AN AWFUL GLADNESS:
AFRICAN AMERICAN EXPERIENCES OF INFANT DEATH
FROM SLAVERY TO THE GREAT MIGRATION

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This dissertation examines the history of infant death in African American communities. It traces the medical, scientific, and cultural ideas of the causes and meanings of black infant mortality from the era of antebellum slavery to the height of black migration in the mid twentieth century. By examining infant death in this shifting landscape, this dissertation explores how widening cultural expectations that all babies should survive, alongside African American demands for equal treatment as citizens and patients, and the growing role of government in matters of infant welfare, generated fierce debates regarding who was responsible for protecting young lives and who was to blame for their deaths.

Chapter One looks at the nineteenth century, exploring the transformation of black infant death in the antebellum period from a problem of plantation management to a racial trait and evidence that blacks’ newly won freedom was detrimental to their health. Chapters Two and Three analyze municipal and federal government responses to black infant welfare in the Progressive Era, first by tracing the rise and fall of a local Washington D.C. agency responsible for the care of abandoned and destitute infants, followed by an examination of the U.S. Children’s Bureau and how it came to see black infant mortality as intimately tied to debates about the “midwife problem.” Chapter Four delves into the artistic works and public forums through which African Americans shared their experiences with infant loss and debated the racial and gender politics of “saving” black babies in an era of Jim Crow. Chapter Five returns to the rural south by way of the 1953 midwife training film All My Babies: A Midwife’s Own Story, to show how black infant welfare concerns became enfolded in growing postwar critiques of the nation’s expanding, but deeply segregated, health care system.
To foreground black experiences of infant death, this study draws on a rich array of archival and primary source material, including slave narratives, folk practices, medical articles, government documents, memoirs, songs, photographs, and film. Through its focus on black health, this project contributes to scholarship in history of medicine and African-American history, while also speaking to scholarship on the history of childhood and the politics of reproduction.
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INTRODUCTION

Disparate Beginnings

In the spring of 1898 W.E.B. Du Bois travelled from Atlanta to Great Barrington, Massachusetts. It was a somber journey for the young scholar; he was returning home to bury his infant son Burghardt. As a first-time father and recent migrant to the Jim Crow South, Du Bois struggled with conflicting emotions which he articulated in an essay published in his acclaimed book *The Souls of Black Folk*. There, Du Bois recalled the sudden onset of Burghardt’s illness, the “swift week and three endless days” in which his son’s health wasted away, his wife Nina’s unwavering care, his own attempts to find medical help, and a funeral procession that journeyed north. For a generally quite reserved man, Du Bois was “unusually moved” by the death of his firstborn.\(^1\) On the day of burial he confessed, “there sat an awful gladness in my heart,—nay, blame me not if I see the world thus darkly through the Veil,—and my soul whispers ever to me, saying, ‘Not dead, not dead, but escaped; not bond, but free.’”\(^2\) At a moment when one would have expected only expressions of grief and sorrow, maybe even fear, Du Bois thought of freedom.

What did Du Bois mean by the phrase, an “awful gladness”? Awful could refer to something frightening, the “dreamless terror” Du Bois endured as he watched his son pass away or the sight of his wife who, because of Burghardt’s death, became “the world’s most piteous thing—a childless mother.” And yet *awe-full* could also mean a profound sense of inspiration

and respect. Du Bois signaled to this alternate meaning when he wrote “well sped, my boy, before the world had dubbed your ambition insolence, had held your ideals unattainable, and taught you to cringe and bow. Better far this nameless void that stops my life than a sea of sorrow for you.”

The first definition frames infant death as a tragedy, a meaning echoed throughout Progressive Era slogans to “save the babies” and halt the “slaughter of the innocents.” This is the perspective historians have relied on when describing the social politics of infant welfare at the turn of the twentieth century. Yet in linking the death of his first-born son to the biblical story of Passover, Du Bois offered a different, prophetic vision at a time when the rise of Jim Crow and racial violence fueled a sense of hopelessness for the race. Even as Du Bois mourned his loss, he viewed it through the lens of a collective racial experience. And he invited his readers, spanning color, gender, and class lines, to contemplate an alternate view of infant mortality, one that joined African American experiences of suffering and sacrifice to a prophetic tradition of deliverance and freedom.

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This dissertation explores the history of black infant death. In five chapters, it traces the scientific, medical, and political debates over the causes and meanings of black infant mortality from the antebellum period when the management of black health and death was deeply intertwined with the slave economy to the mid twentieth century when millions of blacks migrated out of the rural South and navigated new structures of medical care. Within this one-hundred year span, high rates of infant death from a changing range of causes provoked intense public discussion, rising statistical scrutiny, parental anguish, and no small amount of social blame for black mothers and midwives. By examining infant death in this shifting landscape, this dissertation argues that widening cultural expectations that all babies should survive, alongside African American demands for equal treatment as citizens and patients, and the growing role of local, state, and federal government in matters of infant welfare, generated fierce debates regarding who was responsible for protecting young lives and who was to blame for their deaths. Through these debates, black infant mortality transformed from being viewed as a local concern affecting individual families to a national problem eliciting responses from all levels of government, and forcing it to reckon with the welfare of black children and African Americans more broadly. In analyzing the evolving meanings of infant death within the context of socio-political changes including the end of slavery, rural to urban migration, and hardening of Jim Crow segregation, this project sits at the intersection of the history of health and African-American history, while also contributing to scholarship on the history of childhood and the politics of reproduction. To date, no work has examined the long history of black infant mortality
despite the fact that it has been recognized as one of top causes of death for African Americans and continues to be a major concern in U.S. society where racial disparities in health persist.\(^4\)

* * * *

Today we use the word “infant” to refer to children under the age of one. Prior to the twentieth century though, the term had a much more elastic meaning and could refer to a child of various ages, typically under five years old.\(^5\) This did not mean that infancy as a distinct phase of life did not exist, but that rather than relying on a calendared birthdate, parents and physicians were more likely to closely monitor the physical signs of a baby’s health – the healing of the navel cord, teething, and weathering common ailments such as thrush and ear infections. Reaching these developmental milestones marked the transition from the earliest period of life into childhood, and for many families in the nineteenth and early twentieth centuries this transition would have brought increasing hope that their child would survive the first “fatal

\(^4\) A recent dissertation in political science draws, among other fields, on Afro-pessimist scholarship and Bruno Latour’s actor-network theory to examine the biopolitics of black infant mortality, focusing mostly on the twentieth century. See Annie Menzel, “The Political Life of Black Infant Mortality” (Ph.D. dissertation, University of Washington, 2014).

years” of life. Methodologically, this has meant that my archival research has not been limited to instances when the term “infant” appeared, but instead required paying close attention to the changing words, phrases, and contexts used to describe very young children such as “suckling” or “a babe in arms.”

One of the aims of the dissertation is to show how the measurement and meaning of infant mortality has been subject to redefinition and interpretation not only by people like Du Bois but also medical and scientific experts. Just as the word *infant* requires historicizing, so too does the term *infant mortality rate*. The standard formula used to calculate the infant mortality rate today, where an infant is defined as under the age of one, is:

\[
\text{Infant Mortality Rate} = \frac{\text{number of infant deaths during time period}}{\text{number of live births during time period}} \times 1,000
\]

Yet prior to 1915 there was no national infrastructure for registering births, meaning that infant mortality rates in the U.S. were calculated based on the reported population under one year rather than the number of live births recorded for that period. In 1880, the Census Office established the national “death registration area,” which required states to systematically collect mortality data through the implementation of death registration laws (for example, making burial permits

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compulsory) and official reporting of deaths on standardized death certificates. A similarly comprehensive system for registering births was not established until 1915 and completed in 1933, finally producing national data that more accurately captured the ages and deaths of the very young. On the state level, the implementation of birth and death reporting was shaped by local politics and different ideas about government expansion. Southern states, where the majority of African Americans lived, were often the last to join into this centralized system of vital registration. The slow growth of the country’s vital statistics system meant that African Americans were underrepresented in early twentieth century mortality reports, so even while these documents remain important sources of statistical data, they also tell a broader story about the power and limits of government sources in making certain populations visible.

As best as we can estimate, at the turn of the twentieth century well over one hundred infants out of every thousand died in their first year of life. A century later, the rate hovered closer to six deaths per thousand. The remarkable reduction in infant death rates over the course of the twentieth century has been described as one of the “most dramatic and far-

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reaching” revolutions in modern public health. But this story of triumph is also one marked by the troubling persistence of racial disparities in infant survival as seen in the following chart:

Figure A.1

![Infant Mortality Rates, by Race: United States, 1915–2013]

Source: National Vital Statistics System, Center for Disease Control

The chart’s beginning point of 1915 speaks to the rising prevalence of statistics in medicine and public health over the course of the twentieth century. As Ted Porter and Ian Hacking have argued, the bureaucratically-driven “avalanche of numbers” that began in the mid-nineteenth century.

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11 Meckel, *Save the Babies*, 1.
century and continued into the twentieth, reflected a rising belief in quantification as a tool of objectivity, transparency, and surveillance. The increased reliance on statistics in medicine and public health from the late nineteenth century onward was more than the introduction of a new methodological tool, it marked a significant shift in thinking about health that linked ideas of disease and mortality to the language of risk. One important consequence of this shift is that an emerging framework of health based on risk brought with it new efforts to manage risks wisely, and consequently, to assign blame in accord with changing cultural norms. Nowhere was this more evident that in the history of infant death.

As the infant mortality rate has come to be seen as one of the most important indicators of a nation’s health, the stakes for monitoring it have grown enormously. The formula we now rely on to calculate mortality rates remains stable as it travels beyond local contexts, enabling international comparisons and broad use as a metric in public health. One need look no further than national or local newspapers to see how slight dips and upticks in infant mortality rates garner widespread coverage and commentary. Within public health, surveillance of infant

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mortality rates remains a key component of work in global health and maternal and child health. And in economics and the field of economic development, analysis of current trends in infant mortality rates, and even revisions of past estimates, are ongoing fields of inquiry.\textsuperscript{15}

The dissertation makes use of statistical data where available to quantify the prevalence of infant death in the past. This project, however, is not a work of historical demography. Instead, it adopts the perspective that critically engaging with the underlying sources that make such calculations possible is important for interrogating the role of the archive in producing, erasing, and representing the lives and deaths of children at the heart of this study.\textsuperscript{16} For all that statistics illuminate, they can only represent health events as aggregate phenomena. Thus, to get a deeper understanding of the experiences of individuals and families often concealed by numbers, the dissertation makes use of an array of documents to examine the ways African Americans articulated their ideas and responses to infant death. Many of these records exist and have been preserved for other reasons, and as such, part of my methodology has involved reading documents “against the grain” for evidence of black healing practices and communal forms of care.


In order to tell this story, the dissertation uses a wide range of sources. Medical articles and public health reports reveal the evolving causes of death in the nineteenth and twentieth centuries, while other sources, such as slave narratives, interviews with former slaves, and memoirs illuminate who was involved in the work of caregiving during childbirth and when infants became ill, and the role of gender and age in establishing those ties. Encounters with death were not limited to concerns about how to avoid physical suffering, they engaged spiritual beliefs as well and the dissertation considers the role of church practices, religious values, and the rituals of burial. In addition, forms of artistic culture encompassing literature, photography, film, and songs, are important domains of representation and the dissertation uses these to interrogate the struggles over the meaning of black infant death, and its relationship to ideas about black family life and health. In exploring ideas of childhood and health, everyday practices of infant care, the social lives of African Americans, and the meanings made of out of those experiences, whether by physicians, parents, midwives, or government officials, this project is a cultural history of black infant mortality, one that brings together multiple perspectives to bear on understanding the impact and meaning of infant death in black communities. In doing so, this project highlights voices, texts, and healing practices often excluded from professional medicine and history writing.

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Race, Health, and Childhood in History

Over the past three decades, a number of scholars have examined the ways medicine reflects broader changes in society. Historians such as Charles Rosenberg and Judith Leavitt have shown how changes in how and where we give birth, get sick, and die reflect shifting cultural values and social relations.\(^\text{18}\) Medical anthropologist Arthur Kleinman has demonstrated that the way individuals and families respond to sickness and death is not dictated by formal definitions of disease, but shaped by the relationships, responsibilities, and expectations people take on in the face of health events.\(^\text{19}\) This project builds on these earlier contributions, and by focusing on the dynamics of race, gender, and health, aims to shed light on the entanglements of illness experience, racial identity, and social relations.

Early scholarship has seen black infant mortality through the lens of race and health more generally. Some of the first works emerged from 1970s and 1980s explorations of the role of medicine in slavery. In a series of empirically-grounded studies, Todd Savitt, Richard Steckel, Kenneth Kiple, and Virginia H. King drew on methods from fields of demography, nutrition, human development, and the biomedical sciences to reconstruct the disease environments of slaves in the antebellum South, in which discussions of infant mortality figured prominently.\(^\text{20}\) In


explaining this eclectic, social science approach Kiple wrote, “Among the methods I use is one of shining present-day medical knowledge on the past,” which he acknowledged was “fraught with some danger.” Yet Kiple believed such an approach was particularly important in demonstrating the relationship between present-day disease patterns and historical experiences of enslavement.\footnote{Kiple, “The Nutritional Link with Slave Infant and Child Mortality in Brazil,” \textit{The Hispanic American Historical Review}, Vol. 69, No. 4 (Nov., 1989), pp. 677-690.} Subsequently, scholars writing amidst the AIDS epidemic focused their attention on the gendered and urban dimensions of black health, using historical analysis to shed light on current health problems facing black communities.\footnote{David McBride, \textit{From TB to AIDS: Epidemics Among Urban Blacks Since 1900} (Albany: State University of New York Press, 1991); Evelynn Hammonds, “Missing Persons: Black Women and AIDS,” \textit{Radical America} 24:2, (April-June 1990, pub. July 1992) pp. 7-24. Also see Edward H. Beardsley, \textit{A History of Neglect: Health Care for Blacks and Mill Workers In the Twentieth-Century South} (Knoxville: University of Tennessee Press, 1987).} Since then, recent works have looked within and beyond clinical settings and institutions to uncover the experiences of African Americans as patients, objects of experimentation, and practitioners.\footnote{Vanessa Northington Gamble, \textit{Making a Place for Ourselves: The Black Hospital Movement, 1920-1945} (New York: Oxford University Press, 1995); Darlene Clark Hine, \textit{Black Women In White: Racial Conflict and Cooperation In the Nursing Profession, 1890-1950} (Bloomington, Ind.: Indiana University Press, 1989); Susan Reverby, \textit{Examining Tuskegee: The Infamous Syphilis Study and Its Legacy} (Chapel Hill: University of North Carolina Press, 2009); Susan Lynn Smith, \textit{Sick and Tired of Being Sick and Tired: Black Women’s Health Activism in America, 1890-1950} (Philadelphia: University of Pennsylvania Press, 1995).} These works have also interrogated the
notion and legacies of “racial” diseases linked to evolving ideas of racial difference rooted in biology, behavior, and environment.  

“Awful Gladness” expands on these historical studies of African American health by centering the experiences of young children, a focus that brings to the fore themes of blame and responsibility. In a society in which sickness is often linked to individual behaviors, infants fall outside of this calculus and are instead seen as in need of protection. Discussions about infant death, then, are often sites for singling out specific causes and holding particular actors accountable. As David Jones has demonstrated in his study of American Indian health from the seventeenth to the twentieth centuries, by taking a longer view of mortality experiences one can trace the consequences of ideas of health based on notions of biology and behavior, what he terms “the rationalization of epidemics.” This study’s focus on infant wellbeing aims to show that at the heart of public discourses on infant mortality have been concerns about how to assign blame and responsibility for protecting life.


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Generations of historians have explored the ways interest in protecting life has shaped and been shaped by the gender politics of childbirth, childhood, and maternity.\(^7\) In the long history of infant death black women have shouldered much of the blame, portrayed as negligent mothers, ignorant midwives, second-class nurses, and dangerous reproducers who transmit harmful diseases to children. Du Bois was no doubt challenging such stereotypes through his descriptions of Nina’s tender care in nursing Burghardt. The dissertation’s examination of the gendered politics surrounding black infant care, as well as class dynamics governing who could speak about black infant death, contributes to scholarship on African American history engaged in exploring the intersections of race, gender, and class. In particular it considers the ways the politics of reproduction, especially concerning the decision to bear or refuse to bear children, has

long been a contested site of autonomy and resistance for black women. Accounts from black women regarding their efforts to ensure a safe birth, nurse a sick baby back to health, and honor the memory of a lost child, provide rich alternative perspectives on the way infant care figured practically and symbolically in their lives. This project draws from these sources to demonstrate the central role of black women as mothers, laborers, midwives, nurses, and public health leaders in protecting their own health and the health of children.

This dissertation argues that African Americans were acutely aware of their duties as parents, and the racial and gendered responsibilities that came with raising black children. Many carefully weighed their decision to bear children, and they understood the distinct functions involved in raising sons and daughters. For Harriet Jacobs writing in the mid nineteenth century, the thought that her daughter who would grow up to endure the same horrors she experienced as a slave made her heart “heavier than it had ever been before,” leading the young mother to declare “slavery is terrible for men; but it is far more terrible for women.” And through Du Bois’ descriptions of Burghardt as a sacred son we see different ideas about gender and family roles that were taking shape at the turn of the twentieth century. Focusing on debates about black infant health and welfare illuminates the ways in which the Western ideology of childhood innocence is not only a historically rooted concept that emerged in the nineteenth century, but

30 Harriet Jacobs, Incidents in the Life of a Slave Girl (1860), 119.
one that is also deeply racialized. While infants have been viewed as innocent and in need of protection, some scholars have also shown the ways black children have been portrayed as “born guilty,” seen as predisposed to biological inferiority and early death. Attempts to reconcile ideas about black reproduction and childhood vulnerability have influenced responses to managing the health of black infants, at times blurring the lines between preventative health measures and the policing of reproduction.

Finally this project is in conversation with works on the politics of black mourning. Though we need no reminder that “everyone dies,” Vincent Brown’s study of Atlantic slavery powerfully illustrates how mortuary customs were a major site of social conflict between the free and enslaved communities of Jamaica, reflecting different cultural practices and cosmologies that bound the dead to the living. Through the Civil War and after emancipation, tensions over blacks’ ability to honor their dead figured, for example, in appeals by black male soldiers and fugitive black women to the government. By the post-Reconstruction period when Du Bois was writing we see how ideas about death, especially the death of young children, figured into

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debates over the future of the race. For many parents, the loss of a child was attended to with feelings of sadness and even shame. The number of scientific and medical publications debating the causes of black mortality far outweigh publicized accounts from black parents describing their perspectives. Nonetheless, by carefully combing historical sources it is possible to foreground black experiences with infant care and death rather than only rely on white professionals’ views which pathologize black parenting. Finding these voices has at times proven difficult, but not impossible, and has been one of the most rewarding aspects of this project.

Overview of Project

The following chapters are organized chronologically and thematically, exploring themes of blame and responsibility in addition to ideas of prevention, regulation, migration, and access. The story begins in the rural South, with Chapter One examining three moments in the nineteenth century that demonstrate the ways black infant mortality was first seen as an antebellum problem of plantation management, then reframed as a military concern during the Civil War, and by the end of the century interpreted as a sign of racial degeneracy. Through analyzing plantation records, slave narratives and interviews, and medical articles, the chapter argues that the meaning of infant mortality shifted from an event whose significance was deeply tied to experiences of bondage to, by the end of the century, a sign of the new struggles African Americans faced as freed people. In tracing this transformation, the chapter demonstrates that tensions over the management of black infants’ bodies in both life and death were shaped as

much by evolving medical and scientific ideas of the health dangers of infancy as they were by changing African American beliefs about the proper way to lay a child to rest.

The transition from bondage to freedom profoundly shaped African American experiences of infant loss, especially as emancipation brought with it new forms of mobility for African Americans. Chapter Two follows early generations of black migrants as they navigated public institutions and developed lay networks to provide for their youngest children. Focusing on Washington D.C., it looks at the establishment of the Board of Children’s Guardians, a public agency responsible for the care of abandoned and destitute infants and children. The BCG’s rise and fall illuminates some key tensions in early Progressive Era responses to addressing infant welfare, and the ways in which its approach to protecting black infants was shaped by anxieties about black migration and debates over the goals and politics of charitable relief. As the agency’s influence grew, it increasingly saw its mission of child saving to be at odds with keeping black families together, a view grounded in racialized assumptions about what constituted a suitable family and home setting. African American families turning to the BCG for temporary help with child care increasingly found their families separated, and the ensuing controversies reflected different ideas about the kind of assistance the government should provide. By the 1920s, both parents and government officials saw the BCG as an inadequate solution to preventing infant mortality and the broader problem of child welfare, reflecting the limits of a municipal response grounded in late nineteenth century ideas of charity and poor relief.

At the turn of the twentieth century as Americans struggled to understand what children’s lives, livelihoods, and deaths meant in an increasingly commercial and urban nation, a number of individuals and organizations called for the government to play a larger role in preventing early death. Chapter Three examines the work of U.S. Children’s Bureau, the federal agency created in
1912 and charged with reducing the nation’s infant mortality rates, and shows how the Bureau saw the problem of high black infant mortality as intimately tied to debates about the “midwife problem.” In exploring the reasons why black women valued midwives even as the government and physicians increasingly blamed them for deaths during childbirth, the chapter argues that what initially began as a government effort to reduce black infant mortality transformed into a campaign to train and regulate midwives, and consequently, to police the reproductive and family lives of African Americans. One outcome of the government’s intensifying surveillance of midwives was it moved attention away from other, larger health and economic issues that affected infant mortality rates. In tracing the course of the Bureau’s work, the chapter details the contributions of Ionia Whipper, the first black physician to work in the Children’s Bureau, demonstrating how her work in black rural communities across the South was key to raising government awareness of black health needs and modernizing the care black midwives provided.

African Americans no doubt benefitted from government resources and attention to improving their health. But they also knew that public health interventions narrowly focused on targeting specific individuals and behaviors, and in doing so failed to address the broader ways in which racial discrimination impacted black health. Through a variety of forums, including advice columns and Better Baby contests, African Americans from the 1900s to the 1940s debated the politics of “saving” black babies in an era of Jim Crow, as well as their role as parents, while also publicly sharing their experiences with infant loss through personal memoirs, editorials, songs, and funeral photographs. In these spaces, black parents articulated fears about the impact of diseases and behaviors on their ability to raise healthy children, anxieties influenced by contemporary eugenic ideas of fitness and vitality. At the same time, black women connected concerns about infant welfare to ideals of race motherhood and threats of racial violence on
women and children’s wellbeing. Chapter Four traces these multiple sites of black discourse, arguing that by the mid twentieth century the death of a black infant was no longer seen as a poor reflection of parents’ physical fitness or moral character, but as embodying society’s indifference to black children.

This neglect towards black children was most clearly seen in the rural South, where many black births still occurred at home and with a midwife in attendance due to the region’s deeply segregated health care system that limited black access to hospitals and physicians. Chapter Five analyzes how the issue of black infant welfare became enfolded in political battles by looking closely at the 1953 film *All My Babies: A Midwife’s Own Story*, a health training film intended to help lower the black infant and maternal mortality rates in the South, which white public health officials considered embarrassingly high. The film grew out of a collaboration between Georgia public health officials, George Stoney, the black community of Albany, Georgia, and the black midwife and film’s star, Mary Coley. Drawing on a close analysis of the film and archival materials surrounding its production, as well as public health reports and investigative files on midwives, the chapter explores the tensions between the film’s representations of black infant and maternal health and the reality of care African Americans received in the mid twentieth century. This award-winning film drew acclaim and controversy for its portrayal of African American midwifery and its depiction of a live birth. The fraught reception underscored the ways black infant health was a focal point in growing postwar critiques that African Americans received second-class care in the nation’s expanding, but deeply segregated, health care system. Even as officials promoted the film they remained anxious that its portrayal of black life and health would expose the ways in which the status of black infant health reflected deep inequalities in American society.
Through charting these moments we see that the evolution of the meanings of infant mortality were the product of an unfolding set of negotiations within black communities, among communities and the government, and in society more broadly, as racial attitudes and politics shifted from plantation slavery through the rise and decline of Jim Crow. Ultimately, “An Awful Gladness,” evokes Du Bois’ call to journey through time and across a wide geographic landscape to explore the history of infant death in the black experience. To begin, let us first consider the death of a young child on the antebellum plantation.
CHAPTER ONE

“Not Dead, But Escaped”

Black Infant Health and Death in the Nineteenth Century

“Alas, what mockery it is for a slave mother to try to pray back her dying child to life!”

Harriet Jacobs recalled the dilemma she faced as a sixteen-year-old slave when her infant son
became ill. Joseph was fathered by a white man and born into slavery in 1829 in North Carolina.
Thirty years later, Jacobs appealed to the white, female readers of her narrative *Incidents in the
Life of a Slave Girl* and their sense of motherhood as sacred when she asked them to consider
what an enslaved mother should wish for her child, a life in bondage or freedom through death?
She laid bare her struggles as a mother at the risk of reinforcing beliefs that black women lacked
maternal sensibilities. But Jacobs deliberately chose to foreground her experiences, even
including her contemplations of death, in order to highlight an enslaved mother’s love for her
children in the face of dehumanizing oppression, and to “arouse the women of the North to a
realizing sense of the condition of two millions of women at the South, still in bondage.”

For Jacobs, her experiences with pregnancy and birth were deeply shaped by the abuse
she suffered as a slave in the hands of her owners Dr. James and Maria Norcom. The Norcoms
tormented Jacobs because of her race, sex, and age, and their intimidations reached new bounds
as she grew from an adolescent girl to a young mother. While pregnant slaves often relied on
other black women to attend to them during confinement, Jacobs resisted medical attention

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1 Harriet Jacobs, *Incidents in the Life of a Slave Girl. Written by Herself* (Boston, 1860), 96.
2 Jacobs, 6.
knowing that the only person who would be summoned was her master. As Jacobs recalled, when Dr. Flint (the fictional name she assigned to Dr. Norcom) was finally called in, she “began to scream.” The birth left the new mother and newborn in fragile condition. After giving birth, Jacobs described her state as “a mere wreck of my former self.” Joseph was born premature and for weeks “was sickly. His little limbs were often racked with pain.”

Throughout the nineteenth century, childbirth was a dangerous event for mothers and infants across the color line. White and black women experienced difficulties with pregnancy and many died in the process of carrying a pregnancy to term. As historian Judith Leavitt has described, the haunting “shadow of maternity” touched on many aspects of women’s lives as women endured frequent cycles of pregnancy and childbirth, well aware that “maternity, the creation of new life, carried with it the ever-present possibility of death.” What distinguished Jacobs’ experience was the additional “shadow” of slavery. Dr. Norcom closely monitored her and Joseph’s health, never missing an opportunity to remind Jacobs that her son was another addition to his “stock of slaves.”

Despite the difficult birth and cruelties she endured, Jacobs discovered a “new tie to life” through motherhood. She had “often prayed for death,” but no longer sought such an escape realizing that it would leave her children behind to suffer. As Joseph grew, her love for him deepened:

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3 Deborah Gray White, *Ar’n’t I a Woman?: Female Slaves in the Plantation South* (New York: W.W. Norton, 1999), 110-112.
4 Leavitt writes, “The shadow that followed women through life was the fear of the ultimate physical risk of bearing children. Young women perceived that their bodies, even when healthy and vigorous, could yield up a dead infant or could carry the seeds of their own destruction…Nine months’ gestation could mean nine months to prepare for death.” Judith Walzer Leavitt, “Under the Shadow of Maternity: American Women’s Responses to Death and Debility Fears in Nineteenth-Century Childbirth,” *Feminist Studies*, Vol. 12, No. 1 (Spring, 1986), 129-154, 133.
The little vine was taking deep root in my existence, though its clinging fondness excited a mixture of love and pain. When I was most sorely oppressed I found a solace in his smiles. I loved to watch his infant slumbers; but always there was a dark cloud over my enjoyment. I could never forget that he was a slave. Sometimes I wished that he might die in infancy. God tried me. My darling became very ill. The bright eyes grew dull, and the little feet and hands were so icy cold that I thought death had already touched them. I had prayed for his death, but never so earnestly as I now prayed for his life; and my prayer was heard.5

Joseph survived and would go on to escape slavery as an adolescent. Yet Jacobs’ reactions to his early years highlighted the seeming inevitability of infant death, the possibility that it brought a better existence than the one that awaited, and the range of emotions accompanying the acute sense of oppression enslaved parents faced in protecting their children.

This chapter explores the themes Jacobs raised in her narrative to analyze the changing meanings of black infant death over the course of her adult life, from the 1830s to 1890s. It looks at three particular moments to explore tensions in white and black ideas of infant care, the role of medical and scientific expertise in managing the health dangers of infancy, and parents’ beliefs concerning how their children should be laid to rest. Through examining these three periods covering the antebellum period, Civil War, and Post-Reconstruction era, this chapter argues that the meaning of infant mortality shifted over the course of the century from an event whose meaning was deeply tied to experiences of bondage to being interpreted as a measure of African Americans’ ability to survive as freedpeople. In the antebellum period, slaves and slaveowners developed infant care approaches that reflected their social and economic values of infancy. Attention to black infant health was an important aspect of the slave economy and in so far as we know details about the health of enslaved infants it is because slaveowners closely monitored their development and enlisted physicians to make sure their youngest property stayed alive. The

5 Jacobs, 96.
Civil War fundamentally disrupted this logic and system of black infant care, and the meaning and value of black infant life became contested amidst the dislocations of war, broader questions of relief, and the uncertainties of African Americans’ status in the transition from bondage to freedom. By the post-Reconstruction era white physicians became increasingly disengaged from managing the health of African Americans, and saw it as no longer part of their economic interest and responsibility to protect the health of black infants. Drawing on new areas of scientific expertise grounded in statistical measurement and evolutionary theories, scientists and physicians no longer sought to keep black infants alive but instead to track their decline. Thus, by the close of the century the health of black infants was no longer tied to concerns of managing plantation profitability and wartime resources, but instead seen as a sign of the race’s imminent extinction.

Valuing the Health of Enslaved Infants

African American experiences with infant death varied greatly during slavery. The way families sought to prevent and responded to infant death were shaped by differences in plantation size, demography, and family structure including whether families were held by the same owner or split between different owners and regions. African Americans did not have a single approach to navigating issues of infant health and death but their accounts make clear that many held certain beliefs about caring for infants, and drew on communal practices and rituals to make those visions a reality. In addition to plantation records and management guides, this section

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6 Wilma King *Stolen Childhood: Slave Youth In Nineteenth-Century America* (Bloomington: Indiana University Press, 1995). These accounts, among other points, serve to further contradict the claims of the time, which suggested that black women did not have normal maternal feelings for their newborn children. As one former slave told an interviewer, “A mother al’ays loves her chillum…Real love nuver dies, it last’s f’om de cradle to de grave.” Interview of Sarah
makes particular use of slave narratives and interviews, which are some of the earliest records in which African Americans articulated their experiences and thoughts on infancy. Of the over two thousand African Americans featured in the Federal Writers’ Project of the Works Project Administration (WPA) of the 1930s many were in their eighties or older when interviewed, and thus spent part of their childhood as slaves. While scholars have pointed to the seventy years that elapsed since emancipation as one reason to treat these oral histories with caution, the interviews remain some of our only sources for knowing how young African Americans understood their health and experiences with death, and thus are critical sources to use, while recognizing their limitations.

For ex-slaves who published their life story, beginning their narratives by describing their birth and earliest memories conveyed one of the cruelties of slavery, an infant’s physical separation from and restricted time with its mother. As Lunsford Lane explained in his narrative, from the moment he was “ushered into the world…my infancy was spent upon the floor, in a rough cradle, or sometimes in my mother’s arms.” Frederick Douglass opened his first autobiography (he would go on to write two more) noting “my mother and I were separated when I was but an infant — before I knew her as my mother.” It was common practice in that region of Maryland for mothers to be hired out before their child “reached its twelfth month.” When they turned one, infants were placed in the care of an older slave woman, but Douglass’

Fitzpatrick in John W. Blassingame, Slave Testimony: Two Centuries of Letters, Speeches, Interviews, and Autobiographies (Baton Rouge: Louisiana State University Press, 1977), 649. 7 Italics mine. Lunsford Lane, The Narrative of Lunsford Lane: Formerly of Raleigh, N.C., Embracing an Account of His Early Life, the Redemption by Purchase of Himself and Family From Slavery, and His Banishment From the Place of His Birth for the Crime of Wearing a Colored Skin (Boston: J.G. Torrey, 1842), 5-6.
7 Frederick Douglass, Narrative of the Life of Frederick Douglass, an American Slave. Written by Himself (Boston: Anti-Slavery Office, 1845), 2.
mother, who worked several miles away, still stole away each night to be with her son. “I do not recollect of ever seeing my mother by the light of day.” He continued, “She was with me in the night. She would lie down with me, and get me to sleep, but long before I waked she was gone.” Other slave mothers carried out similar forms of resistance. William Wells Brown recalled how as a young child his mother “told me how she had carried me upon her back to the field when I was an infant--how often she had been whipped for leaving her work to nurse me--and how happy I would appear when she would take me into her arms.” In foregrounding these experiences early in their narratives Douglass, Lane, and Brown sought to emphasize to their readers the dehumanizing ways slavery ruptured the bonds between mother and child, which by the early 1800s had become a major focus of antislavery literature. Their personal stories stood as powerful testimony confronting white, middle class sentimental ideas about childhood and domesticity.

Some owners, like South Carolina politician James Henry Hammond who owned over three hundred slaves, developed fixed infant feeding schedules to regulate the time slave mothers had with their children. In his plantation manual Hammond outlined his vision for efficiently managing slaves, a process that began as soon as a slave was born. For the first eight months, nursing mothers, who he referred to as “sucklers,” were “allowed 45 minutes at each nursing to be with their children.” After eight months, the visits reduced to twice a day. When an infant reached twelve months Hammond believed the best method for completing the weaning process

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was to remove the child “entirely from its mother for 2 weeks” and place it in the care of another female slave who did not have a child. The mother was not allowed to nurse during that two week period.\textsuperscript{11} Hammond considered himself a “benevolent” master who took special care of his infant slaves, writing in his diary, “one would think…that I was a monster of inhumanity…and yet I have taken more pains to raise young negroes & nurse all than to do anything else.”\textsuperscript{12} Yet his nursing schedule revealed that his real interest was in maximizing the productive and reproductive labor of his female slaves.\textsuperscript{13} Usually within four weeks of giving birth, slave mothers on Hammond’s’ plantation resumed their \textit{productive} labor in the field or with other chores, and took nursing breaks to attend to their \textit{reproductive} duties and ensure infant slaves survived their early years.\textsuperscript{14} While Hammond and Douglass’s owner developed what they

\textsuperscript{11} Plantation Manual 1857-1858, James Henry Hammond Papers, Manuscript Division, Library of Congress.
\textsuperscript{12} Drew Gilpin Faust, \textit{James Henry Hammond and the Old South: A Design for Mastery} (Baton Rouge: Louisiana State University Press, 1982), 75-77.
\textsuperscript{14} Recent work in disability studies has shed new light on slave health experiences and medical treatment of “unsound” slaves. Within this framework, periods of pregnancy, confinement, and nursing and conditions such as barrenness are examined as disabilities that slaves and slaveowners accommodated in different ways. See Dea H. Boster, \textit{African American Slavery and Disability: Bodies, Property, and Power In the Antebellum South}, 1800-1860 (New York: Routledge, 2013); Boster, “‘I Made Up My Mind to Act Both Deaf and Dumb’: Displays of Disability and Slave Resistance in the Antebellum American South,” in Jeffrey A. Brune, and Daniel J. Wilson, eds., \textit{Disability and Passing: Blurring the Lines of Identity} (Temple University Press, 2013), 71-98; Jennifer L. Barclay, “Mothering the ‘Useless’: Black Motherhood, Disability, and Slavery,” \textit{Women, Gender, and Families of Color} Vol. 2, No. 2, 2014, pp.115 - 140.
believed were efficient, and even generous, methods for managing enslaved mothers and infants, to slaves such actions demonstrated the ease in which families could be separated at an owner’s will. Douglass believed that a slaveowner’s interference at such an early point in a child’s life succeeded in hindering “the development of the child’s affection toward its mother, and to blunt and destroy the natural affection of the mother for the child.”

For many slaveowners, ensuring the health of their overall slave population required paying close attention to the diseases that struck slave children. Childhood, according to historian Todd Savitt, was the “least healthy period of a slave’s life.” Writing to his father from the family’s plantation in Prince George County, Virginia, Edmund Ruffin Jr. wondered whether “every body else has the same ill luck with little negroes that you and I have had.” From 1813 to 1847, of the eighty-five slaves born on the Beechwood estate, thirty-nine died during childhood. And of the six slave children that passed away in 1847, five were mere “sucklings,” so young Ruffin referred to them as “babies in arms.” Ruffin was concerned about the prevalence of diseases among his infant slaves, especially fatal cases of whooping cough, but questioned the value of calling a physician to care for “children too young to express their pains and symptoms.” He wondered, what “earthly good” could “doctors and physick” provide when all infants needed was good nursing? Justifying his position to his father, Ruffin pointed to the family’s other estate in Bellvue where more infants survived into childhood despite the fact that “not half the pains” were taken to call on a doctor when they became ill.

\[15\] Douglass, 2.
\[17\] In the letter Ruffin Jr. gives a full accounting of the births and infant deaths on the family’s plantations. Edmund Ruffin Jr. to Edmund Ruffin Sr., March 13, 1847, Edmund Ruffin Papers, Mss1 R8385 a 184-223, Virginia Historical Society (hereafter VHS).
Monitoring the health of slave infants was an important component of plantation management, and overseers were judged by their ability to promote “the excess of births over deaths…and the health of the children.” In reporting on the health of slaves, overseers updated plantation owners on cases of sickness, births, and deaths, and used their reports to explain their decisions to treat or not provide treatment for slaves. When W. Floyd informed his employer on the health of his slaves, Floyd noted “we hav had better luck with the children than the most of ower neighbors Som has lost 2 or 3 little negros with the hooping cough.” Floyd’s apparent success came from having the infants’ mothers “attend Som of them 2 weakes …and I hope we will hav no more trouble with that complaint.” The health of the infant slaves stood at the center of his assessment of the plantation’s ability to survive the epidemic. Some owners like Virginia planter Richard Eppes took additional measures by hiring a physician, Dr. Virginius W. Harrison, to oversee his one hundred and thirty-five slaves, making the overseer responsible for tending to illnesses on the plantation. The summer of 1855 Harrison reported “we have measles on the Hundreds plantation and I fear it will interfere with our operations – up to this time, it has been confined to the children.” Harrison used his medical training to track down the source of contagion and reported, “Billy, Molly’s son, broke out with it and we could not trace it to any contagion, till about a week since when it was ascertained that a sawyer hired by Mr. Rae had the measles and that Billy had been over without any one’s knowledge.”

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19 W. Floyd to E. C. Cabell, March 31, 1850, Cabell Family Papers, Mss1 C1118 a 153-163, VHS.
20 Account Book, 1851-1861, Richard Eppes Papers, Mss1 Ep734 d 343, VHS.
21 Virginius W. Harrison to Dr. Richard Eppes, August 4, 1855, Richard Eppes Papers, Mss1 Ep734 d 318-331, VHS.
provide a comprehensive account of the disease’s outbreak to Eppes, yet at the same time he shielded himself from blame, accusing someone else of bringing a diseased slave onto the plantation, and thus exposing Eppes’ slaves to measles. As these cases demonstrate, a key part of safeguarding the health of infant slaves involved controlling the spread of infectious diseases such as whooping cough, measles, and cholera.  

While protecting infants from communicable diseases remained a major worry, much of an infant’s survival depended on weathering crises tied to early development, such as the healing of the umbilical cord, weaning, and teething, and the diseases associated with each of these phases. The first month of life posed an especially significant threat. One of the most fatal diseases that struck newborns was *trismus nascentium* (neonatal tetanus). Within the first two weeks of life newborns were particularly vulnerable to infection caused by the bacteria *clostridium tetani* entering through the unhealed umbilical stump and attacking the central nervous system. Infected newborns experienced painful muscle contractions and spasms. The most recognizable symptom is the inability of an infant to breastfeed due to a stiffening of the jaw muscles (hence its more common name, “lockjaw”). The disease moved swiftly and was devastatingly fatal. Once infection set in, very few newborns survived past the first two weeks of life. Often referred to as “nine day fits,” the disease elicited so much fear, that as one enslaved midwife remarked, “till nine days over, we no hope of them.”  


Considered “peculiarly a disease of the negro” and referred to as a “southern planation problem,” slaves and slaveowners closely monitored any signs of neonatal tetanus and developed regimens to help prevent the disease from taking hold. In 1851 twenty-seven year old Sarah, a slave of Anna Matilda Page King and Thomas Butler King of coastal Georgia, gave birth. She was attended to by female slaves Rhina, Maria, and Pussy, a fifty-seven year old nurse who tended to many of the illnesses and births on the Sea Island plantation. A few days after it was born, Sarah’s baby (who is never identified by name or gender, only referred to as “it”) had trouble nursing. Pussy informed her masters that she thought the newborn had lockjaw. Anna seemed to agree with Pussy’s diagnosis and decided the best course of action was to keep the newborn in Pussy’s care. In a letter to her daughter, Flora, Anna wrote, “this is almost as severe a blow to me as it is to poor Sarah who has lost so many children with this distressing complaint.” A couple days later Sarah’s baby seemed to improve and as quickly as the infant’s outlook changed, so did Anna’s assessment of the situation. Anna updated her daughter, “Sarah’s baby may get over this tightness of jaw. Pussy was certain it would die. But the 9th day being past – I did not give it up – and as it can nurse very well I hope it will live.” Whereas before Anna had agreed with Pussy, she now drew a distinction, asserting that she never believed the prognosis to be as dire as Pussy had claimed. And no credit is given to Pussy, either, for her nursing skills in bringing the baby to full recovery. Correspondence on Sarah’s baby fades after this, the infant

26 Italics in original. Anna King to Florence King, November 24, 1851, *Anna*, 118-119.
having survived a crisis Anna considered over. But even in this brief moment it is clear how the mere threat of lockjaw could elicit fear. A menace of early infancy, Anna also viewed lockjaw as an obstacle to her family’s quest for wealth, best captured in her comment that due to the disease “one thing seems certain we are never to grow rich by the increase of our negroes.”

While the Kings relied on a trusted black midwife, other slaveowners sought out professional medical expertise and enlisted the help of physicians to prevent infants from dying of neonatal tetanus. Southern physicians developed a range of theories and regimens intended to reduce incidences of the disease on plantations, and it was one of few black health concerns discussed in planter and medical journals. Physician James Marion Sims, best known for his contributions to surgery and gynecology, which he infamously achieved by experimenting on enslaved women, considered his “first great discovery in medicine,” to be his work on trismus nascentium. After seeing one newborn slave suffer from the disease he concluded that the affliction emerged from too much mechanical pressure placed on the newborn’s occipital bone, located at the base of the brain. Laying newborns on their side instead of flat on their backs, he argued, would reduce the pressure and instantly relieve muscle spasms. Sims criticized slave mothers who cradled their newborn’s head on their knees while breastfeeding, arguing that such

27 Anna King to Florence King, November 22, 1851, Anna, 118. For a recent analysis of slave value across the life course see Daina Ramey Berry, The Price for Their Pound of Flesh: The Value of the Enslaved, From Womb to Grave, In the Building of a Nation (Boston: Beacon Press, 2017).
29 James Marion Sims, Story of My Life (New York: De Capo Press, 1884), 226.
nursing habits caused harm. From 1846 to 1848 Sims published a series of articles detailing his observations and including case reports from other physicians that ostensibly demonstrated the wide acceptance of his theory. But the reality was that most of his colleagues were skeptical, and remained unconvinced that *trismus nascentium* was caused by pressure on the newborn’s skull and that effective treatment involved nothing more than re-positioning an infant onto its side.\(^3^0\)

Physician John Watson was one of these critics, and in his 1859 *Treatise on the History, Etiology, and Prophylaxis of Trismus Nascentium*, the first monograph on the disease, he took apart Sims’ assessment, arguing instead that the disease was not due to anything “peculiar to the African race,” but could be traced to slaves’ living conditions and the dressings used on navel cords.\(^3^1\)

Even as Sims drew critics, he was not alone in tying the mechanism of the disease to slave mothers. Medical management of enslaved newborns hinged on theories of black women’s bodies as either health-giving or corrupt. In the pages of the popular agricultural journal *Debow’s Review*, physician and slaveowner W.D. Daniell shared his method for preventing neonatal tetanus. The first step involved relieving enslaved mothers of their breast milk, which he believed was the source of the disease. “From the birth of the infant until it is ten days old…I have the mothers’ breasts freely drawn and daily emptied of their milk.” The mother could not be trusted to fulfill this task; it was instead assigned to the plantation nurse, as she “should be held responsible for its faithful execution.” Although breastmilk was dangerous for the infant, Daniell


still viewed it as a valuable source of nourishment, and instructed that the milk should not be
discarded but given instead to “the midwife, another and older child, or [to] a puppy.”

The newborn slave was nursed on a diet of sweet oil and molasses. Daniell was confident that if
owners followed his method of separating mothers from their newborns the disease would not
gain hold. As his theory and prevention method demonstrated, Daniell believed enslaved mothers
were an inherent threat to the health of their offspring. He also reserved blame for black female
healers, concluding his advice with “I require no further evidence of neglect in the nurse than the
death of an infant from this disease.” Daniell viewed neonatal tetanus as a challenge to
plantation management and a problem rooted in black women’s bodies, and framed this way a
newborn’s biggest risk in life was to be born to a black mother.

Infants that survived the first two weeks of life still faced other challenges. Teething was
considered one of the “periodic developmental crises” that infants needed to overcome by their
first year “if prospects later life were not to be damaged.” Every infant endured the pains and
discomforts that came with new teeth growing in, but physicians, slaveowners, and parents
remained fearful that if the associated symptoms, mainly drooling, irritability, fever, and

32 For a recent analysis on breastmilk as a commodity and the economy of wet-nursing see West,
“Mothers’ Milk.”
33 W.D. Daniell, “Health of Young Negroes,” Debow’s Review Volume 20, Issue 6 (June 1856),
747a-748a; Long, 11-14.
34 See Charles Rosenberg’s introduction to The Maternal Physician: A Treatise On the Nurture
and Management of Infants, From the Birth Until Two Years Old. Being the Result of Sixteen
Years’ Experience In the Nursery (New York: Arno 1972). Gunn’s Domestic Medicine, a
nineteenth century medical guide that was widely popular for its ‘common sense’ approach to
providing home remedies for health issues, included a section on treating the symptoms of
teething. See John C. Gunn, Gunn’s Domestic Medicine, Or, Poor Man’s Friend: Shewing the
Diseases of Men, Women and Children, and Expressly Intended for the Benefit of Families:
Containing a Description of the Medicinal Roots and Herbs, and How They Are to Be Used In
the Cure of Diseases: Arranged On a New and Simple Plan (Knoxville: Printed by F.S. Heiskell,
1833), 419-421.
restlessness, were not properly managed, it could lead to death.\textsuperscript{35} Slaves developed robust remedies and practices to ease an infant’s pains during this period of development, encompassing treatments taken internally, rubbed on the body, objects worn or carried around, and the uttering of charms. Amulets made out of herbs, animal teeth, mole’s feet, rattles, coins, and buttons were worn around the neck and were believed to be powerful agents to lead children safely through dentition. Special teas and salves applied to the gums also worked to soothe a baby’s discomfort.\textsuperscript{36} The stakes of effectively managing the symptoms were high, as teething was considered an official cause of death. The 1850 census, for example, attributed over 2,400 deaths to the cause.\textsuperscript{37} The dangers of teething also arose in legal debates over the health or “soundness” of slaves. In an 1858 North Carolina case concerning a group of hired out slaves, the owner claimed his slaves were not properly taken care of during their hire term, but the defendant disputed the charges, maintaining that the infants “died from the effects of teething” and not “from want of proper attention.”\textsuperscript{38} In this instance, the defendant viewed the deaths from teething as a normal outcome for children at such a young age and not an indication of negligent care.

\textsuperscript{35} Kate Lindsay MD, “The Care of the Teething Baby,” \textit{Good Health}, February 1899, Issue 2, 103.

By the late 19\textsuperscript{th} century teething was increasingly seen as an ill-defined cause of death, especially in reported cases among children over five years old who had already cut their last set of baby teeth. The 1870 census considered such entries “strange and questionable,” adding that the death’s classification probably reflected the family’s understanding of the cause of death rather than a physician’s professional diagnosis. See Ninth Census, Volume II, June 1, 1870, xvi.
\textsuperscript{38} \textit{Holderness v. Palmer}, 4 Jones Eq. 107, June 1858, North Carolina, in Helen Tunnicliff Catterall, David Maydole Matteson, and James J Hayden, \textit{Judicial Cases Concerning American
When death did occur, disputes over the underlying causes and the losses incurred illuminated the ways slaveowners regarded enslaved infants as assets of little worth but whose economic value was expected to appreciate over time. In 1845 Willa Viley accused Thomas McCargo of misrepresenting the age and condition of two infant slaves he purchased from McCargo. The infants were described as six weeks and six months old and sold in exchange for horses worth a hundred and sixty dollars. Viley claimed that although McCargo declared the children to be “sound, hale and healthy,” they were in fact “extremely delicate, sickly and feeble,” making it “very doubtfull whether they can be raised at all.” Arguing that he had been deliberately misled to believe the infant slaves would grow into profitable investments, Viley sued McCargo for a hundred and seventy dollars, representing the sale price plus interest, and an additional two hundred dollars for damages.

The management of the enslaved newborn was a both an economic undertaking and a social endeavor. While slaveowners weighed the costs and benefits of caring for property that had not yet fully realized its economic value, slaves relied on multi-generational kin networks to provide their youngest with full time care. For day-to-day care parents enlisted the help of older slaves and older children, and for some slaves their earliest responsibilities involved tending to younger siblings. Phillip Evans vividly remembered the day he became a big brother. “I help to bring my brother Richard, us calls him Dick, into de world.” He explained, “when mammy got in de pains, I run for de old granny on de place to come right away. Us both run all de way back.

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39 Petition 20784510, Scott, Kentucky, November 17, 1845, Race and Slavery Petitions Project, University of North Carolina at Greensboro.

Good us did, for dat boy come right away.” In recalling the role he played, Phillip described the rules he had learned as a child and remembered well, the signs to look out for and who to call when his mother needed help. As a young child Phillip also found the experience sudden and disrupting, “as soon as dat boy got here, he set de house full of noise.”\(^{41}\) Growing up on a plantation in Winnsboro, South Carolina surrounded by many sounds, the cries of his new, younger brother distinguished that day from all others. In Barbour County, Alabama, Dicey Thomas remembered that she had “just gotten big enough to carry the bowls” when her mother had another baby. “The old women would tend to this baby and we would sit and rock the cradle till mother would come. I know I wasn’t very old, because I didn’t do anything but sit and rock the baby.”\(^{42}\) Caring for her younger sibling was most likely one of Dicey’s first chores. It was an introduction to the routines of slavery that stuck, she could still recall that a house slave fed the young children and that mothers followed a strict schedule for nursing their babies. On larger plantations where infants were kept in nurseries, children could be called on to assist aged slaves in taking care of babies that were not their siblings. Former slave William Dunwoody explained that if an enslaved mother didn’t have other children to help take care of her newborn, “they’d give her a large one from some other family to look after her children. If she had any relatives, they would use their children for her. If she didn’t then they would use anybody’s children.”\(^{43}\)

Due to their gender or disability, children who did not work in the fields would be trained early on to care for infants. From a young age enslaved girls learned the tasks and duties involved in nursing care. When Sarah was about ten years old she was sent to work in the cabin where mothers took their babies before going to the fields. Along with another girl, Sarah tended

\(^{41}\) Phillip Evans, WPA Narratives, South Carolina, vol. 14, part 2, 35.


to a full nursery, recalling “sometimes we had fifteen or twenty young ’uns to tend. We washed ‘em and fed ‘em and watched over ‘em.” Unlike the other slave children on Colonial Williams’ plantation tasked with carrying water and minding cattle, Frank Fikes spent his time indoors watching over the nursery. Looking back, he considered his work relatively easy, although he was assigned the task because he was crippled. “Something got wrong with my foot when I first started to walking and…I could not get around like the other children, so my work was to nurse all of the time.” With around one hundred slaves on the land, Frank kept busy; “sometimes, as fast as I got one baby to sleep I would have to nurse another one to sleep” and it seemed to him that “nearly every family” on the plantation had a baby. Another slave recalled that as a young girl she was charged with the care of a baby boy who was so young “he didn’t have no name.” This childhood memory suggests that slave naming practices may have reflected ideas about early infant survival. That was at least the case for Liza Moore Turner who explained that although she had thirteen siblings, “some died so young they never was named.”

In writing about his mother’s death Frederick Douglass noted, “never having enjoyed, to any considerable extent, her soothing presence, her tender and watchful care, I received the tidings of her death with much the same emotions I should have probably felt at the death of a stranger.” Douglass emphasized the distance he felt to challenge his white readers to consider the damage that slavery inflicted on familial bonds. Other slaves spoke of the ways death revealed their deep connections to their parents. Julia Cole found that her mother’s death from measles to be traumatic. Her mother was buried in Georgia during the Civil War and Cole, who

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44 Aunt Lucy Minnish (Sarah Garner) Federal Writers’ Project Interview, 3-4.
48 Douglass, 3.
was still very young, remembered, “I jus’ lak to have died when my Mamma died. Dey carried her to de graveyard and put her down in de grave and I jus’ couldn’t help it; I jumped right down in dat grave wid her, and dey had to take me out.”

When infants died, enslaved parents buried their children in accordance with their beliefs, with some slave customs tracing back to West and Central African burial practices. To ease the spirits of the departed, slaves decorated graves with items such as cups, bowls, pitchers, pipes, beads, shells, cloths and material possessions that belonged to the deceased. Jane Lewis, an ex-slave from Georgia explained that “Dem dishes an bottless wut put on duh grabe is …fuh duh sperrit tuh feel at home.” Gravves of babies and children were also decorated with dolls, toys, figurines, and bottles. Former slave Charles Ball, the grandson of an African-born slave, described similar rituals in his 1837 memoir. Ball noted that “native Africans” who had been brought over as slaves to the coastal states of Georgia and South Carolina maintained their beliefs that “after death they shall return to their own country, and rejoin their former companions and friends.”

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51 *Drums and Shadows: Survival Studies Among the Georgia Coastal Negroes* (Athens: University of Georgia Press, 1940), 147.
52 Charles Ball, *Slavery in the United States: A Narrative of the Life and Adventures of Charles Ball, A Black Man, Who Lived Forty Years in Maryland, South Carolina and Georgia, as a Slave Under Various Maters, and was One Year in the Navy with Commodore Barney, During the Late War* (New York: J. S. Taylor, 1837), 219.
illness, Ball helped the parents bury their child. The father, who “had been a priest in his own nation,” performed an African burial ritual on the plantation:

I assisted [them] to inter the infant--which was a little boy--and its father buried with it, a small bow, and several arrows; a little bag of parched meal; a miniature canoe, about a foot long, and a little paddle, (with which he said it would cross the ocean to his own country) a small stick, with an iron nail, sharpened, and fastened into one end of it; and a piece of white muslin, with several curious and strange figures painted on it in blue and red, by which, he said, his relations and countrymen would know the infant to be his son, and would receive it accordingly, on its arrival amongst them.  

The objects were meant to facilitate the infant’s journey to its ancestral home, with the playthings and special cloth reflecting the child’s young age and the father’s desire to ensure his son’s spirit would be recognized and claimed by kin upon its return to Africa. While Ball considered the father to be a “barbarian” to his wife, Ball admired the way the father demonstrated his “affection for his child.” In the final stage of the ceremony, the father “cut a lock of hair from his head, threw it upon the dead infant, and closed the grave.” When the enslaved mother died shortly after, she was buried beside her son, another traditional burial custom performed so the “baby res’ in moder arm.” Beliefs that the deceased needed to be properly laid to rest manifested in other slave funeral rites, such as the practice of handing a baby across its mother’s casket or grave to prevent the mother from haunting the child she has left behind.

53 Ball, 264-267.
54 Elsie Worthington Clews Parsons, Folk-Lore of the Sea Islands, South Carolina (Cambridge: American Folklore Society, 1923), 215.
Blacks found that the ability to bury one’s child was still an act they had to defend and define on their own terms even after they gained their freedom. In his autobiography Ukawsaw Gronniosaw narrated his experiences from his capture in Nigeria to his enslavement in Barbados and New York. He went on to live in England as a free man but his life was still filled with hardship as he and his wife struggled to provide for their children. When one of their young daughters died from a fever Gronniosaw first went to a Baptist minister, then an Anglican parson, and finally a Quaker who all cited various reasons for why they could not bury his daughter. A frustrated Gronniosaw wrote, “we did not know what to do with our poor baby.– At length I resolv’d to dig a grave in the garden behind the house and bury her there.” When the Anglican parson eventually yielded, he informed Gronniosaw that he would bury his daughter but could not “read the burial service over her.” Although Gronniosaw was a devout Christian, in this moment his commitment to giving his daughter a decent burial overrode any unease about observing doctrine. He wrote, “I told him I did not mind whether he would or not, as the child could not hear it.” What Gronniosaw ultimately wanted was for his daughter to be laid to rest in consecrated graveyard, not on common ground. In the antebellum period, slaves and slaveowners wrestled with conflicting ideas concerning the appropriate ways to care for infants, reflecting different approaches and beliefs about nursing, medical treatment, and burial customs. As the country headed to war, these debates would grow in scale and significance.

“Mortality in this Wandering Life”: The Uncertainties of Black Children’s Welfare During War

The Civil War brought death to the center of public concern, and the issue of infant death in particular drew attention to children’s vulnerabilities in wartime environments. Concern over the health and death of black infants became entangled in political debates over the conditions, status, and treatment of African Americans in the transition from slavery to freedom, specifically the welfare of refugee slaves, many of whom were women and children who fled to Union army camps during the war. But the political implications of black children’s welfare extended beyond the boundaries of wartime camps, as African Americans in a variety of circumstances, including black men enlisted as soldiers and those who remained on plantations, asserted their rights to determine their children’s care. They turned increasingly to the government for help, writing appeals for provisions and medical care, while also protesting the treatment they received in the hands of former owners and military officers. As ex-slaves emphasized in their letters to the government and to each other, and as reports from the military and Northern benevolent organizations testified, young children were particularly vulnerable to the combined effects of war and slavery. This section examines the care African American mothers and fathers fought to provide for their young children amidst the tumultuous changes occurring during the war and how these acts, especially efforts to get medical treatment and provide a proper burial, were

important ways newly emancipated African Americans claimed their rights as parents and defined their freedom.\(^{58}\)

As African American men enlisted and were recruited to work on military camps, they left behind female kin to parent alone. Black women bore the responsibility of raising families in the face of cruel treatment from owners and increased demands on their labor. Martha Glover wrote to her husband of the worsening “abuse” she and her children suffered in the hands of their owner embittered by her husband’s service in the Union army. Pleading with him to return she wrote, “You ought not to left me in the fix I am in & all these little helpless children to take care of.”\(^{59}\) Correspondence among partners is filled with concerns for the welfare of children and their future. While the war brought issues of illness and death to the forefront of everyone’s mind, for the formerly and still enslaved, matters of sickness and death became acute concerns as slaveowners were more likely to abuse slaves who remained on plantations. Black women drew on their own medical knowledge and available provisions to manage children’s illnesses without the nearby support of their partners. One wife sent an update to her husband stationed in New York, “I have sad news for you little Fay is very sick he was taken sick tusday morning…I give him som sasuprilea and thought he would be better in the morning but befor dark he was taken out of his head I had hard wourk to keeap him in the bed … you must not wory to much about him he is not dngrious yet and I hope he will be better in the morning but Oh how I wish you could be hear.”\(^{60}\) For some parents, the simple act of seeking medical treatment for their child

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\(^{58}\) Steven Mintz has argued that at the end of slavery, childhood became a “central battleground” in defining the meaning of freedom, see Mintz, *Huck’s Raft a History of American Childhood*, (Cambridge: Harvard University Press, 2004), 113.


\(^{60}\) *Black Military Experience*, 668.
could be contested. In July 1865 Enoch Braston chose to remain on the plantation of his former master after the war ended and work as a free laborer. When his son became ill with dysentery, Braston wanted to get medicine from the town physician. His employer, however, took it as an attack of his authority. He criticized Braston’s decision, calling the physician a “Yankie doctor” and informing Braston, he was “getting mighty high up & if I wanted to shew my freedom, I must get out of that yard.”

Whatever labor arrangement they had settled on, Braston’s employer still could not accept the fact that though Braston worked his land, Braston was free to provide for his children as he saw fit. Forced to choose between keeping his job and caring for his son, Braston asserted his freedom to seek out a physician and, later, requested help from the government to get compensated for work he had performed on his former employer’s land.

African American men, whose status as fathers was often unrecognized under slavery, were especially vocal in claiming their rights to determine their children’s care. Writing from St. Louis in September 1864 Spotswood Rice sent a pair of letters back home. The first went to his children who were still held in bondage, reassuring them “Don’t be uneasy my children, I expect to have you. If Diggs dont give you up this Government will and I feel confident that I will get you. Your Miss Kaitty said that I tried to steal you. But I’ll let her know that god never intended for man to steal his own flesh and blood.” The other letter he sent to Kitty Diggs, who kept his children enslaved. Rice got straight to the point, “now I want you to understand that mary is my Child and is a God given rite of my own. . . now you call my children your pro[per]ty not so with me my Children is my own and I expect to get them.”

Rice demanded to be recognized as his

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children’s father and guardian, and despite the separations that came with war made it clear he was prepared to fight in order to reunite his family.

African Americans traveled great distances to be together as families, and children witnessed the risks their parents took to protect their welfare. In her final year at Hampton Institute in 1881, Virginia Hayes shared one such memory from her early childhood that was so poignant the school’s journal, the Southern Workman, published it in its second issue. During the war, Virginia was around four years old and living in Norfolk with her mother and two-year-old brother. Her brother became infected with smallpox at a time when the disease was “raging” and the city’s quarantine law required anyone infected to be sent to the hospital. As she recalled, “my mother knew this, but she tried every possible way to keep it from being known that he was sick, but in vain. A man would come along every day with a wagon to carry the people out” to the hospital, but her mother could not bear the thought of her son “carried among strangers to die.” Instead, she put her sick son in her arms and traveled on foot three miles to the nearest hospital with Virginia in tow. For the young girl, the destination was as harrowing as the journey. Upon reaching the hospital, Virginia remembered, “I was so frightened at the dead bodies that were lying on the ground, that I pulled away from my mother and started back home. I did not go very far before I was caught by one of the undertakers and carried back. It gave them a good deal of trouble to keep me quiet.” Clearly shaken by the scenes of death she encountered, the young Virginia was probably confused that a place marked by so much death was actually set up to save her brother’s life.

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63 Southern Workman, February 1881, 21; Catherine A. Jones, Intimate Reconstructions: Children In Postemancipation Virginia (Charlottesville: University of Virginia Press, 2015), 33-34.
Virginia’s letter was one of hundreds African Americans wrote describing the war’s impact on the health of their families. In letters to military and government officials black soldiers made clear their demands and expectations that the government help protect their families. They presented themselves as patriots, dedicated soldiers, and honorable men to highlight the indignities they faced in not being able to also fulfill their roles as husbands and fathers. These sentiments were clearly articulated by James Herney, who served in a postwar regiment stationed in Arkansas. Herney was proud of his service, he felt he had done all that was asked of him while on duty and in return expected his request to take a furlough and visit his family to be fulfilled. He wrote to the Secretary of War in 1866, “in August last I lost two of my children I asked for a leaf of absence and was refused.” This was not a unique incident, he informed the Secretary, but an experience many soldiers in his regiment shared, and overall black soldiers were less likely than whites to be paid and receive fair compensation for their service. Only one soldier in Herney’s regiment had been granted leave, the rest remained separated from their kin and some “throgh grief and anziety about their families have pined away and died.” Herney continued, “we stood on the bank and shed tears to think that we who had batled for our country over two years should still be retained and deprived of the privilege of seeing those who are so dear to us, my actions have proved that I have been true to my government and I love it dearley now the war is over and I now want to see those who are dearer to me than my life.”

64 Herney’s words are the words of a grieving husband and father. In offering his military service and demonstrating his loyalty as a soldier, Herney in turn expected the government to honor his request to be with his family during a time of need. And as he made clear, he was not alone in struggling to fulfill his ideals of manhood, fatherhood, and patriotic

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64 Black Military Experience, 778-779.
duty. His decision to register his grievances through a formal complaint to the government testified to the fact that he believed the government had a certain responsibility to provide for black soldiers and their families. And in this sense, letters like this are important sites of black mourning and protest, spaces where African Americans articulated their concerns and conveyed their frustrations over the suffering their wives and children endured.

Songs, too, served as way African Americans bonded over their shared experiences of enslavement and longing for deliverance, including freedom and protection for their children. A collection of black spirituals sung by the First South Carolina Volunteers, the first black regiment in the Civil War comprised of ex-slaves from South Carolina and Florida, included one song that the soldiers “sung plaintively over and over, without variety of words” at an infant’s funeral:

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\begin{align*}
& \text{De little baby gone home,} \\
& \text{De little baby gone home,} \\
& \text{De little baby gone along,} \\
& \text{For to climb up Jacob’s ladder.} \\
& \text{And I wish I’d been dar,} \\
& \text{I wish I’d been dar,} \\
& \text{I wish I’d been dar, my Lord,} \\
& \text{For to climb up Jacob’s ladder.}^{65}
\end{align*}
\]

In invoking Jacob’s biblical dream of seeing a stairway of angels descend from heaven to earth, the song portrayed the infant’s death as a crossing into heaven. The lyrics offered comfort and religious inspiration, reassuring those mourning that although they could not remain alongside “de little baby,” the infant had divine protection on its journey. Although the song is described by a white observer as one of mourning, the solemn performance traced back to slave

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communal traditions of singing and dancing that took place during funeral gatherings. At the same time, this vision of death as a journey to a heaven reflected the rising influence of Christianity in African American religious beliefs and mourning practices. Compared to the African-based burial rituals Charles Ball witnessed, these Civil War soldiers drew on a shared familiarity with the Old Testament and vision of a heavenly reunion. The idea of collective perseverance and soldiering on in faith is evident in the popular African American spiritual based on the same image of Jacob’s Ladder:

We are climbing Jacob’s ladder...
Every round goes higher, higher...
Do you think I’d make a soldier?...
Keep on climbing, we will make it...
Children do you want your freedom...
Soldiers of the cross

Why were a group of black soldiers present at an infant’s funeral during a time of war? The families of black soldiers sometimes lived nearby, and through events like funerals, forged communal networks in the face of the war’s upheavals. The migratory pattern of black women and children escaping to Union army camps was a major way African Americans began their journey to freedom and reconstituted family ties during the war. Accompanied by husbands, sons, brothers, and fathers or in search of them, fugitive black women and children made their way behind Union lines seeking protection and the companionship of male kin. Considered “contrabands of war,” a term typically used to describe property that in the context of the Civil War became synonymous with refugee slaves, black women, children, the elderly, and disabled made up a growing proportion of African Americans living on or near Union army camps as the

66 See Raboteau.
war progressed. For black women and children in particular, whom military officers often viewed as a burden and “nuisance,” the term contraband underscored their “transitional status” in the eyes of whites as neither property nor free, but dependents that were “something in between.” Yet once in camps, black women sought out work that would enable them to support their families.

While federal lines offered some measure of protection to refugee slaves, life on contraband camps was dangerous and deadly. Lack of proper clothing, shelter, and irregular access to rations left women and children vulnerable to disease, harsh weather conditions, and malnutrition. Outbreaks of smallpox and cholera epidemics struck slaves and freedpeople in parts of Washington D.C., North Carolina, South Carolina, Mississippi, Georgia, Louisiana, Arkansas, and Texas. African Americans living on contraband camps were also exposed to communicable diseases resulting from crowded living conditions and poor water sewage, with some military reports estimating mortality rates of twenty-five percent on camps. Mortality among very young children was considered even higher. Correspondence between military officials and reports from Northern missionaries included accounts of children freezing and starving to death. Children received half-rations of food, an amount considered insufficient for

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70 Schwalm; Glymph.
73 *Black Military Experience*, 397-398.
older children and nutritionally deficient for “the preponderance of very young children among the destitute and suffering.”\textsuperscript{74} A medical officer, reporting on the nearly ten thousand women and children who had set up “contraband family camps” along the Mississippi Valley, wrote that based on the diseases and general conditions he observed among young children, “their mortality in this wandering life, appears to be very great.”\textsuperscript{75}

Even efforts by refugee women to establish independent settlements beyond Union lines in order to control their economic and family lives remained vulnerable to threat. In January 1864, a community of women and children living in northern Virginia found themselves the target of a general’s orders to “clear out this village.” With no warning or time to prepare food or clothes for a winter journey, women and children were driven out of the settlement, the evacuation carried out so faithfully “that even a dying child was ordered out of the house.” As the wife of an army chaplain recalled of the scene, “the grandmother who had taken care of [the child] since its mothers death begged leave to stay until the child died, but she was refused.”\textsuperscript{76} Military efforts to drive families from camps, or separate children from their parents by allowing owners to reclaim them, were met with fierce resistance by African American men and women. One medical officer remarked that “they are bound together by family ties and will not willingly be separated. These attachments are not easily broken. In times of sickness and distress, they prefer assisting their relatives.”\textsuperscript{77}

\textsuperscript{74} Caleb W. Hornor, Surgeon United States Volunteers, Chief Medical Officer, Medical Department Report, Report of the Commissioner of the Bureau of Refugees, Freedmen, and Abandoned Lands, 39\textsuperscript{th} Congress, 1\textsuperscript{st} Session, Ex. Doc. No. 11.  
\textsuperscript{75} Families and Freedom, 60-61.  
Through efforts to provide medical care and decent burials to their children, African American parents demonstrated their commitment to bringing their families to freedom, a vision that encompassed the care of both the living and the dead. Northern abolitionist Laura Haviland recalled one Louisiana mother whose baby had been shot “in its mother’s arms” by a pursuing master. Undeterred, the mother continued the risky journey for freedom, reaching Union lines with the baby still in her arms to have her child “buried, as she said, ‘free.’” Another mother Haviland met had witnessed her husband and three older children be sold away, and escaped with her only remaining son to a Union camp in Cairo, Illinois, the southernmost part of the state where the Ohio and Mississippi Rivers meet. He became ill and when army officials began relocating contrabands to a different camp the mother held back. Her son had just died and she refused “to leave my chile on dis bare groun,” where “wharf-rats” swarmed the camp. She only left to better safety once Haviland swore her son would receive a proper, and prompt, coffin burial. A death could become an opportunity for newly emancipated parents to insist on their right to have their child buried using government resources. And Haviland’s accounts illustrate the ways in which the suffering and death of black infants became visible to Northern whites during the war, a visibility which laid the groundwork in reframing black infant mortality from a Southern plantation issue to a more national concern.

If there was a single event that highlighted the wartime sufferings of black children it was the November expulsion at Camp Nelson, Kentucky during the winter of 1864. Covering about four thousand acres along the Kentucky River, a county with one of the largest enslaved populations in the state, Camp Nelson was initially established in 1863 as a supply depot and

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79 Haviland, 246-247.
recruitment camp for white soldiers. By the following June military restrictions against black recruitment in the state had been lifted, allowing any black man, slave or free, to enlist. Within the first five months, nearly four thousand African American men answered the call and as they came, so did their families. While African American men could become free by enlisting, the status of their wives and children as slave or free remained uncertain, reflecting disagreements within the military and government about the status of refugee slaves, and Kentucky’s unique position in the war. Kentucky maintained a deeply fraught relationship with slavery, dating back at least to the Kansas-Nebraska Act of 1854 which allowed its residents to decide the question of whether to allow slavery in the territory. When it became a state just before the war, Kentucky was admitted into the Union as a free, border state despite the fact that it had a slave population of 225,483 slaves, which constituted a fifth of the state’s population.

During the war, Kentucky was officially neutral and loyal to the Union, a designation which meant that African Americans in the state remained legally enslaved, exempt from the 1863 Emancipation Proclamation which only freed slaves held in Confederate states “in rebellion” to the Union. And it was not until March 1865 that President Lincoln signed a law freeing the wives and children of Union soldiers. Thus as women and children in Kentucky fled slavery or were driven out by slaveowners, military officers at Camp Nelson struggled to manage a refugee population that grew quite quickly. Through the spring and summer, the army made several attempts to drive out the nearly four hundred women and children living on the camp, but

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81 Emancipation Proclamation, January 1, 1863.
many women resisted and would return to camp within days. By early November, rations for the refugees had been cut off. On Tuesday, November 22, Brigadier General Speed S. Fry issued a new order for government wagons to transport all refugee women and children beyond Union lines and for the contraband camp to be levelled. 83

Joseph Miller witnessed the expulsion firsthand. His wife, Isabella, and their four young children had accompanied him on the twenty-five-mile journey to Camp Nelson as Miller knew they would be “abused” by his former master if they remained behind. 84 When the order to clear Camp Nelson arrived, the timing could not have been worse, Miller’s young son was “very sick,” and the family was forced out into an unseasonably “bitter cold” and freezing rain. Miller pleaded with the soldier to spare his family, “I told the man in charge of the guard that it would be the death of my boy, I told him that my wife and children had no place to go and I told him that I was a soldier of the United States.” He wrote, “He told me that it did not make any difference.” Miller’s pleas for his son’s life to be saved, his family to be protected, and his military sacrifice to be recognized were all ignored as his wife and children were forced, at gunpoint and “poorly clad,” to board a wagon to leave. Miller followed them on foot as far as he could, and later that evening went in search of his family, finding them six miles away in Nicholasville at a black church. It was a sad reunion, Miller wrote, “I found my wife and children shivering with cold…my boy was dead.” For Miller, the cause of death was

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unmistakable, “I Know he was Killed by exposure to the inclement weather.” The next morning Miller returned to Nicholasville to see his family, including his dead son. He concluded his affidavit, “I dug a grave myself and buried my own child,” emphasizing his own actions in the face of the government’s indifference.

Although thwarted in his efforts to save his son’s life, Miller was still determined to properly bury his son. And in testifying in an affidavit Miller forced others to bear witness to the treatment he and his family suffered in the hands of the Union army. Moved by Miller’s account, Captain T. E. Hall forwarded the affidavit to several high-ranking military officers (it eventually made its way to President Lincoln) and the Northern press, where it was reprinted in the *New York Tribune* and William Lloyd Garrison’s *The Liberator*. The Miller family’s ordeals stood as a patent example of the “deliberate cruelty” black soldiers and their families endured. The public outcry over the tragic death of Miller’s son and others during the November expulsion was swift, and came from several fronts: the military, Northern benevolent organizations, missionaries, and the reading public. In response to the criticism, General Fry’s directive was countermanded and another order given to build a permanent Refuge Home for black women and children at Camp Nelson. While some of the refugee families originally driven out were able to return, the expulsion had proved fatal for the Miller family. By that January, Joseph, Isabella, and their three remaining children had all died.

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86 *Black Military Experience*, 269-271.
87 *New York Tribune*, 28 Nov. 1864; *The Liberator*, 9 Dec. 1864; Cadwallader Curry to Abraham Lincoln, December 5, 1864, Letters Received, ser. 2173, Department of Kentucky, Record Group 393 Pt. 1, NARA as cited in Murrell, 191-192.
88 Affidavit of Albert A. Livermore, 26 June 1865 as reproduced in Sears, 220-221.
As Union and Confederate armies struggled to attend to the mounting numbers of wounded and dead, the ability to provide proper burials to soldiers as well as civilians transformed from a problem of resources and logistics into an undertaking of increasing political and cultural significance. Hall, who oversaw the creation and management of Camp Nelson’s Refuge Home, knew the home was a needed haven for black women and children. To make his point, he explained to the Freedmen’s Bureau Commissioner that “the wife and child of a colored soldier cannot have a burial in some places in Ky [Kentucky],” and went on to describe an encounter when “a colored woman walked from Nicholasville six miles, bringing in her arms the body of her dead child because the Chivalry in Nicholasville, through prejudice refused it burial!” Outraged, Hall personally made sure the mother’s son received a decent burial. He closed his letter with an appeal for his report to be taken seriously and for further investigation, “Remember, I beseech you that this was the child of a soldier, and that soldier away from his family, in the field fighting for that Government that did not or could not protect the body of his own child from insult.”

Amidst the uncertainties Civil War introduced, African American men and women fought to claim their freedom and protect their children. Concerns about infant death and debates over the care of children emerged within the context of broader discussions about the conditions of contraband camps, the status of refugee slaves, and a desire among African Americans to see their children become free, even if that could only be achieved in death. These multiples meanings reflected the uncertainties inherent to times of war and the changing status of African Americans during the Civil War.

As the first part of the chapter demonstrated, during slavery the care of slave mothers and infants was a key concern that occupied slave owners, overseers, and physicians who sought to ensure the increased value of slave property. Following the war, however, whites increasingly objected to being responsible for the medical care of former slaves. As Gretchen Long has shown, labor contracts drawn up in the immediate post-war years documented the extent to which whites resisted providing medical care to black laborers and their families. Regarding black births, whites took a decidedly hands-off approach, a marked departure from their intense management of pregnant and nursing slaves in the antebellum period. They justified this shift by claiming that black women gave birth easily and did not require any assistance beyond the attendance of a family member or midwife, and to support their claims they turned to the science of pelvimetry.

The mid to late nineteenth century witnessed a flourishing of scientific fields that sought to classify and rank human races. Studies of the human pelvis developed alongside and in complement to scientific investigations of vital capacity (lung measurement) and cerebral faculties (measurement of skulls). Like craniometry, the science of pelvimetry was considered

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useful for classifying human races based on measured differences in skeletal structure. But whereas craniometry used skull size to rank human races based on increasing orders of intelligence, by focusing on the structure and function of the pelvis rather than the skull, pelvimetry became an important field for establishing differences in reproductive rather than mental capacity. As a method of human classification, pelvimetry was equally grounded in ideas about sexual and racial difference.

Pelvimetry relied on a series of internal and external measurements through physical examinations and the use of medical tools such as speculums, calipers, and the pelvimeter that enabled precise measurements of the pelvis from different angles. In the 1870s European and American scientists developed pelvic indices to group humans into types. African American

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were classified as having narrower and deeper pelvises, resembling the dimensions found among more primitive, ‘lower’ animals such as monkeys and gorillas.

**Figure 1.1**  
“Pelvis of African Negress”  

**Figure 1.2**  
“Pelvis of American Negress (Mulatto?)”  

**Figure 1.3**  
“White Female Pelvis”  


**Figure 1.4**  

*Skull of White Fetus (Tyler Smith)  
Skull of Negro Fetus.  

*A side-by-side comparison of white and black fetal skulls. In describing the ‘receding forehead’ and ‘peculiar dimensions’ observed in black skulls, Johnson notes “this shape of negro skull...is favorable to easy and rapid parturition.” Johnson, 13-17. Johnson reprinted the images from William Tyler Smith, The Modern Practice of Midwifery: A Course of Lectures on Obstetrics (New York: De Witt, 1858), 320.*
The rise of pelvimetry in the 1870s and 1880s was also driven by significant shifts taking place in American medical practice and physicians’ professional identities. At the time, “orthodox” or “regular” doctors faced intense competition from entrepreneurial quacks and healing sects such as homeopathy and hydropathy that offered alluring, alternative theories for restoring health and managing disease. Within such a crowded medical marketplace, doctors rallied around the idea that ‘rational’ knowledge grounded in observational and experimental sciences was the best method for determining medical treatment. Pelvimetry, with its specialized tools and anatomical knowledge, became part of the science of obstetrics that physicians drew upon to bolster their authority and professional legitimacy. At the same time, gender roles in medical practice were undergoing major shifts. Male obstetricians, especially those affiliated with hospitals such as Johns Hopkins, used pelvimetry to negotiate their way into the female-dominated birthing room by asserting that pelvimetric measurements were indispensable for understanding the mechanics of birth, especially the relationship between a mother’s skeletal structure and the fetus’s presentation during labor. Armed with such knowledge, obstetricians argued that they were best equipped to make informed decisions about how to prevent birth injuries and ensure the survival of both mother and child.

But physicians were not interested in attending all births. Rather, they used pelvimetric findings to argue that white women, specifically those from the “better classes of society,” needed medical assistance during birth. For black women, birth was characterized as “an act of

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97 Joseph Taber Johnson, “On Some of the Apparent Peculiarities of Parturition in the Negro Race, with Remarks on Race Pelves [sic] in General,” *American Journal of Obstetrics and Diseases of Women and Children* 8 (1875). Johnson, who was white, lectured at Georgetown and was an attending obstetrician at Freedmen’s Hospital in D.C. The source base for Johnson’s study is quite interesting: of the two thousand African American women whose case histories he
nature and not of disease.”

Physicians argued that black women, because of their experiences as industrious workers, had developed an “endurance” for pain; they were “hardy” and “courageous” and unlikely to be agitated by the pains of pregnancy and parturition. Black women’s births were “short and uncomplicated” events that progressed “naturally.” Accordingly, they only needed a midwife or family member to assist them during birth. In contrast, white women were delicate, easily “taxed and overburdened by the demands of fashionable society,” and more likely to become “hysterical” during childbirth. White women needed the assistance of trained doctors who could ease their “agonizing” pains through the use of anesthesia, and quicken a prolonged labor with the use of forceps.

The logic of pelvimetry fit neatly with craniometric ideas. Physicians argued that black women had easier labors not only because they had higher pain tolerances but also because the smaller heads of black infants passed easily through the pelvic cavity. White women suffered mentally and physically through labor because they had more delicate nervous systems and gave birth to infants who had larger brains. As one physician remarked in 1875, “the study of craniology suggests that the pelves through which the various crania pass, would be as distinctly characteristic of race as the skulls are themselves; that crania…be accommodated by harmonious

obtained, he personally observed five hundred at Freedmen’s, obtained details on seven hundred cases from two black physicians who practiced at Freedmen’s, and collected eight hundred more cases from black midwives.

98 Johnson, 3.
99 Johnson, 4, 10-11.
100 Johnson, 6-10.
race characteristics in the pelvis.”

Another physician noted, “a peculiar round shape of the pelvic cavity in the negro female and a corresponding limited development of the foetal cranium in the same race do render parturition, as a general thing, more easy in the negro than in the white race.”

Black mothers and infants experienced an easier and more ‘primitive’ birth. Some physicians went even further, asserting that the lack of pain during childbirth was one of the reasons why black women had too many children. While in the context of slavery such a racial trait would have been attractive to slave owners invested in having their female slaves produce multiple offspring, with emancipation the idea of black women having multiple children was considered a problem.

Physicians saw no contradiction in viewing birth as simultaneously natural and pathological since the distinction fell neatly along racial and class lines. In their eyes, African American births were natural, physiological events requiring little to no medical care whereas births among wealthy white women were more akin to disease and demanded the attention of a trained physician. Through this dualistic framing physicians ascribed new, racialized and class-based meanings to their decisions to medically manage births. Yet even as white physicians worked to absolve themselves of any responsibility towards treating black women, the field of pelvimetry remained deeply reliant on the procurement of black women’s bodies.

Studies from the 1870s and 1880s drew heavily from reported observations of African Americans, Africans, Africans.

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102 Johnson, 88–123.
and Malays. Obstetricians in the late nineteenth century complained about the lack of available “Negro pelvises” compared to the relative abundance of human skull collections. Even into the twentieth century studies such as the one conducted at Johns Hopkins University in 1918, relied entirely on autopsies of black women who had died in the hospital’s obstetrical ward. One obstetrician in 1897 explained his decision to include black women in a study by noting, “it is important to know how often we may expect trouble from a deformed pelvis.” Many physicians echoed the necessity of studying black pelvis types, but their discussions of black delivery cases made clear that their preferred course of action when it came to an African American woman giving birth was to take no action at all, and instead let nature runs its course.

In this sense, pelvimetry became one of the tools physicians used to justify their disengagement from managing black health. No longer enlisted and paid by slave owners to ensure the increasing value of slave assets, white physicians felt no responsibility towards caring for African Americans and instead made it clear that their professional duties had shifted to prioritizing the health needs of white women who could afford their services. This position left black mothers and their newborns vulnerable to injuries and diseases that required medical attention, while also perpetuating ideas that black maternal and infant deaths were due to

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106 The details given of the women’s causes of death are slim, and may have purposefully been so as Williams mentions that for two of the reported cases the black women died after “conservative” Cesarean sections were performed. One of the women died from a fatal infection caused by improperly sterilized surgical dressings. John Whitridge Williams, “A Consideration of Some of the Anatomical Factors Concerned in the Production of Deformed Pelves,” American Journal of Obstetrics and Diseases of Women and Children, May 1, 1918; 77, 5: 714-748.
biological deficiencies rather than inadequate health care. Yet by the early twentieth century, physicians would find themselves once again renegotiating their relationship to black births, a shift that will be explored in chapter three. As physicians became increasingly hostile to other practitioners attending births, they sought to persuade black women to stop relying on lay midwives and instead seek the care of physicians, thus reopening debates about the relationship between the medical profession, childbirth, and the management of African American women’s bodies.

Pelvimetry offered a conceptual framework that linked birth outcomes to anatomical differences by race, rooting ideas of racial degeneracy in the black female skeleton. While this field of obstetrical science was largely the domain of physicians, the ideas underlying pelvimetry intersected with larger discussions of black health. Just a few years after the war’s end, scientists, social scientists, and physicians began to suggest that certain diseases and social problems were on the rise among African Americans. They cited census reports and drew on new social Darwinist ideas to demonstrate the black race’s numerical decline and argue that “in the struggle for race supremacy the black race is not holding its own.” The political motives and implications of these claims were unmistakable. For a nation still deeply divided over the place and status of emancipated African Americans, ideas that blacks’ newly won freedom was detrimental to their health held powerful appeal. The recent publication of Darwin’s Descent of Man (1871) bolstered this way of thinking about human evolution. One physician claimed, “too

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much liberty and freedom, so far as the laws of health are concerned, is dangerous to the mental and physical integrity” of the race.\textsuperscript{110} No amount of Northern efforts to assist African Americans could counteract evolutionary forces, and any efforts on the part of blacks to press for political rights were useless. African Americans were headed towards an inevitable extinction, a forecast that provided a natural solution to a political problem.

One of the most influential advocates of this extinction theory was Frederick Hoffman, a German-born statistician and actuary at Prudential Insurance Company based in New Jersey, whose use of statistics to demonstrate black biological inferiority dominated turn of the century racial discourses.\textsuperscript{111} In an early publication, “Vital Statistics of the Negro” (1892), the 27-year old Hoffman outlined his interest in studying the “race problem from the standpoint of vital statistics,” a task that he emphasized was not easy given the limited data available on blacks, especially in southern states. The slim source base, however, did not hold him back from making sweeping claims. In analyzing figures from six Southern cities – Washington D.C., Memphis, New Orleans, Savannah, Charleston, and Richmond – Hoffman attributed higher rates of stillbirths, infant, and maternal mortality among African Americans to the “deteriorated physique of the colored female.”\textsuperscript{112} He drew from two data points, rates of stillbirth and illegitimate births,

to demonstrate African Americans’ constitutional weakness and moral degeneration, and argue that “the penalty” of these tendencies was “premature death.”\footnote{Ibid., 541.} He concluded the article with the provocation that “the time will come, if it has not already come, when the negro, like the Indian, will be a vanishing race.”\footnote{Ibid., 542.} Hoffman spent the next four years gathering more statistical data on African Americans to expand on this bold claim, and in 1896 came out with *Race Traits and Tendencies of the American Negro*, a 329-page report published under the auspices of the American Economic Association. It was the same year as the U.S. Supreme Court’s ruling in *Plessy v. Ferguson*, upholding the “separate but equal” doctrine that would deeply shape black experiences of segregation and discrimination into the twentieth century. Whereas in “Vital Statistics of the Negro,” Hoffman made no mention of his background in *Race Traits and Tendencies* he emphasized his German heritage in an effort to establish himself as an objective, unprejudiced outsider. He amassed an impressive amount of data culled from census reports (especially the eleventh census of 1890 which showed the black population as a decreasing percentage of the overall population), medical reports from the Freedmen’s Bureau and the U.S. Sanitary Commission (which oversaw the medical treatment of Union soldiers during the Civil War), anthropometric tables comparing white and black bodies, and figures on morbidity, mortality, illegitimacy, incarceration, and illiteracy. Across all these sources, Hoffman identified what he believed were clear indicators that blacks were dying out. And he argued that this trend was not influenced by environmental or social conditions, but subject to fixed biological laws. He wrote, “it is not in the conditions of life but in the race traits and tendencies that we find the causes of excessive mortality.”\footnote{Hoffman, *Race Traits and Tendencies of the American Negro*, 95, 148.}
Hoffman’s work received broad support from white social scientists, physicians, and politicians. *Race Traits and Tendencies* was cited as a model of dispassionate, statistical research. It signaled the beginnings of a shift away from studies of racial difference that had first emerged within economies invested in minimizing the risks of slave labor, and towards the embrace of statistics, and with it new ideas of risk, in new economic systems of insurance and government bureaucracies.\(^{116}\) Public figures such as Du Bois and the black sociologist Kelly Miller were among the few contemporaries to criticize the work, both men recognizing the damaging implications of Hoffman’s thesis on African Americans. Still, African Americans could not dispute the work’s wide appeal with one review in the *Southern Workman* noting that *Race Traits* stood as “the most important book that has been written about the Negroes of this country since Uncle Toms Cabin.”\(^{117}\)

Statistical data showing trends in mortality rates stood at the center of Hoffman’s claims. For him, reports of “excessive” mortality among African Americans provided the most “indisputable” evidence of their imminent extinction.\(^{118}\) To justify his belief in the importance of statistical data he quoted Arthur Newsholme, a leading British figure in public health, with saying “mortality statistics surpass all other vital statistics in importance, whether they are considered from a social, actuarial, or sanitary standpoint.”\(^{119}\) Hoffman singled out the “enormous waste of child life” among blacks, writing, “an excessive infant mortality, such as we meet with among the white population in all parts of the country, has at all times been the

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\(^{117}\) “Friday Morning Session: Review of Mr. Hoffman’s Work” *The Southern Workman and Hampton School* September 1897, 180-181, Box 29, Folder 248, Frederick L. Hoffman Papers, Columbia Rare Book and Manuscript Library.

\(^{118}\) Hoffman, *Race Traits and Tendencies of the American Negro*, 37.

\(^{119}\) Ibid., 33.
concern of the philanthropist and economist, but nowhere else do we meet with such a frightful infant mortality as we find prevailing among the colored population of the large cities, both North and South." \(^{120}\) It was within this context that an emerging statistical discourse increasingly focused on the “race tendency of premature death” as a sign of African Americans’ poor health and degeneracy.

Laid to Rest: The Politics of Black Mourning

In *Race Traits and Tendencies* Hoffman offered his interpretation of black funeral customs, writing that whoever “has witnessed the pauper funeral of a negro, the bare pine box and the common cart, the absence of all that makes less sorrowful the last rites over the dead, has seen a phase of negro life and manners more disheartening perhaps than anything else in the whole range of human misery.” By stressing the “inhumane apathy” of black funerals, Hoffman sought to cast African Americans as devoid of any cultural values for honoring their dead. \(^{121}\) It was a damning assessment that, when combined with his views on racial extinction, portrayed African Americans as biologically and culturally degenerate. Hoffman’s findings directly impacted African Americans’ ability to get industrial insurance, a popular form of insurance in the late nineteenth and early twentieth centuries that many families bought in order to protect against a pauper burial. \(^{122}\)

\(^{120}\) Hoffman, *Race Traits and Tendencies of the American Negro*, 45, 68-69, 117, 311.


\(^{122}\) Hoffman, *History of the Prudential Insurance Company of America (Industrial Insurance) 1875-1900* (Newark: Prudential Press, 1900), 209. The problem of how to protect against infant deaths plagued many American insurance companies in the late nineteenth and twentieth centuries. Viviana Zelizer has noted that Metropolitan Life did not insure children in the first
For African American parents like Du Bois who could afford to, holding an elaborate funeral ceremony for a child had personal meaning and stood as a political response to critiques that they cared little for their dead. When the eighteen-month-old Burghardt died, he was laid to rest in a white casket that traveled from Atlanta to Mahaiwe Cemetery in Great Barrington, Massachusetts on a carriage drawn by gloved hands. The funeral services cost Du Bois seventy-seven dollars, a considerable portion of his thousand-dollar professor salary. On the way North he encountered whites who looked disdainfully on his son’s funeral procession. For Du Bois, the funeral’s expense and aesthetics were testaments to his grief and insistence that the proper resting place for his infant son was “in soil where my fathers for more than two centuries lived and died.”

Though they lived at very different moments in the century, Du Bois and Charles year of life until the 1920s when infant mortality rates began to decrease and that black children were not insured until 1881, and received lower benefits than white children. In the 1920s North Carolina Mutual, the largest black-owned life insurance company which specialized in industrial insurance, noted similar difficulties. A 1923 memo to the company’s field agents included the following disclaimer, “Great care must be exercised in the selection of Infantile risks, as the mortality during the first year of life is extremely high. During 1922, we paid a large number of Death Claims on Infants that had only been insured a few weeks, and in some cases, a FEW DAYS. Quite a number of these were sick at the time policy was delivered.” Agents were advised to “personally see infant before writing the application.” The company went on to develop charts listing how much families would be paid out for infant deaths, distributing smaller amounts for infants that died between the age of three and six months (three months’ old was the minimum age to be eligible for insurance) and slightly more for infants that died between six months and one year old. See “Infantile Insurance,” Bulletin No. 8, February 2, 1923, Field Bulletin Book No. 1, 1922-1957, Box 4-D; for underwriters’ pocket charts see Box OV4, North Carolina Mutual Life Insurance Company Archives, David M. Rubenstein Rare Book & Manuscript Library, Duke University, North Carolina; Viviana A. Zelizer, Pricing the Priceless Child: The Changing Social Value of Children (Princeton: Princeton University Press, 1994), 250, n45.


Ball drew on a shared understanding of their duty as fathers to bury their infant sons in a way that tied them to an ancestral home. Through rituals to prepare an infant for its return to Africa, journeys on foot to bury a child in free Union soil, and elaborate funeral processions to lay a child to rest in the North, African Americans in the nineteenth century traveled great distances to ensure their infant children were buried according to their beliefs and visions of freedom.

An 1897 song by the African American songwriter Gussie Lord Davis offered a slightly different take, presenting a more a tragic portrait of black infant death:

Figure 1.5

Away down South, I chanced, one day, to see a fun’ral start,
’Twas in the poorer section of the town,...
And by a little coffin that lay on a common cart,
A colored woman sat with head bow’d down,...
“It’s only one less nigger baby, they don’t count, down here”
Was what somebody near me roughly said,...
But as the weeping mother sat beside that clay, so dear,
Those words bro’t me a different tho’ instead...
It was only a nigger baby, But altho’ its face was black...
That mother would have given all the world to have it back, ...
And tho’ nobody else would miss it, ...
Her heart was filled with woe, ...
For tho’ only a nigger baby, 
It was dear to its mother I know

Not one, in all the world, so wide, except it’s mother there, 
Cared aught about that bit of lifeless clay, ...
But ah! to her naught ever could replace her treasure rare, 
That ’neath the ground would soon be laid away, ...
She’d lov’d him with a mother’s love, the love we all have known, 
The love that draws no color line, ah no!...
And tho’ none shar’d her grief, and she was sorrowing alone 
Still one heart mourn’d that little child I know...  

One of the most commercially successful songwriters of his time, Davis made his mark in the world of Tin Pan Alley, a collection of New York City based songwriters and music publishers that dominated American popular music in the 1890s. This group of mostly white artists popularized the genre of piano-based ballads whose easy melodies found fans among amateur singers and families eager for songs to perform for home entertainment. In what has been described as the “golden age” of the sentimental ballad, some of the most popular Tin Pan Alley hits were “child songs,” melodramatic stories of neglected children, deceased parents, and domestic tragedies that typically sold for a few cents a copy.  

Two of Davis’s biggest hits were written in this style, with “Fatal Wedding” (1893) telling the story of a society wedding that ends with the tragic deaths of both the groom and his infant, and “In the Baggage Coach” (1896), describing a father traveling with a crying infant who cannot be quieted down despite complaints

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125 Raymond A. Browne and Gussie L. Davis “Only a Nigger Baby,” music score, 1897, Music Division, New York Public Library for the Performing Arts.
from fellow passengers. Upon learning that the infant is crying because its mother lies dead in a casket “in the baggage coach ahead,” the passengers’ annoyance turns to pity and sympathy. The song was a huge success, selling over a million copies.\(^\text{127}\) One music critic wrote of Davis, “In an era of sing-‘em-and-weep melodies, Davis did more than his share to open up the tear ducts of America.”\(^\text{128}\)

Thus, by the time he wrote “Only a Nigger Baby,” Davis had already made a name for himself in the commercial music world of “tearjerker” sentimental ballads. “Only a Nigger Baby” pushed the genre’s bounds, portraying the death of a black infant as the ultimate tragedy of a young life gone and ignored by society. The stranger’s remark that the baby does not “count” underscored the idea that black infants were of little value, and not seen as worthy of sympathy or attention. It served as a commentary on this late nineteenth century moment, in which African Americans encountered many fatalistic theories projecting their demise, lending a sense of hopelessness for the race. It is also a decidedly worldly song. In contrast to the spiritual ascent hoped for in “Climbin Up Jacob’s Ladder,” the lyrics emphasize the earthly dimensions of death, with the infant figuring as a form of “lifeless clay” buried “‘neath the ground.” Davis disdained spirituals, regarding them as commercially risky and unsuited to the tastes of his female fans who wanted “refined” songs to perform in their home parlors. And he also considered African American spirituals to be old-fashioned, noting in an 1888 interview “the day


of Negro and jubilee songs is over.”

The song offers no religious consolation of life beyond death, rendering the baby’s death as an end and abject loss.

At the same time, Davis uses the image of the weeping, lone black mother to remind his female fans, as Harriet Jacobs had similarly done in her narrative, that black mothers love their children and deeply mourn their deaths, “a mother’s love, the love we all have known, the love that draws no color line.” There is no indication that this song was a hit, but given Davis’s popularity the sheet music was probably displayed in store windows. Even for those who did not purchase the song they would have seen the sheet’s cover image and title, demanding audiences to have pity for a child’s death even if it is “only a nigger baby.” In this sense, Davis used the sentimental ballad genre to redefine the black infant as a figure deserving sympathy, and his efforts signaled a widening concern for the welfare of all babies that would come to define the turn of the century Progressive Era.

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This chapter began in a period when enslaved African Americans struggled to care for their infants within a slave society that valued infant lives as mere products of slave reproductive labor that would increase in worth over time. Slaveowners enlisted physicians to help protect these assets, yet they also weighed the costs of medical care against the reality that few infants survived the early years of life. Despite the efforts of masters and overseers to control all aspects of infant care, including the time newborns had with their mothers, slave communities innovated forms of child care to protect their youngest and establish kin ties across multiple generations.

129 Davis, Wright, and Lucas, “Gussie Lord Davis (1863-1899): Tin Pan Alley Tunesmith,” 191
Emancipation was a watershed moment in reconfiguring black family life and infant care. Exploring black parents’ efforts to claim their children, secure medical treatment, and ensure their children were properly buried highlights the multiple routes they pursued to bring their children to freedom. No longer in bondage, African Americans faced new challenges in the decades following the war, including scientific theories questioning their ability to survive as freed people. And in that sense African American could not fully escape the question Harriet Jacobs posed as a free black woman looking back at her experiences. As the nineteenth century drew to a close, many African Americans found themselves revisiting the question of whether the freedoms they hoped for themselves and their children could be realized amidst the oppressive conditions they faced in the post-war South. For some, the answer lay in migration. As African Americans began to pursue new economic and living opportunities in cities further north, they carried their ideas about freedom, family survival, and child welfare with them to these new places.
CHAPTER TWO

Networks of Care

Urban Strategies of Black Infant Welfare

In the fall of 1893 a young African American woman named Ida left her home in Culpeper, Virginia for Washington D.C. She traveled the seventy miles not in search of a job but to a secure a bed at Freedmen’s Hospital, the closest public hospital that admitted black maternity cases. There, she gave birth to a healthy son named Daniel. Receiving no support from Daniel’s white father and without any family nearby to help her, upon leaving the hospital she sought relief from the Board of Children’s Guardians, Washington’s newly established agency for aiding dependent and destitute children. Founded less than a year before, the BCG took in all children, regardless of race, and placed them with families or institutions that could provide care. It quickly became a key institution that struggling African American mothers like Ida turned to for assistance at a time when most relief agencies in the city only served whites.

For Daniel to become a ward of the BCG, he and his mother had to appear in court where their case of destitution was presented before a judge. In making his ruling, Judge Miller was sympathetic to the need to ensure the newborn received good care, but was less forgiving of the unmarried parents’ actions. He was frustrated with women like Ida, “from the surrounding country [who] come to the city, dispose of their offspring, and then leave.” In his mind it was the latest, troubling example of African Americans migrating to the nation’s capital and bringing with them a host of problems, including babies born out of wedlock and in need of charitable

1 Case #150, Record of Children Received, July 4, 1893–January 5, 1912, Board of Children’s Guardians, Record Group 351, National Archives, Washington D.C. (hereafter, BCG).
2 Circular No. 1, Office of the Board of Children’s Guardians, Nov. 5, 1893, 3.
relief. The practice of “shifting illegitimate colored children upon the District,” Judge Miller declared, was becoming “too common.”

Reserving some blame for Daniel’s absent father, the judge remarked that if he “could lay hands on the father of the child” he would “send him up the full extent of the law.” As the judge was well aware, black women were often the ones left responsible for raising children. But despite his reproaches, the judge recognized that Ida and Daniel needed help and ruled for the BCG to temporarily assume custody.

The BCG placed the pair with Maria McGuire, a black nurse who resided in the Southwest quadrant of the city and earned ten dollars each month to board and feed them. In February BCG Agent Herbert Lewis visited the home to check on Daniel and Ida, observing that the arrangement was “a good example of what can be done by placing mother and child together. He is thriving well.” McGuire provided a stable home, and Ida and Daniel remained there through June when they were then placed to live with another black nurse, Delilah Woodford, in the Northwest quadrant. But that placement was short-lived. Just four days after relocating and at the age of seven months, Daniel died of spasmodic croup, a respiratory disease.

Daniel’s short life illuminates the strategies and controversies concerning infant welfare that emerged in Washington D.C. at the turn of the century, and their relation to anxieties about black migration, maternal responsibility, and the politics of charitable relief. This chapter traces the history of the BCG from its creation in 1892 to its demise in 1926, examining the agency’s approach to infant care and drawing on an analysis of 374 of the 3,042 children the organization

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4 “Judge Miller Grows Wrathy: Case of an Illegitimate Child Aroused Him to Caustic Criticism” *Washington Post*, Dec 15, 1893, 10. The newspaper account incorrectly notes that baby Gray was born in Virginia.
5 Case #150, BCG. This is one of very few of BCG cases where the mother and infant were placed together, typically only the child was put to board.
served. This selection comprises all the black infants (defined by the BCG as 24 months or younger) committed to the agency’s care, and these cases stand out because whereas children above the age of two were placed out with individual families or institutions, black infants were placed in the care of an extensive network of black “district nurses.” At a time when the city’s foundling asylums and children’s hospitals did not admit black infants, the BCG developed a system for caring for the city’s youngest African Americans, many of whom were children of migrants. The agency’s records provide important details of these infants’ lives including the grounds for commitment, family circumstances, incidences of sickness, and causes of death, shedding light on the everyday realities of black babies and the people who cared for them. Examining these records reveal that as the agency’s influence grew, it increasingly saw its mission of child saving to be at odds with keeping black families together, a view grounded in racialized assumptions about what constituted a suitable family and home setting. African American families turning to the BCG for temporary help with child care increasingly found their families separated, and the ensuing controversies reflected different ideas about the kind of assistance the government should provide. By the 1920s, both parents and government officials saw the BCG as an inadequate solution to preventing infant mortality and the broader problem of child welfare, reflecting the limits of a municipal response grounded in late nineteenth century ideas of charity and poor relief.

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As a border city straddling the North and South, Washington was a major thoroughfare for black migration. Thousands of African Americans came to the city during the Civil War, and during the early decades of the twentieth century many more made their way to and through Washington as part of the Great Migration, in which approximately a million African Americans moved from the South to urban areas in the mid-Atlantic and Great Lakes regions. The capital city drew its share of young black women who came for domestic service jobs, contributing to a steady rise in the city’s black population from 38,663 in 1860 to 86,702 in 1900, and 109,966 in 1920. African Americans migrated out of the rural South for a range of reasons, and in the process, they gave birth, got sick, lived and died. There is a rich scholarship exploring the

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economic and social motivations and experiences of black migrants, but few works have considered how matters of health and illness shaped their journeys and expectations, or where African Americans like Ida turned for help. This chapter offers one perspective through examining efforts to safeguard black children’s health in Washington at a crucial moment in the growth of the city’s black population.


Discovering the “Alley Baby” in Washington’s Black Neighborhoods, 1875 – 1906

Washington’s earliest responses to African Americans moving to the city focused on creating institutional structures to address black health needs, including for black children. In the mid nineteenth century, many African Americans coming to the city were refugees seeking freedom and protection. A local paper reported in February 1862, “Some 25 or 30 contrabands came across the Potomac and through Georgetown to this city yesterday. Most of them were women and young children, and the sight was one to excite the sympathy of the lookers-on at their apparently helpless condition.”\(^\text{11}\) The following month the Freedmen’s Aid Association was established to “furnish assistance and protection to the large number of contrabands, who are flying to Washington for refuge.”\(^\text{12}\) As blacks continued to migrate to Washington, the city established Freedmen’s Hospital and soon after, the National Association for the Relief of Destitute Colored Women and Children was founded to provide aid for “aged or indigent colored women and children,” including receiving “any destitute child or children at the request of the parents or guardians, or next friend, or the mother, if the father be dead, or has abandoned his family, or does not provide for their support.”\(^\text{13}\)

The increase in the city’s black population prompted new levels of investigation into black health and living conditions.\(^\text{14}\) When municipal health officers wanted to study what they referred to as the “alarming” mortality rates among African Americans they decided, in 1875, to

\(^\text{11}\) *Washington Evening Star*, February 13, 1862.
\(^\text{12}\) George M. Kober, *Charitable and Reformatory Institutions in the District of Columbia* (February 14, 1927), 204.
\(^\text{13}\) An Act to incorporate the National Association for the Relief of destitute Colored Women and Children, 650 Thirty-Seventh Congress Session III. CH. 32, 33. 1863.
meet with a delegation of black clergymen. It was a meeting that garnered “considerable interest” among the black Washington elite, and black religious leaders seized on the opportunity to outline the health challenges facing the poor and working class in the city, mainly, lack of adequate food, fuel, and medical attention. Given government inattention to these concerns, black benevolent societies and churches often stepped in to look after families suffering from sickness or poverty. But rather than respond to these concerns, city officials directed attention instead to the death rate among illegitimate colored children, as they viewed cases of illegitimacy as a moral failing, health problem, and financial burden on the District. The medical sanitary inspector noted that of the 302 burials paid for by the city, 286 were for blacks and almost two hundred of those were for “illegitimate children.” In addressing the issue of illegitimacy both Reverend Robert Johnson of Metropolitan Baptist Church and Reverend William J. Walker of Shiloh Baptist Church pushed back against claims that rates of illegitimacy among blacks reflected a racial tendency for immoral behavior. As the moral stewards of their congregations, which totaled near a thousand members, they asserted that the problem did not exist among their congregants and, further, that incidences of illegitimate births were not “confined to the colored population.”

City officials remained convinced that blacks experienced unique health and social problems, and traced the source of these problems to the alleys where many African Americans lived. The attention to alleys was one part of a broader Progressive-Era interest in housing reform and social investigations of health, as seen for example in the contemporaneous discovery

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of tubercular “lung blocks” in urban areas across the country.\textsuperscript{17} A brief look at the construction and evolution of Snow’s Court Alley serves as a useful reference for understanding the rise of alleys in Washington and the social and public health responses to this new urban space. Snow’s Court took its name from the wealthy publisher Chauncey Snow, who in 1860 built a greenhouse and several smaller frame houses behind his residence in the Foggy Bottom area.\textsuperscript{18} He rented out the homes to Irish workers, including some who worked for Snow. At the time the city barely counted fifty inhabited alleys, with most occupied by white laborers, but as the city’s population began to rise in the post Civil War years, both the number of alleys and the racial composition of the alley population underwent dramatic shifts.\textsuperscript{19} Property owners attuned to the growing need for cheap housing carved out larger properties and converted former backyards and stables into residences to rent out. The number of inhabited alleys grew three-fold by the 1870s and reached 187 by 1880. The city experienced a boom in alley construction with nearly 2,500 alley houses built between the early 1880s and 1890s.\textsuperscript{20} By 1897 the local police department conducted its first census of the city’s inhabited alleys.\textsuperscript{21}

Poor and working-class blacks who, because of financial means, job demands, or discrimination, could not find housing in other neighborhoods, rented out rooms in alley residences. A typical residence faced into an interior alley that one gained access to by a narrow entrance and path, typically less than thirty feet wide. Alley houses were two stories high, built

\textsuperscript{17} Samuel Roberts, \textit{Infectious Fear}, 107-137.
\textsuperscript{18} Daniel D. Swinney, “Alley dwellings and housing reform in the District of Columbia,” (PhD, The University of Chicago, 1938), 70.
\textsuperscript{21} \textit{Report of the Metropolitan Police Department of the District of Columbia}, 1897, 63-68.
as simple frame or brick structures directly on the ground, meaning floors could easily become subject to flooding and sewage spills. The interior consisted of several small rooms, often with a rear yard. Outdoor hydrants provided running water and box privies were set up as common bathrooms, as individual houses lacked direct sewer connections. In 1896 an average room rented for four dollars a month, and by 1905 rooms cost between six to nine dollars. The population of alley residents peaked in the early 1890s with over 18,000 people – representing eleven per cent of the city’s population – living in the city’s three hundred alleys. Alleys were segregated from the beginning, but over time they became inhabited predominantly by blacks. By the 1890s black alley residents made up nearly a quarter of the city’s black population, and ninety-three percent of alley residents were black. Snow’s Court exemplified the changes occurring throughout the city, as the largest alley in the Foggy Bottom area in 1905 it had over 230 residents, all of whom were black.

Alleys were considered “festering sores” on the city, and as they grew in number, local officials and reformers increasingly viewed the “alley problem” as not only an inadequate housing situation, but also a social menace. Hidden from street view, the intricate layout of alleys and their reputation as dangerous spaces, alarmed reformers who saw these concealed spaces as breeding grounds for a host of social evils including alcoholism, illegitimacy, idleness, uncleanliness, juvenile delinquency, violence, and crime. The city’s Board of Health reported on

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23 de Graffenried; Weller, 99.
25 Swinney, 72.
26 Mallalieu, 69.
epidemics emanating from alleys and spreading their “black wings over the homes of the whole city,” going on to note, “our experience in dealing with filth, crowd-poison and disease among the people during the past four years has taught us that…Better far to provide for the aged and sick in public institutions of charity, the vagrant in the chain gangs, let the cost be what it may, than to allow them to remain, propagators of public disease, an incalculable expense to the District.”

Even without explicitly mentioning race, the reference to “black wings” highlighted concerns about contagion spreading across the color line. Rates of whooping cough, pneumonia, and tuberculosis were reported as also almost twice as high for blacks living in the alleys compared to those living in the “streets” (the term officials and investigators used to distinguish between the “hidden” world of blind alleys and the front-facing housing on city blocks), with the high prevalence of these respiratory diseases attributed to lack of fresh air, direct sunlight, and clean water.

The suffering experienced by infants stood out as well, with visiting nurses reportedly known to “groan whenever they hear of anyone moving” into alleys like Snow’s Court, which had acquired the reputation as a “peril” to infant life.

Concerns over the alleys as spaces of poor health and high mortality reached such acute levels, by 1906 the city’s health officer began collecting data that noted whether deaths took place in alleys or street dwellings, and did so for infant deaths as well. While newspaper coverage suggested that infant mortality rates were much higher in the alleys than in the streets, surveys the city conducted revealed that the mortality experience was actually quite similar, with roughly thirty percent of all African American babies dying within the first year of life regardless

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29 Mallalieu, 70.
of where they lived. Health officials reconciled this find by arguing that though they aimed to be comprehensive, an undercount of alley deaths nonetheless existed due to difficulties in canvassing the highly mobile population of alley residents. Surveyors may have been primarily interested in tallying incidences of death and sickness, but their house-to-house visits also had the potential to draw attention to overcrowding and structurally unsound residences that could in turn lead to alley residents being evicted or buildings being condemned. Already in tenuous living situations, black alley residents would have had good reason to avoid opening their homes to unnecessary scrutiny. Given the suspicions over what kinds of information were being collected and for what purposes, statistics on alley health and mortality conditions cannot be taken at face value. Yet, the decision to track mortality by race, age, and residency, as seen in the below table, does illuminate the ways local government officials saw the city’s alleys, infant welfare, and black population as interrelated, and that they believed statistical reports to be a key tool for future intervention.

Figure 2.1

<table>
<thead>
<tr>
<th>Age</th>
<th>Death rate.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 1 year</td>
<td>97.50</td>
</tr>
<tr>
<td>1 to 4 years</td>
<td>14.08</td>
</tr>
<tr>
<td>5 to 14 years</td>
<td>2.18</td>
</tr>
<tr>
<td>15 to 19 years</td>
<td>2.39</td>
</tr>
<tr>
<td>20 and over</td>
<td>16.70</td>
</tr>
<tr>
<td>All ages</td>
<td>13.05</td>
</tr>
</tbody>
</table>

An example from 1912 of the city’s efforts to track death rates by race and geographic space. Report of the Health Officer, 1912, 142.

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30 DeGraffenried, “Typical Alley Houses In Washington.”
The solid blocks represent inhabited alleys, many of which are in the Northwest quadrant of the city where the majority of the city’s blacks lived. Thomas Jesse Jones, “The Alley Homes of Washington,” *Survey*, October 19, 1912.

The figure of the “alley baby” emerged amidst these growing debates over the causes and circumstances of the city’s high mortality rates.\(^\text{31}\) Seen as victims of rapid urbanization and inadequate public health surveillance, descriptions of an infant nursing on a consumptive mother’s “wasted breast” and of “pitiful skeletons dying with marasmus” juxtaposed infant life against a backdrop of hunger and disease.\(^\text{32}\) An officer of the Associated Charities of D.C. said of the alley infant mortality rate, “the mental picture of their corpses, if one imagines them collected in the burying grounds, suggest lurid war scenes and the aftermath of battle.”\(^\text{33}\) The picture seemed even more frightful for black infants, for whom rates of infant diarrhea were

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\(^\text{32}\) Weller, 21-23.

\(^\text{33}\) Weller, 31.
twice as high in alleys than in streets. One disease in particular – *atelectasis pulmonum* (a partially or completely collapsed lung) – that struck black infants at higher rates was believed to be due to the poor living conditions in alleys, particularly the “vitiated air” that made it difficult for infants’ respiratory systems to properly develop. These reports on alley babies directed the public’s attention to the circumstances of birth and death for the city’s poor and working-class.

Part of what made the alley baby such a poignant symbol was the fear that it lived in a “hidden” world out of reach from charitable aid and government surveillance. Descriptions of babies born in “blind” alleys (dead-end passageways) evoked images of young lives geographically and socially isolated from the rest of the city. Newspaper accounts of abandoned babies discovered in alleys underscored a perception of these concealed spaces as centers of crime and death. In social reform magazines such as *Survey*, which described itself as “A Journal of Constructive Philanthropy,” scholars such as Thomas Jesse Jones, a white sociology professor who taught at Howard University, pointed to the inadequate police surveillance in the city’s sprawling network of interconnected alleys. For progressives, the brief life and death of the alley baby galvanized a need to physically and metaphorically “open” the alleys to reform. National figures such as photographer and social reformer Jacob Riis, who visited Washington’s alleys in 1903, urged Congress to “think of the awful mortality that exists among the colored children here. Nearly one-half of them die. There is not such an exhibit in the

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34 157.3 (out of every 100,000 black infants) living on the streets compared to 309.5 for black infants in the alleys. D.C. Board of Health, *Report of the Health Officer of the District of Columbia*, 1909, 93.
civilized world. It is scandalous to say the least.”\(^3^8\) While the alley baby was not always explicitly racialized, given the association of alleys as black residential enclaves and the city’s higher black mortality rates, the assumption that an “alley baby” referred a poor, black baby went largely unquestioned.\(^3^9\) Through photography and investigative reports, reformers worked to expose alley conditions, considering it the first step toward improving the city’s health and safety. The image of the alley baby carried much of this campaign for increased scrutiny and surveillance, a characteristic technique of progressives to drive social reform by arousing an outcry of public alarm.\(^4^0\)

The black press saw the issue differently, arguing that reforming the alleys meant more than just child-saving, but tackling the city’s practices of housing discrimination. In contrast to the coverage in white newspapers and social surveys, the *Washington Bee*, the city’s leading black paper at the turn of the century and one which prided itself on its coverage of black elite society, highlighted the work of black civic leaders, especially ministers and clubwomen, in improving alley conditions. Characteristic of black self-help initiatives of the time, black organizations such as the Alley Improvement Association – formed in 1908 by Reverend J. Milton Waldron of Shiloh Baptist Church and Francis J. Grimké, a Presbyterian minister from the well-known activist family – oversaw programs aimed at the “industrial, moral, and spiritual

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\(^3^8\) “Slums of the City: Jacob Riis Tells Congressmen of Local Conditions,” *Evening Star*, December 16, 1903, 1; Groves, 271.

\(^3^9\) This assumption is also evident in Weller’s study he contrasted the “Average Alley” in the city with the “White Alley.”

uplift” of black alley residents.\(^{41}\) Black clubwomen ran day nurseries, Sunday Schools, and held Mothers’ Meetings in Blagden Alley and Willow Tree Alley, two of the city’s largest alleys where blacks lived, to support working mothers and their families.\(^{42}\) While the *Bee* applauded the charitable work of black leaders to uplift the “lowly” alley population, the *Chicago Defender* and the Baltimore-based *Afro-American*, which also covered black Washington news, drew attention instead to the obstacles facing poor and working-class blacks.\(^{43}\) Due to racial discrimination, many blacks were forced to live in alley residences, but as both papers pointed out, reform efforts to abolish alleys made no provisions for alternate places for blacks to live.\(^{44}\) Even the *Colored American*, a magazine aimed at a black elite readership, argued that blacks were victim to multiple forms of discrimination as the very people who “banded together not to rent homes to respectable colored people” were the same ones who “complain[ed]” about blacks living in alleys like Willow Tree and left “many a tot” to grow up amidst “filth and immorality…and vagrancy.”\(^{45}\) In holding whites responsible for creating the “alley problem,” the *Colored American* distinguished between different classes of African Americans that lived in the city, contrasting “respectable” black families who struggled to gain access to decent neighborhoods with black “vagrants” who had no “visible means of support” and inhabited the alleys. The coverage in black newspapers reflected competing ideas over how to represent Washington’s


\(^{42}\) “Helping the Poor,” *Washington Bee*, March 19, 1910, 4.


black community, ideas that had their roots in anxieties about class differences and black urban life. The different approaches black and white newspapers took to framing the alley problem puts in relief the ways the alley baby was simultaneously imagined to be a victim of a poor environment and “submerged” community, a target of racial uplift, and the casualty of a discriminatory housing system.46

Through newspaper coverage and investigative studies, social reformers worked to transform what was initially seen as an problem of cheap housing into an alarming issue of child welfare. Attempts to abolish alleys dated back to the 1890s, but the legislation passed in the late nineteenth century remained unenforced by local government and ignored by private developers. However, by the early twentieth century, the campaign gained momentum aided by the involvement of prominent figures such as Riis, and ultimately rising to a level of importance to capture the attention of President Woodrow Wilson’s first wife, Ellen Wilson, who made several tours of the city’s alleys in 1913-1914 and pressured Congress to pass legislation eliminating alleys.47 Such efforts succeeded in converting some alleys into open streets and playgrounds, but the biggest factor that led to a decrease in alley houses were new modes of transportation including cars, and with them the construction of garages in alleys, and an expanding city streetcar system that enabled residents to live further away from their places of work.

As late as 1923 the alley baby still symbolized the high mortality facing blacks such that in an address to the National Urban League, an official from the Children’s Bureau remarked that the nation’s high black infant mortality rates could be traced to higher death rates among

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46 On alleys as “submerged” communities see Weller, 11.
“children born in rear houses or houses on alleys than among those born in houses on streets.”

Yet despite this remark by a federal official, for the most part the image of the “alley baby” had largely retreated from public view in the mid 1920s as the alley population substantially declined.

A Charitable Beginning: The Board of Children’s Guardians in the 1890s

In the late nineteenth century as Americans struggled to understand what children’s lives, livelihoods, and deaths meant in an increasingly commercial and urban nation, a number of individuals and organizations became invested in preventing early death. The BCG was created within this moment of heightened interest in child welfare, including the specific concern for alley babies. The idea for the agency came from Amos Griswold Warner, an economist and social worker at Johns Hopkins who had developed statistical approaches to studying social problems and in 1891 was appointed by President Benjamin Harding as Washington’s first Superintendent of Charities. One of Warner’s first tasks was to convince Congress, notoriously reluctant to appropriate funds for the District’s municipal administration, that an organization should be created to focus exclusively on the needs of the city’s poor, orphaned, and neglected children. In contrast to existing religious and private organizations this public institution would place no restrictions on children’s eligibility for relief, making it a model municipal institution to other states. Warner succeeded in persuading Congress to establish an agency “for the

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50 Amos G. Warner, American Charities (New York: Thomas Y. Crowell Company, 1908), v-xv. New Jersey established its BCG in 1899, the city of St. Louis did in 1911.
reception and distribution of all children, both white and colored, under sixteen years of age, who become dependent upon the public for support and protection.”

This new agency’s concern over the welfare of alley babies came through in statements that it stood ready to help “every child, white or black, sick or well; from the abandoned infant from the ash-pile or city dump to the reckless girl on the ragged brink of ruin.”

In its early years the BCG cared for a few hundred children, and by the 1900s that number reached a peak of over two thousand. A considerable portion of wards were admitted as babies, some just a few days old, leading one judge who reviewed applications for commitment to remark, “I feel like the superintendent of a nursery.”

The board consisted of nine men and women appointed by judges from the police and district courts to serve terms of up to three years, without compensation. In addition, the board received funds from Congress to employ two agents who oversaw the agency’s placement of children. From the $24,200 the agency received from Congress for 1893 and 1894, the agency set a portion aside specifically for the care of “children under three years of age, white and colored.” In a pamphlet describing its functions, the BCG made clear that it had the power to assume permanent legal guardianship, but acknowledged a willingness to consider requests to have children restored to their families, seeing “the breaking up of a home and family relations [a]s one of the worst things which can come into a child’s life.”

51 An act to provide for the care of dependent children in the District of Columbia and to create a board of children's guardians, July 26, 1892, 27 Stat. 268.
52 Circular No. 1, Office of the Board of Children’s Guardians, Nov. 5, 1893, 10.
53 Kober, 43.
54 “Quieting Eleven Infants Keeps the Court Busy,” Washington Post, Oct 5, 1912, 14
55 Digest of appropriations for support of Government of U.S., on account of service of fiscal year ending June 30, 1894; and of deficiencies for prior years; made by 2nd Session of 52nd Congress Date: July 01, 1893, 102.
56 Circular, 10.
Figure 2.3

Black Infants Committed to the BCG, 1893-1913

<table>
<thead>
<tr>
<th>Year</th>
<th>Cases</th>
<th>Year</th>
<th>Cases</th>
</tr>
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<tbody>
<tr>
<td>1893</td>
<td>9</td>
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<td>1894</td>
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<td>1897</td>
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</tr>
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<td>1898</td>
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<td>1899</td>
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<td>1910</td>
<td>13</td>
</tr>
<tr>
<td>1900</td>
<td>29</td>
<td>1911</td>
<td>17</td>
</tr>
<tr>
<td>1901</td>
<td>23</td>
<td>1912</td>
<td>11</td>
</tr>
<tr>
<td>1902</td>
<td>19</td>
<td>1913</td>
<td>5</td>
</tr>
</tbody>
</table>

In the intake volumes, there are no existing records for infants and children committed to the BCG in 1908.

The BCG was unique in that it took in black infants, a group doubly discriminated due to their race and young age by many of the city’s existing charities. While other institutions, formally, stated that they accepted black infants, the reality was quite different, as demonstrated by the comments of a St. Ann’s Infant Asylum administrator who maintained that the asylum “never refused the admission of any foundling on account of race or color” but went on to explain that applications for “colored foundlings” were, nonetheless, always rejected. “We have to employ a number of wet nurses for nursing children, and whilst we may regret the fact that any race prejudice should exist, yet we are compelled to recognize it as a fact, and it is apparent that the necessary help could not be had, if it should be attempted to keep white and colored
children in the same wards.”

While the administrator sought to blame wet nurses for the asylum’s policy, her comment revealed that the institution was just as unwilling to amend its practice of segregating infants by race. A similar situation occurred at the Children’s Aid Society, when in 1898, denied congressional funds to erect a separate building for colored admissions, the organization ceased accepting black children altogether. For institutions that did not discriminate based on race, they typically only admitted black children above a certain age. The age minimum reflected the expectation that black children placed out in private homes or institutions would earn their keep by performing household chores, farm labor, or industrial training. As one asylum officer commented, “no householder will take into his family a colored child except as a servant and with the intention of getting a full equivalent for what he gives.”

Given such reasoning, black infants were considered of little value, too young to contribute productive labor and not worth the costs of upkeep. Thus, even as more charities at the turn of the twentieth century began to direct their attention to the welfare of children, black infants remained underserved.

In its own work, the BCG encountered difficulties placing black children in schools, hospitals, and other institutions. An 1897 annual report provided “additional evidence of the lack of facilities for the proper care of colored children,” noting that “of the 124 children for whom [Agent Wilson] secured admission to the institutions without the intervention of the Board of

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59 *Report of National Association for the Relief of Destitute Colored Women and Children* (1898), 363; District of Columbia Committee on Appropriations (1894), 182-183.
Children’s Guardians and the courts, 18 were colored and 106 white. Of the 20 in whose behalf he sought the assistance of the Board and the courts, 19 were colored and 1 white.”61 Without the BCG and judges to mediate, black infants and children were rarely granted admission into children’s institutions. The color line governing child welfare was especially clear in instances when newborns appeared white when taken in, but their race “changed” as they grew older. A surprising discovery of an infant’s “true” racial identity completely changed the caregivers’ and institutions’ willingness to assume its care, with nurses and adoptive families returning infants who turned out to be a different race than presumed, and institutions removing infants from their facilities who turned out not to be white.62

This crisis of black infant care was exacerbated because outside of the BCG, institutions serving black infants and children had very high death rates. The Colored Foundling Home, in operation until right before the BCG was established, had a mortality rate of over fifty per cent in its final year of operation in 1892. And while St. Ann’s did not take in black newborns, it did admit young black children up to the age of six in its care. Two physicians who consulted for St. Ann’s noted that the mortality varied with age, “but was necessarily high.”63 A report summarizing the asylum’s activities provided a particularly bleak account:

Of the whites, 38.4 per cent and of the colored, 45.4 per cent, [of deaths] occurred within fifteen days after their admission to the asylum; of the whites 63.4 per cent and of the colored 77.2 per cent died within one month; of the whites 75 per cent of the colored 95.4 per cent died within two months. The average of white

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62 See for example, “Foundling ‘Changes’ Color in Hospital,” Washington Post, Mar 14, 1928, 8.
descendants [sic] was sixty days at entrance, while that of the colored was but thirty-seven days. 64

Such high death tolls were nothing out of the ordinary for foundling asylums in Washington and across the country, as many young children often arrived in a precarious state: malnourished, sick, and suffering from exposure. As the report indicated, for most children, being housed in an overcrowded asylum with other sick children meant that their conditions continued to deteriorate rather than improve during their stay. By the early twentieth century, child welfare reformers were writing off foundling homes as “failures,” referring to the infants kept there as “inmates” and asserting “the mortality rate in these institutions [is] frequently enormous.” 65

BCG officials severely criticized foundling asylums for their mortality rates, claiming the decision between placing a baby with the BCG versus a foundling asylum was as serious a matter as deciding between life and death. Far from providing safe havens, Agent Lewis argued, foundling asylums were more like death sentences for babies. 66 Such statistics mattered to those concerned with the District’s black infant death rates. Five-sixths of the infants the BCG took in were black, and overall it took in more black infants and children than all other local institutions that admitted African Americans, including the National Association for the Relief of Destitute Colored Women and Children, which had about a hundred children in its daily care, and the Children’s Hospital, which had ninety-two beds. 67 In a pamphlet describing its work the BCG

65 Mangold, 470.
66 “Entitled to the Child: Little Edward Cook Turned Over to the Foundling Hospital, An Order Made by Judge Miller Today – The Little One Taken From the Children’s Guardians,” Evening Star, January 1, 1894, news clipping found in Children’s History, 1893, vol. 1, BCG.
noted, “It is said for the foundling asylums that they prevent infanticide and save mothers. We doubt it. Too many mothers turn their backs upon their babes, well knowing that they will die, and the moral effect upon them is precisely the same as though they had quenched the spark of life at birth with their own hand.”68 As the agency saw it, not only did foundling asylums fail in their aim to save the lives of young children, they also failed in their mission to prevent infanticide and abandonment. At least some parents agreed with the characterization of foundling asylums as hazardous places for their children. One news article from 1894 described a mother who tried to remove her infant from the foundling hospital upon seeing that it looked “as though he were nearly dead” and place him instead in the care of the BCG.69

Why did the mother believe the BCG could better care for her child? In accounting for how the BCG’s infants fared better than those placed in foundling asylums, Agent William Redwin Woodward explained that infants were placed out according to a system: no two children under the age of two were put in the same home and “colored children were placed with colored women and white with white nurses.”70 This arrangement grew out of an experiment the BCG began in late 1893, when the agency started placing all nursing babies “in the hands of hired nurses” to provide “skillful medical attendance.” The results proved “highly successful,” with infant mortality rates that were less than half of what transpired in foundling asylums.71 Before Congress Agent Woodward confidently reported that the agency had an infant mortality rate of

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68 Circular, 8; “Denied by Dr. Sowers: The Foundling Hospital Death Rate is Low,” Washington Post, Jun 6, 1898, 8.
69 “Entitled to the Child: Little Edward Cook Turned Over to the Foundling Hospital.”
70 Note that Woodward refers to black caregivers as women, but distinguishes white female caregivers by calling them nurses. “Attack on Hospitals: Children’s Guardians Point to Death Among Foundlings. Claim Their Method is Better.”
twenty percent, a better record of infant survival compared to other institutions of the period but one that still reflected the precariousness of the early years of life. The leading causes of infant death were from communicable diseases such as tuberculosis and pneumonia that took a heavy toll on African Americans in Washington. Black infants were also susceptible to deadly infectious diseases, especially gastro-intestinal diseases such as marasmus and cholera that spread through unclean water and milk formulas.\textsuperscript{72}

Black District Nurses: Institutional and Communal Networks of Infant Care, 1900s-1910s

The extensive network of black district nurses who cared for these young wards was a key component of the agency’s success. District nursing, first developed in England by philanthropist William Rathbone and Florence Nightingale in the 1860s, trained nurses to go into poor districts and conduct home visits.\textsuperscript{73} In the U.S. such nurses could be referred to as district,\textsuperscript{72}

\textsuperscript{72} An analysis of the black infants taken in by the BCG from 1893-1913 shows that 109 (29.1\%) did not survive past the age of two and 38 (10.1\%) died late in childhood. A staff of doctors and nurses made sick calls, and most likely provided the cause of death when it was recorded in the BCG’s files. At some point in 1900s, the agency hired a black physician to oversee the children’s care, noting that the hiring decision was based on the fact that a majority of the wards were black. Around the same time the BCG began setting aside a few hundred dollars annually for burial costs. Report of Commissioners of District of Columbia, Appropriations and Estimated Budget for 1905-1906, 651; Paul J. Taggart, Medical facilities for the colored in the District of Columbia (Wilmington: Press of William N. Cann, Inc., 1940).

public health, or community nurses, and were assigned to city districts, specific neighborhoods, or parishes. The BCG’s district nurses were among the first black women to work in this field, a specialty that across the country had been previously been limited to white women. Jessie Sleet, considered one of the first black district nurses in the country, was a graduate of Chicago’s Provident Training School for Nurses who pursued additional training at Freedmen’s Hospital in Washington. In 1901 she was hired to be New York City’s first paid African American district nurse. In her first few months working as a district nurse, Sleet described a case of a twenty-eight year old mother who was partially paralyzed and unable to care for her thirteen-year old daughter. Sleet convinced the mother to let a “respectable family” look after her daughter, enabling the mother to be hospitalized for further care.\(^74\) Sleet’s account depicts the multiple roles black district nurses took on as part nurse and part social worker. Through the pioneering work of nurses like Sleet and district nurses working with the BCG, new professional opportunities for black women opened. By the late 1920s Adah Belle Thoms, a co-founder and president of the National Association of Colored Graduate Nurses, felt confident in asserting that district nursing, which had the reputation as a field of nursing closed to African American women, was “now an established specialty for colored nurses.”\(^75\)

The BCG relied on a network of 164 black district nurses, almost three quarters of whom lived in the Northwest section of the city. Washington police officers sometimes referred to them

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\(^75\) Thoms, 17.
as “precinct nurses,” suggesting that multiple municipal agencies relied on these women. Rather than go into homes and conduct visits, BCG nurses took in infants into their home for care and supervision. Given how many women were employed by the BCG it is probable that they had varied levels of training, especially since in the 1890s very few nursing schools trained black nurses.\textsuperscript{76} BCG district nurses likely participated in nursing courses at teaching hospitals like Freedmen’s or had a demonstrated record of providing good lay care that brought them to the attention of city officials. Whether they were trained via a formal course of school instruction or other methods, the women identified themselves as nurses. In the 1900 census, BCG nurse Mary Randolph is identified as a “nurse,” and the 1920 census listed BCG district nurse Sarah Robinson’s occupation as “board nurse.”\textsuperscript{77} BCG agents and local newspapers consistently referred to them as district nurses as well, indicating a form of distinction and a specific title that came with their role. Their special designation is reflected in the fact that they earned between eight to ten dollars a month for each infant they took into their care at a time when black women who privately boarded children earned closer to five dollars a month per child.\textsuperscript{78} By the late 1910s the BCG maintained a network of over three hundred white and African American nurses who earned up to nineteen dollars per month and lived throughout the city.\textsuperscript{79}

The BCG’s district nurses took in babies with small chances of survival, some having been abandoned only hours after being born and requiring a significant amount of care such that

\textsuperscript{76} When the BCG began boarding infants in 1893 only four black nursing schools existed in the country – Provident, Hampton, Spelman, and Tuskegee. Freedmen’s Nursing School was founded in 1894. See Hine, \textit{Black Women in White}, Appendix Tables 2-4.
\textsuperscript{77} \textit{Washington, District of Columbia} census entries from ancestry.com.
\textsuperscript{78} The agency’s circular noted that white and black infants “will be placed with women who will nurse them for a sum per month to be agreed upon in each case.” Circular, 8.
nurses usually cared for only one infant at a time. There is no record of BCG officials penalizing or investigating a nurse if an infant died under her care, but officials did keep track of which nurses provided good care and which did not. One nurse sought to adopt a girl she had boarded, but her request was denied with the BCG citing “the poor work done by applicant while she was a nurse for the Board.” For the most part, however, the black district nurses employed by the BCG stood out for their skilled work. One such nurse was Mary Randolph who, between 1894 and 1912, cared for twelve black infants committed to the BCG, and even more who were abandoned in the city and brought to her home by police officers and neighbors. Women like Randolph were well-known within their community for their nursing work, and provided much-needed services for black women and children. While waiting for a train at the city’s grand Sixth Street depot, a “settled colored woman” approached Isabella Johnson and asked Johnson to watch over her two-week old infant while the mother went to ladies’ room. Hours later the mother still had not returned and Johnson decided to take the infant to the home of Mary Reed, another black district nurse who worked with the BCG and who lived about a mile and a half away. From there, Reed notified the authorities about the abandoned infant’s case. This was just one of many examples of black residents relying on district nurses to assume the care of abandoned babies, practices that demonstrate the overlap between the city’s lay and institutional approaches to safeguarding children.

Thus, while the BCG positioned its infant care strategy as innovative and experimental, what is striking is that echoed a communal system of child care African Americans living in Washington already practiced. The parallels between these two systems become clearer if we

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80 Case 1128, BCG.
81 Case 2250, BCG.
consider the health reasons why black women migrated to Washington, and once there, how they balanced the demands of work and infant care responsibilities.

Most black infants taken in by the BCG were born in Washington but had at least one parent born outside of the city. Expectant black mothers traveled from surrounding areas of the Upper South, especially Virginia and Maryland, to Washington to give birth and seek professional medical care. At the turn of the century, sixty percent of black women who gave birth in Washington were attended by a physician either at a private home or in an institution. That number would rise to eighty per cent by 1915. Yet, through to 1920 roughly two-thirds of black women continued to give birth at home, the high statistic reflecting the fact that there were a limited number of beds available in the city’s hospitals for black maternity cases. Freedmen’s and Garfield hospitals accounted for a large share of the city’s black births, with smaller numbers of black women going to Columbia Hospital for Women and Lying-In Asylum and the Homeopathic Hospital as well. These hospitals worked closely with the BCG. When one of Dr. William Alonza Warfield’s patients died in Freedmen’s Hospital while giving birth, the African American physician contacted the BCG to take the orphaned baby. Similarly, a month after giving birth Elizabeth Butler, a live-in servant originally from Maryland, developed a rapidly growing tumor and was taken to Freedmen’s for an operation. With an unlikely chance of survival her infant daughter was placed with the BCG.

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84 Case 1130, BCG.
85 While they did not constitute a large share of admitted cases, a number of black infants came to the BCG through similar channels, based on relationships the BCG maintained with local institutions. See for example case nos. 64, 196, 380, 526, 879, 1382, BCG.
When black women travelled to Washington to give birth, their trips could last several months as they extended their stay in the city by living with relatives or taking up rooms in boarding houses. For those who gave birth at Freedmen’s, women like Ada E. Spurgeon, a missionary from the Church of the Epiphany who worked in the maternity ward, helped black mothers secure places where they could board with their babies after being discharged from the hospital. In the final month of her pregnancy in 1912, Maude Robinson travelled over sixty miles from her home in Markham, Virginia to Washington to be confined in Garfield Memorial Hospital. She stayed with her sister Martha, who lived about a mile away from the hospital, for a total of seven months before and after she gave birth before returning home. In 1922 when Belulah Nelson’s parents found their daughter was having a relationship with a man they disapproved of in their hometown of Maytonsburg, South Carolina, they sent her up to Washington to live with her older brother. Her mother justified the decision as a precautionary measure, saying, “she been with that boy and soon she’ll ‘get big.’” Whether the decision was their own or made by family members, for some women and young girls, being pregnant could be enough reason to leave home. This was a reality that black communities across the country faced. In cities like Pittsburgh with an active National Urban League that connected new migrants to available lodging and needed medical services, black parents made use of these local networks, seeking advice on maternity homes that could take in their young, unwed daughters.

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87 Case 3211, BCG.
Black women knew that being in good health would enable them to not only manage the journey north, but also the demands of securing employment and supporting a family. A 1917 letter written by a hopeful migrant to the *Chicago Defender* made this clear “Dear Sir: I am a good cook age 35 years...I am in good health so I would like for you to send me a transportation. I have got a daughter and baby six months old so she can nurse so I would like to come up there and get a job of some kind. I can wait table cook housegirl nurse or do any work.”90 As the mother’s letter indicated, black women looking for employment were largely limited to opportunities in domestic service, and some were recruited to Washington specifically for that purpose.91 When Signora was ten years old she was brought from her home in Nelson County, Virginia to work as a live-in servant in a private D.C. home. There, she was forced “to work very hard” and was paid no wages. At the age of fourteen she became pregnant by a white man, and her employer reported the baby to the BCG, asking that Signora’s parents in Virginia take charge of the newborn. The employer claimed the girl’s family was “wretchedly poor” and “immoral,” but nonetheless insisted that separating the baby from its mother was the best solution. In some ways the BCG agent agreed, recording in his notes that, “Signora is well-grown and robust. Can do a good deal of work and would be valuable in any house.”92 But the agent also considered

92 Case 1885, BCG.
what Signora wanted, and she asked to be removed from working under her current employer and instead placed with the employer’s daughter who agreed to take her in. Although she was not able to keep her baby, the young mother got herself out of an exploitive environment where she was clearly subject not only to relentless work but also vulnerable to sexual predation.

Domestic service jobs were demanding, and for many female migrants securing a position also meant arranging for their children to be watched over during the day, or even up to weeks at a time. The chief surgeon at Freedmen’s took pains to note that although many of the black women who gave birth in the hospital were unmarried, far from being “bad women” they were “industrious” workers, many employed as domestic servants and supporting their children on “scanty earnings.” Of the 44,424 African American women and older girls (at least ten years old) living in Washington in 1910, sixty percent were gainfully employed. This included over thirteen thousand who worked as servants, over seven thousand employed as laundresses, nearly five hundred midwives and nurses, and ninety-six women who ran boarding houses. By 1940, of the 34,568 African American women employed in Washington, seventy-two per cent worked as servants. Given the high numbers of black women who were employed, finding good child care was essential. As one newspaper reported, “where so many colored women had to work, they should be provided with places where their children could be cared for, instead of having to board them at other places.” One mother described being so nervous with leaving her older

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93 Purvis, Report of the Freedmen’s Hospital, 1886.
children to watch over her baby during the day that, “When any one rings the door bell at the house where I am working, I always jump; I get so nervous a thinkin’ that some one has come to tell me about something awful that has happened to my baby.” 97 Another mother who tried to return to work four days after giving birth, quickly became sick and ended up back in the hospital. Her husband had gone to Chester, Pennsylvania just before their daughter was born, leaving the new mother alone. The BCG agreed to take care of the infant girl for thirty days while the mother recovered to a “condition to again earn money for herself and baby.” 98 That month of assistance proved enough time for the mother’s health to improve so she could bring her baby home, but as both the agency’s statement and its decision not to track down the father made clear, black women were fully expected to be able to support themselves and their children.

To meet these responsibilities, black female migrants recreated family networks and home communities in the North. For newly arrived female migrants, one of the first roles they took on was caring for the babies and young children of other black women who worked during the day. When she left Alabama for Washington in 1911, Sadie Jones first lived with relatives in Willow Tree Court. As she remembered, “when you first come here…you raised up your peoples’ babies and all.” 99 Isetta Peters recalled that as soon as she arrived in Washington from South Carolina in 1922 her sisters and cousin who worked as live-in servants quickly set her up to work. The day after she arrived she “watched the childrens,” she remembered. “That’s right,

97 Weller, 35-36.
98 The infant, taken in on the grounds of “destitution of suitable home,” died a week later from meningitis. Case 2770, BCG.
the next day. Oh they’d always be other peoples’ babies with your peoples for you to mind.”¹⁰⁰

As the eldest of ten, Isetta grew up caring for her younger siblings, and being charged with watching over the infants of female kin offered a continuity to the gendered roles she was used to performing back home, but now did in a new environment. As both women’s experiences illuminate, this form of communal childcare was not ad hoc, but part of a highly-coordinated system of supporting black female migrants. Sisters and cousins would be sent “up from home,” Peters explained, to mind children during the day. “Whoever had somebody that’s where all them left they babies. See, they all had to work so they all helped bring up somebody to watch the babies.”¹⁰¹

For those who arrived in the city without family to rely on, boarding houses were important sites of child care. Whites thought poorly of such infant care arrangements with reports describing black women who, working away from home for twelve to fourteen hours each day, “farmed out” their babies to the “hovels of old women who keep themselves out of the poorhouse by nursing boarded babies in a half-hearted, ignorant, deadly way.”¹⁰² While some boarding arrangements did resemble baby farms with multiple infants watched over by a single woman, the reality was that boarding babies during the day was a common and economically viable practice, one that enabled both working mothers and landladies to earn a living.¹⁰³ Mothers who placed their infants to board typically paid between three and six dollars per month, which included the cost of milk. For older or crippled women, or those otherwise unable to work

¹⁰⁰ Clark-Lewis, 79-81.
¹⁰¹ Clark-Lewis, 41-42, 80.
¹⁰² Weller, 35-36.
service jobs, boarding children could provide a steady source of income. In 1904, Annie Diggs left her baby Edgar in the care of Lucy Tyler, a “cripple,” when he was a few weeks old. Although she did not leave any money for his care, Diggs wrote to Tyler a few months later from Fredericktown, Maryland asking that her son be placed in a home, and Tyler soon after turned the baby over to the BCG. And in April 1910, a sixteen-month-old girl came to the BCG’s attention who had been looked after since she was two weeks old by Hattie Haynes, an “old colored woman who has been making a business of boarding babies.” The private economy surrounding the boarding of black infants led one newspaper to remark “there are colored women scrambling for the care of the board’s children.” With communal networks, institutional charitable services, and private economies all providing different forms of child care, disputes and ambiguities over who should assume the responsibility of infant welfare could arise, especially in cases of abandonment.

Rescuing the “Abandoned Baby”

Abandoned infants posed a problem for Washington police and public health officials. Over a third of black infants brought under the BCG’s care were abandoned, and many of them did not survive past their first years of life. Washington police, on average, discovered between ten to twenty abandoned infants and recovered the dead bodies of nearly a hundred infants each year. Police investigations rarely resulted in arrests of the person(s) responsible, and as such,

104 See for example case nos. 1052, 1128, 1536, 2599, BCG.
105 Case 1536, BCG.
106 Case 2599, BCG.
108 Report of the Major and Superintendent of the Metropolitan Police Department, see years 1897-1909.
abandoned infants typically appeared just as short newspaper notices of unsolved crimes. Yet as Elna Green has suggested, black communities may have maintained certain codes of silence surrounding cases of infant abandonment, alerting police to abandoned infants out of concern for the infant’s wellbeing, but unwilling to provide any further details that could result in continued police investigation and harassment.\textsuperscript{109} City officials saw the problem along racial lines, with one report stating “the abandonment of infants to die or fall into the hands of the police has been traced to servant girls who were unable to keep their children with them while at work, and the cases of still-birth are said to have been due to heavy lifting and overwork, particularly among negro women.”\textsuperscript{110}

Yet classifying an infant as abandoned was a contested matter. When “a tall colored woman” called at the home of Victoria Johnson asking to leave her child while she sought treatment at Georgetown University Hospital and never returned, BCG officials labelled it “a clear case of abandonment.”\textsuperscript{111} But the term abandonment implied an act of neglect and rejection, and many parents resisted such a characterization of their behaviors. In June 1910, Rachel Carter left her three-week-old newborn with a woman while she ran errands as she felt her baby “would be sick” from the sun’s intense heat. When Carter returned, she discovered the police had removed her baby and it had been temporarily committed to the BCG on the grounds of abandonment. Denying that she had any intention of deserting her child, within a few days the mother and infant were reunited, the board’s records noting that Carter “seems fond of the child.”\textsuperscript{112} And when a three-month-old baby boy was left on a door step it was not so much a

\textsuperscript{110} Ingle, 99-101.
\textsuperscript{111} Case 1470, BCG.
\textsuperscript{112} Case 2667, BCG.
case of abandonment, as the BCG initially concluded, but the result of a parental dispute in which the unmarried mother left the infant at the father’s home “to make him realize his duty” to support his child. The quickness with which officials moved to characterize these incidents as cases of abandonment reflected underlying assumptions about African Americans as irresponsible parents unwilling to support their children.

Given the difficulties in locating the parents of an abandoned infant, the conditions in which an infant was discovered provided crucial clues, as a baby abandoned in public was often a carefully constructed act. Signs of illness, malnourishment, exposure, and abuse were important pieces of evidence in determining an infant’s past circumstances and assessing its chances of survival, which the BCG classified in three ways: life, death, or doubtful (often if there were clear signs of malnutrition or exposure to intense hot/cold weather). In 1907, a newspaper notice described a ten-day-old newborn found in an alley. Tucked between garbage boxes, the black infant girl was dressed in linens and lace, with a pink ribbon. The paper reported that the quality of her clothing indicated “the parents had spared no expense” in signaling the kind of home the foundling came from and would hopefully be taken into. The baby was brought to Lucy Jackson, a district nurse who had been caring for the BCG’s black infants for the past thirteen years. Leaving a baby in an alley was a location unlikely to attract the attention of white police, yet at the same time it was a public space, making it likely that an infant would be discovered by black residents relatively quickly. Reports of abandoned babies found in alleys in the early morning hours by domestic servants, watchmen, and milkmen testified to the fact that even such “hidden” spaces were part of the daily landscape where many African Americans lived.

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113 Case 3141, BCG.
and worked. Some parents made use of the city’s geography by leaving babies in alleys and wealthy, “fashionable” neighborhoods along with instructions for the kind of care they wished for their offspring. A note pinned to a one month old boy asked that he be named Lucien. Other babies were found with notes such as, “Please take good care of this baby,” and, “I can’t keep my infant longer; two mouths to feed is too much of a drain on my pocket. I hope and pray God will take care of it, as I can’t.” While seen as the ultimate sign of neglect, even a criminal act, abandonment could also be a survival strategy, a way parents tried to give their children a better chance at life. Placed in locations where they would likely be discovered and receive skilled care, some abandoned infants were meant to be rescued, not left to die.

The BCG had a complicated relationship with abandonment. On the one hand, the number of alley and abandoned babies the BCG took in was consistent with the agency’s mission of saving children. A clear narrative runs throughout the records of BCG agents rescuing babies from “wretched” and “immoral” alley homes and placing them in the care of nurses. Agents believed these “pretty” and “attractive” babies could have “bright” futures if they were first removed from the alleys. And yet, the agency also played a role in creating the very circumstances that led to cases of abandonment and destitution. Several records document mothers going to the board seeking relief, being denied or referred to another agency, and subsequently the infant coming to the BCG’s attention as an instance of abandonment. In the case of baby Kenneth, his mother Helen had traveled from Burke’s Station, Virginia to give birth at Freedmen’s Hospital. Upon leaving the hospital she placed the newborn in the care of

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116 Case 1146, BCG.
118 See for example case nos. 2212, 1065, 606, BCG.
Sadie Coleman, paying ten dollars to cover two months’ board. When the mother failed to return, 
Coleman took the eight-month old to the BCG seeking relief. The BCG refused to help as 
Coleman had “admitted going to Freedmen’s and soliciting children to board,” and she was told 
“she must keep the child.” Unsatisfied with the agency’s decision, she stopped looking after 
the baby and alerted the police when he started to show signs of malnourishment. With the baby 
in the hospital, BCG agents finally agreed that the agency should take over the infant’s care.

The BCG saw its role as rescuing children, but black families had different expectations 
for the kind of assistance the BCG should provide and negotiated to secure the relief they sought. 
In July 1912 Emma Green dragged her daughter Virgie to court claiming Virgie did nothing to 
provide for her six-month-old son and refusing to take care of them both. Virgie, born in 
Virginia, was sent back to the state to serve several months at the Occoquan Workhouse and the 
infant was temporarily committed to the BCG. Once she completed her sentence Virgie found 
work as a laundress back in Washington and took up residence near her mother. The mother-
daughter relationship apparently improved, and the BCG returned the child to Virgie, noting that 
both women agreed to see that the baby was properly looked after. When Louisa Dent was 
arrested in 1905 her sisters initially took care of her newborn, Louisa’s fourteenth child, but only 
the second one to live to be at least six-months-old. Some time later at a court hearing, Louisa’s 
sisters informed the judge that the baby, now sick with pneumonia, would be better off it was 
reunited with its mother. Louisa agreed, and protested the judge’s decision to instead commit 
the infant to the BCG, where she died eleven days later from pneumonia. When fourteen-year-
old Antionette was sent to a reform school in Maryland and had a baby there, her grandmother

119 Case 1487, BCG. 
120 Case 3217, BCG. 
121 Case 1796, BCG.
Florence took the newborn back to Washington to care for it. Soon after, Florence went to the BCG demanding that her granddaughter be released from school so that she could work and learn to take care of her own child. The grandmother believed the best way to raise the baby lay in her granddaughter assuming her maternal responsibilities, and she turned to the board to make that a reality. The BCG, however, chose to remove the baby from the grandmother’s care and place it with a district nurse, a solution that separated three generations of a family from each other. In justifying its decision, the BCG noted that the female-headed family was a frequent recipient of charitable relief and lacked any male relatives to contribute any support. Yet the grandmother had already demonstrated that she was willing to support multiple generations of her family and had a plan for how to continue doing so. From her perspective, the best way to teach her daughter to be self-supporting was for her to get a job and take care of her baby at the same time. But as the BCG saw it, the family’s situation was already hopeless and the infant’s best chances lay in it being placed elsewhere. The case demonstrated the competing visions between family members and city officials over the best way to raise an infant, and the BCG’s growing belief that parents who could not support their children did not have the right to keep their families together.

**A Scandalous End, 1922-1926**

In 1922 the chief of the BCG, Ella H. West, proposed discontinuing the agency’s practice of sending some of its wards to the nearby Industrial Home School, a move consistent with West’s long-held belief that placing children in private homes was preferable to institutional care. During its initial years, the BCG had convinced government officials and the public that the

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122 Case 2284, BCG.
home was the ideal environment for raising children, and pointed to its policy of placing infants in the care of district nurses rather than foundling asylums as having saved countless lives. Older children, too, were often boarded with families, but many were also sent to training and reform schools. Some of West’s fellow board members, including those with ties to the Industrial Home School, however disagreed with the proposal, setting in motion a series of disputes over what was the best model for child care.¹²³

With tensions mounting between board members, and the agency growing increasingly divided, several members resigned their positions and took to local newspapers to criticize the agency’s practices and leadership. The publicized attacks elevated the controversy from an internal disagreement to a municipal scandal, warranting the attention of congressmen, who given their role in determining the BCG’s funding, decided to hold a series of hearings in February 1923.¹²⁴ On its own the investigation into a municipal agency may have seemed trivial, but at a time when multiple scandals were erupting in the late years of President Harding’s administration, the political climate in Washington had shifted and the stakes surrounding the BCG’s investigation were high.¹²⁵

Parents testified before Congress describing the BCG’s refusal to return their children despite their repeated requests, a clear reversal of the agency’s original promise to help restore families that it outlined in its founding documents. Other parents cited incidences of children having medical procedures done without their consent, and of cruel treatment going undetected

¹²⁵ The corruption case involving federal oil reserves known as the Teapot Dome Scandal, as well as charges of bribery and corruption in the Veterans’ Bureau Scandal and Justice Department rocked the Harding administration in the early 1920s.
by agents, to argue that the BCG’s small staff failed to provide appropriate levels of supervision. Accounts of children being repeatedly relocated to different homes were also used to undermine arguments that the home placement model brought a new level of stability into a child’s life. As the testimonies made clear, in becoming the guardian for nearly two thousand children the BCG had acquired significant administrative, legal, and medical powers that it willingly exercised. By the early 1920s the BCG was responsible for two-thirds of the city’s dependent children, with more than two times as many black children committed as wards than white children. Inevitably in managing such a large caseload, the agency had become vulnerable to criticism. These critiques were further fueled by new ideas about the way government should be organized that began to emerge in the post-World War I years. Originally the product of a late nineteenth century vision of child-saving in which the BCG stood out for its “worthy work,” by the 1920s the agency represented an anachronistic model of governance in a culture increasingly drawn to management practices grounded in expertise and the pursuit of greater efficiency. “The ‘progressive’ wing of the board of children’s guardians, composed of

proponents of home care for wards, has been routed,” declared one newspaper, signaling a loss of faith in the home-placement model and the BCG’s standing as a model institution.  

Less than three weeks after the hearings concluded Congress refused to appropriate funds to the BCG, limiting the agency’s capacity and foreshadowing its eventual demise. Within two years Congress reorganized the city’s charitable agencies so that the BCG, along with the Board of Charities and the Industrial Home School were all replaced by a centralized Board of Public Welfare. Combining all three agencies into one eliminated the points of tension between the BCG and the Industrial Home School. And streamlining the city’s administration of charitable relief was seen as enhancing efficiency, with one official noting “under the present system there is too much division of authority and responsibility.” The move mirrored a broader preoccupation in the 1920s with restructuring bureaucratic institutions to “modernize” them that one historian has described as an “organizational revolution.” Thus what had been created in the 1890s as an innovative child welfare solution was, thirty years later, seen as bureaucratically inefficient.

The BCG’s rise and fall illuminates some key tensions in early Progressive Era responses to addressing infant welfare. While the agency’s capacities and functions were specific to Washington’s municipal context, its relationship to Congress meant that its existence depended on politicians across the country remaining convinced it had an effective approach to addressing infant and child welfare concerns. Through the BCG’s efforts to place infants in the care of

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130 “Guardians to Oust Mrs. West As Agent,” *Washington Post*, Jun 3, 1923, 1.
designated nurses, controversies erupted over the spaces, notably hidden alleys, foundling asylums, and boardinghouses, in which infants lived and died, and the people – mothers, nurses, female kin, and landladies – seen as responsible for their livelihoods. The controversies that arose reflected different ideas about what kinds of assistance families needed and what constituted a good home environment for raising children. And yet, despite mounting criticisms that the BCG’s powers had grown out of hand and that the agency unnecessarily interfered in family issues, the agency was ultimately abandoned in favor of greater bureaucratic centralization and control over family welfare. On the municipal level, the Board of Public Welfare became the new agency that oversaw a broad array of relief services. On the federal level, a different agency stepped in to focus specifically on reducing the country’s infant mortality rates and tackling related issues of child welfare. The following chapter explores this new agency and the ways black infant mortality became a major focus of federal government intervention.
Figure 2.4
Infant Mortality Rates by Race in Washington D.C., 1900-1930
deaths per 1000 live births

<table>
<thead>
<tr>
<th>Year</th>
<th>White</th>
<th>Black</th>
</tr>
</thead>
<tbody>
<tr>
<td>1900*</td>
<td>212</td>
<td>391</td>
</tr>
<tr>
<td>1905*</td>
<td>150</td>
<td>328</td>
</tr>
<tr>
<td>1910*</td>
<td>113</td>
<td>261</td>
</tr>
<tr>
<td>1915</td>
<td>82</td>
<td>173</td>
</tr>
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<td>1920</td>
<td>71</td>
<td>137</td>
</tr>
<tr>
<td>1925</td>
<td>67</td>
<td>123</td>
</tr>
<tr>
<td>1930</td>
<td>52</td>
<td>111</td>
</tr>
</tbody>
</table>

*Based on annual average for 5-year period (1896-1900, 1901-1905, 1906-1910 respectively).

Table 2.5
Reported Causes of Black Infant Death, BCG Cases, 1893-1913

Based on total of 109 black infant deaths recorded in files.
Category of “sick” refers to mothers classified with physical or mental incapacities such as crippled, invalid, delicate, insane, crazy. “Unfit” refers to mothers deemed as such, simple-minded or incapable. “Abandoned” refers to mothers who abandoned their infants.
CHAPTER THREE

“To Protect the Mother and the Baby”

The Children’s Bureau Trains Black Midwives

This chapter examines the early twentieth century period when the federal government became involved in preventing black infant mortality. Scholarship on infant welfare in this period has detailed the interventions directed at immigrants and the white poor, but has undervalued the work done in black communities, arguing that interest in reducing diseases such as syphilis, more so than infant mortality, dominated discussions of black health.¹ Yet as the previous chapters demonstrated, black communities have long been involved in efforts to care for expectant mothers and young children. Thus even while infant mortality emerged as a distinct social problem in the early twentieth century, protecting the health of mothers and their children has long been a central concern for African Americans.

Focusing on the work of the U.S. Children’s Bureau, the chapter charts the Bureau’s growing concern over the “midwife problem,” its investigative studies of black infant health, and its hiring of Dr. Ionia Whipper, the only African American female physician on the Bureau’s staff and the key federal employee responsible for training black Southern midwives. From the outset, the government’s interest in preventing black infant deaths focused on training midwives

whom health officials came to see as the primary cause of deaths during childbirth. Over time, however, midwife-training programs transformed into broader surveillance systems that relied on tools such as the birth certificate to scrutinize the actions of midwives and parents. As the initially broad campaign to reduce black infant deaths narrowed to focus on regulating midwives, other causes of mortality were ignored. The midwife became the key figure responsible for protecting the lives of mothers and babies, and the target of blame for any of their deaths.

**Learning to Protect the Mother and the Baby**

The nineteen women arrived toting identical black bags and copies of “The Book,” their name for the official midwife manual distributed by Mississippi’s Board of Health. Having traveled for miles from three neighboring districts on this October day in 1948, they arranged themselves in the front pews of True Light Baptist Church in Hattiesburg and began their monthly meeting. The “business-like affair” wove religious practices into a professional agenda. Seated steps away from a baptism pool and surrounded by stained glass windows, the African American midwives opened their meeting with prayer, performed hands-on demonstrations, read aloud scripture, and presented their bags for inspection. On the leader’s cue the group stood and sang to the children’s tune “Mary Had a Little Lamb”:

<table>
<thead>
<tr>
<th>Why does the midwife wear a wash dress?</th>
<th>Wear a wash dress, wear a wash dress?</th>
<th>Why does the midwife wear a wash dress?</th>
<th>TO PROTECT THE MOTHER AND THE BABY.</th>
<th>(Hold dress)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Why does the midwife wear a clean cap?</td>
<td>Wear a clean cap, wear a clean cap?</td>
<td>Why does the midwife wear a clean cap?</td>
<td>TO PROTECT THE MOTHER AND THE BABY.</td>
<td>(Points to cap)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(Claps hands)</td>
</tr>
</tbody>
</table>
Why does the midwife wear a clean mask? (Puts hands to face)
Wear a clean mask, wear a clean mask?
Why does the midwife wear a clean mask? (Claps hands)
TO PROTECT THE MOTHER AND THE BABY.

Why does the midwife wear a clean gown? (Holds out arms)
Wear a clean gown, wear a clean gown?
Why does the midwife wear a clean gown? (Claps hands)
TO PROTECT THE MOTHER AND THE BABY.

Their uniform symbolized cleanliness, order, and professionalism, and with each stanza the midwives described the care they took in getting dressed for work. Clean clothes were the foundation of their professional attire, a display of their disciplined training as well as a physical shield for safeguarding mothers and infants from deadly germs. The midwives continued singing, drawing attention inward from their clothes to their bodies:

Why does the midwife clean her nails? (Cleans nails)
Clean her nails, clean her nails?
Why does the midwife clean her nails? (Claps hands)
TO PROTECT THE MOTHER AND THE BABY.

Why does the midwife scrub her arms? (Scrubs arms)
Scrub her arms, scrub her arms?
Why does the midwife scrub her arms? (Claps hands)
TO PROTECT THE MOTHER AND THE BABY.

Why does the midwife scrub her hands? (Scrubs hands)
Scrub her hands, scrub her hands?
Why does the midwife scrub her hands? (Claps hands)
TO PROTECT THE MOTHER AND THE BABY.

Why does the midwife soak her hands? (Soaks hands)
Soak her hands, soak her hands?
Why does the midwife soak her hands? (Claps hands)
TO PROTECT THE MOTHER AND THE BABY.

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Why does the midwife make paper pads? (Measures pad)
Make paper pads, make paper pads?
Why does the midwife make paper pads?
TO PROTECT THE MOTHER AND THE BABY. (Claps hands)

The midwives articulated the steps they took to make themselves and their surrounding environment clean in front of a small audience. Seated at the back of the church, Dr. James Ferguson, a professor of obstetrics and gynecology at Tulane University, along with a state health official and two public health nurses listened to the midwives, well aware that given the lack of doctors and hospitals available to African Americans, women like the ones assembled before them still served a great need in the area. These midwives had chosen to meet in a church, a space they regarded as safe and communal. And within this space, uniformly dressed and with their own book and special bags, they displayed a sense of collective pride singing together without shame of the work they did. The words they recited and the actions they demonstrated displayed their knowledge and ability to fluidly move between sacred and scientific practices.

African Americans had long viewed midwifery as a spiritual calling, but the relationship between divine gift and healing work took on new meaning in the context of using a church as a meeting space to bring together black midwives and white health professionals.

Why did midwives across Mississippi’s counties know this rhyme, and why did their gathering draw the attention of local health professionals? At first glance this song seems simple and childish, it was after all based off a nursery song, and maybe it seemed that way to Ferguson and his colleagues. But beginning in the 1920s midwives in Mississippi, Alabama, Georgia, Florida, and across the South sang this tune in state-required midwife training. The song captured the repetitive nature of the classes midwives attended. The question and answer format of each stanza echoed conversations – sometimes escalating into confrontations – between black
midwives and the, mostly white, public health nurses who supervised them. The familiar melody made the song easy to remember and for any midwives who had trouble reading along the accompanying hand motions served as a guide. The repeated refrain, “to protect the mother and the baby,” reminded midwives of the necessity of creating a clean environment for the laboring mother and newborn, linking daily hygienic practices to the life and death stakes of childbirth.

And the reliance on melodies in midwife classes re-appropriated a black oral tradition of transmitting information through songs. Class instructors made use of this form to teach modern health practices, and they warned midwives of the consequences of failing to adopt them. Refusing to comply could result in midwives having their licenses revoked, being fined, or even threatened with jail. For decades songs like “To Protect the Mother and the Baby” were a key feature of midwife trainings, meant to communicate modern health practices to a group of women deemed illiterate.

The song reflected a composite of changes in midwifery practice that began in the 1920s and became fully entrenched by the 1940s when Ferguson and his colleagues visited True Light Baptist Church. Such changes were initiated by the U.S. Children’s Bureau, a federal agency that worked with state and local health departments to reduce the nation’s death rates. Decreasing maternal and infant deaths was an especially critical public health issue within African American communities. Child mortality (ages 0-5) in the first decade of the twentieth century accounted for over a third of all black deaths. The black infant mortality rate in 1915, 181 out of every 1000 births, was almost twice as high as the white infant mortality rate of 99 per 1000.

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mortality was also high in this period. For women ages 15 to 44, childbirth and complications from pregnancy were the leading causes of death, second only to tuberculosis, and with a death rate almost twice as high for black women. Physicians and health officials blamed midwives for these deaths, and claimed that incidences of neonatal tetanus and neonatal blindness were due to midwives’ unclean practices and ignorance of hygienic principles. In the 1910s the midwife was cited as the problem, the reason mothers and babies across the country were dying, but by the 1940s, as the song declared, she was trusted with protecting the health of the mother and the baby. How did a source of blame transform into a model of protection?

Exploring this question requires tracing the ways health officials, midwives, and women understood the potential and dangers of midwifery and its relationship to infant health. While often discussed separately, the history and politics of infant welfare and black midwifery are deeply intertwined. The Children’s Bureau has attracted the attention of scholars interested in the white women who directed the Bureau, many of whom began their careers in Progressive Era settlement work. By focusing on women who led the agency, however, scholars have overlooked the role of Dr. Ionia Whipper, who, while less senior chartered new territory in where the Bureau worked and with whom. Whipper’s official reports and correspondence reveal several

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regional and racial tensions that arose in the course of her work with white health officials and black midwives. Additionally, state health departments kept records on practicing midwives including basic data such as a midwife’s name, address, age, highest level of education, and length of practice. More robust records captured information on who midwives trained under, how they helped women early on in pregnancy, whether they rented or owned their homes, and their health status (e.g. poor eyesight, high blood pressure, positive Wasserman tests for syphilis). Importantly, these records contain investigations into midwife-attended deliveries, illuminating the kinds of pregnancy and health outcomes that drew the attention of the state. Some records include photographic evidence of the disabilities individuals developed as a result of a midwife’s actions during delivery. While the files mostly reflect the viewpoints of white officials investigating black midwives, the records also describe conversations with midwives (during home visits, meetings, and disputes) and contain letters and appeals written by midwives themselves, making them a valuable source for understanding the day-to-day dynamics of African American healthcare.⁷ Alongside these federal and state records, this chapter draws on songs, midwife memoirs, and surveys, to deepen and complicate understandings of how African

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Americans understood their birthing experiences and health care practices, as well as how they viewed the government’s surveillance of their reproductive lives.

The Midwife Problem Before Government Intervention, 1900-1920

Although midwives were well established within black communities, part of a female tradition of healing that existed during slavery, by the early twentieth century physicians across the color line became increasingly critical of their work. They identified a number of reasons for black infant death rates but virtually all agreed that midwives, whom they characterized as dirty, superstitious, and ignorant, were largely to blame. Such cultural, racial, and class-based stereotypes revealed professional anxieties towards unwelcome competition, but they also reflected fears and disgust about the bodies and customs of the largely immigrant and black women who practiced midwifery.

What had been considered the province of female-run households was transforming into the male-dominated, respected medical professions of obstetrics and pediatrics. A growing number of physicians claimed special knowledge on the conditions of women and children. While not quite a disease, pregnancy was seen as a condition with specific symptoms and signs, and infants and children were seen as vulnerable to particular diseases that midwives could not adequately manage. But allowing that they could not completely stop midwives from practicing, professionals sought to control and limit their work.

physicians claimed that midwives needed to meet a series of requirements to ensure proper training, competency, and cleanliness. Facing increased pressure from organized medical associations, states began passing laws requiring midwives to meet a number of obligations in order to practice, including to take written examinations, present certificates of moral character, undergo physical examinations, tests for venereal disease, maintain a strict list of supplies, travel and attend trainings, and promptly file birth records.\textsuperscript{11}

This campaign was not just male resentment toward a female profession. Trained female nurses viewed midwives as rivals, and felt even more threatened by their presence given that the nursing profession lacked the legal recognition and training status that doctors received. Annie Mae Mathis, a black public health nurse working in Texas in the 1920s described the black midwives she encountered as “ignorant and superstitious, very set in their beliefs and careless as well as filthy.”\textsuperscript{12} Moreover, many nurses blamed midwives for the deaths of childbearing women and newborns, with one public health nurse declaring, “if the problem of infant mortality is to be solved through intelligent motherhood…it would certainly simplify matters if we could remove from our midst the midwife.”\textsuperscript{13}

Black physicians voiced additional criticisms that “granny” midwives were an embarrassment to the race.\textsuperscript{14} In the South they saw midwives’ customs as reflecting poorly on


\textsuperscript{14} On black physicians’ training and employment opportunities see Vanessa Northington Gamble, \textit{Making A Place For Ourselves}, (New York: Oxford University Press, 1995); Thomas J. Ward Jr., \textit{Black Physicians in the Jim Crow South} (University of Arkansas Press, 2003).
the region and reinforcing its characterization as backward.\textsuperscript{15} Others disapproved of African American women who migrated North but continued to rely on midwives instead of seeking a doctor’s help. Black physicians criticized the reliance on traditional healing practices, considering it out-of-date within a culture that increasingly promoted standardized, scientific methods. One physician wrote that black mothers who visited his baby welfare clinic in Des Moines, Iowa had to be educated not “to cling to their grandmothers’ methods” and instead adopt modern approaches to prenatal care.\textsuperscript{16}

Yet while midwives were cast as old-fashioned and unscientific they were still seen as competitors. For black physicians in particular, limited opportunities to practice in hospitals due to racial discrimination meant that they relied heavily on local communities to trust and solicit their services.\textsuperscript{17} Establishing such relationships was difficult given that in most areas black midwives easily outnumbered black physicians, and that midwives generally accepted smaller payments than doctors.\textsuperscript{18} Rather than criticize the discriminatory health systems they worked within, in which African American women had limited access to physicians’ services and hospital beds, black physicians argued that the solution to protecting infant and maternal health was to restrict midwifery practice.

\textsuperscript{16} J. Alvin Jefferson “The Artificial Feeding of Infants” \textit{Journal of the National Medical Association} 23 (April – June 1931): 54 \\
\textsuperscript{17} For example, the firing of Godfrey Nurse, one of the most prominent Harlem physicians, from the Harlem Hospital staff in 1929 over an alleged surgical error highlighted the tenuous position of African American physicians and the difficulties in securing even auxiliary medical positions in hospitals. Vanessa Northington Gamble, \textit{Making A Place For Ourselves}, (New York, Oxford University Press, 1995), 57; \textit{New York Amsterdam News}, 19 February 1930. \\
\textsuperscript{18} Byrd, “Maternity and Infant Mortality,” 179.
To this end, black physicians further worked to discredit midwives by portraying them as dangerous and abortionists. One physician writing in a Virginia medical journal claimed, “I have had twenty-seven abortions within the past seven months. The majority of these cases had consulted some negro granny, who told them how to do the work.”\(^{(19)}\) As historian Leslie Reagan has shown, connecting midwives to illegal abortions was a deliberate and central way obstetricians framed the “midwife problem.”\(^{(20)}\) But while Reagan’s study examined debates in Northern cities in which European immigrant midwives were the focus of attack, analyzing critiques of black midwives reveals that black physicians pursued similar arguments. An important distinction, however, was that while black doctors called for the elimination of midwives they also knew that all black practitioners, by virtue of their race and the communities they worked in, were vulnerable to charges of being involved in the dirty work of abortion. Black physicians recognized the problem of those among them who made their living as criminal abortionists “posing as reputable physicians,” and argued that they shared many qualities with midwives by “invading the uterus with various instruments, careless at times or ignorant of antisepsis.”\(^{(21)}\) It was easy to cast midwives as abortionists, but they were not the only ones susceptible to blame.

Black physicians’ attacks on midwives fed into critiques of black mothers as well. In 1904, Dr. H.F. Gamble shared his views in the *Colored American Magazine* on why African Americans experienced such high infant death rates. Trained at Lincoln University and Yale, and

\(^{(19)}\) Kerns, 369-370.
a member of the National Medical Association (NMA), the largest professional group of black physicians (of which he was later elected president), Dr. Gamble reproached those who rushed to the “damp, dark, dismal dens” of cities in search of “a good time.” Such members of the race had shirked their “responsibility of reproduction.” Gamble concluded with the observation:

Since beginning this paper four weeks ago, I have officiated at seven births; four are dead, and death is known to have been directly due to maternal effort to prevent gestation. During this time, I have had three infant deaths from other causes. One was due to consumption, one to syphilis, and one to the congenital poison, which first destroyed the child’s eye and then its life.  

Gamble made space in his article to include his own professional experiences combating infant mortality. His remark served to demonstrate his medical proficiency (in identifying the medical causes of infant death) and indicate how busy his practice was (being present at seven births in four weeks). But Gamble was also careful to protect his professional status, and emphasized that the infants under his care died from diseases he could not have cured and actions he could not have prevented. He thus shielded himself from charges of incompetence by shifting the blame to mothers themselves.

**Calling the Midwife in the Early Twentieth Century**

For many pregnant women, the decision to engage a midwife or physician had little to do with abandoning “old” or embracing “new” ways of giving birth. Black women in the rural South could be poor and geographically isolated but they still made informed decisions about how they would give birth and who would aid them. Doctors were rare sights, more expensive,
and less reliable. One midwife recalled that in several parts of Alabama, doctors only appeared “every now and then.” She continued, “when you call one, even if you call one today, he might come tomorrow. He might come tomorrow…it was the midwife or nothin.” Most likely white and male, the doctor was an unfamiliar presence not only in black communities, but also in a room when a woman was in labor. For black women, depending on a doctor to help during delivery, not a midwife, was the problem.

In the early twentieth century midwives attended more than half of all African American births, and in rural areas far from hospitals and with few physicians this number increased to nearly eighty percent. In 1913 Dr. Albert Wilberforce Williams, who kept a regular health column in the nationally circulating black newspaper the Chicago Defender, received a letter from a pregnant wife. Seeking his advice, she asked “I expect to be confined in July. My husband wants me to have a doctor because I had a midwife with my first child and she had trouble with my case and had to call in Dr. X., and my husband had to pay Dr. X. but I like the midwife because she is cheaper and will take care of the baby. What would you advise me to do?” The expectant mother worried how to balance the care she desired with the costs she could afford, and Williams responded to her letter knowing she voiced a concern shared by many other women. He supported the husband’s suggestion to retain a physician, but offered a compromise—

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23 Onnie Lee Logan as told to Katehrine Clark, Motherwit: An Alabama Midwife’s Story (New York: Dutton, 1989), 57.
the couple should engage a doctor for delivery and call on a midwife for the “after-care” work.25

The solution emphasized the doctor’s delivery skills and the midwife’s nursing care, a familiar approach, as some families would call on both a doctor and midwife, and have the midwife work as a nurse for several days during confinement.26 As a physician, Williams unsurprisingly encouraged his readers to seek out the services of his colleagues. Yet he also recognized that midwives had skills women held dear.

Reflecting back on her decades of work in Virginia, Claudine Curry Smith recalled the care she provided to mothers during and after delivery – cleaning and wrapping the baby, waiting for the afterbirth and burning it afterwards, and tending to the new family. Sometimes she would bring her own sheets and towels if the families she called on were very poor and didn’t have “proper stuff.”27 As a midwife working in the mid-twentieth century, Claudine had additional paperwork, recalling “I had to record everything. I had to write the date, the time, and the weight and name of the baby, the father’s name, the mother’s maiden name and where, the post office, where the baby born. I had to send that within seven days to the registrar for the county the baby born in.”28 But Claudine’s job did not end when she filed official paperwork. She would return daily over the next few days, monitoring the recovery of both baby and mother, on the lookout for signs that either might need a doctor. If no problems arose she would decrease her visits, “I’d go every other day ‘til the cord dropped off and it was all healed. Then my work was complete.”29 While doctors considered a woman’s delivery to mark the end of their obstetrical

27 Claudine Curry Smith, My Bag Was Always Packed: The Life and Times of a Virginia Midwife (Author House, 2003), 55.
28 Claudine Curry Smith, 64-65.
29 Claudine Curry Smith, 65-66.
duties, for midwives the healing of the navel served as a natural, bodily, and symbolic sign that they had completed their work. A healed umbilical cord also signaled that the newborn was no longer vulnerable to infections through the open wound, a significant cause for concern for midwives and the black families they attended. Despite government attempts to redefine her responsibilities, Claudine maintained her own belief of what constituted a good and finished job that was not dictated by health authorities.

Adapting to new state regulations was hard for midwives, but it was more so for the pregnant women who expected their deliveries, and transition to motherhood, to be similar to the experiences of their own mothers, family members, and friends. As such, midwives had to negotiate between complying with state requirements and being receptive to women’s requests for traditional care. Alabama midwife Margaret Charles Smith remembered reaching a point in her practice when she “had to stop fooling with teas and things in labor because my name was getting out.” She feared losing her license if health authorities discovered, or even suspected, she used outlawed items when she attended clients. Her fears were well founded as local boards of health identified a number of possible infractions that could result in revoking or refusing licenses, including the possession of items like black pepper teas that were customarily used to relieve labor pains and control bleeding, but could also be suspected of inducing abortions. But making a clean break from traditional care was difficult. Margaret’s clients sought out her services because of the reputation she had established delivering the children of other women in the community. “Miss Margaret,” they would ask her, “how come you are not using some of that stuff you used on Emma or Lucille? She was telling me about what good stuff you had. Why

30 See for example the midwife records of Mary Traylor, Rosa Little, and Mary Lawler, Box SG022954, Talladega County Midwives 1933-1947, Alabama Department of Public Health midwife records, 1889-1947, ADAH.
don’t you give me some? Fix me some so I can get through with this baby.”

Margaret provided a familiar style of care women took comfort in, and they requested her traditional remedies even as the risks of using them intensified. Eventually Margaret decided she was done using teas, despite the benefits they provided, remarking that laboring mothers were “going to have those babies with what the guide says, ‘cause they told us not to try to help them.” In struggling to maintain control over her practice Margaret found certain constraints were not worth resisting and ended up deferring, at least on paper, to the instructions in public health guides. Exasperated by the restrictions placed on her ability to practice, another midwife informed her supervising nurse that she was resigning, “I think I’ll bring my bag in and give it to you all because you all are not there when this labor is going on.” The strictly enforced list of supplies allowed during delivery, the midwife argued, were useless. She went on, “You don’t know how it goes. Rubbing helps and teas help. If I can’t give them some hot teas which I know will help, I just well ought to give up.” In speaking out against the restrictions she faced, the midwife made it clear that health officials left little to no room for women like her to utilize their skills.

Mothers articulated a number of reasons why they preferred to have women attend their births. They valued midwives because they relied on traditional folk knowledge “handed down from slavery time,” knew how to manage women’s pains and anxieties during childbirth, and were respected members of their communities. To ease pains midwives prepared baths, massaged and rubbed mothers’ bellies, and directed women to brace furniture during

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32 Margaret Charles Smith, 100-101.
33 Texas State Board of Health, Bureau of Child Hygiene, “Report on the Midwife Survey in Texas,” 1924, File 4-10-4-2, Box 275, Records of the US Children’s Bureau, Record Group 102, National Archives, College Park, Maryland (hereafter cited as CB).
Florida midwife Augusta Wilson described how she would get women's minds off their labor pains, “I'd joke around and cut the fool with 'em and tease 'em and go on. And after awhile, they get to laughing and talking and relax themselves.”

The art of passing time and putting women at ease during a moment of painful uncertainty was an important feature of the midwife’s skill. In addition to their pain management techniques, many women preferred midwives because they offered a wider range of services for a smaller fee in comparison to doctors. Two surveys from the 1920s captured the reasons why women called on midwives; a 1924 Texas survey in which nurse-midwives interviewed a number of white, African American, and Latina women about their birthing experiences, and a 1920 survey of mothers and midwives in New Orleans, conducted by a graduate student at Tulane University. The surveys revealed that women distinguished between the normal sicknesses associated with pregnancy and being “sick enough” to see a physician. One mother cited her interaction with a doctor when she had malaria, and her decision to never “have him again,” stating drily that, “Granny helps in your misery.”

Women typically engaged midwives’ services two to three months before their anticipated time of confinement and midwives cared for new mothers after they had delivered, remaining in the home or returning periodically to visit. Another mother believed midwives “took more pains” to help confined women. They also took on roles as housekeepers. As one mother responded, her midwife Molly delivered her baby and did all her washing “and charged me only $5.00. Really worth more.”

“Midwife does more for you, gives tea etc., and helps with her hands,” noted

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34 “Folk Remedies and Treatments used by Florida Midwives,” Box 1, Folder 2, Series 904, State Archives of Florida, Tallahassee, Florida.
36 Helen Watson, “Midwives in New Orleans” (Masters thesis, Tulane University, 1921), Jones Hall University Archives, Tulane University, New Orleans, LA, 11-A.
37 Bradley and Williams, 33.
another mother, specifying the ways in which women like her “got more service” out of midwives.38

Midwives were, and had long been, healers that attended not just to the physical processes of pregnancy and childbirth but also broader aspects of care. Their work required a range of nursing, pain management, and housekeeping skills as well as long time commitments, helping women a few months before their delivery to a few weeks after. Contrary to what physicians argued, for many women midwives were not a problem to be eliminated but a valuable resource to rely on and keep nearby. Yet within this system of care, risks of maternal and infant deaths remained high and were increasingly seen as a national, and racial, problem.

Federal Investigation of Infant Mortality, 1912-1921

“To protect the mother and the baby.” In many ways, the song phrase was an early slogan for the Children’s Bureau, the first federal agency charged with protecting the health of infants and children. From its inception in 1912 the agency decided to “investigate and report…upon all matters pertaining to the welfare of children and child life among all classes of our people, and shall especially investigate the questions of infant mortality.”39 Inaugural director Julia Lathrop was well aware of the political stakes involved in taking up this issue, having spent years in child advocacy work and the settlement movement, notably Chicago’s Hull House.40 As the first female director to be appointed the head of any federal government agency she reasoned that

38 “Report on the Midwife Survey in Texas,” CB.
39 Act Establishing the Children’s Bureau (37 Stat. 79) Approved Apr. 9, 1912.
40 Ladd-Taylor, 8.
tackling infant mortality would raise little alarm in a political climate already besieged by lawsuits and debates concerning child labor and welfare.\footnote{Kriste Lindenmeyer, “The U.S. Children’s Bureau and Infant Mortality in the Progressive Era,” \textit{Journal of Education} 177, 3, 1995, 57-69.} In congressional hearings Lathrop had to convince government representatives that the Children’s Bureau’s mission did not duplicate that of the Census Bureau. When one senator inquired whether the census was already collecting data on infant mortality Lathrop responded, “No sir; nobody is getting [figures] for America. There are no statistics here.”\footnote{U.S. Congress, Senate, Committee on Appropriations, Hearings on the Legislative, Executive, Judicial Appropriations Bill, 62d Congress, 2d session, December 14, 1912, 65.} At the time, the Census Bureau was slowly expanding death registration, consisting of states with organized local registrars and good laws for reporting deaths, as part of an effort to improve national mortality data. But no comparable system existed for tracking births, making it difficult to capture the ages and deaths of the very young.\footnote{Cressy L. Wilbur, “Needs and Present Status of Birth Registration,” \textit{Journal of the National Medical Association}, 7:2 (1915), 121–125.} Only one state, Massachusetts, required that all births and deaths be registered.\footnote{Lindenmeyer, 59.} So, Lathrop set out to collect her own data.

From 1913 to 1923, the Children’s Bureau conducted a series of studies of infant mortality. It dispatched field investigators to personally interview thousands of mothers across the country, conducting house-to-house surveys and reporting on economic conditions and available medical resources. The studies took place in Northern and Midwestern towns, in manufacturing areas such as Johnstown, Pennsylvania; Waterbury, Connecticut; Saginaw, Michigan; and Akron, Ohio. As an arm of the Department of Labor, the Bureau took keen interest in the effects of parental employment on infant welfare. All of its studies analyzed the relationship between the type and wages of a father’s employment and the health of his family.
The Bureau wasn’t alone in linking infant wellbeing to labor. At the turn of the century as industrial-related injuries, accidents, and deaths filled newspapers, “the mere business of being a baby,” a U.S. Public Health Services official noted, “must be classified as an extra-hazardous occupation.” The New York Times echoed this sentiment when it wrote, “the most dangerous occupation in the world is that of being a baby.”

These were important and rigorous reports, but there were key limitations in the information the Bureau collected. The extent of these restraints is reflected, in part, in the Bureau’s choice of sites. Towns with adequate birth registration data like Waterbury were selected in order to make reliable comparisons to census data. But the industrial towns were also chosen because they were distant from urban centers where doctors and major hospitals tended to cluster – places where the Bureau’s presence was deeply unwelcome. The Bureau made clear that it carefully chose its sites expressly for this purpose with Lathrop assuring, “we are not, in this inquiry, going into distinctly medical matters, but into social and industrial and economical surroundings of the families, including the hygienic surroundings of the child, in the community in which it is born.” Within this vein, the Bureau’s reports avoided discussing the impact of specific diseases. Death certificates recorded causes such as “gastric and intestinal diseases or diseases peculiar to early infancy,” but according to Bureau officials these were only clues to the real, underlying causes of infant death, “such as improper feeding, lack of care of the mother

during pregnancy, employment of the mother, or means insufficient to provide proper care for
the infant.” The Bureau believed that identifying the “ultimate causes” of death required
understanding the underlying social and economic circumstances conditions in which children
were born.48

Another limitation of the Bureau’s studies was that they included little information on
African Americans. Few blacks lived in the Northern cities the Bureau investigated, limiting the
racial comparisons and conclusions the Bureau could draw.49 Most scholarship on the Bureau’s
role in studying and preventing infant mortality has focused on its early work in these Northern
areas.50 But two studies it conducted in the South reveal the Bureau’s interest but limited
understanding of black maternal and infant health. An opportunity to examine conditions among
African Americans arose in 1916 when the North Carolina Board of Health asked the Bureau to
conduct a study of the state’s rural children. The Bureau considered it a unique occasion to study
a “typical Southern State.” North Carolina’s geography included Appalachian mountain counties
and lowland coastal plains in the cotton belt, and the majority of its population made their living
growing cotton, raising livestock, tenant farming, and developing timber.51 Bureau investigators
worked their way through towns by car and horseback, holding child health conferences at

48 Jessamine Whitney, Infant mortality: Results of a Field Study in New Bedford, Massachusetts,
49 In its 1915 study of Montclair, New Jersey, a comfortable suburban town, the Bureau found
that Montclair’s highest birth and infant death rates occurred within the “congested section” of
the fourth ward, an area populated by blacks and Italians living in tenement housing.
Opportunities in domestic service drew African Americans to the area, with black women
working as domestics and black men filling jobs as servants, chauffeurs, and janitors. But other
than this brief mention the initial Bureau studies remained silent on black infant mortality. See
Mortality in a Suburban Community Infant Mortality Series No. 4 (Washington, DC:
50 See Ladd-Taylor; Klaus; Skocpol.
51 Bradley and Williams, 9.
schools and churches. There they displayed models showing the state’s infant mortality rate, and presented eye-catching exhibits warning against the dangers of “doping” babies with patent medicines in order to lull them to sleep.

Field agents followed up these public events with house-to-house visits. While the interviews primarily gathered information on the conditions of rural school-aged children, agents also asked mothers questions related to their children’s earliest experiences – the conditions of their birth. Equal numbers of white and black families living in the lowland county were interviewed, as well as the eight black midwives (seven female, one male) that practiced in the area. Fifteen of the 129 black families lived within five miles of a doctor. In this region, as in many others, a mother’s ability to rest during confinement largely depended on the seasonal demands of planting, plowing, picking, and chopping cotton. The maternal mortality rate in 1916, the year before the Bureau conducted its study, was considered “alarmingly high” at 41.5 deaths per 100,000. Agents found that while physicians attended two-thirds of white deliveries the large majority of black women relied on a midwife when they gave birth. Capturing a widely held sentiment, one woman declared that a physician’s presence in no way compared to having a “good woman every time.”

In the North Carolina report, the Bureau’s female field agents Frances Bradley and Margaret Williams highlighted how black communities responded to their presence with great enthusiasm. “Considering the sparsity of the population,” they noted, “the attendance was most unexpected.” Health conferences, which were held separately for each race, had to be repeated in order to accommodate overflowing black crowds. Local black communities raised funds to cover the salary of a black nurse, and in their enthusiasm black audiences “often refused to be

52 Bradley and Williams, 30.
dismissed and were left to discuss the new doctrine after the close of the meeting.”  

African Americans took advantage of the opportunity to receive government advice, literature, and free medical care, and their enthusiasm took Bradley and Williams by surprise. Bradley and Williams credited ministers, and especially midwives, for encouraging attendance. They noted, “[m]ore than one good negro meeting was due to the efforts of the negro midwife…mothers naturally shy about bringing children for examination would obey her arbitrary summons.”

In 1921 the Bureau continued its health work in rural areas, this time in Mississippi. Agents interviewed 295 white and 380 black mothers and obtained their personal and reproductive histories. For its survey of maternal and infant welfare the Bureau focused on the hill country, which was largely devoted to farming. The Mississippi county likely attracted the Bureau’s attention given that it had participated in studies on hookworm and soil pollution conducted by the State Board of Health and Rockefeller Sanitary Commission in the 1910s. Over half the population was black, and most families lived on the river bottom as tenants on large plantations. Moving from farm to farm was common. Due to limited farming opportunities, families tended to stay in one location for no longer than two years. Agents visited homes lacking toilets and papered with newspapers to keep out the cold. The nearest hospitals, located in Jackson, Mississippi and Memphis, Tennessee were over a hundred miles away. Fourteen

53 Ibid., 15-18.  
54 Bradley and Williams, 15-16.  
55 North Carolina and Mississippi were the only two rural studies the Bureau conducted with significant black populations; other surveyed sites included counties in Kansas, Wisconsin, Montana, and Georgia. The Bureau noted that in the Georgia study, it surveyed a 400 square mile area in the Southern part of the Blue Ridge Mountain belt and the people studied were American and of “the sturdiest stocks – chiefly English, Irish, and Scotch…no colored infants or white infants of foreign-born parentage were discovered in the entire canvass.” See Glenn Steele, Maternity and infant care in a mountain county in Georgia (U.S. Government Printing Office, 1923), 2-3.
practicing physicians and about one hundred midwives served a population of nearly 23,000. No county nurses worked in the area. Bureau agents believed the lack of accessible medical care affected mortality rates in the area, concluding “one-tenth of all pregnancies of both white and colored mothers resulted in miscarriage, a stillbirth, or a live-born infant that survived less than 2 weeks.”

Compared to the Bureau’s studies in white industrial towns, the birth attendant more so than the family’s economic situation became the primary lens through which Bureau officials analyzed black health outcomes. The Mississippi report noted that seventy-nine per cent of white women interviewed had a physician present during confinement, while eighty-eight per cent of black women used a midwife. In its popular *Prenatal Care* guide, a free pamphlet first published in 1913 and with millions of copies distributed to expectant mothers across the country, the Bureau recommended the kind of care pregnant women should receive. Women were advised to see a physician once a month during the first six months of pregnancy, and every two weeks in the last month leading up to delivery. During their visits expectant mothers could expect to have their weight, temperature, pulse, and blood pressure recorded as well as a urinalysis, pelvic and abdominal examinations. But Bureau officials were aware that despite the popularity of their pamphlets, they didn’t always reach black homes, raising the question of where black women turned for prenatal advice. One white woman, writing from Norfolk Virginia in 1929 requested a copy of another popular Bureau pamphlet *Infant Care* as she gave hers to a colored maid that she claimed, “apparently needed the books more than I.” In her reply

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57 Dart, 27.
to the request Bureau supervisor Blanche Haines noted, “it is probably true that the colored people do not have the same opportunities for knowing of the help that can be received…and they probably do not read the same type of literature.”59 Of the 116 women in the Mississippi county who received some form of prenatal care, only nine did so because they thought pregnancy was in and of itself a reason for seeking the advice of a doctor.

With few black women engaging a physician during their pregnancies, the Bureau turned a closer eye to the assistance midwives provided. In the majority of cases, women called on midwives once their labor pains had begun, but there were often “chance meetings” where mothers would seek advice from midwives earlier on in their pregnancy. Sometimes midwives stopped in on expectant mothers to see how they were coming along.60 According to the Bureau, such casual encounters did not qualify as prenatal care and Bureau agents dismissed the advice and home remedies midwives offered to be no different than what “any experienced neighbor” could recommend.61 Nevertheless, these “chance meetings” demonstrated that in their day-to-day lives women actively sought advice about managing their pregnancies, and that seeking such information was woven into ordinary conversations with other women. In discounting these informal interactions, Bureau agents also failed to see that midwives were more likely than doctors to provide antepartum care to mothers and newborns.62 None of the mothers who paid a physician less than ten dollars received any type of postnatal care, whereas two-thirds of black women paid midwives less than five dollars and continued to receive care after childbirth.

59 Mrs. Walter Dolbeare to Children’s Bureau, May 31, 1929; Blanche M. Haines to Mrs. Walter Dolbeare, June 4, 1929, File 0-2-9-1-6, Box 368, Central Files 1929-1932, CB.
60 In its North Carolina study the Bureau noted “few of the midwives gave any prenatal care beyond dropping in for an occasional friendly call. None attempted a physical examination or urinalysis,” Bradley and Williams, 30-32.
61 Dart, 25.
62 Dart, 25, 29.
Given the Bureau’s limited understanding of rural black health networks it is not surprising that it had trouble determining the level of infant mortality in these areas. Families moved every year or few years, making it difficult to track and confirm births and deaths. Most mothers could not specify the cause of their newborn’s death, and the information the Bureau obtained it considered “meager and unsatisfactory.” Agents presented figures on infant mortality in the area with caution: 61.2 per 1,000 white live births and 107.2 for black infants. Bureau field agents cited greater obstacles in canvassing black homes and noted that black mothers were “particularly” liable to get confused and misremember how many of their babies died in early infancy. If anything, these difficulties revealed the limitations in the Bureau’s ability to connect with mothers, and the particular prejudices of Bureau agents who were quick to characterize black mothers as forgetful, a sentiment that reflected and reinforced ideas of black mothers as being uncaring and unfit for motherhood.

Dr. Ionia Whipper and the Bureau’s Training of Black Midwives, 1924-1929

The Bureau’s infant mortality studies of the 1910s-1920s started out in major white industrial areas and gradually expanded to rural Southern regions where more African Americans lived. The agency’s understanding of black infant health conditions began to dramatically improve in 1924 when it hired Ionia Rollin Whipper, a Howard University trained obstetrician and the Bureau’s only African American employee. As Assistant Medical Officer, Dr. Whipper had the responsibility of “investigation and educational work among negro midwives.” She worked intensively in rural Southern counties registering midwives, organizing classes, holding

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63 Bradley and Williams, 37.
64 Dart, 48.
well-baby clinics, and overseeing birth registration campaigns. Her work formed the basis of how midwives across the South were trained. This section will examine the lessons she taught midwives, which emphasized hygienic practices to protect against neonatal tetanus and neonatal blindness, and the resources she utilized to reach black communities.

Ionia Rollin Whipper was born in Beaufort, South Carolina in 1872 to William James Whipper and Frances Anne Rollin. Her parents came from free, affluent black families, and Ionia grew up comfortably in a family deeply involved in black social and political life. Her father was the son of William Whipper, a well-known abolitionist in Pennsylvania and the young William James became involved in anti-slavery causes. He volunteered with the 31st Colored Infantry during the Civil War and after the war trained as a lawyer, eventually establishing practices in Beaufort and Washington D.C. He quickly became a well-known figure in South Carolina Republican politics, serving as a judge in Beaufort, a member of the South Carolina state house of representatives, and participating as a member of South Carolina’s Constitutional Conventions in 1868 and 1895. Ionia’s mother Frances, born in 1844, was the oldest of four daughters. She attended a French parish school in Charleston and a Quaker school in Philadelphia before returning to South Carolina to teach in schools established by the Freedmen’s Bureau and the American Missionary Association. In 1867 she successfully sued the captain of a steamboat for refusing her first-class passage from Charleston to Beaufort. She filed a complaint with the Freedmen’s Bureau and in the course of the proceedings met Major Martin R. Delany. Delany encouraged her literary ambitions, and promised to financially support Frances if she undertook to write his biography. With this offer, Frances moved to Boston to focus on her writing and

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while there came to know Wendell Phillips, William Lloyd Garrison (who she considered a “grand noble soul”), William Wells Brown, Charlotte “Lottie” Forten Grimké, and other black intellectuals and anti-slavery leaders.\textsuperscript{66} In 1868 her work \textit{Life and Public Services of Major Martin R. Delany} went to print, although published under the male name Frank A. Rollin. Upon returning to South Carolina Frances began working for, and soon after married, William. She was closely involved in her husband’s political career and also worked with her sisters to establish the state chapter of the American Women Suffrage Association.\textsuperscript{67}

After twelve years of marriage, William and Frances separated and Ionia along with her sister Winifred and brother Leigh moved with their mother to Washington D.C. in 1881.\textsuperscript{68} Ionia attended segregated public schools and received her undergraduate degree from Howard University. She taught in D.C. public schools for ten years before returning to Howard for medical school as one of four women at the school to graduate with a medical degree in 1903. She continued her medical education by taking summer courses on sex hygiene at Columbia University, and further developed her professional experience through a combination of institutional affiliations and community work. She was involved in local Red Cross committees and from 1918 to 1924 she lectured on hygiene for the YWCA, and taught hygiene, obstetrics,

\textsuperscript{66} From Frances Rollin’s diary, selections printed in Dorothy Sterling, \textit{We Are Your Sisters: Black Women in the Nineteenth Century}, 454-462.
and pediatrics as a resident physician at Tuskegee Institute in Alabama. She also delivered babies in the maternity ward of Freedmen’s Hospital, and was a staff physician and lecturer at the local Woman’s Clinic. Within D.C.’s black community Whipper was regarded as a specialist in women and children’s diseases, and commended for her work running clinics for the poor.

Whipper’s public health work broadened when in May 1924 she joined the staff of the Maternity and Infant Hygiene division of the Children’s Bureau. Under the direction of Dr. Blanche Haines, the division employed a number of experienced, well-trained physicians, and Whipper’s colleagues included Sara Josephine Baker, the head of New York City’s Division of Child Hygiene and Alice Weld Taliant, a professor of obstetrics at the Women’s Medical College of Pennsylvania. Through the 1921 passing of the Sheppard-Towner Act (officially, The Promotion of the Welfare and Hygiene of Maternity and Infancy Act) the Bureau distributed millions of dollars in matching grants to states to develop public health programs for women and children. In the seven years the Sheppard-Towner Act operated public health nurses visited over three million women and children, states established almost 3,000 child and prenatal health

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71 “Social Clinic Established” and “The Woman’s Clinics,” Washington Bee, November 18, 1911; Washington Bee, January 06, 1912.
72 Skocpol, 481.
clinics, and physicians, nurses, and dentists conducted nearly 200,000 health conferences. Many states used a portion of the federal funds to create midwifery programs.

Whipper was instrumental in launching health projects within Southern black communities including birth registration work and baby health conferences. While she often stayed in one area for only a few months, she helped local communities acquire health resources that would last much longer. She organized a drive in one Texas county to raise $1,200 for a colored nurse to be hired by the state, and in Tennessee she helped train Mattie Coleman, a black female physician that the state added to its payroll. Her first assignments sent her to Delaware and Virginia, and she made her way further south and west to Tennessee, Georgia, and Texas. In each state she moved county to county, tracking down midwives, registering them with the state, and conducting instructional classes. She asked black churchwomen to spread the word about her work with midwives and met with black school principals to secure meeting spaces for her classes. Ministers made announcements about her health clinics to their congregations and screened some of the Bureau’s health films within their churches. The Atlanta Constitution informed readers in 1925 that Whipper would instruct midwives throughout Georgia. The dates and times of a series of talks at black churches in Atlanta and Pittsburgh, a working-class black suburb of Atlanta, were all published. At times, Whipper’s work with midwives was seen as

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74 Blanche M. Haines to J.C. Anderson, Texas State Health Officer, June 6, 1929, File 4-2-1-2-1, Box 374, Central Files 1929-1932, CB; Box 266 doc.
75 1926 Whipper Tennessee Report, File 4-10-4-2, Box 274, CB.
77 “Urban League Weekly Bulletin,” Atlanta Constitution, March 29, 1925, 10
too involved. Her supervisor had to remind Whipper that while she appreciated Whipper’s commitment to being “in communication with the midwives” and gaining their “confidence,” she should not forget that the primary task was birth registration work.\(^7^8\)

While health officials referred to them only as “midwives,” in reality black women practiced midwifery alongside other jobs including housework, farming, laundry, sewing, and nursing. The fees they collected for attending births ranged from a few crops to a few dollars, and the compensation was not always self-sustaining. Whipper held midwife trainings throughout the week, with classes at times running over three hours, but when possible she scheduled them when midwives had light fieldwork demands and could take time not only to attend class, but travel the long distances to do so. For some midwives, the nearest class was up to fifteen miles away.\(^7^9\) Bad weather, sickness, and travel difficulties prevented midwives from attending regularly. Whipper’s efforts to explain to her supervisors the burden midwives bore in trying to consistently attend contrasts with other Bureau employees who reported absences without explanation, leading state and Bureau officials to infer that midwives deliberately skipped class.\(^8^0\) With each report describing the midwives’ enthusiasm and attendance, Whipper worked to correct the views white health officials held that midwives were irresponsible, evasive, and took their duties lightly.

Whipper was sensitive to the challenges midwives faced as she experienced some of the same hurdles herself. In her diary in May 1928 she noted, “Went to Independence in search of midwives. Called to give registrar several birth certificates. He came on porch followed by his

\(^7^8\) Haines to Whipper, June 15, 1928, File 4-2-1-2-1, Box 267, Central Files 1925-1928, CB.
\(^7^9\) Whipper Marshall, Texas Weekly Report, April 20, 1929, File 4-2-1-2-1, Box 374, Central Files 1929-1932, CB.
\(^8^0\) Whipper Prairie View, Texas Weekly Report June 2 and June 9, 1928, File 4-2-1-2-1, Folder 1, Box 267, Central Files 1925-1928, CB.
wife. I told him I would like to speak to him. He told me to go around to the back. I repeated, thinking he didn’t understand.”

When sent on assignments, white Bureau employees traveled mainly by Pullman railroad cars. Whipper did as well, but as an African American female traveling alone through segregated towns she also had to use more informal modes of transportation. In Southern counties she relied on black farmer’s bureau agents to drive her around, and state health officials would rent her a car so that she could reach midwives’ homes.

Traveling from the Bureau’s D.C. headquarters out into the field required a well-coordinated set of maneuvers. Compared to the sixteen dollars that white nurses employed by the Bureau claimed for non-railroad travel expenses for example, Whipper claimed over $200 on “other” forms of transportation. As the only black female on staff, the tensions between the work Whipper was expected to accomplish and the challenges she faced because of her race did not just manifest when she was stationed in the South. The Bureau also discriminated, paying Whipper, a highly-trained physician, $225 a month – twenty-five dollars less than they did the white nurses staffed on similar assignments.

Whipper’s upbringing in black elite society also shaped her interactions with midwives. While training a group of midwives in Texas in 1928 Whipper found the women, overall, to be quite cooperative but she noted, “when I insisted that every midwife must furnish herself the uniform and bag, many of them regarded themselves as practical nurses.” Whipper’s surprise

81 Ione, 23.
82 Haines to Whipper, January 31, 1928; Whipper Austin, Texas Weekly Report, February 18 and 25, 1928, File 4-2-1-2-1, Box 267, Central Files 1925-1928, CB; also see “Report on the Midwife Survey in Texas”; Handwritten notes on Whipper’s salary, File 4-2-1-2-1, Box 266, CB.
83 “Memorandum to Miss Mitchell,” Folder 1, File 4-2-1-2-1, Box 267, Central Files 1925-1928, CB.
84 Handwritten salary note, File 4-2-1-2-1, Box 266, Central Files, 1925-1928, CB.
that the midwives would react so strongly to being told they needed to furnish their own bags reveals some of the class tensions that arose between Whipper as a government employee and the midwives she worked with, who often struggled to get paid for the deliveries they attended. For these midwives, in asserting that their work was practical nursing, it was a way for them to signal that they did not need class training. They were deliberately blurring the demarcations between nursing, health work and lay care in an effort to avoid unwanted restrictions.

Midwives attended Whipper’s classes as part of a long list of requirements they had to meet in order to practice. Lessons consisted in telling midwives “what not to do and when to send for a physician,” emphasizing that midwives could not administer drugs or folk remedies, perform vaginal examinations, use forceps, and attend to abnormal labors without a physician present. Many of these restrictions grew out of suspicions that midwives’ lack of cleanliness caused deadly infections, and that traditional remedies like herbal teas led to complications during delivery such as excessive bleeding and miscarriages. For midwives in states like Virginia and Alabama, such “inflexible rules” were printed on the back of their permits as a constant reminder. Some midwives outright resisted the new regulations placed on them, arguing that they were “never taught that way” and that their ability to practice as midwives was a calling, not a government-regulated occupation. And for midwives like Lou Strickland, such demands took a toll on their time and health. She informed her supervising nurse, “I am sorry to say I will not

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86 Midwife Permit, 1939 Box 2, Folder 11, Datcher Family Papers, ADAH; Plecker, “Opportunities of Vital Statisticians,” 32.
87 Lula Jemison, Follow Up Midwife Record, February 22 and March 3, 1938, Talladega County Midwives 1933-1947, ADAH.
be able to be in the meetings every first Saturday on the account of my health I am not able to walk. I am giving done…so I will have to resign.”

In her classes Whipper taught midwives how their work “affects the death rate among mothers and babies.” The second aim of the classes was to convey the importance of hygiene, as her syllabus noted, “The absolute necessity of cleanliness; the danger of germs.” The 1920s was the height of popular awareness and alarm over the power of germs to spread disease. This new belief in the role of germs in causing death represented the culmination of long debate within medicine over the relationship between cleanliness and health. As early as the 1840s the Hungarian physician Ignaz Semmelweis had demonstrated a link between hand washing and a reduction of childbed fever, but his findings were met with criticism from physicians outraged by the suggestion that they were the cause of their patients’ deaths. But by the late nineteenth century, laboratory experiments conducted by Pasteur, Koch and others demonstrated a germ theory of disease and from these discoveries cleanliness quickly emerged as an important quality and value of modern life. Whipper’s lessons reflected a widespread interest in conveying the importance of modifying everyday behaviors to avoid deadly disease. Her syllabus incorporated different educational tools to accommodate various levels of literacy, including the use of songs, skits, dolls and puppets, role-playing, and educational films. Practical demonstrations were repeated in class “over and over again” to familiarize midwives with cleanliness procedures. Midwives learned how to wash their hands, prepare sterile supplies, bathe and dress the mother.

88 Lou Strickland, Record of Investigation, Talladega County Midwives 1933-1947, ADAH; Agnes Livingston record, Citrus County, Midwife Records, Box 6, Series 904, Florida.
89 Whipper, “Syllabus of Instructions to Midwives,” Box RCB-23779, RG 26-26-63, Georgia Archives.
and infant, make an improvised incubator, and fill out a birth certificate. Whipper’s syllabus, spanning over eleven pages, expanded the topics and delivery problems midwives learned; a copy of the 1922 syllabus used by Georgia public health nurses before Whipper worked in the state covered all of the lesson plans for midwives in only two pages.\textsuperscript{91} Whipper’s syllabus became the standard model, through at least 1937 health departments in the North and South requested over 1,000 copies.\textsuperscript{92} Joe P. Bowdoin, venereal disease control officer in Georgia, noted that even after Whipper finished her work in the state he continued to rely on her lesson plans, finding them effective and “of the simplest kind.”\textsuperscript{93}

\textsuperscript{91} “Outline for Public Health Nurse’s Instructions to Midwives,” 1922, Unnamed folder, Box RCB-23779, RG 26-26-63, Georgia Archives.
\textsuperscript{92} Bowdoin to Haines, Feb 8, 1929, File 4-7-4, Box 380, CB; J. Warren Smith to Whipper, Feb 17, 1928, File 4-10-4-2, Box 274, CB.
\textsuperscript{93} Bowdoin, 460-462.
A group of midwives in Beaufort, North Carolina gathered in front of where they took classes, the county courthouse. The messages written on some of the signs they are holding include: We Must Call a Doctor, Healthy Mothers and Better Babies, We Must Have a License, We Must Report the Baby’s Birth, The New Midwife Must Be Clean, We Must Put Drops in Baby’s Eyes. The emphasis on hygiene is underscored in the sign that “the new midwife must be clean.” *Health Bulletin*, April 1925, p. 21 and back cover, Wilson Special Collections Library, University of North Carolina at Chapel Hill.

Two techniques – proper ways to treat infant’s umbilical cords and eyes – formed the core of skills midwives were expected to master. As chapter one demonstrated, neonatal tetanus was a feared disease. While considered a disease of enslaved infants, neonatal tetanus continued to haunt Southern states into the twentieth century, causing more infant deaths “than diseases usually considered more important” from a public health standpoint, such as tuberculosis.94 Thus, when health officials developed instructional classes for midwives they devoted several demonstrations to reviewing hygienic techniques for cutting the umbilical cord and the danger

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94 Victor H. Bassett, *Prevention of tetanus neonatorum in the South: with a discussion of the results that may be expected from the public health control of midwives*, read before Southern Branch of the American Public Health Association Meeting, December 1937, RJ320.T4 B37, Georgia Archives.
signs to watch out for if the wound became infected. States like Georgia credited the scrutiny and swift investigation of infant deaths due to tetanus neonatorum as one of their most successful techniques for “controlling” midwives.  

Whipper instructed midwives to wait until the cord stopped throbbing before tying, cutting and dressing the cord with sterile tape and gauze. Midwives practiced the procedure on dolls that had strings coming out of their navels. The cause of infection, Whipper taught midwives, “always comes from without” due to dirty hands, dressings or scissors, and could result in fatal blood poisoning. Midwives were instructed not to use traditional preparations of grease or cobwebs to control bleeding and create a natural aseptic, and homemade dressings like twine, thread, and scorched linen were also not allowed. Having spent time visiting midwives and seeing firsthand the homes they worked in, Whipper understood that sometimes midwives had to improvise. She recognized the difference between midwives that came to her classes, bearing their practical experience and concerns as a result of working in difficult settings, and public health nurses who, trained through textbooks and lectures, “have never cut a cord,” although the latter were often put in charge of leading midwife trainings. Her instructions contained basic expectations for providing care, and midwives that considered her advice useful went on to teach mothers how to keep their homes clean for their infants and children. Frances

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95 Bassett.
96 Margaret Charles Smith, 73; All My Babies, Dir. George C. Stoney, 1953.
98 For the use of these traditional preparations see Watson; Folder “Housewifery – Magic, Charms – Childbirth,” Box 46, Frank Clyde Brown Papers, Duke Archives; Mandy Johnson, Midwife, Interview with Ida Prine, Folder 64, Federal Writers’ Project Papers #3709, Southern Historical Collection, The Wilson Library, University of North Carolina at Chapel Hill.
99 Whipper Weekly Report, Austin Texas, February 18 and 25, 1928, File 4-2-1-2-1, Box 267, Central Files 1925-1928, Records of the US Children’s Bureau, Record Group 102, National Archives, College Park, MD.
Mansfield, a county nurse working in Marshall Texas, wrote to Whipper to let her know that the midwives she had trained over a year ago had moved on to “having class for the housewives teaching them sanitation just as you taught them.”

If any midwife-attended newborns died from tetanus, health officials investigated the death and paid close attention to the materials used to dress the cord. Midwives could have their licenses revoked for attending cases in which the disease developed. The investigations highlighted the intense scrutiny midwives were subjected to, and the seemingly minor ways their actions could raise alarm. Alabama midwife Rosa Little was investigated when an infant she delivered died a day after being born. When the supervising nurse conducted the inquiry she first spoke to the infant’s grandfather who stated that the baby’s navel had bled a “great deal.” After speaking with neighbors who confirmed the conditions of the baby’s death the nurse concluded that the infant had died because Rosa had tied off its umbilical cord using sewing thread, a prohibited item midwives were not allowed to carry in their bags. Maria Bell’s work as a midwife was questioned when, upon a home visit a public health nurse noticed blood on the scissors kept in Maria’s bag, and noted “method of care of scissors and dressings [was] questionable.” When she was asked to present at a monthly meeting, midwife Annie Bledsoe sufficiently demonstrated proper hand scrubbing and cord dressing techniques. But the nurse overseeing the class also recorded that Annie “did not handle scissors well.” As states investigated suspicious cases, midwives were forced to carefully adapt their practices. Willie

100 Frances Manfield to Whipper, May 16, 1929.
101 Hixie Davis correspondence with Georgia Department of Public Health, May 7, 1939, Folder “Special File - Midwife Problems,” Box RCB-37997, 26-26-72, Georgia Archives.
102 Rosa Little, Record of Midwife Investigation, April 16, 1937, Talladega County Midwives 1933-1947, Alabama Archives, Montgomery, AL [ADAH].
103 Maria Bell file, Talladega County Midwives 1933-1947, ADAH.
104 Annie Bledsoe file, Talladega County Midwives 1933-1947, ADAH.
Ann Lucas, a third-generation midwife in Arkansas, recollected how elements of her practice, including caring for the cord, differed from her mother’s and grandmother’s experiences as midwives. When she practiced, “[y]ou carried your own pan because that’s what you had to sterilize your scissors with, and you would put that on and boil your scissors and sterilize them in order so when you cut the navel cord, umbilical cord they call it, then it wouldn’t set up infection or anything. And you had to carry this tape, umbilical tape that you’d tie the cord with before you cut it.”

For Willie, not only her equipment, but also the language she used to describe her work, changed as a result of health officials’ rules and intensifying scrutiny. Midwives were seen as negligent, even criminal, if they didn’t follow state procedures for tying the umbilical cord, but they already had deep familiarity with caring for the navel. Tending to the cord was one of the first duties African American women learned to keep watch of. Anna, a midwife practicing in North Carolina in the mid twentieth century, recalled that as a little girl her mother, who was also a midwife, would “send me out to tend the mother and baby and take care of the cord. We put a ball of lard on it and let it rot off and then we put a scorched piece over it.” As Anna continued to shadow her mother she learned to make sure the “cord didn’t grow back in.” She remembered that she had to “tie the cord in two places, one with a short string to keep it from bleeding and another with a long string,” in order to fulfill her mother’s expectations for proper care.

Blindness could also set in within the first days of an infant’s life and Whipper’s classes stressed the importance of midwives taking preventative measures. State laws required that one

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per cent solution of silver nitrate be put in the eyes of newborns immediately after birth to protect them from developing ophthalmia neonatorum, a common form of infant blindness.\textsuperscript{107}

The preventative measure stemmed from the work of German physician Carl Siegmund Franz Credé who demonstrated the efficacy of the procedure in 1881 while working in the maternity division of Berlin’s Charité Hospital, and the measure became known as Credé’s prophylaxis.\textsuperscript{108}

In the 1890s New York became the first state to pass a law calling for the reporting of infant eye infections, and by the 1920s more states required midwives to have a role in preventing infant blindness.\textsuperscript{109} As midwives reported the births they attended, registrars crosschecked that information against records of silver nitrate ampules that each midwife received for free. In 1928, midwife Martha Ann wrote to the Children’s Bureau requesting more supplies, “Gentlemen, Please send me some more nitrate silver if you can spare, two pkgs. Please send them I need them I got several more ladies to wait on.”\textsuperscript{110} As Martha’s request suggested, the amount of silver nitrate each midwife received could serve as a check and limit to the number of deliveries she could attend. In a survey of New Orleans midwives practicing in the 1920s, the


\textsuperscript{110} Martha Ann Robinson, Keachi Louisiana, Folder 41, Box 2, Dorothy Kirchwey Brown (Mrs. LaRue Brown) A-119 Collection, Schlesinger Library.
contents of their bags varied widely indicating the degrees by which they adhered to state regulations, but virtually all surveyed midwives carried bottles of silver nitrate.\textsuperscript{111}

Unlike tetanus, in which the source of infection was believed to be due to the midwife’s dirty supplies, the cause of infant blindness could be attributed to either the midwife or the mother. The National Committee for the Prevention of Blindness (NCPB) advocated that the prophylactic treatment of silver nitrate should be used at every birth. But black physicians were more measured in their support of treating newborns for sore eyes. The National Medical Association (NMA) supported state and local efforts to prevent blindness, but in its 1915 official endorsement of the NCPB’s campaign, the NMA emphasized that “blindness from ophthalmia neonatorum is not necessarily any reflexion on the virtue of father or mother, but an infection which may occur at any birth.”\textsuperscript{112} Given widespread views of African Americans as infected with venereal disease and early twentieth century scientific studies that linked infant blindness to maternal gonorrheal infection, the NMA recognized a need to stress that an infection leading to blindness could occur in any newborn, and while easily preventable the condition should not be automatically attributed to the parents’ race.

With Sheppard-Towner funds slated to end in June 1929 and Whipper still stationed in Texas, Haines tried to secure a new position for Whipper, “anxious that she should not be lost to the health work among the negroes.”\textsuperscript{113} While Whipper’s work was not included in the Bureau’s published infant mortality studies, and its annual reports mentioned her assignments only briefly, state health officials wrote regularly to the Bureau inquiring if Whipper could oversee projects in

\textsuperscript{111} Watson, 11.
\textsuperscript{113} Haines to J.C. Anderson, June 6, 1929, File 4-2-1-2-1, Box 374, Central Files 1929-1932, CB.
their black communities.\textsuperscript{114} When writing to the Texas Health Officer Haines commended Whipper as “even tempered, tactful, and a hard worker with something of the missionary spirit. She is progressive and never loses an opportunity…to secure the latest information on midwifery and child hygiene.”\textsuperscript{115} Whipper was grateful for her supervisor’s support writing, “it really makes an otherwise irksome job quite a pleasant one.”\textsuperscript{116}

Whipper’s work addressed the health and training needs in black communities, but the introduction of scientific methods did not completely supplant the belief systems and expertise midwives had developed through years of hands-on experience. “Two-thirds of what I know about deliverin, carin for mother and baby, what to expect, what was happenin and was going on, I didn’t get it from the class,” explained Onnie Lee Logan, a midwife practicing in Mobile, Alabama in the mid-twentieth century. “God gave it to me. So many things I got from my plain own motherwit.”\textsuperscript{117}

The Birth Certificate: From Training to Surveillance

As local, state, and federal governments continued to train midwives, the birth certificate became an important tool for regulating midwives’ work and gaining statistical knowledge of African Americans. Midwives who sought to maintain their practices had to adopt this new form of recordkeeping, and while midwives had long kept their own records of the births they

\textsuperscript{114} Children’s Bureau Annual Reports 1925-1929; Haines to J.C. Anderson, June 6, 1929, File 4-2-1-2-1, Box 374 Central Files 1929-1932, CB; Haines to Agnes Morris (New Orleans Director of Bureau of Child Hygiene), April 23, 1927, Folder 4 “U.S. Birth Registration Area,” File 4-2-1-2-1, Box 267, Central Files 1925-1928; Haines to Whipper, April 9, 1929, File 4-2-1-2-1, Box 374 Central Files, 1925-1928, CB.

\textsuperscript{115} Blanche M. Haines to J.C. Anderson, June 6, 1929.

\textsuperscript{116} Whipper to Haines, May 7, 1929, File 4-2-1-2-1, Box 374, Central Files 1925-28, CB.

\textsuperscript{117} Logan, 90.
attended, new laws required that they share that information with the state.\textsuperscript{118} Prompt birth registration was seen as the “first line of attack” against preventing infant mortality and the birth certificate was considered the “raw material” for calculating the statistic.\textsuperscript{119} Blank birth certificates became incorporated into the list of materials midwives had to have ready when called to deliver and midwife trainings increasingly focused on making sure midwives properly filled out certificates, with penalties for missing or incorrect forms. At the same time, the information captured on birth certificates enabled health officials to investigate a range of health and social problems including congenital syphilis, and infants born of mixed-race or illegitimate status.

Another song midwives sang in their classes, this time to the tune of “The Battle Hymn of the Republic,” illuminated the ways trained midwives had become incorporated into an expanding system of health care and vital registration.\textsuperscript{120}

\begin{verbatim}
We put drops in the baby’s eyes
Whether the mother laughs or cries,
The State for us the eye drops buys,
   As we go marching on.

Glory, glory, hallelujah,
Glory, glory, hallelujah,
Glory, glory, hallelujah,
   As we go marching on.

We report births and deaths of all,
\end{verbatim}

\textsuperscript{118} See for example Martha Collum Midwifery Register, 1872-1903, Folder MF 304, Box Doc 6358, 048-01-001, Maternal Health and Family Planning, Georgia Department of Public Health, Georgia Archives, Morrow, GA [Georgia Archives]; Bedside Birth Record, Alice Johnson family papers, 1942-1957 (SPR840), Alabama Archives, Montgomery, AL [ADAH].
\textsuperscript{120} Julia Ward Howe, “The Battle Hymn of the Republic,” \textit{Atlantic Monthly}, February 1862; Volume 9, No. 52; 10.
When anything is wrong, we the doctor call,  
We hope we never from grace fall,  
As we go marching on.\textsuperscript{121}

As the song illustrated, in the early twentieth century births had evolved into a bureaucratic event, bringing together the mother, baby, midwife, physician, and state. The hymn emphasized the specificity of the midwife’s responsibilities, what she could and could not do, while encouraging midwives to perform their work with a sense of religious and patriotic duty. No longer was she wholly disregarded as a practitioner to be eliminated. Instead she occupied an important, albeit limited, role helping mothers during childbirth. The song’s phrase, “The State,” carried meanings of authority and fear – a recognition that midwives’ ability to “go marching on” with their work was largely determined by health officials who monitored their actions.\textsuperscript{122} These interactions aimed to prevent disease and death but sometimes it resulted in conflicts over who had control in the birthing room.

By 1919, forty-one states required that midwives promptly file birth certificates and midwife instructors created songs to make clear the necessity of filling out certificates for every birth.\textsuperscript{123}

Whenever you deliver perhaps a Baby Boy  
Remember he is human, not just a little toy.  
His Birth should be recorded within ten days or less  
And in years to come, you will be blessed.

Be sure His name, the date, the place are right  
If not, in time he’ll be in quite a plight

\textsuperscript{121} “Song of the Midwives” from Ferguson, 90-91.  
\textsuperscript{122} Lois Patrick, “Nursing Observations of a Midwife Delivery” June 11, 1952, Unnamed folder, Box RCB-23779, 26-26-63, Georgia Archives.  
\textsuperscript{123} Foote, 536.
Check and re-check, then have the mother sign
And you will have great peace of mind.\textsuperscript{124}

The birth certificate replaced older forms of recording births, including church records, private journals, and family Bibles.\textsuperscript{125} Midwives had to manually complete and submit correct forms generally within five to ten days of attending a birth.\textsuperscript{126} Mailing certificates or handing them in-person to the registrar, who could be miles away, could easily take additional time and money. To encourage timely submissions, Florida’s public health nurses held meetings where midwives could bring certificates they had made out during the week and receive help correcting any mistakes.\textsuperscript{127} Both midwives and physicians faced penalties for failing to file birth records, but the penalties were much harsher for midwives and included monetary fines (ranging from $10-250), license revocation, and threats of up to six months imprisonment.\textsuperscript{128} While the demand

\textsuperscript{124} See Eugenia Broughton, photo by E.S. Powell, collection of the American College of Nurse-Midwives, National Library of Medicine, Bethesda, MD.
\textsuperscript{127} Mamie O. Hale, “Arkansas Teaches Her Midwives,” \textit{The Child} (October 1946), 1.
\textsuperscript{128} Foote, 542-543. Local registrars received twenty-five cents for each certificate filed. Their reports were sent to state registrar and state health offices who compiled information from all counties before transmitting it to the Children’s Bureau and the Census Bureau in D.C. Midwives and physicians were not compensated as it was considered part of their professional duty to report such activity to the state. William H. Davis, A. A. Whittemore, W. Thurber Fales, Stewart G. Thompson, Carl F. Raver, “Registration Affairs” \textit{American Journal of Public Health and the
for prompt filing served to ensure up-to-date information, it placed an additional burden on midwives with limited literacy. In 1924 a U.S. Public Health Service nurse created a midwife manual which provided a four-page response to the question “How would you report a live birth?” specifying in exacting detail how each section of the birth report should be filled out before concluding that failure to comply would result in a fine of $5 to $100 dollars per offense.129 Facing such demands, many midwives felt forced to retire. Midwife Alice Cunningham flatly told the public health nurse she reported to, “I can not work at this job any longer so I am off.”130 It was, in the words of Alabama midwife Margaret Smith “strict law on us and no pay.”131

In 1928 and 1929 Whipper was sent to Texas to help the state, the last one remaining, gain admittance to the federal birth registration area. Tasked with this assignment Whipper contacted “all the people of influence who could help put the work over,” held as many as five conferences a day, and enlisted college students to conduct house-to-house canvassing of all babies born.132 Much of her success she credited to the involvement of black women and midwives, who as she reported, “have shouldered the responsibility of getting the names of all

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129 Laurie Jean Reid, Manual of Instruction for Midwives (Jacksonville, Florida, 1924).
130 Alice Cunningham file, undated letter, Talladega County Midwives 1933-1947, ADAH.
131 Margaret Charles Smith, 75.
the 1927-28 babies for the census.”

Mothers and expectant mothers attended her meetings, asked questions and brought their babies “from miles around for examination.”

A local Texas newspaper informed its readers, “Dr. Whipper (colored female doctor) sent out by the Federal Government spent the month of March in the county…a great deal of good was accomplished we feel sure.” Whipper was well aware that in order to gain knowledge of black births and deaths she needed to work with local leaders and utilize community networks to circulate health information.

Other health officials, however, maintained a deep distrust towards working with African Americans, especially midwives. State and local health departments knew that midwives, like many African Americans living in rural areas, had limited access to quality education. By requiring midwives to take literacy tests, health officials deliberately used literacy as a proxy for assessing health competence. Midwives who could not read or write were considered unfit to practice. But state registrars also recognized the need to make the language on birth certificates “as simple as possible” and “adapt them to local needs.” Assumptions about midwives’ incompetency not only shaped midwives’ interactions with registrars and public health officials, but also influenced the way states collected vital information. Describing his experience developing a standard birth certificate, Walter Ashby Plecker, physician and Virginia’s first registrar in its Bureau of Vital Statistics, mentioned the need to make small but important

133 Whipper, Austin and Brenhara Texas, Weekly Report, April 21 and 28, 1928, File 4-2-1-2-1, Box 267, Central Files 1925-1928, CB.
134 Whipper, Austin, Texas Weekly Report, March 3 and 10, 1928; Whipper Austin, Texas Weekly Report, March 31, April 7, and April 14, 1928, File 4-2-1-2-1, Box 267, Central Files 1925-1928, CB.
135 Palacios Beacon, Vol. 22, No. 26, Thursday, June 27, 1929, 1.
changes on the state’s birth certificate in order to secure accurate information. According to Plecker, the category “sex” was too vague:

The need for the term ‘Boy or Girl,’ instead of ‘Sex,’ was made apparent to me when remonstrating with a colored midwife for always omitting the answer to that essential question. When I discovered that she did not know the meaning of the word sex, I endeavored to make it plain by telling her that we wished to know whether the child was male or female. Her puzzled look still proved that my language was not sufficiently simple. I then asked, in reference to the certificate in hand, ‘Was the child a boy or a girl?’ The question brought a ready response, and that became the accepted form for the question as to sex.137

While Plecker was quick to dramatize his efforts to secure comprehensible information from the women who attended births otherwise unknown to the state, he left out that midwives cooperated out of fear that they would be punished if they failed to do so. Plecker informed a colleague, “I ‘hold a big stick’” over the 6,000 midwives practicing in the state.138 Plecker also wanted “color or race” to replace the older birth certificate category “color,” seemingly so as to eliminate responses such as brunette, blond, light skinned, and dark. He claimed that the term “color” alone was too vague, but his deeper concern was that many babies were passing as white, when their parents or ancestors had black blood. Including a category that explicitly asked for the newborn’s race legally reinforced ideas of racial classification according to the one-drop rule. And it aided Plecker in his ability to vigilantly enforce Virginia’s 1924 “Act to Preserve Racial Integrity.” Any certificate that did not identify the parents and child as either white or colored was sent back for correction. Plecker’s system rejected terms that reflected mixed race identities.

138 William Plecker to Arthur Estabrook, August 11, 1924, Folder 3, Box 1, Arthur Estabrook Papers, M.E. Grenander Department of Special Collections and Archives, University at Albany, New York.
It also classified all American Indians living in Virginia as colored. In these ways he adapted the birth certificate so that it became a powerful tool for demarcating and policing who counted as white and who counted as black in Virginia.

Registrars closely scrutinized “rural certificates” containing “misleading or valueless” information. Public health officials primarily used information captured on birth certificates to locate where recent births had taken place in order to ensure that mothers were able to care for their newborns, and to identify sickly or premature infants in need of additional care. If a death of an infant or woman of childbearing age occurred, officials investigated whether a midwife was involved. As one midwife observed, “if anything happens bad to the mother, they’re calling you in.”

Health officials paid close attention to reports of stillbirths. Black stillbirths garnered attention because they could be the result of miscarriages, abortion attempts, or diseases such as syphilis. Physicians, midwives, and mothers had conflicting ideas of what caused stillbirths. African American mothers attributed their premature deliveries and miscarriages to overstraining themselves with physically demanding work. A patient of Rebecca McGee believed she had a stillbirth because she washed heavy quilts a day before going into labor. Other mothers accounted for their stillbirths by describing the “hard work” and laundry they did up until labor.

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139 Individuals identifying as Indian wrote to Plecker requesting that they be recognized as Indian. In some instances Plecker consented but not without noting, “in our office…we have only two colors, white and black.”

140 Fraser has described Plecker as having a vision to erect an “efficient and scientific bureaucracy for managing reproduction,” Fraser, African American Midwifery in the South, 60. Also see Peggy Pascoe, What Comes Naturally: Miscegenation Law and the Making of Race in America (New York: Oxford University Press, 2009).


142 Margaret Charles Smith, 102.

143 Rebecca McGee August 1937 record, Talladega County Midwives 1933-1947, ADAH.
pains began. But health authorities almost always suspected that black stillbirths were due to syphilis, and public health nurses urged parents to get a Wasserman test and seek treatment. Even for married black couples, the occurrence of a stillbirth was taken as a sign that the parents were diseased. In cases of accidents, of mothers falling and fatally injuring their fetuses, health officials still stressed the importance of being tested for syphilis. They did not advise women to refrain from heavy work or be more cautious with their movements. Health officials’ insistence on attributing all black stillbirths to syphilis was informed by the work of obstetrician John Whitridge Williams, who had done earlier work in pelvimetry and in 1914 conducted a study of 705 fetal deaths occurring in 10,000 consecutive admissions to Johns Hopkins Hospital. The study was widely cited in its time for demonstrating the role of syphilis in early mortality, profiling the patient population of a general hospital located in a metropolitan area (almost half of the women who gave birth were African American), and for the fact that all infant deaths were subject to autopsies. Williams’ findings were cited for demonstrating that syphilis was “the most important single factor” for fetal death. By reducing all black stillbirths to syphilis,
health officials reinforced ideas of blacks as diseased and ignored other potential causes of fetal death, especially the amount of physical work that black women engaged in while pregnant.148

In addition to identifying sick mothers or infants, health officials used the information on birth certificates to detect certain forms of social deviancy. Such measures extended the reach of states to intervene in private, intimate affairs as well as broader public health issues. Based on the information provided on birth certificates, officials could identify children born out of wedlock, to interracial couples, and syphilitic parents. Physicians and midwives were required to report whether the newborn they delivered came from a legitimate union or not. Using this information, states like North Carolina sent letters to single mothers notifying them that having babies outside of marriage was a serious problem, not only for the mother, but also for the larger community. Health officers obscured the lines between disease, sexuality, and morality, warning mothers that “when a woman has a baby without being married, she has not only committed a sin, but she is exposing herself to diseases which are not only serious for the mother but for the baby as well. Many times babies are born blind or crippled because of these diseases.”149 Health officials played up fears of infectious disease and deformity to scare single women from having sex. An illegitimate birth was seen as socially unacceptable but health officials further argued that it was a risk to the health of the mother and child as well, linking undesirable social behaviors to disease. Embedded within public health warnings to sexually active single women were gendered and racialized norms concerning individual behavior, marriage, respectability,

and parenting. Sin, not sickness, was the root of any bad outcomes that would befall the infant and family, and officials asserted that there were dire health and social consequences for women who refused to restrict their childbearing to marriage.

Additionally, officials verified marital status not only to determine whether the child’s parents were married, but also whether the parents were of the same race. Health officials argued that registering all births was the first step in combating infant mortality. But in states like Virginia and North Carolina, campaigns to reduce infant mortality intersected with dogged efforts to police racial lines, including preventing individuals from passing as white, criminalizing interracial marriages, and policing sexual relationships, making visible how racial and gendered agendas were deeply embedded in reproductive policies including infant mortality campaigns.

Conclusion

What had initially begun as a government effort to reduce black infant mortality transformed into a campaign to train and regulate midwives, and consequently, to police the reproductive and family lives of African Americans. This chapter traced the Bureau’s initial studies of infant mortality and its emerging concern with black infant health that culminated in the hire of Dr. Whipper, whose primary assignment was to train black midwives. But even as health officials focused increasingly on midwives and developed classes and laws to control all aspects of their practice – from the clothes midwives wore to the supplies and techniques they

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used – black communities still placed great value in the work and care midwives provided. Exploring the reasons why African Americans relied on midwives places in sharp relief how the government’s chief interest in reducing black infant mortality by policing midwives failed to address the broader issue that midwives were a vital community resource, often the only practitioners to provide health care and support in rural areas.

As Ferguson and his colleagues prepared to leave True Light Baptist Church the midwives recited a closing prayer before adjourning their meeting:

Our Father who art in heaven…
We thank Thee that every child, regardless of race, color or creed, wherever he may live under the American flag can have a clean healthful place for his birth and the mother can receive good care before birth of the baby, at birth of the baby, and after the baby comes. And may it be Thy divine will that through the instructions we receive in these health measures childbearing will be safer.151

This version of the Lord’s prayer and the other songs midwives learned – one a popular nursery rhyme, another a regional anthem, and the third a well-known Christian prayer – all became married to the idea that the midwife could protect not only the mother and baby, but also the home, region, and country, through God, and the state’s, grace. The songs and prayer Dr. Ferguson and his colleagues heard captured and preserved the content of Whipper’s lessons from a generation earlier, spelling out the midwife’s duty and placing her as the key person responsible for the livelihood of mothers and infants. Nurses used Whipper’s syllabus to train midwives and drawing on African American beliefs of midwifery as a calling, they adapted

151 Ferguson, 95.
songs that linked messages of spiritual duty and public service to Whipper’s lessons on hygiene and professional responsibility. The lyrics outlined the actions the government expected the midwife to take, and the effects of such actions on patients and the midwife’s practice. The midwife’s ability to follow through with these instructions, such as promptly filing an accurate birth record, affected not only the infant’s health but also its claims to citizenship. In these ways midwives, previously singled out as a problem, became responsible for carrying out key duties for the state.

Yet even as government officials trained midwives, they remained vulnerable to penalizations and investigations. The 1910s and 1920s efforts to define the role and responsibilities of midwives is one episode in a larger story of singling out particular causes and holding particular actors – midwives, parents, governments – accountable for young lives. The Children’s Bureau’s work had a lasting impact on the training of subsequent generations of midwives as chapter five will show, illuminating how powerfully the government transformed and reinforced ideas of responsibility in health.

African Americans, of course, had their own ideas for why they suffered from higher incidences of infant death. Targeting individual midwives, as well as mothers, and controlling who could deliver babies and under what circumstances, proved easier than addressing the larger problem that blacks had limited access to adequate healthcare. So much of the government’s emphasis on framing black infant mortality as a problem of incompetent practitioners worked to deflect attention away from the role of Jim Crow segregation in black life and health. As the next chapter will illustrate, African Americans welcomed the increased attention to black infant health, but that did not stop them from criticizing the rhetoric and approaches used to combat poor health outcomes in their communities and developing strategies of their own. At the same
the government was narrowing its focus on midwives, black communities were broadly exploring and discussing a range of approaches to preventing infant death and protecting their children’s physical and spiritual health.
In 1892, the 29-year old Mary Church Terrell was a newlywed struggling to become a mother. The daughter of former slaves, she would go on to become a leading activist for black women’s rights. She helped to establish, and served as the first president of, the National Association of Colored Women (NACW) founded in 1896, and was a charter member of the National Association for the Advancement of Colored People (NAACP) formed in 1909. Before this, however, she was preoccupied with the more personal goal of trying to start a family.\footnote{Terrell’s experiences as a wife and mother stand out, at least in part, because as Linda Gordon has noted, over a third of black female club leaders who were married had no children. See Linda Gordon, “Black and White Visions of Welfare: Women’s Welfare Activism, 1890-1945,” \textit{Journal of American History} 78 (September 1991): 559-590, 568-569.}

In her 1940 memoir \textit{A Colored Woman in a White World} Terrell penned an intimate portrait of a mother’s anguish over losing her young children. “The summer after my marriage I was desperately ill and my life was despaired of,” she wrote. “In five years we lost three babies, one after another, shortly after birth. This was a great blow to Mr. Terrell and me…When my third baby died two days after birth, I literally sank down into the very depths of despair. For months I could not divert my thoughts from the tragedy, however hard I tried.”\footnote{Mary Church Terrell, \textit{A Colored Woman in a White World} (Washington, DC: Ransdell Inc., 1940, reprinted 1992), 106-109.} In recounting this period, one full of distress and loss rather than joy, Terrell chose to describe her experience using the language of illness and affliction. Her family watched in horror as she anticipated each birth only to be gripped by a “paroxysm of grief” as each of her babies failed to survive their first
few days. With her husband’s insistence, she left Washington D.C. to spend time under her mother’s care in New York, a visit that afforded her the space and support to recover “physically, mentally, and spiritually.” Yet she still struggled to convey to her friends, and to her readers, the grief she endured, the “bitter disappointment of never having enjoyed the infant at all whose coming the mother has looked forward so long and upon whom she has built such fond hopes.”

In the forty years between when Terrell began her difficult journey into motherhood and when she made public her experiences with infant loss, much had changed in the way African Americans discussed, responded to, and understood infant mortality. Terrell’s experience with infant death was similar that of many other well-off women living in the nineteenth century – a tragedy contained in the home, managed by female networks of friends and kin, and discussed in private letters and conversations. Her feelings of shame and anguish reflected the era’s view of

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3 While the biographical details of Terrell’s life are illuminating, Terrell warns the reader that despite her commitment to “tell the truth and nothing but the truth,” she maintains that certain incidents in her life can only be discussed “lightly.” Thus, even as she discloses some of her difficulties with becoming a mother, she cautiously leaves out other details. For example, she discusses her emotional and mental suffering following the deaths of her children but only obliquely mentions that she may have suffered from physical complications as well. Darlene Clark Hine’s concept of ‘a culture of dissemblance’ among black women is helpful for situating Terrell’s decision to write a memoir with the “appearance of openness and disclosure” that at the same time shielded her more vulnerable experiences from public view. See Darlene Clark Hine, “Rape and the Inner Lives of Black Women in the Middle West,” Signs: Journal of Women in Culture and Society Vol. 14, No. 4 (Summer, 1989): 912-920. On Terrell’s health and disability see Alison M. Parker, “The Picture of Health: The Public Life and Private Ailments of Mary Church Terrell,” Journal of Historical Biography 13 (Spring 2013): 164-207. Also see Diana Price Herndl, “The Invisible (Invalid) Woman: African-American Women, Illness, and Nineteenth-Century Narrative,” in Women and Health in America, ed. Judith Walzer Leavitt, 2nd ed., (Madison: University of Wisconsin Press, 1999), 131-145.

infant death as a judgement against parents. In asserting that “the maternal instinct was always abnormally developed in me,” Terrell sought to dispel any doubts that her race made her unfit for motherhood.\(^5\) This chapter explores what infant death meant for Terrell’s generation living in a period when the omnipresence of infant death was, slowly, becoming less common but still tied to ideas about racial fitness and survival. Through a variety of forums, including health columns and literature, African Americans debated the consequences of “saving” black babies in an era of Jim Crow. They shared their experiences with infant loss through personal memoirs, songs, and photographs, and in these spaces black parents articulated fears about the impact of diseases and behaviors on their ability to raise healthy children, anxieties influenced by contemporary eugenic ideas. The rise of racial violence in this period introduced new political stakes in the decision to bear children or terminate a pregnancy, and black women connected concerns about infant welfare to ideals of race motherhood and threats of racial violence on women and children’s wellbeing. By 1941, an infanticide trial in Washington D.C. that was closely covered in the black press demonstrated how the death of an infant was no longer seen as a poor reflection of parents’ physical fitness or moral character, but instead as embodying society’s indifference to black children.

Reproductive Health and Fitness in Black Advice Columns

Black newspapers of the early twentieth century played a major role in disseminating health advice to readers across the country, part of a genre of prescriptive literature and advice manuals that outlined the ideal behaviors and roles for moral, physical, and social advancement.\(^6\)

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\(^5\) Terrell, 106-107.

\(^6\) Black newspapers widely reported on infant mortality studies and infant health campaigns taking place in black communities, including for example, the health work done by the National
From 1911 to 1929 the weekly health column “Keep Healthy” ran in the *Chicago Defender*, one of the leading African American newspapers of the time that circulated widely in the North and South. The column’s author was the newspaper’s health editor and respected race leader Dr. Albert Wilberforce Williams, a graduate of Northwestern University’s Medical School and an attending physician at Chicago’s Provident Hospital, the first hospital in the country to be owned and run by African-Americans. Unlike other columns in black periodicals that covered medical topics, such as Dr. Lucien M. Brown’s “Keeping Fit” in the *New York Amsterdam News* and “Health Talks” by Dr. Julian H. Lewis in *Half-Century Magazine*, Williams allowed readers to write in seeking his advice on health issues. Though the column ran a disclaimer, “No Cases Are Diagnosed and No Prescriptions Given in These Weekly Articles,” readers, such as the expectant mother who wanted to know whether to hire a midwife or doctor, asked personal health questions expecting a professional medical opinion and authoritative information. And the letters came overwhelmingly from African American women, making the column an important site for examining black women’s efforts to seek reproductive health advice, and how infant health concerns were framed in public discourse.

African American women took advantage of the opportunity to get advice from Williams in part because communicating through the advice column offered a level of confidentiality and anonymity for discussing sensitive health issues. Women used the venue to seek advice on how to get pregnant, determine if they were pregnant, and protect their pregnancy. They worried how preexisting and coexisting conditions (fibroids, tumors, heart trouble), past medical events (surgical operations), and new symptoms (vaginal discharges, back pains) would affect their ability to carry a pregnancy without causing harm to themselves or their unborn child. The newspaper only identified letter-writers by their initials and, sometimes, where the letter came from, and with such a level of privacy some women felt emboldened to disclose intimate details of their lives. One woman writing from Chicago in 1926 wanted desperately to become a mother but worried her case might be difficult. “Some years ago I had an abortion performed,” she confessed. She felt “perfectly normal” now, but her husband was convinced she must be sterile. Had her past choices permanently destroyed her ability to start a family now that she felt ready to do so? She wanted to know, would a physician “handle” her case as she tried to bear a child?

Williams responded that abortions could produce damaging effects, but since the woman was in

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7 In this same period the Children’s Bureau received hundreds of letters from women, many of them mothers and expectant mothers, seeking information about managing a pregnancy, giving birth, and raising children. Rarely did women identify themselves by their race, but judging by the Midwestern and Northern towns they wrote from, they were often white and living in rural areas far from physicians and hospitals they could turn to for advice. For examples of these letters see Molly Ladd-Taylor, *Raising a Baby the Government Way: Mothers’ Letters to the Children’s Bureau, 1915-1932* (New Brunswick: Rutgers University Press, 1986); Reagan, 7-17.  
8 Barbara Duden has argued that examining historical accounts of births and deaths are important, but “what cannot be read from the statistics is the suffering, the fear, the hemorrhaging between the acts of giving birth, that is, the death that occurred inside the body.” As such, examining letters like these helps us better understand the ways pregnancy and birth were uncertain and terrifying events for many women. See Barbara Duden, *The Woman Beneath the Skin: A Doctor’s Patients in Eighteenth-Century Germany*, trans. by Thomas Dunlap (Cambridge: Harvard University Press, 1991), 159.  
9 Dr. A. Wilberforce Williams, “Fear Sterility,” *Chicago Defender* July 17, 1926, 2.
good health a doctor should be willing to guide her through pregnancy. In fact, he tellingly added, “the fault” of being unable to conceive may actually lie with her husband.

As a reputable physician in high demand, female readers sought to catch Williams’ attention by presenting themselves as informed and willing patients desperate for advice. One woman, twenty-eight years old and living in Arizona, wanted to have children but had experienced a miscarriage and menstruations that were “irregular and scanty and very painful.” She had seen many doctors near her but, as she explained, “they do not do me any good…you know, they are white and do not like to attend to us.” She turned to Williams, having “read about lots of things you have done for others and truly believ[ing] you can help me.” He recommended she get a thorough examination to determine her condition and insisted, “if the white doctors do not care to give you service find a Colored doctor, even if you must travel 1,000 miles.”

He knew a black physician near her who would “take great pride” in treating her. In describing a past miscarriage and womb trouble, a twenty-six-year-old woman writing from Detroit made clear that she was an informed reader and compliant patient. The woman had sought medical advice from several physicians for her reproductive troubles, even travelling to New York to be treated for fibroids. Yet even as she openly shared these details she only obliquely mentioned that she also had syphilis, noting she had “taken 606 and mercury shots at intervals for three years” until she was “negative.” Back at home she felt well but was unsure what to make of recent changes in her body. Was it possible that she could be pregnant, she nervously asked,

given her history of reproductive difficulties? If she were in fact pregnant, would it be “more
dangerous when the baby is born? Could the baby live?” Williams assured her there was no need
to “dread” her confinement. Fibroids could complicate her pregnancy and delivery but, he
maintained, her baby would arrive on time. Although Williams offered these reassurances, his
mention that the child might be born “a little smaller than usual,” suggested that her child could
possibly have a hard time surviving.

With so many women asking about matters of reproductive health and sexual hygiene,
Williams crafted his responses to address broader worries about heredity and fitness. A fourteen-
year-old girl wrote in that ever since she got married she had “been sick” and frightened as a new
mother: “my baby is sick all the time and has never been well since it was born.” What
“worried” her about her situation was that she had not had her period in five months. “Please tell
me what to do,” she pleaded.12 Although Williams provided straightforward advice for the
mother to get herself and her baby under the care of a physician, in framing her letter under the
heading “Married Too Soon” Williams offered an additional layer of commentary on the young
girl’s fitness for married life and the responsibilities of healthy procreation that came with it.
While Williams did not explicitly discourage African Americans from having families, the
language contained in his responses revealed his commitments to eugenic ideas of reproduction
among the fit in order to ensure racial survival.13

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12 Williams, Chicago Defender December 19, 1925, 10.
13 On eugenic ideas of fitness and fit families see Martin S. Pernick, The Black Stork: Eugenics
and the Death of “Defective” Babies in American Medicine and Motion Pictures Since 1915
(New York: Oxford University Press, 1996); Daniel Kevles, In the Name of Eugenics: Genetics
and the Uses of Human Heredity (Cambridge: Harvard University Press, 1985); Alexandra
Minna Stern, Eugenic Nation: Faults and Frontiers of Better Breeding in Modern America
(Berkeley: University of California Press, 2005); Wendy Kline, Building a Better Race: Gender,
Sexuality, and Eugenics From the Turn of the Century to the Baby Boom (Berkeley: University
Williams stressed the role of venereal disease in causing infant and fetal mortality, and in
doing so joined a number of social hygienists in linking infant health to race and venereal
disease.\textsuperscript{14} The advice he dispensed on how to manage a healthy pregnancy and birth grew out of
his agenda to persuade readers to protect themselves from the ravages of venereal disease. He
considered it a major threat endangering the lives of the unborn and frustrating couples trying to
conceive. In describing the pathology of syphilis and gonorrhea, Williams stressed their
gendered and disabling effects in causing permanent damage to women’s reproductive organs,
miscarriages, and sterility in men. The sins of the husband were unfairly inflicted on innocent
women and children, evident in his reference to syphilis as “honeymoon appendicitis.”\textsuperscript{15} He
sought to educate readers on what he considered the “greatest danger…awaiting the unborn or
those to be born,” and attributed a large percentage of stillbirths and miscarriages within the race
to these diseases, going on to insist “whenever you hear or know of frequent deaths of new-born
infants, and whenever you observe mentally defective children, think of syphilis as being the real
cause.”\textsuperscript{16} A major cause of neonatal death was the “taint” of syphilis which parents could have
acquired or inherited. “There is always some mental or physical defect” in babies infected with
syphilis, he wrote, “they are slow to develop and often born deformed.”\textsuperscript{17} By attributing

\textsuperscript{14} Allan M. Brandt, \textit{No Magic Bullet: A Social History of Venereal Disease In the United States
Since 1880} (New York: Oxford University Press, 1985); Christina Simmons, “African
Americans and Sexual Victorianism in the Social Hygiene Movement, 1910-40,” \textit{Journal of the
History of Sexuality} Vol. 4, No. 1, 1993, 51-75; Terence D. Keel, “Charles V. Roman and the
742-766; Courtney Q. Shah, \textit{Sex Ed, Segregated: The Quest for Sexual Knowledge in
Progressive-Era America} (Rochester: University of Rochester Press, 2015), 55-77; James Jones,
\textsuperscript{15} Williams, March 27, 1920. On the concept of “innocent infections” see Brandt.
\textsuperscript{16} Williams, “Talks on Preventative Measures, First Aid Remedies Hygienics and Sanitation,”
\textit{Chicago Defender} March 27, 1920, 20; Williams, “The Venereal Diseases and the Negro,”
\textit{Chicago Defender} August 30, 1919, 20.
\textsuperscript{17} Williams, “Keep Healthy,” \textit{Chicago Defender} November 1, 1913, 4.
problems with conception to venereal disease Williams sought to transform readers’ sexual habits as well as their hygienic practices, stressing moral restraint and the necessity of professional medical testing and treatment before attempting to start a family.\textsuperscript{18}

Williams was not alone in viewing sexual immorality as a root cause of infant mortality. As with other American social hygienists of the early twentieth century he believed achieving and maintaining good health rested on three pillars: the application of modern tools of preventative health, education, and sound morals. Venereal disease infections and other health issues that compromised reproduction, especially giving birth to healthy children, were signs of physical as well as moral corruption. Nashville physician Charles V. Roman, president of the National Medical Association and the first editor of its official journal, shared this perspective, writing in 1915, “a low birthrate among parents with sound bodies and good morals is the true remedy for the excessive infant mortality. The saddest phase of infant mortality is not the death of children, which in most cases should never have been born, but the awful drain upon the vitality, and morals of the parents.”\textsuperscript{19} A few years later in an article titled “Some Ramifications of the Sexual Impulse,” Roman declared “adult morality holds the key to infant mortality.”\textsuperscript{20} But whereas Williams embraced public discussions of sex as a means of educating the public, more conservative social hygienists such as Roman shied away from candid discussions. As Roman

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19 C.V. Roman, “The Negro Woman and the Health Problem,” \textit{Journal of the National Medical Association} 7 (July-September 1915): 189. The \textit{JNMA} was the official journal for the National Medical Association, the oldest medical professional association for black physicians. It was founded in 1895, at a time when the American Medical Association was only open to white physicians.
\end{flushright}
saw it, “Knowledge and goodness do not always go hand in hand…Our enthusiastic advocates of teaching sex-knowledge to the young, erroneously conclude that increased knowledge means increased morals, when the opposite is usually true of knowledge prematurely given.”

Although the letters Williams received came overwhelmingly from women, much of his advice was directed at men as he assumed, and expected, women to convey his messages of sexual hygiene to their partners. A gendered discourse is evident in his recommendations for preventing venereal disease and in the ways he described the causes of infant death. “It often turns out,” he wrote, that the underlying cause of sterility, pregnancy complications, or even crippling neonatal disabilities can be found “not in the wife, but in the husband.” Williams singled out men for their role in the race’s experience with infant death, declaring “Let us men be fair in this, and manfully take our share of the blame and responsibility in the matter, and not put in on the weaker vessel, the woman.” In making this statement Williams saw no contradiction in recasting a concern over women and children’s health into a call for men to assume and assert their masculine duties. Reducing infant mortality could not be left in the “weaker” hands of women but must be addressed head on by black men.

Concerns about sex dominated Williams’ column’s discussion of infant and family health. The Chicago Defender was so overwhelmed with questions about reproduction that by 1925 the newspaper pleaded, “let us get away from the sex questions, such as how to have a baby, miscarriages, pus tube, results of operations, why sterile…as many of our readers must

22 Williams, “Keep Healthy,” Chicago Defender November 1, 1913, 4.
have other medical questions in which they are deeply concerned.”

While editors supported Williams’ mission to raise awareness among African Americans about the dangers of venereal disease they feared “Keep Healthy” would collapse into a column on the “ever-present sex question” and thus invite even more discussions of socially taboo behaviors. Underlying this fear was the concern that readers were drawing too much attention to sexual activities at a time when black women especially were caricatured as sexually promiscuous and unfit mothers. Thus, even as the column sought to educate readers on sexual health it threatened to reinforce ideas of venereal disease as more prevalent among African Americans and blacks as more willing to engage in and tolerate immoral sexual behaviors.

Despite editors’ alarm in discovering the “sex question is the question uppermost in the mind” of its readers, the continued flood of letters made clear that “Keep Healthy” provided a much-needed venue for addressing worries about reproductive health that were otherwise difficult or inappropriate to broach in public. Aware that many readers did not rely on doctors for several reasons – including cost, access, embarrassment, and fear – the paper nonetheless advocated for women to take up their concerns in face-to-face encounters with a physician. “We know that the Colored people feel embarrassed to approach these doctors on questions of family relations, child-bearing, heartaches and yearnings following certain operations in which the pelvic organs have been removed,” editors wrote. “We know that the people are yearning for information concerning impotence, sterility, barrenness on the part of women…but these are subjects that should be taken up in close confidence with the family doctor behind closed doors.”

Sponsoring a health advice column that refrained from candidly discussing sex and reproduction

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24 Williams, “To Our Readers,” *Chicago Defender* April 18, 1925, 12.
25 Williams, “To Our Readers.”
proved a delicate, if not impossible, task. The controversy surrounding the column revealed that even as physicians sought to educate the public on preventative health measures, fetal and infant health problems were still viewed as the consequence of sexual immorality and lack of racial fitness. With such stigma surrounding these health issues, few African Americans felt emboldened to openly discuss their experiences with infant loss, preferring to seek advice through confidential means.\footnote{This conversation would evolve. By the 1930s black physicians and male elites were more willing to voice their support of black women using birth control. Charles H. Garvin, a Cleveland physician and local leader in the NAACP and Urban League, for example argued “race women should learn birth control” to counter low birth rates and the “tremendous and distressing infant mortality rate.” Although his article originally appeared in Margaret Sanger’s Birth Control Review, a journal openly in support of promoting scientific birth control methods, it was soon reprinted in the Chicago Defender. Charles H. Garvin, “The Negro Doctor’s Task,” Birth Control Review (November 1932): 269; “Physician Says Race Women Should Learn Birth Control,” Chicago Defender, 12 Nov 1932, 2.}

**Racial Uplift and the Dilemmas of Black Parenthood**

Alongside advice columns black newspapers widely advertised events and initiatives of interest to black parents, including National Negro Health Week, an annual event held across the country where African Americans could go for infant health information and care. The annual event was established by Booker T. Washington in 1915 and ran for eight days in early April, kicking off with a series of talks, including one on infant mortality, on Sunday, “Lecture and Sermon Day,” which complemented the Well Baby clinics set up later in the week.\footnote{Sandra Crouse Quinn and Stephen B. Thomas, “The national negro health week, 1915 to 1951: a descriptive account,” Minority Health Today (2001) 2, 44–49.} A centerpiece of the week’s events were the Better Baby contests and baby shows, popular events that brought together health education and public entertainment. In African American urban communities, the contests were often held in churches, community health centers, and housing
complexes, areas that could accommodate large gatherings and offer spaces for maternal and infant clinics. The events were opportunities for parents to showcase their children who competed for ribbons and small prizes, and for nurses to demonstrate infant care and feeding techniques, distribute health pamphlets, and conduct physical exams. As historians have noted, better baby contests embodied eugenic ideals of promoting health, fitness, and natural competition. Winning babies and runner-ups received prizes and were often featured in the pages of *Opportunity* and *Crisis*, the periodicals of the NUL and NAACP respectively.

28 Carolyn Leonard Carson ‘And the results showed promise... physicians, childbirth, and southern black migrant women’, *Journal of American Ethnic History* (1994) 14, 32–64. Additionally in April the NACW Health and Hygiene Committee organized Better Babies shows and contests through its local chapters. The Children’s Bureau held Baby Week campaigns in early May, making the early spring a concentrated period of infant welfare work. The seasonal timing made sense as infant deaths tended to spike in the hotter months, the highest infant deaths recorded in June, July, and August.

Figure 4.1

Winning babies and their mothers at the New York City Baby Show, December 1923. The competition featured fifty infants and was held at Lincoln House on West 63rd Street, a settlement house for African Americans. October 1923, *Opportunity.*

Through baby contests and print culture, black communities celebrated the physical health and vitality of infants at a time when caricatures of African Americans as diseased and degenerate prevailed widely. From 1913 to 1934, each October issue of *Crisis* was devoted to children, the Children’s Number, featuring photos of African American babies and children on the magazine’s cover and interspersed throughout coverage of political and social events. The phrase “our children” appears throughout as well, underscoring the idea that the race was collectively responsible for raising a strong and healthy future generation. Editors encouraged readers to send photographs of African American children, pleading, “we want all the good clear

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pictures of healthy human babies that we can get.” As a result the magazine received hundreds of letters, mostly brief inquiries from parents, relatives, and the occasional proud sibling, asking to have their baby featured in the upcoming issue. Other letters included more details about a baby’s features and its distinctions (family background, awards from baby contests) to convince editors their child was an ideal candidate for placement in the magazine. Mrs. R.M. Williams writing from Philadelphia in August 1923 sent Crisis a photo of her infant son Clarence, “just 9 mos old” and weighing twenty-one pounds, hoping his image could be included in the upcoming October issue. She signed her letter “Yours for success,” echoing the publication’s racial uplift rhetoric. In November 1929, a mother from St. Louis wrote to the magazine expressing her disappointment that the latest issue did not feature “just babies” who came from ordinary families, like her ten-month-old daughter Jean, but instead only carried pictures of “NAACP babies.” Her comment hinted at some of the class tensions at play in these public displays of babyhood and race vitality, and her hope that all babies would be judged on the same standards of physical fitness, and not selected because of their elite connections. As she suspected, the photographs Du Bois and magazine editors selected were never random, but carefully chosen representations of healthy babies from ‘degreed and pedigreed’ African American homes. Admitting that her request was “no doubt annoying” she asked for her daughter’s picture to be returned as “it is the only picture I have.” In his response Du Bois noted that he had intended to

34 Carson, 32–64.
publish Jean’s photo in the future but was honoring the mother’s request and returning it, advising the mother to never again “take the risk of sending a valuable photograph.”

Figure 4.2


Early issues of the Children’s Number included positive affirmations and writings on the hopeful future awaiting black children but by 1919 even Du Bois had to admit that the world awaiting unborn children was bleak. He lamented the fact that recent issues of the Children’s Number had to contain reports of racial violence. A surge of race riots, mob violence, and lynchings erupted in dozens of cities and counties across the country in the 1910s and 1920s, prompting protests, activist campaigns, and political action among black organizations including the NAACP. Images of black babies and children were juxtaposed against the Crisis’ coverage

of these developments. “What effect must it have on our children,” he asked, for young readers to come across such horrific reports in an issue celebrating and educating them? While the Children’s Number exposed black children to positive images of themselves, helping instill an appreciation that “being ‘colored’ is a normal, beautiful thing,” at the same time the newspaper saw its duty to inform readers, including young readers, of the violence facing the race. What began as a project of racial uplift and popularizing eugenic ideals was forced to confront a social and political climate increasingly hostile to black survival. And as politically charged discussions of death and racial violence infiltrated conversations about child welfare, it cleared the way for African Americans to begin speaking more publicly and boldly about the challenges they faced as parents.

In seeking to “save” their children, black parents searched for strategies that would help prepare children for the prejudice they would undoubtedly encounter. In his 1933 autobiography James Weldon Johnson stated the problem this way, “the question of the child’s future is a serious dilemma for Negro parents. Awaiting each colored boy and girl are cramping limitations and buttressing obstacles…and this dilemma approaches suffering in proportion to the parents’ knowledge of and the child’s innocence of those conditions.” Parents faced a tough choice: whether to spare their child “the bitter knowledge” of racism or to have it “driven in upon him from infancy.” Johnson was aware that neither option was perfect, and choosing to instill that lesson early on in life or delay it could very well lead to “spiritual disaster for the child.”

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Refusing to Bear “More Dark Bodies for Mobs to Lynch”

Debates among African Americans over the best way to protect young black children, and the meanings of infant mortality, were shaped by race and class as much as they were by gender. African American women were considered the ‘race bearers’ upon which the race’s survival and success depended on. Yet many black women rejected this ideology which stressed motherhood as a pillar of racial uplift, and they pushed back against the vision that their primary role was as mothers responsible for reproducing a new generation. Black women argued that their experiences as women and mothers could not be divorced from the larger landscape of racial indignities, terror, and violence they endured. The question they raised – is it worth bringing a child into a world in which it is doomed to suffer? – echoed the nineteenth century dilemma facing Harriet Jacobs as an enslaved mother, but this early twentieth century discourse wrestled with new cultural ideas of motherhood as voluntary, infant mortality as a social problem, and intensifying forms of anti-black violence.

The realm of theater and literature became, in the mid 1910s into the 1920s, an important site where African American women explored the consequences and burdens of black motherhood. Through novels, short stories, poetry, and plays black female writers of the New Negro movement such as Nella Larsen, Angelina Weld Grimké, Georgia Douglas Johnson, and Carrie Williams Clifford depicted the multiple costs of bearing children on women’s physical, professional, and political lives. They linked infant welfare to concerns about the dangers of

39 And for writers like Grimké who were exploring their sexuality beyond the dictates of heterosexual relationships, such works helped carve out a space for black women to define themselves in a way not tethered to biological reproduction. One literature scholar has argued that in “resisting their assigned motherly roles within the New Negro movement and in their personal lives as well, 1920s black women writers attempted to create a geographic and discursive space for sexual yet childless black women in masculinized Harlem.” See Anne Stavney, “‘Mothers of Tomorrow’: The New Negro Renaissance and the Politics of Maternal
pregnancy and childbirth, responsibilities of marriage, and threats of racial and sexual violence. Their works foregrounded the “unique horror” black women felt in bearing children at a time when the threat of lynching loomed large.\textsuperscript{40} By focusing on the experiences of pregnancy and the fates of unborn lives, black female writers challenged the Progressive Era ideal that every infant life must be “saved,” arguing that their own lives were not protected and that they were being asked to bring children into a world hostile to their existence. It was an action they considered irresponsible, and taken to its extreme, a form of race suicide. In this sense, the idealized rhetoric driving infant welfare campaigns butted up against the violent realities of race relations and white supremacy.

This new wave of literary and theatrical works differed from antebellum portrayals of motherhood and infant death. As previous chapters have explored, African Americans had long viewed infant deaths as consequences of the violence, exploitation, and oppression they endured, and argued that under certain circumstances death could be a liberating act – an act of mercy and love. But whereas slave narratives framed infant death as a desperate but humane course mothers could take to spare their children from lives in bondage, black women writing in the early twentieth century articulated a refusal to bear and raise children that emerged from a desire to both preserve their own health and protect their children from becoming victims of lynch mobs.\textsuperscript{41}


\textsuperscript{41} Another scholar has noted “if infanticide in the slave narrative served as a desperate means of direct action—at once sparing a child the pain of bondage and depriving the master of
Mary Church Terrell’s own birth and her experiences as a mother illuminate some of the concerns black women held over how to protect their children. She opens her memoir by describing how she was born in the wake of crisis and despair. Her mother, Louisa Ayers, had attempted suicide while pregnant with Mary. This “prenatal experience” left no immediate mark, Mary was born healthy and “on scheduled time” a few months after the incident.\textsuperscript{42} But the circumstances surrounding her birth – the “fit of despondency” her mother experienced and the “miracle” of her survival – foreshadowed Terrell’s own struggles to become a mother. Her observation that her mother’s emotional struggles could have had a “decidedly disagreeable, if not fatal” impact on her future reflected a long-held belief that a pregnant woman’s state of mind, encompassing everything from her anxieties to her cravings, could affect the development of her unborn child.\textsuperscript{43} As the letters published in “Keep Healthy” revealed African American women worried about their pregnancies and births, and possible dangers that could arise. One strain of these anxieties concerned the extent to which women’s thoughts could directly influence the health of their unborn children. These beliefs had roots in folklore and science, including Lamarckian theories of the inheritance of acquired characteristics, ideas that the environment’s influences on an individual’s experiences could be passed on to the next

\textsuperscript{42} Terrell, 1.

At an Atlanta University conference held in 1897 on the “causes of excessive mortality among Negroes,” Adella Hunt Logan, an instructor from Tuskegee, called for more women to be attentive to the ways “the sensitive embryo receives the impressions made upon the mind of the mother.”

“If the pregnant woman is constantly wishing that her unborn child were dead…who can wonder that out of such murderous thought there come in truth a murderer!”

Similarly, in a 1914 advice manual *Golden Thoughts on Chastity and Procreation, Including Heredity, Prenatal Influences, etc., etc.* created specifically for African American readers, the authors John Williams and his wife cited several physicians discussing the ways an expectant mother had the “power” to “shape the mental, moral, and spiritual features of her child” especially when the “embryonic” brain was still developing.

African American women worried that certain frights and strange sights could project onto their future children, and that such experiences could cause a miscarriage, premature birth, or early death. One woman, the daughter of a Louisiana sharecropper, remembered advice she

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46 Although the writers were white, this edition featured an introduction by a black physician and all of the drawings and images were of African American families. See chapter III, “Prenatal Influences,” in John William Gibson and Mrs. John William, *Golden Thoughts on Chastity and Procreation, Including Heredity, Prenatal Influences, etc., etc.* ...(Washington D.C.: Austin Jenkins Co., 1914), 39-58.
was given when pregnant not to look at anything “not normal” or it would “mark” her baby. Of all the possible shocks and unnerving sights, expectant mothers avoided encounters with death when pregnant. Black communities maintained beliefs that it was dangerous for a pregnant woman to attend a funeral, as it would harm the soul or disposition of her baby. Expectant mothers were taught not to look into a grave or else they will lose the ability to “feel the baby.” One woman living in Alabama in the 1930s attributed her miscarriage to having attended a funeral a few days before her pregnancy terminated early.

The power of the maternal imagination to shape the child in utero haunted women like Terrell who could not escape news reports of black men and boys killed by white mobs. They worried about the men they knew and the children they were bringing into the world who faced a future of racial violence. Terrell’s depression following the death of her third child was magnified by the news that Tom Moses, a close friend she had known since childhood, had been brutally murdered in Memphis by a white gang, leaving a wife and children behind. Reflecting on these two events she wrote, “As I was grieving over the loss of my baby boy one day, it occurred to me that under the circumstances it might be a blessed dispensation of Providence that his precious life was not spared.” She was troubled by the idea that the horror and resentment she felt over Tom’s death “might have seriously affected the unborn child.”

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47 “Birthin’ & Babies” Tape 771, Side A, Box 20, (Mss. 4730) Louisiana Folklife Program Project Files, Louisiana State University, Baton Rouge, Louisiana.
49 Puckett, Folk Beliefs of the Southern Negro, 98
50 Record of Eliza Grace, Talladega County Midwives 1933-1947, ADAH.
51 Terrell, 108.
connects these two deaths that the reader learns the gender of her third child. Up until that moment Terrell had referred to her child as “it,” “the baby,” or “my baby,” but in light of the news of Tom’s lynching, the death of her “baby boy” takes on deeper meaning. And she uses the revelation to reframe her personal tragedy into a broader, political issue by asking, how many “colored mothers” have “been shocked and distracted before the birth of their babies by the news that some relative or friend had been burned alive or shot to death by a mob?” Her experience was not unique, she argued, but illustrated a painful reality facing black women in an era of Jim Crow.

Terrell’s experiences resonated with a younger generation of black female writers who depicted characters that refused, as Nella Larsen wrote in her 1928 novel *Quicksand*, to give birth to “more dark bodies for mobs to lynch.” Helga Crane, the main character in Larsen’s novel feels trapped by her marriage and multiple pregnancies, as each of her confinements temporarily disables her and limits her independence. Her fourth child dies after “a short week of slight living” and Helga expresses, privately, a “gleam” of relief that she has “one less” to worry about. The closing scene shows her as a mother of three living children with another on the way asking, “marriage—that means children to me. And why add more suffering to the world? Why add any more unwanted, tortured Negroes to America? Why do Negroes have children?”

In the wake of surging racial violence, including race riots, lynchings, and attacks against African Americans, black female writers portrayed characters that rejected motherhood altogether or exercised a voluntary motherhood in protest to the racial terror surrounding them.

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52 Ibid., 108.
54 Larsen, 293.
55 Larsen, 231.
Angelina Weld Grimké intertwined these concerns over motherhood, family, and lynching in a series of plays and short stories. In 1916 the NAACP debuted her three-act play *Rachel*, originally titled *Blessed Are the Barren*. The main character Rachel Loving yearns to be a race mother, professing “I pray God every night to give me, when I grow up, little black and brown babies-to protect and guard.” As Rachel matures, her dreams are shattered by a growing awareness of the racism around her. She learns that her brother and father were lynched ten years earlier, hears comments that it would be “kinder” to kill than to expose future children to violence, and acknowledges the futility of trying to shield family members from violence. Rachel’s despair culminates in her resigning herself to a childless life, declaring “it would be more merciful – to strangle the little things at birth” than to give birth to a black child.

Grimké’s exploration of the burdens of black motherhood continued in a 1919 short story “The Closing Door” featured in a special issue of Margaret Sanger’s journal, *Birth Control Review*, “The New Emancipation: The Negroes’ Need For Birth Control, As Seen By Themselves.” The story followed Agnes, a young, new mother who finds her long-held dream of motherhood tainted after learning that her brother has been lynched. As the reality of the world she is bringing her son into sinks in she exclaims, “‘Yes!—Yes!—I!—I!—An instrument of reproduction!—another of the many!—a colored woman—doomed!—cursed!—put here!—willing or unwilling! For what—to bring children here—men children—for the sport—the lust—of possible orderly mobs.’” Agnes smothers her newborn a few days later, underscoring her decision to have her child die from her own hands than potentially be killed in the hands of a

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hateful mob. In Grimké’s and Larsen’s works, pregnancy and the period of confinement figure as pivotal moments when black women reevaluate their ideas of motherhood.

Black women knew that being pregnant did not shield them from violence, it could in fact make them more vulnerable to abuse and cruelty. During the Progressive Era, over two hundred women were assaulted, tortured, and killed by white mobs, including acts of rape and lynching. At least seven women were documented to have been pregnant when they were lynched. The gruesome May 1918 murder of Hayes and Mary Turner, and nine other African Americans in southern Georgia over a weeklong period deeply shook African American communities across the country. Following the murder of Hampton Smith and wounding of his wife by a black tenant farmer who worked on Smith’s plantation, a white mob hunted down several black men in the area including Hayes. Upon discovering that her husband had been captured and lynched, although he had nothing to do with the murder, Mrs. Turner protested and vowed to seek justice. Such “unwise remarks,” prompted the mob to “teach her a lesson.” Mrs. Turner, eight months pregnant, was taken to a nearby river, tied by her feet and hung upside down on a tree, doused with gasoline, set afire, and riddled with bullets. While she was hanging and still alive, a member of the lynch mob performed a “crude Cesarean,” splitting open her belly, from which her unborn child fell and was crushed.

60 “Fear Race Riots As Result of Negro Lynching,” *Washington Times*, May 20, 1918, 2.
“Mary Turner, a pregnant woman…was taken from her home…” In the early 1930s black activists rallied to persuade President Roosevelt to support the Costigan-Warner anti-lynching bill. Black newspapers published a wave of articles to demonstrate the necessity of the bill, and in this piece Mary Turner’s story figures prominently. Philadelphia Tribune, February 28, 1935, 3.

The gruesome wave of events, particularly the horrific form of dismemberment inflicted on Mrs. Turner, sparked a wave of editorials, investigations, and fueled political momentum supporting the Dyer Anti-Lynching Bill that first went before Congress that same year. In the wake of the mob lynching the NAACP sent Walter F. White down to Georgia to investigate, whose report was the first to note that Mrs. Turner was pregnant when she was killed and to detail the mutilation of her body. In addition, the event catalyzed a wave of creative works and artistic forms of protest: the Ohio black writer and activist Carrie Williams Clifford wrote a poem “Little Mother” in memory of Mrs. Turner, and in 1920 Grimké wrote another short story, “Goldie,” directly inspired by the events. In sending the story for publication in The Atlantic Monthly Grimké noted that her inspiration “is not a pleasant one but is based on fact…The mob

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62 Julie Buckner Armstrong, Mary Turner and the Memory of Lynching (Athens: University of Georgia Press, 2011); Feimster.
63 “NAACP Makes Investigation,” Kansas City Sun August 10, 1918, 3.
64 Carrie Williams Clifford, The Widening Light (Boston: Walter Reid, 1922), 19-20.
made up of ‘chivalrous’ and brave white men determined to teach [Mary] a lesson…While the woman shrieked and writhed in agony, one man … ripped her abdomen wide open. Her unborn child fell to the ground at her feet. It emitted one or two little cries but was soon silenced by brutal heels that crushed out its head. Death came at last to the poor woman. The lesson ended.”

By the early 1920s, a distinct body of black literature had emerged that united concerns about motherhood, infant death, and violence. In her poetry Georgia Douglas Johnson further explored how lynching intensified the perils and pain of black motherhood. Her 1922 collection *Bronze: A Book of Verse* was written in part to answer criticisms that her earlier works were “not at all race conscious.” She told fellow poet Arna Bontemps, “someone said –she has no feeling for the race. So I wrote Bronze –it is entirely racial and one section deals entirely with motherhood—that motherhood that has as its basic note—black children born into the world’s displeasure.” Her poem “Black Woman” portrayed a woman pleading with her unborn:

Don’t knock at the door, little child,
   I cannot let you in,
You know not what a world this is
   Of cruelty and sin.
Wait in the still eternity
   Until I come to you,
The world is cruel, cruel, child,
   I cannot let you in!

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Don’t knock at my heart, little one,
I cannot bear the pain
Of turning deaf-ear to your call
Time and time again!
You do not know the monster men
Inhabiting the earth,
Be still, be still, my precious child,
I must not give you birth.

In exploring maternal feelings of despair and hope Johnson articulated the burdens placed on black women to protect their children and be good mothers. Black literary critics admired Johnson’s skill in exploring these fears, and in his review Alain Locke noted that Johnson had the gift of “seeing the ‘color problem’ at the heart, as it affects the inner life.” Her plays delved into these issues more acutely, interweaving the drama of lynching and infanticide. In Safe, one of six anti-lynching plays Johnson wrote, the main character, Liza Pettigrew, is nine months pregnant and in a “delicate state” when she learns of the arrest of Sam Hose and the plans of a white mob gathering near her home to lynch him. While Liza’s family tries to keep her away from the commotion, she grows agitated over imagining the terror Sam’s mom was experiencing. “I sho hopes mine will be a girl,” she says, “I don’t want no boy baby to be hounded down and kicked ‘round. No, I don’t want to ever have no boy chile.” As she goes into labor a doctor is called in, but as soon as she learns she gave birth to a boy Liza strangles him, muttering “Now he’s safe -- safe from the lynchers! Safe!”

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69 In 1899 Sam Hose was lynched and brutally mutilated in Coweta County, Georgia following a disagreement with his employer that escalated into charges of murder and rape.
Black female literary works from the 1910s and 1920s boldly explored the physical and psychological effects of racism on motherhood in a way that stressed the inhumanity of lynching, challenged cultural values of motherhood, and opened up spaces for women to imagine new roles for their sexuality and relationships in a way not tethered to biological reproduction. Through their acts to reject and limit motherhood they protested racism and racial violence. But these works were also met with criticism. Grimké was criticized for promoting a form of race suicide in her play, *Rachel.*\(^{71}\) The story, and the reactions it sparked, drew attention to the fact that African American women did not resign themselves to cruel fates but actively chose to limit their pregnancies, using birth control, turning away from their children, and sometimes resorting to murder in order to protect themselves and their children from harsher futures.

**Caring for the Infant’s Soul from Cradle Roll to Casket**

In 1938 under the pen name Cecelia Eggleston, Isadore Williams Miles, a teacher at Armstrong High School, a Washington D.C. school for African Americans, took to the pages of *The Forum*, a Southern magazine with a mostly white readership to describe the dilemma facing black women in their decision to bear children.\(^{72}\) Miles wasn’t just speaking hypothetically. She wrote the piece as she was preparing for motherhood, and by the time the *Forum* bought the story she was pregnant, and a mother when it was published. In “What a Negro Mother Faces,” Miles wrote of motherhood as a “grave” duty, for with it came an awareness that a black woman

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is “bringing into the world a child victimized not by disease or extreme poverty but by that over which neither he nor his parents have any control – the color of his skin.” Living in an urban city women like her had access to prenatal care, a situation black women in the South could not as easily secure, but even in the North her ability to protect her child’s physical wellbeing was compromised as she could only “take my baby to the clinic on the special days for negroes.” The cumulative effect of slights like these was considerable, “and thus, before he left my arms,” she wrote, her child would start “to learn day by day in a hundred subtle but nonetheless definite ways that he was different – somehow inferior.” Every aspect of her child’s future – its health and educational opportunities, in addition to its ability to pursue a professional career and travel – would be marred by racial prejudice. What about the church? Could it provide a sanctuary from these hardships and discrimination? As a devout Roman Catholic, Miles grew up learning she had “no choice” but, rather, an unequivocal duty to bear children. Birth control methods, including abortion, were not options. And yet the church in which she would raise her child was no different than other social institutions in the way it treated African Americans. She knew her child’s sense of belonging would be circumscribed by his race, “should his baby feet stray in the house of God beyond the last three rows, frantic ushers would seize him and return him to his proper place.” Her child would grow discouraged in life and disillusioned in faith as it learned to wait to take communion after white congregants. Religious messages of brotherhood and salvation would offer little comfort in the face of such humiliations. Even as she remained committed to her religious beliefs, Miles struggled to reconcile her views towards the church with her responsibilities as a mother. Any black woman who ventured to ask “Should I have a
“Will my child rise up to call me blessed or curse the day that he was born?” 73

As Miles’ piece broached, even as African American increasingly turned to physicians for health advice, the church remained an important space for seeking guidance. The Roman Catholic Church was both a source of counsel and frustration for Miles, but other denominations, especially black Baptist and Methodist churches also provided a range of spiritual and social needs to support their congregations and surrounding communities. The black church had long been the center of black social and political life, and in the early twentieth century it became actively involved in addressing black health needs. Black churches helped organize day nurseries and health campaigns, and organizations such as the NUL made use of the fact that churches were centrally located and could accommodate large numbers of people to host health lectures. In particular the church became an important place to educate congregations and the lay public on issues of family health, including infant health and even birth control. As one doctor wrote “let us respond to the cry of the suffering infant by formulating a program of lectures to be given in our churches. This is the method by means of which the mothers can be most successfully reached.” 74 Through personal ministry, health advice guides, and programs that combined outreach and health work such as cradle rolls, churches were uniquely positioned to help African American families nurture the spiritual and physical health of young children.

Lucy Hubert, a native of Philadelphia’s black community, was among those who insisted that the best child-rearing methods cultivated the infant’s body as well its soul. In her 1898 infant

care guide *Hints on the Care of Children* she taught young mothers the importance of proper infant feeding, of keeping a well-stocked medicine chest, and seeking a doctor’s help. And she included a chapter on religion, noting, “a paper on the care of children would be incomplete without considering their spiritual training.” As the mother of four children and wife to a pastor, Hubert believed her position afforded the necessary experience and opportunity to help other families. For her, attention to a child’s physical ailments was just one aspect of the care mothers and fathers needed to provide, writing, “all the care we can bestow upon a child is worse than useless if while caring for the body we neglect the soul.”

When it came to religious upbringing, she stressed, both parents were equally responsible to guide and “strive for the salvation” of their children.

The ability to properly care of the infant’s soul was one of the concerns that had originally guided the formation of the African Methodist Episcopal Church (A.M.E.). As early as the 1820s black Methodists in Washington D.C. voiced a number of grievances with the way they were treated in white churches, including their confinement to the colored “quarters” of the church’s gallery and the humiliating practice of pastors who “declined to take the Negro children into their arms when administering the rites of baptism.”

Given the importance of infant baptism in the Methodist Church, such discrimination not only fueled blacks’ growing alienation from the church, but more importantly, demeaned black parents precisely at the moment they

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sought to secure salvation for their children’s souls. When the A.M.E. formed as a separate denomination the founding document noted that blacks sought to be freed from the “spiritual despotism” they experienced in white churches, and stated “the baptism of young children is to be retained in the church.” The rules for governing services included specific prayers to be recited when performing the rites of infant baptism.77

Although it did not hold the sacred meaning or provide a path for salvation that infant baptisms did, the rising popularity of cradle rolls among A.M.E. and black Baptist churches at the turn of the twentieth century reflected a continued interest among parents to ensure their children had a welcome, and special place within the church. In the early twentieth century cradle rolls emerged as a popular program through which families and congregations could begin tending to children’s spiritual upbringing. And through cradle rolls, churches joined other social institutions in establishing communal forms to watch over infants and young children. The program had roots dating back to the 1870s, spreading from New England Baptist churches to other denominations and states, and emerging as a key program in many black Baptist and A.M.E. churches by the 1900s. By 1913 over a million babies were enrolled in cradle rolls across the country.78 Black churches boasted of their “little members,” with large congregations claiming over a thousand babies under the age of three under their ministry.79

The program began religious training while the child was still in the cradle, and by paying a vested interest in the baby’s upbringing, churches aimed to draw children and their ‘unsaved’ parents closer to the church. Through congregation networks, a female superintendent and her assistants compiled a list of expectant and new mothers in the area and visited them in their homes. The superintendent checked on infants from birth up until the age of three or four years old, using the home visits to model good parenting and housekeeping skills and offer prayers parents could say over their children. The program reflected an emerging notion of infancy as a formative period of development and training, a time when wholesome habits could be nurtured and improper, irritable, or unhealthy ones suppressed. Relationships with families continued via mail, with superintendents sending cards on special days such as a child’s birthday or in times of sickness.

At the center of this form of ministry was the physical cradle roll, a document distinct from the baptismal certificate. With the parent’s consent the superintendent secured the baby’s name on the cradle roll, a document publicly displayed in the church, and presented parents with a certificate attesting to their child’s placement in the program. The certificate recorded the baby’s name, age, date enrolled, and parent’s names and address. At a time when birth certificates were only beginning to emerge as a key document of citizenship, church records such

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82 Jessie Eleanor Moore, The Cradle Roll Manual for Superintendents of Cradle Roll Departments and Others Interested in Or Responsible for Cradle Roll Activities (New York: Smith & Lamar, 1921)
83 “St. Mark A. M. E. Zion Church,” Philadelphia Tribune 14 June 1924, 14
as baptismal and cradle roll certificates were important documents certifying a person’s identity. Churches hoped that for families, having their child’s name entered on the cradle roll would be a source of pride and accomplishment that would draw parents to participate in other activities sponsored by the church. Churches considered cradle rolls an important way to start “little children in the right way,” serving as a bridge and a “key to homes” otherwise closed off, or indifferent, to religious instruction. The program was a way of carrying Christian ministry and service “into the homes of the community.”

Cradle roll programs drew on several outreach strategies used in infant welfare campaigns including health lectures and baby contests. Black churchwomen sought to foster a welcoming environment for parents by hosting “fathers’ receptions,” special parties, and lectures by health professionals for mothers. In 1937 a group of mothers at Wayland Temple Baptist Church in Philadelphia were treated to a lecture by a black bacteriology professor on the importance of having their children vaccinated, with him explaining that with the “recent discovery” of serums and toxins children no longer needed to be “victims” to diseases like diphtheria, scarlet fever, and measles. Additionally, several churches in a district or county would jointly host cradle roll contests, their adaptation of baby contests, with the proceeds split between the winning baby and its membership Sunday School. These could be big events, a 1924 contest held in Tulsa, Oklahoma at Union Baptist Church drew nearly 800 participants with the crowd paying 10 cents to cast a vote and the winning baby receiving 200 votes. Cradle roll

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84 Some families used the certificate, like a family Bible, to record the births of other children and grandchildren. See for example a Cradle Roll certificate from a black church, [http://findingeliza.com/archives/70](http://findingeliza.com/archives/70) <accessed February 8, 2017>
86 “Reception To Fathers Pleases,” Pittsburgh Courier April 7, 1934, 8.
parties were an additional way churches combined entertainment with health work. In 1914 the First Church of Columbus, Indiana reported on the success of a party held on its Cradle Roll Day, where over a hundred babies and their mothers attended, twenty-two babies were baptized, and afterwards while the infants were being seen by nurses, the pastor delivered a sermon to the mothers.  

In addition to borrowing tactics from infant health campaigns, cradle roll programs also employed well-established methods used by black businesses and mutual aid societies. Like burial aid societies and insurance policies, cradle roll programs brought together a group of individuals and families, and in doing so worked to cultivate a sense of shared responsibility. Some churches went even a step further, requiring parents to pay a small fee of a few cents to have their child included on the roll. Another important similarity with these business schemes was that membership in a cradle roll provided parents with the means to have a decent funeral for their children. In times of sickness and loss, an infant’s membership in a cradle roll facilitated parents’ ability to get additional care and a proper homegoing that could otherwise cost more than their means. The rules governing cradle rolls advised church members to provide “suitable remembrance in case of sickness or death.” When an infant died, its name was transferred from the Cradle Roll to the Heavenly Roll, a separate document kept in the church that preserved the child’s continued presence in the lives of their family and church. The

89 “First Church, Columbus, Indiana,” Western Christian Advocate, May 13, 1914, 594.
90 By the 1930s black newspapers had recognized the popularity of cradle rolls to draw in memberships, and adopted similar campaigns. See, for example, the advertisement that ran in the Afro American on April 22, 1939, 20.
91 Many records of black insurance companies and black funeral homes indicate that families would often pay the costs of their child’s funeral using the payouts from insurance policies. See for example, Gaines Funeral Home Ledger, Volume 2, 1924 March 23 - 1925 September 17, Duke University Library.
92 McFarland and Winchester, 312-314.
superintendent, other Cradle Roll mothers, and congregation members attended the baby’s funeral. The funeral service was not intended to be “sad or gloomy,” its purpose was to honor a young member of the congregation and teach others about the Christian belief in death as marking the soul’s passing from one world into another. A “large congregation” turned out to attend the February 1917 funeral for Baby Barry Waters, a member of the Asbury A.M.E. Church’s Cradle Roll in New Jersey. During the ceremony the Sunday school choir sang, several reverends read scripture, gave a benediction, and led the group in prayer. “Beautiful wreaths” and lilies were laid on the infant’s casket. As one woman, raised in another New Jersey A.M.E church at the same time recalled, “I grew up there, was in the cradle roll, so I’ll be there from the cradle roll to the grave.”

Outside of the church African Americans participated in symbolically rich rituals for honoring the children they lost. African American funeral homes had, by the early twentieth century, emerged as an important and centrally located site for casket viewing and funeral ceremonies. Funeral directors no longer traveled to individual homes to care for the deceased, and instead worked out of funeral parlors where they coordinated the transport and preparation of corpses, from home or hospital to parlor and then cemetery. Families used funeral parlors as a space to visit and take final photographs of, and with, their deceased. Except for portraits

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97 Funeral photographs are also part of a long and rich history of African American funeral practices, dating back to slave nighttime ceremonies and burial aid societies. See Karla F. C. Holloway, Passed On: African American Mourning Stories: A Memorial (Durham: Duke
were set in funeral homes, they maintained the appearance of intimate family portraits, a characteristic most strikingly seen in photographs of parents holding their dead children.

James Van Der Zee’s funeral photographs from the 1920s and 1930s portray some of these black families and project a dignified image of black mourning rituals. The self-taught Van Der Zee was one of Harlem’s leading black photographers of his time, documenting weddings, parades, celebrities and star athletes, and, in the 1920s serving as the official photographer for Marcus Garvey’s Universal Negro Improvement Association. In addition to his studio portraits and documenting of street life, Van Der Zee produced many funeral pictures, a popular keepsake of the time. Like Du Bois and Terrell, his work honoring infant and child loss was close to home. His second child, a son Emile born in 1910 in Harlem, died at the age of one from pneumonia and his first child Rachel died when she was a teenager in 1927. An acute observer of his surrounding Harlem community, when interviewed at the age of 91, half a century after he had taken many of his photographs, Van Der Zee could still recall details of the families who came to his photography studio on Lenox Avenue for postmortem photos. While refraining from characterizing them as extremely wealthy, they were able to afford his $35 photographs – what he considered “good money” back then – at a time when a black family living in Harlem earned an average $25 per week and paid $40 per month for rent. Clients came from all walks of aspiring and working class black life, including the elite (Adam Clayton Powell Sr. chose Van

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Der Zee to photograph his daughter Blanche’s funeral held at Abyssinian Baptist Church in 1926), the entrepreneurial (a taxi driver who owned her own cab), and members of the professional class (a nurse, an employee at NBC Universal with a $2,000 life insurance policy, and the mother of A. Philip Randolph’s secretary).  

Van Der Zee’s portraits reflected the aspirations of African American families and their efforts to maintain poise and dignity even in the face of death. The carefully composed photos of infants in open caskets were taken in funeral parlours where Van Der Zee arranged backdrops, furniture, lighting, and material objects including toys and household furniture. He staged families in intimate home settings, dressing the parents in neat, pressed clothes if they didn’t have any, and arranging their posture, hair, and facial expression in order to create a loving scene. As artist and historian of photography Deborah Willis has argued, in taking such care in the setup and composition of his photographs Van Der Zee created a space for black families to “expand spiritually, emotionally, and symbolically.”

99 Van Der Zee et al, 82-85.
In describing the above photograph, Van Der Zee remembered that he had borrowed a radio from the undertaker to make the scene more “homelike” and that the parents held the child to complete the “natural” ambiance. The camera angle mirrors the way the parents are admiring and holding their child, creating a perspective that feels intimate yet formal, with the infant’s white, swaddling clothes set against the parents’ dark outfits. When asked how parents felt about holding their dead children Van Der Zee noted, “Well it was their baby, they never had any objections.”\(^{101}\)

Van Der Zee employed a number of darkroom techniques, including photomontage, to produce funeral portraits full of religious meaning. He would retouch the images – erasing signs of sickness and physical imperfections – to make his subjects appear beautiful and at peace. And by inserting scripture, images of biblical figures hovering over the infant’s body, and other

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\(^{101}\) Van Der Zee et al, 82-85.
apparitions and symbols Van Der Zee’s portraits conveyed a sense of eternal life. His use of iconographic symbols that brought together the realms of body and spirit had roots in older, Victorian visual traditions, and the mortuary portraits dated back to an earlier era of daguerreotypes, but Van Der Zee’s methods were avant-garde, and he continuously experimented with the photomontage style popular in the 1920s. He would further manipulate images by using multiple negatives to create a single photograph, a process known as combination printing. As he noted, “I always tried to insert something to break the gruesomeness of the picture and make it look more like the realities of life and the beauty of death. According to the scripture, we should be more joyful at the going out and weep at the coming in.”

Through these artistic techniques Van Der Zee innovated a new mourning practice that joined the aesthetic and spiritual to reframe infant death as a pristine portrait of black life.

Figure 4.5

James Van Der Zee et al., *The Harlem Book of the Dead.*

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The convergence of race consciousness and material culture is evident not only in the context surrounding the production of the photographs, but also in how they were displayed.

Visual objects, particularly photographs, of African American children were part of a long history of representing the political stakes of African American freedom and destiny. As historian Michelle Mitchell has argued, the placement of “certain forms of material culture within domestic spaces” such as books and colored dolls in African American homes were symbols of racial progress as much as they were tools for self-education. The domestic display of photographs both signalled and reflected a family’s social and economic status, and had more private meanings and forms of circulation than the baby photographs prominently featured in the pages of *Crisis*. The circulation and exhibition of funeral photographs – whether privately kept, displayed in the home, or shared with relatives – conveyed a family’s losses, their aspirations, and their desire to maintain a continued connection with their loved ones. The considerations guiding how Van Der Zee, in conjunction with his clients, staged the photos illuminate how parents chose to honor their deceased.

Yet underneath their highly-stylized aesthetics, the photos pointed to the harsh realities of black urban life. In Harlem especially, African Americans struggled to find housing that was decently built, affordable, and provided enough space for growing families. Respiratory diseases like pneumonia, tuberculosis, and whooping cough were serious threats in densely populated areas and an acute concern for parents trying to shield their children from disease. As Van Der

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104 Mitchell, 177–179.
Zee recalled, back then, “most of these babies they all died of pneumonia; chest gets filled up with colds because they were living in cold flats. It was a very common thing in those days for people to be without heat.”105 Sporting the highest infant mortality rates in the city, the majority due to pneumonia and tuberculosis, by the 1910s Harlem had become the site of intense efforts by the New York City Department of Health, New York Tuberculosis Association, and other agencies to launch health campaigns including establishing prenatal clinics.106

Figure 4.6

James Van Der Zee et al., The Harlem Book of the Dead.

The tragic nature of infant deaths is reflected in the circumstances surrounding some of Van Der Zee’s photographs. In Figure 3 the baby is posed peacefully sleeping in a crib after it has nursed. When asked why the child was staged this way Van Der Zee explained “the mother had wanted the child to sleep in the crib, but she had never thought she was old enough to put her

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105 Van Der Zee et al, 82-85.
106 Tanya Hart, Health In the City: Race, Poverty, and the Negotiation of Women’s Health In New York City, 1915-1930 (New York: New York University, 2015); Greenberg, 32-33.
in there; so she was always keeping it until she got to be a certain age. In the meantime, the child died of pneumonia.”

The photograph preserved an idealized memory of the infant, one that erased the child’s suffering from sickness and visually realized the mother’s hopes for her child’s future.

Figure 4.7

[Image of a father holding an infant surrounded by floral arrangements and paintings.]

James Van Der Zee et al., *The Harlem Book of the Dead*.

Sometimes, the funeral photographs provided an incomplete but indispensable portrait of a family. The above image of a father and infant framed by an oversized floral arrangement and series of paintings had special significance as Van Der Zee explained, “the reason for having the father hold the child was that the mother was sick in the hospital and couldn’t get out. The child died in the meantime. If it wasn’t for the picture, the mother wouldn’t have seen the child for the last time.” In these ways, funeral photographs were important means through which African American parents maintained ties with their children and coped with their loss.

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107 Van Der Zee *et al.*, 82-85.
108 Van Der Zee *et al.*, 82-85.
Like a photograph, a song, too, could provide an intimate portrait of a parent’s efforts to cope with the loss of a child. As a young musician recently married and living in Chicago’s Southside, Thomas Andrew Dorsey remembered the August day in 1932 his job took him away from his pregnant wife, Nettie, nearly due to give birth to their first child. Although reluctant to leave Nettie, her pregnancy was advancing normally and she was in good care, the couple lived with Dorsey’s Uncle Joshua, one of the few black pharmacists in Chicago who also did doctoring work, and Nettie’s sister, a professional nurse who assisted Joshua. Dorsey traveled to St. Louis for a performance and while there received news that Nettie had gone into a difficult labor. The nearby hospital had no available beds and so she was forced to give birth at home with a physician attending. Nettie died in the process and Dorsey rushed home to find his wife, dead at the age of twenty-six, and a nine-pound newborn son. “I swung between grief and joy,” he recalled, there was “joy on the first floor of the house and sorrow on the second floor, for the mortician had not yet come to move the body of my wife from the bedroom.”

Even this joy was short-lived, as his son died the following day and was buried in the same casket as its mother.

Wracked with guilt that he was not by his wife’s side during her final moments, and suffering from a history of nervous breakdowns, Dorsey fell apart. “For days I closeted myself,” he remembered, “I felt that God had done me an injustice.” Lost in grief he tried to find solace in his faith in God and in his music. Sitting down at the piano days after the funeral, he pieced

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together a melody expressing his need for the Lord to see him through his pain. In an interview years later he recalled:

I found myself stumbling up on some new words which suited my mood of dejection and despair: *Precious Lord--take my hand. Lead me on. Let me stand. I am tired.* True I was so tired. *I am weak. I am worn. Through the storm.* Plenty of storm in my life now. *Through the night.* Hard night. *Lead me on through the light.* There had to be a light somewhere. There must be some happiness left somewhere. There must be success somewhere. *Precious Lord. Take my hand. Lead me on.*

For Dorsey, writing the song “Take My Hand, Precious Lord” was a cathartic experience. The song strengthened his resolve to lean on the Lord, it helped him purge his grief and make sense of an unpredictable tragedy in which he felt powerless. And it also helped fulfill an artistic vision he had been struggling to realize. In composing lyrics that expressed his earthly pain and a plea for divine intervention and spiritual comfort, Dorsey found a way to combine elements of the blues, which he loved so much, with that of the gospel, the musical tradition in which he was raised. In this moment of tragedy he discovered an innovative blend of the sacred with the secular – gospel blues – that would become the hallmark of his career. Born out of terrible loss, the best-known song from the “father of gospel music” would go on to become a highly popular and beloved gospel staple, a favorite of Martin Luther King Jr. and others who identified with the song’s heartfelt call to be delivered from suffering.

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A City’s Neglect on Trial: The Case of Helen Jackson

As African American parents found new outlets for responding to the loss of a child, they crafted new ideas of sentimentality. If there was a single event that most dramatized how the meaning of black infant death had transformed from a judgment against parents to a judgment against society and its indifference towards black children it was the closely covered trial of Helen Kitty Jackson, a young African American woman from Virginia charged with infanticide in 1941. Her murder trial reinvigorated older debates about black migration, illegitimacy, and maternal responsibility, but amidst rising racial tensions during the World War II era, the discrimination that unwed black mothers and their children faced became the primary lens through which Jackson’s case was discussed within the black press.

Reports of infanticide had long filled newspapers appearing as stories of downfall and tragedy, and in many ways Jackson’s story fit with this narrative. She grew up in Staunton, Virginia, the daughter of Albert Sr., a laborer, and Sadie Woods Jackson. After training and working briefly as a beautician, Jackson left for New York in September 1939 where she found a job as a domestic servant earning forty dollars a month, enough to set aside some savings, and later that fall started to see a young man. In June 1940 she discovered she was pregnant and soon after, that her boyfriend was no longer willing to marry her and had been drafted into the war. Whatever image Jackson had of starting a new life in New York was quickly falling apart. She set out for Washington, hoping to stay with a cousin who lived in the capital city.

Unable to locate any family, Jackson took a room in a boardinghouse and on February 8, 1941 gave birth at Freedmen’s Hospital to a red-headed baby girl she named Jane. The new

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113 “Mother, 20, Indicted for Murder of Babe,” Chicago Defender Nov 15, 1941: 8, col. 1.
mother first boarded her baby with Lucille Smith who lived about a mile away from Jackson’s boardinghouse, which did not allow children, paying Mrs. Smith five dollars a week for board and an additional dollar for milk. While there, baby Jane became sick and was taken on three separate occasions to Children’s Hospital to be treated for malnutrition. With each hospital visit, Jackson dipped into her three hundred dollars of savings to cover the medical costs. She also searched for a better place and woman to care for her baby, and found Mrs. Wright who agreed to do so at a rate of six dollars a week. With only a part-time job, Jackson struggled to pay on time and sought the assistance of the Child’s Welfare Bureau and WPA. Both agencies refused to help as Jackson had not lived in Washington long enough to qualify for relief or a job, and recommended that she try the National Urban League Traveler’s Aid, which gave her $2.50. Unable to find a better paying job, and having exhausted her savings and the few charities that could assist her, Helen was out of options. Days later, her landlady, an elderly African American named Alice Parks, led the black detective Sergeant Samuel Scott to Jackson’s room where she had discovered Jane’s dead body. Jackson had dropped her six-month-old daughter on the stairs on her way home one night and found the baby unresponsive. Describing her fear and confusion, Jackson confessed that she then strangled and disemboweled her daughter’s body, sprinkling it with talcum powder to mask the smell, and placed the body in a hatbox.¹¹⁴

The sensational details of Jackson’s story quickly captured the attention of the black press, especially the Baltimore-based Afro-American. Reporters Mable Alston, Margaret Lewis, and the paper’s circulation manager and veteran court reporter Isaac Bannister, all based in the Washington office, covered the case in a series of articles. Together they followed Jackson from her arrest and confession in October 1941, her hearings before a coroner’s jury and later a grand

jury in District Court, where she was indicted for second-degree murder, and through her trial and sentencing the following year.115

Figure 4.8

The comic strip, drawn by Afro American staff artist Eric (“Ric”) Roberts, traced the course of Jackson’s life, portraying “the plight of hundreds of our girls who are betrayed by men, deserted by parents and left to shift for themselves.” A smartly dressed Jackson leaves her hometown drawn to the towering buildings of New York City, and the promise they held of new opportunities in “The Big City.” Soon however, she makes her way to the nation’s capital, arms burdened with a swaddled infant. The two middle panels depict Jackson alone and outdoors, at the peak of her independence and beginning of her downfall. In contrast, the final two panels show her in complementary scenes of confinement: surrounded by white male police officers, one accusingly pointing in her face, and facing two black women, possibly the two female reporters who covered the story.

115 “’Ike’ Bannister, 80, dies; AFRO aide for 65 years,” Afro-American, Mar 14, 1964, 13. Alston started out at the paper writing beauty and society columns in 1938, but after covering Jackson’s case, she also began to publish pieces that dealt more directly with the racial and gender politics of the time. She examined the war’s impact on the black domestic service economy and published an article that ran with the telling headline “Suppression of Birth Control Knowledge Blamed for Poverty: Migrant Mother of Nine Says Suppression of Facts Keeps Families Tied to South,” based on an interview with a Virginia mother en route to Philadelphia who shared her family’s difficulties trying to pursue better opportunities up North. See Alston, “Suppression of Birth Control Knowledge Blamed for Poverty,” Afro-American, Dec 18, 1943, 16; Alston, “Leaving Dixie? Better Do It Before the 15th: New Rules to Keep Workers Home, Start Them at $8; Servants Get $20 in D.C.,” Afro-American, Oct 9, 1943, 1; Alston, “Where Are the Domestics? They’ve Got War Jobs,” Afro-American, Apr 29, 1944, 11; Alston, “D.C. Faces Nation’s Largest Abandoned Baby Home Problem,” Afro-American, Sep 29, 1945, 15.
The cartoon illustrated a common narrative in which reports of infanticide described “fallen” and “seduced” young girls who, finding themselves pregnant and deserted by their lovers and family, resort to the horrendous killing of their offspring. Such narratives dated back to nineteenth century, with newspapers reporting on mothers who were in a fit of temporary insanity when they committed their crimes. In a cultural milieu in which motherhood and childhood were held up as sacred, the act of a mother willingly killing her own, innocent, offspring could only be explained as evidence of her madness. The coverage of Jackson drew on some of these tropes, with the paper describing her as “looking more like a school girl than a mother,” and Jackson herself recalling that when her baby stopped breathing “I became frantic and did not know what to do…I just could not remember anything.”

The public response to Jackson’s story also made sense given the ongoing debates taking place across the country over the health and moral effects of black migration. Newspaper reports of infants left to die fed into arguments that cities were sites of moral corruption and breeding grounds for illicit relationships and illegitimate births, factors that jeopardized infant survival. What troubled black physicians such as H.F. Gamble who practiced in Virginia and West Virginia, was the “willful indifference” of the younger generation to marry and create stable family lives. Instead, young people were shirking their “responsibility of reproduction,” leaving their country homes and flocking to cities in search of “pleasure out of wedlock” and the “mania

117 “Heartbroken Helen Weeps as Witnesses Tell How She Slew Own Baby,” Afro-American, Oct 4, 1941, 12.
for a good time.” Along the way many ended up stuck in “damp, dark, dismal dens” of sin and disease where women sought ways to “prevent gestation” and infants had little chance of surviving.\(^{118}\) This is what he attributed to the race’s embarrassing rates of infant mortality, and he was not alone in espousing these views. As another doctor explained, “you have heard what are considered the causes of infant mortality. This ignorance in a large community is due largely to a changing population, to a population changing from a country to an urban location with the different modes of eating, clothing, and housing.”\(^{119}\) Another black physician concurred, arguing that the social and living conditions found in cities like Washington had an “unfavorable effect” on black infants.\(^{120}\)

For the Afro-American, the troubling question the case raised was not, “why did Jackson do it?” but rather, why was this a scenario many young African American women found themselves? As the paper argued, while Jackson’s actions were shocking, the bigger crime lay with the network of city institutions that systematically denied her any assistance. These were the very institutions that claimed to assist women in need but in reality turned them away. The Afro-American zeroed in on the underlying irony of Jackson’s predicament, “When her baby was warm and alive the State didn’t care; no one would help her keep it that way; doors only closed in her face; yet the State cares now: her baby is dead: she killed it to keep it from being hungry, that’s why she shrugs.”\(^{121}\) When asked by the police why she did it, Helen stated “I choked the baby because I did not have any way to support it and I had been to different places for help and

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\(^{121}\) “Helen Jackson’s Little Red Diary Bares Life as Sin, Suffer, Repent” *Afro-American* Oct 11, 1941, 24.
I could not get any one to help me because I had not been living here long enough.” Many other black mothers in Washington had similar experiences, with some recounting their humiliating experiences trying to get WPA jobs and seek help from relief agencies, and being told they were better off finding a man to support them, taking up work “running numbers” or “walking the street.” Throughout their coverage, the paper’s reporters stressed the hardships and particular forms of discrimination that Jackson and many other black women faced.

For Alston and Lewis in particular, Jackson’s story symbolized the city’s lack of welfare services for African Americans and society’s lack of sympathy for black unwed mothers. Both women were instrumental in raising awareness about the case and raising funds to contribute to Jackson’s legal defense. The fact that no maternity home in the city took in expectant black mothers was one reason why the Lend-A-Hand Club, a Washington organization founded by Dr. Whipper, also stepped in to Jackson’s defense. After working with the Children’s Bureau, Whipper returned to Washington where she continued her medical practice and public service work, including turning her home into a haven for pregnant, school-aged colored girls. Whipper formed the club to establish a permanent home for young black, unwed mothers. First

122 “Mother, 20, Indicted for Murder of Babe.”
126 Ione, 19.
known as “The House of Hope,” it was for a long time the only black maternity home in the Washington area.\textsuperscript{127} For Dr. Whipper, the club existed precisely to help “the Helen Jacksons who have no place to go.”\textsuperscript{128}

Figure 4.9

The three black women who raised awareness about Jackson’s plight, from left: Mable Alston, Margaret Lewis, and Dr. Ionia Whipper. “AFRO ‘Lends a Hand’” Afro-American, Nov 1, 1941, 12.

As the case unfolded, Alston, Lewis, and Dr. Whipper got to know Jackson and her family. Accompanied by Dr. Whipper and a nurse from Freedmen’s hospital, Alston visited Jackson in the district jail and convinced the young woman to share her story with the public. And the newspaper received several letters from readers sharing their views on the case. One


\textsuperscript{128} Margaret Lewis, “Helen Might Have Saved Her Baby if She Had Only Known: House of Hope Offers Haven to Girls in Trouble,” Afro-American, Oct 4, 1941, 12.
woman wrote in describing how she was once in Helen’s shoes. As a young, single mother she too had felt despair as she struggled to raise her children, writing “sometimes things have struck my door the same way and I have had Helen’s idea that my children would be better off, but by coming from a praying family, God was with me each time.” Looking back on that time the woman wrote, the deserted mother “thinks of her child. It has a future, too. The world will always throw his mother’s past in its face.” Rather than deliberate over what was the appropriate punishment for Jackson, the woman suggested that more attention should be given to making the “world safe and comfortable place for unwed mothers.”

The Afro American’s coverage of Jackson’s case represented a turning point in the way African Americans publicly discussed infant mortality, in that Jackson was not blamed or stigmatized for having a child out of wedlock. Instead her story came to symbolize the obstacles young black women faced as they left their hometowns during the war years in search of new opportunities. Jackson’s efforts to secure work and give her infant daughter the best care she could afford elicited sympathy from the press and its readers, who knew of many women like her – young, educated, hard-working – whose dreams were derailed due to their race and gender. As Jackson said of her situation, “it is the woman who pays and pays,” the costs of being mistreated and neglected. Jackson faced multiples burdens as an African American, single mother, and nonresident of Washington in trying to get public assistance. The increasing numbers of black families seeking assistance from relief agencies prompted several institutions to impose eligibility requirements such as residential minimums that made it harder to secure aid. In an interview with Alston, Jackson reflected on the hardships she faced, asking, “Have you ever

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129 “Read This Letter ‘I Was a Helen Jackson’” Afro-American Oct 4, 1941; 12
130 Alston, “The Most Pitiful Character I’ve Ever Met.”
walked the streets of Washington looking for a job with a sick baby and two landlords waiting for their rent and not having a dime in your pocketbook? Well, I have, and the thought kept turning over in my mind, ‘why should my baby have to face such a cruel world?’"  

Jackson’s trial lasted five days. She was represented by Harold P. Hawkins, a white attorney, and her family was present for most of the trial. For a week a mixed-race jury of eleven men and one woman, two black and ten white, heard the testimony of the detectives who discovered Jackson’s crime and a number of people who knew Jackson well. Her pastor and mother spoke of her dedication to the church, her younger sister described how Helen regularly sent money back home, landladies in Washington remembered her as nice and respectful, and several employers in New York and Washington considered her an exceptional worker, “the most satisfactory maid,” and someone they were happy to employ as she led a quiet life and “did not run around.” All who testified were in agreement that Jackson was a hard-working, well-mannered young woman who believed in public service and taking care of her family. The irony was that life in Washington made it difficult for Jackson to continue living by those values.

After deliberating for nearly three hours the jury found Jackson guilty of manslaughter, a lesser offense than the indictment’s charge of second-degree murder. Judge William Campbell sentenced her to a two-to-six year jail term, but recommended that she be sent to a Women’s Reformatory in West Virginia instead. In making his ruling the judge noted, “when we have the case of a first offender, the matter is not one as much of punishment, as one of rehabilitation…the act committed here was not the act of a normal, sane person. To adjust this
person for return to society will require first, mental treatment. I do not consider a penitentiary
such an institution.” Thus, even as the black community saw Jackson’s act as symbolizing the
tragic consequences of societal indifference, the judge viewed the case as just another murder by
a person gone mad. These differing interpretations meant that there were differing forms of
justice at stake: choosing to rehabilitate rather than punish Jackson was one matter, finding a way
to better provide for black women and children in urban areas like Washington.

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The problem of infant mortality pressed hard on the conscience of what it meant to be an
African American parent in an era of Jim Crow. This chapter has explored how African
Americans – from the unsaved recruited through church cradle rolls to believers like Dorsey and
Eggleston, from women who had abortions or those who resorted to murder – articulated their
concerns and experiences with infant suffering and death. It has traced how artistic works and
print culture served as crucial outlets for parents struggling with the challenges of bearing and
raising children, knowing that their children would encounter intense discrimination, and
possibly, violence in their lives. African Americans knew that highly publicized public health
campaigns to “save the babies,” while lauded in newspapers, failed to address these broader,
socio-political concerns of black wellbeing. But that did not mean that the government could not
do more to improve the underlying structures shaping black access to health care. As the next
chapter will explore, the power of film to lay bare the government’s inadequate response to black
health concerns would bring issues of responsibility and access back to the center of public
debates over the meaning of black infant death in a rapidly expanding modern health care
system.
CHAPTER FIVE

“Ain-a That Good News?”

All My Babies and the Postwar Politics of Black Health Care

As early as 1930 Georgia health officials cited a need for a moving picture to teach black midwives and they turned to the U.S. Children’s Bureau and the Association of American Medical Colleges to make that film a reality.¹ From 1950 to 1953, George Stoney, consulting with the AAMC’s new division of the Medical Audio-Visual Institute (MAVI), worked with midwives across the state to produce All My Babies: A Midwife’s Own Story, which taught the virtue of a prepared and healthy pregnancy, and demonstrated techniques for proper hygiene, tying the umbilical cord, and caring for a premature infant. By the mid 1950s, midwives across the South watched and discussed the fifty-five minute film in their training classes. By the early 1960s, hundreds of copies were screened to medical and nursing groups, and distributed to health agencies around the world. Outside of health circles All My Babies also received widespread acclaim, appearing in international film festivals and earning the Robert J. Flaherty award, at the time considered the “equivalent of an Oscar among documentary films.”²

The film is remarkable on several levels; it shows the conditions of rural black health care, an actual childbirth, and the fraught tensions surrounding black midwives and white medical professionals in the middle decades of the twentieth century. The film also helps us see

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¹ Joe Bowdoin to Grace Abbott, July 1, 1930, Central Files 1929-1932, File 4-1-1-6, Box 373, Records of the US Children’s Bureau, Record Group 102, National Archives, College Park, Maryland.
² “Star of the Film ‘All My Babies’ Passes,” 4; Marcello Andrei to Stoney, November 18, 1960, Folder 102, Box 4, George C. Stoney Papers #4970, Southern Historical Collection, The Wilson Library, University of North Carolina at Chapel Hill (hereafter Stoney Papers).
the pivotal role of health training films in the postwar period, as multiple institutions collaborated on *All My Babies* to further different agendas including midwifery training, improving relations between midwives, nurses, and doctors, and propagating the achievements of American medicine to foreign audiences. Yet while Stoney was collaborating with Georgia health officials to produce this educational tool, those same officials were keeping detailed records on midwives and aggressively investigating any deliveries that resulted in infant deaths. Such “black marks” on midwives’ records could lead to revoked licenses and threats of fines or imprisonment, creating an intimidating environment for midwives to practice. Thus even as the film accrued global reach, in its most local setting it was meant to educate, even elevate, the very group the film’s sponsors strove to eliminate.

The film’s underlying contradiction was not an anomaly, but constitutive of a number of tensions, for it turned a spotlight on black midwifery practice as simultaneously a source of professional pride and distrust. The film starred and was narrated by “Miss Mary” Coley, an African American midwife from rural Georgia respected by both blacks and whites in her community. In an early scene in the film her value as a health practitioner is on full display, a white, male physician confirms Coley’s assessment that a patient’s pregnancy is high-risk by indicating on the patient chart the sharp rise in the expectant mother’s weight and blood pressure, and examining her swollen ankles. Her urine was also abnormal, appearing in the test tube sample “cloudy, full of albumin,” Coley observes, “instead of water clear, like a well mother’s.”

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4 All quotations from the film are based on my viewing of the film online, retrieved spring 2016, from <http://www.snagfilms.com/films/title/all_my_babies_a_midwifes_own_story> and the
With textbook signs of pre-eclampsia that the film’s intended viewers would have recognized, the patient agrees to have the physician, rather than midwife, attend her delivery. Throughout the encounter Coley and the physician work as a team, drawing on the same medical language and tools to assess the patient. However, this portrait belied the real-life experiences of many black midwives in this decade, especially in Georgia. Another scene depicted a more likely interaction: a health officer informs a midwife class that a baby recently delivered by a midwife had died. The cause of death, he determined, was an infection of the umbilical cord. Warning the group, “you all know what that means…something wasn’t clean,” he lists the actions that could have resulted in the newborn’s death, attributing each fatal mistake to the midwife. As these two scenes illuminated, *All My Babies* represented the midwife as someone to both model and subordinate, and the collaborations that evolved between Coley, Stoney, and the film’s sponsors shaped the struggles to reconcile the film’s multiple meanings and audiences.

Through a close analysis of the film, its origins, the concerns of key players, and the choices made throughout its production and circulation, this chapter reveals how health officials wrestled with a question at the heart of the twentieth century midwifery debate – whether to eliminate midwives or whether it was possible to incorporate them, through targeted education, into an expanding health care system. Historians have richly examined similar themes by focusing on the tensions of race, gender, and class in health professions.⁵ In recent years, print copy available in the Stoney Papers. The film can also be viewed here: https://www.youtube.com/watch?v=28kp021OuiY

scholars have analyzed the role of health films not only in projecting ideals and anxieties about health and disease, but also in communicating ideas about the ideal patient and medical practitioner, although few have explored films produced to train medical professionals. Using *All My Babies* this chapter argues that in the postwar years the health training film became a powerful tool for mediating the midwife debate as it simultaneously sought to educate midwives and demonstrate the extent to which they did and did not function as medical professionals.

There is an irony in the film’s success and its original goal of improving black health care, for its popularity beyond use as a training tool transformed the film into a dramatic illustration of the reality of African American’s second-class care.

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Black Maternal and Infant Health in Rural Georgia

The film was meant to address a problem facing Georgia health officials in the 1950s; midwives still attended the majority of black births despite efforts to persuade women to seek the care of physicians. In the area where Coley lived, midwives attended over eighty percent of black births, whereas only four black physicians served the town’s nearly 10,000 black residents and only five black nurses worked within the county. Recognizing that midwives were the most accessible health practitioners to be called on in the most rural parts of the South, states like Georgia used federal funding beginning with the Sheppard-Towner Act of 1921 to develop midwife registration and training programs with the aim of regulating the care midwives provided. Georgia midwives took classes that closely followed the format and syllabus first developed by Dr. Whipper, where they “disarmed” themselves of “superstition and a pair of rusty scissors,” and learned modern preventative health measures. State health officials argued that regulating midwives was key to combatting high levels of maternal and infant mortality. But the new rules also discouraged and intimidated many midwives, the majority of whom were.

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9 Bowdoin, “Midwife Plan,” (ca. early 1940s), Folder “History of All My Babies” (hereafter History Folder), Box RCB 23779, Georgia Archives (hereafter GA).
African American women, from practicing; Georgia’s nearly 3,000 midwives registered in 1930 had dropped down to 1,322 by 1950.\(^{11}\)

With the number of midwives dwindling, black women took advantage of increased public health services available. The 1935 Social Security Act Titles V and VI appropriated funds specifically for maternal and child health, and the wartime Emergency Maternity Infant Care Program provided free health care for the wives and infants of servicemen.\(^{12}\) By the 1940s, fourteen thousand African American women, ten times as many as white women, visited Georgia’s 181 public prenatal clinics, the most clinics operated by any state in the South.\(^{13}\) But high infant mortality remained a problem in Georgia. In 1952 the disparity between white and black rates was 23.6 and 44.8 (out of a 1,000 births) respectively, and closely followed national trends.\(^{14}\) By the time Georgia health officials began collaborating with Stoney, midwives still served a vital need, high rates of black infant deaths remained a concern, and prenatal clinics had become important health care sites for black women and children.\(^{15}\)


Collaborating to Make a Health Film

The film’s numerous teaching points reflected the scope of expectations health officials placed on midwives. Officials at Georgia’s Division of Maternal and Child Health handed Stoney a list of over one hundred teaching points to address and Stoney integrated them into a story line that followed Coley from the time she “takes the case” and agrees to provide her services as a midwife to when the newborn is taken to its first Well Baby checkup at the age of six weeks old.\(^{16}\) Coley works with two women through this process, guiding them through pregnancy, childbirth, and postnatal care. The first mother, Ida Flemming, is cooperative and well prepared to have her third child. Already the mother of two healthy children that Coley delivered, Ida keeps a clean, inviting home, and has a devoted husband and mother-in-law who has come to help out with the new baby. The second woman, Marybelle Dudley, lacks Ida’s resources and outlook and as a result has a very different journey to motherhood. She comes to Coley scared. Although this is also her third pregnancy, her first was delivered stillborn and the second “dropped” before she got far along. Marybelle engages Coley late in her pregnancy, takes poor care of herself and her home, and has not bothered to prepare a layette as she and her husband are convinced “this baby’s coming dead anyway.” Health officials wanted expectant mothers to be as prepared as Ida, but needed midwives to be able to help those in difficult circumstances like Marybelle. By interweaving the two stories, the film underscored the midwife’s responsibility to manage both easy and hard cases to ensure the health of mother and child.

\(^{16}\) Report of Committee Meeting, October 2, 1951, Folder 105, Box 4, Stoney Papers; “Georgia Department of Public Health Presents ‘All My Babies’ for The Children’s Bureau Staff and Guests,” History Folder, GA.
The collaboration between Georgia health officials and Stoney reflected a postwar development in enlisting a team of medical, cinematic, and education experts to create effective films. The unprecedented use of movies for training, research, propaganda, and morale during World War II spurred a boom in the production of educational films as millions of Americans became accustomed to teaching with film and learning from it.\(^\text{17}\) *All My Babies* encompassed several features of postwar educational films; borne out of a collaboration between cinematic and medical professionals, it communicated a set of discrete teaching points, was restricted to specific, medical audiences, and was intended to stimulate classroom discussion and inculcate new behaviors.

Stoney brought his wartime experience as a photo intelligence officer for the Air Force, analyzing large-scale photographs for strategic missions, as well as his experience writing and directing health films including *A Concept of Maternal and Neonatal Care* (1951), which featured a delivery.\(^\text{18}\) He also drew on his familiarity working in interracial settings. One of his first jobs out of college was conducting field research for Ralph Bunche, chair of Howard University’s political science department, who hired him to investigate race relations in the South.\(^\text{19}\) Bunche drew on Stoney’s detailed reports to write “The Political Status of the Negro,” one of several essays Bunche authored as part of the research used in Gunnar Myrdal’s ambitious

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\(^\text{19}\) Ralph Bunche to Stoney, November 30, 1939, Folder 11, Box 29, Ralph Bunche Papers, Schomburg Center for Research in Black Culture, The New York Public Library.

As a white North Carolina native who described himself as “a revolting son of a conservative Southern father,” Stoney believed gaining the trust and support of both whites and blacks could help confront and improve local race relations.\(^{20}\) The film’s production team reflected this philosophy. Two registered nurses supervised the film’s technical medical points and worked with the midwives featured in the film. And Stoney enlisted the help of Dr. William A. Mason, a black physician trained at Meharry Medical College and Yale University who ran Georgia’s Office of Health Education for Negroes, to help establish “smooth relations” between the film crew and Albany’s white and black residents.\(^{21}\) Dr. Mason described his role as “serving as a bridge over troubled waters.”\(^{22}\)

MAVI mediated the relationship between the medical and the cinematic aspects of production, representative of a wave of postwar institutions that promoted the use of audiovisual aids in education.\(^{23}\) MAVI’s director, Dr. David Ruhe, placed great faith in cutting-edge cinematic techniques to better situate film for medical schools, believing that postwar technological developments such as magnetically striped film, which allowed sound to be recorded on the same filmstrip carrying the picture, could usher in a “small revolution” in medical education.\(^{24}\) In addition to helping medical schools adapt to a changing landscape that

\(^{20}\) Stoney to Bunche, March 15, 1940, Folder 11, Box 29, Bunche Papers.

\(^{21}\) Stoney to Rice, November 20, 1951, History Folder, GA.

\(^{22}\) Mason to Stoney, August 30, 1950, Folder 790, Box 30; Stoney Interview transcript with Danny Walkowitz, November 13, 1995, Folder 185, Box 7, Stoney Papers; Lynne Jackson, “The Production of George Stoney’s Film ‘All My Babies: A Midwife’s Own Story’ (1952),” *Film History* 1, no. 4 (1987): 369-370.


was becoming increasingly specialized and research oriented, MAVI provided film services to medical organizations, health agencies, pharmaceutical companies, and television channels. And it supplied the U.S. Department of State with over thirty films annually to distribute abroad as part of a public diplomacy agenda to propagate “the real United States” to other nations by highlighting the achievements of American medicine. All My Babies was one of the films sent to London, Sweden, Venezuela, Brazil, Costa Rica, Panama, Lebanon, Liberia, Tanzania, Seychelles, Thailand, and the Philippines. MAVI’s postwar efforts to expand the reach of health films, bridging urban-rural as well as national divides, testified to a “widespread belief in the power of motion pictures to educate and mobilize.”

Finding the Model Midwife: The Role of Black Religious and Maternal Authority

Stoney and Dr. Mason interviewed over twenty midwives across Georgia in search of a midwife, an extensive process indicative of the multiple criteria their ideal midwife needed to meet, in which her reputation and standing with local health officials mattered, and even her physical appearance and religious beliefs were judged. The woman chosen for the title role was Mary Francis Hill, the youngest of four children and only surviving twin, born to sharecroppers.

27 Helen Bellhouse to Dorothy Oshlag, December 16, 1952, History Folder; Oshlag to Nell Enloe Smith, June 12, 1957, Correspondence Folder; Memo from Oshlag to Rice and Bellhouse, October 1, 1953, Correspondence Folder, GA.
29 Stoney to Rice, November 20, 1951.
of Baker County on August 15, 1900. Mary’s parents died when she was young and she spent her childhood in the care of relatives. She left school in third grade and began working as a young nursemaid, eventually marrying Ashley Coley, a carpenter, and moving to Albany in 1930. 30 Left to raise ten children on her own after her husband abandoned the family, she took up practical nursing and with encouragement from a local public health nurse, trained as a midwife. 31 When Stoney and Dr. Mason met Coley in 1951 she had built up a busy practice delivering over 1,400 babies across Dougherty County’s three hundred square miles, and neighboring Lee, Mitchell, and Worth counties, all in the southwest of Georgia. But despite Coley’s popularity and high recommendation from the local health officer, Stoney hesitated to cast her, finding her too heavyset and worrying she would “perpetuate the Aunt Jemima stereotype.” 32 Anyone viewing the film in the 1950s would have associated that role with Hattie McDaniel, the black actress famous for her Academy Award winning performance as Mammy in *Gone with the Wind* (1939). One of the most recognizable actresses of her time, McDaniel was criticized for playing caricatured roles and Stoney may have feared similar controversy shadowing his project. Without resembling McDaniel’s outspoken Mammy character, Coley’s representation of maternal and religious authority still placed her among other film representations of African American women of the time.

Coley’s portrayal in the film points to the importance of religion in communicating health information to African American audiences. Filmmakers drew heavily on tropes of black religion – the charismatic leader, faithful congregants, and singing of spirituals – to represent black life

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30 Mary Francis Hill Coley Endowed Scholarship Program Pamphlet, Folder 113, Box 5, Stoney Papers.
31 Stoney to Bernard Coley, November 3, 2003, Folder 112, Box 5, Stoney Papers.
and culture.\textsuperscript{33} In health education films the church figures as a space where African Americans go to receive health advice and authoritative information about disease. Edgar Ulmer’s 1938 film \textit{Let My People Live}, sponsored by the National Tuberculosis Association in cooperation with the National Urban League and Tuskegee Institute, opens with a black doctor lecturing a congregation on tuberculosis, and later a church member seeks the reverend’s counsel on whether to get tested for the disease.\textsuperscript{34} Similarly in \textit{Feeling All Right}, a 1948 syphilis film that Stoney, Dr. Mason, and composer Louis Applebaum all collaborated on, a black health worker visits a church to spread “the gospel of good health,” showing slides of syphilitic infections and emphasizing that only proper testing and treatment can cure the disease.\textsuperscript{35} Medical practitioners recognized that the best way to reach African Americans was through the church, with even the American Medical Association recommending that another of Stoney’s films \textit{Palmour Street} (1949) be shown among black church groups to stimulate discussion about family life and mental health.\textsuperscript{36}

In \textit{All My Babies} Coley is the devoted, spiritual figure families turn to for counsel. Her connections to the church are implied rather than explicitly shown, and were informed by the three months Stoney spent shadowing Coley. She agreed to work on the film only after discussing the matter with her pastor, Bishop Noah Nothing of the Church of the Kingdom of


\textsuperscript{35} Mississippi State Board of Health and Southern Educational Film Production Service, \textit{Feeling All Right}, 1948, viewed as a DVD at the National Library of Medicine, History of Medicine Division.

God. Before production began, Stoney followed Coley on her midwife visits, attended church services with her, and gave offerings to her Pentecostal church. Their long conversations on religion (Stoney’s father had served as a minister) spilled into their written correspondence, with Coley praising the “Father in the highest” for making *All My Babies* “a success.” Religion played an important role in Coley’s life and for many other midwives who saw their vocation as a calling. But portraying Coley as devout had the potential to cut against the film’s aim of showing the midwife as guided by medical rather than spiritual doctrine. Stoney removed a church scene, the infant baptism of Ida and Tom’s baby, fearing it strayed too far from the film’s objective to train midwives. The religious valences remained, however, in the musical score. Musical director Applebaum composed a soundtrack of African American spirituals that Coley and her church choir sang, and worked with an all-black choir based in Washington D.C. to adapt the songs for the film. The spiritual “Good News” opens the film and reappears throughout, celebrating the sacred and familial joys of birth:

We got a brand-new baby a-comin’
Ain-a that good news?
We got a brand-new baby a-comin’
Ain-a that good news?
Be a joy to this world;
And I’ll hold him close to my heart.
‘Cause he’s the very image of Jesus,
Ain-a that good news.”

37 Mary Coley to Stoney, May 21, 1952, Folder 105, Box 4; Stoney Interview with Danny Walkowitz, Stoney Papers.
39 Stoney to Applebaum, December 3, 1951, File 1979-002-001[03], Louis Applebaum fonds, York University Archives, Toronto, Ontario, Canada.
40 “Good News” song lyrics, Folder 101, Box 4, Stoney Papers.
The allusions to Coley’s work as divine placed her as part Mother Mary figure, as her name evoked, and part medical missionary spreading her “good news.”⁴¹ When Aunt Mattie, Tom’s mother, declares that new mothers should stay away from meat and greens Coley discredits this “clear case of old-fashionitis,” stating that Ida’s diet should remain balanced during confinement. And when Marybelle tries to give birth on the floor Coley deems it “dangerous” and directs the laboring mother to the bed. Through these brief exchanges, Coley illustrated the ways black midwives could adapt to become an agent of, rather than the antithesis to, modern health care, leading the black newspaper the *Atlanta Daily World* to note that “far from being a passing relic” midwives like Coley took pride in practicing “a scientific profession.”⁴² The combination of her faith, maternal authority, and health knowledge established her as an informed and moral member of her community who could be trusted to care for others.

Health officials were willing to portray the midwife as faithful and responsible to her patients, but hesitated to show her being compensated for her work, revealing their deeper ambivalence about how to recognize the status of midwives as trained professionals. In the opening prologue Dr. Mason introduces Coley as a midwife “who helps people.” While Stoney insisted Coley should not be referred to as a “granny” midwife, he debated with health officials over whether the terms “registered,” “licensed,” or “certified” appropriately described her training, or whether the terms would cause confusion for other states that had different systems for regulating midwives.⁴³ The film does not mention any of these terms, but the accompanying

⁴³ Hannah Mitchell to Stoney, September 12, 1952, History Folder, GA; Stoney to Rice, November 10, 1951, Folder 105, Box 4, Stoney Papers.
brochure described her as a “certified local lay midwife.” The question of how to describe a midwife’s training was more than a debate over a technical detail. In deliberating the appropriate way to credit Coley’s expertise, the film’s sponsors struggled to portray her as both a real midwife from Georgia and as representative of black midwives across the South. A similar ambiguity existed in the film’s portrayal of Coley’s work as a form of paid labor. The silence surrounding the costs of engaging a midwife is most noticeable in Marybelle and Adam’s storyline. Visibly poor, their story ends with the proud father and infant son posing in a “Photos While-U-Wait” booth and the photo being added to Coley’s wall of baby pictures. Thus the only transaction that takes place is symbolic; Coley’s clients pay her with photographs of their babies. Including such a gift exchange enabled nurses and doctors to continue regarding midwives as motivated by an ethic of public service rather than working for a living, when in fact their professional training made them vital assets to state and local health departments. By the 1940s, Georgia health officials had acknowledged that any midwife willing to work with them had “increased her responsibilities without increasing her earning power…our more intelligent midwives already realize that some of our practices represent definite exploitation.” The film’s portrayal of Coley working for free suggested that while health officials sought to promote an image of the midwife as a valued member of a health care team, they were unwilling to fully recognize her professional status.

In reality Coley struck a balance as a businesswoman and public servant. Residents of Dougherty County recalled seeing her bring clothes, furniture, and strapping mattresses to her car to give to struggling families. But alongside these acts of charity Coley made a living by

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44 Film Program, History folder, GA.
45 Bowdoin, “Midwife Plan.”
charging for her services as a midwife. One of the first things Stoney and Dr. Mason learned about her was that she delivered half of the babies in her area and typically charged thirty dollars to do so, nearly double the fee of other midwives and higher than what some white physicians in Albany charged.\textsuperscript{46} Coley owned her home, had a car, telephone, assistant, and kept extra equipment for emergencies, all markers of a successful business.\textsuperscript{47} Women who had their children delivered by Coley in the 1940s through 1960s recalled paying a hefty amount, with one woman stating flatly “you had to pay her $20, $25 back in that time.”\textsuperscript{48} Coley was proud of her work, insisting to Stoney early on in production “I don’t lose much on my collections; I makes them pay me.”\textsuperscript{49} Yet another mother recalled that although Coley charged her five dollars, her family could only give her two. Her inability to pay did not impact the type of care she received. As she recollected, Coley “came, every day she came just like we had gave her that five dollars” to check on the mother and newborn.\textsuperscript{50} Other families paid her in crops.\textsuperscript{51} Coley was actually quite shrewd in managing her practice, knowing which families could afford to pay her a good price, which would struggle to come up with a couple dollars, and which needed all her support


\textsuperscript{48} In 2007 Stoney revisited Albany, returning to the film’s original sites and interviewing black and white women who had their children delivered by Coley, this quote comes from the short film based on this behind-the-scenes footage. David Bagnall and George Stoney, \textit{A Reunion of All My Babies} (2010), retrieved June 2016 from http://www.snagfilms.com/films/title/a_reunion_of_all_my_babies.

\textsuperscript{49} Stoney, “Character Studies,” 22.

\textsuperscript{50} Bagnall and Stoney, \textit{A Reunion of All My Babies}.

to get along. Dougherty County’s health officer acknowledged as much, informing Stoney and Dr. Mason, “Mary Coley knows her business.”

Once Coley joined the project, she exerted a major influence on the film. She and Stoney developed the script together, with Stoney writing the dialogue based on what he heard her say during deliveries and home visits. She lined up several pregnant women for the role of Ida, and one of her children and three of her grandchildren had roles in the film. Additionally, Stoney chose to shoot the film in Coley’s hometown, a town Du Bois half a century earlier christened “the heart of the Black Belt” in Souls of Black Folk. The region’s once fertile, cotton-producing land had economically depreciated by the early twentieth century, and blacks living in Georgia were well aware that Jim Crow laws coupled with economic hard times meant that even the smallest of actions could raise suspicion. According to Coley’s grandson, “Who could move around after dark? Ministers and midwives. People recognized that they were on duty,” providing a glimpse into the racial climate his grandmother lived in as well as the high standing midwives like Coley occupied in their communities.

Visualizing an Educational Tool

The inspiration for visually integrating the film’s required teaching points came not from other health films, but from a mainstream source. In December 1951 Stoney along with Life magazine’s five million subscribers read William Eugene Smith’s photo essay, “Nurse Midwife: Maude Callen Eases the Pain of Birth, Life and Death.” Smith had spent years on the frontlines
of the Pacific theater documenting the tragedies of World War II, and with the “Nurse Midwife” assignment he immersed himself in Hell Hole Swamp, South Carolina chronicling the indispensable and compassionate care Callen provided to rural communities.\textsuperscript{56} “Nurse Midwife” came from a very different context than the battlefield, but it too demonstrated the potential of a visual narrative to shape public awareness. Callen trained as a nurse-midwife by taking courses in nursing, public health, and obstetrics; she was as far removed from a “granny” midwife, Smith wrote, as “aureomycin is from asafetida.”\textsuperscript{57} While the two terms would have been equally foreign to \textit{Life}’s mostly white, middle-class readers, Smith’s juxtaposition of asafetida, a yellow herb used in slave remedies, with aureomycin, a potent antibiotic discovered in the late 1940s from the golden yellow \textit{Streptomyces} fungus, marked the distance the postwar midwife had traveled from practicing in an era of folk to scientific medicine.\textsuperscript{58} Thousands wrote to \textit{Life} describing how moved they were to learn of Callen’s work, and the article tapped into readers’ charitable, holiday spirit as many sent money, clothes, and even a portable incubator, all to aid in Callen’s “magnificent endeavor” to build a clinic.\textsuperscript{59}

\textsuperscript{57} Smith, “Nurse Midwife,” 135.
\textsuperscript{59} Letters to the Editor, \textit{Life}, December 24, 1951, 2.
Smith’s profile on Callen was a tremendous success, and enabled Stoney to envision that his film project could have a broader reach and resonance beyond midwife audiences. Like Smith, Stoney’s desire to capture “reality in exact detail” characterized a turn to documentary form and cinematic realism in the wake of the disillusioning effects of World War II.⁶⁰ He sent the *Life* article to Peaslee Bond, a young cameraman with documentary film experience he sought to recruit for production. Bond found the piece “fascinating” but also expressed the need to use care and “diplomacy” in attempting a similar project.⁶¹ Indeed, the black press and civil rights organizations such as the NAACP were unafraid to criticize filmmakers for their caricatured portrayals of African Americans on screen.⁶² And yet, black physicians saw promise in the power of medical films to expose racial prejudice. A 1950 editorial in the *Journal of the National Medical Association* argued, “the identification of the medical profession with the vital concerns of birth and death” made medical films “an easy medium through which to deal with the fundamentals of race problems.”⁶³ Postwar chronicles of the progress and struggles facing black physicians, such as the 1950 film *No Way Out* starring Sidney Poitier as a black Northern doctor who has a white patient die under his care, were central to Hollywood explorations of the “race problem,” dramatizing the day-to-day experiences of African Americans living in Jim Crow society.⁶⁴ Although hired to produce a training film, Stoney realized early on that the

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⁶⁰ Stoney, “A Film for Midwives,” November 7, 1951, 5-7, History Folder, GA.
⁶¹ Peaslee Bond to Stoney, December 6, 1951, Box 25, Folder 671, Stoney Papers.
project had the potential to raise awareness about broader social issues, blurring the line between whether the film would be for targeted medical audiences or for broader consumption.

Filming Birth

Stoney’s expansive vision came up against the decisions he made surrounding the film’s main scene, which depicted Ida’s delivery in graphic detail. Medical educators found filmed births useful for teaching, as it condensed an otherwise long and unpredictable process into minutes of footage. But capturing a model birth on film was difficult, and showing an African American woman giving birth invited additional critique.

While the GDH outlined over a hundred teaching points the film needed to address, the question of whether a live birth needed to be shown – included in the GDH’s list as “Actual delivery???” – remained open. Health officials wanted the film to demonstrate the midwife’s preparations and actions during the different stages of labor, but whether it also needed to capture the newborn as it emerged from its mother was a matter they were willing to leave up to Stoney’s cinematic discretion. Filming a live birth was not easy. It required the ability to capture multiple shots without interfering with the labor, and the flexibility of a crew and budget willing to accommodate the unpredictable onset and duration of birth.

65 Report of Committee Meeting, October 2, 1951.
66 In Hollywood such a scene would have violated the industry’s Motion Pictures Producers and Directors Production Code, adopted in 1930 and in place through the 1960s, which forbade “scenes of actual childbirth, in fact or in silhouette.”
Stoney navigated these challenges by controlling what the viewer could see and hear. Shots of a clock on the Flemming’s decorated bedroom mantle create a sense of the delivery moving at a manageable pace, while also serving to demarcate the stages of labor. As Coley cleans her fingernails with an orange stick and scrubs her hands, brushing noises are clearly audible, underscoring the importance of midwives maintaining high standards of cleanliness even in a home setting. And the lighting throughout the scene is soft, as Stoney was aware he was putting on screen something midwives “were used to pulling down the shades on” and discussing in veiled language. In carefully deploying these cinematic techniques, Stoney transformed an otherwise graphic scene into a model teaching demonstration.

\[67\] Jackson, 380.
Screening the Film to Train and Teach

As a film that primarily targeted midwives, Coley’s main task was to persuade midwives to change their beliefs, practices, and tools. GDH officials envisioned using the film in midwife trainings. At each meeting the supervising nurse gave a lecture, often structured around practical demonstrations that were repeated throughout the course, making audiovisual materials that could be re-played and watched in segments well suited for the class format. Furthermore, health officials saw film in addition to the songs and skits midwives performed to be an antidote to book learning, an effective way to communicate health lessons to a group considered “old, feeble, and illiterate.”

Midwives encountered All My Babies as part of an educational package in which the film and its accompanying discussion guide reinforced each other and the intended teaching points, reflecting the ways health officials drew on multiple pedagogical strategies to train midwives. In the 1950s, post-screening discussions were considered “the real climax” of educational films, an important stage in which the audience had time to review the main facts and ideas. If properly structured, discussions in this critical window of time would leave a “deep, long-lasting impression” on viewers, helping them retain key lessons. The Center for Mass Communication, which distributed All My Babies, regarded film discussions as indispensable, noting, “no longer thought of as a mere additional feature…[t]he film is shown for the sake of the discussion.” Dr. Mason also felt strongly about integrating discussions into film screenings, with Feeling All Right and Palmour Street he had found that asking audiences for their reactions to the films

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68 Division of Child Hygiene, “Midwife Manual,” April 3, 1937, GA.
69 “Memo on Freedom to Read,” 1953, 5, Box 25, Erik Barnouw Papers, Rare Book and Manuscript Library, Columbia University Library.
70 Ibid., 5.
wasn’t enough and cited an “urgent need for some sort of guide to point the way.”71 For All My Babies, the primary purpose was for the midwife to understand that she “is a clean person, [with] clean habits, and from clean surroundings.”72 Midwives watched the film in three sections and participated in a guided discussion after each reel. In addition to reviewing delivery techniques, the discussion guide reiterated lessons on disease etiology and maintaining clean equipment. Discussion prompts also communicated a set of expectations, including the level of cooperation midwives should receive from patients and their families (“Do you get as good help from your grandmothers? …What more could [Marybelle’s husband] have done?”). Midwives attending classes in Talladega County, Alabama watched the film on several occasions followed by an “afternoon discussion” of the “special picture.”73 Through viewing and discussing the film, midwives became active participants in connecting the film’s content to the care they provided.

An important linkage between the film’s drama and the stakes for practicing midwives was the film’s classroom lecture on caring for the umbilical cord. The health officer’s warning that unsterile cutting of the umbilical cord caused infant deaths drew on, and added to, a history of associating the disease neonatal tetanus with African Americans.74 The film’s emphasis on the scrutiny surrounding deaths from neonatal tetanus resonated with midwives. States like Georgia credited the swift investigation of infant deaths due to the disease as one of their most successful

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71 Mason to Stoney, August 30, 1950, Folder 790, Box 30, Stoney Papers.
72 Guide for Film Discussion, March 17, 1953, History Folder, GA.
73 Annie Bledsoe file, Box SG022954, Talladega County Midwives 1933-1947, Alabama Department of Public Health midwife records, 1889-1947, ADAH.

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techniques to “control” midwives.\textsuperscript{75} In September 1952 when one of the babies delivered by Pearl Jackson in Leary (a town twenty-five miles from Albany) died from the disease after living only seven days, she wrote frantically to the state health department, “Please come down so I can talk with you.”\textsuperscript{76} The public health nurse supervising Jackson’s county had taken away her certificate to practice but with seven pregnant women expecting her to wait on them Jackson begged to have her certificate reinstated. Helen Bellhouse, of Georgia’s Division of Maternal and Child Health and an advisor on \textit{All My Babies}, noted that since the incident had gotten Jackson “good and scared” she hoped the midwife would “stay on the straight and narrow path.”\textsuperscript{77} Of the local nurse and medical director, Jackson asserted, “they been after me” since she reported the death and she cast further blame on the health department for taking away “all the good midwives,” leaving expectant women with few options.\textsuperscript{78} A month later in Ludowici County, Georgia Williams discovered a baby she delivered had died a day after it was born, and a local physician blamed her, telling the baby’s family she “had no right to catch babies” in town. Williams wrote to the health department to find out whether or not she could practice and added that with no nurse in the area, “people do need a midwife.” Not everyone, she wrote, was able to

\textsuperscript{75} Victor Bassett, \textit{Prevention of tetanus neonatorum in the South: with a discussion of the results that may be expected from the public health control of midwives}, December 1937, GA.
\textsuperscript{76} Pearl Jackson to Georgia Health Department, September 13, 1952; Virginia Slappey to Bellhouse, October 24, 1952, Folder “Special File – Midwife Problems,” Box RCB-37997, GA.
\textsuperscript{77} Bellhouse to O.F. Whitman, September 17, 1952, Folder “Special File – Midwife Problems,” GA.
\textsuperscript{78} Pearl Jackson to Georgia Health Department, September 12, 1952, Folder “Special File – Midwife Problems,” GA. The letter is incorrectly dated September 12, but was received by the GDH on October 15\textsuperscript{th} and written in reply to the GDH’s September 17\textsuperscript{th} letter. It was likely written on October 12.
go to a hospital and she closed her letter with a request, “please don’t be hard on me for writing you this for I want to do the right thing and stay on the job.”

Another Georgia midwife wrote to her former supervising nurse making clear that in her area there was no one around to take care of expectant mothers and that a number of women were in need help. “I want my job back,” she demanded and went on to reiterate all the lessons she had learned in her classes. She included a self-portrait of herself and two drawings illustrating her care of newborns, adding, “I was tort to be a granni like this…cisus cut to inch to inch.”

Figures 5.2 and 5.3


As these midwives knew, in maintaining their practice they faced a dilemma: if they failed to report diseases and deaths they risked being seen as a “problem” and losing their license, but if they did alert officials they still risked being seen as at fault and having their license revoked.

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79 Georgia Williams to Georgia Department of Public Health, October 28, 1952, Folder “Special File – Midwife Problems,” GA.
Figures 5.4, 5.5, 5.6

Coley demonstrating how to tie the cord. Younger midwives learn from the nurse.

An older midwife practices on her own.

The film modeled the close attention health officials paid to neonatal tetanus, the way midwives learned about the disease, and the key skills involved in preventing it. In a sequence of vignettes, the midwives practice the correct technique on special dolls outfitted with umbilical cords. At one table [Fig. 1] Coley ties the cord using the “thumbs together” method.\textsuperscript{80} She confidently guides her hands, aware that a younger midwife is learning from her even while the supervising nurse carefully watches Coley, on the lookout for any mistakes. She narrates, “I been doing the same thing about eighteen years but I still know I can slip if I don’t keep checking on

\textsuperscript{80} Stoney, “All My Babies: Research,” 82.
myself.” At another table [Fig. 2] two young midwives watch as a nurse walks through the same procedure. The students nod along to the nurse’s instructions, and Coley both as the narrator and as part of an older generation of midwives remarks, “these young girls who are just starting out, they have an advantage because they’re learning the right way to begin.” The camera then turns to an elderly midwife [Fig. 3] sitting in near darkness as she practices tying the cord without supervision. As she works on a doll Coley concludes, “you know folks can change too if they just put their mind to it.” The repetition of this practical demonstration underscored midwives’ responsibility for preventing deadly disease. And the juxtaposition of traditional and modern forms of transmitting knowledge – the lectures and demonstrations characterized modern training methods, whereas the call and response exchange between the midwives and health officer, as well as the images of black midwives bent over white dolls (evoking figures of mammies and child nurses), alluded to more traditional African American roles – told nurse instructors that they were responsible for employing a range of techniques in order to effectively teach midwives.

Another of the film’s lessons drew attention to the midwife’s bag as an important instrument of her practice, one that signified her training and willingness to adhere to state regulations. Showing Coley use clean, state-approved equipment served to bridge the gap between the classroom instruction midwives received and the way they actually practiced. Returning home after attending Ida’s delivery, Coley tries to sleep but cannot shake the health officer’s haunting warning that a newborn died because “something wasn’t clean,” and gets up to repack her black bag with clean supplies. As an agent of the Farm Security Administration in the early 1940s, Stoney recalled seeing midwives along the roads carrying their bags, and later while researching for the film he learned of midwives’ alleged “two bag philosophy.” Some midwives
kept one clean and properly packed bag, ready for inspection, and another filled with items they actually used during deliveries. By the 1950s the black bag had come to symbolize a new era of midwifery; a piece of equipment that like the doctor’s stethoscope or the nurse’s cap clearly identified her as a health practitioner. The film showed Coley packing, preparing, and using all the items midwives were required to keep including soap, towel, apron, gown, cap, scissors, cotton, scrub brush, orange stick, and cord dressings. A Georgia nurse attending a midwife delivery in 1952 observed that Lula the midwife was “proud of her calling, respects her bag and always has the contents clean.” Black bags featured prominently on the cover of midwife manuals, photos of midwife classes, the 1951 Life feature on nurse-midwife Callen, and promotional materials for All My Babies. Albany residents who grew up when Coley practiced recalled that as children they all recognized her by her black bag, with Coley’s grandson recollecting stern warnings as a child to never touch it. One woman remembered as a little girl her pregnant mother sending her to get Coley, the girl went looking for her not knowing what the midwife would do but certain her new sibling “was in the black bag Mary carried.”

In addition to reaching midwives, the film also communicated lessons for African American parents and future mothers. A 1947 editorial in Ebony titled “Goodbye Mammy, Hello Mom” proclaimed that in the postwar years “the Negro mother” had finally “come home,” ushering in an age of “domestic peace.” The point, the editorial argued, was not that black

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81 Ibid., 83.
82 Mitchell to Stoney, December 11, 1951, Folder 671, Box 25, Stoney Papers.
83 Lois Patrick, “Nursing Observations of a Midwife Delivery,” June 11, 1952, Box RCB-23779, GA.
84 Margolies, “Link to the past: Palo Alto man’s Internet search opens up the world of his grandmother, a black midwife in the South.”
85 Bagnall and Stoney, A Reunion of All My Babies (2010).
86 “Goodbye Mammy, Hello Mom,” Ebony March 1947, 36.
women belonged at home, but that with more and more industrial jobs opening up to black men, black families could attain new levels of economic security and “live on the income of one breadwinner.” Accompanying the text was a photograph of a young mother modeling this new vision: sitting beside a curtained window, she prepares a meal while watching her two young children play outside. Her poised appearance reminded female readers that they should not neglect their physical beauty in assuming their household duties. The Flemming family embodied this postwar domestic ideology; their home is tidy and setup with all the proper baby supplies. Both parents remain attentive to their older children even as they prepare for a new baby, and when Ida goes into labor Tom gives her a pair of statin slippers so she can be comfortable and still feel beautiful. The grandmother, acting as caretaker and additional support, completes the portrait of a black nuclear family.

Marybelle’s story, in contrast, illustrated the consequences of failing to follow medical advice during pregnancy. The film didn’t go so far as to suggest Marybelle would die having ignored the prenatal advice she was given, but it did dramatize her pain. During contractions she screams out, “Jesus, Jesus,” her cries for help standing in contrast to Ida’s quiet and calm delivery. Marybelle’s struggles served as a powerful warning that avoiding prenatal care could result in a difficult birth experience and abnormal birth outcome as her early onset of labor results in a premature baby. Even with a portable incubator, a Gordon Armstrong model designed for home settings as it only required a pan of hot water to keep the baby warm, Marybelle and Adam’s house is in disarray adding to the sense that they are unprepared for the new arrival.\footnote{On the emergence of incubators in American medical practice see Jeffrey Baker, \textit{The Machine in the Nursery: Incubator Technology and the Origins of Newborn Intensive Care} (Baltimore: Johns Hopkins University Press, 1996).} The untidiness collapsed distinctions between ideals of health and domesticity,
implying that women who neglect their pregnancies also neglect their homes, putting their families at risk for getting sick in an unhygienic environment. While Marybelle pays the emotional and physical costs for being a bad prenatal patient, the film affirmed the power of American medical technology to compensate for negligent behavior and save lives in the most rural settings. Marybelle’s son survives early infancy, not because of her actions, but because Coley acts quickly to place him in an incubator.

The appearance of an incubator in the film tapped into broader anxieties black families had towards infant death. When discussing the film, midwives were encouraged to share experiences caring for premature infants, including their patient’s reactions to using an incubator. A 1946 folklore collection on Georgia midwives noted that black families often gave birth at home but could borrow a portable incubator from the local health center if needed. The ability to bring the technology into homes helped many newborns survive, but families disliked the machine’s white color and structure because they were “reminded of coffins.” To give the incubators a “more cheerful appearance,” nurses painted them in soft pastel colors and stenciled images of farm animals and nursery pictures. Intended for use in hospitals, the incubator produced a troubling effect in domestic settings, its presence tapping into underlying anxieties about death. Health professionals may have placed full confidence in the incubator’s ability to save young lives, but for many families, embracing the technology came only after seeing it work firsthand to extend a fragile life. Mary Church Terrell described her reaction to the death of her child who was placed in an improvised incubator immediately after birth. For Terrell, the thought “tormented” her that if a proper, “genuine” model had been used her baby’s life may

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have been spared. In *All My Babies*, Adam Jr. spends the first five months in an incubator and when he emerges he is healthy and posing in pictures with his father. In part, then, the film sought to reassure African American parents that their children, no matter how small, would survive. Coley’s ability to comfort families was so convincing, Georgia health officials believed the film could also be taught in mental hygiene classes.

The two delivery scenes conveyed multiple messages to different audiences. Ida’s happy experience and Marybelle’s continued difficulties taught patients that the decision to take control and be proactive about seeking and following medical advice, or not, determined one’s health and the health of one’s children. Prenatal care was just one example of the preventative actions families could adopt to protect their lives. The two deliveries also indicated to midwives the scope of their expected knowledge. Through her preparations and quick-thinking Coley is able to guide Marybelle and her premature son through delivery. Her warm demeanor and flexibility working in different circumstances modeled the positive outlook midwives should assume, and the importance of communicating with patients and doctors. But this message could lead to a different conclusion for the nurses and doctors who supervised midwives: midwives could handle a range of cases so if something went wrong it was because the midwife did not follow the rules. In demonstrating good practices, the midwife set herself up to bear the responsibility and blame for any deaths that occurred.

Dr. Ruhe sought to integrate the film into medical school curricula, believing medical students at all stages of their education would benefit from watching the film. First-year students would see it well before they encountered a real delivery, with the aim of introducing them to the

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90 Terrell, 106-107.
91 “Georgia Department of Public Health Presents ‘All My Babies’ for The Children’s Bureau Staff and Guests,” GA.
“drama of birth,” and the hope that they would experience the film “as humans, fathers-to-be, and only lastly as medical students,” an indication of the gender dynamics in medical school education in the 1950s and Ruhe’s belief in the film’s transformative potential. Second-year students, who had probably observed a birth first-hand in the hospital, would see the film in preparation for their training in home delivery service, a setting in which medical students work “in effect [as] midwives and not yet doctors.” The film would also introduce second-years to their future roles supervising midwives, nurses, and other auxiliary staff. Third-year students, already immersed in their obstetrical training, would only need to see Ida’s delivery in order to “have them identify with the midwife.” In addition to guiding students’ attention to specific teaching points, such framing was also meant to divert attention away from the film’s focus on African American patients and “blunt any of the culturally induced reactions” Ruhe anticipated students would have when shown a film with black actors. Underlying Ruhe’s vision for incorporating the film into clinical instruction was a controversial idea that doctors in training, most likely white and male, would learn from a black female midwife.

In screening the film to other audiences including nurses, college students, fathers, mothers, expectant mothers, and young women, Ruhe maintained that the birth process was “so deeply intrinsic to our most sensitive psychic areas, so interlocked with sexuality, so full of cultural implications, and so vital to human life itself” that even given the film’s rural setting and African American dialect it had a “universal and timeless appeal.” In the spring of 1953 he oversaw eighteen screenings in Chicago to test different audiences’ reactions to the film. He observed that women, including expectant and “potential” mothers, were hesitant to embrace the

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92 Ruhe to Bellhouse, May 14, 1953, History Folder, GA.
93 Ruhe to Rice Memo, “Report on Showings of ‘All My Babies’,” June 10, 1953, 1, History Folder, GA.
film, a conclusion he drew from the fact that they tended to ask more questions, and some of them claimed they would rather “not know the facts of birth.” In contrast, the film was empowering to male viewers for it taught them their importance and responsibility during a birth. In a number of screenings in offices and private homes, men agreed that the film was a “must” for future fathers in helping “explode the mysteries of normal birth.” One father commented, “I’ve got confidence I could really help out if I had to.” Stoney expected this response from men, considering the narrative climax to be not the actual birth but the father’s first look to “admire his newest offspring.” Rather than isolating the laboring mother and creating the impression that birth is an indecent event, Coley enlists the help of fathers during delivery. The male-only screenings reflected a broader cultural shift towards preparing men for fatherhood. Ebony reported on the rising trend in a 1955 article, which followed a black engineer as he took an expectant fathers course at Chicago’s Lying-In Hospital. In class the father practiced preparing infant formula, participated in “diaper drills,” and viewed films on the birth process. Like these classes, All My Babies emphasized that men had important roles to play, as supportive husbands and attentive fathers, when a new baby arrived.

Screening Audiences to Avoid Controversy

GDH officials wanted audiences to come away from the film with the impression that the “delivery of babies is not a dirty or shameful job.” Yet various controversies threatened to

94 Ibid., 2-3.
95 Stoney, “All My Babies: Research,” 93.
96 Report of Committee Meeting, October 2, 1951.
99 Report of Committee Meeting, October 2, 1951.
undermine this goal. One challenge was that Stoney needed to convince Martha Sapp, the college student who played Ida, to give birth as an all-white camera crew filmed and filled the staged bedroom.\footnote{Stoney to Ruhe, January 20, 1952, Folder 671, Box 25, Stoney Papers.} In addition to paying for her delivery supplies and Coley’s fee, Stoney showed Sapp the delivery scene he directed in \textit{Concept of Maternal and Neonatal Care} to assure her that including a birth helped further the film’s goal of “the dissemination of scientific information.”\footnote{“Consent to Use of Photograph or Motion Picture,” Folder 108, Box 5, Stoney Papers.} Despite Stoney’s efforts, Sapp’s cooperation with the project was not without incident. As she waited for her final prenatal checkup a white nurse came up to her and loudly announced to the whole clinic, “Oh, so you’re the mama who’s going to show her bottom to the camera?” Sapp kept cool but alerted Stoney of the event. “I wanted that floor to swallow me up,” she said, and in recounting her humiliation she confronted Stoney, “you told me there wouldn’t be anybody laughing at me like that.”\footnote{Stoney to Rice, January 3, 1953, History Folder, GA.} With Sapp shaken and her involvement with the film uncertain, Stoney worked to regain her trust. Following her request, she and her husband saw the film before it was shown anywhere in Albany and she urged Stoney to exercise discretion over the film’s circulation.

More controversy ensued after the film debuted in January 1953 and travelled beyond Georgia, highlighting the fact that the film’s graphic portrayal raised challenging questions about the boundaries between education and voyeurism, pulling even the AMA into the debate. At one screening navy medical officers laughed at the delivery scene, crudely taking it “out of context” and making fun of its sexually suggestive content.\footnote{Jackson, 387.} Following this incident, the film’s sponsors worked to limit distribution to medical organizations and institutions, hoping to minimize crude
responses. Stoney believed he was uplifting blacks by placing them on screen, arguing that rather than just showing Ida “on the table…[as] one more case,” he was protecting her integrity and humanizing her experience by showing her as part of a loving family. In making this assertion, Stoney recognized that the scene needed to include “whatever is needful for the midwives, without…offending a less experienced audience.” Reactions to the scene ranging from mockery to alarm pointed to an underlying tension in the film’s use as an educational tool. The birth scene had to be explicit in order to be pedagogically useful but in doing so it opened doors to viewers also experiencing the scene as voyeuristic and exploitive, compromising the film’s intended pedagogical function.

Restricting viewership helped legitimate All My Babies as a training film for specific audiences, distinguishing it from other motion pictures meant for popular showing. One reviewer remarked that given the graphic nature, the film “cannot be shown in this country except on a carefully restricted basis,” but held out hope that in the future it would be shown to mass audiences “when the public is ready to see it on a mature basis.” Another reviewer noted that the instructional film depicted “realism so unsparing” that despite its moving content it would never be “given general release for obvious reasons.” Yet the tight gatekeeping affected the film’s financial success. From 1953-1957 over one hundred copies of the film sold for $150 and many more were distributed as $10 rentals of 16mm film. A report mentioned that “sales have

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105 Stoney to Rice, November 20, 1951.
106 Cecile Starr, Review of All My Babies in The Film Forum, clipping from History Folder, GA.
been good” but suggested if sponsors were willing to loosen restrictions, even slightly, earnings would surely increase.\footnote{Oshlag to Smith, June 12, 1957, Correspondence Folder, GA.}

Sponsors sought to control the film’s circulation for another reason in addition to the controversial nature of Ida’s delivery: they worried \textit{All My Babies} could be taken as promoting the practice of midwifery. While the film starred a model, law-abiding midwife, health officials saw the portrayal of midwifery not as “medically ideal,” but instead as “realistic and aimed at the progressive betterment” of rural health.\footnote{Ruhe to Hugh Wood, June 15, 1951, History Folder, GA.} They worried the film might be misconstrued as a recruiting tool to get more midwives into service.\footnote{Mitchell, “Tentative Speech for Premiere of \textit{All My Babies}” January 21, 1953, History Folder, GA.} Reconciling the tensions between improving existing services without encouraging the practice of midwifery came to a head when Stoney and the GDH sought an endorsement from the Children’s Bureau. The Bureau’s director Dr. Martha Eliot had organized an early screening for her staff and staff at the World Health Organization, Point Four Program (President Truman’s foreign aid plan), and state department programs.\footnote{Stoney to Rice, May 12, 1952, History Folder, GA.} Eliot was willing to endorse the film only if it opened with a short address emphasizing that the government strove to provide equal care for all. She feared critiques that in showing midwives, rather than physicians, attend to African American mothers, the government-sponsored training film sent the message that the government was “willing to settle for second-class service for Negro mothers and babies.”\footnote{Mary Taylor to Oshlag, February 24, 1953, History Folder, GA.} The Bureau crafted an explanatory message to display at the opening of the film: “In many ways, people throughout the United States are working to achieve good medical care for all mothers throughout childbearing. Until that goal can be reached, it is
highly important to improve the skills of midwives who carry so much of the responsibility for saving mothers’ and babies’ lives in rural areas where doctors and trained nurses are scarce.” Promotional brochures for *All My Babies* further assured that while the film was for educational purposes it did “not necessarily imply approval or promotion” of midwifery.\(^{113}\) The AMA got behind this stance as well, noting in its review, the film is “an educational picture designed to improve existing services to mothers and children but not necessarily to approve or promote the particular type of care represented.”\(^{114}\)

On its own the film left the government vulnerable to criticism, but when presented with these ‘clarifying’ disclaimers in which midwifery was framed as a stop-gap measure, the film became a tool for delineating the status of midwifery and the state of black health care. The Bureau’s statement provided a partial explanation on why unequal access to health care existed, with the federal agency willing to acknowledge the effects of geographic isolation on families’ abilities to get professional care, but conspicuously silent and purposefully drawing attention away from concerns about racial discrimination. Furthermore, in contrasting “good medical care” with the care midwives provided, the Bureau reinforced the very concern it sought to dispel – that African American women and children living in the rural South were, indeed, receiving second-class health care. As the excitement over using the film bumped up against these intensifying racial concerns, debates over who should see the film blew open. Given the multiple stakeholders driving its production, questions of who controlled the film’s meaning and circulation could never be fully resolved. In this way, the film embodied both the enthusiasm and

\(^{113}\) *All My Babies* program, History Folder, GA.

\(^{114}\) “Medical Motion Pictures,” *JAMA* 154, no. 5 (1954): 442.
anxieties underlying the postwar belief in the power of film to transform health, health care, and medical education.

**Conclusion**

*All My Babies* was an important achievement in cementing a cultural image of black midwives as working both within and in the face of a health care system that stigmatized the health needs of African Americans. The irony was that the film could both illustrate a segregated system of second-class care while also offering a remarkable portrait of Coley’s professional work. When Coley died in 1966, at the age of 65, midwives and nurses travelled from across Dougherty County to bear flowers in her funeral service. The funeral program credited Coley’s biggest contribution to be “*her* film” that she made “for instructional purposes in maternal work.”[^115] At a time when the once quiet town of Albany had emerged as an important battleground in the nation’s civil rights struggle, the political significance of asserting her role in making the film a success was unmistakable. Coley had joined “the tradition of Black women who have spoken out” against a health care system that sought to negate the health needs of her community, using her role in the film to advocate for the professional care black midwives provided.[^116] In many ways, then, the film’s purpose as an educational tool did not end once midwives ceased to be the primary health practitioners in black communities; its lessons remained as a reminder and reflection of the centrality of maternal and infant health concerns to discussions of black health and the profound shifts in health care and race relations underway in the postwar years.


[^116]: Reverby, “Rethinking the Tuskegee Syphilis Study,” 5.
CONCLUSION

Weathering Blame

On February 15, 2017, The Nation ran a long article provocatively titled “What’s Killing America’s Black Infants?”\(^1\) The author, Zoe Carpenter, a young journalist based in Washington D.C., used the Rust Belt city of Milwaukee as an entry point for discussing the various measures that the city, and the nation, has taken to reduce racial disparities in infant mortality in the recent past. The stories of two black women, Tonda and Ebony, and their experiences with infant death are interwoven throughout the piece. Both women did everything right to protect their pregnancies and give birth to healthy children, and yet both mothers ended up burying a child. Ebony’s daughter died from SIDS at the age of eight months, Tonda’s son survived less than a day. After her daughter’s death Ebony felt she “didn’t want to bring any kids into this world or this time.” Tonda had a hard time coping with her loss as well, and commented, there are “too many black babies dying, too many black men dying.” As the two mothers pointed out, the problem of black infant mortality is both a health reality and political concern, and in recent years the Black Lives Matter movement has become a powerful framework for connecting infant death to a broader struggle to protect black lives. In our contemporary moment when racial health disparities and violence against African Americans are issues of pressing concern, the problem of premature death continues to haunt discussions of black life in ways that deeply resonate with the views Du Bois and Terrell voiced over a century ago.

Tonda and Ebony are part of a long genealogy of African Americans who have shared their experiences and articulated their fears about infant death. Reflections on infant death are

\(^1\) Zoe Carpenter “What’s Killing America’s Black Infants?” The Nation, February 15, 2017
threaded throughout the history of black thought and culture. As this dissertation has shown, some of the most iconic narratives and artistic works created by African Americans in the nineteenth and twentieth centuries either deal directly with, or were influenced by, the death of a newborn. The previous chapters have explored these cultural works within their historical contexts in order to shed light on the omnipresence of infant death and to highlight the ways the black struggle for freedom has profoundly shaped African Americans experiences of infant loss and survival. African American parents, concerned for the physical and spiritual health and wellbeing of their children, innovated and maintained communal forms of infant care in the face of changing ideas, political landscapes, and developments in medicine that worked to define infant mortality as a racial problem. From the early nineteenth century to the mid twentieth century, physicians and health officers tied black infant death rates to theories about black women’s bodies, living environments, racial diseases, and emerging hygienic ideals. Medical interest in black infant health waxed and waned as physicians negotiated their relationship to black patients while seeking to expand their professional authority. As African Americans migrated from rural to urban areas they developed new networks of infant care to accommodate changing family needs and structures.

Historical accounts are largely absent from contemporary discussions of infant mortality specifically, and racial disparities in health more broadly. Yet this dissertation has demonstrated that a historical perspective is important for informing evolving health policy and makes at least four contributions to contemporary policy. First, it offers a context for historicizing how race operates not as a naturalized, statistical variable but as a complex socio-political process that is constantly being remade and renegotiated. Second, studying the long-term causes of infant mortality reveals the tensions between efforts that address and stigmatize specific diseases,
individual behaviors, and social conditions. The focus on individual actions often obscures a host of other, structural factors, including the role of racism, and socioeconomic and environmental resources that influence infant survival. As the history of infant mortality reduction campaigns demonstrates, these are only the latest iteration of concerns based on changing ideas about race, family, the role of government, and place of children in society. Third, historically analyzing how disparities emerge and how they have been interpreted over the past two centuries reveals the roots and problems with biological and behavioral explanations of racial differences, while also recovering alternative explanations of health experiences that have been less examined. Being attentive to the socio-political consequences of rationalizing health disparities is crucial for identifying productive rather than stigmatizing interventions. Finally, while modern day reliance on epidemiological data has allowed for the identification of large-scale patterns and trends in infant mortality rates, it has also moved attention away from the meaning and effects of infant deaths on families and communities. A historical study of infant mortality provides a richer and more nuanced understanding of the underlying stakes, challenges, and opportunities in policy-making, while keeping sight of the impact and meaning of infant death on individual families and communities.

Ultimately, the challenge in explaining and reducing health disparities reflects ongoing debates in the allocation of resources, role of preventative measures, and tensions over how we assign blame and responsibility in a society with certain beliefs about health and race. This dissertation reflects the belief that looking at the long history of black infant mortality deepens our understanding of the politics of health and of the African American experience, and pushes us to consider how we can use history as a resource for engaging in our present moment and imagining more just futures.
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