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ANALYSIS OF DEATH TRENDS IN CORONER CASES IN EAST BATON ROUGE
PARISH FROM JANUARY 1, 1991, TO DECEMBER 31, 2001

A Thesis

Submitted to the Graduate Faculty of the
Louisiana State University and
Agricultural and Mechanical College
in partial fulfillment of the
requirements for the degree of
Master of Arts

in

The Department of Geography and Anthropology

by

Gina Ann Dimattia
B.A., Louisiana State University, 2000
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ABSTRACT

Analysis of death trends in a geographic area can provide valuable information regarding the health of the people in that area. Additionally, evaluation of variables such as sex, race, age, and cause of death can aid local health officials in serving the needs of the population. East Baton Rouge Parish is located in southern Louisiana, includes the capital city of Baton Rouge, and has a population of 412,852. An analysis of death cases handled by the Coroner's Office in East Baton Rouge Parish has not been performed until now.

This thesis presents results from an analysis of all deaths in East Baton Rouge Parish that were considered coroner's cases from January 1, 1991, to December 31, 2001. The race, age, sex, cause of death, and year of death of 23,813 coroner cases were analyzed. The results of this study indicate that white males aged 75 and older represent the largest number of deaths. In addition, the results show that heart disease is the number one killer of people in East Baton Rouge Parish, followed by cancer.

These results were compared to the death trends of the state of Louisiana and the death trends of the United States. The goal of this comparison was to determine if the trends in the parish paralleled the trends of the rest of the state and country. The results of this analysis mirrored the death trends of the state of Louisiana. Finally, the results also closely reflected the death trends of the nation.

INTRODUCTION

East Baton Rouge Parish is located in southeastern Louisiana, approximately 70 miles northwest of New Orleans. Baton Rouge, the capital of Louisiana, is in East Baton Rouge Parish. According to the U. S. Census Bureau, the parish had an estimated total population (including temporary residents) of 412,852 in the year 2000. This number is a net increase of 32,747 people (8.6%) from the 1990 census figures. Of the 412,852 people in East Baton Rouge Parish, 215,169 (52.1%) are female and 197,683 (47.9%) are male. The number of white people in the parish according to the 2000 census was 231,886 (56.2%). The number of black people in the parish according to the 2000 census was 165,526 (40.1%). All other races and race combinations comprised 3.7% of the parish population and totaled 15,440.

The United States Census Bureau utilizes information about the population in an area in order to determine who lives where, what services are available to that population, and what additional services are needed for optimum health, education, and prosperity in that population. Information about a population in an area can be extracted from death data, as well. Numerous variables surrounding death can be analyzed in order to provide valuable information about the area or, in this case, the chosen parish. For instance, what causes of death are more prevalent in females than in males, and vice versa? What are the primary causes of death in infants, teenagers, young adults, and the elderly? Is a certain cause of death, such as AIDS, more prevalent in one race over another?

One such variable is age. Causes of death are not the same for all age groups. The leading cause of death in infants and small children will not be the same for people over 75 years of age. On the other hand, there may not be much variation in causes of

death between the groups aged 35-44 years and 45-54 years. As one ages, the body changes and becomes more susceptible to disease. In addition, as one ages, he/she is exposed to different environmental factors. For example, a 22 year-old male is more likely to be a victim of homicide than a five year-old male.

The sex of the deceased is another variable that can provide important information. Certain causes of death, such as suicide, claim the lives of males more than females, while other causes of death may claim the lives of females more than males. For certain, differences between males and females exist. The question is how much of a difference exists.

A third variable that can be studied is race. Bone structure, facial features, and skin color are just a few of the variations among races. Race also plays a role in death. Certain causes of death may affect one race more than another race. For example, death by gun may occur more frequently among blacks than Asians.

In addition, when a death occurs can provide valuable information about a population. The number of deaths changes each year, and what causes those deaths likewise changes each year. The number of infant deaths occurring in one year may be different than the next year. These variations in the number of deaths aid in identifying periods of time with elevated levels of death and disease.

This study involved the analysis of deaths in East Baton Rouge Parish that were considered coroner's cases from 1991 to 2001. There were three primary objectives in this analysis. The first objective was to analyze all the coroner cases in the East Baton Rouge Coroner's System from January 1, 1991, to December 31, 2001. The age, race, sex, year of death, and cause of death of each case considered a coroner's case were

evaluated. The second objective was to compare the results of the analysis to the patterns for the state of Louisiana in order to determine if deaths in the parish follow the death trends for the entire state. The third objective was to compare the results of the analysis to the patterns for the entire United States. The comparison to the nation was also performed to determine if deaths in East Baton Rouge Parish parallel the death trends of the entire nation.

Death in East Baton Rouge Parish can be better understood by this analysis of the age, race, sex, cause of death, and year of death of all coroner cases that have occurred in the parish from 1991 to 2001. With a better understanding of death in the parish, the needs of the population can be assessed and met more accurately and efficiently.

LITERATURE REVIEW

In the United States, medical examiners and coroners are responsible for investigating suspicious, violent, or unexpected deaths, and deaths unattended by physicians. State laws specify the kinds of deaths that are investigated, the official responsible for the investigations, and the qualifications of that official. Approximately 20% of all deaths fall under the range of operation and authority of medical examiners and coroners, depending on the type of jurisdiction (Morbidity & Mortality Weekly Report 1989). In addition, medical examiners and coroners are responsible for providing accurate and legally defensible determinations of the causes of death (DPHSI 2001). The information medical examiners and coroners provide plays a significant role in the judicial system and decisions made by public health and public safety agencies.

Medical Examiners vs. Coroners

Three basic types of death investigation systems are present in the United States (DPHSI 2001). The first type of system is the medical examiner. Usually, medical examiners are licensed physicians with training in pathology and medicolegal death investigation (DPHSI 2001; Hanzlick 1998; Morbidity & Mortality Weekly Report 1989). They are usually appointed and may have state, district, or county jurisdiction. The District of Columbia and 19 states have a state chief medical examiner that is responsible for investigating death in the entire state (Morbidity & Mortality Weekly Report 1989). County medical examiners are elected in Mississippi. Three states have district or county medical examiners but no state chief medical examiner. Michigan and Arizona have county medical examiners appointed by each county's board of supervisors.

Florida has 24 district medical examiners appointed by the governor (Morbidity & Mortality Weekly Report 1989).

The second type of system is the coroner. Coroners do not have to be physicians, and they are usually elected (DPHSI 2001). Generally, the only prerequisites for being a coroner are that the person be at least 18 years old and a resident of the county or district for which he/she is the coroner. In addition, coroners have county or district jurisdiction (DPHSI 2001). Twelve states have district or county coroners who are responsible for investigating the deaths that occur within each county (Morbidity & Mortality Weekly Report 1989).

The third type of system is the mixed medical examiner and coroner. Thirteen states have county or district systems, some of which are run by coroners and some of which are run by medical examiners (Morbidity & Mortality Weekly Report 1989). In each of these states, no one person has supervisory responsibility for the state. However, Arkansas, Kentucky, and Montana have an appointed state chief medical examiner and elected county coroners.

The National Center for Health Statistics (NCHS), U.S. Public Health Service, Department of Health and Human Services, has produced several handbooks for medical examiners and coroners. One of these handbooks, *The Medical Examiners' and Coroners' Handbook on Death Registration and Fetal Death Reporting* (1994), describes the significance of death registration. A death certificate is a permanent record of the death of an individual. The medical examiner or coroner is responsible for completing the medical part of the death certificate, which includes the date of death, time of death, and cause of death (NCHS 1994). The death certificate is then delivered to the funeral

director or other person in charge of interment. He or she completes the parts of the death certificate that contain personal information about the decedent. In addition, the funeral director is responsible for filing the death certificate with the registrar where the death occurred (NCHS 1994).

In states with a local registrar system, the local registrar sends records of events occurring in his or her area to the state vital statistics office. The state vital statistics office examines each record for completeness, promptness of filing, and accuracy of the information (NCHS 1994). Another duty of the state vital statistics office is to process the records and store them for permanent reference. Statistical data from the records are catalogued for use by local and state health departments, other governmental agencies, and various private and voluntary organizations. Information derived from these records is conveyed to the National Center for Health Statistics. NCHS has the authority to administer the vital statistics functions at the national level. From these data, monthly, annual, and special statistical reports are prepared for the United States as a whole. The same reports are prepared for cities, counties, states, and regions by various traits such as sex, race, and cause of death (NCHS 1994).

The statistical data from death certificates are used to identify public health issues and to analyze the results of programs formed to alleviate these problems. In addition, information gleaned from mortality statistics aids in the allocation of medical and nursing services and follow-up on infectious diseases (NCHS 1994). These statistics are used to assess the general health of the population, study medical problems that may be found among certain groups of people, determine the successfulness of medical treatments, and to identify areas in which medical research can achieve the greatest impact in reducing

mortality (NCHS 1994). The quality of each individual death certificate determines the quality of the statistics generated from the data.

The state of Louisiana has the second type of death investigation system—the coroner system. According to the *Louisiana State Coroner Handbook* (1996), each of the 64 parishes in Louisiana, except Orleans parish, has a coroner who is elected at the gubernatorial election for a term of four years. The Orleans parish coroner is elected for a four-year term at the election for parochial and municipal officers in Orleans parish. Coroners are required to be physicians licensed by the Louisiana State Board of Medical Examiners in order to practice medicine in Louisiana. In the event that no licensed physician qualifies to run for the office of coroner, the requirement is waived and anyone can run (Coroner Handbook 1996).

The coroner is not required to investigate every death or view every death, and he or she may perform an autopsy in any case he or she feels is necessary. However, the coroner is required to perform an autopsy whenever a reasonable probability that the violation of a criminal statute has contributed to the death, unless the family of the deceased objects to the autopsy due to religious reasons (Coroner Handbook 1996). In the case of religious objection, an autopsy will not be performed unless the coroner finds that the circumstances of the death necessitate an autopsy be performed in the interest of the public health, safety, or welfare.

According to the *Louisiana State Coroner Handbook* (1996), the state of Louisiana has a state registrar system. The state registrar is located in the vital statistics office in New Orleans, Louisiana. All vital record forms, including death certificates, are

sent to the state registrar. The state registrar processes the records accordingly and transmits necessary information to the National Center for Health Statistics.

Since research has shown the usefulness of data contained in medical examiner/coroner reports, it is desirable to ensure accuracy in medical examiner/coroner databases for use in scientific studies regarding the circumstances of death. However, according to Kung et al. (2001), considerable debate exists on the best way to abstract relevant information from medical examiner/coroner records with the least amount of discrepancy between what is on the reports and what is actually put into the database. Kung et al. (2001) propose that one way to make data abstraction easier is to electronically store relevant data in the medical examiner/coroner records. However, many medical examiner/coroner offices do not have their data completely stored in electronic format. Kung et al. (2001) wanted to determine the level of agreement between multiple records abstractors who extracted defined data elements from printed medical examiner/coroner death records and identify data items that cause problems when records are abstracted manually. The 1993 National Mortality Followback Survey (NMFS) performed by the National Center for Health Statistics provided the data for the study. Kung et al. (2001) randomly chose 494 printed death investigation records from 224 medical examiner/coroner offices. Trained abstractors obtained information for 110 data elements from the reports, as well as additional data elements for each toxicology workup from toxicology laboratory reports. In addition, six-digit Abbreviated Injury Scale (AIS) codes were abstracted for each injury described in autopsy reports. The authors discovered several types of errors that can occur during the abstraction of the reports into a useful database. These errors may result from incomplete reporting of data

by the medical examiner/coroner. Those errors may also result from subsequent errors in interpretation, typography, keying, or coding. Kung et al. (2001) did not achieve satisfactory inter-related reliability for the items associated with the time and location of death, specifics of toxicology evaluations, and specific injury. Possible explanations for the lack of reliability are nonstandard report formats used by medical examiners/coroners; the use of ambiguous language, which made interpretation difficult; the complexity of the toxicology reports themselves and the format of the reports; and discrepancies between the detail of the injury in medical examiner/coroner reports and the criteria used for AIS coding schemes.

The results of Kung et al. (2001) suggest that manual abstraction of several data items in medical examiner/coroner records can be done reliably, but that some items cause problems for the abstractors. The results also suggest that AIS coding may be successfully applied to autopsy reports. However, the application of AIS coding to autopsy report data is more beneficial for some types of injuries than others. More importantly, the results imply that using medical examiner/coroner investigative and autopsy reports for research could benefit from more standardized electronic storage of data, as well as more standardized reporting of some problem-causing variables in a more concordant hard copy format (Kung et al. 2001). Electronic formats would decrease the need for manual abstraction; therefore, the effect of human error would be reduced. According to Kung et al. (2001), electronic standardization could minimize errors, avoid duplication, enhance efficiency, and allow for a more straightforward presentation of medical examiner/coroner reports. In addition, electronic standardization could allow for

the transfer of data between systems and yield better management control of study operations.

DuPre et al. (2001) notes that the North Carolina Office of the Chief Medical Examiner began using a statewide database on all death investigations in its jurisdiction in 1973. According to DuPre et al. (2001), this statewide database provides fast and reliable retrieval of information on cases, eliminating the need for searching through archived files. In order to test whether the centralized statewide database eases the ability to provide and use specific data of interest, DuPre et al. (2001) analyzed shifts over time in homicide victim profiles for the years 1990 and 2000 and compared their findings to population shifts in North Carolina found in data from the U.S. Census Bureau. Age, race, sex, date of death, cause of death, and county of death were chosen as data fields for examination. The results of DuPre et al.'s (2001) study indicated that the homicide victim profile followed the shift in population. In fact, the most noticeable shift in both homicides and population occurred in the Hispanic portion. In North Carolina in 1990, the Hispanic homicide victim accounted for 1.34 percent of all homicides, while the Hispanic population represented 1.04 percent of the total state population. In North Carolina in 2000, the Hispanic homicide victim accounted for 8.01 percent of all homicides and 4.7 percent of the total state population. The study by DuPre et al. (2001) proved the reliability of the North Carolina database in obtaining information about death investigations in the state of North Carolina. In addition, the study demonstrated how easily the state database could compare information with the national census data to track and analyze patterns and trends in death.

Other states in the country have been developing electronic databases like the one in North Carolina for storing death records. According to the National Center for Health Statistics (2002), with electronic records, specifications for developing systems are conveyed to states to ensure comparability. As mentioned in Kung et al. (2001), an electronic death registration system would improve data quality, decrease reporting delays, and increase the usefulness of death information. In order to promote the standardization of cause of death in death registration systems, the NCHS has manufactured specifications for the format, structure, and content of the segment regarding cause of death to be incorporated into these systems. Adherence to the specifications by the NCHS will facilitate comparability in cause of death reporting among registration areas, assure compatibility with mortality processing software, assure complete cooperation with regulations of the World Health Organization, and facilitate high quality data on cause of death.

Death Trends in the United States

Death trends in the United States have been a primary focus of research for decades. Organizations such as the Centers for Disease Control and Prevention (CDC) conduct research on the death patterns and trends in the United States on a regular basis. By gathering data on death from around the country, the CDC and other organizations that utilize the data can protect the health and safety of the population, can promote healthy living, and can enhance health decisions by providing accurate information on crucial health issues.

According to preliminary figures from National Center for Health Statistics, the Center for Disease Control and Prevention (2001), mortality for several leading causes of

death declined in 1999. Heart disease and cancer are the two leading causes of death in the United States and account for more than half of all deaths each year. Nevertheless, in 1999, heart disease and cancer age-adjusted death rates fell. Along with the decline in heart disease and cancer, homicide, suicide, and firearm mortality declined an estimated six percent between 1998 and 1999 (National Center for Health Statistics 2001).

However, several other leading causes of death increased during the same time period.

These causes of death were hypertension (5% increase), diabetes (3.3 % increase), chronic lower respiratory diseases (4 % increase), and septicemia (6.6 % increase).

Death from HIV infection declined more than 70 percent during the years 1996 to 1998.

Mortality from HIV dropped 26 percent in 1996, 48 percent in 1997, and 21 percent in

1998. The NCHS states this trend in HIV deaths continued in 1999 with an almost four

percent decrease. According to the NCHS, HIV no longer ranks among the leading

causes of death in the United States. However, HIV is still the leading cause of death in

black men and ranks fifth among all 25-44 year olds. In the same age group, HIV

infection ranks third among black women. The five leading causes of death—heart

disease, cancer, stroke, chronic lower respiratory disease, and accidents—did not change

from 1998, but some significant changes in the ranking of other leading causes did occur.

Among the leading causes of death, suicide dropped from eighth place to eleventh as the

number of deaths in the United States due to suicide decreased more than five percent

from 30,575 in 1998 to 29,041 in 1999 (National Center for Health Statistics 2001).

The majority of publications emphasize one particular cause of death and the

effect that cause of death has on the population. In a study on heart disease by the

American Heart Association (2002), cardiovascular diseases such as heart diseases and

stroke rank as the number one killer of Americans. Cardiovascular diseases claim the lives of more than 40 percent of the approximately 2.4 million Americans who die each year. In addition, cardiovascular disease is the number one killer of blacks, claiming the lives of more than 37 percent of the approximately 285,000 blacks who die each year.

Another study by the American Heart Association (2002) is a statistical update for heart disease and stroke. According to this study, cardiovascular disease killed 958,775 Americans in 1999. This number accounts for one out of every 2.5 deaths. Of the more than 2,000,000 deaths recorded in 1999, cardiovascular disease was a primary or contributing cause for approximately 1,391,000 of those deaths. The number of male deaths from cardiovascular disease in 1999 was 445,871 (46.5%). The number of female deaths from cardiovascular disease in 1999 was 512,904 (53.5 %). Coronary Heart Disease accounted for 55 percent of the 1999 deaths resulting from cardiovascular disease (American Heart Association 2002). Stroke ranked second in 1999 for deaths resulting from cardiovascular disease, accounting for 17 percent of the deaths.

In a third study that evaluated coronary heart disease in women aged 45 to 54, Sekikawa (2000) described coronary heart disease as the leading cause of death for women in the United States. Between white women and black women, there was a 2.5-fold difference in coronary heart disease mortality: 31 for every 100,000 white women compared to 78 for every 100,000 black women. In coronary heart disease among white women by state, a three-fold difference was found: 16 for every 100,000 in Colorado compared to 53 for every 100,000 in Louisiana. Again, a three-fold difference was found for coronary heart disease among black women by state: 45 for every 100,000 in New Jersey compared to 124 for every 100,000 in Arkansas.

Cancer is another leading cause of death in the United States that has been claiming fewer lives over recent years. In an annual report released by the North American Association of Central Cancer Registries (NAACCR), the CDC, the American Cancer Society (ACS), and the U.S. National Cancer Institute (NCI) (Howe et al.2001), new data for the period between 1992 and 1998 showed that the rates for new cancer cases and deaths for all types of cancer combined continued to decrease in the United States. The data show an average decline of 1.1 percent per year between 1992 and 1998 for the number of new cases of cancer per 100,000 persons. This decline reversed a pattern of rising incidence from 1973 to 1992. According to the report, the majority of the decline can be attributed to a yearly decline of 2.9 percent in white males and 3.1 percent in black males. In addition, cancer death rates continue to decrease at a rate of 0.8 percent for women each year and 1.6 percent for men each year. The decline in cancer death rates in black males is of particular significance. The death rate in black males, who are the group most affected by cancer, decreased the most at 2.5 percent per year between the years 1992 and 1998. The report also showed that cancer of the lung, breast, prostate, and colorectum accounted for approximately 56 percent of all new cancer cases. In addition, these cancer sites were the leading causes of deaths due to cancer for every racial and ethnic group in the United States, including white, black, Hispanic, American Indian/Native Alaskan, and Asian/Pacific Islander populations (Howe et al. 2001). These four cancer sites comprise more than half of all cancer cases; therefore, they have a strong influence on overall cancer trends.

In another study on cancer in the United States, the American Cancer Society (2002) found that black Americans are more likely to develop and die from cancer than

individuals from any other racial and ethnic group. The death rate for all cancers combined is approximately 33 percent higher in black than white Americans. According to the study, the average annual cancer mortality rate from 1992 to 1998 for all cancer sites combined was 218.2 per 100,000 among blacks, 164.5 per 100,000 among whites, 105.4 per 100,000 among American Indians/Native Alaskans, 102.6 per 100,000 among Hispanics, and 101.2 per 100,000 among Asian/Pacific Islanders (American Cancer Society 2002). In all racial and ethnic groups, cancer mortality rates from 1992 to 1998 for all sites combined were significantly higher in males than females.

Another disease which is closely monitored is Acquired Immunodeficiency Syndrome (AIDS). This disease has become a global epidemic. Vass (2001) reports that AIDS is the fourth largest killer worldwide and the leading cause of death in sub-Saharan Africa. 60 million people worldwide have been infected since the epidemic began 20 years ago, and 40 million people currently live with HIV. Vass (2001) notes that the epidemic “threatens human welfare, developmental progress, and social stability on an unprecedented scale.” According to the CDC Morbidity and Mortality Weekly Report (2001), the first AIDS cases were reported in the United States in June, 1981. Since then, the number of cases and deaths due to AIDS increased quickly during the 1980s and peaked in the early 1990s. Subsequently, there were considerable declines in new cases and deaths in the late 1990s. Men who have sex with men and racial/ethnic minorities have been affected the most by the epidemic. In recent years, the number of cases among women has increased, as well as the number of cases due to heterosexual transmission of the virus. In addition, the number of deaths has decreased, while the number of persons living with AIDS has increased. CDC evaluated reported AIDS cases from 1981 through

2000 from all 50 states, the District of Columbia, and U.S. territories (CDC 2001). According to the CDC evaluation, as of December 31, 2000, 774,467 people had been reported with AIDS in the United States. Of these 774,467 people, 448,060 had died, and 3,542 had unknown vital status. The number of people now living with AIDS is 322,865 and is the highest number ever reported (CDC 2001). Of the people living with AIDS, 79 percent were males; 61 percent were black or Hispanic; and 41 percent of those contracted the disease through male-to-male sex. Whites were the most affected group in the early 1980s. However, cases of AIDS among blacks steadily increased over the years. By 1996, more cases occurred among blacks than any other racial/ethnic population (CDC 2001). In addition, 85 percent of the people who contracted the AIDS virus were aged 20-49 years.

Suicide is another leading cause of death that has declined in recent years. In an update released by the National Center for Injury Prevention and Control (NCIPC) of the CDC (2002), suicide was the eighth leading cause of death in the United States as of 1998. As previously mentioned, suicide dropped from the eighth leading cause of death in the United States to the eleventh leading cause of death in 1999. Despite this decline, suicide remains a problem among Americans. In 1998, suicide was committed 1.7 times more than homicide. In addition, suicide is the third leading cause of death in young people aged 15-24, behind accidental injury and homicide. Females are more likely to attempt suicide; however, males are four times more likely to succeed in committing suicide. In 1998, white males accounted for 73 percent of all suicides (NCIPC 2001). White males combined with white females accounted for more than 90 percent of all suicides. Not surprisingly, approximately 57 percent of suicides in 1998 (three out of

five) were committed with a firearm. Suicide rates are the highest they have ever been among Americans aged 65 years and older. The period from 1980 to 1990 was the first decade since the 1940s that the suicide rate for the elderly increased rather than decreased. Among people 65 and older in 1998, males accounted for 83 percent of all suicides. The greatest relative increases in suicide rates from 1980 to 1998 occurred among those aged 80-84, and the rate for males in this same age group rose 17 percent (NCIPC 2001). For both males and females aged 65 and older in 1998, firearms were the most common method used to commit suicide. Of the suicide deaths in this age group, 78 percent were males and 34.8 percent were females. The risk factors associated with suicide among older people are not the same as those among young people. Older people have an increased incidence of depression and social isolation. Older people also use highly lethal methods more frequently than younger people. Among persons 65 and older, fewer attempts per completed suicide are made. The ratio of male-to-female suicide deaths is higher in those aged 65 and over than in other groups as well. Older people generally have more physical ailments and have frequently visited a health-care provider before they committed suicide (NCIPC 2001).

People under the age of 25 are another group greatly affected by suicide—accounting for 15 percent of all suicides in the year 1998. The prevalence of suicide among young adults and adolescents virtually tripled from 1952 to 1995. From 1980 to 1997, the rate of suicide among people 10-14 years old rose by an alarming 109 percent and among those 15-19 years old by 11 percent. From 1980 to 1996, the prevalence of suicide in black males aged 15-19 increased 105 percent. In 1998, more teenagers and young adults died as a result of suicide than from heart disease, AIDS, cancer, stroke,

influenza, pneumonia, chronic lung disease, and birth defects combined. From 1980 to 1997, firearm-related suicide in people 15-19 years old accounted for 62 percent of the rise in the overall rate of suicide (NCIPC 2001).

Data from the American Association of Suicidology (AAS) (2001) for 1999 ranks Nevada as the state with the highest rate of suicide at 22.3 per 100,000, followed by Wyoming at 20.4 per 100,000, and Montana at 18.4 per 100,000. The AAS data for 1999 rank Louisiana 22nd with a rate of 11.8 per 100,000. New York and Washington, D.C. rank 50 and 51 with rates of 6.6 and 5.8 per 100,000, respectively. The region of the United States with the highest rate of suicide (16.3) for 1999 was the Mountain region, which includes Nevada, Wyoming, Montana, New Mexico, Arizona, Idaho, Colorado, and Utah. The Middle Atlantic region of New York, Pennsylvania, and New Jersey had the lowest rate of suicide (7.9) for 1999. For means of comparison, the rate of suicide for the entire nation for the year 1999 was 10.7 (American Association of Suicidology 2001).

Bodkin et al. (2001) performed a comparison of suicide in five counties across the country from 1994 to 1998 using medical examiner/coroner office records. The total number of suicides studied was 1,116. The five counties (and major cities) where these suicides occurred were Clark County, WA (Vancouver), Washoe County, NV (Reno), Hamilton County, TN (Chattanooga), Erie County, PA (Erie), and Lehigh County, PA (Allentown). The results of the study illustrated the five-year mean annual rate of suicides per 100,000 for each county was 27.32 for Washoe, NV, 13.67 for Lehigh, PA, 13.25 for Hamilton, TN, 10.91 for Erie, PA, and 10.03 for Clark, WA. Bodkin et al. (2001) also examined race, sex, age, and method of suicide. Combined over the five-year period for all five counties, white males most frequently committed suicide. The mean

age for suicide in all five counties was 45 years. In all five counties, the most common method employed in suicide was gunshot wounds—50 percent in males and nine percent in females.

At the national level, homicide is measured more precisely and accurately than any other crime. Fox and Zawitz (2001) conducted a study on homicide trends and patterns in the United States for the years 1976 to 1999. According to this study, homicide rates have recently declined to levels that have not been seen since the late 1960s. Since a final peak in 1991, homicide rates have sharply decreased to 5.7 per 100,000 by 1999. Based on data for the time period of 1976 to 1999, blacks are six times more likely to be murdered and eight times more likely to commit murder than whites. Males account for 75 percent of homicide victims and are three times more likely to be murdered than females. In addition, males are eight times more likely to commit murder than females. Approximately one-third of homicide victims are under the age of 25.

From the years 1985 to 1993, the rate for homicide victims aged 14-17 increased nearly 150 percent. The age group with the highest rate of homicide is 18-24 year olds. Since 1993, these rates for teens and young adults have declined; however, they remain higher than the levels of the mid-1980s. There has been a general decline in the homicide rate for adults aged 25-34, 35-49, and 50 and older. Over 25 percent of victims of gang-related homicides for the years 1976 to 1999 combined were under the age of 18. In addition, juveniles in this time period were unusually involved as victims of sex-related (19.8%), family (18.6 %), arson (28.4%), and poison (27.2 %) homicides. At the other extreme, a fairly high number of older people were victims of felony-murder (24.7 %), workplace (38.3%) homicide, and arson (25.8%) homicide. The majority of homicide

victims and perpetrators are male. The homicide victim rate for males has fluctuated since 1976, while the homicide victim rate for females has declined. Males were 3.2 times more likely to be murdered than females in the year 1999 (Fox & Zawitz 2001). Nevertheless, in 1999 the homicide rates for males and females reached their lowest level in more than twenty years. For the entire 23-year period, females were especially at risk for intimate homicides (61.7 %), sex-related homicides (80.7%), and arson (43%) or poison (45%) homicides. Also in 1999, blacks were six times more likely than whites to be victims of homicide. High percentages of blacks were victims of homicides involving drugs (62.5%) and arguments (50.1%). In comparison to whites, blacks are less likely victims of workplace homicide, sex-related homicide, and poison homicide. An interesting observation in the Fox and Zawitz (2001) study is that most murders are intraracial. From 1976 to 1999, whites murdered 86 percent of white victims, while blacks murdered 94 percent of black victims. Guns, particularly handguns, are used in homicides more than any other weapon. In the same manner as the general homicide rate, gun-related incidents increased sharply in the late 1980s and then fell in recent years. During the same time period, homicides involving all other weapons have slowly decreased. In addition, the percentage of homicide victims killed with a gun increases with age up to the age of 18 and then decreases thereafter (Fox & Zawitz 2001).

The southern regions of the United States have historically had the highest rate of homicide (Fox & Zawitz 2001; Parker & Pruitt 2000). Parker and Pruitt (2000) assert that dating back as early as 1880, researchers have consistently attributed the southern region of the United States with the highest rate of homicide in the entire country. However, in recent years researchers have claimed that the homicide rate in the West has

merged with, if not exceeded, the homicide rate of the South for certain racial groups. Parker and Pruitt (2000) investigated the impact of structural conditions on the rates of black and white homicide for various regions of the United States. In their investigation, they focused on the claim that important changes have occurred in regional patterns of homicide, shifting attention toward the western region of the country and away from the southern region. The data used in their study included cities in the United States with a population of 100,000 or more as of the year 1990. The race-specific homicide rates were based on a five-year average of the homicide data for the time period of 1987 to 1991. This method produced a comprehensive sample of the 196 largest cities in the United States. The researchers found the mean homicide rate for whites to be higher in the West (9.13) than in the South (7.19). However, the regional difference in mean homicide rates for blacks was minor—33.91 for the West and 33.89 for the South. The statistics for the entire sample of 196 cities imply the overall mean homicide rate for blacks (34.29) was much greater than the overall mean homicide rate for whites (7.63). The overall model showed that black homicide rates are higher in the West than in any other area of the country.

Parker and Pruitt (2000) found that the large economic deprivation and social isolation experienced by the black population raises the prevalence of black homicide in the cities of the United States. The primary factors influencing white homicide rates in the West were economic factors such as white poverty and income inequality, while the factor affecting homicide rates in the South may possibly be a cultural orientation among whites. Fox and Zawitz (2001) also found homicide rates in the southern regions of the United States to be higher than in other regions. However, they found this pattern across

the entire southern portion of the country. The South Atlantic, East South Central, and especially the West South Central regions have the highest homicide rates. The lowest homicide rates were found in the New England, Mountain, and West North Central regions. Fox and Zawitz (2001) did not discuss the regional differences associated with race; consequently, a comparison between the two studies regarding race and region of homicide rates could not be accomplished.

Another leading cause of death that has been studied closely is accidental/occupational death. A study by the Centers for Disease Control (2001) shows a decline in occupational deaths in recent years. This report by the CDC provides an overview of traumatic occupational deaths among civilian workers with data collected by the National Traumatic Occupational Fatalities (NTOF) surveillance system for the years 1980 to 1997. During this 17-year period, 103,945 civilian workers died in the United States from occupational injuries. The annual number of occupational deaths declined 28 percent, from 7343 in 1980 to 5285 in 1997. The occupational injury death rate for all workers dropped from 7.4 per 100,000 in 1980 to 4.1 per 100,000 in 1997, which is a decline of 45 percent. Males had a death rate nearly 11 times that of females and accounted for 93 percent of all deaths. White workers accounted for 85 percent of deaths; however, blacks had a higher death rate (5.6 per 100,000 workers) than whites (5.0 per 100,000 workers). The highest number of deaths from occupational injury occurred in workers aged 25 to 34 years. Since the year 1980, automobile accidents have been responsible for 24 percent of deaths and were the leading cause of injury-related deaths for workers in the United States (CDC 2001). In 1990, homicide became the second leading cause of work-related deaths (14%), exceeding machine-related deaths

(13%). Deaths resulting from falls and electrocutions were responsible for 10 percent and seven percent of occupational injury deaths, respectively. The industries that had the highest number of deaths were construction (19% of reported deaths—19,179 deaths), transportation/public utilities/communications (17% of reported deaths—17,489 deaths), and manufacturing (15% of reported deaths—15,490 deaths). The industries with the highest death rates were mining (30 per 100,000), agriculture/forestry/fishing (19 per 100,000), and construction (15 per 100,000). The largest number of occupational injury deaths took place in the state of California (10%—10,712 deaths). The state of Texas was not far behind with 10,294 deaths (10%), followed by Florida (6%—6,269 deaths), Illinois (4%—4,582 deaths), and Pennsylvania (4%—4,402 deaths). The work-related death rates were highest in Alaska (22.7 per 100,000), Wyoming (15.8 per 100,000), Montana (11.8 per 100,000), Idaho (10.4 per 100,000), and West Virginia (10.1 per 100,000). Overall, the findings in this report by the Centers for Disease Control show a decline in the annual number of deaths and the annual rates of work-related deaths in the United States during the years 1980 to 1997.

A report from the National Center for Health Statistics, a branch of the Centers for Disease Control, indicates that the 1999 infant mortality rate of 7.0 infant deaths per 1,000 live births was three percent lower than the rate for 1998 (Mathews et al. 2002). In addition, the infant mortality rate decreased 21 percent from the rate of 8.9 at the start of the decade. As a whole, mortality rates were lowest for infants born to Chinese and Japanese mothers, 2.9 and 3.4 per 1,000 live births, respectively. Infants born to Cuban (4.7), Central and South American (5.5), Filipino (5.8), and non-Hispanic white mothers (5.8) had low mortality rates. On the other hand, infants born to Hawaiian (7.1), Puerto

Rican (8.3), and American Indian mothers (9.3) had high mortality rates. The mortality rate for infants born to non-Hispanic black mothers was the highest at 14.1 per 1,000 live births (Mathews et al. 2002). The infant mortality rates differed greatly by state and within states by race and Hispanic origin of the mother. In general, mortality rates were highest in southern states and lowest in western and northeastern states. The infant mortality rates ranged from 4.8 in New Hampshire to 10.3 in Mississippi. The overall mortality rate for male infants in 1999 was 7.7 per 1,000 live births, which was 22 percent higher than the rate 6.3 per 1000 live births for female infants.

The two most significant predictors of an infant's health and survival are birthweight and period of gestation (Mathews et al. 2002). Infants born too small or too early have a greater chance of death and both short-term and long-term disability than infants born with birthweights of 2,500 grams or more or at term (37-41 weeks). For all race and ethnic groups studied, mortality rates were higher for infants with low birthweight (247.0 per 1000 live births) than for infants with birthweights of 2,500 grams or more (2.5 per 1000 live births). The mortality rate for extremely premature infants (less than 32 weeks gestation) was 183.3, while the mortality rate for term infants was 2.7. According to Mathews et al. (2002), nearly 28,000 infants died in the first year of life in the year 1999.

In 1999, the leading cause of death in infants was congenital malformations, which accounted for 20 percent of all infant deaths. The second leading cause of death in infants was disorders related to short gestation and low birthweight, which accounted for 16 percent of all infant deaths. Sudden Infant Death Syndrome (SIDS) was next with nine percent of all infant deaths. The fourth leading cause of death in infants was

maternal complications accounting for five percent of all infant deaths, while respiratory distress of newborn was the fifth leading cause of death in infants, accounting for four percent of all infant deaths. The study by Mathews et al. (2002) showed the order of the leading causes of infant deaths differed substantially by race and Hispanic origin of the mother. Congenital malformations were the leading cause of death in infants for all groups, with the exception of infants of Puerto Rican and black mothers, for whom low birthweight was the leading cause of death. Nevertheless, death rates for congenital malformations in infants of black mothers were 26 percent higher than the rates for infants of non-Hispanic white mothers. In the case of SIDS, mortality rates were highest for infants of American Indian mothers. In addition, infants of black mothers had high death rates due to SIDS. In maternal complications and Respiratory distress of newborn, infants of black and Puerto Rican mothers had the highest death rates.

Death Trends in Louisiana

Contrary to the United States as a whole, death trends and patterns in East Baton Rouge Parish have not been a primary subject of research. The majority of information regarding death patterns and trends in this parish has been part of statistical overviews provided by organizations such as the National Center for Health Statistics and the Louisiana State Center for Health Statistics. Data concerning death trends and patterns in the state of Louisiana are more abundant and easier to locate.

The most recent and comprehensive information on death in the state of Louisiana that could be located for this study came from the 2001 Louisiana Health Report Card (Romalewski 2001). According to this report, 40,976 deaths occurred among Louisiana residents in 1999. The number of deaths in 1999 illustrates a slight increase from the

40,209 deaths that occurred among Louisiana residents in 1998. The number of deaths among males (20,492) virtually equaled the number of deaths among females (20,484). In 1999, the number of white deaths was 28,168; the number of black deaths was 12,637; and the number of deaths in other races was 171. The crude death rate (unadjusted) in Louisiana has been steadily rising since the mid-1980s. This steady rise in crude death rate continued in 1999 with an increase to 937.2 per 100,000 people from 920.3 per 100,000 people in 1998. In comparison, the crude death rate for the United States was 864.7 in both 1997 and 1998, which is the most current year U.S. data are available. The crude death rate in Louisiana surpassed the national rate in 1990 and has sustained an expanding margin ever since (Romalewski 2001). Despite the higher death rate in relation to the country as a whole, Louisiana was within the range of the rates of its neighboring states in 1998— Arkansas (1083.8), Mississippi (1011.8), Alabama (1009.4), and Texas (721.7). Romalewski (2001) claims the increase in crude death rate since the mid-1980s is partly due to the age distribution of the population. Over time, the relatively large 5-24 year old population in 1970 has aged and comprised a large 25-44 population in 1990. In other words, the Louisiana population in 1990 was older than the Louisiana population in 1970. The highest proportion of deaths occurred in the age groups 65-84 and 85 and older. In younger and middle age groups, the number of male deaths was higher than the number of female deaths. Conversely, the number of female deaths in the oldest age group (85+) was higher than the number of male deaths. According to Romalewski (2001), the total number of deaths in East Baton Rouge Parish in 1999 was 3,229 and the death rate was 8.1 per 1,000 residents. In comparison, the total number of deaths in Jefferson Parish was 4,036 and the death rate was 8.9.

The leading cause of death in Louisiana in 1999 was heart disease (29%), followed by cancer (23%), cerebrovascular disease (stroke) (6%), accidents (5%), and diabetes (4%). These five leading causes represented 67 percent of the total 40,976 deaths of Louisiana residents in 1999. Although the rankings may have changed, the top four causes—heart diseases, cancer, stroke, and accidents—have steadily been the leading causes of death in Louisiana for the past 20 years. The fifth-ranked cause has fluctuated among diabetes, chronic obstructive pulmonary disease (COPD), and pneumonia and influenza. In comparison to the United States (1998 final data), the three top causes of death in Louisiana (1999 final data) are synonymous with those of the nation. However, diabetes is a more critical issue in Louisiana than in the United States, in which diabetes is ranked seventh. In addition, accidents are ranked higher in Louisiana (fourth) than at the national level (fifth). Despite the declining trend in heart diseases over the last 20 years, the crude death rate for 1999 of 273.2 per 100,000 residents was higher than the 1998 rate of 270.8 per 100,000 residents.

In a study on cancer incidence in the industrial corridor, Chen et al. (1998) calculated age-adjusted cancer incidence rates for a seven-parish study area from Baton Rouge down to, but not including, New Orleans. These parishes are East Baton Rouge, West Baton Rouge, Iberville, Ascension, St. John, St. James, and St. Charles. The industrialized corridor, where two-thirds of Louisiana Chemical workers are employed, is included in this region. Approximately 14 percent of the state's population resides in this area, with 63 percent white, 32 percent black, and five percent other races. Rates for Louisiana and for the combined Surveillance, Epidemiology and End Results (SEER) were also computed for comparison. According to Chen et al. (1998), dramatically

higher mortality rates for all cancers combined have been seen in men in South Louisiana since 1950. The study found cancer to be most common in black males with an age-adjusted incidence rate of 527 per 100,000 for all cancers. White males followed with 502 per 100,000, then white females with 325 per 100,000, and finally black females with 310 per 100,000. This trend reflects the national pattern for cancer. The researchers found cancer incidence rates for the Industrial Corridor to be similar to or lower than the combined SEER program (national rates) for most of the common cancers and for rare tumors. Lung cancer in white males and kidney cancer in white females were the only two exceptions. These types of cancer were significantly higher than the SEER rates. The results of this study suggest that the excessive overall mortality rates reported in the past were mainly due to the high lung cancer incidence and mortality.

According to Romalewski (2001), the remaining leading causes of death in Louisiana in 1999 were chronic lower respiratory diseases; influenza and pneumonia; nephritis, nephrotic syndrome, and nephrosis; septicemia; Alzheimer's disease; suicide; and homicide. The age-adjusted deaths rates (standardized rates) for the leading causes of death in Louisiana in 1999 demonstrate that males, especially black males, have a higher risk of death due to heart diseases, cancer, and accidents than females. In addition, black males and females have a greater chance of dying from diabetes and strokes than white males and females. Injury deaths—including accidents, homicides, and suicides—account for the cause of death in approximately eight percent of all deaths each year in Louisiana. The combination of the injury mortality data for the years 1996 to 1998 exhibits that the rate of motor-vehicle traffic deaths (21.0 per 100,000) and the rate of firearm deaths (21.7 per 100,000) dramatically exceed the death rates of all other types

of injury deaths. The age-adjusted death rates for the state in 1999 show males, particularly white males, have a greater chance of committing suicide than females. On the other hand, blacks, particularly black males, are at a higher risk for death due to homicide than whites. According to the U.S. Bureau of Justice Statistics (2001), the number of homicides in Louisiana has steadily declined since 1994. While 856 people were murdered in Louisiana in 1994, only 468 people were murdered in 1999. Since 1992, the age groups 18-24 and 25-34 consistently experienced the highest percentage of homicides. In accordance with Romalewski (2001), the U.S. Bureau of Justice Statistics shows black males have consistently been at a greater risk for death by homicide. In addition, guns were used in homicides more than any other weapon in Louisiana for the years 1992 to 1999.

According to Romalewski (2001), 618 infants died in the state of Louisiana in 1999. Of these infant deaths, 385 were black, 227 were white, and 6 were from other races. The infant mortality rate in Louisiana has steadily decreased from 1970 to the mid-1990s. A 41 percent decline in infant mortality occurred between 1970 and 1980. Since 1990, the infant mortality rate has declined 16 percent from 11.0 deaths per 1,000 live births in 1990 to 9.2 deaths per 1,000 live births in 1999. Despite the trend of decline in infant mortality over the past several decades, the Louisiana rate remains high in comparison to the national infant mortality rate. The infant mortality rate for Louisiana has exceeded the national rate by at least 20 percent since 1992. Nevertheless, the infant mortality rate of Louisiana was within the range of its neighboring states in 1998—Alabama (10.2), Mississippi (10.1), Louisiana (9.1), Arkansas (8.9), and Texas (6.4). Infants born to black mothers tend to have higher mortality rates than infants born

to white mothers. In 1999, the infant mortality rate was 5.9 per 1000 live births for whites, 14.1 per 1,000 live births for blacks, and 4.1 per 1,000 live births for other races. East Baton Rouge Parish recorded 60 infant deaths in 1999 and had an infant mortality rate of 9.7 per 1,000 live births. The infant mortality rate for East Baton Rouge Parish for the years 1995 to 1999 was 11.1 per 1,000 live births. In comparison, the total number of infant deaths in Jefferson Parish in 1999 was 45 with a rate of 7.1 per 1,000 live births, while the total number of infant deaths in Orleans Parish was 72 with a rate of 9.4 per 1,000 live births.

Jooma et al. (2001) analyzed Louisiana's linked birth and death infant data set for the years 1990 to 1998. In addition, the authors identified the population with the highest risk for infant deaths. According to Jooma et al. (2001), the state of Louisiana has consistently had one of the five highest infant mortality rates in the United States. Several characteristics of the mother are associated with infant death. These include unmarried marital status, extremely young and old ages, lower levels of education, and prenatal care. Another characteristic of the mother associated with infant death is the mother's race. In Louisiana, infants of black mothers have a higher risk of death than those of white mothers. According to Jooma et al. (2001), the higher infant mortality rate in Louisiana can be viewed as a result of the greater proportion of black births.

The data on death discussed in this chapter illustrate how the death trends at the state level compare to the death trends at the national level. This study on East Baton Rouge Parish will offer a better understanding of death trends in the parish and will demonstrate how those trends relate to the state and the nation.

MATERIALS AND METHODS

The East Baton Rouge Coroner's System is the computer program the East Baton Rouge Parish Coroner's Office utilizes for recording information on any death that is considered a coroner's case. The medicolegal death investigators at the Coroner's Office record information about the deceased on a Death Investigation Form (Fig.1) at the scene of a death. Items such as name, age, address, time of death, place of death, race, sex, and cause of death are included on the Death Investigation Form. Once back at the Coroner's Office, the information recorded is entered into the East Baton Rouge Coroner's System. This program allows for recording and retrieving quickly the detailed information on the deceased, including all of the information recorded on the Death Investigation Form. As a result, a comprehensive evaluation and analysis of death in East Baton Rouge Parish can be achieved. This computer system was the primary source for gathering data for analysis in this study.

Certain requirements must be met for a death to be considered a coroner's case. The death must be considered suspicious, unexpected, or unusual in some way. For instance, someone found dead in his home would be considered a suspicious death because the circumstances surrounding the death are not necessarily known right away. An autopsy and serum tests would be performed in order to determine the cause of death and whether the death warrants further investigation by the respective law enforcement agency. If the death is sudden or violent, or due to unknown or obscure causes, it must be reported to the Coroner's Office. In addition, death as a result of suspected homicide or suicide and death due to criminal means or casualty must be reported.

**EAST BATON ROUGE PARISH
OFFICE OF THE CORONER**
DEATH INVESTIGATION REPORT

INVESTIGATOR: _____ **FILE #:** _____

INITIAL CONTACT INFORMATION:

DATE: _____ **TIME:** _____ **TIME OF ARRIVAL:** _____

PERSON REPORTING DEATH: _____

AGENCY: _____ **TELEPHONE #** _____

DEATH INFORMATION

DATE OF DEATH: _____ **TIME OF DEATH:** _____

NAME OF DECEASED: _____

DECEASED RESIDENCE ADDRESS: _____ City: _____

LOCATION OF DEATH: _____

RACE: _____ SEX: _____ AGE _____ DATE OF BIRTH: _____

SOCIAL SECURITY#: _____

TYPE OF DEATH: NATURAL _____ ACCIDENT _____ HOMICIDE _____
SUICIDE _____ UNDETERMINED _____

CAUSE OF DEATH: _____

ATTENDING PHYSICIAN: _____ PRONOUNCED DEAD BY: _____

MEDICAL HISTORY: _____

PREGNANCY: YES _____ NO _____

SMOKER: YES _____ DATE LAST SMOKED: _____ QUANTITY: _____
NO _____ UNKNOWN _____

FUNERAL HOME:

NAME: _____

REMAINS RELEASED: YES _____ NO _____

Figure 1: Death Investigation Report.

TRAUMA INFORMATION

DATE OF TRAUMA: _____ TIME OF TRAUMA: _____

TRAUMA RECEIVED AT: _____

LOCATION OF TRAUMA ON BODY: _____

DESCRIPTION OF TRAUMA: _____

INVESTIGATING AGENCY/OFFICER: _____

LOPA: _____

AUTOPSY INFORMATION: AUTOPSY: YES NO

LOCATION OF AUTOPSY: _____

DATE OF AUTOPSY: _____ TIME: _____ BY: _____

TAG NUMBER: _____

OTHER AGENCY NUMBER: _____ TELEPHONE: _____

SPECIMEN OBTAINED: _____ TYPE: _____ TIME: _____

OBTAINED BY: _____

DISPOSITION OF SPECIMEN: _____

INV. AGENCY NOTIFICATION: _____

NARRATIVE:

SUPPLEMENT _____

Figure 1 (con't.)

The Coroner's Office is also notified when a death occurs in a prison or while serving a sentence. Any death due to hanging, electrocution, burns, drowning, gunshot wounds, stabs or cutting, starvation, radiation, lightning, exposure, alcoholism, addiction, strangulation, suffocation, smothering, tetanus, or suspected poisoning must be reported to the Coroner's Office. A death following an injury or accident, whether old or new, is considered a coroner's case as well. A death due to trauma from whatever cause is a coroner's case, as well as when someone finds a body. Death due to a virulent contagious disease that may cause or be caused by a public hazard must be reported to the Coroner's Office. Acquired Immune Deficiency Syndrome (AIDS) would be regarded as a virulent contagious disease; therefore, all AIDS deaths are coroner's cases. Some other contagious diseases that would be reported are viral meningitis, hepatitis A,B, and C, diphtheria, tuberculosis, cholera, encephalitis, influenza, measles, and malaria.

Other deaths that are considered coroner's cases involve certain hospital deaths. One such case occurs when someone dies after being in the hospital for less than 24 hours. Other hospital deaths that become coroner's cases include deaths without an attending physician within 36 hours before the time of expiration. Due to these above stated criteria that must be met to be a coroner's case, not every death in the parish goes through the Coroner's Office.

In order to determine the total number of deaths in the parish during the chosen eleven-year period, the Office of Vital Statistics in New Orleans was contacted. The number of deaths in East Baton Rouge Parish for the years 1991 to 2000 was obtained by phone. Since vital statistic reports for the year 2001 is not complete, the number of deaths for that year could not be obtained for this thesis project. Publications and data

on the website for the State Center for Health Statistics supplied any other information on East Baton Rouge Parish and the state of Louisiana.

Reports containing all relevant information on coroner's cases were printed from the Coroner's System computer program. These reports were categorized by cause of death. The causes of death analyzed were classified as homicide, suicide, accidental, AIDS, infant deaths, cardiac, carcinoma, and other natural deaths. When this study began, a program that automatically classified deaths by race, sex, and age did not exist in the coroner's computer system. Consequently, the reports for causes of death other than natural deaths had to be analyzed by hand. Each entry on the reports contained the case number, date of death, name of the deceased, site of the death, age of the deceased, sex of the deceased, race of the deceased, any trauma inflicted on the deceased, and the name of the death investigator assigned to the case. For the purposes of this study, only the race, age, and sex of the deceased were obtained from each entry. All other information on the deceased was ignored. The necessary information obtained from the reports was separated by the year of death and recorded under subheadings. These subheadings were white male, white female, black male, black female, other male, and other female. Each deceased was placed in the appropriate subheading by his or her age. By using ages in the subheadings, the anonymity of the deceased was further ensured. Once each death for the corresponding cause of death was recorded, the number of deaths for each subheading was totaled. The subheading totals were added together to obtain the total number of deaths for each year of the specific cause of death. The year totals were then added together to give the total number of deaths for the eleven-year period for each cause of death.

Once the data were properly categorized and totaled, the data was programmed into Microsoft Excel to formulate graphs. Three graphs were made for each cause of death. The first graph displayed the totals for each year during the eleven-year period analyzed in this study. The second graph displayed the male to female death ratio for each year in the eleven-year period. The third graph illustrated the totals for race for each year in the eleven-year period.

In addition to the graphs, tables were constructed using the age data on Microsoft Excel. For each cause of death that was unnatural, the age of every deceased was placed in the appropriate age range. Once all deaths were accounted for, the totals were calculated and put in the final table. The deaths for each age range were added together to calculate the total for each year. Then, the year totals were added together to give the total for all eleven years combined. The total for each age range over the entire eleven-year period was also calculated. These totals were then added together to give the total for all eleven years combined. Adding the totals for each year and for each age range also served to double-check the accuracy of the grand total. Once each table was complete, the totals were compared to the graph totals for that particular cause of death. The comparison of totals between tables and graphs provided another opportunity to check the accuracy of the numbers for each cause of death.

Another type of table was constructed for suicide, homicide, and accidental deaths. This table illustrated the different types of causes of death under suicide, homicide, and accidental deaths. Deaths by suicide were categorized by the method the deceased used to commit suicide, the sex of the deceased, and the race of the deceased. Deaths by homicide were categorized by the method in which the deceased was

murdered, the sex of the deceased, and the race of the deceased. In the same fashion as suicide and homicide, the type of accident that killed the deceased, the sex of the deceased, and the race of the deceased categorized deaths by accident. In order to ensure accuracy, the totals for each of these tables were compared to the corresponding age range tables.

A third type of table was constructed for displaying the death rates for each cause of death. The death rate was calculated using the formula:

$$\text{Death Rate} = (\# \text{ of deaths} / \text{population}) \times 10,000$$

One death rate table included the overall rate and the rate for white males, white females, black males, black females, other males, and other females for the years 1991 through 1999. Since the population data for the years 2000 and 2001 could not be acquired, the death rates for those years could not be calculated. A second death rate table included the rates for the chosen age groups for the years 1991 through 1999. For infant deaths, the death rate formula used was different:

$$\text{Infant Death Rate} = (\# \text{ of deaths} / \text{infant population}) \times 1,000$$

In order to isolate the infant population from the 0-4 age group in Table 1, the formula provided by the Louisiana State Office of Vital Statistics was used:

$$\text{Infant Population} = \text{population for 0-4 age group} \times 0.2$$

Reports on natural deaths, with the exception of AIDS, were not printed due to their large size. Since the number of deaths due to natural causes was so high, the time required to analyze them by hand was not available. Therefore, new reports were programmed into the East Baton Rouge Coroner's System computer program. One of these new reports automatically broke down the natural death data by race, sex, and cause

of death. This report was manufactured for each year beginning with 1991 and ending with 2001. An additional report containing the above information was produced for the whole ten-year period in order to demonstrate cumulative numbers for the chosen period of time.

The second new report automatically broke down the natural death data into the standard age ranges chosen for this study. The chosen age ranges are <1, 1-4, 5-14, 15-24, 25-34, 35-44, 45-54, 55-64, 65-74, and 75+. The <1 age group was only used in the infant death section of the results. These age ranges made it possible to determine what age groups were at the highest risk of dying from the specific cause of death. This age range report was manufactured for each year in the eleven-year period for each cause of death. In the same manner as the cultural background natural death report, an age range report containing the cumulative numbers for the whole eleven years was manufactured.

Another reason for analyzing the reports by hand was to identify and eliminate errors in the reports. Since employees of the Coroner's Office entered the data in the reports into the computer system, some mistakes were expected as a result of human error. One such error found during examination of the data was duplication. Duplication involves one person being entered into the computer system twice. As a result, the computer views the person as two different people instead of one. Duplication generally occurs when more information on the deceased is obtained after the initial entry into the computer system, and the investigator creates a new file instead of entering the new information in the existing file. Duplication falsely increases the number of deaths. If the number of duplicated cases is high, the accuracy of the data in the computer system is greatly affected.

Another type of error found while analyzing the data for this study involved missing information. Necessary information, such as age or race, was occasionally missing from cases. When this occurred, the individual case was looked up in the computer and the missing information was retrieved. However, the computer did not always have the missing information. On the occasion the information could not be retrieved from the computer, the death certificate needed to be located. Death certificates along with paper files for deaths dating back to 1997 are kept at the coroner's office. For cases older than 1997, the funeral home had to be contacted in order to obtain the necessary information. Since this type of error was not widely found in the data, correcting it was not as difficult or time consuming as the duplication error. Despite the infrequency of this error, missing information still affects the accuracy of the data. Finding and eliminating any errors in the data increased the accuracy of the reports and aided in completing the study properly.

Once the analyses of coroner's cases were complete, they were compared to the records for the state of Louisiana in order to demonstrate the relationship between the parish and the state as a whole. In addition, death data for the United States was obtained from the Center for Disease Control and Prevention. The data for East Baton Rouge Parish was compared to the national statistics for the leading causes of death in order to identify any correlations between the two.

RESULTS

The following chapter reports the results of the analyses of the data collected on the deaths in East Baton Rouge Parish that were considered coroner's cases. In order to better understand the results of the analysis, the population distribution was compiled in Table 1 below (LA State Department of Health Statistics). The distribution of the population for 2000 and 2001 could not be acquired for this study; consequently, they could not be displayed in the table. Table 1 shows an overall increase in the parish population from 1991 to 1994. Beginning with 1995, the population decreases slightly each year. However, the data that are available for the year 2000 show a substantial increase in the population of the parish.

The white population of the parish follows the same basic pattern for both males and females. Both white males and females remain steady until 1994, and then they decline every year afterwards. The 25-34 age group in both sexes decreased every year throughout the period. In addition, the group aged 35-44 increased from 1991 to 1996 and then declined during the remainder of the nine years. The group aged 45-54 in both sexes rose steadily throughout the period. White males increased in the 55-64 age group, while white females remained steady. While the 65-74 age group fluctuated, the group aged 75 and older increased every year.

In the black population, males and females followed the same patterns, as well. Both males and females increased continuously from 1991 to 1999. The group aged 0-4 increased until 1994 and then declined for the remainder of the nine years. The group aged 25-34 decreased in numbers throughout the nine years. The 35-44 age group

Table 1: Population Distribution for East Baton Rouge Parish from 1991 to 1999.

| 1991 | sex | race | 0--4 | 5--14 | 15--24 | 25--34 | 35--44 | 45--54 | 55--64 | 65--74 | 75+ | Total |
|--------------|--------|-------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|----------------|
| | Male | White | 8,211 | 16,281 | 20,699 | 20,968 | 19,895 | 12,476 | 9,179 | 7,037 | 3,333 | 118,079 |
| | Female | White | 7,783 | 15,741 | 21,342 | 20,802 | 20,325 | 13,021 | 10,468 | 8,939 | 6,708 | 125,129 |
| | Male | Black | 6,859 | 13,215 | 12,807 | 10,276 | 8,940 | 4,575 | 3,214 | 2,371 | 1,252 | 63,509 |
| | Female | Black | 6,443 | 12,905 | 13,583 | 12,451 | 11,063 | 5,960 | 4,359 | 3,387 | 2,367 | 72,518 |
| | Male | Other | 275 | 480 | 933 | 733 | 510 | 285 | 152 | 57 | 23 | 3,448 |
| | Female | Other | 194 | 441 | 648 | 572 | 553 | 260 | 143 | 72 | 38 | 2,921 |
| Total | | | 29,765 | 59,063 | 70,012 | 65,802 | 61,286 | 36,577 | 27,515 | 21,863 | 13,721 | 385,604 |
| 1992 | Male | White | 8,216 | 16,282 | 20,823 | 20,510 | 20,095 | 13,363 | 9,256 | 7,171 | 3,426 | 119,149 |
| | Female | White | 7,807 | 15,750 | 21,419 | 20,406 | 20,507 | 13,945 | 10,481 | 9,090 | 6,859 | 126,264 |
| | Male | Black | 7,035 | 13,430 | 13,290 | 10,217 | 9,372 | 4,903 | 3,263 | 2,411 | 1,263 | 65,184 |
| | Female | Black | 6,586 | 13,092 | 14,057 | 12,332 | 11,595 | 6,374 | 4,453 | 3,453 | 2,416 | 74,378 |
| | Male | Other | 287 | 486 | 966 | 750 | 540 | 315 | 168 | 63 | 23 | 3,598 |
| | Female | Other | 209 | 461 | 697 | 585 | 563 | 293 | 158 | 86 | 49 | 3,101 |
| Total | | | 30,140 | 59,501 | 71,252 | 64,800 | 62,672 | 39,193 | 27,779 | 22,274 | 14,036 | 391,674 |
| 1993 | Male | White | 8,146 | 16,134 | 20,611 | 19,848 | 20,394 | 13,901 | 9,316 | 7,317 | 3,525 | 119,192 |
| | Female | White | 7,742 | 15,611 | 21,288 | 19,894 | 20,856 | 14,539 | 10,495 | 9,214 | 7,006 | 126,645 |
| | Male | Black | 7,167 | 13,541 | 13,539 | 10,148 | 9,749 | 5,176 | 3,332 | 2,441 | 1,270 | 66,363 |
| | Female | Black | 6,700 | 13,191 | 14,293 | 12,257 | 12,025 | 6,735 | 4,559 | 3,496 | 2,453 | 75,709 |
| | Male | Other | 301 | 507 | 1,036 | 766 | 561 | 345 | 182 | 64 | 26 | 3,788 |
| | Female | Other | 213 | 470 | 761 | 592 | 580 | 320 | 167 | 149 | 47 | 3,235 |
| Total | | | 30,269 | 59,454 | 71,528 | 63,505 | 64,165 | 41,016 | 28,051 | 22,581 | 14,327 | 394,932 |
| 1994 | Male | White | 8,022 | 15,936 | 20,473 | 19,253 | 20,517 | 14,325 | 9,350 | 7,322 | 3,605 | 118,803 |
| | Female | White | 7,601 | 15,434 | 20,981 | 19,311 | 20,938 | 14,966 | 10,487 | 9,168 | 7,095 | 125,981 |
| | Male | Black | 7,188 | 13,636 | 13,888 | 9,962 | 9,979 | 5,470 | 3,368 | 2,453 | 1,271 | 67,215 |
| | Female | Black | 6,744 | 13,268 | 14,668 | 11,970 | 12,285 | 7,088 | 4,635 | 3,516 | 2,464 | 76,638 |
| | Male | Other | 319 | 516 | 1,055 | 762 | 585 | 367 | 191 | 73 | 26 | 3,894 |
| | Female | Other | 228 | 471 | 790 | 585 | 593 | 350 | 174 | 89 | 49 | 3,329 |
| Total | | | 30,102 | 59,261 | 71,855 | 61,843 | 64,897 | 42,566 | 28,205 | 22,621 | 14,510 | 395,860 |
| 1995 | Male | White | 7,826 | 15,699 | 20,330 | 18,664 | 20,559 | 14,670 | 9,331 | 7,299 | 3,685 | 118,063 |
| | Female | White | 7,418 | 15,204 | 20,735 | 18,729 | 20,956 | 15,289 | 10,448 | 9,092 | 7,179 | 125,050 |
| | Male | Black | 7,154 | 13,595 | 14,302 | 9,750 | 10,136 | 5,782 | 3,419 | 2,469 | 1,285 | 67,892 |
| | Female | Black | 6,726 | 13,219 | 15,060 | 11,695 | 12,438 | 7,498 | 4,701 | 3,523 | 2,484 | 77,344 |
| | Male | Other | 339 | 539 | 1,069 | 778 | 595 | 389 | 207 | 72 | 31 | 4,019 |
| | Female | Other | 244 | 475 | 797 | 611 | 610 | 375 | 180 | 106 | 54 | 3,452 |
| Total | | | 29,707 | 58,731 | 72,293 | 60,227 | 65,294 | 44,003 | 28,286 | 22,561 | 14,718 | 395,820 |
| 1996 | Male | White | 7,539 | 15,110 | 20,155 | 18,168 | 20,626 | 15,106 | 9,422 | 7,210 | 3,783 | 117,119 |
| | Female | White | 7,160 | 14,672 | 20,511 | 18,289 | 21,061 | 15,717 | 10,500 | 8,979 | 7,263 | 124,152 |
| | Male | Black | 6,941 | 13,462 | 14,568 | 9,665 | 10,318 | 6,126 | 3,476 | 2,476 | 1,285 | 68,317 |
| | Female | Black | 6,501 | 13,051 | 15,374 | 11,584 | 12,620 | 7,951 | 4,817 | 3,528 | 2,513 | 77,939 |
| | Male | Other | 338 | 542 | 1,053 | 803 | 614 | 429 | 222 | 83 | 31 | 4,115 |
| | Female | Other | 244 | 476 | 778 | 658 | 606 | 414 | 194 | 109 | 57 | 3,536 |
| Total | | | 28,723 | 57,313 | 72,439 | 59,167 | 65,845 | 45,743 | 28,631 | 22,385 | 14,932 | 395,178 |

Table 1 (continued).

| | | | | | | | | | | | | |
|--------------|--------|-------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|----------------|
| 1997 | Male | White | 7,288 | 14,582 | 20,184 | 17,594 | 20,602 | 15,504 | 9,565 | 7,084 | 3,875 | 116,278 |
| | Female | White | 6,918 | 14,182 | 20,466 | 17,761 | 21,027 | 16,107 | 10,629 | 8,788 | 7,356 | 123,234 |
| | Male | Black | 6,706 | 13,320 | 14,858 | 9,600 | 10,453 | 6,461 | 3,581 | 2,470 | 1,283 | 68,732 |
| | Female | Black | 6,275 | 12,851 | 15,607 | 11,418 | 12,707 | 8,400 | 4,954 | 3,531 | 2,541 | 78,284 |
| | Male | Other | 339 | 537 | 1,048 | 793 | 619 | 449 | 242 | 77 | 33 | 4,137 |
| | Female | Other | 248 | 473 | 774 | 669 | 598 | 447 | 204 | 110 | 61 | 3,584 |
| Total | | | 27,774 | 55,945 | 72,937 | 57,835 | 66,006 | 47,368 | 29,175 | 22,060 | 15,149 | 394,249 |
| 1998 | Male | White | 7,252 | 14,344 | 20,160 | 16,676 | 20,234 | 15,615 | 9,786 | 7,388 | 4,279 | 115,734 |
| | Female | White | 6,889 | 13,940 | 20,640 | 17,109 | 20,782 | 16,260 | 10,869 | 9,117 | 7,883 | 123,489 |
| | Male | Black | 6,542 | 13,252 | 14,615 | 9,177 | 10,458 | 6,747 | 3,655 | 2,715 | 1,430 | 68,591 |
| | Female | Black | 6,167 | 12,856 | 15,803 | 11,190 | 12,570 | 8,677 | 5,040 | 3,841 | 2,830 | 78,974 |
| | Male | Other | 356 | 577 | 1,001 | 766 | 658 | 471 | 257 | 95 | 43 | 4,224 |
| | Female | Other | 255 | 489 | 794 | 664 | 624 | 474 | 209 | 127 | 66 | 3,702 |
| Total | | | 27,461 | 55,458 | 73,013 | 55,582 | 65,326 | 48,244 | 29,816 | 23,283 | 16,531 | 394,714 |
| 1999 | Male | White | 7,220 | 14,137 | 20,211 | 15,968 | 19,812 | 15,884 | 9,956 | 7,295 | 4,398 | 114,881 |
| | Female | White | 6,903 | 13,741 | 20,612 | 16,367 | 20,353 | 16,555 | 11,048 | 9,018 | 7,848 | 122,445 |
| | Male | Black | 6,538 | 13,324 | 14,754 | 9,002 | 10,353 | 7,031 | 3,733 | 2,725 | 1,455 | 68,915 |
| | Female | Black | 6,106 | 12,917 | 15,986 | 10,964 | 12,419 | 9,037 | 5,153 | 3,899 | 2,749 | 79,230 |
| | Male | Other | 341 | 597 | 999 | 723 | 638 | 484 | 251 | 104 | 45 | 4,182 |
| | Female | Other | 247 | 498 | 773 | 633 | 597 | 487 | 211 | 126 | 69 | 3,641 |
| Total | | | 27,355 | 55,214 | 73,335 | 53,657 | 64,172 | 49,478 | 30,352 | 23,167 | 16,564 | 393,294 |

increased in both sexes until 1997; however, the female numbers began to decline in 1998, while the male numbers leveled off. Those aged 45-64 years in both sexes increased throughout the nine years. While the female group aged 75 and older increased continuously during the period, males of the same age group remained steady.

In the other races population, both males and females increased in number until 1998 and then declined in 1999. While the female 0-4 age group increased until 1998, the male 0-4 age group increased until 1995, remained steady through 1997, and then declined in 1998. The groups aged 5-14 years and 25-34 years fluctuated for both males and females. The male 15-24 age group increased until 1995 and then decreased, while females of the same age group fluctuated. For both sexes, the groups aged 45-64 increased throughout the time period, and the 65-74 age group fluctuated. While the

female group aged 75 and older increased slightly throughout the time period, males of the same age group did not show a notable increase in number until 1997.

The database for this study is comprised of 23,813 deaths over the last eleven years. According to the Louisiana Office of Vital Statistics, the total number of deaths in East Baton Rouge Parish for the years 1991 through 2000 is 39,170. As previously mentioned, the number of deaths for the year 2001 is not available yet. The total number of deaths that occurred in East Baton Rouge Parish each year was compared to the total number of deaths that were considered coroner's cases for each year beginning with 1991. Those numbers are displayed below in Table 2.

Table 2: Breakdown of Parish Deaths by Year.

| Year | Coroner Cases | Parish Deaths | Coroner Cases Percentage of Parish Deaths |
|--------------|----------------------|----------------------|--|
| 1991 | 1,860 | 3,628 | 51.3 |
| 1992 | 1,974 | 3,707 | 53.3 |
| 1993 | 2,159 | 3,863 | 55.9 |
| 1994 | 2,172 | 3,786 | 57.4 |
| 1995 | 2,234 | 3,998 | 55.9 |
| 1996 | 2,013 | 3,795 | 53.0 |
| 1997 | 2,224 | 4,074 | 54.6 |
| 1998 | 2,261 | 4,001 | 56.5 |
| 1999 | 2,349 | 4,182 | 56.2 |
| 2000 | 2,274 | 4,136 | 55.0 |
| 2001 | 2,293 | N/A | N/A |
| Total | 23,813 | 39,170 | Average=54.9 |

Table 2 reflects a fluctuation in the parish deaths considered coroner's cases. Coroner cases rose from 1991 to 1995 and then decreased in 1996. From 1997 to 1999, the number of coroner cases increased again. However, the year 2000 demonstrated another decrease in coroner cases followed by a slight increase in 2001. Parish deaths increased as the coroner cases increased up to 1994, where a slight decline in deaths occurred. In 1995, the deaths in the parish rose again. Another decline in parish deaths

occurred simultaneously with the dramatic decrease in coroner cases in 1996. Over the time period of 1991 to 2000, coroner cases comprised slightly more than half of all the deaths in the parish each year.

The breakdown of the number of deaths considered coroner's cases in East Baton Rouge Parish for the years 1991 through 2001 are illustrated in Figure 2. Of these deaths, heart disease claimed more lives than any other cause of death (9,886) and represented 41.5 percent of all coroner cases. The second highest cause of death is cancer with

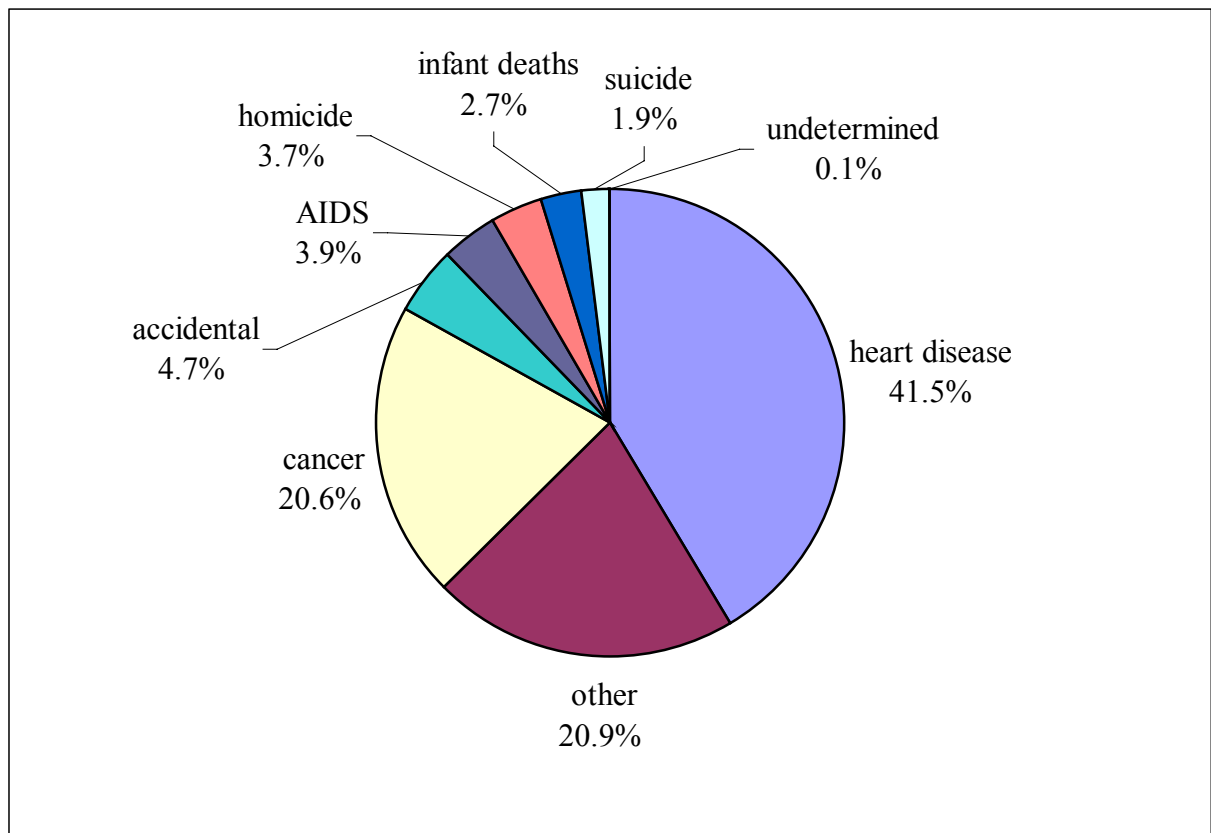


Figure 2: Percentages of causes of death.

4,900 deaths (20.6 %). The general cause of death labeled “other” in the East Baton Rouge Coroner System encompasses diabetes, stroke, septicemia, Alzheimer’s, chronic lower respiratory disease, influenza, pneumonia, and various other causes of death. The

category labeled “other” accounts for 4,988 deaths and 20.9 percent of all coroner cases. This category was not broken down into the specific cause of death due to the inability of the East Baton Rouge Coroner System to break down the category into each cause of death included in the category. Accidental deaths followed with 1,117 deaths and accounted for 4.7 percent of all coroner cases. The fifth highest number of deaths (942) falls into the AIDS category and represents 3.9 percent of all coroner cases. Rounding out the categories was homicide with 878 (3.7%) deaths, infant deaths with 633 (2.7%) deaths, suicide with 452 (1.9%) deaths, and undetermined 17 (0.1%) deaths, respectively.

Of the 23,813 deaths considered coroner cases over the last eleven years, the number of male deaths was 12,324, accounting for 51.8 percent; the number of female deaths was 11,489, accounting for 48.2 percent. The number of deaths in the white population was the highest with 14,653 deaths, accounting for 61.5 percent of all deaths. The number of deaths in the black population was 9,071, accounting for 38.1 percent of all deaths. The number of deaths for all other races combined was the lowest with 89 deaths, which is equivalent to 0.4 percent of the total number of deaths in East Baton Rouge Parish for the years 1991 through 2001.

The age group that experienced the highest number of deaths was 75 and older, as shown in Table 3. This age group had 10,359 deaths, which represents 43.5 percent of all deaths from 1991 to 2001 that were coroner cases. The results of this study are not age adjusted and, as previously mentioned, the population of East Baton Rouge Parish is an older population. In addition, the leading cause of death in the parish—heart disease—becomes more prevalent with age. For these reasons, the oldest age group was expected to have the highest number of deaths. The group aged 65-74 had the second highest

Table 3: Distribution of Deaths by Age

| Age group | Number of deaths | Percentage of all deaths |
|-----------|------------------|--------------------------|
| 0--4 | 758 | 3.2 |
| 5--14 | 133 | 0.5 |
| 15--24 | 784 | 3.3 |
| 25--34 | 1,073 | 4.5 |
| 35--44 | 1,654 | 6.9 |
| 45--54 | 2,043 | 8.6 |
| 55--64 | 2,657 | 11.2 |
| 65--74 | 4,352 | 18.3 |
| 75+ | 10,359 | 43.5 |

number of deaths—4,352, with a percentage of 18.3. The group with the least number of deaths was aged 5-14. This group had only 133 deaths, which represents 0.5 percent of all deaths.

Heart Disease

Heart disease is the leading cause of death of people in East Baton Rouge Parish. As noted previously, the number of deaths resulting from heart disease and considered coroner cases for the years 1991 to 2001 was 9,886, accounting for 41.5 percent of all coroner cases in the parish. Of these deaths, 6,398 were white, 3,465 were black, and 23 were from all other races combined. The white population, accounting for 64.7 percent of coroner cases, was affected the most by heart disease. The number of black deaths represents 35.1 percent of the total deaths from heart disease, while the number of deaths in other races only accounts for 0.2 percent. The female population had 5,276 deaths (53.4%), while the male population had 4,610 deaths (46.6 %).

The 9,886 deaths due to heart disease are broken down by year in Figure 3. The year 1999 clearly had the highest number of cardiac-related deaths with 1,187, followed by 1998 with 1,078. The number of deaths in 1998 and 1999 illustrates a dramatic increase from the previous year, which had only 908 cardiac-related deaths.

The year with the lowest number of deaths resulting from heart disease was 2001, which had 736 deaths. The number of deaths remained fairly stable throughout the years 1991 to 1996.

From 1991 to 1993, the trend for increase in cardiac deaths followed the increase in the population distribution shown in Table 1. However, in 1994, the population continued to increase and cardiac deaths decreased. While cardiac deaths began increasing again in 1996, the population declined for the rest of the period, except for 1998.

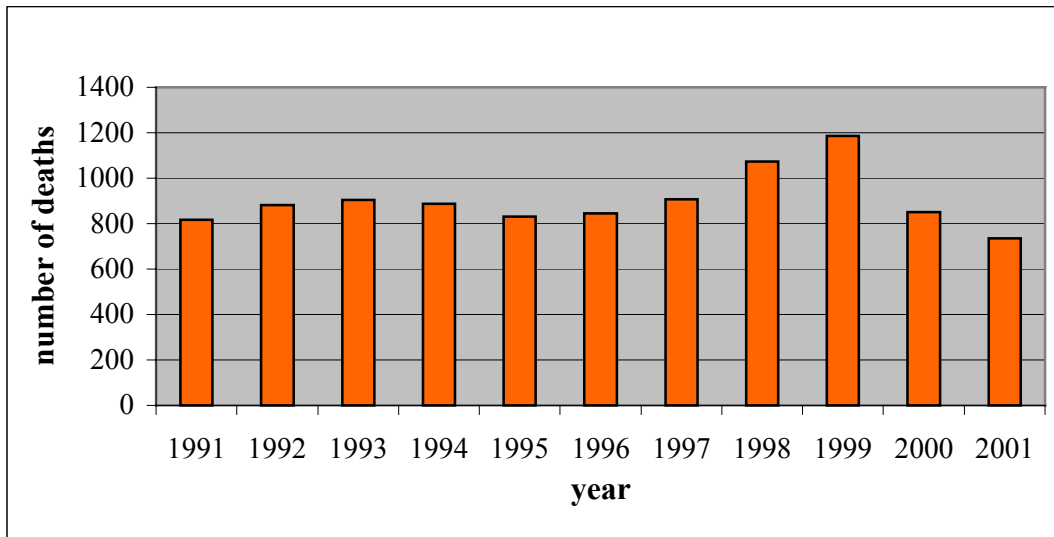


Figure 3: Cardiac-related deaths from January 1, 1991, to December 31, 2001.

In addition, the deaths due to heart disease are broken down by sex in Figure 4. The female population experienced more deaths every year in the chosen period than the male population. In correspondence with the total number of deaths, 1999 had the highest number of deaths for both males and females, 557 and 630, respectively. In 1996, the female deaths exceeded the male deaths by almost 100, which represented the largest gap

between the two sexes for the entire eleven-year period. The smallest gap between deaths in the male population and deaths in the female population occurred in 2001, in which the difference was only 34 deaths.

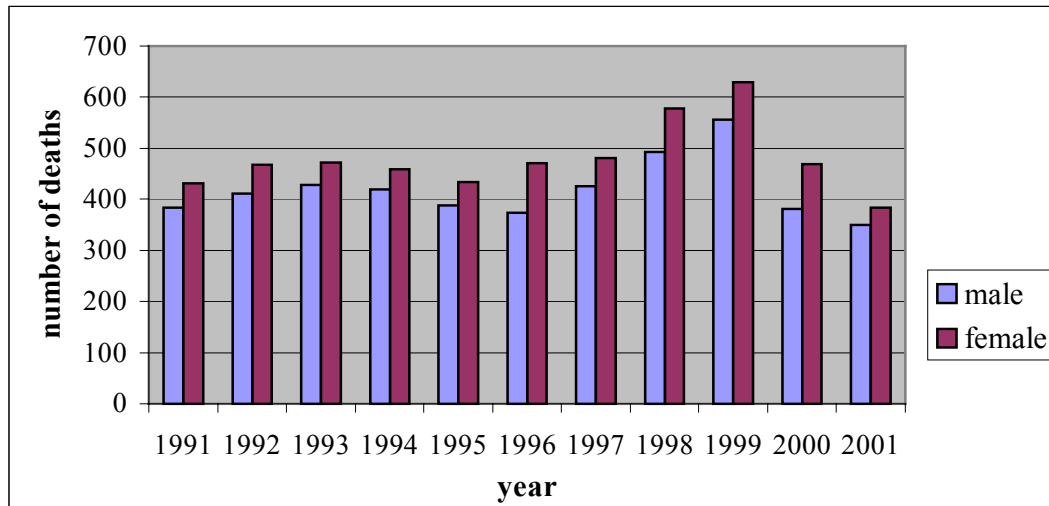


Figure 4: Cardiac-related deaths by sex from January 1, 1991, to December 31, 2001.

This trend for more female deaths did correspond to the population distribution pattern of more females than males. From 1991 to 1996, the male pattern for cardiac deaths followed the pattern for the male population.

The deaths resulting from heart disease are broken down by year in Figure 5. The number of white deaths is almost double that of black deaths every year in the eleven-year period, except in 1992, where the number of white deaths is well over twice the number of black deaths. The lowest number of white deaths was 453 and occurred in 2001, while the highest number was 768 and occurred in 1999. The lowest number of black deaths was 268 and occurred in 1992, while the highest number of black deaths was 413 and occurred in 1999. In 1996, the number of deaths for all other races combined reached its highest point with five deaths.

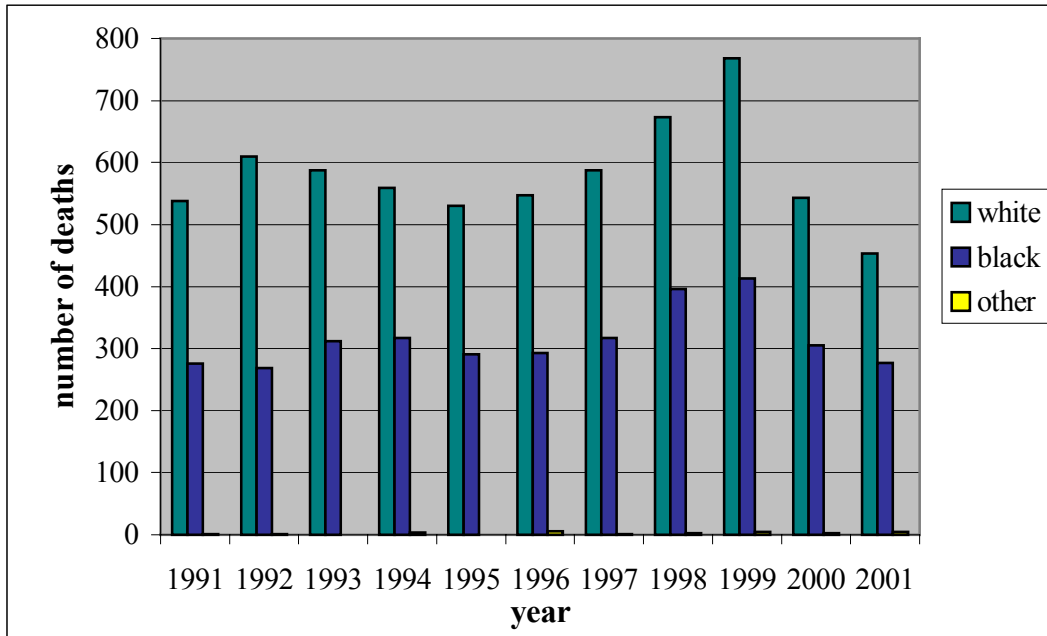


Figure 5: Cardiac-related deaths by race from January 1, 1991, to December 31, 2001.

The trend for race did follow the pattern for the population distribution in that more whites died than blacks and other races throughout the eleven-year period. Death in the white race did not follow the fluctuations in the white population. The increase in deaths in the black race followed the increase in the black population in the latter part of the period.

The overall cardiac death rate fluctuated throughout the time period, as shown in Table 4. From 1997 to 1999, the overall death rate increased sharply. The highest overall death rate was 30.2 in 1999. The lowest overall death rate was 21.2 in 1991. White females had the highest death rate for the majority of the period. Other males consistently had the lowest death rate.

The age group results for cardiac-related deaths are shown in Table 5. As expected, the age group most affected by heart disease was the 75 years and older group. The number of deaths due to heart disease steadily increased with age beginning with the

age group 5-14. Interestingly, the age group 1-4 had a higher number of deaths than the 5-14 age group.

Table 4: Cardiac Death Rates from 1991 to 1999.

| Year | Overall Rate | White Male | White Female | Black Male | Black Female | Other Male | Other Female |
|------|--------------|------------|--------------|------------|--------------|------------|--------------|
| 1991 | 21.2 | 21.2 | 23.1 | 21.1 | 19.6 | 2.9 | |
| 1992 | 22.5 | 23.8 | 25.8 | 19.3 | 19.1 | 2.8 | |
| 1993 | 22.9 | 24.4 | 23.5 | 20.6 | 23.1 | | |
| 1994 | 22.4 | 22.9 | 22.7 | 21.6 | 22.4 | 5.1 | 3.0 |
| 1995 | 20.9 | 21.3 | 22.4 | 20.2 | 19.9 | | |
| 1996 | 21.4 | 19.4 | 25.8 | 21.4 | 18.9 | 2.4 | 11.3 |
| 1997 | 23.0 | 22.8 | 26.2 | 23.1 | 20.2 | 2.4 | |
| 1998 | 27.3 | 26.4 | 29.7 | 26.9 | 26.7 | 4.7 | |
| 1999 | 30.2 | 31.1 | 33.6 | 28.4 | 27.4 | 7.2 | 2.7 |

Table 5: Cardiac Age Statistics from January 1, 1991, to December 31, 2001

| Year | Age range | | | | | | | | | Total |
|--------------|-----------|----------|-----------|-----------|------------|------------|--------------|--------------|--------------|--------------|
| | 1--4 | 5--14 | 15--24 | 25--34 | 35--44 | 45--54 | 55--64 | 65--74 | 75+ | |
| 1991 | 3 | | 1 | 5 | 21 | 65 | 92 | 197 | 431 | 815 |
| 1992 | | | 3 | 6 | 22 | 46 | 137 | 191 | 474 | 879 |
| 1993 | 5 | 2 | 4 | 5 | 19 | 55 | 119 | 221 | 470 | 900 |
| 1994 | 5 | | 3 | 2 | 24 | 72 | 112 | 203 | 458 | 879 |
| 1995 | | | 2 | 7 | 20 | 57 | 90 | 180 | 466 | 822 |
| 1996 | 3 | 1 | 2 | 5 | 31 | 62 | 82 | 159 | 500 | 845 |
| 1997 | | | 5 | 4 | 30 | 68 | 95 | 175 | 529 | 906 |
| 1998 | 2 | 1 | 3 | 12 | 41 | 70 | 93 | 211 | 638 | 1,071 |
| 1999 | 1 | 2 | 1 | 7 | 39 | 93 | 124 | 204 | 714 | 1,185 |
| 2000 | | | 1 | 6 | 21 | 55 | 105 | 148 | 514 | 850 |
| 2001 | | | 1 | 3 | 21 | 61 | 89 | 122 | 438 | 734 |
| Total | 19 | 6 | 25 | 62 | 289 | 704 | 1,138 | 2,011 | 5,632 | 9,886 |

The cardiac death rates for age increased with age, as shown in Table 6. The death rates for the group aged 1-4 years were higher than the death rates for the 5-14 and 15-24 age groups for the majority of the period. Beginning with the group aged 25-34 years, the death rates steadily increased with age. The 75 and older age group had the highest death rate, followed by the group aged 65-74 years. The group aged 5-14 years had the lowest death rate for the majority of the time period.

Table 6: Cardiac Death Rates for Age from 1991 to 1999.

| Year | Age range | | | | | | | | |
|------|-----------|-------|--------|--------|--------|--------|--------|--------|-------|
| | 1--4 | 5--14 | 15--24 | 25--34 | 35--44 | 45--54 | 55--64 | 65--74 | 75+ |
| 1991 | 1.3 | | 0.1 | 0.8 | 3.4 | 17.8 | 33.4 | 90.1 | 314.1 |
| 1992 | | | 0.4 | 0.9 | 3.5 | 11.7 | 49.3 | 85.8 | 337.7 |
| 1993 | 2.1 | 0.3 | 0.6 | 0.8 | 2.9 | 13.4 | 42.4 | 97.9 | 328.1 |
| 1994 | 1.7 | | 0.4 | 0.3 | 3.7 | 16.9 | 39.7 | 89.7 | 315.6 |
| 1995 | | | 0.3 | 1.2 | 3.1 | 12.9 | 31.8 | 79.8 | 316.6 |
| 1996 | 1.3 | 0.2 | 0.3 | 0.8 | 4.7 | 13.6 | 28.6 | 71.0 | 334.9 |
| 1997 | | | 0.7 | 0.7 | 4.5 | 14.4 | 32.6 | 79.3 | 349.2 |
| 1998 | 0.5 | 0.2 | 0.4 | 2.2 | 6.3 | 14.5 | 31.2 | 90.6 | 385.9 |
| 1999 | 0.5 | 0.4 | 0.1 | 1.3 | 6.1 | 18.8 | 40.9 | 88.1 | 431.1 |

Cancer

Cancer is the second highest killer of people in East Baton Rouge Parish. The total number of deaths resulting from cancer for the years 1991 to 2001 was 4,900, which equals 20.6 percent of all deaths considered coroner cases. Of these deaths, 3,392 were white, 1,486 were black, and 22 were from all other races combined. The white population accounts for 69.2 percent of cancer deaths that are considered coroner cases. The black population accounts for 30.3 percent of the cancer deaths, while other races combined only account for 0.5 percent. The total number of males killed by cancer was 2,532 (51.7 %), while the total number of females killed by cancer was 2,368 (48.3%).

The number of cancer deaths per year for the last eleven years is illustrated below in Figure 6. The highest number of deaths due to cancer, 549, occurred in the year 2000. In 1992, there were only 389 deaths resulting from cancer. However, the number of deaths due to cancer did not fall below 400 again throughout the eleven-year period. Spikes in cancer deaths occurred in 1995, which had 474 deaths, 1998, which had 473 deaths, 2000, which had 549 deaths, and 2001, which had 465 deaths.

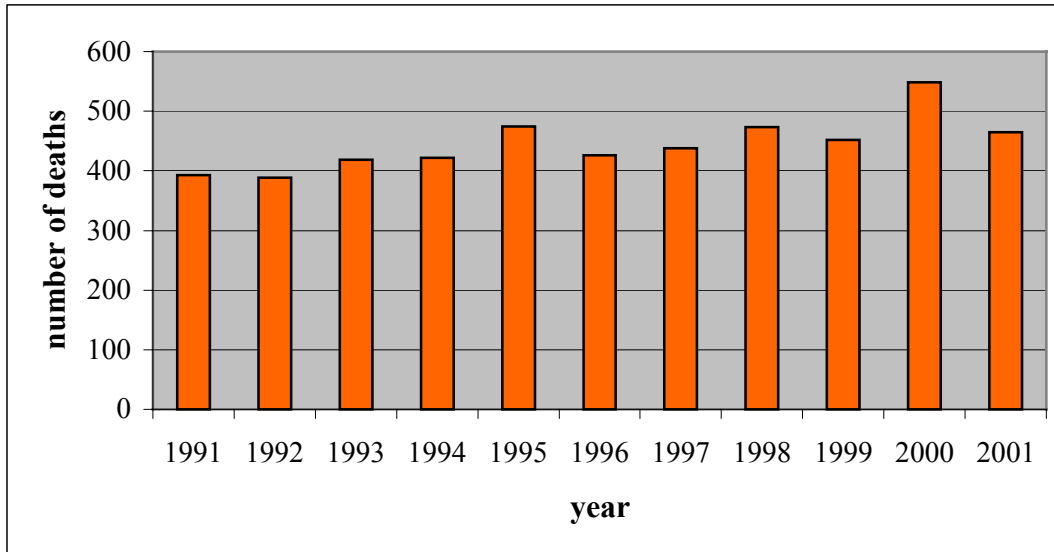


Figure 6: Cancer deaths from January 1, 1991, to December 31, 2001.

Overall, the pattern for cancer deaths does not follow the population distribution pattern shown in Table 1. The increase in cancer deaths in 1993 and 1998 corresponded to the increase in the population in those years.

For the most part, the male population is more affected by cancer than the female population, as demonstrated in Figure 7. The only year until 2000 that more females died from cancer was in 1993. In 2000, female deaths exceeded male deaths by 27. Even though cancer deaths declined in 2001, female deaths remained higher than male deaths. In 1991 and 1996, male deaths surpassed female deaths by more than 40.

Overall, death due to cancer in both male and female populations appears to be increasing over the years and does not have an association with the population distribution pattern. The increase in both male and female deaths in 1993 corresponds to the increase in the male and female populations for that year.

Cancer deaths in the white population are higher than in the black population and all other races combined, as seen in Figure 8. White deaths exceed black deaths by more

than 130 every year of the chosen eleven-year period. Cancer deaths in both white and

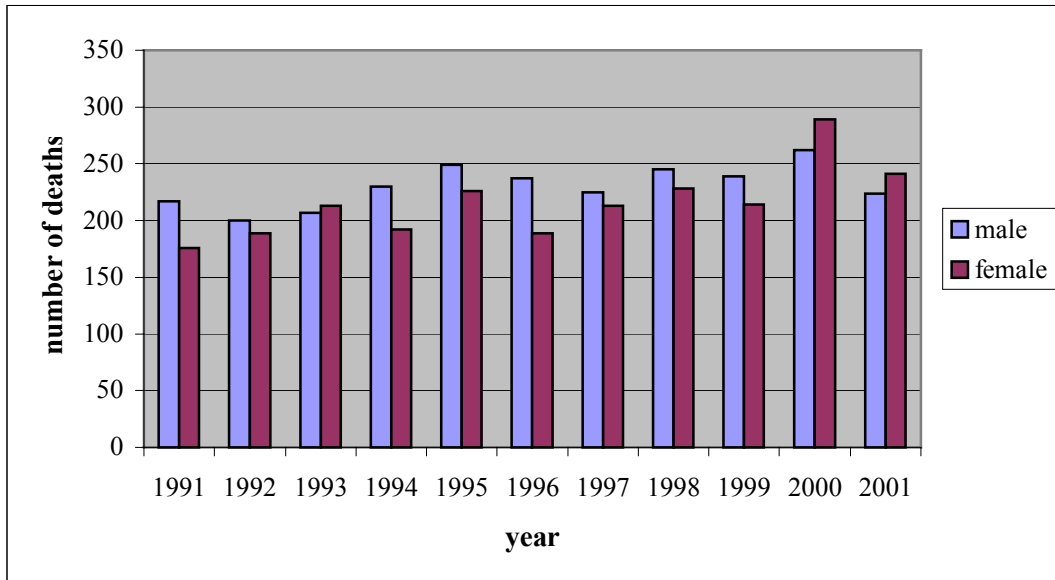


Figure 7: Cancer deaths by sex from January 1, 1991, to December 31, 2001.

black populations have fluctuated over the last eleven years, with more fluctuation occurring in the white population. Despite the small number of deaths in the other races

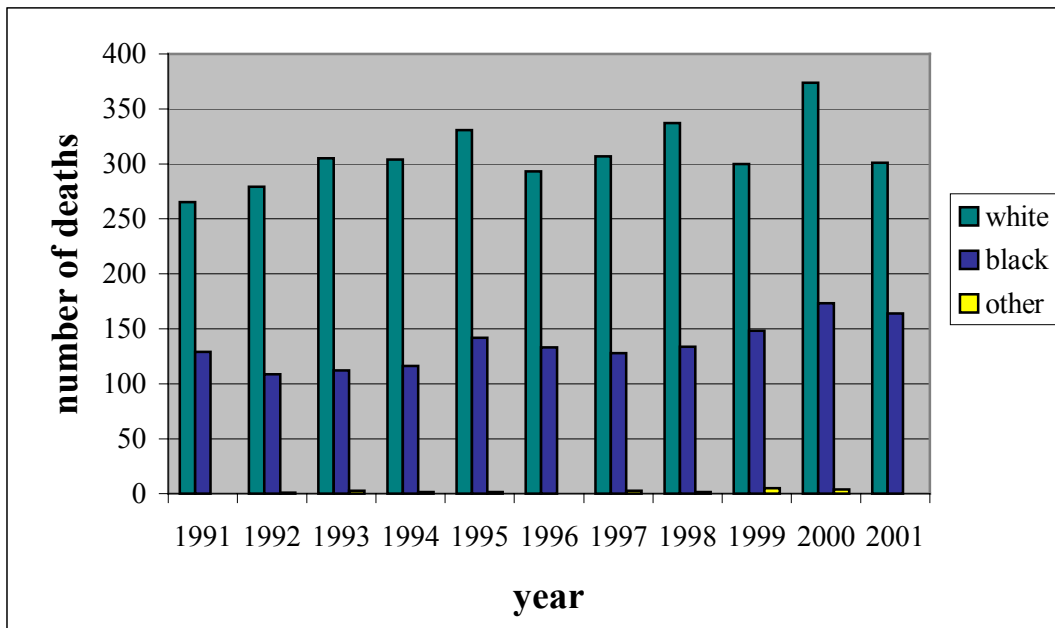


Figure 8: Cancer deaths by race from January 1, 1991, to December 31, 2001.

combined, 1999 and 2000 showed slight increases—1999 with five deaths and 2000 with four deaths.

The trend for more white deaths than black deaths did correspond to the population distribution pattern of more whites than blacks displayed in Table 1. In 1995, 1998, and 1999, the number of black deaths increased along with an increase in the black population, displayed in Table 7. In 1992 and 1993, the number of white deaths increased as the white population increased. In 1993 and 1997, the number of deaths in other races increased as the population of other races increased. However, the number of deaths in other races increased to its highest point in 1999, while the population of other races declined that year.

The overall cancer death rates remained fairly steady throughout the time period, shown in Table 7. The lowest overall death rate was 9.9 in 1992, while the highest rate was 11.9 in 1995 and 1998. For the majority of the period, white males had the highest death rates. Other females had the lowest death rates, except in 1997.

Table 7: Cancer Death Rates from 1991 to 1999.

| Year | Overall Rate | White Male | White Female | Black Male | Black Female | Other Male | Other Female |
|-------------|---------------------|-------------------|---------------------|-------------------|---------------------|-------------------|---------------------|
| <i>1991</i> | 10.2 | 11.3 | 10.4 | 13.1 | 6.3 | | |
| <i>1992</i> | 9.9 | 12.4 | 10.4 | 7.9 | 7.7 | | 3.2 |
| <i>1993</i> | 10.6 | 12.1 | 12.7 | 8.9 | 6.9 | | |
| <i>1994</i> | 10.7 | 13.7 | 11.2 | 9.7 | 6.7 | 7.9 | |
| <i>1995</i> | 11.9 | 14.3 | 12.9 | 11.5 | 8.3 | 5.1 | 2.9 |
| <i>1996</i> | 10.8 | 13.2 | 11.1 | 12.0 | 6.5 | 2.5 | |
| <i>1997</i> | 11.1 | 13.2 | 12.4 | 10.3 | 7.3 | | 8.4 |
| <i>1998</i> | 11.9 | 14.8 | 13.4 | 10.6 | 7.7 | 2.4 | 2.7 |
| <i>1999</i> | 11.5 | 12.4 | 12.7 | 13.3 | 7.1 | 9.6 | 2.7 |

The age group most affected by cancer is the 75 years and older group. The higher number of people over 75 dying from cancer was expected since cancer occurs more frequently as age increases. However, as shown in Table 8, the group aged 65-74

has a fairly high number of deaths due to cancer, as well. Death due to cancer increases with age beginning with the group aged 25-34. In the younger age groups, cancer deaths are the highest in the 1-4 group, and then deaths decrease in the 5-14 and 15-24 age groups. The age group 25-34 had a significantly higher number of deaths in 1992 than in the rest of the eleven-year period. Elevated numbers were also seen in the age groups 35-44 and 55-64 in 1992. However, the groups aged 65-74 and 75+ had their lowest numbers in 1992.

Table 8: Cancer Age Statistics from January 1, 1991, to December 31, 2001.

| Year | Age range | | | | | | | | | Total |
|--------------|-----------|----------|----------|-----------|------------|------------|------------|--------------|--------------|--------------|
| | 1--4 | 5--14 | 15--24 | 25--34 | 35--44 | 45--54 | 55--64 | 65--74 | 75+ | |
| 1991 | | 1 | | 3 | 20 | 34 | 69 | 124 | 142 | 393 |
| 1992 | 1 | 2 | 1 | 11 | 25 | 40 | 87 | 97 | 125 | 389 |
| 1993 | 3 | | 1 | 4 | 14 | 36 | 81 | 117 | 163 | 419 |
| 1994 | 1 | 1 | 1 | 4 | 10 | 39 | 76 | 120 | 170 | 422 |
| 1995 | | | 1 | 5 | 15 | 43 | 85 | 135 | 190 | 474 |
| 1996 | 1 | 1 | 1 | 4 | 17 | 45 | 59 | 126 | 172 | 426 |
| 1997 | 3 | 1 | | 3 | 20 | 47 | 86 | 104 | 174 | 438 |
| 1998 | | | | 3 | 20 | 50 | 81 | 128 | 191 | 473 |
| 1999 | 1 | | 1 | 3 | 11 | 46 | 83 | 120 | 187 | 452 |
| 2000 | 2 | 1 | | 3 | 14 | 58 | 86 | 126 | 259 | 549 |
| 2001 | | 2 | 1 | 3 | 14 | 49 | 70 | 114 | 212 | 465 |
| Total | 12 | 9 | 7 | 46 | 180 | 487 | 863 | 1,311 | 1,985 | 4,900 |

The cancer death rates for age are shown in Table 9. Clearly, the death rates for the group aged 75 and older were the highest, followed by the group aged 65-74.

Table 9: Cancer Death Rates for Age from 1991 to 1999.

| Year | Age range | | | | | | | | |
|------|-----------|-------|--------|--------|--------|--------|--------|--------|-------|
| | 1--4 | 5--14 | 15--24 | 25--34 | 35--44 | 45--54 | 55--64 | 65--74 | 75+ |
| 1991 | | 0.2 | | 0.5 | 3.3 | 9.3 | 25.1 | 56.7 | 103.5 |
| 1992 | 0.4 | 0.3 | 0.1 | 1.7 | 3.9 | 10.2 | 31.3 | 43.5 | 89.1 |
| 1993 | 1.2 | | 0.1 | 0.6 | 2.2 | 8.8 | 28.9 | 51.8 | 113.8 |
| 1994 | 0.4 | 0.2 | 0.1 | 0.6 | 1.5 | 9.2 | 26.9 | 53.0 | 117.2 |
| 1995 | | | 0.2 | 0.8 | 2.3 | 9.8 | 30.1 | 59.8 | 129.1 |
| 1996 | 0.4 | 0.2 | 0.1 | 0.7 | 2.6 | 9.8 | 20.6 | 56.3 | 115.2 |
| 1997 | 1.4 | 0.2 | | 0.5 | 3.0 | 9.9 | 29.5 | 47.1 | 114.9 |
| 1998 | | | | 0.5 | 3.1 | 10.4 | 27.2 | 54.9 | 115.5 |
| 1999 | 0.5 | | 0.1 | 0.6 | 1.7 | 9.3 | 27.3 | 51.8 | 112.9 |

Beginning with the 25-34 age group, the death rates increase with age. The 15-24 age group had the lowest death rates. The 1-4 age group had higher death rates than the groups aged 5-14 years and 15-24 years.

“Other”

The death category labeled “other” in the East Baton Rouge Coroner System had the second highest number of deaths of all coroner cases. However, this category combines any natural deaths besides cardiac, cancer, and AIDS. Even though the total number of deaths in the “other” category is higher than the total number of cancer deaths, it cannot be considered the second leading cause of death in East Baton Rouge Parish because it is comprised of a combination of several diseases (septicemia, Alzheimer’s, stroke, diabetes, etc.). Nevertheless, some of the causes of death included in the “other” category are considered leading causes of death in the United States and in Louisiana. As noted previously, limitations in the database used for gathering data prevented breakdown of the “other” category into the specific causes of death.

The total number of deaths in the other natural category equaled 4,900 (20.9% of all coroner cases), as noted previously. The total number of male deaths was 2,252 (45.1%), while the total number of female deaths was 2,736 (54.9%). Of these 4,900 deaths, 3,283 (65.8%) were white, 1,681 were black (33.7%), and 24 (0.5%) were from all other races combined.

The number of deaths for each year from 1991 to 2001 is displayed in Figure 9. The deaths fluctuated throughout the eleven-year period. Deaths in this category rose until 1995 (505 deaths), then the number dropped dramatically to 365 in 1996. In 1997, however, the number of deaths jumped back up to 482, followed by

another decline in 1998 to 351. A sharp increase to 544 deaths occurred in 2000, followed by another sharp increase to 729 in 2001. Only 318 deaths occurred in 1991, which was the least number of deaths during the entire eleven-year period.

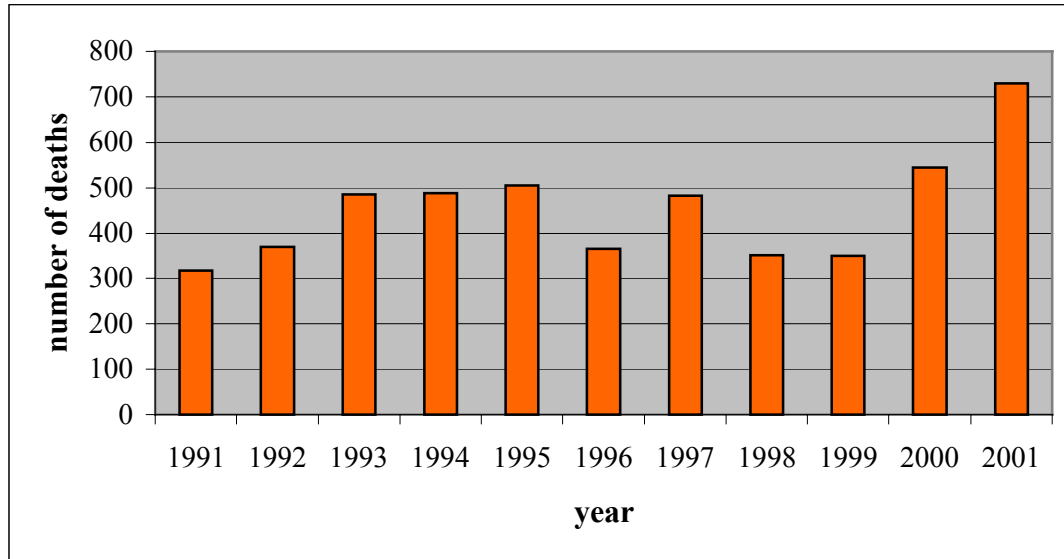


Figure 9: “Other” deaths from January 1, 1991, to December 31, 2001.

From 1991 to 1994, the pattern in “other” deaths followed the population distribution pattern. After 1994, the population began to decrease slightly every year, while deaths in the “other” category fluctuated.

In comparing the male and female populations, the female population experienced more deaths every year. The difference between the sexes is illustrated in Figure 10. In 1998, female deaths exceeded male deaths by only three. The only other year in which the number of male deaths came close to the number of female deaths was 1996. Female deaths were drastically higher than male deaths in 2000 and 2001. In 2000, the number of male deaths was 227, while the number of female deaths was 317. This large gap is a difference of 90 deaths. In 2001, the number of male deaths was 280, and the number of female deaths was 449, which is a difference of 169 deaths.

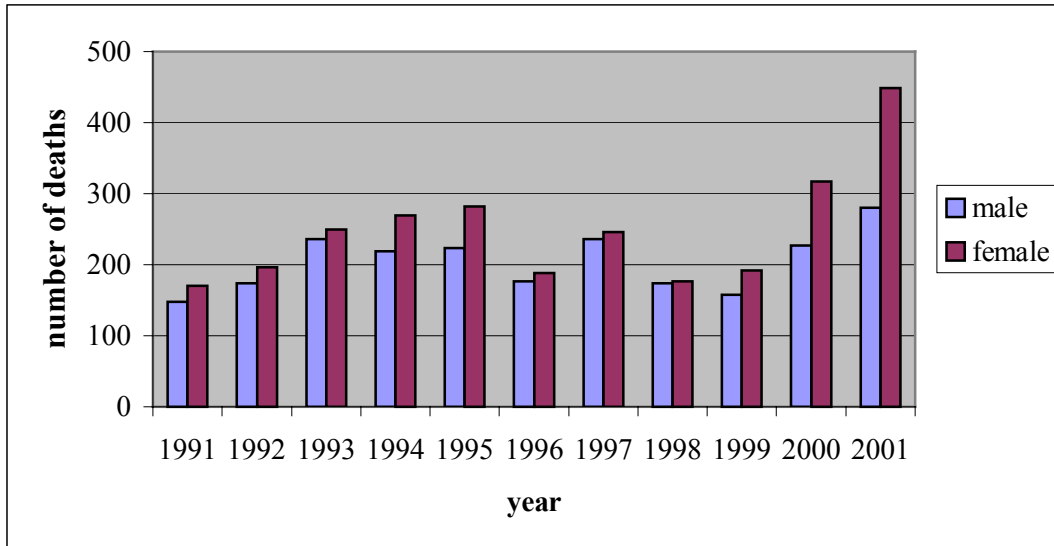


Figure 10: “Other” deaths by sex from January 1, 1991, to December 31, 2001.

This trend did follow the pattern of a larger number of females than males in the population distribution. From 1991 to 1993, the increase in deaths in both males and females corresponded to the increase in the population. In 1994 and 1995, the female deaths continued to rise and the female population continued to rise. However, male deaths decreased while the male population increased. The remainder of the time period did not follow the population pattern.

Deaths due to “other” natural causes in the white population surpass the black population and all other races combined every year of the eleven-year period. The differences among the races are illustrated in Figure 11. Deaths in the white population exceed deaths in the black population by more than 75 every year in the eleven-year period. Deaths in both blacks and whites rose from 1991 to 1994. In 1995, however, black deaths declined while white deaths continued to rise. Deaths in both blacks and whites declined considerably in 1996. Deaths in all races increased in 1997—other races combined were at their highest with eight deaths. After 1997, deaths in other races

combined did not rise above four. Despite another decrease in both blacks and whites in 1998 and 1999, the number of deaths sharply increased in 2000. In 2001, white deaths skyrocketed to 496, while black deaths only rose moderately to 229.

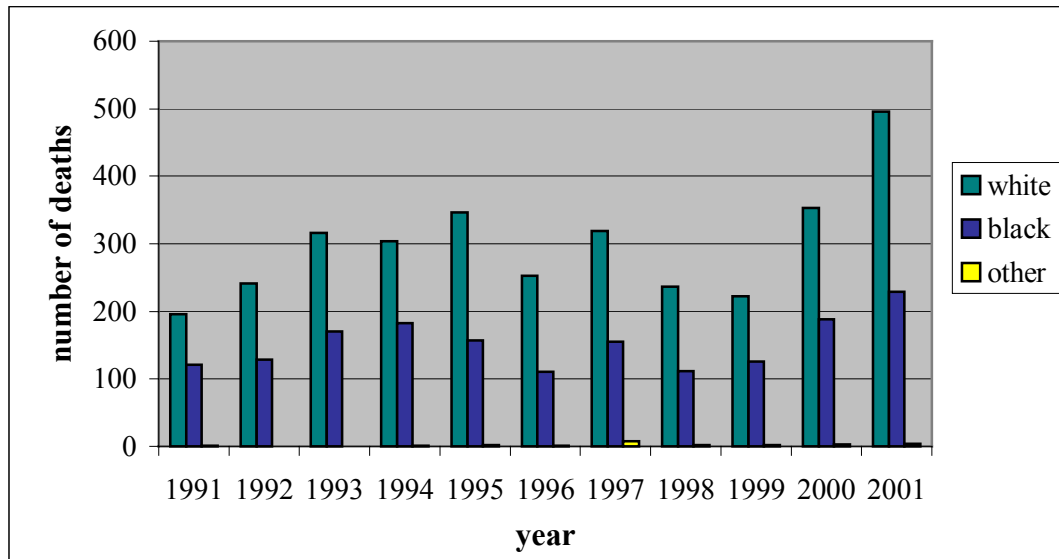


Figure 11: “Other” deaths by race from January 1, 1991, to December 31, 2001.

This trend for more white deaths than black deaths did follow the pattern for the population distribution. From 1991 to 1994 and 1998 to 1999, the white death trend followed the population distribution pattern. The black death trend also followed the population pattern from 1991 to 1994.

The overall “other” death rates fluctuated during the nine years recorded, as shown in Table 10. The highest death rate was 12.8 in 1995. The lowest death rate was 8.2 in 1991. White females consistently had the highest death rates throughout the period. Other males had the lowest death rates. However, the death rate of other males rose sharply to 14.5 in 1997.

Table 10: “Other” Death Rates from 1991 to 1999.

| Year | Overall Rate | White Male | White Female | Black Male | Black Female | Other Male | Other Female |
|------|--------------|------------|--------------|------------|--------------|------------|--------------|
| 1991 | 8.2 | 6.7 | 9.4 | 10.7 | 7.3 | 2.9 | |
| 1992 | 9.4 | 9.2 | 10.4 | 9.8 | 8.7 | | |
| 1993 | 12.3 | 12.8 | 12.9 | 12.7 | 11.4 | | |
| 1994 | 12.3 | 11.4 | 13.4 | 12.5 | 12.9 | | 3.0 |
| 1995 | 12.8 | 12.6 | 15.8 | 10.8 | 10.9 | 2.5 | 2.9 |
| 1996 | 9.2 | 9.8 | 11.1 | 8.9 | 6.4 | 2.4 | |
| 1997 | 12.2 | 12.8 | 13.8 | 11.8 | 9.5 | 14.5 | 5.6 |
| 1998 | 8.9 | 9.2 | 10.6 | 9.6 | 5.8 | 4.7 | |
| 1999 | 8.9 | 8.0 | 10.6 | 9.4 | 7.7 | 2.7 | 2.7 |

As illustrated in Table 11, the age statistics for “other” deaths followed the same pattern as heart disease and cancer—the age group 75 and older had the highest number of deaths. In fact, the number of deaths in the 75 and older age group was nearly 1,700 more than the number of deaths in the 65-74 age group. The age group 1-4 had more deaths than the 5-14 age group. Beginning with the 15-24 age group, the number of deaths increased as age increased. The number of deaths in the group aged 65-74 was almost twice the number in the group aged 55-64. In 1993, deaths in the groups aged 15-24, 25-34, and 35-44 were at their highest. In 1997, the age group 65-74 reached its highest with 104 deaths.

Table 11: “Other” Age Statistics from January 1, 1991, to December 31, 2000.

| Year | Age range | | | | | | | | | Total |
|--------------|-----------|-----------|-----------|------------|------------|------------|------------|------------|--------------|--------------|
| | 1--4 | 5--14 | 15--24 | 25--34 | 35--44 | 45--54 | 55--64 | 65--74 | 75+ | |
| 1991 | 1 | 4 | 5 | 10 | 32 | 17 | 46 | 68 | 135 | 318 |
| 1992 | 2 | | 3 | 13 | 31 | 27 | 48 | 67 | 179 | 370 |
| 1993 | 2 | 6 | 10 | 20 | 46 | 45 | 49 | 81 | 227 | 486 |
| 1994 | 8 | 3 | 7 | 10 | 44 | 41 | 54 | 91 | 230 | 488 |
| 1995 | 7 | 3 | 6 | 16 | 37 | 40 | 46 | 95 | 255 | 505 |
| 1996 | 1 | 1 | 5 | 9 | 33 | 37 | 30 | 74 | 175 | 365 |
| 1997 | 2 | | 6 | 9 | 37 | 53 | 46 | 104 | 225 | 482 |
| 1998 | 8 | 4 | 6 | 10 | 23 | 39 | 26 | 59 | 176 | 351 |
| 1999 | 9 | | 5 | 12 | 23 | 38 | 28 | 58 | 177 | 350 |
| 2000 | 1 | 2 | 6 | 10 | 32 | 38 | 52 | 81 | 322 | 544 |
| 2001 | 2 | 7 | 6 | 12 | 31 | 53 | 57 | 96 | 465 | 729 |
| Total | 43 | 30 | 65 | 131 | 369 | 428 | 482 | 874 | 2,566 | 4,988 |

Beginning with the 5-14 age group, the age death rates increased with age (Table 12). However, the increases were minor up to the 45-54 age group. Of all the age groups, the 1-4 age group displayed the most fluctuation, with a range of 0.4 to 4.1. The group aged 75 and older had the highest death rates, followed by the 65-74 age group. The group aged 5-14 years had the lowest death rates.

Table 12: “Other” Death Rates for Age from 1991 to 1999.

| Year | Age range | | | | | | | | |
|------|-----------|-------|--------|--------|--------|--------|--------|--------|-------|
| | 1--4 | 5--14 | 15--24 | 25--34 | 35--44 | 45--54 | 55--64 | 65--74 | 75+ |
| 1991 | 0.4 | 0.7 | 0.7 | 1.5 | 5.2 | 4.6 | 16.7 | 31.1 | 98.4 |
| 1992 | 0.8 | | 0.4 | 2.0 | 4.9 | 6.9 | 17.3 | 30.1 | 127.5 |
| 1993 | 0.8 | 1.0 | 1.4 | 3.1 | 7.2 | 10.9 | 17.5 | 35.9 | 158.4 |
| 1994 | 3.3 | 0.5 | 0.9 | 1.6 | 6.8 | 9.6 | 19.1 | 40.2 | 158.5 |
| 1995 | 2.9 | 0.5 | 0.8 | 2.7 | 5.7 | 9.1 | 16.3 | 42.1 | 173.3 |
| 1996 | 0.4 | 0.2 | 0.7 | 1.5 | 5.0 | 8.1 | 10.5 | 33.1 | 117.2 |
| 1997 | 0.9 | | 0.8 | 1.6 | 5.6 | 11.2 | 15.8 | 47.1 | 148.5 |
| 1998 | 3.6 | 0.7 | 0.8 | 1.8 | 3.5 | 8.1 | 8.7 | 25.3 | 106.5 |
| 1999 | 4.1 | | 0.7 | 2.2 | 3.6 | 7.7 | 9.2 | 25.0 | 106.9 |

Accidental

Accidents were the fourth leading cause of death in East Baton Rouge Parish, claiming 1,117 (4.7%) lives over the last eleven years. Of these 1,117 deaths, 785 were male and 332 were female. The male deaths accounted for 70.3 percent of all accidental deaths, and the female deaths only accounted for 29.7 percent. The white population was affected the most by accidents with 661 deaths, accounting for 59.2 percent of all accidental deaths. The black population followed with 452 deaths, which accounted for 40.4 percent of accidental deaths. Only four deaths occurred in all other races combined, which accounts for 0.4 percent of accidental deaths.

The accidental deaths over the last eleven years are broken down by year in Figure 12. The beginning years and the ending years of the chosen period have the highest number of deaths. The lowest number of deaths was 80 and occurred in 1996.

In 2001, there were 125 accidental deaths, which was the highest amount of all the years studied. The number of deaths decreases from 1993 to 1996, after which they begin to increase again.

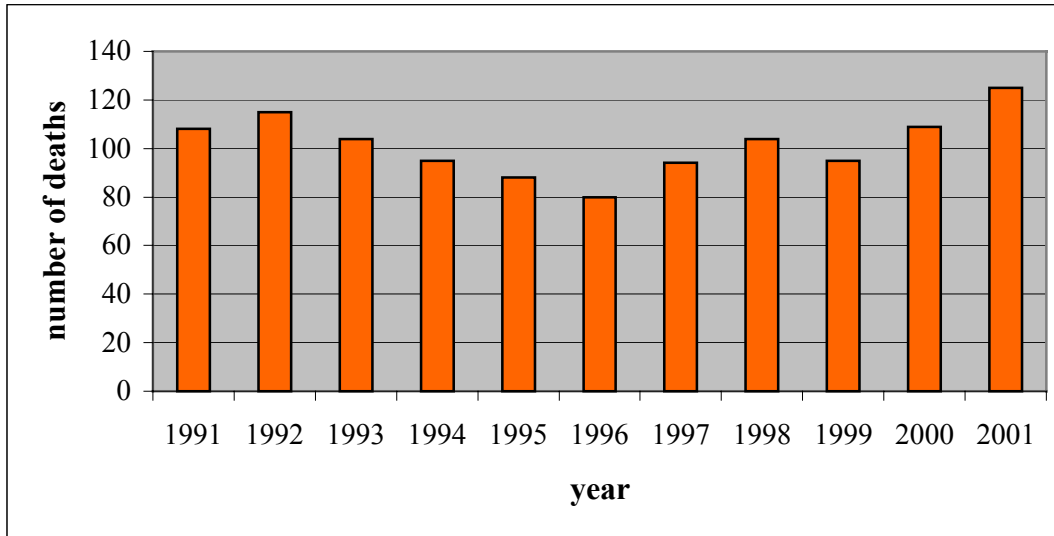


Figure 12: Accidental deaths from January 1, 1991, to December 31, 2001.

The overall trend in accidental deaths partially followed the pattern for the population distribution. While the population increased through 1994, the number of deaths began to decline in 1993. Both the population and the number of deaths decreased in 1995 and 1996; however, deaths increased in 1997 and the population continued to decrease. The death trend for 1998 and 1999 corresponded to the population pattern.

Males are more affected by accidents than females. The comparison of male deaths to female deaths is shown in Figure 13. Male deaths exceed female deaths by more than 25 every year of the eleven-year period. In 1993, female deaths declined to 21, while male deaths reached their peak of 83 deaths. Female deaths peaked at 49 in the year 2001. In 1996, female deaths reached their lowest with only 18 deaths due to accidents. Male deaths were at their lowest in 1995 and 1996 with 62 deaths in each

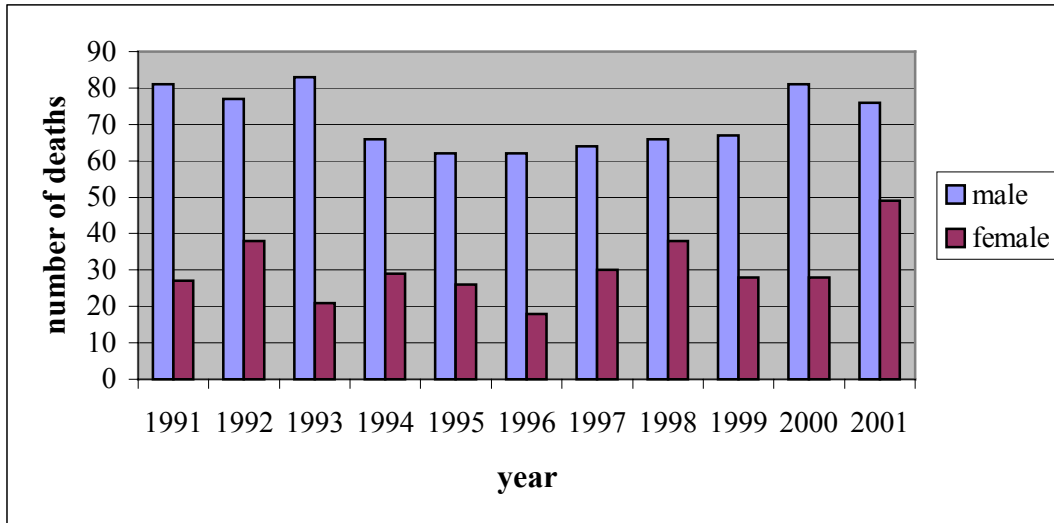


Figure 13: Accidental deaths by sex from January 1, 1991, to December 31, 2001.

year. Male deaths remain steady from 1994 to 1999, while female deaths fluctuated more.

This trend did not follow the population distribution pattern of a larger female population. From 1997 to 1999, the female death trend followed the population trend. The male death trend did not follow the population trend throughout the period.

From 1991 to 1996, more whites died as a result of accidents than any other race. However, in 1997, the number of blacks that died from accidents was almost equivalent to the number of whites that died from accidents (Figure 14). The highest number of black deaths was 58 and occurred in 2001. The lowest number of black deaths was 30 and occurred in 1996. The highest number of white deaths was 73 and occurred in 1991, while the lowest number of white deaths was 47 in 1997. Only four deaths occurred in all other races combined for the entire eleven-year period—one death in 1991, 1997, 1998, and 2001. Deaths from accidents appear to be leveling off in the white population and increasing in the black population.

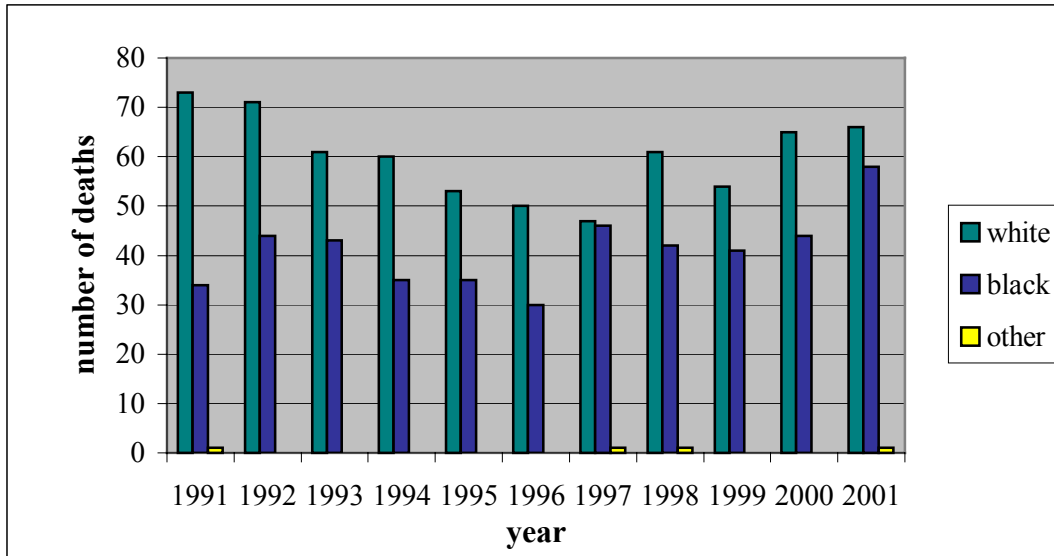


Figure 14: Accidental deaths by race from January 1, 1991, to December 31, 2001.

The trend for more white deaths corresponded to the population distribution pattern of a larger white population displayed in Table 1. The white death pattern followed the population distribution from 1993 to 1997. The black death pattern did not follow the population pattern.

The overall death rates remained steady throughout the period and ranged from 2.0 to 2.9, as shown in Table 13. Black males had the highest death rates for the entire period. For the majority of the period, black females had the lowest death rates.

Table 13: Accidental Death Rates from 1991 to 1999.

| Year | Overall Rate | White Male | White Female | Black Male | Black Female | Other Male | Other Female |
|------|--------------|------------|--------------|------------|--------------|------------|--------------|
| 1991 | 2.8 | 4.5 | 1.8 | 4.9 | 0.7 | 2.9 | |
| 1992 | 2.9 | 4.0 | 1.9 | 4.6 | 2.0 | | |
| 1993 | 2.6 | 4.1 | 0.9 | 5.3 | 1.2 | | |
| 1994 | 2.4 | 3.5 | 1.6 | 4.0 | 1.2 | | |
| 1995 | 2.2 | 2.9 | 1.4 | 4.3 | 1.2 | | |
| 1996 | 2.0 | 3.2 | 1.0 | 3.7 | 0.6 | | |
| 1997 | 2.4 | 2.4 | 1.6 | 5.5 | 1.1 | | 2.8 |
| 1998 | 2.6 | 2.9 | 2.2 | 4.7 | 1.4 | | 2.7 |
| 1999 | 2.4 | 3.3 | 1.3 | 4.4 | 1.5 | | |

Despite the low number of accidental deaths in other races, their death rates were fairly high.

The age statistics for accidental deaths are highest in the 15-24 age group. As seen in Table 14, the group aged 15-24 had 253 deaths over the last eleven years. The group aged 25-34 followed with 200 deaths over the last eleven years. The younger age groups, 1-4 and 5-14, have the fewest number of deaths due to accidents. In addition, the 55-64 and 65-74 age groups have fairly low death totals. The number of deaths increases again in the 75 and older age group. Clearly, young to middle-aged adults and the elderly are affected the most by accidents.

Table 14: Accidental Age Statistics from January 1, 1991, to December 31, 2001.

| Year | Age range | | | | | | | | | Total |
|--------------|-----------|-----------|------------|------------|------------|------------|-----------|-----------|------------|--------------|
| | 1--4 | 5--14 | 15--24 | 25--34 | 35--44 | 45--54 | 55--64 | 65--74 | 75+ | |
| 1991 | 1 | 7 | 23 | 19 | 15 | 7 | 9 | 9 | 18 | 108 |
| 1992 | 5 | 8 | 25 | 28 | 15 | 10 | 5 | 10 | 9 | 115 |
| 1993 | 4 | 6 | 28 | 24 | 18 | 6 | 4 | 4 | 10 | 104 |
| 1994 | 1 | 11 | 26 | 17 | 9 | 13 | 5 | 3 | 10 | 95 |
| 1995 | 5 | 5 | 15 | 16 | 15 | 8 | 6 | 6 | 12 | 88 |
| 1996 | 5 | 2 | 21 | 12 | 9 | 7 | 6 | 7 | 11 | 80 |
| 1997 | 2 | 10 | 18 | 12 | 13 | 15 | 5 | 10 | 9 | 94 |
| 1998 | 1 | 3 | 21 | 20 | 13 | 11 | 9 | 9 | 17 | 104 |
| 1999 | 3 | 5 | 20 | 18 | 20 | 9 | 5 | 6 | 9 | 95 |
| 2000 | 3 | 3 | 30 | 17 | 23 | 15 | 5 | 4 | 9 | 109 |
| 2001 | 3 | 5 | 26 | 17 | 24 | 12 | 8 | 14 | 16 | 125 |
| Total | 33 | 65 | 253 | 200 | 174 | 113 | 67 | 82 | 130 | 1,117 |

The death rates for age remained fairly stable throughout the nine years recorded. The group aged 75 years and older had the highest death rates, followed by the group aged 65-74 years (Table 15). The group aged 15-24 years had the third highest death rates. In addition, the group aged 25-34 years had high death rates. The group aged 5-14 years had the lowest death rates, followed by the 1-4 age group.

Table 15: Accidental Death Rates for Age from 1991 to 1999.

| Year | Age range | | | | | | | | |
|------|-----------|-------|--------|--------|--------|--------|--------|--------|------|
| | 1--4 | 5--14 | 15--24 | 25--34 | 35--44 | 45--54 | 55--64 | 65--74 | 75+ |
| 1991 | 0.4 | 1.2 | 3.3 | 2.9 | 2.4 | 1.9 | 3.3 | 4.1 | 13.1 |
| 1992 | 2.1 | 1.3 | 3.5 | 4.3 | 2.4 | 2.6 | 1.8 | 4.5 | 6.4 |
| 1993 | 1.7 | 1.0 | 3.9 | 3.8 | 2.8 | 1.5 | 1.4 | 1.8 | 6.9 |
| 1994 | 0.4 | 1.9 | 3.6 | 2.7 | 1.4 | 3.1 | 1.8 | 1.3 | 6.9 |
| 1995 | 2.1 | 0.9 | 2.1 | 2.7 | 2.3 | 1.8 | 2.1 | 2.7 | 8.2 |
| 1996 | 2.2 | 0.3 | 2.9 | 2.0 | 1.4 | 1.5 | 2.1 | 3.1 | 7.4 |
| 1997 | 0.9 | 1.8 | 2.5 | 2.1 | 1.9 | 3.2 | 1.7 | 4.5 | 5.9 |
| 1998 | 0.5 | 0.5 | 2.9 | 3.6 | 1.9 | 2.3 | 3.0 | 3.9 | 10.3 |
| 1999 | 1.4 | 0.9 | 2.7 | 3.4 | 3.1 | 1.8 | 1.6 | 2.6 | 5.4 |

The different types of accidents that killed people in East Baton Rouge Parish are listed in Table 16. The leading type of accidental death was motor vehicle accidents (MVA). MVA's claimed 696 lives over the last eleven years. White males had the highest number of deaths due to MVA's. Accidental fall was the second leading type of accidental death, claiming 77 lives. Again, white males died from falls more frequently. Deaths from fires and/or burns were the third highest cause of accidental deaths with 73. Black males had the highest number of deaths due to fires and/or burns.

Table 16: Accidental Cause of Death from January 1, 1991, to December 31, 2001.

| Cause of death | Sex and race of deceased | | | | | | Total |
|-----------------------------|--------------------------|--------------|------------|--------------|------------|--------------|--------------|
| | white male | white female | black male | black female | other male | other female | |
| MVA | 291 | 123 | 197 | 83 | 1 | 1 | 696 |
| gun | 15 | | 5 | 4 | | | 24 |
| fire/burns | 19 | 15 | 26 | 13 | | | 73 |
| industrial/machinery | 26 | | 16 | | | 1 | 43 |
| fall | 32 | 27 | 16 | 2 | | | 77 |
| drowning | 14 | 9 | 30 | 6 | | | 59 |
| fight | 2 | 1 | | | | | 3 |
| alcohol/drug overdose | 15 | 13 | 11 | 1 | | | 40 |
| electrocution | 9 | | 9 | 1 | | | 19 |
| crushing | 3 | | 2 | | | | 5 |
| choking/strangulation | 7 | 6 | 10 | 1 | | | 24 |
| recreational vehicle | 4 | 2 | 2 | | | | 8 |
| poisoning/allergic reaction | 1 | 1 | 1 | 2 | | | 5 |
| jump | | 1 | | 1 | | | 2 |
| other | 14 | 9 | 8 | 7 | 1 | | 39 |
| Total | 452 | 207 | 333 | 121 | 2 | 2 | 1,117 |

AIDS

AIDS claimed 942 lives in East Baton Rouge Parish from 1991 to 2001, which accounts for 3.9 percent of all coroner cases. Of these 942 deaths, 736 were male (78.1%) and 206 were female (21.9%). The total number of whites killed by AIDS was 260, accounting for 27.6 percent of all AIDS deaths. The total number of blacks was 680, which accounted for 72.2 percent of all AIDS deaths. Only two people from all other races combined died from AIDS, which comprises 0.2 percent of all AIDS deaths.

The number of AIDS deaths for each year of the chosen eleven-year period is displayed in Figure 15. In 1991, AIDS deaths were at their lowest with 53 deaths. AIDS deaths quickly escalated during the early 1990s until they peaked at 131 in 1995. After 1995, the number of deaths due to AIDS began to decline. They continued to decline until 2000. However, in 2001, the number of deaths due to AIDS increased to 94.

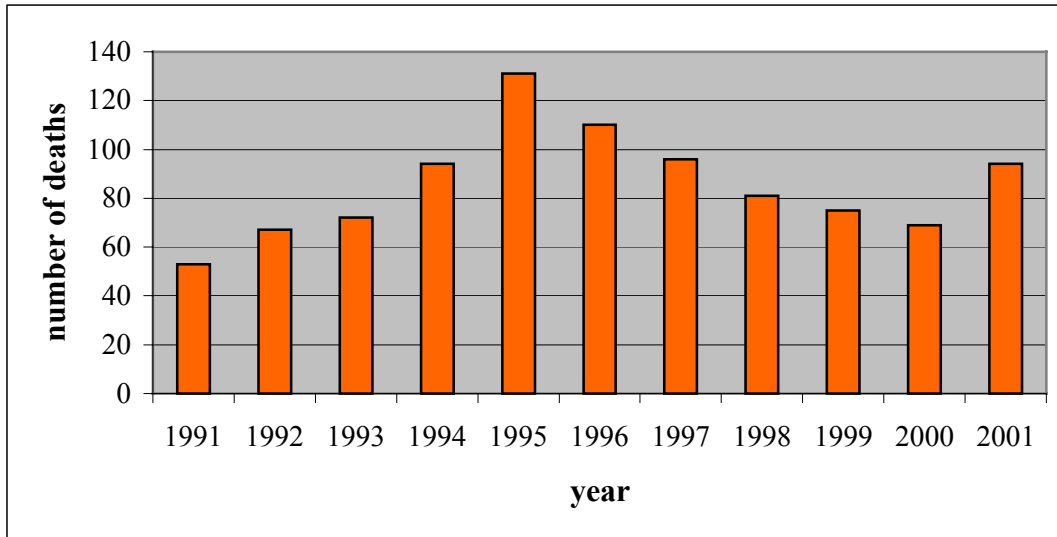


Figure 15: AIDS deaths from January 1, 1991, to December 31, 2001.

Basically, the trend for AIDS deaths followed the population distribution pattern from 1991 to 1994. As the population began to decline in 1995, AIDS deaths reached

their highest point. The decline in AIDS deaths in 1996 and 1997 corresponded to the decrease in the population for those years. However, the population increased in 1998, while AIDS deaths continued to decline.

For the majority of the eleven-year period, more males died from AIDS than females, as illustrated in Figure 16. However, in 2001, the number of females that died from AIDS surpassed the number of males that died from AIDS. The lowest number of female deaths was four and occurred in 1993. The lowest number of male deaths was 40 and occurred in 2001. Male deaths peaked at 108 in 1995. Male deaths from AIDS are declining while female deaths from AIDS are rising.

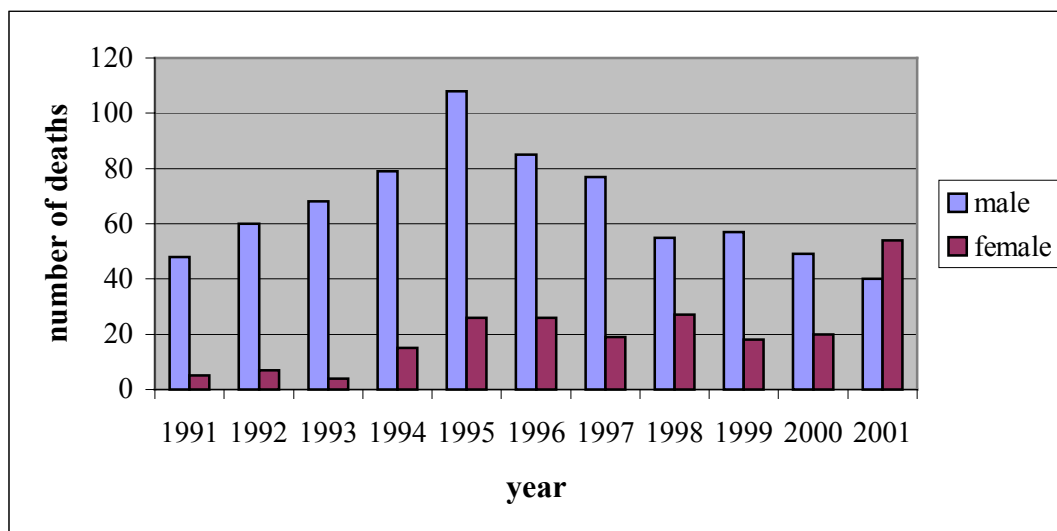


Figure 16: AIDS deaths by sex from January 1, 1991, to December 31, 2001.

This death trend of more male deaths did not follow the population distribution pattern of more females than males. The AIDS death trend did not appear to have an association with the population distribution pattern.

AIDS deaths in the white population exceeded that of the black population in 1991 and 1992. After 1992, more deaths occurred in the black population than in the

white population for the remainder of the chosen period (Figure 17). White deaths peaked at 44 in the year 1994. White deaths declined after 1994 until they reached their lowest of seven in 2000. In 1995, AIDS deaths in the black population skyrocketed to 93. After this peak, AIDS deaths in the black population declined until the year 2000. However, black deaths due to AIDS increased again to 83 in 2001. Only two deaths occurred in all other races combined—one in 1998 and one in 2000.

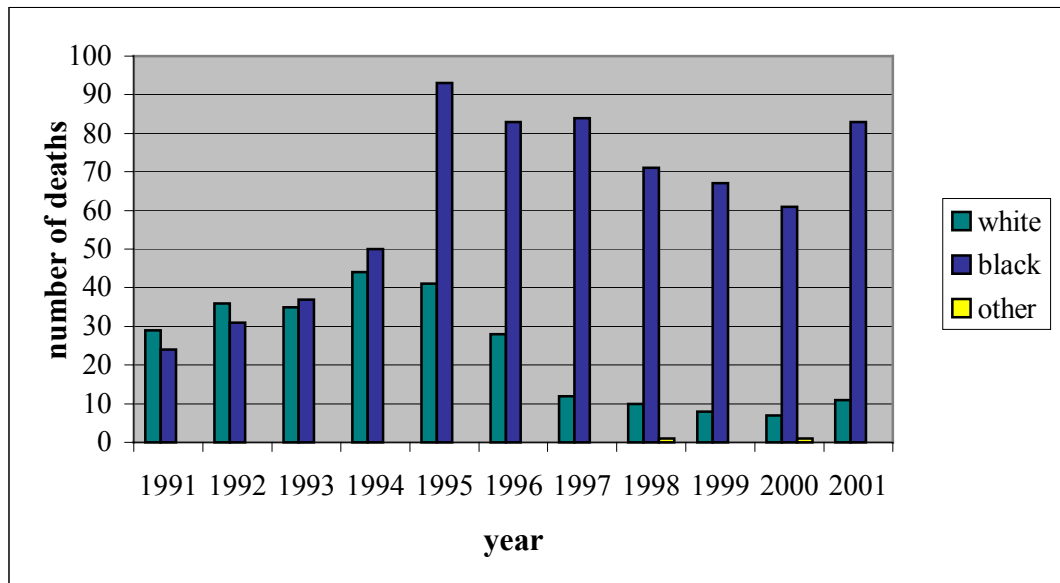


Figure 17: AIDS deaths by race from January 1, 1991, to December 31, 2001.

This trend partially followed the population distribution trend. In 1991 and 1992, the higher number of white deaths followed the population trend of more whites. In addition, the decrease in white deaths from 1995 to 1997 corresponded to the decrease in the white population during those years. The black death trend only followed the population distribution pattern from 1991 to 1994.

The overall death rate for AIDS did not exceed 3.3, which occurred in 1995. In 1991, the death rate was 1.4, which was the lowest it reached. The death rate for white

males peaked in 1994 and decreased every year thereafter (Table 17). The death rate for black males steadily increased until it peaked at 10.2 in 1995, and then fluctuated. The black death rate exceeded the white death rate for both sexes throughout the period. The death rate for black females peaked at 2.9 in 1998.

Table 17: AIDS Death Rates from 1991 to 1999.

| Year | Overall Rate | White Male | White Female | Black Male | Black Female | Other Male | Other Female |
|------|--------------|------------|--------------|------------|--------------|------------|--------------|
| 1991 | 1.4 | 2.3 | 0.2 | 3.3 | 0.4 | | |
| 1992 | 1.7 | 2.9 | 0.1 | 3.8 | 0.8 | | |
| 1993 | 1.8 | 2.9 | 0.1 | 5.1 | 0.4 | | |
| 1994 | 2.4 | 3.4 | 0.3 | 5.8 | 1.4 | | |
| 1995 | 3.3 | 3.0 | 0.3 | 10.2 | 2.8 | | |
| 1996 | 2.8 | 2.0 | 0.3 | 8.8 | 2.8 | | |
| 1997 | 2.4 | 1.0 | 1.6 | 9.5 | 2.4 | | |
| 1998 | 2.1 | 0.6 | 0.2 | 6.9 | 2.9 | 2.4 | |
| 1999 | 1.9 | 0.4 | 0.2 | 7.5 | 1.9 | | |

AIDS affects young adults and middle-aged adults the most. Table 18 shows that AIDS deaths are highest among those aged 35-44. Deaths in the age group 35-44 steadily increased to 56 deaths in 1995 and then began to decline until 2000. However, deaths in this group rose again in 2001. The group aged 25-34 had 256 deaths, which is the second

Table 18: AIDS Age Statistics from January 1, 1991, to December 31, 2001.

| Year | Age range | | | | | | | | | Total |
|--------------|-----------|----------|-----------|------------|------------|------------|-----------|-----------|----------|------------|
| | 1--4 | 5--14 | 15--24 | 25--34 | 35--44 | 45--54 | 55--64 | 65--74 | 75+ | |
| 1991 | | | 6 | 17 | 21 | 6 | 2 | 1 | | 53 |
| 1992 | | | 2 | 29 | 25 | 5 | 4 | 2 | | 67 |
| 1993 | | | 2 | 22 | 33 | 11 | 3 | 1 | | 72 |
| 1994 | 1 | | 3 | 35 | 37 | 11 | 4 | 3 | | 94 |
| 1995 | 1 | 1 | 5 | 37 | 56 | 22 | 4 | 2 | 3 | 134 |
| 1996 | | | | 34 | 50 | 17 | 4 | 3 | 2 | 111 |
| 1997 | 2 | | 4 | 18 | 37 | 28 | 3 | 2 | 2 | 96 |
| 1998 | 1 | | 3 | 21 | 27 | 22 | 4 | 2 | 1 | 82 |
| 1999 | | | 1 | 18 | 26 | 24 | 2 | 3 | 1 | 75 |
| 2000 | | | 2 | 11 | 25 | 23 | 7 | 1 | | 69 |
| 2001 | | | 2 | 14 | 42 | 31 | 3 | 2 | | 94 |
| Total | 5 | 1 | 30 | 256 | 379 | 200 | 40 | 22 | 9 | 942 |

highest number of AIDS deaths. This age group, along with the remaining age groups fluctuated throughout the eleven-year period. Only one death occurred in the 5-14 age group in 1995. Behind the 5-14 age group, the groups aged 1-4 and 75 and older had the lowest number of deaths due to AIDS.

For the majority of the time period, the group aged 35-44 years had the highest death rate, followed by the 25-34 age group. Both groups peaked in 1995, as shown in Table 19. Besides the 1999 rate for the 15-24 age group, the group aged 5-14 years had the lowest death rates.

Table 19: AIDS Death Rates for Age from 1991 to 1999.

| Year | Age range | | | | | | | | |
|------|-----------|-------|--------|--------|--------|--------|--------|--------|-----|
| | 1--4 | 5--14 | 15--24 | 25--34 | 35--44 | 45--54 | 55--64 | 65--74 | 75+ |
| 1991 | | | 0.9 | 2.6 | 3.4 | 1.6 | 0.7 | 0.5 | |
| 1992 | | | 0.3 | 4.5 | 3.9 | 1.3 | 1.4 | 0.9 | |
| 1993 | | | 0.3 | 3.5 | 5.1 | 2.7 | 1.1 | 0.4 | |
| 1994 | 0.4 | | 0.4 | 5.7 | 5.7 | 2.6 | 1.4 | 1.3 | |
| 1995 | 0.4 | 0.2 | 0.7 | 6.1 | 8.6 | 4.9 | 1.4 | 0.9 | 2.0 |
| 1996 | | | | 5.7 | 7.6 | 3.7 | 1.4 | 1.3 | 1.3 |
| 1997 | 0.9 | | 0.5 | 3.1 | 5.6 | 5.9 | 1.0 | 0.9 | 1.3 |
| 1998 | 0.5 | | 0.4 | 3.8 | 4.1 | 4.6 | 1.3 | 0.9 | 0.6 |
| 1999 | | | 0.1 | 3.4 | 4.1 | 4.9 | 0.7 | 1.3 | 0.6 |

Homicide

From 1991 to 2001, homicide claimed the lives of 878 people in East Baton Rouge Parish. These 878 deaths represent 3.7 percent of all the deaths considered coroner cases over the last eleven years. Of these deaths, 702 were male and 176 were female. The male deaths account for 79.9 percent of all homicides, while the female deaths account for 20.1 percent. The black population had 727 deaths, which accounted for 82.8 percent of all homicides. The white population had 148 deaths, which

represented 16.9 percent of all homicides. All other races combined had only three deaths accounting for 0.3 percent of all homicides that were considered coroner cases.

Homicides have fluctuated over the last eleven years, as shown in Figure 18. They increased from 1991 to 1993 where they were at their highest with 99 deaths. After 1993, homicides began to decline. However, in 1996, the number of deaths due to homicides increased again to 95. After 1996, homicides declined steadily for the rest of the chosen time period. In fact, with 62 deaths, the year 2001 had the lowest number of deaths due to homicide for the entire eleven-year period.

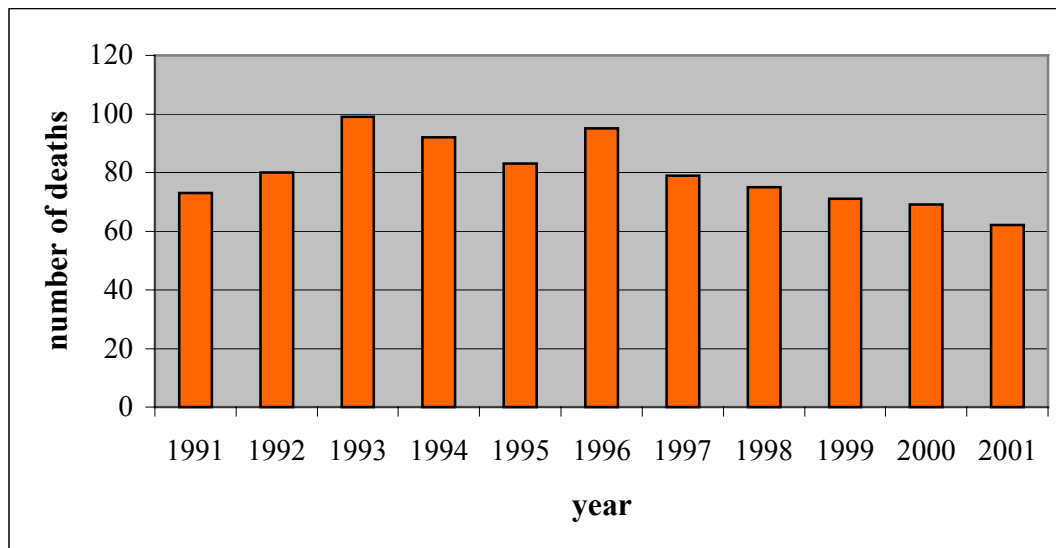


Figure 18: Homicide deaths from January 1, 1991, to December 31, 2001.

From 1991 to 1993, the homicide pattern followed the population distribution pattern as shown in Table 1. In 1995 and 1997, both deaths due to homicide and the population decreased. The remainder of the time period did not follow the population pattern.

From 1991 to 2001, males had more deaths due to homicide than females (Figure 19). Male deaths peaked at 82 in 1994, and female deaths peaked at 23 in 2000. The

lowest number of male deaths was 48 in 2000. The lowest number of female deaths was eight in 2001. Male deaths exceeded female deaths by 25 or more each year of the chosen eleven-year period. Deaths in both male and female populations fluctuated over the last eleven years, showing no consistent pattern. The year 2000 showed remarkable numbers—female deaths at their highest and male deaths at their lowest.

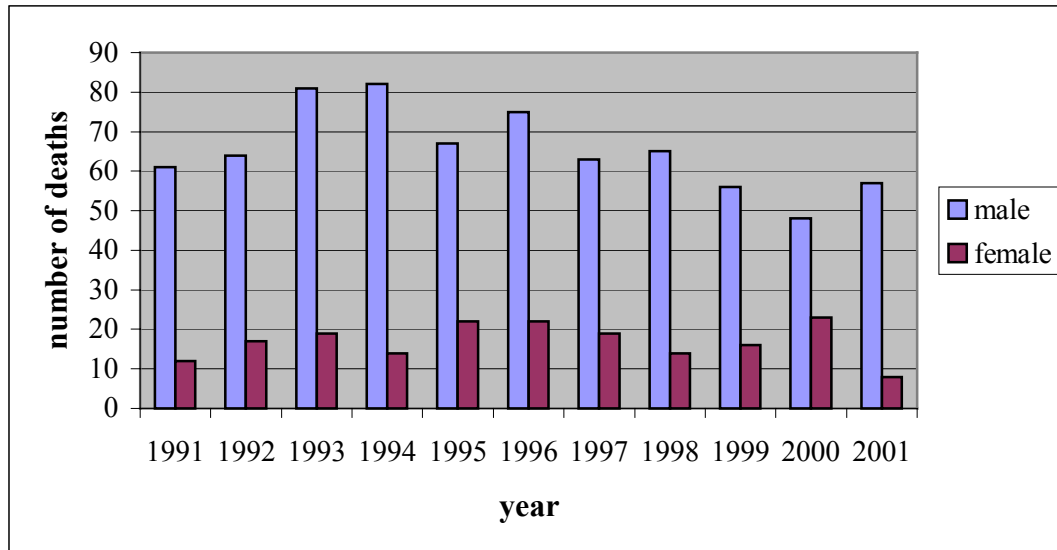


Figure 19: Homicide deaths by sex from January 1, 1991, to December 31, 2001.

From 1991 to 1993, both male and female deaths increased as did the population. For the remainder of the time period, the death trend did not conform to the population distribution pattern displayed in Table 1.

Homicide in the black population was consistently higher than homicide in the white population from 1991 to 2001, as illustrated in Figure 20. At 26, white deaths were their highest in 1993. In 1991, only five whites were victims of homicide. Black deaths due to homicide peaked at 81 in 1996. In 2001, homicide deaths in the black population were at their lowest with 55 deaths. Since 1997, homicide in both blacks and whites

generally has been declining. Only three deaths due to homicide occurred in all other races combined, one each in 1992, 1999, and 2000.

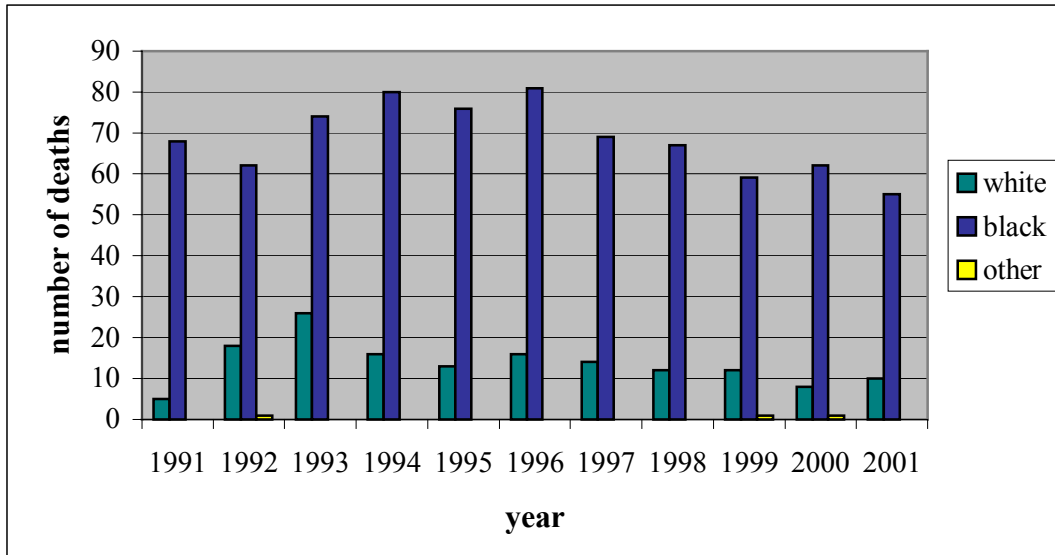


Figure 20: Homicide deaths by race from January 1, 1991, to December 31, 2001.

From 1992 to 1994, the increase in black deaths corresponded to the increase in the black population. From 1991 to 1995, the white death trend followed the population distribution pattern. This death trend did not follow the pattern for the population distribution for the remainder of the time period.

As illustrated in Table 20, the overall death rate for homicide fluctuated throughout the entire period. In 1993, the death rate was 2.5, which was its highest point. The lowest death rate was 1.8 in 1999. Black males consistently had the highest death rate, which peaked at 10.1 in 1994. White females had the lowest death rates. Even though only two deaths occurred in other races, the rates for those deaths were high

Young adults are affected the most by homicide (Table 21). The group aged 15-24 had the highest number of homicide victims with 307 deaths, followed by the group aged 25-34 with 271 deaths. The group aged 75 and older had the lowest number of

homicides with only three deaths. Overall, homicides increased with age until they peaked in the 15-24 age group and subsequently decreased with age for the remainder of the age groups. The 25-34 age group peaked at 37 deaths in 1993. With 36 deaths each, the years 1993 and 1994 had the highest number of deaths for the 15-24 age group. The 35-44 age group peaked at 19 in 1996.

Table 20: Homicide Death Rates from 1991 to 1999.

| Year | Overall Rate | White Male | White Female | Black Male | Black Female | Other Male | Other Female |
|------|--------------|------------|--------------|------------|--------------|------------|--------------|
| 1991 | 1.9 | 0.2 | 0.2 | 9.3 | 1.2 | | |
| 1992 | 2.0 | 0.9 | 0.5 | 7.9 | 1.3 | 2.8 | |
| 1993 | 2.5 | 1.4 | 0.6 | 9.5 | 1.5 | | |
| 1994 | 2.3 | 1.2 | 0.2 | 10.1 | 1.4 | | |
| 1995 | 2.1 | 0.6 | 0.5 | 8.2 | 1.8 | | |
| 1996 | 2.4 | 0.9 | 0.5 | 9.4 | 1.9 | | |
| 1997 | 2.0 | 1.0 | 0.2 | 6.9 | 2.2 | | |
| 1998 | 1.9 | 0.6 | 0.4 | 8.5 | 0.8 | | 2.7 |
| 1999 | 1.8 | 0.8 | 0.2 | 6.8 | 1.4 | | |

Table 21: Homicide Age Statistics from January 1, 1991, to December 31, 2001.

| Year | Age range | | | | | | | | | Total |
|--------------|-----------|-----------|------------|------------|------------|-----------|-----------|-----------|----------|------------|
| | 1--4 | 5--14 | 15--24 | 25--34 | 35--44 | 45--54 | 55--64 | 65--74 | 75+ | |
| 1991 | | 1 | 32 | 24 | 9 | | 4 | 3 | | 73 |
| 1992 | 1 | | 29 | 27 | 15 | 5 | 3 | | | 80 |
| 1993 | | 2 | 36 | 37 | 17 | 3 | 1 | 3 | | 99 |
| 1994 | 2 | 2 | 36 | 23 | 17 | 5 | 1 | 4 | 2 | 92 |
| 1995 | 1 | | 32 | 23 | 16 | 9 | | 2 | | 83 |
| 1996 | 2 | | 26 | 31 | 19 | 9 | 4 | 4 | | 95 |
| 1997 | | | 31 | 25 | 12 | 6 | 2 | 2 | 1 | 79 |
| 1998 | | 1 | 25 | 25 | 14 | 5 | 5 | | | 75 |
| 1999 | 1 | 3 | 25 | 16 | 17 | 8 | 1 | | | 71 |
| 2000 | 2 | 2 | 16 | 24 | 16 | 4 | 2 | 3 | | 69 |
| 2001 | 1 | 1 | 19 | 16 | 15 | 7 | 2 | 1 | | 62 |
| Total | 10 | 12 | 307 | 271 | 167 | 61 | 25 | 22 | 3 | 878 |

The age death rates for homicide are shown in Table 22. The death rates fluctuated throughout the period. The death rates for the groups aged 15-24 years and 25-

34 years were the highest. The group aged 5-14 years consistently had the lowest death rates, followed by the 1-4 age group.

Table 22: Age Death Rates for Homicide from 1991 to 1999.

| Year | Age range | | | | | | | | |
|------|-----------|-------|--------|--------|--------|--------|--------|--------|-----|
| | 1--4 | 5--14 | 15--24 | 25--34 | 35--44 | 45--54 | 55--64 | 65--74 | 75+ |
| 1991 | | 0.2 | 4.6 | 3.6 | 1.5 | | 1.5 | 1.4 | |
| 1992 | 0.4 | | 4.1 | 4.2 | 2.4 | 1.3 | 1.1 | | |
| 1993 | | 0.3 | 5.0 | 5.8 | 2.6 | 0.7 | 0.4 | 1.3 | |
| 1994 | 0.8 | 0.3 | 5.0 | 3.7 | 2.6 | 1.2 | 0.4 | 1.8 | 1.4 |
| 1995 | 0.4 | | 4.4 | 3.8 | 2.5 | 2.0 | | 0.9 | |
| 1996 | 0.9 | | 3.6 | 5.2 | 2.9 | 1.9 | 1.4 | 1.8 | |
| 1997 | | | 4.3 | 4.3 | 1.8 | 1.3 | 0.7 | 0.9 | 0.7 |
| 1998 | | 0.2 | 3.4 | 4.5 | 2.1 | 1.0 | 1.7 | | |
| 1999 | 0.5 | 0.5 | 3.4 | 2.9 | 2.6 | 1.6 | 0.3 | | |

Guns were used more frequently in homicides than any other weapon, as displayed in Table 23. Out of 878 homicides, 687 died from gunshot wounds. The second most frequent form of homicide involved knives. However, only 88 deaths resulted from knife wounds. While guns constituted 78.2 percent of all homicides, knives only accounted for 10.0 percent of all homicides. Of the 687 homicides resulting from gunshot wounds, 496 were black men, which accounts for 72.2 percent. Black males

Table 23: Homicide Cause of Death from January 1, 1991, to December 31, 2001.

| Cause of death | Sex and race of deceased | | | | | | Total |
|----------------|--------------------------|--------------|------------|--------------|------------|--------------|------------|
| | white male | white female | black male | black female | other male | other female | |
| gun | 70 | 32 | 496 | 86 | 2 | 1 | 687 |
| knife | 15 | 5 | 51 | 17 | | | 88 |
| beating | 8 | 5 | 33 | 10 | | | 56 |
| strangulation | 1 | 4 | 2 | 11 | | | 18 |
| hit by car/MVA | 4 | | 9 | | | | 13 |
| burns | 1 | | 1 | 1 | | | 3 |
| shaking | | | 1 | | | | 1 |
| fall | | | | 1 | | | 1 |
| drowning | | 2 | | | | | 2 |
| crushing | | | 1 | | | | 1 |
| other | | 1 | 7 | | | | 8 |
| Total | 99 | 49 | 601 | 126 | 2 | 1 | 878 |

were the victims of homicide more often in every form of homicide except strangulation. In the case of strangulation, black females were the victims most frequently. Crushing, fall, and shaking were the three lowest types of homicide, with one each.

Suicide

From 1991 to 2001, 452 people have committed suicide in East Baton Rouge Parish. These 452 deaths represent 1.9 percent of all coroner cases for the last eleven years. Of these 452 deaths, 355 were male and 97 were female. The 355 male deaths account for 78.5 percent of the total number of suicides, and the 97 female deaths account for 21.5 percent. The white population had the highest number of suicides with 342, which accounts for 75.7 percent of all suicides. The black population represents 22.8 percent of the total number of suicides with 103 deaths. Only seven suicides occurred in all other races combined. These seven deaths account for 1.5 percent of all suicides considered coroner cases for the last eleven years.

During the last eleven years, suicide was at its highest in 1991 with 54 deaths (Figure 21). From 1992 to 1999, suicide deaths remained fairly steady, with an average

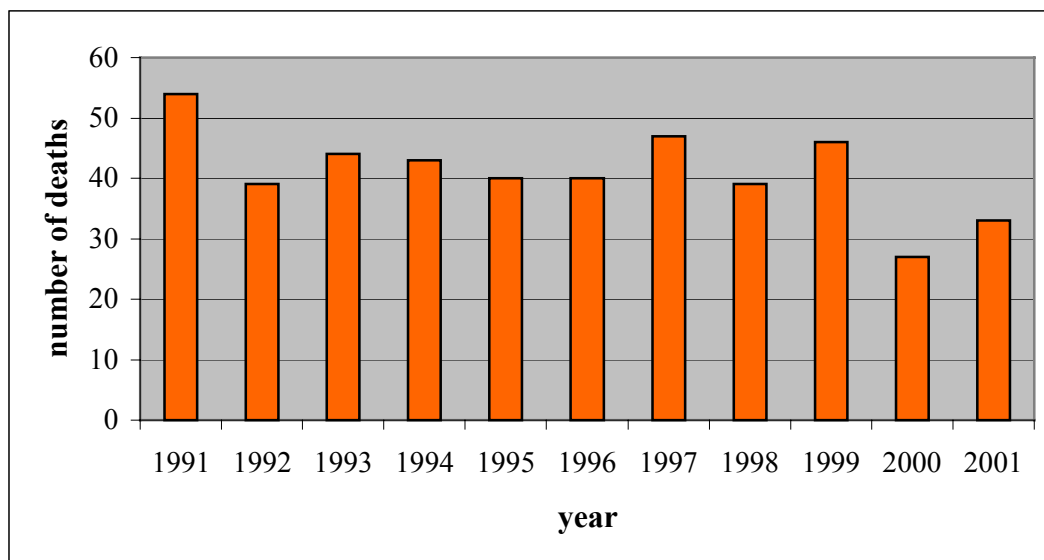


Figure 21: Suicide deaths from January 1, 1991, to December 31, 2001.

of 42 deaths per year. In 2000, the number of suicides dropped to their lowest point of 27 deaths. Deaths from suicide increased in 2001 to 33. However, the number of deaths for 2001 was still below the average for the previous years in the eleven-year period.

The pattern for suicides did not follow the population distribution pattern. The increase in suicides in 1993 corresponded to the population increase for that year. The decrease in suicides in 1995 corresponded to the population decrease for that year. For the remainder of the period, there were no other associations between suicides and the population.

Males have consistently committed suicide more than females, as shown in Figure 22. Male deaths exceeded female deaths by more than ten deaths each year. In 1999, the number of males surpassed the number of females by 36 deaths, which was the largest gap between the two sexes. The smallest difference between males and females was eleven deaths in 2001. The highest number of male deaths was 41 in 1999. The lowest number of male deaths was 22 in 2001. The highest number of female deaths was 17 in 1991, while the lowest number of female deaths was three in 2000.

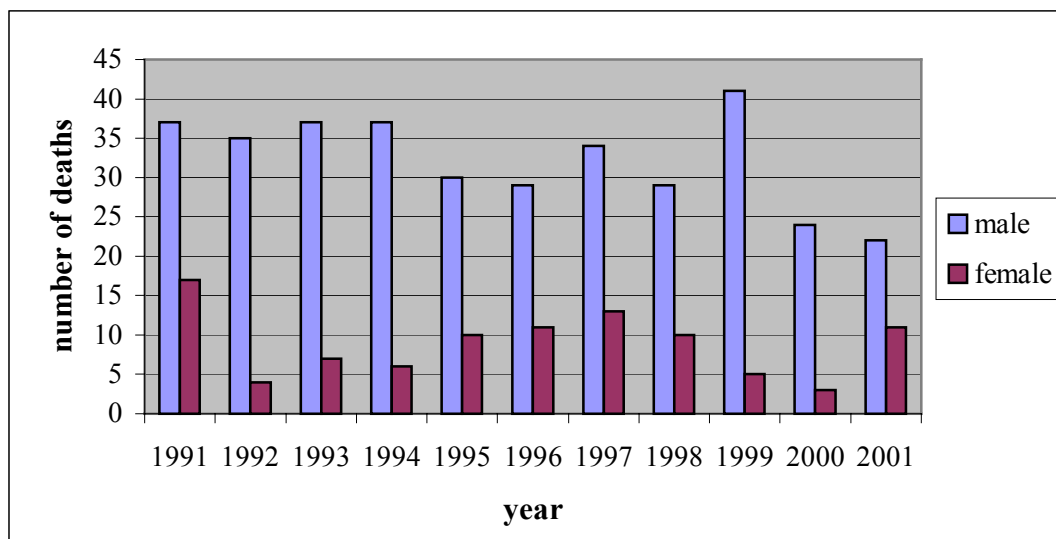


Figure 22: Suicide deaths by sex from January 1, 1991, to December 31, 2001.

The trend for more male suicides did not follow the population distribution pattern for more females. The increase in deaths in 1993 followed the increase in the population for that year. The decrease in male deaths in 1996 followed the population decrease for that year.

The white population committed suicide more often than the black population and all other races combined. Figure 23 illustrates the staggering differences in suicide among races. In 1998, the difference between the number of whites and the number of blacks was ten—the closest that black suicides came to white suicides. The highest number of white suicides was 42 and occurred in 1991. The lowest number of white suicides was 21 and occurred in 2000. In 1998, black suicides peaked at 14. The years 1993, 1999, and 2000 each had six black deaths due to suicide, which is the lowest number that suicide reached in the black population. In 1993, there were two suicides in other races. Five of the remaining years of the eleven-year period—1991, 1994, 1995,

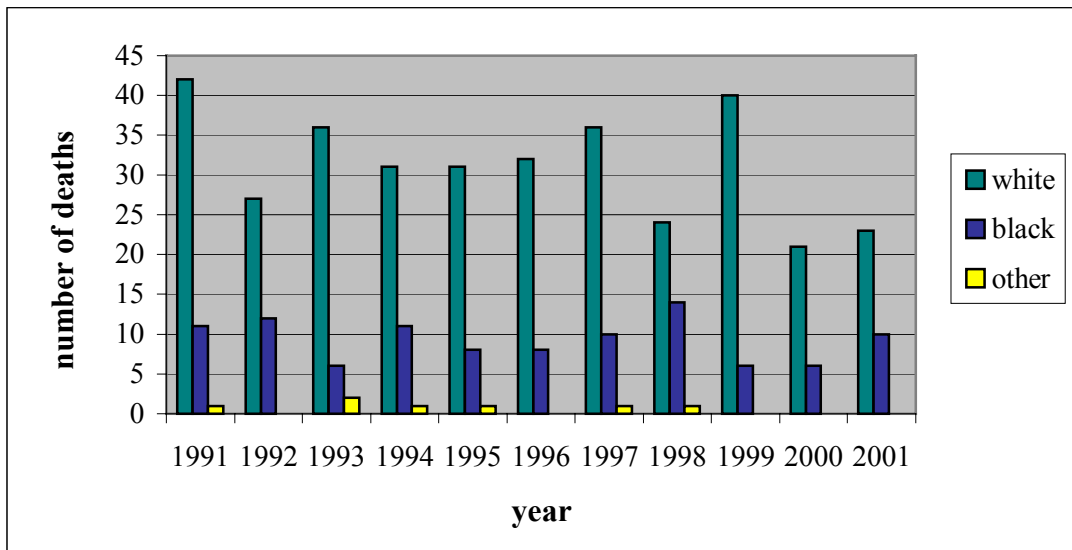


Figure 23: Suicide deaths by race from January 1, 1991, to December 31, 2001.

1997, and 1998—had only one suicide in other races, while the other five remaining years—1992, 1996, 1999, 2000, and 2001—did not have any suicides in other races.

The higher number of white deaths corresponded to the higher number of whites in the population distribution. In addition, the increase in black suicides from 1996 to 1998 followed the increase in the black population for those years. Suicide in other races did not follow the population distribution pattern.

The overall death rates for suicide remained fairly stable throughout the time period, as illustrated in Table 24. The year 1991 had the highest death rate of 1.4. The years 1992 and 1998 had the lowest death rates of 0.9. Despite the low number of deaths in other races, their death rates were the highest for both males and females. In addition, white males consistently had high death rates and peaked at a rate of 3.0 in 1999. Black females had the lowest death rates.

Table 24: Suicide Death Rates from 1991 to 1999.

| Year | Overall Rate | White Male | White Female | Black Male | Black Female | Other Male | Other Female |
|-------------|---------------------|-------------------|---------------------|-------------------|---------------------|-------------------|---------------------|
| <i>1991</i> | 1.4 | 2.3 | 1.2 | 1.6 | 0.1 | | 3.4 |
| <i>1992</i> | 0.9 | 2.1 | 0.2 | 1.5 | 0.3 | | |
| <i>1993</i> | 1.1 | 2.4 | 0.6 | 0.9 | | 5.3 | |
| <i>1994</i> | 1.1 | 2.3 | 0.3 | 1.5 | 0.1 | | 3.0 |
| <i>1995</i> | 1.0 | 1.9 | 0.6 | 0.9 | 0.3 | 2.5 | |
| <i>1996</i> | 1.0 | 1.9 | 0.8 | 1.0 | 0.1 | | |
| <i>1997</i> | 1.2 | 2.2 | 0.9 | 1.2 | 0.3 | 2.4 | |
| <i>1998</i> | 0.9 | 1.6 | 0.5 | 1.6 | 0.4 | | 2.7 |
| <i>1999</i> | 1.2 | 3.0 | 0.4 | 0.9 | | | |

Young to middle-aged adults commit suicide more frequently than all other age groups (Table 25). Of the 452 suicides from 1991 to 2001, the group aged 25-34 had the highest amount with 103 deaths, followed by the age group 15-24 with 96 deaths and the 35-44 age group with 91 deaths. After the 35-44 age group, suicide numbers decline with age. However, suicide in the 75 and older group was slightly higher than in the 65-74

age group. The 1-4 age group had no suicides, and the 5-14 age group had nine deaths due to suicide. Both the 15-24 and 35-44 age groups had their highest number of suicides in 1991, while the highest number of suicides in the group aged 25-34 was in 1994.

Overall, suicides regularly fluctuated among the age groups.

Table 25: Suicide Age Statistics from January 1, 1991, to December 31, 2001.

| Year | Age range | | | | | | | | | Total |
|--------------|-----------|----------|-----------|------------|-----------|-----------|-----------|-----------|-----------|------------|
| | 1--4 | 5--14 | 15--24 | 25--34 | 35--44 | 45--54 | 55--64 | 65--74 | 75+ | |
| 1991 | | | 13 | 13 | 15 | 4 | 3 | 2 | 4 | 54 |
| 1992 | | 1 | 5 | 8 | 8 | 7 | 4 | 3 | 3 | 39 |
| 1993 | | 2 | 11 | 7 | 6 | 7 | 6 | 3 | 2 | 44 |
| 1994 | | | 9 | 14 | 8 | 3 | 2 | 3 | 4 | 43 |
| 1995 | | | 6 | 5 | 14 | 2 | 6 | 3 | 4 | 40 |
| 1996 | | 2 | 5 | 10 | 8 | 7 | 2 | 6 | | 40 |
| 1997 | | 2 | 12 | 10 | 5 | 2 | 8 | 5 | 3 | 47 |
| 1998 | | 1 | 11 | 8 | 9 | 4 | 2 | 1 | 3 | 39 |
| 1999 | | 1 | 9 | 13 | 11 | 6 | 2 | 1 | 3 | 46 |
| 2000 | | | 9 | 5 | 4 | 3 | 3 | 1 | 2 | 27 |
| 2001 | | | 6 | 10 | 3 | 4 | 4 | 2 | 4 | 33 |
| Total | 0 | 9 | 96 | 103 | 91 | 49 | 42 | 30 | 32 | 452 |

The death rates for age in suicide did not display any significant differences, as shown in Table 26. However, even though the 25-34 age group had the most suicides, the death rates for the group aged 75 years and older consistently were the highest. The group aged 5-14 years had the lowest death rates.

Table 26: Age Death Rates for Suicide from 1991 to 1999.

| Year | Age range | | | | | | | | |
|------|-----------|-------|--------|--------|--------|--------|--------|--------|-----|
| | 1--4 | 5--14 | 15--24 | 25--34 | 35--44 | 45--54 | 55--64 | 65--74 | 75+ |
| 1991 | | | 1.9 | 1.9 | 2.4 | 1.1 | 1.1 | 0.9 | 2.9 |
| 1992 | | 0.2 | 0.7 | 1.2 | 1.3 | 1.8 | 1.4 | 1.3 | 2.1 |
| 1993 | | 0.3 | 1.5 | 1.1 | 0.9 | 1.7 | 2.1 | 1.3 | 1.4 |
| 1994 | | | 1.3 | 2.3 | 1.2 | 0.7 | 0.7 | 1.3 | 2.8 |
| 1995 | | | 0.8 | 0.8 | 2.1 | 0.5 | 2.1 | 1.3 | 2.7 |
| 1996 | | 0.3 | 0.7 | 1.7 | 1.2 | 1.5 | 0.7 | 2.7 | |
| 1997 | | 0.4 | 1.6 | 1.7 | 0.8 | 0.4 | 2.7 | 2.3 | 1.9 |
| 1998 | | 0.2 | 1.5 | 1.4 | 1.4 | 0.8 | 0.7 | 0.4 | 1.8 |
| 1999 | | 0.2 | 1.2 | 2.4 | 1.7 | 1.2 | 0.7 | 0.4 | 1.8 |

Analysis of the methods utilized in suicide for the last eleven years show that guns were used most frequently (Table 27). Guns were used in 318 of the 452 suicides, which is 70.4 percent of all suicides. Of the 318 suicides committed with guns, white males comprised 58.2 percent with 185. Hanging was the second leading method of suicide, accounting for 11.3 percent of all suicides. Drug overdose, which represented 8.4 percent of all suicides, was the third leading method of suicide. Of the 38 suicides by drug overdose, white females had the highest number with 14 deaths accounting for 36.8 percent. Black females used guns and drugs most often to commit suicide. Males of other races only used guns and hanging to commit suicide.

Table 27: Suicide Cause of Death from January 1, 1991, to December 31, 2001.

| Cause of death | Sex and race of deceased | | | | | | Total |
|--------------------------|--------------------------|--------------|------------|--------------|------------|--------------|------------|
| | white male | white female | black male | black female | other male | other female | |
| <i>gun</i> | 185 | 54 | 70 | 6 | 2 | 1 | 318 |
| <i>hanging</i> | 31 | 4 | 14 | | 2 | | 51 |
| <i>drug overdose</i> | 13 | 14 | 3 | 7 | | 1 | 38 |
| <i>CO poisoning</i> | 16 | 4 | | | | | 20 |
| <i>knife</i> | 5 | 1 | | | | | 6 |
| <i>jump from bridge</i> | 2 | | 2 | | | | 4 |
| <i>suffocation</i> | 3 | | | | | | 3 |
| <i>drowning</i> | 2 | | | | | 1 | 3 |
| <i>MVA/hit by car</i> | | 2 | | | | | 2 |
| <i>poison</i> | 1 | | | | | | 1 |
| <i>fire/burns</i> | | 1 | | | | | 1 |
| <i>electrocution</i> | 1 | | | | | | 1 |
| <i>alcohol poisoning</i> | 1 | | | | | | 1 |
| <i>other</i> | 2 | | | 1 | | | 3 |
| Total | 262 | 80 | 89 | 14 | 4 | 3 | 452 |

Infant Deaths

From 1991 to 2001, 633 infants have died in East Baton Rouge Parish. These 633 infant deaths represented 2.7 percent of all coroner cases for the last eleven years. Of these 633 deaths, 340 were male and 293 were female, accounting for 53.7 percent and

46.3 percent of infant deaths, respectively. The black population had the highest number of infant deaths with 469, which represented 74.1 percent. The white population had 160 deaths, which accounted for 25.3 percent of all infant deaths. Only four deaths occurred in all other races combined, accounting for 0.6 percent of all infant deaths.

Infant deaths, as illustrated in Figure 24, were at their lowest levels in the beginning of the decade. In 1992, there were only 34 infant deaths. Infant deaths climbed to 58 in 1994, after which they skyrocketed to 91 deaths in 1995. In 1996, infant deaths dramatically declined to 51. Despite this decline in 1996, infant deaths increased again to 81 and remained elevated until 2000. In 2000, infant deaths began another descent and have continued to slowly decline.

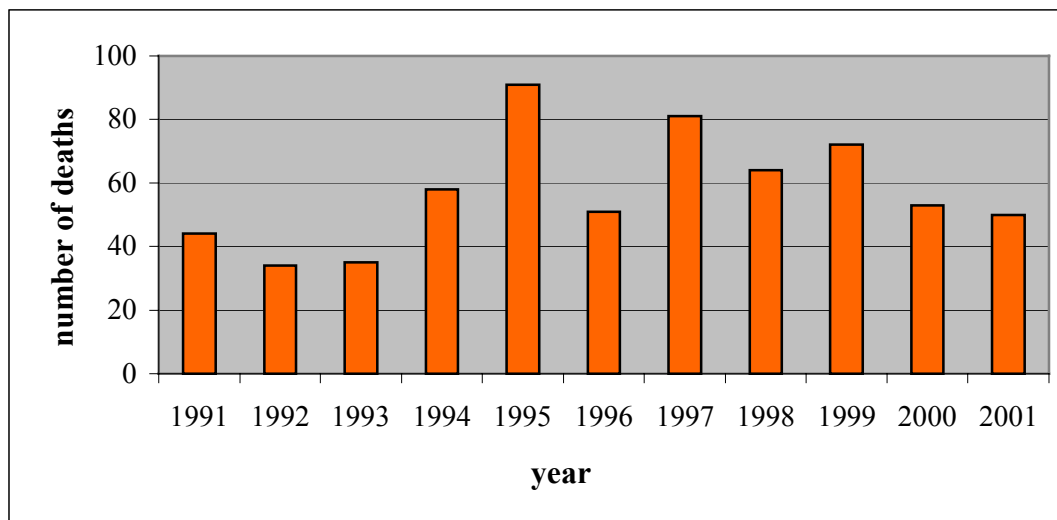


Figure 24: Infant deaths from January 1, 1991, to December 31, 2001.

The infant death pattern did not follow the population distribution pattern as shown in Table 1. In fact, the trend for infant deaths appeared to do the opposite of the population distribution pattern.

For the majority of the eleven-year period, infant male deaths exceeded infant female deaths (Figure 25). Female deaths surpassed male deaths in 1992, 1998, 1999, and 2000. In 1995, male deaths were at their highest with 53. Male deaths were at their lowest with 16 in 1992. In both 1995 and 1997, female infant deaths peaked at 38. In 2001, female deaths reached their lowest point with 16 deaths. During the late 1990s, female infant deaths remained high until the year 2001. On the other hand, male deaths appeared to be declining until the year 2001.

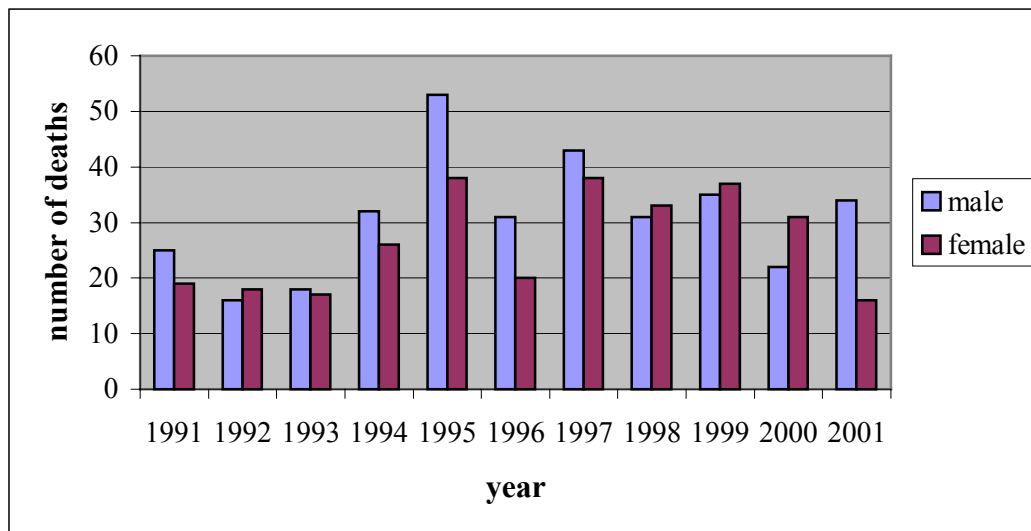


Figure 25: Infant deaths by sex from January 1, 1991, to December 31, 2001.

This male/female infant death pattern did not follow the population distribution pattern. Much like the overall death trend for infant deaths, the sex death trend appeared to do the opposite of the population trend.

Infant deaths in the black population exceeded those in the white population and all other races every year from 1991 to 2001, as demonstrated in Figure 26. In fact, black deaths surpassed white deaths by 14 or more each year. In 1995, white infant deaths peaked at 27. Infant deaths in the white population were at their lowest with eight deaths

in 1993. In 1997, infant deaths in the black population peaked at 66. In 1992, black infant deaths were at their lowest with 24 deaths. Only four infant deaths occurred in all other races combined—one in 1994, two in 1998, and one in 2001.

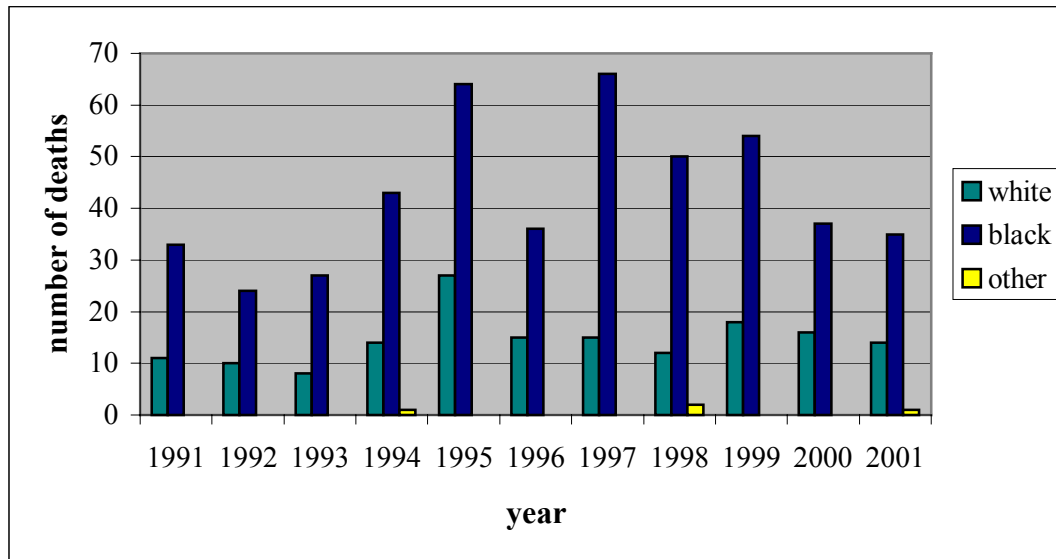


Figure 26: Infant deaths by race from January 1, 1991, to December 31, 2001.

This death trend for race did not conform to the typical population distribution pattern shown in Table 1. The death trend for whites and other races did not follow the population. However, the increase in black deaths from 1992 to 1995 did follow the increase in the black population for those years.

Infant death rate is the number of infants that die within the first year of life per 1,000 live births. The overall death rates for infant deaths fluctuated throughout the entire period, as displayed in Table 28. The highest rate was 15.3 in 1995. The lowest rate was 5.6 in 1992. Black males had the highest death rates for the majority of the period. Black female death rates exceeded that of black males in 1992, 1998, and 1999. White females had the lowest death rates for the majority of the period. Only three

deaths occurred in other races from 1991 to 1999; however, the death rates for other races were the highest for the year in which they occurred.

Table 28: Infant Death Rates from 1991 to 1999.

| Year | Overall Rate | White Male | White Female | Black Male | Black Female | Other Male | Other Female |
|-------------|---------------------|-------------------|---------------------|-------------------|---------------------|-------------------|---------------------|
| 1991 | 7.4 | 3.7 | 3.2 | 13.8 | 10.9 | | |
| 1992 | 5.6 | 3.0 | 3.2 | 7.8 | 9.9 | | |
| 1993 | 5.8 | 2.5 | 2.6 | 9.8 | 9.7 | | |
| 1994 | 9.6 | 5.6 | 3.3 | 15.9 | 14.8 | | 21.8 |
| 1995 | 15.3 | 12.1 | 5.4 | 23.8 | 22.3 | | |
| 1996 | 8.9 | 4.6 | 5.6 | 17.3 | 9.2 | | |
| 1997 | 14.6 | 5.5 | 5.1 | 26.1 | 24.7 | | |
| 1998 | 11.7 | 4.1 | 4.4 | 17.6 | 21.9 | 28.2 | |
| 1999 | 13.2 | 6.2 | 6.5 | 19.9 | 22.9 | | |

From 1991 to 2001, the leading cause of death in infants was prematurity with 276 deaths (Table 29). Of the 276 deaths due to prematurity, black males and females had the highest numbers with 106 deaths each. The second leading cause of death in infants was multiple abnormalities with 139 deaths. Again, black infants of both sexes were affected the most. With 113 deaths, the cause of death category “other” ranked third in infant deaths. These “other” deaths in infants include the same diseases and causes as in the “other” natural category previously discussed. Cancer and AIDS do not appear to be a major cause of death in infants. Black infants had the highest number of deaths due to “other” natural causes, with 47 deaths in males and 35 deaths in females. For each cause of infant deaths, black males had at least one death. The highest number of white infant deaths was due to prematurity, with 33 male deaths and 29 female deaths. Black females had the highest number of cardiac deaths, followed by white males. Black males had the highest number of infant deaths due to Sudden Infant Death Syndrome. The causes of death in other races were prematurity (2), cardiac (1), and SIDS (1). Overall, infants born to black mothers in the last eleven years have died more frequently

in every cause of infant deaths. In addition, infants born to mothers of other races have died less often than any of the other races.

Table 29: Infant Death Cause of Death from January 1, 1991, to December 31, 2001.

| Cause of death | Sex and race of deceased | | | | | | Total |
|---------------------------|--------------------------|---------------------|-------------------|---------------------|-------------------|---------------------|------------|
| | <i>white male</i> | <i>white female</i> | <i>black male</i> | <i>black female</i> | <i>other male</i> | <i>other female</i> | |
| multiple abnormalities | 26 | 15 | 52 | 46 | | | 139 |
| prematurity | 33 | 29 | 106 | 106 | | 2 | 276 |
| cardiac | 11 | 4 | 5 | 17 | 1 | | 38 |
| other | 10 | 21 | 47 | 35 | | | 113 |
| cancer | 1 | | 1 | 1 | | | 3 |
| AIDS | 1 | | 5 | 1 | | | 7 |
| fall | 1 | | 1 | | | | 2 |
| drowning | | 1 | 1 | 1 | | | 3 |
| suffocation/strangulation | | | 9 | 2 | | | 11 |
| SIDS | 2 | | 10 | 3 | 1 | | 16 |
| fight/beatng | 1 | 1 | 1 | 1 | | | 4 |
| knife | | | 1 | | | | 1 |
| gun | | | 6 | 2 | | | 8 |
| electrocution | | | 1 | | | | 1 |
| MVA | 2 | | 2 | 2 | | | 6 |
| malnutrition | 1 | | 1 | | | | 2 |
| hypothermia | | | 1 | | | | 1 |
| shaking | | | 1 | 1 | | | 2 |
| Total | 89 | 71 | 250 | 219 | 2 | 2 | 633 |

Overall, the results from the analysis of the coroner's cases reflect a variety of elements that occurred in the parish. These results will be discussed in the following chapter.

DISCUSSION

As reported in the results chapter, 23,813 of the 39,170 deaths that have occurred in East Baton Rouge Parish from 1991 to 2001 were considered coroner's cases. These coroner cases were categorized by cause of death. In addition, the sex, race, and age of each coroner case was evaluated. This chapter discusses the evaluation of the chosen characteristics and how death in East Baton Rouge Parish compares to death in the state of Louisiana and in the United States.

As mentioned previously, the female population in East Baton Rouge is larger than the male population. The analysis of the coroner cases in East Baton Rouge Parish shows that, despite the larger female population, more males than females died between the years 1991 and 2001. However, the difference between the two sexes is small—835 deaths. The close numbers for deaths in males and females is comparable to the virtually equal numbers of deaths in males and females for the state of Louisiana as a whole in 1999. The number of deaths in the female population exceeded the number of deaths in the male population for the United States. However, the difference between the two sexes was minimal. Overall death numbers between the sexes in the parish seem to follow the pattern for death numbers between the sexes for the state.

The white population constitutes 56.2 percent of East Baton Rouge Parish, while the black population comprises 40.1 percent of the parish. All other races combined comprise 3.7 percent. This study determined that more deaths occurred in the white population (14,653) from 1991 to 2001 than in the black population (9,071) and in all other races combined (89). Unlike the findings for the sexes, these results for race are concordant with the population percentages. In other words, the race that comprises the

majority of the parish population—white—also has experienced the highest number of deaths in the past eleven years. In addition, the results for race in the parish parallel the state deaths and the national deaths. In the state of Louisiana, the white population has experienced the highest number of deaths. In the United States, the white population has consistently experienced the highest number of deaths.

As mentioned in the literature review, the population of Louisiana is older now than 30 years ago, mainly due to the large 5-24 age group in 1970 becoming a large middle-aged group in the 1990s. As expected, the greatest proportion of deaths in East Baton Rouge Parish occurred in the 75 and older age group (43.5%), followed by the 65-74 age group (18.3%). However, the parish population distribution for 1991 through 1999 showed the groups aged 65-74 and 75 and older consistently had the lowest numbers. For the state as a whole, people 65 years and older have the highest number of deaths; therefore, the findings of this study follow the same trend as the state. At the national level, people aged 75 and older have the highest number of deaths; therefore, the results of this analysis parallel the death trend for the nation.

The analysis of the coroner cases indicates that the leading cause of death in East Baton Rouge Parish from 1991 to 2001 was irrefutably heart disease. Cardiac-related deaths accounted for 41.5 percent of the total number of deaths. Heart disease consistently has been the leading cause of death in Louisiana for the past 20 years. In addition, heart disease consistently has been the leading cause of death in the United States. Of the deaths due to heart disease in the parish, white females aged 75 years and older had the highest number of deaths. Since 2000, deaths resulting from heart disease have been declining in the parish. The overall death rate for cardiac deaths fluctuated

throughout the period. White females had the highest death rates, while other males had the lowest death rates. The death pattern for heart disease did not conform to the typical population distribution pattern. However, the larger number of female deaths appeared to follow the distribution pattern of a larger female population. In addition, the higher number of white deaths every year followed the distribution pattern of a larger white population. Since the cardiac death trend did not follow the population distribution pattern, the pattern for cardiac deaths more than likely is related to lifestyle. People consume large amounts of fast food, work long hours, watch television and surf the web instead of exercising. These behaviors inevitably lead to heart disease. In addition, people are living longer than ever before.

For the state of Louisiana, white females aged 75 years and older had the highest number of deaths due to heart disease; therefore, the parish results for this study correspond to the figures for the state. In addition, heart disease deaths in the state generally have been declining but showed a slight increase in 1999. This increase corresponded to the increase in the parish results for 1999. The results for the parish are more analogous to the state than the United States figures. For both the parish and the nation, females have the highest number of deaths due to heart disease. However, black females have the highest number of deaths resulting from heart disease in the United States. Heart disease has also been declining in recent years at the national level. No comparison for age could be made between the parish and the nation.

As in East Baton Rouge Parish, cancer is the second leading cause of death in the state of Louisiana and the United States. In the parish, white males aged 75 years and older had the highest number of deaths due to cancer for the last eleven years. The

overall cancer death rates did not show much fluctuation. White males had the highest death rates, and other females had the lowest. Those aged 75 years and older had the highest death rates. The cancer death trend did not conform to the typical population distribution pattern. However, the death trend for race had an association with the population trend. More whites died than blacks and other races. In addition, black deaths followed the population pattern for several years. The pattern for cancer deaths is most likely associated with age and population. People are living longer and the population of people aged 65 years and older is increasing. The longer people live, the greater their chance of developing cancer.

In Louisiana, white males aged 65 and older had the highest number of deaths from cancer. In the United States, black males had the highest number of deaths resulting from cancer. In addition, cancer deaths in the nation as a whole have been declining in recent years, but they have not been declining in East Baton Rouge Parish. Again, no comparison for age could be made between the parish and the nation.

The “other” natural death category, as discussed in the results chapter, encompasses several causes of death. This category accounted for 20.9 percent of all coroner cases in the parish. Of these deaths, white females aged 75 and older had the highest numbers of “other” deaths. In addition, deaths due to “other” causes have been rising since 2000. The overall “other” death trend only conformed to the typical population distribution pattern from 1991 to 1994. The larger female population of the parish followed the higher number of female deaths due to other causes. In addition, the larger white population followed the higher number of “other” deaths in the white population. From 1991 to 1994, both white and black death patterns followed the

population pattern. The overall death rates fluctuated during the period. White females had the highest death rates and other males had the lowest. The age death rates increased with age. The group aged 75 years and older had the highest rates. The 5-14 age group had the lowest death rates. The 1-4 age group showed the most fluctuation and had higher rates than the 5-14 age group. These higher death rates and larger number of deaths than the 5-14 age group are most likely due to decreased fitness resulting from birth-related problems.

Due to previously mentioned limitations, complete analysis of this category could not be conducted. Nevertheless, two of the leading causes of death in Louisiana—stroke and diabetes—are included in this category. Stroke, as well as chronic lower respiratory disease, remains in the top five causes of death for the nation. Other causes of death in the other natural category—hypertension, diabetes, and septicemia—have recently increased in the United States. Even though the deaths in this category could not be fully analyzed, the large number of deaths due to other causes more than likely follows the state and nation trends.

As discussed in the results chapter, accidents were the fourth leading cause of death in the parish, accounting for 4.7 percent of all parish coroner cases analyzed. Of these deaths, white males aged 15-24 years had the highest number of deaths. The overall accidental death trend partially conformed to the typical population distribution pattern. The sex death trend did not conform to the typical population distribution pattern. The race death trend for whites did follow the population distribution pattern. Motor vehicle accidents were the number one cause of accidental deaths from 1991 to 2001. The overall death rates remained steady. Black males had the highest death rates, and black

females had the lowest. The age group 75 and older had the highest death rates, and the 5-14 age group had the lowest. In addition, accidental deaths have been increasing in recent years. This death pattern for accidents is most likely due to a combination of factors. One of those factors is the population changes. The number of vehicles on the road is directly related to the population. The larger the population is, the higher the number of vehicles, which results in an increase in the number of fatal motor vehicle accidents. A smaller population means fewer vehicles, which in turn means fewer fatal motor vehicle accidents. Another factor could be related to occupational fatalities at the numerous industrial and chemical plants in the area. Types of accidental deaths found at plants include fall, crushing, industrial/machinery, and fire.

In agreement with the results in this study, accidents have been the fourth leading cause of death in the state of Louisiana. However, accidental deaths rank fifth at the national level. In the state, white males aged 35-44 years are most affected by accidental deaths. The leading cause of accidental death in Louisiana consistently has been motor vehicle accidents. At the national level, white males aged 25-34 had the highest number of deaths resulting from occupational/accidental injuries. In addition, motor vehicle accidents were the leading cause of accidental deaths in the nation. In contrast to the parish, accidental deaths have been decreasing in recent years in the United States. Meanwhile, deaths due to accident have remained steady at the state level.

In this study, AIDS accounted for 3.9 percent of all deaths from 1991 to 2001 in East Baton Rouge Parish. Of these AIDS deaths, black males aged 35-44 had the highest number of deaths. The overall death trend generally followed the population distribution pattern from 1991 to 1994 and 1996 to 1997. The sex death trend did not conform to the

typical pattern for the population distribution. The white death trend followed the population pattern from 1991 to 1992 and 1995 to 1997. The black and other races death trends did not follow the population pattern. From 1995 to 2000, deaths due to AIDS declined. However, the year 2001 showed an increase. The AIDS death trend is related to education and available care facilities. All of the races have access to education about AIDS and treatment for HIV/AIDS. However, more whites have listened to what they have been taught and put it into action. In addition, treatment for AIDS is expensive. A large percentage of the people living with AIDS do not have the resources necessary for proper treatment or for transportation to the clinics designed to serve the less fortunate. Whether AIDS deaths continue to rise or begin to decrease again in the future is uncertain. An increase in outreach to the impoverished AIDS victims and better access to the care facilities would further decrease the number of lives lost to the disease.

At the state level, AIDS is not even ranked in the top 12 causes of death. Nevertheless, deaths resulting from AIDS have followed the parish trend of decline since 1995. Of the AIDS deaths in Louisiana, black males aged 35-44 years had the highest number of deaths. At the national level, AIDS is also no longer a leading cause of death. Just as in the parish and the state, deaths due to AIDS have declined in recent years. AIDS in the United States affects black males aged 25-44 years the most.

Analysis of homicide in East Baton Rouge Parish indicates that homicide accounted for 3.7 percent of all deaths considered coroner's cases for the last eleven years. Of these deaths, black males aged 15-24 had the highest number of deaths. From 1991 to 1993 and 1995 to 1997, the overall death trend followed the typical population distribution pattern. From 1991 to 1993, the trend for sex conformed to the population

distribution pattern. Black deaths followed the black population pattern from 1992 to 1994. White deaths followed the white population pattern from 1991 to 1995. The overall death rates for homicide fluctuated throughout the period. Black males had the highest death rates. White females had the lowest death rates. The rates for other males and females were elevated despite the low number of deaths. The groups aged 15-24 and 25-34 had the highest rates, while the 5-14 age group had the lowest. The weapon used most frequently in homicides in the parish consistently has been guns. Since 1996, homicides have been decreasing in the parish. The decrease in recent years is most likely associated with the economy. In recent years, the economy has improved and more jobs have become available. A better economy and a reduction in the number of people without jobs results in a decrease in crime. A decrease in crime causes a decrease in homicides.

At the state level, homicide repeatedly has been in the top 12 leading causes of death, and black males aged 15-24 years have the greatest chance of being homicide victims. As in the parish, homicide in Louisiana has been declining in recent years. Following the parish and state trend, the number of homicides has been decreasing in the United States. In addition, black males aged 18-24 years had the highest number of deaths due to homicide at the national level. Overall, the parish death analysis for homicide reflects the trends for Louisiana and the United States.

In East Baton Rouge Parish, suicide only accounted for 1.9 percent of the analyzed deaths. The results indicated that white males aged 25-34 had the highest number of suicides in the parish. The death trend, as well as the sex trend, for suicide did not follow the population distribution pattern. The death trend for race did follow the

pattern for the distribution of the population. More whites committed suicide, which corresponded to the larger white population. In addition, the increase in black suicides from 1996 to 1998 corresponded to the increase in the black population. The overall death rate remained steady during the period. White males had the highest death rates, while black females had the lowest. Despite the low number of deaths in other races, their death rates were among the highest. The group aged 75 years and older had the highest death rates. The group aged 5-14 had the lowest. The most frequently used method for committing suicide was gunshot wounds. Deaths due to suicide declined at the end of the eleven-year period. Since the suicide death trend is not related to the population, it is most likely related to the economy and how people are treated by others. As with homicide, the improved economy resulted in more jobs. A better job market reduced financial insecurity, which reduced the number of suicides. In addition, how people are treated by others affects their state of mind and can lead to depression. In this situation, elementary and high school students are especially prone to commit suicide as a way to find relief from the harsh treatment they receive from their peers.

Suicide consistently has been in the top 12 causes of death in Louisiana. However, suicide deaths in the state decreased in recent years and dropped out of the top 10 causes of death. In Louisiana, white males aged 25-34 years commit suicide most often. Suicide has decreased in recent years and dropped out of the top 10 causes of death in the United States. However, at the national level, white males aged 15-24 experienced the highest number of suicides. In addition, guns were used the most in committing suicide. The parish death analysis for suicide generally reflects the trends for

the state and the nation. Yet, the age group with the most suicides in the parish was not the same as the age group in the nation.

The analysis of infant deaths from 1991 to 2001 in East Baton Rouge Parish demonstrates that infant deaths represented 2.7 percent of all coroner cases. Black males had the highest numbers of infant deaths. The death trends for infants did not conform to the typical pattern for the population distribution. In fact, the overall death trend and the sex death trend appeared to do just the opposite of the population distribution pattern. Additionally, the white and other races death trends did not follow the population pattern. However, the black death trend conformed to the population pattern from 1992 to 1995. The overall infant death rate fluctuated. Black males had the highest death rates. The black female death rate exceeded the black male death rate in 1992, 1998, and 1999. White females had the lowest death rates. The leading cause of death in infants in the parish was prematurity. In the latter part of the decade, infant deaths declined in the parish. The infant death pattern is associated with education and access to proper prenatal care. Women who are better educated about sex and pregnancy are less likely to get pregnant. In addition, they are more likely to receive adequate prenatal care. Women who are not educated about sex and pregnancy are more likely to get pregnant at a young age or out of wedlock, and they are less likely to seek prenatal care. Poor prenatal care can cause poor health in infants and severe prematurity. On the other hand, some women may be educated about pregnancy, but may not have access to a doctor or a healthcare facility because of lack of financial resources and/or transportation. As a result, proper prenatal care is not achieved.

In Louisiana, infant deaths were most prevalent in infants born to black mothers. No information was obtained on the sex of infants with the highest number of deaths in the state or the leading cause of death; consequently, a sex comparison with the parish and the United States could not be performed. As in the parish, infant deaths have been declining in the state in recent years. In the United States, infant deaths have decreased in the last eleven years. Infants born to black mothers and male infants had the highest number of deaths in the nation. The national leading cause of death in infants was congenital malformations (multiple abnormalities), not prematurity. The parish results for infant deaths parallel the state and the United States trends for race and decline in number of deaths.

CONCLUSION

This study involved the analysis of deaths in East Baton Rouge Parish that were considered coroner's cases from 1991 to 2001. The objectives of this study were threefold. The first objective was to analyze all the coroner cases in the East Baton Rouge Coroner's System from January 1, 1991, to December 31, 2001. The second objective was to compare the results of the analysis to the patterns for the state of Louisiana in order to determine if deaths in the parish follow the death trends for the entire state. The third objective was to compare the results of the analysis to the patterns for the entire United States. The comparison to the nation was also performed to determine if deaths in East Baton Rouge Parish parallel the death trends of the entire nation.

The results of the analysis illustrated that white males aged 75 years and older had the highest number of deaths in East Baton Rouge Parish from 1991 to 2001. In the state of Louisiana, white males aged 65 years and older had the highest number of deaths. At the national level, white females aged 75 years and older had the highest number of deaths. Even though females experienced more deaths at the national level, the difference between the sexes was minor. As discussed in the previous chapter, the trend for the parish and the state for deaths classified by sex were virtually equal, with males having slightly more deaths than females.

In addition, the results show that heart disease was the number one killer of residents of East Baton Rouge from 1991 to 2001. The leading cause of death at the state level for the same eleven-year period was heart disease. In the United States, heart disease has also claimed more lives than any other cause of death in recent years.

Additionally, the second leading cause of death in the parish, the state, and the nation was cancer.

However, the results for sex, race, and age for individual causes of death did not always match the trends for the state and the nation. For AIDS, homicide, suicide, accidents, and infant deaths, the parish results in this study were identical to the trends of the state and the nation for the sex and race with the most deaths. The parish results matched the state and the United States trends for age in AIDS and homicide. The results for the remaining causes of death in the parish, such as heart disease and cancer, showed more variation in comparison to the state and the nation. For instance, the parish paralleled the state, but not the nation, for the age group most affected by suicide. In addition, heart disease claimed the lives of white females in the parish and the state the most, while black females were most affected by heart disease at the national level. The results for East Baton Rouge Parish appear to follow more closely the death trends of the state of Louisiana, rather than the death trends of the United States.

This review of the records obtained from the Coroner's Office can be used to expand on the records that are currently available for study and to provide insight into the parish. The information that can be acquired from the coroner's database can aid in determining what percentage of all deaths are actually reported to the coroner. Information from the coroner's database can also help to more accurately report statistics which are used to identify public health issues and analyze the results of programs implemented to alleviate those issues. Currently, the Louisiana Office of Vital Statistics does not keep any record of coroner cases. Without those records, evaluation of accuracy

of death reports and comparisons of coroner's records to other death records and statistics cannot be fully accomplished.

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