was not exempt from "doctoring," whether it was watered down or mixed with "fillers" (be that formaldehyde or grain alcohol) to make it go further. There was a great uncertainty every time a man ordered a drink in a less-than-reputable-establishment.⁴⁸ Secondly, in a day and age where it was not only permissible, but even common to drink

⁴⁷ James Marten, "Nomads in Blue: Disabled Veterans and Alcohol at the National Home," in David E. Gerber, ed., *Disabled Veterans in History* (Ann Arbor, MI: University of Michigan Press, 2000), 280.

⁴⁸ Jacob Riis, *How the Other Half Lives* (New York: Charles Scribner's Sons, 1890), 74-76.

on the job, alcohol further added to the dangers of the workplace. When a large portion of the city's workforce were employed by companies that regularly gave them free or cheap beer, the dangers of drinking on the job became even more apparent.⁴⁹ For jobs that demanded split second reactions, be it in the bottle houses of the Pabst Brewery or the tanning vats of Pfister and Vogel, being inebriated to any extent could mean the difference between life and death. For the chronic drinker, one beer at lunch was not the last one of the day. Moreover, men typically "cashed" their paychecks at the local saloon on the way home from work. Here, in this male social world dominated by drink, alcohol-influenced violence reared its head.

Violent behavior was frequently exaggerated with increasing alcohol consumption. While alcohol consumption did not necessitate violent behavior, it often contributed to escalations in conflicts. Coroner's reports frequently focused upon stories of blunt force trauma or violent deaths that had started in taverns, pool halls, or other dives.⁵⁰ Alcohol often led men deeper into the violence of city life and crime. Violent crime, suicide, infanticide, and sexual assault permeate the pages of newspapers, official reports, and even medical records. The Johnston Emergency Hospital as well as the county hospital consistently saw men suffering gunshot wounds, stabbings, broken bones, and even human bites entering their doors.⁵¹ Figure 18 presents the cases of male gunshot and stabbing victims who were treated at both the County Hospital and the Johnston Emergency Hospital. True to the American love of firearms, shootings

⁴⁹ John Gurda, *The Making of Milwaukee* (Milwaukee: Milwaukee County Historical Society, 1999), 148.

⁵⁰ Milwaukee County Coroner's Office, Annual Reports, Mss 2076, Milwaukee County Coroner's Office, MCHS.

⁵¹ While one expects gunshot wounds, stabbings, and even broken bones in bar fights and altercations, human bites were less anticipated.

outweighed stabbing cases, in all years but two (1927 and 1928) when they were tied in number.

	1908	1909	1910	1914	1915	1916	1918	1921	1922	1923	1924	1925	1926	1927	1928	1929
Gunshot Wounds	12	26	36	34	32	41	29	31	34	32	47 ⁵²	9	20	10	10	51
Stab Wounds	17	23	24	20	23	33	25	22	2	2		4	5	10	10	34

Figure 18: Gunshot and Stab Wound Cases at the Milwaukee County Hospital and the Johnston Emergency Hospital⁵³

The Milwaukee County Pauper's Cemetery bears out the facts of this violent male lifestyle as numerous unclaimed, unidentified men were the victims of bar brawls, robberies, street fights, random shootings, and stabbings. The detailed notes of the medical examiner recorded placement of bullet wounds on a body, a pool cue's impact on a skull, or the method of poison in a murder case. While Milwaukee was not quite the gun slinging "Old West," the right combination of alcohol, bad temper, and troubled people could quickly develop into a bar brawl or a case of domestic violence. Nathan Albright died on July 4, 1908 in a bar brawl when he was repeatedly hit over the head with a wooden plank causing fractures to his skull and extensive brain trauma. Charles Daley met a similar end two years later in November 1910 when he was killed by blows

⁵² Stab and Gunshot wounds combined during this year of reporting.

⁵³ Johnston Emergency Hospital, Annual Reports, Mss 723, Milwaukee County Institutions and Departments, MCHS; Milwaukee County Hospital, Annual Reports, Mss 723, Milwaukee County Institutions and Departments, MCHS. The figures are the combined totals from both the Milwaukee County Hospital and the Johnston Emergency Hospital. Years missing in the chart reflect a lack of annual reports for those particular years.

to the face during a bar fight. Charles Daley, however, had seen trouble before; the coroner noted that outside of numerous old, healed fractures, Charles Daley was also missing his right eye from some sort of traumatic injury in the past. A stabbing in 1911 left “unknown man #52” unclaimed in the county morgue and Emil Mittelstadt in 1929 found his way to a pauper’s grave from homicide by arsenic poisoning.⁵⁴ Although Milwaukee did not have the dangerous reputation of other large cities, it still presented the reality of what urban America was like a hundred years ago. A society under dramatic change with a population in constant flux and a social system attempting to maintain the moral order will manifest the evidence of the turmoil beneath the surface. For some, the city was a prosperous dream that came true; for others, it was all too quickly tarnished by violence, alcoholism, and drug use.

Drug use, while not as common as in the modern world, was still a prominent concern for Milwaukee health officials. The two prominent forms of drug addiction in the late nineteenth and early twentieth centuries were morphine (and other opiates) and cocaine. While the numbers may have been small compared to modern estimates of those addicted to controlled substances, they were a regular enough occurrence to stimulate a growing discussion (and a growing business) around treating addiction. By 1913, a number of the German newspapers in the city were concerned over the growing cocaine trade in the city.⁵⁵ While the figures below do not suggest a rampant drug problem, the steady numbers of individuals admitted to the hospitals for drug related issues suggest a continuing problem. Those admitted for drug problems were most likely extreme cases

⁵⁴ Register of Burial, Milwaukee County Poor Farm, personal collection.

⁵⁵ “Anwolte in Streit greaten,” uncited newspaper, March 21, 1913; “Die Königin der kokainsüchtigen,” uncited newspaper, March 1913, and “Kokain und kein Ende.” uncited newspaper, March 11, 1913, Milwaukee Features Microfilm, MCHS.

because drug abuse similar to alcoholism was a habit that carried deep feelings of shame and was secretive in nature. Problems of alcohol and drug addiction, more than most others, would have been highly underreported because of the social disgrace that might come with the admittance of this sort of problem. Figure 19 presents the cases of drug treatment that were seen at the County Hospital and the Johnston Emergency Hospital. Morphine and cocaine were the preferred drugs of those seeking treatment, but the hospitals also saw cases of opium, heroin, ether, chloroform, and laudanum addiction.

The National Soldier's Home once again provides an example of substance abuse in the larger population. While some veterans drank because it provided pain relief, others were addicted to much stronger painkillers by the time of their admittance. James Marten notes that "physicians prescribed countless medicines containing opium and morphine derivatives."⁵⁶ Morphine and laudanum were the common opiates of the day and cut across class as well as gender lines to become a significant problem in the early twentieth century. Milwaukee's emergency hospital and county hospital as well as the Soldiers' Home faced the difficulty of attempting to minister to the health needs of these men, but at the same time not aiding and abetting their alcohol or drug problems.

⁵⁶ Marten, 280.

1906	1	1921	38
1908	5	1922	27
1909	7	1923	6
1910	6	1924	15
1914	10	1925	15
1915	9	1926	10
1916	7	1927	13
1917	10	1928	7
1918	15	1929	5
1919	2		

Figure 19: Drug Habit Cases at the Milwaukee County Hospital and Johnston Emergency Hospital⁵⁷

Both drug and alcohol abuse issues proved difficult vices to combat. The city struggled to provide any sort of cohesive care for those suffering from these addictions. A 1927 letter from John P. Koehler, the Commissioner of Health for the City of Milwaukee, to Mayor Daniel Hoan warned that medical services for such addicts presented itself as a complicated and delicate problem. Koehler struggled with the lack of drug treatment facilities in the city and suggested that Milwaukee County was “much better equipped to handle drug addicts than the city could ever hope to be” as the county had at its disposal for the treatment of drug addicts the county jail, the House of Corrections, the county hospital, and the Hospital for Mental Disease.⁵⁸ The health commissioner was reluctant to allow extensive care at the Johnston Emergency Hospital as drug treatment was not considered “emergency” treatment and noted that the city had no institution solely devoted for drug treatment. Already caught in budget struggles

⁵⁷ Milwaukee County Hospital, Annual Reports; Johnston Emergency Hospital Reports, Annual Reports, Mss 723, Milwaukee County Institutions and Departments, MCHS.

⁵⁸ Letter from John P. Koehler to Mayor Daniel Hoan, April 17, 1927, Mss 546, Box 18, “Health Department, 1926-1929,” Daniel W. Hoan Collection, MCHS.

between the county and the state, the creation of a hospital whose sole purpose was to treat drug and alcohol addicts would have been too expensive to build or maintain for any length of time. While Koehler would have rather seen drug addicts given over to the county or state for treatment, the political jockeying between the county and city frequently left patients with no clear course of action. Funding and power sharing issues between the city of Milwaukee and the county stymied medical treatment for much of the first half the twentieth century. Private institutions increasingly bore the case load of drug and alcohol cases.

One solution to this lack of city involvement was the establishment of private “institutes” and hospitals that were established to care for those with addiction problems. Few other institutions, even public ones, were capable of managing the detoxing alcoholic or drug addict. Men were frequently relegated to mental institutions in the public system that saw addiction as a mental illness, not a physical one. As alcoholism was understood to be a psychological, even a moral deficiency and not understood to be a medical condition, there was significant debate on how to handle and treat this condition.⁵⁹ Private institutions offered new “cures” for those wishing to overcome their addictions. While some of the “cures” were as addictive as what they were trying to cure and others were quack medicines preying on false hopes, a few made dramatic attempts to cure both the mind and body of the troubled patient.

As an example, the Keeley Institute was established in Milwaukee in 1891. Newspaper accounts from that year note that it was “now definitely settled that Milwaukee is to have a sanitarium institute for the cure of drunkenness under the Keeley

⁵⁹ American Association for the Study and Cure of Inebriety, *The Disease of Inebriety* (New York: E.B. Treat Publishers, 1893).

system⁶⁰ Dr. Leslie Keeley, the founder of the nationwide institutes, came to believe that instead of alcoholism being a moral problem, it was a physiological problem, a matter for doctors, not necessarily for God. The Keeley cure consisted of an injection of gold chloride (or bichloride depending on the account) to the institutionalized patients and a gradual tapering off of the alcohol they were allowed to drink. In conjunction with the injections, patients also drank a “health tonic” whose ingredients were a closely guarded secret. In addition to the medicinal aspect of the treatment, the Keeley system also encouraged group therapy and community involvement as a way of reintegrating the alcoholic into the larger environment and helping to keep them sober with “honest” work.⁶¹

While the “gold cure” was discredited in its day as patients frequently relapsed, it did not prevent other private institutions from springing up to minister to a growing clientele. A 1902 advertisement in the Milwaukee Business Directory promoted the “Darby-Nugent Institute,” located across the street from the public library.⁶² Similar to the Keeley Institute, the Darby Nugent Institute sought to treat liquor and drug habits, in this case using “nurses [with] special training for this particular work...and electro, vapor and steam baths.”⁶³ It maintained, however, that it had the “most modern, scientific, and safe treatment . . . not a ‘Gold Cure’.”⁶⁴ Already a number of the institutions were attempting to distinguish themselves as “scientific and modern” as opposed to what some saw as little more than quack medicine. In 1937, the *Wisconsin Medical Journal* ran an

⁶⁰ “Local Keeley Institute” November 5, 1891, uncited newspaper, Milwaukee Features Microfilm, “Drugs,” MCHS.

⁶¹ Ibid.

⁶² Milwaukee Business Directory, “Advertisement for the Darby Nugent Institute,” (1902), 1379, Directory Collection, Mss 488, Milwaukee Business Directory, MCHS.

⁶³ Ibid.

⁶⁴ Ibid.

advertisement for the Shorewood Hospital/Sanitarium which was established for the treatment of “nervous and allied disorders, alcohol and drug addictions.”⁶⁵ Private institutions relied on their assurances of quick cures, confidentiality, and comfortable surroundings to attract their cliental. Institutions, like the Shorewood Hospital, treated what they saw as the three main problems in male health: nerves, drugs, and alcohol. While not affordable to most working class Milwaukeeans, they provided some focused treatment in an otherwise empty medical niche.

Venereal Disease

For reformers, along with alcohol and drugs, venereal disease became the focus for both a moral and medical crusade. While illicit sexual behavior had long been socially stigmatized, by the early twentieth century medical concerns had begun to grow about how American sexual behaviors affected the physical health of individuals and communities. Venereal disease became a preoccupation of health departments and citizens alike in the first two decades of the new century. Advances in medical diagnostics and the growing awareness of the prevalence of venereal disease in the American population, especially among young men, caused a significant stir throughout society.⁶⁶ Milwaukee, no differently than other cities, increasingly struggled with ways to detect, treat, and manage those infected with venereal disease on both a medical and a moral level.

⁶⁵ “Shorewood Hospital/Sanitarium,” Advertisement, *Wisconsin Medical Journal*, 36 (October 1937): 810.

⁶⁶ Allan M. Brandt, *No Magic Bullet: A Social History of Venereal Disease in the United States Since 1880* (New York: Oxford University Press, 1987), 13-23.

By the late 1910s, Milwaukee County Hospital and the city health department had implemented a more reliable test to detect both syphilis and gonorrhea, the two most common and most devastating venereal diseases of this period. Examining the annual reports from the Emergency Hospital and the County hospital during this period, one notices a spike of reported cases of both diseases as well as associated conditions and ailments. The Emergency Hospital's venereal cases (Figure 20) were fewer and more sporadic than the County Hospital, owing to the stated mission of the Emergency Hospital itself. The hospital was meant to treat accidents, traumas, and emergency cases; venereal diseases rarely fell into those classifications. This is also the reason behind some years having no reported cases, as these male patients were most likely diverted to other institutions for care. Figure 21 illustrates the caseload from the County Hospital, where numbers of venereal cases more consistent and greater in number. While the Emergency Hospital saw dozens of cases, the County Hospital saw hundreds of men seeking treatment for venereal diseases. The one other medical institution that was recording and treating cases, outside of the health department, was the County Dispensary. Unfortunately, while the Dispensary's annual reports note the hundreds of venereal cases they treated, as well as Wasserman tests that were being performed (to detect syphilis), they do not break down the data along gender lines.

Along with syphilis and gonorrhea, references to locomotor ataxia (the shuffling gait which was associated with lesions on the spinal column and a growing loss of motor control resulting from syphilis), tabes dorsalis (degeneration of nerve endings in the spinal column and brain associated with syphilis), orchitis (inflammation and infection of the testicles, sometimes associated with gonorrheal infection), lues (another name for

syphilis), chancroids/chancres (a sore or ulcer usually of a syphilitic nature), and rheumatism (early onset was frequently a symptom of gonorrheal infection), all referred to venereal disease infections.⁶⁷ Hospitals were not only treating the full-blown cases of syphilis and gonorrhea, but also the associated conditions of those diseases.

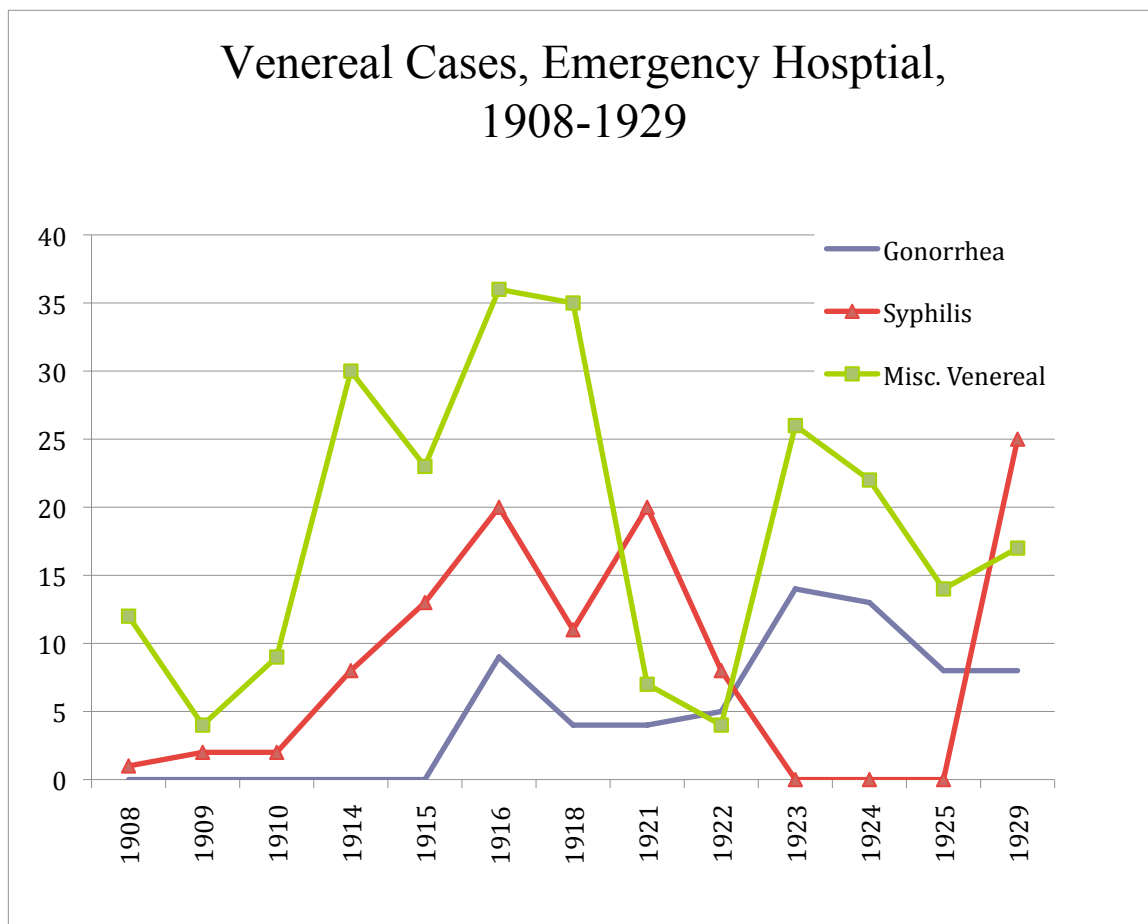


Figure 20: Venereal Cases, Emergency Hospital, 1908-1929

⁶⁷ James R. Hayden, *Venereal Disease: A Manual for Students and Practitioners*, 3rd ed. (Philadelphia: Lea Brother and Company, 1901).

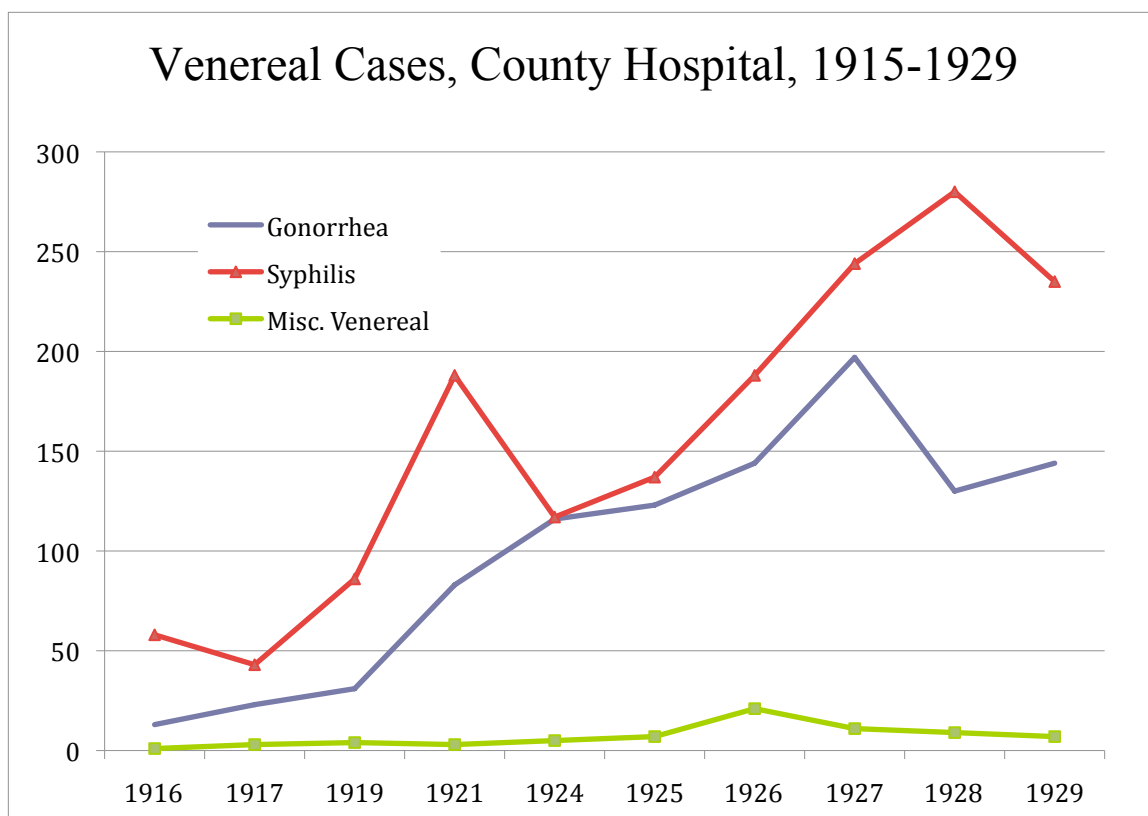


Figure 21: Venereal Cases, County Hospital, 1915-1929

For those infected, the access to treatment was a significant factor in who was ultimately cured. Shame, embarrassment, fear, and even poverty led many who were infected to seek treatment from less than reputable sources and non-traditional healers. Dispensers of street medicines attempted to capitalize on these issues and soon found that the “treatment” of venereal diseases was a lucrative business.⁶⁸ Quack medicines and “quick cures” were a popular and profitable venture of the day. A certain “Dr. LaVine,” previously mentioned, frequently advertised in variety of periodicals, including the

⁶⁸ I have put “treatment” in quotes as most of these “cures” were nothing of the sort. Some were simply harmless tonics and alcohol concoctions; others were much more deadly mixtures with arsenic and mercury in unregulated form.

“Sporting and Club House Guide”⁶⁹ regarding the efficacy of his “positive cure.” Just as he promised quick cures for women, he also targeted a male audience promising that “any case of syphilis cured in three months. Any case of Gonorrhoea [sic] cured in four days.”⁷⁰ By using Dr. Levine’s cure, men were promised they could not catch any venereal disease, that is was harmless and easy to use, and that one package would be enough for an entire year’s worth of treatments.⁷¹ Individuals easily fell victim to the schemes and tricks of these snake oil salesmen by not wanting to expose themselves to public condemnation or scrutiny. Instead they sought out quick cures with the hopes of restoring their health in the most discreet way possible. In the growing public health campaign to combat both syphilis and gonorrhoea, health officials struggled with moral and shame factors in attempting to coax ill patients in for treatment. Likewise, considering the medically approved treatments involved painful regimes of arsenic and mercury based cures, one can understand why a person might seek these alternative, albeit quack, treatments⁷².

Most syphilis as well as gonorrhoeal treatments prior to the discovery and use of modern antibiotics in 1928 were ineffective at best. The two most common compounds, which formed the basis for the majority of venereal treatments, had their roots in either mercury or arsenic based compounds. They could be topically applied, taken as oral

⁶⁹ Sporting and Club House Guides were guides to the brothels and houses of “ill fame” in a particular city. They detailed the locations, specific attractions, and even which particular “ladies” one should inquire about at each of the establishments. In addition they were also filled with advertisements for the latest cures for syphilis, gonorrhoea, and any sort of “female complaints.”

⁷⁰ *Sporting and Club House Guide to Milwaukee*, Mss 1384, MCHS.

⁷¹ *Ibid.*

⁷² Alfred Fournier, *The Treatment and Prophylaxis of Syphilis*, trans., C.F. Marshall (New York: Rebman Company, 1907).

tablets, or, most unpleasantly, injected directly into the urethra.⁷³ While these treatments seemed to help relieve some of the symptoms and moderate the course of the disease, they did not cure the illness and frequently made those undergoing treatment sicker from the side effects. Considering the large doses of mercury and arsenic patients were ingesting, it was not uncommon for patients to lose their hair and teeth, and even suffer hemorrhages of the bowel. Malaria was also used to treat syphilis and was found to be somewhat successful in combating the illness. Some patients who developed high fevers were cured of the syphilitic infection. Physicians began to purposely infect patients with malaria in order to produce prolonged fevers in the hopes of killing off the syphilitic infection. Malaria infections were more easily managed than syphilitic ones and could be eliminated with doses of quinine.⁷⁴

The reluctance of patients to seek legitimate treatment, be it from fear of the side effects of approved medical treatments or the shame over their condition, led to serious and often irreversible advancements in their conditions. Not completing a course of treatment potentially created drug resistant strains of these diseases and frequently left patients in debilitated states as a consequence of both the treatment and the disease. Also, the general reluctance for, and in some cases illegality of, “straight” talk about sexuality and venereal disease left many in the public with fear and misinformation. Comstock laws, which forbid the mailing of any materials deemed “indecent” (including material related to sexual health), stymied health care providers in their attempts to correctly

⁷³ Brandt, 12.

⁷⁴ Kevin Brown, *The Pox: The Life and Near Death of a Very Social Disease* (Stroud: W. Sutton: 2006), 85-111.

educate their patients and the public. An even greater problem was that patients also faced the challenge of finding the proper place to seek treatment.

Most hospitals refused admission of venereal disease cases fearing a larger contamination of their other “healthy” patients.⁷⁵ While it was understood that diseases such as syphilis and gonorrhea were transmitted sexually, there was little clear knowledge about other modes of transmission.⁷⁶ Men infected with syphilis were of course cautioned against sexual intercourse with their wives unless permitted by a physician after the danger of transmission had passed. These men were also to “avoid kissing and should use only his own brushes, pipes, razors, towels, etc., and not let others use them without scalding.”⁷⁷ The fear of casual transmission of these diseases preoccupied the minds of health officials as well as the general public. As numbers of detected cases grew, much of it due to better reporting systems, the city realized that steps needed to be taken in order to treat those active cases in the city, control any further spread of the diseases, and educate the public regarding the dangers of these venereal diseases. Increasingly, it fell to the city dispensary and health department along with the county hospital to treat these cases because few other hospitals or clinics would admit them. By 1926, the health department was overwhelmed, noting in its annual reports from that year that there was “continually more gonorrhea and syphilis prevalent in

⁷⁵ Within the rules and regulations of St. Mary’s, Passavant, Deaconess, St. Joseph’s, and Mt. Sinai hospitals were clear stipulations that they did not accept venereal disease cases and were in their rights to terminate care for anyone who was deemed to have a venereal disease. See, Milwaukee Hospital, Annual Reports, 1907-1916, Box 37, Manuscript Collection 108, Sinai Samaritan Medical Center Collection, UWM; and St. Mary’s, Annual Reports, Milwaukee Micro Collection 17, St. Mary’s Hospital Records, UWM.

⁷⁶ Lynn Sacco, “Sanitized for Your Protection, Medical Discourse and the Denial of Incest, in the United States, 1890-1940,” *Journal of Women’s History* 14, n. 3 (2002): 85.

⁷⁷ “Manpower,” (Madison, WI: Wisconsin State Board of Health, 1919), 9, Mss 546, Daniel W. Hoan Collection, Box 12, “Pamphlets-Health,” MCHS.

Milwaukee than all of the other contagious diseases combined.”⁷⁸ The City Club of Milwaukee in 1920 noted that venereal disease was of “greater importance than the tuberculosis problem.”⁷⁹ A growing concern was also echoed that the numbers of those infected with venereal diseases would continue to rise unless the health department was able to isolate and essentially quarantine those who were ill.⁸⁰

This idea of isolation, control, and quarantine of venereal diseases also filtered into the law enforcement agencies of Milwaukee as they also attempted to combat venereal disease in the House of Corrections as well as in the county and city jails. John P. Koehler, who was health commissioner from 1924 to 1940, emphatically wrote that he believed “that every effort should be made to have laws passed . . . [to] make it possible to examine all individuals for venereal disease who have been convicted of fornication, adultery, prostitution, vagrancy, and lewd and lascivious conduct.”⁸¹ By examining those who had been jailed for a certain set of “morality” based crimes, health and police officials hoped to separate those found to be infected with venereal diseases and direct them into treatment programs. The target was not only the prostitutes of the vice district, but also men arrested under a wide range of crimes. While health officials hoped to stem the growing threat of venereal disease, the city attorney of Milwaukee took a position based more in civil liberties than in public health. Joseph Benarek noted that under the existing statutes Milwaukee did not have the ability to detain individuals afflicted with

⁷⁸ Milwaukee Health Department, “Annual Report,” 1926, Mss. 546, Daniel W. Hoan Collection, Box 18, “Health Department 1926-1929,” MCHS.

⁷⁹ “Health Department Budget Report, 1920,” Milwaukee Manuscript Collection AS, Box 8, “Public Health 1917-1920,” City Club of Milwaukee, 1909-1960, UWM.

⁸⁰ Health Department, Annual Report, 1926.

⁸¹ Letter from John Koehler to Thomas Duncan, Secretary to the Mayor, August 26, 1926, Mss 546, Box 18, “Health Department, 1926-1929,” Daniel W. Hoan Collection, MCHS.

venereal diseases without a proper court proceeding.⁸² He further advised that unless those arrested voluntarily consented and submitted to the venereal examinations that the city had no right in compelling an examination or refusing them bail until such time an examination was made.⁸³ Concerns over liability were also mixed with practical concerns for both the police and health departments on the efficacy of such plans. Bednarek noted that over 3,000 persons were arrested each year on the charges which would have warranted the venereal examinations.⁸⁴ The impracticality of examining countless individuals, with an already understaffed police force, was another reason that Bednarek cautioned against any mandatory examination orders.⁸⁵

The medical profession sought to tie the growing awareness of venereal disease to issues of morality, efficiency, and to the ever-growing popularity of the eugenics movement. In the Progressive era, health, wellness, and sickness were not isolated issues but were intricately tied to the efficiency of the nation, the progress of the United States economy, and the overall development of the American race. Any element that detracted from the overall goal of “progress” was seen as unhealthy, inefficient, and decidedly un-American. Concerns over venereal diseases fit nicely into this Progressive Era package. It was noted by the Wisconsin Board of Health in the late 1910s that “venereal disease costs the United States three billion dollars a year,” much of this as a result of lost productivity

⁸² Letter from Joseph L. Bednarek, Assistant City Attorney to J.G. Laubenheimer, Chief of Police, August 13, 1926, Mss 546, Box 18, “Health Department, 1926-29,” Daniel W. Hoan Collection, MCHS.

⁸³ Ibid.

⁸⁴ These charges include fornication, adultery, prostitution, vagrancy, lewd and lascivious conduct, keepers, inmates and frequenters of houses of ill fame, and those convicted of being drunk and drunk and disorderly. Letter from J.G. Laubenheimer, Chief of Police, Milwaukee to Thomas Duncan, Secretary to the Mayor, August 13, 1926, Mss 546, Box 18, “Health Department, 1926-29,” Daniel W. Hoan Collection, MCHS.

⁸⁵ Ibid.

and a loss of man hours.⁸⁶ Venereal disease was much more than just a discussion about disease; it was a growing concern for the entire United States economy and for all of American society.

Young men entering the army during World War I and undergoing their required medical exams provided the first real proof of the poor general health of the population and the widespread infection of venereal disease. Overnight a flurry of literature and controversy arose over the extent of venereal disease in the country's population and the long term affects on the American society as a whole. This fear became linked to the explosion of nativist and anti-immigrant sentiments during the period, furthering fears of "race suicide." The stage has now been set for an explosive mixture of a genuine medical concern, prejudicial fear, and mass hysteria. The Army and Navy had long realized the link between a strong military fighting force and a healthy military fighting force. In order to run an effective military, both branches during World War I and in the interwar period saw the creation of a strategic campaign against the two most prevalent and the most devastating of the venereal diseases, gonorrhea and syphilis.⁸⁷ Because of campaigns against these diseases, venereal disease rates in the army dropped from three hundred per thousand year to ninety per thousand per year by the early 1920s.⁸⁸

Pamphlets printed by the United States Public Health Service, but specifically geared toward military men tried to appeal to them in a common sense manner, noting "that unless they kept their bodies clean and free from disease, there was a possibility of

⁸⁶ State Board of Health, Madison, WI, "The Moral and Healthy Community: An Appeal to the Clergy of Wisconsin," (Madison, WI: State Board of Health, n.d.) 11, Mss 546, Pamphlets-Health, Box 12, Daniel W. Hoan Collection, MCHS.

⁸⁷ "Manpower," 3.

⁸⁸ Ibid.

ruining their chances to become fathers of healthy children.”⁸⁹ By appealing to their natures as potential husbands and fathers, the health officials hoped to direct them away from behaviors that might lead to infection. The impact of the eugenics movement saturated the literature with discussions of “fitness” and “future generations.” In a movement that fixated heavily on genetics and familial traits, the possibility of transmitting these diseases or at least their ill effects to subsequent generations was an abhorrent thought.

Both gonorrhea and syphilis, in some variant, could be passed on to the children of those infected. Gonorrhea was easily passed from mother to child during the actual birthing process. The gonococcus bacterium could infect the eyes of the newborn and produce a condition called ophthalmia neonatorum that could eventually lead to blindness if not treated early enough with silver nitrate drops.⁹⁰ Syphilis, on the other hand, was much more deadly in its transmission to children of syphilitics. Hereditary or congenital syphilis was an almost certain death sentence to a child infected in utero. Most children who were born with congenital syphilis did not survive past their early teens and usually suffered a host of physiological and mental impairments because of their condition. Delayed in physical growth, and frequently cognitively challenged, these individuals would have been poster children for those who wished to warn men about their sexual license.⁹¹ Similarly to the arguments made to mothers, health departments also sought to target fathers as they battled childhood cases of venereal disease. A state board of health pamphlet noted that an unwitting transmission from husband to wife, and then mother to

⁸⁹ “The Moral and Healthy Community: An Appeal to the Clergy of Wisconsin,” 4.

⁹⁰ *Ibid.*, 6.

⁹¹ Thomas Lutz, *American Nervousness, 1903* (Ithaca, NY: Cornell University Press, 1991), 2-4.

child could result in “the child will be born dead, or so that, if it is born, it will be crippled in mind and body. Syphilis is transmitted to the offspring in full virulence and its inherited effects are appalling.”⁹² There was no masking the horrifying effects of the disease and what it could do to the subsequent generations if not stopped.

Urban Life

Not only did the urban dweller have alcoholism, drugs, and venereal disease to worry about; his very existence in the city could also be making him deathly ill. Some saw urban life as an environment that robbed individuals of their energy, their vitality, and their productiveness. Cities presumably drained individuals through sights, smells, and sounds. The city had the power to mentally disturb workers and urban inhabitants, and quickly became, in the eyes of some, the downfall of American society. Cities through the nineteenth and into the twentieth centuries had been seen both as places of progress and pollution, innovation and decadence, America’s identity and America’s downfall. Increasingly in the midst of the progress and innovation of the early twentieth century, the golden promises of what the industrial age could bring were being tarnished. The city by the early twentieth century came to be viewed as an energetic influence in the lives of urban dwellers. With the development the discipline of sociology, the city was no longer viewed as just a place, but increasingly an agent of change on the people who lived within its boundaries. With population density came the risk of epidemic disease. Industrial growth translated into increased pollution. And most disturbing for physicians,

⁹² “Manpower,” 7, MCHS.

as well as certain intellectuals, was the impact of urban space on the psyche of its residents. Not only could the city disturb the body, but it could disturb the mind as well. George Simmel in his essay “The Metropolis and Mental Life” noted that the psychological basis of the urban dweller, or “metropolitan type” was “the *intensification of nervous stimulation* which results from the swift and uninterrupted change of outer and inner stimuli.”⁹³ The city fundamentally changed how people interacted in the urban landscape, and how they physically and mentally experienced that environment.

Sociologists and psychologists noted that as American life became more mechanized, industrial, and hectic, increasing numbers of American males were falling victim to nervous disorders. People were unable to keep pace with an increasingly frenetic lifestyle, one that drained men of energy just as industry sucked power from generating stations. Industrial America was insatiable in its growth and in what it demanded from those who lived within it. Advertisements in local publications touted the benefits of various tonics to help allay the symptoms of nervous disorders. Sanatogen, for instance, was promoted as being able to “restore wasted energies and to compose the nerves in case of long sustained effort and exhaustion.”⁹⁴ The advertisement depicted a tired, overworked, and perhaps exhausted husband whose return from his “hot office” to the “country life he longed for” is anxiously watched by his concerned wife (See Figure 22). This well established dichotomy between the city and country life was quite recognizable to Americans of the era. Sanatogen promised to restore “nerve force” and the ability to provide some “stability of nerve,” in what for some was an age of anxiety.

⁹³ Georg Simmel, “The Metropolis and Mental Life,” *The Sociology of George Simmel*, ed. K. Wolf (Glenco, IL: The Free Press, 1950), 410.

⁹⁴“Sanatogen” advertisement August 9, 1915, uncited newspaper, Milwaukee Features Microfilm, “Health,” MCHS.

AUG 9 15

When country air alone is not enough—

WHEN evening after evening he comes home to that country life he longed for, only to wake and face the long day's work in a hot office as tired as when he went to bed, many a man has begun to wonder "What can help me?"

And "Sanatogen" is the logical answer. Not only from the 21,000 physicians who have written such enthusiastic letters, but from the multitudes of brain-workers in tropical countries who find in Sanatogen the nourishing help they must have to keep up under the enervating pressure of hot weather.

For after all, health in summer is largely a matter of diet. And Sanatogen, bringing to the nerve cells and tissues the very foods they must have, and in the purest and most easily assimilable form, restores and revivifies the whole system. And helping other food digest, it lightens the tax upon stomach and nerves.

It is this two-fold effect of increasing and conserving nerve force that makes Sanatogen so helpful in hot weather. And not until you have felt its splendid vitalizing effects will you begin to know how much Sanatogen can help.

Sanatogen is sold by good druggists everywhere in three sizes, from \$1.00 up.

Hon. Wm. C. Adamson,
Chairman Committee on
Interstate and Foreign
Commerce, U. S. Wash-
ington, D. C., writes:

"I have found Sanatogen very satisfactory. Its effect on the stomach and digestion is most pleasant and it is very valuable to restore wasted energies and to compose the nerves in cases of long-sustained effort and exhaustion."

Grand Prize International Congress of Medicine, London, 1913

SANATOGEN

ENDORSED BY OVER 21,000 PHYSICIANS



Figure 22: Sanatogen Advertisement, 1915.⁹⁵

⁹⁵ Ibid.

The city pressed on people's "nerves" in a variety of ways, including noise, air, and water pollution as well as overcrowding. There were frequent complaints to city hall regarding the noise levels of traffic and streetcars, both around City Hall proper and the city at large. A noise survey was even conducted in the 1920's under the Hoan administration in an attempt to assess the problem spots. Streetcars were asked to refrain from using whistles and horns unless appropriate, and factories were asked to refrain from using their whistles. Even as late as 1931, streetcar noise was a concern for the mayor's office and consequently for the health department. In an unsigned letter, Mayor Hoan's Assistant Secretary wrote a strong letter to Dr. John Koehler, health commissioner at the time noting: "My pet peeve are noisy street cars. Not only do they annoy me with their ear-splitting clatter during the day, but the grinding of wheels and screeching of brakes disturbs my rest at night in a district, near North Shore Park, which might reasonably expect to be spared such annoyance."⁹⁶ He believed that his present location in an area outside of the congested and busy downtown would afford him some peace and quiet, especially at nighttime. The assistant secretary went on to note that the "sudden starting and stopping of these cars [one-man cars] causes nerve-grating noise to the point of being an absolute nuisance and health menace."⁹⁷ Mayor Daniel Hoan chimed in with a letter to T.M.E.R & L. Co. president S.B. Way. Hoan wrote the T.M.E.R. & L. Co. after listening to a discussion about the effects on noise on the human system. In Hoan's mind, the worst perpetrators of "the most abominable noises" were streetcars. He was concerned over the "frightful barrage of pounding" which downtown

⁹⁶ Letter from the Assistant Secretary to the Mayor (Dan Hoan) to John P. Koehler, Health Commissioner, October 12, 1931, Mss 546, Box 26, "Noise," Daniel W. Hoan Collection, MCHS.

⁹⁷ Ibid.

workers had to endure and believed it might even send some to “early graves.” Hoan went so far as to liken the streetcar noise to the shelling on the Western front during World War I: “if the gunfire on the Western Front was any worse than what we must endure, there is little wonder that the hospitals are filled with boys who are there because of being nervous wrecks.”⁹⁸ It was not until 1937, however, that the creation of various “quiet zones” in the city was suggested.⁹⁹

All this was done in the name of creating a more civilized and pleasant city environment. Smoke and soot in the air also contributed to concerns over the urban environment on individual and community health. A former Milwaukee City Hall employee, in a letter to Mayor Hoan, remembered their tenure in city hall and the impairment to their health for “being seated near the windows and so close to the busy street; soot and dust in unbelievable quantities settled on my desk constantly, proving that we all breathed the dust laden air and the inevitable results were continuous colds and other implications.”¹⁰⁰ While a personal anecdote, the reminiscence was supported by commission reports during the 1920s and 1930s that repeatedly called for legislation to restrict pollutants in the city from industry and personal sources.¹⁰¹

⁹⁸ Letter from Daniel W. Hoan, Mayor to Mr. S.B. Way, T.M.E.R. & L. Co., October 24, 1931, Mss 546, Box 26, “Noise,” Daniel W. Hoan Collection, MCHS

⁹⁹ Daniel W. Hoan Collection, Mss 546, Box 26, “Noise,” MCHS.

¹⁰⁰ Letter from Ms. Rita Pollo to Daniel W. Hoan, November 17, 1937, Mss 546, Box 1, “Air Pollution,” Daniel W. Hoan Collection, MCHS.

¹⁰¹ The City Club of Milwaukee and the United Community Services as well as the Health Department focused on air pollution at various times over the 1920s and 1930s, especially as a contributing factor to other health problems.

Suicide

In examining the stresses of the city as well as the psychological impact of urban life, one cannot avoid a discussion of suicide in Milwaukee in the period under study. The reasons individuals committed suicide were personal and private decisions, but their stories and experiences detail the consequences of the American dream when it turned into a nightmare. Destitute, detached from anything familiar and comforting, some individuals realized that the American dream was not theirs to have and chose to end their life rather than continue. The Milwaukee County Pauper's Cemetery often became the final resting place for suicide victims from the city of Milwaukee. Those who died by poisoning, hanging, gun violence, and railroad "accident," were frequently interred in the potter's field. This cemetery was the final resting place for those without family or for those too poor for a "proper" burial.¹⁰² Suicides frequently would have been refused burial on consecrated ground as a number of religious faiths saw suicide as a moral crime against self and therefore reason to deny religious burial. Even in death, they found little sympathetic company or compassion.

Every year in March and April, as the ice broke on the Milwaukee River and on Lake Michigan, "floaters" would surface; those who had committed suicide sometime in late fall or winter and had not been discovered because of the frozen waters. As the coroner attempted to determine an actual cause of death (to establish suicide rather than murder), he also set about attempting, if possible, the identification of the body. Coroner's reports from this period often contained detailed descriptions of the victim's

¹⁰²Achille Vander Heeren, "Suicide." *The Catholic Encyclopedia* Vol. 14 (New York: Robert Appleton Company, 1912), <http://www.newadvent.org/cathen/14326b.htm> (accessed June 15, 2009).

clothing, personal objects found on the body, or any distinguishing marks and unusual physical traits the victim might have had. Unknown men pulled from the river frequently had detailed descriptions in their coroner's reports with notes of "black hair, thin mustache" and "striped blue shirt." There was always the hope that perhaps with a careful recording someone someday might recognize a long lost father, husband, or brother. Some reports even contained bits of clothing snipped from the victims or personal affects, and even photographs taken for later identification.¹⁰³ This careful and methodical documentation of the known and unknown dead hint at the larger consequences of urban life. Ironically those who sought oblivion in death were also the same whose deaths were recorded in exquisite detail for all of posterity. Their misfortune was the researchers boon. Testimonials presented at the coroner's hearings spoke of troubles at work, financial difficulties, drug and alcohol addition, and the stresses of attempting to survive in a new place.

One of the most tragic stories in the coroner's records relates the story of a father and widower who journeyed from Germany in the late 1800s with his three children and his mother-in-law. Promised a job and a place to live by his brother-in-law who already lived in the city, they arrived in Milwaukee full of a hope that quickly turned to tragedy. Within the first week of their arrival in Milwaukee, two of his children lay dead from diphtheria and a third gravely ill from the same disease. What should have been a time of hope and promise turned into a nightmare. In a final act of utter desperation, Fredrich Reuchert drowned himself in a shallow pool of muddy water, no longer able to bear the

¹⁰³ Photographing the unknown dead was more common in the later portion of the 1920s and into the 1930s. Milwaukee County Coroner, Mss 306, MCHS. My examination of suicide cases originated during my work with the pauper cemetery burials. My discussion of suicides in Milwaukee is informed through an investigation into more than 120 coroner's suicide cases between 1880 and 1929.

pain of what had been wrought. As the coroner checked his pockets for identification or personal effects, he came across the family's ship ticket from Bremenhaven still folded carefully and tucked in a vest pocket for safekeeping. (This ticket is still bundled with the rest of the coroner's report.) One can imagine Fredrich looking at that ticket and grieving over the choice he made before drowning himself.¹⁰⁴ For many, the icy waters of the Milwaukee River or the crushing weight of a Milwaukee Road rail car were the final culmination of a journey of despair, unfulfilled dreams, and loss.¹⁰⁵ For those whose stories and names are known, the coroner's reports become chronicles of the failure of the American dream. Stories of job uncertainty, addiction to alcohol, inability to be reunited with family members, or even the devastating loss of loved ones fill these coroner's reports, as family members, friends, and colleagues came forward in an attempt to clarify the state of mind of the deceased. For some, the burden was too great to bear. The urban environment, while not necessarily destroying lives and the health of city inhabitants, frequently facilitated a sense of isolation and distance among peoples. While most would seek to overcome this sense of isolation, distance, and even failure, others would lose the battle.

¹⁰⁴ The very same mud that covered the ship ticket had a profound effect on a particular researcher as she sat in the Milwaukee County Historical Society and knew their stories had to be told. Fredrich Reuchert, Mss 306, Autopsy Report, 1883, Milwaukee County Coroner's Office, MCHS.

¹⁰⁵ Every year the Milwaukee river gave up at least five bodies in the early spring thaws of March and April. Milwaukee County Coroner's Office, Mss 306, MCHS; Register of Burial, Milwaukee County Poor Farm, personal collection.

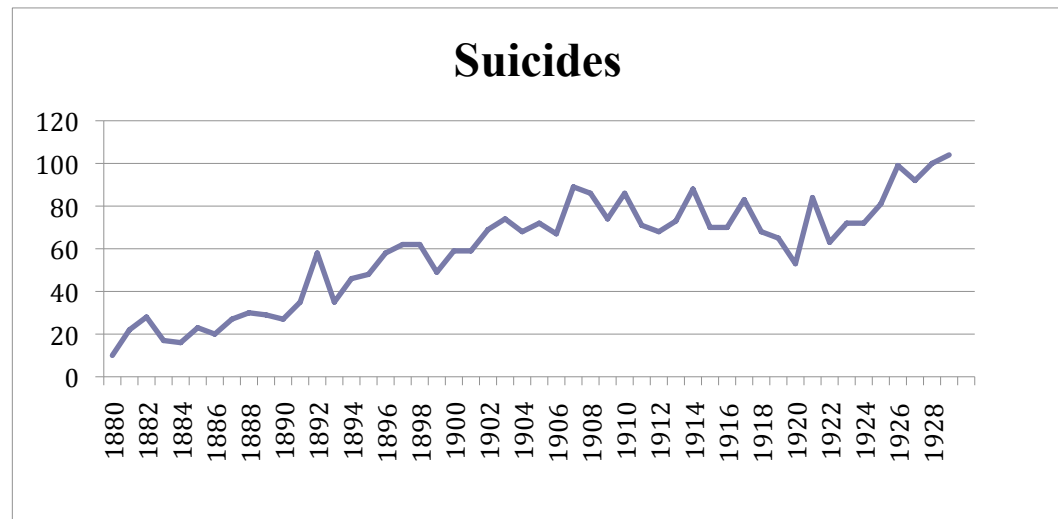


Figure 23: Suicides¹⁰⁶

Figure 23 presents the numbers of suicide cases recorded by the city of Milwaukee's Vital Statistics Office. While distinctly showing an upward trend in the numbers of suicides between 1880 and 1929, this may simply be a reflection of the city's growing population, not any real increase in numbers of suicides. The rate of suicides, in comparison to the total deaths throughout the city rose very little during the same period from a 0.5 percent of the city's total dead in 1880 to 1.7 percent in 1929.¹⁰⁷

Coroner's reports were not the only place to find details of suicides in Milwaukee. Local newspapers were also filled with sensational and frequently lurid stories of suicides in the city. In 1902, Clement Hausknecht, in poor health and having recently lost his wife, beat his own head in with a metal hammer. Witnesses attested to his distraught nature over the recent death of his wife and his subsequent desire to end his

¹⁰⁶ Vital Statistics, Statistical Tables, City of Milwaukee Vital Statistics Office.

¹⁰⁷ Ibid.

life.¹⁰⁸ These sensational stories sold newspapers, as they still do today. Murder-suicides were also not uncommon to this age. An undated article related the torrid story of a love triangle as Charles Yance shot two women (Elsie Dittman and Emma Behrndt) who were prostitutes living on River Street, and another man in a fit of jealousy over the women. He subsequently turned the gun on himself with a fatal blow to the head.¹⁰⁹ Finally, one of the most sensational stories was the murder suicide of W.B. Miller (no relation to the brewing family) and Alma Nunnemacher (who was a member of the prominent Nunnemacher family). These deaths derived from her parent's refusal to allow them to marry until Mr. Miller had established himself in business, which was difficult because he was never in good health. Despondent over their situation, they ran off together and were found shortly afterwards dead in the woods near the city.¹¹⁰ While financial stress and hard times could lead some to take their own lives, suicide was not only a solution for the poor and destitute.

Conclusion

While not as clear cut or easily defined as women's and children's health, the health of men in the city of Milwaukee was as important and omnipresent on the minds of health officials, and we can assume among the community itself. For working men in the city, poor health translated into lost hours at work, lost wages, and perhaps even the loss

¹⁰⁸ "Beat Out Brains," June 25, 1902, uncited newspaper, Milwaukee Features Microfilm, "Suicide," MCHS.

¹⁰⁹ "Bullets End The Lives of Three in a Low Resort," undated, uncited newspaper, Milwaukee Features Microfilm, "Suicide," MCHS.

¹¹⁰ "United in Death," March 17, 1893, *Evening Wisconsin*, Milwaukee Features Microfilm, "Suicide," MCHS.

of a job. For the city and its industries, an unhealthy workforce meant a loss in productivity and therefore a loss in profits. The two factors were intertwined as the city grew into one of the great manufacturing centers in the country. If Milwaukee wanted to succeed she had to insure the health of her primary workforce, her laboring men.

Workplace accidents and conditions had to be addressed, living conditions improved, and venereal disease combated by both individuals and the city.

The wellness of Milwaukee's men, however, was much more complex than a simple medical definition. Health was also intricately tied to social and psychological factors. Alcoholism, drug use, venereal disease, and suicides were seen as much as social ills as they were medical issues. Treat the social problem and you could eliminate the need to treat the physical manifestations of those conditions. Venereal disease even went by the moniker, the "social evil." These were not medical issues alone, but societal ones. The complicated mixture of health and morals, psychology and physiology, body and mind changed the discussion of what it meant to be a "healthy" male at the turn of the last century. Healthy bodies, healthy minds, and healthy appetites could be socially created and controlled. Likewise broken bodies, depraved minds, and lustful appetites were also a construct of the society in which these men lived. Milwaukee's male population had to negotiate not only a changing world of industry and urban living, but also the stressors which resulted from both phenomena and which would have a dramatic impact on their lives.

Chapter Four

Immigrant and African American Health

Introduction

The history of Milwaukee cannot be understood without an examination of the immigrant groups that called it home. The demography of this city, similar to other urban areas during this period in American history, was composed of a diverse mix of native and foreign-born populations. For Milwaukee, this combination influenced the city's cultural development, civic growth, and industrial expansion. This ethnic, and racial, and cultural diversity also created difficulties for the general health of the city's population, and especially the health of those ethnic and minority groups. As the city came to increasingly rely upon new immigrants to form the industrial backbone of the city's economy, their health and wellness became a pressing issue. Not only were these immigrants an economic advantage, but their health and living conditions played an integral role in the health and well being of the city overall. A growing awareness of the amount and type of immigrants, their living and working conditions as well as the health issues they struggled with became essential for understanding the city's health as a whole. To completely ignore the health and welfare of a significant percentage of the

city's population would be foolish at best and dangerous at worse in light of epidemic disease.¹ In addition to the difficulties of the urban environment, the unique challenges of language, custom, and prejudice weighed heavily on Milwaukee's ethnic populations. Ethnicity and race created an additional layer of complexity to Milwaukee's urban health picture.

To exemplify the immigrant experience, a few prominent immigrant groups have been chosen for a closer study. Each of their experiences highlights a different aspect of what made the immigrant experience so trying in this industrializing city. Jewish, Polish, Italian, and African American populations, while sharing some common problems, had unique experiences in their attempts to assimilate and acculturate into not only American society, but Milwaukee's as well. These groups were selected because they were the newest arrivals to Milwaukee at the turn of the century, still struggling to find a place for themselves. These groups are also better documented than some of the other immigrant groups, making the search for evidence easier. Finally, these four serve as case studies for other immigrant groups of this period, and even today. These immigrants, while each facing their own battle for social and economic stability, shared many of the same challenges to secure good housing, good food, a safe work environment, and healthy bodies.

¹ Milwaukee's foreign born population during this period of study (1880-1929) never fell below 20 percent of the city's total population, and peaked at 40 percent at the start of the under period of study. While Germans remained the dominate group throughout this period, the growing influence of southern and eastern European immigrants made these groups and their health issues a concern for the city. See Table 4.1 for further reference.

Immigration Overview

Milwaukee's early history followed the immigrant pattern of other urban areas in nineteenth century America. By the middle of the century, Milwaukee was increasingly the home for a growing number of newcomers from areas of northern and western European. Scandinavians fleeing economic hardship, Irish escaping the Great Famine, and Germans leaving behind political and social strife found refuge in the growing city of Milwaukee. The Scandinavian immigrants quickly dispersed to the countryside of Wisconsin, which left primarily the Irish and German immigrants to shape the early history of Milwaukee.² This diversity of immigrant influence was further narrowed following the sinking of the *Lady Elgin* on September 8, 1860, a pleasure barge on a return trip from Chicago. While the final numbers will never be known as the passenger log sank with the ship, it is estimated that over 300 lives were lost of various ethnicities and classes. The Irish community in Milwaukee, however, sustained the most significant damage, because it was estimated that one out of every three Third Ward households (Irish households) in Milwaukee had lost a relative in the disaster.³ While the Irish would continue to play a strong cultural as well as religious role in Milwaukee's history, the loss of life on the *Lady Elgin* decimated families and the fledgling Irish community that was developing.⁴ The Irish influence was soon dwarfed by the greatest immigrant group of this period, the Germans.

² Kathleen Conzen, *Immigrant Milwaukee* (Cambridge, MA: Harvard University Press, 1976), 20-21.

³ Conzen, 171.

⁴ For further discussion of the *Lady Elgin* and the disaster's impact on Milwaukee and the Irish community, see *New York Times*, September 12, 1860; *Milwaukee Daily News* October 18, 1860; Charles N. Scanlan, *The Lady Elgin Disaster, September 8, 1860* (Milwaukee: n.p., 1928); Bayrd Still, *Milwaukee: The History*

German immigrants by the mid-nineteenth-century had quickly become the principal cultural, economic, and social force in Milwaukee. German language newspapers, theaters, and schools as well as the Sängerverein⁵ and the famous Turnerverein⁶ dominated the cultural and educational landscape of Milwaukee. Significantly better off than most Irish immigrants, the German migration to Milwaukee was still a mixture of social and economic groups. While there were large numbers of farmers who migrated to the state during this period, a sizable portion of Germans who stayed in the city came from middle class to lower middle class backgrounds. Kathleen Conzen notes that biographical information, albeit from those who became prominent in Milwaukee, presents a picture of well-educated (both intellectually and technically) group of individuals. In her survey of biographical histories, she noted that two-fifths indicated they had received apprenticeship training to be artisans, one-third had either a university background or professional training, and 13 percent had mercantile training.⁷ The German community saw themselves as a cultured and learned group, with knowledge of literature, music, theater, and the sciences. They were not mere peasants, but were businessmen, doctors, and educators. With this background, they came to shape the political, cultural, philanthropic, and medical history of Milwaukee.

One of the best examples of this diverse involvement in the city's affairs is exemplified by Dr. Francis Huebschmann, the first German physician in Milwaukee. Soon after his arrival in 1842, he would be elected school commissioner, a post he would

of a City (Madison, WI: State Historical Society of Wisconsin, 1948), 153; Conzen, 171-72; and John Gurda, *The Making of Milwaukee* (Milwaukee: Milwaukee County Historical Society, 1999), 95-96.

⁵ German singing societies.

⁶ German gymnastic organization.

⁷ Conzen, 31.

hold for eight years; later he was appointed United States Superintendent of Indian Affairs from 1853 to 1857, with jurisdiction over areas of New York, Michigan, Wisconsin. He also served as an alderman in 1852 and even acting mayor (in place of William Pitt Lynde) in 1860. Huebschmann's quick involvement in political affairs, however, did not take a back seat to his love of culture, education, and the arts. He would be one of the founding members of the Milwaukee Musical Society and the German-English Academy (later the University School of Milwaukee). He was an immigrant actively involved in the political, social, and educational life of the city as well as being one of its notable physicians.⁸

The vestiges of Germany's impact upon Milwaukee can be seen in the creation of an extensive German press network (*Germania, Herald, Seebote*), the establishment of hospitals by German religious orders (Evangelical Deaconess Hospital), the strong socialist/reform political ideal which became the foundation for Milwaukee politics for years to come, and even in the landscape with sites such as the Schlitz Palm Garden which brought a bit of German *gemutlichkeit* to the urban environment. While beer would make a number of Milwaukee Germans very famous and rich, it was not the only lasting legacy of this immigrant group on the city.⁹ The late nineteenth century saw the emergence of a "Deutsche Athens" in Milwaukee. Milwaukee would earn this nickname from the dynamic and robust cultural life that the Forty-Eighters supported in the city.¹⁰

Mid-nineteenth century immigrants (the Germans and Irish in particular) laid the groundwork for later groups who would follow them and help define the character of this

⁸ Dr. Louis Frederick Frank, *The Medical History of Milwaukee, 1834-1914* (Milwaukee: Germania Publishing Company, 1915), 9-10.

⁹ Still, 73-88, 112-128; Gurda, 59-74.

¹⁰ *Ibid.*, 63.

Midwestern city. Historian John Gurda even asserts that the dominance of foreign born in Milwaukee, as high as 79 percent in the mid-nineteenth-century, laid a foundation of greater toleration for other immigrant groups, developed a community that saw itself as fundamentally “ethnic” in character, and offered fewer pressures for immigrants to assimilate into American society.¹¹

Starting in the 1880’s, the “New Immigration” resulted in the influx of unprecedented numbers of immigrants from southern & eastern Europe into American cities. Russian Jews, Polish villagers, Italian farmers, and Slavic peasants were only a part of the millions of individuals who flooded American shores from the early 1890s until the mid-1920s. Lured by the promise of home ownership and excellent jobs and wages, many instead found wretched living conditions, environmental nightmares, and hazardous working conditions. Much of the industrial heartland of the United States and the industrial growth of the country were built upon the labor of these southern and eastern European immigrants. From the Carnegie steel mills in Pittsburgh to the Union Stockyards of Chicago to the machine shops of Milwaukee, the United States ran on immigrant labor. Large numbers of Polish immigrants settled on Milwaukee’s south side in the area near Mitchell Street and east of Forest Home. As the Irish moved out of the Third Ward to areas near present day Marquette University and Merrill Park, new Italian immigrants moved into their abandoned neighborhoods.¹² Various other southern and eastern European immigrants (Greeks, Turks, Slovenes, Serbs, and Hungarians) settled in small pockets throughout the city in areas deemed less desirable by those of higher social status. Figure 24 presents the percentages of certain ethnicities among the foreign born in

¹¹ Ibid., 65.

¹² Gurda, 175.

Milwaukee. The German immigrants will consistently have the highest percentages throughout the period, with the Poles a close second. Eventually, a number of these communities would soon come to the notice of various governmental, philanthropic, and health officials in their battle for better health and better living conditions.

Census Year	Percentage Foreign Born	Percentage Within the Foreign Born								
		Germans	Irish	Polish	Bohemian/Czechs	Hungarians	Jugoslavia	Russian	Austrian	Italians
1880	40%	27	3.2	1.5	1.3	---	---	---	.82	---
1890	39%	27	1.7	4.5	.71	---	---	---	.45	---
1900	31%	19	.93	6	.60	---	---	.40	.57	.25
1910	30%	17 ^a	.52	---	---	1.4	---	3.2 ^a	3 ^a	.90
1920	24%	8.7	.31	5	.98	1	.91	1.6	1.2	.88
1930	19%	7.2	.18	3.4	.76	.65	.98	1.2	1	.86

Figure 24: Percentage Foreign Born in Milwaukee, 1880-1930¹⁴

The final migratory group moving into Milwaukee during the early twentieth century were African Americans arriving from the southern United States, particularly Kentucky, Missouri, Tennessee, and Virginia.¹⁵ The African American community had been a very small community until World War I when European migration was cut off. Similar to European immigrants, blacks traveled north in search of better jobs and the chance to join others already located in the city. Although the industrial nature of the city lured blacks north, the domestic and service industry became the primary employer for Milwaukee's African American population.¹⁶ While their numbers continued to be rather small, they were still determined to create institutions (St. Mark's AME Church in 1869,

¹³ Still, 574.

¹⁴ Still, 574-575.

¹⁵ Joe Trotter, *Black Milwaukee: The Making of an Industrial Proletariat*, 2nd ed. (Chicago: University of Illinois Press, 2006), 8.

¹⁶ *Ibid.*, 8-10.

St. Benedict the Moor Catholic Church in 1908, and a newspaper, the *Milwaukee Enterprise Blade* in 1916) and organizations (the Urban League, 1919, and a local branch of the NAACP, 1915).¹⁷ Also, similar to European immigrants, especially those from southern and eastern Europe, blacks established a home in some of the most dilapidated of Milwaukee's housing and found employment in some of Milwaukee's most dangerous jobs. Both European immigrants and black migrants struggled with poor working and living conditions as well as bias from the established community, all the while attempting to create a cohesive ethnic and racial community in distinctly foreign surroundings.

These new migrants to the city of the Milwaukee, both African American and European, shared similar dreams for better jobs, better opportunities, and a better future for themselves and their children. As they each faced their own unique challenges to assimilation and acculturation, they shaped the dialog for future generations of immigrants, as well as those who attempted to minister to them. Through an examination of Jewish, Polish, Italian, and African American immigrants a clearer picture of the Milwaukee's ethnic health dynamic becomes clear. (Figure 25 and Figure 26 present residential and occupational settlement patterns for Milwaukee during the late nineteenth century.)

¹⁷ Gurda, 258-59.

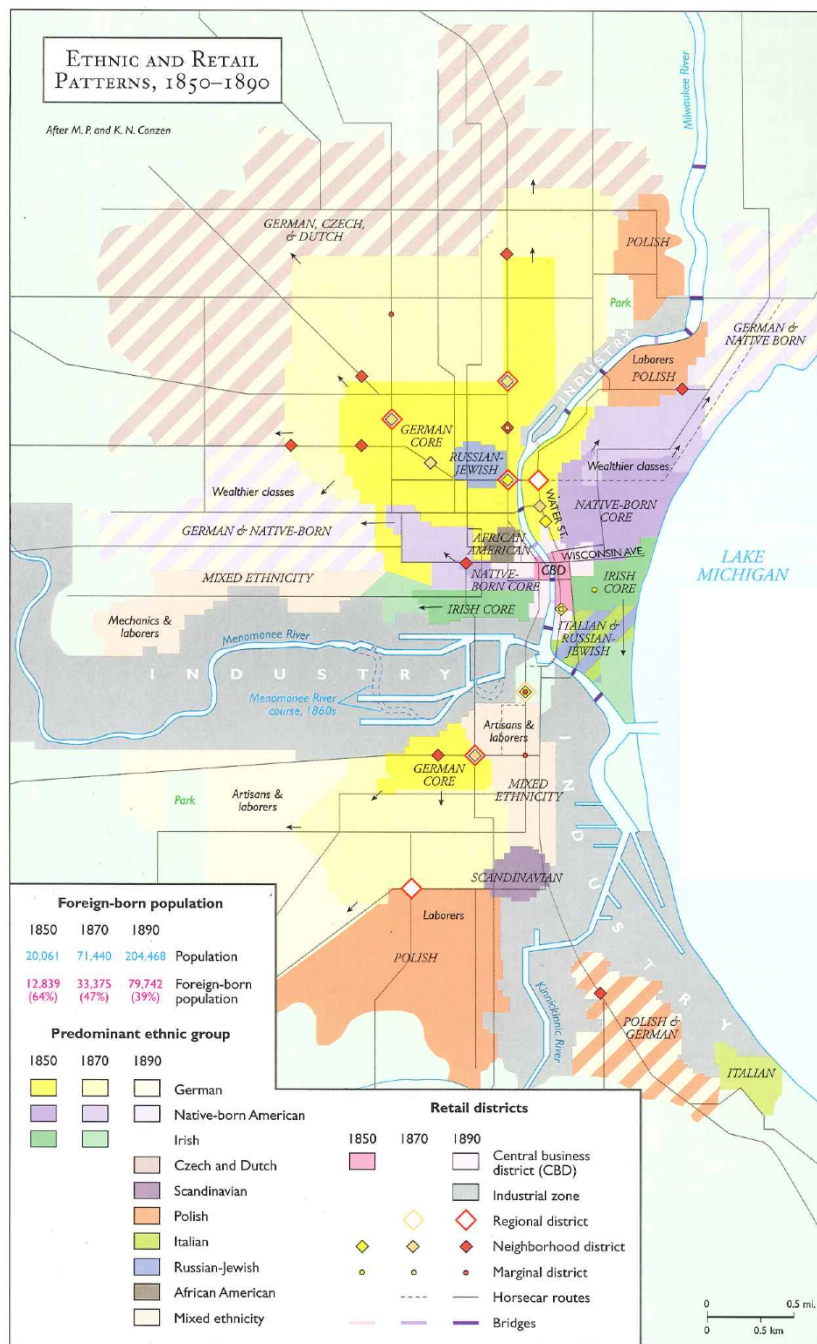


Figure 25: Ethnic and Retail Patterns, 1850-1880¹⁸

¹⁸ Wisconsin Cartographers Guild, *Wisconsin's Past and Present: A Historical Atlas* (Madison: Wisconsin Cartographer's Guild, 1998), 30

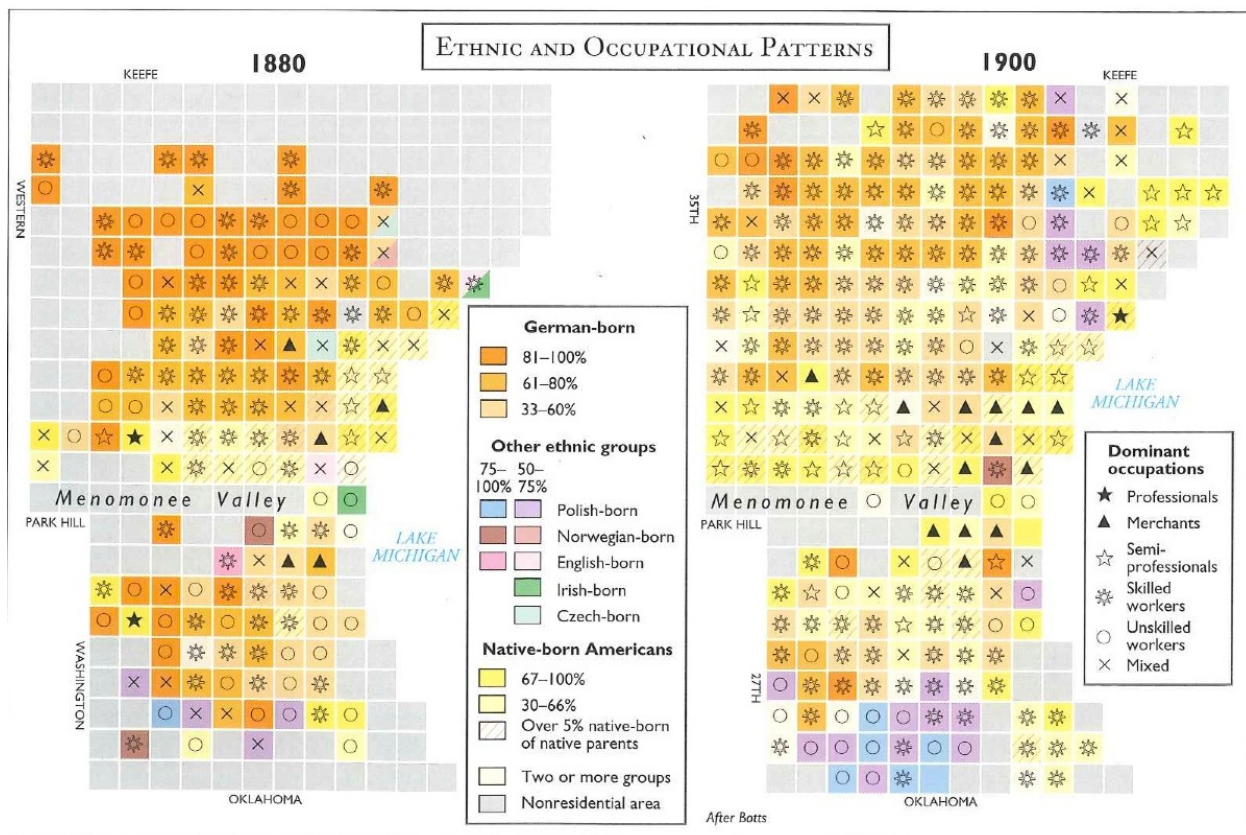


Figure 26: Ethnic and Occupational Patterns, 1880 and 1900¹⁹

Jewish Immigrants

Milwaukee's Jewish population established itself in the mid-nineteenth century as a consequence of the German migration. While the first Jewish resident in the city arrived by 1844, the first significant group was established by 1847 when twelve families came together to form a loose congregation.²⁰ A number of these early German Jewish settlers became prominent members within Milwaukee's business, intellectual, and social circles. Successful businessmen and prosperous merchants, this segment of Milwaukee's Jewish

¹⁹ Ibid., 29.

²⁰ Conzen, 166-67.

population quickly developed into part of middle class life of the city. Many of these mid-nineteenth century Jews came from urban settings and were on average a literate, and by many accounts, a relatively well educated population.²¹ The German Jews, while retaining their Jewish customs and identity, also were fiercely German, identifying and allying themselves with the dominant ethnic group.²² By 1881, however, the German Jewish population would be faced with a new influx of Jews into Milwaukee, but a Jewish population that was significantly different from the earliest arrivals.

The Jews who started migrating to Milwaukee in October of 1881 were fleeing the tsarist pogroms that terrorized villages across current day Poland and Russia.²³ By 1895, they had grown to a population of over 2,500; by 1900, over 7,000 Russian Jews had settled in Milwaukee.²⁴ These new Jewish immigrants settled in an area known as the “Haymarket” (bounded by Walnut Street to the north, Chestnut Street -- later Juneau Street -- to the south, and Third and Eighth Streets to the east and west.²⁵ By 1910, this Jewish district had expanded from Juneau to North Avenue, and west to Thirteenth Streets.²⁶ The area would be described as not “exactly the locality to which a loyal resident of the town would care to take a stranger...it is old as the city goes, and none too clean in its physical aspects whatever its morals may be.”²⁷ The area had already garnered a reputation for being dilapidated and possibly morally unsound, as many

²¹ Still, 277.

²² Gurda, 137.

²³ Still, 277.

²⁴ *Ibid.*, 277-78.

²⁵ *Ibid.*

²⁶ Gurda, 179.

²⁷ “Here the Settlement Will Do its Work,” April 15, 1900, *Milwaukee Sentinel*, Mrs. Simon Kander Collection, MKE Manuscript Collection DN, Box 1, Clippings, 1879-1929, UWM.

reformers saw a link between physical environment and moral behavior. Polluted and dirty environments bred polluted and dirty people.

The new groups of Russian Jews were quite different from their German brethren. Newly arrived Jewish immigrants were “content to live in crowded conditions” and “engaged in much humbler pursuits than their fellow Hebrews of the earlier migration.”²⁸ While they were initially met with a warm reception, the cultural differences between the German and Russian populations became more apparent. The more Eastern European Jews that arrived in the city, the deeper and wider the gulf between the groups became.²⁹ Increasingly, the Russian and Polish Jews were seen by the larger community as dirty, uneducated, backwards, and even uncivilized. However, the harshest criticism regarding their living conditions and their overall cleanliness did not come from health officials or anti-immigrant groups, but from within their own community, specifically from established members of the German Jewish community. American and German Jews frequently would not associate with Russian Jews: “the first lesson the German Jew hears in this country is to hate his Russian brother with all his might and all his soul.”³⁰ While some would dispute this animosity, there was a marked belief that the Russian Jewish population was of lower status than the German Jews because they were viewed as a “people difficult to reach because of their great conservatism, their distrust of the world and their clannishness.”³¹

²⁸ Still, 277-78.

²⁹ Gurda, 137.

³⁰ “An Insult to Russian Jews,” undated, uncited newspaper, Milwaukee Manuscript Collection DN, Mrs. Simon Kander (Lizzie Black Kander) Papers, “Clippings – undated,” Box 1, UWM.

³¹ “Here the Settlement Will Do its Work,” April 15, 1900, *Milwaukee Sentinel*, Milwaukee Manuscript Collection DN, Mrs. Simon Kander (Lizzie Black Kander) Papers, Box 1, Clippings, 1879-1929, UWM.

Coming from rural backgrounds in Russia and what is today eastern Poland, these newcomers were not the erudite urban German Jews who had made their home in Milwaukee decades earlier. Much poorer and in many respects more conservative than their Jewish brothers, they were quickly taken on as an improvement “project” within the fervor of Progressive era reformers. The destitute conditions that Russian Jews lived in were blamed on the habits of the individuals: they were poor Jews who did not know and practice the Mosaic cleanliness laws.³² Others, however, realized the real reason behind their unclean conditions: poverty. Poverty superseded even the most observant Jews attempts to keep up proper levels of cleanliness.³³

Over the decades, the German Jewish population had organized numerous social welfare programs and organizations, including the Hebrew Relief Association, the Federated Jewish Charities, and the Jewish Social Services Association. These groups helped not only German Jews, but more pointedly the Russian Jewish populations in Milwaukee.³⁴ Various programs were implemented to assist the Russian Jewish populations regarding issues of cleanliness, Americanization classes, medical examinations, and poor relief. One of the most important and ardent of these Jewish reformers was Elizabeth Black Kander, or “Lizzie” as she was more commonly known. Lizzie Kander was the founder of the Abraham Lincoln Settlement House, located at 601 Ninth Street, which would later become the Jewish Community Center in Milwaukee.³⁵

³² “The Art of Cleanliness,” undated, uncited newspaper, Milwaukee Manuscript Collection DN, Mrs. Simon Kander (Lizzie Black Kander) Papers, “Clippings – undated,” UWM.

³³ “An Insult to Russian Jews,” Ibid.

³⁴ City of Milwaukee, City of Milwaukee Directories 1880-1929, MCHS.

³⁵ The address of the Abraham Lincoln Settlement House is a pre-1930 address. The city undertook a massive reordering of the street numbering system in the early 1930s so historic addresses do not necessarily correspond with modern day addresses.

In an undated speech from the 1910s, Lizzie made a point of the impoverished living and social conditions of the newly arrived Russian Jewish population. She noted:

9/10 of the heads of the households of our protégés [the Russian Jewish population] can do nothing towards supporting their families except rag picking which in itself is enough to bring dirt and disease into any home. The women as a rule can neither cook or sew and consequently make miserable housekeepers . . . preach to them as much as you can to be clean, to mend their clothes, to get ahead in the world so as to gain the respect of others . . . they [Russian Jewish immigrants] will always remain paupers until we can lift them out of the darkness of their ignorance and teach them at least some of the advantages of the schooling we have had.³⁶

Seen as having little insight or knowledge into either their own health or welfare, Russian Jews became one of the target groups for social reformers such as Lizzie Kander who sought to improve the health of Milwaukee's Jewish community, and thereby the community at large.

Kander and like-minded individuals set out to create a settlement house that would minister to this underserved population. The Abraham Lincoln Settlement House focused on a wide range of health and beneficial programs for the Jewish community that surrounded it. The settlement began offering nutrition classes, cooking classes, "Little Mother's Classes" (home and child care skills for young girls), and English language classes. They also sought to provide baths at the settlement house for members of the community to use in an effort to reinforce ideas of hygiene and sanitation within the community.

In an effort to minister to the community, the Abraham Lincoln House held a number of child welfare clinics. Designed to promote infant care and health, these clinics monitored the weight of infants and children up to six years of age, administered

³⁶ Undated handwritten speech, Mrs. Simon Kander Collection, MKE Manuscript Collection DN, Box 3, "Writings of Lizzie Black Kander, Undated," UWM.

vaccinations for childhood illnesses, and checked for any more serious conditions and ailments. The child welfare clinics were extremely popular with the residents of the community, with the clinics serving over 1509 cases by 1921.³⁷ Not only were the child welfare clinics well attended, other opportunities for better health and hygiene were also fully utilized by residents in the area. It was not a conscious choice to be dirty, but few had the resources to remain perfectly clean. One of the most popular of services were the baths at the Abraham Lincoln House. Monday through Thursdays from eight in the morning until eight in the evening, residents could make use of the settlement's baths free of charge.³⁸

The settlement would provide much needed services for the community on a number of different levels. The English language classes, the Americanization instruction, and a penny savings bank were instrumental in creating a "better" Jewish community. These cultural improvements would be tied into physical and welfare improvements in the form of baby clinics, mother's classes, baths, and playground reform to not only transform the Jewish community, but the area in which they lived as well.

Polish Immigrants

Polish immigrants to Milwaukee who were not Jewish faced the same prejudices, struggles, and impediments as their Jewish brothers and sisters. Similar to the Jewish migration, an earlier migration of German Poles arrived in Milwaukee in the mid-

³⁷ Federated Jewish Charities, "Annual Report," 1921, Milwaukee Manuscript Collection 87, Box 1, Federated Jewish Charities, Hebrew Relief Association, Jewish Family and Children's Services, UWM.

³⁸ "Settlement House Papers, 1900-1915," Milwaukee Manuscript Collection DN, Box 2, Mrs. Simon Kander (Lizzie Black Kander) Papers, UWM.

nineteenth century and helped to establish the Catholic Polish community in this city.³⁹

Those who began arriving later in the 1880s were a very different group of migrants. Primarily from the eastern section of Poland (what was then part of Russia), the vast majority of these immigrants were impoverished coming to the United States “for bread.”⁴⁰ The Poles came to comprise the core of Milwaukee’s industrial workforce. They came searching for jobs and found plenty in the industrializing city.

The Poles were “promising to become [the] most influential of all the newcomers,” by the turn of the twentieth century.⁴¹ They made their presence in Milwaukee known, through sheer numbers and cultural force. By 1910, the city included over 70,000 Polish residents, creating a presence that could no longer be ignored. Charles King (author, general, and son of Rufus King) remarked that there were places in the city where “no name but those that end with a sneeze” can be found.⁴² The Southside Polish community was also a devoutly Catholic community, which provided spiritual as well as financial assistance to newly arriving immigrants.⁴³ William George Bruce noted that Polish immigrants could be found at Milwaukee’s rail stations “among the boxes, bundles, and bedding of an old world household.”⁴⁴ The image of the newcomer surrounded by their meager earthly possessions, the vestiges of their Old World lives, had become a familiar site. These new immigrants quickly tried to settle into their new homes and new lives seeking economic and political security, something their homeland could not offer them.

³⁹ Still, 131.

⁴⁰ Gurda, 133.

⁴¹ *Ibid.*, 267-68.

⁴² Still, 268.

⁴³ Still, 260, 270.

⁴⁴ William George Bruce, *Born in America* (Milwaukee, WI: Bruce Publishing Company, 1937), 321-22.

Polish immigrants settled in two particular areas in the city, the fourteenth ward on the city's south side and on Jones Island. Settling near the mills and factories on Milwaukee's south side, the Poles created a dense, "clannish," and distinctly Polish area of the city.⁴⁵ Health Commissioner George Ruhland in a 1916 housing report noted that a visit to a Polish family in this district "found a bedroom barely large enough to contain two double beds with a narrow space between them, and only one dim window, used as sleeping quarters for five people"⁴⁶ Ruhland noted that these family incomes were less than adequate to provide sanitary and suitable housing. But the Poles had a passion for home ownership.⁴⁷ While Ruhland, and other health officials would decry the way that Poles lived on the south side of the city, historian Roger Simon's groundbreaking work suggests that the poor housing of Poles was a more complex issue.⁴⁸ Homes, not labor, were essential for the Poles in Milwaukee. They sought to own their own homes at whatever the cost.⁴⁹ The area of Polish settlement became one of the most densely settled areas in the city with as many as four to five families per thirty-foot lot (which was the norm). One social work report even noted one twenty-five foot lot that had five houses and three families to each house.⁵⁰ Polish immigrants increased the housing density by jacking up the original home, bricking in a half basement and creating a second living area in the home. The "Polish flat" as it came to be known not only added to the incomes of the Polish immigrants, but also reinforced the importance of land ownership. Although

⁴⁵ Gurda, 136.

⁴⁶ George Ruhland, *Housing Conditions in Milwaukee* (Milwaukee: Milwaukee Health Department, 1916), 11, Mss 2126, Annual Report, 1916, Milwaukee Health Department, MCHS.

⁴⁷ Still, 455.

⁴⁸ Roger Simon, *The City Building Process: Housing Services in New Milwaukee Neighborhoods 1880-1910* (Philadelphia: American Philosophical Society, 1996), 118-124.

⁴⁹ Gurda, 136.

⁵⁰ Ruth Harman and Charlotte Lekachman, "The Jacobs House," *Wisconsin Magazine of History* (March 1933), 261.

this style of housing reinforced important social values for the Polish immigrants, health officials viewed this housing as dismal and damp, with poor ventilation, little light, and tremendously overcrowded.⁵¹ While their homes and lots may have been small, the Polish immigrants created a vibrant Polish community on the south side of the city.⁵²

Just as Lizzie Black Kander set out to assist newly arriving Jewish immigrants, so did Herbert H. Jacobs for non-Semitic Poles. Jacobs had studied sociology at Oxford in the late 1890s and had spent time at the Mansfield Settlement in the East End of London. After these experiences there, he became convinced that his hometown of Milwaukee also was in dire need of a settlement.⁵³ Jacobs had a strong interest in social issues and had instituted at Hanover Street Congregational Church, where he was a pastor, an open forum on workman's issues.⁵⁴ He eventually convinced the University of Wisconsin to send students to Milwaukee for sociological fieldwork. One of the earliest students to take advantage of this opportunity was Benjamin Hibbard who made a study to determine what part of the city was best suited for settlement work. Hibbard's work determined that the best place for the settlement would be the old Fourteenth Ward.⁵⁵ The settlement organizers sought to minister to the underserved and needy South Side district as well as aid the Polish population in their transition to an American life. Located at the intersection of 1st Avenue and Beecher, the settlement became a voice for the surrounding Polish population regarding employment, housing, and the Americanization process.

H.H. Jacobs saw a desperate need for the settlement to help with health and sanitation

⁵¹ Gurda, 173.

⁵² Still, 273.

⁵³ Harman and Lekachman, 253.

⁵⁴ Herbert Jacobs and his wife would even be honored by Marquette University during the second annual civic convocation for their active work in the city and state for the Anti-Tuberculosis Association, the University Settlement, and various other social welfare agencies. Harman and Lekachman, 256.

⁵⁵ *Ibid.*, 254-55.

issues, child labor problems, tuberculosis rates, infant mortality, smallpox, school attendance, and living conditions.⁵⁶ In Jacob's mind and likely in the minds of city officials, the Fourteenth ward Polish district was in need of housing and health reform. Hibbard's recommendation was validated by later sociological studies that noted the high rates of infant mortality and juvenile offenders, congested living conditions, significant use of child labor, and the "greatest amount of dependency . . . and [the] highest rate of tuberculosis" in the city.⁵⁷

The Fourteenth Ward had a high population density, with over 60,000 Poles mixed among Lithuanians, Slovaks, and other southeastern European immigrants. Added to this dense living situation was the proclivity of what became known as the aforementioned "Polish flats" or occupancy of basement living quarters to accommodate additional family members or to house boarders to provide extra income for the household.⁵⁸ With this high density of population also came the concern over communicable disease as health officials targeted their campaigns in this area. In 1904, the Fourteenth Ward had the highest mortality rate in the city with a total of forty-eight deaths, thirty-nine of which were children.⁵⁹ The following year in 1905, 43 percent of the smallpox and 32 percent of the infant mortality in the city were located in this one district.⁶⁰ The settlement sponsored a number of clinics run by the Health Department and Visiting Nurses Association. These clinics focused on improving the health and nutrition of infants in the community through education classes, baby weighings, and the

⁵⁶ University Settlement House, *Record Book*, September 26, 1905, Milwaukee Features Microfilm, "Settlements," MCHS.

⁵⁷ Harman and Lekachman, "The Jacobs' House," 261-262.

⁵⁸ *Ibid.*

⁵⁹ *Ibid.*

⁶⁰ Milwaukee Health Department, Annual Report, 1905, Mss 2126, Milwaukee Health Department, MCHS.

distribution of specially sterilized and bottled milk in the hot summer months.⁶¹ In addition, the University Settlement also offered childcare classes for the mothers and young girls of the community. Jacobs saw the settlement as a “school of citizenship” where the district’s immigrants could learn not only English, history, and math, but also proper hygiene, feeding, and health practices.

Italian Immigrants

The migration of Italians to Milwaukee started later than both the Jewish and Polish populations. Landlord disputes, high taxes, economic hardships, and a general inability to support themselves and their families led many Italian immigrants to American shores.⁶² A group of Sicilians from Palermo moved north from the “colony of Chicago” in 1895 to form the core of Milwaukee’s Italian community.⁶³ Milwaukee offered occupational as well as residential “breathing space” for these migrants from Chicago. While the Italian community in Milwaukee by 1910 had reached 4,685 (with over three-fourths that number being foreign-born), in Chicago the Italian population was well over 45,000.⁶⁴ Italians in the Brew City settled in the Third Ward among the Irish who still remained in the area, although by the 1920s, the area was becoming distinctively Italian in flavor. (After the 1892 fire which devastated over 16 square blocks of the Third Ward, the Irish decided to move further west into the Merrill Park neighborhood.) Additional settlements among Italians would also crop up along the

⁶¹ Harman and Lekachman, 277.

⁶² Walter Nugent, *Crossings* (Bloomington, IN: Indiana University Press, 1995), 96-97.

⁶³ Still, 276.

⁶⁴ Martin Hinz, *Italian Milwaukee*. (Charleston, SC: Arcadia Publishing, 2004), 7.

Milwaukee River on the near east side, in Bay View, and in smaller settlements scattered throughout the city. Italians who came from different areas of Italy tended to settle in separate colonies in Milwaukee; there was little mixing among these regional groups. Tuscans lived separately from those from Palermo, who lived apart from those immigrants originating in Messina, for instance.

Similar to Polish immigrants, most Italians were from rural settings, primarily farming and agricultural backgrounds. Language was a significant barrier to their employment as it barred them from many skilled trades. These Italian workers had to learn a completely new trade in order to support themselves and their families.⁶⁵ By most accounts, they were “forced to do the hardest work in the foundries, coal yards, docks, tracks,” and other industrial trades.⁶⁶ Approximately 75 percent of employed Italians were common laborers, mainly concentrated in the manufacturing sector, including Allis Chalmers, Falk, the Bay View Rolling Mills, and the Pfister and Vogel Tannery.⁶⁷ Italian immigrants, as the Poles before them, would come to play an important role in the industrial development of the city.

The few Italian professionals who immigrated during this period (15 percent of the Italian workforce) were mainly from the more urbanized, northern Italian regions. Lastly, the remaining 10 percent was made up of saloonkeepers, grocers, and collectors of garbage. Italians owned over forty-five groceries in the city of Milwaukee; over thirty-eight of those groceries were located in the Third Ward where the Italians were concentrated. Italians, more than other groups, were reluctant to work or socialize outside

⁶⁵ Ibid.

⁶⁶ G. LaPiana, *The Italians in Milwaukee, A General Survey* (R & E. Research Associates: San Francisco: 1915), 5.

⁶⁷ Ibid, 8.

of this colony -- even being described as “clannish” at the time. Their difficulty with the English language, as well as their strong focus on family and community, led them to be more insular than many of the other immigrant groups of the period.

Similar to the other immigrants, there was a marked concern by health officials regarding the unsanitary and dilapidated conditions in which the Italians lived, especially in the Third Ward. The low elevation of the Third Ward (almost on level with the Milwaukee River and Lake Michigan) left the area prone to flooding and poor drainage, which could easily breed a variety of communicable disease. The Third Ward, perhaps because of its location on the river and near the shipping channels, was a mixed-use area of warehouses, stables, homes, and businesses. Without zoning, stables could be located near bakeries and houses could be found in the backyards of garbage incinerators. An observer in 1915 noted that the Third Ward was a complex mixture of “vapors from the lake and river, smoke from chimneys and trains, gas from tanks, odors and insects from stables, and the crowding together of a population of workmen who often have no conveniences for cleanliness.”⁶⁸ Hygiene and cleanliness were almost impossible for the Italians in the Third Ward as over four times the recommended number crowded into the area’s housing stock.⁶⁹

In the minds of observers, poor living conditions were not wholly the fault of the Italian immigrants. G. LaPianna, writing for the Associated Charities of Milwaukee, noted that the uncleanliness of some homes was only temporary, that 60% of homes

⁶⁸ Ibid, 14.

⁶⁹ Mayor’s Commission on Housing, *Report of the Mayor’s Commission on Housing* (Milwaukee, The Commission, 1933), 13.

could be classified as “very clean.”⁷⁰ Italian housewives took care and pride in their modest homes and only occasionally fell behind in their housework duties. While a large portion of the Italian migration was composed of family groups, the unmarried men who came to the United States were begrudgingly welcomed into Italian households as boarders. The reluctance to accept boarders was a cultural issue. Strangers, especially men, were not generally admitted into the sanctity of the family home. This complicated but essential social and economic relationship tested the boundaries of Italian communities and marriages. Frequently, families had little choice but to accept the boarders. They then kept a closer eye on their wives and daughters in order to protect their honor and names. This was a price many fathers and husbands were willing to pay because boarders helped pay the rent.

Reformers also pointed out that the physical constitution of Italians, similarly to African Americans, were more accustomed to rural surroundings with plenty of fresh air and sunshine, not the dank, crowded, polluted urban environment in which they were now forced to live. The jump from rural to urban life was a point that health officials and reformers frequently pointed to as reason for much of the urban ill health of these previously rural populations. The countryside was seen as an environment of vibrancy, health, and strength. The urban environment to reformers was one characterized by illness, degeneration, and weakness. Some reformers believed that like flowers in the fields, these rural populations thrived and flourished in the country only to wither and becoming sickly when too long in the city. Even something as simple as air temperature was part of the Italian learning experience in Milwaukee. Stoves, which had been

⁷⁰ Ibid, 15.

infrequently used in Southern Italy, caused problems for women attempting to heat their homes on cold winter mornings. The Italian immigrants were also unaccustomed to the extent of the cold. They were frequently seen out and about in the city on the coldest and wettest days without proper winter attire.⁷¹ The acclimation, as well as their acculturation, would come only after a long time in the city.

That said, most reformers and health officials noted the overall good health of the Italian community. In comparison to other immigrants, Italians had a lower than average rate of many diseases. Some credit might be given to the diet to which southern Italians adhered. A hearty peasant diet of macaroni, wheat breads, tomatoes, and wine was seen as keeping them healthy and strong, but once in Milwaukee they had to make dramatic alterations to their diet.⁷² Unable to find the familiar foods of home and not able to acquire quality food, they struggled with ill health and nutritional problems from deficiencies in their diets. Long months without work and assistance from charitable organizations left them with inadequate diets. Not all the food provided by the county poor department was palatable to the Italian immigrants. The flour was often of poor quality; corn was considered useful only if you were raising chickens; and foods such as oatmeal and cornmeal were not familiar foodstuffs to most southern Italians. Beer, a staple in Milwaukee, was an “unknown drink” when compared to wine, and the southern Italians had little use for hard liquor which was more common among northern Italians. Cultural misunderstandings led to public agencies that did not understand the importance of certain types of food to the cultural and dietary health of the Italian community.⁷³

⁷¹ LaPiana, 27-28.

⁷² I. Burney Yeo, *Food in Health and Disease* (Chicago, W.T. Keener, 1880).

⁷³ LaPiana, 23.

While the Italian grocers expanded the palate of Milwaukeeans, a new climate, budget constraints, and a new culture severely limited the diet of Italian immigrants.

Despite dietary challenges, the majority of the Italian population was relatively healthy in comparison to other immigrant populations in the city. Of the 2,032 tuberculosis cases reported by the health department in April of 1915, only 13 of those cases involved Italians.⁷⁴ Also a large majority of those diagnosed with tuberculosis were native born populations of Italian heritage. There is, however, another element that explains these low tuberculosis numbers. Italians who suspected they were infected or who had been positively diagnosed by the Health Department fled to Italy for fear of shaming their families. As tuberculosis was seen as disease associated with dirty surroundings and poor housing, they saw it as a shameful experience for the whole family when they contracted the disease. Furthermore, they believed that the better climate and warmer air of Italy would speed up their recovery.⁷⁵

The main source of ill health for most Italians originated from the dislocation that they experienced here in the United States. Differences in the climate from Sicily to Milwaukee left Italians vulnerable to pneumonia, influenza, and other respiratory diseases. Insufficient and uncertain employment led to deficient nourishment and the likelihood of nutritionally based illnesses. Unhygienic and overcrowded housing conditions also led to a greater incidence of communicable disease brought on by these conditions. The health of children was also of great concern to health officials when they focused on the Italian community. Seventy-five percent of children examined by health officers in 1915 were found to be suffering from gastrointestinal diseases, much of that

⁷⁴ Milwaukee Health Department, *Annual Report*, 1915, Milwaukee Health Department, Mss 2126, MCHS.

⁷⁵ *Ibid*, 23.

owing to improper feeding practices. Most immigrant mothers fed their children in the way they had been raised, with solid foods, alcohol, and folk cures. Artificial formulas, a growing trend in the early twentieth century, were difficult to mix and an unfamiliar food source for immigrant mothers; women resorted to what they knew from the old country. Unfortunately children did not respond well to these ill prepared formulas or were unable to digest and process the solid foods given to them. Despite these issues, it was noted that Italian children were still in much better health than the children of other nationalities in the city.⁷⁶

In assessing the overall health of Italian immigrants, one needs also to examine the occupations in which Italians were employed. Much of the manufacturing and industry in which Italians worked subjected them to irritants of the eyes, skin, and especially their lungs. Among factory owners, it was believed that “the Italians cannot endure long; rarely can they work more than nine or ten years under the best conditions, without completely ruining their health.”⁷⁷ Dust, poisons, fumes, and vapors as well as the excessive heat and humidity of the factory floors all contributed to the ill health of the Italian population. While not overtly ill with a contagious diseases, the Italian colony was slowly being worn down by debility, accident, and overwork.⁷⁸

The Italians, like the Germans before them, viewed hospitals and hospitalization with a skeptical eye. It was generally found that Italians were unwilling to be taken to American hospitals. They preferred “to suffer and die in their own homes without means for being properly treated and putting themselves to great expense, even refusing free

⁷⁶ Ibid., 32.

⁷⁷ Ibid., 28.

⁷⁸ Ibid., 27.

treatment at the hospitals.”⁷⁹ Hospitals in Italy were typically charitable institutions and places for the destitute, and that perception pervaded the Italian community on this side of the ocean as well.⁸⁰ To go to the hospital was to have fallen on the worst of hard times. It was a shame and a disgrace to community, family, and self. In addition, Italians, especially workingmen, felt very self-conscious of their difficulty in speaking English. For many, an attempt to explain to the doctor their problem made, “the sick one nervous . . . [for] he suffers physically and mentally.”⁸¹ The whole experience of doctors and hospital filled Italians with a “feeling of dismay and spiritual isolation . . . [N]o wonder, he prefers to stay home where his wife and children are always near to encourage him and keep his spirits up.”⁸² Consequently Italians preferred to stay within the familiar surroundings of one’s home, rather than seek outside medical care. In addition, the stigma of being seen as a charity case prevented many from outwardly seeking the help of the county institutions. This sense of pride pushed Italians to succeed, but it also drove them away from the medical attention and hospitalization so many desperately needed.

⁷⁹ LaPianna, 36.

⁸⁰ Ibid.

⁸¹ Ibid., 37.

⁸² Ibid.

African Americans

	Milwaukee's African American Population	Milwaukee's Population	Percentage of African American Population to Total Population
1870	176	71,440	.246361
1880	304	115,587	.263005
1890	449	204,468	.219594
1900	862	290,000	.297241
1901	980	373,857	.262132
1920	2229	457,147	.487589
1930	7501	578,249	1.297192

Figure 27: Milwaukee's African American Population and Percentage of Total Population, Milwaukee⁸³

Studying the health of African Americans in Milwaukee during this period presents an interesting set of challenges as records for the community and their health history are relatively scattered and sparse. While the first black settler, a cook for Solomon Juneau, came to the Milwaukee area in 1835, by 1850 the black population of the city only numbered twenty-three individuals.⁸⁴ As the first significant migrations occurred concurrent with the First World War, African Americans found unskilled jobs open to them in the city's tanneries, packing plants, foundries, and construction sites.⁸⁵ Most African American migrants came from Kentucky, Missouri, Tennessee, and Virginia. This population was predominately male (148 men for every 100 women).⁸⁶

⁸³ Trotter Joe. *Black Milwaukee*. (Urbana, IL: University of Illinois Press, 1985), 5.

⁸⁴ Conzen, 21.

⁸⁵ Gurda, 257.

⁸⁶ Trotter, 8.

Despite the work they performed, it was not uncommon for these migrants to be educated, forced into laborer positions and domestic service because of their race.⁸⁷

⁸⁷ Ibid., 9.

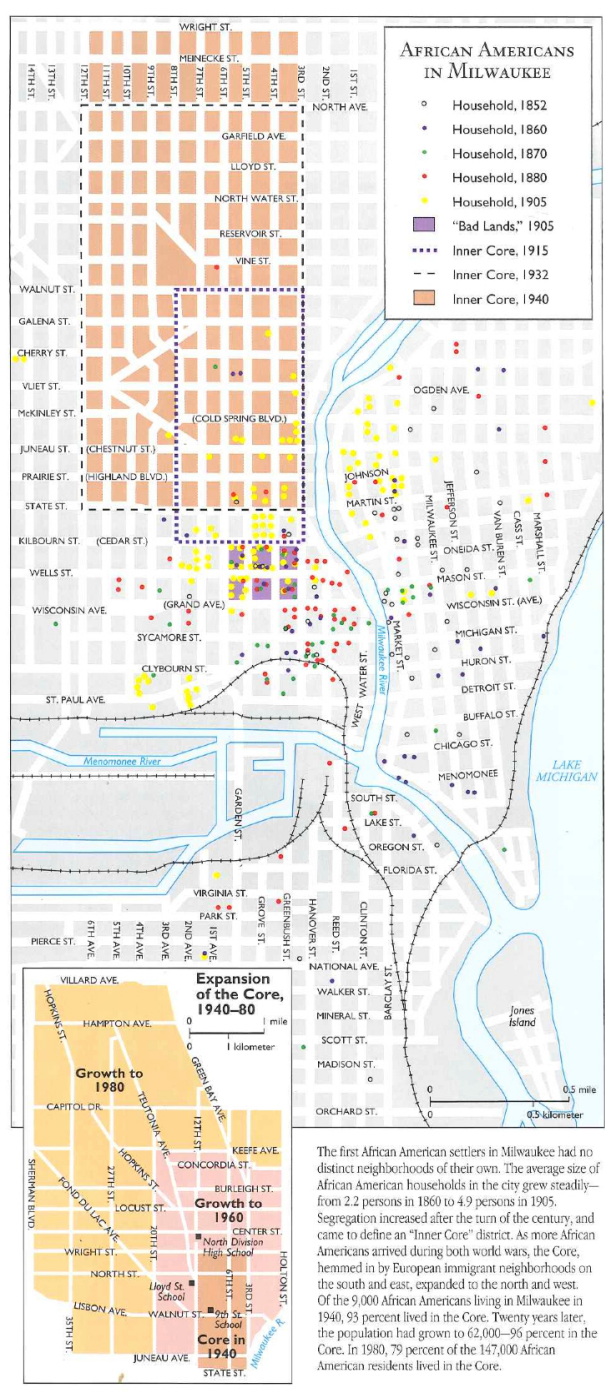


Figure 28: African Americans in Milwaukee⁸⁸

⁸⁸ Wisconsin Cartographer's Guild, *Wisconsin Past and Present* 32.

The area in which the majority of the African American housing was found by the 1930s was the area from Third to Twelfth Streets and from Juneau north to Brown.⁸⁹ African Americans moved into the neighborhoods that Jews were vacating in their move to the northwest side of the city. This district quickly became known as the “Negro district” even though by World War I, the area was still 50 percent white. The African American population who lived there frequently found themselves tenants of Jewish landowners who turned large homes into apartments or rooming houses.⁹⁰ A small but recognizable community of blacks was also beginning to emerge on the city’s near north side (See Figure 28). Another group of African Americans settled near the West Side yards and shops of the Milwaukee Road, in the Merrill Park neighborhood among the Irish population already established there.⁹¹ The city’s African American community, however, still grew slowly during this period, as blacks migrating from the South were delayed in any further movement north by the lure of jobs and a much larger African American community in Chicago.⁹²

A majority of African Americans were employed in the domestic and service trades, including employment as personal maids, domestics, and chauffeurs by 1915.⁹³ However, after 1916, with the growing expansion of the city’s industries, there was also a greater demand for cheap labor. Drawn by the lure of jobs in heavy industry, African American men came north from areas of the Deep South hoping to capitalize on new economic opportunities. Some would only be transitory residents in the city, returning to

⁸⁹ Thomas P. Imse, “The Negro Community in Milwaukee” (Master’s thesis, Marquette University, 1942), 2.

⁹⁰ *Ibid.*, 9.

⁹¹ Imse, 2.

⁹² Trotter, 8-9.

⁹³ Imse, 3.

the South when the jobs disappeared or when economic difficulties arose. But because it was predominately a male migration it was decidedly not a family migration. In this environment of boarding houses and day labor, life was transitory and disconnected. Housing for African Americans was very poor in construction, upkeep, and overall sanitation.

While there was a growing African American community in the city during the late nineteenth- and early twentieth-century, they were a statistical minority in comparison to other ethnic groups in Milwaukee's population makeup (See Figure 27). Consequently official agencies often did not keep separate records detailing African American health. The health department did not start to keep uniquely African American health statistics until 1939.⁹⁴ It took until 1941—under special request of the Milwaukee Urban League—for the city health department to conduct a health survey of the district in which most African Americans lived.⁹⁵ There was even a certain sense of timidity among city officials to enter the Black districts, so accurate population numbers as well as an accurate assessment of the health of the community were difficult to measure.

African Americans also faced a sort of culture clash in Milwaukee. Milwaukee health officials as well as city residents, perhaps more used to German and Eastern European accents, were stymied with black southern drawls and dialects. Margerite Willadene Brewer, by some accounts Milwaukee's first black nurse, was given the position and title of "interpreter" to Milwaukee's black community in the 1920s, even

⁹⁴ Interestingly, this is the same year that the health department, via the Office of Vital Statistics, also sought to initiate the keeping of statistics which focused solely on Mexicans in Milwaukee. One can assume that both populations, by 1939, had reached a tipping point where Mexican presence and their subsequent health issues were significant enough for official agencies to take notice of these "minority" groups.

⁹⁵ Imse, 17.

though she was a qualified public health nurse. She noted that accents of the newly arriving southern migrants were often difficult for white health department officials to understand. Her “translation” skills allowed for the health officials to more ably understand, diagnose, and treat illnesses within the African American community.⁹⁶ Language and cultural differences proved to be significant barriers to the access of medical care, even for those who were for all intensive purposes considered English speakers. Communication difficulties did not only apply to those who had come from foreign lands. Regional differences in speech proved to be a significant barrier to quality health care. A doctor’s inability to understand a patient or a medical professional who used complex medical terminology only created confusion and distrust for both parties. This is still one of the greatest barriers to immigrant communities today.

Slow population growth, coupled with marked prejudice from Milwaukee’s native-born and immigrant communities, hindered blacks in their search for both better health and better living conditions. Few hospitals, prior to 1930 and the founding of St. Anthony’s Hospital, admitted African Americans, with two exceptions: the Milwaukee County Hospital (and its associated public institutions -- the County Infirmary and the Emergency Hospital), and Mt. Sinai Hospital, the city’s Jewish facility. African Americans by most accounts were not welcome at other hospitals. The *Wisconsin Enterprise Blade* made special note of Mount Sinai Hospital, commenting in 1918 that there was “no color line” at Mt. Sinai and that the hospital was “ever ready to render assistance to any members of the Race.”⁹⁷ The paper went further to note that not only

⁹⁶ “Years ago...Black Nurse Knew Bias,” August 16, 1977, *Milwaukee Journal*, Milwaukee Features Microfilm, “Ethnic Black Americans,” MCHS.

⁹⁷ “No Color Line at Mt. Sinai Hospital,” September 1, 1928, *Wisconsin Enterprise Blade*.

was there no color line but that patients, regardless of color received care from a private nurse who showed a “marked interest in the health of the patient.”⁹⁸ Normal care was something exceptional for most African Americans in the early twentieth century. While having fled the blatant racism of the southern United States, African Americans were confronted with the more subtle, and at times more menacing, racism of the North.

By 1941, however, a health department survey noted that 79 percent of African American births took place in hospitals and 78 percent of deaths took place in hospitals. Apparently “the Negro is receiving good medical care, at least as he enters and leaves the world.”⁹⁹ By this time, one can suppose that the bulk of that hospital work was conducted by St. Anthony’s Hospital and to a lesser extent the county hospital rather than by a sudden interest of the other private hospitals. St. Anthony’s Hospital was created as part of the St. Benedict the Moor Mission at Tenth and State Streets. The Capuchin fathers who ran the mission wanted to not only address the spiritual health of the congregation, but also their physical health. Father Philip Steffes, of St. Ben’s, travelled to the Tuskegee Institute in Alabama and returned convinced of the need for a hospital focused around the needs of African American patients. The hospital was finally dedicated on May 10, 1931, serving not only the African American population but eventually the entire downtown area as well.¹⁰⁰ The health department noted most of the medical assistance, prior to the building of St. Anthony’s was done at public expense at county institutions.

⁹⁸ Ibid.

⁹⁹ Imse, 21.

¹⁰⁰ St. Benedict the Moor Mission, “The Dream of Father Stephen,” *Mission Annual*, 1949, Mss 2345, Father Stephen Eckert OM, CAP Collection, MCHS.

Thomas Imse in a survey of the “Negro Community in Milwaukee” in 1942 noted that the “health of the Negro is dependent, to a large extent , upon the quality of housing of the Negro, which is dependent, to a large extent, upon the possibility and the kind of employment the Negro can secure”¹⁰¹ For Imse, the link between good employment and good housing were intrinsic elements to the good health of the African American population in the city. Living units for African Americans were usually considered substandard, lacking minimum sanitary facilities. Numerous surveys of African American population and housing conditions in the city from the 1910s until the 1940s noted that housing for blacks was uniformly poor. A 1939 WPA housing survey noted that of the 3,698 residential units surveyed, 77 percent of housing units for Blacks were noted to be substandard, 41.8 percent of the units had less than five rooms, and 40.2 percent of the units had no private toilet or baths.¹⁰²

Advocates, both white and black, noted that African American housing was on average much worse than poor white housing in the city, even those in the same districts and neighborhoods. A 1926 survey by the Urban League noted that the 275 houses surveyed were not “adequate for the average comfort.” They further noted that despite this inadequacy rents for these dwellings had been raised “from 30 to 200 per cent when the houses are rented to Negroes.”¹⁰³ Without proper sanitation, black districts saw the spread of communicable diseases, frequently gastrointestinal in nature such as dysentery, gastroenteritis, typhoid, and various diarrheal diseases. Inadequate ventilation helped to spread airborne diseases such as diphtheria, influenza. Of special concern for the African

¹⁰¹ Imse, 1.

¹⁰² Imse, 10-13.

¹⁰³ “Housing of Negroes Milwaukee Problem,” *Milwaukee Enterprise Blade*, October 16, 1926.

American community was tuberculosis. The effects of these situations were cumulative. Uncertain employment prospects and difficult working conditions meant the lowest salaries which forced them to live in the cheapest accommodations available. Cheap housing usually translated into poor health.

The link with higher than average venereal disease rates, specifically syphilis, may stem from less access to treatment at venereal disease clinics, as well as a reluctance by African Americans to seek treatment for a disease which carried a set of social and moral condemnations. African Americans suffered from syphilis rates almost three times the rate of non-Blacks (61 per 100,000 versus 24 per 100,000). Some in the community attributed this disproportionate rate of syphilis to perceived lower standards of morality in the African American population. Imse noted that “it must be remembered that low standards of morality, syphilis and illegitimacy are common to all groups of low income standards. According to members of the Negro community, there has been a noticeable change in the moral tone of Negroes in the past ten years or so.”¹⁰⁴ Some in the African American community saw the newcomers from the Deep South as less educated and less morally grounded than their predecessors. The Urban League’s 1926 housing survey had also noted the problem of boarders in the African American community. As a way to ease the burden of rent, many families took in boarders but they were seen as a “constant menace to family life.”¹⁰⁵ Similar to the Italian situation, these new tenants were a constant source of concern for the young women in the household, but their presence was tolerated for economic reasons.

¹⁰⁴ Imse, 20.

¹⁰⁵ “Housing of Negroes Milwaukee Problem.”

Tuberculosis for the African American community and health reformers was a great puzzle, and one of the greatest concerns for both groups. African Americans suffered and died from tuberculosis in rates from seven to thirteen times that of white population. A 1938 report noted that the death rate among Negroes was 135 per 100,000 population while the rate for whites in Milwaukee was only thirty-nine per 100,000, a ratio of three and one-half to one.¹⁰⁶ A 1940 report noted that the ratio of tuberculosis deaths had actually increased to 193 per 100,000 population, with a tuberculosis rate of 258.8 per 100,000 compared to 37.5 per 100,000 for the rest of the city's population.¹⁰⁷ While no one single factor can be pointed to in explanation for this skewed ratio, a series of converging elements might help to explain the phenomena. There are studies suggesting that Africans, and thereby African Americans, have a genetic variation that leads them to be more susceptible to diseases like tuberculosis.¹⁰⁸ That genetic predisposition factored with crowded living conditions and poor ventilation in housing led to higher than average rates of tuberculosis.

The Milwaukee Health Department pointed to extraneous factors as the reason for high mortality and morbidity rates among African Americans, for they perceived that blacks were receiving adequate medical care in the city. The Health Department believed that the higher rates for mortality were due "to either poor environment or to some innate biologic conflict to be found in all Negroes."¹⁰⁹ Some scientists suggested that African Americans had a genetic vulnerability to tuberculosis, in particular, because of their late

¹⁰⁶ "Tuberculosis Claims Many Milwaukee Negroes," January 12, 1941. Condensed and adapted from "The Survey Graphic" by Louis I. Dublin, uncited newspaper clipping, "Ethnic-Negroes Clippings," MCHS.

¹⁰⁷ Ibid.

¹⁰⁸ Richard Bellamy, et al., "Genetic Susceptibility to Tuberculosis in Africans: A Genome-Wide Scan," *Proceedings of the National Academy of the Sciences* 97, No.14 (July 2000): 8005-8009.

¹⁰⁹ Imse, 21.

arrival to the urban world.¹¹⁰ This reasoning assumed that European immigrants had a longer exposure to more dense living conditions and that this long exposure to crowded and often unsanitary conditions led to a growing immunity to some chronic (non-epidemic) diseases.¹¹¹ Moreover, African Americans, reformers, and health officials pointed to the inadequate and insanitary housing that African Americans were forced to live when they arrived in Milwaukee at the beginning of the twentieth century as an explanation for the high rates of tuberculosis among this population. Crowded, poorly ventilated housing became an incubator for all communicable diseases, but especially tuberculosis.

Louis Dublin, a statistician and health writer, noted that when blacks moved north they moved out of the environment they had become accustomed to and into the cities, a completely foreign environment for them. Leaving behind warmer climes, fresh air, and rural surroundings, they were “forced to live in the poor areas which are always about the center of the city and near the manufacturing, which means a very unhealthy atmosphere.”¹¹² Dublin not only saw a connection with their living conditions and their overall health, but in the type of employment which African Americans took on when they arrived in Northern cities. Used to hard outdoor manual labor in hot, muggy

¹¹⁰ Frederick S. Crum, “The Mortality from Consumption in Small Cities,” *Publications of the American Statistical Association*, Vol. 10, No. 80 (December 1907): 448-479; Marion M. Torchia, “The Tuberculosis Movement and the Race Question, 1890-1950,” *Bulletin of the History of Medicine*, Vol. 49, No. 2 (Summer 1975), 152-168.

¹¹¹ While tuberculosis would be rampant in Europe and the United States throughout the nineteenth and twentieth centuries, the disease had evolved such that it was able to keep its host alive for decades before the host finally succumbed to the disease. Both the tuberculosis bacillus and human biology had adapted to one another, but to neither’s real benefit. For more information regarding the evolution of the tuberculosis bacilli, see Thomas Dormandy, *The White Death: A History of Tuberculosis* (London: Hambledon Press, 1999); René and Jean Dubos, *The White Plague: Tuberculosis, Man, and Society* (New Brunswick, NJ: Rutgers University Press, 1996); and Shelia M. Rothman, *Living in the Shadow of Death: Tuberculosis and the Social Experience of Illness in American History* (Baltimore: Johns Hopkins Press, 1994).

¹¹² Louis I. Dublin, *Health and Wealth: A Survey of the Economics of World Health* (New York: Harper, 1928), cited in Imse, 21.

conditions, the factory and laboring jobs in the industrializing North were far from their work experience in the South. Working at repetitive factory stations or dangerous cutting floor work, both the condition and type of work was new to many blacks. According to Dublin, it would take years for the body and physiology to adapt to the new work and home environment. The intermediate period would prove to a difficult period of adaptation where they would be susceptible to illnesses more historically associated with urban inhabitants. Dublin saw Southern blacks as primarily a rural population who had “certain basic needs of diet and sunshine to keep them in comparatively good health.”¹¹³ Cold Wisconsin winters might have been the most stark adaptation that those who worked outside. While Dublin’s ideas might seem somewhat antiquated, biological adaptation of human populations is a proven concept and it is just as likely to happen in shorter historical episodes as in larger geologic epochs.¹¹⁴ Confronting a markedly different climate, disease pool, and working conditions would likely have left African Americans with a weakened immune system and more susceptible to the endemic diseases of Milwaukee.¹¹⁵ Attempting to eke out a living in some of the poorest working conditions, dilapidated housing, and a climate much different from what they had known was a challenge both economically and biologically for the African American population of Milwaukee. Disease knew no color lines and was not affected by the prejudices of people. While some did not see African Americans as equals, the “health of Negroes is

¹¹³ Ibid, 22.

¹¹⁴ Joseph Alexander Tillinghast, “The Negro in Africa and America,” *Publications of the American Economic Association*, 3rd Series, Vol. 3, no. 2, (May 1902): 1-231.

¹¹⁵ Ibid.

the concern of all. If Negroes have any diseases it is likely to be communicated to whites.”¹¹⁶

Trials of the City

Tuberculosis

While we have already addressed the issue of tuberculosis for African Americans, the disease was a serious concern for many other immigrants as well. For those immigrants arriving as part of the “New Immigration,” housing and living conditions in the city of Milwaukee were less than desirable. Immigrants were often forced into the substandard housing that had been occupied by earlier arriving groups. While immigrants would have preferred better housing conditions, the reality of housing conditions in the city forced them into older housing stock and their unsanitary conditions. While these poor housing conditions were a focus of the medical and philanthropic organizations, the residents themselves also sought to change their situation and improve their lot in life.

By the 1910s, a growing campaign by health officials, social agencies, and even journalists sought to raise awareness regarding poor housing in the city and to evoke changes in municipal policies and living conditions. Clear associations were drawn between poor housing conditions and poor health. Both chronic and contagious diseases easily spread in the crowded and unsanitary conditions, and made these congested areas

¹¹⁶ “The Health of Negroes is the Concern of All” undated, uncited newspaper, Milwaukee Features Microfilm, “Ethnic-Black, Negroes,” MCHS.

centers of disease outbreaks. From 1911 to 1915, the health department noted that 25.5 percent of the deaths from contagious diseases (3,388 deaths) occurred in districts of bad housing, areas that contained only 8.5 percent of the city's population.¹¹⁷ Similar ratios can be seen as well for tuberculosis, where for the same time period, of the 4,550 cases of tuberculosis, 1,245 or 27.3% of all the cases occurred in the areas of poor housing.¹¹⁸ The link between poor housing and poor health was clear to both those living within the conditions as well as those attempting to minister to those populations.

Tuberculosis was one of the great winnowers of human populations at the turn of the last century. While frequently associated with poor, urban, and unsanitary conditions, the Milwaukee community came to realize that tuberculosis was no longer a disease exclusively of the poor as increasing numbers of affluent members of urban communities contracted the disease as well. A growing concern for the spread of this disease into more comfortable areas of the city alarmed both the wealthy residents as well as health officials attempting to combat the disease. Controlling tuberculosis in the poorer areas of the city became a benefit to all, rich and poor alike.¹¹⁹ Health officials closely tied tuberculosis with overwork, poor working conditions, and the overexertion of the urban lifestyle. A 1909 report by the Federated Jewish charities directly tied poor housing, working and living conditions with the onset of tuberculosis.

Those who are engaged in unskilled and underpaid occupations, must by force of necessity, resort to unreasonably long hours of activity; thus, owing to an irregular mode of living and physical over-exertion, and lacking the necessary sustenance where-with to replenish the expended energy, the physical structure

¹¹⁷ Ruhland, *Housing Conditions*, 7.

¹¹⁸ *Ibid.*

¹¹⁹ Federated Jewish Charities, "Annual Report," 1909, Milwaukee Manuscript Collection 87, Box 3, Annual Reports, 1909-1923, 1925-1930, Federated Jewish Charities, Jewish Family and Children's Services, UWM.

becomes devitalized, and if the individual chances to resist an attack of the dreadful white plague, he must eventually succumb to other forms of diseases...he is forced to extreme economy of living in quarters unfit for human beings. Under-feeding, insufficient clothing, improper housing, over-work and lack of health and necessary recreation are the primary causes of tubercular and other diseases.¹²⁰

Control those elements and the cases of tuberculosis would be markedly reduced. While concern over tuberculosis was of greater concern in the Jewish and African American communities because of its prevalence, it remained a constant concern for all Milwaukee's citizens and health officials. The Anti-Tuberculosis Association offered numerous informational clinics, screenings for the disease, and economic and social service aid for those infected. As early as 1882, a group of Milwaukee women, led by Mrs. Robert C. Reinersten, set out on a "crusade against expectoration."¹²¹ This anti-spitting campaign hoped to curb the unsanitary habits of Milwaukeeans and thereby curb the spread of communicable diseases, especially tuberculosis which was easily spread through contact with infected sputum and mucus. By all accounts, Mrs. Reinersten's campaign was quite successful for the Board of Health eventually passed health legislation making it illegal to spit on streetcars and in other enclosed spaces. Teaching immigrants "American ways" was much more than simply teaching them the English language, but also instructing them in "proper" public behavior.¹²²

Even with campaigns such as the anti-spitting movement, tuberculosis still claimed countless lives and hours of productivity. Those diagnosed with tuberculosis in

¹²⁰ Ibid.

¹²¹ "Start Crusade on Spitting," February 22, 1903, uncited newspaper, Milwaukee Features Microfilm, "Women of Milwaukee," MCHS.

¹²² James R. Barrett, "Americanization from the Bottom Up: Immigration and the Remaking of the Working Class in the United States, 1880-1930," *Journal of American History* 79, no.3 (December 1992): 996-1020.

the city of Milwaukee were sent to one of a number of institutions depending on the severity of the illness and the age of the patient. Muirdale Sanatorium in Wauwatosa was the primary tuberculosis hospital for those diagnosed with active cases of the disease. At Muirdale, patients received the standard cures of the day: fresh air, sunlight, and rest. The prevailing medical opinion in the early twentieth century held that fresh country air was best for the tubercular patient, as it did not contain the pathogens and pollutants that caused the problem in the first place. This fresh air treatment regime was applied to the patient on a year round basis. Patients in Muirdale slept, ate, worked, and recreated with windows open year round. Sunlight “cures” were also used as a way of making sure that patients received much needed vitamin D from sunlight. The sunlight treatments, in addition to the “fresh air” therapy, while not a replacement for pharmaceutical treatments, were an attempt to provide patients with the “ideal” environment in which to battle the disease. Finally, and perhaps the most important part of the cure from this period, patients received much needed rest. A criticism leveled in the 1911 annual reports of the Federated Jewish Charities noted that when patients were finally diagnosed, the time suggested for treatment in the sanatoria (three to six months) was often insufficient for advanced cases. “At the most critical period in the patient’s history, he is discharged hopeless and helpless, and invariably not cured; and it is at this crucial hour that the indigent patient is forced to seek aid from either private or public charities, only too often to remain a permanent charge upon society.”¹²³ Not only did tuberculosis debilitate the body, but it left individuals and families economically crippled as well.

¹²³ Federated Jewish Charities, Annual Report, 1911, MKE Manuscript Collection 87, Box 1, Board Meeting Minutes, 1914-19, Jewish Family and Children’s Services, UWM.

Individuals suspected of being exposed to tuberculosis, but not yet manifesting positive symptoms were housed at the Blue Mound Preventorium on Bluemound Road in Wauwatosa near the County Institutional Grounds. The largest group of Preventorium patients was children who had been removed from tubercular households. Health officials hoped to eliminate any chance that the disease would become a chronic condition in later life by exposing them to the same treatments as adults.¹²⁴ Subjected to rigorous exercise, fresh air, heliotherapy health officials hoped the children's immune systems would grow stronger away from the urban environment. In an age prior to the widespread use of antibiotics, "healthy living" with better housing, ventilation, and sanitation were frequently the only tools at the disposal of health officials to treat this deadly disease.

Housing

Figure 29 presents an image of the "congested" housing districts in Milwaukee in 1916. The areas darkened in the map are also coincidentally areas that had high immigrant populations—Jewish, Polish, and African American areas specifically.

¹²⁴ Milwaukee Health Department, Annual Report, 1916, Mss 2126, Milwaukee Health Department Collection, MCHS.

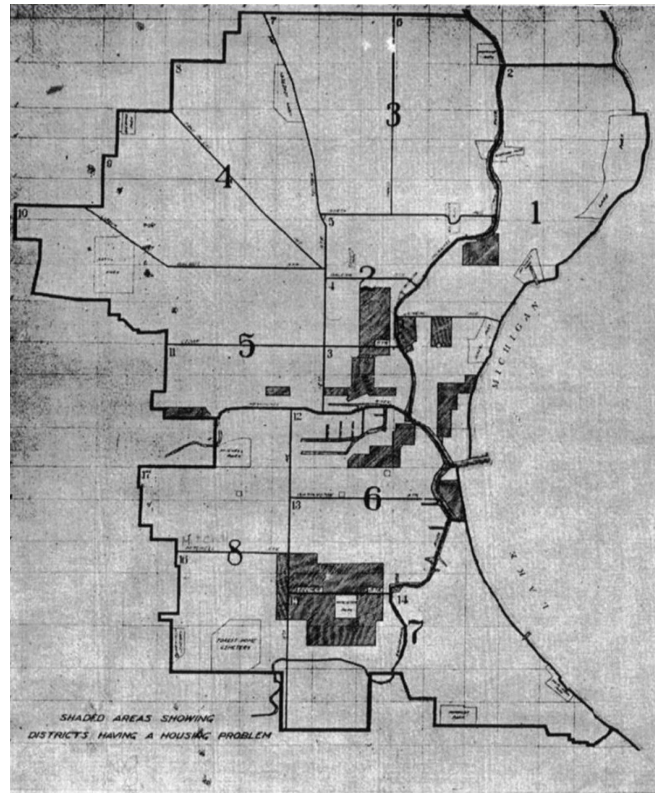


Figure 29: Areas of “Housing Problems” in Milwaukee, 1916¹²⁵

One major factor in disease rates, especially tuberculosis, was the state of housing in Milwaukee. But housing affected much more than disease. It also affected the moral and psychological behavior of residents. A few districts in the city, particularly areas on the city’s near south and north sides, were problematic in the eyes of reformers. A Health Department study conducted over four years from 1911 to 1915 showed that “26.5 per cent of the deaths from acute diseases of childhood, plus tuberculosis and typhoid, occurred in areas of poor housing which contained only 12 per cent of the population.”¹²⁶

¹²⁵ George Ruhland, *Housing Conditions in Milwaukee* (Milwaukee: Milwaukee Health Department, 1916), 5, Mss 2126, Annual Report, 1916, Milwaukee Health Department, MCHS.

¹²⁶ Edith Elmer Wood, “Slums and Blighted Areas in the United States,” (1935): 64, Mss 546, Box 12, Pamphlets, “Housing,” Daniel W. Hoan Collection, MCHS

These troubled districts had higher rates of death, sickness, arrests, and juvenile delinquency, and were estimated to have covered 3.7 of the city's total area.¹²⁷

While some might have thought that these problems only existed in places like New York or Chicago, Milwaukee quickly developed housing problems as well. Districts considered “slums” or “blighted” areas were “not conducive to the physical and moral health of the inhabitants”¹²⁸ A survey of the African American district of Milwaukee found that of the 2,068 dwellings in the area, 2 percent fronted on alleys, 13 percent were behind other buildings, 57 percent were less than five feet apart, 46 percent shared a toilet between two or more families, and 63 percent of the housing lacked central heating.¹²⁹ A significant amount of the African American community clearly lived in substandard housing, which directly contributed to their rates of sickness and disease.

These examples of African American housing touched on a number of problems that made housing so poor and dangerous to the health of the immigrant and minority communities in Milwaukee. Poor ventilation was a constant problem and was long known to be a culprit in the spread of diseases, especially tuberculosis.¹³⁰ Rooms often had only one window, which opened onto an interior court or even worse to an airshaft with no direct sunlight or fresh air reaching these rooms.¹³¹ Congestion also factored into the dilapidation of this housing stock. Immigrants, with little money, crowded into rooms

¹²⁷ “Poor Housing Perils Health and Morals, is Survey Finding,” 1916, uncited newspaper, Milwaukee Features Microfilm, “Housing,” MCHS. A study by the Health Department noted problems in the First, Second, Third, Fourth, Fifth, Sixth, Eighth, Eleventh, Twelfth, Fourteenth, Sixteenth, Seventeenth, and Twenty-fourth Wards, and Jones Island.

¹²⁸ Wood, 65.

¹²⁹ Ibid, 64.

¹³⁰ United States Public Health Service, “The Relation Between Housing and Health,” *Public Health Reports* 49, no. 44 (November 2, 1931): 1306.

¹³¹ Ibid.

designed for far fewer people. These conditions also led to a greater potential for accidents, such as fires, within dangerously dilapidated structures.

These housing conditions had a profound effect on physical health and development. Children's growth was stunted as they did not receive enough sunlight, leading to an epidemic of rickets in slum areas. The slums themselves as well as the entire urban environment made it difficult for children to play outside as they constantly ran the risk of accident and disease from the dirty city streets.¹³² As previously noted, tuberculosis raged in these slum areas, accounting for over 27.3% of tuberculosis cases.¹³³ These were areas where one could not avoid sickness and debility.¹³⁴ The housing physically wore people out through insufficient sunlight, fresh air, and clean surroundings.

Poor housing also had an effect on the morals of the community as "34% of all the bad housing is a direct and immediate menace to the health and morals of the occupants."¹³⁵ A connection was frequently drawn at the turn of the century between morality and sickness. It was reasoned that those who lived in squalid, unhealthy conditions were somehow morally corrupt and deficient, that they were somehow to blame for their condition. George Ruhland, the city's health commissioner, refuted these ideas after he saw that both immorality and tuberculosis were not confined to the slum districts. While there was a tendency to blame residents of those districts for the housing conditions, Ruhland believed it was entirely legitimate to indict all of society that allowed

¹³² Ibid, 1307.

¹³³ Ruhland, "Housing Conditions in Milwaukee," 7.

¹³⁴ City Club, "The Extent of Poverty in Milwaukee," City Club of Milwaukee, MKE Manuscript Collection AS, Box 4, Social Problems Committee, 1916-17, UWM.

¹³⁵ "Poor Housing Perils Health & Morals is Survey Finding," 1916, uncited newspaper, Milwaukee Features Microfilm, "Housing," MCHS.

those conditions to continue.¹³⁶ He held to the growing belief in the new field of sociology that bad housing had a definite influence on people's health and habits. Ruhland quoted Charles Dickens who suggested that, "reform of the habitation of the masses of the people must precede all other reform and without it all other reforms must fail."¹³⁷ Ruhland fundamentally believed that "environmental influences bear a definite relation to the physical, moral and social status of man . . . if housing conditions are poor, the health, morality and citizenship of those living under such conditions will likewise be on a low-plane."¹³⁸

Poor housing was directly connected with rates of poverty in the city. Poor people by default lived in poor housing and suffered the consequences of both. A survey of poverty in Milwaukee in 1917 determined that "25,000 or 23.6% of the families out of 105,000 enumerated by the Telephone Company are below the poverty line . . . If the families average five members each, this means that 100,000 persons are living in inadequate dwellings."¹³⁹ To maintain a "decent" standard of living was a difficult task in light of economic and health uncertainties. A 1915 study estimated that \$750 was the yearly base minimum that a family of four could survive on. It was estimated that same year, however, that over 25,000 Milwaukee families fell well below that \$750 poverty line.¹⁴⁰

Families found various ways to work around these issues of poverty. Some sought help from Milwaukee County institutions, including the Poor Office, the County

¹³⁶ Ruhland, 12.

¹³⁷ Ibid., 7-9.

¹³⁸ Ibid., 3.

¹³⁹ "The Extent of Poverty in Milwaukee."

¹⁴⁰ City Club of Milwaukee, *Povometry*, (1917), 22-a. Milwaukee Manuscript Collection AS, Box 55, "Povometry, 1917," City Club of Milwaukee, UWM.

Hospital, and the Home for Dependent Children. Others turned to private agencies for assistance including the Salvation Army, the Hebrew Relief Association (Jewish Family and Child Services), and numerous other religious charities. The Department of Outdoor Relief, the Associated Charities, and the United Hebrew Charities were the three largest relief organizations in the city.¹⁴¹ Some families simply did without. When money became tight, one place that families cut back on was food. Wives would frequently feed their breadwinners first, with the youngest children and her eating last. Others found “cases [where] the entire family is underfed, in others they are crowded into quarters that are too small, while many parents are forced to take their children out of school and put them to work to make both ends meet.”¹⁴² Desperate times called for desperate measures. Malnutrition not only caused problems for the next generation, but created a population that would be more sickly, more stunted, less efficient, and who would have lower life expectancies.

Poverty also drove many to a criminal life (theft, prostitution, larceny) to survive the difficult times, but this action created a negative pall over all the poor -- criminal or honest. Criminality in the city also factored into discussions of the “wellness” of the community. For Progressive Era America, there was a direct link between poor housing, poor health, and immorality. This link also played into nativist and racist ideas that attempted to put the blame of poor sanitation, poor housing, and poor health at the feet of the immigrant and African American communities. If crime and vice could be eliminated in these areas, then logically they would physically improve as well.

¹⁴¹ Ibid.

¹⁴² City Club of Milwaukee, “30,000 in Poverty,” *Milwaukee Journal*, April 7, 1917, Milwaukee Manuscript Collection AS, Box 4, “Social Problems Committee, 1916-17,” City Club of Milwaukee, UWM.

Thomas Imse, in his study of the African American community, noted that a considerable amount of crime was a “typical phenomena of any low income class group.” Criminality in the African American community was linked to housing problems, job uncertainty, and poor health. Problems of domestic disputes and poor parenting, while seen as the cause for a growing criminal element, were also traced to environmental factors. The nature of African American family life provided a target for the white community, which frequently pointed at lack of two parent households, poor parental guidance, and rates of illegitimacy for the poor situation of blacks found themselves.¹⁴³ While the majority of crimes attributed to African Americans were either petty (larceny, purse snatching, stealing, or burglary) or moral (drunkenness or drunk and disorderly) in nature, nevertheless in the minds of reformers and officials they contributed to the overall poor state of life for blacks within the city limits.¹⁴⁴

The University Settlement also raised warning flags regarding morality and health issues in the Polish community of the South Side. In advocating for a larger facility for the settlement, its leadership believed in the “intrinsic worth in sound clean bodies and cleaner minds.” By providing a place for young men and women to gather for sports, dramatics, socials, and even dances, they could limit the detrimental effects of the surrounding community. Of special concern was the vice of the saloon dance hall which H. H. Jacobs, the founder of the settlement, believed was “the gateway to a downward path for many of these factory girls.” Avoiding the vices of the street meant that men,

¹⁴³ Imse, 39.

¹⁴⁴ Milwaukee County House of Corrections Annual Reports, 1905-1930. Personal Collection.

and especially women, would be spared from the devastating effects of sin, drink, drugs, and venereal disease.¹⁴⁵

While the highest number of arrests occurred among those who identified their nativity as “United States,” newly arrived immigrant groups followed close behind. Between 1909 and 1939, 1200 to 2500 inmates were incarcerated yearly in the House of Corrections. Of those inmates between 300 and 500 were German, between 200 and 400 were Russian, between 200 and 500 were Polish, and between 200 and 300 Austro-Hungarian.¹⁴⁶ While the majority of crimes centered on alcohol-related crimes, larceny, and vagrancy, these crimes shaped how people viewed immigrant groups. The perception of criminality was enough to focus considerable nativist sentiment toward individuals or ethnicities were considered undesirable.

Unfortunate Ends

For many immigrants, the dreams and promises of what Milwaukee could provide were hopelessly dashed. For some, no matter how hard one worked, how careful every penny was saved, or how cautiously one guarded against illness and injury, they somehow found themselves on the charity rolls, with only one place to turn: the Milwaukee County Department of Outdoor Relief. This was the gateway agency through which one had to pass in order to gain access to any of the county institutions and agencies. A significant majority of the city’s immigrant poor found themselves in its care

¹⁴⁵ University Settlement House, *Record Book*, December 14, 1909, Milwaukee Features Microfilm, “Settlements,” MCHS.

¹⁴⁶ Milwaukee House of Corrections, Annual Reports.

at some point of their lives. County institutions were salvation when all hope was lost, the locations of last resort when no other help could be found. They were also a place of desperation for many who entered as their journey ended in the pauper's grave.

Milwaukee County had in the 1860s established the Milwaukee County Institutional Grounds just west of the Town of Wauwatosa, far in the countryside outside of the city of Milwaukee. The grounds housed an almshouse, originally known as the poor farm, which transformed in the twentieth century into the county infirmary, the old age home for the county. Also on the grounds were two tuberculosis sanatoriums, Muirdale and the Blue Mound Preventorium, the county hospital, the Hospital for Mental Diseases, the Home for the Chronically Insane, and the Home for Dependant Children (part orphanage and part foster facility for children under eighteen). The county hospital was the hospital of last resort for most city residents. Special permission had to be granted for admission to the county hospital, but the hospital treated all races, religions, and all cases of illness, including venereal diseases that private hospitals would not accept.¹⁴⁷

The most feared "institution" located at the county grounds, however, was the pauper's cemetery that served these county institutions. Burial in a potter's field was relegated to those who were too poor to bury their loved ones in a private cemetery, those who for moral reasons (suicide) were denied burial in religious cemeteries, and those died unclaimed at other institutions or at the county morgue. This place was the ultimate point of destitution, the lowest one could descend in society and life: burial in a simple white shroud and pine box, with little certainty how long your remains would actually rest in

¹⁴⁷ Milwaukee County Hospital, Annual Reports, 1902, Mss 723, Milwaukee County Institutions and Departments, MCHS.

that ground.¹⁴⁸ Impoverished immigrants ended their lives here at the potter's field.

Ethnic names such as Reuchert, Alioto, and Budzinski dominate the hand written ledger.

When the Milwaukee County Poor Farm cemetery was disinterred in the early 1990s, 1,649 skeletons were exhumed from what was left of the 1880 to 1929 burial plot. These remains were a telling reminder of the harsh living and working conditions of Milwaukee's immigrant poor. Of the 1,649 skeletons, over 600 were infants less than three years of age. The remaining individuals were primarily adults, with a small handful of juvenile individuals in the collection. The adult skeletons told the story of long hours of backbreaking work, exposure to communicable diseases, and physical traumas in life. A number of women in the collection suffered from ossification of the ligament, their tibias (lower leg bones) affected by a condition called "washer-woman's knee" brought on by long hours typically spent scrubbing floors. Numerous men presented with fused vertebrae and collapsed disks, no doubt from carrying heavy loads and repetitive stress to the neck and back. Tuberculosis was also common throughout the skeletal collection, with evidence present on the ribs and vertebrae of infected victims.

Along with the anonymity of the pauper grave came the uncertainty of permanent burial. Prior to the 1990s excavation (which was an "accidental" uncovering of the cemetery), numerous graves had been destroyed after steam tunnels, fiber optics lines, and new construction was placed in and around the County Institutional Grounds. When a nurses residence was built upon the burial site, only *five* years after the last interment, the project destroyed an estimated 2,000 graves. The poor in life, were rarely at peace in death. Dozens of skeletons also showed evidence of autopsies, and even use at the

¹⁴⁸ This section would be moved once more in the early 1990's as further construction at the County Hospital necessitated the removal of over 1600 individuals and their subsequent storage elsewhere.

medical college for anatomy classes. Hesitant and amateur cuts with a striker saw, pins and hooks still in skulls all attest to the “use” of these poor individuals. Finally, the way in which they were buried also hints at their social status. Plain wooden coffins, few identifiable personal objects, even extra body parts and garbage (usually beer bottles) tossed into graves spoke to how they were thought of in life and death.

A further examination of both the burial ledger and the coroner’s reports linked to these burials attest not only to the tragic lives of these individuals, but to the distinctly ethnic character of those seeking care at the county institutions and to those being buried in the potter’s field. What is also striking to note is the greater proportion of men to women at the burial grounds, which also mimics the overall trend of European migration during this period. One finds within these records the likes of Susie Glodowski’s son, suffocated by his mother when only a few hours old; Jacob Zoeller who shot himself in a downtown hotel; Dorthea Zimersdorf, eighty-two years of age, who supposedly “went out of her mind on the ship coming over” and hung herself once here in Milwaukee; and Elizabeth Hoffman, a native of Germany, who was found in a downtown hotel, the victim of a brutal bludgeoning. These, like so many others, had sought the American dream, but instead found themselves with an American heartache.

Conclusion

Immigrants group struggled with cultural and medical ideals that conflicted with that of medical authorities. Traditional culture and folk medicines frequently clashed with the “modern” medical establishment and authority. For many immigrant groups, when members of their family or community fell ill they were cared for by the local

community. Hospitals were places that individuals went to die, not recover. Even more frightening were the isolation hospitals where individuals were quarantined without the privilege of visits from family or friends. Immigrants feared and reviled health authorities for they saw them as a threat to their community, their family, and their way of life.

In 1916, in an attempt to provide for a greater self-identification of medical and health problems, the City Club of Milwaukee conducted a comprehensive one-day survey of Milwaukee's health. Similar in concept to a census report, the City Club organized a large group of volunteers, social workers, and health officials to canvas the city in an attempt to have average Milwaukeeans complete a survey on their health and the health of their family. Letters were sent in a number of languages to members in the community and to various religious leaders in the community. The survey even received a vote of confidence from Mayor Hoan. What the survey showed was a decidedly sick city, where on a given day over 10 percent of the population as ill (approximately 40,000 individuals). What deeply concerned the underwriters of the survey was the rate of sickness amongst the poor and immigrant groups. Eleven percent of the patients, despite being sick, had not seen a doctor in six months, and among the poor and immigrant populations that number rose to 37 percent.¹⁴⁹ For a number of reasons both economic and social, the immigrants and poor in Milwaukee's society were not seeking medical care or receiving it when it was desperately needed. Something had to be done and eventually was done.

Immigrant communities benefited as social welfare organizations created programs to minister directly to them. Increasingly, as immigrants gained more stability

¹⁴⁹ "A Cooperative Census of Sickness," *The Survey*, November 11, 1916.

in their homes, occupations, and even the local language, they also began to advocate for themselves and their self-interests. Instead of simply having those in power dictate the health discussion and direction of health work in the city, a progressive step was taken by involving the citizenry in their own health, and in the end, in the overall health of the city.

The history of health and immigrants in Milwaukee has been a negotiation of linguistic, cultural, and social understandings. Each new group brought to Milwaukee their systems of healing, their conceptions of medical care, and their hygienic and dietary practices. Once in the city, however, a complex and frequently awkward system of translation between ethnic and racial community and those in the health care establishment began to be negotiated. For just as the newcomers brought their traditions, prejudices, and practices, those who held power and control in the city's health and welfare agencies brought their own to the negotiating table. Each side frequently failed to realize the different languages being spoken, but in the end what resulted, while at times difficult and strained, was a delicate negotiation to promote good health, good citizens, and overall a better Milwaukee. The health of those most marginalized also was a reflection on society as a whole. For the "health of urban American, particularly that of minority citizens" is so poor in "comparison to that of the rest of our nation's citizens that it constitutes a national disgrace and an embarrassment."¹⁵⁰ While health officials, social reformers, and the immigrants themselves would try to change this situation they frequently fell well short of their goals.

¹⁵⁰ Reed Tucker, "Urban Health Issues," *Journal of Negro Education* 58, No. 3 (Summer 1989): 276-280.

Conclusion

Milwaukee by 1929 finally achieved the title of the “healthiest city” in the country. The city would hold that honor for two years (1929 and 1931), before being barred from competition in the nation-wide health contests.¹ Despite the Great Depression, Health Commissioner John P. Koehler would declare that 1933 had been the “most healthful year in the history of Milwaukee.”² The rates of female mortality dropped throughout the early twentieth century. The number of puerperal deaths held steady at a few dozen cases per year by 1936, despite Milwaukee’s growing population. The introduction of penicillin dramatically altered both rates of puerperal infection and caesarian section, as doctors were now more capable of controlling an infection post-surgery and post-delivery. While women were surviving childbirth in ever increasing numbers, the 1930s and 1940s brought new controversies as the eugenics movement

¹ “Health Contests,” City of Milwaukee, Vital Statistics Office. “The Healthiest City” was an award presented to the city of Milwaukee in 1929 by the Chamber of Commerce of the United States for Milwaukee’s first place in the national health conservation contest. The contest measured various aspects of health in the city including infant mortality rates, general mortality rates, general health improvements, and improvements in environmental health. George Dundon, “Health Conservation,” *Milwaukee Health Department Bulletin* 20 (1931): 9-11. In the years, after Milwaukee was afforded a “special” award for cities who had previously won (and were thereby barred from competing in the process) but who still had excellent health records.

² Milwaukee Health Department, Annual Reports, 1933, Mss 2126, Milwaukee Health Department Collection, MCHS.

gained momentum and increasingly targeted women whom they deemed immoral or feeble-minded. The battle for women's bodies and their reproductive rights was a battle that was far from over.³

For children in Milwaukee, the situation was also dramatically improving. Koehler noted in the same annual report of 1933 that the infant mortality rate was declining each year.⁴ The Health Department seemed to be winning their battle against childhood and communicable diseases, as the epidemics of scarlet fever, diphtheria and even smallpox had all but ended by the late 1920s. The campaign to clean up the city's milk supply, while a violent and contentious issue, dramatically lowered rates of both tuberculosis among children and made milk a staple for most children's diets.⁵ Even the working and living conditions of children were dramatically improved by the 1950s. Herbert Jacobs of the University Settlement House was instrumental in passing legislation for a legal minimum age for factory workers; restrictions on the number of hours children could work, minimum physical requirements for child workers, and even promoted the necessity of parks where children were allowed to play on the grass. Safe spaces at work and safe spaces to play created healthier children, and eventually, healthier adults.⁶

Despite the Great Depression, the lives of working men also improved during this decade. The same Herbert Jacobs who helped to promote legislation surrounding children

³ Wendy Kline, *Building a Better Race* (Berkeley, CA: University of California Press, 2005), 32-60.

⁴ Milwaukee Health Department, Annual Report, 1933.

⁵ Judith Walzer Leavitt, *The Healthiest City: Milwaukee and the Politics of Health Reform* (Madison: University of Wisconsin Press, 1996), 183-189.

⁶ Ruth Harman and Charlotte Lekachman, "The Jacobs House," *Wisconsin Magazine of History* (March 1933), 273.

in the workplace also fought to provide fair compensation for workers injured on the job.⁷ With a growing industrial health program run by the Visiting Nurses Association, the workplace increasingly became a safer space. Venereal disease clinics, run by the Milwaukee Health Department, expanded their services and rebranded themselves as “Social Hygiene Clinics” in attempt to both broaden their focus and remove some of the associated shame. Despite improvements in overall health, the men who helped make Milwaukee the “machine shop to the world” would continue to struggle with the challenges of occupational, environmental, and general health.

As Milwaukee entered the Depression years, frequent calls were made to protect the health and nutrition of Milwaukee’s next generation. Studies by the City Club and the Board of Health demonstrated that significant proportions of the city’s children were not receiving enough nutrients for proper growth, many even bordering on malnutrition. City and county agencies struggled to provide care for a growing number of needy in the city, but at the same time attempted to discern who was “deserving” of the aid provided. The Depression era would see more disagreements about funding among city, county, and state health appropriations as the state health agencies attempted to control the federal appropriations coming into Wisconsin. Venereal disease came to be an intense battleground over funding. Mayor Daniel Hoan struggled to bring money directly to the city in order to fight what was seemed to be a growing venereal disease issue even as the state directed monies to more generalized programs throughout the state. Hoan petitioned the Rockefeller Foundation and Senator Robert LaFollette, Jr., in his attempt to secure direct resources for the city.

⁷ Ibid., 273-74.

But in the end, over the course of the twentieth century, this story is not about the conflict between state and local politics. Although this fight cannot be ignored, the real story here is about the people themselves. The demographics of the city were under dramatic flux in the mid and late twentieth centuries. A city that initially was defined by German, Polish, and Italian immigrants would soon find very different migrants at its doors. The ethnic names, the languages spoken, and the cuisines prepared would noticeably shift over the next eighty years. Milwaukee's African American population rose dramatically in the decades following the 1910s. The growing African American population added another layer of complexity to Milwaukee's ethnic makeup. As the black population grew large enough that their presence could no longer be ignored, their health and social concerns also became an important part of Milwaukee's history.

Along with growing numbers of African Americans, Milwaukee saw rising numbers of Asian and Hispanic migrants entering the city. The city would remain an ethnically based city into the twenty-first century, but the names, faces, and cultural backgrounds of its citizens would undergo a significant shift. African Americans would become neighbors with ethnic German refugees in Merrill Park; St. Rose's Parish⁸ would start offering masses in Vietnamese; and Hispanic families have made themselves at home in the neighborhoods where Polish home ownership is still something of which to be proud. While these newest groups are culturally very different from their predecessors, the issues facing recently arrived Milwaukeeans are very similar to turn of the century immigrants.

⁸ On 31st street between Michigan and Clybourn

These new immigrants, like their predecessors, frequently populate the lowest economic strata, come from places where authorities are frequently feared, and struggle through both linguistic and cultural challenges. They live in some of the oldest stock housing in the city, much of it in significant need of repair and upkeep. The dilapidated housing stock also brings with it environmental health concerns of lead poisoning, higher asthma rates, and vermin infestations. They negotiate the difficult world of cultural and linguistic misunderstandings as they make a life in the new city. As with the immigrants that came before them, their fears and wariness towards those in power have shaped the way they interact with doctors, health officials, and others in positions of power. While there have not been health riots in the city since 1894, health practitioners frequently struggle to convince newly arrived immigrants about the efficacy of western medical practices, the dangers of some more traditional medicine, and the familiar difficulties of medical diagnosis and treatments lost in translation.

Finally, for many of these immigrants, new and old, is the issue of economics. Food and shelter are higher rated priorities than vaccinations, preventive health care, or even prescriptions. For many new immigrants, the main focus of life in their new setting is primarily around finding employment and shelter for themselves and their families; health care becomes a secondary concern to more basic necessities. Those in dire economic conditions are more likely to postpone medical care, both preventive as well as urgently, needed as their economic situation deteriorates. Inattention to their medical care, linked intrinsically to their economic condition, might also lead to malnutrition and other stress-related medical conditions that a life in poverty frequently produces.

The health of the city as a whole, as well as of its everyday citizens, is a strong indicator of the general economic, social, and physical health of the city as a whole. Sick citizens create a sick city, both on a biologic level, but also and perhaps more importantly, on an economic level. Malnourished, ill, and vulnerable populations cannot fully contribute to the economic health and prosperity of the city as a whole. In order for an urban community to realize its fullest potential, its citizenry must realize theirs as well. Wasted health and wasted lives translate into a wasted economy. Without a healthy populace, a city cannot thrive, develop, and survive. To ignore the link between health and economics, health and prosperity, and health and growth is to ignore a fundamental part of the organism that is the city. Cities function as systems, relying on the health of any one part to contribute to the health of the whole. Remove a healthy element or allow a sick element to remain unchecked and you risk the healthy integrity of the whole. Unhealthy, immigrant, and minority populations are not to be shunned, ignored, or marginalized, but need to be treated, cured, and sustained for the benefit of all because the way that we treat the most vulnerable and the most in need speaks volumes about us as a city system, but also a society in general.

This journey began when I gazed into the empty eye sockets of the immigrant dead from the Milwaukee County Institution Grounds. Being a student of history and the child of immigrants, I had come to understand how the American dream could succeed. Confronted with the physical evidence of failed dreams and aspirations from the pauper's grave, I was reminded of the vulnerability of populations both past and present. While Milwaukee became the "healthiest" city in 1931, it was an accolade that not all of its population equally shared. Health conditions had indeed improved throughout the city in

regards to food safety, communicable disease, and infant mortality. Unfortunately those who bore the largest brunt of the ill health, poor working conditions, and difficult lives in the city would still struggle in this “healthy” city. Those least able to advocate for better health, most likely to be victims of disease and industrial accident were, and still are, bellwethers for our society and community as a whole. The better their health and living conditions, the better it is for the entire community. Everyone within the city, no matter how marginalized, are instrumental for the proper functioning of the whole.

Health Commissioner, George Ruhland, in 1919, noted that “[M]odern health work is based on the belief that life and health are our most valuable possessions. Sickness and death are expensive, not only to the individual family, but to the community and nation as well.”⁹ Ruhland could not have spoken truer words. Sickness and high mortality rates would be costly to the community, both in pure economics and a larger social cost as well. A healthy community is a functioning community, a prosperous community, and a community with a bright future. The most valuable possession Milwaukee had was not its factories, its breweries, or its arts, but the health of its people, the life force behind the city itself.

⁹ Milwaukee Health Department, Annual Report, 1919, Mss 2126, Milwaukee Health Department Annual Reports, MCHS.

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