Lying-in Transition:
The Modernization and Professionalization of Childbirth in Rural Alabama 1870-1910

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Introduction

The idea of childbirth evokes a multitude of feelings. Typically, it is excitement for a new life, family member, or adventure. But childbirth comes with risks to both mother and infant. It is essential to acknowledge that risk and mitigate it. Risk reduction can be accomplished with various methods; perhaps the parturient gives birth in a hospital or has an experienced obstetrician present; however, that was not always possible throughout history. The modernization and professionalization of childbirth are relatively new as far as history is concerned. Birthing rooms, attendants, and medical interventions all began to modernize in the late nineteenth-century. This dissertation examines the changes in modernization and professionalization of childbirth in rural Alabama from 1870-1910 as it shifted from midwives attending home births to physicians providing medical care within a hospital.

It is essential to address the rationale that led this dissertation to specific regions- Dallas, Greene, Hale, Sumter, and Marengo Counties, Alabama- though what I found was unexpected and drastically changed the final product. My research to write this dissertation comes from a personal quest for answers. After the birth of my second child, I went into (PPCM) postpartum cardiomyopathy, a form of hormone-induced heart failure that can occur during pregnancy—referred to as peripartum—or up to six months after a baby's delivery. The likelihood of the general public knowing of it is slim, as it is not commonly discussed. I learned about it while holding a newborn in the Emergency Room, worrying about a toddler at home, and not understanding what “heart failure” meant. Fortunately, my definition of heart failure was wrong-

I was sure my heart would stop at any moment. At the risk of oversimplifying the term, heart failure indicates that the heart is not working correctly- in my case, not pumping to its full ability.

Nevertheless, I will spare the heartbreaking details of the ordeal and focus only on the positive outcome- I completely recovered. Unfortunately, not every PPCM patient is as fortunate as I am to be a survivor. As lucky as I am after the birth of my second child, I have neglected to note the allegedly eradicated condition that almost ended my life after my first child was born.

As I overcame a second issue, one which I was unaware of as being a deadly risk of childbirth, I began to ask questions about the history of childbirth. How did women survive before the modernization of medicine? The answer I found was that many women did not survive or were altered/scarred afterward. It was simpler than I had expected and written about in great detail; thus, it would not make for a good dissertation. As I searched further, I learned that the modernization and professionalization of childbirth largely occurred around the same time, so as medical schools grew, science advanced, and reformers pushed for change. As I began to connect these dots, I searched for a location that would narrow the scope of my research. It was my outstanding dissertation advisor who suggested examining Alabama. I am grateful for that suggestion because Alabama's unique social, economic, and political structure influenced fascinating changes within this topic. Thus, the quest to analyze the impacts of the modernization and professionalization of childbirth in Alabama from 1870-1910 began.

This dissertation will argue that the reason for the professionalization of childbirth was due to the growing demand by women for safer birthing conditions that developed around the evolving relationship between social status, race and ethnicity, and regional location distinctions,

which were made possible by the modernization of medicine and the professionalization of tocology available during the nineteenth- and twentieth-centuries in America.

Historical Significance

Dangers are always present during childbirth; however, a qualified birth attendant can reduce them. A birth attendant is someone present at the time a parturient undergoes labor and delivery. Training and preparedness to manage any situation is critical to ensure a safe delivery for both mother and child. Today, most people take for granted the relatively low mortality rate that modern medicine affords. According to the Centers for Disease Control and Prevention,

> Maternal death is defined by the World Health Organization as the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, by not from accidental or incidental causes. [1]

The maternal death rate for women in the United States in 2021 was "32.9 deaths per 100,000 live births." Donna Hoyert continues to break down the death rate by ethnicity, which is critical to this examination because in rural Jim Crow Alabama, race was a crucial factor in medical care. In 2021, "the maternal mortality rate for non-Hispanic Black (subsequently, Black) women was 69.9 deaths per 100,000 live births, 2.6 times the rate for non-Hispanic White (subsequently, White) women (26.6)."[2] This statistic is fascinating because there are shocking claims that Blacks were dying at twice the rate of Whites from 1870-1910, which prompted cries for reform; however, in 2021, the rate is higher. Even though the population is larger, as with the 1880

[1] Donna L. Hoyert, "Maternal Mortality Rates in the United States, 2021," *Health E-Stats: National Center for Health Statistics* (March 2023): 1.

[2] Hoyert, "Maternal Mortality Rates," 1.

census, the ratio is directly proportionate to the population. Thus, it raises the question of how the modernization and professionalization of childbirth made it safer for women and infants when the statistics are worse.

It was during the late nineteenth- and early twentieth- century in America that childbirth attendants professionalized from nonacademically-educated and unregulated midwifery to academically-trained and state-licensed obstetrics, which evolved out of a complex relationship to ideally improve the lives of patients and the socioeconomic status of the medical practitioners. Physicians in America replaced midwives, and formal training began modernizing birth. Women began birthing in hospitals rather than at home. The turn of the century would usher in the modern medical practice of tocology.

Accompanying the modernization of medicine and the professionalization of tocology was the social, racial, and regional distinction between groups of women and their treatment at parturition. The evolution of technology in America's North developed more rapidly than that of the South; thus, women in the North had greater access to the most modernized medical practices available within the United States. Wealthy White women typically had more comforts regarding childbirth; they dictated who was present at their delivery and who would administer rudimentary pain management. The options were limited and largely unsafe by today's standard, but middle- and upper-class groups of White women had unsophisticated available options.

On the other hand, lower-class Whites and minorities were often limited in controlling who was present at childbirth. The lack of control was not due to the misconception that controlling patriarchy dictated their birth attendants. Instead, it was due to a lack of options. Poor women in the North were increasingly ushered into what was known as a lying-in hospital. The term lying-in refers to a room where a woman gives birth; thus, a lying-in hospital was dedicated

to childbirth. These hospitals were notorious for their unsanitary conditions and gained a reputation as a death sentence for mothers. In the South, childbirth generally occurred within the home with a midwife birth attendant or a physician if available and only if the patient could afford the service.

The nineteenth-century is celebrated for the technological advances that accompanied the Industrial Revolution; medical advances during this period would alter the future of the field. While this era was not the first to recognize the need for the professionalization of obstetrics, it was the first era with enough potential to make medical advances possible due to the great strides in technology, industry, and education. The practice of obstetrics was in its medical infancy despite midwifery being a common practice.

Midwifery was present in America long before America gained its independence. As with many historical biases, this dissertation takes on a Eurocentricity, presenting a brief history of midwifery in the American Colonies. Due to the nature of this project, the influences of native cultures have little impact on the overall analysis of the modernization and professionalization of childbirth. However, excluding this brief history as background and supporting information that is critical to the readers' understanding would be neglectful. Before the late eighteenth- century in the American Colonies, all midwives in the colonies were trained through apprenticeships or informal education. Midwives passed down their knowledge through the generations. The older generations taught the newcomers the importance of having an assistant during childbirth. Many of the rituals and tonics used by nineteenth-century midwives were established during this period.

The importance of birth attendants is vital to a safe delivery due to the anatomy of women, and the path the infant follows while exiting the birth canal makes it unsafe to give birth

alone. To be clear, when an infant moves through the birth canal, it faces the opposite direction of the mother, thus making it extremely difficult and dangerous for the laboring mother to assist in her own delivery. To effectively catch the baby, the laboring mother would have to bend forward at the waist during a contraction, reach over her large stomach, and retrieve the newborn. Of course, this is not impossible, but it is challenging and comes with risks, such as dropping the baby. The dangers presented due to the pelvic anatomy, coupled with the about-facing birth descent from the canal, generated fear and anxiety that caused early women to seek the assistance of other women during birth. The presence of a birth assistant helped to decrease mortality rates; a highly skilled assistant decreased those rates even further.[3]

In addition to needing help due to the physical challenges of childbirth, the childbirth attendant was a social role of women. This social role of childbirth extended beyond culture and time. According to historians Karne Rosenberg and Wenda Trevathan, a knowledgeable woman was designated as a birth attendant at some point in the ancient world, and she began passing down her knowledge to generations of women. While the presence of an aide made birth safer, the lack of knowledge in health, hygiene, and disease continued to make delivery dangerous. It would not be until decades later that germ theory will clarify sterilization's importance. Furthermore, fear and anxiety were common among expecting mothers, and this is evident within the text of the Bible, Genesis 35:17, where the first recorded words of a midwife said, "Fear not." This utterance was intended to help soothe the frightened parturient as she underwent the most painful of life experiences without modern pain relief (not that modern pain relief methods are always effective). During this era, midwives had little medicine to offer the

[3] Genesis 35:17.; Karen Rosenberg and Wenda Trevathan, "Birth, Obstetrics and Human Evolution." *BJOG: An International Journal of Obstetrics and Gynecology* 109, no. 11 (2002): 1205-1206.

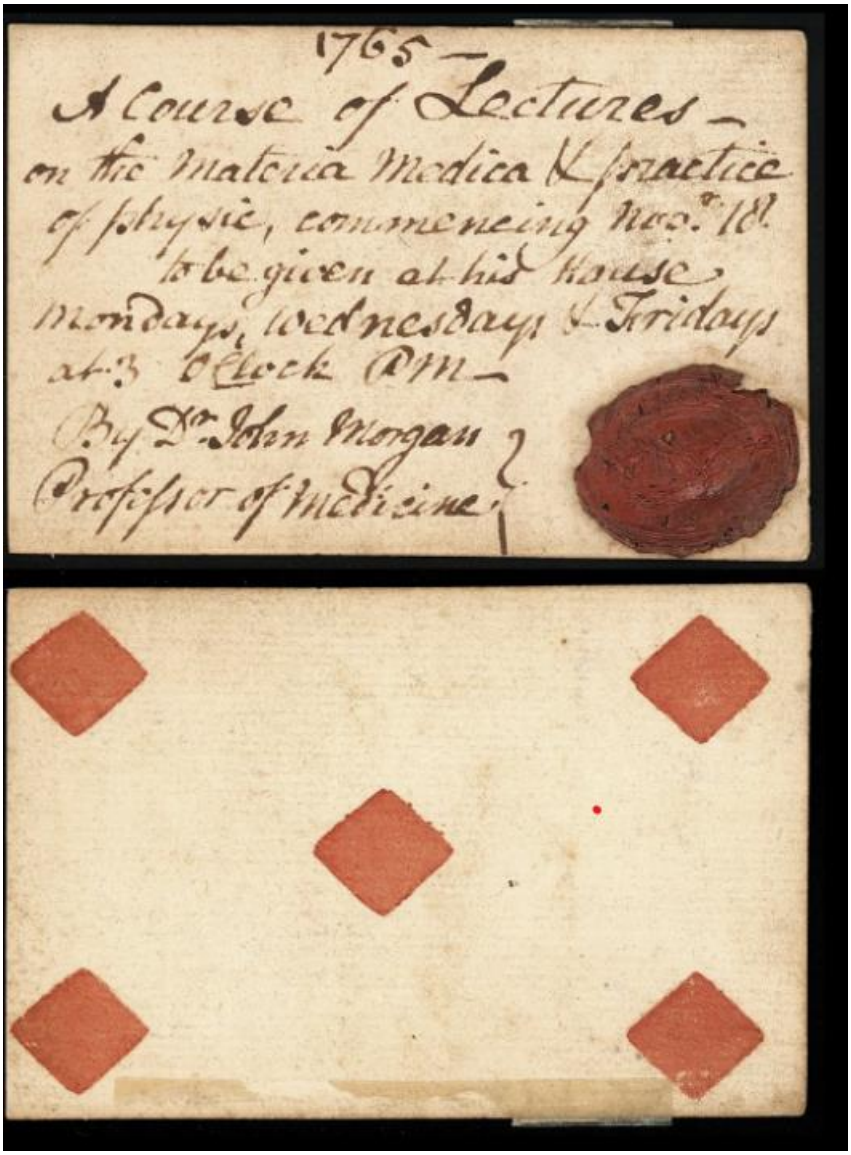
expectant mother besides herbal tonics, balms, prayers, and encouragement. While it is unclear exactly when women took on the role of childbirth assistant in human history, evidence displays when women began to be formally educated as midwives. It was not until 1765 that the first medical school would be established in Philadelphia, Pennsylvania. Both men and women were formally trained at this institution; men were trained as physicians, while women received training in midwifery.[4]

In the late eighteenth-century in the American Colonies, the first school providing training and development of midwives was organized. Doctor William Shippen introduced the School for the Physick in Philadelphia in 1762. Shippen's medical origin is a tale of self-education. He studied medicine without the guidance of a mentoring physician or a structured set of courses. Once he felt he had acquired enough medical knowledge, he opened an extensive practice, working as a physician at Pennsylvania Hospital from 1753 to 1778. Shippen had a very successful career in the medical field, even assisting in establishing several prominent institutions such as the Academy and College of Philadelphia and the College of New Jersey. The curriculum of the School for the Physick originated from his time in Great Britain, where he learned that through the teachings of anatomy and the practice of midwifery, medical education was possible in a hospital-based approach. Imagine a colonial *Grey's Anatomy*, where students learn and practice alongside veteran physicians. However, a hospital-based approach would not be as successful in the colonies, where a college had more prestige and political power than a hospital. It was not until John Morgan took Shippen's plans to the Board of Trustees of the

[4] Mary C. Brucker, "Midwifery in American Institutes of Higher Education: Women's Work, Vocations and the 21st Century," *Forum on Public Policy* (2009): 0-1. Mary C. Brucker CNM, Ph.D., FACNM works at Baylor University, the Louise Herrington School of Nursing in Dallas Texas as a professor and Director of Graduate Programs.

College of Philadelphia that the college was established in 1765. Morgan was a classically trained physician who received his education from the College of Philadelphia and studied under Doctor John Redman, renowned for teaching many prominent physicians. In addition to founding the American colonies' first medical school, Morgan offered lectures on anatomy and obstetrics in Philadelphia. [5]

[5] "William Shippen: 1712-1801." University Archives & Records Center. Penn Libraries: the University of Pennsylvania, accessed July 22, 2022, https://archives.upenn.edu/exhibits/penn-people/biography/william-shippen/ ; Elan Daniel Louis, "William Shippen's Unsuccessful Attempt to Establish the First 'School for Physick' in the American Colonies in 1762," *Journal of the History of Medicine and Allied Sciences* 44, no. 2 (1989): 239.; "John Morgan: 1735-1789," University Archives & Records Center. Penn Libraries: the University of Pennsylvania, accessed July 22, 2022, https://archives.upenn.edu/exhibits/penn-people/biography/john-morgan/; "Admission Ticket, John Morgan's Lectures on Materia medica and Practice of Physic," Digital Images, Place: UPA 3, Archives General Collection, Box 1, 1765, https://library.artstor.org/asset/SS7732016_7732016_12330752 ; an ABC Studios production ; Shondaland ; created by Shonda Rhimes. *Grey's Anatomy*. Burbank, Calif. :Distributed by Buena Vista Home Entertainment, 2005.



Chapter 1: Figure 1- Admission Ticket[6]

The image above is an admission ticket to one of Dr. John Morgan's lectures on medicine and medical practices (Chapter 1: Figure 1- Admission ticket). Lectures on medicine were presented with regularity to help educate fellow physicians. The lectures were to begin on

[6] "Admission Ticket, John Morgan's Lectures on Materia medica and Practice of Physic," Digital Images, Place: UPA 3, Archives General Collection, Box 1, 1765.

November 18th at the doctor's residence, where he would present multiple sessions on various subjects covered under the "materia medicia & practice of physic" title.[7]

Despite the founding of the School for the Physick and the availability of lectures, education had a variety of limitations. Access to education in midwifery was no exception. One of the constraints that affected a large portion of the population was the school's location. Midwives in the North had greater access to the School for the Physick because they were closer to the school, while midwives in the South were limited in their ability to travel and attend. Another limitation was socio-economic status. Not everyone could afford the costs of medical training. Women still gave birth across the United States; thus, due to geographical and socio-economic constraints on education, southern midwives learned through apprenticeship.

This brief introduction to the medical history of midwifery is intended to illustrate the field's evolution. Midwifery evolves very gradually, and then all at once it appears. The industrial, communication, and technological revolutions seemingly advanced thousands of years of slow progress overnight. Medicine evolved in a historical instant; however, the human element that resists change pushed back. Midwives will not give up their positions without a fight, physicians will not enter the lying-in rooms without nervous anticipation, and politics will assert dominance. This intertwining, complex relationship among patient, birth assistant, and formal regulation will not only modernize childbirth, but it will also thrust the action into the professional realm faster than ever before.

Methodology

[7] "Admission Ticket, John Morgan's Lectures."

To thoroughly analyze the impacts of the professionalization and modernization of childbirth in rural Alabama, a variety of sources were utilized. Luckily, since the COVID pandemic, many archived resources have become available online. The methodological approach that will be used to support this dissertation includes statistical data, diaries, letters, medical journal publications, and books. A preconceived notion that I possessed at the beginning of this project was that only middle and upper-class women had control over their birth attendants. This was a modern connotation assuming that women had a choice in birth attendant. Women had access to only what was available. Yes, women could choose from the available options; however, many had only one choice.

Looking specifically at the South, women's control of labor and delivery is distinctive in a period when women were largely excluded from advancement; women were excluded from formal education, political engagement, and professional careers. By studying the importance of women as they pertain to the professionalization of tocology and the modernization of medicine, historians can gain better knowledge of the long-term benefits acquired in different regions, ethnic groups, and classes of social status. Obstetrics offered a unique professional opportunity to women that they would seek to take advantage of in the coming years.

Scholars have illuminated the importance of women in the history of tocology. Women desired more control over their birthing experience; to accomplish this, women required more education on their anatomical processes relative to reproduction. The greater need for education is evident in the medical pamphlet published by William Buchan, *Advice to Mothers, on the Subject of Their Own health, and the Means of Promoting the Health, Strength, and Beauty of Their Offspring* (1804). This pamphlet helps illustrate the cultural awareness to improve birthing conditions and advance hygienic practices. Educational texts are critical to understanding the

relationship between societal knowledge and the modernization of medicine. Safe pain management evolved throughout the latter part of the nineteenth-century, early sources on pain management were presented in William P. Dewee's *An Essay on the Means of Lessening Pain and Facilitating Certain Cases of Difficult Parturition* (1860). Throughout this text, birth attendants are offered advice on pain control methods and how to manage problems that may arise during delivery.[8]

Interestingly, many of these sources began as diaries and were later published as crude "how-to" manuals for those attempting to deliver a child without a practiced birth attendant present. John C. Gunn's *Domestic Medicine or Poor Man's Friend* (1838) is an example of this. Through the analysis of such sources, this dissertation will argue the socioeconomic and racial evolutionary pressure placed on reformers and the government to improve the childbirth experience for women. [9]

Letters and diaries from women such as Katie Chopin and Maria Bryan will be utilized throughout this dissertation. Ideally, their analysis will shed light on the personal experiences of women at the time of childbirth, but a shortcoming of diaries and letters arises from the social expectation that women were to speak of their birthing experience in a positive way; thus, the hardships will be somewhat glossed over at times. This issue presents the need for additional

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[8] William Buchan, MD., *Advice to Mothers, on the Subject of Their Own Health, and the Means of Promoting the Health, Strength, and Beauty, of Their Offspring,* (Philadelphia, 1804).

[9] Martha Rampton, "Four Waves of Feminism," *Pacific University Oregon,* date modified October 25, 2015. https://www.pacificu.edu/magazine/four-waves-feminism#:~:text=The%20wave%20formally%20began%20at,movement's%20ideology%20and%20political%20strategies.;William P. Dewees, *An Essay on the Means of Lessening Pain and Facilitating Certain Cases of Difficult Parturition,* (Philadelphia: John Oswald, 1860).; John C. Gunn, *Domestic Medicine or Poor Man's Friend,* (Ohio: J.H. Purdy, 1838).

resources, such as medical journals and statistics, to show the hardships and dangers brought about by the event. Using primary sources such as those discussed herein, this dissertation will analyze the reasons for the professionalization of childbirth.

When I began this project, I assumed that I would rely on diaries and letters heavily; however, I realized that census data showed a more interesting story. Through this collection of quantitative data, the more fascinating rural Alabama became. Once I discovered that the maternal morbidity rate for Black women was two times that of White women both in 1880 and in the modern day (while today it is 2.6), I wanted to uncover the reason. Thus, this dissertation will present a large amount of census data on social, medical, and economic theories in an attempt to understand this troubling statistic.

Historiography of the Professionalization of Childbirth

Initially, I made the following claim to begin this section; "Historically, childbirth has been incredibly dangerous to both mother and infant; however, advances in modern technology have made the practice safer, but by no means is it without risk." After conducting research, I wondered if the more significant question was, "Did the modernization and professionalization of the art of childbirth make it safer? Or was it an attempt to regulate midwives in a way that discredited all their hard work and successes, casting them as villains in their own stories? Had I read that statement at the beginning of my research, my answer would have been a resounding YES. But now, I am not convinced it has made childbirth safer, but rather different. The United States still has an alarmingly high mortality rate during childbirth. The current rate is drastically lower than in 1870 compared to the overall population, but is it because the art of childbirth has

changed, or is it because of scientific theories such as germ theory? Or is the modernization of medicine and the professionalization of childbirth one and the same? These questions will be discussed throughout this dissertation; however, the discussion seems to lead to more questions.

First, it is critical to examine the scholarship on this topic through a historiography. It was not until recent years that scholarships addressed the history of childbirth; prior to the critical changes in historical analysis of the 1970s, the history of childbirth was known as the history of obstetrics. The intentional transition to childbirth also redirected the historian's focus from the linear progression of the medical history of obstetrics, which is evident in books such as Harvey Graham's *Eternal Eve* (1950), to focus on the social history of childbirth, which is evident within the works of Richard and Dorothy Wertz *Lying-In: A History of Childbirth in America* (1989). Specifically, these new feminist revisionists pay close attention to who was present during the act of giving birth: the birth attendants. *Lying-in* is a well-documented source that is careful not to attempt to answer the problems of childbirth; instead, it addresses the issues of the treatment of the parturient and the societal impacts on the practice itself. A significant shortcoming of this text, as with many others pertaining to this dissertation, is that it focuses on the northern regions of America. However, the underlying themes throughout the text help support the overarching problems with obstetrics throughout America. Wertz addresses a resounding issue with the research in this area: systematic data. Birth and death were not recorded accurately or at all during the era. Thus, it makes research extremely difficult.[10]

[10] Harvey Graham, *Eternal Eve*. (London: William Heineman, 1950), introduction.; Richard, and Dorothy Wertz, *Lying-In: A History of Childbirth in America*. (Yale University Press: New Haven, 1989).; Nancy Schrom Dye, “History of Childbirth in America,” *Signs* 6, no. 1 (1980): 97-100.; Barbara Howe, "Lying-in: A History of Childbirth in America. Richard W. Wertz , Dorothy C. Wertz." *The American Journal of Sociology* 85, no. 2 (1979): 481-483.

Another view on the history of tocology, according to an article by Nancy Schron Dye titled "History of Childbirth in America" (1980), is that the history of childbirth can be neatly broken into three categorical periods. The first period falls into the time frame of Colonial America until the late eighteenth-century. During this period, childbirth was exclusively a female event and strictly a social affair rather than a medical one. The birth attendants were typically midwives, female family members, or neighbors. Women would gather during labor and delivery to socialize and support the expectant mothers. Their support took many shapes; some women would help tend to the household chores or elder children while others remained with the laboring mother attending to her needs. All the while, these supporting women would take this opportunity to socialize. The second categorical period lands between the late eighteenth and early twentieth-century; this period is a transitional period from a strictly social affair to the professionalization of the medical field. During this modernization of medicine, the birth attendants entered formal academic educational institutions; there was a growth in the understanding of medicine, hygiene, disease, treatment for pain control, and infections were introduced into childbirth. The transitional period will be the focus of this dissertation. The last period falls beyond the scope of this examination, around the 1920s, which marked the most modern completion of the professionalization of the medical field. To adequately understand the transitional period of the historiography of tocology as it pertains to the parturient and the development of the skilled birth attendant it is critical to examine a brief history of American childbirth.[11]

The first period of Colonial America to the late eighteen-century, which will henceforth be referred to as the social period of childbirth, is unique because birth aides were trained

[11] Dye, “History of Childbirth in America,” 98.

through apprenticeships with the handing down of heirlooms in the form of tonic and herbal recipes.[12] Bridget Lee Fuller, the earliest known midwife to enter the American Colonies, arrived aboard the Mayflower in Plymouth, Massachusetts, in 1620. Fuller began her work even before the ship arrived in the New World as she delivered three babies while sailing across the Atlantic Ocean.[13]

After her arrival, she continued to work as a midwife while training new midwives until she died in 1664. In *A History of Midwifery in the United States: The Midwife Said Fear Not* (2015) by Dr. Joyce Thompson and Helen Varney Burst, the authors trace the history of birth attendants through the colonial period. This medical history illustrates early colonists' challenges while attempting to safely bring new inhabitants into the New World.[14]

Scholars who focus on childbirth in the seventeenth-century tend to focus on the importance of the midwife. During this period, her role, status, and reputation were unquestioned as she was the only "trained" birth attendant present during delivery. These scholars' primary challenge is that seventeenth-century midwives' identity, status, and training is essentially a mystery despite their incredible importance. After all, childbirth took a significant role in the lives of colonial women from roughly the age of twenty through forty; women did not have legal access to birth control, and chronic pregnancies plagued them. In Colonial America, the typical

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[12] Heirloom something of special value handed down from one generation to another. In the case of midwifery this could a recipe book filled with tonics or medical practices that have proven successful over the years.

[13] Joyce Thompson Dr., DrPH, RN, CNM, FAAN, FACNM, and Varney Burst, Helen, RN, CNM, MSN, DHL (Hon.), FACNM., *A History of Midwifery in the United States: The Midwife Said Fear Not,* (New York: Springer Publishing Company, 2015), Section 1, particularly 5-7.

[14]Thompson and Burst, *A History of Midwifery in the United States,* Section 1, particularly 5-7.

woman carried between six to eight pregnancies, and a woman's value was placed on her ability to have a child.[15]

According to Catherine M. Scholten's article "On the Importance of the Obstetrick Art" (1977), the late seventeenth and the early eighteenth-century marked a transition from childbirth being an open affair to becoming one that was restricted. Women still gave birth at home; however, visiting the birthing room or lying-in room during delivery was no longer considered a social affair. In the 1760s, when male physicians slowly entered lying-in rooms, the birthing process became embarrassing, due to modesty and gender roles, for both the male physician and the parturient. To make the examination of a pregnant woman by a male doctor less uncomfortable, physicians began to insist on having fewer birth attendants present in the lying-in rooms.[16]

Moving forward into the next categorical stage within the history of childbirth is the transitional period that occurred around 1750-1770. Scholarship suggests it was easy for early American historians to romanticize childbirth during this era. As Wertz states, "birth continued to be a fundamental occasion for the expression of care and love among women."[17] Women gave birth within the confines of their homes, surrounded by loved ones. Occasionally, when labor and delivery took an unexpected turn or a complication arose, a male physician was called in; however, that was in rare cases.[18]

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[15] Catherine M. Scholten. "'On the Importance of the Obstetrick Art': Changing Customs of Childbirth in America, 1760 to 1825." *The William and Mary Quarterly* 34, no. 3 (1977), 426-430.

[16] Scholten, "On the Importance of the Obstetrick", 443-445.

[17] Wertz, *Lying-In*, 6.

[18] Wertz, *Lying-In*, 6.

Nevertheless, Wertz points out that this is a flawed interpretation. Home deliveries were dangerous and terrifying for both parturient and birth attendants. The ordeal was frightening because of the perceived notion of death. The mortality rates of the eighteenth-century were not significantly elevated compared to the number of births. Women feared death because of the cultural emphasis on the likelihood of death during childbirth. Puritans, for example, had ministers who would deliver sermons on the possibility of dying during childbirth. Society had instilled fear into many women during this era.[19]

In addition to the misperceptions of childbirth, women of the transitional period began to seek assistance from formally trained medical doctors. It was typically upper- and middle-class White women who insisted on having a physician present during delivery. It is critical to note that the transition from midwife to physician was gradual. It was not until the twentieth-century that physicians took over as primary birth attendants. In Charlotte Borst's *Catching Babies* (1995), she discusses the notion of gradual transition. Within her text, Borst argues that midwifery was not compatible with the modern profession of obstetrics. She asserts that midwives worked locally. They would help their neighbors while maintaining a family at home. They typically worked with immigrants and African-American communities and received little pay for their services. Borst claims that it was due to these reasons that midwives did not have access to proper education and training, both of which were important to upper- and middle-class women as they sought birth attendants. As pointed out in the text of Steven Stowe's article "Obstetrics and the Work of Doctoring in the Mid-Nineteenth Century American South" (1990), the 1830s started a debate that addressed whether a birth attendant should be trained on the job or

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[19] Wertz, *Lying-In*, 6.

via medical school. First-wave feminists such as Margaret Sanger pushed for reproductive rights for women out of the ideology that women could not gain equality to men until they had control over their reproduction, this includes childbirth. Chronic pregnancies lead to the continuation of poverty. According to Sanger, birth control and safer birthing conditions would present women with the opportunity to ascend the socioeconomic ladder.[20]

Despite the lack of formal education and training, the importance of midwives and their cooperation with physicians during the nineteenth-century is critical to understanding the gradual transition to the field's professionalization. Class culture plays a vital role in the professional evolution of delivery. Slaves, indentured servants, and lower classes of women had a very different birth experience than women in the upper and middle classes. Stowe asserts that one of the reasons that slaves preferred a midwife to a doctor was because the midwife had a better understanding of slave culture. This understanding comes from midwives working locally with people from their regional areas. This preference was also clearly visible during the Reconstruction Era. The formerly enslaved population in the South felt a strong sense of community and cultural understanding by utilizing the Granny midwives. Grannies were typically elderly Black women in the community who worked as midwives.[21]

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[20] Charlotte G. Borst, *Catching Babies: The Professionalization of Childbirth, 1870-1920,* (Cambridge: Harvard University, 1995), 288.; Steven M. Stowe, "Obstetrics and the Work of Doctoring in the Mid-Nineteenth-Century American South," *Bulletin of the History of Medicine* 64, no. 4 (1990): 543-545.; Debra Michals, “Margaret Sanger,” *National Women’s History Museum*, date modified 2017, https://www.womenshistory.org/education-resources/biographies/margaret-sanger.

[21] Katherine Beckett, “Choosing Cesarean: Feminism and the Politics of Childbirth in the United States,” *Feminist Theory* 6, no. 3 (2005), 252-253.

An author with a similar interpretation to that of Stowe is Phyllis L. Brodsky in her text *The Control of Childbirth* (1936), in which she has gathered a collection of individual childbirth experiences throughout America's South. Within the text, she follows the career of Doctor J. Marion Sims, who moved to Alabama, where he worked with midwives throughout his career. Brodsky concludes that while physicians tended to be cruel to slaves, they gained tremendous experience. Physicians in the South had less access to academic training; thus, they relied heavily on hands-on training. Many southern physicians were trained as general practitioners, having never delivered a baby until they opened their practices. There was a significant margin for error in these instances. However, in regions heavily populated with slaves, these physicians would have a lot of opportunities to practice delivering babies. Doctors also worked under the misconception that Blacks felt less pain than Whites, so doctors would practice without worrying about inflicting severe pain on the slave women.[22]

As Marie Jenkins Schwartz states in her book *Birthing a Slave* (2006), "after the United States stopped importing slaves in 1808, slavery and the southern way of life could continue only if children were born in bondage."[23] The law created a unique relationship among the slave, slaveholder, midwife, and doctor. Slaveholders understood that it was more important than ever to ensure that slaves could successfully reproduce to sustain and increase the slave population of the South. Due to this, physicians were exposed to more births, gaining experience and confidence in their field. Despite midwives historically being the norm for birth attendants, they

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[22] Stowe, "Obstetrics and the Work of Doctoring," 543-545.; Phyllis L. Brodsky, *The Control of Childbirth: Women Versus Medicine Throughout the Years*, (North Carolina: McFarland Company, 1936): 115.

[23] Marie Jenkins Schwartz, *Birthing a Slave: Motherhood and Medicine in the Antebellum South*, (Cambridge, Mass.: Harvard University Press, 2006), 1 and 146-145.

were not adequately trained and often caused more harm than good. Referred to as Granny midwives, older enslaved Black women assisted in childbirth regularly throughout the nineteenth-century. Physicians liked having Grannies present at births, as long as they knew their limits because they did more than assist in childbirth. They helped with household chores, cared for older children, and attempted to keep the parturient comfortable as she neared the end of pregnancy. In his doctors' notes, Wooster Beach reported in *An Improved System of Midwifery Adapted to the Reformed Practice of Medicine* (1853) that midwives were valuable since they could stay with the parturient and call the doctor when delivery neared. Their presence allowed doctors to tend to his other patients in the meantime.[24]

There is a wide array of texts dealing with childbirth in this transitional phase because of the complexity of the relationship among midwife, doctor, and parturient. There has been a publication boom of texts similar to that of Schwartz, which examine how the transition of birth attendants affected specific groups of people. These texts include Brianna Theobald's *Reproduction on the Reservation* (2019) and Alicia Bonaparte and Julia Oparah's *Birthing Justice* (2019). Other authors focus on personal letters to trace the birth experience of the individual, comparing it with other individuals to create a more cohesive image. Some examples include *Anna: The Letters of a St. Simons Island Plantation Mistress, 1817-1859* (2002), edited by Melanie Pavich-Lindsay, and Maria Bryan's *Token of Affection* (1996). [25]

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[24] Wooster Beach, *An Improved System of Midwifery Adapted to the Reformed Practice of Medicine* (New York: Charles Scribner, 1853): 19-21.

[25] Brianna Theobald, *Reproduction on the Reservation: Pregnancy, Childbirth, and Colonialism in the Long Twentieth Century*, (Chapel Hill: University of North Carolina, 2019).; Alicia D. Bonaparte and Julia Chinyere Oparah. *Birthing Justice: Black Women, Pregnancy, and Childbirth*. (New York: Routledge, 2016).; Anna Matilda Page King, *Anna: The Letters of a St. Simons Island Plantation Mistress, 1817-1859,* edited by Melanie Pavich-Lindsay, (Georgia:

R. J. Knight provides a comprehensive look at the complicated relationship between African and White Americans in his article "Mistresses, Motherhood, and Maternal Exploitation in the Antebellum South" (2017). Knight examines the complicated relationship between the plantation mistress and her slaves regarding childbirth. Similarly, in "The Mistress, the Midwife, and the Medical Doctor" (2010) by Tanfer Emin Tunc, the complicated relationship among the mistress, slave, and the physician is examined. This relationship took multiple factors into account, such as the ability to act as a wet nurse for the mistress.[26]

On the other hand, the intertwined relationship between the public and private dichotomy of childbirth derives from the cultural norms of gender roles and gender identity. In Kathy Peiss's article "Going Public: Women in Nineteenth-Century Cultural History" (1991), the author discusses the societal fears that accompany the idea of giving women too much power; in this case, it meant too much power to the midwife through a position of authority. This fear was illustrated through the titling of women with terms such as advanced, manly, and wild. Women, at this time, were to remain submissive and within their domestic sphere. Society at large considered women to be too delicate for the intensity of the public arena. The overwhelming transition from public to private was only exacerbated by its introduction into the lying-in rooms.[27]

University of Georgia Press, 2002): 10.; Maria Bryan, *Tokens of Affection: Letters of a Planter's Daughter in the Old South*, edited by Carol Blesser, (Georgia: University of George Press, 1996).

[26] R. J. Knight, "Mistresses, Motherhood, and Maternal Exploitation in the Antebellum South." *Women's History Review* 27, no. 6 (2017): 995.; Tanfer Emin Tunc, "The Mistress, the Midwife, and the Medical Doctor: Pregnancy and Childbirth on the Plantation of the antebellum American South, 1800-1860," *Women's History Review* 19, no 3 (2010): 396.

[27] Kathy Peiss, "Going Public: Women in Nineteenth-Century Cultural History," *American Literary History* 3, no. 4 (1991): 817-820.

In another similar text by Patricia A Vertinsky, *The Eternally Wounded Woman* (1994), the author examines women's mental, physical, and moral dangers of excessive exercise and childbirth. Early literature demonstrates a Victorian ideal of motherhood, prescribing pregnancy as a disease that must be alleviated. Vertinsky further examines the introduction of women into the field of obstetrics. Medical schools began to seek out females over males for training in obstetrics because women better understand their anatomy, and there was less of a concern for modesty. While this era was moving away from the Victorian Ideal, modesty was still critical when a male physician was present. The male physicians were held to strict, modest standards of medical practice, taught to them throughout their medical training. Expectant mothers would wear a "modesty skirt" while receiving a pelvic exam by the male doctor; they would also remain standing for the experience. The practice of modesty created a range of complications for both physician and parturient. Due to these complications, women began to be encouraged to enter the medical field of obstetrics—after all, they understood the female anatomy far better than men.[28]

Several historiographies cover the social history of women's health and childbirth; however, for this work, the historiography closely analyzed was the article "Whose Body? Recent Historiography Relating to Women, Health and Health and the Medical Profession," by Megan Davies. In this writing, Davies examines several essential texts on this topic, including *The Nature of Their Bodies* (1991), *Catching Babies* (1995), and *Women, Health and Medicine in America* (1992). These texts are vital to the professionalization of childbirth in nineteenth-century America. Throughout her analysis, Davies illustrates that the waves of feminism affected the topic's historiography. Later works show that women wanted more control over their bodies

[28] Patricia A. Vertinsky, *The Eternally Wounded Woman: Women, Exercise, and Doctors in the Late Nineteenth Century*, Chicago: University of Illinois Press, 1994), 279-285.

and took an active role in the field, pushing for the field's professionalization while criticizing improperly trained midwives. The significant issues within the scholarship seem to remain similar: gender and sexual inequality, and the primary "voices" are those of the middle and upper classes. This problem illustrates an exciting avenue for future research into the lower classes of society to examine how the shift to professionalized childbirth affected that social class. While the professionalization of medicine has benefited society overall, the early stages excluded certain groups. Further research into how those excluded managed their new challenges would add breadth to the field.[29]

Literature on childbirth extends beyond the subdiscipline of social and medical history. It includes economic history as well. As we know, childbirth is expensive; it takes a great deal of financial resources to provide care for a parturient. Thus, it caught the attention of early nineteenth and twentieth-century economists, especially as it pertained to the economic influence of freed Blacks during Reconstruction.

During the Reconstruction Era, the formerly enslaved population grew. The rights that Blacks throughout America experienced included fundamental freedoms to move, marry, and expand upon that family. The growth of this ethnic population became a central focus for the radically racist White population. Amongst this group were prominent economists who felt the need to thoroughly analyze what would become of the Black population in America now that this group was left to their devices. One theory that will be analyzed throughout this dissertation is

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[29] Megan J. Davies, "Whose Body? Recent Historiography Relating to Women, Health and the Medical Profession." *Gender & History* 9, no. 2 (August 1997): 380-384. Wendy Mitchinson, *The Nature of Their Bodies: Women and Their Doctors in Victorian Canada*, (Toronto: University of Toronto Press, 1991).; Borst, *Catching Babies*, Introduction.; *Women, Health and Medicine in America: A Historical Handbook*. Edited by Rima D. Apple. (New Brunswick: Rutgers University Press, 1992).

the Disappearance Hypothesis, which states that within the thirty-year period that followed emancipation, all Blacks within the United States would disappear through migration or death. This theory was presented throughout texts such as Frederick Hoffman's *Race Traits and Tendencies of the American Negro* (1896), Joseph Tillinghast's *The Negro in Africa and America (1902),* and Alfred Holt Stone and Walter Francis Willcox's *Studies in the American Race Problem.* These texts are critical to understanding the formulation of the hypothesis and, ultimately, the theory's downfall as it was proven to be incorrect and racist. [30]

By the end of the nineteenth-century, the history of childbirth was still in its transitional period. The gradual shift from a public midwife to a private physician-assisted birth took decades to go into effect entirely. However, historical scholarship on childbirth is just in its infancy. It is important to note that while this literature review discusses many important texts on the history of childbirth this is not a complete list. This topic has been researched and analyzed by many historians, all of whom make a valent attempt to understand the history of professionalization and modernization; however, this dissertation is unique as it explores this topic as it specifically pertains to rural Alabama. Childbirth practices, traditions, and rituals must be further explored because the delicate relationship among parturients, doctors, and midwives is complicated but has tremendous implications on social history.

Conclusion

[30] Frederick L. Hoffman, *Race Traits and Tendencies of the American Negro*, (Clark, N.J: Lawbook Exchange, 2004).; Joseph Alexander Tillinghast, "The Negro in Africa and America." *American Economic Association* 3 (1902): 1-232. Alfred Holt Stone, and Walter Francis Willcox. *Studies in the American Race Problem*, (New York: Doubleday, Page & Company, 1908).

This dissertation will analyze the underlying reasons childbirth became professionalized, which was due to the growing demands by women for safer birthing conditions. The demand evolved out of the complex relationship among social status, race and ethnicity, and regional locations, all made possible by the modernization and professionalization of tocology that became available during the latter part of the nineteenth and beginning of the twentieth-century. The history of childbirth is a critical topic because, as previously mentioned, the maternal mortality rate in the United States in the twenty-first-century is still incredibly high for a developed nation. Women deserve safer birthing conditions. Those who assist in ushering new life into the world are responsible for protecting both mother and infant. This work will primarily focus on the transformational period of the professionalization and modernization of childbirth; however, it is critical in some instances to extend the time frame to gain a better understanding of the matter at hand.

Text Summary

Chapter 1 briefly introduces the art of childbirth, discussing the evolving relationship between socioeconomic groups. Additionally, the reader is introduced to the examination region, rural Alabama: specifically, Hale, Greene, Dallas, Sumter, and Marengo Counties. The region was selected for its unique socioeconomic climate. In the nineteenth-century, the field of academic obstetrics was in its infancy. Midwives and physicians had a turbulent relationship as both thought the other was intrusive and careless. However, it is necessary for a woman to be accompanied by a birth attendant during delivery to help preserve the life of both mother and child—a point that both physician and midwife agree upon. The question becomes who is better

at providing healthcare to both mother and infant while preserving the cultural climate that these women so desperately want. Who knows what is best for the parturient and why becomes a focal point for this dissertation with the ultimate goal of analyzing the overall thesis. This dissertation will argue that the reason for the professionalization of childbirth was due to the growing demand by women for safer birthing conditions that developed around the evolving relationship among social status, race and ethnicity, and regional location distinctions; reform was made possible by the modernization of medicine and the professionalization of tocology available during the nineteenth- and twentieth-centuries in America.

Chapter 2 will examine the socioeconomic climate of rural Alabama, specifically in Hale, Greene, Dallas, Sumter, and Marengo Counties. These counties are five of the wealthier counties in Alabama during a period of extreme poverty. From 1870-1910, Alabama had a shifting diversity of ethnicity as it experienced a period of White Flight. This period was when more Whites left Alabama than entered or resided in it, providing open opportunities to the newly freed Black population. This chapter analyzes the trends in population shift as well as the financial stance of the region. Through census data, historians can better understand the class struggles in Alabama; however, the data is imperfect, presenting obstacles at every turn. Additionally, this chapter will analyze the vital statistics presented for Alabama from 1870 to 1910 to illustrate the maternal and infant mortality rates in the state, nation, and world.

Chapter 3 analyzes the question “Why Are You the Way You Are?” to understand the growing tension among society, midwives, and physicians. To attempt to answer that question, the geo-occupational configuration of the population will illustrate the high rural population and the agricultural occupations of the state’s inhabitants. Alabama’s population was mostly rural

farm workers of both genders. This chapter will further analyze the causes for women working in agriculture and why that was important to childbirth.

Moreover, racial ideology will be examined in relation to quality birth attendants, education, and the societal pressure to ignore the Black population through the lens of the Disappearance Hypothesis. Lastly, as statisticians examine the vital statistics of the region reformers recognize the need for intervention because of the presented statistical analysis drawing parallels between race and death rates. The question becomes how?

Chapter 4 discusses The Problematic Midwife. In a rural, poor, primarily Black population, women still needed quality birth attendants. Physicians were too expensive for the majority of parturients, so they leaned on the support of Granny midwives. The women did more than catch babies as they entered the world; thus, socially, they were accepted and respected, at least until physicians began to attack their lack of education. But who was to blame- the overworked, undereducated midwife who was doing the best that she could or the overpriced classically trained physician? The midwives were victims of societal making, damned if she did and damned if she didn't.

Chapter 5, Along Came a Doctor, examines the medical revolution the United States underwent during the latter part of the nineteenth-century through the twentieth-century. Medical schools were evolving, and with them, a new specialized physician was looking for a better society and an increase in social and financial status. The quest for the “almighty dollar,” as Washington Irving called it, may have altered many physicians' regional path and moral compass. As medical advancements stimulated change for patients within hospitals, Blacks were excluded from such services due to Jim Crow Laws.

The modernization of tocology was developed to provide physicians with the skills necessary to assist in delivery; however, ethical dilemmas arose from learning techniques. Men like Dr. J. Marion Sims and Josiah Nott utilized Black women in developing medical procedures, often with little pain management, which they justified through the assertion that Blacks experience less pain than Whites. Moreover, academia struggled with the ethical dilemma of practicing their skill on pregnant women. It takes creativity to overcome this challenge to educate blossoming physicians.

In conclusion, the transitional period between home and medically sanctioned childbirth deserves additional research. While scholars claim that modernizing obstetrics made childbirth safer, I argue that the more accurate assertion is that it changed childbirth. Midwives who had limited resources provided for a community unselfishly in an attempt to fulfill a need. That selfless commitment was demonized and degraded because of their race or social status. Had the Granny midwife been a White wealthy male, he would have been hailed a hero for his efforts; however, the political, social, and economic makeup of rural Alabama generated the perfect conditions to allow hatred to grow.

Chapter 2: Feast to Famine: Alabama's Socioeconomic Condition Affects Tocology

Introduction

To understand the impact of the professionalization and modernization of childbirth on American society between 1870 and 1910, it is critical to narrow the research down to a specific location because each state had drastically different social classes, ethnicities, religious factions, political structures, and economic conditions. People throughout this time had independent experiences depending on the region of the United States where they were located. This is especially true for women during pregnancy, childbirth, and postpartum. For example, those in New York City may have had greater access to healthcare during pregnancy and delivery than those in rural Alabama. The New Yorker may have had access to a lying-in hospital, which was usually a hospital wing specially dedicated to labor and delivery. However, these hospitals caused more harm than good due to inadequate sanitation and sterilization available during the era.

On the other hand, the citizens of rural Alabama had limited access to healthcare. Often, they lived their entire lives without having ever been seen by a doctor. Childbirth occurred in the home instead of a lying-in ward under the care of Granny midwives rather than academically trained physicians.

The initial intention of this dissertation was to conduct a case study of five prominent Alabama counties between 1870-1910, which lie along the rural region known as the Black Belt (Dallas, Greene, Hale, Marengo, and Sumter Counties). However, it became a challenge to locate information on a prominent midwife or a specific physician within one or more counties who

was not already written about. Not wanting to regurgitate information that other scholars have already discussed, I was led to a different path that ultimately illustrates control over childbirth. It would be incorrect to state that the control was limited to one sector, but, rather, childbirth fell under the control of society, politics, and the economy; thus, this case study is slightly non-traditional in the sense that it will be examining how macro-regulation ultimately influenced the micro-aspects of the art of childbirth and how circumstances of geo-occupational and socioeconomic status forced midwives to be victims of a system that was designed to undermine their abilities due to their lack of formal education.

Hale, Greene, Dallas, Sumter, and Marengo Counties were home to thousands of inhabitants who were steadily increasing the population through natural means. The vital statistics gathered by the Census Bureau on the region illustrate social, economic, and political influences that both assisted and hindered the development of obstetrics and the art of childbirth. During this era, the United States and many parts of the world were undergoing a transformation that would lead to the advancement of scientific enlightenment and, ultimately, to the modernization of medicine. The significant advancements that those living in the early twentieth-century would benefit from began decades earlier. Despite Alabama being a prosperous state during its Antebellum period, the economics of the state entered a period of poverty during the Reconstruction Era. The state's complex history greatly influenced the modernization and professionalization of childbirth in Alabama from 1870 to 1910, the socioeconomic status of its inhabitants, and the presentation of statistical data via prominent statisticians.

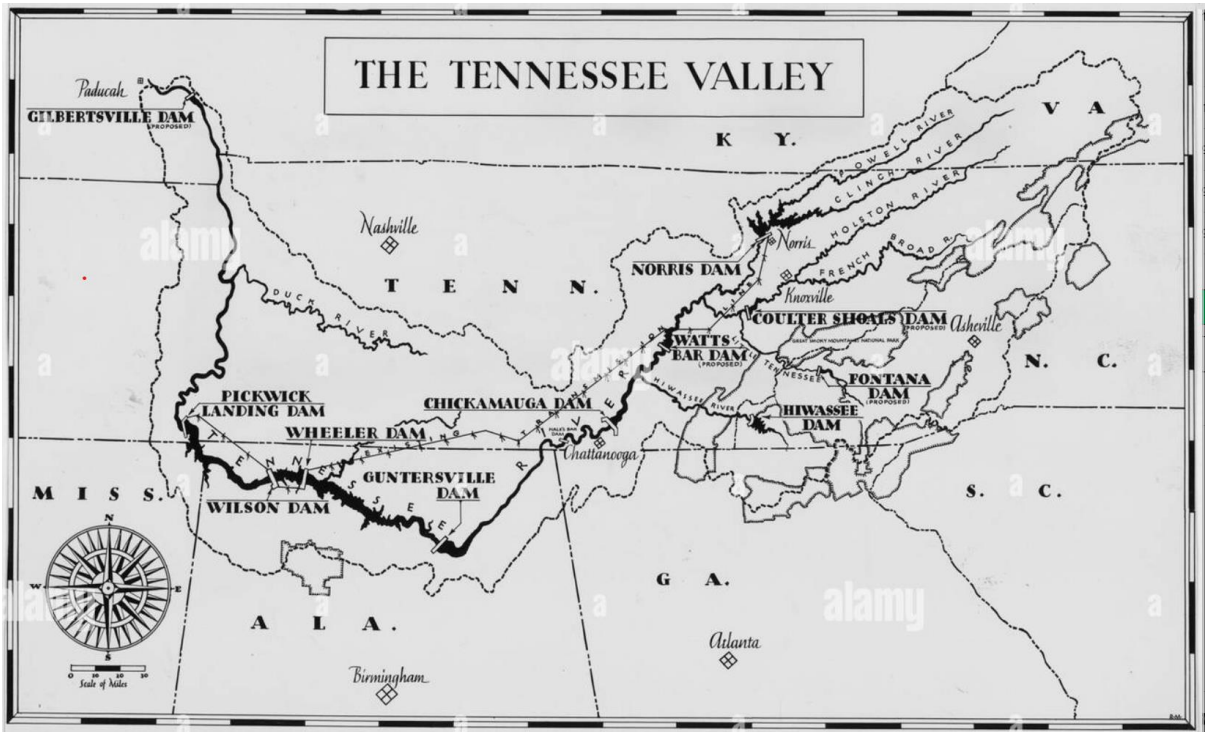
History of Alabama

In the years leading up to 1870, Alabama experienced a dramatic transformation. Having been admitted into the Union in 1819, Alabama was a relatively young state filled with rich horticultural promises. That would rapidly develop from sustenance- to industry-based agriculture during its first decade in admittance. The industrialization of farming was mainly due to the rich soil, even climate, and complex river system. During the antebellum years, the state's rich soil offered a promising opportunity for anyone willing to cultivate. The growing cotton prices during this era counterbalanced the risk associated with relocation and farm operations. The promises of rising cotton prices in the mid-nineteenth-century lured White farmers in the region. These White farmers brought with them Black slaves to work the fields. This migration allowed the state's population to blossom, leading to radical racism, segregation laws, and an economic bust for the inhabitants. [1]

To properly understand the time of this case study, it is critical to provide a general statistical background of Alabama's demography, economy, and educational history in the nineteenth-century. Additionally, this dissertation will provide a brief history of Alabama and the counties under examination. In the Antebellum years, Alabama was an agriculturally rich region that depended on slavery to develop and sustain the economy. The systematic data presented within this dissertation illustrates the population that the termination of slavery will enormously impact. The overall population of Alabama snowballed during the early to mid-nineteenth-century. From 1820, only one year after the state's admission to the Union, until 1850, the

[1] "The History of Agriculture in Alabama: A Historic Context." *Alabama Historical Commission: The State Historic Preservation Office.* Accessed November 3, 2022. 7. https://ahc.alabama.gov/architecturalprogramsPDFs/History%20of%20Agriculture%20in%20Alabama.pdf

population grew by over half a million. This rapid increase was likely due to the rise in cotton prices; by 1818, cotton was twenty-five cents a pound. Cotton prices would drive a series of small economic bust and boom cycles for planters in Alabama. When cotton prices boomed, farmers would purchase more land than they could farm, ideally, to make a future on the market. But, when the price dropped, these farmers would find themselves in a situation where they could not pay their loans. Many early Alabama settlers found themselves around the Tennessee Valley, located in the northern part of the state. The land there was fertile and excellent for the cultivation of cotton. (Chapter 2: Figure 1- Tennessee Valley).[2]

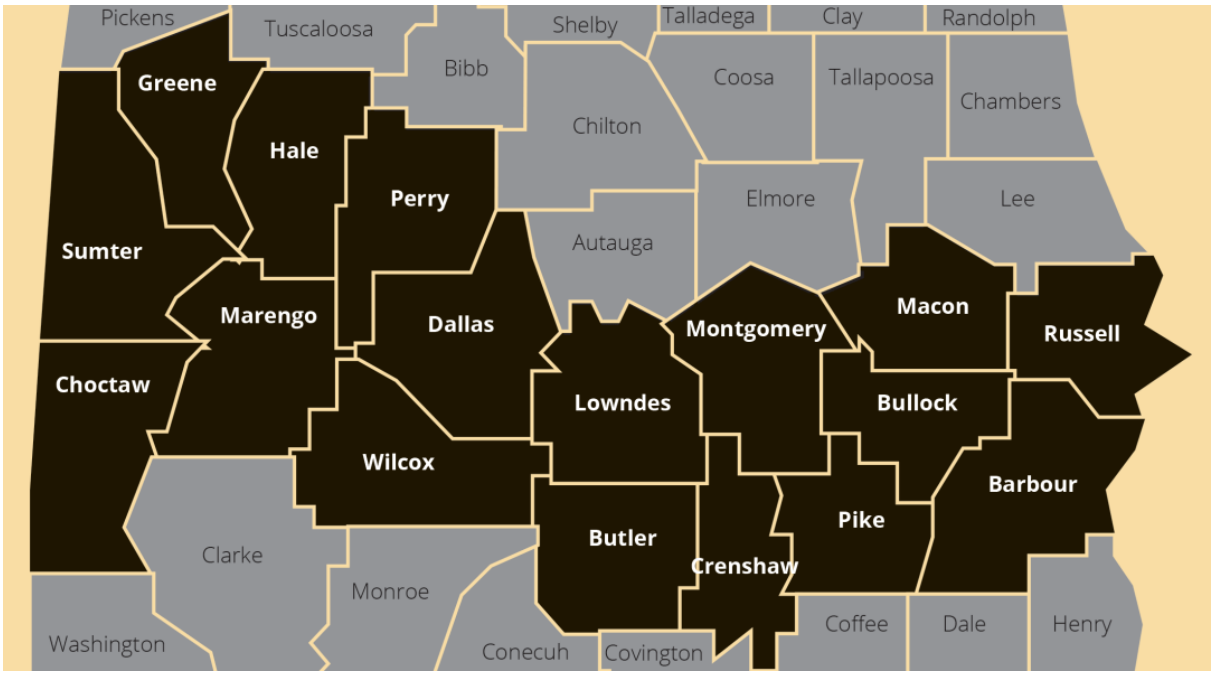


Chapter 2: Figure1- Tennessee Valley.[3]

[2] "The History of Agriculture in Alabama," 7.

[3] *The Tennessee Valley.* Alamy Stock Photo, 2009.

It was not until the 1830s that the Black Belt was recognized for its agricultural potential, which was made possible when a new genetic modification of cotton became available. After this, the Black Belt, the areas in which Dallas, Hale, Greene, Sumter, and Marengo Counties lie, became known for its large plantations. (Chapter 2: Figure 2- Alabama Black Belt).[4]



Chapter 2: Figure 2- Alabama Black Belt.[5]

Within the Black Belt region of the state is where cotton cultivation began to dominate Alabama's horticultural industry. It was so crucial to the state that British Naval officer, traveler, and author, Captain Basil Hall wrote:

> Every flow of wind from the shore wafted off the smell of that useful plant; at every dock or wharf we encountered it in huge piles or pyramids of bales and our decks soon choked up with it. All day, and almost all night long, the captain, pilot, crew and passengers were talking of nothing else; and sometimes our ears were so

[4] "The History of Agriculture in Alabama," 8.

[5] *The Alabama Black Belt*. The Alabama Black Belt. Accessed July 25, 2023.

> wearied with the sound of cotton! cotton! cotton! that we gladly hailed a fresh inundation of company in the hopes of some chant – but alas! [6]

Throughout the Black Belt region, true plantations were cropping up in an attempt to make their future from cotton. I use the term "true" plantations here because it was common for farmers to call their large farm a plantation, but by definition, a plantation is.

> A landholding large enough to be distinguishable from a family farm, at least 250 acres; a distinct division of labor and management; specialized agricultural production, such as focusing on one cash crop; distinctive settlement forms with a focus on spatial relationships; a relatively large amount of cultivation put into each acre.[7]

In Alabama's early years, farmers planted cotton above all other crops because it showed the most promise financially. In many ways, these farmers had no choice; they purchased supplies and seeds on credit, often seeing a different price for those purchased with cash. Cotton's economic success allowed farmers to pay off their large amounts of debt. Despite the early adoption of cotton as Alabama's cash crop and the common misconception that all cotton farmers housed large numbers of enslaved people, most free people in Alabama owned fewer than ten slaves. The majority of Alabama's population was made up of small farmers. It would not be until the 1860s that the Black Belt began to see large numbers of slaves on plantations. However, the image of grand plantations with hundreds and hundreds of slaves was not the norm. There were few extensive plantations; nevertheless, most of the large plantations in Alabama were in the Black Belt region, and those plantations held the largest concentration of slaves in the state. The number of slaves in the Black Belt region drastically increased after about 1840. According to

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[6] Captain Basil Hall, *Travels in North America in the Years 1827 and 1828,* (Edinburgh: Cadell & Co., 1829), 310-311.

[7] Charles S. Aiken, "The Fragmented Neoplantation: A New Type of Farm Operation in the Southeast," *Southeastern Geographer* 11, no. 1 (April 1971): 43.

Alabama Historic Commissioner's office, "in Marengo County, in the heart of the Black Belt, slaves made up over seventy-five percent of the population, with fifty slaveholders owning more than one hundred slaves."[8]

While the region was imbued with cotton farms, an issue that many farmers failed to realize was how detrimental cotton crops were to the soil. If a farmer continuously plants cotton in a field without rotating different crops, the cotton depletes the nutrients in the soil so drastically that crops cannot grow. The depletion in the soil would ultimately force many farmers to abandon fields in search of richer soil. Regardless of this complication, by the 1850s, the Cotton Kingdom, as it became known, was at its all-time high, with the price of cotton at "12.34 cents a pound."[9]

In 1858, Hiram Fuller described the region after a visit as

> where the people live in cotton houses and ride in cotton carriages. They buy cotton, sell cotton, think cotton, eat cotton, drink cotton, and dream cotton. They marry cotton wives, and unto them born cotton children. In enumerating the charms of a fair widow, they begin by saying she makes so many bales of cotton. It is the great staple – the sum and substance of Alabama. [10]

From 1850 until 1870, that population increased by yet another two hundred thousand people. This population explosion of approximately 700,000 people in fifty years can be attributed to a promising agricultural climate offered by rural Alabama's rich soil. The Antebellum cotton industry of the region lured both Black and White migrants into the region, and with them came their families, which is illustrated in the United States Census reports. To break this statistic down further, with the increase in population, there was an increase in

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[8] "The History of Agriculture in Alabama," 10-13.

[9] "The History of Agriculture in Alabama," 15-16.

[10] Hiram Fuller, *Belle Brittan on a Tour at Newport and Here and There* (New York: Derby and Jackson, 1858), 112.

diversification. According to Census reports, the White population increased from 426,514 in 1850 to 521,384 in 1870, representing a 22.24% increase in population size in twenty years. To adequately sustain a large farm, these White farmers brought with them Black slaves as well as other employed farmhands. In 1850, 44.70% of the population was Black, roughly 345,109. Twenty years later, by 1870, that number increased to 475,510, 47.69 %, representing a 37.79% increase.[11]

Only examining population statistics would neglect to examine the historical transformations occurring regionally and nationally during the nineteenth-century. Between the years of Alabama's founding and the American Civil War lies the Antebellum Period (1820-1865). During this period, Alabama was imbued with slavery due to its fertile rural environment, with cotton as a cash crop for the region; the years before the Second Agricultural Revolution required significant manual labor for harvesting. This period lies before modern machinery. For a large cotton plantation to be profitable, it required much manual labor, and slaves filled this position. From 1820 until 1860, the slave population rose from 41,879, which represented roughly 32.7% of the total population to, 435,080 Black slaves, approximately 45% of the total population, on the eve of the American Civil War 1860. There was also a population of free Blacks in Alabama on the eve of the Civil War. This population was 2,690, which is just a fraction of the population.[12]

As was quoted by author John Michael Vlach in his book *Back of the Big House* (1993)

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[11]"The History of Agriculture in Alabama," 7.; Campbell Gibson and Kay Jung, "Population Division: Historical Census Statistics on Populations Totals by Race, 1790 to 1990, and by Hispanic Origin, 1970 to 1990, for the United States, Regions, Divisions, and States," *U.S. Census Bureau: Working Paper No.* 56 (September 2002): 33.

[12] Gibson and Jung, "Population Division." 33.

> Imagine a universe of ten slaveholders, eight owning two slaves a piece, one owning twenty-four, and the tenth possessing sixty. Obviously most slaveholders (80 percent) would own fewer than five slaves, but most slaves (84 out 100) would reside in units of more than twenty. Such an imaginary model suggests what the numbers reveal. In 1850 over half [of the slaves], 51.6 percent, resided on plantations of more than twenty bondsmen. The figures were more pronounced in the Deep South, and still more so in 1860, when fully 62 percent of the slaves in the Deep South lived in plantation units.[13]

As is present by Vlach, the average plantations did not have hundreds of slaves, rather it was the large plantations that held the majority of slaves within the region. During the antebellum period, Alabama was home to many large plantations, which would account for the large amounts of freed men entering the free population.

The American Civil War forever changed Alabama's economic status and its five counties under examination here—Dallas, Greene, Hale, Marengo, and Sumter. The war devastated the geographic surface of the state; the battles destroyed farms and the livestock that called it home, leaving the owners with nothing but the land lost value. The Confederate and the Union soldiers who bravely fought confiscated the property. Investments into which Alabamians injected money and effort were suddenly worthless as Confederate bonds and railroad stock lost value while slaves were set free. According to Alabama's Governor Robert Miller Patten, who served from 1865-1868, the state suffered property loss of $500,000, including the loss of slaves. The end of the Civil War ended the old agricultural system that Alabamians had relied so heavily upon. Now, the state and its inhabitants would have to create a new economic system dependent on paid free labor.[14]

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[13] John Michael Vlach, *Back of the Big House: The Architecture of Plantation Slavery*. Chapel Hill, N.C.: University of North Carolina Press, 1993), 12.

[14] Albert Burton Moore, *History of Alabama*. (Tuscaloosa, AL: Alabama Book Store, 1951), 456.

Not only did the Civil War end the old agricultural system, but it also impacted the socioeconomic conditions of the state. During the war, farmers in the region replaced their cotton fields with crops that could be used to supply troops, and very few farmers had the luxury of reserving field space to grow cotton. According to the laws of supply and demand, when the supply of a product decreases, the price will increase; thus, there was a spike in cotton prices by 1866. The price of cotton had risen to a high of $0.43 per pound. What little reserve supply of cotton the southern farmers had was useless to the farmers' financial troubles because it was impossible to get these supplies shipped to the northern and European markets. So, the reserves sat dormant in barns and storage areas.[15]

The misfortune of the Alabamian farmers was far from over when, in 1865-1866, most of the crops in the region were destroyed by inclement weather, pests, and lack of labor to harvest. Not only did the region have financial trouble due to the issues with cotton, but now the region had lost its food supply. This would ultimately lead to starvation for many inhabitants, causing the United States government to intercede. In March of 1865, the United States Congress established the Bureau of Refugees, Freedmen, and Abandoned Lands, more commonly known as the Freedman's Bureau. This organization oversaw all matters concerning Black Americans, as well as the distribution of food to the famished regions of the state.[16]

As the state's economy and resources continued to decline, the White population within Alabama began to leave the state in search of better opportunities and living conditions. From 1860 until 1870, the White population in Alabama declined from 526,271 to 521,384, a 0.929%

[15] "The History of Agriculture in Alabama," 18.

[16] "The History of Agriculture in Alabama," 18-19.

decrease. On the other hand, the Black population in the state grew during the same period by 8.62% from 437,770 to 475,510. Most formerly enslaved worked as tenant farmers or sharecroppers in the rural counties of Alabama. (Chapter 2: Figure 3) [17]

(See text for sources, definitions, and explanations)

Census year	Total population	Race					Hispanic origin (of any race)	White, not of Hispanic origin
		White	Black	American Indian, Eskimo, and Aleut	Asian and Pacific Islander	Other race		
NUMBER								
1990	4 040 587	2 975 797	1 020 705	16 506	21 797	5 782	24 629	2 960 167
Sample	4 040 587	2 975 247	1 019 743	18 295	21 754	5 548	23 579	2 959 793
1980	3 893 888	2 872 621	996 335	7 583	9 734	7 615	33 299	2 855 558
Sample	3 893 888	2 873 289	996 283	9 304	10 660	4 352	33 923	2 854 919
1970	3 444 165	2 533 831	903 467	2 443	2 825	1 599	(NA)	(NA)
15% sample [1]	3 444 148	2 535 881	902 869	2 153	(NA)	(NA)	13 313	2 524 453
5% sample	3 444 165	2 535 843	903 467	(NA)	(NA)	(NA)	38 848	2 507 466
1960	3 266 740	2 283 609	980 271	1 276	915	669	(NA)	(NA)
1950	3 061 743	2 079 591	979 617	928	338	1 269	(NA)	(NA)
1940 [2]	2 832 961	1 849 097	983 290	464	110	(X)	*439*	*1 848 658*
5% sample [2]	(NA)	1 853 120	(NA)	(NA)	(NA)	(X)	440	1 852 680
1930	2 646 248	1 700 844	944 834	465	105	(X)	(NA)	(NA)
1920	2 348 174	1 447 032	900 652	405	85	(X)	(NA)	(NA)
1910	2 138 093	1 228 832	908 282	909	70	(X)	(NA)	(NA)
1900	1 828 697	1 001 152	827 307	177	61	(X)	(NA)	(NA)
1890 [3]	1 513 401	833 718	678 489	1 143	51	(X)	(NA)	(NA)
1890 [4]	1 513 017	833 718	678 489	759	51	(X)	(NA)	(NA)
1880	1 262 505	662 185	600 103	213	4	Black		
1870	996 992	521 384	475 510	98	-	Total	Free	Slave
1860	964 201	526 271	437 770	160	-	437 770	2 690	435 080
1850	771 623	426 514	345 109	(NA)	(NA)	345 109	2 265	342 844
1840	590 756	335 185	255 571	(NA)	(NA)	255 571	2 039	253 532
1830	309 527	190 406	119 121	(NA)	(NA)	119 121	1 572	117 549
1820	127 901	85 451	42 450	(NA)	(NA)	42 450	571	41 879
1810	9 046	6 422	2 624	(NA)	(NA)	2 624	59	2 565
1800	1 250	733	517	(NA)	(NA)	517	23	494
PERCENT								

Chapter 2: Figure 3– Populations Totals by Race.[18]

This information is relevant to this case study examining 1870 to 1910 because it is vital to understanding the social classes of Alabama in the 1870s. The enactment of the Emancipation Proclamation of 1963, the ratification of the Thirteenth, Fourteenth, and Fifteenth Amendments (also known as the Reconstruction Amendments of the United States Constitution) changed the

[17] Gibson and Jung, "Population Division," 33.

[18] Population Division: Historical Census Statistics on Populations Totals by Race, 1790 to 1990, and by Hispanic Origin, 1790 to 1990, for the United States, Regions, Divisions, and States.

status of the formerly enslaved. These pieces of legislation would transform the demographic landscape of Alabama and the entire United States of America. Adapting the Reconstruction Amendments and Radical Reconstruction of 1867 transformed citizenship within the United States. During Radical Reconstruction, radicals felt that it was their responsibility to punish the Confederacy for its actions during the American Civil War and that they needed to be the front runners in the fight for Black civil rights. [19]

These legislative acts increased the number of free people in Alabama's poor class by freeing, granting citizenship to, and granting male suffrage to the formerly enslaved. The new citizens entered the paid workforce with no education or job placement opportunities in a racially-driven region of the country. Black Americans in the South lived in desperate rural poverty, Black Alabamians were no exception. Poverty led the newly freed Blacks back onto the farms of their former masters to work as tenant farmers or sharecroppers, neither of which position overtly led to socioeconomic ascension. According to historian Harold Woodman,

> In sharecropping, the laborer works an area of land for the landowner, and is paid with a portion of the crop. In the tenant system, the tenant rented the land from the landowner, and pays his rent to the landowner with a portion of the crop. The fundamental distinction between the relationships of landlord and cropper and landlord and tenant is in the fact that the status of a cropper is that of a laborer who has agreed to work for and under the landlord for a certain portion of the crop as wages, but who does not thereby acquire any dominion or control over the premises upon which such labor is to be performed, the cropper having the right

[19] "U.S. Const. art. 13 § 1." "Neither slavery nor involuntary servitude, except as a punishment for crime whereof the party shall have been duly convicted, shall exist within the United States, or any place subject to their jurisdiction."; "U.S. Const. art. 14 § 1." "All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws."; "U.S. Const. art. 15 § 1." "The right of citizens of the United States to vote shall not be denied or abridged by the United States or by any State on account of race, color, or previous condition of servitude—".

> merely to enter and remain thereupon for the purpose of performing his engagement; whereas a tenant does not occupy the status of a laborer, but under such a contract acquires possession, dominion, and control over the premises for the term covered by the agreement, usually paying therefore a fixed amount either in money or specifics, and making the crop performs the labor for himself and not for the landlord. [20]

Tenant and crop-share farming were essentially a contractual version of slavery under which the promisee could perpetually be indebted to the promiser. In addition to these two types of farming systems, farms offered opportunities for individuals to work as paid labor. This was considered to be the lowest rung of the "New South's Agricultural Ladder," which illustrated the idealized ascension into land ownership. Both the tenant farming and the crop-sharing systems (which would be replaced by the cash-share system in the 1900s) led to indebted farmers. Money was required to purchase the supplies necessary for planting and tending to fields. Farmers relied on credit to acquire the supplies necessary to plant and harvest a crop successfully, which led to increased debt loads. Additionally, the new scientific methods of crop rotation were controversial to many farmers due to the financial resources required to practice the new techniques. Most landlords required that their tenants farmed cotton because of its wealthy history. When cotton crops failed, the responsibility of the rent still fell on the indebted tenant farmers. The financial disparity affected all aspects of life as these tenants lived in rundown, poorly constructed homes, often infested with vermin. Despite the infrequency of social fluidity, it was possible for these

[20] Woodman, Harold D. "Post-Civil War Southern Agriculture and the Law." Agricultural History 53, no. 1, Southern Agriculture Since the Civil War: A Symposium (January 1979): 324-325. Woodman was an American Historian and author at Purdue University (1971-1997).

farmers to move up the rungs of the social ladder. Some made it out of poverty; however, the vast majority lived their entire lives in desperate conditions.[21]

Socioeconomic Status of Inhabitants

Alabama is a fascinating case study due to the fallout of the Reconstruction Amendment and Radical Reconstruction. This fallout affected more than just the Black Americans within Alabama's border. White Americans, particularly those holding a significant portion of the wealth in counties such as Greene, Hale, Dallas, Marengo, and Sumter, were affected by the policies brought forth from these acts of legislation. It is difficult to ascertain precisely how much the wealth of these counties was affected overall due to the advanced changes within the methodology employed by the United States Census Bureau and on January 10, 1921, a fire at the United States Department of Commerce building in Washington D.C., destroyed a significant portion of the 1890 census information. Due to the changes and the fire, a gap was created within the information, and during that gap period, a significant change happened to the state's wealth.

Despite these challenges, several factors can be determined based on the surviving documents. According to the United States Census in 1870, the values of the counties of Hale, Dallas, Greene, Marengo, and Sumter have been evaluated in both assessed values and true (market) values. The assessed value is the portion of the total value the individual must pay taxes on. On the other hand, true or market values are the most "probable price in cash, or terms equivalent to cash, that a property would sell for on the open market."[22]

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[21] "The History of Agriculture in Alabama," 18.

[22] "A Taxpayer's Guide to Reassessment." Reassessment Office Country of Lycoming Pennsylvania (2004).

With those differences in mind, the true total assessed values of each county in 1870 are as follows:

County	True Assessed Value
Dallas	$12,722,277
Greene	$4,708,610
Hale	$5,717,318
Marengo	$4,481,457
Sumter	$4,156,041

Dallas was the wealthiest of the counties noted in this dissertation. While it had significantly more financial wealth, all of the counties have similar demographics and agricultural settings. So, the financial variances will illustrate how socioeconomic differences affect the treatment of patients by physicians. (Chapter 2: Figure 4 and Figure 5).[23]

[23] "Table II. Wealth, Taxation, and Public Indebtedness of Each State and Territory, (By Counties)." *The United States Census Bureau* (1870): 15.

WEALTH, TAXATION, AND PUBLIC INDEBTEDNESS. 15

TABLE II.—STATE OF ALABAMA.

COUNTIES.	VALUATION.				TAXATION, NOT NATIONAL.				PUBLIC DEBT.			
									COUNTY.		TOWN, CITY, ETC.	
	Assessed value of real estate.	Assessed value of personal estate.	Total assessed value of real and personal estate.	True valuation of real and personal estate.	State.	County.	Town, city, &c.	Total.	For which bonds have been issued.	All other.	For which bonds have been issued.	All other.
Total	$117,223,043	$38,359,552	$155,582,595	$201,855,841	$1,456,024	$1,122,971	$403,937	$2,982,932	$1,457,128	$247,045	$2,773,900	$321,063
Autauga	1,403,300	463,740	1,867,040	2,379,744	15,996	14,002	.....	29,998	.....	.....	.....	.....
Baker	312,023	76,121	388,144	512,291	4,332	2,911	.....	7,263	.....	.....	.....	.....
Baldwin	471,950	543,507	1,015,457	1,220,827	8,201	5,569	.....	13,770	.....	2,500	.....	.....
Barbour	3,369,838	1,204,589	4,574,427	5,953,446	44,296	69,245	.....	113,541	314,100	96,000	.....	.....
Bibb	641,944	236,923	878,867	1,130,089	8,328	4,614	.....	12,942	.....	2,520	.....	.....
Blount	614,552	143,341	757,893	961,690	7,497	5,770	4,215	17,482	3,000	.....	.....	.....
Bullock	3,084,232	1,006,687	4,090,919	5,389,830	27,638	19,916	7,460	55,014	1,000	.....	25,000	.....
Butler	1,366,720	428,147	1,794,867	2,471,910	17,795	13,366	.....	31,161	4,500	8,000	.....	.....
Calhoun	1,407,530	294,728	1,702,258	2,679,055	16,252	16,070	.....	32,322	5,000	.....	.....	.....
Chambers	1,381,138	306,738	1,687,876	2,218,770	14,713	12,658	.....	27,371	150,000	22,000	.....	.....
Cherokee	1,051,515	316,838	1,368,353	1,809,405	12,163	10,856	.....	23,019	.....	5,000	.....	.....
Choctaw	821,732	283,243	1,104,975	1,452,755	10,335	6,212	.....	16,547	.....	.....	.....	.....
Clarke	942,296	282,118	1,224,414	1,620,064	11,953	9,183	.....	21,136	.....	.....	.....	.....
Clay	542,060	61,512	603,592	801,268	5,821	4,526	.....	10,347	.....	.....	.....	.....
Cleburne	403,608	40,773	444,381	568,634	4,469	3,198	.....	7,667	4,000	.....	.....	.....
Coffee	297,493	54,794	352,217	467,036	3,987	6,579	.....	10,566	.....	9,870	.....	.....
Colbert	1,365,347	469,376	1,834,723	2,178,058	16,229	13,050	.....	29,288	10,000	.....	.....	.....
Conecuh	723,091	237,292	960,383	1,250,635	9,550	7,210	.....	16,760	.....	7,270	.....	.....
Coosa	748,346	195,529	943,875	1,240,203	9,950	7,079	.....	17,029	500	.....	.....	.....
Covington	144,601	45,021	190,222	252,788	2,190	2,139	.....	4,329	.....	1,336	.....	.....
Crenshaw	655,144	136,575	791,719	1,046,027	8,694	5,938	.....	14,632	.....	4,000	.....	.....
Dale	757,600	150,380	907,980	1,198,152	9,528	8,511	.....	18,039	.....	5,000	.....	.....
Dallas	7,011,966	2,767,611	9,779,577	12,722,277	88,408	75,825	46,000	210,233	.....	.....	287,000	55,000
De Kalb	546,755	107,874	654,629	872,358	6,875	5,384	.....	12,259	5,000	.....	.....	.....
Elmore	1,618,588	689,099	2,307,687	2,931,364	21,664	18,320	.....	39,984	.....	.....	.....	.....
Escambia	138,699	129,923	268,622	345,616	3,516	2,014	.....	5,530	.....	.....	.....	.....
Etowah	875,064	116,733	991,797	1,168,222	9,854	7,009	.....	16,863	8,000	.....	.....	.....
Fayette	441,235	188,182	629,417	775,693	6,079	4,654	.....	10,733	3,000	7,000	.....	.....
Franklin	637,661	156,278	793,939	3,302,081	8,988	19,812	.....	28,800	9,000	.....	.....	.....
Geneva	140,732	62,201	202,933	266,633	2,021	1,521	.....	3,542	.....	.....	.....	.....
Greene	2,763,492	850,734	3,614,226	4,708,610	33,107	20,304	3,957	57,368	80,000	.....	20,000	.....
Hale	3,210,595	1,178,230	4,388,825	5,717,318	39,461	32,916	6,000	78,377	.....	.....	15,000	4,000
Henry	942,655	461,586	1,404,241	1,852,582	14,147	10,541	.....	24,688	.....	9,000	.....	.....
Jackson	1,615,229	320,010	1,935,239	2,137,200	18,979	12,823	.....	31,802	4,500	12,000	.....	.....
Jefferson	1,072,099	278,531	1,350,630	1,557,197	12,667	9,343	.....	22,010	.....	7,500	.....	.....
Lauderdale	2,307,657	871,108	3,179,565	3,442,596	28,718	20,655	.....	49,373	14,828	4,234	600	2,855
Lawrence	1,467,817	359,855	1,827,672	3,000,000	18,294	17,964	220	35,758	.....	4,000	.....	.....
Lee	1,767,685	461,352	2,229,037	2,922,373	19,559	16,685	2,360	38,604	200,000	.....	50,000	.....
Limestone	2,195,921	497,135	2,693,056	3,351,651	24,542	20,109	.....	44,651	.....	.....	.....	.....
Lowndes	2,438,177	849,439	3,287,616	4,283,954	30,922	18,389	.....	49,311	.....	5,000	.....	325
Macon	2,114,040	584,719	2,699,659	3,530,490	25,210	20,246	1,875	47,331	.....	.....	.....	225
Madison	6,658,949	1,311,796	7,970,675	8,100,000	73,982	54,219	.....	127,481	149,000	.....	.....	.....
Marengo	2,920,903	769,273	3,390,176	4,481,457	42,854	41,861	.....	90,715	.....	8,376	.....	1,500
Marion	236,787	54,506	291,293	683,191	3,161	4,114	.....	7,275	.....	.....	.....	.....
Marshall	760,471	268,311	1,028,782	1,325,737	9,537	7,954	.....	17,491	5,000	10,000	.....	.....
Mobile	17,576,934	6,166,765	23,743,719	30,510,869	201,341	91,780	203,769	496,890	100,200	.....	1,838,300	237,158
Monroe	905,050	538,704	1,444,753	1,874,108	14,078	8,126	.....	22,204	.....	.....	.....	.....
Montgomery	8,839,040	4,094,741	12,934,881	16,614,637	125,923	95,003	126,500	347,426	50,000	.....	538,000	.....
Morgan	1,228,011	272,593	1,500,304	1,910,641	14,366	8,357	.....	22,723	2,500	.....	.....	.....
Perry	3,257,515	1,464,015	4,721,530	6,156,480	43,624	26,237	.....	69,861	14,000	.....	.....	.....
Pickens	1,132,081	349,929	1,482,010	1,953,071	14,656	11,115	.....	25,771	.....	.....	.....	.....
Pike	1,372,050	327,278	1,699,337	2,245,440	16,286	12,744	.....	29,030	.....	.....	.....	.....
Randolph	765,969	116,303	882,332	1,170,408	8,505	4,900	.....	13,555	100,000	3,639	.....	.....
Russell	2,138,778	406,701	2,635,477	3,483,797	25,837	19,766	.....	45,603	.....	23,000	.....	.....
Sanford	600,000	200,000	800,000	1,000,000	6,435	6,000	.....	12,435	.....	5,000	.....	.....
Shelby	935,057	266,112	1,202,069	1,580,501	12,425	8,751	.....	21,176	.....	11,500	.....	.....
St. Clair	349,977	93,229	643,206	841,037	6,633	5,031	.....	11,664	.....	8,000	.....	.....
Sumter	2,415,290	749,300	3,164,590	4,156,041	31,079	31,645	815	63,539	15,000	20,000	.....	.....
Talladega	2,730,107	811,563	3,541,690	4,632,823	31,658	26,610	.....	58,268	.....	.....	.....	.....

Chapter 2: Figure 4– Wealth, Taxation, and Public Indebtedness 1870.[24]

[24] "Table II. Wealth, Taxation, and Public Indebtedness of Each State and Territory, (By Counties)." *The United States Census Bureau* (1870): 15.

GENERAL TABLES

TABLE 1.—ASSESSED VALUATION OF ALL PROPERTY SUBJECT TO GENERAL PROPERTY TAXES OF STATES, COUNTIES, AND ALL OTHER CIVIL DIVISIONS, BY GEOGRAPHIC DIVISIONS AND STATES: 1922, 1912, 1902, 1880, AND 1860

[Expressed in thousands]

GEOGRAPHIC DIVISION AND STATE	1922	1912	1902	1880	1860
Grand total	$124,616,675	$69,452,936	$35,338,317	$17,139,903	$12,084,560
NEW ENGLAND	10,249,809	7,541,527	4,924,027	2,692,843	1,606,468
Maine	637,403	416,891	352,229	235,979	154,380
New Hampshire	617,981	439,683	204,092	205,587	123,810
Vermont	307,255	221,530	162,788	86,807	84,759
Massachusetts	5,677,715	4,803,079	3,115,426	1,584,757	777,158
Rhode Island	1,046,691	619,010	424,398	252,536	125,104
Connecticut	1,962,764	1,041,334	665,094	327,177	341,257
MIDDLE ATLANTIC	29,260,038	18,691,072	10,841,399	5,037,917	2,406,400
New York	15,390,399	11,131,779	5,969,913	2,651,940	1,390,465
New Jersey	4,102,365	2,490,490	952,561	702,518	296,682
Pennsylvania	9,767,274	5,068,803	3,918,925	1,683,459	719,253
EAST NORTH CENTRAL	30,668,599	15,507,238	7,361,138	3,972,762	2,109,595
Ohio	10,406,661	6,481,059	1,990,885	1,534,361	959,967
Indiana	5,225,700	1,898,307	1,417,363	727,815	411,042
Illinois	4,000,497	2,343,673	1,030,292	786,617	389,207
Michigan	5,929,615	2,317,562	1,418,252	517,666	163,333
Wisconsin	5,106,126	2,466,637	1,504,346	406,303	185,946
WEST NORTH CENTRAL	18,796,060	8,094,365	3,445,664	1,490,439	534,067
Minnesota	2,353,695	1,474,585	761,760	258,029	32,019
Iowa	1,766,003	902,093	572,841	398,671	205,167
Missouri	4,633,400	1,860,088	1,246,401	561,940	266,936
North Dakota	1,308,315	293,048	133,876	[1] 20,321	----------
South Dakota	1,977,128	354,279	187,531		
Nebraska	3,202,706	463,372	180,091	90,586	7,427
Kansas	3,554,813	2,746,900	363,164	160,892	22,518
SOUTH ATLANTIC	11,577,386	5,816,457	2,896,097	1,694,546	2,503,788
Delaware	227,070	93,814	68,983	59,952	39,797
Maryland	1,685,496	1,235,458	732,271	497,308	297,135
District of Columbia	1,175,867	359,932	223,392	99,402	41,085
Virginia	1,826,263	864,963	502,939	318,331	657,021
West Virginia	2,092,557	1,168,013	255,488	146,992	----------
North Carolina	2,521,115	747,501	346,879	156,100	292,208
South Carolina	436,000	291,531	195,786	133,560	489,319
Georgia	1,191,569	842,358	467,311	251,963	618,233
Florida	421,449	212,887	103,048	30,938	68,930
EAST SOUTH CENTRAL	5,786,887	2,635,219	1,654,798	832,393	1,852,380
Kentucky	2,404,147	1,031,174	711,258	370,743	528,213
Tennessee	1,730,828	625,687	406,215	228,155	382,495
Alabama	943,516	566,807	296,136	122,867	432,199
Mississippi	708,396	411,551	241,189	110,628	509,473

Chapter 2: Figure 5– Assessed Valuation.[25]

In 1912, the assessed value for Dallas was $8,154,108, Hale was $6,771,261, Greene was $4,791,661, Marengo was $7,370,780, and Sumter was $6,287,329. Of the five counties, only Dallas County had a 35.9069% decrease in wealth over the forty-year period. On the other hand,

[25] "Table I.--Assessed Valuation of All Property Subject to General Property Taxes of States, Counties, and All their Civil Divisions, by Geographic Division and States: 1922, 1912, 1902, 1880, and 1860" *The United States Census Bureau* (1870): 14.

Greene County experienced a 1.7638% increase, Hale County had an 18.4342% increase, Marengo had a 64.4728% increase, and Sumter had a 51.2817% increase. The subsequent increases and decreases resulted in counties that had very similar wealth distributions. (Chapter 2: Figure 6, Figure 7, Figure 8, Figure 9, and Figure 10).[26]

TABLE 1.—FARMS AND FARM PROPERTY,

[Comparative data for June 1, 1900, in italics.]

		Conecuh.	Coosa.	Covington.	Crenshaw.	Cullman.[1]	Dale.[1]	Dallas.	Dekalb.
1	**Population**	21,433	16,634	32,124	23,313	28,321	21,608	53,401	28,261
2	*Population in 1900*	*17,514*	*16,144*	*15,346*	*19,698*	*17,849*	*21,189*	*54,667*	*23,553*
3	**Number of all farms**	3,527	2,858	3,333	3,770	4,528	3,428	8,182	4,932
4	*Number of all farms in 1900*	*2,457*	*2,595*	*1,941*	*2,972*	*2,998*	*3,002*	*7,141*	*4,004*
	Color and nativity of farmers:								
5	Native white	1,954	1,880	2,895	2,763	4,266	2,644	759	4,844
6	Foreign-born white	5	.....	3	1	214	.....	4	15
7	Negro and other nonwhite	1,568	978	435	1,006	48	784	7,419	73
	Number of farms, classified by size:								
8	Under 3 acres	2	1	.....	.....	1	1	1	.....
9	3 to 9 acres	282	66	70	90	104	67	1,236	107
10	10 to 19 acres	397	292	135	192	410	131	1,288	507
11	20 to 49 acres	1,481	821	1,260	1,623	1,551	1,300	3,990	1,761
12	50 to 99 acres	699	650	812	901	1,331	758	1,060	1,449
13	100 to 174 acres	373	649	695	587	799	631	324	793
14	175 to 259 acres	149	207	210	203	226	256	104	211
15	260 to 499 acres	97	141	119	148	99	104	109	99
16	500 to 999 acres	32	30	22	22	7	26	37	12
17	1,000 acres and over	15	1	10	4	.....	4	24	3
	LAND AND FARM AREA								
18	Approximate land area.....acres..	543,360	419,200	666,880	395,520	488,320	360,320	612,480	503,040
19	Land in farms.....acres..	269,779	272,964	315,249	309,836	343,008	314,874	362,745	363,521
20	*Land in farms in 1900*.....acres..	*270,515*	*299,445*	*260,001*	*288,554*	*269,794*	*357,270*	*455,569*	*340,884*
21	Improved land in farms.....acres..	104,645	108,388	119,812	149,297	142,888	159,282	256,586	151,033
22	*Improved land in farms in 1900*.....acres..	*89,098*	*98,176*	*67,778*	*151,413*	*94,116*	*148,703*	*220,269*	*126,663*
23	Woodland in farms.....acres..	153,127	132,431	191,808	113,319	195,081	126,214	83,672	203,977
24	Other unimproved land in farms.....acres..	12,007	32,145	3,629	47,220	5,039	29,378	22,487	7,911
25	Per cent of land area in farms	49.6	65.1	47.3	78.3	70.2	87.4	59.2	72.3
26	Per cent of farm land improved	38.8	39.7	38.0	48.2	41.7	50.6	70.7	41.7
27	Average acres per farm	76.5	95.5	94.6	82.2	75.8	91.9	44.3	73.7
28	Average improved acres per farm	29.7	37.9	35.9	39.6	31.6	46.5	31.4	30.7
	VALUE OF FARM PROPERTY								
29	**All farm property**.....dollars..	5,278,417	3,008,752	5,503,568	5,166,435	6,170,474	4,567,858	8,154,108	6,297,037
30	*All farm property in 1900*.....dollars..	*1,798,580*	*1,708,125*	*1,537,494*	*1,794,610*	*2,812,301*	*2,196,191*	*5,033,910*	*2,806,554*
31	Per cent increase, 1900–1910	193.5	79.7	296.7	187.9	.....	.....	62.0	124.4

Chapter 2: Figure 6- Dallas County.[27]

[26] "Supplement for Alabama: Population, Agriculture, Manufactures, Mines, and Quarries." *The United States Census Bureau.* (1910): 634-638.

[27] Thirteenth Census of the United States Taken in the Year 1910: Statistics for Alabama Containing, Statistics of Population, Agriculture, Manufactures, and Mining for the State Counties, Cities, and Other Divisions.

BY COUNTIES: APRIL 15, 1910—Continued.

[Comparative data for June 1, 1900, in italics.]

	Elmore.	Escambia.	Etowah.	Fayette.	Franklin.	Geneva.[1]	Greene.	Hale.	Henry.[1]	Houston.	Jackson.	Jefferson.	Lamar.
1	28,245	18,889	39,109	16,248	19,369	26,230	22,717	27,883	20,943	32,414	32,918	226,476	17,487
2	*26,099*	*11,820*	*27,301*	*14,158*	*16,511*	*19,066*	*24,132*	*31,011*	*36,147*	(1)	*30,508*	*140,420*	*16,084*
3	4,033	1,677	3,068	2,807	2,650	3,365	4,099	4,510	3,419	4,301	4,860	3,917	3,027
4	*3,481*	*959*	*2,735*	*2,371*	*2,239*	*2,290*	*4,130*	*3,805*	*4,609*	(1)	*4,244*	*3,776*	*2,596*
5	2,301	1,388	2,847	2,588	2,529	3,000	562	944	1,843	3,448	4,466	3,372	2,505
6	5	7	8		3		1	13	2			83	2
7	1,727	282	213	309	118	365	3,536	3,553	1,574	853	394	462	520
8	4	1	2		1	1		1	2	2		52	1
9	177	74	91	45	65	56	362	336	68	99	108	503	51
10	518	196	293	419	346	114	663	696	113	189	516	665	338
11	1,635	680	1,056	738	699	1,497	1,901	2,161	1,599	2,057	1,849	1,261	742
12	853	365	769	577	565	829	595	640	808	1,042	1,063	752	694
13	552	246	572	605	614	596	260	320	438	609	749	448	694
14	150	53	178	295	203	152	130	151	183	176	275	139	202
15	104	43	83	188	131	90	112	119	155	92	213	73	184
16	27	15	17	26	21	26	48	44	40	26	73	21	27
17	13	4	2	4	5	4	23	33	13	9	14	3	4
18	308,080	612,480	346,880	411,520	414,080	369,920	406,400	413,440	358,400	370,560	729,600	726,400	384,640
19	296,754	127,034	249,368	296,019	256,927	275,006	279,575	328,705	308,069	324,608	443,289	235,820	313,065
20	*512,536*	*102,794*	*235,369*	*310,470*	*275,225*	*295,019*	*296,042*	*336,133*	*357,022*	(1)	*445,598*	*287,045*	*285,570*
21	140,716	43,102	112,123	92,816	90,826	131,908	158,155	185,160	164,890	184,319	109,300	95,856	94,926
22	*189,533*	*35,131*	*99,710*	*82,812*	*80,944*	*101,558*	*180,067*	*174,795*	*229,533*	(1)	*155,052*	*103,570*	*94,013*
23	127,109	62,804	127,446	187,701	151,040	121,800	92,834	100,268	121,022	135,363	260,043	128,314	179,299
24	10,929	21,128	9,799	15,502	14,355	22,198	28,586	43,277	19,557	4,926	13,356	11,650	38,840
25	74.5	20.7	71.9	71.9	62.0	74.5	68.8	79.5	85.4	87.6	60.8	32.5	81.4
26	50.4	33.9	45.0	31.4	35.4	47.0	56.6	50.3	53.9	58.8	38.3	40.6	30.3
27	73.6	75.8	81.3	102.2	96.9	81.0	68.2	72.9	89.5	75.5	91.2	60.2	103.4
28	37.1	25.7	36.5	32.0	34.3	39.2	38.6	41.1	48.2	42.9	35.0	24.5	31.4
29	6,022,741	2,629,153	4,673,309	3,337,050	3,435,302	5,547,259	4,791,661	6,771,261	4,771,464	7,031,404	7,252,402	13,819,700	3,034,671
30	*2,730,689*	*815,874*	*3,264,197*	*1,562,795*	*1,586,514*	*1,770,917*	*2,734,740*	*3,935,228*	*3,649,787*	(1)	*4,770,744*	*4,295,710*	*1,777,827*
31	119.8	222.2	43.2	113.5	116.5		72.1	69.9			52.0	221.9	104.9

Chapter 2: Figure 7- Greene County and Hale.[28]

[Comparative data for June 1, 1900, in italics.]

		Lauderdale.	Lawrence.	Lee.	Limestone.	Lowndes.	Macon.	Madison.	Marengo.
1	**Population**	30,936	21,984	32,867	26,880	31,894	26,049	47,041	30,922
2	*Population in 1900*	*28,559*	*20,124*	*31,886*	*22,887*	*30,651*	*23,126*	*43,708*	*28,815*
3	**Number of all farms**	4,440	4,003	3,869	4,709	6,436	4,475	5,854	6,621
4	*Number of all farms in 1900*	*3,210*	*3,193*	*3,551*	*3,584*	*7,088*	*3,824*	*5,142*	*5,833*
	Color and nativity of farmers:								
5	Native white	3,487	2,820	1,295	2,901	670	632	3,244	1,470
6	Foreign-born white	44	2		28	5	1	15	2
7	Negro and other nonwhite	909	1,181	2,574	1,780	5,755	3,842	2,595	5,149
	Number of farms, classified by size:								
8	Under 3 acres			1		3	1	1	2
9	3 to 9 acres	84	74	146	83	1,326	434	113	626
10	10 to 19 acres	557	301	187	671	732	358	497	1,310
11	20 to 49 acres	1,706	1,576	1,504	2,139	3,007	2,299	2,831	2,943
12	50 to 99 acres	1,057	997	957	1,059	902	865	1,328	840
13	100 to 174 acres	655	636	731	499	223	329	659	460
14	175 to 259 acres	222	195	191	142	89	64	215	176
15	260 to 499 acres	117	130	117	86	87	93	150	147
16	500 to 999 acres	27	31	30	36	42	23	54	63
17	1,000 acres and over	15	3	5	4	25	9	6	50
	LAND AND FARM AREA								
18	Approximate land area.....acres	444,160	448,000	404,480	381,440	472,960	392,960	519,040	618,240
19	Land in farms.....acres	345,502	311,481	318,199	298,393	307,899	251,265	408,781	453,380
20	*Land in farms in 1900*.....acres	*281,515*	*291,445*	*287,953*	*289,588*	*343,460*	*256,470*	*389,970*	*452,476*
21	Improved land in farms.....acres	163,793	162,022	191,535	163,292	204,396	171,118	245,056	238,944
22	*Improved land in farms in 1900*.....acres	*127,490*	*156,934*	*171,187*	*139,730*	*222,608*	*148,558*	*235,334*	*236,784*
23	Woodland in farms.....acres	163,180	140,566	90,711	127,272	56,609	71,559	141,899	163,997
24	Other unimproved land in farms.....acres	18,529	8,893	29,953	7,829	46,884	8,858	21,826	51,378
25	Per cent of land area in farms	77.8	69.5	78.7	78.2	65.1	63.9	78.8	73.3
26	Per cent of farm land improved	47.4	52.0	60.2	54.7	66.4	68.1	59.9	52.7
27	Average acres per farm	77.8	77.8	82.2	63.4	47.8	56.1	69.8	68.5
28	Average improved acres per farm	36.9	40.5	49.5	34.7	31.8	38.2	41.9	36.1
	VALUE OF FARM PROPERTY								
29	**All farm property**.....dollars	6,089,001	5,447,263	6,076,170	7,508,603	6,271,079	5,422,585	10,947,142	7,370,740
30	*All farm property in 1900*.....dollars	*3,033,789*	*2,718,855*	*3,221,418*	*3,480,000*	*4,161,400*	*2,558,887*	*6,068,801*	*4,418,631*
31	Per cent increase, 1900-1910	115.9	100.3	88.6	117.5	51.1	111.9	81.7	66.8

Chapter 2: Figure 8- Marengo County.[29]

[28] Thirteenth Census of the United States Taken in the Year 1910.

[29] Thirteenth Census of the United States Taken in the Year 1910.

[Comparative data for June 1, 1900, in 1

		Sumter.	Talladega.	Talla
1	**Population**	28,699	37,921	
2	*Population in 1900*	*28,710*	*35,778*	
3	**Number of all farms**	4,624	4,546	
4	*Number of all farms in 1900*	*5,140*	*3,954*	
	Color and nativity of farmers:			
5	Native white	740	2,349	
6	Foreign-born white	4		
7	Negro and other nonwhite	3,880	2,197	
	Number of farms, classified by size:			
8	Under 3 acres	2	1	
9	3 to 9 acres	191	132	
10	10 to 19 acres	524	417	
11	20 to 49 acres	2,321	2,280	
12	50 to 99 acres	842	963	
13	100 to 174 acres	366	476	
14	175 to 259 acres	132	172	
15	260 to 499 acres	132	76	
16	500 to 999 acres	69	23	
17	1,000 acres and over	45	6	
	LAND AND FARM AREA			
18	Approximate land area.....acres..	581,120	483,200	4
19	Land in farms.....acres..	371,291	283,084	4
20	*Land in farms in 1900*.....acres..	*406,801*	*287,128*	*4*
21	Improved land in farms.....acres..	211,670	164,935	1
22	*Improved land in farms in 1900*.....acres..	*220,071*	*166,546*	*1*
23	Woodland in farms.....acres..	120,844	105,451	1
24	Other unimproved land in farms.....acres..	38,777	12,698	
25	Per cent of land area in farms	63.9	58.6	
26	Per cent of farm land improved	57.0	58.3	
27	Average acres per farm	80.3	62.3	
28	Average improved acres per farm	45.8	36.3	
	VALUE OF FARM PROPERTY			
29	**All farm property**.....dollars..	6,287,329	6,168,923	6,8
30	*All farm property in 1900*.....dollars..	*3,720,894*	*3,676,974*	*3,6*
31	Per cent increase, 1900-1910	69.0	67.8	
32	Land.....dollars..	3,621,979	3,556,117	3,9
33	*Land in 1900*.....dollars..	*1,991,250*	*2,131,480*	*2,0*
34	Buildings.....dollars..	1,052,975	1,210,788	1,4

Chapter 2: Figure 9– Sumter County.[30]

In addition to holding a large portion of the state's wealth in 1870, all five of these counties have a large free Black population that equaled more than three-quarters of the county's inhabitants. The population is broken down as follows. (See Chapter 2: Figure 8 and Figure 9)[31]

[30] Thirteenth Census of the United States Taken in the Year 1910.

[31] "Table II. Population of Each State and Territory (by Counties) in the Aggregate and as White, Free Colored, Slave, Chinese, and Indian, at all Censuses." *US Census Bureau* (1870), 11.

County	Total Population	Percent Whites	Percent Black
Greene	18,399	21%	79%
Hale	21,792	22%	78%
Dallas	40,705	21%	79%
Marengo	26,151	23%	77%
Sumter	24,109	22%	78%

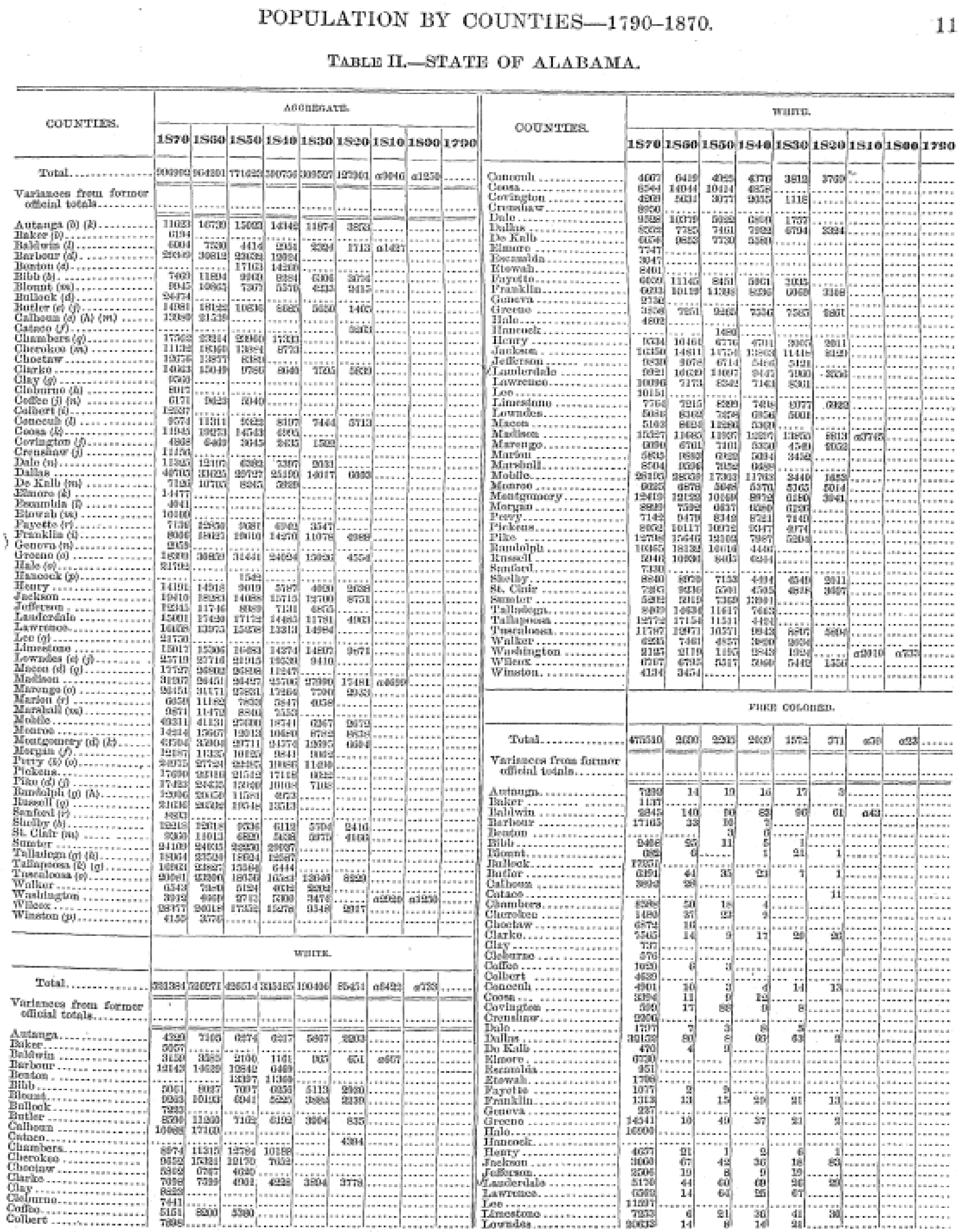
POPULATION BY COUNTIES—1790-1870. 11

TABLE II.—STATE OF ALABAMA.

Chapter 2: Figure 10– Population of Each State.[32]

[32] "Table II. Population of Each State and Territory (by Counties) in the Aggregate and as White, Free Colored, Slave, Chinese, and Indian, at all Censuses." *US Census Bureau* (1870), 11.

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POPULATION BY COUNTIES—1790-1870.

TABLE II.—STATE OF ALABAMA—Continued.

COUNTIES.	FREE COLORED. 1870	1860	1850	1840	1830	1820	1810	1800	1790
Macon	12020	1	16	27					
Madison	15740	102	164	144	152	46	a6		
Marengo	20058	1	37	12	13	15			
Marion	224	5	3		6				
Marshall	1307	51	26	24					
Mobile	21107	1195	941	787	546	183			
Monroe	7572	46	40	18	70	30			
Montgomery	31285	76	115	115	65	6			
Morgan	3358	37	51	45	42				
Perry	17833	30	20	22	23				
Pickens	9638	8	6	7	17				
Pike	4025	4	24	30	26				
Randolph	1641	23	26	1					
Russell	15090	18	32	3					
Sanford	1563								
Shelby	3378	26	7	2	10				
St. Clair	2803	9	7	8	3	6			
Sumter	18907	25	50	118					
Talladega	8505	21	36	26					
Tallapoosa	4190	1		7					
Tuscaloosa	8294	84	8	66	46				
Walker	308		1	1					
Washington	1787	56	22	23	16		a10	a82	
Wilcox	21610	20		94	16	7			
Winston	21								
	SLAVE.								
Total		435080	342844	253532	117549	41879	a2565	a494	
Variances from former official totals									
Autauga		9607	6730	8109	2990	1047			
Baldwin		3714	2218	1797	1263	1001	a717		
Barbour		16150	10789	5548					
Benton			3763	2804					
Bibb		3842	2861	2023	1192	746			
Blount		690	420	344	330	173			
Butler		6618	3630	2470	1730	569			
Calhoun		4342							
Cataco						858			
Chambers		11840	11169	7141					
Cherokee		3062	1601						
Choctaw		7094	3709	1112					
Clarke		7436	4876	4310	3672	2035			
Coffee		1417	537						
Conecuh		4882	4304	3817	3618	1931			
Coosa		5219	4129	2195					
Covington		821	480	371	306				
Dale		1809	737	530	209				
Dallas		25760	22258	17208	7109	2077			
De Kalb		868	306	340					
Fayette		1703	1221	981	512				
Franklin		8405	8197	6003	4058	1667			
Greene		23598	22127	16431	7420	1091			
Hancock			62						
Henry		4433	2342	1084	1030	636			

COUNTIES.	SLAVE. 1870	1860	1850	1840	1830	1820	1810	1800	1790
Jackson		3405	2292	1818	1204	530			
Jefferson		2649	2207	1036	1715				
Lauderdale		6737	6015	4903	3795	1376			
Lawrence		6788	6832	6143	6556				
Limestone		8085	8063	6840	6089	2913			
Lowndes		19340	14649	12589	4388				
Macon		18176	15396	3851					
Madison		14573	14326	13205	13077	8622	a948		
Marengo		24409	20692	11102	3138	866			
Marion		1393	948	753	490				
Marshall		1821	808	841					
Mobile		11376	9356	6191	2261	836			
Monroe		8705	6325	5392	3541	3794			
Montgomery		23710	19427	15486	6450	2655			
Morgan		3706	3437	3216	2894				
Perry		18206	13017	10343	4318				
Pickens		12191	10534	7784	1031				
Pike		8783	3794	2111	1878				
Randolph		1984	938	526					
Russell		15638	11111	7906					
Shelby		3022	2370	1816	1139	405			
St. Clair		1708	1321	1125	1154	333			
Sumter		16001	14831	15920					
Talladega		8865	6971	4896					
Tallapoosa		6078	4073	2813					
Tuscaloosa		10145	7477	6554	4793	2335			
Walker		519	266	211	168				
Washington		2494	1496	2634	1539		a906	a494	
Wilcox		17797	11835	9294	4980	1354			
Winston		122							
	INDIAN.								
Total	98	160							
Variances from former official totals									
Autauga	2	12							
Baldwin		21							
Barbour	1								
Choctaw	2								
Conecuh	6								
Coosa	7	4							
Dale		2							
Dallas	1								
Escambia	42								
Lee	2								
Macon	4	1							
Madison		1							
Marengo	3								
Marion		1							
Marshall		4							
Mobile	9	1							
Monroe	17	38							
Montgomery		2							
Tallapoosa	1								

(a) Then in the Territory of Mississippi.
(b) In 1868 Baker from Autauga, Bibb, Perry, and Shelby.
(c) In 1858 name changed from Benton to Calhoun.
(d) In 1866 Bullock from Barbour, Macon, Montgomery, and Pike.
(e) In 1830 west half township 11, range 16, from Lowndes.
(f) In 1821 name changed from Cataco to Morgan.
(g) In 1866 Clay from Randolph and Talladega.
(h) In 1866 Cleburne from Calhoun, Randolph, and Talladega.
(i) In 1867 Colbert from Franklin.
(j) In 1866 Crenshaw from Butler, Coffee, Covington, Lowndes, and Pike.
(k) In 1866 Elmore from Autauga, Coosa, Montgomery, and Tallapoosa.
(l) In 1868 Escambia from Baldwin and Conecuh.
(m) In 1866 Etowah from Blount, Calhoun, Cherokee, De Kalb, Marshall, and St. Clair.
(n) In 1868 Geneva from Coffee and Dale. In 1869-'70 extended to Florida line.
(o) In 1867 Hale from Greene, Marengo, Perry, and Tuscaloosa.
(p) In 1850 Hancock, name changed to Winston.
(q) In 1866 Lee from Chambers, Macon, Russell, and Tallapoosa.
(r) In 1867 Sanford from Fayette and Marion.

Chapter 2: Figure 11- Population by Counties– 1790-1870.[33]

To illustrate the growth, a comparison with the overall population by county in 1910 is necessary. In all five counties, the population grew between 1870 and 1910. The following chart represents the population growth from 1870 to 1910 and the percentage of increase.

[33] "Table II. Population of Each State and Territory, 11.

Growth Chart					
County	**Year**	**Population**	**Year**	**Population**	**Percent Increase**
Greene	1870	18,399	1910	27,717	23.47%
Hale	1870	21,793	1910	27,883	27.95%
Dallas	1870	40,705	1910	53,401	31.19%
Marengo	1870	26,151	1910	39,943	52.74%
Sumter	1870	24,109	1910	28,699	19.04%

[34]

To further extrapolate this data, the United States Census Bureau has broken the population of 1910 down into categories such as race and gender. A consistent statistic that persisted from 1870 to 1910 is that the five counties under examination had a colored or Black population as the majority, which grossly outnumbered the White inhabitants in the areas, as can be seen on the following chart.[35]

1910 Race Chart by County

[34] "1910 Census: Volume 2. Population, Reports by States, with Statistics for Counties, Cities, and Other Civil Divisions: Alabama-Montana." *The United States Census Bureau* (April 1915): 51-59.

[35] "1910 Census: Volume 2. Population, Reports by States, with Statistics for Counties, Cities, and Other Civil Divisions," 51-59.

County	Total Population	Total Number of White	Total Percent of White	Total Number of Black	Total Percent of Black
Greene	22,717	2,109	13%	19,705	87%
Hale	27,883	5,895	21%	21,987	79%
Dallas	53,401	9,890	19%	43,511	81%
Marengo	39,943	9,070	23%	30,816	77%
Sumter	28,699	5,377	19%	23,322	81%

It is necessary to break this data down into arguably the most critical data for this dissertation- gender. After all, this is a study on the professionalization and modernization of childbirth—it is women who give birth. It is critical to illustrate what percentage of the population was most directly affected by this shift in medicalized practice. In all five of the counties under examination women made up more than half of the population, this meant that the majority of the population was directly affected by the transition period of childbirth. (Chapter 2: Figure 12, Figure 13, Figure 14, and Figure 15). [36]

1910 Gender Chart by County

[36] "1910 Census: Volume 2. Population, Reports by States, with Statistics for Counties, Cities, and Other Civil Divisions," 51-59.

County	Total Population	Total Number of Women	Total Percentage of Women
Greene	22,717	11,830	52%
Hale	27,883	14,155	51%
Dallas	53,401	27,704	52%
Marengo	39,943	20,335	51%
Sumter	28,699	14,791	52%

POPULATION FOR THE STATE AND FOR COUNTIES—Continued.

SUBJECT.	Conecuh.	Coosa.	Covington.	Crenshaw.	Cullman.[1]	Dale.[1]	Dallas.[1]	Dekalb.	Elmore.[1]	Escambia.
SEX										
Total...Male	10,822	8,348	16,860	11,706	14,458	10,821	25,697	14,278	14,302	9,665
Female	10,611	8,286	15,264	11,607	13,863	10,787	27,704	13,983	13,943	9,224
White—Male	5,821	5,228	12,422	7,902	14,163	7,917	4,996	13,857	7,618	6,742
Female	5,532	5,150	11,581	7,836	13,625	7,880	4,894	13,550	7,381	6,414
Negro—Male	5,000	3,120	4,378	3,743	295	2,903	20,701	421	6,684	2,842
Female	5,079	3,136	3,623	3,771	238	2,907	22,810	433	6,562	2,727
MALES OF VOTING AGE										

Chapter 2: Figure 12- Dallas County.[37]

POPULATION FOR THE STATE AND FOR COUNTIES—Continued.

	Etowah.	Fayette.	Franklin.[1]	Geneva.[1]	Greene.	Hale.	Henry.[1]	Houston.[1]	Jackson.	Jefferson.[1]
SEX										
Total...Male	20,171	8,245	9,888	13,416	10,887	13,728	10,491	16,475	16,692	117,792
Female	18,938	8,003	9,481	12,814	11,830	14,155	10,452	15,939	16,226	108,684
White...Male	16,519	7,286	8,959	11,170	1,496	3,035	5,483	11,571	15,109	71,012
Female	15,786	7,096	8,568	10,754	1,516	2,860	5,310	11,245	14,557	64,827
Negro...Male	3,652	959	929	2,245	9,391	10,692	5,008	4,903	1,519	46,761
Female	3,152	907	913	2,060	10,314	11,295	5,142	4,694	1,617	43,856
MALES OF VOTING AGE										

Chapter 2: Figure 13- Greene and Hale Counties.[38]

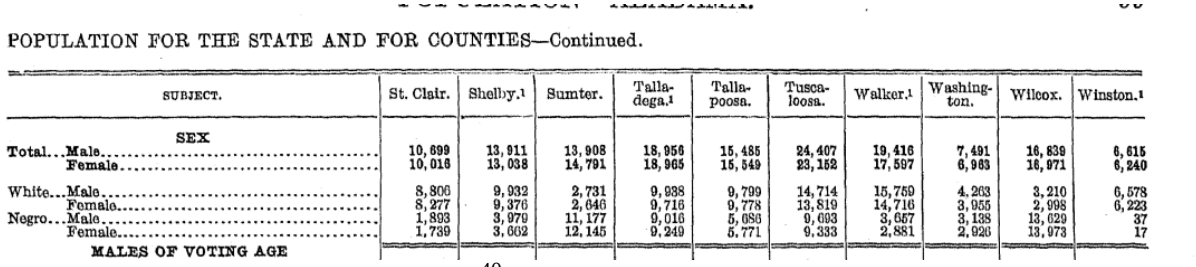
POPULATION FOR THE STATE AND FOR COUNTIES—Continued.

SUBJECT.	Lamar.[1]	Lauder-dale.	Law-rence.[1]	Lee.	Lime-stone.	Lowndes.	Macon.	Madison.	Marengo.	Marion.
SEX										
Total...Male	8,814	15,446	11,018	15,828	13,610	15,574	12,597	23,282	19,588	8,871
Female	8,673	15,490	10,966	17,039	13,270	16,320	13,452	23,759	20,335	8,624
White...Male	7,236	12,001	7,035	6,424	8,560	1,870	2,013	14,138	4,590	8,608
Female	7,071	11,839	7,411	6,800	8,065	1,899	1,994	14,008	4,480	8,367
Negro...Male	1,578	3,445	3,982	9,404	5,050	13,704	10,581	9,143	14,996	263
Female	1,602	3,651	3,951	10,239	5,205	14,421	11,458	9,751	15,850	257
MALES OF VOTING AGE										

[37] 1910 Census: Volume 2. Population.

[38] 1910 Census: Volume 2. Population.

Chapter 2: Figure 14- Marengo County.[39]



POPULATION FOR THE STATE AND FOR COUNTIES—Continued.

SUBJECT.	St. Clair.	Shelby.[1]	Sumter.	Talladega.[1]	Talladoosa.	Tuscaloosa.	Walker.[1]	Washington.	Wilcox.	Winston.[1]
SEX										
Total...Male	10,699	13,911	13,908	18,956	15,485	24,407	19,416	7,491	16,839	6,615
Female	10,016	13,038	14,791	18,965	15,549	23,152	17,597	6,963	16,971	6,240
White...Male	8,806	9,932	2,731	9,938	9,799	14,714	15,759	4,263	3,210	6,578
Female	8,277	9,376	2,646	9,716	9,778	13,819	14,716	3,955	2,998	6,223
Negro...Male	1,893	3,979	11,177	9,016	5,686	9,693	3,657	3,138	13,629	37
Female	1,739	3,662	12,145	9,249	5,771	9,333	2,881	2,926	13,973	17
MALES OF VOTING AGE										

Chapter 2: Figure 15- Sumter County.[40]

In summary, the socioeconomic picture of Alabama and the counties of Dallas, Hale, Greene, Marengo, and Sumter illustrated a community that was primarily Black Americans with women representing more than half of the large population. The region's overall population was steadily increasing and presenting a growing need for birth attendants.

Presentation of Statistical Data

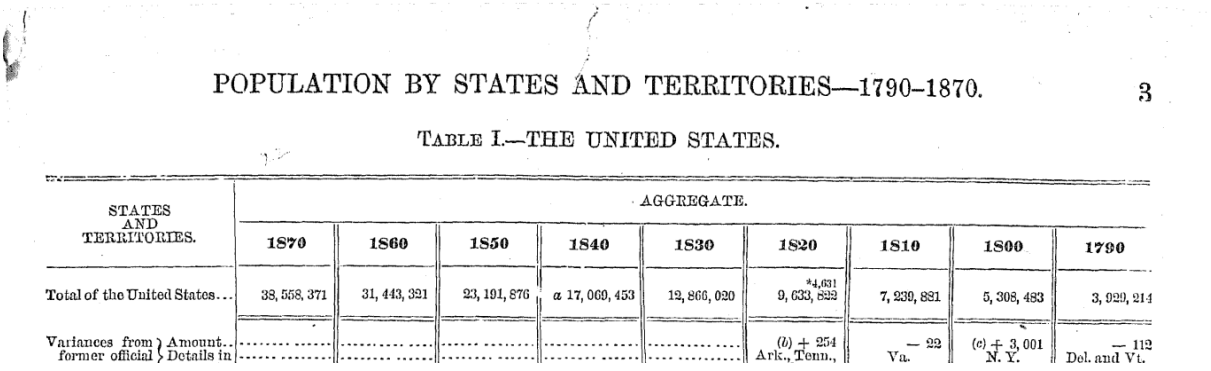
The introduction explicitly explains why a parturient should have a birth attendant present during delivery. Having such a person present helped ensure the safe delivery of the infant, ideally protecting it from harm as it exits the birth canal. Without the presence of a skilled birth attendant, it was likely that the chances of fatality for both the parturient and infant would increase. In Alabama, where the population was largely poor Black women, midwives were the most utilized birth attendants.

In a location where the population was increasing primarily due to natural increase, examining the death statistics related to childbirth is essential. The vital statistics for Alabama are recorded in state totals according to the 1870 vital statistics census. Per these statistics, in the

[39] 1910 Census: Volume 2. Population.

[40] 1910 Census: Volume 2. Population.

entire United States, which had a total population of 35,558,371 in 1870, only 4,810 maternal deaths are indicated because of childbirth. That represents only 0.125% of the total population. Whereas the total population for the state of Alabama was 996,992, the total maternal deaths equated to only 162 women in that population or, 0.01625%. (Chapter 2: Figure 1, Figure 17, Figure 18, and Figure 19).[41]



POPULATION BY STATES AND TERRITORIES—1790–1870. 3

TABLE I.—THE UNITED STATES.

STATES AND TERRITORIES.	AGGREGATE.								
	1870	1860	1850	1840	1830	1820	1810	1800	1790
Total of the United States...	38, 558, 371	31, 443, 321	23, 191, 876	a 17, 069, 453	12, 866, 020	*1,631 9, 633, 822	7, 239, 881	5, 308, 483	3, 929, 214
Variances from former official } Amount...	.....	.....	.....	.....	.....	(b) + 254	— 22	(c) + 3, 001	— 112
Details in	.....	.....	.....	.....	.....	Ark., Tenn.,	Va.	N. Y.	Del. and Vt.

Chapter 2: Figure 16– Population by State and Territories– 1790-1870.[42]

[41] "Table I. Population of the United States (By States and Territories,) in the Aggregate, and as White, Colored, Free Colored, Slave, Chinese, and Indian, at each Census (1870), 3.

[42] Table I. Population of the United States, 3.

TABLE VI.—THE UNITED STATES—DEATHS BY CAUSES, SEX AND MONTH—1870—Continued.

CAUSE OF DEATH.	SEX AND MONTH—FEMALE.													
	Total.	Unknown month.	January.	February.	March.	April.	May.	June.	July.	August.	September.	October.	November.	December.
12. Diarrhœa	6396	25	176	183	215	202	391	504	1122	1470	1123	565	265	178
13. Cholera infantum	9511	25	228	246	270	305	552	960	1906	2140	1418	647	215	232
14. Colic	419	.....	37	36	44	42	44	25	30	30	30	31	30	34
15. Constipation	69	.....	3	4	7	7	11	4	5	8	6	6	3	5
16. Fistula	12	.....	1	1	1	.....	1	1	.....	5	.....	2	.....	.....
17. Other diseases of bowels	1156	1	78	82	76	95	118	81	94	148	127	116	80	60
18. Hepatitis	647	.....	50	56	62	60	78	37	43	66	61	41	49	44
19. Cirrhosis of liver	113	.....	14	11	9	4	12	11	7	6	10	10	11	8
20. Jaundice	579	.....	59	63	54	54	55	43	43	41	47	41	45	34
21. Biliary calculi	16	.....	.....	.....	1	.....	.....	2	2	4	2	2	2	1
22. Other diseases of liver	1037	.....	86	81	104	113	123	77	68	86	77	85	74	63
23. Peritonitis	585	.....	52	57	53	61	60	41	47	52	30	42	46	44
24. Ascites	735	1	56	72	70	68	77	46	73	69	66	52	39	46
25. Other diseases of this group	1050	1	86	81	93	87	100	77	80	103	109	93	63	69
Diseases of the urinary system and male organs of generation.														
Total	1200	.....	113	112	128	119	133	79	90	72	82	102	84	86
1. Bright's disease	642	.....	68	59	59	66	68	45	52	33	38	63	42	49
2. Nephritis	116	.....	6	13	18	9	9	8	7	11	11	4	11	9
3. Other kidney diseases	303	.....	30	25	35	29	40	16	18	18	21	26	24	21
4. Cystitis	44	.....	3	3	7	5	6	2	5	2	3	4	2	2
5. Calculus	7	.....	.....	.....	.....	.....	.....	2	2	.....	.....	1	.....	2
6. Other diseases of this group	88	.....	6	12	9	10	10	6	6	8	9	4	5	3
Diseases of the female organs of generation.														
Total	1318	1	113	103	122	144	155	74	88	115	104	86	108	105
1. Ovarian tumors	169	.....	16	11	11	10	18	12	12	5	22	14	20	18
2. Diseases of uterus	1029	.....	87	88	97	117	120	52	69	100	78	63	82	76
3. Other diseases of this group	120	1	10	4	14	17	17	10	7	10	4	9	6	11
Affections connected with pregnancy.														
Total	4810	1	452	471	553	509	522	309	325	332	339	331	283	392
1. Abortion	188	.....	14	16	15	19	15	17	16	15	13	21	16	11
2. Childbirth	4406	1	421	434	515	466	489	267	290	301	313	294	255	360
3. Puerperal convulsions	216	.....	17	21	23	24	18	16	19	16	13	16	12	21
Diseases of the organs of locomotion.														
Total	699		80	60	60	83	80	65	70	74	63	62	50	69

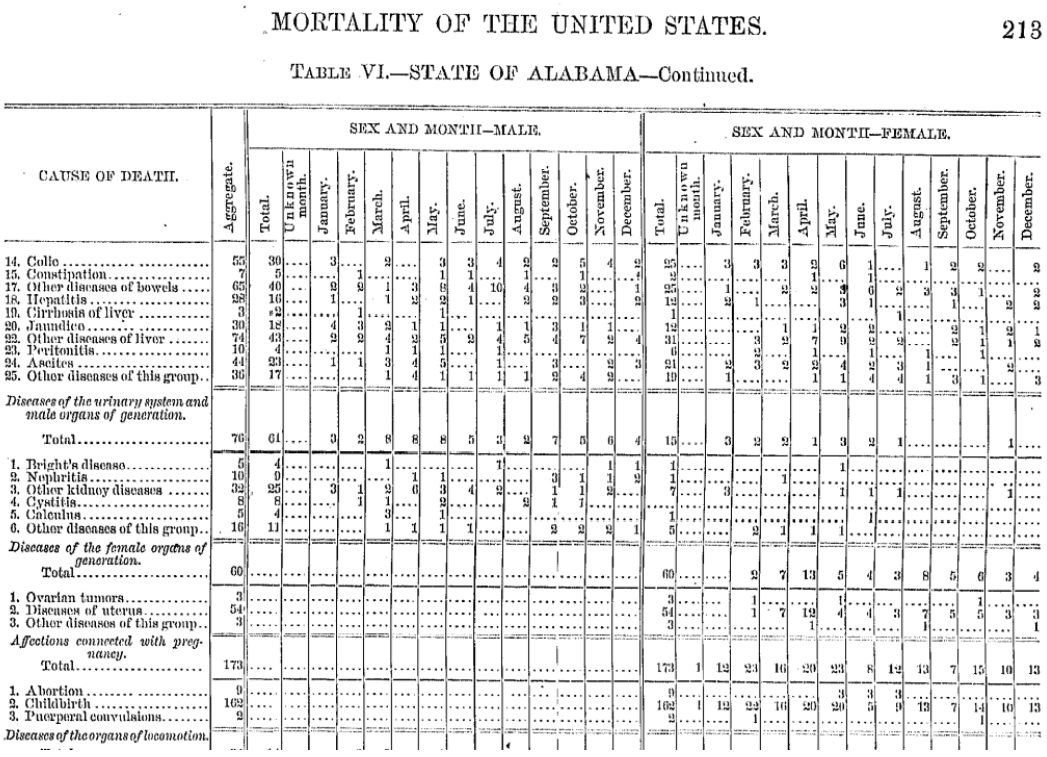
Chapter 2: Figure 17– Mortality.[43]

former official totals. } Details in Table II.									Ark., Tenn., and Vt.		Va.		N. Y.		Del. and Vt.	
Total of the States	38, 115, 641		31, 183, 744		23, 067, 262		17, 019, 641		12, 820, 868		9, 600, 783 *4,631		7, 215, 858		5, 204, 390		3, 929, 214	
Alabama	16	996, 992	13	964, 201	12	771, 623	12	590, 756	15	309, 527	19	127, 901 *18	.....	.....	.....	.....	.....	.....
Arkansas	26	484, 471	25	435, 450	26	209, 897	25	97, 574	27	30, 388	25	14, 255	.....	.....	.....	.....	.....	.....
California	24	560, 247	26	379, 994	29	92, 597	.....	.....	.....	.....	.....	*109	.....	.....	.....	.....	.....	.....
Connecticut	25	537, 454	24	460, 147	21	370, 792	20	309, 978	16	297, 675	14	275, 148	9	261, 942	8	251, 002	8	237, 946
Delaware	34	125, 015	32	112, 216	30	91, 532	26	78, 085	24	76, 748	22	72, 749	19	72, 674	17	64, 273	16	59, 096
Florida	33	187, 748	31	140, 424	31	87, 445	27	54, 477	25	34, 730	.....	.....	.....	.....	.....	.....	.....	.....
Georgia	12	1, 184, 109	11	1, 057, 286	9	906, 185	9	691, 392	10	516, 823	11	*4 340, 985	11	252, 433	12	162, 086	13	82, 548
Illinois	4	2, 539, 891	4	1, 711, 951	11	851, 470	14	476, 183	20	157, 445	24	*49 55, 102	23	12, 982				

Chapter 2: Figure 18– Population of the United States.[44]

[43] Table VI. Mortality of the United States and of Each State and Territory, from Each Specified and Class of Disease, with Distinction of Sex and Month of Death, 211.

[44] Table I. Population of the United States (By States and Territories,) in the Aggregate, and as White, Colored, Free Colored, Slave, Chinese, and Indian, at each Census (1870).



MORTALITY OF THE UNITED STATES. 213

TABLE VI.—STATE OF ALABAMA—Continued.

CAUSE OF DEATH.	Aggregate.	SEX AND MONTH—MALE.													SEX AND MONTH—FEMALE.											
		Total.	Unknown month.	January.	February.	March.	April.	May.	June.	July.	August.	September.	October.	November.	December.	Total.	Unknown month.	January.	February.	March.	April.	May.	June.	July.	August.	September.	October.	November.	December.
14. Colic	53	30		3		2		3	3	4	2	2	5	4	2	23			3		2	6	1		1	2		2
15. Constipation	23	5			1			1	1		1		1		1	18				1		5	1			1		2
17. Other diseases of bowels	65	40		2	2	1	3	5	4	10	4	2	2		1	25			1		2	2	1	2		1		
18. Hepatitis	125	16		1		1	2	2	1		2	2	2		1	12				1		2	1		1			2
19. Cirrhosis of liver	3	2			1			1								1								1				
20. Jaundice	30	18		4	3	2	1	1		1	1	3	1	1		12				1	1	2				1	2	1
22. Other diseases of liver	74	43		2	2	4	2	5	2	4	3	4	7	2	4	31			3	2	7	2		2	1	1	1	2
23. Peritonitis	16	4				1	1	1		1						6					1	1		1		1		
24. Ascites	44	23		1	1	3	4	5		1		3		2	3	21					3	4		3	1		2	
25. Other diseases of this group	36	17				1	4	1	1	1	1	2	4	2	1	19			1			1		4	1	3	1		3
Diseases of the urinary system and male organs of generation.																												
Total	76	61		3	2	8	8	8	5	3	2	7	3	6	4	15		3	2	2	1	3	2	1				1	
1. Bright's disease	5	4				1				1			1	1		1					1							
2. Nephritis	16	9					1	1				3	1	1	2	1				1								
3. Other kidney diseases	32	25		3	1	2	6	3	4	2		1	1	2		7		3				1	1	1				1
4. Cystitis	8	3			1	1		2			2	1	1															
5. Calculus	5	4				3		1								1												
6. Other diseases of this group	16	11				1	1	1	1			2	2	2	1	3			2	1	1		1					
Diseases of the female organs of generation.																												
Total	60															60			2	7	13	5	4	3	8	5	6	3	4
1. Ovarian tumors	3															3												
2. Diseases of uterus	54															54			1	7	12	4	4	3	7	5	5	3	3
3. Other diseases of this group	3															3					1				1				1
Affections connected with pregnancy.																												
Total	173															173	1	12	23	16	20	23	8	12	13	7	15	10	13
1. Abortion	9															9						3	2	2					
2. Childbirth	162															162	1	12	22	16	20	20	5	9	13	7	14	10	13
3. Puerperal convulsions	2															2			1								1		
Diseases of the organs of locomotion.																												

Chapter 2: Figure 19– Mortality, Class of Disease.[45]

The mortality statistics from 1870 must be compared with those from the 1910 census. In 1910, the methodology by which the bureau collected and listed data had evolved from forty years earlier. In this census collection, maternal deaths caused by childbirth had more technical terminology to describe the actual cause of death. This evolution shows that the medical field was progressing rapidly. Doctors were gaining a better understanding of the underlying cause of death. Rather than simply listing a "death from childbirth," the 1910 census includes causes,

[45] Table VI. Mortality of the United States and of Each State and Territory, from Each Specified and Class of Disease, with Distinction of Sex and Month of Death.

such as "puerperal hemorrhage," meaning bleeding in the six weeks after giving birth. (Chapter 2: Figure 20 and Figure 21). [46]

TABLE 4.—DEATHS (EXCLUSIVE OF STILLBIRTHS) FROM EACH CAUSE AND CLASS OF CAUSES, BY AGE OF DECEDENT, FOR THE REGISTRATION AREA: 1911—Continued.

Detailed List No.	CAUSE OF DEATH.	All deaths.	DEATHS AT AGE OF—															Deaths at unknown age
			Under 1 year.	1 year.	2 years.	3	4	5 to 9	10 to 19	20 to 29	30 to 39	40 to 49	50 to 59	60 to 69	70 to 79	80 to 89	90 to 99	100 and over.	
	V.—Diseases of the digestive system—Continued.																		
111	Acute yellow atrophy of the liver	302	26	2	2	1	1	6	10	52	33	39	43	49	29	8	1	.....	.....
112	Hydatid tumor of the liver	24	.....	.....	.....	.....	2	.....	1	4	6	4	2	2	3	.....	.....	.....	.....
113	Cirrhosis of the liver	8,310	21	11	10	7	2	23	52	194	898	1,673	2,030	1,840	1,221	301	20	1	6
114	Biliary calculi	1,749	.....	.....	.....	.....	.....	.....	3	46	167	288	427	437	295	78	7	.....	1
115	Other diseases of the liver	3,076	150	22	20	15	9	29	79	202	318	459	536	532	483	203	18	.....	1
116	Diseases of the spleen	124	3	1	3	2	.....	.....	4	14	17	20	20	24	10	6	.....	.....	.....
117	Simple peritonitis (nonpuerperal)	2,349	162	52	39	29	21	108	254	425	383	264	212	196	144	51	6	1	2
118	Other diseases of the digestive system (cancer and tuberculosis excepted)	467	11	1	2	3	3	5	24	38	76	98	92	60	44	9	.....	.....	1
	VI.—Nonvenereal diseases of the genito-urinary system and annexa	67,348	954	273	220	165	131	507	1,215	3,623	5,903	8,533	11,209	13,898	13,857	6,062	683	25	70
119	Acute nephritis	5,956	424	147	128	93	69	253	320	651	801	837	807	651	539	210	23	1	2
120	Bright's disease	51,847	332	102	83	65	56	239	707	1,913	3,782	6,397	9,446	12,014	11,401	4,712	518	20	60
121	Chyluria	1	.....	.....	.....	.....	.....	.....	.....	1	.....	.....	.....	.....	.....	.....	.....	.....	.....
122	Other diseases of the kidneys and annexa	1,343	123	18	6	4	4	9	26	92	135	166	184	211	216	130	19	.....	.....
123	Calculi of the urinary passages	361	3	.....	1	2	1	4	10	20	40	51	67	70	69	22	1	.....	.....
124	Diseases of the bladder	1,532	33	2	1	.....	1	1	4	27	41	51	120	215	532	438	62	3	1
125	Diseases of the urethra, urinary abscess, etc	285	5	2	.....	.....	.....	1	3	25	39	66	49	43	39	13	.....	.....	.....
126	Diseases of the prostate	2,175	.....	.....	.....	.....	.....	.....	.....	10	7	30	135	483	930	520	55	1	4
127	Nonvenereal diseases of the male genital organs	49	20	.....	.....	1	.....	.....	.....	4	3	6	2	4	7	1	1	.....	.....
128	Uterine hemorrhage (nonpuerperal)	76	.....	.....	.....	.....	.....	.....	4	13	23	24	3	5	3	.....	.....	.....	1
129	Uterine tumor (noncancerous)	892	.....	1	.....	.....	.....	.....	1	52	201	345	155	80	43	13	1	.....	.....
130	Other diseases of the uterus	770	.....	.....	.....	.....	.....	.....	46	181	207	192	95	25	15	6	1	.....	2
131	Cysts and other tumors of the ovary	628	.....	1	.....	.....	.....	.....	9	81	135	138	107	86	54	15	2	.....	.....
132	Salpingitis and other diseases of the female genital organs	1,401	3	.....	1	.....	.....	.....	83	550	485	228	36	8	6	1	.....	.....	.....
133	Nonpuerperal diseases of the breast (cancer excepted)	32	11	.....	.....	.....	.....	.....	2	3	4	2	3	3	3	1	.....	.....	.....
	VII.—The puerperal state	9,456	.....	.....	.....	.....	.....	.....	785	4,316	3,593	741	9	.....	.....	.....	.....	.....	12
134	Accidents of pregnancy	908	.....	.....	.....	.....	.....	.....	33	380	434	60	1	.....	.....	.....	.....	.....	.....
135	Puerperal hemorrhage	851	.....	.....	.....	.....	.....	.....	36	298	404	112	.....	.....	.....	.....	.....	.....	1
136	Other accidents of labor	911	.....	.....	.....	.....	.....	.....	39	375	393	101	1	.....	.....	.....	.....	.....	2
137	Puerperal septicemia	4,376	.....	.....	.....	.....	.....	.....	402	2,143	1,537	283	6	.....	.....	.....	.....	.....	5
138	Puerperal albuminuria and convulsions	2,094	.....	.....	.....	.....	.....	.....	263	981	700	146	.....	.....	.....	.....	.....	.....	4
139	Puerperal phlegmasia alba dolens, embolus, sudden death	266	.....	.....	.....	.....	.....	.....	10	115	108	33	.....	.....	.....	.....	.....	.....	.....
140	Following childbirth (not otherwise defined)	48	.....	.....	.....	.....	.....	.....	1	23	17	6	1	.....	.....	.....	.....	.....	.....
141	Puerperal diseases of the breast	2	.....	.....	.....	.....	.....	.....	1	1	.....	.....	.....	.....	.....	.....	.....	.....	.....
	VIII.—Diseases of the skin and of the cellular tissue	3,010	548	59	21	15	11	30	51	80	109	156	266	408	630	505	113	2	6
142	Gangrene	1,656	49	11	8	5	7	13	6	23	28	58	131	272	517	429	92	2	5
143	Furuncle	285	64	6	2	2	.....	2	7	18	21	30	49	42	27	12	3	.....	.....

Chapter 2: Figure 20– Bulletin 112 Mortality Statistics 1911.[47]

[46] E. Dana Durand, *Department of Commerce Bureau of the Census: Bulletin 112 Mortality Statistics 1911,* (Washington: Government Printing Office, 1913), 102.

[47] Durand, *Department of Commerce Bureau of the Census,* 63.

TABLE 5.—DEATHS (EXCLUSIVE OF STILLBIRTHS), AND DEATH RATES PER 100,000 POPULATION, BY CAUSES, ACCORDING TO THE DETAILED INTERNATIONAL LIST, FOR THE REGISTRATION AREA: 1908 TO 1911—Continued.

[The causes of death originally classified according to the first revision of the International List, which was in effect for the years 1900 to 1909, are rearranged, as far as practicable, to correspond with the second revision, in effect January 1, 1910. Changes depending upon new titles or markedly affecting the comparability of the figures, are indicated by asterisks (*) following the titles, and reference should be made to the statements in the text (p. 27) relative to changes in classification.]

Detailed Int. List No.	CAUSE OF DEATH.	NUMBER OF DEATHS.						DEATH RATE PER 100,000 POPULATION.					
		1911	1910	1909	1908	Annual average: 1906 to 1910.	Annual average: 1901 to 1905.	1911	1910	1909	1908	Annual average: 1906 to 1910.	Annual average: 1901 to 1905.
	VI.—Nonvenereal diseases of the genito-urinary system and annexa—Con.												
124	Diseases of the bladder	1,532	1,561	1,484	1,476	1,484	1,415	2.6	2.9	2.9	3.2	3.1	4.3
125	Diseases of the urethra, urinary abscess, etc	285	237	234	190	204	136	0.5	0.4	0.5	0.4	0.4	0.4
126	Diseases of the prostate	2,175	2,020	1,873	1,495	1,628	862	3.7	3.8	3.7	3.2	3.4	2.6
127	Nonvenereal diseases of the male genital organs	49	75	49	39	49	35	0.1	0.1	0.1	0.1	0.1	0.1
128	Uterine hemorrhage (nonpuerperal)	76	81	79	90	79	89	0.1	0.2	0.2	0.2	0.2	0.3
129	Uterine tumor (noncancerous)	892	933	802	845	837	581	1.5	1.7	1.7	1.8	1.8	1.8
130	Other diseases of the uterus	770	774	759	717	734	564	1.3	1.4	1.5	1.5	1.6	1.7
131	Cysts and other tumors of the ovary	628	500	518	454	472	430	1.1	0.9	1.0	1.0	1.0	1.3
132	Salpingitis and other diseases of the female genital organs	1,401	1,298	1,146	1,015	1,034	671	2.4	2.4	2.3	2.2	2.2	2.1
133	Nonpuerperal diseases of the breast (cancer excepted)	32	31	26	31	26	17	0.1	0.1	0.1	0.1	0.1	0.1
	VII.—The puerperal state	9,456	8,455	7,791	7,344	7,330	4,643	16.0	15.7	15.3	15.7	15.5	14.2
134	Accidents of pregnancy	908	877	834	772	800	549	1.5	1.6	1.6	1.6	1.7	1.7
135	Puerperal hemorrhage *	851	754	357	425	491	337	1.4	1.4	0.7	0.9	1.0	1.0
136	Other accidents of labor *	911	830	788	598	629	295	1.5	1.5	1.5	1.3	1.3	0.9
137	Puerperal septicemia *	4,376	3,892	3,427	3,271	3,224	2,057	7.4	7.2	6.7	7.0	6.8	6.3
138	Puerperal albuminuria and convulsions *	2,094	1,824	1,706	1,619	1,593	911	3.5	3.4	3.4	3.5	3.4	2.8
139	Puerperal phlegmasia alba dolens, embolus, sudden death *	266	230	23	13	61	4	0.4	0.4	(1)	(1)	0.1	(1)
140	Following childbirth (not otherwise defined) *	48	53	650	643	528	488	0.1	0.1	1.3	1.4	1.1	1.5
141	Puerperal diseases of the breast	2	5	6	3	3	1	(1)	(1)	(1)	(1)	(1)	(1)
	VIII.—Diseases of the skin and of the cellular tissue	3,010	3,008	2,985	2,817	2,869	2,392	5.1	5.6	5.9	6.0	6.1	7.3
142	Gangrene	1,656	1,748	1,691	1,562	1,656	1,457	2.8	3.2	3.3	3.3	3.5	4.5
143	Furuncle	285	273	257	203	221	149	0.5	0.5	0.5	0.4	0.5	0.5
144	Acute abscess	456	506	534	514	512	473	0.8	0.9	1.0	1.1	1.1	1.4
145	Other diseases of the skin and annexa	613	481	503	538	480	312	1.0	0.9	1.0	1.1	1.0	1.0

Chapter 2: Figure 21– *Bulletin 112 Mortality Statistics 1911*, Conti.[48]

When comparing the United States with other countries throughout the world in 1870, America, a developed country, had a significantly higher infant death rate, which indicates that it was more dangerous to give birth in America than in other developed nations. This is likely due to the advances in the Medical Revolution that was taking place in Europe. (Chapter 2: Figure 22). [49]

[48] Durand, *Department of Commerce Bureau of the Census*, 64.

[49] "Table XX. Birth of Persons Born in Each Census Year and Surviving at the Close of Each Census Year, by Months and Quarter-Years at the Censuses of 1870; for the Entire Year the Census of 1860 and 1850; with the Proportion of such persons to Population." *The United States Census Bureau* (1870): 531.

TABLE C.—*Population of different countries by single years under five years of age and by five-year periods under the age of twenty-five years; also giving the proportion at the different ages to 100,000 of total population; also the annual average of these numbers.*

YEARS.	UNITED STATES—1870. (Observed.)			UNITED STATES—1870. (Adjusted with addition of 100,000 under age 5.)			ENGLAND AND WALES—1861.		
	Numbers.	Proportion in 100,000, at total specified ages.		Numbers.	Proportion in 100,000, at total specified ages.		Numbers.	Proportion in 100,000, total population.	
		Amount.	Annual average.		Amount.	Annual average.		Amount.	Annual average.
Under 1	1,100,475	2,854	2,854	1,241,519	3,219	3,219	503,731	2,959	2,959
1 to 2	1,078,893	2,798	2,798	1,154,698	2,997	2,997	543,040	2,706	2,706
2 to 3	1,143,130	2,965	2,965	1,166,754	2,893	2,893	535,981	2,671	2,671
3 to 4	1,113,782	2,889	2,889	1,070,087	2,776	2,776	516,296	2,573	2,573
4 to 5	1,078,514	2,798	2,798	1,041,055	2,699	2,699	511,744	2,550	2,550
Under 5	5,514,713	14,304	2,861	5,614,713	14,584	2,905	2,700,792	13,459	2,692
5 to 10	4,814,713	12,487	2,497	4,872,403	12,654	2,521	2,344,006	11,682	2,336
10 to 15	4,786,189	12,413	2,483	4,402,489	11,543	2,309	2,105,176	10,494	2,098
15 to 20	4,040,588	10,479	2,096	4,154,121	10,746	2,149	1,932,642	9,631	1,926
20 to 25	3,748,290	9,721	1,944	3,900,776	10,030	2,018	1,829,403	9,117	1,823

YEARS.	FRANCE—1861.			ITALY—1861.			NORWAY—1865.		
	Numbers.	Proportion in 100,000, total population.		Numbers.	Proportion in 100,000, total population.		Numbers.	Proportion in 100,000, total population.	
		Amount.	Annual average.		Amount.	Annual average.		Amount.	Annual average.
Under 1	810,743	2,169	2,169	729,726	3,319	3,319	51,764	3,042	3,042
1 to 2	719,985	1,926	1,926	571,830	2,626	2,626	47,004	2,818	2,818
2 to 3	722,585	1,933	1,933	685,265	3,147	3,147	46,814	2,751	2,751
3 to 4	689,120	1,843	1,843	567,744	2,331	2,331	43,721	2,569	2,569
4 to 5	669,728	1,791	1,791	472,126	2,168	2,168	40,198	2,362	2,362
Under 5	3,612,161	9,662	1,932	2,926,691	13,591	2,718	230,401	13,542	2,708
5 to 10	3,272,759	8,754	1,751	2,345,701	10,771	2,154	223,694	11,234	2,247
10 to 15	3,235,448	8,654	1,731	2,215,358	10,173	2,035	179,835	10,569	2,114
15 to 20	3,247,835	8,687	1,737	2,025,232	9,300	1,860	160,704	9,443	1,889
20 to 25	3,074,775	8,224	1,645	1,902,549	8,736	1,747	138,204	8 122	1,624

Chapter 2: Figure 22– Remarks on the Table of Births.[50]

[50] Table XX. Persons Born in Each Census Year and Surviving at the Close of Each Census Year, 65.

It is critical to note that statisticians analyze a successful birth through a momentary lens. They did not take into account those survival rates beyond the initial birth. The below table- illustrates the statistics on infants within their first year of life; according to the census the reported monthly mean is 116.879, but in the second half of the year that number decreases by 43% to 66,543. It is likely that the children born in the first half of the year did not survive past the six-month mark. Similarly, the following chart shows the months following birth that indicated the number of infants who were still alive. (Chapter 2: Figure 22 and Figure 23). [51]

[51] "Table XX. Birth is of Persons Born in Each Census Year and Surviving at the Close of Each Census Year," 513-519.

REMARKS ON THE TABLE OF BIRTHS.

Age.	United States census of 1870.			
	Months of birth.	Number of persons surviving at different intervals of age	Proportion to 100,000 persons of all specified ages.	Proportion to 100,000 children under one year of age.
Quarter-years.				
0 to 3	May, 1870 April, 1870 March, 1870	355, 130	921	32, 271
3 to 6	February, 1870 January 1870 December, 1869	346, 142	898	31, 454
6 to 9	November, 1869 October, 1869 September, 1869	273, 272	709	24, 852
9 to 12	August, 1869 July, 1869 June, 1869	125, 031	327	11, 443
Years.				
0 to 1		1, 100, 475	2, 854	100, 000
1 to 2		1, 078, 803	2, 798	
2 to 3		1, 143, 139	2, 965	
3 to 4		1, 113, 782	2, 889	
4 to 5		1, 078, 514	2, 798	
0 to 5		5, 514, 713	14, 304	
5 to 10		4, 814, 713	12, 488	
10 to 15		4, 786, 189	12, 414	
15 to 20		4, 040, 588	10, 481	
20 to 25		3, 748, 260	9, 723	
All other specified ages		15, 548, 708	40, 300	
All specified ages		38, 553, 210	100, 000	
Unknown ages		5, 161		
All ages		38, 558, 371		

Chapter 2: Figure 23– Remarks on the Table of Births, Conti.[52]

[52] Table XX. Birth is of Persons Born in Each Census Year and Surviving at the Close of Each Census Year, 513-519.

Age.	United States census of 1870.			
	Months of birth.	Number of persons surviving at different intervals of age.	Proportion to 100,000 persons of all specified ages.	Proportion to 100,000 children under one year of age.
Months.				
0 to 1	May, 1870	117,681	394	16,639
1 to 2	April, 1870	115,421	299	16,488
2 to 3	March, 1870	122,628	318	11,143
3 to 4	February, 1870	115,153	299	16,464
4 to 5	January, 1870	114,492	297	16,464
5 to 6	December, 1869	116,497	302	16,586
6 to 7	November, 1869	91,583	238	8,323
7 to 8	October, 1869	93,391	242	8,486
8 to 9	September, 1869	88,288	229	8,023
9 to 10	August, 1869	69,679	181	6,332
10 to 11	July, 1869	42,463	110	3,859
11 to 12	June, 1869	13,789	36	1,253

Chapter 2: Figure 24– United States Census of 1870- Births.[53]

To summarize the presentation of statistical data on mortality and infant morbidity from 1870 to 1910, statisticians advanced the terminology and understanding of the vital statisticsanalysis of Alabama and the United States. As medical knowledge advanced, statisticians were able to provide more accurate causes of death, which illustrated that previous data may have neglected to link death during the postpartum period with relation to childbirth. Additionally, a direct link exists between the modernization of medicine within a country and lower maternal and infant mortality rates.

Conclusion

In conclusion, the professionalization and modernization of childbirth in Alabama was a complex intertwining of state history, the socioeconomic picture, and the presentation of

[53] Table XX. Birth is of Persons Born in Each Census Year and Surviving at the Close of Each Census Year, 513-519.

statistical data. The Reconstruction Era marked significant changes to Alabama and its Hale, Dallas, Greene, Marengo, and Sumter counties. The state drastically evolved throughout the nineteenth-century due to events like emancipation, White Flight, climate change, and stark famine putting incredible pressure on a growing population. The diverse inhabitants of this region required intervention for better living standards, economic relief, and medical care.

As the state's government attempted to rectify some of the socioeconomic complications with the Bureau of Refugees, Freemen, and Abandon Land administration, the state's population continued to increase, requiring enormous demands for birth assistants. Ideally, this should have attracted physicians seeking financial growth; however, most of the population was Black. In the radically racial environment of the Deep South, physicians were not prepared to handle the complex relationship emerging among the diverse ethnic groups.

Collecting vital statistics added pressure to an already complicated racial relationship, which illustrated an increasing demand for quality birth attendants while maternal and infant mortality rates continued to rise.

Chapter 3: Why Are You the Way that You Are?

Introduction

The title of this chapter was inspired by my dog, Luma. She is a charcoal Labrador retriever with a ton of energy. As a puppy, she would jump, scratch, and even bite me, attempting to get my attention. She never meant any harm by her actions; nevertheless, it hurt all the same. I used to ask her daily, "Why are you the way you are?" Naturally, I got no response, but when I analyzed her actions, searching for the root of the behavior, I found the answer. She loved me and wanted my attention- such a simple answer. When I began to write this dissertation, I asked the same question: "Why are you the way you are?" However, I knew the answer would be far more complex. What were the root causes of the problems among midwives, doctors, and society? To have a clearer understanding of these complex and intricate relationships required a closer look at the behaviors, actions, and traumas of this complicated relationship to reveal the underlying motives and ideologies. In many instances, the offender, often in the form of gender biases, or, in the case of my inspiration, my dog, did not mean to inflict harm on the other party; nevertheless, their actions had far-reaching negative consequences.

Alabama's population was continuously growing. Blacks were moving into the region for opportunities in agriculture, while White Flight caused the native White population to look to Texas and other regions for more opportunities. The price of cotton was unstable during the Reconstruction Era, funneling through a cycle of busts and booms. Additionally, the newly freed population of Blacks in the region entered tenant farming, sharecropping, or labor contracts with

former masters. Historians argue that these agricultural contracts were an extension of slavery due to the extension of servitude that was driven by the increase of debt owed to the landowner.[1] For many, the agricultural ladder- of gradually working one's way up from laborer to sharecropper, tenant farmer, to landowner- the new South was a far-reaching dream as the Black contract farmers continued to incur debt. Thus, due to the shifting population, unreliable agricultural production, and collapsing economic state, Alabamians struggled for necessities in the decades before the formation of American-based poverty relief programs such as the Salvation Army.[2]

This chapter examines the background of the relationship among parturients, practitioners, and politics in an attempt to answer the question, "Why are you the way that you are?"[3] Prescribing to the doctrine of personal sin rather than original sin, people are not born knowing hatred and cruelty. To quote best-selling author C.J. Roberts, "monsters aren't born, they're made." They learn it through experience. A woman does not simply mistrust a doctor or a midwife without reason; ideological and theological notions influence the individual to believe that someone or something is dangerous. Both physicians and midwives will suffer from misplaced blame and judgment. During the latter part of the nineteenth-century, childbirth in Alabama was forced to modernize and professionalize due to the geo-occupational configuration of the population, racial ideologies, and demands indicated by statisticians for reform.

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[1] Woodman, "Post-Civil War Southern Agriculture and the Law," 324-325.

[2] "Slossfeild, Midwifery, and Birmingham Historical Society – Then & Now," *Birmingham Historical Society: Research, Publishing, and Education,* date modified March 2022, https://birminghamhistoricalsociety.com/tag/salvation-army/.

[3] C.J. Roberts, *Seduced in the Dark*, (London: Delta, 2013).

The Geo-Occupational Configuration of the Population

As the United States marched through the Gilded Age to the Progressive Era, early reformers looked to curb abuses and alter federal legislation to impact the healthcare of women and infants. The need for such intervention grew increasingly apparent as reformers examined the death rates throughout the country, particularly those statistics in the southern regions such as Alabama. These vital statistics presented a distressing image. According to historian Annie Menzel, Black babies died at approximately twice the rate of their White counterparts. The elevated infant mortality rate suggests that outside influences may have altered the survival rates of the fetus, infant, and mother. In this instance, outside influences came in the shape of socioeconomic challenges, which included poor nutrition and limited access to healthcare, and access to formally trained physicians. Patients who came from wealthier socioeconomic regions of America had access to more modernized healthcare and academically trained birth assistants, which in turn helped improve the survival rates of infants. This comparison becomes problematic when comparing those regions with new lying-in-ward within the hospital; however, education and the development of germ theory helped to revolutionize these northern regions.

Another influence that significantly impacted the survival rates was the radical racism of the region. In the wake of the Civil War and the formal emancipation of slaves throughout America, the predominantly Black regions in the Deep South had less access to the services needed for proper obstetric care; under the umbrella of obstetric care lies healthcare, diet, and education. Formal, academically trained physicians were too expensive for most Black families, particularly those in Greene County. As noted within the text *Listen to Me Good* (1996) by

Margaret Charles Smith and Linda Janet Holmes, while Dr. Halle T. Johnson prepared to solicit funds for a dispensary in Alabama, at

> the Nineteenth Annual Meeting of the Alumnae Association of the Women's Medical College of Pennsylvania, Johnson reported that families living far from town could not afford medical care because physicians charged two dollars per mile for a visit—plus the cost of medicine—and demanded cash or reliable assurance of payment before coming.[4]

According to Johnson, a physician could charge two dollars per mile, which was not included under the umbrella of other services, such as medicine that the patient was likely to require.[5] The mileage cost would have been excessive in rural Alabama, where the inhabitants often lived miles from the nearest physician. This cost was beyond the reach of most laborers, sharecroppers, or tenant farmers who earn modest wages. The images below represent the "History of Wages in the United States from Colonial Times to 1928: Bulletin of the United States Bureau of Labor Statistics, No. 499." Within the data, the average wage of farm laborers

[4] Margaret Charles Smith and Linda Janet Holmes, *Listen to Me Good: The Life Story of an Alabama Midwife*, (Columbus: Ohio State University Press, 1997), 20. Margaret Charles Smith, born 1906, became one of the most famous midwives in Alabama claiming to have "delivered over 3,500 babies and never lost a mother" according to the Alabama Women's Hall of Fame website. She worked together with independent scholar Linda Janet Holmes to write *Listen to Me Good.*; Halle T. Johnson, "The Lay Fayette Dispensary," *Report of proceedings of the Nineteenth Annual Metting of the Alumnae Associations of the Women's Medical College of Pennsylvania* (May 9-10, 1894): 105-106. Johnson was the women physician to be licensed in the state of Alabama.

[5] Halle T. Johnson, "The Lay Fayette Dispensary," *Report of proceedings of the Nineteenth Annual Metting of the Alumnae Associations of the Women's Medical College of Pennsylvania* (May 9-10, 1894): 105-106.

indicates that the average monthly income for the entire United States is as follows. The monthly income is calculated both with and without board included.[6]

Average Monthly Income for Agricultural Laborers in the United States		
Year	**With Board**	**Without Board**
1880	$11.71	$17.53
1890	$13.29	$19.45
1902	$15.51	$22.12
1911	$19.58	$28.04

Based on these findings, the average laborer would not have been able to afford the expensive mileage charge for a doctor to attempt an average birth. Even within close proximity, the cost of mileage alone would be at least $2.00, and in 1911, $2.00 was approximately 10.12% of the monthly average income (Chapter 3: Figure 1). [7]

[6] Estelle M. Stewart, and Jesse Chester Brown. "History of Wages in the United States from Colonial Times to 1928: Bulletin of the United States Bureau of Labor Statistics, No. 499." *Bureau of Labor Statistics* (October 1929): 227.

[7] Stewart and Brown, "History of Wages in the United States from Colonial Times to 1928," 227.

TABLE D–2.—*Farm laborers, males, 1866–1927, by year and index number*

Year	Average yearly farm wage [1]				Index numbers of farm wages—1910–1914 = 100 [2]
	Per month—		Per day—		
	With board	Without board	With board	Without board	
1866 [3]	$10.09	$15.50	$0.64	$0.90	55
1869	9.97	15.50	.63	.87	54
1874 or 1875	11.16	17.10	.68	.94	59
1877 or 1879 [4]	10.86	16.79	.61	.84	56
1879 or 1880	11.70	17.53	.64	.89	59
1880 or 1881	12.32	18.52	.67	.92	62
1881 or 1882	12.88	19.11	.70	.97	65
1884 or 1885	13.08	19.22	.71	.96	65
1887 or 1888	13.29	19.67	.72	.98	66
1889 or 1890	13.29	19.45	.72	.97	66
1891 or 1892	13.48	20.02	.73	.98	67
1893	13.85	19.97	.72	.92	67
1894	12.70	18.57	.65	.84	61
1895	12.75	18.74	.65	.85	62
1898	13.29	19.16	.71	.94	65
1899	13.90	19.97	.75	.99	68
1902	15.51	22.12	.83	1.09	76
1906	18.73	26.19	1.03	1.32	92
1909	20.48	28.09	1.04	1.31	96
1910	19.58	28.04	1.07	1.40	97
1911	19.85	28.33	1.07	1.40	97
1912	20.46	29.14	1.12	1.44	101
1913	21.27	30.21	1.15	1.48	104
1914	20.90	29.72	1.11	1.43	101
1915	21.08	29.97	1.12	1.45	102
1916	23.04	32.58	1.24	1.60	112
1917	28.64	40.19	1.56	2.00	140
1918	35.12	49.13	2.05	2.61	176
1919	40.14	56.77	2.44	3.10	206

Chapter 3: Figure 1- Farm laborers, males, 1866-1927.[8]

The Bureau of Labor Statistics breaks down the average monthly income for laborers in each state; however, Alabama is not accounted for until 1910, which is at the outer limit for the period of this dissertation. Nevertheless, a few things can be noted about the average incomes, even at the outer limit compared to Alabama. As shown above, Alabama's lowest monthly income was earned in 1910. When comparing Alabama to similar states that fall under the title of "South Central," the income per month with board is as follows:

[8] Stewart, and Brown. "History of Wages in the United States from Colonial Times to 1928," 227.

Average Monthly Income with Board			
State	**Income**	**State**	**Income**
Kentucky	$16.00	Tennessee	$14.00
Alabama	$13.00	Mississippi	$13.30
Louisiana	$13.50	Arkansas	$16.25
Oklahoma	$19.10	Texas	$18.00

Alabama has the lowest income and is significantly lower than all but two states, Mississippi and Louisiana, both of which had similar socioeconomic make-ups (Chapter 3: Figure 2).

TABLE D–3.—*Farm laborers, males, 1910–1928, by geographic division and State*

Per month with board

Geographic division and State	1910	1917	1922	1923	1925	1926	1927	1928
NORTH ATLANTIC								
Maine	$23.50	$36.00	$38.00	$41.00	$43.00	$45.00	$45.00	$47.00
New Hampshire	23.50	35.00	38.60	46.50	46.00	50.00	49.00	49.00
Vermont	25.00	35.00	35.00	40.60	46.00	36.00	47.00	48.00
Massachusetts	22.75	38.00	41.00	50.00	50.00	52.00	52.00	49.00
Rhode Island	21.00	31.00	40.00	50.00	50.00	51.00	52.00	54.00
Connecticut	21.00	35.00	40.00	52.00	51.00	54.00	54.00	53.00
New York	23.50	35.00	39.70	45.50	48.00	50.50	49.75	49.75
New Jersey	19.50	32.00	40.00	44.50	46.00	54.00	47.00	47.00
Pennsylvania	18.75	30.00	33.00	38.00	39.50	41.75	41.00	39.75
Average	21.65	33.26	37.14	43.42	45.29	47.75	47.01	46.58
NORTH CENTRAL								
Ohio	21.00	31.00	32.60	36.80	38.00	39.00	39.25	38.75
Indiana	20.50	29.00	30.20	35.40	35.00	37.00	37.00	37.00
Illinois	24.50	33.00	33.90	40.20	42.00	42.00	42.50	43.25
Michigan	23.00	34.00	33.60	40.00	41.00	43.50	42.50	43.00
Wisconsin	26.00	36.00	37.00	45.00	46.50	48.50	49.00	48.75
Minnesota	26.00	39.00	35.00	37.00	45.00	46.75	47.25	47.00
Iowa	28.00	41.00	36.80	43.30	45.50	46.25	46.75	47.75
Missouri	21.50	29.00	28.70	31.00	32.00	34.00	33.00	33.00
North Dakota	29.00	41.00	38.70	40.30	49.50	49.50	53.25	54.25
South Dakota	27.00	42.00	36.40	43.20	46.50	43.75	48.25	48.25
Nebraska	26.50	39.00	34.50	40.00	40.00	40.00	43.00	43.00
Kansas	24.00	33.00	32.50	35.90	36.00	37.00	37.75	39.25
Average	(1)	(1)	(1)	(1)	40.80	41.91	42.47	42.73
SOUTH ATLANTIC								
Delaware	16.00	29.00	27.10	32.80	32.00	35.00	33.00	32.00
Maryland	13.50	24.00	28.50	32.00	34.50	35.75	36.75	36.00
Virginia	14.00	22.00	24.80	28.00	30.00	30.00	31.00	30.00
West Virginia	19.40	31.00	33.20	35.50	36.50	34.75	34.00	33.25
North Carolina	13.00	25.00	24.00	28.00	29.00	30.00	27.50	27.75
South Carolina	12.00	18.00	16.20	20.00	21.25	21.00	20.50	21.00
Georgia	13.00	19.00	15.60	17.30	20.50	21.50	20.25	19.50
Florida	15.00	22.00	23.40	26.00	26.00	28.00	24.25	24.00
Average	13.77	22.44	22.12	24.93	26.20	26.76	25.77	25.43
SOUTH CENTRAL								
Kentucky	16.00	24.00	25.90	28.10	27.25	28.50	27.50	27.25
Tennessee	14.00	21.00	22.30	24.60	25.50	24.75	25.75	24.50
Alabama	13.00	16.00	17.60	19.90	26.00	22.50	22.00	21.00
Mississippi	13.30	17.00	18.20	20.00	22.00	23.75	23.50	21.75
Arkansas	16.25	23.00	21.35	23.00	25.00	30.00	25.50	26.00
Louisiana	13.50	19.00	22.40	21.00	23.00	24.00	23.50	25.75
Oklahoma	19.10	28.00	26.00	27.40	29.50	31.50	30.25	31.25
Texas	18.00	25.00	24.20	28.30	29.00	30.00	26.50	31.25

Chapter 3: Figure 2–Farm laborers, males, 1910-1928. [9]

[9] Stewart and Brown. "History of Wages in the United States from Colonial Times to 1928," 228.

Furthermore, the income indicates a few factors. First, since the average monthly income with board is lower than all of the states in the surrounding region, the state of Alabama is likely lacking both the financial resources to pay more for labor and job prospects to increase the wages of these workers. Next, the monthly income with board was below the national average for 1910. The national average in 1910 was $19.58 per month. Not only is Alabama's $13.00 per month lower, but it is also 66.4% lower than the national average. This low income placed low-class Alabamians at a continuous disadvantage. Thus, for laborers to pay a physician to travel at $2.00 a mile would have been almost impossible.[10]

Additionally, most people living in Alabama from 1870-1910 were from rural areas of the state. In ascending years, Alabama in 1870 had a total population of 996,992, with an urban population of 62,700 (6.3%) and a rural population of 934,292 (93.7%). In 1880, the state's population increased to 1,262,505, with an urban population of 68,518 (5.4%) and a rural population of 1,193,987 (94.8%). Annually, the state's rural population increased by over one-hundred-thousand. In 1890, the state's population increased to 1,513,401, with an urban population of 152,235 (10.1%) and a rural population of 1,361,166 (80.9%). It was in 1890 that the urban population began to grow; this coincided with the Industrial Revolution as cities began to grow, utilizing push and pull factors of industry and opportunities. Similarly, 1900, the state's total population equaled 1,828,697, with an urban population of 216,714 (11.9%) and an urban population of 1,611,983 (88.1%). Finally, in 1910, the total state population in Alabama was 2,138,093, with a total urban population of 370,431 (17.3%) and a rural population of 1,767,622

[10] "Alabama." *United States Census Bureau*, accessed August 31, 2023. https://www2.census.gov/library/publications/decennial/1940/population-volume-1/33973538v1ch03.pdf

(82.7%). In slightly more than fifty years, the rural population never dips below 80% of the overall state population (Chapter 3: Figure3).[11]

TABLE 1.—POPULATION OF ALABAMA, URBAN AND RURAL: 1820 to 1940

[Percent not shown where base is less than 100]

CENSUS YEAR	THE STATE			URBAN PLACES				RURAL TERRITORY			PERCENT OF TOTAL	
	Population	Increase over preceding census		Number of places	Population	Increase over preceding census		Population	Increase over preceding census		Urban	Rural
		Number	Percent			Number	Percent		Number	Percent		
1940	2,832,961	186,713	7.1	59	855,941	111,668	15.0	1,977,020	75,045	3.9	30.2	69.8
1930	2,646,248	298,074	12.7	53	744,273	234,956	46.1	1,901,975	63,118	3.4	28.1	71.9
1920	2,348,174	210,081	9.8	39	509,317	138,886	37.5	1,838,857	71,195	4.0	21.7	78.3
1910	2,138,093	309,396	16.9	28	370,431	153,717	70.9	1,767,662	155,679	9.7	17.3	82.7
1900	1,828,697	315,296	20.8	27	216,714	64,479	42.4	1,611,983	250,817	18.4	11.9	88.1
1890	1,513,401	250,896	19.9	19	152,235	83,717	122.2	1,361,166	167,179	14.0	10.1	89.9
1880	1,262,505	265,513	26.6	7	68,518	5,818	9.3	1,193,987	259,695	27.8	5.4	94.6
1870	996,992	32,791	3.4	7	62,700	13,799	28.2	934,292	18,992	2.1	6.3	93.7
1860	964,201	192,578	25.0	5	48,901	13,722	39.0	915,300	178,856	24.3	5.1	94.9
1850	771,623	180,867	30.6	4	35,179	22,507	177.6	736,444	158,360	27.4	4.6	95.4
1840	590,756	281,229	90.9	1	12,672	9,478	296.7	578,084	271,751	88.7	2.1	97.9
1830	309,527	181,626	142.0	1	3,194	3,194		306,333	178,432	130.5	1.0	99.0
1820	127,901							127,901				100.0

URBAN AND RURAL POPULATION OF ALABAMA: 1820 to 1940 | Geographic subdivisions.—In tables 2 to 5 the

Chapter 3: Figure 3: Table I. –Population of Alabama, Urban, and Rural: 1820 to 1940.[12]

Moreover, as can be viewed in the Census table pictured below, in 1880, the occupation statistics for the United States indicated that Alabama had a total population of people over ten years of age of 851,780, which can be broken down into 414,095 males and 467,685 females. Out of that total population, statisticians indicate that the total population that is "engaged in all classes of occupations" is 492,685 (57.84%), which can be broken down into 368,734 (74.84%) males and 124,056 (25.18%) females. Out of that total occupied population, the total number "engaged in agriculture" equals 380,680 (77.27%), which can again be broken down into 201,477 (52.93%) males and 80,153 (21.06%) females. To examine this data more closely, over

[11] "Alabama." *United States Census Bureau*, accessed August 31, 2023. https://www2.census.gov/library/publications/decennial/1940/population-volume-1/33973538v1ch03.pdf

[12] "Alabama." *United States Census Bureau.*

half of the entire state population was employed in some kind of occupation in 1880. Out of those employed, over three-fourths of the population worked in agriculture. This data correlates with the rurally inhabited imagery already provided (Chapter 3: Figure 4).[13]

[13] "Occupations: Table XXIX.-The Number of Persons in the United States Engaged in Each," *1880 Census: Volume 1. Statistics of the Population of the United States,* Accessed September 5, 2023, 712. https://www2.census.gov/library/publications/decennial/1880/vol-01-population/1880_v1-20.pdf

TABLE XXIX.—THE NUMBER OF PERSONS IN THE UNITED STATES ENGAGED IN EACH

	States and Territories.	POPULATION, 10 YEARS AND OVER.			ENGAGED IN ALL CLASSES OF OCCUPATIONS.			ENGAGED IN AGRICULTURE.		
		Total.	Male.	Female.	Total.	Male.	Female.	Total.	Male.	Female.
	The United States	36,761,607	18,735,980	18,025,627	17,392,099	14,744,942	2,647,157	7,670,493	7,075,983	594,510
1	Alabama	851,780	414,095	437,685	492,790	368,734	124,056	380,630	291,477	89,153
2	Arizona	32,922	24,267	8,655	22,271	21,800	471	3,435	3,423	12
3	Arkansas	591,876	278,185	253,691	260,692	230,076	30,616	216,655	195,002	21,653
4	California	681,062	425,170	255,892	376,565	348,363	28,202	79,396	78,785	611
5	Colorado	158,220	110,893	47,324	101,251	96,472	4,779	13,539	13,462	77
6	Connecticut	497,303	242,392	254,911	241,393	192,063	48,670	44,020	43,936	90
7	Dakota	99,849	64,343	35,506	57,844	54,993	2,851	28,508	28,368	140
8	Delaware	110,856	56,003	54,853	54,580	46,652	7,928	17,849	17,609	240
9	District of Columbia	136,907	63,429	73,478	66,624	46,966	19,658	1,464	1,445	19
10	Florida	184,650	93,475	91,175	91,536	73,752	17,784	58,781	47,465	11,296
11	Georgia	1,043,840	509,830	534,010	597,862	445,530	152,332	432,204	329,856	102,348
12	Idaho	25,005	17,910	7,095	15,578	15,287	291	3,858	3,847	11
13	Illinois	2,269,315	1,178,131	1,091,184	999,780	893,679	106,101	436,371	433,796	2,575
14	Indiana	1,468,995	752,405	715,590	635,080	583,658	51,422	331,240	329,614	1,626
15	Iowa	1,181,641	623,675	557,966	528,302	483,457	44,845	303,557	302,171	1,386
16	Kansas	704,297	388,148	316,149	322,285	302,934	19,351	206,080	205,234	846
17	Kentucky	1,103,498	526,424	577,074	519,854	465,432	54,422	320,571	315,445	5,126
18	Louisiana	649,070	322,004	327,066	363,228	268,176	95,052	205,306	147,538	57,768
19	Maine	519,669	258,587	261,082	231,903	198,465	33,528	82,130	81,887	243
20	Maryland	695,364	341,621	353,743	324,432	265,632	58,800	90,927	89,176	1,751
21	Massachusetts	1,432,183	681,786	750,397	720,774	546,591	174,183	64,973	64,746	227
22	Michigan	1,236,886	659,101	577,585	569,204	514,191	55,013	240,319	239,346	973
23	Minnesota	559,977	307,449	252,528	255,125	230,048	25,077	131,535	130,817	718
24	Mississippi	753,603	375,561	378,132	415,506	305,089	110,417	339,938	253,324	87,614
25	Missouri	1,557,631	816,962	740,669	692,959	630,016	62,943	355,297	351,681	3,616
26	Montana	31,969	24,558	7,431	22,255	21,748	507	4,513	4,504	9
27	Nebraska	318,271	181,022	137,249	152,614	142,159	10,455	90,507	89,881	626
28	Nevada	50,636	36,211	14,455	32,233	30,730	1,503	4,180	4,146	34
29	New Hampshire	286,188	139,807	146,381	142,468	112,340	30,128	44,490	44,209	101
30	New Jersey	865,591	426,451	439,140	396,879	330,103	66,776	59,214	58,819	395
31	New Mexico	87,966	48,266	39,700	40,822	38,560	2,262	14,139	14,025	114
32	New York	3,981,428	1,950,059	2,031,369	1,884,645	1,524,264	360,381	377,460	375,213	2,247
33	North Carolina	959,951	465,268	494,683	480,187	393,211	86,976	360,937	314,228	46,709
34	Ohio	2,399,367	1,209,435	1,189,932	994,475	881,836	112,639	397,495	396,120	1,375
35	Oregon	130,565	81,031	49,534	67,343	64,564	2,779	27,091	27,000	91
36	Pennsylvania	3,203,215	1,591,056	1,612,159	1,456,067	1,239,984	216,083	301,112	299,809	1,303
37	Rhode Island	220,461	104,980	115,475	116,079	87,120	29,859	10,945	10,910	35
38	South Carolina	667,456	324,364	343,092	392,102	272,015	120,087	294,602	208,672	85,930
39	Tennessee	1,062,130	524,559	537,571	447,970	391,562	56,408	294,158	275,620	18,538
40	Texas	1,064,196	568,928	495,268	522,133	463,190	58,943	359,317	330,125	29,192
41	Utah	97,194	50,580	46,614	40,055	37,108	2,887	14,550	14,470	80
42	Vermont	264,052	132,036	132,016	118,564	102,417	16,167	55,251	55,037	214
43	Virginia	1,059,034	516,395	542,639	494,240	411,043	83,197	254,999	238,951	15,148
44	Washington	55,720	36,085	19,635	30,122	29,059	1,063	12,781	12,709	72
45	West Virginia	428,587	217,650	210,937	176,190	164,691	11,508	107,578	106,980	598
46	Wisconsin	965,712	503,434	462,278	417,455	371,062	46,393	195,901	194,380	1,521
47	Wyoming	10,479	11,950	4,529	8,884	8,420	464	1,639	1,635	4

Chapter 3: Figure 4: Occupations.[14]

[14] "Table XXIX. –The Number of Persons in the United States Engaged in Each," *1880 Census: Volume 1. Statistics of the Population of the United States,* Accessed September 5, 2023, 712.

Perhaps equally thought-provoking is the number of females employed in agriculture compared to the other territories throughout the United States. In the years immediately preceding the Civil War, the distribution of slaves was primarily throughout America's South. The states with the highest concentration of slaves include Virginia, Georgia, Mississippi, South Carolina, and Alabama. When examining the occupation statistics provided above, it is evident that Alabama, Georgia, Mississippi, and South Carolina had the most significant number of female workers in agriculture when listing the states from the most considerable number of females with occupations in agriculture to the lowest. Georgia had 102,348 female workers, representing 23.68%. Mississippi had 87,014 females, representing 25.6%; South Carolina had 85,930 females, representing 27.17%; and Alabama had 89,153 females, representing 25.6% of women with an occupation in agriculture. Within the industry of agriculture, 89,153 women took employment: 84,212 (94.46%) agricultural laborers, 3 (0.003%) dairywomen, 4 (0.0045%) farm and plantation overseers, 4,825 (5.41%) farmers and planters, 107 (0.12%) gardeners, nurserymen, and wine-growers, 1 (0.001%) stock herders, and 1 (0.001%) stock raisers (Chapter 3: Figure 5). [15]

[15] "Occupations: Table XXXIII," 711.

TABLE XXXIII.—THE NUMBER OF PERSONS IN THE UNITED STATES ENGAGED IN EACH

C—NUMBER OF FEMALES OCCUPIED.

	OCCUPATIONS.	United States.	Ala.	Ark.	Cal.	Colo.	Conn.	Del.	Fla.	Ga.
	ALL OCCUPATIONS	2,647,157	124,056	30,616	28,202	4,779	48,070	7,928	17,784	152,332
	AGRICULTURE	594,510	89,153	21,653	611	77	90	240	11,266	102,348
1	Agricultural laborers (a)	534,900	84,212	19,562	134	15	22	117	9,980	96,785
2	Apiarists	17		1	2					
3	Dairymen and dairywomen	710	3	2	22	5	6	2	7	16
4	Farm and plantation overseers	193	4		4	3			1	
5	Farmers and planters	56,809	4,825	2,087	398	37	58	120	1,251	5,444
6	Florists	230			7	3	4		2	1
7	Gardeners, nurserymen, and vine-growers	1,309	107	1	25	2		1	8	85
8	Stock-drovers									
9	Stock-herders	94	1		2	8			3	
10	Stock-raisers	122	1		17	3			7	
11	Turpentine farmers and laborers	125							7	17
12	Others in agriculture	1				1				
	PROFESSIONAL AND PERSONAL SERVICES	1,361,205	31,024	8,182	18,228	3,580	20,640	5,561	5,825	42,242
13	Actors	1,820		7	112	77	5			14
14	Architects	17								
15	Artists and teachers of art	2,061	8	8	104	12	47	1	3	9
16	Auctioneers	3								
17	Authors, lecturers, and literary persons	320	2	2	16	5	8	2		1
18	Barbers and hairdressers	2,902	7	1	151	12	32	8	3	7
19	Billiard- and bowling-saloon keepers and employés (b)	44						32		
20	Boarding- and lodging-house keepers	12,313	85	89	482	248	230	11	43	194
21	Chemists, assayers, and metallurgists	48			3					
22	Clergymen	105	1	1	6		1	5		4
23	Clerks and copyists (not otherwise described)	1,647	2	1	53	4	22			4
24	Clerks in government offices (c)	1,976		1	14		11			1
25	Clerks in hotels and restaurants	246	4		8	3	3			
26	Collectors and claim agents	26				1				
27	Dentists	61			2	2	1			
28	Designers, draughtsmen, and inventors	56								
29	Domestic servants	938,010	16,340	4,772	10,698	1,847	14,001	4,407	3,471	20,011
30	Employés of charitable institutions	1,615	19	2	7	11	21	5	7	21
31	Employés of government (not clerks) (c)	3,108		4	125	6	62	1		52
32	Employés of hotels and restaurants (not clerks)	31,065	83	61	413	259	434	20	18	204
33	Engineers (civil)									
34	Hostlers									
35	Hotel keepers	2,136	37	41	112	61	15	16	13	42

Chapter 3: Figure 5– Occupation of Females in 1880.[16]

When examining the data, it is noticeable that Alabama consisted of a mainly rural population, of whom the overwhelming majority worked in agriculture. The average daily wage paid in this industry was far below the national average, which likely is why so many women worked alongside their significant other. In a poverty-stricken region, it would have been necessary for the women of the family to work in addition to the men because the added income was required to feed, clothe, and house their family members. According to the Census Bureau, 213,143 males and 65,996 females worked in agriculture between the ages of 16 and 50. Most

[16] "Occupations: Table XXIX.-The Number of Persons in the United States Engaged in Each," *1880 Census: Volume 1. Statistics of the Population of the United States,* Accessed September 5, 2023, 712.

workers within the agricultural industry, men and women alike, would fall within what is considered childbearing age, 16 to roughly 50, with 50 beginning the end of reproductivity (Chapter 3: Figure 6).[17]

TABLE XXX.—THE NUMBER OF PERSONS IN THE UNITED STATES ENGAGED IN EACH STATES AND AGRICULTURE.

	States and Territories.	Persons occupied.	AGE AND SEX.							
			All ages.		10 to 15.		16 to 59.		60 and over.	
			Male.	Female.	Male.	Female.	Male.	Female.	Male.	Female.
	The United States	7,670,493	7,075,983	594,510	584,867	135,862	5,888,133	435,920	602,985	22,728
1	Alabama	380,630	291,477	89,153	53,854	20,608	213,143	65,996	24,480	2,549
2	Arizona	3,435	3,423	12	89	.....	3,257	7	77	5
3	Arkansas	216,655	195,002	21,653	26,118	6,138	160,546	14,951	8,338	564
4	California	79,396	78,785	611	1,128	30	72,762	518	4,895	63
5	Colorado	13,530	13,462	77	335	6	12,569	66	558	5
6	Connecticut	44,026	43,936	90	1,214	3	34,632	62	8,090	25
7	Dakota	28,508	28,368	140	570	12	26,786	111	1,012	17
8	Delaware	17,849	17,609	240	1,634	36	14,308	160	1,667	44
9	District of Columbia	1,464	1,445	19	11	.....	1,313	15	122	4
10	Florida	58,731	47,465	11,266	5,649	2,680	38,108	8,121	3,708	465
11	Georgia	432,204	329,856	102,348	56,695	25,908	248,513	73,484	24,648	2,956
12	Idaho	3,858	3,847	11	50	.....	3,667	9	130	2
13	Illinois	436,371	433,796	2,575	27,998	310	378,360	1,953	27,438	312
14	Indiana	331,240	329,614	1,626	25,413	253	280,370	1,141	23,831	232
15	Iowa	303,557	302,171	1,386	15,210	109	267,172	1,029	19,789	188
16	Kansas	206,080	205,234	846	11,781	83	184,294	648	9,159	115
17	Kentucky	320,571	315,445	5,126	30,141	885	263,684	3,729	21,620	512
18	Louisiana	205,306	147,538	57,768	20,045	10,416	110,017	39,356	16,576	1,996
19	Maine	82,130	81,887	243	1,968	10	64,473	180	15,446	53
20	Maryland	90,927	89,176	1,751	5,510	256	75,245	1,323	8,421	172
21	Massachusetts	64,973	64,746	227	1,229	10	50,163	168	13,354	40
22	Michigan	240,319	239,346	973	7,185	76	210,264	750	21,897	147
23	Minnesota	131,535	130,817	718	3,669	48	118,254	503	8,894	77
24	Mississippi	339,938	252,324	87,614	29,300	15,449	204,993	69,655	18,031	2,510
25	Missouri	355,297	351,681	3,616	24,043	255	305,431	2,896	22,207	405
26	Montana	4,513	4,504	9	51	2	4,356	7	97	.....

Chapter 3: Figure 6– Table XXX. –The Number of Persons in the United States Engaged in Each State and Agriculture

[17] "Occupations: Table XXIX," 712.

To summarize the findings, Alabama was a poor rural community that worked mainly in agriculture. The men and women who worked the fields were relatively young, within their childbearing years, and many enjoyed their newly established freedoms. These freedoms included ownership over one's offspring; thus, young families were eager to have children and were limited to access to birth control. However, the average income of the agricultural lower class was much too low to afford a physician to act as the parturient's birth attendant. Thus, the burden of birth attendants fell on the shoulders of the local Granny midwives.

The limited access to physicians is attractive to examine because, according to Ronald Hamowy, the United States created an abundance of physicians in the years leading up to the Civil War. Medical schools cropped up in great numbers, many of which were privately owned and operated, making acceptance relatively easy. In addition to extensive acceptability, medical education was relatively inexpensive; thus, men began to enter the profession at high rates. According to Hamowy, "in 1860, the census data indicate that the country possessed over 55,000 physicians, or 175 per 100,000 population, almost certainly the highest number of doctors per capita of any nation in the world."[18] According to the Census Bureau in 1880, Alabama had 1,535 physicians and surgeons with only 95 midwives.[19] So again, why in 1870 did Alabamians need to rely on Granny midwives instead of doctors, which the United States purportedly had in abundance? Can this reliance be simply explained by the lack of financial resources explained above? That would oversimplify the explanation; the actual reason is far more complicated. A plausible explanation is that the Civil War's death toll of approximately 620,000 included many

[18] Ronald Hamowy, "The Early Development of Medical Licensing Laws in the United States, 1875-1900." *Journal of Libertarian Studies* 3, no. 1 (1979): 73-74.

[19] "Occupations: Table XXIX," 776.

doctors, which is plausible considering the entire country had to contribute to the war effort. Fewer doctors in the years following the Civil War would allow those remaining to increase their prices. The most probable explanation was a combination of the war, the increase in the total free population, and the lack of financial resources of the general public. Before the Emancipation Proclamation was issued on January 1, 1863, Blacks in the South were property, so the use of an academically trained physician was at the discretion of the master and was reserved for Whites or extreme emergencies.[20] Thus, Granny midwives were the more practical choice for attending the birth of enslaved and lower-class women.

Similarly, a slave was intended to make, not cost, the owner money, so the idea of paying a physician, except in extreme cases, was out of the question. Of course, this is a generalization, the willingness to pay for an academically trained White physician was up to the individual master. Therefore, midwives would serve as birth attendants for a large portion of the population because, in many regions of the Deep South, Blacks outnumbered Whites 2:1. During this time, midwives would occasionally be paid monetarily, but the vast majority were paid in trade.

I would be remiss if I did not note the importance of successful pregnancy, labor, and delivery of enslaved children in the years following the 1808 ban on the importation of slaves into the United States. Due to this act, slaveholders could no longer rely on the importation of additional African slaves; thus, the number of slaves could only be naturally increased. Women of childbearing years who could successfully carry and deliver healthy children became incredibly valuable on plantations, and the demand for quality birth assistance rose. [21]

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[20] Abraham Lincoln, *Preliminary Emancipation Proclamation.* 1862. Pdf. https://www.loc.gov/item/scsm000950/.

[21] U. S. Laws, Statutes, Etc. An act to prohibit the importation of slaves into any port or place within the jurisdiction of the United States, from and after the first day of January, in the

At the end of the Civil War, the population in rural Alabama was primarily Black. In Hale, Dallas, Greene, Marengo, and Sumter counties, more than three-quarters of the population were free Blacks. The newly freed Black population made a modest living; the majority could not afford to pay a physician's costs on the wages of a sharecropper or tenant farmer. Thus, they had to rely on midwives who accepted other forms of payment. A physician entering the medical field was doing it with the hopes of making a good living and gaining the respect that comes with the title. For physicians to make a living in their practice, they need to work within a community that has the means to pay monetarily for the services provided. In poor regions of the United States, a physician would not have been as profitable as in urban settings with a large population. It was in 1907 that C.L. Girard expressed concerns about the finances of physicians, stating that "it has been estimated that it requires one thousand of the population to insure a physician a decent living, yet in these United States the average is one physician to seven hundred or eight hundred population."[22] For rural Alabama, the population size was large enough for a doctor to make a "decent living;" however, the inhabitants of the region did not have the means to pay for the services outside of trade.

Yet, another reason that Granny midwives were well accepted by both the Black and White communities in rural Alabama was due to the shift in medical methodologies that were occurring all over the United States. Physicians and medical schools were starting to limit the number of metallic medicines, instead utilizing homeopathic treatments. Homeopathic medicine

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year of our Lord, one thousand eight hundred and eight ... March 2,. Approved. Washington, 1810.

[22] Sydney Shead, "'Granny' Midwife to Nurse-Midwife: The Decline of Southern Black Midwifery in the 20th Century." *Historical Perspectives: Santa Clara University Undergraduate Journal of History, Series II* 27, art. 9 (2022): 54.

relies on using botanicals and herbs, which was the midwife's most relied-upon tool. The rural South did not wholly abandon the traditional medicine route; however, the region focused on eclecticism or the belief that a mixture of various treatments was better than all other options. [23]

Demands Indicated by Statisticians for Reform

Despite the influence and popularity of the Disappearance Hypothesis, midwives and physicians were delivering Black babies in America's South daily. The birth rates for Blacks, particularly in the Deep South regions, were high. The dangers of childbirth were evident in the census data on vital statistics. As addressed by the Census Bureau, the statistics from 1880 were not wholly accurate because "No attempt was made to secure returns of births through the enumerators." Meaning that the census survey administrator took no additional steps to ensure that the survey regarding births was filled out. To overcome this inaccuracy, retired Deputy Surgeon-General John S. Billings, M.D. of the United States Army, and members of the Census Bureau decided to add the number of infant deaths to the number or number of infants born to get an accurate account of the birth rate. [24]

> The population reported as under 1 year of age on June 1, 1890, was 1,566,734, and the number of those reported as born during the year, but dying before its close, exclusive of stillbirths, was 104,087, making a total of 1,670,821 births, and giving a birth rate of 26.68 per 1,000 of population.
>
> In 1880 the population reported as under 1 year of age was 1,447,983, and the number of the "Born and Died", excluding stillbirths, was 104,314, making a

[23] Hamowy, "The Early Development of Medical Licensing Laws in the United States," 74.

[24] "Section XII, Births and Birth Rates," edited by John S. Billings, 481.

> total of 1,552,297 estimated births, and giving a birth rate of 30.95 per 1,000 of population. [25]

These statistics represent the birth rate in the United States from 1870 to 1890. It can be concluded that the birth rate decreased, but only slightly, over the decade between 1880 to 1890. With a birth rate of 26.68 births per 1,000 people, there is a significant demand for birth attendants to assist at the time of delivery. As this dissertation focuses on a specific region within Alabama, it is critical to examine the birth rates for the state. For the statistics provided by the Census Bureau on registered territories, the bureau addresses the likelihood of inaccuracies.

> the births and birth rates given, which are estimated upon the number of children under 1 year of age on June 1, 1890, as reported, plus the number of "Born and died", are from 20 to 25 percent too low, but the deficiency in the enumeration of children in the different states and areas varies so greatly that any correction based upon a uniform percentage of omission would be unreliable, and the figures are given, therefore, without correction.[26]

According to the 1890 Census, Alabama was among the top seven states for the highest birthrates in the United States, alongside Texas, New Mexico, Utah, Idaho, and North and South Dakota.[27] Fascinatingly, Alabama is the smallest state based on the square mileage of those listed. From largest to smallest, the square mileage is as follows: Texas 268,592 sq. ft., New Mexico 121,590 sq. ft., Utah 84,897 sq. ft., Idaho 83,569, South Dakota 77,116, North Dakota 70,698, and finally Alabama at 52,420 sq. ft.[28] The size of the state is essential when examining

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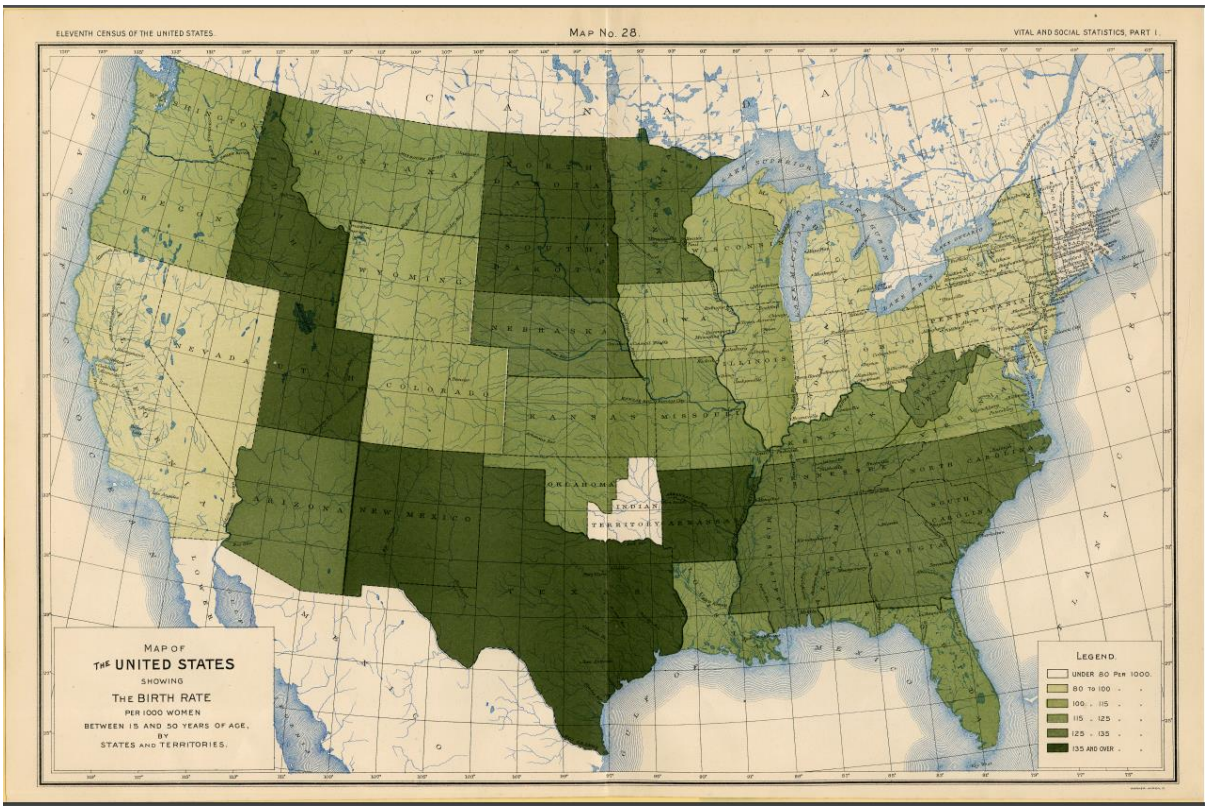
[25] "Section XII, Births and Birth Rates," edited by John S. Billings, 481.

[26] "Section XII, Births and Birth Rates," edited by John S. Billings, 481.

[27] "Size of the US States by Area." Nations Online Project. Date Accessed May 2, 2023. https://www.nationsonline.org/oneworld/US-states-by-area.htm

[28] "Size of the US States by Area." Nations Online Project.

birthrate because it indicates that inhabitants were reproducing at a high rate in a relatively small area. From an outside perspective, one would assume that the state's high birthrate and small size would be an alluring factor to blossoming physicians and midwives; however, this region lacked formally trained midwives and doctors (Chapter 3: Figure 7).[29]



Chapter 3: Figure 7– Section XII, Births and Birth Rates.[30]

Evidence suggests, the region needed birth assistants due to high birth rates. The census breaks down birth rates in Alabama into three categories: “Females of All Ages,” “Females

[29] “Size of the US States by Area.” Nations Online Project.

[30] “Section XII, Births and Birth Rates,” edited by John S. Billings M.D. in *Report on Vital and Social Statistics in The United States at the Eleventh Census: 1890. Part I.- Analysis and Rate Tables.* Washington, D.C.: Government Printing Order, 1896.

between 15 and 50 Years of Age," and "Married Females Between 15 and 45 Years of Age." The categories illustrate the total group of women giving birth, and the number of single and the number of married women giving birth. These categories are further broken down into White, which includes Mexican-Americans, and colored groups referred to hereafter as Black. According to the "Vital and Social Statistics Table" listed below, the total birth rate for the entire United States was 54.68 (5.468%) per 1,000 people and 54.11 (5.411%) for White 58.78 (5.878%) for Black. In Alabama specifically, the total birth rate was 60.85 (6.085%) per 1,000 of the population 63.11 (6.311%) were White inhabitants and 58.12 (5.812%) were Black. This data is further broken down into the designation of "Females Between 15 and 50 Years of Age" as follows: the total birthrate 127.01 (12.702%); White birthrate, 132.08 (13.208%), and Black, 120.94 (12.094%) per 1,000 people. Additionally, the "Married Females Between 15 and 45 Years of Age," the total birthrate was 244.24 (24.424%); White birthrate, 250.46 (25.046%), and Black birthrate, 236.52 (23.652%). As expected, the highest birth rate falls under the umbrella of married women (Chapter 3: Figure 8 and Figure 9).[31]

[31] "Section XII, Births and Birth Rates," edited by John S. Billings M.D. in *Report on Vital and Social Statistics in The United States at the Eleventh Census: 1890. Part I.- Analysis and Rate Tables.* Washington, D.C.: Government Printing Order, 1896), 482.

The following table shows, for the United States, for several groups of states, and for each state and territory, the birth rates per 1,000 females of all ages, per 1,000 females between 15 and 50 years of age, and per 1,000 married females between 15 and 45 years of age, with distinction of color:

STATES AND TERRITORIES.	FEMALES OF ALL AGES.			FEMALES BETWEEN 15 AND 50 YEARS OF AGE.			MARRIED FEMALES BETWEEN 15 AND 45 YEARS OF AGE.		
	Total.	White.	Colored.	Total.	White.	Colored.	Total.	White.	Colored.
The United States	54.68	54.11	58.78	106.13	104.20	120.73	209.40	205.63	237.80
North Atlantic division	46.73	46.73	46.76	85.45	85.59	77.97	182.49	182.67	172.28
Maine	35.80	35.82	29.87	69.03	69.07	54.00	140.52	140.56	122.55
New Hampshire	36.42	36.41	44.07	68.34	68.32	82.28	145.44	145.34	232.14
Vermont	37.73	37.70	48.35	74.24	74.17	99.55	145.52	145.36	209.52
Massachusetts	41.83	41.79	45.33	73.18	73.17	74.16	172.68	172.78	163.93
Rhode Island	43.57	43.56	43.82	76.84	76.90	74.46	177.96	178.12	171.29
Connecticut	42.11	42.13	40.94	76.52	76.60	72.05	171.06	171.29	158.43
New York	46.22	46.27	42.57	83.02	83.23	68.19	177.40	177.68	155.95
New Jersey	50.20	50.15	51.71	91.33	91.47	87.74	188.70	188.73	187.82
Pennsylvania	52.11	52.18	48.95	98.60	98.97	82.67	203.00	203.51	180.20
South Atlantic division	57.56	56.21	59.84	118.12	114.13	125.05	238.02	230.74	250.59
Delaware	50.57	49.17	57.49	96.66	93.25	114.49	191.63	185.68	221.70
Maryland	51.20	50.06	55.49	97.85	95.32	107.64	212.49	207.58	231.21
District of Columbia	43.99	41.11	49.42	74.48	70.56	81.60	184.94	173.31	206.69
Virginia	54.00	53.38	54.98	110.90	108.63	114.51	241.61	230.47	260.72
West Virginia	62.28	62.50	56.86	129.16	129.84	113.36	252.34	253.33	228.35
North Carolina	59.09	59.07	59.15	125.65	125.53	125.89	255.77	249.82	267.59
South Carolina	61.80	57.36	64.76	132.63	119.63	141.73	250.05	235.36	259.63
Georgia	60.71	58.97	62.70	126.75	122.10	132.14	238.54	233.05	244.72
Florida	58.47	58.95	57.85	117.71	117.89	117.48	211.30	208.13	215.65
North Central division	55.88	55.95	52.37	108.51	108.74	97.55	206.74	206.98	194.61
Ohio	48.69	48.66	49.69	92.45	92.49	90.62	187.06	187.12	184.73
Indiana	51.62	51.68	48.57	99.38	99.60	89.08	190.00	190.18	181.06
Illinois	57.02	57.14	48.39	108.12	108.47	86.10	211.34	212.06	166.14
Michigan	51.82	51.84	50.29	99.47	99.53	94.16	180.14	180.14	179.77
Wisconsin	56.11	56.09	62.46	114.75	114.69	131.39	223.34	223.28	240.00
Minnesota	64.26	64.34	44.47	128.16	128.39	78.50	243.94	244.42	144.53
Iowa	54.49	54.53	48.98	107.73	107.84	88.96	208.08	208.32	168.97
Missouri	59.46	59.65	56.48	115.90	116.46	106.96	221.04	221.26	217.25
North Dakota	83.02	83.01	86.27	167.24	167.28	156.03	272.13	272.10	282.05
South Dakota	72.41	72.03	165.28	147.70	146.93	341.38	243.20	241.98	532.26
Nebraska	63.66	63.90	40.90	125.03	125.65	72.40	214.48	215.21	142.56
Kansas	59.55	59.81	52.62	118.07	118.61	103.79	209.73	209.91	204.56
South Central division	62.53	63.82	59.85	129.79	131.98	125.17	242.40	243.51	230.96
Kentucky	59.76	60.45	55.77	120.36	121.96	111.15	235.51	235.94	232.85
Tennessee	61.75	61.65	62.05	126.22	126.04	126.75	245.98	242.79	256.13
Alabama	60.85	63.11	58.12	127.02	132.08	120.94	244.24	250.46	236.52
Mississippi	60.65	61.11	60.32	128.10	127.67	128.41	242.52	246.16	239.92
Louisiana	59.16	60.49	57.84	122.21	122.85	121.56	236.33	246.25	226.94
Texas	65.76	67.14	61.09	139.32	141.67	131.26	242.57	240.30	251.38
Oklahoma	60.88	61.16	55.68	120.69	121.42	107.34	182.64	182.68	181.82
Arkansas	70.26	72.33	64.87	148.16	153.25	135.11	254.31	260.08	238.87
Western division	55.94	56.34	39.79	108.48	104.38	69.96	199.10	197.59	197.46

Chapter 3: Figure 8– Vital and Social Statistics.[32]

[32]"Chapter C. Vital Statistics, Health, and Nutrition (Series C 1-155)." *Historical Statistics of the United States, 1789-1945*, 46.

Series C 39–44.—VITAL STATISTICS—DEATH RATES, INFANT AND MATERNAL MORTALITY: 1915 TO 1945

[For birth-registration States. Mexicans included with white each year except 1932, 1933, and 1934]

YEAR	INFANT MORTALITY RATES [1]			MATERNAL MORTALITY RATES [2]			YEAR	INFANT MORTALITY RATES [1]			MATERNAL MORTALITY RATES [2]		
	Total	White	Nonwhite	Total	White	Nonwhite		Total	White	Nonwhite	Total	White	Nonwhite
	39	40	41	42	43	44		39	40	41	42	43	44
1945	38.3	35.6	57.0	2.1	1.7	4.5	1930	64.6	60.1	99.9	6.7	6.1	11.7
1944	39.8	36.9	60.3	2.3	1.9	5.1	1929	67.6	63.2	102.2	7.0	6.3	12.0
1943	40.4	37.5	62.5	2.5	2.1	5.1	1928	68.7	64.4	106.2	6.9	6.3	12.1
1942	40.4	37.3	64.6	2.6	2.2	5.4	1927	64.6	60.6	100.1	6.5	5.9	11.3
1941	45.3	41.2	74.8	3.2	2.7	6.8	1926	73.3	70.0	111.8	6.6	6.2	10.7
1940	47.0	43.2	73.8	3.8	3.2	7.7	1925	71.7	68.3	110.8	6.5	6.0	11.6
1939	48.0	44.3	74.2	4.0	3.5	7.6	1924	70.8	66.8	112.9	6.6	6.1	11.8
1938	51.0	47.1	79.1	4.4	3.8	8.5	1923	77.1	73.5	117.4	6.7	6.3	10.9
1937	54.4	50.3	83.2	4.9	4.4	8.6	1922	76.2	73.2	110.0	6.6	6.3	10.7
1936	57.1	52.9	87.6	5.7	5.1	9.7	1921	75.6	72.5	108.5	6.8	6.4	10.8
1935	55.7	51.9	83.2	5.8	5.3	9.5	1920	85.8	82.1	131.7	8.0	7.6	12.8
1934	60.1	54.5	94.4	5.9	5.4	9.0	1919	86.6	83.0	130.5	7.4	7.0	12.4
1933	58.1	52.8	91.3	6.2	5.6	9.7	1918	100.9	97.4	161.2	9.2	8.9	13.9
1932	57.6	53.3	86.2	6.3	5.8	9.8	1917	93.8	90.5	150.7	6.6	6.3	11.8
1931	61.6	57.4	93.1	6.6	6.0	11.1	1916	101.0	99.0	184.9	6.2	6.1	11.8
							1915	99.9	98.6	181.2	6.1	6.0	10.6

[1] Number of deaths under 1 year (exclusive of stillbirths) per 1,000 live births. [2] Number of deaths from maternal causes per 1,000 live births.

Chapter 3: Figure 9–Vital Statistics.[33]

Racal Ideologies

In rural Alabama, Black Americans had limited access to healthcare, which included professionally trained physicians who had experience in obstetrics—however limited that obstetrics experience might have been. Physicians who had received a high-quality formal medical education typically became providers for members of the middle- and upper-class; thus, these socioeconomic groups had greater survival rates during childbirth. Nonetheless, if one was a member of the lower classes, the access to quality healthcare was limited to primarily midwives. Reformers seeking to improve social conditions for impoverished individuals examined survival rates, noting that race, social status, economics, and regionalism played a significant role in medical treatment during childbirth (obstetric racism continues to be a problem in modern-day America). The findings of their investigation indicated the need for

[33]"Chapter C. Vital Statistics, Health, and Nutrition (Series C 1-155)," 46.

reform. Unfortunately for impoverished Blacks, reformers focused on White citizens and European immigrants. It would not be until the early twentieth-century that the needs of minorities would be addressed. [34]

To exacerbate the racial and socioeconomic divide, vital records did not accurately represent social statistics for all groups during this era. Antebellum ideology persisted that Blacks were property, despite gaining their freedom in 1861 with the passage of the Emancipation Proclamation. This concept is evident in the methodology employed by statisticians when recording the deaths of Black infants who often record these statistics under property loss rather than deaths. This evidence is presented by Hazel Carby, who asserts that "the cult of true babyhood" was a critical ideology for reformers. Under this notion, White babies were priceless; thus, every measure should be taken to secure their safe birth while Black babies were viewed as priced objects. The end of slavery allowed a unique sense of racism that would grow through a combination of Reconstruction Era ideology, Social Darwinism, and miscegenation in the form of Jim Crow radicalism. This racial ideology led to the creation of accurate vital records of White citizens and European immigrants, which became the central focus of progressive reformers. The vital records of Blacks had gaps within the evidence and did not account for the population as a whole. This weakness needs to be carefully considered when

[34] Annie Menzel, "The Midwife's Bag, or, the Objects of Black Infant Mortality Prevention," *Journal of Women in Culture and Society* 46, no. 2 (2020): 284-286. Menzel is a political theorist, former midwife, and professor of Gender and Women's Studies at the University of Wisconsin-Madison.**;** Hazel Carby, *Reconstructing Womanhood: The Emergence of the Afro-American Woman Novelist*, (New York: Oxford University Press, 1987), 23.; Carby is the Charles C. and Dorothea S. Dilley Professor Emeritus of African American Studies and Professor Emeritus of American Studies at Yale University.; Dána-Ain Davis, "Obstetric Racism: The Racial Politics of Pregnancy, Labor, and Birthing," *Medical Anthropology* 38, no. 7 (2019): 560-573.

conducting research on the topic. Generational racism and the growth of Jim Crow radicalism pushed the agenda that White life was more important than Black life.[35]

The end of slavery did not end racism; rather, it made radical racism a significant obstacle in America's South. The formerly enslaved, now part of the free population, sensed a new perceived threat to the already angry southern White inhabitants. Freed Blacks were becoming citizens searching for jobs that poor Whites usually filled. In many locations, the only concept that separated the poor White population from the slave population was freedom, but the Thirteenth Amendment changed that, causing resentment. On March 3, 1865, the government attempted to address freed Blacks' healthcare needs by establishing the Freedmen's Bureau. This organization was tasked with overseeing and providing healthcare for Blacks, specifically in the South. The medical division created urban hospitals and rural dispensaries to provide care for Blacks. The urban hospital was small, only staffing 8 to 10 employees and housing between 20 and 200 patients. The rural dispensary only employed a physician and a druggist to provide free medication and home visits when the bureau determined the need. The Freedmen's Bureau was only in existence for approximately four years, and after that, healthcare turned from exclusion to segregation. Blacks and Whites had separate facilities.[36]

A critical hypothesis developed in the years following the Civil War is known as the Disappearance Hypothesis. The development of this hypothesis can be accredited to the American Economic Association (AEA), founded by Walter Wilcox, a professor at Cornell University between 1891 and 1931. The AEA played a critical role in the development of social

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[35] Menzel, "The Midwife's Bag," 284-286.

[36] Mitchell F. Rice, and Jones Woodrow, *Public Policy and the Black Hospital: from Slavery to Segregation to Integration*, (Westport, Conn: Greenwood Press, 1994), 4-6.

science research as it pertains to race and racial differences. The intention of its founding was to create a committee dedicated to investigating what Wilcox termed "the Condition of the Negro."[37] It was under the umbrella of American social science research that eugenics, statistics, and racism came together under the ideology of radical progressivism. Wilcox was crucial in getting the AEA to publish works such as Frederick Hoffman's *Race Traits and Tendencies of the American Negro* (1896) and Joseph Tillinghast's *The Negro in Africa and America* (1902). Through the publication of such works that supported and pushed racial ideology, the AEA began searching for answers as to whether the Black population in America would mushroom or decline. The White population within the country had a growing racially charged concern that the Black population would likely mushroom after emancipation, leaving the White population the minority. This concern pushed for answers, and the committee that would later address the "condition of the negro" drew evidence from Hoffman and Tillinghast as well as other works that economist Mark Aldrich described as "thoroughly racist."[38] The works parallel in ideology, asserting that it is due to heredity that Blacks had a predisposition to "constitutional and mental inferiority." In order to understand the label constitutional inferiority, one needs to compare this term to modern mental health diagnoses. Constitutional inferiority would be comparable to antisocial personality disorder, which is defined as, "a deeply ingrained and dysfunctional thought process that focuses on social exploitive, delinquent, and criminal behavior most commonly known due to the affected individual's lack of remorse for these behaviors."[39]

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[37] William Darity Jr., "Many Roads to Extinction Early AEA Economists and the Black Disappearance Hypothesis." History of Economic Review 21, no. 1 (1994): 47-49.

[38] Hoffman, *Race Traits and Tendencies of the American Negro*.; Tillinghast, *The Negro in Africa and America*.

[39] Tillinghast, *The Negro in Africa and America*.; Mark Aldrich, "Progressive Economists and Scientific Racism: Walter Wilcox and Black Americans, 1895-1910," Phylon 40, no. 1

Under the assumption that Blacks were indeed constitutionally inferior, "Blacks were more susceptible to diseases and more inclined toward indolence. Such characteristics were not the consequence of slavery but found their origins in the pre-slavery climatic and genetic history of the Africans." [40] Thus, Blacks were best suited for slavery and, by biology alone, were not suited for freedom. Instead, slavery served as a "school of industry" for these individuals. The protection that the institution of slavery provided to Blacks protected them from disease and poor decision-making. A significant category listed under the umbrella of poor decision-making was excessive procreation. Early slavery apologists suggested that the Black race might procreate at an extraordinary rate and, eventually, outnumber America's White majority. [41]

Additionally, according to this theory, because Blacks naturally had weak constitutionality, they were potentially dangerous to themselves and the general public, but specifically the White public. The definition of danger was far-reaching, from criminal activity to over-reproduction. American economist and social science researcher William Darity illustrates these fears expressed by Virginia planter Philip Bruce in his work "Many Roads to Extinction Early AEA Economists and the Black Disappearance Hypothesis" (1994).

> Bruce, while harping on the physical and mental defects of Blacks, also argued that moral weaknesses led to excessive procreation and the possibility for Blacks

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(Spring 1979): 2. Mark Aldrich is a Professor of economist at Smith College located in Northampton, Massachusetts, best known for his texts *Back on Track: American Railroad Accidents and Safety, 1965-2015* and *Safety First: Technology, Labor, and Business in the Building of American Work Safety, 1870-1939.*; Darity, "Many Roads to Extinction Early AEA Economists and the Black Disappearance Hypothesis," 48.

[40] Willim Darity, "Many Roads to Extinction Early AEA Economists and the Black Disappearance Hypothesis," 48. This quote is taken from Darity as he is paraphrasing the argument that is made by Tillinghast in *The Negro in Africa and America in 1902.*

[41]Tillinghast, *The Negro in Africa and America*, 139.; Kristy A. Fisher and Manassa Hany, "Antisocial Personality Disorder," *StatPearls* (August 15, 2022): 1-2.

> to gain a favorable numerical disproportion throughout the South. White Southerners were faced with the horror of being overrun by 'morally and intellectually deficient' Blacks.[42]

However, it was Francis Amasa Walker who countered this argument with the introduction of the Disappearance Hypothesis. To ease the concerns of apologists such as Tillinghast and Hoffman regarding a growing Black population in the South, Walker explained that the original Black population was not due to reproduction because Blacks were not native to America. The Atlantic Slave Trade brought Blacks into America; thus, it was due to the slave trade that the southern Black population had grown exponentially. If it were not for the slave trade bringing Black slaves directly into America, the slaves would have ended up elsewhere because these ethnic groups have a predisposition to certain climates, and by nature, Blacks prefer a different climate; thus, they would have dispersed into different regions around the world. "The slave trade had ended in 1808, and no significant immigration of Blacks had occurred since then, forced or otherwise 'substantially all of the 7,500,000 colored persons in the United States today are descended from the 700,000 women of the race found in the United States in 1810.'"[43]

According to this theory, because Blacks did not find the climate and environment of America favorable, it is more likely that by the laws of nature, Blacks would begin to disappear from America. Walker's most pressing argument for the Disappearance Hypothesis came in his

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[42] Darity, "Many Roads to Extinction Early AEA Economists and the Black Disappearance Hypothesis," 48.; Philip Bruce, *The Plantation Negro as a Freeman: Observations on His Character, Condition, and Prospects in Virginia,* (New York: G.P. Putnam's Sons, 1889), 256.

[43] Darity, "Many Roads to Extinction Early AEA Economists and the Black Disappearance Hypothesis" 48.; Francis Amasa Walker, "The Colored Race in the United States," *The Forum* 11 (July 1891), 502.

work "Statistics and Economics" (1888), in which he followed the census data from 1790-1890 and concluded that while the Black population in America snowballed from approximately 760,000 persons in 1790 to 7,500,000 people in 1890, the increase was due to the slave trade.[44] Since the termination of the legalized slave trade was in 1809, the census immediately concluded that closure illustrated a major decrease in the Black population. This decrease was not a true decrease because it represented the sudden halt of incoming Blacks into America. This decrease can be seen in the total percentage of Blacks in America's population. In 1810, Blacks comprised 19% of the total population whereas in 1890, that percentage decreased to only 12%. Therefore, according to Walker's logic, he concluded that if this decrease rate continued, it would be highly probable that the Black population would disappear from America altogether. [45]

However widespread Walker's testimony to the Disappearance Hypothesis was, the theory did not gain popularity until the interjections of Frederick Hoffman. Hoffman worked as a professional statistician in the actuary department of Prudential Insurance Company of America in Newark, New Jersey. Throughout his tenure at Prudential, Hoffman studied the Black population's life expectancy and disease patterns, which ultimately helped the company justify its refusal to extend life insurance to Blacks. [46]

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[44] Darity, "Many Roads to Extinction Early AEA Economists and the Black Disappearance Hypothesis," 49.

[45] Walker, "Statistics and Economics," 24.

[46] Francis J. Rigney, Jr., "Frederick L. Hoffman (1865-1946)," *Amstatnews: The Membership Magazine of the American Statistical Association* (October 29, 2018): 1-2.; Megan J. Wolff, "The Myth of the Actuary: Life Insurance and Frederick L. Hoffman's Race Traits and Tendencies of the American Negro," *Public Health Rep* 121, no. 1 (Jan-Feb 2006): 844-86.; Darity, "Many Roads to Extinction Early AEA Economists and the Black Disappearance Hypothesis," 49-52.

After years of studying these statistics, Hoffman reached his conclusion, which was published in *The Area* (1892), in which he stated,

> the colored population of the United States is an isolated body of people, receiving no addition in numbers by immigration, and in consequence present conditions essentially different from those of other races and nationalities that have settled on American soil. The Indian is on the verge of extinction, many tribes have entirely disappeared; and the African will surely follow him, for every race has suffered extinction wherever the Anglo-Saxon has permanently settled.[47]

The entirety of Hoffman's conclusion was built upon the ideology of racial superiority; because Blacks were considered naturally inferior to the White population, it was inevitable that the Black population would eventually become extinct. He further asserted that those statisticians who believed that the United States would eventually become dominated by Black inhabitants were factually incorrect. The logic was that these statisticians failed to consider the death rate of Blacks. Hoffman went on to confirm that Black reproduction was high; however, the survival rates of this population outweighed the birth rate. Thus, it was only a matter of time until the population slowly died out due to its natural inferiority. A significant weakness that fellow apologists did not consider was the way in which the indigenous inhabitants perished. The vast majority of Amer-Indians were exterminated through some means of genocidal tendencies, not constitutional weaknesses. Notwithstanding this weakness, Hoffman asserted that despite some initial gains, the Black population would start to disappear in about 30 years from 1892.[48]

A critical building block on which Hoffman rested his conclusions was the high mortality rates of Blacks. He claimed that the reasons for the high rates were a combination of

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[47] Frederick L. Hoffman, "Vital Statistics of the Negro," *The Arena* 29 (April 1892): 531.

[48] Darity, "Many Roads to Extinction Early AEA Economists and the Black Disappearance Hypothesis," 49-52.

predisposition to disease and their living conditions. Hoffman claimed that Blacks were prone to live in poverty in unsanitary conditions with poor nutrition. Furthermore, the population was generally ignorant of the law, thus, rape was termed as promiscuity and unsafe sexual practices in youth. Moreover, general ignorance led to unwise lifestyle choices that ultimately gave rise to exposure to disease, alcoholism, and premature maternity. [49]

The high mortality rate evidence that Hoffman builds this theory upon illustrates that non-Whites were dying at a higher rate than Whites at the beginning of the twentieth-century. It is important to note that under the White categories, Mexican-Americans were considered. This information is critical to illustrate that the White category consisted of White, native-born American or European immigrants. As illustrated in the previous chapter, the methodology employed by the Census Bureau regarding data collection evolved during this era; thus, as statisticians enter the mid-to-late part of the twentieth-century, the census data becomes more detailed in category. The following data comes from the vital records from 1900 to 1910. This data set indicates that the overall death rate declined for both White and non-Whites from 1900 to 1910. Each of the following data sets represents the number of deaths per 1,000 people. In 1900, the death rate from childbirth in the White population was 17.0 (1.7%), whereas in 1910, that number decreased to 14.5 (1.45%). On the other hand, the non-White portion of the population had a significantly higher death rate; in 1900, the rate was 25.0 (2.5%), but it decreased to 21.7 (2.17%) in 1910 (Chapter 3: Figure 10).[50]

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[49] Darity, "Many Roads to Extinction Early AEA Economists and the Black Disappearance Hypothesis," 49-52.

[50] "Chapter C. Vital Statistics, Health, and Nutrition (Series C 1-155)." *Historical Statistics of the United States, 1789-1945,* 47.

Series C 45–55.—VITAL STATISTICS—DEATH RATES, BY RACE AND SEX: 1865 TO 1945

[Exclusive of stillbirths. Rates, except series C 52, are number of deaths in specified group per 1,000 population of that group, based on estimated midyear population

YEAR	DEATH-REGISTRATION STATES							Age-adjusted death rates [2]	MASSACHUSETTS [3]		
	All races	White [1]			Nonwhite [1]						
		Total	Male	Female	Total	Male	Female		Total	Male	Female
	45	46	47	48	49	50	51	52	53	54	55
1945 [4]	10.6	10.5	12.6	8.6	12.0	13.7	10.5	9.6	12.2	----------	----------
1944 [4]	10.6	10.4	12.3	8.8	12.4	13.9	11.0	9.8	12.4	----------	----------
1943 [4]	10.9	10.7	12.2	9.2	13.6	14.0	11.6	10.3	12.8	----------	----------
1942 [4]	10.4	10.1	11.5	8.7	12.7	14.0	11.4	10.0	11.7	----------	----------
1941 [4]	10.5	10.2	11.4	8.9	13.5	14.8	12.2	10.3	11.6	----------	----------
1940 [4]	10.7	10.4	11.6	9.2	13.8	15.1	12.5	10.7	11.9	12.6	11.1
1939	10.6	10.3	11.3	9.2	13.5	14.7	12.4	10.7	11.6	12.3	10.9
1938	10.6	10.3	11.3	9.2	14.0	15.2	12.9	10.9	11.2	12.0	10.4
1937	11.3	10.8	12.0	9.6	14.9	16.4	13.4	11.7	11.8	12.7	11.0
1936	11.6	11.1	12.3	9.9	15.4	16.9	13.9	12.2	11.8	12.6	11.0
1935	10.9	10.6	11.6	9.5	14.3	15.6	13.0	11.6	11.5	12.2	10.8
1934	11.1	10.6	11.7	9.6	14.8	16.0	13.5	11.9	11.7	12.6	10.9
1933	10.7	10.3	11.2	9.3	14.1	15.1	13.1	11.6	11.9	12.6	11.2
1932	10.9	10.5	11.3	9.6	14.5	15.4	13.5	11.9	11.6	12.2	11.1
1931	11.1	10.6	11.5	9.6	15.5	16.5	14.5	12.1	11.5	12.1	10.9
1930	11.3	10.8	11.7	9.8	16.3	17.4	15.3	12.5	11.6	12.2	11.1
1929	11.9	11.3	12.2	10.4	16.9	18.0	15.8	13.2	12.3	12.8	11.8
1928	12.0	11.4	12.3	10.5	17.1	18.0	16.2	13.4	12.1	12.6	11.7
1927	11.3	10.8	11.6	10.0	16.4	17.2	15.6	12.6	11.7	12.2	11.2
1926	12.1	11.6	12.3	10.8	17.8	18.7	16.9	13.5	12.6	13.1	12.0
1925	11.7	11.1	11.8	10.4	17.4	18.2	16.6	13.0	12.5	13.0	11.9
1924	11.6	11.0	11.8	10.3	17.1	17.9	16.3	12.9	12.0	12.6	11.5
1923	12.1	11.7	12.3	11.0	16.5	17.0	16.0	13.5	12.9	13.2	12.6
1922	11.7	11.3	11.9	10.7	15.2	15.7	14.8	13.0	12.7	13.1	12.4
1921	11.5	11.1	11.6	10.6	15.5	15.7	15.4	12.7	12.1	12.4	11.8
1920	13.0	12.6	13.0	12.1	17.7	17.8	17.5	14.2	13.8	13.9	13.6
1919	12.9	12.4	13.0	11.8	17.9	18.1	17.8	14.0	13.8	14.3	13.3
1918	18.1	17.5	19.3	15.8	25.6	26.7	24.4	19.0	21.3	23.5	19.3
1917	14.0	13.5	14.6	12.4	20.4	21.4	19.4	15.3	15.2	16.2	14.2
1916	13.8	13.4	14.4	12.4	19.1	19.9	18.4	15.1	15.1	16.1	14.2
1915	13.2	12.9	13.7	12.0	20.2	20.8	19.5	14.4	14.3	15.0	13.7
1914	13.3	13.0	13.9	12.1	20.2	20.9	19.4	14.5	14.5	15.4	13.7
1913	13.8	13.5	14.5	12.5	20.3	21.0	19.6	15.0	15.1	16.1	14.1
1912	13.6	13.4	14.3	12.4	20.6	21.3	19.7	14.8	15.2	15.9	14.5
1911	13.9	13.7	14.5	12.8	21.3	21.9	20.6	15.2	15.7	16.5	14.8
1910	14.7	14.5	15.4	13.6	21.7	22.3	21.0	15.8	16.1	17.0	15.3
1909	14.2	14.0	14.9	13.2	21.8	22.3	21.2	15.3	15.4	16.1	14.7
1908	14.7	14.5	15.3	13.6	22.4	22.8	22.0	15.8	15.8	16.7	15.0
1907	15.9	15.7	16.8	14.5	24.3	25.0	23.5	17.1	16.9	17.8	16.1
1906	15.7	15.5	16.5	14.4	24.2	24.7	23.6	16.7	16.2	17.1	15.4
1905	15.9	15.7	16.5	14.8	25.5	26.8	24.3	16.7	16.7	17.6	15.8
1904	16.4	16.2	17.1	15.3	26.1	27.6	24.7	17.3	16.3	17.0	15.7
1903	15.6	15.4	16.2	14.6	24.5	25.5	23.4	16.5	16.7	17.5	15.9
1902	15.5	15.3	16.2	14.4	23.6	24.8	22.3	16.2	16.6	17.4	15.9
1901	16.4	16.2	17.1	15.4	24.3	25.6	23.1	17.2	17.3	18.2	16.3
1900	17.2	17.0	17.7	16.3	25.0	25.7	24.4	17.8	18.4	19.2	17.6

Chapter 3: Figure 10– Vital Statistics.[51]

Hoffman continued to argue that even if the White citizenry were exposed to similar circumstances of poverty, disease exposure, and lifestyle choices, they would be more likely to recover because they do not have the same disposition to disease as Blacks. The proof of these assertions was presented through medical data gathered during the Civil War regarding consumption, also known as tuberculosis. This data purported that Blacks were two times more likely to die after contracting tuberculosis than their White counterparts. Even in the years that followed the war, Hoffman reported that the deaths of Whites and Blacks were not dependent on

[51] "Chapter C. Vital Statistics, Health, and Nutrition (Series C 1-155)," 47.

the environment. He asserted that "we [have] reached the conclusion that the colored race is showing every sign of an undermined constitution, a deceased manhood and womanhood; in short, all the indications of a race on the road to extinction."[52]

The summation of the apologists' theoretical projections of the American Black population provided a strong foundation for southern Jim Crow radicalism to withhold the medical attention that the region so desperately needed by the logic presented by Tillinghast, Hoffman, and Walker, which theorized that Blacks, especially those in the South, were in a constant state of poverty because of their natural inferiority. Moreover, because they were destitute, they were more likely to suffer the ill effects of such poverty-related circumstances as malnutrition. Furthermore, by nature, Blacks had a weak constitution, which caused them to make poor choices, leading them into situations that would likely cause death due to exposure to disease. Thus, it was natural for Blacks to have higher mortality rates, and it was logical that infant and maternal mortality rates would be elevated. So, when White reformers identified the crisis of high infant and maternal mortality rates, they had the propensity to place a higher value on White life because, by nature, Black life was less likely to be sustainable. Furthermore, it would have been fruitless for White reformers to pursue initial legislative action to support Blacks because, according to leading apologists of the time, the Black population would disappear due to the group's predispositions. Legislative actions would be most beneficial to the remaining inhabitants, the White American-born citizens and European immigrants.

The Disappearance Hypothesis was accompanied by other ideologies of the era, such as eugenics and craniometrics, all of which pushed the notion of racial superiority, promoting

[52] Darity, "Many Roads to Extinction Early AEA Economists and the Black Disappearance Hypothesis," 49-52.

justification for bigotry. In brief explanation, eugenics was presented by Francis Galton in 1883, where he attempted to promote the advancement of society by genetically aligning ideal partners for reproduction or, essentially, "breeding out" bad qualities.[53] In a similar pseudoscientific approach to racism, craniometrists asserted that Whites and Blacks were different species altogether.[54]

> Some nineteenth-century scientists, like Harvard's Louis Agassiz, were proponents of "polygenism," which posited that human races were distinct species. This theory was supported by pseudoscientific methods like craniometry, the measurement of human skulls, which supposedly proved that White people were biologically superior to Blacks. Early statistical health data was weaponized against Black Americans in the late 1800s, as it was used to claim they were predisposed to disease and destined for extinction. [55]

The radical racial rhetoric of the Reconstruction Era is not difficult to identify in many aspects of life. The era was developed to manage the reconstruction of these United States and the population of formerly enslaved individuals who would have difficulty transitioning into society due to radical racism. Justifications for treatment, segregation, and cruelty are ingrained into every aspect of society—healthcare and childbirth are no exception. When progressivists began to push for better conditions for all, they were met with resistance. Whites were fearful

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[53] Darity, "Many Roads to Extinction Early AEA Economists and the Black Disappearance Hypothesis," 49-52.

[54] Darity, "Many Roads to Extinction Early AEA Economists and the Black Disappearance Hypothesis," 49-52.

[55] Steven A. Farber, "U.S. Scientists' Role in the Eugenics Movement (1907-1939): A Contemporary Biologist's Perspective," *Zebrafish* 5, no 4 (2008): 243.; "Scientific Racism: Confronting Anti-Black Racism Resource." Harvard Library, accessed August 9, 2023, https://library.harvard.edu/confronting-anti-Black-racism/scientific-racism

that Blacks would overrun a society built on bigotry, which would lead to the potential threat that Whites would become the target of hatred.

Conclusion

In summation, Alabama was overwhelmingly rural with an enormous collection of poor farmers. The geo-occupational configuration of the population generated an environment with limited resources both nutritionally and economically. The lack of economic prosperity acted as a deterrent for many blossoming physicians who were entering the field for financial opportunities as well as the prestige of the field. Those physicians willing to work within the confines of the state focused their energy on the classes that could financially support their business.

Rural Alabama had a large female population that worked alongside their significant others in the field of agriculture. The image of an egalitarian society comes to mind when envisioning teamwork; however, women toiled in the fields out of economic necessity, not from the modernized ideology of equality. Many of these poor farmers enjoyed their newfound freedoms and expanded upon their families. Alabama's high birth rate is 60.85 per 1,000, and breaking that statistic down shows 63.11 per 1,000 White and 58.12 per 1,000 Black births.[56]

The elevated numbers of childbirths throughout Alabama left resounding demands throughout the state. Women needed birth attendants, someone who could assist in childbirth and safely help both mother and child during this dangerous process. The distribution of Whites and

[56] "Section XII, Births and Birth Rates," edited by John S. Billings M.D. 482.

non-Whites throughout the state, bred conditions that would exist under radical racism for generations to come.

As women sought birth assistance, they learned that the physicians, in many cases, were outside of their financial capabilities and were faced with the radical racism of the era. While racism came in many forms, the Disappearance Hypothesis heightened the challenge of locating a birth assistant who would protect poor Black mothers and infants from the preventable dangers of childbirth. According to Hoffman and Tillinghast, the promise of the Disappearance Hypothesis eliminated the need to extend quality healthcare to the Black communities in the country.[57] He concluded that within thirty years, the Black population would altogether disappear; thus, making the effort fruitless.[58] Instead, healthcare reformers were encouraged to place their efforts into that White, native-born American and European immigrant population.

Regardless of radical racism, poor Black women in Alabama needed quality birth assistants. This responsibility would fall on the shoulders of informally trained midwives willing to travel, help with other responsibilities, and assist in the patient's delivery. The midwives were not always successful in safely delivering the infants or protecting the mothers from preventable harm, but they were the best option that overpopulated rural Alabama had available. Midwives did the best that they could with the information that they had available to them. These unsung heroes stepped into a position they were ill-qualified to fulfill and became themselves, victims of hatred and prejudice, by both society and the medical community.

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[57] Darity, "Many Roads to Extinction Early AEA Economists and the Black Disappearance Hypothesis," 49-52.

[58] Darity, "Many Roads to Extinction Early AEA Economists and the Black Disappearance Hypothesis," 49-52.

Chapter 4: The Problematic Midwife

Introduction

Midwives played a vital role within their field. They were trusted community members who often had delivered babies for generations. It is crucial that when a woman is going through pregnancy, labor and delivery, and post-partum recovery, she has a birth attendant that she trusts. In a predominately Black region of the country where racism was integrated into every aspect of life, Black women needed to have a woman who understood their unique position in society. This, among other reasons, helped promote the use of midwives for many generations.

In rural Alabama, women had very few choices as it pertained to childbirth. As Margaret Charles Smith described in her autobiography,

> In the tenant-farm system, women had few choices about anything. When it came time for birth, who delivered their babies and where the babies were born had much more to do with rural isolation, race, and economics than with choice. Some women told me that they just managed to get to their cabins from the cotton fields in time to make a pallet on the floor to catch their own infants. Sometimes close family members and friends provided emotional support before and after the birth. Even when a community midwife or a doctor who might hired by the plantation owner was called, the baby might be born before the official birth attendant arrived. On some occasions, however, women like Mrs. Smith wanted or had to guide themselves through the birthing process, seeking help only to cut and tie the umbilical cord. [1]

In the late nineteenth-century, Alabama residents of all races, especially in Dallas, Hale, Greene, Marengo, and Sumter counties, relied heavily upon the expertise of Granny midwives to assist in labor and delivery. The state's rural geography made midwives the preferred birth

[1] Smith and Holmes, *Listen to me Good*, 35.

attendants due to their unique connection to the community and the only reasonable, affordable option. The state's rural geography and its inhabitants' socioeconomic conditions made transportation difficult. Most families needed access to the transportation required to travel to more extensive urban settings to seek the medical opinion of academically trained physicians. Furthermore, the rural inhabitants of the state primarily worked in agriculture, making a modest living, and academically trained physicians routinely charged traveling expenses on top of their fees for patient care, making it improbable for the parturient's family to afford the costs that would be incurred by having a doctor in attendance. Making roughly thirteen dollars a month did not allow for the extraordinary cost of a two-dollar-per-mile surcharge on top of medical fees.

Unlike the North's more liberal approach to race relations, the South had radical racism to contend with, and Jim Crow laws made segregation a formidable opponent for Blacks in their search for proper healthcare. As hospitals and dispensaries rose in number, the availability of Black-only hospitals did not. The majority of hospitals in Alabama were White only, meaning provisions in the state legislature made it possible for the business owners and, in this case, hospital boards to enforce policies that either forced a Black patient to give up his or her bed upon the arrival of a White patient or outright refuse service to the Black patient. In a region with already limited medical care due to its rural setting, provisions such as this made it next to impossible for Blacks to receive on-site quality healthcare.

Consequently, poor Black and White women made the Hobson's choice to labor and deliver their children at home with the local birth attendant present.[2] Thus, it was the Grannies who delivered the babies. According to historian Sydney Shead, "The term "Granny" was used

[2] Hobson's choice, according to the Cambridge Dictionary, is "a situation in which it seems that you can choose between different things or actions, but there is really only one thing that you can take or do."

to describe traditional Black midwives specifically… Black patients used the term "Granny" out of respect while the medical elites used it as a derogatory term to degrade Black midwives based on their race."[3] This endearing term for Black midwives was overcast by the prejudice and cruelty of physicians who deemed their title superior. Nevertheless, Grannies were not always Black. Some White Grannies worked in the South. According to Professors of Nursing Joyce Thompson and Helen Burst, the definition refers to much more than Black midwives, stating

> "Granny" midwife is a generalized term used to describe midwives after the colonial, early American, and antebellum slave midwife voices have been silenced; midwives other than the immigrant midwives in the late 1800s and up to the mid-1900s; and before the resurgence of community lay midwives in the 1970s. The literature referring to Granny midwives usually describes midwives located in the southern states of Georgia, South Carolina, Alabama, Mississippi, Louisiana, Florida, Arkansas, Missouri, Tennessee, Virginia, West Virginia, North Carolina, Texas, Oklahoma, Kentucky, and Maryland.[4]

Interestingly, these two sources provide differing definitions of the term Granny; just as these authors understood the term differently, so did the community, physicians, and patients. Shead likely neglected to reference White Grannies due to her research agenda rather than an acute misunderstanding of the term. Nevertheless, Grannies were not only African American women; White midwives were also referred to as "Granny women." "Midwives called "Granny women" got their name because they were middle-aged with grown families by the time they had completed an apprenticeship with a more experienced midwife."[5] It is evident by this statement that while Grannies did not have the traditional academic education and training of a physician, they underwent a lengthy apprenticeship to gain as much knowledge and practice as possible.

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[3] Shead, "'Granny" Midwife to Nurse-Midwife," 52.

[4] Thompson and Burst, *A History of Midwifery in the United States*, 4.

[5] Thompson and Burst, *A History of Midwifery in the United States*, 4.

Regardless of race, Grannies regularly acted as birth attendants for both Black and poor women in rural Alabama.[6]

This community's love for midwives is evident in the number of childbirths they attended. “In rural America, Grannies attended up to 75% of births until the 1940s.”[7] Grannies were ushering in the next generations of Alabamians as physicians began to professionalize their specialty. Grannies were the closest thing to a medical professional that many of these communities had access to, and it was the Grannies who gained the respect of their communities through a steady-handed presence. Thus, this chapter will analyze reasons that Grannies were respectfully replied upon, the sociopolitics challenges, and societal bigotry of midwifery.[8]

Reasons Grannies Were Great

Granny midwives were loved within their communities. They cared for their patients as if they were members of their own families.

> The frustration and hostility of the White medical establishment toward Black midwives stands in sharp contrast to the respect these women earned in their own communities. White doctors ignored the problems midwives faced in aiding neighbors struggling in poverty and oppressed by the social, political, and economic conditions of the Jim Crow South. Throughout her youth, Mrs. Smith [referring to midwife Margaret Charles Smith of Alabama] witnessed hard times and endured strict disciplinary measures. She spent most of her childhood working. She says, “We worked our ass off all through the week and we had no

[6] Thompson and Burst, *A History of Midwifery in the United States*, 4.

[7] “A Brief History of Midwifery in America,” *Center for Women’s Health,* accessed September 14, 2023, https://www.ohsu.edu/womens-health/brief-history-midwifery-america

[8] “A Brief History of Midwifery in America,” *Center for Women’s Health,* accessed September 14, 2023.

> money and no clothes to show for it." But she also remembers the strength of women in her community with pride: "People cared about each other back then." [9]

The growing frustration Black Granny midwives likely felt towards the White medical professionals was indicative of their hesitation to invite White male physicians into the lying-in rooms. Grannies felt they had more than just the responsibility of "catching babies," as Margaret Charles Smith put it. Grannies provided services to the families for which no physician would make the time. These additional services provided by the Grannies came directly from the spirit of communal support. As illustrated above, Smith asserts, "people cared about each other back then," this declaration was about the community of women who supported one another in times of hardship and jubilation. The term "support" to these Granny midwives meant more than just delivering the baby and leaving; it meant offering support to the patient's family and allowing the patient the time to heal.

Grannies did not receive a traditional academic education; they learned through apprenticeships under which knowledge, rituals, tonics, and practices were handed down through the generations. According to Linda Homes's article, "Medical History: Alabama Granny Midwife," "It is not surprising that so little has been written about the Granny midwife; historically, Granny midwives in America's southeastern states primarily have been older, empirically trained, low-income Black women who were tolerated by physicians as necessary evils."[10]

Moreover, many of the practices passed down were laced with African roots. This is due to the heritage of many Africanized slave women working as midwives throughout the

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[9] Smith and Holmes, *Listen to Me* Good, 23.

[10] Linda J. Holmes, "Medical History: Alabama Granny Midwife," *Journal of Medical Society of New Jersey* 81, no. 5 (1984): 389.

Antebellum Period. As a way to maintain their African autonomy, enslaved women passed down techniques critical to cultural bequest. Over the generations, midwives adopted cultural practices and continuously passed them down to their apprentices while training. By preserving their heritage, Black women felt a connection to the culture of their ancestors. Most Africanized practices were done to protect mother and child during this potentially life-threatening event and were conducted in both the homes of Black and White women. Midwives worked within the homes of all races to help families prepare for their newest members while attempting to protect the matriarch from the dangers of childbirth. Since midwives were so admired by their community, White families accepted many of these Africanized practices into their homes, assuming that the midwife was doing everything in her power to help ensure a safe delivery.

As indicated above, childbirth was a particularly dangerous moment in a woman's life. There are no guarantees when it comes to childbirth, especially at a time when the mortality rate for both mother and child is high. To make childbirth that much more dangerous, the understanding of things such as germ theory and proper sterilization of equipment was in its infancy. Scientists themselves were just gaining headway on contaminant prevention. Physicians and midwives alike understood that cleanliness was critical within their practice; however, they may not have understood the dangers to which they exposed women to unknowingly.

Moreover, not every midwife entered the field with enthusiasm. Women entered the profession, or what might be more accurately described as the non-professional world of midwifery, because pregnant women needed birth attendants; non-professional in the sense that they often did not charge a fee for delivery or were willing to barter. Midwives lacked formal training and academic education, for which physicians fault them, claiming they did more harm than good. As scholar Linda J. Holmes noted, “many midwives requested fees for services

charging $5.00 per birth when they began their practices." However, not all midwives charged a fee, "midwives often provided care as a God-given duty without expecting cash payment."[11] Midwifery was not only taxing because of the dangers women endured during pregnancy, but it was also exhausting because women were expected to travel to locations where they were giving birth. Babies do not arrive during regular business hours. Children are born all the time, in all weathers. Thus, a midwife would be required to travel at all hours of the day and night, away from her own family for days at a time and go without sleep as long as necessary to support the laboring mother.

Again, women were not always eager to enter midwifery because pain and death had a familiar, well-known place in childbirth. Women were often terrified to give birth due to the likelihood that they themselves or their infants would die. If a woman survived childbirth, she would go on to tell horrifying tails of pain and trauma that she endured during childbirth. Alabama midwife Margaret Charles Smith was no stranger to the dangers of childbirth; however, when faced with the delivery of a stillborn, she was forced to confront her fears just as every midwife would at one point or another.

> I know he [the doctor] saw my complexion change when he said, "He's going to be dead."
> Then the doctor told me, "All you got to do is go there and wait till the baby comes. That's all you got to do and bring the birth certificate by me."
> I said, "Yes sire," but I like to die.
> Then he told me, "You got to dress him."
> That's when I said, "I'm sorry, but I can't do that."[12]

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[11] Holmes, "Medical History," 390. It should be noted that Holmes neglected to provide accurate dates for the $5.00 per birth fee that midwives were charging. She notes this fee under the subsection "Tradition" along with addressing Africanized traditions of early midwives.

[12] Smith and Holmes, *Listen to Me Good*," 71.

The fear for Smith did not end when she arrived at the scene of the delivery, she went on to confess: “When the baby come, I was sweating just big drops of sweat, trying to bathe this baby– put the baby on the quilt. You could look up in that house and see the stars. The wind was blowing, but that was all right ‘cause I was still dropping big beads of sweat.”[13]

Working as a midwife was not for the faint of heart, and women who had received very little training on death management of infants or mothers were forced to confront their fears while on the job. I doubt that any amount of training, whether an apprenticeship or an academic facility, could adequately prepare a birth attendant for such a tragedy as a stillbirth. Learning how to handle death comes from first-hand experience as healthcare providers are forced to confront their fears as well as comfort their families. The compassion that midwives showed at times of tragedy illustrates the reasons that women within these communities have such admiration for their Grannies. Grannies did not simply leave once tragedy struck as a physician might. The Granny remained, temporarily, with the family to comfort and support those as they grieved for the loss of their mother or child.

Regardless of the fear that midwives may have felt, an expectant mother needed someone with a set of skills who would help her through what was likely to be the worst physical pain she may ever experience. As often as a baby is born and as crucial as the continuation of the human race is, birth attendants do not get the credit they deserve. Midwives, especially those in rural Alabama, lacked social recognition for their work and the respect of the medical community. Midwives did much more than catch babies; they became essential heroes for those mothers with few options. They became influential community members, vital to those they served because of Alabama's geographic nature, the inhabitants' socioeconomic status, and the desperate poverty

[13] Smith and Holmes, *Listen to Me Good*, 71.

that saturated the region. Sadly, these unsung heroes will become victimized for many aspects of their work that were outside of their control. This victimization is shocking, especially considering these women may not have had the resources or education to do beyond their skills. But their efforts were significantly better than no help. The lack of recognition is a disservice to the group of women who ushered future generations into the world.

However, the victimization is more than just a lack of recognition, and early twentieth-century Alabama outlawed the practice of lay midwifery. It was in 1976 that the last license to practice lay midwifery was issued within the state of Alabama. This de facto ban forbade midwives from practicing outside of the hospital setting, effectively prohibiting birth centers and home births. This ban continued to affect women in modern-day Alabama, especially those in rural areas, due to their lack of ability to travel to hospitals or financially afford medical treatment. This law was not overturned until 2018 after lobbyists pushed for support to reinstate lay midwives. The continuation of such radical discriminatory acts isolates Black women in rural Alabama from having quality birth attendants yet again. [14]

Moving forward, it is evident through statistics that women in Alabama were giving birth during the late nineteenth-century, arguably some of the highest rates in the country; however, these expectant mothers were limited in their options for birth assistants.[15] Physicians did not enter the lying-in rooms until the late nineteenth and early twentieth-century unless there was an emergency; however, many could not afford a doctor even in the event of an emergency. So, the

[14] Anna Claire Vollers, "Midwives can Legally Deliver Alabama Babies for First Time in Decades as State Issues Licenses," *AL.com: Alabama,* January 19, 2019.

[15] "Part II Comparative Occupation Statistics 1870-1930: A Comparable Series of Statistics Presenting a Distribution of the Nation's Labor Force, by Occupation, Sex, and Age," 112.

midwife stood in the place of the academically-trained medical professional. The following statistics were presented by the United States Census Bureau, which provides data on the occupation of individuals throughout the United States. (See Chapter 4: Figure 1). Throughout the United States, the Census Bureau indicated the number of "Midwives and nurses (not trained)" are as follows:

Year	**Number of "Midwives and Nurses (not trained)**
1910	113,043
1900	109,152
1890	42,997
1880	14,064
1870	11,365

The steady increase of midwives and nurses (not trained) suggests that the population was steadily growing; with it came the demand for birth attendants.[16]

[16] "Part II Comparative Occupation Statistics 1870-1930: A Comparable Series of Statistics Presenting a Distribution of the Nation's Labor Force, by Occupation, Sex, and Age," *The United States Census Bureau* (1940): 112.

1870 TO 1930—Continued

[Detailed information with respect to estimates involved is presented in Appendix A, beginning on page 137, under numbers corresponding to the numbers in parentheses at the end of each footnote.]

OCCUPATION, 1930 CLASSIFICATION	1930	1920	1910	1900	1890	1880	1870
Professional service—Continued							
All other occupations—Continued.							
Technicians and laboratory assistants	15,988	(203)	(203)				
Attendants, pool rooms, bowling alleys, golf clubs, etc.	16,168	(209)	(209)				
Helpers, motion picture production	2,213	(210)	(210)				
Laborers, professional service	25,383	(211)	(211)				
Laborers, recreation and amusement	29,893	(211)	(211)				
Stage hands and circus helpers	4,274	5,893	6,836				
Theater ushers	12,461	5,221	2,278				
Officials of lodges, societies, etc.	14,515	11,736	8,215				
Other occupations (semiprofessional and recreational pursuits)	10,521	4,257	4,720				
Dentists' assistants and attendants	13,715	6,708	2,048				
Physicians' and surgeons' attendants	14,042	7,051	4,140				
Other attendants and helpers	50,370	4,650	(36)				
Domestic and personal service	4,952,451	3,379,995	3,755,798	[212] 2,819,443	[212] 2,233,958	[213] 1,523,725	[213] 1,252,715
Barbers, hairdressers, and manicurists	374,290	216,211	195,275	[214] 132,826	[214] 85,848	[214] 45,412	[215] 24,660
Boarding and lodging house keepers	144,371	133,392	165,452	71,281	44,349	19,053	[216] 12,894
Hotel keepers and managers	56,848	55,553	64,504	54,797	44,076	32,453	[217] 26,666
Janitors and sextons	309,625	178,628	113,081	50,577	26,538	9,212	[218] 2,949
Elevator tenders	67,614	40,713	25,035	[219] 53,547	[219] 39,182	[219] 25,559	[219] 17,113
Laborers, domestic and personal service	71,087	32,893	53,480				
Launderers and laundresses (not in laundry) [220]	361,033	396,756	533,697	[221] 392,140	[221] 251,940	[221] 123,405	[222] 64,055
Laundry owners, managers, and officials	24,545	13,692	18,043				
Laundry operatives [220]	240,704	120,715	112,264				
Midwives and nurses (not trained)	157,009	156,769	133,043	109,152	[223] 42,997	[223] 14,064	[224] 11,365
Restaurant, cafe, and lunch room keepers	165,406	87,987	60,832	33,844	19,283	13,074	[225] 9,764
Housekeepers and stewards	256,746	221,612	189,273	155,153	92,036		

Chapter 4: Figure 1– Part II Comparative Occupation Statistics 1870-1930.[17]

It is equally important to note that not all midwives and nurses were female. Men worked within this field as well. According to census data, (See Chapter 4: Figure 2).

> Trained nurses were classified separately in 1900, but in 1890, 1880, and 1870, respectively, they were included in the group "Nurses and midwives." In 1900, the 758 male trained nurses formed 6.18 percent of the 12,265 male "Nurses and midwives," and the 11,046 female trained nurses formed 10.16 percent of the 108,691 female "Nurses and midwives." It was assumed, in the case of each sex, that trained nurses formed the same proportion of "Nurses and midwives" in 1890, 1880, and in 1870, as in 1900. With this assumption, the distribution of "Nurses and Midwives" was as follows:

[17] "Part II Comparative Occupation Statistics 1870-1930: A Comparable Series of Statistics Presenting a Distribution of the Nation's Labor Force, by Occupation, Sex, and Age," *The United States Census Bureau* (1940): 112.

of "Nurses and midwives" was as follows:

OCCUPATION	MALE			FEMALE		
	1890	1880	1870	1890	1880	1870
Nurses and midwives	6,190	1,189	806	41,396	14,412	11,356
Trained nurses [1]	383	73	50	4,206	1,464	1,154
Midwives and nurses (not trained) [1]	5,807	1,116	[2] 756	37,190	12,948	[2] 10,202

[1] Estimated.
[2] The 1870 figures do not include 17 males and 390 females added in tables 8 to 10 because of an undercount of the population in 13 Southern States.

Chapter 4: Figure 2– Part II Comparative Occupation Statistics 1870-1930.[18]

In 1870, Alabama was home to more than 996,000 residents; however, census records indicate that only 61 of those residents categorized themselves as midwives. As previously illustrated, the entire United States was home to 11,365 "Midwives and nurses," nurses made up the majority in the group with 10,170 nurses and 1,186 midwives.[19] In Alabama, only 61 midwives resided, along with the 258 nurses. The Census Bureau breaks down the statistics of midwives in 1870 to male versus female. All 61 categorized midwives identified as female in Alabama. The census data that indicates that both females and males work as midwives and nurses should more accurately indicate that males work as nurses. The large state population was home to just a few midwives and nurses. So, does that mean the 61 midwives (0.0061% of the state's total population) delivered all of the babies? In short, that answer is no. Physicians and

[18] "Part II Comparative Occupation Statistics 1870-1930: A Comparable Series of Statistics Presenting a Distribution of the Nation's Labor Force, by Occupation, Sex, and Age," *The United States Census Bureau* (1940): 151.

[19] "Table I. –The United States: Population by States and Territories –1790-1870," *The United States Census Bureau* (1870), 3.; "Table XXVII (B.)-- The United States: Females Engaged in Each Occupation." *United States Census Bureau* (1870), 686.; "Table XXVII (A.) – The United States– Continued: Persons Engaged in Each Occupation," *United States Census Bureau* (1870), 676.

surgeons also helped deliver babies. In the United States in 1870 approximately 62,383 people identified as working as a "Physician and Surgeon."[20] In the state of Alabama 1,418 (0.142% of the total state population) individuals categorized themselves as either a physician or a surgeon; only three of these individuals identified as female. (See Chapter 4: Figure 3 and Figure 4).[21]

Again, according to the statistics for almost one million people within the state's limits, there were roughly 13,000 medical professionals who were qualified through training to deliver all of the babies. It is highly improbable that these medical professionals, or non-professionals in the case of midwives, have attended each one of these births. It would have been necessary for many lay midwives to catch the babies for those individuals, especially in rural areas. (See Chapter 4: Figure 3 and Figure 4).[22]

[20] "Table I. –The United States: Population by States and Territories –1790-1870," 676.

[21] "Table I. –The United States: Population by States and Territories –1790-1870," 676.

[22] "Table I. –The United States: Population by States and Territories –1790-1870," 676.

686 FEMALES ENGAGED IN EACH OCCUPATION.

TABLE XXVII (B.)—THE UNITED STATES.

	OCCUPATIONS.	The United States.	Alabama.	Arkansas.	California.	Connecticut.	Delaware.	Florida.	Georgia.	Illinois.	Indiana.	Iowa.	Kansas.	Kentucky.	Louisiana.	Maine.
	POPULATION, FEMALE, 10 YEARS AND OVER	13,070,079	303818	160542	140704	210770	46312	65446	434382	903880	585104	303895	109890	463374	265222	248142
	OCCUPATIONS, (FEMALES ENGAGED IN)	1,836,288	89618	15794	13780	33061	6007	9886	115490	63283	31110	23190	6509	50293	58094	22141
	AGRICULTURE	396,968	64860	8641	263	130	66	5548	73093	1034	429	350	310	3634	29237	52
1	Agricultural laborers	373,332	63694	8354	73	17	54	5350	72175	244	22	109	10	2120	20276	13
3	Dairywomen	417	4		115	3		17	21	3	1	1	1	10	5	1
5	Farmers and planters	22,681	164	256	91	106	12	180	1783	775	404	232	296	1490	648	38
6	Florists	39			1	2				1				1		
7	Gardeners	233	5	1				1	14	10	1	24		18	7	
9	Stock-herders	45			1											
10	Stock-raisers	30								1					1	
12	Turpentine laborers	184	3													
13	Vine-growers	7														
	PROFESSIONAL AND PERSONAL SERVICES	1,066,672	22670	6856	10062	17554	4774	4005	30648	52504	26552	19953	5450	42030	28161	15406
14	Actors	692	6	2	78				3	57	28	5	7	6	3	
15	Apprentices to learned professions	45			1									4	1	
16	Apprentices to barbers	6													1	
17	Apprentices to dentists	1														
18	Architects	1														
19	Artists, (not specified) (a)	293	1	1	10	8			1	8	2			4	3	16
20	Auctioneers	18														
21	Authors and lecturers	115	1		2	3			1	13	7					4
22	Barbers and hairdressers	1,172	3	1	22	7	1			49	13	5	4	2	56	1
23	Bath-house keepers	5														
24	Billiard and bowling saloon keepers and employés	3														
26	Boarding and lodging house keepers	7,000	28	11	362	161	21	19	50	614	224	137	70	132	83	132
28	Card-writers	3					1									
31	Chiropodists	2														
33	Clergy	67	1	1	2	3	4		1	2	2	3		1		2
34	Clerks and copyists	247	1		2	1				13	1					2
35	Clerks in Government offices	943				2	1			4				1		4
36	Clerks in hotels and restaurants	77				9				3						
37	Dentists	24				2				1				1		
38	Designers and drawers	13														
39	Domestic servants	867,354	18306	5636	7715	14006	4383	3125	31215	42046	21342	14772	4002	37690	21390	10800
40	Employés of companies, (not specified) (b)	53								10				1		
41	Employés of Government	401				16				17		3		26	18	
42	Employés of hotels and restaurants, (not clerks)	6,930	6		70	124	6		85	1365	712		60	133	68	52
44	Hostlers	3														
45	Hotel-keepers	865	10	6	65	6	7	2	16	60	22	12	9	43	9	
46	Hunters and trappers	3										2				
48	Intelligence-office keepers	27				1				2						1
50	Janitors	146								3				2	3	
51	Journalists	35			1					4	4	1				2
52	Laborers, (not specified)	21,321	1002	79	144	170	64	51	1257	118	62	4	25	226	2488	43
55	Laundresses	55,609	1934	907	780	364	10	633	1912	1511	837	230	362	2057	2202	[illegible]
56	Lawyers	5													1	
57	Librarians	43								1	1	2		1		1
58	Livery-stable keepers	11											1			
60	Messengers	80										1				
62	Midwives	1,186	61	8	44			8	110	62	21	19	9	32	125	
63	Musicians, (professional) (c)	173	1		10	6				6	3			4	4	2
64	Naturalists	1														
65	Nurses	10,170	228	140	311	367	51	33	356	225	94	78	27	100	190	37
67	Officials of companies, (not specified) (d)	58			3	1				3				2		1
68	Officials of Government	414	7		3	11	1	2	7	23	17		2	2	8	12
69	Painters (e)	58				6				7	1			1		1
70	Physicians and surgeons	525	3		12	4	2	1	11	24	15	6	7	10	3	5
71	Restaurant-keepers	643	2		30	10		1		32	10	2	2	7	7	
73	Scavengers	2														
74	Sculptors (e)															

Chapter 4: Figure 3– Table XXVII (B.)-- The United States: Females Engaged in Each Occupation.[23]

[23] "Table XXVII (B.)-- The United States: Females Engaged in Each Occupation." *United States Census Bureau* (1870), 686.

676 PERSONS ENGAGED IN EACH OCCUPATION.

TABLE XXVII (A.)—THE UNITED STATES—Continued.

	OCCUPATIONS.	The United States.	Alabama.	Arkansas.	California.	Connecticut.	Delaware.	Florida.	Georgia.	Illinois.	Indiana.	Iowa.	Kansas.	Kentucky.	Louisiana.	Maine.
57	Librarians	213	2	.....	10	16	.....	.....	1	6	1	3	1	1	.....	4
58	Livery-stable keepers	8,504	72	41	457	231	17	14	81	630	334	340	174	246	53	203
59	Marines, (United States)	477	.....	.....	69	.....	.....	66	.....	.....	.....	.....	.....	.....	.....	1
60	Messengers	8,717	12	38	118	18	42	40	22	171	21	159	19	107	204	30
61	Metallurgists	164	.....	.....	64	1	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
62	Midwives	1,186	61	8	44	.....	.....	8	119	62	21	19	9	39	125	.....
63	Musicians, (professional) (a)	6,519	21	18	357	84	6	2	33	351	93	60	48	110	157	41
64	Naturalists	287	.....	3	9	3	2	.....	3	15	1	4	1	2	.....	2
65	Nurses	10,976	267	144	354	279	53	74	380	238	106	111	29	198	204	218
66	Officers of the Army and Navy, (United States)	2,286	9	3	102	74	24	21	14	42	27	.....	22	27	57	36
67	Officials of companies, (not specified) (b)	3,410	17	2	233	95	7	24	30	77	17	92	6	81	119	61
68	Officials of Government	44,743	637	403	1282	562	102	312	890	3301	1916	759	495	1371	1655	526
69	Painters (c)	775	2	.....	5	62	2	.....	3	128	16	10	3	23	10	13
70	Physicians and surgeons	62,383	1418	1026	1257	680	170	248	1537	4861	3613	1865	996	2414	930	818
71	Restaurant-keepers	35,185	52	85	2347	735	73	28	82	3578	1314	1107	437	574	372	280
72	Sailors, (United States Navy)	780	.....	1	303	4	.....	27	.....	7	13	.....	.....	.....	.....	8
73	Scavengers	301	5	.....	21	4	6	.....	.....	23	1	.....	1	7	14	2
74	Sculptors (c)	250	2	.....	4	3	1	.....	1	15	1	4	.....	9	5	.....
75	Sextons	1,151	6	6	16	25	4	2	19	40	32	12	4	52	29	17
76	Short-hand writers	154	.....	1	8	2	2	.....	8	22	.....	1	1	.....	1	3
77	Showmen and showwomen	1,177	4	1	80	14	2	.....	3	78	47	17	4	17	18	21
78	Soldiers, (United States Army)	22,081	363	117	940	62	63	398	719	139	72	.....	1219	405	411	173
79	Teachers, (not specified)	126,822	2004	994	1953	2711	361	250	2119	8869	5018	6012	1406	2961	1470	4183
80	Teachers of dancing	149	1	.....	10	7	.....	1	4	7	1	1	.....	2	3	5
81	Teachers of drawing and painting	108	1	.....	.....	9	1	.....	.....	6	4	3	.....	3	.....	2
82	Teachers of music (a)	9,491	88	17	240	267	15	.....	102	826	338	287	72	173	97	223
83	Translators	21	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
84	Veterinary surgeons	1,166	6	1	13	6	3	.....	2	136	44	65	13	10	5	8
85	Whitewashers	2,873	27	34	53	32	10	2	37	130	60	37	9	167	72	6

Chapter 4: Figure 4–Table XXVII (A.) –The United States– Continued: Persons Engaged in Each Occupation.[24]

To illustrate growth and change over fifty years, I have analyzed how the numbers and percentage of midwives to physicians grew from the 1870 census report to the 1910 census data—in 1910, Alabama's population had grown exponentially from that of the 1870 census 996,993 to approximately 2,138,093 inhabitants, which indicated a 114.45% increase. As previously indicated, the number of "midwives and nurses (not trained)" equals 133,043, which illustrates the total number within the United States. In Alabama, "midwives and nurses (not

[24] "Table XXVII (A.) –The United States– Continued: Persons Engaged in Each Occupation," *United States Census Bureau* (1870), 676.

trained) represent only a fraction of the 133,043. Only 2,370 individuals identify as nurses or midwives within the state. Of those 2,370 individuals, only 293 midwives (0.014% of the state's population) patrol the entire state, with the remaining 2,077 representing untrained nurses. To help assist in the delivery process and likely handling the more severe cases were "Physicians and Surgeons," totaling 2,583 individuals (0.121% of the state's population), of which 30 identified as female.[25] In addition to the midwives, nurses, physicians, and surgeons, "Healers" assisted in childbirth when necessary. "Healers" included 16 individuals (0.0007% of the state's population).[26] The increase of midwives in Alabama over fifty years is 380.328%, which is an enormous expansion in the field. However, as large as this growth was, it was still not enough to properly support the state's growing population. (See Chapter 4: Figure 5).[27]

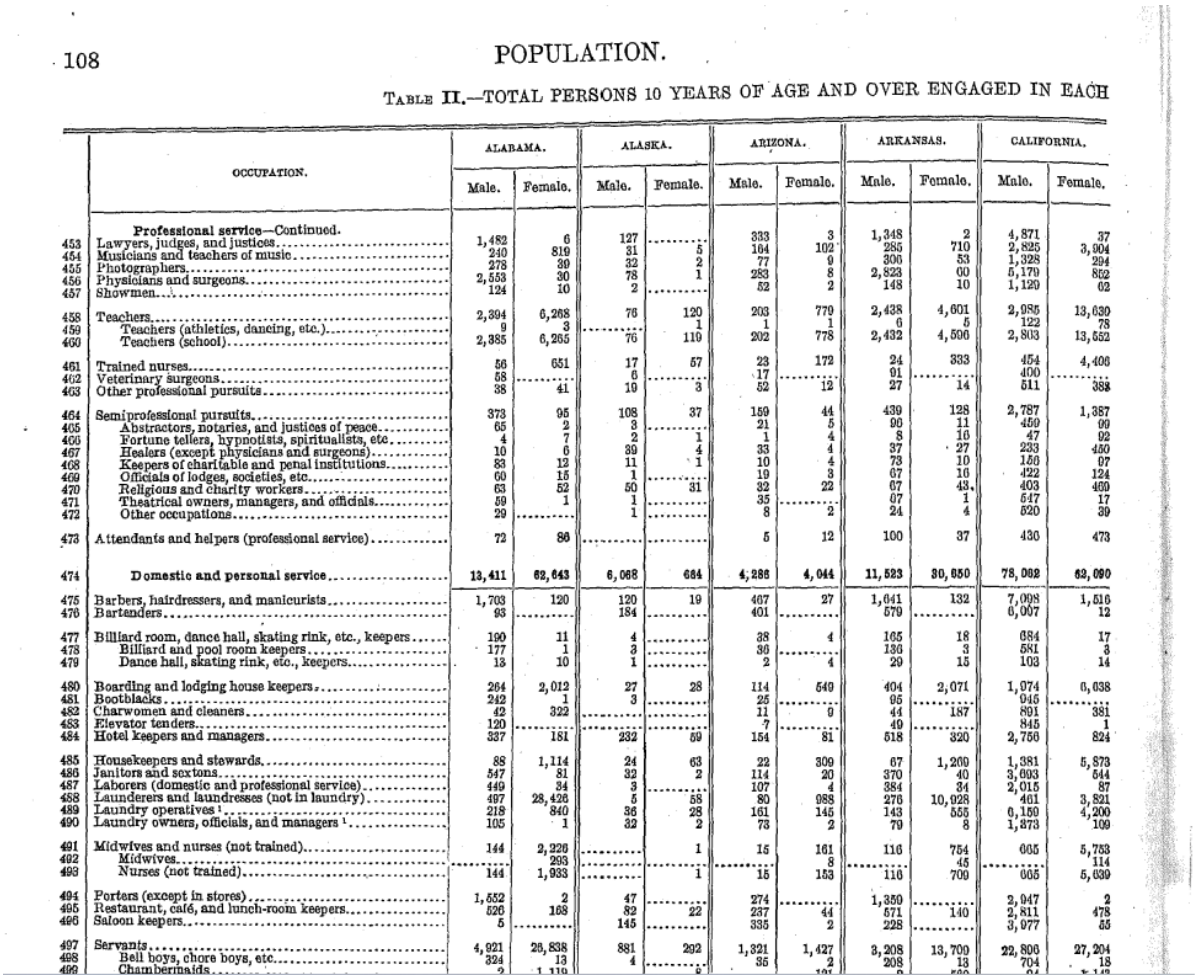
Moreover, physicians and surgeons grew by 82.158% during the same period. This data shows that midwives were attempting to keep up with the ever-growing demand for birth attendants, whereas physicians and surgeons grew but at a much slower rate. A potential interpretation of this data could suggest that while physicians and surgeons were entering into the field to gain prestige and financial opportunity, the midwife, being a strong supporter of her local community, entered the field out of civic necessity. When comparing the sheer enormity of the state's total population to the number of statistically reportable birth attendants, it is overwhelming regardless of the growth rate. It would take more than just those identifying as

[25] "Table II. –Total Persons 10 Years of Age and Over Engaged in Each: Population," 20.

[26] "Table II. –Total Persons 10 Years of Age and Over Engaged in Each: Population," 20.

[27] "Table II. –Total Persons 10 Years of Age and Over Engaged in Each: Population," 20.

birth assistants to assist in every child's birth. It would take an entire community of supportive people to assist in ushering in future generations. (See Chapter 4: Figure 5).[28]



108 POPULATION.

TABLE II.—TOTAL PERSONS 10 YEARS OF AGE AND OVER ENGAGED IN EACH

	OCCUPATION.	ALABAMA.		ALASKA.		ARIZONA.		ARKANSAS.		CALIFORNIA.	
		Male.	Female.	Male.	Female.	Male.	Female.	Male.	Female.	Male.	Female.
	Professional service—Continued.										
453	Lawyers, judges, and justices	1,482	6	127	.....	333	3	1,348	2	4,871	37
454	Musicians and teachers of music	240	819	31	5	104	102	285	710	2,825	3,904
455	Photographers	278	30	32	2	77	9	306	53	1,328	294
456	Physicians and surgeons	2,553	30	78	1	283	8	2,823	60	5,179	852
457	Showmen	124	10	2	.....	52	2	148	10	1,120	62
458	Teachers	2,394	6,268	76	120	203	779	2,438	4,601	2,985	13,639
459	Teachers (athletics, dancing, etc.)	9	3	.....	1	1	1	6	5	122	78
460	Teachers (school)	2,385	6,265	76	119	202	778	2,432	4,596	2,803	13,552
461	Trained nurses	56	651	17	57	23	172	24	333	454	4,406
462	Veterinary surgeons	68	.....	6	.....	17	.....	91	.....	400	.....
463	Other professional pursuits	38	41	19	3	52	12	27	14	511	383
464	Semiprofessional pursuits	373	95	108	37	159	44	439	128	2,787	1,387
465	Abstractors, notaries, and justices of peace	65	2	3	.....	21	5	90	11	459	99
466	Fortune tellers, hypnotists, spiritualists, etc	4	7	2	1	1	4	8	16	47	92
467	Healers (except physicians and surgeons)	10	6	39	4	33	4	37	27	233	450
468	Keepers of charitable and penal institutions	83	12	11	1	10	4	73	10	156	97
469	Officials of lodges, societies, etc	60	15	1	.....	19	3	67	16	422	124
470	Religious and charity workers	63	52	50	31	32	22	67	43	403	469
471	Theatrical owners, managers, and officials	59	1	1	.....	35	.....	67	1	547	17
472	Other occupations	29	.....	1	.....	8	2	24	4	520	39
473	Attendants and helpers (professional service)	72	86	.....	.....	5	12	100	37	430	473
474	**Domestic and personal service**	13,411	62,643	6,068	664	4,286	4,044	11,523	30,650	78,062	62,090
475	Barbers, hairdressers, and manicurists	1,703	120	120	19	467	27	1,641	132	7,098	1,516
476	Bartenders	93	.....	184	.....	401	.....	579	.....	6,007	12
477	Billiard room, dance hall, skating rink, etc., keepers	190	11	4	.....	38	4	165	18	684	17
478	Billiard and pool room keepers	177	1	3	.....	36	.....	136	3	581	3
479	Dance hall, skating rink, etc., keepers	13	10	1	.....	2	4	29	15	103	14
480	Boarding and lodging house keepers	264	2,012	27	28	114	549	404	2,071	1,074	6,038
481	Bootblacks	242	1	3	.....	25	.....	95	.....	945	.....
482	Charwomen and cleaners	42	322	.....	.....	11	9	44	187	891	381
483	Elevator tenders	120	.....	.....	.....	7	.....	49	.....	845	1
484	Hotel keepers and managers	337	181	232	59	154	81	518	320	2,756	824
485	Housekeepers and stewards	88	1,114	24	63	22	309	67	1,200	1,381	5,873
486	Janitors and sextons	547	81	32	2	114	20	370	40	3,693	544
487	Laborers (domestic and professional service)	449	34	3	.....	107	4	384	34	2,015	87
488	Launderers and laundresses (not in laundry)	497	28,426	5	58	80	988	276	10,928	461	3,821
489	Laundry operatives [1]	218	840	36	28	161	146	143	555	6,159	4,200
490	Laundry owners, officials, and managers [1]	105	1	32	2	73	2	79	8	1,373	109
491	Midwives and nurses (not trained)	144	2,226	.....	1	15	161	116	754	665	5,753
492	Midwives	.....	293	.....	.....	.....	8	.....	45	.....	114
493	Nurses (not trained)	144	1,933	.....	1	15	153	116	709	665	5,639
494	Porters (except in stores)	1,552	2	47	.....	274	.....	1,350	.....	2,947	2
495	Restaurant, café, and lunch-room keepers	526	168	82	22	237	44	571	140	2,811	478
496	Saloon keepers	5	.....	145	.....	335	2	228	.....	3,977	55
497	Servants	4,921	28,838	881	292	1,321	1,427	3,208	13,709	22,806	27,204
498	Bell boys, chore boys, etc	324	13	4	.....	35	2	208	13	704	13
499	Chambermaids	2	1,119		5		101	9	539	94	1,148

Chapter 4: Figure 5– "Table II. –Total Persons 10 Years of Age and Over Engaged in Each: Population." [29]

[28] "Table II. –Total Persons 10 Years of Age and Over Engaged in Each: Population," 108.; "Population– Alabama: Chapter 1. –Number of Inhabitants," 20.

[29] "Table II. –Total Persons 10 Years of Age and Over Engaged in Each: Population," 108.

Moreover, it is vital to understand the difference between statistically reportable midwives (traditional midwives) and lay midwives.

> "lay" midwives, also referred to as "direct-entry," "independent," or "Granny" midwives and nurse-midwives. Lay midwives generally do not have nursing degrees; instead, they have gained proficiency in birthing through practice and apprenticeship, many lay midwives today combine apprenticeships with some type of training at school for lay midwives, like the Seattle Midwifery School.[30]

Between 1870-1910, most lay midwives, women within the community who had the most experience with childbirth, often neglected to report themselves as midwives on census data.[31] This omission to report was likely due to the illiteracy rate of the Black Grannies. The communal lay midwife may have been trained through an apprenticeship or, more likely she was the woman who had experienced a more significant number of children being born. While midwives did not have formal training for families the circumstances of their lives made them the best option. Thus, potentially, the problematic midwives to whom the Physicians referred were not those who were trained and well-prepared. It was the lay midwife who was attempting to help her neighbor in a time of need, who unwittingly exposed the parturient to bacteria increasing their risk of infection. Yet the question remains: what could be done in a society whose population was staggeringly out of proportion to the population of those trained to attend at birth? Expectant mothers needed assistance regardless of the availability of those who were well-trained. The baby was coming regardless of who was available to help deliver it.

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[30] Stacey A. Tovino, "American Midwifery Litigation and State Legislation Preferences for Physician-Controlled Childbirth," *Cardozo Women's Law Journal* 11, no. 61 (2004): 68. Tovino paraphrases the definitions of a lay midwife from The Midwives Alliance of North America (MANA).

[31] Tovino, "American Midwifery Litigation and State Legislation," 68.

Midwives lacked formal academic training; they learned how to serve as midwives through apprenticeships with more experienced midwives. These practices often included untested rituals and tonics, allowing potentially harmful products to be utilized during birth. African-American Grannies believed that pregnancy and childbirth drew together the physical and spiritual worlds, which could be beneficial and dangerous if not handled properly. The coexistence of these two planes presented Grannies with the unique challenge of drawing out the benefits of spiritual encounters while preventing the evil spirits from excreting their influence. The benefits could include spiritual guidance or protection for the mother and infant.[32]

Additionally, the two planes' existence could allow the mother and child to have a unique bond with one another. Grannies often relied on folklore magic to aid in childbirth. For example, bodily fluids were particularly important in matters of love magic. It was common practice for Grannies to utilize the blood, sweat, or tears from the head, the emotional center, to create an emotional bond between two people. So, when a woman was in labor, it was common for her to wear the father's hat on top of her head to help relieve some of the labor pains.[33] Many of these practices would persist throughout the late nineteenth into the early twentieth-century; however, germ theory began to take precedence in the latter part of the nineteenth-century— hence the professionalization and modernization of childbirth. Germ theory asserts that particular microbes cause specific diseases. The introduction of germ theory will become a weapon for physicians against midwives to ultimately regulate and constrain the midwife's ability to practice obstetrics. Grannies were aware of the medical community's scientific introduction of germ theory.

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[32] Laurie A. Wilkie, "Expelling Frogs and Binding Babies: Conception, Gestation and Birth in Nineteenth-Century African-America Midwifery," World Archaeology 45, no. 2 (2013): 274-275.

[33] Wilkie, "Expelling Frogs and Binding Babies," 274-275.

Evidence suggests that Grannies were influenced by germ theory while they continued their African-rooted practices.[34]

Some of the rituals that reflected the Africanized roots included the methods of disposing of the afterbirth, a postpartum seclusionary period, and a ritual that would help a mother be reintroduced into everyday life. Another common practice was midwives insisting that no fire could be removed from the house. This included the removal of ashes from the fireplace. Also, midwives insisted that it was taboo to sweep the house, especially under the mother's bed. As is quoted in Linda Holmes's article, the following is a description from a mother following her childbirth of the behaviors and rituals of her Midwife birth assistant,

> Well, when the midwife came back and she took me up and I remember her giving me a dose of medicine and it was some castor oil to get all the filth and stuff out of you, so they told me. And then you had to walk all the way around the house and come back. It would be up in the day [late in the day]. If it was in the wintertime, they would make sure it would be a nice warm day. The coldest time I had a baby was in March. The midwife would not let me go outside on that day. She waited till she found a better day. She came and she got me up, but made sure I was back in the bed before she left. It would be a month before they threw the ashes away. If you smoked a cigarette in there you couldn't take it out of there. You couldn't take no fire out of the fireplace where they burned the afterbirth.[35]

Additionally, women appreciated the extra help that came with using a midwife rather than a physician. Midwives helped with household chores, cooked meals, and tended to elder children, which are tremendous tasks for women who are in late-stage pregnancy or recovery from delivery.[36]

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[34] Wilkie, "Expelling Frogs and Binding Babies," 274-275.

[35] Holmes, "Medical History," 390.

[36] Holmes, "Medical History," 390.

Before analyzing the services and methodology employed by midwives, it is essential to examine how society at large viewed pregnancy. According to the ongoing twenty-first-century polio-medicine debate, life begins within the first eight weeks of gestation. This is mainly because modern medicine has enabled society to detect early pregnancy. At-home pregnancy tests allow women to detect the human chorionic gonadotropin (hCG) hormone as early as four weeks gestation. Still, the first at-home pregnancy test looked slightly different from the modern version. It was in the 1960s that Margaret Crane created the patent on the Predictor. Crane was a graphic designer from New York who worked with Chefaro, a subsidiary of Organon, a Dutch pharmaceutical company that manufactured and marketed Predictor. The Predictor through urine collection allowed women to find out in as little as two hours whether she was expecting a baby. This technology was not marketed as new but rather as the first for domestic use. Before this, a woman had to go to the doctor's office to have her sample tested.[37]

Prior to this, the development of pregnancy from conception to delivery was not well understood in the medical sense. Pregnancy was not determined until a woman could feel "'Quickening,' or the first detection of fetal movement by the mother, served to diagnose pregnancy."[38] The first fetal movements are generally felt around twenty weeks gestation. Before that period, women diagnosed themselves with delayed menses. There were various herbal medicines known as emmenagogues that a Granny could advise the woman to take to start menses.

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[37] Jesse Olszynko-Gryn, "Predictor: The First Home Pregnancy Test." *Journal of British Studies* 59, no. 3 (July 2020): 638-640.

[38] Laurie A. Wilkie, "Expelling Frogs and Binding Babies: Conception, Gestation and Birth in Nineteenth-Century African-America Midwifery," *World Archaeology* 45, no. 2 (2013): 275.

> Very much recommended as an emmenagogue… A strong decoction, or infusion, of the herb (tansy) is in common use. Some prefer a syrup, made thus: - Put into the oven a jar of tanzy just covered with water; bake it an hour or two; add half a pint of into the strained liquor' sweeten it, and cork it in bottles. Half a wine glass may be taken two or three times a day.[39]

In the late nineteenth-century, people did not believe that a fetus had a soul until quickening began; thus, late induction of menstruation was not considered abortion. Abortion took place after diagnoses of pregnancy, which was recognized near around twenty weeks gestation, and remained the legal standard for the recognition of life until 1860. Abortion did not become a criminal offense in select states until the second half of the nineteenth-century, which was arguably due to the Jim Crow radicalism's approach to increasing the White middle class. By the 1880s, all states had legal restrictions on abortion, with the exception of medical necessity.[40] While abortion is important to note because it was one of the services that a midwife could provide, it is not the central focus of this dissertation. The more important information that this examination can gain is that midwives used homeopathic techniques to administer treatment for a common complaint of women- late menstruation.

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[39] Lydia Child, *The Family Nurse*. (Bedford, MA: Applewood Books, [1837] 1997), 107. Lydia Child (1802-1880) was an abolitionist, Women's Rights Activist, and an author who published several domestic manuals such as *The Frugal Housewife* (1829).

[40] J.C. Mohr, "Patterns of Abortion and the Response of American Physicians, 1790-1930." in *Women and Health in America*, ed. by J. W. Leavitt, (Madison, WI: University of Wisconsin Press, 1984), 119.; A. Davis, "Racism, Birth Control, and Reproductive Rights," in *From Abortion to Reproductive Freedom*, ed. by M.G. Fried, (Boston, MA: South End Press, 1990), 15.; "Historical Abortion Law Timeline: 1850 to Today," *Planned Parenthood*, date accessed October 30, 2023, https://www.plannedparenthoodaction.org/issues/abortion/abortion-central-history-reproductive-health-care-america/historical-abortion-law-timeline-1850-today#:~:text=1880s%3A%20Criminalization%20and%20Vilification&text=By%201880%2C%20all%20states%20had,the%20stigma%20surrounding%20it%20grew.

Midwives did much more than offer advice that could be used for termination. They attempted to reduce the maternal and infant mortality rates by guiding women through childbirth and beyond. Having a midwife present during confinement and delivery was a blessing because the Granny would help prepare food for the parturient, do laundry, tend to elder children, and do other household chores—a doctor would not provide such services.[41]

It is critical to note that African-American Grannies had a different view on how a baby's soul and personality were developed than their White European counterparts. Grannies believed that the personality and soul of the baby came from a fully formed child in the spirit realm; thus, things done during pregnancy would not influence it. Europeans, on the other hand, believe that if the expected mother had a bad temper or bouts of depression, the child would likely be born exhibiting the same qualities. [42]

Grannies believed that if an infant died, it was because the child's spiritual mother reclaimed the baby; therefore, many of the practices that Grannies performed during childbirth were to help fuse the baby to this world. The practice of midwife fusing became problematic when the federal government began to regulate midwifery in the 1920s. "Fusing" occurs during the second stage of labor, when labor contractions start at regular intervals but are not strong enough to stimulate delivery. At this stage, Grannies would bring close female friends and family members into the lying-in room to care for the expectant mother. The mother was massaged with oils and perfumes while having her hair styled. This was all done in an attempt to prepare the mother for the infant. The midwife carefully selected the scents used as a love spell to help fuss the infant to

[41] Wilkie, "Expelling Frogs and Binding Babies," 278.

[42] Wilkie, "Expelling Frogs and Binding Babies," 278.

its earthly mother, hoping the baby will stay rooted to this body. The concept of fusing became problematic with the introduction of germ theory, hygiene, and sterilization practices. By bringing women into the delivery room, the midwife was also bringing in a variety of new germs to introduce to the immuno-compromised parturient and the infant. The risk of infection would have increased with their presence.[43]

While Grannies performed rituals for babies to enter this world safely and remain in the arms of their earthly mother, they also emphasized that they did not deliver the baby; instead, they caught babies. Midwives attempted to use non-invasive methods to help ease the infant into this world. It was common practice for the Granny to perform a perineum massage to lessen the likelihood of tearing during delivery. Perineum tears could potentially lead to a multitude of complications for the recovering mother. Grannies also relied on rituals such as using the father's hat to lessen labor pains or putting a knife under the mattress of the parturient to cut the labor pains. The knife derives from the African belief that the magical powers could be derived from the God of Iron, Ogun; thus, placing an iron knife under the bed would help alleviate the pains of childbirth. [44]

The Grannies did not have access to formal academic training. Hence, they had to utilize anything that could potentially help women who were undergoing what was very likely the worst pain that they ever felt in their lives. There is significant evidence that the method employed by Grannies in America's South, while seemingly unorthodox, are filled with medical beneficial truths. For example, Grannies encouraged laboring women to breathe into a blue bottle to help

[43] Wilkie, "Expelling Frogs and Binding Babies," 278-279.

[44] Wilkie, "Expelling Frogs and Binding Babies," 279-280.

ease their pain. Modern Lamaze coaches agree with this point, asserting that focused breathing can help ease labor pain. The blue coloring of the bottle purportedly protected against evil spirits. Additionally, Grannies would use Vaseline to help lubricate the perineum during delivery to prevent tearing. Modern midwives use this practice, knowing that tearing can cause many complications, such as Rectal Vaginal Fistula (RBF), which allows feces to exit through the vagina, which raises the risk of infection.[45]

As noted before, Grannies did more than catch the babies; they helped with the housework, tended to the elder children, and provided after-postpartum care. Once a child was born, the Granny would lather the baby in Vaseline to protect the skin, wrap the baby into a swaddle, and hand the child to the mother. According to Lydia Child, "A newly born infant should be rubbed with fresh lard, and then carefully washed with warm water."[46] Grannies were diligent in protecting the newborn child so that it would not return to the spirit realm, especially when infant mortality rates were high. Midwives also helped new mothers learn the art of breastfeeding. I describe breastfeeding as an art because it is more complex than experts describe. The infant must have the proper latch, which could be hindered by several issues, such as a tongue tie or the shape of the mother's nipples. If the conditions are not perfect, breastfeeding can be extremely painful, if not completely impossible. In the nineteenth- and twentieth-centuries, "formal" feeding, as it is termed in the twenty-first-century, did exist; however, alternative milk was not as nutritious or accessible as mother's milk. Thus new mothers needed to take advantage of her lactation. Having a wet nurse

[45] Wilkie, "Expelling Frogs and Binding Babies," 279-280.

[46] Child, *The Family Nurse,* 35.

was also a common practice; women would often plan pregnancies at the same time as a house servant in order to have help feeding the child in the event of the mother's absence.[47]

Having access to a wet nurse provided a unique opportunity for racism. According to Grannies, it was via breastmilk that children acquired what was known as "mother's wit" or their intelligence. As previously noted, this was accomplished through the magical bond formed by exchanging bodily fluids. So, a Black mother breastfeeding her own child allowed her intelligence to pass to the child; however, if a Black mother served as a wet nurse for a White child, that White child did not inherit any of the Black mother's wit because the wetnurse was not the child's mother and the superiority of White intellect by nature will suppress the inferiority of Black wit. Racism supported the assertion that White mothers and children were intellectually superior to their Black counterparts.[48]

Interestingly, the breastfeeding methods employed by the Grannies were laced with medical evidence without their academic understanding. Modern lactation specialists encourage mothers to nurse from both breasts to help prevent milk duct clogging; however, it is common for an infant to prefer one breast to the other because of the speed at which milk may exit the breast. Author Lydia Child recommended that infants should be nursed on both breasts, otherwise, "a child constantly nursed from one breast is apt to grow crooked, and acquire the habit of squinting, from having the eyes constantly directed at one point."[49] While the reason for alternating differs from modern standards, it is evident that early Grannies understood the

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[47] Child, *The Family Nurse*, 35.; Wilkie, "Expelling Frogs and Binding Babies," 280. Child was an author of domestic manuals that women could refer to for advice on household issues and properly mothering children.

[48] Wilkie, "Expelling Frogs and Binding Babies," 279-281.

[49] Child, *The Family Nurse,* 35.

importance of the act. Grannies did their best with the information they possessed to protect and serve their patients. Both White and Black Southern women depended on them for obstetric care. Grannies set the stage for obstetric care in the South for generations. That is until the early twentieth-century when the national debate of the "midwife problem" entered the sociopolitical arena. [50]

The Sociopolitics of Midwifery

At the turn of the twentieth-century, historians reported on what they termed the "midwife problem," which shows that the utilization of midwives as birth attendants started to decline due to the introduction of new scientific theories and the professionalization of medicine. Places such as rural Alabama were slower to feel the effects of this due to the demand for midwives. Physicians were not as available in these regions; consequently, the inhabitants had no choice but to remain under the care of a midwife- new scientific theories, such as germ theory, drastically altered medical practices. Midwives who worked within the home of the parturient did not understand the spread of diseases well enough to combat germs properly. As noted during the fusing stages of labor, midwives invited members of the parturient family and friend groups into the lying-in room, which exposed the patient to a variety of new germs. As society began to understand the spread of germs, people grew weary of these practices.[51]

[50] Child, *The Family Nurse*, 35.

[51] Shead, "'Granny" Midwife to Nurse-Midwife," 48-49.

Moreover, by the end of the nineteenth-century, physicians were striving to solidify their profession to increase their socioeconomic standing. Doctors blamed the midwives for their lack of respect and lower pay. It was in 1910 that the midwife problem was pushed to the forefront of the polio-medical arena as doctors and public health officials "portrayed all midwives—paradigmatically presented as 'undesirable' European immigrants and Black Southerners—as unhygienic, superstitious, and ignorant."[52] In the South, where the Black population was high along with the mortality rate of infants and mothers, "authorities both demonized Black midwives as the cause of high infant maternal morality and conscripted them as a stopgap remedy, bespeaking the category difference between Black and non-Black infancy and motherhood within the White medical worldview."[53]

Public health officials viewed the problematic midwife as a singular problem that existed on its own with no outside influences. The evidence presented within this dissertation points to a perfect storm of issues that created the overarching problem. Yes, midwives lacked formal education. They lacked the proper techniques to sterilize their instruments or the understanding of germ theory and the spread of pathogens. Midwives had limited tools available to help women when an emergency arose during delivery. But the midwife was available, affordable, and supportive for a class of people with no other alternative. Also, a perfect storm does not culminate under one single condition alone. It takes multiple issues to influence the adverse effect. Dallas, Hale, Greene, Marengo, and Sumter counties all had large Black populations; roughly three-quarters of the population was Black. The counties comprised the majority of the state's wealth during the antebellum years, which attracted people to economic endeavors and job

[52] Menzel, "The Midwife's Bag," 287-288.

[53] Menzel, "The Midwife's Bag," 287-288.

opportunities. Much of the region's wealth originated from large plantations, which, after the Civil War and the Emancipation Proclamation, would provide job opportunities for those formerly enslaved who had experience working in agriculture. The dissolution of these plantations allowed migrants to enter the region for work opportunities, bringing with them their families. The former plantation owners took part in White Flight to different areas of the United States, such as Texas.[54]

From 1870 to 1910, midwives in rural Alabama were the primary birth assistants for most of the inhabitants. Midwives focused on providing the best care possible for their patients while helping with issues beyond obstetrics. Grannies were known for caring for their patients from birth to death. They were well-known and trusted community members, which was especially critical in areas with limited access to academically trained physicians. As science began to advance, the knowledge of hygiene and healthcare grew exponentially. Techniques that were once trusted within the Granny community were becoming questioned as many infants and mothers were dying during childbirth. Progressive reformers knew legislation needed to examine and regulate obstetrics, but how would this alter childbirth?[55]

Midwifery and obstetrics were largely unregulated at the end of the nineteenth-century and the beginning of the twentieth-century, political activists and social reformists recognized a need for political intervention. However, the march progressed slowly. Historians such as Annie Menzel conclude that medical and social racism were significant contributing factors in

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[54] Menzel, “The Midwife’s Bag,” 287-288.; Anderson, Brown, Charles, “The Effect of Occupational Licensing on Consumer Welfare: Early Midwifery Laws and Maternal Mortality,”47.

[55] Menzel, “The Midwife’s Bag,” 287-288.; Anderson, Brown, Charles, “The Effect of Occupational Licensing on Consumer Welfare: Early Midwifery Laws and Maternal Mortality,”47.

prolonging progressive acts of legislation, such as the 1918 Licensing Act in Alabama and the later Sheppard-Towner Act (1921 to 1929), from having a significant effect on the region. In 1918, "Midwives were required to pass an examination and register with the Alabama State Board of Health."[56] Since midwives in this region had been practicing unregulated within the state of Alabama, the state's legislature passed the law requiring the licensing of midwives. In response to this, Tuskegee Institute created a short program designed to provide robust training for midwives over four weeks.[57]

Similarly, The Sheppard-Towner Act was the federal mandate that mothers and infants have access to educational support and healthcare.[58] Conversely, this act would go into effect in the Progressive Era; hence, mothers and infants received unregulated medical and educational support in the earlier years. Another factor that played a dominant role in the height of maternal and infant mortality rates was the midwife herself. Before the twentieth-century, midwives had little formal academic training; their training was through an apprenticeship. Older, more experienced midwives would teach the incoming women the field's methods, rituals, and remedies. Most remedies and rituals were home-spun methods passed down through the generations with little scientific evidence or academic knowledge to support their effectiveness.

Nonetheless, there is little evidence that supports the assertion that midwives were more harmful than helpful. Women such as Margaret Charles Smith and before her Ella Anderson had acquired skills that impressed White physicians. Midwives were far from unskilled, unpracticed

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[56] Anderson, Brown, Charles, "The Effect of Occupational Licensing on Consumer Welfare: Early Midwifery Laws and Maternal Mortality,"47.

[57] Anderson, Brown, Charles, "The Effect of Occupational Licensing on Consumer Welfare: Early Midwifery Laws and Maternal Mortality,"47.

[58] Menzel, "The Midwife's Bag," 283.

birth attendants most had delivered thousands of babies throughout their tenure and provided care beyond obstetrics to poor families in need. Regardless of selected birth attendants, childbirth has never and will never be without risk many things can go wrong during pregnancy, labor, and delivery. Childbirth is a hazardous event that can turn tragic even in the hands of the most educated and experienced professionals.

The Effects of Bigotry

The need for birth attendants in the growing Alabama population is evident through the examination of census data, diaries, and medical journals. Scholars, midwives, and physicians debate birth attendants' expertise and educational requirements in an attempt to provide quality patient care. At least, that is what physicians argue; however, gender issues, race relations, and socioeconomic status play a complicated role in defining quality care. Initially, this text's central focus was to better understand the modernization and professionalization of childbirth, which helped decrease the mortality rates of both mother and child. However, the evidence does not support this assertion. Scholars have examined the phenomena of obstetrics modernization; historians assert that the march towards progress was done with the underlying intent to improve the safety of birthing conditions. The justification for the march ranges dramatically from racial relations, gender issues, and issues of professionalization; the list is extensive. During the Reconstruction Era, society at large began to recognize the dangers of pregnancy, labor, delivery, and postpartum; thus, society looked towards progressivists to push childbirth to the forefront of the political arena during the era of medical modernization and professionalization.

It is critical to examine the methods employed by the federal government to provide healthcare to the formerly enslaved to modernize the field. After the formal emancipation of the slaves, the federal government attempted to intervene in healthcare. While in slavery, most Blacks were under the care of the plantation master, who would call upon a doctor when necessary. How, when, and where a doctor became necessary is another discussion; however, necessity was often tied to the complexity of birth. Nevertheless, after emancipation, it was on the shoulders of the newly freed individuals to acquire and financially support their healthcare requirements. The United States government recognized the need for intervention for the newly-released population. Thus, with the establishment of the Freedmen's Bureau came the organization of urban hospitals and rural dispensaries to provide for the Black population.

In the years that followed the dissolution of the Freedmen's Bureau, healthcare, especially in America's South, transitioned from regulated inclusion to segregation access. In the South, Whites and Blacks were mandated to remain separate due to segregation laws, more commonly referred to as Jim Crow Laws. Jim Crow Laws were designed to keep the colored population separate from the White population in an attempt to prevent White exclusion at the hands of the Black population. The racial ideology of the superiority of Whites allowed for segregation to affect both the private and public sectors of society and created unequal conditions for all that it touched. The system was operated under the umbrella of radical racism. The "separate but equal" doctrine established in *Plessy v. Ferguson* (1896) was anything but equal.[59] Blacks and Whites were exposed to radically different conditions– Blacks received old rundown amenities while Whites received the new and pristine.

[59] Plessy v. Ferguson, 163 U.S. 537 (1896).

As with most public and private business structures, hospitals operated under this exclusionary umbrella; White-only hospitals did not permit Blacks to access their services, and if a hospital allowed a Black patient, that patient would be required to give up his or her bed if a White patient arrived. Provisions in segregation made it possible for Blacks to be treated at White hospitals, but White patients took precedence. However, many White doctors and hospitals outright refused to treat Black patients before the end of segregation. Nonetheless, discrimination made healthcare that much more difficult for Blacks to obtain. In addition to the limited access to hospitals and hospital staff, hospitals of the era were known for their lack of adequate sterilization. For patients lucky enough to be seen by a physician at the hospital, there was the constant threat of exposure to harmful pathogens. [60]

Due to the lasting impacts of radical racism and Jim Crow politics, Blacks were leery of hospitals. According to an article published in *Services of a Negro Hospital* by Dr. John A. Kenney, who was the first medical director of Tuskegee's John A. Andrew Memorial Hospital,

> It has been no simple task in this section to induce people to come to the hospital for treatment, because, isolated as they are, they have inherited the very common and very erroneous idea that a hospital is the last resort in case of sickness. It has required patience, perseverance and education gradually to change this idea. It was rather difficult to make the Tuskegee students feel at home in the hospital, and the admission of an outside patient from the surrounding communities was a rarity. [61]

For many rural Alabamians, hospitals were not a vision of salvation during a medical emergency or childbirth, it was a new, unfamiliar environment where they would be surrounded

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[60] Rice and Woodrow, *Public Policy and the Black Hospital,* 4-6.; Holmes, "Medical History," 143.

[61] John A. Kenney, MD., "The Negro in Medicine," *Tuskegee University Archives: Services of a Negro Hospital* (1912), 3.

by White medical professionals who were not happy about their presence and often refused to treat them. The majority of Blacks in the South did not want to visit a hospital; instead, they preferred the comforts of home surrounded by lay midwives and local healers. Many of these rural inhabitants spent their entire lives without ever seeing the inside of a hospital or medical office. With that being said, it was common for pregnant Blacks to actively avoid delivering within a hospital.[62]

Another racially-charged issue was the utilization of midwives between 1835 and 1935 due to a period of decreased fertilization within the United States. Scholars now recognize that this period of decrease in fertility was likely due to the increase in the immigrant population. An immigration wave brought more than just immigrants into the country. It brought with them health issues, such as sexually transmitted infections that were likely the cause of the decrease in fertility rates. However, medical professionals used statistical data to implicate the "problematic midwives" for performing subpar work that negatively impacted the lives of their patients. Women had babies in high numbers; however, it was more challenging to become pregnant and maintain a healthy full-term pregnancy. According to historians J. David Hacker and Even Roberts, "Total fertility in the United States fell from 7.0 in 1835, one of the highest rates in the Western world at the time, to 2.1 in 1935, one of the lowest." This data was greatly affected by the immigration patterns of the era. As more European immigrants flooded into the country's urban regions looking for opportunities presented by the Industrial Revolution, fertility rates fell. As was previously indicated throughout this dissertation, statisticians were overtly preoccupied with vital statistics on both the native-born White population and the White European immigrant population that the Black Americans were overlooked. Accordingly, fertility rates were likely

[62] Kenney, "The Negro in Medicine," 3.

incredibly low because the Black population was omitted by statisticians, making the evidence challenging to locate.[63]

Radical racial theories such as the William Willcox Disappearance Hypothesis would have provided a foundation for statisticians to omit Black data from the census reports. If the assumption was correct that within thirty years, the Black race would altogether disappear from America, then why would statisticians waste their efforts, resources, and time concerning themselves with the declining fertility rates as they pertain to the Black population? [64]

In the 1930s and 1940s, an ex-slave narrative project was federally funded. This project provides historians with a rich collection of practices, rituals, and traditions that Grannies utilized throughout pregnancy, childbirth, and postpartum. A significant problem with this resource is that those collecting the data allowed their White biases to influence the evidence. During this era, the folklorists collecting and analyzing data were primarily White men who did not think that American Africans had their own cultural practices. Instead, the traditions and practices that the Grannies performed were a collection of old European practices learned through their prolonged exposure to Whites. Additionally, those conducting the interview were members of the Works Progress Administration (WPA), and those members were primarily White. Additionally, according to anthropologist Laurie A. Wilkie, it is highly likely that many of the traditions and practices done by Grannies were altered to reflect their clientele, which consisted of many White women.[65]

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[63] David J. Hacker and Evan Roberts, "Fertility Decline in the United State, 1850-1930: New Evidence from Complete-Count Datasets," *Ann Demogr Hist* 138, no. 2 (2019): 143.

[64] Darity, "Many Roads to Extinction Early AEA Economists and the Black Disappearance Hypothesis" 48.

[65] *Alabama and Indiana Narratives: The American Slave, Vol.* 6. ed. By George Rawick (Westport, Ct: Greenwood, 1973). Wilkie, "Expelling Frogs and Binding Babies," 272-273.

In addition to racism, midwives were labeled problematic by White male physicians because it was assumed that midwives were not as capable as physicians in caring for their parturients. The reason that midwives received the troublesome label was complex. Scholars have studied the relationship between midwives, physicians, and society in great detail; however, the evidence that physicians utilize to justify their behavior is severely lacking. A potential interpretation of this relationship is based on gender roles. Midwives worked outside of their gender role for the era. Women were expected to remain within their domestic sphere and maintain a passive character. Male physicians demand that a woman's place should be at home caring for the house and her family, not in a career that was constantly on the move between locations at all hours of the day. Additionally, the career of a midwife allowed a degree of financial independence and allowed the midwives to gain intellectual self-worth. Because of this growing independence in a gender-role-specific society, male physicians were not able to maintain a position of dominance within the medical community.[66]

The assertion that midwives were often more harmful than helpful was unfounded. According to Tovino, "early studies showed that maternal and infant mortality rates were about the same in the early twentieth-century for Black Alabama women whose deliveries were attended by midwives and White Alabama women whose deliveries were attended by physicians, Black midwives were still associated with high mortality rates." Despite the statistical data revealing that death rates were incredibly similar between Black and White women regardless of birth attendant, Grannies were still being demonized for subpar work when, in reality, their work

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Wilkie is an anthropologist and professor at the University of California, Berkeley, where is researches social inequality in early American history.

[66] Tovino, "American Midwifery Litigation and State Legislation," 106.

was as good as the White physicians or better. Claims that academically trained physicians were the safer option were again unsupported. In 1912, J. Whitridge Williams, a John Hopkins Medical School professor, stated that "the average practitioner, through his lack of preparation for the practice of obstetrics, may do his patients as much harm as the much-maligned midwife." Williams concluded by observing that most medical students could only witness a birth instead of actively participating in the delivery. It is evident through this assertion that while gender was a societal misunderstanding, in reality, it was the un-practiced birth attendant who was more harmful.[67]

Furthermore, it is incorrect to say that all physicians viewed midwives as harmful. That is evident within the text of Margaret Charles Smith, who asserted that the physician with whom she worked the most closely almost always spoke positively about her skills and the impressive outcome of positive cases with which she was involved. As with most things, it is incorrect to provide a blanket statement such as "all doctors thought that," because generally, not everyone feels the same about a topic. Historians such as Tovino provide theorized interpretations about why a White physician would make a claim that a Granny midwife was so skilled. She asserts that it is a combination of lowering the expectation of midwives to fit the surroundings. For example, the midwives in Europe at the time had more regulations that required more education than in the United States. It was unreasonable to expect similar expertise out of the poor, uneducated Black southern population because they lacked the ability to retain such information-again, racially charged. A further interpretation claimed that White physicians in locations such

[67] Tovino, "American Midwifery Litigation and State Legislation,"71.; Judith Walzer Leavitt, Brought to Bed: Childbearing in America, 1750-1950. (New York: Oxford University Press, 2016): 63.

as Alabama felt less pressure to compete with Black midwives. In these rural areas, most of the patients were poor Black women who regardless of the abilities of the physician, could not afford to pay the rates that they were charging. [68]

To offer a more liberal, new revisionist approach to the interpretation, many of the Grannies in rural Alabama were likely skilled at their practice because of the practice, meaning that these Grannies delivered hundreds of babies and the master midwife who had trained them herself delivered hundreds of babies. Generations of skills and knowledge were passed down to the practitioners- skills that can only be learned through hands-on training. During her life, which extends far beyond the time frame for this dissertation, Smith delivered more than three thousand babies. With such an impressive demonstration of skills, it is very likely that the physician she worked most closely with recognized her skill set and gave her the credit she clearly deserved.

Conclusion

In summation, the rural setting of Alabama and the poor socioeconomic status of its citizens brewed the ideal conditions for home care by a Granny midwife. The inhabitants of the state had very little money for necessities, so they were not in a position to hire a traditional physician to assist in an average labor and delivery. Midwives were experienced, affordable, and local. Race relations in the South indicated that separate but equal was the best alternative for dealing with new relationships that developed out of emancipation. Blacks were to be separated from Whites due to Jim Crow laws that existed throughout regions such as Alabama. These exclusionary laws created Hobson's choice for patients. Black patients had the perceived option

[68] Smith and Holmes, *Listen to me* Good, 21.

of either obtaining a traditionally-trained physician or a lay midwife. But, due to sociopolitical tension in the region, Blacks' only choice was to labor and deliver at home.

Grannies were an excellent choice for birth assistance for regional Blacks and Whites. Grannies were admired, trusted, and supported members of their community. They instilled their heritage through the use of Africanized rituals, which were to ensure the safe delivery of babies during a moment when the two planes, the living and the dead, were close to one another. Grannies provided more services than just catching babies. They provided medical assistance when necessary, supported the family while the mother gave birth, taught the new mother the art of breastfeeding, and provided postpartum care.

Unfortunately, racism reached every aspect of childbirth in the South, and the Granny was no exception. Racism was instilled in the ideology of breastfeeding where the Black mother would pass down ignorance to her child. Whereas, a White mother would pass down her intelligence to her White child. However, if a Black woman were to serve as a wet nurse for a White woman, then the White child would not inherit any of her ignorance.

It would not be until after the end of the time frame for this case study that regulations on midwives would begin to emerge. In 1914, the regulation of "The Midwives Bag" was enacted. Legislation assumed that by controlling the contents of the midwife's bag, they could control the instruments that would be utilized on the patients. That was followed shortly by the 1918 licensing requirement that the state of Alabama would pass.

From 1900 until 1910, bigotry entered the medical field as White physicians became increasingly intolerant of Black midwives. Racism was not the only issue that was growing during this era. Gender issues also surfaced as male Physicians questioned women's abilities to be able to work within the medical field. Women were thought to be too delicate for the field.

Some physicians even argued that too much education in medicine would cause women to enter into a derelict state.

Lastly, examining these intermediate periods throughout history is critical where legislation has not caught up with the ideologies and societal connotations. These intermediate periods forecast the changes that are on the horizon while highlighting the reasons that those changes are imperative to the field. As many scholars have studied the reasons behind the mistrust of midwives, a new historicism view illustrates that the political, social, and economic condition of people in rural Alabama generated a Hobson's choice, in which midwives arose as victors. Until political, social, and economic changes relieved midwives as the only viable option for patients in this region, midwives utilized the training that they received to help deliver babies. While this training was not traditional, it was effective, which was seen in the track record of women like Margaret Charles Smith who delivered thousands of babies safely and was praised for it.

In a rural poor, primarily Black population, women still needed quality birth attendants. Physicians were too expensive for the majority of the parturients, so they leaned on the support of Granny Midwives. The women did more than catch babies as they entered the world; therefore, socially, they were accepted and respected, at least until physicians began to attack their lack of education. But who was to blame the overworked, undereducated midwife who was doing the best that she could or the overpriced classically trained physicians? The midwives were victims of societal making, "both damned it she did and damned if she didn't."

Chapter 5: Along Came a Doctor

Introduction:

In contrast to the midwife, there was the academically-trained physician. The title of this chapter evokes a certain image. Take a moment to close your eyes and think of a doctor entering into a room in 1880. What does that look like? For me, the doctor is a White male, most likely European in ethnicity, average features wearing a White lab coat. Does your image look similar? Now, the better question is, why? Why is the image that of a male? Why is that male White? The answer to these rhetorical questions are not simple; rather, the answer comes in the complex form of educational experiences, personal experiences, and even how history is recorded. Until the 1970s, history was largely recorded from a patriarchal perspective. As discussed in the previous chapters, men were the main historical characters and women served as supporting characters. Many of us have been taught history from that perspective, I will even be so bold as to argue that those of us who view history through a lens of modern women's history have been accused of interpreting history strictly from a feminist perspective, which again pigeonholes interpretations. When examining medical history, especially that of obstetrics, gender does play a role in birth attendants. But, not in the misguided notion that a man hand-selected a female birth attendant for his mate, rather in the sense that the parturient was more inclined to select a birth attendant that was accessible. Many times, the only accessible birth assistant was a Granny, other times the birth attendant was an academically-trained physician. Think back to the image of the doctor, did you imagine a female physician? What was her ethnicity? Women were entering into medical schools are increasing rates, both White and Black. It was very possible for a doctor in the 1880s to have been female- even a Black female.

Today, in rural areas of America, access to quality healthcare is problematic. Many people must drive for hours to reach doctors or hospitals. However, in the years before the turn of the twentieth-century, access to affective healthcare or healthcare of any quality at all was significantly less obtainable. Many people in rural Alabama had little to no access to healthcare. This was partly because throughout most of the nineteenth-century formal academically-trained physicians received their education in other areas of the country and then moved to Alabama. The alternative location for educational acquisition is largely due to the lack of medical colleges in Alabama. The reason that many young physicians would return to the area was the enormous demand for educated physicians and recruitment from activists such as Booker T. Washington. Alabama had a rapidly growing population, in part due to migration but mainly due to natural increase. People in this region were having children, which provided these newly educated doctors with the opportunity to practice and fine-tune their skills. The high birth rates were accompanied by very high mortality rates for both mother and infant. Thus, it was critical for physicians to make an impact by reducing the mortality rates. This chapter will examine the modernization and professionalization of childbirth through the lens of the physician, who utilized their expansive medical knowledge to improve the field as a result of understanding the history of childbirth, the development of tocology training, and the modernization of the physician.

Development of Modern Tocology

It is vital to explain that this dissertation examines the modernization and professionalization of childbirth in rural Alabama from 1870 to 1910. So, this dissertation will

solely focus on the medical history of Alabama as it pertains directly to prenatal care, labor and delivery, childbirth, and postpartum care.

Thus, it is important to gain an understanding of the history of childbirth. To provide a brief background on the history of childbirth, it is critical to note this study can be broken down into roughly three periods. The first period occurs from the establishment of written human record of modern history until roughly the end of the eighteenth-century. Certainly, this is a huge chunk of human history; however, during this period, childbirth was viewed as a social event. A child's birth was a reason for women to gather, socialize, and help one another through a major life event. Women not only assisted in the delivery of the child, but they also helped the expectant mother with household chores, tended to other children, and provided support to the laboring mother.[1]

The second categorical period occurred in the nineteenth-century when the social element of childbirth transitioned into medically managed birth. As previously noted, the nineteenth-century is the era when medical school establishment accelerated. It was during this era that medical technologies began to show stark similarities to those that are used today and the professionalization of the medical field truly began to blossom into a thriving industry.[2]

Finally, the third period of obstetrics history began after 1920 when the major transformation from socially-medically-managed childbirth was complete. Meaning that the

[1] Nancy Schrom Dye, "History of Childbirth in America," *Women: Sex and Sexuality* 6, no. 1 (1980): 98.

[2] Dye, "History of Childbirth in America," 98.

medical model of childbirth goes unchallenged as a medical profession that requires medical training and intervention.[3]

Historically during childbirth, the parturient was accompanied by a birth attendant. This was due to the anatomy of women, during childbirth the infant descends through the birth canal facing to the posterior of the mother. Delivering a baby without a birth assistant increases both the risk of injury to both mother and child. Throughout history, birth attendants have taken a variety of forms; however, the most common were a midwife or a physician. Traditionally, midwives did not receive formal training. It was during the mid-eighteenth-century that increasing numbers of Americans were traveling to Great Britain to receive their medical training. It was in Great Britain that these students learned that midwifery should be considered a part of medical science. It would not be until the late nineteenth and early twentieth-century before institutions began to train and certify midwives in America. Due to the lack of formal training of midwives, physicians often view these women as problematic. Midwives acquired enough knowledge to become overconfident in their abilities, causing them to overestimate their skill set. The transition from a social birth to a medically-managed birth was accompanied by the shift from female birth attendants to male birth attendants.[4]

In addition to the lack of medical schools, there is a lack of knowledge in the medical field, this lack of anatomical understanding had negative effects on how physicians were treating their patients. The nineteenth-century marked a period of informational growth as scientists began to understand more about anatomy, microbiology, and health. Some of that understanding came with new techniques that were being introduced into the medical field. One such technique

[3] Dye, "History of Childbirth in America,"
[4] Dye, "History of Childbirth in America," 100.

is what was referred to topographical anatomy during the Ice Age of Anatomy and Obstetrics. This revolutionary technique was introduced in 1870 by Wilhelm Braune during his tenure at the Lepzig institution when he received the body of a young woman who had hung herself during the final months of her pregnancy. Instead of dissecting the body and studying the organs, which was common practice at the time, Braune made the decision to freeze the woman, he then decided to take slices, or sections, of specimens so that those studying could get a more accurate 3-dimensional vision of the human body and anatomy.[5]

Bruane's introduction of frozen sections helped aspiring physicians understand the female anatomy better than in previous decades. Due to the etiquette practices, ethics, and moral standards, medical students were not permitted to practice on living, pregnant women. Instead, they were introduced to childbirth via skeleton models and ragdolls that would be used to simulate a fetus passing through the birth canal. This method, while perhaps the best alternative at the time, was inadequate because it lacked the muscular structures of a living woman. Students had a hard time envisioning the ascension and evacuation of the fetus. Topographical anatomy is one of many techniques that helped aspiring physicians gain a better understanding of the birth canal and ascension thereinto.[6]

Because of new teaching tools and "on-the-job practice," physicians were exposed to more births, gaining experience and confidence in their field. Despite midwives historically being the norm for birth attendants, they were not adequately trained and many times caused more harm than good according to physicians. Referred to as Granny midwives, older Black

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[5] S. Al-Gailani, "The 'Ice Age' of Anatomy and Obstetrics: Hand and Eye in the Promotion of Frozen Sections around 1900," *Bull History Med.* 90, no 4 (2016); 311-313.

[6] Al-Gailani, "The 'Ice Age' of Anatomy and Obstetrics," 311-313.

enslaved women assisted in childbirth regularly throughout the early nineteenth-century. Grannies continued to practice even after male physicians began assisting during childbirth. They helped with household chores, took care of older children, and attempted to keep the parturient comfortable as she neared the end of pregnancy. Wooster Beach reported in his doctors' notes that midwives were valuable since they could stay with the parturient and call the doctor when delivery neared. Their presence allowed doctors to tend to his other patients in the meantime.[7]

Furthermore, doctors stressed the importance of a midwife knowing her medical limits and when to call a physician. In the Charleston Medical Journal (1860), Doctor T. P. Bailey of North Santee, South Carolina, wrote of a patient named Delia, an enslaved Black woman, who was giving birth to twins when complications arose. The midwife assisting Delia attempted to work beyond her knowledge after the first child was born, the second presented by the arm. The midwife pulled on the infant's arm, causing extensive damage. Once Bailey arrived, he successfully turned the infant, delivered it, and revived the baby. Unfortunately, the child only lived for a few weeks before dying of "excessive handling," according to Bailey.[8] This account is not an isolated incident. Throughout Schwartz's text, she gives countless examples of slaves who were both helped and harmed by midwives and doctors. Fascinatingly, she does not condemn the midwife's lack of training; instead, the midwife was dealing with the circumstances of the time.[9]

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[7] Beach, Wooster. An Improved System of Midwifery Adapted to the Reformed Practice of Medicine. New York: Charles Scribner, 1853.

[8] Schwartz, *Birthing a Slave*, 146-145.

[9] Schwartz, *Birthing a Slave*, 146-145.

Importantly, midwives and physicians did not view childbirth through the same medical lens. According to Janet Bogdan's article "Care or Cure? Childbirth Practices in Nineteenth-Century America," she defines the two concepts into which labor and delivery were categorized as either a natural process or a disease that needed to be cured. Midwives viewed childbirth as a natural process, often opting for the patient, letting nature take its course to expel the child. Physicians, in contrast, viewed childbirth as a disease that needed to be treated using medication, tools, and procedures. Of course, doctors did allow time for nature to take its course before using medical treatment; unlike midwives, they were less patient and better trained to spot a complication.[10]

Additionally, heroic medicine was practiced throughout most of the nineteenth-century. Heroic medicine was the practice of performing "harsh and unpleasant therapeutics" on the parturient. Examples of heroic medicine are bleeding and blistering. The doctor hoped that these methods would help the body expel the fetus more quickly. Samuel Hogg accounts for an interaction with a slave patient where he drew blood via bloodletting a total of four times over two days before the child was born.[11]

Furthermore, there was a common racial misconception in America that African slaves felt less pain than White Europeans. The origins of this concept arose from many different theorists such as Josiah Nott. William P. Dewees presents one theory in *An Essay on the Means of Lessening Pain and Facilitating Certain Cases of Difficult Parturition* (1806) when he

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[10] Janet Bogdan, "Care or Cure? Childbirth Practices in Nineteenth-Century America," *Feminist Studies* 4, no. 2*, Toward a Feminist Theory of Motherhood* (1978): 92-94.

[11] Hogg, Samuel. "Miscellaneous Cases." *Western Journal of Medicine and Surgery 6* (October 1842): 252-256.

attributes the pain tolerated to savagery and societal differences.[12] Claiming that, due to the challenging environment, that Black women originate in, they do not experience pain in the same way as more civilized White Europeans because of the brutality of their African environment and tribal culture. Racial prejudices of the era contributed to this erroneous belief. Doctors and physician used this social ideology as justification to perform procedures on Black women with little, or, more commonly, no pain management.

The growing presence of male physicians in the Antebellum South could have emphasized gender issues; however, that was not the primary factor in the professionalization of childbirth. Steven M. Stowe discusses the role of the physician in the Antebellum Deep South in his article, “Obstetrics and the Work of Doctoring in the Mid-Nineteenth Century American South.” In his article, Stowe points out that gender in terms of the birth attendant exited the social arena in the 1830s. The more critical issue was whether an attendant's training should be medicine-based or experience-based. Additionally, a significant reason that slaves preferred midwives over physicians was the midwife’s understanding of slave culture. Stowe refutes that idea, claiming that a physician who tended to slaves during birth understood slave culture better than anyone else due to the close nature in which they worked.[13]

Another infamous physician was J. Marion Sims, born in North Carolina, where he attended medical school before moving south to Alabama. In Alabama, Sims made a name for himself professionally and learned the practice of obstetrics. He worked with many slaves and Granny midwives throughout his career. Because the slave population in Alabama was high,

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[12] Dewees, *An Essay on the Means of Lessening Pain*," 7.; Schwarts, *Birthing a Slave*, 166-167.

[13] Steven M. Stowe, "Obstetrics and the Work of Doctoring in the Mid-Nineteenth-Century American South," *Bulletin of the History of Medicine* 64, no. 4 (1990): 543-545.

most of his clients were Black enslaved women. Sims used this opportunity to practice different techniques. Despite unethical and painful procedures imposed by Sims, physicians gained valuable knowledge and experience working with the enslaved population. The knowledge gained has proved beneficial as mortality rates declined.[14]

Regardless of the medical advances available through trained doctors, many slaveholders either could not afford or thought they, themselves, would handle the birthing process of their slaves. Medical publications by doctors, such as Buchan, gave slaveholders undeserving confidence to treat their slaves. Physicians could be very expensive due to the unpredictability of labor. A physician often added additional fees onto their bill for labor lasting more than twelve hours, causing slaveholders to wait as long as possible to call for the assistance of a doctor. Because midwives and physicians were not the only options for the caregiver during the birthing process, it was more dangerous because an untrained and often the cruelest of hands affected the lives of the mother and infant.

John C. Gunn wrote another example of literature used by slaveholders, *Domestic Medicine or Poor Man's Friend,* and Samuel Bard's *Compendium of the Theory and Practice of Midwifery, Containing Practical Instructions for the Management of Women during Pregnancy, in Labor, and in Child-bed* (1838). In his text, Gunn explains different procedures in plain language so that a caregiver could refer to them before or during childbirth. Similarly, Bard's text provided detailed instructions on the use of instruments during childbirth. Bard also wanted to ensure everyone could afford and understand his book; thus, it was readily available and inexpensive. Slaveholders cared about the lives of their slaves; they did not want them to perish.

[14] Phyllis L. Brodsky, *The Control of Childbirth: Women Versus Medicine Throughout the Years*, (North Carolina: McFarland Company, 1936): 115.

Unfortunately, texts such as these gave slaveholders enough knowledge and confidence to be dangerous.[15]

On the other hand, White mistresses often played pivotal roles in the slave's childbirth process. For example, Anna Matilda Page-King was a southern plantation mistress, married and expected to care for her husband, children, and laborers; however, an absent husband and failing farm forced King to retreat to St. Simon's Island, a property trusted to her by her father. There King had to work hard to keep her family cared for, sustain the farm, and provide care for her enslaved laborers whose numbers rose due to natural increase. Within King's letters presented in *Anna: The Letters of a St. Simons Island Plantation Mistress 1817-1859* (2002), she accounted for the winter of 1852. King received news of a slave infant who perished at ten days old. She expressed frustrations at the news, asserting that her failing farm would never turn profitable if its slaves did not successfully reproduce. King does not express any remorse for the mother or child in her writing.[16]

Additionally, White mistresses had primary control over the distribution of items that slaves needed to care for their infants, such as blankets. This responsibility gave the mistress the burden of playing mother to her slaves, creating resentment, which caused issues of neglect as well as unwelcome interventions. Further, the plantation mistress would stay in constant contact with physicians to control the birthing process as much as possible. As recounted by Knight, "Slaveholders, such as Mary Ferrand Henderson watched closely over medical supplies 'for

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[15] Gunn, *Domestic Medicine or Poor Man's Friend*, 1-25.; Samuel Bard, *Domestic Medicine or Poor Man's Friend* and Samuel Bard's, *Compendium of the Theory and Practice of Midwifery, Containing Practical Instructions for the Management of Women during Pregnancy, in Labor, and in Child-bed,* (New York: Collins, 1817): 1-10.

[16] King, *Anna: The Letters of a St. Simons Island Plantation Mistress,"* 10.

servant waste medicine terrible pain-easin' medicine' was inaccessible to many slaves." [17] The mistress did not want slaves to take advantage of this vulnerable period. [18]

On the contrary, the complicated relationship between the plantation mistress, the slave, and the medical doctor proved problematic for all involved. The dependence grew between slave and mistress because each heavily relied upon the other in times of crisis, stillborn or death, and in times of jubilation, the delivery of a healthy infant. This relationship was much more complicated than one group controlling another. In times of maternal death, it was typical for the slave or mistress to help raise the children of the departed, illustrating a strong commitment to children regardless of race. [19]

Now that a brief history of the medicalization of childbirth, gender issues of those in the South, and race relations pertaining to childbirth have been discussed. It is critical to understand the development of tocology training. Physicians worked tirelessly within academia to improve their skills to assist in childbirth properly.

Reformers, politicians, and physicians joined together to blame the problematic midwife, asserting that education and regulations would help correct the problem they were causing. Midwives were largely uneducated, or at least undereducated in the classical sense, and unregulated; due to this, midwives did not fully understand the impacts of sterilization or germ theory. It would not be until 1859 that a medical college would enter into the Alabama region.

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[17]R. J. Knight, "Mistresses, Motherhood, and Maternal Exploitation in the Antebellum South." *Women's History Review* 27, no. 6 (2017): 995.

[18]R. J. Knight, "Mistresses, Motherhood, and Maternal Exploitation in the Antebellum South." *Women's History Review* 27, no. 6 (2017): 995.

[19] R. J. Knight, "Mistresses, Motherhood, and Maternal Exploitation in the Antebellum South." *Women's History Review* 27, no. 6 (2017): 995.

The first legislated orthodox medical school entered Alabama in the legacy of Josiah Nott. The medical school was connected to the eastern side of Mobile City Hospital. Nott had a lasting impression on the medical field long after his death. Born in South Carolina in 1804, Nott had four brothers and three sisters. All his brothers would grow to become influential members of the medical and academic communities. Nott quickly advanced through school, where he first studied at South Carolina College under the influence of renowned surgeon and anatomist Dr. Valentine Mott. He later studied at the University of Pennsylvania under Professors Physick and Horner. Upon completing college, Nott practiced medicine in South Carolina for approximately six years before traveling to Europe to further his medical training. When Nott returned from Europe, he made his home in Mobile, Alabama.[20]

Nott was fascinated with anthropology; he had a strong desire to learn what makes the races of man different from one another. Nott had written several texts on anthropology and anatomical differences between races which include but are not limited to *Types of Mankind* (1860), *Two Lectures on the Natural History of the Caucasian and Negro Races* (1844), and *The Moral and Intellectual Diversity of Races* (1856).[21] Amongst his many conclusions, Nott

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[20] Emmett B. Carmichael, "Josiah Clark Nott." Bulletin of the History of Medicine 22, no. 3 (1948): 249-262.

[21] Nott, Josiah Clark, George Robins Gliddon, Samuel George Morton, Louis Agassiz, William. Usher, Henry S. Patterson, and Henry S. (Henry Stuart) Patterson. *Types of Mankind: or, Ethnological Research, Based Upon the Ancient Monuments, Paintings, Sculptures, and Crania of Races, and Upon Their Natural, Geographical, Philological and Biblical History. Eighth edition.* (Philadelphia: J.B. Lippincott & co., 1860).; Nott, Josiah C. *Two Lecture on the Natural History of the Caucasian and Negro Races*. (Mobile: Dade and Thompson, 1844).; Holtz, H. and J. C. Nott. *The Moral and Intellectual Diversity of Races.* (Philadelphia: J.B. Lippincott & Co., 1856).

ascertained that not only do different races have different physical characteristics, but they also experience feelings differently, whether those feelings be emotional or physical. Nott asserted that Blacks do not experience pain in the same ways as Whites; thus, Blacks did not need the same level of pain management during medical procedures or, more critical to this dissertation, during childbirth through labor and delivery. Blacks were better equipped to endure pain than their White counterparts, which excused new physicians' unwillingness to practice medically on this portion of the population. Racial profiling would perpetuate the misconception of the pains of childbirth during the duration of the Reconstruction period.[22]

Because Alabama's medical colleges blossomed later than other regions in the United States, it slowed the progress of physicians in the area. The late start to education is attributed to what author C. B. Rodning asserts in his article "Medical College of Alabama in Mobile 1859 – 1920: A Legacy of Doctor Josiah Clark Nott" as "rural isolation, restricted communication, limited transportation, sparse population, cultural deprivation, and climatologic enervation." [23]

In rural Alabama in the late nineteenth-century, the population had strict limitations due to the complication of race relations that restricted people of different ethnicities and the lack of education that plagued the Black Belt counties. The predominately Black, poverty-stricken population in this region did not have the financial resources to entice physicians and medical colleges. Eventually, the state will be forced to intervene as the demands for medical attention increase.

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[22] Nott, Gliddon, Morton, Agassiz, William, Patterson, and Patterson. *Types of Mankind: or, Ethnological Research*." Nott, *Two Lecture on the Natural History of the Caucasian and Negro Races*.; Holtz and Nott. *The Moral and Intellectual Diversity of Races.*

[23] C. B. Rodning, "Medical College of Alabama in Mobile, 1859-1920: a Legacy of Dr. Josiah Clark Nott," *South Medical Journal* 82, no. 1 (1989): 53.

According to Rodning's article, there were ultimately three reasons that the state insisted on the introduction of medical schools into the region. The first was to provide rural Alabama with its own supply of physicians who were trained specially to handle the diverse clientele that they would encounter. The second was to help the economy. There was an economic strain and cultural drainage placed on the state due to the number of students traveling to out-of-state institutions to receive an academic medical education. Third was that, by placing medical colleges in rural Alabama, the universities could tailor their educational program to illustrate the unique skill sets that would be required to treat Black and poor Americans.[24]

In Alabama during the Civil War and the following Reconstruction Era, racial tension was elevated in Alabama. The elevation was largely due to the large number of Black inhabitants in the region. The number of Blacks outnumbered the White inhabitants, which caused anxiety. Aggressive race and gender biases allowed for the generation of Jim Crow politics, which promoted the segregation and control of Blacks in this region. Jim Crow politics was presented to the public sphere in the form of Black Codes, which were a set of laws designed to segregate the population from Whites.

Alabama's inhabitants were not only subjected to racial prejudice, but gender also segregated the civilians. Women were expected to remain primarily within the domestic sphere of their sex. According to historian Barbara Welter, the "cult of True Womanhood" was utilized to keep women hostage to the home. At the same time, men worked as the architects and engineers for the public sphere.[25] In the nineteenth-century the works of Catherine Beecher such

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[24] Rodning, "Medical College of Alabama in Mobile," 53-55.

[25] Barbara Welter, "The Cult of True Womanhood: 1820-1860," *American Quarterly* 18, no. 2 (Summer 1966): 151-173.

as the *Treatise on Domestic Economy for the Use of Young Ladies at Home and at School,* supported the Victorian ideology that women held influence of the home and hence should be accordingly educated, while men entered into, the public arena.[26]

However, due to the increase in academic medical education, a diversification in physicians' gender began to emerge. In other regions of the country, women were encouraged to apply to and attend medical colleges. This is especially true for regions in the north such as Pennsylvania, where women were sought after for careers in obstetrics. It was thought that women had a better understanding of the female anatomy than men; accordingly, making them better suited for roles in obstetrics. Even when Alabama introduced its first medical schools, the first class of students was made up of males. It would not be until September 1923 when Jimmie Ethel Montgomery entered the University of Alabama's medical school as the first full-time female student, and the first African-American woman to receive a license to practice medicine in Alabama was Halle Tanner Dillion Johnson in 1891. Therefore, in Alabama, most physicians were White males attempting to fulfill the needs of a diverse clientele.[27]

The modernization of healthcare pushed for better living conditions and health standards. To positively impact the health standards of a growing population, one area that required special attention was childbirth. Between 1870 and 1910, Alabama's population grew as a result of natural increase, it became apparent that regulations were required to ensure labor and delivery occurred as safely as possible. It is difficult to determine exactly how many children were born in Alabama during this period because Alabama did not officially begin recording births until

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[26] Catherine E Beecher, *Treatise of Domestic Economy, for the Use of Young Ladies at Home, and at School,* (New York: Harper and Brother Publishers, 1848), 11-25.

[27] Rodning, "Medical College of Alabama in Mobile," 53-55.

1908. We know that the total population of Alabama grew by 114.454% (996,992 to 2,138,093) between 1870-1910. During this period, African American migration took place as this was the eve of the Great Migration; however, from 1870-1910, the Census Bureau data provided above indicates that no major migration of Blacks occurred in Alabama. For a short period of time, White Alabamians left the state for better opportunities in Texas, so it can be ascertained that the majority of population growth can be attributed to small-scale migration and natural increase. [28]

As illustrated, Dallas, Hale, Greene, Marengo, and Sumter are rural counties within the state of Alabama. The primary inhabitants of these regions were Black and likely impoverished, and the state severely lacked academically trained doctors. Despite all of these shortcomings, the population in this region was growing. Most of the women in Alabama who were giving birth had multiple pregnancies, but whether those pregnancies resulted in a live birth is another story. Procreation exists regardless of socioeconomic status and disparity. The challenges that this region faced had a major impact on expecting mothers.[29]

Throughout the nineteenth-century, most parturients delivered within the confines of their home mainly with a midwife birth attendant. An incorrect assumption about childbirth during this era is that the patriarchy controlled the process when in fact, women called the shots. Of

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[28] "Vital Records." Alabama Public Health, April 5, 2022. https://www.alabamapublichealth.gov/vitalrecords/birth-certificates.html#:~:text=Records%20Available,for%20persons%20born%20in%20Alabama; Ewbank, Douglas C. "History of Black Mortality and Health before 1940." The Milbank Quarterly 65 (1987): 104-106.; Campbell Gibson and Kay Jung, "Population Division: Historical Census Statistics on Populations Totals by Race, 1790 to 1990, and by Hispanic Origin, 1970 to 1990, for the United States, Regions, Divisions, and States," U.S. Census Bureau: Working Paper No. 56 (September 2002): 33.

[29] Ewbank, Douglas C. "History of Black Mortality and Health before 1940." The Milbank Quarterly 65 (1987): 104-106.; Gibson and Jung, "Population Division: Historical Census Statistics on Populations Totals by Race, 1790 to 1990, and by Hispanic Origin, 1970 to 1990, for the United States, Regions, Divisions, and States," 33.

course, there are exceptions to this, but women pushed for better birthing conditions. Male physicians did not increase in popularity until the late nineteenth-century. Under the care of midwives, parturients received a low standard of care, most likely due to the lack of proper training.[30]

Additionally, midwives tended to intervene as little as possible. Later, physicians will learn that with adequate monitoring, less intervention is better. However, during the transitional period when medicine was modernizing and physicians were demonizing midwives, physicians would not have dreamed that the midwife's methods might in some fashion be superior. Midwives, during this era, did not have to attend formal training. Instead of receiving an orthodox academic education, midwives relied on apprenticeships. Much of their education was learning from texts such as John C. Gunn's *Domestic Medicine or Poor Man's Friend* (1838), T. P. Bailey's "Obstetrical Cases" (1860), and J. D. Kellogg's *Ladies' Guide in Health and Disease* (1893), are "how-to" manuals for delivering babies at home. These texts provided suggested procedures to help midwives through difficult childbirths. Many times, the texts were referenced by physicians who had little experience as well. It was in Europe in 1902 that legislation stepped in with the passing of the Midwives Act. Under this act, midwives were no longer permitted to assume their certification through experience in the field alone. This Act pushed for formal education similar to that received by physicians. Americans looked to Europe for the future in

[30] Laura Kaplan, "Changes in Childbirth in the United State 1750-1950," *Journal of Medical Humanities* 4, no. 4. (2012): 1.

medicine. Europe offered more advanced tools, practices, and education in the medical field than the United States.[31]

Moreover, physicians received little direct training in childbirth within the United States, especially in the undereducated region of Alabama. Despite medical schools popping up in the northeast, education on the specialty of obstetrics was lacking. Many male physicians struggled to understand the female anatomy, especially considering modesty, which was protected by women wearing skirts during pelvic exams. The ideology of modesty derives from American Victorianism, which was modeled after British Victorianism. American Victorianism dictated that men and women should remain within separate spheres and maintain a level of modest behavior towards one another.[32] The first professor of obstetrics at Harvard Medical School, Walter Channing, explains that students did not practice on live women. Instead, the professors would bring a skeletal pelvis of a woman and use rag dolls to illustrate the fetus passing through the birth canal. Most physicians did not witness a live birth until they completed school and were working in their field. The specialty of obstetrics remained outside of the hospital until the 1950s. It was not until Dr. Palmer F. Findley of the American Association of Obstetricians, Gynecologists, and Abdominal Surgeons renounced teaching obstetrics outside of the hospital in 1928 that the teaching of tocology transferred into the hospital.[33]

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[31] Loudon, "General Practitioners and Obstetrics: A Brief History," Journal of the Royal Society of Medicine 101, no. 11 (2008): 531-3.; James Niven, "The Midwives Act, 1902," *Public Health* 18, (1905): 499-500.

[32] Daniel Walker Howe, "American Victorianism as a Culture," *American Quarterly* 27, no. 5 (1975): 507–510.

[33] Leavitt, *Brought to Bed*, 40-2. In this text, Leavitt provides photos of physicians conducting pelvic examines on patients while maintaining modesty for the parturient. Dr. Walter Channing's quotation appears within Leavitt's text, in which he explains the theoretical approach to delivering a baby. Borst, "Teaching Obstetrics at Home," 220-21.

The push for women in the field created a demand on higher education. The first female medical schools originated in Pennsylvania: The Women's Medical College of Pennsylvania (1860) and the Women's Medical College of Philadelphia (1861). More medical schools for women began to appear throughout the Northeast and women were entering medical schools at high volumes to become obstetricians. Prior to the blooming of the specialty, most doctors who attended births were general practitioners because they were the closest to an obstetrician in the region. Abraham Flexner, in 1910, noted that hospitals were essential to medical schools, agreeing with Dr. Findley that there needed to be a collaboration between hospitals and universities to create teaching hospitals so students in specialties like tocology could gain experience before entering a delivery room.[34]

Modernization of Doctors

To adequately understand the modernization of the physician, it is critical to examine the method of birth assistant selection used during the Antebellum Period in the years just before the transition to modernization. The effects of the professionalization of childbirth were not limited to Black women. White southern women also made the switch from midwives to male physicians. Before emancipation, Black enslaved women had their birth attendants selected by the plantation master or mistresses, but this was not the case for the mistress. As presented in *Lying-In* (1989) by Richard W. and Dorothy C. Wertz, White women were free to choose a doctor or a midwife. The patriarch did not determine her decision; education, training, and

[34] Stowe, "Obstetrics and the Work of Doctoring in the Mid-Nineteenth-Century American South," 540-1.

experience influenced her choice. Also, Wertz theorizes that female midwives began to exit the profession around this time so that they could pursue formal education in obstetrics.[35]

This interpretation of the exiting of midwives from the profession is a romanticized view of the transition. While likely it was accurate that some White midwives in the North had the opportunity to forgo midwifery for the academic rigor of becoming a physician; however, in Alabama's South, where the majority of midwives were poor Blacks who lived miles from training hospitals, it was bigotry that pushed them from their field. Poor Black and White women in Dallas, Hale, Green, Marengo, and Sumter Counties Alabama did not have the luxury of selecting a birth attendant from a list of well-qualified options. They were left with the Hobson's choice the local community midwife. It was unlikely that the local midwife would leave her charges and family to travel far from home to pay the high expense of medical school.

To further illustrate the romanticized version of childbirth and birth assistant, scholars have been able to study primary sources of women from the era. Many White southern women kept journals and diaries, accounting for their life experiences. In *Tokens of Affection: Letters of a Planter's Daughter in the Old South* (1996), Maria Bryan the wife of a Georgia farmer notes that women were socially expected to regard childbirth positively. They were not allowed to speak or write ill of the childbirth experience since it was God's will for women to experience the pains of labor. Within her letter, Bryan discloses the trauma of labor pains then insisted her sister burn the letters after reading them, to keep her thoughts private.[36]

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[35] Dorothy Wertz, *Lying-In*, 47-50.

[36] Maria Bryan, *Tokens of Affection: Letters of a Planter's Daughter in the Old South*, edited by Carol Blesser, (Georgia: University of George Press, 1996): 5-8.

Additionally, Kate Chopin, author of *The Awakening* (1899), had experienced childbirth on six separate occasions and delivered in the presence of "unconventional physicians" in the most modern way. As a White southern woman, Chopin experienced childbirth differently than most minorities and slaves in the region. During all of her births, Chopin had a quadroon nurse present as well as a male physician.[37] Chopin explains through her writing that she was fortunate enough to have a "painless" birth due to the use of chloroform. Doctors did use chloroform by inhalation and by direct application as well as other methods of pain relief, often a more extensive medical bill accompanied the medical comfort. Chopin understood the dangers of childbirth, as she lost at least two beloved people in her life to it: her daughter-in-law and a second cousin. That may have contributed to her decision for a physician-assisted birth. Chopin's feminist account clarifies the modernization of this practice and helps illuminate the modern luxuries becoming available for select members of society.[38]

Most of the accounts of childbirth, especially those who were attended by a physician, were written by White women, many of whom would be considered middle to upper-class. While women romanticized the experiences of childbirth, physicians and scientists were working to bring the vision into fruition. Physicians were using more advanced medical equipment and drugs during childbirth. Physicians routinely used chloroform, ether, opium, and nitrous oxide to manage labor pains, all of which had a host of adverse side effects. None of these pain control methods were safe for extended use, so physicians began researching the possible use of

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[37] According to the Oxford Dictionary a Quadroon is a person who is one-quarter Black by decent.

[38] The Kate Chopin International Society, "Kate Chopin," (accessed November 18, 2019), https://www.katechopin.org/; "Miscellaneous: Physico-Medical Society," *New Orleans Medical News and Hospital Gazette* 1 (1 May 1854): 117.

anesthetic drugs during delivery. A major challenge of anesthesia during birth is that it affects both mother and child. An Austrian doctor named Richard von Steinbüchel suggested using the drug scopolamine during labor and delivery. The drug was known for its ability to cause the parturient amnesia while remaining in a semi-conscious state. It was Steinbüchel who first researched adding morphine to reduce pain to the scopolamine cocktail.[39]

But it was Bernhardt Kronig and Karl Gauss who continued Steinbüchel's research in the twentieth-century. This combination of morphine and scopolamine is more commonly known as twilight sleep. During the experimental stage, Kronig and Gauss considered the harmful side effects, recording them in order to present to the National Obstetric Conference in Berlin in 1906. The side-effect included "slowed pulse, decreased respiration, and delirium."[40] At this conference, the physicians were met with skepticism by their peers despite Kronig and Gauss's claims that the patients had fewer complications and a faster recovery time. After their presentation, wealthy German women began to travel to the physicians to deliver under twilight sleep. The stories of women having pain-free childbirth began to circulate, eventually finding their way to America.[41]

In 1914, Marguerite Tracy and Mary Boyd, two travelers from the United States, visited Freiburg and underwent a twilight birth. The women gushed with the comfort and positivity the sedative provided them during what Dr. Laura H. Branson asserts is "no suffering that is more

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[39] Jessica Pollesche, "Twilight Sleep," *The Embryo Project Encyclopedia* (2019):1-2.; L. I. Breitstein, "Morphine-Scopolamine Anesthesia in Obstetrics," California State Journal of Medicine 13, no 6. (1915): 215-20.

[40] Breitstein, "Morphine-Scopolamine Anesthesia in Obstetrics," 215-220.

[41] Breitstein, "Morphine-Scopolamine Anesthesia in Obstetrics," 215-220.; Pollesche, "Twilight Sleep," 1-2.

dreaded in order to fulfill the plans of the creator."[42] Regardless of the cries of excellence, twilight sleep was not accepted with open arms by American physicians. First-wave feminists had to fight for the right to painless childbirth, founding The Twilight Sleep Association in 1914, to assist in the fight. This organization was established by middle to upper-class women such as,

> Mrs. Jesse F. Attwater, editor of *Femina* in Boston; Dr. Eliza Taylor Ransom, active women's rights advocate and physician in Boston; Mr. Julian Heath of the National Housewife's League; author Rheta Childe Dorr of the Committee on the Industrial Conditions of Women and Children; Mary Ware Dennett of the National Suffrage Association; and Dr. Bertha Van Hoosen, outspoken women's leader in medical circles in Chicago.[43]

These prominent women pushed for access to twilight birth in America. Dr. Bertha Van Hoosen wrote about the first time that she witnessed a twilight birth in 1904. She asserted that "natural sleep, death, hypnosis, catalepsy, and intoxication all seemed to be blended." Van Hoosen was so amazed by the procedure that she hosted clinics for nurse instruction. The procedure itself was relatively simple. The injectable medications were a mixture of "scopolamine, a belladonna alkaloid and amnesic together with morphine."[44] This combination produced twilight sleep sedation.

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[42] Marguerite Tracy and Constance Leupp, "Painless Childbirth," *McClure's Magazine* 43 (1914): 37-9. https://babel.hathitrust.org/cgi/pt?id=uiug.30112004909625&view=1up&seq=219

[43] Marguerite Tracy and Constance Leupp, "Painless Childbirth," 37.Laura H. Branson, "Anesthesia in Obstetrical Practice," *Woman's Medical Journal* 18 (May 1908): 95.; Judith Walzer Leavitt, "Birthing and Anesthesia: The Debate over Twilight Sleep," Signs 6, no. 1 (1980): 153-154.

[44] Bertha Van Hoosen, *Scopolamine-Morphine Anesthesia.* (Chicago: House of Manz, 1915): 15.; Tracy and Leupp, "Painless Childbirth," 37-39.; Branson, "Anesthesia in Obstetrical Practice," 95.; Leavitt, "Birthing and Anesthesia," 153-154.; Leavitt, *Brought to Bed*, 128.; Sarah Laskow. "In 1914, Feminists Fought for the Right to Forget Childbirth," Atlas Obscura. February 23, 2017. https://www.atlasobscura.com/articles/twilight-sleep-childbirth-1910s-feminists

Upon the arrival of the laboring parturient, the medical staff gave the mother an injection of the cocktail. Twilight sedation was considered superior because it could be given throughout the entire procedure but did not affect muscle function. The Gauss-Kronig method monitored the parturient closely, administering additional medication to maintain sedation only as needed. There was an attempt to simplify this process called the Siegel method. This method gave a predetermined dosage to women throughout their labor and delivery. The Siegel method was available in lower-class wards due to its simplified nature. According to Dr. Stella Lehr in her report, which she wrote after visiting both the lower-class third and fourth-class-wards and the first-class ward, twilight sleep was incredibly dangerous, especially the Siegel method. She stated its use should be avoided or, better yet, not at all. She witnessed mothers being repeatedly dosed with the cocktail, essentially remaining asleep except for the height of the pain, and babies were born not breathing; in one specific case, the infant did not breathe for ten minutes.[45]

However, the laboring mother was still experiencing labor pains, but she did not remember it upon waking from this state. That means that patients would writhe and scream in pain, and to prevent the expectant mother from harming herself or the baby, physicians installed canvas cribs. A canvas crib is a cloth enclosure that would fit over the hospital bed. It could be closed entirely to prevent the patient from getting out of bed. Further, patients wore a garment called a continuous sleeve. This garment is essentially a long-sleeved shirt, which could have the sleeves tied together at the wrists. Again, this was a preventative measure to stop self-harm or harm to the unborn child. While under sedation, medical staff would administer two tests that would indicate the need for more medication. The first test is referred to as the "calling test,"

[45] Stella Lehr, M. D., "A Possible Explanation of the Conflicting Reports on Twilight Sleep," *California State Journal of Medicine* 13, no. 6, (1915): 220-21.

during this, the doctor would call out the patient's name loudly if the patient did not arouse, then she passed the test and did not need more medication. The second test was the "incoordination test."[46] During this test, the movement of patients were examined for the normal appearance of coordination, if those movements appeared to uncoordinated the administering physician concluded that the patient had receive the proper amount of medication. These tests were performed due to the lack of proper dosage amount per individual. Each person received a different amount of sedation based on the test results after the initial dosage. [47]

It should be noted that the expectant mothers saw twilight birth as a miraculous treatment. Labor pain during childbirth is so horrendous that not remembering the trauma outweighed the knowledge that the procedure was not painless, just memory-less. In another article written by feminist supporters Tracy and Boyd, "Twilight Sleep," they noted the experience of Mrs. Cecil Stewart, who described her twilight birth. Stewart asserted the procedure was simple in so far as she got a shot, fell asleep, awoke the following day, and the nurse handed over her baby. She described the experience as extraordinary, stating she was overjoyed with her twilight birth. Tracy and Boyd concluded that twilight birth was a "blessing" to the mothers and was not harmful to the baby. It reduced the likelihood of requiring the forceps. Regardless of educational literature stating “patience, minimal interferences, and strict antisepsis," doctors confidently used medical tools such as forceps during birth to speed up the process.[48] The forceps proved to be potentially fatal to babies and harmful to the delivering

[46] Leavitt, “Birthing and Anesthesia,” 149.

[47] Lehr, “A Possible Explanation of the Conflicting Reports on Twilight Sleep,” 220-221.; Leavitt, “Birthing and Anesthesia,” 149.; Leavitt, *Brought to Bed*, 129.

[48] Leavitt, *Brought to Bed*, 129.

mothers. At the same time, physicians claimed to not have a single fatality due to twilight sedation.[49]

The alluring notion that a parturient could forgo the trauma of a painful labor seem like gift from God to women of the twentieth-century. Dr. William H.W. Knipe routinely conducted this procedure in a New York hospital. His medical staff describes awful noises of the parturient as they writhe in pain. It was common practice for the mother to be blindfolded with noise-canceling ear protection because outside stimuli caused the patient to become combative and delirious.[50]

Further, the drama of a twilight birth had lasting implications on the postnatal mental health of the mothers. The scholarship only suggestively mentions mental health, although the initial research indicated that possible depression was a side effect. Regardless of the negative experiences of the staff and mothers, twilight births were advocated for publication in *McClure' Magazine* in 1914, where the accounts of two women, Marguerite Tracy and Mary Boyd, had traveled to Germany where they witnessed twilight sedated childbirth. "Women activists accused American doctors of 'holding back [because it] takes too much time" for the baby to arrive. [51]

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[49] Marguerite Tracy and Mary Boyd, "Twilight Sleep." New York Times Archive (April 11, 1915). 188-89.; Tracy and Boyd. *Painless Childbirth."*; Lehr, "A Possible Explanation of the Conflicting Reports on Twilight Sleep," 220-221.; Leavitt, "Birthing and Anesthesia," 149.; Leavitt, *Brought to Bed*, 129.; Loudon, "General Practitioners and Obstetrics" 531-533.

[50] Tracy and Boyd, "Twilight Sleep," 188-189.; Tracy and Boyd. *Painless Childbirth."*; Lehr, "A Possible Explanation of the Conflicting Reports on Twilight Sleep," 220-221.; Leavitt, "Birthing and Anesthesia," 149.; Leavitt, *Brought to Bed*, 129.; Loudon, "General Practitioners and Obstetrics" 531-533. Leavitt, *Brought to Bed*, 129.

[51] G. A. Skowronski, "Pain Relief in Childbirth: Changing Historical and Feminist Perspectives." *Anaesth Intensive Care* (2015): 26.

Pain tolerance was also linked to the parturient's social status and ethnicity. In 1892, an American physician named Silas Wier Mitchell worked as an obstetrician for African-American women. He claimed that he noticed that Black women could more easily tolerate labor pains during their time at this service. Mitchell stated that "the savage does not feel pain as we do," referencing African-American women.[52] It was the more prosperous women who experienced more pain, therefore needing pain relief. This theory most likely has to do with the expense of medicated birth, such as twilight birth. If society acknowledged that pain is the same across class and race, progressivists would have demanded a better standard of care. When a woman has no options except to endure labor pains, weakness is not an option. [53]

Furthermore, the claim of Grantly Dick-Read in 1943 was that Western women do not experience as much pain as they claim. Modern medicine has made women weak. The fear that parturients experience before giving birth is what causes their pain. It is mainly in their heads. He goes so far as to argue that because women of the early twentieth-century were mentally weak, they had fewer children thus diluting the gene pool and giving the lower classes the upper hand. Dick-Read's assertion echoes that of Dr. Louis I. Breitstein in his article "Morphine-Scopolamine Anesthesia in Obstetrics." Breitstein states that women experience more pain due to their state of mind during delivery. If a drug is going to be effective for these scared women, it must ease the fear and anxiety they experience. According to Dick-Read's evaluation, this would

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[52] Donald Caton, *What a Blessing She Had Chloroform the Medical and Social Response to the Pain of Childbirth from 1800 to the Present* (New Haven: Yale University Press, 1999): 95.

[53] Caton, *What a Blessing She Had Chloroform the Medical*, 95.; S. W. Mitchell, "Civilization and Pain," Journal of the American Medical Association 18 (1892): 108.

have potentially aided the country's economic growth because there would have been more working-class available to fulfill jobs of the New Era.[54]

Despite the first-wave feminist's advocation, not all women had access to a twilight birth. This procedure was a "superadded luxury of the wealthy mother" due to the high costs. At the beginning of the twentieth-century, lower-class women did not have the luxury of delivering in a hospital due to the high costs. Similarly, minority women faced racism when attempting to receive medical attention, often regardless of financial status—forcing women to give birth at home or a clinic lacking this service. The added expense of a twilight birth is the amount of time the physician has to allocate to the procedure and the hospital expenses. The practice was often as expensive as having surgery. In the 1910s, the average price of a doctor attending an at-home birth was $25. The cost of at-home deliveries was controllable due to the common practice of waiting until the last possible minute to summon the physician. Birth attendants or midwives would be present to monitor labor progression when they recognized that the baby was about to be born, and then they called the doctor. In this situation, midwives were extremely helpful to have in attendance. Further, doctors charge by the hour, so the delay in calling on the physician decreases the expense. [55]

On the other hand, a twilight birth cost $85. Wealthy women were able to not only select the hospital where they wanted to give birth but they also were able to select the obstetrician and

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[54] Caton, *What a Blessing*, 95.; Mitchell, "Civilization and Pin," 108.; Skowronski, *Pain Relief in Childbirth*, 27.; Breitstein, "Morphine-Scopolamine Anesthesia in Obstetrics," 215.

[55] Caton, *What a Blessing*, 95.; Mitchell, "Civilization and Pin," 108.; Skowronski, *Pain Relief in Childbirth*, 27.; Breitstein, "Morphine-Scopolamine Anesthesia in Obstetrics," 215., *Painless Childbirth*, 145.; Beach, *An Improved System of Midwifery Adapted to the Reformed Practice of Medicine*, 19-21.

pain control method. Twilight birth became a luxury for the rich. The era, filled with racism and classism, asserted that special medical treatment for the wealthy would make society stronger, meaning that the wealthy would labor and deliver their children more safely, preventing unnecessary deaths. At the same time, the lower classes would decrease by the natural selection of natural childbirth. Working-class mothers insisted that they were more robust than the upper classes and that the upper classes needed to toughen up because childbirth is painful. [56]

To examine the physicians' economic growth, one needs to consider the price difference between home delivery and a hospital twilight birth. There is roughly a $60 difference between the two options. The physicians who delivered in the hospital made more money, allowing them to spend less time moving between patients. This shift improved the standard of care that each patient received. Additionally, the physician was assisted by trained medical staff, who also received payment from the hospital, rather than an assistant that the doctor would have to pay out of pocket. The financial advantages of working in a hospital as an obstetrician surpassed those of delivering at home. The financial opportunity was just one of the many reasons that obstetrics moved from home to the hospital.[57]

The ten years between 1910 and 1920 are notable in that physicians and midwives received inadequate training. Dr. Joseph B. DeLee was a significant contributor to this push for preventative care. His work changed the medical protocol from responsive to preventative, so, instead of waiting for a complication, DeLee wanted physicians to correct the issue before it

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[56] Caton, *What a Blessing*, 95.; Mitchell, "Civilization and Pin," 108.; Skowronski, *Pain Relief in Childbirth*, 27.; Breitstein, "Morphine-Scopolamine Anesthesia in Obstetrics," 215., *Painless Childbirth*, 145.; Beach, *An Improved System of Midwifery Adapted to the Reformed Practice of Medicine*, 19-21.; Breitstein, "Morphine-Scopolamine Anesthesia in Obstetrics," 181.

[57] Judith P. Rooks, "The History of Midwifery." *Our Bodies Selves* (2012): 2-3.

became a complication. However, the progress DeLee hoped to see quickly was slow to come. There was an increase in infant mortality rates between 1915-1929. This period was the height of the training shift from home to hospital, where students could now practice on living patients rather than skeletal dummies. This period also marks the introduction of the use of birth tools such as the forceps. With the increase in medical students and the new ability for live practice, the increase in infant deaths may have been due to student error, especially because the shift from home to hospital pushed midwives out of the birthing room. In 1900, midwives attended half of all the births in America; however, in 1925, midwives only attended 15% of births. Because midwives were beginning to be phased out of the birthing process, many women entered medical school to become physicians; thus, the socio-economic status of women improved. [58]

As it became more evident to the medical community that prevention is superior to response treatment, there became increasing awareness that the wealthy should not be the only group to receive a better standard of care. Henry Smith William in *Twilight Sleep* had the first-hand experience of watching patients undergo the treatment. He knew that philanthropy would be necessary to make this a viable option for the lower classes. Furthermore, the government became involved in 1921, by passing the Sheppard-Towner Maternity and Infant Act. This act was a publicly funded maternal and child health care service that received funding through grant-in-aid and incentives. This act improved the standard of care for all parturients.[59]

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[58] Rooks, "The History of Midwifery," 2-3.

[59] Carol S. Weisman, *Women's Health Care: Activist Traditions and Institutional Change*, (United Kingdom: Johns Hopkins University Press, 1998): 24.

While it is critical to understand the development of tocology and its impact on the nation, this is a case study of rural Alabama and its primarily Black inhabitants. Segregation laws made it difficult, at times impossible, for Blacks to be seen by a physician. In many documented cases, people lived their entire lives in the rural parts of Alabama without ever being seen by a doctor or seeing the inside of a hospital. So, what were the options for the African-Americans in the racially-charged environment of the radical Jim Crow South? It was becoming increasingly important for medical intervention. The newly freed southern Blacks were suffering from a lack of healthcare; according to historian Susan Lynn Smith, "A Montgomery, Alabama newspaper reported on the tragic incident of a Black woman who died after giving birth in an old dump cart, only to have the surviving infant eaten by hogs."[60]

As laid out in this chapter, the medical field was advancing. Childbirth was becoming modernized through the abilities of modern science, medical academia, and advanced experience within the field. While this modernization advanced the ability to improve the lives of all that it touched, African Americans were segregated from these advancements. The Freedmen's Bureau provided healthcare to the newly freed and formerly enslaved. Through the use of dispensaries and home visits, medical professionals were able to provide services for the Black community. However, the public health industry, while it was innovative and offered some progressive attempts to support a unique clientele, was hardly prepared to treat large populations such as that of rural Alabama.[61]

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[60] Susan Lynn Smith, *Sick and Tired of Being Sick and Tired Black Women's Health Activism in America, 1890-1950,* (Philadelphia: University of Pennsylvania Press, 1995), 6.

[61] Rice and Woodrow, *Public Policy and the Black Hospital,* 7.

After the bureau disbanded, as previously mentioned, the Black community was largely left to fend for themselves. While all these new advancements in childbirth were wonderful for society it was for stable White society. Alabama's rural South was primarily made up of poor Blacks and Whites. While the poor Whites did have more acceptance at local hospitals, there were few hospitals available for them to choose from. The Black residents were excluded due to segregation.

It was not until the end of the nineteenth-century that Black physicians and Black progressives grew concerned with the lack of adequate hospital facilities- thus began the Black Hospital movement. The Black Hospital Movement ultimately came as a triad of solutions. The first leg of the movement was to recognize and improve upon the need for Black professionals to have proper Black hospitals and training facilities so that they could gain better knowledge of their craft. The second leg acknowledged that the lack of proper training and healthcare facilities ultimately made significant contributions to the poor health of the Black community. Lastly, the Black Hospital Movement was acknowledged to be just one step in improving the social standing of the Black community. [62]

As this movement started to gain headway, the first Black hospitals and training facilities were opened in the North. By 1910, there were over one hundred training facilities and hospitals nationwide. In Alabama by 1910, there were six Black training hospitals in creation. One of the earliest Black teaching clinics was started by Dr. Daniel Hale Williams in Tuskegee, Alabama called the John A. Andrews Hospital. As the years progressed, increasingly more hospitals were

[62] Rice and Woodrow, *Public Policy and the Black Hospital,* 15.

created to deal with segregation. However, looking at the years between 1870 and 1910, Alabama only had six teaching and training hospitals for Blacks.[63]

Facility	Location	Year
Hale Infirmary	Montgomery	1889
Holy Family Hospital	Ensley	1901
Tuskegee Institute Hospital and Nurse Training School	Tuskegee	1892
John A. Andrew Memorial Hospital	Tuskegee	1902
Cottage Home Infirmary	Decatur	1900
Burrell's Infirmary	Selma	1907

In 1910, there were a total of six Black teaching hospitals in the state of Alabama. Out of those six hospitals, only one was within the counties included in the case study Hale, Dallas, Green, Sumter, and Marengo. Dallas is home to Selma, where Burrell's Infirmary was located. Outside of Dallas, the closest hospital would have been in Montgomery, which was a 60-mile trek from Dallas. The majority of poor Blacks in these counties would not have been able to afford the travel nor the time off from farming to make a 60-mile trip to the local hospital. Aside from the distance, the majority of Blacks were apprehensive about traveling the distance to an unfamiliar hospital. (See Chapter 5: Figure 1).[64]

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[63] Rice and Woodrow, *Public Policy and the Black Hospital*, 17-18.

[64] "Black Hospital Movement in Alabama." Encyclopedia of Alabama. Auburn University Outreach: Humanities Alliance, Date Accessed October 5, 2023. https://encyclopediaofalabama.org/article/Black-hospital-movement-in-alabama/; "Holy Family Community Hospital." Birmingham Public Library Digital Collections: Jefferson County Ala. Board of Equalization. Date Accessed October 5, 2023. https://bplonline.contentdm.oclc.org/digital/collection/p4017coll6/id/1523/ ;"Alabama." The National Atlas of the United States of America. U.S. Department of the Interior: U.S. Geological Survey. Date Accessed October 5, 2023. https://gisgeography.com/alabama-county-map/

Chapter 5: Figure 1- Map of Alabama Counties.[65]

[65] "Alabama." The National Atlas of the United States of America. U.S. Department of the Interior: U.S. Geological Survey. Date Accessed October 5, 2023. https://gisgeography.com/alabama-county-map/

Conclusion

In conclusion, as ideology shifted from traditional Victorianism towards modernism, physicians began to enter the lying-in rooms to assist in childbirth. The image of the male doctor, as indicated at the beginning of this chapter, excluded a variety of ethnicities and genders. The growth and professionalization of the medical physician excelled in society; however, Alabama consisted of a growing population of poor Blacks with limited options. The medical history of childbirth indicates that the three periods of childbirth known as the social, transitional, and medical stages propelled the evolution of obstetrics. This case study focuses on this transitional period when childbirth assistants went from being community midwives to academically-trained physicians. Scholars primarily focus on the beginning stages and end stages of this transition, but it is critical to examine the intermediate period to acknowledge the moments that propelled the transition forward and halted the previous stages in order to understand development.

Obstetrics was in its medical infancy; even academically-trained physicians were still learning proper techniques for the safe delivery of infants. Men like Dr. Sims conducted experiments in an attempt to improve medical science- the unethical practices he conducted are for another debate. However, race influenced the training of tocology, and influences from Josiah Nott, while thoroughly racist, illustrate the progressive intent to improve healthcare. As the United States looked for inspiration in Europe for advances, progressives stressed the point that better-educated people live healthier lives. Additionally, women were included in obstetrics, when they were invited into medical schools largely due to the 1910 Flexner Report that indicated that both genders should be trained in medicine.

As the profession modernized, so did the medical techniques physicians were using, such as chloroform for pain relief and forceps to assist in difficult deliveries. It was not long before

Europe's Twilight Sleep Sedation made its way to the United States. The ethical and moral issues accompanying this method of childbirth created a short-lived sensation. However, there is the persistent influence of the progressive concept that healthcare, specifically in this case, as it pertains to childbirth, required improvement. Expectant mothers and their children needed to be protected by medical professionals. Moreover, if the physician was correct and the midwife was doing more harm than good, she needed to be eliminated from the birthing process to protect the patient.

However, when it came to childbirth in Alabama, birth assistant had less to do with gender and more to do with availability. As physicians began to professionalize the field of obstetrics, steering society away from the midwife and towards the professional physician presented a new challenge- accessibility. It is evident that in the late nineteenth-century and early twentieth-century that the modernization of medicine allowed for childbirth to be professionalized, creating a new breed of skilled, modern physicians to assist. The inhabitants of rural Alabama, however, were largely excluded from this due to their geographical locations, socioeconomic status, and ethnicity.

For Blacks who could access hospitals, segregation prevented them from adequate health care due to the exclusions of Whites only. For other Blacks, it was their socioeconomic condition that made it improbable for them to be able to afford a physician. In the case of a house call, physicians were charging exorbitant mileage rates on top of their delivery fees. At the Black hospitals, the cost of healthcare would have been out of reach for many in the socioeconomic condition. Blacks were largely excluded from the professionalization and the modernization of childbirth; however, Blacks were having children in large numbers. This was partly due to the large population size, the liberties that their newly found freedom provided them, and the lack of

access to birth control. They were left with a Hobson's choice of a midwife. This choice was condemned by physicians who claimed that the problematic midwife was hazardous during childbirth.

Chapter 6: Lying-in Confusion

By analyzing the professionalism of obstetrics, it becomes apparent that progressivism and scientism propelled the growing demands by women for safer birthing conditions often to clean up urban societies. The demand evolved out of the complex relationship between social status, race and ethnicity, and regional locations, all of which were made possible by the modernization and professionalization of tocology that became available during the latter part of the nineteenth- and beginning of the twentieth-century. The history of childbirth is a critical topic to pursue because, as previously mentioned, the maternal mortality rate in the United States in the twenty-first-century is still incredibly high for a developed nation.

Throughout the historiography presented, scholars offer a multitude of interpretations for the causes of the transitional period, often romanticizing the transition as a feminist choice. Scholarship presents an image of women being surrounded by options for birth attendants while happily laboring. This fallacy is derived from the Victorian notion that women should only speak positively about childbirth. Even today, if a mother tells a story of childbirth, it is usually followed by some variant of "but I love my child." Women feel the need to qualify their pain as if, by some odd assumption, the listener will assume because childbirth was an awful experience, she loves her child less. This concept deserves further attention.

Furthermore, the professionalization and modernization of childbirth in America and, more specifically Alabama was a complex intertwining of population and education. The Reconstruction era marked significant changes to Alabama and its counties of Hale, Dallas, Greene, Marengo, and Sumter. What was once a slave population became free but very impoverished. White Flight drove many of the White inhabitants of the state to alternative locations throughout the United States. Alabama's agriculture suffered from crop selection,

periods of drought, and depleted soil, which led to famine. The changing demography of the region illustrated a growing demand for social reform. The diverse inhabitants of this region required intervention for better living standards, economic relief, and medical care. The state's government would have to intercede before things got worse.

Alabama's history was a complex intertwining of socioeconomics presented within statistical data. The Reconstruction Era marked significant changes to Alabama and its Hale, Dallas, Greene, Marengo, and Sumter counties. As the state's government attempted to rectify some of the socioeconomic complications with the Bureau of Refugees, Freemen, and Abandon Land administration, the state's population continued to increase, creating enormous demands for birth assistants. Ideally, this should have attracted physicians in search of financial growth; however, most of the population was Black. In the radically racial environment of the Deep South, physicians were not prepared to handle the complex relationship emerging between the diverse ethnic groups. Adding pressure to an already complicated racial relationship was the collection of vital statistics that illustrated a need for quality birth attendants. At the same time, maternal and infant mortality rates continued to rise.

Alabama was overwhelmingly rural, with an enormous collection of poor farmers. The geo-occupational configuration of the population generated an environment with nutritionally and economically limited resources. The lack of economic prosperity was a deterrent for many blossoming physicians entering the field for financial opportunities and prestige. Those physicians willing to work within the confines of the state focused their energy on the classes that could financially support their business.

Rural Alabama's large female population worked alongside their significant other in agriculture. The image of an egalitarian society comes to mind when envisioning teamwork;

however, women toiled in the fields out of economic necessity, not from the modernized ideology of equality. Many of these poor farmers enjoyed their newfound freedoms and expanded upon their families. Alabama's high birth rate is 60.85 per 1,000, breaking that statistic down into 63.11 per 1,000 White and 58.12 per 1,000 Black births.

The elevated numbers of childbirths throughout the state of Alabama brought people resounding demands. Women needed birth attendants who could assist in childbirth and safely help both mother and child during this dangerous process. The distribution of Whites and non-Whites throughout the state, bred conditions that would exist under radical racism for generations to come.

As women sought birth assistance, they learned that physicians, in many cases, were outside of their financial capabilities and were faced with the radical racism of the era. While racism likely was exacerbated by Social Darwinism, it was presented in many forms. The Disappearance Hypothesis, eugenics, and craniometrics heightened the challenge of locating a birth assistant who would protect poor Black mothers and infants from the preventable dangers of childbirth. According to Hoffman and Tillinghast, the promise of the Disappearance Hypothesis eliminated the need to extend quality healthcare to the Black communities in the country, concluding that within thirty years, the Black population would altogether disappear making the effort fruitless. Instead, healthcare reformers were encouraged to place their efforts into that White native-born American and European immigrant population.

Regardless of radical racism, poor Black women in Alabama needed quality birth assistants. This responsibility would fall on the shoulders of informally trained midwives who were willing to travel, help with other responsibilities, and assist in the patient's delivery. The midwives were not always successful in safely delivering the infants or protecting the mothers

from preventable harm, but they were the best option that overpopulated rural Alabama had available. Midwives did the best that they could with the information that they had available to them. These unsung heroes stepped into a position they were ill-qualified to fulfill and would themselves become victims of hatred and prejudice by both society and the medical community.

The rural setting of Alabama and the poor socioeconomic status of its citizens brewed the ideal conditions for home care by a Granny midwife. The inhabitants of the state had very little money for necessities, so they were not in a position to hire a traditional physician to assist in an average labor and delivery. Midwives were experienced, affordable, and local. Race relations in the South indicated that separate but equal was the best alternative for dealing with new relationships that developed out of emancipation. Blacks were to be separate from Whites due to Jim Crow laws that existed throughout regions such as Alabama. These exclusionary laws created a Hobson's choice for patients. Black patients had the perceived option of either obtaining a traditionally trained physician or a lay midwife. But, due to sociopolitical tension in the region, Blacks' only choice was to labor and deliver at home.

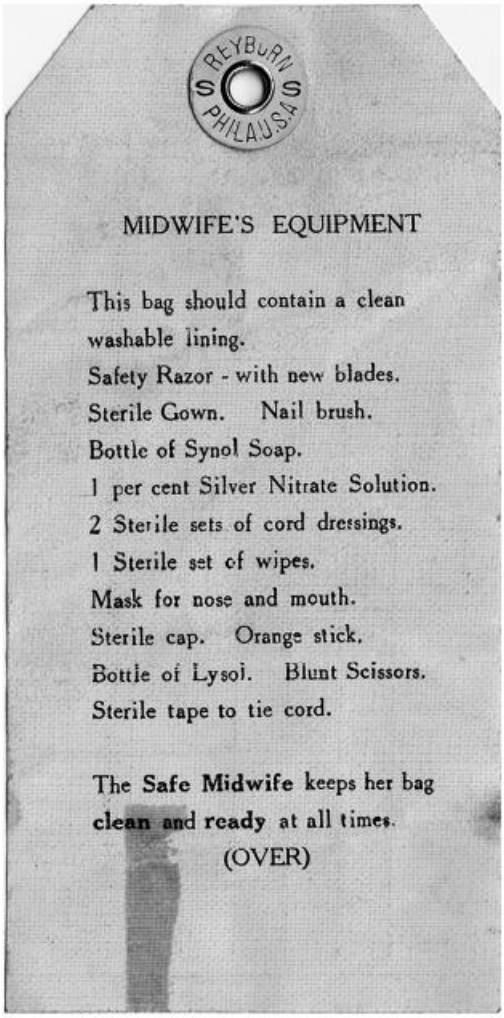
Grannies were an excellent choice for birth assistance for regional Blacks and Whites. Grannies were admired, trusted, and supported members of their community. They instilled their heritage through the use of Africanized rituals, which were to ensure the safe delivery of babies during a moment when the two planes, the living and the dead, were close to one another. Grannies provided more services than just catching babies. They provided medical assistance when necessary, supported the family while the mother gave birth, taught the new mother the art of breastfeeding, and provided postpartum care.

Unfortunately, racism reached every aspect of childbirth in the South and the Granny was no exception. Racism was instilled in the ideology of breastfeeding, where the Black mother

would pass down ignorance to her child, and a White mother would pass down her intelligence to her White child. However, if a Black woman were to serve as a wet nurse for a White woman, then the White child would not inherit any of her ignorance because White genetics were naturally superior.[1]

It would not be until after the end of the time frame for this case study that regulations on midwives would begin to emerge. In 1914, the regulation of "The Midwives Bag" went into effect. Legislation assumed that by controlling the contents of the midwife's bag they would be able to control the instruments that would be utilized on the patients. Illustrated below is a Midwives Bag Tag from 1935, which outlines the regulated items that a midwife's bag should contain.

[1] Wilkie, "Expelling Frogs and Binding Babies," 279-281.



Chapter 6: Figure 1- Midwife bag.[2]

Following the legislation of the Midwife's Bag, in 1918, a licensing requirement was passed by the state of Alabama. In the years leading up to 1914, intolerance for midwives grew as tension percolating between society, the midwife, and the physician came to the political forefront.

[2] Midwife bag tag, circa 1935: "The Safe Midwife keeps her bag clean and ready at all times." Series: S 900. Florida State Board of Health Subject files, 1875–1975. See https://www.floridamemory.com/learn/exhibits/medicine/documents.php?id5110. Courtesy of Florida State Archives. Reprinted with permission. A color version of this figure is available online.

From 1900 until 1910, bigotry was an ever-present issue within the medical field as White physicians became increasingly intolerant of Black midwives. Racism was not the only issue that was growing during this era. Gender issues also surfaced as male physicians questioned women's abilities to be able to work within the medical field. Prejudice against women entering the medical field existed for centuries before this case study; however, it was more clearly present during this era due to an increase in women pursuing educational and occupational opportunities. During this period, women were thought to be too delicate for the field. Some physicians even argued that too much education in medicine would cause women to enter into a derelict state. This ideology was altered after the 1910 Flexner Report, which indicated that men and women should both enter the field and be trained side by side.

Lastly, it is critical to examine these intermediate periods throughout history where legislation perhaps had not caught up with the ideologies and societal connotations. These intermediate periods forecasted the changes that were on the horizon while highlighting the reasons that those changes are imperative to the field. As many scholars have studied the reasons behind the mistrust of midwives, a new historicism view illustrates that the political, social, and economic condition of people in rural Alabama generated a Hobson's choice, in which midwives arose as victors. Until political, social, and economic changes relieved midwives as the only viable option for patients in this region, midwives utilized the training that they received to help deliver babies. While this training was not traditional, it was effective, which was seen in the track record of women like Margaret Charles Smith, who delivered thousands of babies safely.

In a rural, poor, primarily Black population, women still needed quality birth attendants. Physicians were too expensive for the majority of the parturients, so they leaned on the support of Granny midwives. The women did more than catch babies as they entered the world;

therefore, socially, they were accepted and respected- at least until physicians began to attack their lack of education. But who was to blame- the overworked, undereducated midwife who was doing the best that she could or the overpriced classically-trained physicians?

The modernization and professionalization of childbirth in Alabama is more complex than current scholarship states. Historians and medical professionals have presented a plethora of arguments and interpretations as to why this complicated relationship has developed in the ways that it has. However, scholarship has neglected to assert that the lack of options during the transitions created the perfect storm under which midwives could be demonized. Alabama had a chaotic socioeconomic development in the years following its founding. The state's economy went through a series of busts and booms, exacerbated by emancipation in the granting of citizenship to African-Americans. The state's population withstood White Flight, starvation, and destitute living conditions. While not every Alabamian experienced the destitute condition of poverty, the majority lived in a state of constant struggle, constant fear of radical racism, and exclusionary medical practices.

Previously, scholars noted that the modernization and professionalization of childbirth in this region was predominantly a gender issue in response to advances in medical technology. Other historians have noted the turbulent relationship that existed between midwife, physician, and patient, indicating this relationship was a development of medical practices and social beliefs. My expectations were to examine the stories of midwives in Dallas, Hale, Green, Marengo, and Sumter Counties Alabama. I expected to hear the stories of women who served as birth attendants, who provided their medical expertise, as limited as it may be, to women who selected midwives over physicians. Moreover, I expected the women had an option when it came to birth attendants, and this just was not the case. I wanted to tell an untold story of the heroism

of midwives as they faced decline because women chose to invite, male physicians into their lying-in room. I wanted to examine how midwives treated patients and what happened in society that caused the transition towards the modernization and professionalization of childbirth, what influences existed that would push women away from original birth attendants, the midwives, towards a new male physician. I anticipated that the transition from midwife to physician centered around gender or racial issues in society, but my expectations and early assertions were misguided.

Gender issues do play a role in the modernization and professionalization of childbirth, but not as I expected. The expectation was that society viewed the male presence to be more intelligent, more academically trained, or more capable within their field. Instead, women were invited to attend medical schools and often they were regarded as more qualified to work in obstetrics because they understood the female anatomy in a way that men did not. The transition from midwives to physicians was not a result of society thinking that men were more qualified to be doctors. It was because of the training and education that medical schools provided. However, that transition was almost impossible in rural areas. Early assumptions that a strong patriarchal cultural morale pushed for the advancement of men in obstetrics have been proven incorrect by the research presented herein.

My initial intent when addressing my research questions was to provide an intricate picture of childbirth in Alabama from 1870 to 1910. Ideally, this picture would have illustrated the critical importance of a midwife at the center with all of the social, economic, and political issues in the background to support her decisions and influence the parturients choices in birth attendant; however, that is not what I found. Moreover, I wanted to show how the intellectual and scientific revolution pushed for the modernization out of concern for better healthcare and

social improvement. This statement is somewhat accurate but the reasons for this push hinged on socioeconomics and racism. This stance was supported by a growing hatred for midwives by physicians. Physicians who had influence in society, namely in the upper echelons of the socioeconomic brackets, and who could print scholarship on the harm that midwives were causing the geo-occupational configuration of Alabama, coupled with the racial and socioeconomic conditions, slowed the modernization and professionalization of childbirth creating a unique Hobson's choice- at once giving the illusion that transitioning to physician assisted birth is for the betterment of society while not providing access to the people who needed it the most. Moreover, African American women within the United States today still die during childbirth at a statistically higher rate than White women. Obstetric racism is a potential explanation for the elevated percentage, additional scholarship on this area would be beneficial to gain a greater understanding of the influencing factors of this trend.

In conclusion, the transitional period between home and medically-sanctioned childbirth deserves additional research. While scholars claim that modernizing obstetrics made childbirth safer, I argue that the more accurate assertion is that it changed childbirth. Midwives who had limited resources provided for a community unselfishly in the attempt to fulfill a need. That unselfish commitment was demonized and degraded because of their race or social status. Had the Granny midwife been a White wealthy male, he would have been hailed a hero for his efforts; however, the political, social, and economic makeup of rural Alabama generated the perfect conditions to allow hatred to grow.

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