Health Care for African Americans in Mississippi, 1877-1946

Dissertation

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By

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Abstract

This dissertation explores the impact of racial segregation and exclusion on health care for black Mississippians from 1877 through the first half of the twentieth century, when both the federal government and the state of Mississippi passed laws that increased the number of medical facilities. It studies the impact of race on the social history of medicine and public health. It focuses on lay and professional health care providers and recipients. In addition, the dissertation discusses black Mississippians’ efforts to build medical institutions and address inadequate access to health care in their communities. I argue that the separate and unequal medical care that blacks endured represented a form of cultural and structural violence. However, African Americans, responded to Jim Crow both through traditional means of racial self-help and as well as working with the state to improve conditions.
Dedication

Dedicated to my grandparents
Acknowledgements

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Introduction:

Reconstruction and the Rise of Jim Crow

Reconstruction began as a time of hope for many African Americans throughout the South when laws and constitutional amendments dismantled slavery, bestowed citizenship on African Americans, and gave black men the right to vote. It was a time when the hierarchical labor and social systems of the Old South were briefly, though not completely, upset. In Mississippi, as in other states, some members of the black elite even capitalized on the political control of the Radical Republicans to gain state or national prominence.\(^1\) By the 1870s, however, contentious elections and violence showed that the Republican Party was losing power in the state. As a result black men were losing their tenuous hold on their political power. Dictated at first by custom and subsequently by laws as well, whites began to place a number of restrictions on African Americans’ citizenship rights, movement, and access to public facilities. These attacks on black freedom were the beginnings of the racial-social system that came to be known as Jim Crow.

Mississippi was the second state to secede from the Union on January 3, 1861. Eventually, more than 80,000 Mississippians served in the Confederate Army, approximately one-third of whom did not return. In 1865, the end of the Civil War and the ratification of the Thirteenth Amendment brought freedom to four million slaves living in the United States. More than 430,000 lived in Mississippi alone, constituting over half the state’s population.\(^2\) The United States then faced critical questions about what to do with the former slaves, many of whom were destitute and without homes and jobs.

Although most former slaves remained in the rural areas, blacks also took advantage of their newly earned freedom and began migrating to towns and cities in search of employment and to escape plantation life. Thousands of freedmen and freedwomen landed in Vicksburg or Natchez, the two largest cities in Mississippi. Without a way to sustain themselves, the freedmen often lived on the edge of poverty and in crowded conditions. Their living conditions made them susceptible to disease, which contributed to public health concerns during Reconstruction.\(^3\)

Not yet ready to concede blacks’ freedom, the Mississippi legislature passed its infamous Black Code in 1865, in an effort to control the black population. Unlike slaves,

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the freedpeople were able to testify in court and to own property, but the Black Code is known mostly for the freedoms it restricted. Under vagrancy laws, blacks without homes or jobs were subject to arrest. They could then be leased to work for whites. An apprentice law made it easy to declare minor children to be orphans, who could then be placed under white control. The Civil Rights Act of 1866 overturned the black codes enacted in Mississippi and other southern states. This act was solidified with the Fourteenth Amendment which made African Americans citizens of the United States and of the states where they resided.4

In the end, the Republican-controlled Congress took over Reconstruction and passed three acts in 1867. The first divided the South into five military districts, sending federal troops to maintain order and protect freedpeople. The second required that the states of the former Confederacy hold conventions and draft constitutions guaranteeing black male suffrage. The third stated that the states must ratify the Fourteenth Amendment before they would be permitted to send representatives to Congress again.

These Reconstruction acts, along with the Freedmen’s Bureau, established in 1865 to aid former slaves and others displaced by the war, were the basis of reform in the southern states. The Freedmen’s Bureau was charged with assisting blacks and whites who had been left destitute by the war by distributing food, clothing and abandoned lands; settling legal disputes between blacks and whites; providing medical care; securing work for former slaves; and providing education.5

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The freedmen and freedwomen wanted an opportunity to own their own land, but most of the abandoned land confiscated by the federal government was quickly returned to the former Confederate owners during Andrew Johnson’s administration rather than being redistributed to the former slaves. Freedmen’s Bureau agents worked to convince blacks to accept the wage labor arrangements offered by white plantation owners. These annual work contracts could be exploitative, with planters frequently trying to reinstitute conditions that rivaled slavery.\(^6\)

During Reconstruction there was a struggle between local and federal authorities over which agencies should be responsible for the sick, elderly, poor and destitute former slaves. In the antebellum period, plantation owners or the enslaved people themselves had the responsibility for health care.\(^7\) While many slaves were in poor health and the medical care that they received was minimal, planters did recognize a responsibility to keep their slaves physically functional, if only to continue working and protect plantation capital. After freedom, as African Americans became wage laborers, tenant farmers, and sharecroppers, they did not represent a capital investment for white planters. Thus, they did not have the same incentive to provide care.

During its existence, the Freedmen’s Bureau established more than one hundred hospitals and treated more than five hundred thousand patients. Between 1865 and 1869, the Freedmen’s Bureau ran nine hospitals, five dispensaries, and treated thousands of

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\(^6\) Frankel, *Freedom’s Women*, 57-60.

patients in Mississippi. A surgeon-in-chief, assigned to each state, supervised sanitary conditions and medical care among the freedmen and refugees. Major public health concerns included epidemic diseases like cholera and sanitation. The state government also operated charity hospitals in Vicksburg and Natchez; both of these hospitals treated African Americans on a segregated basis, in separate wards. By the end of 1869, all of the Freedmen’s Bureau’s medical facilities closed.8

In the political arena, the Republican Party was established in Mississippi in 1865. Most of the party consisted of African Americans, but the Republicans also attracted a number of Democrats and former Whigs to its ranks. The ratification of the Fifteenth Amendment in 1870 gave African American men the right to vote, and Mississippians elected black officials at the county, state, and national level. Mississippi had 226 black officeholders during Reconstruction, more than any other state except for South Carolina.9

Hiram Revels, Blanche K. Bruce, and John R. Lynch are perhaps the most famous of the black politicians from Mississippi because they held national offices. In 1870, the Mississippi state legislature chose Hiram Revels to serve the remainder of Jefferson Davis’ unexpired senate term. Davis had resigned to become the leader of the Confederacy. Revels served through March 1871. He later became the first president of

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9 Cresswell, Rednecks, Redeemers, and Race, 4; Eric Foner, Freedom’s Lawmakers: A Directory of Black Officeholders during Reconstruction (New York: Oxford University Press, 1993), xiv. South Carolina, a state with a black majority like Mississippi, had 316 black officeholders.
Alcorn College (now Alcorn State University), the first land grant college for African Americans. In 1874, Blanche K. Bruce was elected to serve a full term in the Senate (1875 to 1881). Bruce held several county positions, including sheriff of Bolivar County. Neither Hiram Revels nor Blanche K. Bruce was a native Mississippian; they moved to Mississippi after the Civil War. Revels had been a free man prior to the war while Bruce escaped from slavery during the war.10

Former slave John R. Lynch was one of the most prominent black politicians within the state. In Natchez, he served as justice of the peace. Elected to the Mississippi legislature, he became the first black speaker of the house in 1872. Later, he won election to the U.S. House of Representatives, where he served from 1873 to 1877.11

The political situation began to deteriorate in the 1870s, with “threats, violence, and fraud” being used to ensure the election of white Democratic candidates. The violence fueled fears that a race war was imminent. Then, after several Republican leaders were murdered in 1875, Governor Adelbert Ames threatened to send out the state militia to restore order and ensure fair elections. There was a strong black presence in the militia; therefore, Ames’ actions made him extremely unpopular among whites. Ames ultimately relented when the Democratic leadership agreed not to disrupt the fall elections. But despite promises to the contrary, the elections were violent as before. With the 1875 election, the Democrats regained the majority in the state legislature. Once in office, they began to purge the government of Republicans. They instituted


11 Revels, “Redeemers, Rednecks and Racial Integrity,” 615.
impeachment hearings on many of the remaining Republican officeholders, including the black lieutenant governor, Alexander K. Davis, and Gov. Ames. Davis was convicted, but Ames agreed to resign in order to halt the impeachment.\(^\text{12}\)

By the end of Reconstruction the “redeemers” had taken control of politics in Mississippi and throughout the South, attempting to eliminate many of the small gains that freedmen and freedwomen had made since emancipation. In 1876, Mississippi Democrats were victorious in their congressional races, leaving Senator Bruce as the only Mississippi Republican in Congress.\(^\text{13}\) The Compromise of 1877 brought an official end to Reconstruction when a congressional commission agreed to give the Republican Rutherford B. Hayes the disputed electoral votes in the 1876 presidential election over the Democrat Samuel Tilden. Hayes won the presidency and guaranteed the removal of federal troops from the South, the promise of aid for internal improvements in the region, and the tacit agreement that the federal government would no longer interfere in the “race problem” in the South.

The end of Reconstruction brought with it the rise of the “New South,” a term coined by Henry W. Grady, editor of the Atlanta Constitution, who envisaged a modern, industrialized economy taking root in the South. Although there was some industrialization in the South, the region remained primarily rural and agricultural into the twentieth century. Hence, much about the “New South” was a theory rather than a


\(^{13}\) Revels, “Redeemers, Rednecks and Racial Integrity,” 592.
reality. Both the “Old South” and the “New South,” however, embraced the doctrine of white supremacy.

In the absence of slavery, the New South developed another system of racial control known as Jim Crow. Taking the name from a blackface minstrel character created by Thomas Rice in the antebellum period, Jim Crow became a system of white over black racial oppression that imposed racial segregation and exclusion; denied blacks the means to upward mobility; kept them in an inferior social and economic position vis-à-vis whites; prevented them from exercising their constitutional rights; and subjected them to both physical violence and demeaning racial etiquette that reinforced white supremacy.

Although voting was a constitutional right, it became the almost exclusive domain of white men in the South. In just a few years, the majority of black men in Mississippi had been disfranchised. In 1868, 96.7 percent of the eligible black male voting population was registered to vote. By 1892, that percentage had declined to 5.9 percent.\textsuperscript{14} Eliminating the black vote was accomplished not only through intimidation, threats, and violence but also through legal means. The Mississippi Constitutional Convention of 1890 instituted various voting requirements that led to the decline in the number of black men eligible to vote. With 133 white delegates and one black delegate, the representatives at the convention agreed on strict residency restrictions and a poll tax, which had to be paid for the two preceding years in order to qualify as a voter. In addition, a literacy test required that potential voters be able to read and interpret a

section of the state constitution. It also provided a loophole, whereby illiterate whites or “exceptional” blacks could still register, provided they understood the selection from the constitution if read to them. In 1898, the Supreme Court upheld the constitutionality of Mississippi’s voting requirements in *Williams v. Mississippi*.

During Reconstruction, restaurants, trains, steamships, hotels and other public spaces in Mississippi were already being racially segregated without the rule of law. Congress tried to address the increasing exclusionary policies against African Americans during Reconstruction with the Civil Rights Act of 1875. It provided that blacks could not be excluded from most public accommodations on the basis of race. Proving damages under this law was difficult. It required blacks to bear the expense of a court case in order to prove that their rights were violated. Therefore, there were few challenges to racialized restrictions. As the Supreme Court turned away from upholding black rights, the Civil Rights Act of 1875 was determined to be unconstitutional in the ironically titled *Civil Rights Cases* in 1883.

Eventually, however, the ownership and “racing” of space, was codified by law. Mississippi’s legalized segregation began on railroad trains and waiting rooms in 1888. Throughout the South, not only were inanimate objects like schools, taxis, bibles, and water fountains reserved for people of the white or “colored” races, but this also extended

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to public spaces.\textsuperscript{16} The spaces designated as “colored” were usually inferior in quality to white spaces. Finally, \textit{Plessy v. Ferguson} (1896), which concerned blacks being relegated to segregated railroad cars, declared that laws that provided for the racing of space were not unconstitutional as long as the facilities were equal.

The health care system was also racially coded. In the late nineteenth century and early twentieth century, white hospitals sprang up in urban areas, but mostly rural Mississippi had very few. The hospitals that did exist either did not admit black patients or treated them on an unequal basis. Many white physicians refused to treat black patients, and there were not enough black physicians to serve the large black population.

In fact, well into the twentieth century, access to health care facilities for African Americans in Mississippi remained limited and segregated.\textsuperscript{17} State-run institutions had separate facilities for blacks and whites. In theory, the care that blacks and whites received was equal, but, in practice, the black wards were often understaffed and sometimes relied on African American communities to provide additional funding and supplies.\textsuperscript{18}

Mississippi and other southern states attempted to maintain a two-tiered health care system. Inevitably, those who were valued in society (whites) had a better chance of obtaining adequate medical treatment. In this environment, traditional lay practitioners


\textsuperscript{17} Laura D. S. Harrell, “Medical Services in Mississippi, 1890-1970,” chap. in \textit{A History of Mississippi} Volume II, ed. Richard Aubrey McLemore (Hattiesburg, Mississippi: University & College Press of Mississippi, 1973), 531

\textsuperscript{18} Harrell, “Medical Services in Mississippi, 1890-1970,” 560.
of medicine had great importance and influence in black communities. Midwives, for example, were far more common than physicians and attended the majority of African American births until the 1950s in Mississippi.\(^{19}\)

The state often suffered from a shortage of physicians, which was intensified after World War II. By the mid-1940s, nearly 35 percent (388) of the physicians in Mississippi were more than sixty-five years old; almost 33 percent were between 56 and 65. In some counties, 50 percent of the doctors were over 70.\(^{20}\)

The impact of Jim Crow was felt throughout the society. Although the Supreme Court had affirmed the states’ rights to create separate but equal facilities, Jim Crow never provided equal opportunities and advantages for African Americans.


\(^{20}\) John J. MacAllister. Hospital and Medical Facilities in Mississippi (State College, Mississippi: Business Research Station, School of Business and Industry, 1945), 9; Dorothy Lee Black, How Serious Is the Doctor Shortage? (Delta Council, 1945), np, Box 8383, Series 2184, Mississippi Department of Archives and History, Jackson, Mississippi.
Chapter 1: Second-Class Health Care

Because Jim Crow meant that blacks were excluded from the rights and privileges of American citizens, African Americans living in the Jim Crow South have often been described as “second-class citizens.” “Second-class” refers to the separate and unequal seating reserved for blacks on passenger trains; the first-class car was reserved for whites only. In their daily lives, African Americans coped with inferior accommodations reserved for them because of their race. To the extent that black Mississippians had access to health care in Mississippi during the Age of Jim Crow, it was second-class health care.

*Health Care for African Americans in Mississippi, 1877-1946* is a history of African-American public health and the impact of racial segregation and exclusion. It investigates the nature of Jim Crow health care in Mississippi and discusses local and state efforts to address racial health disparities. The dissertation focuses on both the providers of health care and the patients. It is an interdisciplinary study incorporating traditional historical methodology, literature, autobiography, cultural studies, trauma studies, critical race theory, and peace/violence studies. It illustrates that restricted access to health care was a part of the structural and cultural violence of the Jim Crow South and the concomitant disregard for black lives. Both whites and blacks attempted to address the access to health care among blacks within the confines of Jim Crow. Whites were
maintaining the racial status quo, while blacks were often responding to the inability to gain access to white facilities on an equal basis.¹

The use of the term “violence” more accurately represents the impact of Jim Crow than terms like “discrimination” or “prejudice.” “Structural violence” is a term credited to Norwegian sociology professor, Johan Galtung (peace and conflict research), founder of the International Peace Research Institute in Oslo, Norway and The Journal of Peace Research.² In contrast to direct or personal violence, structural violence is an institutional form of violence. While structural does not cause direct physical pain, it can lead to physical or psychological injuries, illness or even death. This violence is brought on by society’s structural inequities, including racism, sexism and poverty, which prevent “individuals, groups and societies from reaching their full potential.”³

Structurally violent systems lead to advantages or disadvantages based on a person’s position within the social hierarchy. Those on the top of the hierarchy receive advantages unavailable to those at the bottom, who “may in fact be so disadvantaged that they die or live in a constant state of misery because they do not have the resources to provide for their own well being.”⁴ This is intensified, Galtung asserts, when those


⁴ Ibid., 292-93.
without economic resources also lack political power and access to education and medical care. Thus, the systemic inequities brought on by Jim Crow represented a form of structural violence as African Americans were politically disfranchised, prevented from gaining access to an equal education, and forced to contend with substandard health care.  

The ubiquitous nature of structural violence can cause it to become normalized in a society and to go without interrogation. The static nature of structural violence “may be seen as about as natural as the air around us.” Racially oppressive societies can and do acknowledge direct violence, even when there is no penalty for it. For example, lynchings of blacks in the South were often recorded as deaths that happened at the hands of persons unknown. While black people were often unwilling to name the perpetrators of violence, it does not mean that living victims were unable to do so. Structural violence, however, is deeply entrenched within the institutions, and victims can not identify an aggressor or direct perpetrator.  

Finally, Galtung writes, “Just as political science is about two problems—the use of power and the legitimization of the use of power—violence studies are about two problems: the use of violence and the legitimization of that use.” Cultural violence consists of the methods used to make direct and structural violence socially acceptable

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practices. For example, blacks’ alleged inferiority or depravity was often used as an excuse or as legitimization for Jim Crow.

This dissertation focuses primarily on the Age of Jim Crow, an historical period that does not have definite beginning and ending dates. The first Jim Crow laws came about in the 1880s although political disfranchisement of blacks in Mississippi began in the mid-1870s. Often scholars set the end (or the beginning of the end) of the Age of Jim Crow at 1954, the year that the Supreme Court decided on Brown v. Board of Education of Topeka, Kansas, making racially separate public schools unconstitutional. However, it was the Civil Rights Act of 1964 that made separate public accommodations a violation of federal law.

I frame the dissertation with the watershed moments of 1877, the end of Reconstruction and the beginning of the Mississippi State Department of Health, and 1946, the year the federal and state governments passed critical health legislation—the Hill-Burton Act and the Mississippi Commission on Hospital Care Act. In my discussion of public health and lay and professional health care providers, I follow the narratives to their conclusions, although this may extend beyond 1946.

While many scholars have documented the political disfranchisement, economic and educational disparity, racial violence and lynching during the Age of Jim Crow, the history of segregation and exclusion in medical care in the post-bellum South has been explored less thoroughly. Although there are numerous studies of race relations in the South, most scholars, even those who focus on the “Age of Jim Crow,” do not

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incorporate medicine as a category of analysis. Likewise, many scholarly monographs on the social history of medicine do not use race as a category of analysis.

One of the early race relations studies of black Mississippians was Vernon Wharton’s *The Negro in Mississippi, 1865-1890* (1947). Wharton describes the efforts by white Mississippians to keep blacks “in their place” through legal and extralegal means after the Civil War. According to Wharton, the institution of slavery had a civilizing influence on blacks, and it also made them very docile. This explained why whites easily overthrew Reconstruction governments. Throughout the monograph, however, he painstakingly explains the methods that whites used in order to deprive African Americans of their rights and reinstitute the racial and social hierarchy, a process that would have been unnecessary if the former slaves had internalized docility as Wharton suggests.  

Race relations and labor are the major themes in Stephen Cresswell’s, *Rednecks, Redeemers, and Race: Mississippi after Reconstruction, 1877-1917*. In addition, he examines industrialization, urbanization, transportation, and public health. He asserts that the years from 1877 to 1917 represented both continuity and change in Mississippi. While noting that the state underwent substantial changes, these changes did not significantly affect the way Mississippians lived. In 1917, Mississippi was the most rural state, and it lagged behind the rest of the nation in modernization and urbanization.

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In Reconstruction historiography, scholars have addressed the health crisis after the end of the war. The Freedmen’s Bureau encountered racial, bureaucratic and financial problems that prevented it from being effective in its efforts to care for freedmen.\(^\text{10}\) Gaines M. Foster’s *The Limitation of Federal Health Care for Freedmen, 1862-1868* supports the contention that historians have not thoroughly investigated the problem of medical care for the freedmen. Foster asserts that the federal healthcare programs were inadequate and did not break the “pattern of dependence on whites.” Further, he states that racism helped to limit the Freedmen’s Bureau’s effectiveness and contributed to the failure of the agency.\(^\text{11}\)

Although the notion of Jim Crow (or separate) facilities for blacks and whites had begun in the North prior to the Civil War, C. Vann Woodward postulates that the system of racial segregation and exclusion reinforced by violence did not define the southern social order until toward the end of the nineteenth century.\(^\text{12}\) Neil McMillen’s *Dark Journey: Black Mississippians in the Age of Jim Crow* (1990) offers a qualification to Woodward’s argument. In the Deep South, and Mississippi in particular, blacks enjoyed


a much shorter period of fluid race relations. De facto segregation and exclusion against blacks was solidified in the 1870s, well before the institutionalization of Jim Crow laws in the 1890s. Rather than focusing solely on oppression or white supremacy, McMillen’s work can be included in more recent, late twentieth-century historiographical trends that also focus on agency and black activism. McMillen acknowledges that health care access is a part of the discussion of Jim Crow, but health care is peripheral to his narrative.

In the late-nineteenth century, the rise of scientific racism coincided with the abolition of slavery. Proponents of this ideology contended that objective science could “prove” that African Americans were inferior to whites. Scientists, physicians, statisticians, economists, and racial theorists used various measurements and anecdotal information to conclude that their previous suspicions had been correct. Some argued that freedom was an unnatural condition for blacks and that it had led to the decline in health among African Americans.

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14 Although Howard Rabinowitz’s *Race Relations in the Urban South, 1865-1890* is not focused on one state, he does include health and welfare in his discussion of segregation during this period.

Some of the most damaging statistical information came from the U. S. Sanitary Commission’s anthropometric studies of black and white soldiers during the Civil War. The measurements were manipulated to illustrate that blacks were degenerating after slavery. This, along with the federal census of 1870, suggested blacks were in decline. Some argued that they would become extinct. And if blacks were going to disappear as a race, some whites saw no benefit in trying to “save” them.\(^\text{16}\)

John S. Haller provides a thorough discussion of scientific racism in *Outcasts from Evolution: Scientific Attitudes of Racial Inferiority, 1859-1900* (1971). In *The Black Family in Slavery and Freedom, 1750-1925*, Herbert Gutman refers to arguments about the decline of black people as “retrogressionist” ideology. It suggested that blacks had regressed to a state of barbarism and immorality after the end of slavery, because they no longer had the benefit of close contact with superior, white civilization. Starting with the assumption that blacks were inferior, whites used pseudo-science and statistics to confirm their opinions.\(^\text{17}\)

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\(^\text{16}\) The results of this census are now disputed.

Many scholars of Jim Crow study gender as a category of analysis as well as race.\(^\text{18}\) While race uplift among African American men and women during this period has garnered much scholarly attention, Mississippi has not been adequately addressed in the regional studies of black women.\(^\text{19}\)

In the social history of medicine, many scholars give little more than passing reference (if any at all) to the issue of race. John Duffy’s history of American medicine includes very brief chapters at the end on women and African Americans.\(^\text{20}\) Similarly, Laura D. S. Harrell’s article “Medical Services in Mississippi, 1890-1970” provides an overview of Mississippi’s major health problems, efforts to combat disease, the development of private and public (county and state) medical facilities, and medical education, yet, there is little discussion of African Americans, segregated facilities, and


the prevalence of diseases like tuberculosis (or the efforts to combat disease) in black communities.\textsuperscript{21}

Notable scholars who have produced works discussing race and the social history of medicine include historians Todd L. Savitt and Vanessa Northington Gamble. Savitt’s *Race and Medicine in Nineteenth- and Early-Twentieth-Century America* is a compilation of his articles on medical history, focusing on black medical schools, black physicians, disease and experimentation.\textsuperscript{22} Gamble’s *Germs Have No Color Line: Blacks and American Medicine, 1900-1940* is an edited volume that brings together a collection of journal articles that defined and addressed what was known as the “Negro health problem.” Much of the focus is on morbidity and mortality among African Americans, especially as it compared to whites. Many physicians, public health advocates, and social scientists offered their opinions regarding both the causes of the health problem and the solutions.\textsuperscript{23}

Taking its name from Gunnar Myrdal’s 1944 study, *An American Dilemma The Negro Problem and Modern Democracy*, W. Michael Byrd and Linda A. Clayton’s *An

\textsuperscript{21} Harrell, “Medical Services in Mississippi, 1890-1970,” 516-569. Hattiesburg, Mississippi: University & College Press of Mississippi, 1973. These passing references include mention of the first black nursing students admitted to and graduated from Mississippi Baptist Hospital (552). Harrell does, however, provide a list of Mississippi hospitals, including black hospitals (561-65).


American Health Dilemma: A Medical History of African Americans and the Problem of Race (2000) provides a survey of racial attitudes toward blacks from ancient times through the twentieth century. The authors discuss the origin, development, and contemporary impact of the race- and class-based health system in the United States.\(^\text{24}\) Myrdal’s “comprehensive study of the Negro in America” examined race relations and the status of blacks in the United States. The “race problem” was the American dilemma because it represented a contradiction between America’s egalitarian and Christian principles and its oppressive Jim Crow reality for blacks. Myrdal addressed health concerns only briefly, but Byrd and Clayton point out that African Americans face many of the same problems, including health disparities between blacks and whites, at the end of the twentieth century as they did in 1944.\(^\text{25}\)

As the authors of An American Health Dilemma illustrate, access to health and medical care was restricted by race as well as class. Edward Beardsley’s A History of Neglect: Health Care for Blacks and Mill Workers in the Twentieth Century South contends that the economic exploitation of the white mill workers by the white-middle class put them in a similar position as racially and economically exploited blacks. Middle-class whites referred to these working-class whites despairingly, just as they did blacks. The white mill workers had difficulty gaining access to health care and faced


some of the same health issues as blacks. While their problems were analogous, they were not identical. Because the mill workers were white, they were not subject to racial segregation and exclusion.\textsuperscript{26}

The assumption of black inferiority influenced medical treatment well into the twentieth century. James Jones’ \textit{Bad Blood: The Tuskegee Syphilis Experiment} traces the history of one of the most infamous cases of medical experimentation in the United States, the Tuskegee Study of Untreated Syphilis in the Negro Male. Commonly known as “The Tuskegee Experiment,” it lasted from 1932 to 1972. The study of the progression of untreated syphilis on black men continued until it was exposed by a journalist in the early 1970s, even though penicillin, which was determined to be an effective treatment, was widely available by the end of the 1940s. Jones’ monograph is the standard scholarly study of Tuskegee, but Fred Gray’s \textit{The Tuskegee Syphilis Study: An Insider's Account of the Shocking Medical Experiment Conducted by Government Doctors against African American Men} provides a more personal perspective. Gray was the attorney for the survivors of the study and sued the federal government on behalf of the survivors after the study was exposed.\textsuperscript{27}

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\textsuperscript{26} Edward H. Beardsley, \textit{A History of Neglect: Health Care for Blacks and Mill Workers in the Twentieth-Century South} (Knoxville, Tenn.: The University of Tennessee Press, 1987), 1, 3-4, 6, 8.  \\

The survivors also turned to Fred Gray after HBO aired the film \textit{Miss Evers’ Boys}, based on a play of the same name. The film was about the Tuskegee Experiment, but the survivors found the characterization of the study “volunteers” demeaning. Its focus was on a group of study participants who formed a dancing group known as “Miss Evers’ Boys.” The men eventually received a presidential apology from President Bill Clinton in 1997. The Clinton Administration also designated funds for a center for bioethics that is located at Tuskegee University. See also \textit{Miss Evers Boys}, New York: Home Box
\end{flushright}
While the Tuskegee Experiment is perhaps the best known example of experimentation on African Americans, Harriet A. Washington’s *Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present* expands the scope of the historiography beyond isolated events and provides a comprehensive study of medical experimentation on blacks and medical ethics. She contends, “Dangerous, involuntary, and nontherapeutic experimentation upon African Americans has been practiced widely and documented extensively at least since the eighteenth century.” This medical research and experimentation on blacks has often been “malevolent.” Events like the Tuskegee Experiment were not merely “episodic,” they represent part of the well-worn pattern of the medical exploitation of African Americans.28

One of the most recent editions to the discussions of medical ethics and experimentation on African Americans is Rebecca Skloot’s *The Immortal Life of Henrietta Lacks* (2010). Cells belonging to Henrietta Lacks, an African-American woman who died of cervical cancer in 1951, have been used in medical research for decades. The cells, known in medical circles as “HeLa,” were harvested from Lacks’ cervix before she died. Scientists had been unsuccessful at keeping human cells alive in a laboratory, but Lacks’ cells lived and reproduced, thus becoming “immortal.” Neither Lacks nor her family had given consent to have her cells harvested for medical research.

While *The Immortal Life of Henrietta Lacks* is another episodic treatment that “raises

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important issues regarding science, ethics, race, and class,” it also reinforces Harriet Washington’s research in *Medical Apartheid*.²⁹

Although the late twentieth-century disease Acquired Immune Deficiency Syndrome (AIDS) is beyond the scope of this study, the racialization of the disease shows a connection to twentieth-century discussions of syphilis. In fact, James Jones writes about this in the revised edition of *Bad Blood*. He and other scholars mark the relationship between historical actions and attitudes toward African Americans and contemporary implications of racial disparities in health and health care. In “Missing Persons: African American Women, AIDS, and the History of Disease” Evelyn Hammonds argues that black women are disproportionately affected by AIDS due to “the long-term and persistent failure of the public health practices to control sexually transmitted diseases in the African American community.”³⁰

Physician-anthropologist Paul Farmer also writes about race, disease, and structural violence. Farmer contends that gender inequality and racism put poor women of color at higher risk than others. He also makes historical links with AIDS

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For another useful study on medical experimentation, see Allen M. Hornblum, *Acres of Skin: Human Experiments at Holmesburg Prison* (New York: Routledge, 1999). Between the 1940s and the 1970s, inmates at Philadelphia’s Holmesburg Prison were used for medical experiments. Many, though not all, of the inmates were African American. They represented a captive, economically disadvantaged population who were easily exploited. There is also a documentary with the same title as the book. See *Acres of Skin: The Documentary* (Films for the Humanities, 2005), DVD.

susceptibility to New World expansion, slavery and racism.\(^{31}\) Similarly, in “Racial Disparities in Health and Wealth: The Effects of Slavery and Past Discrimination,” the authors argue that “current racial disparities in health and wealth” can be traced to governmental and societal restrictions on African Americans during enslavement and the Age of Jim Crow. Statistically, blacks have a shorter life expectancy, higher rates of chronic disease, and are less likely to receive adequate medical care than whites.\(^{32}\)

Many of the studies of race and medicine are institutional histories or studies of the “great men” of medicine and their institutions. Herbert M. Morais’ *The History of the Negro in Medicine* focused on medical professionals and patients and problems that they faced within America’s racial caste system. His book served as a “preliminary account” of blacks in medicine, but Morais also wanted to motivate further scholarship.\(^{33}\) Late twentieth-century and early twenty-first scholarship on black hospitals, physicians, and health include Vanessa Northington Gamble’s *Making a Place for Ourselves: The Black Hospital Movement, 1920-1945*, David Beito’s “Black Fraternal Hospitals in the Mississippi Delta, 1942-1967,” David T. and Linda Royster Beito’s “‘Let Down Your Bucket Where You Are’: The Afro-American Hospital and Black Health Care in Mississippi,” and Thomas J. Ward, Jr.’s, *Black Physicians in the Jim Crow South* (2003).

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Gamble focuses on the black hospital movement, the establishment of facilities to serve African American patients and as places where African American doctors could maintain staff privileges and treat their patients.\(^{34}\) David Beito’s research examines fraternal and mutual aid societies and their significance in providing health care. He discusses the importance of black fraternal hospitals in Mississippi, including Taborian Hospital (Mound Bayou), Friendship Clinic (Mound Bayou), and the Afro-American Hospital (Yazoo City). He asserts that fraternal hospitals declined after World War II with increasing state regulations and the decline of “enforced racial segregation.”\(^{35}\) Thomas J. Ward, Jr.’s *Black Physicians in the Jim Crow South* looks at the black physicians, their education and experiences while practicing medicine between the 1890s to the 1960s. Ward contends that black physicians have been ignored by scholars who focus on physicians and those who focus only on the black masses in their examinations of Jim Crow.\(^{36}\)

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Spencie Love’s *One Blood: The Death and Resurrection of Charles R. Drew* traces the “Drew legend,” the death of this well-known physician and pioneer of medical technology being caused by his refusal to be admitted to a white hospital. Although Drew did not die because he was refused treatment, it was a situation that happened to many black people. While clearing up the “Drew legend,” Love is also making a case for the violence (or brutality as she calls it) of Jim Crow. Her work also investigates the use of folklore and legend in African American health narratives.\(^\text{37}\)

A number of late twentieth century works discuss the importance of traditional lay midwives among the black population during the first half of the twentieth century and the elimination of lay midwifery. Susan L. Smith’s *Sick and Tired of Being Sick and Tired: Black Women’s Health Activism in America, 1890-1950* contends that the historical literature on public health and reform often neglects African Americans, women, and rural areas. She examines the activities of rural areas in a number of communities, including midwifery and public health nursing in Mississippi.\(^\text{38}\) A number of monographs have recorded the experiences of traditional midwives in various states, including Alabama and New Mexico.\(^\text{39}\)


The research in this dissertation builds on a body of scholarship by historians and other scholars in the humanities, social sciences, and medicine who study race, the social history of medicine, and theory. 40 “Reconstruction and the Rise of Jim Crow,” is the introduction which discusses the rise and fall of Reconstruction in Mississippi as well as the growth of Jim Crow. Chapter one, “Second-Class Health Care,” is an historiographical essay on Jim Crow and the social history of medicine. It also explains the theoretical concept of structural violence. Chapter three, “The Midwife Problem in Mississippi,” focuses on the Midwife Program instituted by the Mississippi State Department of Public Health in the 1920s. Chapter four, “‘Blues Singers’ Queen Dead’: Bessie Smith and the ‘Ethics’ of Jim Crow Medicine,” investigates the impact of racialized structural violence in emergency care situations. Chapter four, “To ‘Find Decent Hospitalization’: Segregated Facilities,” is also about segregated (white) facilities, but its focus is on how blacks were treated when they were segregated rather than excluded and efforts by whites to increase blacks’ access to hospitals. Chapter five, “‘Foresight, Faith, and Endurance’: The Afro-American Hospital and Tradition of Self-Help,” focuses on the Afro-American Sons & Daughters fraternal hospital in Yazoo City and the efforts by African Americans to address the health care needs in their communities. The epilogue, “To Make Mississippi a More Healthful State” is a discussion of some of the pivotal changes for health and medicine within the state beginning in 1946.

Chapter 2: The Midwife in Mississippi

In 1951, the Mississippi State Department of Health responded to a letter from the U.S. Children’s Bureau regarding a proposed film on lay midwives. The agency had apparently solicited advice from several southern states that had lay midwifery programs. Mississippi’s response, from Dr. D.V. Galloway and Nurse Louise Holmes, offered a critique of the proposal’s questionable points and inaccuracies, all the while illustrating ambivalence toward midwives. The proposal, for example, had referred to midwives as “unofficial health educators,” but Galloway and Holmes insisted that Mississippi’s midwives were not involved in health education. They also disapproved of the more colloquial term “granny” midwives and preferred “untrained midwives.” They were even unclear about whether there was actually a state program to train lay midwives, asserting that new midwives had not “entered the calling since the health department started a training program, since we really have no training program.” Finally, while admitting that the Children’s Bureau had submitted a good outline, they questioned whether a film on midwives was needed since they were trying to eliminate “the midwife problem” in Mississippi.  

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1 D. V. Galloway, M. D. and Louise Holmes, R.N. to Dr. Lucille Marsh, 3 December 1951, Box 8416, Series 2036: Midwife Program Files and Photos—Public Health Nursing Division, 1911-1976, Mississippi State Department of Health, Mississippi Department of Archives and History, Jackson, Mississippi (hereafter Department of Health Records). Holmes was the director Public Health Nursing. Emphasis added.
Despite the assertion that a film was unnecessary, the Georgia Department of Health—with funds provided by the Children’s Bureau—produced a documentary, *All My Babies: A Midwife’s Own Story*, in 1952. It was used as a training film for midwives and showed the cooperation among midwives, public health nurses, and physicians. *All My Babies* featured Mary Coley, an African-American midwife who practiced in Albany, Georgia, illustrating the “by-the-book” method of delivering babies that was endorsed by the state.

The film’s storyline provided two different examples of expectant mothers’ living situations and deliveries. The first family, the Flemings, lived in a modest home and had everything prepared for a home delivery. The expectant mother, Ida Fleming, had engaged Mrs. Coley’s services for the third time, and she already had two healthy children. Mrs. Fleming knew that she needed to go to the health department for prenatal checkups and that she needed proper nutrition to have a healthy baby. The second family, the Dudleys, was in a more dire condition. Their home was a sparsely furnished, one-room dilapidated cabin. It represented the poverty that lay midwives in the South

In this chapter, I generally refer to traditional African American midwives without formal (academic) training as “lay midwives” or “midwives.” However, there is no consensus about the use of this terminology. A list of the terms utilized by scholars and lay persons includes “grannies,” “granny” midwives, indigenous midwives, folk midwives, common midwives, lay midwives, traditional birth attendants, and cotton dolls. “Granny” was a term that was particular to southern black midwives, and when used by whites it often had a negative connotation, but Valerie Lee embraces the term “as a derivative of grand,” and uses it in her work on black midwives. See Valerie Lee, *Granny Midwives and Black Women Writers: Double-Dutched Readings* (New York: Routledge, 1996), 5; Hans A. Baer, “Toward a Systematic Typology of Black Healers,” *Phylon* 43 (Fourth Quarter 1982): 327-43; Margaret Charles Smith and Linda Janet Holmes, *Listen to Me Good: The Life Story of an Alabama Midwife* (Columbus: Ohio State University Press, 1996), x.

Midwives were sometimes considered folk healers or conjurers. Fran Leeper Buss writes that in Mexican folk culture there are at least three categories of folk healers—*la parteras, médicas*, and *curanderas*. *La Parteras* were the female healers who were most like traditional lay midwives. See Fran Leeper Buss, *La Partera: Story of a Midwife* (Ann Arbor: The University of Michigan Press, 1980), 5-6.
often encountered. Marybelle Dudley was also pregnant for the third time, but she had lost two previous children. She was at least six months pregnant by the time she contacted Mrs. Coley, who took her to the health center to see a physician. This expectant mother had none of the birthing materials ready for the midwife when she arrived, presumably because she was too poor to provide them. Nevertheless, Mrs. Coley skillfully handled both births—although the Dudley’s baby was underweight—and performed aftercare to make sure that both mothers and newborns were doing well.²

_All My Babies_ demonstrated the importance of black midwives in the rural South, but Mississippi’s letter regarding the proposal provides some indication of the difficult relationship between black midwives and the white-controlled Mississippi State Board of Health throughout the history of the state’s midwifery program. Since the implementation of the state’s registration and training program in the 1920s, midwives were viewed as a “necessary evil,” needed only until “adequate medical, nursing and hospital care for all our maternity patients” were available. Yet, more than two decades after the beginning of the state’s lay midwifery registration program, public health

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² George C. Stoney, prod., _All My Babies: A Midwife’s Own Story_ (Atlanta, Georgia: Georgia Department of Public Health), 1952; George C. Stoney, “All My Babies: Research,” 1959, 5, 7. It is clear that Galloway and Holmes’ letter does in fact refer to _All My Babies_, as the letter refers to characters and scenes from the film.

“All My Babies: Research” is an essay, written by the director about the research for the film, that is included inside the DVD case. The film has been used in midwifery training throughout the world by the United Nations Educational, Scientific, and Cultural Organization (UNESCO). _All My Babies_ was added to the National Film Registry in 2002. The National Film Preservation Act (1988) authorized the Librarian of Congress to add as many as twenty-five “culturally, historically, or aesthetically significant” films to the registry for preservation each year. See: National Film Registry Titles of the U.S. Library of Congress; available from http://www.filmsite.org/filmreg.html; Internet; accessed 30 April 2009.
officials conceded that the state was still unable provide “adequate” care and that the midwife “problem” might be prolonged for another twenty years.³

Though often characterized as a “problem” and even a “menace” by physicians and public health officials, midwives were important health care practitioners whose valuable contributions to public health were often unheralded. State public health officials constantly devalued their contributions and maligned them as ignorant and unsanitary.⁴ Their public health and medical activities addressed problems that were the result of living in a poor, rural state where access to adequate health care was limited further through the prevalence of Jim Crow or structural violence.

In the mid-nineteenth-century, public health departments mainly themselves concerned with sanitary reform. The Mississippi State Board of Health was established in 1877, but the board had relatively little power until 1880. For the rest of the nineteenth century, the board’s major emphases were controlling contagious diseases and preventing epidemics.⁵

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³ D.V. Galloway to Dr. Lawrence N. Bellew, 7 December 1951, Box 8416, Series 2036; D. V. Galloway, M.D. and Louise Holmes, R.N. to Dr. Lucille Marsh, 3 December 1951, Box 8416, Series 2036; “Mary D. Osborne, 1875-1946,” State Board of Health, 147, October 1946, Box 8752, Series 2012; Public Health Library Subject Files, 1931-1985; “The Relation of the Midwife to the State Board of Health,” 1, 3, Box 8416, Series 2036; Laura Jean Reid, “The Plan of the Mississippi State Board of Health for the Supervision of Midwives,” 1921, 7, Box 8752, Series 2012, Department of Health Records.

⁴ D.V. Galloway to Dr. Lawrence N. Bellew, 7 December 1951, Box 8416, Series 2036; D. V. Galloway, M.D. and Louise Holmes, R.N. to Dr. Lucille Marsh, 3 December 1951, Box 8416, Series 2036, Department of Health Records; U. S. Department of Labor, The Seven Years of the Maternity and Infancy Act (Washington, D.C.: U.S. Government Printing Office, 1931), 4; “Mary D. Osborne, 1875-1946,” State Board of Health, 147, October 1946, Box 8752, Series 2012; “The Relation of the Midwife to the State Board of Health,” 1, 3, Box 8416, Series 2036; Reid, “The Plan of the Mississippi State Board of Health for the Supervision of Midwives,” 1921, 7, Box 8752, Series 2012, Department of Health Records.

In the early twentieth century, as reliance on lay midwives was decreasing outside of the South, state public health officials began to focus on the complications resulting from childbirth. In 1917, the executive secretary of the Mississippi State Board of Health, Dr. W.S. Leathers, contended that there was “no greater need” than studying and reducing infant mortality. The state board proposed the creation of a child welfare division but did not act on this until 1920. While the poor had the highest mortality rates, it was an acknowledged problem for the United States as a whole. In the early twentieth century, almost 20 percent of all deaths were of children under a year old. Statistics from 1918 showed that the United States ranked seventeenth in maternal mortality and eleventh in infant mortality in the world.

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6 Felix J. Underwood, “Twenty-Five Years in Maternal and Child Health,” Reprint from American Journal of Public Health, 38 (November 1948): 1512-13. Infant mortality is a statistic that can be used to evaluate the effectiveness, accessibility, and quality of a particular nation’s health care system, with infant mortality rates of 15 or less per 1,000 indicating an effective system. See American Medical Association, Complete Medical Encyclopedia, s.v. “infant mortality;” Alice Park, “America’s Health Checkup,” Time, 1 December 2008, 43, 47. According to Time, the United States’ 2008 infant mortality rate was 6.9 per 1,000. While this is a marked improvement over early twentieth century statistics, the United States was still only twenty-ninth best in the world. African Americans have the highest infant mortality rate of all ethnic groups in the country—13.7 per 1,000.


For 1907 and 1909, deaths for those under one year accounted for 19.1 percent of all deaths; for 1908, it was 19.7 percent. These mortality statistics do not provide the infant mortality rate per 1,000 live births. The reason given was that the birth registration data was inaccurate, both for the country as a whole and the South in particular.

8 J. Stanley Lemons, “The Sheppard-Towner Act: Progressivism in the 1920s,” The Journal of American History 55 (March 1969): 776. Maternal mortality is determined by dividing the number of women who die during pregnancy or childbirth by the number of pregnancies. Like infant mortality, it is
Mississippi’s Department of Vital Statistics began registering births in 1912, but the state was not included in the “birth-registration area,” an area with “approximately complete” death records until 1921. Of the states that had at least 500 live births of black infants, only California’s infant mortality rate of 81 was lower than Mississippi’s 85. The birth-registration area included over 90 percent of the black population by 1928 and the entire black population by 1933. Of the twenty-nine western, northern and southern states (including the District of Columbia) listed, only Arkansas had a lower infant mortality than Mississippi in 1935. For the entire South, infant mortality had decreased by more than half with 174 deaths per 1,000 in 1915 and 83 per 1,000 in 1935. Mississippi had reduced from 85 deaths per 1,000 in 1921 to 59 per 1,000 in 1935. Although the rates decreased over time, the infant mortality rates for black infants were significantly higher than for white infants.9

In 1921, according to Mississippi’s supervisor of midwives, childbirth was the second leading cause of death for women between fifteen and forty-five. One of the contributing factors was that only about half of all mothers obtained proper prenatal and postnatal care. She was concerned about “careless physicians,” but most of the criticism seen as an important indicator for the quality and effectiveness of a nation’s health care system. This is often expressed a number of deaths per 100,000. See American Medical Association Complete Medical Encyclopedia, s.v. “maternal mortality.”

was reserved for “illiterate and ignorant” midwives.\textsuperscript{10} An article by Felix J. Underwood, director of the Mississippi State Board of Health from 1924 to 1958, illustrates this. He referred to an unnamed published article from the early 1900s, which reportedly stated that “the huge death rate in Mississippi from the puerperal state can be readily accounted for as being due to the fact that the state does not require midwives to be licensed.” This, he asserted, had caused 447 deaths in 1912, and could only be reduced when the state’s midwives “have at least some knowledge of cleanliness.”\textsuperscript{11} The assertion that midwives were to blame for high infant mortality rates was reiterated by public health officials in other states as well. In a letter to the Julius Rosenwald Fund in 1926, the Commissioner of Public Health in Tennessee wrote, “The solution of the problem of infant mortality will come about through education of the colored race in the principles involved in the protection of infant life and in the correction of malpractices by a number of ignorant negro [sic] midwives.”\textsuperscript{12}

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\textsuperscript{10}Laura Jean Reid, “The Plan of the Mississippi State Board of Health for the Supervision of Midwives,” 1921, 1-2, Box 8752, Series 2012, Department of Health Records.

The Mississippi State Board of Health originally defined a midwife as a woman who made a practice of attending women and children during childbirth. Later “woman” was changed to “person.” Presumably, this meant that men could also be midwives, but I have found no references to male midwives in Mississippi. However, in Onnie Lee Logan’s memoir of her life as a midwife in Alabama, she explained that her brother-in-law was a midwife. See, Manual for Midwives: For Protection of Maternal and Infant Life and Prevention of Blindness in the Newborn, rev. 1928, 3; Minutes of Executive Committee Meeting, 14 April 1921, 116-17, Box 8416, Series 2036, Department of Health Records; Onnie Lee Logan and Katherine Clark, Motherwit: An Alabama Midwife’s Story (New York: Plume, 1989), 30.


White physicians did not have a monopoly on negative portrayals of midwives and midwifery. In Dr. G. N. Woodward’s presidential address at the annual meeting of the John A. Andrew Clinical Society in 1924, he referred to midwives as a “mysterious apostle of ignorance and superstition—a living relic of witchcraft” and as “careless” and “ignorant.”

Woods, an African-American physician, utilized language similar to Underwood’s, but his critique was based on midwives’ improper medical training rather than their presumed racial inferiority. Underwood, however, conflated ignorance, inferiority, and filth with blackness.

The much maligned lay midwives in Mississippi were, according to Felix J. Underwood, “untrained,” “unlettered,” and “without any idea of what constitutes physical cleanliness.” His 1925 depiction painted an ominous picture which drew on commonly-held, negative stereotypes about blacks.

What could be a more pitiable picture than that of a prospective mother housed in an unsanitary home and attended in this most critical period by an accoucher [sic], filthy and ignorant, and not far removed from the jungles of Africa, laden with its atmosphere of weird superstition and voodooism? And yet, that is a true description of the condition that prevailed in Mississippi at the birth of at least one-half of our white and of all of our colored babies, during the past half-century.

Underwood’s rhetoric reinforced ideas of primitiveness and painted blacks as uncivilized and incapable of intelligence or cleanliness. In fact, as Valarie Lee argues in

Granny Midwives and Black Women Writers: Double-Dutched Readings, “the campaign

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14 Underwood, “The Development of Midwifery in Mississippi,” November 1925, 1, Box 8752, Series 2012; Underwood, “Twenty-Five Years in Maternal and Child Health,” 1516, Box 8752, Series 2012, Department of Health Records. Accoucher is a French word for a man who is trained to assist a woman during childbirth, or midwife. It appears to have been acceptable in American English to use to masculine noun to apply to women, rather than the feminine, accoucheuse. Emphasis added.
to discredit the granny focused on more than vocational incompetence. The granny midwife’s very body . . . was seen as unclean and deviant.” The label of “dirty” was often projected onto the racialized “other.” Associating black women with “pollution” (of the white race) or with filth can also be seen as a way of reinforcing the social order and illustrating that blacks had no legitimate claim to upward social mobility. This was also an indication of the malleable ideology of Jim Crow. While black women midwives were attacked for being unclean, black women domestics, responsible for cooking, cleaning, and caring for children, were ubiquitous in the homes of middle-class whites across the South.  

The contention that black midwives were dangerous because they were “ignorant” or unintelligent, superstitious and unclean was not a new concept in the early twentieth century. Enslaved black midwives during the nineteenth century had faced similar criticism. When the United States ended its participation in the Atlantic Slave Trade in 1808, planters focused more attention on the reproductive capability of their female slaves to provide them with human capital for the continuation of the slave system. Suspicious planters blamed midwives for their slaves’ infertility, stillbirths, and infant mortality. Although black “nurses” and midwives were responsible for much of the

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medical care on antebellum plantations, planters viewed them as potentially dangerous folk practitioners, who required close supervision by physicians.\textsuperscript{16}

The colloquial meaning of “ignorance” implied not only a lack of knowledge but also “denseness,” or a kind of racial inability to learn. Ignorance—in its true sense—could be explained because of the low value that whites placed on black education. One of the paradoxes of Jim Crow was that black people were often denied access to an education and then derided for their lack of knowledge. While only 10 percent of the midwives surveyed in 1921 were literate, any indictment of ignorant and “unlettered” midwives really exposed the separate and unequal school system that kept many black Mississippians from obtaining little more than a rudimentary education. In 1910 and 1920, the illiteracy rates for African Americans in Mississippi were 35.6 percent and 29.3 percent respectively. Still, these were not the worst black illiteracy rates in the country. Mississippi had the fifth highest illiteracy rate for blacks in 1910, and it was tied for the third highest in 1920.\textsuperscript{17}


\textsuperscript{17} “The Relation of the Midwife to the State Board of Health,” 1, 4, Box 8416, Series 2036, Department of Health Records; U. S. Department of Commerce, \textit{Statistical Abstract of the United States}, \textit{1930}, 34. The illiteracy statistics applied to people at least ten years old. Whites are divided into native and foreign born. The illiteracy rate for native whites was 5.2 percent in 1910 and 3.6 percent in 1920. Although foreign-born whites had a higher illiteracy rate, it was still much lower than the rates for African Americans—15.1 percent in 1910 and 13.3 percent in 1920. The black illiteracy rate in Mississippi was also higher than the black illiteracy rate for the Continental United States—30.4 percent in 1910 and 22.9 percent in 1920. The states with higher illiteracy rates than Mississippi were also in the South.

By 1940, Charles S. Johnson’s \textit{Statistical Atlas of Southern Counties} showed that the black population’s illiteracy rate was 23.2 percent as opposed to 2.7 percent for the native white population. Most of the county illiteracy rates were between 20 and 25 percent. See Johnson, \textit{Statistical Atlas of Southern Counties: Listing and Analysis of Socio-Economic Indicies of 1104 Southern Counties} (Chapel Hill: The University of North Carolina Press, 1941), 161.
Many whites contended that blacks were not suited for and did not deserve an education. During the Age of Jim Crow, Mississippi spent less than any other state on black education. At the beginning of the twentieth century, Neil McMillen writes in *Dark Journey: Black Mississippians in the Age of Jim Crow*, black students received only 19 percent of state public school funding while they were 60 percent of the enrollment in the public school system. Though it seems almost improbable, by World War II, blacks received an even smaller percentage of state funding. Still in the majority with 57 percent of public school enrollment, black students received 13 percent of the available funding.\(^\text{18}\)

The Supreme Court’s decision in a case originating in Georgia, *Ware v. School Board of Richmond County*, upheld the school board’s decision to close the county’s only black public high school and divert its funding to the primary school. According to the Julius Rosenwald Fund, a charitable organization that provided funding to build schools in southern states, there was only one public high school for Mississippi’s black students in 1917. As late as 1940, twenty-five of the state’s eighty-two counties had no public high schools for black students. By 1947, there were 100 black high schools, but the Fund estimated that the state probably needed eight times as many schools, based on the number of black students who completed the eighth grade. Thus, there was no pretense of trying to maintain “separate but equal” facilities for black Mississippians. “By virtually every objective measure,” contends McMillen, “they were the nation’s most educationally deprived people.”\(^\text{19}\)

In higher education, Governor James K. Vardaman facilitated the closing of Holly Springs State Normal School, the two-year teacher’s college for African Americans, by vetoing a funding bill passed by the Mississippi legislature in 1905. Vardaman firmly believed that higher education was detrimental to blacks; he was in favor of an education that would make blacks into better (for whites), more subservient laborers. The closing of Holly Springs left Mississippi without a state-supported “normal” college to train teachers until Jackson College became a state institution in 1940.20

African American women in the rural South had little or no access to physicians and hospitals, and many of them continued to rely on lay midwives during the first half of the twentieth century. In contrast to the thousands of lay midwives reported in southern states like Mississippi, Alabama, and Georgia, New Hampshire had seven and New York had 428 in 1922. In Mississippi, South Carolina, Arkansas, Georgia, Florida, Alabama, and Louisiana, midwives attended more than 66 percent of African American births. In Mississippi, midwives attended 84 percent of African American births, the largest

19 McMillen, Dark Journey, 83-85; Johnson, Statistical Atlas of Southern Counties, 161; Negro School Buildings in the Southern States, 1917-1947, 1-2, nd, Box 76, Folder 10, Rosenwald Fund Archives. Mississippi’s population was 50.2 percent black in 1940. I make the assumption that the Fund’s accounting refers to public schools and does not include private schools or academies. The 100 schools accommodated approximately 10,000 students.

The education of white children was clearly much more important than the education of black children. However, Mississippi did not implement a nine-month school year until 1958. See Reuben W. Griffith, “The Public School, 1890-1970,” chap. in A History of Mississippi, Volume II, ed. Richard Aubrey McLemore (Hattiesburg, Miss.: University & College Press of Mississippi, 1973), 408.

20 McMillen, Dark Journey, 86, 107; William F. Holmes, The White Chief: James K. Vardaman (Baton Rouge: Louisiana State University, 1970), 121-22; Jackson College for Negro Teachers, Jackson, Mississippi, 1951, 1-3, Z/1931.000: Mississippi Federation of Women’s Clubs State Institution Reports, Z1931.000. Alcorn Agricultural & Mechanical College (now Alcorn State University), the first-state supported black college, was another alternative. It offered four-year degrees, but it had the disadvantage of being rural. Jackson College (now Jackson State University) was founded by the American Baptist Home Mission Society of New York in Natchez in 1877, but the society moved the school to Jackson in 1882. It became a state teachers’ college only after the American Baptist Home Mission Society ended its support of the institution.
percentage in the country. Statistics from the 1930s demonstrate the disparity between the numbers of whites and blacks attended by physicians and in hospitals. Between 1936 and 1938, 45 percent of black births and 95 percent of white births were attended by physicians. During the same period, 20 percent of black births and 52 percent of white births occurred in hospitals.\textsuperscript{21}

Ideally, many physicians and public health advocates would have preferred to eliminate lay midwifery immediately and completely, but a shrinking population of physicians and few other alternatives for obstetrical care made that an impractical solution. While the number of physicians in the state increased slightly from 1761 in 1910 to 1775 in 1920, the numbers steadily declined for more than two decades after that. By 1944, there were only 1169 practicing physicians in Mississippi.\textsuperscript{22}

Some medical professionals considered nurse-midwives to be a better alternative for maternal care than the “objectionable type of woman engaged in midwifery here in America” because the latter were not “midwives in any true sense of the word.” In a 1914 article in \textit{Public Health Nurse Quarterly}, Dr. Fred J. Taussig suggested creating schools of midwifery that only admitted graduate (trained) nurses for a course in advanced obstetrics. However, there were few schools offering nurse-midwifery

\textsuperscript{21} U. S. Children’s Bureau, \textit{The Promotion of the Welfare and Hygiene of Maternity and Infancy}, 14; Elizabeth C. Tandy, \textit{Infant Mortality Among Negroes}, 4, 6; Tandy, \textit{The Health Situation of Negro Mothers and Babies in the United States}, (Washington, D.C.: U.S. Department of Labor, 1940), 2-3. According to a study by the Children’s Bureau, in both Mississippi and Alabama between 1933 and 1935, more than 90 percent of black children were born in the rural areas.

Mississippi had the second highest number of midwives under public health supervision (3,121); Georgia had the highest (3,171). Both Alabama (4,967) and Texas (4,000) had more practicing midwives than Georgia and Mississippi, but their numbers under supervision were far lower—Alabama (2,879) and Texas (500).

\textsuperscript{22} “The Relation of the Midwife to the State Board of Health,” 3, Box 8416, Series 2036, Department of Health Records; Mississippi State Board of Health, \textit{Manual for Midwives}, rev. 1956.
programs in the first half of the twentieth century. Most people recognized that “if these
untrained midwives were not permitted to practice—say tomorrow—there is no one on
the horizon at the moment to take their place.” Therefore “well-trained” lay midwives
were a more realistic solution to address the shortage of physicians in rural areas.23

In 1920, the state board of health created the Bureau of Child Welfare. To initiate
its public health work related to children, nutrition, prenatal care, and midwifery
supervision, the state appropriated $40,000.24 Laurie Jean Reid, a nurse with the United
States Public Health Service, became Mississippi’s first state supervisor of midwives.
She conducted a statewide survey of midwifery in 1921 which found 4,209 practicing
midwives in the state; the overwhelming majority—between 97 and 99 percent—were
black.25 Mississippi established its lay midwifery education, training, and supervision

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23 Hattie Hemschemeyer, “Midwifery in the United States: How Shall We Care for the Million
Mothers Whose Babies Are Born at Home?” The American Journal of Nursing 49 (November 1939):
the Welfare and Hygiene of Maternity and Infancy, 15; J. Clifton Edgar, “The Education, Licensing and
Supervision of the Midwife,” in The American Midwife Debate, 130-31, 133-34. Emphasis added. The
Bellevue School for Midwives in New York City, which opened in 1911, was the first school of its kind in
the United States.

Nurse-midwives usually work in association with physicians, but their advanced medical training
enables them to handle deliveries and perform prenatal and postnatal care. See American Medical
Association, Complete Medical Encyclopedia, s.v. “nurse” and “nurse-midwife.”

24 Underwood, “Twenty-Five Years in Maternal and Child Health,” 1513, Box 8416, Series 2012,
Department of Health Records.

25 “Midwife Supervision,” 103, Box 8416, Series 2036; Underwood, “Twenty-Five Years in
Maternal and Child Health,” 1512, 1516; “Midwife Supervision,” 104, Box 8416, Series 2036; Underwood,
“The Development of Midwifery in Mississippi” November 1925, 1, Box 8752, Series 2012; “The Relation
of the Midwife to the State Board of Health,” 1, Box 8416, Series 2036, Department of Health Records.
The estimates for the number of practicing midwives in 1921 ranged from 4000 to 5000. However, the
most consistent number used by the state health officials was 4,209. The state records almost never
mention white midwives. By using the state’s tally of midwives, there must have been somewhere between
42 (1 percent) and 126 (3 percent). In 1951, there were reportedly around thirty white midwives. See D. V.
program in 1921. Before this, midwifery was mostly unregulated; however, there was a 1917 state law requiring midwives to place silver nitrate drops in newborns’ eyes to prevent infant blindness, or *ophthalmia neonatorum*.26

After the creation of the Division of Maternity and Infant Hygiene in February 1922, Reid’s position was eliminated. The Director of Public Health Nursing, Mary D. Osborne, R.N., became responsible for the midwife program. Nurse Osborne, who was with the Mississippi State Board of Health from 1922 until her retirement in 1946, also supervised the state’s public health nurses.27

Funds secured through the Sheppard-Towner Act helped Mississippi and other states to create and administer health and welfare programs beneficial to mothers, infants, and small children, including the midwifery program. Originally introduced in 1918 by Janette Rankin, the first woman to serve in Congress, and sponsored by Julia Lathrop,

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26 Reid, “The Plan of the Mississippi State Board of Health for the Supervision of Midwives,” 1921, 3, 7, Box 8752, Series 2012; “The Relation of the Midwife to the State Board of Health,” 1, Box 8416, Series 2036; Mississippi State Board of Health, *Mississippi Laws and Extracts of Laws Deal with Public Health and Certain Laws Relating to Medical Education, Licensure and Hospitals*, January 1, 1947, 19, Box 8416, Series 2036, Department of Health Records; Gertrude Jacinta Fraser, “Afro-American Midwives, Biomedicine and the State: An Ethnohistorical Account of Birth and its Transformation in Rural Virginia” (Ph.D. diss., The Johns Hopkins University, 1988), 150-51. In some ways, elderly was seen as synonymous with unfit because older midwives were thought to be wedded to “backwards” traditions, whereas as younger women were considered more educable.

The blindness is caused by conjunctivitis, an infection of the eye. Infants can contract the infection when passing through the birth canal if the mother has gonorrhea or chlamydia. Untreated infections of this type can lead to impaired vision or even blindness. Before antibiotics were prevalent, silver nitrate drops, a mandatory supply item for midwives, were used to prevent or kill the infection. Neglecting to place the drops in newborns’ eyes was considered a misdemeanor, punishable by fines.

27 “Midwife Supervision,” 104; Underwood, “Twenty-Five Years in Maternal and Child Health,” 1513-14, 17; Louise Holmes to Mrs. Johnny Anderson, 13 July 1953, Box 8416, Series 2036, Department of Health Records; Felix J. Underwood, M.D. to Honorable Edwin R. Embree, 23 December 1929, Folder 8, Box 222, Rosenwald Fund Archives; Mary D. Osborne, 1875-1946,” *State Board of Health* 148, October 1946, 147-48, Box 8752, Series 2012. The Division of Maternity and Infant Hygiene was part of the Bureau of Child Welfare. Its focus was the health of mothers, infants and children under age two.
chief of the Children’s Bureau, the act’s supporters wanted to reduce the infant and maternal mortality rates by providing increased access to prenatal care. The bill eventually passed in November 1921, after being reintroduced by Senator Morris Sheppard of Texas, a Democrat, and Congressman Horace Towner of Iowa, a Republican. Each participating state received $5000 for maternal and child welfare programs but was also eligible for supplemental money if it could provide matching funds. States used the funds in a variety of ways, including, health conferences and health centers. Mississippi used its funds to support its lay midwifery training and supervision program, to hire public health nurses, and to pay salaries and expenses for nurses, including Nurse Osborne. By the time the Sheppard-Towner Act expired in 1929, Mississippi had been receiving $23,000 per year for seven years.28

Mississippi’s registration and training program was supposed to address the “abysmal ignorance” of the black midwives who were “without the knowledge of the first principles of ordinary soap and water” and ensure that only suitable midwives were allowed to practice. Initially, public health nurses visited each county, holding classes and investigating the midwives’ backgrounds over a three-day period. Those who passed

28 Felix J. Underwood to Michael M. Davis, 31 January, 1930; Felix J. Underwood to Edwin R. Embree, 24 May 1929; Felix J. Underwood to Edwin R. Embree, 23 December 1929, Folder 8, Box 222, Rosenwald Fund Archives; Sam Shapiro, Edward R. Schlesinger, and Robert E. L. Nesbitt, Jr., Infant, Perinatal, Maternal, and Childhood Mortality in the United States (Cambridge: Harvard University Press, 1968), 224; J. Stanley Lemons, “The Sheppard-Towner Act: Progressivism in the 1920s,” The Journal of American History 55 (March 1969): 777; U. S. Children’s Bureau, The Promotion of the Welfare and Hygiene of Maternity and Infancy, 1; Underwood, “Twenty-Five Years in Maternal and Child Health,” 1514; Lemons, “The Sheppard-Towner Act: Progressivism in the 1920s,” 781; U.S. Department of Labor, The Seven Years of the Maternity and Infancy Act, 2, 4-5. After the Sheppard-Towner Act expired, the state board of health applied to the Julius Rosenwald Fund to assist with one quarter of Nurse Osborne’s salary and expenses ($4500) for 1930. In order to increase the number of black public health nurses, the Fund initiated a program that paid a portion of the nurses’ salaries over a two-to-five year period. Dr. Underwood asked for and received an exception for Nurse Osborne, who was white; the state received $975.00 to contribute towards her salary. See also Michael M. Davis to R. D. Dedwylder, 24 May 1929, Folder 8, Box 222, Rosenwald Fund Archives.
background inquiries on their cleanliness (personal and equipment); character and reputation; qualifications; and ability to follow directions were allowed to have a state permit. Dek Registered midwives had to be in relatively good health and free of contagious diseases. To that end, they received vision exams and chest x-rays. They were also tested for syphilis and received vaccinations for smallpox and typhoid fever. Of the estimated 5,000 midwives active before the background inquiries, only 4,209 received permits. By 1929, the numbers of active midwives had fallen to 3,040.

Training held between 1925 and 1927 was somewhat longer than the initial training held in the early 1920s. Midwives attended a series of eight training sessions, held over a two-month period. A 1924 Children’s Bureau report asserted that most of the midwives were “pathetically eager to attend classes.” These classes were taught by public health nurses and, sometimes, by experienced midwives.

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30 Underwood, “The Development of Midwifery in Mississippi,” 3; Mississippi State Board of Health, Manual for Midwives, rev. 1928, 19, Box 8752, Series 2012; “Midwife Supervision,” 103, Box 8416, Series 2036, Department of Health Records; Mississippi State Board of Health, Study of Midwife Activities in Mississippi, July 1, 1921-June 30, 1929, Box 222, Rosenwald Fund Archives.

“The Relation of the Midwife to the State Board of Health” from the Midwife and Program Files and Photographs Series of the Department of Health Records at the Mississippi Department of Archives and History gives some slightly different statistics on the number of midwives active in 1929. It states that 2707 midwives retired and 699 died. Thus, the number no longer practicing, out of 6210, was 3406. It is unclear which is more accurate since the Julius Rosenwald Fund’s records were probably provided by the state board in correspondence with the director, Felix J. Underwood.


32 U. S. Children’s Bureau, The Promotion of the Welfare and Hygiene of Maternity and Infancy, 15.
The training was intended to teach the proper, state-approved procedure for home delivery. In “plain,” “easily understood” language, instructors taught the midwives how to prepare beds for delivery and how to clean and sanitize equipment correctly. Perhaps, most importantly, the training was designed to teach midwives to recognize the limitations of their knowledge and ability. They were warned never to conduct vaginal exams. In addition, the assertion that midwives were not adequately trained to perform digital exams, public health officials feared that unclean hands would cause infections like puerperal, or child bed, fever. In the case of breech births, excessive bleeding or vomiting, convulsions, or birth canal obstructions, midwives were advised to call a physician rather than attempting to handle difficult or abnormal births alone. When the training was completed, midwives received one-year, renewable permits, which stated that they had registered with the county health office and received instruction on preventing infant blindness and birth registration. State public health officials were careful not to call the permits a “regular license to practice.” In fact, the director of the Division of Maternal and Child Health contended in a 1951 letter, “The Legislature has never granted any agency the authority to license midwives, and all that we do is voluntary between the health department and midwives.” The difference in meaning between a “permit” and a “license” seems negligible, but officials may have thought licensing would be viewed as a license to practice medicine. That was clearly the domain of physicians.\(^{33}\)

Aside from learning about their new restrictions, the state’s training program may not have taught midwives much that they did not already know as a result of their own training and experience. Before practicing alone, it was common to serve as an apprentice to another lay midwife who taught and supervised her apprentice, sometimes for as long as a year. Midwife Otha Bell Jones from Itta Bena was an apprentice to Sister Nancy Wright, who “would let me do all the work” while she observed. By the time she received a permit from the state, she had already “nursed” thirty-six women. Midwife Johnnie Lee Smith, who began working in Lee County in 1938, delivered 523 babies during her career, but first she helped Mrs. Henrietta Shambry until she retired. Midwife Mittie Patterson, who practiced for forty-five years in and around Corinth, Mississippi, trained under her mother Lou Taylor and later Dr. R. E. Honnell. In fact, she attended her first delivery because her mother was sick. Margaret Charles Smith, an Alabama midwife, trained with Miss Ella Anderson for approximately a year before she handled deliveries alone. Beginning in 1942, Midwife Sadie Mae Singleton trained for two years under experienced midwives in Bolton, Mississippi before she was on her own.\footnote{Marie Jenkins Schwartz, \textit{Birthing a Slave: Motherhood and Medicine in the Antebellum South} (Cambridge: Harvard University Press, 2006), 130; Smith and Holmes, \textit{Listen to Me Good}, 75; Sharla M. Fett, \textit{Working Cures: Healing, Health, and Power on Southern Slave Plantations} (Chapel Hill: The University of North Carolina Press, 2002), 130, 147-48; Otha Bell Jones to Mary D. Osborne, Midwife’s Report Leflore County, 13 April 1938, Box 8416, Series 2036, Department of Health Records; Johnnie Lee Smith, \textit{My Life and How I Saw the Caldwell Memorial Hospital Grow and Pass Away}, 27; Beulah M. D’Olive Price, “‘Birthin’: A Past Life for an Alcorn Midwife,” \textit{The Daily Corinthian}, 10 November 1976, Subject File: Midwives, Mississippi Department of Archives and History (MDAH); Smith and Holmes, \textit{Listen to Me Good}, 75, 85; “Grannies: The Roots of Midwifery,” \textit{The Clarion-Ledger}, 1 January 1982, 9e, Subject File: Midwives, MDAH.}
Historically, medical education through apprenticeship was not uncommon. It was the primary way of becoming a physician in the colonial period. Medical apprentices assisted an established physician and read medical books for a number of years, usually three, before earning a certificate of proficiency and the right to practice alone. The proliferation of medical colleges in the nineteenth century led to increasing numbers of students receiving their education through medical schools and the end of the apprentice system for physicians. Because few medical programs accepted women applicants, the professionalization of medical education also led to women being almost completely excluded from medical training. This included those who wanted to become physicians as well as midwives.\(^{35}\)

Mississippi’s midwife training was reinforced through the manuals and meetings of the midwife clubs. The first midwife manual was completed in 1924. It was an attempt to ensure that midwives adhered to the state’s regulations and recognized what they “should do and should not do.” As in the training sessions, the manual provided step-by-step instructions on preparing themselves and their patients’ bedrooms for delivery; delivering the baby; and caring for the mothers after the birth.\(^{36}\)

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Otha Bell Jones kept track of her deliveries. In 1938, she had “nursed” for thirteen women. Over twenty-three years, she had filled fifteen books with the names of babies she delivered.


Because the lack of cleanliness had been one of the main criticisms leveled at lay midwives and their folk medicine practices, the manuals predictably focused on cleanliness as a major theme. Among the qualities of good midwives, the 1928 manual first lists that they “are CLEAN in person, home, and equipment.”\textsuperscript{37} To further stress this point, the midwife song, “Protect the Mother and Baby,” sang to the tune of “Mary Had a Little Lamb,” explained why midwives wore clean clothes, scrubbed their arms and hands (with soap), and soaked their hands.\textsuperscript{38} The white uniforms they wore while on a “case”—white dress, apron, and cap—symbolized cleanliness and order. It also provided a contrast between their “disorderly” everyday apparel. The message was that “midwives were never clean enough.”\textsuperscript{39} “Song of the Midwives,” written by Nurse Osborne, extended the cleanliness theme beyond the midwives bodies and uniforms, exclaiming, “We have clean homes, clean yards, clean town,/We’ll make OUR COUNTRY OF GOOD RENOWN.”\textsuperscript{40}

\textsuperscript{37} Mississippi State Board of Health, \textit{Manual for Midwives}, rev. 1928, 20, Box 8752, Series 2012, Department of Health Records. The theme of cleanliness is repeated throughout the Mississippi manual. Original emphasis.

\textsuperscript{38} Mississippi State Board of Health, \textit{Manual for Midwives}, 1939, 41, Box 8752, Series 2012, Department of Health Records; Mississippi State Board of Health, \textit{Manual for Midwives}, rev. 1956, 55. “Protect the Mother and Baby” was written Nurse Mary D. Osborne; there were movements that went along with the words. The 1928 manual had a different midwife song, “Song of the Midwives.” It was sung to the tune of “As We Go Marching On.” This song reiterates all of things that good midwives should do, but it does not focus as much on the cleanliness issue. See \textit{Manual for Midwives} 1928, 30.

\textsuperscript{39} Lee, \textit{Granny Midwives and Black Women Writers}, 38. Pictures taken of midwives often illustrated a before-and-after scenario. In the “before picture,” they wore their “everyday” clothes; in the “after picture,” midwives had on the white dresses and caps that symbolized order and cleanliness.

\textsuperscript{40} Lee, \textit{Granny Midwives and Black Women Writers}, 38; Mississippi State Board of Health, \textit{Manual for Midwives}, rev. 1956, 54. Original emphasis. Pictures taken of midwives often illustrated a before-and-after scenario. In the “before picture,” they wore their “everyday” clothes; in the “after picture,” midwives had on the white dresses and caps that symbolized order and cleanliness.
Further emphasizing the importance of cleanliness, the Division of Public Health Nursing required midwives to set up model delivery rooms in their homes every year, beginning in 1931. The midwives “neatly dressed in regulation white” explained to their visitors the importance of having the necessary supplies on hand and preparing the “delivery room,” the patient’s bedroom, before the midwife arrived. There were more than 3,000 model delivery rooms set up in 1933, but by 1938 the number had declined to 1,168.\(^4\) A midwife from the Little Do Better Midwife Club noted that a total of 220 people—196 blacks and 24 whites—had come to “inspect” what she called the “government bed.” This number included two county nurses. Occasionally, state public health officials also visited some of the model delivery rooms. For instance, several state officials including Executive Director, Dr. Felix Underwood, visited home demonstrations by midwives Mary Nichols and Mary Catchings in Jackson in 1933.\(^4\)

The model delivery rooms served several purposes. It was required for a midwife to “stay in good standing” and keep her permit. For perspective clients visiting the model delivery rooms provided helpful information for selecting a “good” midwife. Expectant parents learned what supplies they needed to have on hand to prepare for a home delivery. The list of items included: bed linen; towels; clean white rags; cotton; sterilized pads and newspaper pads; night gowns; two basins; a wash tub; a bed pan; a slop jar or bucket; and mild soap. Additionally, setting up the rooms provided practice

\(^4\)“Midwife Supervision,” 106, Box 8416, Series 2036; Mississippi State Board of Health, \textit{Manual for Midwives}, rev. 1928, 7-8, Box 8752, Series 2012, Department of Health Records.

\(^4\)Little Do Better Midwife Club Report, n.d. (circa mid 1930s to early 1940s); “Midwife Supervision,” 106; “Midwives and Health Work,” 30 September 1933, Box 8416, Series 2036, Department of Health Records. Newspaper clipping in file with date 9-30-33 written in pencil.
for the midwives and “stimulated [them] to do better work.” If midwives were actively attending deliveries, however, it is doubtful that they would have needed to “practice” to improve their skills. The unstated purpose of these model delivery rooms was surveillance, which allowed public health officials, physicians, and the community to supervise the midwives and, perhaps, more importantly, to inspect the cleanliness of their homes. The State Board even recommended times when the model delivery rooms were likely to get more attendance—after the cotton was chopped (weeded) in the spring and early summer and after it was picked in the fall.43

Each model delivery room set-up included a visitor registration log for attendants’ comments. Some visitors wrote letters to state officials evaluating the delivery rooms. In 1944, Mr. and Mrs. J. C. Cannon, who identified themselves as white, visited Midwife Lottie Rucker’s model delivery room in Holmes County (Cruger, Mississippi).

According to Mrs. Cannon’s letter, the midwife needed at least four white people to inspect her setup, and she found that everything was “in fine condition, clean and well prepared.” “The house,” Mrs. Cannon added, “was clean too.” This focus on cleanliness was reaffirmed by Eloise Conn, R.N., in an article about Amite County Midwives (circa 1942). She stated that a midwife’s “home and surroundings must be kept clean, because

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43 “The Relation of the Midwife to the State Board of Health,” Circa 1944, 6-7, Box 8416, Series 2036; Mississippi State Board of Health, Lesson Outlines for Teaching Midwives, 6-7; Mississippi State board of Health, Manual for Midwives, rev. 1956, 6, 27-28; Mississippi State Board of Health, Manual for Midwives, rev. 1928, 7-8, Box 8752, Series 2012; “Midwife Supervision,” 106, Box 8416, Series 2036; Eloise Conn, R.N., “Amite County Midwives,” Southern Herald (Liberty, Mississippi) 12 November circa 1942 (News Clipping), Box 8416, Series 2036, Department of Health Records. The Manual for Midwives listed the following items needed for a new baby: bath cloths and towels; a baby bed with linen; baby clothes; diapers; safety pins; belly bands; a tub; oil; and mild soap.
she is taught that unless she keeps her home clean she can’t teach her patient to be clean.”

Another way of reinforcing the state’s training was through the county midwife club meetings. By attending these meetings, midwives stayed current on their training which would in turn raise midwifery standards. The meetings were generally held monthly and often included singing hymns and group prayer as well as lessons or readings from the midwife manual, equipment demonstrations, or lectures. The meetings, the state board contended, “gradually changed from a chaotic, disorderly group of women dressed in clothes of all descriptions[,] including woolen dresses and fancy hats, many talking and paying little attention, to midwives dressed in clean white uniforms and white caps” that covered their hair.

There were as many as 505 of these clubs in the early 1940s. Not all counties were actively engaged in close supervision of their midwives, however. Although there were twenty-seven midwives practicing in Harrison County in 1932, nine of whom were white, there were no midwife clubs until 1941.

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44 Mr. and Mrs. J. C. Cannon to Miss Mary D. Osborne, 1 September 1944, Box 8416, Series 2036; Mississippi State Board of Health, Lesson Outlines for Teaching Midwives, 7; “Midwife Supervision,” 106, Box 8416, Series 2036; Eloise Conn, R.N., “Amite County Midwives,” Southern Herald (Liberty, Mississippi) 12 November circa 1942 (News Clipping), Box 8416, Series 2036; Mississippi State Board of Health, Manual for Midwives, rev. 1928, 4, 5, 30, 1928, Box 8752, Series 2012; Department of Health Records. If accurate, Cannon’s assertion that a certain number of whites needed to provide statements may have been an unwritten policy.

45 Mississippi State Board of Health, Manual for Midwives, rev. 1928, 4, 5, 30, 1928, Box 8752, Series 2012; Mississippi State Board of Health, Lesson Outlines for Teaching Midwives, 5; Ferguson, “Mississippi Midwives,” 88, Box 8752, Series 2012; “The Relation of the Midwife to the State Board of Health,” Circa 1944, 2, Box 8416, Series 2036; Midwife Club Report, Waynesboro, Mississippi, 3 March 1945; Midwife Club Report, Humphreys County, 3 September 1942; Lee County Midwife Club Report, 7 November 1942, Box 8416, Series 2036, Department of Health Records. Emphasis added.

46 History, July 1, 1935 to June 30, 1937, Box 15772, Series 1706; “The Relation of the Midwife to the State Board of Health,” Circa 1944, 2, Box 8416, Series 2036; Mississippi State Board of Health,
At the midwife club meetings, the club leader distributed the eye drops and performed equipment inspections of members’ midwife bags, making sure that only approved items were inside. The approved contents of the black leather midwifery bag were: an inner bag of washable material; a cap and gown; a hand brush; a wooden nail cleaner; blunt scissors; a bottle of synol soap; a bottle of Lysol; one percent silver nitrate solution; sterile tape, band, and eye wipes; a thermometer; a funnel with rectal tube; the midwives’ manual; midwifery permit; and birth certificates.\textsuperscript{47} The state emphasized having “uniform equipment” and the proper use of that equipment. Midwives who were unable to “learn how to assemble equipment, care for it properly, and understand the use of each article” were not considered fit to be midwives. At a Forrest County midwife club meeting in 1948, a physician from the State Board warned the midwives in attendance that 176 women had died during or after childbirth in 1947, many because of infections caused by midwives’ unclean equipment.\textsuperscript{48}

White public health officials were also determined to eliminate the folk practices they regarded as backwards and/or dangerous although many, but not all, of the practices were innocuous. Traditional lay midwives used various kinds of teas and soups, some to

\textsuperscript{47} Mississippi State Board of Health, \textit{Lesson Outlines for Midwives}, 6; Mississippi State Board of Health, \textit{Manual for Midwives}, rev. 1928, 4, Box 8752, Series 2012, Department of Health Archives.

\textsuperscript{48} Mississippi State Board of Health, Lesson Outlines for Teaching Midwives, 4; Ferguson, “Mississippi Midwives,” 94. Cleanliness of the tools of the trade is also a theme in \textit{All My Babies}. In one scene, Mary Coley returned from a delivery and wanted to go directly to bed and clean and sterilize her equipment when she got up the next morning, but a warning she had received from a physician at the health department caused her to reconsider. In a meeting, the doctor told the midwives that unclean equipment had led to a death.
induce labor and others to reduce pain. To induce contractions, some midwives used hot, spicy soups or various kinds of teas ("bamboo briar," golondrina, spearmint, lavender, wasp nest and dirt dauber). “Mayapple root” tea could be used to both induce labor and reduce pain. Another common practice was placing an ax, knife, fork, or a pair of scissors under the patient’s or the baby’s mattress or bed. This was done to “cut” the labor pain. Others gave the mothers medicinal baths when labor began. To stop hemorrhaging, a midwife survey in Texas noted that practices included giving mothers abdomen massages and putting sugar and soot into the birth canal. Midwives often gave newborns oil baths and applied grease to their umbilical cords. Many midwives insisted on maintaining a fire both during and after birth. Finally, some recommended naming a baby seven or nine days after birth, when the child’s spirit had settled. Midwives in Mississippi who carried unauthorized supplies in their bags ran the risk of not receiving a permit or having their permits rescinded. In other states, midwives were threatened with jail.49 Because the practices were considered taboo, midwives did not generally discuss them, making them difficult to track.

At the meetings, midwives helped each other with required paperwork. They also applied for birth certificates and recorded stillbirths, miscarriages and deaths.50

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health nurses and expectant mothers attended some of the meetings. They recommended that mothers get adequate bed rest after birth. They encouraged them to get proper nutrition by eating “good and building food” like soup, bread, fruit, vegetables, lean meat, fish, and dairy.  

A midwife was expected to “become teacher of health in the community and an example for others to follow,” assist doctors and nurses at medical conferences, inform the community about the public health services available. The clubs’ monthly activity reports—most from the mid-1930s to the mid-1940s—to the state supervisor give some indication of the midwives’ public health work, not all of which was devoted to maternity clients. While these reports were certainly meant to be viewed by state officials, they were written by the midwives. Therefore, they provided important opportunities for midwives to explain their roles, contributions, and activities rather than have them

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51 Waynesboro, Mississippi Midwife Club Report, 3 March 1945; Lee County Midwife Club Report, 7 November 1942, Box 8416, Series 2036, Department of Health Records; Midwife Club Report, Humphreys County, 5 September 1942, signed by Irene B. Brisco and Louise Ceal, Box 8416, Series 2036, Department of Health Records.

According to midwife Jesusita Aragon, in Mexican tradition, there were special customs and diet restrictions that new mothers followed for forty days after birth. The dieta gave the mothers time to recover from childbirth. New mothers were also allowed to have beef, lamb, chicken, tortillas, turnovers, and atole—a hot drink made with corn meal, water, sugar, cinnamon, vanilla and sometimes chocolate or fruit. However, women were not supposed to eat potatoes, beans or chili. They were to remain in bed for at least eight days. Weather permitting, they could go outside after fifteen days. Finally, they were not supposed to do housework or sleep with their husbands. Aragon notes, however, that her family did not allow her to follow the dieta when she was a young mother. See Buss, La Partera, 66.

52 Mississippi State Board of Health, Lesson Outlines for Teaching Midwives, 3.

53 Mississippi State Board of Health, Manual for Midwives, rev. 1928, 4, 5, 30; Ferguson, “Mississippi Midwives,” 88, Box 8752, Series 2012; “The Relation of the Midwife to the State Board of Health,” 2; Midwife Club Report, Waynesboro, Mississippi, 3 March 1945; Midwife Club Report, Humphreys County, 3 September 1942, Box 8416, Series 2036, Department of Health Records.

The bulk of the documents in the Department of Health’s records are from the mid-1930s through the early-to-mid 1940s. There are also two scrapbooks (circa 1930) with pictures of midwives in classes; children and adults lined up to receive vaccinations; and babies delivered by midwives. See Photograph Scrapbooks, circa. 1930, Box 8773, Series 2176, Department of Health Records.
interpreted by the state. These reports show that midwives were instrumental in educational and public health efforts. They helped to arrange public health conferences and then provided assistance to doctors and nurses at those conferences. In fact, the *Manual for Midwives* noted that participation in clinics, conferences and community work was part of midwives’ duty to the health department. They also participated in Child Health Day and Negro Health Week activities. They encouraged mothers to attend classes and to go to the health department for medical services, often bringing people to health departments and other local sites for immunizations and treatment for sexually transmitted diseases. Because of their knowledge of local communities, the state sought their assistance in conducting public health surveys.\(^{54}\)

Midwives in Monroe County, along with other community organizations, public health officials, doctors and nurses, organized monthly health conferences in 1936 where expectant mothers could get physical examinations, prenatal and postnatal counseling. In 1937, the secretary of Lee County Midwife Club, Lillie Bell Hill, reported that in addition to delivering and registering 124 babies that year, members of her club had participated in a “Clean-Up Campaign,” visited people who were sick, and helped “the needy.” They expected to continue and increase their activities in 1938.\(^{55}\)

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\(^{54}\) “The Relation of the Midwife to the State Board of Health,” 4-5, Box 8416, Series 2036; Picture 2036-57-60, 9 September 1942, Box 8419, Series 2036; Eloise Conn, R.N., “Amite County Midwives,” Liberty *Southern Herald*, 12 November circa 1942 (News Clipping), Box 8416, Series 2036; History, July 1, 1935 to June 30, 1937, Box 15772, Series 1706; Mississippi State Board of Health, *Manual for Midwives*, rev. 1956, 14, Department of Health Records.

Negro Health Week was started in 1915 by Booker T. Washington to focus on African Americans’ health issues. Child Health Day has been celebrated since 1928; the day’s activities focused on bringing attention to and preventing children’s health problems. Some health departments in Mississippi observed the day with a parade.

\(^{55}\) Virginia Thompson to Miss Mary D. Osborne, 21 July 1936; Annual Report for Lee County Midwife Club, 1937, Box 8416, Series 2036, Department of Health Records.
Some midwives filed individual reports that explained their activities in greater detail than the club reports. A report from Mollie Gilmore, a midwife from Vicksburg, Mississippi (Warren County), indicated that she delivered twenty-five babies between July 1936 and December 1937. Most of her clients were black, but she had nursed “8 white ladies in all” and assisted a physician with deliveries for four more white patients. She made numerous home visits to patients, some with the county nurse, for prenatal and infant care. By the end of December 1936, she had spoken with more than one hundred different people, referring some of the women to physicians. She had set up her model delivery room. She had also encouraged county residents to get vaccinations. She noted that on at least two occasions, Mississippi officials had her speak to visitors to the state and demonstrate some of her equipment and duties, confirming that public health officials acknowledged her skills and abilities.\footnote{Report of Work of Mollie Gilmore, Midwife, July 1936 to December 1937; Mississippi State Board of Health, Minutes of the Executive Committee Meeting, 14 April 1921, 116, Box 8416, Series 2036, Department of Health Records. Midwives were required to submit monthly reports to the state supervisor of midwives; however, there are few reports that are as detailed as Gilmore’s. It is unclear whether reports were generally saved. Also, inability to write may have prevented a significant number of the midwives from submitting reports.}

Midwife Della Falkner of Holly Springs detailed her personal and professional history in a 1937 booklet, complete with a picture of herself. Falkner listed the names of 133 babies she delivered, with only two stillborns. She stated, “God has blessed me to call in many homes, both white and colored, with which I have rendered much aid to the suffering.” Although the vast majority of her clients had been black, she had also delivered thirteen white babies. She noted that her work as a midwife began in March 1927, but her records indicated that she had delivered six children before that time, which
perhaps speaks to a period before she obtained a state permit or worked as an apprentice.  

Correspondence from club leaders and other midwives with public health nurses might also discuss meetings, model delivery rooms, community activities, births and deaths, retirements, or holiday greetings. They could also alert officials to potential public health problems. Midwife Estelle W. Christian was on a case in Rocky Springs in October 1939 when a woman covered with sores came to the expectant mother’s home to see her. In August, at a health lecture in Willows, Mississippi, she advised those who “had any sores or the least suspicion that they were infected with that dreaded disease syphilis to please tell some one before it is too late.” The next time Christian returned for a delivery, a woman who feared she had contracted syphilis came to the house. Christian wrote in her letter to the county nurse, “So I had to tell her in a nice way [that] we could not have her around the patient, nor the baby, and please don’t come back until I could see what could be done for her.” She continued with what seemed more like a demand than a request, “Now could you go out there at once to see about this.” She also advised that she would take the nurse to where the patient lived. The woman was sent to a physician to be tested for syphilis. The county nurse, Viola Jones, was impressed with Christian and forwarded her letter to Nurse Osborne stating, “This is from one of the

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57 “History of Della Falkner, Mid-Wife, and Register of Her Patients,” 26 February 1937, Box 8416, Series 2036, Department of Health Records. This pamphlet may have been to commemorate Falkner’s retirement from midwifery.
midwives who is doing so much to educate her people that I feel real proud of her[,] and I wanted you to see this letter.”

Thus, there were public health workers people who were willing to acknowledge midwives’ positive impact on their communities. A 1925 physicians’ poll indicated that 85 percent of the respondents had already recognized improvements among the midwives’ “personal cleanliness.” In the areas of consulting physicians for abnormal cases; caring for mothers and infants; maintaining their equipment properly; and reporting births, a majority conceded that the midwives had made some progress.

A report from the Mississippi State Board of Health’s Director of Epidemiology credited the state’s midwives with reducing typhoid fever rates in 1930. In addition, by encouraging thousands to be inoculated, “Midwives played no small part in the diphtheria control program[,] as they have consistently where inoculation was available, influenced negro [sic] parents to bring infants and preschool children to the conferences to be protected.” Brooksie W. Peters, a registered nurse working with the Lauderdale County Health Department in 1947, explained in a letter to the director of public health nursing, that midwives were “serving a real need.” They were highly respected in their communities, and they understood the problems of people in rural areas.

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58 Estelle W. Christian to Viola M. Jones, October 1939, Box 8416, Series 2036, Department of Health Records. The Wassermann test was used to detect syphilis. It is named for the German bacteriologist who developed it, August von Wassermann.

59 “The Relation of the Midwife to the State Board of Health,” 8, Box 8416, Series 2036. This document does not reveal the number of questionnaires mailed to doctors or the number that responded. However, since the state board reported that there were 1775 physicians in Mississippi in 1920 and 1490 in 1930, the number surveyed may lie somewhere in between those figures.

60 “The Relation of the Midwife to the State Board of Health,” 9; Brooksie W. Peters, R.N. to Miss Lucy E. Massey, 14 July 1947, Box 8416, Series 2036, Department of Health Records. Typhoid fever rates decreased in 1930 despite a public health warning that Southern states would experience an increase.
Whether the state chose to acknowledge them or not, the midwives were in fact uncompensated public health workers. Public health nurses and doctors employed by the state were paid to visit patients and set up conferences and clinics. Midwives performed many of the same activities without pay. They delivered babies and took care of both the mother and baby after the birth, often cooking meals, cleaning, and caring for older children in the home during the mother’s “lying-in” period, extra tasks that physicians did not and were not expected to do. The midwife manual suggested a “lying-in” period of several days for mothers. The midwife “made [the mother] comfortable in a clean bed” and also cleaned, weighed, and dressed the baby. Then, for three days, midwives were to care of both mother and baby, giving each a daily bath. They had to make sure that the women were getting proper nutrition and breastfeeding. Before leaving, midwives were expected to teach someone else how to care for the mother until she recovered.61

Midwives in Mississippi and throughout the South were bound by strict regulations, but as Margaret Smith noted in her memoir about midwifery in Alabama, “They didn’t have no law to make them pay us.” The Mississippi Midwife Manual addressed payment for services in 1956 by stating that mothers had a “duty” to “pay midwife according to agreements.” Thus, midwives were responsible for privately negotiating acceptable contracts with their clients. The only remuneration they received was what their patients could afford to pay, often not very much.

Most fees appear to have been set on an individual basis. Although Mrs. Bessie Sutton of Monticello, Mississippi, was attended by a physician, who charged $10.00, for

61 Mississippi State Board of Health, Midwife Manual, rev. 1928, 11-15; Mississippi State Board of Health, Manual for Midwives, rev. 1956, 43, 45. Although this is what the manual suggested, it is unclear whether most midwives were able to spend three full days with their patients.
the birth of her first child, she only received $1.50 for performing her first delivery in the early 1920s. When she retired in 1962, her fee was twenty dollars. Midwife Mittie Patterson’s fee was five dollars when she began but twenty-five dollars at the time of her retirement. During the Depression in 1931, Mrs. Susie W. Walker’s midwife in Canton charged twenty-five dollars. In February 1944, the midwives in Monroe County agreed to charge a fifteen-dollar fee for their services. While the fee that Mrs. Walker’s midwife charged may seem exorbitant when compared the Monroe County midwives’ fifteen-dollar fee years later, the midwife stayed with the Mrs. Walker for nine days, six days longer than recommended by the state. This may have resulted from Walker’s inability to produce breast milk at first.62

Anne Moody revealed in her autobiography, Coming of Age in Mississippi, that Aunt Caroline, an elderly midwife who delivered her younger sibling, charged only ten dollars, which meant that “she must have had to del iver a lot of babies to keep alive.” When the midwife came to assist her mother during her delivery, she wondered what the “old lady” could possibly know about delivering babies, but she later learned that Aunt

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The article does not indicate when Midwife Patterson began or ended her practice, only that she practiced for approximately forty-five years and had retired a few years prior to the article being written because of her high blood pressure and poor eyesight.
Caroline and another midwife, Aunt Mary Green, “had been midwives for every Negro baby between Woodville and Centreville[,] Mississippi] for the past forty years.”

Midwives sometimes had trouble collecting their modest fees. This is not surprising considering that some of their clients were “just barely living,” without adequate food, indoor plumbing, or decent furniture. There were times when Midwife Mittie Patterson did not get paid at all. Some patients resorted to the barter system to settle the bill, as in Alice Walker’s poem, “Three Dollars Cash.” The midwife had collected “Three dollars cash/For a pair of catalog shoes” for the last child born. But, previously for another child, the family allowed her to choose a pig. Midwife Sadie Mae Singleton of Bolton, Mississippi had just that experience. When she began in the 1940s, she charged ten dollars per delivery, if the family had the ability to pay. Her fees were thirty-five dollars by 1950. However, she had also received payment in the form of a hog and pigs. Onnie Lee Logan, an Alabama midwife whose mother had also been a midwife, revealed a similar pattern. When clients had no money, vegetables from their gardens were commonly used for payment. In most cases, being a midwife in the rural South was not financially lucrative. In fact, Midwife Bessie Sutton contended, “If I’d a stopped ’cause they didn’t pay me, I’d a stopped a long time ago.”

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Many midwives asserted that they entered the profession not for money but because midwifery was a God-given gift, talent, or “calling” that was often, but not always, passed from one generation to the next. Mary Breckinridge, founder of the Frontier Nursing Service in Kentucky, referred to it as a “calling so ancient that the medical and nursing professions, in even their earliest traditions, are parvenus beside it.” It was “more than primeval; it is primordial.” Because God had provided them with the “gift” and the knowledge to help bring children into the world, many midwives felt morally and spiritually bound to continue their work even when families paid in trade, paid late, or failed to pay at all.  

Inability to pay was not a problem for all women. Some black women who had access to and could afford a hospital stay for delivery, still chose midwives. Mrs. Eunice Nelson, a nurse at the Afro-American Hospital in Yazoo City, recalled that women often brought their midwives to the hospital, and they stayed until the women delivered. 

Another source of information about midwives’ activities comes from programs honoring them upon retirement. In the late 1940s, Mississippi began to “encourage” elderly midwives to retire; however, there was no specified retirement age. Elderly midwives had been targeted since the 1921 survey. They were thought to hold more


All midwives were not so altruistic when it came to the fees for their services. In 1939, Mamie Reed, a Leflore County midwife “repossessed” a baby and tried to hold it as collateral when a family did not finish paying her. Reed was arrested and charged with kidnapping, and the baby was returned to its family. See “Leflore Mid-Wife Fails on Fee, Takes Baby,” Jackson Daily News, 8 November 1939, Box 8416, Series 2036, Department of Health Records.

67 Mrs. Daisy Greene and Mary Louise Miller, interview by Barbara Allen, 3 April 1980, interview OH 80-37, transcript; Mrs. Eunice Nelson, interview by Barbara Allen, 6 May 1980, interview OH 80-70, transcript, Yazoo County Scholar-in-Residence Oral History Project, B.S. Ricks Memorial Library, Yazoo City, Mississippi.
superstitious ideas whereas younger midwives could more easily be trained in “modern” practices. The state also began to make it increasingly difficult to obtain or renew midwifery permits. Physicians had the power to allow midwives to continue practicing or to prevent them from doing so. To renew a permit, a county physician had to agree that midwives were still needed in a particular county. If a physician’s examination determined that a midwife should no longer make deliveries, her permit was not be renewed. If a midwife could not get her permit renewed, she was forced into retirement. After a midwife turned in her permit and agreed not practice anymore, she was eligible for a retirement ceremony during which she received the Nurse Mary D. Osborne Retirement Badge from the state and sometimes a small token of money as a retirement gift from her church and community members.  

When Midwife Catherine Lyons retired, she received a gift of six dollars at the program honoring her. The service included hymns, scripture reading, the Lord’s Prayer, and a “Health Sermon” by Rev. D. L. Lewis. A ceremony at St. John Methodist Church in Palmer’s Crossing in November 1948 honored two of the stork’s “oldest and most faithful Forrest County helpers,” Midwives Mollie Merrill and Josephine Franklin, with the “coveted” retirement badge. In their combined seventy-five years of service, they had

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Nurse Osborne died July 7, 1946 in Cleveland, Ohio, only days after her official retirement. See: Louise Holmes to Mrs. Johnny Anderson, 13 July 1953, Box 8416, Series 2036, Department of Health Records. There is also a retirement song, “A Salute to the Retired Midwives,” in the 1956 midwife manual.
delivered more than 500 babies.\textsuperscript{69} At a Hinds County retirement ceremony in 1975 where thirteen midwives “quietly accepted their retirement” Dr. Eric McVey’s comments provided little indication of the troubled relationship between lay midwives and the Mississippi State Department of Health. The Hinds County health officer asserted that the ceremony “show[ed] them the kind of respect we’ve always had for them.” “We had to depend on them,” he contended, or providing obstetrical care for a large percentage of Mississippi’s mothers and infants “would have been impossible.”\textsuperscript{70}

In the second half of the twentieth century, fewer women became lay midwives as older women retired or died, perhaps indicating the effect of the new regulations on permits. Some women had gravitated towards this work because it provided them with an alternative to domestic labor, and they were able to help people in the community. Also, in many families, midwifery had been a tradition, passed down from one generation to the next. Other women went into midwifery to supplement the family income. By the 1960s, more potential clients had access to private insurance and public, low-income medical insurance. Medicaid was introduced in 1965 to assist disabled and low-income residents with health coverage. Both Medicaid and private insurance plans covered hospital charges associated with birth and delivery, but these plans did not cover midwife-assisted deliveries. Some practicing midwives still found a niche because the

\textsuperscript{69} Unsigned letter to Nurse Osborne, Pocahontas, Mississippi, May 4, 1950, Box 8416, Series 2036, Department of Health Records; Robert Loftus, “Stork Loses Two Long-Time Forrest County Helpers,” \textit{Hattiesburg American}, 29 November 1948. (This is the re-typed content from the article in the newspaper.)

\textsuperscript{70} Brenda Boykin, “Midwives Recall Way Childbirth Used To Be,” 15 February 1976, \textit{The Clarion-Ledger}, 9C, Subject File: Midwives, MDAH. As a result of the retirements, there were only two midwives remaining in Hinds County.
amount that Medicaid would provide was often less than doctors were willing to accept for a delivery.\textsuperscript{71}

There was not much change in the number of deliveries by midwives early on, but by the late 1960s the goals of reducing the numbers of midwives and midwife-assisted deliveries while increasing the number of physician-assisted and hospital deliveries were finally being realized. During the 1920s, the percentage of black births attended by midwives declined from 84 percent to 79 percent in 1929, at one point dropping to 77 percent. In contrast, white births attended by midwives never exceeded 10 percent. Nevertheless, midwives were still delivering more than 44 percent of all babies—20,451—in 1929.\textsuperscript{72}

Lay midwifery in Mississippi remained significant for several decades despite the declining numbers of midwives and midwife-assisted births. In 1948, \textit{The Booneville Independent} reported that there were 2,300 midwives in the state. A 1952 survey showed that midwives delivered 32.1 percent of all babies. Because of the increase in the number of births, however, midwife-assisted deliveries were still a sizable number—20,732. By the late 1960s, however, the director of public health nursing referred to midwifery as “a dying avocation.” There were between 600 and 900 midwives who assisted 10,000 to

\textsuperscript{71} State Health Agency Calls Midwifery ‘Dying Avocation’,” \textit{The (Jackson) Commercial Appeal} (Jackson, Mississippi) n.d. (circa mid-to-late 1960s), Box 8416, Series 2036; Brooskie W. Peters, R.N. to Miss Lucy E. Massey, 14 July 1947, Box 8416, Series 2036, Department of Health Records; Smith and Holmes, \textit{Listen to Me Good}, 63, 136-3; Starr, \textit{The Social Transformation of American Medicine}, 333; Jim Ewing, “Midwife Maintains Practice,” \textit{Jackson Daily News}, 15 October 1980, 1c, Subject File: Midwives, MDAH.

\textsuperscript{72} “Births Attended by Physicians and Midwives,” Box 8416, Series 2036, Department of Health Records; “Births Attended by Physicians and Midwives,” Folder 8, Box 222, Rosenwald Fund Archives. The percentage of black children delivered by midwives was as high as 80.7 percent in the 1920s. In fact, the 1952 numbers for midwife-assisted births were more than in 1929.

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12,000 births each year. In 1975, there were 259 registered lay midwives in the state; by 1982 there were thirteen. An example can illustrate this dramatic decline in the number of midwives over time. Sunflower County had fifty-two midwives in 1921 but only seven in 1973. The state-sponsored lay midwifery program faded away as the Mississippi Department of Health stopped issuing lay midwifery permits in the mid-1980s.

There was a stark contrast between the black community’s perception of midwives and those of the Mississippi State Board of Health. Midwives were greatly respected in their own communities. Although there were some exceptions, the state

73 “Midwifery in Mississippi,” The Booneville Independent, 1 April 1948, Subject File: Midwives, MDAH; Jessie Lynn Ruff to Harold Mantell, Box 16009, Series 1706, Department of Health Records; Underwood, “Twenty-Five Years in Maternal and Child Health,” 1517; “State Health Agency Calls Midwifery ‘Dying Avocation’,” The (Jackson) Commercial Appeal n.d. (circa mid-to-late 1960s), Box 8416, Series 2036; Brooksie W. Peters, R.N. to Miss Lucy E. Massey, 14 July 1947, Box 8416, Series 2036, Department of Health Records; From Subcommittee on Employment, Manpower, and Poverty, 90th Congress, July 11 and 12, 1967, Statement of A. L. Gray, M.D., Executive Officer and Secretary, Mississippi State Board of Health, 80.

Nationally, the number of midwife-assisted deliveries had declined as well: They assisted: 8.7 percent of all live births in 1940; 4.5 percent of live births in 1950; and 1.5 percent of live births in 1964. Despite this decline, the pattern of nonwhites having higher rates of midwife-assisted deliveries continued. Among nonwhites, midwife-assisted deliveries were 8 percent of live births in 1964. See Sam Shapiro, Edward R. Schlesinger, and Robert E. L. Nesbitt, Jr., Infant, Perinatal, Maternal, and Childhood Morality in the United States (Cambridge: Harvard University Press, 1968), 258.

74 “Grannies: The Roots of Midwifery,” The Clarion-Ledger, 31 January 1982, 9e, Subject File: Midwifery, MDAH; Sunflower County Midwives, 19 July 1973, Box 8416, Series 2036, Department of Health Records. The following were listed as midwives in Sunflower County in 1973: Sadie Mae Benford (Indianola), Elnora Bluett (Ruleville), Millie B. Cotton (Doddsville), Mary Lyles (Indianola), Martha Poole (Drew), Janie Thomas (Doddsville), and Julia Thomas (Indianola).

generally viewed them as either dangerous folk practitioners or as a group who would only be tolerated until the number of physicians increased. They were often disparaged by white public health officials and defined as a problem, but they cooperated with the state to provide health solutions in the absence of physicians and “modern” health care facilities in Mississippi’s poor, rural black communities.
Chapter 3

“‘Blues Singers’ Queen Dead’\textsuperscript{1}: Bessie Smith and the “Ethics of Jim Crow Medicine”

In 1938, Mississippi native Richard Wright published his first book, a collection of short stories called \textit{Uncle Tom's Children}. In the autobiographical essay, “The Ethics of Living Jim Crow,” added to the collection in 1940, Wright recounts racialized experiences that happened to him while living in Arkansas, Mississippi and Tennessee. Wright often appeared to be shocked by the violence he witnessed and experienced, even as he acknowledged that it was a frequent occurrence for African Americans in the South.

When he was working as a porter in a clothing store, Wright’s employer severely beat a black woman for being delinquent on her bill. Later, Wright told the story to his “fellow Negro porters” while eating lunch, but “no one seemed surprised.” In fact, one of his companions contended that the woman was “lucky” the white men “didn’t lay her when they got through.”\textsuperscript{2} From the reader’s perspective this is striking, but this demonstrates that the violence of Jim Crow had become so normalized that its victims had to consider themselves fortunate if they only received a beating.

\begin{footnotesize}
\begin{enumerate}
\item Richard Wright, “The Ethics of Living Jim Crow: An Autobiographical Sketch,” in \textit{Uncle Tom's Children} (New York: HarperPerennial, 1938, 1940), 7-8. This is later used in Wright’s autobiography, \textit{Black Boy}.
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\end{footnotesize}
Wright’s title, “The Ethics of Living Jim Crow,” has more than one meaning. It is an oxymoron and useful as a rhetorical device. Certainly, there was nothing ethical about this system of racial oppression and violence, and the essay stresses this paradox. At the same time, however, Wright’s experiences in his youth indicated that there was a set of principles that governed black-white interactions within the confines of Jim Crow. An important element of those interactions was violence or the threat of violence. Whether implicit or explicit—direct or structural—violence permeated every aspect of the Jim Crow system. The system punished black people violently when they ran afoul of accepted practices while keeping others’ behavior in order with spoken or unspoken violent threats.

Within the system of Jim Crow medicine, the inferior treatment that blacks received became normalized as well. The unequal system of medical care indicated that African Americans were not entitled to the best, or even adequate, medical care. Well into the twentieth century, access to private and public health care facilities for African Americans in Mississippi remained separate and unequal, limited, segregated, or nonexistent. The ethics of Jim Crow medicine were perhaps most vividly displayed in response to a “critical medical event,” a medical emergency with life or death consequences.³

For those familiar with racial segregation and exclusion in the South, the events that surrounded the death of Bessie Smith were another lesson in the “ethics of living Jim Crow.” Smith died on September 26, 1937, from injuries she sustained in an automobile

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³ Mary Jenness, Twelve Negro Americans (Freeport, New York: Books For Libraries Press, 1936, 1969 reprint), 179. Dr. Fon L. Gordon helped me come up with this terminology in my conversations with her about Bessie Smith.
accident in Clarksdale, Mississippi. Her death came just as her career appeared to be recovering after a precipitous decline at the beginning of the Depression. Taken by itself, her death may have appeared to be the tragic, unintended outcome of an accident, but when analyzed within the context of America’s racial caste system, it is clear that the events following the accident were an illustration of structural violence. Smith’s fame prevented her death from going completely unnoticed and exposed the reality of the connection between Jim Crow medicine and death. While the experiences that blacks had with the health care system did not always result in death, it is clear that many African Americans made a connection between Jim Crow medicine and violence or death. In fact, poor medical treatment, violence and death are familiar themes in African American folklore, literature, and the history of Jim Crow health care.

Bessie Smith was a tough, rebellious singer who became known as the “Queen” or “Empress of the Blues” in the 1920s. Born in Chattanooga, Tennessee, probably in 1894, she pulled herself out of poverty through her career as an entertainer. She began as a street performer, singing and dancing while her brother Andrew accompanied her on guitar. Later she sang and danced with minstrel troupes and in vaudeville shows. Eventually, she became a headliner on the all-black vaudeville circuit, the Theater Owners’ Booking Association (TOBA), founded in Chattanooga in 1920. In the 1910s

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4 “Blues Singers’ Queen Dead,” 24.

5 Karla FC Holloway, Passed On: African American Mourning Stories (Durham: Duke University Press, 2003), 2, 6, 113-14; Spencie Love, One Blood: The Death and Resurrection of Charles R. Drew (Chapel Hill: The University of North Carolina Press, 1996), 261. Holloway’s book provides an important discussion on the centrality of death in black life and culture during the twentieth century although it does contain some errors. For example, her book asserts that Bessie Smith’s accident happened in Alabama rather than Mississippi. She also contends that Derricotte was taken by white physicians to the hospital in Chattanooga, Tennessee, because the Dalton hospital did not accept black patients. In fact, the attending physicians in Dalton had nothing to do with the decision to take her to the Chattanooga hospital. A black physician who came from Chattanooga decided to move Derricotte to Chattanooga.
and 1920s her “down home blues” were very popular, especially with black southerners and black southern migrants to the North. In the early 1920s, a number of record companies responded to the consumer demand for popular black artists by creating “race records” divisions to produce records for black audiences. After signing a recording contract with Columbia Records, her first record, “Down Hearted Blues,” sold 780,000 copies in 1923. Smith recorded several popular songs in the 1920s. Columbia Records had crowned Smith the “Empress of the Blues,” but to her fans she was known as the “Queen of the Blues.” At the height of her popularity, she commanded a salary in excess of $2500 per week, but her career began to decline with the onset of the Depression as record sales were devastated by the economic downturn. When her record contract with Columbia expired in 1931, it was not renewed, although she did have another recording session arranged by producer John Hammond in 1933.6

By the mid-1930s, however, Bessie Smith’s career appeared to be rebounding. In 1935, she performed at the Apollo Theater in Harlem. Later, she appeared in a Broadway show, substituting for Billie Holiday in Stars over Broadway. Throughout 1937 she had numerous singing engagements in southern cities including Memphis, Tennessee, where she had joined the Broadway Rastus show two weeks before her automobile accident.


The TOBA was a black vaudeville circuit known by the performers to be “Tough on Black Asses” or “Tough on Black Artists.” Although the performers on the circuit were black, the majority of the stockholders were white. It was also commonly known as the “chitlin’ circuit.”
She performed in Memphis on Saturday, September 25, and the following night she was scheduled to appear in Darling, Mississippi. She and her companion, Richard Morgan, left for Mississippi at the close of the Memphis show.\(^7\)

Richard Morgan was driving Smith’s car when he collided with a truck parked alongside Route 61, a two-lane highway, about ten miles from Clarksdale, Mississippi. Morgan did not seriously injure himself in the crash, but Bessie Smith’s arm was partially severed. Many of post-accident details are in dispute though. The truck—which by one account was a postal truck and another a National Biscuit Company truck—left the scene after the accident. Dr. Hugh Smith, a white physician on his way to a fishing trip, stopped to help. Minutes later, a white couple crashed into Dr. Smith’s car, rendering it inoperable and adding another injured party, a white woman, to the accident scene. Some time afterward, two different ambulances arrived—which could have been called by the truck driver, by Dr. Smith’s passenger, or perhaps by someone else entirely—and took the two accident victims to hospitals. Smith was treated at the Afro-American Hospital in Clarksdale where doctors performed surgery to amputate her arm, but she died from shock and “possible internal injuries.”\(^8\)

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\(^7\) Albertson, *Bessie*, 214; James Sellman, “Smith, Bessie (1894-1937);” “Blues Singers’ Queen Dead,” 24. Bessie Smith’s accident was in Clarksdale, which is in Coahoma County. She was driving to Darling, which is in Quitman County; it borders Coahoma County. See “‘Negro Blues Singer’ Dies in Car Smash,” Clarksdale (Mississippi) *Register*, 27 September 1937, 1.

\(^8\) Albertson, *Bessie*, 219-22; Mississippi State Board of Health, Standard Certificate of Death, File No. 15284; Grimes, *The True Death of Bessie Smith*, 72, 113. The death certificate lists her place of death as the Afro-American Hospital, but at least two biographies list the hospital as the G.T. Thomas Hospital. It may have been known as the G.T. Thomas Afro-American Hospital. See Albertson, *Bessie*, 222-23 and Paul Oliver, *Kings of Jazz: Bessie Smith* (New York: A.S. Barnes and Company, 1971), 71. Bessie Smith also fractured bones in her legs and arms. At the time of her death, Smith was still legally married to Jack Gee; however, she and Richard Morgan, a Chicago bootlegger, had a long-term relationship.
The accusations that Bessie Smith died as a result of racism began to surface soon after her death. Capitalizing on details reportedly circulated by members of the Chick Webb Orchestra, Columbia Records producer, John Hammond, wrote an article in the November issue of *Down Beat*, a jazz and blues magazine, “Did Bessie Smith Bleed to Death While Waiting for Medical Aid?” In the article, Hammond claimed that a Memphis hospital had refused to treat Smith, causing her to die after losing too much blood. While admitting that his version of the story was unconfirmed, Hammond declared that the South in general and Memphis in particular, had a reputation for violence; therefore, he was “prepared to believe almost anything.” Hammond’s confusion over where Smith died is somewhat understandable because of Memphis’ close proximity and connection to northwestern Mississippi. Many poor people from rural northern Mississippi and eastern Arkansas came to Memphis health care facilities. Hammond penned another article in the December issue of *Down Beat*, but it focused on Bessie Smith’s career rather than the post-accident details. Both of Hammond’s articles advertised the release of a special album of Bessie Smith’s recordings that Columbia released as a memorial to the singer.

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Sally Grimes’ 1969 *Esquire* article conflicts with Hammond’s 1937 *Down Beat* article about the origin of the story that Hammond heard. According to Grimes, the owner of the tent show, where Smith was performing on September 26, told Hammond.

The dearth of written records and first-hand accounts from the day of the accident also helped to fuel the controversy. Bessie Smith’s death certificate appears to be the only readily available document from that day. According to Chris Albertson, one of Bessie Smith’s biographers, he was unable to obtain records from the Clarksdale Police Department. Apparently, there were no published interviews with Richard Morgan, who died in 1943. However, Albertson writes that Morgan related the details to Bessie Smith’s son, Jack Gee, Jr. Based on this account, Gee was convinced that the first ambulance at the scene of the accident privileged the injured white woman in the second vehicle, by taking her to the hospital first and making Bessie Smith wait for a second ambulance. Then, the ambulance took Smith to a white hospital where physicians refused to treat her. Finally, she was taken to a black hospital in Clarksdale where she died during surgery.\(^{11}\)

The element of the story that has been repeated most often was that the first (white) hospital turned Bessie Smith away. It was utilized both in Hammond’s *Down Beat* magazine article and in playwright Edward Albee’s *The Death of Bessie Smith*, more than twenty years later. The play showed that there was continued interest in the

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In the second article, Hammond mentioned that Bessie Smith had become obese, weighing about 200 pounds in “her last few years.” Nevertheless, she was steadfast in her pleasant demeanor, becoming the “personification of the old southern mammy.” Presumably, this was supposed to endear Bessie Smith to the white readers of *Down Beat* and show them that she was a “wonderfully sympathetic and genuine person.” What it illustrates is that Hammond, who excoriated southern racists in the November article, reified Jim Crow by embracing a stereotype to sell more “memorial” albums. Her weight may have been one of the few similarities to this comforting symbol of the Old South. Finally, it is unclear how much the Columbia producer could have seen Smith in “her last few years” since her last recording session was in 1933.

\(^{11}\) Albertson, *Bessie*, 218, 225-26; Grimes, “The True Death of Bessie Smith,” 72. Gee could also have been influenced by other accounts of the accident. Another popular version was that Dr. Smith allowed Bessie Smith to bleed to death rather than put her into his new car and take her to the hospital. According to Dr. Smith, after the second couple crashed into his car, it was not drivable.
blues singer’s tragic end. Ostensibly a play to protest racial injustice, it premiered in Berlin in 1960 before coming to the United States as an off-Broadway play in 1961. In the play, Smith’s companion, “Jack,” drove her to a white Memphis hospital, after the accident. The hospital did not directly refuse to admit “Bessie” but told “Jack” to wait for assistance that never came. “Jack” gave up and drove “Bessie” to another hospital, but she died before arriving at the second hospital.\(^\text{12}\)

The play focuses primarily on the employees at the second hospital, a white intern, two white nurses, and a black orderly. Although the play is about Bessie Smith’s death, she does not appear as a character and is peripheral to the plot. Thus, she is not even the star in a story about her death. Albee may have been attempting to show the whites as self-absorbed and callous. Perhaps the audience was supposed to recognize Bessie Smith’s death as a tragedy at the hands of people who cared more about maintaining segregation than saving a life.\(^\text{13}\)

“Jack” was probably a reference to Bessie Smith’s husband, Jack Gee, rather than her companion Richard Morgan. Richard Morgan did not drive Smith to the hospital because the car was inoperable; she arrived in an ambulance. A black ambulance driver contended that he drove Bessie Smith directly to the black hospital without stopping at a white hospital. While the customs and culture of Jim Crow in Mississippi may have been


unknown or confusing to strangers like Richard Morgan, the local ambulance driver, regardless of race, would have known that the white hospital would not treat blacks.\textsuperscript{14}

Rather than a case of direct violence, the events following Bessie Smith’s accident exemplified the accepted institutionalized practice of structural violence. It did not involve direct contact. No one physically turned her away; nevertheless, the violence was brutal and normalized.\textsuperscript{15}

Bessie Smith’s death fits within a larger context of blacks’ critical medical events because it was far from being an isolated incident. A short book published in 1952 by the Southern Conference Educational Fund illustrated the widespread nature of “medical Jim Crow.” \textit{The Untouchables: The Meaning of Segregation in Hospitals} profiled twelve different cases (in the South, Midwest and Northeast) from 1930 to 1951. The examples included women in labor and accident victims who were denied admittance to hospitals.\textsuperscript{16} By refusing to offer medical aid, the hospitals reified African Americans untouchable “caste” status.

One of the well-known cases profiled in the book involved the deaths of Juliette Derricotte and Nina Johnson after an automobile accident outside Dalton, Georgia in November 1931. Born in Athens, Georgia in 1897, Derricotte was a graduate of Talladega College (Alabama) and Columbia University. She had previously been the

\textsuperscript{14} Albertson, \textit{Bessie}, 222-23.


student secretary of the National Council of the Young Women’s Christian Association. Derricotte was the first black Dean of Women at Fisk University, a historically black university in Nashville, Tennessee, and her three passengers, Nina Johnson, Miriam Price, and Edward Davis, were students at the university. On November 6, Derricotte was driving to her parents home in Athens, Georgia; the students riding with her were also from Georgia. At around four in the afternoon, Derricotte’s Model “A” Ford roadster and a Model “T” Ford sedan “sideswiped each other,” causing Derricotte’s car to flip over and land in a ditch. After the accident, local white residents took Derricotte and her passengers to doctors’ offices in Dalton because there was no black hospital and no “Negro ward” at the public hospital, George W. Hamilton Memorial. There were also no black physicians in the city of Dalton or in Whitfield County.

After Dr. J. H. Steed treated Nina Johnson and Dr. O. E. Shellhorse attended to Juliette Derricotte, the doctors transferred the patients to what was euphemistically known as the “colored sanitarium,” the home of Mrs. Alice Wilson, a practical nurse whose home was utilized by white physicians to “hospitalize” their black patients and perform surgeries. However, Dalton residents who needed hospitalization typically preferred to travel to hospitals outside Dalton, in Chattanooga or Atlanta (if they could


18 W. E. B. Du Bois, “Dalton, Georgia,” The Crisis, March 1932, 85-87; Jean Cazort, “Derricotte, Juliette,” in Black Women in America: An Historical Encyclopedia, Volume I, A-L; Thomas E. Jones to Mr. Walter R. Brown, 20 November 1931, Box 31, Folder 6; Unsigned copy to Miss Leslie Blanchard, 13 November 1931; Report of the Commission on Interracial Cooperation, Regarding the Automobile Accident in Dalton, Ga, November 6, 1931, Box 31; Report of Mr. Edward Davis, nd, Box 31, Folder 10, Jones Papers. Whitfield County had a population of 20,808; the population was 6.6 percent black. There were approximately 8,000 people in Dalton.
afford to do so), rather than use the services of the Dalton “sanitarium.” With a fractured skull and internal bleeding, Johnson never regained consciousness. In fact, the doctors were convinced that she would not survive. Derricotte drifted in and out of consciousness and lucidity, vomiting blood several times. When conscious, she complained of pain in her chest and hip.

Miriam Price and Edward Davis had minor injuries—a dislocated shoulder, and a broken collar bone respectively. Price contacted the university and J. F. Trimble, an undertaker and a friend of Derricotte’s from Chattanooga. When Trimble reached Dalton with an ambulance and a physician, Dr. L. L. Patton, the two critically injured patients had languished at Wilson’s home for several hours. Patton determined that Derricotte and Johnson should be hospitalized and sent them by ambulance to Walden Hospital, a black hospital in Chattanooga, a trip that took approximately an hour due to poor road conditions. Johnson died en route to the hospital from a cerebral hemorrhage; Derricotte survived the trip from Dalton but died at the hospital the next day from internal injuries, lung congestion, shock and heart failure.  

In the aftermath of the deaths of Johnson and Derricotte, members of the Atlanta-based Commission on Interracial Cooperation (CIC) and several representatives from Fisk University investigated the incident and issued reports. The dean’s brother, J. Flipper Derricotte traveled to Dalton with Arthur Raper of the Commission on Interracial Cooperation.

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19 Report of J. Flipper Derricotte, 7, 9-10; Report of the Commission on Interracial Cooperation; Du Bois, “Dalton, Georgia,” 86; Mrs. Upshaw to Miss Leslie Blanchard, Re: Telephone Conversation, 15 November 1931, Folder 31, Folder 6; Report of Dr. L. L. Patton; Report of Mr. Warner Lawson (Faculty) Re: Dalton Auto Accident Which Occurred November 6, 1931; Dr. L. L. Patton to To Whom it May Concern; Ethel Gilbert to Leslie Blanchard, 10 November 1931 (9); Report of Mr. Edward Davis (A member of the party wrecked in the Derricotte car at Dalton, Georgia—November 6, 1931, n.d., Box 31, TEJ Papers.

Derricotte and the students had lunch at Trimble’s home the day of the accident.
Cooperation to interview Dalton residents who had information about the treatment of his sister and Nina Johnson. Several reports, including Derricotte’s, expressed that residents were “disturbed” about the reports that the accident victims had been mistreated, but Derricotte surmised that the doctors’ concern seemed to manifest itself only after the patients had left Dalton. According to J. Derricotte, Dr. Shellhorse never gave consent for his patient to be transferred to a hospital. Shellhorse thought that the proper course of action was for her to remain at the sanitarium. In fact, he contended that it was a breach of professional ethics for his patient to be moved without consulting him.  

The CIC’s report stated that Miss Duke, the “resident nurse in charge” at the “modern” Hamilton Memorial Hospital had been asked whether the injured black people could have been treated there. Duke suggested that if Derricotte and the students had been brought to Hamilton that the staff would have been obligated to treat them. Yet, there was no legal obligation requiring a hospital in Georgia to provide emergency medical treatment. Duke admitted, however, that she had never been required to address such a situation because people “generally understood that Negroes were not treated there.” Clearly, this general understanding also applied to Dalton’s white physicians who failed to suggest that their patients be taken to the local hospital.

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20 Report of J. Flipper Derricotte, 11-14, Box 31, Folder 10 Report of the Commission on Interracial Cooperation; Report by Dr. Thomas E. Jones of the investigation of the automobile accident occurring in Dalton, Georgia on November 6, 1931, 6, 11, Box 31, Folder 10, Jones Papers.


An Illinois law (1927) required hospitals to provide emergency treatment. Those that did not could be held liable if a death occurred. Still, refusing to provide emergency aid was only a misdemeanor punishable by fines of between $50 and $200. See Pauli
Ethel Gilbert, white head of publicity at Fisk, recognized that African Americans received a lower standard of medical treatment than whites because their lives were considered less valuable. When she had needed an emergency operation, she had the privilege of well-trained nurses and doctors, a well-equipped operating room, and a comfortable, clean hospital room in which to begin her recovery. After her investigation she wrote, “If anybody makes a report that says in effect ‘everything that could be done was done,’ it merely means that everything that could be done for Negroes was done.”

Ironically, driving one’s own automobile was often an option taken to avoid Jim Crow accommodations on passenger trains.22

On the surface, Juliette Derricotte, a member of the black elite, and Bessie Smith, a musical artist and “queen” among the “folk,” had very little in common. But their deaths connected them within African American medical history and folklore narratives. The status they held in their respective communities meant that there were influential people who questioned the treatment they received.23 The deaths of Bessie Smith and of Juliette Derricotte told a story that African Americans had heard many times. Their

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Murray, States’ Laws on Race and Color (Cincinnati: Women’s Division of Christian Service, 1951), 133.

22 Du Bois, “Dalton, Georgia,” 86; Ethel Gilbert to Leslie Blanchard, 10 November 1931, 9-10, Box 31, Jones Papers, Franklin Library, Fisk University Archives.

23 Fisk University received numerous letters inquiring about the circumstances of surrounding Juliette Derricotte’s accident and death as well as letters expressing sympathy and outrage. The list of concerned parties represented the following universities and organizations: Columbia University Department of Rural Education; Duke University Department of Religious Education; Winston Salem State Teacher’s College; Florida A&M; Howard University; the Committee on Race Relations; the Southern Commission on the Study of Lynching; American Board of Commissioners for Foreign Missions; the Young Women’s Christian Association; the National Association for the Advancement of Colored People; the American Association of Freedom; the Commission on Interracial Cooperation; the American Missionary Association; Nazarene Congregational Church (in Brooklyn, New York); the Federal Council of Churches of Christ in America; and the Commission of Missions of the General Council of Congregational and Christian Churches. See Juliette Derricotte, Box 31, Folder 13, Jones Papers.
deaths also illustrated that African Americans of wealth and status were not insulated from Jim Crow’s reach.

Dr. Charles R. Drew’s death became a part of African American medical folklore in 1950 when he died following a car accident in North Carolina. Born in Washington, D.C. in 1904, Drew graduated from Amherst College in 1926 and earned an M.D. at McGill Medical College in Canada. At Columbia University Medical School, where he earned his Doctor of Science degree, his research focused on banking blood and preserving blood for transfusion. During World War II, he was selected to direct the “Blood for Britain” program in 1940 and the American Red Cross Blood Bank in 1941. According to Spencie Love’s One Blood: The Death and Resurrection of Charles R. Drew, he stepped down early from his position with the Red Cross to become the chief of surgery at Howard University’s Freedmen’s Hospital. Other scholars assert that his resignation was actually in protest to the Red Cross policy of segregating blacks’ and whites’ blood donations. In reality, Love asserts, the Red Cross announced this policy after Drew’s resignation, not before.²⁴

Early in the morning of April 1, 1950, Dr. Drew and three colleagues (Dr. Samuel Bullock and interns Walter R. Johnson and John R. Ford) left Washington, D.C. headed for a black medical conference in Tuskegee, Alabama. On the first part of their two-legged road trip, they planned to drive through the night and day to reach Atlanta, Georgia, where they would stay the night at the local Young Men’s Christian Association

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(YMCA). The next day they would then continue on to Alabama. Because hotels in South were generally exclusive to whites, they planned ahead and secured their lodging in advance. The group left Washington D.C. after midnight on April 1, but they never made it to Georgia. While driving through Alamance County, North Carolina, Dr. Drew lost control of the vehicle (perhaps because he fell asleep). He veered off the road, and the car flipped over.  

Both Dr. Drew and Dr. Ford were injured, but Drew’s injuries were more severe. They were taken by ambulance to Alamance County General Hospital, a private, segregated hospital with rooms for black patients in the basement. Dr. Drew’s colleagues informed the hospital staff that their patient was the famous Dr. Drew. Doctors performed surgery, but with Drew’s brain injury and internal hemorrhaging, they were unable to save his life.  

As the news of Dr. Drew’s death spread, rumors began to circulate that his surgery had been delayed or denied because of the hospital’s policy regarding the treatment of blacks. Some rumors suggested, ironically, that the man instrumental in creating blood banks did not receive life-saving plasma because of the hospital’s racist policies. Others contended that Alamance County Hospital refused to accept Drew in the emergency room, only to have him die on the way to black hospital. Over time the rumors gained increasing credibility because they appeared in newspaper columns, books, and at least one history textbook. Many of the elements that were repeated about


26 Love, One Blood, 18-21, 23.
Drew’s death were reminiscent of Bessie Smith’s. The “Drew legend” became another “unstoppable” rumor. These stories resonated with blacks because they reified a “many-layered foundation of black beliefs, tales, and well-founded superstitions.”

Although Drew had been treated at the white hospital, it was not inconceivable to African Americans that famous or prominent blacks could meet their demise as a result of structural violence because Jim Crow medicine operated by its own inhumane rules. Although Dr. Drew’s death was not because Alamance County Hospital’s policy of exclusion, he was still impacted by an inhumane system that “compelled” black travelers to drive long distances without stopping because of the uncertainty of finding sleeping accommodations.

Jazz great Billie Holiday made the connection between medical care and death following her father’s death in February 1937. She writes in her autobiography, *Lady Sings the Blues*, that Clarence Holiday caught pneumonia while performing in Dallas, Texas. As a traveling musician, he may have been unfamiliar with the city and uncertain about where blacks could receive medical treatment. After having trouble finding a hospital that would treat African Americans, he finally ended up in the Jim Crow ward at the veteran’s hospital, where he later died. Holiday’s father was a World War I veteran. His difficulty finding a hospital paralleled that of many black veterans who could not be treated or were forced into Jim Crow wards at veteran’s hospitals. Although one of her signature songs, “Strange Fruit,” was written about lynching, it resonated with Holiday more metaphorically than literally. Of course, Holiday heard the story of her father’s

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death second hand, but what was important was the connection that she made with lynching. For her the song “seemed to spell out all the things that had killed Pop.”

In the 1940s, Pulitzer-Prize winning reporter Ray Sprigle had found it difficult to accept that a hospital would fail to admit black people in emergency situations, but the title of one of his chapters in his book *In the Land of Jim Crow*, “White Hospitals and Black Deaths” suggests that he was eventually convinced of that reality. Disguising his skin with a three-week Florida suntan and his hair by shaving his head, the white reporter from Pittsburg went on a fact-finding mission to investigate the impact of Jim Crow. For “four endless, fear-filled weeks” he attempted to live as a light-skinned black man in the South, during which he “ate, slept, traveled [and] lived black.”

Sprigle contacted the white hospital in Clarksdale about Bessie Smith’s accident and wired the director of Hamilton Memorial Hospital, in Dalton, Georgia about the

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Post-war pressure from African American organizations eventually led to the federal government building a hospital for black veterans. The first was Tuskegee Veteran’s Administration Hospital which opened in 1923. It is now a part of the Central Alabama Veterans Health Care System. The Veteran’s Administration issued an order ending segregation in 1954. See Vanessa Northington Gamble, *The Black Community Hospital: Contemporary Dilemmas in Historical Prospective* (New York: Garland Publishing, Inc. 1989), 38-39, 188 (n).

Holiday writes in her autobiography that “Strange Fruit” always depressed her and singing it made her physically ill. Because of the song’s effect on her, she usually waited until the end of her performance to sing it. The film *Lady Sings the Blues*, which is only loosely based on Billie Holiday’s autobiography, uses a lynching scene in the South to suggest the impact of “Strange Fruit” on Holiday. There is also a scene where her band’s bus encountered a nighttime Ku Klux Klan rally. See Berry Gordy, prod, *Lady Sings the Blues*, Paramount Pictures, 1972, digital video disc, 144 minutes.

30 Ray Sprigle, *In the Land of Jim Crow* (New York: Simon and Schuster, 1949), 135. This is chapter twenty-one.

Derricotte incident to ask if the hospital would treat black patients in emergencies. Not surprisingly, no one responded to his communication.\textsuperscript{32} Sprigle also met a black dentist in Clarksdale, Mississippi whose reaction to an emergency situation with his wife provided an answer about the Clarksdale Hospital. Dr. P.W. Hill’s wife and child had died during childbirth. Like many black women in Mississippi, Marjorie Hill had planned a home delivery. However, she had access to and could afford to have black physicians in attendance. When she started to experience complications, the doctors told Hill she needed a Caesarian section. Dr. Hill drove his wife to a black hospital in Memphis, more than seventy miles away, an acknowledgement that the twelve-bed black clinic in Clarksdale was not equipped to handle such emergencies or complicated cases.\textsuperscript{33}

While small proprietary clinics and hospitals were often set up by black physicians seeking to serve the community, they were generally poorly funded and lacked the modern technology that was available in white facilities.\textsuperscript{34} One worker at a public health clinic in Greenwood suggested that the “colored hospitals” in Mississippi towns were a farce and only allowed to operate so whites could say, “We do not treat Negros [sic]. There is a Negro Hospital.”\textsuperscript{35}

\textsuperscript{32} Sprigle, \textit{In the Land of Jim Crow}, 135-38


\textsuperscript{35} Grace A. Hill to Mr. Edwin Embree, 13 August 1945, Box 153, Folder 1, Rosenwald Fund Archives.
Neither Mrs. Hill nor her baby survived the surgery. Dr. Hill’s response conveyed a sense of hopelessness. He expected nothing from Jim Crow medicine. Even in a state of panic, he did not attempt to take his wife to the white hospital in Clarksdale, a decision he summed up matter-of-factly:

In the South, when you’re black[,] you don’t try to fight the pattern. [White] Hospitals are for white people. White people do not admit black folk to their hospitals. Black folk do not even ask for admission. They just die.36

Thus, segregation did not have to be “studiously applied.” It “was so pervasive and so ingrained that it simply existed” and its rules were understood by both whites and blacks.37

The crises experienced by the Clarence Holiday, Marjorie Hill, Juliette Derricotte, Nina Johnson, Charles Drew, and Bessie Smith were part of a disturbing trend that emphasized the diminished value of black lives to the medical field and in American society as a whole. Usually portrayed as a benign institution, the African American counter-narrative depicted the institution of medicine as malevolent. Medical care influenced by structural violence, contends historian Spencie Love, “was predicated on rules excluding a group of people because of their race [and] inevitably resulted in brutality, especially in emergencies.”38

In 1969, an article in Esquire magazine, “The True Death of Bessie Smith,” tried to ascertain what had happened to Bessie Smith by interviewing Dr. Hugh Smith, the


physician who had been at the accident scene in 1937. It was his opinion that due to the state of medicine in 1937, Smith could not have survived her injuries, even if she had been “on the front steps of the University Hospital in Memphis.” It is unclear whether Bessie Smith could have survived her injuries if she had been taken to a modern, white hospital. The Jim Crow system, however, never gave her the opportunity to find out.

Since her death, Sally Grimes noted that Bessie Smith had become recognized “more as a victim of racism than as a great American artist” which is “perhaps the most telling injustice of all.” Clearly, her death was a tragedy, but it is only because of her stature as an “American artist” that the details of the case are recounted and widely debated. Many African Americans suffered violence and deadly consequences dealing with a racialized medical system. Often, these stories are obscured by the anonymity of the victims, but sometimes the victims were well-known and their lives’ tragic ends became part of history and folklore of the separate and unequal health care system.

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41 Ibid.
Chapter 4

To “Find Decent Hospitalization”\(^1\): Segregated Facilities

An incident featuring a white physician is described in Fannie Hurst’s 1933 novel about a black woman with a daughter light enough to pass for white, *Imitation of Life*. In the book, Peola Johnston was the daughter of Delilah Johnston, and a “light-colored pap.” The Johnstons “lived-in” with a white woman named Bea and her daughter. One night Peola was “in a state of nervous collapse” because of an incident at school. The white doctor who made the house call assumed that Peola was Bea’s daughter, not Delilah’s. He appeared to take Peola’s condition very seriously until he realized that Delilah was Peola’s mother. He had recommended that Peola have “individual instruction” either at school or another location because of the shock she had at school. When the doctor realized that Peola was black, he abruptly ended his examination and recommended spanking and castor oil to cure her “spasms.”\(^2\) The doctor’s concern for Peola was based on her being a white child. When he discovered her “true” identity, his medical prescription included violence.

\(^1\) W. H. Holtzclaw to dr. H. R. Shands, 1 September 1936, Box 240, folder 1, Rosenwald Fund Archives. William H. Holtzclaw was the principal of Utica Normal & Industrial Intitute, a training school for blacks modeled on the program at Tuskegee. Holtzclaw was very interested in Dr. Shands efforts to build a ward or facility for African Americans in 1936. On the hospitalization situation for blacks, he writes, “We of the Negro race here in the good state of Mississippi number more than a million, but not five hundred of us could find decent hospitalization any where in the state today.”

Although Hurst’s examination of race is fictional, writer and anthropologist Zora Neale Hurston experienced similar treatment in 1931 when she went to see a physician in Brooklyn. Hurston was experiencing “disturbances of the digestive tract,” and her benefactor offered to pay for a visit to a specialist. At the doctor’s office, she noted that the nurse seemed surprised that the new patient was a black woman. Then, the nurse ushered Hurston into a so-called examination room that was more like a dirty linen closet with a chair thrown in for her benefit. Like the physician in Fannie Hurst’s novel, the specialist tried to finish the examination as quickly as possible.3

Because many white physicians embraced the ideology of black inferiority, many blacks avoided going to the doctor. Experiences with white physicians could be uncomfortable and even humilitating. Some African Americans were even afraid that they would be given “the black bottle,” or poison, by white physicians. In Medical Apartheid, Harriet Washington refers to this fear of white medical professionals and institutions as “black iatrophobia.”4

Not all white physicians expressed contempt for their blacks as patients, behaving as if blacks were “too filthy to put his hands on,”5 but encountering whites with an aversion to being around or touching black bodies was a reality in the Age of Jim Crow. Another sobering reality was that many black Mississippians had no other choice than


5 Logan and Clark, Motherwit, 58, 102.
patronize white physicians and segregated (white) facilities because there were few black physicians.  

While the previous chapter focused on the impact of blacks’ inability to use white hospitals, this chapter discusses the hospitalization options that were available at segregated hospitals. Race remained a significant factor in determining what level of treatment people deserved, even as some white physicians in Mississippi acknowledged the need for more and better hospitals for blacks. Whites were the arbiters of what medical attention was suitable for blacks.

For its African American population of above one million, Thomas Ward writes in *Black Physicians in the Jim Crow South*, Mississippi had “by far the worst ratio in the nation,” one black physician per 18,527 black residents between 1932 and 1942. Ward states that there were fifty-eight black physicians during this period, but the numbers were often even lower. In 1938, there were fifty-one black physicians and in 1946 there were 54. The largest numbers of physicians were usually clustered in the counties that contained the largest cities, including Hinds, Lauderdale, Warren, and Washington. More than 70 percent of the counties had no black physicians at all.  

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6 I use the terms “segregated hospital” or “segregated facility” to mean those white institutions that treated African Americans but segregated them within the facility on the basis of race. I want to distinguish them from black hospitals which were often formed in response to segregation in or exclusion from white facilities.


8 List of Mississippi Physicians 1927; Roster of Mississippi Physicians 1938; Roster Mississippi Physicians, Mississippi State Board of Health, Jackson, Mississippi, 1946, Subject File: Physicians, MDAH.
were located in the larger towns and cities, even though much of Mississippi’s population
was rural.

When black Mississippians utilized white hospitals in the state, they had to
contend with Jim Crow laws and customs, which addressed the separation of the races in
public and private life. Mississippi had Jim Crow laws that governed education,
miscegenation, prisons, marriage and divorce, social equality, transportation, and
hospitals. Jim Crow laws also defined who was considered a “Negro” and thus subject to
Jim Crow laws. Persons “having any appreciable mixture of Negro blood” were
considered black.  

In Mississippi’s public and private hospitals, a mixture of custom and law dictated
the treatment of black patients. In private hospitals, it was an observed custom as well as
a hospital policy that blacks had to be treated in separate wards if they were treated at all.
If blacks were admitted to white hospitals, there was usually a separate wing, building,
floor, or ward or where they were treated. White hospitals like the Mississippi Baptist
Hospital and Jackson Infirmary, treated black patients in the basement. At Dr. Willis
Walley’s Hospital, Medical and Surgical Clinic, there was a separate building, behind the
main building, reserved for black patients.  

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10 Idella Parker, Idella: Marjorie Rawlings’ “Perfect Maid” (Gainesville: University Press of
Florida, 1992), 90-91; Midian O. Bousfield, Report on Visit to Jackson, Mississippi, July 5, 1934, Re:
Health Center, Upon Invitation of Dr. W. E. Noblin, Hinds County Health Officer, 1-5, Box 152, Julius
Rosenwald Fund, Franklin Library; Harrell, “Medical Services in Mississippi, 1890-1970,” 564. Dr. Willis
Walley was a past president of the Mississippi State Medical Association (1917-1918). He had been the
chief surgeon of his private hospital since it opened in 1923, and he had also been the superintendent and
chief surgeon at the state charity hospital in Jackson from 1930 to 1934. He had worked in several
different capacities for the State Board of Health. He also had a training school for nurses. In an
anniversary booklet published in 1939, it noted that there had been forty-seven graduates of their three-year
nurse’s training course. Of the forty-four graduates listed in the anniversary booklet, one graduate, Neva B.
Mississippi and other southern states developed laws and customs that supported the separation of the races in general public hospitals, mental hospitals, and tuberculosis sanatoria. Mississippi and South Carolina had statutes ordering segregation in their public hospitals. South Carolina maintained a separate “Negro Department” at the state hospital. In Mississippi’s charity hospitals, located in Hattiesburg, Jackson, Laurel, Natchez, and Vicksburg, blacks and whites had separate wards, separate entrances, and separate nurses. Thirteen states, including Alabama, Arkansas, Georgia, and Oklahoma provided separate facilities for black and white mental patients.

The Mississippi State (Mental) Hospital at Whitfield, Mississippi was built in 1922 to house 3000 patients. There were separate facilities for blacks and whites, including a general hospital, receiving wards, barber and beauty shops, dining halls, a kitchen, and employee living quarters. The hospital had already exceeded capacity by 1937, but by the 1950s, the black section for blacks was “overflowing” with “no relief in sight.”

Hannah, was African American. Her race is designated by “Col” in parenthesis behind her name. Interestingly, she is also the only one of the nursing graduates listed without a courtesy title (Miss or Mrs.). See Dr. Willis Walley Hospital, Medical and Surgical Clinic, 1923. . . Better Service. . . 1939, Sixteenth Anniversary Booklet (Jackson, Mississippi: 1939), np; History of the Mississippi State Medical Association, Second Edition, Jackson, 1949, 95, Box 8392, Series 2178, MDAH.

11 Murray, States’ Laws on Race and Color, 17.


13 Murray, States’ Laws on Race and Color, 17, 245-46, 339, 415, 437, 470, 510. The North Carolina law included Native Americans as well as blacks and whites. Mental hospitals in Raleigh, Mongantown, and Goldsboro were for African Americans. Native Americans were treated at the facilities designated for whites.

14 Mississippi Federation of Women’s Clubs State Institution Records, Report on The Mississippi State Hospital, 10-14, 19. Box 1, Z1913.000.
In Mississippi and six other states, there were also laws that mandated segregated facilities in tuberculosis sanatoria. The Mississippi Tuberculosis Sanatorium and Preventorium opened in February 1918, with the ability to house forty patients. The allocation of resources made it clear that whites would receive an unbalanced amount of services, even though statistics showed that blacks were disproportionately affected by tuberculosis. Each county was allotted space for one white patient for every 4,000 white residents but only one black patient for every 25,000 blacks. The sanatorium’s rates were based on a patient’s ability to pay. The sanatorium rates listed in 1939 were $7.00, $10.50, $14.00, $17.50 and $21.00 per week. The rates for the preventorium were $3.50, $7.00, $10.50, and $14.00.\textsuperscript{15}

Tuberculosis had been the leading cause of death in the nineteenth century, but it had a particularly devastating impact on African Americans in the late nineteenth and early twentieth century. Tuberculosis is a bacterial disease that usually begins in and affects the lungs, but it can also damage the bones, brain, kidneys, and other organs. Before the development of antibiotics, like penicillin and later isoniazid, to fight the disease, the Mississippi Tuberculosis Sanatorium prescribed rest as the main treatment. In addition, the physicians also collapsed the lungs to allow recovery.

Respiratory deaths accounted for the vast majority of deaths in the twentieth century. The percentage due to pulmonary tuberculosis was from 1936 to 1938 was more

\textsuperscript{15} Murray, States’ Laws on Race and Color, 17; Mississippi State Sanatorium, 29, 57, 91. “Mississippi People Regain Health in Great State Institution,” The Thermometer, August 1927, 1, 9, Folder 1, Box 1, Henry Boswell Collection, 1926-1958, Z1280.000, MDAH; Mississippi State Sanatorium: A Book of Information About Tuberculosis and Its Treatment in Mississippi (Sanatorium, Mississippi: Mississippi State Sanatorium and Mississippi Tuberculosis Association, 1939), 12; available http://www.brc.state.ms.us/images/tbs2.pdf; Internet; accessed 24 February 2008. The Thermometer was newspaper published monthly by the Mississippi State Sanatorium (from September 1926 to June 1932).
than 93 percent each year. The disease flourishes in crowded, poorly ventilated dwellings. In the post-bellum period, many black neighborhoods fit this description.\textsuperscript{16}

Despite the fact that tuberculosis was more prevalent among blacks, whites had seven times more beds available in the tuberculosis sanatorium. Between 1914 and 1928 the tuberculosis death rate (mortality) for blacks was 3.51 to 4.48 times higher than the white death rate. During this same time period, no more than 511 whites died in any given year. In contrast, the number of blacks who died was never less than 1,432 and 2,287 at its highest. Between 1919 and 1938 the total number of deaths due to tuberculosis was 33,169. The number of blacks who died was 25,831, while only 7,338 were white.\textsuperscript{17}

As the sanatorium’s capacity expanded, there was room for 300 whites in a modern, four-story building and forty black patients in the separate “Negro Infirmary.” The infirmary had a separate kitchen, dining room and nurses’ quarters. While a white physician was in charge of the black facility, state law required black patients to have nurses of their own. Felix Underwood praised the “Negro Infirmary” as one of “the most modern building[s] so far erected in America for the [N]egro race.” This was clearly hyperbole, but whites often exaggerated the level of accommodations they provided for African Americans.\textsuperscript{18}


\textsuperscript{17} “Negro Infirmary, Mississippi State Sanatorium,” \textit{The Thermometer}, August 1927, 16, Folder 1, Box 1, Henry Boswell Collection, 1926-1958, Z1280.000, MDAH; Picture with caption: “Deaths,” Henry Boswell, “Facts About the Mississippi State Sanatorium,” \textit{The Thermometer}, June 1930, 2, Folder 1, Box 1, Henry Boswell Collection, 1926-1958, Z1280.000, MDAH; \textit{Mississippi State Sanatorium}, 91.
Over the years, the sanatorium added more rooms for white patients, but the capacity of the “Negro Infirmary” remained unchanged. In 1939, the sanatorium could house 335 white patients. There was also living space for black and white employees including physicians. The sanatorium also had a facility for children, a “preventorium,” that opened in 1930. It was for white children between from four to eleven years old who were “undernourished or otherwise physically subnormal,” yet without any communicable diseases, including tuberculosis. By 1947, the Tuberculosis Sanatorium and Preventorium reported that there were not enough beds for blacks or whites. Whites needed at least 300 more beds and blacks 600 more.

The large numbers of black Mississippians affected by the disease did not cause a change in policy to provide more beds to those most affected. *The Thermometer*, the sanatorium newspaper, contended that black people were “more susceptible to the acute form of tuberculosis that kills quickly.” In fact, as Tera Hunter argues in *To Joy My Freedom: Southern Black Women’s Lives and Labors after the Civil War*, in the late-

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18 “Mississippi People Regain Health in Great State Institution,” *The Thermometer*, August 1927, 1, 9, Folder 1, Box 1, Henry Boswell Collection, 1926-1958, Z1280.000, MDAH. Felix J. Underwood, “State Tuberculosis Sanatorium,” *The Thermometer*, August 1927, 9, Box 1, Henry Boswell Collection, 1926-1958, Z1280.000, MDAH; “Negro Infirmary, Mississippi State Sanatorium,” *The Thermometer*, August 1927, 16, Box 1, Henry Boswell Collection, 1926-1958, Z1280.000, MDAH; “Deaths,” Henry Boswell, “Facts About the Mississippi State Sanatorium,” *The Thermometer*, June 1930, 2, Box 1, Henry Boswell Collection, 1926-1958, Z1280.000, MDAH; “Negro Infirmary, Mississippi State Sanatorium,” *The Thermometer*, August 1927, 1, 9, Folder 1, Box 1, Henry Boswell Collection, 1926-1958, Z1280.000, MDAH. From the pictures, the maids, orderlies and kitchen staff appear to have been exclusively black. However the book contended that one hundred beds were not being used because of budget shortfalls.

19 *Mississippi State Sanatorium*, 28, 60, 64-65, 84. From the pictures, the maids, orderlies and kitchen staff appear to have been exclusively black. However the book contended that one hundred beds were not being used because of budget shortfalls.


nineteenth and early twentieth century, there was an effort to argue that tuberculosis was a disease particular to blacks, not particular to the conditions in which they lived.

Blacks’ alleged susceptibility or immunity to certain diseases had been theorized since at least the antebellum period. Historian Todd Savitt contends that blacks in the antebellum period were more susceptible to the miliary form of tuberculosis, which is “the most serious and fatal form of the disease.” Known then as “Negro Consumption,” blacks’ susceptibility may have been because it was a fairly “new” disease for West Africans; they had not built up a resistance over centuries as Europeans had. Both susceptibility and immunity were used to illustrate “difference” and hence black inferiority and suitability to slavery. Savitt asserts that blacks and whites were medically different in some respects; yet, he does not interpret that “difference” as inferiority.22

Treatment often seemed secondary to espousing theories black dysfunction and pathology. Many physicians in the late-nineteenth and early-twentieth century maintained that tuberculosis had been almost unknown in blacks before the Civil War. Left to their own devices, blacks were indulgent and did not know how to care for themselves. It was the basis of a “post-slavery, pro-slavery argument” that contended, at least implicitly (sometimes explicitly), that blacks had been better off as slaves.23


“Post-slavery, pro-slavery argument” is a term that I coined in an effort to explain how whites employed the pro-slavery argument after Emancipation.
Hospitalization for blacks at state facilities was available but inadequate, but there was also criticism of private hospitals. Correspondence white between physicians and the Julius Rosenwald Fund often discussed the hospital “situation,” with physicians asking for the Rosenwald Fund’s help to provide adequate hospital services. The Julius Rosenwald Fund was a charitable foundation started in 1917 by Julius Rosenwald, the chairman of the board of Sears, Roebuck & Co., formed for “the well-being of mankind.” Although the Fund was engaged in numerous charitable pursuits, it was perhaps best known for its efforts building rural schools in southern states.  

The Fund became involved in “Negro Health” issues because “Facilities for Negroes are generally far below those for whites, and Mr. Rosenwald has had a long-standing interest in the Negro.” Many of the requests for assistance were addressed to Dr. Midian O. Bousfield, Director of Negro Health for the Julius Rosenwald, a former president of the National Medical Association. After making donations to eighteen hospitals, the Fund ended its program of making contributions to build and equip black hospitals in 1930, encouraging local communities to take on the responsibility. The Fund wanted to limit its support to black hospitals that provided training for nurses and interns. The foundation contended that the problem of “Negro Health” was simply too massive for one organization to try and confront, but the requests for help continued to come. As

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24 Rosenwald Rural Schools, nd.; Activities of the Fund; The Julius Rosenwald Fund, November 1, 1917-June 30, 1921; Julius Rosenwald Fund Charter and By-Laws, 5; Box 76, Rosenwald Fund Archives.
late as 1939 Bousfield observed, “There is not a week in which we do not receive appeals to do something about the hospitalization of colored people.”

The letters were generally inquiries about the possibility of building a black hospital. By 1920, there were several white-owned and controlled hospitals established to serve the black population, including Greenville’s King’s Daughters Hospital for Negroes, Greenwood’s Colored Hospital, and Rosedale’s Hospital for Colored People. Although the white physicians expressed dissatisfaction with the white facilities, their criticism was not of Jim Crow, and their solutions were in keeping with the customs of Jim Crow.

L. B. Austin, a physician from Bolivar County appealed to the Julius Rosenwald Fund for assistance in 1928, asking for help to build a hospital for blacks. Austin worked for the State Board of Health, but through this appeal he offered a critique of the state’s handling of African Americans’ public health issues. Austin made a connection between the Fund’s work building schools in the South and the black children that should have been attending those schools. He wrote:

I am making speeches to the colored people all over this part of the state [the Delta] trying to educate them in health matters. I find that thousands of them are sick and need treatment. Many of the children attending your schools need treatment before they can take advantage of your schools.

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25 M. O. Bousfield, M.D. to Miss Gertrude Butler, 5 March 1941, folder 2, Box 240, M.O. Bousfield, M.D. to Mr. Harold H. Dorn, 14 December 1939, Folder 7, Box 152; Michael M. Davis to Eugene P. Booze, 18 April 1929, Box 240, Folder 5; M. O. Bousfield, M.D. to Dr. H. R. Shands, 15 September 1936, Box 240, Folder 1; M. O. Bousfield, Negro Health Programs, Memorandum, 1, 1 August 1937, Folder 19, Box 76, Rosenwald Fund Archives.

26 Laura D. S. Harrell, “Medical Services in Mississippi, 1890-1970,” in A History of Mississippi, Volume II (Hattiesburg: University & College Press of Mississippi, 1973), 534-35. Greenville’s hospital was established in 1908 with ten beds; Greenwood’s Colored Hospital was established in 1912 with twelve beds; Rosedale’s hospital was established in 1903 with eight beds.
Many of the children had infected tonsils and adenoids, malaria, syphilis, and rickets, but, he continued,

The State Board of Health does not appropriate any money to treat these cases. We need a hospital where these cases could be sent from these schools and treated until they are physically and mentally fit. Then they could be returned to school in a better condition to be taught.\(^\text{27}\)

In 1934, Bousfield visited Mississippi at the request of the public health officer in Hinds County, Dr. W. E. Noblin, who wanted to create a health center for blacks in Jackson. Bousfield observed that there were few hospitalization options for blacks. He contended, “No one has ever known how many beds in white hospitals are available for Negroes because not all of the white hospitals set aside a certain number of beds exclusively for their occupancy nor classify beds according to color.”\(^\text{28}\)

Bousfield toured some of Jackson’s medical facilities. Black institutions included a small fraternal hospital that was “the usual converted residence” and a small outpatient clinic and dispensary at St. Mark’s Episcopal Church, staffed by four black physicians and a public health nurse.\(^\text{29}\) He visited the state charity hospital, Mississippi Baptist

\(^{27}\) Midian O. Bousfield, Report on Visit to Jackson, Mississippi, July 5, 1934, Re: Health Center, Upon Invitation of Dr. W. E. Noblin, Hinds County Health Officer, 1-5, Box 152; L.B. Austin, M.D. to President Rosenwald, 18 August 1928, Folder 8, Box 222, Rosenwald Fund Archives.

\(^{28}\) Julius Rosenwald Fund, Medical Service Projects, 1929, A-4, Folder 10; Midian O. Bousfield, Report on Visit to Jackson, Mississippi, July 5, 1934, Re: Health Center, Upon Invitation of Dr. W. E. Noblin, Hinds County Health Officer, 1-5, Box 152, Rosenwald Fund Archives.

\(^{29}\) Midian O. Bousfield, Report on Visit to Jackson, Mississippi, July 5, 1934, Re: Health Center, Upon Invitation of Dr. W. E. Noblin, Hinds County Health Officer, 1-5, Box 152, Julius Rosenwald Fund, Franklin Library; Harrell, “Medical Services in Mississippi, 1890-1970.” 564.

St. Mark’s was and is a African American church. Nettie M. Perkins, the black public health nurse who worked in Jackson, often mentioned St. Mark’s Clinic in her quarterly reports to the county health officer. During the 1930s, the clinic was noted for providing physical examinations, vaccinations, and treatment for people venereal diseases, including syphilis. See: Narrative Report of work carried on by Nurse Nettie M. Perkins for the quarter ended March 31, 1935; Narrative Report of work carried on by Nurse Nettie M. Perkins for the quarter ended June 31, 1935; Narrative Report of work carried on by Nurse Nettie M. Perkins for the quarter ended June 30, 1934, Box 222, Folder 8, Rosenwald Fund Archives.
Hospital, Dr. Wallis Waley’s private hospital, and Jackson Infirmary. During his visit, observed Bousfield,

I was treated with the greatest of deference and courtesy during the entire time I was in Jackson. I was assured that there was a very fine feeling between the two races in Jackson and, as in every city of the South, white people repeatedly told me that it was the best city in the entire south as far as its treatment of Negroes was concerned. Negroes, however, are not in accordance with that statement.  

Bousfield no doubt recognized this narrative of congenial race relations and “good” treatment for blacks as performance for his benefit, even though he had been invited by a white health officer who acknowledged Jackson’s need for a hospital.

Bousfield’s 1934 visit did not end the correspondence, however. Dr. H. R. Sands, a white physician at the Mississippi Baptist Hospital in Jackson, asserted that “there really are not suitable hospital accommodations for colored patients anywhere in this section of the State, and really very few in the State of Mississippi.” The executive director of the Mississippi State Board of Health concurred with Shands’ assessment. He contended, “The hospital care given to the Negroes of this section [of the state] amounts to practically nothing. The plight of the sick Negroes needing hospital care is pitiable.” Shands wanted a separate building or wing for blacks at Mississippi Baptist Hospital and estimated the cost to be between $100,000 and $125,000.

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30 Report of Visit to Jackson, Mississippi, July 5, 1934, Re: Health Center, Upon Invitation of Dr. W. E. Noblin, Hinds County Health Officer, Box 152; H. R. Shands, M. D. to Mr. John Maclauchlin, 11 August 1936, 3, Folder 1, Box 240, Rosenwald Fund Archives.

31 H. R. Shands, M. D. to Mr. John Maclauchlin, 11 August 1936, 2, Folder 1, Box 240, Rosenwald Fund Archives.

32 Felix J. Underwood, M.D. to Mr. Edwin R. Embree, 17 September 1935, Folder 1, Box 240, Rosenwald Fund Archives.

33 Wayne Alliston to Mr. Edwin Embree, 24 September 1936; H. R. Shands to Dr. Judson Cross, 12 October 1936, Box 240, Folder 1, Rosenwald Fund Archives.
In October 1936, the hospital project was reinvigorated when Richard Howard Green, a Jackson wholesale grocer, died and left $240,000 of his estate to provide hospitalization for blacks in Jackson. The executors of his will established the R. H. Green Foundation. Green had directed them to liquidate his estate and to use the money to “build, purchase, equip and/or maintain a hospital for negroes” or to provide and maintain a ward or wards for hospitalization for blacks in the Jackson area. It was an opportunity to provide African Americans with “first-class hospital services.”

The R. H. Foundation gave the Mississippi Baptist Hospital $100,000 to increase its size and create a separate facility “fairly comparable to that furnished to whites.” The Foundation also provided $5,000 per year to be used as part of a medical outreach program to pay the hospital for the care of indigent blacks who needed surgery.

In the end, the plans for the separate building for blacks were scaled down. Mississippi Baptist Hospital added a $100,000 wing. Critics charged that the hospital most of the funds from the R. H. Green Foundation to benefit whites patients. The hospital had added twenty-five additional beds (for a total of thirty-five) for blacks, but the assurance that black physicians could treat their patients in the hospital was only partially fulfilled. Black physicians could treat their patients, yet they needed white supervision to operate on their black patients.

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34 Richard Howard Green, 1869-1936, 5-8, Box 240, Folder 1, Rosenwald Fund Archives.

35 R. H. Green Foundation Indenture, 1 July 1938, 4-6, Box 240, Folder 1, Rosenwald Fund Archives.

36 M. O. Bousfield, M.D. to Dr. L. A. Smith, 18 July 1940, Box 240, Folder 1; A. W. Dent to M. O. Bousfield, 4 December 1940, Box 240 Folder 1, Rosenwald Fund Archives.
In 1940, the president of the Coahoma County Chamber of Commerce, J. B. Snider, wrote to the Julius Rosenwald Fund to discuss the need for a hospital to be built in the county. There was a white hospital, which received part of its support from the city and county for charity patients, but “no negroes are accepted.” He stated that “hundreds” died because they were unable to get surgical attention. There were less than thirty beds available for black patients and that the city needed a 300-bed hospital for blacks. Although these white physicians were quick to point out that there were not adequate hospital accommodations for black Mississippians, the solutions they offered were to build separate hospitals. They did not offer a critique of the segregated system. In Coahoma County, as in others, public money collected from the citizens was used to help support to hospitals that its black citizens, who were in the majority in the Delta, could not use.

It is difficult to assess blacks’ access to segregated hospitals. In the 1930s and 1940s there were several studies that provide some quantitative information on black and white Mississippian’s access to medical care. As a region, the South had the fewest hospital accommodations, and Mississippi was often ranked close to or near the bottom in important health-related categories. Mississippi had the worst ratio of nurses to population and physicians to population. It also had the least number of hospital beds per 100,000 people (1938). A public health bulletin published in 1938 noted that Mississippi

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37 J. B. Snider to Julius Rosenwall [sic] Foundation, 30 April 1940, Folder 7, Box 233, Rosenwald Fund Archives.

had only 145 beds per 100,000 in population, whereas Arizona, which had the most per 100,000, had 711.39 In 1940, Mississippi had eighty-two general hospitals that were approved by the American Medical Association (AMA) for its population of 2,183,796. This meant that there were 3,299 beds, 1.6 beds for every 1,000 people when the recommended standard was 4 per 1,000. In order to comply with AMA regulations, Mississippi needed more than 8,000 additional beds.40

A study published by Mississippi State College in 1945, *Hospitals and Medical Facilities in Mississippi*, found that there were thirty-one counties without any hospitals and thirty-seven with no hospitals for blacks.41 However, cities of more than 10,000 people were supposed to have “adequate” facilities for blacks and whites.42 In the 1940s, there were twelve cities in the state that fit this criterion, including Clarksdale and Jackson.43 The study noted that blacks and whites had equal facilities in Alcorn County, while there was “an acute shortage of facilities for colored” in Bolivar County (Clarksdale).44


40 “Our Medical Needs,” Box 8383, Series 2184, MDAH.

41 MacAllister, *Hospitals and Medical Facilities in Mississippi*, 1, 4.


A pamphlet published the Mississippi State Board of Health in June 1945, *The Mississippi Doctor Shortage and What to Do About It*, discussed some of the same issues as in *Hospital and Medical Facilities in Mississippi*. By June 1945 there were 135 hospitals in Mississippi, with a total 4035 beds. Despite being almost one half of the population (49 percent), blacks could only access only 963 (23.9 percent) of those beds. In fact, in every region of the state—the Delta, Bluff, Northeast, South Central, and Coastal—there were more beds available for whites than blacks. The numbers were the closest in the eleven county Delta region, where there were 589 total beds available—338 for whites and 251 for blacks.45 A study published by the Julius Rosenwald Fund in 1931 showed that South Carolina had a similar access problem. Despite African Americans being 52 percent of the population, only 26 percent of the hospital beds were available to them.46

The issues of race were compounded by Mississippi’s “ruralness” and poverty. Mississippi’s population was still more than 80 percent rural and had just ten counties where the population exceeded 40,000. Hospitals tended to be established in metropolitan areas, with large population and high per capita income. The United States

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44 McAllister, *Hospital and Medical Facilities in Mississippi*, 14-16. Neshoba County reported that there were hospital facilities (presumably for whites) in the city of Philadelphia as well as a hospital for Indians. Neshoba County is home to the Mississippi Band of Choctaw Indians.

45 Mississippi State Board of Health, *The Mississippi Doctor Shortage and What to Do About It*, 1945, np, Box 15772, Series 1706, MDAH. This pamphlet had slightly different results than John MacAllister’s research which was also published in 1945. This research found only 103 hospitals in Mississippi (32 less than the state board’s pamphlet), but a total of 4,426, which accounts for 391 more beds than the state board’s estimate. For both surveys, however, the number of beds reserved for whites was still more than 70 percent. In MacAllister’s study, it was 72 percent and in the state board’s it was 76.1 percent. See John J. MacAllister, *Hospital and Medical Facilities in Mississippi* (State College, Mississippi: Business Research Station, School of Business and Industry, 1945), 1.

Public Health Service’s study of hospital facilities in 1938 found that 60 percent of all hospitals were located in counties with a population of 40,000 or more.\textsuperscript{47} The state had only one metropolitan district, a city of 50,000 or more, in 1940, which was Jackson, the state’s capital.\textsuperscript{48}

This chapter illustrates the complex nature of Jim Crow medical care. Not all aspects of Jim Crow in hospitals and facilities in Mississippi were determined by law; customs dictated in many cases. Many blacks and whites showed concern over black inability to access hospital care and the quality of that care. Often the solutions they formulated lay in creating a separate black facility; thus, their continued in line with Jim Crow.

\textsuperscript{47} U.S. Treasury Department Public Health Service, \textit{Hospital Facilities in the United States}, 44.

\textsuperscript{48} \textit{Sixteenth Census of the United States}, 567, 569; U.S. Treasury Department Public Health Service, \textit{Hospital Facilities in the United States}, 9, 26. Urban areas are those incorporated places of 2,500 residents or more.
Chapter 5:

“Foresight, Faith, and Endurance”¹:

The Afro-American Hospital and the Tradition of Self-Help

In 1935, Mississippi native Willie Morris was less than a year old when he was stricken with convulsions and a “crazy fever.” He was near death. Unable to reach the family physician, or any other white physician for that matter, his parents called “the Negro doctor” in Yazoo City, Dr. Lloyd Tevis Miller, a well-known physician in the Yazoo-Mississippi Delta and the medical director of the Afro-American Sons & Daughters Hospital.² Like Kenneth Harper, the black physician in Walter White’s 1926 novel Fire in the Flint, Dr. Miller was summoned to the bedside of a gravely ill white child. In the novel, the white physician in town had reluctantly suggested Dr. Harper

¹ Papers in Support of National Register of Historic Places, Afro-American Hospital Vertical File, B.S. Ricks Memorial Library, Yazoo City, Mississippi. The Afro-American Sons and Daughters logo was a triangle inside of a circle that read “Afro-American Sons and Daughters.” The triangle had the words “foresight,” “faith,” and “endurance,” on its borders. Inside the triangle was a nurse dispensing medication.

² Willie Morris, North Toward Home (Boston: Houghton Mifflin Company, 1967), 8. Willie Morris was born in Jackson, but his family moved to Yazoo City when he was quite young. Morris graduated from the University of Texas and was a Rhodes Scholar.

He was an editor for Harper’s Magazine and an influential southern writer of fiction and non-fiction. Morris did not use the physician’s full name, Lloyd T. Miller, but he was certainly “the Negro doctor” in Yazoo City. L. T. Miller had a brother James who also practiced medicine, but he practiced in Meridian and later in Greenville. Dr. Robert Fullilove may have been the only other black physician in Yazoo City at the time.

The Yazoo-Mississippi Delta is area between the Yazoo and Mississippi Rivers. It is known for its rich soil, cotton, and for being one of the poorest areas in the United States. The region consists of seventeen counties: Bolivar, Carroll, Coahoma, DeSoto, Holmes, Humphreys, Issaquena, Leflore, Panola,Quitman, Sharkey, Sunflower, Tallahatchie, Tunica, and Warren, Washington, and Yazoo. Sometimes Yazoo County is not included as part of the Mississippi Delta region but rather the “the Gateway to the Delta.”
because a young girl was hemorrhaging internally. As he performed surgery, White writes, “The colour and race of the surgeon had been almost forgotten in the strange circumstances.”

Morris did not note what treatment Dr. Miller provided, but he credited the doctor with saving his life in his memoir, *North Toward Home*. In Dr. Miller’s case, it is doubtful that Jim Crow etiquette was forgotten, however. To perform those life-saving measures, Miller, in all likelihood, had entered through the Morris family’s back door.

In 1924, Dr. Lloyd T. Miller and Thomas Jefferson (T. J.) Huddleston, a Yazoo City businessman, were instrumental in forming a new fraternal order known as the Afro-American Sons & Daughters. Four years later, the “Afros,” as they called themselves, opened the Afro-American Sons & Daughters Hospital that provided free hospitalization to members and brought medical care to African Americans in Yazoo City and the surrounding area for forty-four years.

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3 Walter White, *Fire in the Flint* (New York: Negro Universities Press, 1969), 208-17; 297-98. Later, Dr. Harper made another house call in order to tend to his patient and was murdered by members of the Ku Klux Klan as he was leaving the patient’s home.

There was a similar situation in Charles Chesnutt’s 1905 novel *The Marrow of Tradition*; whites were forced to rely on a black physician’s expertise as a last resort. Early in the novel, Dr. William Miller was asked by his former white professor, to consult on the case of Major Carteret’s child, Dodie, who had an object lodged in his throat. Carteret did not wish to have a black doctor involved and explained to Dr. Burns, a Northerner, that “in the South we do not call negro doctors to attend white patients.” Later, the child became sick in the midst of a race riot, during which Dr. Miller’s son had been killed. The child needed a tracheotomy, and all of the white doctors who could have performed the surgery were unavailable. Major and Mrs. Carteret were forced to come to Dr. Miller’s home and beg him to treat their child. At the end of the novel, Miller relented. See Charles W. Chestnutt, *The Marrow of Tradition* (New York: Arno Press, 1969), 51, 68-78, 313-29.

4 Morris, *North Toward Home*, 8. It is unclear whether Morris eventually realized the status of Dr. Miller in Yazoo City or not. He did indicate this in his book.

5 Historian Vanessa Northington Gamble divides black hospitals into three different categories—segregated, black-owned and demographically determined. Segregated facilities were established by whites, while black-owned facilities like the Afro-American Hospital were created and controlled by black medical professionals. Demographically determined black hospitals were not originally constructed for African Americans, but population shifts led the hospitals to serve a primarily black community over time.
The Afro-American Sons & Daughters were dedicated to the ideology of racial uplift and self-help. Establishing a hospital was a way to respond to structural violence and racial disparities in health care. As the previous chapter indicated, blacks in Mississippi and throughout the South could not assume the white medical establishments would admit them or that white medical professionals would treat them. By having their own hospital, the Afros were assured that their members could receive “first-class” medical care. The fraternal order and the hospital’s dedicated staff were able to keep the hospital open for many years, but changing hospital regulations, integration, and a lack of funding eventually led to the hospital’s closure.

The establishment of the Afro-American Sons & Daughters was directly connected to the departure of another African-American fraternal order from Mississippi, the Woodmen of Union. Founded in 1905, the Woodmen were active mostly in the South. In 1923, the Supreme Custodian, John L. Webb, moved the organization’s headquarters from Mississippi to Hot Springs, Arkansas. The next year the Woodmen

Thomas Ward, Jr.’s discussion of “black hospitals” refers to hospitals that serve a black or mostly black population. He does not take into consideration the ownership of those institutions.


opened a new well-equipped headquarters building that housed a hotel, a hospital, a nurses’ training school, an insurance company, an auditorium, and a dance hall.\footnote{David T. Beito and Linda Royster Beito, ““Let Down Your Bucket where You Are”: The Afro-American Hospital and Black HealthCare in Mississippi, 1924-1966,” \textit{Social Science History} 30 (Winter 2006): 553; \textit{Arkansas Preservation Digest}, Newsletter of the Historic Preservation Alliance of Arkansas, Summer 2006, 3-4; W. E. Mollison, \textit{The Leading Afro-Americans of Vicksburg, Mississippi}, 74.}

Both Dr. Miller and T. J. Huddleston had been members of the Woodmen. According to Huddleston’s children, the idea of the lodge came as a result of a dream “to further help meet the needs of his black people.”\footnote{T. J. Huddleston, Jr. and Mrs. Henry [Willie Jean] Espy interview.} In September 1924, the year after the Woodmen of Union left Mississippi, the Supreme Lodge of Afro-American Sons & Daughters received their charter, with Huddleston as the Supreme Custodian and Lloyd T. Miller as the Supreme President and Grand Medical Director. The board of incorporators also included Dr. Robert E. Fullilove, Miller’s professional associate; Dr. B. H. Dilworth; R.J. Pierce; Prof. J.H. Webber; and K. B. Jamison.\footnote{Charter of Incorporation, 8 September 1924, Afro-American Hospital Vertical File; \textit{Charter and Constitution of the Afro-American Sons and Daughters}, As Amended at Jackson, Miss. August 21, 1936, 1-4, By the Grand Lodge, Yazoo City Mississippi; Afro-American Hospital Vertical File, B.S. Ricks Memorial Library, Yazoo City, Mississippi; T. J. Huddleston, Jr. and Mrs. Henry [Willie Jean] Espy interview; Mr. Austin P. Barbour, Congratulations, \textit{Afro-American Courier}, March 1938, 1. The Grand Custodian was a position akin to both secretary and treasurer combined or a “director of the board.”

I use the \textit{Afro-American Courier} throughout this chapter. It was the newspaper of the Afro-American Sons & Daughters. The Mississippi Department of Archives and History (MDAH) has issues on microfilm from 1926 through 1957. It was published monthly until 1932 when it became bi-monthly. The archives do not have the complete run of this paper; there are numerous issues that are missing. The \textit{Century Voice}, the organ of the Century Burial Association, also carried information regarding the Afro-American Sons & Daughters and the hospital. This newspaper also MDAH has issues from August 1942 to February 1963.

T. J. Huddleston, Jr. edited both the \textit{Afro-American Courier} and the \textit{Century Voice}. Members could pay an extra fee to have the \textit{Afro-American Courier} mailed to them monthly. The September 1938 newspaper reported that the cost was twenty-five cents. See Proclamation of the 13th Grand Lodge Just Closed in Greenwood, August 1938, \textit{Afro-American Courier}, September 1938, 1.}

T. J. Huddleston was born in Silver City, Mississippi in 1877 or 1879, and he became one of the most prominent residents of Yazoo City. Despite being unable to
finish high school after his father’s death, he became a prosperous landowner and successful businessman, who eventually owned both Century and Mid-Century Burial associations, a casket manufacturing plant, and a number of funeral homes throughout Mississippi.¹⁰

Born in Natchez, Mississippi in 1874, L. T. Miller was the youngest of seven children born to former slaves. Miller attended Natchez College, a school started by the state’s black Baptist convention in 1885. He followed a traditional trajectory for black men who desired medical careers, graduating from Meharry Medical College in 1893.¹¹

Until the late 1960s, most African American physicians received their medical education at one of the historically black medical schools, the most important being Howard University Medical School, in Washington, D.C., which opened in 1868, and Meharry Medical College, in Nashville, Tennessee, which opened in 1876.¹²

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Joseph C. Thomas lists Huddleston’s birth as 1879. According to the Afro-American Courier, Huddleston was also the founder of Louise Agricultural High School, a school for black children. See “T. J. Huddleston,” Afro-American Courier, April 1934, 1. T. J. Huddleston purchased Central Burial in 1927 and changed the name to Century Burial Association, eventually making it into the largest burial association in Mississippi. Huddleston died in 1957.


Thomas asserts that there was a sanitarium for blacks in Yazoo City in the late nineteenth century or early 1900s run by Drs. Hudson, Crister, and Johnson.

In 1900, Dr. Miller was one of the founders of the Mississippi Medical and Surgical Association, a medical association for black physicians. Before settling in Yazoo City, he had practiced in Natchez for a short time. Although he was trained as a general practitioner, he was known to have a “gift” for surgery. Early on, he rented space from local residents for his post-operative surgical patients. In 1907, Miller opened a small facility with eighteen beds for his patients called Miller’s Infirmary. Since black physicians in the South were prevented from having staff privileges at white hospitals, they often had to find alternative places to treat and house their patients. As of 1934, eighteen hospitals in Mississippi accepted black patients, but black physicians could attend to their patients in only four Mississippi hospitals. Miller and his wife Emma also owned a pharmacy, Peoples Drug Store, located on Commercial Street in Yazoo City.\(^\text{13}\)

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Although the first “black-controlled” hospital, Provident Hospital and Nurse Training Center in Chicago, was opened in the North, most black hospitals were located in the South. Provident’s founder, Dr. Daniel Hale Williams, had urged African Americans to open their own institutions rather than continuing to seek accommodation in “unfriendly” white institutions. From its inception, the Afro-American Sons & Daughters were committed to the plan to build their own hospital. The lodge sought “to

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15 I. E. Edwards, “Our Hospital,” *Afro-American Courier*, March 1938, 9. Stressing that having a hospital was not an “added feature” may have been a reference to efforts by the International Order of Twelve Knights and Daughters of Tabor to establish Taborian Hospital, which they opened in Mound Bayou in 1942. The Knights and Daughters of Tabor announced the hospital project at their forty-ninth annual meeting, which was held in Yazoo City in November 1938. T. J. Huddleston delivered an address at the conference. Since he and the Custodian and Grand Mentor Sir P. M. Smith knew each other, it is possible that Huddleston knew their intention prior to their annual meeting. David T. Beito writes that P.M. Smith, who had been a member of the Afro-American Son & Daughters, was inspired to open a hospital in Mound Bayou after one of his children received excellent service at the Afro-American Hospital. (They had previously gone to a white emergency room but were ignored by the staff.) The United Order of Friendship of America also opened a fraternal hospital in Mound Bayou, Friendship Clinic, 1948. Friendship Clinic and Taborian Hospital merged in 1967 to form Mound Bayou Community Hospital. This hospital closed in 1983. See “Sir Knights & Daughters Hold Annual Meeting,” *Afro-
combine all persons of sound bodily health, exemplary habits and good moral character, between the ages of three and sixty years of age into a fraternal, beneficiary, and benevolent order;” “to provide for their relief;” “to provide a hospital for the relief of the sick and disabled members;” as well as offer elderly and death benefits. Many fraternal societies provided some form of health care service, disability payments, or burial insurance to members.

Using dues money collected from new members, T. J. Huddleston was able to post the one thousand dollar bond that Mississippi required of fraternal insurance organizations. He also acquired a bank loan to help finance hospital construction. By 1927, there were more than 16,000 members of the fledgling fraternal order whose dues had provided $20,000 toward the construction of their new hospital.

In November 1927 the executive board members met to decide on a location for the hospital. They considered Indianola, Jackson, Kosciusko, and Yazoo City as possible locations for the new hospital, but they voted nine-to-eight in favor of Jackson as the location of the hospital to serve south Mississippi and Louisiana. All members would continue to utilize Dr. Miller’s Infirmary while the Jackson facility was being completed.

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16 Charter and Constitution of the Afro-American Sons and Daughters, As Amended at Jackson, Miss. August 21, 1936, By the Grand Lodge, Yazoo City, Mississippi, 5-6, 15, 26, Afro-American Vertical File, B. S. Ricks Memorial Library Yazoo City Mississippi.


Once the new hospital was built, Dr. Miller was going to be the medical director for both locations.\textsuperscript{19}

Eventually, however, the new hospital was built in Yazoo City. The Afros dedicated their new $50,000 hospital on December 27, 1928.\textsuperscript{20} According to many sources, the Afro-American Sons & Daughters Hospital (or more commonly the Afro-American Hospital) was “the first Negro Fraternal Hospital, operated and owned by Negroes in Mississippi.”\textsuperscript{21} The original structure was 12,070 square feet with thirty-five patient beds. It had a labor room with a nursery, admitting and waiting rooms, a dining room and kitchen, a laboratory and x-ray room, an operating room, and physicians’ offices. Later they added an annex with fifteen additional beds in 1935. Although the Afros discussed having at least two hospitals, they never operated more than one.\textsuperscript{22}


The location change was probably discussed in the missing issues that are not in the archives. For example, in 1927 the MDAH has the Courier for only October, November, and December. For 1928, the archives has August, November, and December.


\textsuperscript{22}“Birth and History of the Afro-American Sons and Daughters,” \textit{Afro-American Courier}, November-December 1928, 6; Narrative Statement of Significance, National Register of Historic Places Continuation Sheet, 1-2; Afro-American Hospital Vertical File, B.S. Ricks Memorial Library, Yazoo City, Mississippi; Here and There, \textit{Afro-American Courier}, November 1935, 3; T.J. Huddleston to the Officers and Members of the Afro American Sons and Daughters, \textit{Afro-American Courier}, May 1937, 4.

In the May 1937 \textit{Afro-American Courier}, T. J. Huddleston stated that the organization was considering building “at least two more hospitals” in Mississippi. The second hospital should start “in at least 12 months.” He suggested that Hattiesburg could be an ideal location if there were at least 5,000 members.
The Afros embraced the ideology of “uplifting the race” and self-help. In fact, the motto of the Afro-American Sons & Daughters’ newspaper, the *Afro-American Courier*, was “Let Down Your Bucket Where You Are.”

“Cast down your bucket where you are” was the main theme and refrain of Booker T. Washington’s 1895 “Atlanta Exposition Address,” often referred to as the “Atlanta Compromise” speech. This speech helped catapult Washington into his role as one of the primary spokesmen for African Americans until his death in 1915. In the address, he suggested that, despite racial antipathy, whites and blacks could be allies in building the New South. Whites could count on the loyalty of the southern blacks; therefore, they should cast down their buckets among the eight millions of Negroes whose habits you know... who have, without strikes and labour wars, tilled your fields, cleared your forests, builded your railroads and cities, and brought forth treasures from the bowels of the earth, and helped make possible this magnificent representation of the progress of the South.

Washington’s philosophy stressed economic self-sufficiency, thrift, and hard work for the black masses. There was no shame in starting at the bottom in life, but blacks should become landowners, excel at industrial skills, and focus on education of the “hand, head, and heart” as a means of uplift. At the same time, they should put aside the quest for social and political equality with whites.

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But race uplift is a contradictory and contested ideology. It can be viewed as both a unifying survival technique and a “struggle for a positive black identity” to combat the reality of Jim Crow. But this ideology that “espouse[d] bourgeois values of race progress” could also deteriorate into a way of thinking that blamed the black victims of racism for their “failure” to live up to white middle class standards. The Afro-American Sons & Daughters, however, seemed to operate in the best sense of race uplift, race pride, self-help, and intra-racial cooperation. The organization’s newspaper insisted that the “true principle of the Afro-American Sons and Daughters” lay in helping those who were “hungry, destitute, and down-and-out.” Huddleston wanted to help the “black sons and daughters of Ham.” Emphasizing the “familial” or fictive kin relationship with other African Americans, he often referred to everyone as his “cousins” and was known as “Cousin Tom.”

Building “a first-class hospital in Yazoo City” filled the Afros with “race pride” because the hospital addressed “a long-felt need of the race here in the State.” It was a

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27 T. J. Huddleston, Jr. and Mrs. Henry [Willie Jean] Espy interview. Black people were often referred to as “the Sons of Ham.” This is a reference to an interpretation of “the Curse of Ham,” also called “the Curse of Canaan” explained in the book of Genesis in the Bible. Ham, Shem, and Japeth were all sons of Noah. In Genesis, Noah was drunk and had fallen asleep. When Ham saw his father lying naked in bed he did not cover him. Instead, he went to tell his brothers who covered Noah but were careful not see him naked. Noah responded by cursing Canaan, Ham’s son, to be a “servant of servants” to his brothers. In the nineteenth century, pro-slavery advocates looking to align slavery with the will of God contended that the curse was blackness. Thus, black people, Ham’s descendants were destined to be slaves. See Gen. 9: 18-27, KJV (King James Version); Jan Nederveen, *White on Black: Images of African and Blacks in Western Popular Culture* (New Haven: Yale University Press, 1992), 44.

28 Hospital Report Received by Grand Lodge, *Afro-American Courier*, 1 August 1928, 2-3.
significant achievement, but African Americans still needed much more. Even with the addition of the Afro-American Hospital’s thirty-five beds, there were less than sixty-five beds hospital beds available for the use of Mississippi’s black population that numbered more than one million in 1930.29

Nevertheless, the hospital was a place where tenant farmers, housewives, and domestic workers could be treated respectfully and professionally, something that often did not take place elsewhere in Jim Crow society.30 T. J. Huddleston made this point in the Custodian’s Message, published in the *Afro-American Courier* in 1941. He asserted that the “efficient and cheerful service” at the hospital staff cost less than one cent per day and emphasized the qualified service offered by both the hospital and the Afro home office employees. Huddleston wrote:

> We have here in this state the only all Negro hospital in operation, approved by the State Board of physicians and surgeons of the South. We have here two of the most competent physicians and surgeons of the South [Dr. L. T. Miller and Dr. Robert E. Fullilove]. We have here a staff of nurses who are well versed in their chosen field of work.

He asked rhetorically, “Where else in Mississippi do we find as many colored girls employed in office work as we find at our own Home Office of the Afro-American Sons

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30 Dr. Daisy Balsley, interview by Barbara Allen, 1980, interview 80-5, transcript; Mrs. Eunice Nelson, interview by Barbara Allen, 6 May 1980, interview OH 80-70, transcript; Mrs. Daisy Greene and Mary Louise Miller interview.
& Daughters and at the Century Burial Office in the same city of the Afro Office?" The Afros owned an office building where they employed stenographers, clerks, accountants, printers, financial secretaries, counselors, underwriters, and field inspectors.

The Afro-American Sons & Daughters offered pre-paid medical insurance similar to a health maintenance organization. After belonging to the fraternal order for six months, members were eligible for sixty days of free hospitalization per year at the Afro-American Hospital. Members paid a joining fee and then a monthly premium to keep their policies up to date. Members with chronic, longstanding illnesses were required to pay for their treatment at the hospital. However, the medical director could use his own discretion in these cases. Non-members also used the hospital on a fee-for-service basis.

In addition to “free” hospitalization, members were eligible for sick and death benefits. If a member were “in bed sick” for seven days, he or she was entitled to claim

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The valuable service that the hospital provided for a minimal cost and the opportunities that the organization gave to African-American “girls” working in the Afro office were messages that Huddleston clearly deemed worthy of repeating. He printed a very similar message in the September 1937 Custodian’s Message to the Twelfth Grand Lodge. See Custodian’s Message of the Afro-American Sons and Daughters at the Twelfth Grand Lodge, August 18-20, 1937, Afro-American Courier, September 1937, 3.

The fraternal order purchased Afro Office Building from Dr. Miller; it had once housed his infirmary. See “What the Afro-American Sons and Daughters Have Accomplished in 16 Years,” Afro-American Courier, 1.

32 “Gets Vote of Confidence; Relates Struggles,” The Century Voice, September 1943, 1.

33 Narrative Statement of Significance, National Register of Historic Places Continuation Sheet, 2; Lionel Fraser, M.D., “Was One of This Nation’s First HMO’s Started by African Americans?”; Charter and Constitution of the Afro-American Sons and Daughters, As Amended at Jackson, Miss. August 21, 1936, By the Grand Lodge, Yazoo City, Mississippi, 5-6, 15, 26, Afro-American Vertical File, B. S. Ricks Memorial Library Yazoo City Mississippi.

34 “Afros Still Growing at a Marvelous Rate,” Afro-American Courier, 1 May 1929, 5; Information to F.S. & Agents, Afro-American Courier, November 1936, 3; Mrs. Daisy Greene and Mary Louise Miller interview; Dr. Daisy Balsley interview.
weekly sick benefits. At death, the member was entitled to the monetary value of the policy.\textsuperscript{35} Table 5.1 shows the different policy levels, eligibility fees, and benefits for November 1936.

**Table 5.1: Policies Issued by Afro-American Sons & Daughters, November 1936\textsuperscript{36}**

<table>
<thead>
<tr>
<th>Policy Grade</th>
<th>Death Benefit</th>
<th>Eligibility</th>
<th>Joining Fee</th>
<th>Monthly Dues</th>
<th>Weekly Sick Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Superior</td>
<td>$500</td>
<td>Ages 12-45</td>
<td>$2.25</td>
<td>$1.60</td>
<td>$2.50</td>
</tr>
<tr>
<td>Royal</td>
<td>$300</td>
<td>Ages 12-50</td>
<td>$1.50</td>
<td>$1.10</td>
<td>$1.00</td>
</tr>
<tr>
<td>Royal Special</td>
<td>$300</td>
<td>Superior and Educator policy holders under 45</td>
<td>$1.00</td>
<td>$1.00</td>
<td>None</td>
</tr>
<tr>
<td>Educator</td>
<td>$200</td>
<td>Ages 12-50</td>
<td>$1.25</td>
<td>$0.85</td>
<td>None</td>
</tr>
<tr>
<td>Juvenile</td>
<td>$100</td>
<td>Ages 3-21</td>
<td>$0.25</td>
<td>$0.25</td>
<td>$0.50</td>
</tr>
<tr>
<td>Juvenile B</td>
<td>$50</td>
<td>Ages 3-10</td>
<td>$0.10</td>
<td>$0.10</td>
<td>$0.50</td>
</tr>
<tr>
<td>Hospital Service Only</td>
<td>None</td>
<td>N/A</td>
<td>$0.25</td>
<td>$0.25</td>
<td>None</td>
</tr>
</tbody>
</table>

The cost of the policies changed over time, but the incremental increases of dues or joining fees were quite small—usually less than $1.00. For example, the August 1939 Courier did not list a Superior Policy but added an Intermediate Policy valued at $150.00 with a joining fee 60 cents of and monthly dues of 70 cents. The costs associated with most of the policies were unchanged from November 1936.\textsuperscript{37}

\textsuperscript{35} New Information, Afro-American Sons & Daughters, Afro-American Courier, March 1935, 2; New Information, Afro-American Sons & Daughters, Afro-American Courier, November 1935, 6; David T. and Linda Royster Beito, “‘Let Down Your Bucket where You Are,’” 557.

\textsuperscript{36} Information to F.S. & Agents, Afro-American Courier, November 1936, 3.

\textsuperscript{37} Custodian’s Letter (T.J. Huddleston to Financial Secretary), 15 July 1939, Afro-American Courier, August 1939, 6.
The Afros’ membership came from throughout Mississippi and from the adjacent states of Arkansas and Louisiana. Likewise, patients from “everywhere” came to the hospital, including Biloxi, Clarksdale, Columbus, Greenville, Gulfport, Hattiesburg, Indianola, and Kosciusko, and Meridian, Mississippi; Arkansas; and Louisiana. Many blacks came to Yazoo City for hospitalization because their physicians did not have staff privileges elsewhere.

A 1936 study of the 3300 acre Delta cotton plantation, Trail Lake located in Washington County, revealed that 60 of the 589 tenants were members of the Afro-American Sons & Daughters, even though the hospital was more than 50 miles away. Some Mississippians kept their memberships after moving out of the state and returned to have surgery or other medical treatment when necessary. Willie Jean Espy, the daughter

38 T. J. Huddleston, Jr. and Mrs. Henry [Willie Jean] Espy interview; Mrs. Daisy Greene and Mary Louise Miller interview; Rev. Mose (Arkansas City, Ark.) Carter to Letter to the Editor, *Afro-American Courier*, 1 March 1930, 1; Custodian’s Visits, *Afro-American Courier*, 1 March 1930, 1; “New Grand Lecturer” and “Notice for Arkansas Lodges,” *Afro-American Courier*, November-December 1928, 3.


A feature in the *Afro-American Courier* called “In Our Hospital” listed the patients (members and non-members) in the hospital and where they were from.

40 Daisy Miller Greene, interview by Clinton Bagley, 30 January 1975, interview OH 75-21 transcript, (3-4) Mississippi Department of Archives and History, Jackson, Mississippi.


Trail Lake Plantation was owned by William Alexander Percy, a Harvard-trained lawyer and writer from Greenville, Mississippi. The tenants other options for medical treatment included having the landowners pay for a doctor’s visit, which would then be added to the total owed the landowner when the cotton was harvested, going to a private black or charity hospital.
of T. J. Huddleston, gave birth to seven children at the hospital, returning from Little Rock, Arkansas for each of her deliveries.42

The longevity of the Afro-American hospital was due in part to the dedicated staff. During its existence, there were three medical directors of the Afro-American Hospital, Drs. Lloyd T. Miller, Robert E. Fullilove, and Cyril A. Walwyn. They were also supported by a host of nurses and other staff members. They could have had more financially lucrative careers, but they stayed with the hospital.43 Like the black midwives, these doctors and nurses may have seen their professions as more of a “calling,” or “duty” to the community. As Stephanie Shaw writes in What a Woman Ought to Be and to Do: Black Professional Women Workings during the Jim Crow Era, “Work as a calling implies public responsibility.” Therefore, she states, “The value of the work in this instance was determined not by the income it earned but by the good it accomplished.”44

Though T. J. Huddleston is recognized as “the founder” of the Afro-American Sons & Daughters, it is clear that Dr. Miller was credited with much of the hospital’s endurance, success, and fame.45 The Afro-American Courier noted that he “was a born

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42 T. J. Huddleston, Jr. and Mrs. Henry [Willie Jean] Espy interview; Mrs. Leola Galloway and Mrs. Carrie White, interview by Barbara Allen, 3 April 1980, interview OH 80-30, transcript; Mrs. Eunice Nelson, interview by Barbara Allen, 6 May 1980, interview OH 80-70, transcript, Yazoo County Scholar-in-Residence Oral History Project, B.S. Ricks Memorial Library, Yazoo City, Mississippi. Mrs. Willie Jean Espy’s children include Henry Espy, the current mayor of Clarksdale, Mississippi, and Mike Espy, former U.S. Secretary of Agriculture.


44 Shaw, What a Woman Ought to Be and to Do, 138.

physician and surgeon” who had all the “traits necessary to his profession.” This was fortunate because

he finds sick people with every turn. If he goes home, they find him there; if he goes to his office, they are there; to church, they find him there; when goes to the hospital, they are waiting for him there; there seems to be no escape for him.46

Another article in the Courier, referred to him as both “the most popular Negro physician in the South” and “the greatest Negro physician in Mississippi.”47 Miller was even profiled in a 1950 Ebony magazine article which stated that he had performed more than 34,000 surgeries during his career. At the time, he was in his mid-seventies, but he had yet to slow down or retire. In fact, he continued to perform approximately sixty-five surgeries per month, which was comparable to the numbers the Afro-American Courier listed in the 1930s.48

Dr. Miller was a great race man but a poor businessman. Thomas H. Campbell, Jr., a white Yazoo City attorney whose firm represented the fraternal order, noted that the hospital “did a lot of good,” but Miller could have been “a very, very wealthy man” if he had not charged reduced rates for all the operations he performed.49

Dr. Miller had long-standing professional relationship with Dr. Robert E. Fullilove, who became the second medical director of the hospital. Both men were

46 “Afro-Americans to Hold Hospital Celebration Day Sunday, April 2nd,” Afro-American Courier, January 1939, 1.


founding members of the Afro-American Sons & Daughters. Although younger than Miller, they had similar backgrounds. Fullilove’s parents had also been slaves, but he was born free. He graduated from Rust College, an African-American school founded by the Methodist Episcopal Church in Holly Springs, Mississippi in 1866 and from Meharry Medical College in 1907. After medical school, Fullilove practiced in Tupelo but later moved to Yazoo City in 1911, where he maintained a private practice but also worked with Dr. Miller at his infirmary. Although he did not have a particular specialty, he was “exposed” to surgery. As Dr. Miller’s assistant, the two men performed many surgeries together, including tonsillectomies, mastectomies, appendectomies, goiter removal, and tumor removal, with a nurse or Dr. Miller handling the anesthesia. The Courier often contained stories about the hospital and letters to the editor praising the work of Dr. Miller and Dr. Fullilove and their surgical success. In July 1934, J.C. Lindsay, the “Tiny Baby” who was born at the hospital and weighed only a pound and a half but survived, celebrated her first birthday.

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50 Dr. Daisy Balsley interview; McMillen, Dark Journey, 98; George Alexander Sewell and Margaret L. Dwight, Mississippi Black History Makers, Revised and Enlarged ed. (Jackson, Miss.: University Press of Mississippi, 1984), 364; Vivian Ovelton Sammons, Blacks in Science and Medicine (New York: Hemisphere Publishing Corporation, 1990), 172; T. J. Huddleston, Jr. and Mrs. Henry [Willie Jean] Espy interview; Mrs. Eunice Nelson interview; Mrs. Leola Galloway and Mrs. Carrie White interview.

Dr. Miller had a stroke in December 1950 and died in March 1951. After Miller’s death, Fullilove became the head surgeon and medical director. He remained in that position until his death in 1957.\textsuperscript{52}

Dr. Miller was also responsible for recruiting the Afro’s head nurse, Leola G. Galloway, a 1927 graduate of the nurse’s training program at Laurel (Mississippi) General Hospital. Dr. Miller met Mrs. Leola Galloway in Jackson working at a sanatorium and persuaded her to come to Yazoo City to work at the Afro. Nettye McDowell (later Perkins) was the head nurse at the hospital when Galloway arrived, but she left the hospital to become a state public health nurse. McDowell’s reasons for leaving may have been salary related. The least that a black public health nurse made in 1931 was $1200 per year. In the early years, the hospital paid Galloway approximately one dollar per twelve hour shift. “But,” she remained because “we wanted it [the Afro-American Hospital] to live . . . And we were hoping that later we would get enough money to pay [us] for the service.”\textsuperscript{53}

Galloway assisted the physicians and helped to train nursing students at the Afro-American Hospital School of Nurse Training. The school, which offered a three-year course, was the first of its kind in the state for black women. It opened in the mid-1930s and continued into the 1940s. As was typical of many training schools for black nurses, the Afro-American training school was quite small. In fact, the fifth graduating

\textsuperscript{52} Dr. Daisy Balsley interview; Sewell and Dwight, \textit{Mississippi Black History Makers}, 364; Vivian Ovelton Sammons, \textit{Blacks in Science and Medicine} (New York: Hemisphere Publishing Corporation, 1990), 172; T. J. Huddleston, Jr. and Mrs. Henry [Willie Jean] Espy interview.

\textsuperscript{53} Mrs. Leola Galloway and Mrs. Carrie White interview; Negro Public Health Nurses’ Salaries, Box 225, Folder 3, Rosenwald Fund Archives.
class in October 1943 had only graduate, Miss Lillian Humphrey. Other nurses who worked at the hospital included Eunice Nelson and Modesta Walker. The hospital usually had two registered nursing working plus several nursing students on a twelve-hour shift.

By the time Dr. Cyril Walwyn joined the Afro-American Hospital in 1954, Dr. Miller had already died, and Dr. Fullilove’s health was declining. Walwyn became medical director after Fullilove’s death in 1957 and remained at the hospital until it closed in 1972.

Walwyn was from the Nevis, in the West Indies, but came to the United States to study medicine in 1919. He attended Morgan College (now Morgan State University) in Baltimore and transferred to Howard University, where graduated with a science degree in 1924. He graduated from Howard University Medical School in 1928. Walwyn had a


55 Narrative Statement of Significance, National Register of Historic Places Continuation Sheet, 3; Mrs. Leola Galloway and Mrs. Carrie White interview; Eric Stringfellow, “First Black Hospital in Miss. Should Be Museum,” Jackson Clarion-Ledger, January 25, 2005, B-1, Afro-American Hospital Vertical File, B.S. Ricks Memorial Library, Yazoo City, Mississippi.

56 From Subcommittee on Employment, Manpower, and Poverty, 90th Congress, July 11 and 12, 1967, statement of Cyril Walwyn, M.D., Medical Adviser to Friends of the Children of Mississippi, Yazoo City, Miss.11-13; Dr. Cyril a. Walwyn, interview by Barbara Allen, 26 March 1980, interview 80-102, Yazoo County Scholar-in-Residence Oral History Project, B.S. Ricks Memorial Library, Yazoo City, Mississippi. The Yazoo County interview states that Walwyn began working at the Afro-American Hospital in 1955. Walwyn maintained a private practice and worked with the Head Start program as well. Emphasis added.

one-year internship, where he gained additional experience working at the student medical clinic, assisting professors, and treating patients. Although internships became a standard part of medical education during the early twentieth century, there were few available open to black medical school graduates until 1936. In the 1920s, most of the internships open to black medical graduates were in the all-black hospitals, but only fourteen had accredited internships by 1927.\(^58\)

Dr. Walwyn held positions at Howard and John A. Andrew Memorial Hospital at Tuskegee Institute, where he remained from 1938 to 1950. He then established a clinic in Ruston, Louisiana. He had been there only a few years when escalating operating costs, declining revenue and changing state regulations persuaded him to accept the offer from the president of the Afro-American Sons & Daughters. The representatives from the Afro convinced him that “it was not only my racial duty but my patriotic duty and my professional duty, to come and salvage this hospital.”\(^59\) After Dr. Fullilove’s death he stayed to “supervise and take care of the hospital” and those who depended on it.\(^60\)

The Afro-American Hospital had opened on the eve of the Depression. Rather than declining during the Depression, the Afro-American Sons & Daughters continued to grow. The Afro-American Courier often reported “splendid increase” of several hundred (and as many as 1200) members per month from the mid-1930s through the early 1940s.

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\(^58\) Ward, *Black Physicians in the Jim Crow South*, 61-62, 65; Dr. Cyril A. Walwyn interview; Harbsa F. Bouyer, M.D. to Dr. M.O. Bousfield, 28 March 1936, Box 546, Folder 3, Rosenwald Fund Archives.

\(^59\) From Subcommittee on Employment, Manpower, and Poverty, 90\(^{th}\) congress, July 11 and 12, 1967, Statement of Cyril Walwyn, M.D., 11; Dr. Cyril A. Walwyn interview.

\(^60\) From Subcommittee on Employment, Manpower, and Poverty, 90\(^{th}\) congress, July 11 and 12, 1967, Statement of Cyril Walwyn, M.D., 12.
In fact, the fraternal order claimed 30,000 members in 1939 and 35,000 by 1940.

Because of the uncertain economic times, investment in an Afro-American policy assured that a family would be financially devastated in the case of a loved one’s death.⁶¹

But the organization was not able to sustain this growth. In 1950, the Afro-Americans Sons & Daughters had approximately the same membership as in 1939. The Afro’s membership declined throughout the 1950s. The leadership of the organization refused to increase membership rates. Huddleston argued that those who needed the hospitalization plans the most— “the masses, the wash-woman, day-laborers, wage-earners, farmers and in fact all of our people”— would be unable to pay higher premiums.⁶²

The Afro-American Sons & Daughters became more aggressive on member recruitment, dues, and especially fundraising, applying increasing pressure to its lodges. There were several days meant to celebrate the organization and have members raise money.⁶³ Member donation had always been an important part of the upkeep of the

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⁶¹ “Afro-American Sons & Daughters Enjoying Splendid Increase, Afro-American Courier, November 1936, 1; Growth of the Organization October 1936, Afro-American Courier, November 1936, 2; Growth of the Organization, Afro-American Courier, May 1938, 3; The Growth of the Organization for the Month of August, 1938, Afro-American Courier, September 1938, 7; The Growth of the Organization for the Month of August, 1938, Afro-American Courier, September 1938, 7; Growth of the Organization for September, Growth of the Organization for October, Afro-American Courier, November 1938, 6; Growth of the Organization for November, Afro-American Courier, January 1939, 5; Growth of the Organization for December, Afro-American Courier, January 1939, 7; Number of Applications for the Month of April, Afro-American Courier, May 1940, 6; Card of Thanks, Afro-American Courier, August 1939, 1; Telegrams, Afro-American Courier, September 1940, 1; Leslie Brown, Upbuilding Black Durham: Gender, Class, and Black Community Development in the Jim Crow South (Chapel Hill: The University of North Carolina Press, 2008), 291.

⁶² “Delta Doctor Performs 34,000 Operations,” 27; Dr. Cyril A. Walwyn interview; Willeva Lindsey, Interview by Barbara Allen, 25 March 1980, Interview OH 80-61, transcript; Thomas H. Campbell, Jr., interview; Charlie W. Stewart, “Join the Afros,” Afro-American Courier, January 1938, 3.

⁶³ Proclamation of the 13th Grand Lodge in Greenwood, August 1938, Afro-American Courier, November 1938, 4.
hospital. Since its opening, the lodges had been contributing items to the hospital, including kitchen and bathroom towels, glassware, bed linen, flatware, glassware, pillowcases.” The statewide celebration of the founder’s birthday was designated a fundraising event for the lodges and for the hospital. The Afro-American Sons & Daughters had an annual hospital celebration day beginning in 1931 during which Dr. Miller held a free clinic for medical examinations. It was opportunity for community health outreach and to highlight the benefits of membership. For the linen shower, held during the Hospital Celebration, lodges donated money to provide linen for the hospital. And there was a linen shower for the hospital.

In 1956, the executive board raised membership fees by adding eight dollars in permanent to each policy annually. Each member was reminded that “a financial Afro is one who has paid ALL Assessments and Tax[es].” An article in the Courier informed members that the Hospital Anniversary and the Custodian’s Birthday proceeds were part of the hospital’s annual budget. The Afro lodges were expected to “cooperate fully.” Those that did not were “rightfully labeled SABOTAGERS of the Afro-American...
Hospital.” This unusually strong admonishment toward members conveyed desperation.  

By the early 1960s, the Afro-American Hospital “had fallen on hard times.” The fraternal order’s leaders began to explore “all avenues that we think we can get help for the support of our hospital.” After contacting the Yazoo City Board of Aldermen, they provided the hospital with a monthly $100 subsidy. They also unveiled three newly furnished hospital rooms in honor of Dr. L. T. Miller, Dr. R. E. Fullilove, and T.J. Huddleston, Sr. These rooms were for non-Afro members with insurance paying at least ten dollars per day for hospitalization. The next year the fraternal order acknowledged a “major financial struggle.” The hospital needed at least $35,000 for building repairs and improvements. Since its opening, the hospital had only one major renovation in 1935, although the number of beds had increased to 104.

The Afro-American Hospital needed to make improvements in order meet state and federal regulation. The State Commission on Hospital Care had evolved from a position of benign neglect to more strict enforcement. It began to issue citations for

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67 “Founder’s Birthday Celebration by All Afro Lodges June 1st,” Afro-American Courier, May 1957, 1. Original emphasis.

68 Dr. Cyril A. Walwyn interview.


The Afro-American Sons & Daughters Hospital building has been designated as one Mississippi’s ten most endangered historic places. The Afro-American Sons and Daughters Foundation is attempting to restore the building, with plans to have a black history museum that focuses on black men and women in health care. The foundation has a goal of raising $1.6 to complete the project. See Mississippi Heritage Trust, Mississippi’s 10 Most Endangered Historic Places (Jackson, Mississippi, 2007), 3.
hospitals failing to comply with regulations. This affected the black hospitals operated by the Afro-American Sons and Daughters as well as the Knights and Daughters of Tabor and the United Friends in Mound Bayou. Some of the Afro’s problems included wards that were too small and too crowded. The structure was also not fireproof.  

Unable to meet its financial obligations by 1966, the hospital came close to closing. County leaders offered an arrangement to keep the hospital open because it was the only hospital in the county that served African Americans. Yazoo County leased the hospital from the fraternal order and spent more than $200,000 renovating and updating the hospital’s facilities, patient rooms and equipment to comply with federal and state regulations. The county appointed a community supervisory board to oversee the hospital operations, which included T. J. Huddleston, Jr.; R. D. Hines, the president; T.H. Fouche, Jr., the vice-president; Sam Parker; and Hubert Owens, the head of the community board. Dr. Walwyn continued to be the medical director and his staff remained, but the board also brought in additional staff from Yazoo City’s King’s Daughters’ Hospital, including physicians, a bookkeeper, a registered laboratory technician, clerks, and several registered nurses (nuns). The county also changed the name from the Afro-American Sons & Daughters Hospital to the Yazoo County Afro Hospital.

71 Beito, “Black Fraternal Hospitals in the Mississippi Delta,” 135-36; Dr. Cyril A. Walwyn interview.

72 Hubert Owens interview; Thomas H. Campbell, Jr. interview; Mrs. Eunice Nelson; David T. and Linda Royster Beito, “‘Let Down Your Bucket where You Are,’ 565; From Subcommittee on Employment, Manpower, and Poverty, 90th congress, July 11 and 12, 1967, Statement of Cyril Walwyn, 13. Dr. Walwyn’s statement complaining about the condition of the hospital was in 1967. According to Nurse Nelson, the county brought in Drs. Sigrest, Thomas, Hogue, Mangold, and Pittman to assist Dr. Walwyn.
The name change indicted the hospital’s conversion from a fraternal entity to a county hospital, where the Afro members would have limited access. The Afro American Sons & Daughters were to pay the hospital for their members who were treated at the hospital. The hospital staff remained, including Dr. Walwyn as the medical director of the hospital. In practice, Dr. Walwyn continued to admit patients who could not pay, and the board made no real effort to collect the hospital’s debts.\textsuperscript{73}

The infusion of county funds meant that facilities and salaries improved. When Dr. Walwyn became the director, the low salaries had made it difficult to recruit additional nurses. The “three old, aged nurses” on staff made less than $150, while his salary was just $250 per month. In fact, he needed his private practice to supplement his salary “because the hospital could not pay me enough.” The hospital’s monthly payroll had been less than $2,000, but after the county takeover it was more than $7,000 per month.\textsuperscript{74} The low salaries may have been an attempt to keep rates low at the hospital and dues low in the Afro-American Sons & Daughters, so the people in the Delta could afford to keep their memberships.

As the Afro-American Hospital declined, white hospitals in the area were beginning to accept black patients, taking away many of the Afro’s potential members.

\textsuperscript{73} Thomas H. Campbell, Jr. interview; Hubert Owens interview. Owens stated that the number of beds that were available to Afro members was reduced to seven.

\textsuperscript{74} From Subcommittee on Employment, Manpower, and Poverty, 90\textsuperscript{th} congress, July 11 and 12, 1967, Statement of Cyril Walwyn, M.D., 11-12; Mrs. Eunice Nelson interview; Hubert Owens interview. Hubert Owens gave different salary information than Dr. Walwyn. He asserted that the registered nurses made $200 per month, and their salaries were increased to $450. Licensed practical nurses’ salaries increased to $350.
As a result of the Hill-Burton Act in 1946 and the Civil Rights Act of 1964, black patients began to have access to hospitals that were previously segregated or racially exclusive. King’s Daughters Hospital, which had been for the “snow white folks,” and other hospitals in cities like Greenville, Belzoni, Vicksburg and Jackson began to accept black patients. Many people connected with the Afro saw integration of the surrounding hospitals and the Afro’s failure to “keep up with the times” as reasons it failed. Meanwhile, whites were not excluded from the Afro, but they not utilize the hospital because, “No white person would be caught dead out there in the bed with black folks.”

That would have been an indication of social equality between blacks and whites.

Yazoo County ended its subsidy of the hospital in 1972, and the hospital closed the same year. The Mississippi State Insurance Commission ordered that the property of the Afro-American Sons & Daughters be sold; this was done at a public auction in 1974. The Afro-American Hospital’s decline and eventual closure was a part of a historical trend affecting black hospitals in the late twentieth century. Between 1961 and 1988, seventy-one of these institutions were forced to merge, close their doors, or consolidate with other institutions.

For many years, the Afro-American Hospital was the only place in the Yazoo City area where blacks could receive medical treatment while being treated with respect.

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75 Mrs. Daisy Greene and Mary Louise Miller interview; Dr. Cyril A. Walwyn interview; Hubert Owens interview.

76 Hubert Owens interview; Dr. Cyril A Walwyn interview; Narrative Statement of Significance, National Register of Historic Places Continuation Sheet, 2, Afro-American Hospital Vertical File, B.S. Ricks Memorial Library, Yazoo City, Mississippi; Newspaper Clipping, n.d. (1974) From Paul Cartwright files.

77 Rice and Jones, Public Policy and the Black Hospital, 102.
While engaging in institution building and racial uplift, T. J. Huddleston and Dr. L. T. Miller had tried to address the problems of structural violence and access to health care through the Afro-American Sons & Daughters fraternal order and hospital. Huddleston remained faithful that, starting with a thousand dollars and a thousand members, he could build a hospital. He, as did Dr. Miller and the other staff, remained devoted to the venture because of its significance to the Afros in Yazoo City and elsewhere. Over the years, thousands of patients had treatment and received operations at this institution that endured for forty-four years. Even though it closed, the Afro-American Sons & Daughters had lived up to their motto, “foresight, faith and endurance.”
Epilogue:

“To Make Mississippi a More Healthful State”¹:

The Impact of Federal and State Legislation

During the 1940s, there was an increased interest in public health in Mississippi and in the country as a whole. World War II caused more people to show more concern for the overall health of the population. After the war, the federal government passed legislation to expand the availability of hospitals in country. In turn, the Mississippi legislature also passed some significant laws to increase hospital quality and access and to bring more physicians into the state. Many of the changes were made in an effort to address some of the state’s problems and shortfalls in health care in order “to make Mississippi a more healthful state.”² Health care policy changes in the mid-twentieth century, combined with the effects of civil rights legislation, brought noteworthy changes to health care access. As a result, African Americans had increased access to health care, but legislation did not eliminate racial disparities in health.

In some respects, the war caused people to think about the health of the nation and reason that everyone needed to be healthy in order to defeat a common enemy. In fact,

¹ “Public Health Pays,” Scrapbook of Activities, circa 1947, Box 8772, Series 2040: Scrapbook-General, 1947, MDAH.

² Ibid.
Felix Underwood argued, “Everyone has a part in the war, no matter what their physical station, color or creed, and to successfully do the job physical fitness is the first essential.”\(^3\) Others argued that a healthy population was an economic asset, while an unhealthy population was an economic liability.\(^4\) Despite these signs of progress, the public health programs were often administered keeping with the ideology of black inferiority and the practices of segregation and exclusion.

There is some indication that the state was under pressure to change its policies toward the treatment of blacks. A five-year survey (1939-1943) of public health services provided for blacks in the state, *For the Benefit of Negro Health*, took a defensive posture and refuted charges that the South had provided inadequate care for economically disadvantaged people, especially African Americans. The publication discusses the various services provided by health departments, including immunizations, disease control, physical exams, maternity services, and sanitation. There was some acknowledgement that health problems in the Delta were exacerbated by “segregation and racial problems,” but many of the reports issued by county public health directors refused to accept this. For example, Dr. R. W. Williams, director of the Yazoo County Health Department, asserted “without fear of contradiction that the State of Mississippi takes excellent care of the colored race.” In fact, William thought it would be “wonderful


\(^4\) “Public Health Pays,” Scrapbook of Activities, circa 1947, Box 8772, Series 2040: Scrapbook-General, 1947, MDAH. In some ways, this is a related concept as expressed with the “Germs Know No Color Line Campaign” that reminded whites that failure to control diseases like tuberculosis in black neighborhoods could lead to it being spread to the white community through black employees. The “Germs Know No Color Line” campaign seemed to operate out of fear of black “disease.” The public health message being spread in this case, at least on its face, appeared to be focused on the positive aspects of maintaining health.
if the indigent white people of the North were given the same consideration about their health.”

Two pamphlets published in 1945—*How Serious Is the Doctor Shortage?* and *The Mississippi Doctor Shortage and What To Do About It*—focused on another serious health care issue in Mississippi. *How Serious Is the Doctor Shortage?* contended that only the urban centers had “anywhere near enough doctors,” but they were overworked and rushed because the state needed many more.

In 1946, federal and state legislation addressed the shortage of hospitals and the shortage of physicians in the state. The long process of dismantling segregated health care had begun. President Harry Truman asked Congress to pass legislation that would guarantee health care for every American citizen. The legislation that came out of this was somewhat less than comprehensive. The Hospital Survey and Construction Act, commonly known as the Hill-Burton Act, passed in August 1946. It did not provide a national healthcare system, but it allocated federal funds to improve the country’s hospitals and to build hospitals where there were shortages. Congress provided money to conduct surveys to determine the need for medical facilities and provided $75 million per year for five years to the states to assist in the hospital construction. The Hill-Burton program of hospital modernization and reconstruction was reauthorized by Congress through 1974. It helped to build approximately 11,500 hospitals. Private and public hospitals were able to receive funding, many of them under “separate but equal clauses”

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6 Mrs. Dorothy Lee Black, Delta Council, *How Serious Is the Doctor Shortage?* 15 August 1945, np, Box 8383, Series 2184, MDAH.
that discriminated against African Americans despite Hill-Burton’s nondiscrimination clauses.\(^7\)

The same year as the Hill-Burton Act, the state passed the Mississippi Commission on Hospital Care Act to improve the quality of the state’s hospitals and to facilitate the building of new hospitals. Neither of these acts solved the problem of access to medical care for African Americans, but they were an acknowledgement of a health care crisis.

Support began to grow for a four-year medical college in the mid-1940s. The shortage of physicians had been intensified by the war, but one of the main problems was that Mississippi was without a four-year medical college. In the early twentieth century, there had been a four-year medical school in Meridian, but it closed after the state legislature refused to provide funds for its maintenance in 1911. After that school closed, Mississippi had only a two-year medical school located at the University of Mississippi. After two years, medical school students had to transfer out of state to complete the final two years of training. After leaving the state, the majority of medical students did not return to practice medicine in Mississippi. Because the overwhelming majority of physicians who practiced in Mississippi had been born in Mississippi, it was important to stop this exodus that was taking place because of the two-year medical school.\(^8\)

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\(^8\) Mississippi State Medical Association, Report on Medical Association, May 1944, Box 8383 Series 2184, MDAH; Untitled Memo, Box 8383, Series 2184, MDAH; Lucie Robertson Bridgforth, *Medical Education in Mississippi: A History of the School of Medicine* (Jackson, Mississippi: Medical Alumni Chapter and Guardian Society of the University of Mississippi Alumni Association, 1984), 102. In
Dr. Felix J. Underwood, executive director of the Mississippi State Board of Health, was a major supporter of this movement. Various clubs showed their support as well by passing resolutions that supported the bill to create a four-year institution because “there are only 1063 white doctors in the state of MS, of which 518 of these doctors are under 60 years of age, creating a most acute shortage in normal times which would be disastrous in the case of an epidemic.” The state legislature passed the bill authorizing the creation of a new four-year medical school at the University of Mississippi in April 1946.9

The university medical school was a long range project. In the short term, the legislature also created a Medical Education Board. The board was authorized to grant loans of up to $5000 to Mississippi residents seeking a four-year medical education. Physicians could avoid repayment of the loan by returning to the state to practice medicine for five years after completing their degrees. This program was referred to as “Mississippi’s Medical March.” Forty-seven students attending eleven different medical colleges throughout the country took advantage of the program when it was introduced.10

About 10 percent of the medical students taking part in the program were black. The legislature created a system whereby state funds would be used to support Meharry Medical College, in return for accepting the black students supported by the Medical Education Board. Fourteen additional states had similar arrangements with Meharry to comparison, ten out of the fifteen graduates from the class of 1909 at the four-year school in Meridian stayed in Mississippi.

9 Bridgforth, Medical Education in Mississippi, 108, 112; Resolution for the Establishment of a Four-Year Medical College and General Hospital, Box 8383, Series 2184, MDAH.

10 “Public Health Pays,” Scrapbook of Activities, circa 1947, Box 8772, Series 2040: Scrapbook-General, 1947. MDAH.
educate black physicians.¹¹ Nine years after state legislation approved a new University
of Mississippi School of Medicine, it opened in Jackson in 1955. Keeping with
contemporary practices of racial segregation and exclusion, no black student was allowed
to enroll until 1966.¹²

Not all of Mississippi’s problems were addressed by legislation, however. High
infant mortality continues to plague African Americans, especially in the Delta, where the
soil is rich but many of the people are poor and black. Thus, at the beginning of the
twenty-first century, Mississippi faced similar problems as it faced in the early twentieth
century. It has been “federally designated as medically underserved.” Once again, rising
infant mortality is one of the major public health concerns. Between 2004 and 2005
infant mortality increased almost 18 percent. Among African Americans, the rate of
seventeen per thousand was more than twice the national average. Many of the mothers
are inexperienced teenage girls.

One program that has been implemented in Sharkey and Issaquena counties to
educate young mothers about proper diet and care for themselves and their children is
operated by the Cary Christian Center in Cary, Mississippi. Since 1989 the center has
been providing prenatal classes, education, medicine and transportation for the young
women in the two counties. Although there is not necessarily a direct correlation

¹¹ Bridgforth, Medical Education in Mississippi, 123.
¹² Ibid., 143-44; 175.
between the program of the center and the infant mortality rate, infant mortality rates in Sharkey and Issaquena have not spiked.\textsuperscript{13}

The Cary Christian Center’s services are provided by laypeople, like the midwives who once numbered in the thousands. Those women are long gone, but the success of the Cary program illustrates that the services the lay midwives provided was important to public health.

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