COUNTY OF LOS ANGELES

BIENNIAL REPORT

OF

THE CORONER

THEO. J. CURPHEY, M.D., *Coroner*

1959-60 - 1960-61

COUNTY OF LOS ANGELES

ANNUAL REPORT

OF

THE CHIEF MEDICAL EXAMINER- CORONER

THEO. J. CURPHEY, M.D., CHIEF MEDICAL EXAMINER-CORONER

Fiscal Years July 1, 1959 - June 30, 1960
July 1, 1960 - June 30, 1961

BOARD OF SUPERVISORS

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COUNTY OF LOS ANGELES
OFFICE OF CHIEF MEDICAL EXAMINER-CORONER
HALL OF JUSTICE
LOS ANGELES 12, CALIFORNIA

THEODORE J. CURPHEY, M.D.
CHIEF MEDICAL EXAMINER-CORONER

Honorable Board of Supervisors
County of Los Angeles
Los Angeles, California

Gentlemen:

Herewith is presented the biennial report of the Department of Chief Medical Examiner-Coroner of Los Angeles County for the fiscal years 1959-60 and 1960-61.

The report contains a summary of operations; an outline of the functions and services of the Department, as well as of the organization, and with this various tables of selected statistics. The Summary of Operations also lists in near chronological order the changes that have been instituted in the operational pattern of the office during the five fiscal years that the Coroner's Office has been separated from the Public Administrator's Office and a graduate in medicine certified in pathology appointed as coroner.

With the submission of this report goes my sincere gratitude to the Board of Supervisors and the Chief Administrative Officer and his staff for their sympathetic understanding and support of the efforts being made by the members of this office towards the ultimate establishment of a modern medico-legal agency aimed at serving the interests of the entire community, through the medium of accurate and prompt medical reports in cases of sudden and unexpected death in the community, no matter from what cause.

With the increasing socio-economic significance that is being attached to the proper and complete medical investigation of those cases of sudden death unassociated with criminal violence and involving mainly the problems of economic indemnification as provided by insurance programs, governmental and otherwise, the medico-legal office in a community such as ours is destined to become an agency of increasing importance to the citizen, especially in the safeguarding of his financial interests. Hence, one of the deliberate aims in the development of our program is to utilize the same scientific skills and effort in the investigation of these non-criminal deaths as is now the case in the investigation of homicidal deaths.

Finally, as Chief Medical Examiner-Coroner, I wish to express my personal thanks to the various law enforcement agencies of the County, who supplied us with the investigative data, as well as to those funeral directors who provided us with the physical facilities necessary for the handling of the cases in their respective communities.

To the entire staff of the office goes my sincere gratitude for their loyal service and their evident willingness to adjust to the changing pattern of the organization during the transitional period of the past five years. With my gratitude too goes the assurance that it is their efforts during this period that have supplied the bedrock for future growth and progress of the office in its service to the community.

Respectfully submitted,

Theo: J. Curphey

Theodore J. Curphey, M.D.
Chief Medical Examiner-Coroner

TABLE OF CONTENTS

		Page
LETTER OF TRANSMITTAL		3
TABLE OF CONTENTS		7
I	SUMMARY OF OPERATIONS	8
II	FUNCTIONS AND SERVICES OF THE DEPARTMENT	10
III	ORGANIZATION OF THE DEPARTMENT	12
IV	SELECTED STATISTICS	14
	Table No. 1 - Cases Investigated by the Coroner	14
	Table No. 2 - Manner of Death	14
	Table No. 2a - Deaths from Natural Causes	15
	Table No. 2b - Total Deaths by Age Group	16
	Table No. 3 - Motor Vehicle Fatalities	16
	Table No. 4 - Home Accidents	17
	Table No. 3a - Incidence of - Alcohol - Auto Accidents	18
	Table No. 3b - Alcohol in Relation to Fatal Vehicular Accidents of Drivers and Pedestrians	19
	Table No. 5 - Occupational Accidents	20
	Table No. 6 - Other Accidents	21
	Table No. 7 - Suicides	22
	Table No. 8 - Homicides	22
	Table No. 9 - Incidence of Alcohol - Homicides - Suicides	23
	Table No. 10 - Miscellaneous Data	24
	Table No. 11 - Laboratory Tests	25
	Table No. 12 - Photography	25
V	EXPENDITURES	26
VI	REVENUES COLLECTED	26

I. SUMMARY OF OPERATIONS

During 1959-60, the case load of the Department was 10,786 cases and at the close of the fiscal year 1960-61 our case load reached 10,825.

Of the 10,786 cases, 4,713 were processed in our Hall of Justice facility while 6,073 cases were handled in private mortuaries beyond the metropolitan area serviced by the Chief Medical Examiner-Coroner's facility.

During 1960-61, 4,850 cases were handled at the Chief Medical Examiner-Coroner's facility, and 5,975 cases were handled in the private mortuaries.

The autopsy rate for these two years was 44.7 per cent and 40.1 per cent respectively. The shortage of medical personnel has materially affected our autopsy rate.

Deaths due to natural causes amounted to 6,671 in 1959-60 and 6,651 in 1960-61. Natural deaths frequently require considerably more medical investigation and laboratory analyses than deaths resulting from trauma because medical history of illness or hospitalization may not be avilable to the deputy medical examiner.

Deaths as a result of homicide amounted to 282 in 1959-60 and 296 in 1960-61, or 2.61 per cent and 2.73 per cent of the total for the respective years.

There were 973 cases of suicide (9.0%) investigated in 1959-60 and 937 cases of suicide (8.7%) investigated in 1960-61.

Motor vehicle fatalities have decreased for the past four consecutive years. For 1959-60, there were 935 such deaths and 918 vehicle fatalities for 1960-61.

For the 1959-60 total, pedestrians accounted for 330, vehicular collisions for 423, and non-collision accidents for 182. For 1960-61 total, pedestrians accounted for 314, vehicular collisions for 382, and non-collisions for 222.

The following is a review of the operational changes in the office fore the five year period 1957-61:

1. Modernization of embalming and autopsy areas and installation of refrigeration facilities so as to permit post-mortim examination befor embalming.

2. Initiation of a program of more complete medical investigations with more definitive documentation of the medical findings. This included a change in dictating and transcribing equipment and a change in the official forms aiming at simplification.

3. Establishment of a priority system in handling certain cases in which the time factor is important to the law enforcement agency or where delay in certification might work an economic hardship on the families involved.

4. Employment of part time deputy medical examiners because of inability to obtain full time men at the established salary level and also because of initial shortage of full time career pathologists in the field. This problem has been partly ameliorated since the increase of salaries instituted in 1961, following which four full time deputies have been added to supplement a previous staff of three full time appointees.

5. Modernization of the toxicological laboratory with installation of time-saving technical equipment.

6. Establishment of a central control desk for processing our case records and for handling outside inquiries concerning the status of an individual case.

7. Lengthening the daily medical working time by establishing a night shift, where deputy medical examiners investigate cases and perform autopsies in the central morgue and the mortuaries of the County from 4:P.M. to Midnight in addition to the regular 8:A.M. to 4:P.M. day shift, both shifts operating on a seven day weekly basis.

8. Amendment to the State Law (Legislative Session 1959) to permit the Coroner the right to retain tissue necessary to the investigation of a case or for the verification of his findings. This amendment stemmed from successful prior litigation in the Superior Court, the District Court of Appeals and the State Supreme Court to establish the legality of the pathologist's performance of his medical acts as they concern the retention of tissues after a medico-legal autopsy. As a result of this legislation, California is now the first and only State in the Nation that legally clarifies the procedure.

9. Change of title of Coroner in the Administrative Code of the County of Los Angeles to that of Chief Medical Examiner-Coroner, effective November, 1960, so as to define more accurately and to emphasize the medical nature of the office as established by the Charter amendment of 1956.

10. Utilization of a consulting group of psychiatrists, psychologists and psychiatric social service workers to assist the Chief Medical Examiner-Coroner and his staff in the accurate certification of deaths in which suicide is the mode in question. To our knowledge, this is the only consulting group of its kind in existence anywhere and, as a result, has received widespread and favorable national public attention. Their professional services are donated to the County as part of a program concerned with the study of suicide and its prevention in Los Angeles County.

11. Abandonment of the use of jurors chosen at random from the city streets for Coroner's inquests, substituting instead jurors screened for service in the Superior Courts (November, 1960).

12. Amendment on June 1, 1961, of Section 27491 of the Government Code relating to coroner's inquests in Counties of 4,000,000 or more, substituting an advisory verdict for the previously established coroner's verdict and setting forth in such an advisory verdict whether the death was occasioned by the act of another and whether it was occasioned by criminal means, without naming any person as being responsible therefor.

13. Establishment of a department of microbiology and appointment of a trained and licensed microbiologist to assist in the investigation of deaths that have significance in the field of public health and also in certain deaths of a criminal nature.

14. Institution of a program of public education relating to the functions of the medico-legal office. From March, 1957, to June, 1961, the Chief Medical Examiner-Coroner has made 322 public appearances in the form of speeches and lectures to Service Clubs, Law Enforcement Agencies, Funeral Directors' Associations, Bar and Medical Associations, Chambers of Commerce, Press Clubs, Public Relations Counsellors, Radio and Television broadcasts, Church groups, American Legion Meetings, Safety Councils, Hospital Staff meetings, and National Medical Associations. He has also addressed two international medical meetings, one in Mexico and the other in the United States, besides having lectured annually to the medical students of the University of Southern California, University of California at Los Angeles and the College of Medical Evangelists (Loma Linda University). It is felt that this effort aimed at a wide dissemination of information relative to the functions, responsibilities and operation of a modern medico-legal office should provide a better understanding on the part of the lay and professional public as to the contribution that this office makes to the community, not only in the area of crime detection but also in the protection of their socio-economic and professional interests.

II. FUNCTIONS AND SERVICES OF THE DEPARTMENT

It is the responsibility of the Chief Medical Examiner-Coroner under the laws of the State of California to investigate all cases of sudden and unexpected death within the County. This responsibility is not limited to homicides, suicides, and death under suspicious circumstances, which are commonly thought to be the province of the Chief Medical Examiner-Coroner, but extends to deaths in which no physician attended the deceased in life, to accidents of all sorts which result in death, and to deaths attributable to industrial or occupational causes. The Medical Examiner-Coroner's investigations of these deaths are medical investigations and supplement the investigations made by other law enforcement agencies. Investigation by the Chief Medical Examiner-Coroner may include a visit to the scene of death by the medical examiner assigned to the case, the study of the medical history of the deceased, examination of the body, autopsy, toxicological examination of body fluids and organs, and microscopic study of tissues to reveal pathological conditions not observable on simple visual examination. Each case is a particular problem, unique in itself, and each requires a different combination of medical techniques.

The investigation conducted by the medical examiner of the circumstances and cause of death permits the Chief Medical Examiner-Coroner's Department to issue death certificates in which these circumstances and cause of death become a matter of permanent public record. The cause of death and the manner in which it occurred, as certified by the Chief Medical Examiner-Coroner, may become the basis of criminal or civil action in the courts. In such cases the medical examiners, toxicologists, and technicians of the Department appear as expert witnesses. It is important to observe that the Chief Medical Examiner-Coroner's investigation is impartial, factual, and based upon scientific knowledge and experience. Members of the staff of the Department appear in court to state the facts as these have been determined, not to support the contentions of either prosecution or defense.

The investigation of the Chief Medical Examiner-Coroner produces permanent medico-legal records of autopsies performed and laboratory investigations completed. These are available to the District Attorney, the Public Defender, law enforcement agencies of municipalities, the insurers of the deceased, and other interested public and private agencies. The primary medical records are also made available to hospitals in which the deceased were patients, or to physicians who treated them in life. For both mandatory legal reasons and equally cogent reasons of medical knowledge, it is important that these records be complete, accurate, and available to those whose interest requires the study of these documents.

In addition to the primary responsibility of the Chief Medical Examiner-Coroner for the medical investigation of cause of death, it is also the responsibility of the Department to assume custody of the bodies and property of deceased persons, the circumstances of whose deaths require the Chief Medical Examiner-Coroner's investigation. In the central metropolitan area of the County, the bodies of deceased persons are brought to the Chief Medical Examiner-Coroner's morgue in the Hall of Justice by the personnel and equipment of the Department. In areas lying outside of this area, this service is performed for the Department by cooperating mortuaries, which act for the Chief Medical Examiner-Coroner in their districts. In districts having more than one mortuary, this service is handled by rotation on a monthly basis. Under present conditions, approximately one-half of all Chief Medical Examiner-Coroner's cases are handled in the central morgue, with the remaining half being handled in districts outside the central area. All homicide and abortion cases are handled in the central morgue.

The service rendered by the Chief Medical Examiner-Coroner in the investigation of those deaths which require his legal intervention is an essential service of local government. It is essential not only in the obvious cases of possible homicide or suicide, but in

the less obvious cases of death occurring from occupational disease, industrial accident, epidemic disease, and in differentiating natural deaths from those which result from accident. The facts revealed by the medical examiner's investigation can contribute to the public health as well as the public safety, may direct attention to hazardous conditions of employment, may detect the presence of unsuspected disease of epidemic nature, or reveal the existence of hazards to health which preventive measures can eliminate.

In addition to the primary function of the medical investigation to determine the cause and circumstances of death, the Chief Medical Examiner-Coroner may, in his discretion, hold a formal inquest. Transcripts of the inquest proceedings are made available to the District Attorney for review and possible action by his office. The function of the inquest is primarily that of determining criminal responsibility for death.

In the performance of its legal duties, the Department provides such services as the fingerprinting and identification of deceased persons, the notification of next of kin and notification of law enforcement agencies, the Veterans Administration and other branches of government of the death of persons in whom these agencies have an interest.

III. ORGANIZATION OF THE DEPARTMENT

The Department is headed by the Chief Medical Examiner-Coroner, Theodore J. Curphey, M.D., and its functions are performed by six major divisions: (1) Medical (Professional); (2) Medical (Stenographic and Control); (3) Toxicology; (4) Mortuary; (5) Records, and (6) Inquest.

The Medical Division is responsible for the professional medical investigation of each case handled by the Department and for the determination of the cause and mode of death. This work is performed by deputy medical examiners under the direction of the Chief Deputy Medical Examiner. In addition, the Bacteriology Laboratory and the Histopathology Laboratory, which prepares microscopic slides for the deputy medical examiners, are under the supervision of the Chief Deputy Medical Examiner.

The Medical Division - Stenographic and Control is responsible for the transcribing of dictated cases, taking medical dictation, obtaining medical histories and police reports over the telephone, locating by telephone all doctors on outside runs at the various mortuaries throughout the County, and answering all the telephone calls for the doctors or for medical information. The Control Section is responsible for keeping account of approximately 11,000 cases per year and approximately 50,000 miscellaneous laboratory, police, case history, and toxicological reports, and preparing monthly statistical control reports.

The Toxicology Division is responsible for the chemical analysis of specimens submitted by the deputy medical examiners for laboratory study. These specimens include blood, tissue, and other organic substances. Laboratory studies are made to determine the presence or the absence of toxic agents such as the alcohols, narcotics, barbiturates, carbon monoxide, heavy metals, and other poisons. In many cases, such studies are fundamental for the positive determination of the cause of death.

The Mortuary Division is responsible for the transportation of bodies of deceased persons whose deaths occur in the metropolitan area as well as for the transportation of all suspected homicide cases that occur in any part of the County. Personnel of the division have an important duty in gathering information and evidence at the scene of death, making preliminary classification as to type of death, as well as assuming custody of property found on the person of the deceased. This division operates the Chief Medical Examiner-Coroner's Morgue in the Hall of Justice, has custody of remains, performs restorative work and releases remains to funeral directors. In addition, personnel of this division assist deputy medical examiners at the autopsy table, and take photographs of remains and organs as required.

The Records Division has responsibility for the receiving of reports of death; of maintaining the case records pertaining to all Chief Medical Examiner-Coroner's cases; of notifying the next of kin of the deceased; of releasing remains on authorization of persons entitled to claim remains; of holding and releasing property; of issuing death certificates, and maintaining the Coroner's Register as required by law. In addition, this division receives the bulk of all incoming telephone calls requesting information regarding cases. All personal contacts with the public and relatives of deceased are handled by this division, including accompanying identification witnesses to view the remains of deceased relatives, friends, etc.

The Inquest Division is responsible for the holding of formal inquests into the deaths of persons from unnatural causes. Purpose of the inquest is to determine if death is the result of a criminal act on the part of another. Inquests are held in the Hall of Justice, or in the area where the death occurred. Proceedings are conducted by one of two inquest deputies, and the verdicts are rendered by the Chief Medical Examiner-Coroner's juries convened

for that purpose. The proceedings are recorded and transcripts are made available to the District Attorney, City Attornies, and others.

SELECTED STATISTICS

TABLE NO. 1

Cases investigated by the Medical Examiner	1959-60	1960-61
In the Metropolitan Area	4713	4850
In other areas of Los Angeles County	6073	5975
	10786	10825

TABLE No. 2 - MANNER OF DEATH

Natural Causes*	6671	6651
Motor Vehicle Fatalities	935	918
Home Accidents	1086	1150
Occupational Accidents	108	108
Aircraft Accidents	18	13
Railway Accidents	4	9
Other Accidents	598	620
Suicides	973	937
Homicides	282	296
Still births	69	73
Abortions	10	17
Undetermined (Senility and ill-defined conditions)	32	33
	10786	10825

* Excluding symptoms of senility and ill-defined conditions shown in Table 2a.

SELECTED STATISTICS

TABLE No. 2a

DEATHS FROM NATURAL CAUSES - IN MAJOR GROUPS

(International List)

	1959-60	1960-61
Infective and parasitic diseases	67	45
Neoplasms	190	216
Allergic, endocrine, metabolic and nutritional diseases	49	56
Diseases of the blood and blood forming organs	11	9
Mental, psychoneurotic and personality disorders	141	107
Diseases of the nervous system and sense organs	212	170
Diseases of the circulatory system	4890	5038
Diseases of the respiratory system	665	616
Diseases of the digestive system	327	316
Diseases of the genito-urinary-system	35	10
Diseases of pregnancy, childbirth and the puerperium	7	6
Diseases of the skin and cellular tissue	2	2
Diseases of the bones and other organs of movement	4	11
Cogenital malformations	38	27
Diseases of early infancy	33	22
Symptoms, senility and ill-defined conditions	32	33
	6703	6684

TABLE No. 2b - TOTAL DEATHS BY AGE GROUP

AGE	NUMBER OF DEATHS	
	1959-60	1960-61
Stillborn	69	73
Under 1 month	81	86
Under 1 year	425	430
Under 15 years	348	336
Under 30	683	682
40	778	746
50	1233	1240
60	1746	1659
70	2023	2059
Over 70	3400	3514
Total	10786	10825

TABLE No. 3 - MOTOR VEHICLE FATALITIES

	1959-60	1960-61
Pedestrians	330	314
Vehicular Collisions	423	382
Non-collision Accidents	182	222
Total	935	918

TABLE No. 3a - MOTOR VEHICLE FATALITIES

Incidence of Alcohol (see next page)

TABLE No. 4 - HOME ACCIDENTS

	1959-60	1960-61
Burns and Explosions	90	136
Electrocutions	See Misc.	See Misc.
Falls	693	748
Firearms	17[3]	11[1]
Mechanical Asphyxia	48	27
Drowning	41[1]	45[2]
Miscellaneous	84	66
C. O.	41[2]	54[3]
Poisoning	72	59[4]
Violence of Undetermined Origin	See Misc.	See Misc.
Total	1086	1146

1959-60

1 Includes 20 children in private pools
2 Includes 4 gas heaters in closed rooms
3 Includes 6 accident or suicide undetermined

1960-61

1 Includes 2 accident or suicide undetermined
2 Includes 27 children in private pools
3 Includes 1 accident or suicide and 14 gas heaters
4 Includes 36 accident or suicide undetermined

TABLE No. 3a - INCIDENCE OF - ALCOHOL - AUTO ACCIDENTS

1959-1960

	Total	Number Tested	Negative	.01%-.04%	.05%-.09%	.10%-.15%	Above .15%	Per Cent of Cases .15% or Above
Drivers	422	324	167	14	22	31	90	27.7%
Pedestrians	330	175	115	4	8	7	41	23.4%
Passengers	183	120	72	3	13	15	17	14.2%

1960-1961

	Total	Number Tested	Negative	.01%-.04%	.05%-.09%	.10%-.15%	Above .15%	Per Cent of Cases .15% or Above
Drivers	399	299	170	9	13	22	85	28.5%
Pedestrians	314	172	111	4	4	8	45	26.1%
Passengers	205	114	75	4	14	8	13	11.4%

TABLE No. 3b - ALCOHOL IN RELATION TO
FATAL VEHICULAR ACCIDENTS OF DRIVERS AND PEDESTRIANS

Drivers	Total Cases	Number Tested	Number Above .15%	Per Cent	Number of .1% and up	Per Cent
1958-59	411	299	84	28.0	116	38.7%
1959-60	422	324	90	27.7	121	37.3%
1960-61	399	299	85	28.5	107	35.7%
Pedestrians						
1958-59	323	189	48	25.3	59	31.2%
1959-60	330	175	41	23.4	48	27.4%
1960-61	314	172	45	26.1	53	30.8%

TABLE No. 5 - OCCUPATIONAL ACCIDENTS

	1959-1960	1960-1961
Electrocution	5	6
Explosions	1	0
Falls	20	34
Machinery	3	2
Others	79	66
Total	108	108

TABLE No. 6 - OTHER ACCIDENTS

	1959-1960	1960-1961
Burns and Explosions	12	18
Drowning	57[1-2]	47[2]
Falls	402	412
C. O.	5[4]	4
Firearms	10	1
Mechanical Asphyxia	11	3
Miscellaneous	80	125
Poisoning	21[3]	10[1]
Total	598	620

1959-60

1 Includes 15 children in public pools
2 Includes 4 accident or suicide undetermined
3 Includes 3 accident or suicide undetermined
4 Includes 4 C.O. deaths - gas heater in closed room

1960-61

1 Includes 5 accident or suicide
2 Includes 2 children in public pools and 1 accident or suicide

TABLE No. 7 - SUICIDES

	1959-1960	1960-1961
Shooting	278	313
Poisoning (Barbiturates	283	263
Poisoning (Others	73	64
Jumping	37	28
Drowning	7	12
Hanging	144	102
Carbon Monoxide - Auto Exhaust	95	77
All Others	56	78
Total	973	937

TABLE No. 8 - HOMICIDES

	1959-1960	1960-1961
Assault	33	35
Poisoning	4	0
Shooting	157	166
Stabbing	46	55
Strangulation	21	23
All Others	21	17
Total	282	296

TABLE No. 9 - INCIDENCE OF ALCOHOL - HOMICIDE - SUICIDES

1959-1960

	Total	No Test	Negative	.01%-.04%	.05%-.09%	.10%-.15%	Above .15%	Per Cent of Cases .15% or Above
Homicide	282	67	103	10	15	23	64	22.7
Suicide	973	274	472	33	40	40	114	11.7

1960-1961

Homicide	296	64	129	3	16	25	59	20.0
Suicide	937	277	392	29	38	57	144	15.4

TABLE No. 10 - MISCELLANEOUS DATA

	1959-1960	1960-1961
Number of autopsies performed	4,818	4,351
Bodies embalmed for which fees were collected	~~3,198~~ 3495	3,433
Bodies processed at Coroner's Mortuary Hall of Justice	4,948	5,085
Miles traveled by Medical Examiners	85,527	87,489
Non-Coroner's cases (cases reported to Coroner and found not to be Coroner's cases but requiring notification be sent to Health Department.)	188	149
Number of Inquest Hearings[1]	349	299
Number of miles traveled by Coroner's vehicles to transport bodies	41,020	42,469
Miles traveled by Inquest Deputies, etc.	13,554	9,358

1 Statistics prior to 1959-60 included the number of person on whom inquests were held. Present statistics include actual number of hearings only.

TABLE No. 11 - LABORATORY TESTS

	1959-1960	1960-1961
Microscopic Examinations	18,149	13,866
Bacteriological Examinations	31	16
Cytology Examinations	209	182
Routine Tissues Filed (Hold Jars)	3,798	4,508
Special Tissue Stains	76	91
Total	22,263	18,663

TABLE No. 12 - PHOTOGRAPHY

	1959-1960	1960-1961
Number of Negatives Made and Processed	1,431	1,522
Number of Prints Made and Processed	2,664	3,123
Number of Color Slides Prepared	20	28
Number of Black and White Slides Prepared	64	38
X Ray	14	8
Enlargements	96	49
At Scene - program started July, 1960	None	441
Number of Micro-color Slides	11	39
Number of Micro-black and white Slides	1	0
Total	4,301	5,248

V. EXPENDITURES

	1959-1960	1960-1961
Salaries and Wages	$622,268.04	$634,111.44
Maintenance and Operation	53,935.61	52,705.48
Capital Outlay	2,952.69	8,987.93
Total	$679,156.34	$695,804.85

VI. REVENUES COLLECTED

General Fund:		
Embalming Fees	$ 87,357.52	$ 85,825.00
Sale of Documents	6,973.00	6,543.94
Total	$ 94,330.52	$ 92,368.94
General Fund:		
Witness Fees	$ 344.15	$ 394.40
Refund of Transportation	357.57	826.72
Total	$ 701.72	$ 1,221.12