1966–67, 1968–69

BIENNIAL REPORT

of the

CHIEF MEDICAL EXAMINER-CORONER

THOMAS T. NOGUCHI, M.D.

Chief Medical Examiner-Coroner

County of Los Angeles

COUNTY OF LOS ANGELES

BIENNIAL REPORT

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THOMAS T. NOGUCHI, M.D.

CHIEF MEDICAL EXAMINER-CORONER

FISCAL YEARS

JULY 1, 1966 - JUNE 30, 1967
JULY 1, 1968 - JUNE 30, 1969

BOARD OF SUPERVISORS

ERNEST E. DEBS, CHAIRMAN, 1968-1969

FRANK G. BONELLI
BURTON W. CHACE
WARREN M. DORN
KENNETH HAHN

LINDON S. HOLLINGER
CHIEF ADMINISTRATIVE OFFICER

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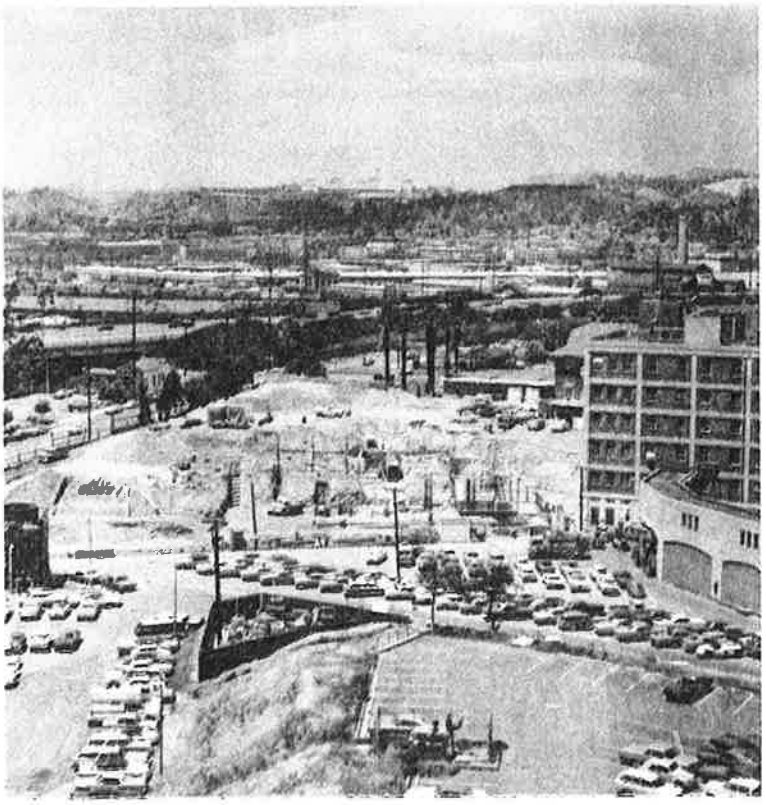
Dedication ceremonies of ground breaking of the new Chief Medical Examiner-Coroner's Building held on February 20, 1970



Photograph taken April 27, 1970 showing building construction

COUNTY OF LOS ANGELES
DEPARTMENT OF CHIEF MEDICAL EXAMINER-CORONER

HALL OF JUSTICE, LOS ANGELES, CALIFORNIA 90012
THOMAS T. NOGUCHI, M.D.
CHIEF MEDICAL EXAMINER-CORONER

Honorable Board of Supervisors
County of Los Angeles
Hall of Administration
500 West Temple Street
Los Angeles, California 90012

Gentlemen:

I hereby respectfully submit our Biennial Report, covering the period between the fiscal years 1967-1969.

I was appointed as the Chief Medical Examiner on December 19, 1967, and therefore was not in charge of this department during the entire Biennial period covered by this report.

During this period, many unexpected, unusual events occurred, including several catastrophic disasters.

- On May 14, 1968, a Los Angeles Airway helicopter crashed in Paramount, California, with a loss of 23 lives.
- On June 5, 1968, at 0014 hours, Senator Robert F. Kennedy was shot at the Ambassador Hotel and passed away the following day.
- On May 22, 1968, a second helicopter accident occurred in the City of Compton, with a loss of 21 lives.
- During the months of December, 1968 and January, 1969 there was an increased number of deaths from Hong Kong 'flu.
- On January 13, 1969, Scandanavian Airlines 707 crashed off Malibu, with a loss of 15 lives.
- Less than a week later, on January 18, 1969, United Airlines 727 crashed into the ocean off Redondo Beach, with a loss of 38 lives.

These tragic disasters added an enormous burden to the already overworked staff, but they responded magnificently. Personnel in my department worked day and night, and coordinated with all agencies in the necessary investigation.

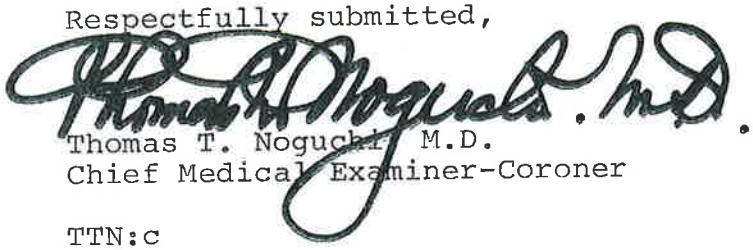
Aside from the in-service training program, since I became the Chief, a nationwide recruitment program was initiated to attract qualified pathologists to our forensic pathology training program. We are approved by the American Board of Pathology for six (6) pathologists each year. We have been successful in attracting a number of full time staff, but we feel a continuous recruitment program is necessary to maintain our staff because of the national shortage of certified forensic pathologists.

We are looking forward to completion of our new building in mid 1971. The greatly improved facilities offered by the new building will enable us to attract qualified personnel and give better service to the community.

Because this County is heavily populated and encompasses a large area, it is neither efficient nor economical to investigate coroner's cases from our central facility beyond the central Metropolitan district. It is our firm conviction that branch facilities should be established in outlying areas of the County. Long Beach is the location of the first branch office, established earlier this year.

We hope to continue to improve service to the people of the community by persistent effort in the area of good management, staffing, adapting up-to-date technology to our needs, and cooperation with various agencies.

Respectfully submitted,



Thomas T. Noguchi, M.D.
Chief Medical Examiner-Coroner

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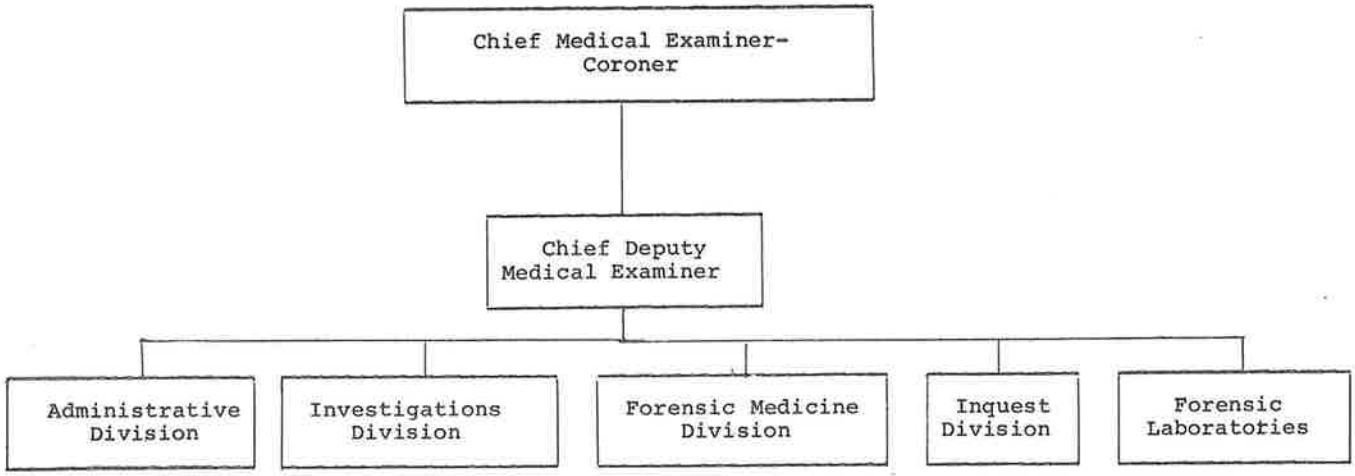

Chief Medical Examiner-
Coroner
Chief Deputy
Medical Examiner
Administrative
Division
Investigations
Division
Forensic Medicine
Division
Inquest
Division
Forensic
Laboratories

ORGANIZATIONAL STRUCTURE

During the 1966-67 fiscal year, management surveys were conducted which resulted in a reorganization of certain functional areas with this department.

Within the framework of this structure, this department expects to systemize procedures and controls to the end that more effective service can be offered the public. A systems concept will provide more effective information feedback and lead to the development of even better management tools.

FINANCIAL STATEMENT

Expenditure

	1966-67	1968-69
Salaries and employee benefits	$883,319.	$1,480,071.
Services and supplies	80,610.	105,352.
Fixed assets	14,014.	21,658.
	$977,943.	$1,607,081.

Income

	1966-67	1968-69
Embalming fees	$162,848.	$185,206.
Sale of documents	9,468.	10,862.
Witness fees	370.	465.
Transportation refunds	1,564.	2,354.
Autopsies*	--	1,088.
	$174,251.	$199,975.

*This is a new source of income due to change in Code which occurred in the 1967-68 fiscal year.

OFFICE OF THE CHIEF MEDICAL EXAMINER-CORONER

The Chief Medical Examiner-Coroner is responsible for investigating and determining the circumstances, manner and cause of all sudden, unexpected, or unusual deaths in the County of Los Angeles. During the fiscal years 1966-1967 and 1968-1969, there were 123,289 deaths recorded in Los Angeles County. Of these, 26,168 deaths, or 21.2 percent, were within the jurisdiction of the Chief Medical Examiner-Coroner and investigated by this office.

During this report period 11,458 deaths were investigated and handled in our central facilities located in the Hall of Justice. The remaining 14,710 deaths were handled at those private mortuaries who act as representatives of the Chief Medical Examiner-Coroner.

Table No. 1

NUMBER OF CASES INVESTIGATED

	1966-67	1968-69	Total
In central examining facilities	5,401	6,057	11,458
In other than central examining facilities	6,986	7,724	14,710
	12,387	13,781	26,168

With the increasing case load, and the complexity of modern pathological methods, this office finds it difficult to meet the minimal requirements of our responsibility to the citizens in Los Angeles County. Modern facilities are imperative if we are to fulfill our legal obligations in this sensitive area of public service.

REPORTABLE DEATHS TO THE CORONER

The Government Code of the State of California, Section 27491, directs the Coroner to inquire into and determine the circumstances, manner and cause of the following deaths which are immediately reportable to the Coroner:

1. Without medical attendance.
2. Wherein the deceased has not been attended by a physician within 10 days prior to death.
3. Where the attending physician is unable to state the cause of death.
4. Known or suspected homicides.
5. Known or suspected suicides.
6. Where the deceased died as a result of an accident.
7. Related to or following known or suspected self-induced or criminal abortion.
8. Therapeutic misadventures.
9. Accidental poisoning (food, chemical, drugs, therapeutic agents.)
10. Poison deaths.
11. Drowning, fire, hanging, gunshot, stabbing, cutting, strangulation, exposure, heat prostration, alcoholism, drug addiction, aspiration deaths, and suffocation.
12. Occupational diseases or occupational hazards.
13. Known or suspected contagious diseases constituting a public hazard.
14. All deaths of unattended persons.
15. Under such circumstances as to afford a reasonable ground to suspect that the death was caused by the criminal act of another.

MEDICAL DIVISION

Chief, Forensic Medicine Division

The Chief, Forensic Medicine Division, is responsible to the Chief Medical Examiner-Coroner for the Medical Division. Two medical service programs are conducted by this division; Forensic Autopsy Service and Forensic Medicine Education.

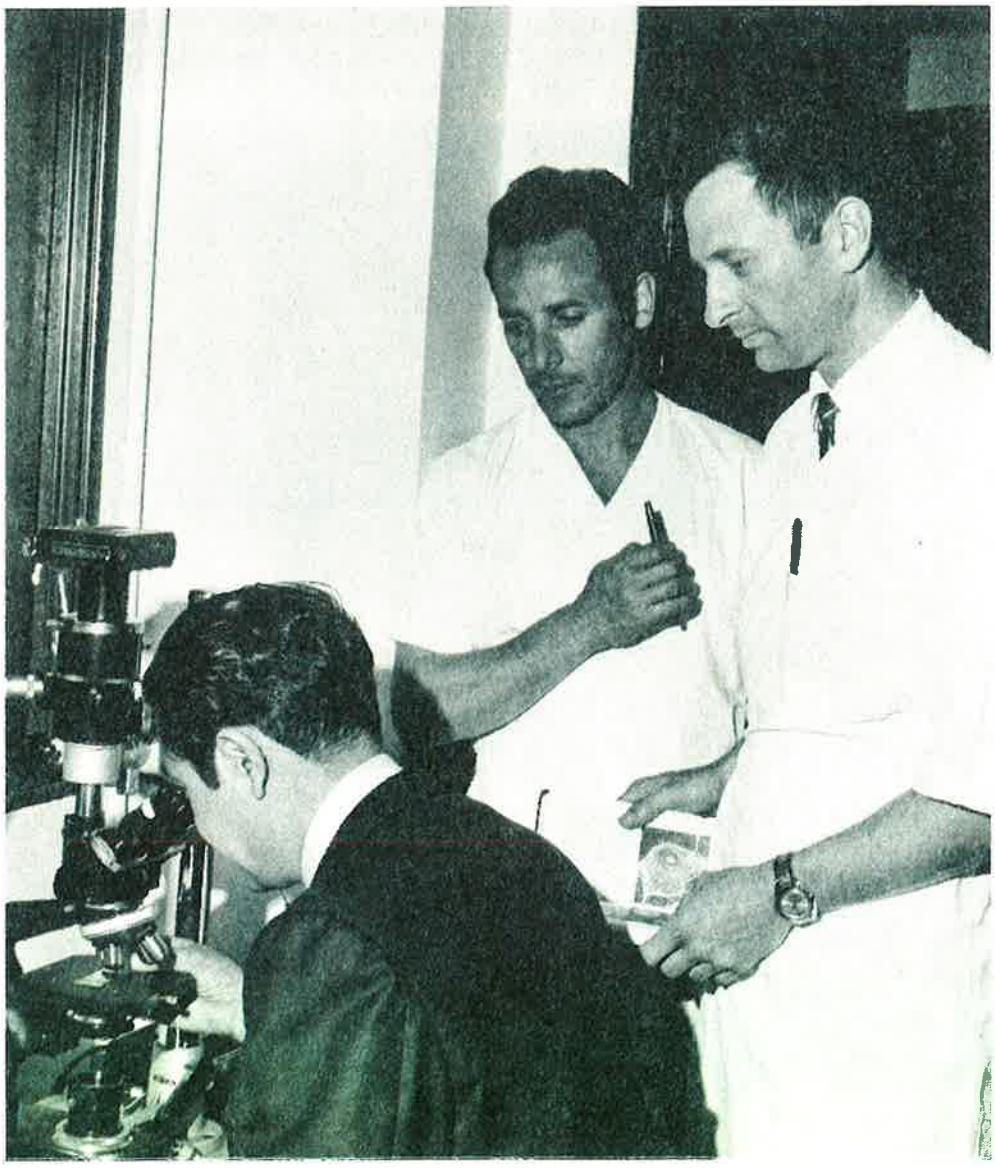
Forensic Autopsy Service

The post-mortem medical investigation is conducted by doctors of medicine in a specialized branch of pathology. The service rendered by the Deputy Medical Examiners can reveal facts which may direct attention to hazardous conditions of employment, the existence of disease or the commission of a crime. The post-mortem examinations are conducted in our Hall of Justice facility and at mortuaries who act as representatives for the Coroner.

Forensic Medicine Education

The Senior Deputy Medical Examiner on each shift is responsible for conducting a training program designed to acquaint new Deputy Medical Examiners with the methods and procedures of the Chief Medical Examiner-Coroner's Office.

This program will encompass a review of the gross autopsy findings in assigned cases, preparation of the medical report, the format of the autopsy protocol, and exposure to the other records relating to a coroner's case. This educational program utilizes specialists in related fields, such as neuropathologists, forensic toxicologists and human behavioral scientists.



ADMINISTRATIVE DEPUTY, CORONER

The Administrative Deputy, Coroner, is responsible to the Chief Medical Examiner-Coroner for the administrative functions with which this office is charged. Public information and non-medical liaison are responsibilities personally supervised by the Administrative Deputy. His other functional tasks are within three distinct areas of operational control; (1) The Administration Division, (2) the Inquest and Public Services Division, and (3) the Investigations Division.

ADMINISTRATION DIVISION

The Administration Division is responsible for financial planning, personnel, maintenance of the Chief Medical Examiner-Coroner's permanent records, payroll and accounting.

Also within the Administration Division, the Stenographic and Control Section provides secretarial service to the professional staff as well as maintaining files on approximately 13,000 cases annually.

INQUEST DIVISION

The Inquest Division, sets, prepares, conducts, reports and transcribes all formal inquests heard in Los Angeles County. Inquests are set at the initiation of the District Attorney, or concerned police agencies, where the circumstances surrounding a decedent's death raise some questions of doubt. The hearing is basically of a fact-finding nature, and is open to the public. Approximately three inquests are set each week.

At the present time, the formal inquest is conducted by a Hearing Officer who is an experienced attorney at law. At the conclusion of each hearing, the coroner's jury is instructed as to the law by the Hearing Officer and the coroner's jury then retires to deliberate and return its verdict in the matter. The coroner's jury consists of a least six jurors who are obtained from the regular Superior Court Jury Panel, by the Jury Commissioner. At the present time, the jury is empowered, among other things, to determine the mode by which the decedent came to his death.

All formal inquests are recorded by a reporter, and then transcribed. The transcribed original of the testimony at each inquest is then filed in the office of the County Clerk.

Interested parties are permitted to purchase copies of the inquest transcript, at a stipulated fee payable to the Medical-Examiner Coroner's office. The inquest division is required by law to provide copies of Inquest Transcripts gratis, to the District Attorney, concerned police agencies, the armed services and certain governmental departments.

PUBLIC SERVICES SECTION

The initial reports of death are received by this section and, after tape recording, the reports are processed in a manner designed to ascertain whether cases are within the jurisdiction of the Chief Medical Examiner-Coroner's Office.

Public Services responsibilities include notifying next of kin, assuming custody of personal property and the release of remains and property of deceased persons, preparation and issuance of death certificates and maintenance of statistical data.

INVESTIGATIONS DIVISION

This division is responsible for the investigative operation of the Chief Medical Examiner-Coroner's Office, operating out of the Hall of Justice and Long Beach. Its personnel work closely with all law enforcement and other governmental agencies in the on-the-scene medico-legal investigations of coroner's cases. This division also assumes custody of personal property found on the person of the deceased, transports or causes to be transported the cases coming under the Coroner's jurisdiction to the Hall of Justice or specified mortuaries.

In addition, the personnel of the Investigations Division assist the Deputy Medical Examiners during the different phases of their scientific examinations. Personnel also take at-the-scene photographs, photographs during examinations, x-rays and perform fluoroscopy examinations. Because of the medical examination without artifact, and because of the availability of scientific equipment and competent sources of consultation, deaths suspected to be due to homicide, narcotics, abortion, airplane or scuba diving accidents are investigated and processed at the Hall of Justice no matter where they happen within Los Angeles County.

During the fiscal years, 1966-1967 and 1968-1969, the Department profited by the benefits of the in-service training program in medical investigations which had been made available to the personnel of the division in the previous years. The training and specialized assignments resulted in the creation of a new investigative approach which resulted in the expansion and opening of a branch office in Long Beach, encompassing Long Beach, Signal Hill and North Long Beach. The branch office has greatly improved the service to the people of this area and it is hoped other branch offices will be authorized in the near future by the Board of Supervisors so the public in the entire County can benefit from this type of community-oriented service.

INVESTIGATIONS DIVISION ACTIVITIES

Table No. 2

Investigations Division

	1966-67	1968-69	Total
Number of bodies embalmed	3,728	4,242	7,970

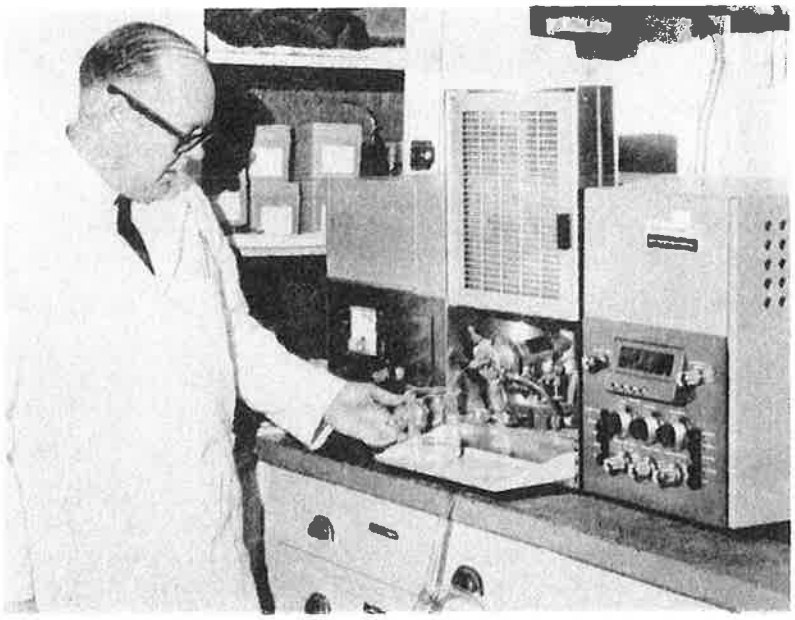
Table No. 3

Photography

	1966-67	1968-69	Total
Negatives made and processed	3,563	4,886	8,449
Black-and-white prints made and processed	7,177	9,823	17,000
Black-and-white slides	7	31	38
X-rays	457	398	855
Enlargements	42	39	81
At-scene prints	2,733	4,331	7,064
	13,979	19,508	33,487

DIRECTOR OF LABORATORIES

The Toxicology Laboratory is responsible for conducting qualitative and quantitative analyses on specimens submitted by the Deputy Medical Examiners to determine the presence or absence of poisons, drugs or other chemicals. It is also responsible for related duties such as interpretation of toxicological tests and testifying in court.



The purpose of toxicological tests is to assist the Deputy Medical Examiners in determining the cause of death, and in some instances, the mode of death. Many poisons, chemicals and drugs will have indeterminate or no pathological evidence of ingestion. In these cases, the sole physical evidence of a drug death may be a toxicological report. In addition to assisting in the determination of the cause of death, there are some chemical tests, notably blood alcohol determinations, which are extremely important in contributing to the mode of death. Criminal responsibility also may be determined by toxicological tests.

Since the consequence of the toxicological testing are of such a vital nature, it is mandatory that they be conducted by a fully professional staff, equipped with the necessary scientific equipment.

The testing procedures are far from routine due to difficulties of working with biological material and to an almost unlimited number of poisons which may be encountered by the toxicologist. Any of the medicines or their metabolities on the market today may be encountered by the toxicologist in a search for poisons. Biological material also contains substances closely resembling some of these drugs and poisons. The search for these materials and interpretation of findings are what constitutes the field of forensic toxicology. Because of the unique nature of this field, it is necessary that the staff maintain communication with the relatively few other toxicologists in the world, both through professional societies and published papers.

The following are a few illustrative cases in which a toxicological report was vital:

1. Case of accidental poisoning of juvenile.

   A boy, 13 years old, passed out at a juvenile party where the children had been inflating balloons with the contents of aeresol preparation in order to get "kicks". A fire rescue unit was unable to resuscitate the child, and he was pronounced dead. Extensive laboratory tests showed the presence in the blood and the lung of significant amounts of Freon 11 and Freon 12. This was not a unique case since we have encountered, in the last two years, more than a dozen Freon deaths.

2. A narcotic death.

   Many deaths are caused by overdosages of morphine. Some are suicides, and a number of these are accidental. Accidental poisonings are caused by a combination of alcohol and narcotics.

   A young man was found dead, and no cause of death could be determined at autopsy. Blood alcohol level was found to be .21 percent. Morphine could not be detected in the liver, bile and urine. Traces of morphine were detected in the blood. This indicated that death occurred shortly after injection of morphine. This amount of morphine may not have been fatal under ordinary circumstances, but in combination with the amount of alcohol in the blood, it constituted the cause of death.

It took three and one-half weeks of thorough analysis on a number of specimens before this case could be completed successfully.

3. Criminal liability.

A person was charged with committing murder by injecting insulin in his victim. The victim has taken a barbiturate earlier and a slight amount of barbiturate was shown in the blood. It was contended in court that the barbiturate could have been the cause of death. The Toxicologist from this department testified that the amount of barbiturate detected in the blood could not be considered toxic enough to cause death.

These cases were selected to illustrate a few of the ways a toxicological report can be of value, not only to the citizens of the community, but to the survivors of the deceased from an economic, social or legal standpoint. The relatively modest investment of the taxpaper's money for these services continues to be one of the best bargains available in government today.

IMMEDIATE CAUSES OF DEATH DETERMINED BY LABORATORY TEST

Table No. 4

1966-67

Type of Test	Total Tests	Total Number of Cases Certified	Percent of Total Cases Tested
Alcohol	4,630	33	.07%
Barbiturates	892	335	37.6%
Carbon monoxide	302	115	38.1%
Narcotics	235	117	49.8%
Poisons	821	85	10.4%
	6,880	685	10.1%

Table No. 5

1968-69

Type of Test	Total Tests	Total Number of Cases Certified	Percent of Total Cases Tested
Alcohol	9,325	1,840	32.6%
Barbiturates	3,052	950	45.2%
Carbon monoxide	343	207	62.1%
Narcotics	840	205	62.1%
Poisons	1,363	281	20.6%
	14,923	3,443	23.1%

HISTOPATHOLOGY LABORATORY

This laboratory has the responsibility of processing and preparing microscopic slides, as requested by the Deputy Medical Examiners.

Table No. 6

HISTOPATHOLOGY LABORATORY SERVICES

	1966-67	1968-69	Total
Microscopic examinations	17,933	24,001	41,934
Special tissue stains	225	630	855
Routine tissues filed (hold jars)	5,748	6,701	12,449
	23,906	31,332	55,238

Our laboratory is concerned primarily with the histology of tissue from victims of trauma or disease. Microscopic studies are invaluable to our Deputy Medical Examiners in the determination of causes of death.

FORENSIC BIOLOGY LABORATORY

This laboratory is responsible for conducting bacteriological studies. Studies may or may not indicate the presence of communicable disease in specimen samples from deceased persons. The discovery of the presence of these diseases may contribute effectively to the early control of possible epidemics.

All laboratories contribute to the Deputy Medical Examiner's investigation into the cause of death. As the science of pathology continues to develop, the laboratory function becomes increasingly more important.

S T A T I S T I C S

Table No. 7

MANNER OF DEATH - MEDICAL EXAMINER CASES

1966-1967

MANNER OF DEATH	TOTAL CASES	PERCENT OF TOTAL	TOTAL CASES	PERCENT OF TOTAL
Natural Causes *	7,342	59.3	8,051	58.3
Home Accidents **	1.061	8.5	1,319	9.6
Vehicular Accidents	1,218	9.8	1,306	9.6
Suicides	1,197	9.7	1,113	8.0
Homicides	503	4.1	683	5.0
Other Accidents **	687	5.5	878	6.3
Industrial accidents	134	1.1	124	.8
Aircraft accidents	23	.2	63	.4
Railway accidents **	8	.1	4	.1
Misc. Accidents **				
Accident-Suicide				
Accident-Homicide				
Unspecified	211	1.7	240	1.9
TOTAL	12,384	100.0	13,781	100.0

* including symptoms of senility and ill-defined conditions shown in the table - as marked *, stillborns and undetermined-natural.

** Undetermined deaths as to mode from other accidents and home accidents as marked.

Table No. 8

AUTOPSIES PERFORMED AND MANNER OF DEATH

MANNER OF DEATH	1966-67 Total Cases	1966-67 Autopsies Performed	1966-67 Percent of of Cases Autopsied		1968-69 Total Cases	1968-69 Autopsies Performed	1968-69 Percent of Cases Autopsied
Natural causes	7,342	2,084	28.3		8,051	1,673	20.8
Home accidents	1,206	375	31.1		1,484	766	51.0
Vehicular accidents	1,218	1,088	89.2		1,306	1,075	82.3
Suicides	1,197	552	46.2		1,113	473	42.5
Other accidents	753	219	29.1		953	470	49.3
Industrial Accidents	134	118	88.1		124	115	93.0
Homicides	503	460	91.2	*	683	679	99.4
Aircraft Accidents	23	23	100.0	**	63	41	65.9
Railway Accidents	8	4	50.0		4	4	100.0
TOTAL	12,384	4,923	39.8		13,781	5,296	39.0

* Homicides not autopsied were homicide-suicide cases.

** Pilots autopsied in each accident.

Table No. 9

DEATHS FROM NATURAL CAUSES - IN MAJOR GROUPS
INTERNATIONAL WORLD HEALTH CODE

	1966-1967		1968-1969	
	TOTAL CASES	PERCENT OF TOTAL	TOTAL CASES	PERCENT OF TOTAL
Infective and parasitic diseases	55	0.8	33	0.7
Neoplasm-cancer-tumors	147	2.0	182	2.4
Allergic, endocrine, metabolic and nutritional disease	26	0.3	61	0.9
Diseases of the blood and blood-forming organs.	6	0.1	10	0.1
Mental, psychoneurotic and personality disorders.	47	0.5	317	4.0
Diseases of the nervous system and sense organs.	235	3.4	225	3.0
Diseases of the circulatory system	5,422	74.0	6,045	74.0
Diseases of the respiratory system	600	8.2	596	7.4
Diseases of the digestive system.	557	7.5	378	5.0
Diseases of the genitourinary system.	21	0.3	16	0.2
Diseases of pregnancy, childbirth and the puerperium.	2	0.1	8	0.1

Table No. 9

	TOTAL CASES	PERCENT OF TOTAL	TOTAL CASES	PERCENT OF TOTAL
Diseases of the bones and other organs of movement.	2	0.1	6	0.1
Congenital malformation.	20	0.2	48	0.6
Diseases of early infancy, prematurity.	52	0.7	31	0.4
Symptoms, senility and ill-defined conditions	87	1.0	39	0.5
Stillbirths	63	0.8	50	0.7
Diseases of the skin and cellular tissue.			6	0.1
TOTAL	7,342	100.0	8,051	100.0

Table No. 10

OCCUPATIONAL ACCIDENTS

TYPE OF ACCIDENT	1966-67	1968-69	TOTAL
Drowning	3	1	4
Crushing	7	5	12
Falls	38	31	69
Caught in machinery	15	24	39
Electrocutions	6	15	21
Burns	29	18	47
Miscellaneous	35	26	61
Carbon Monoxide	1	4	5
TOTAL	134	124	258

Table No. 11

HOME ACCIDENTS-TYPE OF ACCIDENT

TYPE OF ACCIDENT	1966-67	1968-69	TOTAL	
Electrocution	8	4	12	
Barbiturates	-	159	159	**
Suffocation	23	31	54	
Burns	172	144	316	
Firearms	16	32	48	
Drowning	78	82	160	
Poisons	41	98	139	
Carbon monoxide *	-	84	84	**
Crushing	7	5	12	
Narcotics	-	96	96	**
Plastics	5	9	14	
Miscellaneous	55	90	145	
TOTALS	1,061	1,484	2,545	

* New classification started since 1968

** Total only for 196-69.

Table No. 12

VEHICULAR ACCIDENTS - TYPE OF ACCIDENT

TYPE OF ACCIDENT	1966-67 TOTAL CASES	1966-67 PERCENT OF TOTAL	1968-69 TOTAL CASES	1968-69 PERCENT OF TOTAL
Pedestrian - truck	36	3.0	26	1.9
Pedestrian - auto	357	29.0	370	28.4
Pedestrian - motorcycle	-	-	1	.1
Pedestrian - bus	11	1.0	4	.1
Pedestrian - Motor scooter	-	-	11	.1
Auto - auto	309	25.4	319	25.2
Auto - bus	1	-	2	.1
Auto - truck	50	4.1	82	6.4
Auto - train	15	1.2	11	.1
Auto - motorcycle	44	3.6	66	5.8
Auto - overturned	15	1.3	45	3.5
Auto - fixed object	193	16.0	196	15.7
Auto off roadway	79	6.5	60	4.7
Fell of moving vehicle	4	.3	10	.1
Motorcycle - fixed object	24	2.0	37	2.0
Miscellaneous	80	6.6	66	5.8
TOTAL	1,218	100.0	1,306	100.0

Table No. 13

OTHER FATAL ACCIDENTS

TYPE OF ACCIDENT	1966-67	1968-69	TOTAL	s *
Barbiturates *	-	46	46	**
Suffocation	2	16	18	
Burns	25	27	52	
Firearms	8	16	24	
Drowning	37	55	92	
Falls	514	495	1,009	
Poisons	7	34	41	
Carbon monoxide	2	12	14	
Crushing	2	6	8	
Narcotics *	-	108	108	**
Theraputic accidents	68	40	108	
Miscellaneous	22	98	120	
TOTAL	687	953	1,640	

* New classification started since 1968.

** Totals only for 1968-69.

Table No. 14

SUICIDES

MANNER	1966-67	1968-69	TOTAL
Vehicles	1	0	1
Firearms	426	348	774
Hanging	96	105	201
Carbon monoxide	95	63	158
Jumping	42	32	74
Barbiturates	315	386	701
Poisons - all others	144	116	260
Sharp instruments	29	25	54
Drowning	1	8	9
Suffocation - Plastic bag	23	12	35
Burns	22	7	29
Miscellaneous	3	10	13
Narcotics	-	1	1
TOTAL	1, 197	1,113	2,310

Table No. 15

HOMICIDES

MANNER	1966-67	1968-69	TOTAL
Firearms	291	402	693
Sharp instruments	87	135	222
Blunt instrument	12	41	53
Strangulation	27	24	51
Assault	73	42	115
Criminal abortions	3	1	4
Miscellaneous	13	15	28
Battered child Syndrome		13	13 **
Suffocation		2	2 **
Vehicle *		1	1 **
Decapitation *		3	3 **
Burns *		4	4 **
TOTAL	506	683	1, 189

* New classification started since 1968.

** Total only for 1968-69.

Table No. 16

DEATHS CAUSED OR CONTRIBUTED TO BY ALCOHOLISM

CLASSIFICATION	1966-67	1968-69	TOTAL
Acute alcoholism	31	50	81
Chronic alcoholism	9	307	316
Cirrhosis and fatty liver	321	328	649
Homicides	157	207	364
Suicides	254	231	485
Home accidents	343	228	571
Other accidents	34	125	159
Vehicle accidents	287	311	598
Industrial accidents	3	7	10
Airplane accidents	-	2	2
Railway accidents	3	-	3
TOTAL	1,442	1,796	3,238

Table No. 17

INCIDENCE OF ALCOHOLISM IN HOMICIDES

SUICIDES AND ACCIDENTS

1966-1967

MANNER	TOTAL CASES	ABSENT	0.01-0.04	0.05-0.09	0.10-0.14	0.15- & UP	PERCENT INCIDENCE ALCOHOLISM
Homicides	503	296	17	33	34	123	41.2
Suicides	1,197	838	50	55	67	187	29.9
Home Accidents	1,061	621	30	67	61	282	41.5
Other Fatal Accidents	687	641	6	6	4	30	6.7
Vehicular Accidents	1,218	863	23	45	52	235	20.9
Pedestrians	467	378	2	6	10	71	19.0
Passengers	243	166	16	19	13	29	27.6
Drivers	501	302	15	20	29	135	39.7

Table No. 18

1968-1969

MANNER	TOTAL CASES	ABSENT	0.01-0.04	0.05-0.09	0.10-0.14	0.15- & UP	PERCENT INCIDENCE ALCOHOLISM
Homicides	683	314	28	34	47	126	30.3
Suicides	1,113	700	47	61	53	117	20.9
Home Accidents	1,484	312	19	36	37	155	15.4
Other Accidents	953	209	16	25	17	83	13.1
Vehicular Accidents	1,306	565	42	52	65	194	23.9
Pedestrians	403	156	7	6	14	43	10.7
Passengers	256	123	12	14	9	31	21.1
Drivers	635	283	13	31	40	118	29.6
Unknown drivers or Passengers	12	3	-	-	2	2	41.7

Table No. 19

DEATHS BY AGE GROUPS

1966-1967

AGE GROUPS	NATURAL	ACCIDENT	SUICIDE	HOMICIDE	TOTAL
Stillbirths	63				63
Under 1 month	66	6		3	75
1 Month to 1 Year	348	35		11	394
1 to 14 Years	91	325	4	27	447
15 to 29 Years	145	555	216	181	1,097
30 to 39 Years	266	295	186	122	869
40 to 49 Years	841	333	273	73	1,520
50 to 59 Years	1,528	325	253	52	2,158
60 to 69 Years	1,704	310	141	15	2,170
70 to 79 Years	2,283	1,152	124	20	3,579
100 Years and Over	2	5			7
Age Unknown	5	1		2	8
TOTAL	7,342	3,342	1,197	506	12,387

Table No. 20

DEATHS BY AGE GROUPS

1968-1969

AGE GROUPS	NATURAL	ACCIDENT	SUICIDE	HOMICIDE	TOTAL
Stillbirths	50				50
Less than 1 Month	83	6			89
1 Month to 1 Year	320	69		5	394
1 Year to 14 Years	56	313	4	29	402
15 Years to 19 Years	38	273	60	68	439
20 Years to 29 Years	127	648	192	196	1,163
30 Years to 39 Years	291	362	161	128	942
40 Years to 49 Years	1,036	365	220	105	1,726
50 Years to 59 Years	1,656	379	215	62	2,312
60 Years to 69 Years	1,852	330	148	27	2,357
Over 70 Years	2,542	1,189	113	63	3,907
TOTAL	8,051	3,934	1,113	683	13,781