control of infectious disease to the management and prevention of degenerative disease and prolonged illness.

It is of interest to indicate how sharply the demand for bedside nursing reflects the problem of prolonged illness. It has already been seen that almost 75 percent of the patients seen by the Home Medical Service are less than 20 years of age. In terms of 50 random referrals to the Visiting Nurse Association, however, it is noted that the average age of these patients is over 53 years. If the patients who are referred more than once are selected, the average age rises to just over 60 years. An overwhelming number of patients who are referred have chronic cardiac disease, and, except for three instances of pediculosis and one of measles, all fall into the category of prolonged illness.

Nursing service, although utilized for medical education in this program, has not been readily adapted to nursing education. A most productive and gratifying relationship exists between the Visiting Nurse Association and the Home Medical Service. In the area of bedside nursing, this organization is making a very real contribution from the point of view of education and integration in the general problem of the provision of medical care. Externs from the Home Medical Service, as a result of periodic conferences provided by the Visiting Nurse Association, are made familiar with the types of service which are available. They readily utilize these services in the day-to-day problems which arise. This has been a mutually beneficial experience. Each group of externs has a conference with the supervisor of the Visiting Nurse group at the South End Health Unit. On the other hand, the supervisor of the unit and other nurses attend the social service and psychosomatic conferences held by the Home Medical Service.

Participation in other areas of nursing education is fairly sharply limited at present. Student nurses from the Massachusetts Memorial Hospitals attend social service and psychosomatic conferences on the Home Medical Service during their outpatient assignment. While this is a brief and somewhat limited experience, it does serve to make students at this level aware of the fact that nursing and medical problems exist outside the walls of the hospital.

The preponderant number of patients in the young age groups and the volume of communicable disease in an area where poverty, poor housing, and disease go hand-in-hand create a very apparent problem in regard to community health. This is not confined completely to the young age group. One need go no further than to note the mortality rate from pulmonary tuberculosis in the south end of Boston to appreciate how severe this problem may be. In this area, the current mortality rate equals the national mortality rate of 50 years ago, despite the fact that since that time the national rate has been reduced by 85 percent.

It is fairly obvious that the utilization of the Home Medical Service as a means of providing field training in public health nursing is a matter which should be explored more fully. Although the present situation has gone little beyond the thinking stage, the organization of the medical service presents almost limitless possibilities in respect to nursing education, particularly in the sphere of public health nursing.

It is beyond question that the nurse is an essential member of the team which provides medical care. It would appear inevitable that, in order to be a more effective member of this team, knowledge and understanding of the social aspects of illness are primary requisites. The ultimate goal of those concerned with the health professions is the utilization and adaptation of measures which will continue to improve the quality and availability of medical care. It is clear that this aim implies an acceptance of social responsibility that extends beyond the need for prescription and administration.

A high quality of medical care does not result simply from efficient organization of service, personnel, and facilities. Understanding, appreciation, and acceptance of this objective should begin in the educational experiences of all the health fields.
Integration, cooperation, and coordination in this respect, while producing mutually beneficial results, will also lead to broadening of understanding and depth of insight. The services of any member of the health team will thus be greatly enhanced by an approach to medical care which is directed not only at the complaint of the patient but the underlying implications of the illness in relation to the individual himself, his family, and the community as a whole.

**Patient Expectations**

**Theodore Pemberton**

In December 1946, while working as a roofer, I fell 16 feet and since then have been paralyzed below the waist. This accident was peculiar (I had fallen before from higher points) because I landed in a sitting position against a snow bank and, in so doing, cracked my spine. During the four years since my accident, I have spent two in the hospital—not continuously, but at sixth-month intervals.

My illness has been no expense to me because all medical care has been provided by the insurance company and I have Workmen’s Compensation to help toward the support of my family. At the time of my accident, two of my sons were employed, and, as I own my own home, we have been able to manage. Recently, my sons have married, and, since my youngest child is now old enough to take care of himself with my supervision, my wife has gone to work as a clerk in a local hospital.

In August 1947, I was asked by the hospital to participate in a radio broadcast in a medical series. Another member of the panel was a representative of the State Department of Vocational Rehabilitation who, from this meeting, became interested in me; as a result, I have been trained in watch repairing, and I am able to earn money at this trade.

These long periods of hospitalization and enforced inactivity have been very hard for me, and, coupled with the newness and confusion of hospital routine, I often felt discouraged and pessimistic over prospects for the future. The insurance company provided me with a special duty nurse for an eight-hour period, and the rest of the time I was under the care of regular staff nurses.

I always found the nurses prompt in giving me all of the care I needed, interested in the progress I made, and careful to explain to me the treatment I was receiving. All of this helped me to feel as if I were participating in my own care and made it easier for me to accept the inevitable pain and discomfort which went along with my condition. I was also taught how to care for myself so that when I was discharged from the hospital I would not be completely bewildered.

It is not possible for me to express how much these nurses did to ease my adjustment into institutional routine and to enable me to face the future with less apprehension and foreboding. They became both my family and my friends—kidding me when I needed to be kidded, fussing with me over a cribbage game, sympathizing with me when it was deserved, and, above all, encouraging me to take up an interest in life.

When I was ready to be discharged home after eight months, the hospital referred me to the visiting nurse association for surgical dressings. As my physical condition improved, the nurse suggested that she would ask the doctor if I might begin more activity and so I came to know the physical therapist of the visiting nurse association. The doctor told me about a school in Medford which was teaching paraplegics to walk, and, with the insurance company paying the tuition, I enrolled in this school. The Red Cross was suggested as a source of transportation and I was able to secure this service. I always like to do things for myself and was glad that, even though I was incapacitated, I could still continue to make plans for myself.

A friend of mine rigged up some iron bars for me so that I could practice walking
at home in between my lessons, which I had twice a week, and the physical therapist came the other days so that I would not forget what I had learned. By this time, I no longer had any need for bedside nursing, but I still kept up my friendly relations with the nurses at the hospital.

About every six months I had to be readmitted to the hospital for further treatment, but now it was like going to my “home away from home.” I knew that I would find my nurse (I always had the same special nurse) understanding, friendly, and ready to meet whatever situation should arise.

It has been my good fortune to live in a community which is organized to provide the resources to meet my needs and to which I was referred when I was ready for the next step. All patients in other communities may not have the same resources available, but I am sure the nurses in the hospitals would be able to direct the patient to whatever resources are available.

**Nursing Education Meets Society’s Needs**

**JANE S. BRAGDON, R.N.**

The hospital is rapidly becoming as much a community agency as the other neighborhood groups with which we are all familiar. However, this attitude toward the hospital is a new one and is not altogether universal. Too many adults today still consider a trip to the local hospital the last thing which they want to encounter in the course of an abnormal state of health, and children still harbor fears about nurses and doctors. These feelings must be overcome if we, in hospitals, are to meet our community responsibility adequately. Through education for nursing service we are approaching our goal, and with continued advances we may realize shortly that the hospital stay can be remembered pleasantly. When this ideal is satisfactorily achieved the hospital will be an integral part of everyday living.

In order to consider society’s need for nursing service, it is necessary to examine some of the needs and then outline briefly how we, in nursing education, are preparing our students to help those members of society who become “our patients” to get the nursing service which they require. The necessity for understanding ourselves first in order to understand others better is one of these requirements. When one works closely with people it is of paramount importance that this need is realized and met not only among ourselves, but with the patients who are depending on our skill and knowledge to help them to return to the society in which they live. We must, in other words, help them to understand themselves and others.

Very early in the program of the student she is directed to evaluate herself and her own behavior in order that she may understand better the reactions of others. By doing this she begins to see the answers to some of the difficult problems which she has encountered and will continue to meet. Insight and understanding begin to evolve and the student finds that discussions with patients become purposeful both for herself and for the patient, and that this information often augments the nursing care which she has given previously. Reactions which heretofore she either didn’t understand at all or which she interpreted incorrectly now take on significant meaning and she feels more confident in redirecting the patient’s ideas.

Another need of society which is apparent is the knowledge and understanding of one’s own community, its inhabitants and their customs. All of these contribute to a broader understanding of each other. If the student is to provide nursing service which will meet the requirements of society, she must be cognizant of community problems in general and specifically. She must be aware of what they mean to her and to her patients, and realize that the patients will look to her for guidance in some of these areas.
Usually in the first semester's work, the student is given the opportunity to learn about her home community and the one in which she is living while learning her newly chosen profession. Many mistaken ideas are brought forward and corrected; allied groups are studied so that customs and habits which differ from hers no longer seem unreasonable as she encounters them in the daily care of patients. Religious and racial differences are discussed in order that understanding may take the place of ignorance and superstition. Through this kind of learning the student gains more confidence as well as additional knowledge. Both of these will serve her well in her relationships with patients who need her special kind of care.

To remember that the patient is a person is a real need in the nursing service of today. The consideration of this point is a prominent feature in nursing education, and gradually we are realizing the full development of this idea. Almost from her first day in a school of nursing, the student learns about the care of the "whole patient." Comprehensive nursing care becomes a byword. At first, these three words sound very impressive, but gradually they take on special meaning as each student strives to give just that kind of care to every patient. In the actual teaching program, comprehensive nursing care is emphasized by means of the so-called integrated course. Here the teaching is presented to the student in such a way that it helps her to see the patient as a person and to realize that he is a person much longer than he is a patient. No longer is the disease condition presented as an isolated problem; instead, the person who is admitted to the hospital with a particular condition is presented to the students. This kind of visual aid cannot be surpassed in its value in the learning process.

The replacement of fear with intelligent interpretation is a particularly important need of society which can be met through alert nursing service. As the student progresses in her education, she acquires more and more valuable knowledge about the care of patients. At all times she is reminded how she can do the most to help the patient and his family. One way in which she can be of real service to the patient is by helping him to overcome fears which may have existed prior to hospital admission or have developed since, perhaps during his visit. For it is these fears which contribute toward the patient's attitude about the hospital and his stay in it. The suggestion which has been made recently in nursing education for meeting this need is to talk with the patient to discover the source of his apprehension. The inability to find the time to do this is frequently reiterated by the nurse in the clinical field. However, if the student is taught and shown how to make use of all opportunities to talk with the patients, it becomes easier to "find the time" and most fears can be discovered and conquered.

Effective nursing care is perhaps the utmost need of society. This, of course, is the desired result of all our programs. That the student learns the basic knowledge necessary, goes without saying. However, learning the special aspects of nursing in order to be a more valuable member of the health team is another problem. As the nurse works with the doctor, the nutritionist, the social worker, she finds her rightful place and makes her unique contribution to the total care of the patient. If the nurse is to carry her share of the responsibility she must not only be prepared to participate intelligently in her own area, but she must also have an understanding of the functions of the other members of the team. Therefore, throughout the curriculum, members of the hospital personnel are used as guest lecturers, each presenting his relationship to patient care. By means of this kind of planning, the student learns the role of the hospital chaplain; that the field of social service is broader than a source of financial aid; that the nutritionist does not plan meals on a large scale. She begins to realize that as a nurse she is a public relations agent in disguise.

Aside from the special skills and technics which the student learns, perhaps one area which proves to be of particular value is public health and its relationship to
NURSING EDUCATION MEETS SOCIETY'S NEEDS

the care of the patient in the hospital. Social aspects of health and disease are two other areas which prepare the student to meet some of society's needs presented to her as she cares for her patients. Problems such as home care, changing causes of death and illness, age as a factor in health and disease, and health education are a few of the ingredients of this sphere of student education.

The community resources and agencies should be thoroughly studied and understood by the student. Some of the ways in which this may be done are: special projects, field trips, guest lecturers who will explain duties and functions, planned reading assignments, and observation with agencies, including pre- and post-observation conferences to absorb the maximum benefit from the experience. In addition, these conferences, held in groups, allow for the interchange of ideas, which is definitely healthy for minds which are yet malleable. This kind of preparation, coupled with the fundamental nursing principles, aims to prepare the student to give the kind of nursing care which society is demanding as it increases its contacts with hospitals through health care plans.

If the nurse is to give service to the "whole patient," as has been mentioned previously, some plans for future care must be made. Care after discharge, or home follow-up, is another need of society which can be met through education for nursing service.

At times it is somewhat difficult for us who teach nurses to help them to understand that the length of time the person spends in the hospital is quite insignificant when compared with the time the same person enjoys good health. Nevertheless, the point is most important if we are to teach the nurse how to stress to her patient the necessity for remaining healthy once he has returned home. Oftentimes the student tends to isolate her thinking to the hospital experience, forgetting the fact that the person had been living a supposedly adequate life before hospital admission and should return to that life after discharge. It is quite natural for the student to do this, for it is the hospital which she knows best and in which she feels most secure, and she therefore thinks the patient must also find the hospital that kind of a place. She usually does her very best to teach the patient all about the hospital and his care therein, but she needs some special guidance to go beyond this or to think back to the time when the person was not in the hospital.

Through the interpretation of an interagency referral plan, if one is in operation, the student can help the patient to continue his care which may be currently needed and, too, can help him to become aware of the presence of the agencies whose aid he can seek to remain healthy. The hospital referral plan, what it means, and how it functions should be explained carefully to the students. The public health coordinator may do this as she works with the student by teaching the actual mechanics of the system as well as by indicating various types of solutions to problems through methods other than the referral plan. Because the nurse spends more time with the patient than any other person caring for him, she can best initiate this referral which should start him on his way back to his previous life. Moreover, through the use of the referral system, the student considers the patient, his family, his occupation, and any problems which he may have. This referral to an outside agency should start while the patient is in the hospital, thus assuring continuity of care once the patient is ready for discharge.

Another need which may be felt by the person, as a member of society, is appropriate consideration as a member of a family and a member of a community as well as an individual. At the outset of caring for a new patient the student is "family conscious." This has been stressed to her in the classroom; it has been vitalized in her relationships with patients and their families; it has been re-emphasized in studying the patient’s medical records. The student is often asked to discuss this aspect of patient care in a ward teaching class, and she may be assigned to write a family care study.
In varied ways the nurse is aware that the patient rarely exists without a family and does what she can to include the family in the plans for the patient.

It would indeed be remiss in an evaluation of any part of the nursing curriculum to fail to mention that the details of teaching the patient per se cannot be separated from nursing care. This has not been considered here as a particular need of society, because it is felt that opportunities for the giving and receiving of health education and guidance are available to the nurse and to the patient and his family during every contact with each other.

These needs which have been discussed are only a few of the many which could be suggested for fulfillment through effective nursing service. The mechanics for meeting the requirements may or may not be applicable to all programs, and, doubtless, others might be developed which would likewise prove valuable. However, in either case, the methods used should prepare the student nurse to be instrumental in initiating a continuity of care which will help the hospital to bring into concrete existence its responsibility as a protector of the public's health. If we, in hospitals, can perform this one function thoroughly, we can greatly influence the personal usefulness of the individual who comes to us for the re-establishment of health and life's happiness.

**PROGRAM MEETING**

**Wednesday, May 9—10:00–11:00 a.m.**

**WHAT IS SOCIETY'S NEED FOR NURSING SERVICE?**

*Presiding: Eugenia K. Spalding, R.N., Associate Professor, Division of Nursing Education, Teachers College, Columbia University, New York, New York*


**OUR NURSING NEEDS**

*MARGARET G. ARNSTEIN, R.N.*

What is society's need for nursing service? This is a question we are increasingly being called upon to answer in the state-wide and regional surveys that have been conducted. By now, 28 surveys of nursing needs have been conducted in every part of the country. More are under way. They have varied as widely as the states and communities conducting them in the immediate reasons for which they have been undertaken, in their scope, and in their results.

All, however, have shared a single purpose—to appraise present local nursing resources in order to improve them and in order to enable nurses to make a maximum contribution to the health of the community. All of them have sought to determine how many nurses the state actually has and how many it needs for effective functioning in the foreseeable future. And all of them have yielded certain almost identical general findings: an over-all shortage of nursing personnel; insufficient specialized training in such fields as mental health, tuberculosis, and nursing in rural and nonmetropolitan communities; and a frequent lack of diversified student experience.
Before the surveys were made, we all tended to assume that when we talked of "need" and of "nursing service," we were talking the same language and were agreed on the meaning of these terms. But very early in this program we were brought right up against the problem of definition. Like "Alice in Wonderland," we had to be sure that we not only meant what we said, but that we said what we meant. And, for our work and our reasoning to make sense, we did have to thresh out the meaning of those terms.

In relation to need: society—the community—the group—may be compared to an individual. Let us consider "need" in terms of ourselves for a few moments. Do you want everything you need? And, conversely, do you need everything you want? Examples of this kind of conflict confront us at every turn—in ourselves and in the people we encounter.

Think of the thousands of overweight people who should lose weight not merely to satisfy their vanity but to combat real illnesses; yet their love for rich foods—or just lots of food—is so strong, or their need for the compensations furnished by food is so great, that vanity and health both go by the boards, and basic needs are superseded, if not ignored.

There are the children who prefer taffy and popcorn to the milk and vegetables they may need—and I am not referring to children who are feeding problems. There is the alcoholic who needs Vitamin B₁ and reaches for another drink. There is the girl who is tired and needs rest but still prefers to go dancing. The children are completely unaware of needs. The alcoholic misinterprets his need. And the girl who wants to go dancing faces conflict about needs.

Likewise, a community, city, state, or nation may suffer from a lack of essential health services of various kinds but may either not recognize such needs, choose not to recognize them, be in conflict about them, or refuse to expend the effort or the money to get them.

The awareness of nursing needs is different at different times and for different people. If one is lying in bed ill and in pain, the awareness of need for nursing service is very keen. Limited family funds may be expended for special nurses in order to provide for this acute need.

The members of a survey committee sometimes find themselves acting as dual personalities. While conducting the survey and concentrating their full attention on the health needs of a community, they may feel strongly that the needs should be met and that the community should expend money to accomplish this. A month later, however, in their role as taxpayers, the very same persons may vigorously protest the proposed increase in real estate or income tax rates which would give the necessary funds to carry out the health program.

The citizen who is not on the committee, even the one who paid for private duty nurses when he was sick, may be irritated more often by the holes and bumps in the road he travels daily than by the shortage of nursing service that rare time when he gets sick. So he approves a road repairing scheme, but he disapproves a proposal for an increase in the city health department or hospital budget, and he gives little to the community chest which supports the voluntary hospitals. Transportation and health services are two real community needs which must be balanced, and it is often difficult to determine which should take precedence.

Then, of course, there are those who are opposed to any raise in taxes for any purpose on general principles. They need the money for food and clothing; they want it for television sets, movies, ballgames, and other recreation.

We, who are interested in health services and have such a real and solidly based conviction of their efficacy, tend to be critical of those who don't see eye-to-eye with us on health needs. Yet, everyone needs play as well as "what is good for him" by our lights—and, indeed, play is good for him by our lights too. People need good
roads, good schools, proper police protection, and even the freedom to pursue their economy drives—that, of course, doesn’t mean victimizing the community with them. Deciding what proportion of a personal or community budget should go for the various essential items is always a difficult task. What’s more, it is not desirable that such budgets should be organized along identical lines for all individuals and all communities.

In the state surveys, a differentiation has been made between need and demand. "Need" has been defined as the service people should have according to standards set by the profession. "Demand" represents society’s wish for services and is measured in terms of money appropriated, budgeted positions, or requests for services for which individuals or groups are prepared to pay. As I have indicated, demand is highly variable, depending on experience, prejudice, standards, and even previous commitments. It also depends on the play of these factors on the people who are most vocal and influential in the community. There is often a wide discrepancy between need and demand when they are defined in this fashion—the difference between what is required and what is wanted. One of the functions of the survey is to bring these two closer together.

If now we turn to the various interpretations of "nursing service," we find equally wide variation in the mental picture conjured up by these words by different people. Perhaps the most common definition would be in terms of hospital nursing service. For many, this includes the staff nurse, the auxiliary nurse, and perhaps the head nurse. More people have some experience with hospital nursing than with any other branch of nursing service. However, the school child may think only of the school nurse; the labor union leader may think primarily of the industrial nursing service; and those who have known the services of a public health nurse may think only of this group.

This mental picture is colored not only by frequency of experience but by intensity. If we are sick and miserable in a hospital, the adequacy or shortage of nursing care will be very forcibly impressed on us. The experience will leave a much deeper imprint than might a contact with a public health nurse who was pointing out the importance of immunization for our children.

There are other influences at work also—for example, everyone tends to push aside the unpleasant things in life. Thus, if we do not have a friend or relative in a mental hospital, we conveniently forget what we have heard or read about the needs in that area so that the words "nursing service" may not even evoke the picture of nursing in that type of hospital. One could go on with many illustrations of this type, but I will leave it to each of you to supply your own.

Next door there is a symposium going on discussing this question of need, and of nursing service from the viewpoint of evolving health care plans. This is one aspect of the total problem which must, of course, be included in consideration of state and regional plans.

While I will make no attempt to analyze what "society" is or how it functions, we might just have in mind that it is made up of many different kinds of people and groups with differing, and even competing, interests. We must also remember that nurses are part of that society, and the nursing groups have interests which compete with some of the others.

With these concepts in mind—the variability in people’s needs, their differing ideas as to what constitutes nursing service, and the conflicting pulls of society on our human and financial resources—let us look at the part state surveys have played in planning to meet society’s need for nursing service.

The undertaking of a state survey is a tacit acceptance of the fact that broad planning should precede development, that patching one hole at a time is not the best way to make the garment fit the rapidly growing wearer. Therefore, the state looks at its nursing situation as a whole and plans for the whole state rather than letting each city or county try to make local plans to meet immediate local needs. Even the state is not a big enough area for certain types of planning, and, therefore, states have
formed regional groups and are planning for higher education and special facilities on a regional basis.

Although the desire to make a state-wide survey may arise for different reasons and may first be initiated by one group, eventually many groups become involved. The organized nursing groups are usually the initiators. They may be well aware of certain needs but may wish to stimulate the demands of the citizens of the state so that the demands may more nearly approximate the needs as seen by the profession. The survey may be conducted to answer a specific question, such as whether a university school of nursing offering a basic program should be established or whether practical nurse programs should be started or expanded. The data necessary to answer such questions are much the same in type and scope as that required for more general purposes, such as the determination of the state's needs for nurses.

The survey is conducted in such a way that the people of the state take part in the collection and analysis of the data. As they engage in this activity, they become aware of many needs which they themselves have never felt in their own lives, and they are more ready to demand that these newly realized needs be fulfilled. They come to appreciate that "the entire community has a responsibility for supplying its own needs, whatever they may be. In relation to nursing service, the community is responsible for providing sufficient funds and support for nursing education and nursing service so that its needs may be met. Once these conditions have been met by the community, however, it is primarily the responsibility of the nursing profession to meet the nursing needs of the population. The philosophy of the conduct of the study is based on this combined responsibility of the profession and the community."

It is generally recognized that many segments of society—many more than just the nursing and medical groups—are involved in nursing problems and surveys. This is evidenced by the fact that every state survey has been guided by broadly representative committees. The members of such committees bring to the committee discussion the entire gamut of awareness of need for nursing service, and they bring different experiences in health and sickness. At one extreme end of the scale might be a member of the state budget committee who has never been sick a day in his life nor had any personal experience with illness. Besides, he is battling constantly in an effort to keep down costs in the state government. At the beginning of the survey, he probably represents the lowest awareness of need to expand nursing services. At the other end of the scale is the director of nursing service of a hospital who wants to give the patients good care but has too few nurses to make this possible. In addition, she faces the problem of a high staff turnover rate which appears to be due primarily to the fact that the staff is overworked and pressed and therefore unwilling to stay for any length of time. She very likely represents the highest awareness of need for increased nursing services. These, of course, are merely examples, and both ends of the scale could be illustrated by many persons with other experiences.

In working together, the various members of the committee come to appreciate more fully the needs of the groups with which they were not previously acquainted. The budget-minded officer comes to appreciate the fact that nursing needs are worth the money. Those who have happily been spared illness appreciate the problems it constitutes for those who have coped with it or for those—like themselves—who may have to cope with it. On the other hand, nurses who have been absorbed in their professional problems get deeper insight into the competing demands of society for many services besides health or nursing service. The recommendations of the survey seek to achieve some equitable balance among such conflicting pulls.

How does a state-wide nursing survey proceed to solve some of these problems, to reconcile need and demand, to bring diverse community elements closer together, to

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achieve willing compromise, to avoid forced concessions? First, they get at the facts. They count the number of nurses actually practicing in the various fields of nursing—in hospitals, in public health services, in industry, in private duty, in doctors' offices, and in nursing education. Are these numbers enough? This question can't be answered until more spadework has been done. The committee has to find out the number of hospital beds in the state and how many patients occupy them; the number of industrial plants and how many workers they employ; what the population is in the cities and counties. This census-taking job gradually develops more meaning as you relate the number of nurses on hand to other factors; to the number of people who need nursing service and to currently accepted standards of patient care. When these ratios have been worked out, you have a picture of present supply in relation to current need.

At this point, we are again reminded of the discrepancy between need and demand, and we find further familiar examples of it. We all know there are hospitals and counties where budgets are insufficient to employ the number of nurses required according to our present standards—where need exceeds demand. On the other hand, demand rises above the need when patients continue to employ private duty nurses even though they no longer require such nursing service. Market demand can be ascertained by obtaining facts regarding the number of vacant positions listed by health agencies and the number of unfiled calls at the registries.

Let us take a glance at some of the needs which have been manifested in the various state surveys. I touched upon them very briefly at the beginning of my talk. The list will be no surprise to most of you, although the extent and variation in the needs in the different states may be astonishing to some.

Turning first to numbers of personnel, we find that all but one survey has shown a need for more professional nurses of all kinds. Most of them have also shown a need for more nonprofessional nurses, although in two there were more nonprofessional workers than were needed according to the standards selected by the committees.

The greatest shortage, percentage-wise, is in mental hospitals, with the next greatest shortage usually in tuberculosis hospitals. Still speaking percentage-wise, public health in most states comes third on the list.

The standards of service in industrial nursing are not clearly enough defined at present to indicate the need in this field, and we do not have any way at present to measure the need in doctors' offices. Reports from nurse registries and questionnaires give us some indication of the need for private duty nurses. In a few states, there is clearly an inadequate number of private duty nurses, but in most cases it has been difficult to estimate the extent of this need.

When we turn to needs in terms of preparation of personnel, we again get few surprises. Most states have agreed that instructors in schools of nursing should have at least the academic preparation represented by a bachelor's degree and that supervisors and head nurses should have preparation beyond basic nursing in the field in which they are supervising. Judging by these standards, we find a high percentage of unprepared instructors, supervisors, and head nurses in schools of nursing and hospitals. There are states where only 25 percent of the instructors have a college degree and others in which 87 percent have this much preparation. Again, if we accept the standard that public health nurses should have preparation in this field, we find a range of 13 to 85 percent of staff nurses who had this preparation, while the range for supervisors is 60 to 100 percent. How shall we, then, bring prevailing practice up to standard?

In drawing conclusions from limited figures, we must watch out for dangerous pitfalls, for numbers alone do not give us a complete picture. The whole matter of degrees bears very careful examination and the constant application of independent judgment. For example, the state or school which can point to a high percentage of its faculty with academic degrees cannot relax in a self-satisfied manner at that point. All this shows is that its instructors have a minimum of the preparation needed. We are all
aware that the mere acquiring of a degree does not automatically make a good teacher. Academic degrees measure what the teacher has learned, not necessarily what he can effectively teach.

Therefore, more information is needed to appraise the quality of teaching than how many degrees the teaching staff possesses. We should know what the students learn in terms of factual content, of attitudes, and of enjoyment in the learning. We should know whether they are learning in such a fashion that they can keep on learning and growing.

It is easy to fall into the same kind of pitfall in appraising the nursing education system in the state. The state must know more than the bare fact that all students have experience in tuberculosis and psychiatric nursing; they must know what kind of experience it is, and what the students learn. If it is not a good experience, the students may learn exactly the opposite of what is desired. They may learn to be fearful of nursing psychiatric or tuberculosis patients. They may learn to dislike these services. They may learn poor ways of dealing with such patients rather than all the things that you who are gathered together here know they should learn.

- The state in which a high percentage of students pass their state board examinations can take some satisfaction in this record but it is a minimum achievement. Certainly, students must pass such examinations, but a high mark on examinations only indicates the absorption of factual knowledge and does not reveal whether these graduates will give thoughtful understanding care to their patients. We must look further to different types of studies for an appraisal of the other factors in success in nursing.

After the state survey committee has gathered its facts, it is faced with the problem of estimating the needs. If you will review in your minds what we said at the beginning of this talk on the subject of need and demands, the difficulty of this task becomes apparent. There are problems and possible pitfalls here, too, particularly in terms of estimating future needs. We do not know what changes in medical practices will be occurring in the next ten years. For example, think of the changes that penicillin has made in nursing practice. We do not know whether future changes will influence the amount and kind of nursing care needed. The present “standards” we use are based on present practice in good organizations. Studies which are now in progress may give us more reliable and solid foundation for our standards, but, in the meantime, we must take some steps forward, so we use the best information we have. We do not know how much nursing care would be needed if we met adequately all the physical and psychological needs of our patients; therefore, the estimate of needs as given in any survey should not be considered the final answer. Continuous active appraisal of changing conditions and their effect on the needs for nursing service should be carried on. New data and the modified recommendations necessitated by them could be attached to the survey report and used as the years go on in place of the original recommendations. The survey committee might even decide to do this regularly once a year. This would avoid the possibility of the survey being forgotten or of the data and recommendations solidifying as of the year it was made.

Recommendations will be carried out to the extent that the members of the survey committee have been actively engaged in collecting data and making decisions. In this fashion, the committee members become identified with the needs which the survey brings to light. Unless this participation and identification occur, the survey is apt to find a peaceful resting place in a file drawer.

If we were to accomplish all the things which the nursing surveys have recommended, we would indeed have done a Herculean job. We all recognize, however, that changes in social patterns, acceptance of the necessity for additional appropriations, and changes in attitudes take a long time to achieve. No one looks for quick results, but everyone feels that progress is being made if there is continued interest and activity and effort to carry out the recommendations. Some of the state surveys were conducted long enough ago—four to five years ago—that the communities have already been able to
take some steps recommended by the survey committee. Each of you knows the steps taken in your own state, but you might be interested to have a sample of activities from other states.

In each of two states where no university facilities for nurse education were located within the state or near by, funds were appropriated for the establishment of a state university school of nursing. In several states where nurse students were receiving no training in the care of psychiatric and tuberculosis patients, field coordinators have been appointed who are already arranging these affiliations for all student nurses in the state. Many schools have added public health experience as an integral part of the basic curriculum. Institutes and short courses have been provided to bring head nurses, supervisors, and instructors abreast of developments in medical science. Elsewhere, state funds have been appropriated to provide scholarships for advanced training for graduate nurses.

In certain states, the survey revealed an urgent need for the expansion of practical nurse training, and plans are under way for the establishment of schools of practical nursing. Not all states have been equally successful.

This is by no means a complete list, but even this partial list is encouraging. It is encouraging because most of the surveys have entailed significant community participation, and most of them have served as a springboard for specific action.

The most encouraging aspect of these surveys, however, is the fact that they usually come from the nursing profession and are a measure of its maturity. They reveal our growing ability to appraise ourselves objectively and to participate in larger community planning projects. To the extent that we do so, we are really doing our utmost, not only as nurses but as citizens, to meet the basic needs of society.

**STUDENT NURSE LUNCHEON**

**Wednesday, May 9—11:30 a.m.–2:00 p.m.**

*Presiding:* RUTH KATZ, Student Nurse, Beth Israel Hospital School of Nursing, Boston, Massachusetts, and Chairman of Activities, Massachusetts State Council of Student Nurses

*Speaker:* J. WENDELL YEO, Ph.D., Professor of Education, Boston University School of Education, Boston, Massachusetts

Dr. Yeo spoke on the subject "Student Leadership."

**DEMONSTRATION SESSIONS**

**Wednesday, May 9—2:00–4:00 p.m.**

PREPARING FOR QUALITY NURSING

Demonstration sessions on various aspects of nursing education were held in four Boston Hospitals.

At the Massachusetts General Hospital, a panel discussed "Teaching Implications Arising from the Referral Plan." Ruth Farrisey, public health instructor at the Massachusetts General Hospital School of Nursing, introduced the subject and pointed out the particular educational needs of student nurses who receive their clinical learning
experiences in a hospital where an active referral system is functioning. Other panel participants presented the history of a patient from the viewpoints of the head nurse, the hospital social worker, and the community nurse of the visiting nurse association. The final speaker was a student nurse who summarized what the referral of a patient from a hospital to a community agency can mean in terms of better medical and nursing care.

At the Massachusetts Memorial Hospitals, five students at the Massachusetts Memorial Hospitals School of Nursing participated in a symposium on "Bedside Teaching in Cardiovascular Disease." The medical, nursing, dietary, psychosomatic, and public health aspects of care were discussed in relation to a patient who was known to all the students. The public health aspects were presented by a student who was receiving experience, under affiliation arrangements, at the Boston Visiting Nurse Association and who knew the patient's family. This ward teaching hour was a part of the regular weekly program. Dorothy Mitchell, clinical instructor in medical nursing at the Massachusetts Memorial Hospitals School of Nursing, was the leader, and the group attending included all students assigned to the medical clinical area.

At the Children's Hospital, there was a demonstration session on "Nursing of Cancer in Childhood" which was illustrative of the symposium method of instruction as used in the clinical teaching program of the Children's Hospital School of Nursing. Muriel B. Vesey, director of the Children's School of Nursing, presided. Dr. Sidney Farber, chairman of the division of laboratory and research, spoke on "The Social Significance of Cancer Research," and Ethel Trafton, supervisor of clinical instruction, presented the subject, "The Symposium as a Part of the Clinical Teaching Plan." The participants in the symposium and their subjects were: Dr. Rudolf Toch, research fellow in tumor therapy—"The Patient and His Family"; Lois Jenkins, head nurse in the tumor therapy division—"The Nursing Care in the Hospital"; Constance Dunbar, supervisor, orthopedic divisions—"The Orthopedic Aspects of Care"; Marion Hall, director of the social service department—"Social Service Aspects of Care"; Elizabeth Jackson, head nurse in the tumor therapy clinic—"Follow-up Care"; Dr. Dane Prugh, physician to the Trenton psychiatric unit of the Children's Medical Center—"Emotional Factors."

At the St. Elizabeth's Hospital the session on "Teaching Obstetric Nursing in the Clinical Situation" included a discussion of how to teach the mother good, practical home care of herself and her baby, and, in so doing, to utilize patient education as a learning experience for the student nurse. A pamphlet which is given to mothers was thoroughly discussed, and one of the students at the St. Elizabeth's Hospital School of Nursing gave a baby bath demonstration. The session was also attended by a few mothers. The leader was Rose A. Malamphy, clinical instructor in obstetric nursing at St. Elizabeth's Hospital School of Nursing.

**League Dinner**

Wednesday, May 9—7:00–10:00 p.m.

**Presiding:** LYNDON M. MCCARROLL, R.N., President, Massachusetts League of Nursing Education

**Invocation:** RABBI CHARLES FREEDMAN, Director, Hillel Foundation, Boston University, Boston, Massachusetts

**Speaker:** LUCILE PETRY, R.N., Assistant Surgeon General, Federal Security Agency, Public Health Service, Washington, D. C.
FIFTY-SEVENTH ANNUAL REPORT

SETTING OUR SIGHTS

LUCILE PETRY, R.N.

The dynamic push that is America is breathtakingly accelerated. The frontiers of that push are global. Suddenly, we are a world power and at the same time a leading exponent of a way of life in which freedom to think, invent, create is paramount. And our way is set off in opposition to another in which these freedoms are violated. The struggle is gigantic, and, if we lose, mankind’s centuries-long progress will be set back to an unknown date in the dim past. The struggle is so tightly drawn that our mere survival is in doubt. Our major source of strength is the trained intelligence and resourcefulness of our people, the very product of our way of life.

We find ourselves in a maelstrom of events and ideas. We seek a course toward a goal. The goal? Securing the opportunity for man to create according to the best that is within him—for ourselves and free peoples everywhere; and securing this state of affairs without a devastating war if that be possible, this is our goal. The best our leaders promise us who live in this nation is a long period of international tension during which we may hope for peace but be ready for war. The readiness itself is a means of maintaining peace.

This is our setting tonight. What does a profession like nursing throw into this world-wide effort?

The responsibility of a maturing profession is to size up the situation realistically, make decisions regarding steps to be taken—this with a broad view of interrelated elements—and then lead in action. We, in the nursing profession, have specific responsibility to meet the needs of as nearly all our people as is possible—needs for the whole variety of health services which fall within our province. In such times as these we must work toward our goal—a better chance of health for every human being, as Florence Nightingale termed it—in such a fashion as to demonstrate that democracy works. And, too, the members of a profession have an obligation to be among the multiform nuclei of morale stabilizers, maintainers of faith in these times when uncertainty is hard to tolerate, when panic will sometimes threaten us, and when the long haul seems grudgingly discouraging.

And so we set our sights. Perhaps a better way of saying it is that we face reality. Let us select just two related realities for analysis and then discuss a few of the means of progress toward the goal we sight.

The first reality is the necessity for provision of all kinds of services. This year, in comparison with three years ago, shows additional necessities—those of military service and civil defense. These times call out for emphasis on industrial safety and health, on rehabilitation, on health for migratory agricultural labor; and for early diagnosis, for rapid therapy, for prevention, and for promotion of an optimum standard of health which makes our people strong and psychologically less vulnerable. There is no need here to enumerate all the demands, old or new, upon nursing services.

Facing the situation realistically, let us ask ourselves what proportion of our total nursing personnel should be found in each of the various categories which, when combined and coordinated, give total service. We hear much about the spectrum of services needed. How many blue-indigo, green-yellow, red-orange nurses do we need? What proportion of the total can perform effectively with in-service training only? Here we are speaking of auxiliary personnel who have no pre-employment training. At present, of the more than 300,000 persons engaged in giving nursing care to a million and quarter patients in hospitals, practically half have had only in-service training, much of it sketchy indeed. Is that proportion satisfactory? Having done some hard-headed thinking, and deciding that X number of these workers are needed, we think next of the in-service training they need. We hear a great deal about what can be learned from industry in this respect. What nurses are learning these tested
and effective methods? What universities are preparing nurses for optimum use of in-service training methods for nearly 200,000 workers who have close contact with our hospital patients?

We know that this problem is also a major concern of hospital administrators, singly and organized. What committees, national, state, or city—representing both interests—are active? A few of us hear in passing that a hospital in Ohio or Rhode Island has excellent programs—but who knows about them? We hear of the lovely older woman who has been a faithful and useful auxiliary worker for years—but where will Detroit find 1,000 like her?

And as we plan the good in-service training programs we are likely to find that, for some positions, the amount of training needed is so great as to warrant pre-employment training. How does this dovetail with the 6 to 12 month practical nurse training program? We have been planning practical nurse training in relation to professional nurse education. This other relationship needs exploring too.

Here is an example of a hard reality which the nursing profession and hospital administration face together—one of our major propositions if we face our total responsibilities. The potential rewards in terms of improved service are a gold mine awaiting our digging.

The realistic problem in practical nursing today is that of proper utilization of the trained practical nurse. I will leave to your imagination the 20 questions which an analysis of this problem entails.

What proportion of graduate registered nurses are needed for direct services to patients in hospitals, public health agencies, doctors' offices, and industry? Remember the 1½ million patients in existing hospitals and the new hospitals under construction as well as the 150,000,000 people for whom expanding public health services are to be given. What proportion of the total number of graduate registered nurses should be in what I shall call directing services—supervision, administration, consultation, research, planning, writing? On the answers to these two questions depends, in part, the decision as to how many graduates from degree programs are needed. Parenthetically, may I say that any of you who are relieved that this discussion has now come a little closer to an interesting problem are not realistic. How realistically have we planned for the known decrease until 1958 in high school graduates who are our candidates? What do we know of the magnitude of the competitive demands of mobilized industries year by year for these same candidates?

What proportion of students should enter degree programs? Let us venture a guess at from ¼ to ½. How many such programs are needed to admit this ½? What is the significance of the fact that many such schools now in existence could double their admissions without doubling their expenditures for instructional facilities and personnel? Since high tuition seems to be a barrier, how can we entice the young woman who was going to college anyway to spend her tuition money in a university school of nursing? And where do we secure extensive scholarship funds for others?

The backbone of nursing service of this country comes from graduates of our diploma schools. How many such schools do we need? To what extent can we save instructional personnel and improve quality of education by centralizing schools, combining small community facilities with large medical center facilities? Will this increase enrollment? What should be the answer of the director of a school with very high admission standards when asked to integrate with those in that school the students from a smaller school with lower admission standards? If she says no, has she a right to criticize the smaller school for existing? Where should the clientele of such schools receive their nursing education?

Can we shorten the three-year program and produce practitioners as good as or better than those now being graduated?

All of these troublesome questions and dozens more in each of these fields and in
the field of graduate education cannot be ignored if we take professional responsibility for facing reality. These questions relate to the reality of making our standards operable as we engage in the process of preparing nursing personnel to meet the over-all needs for service as fully as possible.

A second reality we must face—and I shall deal with it briefly—is that of how nursing education of all kinds shall be financed. We know the present sources of income. To what extent will these sources be affected by changes in program—shortening the diploma program, for example? Where is the substitute income for the value of student service in situations where a decrease in service is proposed? Should we plan to decrease the amount of student service, or should we, for educational purposes, try to eliminate it?

The trend to favor a shift in control from service auspices to educational auspices will not answer this question of financial support but will merely shift the responsibility for financing to other shoulders. Whose shoulders? Have we prepared those shoulders to accept this new weight? How great is that financial weight? And how do we sell nursing education to new sponsors? Can we justify an increase in taxes to finance the schools seeking state and municipal funds? Either those taxes must be increased or tax money now used other ways be diverted to nursing education.

Last week I counted in my experience as a single individual my contacts with universities in the past few months. Nine out of ten university administrators said, "We want this new program in nursing education which you nurses are trying to sell. We will be glad to work it out when you bring the money with you."

A wise man in a foundation asked, "Shall we build a few more schools which are lighthouses—beacons for other schools to follow?" I wondered to what schools are these beacons to beckon when foundation funds can only build beacons. We have all heard the wise representatives of community leadership and the consumers of service who join our deliberations say, "These are beautiful and useful ideas you discuss, but when are we going to come to grips with the real nub of the matter?"

And so here, hard cold cash is another reality to face. I would so much prefer to speak prettily on this charming occasion—speak prettily of new challenges to nursing. Of how health concepts are changing and nursing will follow new patterns. Of new integrations in the curriculum. Of how educators in other fields have come to sense the fascinations of our field. Of ways to elevate educational standards. It is pleasant to formulate standards on paper. Others at this convention have dealt with these subjects and have dealt with them in a practical fashion. I ask only two questions: how can these ideas be put into operation all over the country so that all of our patients and the people we serve will benefit, and who will pay for the educational systems which prepare nurses to carry out these ideas?

I wish to emphasize two promising fields of action much discussed here this week which, if pursued, will help answer these troublesome questions. I refer to studies, investigations, research, and experiments, and to regional planning. The first will give us data and facts and practical bases for improvement of service and education and will answer questions regarding costs. Everyone is encouraged by the amount of study and experimentation which is under way and contemplated. To be realistic in this field we need more nurses prepared to conduct studies and investigations; particularly do we need assistance of other disciplines: statisticians, social scientists, and research designers. We run some danger of wasting money and effort if amateur investigators do not have the guidance of experts in research methods. We have reached the point of nationwide development of studies and researches where we could gain much from sharing experience, using a clearing house, noting abstracts and analyses of research, and having an avenue of publication. The investigators in nursing need to get together and know each other. They need to pool ideas, watch for duplication of projects, lay out in a preliminary fashion the total field to be covered and detect the major gaps in coverage. Isn't it wonderful that we have come so far so
quickly and that progress has already been made toward better planning of individual studies and of the field as a whole? Excitement over our beginnings should stimulate, rather than deter, us from keeping a realistic approach to research. The small funds we secure will multiply if we plan wisely. They will dry up if we turn unscientific.

The second process which will help us solve realistically the two problems I posed—provision of total service and financing education—is that of regional planning. It is a way of sizing up the situation, making a comprehensive plan, and engaging action—the three responsibilities of a maturing profession. Regional planning also has been ably discussed at these meetings. I would emphasize only a few points. Regional planning in nursing should be integrated with other regional planning in higher education, in hospital facilities, in public health, and in other fields. It should be undertaken imaginatively and should produce new ideas; for example, prepaid home nursing care plans and a new system of nursing homes, as well as the ideas which come first to mind. It should help to answer questions as to how educational facilities can be pooled; how economies can be effected; how nursing education at a medical center can influence nursing care in many coordinated agencies and hospitals; which schools should become collegiate. It should give a basis of comparison between states; which states are contributing a desired proportion of youth resources to nursing; what can be done to tap unused resources. It should stimulate educational experimentation. It should facilitate the choice of the most likely sites for development of highly specialized types of graduate education. Regional planning, even more than research, affords opportunity to synchronize and synthesize the contributions, interests, and efforts of related groups. It gives us a chance to invite statesmanship of other disciplines and to engage the backing of those whose support is essential for progress. Here, too, we need experts, those who understand community structure and methods of group work. Regional planning builds a fabric into which services like those of the National League of Nursing Education can fit. Regional planning makes “splendid isolation” and professional provincialism impossible.

Regional planning, too, must remain realistic and must choose first action steps wisely. Surveys of nursing resources and needs which are an instrument of regional planning always bring forth a list of proposed action steps. Choosing from among these the few steps to be taken first, calls for greater wisdom and foresight than any other single problem in regional planning. I remember a chief I once had who exhibited this kind of wisdom on many occasions. When I would approach him with a problem he would ask me to analyze the steps which should be taken in solving it. When I enumerated the five or six steps which seemed to me essential, he would sometimes say that we should select step 2 and step 5 for first action. I would then see that my steps 1, 3, and 4 could be accomplished during the effort of accomplishing steps 2 and 3, and that to begin with my step 1 would have entailed much unnecessary effort. It is this kind of wisdom we must use as we select first action steps from among those proposed after analysis of a situation.

Regional planning takes courage; once we invite reaction we must do something with it. We have faith in intelligence and judgment and that the reactions we elicit from others can be turned to good account. Are we grown up enough to seek even more comprehensive interrelations than those on which we now pride ourselves? Do we dare think in an even larger whole?

Summary

Our sights are on a better chance of health for every human being. Our resolve in setting our sights is to face reality. Two realities were used as examples: the challenge to provide service of all kinds and the need to find ways of financing education. Two methods of progressing realistically toward the goal are: scientific investigations and experimentation, and regional planning. Both at once help us
clarify and achieve our goals. Both engage us in activities highly appropriate to our time. Both are positive, therefore giving us optimism for the job of the professions in these times—that of morale stabilizer. Both give proof of professional maturity. We are a part of that dynamic push that is America. We embrace her obligation to push for freedom. We are united and in union not alone. Wordsworth said:

... Thou hast great allies;
Thy friends are exaltations, agonies,
And love, and man's unconquerable mind.¹

PROGRAM MEETING
Thursday, May 10—9:00 a.m.—12:00 m.

IMPROVEMENT OF NURSING SERVICE

Presiding: Elizabeth K. Porter, R.N., President, American Nurses' Association

Moderator: Rita P. Kelleher, R.N., Dean, Boston College School of Nursing, Boston, Massachusetts

Speakers:
Leo Simmons, Ph.D., Visiting Professor of Anthropology in Medicine, Cornell University Medical College, and Visiting Professor of Anthropology in Nursing, Cornell University—New York Hospital School of Nursing, New York, New York

Harriet H. Smith, R.N., Assistant Professor of Nursing, University of Washington School of Nursing, Seattle, Washington

Lucy D. Germain, R.N., Director, Departments of Nursing and Nursing Education, and Assistant Director, Harper Hospital, Detroit, Michigan

THE MANIPULATION OF HUMAN RESOURCES IN NURSING CARE

Leo Simmons, Ph.D.

It is a rare and somewhat apprehensive privilege to be invited to come and talk to an audience like this—a select group of educators in nursing—with everyone knowing so much more about the subject than the speaker can ever hope to learn. But then it occurred to me that if I were a nurse, even a good one, I probably would not have been asked to speak here at all. Thus was I encouraged to think that perhaps you wished to get a view of nursing through the eyes of a patron and a friend, a plain ordinary person, who is, after all, a potential patient. Therefore, I assume that you would prefer to have me frank and forthright in statement; and that you can be trusted to sort out any grains of wheat which fall with the chaff.

In a hospital it is easy to hear comments from doctors and nurses about "first loyalties," especially the first loyalty of the nurse, which is to the doctor, some think, and others say to the patient. For me there is no question of first loyalty. I identify

¹To Toussaint L'Ouverture.
immediately with the person who is on the receiving end of medicine, the poor fellow on the table or in the bed. It is difficult to do otherwise. I am caught up in a sort of vicarious experience and imagine myself in the patient's place. Thus have I had a lot of ailments lately and suffered some major treatments, even in my dreams.

One may wonder, then, how an anthropologist can wish to spend as much as two or more years of his life in a hospital, and without doctor's orders at that. But this privilege to range freely, day and night, over the floors of one of our finest institutions of medicine has turned out to be a very valuable experience to both the "internist" and his friends—i.e., his associates in the social sciences. There is no doubt now but that he can learn a great deal that will be of interest to them and of profit to himself. The major question that remains is whether he can learn and impart anything of value to the medical and nursing professions that have made his project possible.

To a layman, it is something of an eye opener and ear shock to look in and to listen in daily on the very personal and closely guarded doctor-patient and nurse-patient relationships. These experiences have been shared with me all the way from the sterility clinic, through birth, accident, sickness, death, and finally to the autopsy. Some time, perhaps, to round out the picture, there should be a few rides, as a sympathetic fellow passenger, in the ambulance and the hearse, and also in the family car behind the hearse. This is the drama of life, disease, and death that I am permitted to witness and to share; and from the seamy side at that. And since truth is stranger than fiction, it is these sharp and subtle, as well as blunt and raw, realities of life that have quickened my mind most and opened my eyes the widest.

What I have been able to see with an untrained eye has been impressive, to be sure; but the firsthand experiences that I have been privileged to hear are more important. Mine has been a most rare opportunity to listen daily to the personal accounts of attendants and student nurses, staff and head nurses, supervisors, and the physicians who are willing to share their experiences. But perhaps what the patients have told me is the most important of all. And almost all of these interviews, nearly 600 hours of them now, are recorded verbatim, in confidence, but open and aboveboard. Certainly with such fine cooperation, the cultivation of a listening ear has been much more rewarding than a seeing eye, but the eye, too, has improved. And it is hoped that in due time this accumulation of information will add up to some new knowledge and insights into the problems of interpersonal relationships as they exist in medical care.

Thus, in a sense, anything that I can say to you is really not much more than the echoes of your own co-workers' communications to me, ideas that have been filtered out, synthesized somewhat, and reflected back to you through the mind and the professional experience of a very much favored layman.

Perhaps it is well to point out in a sentence just what we are trying to learn together. To me, and for our joint purpose, the most significant concept in the theory of medical care is the familiar, but as yet inadequately explored and implemented, idea of the whole person adjusting as well as he can to his environment. In the beginning, life starts with the individual and the environment. The individual, even before birth, acts on the environment and the environment reacts on the individual, and this acting and reacting goes on continuously even to the end of the life of the individual at any rate.

Now a very important aspect of these reacting relationships involves people and their responses toward one another. This is true even for the healthy portions of life. Strained and stressful interpersonal relations can hamper, if not spoil, life even at its best. How much more significant become these interpersonal relationships in a setting of illness when they are so often intensified, exaggerated, and overdramatized by the fact that the sick person takes to his bed and his associates gather around him with friendly or indifferent responses.

While in some respects a person's bed may be regarded as a cosy retreat from
stressful situations, in a more important sense, when sick, we go to bed to do battle. Indeed, it is quite rare in stressful therapeutic situations that any of us would really prefer to change places with the patient. Some of the nurses tell me that when stress of duty reaches a breaking point for them, they can and do reinforce themselves by the simple thought that, after all, the situation is much worse for the patient. Then, too, they say, "I am young and full of life and will recover with rest, while so often the patient is old and worn out." Incidentally, I am greatly impressed with what appears to be so many young people, both physicians and nurses, at the bedsides of so many old people in this battle of disease and death. It builds up one's faith in, and appreciation for, the youth of our land.

It was also very easy for me to discover with layman's eyes that, when it comes to illness, there is a great difference in whether the patient goes home to his bed or to a hospital into one of our beds. The prescribed medical care may be about the same, but there is a tremendous amount of contrast in the interpersonal relationships.

In our American traditions, a man's home still is his fortress, if not his castle, and even though he becomes a "patient" there, he still retains a proprietary sense of his rights and privileges, and he can insist on being treated on his own terms. Moreover, he generally is reinforced in these feelings by friends and family sentiments which accord to him special concessions, because of his illness. There is among us in family and community life an attitude and a set of customs which appropriately can be called "the culture of illness" in the home.

Now the significant contrast is that the sick man's personal prerogatives undergo very important changes when he is moved out of his home and his bed and into our hospital and one of our beds. Whereas at home he retained his work-a-day apparel and accoutrements which provided a sense of competence and self-sufficiency, in the hospital all this equipage and the associated symbols of power are stripped from him and locked away out of his sight and reach—or even sent back home. Now, to the degree that such things are said to "make the man," not much, really, can be said for the patient in our routine institutionalized outfits.

Moreover, at home physical surroundings were familiar and afforded a sense of security. Home is a haven the world over, we are told, even if it is no more than the place where a man routinely hangs his hat. But the hospital surroundings are very different, strange, and disquieting to say the least, and this includes some of the smells and the nuisance noises as well as the unfamiliar routines. Indeed, the contrast between the physical environment of the home and of the hospital may be regarded even by the physician as sufficiently upsetting to justify some prescribed sedation, just to numb the patient's sensitivity to the disturbing ward practice, especially at night. Added to this is the general impression which a patient can easily acquire that something very serious is about to take place to call for such an important move.

The social environment changes even more radically. People in white begin now really to rule this man's life, and, not infrequently, they appear to hold his life, if not his death, in their hands. The resident physician can become nearly all powerful (or at least next to God); and a little head nurse is without doubt the boss of the place in all but the major matters of life and death.

Even aides and orderlies find themselves in position to grant or to withhold what are really small but what now become, to the patient, very precious favors. And, incidentally, we know that some of the spoils of the siege, in the form of tips and a certain amount of deep personal gratitude, quite frequently go to these lowly aides and attendants. It was surprising to me to note how often these little people are mentioned in letters of gratitude which patients send to the hospital administrators. It can be observed sometimes, and it is not infrequently reported to me by patients, that the flow of human warmth between these little laymen and themselves can surpass that which is felt between the patients and the professionals. As one patient
put it, "Head nurse So-and-So is really a colonel at heart, and, as for Dr. ——, for all his courtesy, when it comes to treatment he is a cold potato." Perhaps this implies no more than the thought that the culture of illness is different in the home and the hospital, and that the little nonprofessionals in the latter are in a position to manifest more of the homely traits. This is not to imply, however, that the milk of human kindness flows not freely between professionals and their patients. It is merely that the above-described contrast occasionally jolts the naive spectator. No doubt, with adequate knowledge and insight, the apparent discrepancy will disappear.

The fact remains, however, for even the casual observer to see, that the social characteristics of the hospital (or its culture) tend to stimulate a considerable amount of dread and apprehension on the part of the patient. And there is no question but that some of the very necessary treatments can come to appear to an ill-prepared and apprehensive person as not far short of unfriendly intent and even torture. However well-meaning the staff, and however justifiable the treatment, if a patient worries about explanations which are never given or fails to understand them if they are, if he is full of misgivings and emotional sets against the procedure, and if he feels that he has been tricked or coerced into something more severe than was necessary, then stressful interpersonal relationships have already complicated the situation, and they may, not insignificantly, affect the course of treatment. It has been my experience that any impartial observer can easily recognize a considerable amount of fear and sometimes panic on almost any one of our typical hospital wards, and that much of this could be avoided or softened through the skillful manipulation of available human resources in therapy. And, as stated before, it is my opinion that much of this anxiety is stimulated by the contrasting "cultures of illness" as manifested in home and hospital.

Symbols of the contrast between independence and a feeling of security at home, and dependence and an air of apprehension in the hospital are easy to spot in prevailing practice and especially in our conventional terminology. In the hospital, for instance, the patient rings the bell and waits prayerfully for nurse or doctor, while at home the nurse and the doctor ring the bell and wait patiently on the threshold. In the hospital the patient is "admitted" and "discharged" and all the relatives are visitors, if you please, while at home the physician is "on call" and can be "changed," and even the nurse is a visitor. "Orders" are written in the hospital, while "prescriptions" are expected in the home. In the hospital, patients are "pushed" around from place to place with not much time for explanation, but at home they are "led" about with both explanations and persuasions. In the hospital a nurse is "assigned" to the patient, while at home she may be "hired" and "fired." In the home, nurses come and go while the patient stays on, but in the hospital it is just the reverse, with the nurse holding tenure. Perhaps for many people there are few moves in life which are more ominous than the move from the home to the hospital.

An impartial observer of typical ward practice and patient responses to it may have cause to marvel at how docile and submissive our brave, bold, liberty-loving American citizens become when they find themselves admitted to our hospitals and even into some of our clinics. In a sense, it would appear that we Americans are once adults and twice childish—when we grow old and when we enter a hospital.

Perhaps not insignificant also is the fact that, while the patient was at home, he was obviously the sickest person in the family circle and thus deserving of special attention and consideration. Now that he is in the hospital, especially if on a ward floor, there are others who appear to be more seriously ill than he, and they seem to require much more special attention. And although misery may love company, it can be cold comfort to be told pointedly that some of these other patients are "much worse off" and even "so much better behaved and cooperative."

This contrasting symbolic terminology could be carried on into further detail, but its purpose here is only to emphasize the principal point that the challenge of com-
prehensive nursing care needs to be emphasized in the hospital setting even more than in the home, because here the social and cultural forces which call for it are weaker and it can be easily overlooked or forgotten more or less. It can be observed on almost any ward that a staff nurse is able to rely upon much more autocratic and bureaucratic methods of patient management than she could safely get by with in the home. Indeed, it is possible for her to ignore or to ride roughshod over a patient's apprehensions and resentments and yet be rated as a very efficient nurse who "gets things done." She can become an outstanding head nurse without ever approaching the bedside of a patient except on rounds with the physicians, and she may be all but unaware of what is going on in the heads and in the hearts of the diseased and distressed bodies in her charge. Sometimes it is easy to conclude that "headaches" and "heartaches" in our modern hospitals now surpass the physical pains, thanks perhaps to the almost miraculous "pain-killers." This accounts substantially, in my mind, for the increasing importance of the cultivation of improved interpersonal relationships in the very highly controlled hospital environment. And this is precisely because of the pronounced contrast in the "culture of illness" as we learn it in our homes and experience it as patients in our hospitals.

This is not to minimize for one moment the important emphasis that is placed upon physical and biological factors in hospital context. After all, there is a human body, male or female, assaulted by harmful elements or the privations of the physical environment, and the immediate and primary objective is to keep the body alive and to restore it to health. The progress in knowledge and the skills and technics on this level of therapy have become a marvel to behold, and for anyone to play them down is no less than folly.

But there is another level of reactions of equal importance, and, for short, we have called it the level of interpersonal relationships. There is the sick man a person as well as a body. There are powers of personality within him for healing and for health, and also for sickness and death. Associated with him are other persons equally endowed with such powers. We know, and it can be demonstrated experimentally, that the relationship of these persons to one another and to the patient are laden with both constructive and destructive possibilities. Every physician and nurse knows the difference it can make in a sick person to feel rejected and without interest in the fight for life, on the one hand, or warmly wanted and stimulated to live, on the other. The balances here are often pivoted on a fine point, and it is not infrequently the little human touches that tip the scales. A head nurse said of a depressed patient recently, "If only we can get to him, I think we can save him."

In our attempts to explore the therapeutic possibilities of the interpersonal relationships in the treatment of disease, we have deliberately chosen to concentrate on certain of the key characters: the patient, his fellow patients, the physician, the staff nurse, the auxiliary help, the relatives, and friends. From here on in this paper, an experimental project will be described, and discussion will be limited to only three of the principal characters: the patient, the doctor, and the staff nurse.

In December, 1949, a very sick patient, in a period of despondency, jumped from a high window in the New York Hospital and ended his life. This was regarded by certain members of the nursing staff as a default in interpersonal relationships, perhaps by acts of omission as well as commission.

Mrs. Elizabeth Wright, head of the Payne Whitney Psychiatric Nursing Staff, proposed a new program, a Psychiatric Consultation Service for nurses in the general hospital similar to the Psychiatric Consultation Service for physicians. The purpose was not to duplicate but to supplement the physicians' service.

With the sanction and support of the general Nursing Service, Miss Hannah Ziering, a gifted psychiatric nurse, was appointed as consultant, and her services were made available, on call by head nurses or supervisors, to all parts of the hospital.
The plan was designed to provide consultation and counsel to any staff nurses who reported any serious mental and emotional stress on the part of any one of their patients, thus a nursing problem. The project received the approval of the Department of Psychiatry and a certain amount of personal guidance was provided by the director of the Psychiatric Consultation Service.

It was my good fortune to learn about the project early and to provide for ample documentation from the start. In order to illustrate how this service functions, there follows an abstract of the record of one of the very early consultations which occurred just one year ago, "in the old days," as Miss Ziering has said.

The call came for a consultation for Mr. Spark, a cardiac with a long history of hospitalizations, about fifteen times in five years. He was now depressed and considered a suicidal risk.

Since I arrived early, I had a chance to go over the chart and look around on the pavilion. Many comments were made about the patient by persons passing to and fro: doctors, aides, orderlies, attendants, and even the ward clerk.

All had something to say about Mr. Spark. It didn’t matter what he did, nobody approved. He had spilled some urine on the floor, and for Mr. Spark to do it seemed worse than anybody else. A light went on and the clerk looked around and said, "Probably Mr. Spark." The doctor standing by when I reached for the chart had laughed and said, "What do you want that chart for?" A nursing aid and an attendant walked past and one said, "Who do you want to do?" "Not Mr. Spark," said the other. Altogether it was a picture of rejection complete, down to everybody—I’ll bet including the guy who cleaned the floor.

In conference, among the things that the staff complained of were: He made too many demands on them—he was inconsiderate. For example, a nurse passed with a heavy tray. He beckoned and called in a low voice and when she came close to him he said, "Say, whatever happened to old Mr. Collins, remember?" At this point, annoyed, she ignored him. Then Mr. Spark, apparently feeling sad or guilty, wrapped up a few candies in a tissue and sent them out to her. For this further offense, the nurses said, "Does he think he can bribe us?"

And this sort of thing was repeated many times a day. If a nurse came to do something for a patient nearby, Mr. Spark would interrupt her treatment, perhaps a dozen times, they said, to raise his bed just a little, lower it just a little, adjust the shade, pour a glass of water, etc. Those were some of the things he did to annoy the staff. They said, also, that he had a chronic, whiny voice, and that they wished he would cheer up a bit.

Something about Mr. Spark’s history: A shoe salesman, eighteen years with the same company, worked up to manager, described as an outgoing, good-natured, devil-may-care fellow, easy in contacts and once enjoying considerable prestige. A wife and two children.

Illness had begun five years ago with a collapse at a ball game. With the third or fourth stay at a hospital he had become suspicious that his complaint was chronic. With succeeding trips the experience had become more traumatic, and each return to work was more difficult, until just before this fifteenth trip he had been demoted, which was a terrible blow to his pride, as well as unfair, he thought.

Thus he had become discouraged, irritable at home, impatient with the wife and children. In the beginning the wife had been concerned about his illness, and solicitous for his comfort. As hospitalizations had continued she had shown impatience, complained of being tied down, of becoming a servant to him, and with less money coming in. Now she had begun proceedings for a legal separation. She didn’t want to live with him any more, even if he did come home from the hospital. When she visited him, she would begin some statements with the phrase, "If you ever do get out of the hospital again —" Only a sister seemed warm and tender now, and offered to take him to her home. Surprising enough, the nurses had come to dislike the sister, too, and were siding with "this poor wife."

It turned out also, a significant point perhaps, that Mr. Spark was one of six patients in a group in the pavilion. All the other five were more obviously quite ill—more acutely uncomfortable at any rate—so that they got infusions, transfusions,
intermuscular injections, and all sorts of treatments and attention. And they re-
quired more physically, perhaps, while he required more emotionally, which was
not recognized.

Also Mr. Spark had received placebos, sterile hypos for pain, for he sometimes
grunted and groaned so loudly that he could be heard clear down the hall to the
kitchen. Some of these sterile hypos had had good effect, and, to the staff, that
clinched their evaluation of him. It seemed that they had overlooked the fact that
even this fake treatment had had important emotional value to him. When this
was suggested to the staff, they greeted it warily, "You don't really believe that,
do you? Well, maybe so sometimes, but not for Mr. Spark." Thus it looked as
though a successful sterile hypo was helping to make the nursing care more sterile.

Moreover, with this patient it seemed to have just so happened that no nursing
plan had been made out, while there were such plans for the other patients on the
floor. The head nurse was sure that such a plan must have been made up for him
and was surprised that it could not be found. It was suggested that a nursing plan
be made and that it include, among other things, an order that someone talk to the
patient at least every half hour. This was laughed at, hardly acceptable at all,
although it was pointed out that there was a similarity between this and a post-
operative order written on a card to "turn the patient every hour." And it was
pointed out that this would be done religiously, and no questions asked. It was
finally accepted by the staff, grudgingly, as an experiment. It was also suggested
that the staff try to anticipate as many of his needs as possible, and thus cut down
on his requests. But there were reasons against this. "If we change his bed thirty
times a day, he then will require it sixty times."

I think the essence of our conference, which lasted a full hour, was a strain all
around. It was a strain on me to see and cope with the rejection and a strain on
the nurses to accept the suggestions. They frequently pointed out, more often than
was necessary, the obvious fact that it was a busy service, with lots of sick patients,
many obligations, with the teaching of students, and that they really did not have
the time to do these things.

Some days later I was invited to be present when the students presented a patient
in their weekly conference on the floor—it was Mr. Spark. One student presented
the medical history and another the nursing care, and she did a beautiful, sympathetic
job of it, leaving out none of the patient's problems, and stressing his emotional
needs. I was terribly proud of her.

Others of the eleven students in the group contributed what they knew about the
patient and described their relationships with him. They had found that he was
a cheerful man, warm and cordial to them, and even helpful. Several students men-
tioned that on days that they were awfully busy, he would assure them that they
need not hurry to get to him, because he could do so many things for himself. One
day a freshman had several patients assigned to her and had a class and was very
anxious about completing the assignment. Mr. Spark had whispered to her that she
could just pull the sheets smooth on top, no one would ever know that the bed
was not made, that he really had not exerted himself, had not been playing in mud
pies and wasn't really dirty, and if she just gave him the basin he could wash him-
self a little.

That was typical of the relationships with the student nurses. They, on the other
hand, had found him jolly company, were tickled with the order to talk to him
"every twenty minutes," because often when they stopped to talk to a patient they
were considered idle. This was a uniform attitude on the part of all eleven students,
each seemed to be supporting the man, almost belligerently. They seemed to be
reacting to the rejective atmosphere. We did not discuss this openly, because it
would seem that we were criticizing the graduate staff, and that is neither ethical
nor good teaching—it does not serve a great purpose.

The students were really too optimistic. They were sure the plan would continue
to work, that Mr. Spark would continue to respond beautifully, that he would get
well, that his wife would make up with him, and that he would win back the
affection of his children, and his former job. Well, he did continue to respond
beautifully for about two weeks more, when he died.
The possibilities apparent in such a plan were so encouraging that funds were provided by Russell Sage Foundation to free Miss Ziering of one third of her time to concentrate on one of the surgical floors—working along with the staff nurses in order to discover patient problems early in their development and to try out the possibilities of training staff nurses along the same lines. After four months this also proved to be valuable enough to justify funds to secure Miss Ziering for full-time work on two floors, one in surgery and another in medicine, and at the same time remaining on call for consultation elsewhere in the hospital. Out of this experience we have accumulated nearly 200 records of nursing consultation on patient problems, and from them a systematic study will be prepared and published. All that can be reported here are some preliminary impressions, chosen because of their bearing upon our subject, the manipulation of human resources in nursing care.

We certainly have learned all over again that, in practically every patient, however disagreeable he may appear, there are untapped resources in warm, wholesome, and recuperative response, if only we can learn how to elicit them. And there may also be unexpected self-healing powers. The conviction grows upon us that the revitalizing resources of patients as persons are woefully underrated and too often ignored on the wards of our hospitals. We demonstrate daily in our Nursing Consultation Service that when we put our heads together, learn all we can about a particular patient as a person, and skillfully plan a course of action with him, he can nearly always be reached; his spirit can be boosted immeasurably and a cooperative response can be elicited, at least a wink, indicating that he is "game" again and back in the fight with us. Indeed, the surprising fact in patient after patient is that so much can be accomplished with so little effort when it is guided by good insight and skillful planning. There is every reason to believe that there are in the plain people, our ward patients, tremendous untapped resources for recuperative power; but it takes finer skills and more time and patience to cultivate the spirit of man than to care for his body. Until certain aspects of our hospital system are changed, there probably will remain a significant lag in the utilization of these human resources.

A significant part of the system is the attitude of the average physician toward the ward patient as a person. For the lay spectator, there is in the average intern a noteworthy lack of recognition of the potential personality of the patient and sometimes little apparent respect for his personal capacity, as evidenced by the fact that the patient often is told so little about his ailments and the reason for certain treatments, that he may be ignored in long discussions in his presence or occasionally addressed in ultra-simple terminology as if he were unintelligent, or he may often be spoken to in louder voice than normal, as if he were somewhat deaf as well as dull. At the same time, earshot comments may be expressed freely to colleagues without much awareness for the patient's sensitivities or possible anxieties. Moreover, no matter how easily available resources for personal support to the patient may be through other services, they are often treated casually by the intern or even ignored. In other words, there is not on the part of many interns a well-developed concept of team-spirit and teamwork in the utilization of human resources in therapy. All these general statements can be amply documented from our materials, but the illustrations only serve to make the situation appear even worse and would give the impression that the speaker is out of sympathy with the physician, which is very definitely not the case. He, too, were he an intern in the present system, would probably display a similar attitude.

Another important part of the system is the attitude of the physician toward the staff nurse. Traditionally, the nurse has been a servant at the bedside, not really a co-worker in patient care and therapy. But when the patient is treated seriously as a person instead of as a case, and therapy is boldly extended to utilize the resources of the personality, then the modern nurse is, both by training in our better schools of nursing and by the fact that she can spend so much more time with the patient,
at some real advantage over the hurried and harried interne in her understanding of the patient as a person. As yet, this is not adequately appreciated by the average interne and may be inwardly resented. This only means that the ideas and the ideals of some of our schools of nursing are way out ahead of the attitudes and the realities which exist on our hospital wards, and this constitutes a kind of therapeutic lag which results in some frustration for both the interne caught in the system and for the nurse who is capable and well trained. The results, of course, are compromises at the expense of the better patient care. Until the interne in his busy schedule can catch up with modern trends in personnel relations, and perhaps until the hospital system can be changed somewhat, this lag is apt to remain.

Perhaps most important of all for our discussion today are the human resources latent in the nurse. It is somewhat distressing ever to hear a patient say that the aide or attendant is a warmer and more supportive human being than is the staff nurse. But I have heard even nurses, when they were patients themselves, say that about other nurses. Even worse, patients sometimes speak with pent-up feeling about the severe formality, the hardened attitude, the masked face, the faraway look, or the starched smile of the staff nurse.

From what I can learn from the student nurses, none of this protective shell develops or hardens in the average girl before she reaches full-time duty on the hospital ward. If it is ever acquired, it comes with disillusionment, frustration, and compromise in ward practice, and may be attributed in part to a system that fails to recognize, cultivate, and reward adequately the further exercise of these once challenged human capacities of the nurse.

The most important evidence of this to us is the response which certain of the staff nurses have made to our experiment in the Nursing Consultation Service. I only wish there were time and space to document in detail for you the progress which some of these nurses have made in the skillful manipulation of human resources both in themselves and in their patients.

On one floor the progress can be sketched somewhat as follows. At first it was a little difficult for the nurses to find and to report patients who were nursing problems, except the outstanding ones like Mr. Spark. One nurse said, "We just tried not to think about it." Then they began to increase the list with minor or potential problem patients. Soon they were noting patients who were problems to each other but not especially to the nurses themselves. This advanced on to consideration of the "model" patient who is no problem to anyone particularly, "but must be a tremendous problem within himself because he is so quiet, withdrawn, pensive, sometimes tearful, and over-cooperative." The big challenge became how to "get through" to him. And then, finally, some nurses began saying, "In the case of this patient, I must be the problem, for somehow we still fail to click."

The staff nurse progress in meeting the problems has also been interesting and instructive. At first, they merely reported problems in consultation. Later, each nurse tended to advance to making suggestions and working out nursing plans to propose in group discussion. And now, each day a staff nurse exchanges place with Miss Ziering and assumes the role of the counselor who gathers up the complaints and leads in the group discussions. And the staff nurses tell me that when the "study" is concluded, they intend to carry on in the same way, even in the face of system inhibitions. That remains to be seen, of course.

Perhaps this paper should not close without some discussion of the concept of manipulator and a few guiding principles which may be of use to the staff nurse who accepts the challenge to utilize to the best of her capacity the human resources at hand.

But what is a manipulator? The dictionary states: "To manipulate is to manage with artful skills." And a nurse in a hospital setting who is, in principle, against
autocratic and bureaucratic methods of patient management, which, after all, may blunt and inhibit human resources in therapy, will certainly be challenged to cultivate and to practice the "artful skills." Therefore, some possible suggestions are as follows:

1. Size up the situation with realism and set for yourself reasonably obtainable goals. No one can manipulate the impossible. Perhaps all a nurse can do in certain situations is to help the patient to die in comfort and as much peace as possible and provide what solace she can to the bereaved relatives. Even this is not "bread cast upon the waters."

2. Get in line with the legitimate medical and social forces in operation in a particular situation. The nurse may not approve of the setup of the ward or the plan of the treatment, but it is far better to team up and cooperate under a plan of action than to try to go it alone, even in her personal relationships to the patient or his relatives.

3. When a nurse encounters a persistent and deeply seated patient protest, she should never attack it head-on and with an ultimatum. The better course is to dig out the legitimate principle behind the protest, respect it, and circumvent it with a choice of alternatives presented to the patient, if at all possible. In skillful nursing care there is really not much justification for straight out opposition to the patient at the expense of cutting him out of the team relationship.

4. Make all interpretations truthful as far as possible and in terms of the patient's own psychological and cultural background. This rule is very important and perhaps calls for the greatest art and skill of all. Frequent neglect and failure here creates a most significant hiatus in typical ward relationships.

5. A nurse should give of herself but never lose herself in the patient's cause. This giving of one's self is a very subtle art. It may consist of a small and unexpected favor, a glance, a touch, or even a suitable silence. It may be nothing more than a bit of one's real feeling breaking through the emotional mask and formalized function of the nurse. A very ill patient observed recently: "When this nurse gives me the hypo, it helps. When the other nurse gives it to me, it doesn't help at all. Is her hypo sterile?" Their hypos were really the same, but perhaps the nursing care of the latter was sterile. One nurse was recently heard to remark, "I keep my heart out of my work." Another nurse who didn't, commented, "I wonder what she is keeping it for."

6. Wait and watch for an "opening" to reach the patient. Staff nurses on a bustling ward are hardly aware of the degree to which patients are expected to fit into staff routines. And a patient who doesn't respond on the spot can be easily labeled uncooperative. There may even be days when a patient prefers to brood and sweat it out and to feel that he has a right to his depression if he wants it. But the watchful nurse will find her chance and approach for a wholesome contact when it is wanted. Perhaps artful waiting to act should be listed among the finest skills in the healing art. There is a sense in which nature takes its course in human relations as well as in the biological processes. Blessed be the name of the nurse who can work along with nature on this level.

The artful manipulation of human resources in good nursing care cannot be a cut-and-dried procedure, right out of the procedure manual, and like so many of the medical technics. It is a challenge on a higher level and has to be played with the heart and by ear, and sometimes with the fingers crossed, but always with an abiding trust in the essential goodness latent in the common man.
Improvement of Nursing Service through Adjustments in the Physical Plant

Harriet H. Smith, R.N.

The problems of nursing service are receiving a great deal of attention these days. The reasons for this interest—and all of us are familiar with them—are many and complicated. Suggestions are made for improvement through basic education, programs for practical nurse education, re-allocation of non-nursing duties. Studies are constantly reported as to what nurses do, or don’t do, or should not do; what patients think about it; and many helpful conclusions are drawn from all this material. But nursing service continues to present problems, and we continue to search for the answers.

One of the most vital but less discussed aspects of possible solution lies in the realm of physical facilities. One can draw all kinds of comparisons with our everyday life in other than the hospital environment. We might compare the problem of non-nursing duties in our nursing service to a home situation. The nurse-mother has deserted her patient-child and doctor-father in favor of the more attractive company of the administrator-travelling salesman. She has found life away from home more attractive than devoting herself to the happiness and welfare of her family. But before we condemn her as an irresponsible hussy or an indifferent parent, let us examine her environment more closely and apply some of our practical psychology to her case. Just what kind of a home is she living in these days?

Probably the house was built some 30 or 40 years ago. Perhaps it is even a make-over store or garage, and, probably as her family has grown, additions have been made to complicate her problem. The house was doubtless in a neighborhood which has been deteriorating from a pleasant residential development into one of shabby rooming houses and dirty industry. While the modern hotels and apartment houses uptown are installing all the latest electrical conveniences which she sees advertised daily in the newspapers, and the new houses in the suburbs are built on functional lines which she sees depicted every month in the Ladies’ Home Journal, she is still having to do the laundry in the tubs in the basement, heat water on a coal stove, and carry hot water from the kitchen to the bathroom to take a bath. She is very likely demonstrating her devotion as a loving housewife—or conscientious nurse—in this way, while the father is turning in last year’s car on a new model to compete with his business associates—or the hospital is buying a new x-ray machine or a fancy new plate glass door for the entrance.

It is quite possible that she is thus using her strength and energy and has little left for the proper care of her child, or time to plan to make herself more attractive and her home a more pleasant place for the child and father. Furthermore, there are other agencies in the neighborhood taking an interest in her child’s welfare, and the father becomes more involved in work at the office or the lab, has less time at home, and soon she is having to take on some of the little jobs he used to do.

Is it any wonder that she finds the Fuller brush man or the vacuum cleaner salesman interesting and attractive? At least they are trying to make life more pleasant, although at the same time their time-saving gadgets merely serve to increase her dissatisfaction with her environment and deepen her realization that she is not doing the best possible for her family.

But give her the modern conveniences, a redecoration of the house, a chance to send the laundry out and bring the cleaning woman in, and she then not only has more time to spend with her child in understanding her growth and development needs, she can go to the Parent-Teacher Association meetings, take her place among the other mothers. She may even be able to teach her child to help herself and take her
share in the smooth running of the house. She can have time to read a little of current affairs and inform herself about the father's business. He then finds her a helpful and interesting person to talk to again, and she has time to spend on her appearance and her friends and her child's friends. And, best of all, she begins to feel some satisfactions in her life and what she is able to accomplish.

I need not prolong this analogy. How can we expect better nursing care for our patients until we provide better environment for the nurse to work in? We can continue to make studies on what nurses do, prepare tables and graphs and charts showing the percentage of her time spent in other than nursing duties, and decide that others should do many of them. But what price all these conclusions if the environment in which these changes can take place is not provided? We cannot expect to park our automobile in the corner of the basement where we used to keep our bicycle. It is equally futile to say that the nurse should stop doing clerical work unless we provide the clerical worker, prepared in all ways to do the job, give her a place in which she can do her work, and, what is perhaps most difficult of all, educate those with whom she will work as to what her functions are so that they will understand and accept the change.

Let us look more closely at the hospital and the problem concerned with this business of physical facilities affecting nursing care. It really begins with the fundamental philosophy and policies of the hospital and their translation into action by the hospital administrator and the director of nursing service. If the administrator believes in the importance of keeping the personnel equipped with good modern devices in surroundings which are conducive to high quality of work, and the director of nursing service is skilled in eliciting ideas from her staff, evaluating the needs of her department, and has the ability to present these needs in a convincing and effective manner, then the problem is nearly solved.

We would probably agree that the hospital has responsibilities for the physical facilities within its walls, but might there not be some concern for cooperation and assistance in the matter of transportation and, perhaps, housing? Not that nurses wish to be treated in a paternalistic manner by their employer. Yet, when the hospital is located in an undesirable neighborhood, is it not a hospital obligation as well as part of the public relations policy that begins at home for the hospital to arrange for police supervision of the route between hospital and bus when the nurses change hours of duty at night? It is, furthermore, only fair that they dicker with the transport service to have a bus or street car scheduled to stop at the corner at a time convenient for those who are coming or going at that late hour. Strictly speaking, this is not, of course, in the physical facilities within the hospital.

But to be more concerned with that part of it, what arrangements are there for the nurse as she comes on duty, before she ever starts her work? Where is her locker room with reference to the entrance? What kind of a dressing room does she have, not only for changing her clothes but for rest at odd hours or when she may need to lie down during the day? The assumption that this space should be crowded and unattractive, lest the nurses leave their place of duty and congregate there, has always seemed inconsistent with the degree of judgment for decisions in the care of patients which we expect of even the youngest staff nurse. Where is this room located with relation to the dining room and elevators? Is there adequate elevator service to take her to her ward or department, or are there so many other departments scheduled on duty at the same time that she either has to come far ahead of time or wait and be delayed on duty? Does she have to wait again going to meals so that she either takes time from the care of patients or from her own mealtime to wait for the elevator and then, perhaps, walk a long distance to the dining room? In case the hospital is so constructed that these features cannot be remedied, then is there cooperative planning among department heads so that these facilities may be used in succession and are not all crowded at one time?
Let us turn our attention to the nursing unit itself. Unfortunately, it is not possible to change the shape of the hospital, widen the corridors, or shorten the building, so what can be done otherwise to improve the environment of the nursing staff? Let us look at the nurses' station to start with. It is usually a small space running back to the outer wall, or a wide shape with front open to the hall. I need not describe the amount of traffic milling in and out, the diversity of persons, the confusion of telephone conversation, the insistent doctor, the anxious relative, the dietitian, lab technician, operating room orderly, janitor, and any number of others who need to discuss their particular important matters with the nurse in charge. We sometimes seem to forget that, with reduction in hours on duty and the increase in nursing personnel with the various types of workers, we have in some cases neglected to increase the space provided for them to do the business which has to take place in the nurses' station. The loss of time through this confusion, as well as the difficulty of the head nurse to operate efficiently in such an environment, are factors in the problem of nursing service.

Arrangements should be made for space for a lavatory for nurses on each unit. This should include not only toilet and hand-washing facilities, but small lockers into which each nurse could put her purse and other personal articles and perhaps her cap when she goes off duty. If it would also provide accommodation to sit down and lie down, it might be possible to allow a few moments of rest so often needed in the middle of a busy morning to give the nurse renewed enthusiasm.

Fortunately, we find in many nursing units a conference room for the use of nurses so that the head nurse or supervisor may have an opportunity to discuss with individuals or groups, without interruption, the problems and progress of nursing care. Just as we are becoming more sensitive to the efficacy of discussing patient progress in a conference room apart from the bedside of the patient in a large ward, so we recognize the greater satisfactions to all concerned in having quiet and privacy in conferences among nursing personnel.

Space in the nursing station is not the only consideration. What about the lighting? Has the adequacy of the light for the best results been checked recently by engineers who are specialists in this field? Has the area been sound-proofed or treated so as to reduce noise? Are the floors covered with material conducive to the greatest foot comfort for those who spend the bulk of their time walking back and forth? Has the ventilation, heating, humidifying, or perhaps air-conditioning been taken care of so that the workers will be kept in an environment most favorable for giving best possible care to their patients? The director of nursing service can find plenty of evidence to support her insistence that attention to these details will result in improved efficiency of her nurses.

Although there may not be much we can do to change the shape of the building, there are several things which can be done to reduce the number of times the nurses have to travel back and forth. There are several business firms concerned with inter-office communication systems and their application to nurse-patient communication. Those who have used such systems successfully can testify to the satisfaction experienced by patients who can make requests or give information by such a system to the clerk on duty at the desk. If the system is further developed to include a signal for the nurse to register when entering a patient's room, it is then possible for the clerk to locate her quickly when needed for an emergency call elsewhere on the unit. Such systems may be expensive to install, especially in an existing building, but would pay large dividends in improved service to patients and saving of nurses' time.

Communication between the nurses' station and other parts of the hospital is often a problem in the effort to conserve time and insure accuracy. We depend on telephone messages, written memoranda, or word of mouth. In any of these cases, there are chances for error. The telephone line is busy, one has to wait for the person to be found, and irritation sometimes results. If the information is written, there is the
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problem of its transmission to the proper person within the proper limit of time, and then, if an answer is written, the possibility of further delay in receiving a reply. It would be more satisfactory in many ways if one could talk directly to the other person on each occasion, but this, of course, is impossible. Therefore, it is necessary to plan the use of the telephone so that extraneous matters are diverted elsewhere and lengthy conversations discouraged. A well-trained clerk can actually take care of most of the telephone messages coming to the nurses' station. Repeated observations and records have been made to identify the nature of these messages, and the inevitable conclusion is that such a person can save many hours of nurses' time in a week. The problem of where to put the clerk is not so easy to solve. To add one more person with a desk and chair to the already overcrowded station is viewed with no enthusiasm by the nurses working there. And the clerk, under such conditions, becomes involved in conversations taking place between nurses and interns and visitors, adding further distraction. The moral to this is very obviously the arrangement of the station in such a way as to permit this person to perform effectively.

As for the written memoranda, the pneumatic tube system has proved effective wherever it is used. The rapid transmission of slips and notations, of small pieces of equipment, and of nonliquid medications from the pharmacy in small quantities, has made for speedier service and less tension caused by waiting. We see demonstrated at conventions and advertised in professional journals systems of reproduction of writing at distant stations in the hospital, and the use of forms prepared for wards with the patient's name and number stumped on in the admission office. All such devices should be investigated and evaluated in relation to their possible use in saving nursing time.

We hardly know what future use will be found for communication by radio and television. There is a gadget, I understand, which the doctor carries in his pocket, a little receiving instrument which picks up his particular wave length and produces a buzzing sound broadcast from a central control room, thereby eliminating the "Call for Dr. Kildair" over a loud-speaker. Some such arrangement to call evening and night supervisors and doctors would certainly save hours of time and quarts of adrenalin.

Speaking of communication, I have been reminded to mention the use of dial phones within the hospital so that calls may go directly and not through an operator. To this I would add telephones in patients' rooms so that it is possible for those relatives who find it inconvenient or impossible to come in person, to chat directly with the patient. This would make both parties happy, and should reduce the amount of visiting out of hours, one of the common sources of irritation and annoyance to visitors and hospital personnel as well.

In organizing activity on the nurses' station, we find a growing tendency to eliminate or at least reduce the responsibility of the head nurse for the care of supplies for her individual unit. Plans for linen standards, or use of packs according to census, or even complete release of responsibility of the head nurse for ordering linen, with the linen department taking on more of this detail, has, in some instances, practically eliminated the old familiar ward linen room. The linen may be brought in trucks which are placed in an alcove or room so that no one has to transfer articles from the deep truck at floor level to shelves above one's head. Where more than one unit of similar use is located on a floor, it is possible to plan a branch linen room, with an attendant to give out linen as needed for all the units.

Central supply service to each unit either by dumb-waiter, or by a system of delivery where the hospital is spread out horizontally, is in use in many hospitals. The increase in the use of disposable equipment has reduced the size of, and in some cases eliminated, the old utility room. Certainly, the less variety and number of articles to be checked and ordered and accounted for by the head nurse will release her for time to spend on her nursing duties. Were the linen room mentioned above included with
a utility area where nurses could obtain the equipment needed for treatments, and to which they could return it after use for an auxiliary worker to take care of, there would be practically no need for a utility room of any size. Perhaps the space could be diverted to increase the size of the nurses’ station!

In connection with equipment, we might mention a method of transportation which is time saving and would make for better service. This is the use of small carts or tables on quiet casters on which trays or other equipment could be taken to the patients’ rooms. To be sure, there would need to be quite a number of these per unit, but think of the satisfaction and efficiency resulting from not having to clear off a bedside stand, bureau, or window ledge in order to have a place for an intravenous set or a catheterization tray.

Now that we are in the patient’s room, let us look around to see what could be done there to improve the nursing care. The availability of running water in the patient’s room is a must. I know it is often argued that it is impossible to install such facilities in an old building. I am sure, on the contrary, that it would be possible but often expensive. The arguments for having water available for patients, nurses, and doctors are so apparent to this audience that I need not insult its intelligence by listing them. The whole aspect of hygienic care as well as simple cleanliness; the barbaric routine of early face washing, a practice which we all deplore yet often perpetuate; and the problem of how to isolate a suspected infection are, of course, a few of the factors involved.

In addition to water in the patient’s room, I believe the adjoining lavatory could provide a work space for the nurse for rinsing equipment and preparing treatment material as well as include toilet facilities for the increasingly ambulatory patients. These fundamental items in physical environment should be standard and not according to the price of the room. It is difficult to understand why patients who pay more for their rooms are provided with bathtubs and toilets as if their hygienic needs were more acute and their elimination technics somehow different from those in the ward. Does having a bath imply that one is more in need of bathing, or more likely to be contaminated by sharing with another? There is, probably, some sociological implication in our American culture where the bathtub is an important symbol of economic status, whether it be used by the Colonel’s lady for a bubble-bath or by Mrs. O’Grady for storing her coal. It seems strange that in a hospital where patients are really at our mercy we should inflict further hardship by discrimination on the basis of ability to pay for privacy. The lack of respect for human dignity which occurs in some of our large wards may be one of the factors contributing to the problem of rendering good nursing care in relation to physical facilities.

I have watched with interest and enthusiasm the development of beds for hospital use which can be lowered to a normal home level for the ambulatory patient or raised to hospital level for those receiving care in bed. Surveys show that up to 80 percent of patients in a general hospital may be ambulatory—that is, out of bed for some part of the day. There always seems to be an ironic twist to the situation where the patient is told by a cheerful nurse that he can get up today, and then comes the almost impossible task of accomplishing this desirable experience. The little nurse and the big patient; the moving bed, the elusive footstool, or the shaky chair; the too short hospital gown, the fascinated visitor passing the door, the drainage tube, the indwelling catheter, the slippers falling off . . . need I go on?

Now, take the bed which can be lowered to a place where the patient can sit on the edge and rest his feet on the floor. What a contrast, what a pleasant experience for the patient and the nurse, what a disappointment to the curious passer-by! Best of all, what a saving in time, and what a reduction in the chance of accident to the patient. A review of reports of patients falling out of bed is quite appalling. The usual system of controlling such accidents has been to apply side rails, or restraints of some sort.
The increasing number of elderly patients who become confused at night and are usually looking for the toilet—if not to go out to feed the chickens—has increased the responsibility of the night nurse. No one seems to think that the mere application of side rails will do more than further confuse the patient, add to his disturbance, and certainly not control his bladder. I believe that if such patients were in low beds with the floor at a familiar distance and the toilet near by, the accident rate from falls from bed or over side rails would be markedly decreased. I would not be prepared to say what implications there might be for increased problems in relation to wandering off into the wrong room or into the wrong bed! In case there are not toilet facilities, the use of commodes is recommended. They might even be made to look like a respectable piece of bedroom furniture. If Mr. Pullman can do it, why can’t we?

The care of patients’ clothes has been a problem in hospitals for a long time. We have devised all kinds of systems for listing them, sending them off to a clothes room somewhere, locking them in a room on the unit or in special lockers on the floor, or sending them home with a reluctant member of the family. This has never taken care of the incidental articles brought in or taken home during the patient’s stay in the hospital. Now that the average length of stay is shorter and the patient is so often ambulatory, it would seem that a closet or locker in his room, or adjacent to his bed in a ward, could well contain his clothes and be within sight or reach of the patient himself. If we are concerned about his emotional as well as his physical welfare, we should recognize the value of his feeling of security by having some familiar personal objects within sight other than his false teeth on the bedside stand, which are often the only personal possession he is permitted to retain.

The piping of oxygen and suction to each patient’s room is most important in the original construction of hospitals or as a later addition. For years we have struggled with the problem of oxygen tanks. Whose responsibility is it to transport them, service them, connect and disconnect them, and all the rest of it? Think of the situations you have experienced in which the orderly did not come promptly and the oxygen tank was empty, or he came so soon that the tank still showed so much in it that he refused to change it. Or the occasion when the engineer was called to bring oxygen at once, and the elevator was in use and the delay was disastrous. I need not elaborate on this theme, but, certainly, to have oxygen at hand in the patient’s room is important. As for suction, we can recall many situations in which nurses, patients, and doctors would have benefited immeasurably by having it right there when needed. The amount of time and activity saved is hard to estimate but pleasant to contemplate. And to have a patient’s bedside uncluttered with tanks and machines and other formidable equipment would not only relieve the patient’s apprehension but give the nurse room to move around without hazard.

In most hospital plans now, we find provision for a solarium on each floor or in connection with each unit. This is usually designated for use of patients, perhaps for visitors too. In any case, it is important to have provision for both. If we are concerned with rehabilitation of patients and interested in restoring them to their customary place in society, or in preventing their becoming dependent while in the hospital, would it not be better nursing care to have a room in which ambulatory patients could eat together, dressed in the clothes from their own closets or lockers? I do not believe the problems of serving them or supervising meals would be any more difficult than when they are eating in or beside their beds.

I have discussed here only a few of the many devices and arrangements which make for improvement of nursing care. I would like to suggest a few ways we might go about obtaining some of them, or at least finding out more about them.

I indicated the importance of the relationship between the hospital administrator and the nursing service director in matters of policy affecting the improvement of
physical facilities. This means that the director needs to keep herself informed of progress in this respect and to have an earnest conviction that by these means she will improve the morale as well as the efficiency of her nursing staff. Her staff, in turn, as the people most closely concerned with these improvements, needs to develop skills in this respect. There must be good relations between the nursing department and the hospital purchasing agent or whoever may be in contact with the representatives of the firms supplying hospital materials. The purchasing agent needs to know what kinds of materials the nursing department is interested in, what its needs are, call its attention to something new which might be of help, ask its advice on the quality of material coming in for trial, and in all kinds of ways work together with the department. The director of nursing service and her staff should keep themselves informed through publications, mainly the professional nursing and hospital magazines, and through attendance at hospital conventions where all kinds of new materials and equipment are on display. Individual ideas and ingenuity should be encouraged and time provided for experimentation and study by members of the staff. They need to be skilled in testing articles and evaluating them. They should be able to prepare evidence and arguments in favor of some sort of change in order to present it convincingly to the hospital administrator. The nurses need to be aggressive in identifying their own needs and persistent in supporting them. No one in the organization is going to have their interests at heart so much as they themselves. If they wait for someone else to find out about these needs, or if they are going to dissipate their energies in talking and complaining about conditions, then no improvement will result. Lack of coordination and ineffective activity indicate that there is something the matter with the organization within their department.

To show what might be done even in a small institution, I shall quote from a letter I received recently from a graduate nurse in charge of a 60-bed hospital in a rural town in the West. She is a graduate of a course for hospital administrators in addition to being a person of imagination and ability. She writes:

I am listing below some of the facilities which we have installed during the six months I have been here which add up to better nursing service as well as more convenient operation. I cannot tell the exact time saved as I have not yet been able to make a detailed study, but I am sure you can imagine the difference. For example:

Two shower baths were installed on the obstetric service. Cost—materials $81 (including freight), labor $48, total $129.

Graduate nurse service—$255 per month of 22 working days, or $1.45 an hour.
(Nurses start at $215 per month, increasing $10 a month after each year, four times.
Most of the nurses have been here much more than four years.)

Five patients receive morning care in one hour by use of showers, as compared with five patients receiving bed baths at one-half hour each previously. This is a saving of one and one half hours of nursing time worth $2.18. With two nurses on a unit, this amounts to $4.36 a day. (This does not include the satisfaction to the patients who enjoy the shower, and the pretty dressing room where they can sit and do their hair and apply their make-up.)

We have on the second floor, room for 26 patients. There was no bedpan sterilizer. The nurses emptied the bedpans down the toilet and then carried the pan to the adjoining utility room to wash it out in the small hopper. If a patient was enfeebled on the toilet, the bedpans were stacked up in the utility room until emptied. A bedpan sterilizer has now been installed in the utility room. This saves nurses' time and keeps the place in better order.

Establishment of a central drug storage room from which drugs are dispensed to the floors and charged directly to the patients is a great time saver. Previously each nursing unit had a stock supply of drugs with much duplication. Charges were written on a large sheet and transferred to the business office and copied repeatedly there. Often it was necessary for the business office personnel to scrutinize the charts to get the correct charges.

Central supply. We are just in the throes of opening the central supply, and I
hope to have an article ready for publication on the advantage of having this in a small institution. At the present time we have one aide who will work in central supply under the supervision of the graduate nurse in surgery. At this time, when so much medication is given by hypodermic and intravenously, I believe the nursing time saved by having this equipment prepared in central supply will be considerable. Also, the reduction in duplication of supplies and material throughout the hospital is very worth while.

The use of ice and the transportation of it from the kitchen to the various places where it is used is a waste of time. As soon as I have an opportunity, I want to investigate the cost and advantage of having a small ice machine strategically located in the building.

I think most of these changes have added to a more satisfactory as well as a more economical program. I am very cost-conscious, and I think the days are long past when we can afford to pay people just to walk around looking for things and carrying things from place to place.

This is just one example of the kind of activity in which one nurse is engaged to improve nursing care through improvement of the physical plant. But lest we think that we have discovered something new or are responsible for a wonderful, original solution to the problem of improving nursing care, let me quote a short passage from the recently published Florence Nightingale, by Cecil Woodham-Smith. She was preparing to become superintendent of "The Institution for the care of Sick Gentlewomen in Distressed Circumstances," to reorganize it before it was moved to new premises.

"I am living in an ideal world of lifts, gas, baths and double and single wards," wrote Miss Nightingale to Hilary Bonham Carter in the summer of 1853. . . . Her requirements were not merely exacting; they were revolutionary. She had a scheme for saving work by having hot water "piped up to every floor." She wanted "a windless installation," a lift to bring up the patients' food. On June 5, 1853 she wrote to Lady Canning: "... The nurse should never be obliged to quit her floor, except for her own dinner and supper. . . . Without a system of this kind, the nurse is converted into a pair of legs. Secondly, that the bells of the patients should all ring in the passage outside the nurse's door on that story and should have a valve which flies open when its bell rings, and remains open in order that the nurse may see who has rung."1

I would like to suggest a slogan for all nurses interested in improvement of nursing care through improvement of physical facilities—an open mind, a kind heart, an eager spirit, a lively imagination, and indomitable persistence. In light of all the possibilities in the way of technical improvements, advances in medical care, re-evaluation of present facilities, and the prospect of scientific progress, we realize how difficult it is to predict what the nurse of tomorrow will really be doing, or what her preparation will need to be, or how many nurses it will take to do the job. Let us strive for a reasonable balance between the security of the past with its proven values, the opportunities of the present with their daily demands on our knowledge, skills, and understandings, and the future with its unknown opportunities and challenges for our imagination and progress.

IMPROVEMENT OF NURSING SERVICE THROUGH CONTINUING IN-SERVICE EDUCATION

LUCY D. GERMAIN, R.N.

An in-service education program is an essential element in any good service. It is the core of activity for satisfactory and satisfying personal performance. It is a tool in a democratic administrative process. It is a technic of supervision. It provides a

medium for the growth of people as individuals, as participating members of a group—as acceptable citizens of a community.

It has a high priority in nursing service. Reasons for this are evident and numerous, but among them might be mentioned (1) keeping nursing personnel abreast of the continuous changes in other fields, such as medical practice, and how these affect nursing; (2) giving a better understanding of the policies, philosophy, and working environment of the particular organization of which she is a member and hence a feeling of belonging on the part of the individual; and (3) providing safe and more adequate nursing care to patients.

Improvement of nursing service through continuing education presupposes several assumptions. They fall in two areas and are as follows:

1. For the organization—
   a. The need for such a program is recognized by both the hospital and nursing service administrators.
   b. The time necessary to plan and carry out the program is accepted as a regular contribution to the organization.
   c. The money needed is forthcoming in reasonable amounts from the usual source of income—for example, it is included in the budget.
   d. The employing agency recognizes that such a program pays dividends in the quality of service given and in the degree of satisfaction of the worker.

2. For the individual—
   a. Recognizes that an opportunity to learn and grow on the job is part of his remuneration.
   b. Feels that whatever part he plays in the program enhances his opportunity for personal advancement.
   c. Understands that any degree of participation will require time and effort, frequently beyond the circumscribed tour of duty pertaining to his position.
   d. Participation promotes the feeling of belonging.

There are two types of in-service education. They might be called (1) the formal or planned, and (2) the informal, incidental, or concomitant. Every professional nurse in a service organization has a part in the program, from the general duty staff nurse to the director of the service. Each might be described as the hub of the wheel for those in her immediate circle—the general duty nurse for other general duty nurses, practical nurses and auxiliary workers; the head nurse for all floor personnel; and the director of the service for the supervisors and the assistant directors of nursing service.

A survey of the literature shows a wide variety of in-service programs, but the majority of them are closely allied to the activities of a school of nursing. Considerable has been written about orientation, why it is necessary, and the general content of such a program. The majority of professional registered nurses employed in hospitals with schools receive vicarious benefit from the educational program. In other words, in-service educational programs, in the main, appear to be geared for the betterment of student teaching and performance rather than for direct improvement of the care of the patient.

I feel that there may be those in the audience who will take exception to this point of view. Frankly, it is so stated in order to steer the thinking toward nursing service and how to improve the immediate quality and quantity of care given to patients.

For far too long the content of in-service programs has centered upon technical knowledge in nursing. Review a series of programs, and, usually, subjects such as these will predominate: (1) care of the diabetic patient, (2) care of the patient who has had a laminectomy, and (3) newer drugs. A program for supervisors and head nurses will predominate in the technics and knowledge required to supervise and lead others but, as a rule, not too much in real nursing content. Presently there is need for a new emphasis
based wholly upon what is happening in nursing service. What are some of these observations? Do they have indications for content in in-service programs?

1. The participation of other than professional registered nurses in patient care, such as the practical nurse, nursing aide, ward clerk.
2. The recognition that the care of the patient is directly or indirectly the responsibility of all departments in a hospital.
3. The advances in medical science necessitating the use of more complicated equipment; early ambulation; and continuous research or investigation.
4. The shorter patient-nurse contact brought about by the decreased length of stay in the hospital as well as the delegation of supportive nursing measures to other than professional registered nurses.
5. The recognition that “nursing” service has included duties that are not nursing but for one reason or another have been included as the responsibility of the nursing department, such as (a) information to family and friends of a patient, (b) serving diet trays, (c) housekeeping duties, and (d) taking patients to and from such selected special services as x-ray and basal metabolism rooms.
6. The faster tempo of the environment due to a heavier and different kind of work load and the variety of nursing personnel.

Translated into educational needs, it is readily understood that a different kind of content must be included in in-service educational programs. The already accepted content should be evaluated, streamlined, deleted, or augmented in light of the current situation. Just as the social and health aspects of nursing have been made an integral part of other subject matter in the basic curriculum, so should a like change be instituted in the educational programs in nursing service relative to:

a. The art and skills of working closely with others who are now performing the work that was once performed solely by the professional nurse.
b. A working knowledge of other departments and how they contribute to nursing care of patients—housekeeping, admitting, and so forth.
c. A better understanding of patients as people and how to acquire the technics of knowing them better in a shorter length of time.
d. Leadership qualities.
e. Every professional registered nurse skilled not only in the art and science of nursing, but also having the “know how” of working well with people. In addition, there are other areas that are increasingly important, namely, (1) the requisite that every professional registered nurse be encouraged to be an active member of professional and community groups in order to broaden her perspective and hence the contribution to her job, and (2) the recognition that on-the-job education should be available to every worker in the nursing department and that each one be given opportunity to advance insofar as the situation (organization, personal ability) permits.

Ideally, an in-service education program should be geared to meet these changing and immediate needs. It should be a definite part of each administrative activity, either individually or in groups. It should be broad and varied enough to meet the needs of many types of people working in an ever-changing situation. The kind of situation will influence the emphasis in any in-service program, namely:

1. If the institution or organization has no students in basic nursing, the content would be weighted in nursing service but should include subject matter on nursing education, the growth of the individual nurse, and her contribution to student development and welfare.
2. If the institution or organization has a school of nursing, the content would be equally balanced and integrated, one with the other—that is, it would provide a
suitable learning environment for the students and, at the same time, a program directed specifically to the improvement of patient care. Assuredly, both are a part of the improvement of patient care, but there is a difference in approach.

The remaining part of this paper deals with suggestions of how to accomplish an in-service education program in situations like the two above. Designated groups or individuals are responsible for selected phases of the program either because they hold a specific position or are selected as chairmen or members of committees. Each worker is given an opportunity to suggest what members would like to have included in the content, which, in turn, is broadened to include subject matter which will widen the horizon of the individuals and strengthen current performance. The time and day of meetings are determined and known in advance. Attendance is not required but is strongly encouraged. On a day off the individual attends only if she wants to do so. Minutes are written for each meeting and made available to interested people. Formal programs are planned in advance, posted on the bulletin board, noted in the record, and announced at meetings.

In-service education according to type of nursing personnel

The commonly accepted way to develop an in-service program is according to vertical levels of positions; for example, faculty, general duty nurses, practical nurses, auxiliary workers. The advantage is that the content is direct and specific, but the disadvantage is the lack of opportunity to learn together as a team. Eventually, they should be taught together within the framework of knowledge for which they are collectively responsible.

It is assumed that all nursing personnel are carefully selected according to the accepted job descriptions. They are oriented to the job through a well-thought-out orientation program. The immediate supervisor plans and carries out such a program. Recently, a new head nurse was given an opportunity to learn about her responsibilities, the working environment, and her place in the organization through the following program:

1. The objective was clearly stated to become acquainted with (a) nursing personnel, (b) general ward routine, (c) the educational program for students, (d) responsibilities of the head nurse, personnel policies, working relationships, and (e) relation of other departments to nursing.

2. The content included (a) organization of the nursing departments, (b) rounds with immediate supervisor, learning about the patients and their environment, (c) orientation to hospital policies, (d) orientation to program for auxiliary workers, (e) observation of methods used in the administration of medicines, treatments, and other procedures, (f) observation of time planning, method of assignment, ordering supplies, and (g) orientation to other departments, including the school program.

3. Methods used were (a) conferences with selected people, (b) attending any scheduled meeting in the department—whether or not it was one she would ordinarily attend, (c) rounds on the 7:00 a.m.-3:00 p.m., 3:00-11:00 p.m., and 11:00 p.m.-7:00 a.m. periods, (d) periods of observation of patient care on selected units, including surgical procedures on orthopedic patients.

4. The plan called for concentration of activities for the first week, after which the head nurse gradually became familiar with her own unit while continuing the orientation program.

Once the orientation is completed, continuous educational programs will help the individual to keep up to date, have a sense of belonging, and know what is going on in her organization. The last may affect her directly or indirectly. If a special project, such as a "Study for the Improvement of Patient Care," is being carried out, everyone should know about it. If the ward helpers are to be upgraded to nursing aides
through an in-service program, that particular group should know it, because it concerns them as individuals. Every other group should know it, too, because it may affect their work.

An analysis of a few formal in-service programs carried out in one nursing service during 1950 gave the following content:

For practical nurses
1. Working relationships
2. Personal health and grooming
3. Participation in nursing care of specific conditions as requested; cardiac, diabetic, orthopedics
4. Review of procedures and measures of nursing; presentation of revised procedures within the framework of the practical nurse functions

For floor clerks
1. Working relationships with associates and patients
2. Working relationships with various departments, such as the record room, admitting, and dietetics
3. Review of telephone manners, personal grooming, and so forth

For aides
1. Working relationships
2. Personal health and grooming
3. Demonstration and practice of aide duties, with additional time for discussion of ethics, individualization of patient care, and acceptable personal attitudes

For general duty nurses
1. Care of the patient with selected conditions
2. Current trends in nursing
3. Problems in ward and hospital administration
4. New drugs

For head nurses
1. Participation of the head nurse in nursing administration
2. Discussion of the responsibilities of other departments which participate in patient care
3. Personnel practices, including job specifications; knowledge of the selection process
4. The program of the school of nursing

For the faculty
The general theme for the program of this group was nursing ethics. Among the subjects presented were (1) a round table on the philosophy underlying an ethical code, (2) a lecture on the importance of good human relationships in everyday living, and (3) a panel on the ethical obligations of the professional registered nurse to her various groups of co-workers.

In-service education as part of administrative practices
As the needs for more and improved patient care become intensified with less professional nurse personnel available, the time factor presents a problem of great dimension. Here, the director of nursing should use all the ingenuity possible—her own and that of her co-workers—to find ways and means to carry on the program. The number of hours taken for such a project should be carefully scrutinized and decreased where possible. At the same time, other avenues of education or channels of communication should be developed in order to continue the program. Among these are:
1. Daily meetings of administrative nursing personnel. Each member participates. Discussion centers around the condition and care of patients, special problems which arise and how they should be met; new equipment and how it helps meet the situation; vacancies and appointments to the staff; new procedures or routines; a pertinent article in a current professional magazine, or a new publication in the library; new hospital policies and contemplated changes in nursing; selected correspondence and other information which has some bearing on the current picture, such as reports of meetings which members have attended.

Each member knows that she is responsible for keeping the group informed of her activities. She, in turn, is expected to carry on a similar round table with her own group but, unless absolutely necessary, at less frequent intervals. It is desirable for the head nurse to carry out a similar plan for nursing personnel closely allied with patient care.

2. Conferences. Regular conferences are planned with the administrative and teaching personnel, and, here again, educational content is injected of a more specific and personal nature. It may run the gamut from tactics of management to ways and means of developing a teamwork concept in nursing. If the person is a new employee, a discussion of the job, its responsibilities, the organization, and the people who are her co-workers may well be part of the conference.

In-service education allied to professional and other community activities

Another way to carry on in-service education is to encourage personnel to attend meetings, institutes, or other special courses. Nurses should be given time to participate in the committee activities of such organizations as the state or local league, the district nurses’ association, or the American Red Cross Nursing Service. Of course, this privilege, of necessity, should be well distributed, and the wise director will serve as a clearing house for such participation. It is she who is responsible for the nursing personnel and how they spend their time. They, in turn, should recognize this and be aware of their responsibility to the organization.

Fortunately is the nursing staff that works in a community where there is a university. The offerings of such an institution may well be included in the in-service program. It is advantageous both to the individual and the organization if the individual arranges her time so that she may attend selected courses in ward management, sociology, and other fields. Institutes in areas of clinical nursing, methods of teaching, supervision, guidance, and other subjects may also be available. Staff members should be encouraged and expected to attend, if at all possible. For example, the head nurse will find it stimulating and worth while to attend an institute on premature care. The coordinator of practical nurses will do a more satisfactory job both in her own estimation and that of her supervisor if she attends a workshop on practical nurse education. Arranging for a leave of absence for any one to attend a college or university is part of the over-all educational program. It is stimulating to the person and serves as a constructive force for her co-workers. It is just as important, however, to provide the means for her to carry out a particular pet project when she returns, or to guide and encourage her in making selected changes in curriculum content, ward teaching, or developing a new tool of administrative practice, such as a manual.

Other methods of in-service education

Experience has shown that it is worth while to bring in a consultant for one day to a week or more to work with supervisory personnel. The consultant who is selected should be working in an area in which the group is interested—for example, guidance, curriculum content, methods of teaching, supervision, or head nursing. There are a number of advantages to this, namely, (1) more people are reached while on the job, (2) it is stimulating to the entire group, (3) there is a close consultant-nurse rela-
tionship, and (4) there are many concomitant values which are only discernible long after the visit.

Summary

This presentation of the improvement of nursing service through continuing in-service education has covered a broad expanse of activities. It has included planning which is formal according to vertical levels of positions, and informal in that educational content is injected into daily administrative practices and the use of professional and other educational resources in the community. It has also indicated that, for best results, a possible change in the approach to better service might well be a horizontal, rather than vertical, plan. In addition, in-service programs should be strengthened by (a) reaching more adequately the newer members of the nursing team as well as the professional registered nurses, and (b) in some way developing an attitude toward continuing education among all nursing personnel.

The patient is a "new-comer" in the area of in-service education. He is important, however, and before long it may be anticipated that he, too, will have a better understanding of his place in the improvement of nursing service with respect to such matters as orientation to the hospital, movies, discussion groups, and an improved acceptance by personnel.

Emphasis has been placed on nursing service personnel in-service education. The student was not mentioned, but, to the extent that in-service education in nursing service improves nursing service performance, to that degree will it support and strengthen nursing education for basic and graduate nurse students.

Program Meeting

Thursday, May 10—9:00 a.m.—12:00 m.

Modernizing Nurse Education

Presiding: Lulu K. Wolf, R.N., Dean, School of Nursing, and Chairman, Department of Nursing, University of California at Los Angeles, California

Speaker: Ralph W. Tyler, Ph.D., Dean, Division of Social Sciences, University of Chicago, Chicago, Illinois

Symposium moderator: Myrtle E. Kitchell, R.N., Dean, College of Nursing, University of Iowa, Iowa City, Iowa

Participants:

Florence K. Wilson, R.N., Dean, School of Nursing, Duke University, Durham, North Carolina

Sister Cyril, R.N., General Supervisor of Hospitals and Schools of Nursing, Sisters of Charity, Cincinnati, Ohio

Florence Kempf, R.N., Head of Department of Nursing Education and Professor of Nursing Education, Michigan State College, East Lansing, Michigan

Mabel Korsell, R.N., Director of Nursing, Columbus City Hospital School of Nursing, Columbus, Georgia
Since I am not a nurse and am not directly engaged in nursing education, my comments will lack concreteness and will often, I fear, miss the significant problems you are facing. Nevertheless, all of us in the various professional fields have in common certain important problems in making the professional curriculum an effective one. As a student of learning and the curriculum, I shall try to bring general factors in curriculum development to your attention.

The topic assigned to me carries certain obvious implications. In the first place, the term "functional curriculum" emphasizes a functioning rather than a nonfunctioning curriculum. In education generally we have been confronted with two major aspects of nonfunctioning educational programs. On the one hand, a great many schools and colleges are aiming at objectives which are not vital and significant, and, on the other hand, large numbers of students fail to apply or carry over into their lives outside of school or college what they may have learned. These two deficiencies in educational programs are so serious and so widespread that major efforts are needed to overcome them.

A second obvious implication of our topic comes from the term "evolving." This term reminds us that an effective functional curriculum cannot be built overnight. It is a task requiring several years and to which we need to assign regular time and effort. The major part of my presentation will deal with the steps involved in carrying out this task.

In developing a functional curriculum, four problems must be attacked.

1. Deciding on the objectives to be sought. Objectives are important in an educational program because they serve as the chief guides for planning and conducting the program. If we are not clear about our goals we have no sound basis for operation.

2. Selecting learning experiences that are likely to attain the desired objectives. Education is accomplished by means of the activities students carry on through which they learn. These are commonly referred to as "learning experiences."

3. Organizing the learning experiences so as to maximize their cumulative effect. Isolated, unrelated learning experiences, no matter how helpful each one is individually, can produce little, if any, fundamental changes in students. Really significant learning takes place from one experience built upon another so that over the months and years great developments have taken place in the knowledge, habits of thought, attitudes, skills, and interests of students. This building of one experience upon another so as to provide effective reinforcement is called "organizing learning experiences."

4. Devising means for evaluating the effectiveness of the curriculum. So many factors are involved in any complex learning program that one cannot predict in all cases how well the program will work out. Hence, appraisal is necessary so that weak spots may be identified and improved and the effective parts of the program retained and strengthened.

Since these four problems must be attacked in evolving a functional curriculum, let us examine each in turn.

Deciding on objectives

How can objectives be wisely chosen? A procedure for selecting objectives may be seen more clearly from a consideration of the nature of educational objectives. Education is a process for changing the behavior of students in desired directions. This definition of education uses the term "behavior" in the broad sense to include think-
ing, feeling, and acting. When a student is educated he behaves differently. He may have acquired ideas which he did not previously possess, new habits, ways of thinking about problems which he did not have before he went to college, professional skills which he developed at school. In brief, his behavior has been changed.

From this definition of education it is also clear that educational objectives are the behavior patterns which the school is seeking to develop in the students. The knowledge which the student is expected to acquire, the habits he is expected to develop, the methods of thinking he is expected to adopt are illustrations of educational objectives. They are the kinds of behavior the school tries to develop in the students.

In schools and colleges generally there are four very common weaknesses as far as educational objectives are concerned. In the first place, there are some programs for which no objectives have been formulated. Without objectives a program is based upon traditional content and teaching methods handed on from year to year with no clear guide for its appraisal and improvement, or else the program fluctuates from time to time on the basis of personal preferences and current fads also without a stable guide.

A second weakness, so far as objectives are concerned, is a statement of aims in terms too vague to act as a clear guide. Among such vague terms are likely to be: "to teach students to think," "to develop character," "to inculcate discipline." These terms may be useful as headings under which clearer definitions of aims are given but too often no further definition or analysis has been made so that the objectives are only vaguely understood and provide little if any basis for further planning.

A third weakness in objectives is the practice of selecting them in terms other than their significance for effective working and living. Although it is possible for students to acquire many different patterns of behavior, the individual and social justification for teaching anything is the value of the new pattern of behavior to effective life, professionally and personally. If the knowledge, skill, habit, or the like learned in school does not help the student to render a greater professional contribution or to live a happier or more productive life, we have wasted valuable time, and worse, we have hindered the fuller development of a person.

In spite of this principle, objectives are sometimes chosen because of the particular hobbies of the instructors, or because of a previous, but outworn, tradition, or because of the pressure from some special interest group trying to get its own dogmas or doctrines taught. This is a serious deficiency in some statements of objectives.

A fourth weakness is the listing of too many goals. Really significant changes in behavior take time and concentrated effort. Hence, the number of such aims that can be attained in the time commonly available in schools and colleges is definitely limited. To list a hundred or more objectives for an educational program is to set far more goals than can possibly be realized and by this means either scatter the effort so that no goal is reached or to make the attainment of goals so clearly impossible that the list of objectives is not used to guide the planning and conduct of the program. What is required is a formulation of a few very important aims, clearly defined and serving to guide the development of all aspects of the program.

The common weaknesses so far as objectives are concerned can be overcome by following a more careful and systematic procedure in developing a list of objectives. One step in this procedure is to make a careful analysis of the nursing profession to identify demands being made or likely to be made upon nurses for certain competencies or other forms of behavior. In making this analysis, give special attention to the changing demands being made on nursing and the changing character of the nursing profession. It seems quite probable, from what I have read, that the professional nurse of today is becoming more of an administrator and teacher, supervising the activities of several types of personnel that assist the nurse in performing the total nursing services.
These changes in the nursing profession have implications for the educational objectives of a school of nursing. For example, if a nurse is expected to teach patients about their health problems, then, student nurses might be expected to develop certain teaching skills, certain attitudes toward patients, certain knowledge of health problems which would be required for the nurse to do such teaching effectively. This illustration indicates both the fact that an analysis of the changing profession has implications for educational objectives and the fact that the implied objectives are not obtained directly from the analysis of the profession but must be inferred from the analysis.

This point may need further emphasis. An analysis of a profession (so-called "job analysis") does not directly give educational objectives. It gives only facts about the profession including the duties, the changing demands, the changing organization of the profession, and the like. From this, educators have to draw inferences regarding the kinds of behavior patterns which can be developed in students and are likely to help them carry on the duties of the profession, meet its changing demands, and assume professional responsibilities.

Many people who have used job analyses have seemed to feel that what one gets from a job analysis is a list of duties which are themselves the objectives of education for the job. It is true that the person who is being educated must carry away from the educational institution competence to do the job, but it is not always true that direct training in the job is the best way to gain this competence. If, for example, the job demands a person who is able to meet new problems, it may well be that the best emphasis, as far as objectives are concerned, is upon effective ways of thinking, including ability to analyze problems and to use basic principles in attacking problems, rather than to emphasize the specific problems of the job. In brief then, an analysis of the nursing profession does not tell one the objectives for schools of nursing. It only indicates the situations, the kinds of problems the nurse will meet. From this can be inferred the kinds of qualities and competencies in a nurse that the school can develop in the student to enable the nurse to meet these situations more effectively. In many cases these will be background competencies, like understanding, like methods of problem-solving, like basic skills in working effectively with people that will enable the nurse to carry on the particular responsibilities.

Perhaps this is enough to suggest the value of this step. It appears that in every professional field better objectives are obtained by looking carefully at the developing profession.

A second step in selecting objectives is to study the students. This is helpful because if the curriculum is to be functional it must begin where the students are. We need to find out whether students already have certain competencies. These need not be taught again for this would be wasteful and boring. On the other hand, if there are gaps in their background, these omissions need to be met.

Furthermore, the nature of the students' preoccupations, the problems they have, their outlook, attitudes, interests, and so on, have implications for educational objectives. They indicate where the students are, what emphases can be made at a given time so as "to strike while the iron is hot." Part of the analysis of students needs to be made by every school since each school has a somewhat different body of students. Nationwide studies of student nurses, or even more generally of adolescents, throw some light on problems that most adolescents have, on their preoccupations, their competencies, and the gaps in their background. But for the less general matters, we need studies of our own students.

Like the analysis of the profession, the study of students does not directly give a list of objectives. It shows us what characteristics students have, the problems they have, their present attitudes, and so on, and from these we again infer what kinds of emphasis in education can best help them meet their problems, can help them fill gaps, and can capitalize on their interests.
A third step in selecting objectives is to call upon the subject specialists in fields directly allied or contributing to nursing education, and to ask them what their fields can contribute. True, suggestions may not always be to the point but we have found, in general education, that subject matter committees or groups often make important contributions that should not be overlooked. For determining nursing educational objectives the problem is to identify the specialists and groups which can contribute.

Ten or fifteen years ago the answer would have been the nursing people themselves, and those in background fields—bacteriology, the biological sciences, medicine, and hospital administration. But it is clear now that other disciplines can contribute. Possibly because I am a social scientist I am conscious of the objectives that social science can contribute in the way of understanding the problems of the patient, understanding human behavior, understanding the relation of personality to culture, understanding the impact of the community on the hospital, and so on. Even economics is increasingly significant, especially in the field of health and education. Perhaps persons in all of these fields should be used to get their notions of the contributions they think they can make to nursing.

In asking these groups for their suggestions it is necessary to emphasize that the request is for suggestions regarding objectives for the education of nurses because the tendency is to state objectives for the preparation of specialists in their own fields. Thus, the sociologist may start to talk about objectives for the training of the sociologist. Reiteration may be necessary to get the purpose in mind, but the effort is usually worth the time because some added notions about educational objectives are often obtained.

Out of these three sources: (1) the study of the profession, (2) the study of students, and (3) the contributions of other professions can come more objectives than can possibly be used, more than can possibly be reached. Hence, it is necessary to make a selection from the large list collected from these sources. Two types of criteria are useful. One is the philosophy of nursing education formulated by your own particular institution or the philosophy of the national organization. By using a philosophy of nursing education as a criterion, one may set against each possible objective to judge whether (a) it is very important in terms of this philosophy; (b) it is contrary to the philosophy and should not be used; or (c) it is not very important and not to be given great emphasis if used at all.

Now, in what way can philosophy help make these judgments? A philosophy of nursing education ought to answer such questions as: What is the ideal of a desirable nurse, what is the nature of a good society for nursing, what is a good life for nurses, and so on. For example, I would suppose that because you are a profession two things would stand out in your philosophy. One of these would be an emphasis upon solving problems by use of principles rather than by routine skills or the formulas of the trade. My understanding of what a profession is carries the notion that a profession has basic principles that can be drawn upon as new problems arise rather than an occupation that follows the same pattern from generation to generation. Now, if this be true, a nursing school would emphasize as objectives the understanding of basic principles, and an ability to apply these principles in the solution of new problems.

Another characteristic of the philosophy of a profession is its employment of an ethical system. A profession has an ethical system that dedicates its members to values beyond the individual or the immediate group. The nurse dedicates herself to the service of society. This would mean that the objective of developing ethical values would be given high priority.

The educational philosophy of a school of nursing will probably include other points. It may emphasize the importance of the dignity and worth of the individual, the basic tenets of democracy, the acceptance of social change and the like. Each of
these points implies certain objectives as more important for the school and, on the other hand, some objectives that are contrary to these points.

A second type of criterion for selecting objectives is what we know about the psychology of learning. Objectives should certainly involve behavior patterns that can be learned rather than those that cannot. They should be in terms of patterns that can be acquired in the educational institution more easily than on the job, patterns that are especially well learned at the age level with which you deal rather than those learned at an earlier level. For example, certain aspects of personality structure are hard to change at the age of seventeen or eighteen. And, if these characteristics of personality are important for effective nursing, they should be used as one criterion for the admission of students rather than attempting a well-nigh impossible task of developing a new personality in the school of nursing. Hence, by using what is known of the psychology of learning, it is possible to select objectives that are most likely to be learned at this age level.

From the three sources of objectives and by the use of these two types of criteria it is possible to select a small number of objectives that are attainable and to make them the goals of nursing education.

For these goals to serve most helpfully in developing a functional curriculum it is necessary to define them clearly in terms of behavior and of content. For example, consider an objective stated as: "understanding the concepts and principles which are useful in explaining the treatment of diseases of the heart." If the school is to help the student develop this understanding, we must have a clear notion of what is meant by understanding. Most instructors would probably define it as more active than memorization, as not only remembering but as the ability to explain a concept or principle in one's own words, the ability to interpret, to illustrate, and to compare and contrast it to related ideas. Such a definition clarifies what behavior the student is to develop, this behavior called understanding. This is defining the objective in terms of behavior.

The other aspect of the definition of the objective is the content. What is the student expected to understand? What content? This involves listing the types of concepts, principles, and the like which are to be understood. This aspect of the definition of the objective helps to develop and define the curriculum content.

As another illustration of defining objectives, consider the objective frequently listed as "developing critical thinking." A definition of this in terms of behavior might include such notions as "able to solve new problems, able to analyze new problems, able to see the consequences of action, able to judge the advantages and disadvantages of proposed treatments, and so on." Such statements of behavior would help to define the behavior aspect of cultural thinking. The content aspect would be defined by listing the kinds of problems the student is expected to solve and the like.

Another type of objective frequently listed is "skills." This may include both manual and intellectual skills. Manual skills in nursing, I suppose, are fairly easily defined. Intellectual skills might include the ability to read, to listen accurately, and to write clear and well-organized reports. Habits are another kind of objective commonly sought. The important thing about a habit is that it is typical performance, not what one can do but what one does do day after day. Attitudes represent another kind of objective often emphasized. The definition usually given to attitude is a way of looking at things, the perspective with which one approaches phenomena—for example, looking at all patients no matter what their economic, social, or nationality background may be as human beings deserving help and sympathetic attention. The development of this kind of behavior is often stated as an objective.

"Interest" represents another common kind of objective. It may include interest in nursing as a profession, interest in one's own education, interest in working with patients, and so on. Perhaps these illustrations are sufficient to suggest what is meant
by defining objectives in terms of behavior and of content. Only clearly defined objectives can serve most usefully in the further development of the curriculum.

Selecting learning experiences

The second main problem in developing a functional curriculum is to select learning experiences likely to contribute to these objectives. This problem raises a previous question: how do persons acquire these desired changes in behavior patterns? They acquire them by practicing them. This is a simple but fairly accurate answer. However, getting students to practice the desired behavior is not the easiest thing in the world. A student develops understanding by recalling ideas, by explaining them in his own words, by finding illustrations of them. Skill in ways of thinking are developed by practicing problem-solving again and again. Manual skills are developed by continuous practice of these skills. Habits are also acquired by practice. An attitude is acquired by having the student look at the phenomenon from the new perspective again and again. Interests are acquired by getting satisfaction again and again from certain kinds of experiences so that these experiences become increasingly satisfying. For all these kinds of behavior it is true that students acquire new behavior patterns by practicing them.

One fact which clearly emerges from this analysis is that the teacher cannot learn for the student. The teacher can have a good understanding of something and practice it, again and again, but this does not mean that the student develops a similar understanding. Whether or not the student develops understanding will depend upon what is going on in his mind, rather than in the teacher's. We have been making some studies of student learning by recording a class session and then bringing in, within 24 hours, one at a time, a good representative sample of the students. The record is played back and stopped at intervals, and the student is asked if he remembers what was going on in his mind at the time this part of the class session was in progress. By this means we identify the points in the class session where the student stopped thinking about the material and wandered off to something else. We are thus able to identify the kinds of things the teacher does which may help to stimulate students' attention or to distract it. I used to tell funny stories in my classes to illustrate major points but I found that the stories distracted students. They thought about the stories and not the points being emphasized.

If the teacher cannot learn for the student, what is his role? There are four ways a teacher can contribute to the student's learning. (1) He can stimulate the student to want to try the new behavior, that is, to want to understand, or to solve problems, or to acquire skills, or to develop new interests and the like. (2) He can guide the student's reaction so that appropriate behavior will result. This is most obviously seen in developing manual skills in which you show the person how to do it. The teacher's example is the guide which the student follows. A teacher can also guide intellectual behavior by example, by pointing out things to consider, by raising questions, and the like. This is what I am trying to do in this presentation to guide you in thinking about the curriculum. A teacher can also help to guide emotional reactions so as to influence attitudes and interests. (3) The teacher also influences the student's learning by helping to see that the student gets satisfaction from the desired behavior. We help him to see that he is progressing; we give encouragement and praise when he is making progress. (4) Finally, the teacher influences learning by providing opportunity for the student to practice the behavior often enough to learn it.

With these principles in mind, we return to the problem of selecting learning experiences likely to contribute to the objectives. Our problem has now become one of outlining activities that students can and will perform, that will give them a chance to practice the behavior implied by our objectives. This means setting up problems for students to attack in order to gain understanding and develop critical thinking, and providing tasks which require students to practice manual and intellectual skills.
and habits. These may appear to be fairly straightforward jobs of course planning; many instructors, however, do not see how one plans learning experiences likely to develop attitudes. If this involves the student practicing a different way of looking at nursing or at patients, how does one get the student started looking at something in a different way? One lead is to put him in a situation where the normal way of looking at the "something" is this new way you are trying to develop. For example, in a job situation on the ward, the student begins to look at things differently because that is the normal way of looking at them in the job setting. He never looked at it this way before, but here it is easy for him to look at it from the point of view of a professional nurse rather than from that of a student. Another way of helping a student develop a new attitude is by getting him to identify with someone else who has the desired attitude. For example, in reading a gripping novel one commonly identifies with some character in the book and feels much like that character. He also finds himself looking at things as this character looks at them. In this way he starts practicing a new attitude. Plays serve the same purpose, helping one to identify with characters and to look at things through their eyes. We can even have students acting out little skits which require them to take roles of characters with whom we hope they will learn to sympathize, and in this way to develop new attitudes. It is amazing how, in the effort to play their roles well, persons will begin to look at things in a different fashion.

I comment more at length on learning experiences to develop attitudes because more questions are commonly asked about ways of attaining this kind of objective. However, for all kinds of objectives the planning of learning experiences involves primarily outlining activities in which students can practice the desired behavior and will be stimulated to do so.

Organizing learning experiences

The third main problem in developing a functional curriculum is to organize the learning experiences so as to maximize their cumulative effect. The cumulative effect of learning experiences can be increased in two ways, namely, through sequential organization and through integration. It has been shown that 50 hours of practice distributed so as to lead the student on from week to week into broader and deeper applications results in far greater learning than when the 50 hours are distributed at random without a developing sequence.

The other way in which the cumulative effect can be increased, integration, involves relating what goes on in one part of the educational program to what goes on in another part. For example, in general education, if the student is learning to write in his English class and is asked to utilize his new skills in his science class, this integration increases the cumulative effect. Or, if the concept of evolution is developed in the biology class and the social science teacher also brings up the term, helping the student to see how the concept of evolution as used in the social sciences is both like and different from the concept as used in biology, the understanding developed by the student will be greater than would have been the case if there had been no connection between the points taken up in both classes. Hence, effective organization of learning experiences involves planning both for sequence and for integration.

Several principles need to be kept in mind in planning the organization of learning. In the first place, it is necessary to provide for a continued emphasis upon the major objectives, term after term, year after year, in a sequential way. These objectives are the main threads around which an effective sequential organization can and should be planned.

In the second place, one of the chief aspects of integration likely to need continuing attention is that of theory and practice. The danger is that theory will be scheduled to one time in the student's program and practice at a much later or
earlier time. However, they play closely interrelated roles. The role of theory is to make sense out of what would otherwise be a series of isolated events. Theory should help the student to make sense out of what would otherwise be meaningless. On the other hand, the role of practice is to keep theory from being speculative, and to raise problems that theory must explain. Only by a close tie-up can the maximum value of the relation between theory and practice be advanced. Hence, in our curriculum it is important to see that theory and practice keep playing back and forth in relation to each other in the training program.

In the third place, through both sequence and integration we need to relate consequences to actions. We often teach persons this is what they should do, but the way in which students usually learn ethics (what they should do) is by seeing and feeling the consequences and not by being told of them. It is very important that as ideas about action are developed the students have a chance to see the consequences of such action and begin to judge their own behavior in terms of consequences of their acts. Through providing a close interrelation between theory and practice and between actions and their consequences, we are more likely to achieve one of the most important kinds of integration—integrating thought, feeling, and action—rather than having students who can think but can’t do, or who feel but are not guided in their feelings by any rational understanding of what they are doing. We want a program which will help markedly to develop an humane nurse who understands the principles that she uses, who understands and strongly believes in the social ethics of her profession and who is able to act in harmony with her feelings and her understandings.

Evaluating the effectiveness of the curriculum

The fourth and final main problem in developing a functional curriculum is to evaluate its effectiveness. This problem I shall have to pass over rather quickly both because of the present pressure of time and because the general subject of evaluation has been given rather extensive discussion by the League during the past several years. It may perhaps be sufficient at this time to remind ourselves that evaluation requires an appraisal of the extent to which our objectives are actually being attained. This requires evidence of changes in student behavior during the time they are carrying on the educational program. It means appraisals early in the course as well as near the end. It involves evidence relating to all of the important objectives toward which we aim. Such evidence will help us to identify the respects in which the curriculum is effective and the places where improvements are needed. This is at times a difficult, but nonetheless essential and rewarding task.

In summarizing this presentation, the emphasis will be placed on evolving a functional curriculum. Evolving means a step by step progress, not a precipitate revolution. Evolving a functional curriculum means selecting significant objectives, devising learning experiences likely to attain the objectives, organizing these experiences to maximize their cumulative effect, and evaluating the results to provide a basis for continuing improvement. These tasks are continuous tasks. The effective curriculum is always evolving; it is never finished and perfect. These steps take time. They should involve all the faculty and, if possible, the students and others concerned with nursing care in order that the curriculum will not be something on paper but will be understood and carried on by the whole institution.

These steps can be viewed as a cycle, not necessarily starting with the first one first. In evolving the functional curriculum, the beginning is always with problems that are recognized by the faculty as being important. Now if the faculty recognizes problems suggesting the need for a reformulation of objectives, well and good. If, on the other hand, the faculty recognizes a problem at some other stage, begin at another stage. Eventually, questions will be raised that will lead the attack around the several steps comprising the cycle; questions will arise regarding learning experiences, questions regarding organization and about evaluation. Questions will arise because a
great deal of evidence is accumulating which shows that most educational programs have not begun to attain the educational results possible from a highly effective and efficient curriculum. By choosing important objectives—not too many, but important ones—by selecting and using effective learning experiences, by organizing them efficiently, and by continuing appraisal to identify spots needing improvement, we can increase our educational efforts tremendously.

DISCUSSION

Question: How can cooperative groups in an institution come together to secure the integration which you describe? For instance, who shall initiate the bringing together of teachers from the fields of biology, sociology, and so on to develop this type of integration?

Answer: I assume the question here is the bringing together of those outside of the school of nursing. There are two ways being used. One is the official way: the administrative officer of all the groups involved, on request from the dean of the school of nursing, invites the group to come together. The other is the unofficial, used more often. The person responsible for nursing invites persons in other fields to work with nursing in an advisory capacity.

Question: You suggest that the faculty should study the needs of students and formulate objectives from these studies. What part should the students play in formulating these objectives?

Answer: It is clear that responsibility for educating professional nurses cannot be delegated by the faculty. I am not proposing that the students be given the responsibility; it is too important for the protection of society. On the other hand, participation of students or student groups in a study of their problems and their needs and their recommendations concerning the way that the educational program can help them is a method used in a number of instances. Their aid is very helpful even though the responsibility is the faculty's.

Question: How can we determine competency levels at the various years—one, two, and so on?

Answer: I have been using the term "objectives" in terms of the directions to be moved and not in terms of how far we are going to move. In setting acceptable levels of competency consider at least two factors: first, the level required for employment, say at graduation. You cannot graduate and recommend a nurse who is below this level of competency. Second, consider your experience in the levels students have been achieving. In working with them on certain objectives we note how far they do progress. We can then begin to say: With this kind of a program within a year students are developing to this point. If the actual levels attained are not high enough there are two possibilities: to spend more time so as to reach a high level, and/or to drop or to deny admission to certain students who are too far below the desired level.

REGIONAL PLANNING

FLORENCE K. WILSON, R.N.

In midwestern accents and from a background of several years in New York, I bring greetings from the South. In that salutation is one of the safeguards in regionalism. The people in the United States move about freely from one region to another, therefore guarding against provincialism. The other safeguard is to keep in close relationship with the national professional nursing organizations, keeping them informed
as to what you are doing in your region, and obtaining as much information from them as possible as to what is happening on the national scene.

"At present, there are several experiments in regional nursing education in the various parts of the United States, usually under private auspices, such as the one in New England associated with the Bingham Associates and financed by the Kellogg Foundation, and the one in the Rochester area of New York State, financed by the Commonwealth Fund. This discussion, however, is concerned entirely with the plan in the South, which is to be carried on through official channels, with the nursing profession in an advisory capacity. An attempt will be made to outline the steps taken in regional considerations in general education, indicating how the Southern Regional Conference of State Leagues of Nursing Education has tried to develop a relationship with the regional movement in professional and graduate education.

For some time the governors of the 48 states have been holding conferences to discuss common problems. They have found that some of these problems have a definite similarity in certain regions of the country. The governors of the 15 southern states have been meeting at intervals to discuss the questions arising in the South. In October 1947, the first definite step toward creation of a regional education program was taken at the Southern Governors' Conference, held in Asheville, N. C. The motion was adopted "... that the Committee on Resolutions be directed to bring in a resolution which will define the purpose of this conference to be the provision, either within the several states or without, of adequate facilities for higher education for both whites and Negroes, and ... the appointment of the committee to study this particular question."

The next step was taken in February 1948, when the governors in 14 states signed a compact which led to the establishment of the Regional Council for Education. Following this meeting, a headquarters office was established in Atlanta, Ga., with Dr. John E. Ivey as director, and William J. McGlothlin, associate director. The fields of professional and graduate education were surveyed, and it was decided to focus attention first on human medicine and related fields, and veterinary medicine. Nursing was considered as a related field, but, since the commission which had been established on nursing recommended that each state have a collegiate school of nursing, it was believed that nursing was a state, rather than a regional, problem. The Regional Council initiated a program of contracts between states and institutions in the field of medicine, dentistry, and veterinary medicine. The contracts were between the Regional Council and states and between the Regional Council and the institutions. The institutions save a certain number of places for students, and the states make payments through the Regional Council to the institutions. This saves the states from establishing and financing expensive programs in professional education and helps the institutions financially. In 1949, places for 388 students were provided under 40 contracts—207 for white students, 181 for Negro students. During 1950-51, places for 600 students will be provided.

In January 1949, Alma E. Gault, president of the Tennessee league, wrote to the presidents of the leagues in the 15 southern states, asking them if they would be interested in meeting together at the Atlanta headquarters of the Regional Council to discuss what might be done in nursing education. The Brown Report had just been released, and all of us were very interested in making plans for nursing education. Representatives from 10 states in the South met April 1-2 in Atlanta. Gladys Benz, director of the NLNE Department of Advisory Service to State Leagues, attended this meeting as a representative of our National League.

The agenda for the meeting was concerned with the surveys of nursing needs and resources which had been conducted in a number of southern states. The discussion showed that 7 of the 10 states represented had either had a survey or were in the
process of having such a survey. The group recommended that all of the southern states be encouraged to undertake such a study.

Dr. Ivey met with the group at this time and gave an overview of the plans of the Regional Council. Also, a constitution and bylaws were discussed, and temporary officers were elected for an organization to be known as the Southern Regional Conference of State Leagues of Nursing Education.

By May of 1949, the constitution and bylaws had been written, and, at the annual convention of the National League in Cleveland, a meeting was called of state league presidents or their alternates from the southern states. They were given the constitution and bylaws and instructed to present them to the membership of each state league in the South; if approved, they were to notify the secretary. The constitution and bylaws state the purpose of organization: (1) For exchange of ideas, dissemination of information, and recommendation of action in order to improve nursing service through better education in such of the 14 southern states as ratify this memorandum. (2) To establish working relationship with the Regional Council for Education.

Other business taken up at the meeting was a discussion of a form for assembling the facts from the various states in regard to needs and resources. Those of you who heard Miss Arnstein[1] speak on this subject, know of the difficulties we encountered in trying to assemble this material on a regional basis.

In June 1949, the Regional Council for Education became the Board of Control for Southern Regional Education, an official agency of the states approving the contract. It is made up of the governor of each participating state and three citizens of his state, one of which must be an educator and one a Negro. Since this is an official organization, the nurses could have no direct relationship with it as they are professional, but the staff of the Board of Control welcomed the advice of the Southern Regional Conference of State Leagues of Nursing Education. The relationship is similar to the relationship of the International Council of Nurses to the World Health Organization.

In January 1950, the Southern Regional Conference of State Leagues met again in Atlanta. At the time, Margaret Bridgman was just starting her tour of the South as consultant for the collegiate schools of nursing, and she was able to meet with us. Mr. McGlothlin outlined the further developments under the Board of Control for Southern Regional Education and attended our morning meeting to get acquainted with the group. We divided into four discussion groups and later came back with recommendations in the following four areas: (1) schools for practical nurses; (2) hospital schools of nursing; (3) collegiate schools of nursing, and (4) programs for graduate nurse education. These recommendations were sent to the National League for comment, and the suggestion was made that the president from each of the state leagues take the recommendations back for discussion with the membership in her state.

The Southern Regional Conference of State Leagues met again in Atlanta in November 1950. Marion Sheahan, director of the National Committee for the Improvement of Nursing Services, met with the group at that time, since one of the projects of the NCINS is to work closely with regional developments. It was reported that the Board of Control is trying to secure from the colleges and universities of the South the fields of graduate and professional education in which they wish to build strong programs. The various states would then share these facilities, thereby making it unnecessary to duplicate facilities in each state. This would result in strong centers with various offerings supplying the needs of the region.

At this meeting, the following resolution was passed: That the Board of Control for Southern Regional Education be asked to appoint a Commission on Nursing Education as soon as possible for the purpose of studying nursing education and identifying the ways, if any, in which regional arrangements would be beneficial. The recommendation was accepted by the Board of Control since it had already approved extension of

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the program to include nursing education. In February 1951, however, a letter from the associate director of the Board of Control indicated that the establishment of the Commission on Nursing Education had been delayed because the Board of Control staff is working out ways and means by which the Board can assist the national mobilization effort by finding out what services the government agencies wish from colleges and universities and what the colleges and universities can offer as services to the government agencies.

This report has tried to give information on the development of the South’s regional education program. On that basis, it is coldly factual. "But those facts cannot help but reflect the vision and determination of the educators and political leaders responsible for making of this plan a reality. On that basis, it will reflect spirit and inspiration, evident whenever and wherever men work together for the common good, with courage to seek new paths to higher goals."

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**COORDINATING RESOURCES IN NURSING**

**SISTER CYRIL, R.N.**

To introduce our discussion of coordinating resources, possibly we should first pause to agree on the meaning of the terms. The common definitions of these terms are those which are descriptive of the discussion at hand this morning.

1. Coordination—to bring into common action, to harmonize
2. Resources—available means

Coordinating resources in nursing would then appear to be a bringing together of available means into harmonious action.

If I may, I should like to discuss, as a practical example, the coordination of resources in nursing in the situation which I know best, namely, the circumstances which led to the establishment of a collegiate program in nursing under Catholic auspices in the Rocky Mountain Region.

To successfully coordinate resources it is imperative that there be a recognized need. It is also equally important that the groups believe in the plan of coordination and are in sympathy with the results. In Colorado we have a number of well-organized diploma schools of nursing. The faculties of these schools have worked very hard to raise standards, and Colorado is proud of its programs of nursing education. Following the publication of *Nursing for the Future* by Esther Lucile Brown, we saw that it was necessary to develop a new blueprint of nursing and nursing education. To quote from Dr. Brown,
It is the opinion of this group (Regional Conference on Nursing) that in the latter half of the twentieth century the professional nurse will be one who recognizes and understands the fundamental (health) needs of a person, sick or well, and who knows how these needs can best be met. She will possess a body of scientific nursing knowledge which is based upon and keeps pace with general scientific advancement and she will be able to apply this knowledge in meeting the nursing needs of a person and a community. She must possess that kind of discriminative judgment which will enable her to recognize those activities which fall within the area of professional nursing and those activities which have been identified with the fields of other professional and non-professional groups.

She must be able to exert leadership in at least four different ways: (1) in making her unique contribution to the preventive and remedial aspects of illness; (2) in improving those nursing skills already in existence and developing new nursing skills; (3) in teaching and supervising other nurses and auxiliary workers; and (4) in cooperating with other professions in planning for positive health on community, state, national, and international levels.1

To translate this blueprint into a plan for nurse preparation, it was necessary to ask ourselves several questions:

1. If the preparation of the professional nurse for the future belongs within an institution of higher learning, do we have such an institution within reasonable distance of hospitals and community agencies, and also one in which the philosophy and religion would offer continuity in teaching?

2. Do we have hospital and community agencies of sufficient size and variety of service to merit college credit as practice fields?

3. Do our hospitals give a type of nursing care which would insure that good nursing could be taught?

4. Do we have financial resources which would permit a period of study and implementation?

5. Do we have resources for recruitment, selection, and retention of qualified faculty?

6. Will we be able to attract students in sufficient numbers who would be able to benefit from a collegiate program in nursing?

While these questions of physical facilities were under consideration, another closely related area was reviewed—that of interpersonal relationships. The college under consideration and the two (or four) hospital schools of nursing were under different religious orders; each had operated its own educational system and had been responsible only to its own community form of organization. In an enterprise which aims to coordinate resources which are heavily staffed, the matter of personnel administration becomes of paramount importance. Could each of the groups concerned lose its identity and work for a common cause? True, the educational control would rest with the college, but every participating religious order became a stockholder in this new venture. In the organizational planning and functioning, recognition would need to be given to the dual ownership of the program.

Time does not permit a detailed discussion of the steps taken in the development of the project; instead, may I just give a brief summary of accomplishments to date under the two main headings proposed above, namely, coordination of physical resources and coordination of human resources.

Coordination of physical resources

Loretto Heights College was selected as the educational institution. It is conducted by the Sisters of Loretto and is a liberal arts college which for many years has been accredited by the North Central Association of Secondary Schools and Colleges.

Two hospitals are the official clinical units in this program. One is the Glockner-

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Penrose Hospital in Colorado Springs, which had been the central unit for the Seton School of Nursing. The Seton School of Nursing was a school which for years had been accredited by the National League of Nursing Education and had in itself been a pioneer in development of an autonomous school through the use of the facilities of a number of hospitals in Colorado. It was logical for the Seton School of Nursing to move forward into the more progressive pattern for it had long been out in front in its educational planning.

St. Anthony's Hospital had also operated a good school of nursing for many years and had made application for survey by the National League of Nursing Education. Both hospitals were recognized for the quality of nursing care and high standing of their medical staffs. These hospitals are prepared to give instruction in medicine, surgery, obstetrics, and tuberculosis nursing. Resources for clinical teaching in psychiatric, pediatric, out-patient, public health, and rural nursing were secured.

To use the field of pediatric nursing as an illustration, may we show how we approached the subject of coordination of resources. We had several possibilities for instruction in pediatric nursing in our immediate area. We wondered which one would lend itself best to the educational program which we had in mind. We invited Lucile Perozzi, regional consultant of the United States Children's Bureau, to direct a study of resources and to give us her recommendations. Miss Perozzi, together with representatives from each of our clinical units, made visits to the institutions offering pediatric affiliation. She also visited the day nursery which was under the auspices of the Sisters of Charity and which we hoped to use for a clinical teaching field. Following this study, Miss Perozzi wrote a very helpful report which assisted the faculty in making the decision in regard to the teaching field which we desired for pediatric nursing.

**Coordination of human resources**

This was brought about through the promotion of good interpersonal relationships. In the development of a program which has regional implications, it is important in early planning to share with as many interested community groups as possible. The college had an active advisory committee of influential citizens, bankers, lawyers, businessmen, career women, and housewives. Nursing has a regular place on the agenda for meetings of this committee.

Nurse leaders in the community have actively participated in curriculum planning. Special tribute should be paid to the public health nurses in the region. In over-all planning, in the development of practice fields they have been most helpful; they spearheaded the development of the rural nursing field which utilizes a public health agency and a rural hospital.

As a part of our total organization plan, in which a division of nursing was established within the college, a coordinating council was created with the president of the college as chairman, the director of the division of nursing as secretary. The membership of the council includes the hospital administrators of each official clinical unit, the directors of the units, the dean of the college, and the public health coordinator. It is the purpose of this group to study the needs of the division of nursing, to promote good working relationships, and to develop administrative policies.

An active faculty organization is of paramount importance in promoting good interpersonal relationships and also to provide for the development of the program and the growth of the individual worker. Active, functioning, faculty committees bring about individual participation in less complex groups.

Another means which we have used that we could certainly recommend to anyone who is attempting a coordinated program of this kind is the use of consultants. I should like to mention those who have participated and given us very valuable assistance in the development of our program:
Minnie Pohe, Nurse Consultant, Federal Security Agency, Public Health Service—two weeks
Sister Olivia Gowan, Dean, School of Nursing, The Catholic University of America—summer workshop
Marcella Fay, Nurse Consultant, Federal Security Agency, Public Health Service—one month
Lucile Perozzi, Regional Nursing Consultant, Federal Security Agency, Children's Bureau—study of pediatric resources
Margaret Bridgman, Consultant in Nursing Education, Russell Sage Foundation
Chester Harris, former associate of Dr. Ralph Tyler, now Professor of Education, Wisconsin University—summer workshop, evaluation of basic collegiate program in nursing

Local Public Health Nurses:
Through committee work and individually, the public health nurses in this region have been of direct assistance to us.

Lily Hagerman, Regional Consultant, Federal Security Agency, Public Health Service. It is our plan to concentrate on a mental hygiene strand through the curriculum. Miss Hagerman has agreed to assist us.
Vesta Bowden and her staff, State Department of Public Health Nursing—in the establishment of public health practice fields and rural nursing
Mary Emberton and her staff, Denver Visiting Nurse Association—in the development of day nursery program, parents' classes, home visits

One official clinical unit is 70 miles from the college. While this does create its problems it also serves as a challenge in the promotion of good interpersonal relations. Meetings are rotated to minimize travel for any one group.

In April, the program was surveyed by the National Nursing Accrediting Service. We hope to meet with the approval of the board of review.

Conclusion
In conclusion, I have aimed to discuss the coordination of resources as it centers around a particular situation and to emphasize just two main areas in such coordination, namely:

1. The physical resources to be coordinated
2. The human resources, which can only be coordinated through good interpersonal relationships

Although I have described a particular situation, I would feel that the basic principles discussed would apply equally well in other related areas.

STREAMLINING

FLORENCE C. KEMPF, R.N.

What is the visual image that appears before us as we hear this term—streamlining? In a person—curves in moderation, in the right places, no surplus tissue. In an industrial product—a sleek, fast, smooth-moving object, suggesting motion even when stationary. Whether we apply the term to a person or a car, the composite many of us see is a trim chassis, upholstering in good taste, grace in motion, effectiveness and speed in action.

Probably few of us have applied the term to education; certainly I had never thought of it as applied to nursing education, but the subject has intrigued me as I have men-
tally pushed it around. The logical approach, it would seem, with the aforementioned points in mind, would be analysis of nursing curricula to see what essentials are now included—and have some been omitted that should be added? What subject matter, skills, attitudes, and practices represent excess baggage which we need to pare down or delete entirely?

It is easier to add than it is to remove judiciously since future situations may require almost any knowledge, skill, or attitude adaptability known to man. We therefore have to keep our goal, "streamlining nursing education," ever before us, never losing sight of the fact that we work with minds, bodies, and souls, not mechanistic products as does industry.

Some key steps basic to our objective would seem to me to be:

Increasingly effective selection of students—bringing to bear all aids now available and developing new ones to select wisely

An orientation program which informs, and supports as well as motivates the use of students’ own resources

Counseling which stimulates the students' thinking through to effective responses; recognition of and identification with purposes of profession, institution, and co-workers

Guidance of development of skills of membership and leadership

Acquaintance with the Person-Centered Approach in working with and understanding patients and co-workers

For expediency I have chosen the four-year basic collegiate program for the streamlining discourse because this represents my present area of activity; wishful thinking as well as facing of reality may be recognized in the discussion. Since we are planning a course at Michigan State College leading to a degree plus the certificate in nursing in four calendar years, it becomes immediately obvious that we are not following the traditional pattern. The basic college offers seven core courses, five of which are required to be taken in the first two years by all students entering the college. I have designated the five basic courses for which students enroll who elect a nursing preference. These courses, in my opinion, provide a foundation of well-rounded education which will make possible increased understanding and appreciation of the needs of society as a whole as well as of the individuals comprising it. The core courses are as follows:

**Biological science**—through one school year. A comprehensive study of biological science to motivate and guide the student in the development of an active interest in her position in the biological world. The fundamental principles of the biological sciences are studied with special emphasis on their relation to man as a biological organism and a philosophy of health which functions in living.

**Written and spoken English**—through one school year. This course is planned to improve the student's ability to communicate clearly in speech and in writing and also to comprehend spoken and written discourse. Emphasis is given to principles of logical thinking with expression to reading, speaking, writing, and listening; technics involved in doing investigative reporting; development of critical awareness to use of language in guidance, persuasion, and as a medium of communication.

**Effective living**—through one school year. The purposes of this course are to help the student clarify her life goals and increase her understanding and skills in human relationships. Relevant materials and concepts are drawn from the specialized fields in the humanities and the social sciences (such as philosophy, psychology, sociology, education, and home economics) as can be used by the student in order to deal realistically with the important life problems confronting her as a citizen and a nurse.

Some of these everyday life problems are: discriminating between the various ways of life open to us, developing a vital philosophy of life, maintaining mental and physical health, adapting satisfactorily to college, learning to get along with others, selecting
a vocation and avocation consistent with one's life goals, making a wise choice of a mate, adjusting satisfactorily to marriage or non-marriage, attaining competence in dealing with economic problems in the family, realizing the importance of groups in attaining our basic values, understanding the effect of groups on the individual, acquiring skills in democratic technics, becoming sensitive to group differences, contributing to increasing group harmony, and helping change our environment in order to make it more consistent with the ideals toward which we strive.

Social science—through one school year. The object of this course is to familiarize the student with the origin, character, and solutions of significant social problems which confront man in contemporary world society. The material for the study of these problems is drawn from the various social sciences, including economics, political science, sociology, anthropology, psychology, history, and geography. This material is interrelated and unified in order to contribute to the student's understanding of the realities of the world in which she lives.

History of civilization—through one school year. The purpose of this course is to provide the student with a better understanding of the civilization in which she lives by imparting to her a knowledge and appreciation of the great cultures in which it has its roots. A knowledge of history is an indispensable basis for understanding in every field of human activity. The institution and ideas which are studied, always in their own cultural setting and with historical insights, are those which have special meaning and significance as factors in the historical tradition of the western world and which constitute, therefore, the foundations of contemporary American civilization.

The introduction to nursing course is given concurrently with these courses described. The nurse instructor can thus help the student to interpret for herself why the material covered in the core courses is fundamental in her education; to think how she will apply the knowledge and attitudes gained, in living and in her profession; to clarify her values based not only on adolescent experiences but on principles which are inherent in the comprehensive material she is studying. A few applications are included to demonstrate carry-over of technics taught in the core courses.

(1) During the past six months our students have written letters to their parents monthly. In those letters they have not only interpreted professional nursing and nursing education and characteristics requisite for a good nurse, but they have told their families why they are including the subjects already described in their programs; what they learn in them which applies to nursing and living. This, I consider, is extending education through a logical channel. It is relaying some concepts basic to broader understandings to the people who are paying for the education. It is also giving me considerable acquaintance with what is taught in the courses described, and, incidentally, it is giving me some startling surprises as to what I am teaching! The letters are read, scored, and corrected in pencil by the teacher, returned to the students, corrected, and sent home. Some messages from the parents, by the way, have been gratifying, and many of the students have improved in their written English and spelling.

(2) Many methods of teaching are used to give students practice in leadership as well as participatorship; learning to think on their feet, to disagree with good grace, to accept correction from their contemporaries and teacher without angry words or sulking silence. Circular discussion led by a student on "Is Nursing a Profession?" practically necessitated my leaving the room—I wanted to take over so badly, but, strangely enough, the summary was better than mine would have been.

Much of the content of the introduction to nursing course parallels discussions in effective living and social sciences. Relationships to nursing and living are thought through by the students before time erases them, and student satisfactions are heightened as they are helped to apply and evaluate material covered in all their courses.

Another setting for guidance of thinking with use of materials from several courses is the basic need of persons for a sense of security in strange surroundings. Each
student observed the admission of a patient to a neighboring hospital. Their reports, which were required, indicated what was done in the admitting procedure to provide for the person, as a patient, a high degree of mental, emotional, social, and physical security. Since our students had not yet been taught any procedures, technics did not get in the way of observations which any one of them, as a person entering the hospital, would have desired as part of her orientation as a patient. This gave them their first patient contact which they yearned for and strain toward as soon as they decide on nursing as their major. I am hoping their observations and discussions which followed will assure this particular "first" a lasting impression.

The history of civilization course precedes history of nursing and serves as a backdrop for the medical and nursing developments through the centuries. As part of the history of nursing final examination, students will write a letter to their parents summarizing the developments of nursing through the centuries, with emphasis on the current situation.

The sciences included during the first two years are chemistry, microbiology, physics, anatomy, physiology, foods and nutrition. Much thought and work is required with the instructors of these courses to emphasize basic health fundamentals instead of pure science principles. Joint thinking is preceding present presentations. The nursing arts instructor will have the opportunity of attending all these courses through at least one presentation, after which revision of course content can be continued as needed as a joint project of all the teaching personnel. The nursing arts instructor then will apply in nursing arts the concepts and principles presented in the science course. This may be heresy, but I believe it is in nursing arts where some streamlining might be started. Principles are basic for the nurse of tomorrow; skills stressed to the point of indoctrination that there is only one right way, I believe may have been overtaught.

If we take nursing in atomic warfare seriously, the addition of some technics such as administration of intravenous fluids should be considered for inclusion in nursing arts in the clinical situation.

The social sciences, with psychology and sociology required and religion, anthropology, political science, or economics as elective, are also attended whenever possible by the nursing arts instructor and principles integrated in the teaching of nursing. The elementary or home nursing content is taught in the seventh term in our program, after which students move to the hospitals for clinical experience and related class work at the beginning of the eighth term.

A two-week orientation interval is planned, during which time students will be introduced to the hospital situations and will be reviewing basic nursing principles in relation to the care of all patients. The service experiences for the first year, because of hospital divisions set-up, will follow traditional patterns. Methods of teaching used will seek student recognition that good nursing care of ill persons does not depend on service classification but on realization that here are persons, members of our communities, who have health problems. The program pattern as it is now developed integrates diet planning and preparation, pharmacology and outpatient orientation with medical nursing; central supply room, operating room nursing, emergency nursing, and related outpatient experience with surgical nursing; prenatal, labor and delivery, postnatal, and dietary guidance with obstetric nursing in mother and child care; growth and development, premature infant, well children, sick infants and older children, nutrition and feeding, related outpatient department observation and experience in child health services.

The second year of experience and related learnings are still in the planning stage. We know we wish to include tuberculosis nursing and communicable diseases if such clinical experience can be located and psychiatric nursing and community and rural nursing with observation and experience in a hospital and the related agencies. Some
guided experience in ward management and teaching is also desired, but its tie-up is indefinite at this time.

During the last six weeks of the fourth summer, our students will return to the campus to summarize learnings in seminars and to give thought to their future plans. They will also be asked to participate in an evaluation of their program of nursing education, carrying through with recommendations for changes, additions, or deletions.

I forewarned your Committee on Program that I would not be in a position to make suggestions based on the acid test of trial except for the first year. They very kindly encouraged me to preview some of our thinking for future developments. Our Faculty Committee on Nursing is interested in experimentation for sound, practical ends; as more nurse minds are added to our faculty, definite plans will take shape, based on analysis of the situation and needs confronting us.

"Newer Trends in Nursing Education" as our topic for discussion and thought denotes that all of us are moving with the times and seeking answers; it is the privilege of each one of us to experiment within the area of sound principles. If we are going to streamline nursing education we must teach students instead of subject matter. We must, however, select subject matter and experience with which our students may think and work to satisfying performance. We must prepare the professional nurse of tomorrow to lead in the areas of health care so that she can guide other members of the nursing care team with an awareness of their unity and purpose. Special skills must be lived daily so that self-consciousness can be left behind and mutual effort expressed in a contribution that is smooth, vigorous, expeditious, yet characterized by the gentleness of love and intelligent sympathy.

In closing may I say that I believe if we pray as we work for wisdom to know the right, strength and courage to do the right, we can increase our effectiveness and serenity as we face our opportunities and responsibilities.

BROADENING THE BASE OF NURSING EDUCATION

MABEL KORSELL, R.N.

Before endeavoring to broaden the base of nursing education, it is necessary to recognize the narrow or limited areas of the base. To find what such a subject meant to various nursing educators and students now endeavoring to improve schools of nursing, several were asked what should be included and where weaknesses lay.

Deans of university schools made diverse statements. One said, "We need to begin with the faculties"; another, "We are endeavoring to mold all schools of nursing into one pattern without any real knowledge of needs." Still others made statements like these: "We verbalize about integration, but it is a concept only"; "We are not certain of our direction."

Directors of three-year schools made the following varied statements: "Our objectives are not clear"; "Members of our faculties have had democratic theory superimposed upon old 'training school' methods—how can they teach what they have never experienced?"; "Our curriculums are confusing to both teachers and students." One said vehemently, "We shall achieve very little until nursing education is broadened to include hospital administrators who now see students principally as a means of keeping red ink from the hospital's financial statements."

Instructors said, "We must improve the nurses' ability to work with allied professions"; "The students come with an immediate service concept—the curriculum as now taught tends to disregard this motivating force"; "General education needs first to be improved—note the students' English, spelling, arithmetic!" One thought that "the real need is an understanding of logic and of ethics." Another thought programs should "give students a better understanding of what various branches of
nursing involve—make more actual practice in, and visits to, industrial plants, public health nursing stations, and the like, part of every program." One optimistic instructor said, "It means doing what we are doing—incorporating public health nursing into all areas of the curriculum."

A psychiatrist commented, "Wherein do your real difficulties lie? Because students do not possess technical knowledge or are the real difficulties in the emotional sphere?" He was criticizing our psychiatric nursing programs which, he said, emphasize the conditions of the intra-mural patients and do little to aid the student in understanding herself or in understanding the borderline patients seen often in the general hospital, or, for that matter, in the general community.

Senior students in a class studying professional adjustments were asked to consider what was needed to broaden the base of nursing education. After considering, they came back with a rather surprising response: "We need, more than anything, a study of comparative religions." When asked to explain the reason for such decision, they said, "If we are to aid in world health, we need a better understanding of all peoples."

One student, in thanking a school of nursing advisory committee for supporting a student activity, said in part, "What we appreciate especially is that this committee has made us feel that the community really is glad that we are studying nursing—being a senior, I was a student before this committee was organized, and I remember when we were quite sure that nobody in the community knew or cared about what we were doing."

These and many other statements were a somewhat bewildering assortment from which to formulate a ten-minute discussion, although they made plain the need felt for broadening the base of nursing education.

None of those interviewed mentioned good selection of students as a method of broadening the base. Perhaps all took good selection for granted. Nevertheless, selection of good potential nurses cannot be too strongly emphasized or too carefully done. If nursing education is to produce women who are to function in so very many capacities, who are to find direction, who are to be able to clear the chaos of thinking, who are to live up, somewhat, to what is expected of the nurse, we need, certainly, to consider carefully today's candidate. It has been estimated that 32 percent of our population has the mental ability to complete specialized professional education. Are candidates for professional nursing selected from this 32 percent? We should learn more about, and continue to improve, methods of selection.

To achieve better selection, we also need an informed public. To accomplish this in the local community, a school of nursing advisory committee is second to none in importance, especially if recruitment be one of its principal objectives. If the committee is truly representative of the community, it will voice what the community is thinking, and it behooves the administrative body of the school of nursing to listen, to correct false impressions, and to rectify errors pointed out by such a committee.

Those working in the field of general education will agree that general education needs to be improved. Nurses can assist tremendously by becoming acquainted with its leaders and with their problems. We can learn from their methods and can contribute as well. Many counselors in colleges and in high schools will welcome nursing periodicals and suggestions from nurses. We still find high school and college counselors referring the low-ranking student to nursing because she is "kind and strong" and because "she would never be able to achieve success in college." A high school counselor who also teaches mathematics and who has for years been interested in nursing, stated recently that no one had ever suggested to her in her many years of work with students that a good understanding of mathematics is of tremendous value to a nurse.

The value of student nurse assistance in planning and evaluation has been generally overlooked. How many schools include students on admission committees? At
Columbus City Hospital School of Nursing in Georgia, we have included two students on the admissions committee. After all of the faculty members had approved admitting a somewhat doubtful candidate at one meeting, one of the students said, "I would not vote to admit her; she would never make it"—and pointed out valid reasons from information in the application which the faculty members had overlooked. The program is very close to the students and they recognize certain needs of the candidate student as perhaps a faculty cannot.

Students prove exceptionally valuable on curriculum and library committees. Last year we had no evening librarian, and the students on the library committee arranged to have various students take turns to serve at the desk so that the library might be open from 7 until 9 p.m. three evenings a week. Time does not permit enumeration of the many ways the students have lent valuable assistance to the faculty of this school. The abundant enthusiasm of youth, tempered by experience of faculties, make a good combination.

There is evidence in many schools that little attention has been given to inclusion of ethics, logic, and religion. We expect nurses to be reasonable women and to be able to think logically, yet the learning of the elements of such thinking are left largely to chance. How these important elements may be included should be studied carefully. We need the aid of members of the clergy and persons in general education. Except for teaching of certain areas of the curriculum, how much is the counsel of members of the faculties of the various community colleges and universities utilized by nursing schools? Or how much do we know about persons living in the community who would be glad to lend valuable assistance in the nursing program? Last year in Columbus, the Junior League sponsored a "Personality Development" course for students during their first quarter of our school of nursing. One of the members termed it a "painless course in English, Speech, and Accepted Etiquette." It included, among other things, recording of voices by a manager of a local radio station, instruction in spoken English by the wife of an Army officer, suggestions in proper coiffure by the head of a school of beauty culture, and the finale was a fashion show sponsored by one of the ready-to-wear establishments demonstrating proper dress for various occasions.

Protestant ministers, a Catholic priest, and a rabbi have given generously of their time, instructing student nurses in what understandings the persons of various faiths expect of a nurse.

Recognizing students as students and not as a means of hospital economy has been improved. However, until some plan of financial aid to schools of nursing is found, it is doubtful that acceptable progress in actual teaching and learning within the clinical units will be an accomplishment in fact. Many administrators are sympathetic but can find no way of financing one of the most important components of nursing education. When we consider assignments of students on the clinical unit, supervision, understanding of the contributions of the allied professions, development of the clinical program from the more easily understood to the more complex, and evaluation of learnings, we have, in the vernacular of our part of the country, "a far piece to go" before clinical teaching is good.

Fusion of the curriculum is necessary for proper understanding and learning, and yet methods of fusion are little understood. Old requirements of a certain number of hours, a certain number of days, and a certain number of beds too often stand only on precedent. State boards and schools of nursing need to work together in re-evaluating requirements to permit research and experimentation. Most of our methods are still based on opinion or on trial and error rather than on sound research.

Fusion of understandings of positive health, of physical, social, spiritual, and psychological principles, of the place of nursing and the allied professions in the welfare of the patient and the community is essential for students; yet, in any faculty confer-
ence, it is plain that such fusion is far from having a common ground of understanding. We need to review faculties, to recognize what each member can contribute and—yes—how some may be impeding progress of a program. While most nursing programs have developed highly individualistic qualities in the nurse, true group work is new in nursing schools. Many conferences and sharing of ideas, opinions, and knowledge are necessary in a faculty. A member who frankly cannot work in a group may be given individual assignments. Her contributions can perhaps best be made by formal reporting of her work and findings.

In planning any broadening program, a faculty should be prepared to face disappointment. As Phoebe Kandel, educational director with the Board of Nurse Examiners in Mississippi, has put it: "If your apples are spilled from one basket, pick them up and put them in another—perhaps into two or three others."

We need to define our goals, to plan, to evaluate, to learn facts by research methods, and to learn to face facts. We need to come to a common understanding of what nursing should include, and, above all, we need to work together. There should be over-all common aims and common effort; at the same time, within the scope of these aims there should be permitted much flexibility for development of individual ideas. We need to broaden our individual lives and our individual understandings so that verbalizing and writing about needs in nursing education may truly result in more desirable nursing practice. In this way, there may be real development and real progress toward the over-all aims through study and good practices by the individual and by the group.

**Program Meeting**

**Thursday, May 10—2:00–4:00 p.m.**

**Improving Nursing Through Improved Graduate Nurse Education**

*Presiding: Ruth Harrington, R.N., Assistant Director, School of Nursing, University of Minnesota, Minneapolis, Minnesota*

*Speakers:*

*Frances Reiter, R.N., Instructor, Division of Nursing Education, Teachers College, Columbia University, New York, New York*

*Herman Finer, D.Sc., Director, Nursing Services Administration Research Project, Department of Social Sciences, University of Chicago, Chicago, Illinois*

**Broad Foundations versus Specialization**

*Frances Reiter, R.N.*

In these meetings so much has been said of "social climate" that I am perhaps hypersensitive to it. But being here with old friends in the Boston atmosphere makes me feel so much at home again that I feel more comfortably free to share with a larger audience than I should elsewhere. It would not be possible for a person to
express deep feelings with so large a group as this unless she had the security and trust I have in this setting.

This topic is on the program because the members of the board of review for postgraduate programs of the National Nursing Accrediting Service, questioning the wisdom of their guidance to faculties, spent several days deliberating and seeking some values on which to base their judgments. We examined programs of study for graduate nurses against the standard of professional nursing practice that should be available to the public—both quantitatively and qualitatively. In an attempt to clear our sights before recommending directions that faculties might pursue, we balanced many factors, one against the other. We kept the wants and needs of the consumer of nursing in the foreground of our thinking constantly. We considered the expectations of the graduate nurses entering college programs. We examined the curricular offerings of the programs seeking accreditation. We listened to the points of view of one member, then another, then another—and each grew in the process. I wish that you all might have gone through this experience as we did. Or, in lieu of this, that all the members of this reviewing board might be here with me to re-enact for you our way of thinking—to bring you their individual concerns. An outline of our critical analysis and the basis of our thinking, together with our conclusions and recommendations to the Joint Board of Directors of the Six National Nursing Organizations is in the May 1951 issue of the American Journal of Nursing. It is based on three simple assumptions:

1. That, as part of the shortage of "enough" nursing care, there is neither "enough good" nor "good enough" nursing care being provided for the consumer and public to choose to what extent they will use and support it.

2. That the responsibility of this board was to show directions and give guidance for programs to prepare "competent" professional nurse practitioners as well as, and differentiated from, professional teachers, administrators, and supervisors of nursing.

3. That one of the greatest influences on the quality of nursing service being provided is the nursing competence of the staff nurse, head nurse, instructor, and supervisor, all of which is reflected in the practice of the students of nursing. The gist of this statement is that colleges and universities should re-examine their program offerings to graduate nurses for the purpose of moving as rapidly as possible toward a sounder foundation for nursing practice and toward increased depth and breadth in general education. That programs leading to a baccalaureate degree should require as short a time as is consistent with programs for other types of professional and general education. To that end, they should be supplemental in nature, consistent with the goals of sound basic collegiate education for professional life, and with nursing practice of a professional level. That programs leading to a Master's, or higher, degree should provide for (1) truly advanced clinical nursing, and for consultation and research in nursing; and (2) the specialization of administration, supervision, and teaching.

I shall try to recapture, however ineptly, the philosophical considerations which underlie this statement.

What makes nursing care professional? What should any collegiate professional nurse be able to offer her patients that other nurses might not? What differentiates nursing practice of a professional nature from that of other nursing? What is the nature of the present practice?

The most common type of nursing care is that which we generally think of as being received by patients in large institutions, sanatoria, and some of the large or small public hospitals, particularly those for persons with mental or chronic illness. It is predominantly limited to providing the basic, essential physical needs. It requires
few limited skills and little judgment of the aides, attendants, orderlies, practical nurses, and the relatively few registered nurses giving direct care. It is minimal in scope but the quality may be "good custodial" or "poor custodial" depending on the provisions for kindness, general health, comfort, and a safe environment. It costs less per diem to provide than other kinds, although it is more expensive over the long haul. Since it is done for a person, it encourages dependency and is wasteful of unutilized human potentials within the patient himself.

Next in quantity is that nursing care received by patients in the greatest number of hospitals—large and small, rural and urban, private, general, special, in medical centers and centers for research, in hospitals where there are schools of nursing, affiliating programs, and postgraduate field experience. This nursing care is predominantly providing physiological safety, and administering tests, medicines, and treatments. It is restorative for the person who is hospitalized during a relatively short period of time, usually during the intensive acute episode, and although more costly than custodial, together with the nursing related to preventive medicine, it has notably increased survival and life expectancy and is well supported by the public.

Direct nursing care of this type is given by aides, orderlies, attendants, and practical and registered nurses, generally under the direction of registered nurses with little or no additional preparation, in those hospitals with no school of nursing or affiliation. This is the type of nursing that the largest body of students of nursing observe about them and practice under the guidance of an instructor—in the daytime. It demands considerable physical effort and emotional control, skill and ingenuity in many complex procedures, a sense of timing and speed in performance, a concept of aseptic technique, operation of much technical equipment, a knowledge of pharmacological terminology, the expected action of drugs and vital signs, also a fund of knowledge of hospital policy and procedure. Considerable judgment may be exercised, but routine hospital policies and procedures are established for safety.

The technical nature of this type of nursing care has emphasized the knowledge of facts and the utilization of principles from the biological and physical sciences, which has led into a false sense of security in the professionalization of care. Like custodial, it ranges from "good" to "poor" to "dangerous." Additional criteria used are the immediate therapeutic effectiveness of the treatment given and the patient's knowledge of how to effect long-term effectiveness. Whatever we name this type of nursing care, it is highly technical in nature and, as well as doing something for a person, much is done to him.

Professional nursing practice is not separate from "good" custodial nursing practice for the person's safety and comfort, nor from "good" technical nursing practice administered to the person for his survival and recovery, but it incorporates both these into something more. Professional nursing practice is a working together with the patient and family toward optimum rehabilitation and self-direction and health promotion. Quantitatively, it is the least common and so relatively rare that the average consumer of nursing may not know it exists. It is something found in some parts of some hospitals or homes or communities and only where there is a fully competent professional nurse practitioner who has developed a peer and equal relationship with doctors and members of other allied professions. This is so important it bears elaboration.

It may be that there is no new and different definition of the function of nursing by which to appraise the quality of care that patients receive, but today, with the growing knowledge of social and psychological sciences, the old statements have a broader application and take on a new meaning—a greater depth and penetration of meaning. At its best, nursing is to fill the role of mother substitute. Psychologically, this has tremendous importance. At its best, it is still to nurture and promote growth. Its uniqueness lies in those services which the patient received earlier in life from the
mother—bathing, feeding, toileting, dressing; providing warmth, and rest, and ease, and trust throughout the day and throughout the night. It is these services, distinctly motherly, that neither the doctor, nor the social worker, nor the dietitian, nor any others of the allied health professions give, which are unique to nursing.

It is through this mother-substitute relationship that nurses can participate with patients in their common family experiences with pregnancy and birth, illness and injury and surgical intervention, in ageing and grief and death. It is upon this basic, intimate, direct, participating relationship that other aspects of care become professionalized. Without this, the giving of medicines or tests or treatments are purely technical functions and the charting of these only a record of orders carried out. Without this, the directing of nursing by others is only managerial. But, with this, we have a common meeting ground to contribute and share and participate equally with the doctor and social worker, nutritionist, chaplain, and all others of the allied professional groups.

The professional characteristic of nursing practice lies in the use of judgment based on understandings. These understandings are of a three-dimensional nature:

1. The understanding of the human and his physical, mental, emotional, spiritual, and social capacity to plan his way of carrying out the purpose of treatment at his rate of growth, and to incorporate it into his way of living.
2. The scientific understanding of the rationale of all parts of the total therapeutic plan and their interrelationships.
3. The social understanding of the setting which she and the patient share, and of the family, the culture, and the community to which the patient returns.

The experiences necessary to gain and to use these understandings for developing professional competence and maturity in the practice of nursing are the contents of a baccalaureate nursing curriculum for the graduate nurse as well as the basic collegiate student of nursing. It is the nucleus of professional nursing practice which a profession is charged with protecting, preserving, and promoting in its educational system, whatever the demands for quantity, for the growth and reproduction and life of a cell depends upon the health of its nucleus.

Learning is an individual selection process. We select those things which have meaning for us. We each have heard only parts of what has been said—not only because of the limitation of expression or the selectiveness of listening, or hardness of listening, but because the clamor of the problems in our work-a-day situation intensify our hardness of hearing. But some old, deep-rooted satisfactions in nursing which we have each experienced must respond to the sincerity and convictions and deep sense of responsibility for accreditation which underlies the board of review’s statement of belief.

To the extent that each of us can accept these beliefs, we will effect changes in the education of graduate nurses which will improve the quality of professional nursing practice that patients and families receive.

PREPARATION FOR ADMINISTRATION OF NURSING SERVICES

HERMAN FINER, D.SC.

This afternoon, I am going to give you something of the tentative results which we have reached in discussion of Nursing Services Administration in the course of a six months’ seminar we have conducted at the University of Chicago. It will not be amiss if I spend half a minute in explaining exactly what this cryptic assembly is. The Kellogg Foundation gave a grant to the University of Chicago in order that it
might call upon some 12 universities which have schools of nursing and hospitals; and to add to that certain representatives of the Armed Forces nursing corps and the United States Public Health Service. The idea was that, in the course of some six months' discussion between those people who understand something of administration and curriculum outside the hospital with those who do understand these things, we might, toward the end of the time, be able to formulate answers to some fundamental problems. These were: first, whether administration means anything at all in the hospital situation. If it does, just what does it mean? Second, what social sciences or what segments of the social sciences would it be advisable for us to introduce into the curriculum of nursing services at some stage in order to improve our capacity for giving better patient care?

Now, we have not quite finished our work and what I say does not commit our seminarists, as I call them (there are 36 of them); nor does it finally commit myself, for I never feel committed even down to the point of actual publication, and, if I could possibly change things at that stage, I would, as many a publisher knows to his—well, to my—cost, because they charge the author if he makes late changes!

The aim and quest of all of us is the care of the patient. We think of him or her at the threshold of the hospital, through all its attendance and down beyond the threshold, at home, and beyond that, too, because we are conscious of the various family relationships that affect his condition. Of course, we also remember the costs, for we haven't any inexhaustible supply of funds; the patient hasn't any inexhaustible supply of money. He has many other needs besides being put on his feet again. So we have this dual relationship of getting the best possible patient care that science can teach us is available, alongside the greatest possible reduction of costs.

Various circumstances have demanded in this present age that if we are to solve the problems involved in both these standards I have established, we need a greater awareness of administration. What resources have we, in addition to clinical capacities and skills, in order to give the best patient care at the minimum of cost? The reasons why administration has been thrust forward and the modern advancement of the nursing profession has been made dependent upon it, arise out of certain problems which I will enumerate and then say a word or two about, because it is on this foundation that the argument is based for adding to the curriculum a study of administration and certain of the social sciences.

We have these basic problems. (1) The scarcity in the number of nurses compared with our needs. (2) The fact that we tend to serve in the hospital in what may be called a large-scale unit. The true small-scale unit of nursing would be one patient in his own home with all the skills, all the people, and all the equipment available for him and him alone. For various reasons, technical and financial, such concentration is impossible, and as we move away from that ideal, we become a large-scale organization, and large scale, of course, is a question of degree. We know there are hospitals with from 25 to 40 beds; we know there are some that run into as many as the hundreds and even thousands. But in the wards themselves or other units of the hospital, we have largish numbers of people per unit of service. (3) Nursing service is concerned and connected with, and operates through, a multiplicity of departments, each with a diverse skill. (4) Within nursing service itself, there is a multiplicity of diverse nursing skills and tasks. (5) And, finally, a point Frances Reiter referred to, the quality of nursing service is very hard, perhaps impossible, to describe or measure arithmetically. It has to be stated in language, being a qualitative matter, 3.5 hours, nurse-hours per patient the standard, the target, around which discussion has revolved—you may be able to put it more accurately—means nothing except when related to all the problems of quality of patient care.

Now, a word or two on each of these factors in order that I may explain myself and set a foundation for what follows. We are, to begin with, interested in quality
that is attainable through better education, because we are concerned about the scarcity, the insufficient quantity of nursing personnel. If quality were better, if resources that are available, scarce as they are, were better used, we would have less anxiety. The anxiety would not be entirely abolished, but we would have a lesser problem of quantity. I have actually heard people argue that the nursing problem today is not one of scarcity at all; it is quantity in relation to service, in relationship to time that has to be planned, in relationship to the fatigue of the people doing the work, in relationship to the amount of wear and tear on the nurse, and so on—and would be, to a very large degree, if not entirely, soluble, by more enlightened concern for the use, the better use of the resources actually available. In any case, this is one of the factors that is very important to us. I may be permitted to guess that, whatever administration comes into office in future years in this country, there is no doubt that certain intense and basic sociological drives must lead to more medical care and hospital care, and, therefore, to stronger demand for nursing assistance, far bigger, even, than that forecast by Ruth Kuehn the other day in her discussion on the scarcity of nurses. If we have any difficulties in regard to quantity, then all the more reason why, in view of future increased needs, we must pay urgent attention to quality.

Secondly, this question of the number at work in any nursing unit, itself raises a problem of coordination and cooperation with people. My argument will be appreciated that it is administration that gives us the key to handling the interrelationships, the personal interrelationships, where numbers are engaged in a collective enterprise.

Thirdly, we are faced in the hospital with a number of diverse departments—departments, for example, of admission, personnel, clerical, x-ray, diet, social service, finance and business, pharmacy, laundry, records, maintenance, housekeeping, stores and purchasing equipment, religious ministrations, and so on—all of which must be brought together in some harmony, and, in fact, be brought together by the nurse. The nurse has been called the “buffer” of all the nursing services. Those who are buffers, are buffeted! She may be likened to the prism which brings together the colors of the spectrum to produce the white light on the screen. This is the nurse’s function, though I must hope that she is more practical and alive than a prism!

It is the purpose of the science and art of administration to make the nurse more practical. In the necessity for coordination, to secure the best possible focus of service, the best possible marshalling of services, the right proportion, the right timing, of all these various services, the nurse plays the part of focus and funnel and channel and applier to the particular imperative, which is—the particular patient. The difficulty about nursing administration or the rendering of nursing service and, therefore, of the administrator to see that these services are best rendered, is that no patient is exactly like any other. Even if a patient is one who falls within a certain branch of medical specialization—for example, neurology—still, within that, there’s a technical specialization within a specialism, and not only that, but, of course, his own personality and his own physiological and psychological history once again puts demands upon the nurse for the bringing together and applying in proper proportion and at the right times all of these diverse services. This involves a remarkable number of personal relationships. Moreover, her service is continuous; it never stops. The doctor can go home—sometimes he may put in an extra visit to the hospital; the interns can be “out-tums,” as it were, from time to time; and even the resident can have his time off. But the nursing service—that is the stalwart watchman with a 24-hour vigilance.

That is not all. There is a remarkable amount of what I call “contingency” about nursing service. By contingency, I mean the opposite of routine. No one can say the patient is going to be the same all through the 24 hours, or day by day, or that the man next door is going to follow the same march so that it would be simple to act and to coordinate one’s action to the elements, as it were, of accident. I don’t mean desperate accident. I mean that erratic deviation from predictable routine is a special mark of nursing services to follow contingent variations in the conditions of the patient.
And, moreover, as it has been brought home to me, there’s a rather more acute intensity of emotion involved in patient-nurse relationships than in most other relationships. When I don’t get a room any time in any hotel as promised me—it didn’t happen here, by the way—I may show some very visible emotion, but I notice that the man behind the desk doesn’t show very much. I can’t think of a business enterprise which, excepting in extraordinary circumstances, involves this intensity of emotion in the relationship between the two people most concerned. Now, this implies that the team which has to be charged with that situation is continuous, diverse, contingent; that it requires to be changed in its numbers, its pattern of activity, and its composition from time to time. In other words, nursing service is like having your football players out in the field with an indefinable number of plays which can’t very well be worked out beforehand as a coach works them out on the blackboard before the game starts. But I don’t want to go too far in that direction; otherwise I’ll cut the ground from underneath my own feet. For I am going to prove that by taking forethought and studying certain of the basic relationships between human beings who are connected with a collective enterprise, we may be able to do something to be ready for contingency, diversity, change in people, and the number of people we want to get together to cooperate and coordinate in any particular situation.

Out of this situation, of course, I have omitted certain elements which I shall inject without having the time to define them any further. At night, the nurse supervisor herself will be the administrator of the whole hospital. True, we have but delegated the authority, yet, nevertheless, there will be certain situations in which she is virtually the administrator. In small hospitals, day and night, she will not only be the supervisor or director of nursing services, but will also be the regular administrator, and this broadens her interest in the field of relationships—that is to say, of administration. I have omitted the relationship between the whole of the nursing services and hospital administrator, whatever he may be called—director or superintendent—and with a board of trustees. I have also omitted the relationship with the doctors, which I have reflected upon very carefully. As you know, the medical staffs do constitute, in the hospital situation, an independent master. The nurse is—let’s put it this way—the nurse is somewhere in the line between the director of nursing services and the one who is rendering the direct services to the patient. Maybe all the way down the line, but certainly somewhere in it, she is always subject to two masters—the hospital administrator, who attends to certain outside factors, and then what I call the submarine or torpedo shooter, that is, the doctor, who comes in and gives his particular orders or makes his demands. I don’t say this in any derogatory sense; I say it only in realistically reading any administration chart. But it has its consequences. To be a servant to two masters means the ability, as one doctor told us, to handle at least one of them with tact and with the arts of management which are available, he appeared to believe, peculiarly to women.

Besides the points I have already made, there are, of course, the diverse skills within the nursing services themselves. One of the most important advances made in nursing services in the last 30 to 40 years is the subdivision of labor or the recognition of the specialization of skills. That is to say, not everybody needs to do everything; not everybody ought to do everything. There’s a place for the reassignment of the tasks which are tied together in what we call the role of nursing among different operatives, among different skills. We immediately recall the practical nurses, the nurses’ aides, the ward helpers, the orderlies, the clerical officers, and so on. Now, this is a very significant advance, for all professional advancement, all industrial advancement, has been marked by specialization of function and the division of labor. In other words, they have chopped up what was formerly asked of a single person, a single mind in a single body, the professional nurse, into a number of functions, some of which can be assigned away to those with other skills. This process has meant that, good or bad, the integra-
tion of the single mind and personality has given way to the integration of a team. The team is in the ascendant.

The disintegration of the personal function and the assignment of the assortment of functions to a number of people, as a collective entity, now demands from a collective mind what used to be demanded from a single mind. Now, even when a single mind isn’t such a superior one, it has considerable advantage: it is supposed to be coherent. Leaving aside all problems of schizophrenia (and you may have collective schizophrenia, too), let’s not move from an integration of the personality to a schizophrenic team; that would really be a declension in effort.

My point is, if we want the advantage that the team does have over the single person—namely, the possibility of specializing skills, using special endowments, and, in addition, the tapping of those sources in our population which have been unable and are still unable to take the full professional education but which can come in at other stages and do a good day’s work—then it is necessary for us to supply to the team coherence, articulation, and, above all, a continuity of concern. Someone must always be concerned; someone must be concerned who is a part—top or middle—of the team, because we probably couldn’t explain beforehand sufficiently well to the fringes of our workers what the true ethos of nursing service requires. If we could, they ought to be at the top; and maybe they should be there in any case, with education for the higher skills open to them.

I want to insist again, because it is the essence of what I have to say, that if we are to benefit from all the advantages of economic thinking, good work, and the best use of population resources by substituting the team for the individual person, then we must supply to the team (which is, after all, an irresponsible number of people unless responsibility is put into it) the conditions of coherence. The team must be made a team. Its members must be articulated. Who wants a spine made up of individual vertebrae? Someone must give a continuity of concern, and that someone has to care 24 hours of the day. The hospital administrator goes home to sleep; the doctor goes home to his office and his patients. But some nursing personnel are rotating on the wards during the whole course of the 24 hours. Somebody has to have a continuity of concern in order to bring together and to apply to the patient, in his individual speciality of sickness, all the best skills that the team can muster.

If, then, a collective mind has replaced the mind of a single person, we need all the administrative arts that mankind can devise: the ability to recruit, the ability to plan, the ability to use consultative methods, the ability to command, the ability to supervise, the ability to correct, and all the rest. If not, we disperse responsibility; we defeat good care and, besides that, invite all kinds of financial waste.

Finally, there’s the question of quality of nursing care which was raised by Frances Reiter. Wherever you can’t state quantitatively by weights and measures, kilowatts, hours, number of punch cards filed, and so on, the service product of a person such as we employ in the higher ranges of action and interpersonal relationships, then quality of service has to be stated in language, and language is not as exact as numbers. We can’t state our nursing efficiency in dollars and cents, in calories, and so on. If you want to appreciate the truth of this, look at one of the very fine documents produced by the University Hospitals of Cleveland—Manual on Performance Evaluation of Nursing Service Personnel.1 It is an excellent piece of highly sophisticated work. They have tried their best to formulate the performance evaluation sheets for staff nurse and head nurse. It’s a grand job. If I had the time, I could show you at what point in the history of efficiency ratings this manual comes. It is sophisticated; it is sensible; it is a really excellent job. And yet, it still has to rely upon what it calls “subjective” factors. You can’t avoid it, objective as you try to be. Well, then, what’s the answer?

This: If you can’t have a convincing demonstration of efficiency or inefficiency by

1 Kempf, Florence C., ed. Cleveland, University Hospitals of Cleveland, 1950.
a figure, by arithmetic; if you can't make your arithmetic accurately argumentative; then all the more attention must be paid to the process, the traits of people, by which you may produce efficiency. In other words, we are thrown back where we can't measure the product exactly; we are thrown back, if we want a good nursing service product, to assessing all the administrative relationships concerned that are calculated to produce good work.

I now wish for a moment, before I come to the second part of my discussion, to give an example or two from a recent experience I had. Before Christmas, joking with a member of Time magazine staff, I had been half persuaded to go into Billings Hospital, in Chicago, incognito, to be a patient, as part of my research work. This was impossible, because I have engaged in various debates with certain medical authorities that have brought me to the notice of the interns. Consequently, the moment I walk into a corridor, someone pops out of a room where he has been attending a patient and calls out my name. This half jocular attempt was ruined, partly because it was only half-hearted, and partly because I can't be incognito on my own campus.

Well, fate took a hand, and so, on a professional journey out, I became quite sick in another city, and was in a hospital for two weeks. Fourteen days isn't a bad point of view from a worm's eye—or, I mean from the patient's—point of view, but I don't recommend anybody deliberately undertaking research so realistically. Oh, I know there have been great predecessors of mine in this respect—that man in Belgium who keeps going up in balloons, for example, or going down in diving bells. It will end up badly one of these days and he won't be able to record his research, so I don't recommend it.

I am going to mention one or two things that I noticed while in the hospital. I beg you, do not regard this as a reflection upon the profession in general, a reflection upon the hospital, or upon the people who attended me! Because the main point is that they all came to my rescue; I am well, I am talking to you; that's their work, and I am grateful.

Yet I just want to mention one or two things which, it seems to me, might, with some understanding of administration, be avoided. Take the question of peas in one's diet. I am almost prepared to write an essay on the inevitability of peas. I know peas are very good for you. I know they are very nourishing. But I must say that when a person has a very heavy internal complaint with acute gas pains it is no improvement to be given a regular diet of peas. Now does this matter, or doesn't it? Perhaps it doesn't. Because I could say, "I don't want them." This I did, and just put them aside. But it took some seven days for the peas to cease to come up, and I understand that the food that goes out on the trays is actually wasted. I hope it wasn't in that case, but it might be. Why do we waste that? Just a word or two with me at the beginning and a word or two going back down the line might have avoided the waste.

Second, I was washed and bathed by a nurse who was remarkably efficient, and I shall never forget her. She was so determined and knew her job so well that I actually called her by a nickname, "Brawny." Now I say that in love and affection and I mean it. She really did know her job; she infused her strength into me. The only thing is, I could never persuade her to modify her vigor when she approached the catheter. The body and nothing but the body—that was her point of view.

However, there I was being punctured, perhaps too frequently in view of my own sedentary occupation, with streptomycin and penicillin and so on. Surely, I suppose that prevented me from catching any germs. But I must say, I did feel nervous when one of my nurses, one who was supplying me with food, too, had a streptococcal throat. I thought that the march of science indicated that people with such an infection should be laid off—at any rate, from that kind of service. Well, maybe it doesn't matter. Maybe the antibiotics in me coped with that well enough, and you don't need the art of administration there. That may be; I honestly, I freely, assent to that. And yet, it may not be, either.
Another tentative illustration. Six o'clock in the morning, or a quarter to six—and I had reasons for really being afraid—a young gentleman who looked rather like a football player, but was clothed in official white garb of something or another and was carrying a number of instruments and bottles, came into my room, looked at me, and said, "I have bad news for you!" I really sank very low, and I had reason for it. After a moment's pause, I said, "Come along, out with it; what is it?" "Oh, I just want to take a blood count." What was that gorilla doing there? I am capable of psychological resistance. But I expect there would be people who, sicker than I was, would be really thrown down in their morale. Does it matter or doesn't it?—that's what I want to know. If it does matter, why hadn't someone warned, "Here's Mr. Finer's history; look at that record. Now, if you go in and you can't smile because you've got a hangover, at any rate, just go about your work; say, 'Can I have your arm, please? I want some venous blood,' and then clear out—or something to that effect." As he was going out, he said to me, "There's one thing wrong with hospitals." By that time I had recovered my humor and I asked, "What's that?" "Why," he said, "they start too early in the morning!" He had been out late at night, I suppose. I rejoined, "No, there are two things wrong; one is the fact that we start too early; but the other is the fact that people like yourself come in here and give a patient the shock you gave me. I hope you will change." I don't know what produced the change. Later on when he came in, he was noncommittal, as it were, or else he would smile and make some kind of joke. It was bound to be feeble in that case, because he was not personally capable of rising to any heights of nobility or magnanimity.

One final point: if you have an internal complaint, you don't like to cough. Every time you cough, it gives you pain in the side and you should not be in that kind of internal contortion, I suppose. I'm not a doctor, but, from the patient's point of view, it is better to be restless than to have internal contortions from coughing. Why do they open the door and leave it open when the man in the other room continually smokes heavy cigars? Isn't there any kind of an understanding? Can't they ask you, "Can you bear cigar smoke?"

I plead that you will not take these small matters out of proportion. Perhaps, merely by mentioning them, I have been out of proportion. The main thing was that I was looked after, people gave me their care, and I got better and got back to my work. But, if we don't look after the 10 or 15 percent improvement that we can make, what are we doing? Why more education?

It is thoughts of this kind—the lack of numbers, the need for the team to work together, the diversity of skills, the need for coherence in a team, and so on—that lead one to ask for administrative skill. We must grow counter-habits. We have to grow counter-habits because we, as nurses, serve a purpose, and that purpose, patient care, is our master. If these difficulties I have mentioned come in the way (and there are many others, also), we, like various other living creatures, have to grow extra claws or a crust around us like the crustacean family; we have to grow habits of various kinds, demeanors, ways of activity, deliberate procedures, in order to counteract the tough factors inherent in the situation.

What is administration? I offered my own team a definition: all the actions rationally performed by one person, or a number of persons in concert, to fulfill a common purpose set by themselves, or set by someone else for their accomplishment. It includes things like planning time, and planning cooperation; planning services and planning the extension of services; the description of jobs, the justification of the budget; the understanding of costs; the evaluation of performance; the understanding of hierarchy and discipline in an organization in which purpose and not our own enjoyment is the first command; the understanding of staff consultation, and the part to be played by the democratic principle in it; the rights of authority and expertness; human relationships among staff personnel; the relationship of the hospital and the community;
comprehension of the delegation of responsibility; our relationships with the public, and the right and proper ways to approach them, and the wrong and improper ways that should be avoided. It is not my business today to give you a total description.

For this science and skill we have principles that we have derived from centuries of human experiences. Take one that came out of the Pearl Harbor attack inquiry. Of all the things in the world, you might ask, what's that got to do with nursing services administration? Yet here's a principle (one of a score) that came out of it: "Friendship is not a liaison, and ought not to be confused with it." Friendship is not administrative liaison. When General Short and Admiral Kimmel played golf together on the course at Pearl Harbor, it was not the appropriate relationship to prepare for an attack on Pearl Harbor. Friendship can even sometimes damage administrative liaison. Now there are many principles of this kind. They are not cut and dried and 100 percent perfect. They are good shots at a target on what human nature will do when faced with a collective purpose.

We learn that before ever a person gets into relationships with other people in a situation, there's such a thing as self-administration. If you were to look at the counseling which is suggested in the Manual on Performance Evaluation which I keep praising, deservedly, you will see that the supervisor reporting on the head nurse is expected to control herself if she wants to do a good job of evaluation. Watch your own prejudices; you are looking for performance, not your own likes and dislikes. And I could take numerous other examples of the prior need for self-administration. We know very well that our own natures are turbulent. Or, if you like, placid. Which of the two doesn't matter, for the question is the relationship between ourselves and a purpose. Anyone who has a purpose, you know very well, unless he be a lunatic, must go back and control the rebellious parts of his own nature in order to say, "By limiting myself, I can achieve my purpose."

Now, we can draw our understanding of these ideas and attitudes from public administration, from business administration, from educational administration, and from more advanced studies of the nursing situation itself, many of which, I am glad to say, are being pursued by various research organizations, and some of which have been contributed to (and even more will be) by our own collaborator this afternoon, Frances Reiter. Knowledge helps transform coercion into persuasion. If all the people engaged in a situation don't know how to conduct themselves (conduct is the heart of administration), then we have to proceed by command and fear; if we know, then in time we can count on persuasion. The authority of the situation persuades; it doesn't need to be the authority of command alone.

I hope, in our nursing curriculum, we can give this understanding of administration, up the scale, from our basic studies to the director of nursing services. I have been exercising my mind on how much we should do in the basic studies. Of one thing I am sure: it's got to begin there. Administration is a two-way affair. You receive commands or you give commands; if you are in the middle, you're doing both. The recipient of commands has to know as much about administration—well, now I won't go all that way—ought to know much about administration in order to understand that what is being commanded of her is not personal arbitrariness, but is something that lies in the situation; or to enable her to discern which is which. I have looked very carefully into the curriculum for the basic studies. I wouldn't add administration to them as a separate study. But I would use the opportunities offered in sociology, professional ethics, the history of nursing, and psychology; I would humanize them, and I would inject my administrative understanding into them. So you can begin with that. Then, of course, in practice on the ward the head nurse and the others who come in contact with student nurses can add much to this, presuming they themselves have been more thoroughly educated in these fields. In education, nursing enjoys a great advantage which other professions don't have—the immediate, or almost immediate,
entrance upon practical duties. Almost every school of nursing has at its disposal, and immediately next to it, a practical clinical possibility which, by contrast, an official going into public work doesn’t have. The latter has to do his three, or four, or five years of studies before he ever becomes an intern in some job. In a sense, student nurses are interns practically after the first four or five or six months of entering upon their studies. But it’s awareness that we want; we want awareness of the administrative relationships and the injection of that awareness into these basic studies at the most fruitful places. As for the rest, especially in this period of transition, administrative education would have to be provided by various in-service arrangements. I can just imagine, all over this country, in the proper centers—regional centers, if necessary—courses being instituted for those who may be natural-born geniuses at administration but who would not lose anything by some extra theoretical awareness of these things upon which human beings have pondered for hundreds of years.

Can people learn to be administrators? Can they learn to act? Because administration is action. Well, if they can learn to think, I believe they can learn to act, to an extent; I won’t say 100 percent. Hamlet, of course, would hardly have made a good director of nursing services. Apart from the fact that he threw off poor Ophelia, killed Polonius and all the rest of them, which demonstrated a want of care for patients, he unpacked his heart with words. The administrator must unpack her heart with deeds.

I heard someone say a little while ago: “You can’t make a silk purse out of a sow’s ear.” A man of some distinction said it and it was not meant in an unkind way. He wanted to point out that some people never could be made administrators. Well, that is true. Some people are too good to be administrators—the vague, poetic, and the rest. Some people are too poor-minded. But most people, for the most of the jobs to which they aspire, can get along. The need is to help them to get along better by making them aware of many points of view, many conditions which they otherwise would miss. And, although I have educated many generations of students, and although I wouldn’t employ all of them with B.A.’s, M.A.’s, Ph.D.’s for myself as my assistants, still, very many of them would be employable, and all have been improved by being educated to see objectively the stated conclusions of many generations of human beings in their relationships to a collective purpose, in various historic situations.

The skills nursing service administrators need you can learn through administration, through sociology, through human relations, through group dynamics, and through some introduction to economics. I think I have seen that in my own group of 36 Kellogg seminarists. It can be done and will be done; about this, there’s no doubt. We can give a humane and liberal education through administration in nursing services. If we did that, we would so much the better qualify the resources we have; we would take that education to the top of all our ability, our ambition, and the dignity of our profession. If we did that, we would deserve to have more people come into the profession, and, deserving more, I think that more would be attracted.

I think that this profession can never pitch its professional standards and dignity too high, and I would conclude with this tentative possibility—perfect administration casteth out fear and fear, I know, has too long reigned in many administrative situations in the conduct of nursing services.

**DISCUSSION**

**QUESTION:** In this approach to the patient, in this teamwork, this integration of all the various people that work together, should not the person who has to have this approach or gather it together, be this warm, loving, understanding person, the mother substitute that Miss Reiter talks about? How would you get such a person to be the buffer between all these groups who are going to come in and do things to the patient like the mother, and the teacher, and the Boy Scouts? How can we keep her near the
bedside doing these intimate, everyday things that makes her so important in the life of a patient? If she gets too highbrow, she won’t do these things.

DR. FINER: How do you get anybody to do anything in any profession? You are careful with improvements in you selection; you are careful all the way up through the ladder—the professional ladder. If you know what you want, selection becomes more aware and conscious; your selection goes along those lines. One of the arguments that I think we have to try to face, and, I believe, resist, is one to the effect that most people who become, let us say, more learned in their professions, are going to lose any of the attributes of tender-heartedness. I pride myself on being of average learning in my own work, but I never close the door to any student. I tell students that if they’re in trouble or in difficulty and can’t find me because I have gone to a committee meeting, never mind about office hours, they can get me. Please absolve me from any immodesty about it. I don’t regard myself as a person; I am just a serviceable object. So, therefore, I think we can beware of believing (and I’m sure it is not really implied in our questioner’s question) that the acquisition of our necessary administrative skills would make us hard, with less of the tender-heartedness and loving-kindness which is really the essence of this profession. I think not. I think administration would be an arm; we would have another instrument for the expression of nursing care.

ALMA GAULT: Do you, Dr. Finer, think part of our problems may have been almost promoted by the fact that administration—at least, our ward administration—has been pretty constantly on the apprenticeship method? Has that added to our problems?

DR. FINER: Yes, that’s what I have gathered by being together with my 36 research workers in the course of this year. My answer doesn’t mean to say that I am the opponent of what is called field experience; on the contrary, I think one of the finest things about nursing education is the early combining of classroom with practice. What I would like to see is something more conscious among those who are in charge of the student nurses, giving them hints. They don’t have to be too pointed and obtrusive; a good person knows how to teach without the appearance of the teaching process going on.

ANN KIRSCHNER: Should there be a continuous blending of learning experiences in administration throughout the basic program in nursing, or should such experiences be acquired later in a course in administration?

DR. FINER: I see the first part of administration, the introduction to it, coming in the basic course. I see it coming, not as an introduction of a course in administration—expediency rules against that. I have investigated the basic studies, and it seems to me that the nonclinical studies already in the basic program are valuable, and would lend themselves very much to the imparting of administrative understanding. I know that there’s a distinction between the courses prescribed in the Curriculum Guide published by the League in 1937 and the best educational practice today. The sections on sociology in the Curriculum Guide, good as they were in their time, do rather smack of 1890. We can do better, and I am sure the schools in practice do do better, because the people have come out of the schools, the books are new, and so on. Still, to be sure that everybody, everywhere, is getting the best that sociology can now offer in its various branches, the out-of-date can be remedied. I could see the history of nursing services, sociology, psychology, and professional relationships made thrilling. They can be made thrilling, and no doubt they are in various places. The history of nursing would not be merely the annals of nursing, but a liberal education in human culture; and, in it, you can show the administrative questions that arose from time to time—for example, some of the things we have talked about today. Well, then, these students at the same time are blending because they are on the wards. As student nurses they are blending. Now, the problem is, what to do about those who have made their way, partly by their innate capacities for the job, partly by their education, into
the higher branches. Could we contribute something to them? Certainly, by in-service education. They don't necessarily have to go away from their work for a long time, although I think that, for some people, the idea of a sabbatical three months once in five years wouldn't do any harm. As my friend H. G. Wells used to say, "Even a house gets repainted inside once in three years." So it may be that means and time can be found, at any rate, for a minimum. People in practice might get a short leave, maybe spread over some time, not all in a continuous 12 weeks, let's say; but a couple of weeks, then two weeks more over the time; and in time that is regarded as slack, if there is a slack time in the profession we are concerned with.

Anna D. Wolf: I was very much impressed by the statement which Dr. Finer made in relation to the change toward subdivision of activities and services. Those of us who have been experimenting in this field of subdividing nursing activities in nursing services are also faced with the question, which comes from patient relationships, as to whether the larger numbers of individuals giving care to the patient are giving as much satisfaction to the patient as a single individual giving this care. Is any attempt being made in Dr. Finer's studies to determine the point at which we may be assured we are not sending too many people to one single patient's bedside? It has been a very real problem in relation to care of certain patients.

Dr. Finer: Of the five working groups into which the 36 participants in our nursing services administration seminar at the University of Chicago have been divided, one called the Application of Administration of Nursing Services Administration does have this in mind. I can give you no idea of what conclusions they came to, because they don't report to me until May 21. But they are certainly very sophisticated and awake to their problems.

Mary A. Maher: I think Frances Reiter has given us a great deal to think about, particularly in regard to the belief which she had with us, which is actually the belief of the philosophy of the Board of Review of the National Nursing Accrediting Services in regard to the baccalaureate degree; and she has pointed out, it seems to me, the importance of having this nurse practitioner really able to give this professional kind of care. Implied in this whole thing is the great importance of having this nurse have experience in situations wherein she will have an opportunity to become this professional self. Would Miss Reiter talk to us a little bit about the opportunity for those of us in universities and field agencies to get together to provide this kind of experience in the field area?

Miss Reiter: I can give an example of an experience we had in New York City through the league of nursing education in that area. All members of the league of New York City were offered the opportunity of participating in a work conference at which consultants in curriculum from the area of general education served as resource personnel. The work conference was largely centered around instructional problems, and we encouraged participation by those who give direct instruction and those who are responsible for the educational direction of the program. We also asked the administrative directors to attend some of the sessions. About 150 people met the first afternoon to bring out their concerns in giving better teaching to students of nursing. There followed two days of intensive workshops at which the participants grappled with the problems in small groups of 20, each with a curriculum consultant, each with the services of a prepared person to lead and a person prepared to report the thinking of the group. These groups were charged not just with finding some of the basic factors in the problems, but also with saying what the first steps toward the improvement of teaching might be. The reports that came from these seven groups were remarkable; no one could have anticipated the thought, the interest, the participation, and the growth of all who participated. There followed a group meeting on: "How, then, can we have relationships to try to get some of these first steps started?" Later, there was still
another group meeting with members of the curriculum committee of the league and 
all its subcommittees to try to plan what the league might do for its members next 
year in curriculum construction. At this last meeting there were 200 people.

I am sure it is not only through the exchange of ideas, but through the use of 
consultants from other disciplines and through some facility in the technics of group 
work that we may approach the solution to many of our own problems. It is important 
that we secure the cooperation not only of the discipline of teaching, but also of the 
other disciplines with whom we are associated in a colleague way for the improvement 
of care. We have, in common with this group, loyalty to the patient. It is through 
getting together with them and securing some help in the ways of getting together 
that we can share our own great potential of resources.

LORETTA E. HEDGERKEN: I address this to either one of the two speakers. To many 
nurses, the idea of professional nurse practice has become identified with administration, 
and I believe the first questioner voiced a certain fear that the other workers in the 
team will be engaged in those activities that Miss Reiter described as belonging to 
mother substitute, such as taking care of the patient, bathing the patient, and feeding 
the patient. There is concern that because of pressure, the professional nurse will yield 
the direct care of the patient to others. So many of our graduates, college graduates, 
are immediately pushed into head nursing. They say: "I don't have a chance to practice 
nursing. And I am afraid the patient no longer thinks of me as the person who does 
nursing, but as one who introduces the needle, does this, and does that." What can 
we do about this? How can we make a job for the professional nurse in the nursing 
situation? I believe something must be done in order to interest more young college 
students in nursing.

MISS REITER: Dr. Finer has brought out, and we know, many of these tasks which 
have accumulated and are taking our strength and energies are being given to those 
persons whose preparation is of a lower order. I can see that this is not the only 
approach to the solution of this problem. There are also tasks predominantly within 
the province of hospital administration which we, too, have accumulated and for 
which we have not been prepared. In this day and age, there are people who can 
do these tasks better than we. The fundamental point we must establish is that it 
is necessary to render unto Caesar the things that are Caesar's—to give to hospital 
administration those tasks which are of a hospital managerial order so that our 
supervisory groups, our nursing administration groups, our head nurse groups are 
freed to give more time to that which is their primary function: the improvement 
of the direct care to patients.

I have been very interested in a study which has just been published in California, 
_A Functional Analysis of Nursing Service._ I had estimated, from the experience of 
300 staff nurses, that approximately 50 percent of their time was spent in tasks away 
from the patient so that, although the hospital may provide 3.5 hours of nursing care 
per patient, only half of this would actually be received by the patient. This study 
which has just been published substantiates this; more than 50 percent of the time of 
staff nurses is not spent on the nursing care of the patient. I would predict that, 
in the case of head nurses, the proportion of time spent in non-nursing activities is 
closer to 75 percent; in the case of supervisors, it is closer to 90 percent. These are 
our key people whose competency in giving and improving nursing care is being 
misused. I think it is the administration of hospital services, which are only related 
to nursing services, which exsanguinate us.

DR. FINER: That is a word Miss Reiter invented when she came to Chicago. It 
means 'take the blood out of us.' Well, I agree with this, of course, and I think one 
might add, even with a reduction of the amount of time spent in administration services

1University of California School of Nursing, San Francisco, 1951.
that rightly belong elsewhere, there still might be quite a time spent away from the patient once you’ve accomplished the reorganization. In that case, the satisfaction that one has as recompense for this is that the whole of the team is supposed to be doing a better job for the patient than under the old system. If you really want to get back to the patient, there’s no real reason why one should not take a holiday. Supposing you said: ‘Now for these two weeks, I’m not an administrator any more. Somebody else will get a vacation, or there will be transfers. And for two weeks, one week this part of the year and one week in another part of the year, I am going back to my old work.” What’s wrong with that? What could be nicer or more refreshing? University professors who are doing research arrange for guest lectures in the college. Why shouldn’t a director of nursing services do some guest patienting?

MARThA RuTH SMITH: Miss Reiter, do you think the director of nursing service today can give that professional, competent kind of nursing care that you have talked about? And my second question is this: In improving graduate nurse education and in preparation for administration of nursing services—I am thinking of top administration at this point—is consideration being given to the nursing component in order that the leader may lead us in the direction of the kind of nursing practice that Miss Reiter talks about?

MISS REITER: The technical aspects of nursing have changed, but the concern for the patient and his welfare is as old as nursing. The director of nursing service or the nurse who is spending 100 percent, 90 percent, or 75 percent of her time, can, I am sure, give this care, this attention, to all of her workers; she need not have the technical competence for the changes that have come about, but some of the old core she still has and can give.

FloREncE KEMP: I would like to ask Dr. Finer what practical suggestions he would make whereby we may get all these individuals who comprise our nursing care team to forget the forces that play within them, the forces that play upon them in the hospital and in the community, and leave self-consciousness behind, and identify themselves with the common purpose—good whole patient care?

Dr. FInER: That is a very tall order. It involves no less than every technic of education and command and consultation which will make people dedicate themselves to a purpose, forgetting their individual ambitions, forgetting their families, forgetting their communities. That wouldn’t be very desirable in itself. I have the same problem when it comes to getting a public official in the top places in this country to forget his own ambitions, to forget his own prejudices, to remember that administration is global and not a little single territory in one part of the world. Even some of the finest educational systems in the world don’t quite achieve it. Now, you can guess when we will achieve this state—or be nearer to it—when the day comes that our society makes it possible for a person without presuppositions to choose his vocation and not be compelled to take the vocation that is the most accessible to him for various pecuniary and other compulsions.

QUestion: This is a question for Dr. Finer and I think Miss Reiter, too. Dr. Finer pointed out that continuity of concern is vital if a collective mind replaces the single mind, and he pointed out what we need to do in recruiting, planning, consulting, commanding, supervising, and correcting. My question is: Do you think that we can leave to chance the leadership or must the leadership be designated?

Dr. FiNER: Definitely, the leadership must be designated. There’s no doubt about that. If you start with the idea of a hospital as consumer-centered, if it first is concerned with the consumer and not the producer—now, I mean the consumer in the first place—then the whole organization of the hospital and everybody within it and all its equipment really should pivot around designated leaders. Without a designated
leader, which really means the location of authority and responsibility in some specified people, how can you possibly establish an authority? Would there be a referendum on each particular item of service and administration? There couldn’t be. To say designated leaders does not mean to say that the people who form the great part of the pyramid of command—I mean the masses as you come down from the top—should not participate. On the contrary! I see that the best counsel and the best thinking in the nursing profession leads toward far more consultation, far more mutual and collective consideration of what’s to be done, and how it’s to be done, and the items of job performance. All that’s to the good. But since the imperative is the patient’s, he passes that on to someone in nursing service who must say: “I represent that patient, and, in the end, when all the consultation is over, and if you still do not agree 100 percent, well, his wound still needs to be dressed; still some action must be taken.” Someone must have the final responsibility for action, and, therefore, we are obliged to have our designated leadership. That is not antidemocratic; on the contrary. A group of people can be nondemocratic, and a single person can act democratically.

Miss Harrington: Before we adjourn, I would like to thank Miss Reiter and Dr. Finer for their fine presentations. Perhaps the significance of today’s program is that it indicates we are really in the process of attacking our problems from a constructive point of view. Now, I know it’s customary for the chairman to assure the speakers that we have all been challenged and stimulated by their talk, but this afternoon, all I have to say is: If you haven’t been stimulated by our speakers, you are having an untoward reaction to the treatment.

PROGRAM MEETING
Thursday, May 10—2:00–4:00 p.m.

IMPROVING NURSING EDUCATION THROUGH STUDYING OURSELVES

Presiding: Julia M. Miller, R.N., Executive Director, National League of Nursing Education

Speakers:
R. Louise McManus, R.N., Director, Division of Nursing Education, Teachers College, Columbia University, New York, New York
Helen Nahm, R.N., Director, National Nursing Accrediting Service
Lillian M. Bischoff, R.N., Director, Schools of Nursing, Grady Memorial Hospital, Atlanta, Georgia

IMPROVING NURSING THROUGH ACTION RESEARCH

R. Louise McManus, R.N.

At the Joint Nursing Curriculum Conference held last November, one group was asked to consider how research within the various curricula might best be stimulated, exchanged, and disseminated to provide information and guidance to schools concerned with curriculum development. As an outgrowth of its deliberation, that group recommended that a discussion session such as this be planned at the National League of
Nursing Education annual meeting to secure wider consideration of certain proposals evolving from the Curriculum Conference and dealing with national planning for research in nursing education. A full account of the group’s findings and recommendations is available in the newly published Curriculum Conference report. Chief among the recommendations are:

1. That schools of nursing be encouraged to study and evaluate their own curricula to improve them and also to stimulate in-service staff education
2. That students in nursing education be given an opportunity to learn how to recognize and solve nursing problems
3. That machinery for the organization for, and conduct of, studies of research in nursing service and nursing education be established on local, regional, and national levels
4. That periodic conferences be planned for those members of the nursing profession interested in, and concerned with, research
5. That techniques be strengthened and developed for the dissemination of information concerning studies and research either completed or in progress, as follows:
   a. A publication area of research in nursing be established
   b. Functions of the Clearing House established by the American Nurses’ Association for studies and research in nursing be expanded
   c. Consideration be given by the Joint Committee on Research and Studies to national or international indexing of nursing literature

The major areas of needed curriculum research in nursing education as identified by the group were: (1) research in the functions of nursing, (2) the organization of personnel for carrying out the functions of nursing, (3) preparation of various groups to carry out the functions of nursing, and (4) evaluation of the educational product.

It is my task here today to discuss the viewpoint accepted by the group about the nature, purposes, and methods of action research—the kind of research which the group believes would be likely to be most suitable for helping us—and to suggest ways and means by which nursing groups might cooperate in solving these problems. The definition of nursing research accepted by the group for the purpose of the conference was "the systematic study of nursing problems carried through to the point of drawing and reporting conclusions and making recommendations for further action." The problem is, what kind of systematic study—how do we proceed? What steps do we take?

One of my associates, Dr. Ruth Cunningham, has said very simply that "research is merely a prestige word for the process of trying to find honest answers to honest questions" and that the steps are simply those of solving any problem, namely:

1. Decide what the trouble really is.
2. Develop a hunch or two about how the problem might be solved; find out what’s causing the trouble and what might change the situation to eliminate the problem.
3. Try out the hunch or hunches—take action.
4. See what happens—examine the results of action.
5. Decide whether the problem has been solved or at least remedied.

Textbooks on research describe these same steps in scientific parlance, but the meaning is identical:

1. Define and delimit the problem.
2. Develop a hypothesis or hypotheses.
3. Test the hypothesis.
4. Analyze the data.
5. Draw conclusions and make recommendations.

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*National League of Nursing Education, Department of Services to Schools of Nursing. Joint Nursing Curriculum Conference: Curriculum Bulletin No. 2. New York, NLNE, 1951*
Any scientist, whether in an exact science, such as chemistry, or a more complex one, such as sociology, will agree on these steps to problem-solving. Many technical problems in nursing can be solved by utilizing these steps, which are characteristic of test tube or pure research in an exact science. On the other hand, many other problems in nursing—certainly, curriculum development and nursing education problems—must be solved by utilizing research methods somewhat different from those of the physical scientist. Patients and families and student nurses won’t stay put in a test tube for careful analysis in isolation. A functioning curriculum in a school of nursing can’t be pulled apart and put together again as a neat chemical formula. Different and better ways must be found to adapt research methods when applied to the studies of the problems involving human beings and social situations.

Social scientists have developed and are beginning to utilize widely a new approach to the study of such social problems. They are beginning to ask special questions about research in such fields. For example, in the field of education—an important social science—Dr. Cunningham says the social scientists ask:

1. In a complex situation, rather than trying to isolate certain factors as is done when control groups are set up to investigate a single factor, shouldn’t we look at all the factors that make a difference? Rather than keeping things “pure,” shouldn’t they be studied as they are? Then the solutions will be more applicable to other complex situations.

2. Rather than merely being observers, shouldn’t the research workers be participants in the situation—be a part of what has happened—and study their part as a factor in the situation, too?

3. Rather than having the research worker alone decide whether or not the hunch or hypothesis works, shouldn’t we look to whether it works as seen by all who are involved—patients, the family, the professional team member, and the public?

4. Rather than seek a solution to a significant, widespread, professional problem—such as curriculum innovation—by studying in a single situation, shouldn’t nurses from several agencies or communities faced with the same or similar problem plan cooperatively for simultaneous, systematic investigation, sharing with each other their know-how of process, comparing their findings, pooling their results?

These questions are those characteristic of a research method which the social scientists are increasingly calling “action research.” Individuals, families, hospitals and other health agencies, communities, and society as a whole are continuously changing. The range of forces in the situation in which people are, should be studied through research methods adapted to changing situations.

Corey, in a report read before the American Educational Research Association in 1949, differentiated between traditional or fundamental education research and action research in terms of primary purposes and criteria for judging the quality of research. The immediate concern of the fundamental research worker, he indicated, is to establish new generalizations, observe uniformities and explanatory principles of scientific law. The purpose of the action researcher, on the other hand, is the improvement of the educational practice in which he engages; he therefore undertakes research to find out how to do his job better, and, in so doing, his research affects action.

Action research almost invariably requires the joint efforts of a group of people who are working along with the research specialist and not only share in getting data they need to improve their practice but also learn through their participation the process of continued improvement. The quality of fundamental research is judged good if the findings are generalizations which add to the knowledge already available. The value of action research, on the other hand, is determined by the extent to which the methods evolved and the findings make possible improvements in practice and add

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to the practitioner's functional knowledge about the phenomenon with which he must deal. In both types of research, the interpretation of results must be limited to the situation, and the results may need to be retested for other situations in which the influencing factors may differ. This qualification need not lessen the enthusiasm for the findings, however. The fact that the result is true for one situation is significant and important to knowledge about situations in general, even though we might hesitate to suggest that it might be true for similar situations everywhere. Yet, the fact that it happened in one situation is important information for all situations.

Although cooperative action research in education is being used successfully in many places, I am most familiar with a research program conducted under the several institutes of research set up by Teachers College, Columbia University, for the administration of its organized educational research program. The Horace Mann Lincoln Institute of School Experimentation, for example, carries on cooperative research in curriculum with public school systems in various sections of the United States. Both the method and the result of one phase of this institute's research program is described in the new publication of the institute's staff, Understanding Group Behavior of Boys and Girls.³

The staff, together with a group of teachers at an institute workshop, were eager to learn (1) how pupils and teachers working together with parents might study the group behavior of boys and girls, and (2) what the findings might mean for the experiences provided for pupils in elementary and secondary schools. They agreed upon one aspect of behavior—the acceptance and rejection of individuals and groups by individuals and groups—as a point of departure. Three teachers with a first, fourth, and eighth grade group respectively, agreed to pioneer in exploring the area, discover the questions involved, test the means of studying the questions, and examine their implications for successful experiences for boys and girls. A representative from the central office of the city's school department and a member of the Teachers College Research Institute staff served as consultants and resource people.

With the objective clearly in view and the point of departure agreed upon, the school work for the year started. As the teachers talked with boys and girls and parents and one another, problem definitions shifted but continued to broaden and clarify as the study progressed. The cooperation of boys and girls and parents in the problem definition was the important factor in developing insight into the nature of the problem and its eventual development into a concept unforeseen by the original planners as the problem reflected in the title of the book, Understanding Group Behavior of Boys and Girls.

As the definition of the problem evolved, the need emerged for finding or inventing suitable techniques for studying each aspect. The research staff gave direction to this task. The three teachers and consultants operated as coordinators and as a team in organizing the process and setting the stage for interaction of the wide group of pupils, parents, and other teachers in the school system. It is this core group that has now prepared the report, drawing upon the experiences of all to tell how they operated as well as what was discovered in the belief that these two elements should be so intimately related as to be meaningful only if both are reported together.

Another institute of research, the Institute of Administrative Research, which is concerned with cooperative improvement of school systems, is affiliated with a number of projects, including the Metropolitan School Study Council, the Associated Public School System, and the Central School of Study. Each of these projects stem from membership groups and bring together educators, lay people, and research staff for cooperative action in a concerted effort to improve education in the communities represented.

The blueprint for the Institute of Nursing Education Research, Experimentation, and Field Service at Teachers College has been planned to provide for cooperative

research activities which would somewhat parallel in plan and purpose the work of the institutes in other divisions of the college. We will profit from the "know-how" growing out of the experiences of other institutes. While waiting for the nursing education institute to be established, however, the nursing faculty has gone ahead in some action research which seems vital and should no longer be delayed. Further, in its study of nursing functions, the nursing staff is learning more about how to utilize effectively the principles and methods of action research. With the improvement of nursing care as the objective, we recognize that the first step must be to achieve a clearer concept of what the functions of nursing should be. Determining what "should be" is a philosophical procedure and one which we felt could best be done within the frame of reference of the opinion of members of allied professional fields. The appointment of the Committee on Nursing Functions culminated in a publication of this committee's report, *A Program for the Nursing Profession.* This report includes certain assumptions about what the functions of nursing should be.

Testing the assumption of what "should be" called for action research, some tentative hypotheses about nursing functions in team organizations, and opportunity to test them in actual work situations in cooperation with nursing service staffs of the hospitals participating in the projects. The understanding and support of the doctors, hospital administrators, and nursing service administrators were first gained as well as the full cooperation of all the nursing service personnel in the clinical units in which the experiment was initiated. Our research staff joined with the clinical staff in working out, together and continually, the plan for trying out team organization of nursing personnel in accordance with the assumption accepted. Modifications in the team concept as well as in the procedure of team activities were made as experiments continued.

The research staff then carried the partially accepted ideas to a new ward, and, with the cooperation of the nursing staff, again worked out the plan to test further the hypotheses. The action research program of the study of nursing functions is not yet complete, but the results to date are encouraging. Cooperative action research units have now been set up in a total of nine wards in three different types of hospitals. Considerable "know-how" has been developed and our understanding about team function and the team function of nursing has already been enlarged. The hospital administrative and nursing administrative staffs report that the effect of action research has been beneficial to patients' care, nursing service administration, and the morale of all groups of workers, and has been particularly satisfying to the individual workers themselves. We would hesitate to generalize about these situations, as to what would be true for all places, but the fact that these results are being obtained here may be of interest and importance to nurses in other places.

The Curriculum Conference believed the concept of action research to be of primary importance to nursing, since the purpose of action research is the direct improvement of practices through the research process itself, and the cooperative group process, in turn, promotes staff growth. An organized, cooperative action research program in nursing and nursing education should not only seek ways to bring about improvement in practice but also should reduce the lag in the application of educational theories and nursing knowledge through nursing practice. The system of nursing education must adjust continuously to cope with the change in problems in rapidly developing health and medical social welfare programs. The program of action research undertaken as the joint effort of several groups who want to find out how to do the job better will facilitate this adjustment and, at the same time, contribute to the improvement of practice in research situations.

Because cooperative curriculum research gives opportunities for wide testing of new ideas in specific nursing situations, it is likely that valid and usable results would be obtained more rapidly and more nurses would become skilled in the process of

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research and its application than in the case of individual research. It is increasingly clear that many of the critical issues in nursing and nursing education require investigation through an organized program of cooperative research and experimentation, and that nurses are eager to learn how to get ahead in their tasks and willing to join with other nurses and other groups to this end.

**ACCREDITATION AS A MEANS OF IMPROVING NURSING AND NURSING EDUCATION**

**HELEN NAHM, R.N.**

At this time, when we continue to face such grave problems which grow out of the ever-present shortage of nurses as well as lack of qualified personnel for the more responsible positions, it may seem to many individuals associated with schools of nursing that preparation for accreditation would only place one more heavy burden on an already overworked faculty. Yet, I should like to suggest at this time that the steps which are taken in preparing for accreditation are the same as those which need to be taken in solving both our present and our long-term problems. I should also like to suggest that it is not accreditation as such for which a school should strive but, rather, the improvement of the educational programs to the end that better nursing care is available to all people. In the improvement process, accreditation assumes its rightful place and comes to be looked upon as a means of improvement, not as a goal or an end in itself.

The concept of growth and development permeates our present-day thinking—growth and development of the individual to physical, social, and emotional maturity; growth and development of groups and of our entire society to the acceptance of responsibility for creating a better world in which to live. The concept of growth and development of our schools and of all individuals associated with them is inherent in the idea that accreditation is a means to improvement and not a goal to be achieved.

As I am sure you know, there are serious criticisms of the entire accreditation movement at this time. Colleges and universities in particular, have rebelled against what they believe to be the abuses which are corollaries of accreditation. They have objected to the rather arbitrary standards which some agencies have attempted to apply, standards which have discouraged experimentation and change and which have too often resulted in stereotyped and static programs. They have rebelled against the imposition of standards by agencies outside the institution, and have felt that the faculty should have the primary responsibility for determining goals, formulating procedures, and evaluating outcomes. The National Commission on Accrediting, which was established about two years ago to accredit the accrediting agencies, is a result of the dissatisfaction of colleges and universities with present accrediting services.

The National Nursing Accrediting Service has been in contact with the National Commission ever since the latter was first organized. During the past few weeks, the Commission held a series of interviews with representatives of the various accrediting agencies. On April 14, Lucile Petry, assistant surgeon general of the Public Health Service, Veronica Lyons, chairman of the Joint Committee on Unification of Accrediting Activities, and I met with Reuben G. Gustafson, chancellor of the University of Nebraska and president of the Commission, and Dr. Cloyd Marvin, secretary. We were gratified at their interest in nursing and their concern about our problems. We are confident that, through cooperation with the Commission, improved methods of evaluating our programs will evolve. However, we also know that the continued existence of every accrediting service will probably depend upon the soundness of the procedures.
which are used, the wisdom of the decisions which are made about nursing programs, the ultimate results in terms of improved educational programs and improved service.

The NNAS is still very new. It only came into being in January 1949. The first surveys were made in February 1950. Each board of review has had only two meetings. The full-time staff has been limited, and funds to operate the service have been at a minimum. Under the circumstances, the support of schools of nursing and individual nurses throughout the country has been phenomenal. During 1950, 69 different individuals from hospital schools, collegiate schools, state boards of nurse examiners, and other agencies assisted with surveys. The majority of these persons say that the experience has been invaluable. In the future, insofar as it is possible to do so, we shall plan always to send one member of our staff from headquarters. However, we shall continue to select the second person from some other school or nursing agency. In this way, accreditation becomes a means for the development of understanding between individuals from schools of nursing and other agencies which are sometimes located long distances apart, for the exchange of ideas, and for the mutual stimulation so essential to continued progress.

The opportunity which the boards of review have to review annual reports and survey reports on many programs also provides a means for the improvement of nursing education. As each program of a particular kind is viewed in relation to others of a similar nature, certain trends and problems emerge.

During the 1950 meetings, statements of problems were formulated by the boards of review. These were published in the April and May issues of the American Journal of Nursing and are thus available to professional nursing groups for discussion and further clarification.

Because we believed that schools which had been visited by NNAS representatives during 1950 were in the best possible position to evaluate the Service, a brief questionnaire was sent during March 1951 to each of the 91 schools which had had surveys. Fifty-two of the questionnaires, including 36 from hospital schools and 11 from collegiate schools, have been returned. Questions which were asked are the following:

1. How do you and members of your faculty feel about the entire accreditation process, including the material which you were asked to submit, the actual survey visit, and the reports which you have received?
2. What suggestions would you make for change and improvement?

We stated that, in replying, the name of the school need not be given. However, of the 52 questionnaires returned to date, only 4 are unsigned. There are many favorable comments and a number of well-deserved criticisms. However, of the 52 questionnaires returned, only one is wholly negative. It is of course possible that the schools which have not replied are the ones least satisfied with the Accrediting Service.

Many schools said that preparation for the survey stimulated interest and a spirit of cooperation; that the amount of material requested was reasonable; that the actual survey was a pleasant and stimulating experience for all concerned; that they liked the visitors and found them helpful; and that the reports, including the summary of strengths and weaknesses, were of value.

Other schools said that the volume of material requested was too great and that there was too much duplication on the forms which were used; that visitors needed to be better selected and oriented; that more time is needed for the survey; and that the final reports were too long in coming. A few schools said that some parts of the reports were inaccurate; that weaknesses were played up and strengths overlooked; and that visitors failed to give the understanding and encouragement which is needed. One school said that it felt that its program had not been evaluated in the light of its stated aims and that the report had discouraged it from progressing along experimental lines.

Suggestions for improvement of the Service included the following:

1. Select visitors with experience comparable to that of individuals in the school being visited and with knowledge of survey technics.
2. Improve the forms which are used.
3. Plan more time for the visit.
4. Don't make visits unless there is assurance that the program will be approved.
5. Take time to talk to the staff as a group to explain the meaning of accreditation and how the visit is to be conducted.
6. Develop a rotation plan so that competent personnel from all schools of nursing may serve as visitors.
7. Provide not only suggestions for further improvement but advice as to how this may be accomplished. Send a representative upon request for counsel, or provide a counseling service at headquarters.

We are glad to have favorable comments, and we feel that the criticisms and suggestions are objective and, for the most part, justified.

It has been difficult, during the past year, always to send individuals trained in survey technics because we simply do not have a large number of nurses who have had training of this kind. Without the invaluable assistance of many nurses who gave their time and energy to a difficult task, even though they knew they lacked the requisite training, we could not have visited 91 schools during 1950. However, these nurses learned a great deal in the process, and, as a result, we now have a larger number of persons with some competence in survey technics.

Our forms have been revised and new forms are now being tried out. They are still much too long, but, as soon as possible, further revisions will be made. A manual to orient visitors has been developed and is also being tried out at this time. Every effort is being made to select visitors more carefully, to always send an inexperienced person with someone from our permanent staff, and to send reports out more promptly. It will also be possible, in the future, for the boards of review which are concerned with basic programs to meet more frequently. The time between the survey visit and the notification of action taken will thus be shortened.

From the experience of the past year and the comments and suggestions which have been received, I am convinced that great potential value for any school lies in the process of preparing for accreditation. Values grow out of the fact that it must be a cooperative process which involves all individuals who are in any way concerned with the educational program of a school.

In preparing for accreditation, individuals concerned with the educational program are asked to state the philosophy and purposes of the school; to describe the administrative organization; and to give information about the adequacy of financial support, the preparation and qualifications of faculty, and the methods of selecting students. They are asked to provide information about the curriculum, on the experiences which students have in classrooms, hospital divisions, residences, and community. Information is sought as to methods of instruction which are used, the clinical and other resources available for teaching, the procedures used in the evaluation of educational outcomes, and the plans which have been made for the future. When people become involved in the tasks which are necessary in providing this information, they are not just preparing for accreditation. They are being stimulated to think and to clarify their own beliefs and goals. They are moving in a positive direction, with little time left for negative ideas and reactions.

Many people are frightened when they are asked to state the philosophy and purposes of a school. Yet when groups of people begin to think seriously as to why a school of nursing should continue to exist, and in what direction it should move to meet the needs of people in an area for better nursing service, stating its philosophy and purposes will not be so difficult. It is not so much the completeness of the formu-
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lated statements which is of value, but the working and thinking together which leads to
their formulation, and the unity of action which grows out of common understandings.

To carry out the purposes of a school, a sound administrative organization is needed. To
develop a sound organization, the understanding and application of basic principles
of administration is essential. Through efforts to understand and apply these prin-
ciples, relationships between nursing education and service are clarified as well as
responsibilities of each person toward others with whom he works.

To carry out purposes of a school, adequate financial support is needed. Although
many budgets submitted at present show little more than income from student fees
and direct costs of the school, the preparation of even a minimum budget requires
thoughtful planning and cooperative action. When efforts are directed toward the
preparation of a more refined budget which includes indirect as well as direct costs,
individuals concerned develop even greater understanding of the need for sound
financing and of their own responsibility for the most effective use of all resources
available, including time and energy of people.

Directors occasionally ask why they should use valuable time in preparing a budget.
This is most likely to happen in instances in which the hospital administrator and
members of the board of trustees are interested in the school and generous in their
provisions for it. Yet, failure of nurse faculty members to accept responsibility for
determining costs of a school only perpetuates dependency on others. It discourages
sound cost accounting to determine the value of student service. It discourages the
development of mature and responsible behavior on the part of individuals primarily
responsible for a school. When nurses accept the same responsibility for estimating
and justifying costs of a school as others are required to do in comparable enterprises,
administrative officers in an institution will be more likely to accord them the respect
which is their just due.

In preparing for accreditation, serious consideration must be given to the learning
experiences which are provided for students. These experiences are affected by many
factors, including the clinical resources which are utilized, the adequacy of staffing,
the equipment and supplies available and the structural arrangement of hospital divi-
sions, the classroom and living facilities, and the size and general character of the
community in which the school is located. A factor of primary importance, however,
is the competency of all individuals who affect the learning experiences of students
and the quality of the interpersonal relationships among these persons. The faculty
of a school is ordinarily defined as the group primarily responsible for planning and
administering the program of a school. Yet, students are placed in learning situations
in hospital divisions, in residences, and in the community. In these situations, they are
affected, for better or worse, by many individuals other than full-time faculty members
of a school. A student will not learn to apply basic scientific principles in giving
nursing care if she repeatedly observes care being given in which those principles are
violated. She will not become concerned about emotional and health problems of
patients in situations in which these problems are constantly ignored. She will not
learn how to establish effective relationships with others in situations in which there
is conflict between nurses and administrative officers, between nurses and patients, or
between nurses and doctors. Individuals concerned about a sound curriculum in a
school of nursing must give attention to the total environment in which students learn,
and to the functions and qualifications of all persons who affect that environment.

Qualifications of students also determine the extent to which objectives of a school
will be realized. In preparing for accreditation, individuals responsible for a school
are stimulated to examine those qualifications objectively—to ask whether or not better
methods of selection would result in a lower withdrawal rate, a more effective teaching
program, and a saving of time and energy of all concerned.

Again, in preparing for accreditation, schools are asked to furnish information about
methods used to facilitate effective learning. In what areas are students given freedom to plan and manage their own activities? To what extent are initiative and self-direction encouraged? What kind of assistance is available to students with emotional or other problems which interfere with effective learning? What methods are used to evaluate progress of students toward the achievement of objectives? How is information which is obtained through evaluation utilized in the improvement of the program of a school?

Too often the stated aim of a school is simply to produce good nurses. Admittedly, this is the primary aim for which schools exist. Yet, what is a good nurse? What kinds of learning experience must students have to become good nurses?

Too often the only method of evaluation is the statement that "we have always had a good school of nursing." Yet, what is a good school? Is it good because it is old or because it is new, or associated with a famous hospital or a well-known medical center? Or is it good because patients repeatedly say, "I like to have nurses from this school take care of me when I am ill," or because nursing service agencies are always glad to employ them because they can be depended upon to do a good job? There are many questions which might be asked. Are the nurses from this school interested in learning new things? Do they accept responsibility for improving the institution with which they are associated, and for solving problems of their own profession? Are they happy and reasonably well-adjusted human beings, able to work well with others in group situations?

Accreditation is a process which encourages the asking of questions like these, and the seeking of answers to questions which are raised. It is a process which sets activity in motion and encourages individuals to work together toward common goals. Once the process is started, it tends to perpetuate itself. It leads to continuous self-study, to the trying out of new methods, and to the evaluation of each method which is tried. It leaves no room for defeatist attitudes, for negative reactions, for criticism of others, for excuses for self. It leads to the creation of a better environment—an environment in which students can learn, in which all individuals who participate in the process can grow and develop, and in which people who are sick and troubled will be given the assistance which they need.

I would like to think that accreditation is only a means, a tool of the present which brings these things about. The ultimate goal in any institution is continuous self-study and self-evaluation. When this takes place, accreditation—or stimulation by an outside agency—should no longer be necessary.

PROGRAM OF TEMPORARY ACCREDITATION

In this paper, I have purposely first presented what I believe can happen through accreditation, and have reserved the discussion of one means now at our disposal through which we hope the entire process can be hastened. I refer to the program of temporary accreditation about which many of you are already informed. However, for those of you who did not attend pre-convention meetings, I will attempt to summarize background information and the steps to be taken in carrying out the program.

Background information

When the Interim Classification of Schools of Nursing was published in the American Journal of Nursing, in November 1949, by the National Committee for the Improvement of Nursing Services, schools of nursing were promised that a second or follow-up study would be made within two years. In March 1950, this committee asked the Joint Committee on Unification of Accrediting Activities whether the NNAS would assume responsibility for the second study. It was agreed at this time that the NNAS would assume the responsibility, provided the necessary funds were raised by the National Committee for the Improvement of Nursing Services.
Plan for temporary accreditation

A special committee, which was appointed to formulate plans for the second study, proposed that, instead of a second classification of schools of nursing, a program of temporary accreditation extending over a five-year period be carried forward. The steps included in this plan are the following:

1. Invite each school of nursing which offers a basic program not yet accredited by the NNAS to participate.
2. Ask each school which wishes to participate to fill out a questionnaire designed to give information about progress which has taken place during the past two years, and to describe plans for the future. Utilize additional information in the files upon which the first study was made.
3. Plan for each school to have a one-day visit by a qualified person from another state. The major purposes of the visit are:
   a) To verify questionnaire information
   b) To secure additional information
   c) To explain the entire program in more detail
   d) To establish better relationship between the school and the NNAS

The visitor will write a short supplementary report on each visit.
4. Present information about each program to the boards of review of the NNAS. Programs of collegiate schools will be considered by the Collegiate Board of Review; those of hospital schools by the Noncollegiate Board of Review.
5. Publish a list of school programs which have been granted temporary accreditation for a period of five years.
6. Through a series of regional as well as some individual conferences, help schools on the temporary list to prepare for full accreditation.

Criteria for temporary accreditation were developed by a special committee in December 1950. These criteria are such that it should be possible to include from 600 to 800 basic programs on the temporary list. As there are now 168 programs, including 131 noncollegiate and 37 collegiate, on the fully accredited list, it seems probable that only a rather small proportion of existing basic programs will not be included on either list.

Individuals who make the one-day visits will be carefully selected. An orientation conference to prepare them for the visits will be held. It is believed that the personal contact with a representative from the Accrediting Service will be of value, even though the visit must, of necessity, be brief. Visitors will not be sent from the same state but will be sent from another state in the same region.

Financing the program

There will be no cost to the school for the program of temporary accreditation. It is believed that each school should have an opportunity to participate if it desires to do so, and that the cost of even a short visit should not be a factor which would prevent such participation.

Funds to finance the program during the first year and to partially finance it during second and third years are now available. Grants which have been made to date to the NNAS are as follows:

Commonwealth Foundation ........................................... $75,000
(distributed over a three-year period)
National Foundation for Infantile Paralysis .......................... 61,250
(distributed over a three-year period)
Rockefeller Foundation ............................................. 65,000
(to be spent during first year)
Additional funds will be raised during the second and third years from small fees paid by participants in regional conferences. Individuals from schools on the temporary list and representatives from state boards of nurse examiners will be invited to attend these conferences.

Objectives of the program

I am convinced that the Accrediting Service, as it now operates, is soundly conceived. Soundness grows out of the fact that it provides for wide participation by nurses all over the United States—participation through membership on committees and boards of review, and also through the plan always to select one visitor from the region in which the school is located. The program of temporary accreditation will make it possible to extend the degree of participation.

Soundness lies in the fact that schools are encouraged to state their own philosophy and purposes and are evaluated in the light of these statements. In this way, experimentation is encouraged, and there is less danger of bringing about static and stereotyped programs.

Soundness also grows out of the present practice of evaluating programs in relation to their overall strengths and weaknesses rather than in relation to specific and rigid standards. The responsibility for developing a good program is thus put squarely where it belongs—on the persons who are primarily responsible. Individuals from the outside can give assistance when it is needed. However, the day of depending on others to tell us what we ought to do and how things should be done is rapidly passing. Depending on others only perpetuates immaturity. At the same time at which we are asking others what we should do, we may also be deciding how little of their advice we will follow. To meet present-day needs, it is essential that we have mature schools of nursing, as well as mature individuals in them.

Needless to say, there are difficulties and inadequacies in our present methods of accreditation, as well as strengths. It is difficult, even when the best methods which are available are used, to evaluate effectively the product of a school. The achievement tests which have been developed by the NLNE Department of Measurement and Guidance, including the State Board Test Pool Examinations, are of great value in measuring certain curriculum outcomes. However, extensive research is needed in the development of other measures to evaluate the products of our schools.

Until better methods of evaluation have been developed, the boards of review of the NNAS must continue to make the best judgments of which they are capable from the information presented to them. The boards are made up of highly competent nurses who are genuinely concerned about the decisions which they are called upon to make. They are concerned about the effect upon the faculty, students, and others when they feel that an adverse decision about a program must be made. However, they must also be concerned about the welfare of students who enroll in programs under the assumption that they are outstanding merely because they appear on the list published by the NNAS.

It is not so much the decision made about a school which is of importance, but the reaction of the school to the decision. It is, of course, possible that information presented to a board of review may not give a clear picture of a school. Under such circumstances, the school should exercise its right of appeal—a right which is inherent in any democratic organization. However, if a fair decision has been made, the school which can objectively face its own inadequacies and quickly set about making needed changes is, in the end, in a far stronger position than the school which rationalizes its failures and postpones the taking of constructive steps which would tend to correct its weaknesses.

The ultimate purpose of the program of accreditation is to help schools of nursing to improve their programs to the end that better care will be available to all people.
However, there are also concomitant values both to the school and to all individuals concerned. Accreditation encourages self-evaluation and stimulates schools to take steps which are necessary to over-all improvement of their programs. It necessitates the working together toward objectives which are accepted as desirable. It calls for a constant re-evaluation of those objectives in the light of changing needs of society.

I came across a statement a few days ago which said that the life of a person does not amount to much until it is focused, disciplined, and dedicated. It seems to me that the same could be said of our schools of nursing. If each school could be stimulated to think about where it is going in relation to the needs of a world society and could dedicate itself to achievement of those ends, the discipline would take care of itself. In the process of working toward something in which we believe, not only is the welfare of an institution assured but also the growth and development of each person who contributes to the process.

STRENGTHENING RESOURCES AVAILABLE

LILLIAN M. BISCOFF, R.N.

To define is to limit, but it seems necessary to attempt some explanation of terminology as we think together about strengthening resources.

The word "strengthen" may refer to some action designed to bring together the component parts of a whole to create a power. To strengthen may refer to the application of a principle in physics to create force; for example, the engineer who applied the principle of the lever to create the giant cranes procured a strength great enough to move mountains, create lakes, and change an entire segment of our social economy.

"Resources" refers to those disciplines that make up the individual, family, community, state, nation, and the universe. The subject is broad and implies freedom of development. An attempt is made here to discuss how we may apply some of the principles of human relations, administration, and research to local situations for the benefit of nursing education and nursing service.

We must be strong ourselves if we are to strengthen others. Emerson says, "A man already strong is listened to and everything he says is applauded." A man is strong in proportion to his faith. Our faith in nursing, in our own power to help save, maintain, and preserve life, coupled with our demonstrated achievements thereto, opens channels to strengthen the physical and spiritual lives of people in every walk of life in all parts of the world. Our faith in nursing has been greatly strengthened this week as we have listened to the reports of social and pure research that has taken and is taking place in our schools. There is, at last, a sense of emancipation, of maturity, which should give confidence to the nurse as she works with other professional people.

We do not always feel an independent professional status; for example, a nurse recently wrote a theme in which the words doctor and nurse were used. She invariably used a capital D and a little n throughout the paper. Unfortunately, some nurses, some doctors, and others do think of the nurse with a small n and doctors and other allied professional persons with capital letters. The individual nurse and nurses in groups need strength. The "why" has been discussed in nursing for years; the "how" is ours for the asking in most communities today—for example, the university has been brought to our concentrated centers; the League, through the American Journal of Nursing and other channels, has given so many examples of how the graduate group can be strengthened by continuing staff education programs.

Initiative, organization, and utilization of resources within our own staff, city, county, and state can nourish and strengthen the staff nurse who gives so much of herself to her job. Application of the principles of democracy pays great dividends. Strength for the individual comes with maturity, with knowledge, with feelings of satisfaction
and security. Control of these factors, for the individual, depends on the leadership qualities and human relationships of those in authority. Too often, the nurse administrator is given responsibility without authority. The authority to provide these essentials of a happy life to the nurse may come about by strengthening those persons in the hierarchy of our organizations.

We, as nurses, have one concept of what is right in nursing services and nursing education, while those who have authority by virtue of position or by holding the purse strings have a different concept. How can we bring the two concepts together and, by so doing, strengthen each other? Since a majority of our schools of nursing are conducted by the hospital, the following discussion applies to this type of situation.

First, we should know ourselves, our own strengths and weaknesses as nurse administrators. We have a fundamental lack in the use of sound business methods. Hospitals have entered the field of big business, and the administrator expects each department to know his job and to strengthen the whole by maintaining a strong link in the chain. Do we know, in a given situation, how many nurses are needed on each tour of duty; how many teachers are needed; how many students can be accommodated; how to make a budget? How many aides are needed? How many orderlies? Do we know the potential of each type worker? Do we know how to determine each of these factors? What are the yardsticks? We have the studies of Miss Pfeifferkorn and the manual written by the League and the American Hospital Association, but do we know how to use these tools? Is it true that these criteria are out of date in light of modern developments, but they are the best that we have, and applications of the principles outlined in these first studies of this nature are useful.

I recently accepted responsibility for a school of nursing and a nursing service and was faced with these questions. Having learned from Sister Olivia, I knew the steps to take in making studies, so I utilized the staff education programs to determine certain basic facts in the situation. Committees were appointed from among the head-nurse group to study various activities in each of the specialities. We determined the kind of activities; the number of times each activity was performed during the 24-hour period; the hours that major activities were performed; and the person responsible for each procedure. (This total study is not yet complete.) We then planned to do the time study for each major activity.

Following this, the study of personnel assigned to each tour of duty was applied to the activity. By showing the activities and the personnel assigned to each tour of duty, we were able to see what we had and what we needed in terms of personnel. These facts were presented to the administrator in the form of a report. The recommendations were justified and "backed up" with facts not only from the wards in this hospital but with a comparative study of personnel in other similar hospitals.

A study of the tools used by the nurses was made to show the need for supplies and equipment. The comparative costs of expendable supplies by wards were most interesting and instructive for the staff and the administration. A tabulation of accidents to patients accompanied a recommendation for qualified supervision on the wards.

These business men want facts and figures, and providing them with daily, monthly, and yearly reports of the volume of work in each unit should provide evidence of the work load and an accompanying appreciation of the need for the quantity and quality of personnel needed to make hospital care of patients safe, as well as the paramount need for sound nursing education. By doing our job well, we strengthen our own position and thereby strengthen the knowledge and understanding of the hospital administration. The administrator wants to be informed, he wants to "share" the responsibilities of nursing service and nursing education. Just as we want to be "in" on the ground floor, the hospital administration wants to be "in" during the planning stage.
The doctor's understanding of "our" concepts of nursing education needs strengthening, and most of them are interested; some with fixed attitudes of education designed toward the full development of the individual, and others with an attitude of satisfaction that the traditional hospital training school makes the best nurse. The widespread idea that modern nursing education takes the nurse away from the patient is partly due to weaknesses within our own ranks. The physician is one of our closest allies. We should bring him into closer union with our basic plans for nursing education. The elements of human relations again play a great part in strengthening the understanding and support of the medical group about the true purpose and plans in nursing education. A prominent surgeon demonstrated a negative attitude toward nursing education recently by telling about the poor care that one of his patients received in the hospital. The program of teamwork is surely one means of making the physician aware of the strategic role that the nurse plays in the total care of patients. Intelligent recording of observations and reporting of same is accepted in principle by the nursing group, but poorly practiced in many patient-care situations. Unity of purpose within our own group will probably do more to strengthen the medical group and thus strengthen the program of nursing education than any other one factor in the situation.

There are many other resources to strengthen, but time does not permit discussion for more than one other important and urgently needed resource, namely, the city or municipal hospital. Some of our very best and most progressive schools are allied with institutions supported by the public from tax funds, such as Minneapolis General Hospital, Philadelphia General, Los Angeles General, and Kings County, to mention only a few of the most outstanding. The resources for clinical study and nursing experience at the bedside are unlimited as to the usual conditions as well as the unusual. In these hospitals, the patient frequently cannot afford a private duty nurse, and so he depends on staff and student personnel for nursing care. Also, in these hospitals, the junior and senior medical student, intern and resident physician study the science of medicine, and it is here that they gain at first hand their knowledge and understanding of nurses and nursing. Many schools of nursing associated with these hospitals are still in the poor apprentice stage of development through no fault of their own. If the hospital trustees and administrators do not see fit to employ qualified nursing administrators for these institutions, and if the citizenry does not provide funds for establishing the nursing service in these hospitals on a sound basis, and if the authorities do not appropriate funds for nursing education, then the condition will continue in the circle of circumstances. These institutions need strengthening probably more than any other resource. Good schools of nursing send their students away for affiliation in clinical fields, particularly in pediatrics and psychiatry when the clinical resource is probably two blocks away. The patients in these hospitals need the best that nursing has to offer; the student doctors need to see and experience the best in nursing service as do other professional personnel and students; and the student nurses in these hospital schools deserve the very best that can be found in part payment for their sacrifices.

You probably see and feel my own emotions expressed in the statement above, and so they are, probably because of the wish to help do something about the situations existing in our patient care institutions. Your interest in seeing, at first hand, the conditions in your local municipal hospital should help. It is your responsibility as a good citizen to do more to see that undesirable conditions (if they exist) are corrected. If there is not enough money appropriated to sustain the institution, or if the appropriated money is not distributed and utilized for the best advantages to the patients, then your responsibility as a citizen is clear in this, our democracy. Strengthening the resources within the municipal hospital is the responsibility of the community. I have had an opportunity to serve in four different municipal hospitals in three sections of the country within the past 25 years; conditions affecting patient care and
policies governing personnel practices were about the same in each institution. Time has changed some of them, while others have stood comparatively still.

Summary

Strengthening resources is a fluid term in that any strength that flows from nursing to an individual or to a specialized group returns to reward and strengthen nursing. The thesis of this paper deals with some responsibilities of nursing for strengthening ourselves and our immediate "family." To strengthen ourselves, it is suggested that we utilize the university, junior college, institutes, workshops, and continued staff education. To strengthen our "family" resources it is suggested that we:

1. Strengthen our relationship with hospital administrations and sell our wares to them by establishing and practicing sound business methods in nursing administration.
   a. Make studies of our own situations to show volume of work in each area; kind and frequency of each procedure; comparative costs of expendable supplies; distribution of personnel in relation to work loads; comparative personnel practices; nursing personnel "turnover" with possible causes; school of nursing needs, and others as indicated. Know our facts, bring the administrators into our confidence, and motivate, if necessary, their wish to know the truth about nursing care of patients in the hospital.
   b. Provide periodic reports of the work and problems in each unit.
   c. Justify recommendations with factual data.
   d. Utilize what we have to the best advantage of the patient and the hospital.

2. Strengthen relationships with the medical groups by:
   a. Working with them on a professional level.
   b. Providing good care to patients.
   c. Helping to establish a program of teamwork for the benefit of the patient.
   d. Bringing the doctor into the basic planning stage and seeing to it that relationships are such that we will be a part of his planning, too.

3. Strengthen our municipal hospitals by:
   a. Getting first-hand information about our city hospitals by visiting and associating with the staff and offering assistance.
   b. Employing and exercising our responsibility as good citizens.

Special Student Session

Thursday, May 10—2:00—4:00 p.m.

Presiding: JANET STREETER, Student Nurse, Newton-Wellesley Hospital School of Nursing, Newton Lower Falls, Massachusetts, and President, Massachusetts State Council of Student Nurses

Speaker: ROBERT M. STROZIER, PH.D., Dean of Students, University of Chicago, Chicago, Illinois

Discussion leader: DOUGALD ARBUCKLE, PH.D., Director, Student Personnel, Boston University School of Education, Boston, Massachusetts
Round Table participants:

MARY A. GARRIGAN, R.N., Member, Massachusetts State League of Nursing Education Advisory Committee to the Massachusetts State Council of Student Nurses

EMILY C. CARDEW, R.N., Coordinator and Assistant Professor of Nursing Education, University of Illinois, Chicago and Bloomington, Illinois

STUDENT NURSES

STUDENT LEADERSHIP AND GOVERNMENT ON LOCAL, STATE, AND NATIONAL LEVELS

ROBERT M. STROZIER, PH.D.

Self-government is one of the simplest, yet most complex, concepts of any society. Living as we do in a democracy where a suspended general can address the Congress of the United States while the President of the country sits near by in his presidential mansion without interfering in any way makes us neglect to examine the steps in society which have made it possible for such a situation to exist. There are but few countries in the world even today where such a situation could exist, and there have been, in the past, only a few where it could have happened.

We are likely to think of the Golden Age of Greece as exemplifying democracy at its best in ancient days. But when we examine the true situation that existed there even in such an enlightened society, we find that there were slaves who could not be citizens, and that the concept of democracy in that noble country was not complete or sufficient.

Rome in its day presented an interesting picture of government by an important segment of the population, by the citizens, in fact, but being a citizen of Rome did not follow the simple fact of birth within the country as we know the practice today. One kept in power by keeping one’s strength superior, and the picture of the Caesars and their struggle for supreme power presents one of the most fascinating series of events in our historical lore.

To differentiate between leadership and hero-worship is not easy, yet it is fundamental to a true concept of democracy. It is impossible to accept the mystical qualities of a Hitler even in our own day and to see clearly how democracy functions and what is at its base. Recently we have been treated to a great spectacle in our own country—that of a returning general who has personified for the mass of Americans the conquering hero, almost, I fear, the superman. True, antipathy to an elected leader has mingled in a subtle way with the reception given the general, but the fact remains that the kind of welcome afforded the general has hardly been that to be expected in a true democracy. It might suggest to some that we should like to have a dictator; to others it might suggest only the need for leadership and a desire on the part of masses of the people for forceful intelligent direction; to all of us it might suggest that we wait a year to see whether or not the affections of the people are only on the surface and that, after say a year, a true evaluation should be made of the state of our emotions on this particular subject.

We who have matured in the Anglo-Saxon tradition have felt a certain sense of pride in the history of democracy from the days of King John and the Magna Charta down to the age in which we live. We, as a young and undeveloped country, lacking the sense of tradition that has characterized our British cousins, wanted nothing to
do with kings and potentates. We have thus been nourished in a democratic tradition. We cannot examine our entire heritage too closely lest we find some discrepancies which we should prefer to overlook, yet a certain sense of the justice and rightness of our tradition has remained firm in our minds and hearts.

Real men in a real world live together. The fact of society has led to the fact of government. Governments, or organized communities of people living peacefully together, are the hallmarks of our civilization.

Monkeys and apes are not self-governing animals, because the act of self-government is a rational act and, being rational, is complicated. The human experience of living, working, learning, and playing together invariably results in problems which rational men have classified social, economic, and cultural. Social, economic, and cultural problems are the subject matter of government. The existence of these problems presupposes differences of opinions regarding solutions. Differences of opinions mobilize into parties and factions, and the interaction of parties and factions concerned with solving problems has given rise to a science called "politics." Politics have become so much the stuff of governments—and properly so—that a simple dictionary definition of "government" necessarily states what too many American educators have been reluctant to acknowledge, namely, that "government" is a "politically organized community."

In foreign lands, almost without exception, politics normally concern and involve students. In foreign areas where civilizations have flourished far longer than our own, it is generally a more pressing problem to cope with the dynamics of student politics than it is to encourage the existence of politics among students.

In communities where people purport to govern themselves, citizens without politics, or without political experiences, are not good citizens. The necessity to encourage the existence of politics among students casts a dark shadow upon the system which educates for democratic living.

In our own land the student body still struggles to become civilized in this respect. Confronted with the fact of group living, students have instinctively organized. The abundance of their organization reflects accurately the multitude of problems which healthy students confront. Whether we look in athletic stadia, fraternity houses, dance committees, or student newspapers, we find organization—presidents, secretaries and treasurers, typewriters, pencil sharpeners, telephones, and all the rest of the paraphernalia of organization. At the drop of a hat, American students organize, and the typical American college or university finds its student body structured with everything from debating societies to ballet and aquarium clubs. Unfortunately, instinctive organization has not been followed by instinctive ability to solve the problems of organization. The task of government, which organization implies, has overwhelmed more than one student organization. Ignorance of the nature of politics has shattered more than one noble student cause.

If politics and government are sciences—that is, if they consist of rational subject matter—they must be taught. Men are born with an ability to reason, but men are made, not born, rational. If these subjects must be taught, then as educators, we must teach them. The question remains whether or not these subjects should be taught; and if they should be taught, whether or not actual experience in these subject areas is legitimate education.

If any student activity on campuses is to be permitted to exist outside of the classrooms, both of these questions must be answered in the affirmative.

Unfortunately, American educators are not satisfied with simple affirmative answers to these questions. Theirs has been a schizoid response. On the one hand they have recognized a certain red-bloodedness in the extracurricular. Graying professors have nodded with approval over properly chaperoned dances or parties properly planned by some proper agency of student self-government. Wholesome qualities are still attached to collegiate athletic programs in spite of the New York scandals. Even student
attendance at a speech given by a prominent politician is occasionally approved on campus—providing the speech is basically nonpolitical.

In the classrooms elaborate courses have been devised to explain the art of self-government. In the classrooms the words "Democrat," "Republican," or "Communist" are sometimes necessarily articulated in order to pose some fact or to demonstrate some principle. But outside the classroom on the campus, such words are not permitted, and frequently the facts or principles themselves are treated as if they did not exist.

Most of America's student governments exist without responsibility, without authority, and without power. They exist without responsibility, authority, or power because the benevolent college faculties and administrations from whom they must derive responsibility, authority, and power have been reluctant to deal with these governments as governments. They have refused to deal with these governments as governments because implicitly political problems have been involved, and the general view has been that American students are—or should be—apolitical.

If student governments are generally weak, if student constituencies are generally apathetic to the problems of government, other grave manifestations of the weakness and apathy are present on the American campus. College campuses are off-limits for politicians, although a high percentage of our students are of voting age and should be interested in what the politicians have to say. Indeed, most of our students now find themselves directly affected by what the politicians do. Not only are student governments tolerated as necessary evils, but much student political activity is prohibited, suspended, or banned from the campus. The communist hysteria has served only to accentuate the already existing trend. The result has been, and is, demoralizing. In summary, as one American educator-philosopher (Dewey) has said: "The distinguishing trait of the American student body in our higher schools is a kind of intellectual immaturity. This immaturity is mainly due to their enforced mental seclusion; there is, in their schooling, little free and disinterested concern with the underlying social problems of our civilization."

Intellectual immaturity resulting from enforced mental seclusion is a problem deeply embedded in our classroom approach to the world in which we live. But living experience with the political problems of self-government in the world in which we live is one way to terminate the seclusion.

Too much talk about student government ignores the meaning of the subject. Let us examine one real case. On a campus of seven thousand students, in October of this academic year, three political parties and more than one hundred and forty candidates vied for seats in the three-year-old student government.1 The contesting parties were political. One represented a coalition of left-wing student groups with national affiliates. Among these were the Young Progressives of America, the remnants of the youth wing of the ill-fated Henry Wallace party, several splinter socialist groups, and a few Marxists. The incumbent party seeking re-election had as its core students from the New Dealing Students for Democratic Action, and members of the Young Democrats Club on campus. The third party consisted of the Young Republicans and friends.

The issues of the campaign were also political. Key among the issues was the record of the party seeking re-election in the management of various student services on the campus. It was charged that the student book exchange, a cooperative project operated by the government, had been mismanaged. It was claimed that the incumbent party had done nothing to influence the administration of the university to reduce the prices of meals and sandwiches in the administration-operated cafeterias on the campus. But the vital issue was the contention of one party that the proper concern of student government included any matter, local, state, national, or international, which in any way affected students. Among the problems framed for discussion were the attitudes

1Based upon the experience at the University of Chicago.
of American students toward the Korean War, universal military training, segregation in the armed forces and in education, and affiliation with the Communist International Union of Students in order to create a sort of student-level United Nations.

The campaigning was hot. Students contributed money to each of the parties for posters and leaflets. On election day each party furnished automobile service to bring commuting students to the polls. Poll-watchers from each group enforced the election regulations promulgated by a committee of the government. Three thousand votes were cast, and the government was constituted.

But once born, the problems of this government were growth. First on its agenda was a proposal to wrest from the administration of the university the power to legislate and to enforce student regulations concerning the rights of student organizations and the conduct of students. This problem was solved by a statute, elaborately written and debated, which gave to the government—with administration consent—this power, and which established a student-faculty court to decide controversies resulting from the exercise of this power. Experience led to the adoption of a bill regulating the expenditures of parties in future elections. A bill was passed ordering local fraternities to work for the removal of discriminatory clauses in their national charters. The proposal of the state legislature to investigate colleges in the state for communism and to impose a loyalty oath upon faculty members sent delegations of the student government to the capital of the state to testify. The budget of the government grew quickly from $800 a year to more than $5,000, and a multitude of technical budgetary and financial problems soon found their way onto the floor of the student assembly.

Through this student government, operated and for the most part financed by students, scores of young citizens have obtained their initial experience with the politics, economics, and practical problems of democracy. If, in their experiences, they have encountered mismanagement and graft, hard work and Communists, stupidity and frustration, mistakes and but little concrete accomplishment, are not these things the stuff of which their country and their lives are made?

If professional educators are often amazed by the stew concocted in the student political pot, the students are equally amazed both by their achievement and by their potentialities. The importance of their problems in a nation of which they are, after all, a substantial party frequently startles them and us.

In California it is the student body of the state which now spearheads the opposition to the loyalty oaths imposed by the Board of Regents over the objections of the governor of the state. American students now bear the greater part of the burden of relief to European students and universities through their World Student Service Fund. In the formulation of the recently announced selective service policy, the student voice played a vital part. In the recent congressional elections in Minnesota, students pushed more doorbells and did more talking than did any other single occupational group.

These phenomena, which actually should startle no one, are nonetheless startling in our country. Here, there remains great doubt in important quarters as to whether these are the things American students should be doing, as to whether these are the interests which American students should possess. Tacitly, if not expressly, it is argued that enforced seclusion is safer. It could be that those who educate for democracy really have little faith in the ability of young people to make democracy work.

Local discussion of these adult problems has naturally led to national student debate of the political issues of our time. Indeed, the genesis of national student organization has been these very issues. The Young Democrat and Republican clubs, the Students for Democratic Action, and the Young Progressives of America all originated as a result of student interest in, and desire for, action in the realm of practical politics. Each of these groups has mobilized the students on campuses not only to take active roles in political campaigns, but also to engage in long-range discussion and action related to the problems of defense, labor, the national economy, and international rela-
tions. The last National Interfraternity Conference found the subjects of racial discrimination and Communism spotlighted on its agenda. The Association of Intern and Medical Students has found the issue of socialized medicine inescapable in its meetings. A substantial portion of the National Association for the Advancement of Colored People consists of student chapters. Even the social and purely recreational affairs usually channeled through student unions are integrated nationally through the Association of College Unions which held its annual convention last month in Michigan.

The existence of a National Students Association brings the whole theme into sharp focus. For the most part, the interaction of American war veterans with foreign students brought the Association into being. Poignant personal experiences and broadened contacts opened the eyes of these American students. A burning cause—international brotherhood among students—sparked the growth of the Association. Unlimited opportunities for foreign exchange, international discussion, and learning excited young imaginations and generated, for a while, unusual energies. Five years ago Czechs, Poles, and Russians were still allies, although the rivets were even then being driven into the Iron Curtain. Englishmen, Frenchmen, and Dutchmen seemed eager to clasp the hand of the American student. And, to the founding fathers of the Association, working for international peace and understanding seemed as practical as reporting for football practice or a nine o'clock class.

Events since 1946 have changed the character of the Association, even as they have markedly changed the character of our world. Not a thousand classroom hours nor a million printed words could have taught the students involved in NSA more about the intricacies of international politics than their practical experience in the field. Students have learned the hard way that learning itself, which transcends political lines, has been hopelessly divided by the current struggle. But if the international aspirations of NSA have been transformed and altered, the Association has nevertheless held fast to its optimism, and has grown. Significantly, its growth has been simultaneous with, and a result of, its emphasis upon student awareness of national affairs and student relatedness to international events. The considerations of the last NSA National Congress highlight this fact.

In the realm of educational affairs, the eight hundred delegates to the last congress took action upon the subjects of federal aid to higher education, the rising cost of student-living, admission, and graduation standards, facilities and teaching methods, discrimination, and the peculiar problems of the increasing number of graduate students. The congress spelled out a new definition of student rights, evaluated athletic and welfare services in universities, and investigated the host of new problems stemming from violations of academic freedom.

Internationally, the Association planned its future program of exchange with Western Europe and Latin-America, reconsidered the position of American students toward Eastern European student groups, discussed the Korean War as it affected American students, and discussed the Association's relationship to UNESCO, in which it holds a formal seat.

But, inescapably, the most vital concern of the congress was the problem of student government—the recurring problem of authority, and power, financing, and programming. Ironically, self-government remains the most pressing issue for the students of this democracy.

How long NSA will survive is now a moot question. The national student body is shrinking. The financial problems of the Association have grown. Innumerable, inescapable, political knots have tied up the Association's progress. Southern schools have been reluctant to join a national organization so outspoken on the issues of discrimination and segregation. Federal aid to education split parochial schools from other private and state school representatives. Western constituents suspect Eastern domination of the Association. And, while American educators have watched the Association
with bemused interest, and in a few cases actual enthusiasm, for the most part they have merely watched. No foundation has endowed this kind of education. No university has lent facilities to this educational project. National educational associations have listened to the Association; some have applauded the Association. But few, if any, have invested in the Association.

The collapse of NSA would serve only to accentuate the desperate need of our students for communication and an active concern with the politics of our time. Today no special interest group in the academic world—whether it be of nurses and doctors, archeologists and atomic scientists, students and professors—can be immunized from the general community. In a sick world of which we all are a part, no special segment can retain its health in isolation. There is no cure but constant exposure, intelligent exposure.

But in exposure, intelligent exposure, there is some hope. Grappling with the universal problems as each of us see them from our own professional, social, and academic perspectives re-emphasizes the simple fact that ours is after all a common stake. Especially those of us who have been fortunate enough to have learned some of the secrets of knowledge and science bear a special responsibility in this matter. For ultimately all of the moral values we cherish depend upon the application of reason upon the government of men. A nation of intelligent men would pay no taxes to support a Kefauver Committee, as no need for such a committee would exist. And, if peace and freedom are to be achieved by this generation, it will be achieved only as a result of leadership evolving from the application of intelligence to the problems of the general community which is yours.

Eduard Benes, the symbol of democracy in Czechoslovakia, and for a while a professor at the University of Chicago, wrote before his unhappy death: "The democratic leader must combine in his personality in a very harmonious synthesis a high type of man of great intellectual culture and scientific erudition with keen intuition and instinct, of spirit, of rapid decision and quick action, and of physical and moral courage... For these reasons, leadership, especially in the democracies, will always be a question of good education and of careful selection... And it is therefore necessary that higher types of individuals should become more interested in politics in a democracy... In modern life and in the democratic states, to engage in politics without very hard intellectual work... is simply impossible."

We must now ask: Has the day yet arrived when through intelligent local and national organizations, a new American student can be built? To American students I say, "If you have a voice and a brain, use them now!"

**General Session**

**Thursday, May 10—8:30-10:30 p.m.**

**Presiding:** MARtha Ruth Smith, R.N., Dean, Boston University School of Nursing, Boston, Massachusetts

**Moderator:** Frank W. Cyr, Ph.D., Professor of Education, Teachers College, Columbia University, New York, New York

**Panel participants:**

Lois A. Bliss, R.N., Superintendent, Franklin Hospital, Franklin, New Hampshire
Philip D. Bonnet, M.D., Administrator, Massachusetts Memorial Hospitals, Boston, Massachusetts

Leon A. Bradley, Ph.D., Head of Department of Bacteriology and Public Health, University of Massachusetts, Amherst, Massachusetts

Edna Lepper, R.N., Assistant Director of Nursing Service, Massachusetts General Hospital, Boston, Massachusetts

John MacGregor, President, MacGregor Instrument Company, Needham, Massachusetts

Mary A. Maher, R.N., Director, Bingham-Kellogg-Boston University Regional Nursing Project, Boston, Massachusetts

The meeting opened with an invocation by the Rt. Reverend Monsignor Augustine C. Dalton, Spiritual Director, Boston Archdiocesan Council of Catholic Nurses, following which James R. Houghton conducted the Men’s Glee Club of Boston University in several songs.

The Process of Getting the Job Done

Dr. Frank W. Cyr, moderator of the panel session, stated that the topic “The Process of Getting the Job Done” might be interpreted as the process by which sociological change is brought about. He pointed out that research studies in the field of general education show a lag of fifty years from the tryout of a new design or service, like a school library, and its widespread adoption in practice. He added that research is now under way to discover methods for decreasing this lag, for speeding up the process of “getting the job done.”

Dr. Cyr then explained that the panel would be a demonstration helpful to those endeavoring to work through conflicts and resolve problems; that each member of the panel would identify a problem which he or she considered outstanding in nursing education; that through discussion the panel participants and those present at the meeting would suggest possible solutions to the problems. “Nursing education,” he said, “I think, is changing more rapidly than any other profession. These problems are caused by growing pains.”

The problems identified by the members of the panel may be described as follows:

1. How to get the job done by producing the right kind of nurse the public needs and wants
2. How to get the job done by using the help of lay people
   a) in financing
   b) in providing social situation needed
   c) in securing impetus and interest required
3. How to get the job done in rural areas
4. How to get the job done by recruiting new nurses, including men nurses

Mr. MacGregor said he agreed with a statement he had read that “nothing short of a revolution in the philosophy and practice of many nursing schools will produce the environment sufficiently free for the nurse to have an opportunity to grow toward gentleness, kindness, inner quietness, and security essential for performing the healing art.” He added: “There’s an art to the practice of medicine as well as a science, and it’s equally true of the nursing profession. I think the major question is getting the right kind of girls into our training schools.”
Realizing the close relationship of preparation and training to producing the right kind of nurse, Dr. Bonnet said: "Hospital schools of nursing are far better educational institutions than they were, perhaps, even twelve years ago." Miss Lepper posed that one of the problems in this connection is to know when the student has learned. This instigated Dr. Cyr to ask if it would not be possible "just to put students in the hospital and do away with classes." Miss Maher in reply spoke of some experimental work being done in certain hospital nursing schools where the students spend very little time in the classroom but are right in the hospital—"the real laboratory"—with a ratio of one instructor to five students.

Miss Lepper then referred to another experimental hospital school program. In this program, being tested at the Massachusetts General Hospital, the student has twenty-eight months of course work which is followed by an internship in the hospital for the remainder of the three years. Miss Lepper said: "... we found, through testing, that after 28 months the student appears to have developed skills that other students had developed in three years, through concentration and better teaching and better supervision."

Dr. Cyr warned that any training that isolated the school from the hospital without providing for an adequate internship would prove unsatisfactory and costly to remedy. He based his statement upon his experience in the field of general education. "We set up our institutions for training school administrators entirely separate from the public schools, and I'm afraid a good part of the time there was no relation to them," he said. "And here, about four years ago, we discovered that there ought to be some way that these people training to go into school administration should have a chance to practice on the job, and so we got several hundred thousand dollars from Kellogg Foundation to see if we can find out how to train interns, how to put young school administrators out into the schools. We got completely isolated and insulated from the actual situation and now we are trying to build that gap back."

Mr. MacGregor introduced the problem of finance and its "tremendous effect upon every hospital and every nursing school." He stressed the difficulty of explaining to the layman why hospital care is so expensive. Dr. Cyr stated that this is vitally concerned with "getting the job done"; that you only begin to get it done "when you work with and through lay people, lay leaders, or leaders of their group. No institution develops itself from within." It was stated that the education and selection of hospital trustees is of important significance in getting the interest and cooperation of lay people in the community.

With respect to the kind of aid that any number of "good, outstanding laymen" in any community can give to a worth-while project, Dr. Cyr cited the support of "The Central School Study" in general education directed by Teachers College, Columbia University. In this project, he said, 412 consolidated schools in New York State "are working together to improve themselves and bring about new adaptations." Five enthusiastic elderly laymen are responsible for raising the funds needed for the project. They stimulated the collection of 15 cents from each pupil in each school district concerned. "They make better speeches than any professional educators I've ever heard," said Dr. Cyr. "The professional people work with them and advise them right along on the operation of the thing, technical problems, and carrying through what they want done."

Applying the above example to nursing education, Dr. Cyr continued: "I think it is pretty clear that if we are really going to move ahead and make the changes and adaptations and expansions in nursing and nursing education that we must have if we are going to take care of the health of our people, we will have to find ways of involving the layman." He advised that the best way is to have a "kitchen conference," adding that this was the way the 412 schools were centralized. A group of lay people studied the situation, got the facts and the issues, and saw what was involved. Then
they arranged to go and sit in the kitchen with every family in the community and talk things over. Emphasizing the value of laymen, Dr. Cyr said: "Lay people have a lot of good ideas; we ought to find out what they are."

The problem of how to provide for adequate nursing education and service in rural areas was posed by Miss Bliss. She said there was a definite lack of well-trained personnel in rural communities. She felt that even though the small hospital of perhaps 50 beds is not large enough for a school of nursing, it does have something to offer nursing education. "After the nurses get educated, we want to get them back to the bedside," she stated.

Miss Lepper expressed the concept that one way of getting the nurse back to the bedside is by building attitudes during the period that she is being educated, "attitudes of service." "And," she continued, "we can only do that by having the nurse give service."

Miss Maher spoke of the efforts being made in rural areas by the Bingham-Kellogg-Boston University Regional Nursing Program which resulted from the request of nurses in Maine for in-service education. "We felt if we could have some kind of program that would be established on a continuing basis which would use Boston University as a base, probably we would be able to do something that would meet the needs of the nurses in these community hospitals. The faculty of Boston University had become so interested in the whole project—as a matter of fact, were in on the very beginning of it—that they themselves have said they would be willing to function as members of the project staff, going into the community after we had identified the need. They can act as specialists, giving these people the kind of consultation they need. It is hoped eventually that this program will so "build up these regional hospitals and community hospitals" that students who seek an internship period of rural experience will want to return to "function as head nurses and nursing service administrators in these small community hospitals."

Miss Bliss stated that unless students could serve internships in sufficient numbers and for an adequate length of time in hospitals in rural areas so that there would be some of these students in the hospital the year round, the experiment would be of little value to the hospitals. In addition, she advised: "We (in New Hampshire) can't possibly offer this type of education and experience to nurses unless we can get someone in the area to supervise their work. Whether the answer is an itinerant supervisor to whose salary we (the small hospitals in the area) could all contribute and could work with a university group—be guided by an educational group in the supervision of these students and in laying down plans for these students—I don't know."

Dr. Bonnet said he believed in order to solve the nursing problem in rural areas it was necessary to create "the social situation which will attract the kind of people" desired. To accomplish this, he stressed, it is necessary to have the help and cooperation of lay people. This has been secured, he stated, in the case of a shortage of doctors in a rural area. Physical facilities have been offered free or at a minimum charge when necessary to attract a physician, and arrangements made between two or more communities so that hours of service would be reasonable.

Another point brought out in connection with service provided in a rural area was the importance of making the pattern individual to fit the area need, and not to conform with the urban concept. Dr. Cyr stated that too often a small-sized edition of the city method was expected to work in the rural area. He said: "We need to invent some new ways of training these rural nurses, of helping them to find out what the job is, and of helping them to do the job they ought to do."

Dr. Bradley indicated that a clinical situation for learning how to work with and through people is an essential need in education, including nursing education in rural areas.
Mr. MacGregor introduced an idea for recruitment of nurses which came to him as a result of his recent visit to Washington. In carrying out the education program of the Civil Defense Administration, he stated, many nurses will be teaching young people in their community, including girls of high school age, the first-aid treatments to be followed in case of an A-bomb attack or a major disaster. The way this teaching is presented "may be just the decisive factor in their lives that will make them decide that nursing is a great profession and the thing they want to do." In using the term "young people," Mr. MacGregor referred to boys as well as girls, since it was the consensus of the panel that more men nurses were desirable.

CLOSING BUSINESS SESSION

Friday, May 11—9:00–10:15 a.m.

The closing business session was called to order at 9:00 a.m. on Friday, May 12, by Agnes Gelinas, the president. The roll call indicated that members of 43 state leagues were present.

The secretary read a brief report prepared by Edith Williams on a recent meeting in Washington on civil defense which had been attended by several representatives of the nursing profession.

The secretary read a telegram from the members of the headquarters staff not attending the convention expressing their appreciation for the fine support of the membership; a telegram from Mildred I. Lorentz, a member of the Board of Directors, expressing her regret at not being able to be present; and an excerpt from a letter from Adelaide A. Mayo, past executive director, describing her new activities "trying to keep ahead of nature" in her garden.

THE ROLE OF LEAGUE MEMBERS IN LEGISLATIVE ACTIVITIES

Alma E. Gault, chairman of the Committee to Consider Federal Legislation on Nursing Education, told of a meeting that had been held on the previous day because of rumors of possible activity in Congress concerning some of the pending bills on federal aid for nursing education. This meeting was attended by members of the Committee to Consider Federal Legislation on Nursing Education who were at the convention; Leila I. Given, Associate Executive Director of the American Nurses' Association; Donald Smith, the League's attorney; and some members of the staff. The possible "next steps" for the nursing profession had been discussed, and some resolutions had been drafted and referred to the Committee on Resolutions. Miss Gault then presented the following report:

"The Committee to Consider Federal Legislation on Nursing Education wishes again to call your attention to the fact that we, as individuals, have responsibilities in our personal contacts with those who mold opinion and with our legislators, to inform them of the legislative program based on the essential considerations for federal aid to nursing education approved by the Board of Directors of the National League of Nursing Education.

"We should like to call to your attention, further, that the American Nurses' Association is the organization which implements the legislative programs for nursing. This is a legal requirement for the tax-exempt status of the League.

"The Chairman of the League Committee to Consider Federal Legislation on Nursing Education is a member of the ANA Special Committee on Federal Legislation. Also, Mrs. Eugenia K. Spalding, a member of the League committee, has been selected by
the ANA committee to present testimony, and acts as consultant in this important legislative enterprise.

"I should like to repeat that this official channel in no way removes from the individual member her responsibility as a citizen and a nurse, and every effort is made to keep her informed through the American Journal of Nursing, the League Letter, and other official publications."

1952 CONVENTION

The president announced that the 1952 convention of the National League of Nursing Education, which would be held jointly with the American Nurses' Association and the National Organization for Public Health Nursing, was scheduled for June 16-20, 1952 in Atlantic City, New Jersey. She expressed thanks to all those who had so cordially invited the League to hold its next convention in their cities.

EXPRESSIONS OF APPRECIATION

The members of the Committee on Program and Convention Arrangements, and of the subcommittees which had worked with them, were individually introduced to the membership and congratulated on their splendid accomplishments. Janet Streee, the president of the Massachusetts State Council of Student Nurses, introduced the chairmen and co-chairmen of the committees which had been responsible for the students' excellent program, pointing out that all the chairmen were students, and the co-chairmen faculty advisers.

In addition to many individual expressions of appreciation to those who had contributed so much to the success of the convention, the group as a whole registered its appreciation by a rising vote of thanks.

REPORT OF THE COMMITTEE ON RESOLUTIONS

The Committee on Resolutions then presented the following report which was adopted by the vote of the membership:

Be it Resolved

1. That, since joint conferences and joint planning on the part of the NLNE and the Conference of State Boards of Examiners of Nurses have proved to be a profitable and effective means of clarifying our thinking, further opportunities should be provided for these joint activities.

2. That we reiterate our previously stated position in relation to the securing of public and private financial assistance for nursing education.

3. That the NLNE pledge the use of its resources in planning how nursing education can meet the needs of civilian defense, the armed services, and the civilian health programs.

4. That we recognize the accomplishments of the Committee on Structure of the NLNE and the Joint Board of Directors of the Six National Nursing Organizations toward implementing the directives on structure given by the memberships of all six national nursing organizations.

5. That every effort be made to recruit, prepare, and retain qualified faculty in adequate numbers to meet the educational needs of the nursing personnel required for all nursing services.

6. That we recognize the significance of the programs for temporary and full accreditation in the improving of nursing education and we urge full participation by the membership of the NLNE.
7. That we recognize the necessity of regional planning for the more effective utilization of available resources for the improvement of nursing services.
8. That we recognize the need for sound research in all areas of nursing education and nursing service as well as the need for clarification and dissemination of information relating to research.
9. That the members of the NLNE express to the National Education Association our appreciation of the resolution on nursing formulated at their recent meeting and that this expression of appreciation be communicated to that organization.
10. That we express to Miss Gladys S. Benz, retiring director of the Department of Advisory Service to State Leagues of Nursing Education, our appreciation for her sincere, devoted, and enthusiastic help to local and state leagues.
11. That we express to the Committee on Convention Arrangements and the subcommittees on special arrangements our sincere thanks for their excellent planning which has facilitated the success of this convention.
12. That we express to the Committee on Program our thanks for its successful efforts in planning an exceedingly helpful, interesting, and enjoyable experience for all.
13. That we express to the Massachusetts League of Nursing Education our sincere appreciation for its warm hospitality and many courtesies.
14. That we express to the Massachusetts State Council of Student Nurses our appreciation of the fine program and arrangements they have made as hostesses to the visiting students and for their assistance in the total program, and to all the students attending the convention our appreciation of their enthusiasm which has been a stimulation to the entire convention.

Respectfully submitted,
SISTER ANCINA, Chairman
EMILY C. CAREW
EVA A. DAVIS

APPRECIATION TO MARGARET BRIDGMAN

It was then moved, seconded, and voted to add to the resolutions that the National League of Nursing Education express appreciation to Margaret Bridgman for her services in the advancement of nursing education, to Skidmore College for releasing her for this service, and to the Russell Sage Foundation for financing the program that Miss Bridgman is carrying out.

RESOLUTIONS ON FEDERAL LEGISLATION

The following resolutions were then adopted by vote of the membership present:

WHEREAS the Board of Directors at its meeting in January 1951 approved certain essentials to be contained in any legislation affecting federal aid for nursing education (published in the February 1951 issue of the American Journal of Nursing); and

WHEREAS several bills on federal aid for nursing education are now pending in Congress;

Be it therefore Resolved that the members of the National League of Nursing Education, in convention assembled, do hereby express their approval of the provisions contained in H.R. 910, formulated and introduced by the Honorable Frances Payne Bolton, as most consistent with the above-mentioned essentials; and

Be it further Resolved that the National League of Nursing Education express
to Mrs. Bolton the appreciation of its members for this important service to nursing and nursing education; and

Be it further Resolved that the appreciation of the National League of Nursing Education be expressed to the American Nurses' Association for its program of vigorous action in behalf of federal aid for nursing education.

REGISTRATION

The president then announced the registration for the convention: Total number of registrants—2,057; League members and guests—1,581; Nursing students—476.

CLOSING REMARKS OF THE PRESIDENT

There being no further business proposed, Miss Gelines made a few concluding remarks:

"Most of us in the service of nursing education are busy every day with the activities and the responsibilities of our own jobs. The national emergency is creating new challenges which, as American nurses, we are preparing to meet. Most of the time, perhaps, we live in a world of our own in relative isolation and away from the broad range of activities that are common to nursing education throughout the country and throughout the world.

"To those of us whose views, necessarily, are restricted to our own immediate activities, it is encouraging to discover that, in meetings like this, other people have some of the problems that we face back home. Most of all, it is broadening to realize that the activities each of us carries on in her own local situation somehow fit into a large pattern, the total service of a national program for education for the health services.

"We should go back to our local activities and responsibilities with a few ideas that we can put into practice for the improvement of our own school services. We should also carry back a new and an enlarged perspective on our local efforts, seeing them not only in their immediate settings, but also in the light of our total efforts in nursing education in this country and in the whole world."

Upon motion duly seconded and carried, the meeting adjourned at 10:15 a.m.

MEETING OF THE COUNCIL OF STATE LEAGUES

Friday, May 11—10:30 a.m.—12:30 p.m.

The post-convention meeting of the Council of State Leagues was held in the Georgian Room of the Hotel Statler in Boston, Massachusetts, on Friday, May 11, 1951. The chairman, Agnes Gelinas, called the meeting to order at 10:30 a.m. The secretary, Henrietta A. Loughran, called the roll to which 40 state league presidents or their alternates responded. Also present were members of the Board of Directors and other members of the League.

PLANNING FOR NATIONAL CONVENTIONS

The chairman pointed out that representatives of the Council of State Leagues had planned the agenda of the Council meetings at the convention, and suggested that comments regarding this method of planning the agenda for Council meetings be sent
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to Headquarters. She also requested that suggestions be sent in regarding the role of state league presidents in assisting the Committee on Program plan the program for the entire national convention.

TEMPORARY ACCREDITING

The chairman suggested that, as a result of the reports which the National Nursing Accrediting Service had made during the week, the members of the Council of State Leagues might have further questions. In response to a question by Gertrude Nalhe (Mich.), Helen Nahm, director of the NNAS, stated that fully accredited schools of nursing would be sent the questionnaire designed for those applying for temporary accreditation. In the case of the fully accredited schools, the answers on the questionnaire would be used in lieu of an annual report from the school.

In response to a question concerning how information would be obtained about agencies or institutions with which schools of nursing have affiliations, Miss Nahm stated that the NNAS would not accredit affiliating institutions but would limit accreditation to the schools since they, in the final analysis, should assume total responsibility for the entire educational program. The schools would therefore be requested to obtain the information needed by NNAS from the institutions with which they have affiliations. In order to avoid as much duplication of effort as possible, the NNAS would try to assemble information about affiliating agencies in such a way that when such an agency is used by more than one school the data would be collected only once.

NURSING RESEARCH JOURNAL

Emily Holmquist (Pa.) reported that 177 subscriptions had been taken for the proposed journal Nursing Research which the Association of Collegiate Schools of Nursing was sponsoring. Further subscriptions, she stated, should be made through Frances Thielbar of the University of Chicago.

REPORT OF ACSN MEETING

Julia Hereford (Tenn.) reported on the recent meeting of the Association of Collegiate Schools of Nursing at which a new statement of standards of membership had been accepted. She further stated that another statement of ACSN, "Fundamental Considerations in the Planning and Conduct of Collegiate Schools of Nursing," would shortly be published and available not only to nurses but to persons in general education.

REPORT OF THE COMMITTEE ON RESOLUTIONS OF THE COUNCIL OF STATE LEAGUES

The following report of the Committee on Resolutions of the Council of State Leagues was adopted by vote of the Council membership.

Be it Resolved

1. That state leagues of nursing education endeavor to establish and/or further functional relationships with state boards of nurse examiners.

2. That state boards of nurse examiners continue to give consideration to broader and more flexible interpretation of requirements for licensure with particular reference to (a) competency in nursing and (b) controlled experimentation in nursing programs.
3. That state leagues of nursing education assume responsibility for interpreting the need, and for distributing information, regarding resources relative to the preservation of records whereby records of schools of nursing pertaining to nursing credits and achievements of students and graduate nurses may be microfilmed and stored in bomb- and fire-proof vaults.

4. That the Council of State Leagues commend the plans for coordination of the activities of the NLNE Department of Services to Schools of Nursing, the NLNE Committee on Nursing Curricula, and the Advisory Subcommittee for Coordination of Improvement of Education of the National Committee for the Improvement of Nursing Services.

5. That presidents of state leagues and regional representatives assume greater responsibility for continuing to help provide equitable distribution of representatives for National League activities. There is a felt need for long-range planning whereby wide regional representation can be attained. Committee appointments should be made in sufficient advance to fit attendance into local plans. It is further urged that the place for committee meetings be arranged to meet the need for geographical distribution.

6. That the Council of State Leagues approve the establishment and promotion of regional plans for programs for graduate nurses.

7. That the Council of State Leagues urge that recruitment for nursing be sponsored jointly by all state professional nursing organizations.

8. That the professional nursing organizations jointly sponsor the organization of local, regional, and state student nurse associations.

9. That the Council of State Leagues commend the committee of state league presidents for the fine agenda that was designed by chosen representatives from each region and recommend a continuance of this plan.

10. That regional representatives of the Council of State Leagues be called in the fall to plan the agenda for the Council of State Leagues meeting and be invited to assume a more active role in the preparation of the annual program of the National League of Nursing Education.

11. That the Council of State Leagues express sincere appreciation to Miss Benz for her untiring efforts and the fine contributions she made to the state and local leagues and to the membership. The Council regrets the termination of her services by resignation.

12. That the Council of State Leagues express appreciation to the NLNE Committee on Program, to the Eastern Massachusetts League of Nursing Education, and to the Massachusetts State League of Nursing Education for the enriching experience and for the warm hospitality that each of us has felt during our visit here.

LILLIAN M. BISCHOFF, Chairman
LUCIA G. ALLYN
MARJORIE BARTHOFF
DOROTHY E. GLYNN
BEATRICE C. KINNEY

REGIONAL AND STATE PLANNING

Henrietta A. Loughran briefly summarized the types of regional planning to which the nursing profession should be giving consideration, pointing out the fact that the word "region" could be variously interpreted as a city, a county, a state, or a group of states, and that planning for a region could involve a single organization, a single profession, a group of professions, or the entire public through appointed and elected representatives.
Specifically, Mrs. Loughran mentioned that the type of regional planning exemplified by the Bingham Associates Plan is broad from many standpoints in that it involves planning for several health professions from both the service and educational points of view and includes both rural and urban areas of several states. Insofar as educational planning for nursing education is concerned, there is the type whereby the universities in a region each emphasize a specific area of advanced preparation; for example, one would emphasize preparation for psychiatric nursing education, another preparation for nursing service administration, and so on. The Southern Regional Conference on Nursing Education, Mrs. Loughran stated, is an example of the type whereby planning for nursing education would be coordinated with planning in other areas of higher education. In this connection, Mrs. Loughran repeated the explanation she had made at the opening meeting of the Council of State Leagues relative to the Western Conference on Higher Education: nursing had not been barred from participating in the Conference in any legal way and she hoped that nursing would soon be able to assume its proper place in this Conference.

Another type of regional planning, Mrs. Loughran pointed out, was that which the League was furthering through the medium of the three regional work conferences being held during the summer. There followed a discussion concerning some of the details involved in planning these conferences. Florence K. Wilson (N.C.), chairman of the group planning the conference in the Southern area, and Katherine Brim (Utah), chairman of the group planning the Western conference, told of meetings they had held during the convention with groups from their areas in which they had planned how they would collect suggestions as to problems to be discussed at the conference and let the participants know of the suggestions which had been made.

RESEARCH

Frances Reiter (N.Y.) opened the discussion of the guide for action by state and local leagues of nursing education in the field of research. The first activity suggested by Miss Reiter was the creation of a channel by which information about research projects could be exchanged. She suggested that some person might be appointed in each state to familiarize herself with research under way not only in her state but in other areas; this person would then become the channel for exchange of information.

The second area discussed by Miss Reiter concerned the proposal that state boards of nurse examiners establish a national critical score on the State Board Test Pool examinations for reciprocity purposes. Miss Reiter proposed that the critical score be established at the highest cut-off point used by any state, pointing out that if the lower critical score which had been proposed (1½ standard deviations below the national mean) were used, all except the lowest 7 percent who pass the state board examinations would be brought into the exchange. In any event, Miss Reiter suggested that state board personnel should study what percentage of nurses licensed in their own states would be included in this reciprocity exchange under each proposal and also that they make follow-up studies of the two groups—those who would be licensed if the higher critical score were used and those who would be licensed if the lower score were accepted. Miss Reiter also suggested that nurses who achieve scores above the higher cut-off point receive a qualifying certificate for excellence.

The third point discussed by Miss Reiter concerned the facilitation of experimentation within schools of nursing. In order to distinguish between changes which might be classified as normal progress and real experimentation, she offered the following definition: "Experimentation is when the plan proposed so deviates from existing standards that there must be a change in the standards for curriculum or the standards for administration and control of the school." Miss Reiter expressed the opinion that to assist state boards of nurse examiners in passing on proposals involving this type of
experimentation, there should be established an advisory committee composed of representatives from nursing education and general education and someone who is familiar with educational research. It would be the responsibility of this advisory committee to review plans for experimentation in respect to the following points: a statement by the school concerning the intent of the experiment and the responsibility it is willing to assume, the earnestness and capability of the faculty, the inclusion of courses in civilization, society, community skills, and interpersonal relations to the extent that the curriculum might follow principles already evolved from other educational patterns, and provision for following the progress of the students as the experiment proceeds so that any deficiencies might be discovered before the end of the experiment. Miss Reiter emphasized the point that there should be no expectancy that a set curriculum could be presented for approval; the curriculum must be allowed to evolve throughout the course of the experiment and thereafter. A second responsibility of the advisory committee would be to establish and maintain access to the national Joint Committee on Research and Studies, which, Miss Miller explained, was a committee recently established by the Joint Board of Directors of the Six National Nursing Organizations to be administered by the American Nurses' Association. In response to a question as to who would be responsible for evaluating and continuing the evaluation of the experiment, Miss Reiter suggested that the legally authorized approving agency should not abdicate its responsibility in this respect but that it should liberalize the interpretation of its standards and seek the guidance of its advisory committee as to criteria for evaluating experimental programs.

At the request of members of the Council, Elizabeth K. Porter, president of the American Nurses' Association, reported on the progress being made by the ANA Committee to Study the Functions of Nursing. She stated that, in realization of the need for a study of the functions of nursing, the ANA House of Delegates had, in May 1950, voted that the ANA undertake a program of research directed toward this end. To support this program each member of the ANA was asked to contribute $1.00 per year for a period of five years. A technical committee, composed of two nurses familiar with research technics, studied the credentials of various research workers throughout the country, and a selection was made of three—one from the field of psychology, one from sociology, and one from business administration. All requests for ANA financial support of research were being examined by this group from the standpoint of whether the project fits into the scope of the over-all plan, as well as from the point of view of method, facilities, and so on.

Mrs. Porter further reported that $60,000 had already been raised for this program and, at the ANA Board of Directors meeting the previous week, funds had been allocated to seven projects. All of these projects, directly or indirectly, relate to the study of nursing functions. Mrs. Porter emphasized, however, that a study of nursing functions was broader than a mere job analysis; it was concerned with quality and with the functions which nurses should be performing as well as those which they actually perform at the present time.

Mrs. Porter mentioned some of the points which should be observed by those applying for funds. The request must be channeled through the state nurses' association and it should state specifically the purposes, plans, and resources of the project.

At the conclusion of Mrs. Porter's presentation, Anna D. Wolf moved that the Council of State Leagues go on record as approving the work started by the American Nurses' Association and ask state groups to give full support to it. This motion was seconded by Evelyn J. Fisher (D.C.) and carried unanimously.

One participant then spoke of the need for assistance from the League members in certain types of research. In particular, their help would be valuable in any research project designed to establish ways by which the successful nurse could be distinguished from the unsuccessful nurse. Such a cooperative research project would involve two
areas of interest in nursing education—curriculum development and student evaluation and guidance.

STRUCTURE

Frances H. Cunningham (Ohio), co-chairman of the League Committee on Structure, led the discussion on the guide for action in state and local leagues with regard to structure. She pointed out that the plans for the new Nursing League of America which had been presented at the meeting on May 7 were merely tentative and urged that state and local groups encourage the study of these plans and send suggestions about them to the League Committee on Structure. Concerning the first steps toward structure reorganization at the state and local level, Miss Cunningham referred to League Memo No. 4 which had been sent to presidents of state and local leagues in February 1951 and to articles which had appeared and would continue to appear in the American Journal of Nursing, stating that through these channels it had been recommended that, in areas where there is more than one nursing organization, joint boards and joint committees of the organizations be set up. In response to a question as to what constitution and bylaws should be used for these joint boards in state and local areas, Miss Cunningham stated that the Joint Board of the Six National Nursing Organizations operates under rules and regulations, copies of which were distributed with League Memo No. 4. Mrs. Porter indicated that the Joint Structure Committee was now considering the term "coordinating council" as being more descriptive of the functions of the joint body than the term "joint board."

Gladys S. Benz, director of the Department of Advisory Service to State Leagues of Nursing Education, suggested that committees on bylaws of state and local leagues, many of which are currently inactive, begin to make plans for re-writing the bylaws of state organizations in line with structural reorganization. To prepare for this, one member of each of these committees might plan to attend the 1952 convention to hear the discussion of the national bylaws of the new organization.

Considerable discussion occurred as to the place of students in nursing in connection with the new structure. It was brought out that there are now over twenty student nurse associations, many of which operate under the sponsorship of the American Nurses' Association. The ANA cannot grant membership to students; however, provision for student membership had been proposed in the Nursing League of America. Again, the resolutions just passed by the Council of State Leagues called for joint sponsorship of state student nurse organizations by the professional nursing organizations, and Emily C. Cardew (I.Il.) asked whether this was in conflict with the proposal for conferences of students within the NLA. Lyndon McCarroll (Mass.) suggested that groups in states where there is some form of student organization might send in suggested patterns to Headquarters so that they could be studied with the thought of evolving a pattern for the new structure.

UNIFICATION OF STATE BOARD AND LEAGUE OBJECTIVES

Carrie M. Spurgeon, ex-chairman of the ANA Special Committee on State Boards of Nursing Education and Nurse Registration, then opened the discussion on the guide for action in state and local leagues regarding the unification of state board and league objectives by reading a summary of the League-State Board Conference which had been held in Boston on May 5, 1951.

"The conference of state league presidents, representative of the National Nursing Accrediting Service, and representatives of state boards of nurse examiners, called by the Board of Directors of the National League of Nursing Education, was history-making
and timely. It was the first effort to interrelate the thinking and planning of the four groups in this way, and it occurred at a time when there is great need for concerted effort and unified action in studying problems of nursing education.

Plans now in operation with a purpose of improved curriculum were presented, and the group looked for means of more closely coordinating the activities of state leagues and state boards of nurse examiners for further developing specific areas in curricula operation. A few of the suggestions were:

1. Regular state league-state board conferences to study state board requirements and make suggestions for revisions
2. The appointment of state board representatives as ex officio members of state league and state nurses' association board of directors
3. The appointment of the state board representative as an active member of the state league curriculum committee
4. The National League and state leagues assuming further their responsibility for professional guidance and standard-setting

"In presentation of the plan for temporary accreditation, Miss Nahm asked for suggestions relative to questionnaires that would need to be filled out by all schools applying for temporary or full accreditation, and those already fully accredited.

"The following resolution was presented by appointed members of the group and accepted by the conference.

Resolution

Since it is reported that the preparation of annual reports and questionnaires creates an administrative problem in schools of nursing and is the concern of this group, it is resolved that:

1. In states where it is possible, the NNAS questionnaire for temporary accreditation be accepted this year, 1951, in lieu of the usual annual report to state boards of nurse examiners.
2. If additional information is required by state boards of nurse examiners it may be supplied on supplementary forms.

JOY ERWIN
VIRGINIA HARRISON

"Further discussion of the accreditation procedure pointed to the need for coordinated action of state boards of nurse examiners and the National Nursing Accrediting Service. The following resolutions were prepared by appointed members of the conference group, presented, and accepted.

Resolution

Since the goals of the National Nursing Accrediting Service and the state boards of nurse examiners are similar in kind if not in degree, it is important that a working relationship between the NNAS and the respective state boards be further developed.

It is recommended that the principles set up for reviewing and evaluating schools for full accreditation be followed for temporary accreditation.

Therefore, we believe if the following procedure be put into effect for temporary accreditation, it should be included as part of the process for full accreditation as soon as possible.

After consideration of all the discussion from the group, the Committee recommends for consideration by the Joint Committee on Unification of Accrediting Activities the following procedure:
1. A questionnaire be designed containing relatively few, but discriminatory, items to be sent to each of the state boards and filled out for each school. These should be returned to the NNAS as supplementary information to the report of the visit. The anonymity of the school shall be respected in submitting this material to the NNAS board of review.

2. That a plan be made to offer opportunity for representatives from each state board to spend a day with a NNAS board of review to observe at first hand the process of reaching a decision. The plan should make provision for the number of representatives, the timing, and the extent of participation by the state board representative.

Several other possibilities were discussed, but the committee hesitated to recommend them because, at this time, the expense involved, the time needed, and the limitation of personnel made them prohibitive.

FLORENCE FLORES
MARION W. SHEAHAN
HELEN C. GOODALE
SISTER M. EUCHARISTA

"An important issue as to how good schools of nursing can experiment with time requirements and other plans of the school program was not entirely resolved. Criteria for experimentation as proposed by the Association of Collegiate Schools of Nursing and accepted with slight modification by the State Boards Committee was referred to, but no machinery has been established for its implementation. The need for revision of A Guide for the Use of League Records was pointed out, and it was reported that the League Board has already placed this task high on its priority list.

"A report of some of the resolutions that came out of the recent State Boards Conference included those that are aimed toward further simplification of reciprocity procedure.

"They were:

1. Recommendation to state boards for establishing a national critical score (1.5 standard deviations below national mean) for reciprocity purposes beginning with the 1951 Test Pool series.
2. An effort to further validate the licensing examinations by defining competence to practice.
3. The adoption of a simplified uniform reciprocity application form to be used by states as they find it possible and appropriate.

"The form eliminates the need for requesting the school final record except in the case of problem schools.

"The Committee of State Boards of Nurse Examiners and the Conference have felt a need for a more direct channel and clearer means of exchange of information with the National League Board of Directors. The recent joint conference provided a means of meeting this need. Many members of the state board group have expressed a hope that such a conference will be held at the next convention."

CARRIE M. SPURGEON, Ex-chairman
ANA Committee on State Boards of Nursing Education and Nurse Registration

Following Miss Spurgeon's report, several of the state league presidents reported on the arrangements which had been made in their states for furthering cooperation between state leagues and state boards of nurse examiners. In several instances, it was reported that the executive secretary of the state board of nurse examiners was a member
of the state league committee on curriculum; in some instances, she was a member of the state league board of directors. One state league reported having a liaison committee between the state league and state board.

At the close of the meeting, Anna D. Wolf expressed appreciation for the distribution of the League Letter to all members of the League as had been recommended at the 1950 meeting of the Council of State Leagues.

Miss Gelinas, on behalf of the Council membership, thanked the committee, consisting of Carrie Benham, Veronica Lyons, Lillian Patterson, and Ada Fort (chairman) which had planned the closing meeting of the Council of State Leagues.

The meeting adjourned at 12:30 p.m.
NATIONAL LEAGUE OF NURSING EDUCATION

THE AMERICAN SOCIETY OF SUPERINTENDENTS WAS REGISTERED APRIL 26, 1907, AND ON CHANGE OF NAME THE NATIONAL LEAGUE OF NURSING EDUCATION WAS REGISTERED JULY 22, 1914, IN NEW YORK COUNTY.


AMENDMENT TO CERTIFICATE OF INCORPORATION RECORDED OCTOBER 18, 1946.

Bylaws amended June 21, 1924; May 29, 1925; May 22, 1926; June 17, 1929; June 10, 1930; April 11, 1932; June 12, 1933; April 23, 1934; June 3, 1935; May 10, 1937; April 25, 1938; May 17, 1940; May 19, 1942; June 19, 1943; September 23, 1946; September 8 and 11, 1947; May 2, 1949; May 8, 1950.

CERTIFICATE OF INCORPORATION*

KNOW ALL MEN BY THESE PRESENTS, that we, the undersigned, citizens of the United States, Jane Delano, Clara D. Noyes, and Georgia Nevins, citizens of the District of Columbia, and Lillian Clayton, a resident of Philadelphia, Pa., and Elizabeth A. Greener, a resident of the City of New York, desiring to avail ourselves of the provisions of Sec. 599, et sequitur, of the code of law of the District of Columbia, do hereby certify as follows:

1st. This organization shall be known as the National League of Nursing Education.

2d. The term for which it is organized shall be perpetual.

3d. The object of this association shall be to consider questions relating to nursing education; to advance educational aims and standards in nursing; to assist in furthering the development of public health; to aid in measures for public good by co-operating with other bodies, educational, philanthropic, and social; to promote helpful and cordial professional relationships, and to develop and maintain the highest ideals in the nursing profession.*

4th. The number of its trustees for the first year of its existence shall be thirteen.

IN WITNESS WHEREOF we have hereunto set our hands and seals on this 13th day of March, 1917.

James Picker, E. J. Morton as to

Robert E. P. Kreiter as to

Elizabeth Greener, R.N. (Seal)
Lillian Clayton, R.N. (Seal)
Jane A. Delano (Seal)
Georgia Nevins (Seal)
Clara D. Noyes (Seal)

*As amended; amended September 23, 1946, by vote of the League membership in convention; amendment recorded October 18, 1946.
BYLAWS

ARTICLE I

MEMBERSHIP

SECTION 1. Members in the National League of Nursing Education shall be classified as follows:

A. Nurse members with qualifications as set forth in Sections 2 and 3:
   Active, including sustaining

B. Lay members with qualifications as stated under Section 4:
   Active, including sustaining

C. Honorary members as defined in Section 5

SEC. 2. An applicant for nurse membership shall, after October 1, 1949, qualify by:

a. (1) Having been graduated from a school of nursing accredited by the legally authorized state accrediting agency and connected with a hospital having a daily average of 50 patients during the final year of the applicant’s course and offering a program consisting of practice and instruction in medical, surgical, obstetric, and pediatric nursing; or
   (2) Having been graduated from a school of nursing accredited by the legally authorized state accrediting agency and connected with a hospital having a daily average of from 30 to 49 patients, and either having had in her undergraduate course an affiliation or affiliations of not less than six months in a state-accredited school of nursing connected with a hospital having a minimum daily average of 100 patients, or having completed satisfactorily, after graduation, a course or courses of not less than six months; or
   (3) Having been graduated from a school of nursing in a foreign country, such school of nursing having been accredited by a board or other authority constituted for that purpose in the country in which such school of nursing is located.

b. Having become a registered nurse in one or more states.

c. Being a member of the American Nurses’ Association.

d. (1) Holding a position carrying administrative or teaching responsibilities in a school of nursing or educational organization or health agency or in a government service employing nurses; or
   (2) Holding a position as director of nursing service in a hospital without a school of nursing; or
   (3) Holding a position as administrator or instructor in a school of practical nursing approved by the legally authorized state accrediting agency or the National Association for Practical Nurse Education.

e. (1) Being approved for active membership by a state or local league; or
   (2) Being approved for active individual membership by the executive director.

SEC. 3. A sustaining member is an active member interested in furthering the financial welfare of the League, who has paid the dues required of such membership.

SEC. 4. An applicant for lay membership shall qualify for active or sustaining membership by:

a. (1) Having been or being a member of a board of trustees of a hospital conducting a school of nursing; or
   (2) Having been or being a member of a school of nursing committee; or
   (3) Having been or being a member of a board of trustees or of a faculty of a college or university concerned with nursing education; or
(4) Having been or being a member of a board or a committee member of a public health agency concerned with nursing education for student or graduate nurses; or
(5) Having been or being a member of the administrative or teaching staff of a school of nursing; or
(6) Having made or making important surveys or studies or other recognized contributions to nursing education.

b. (1) Being approved for lay membership by a state or local league; or
(2) Being approved for lay individual membership by the executive director.

SEC. 5. Honorary membership may be conferred by a unanimous vote of the voting body at the annual convention or business meeting on persons who have rendered distinguished service or valuable assistance to the nursing profession, the names having been recommended by the Board of Directors. Honorary membership shall not be conferred on more than two persons at any convention. Honorary members do not pay dues.

SEC. 6. a. An applicant for active membership in the National League of Nursing Education shall be accepted in one of four ways:

(1) As a member of a local league of nursing education, which gives automatic membership in state leagues and the National League of Nursing Education; or
(2) As a member of a state league where there is no local league, which gives automatic membership in the National League of Nursing Education; or
(3) As an individual member if residing in a state which has no state league, or upon special action of the Board of Directors; or
(4) As an individual member if residing in a state where Negro nurses are not eligible for membership in the state league. Membership in the National Association of Colored Graduate Nurses will be accepted in lieu of membership in the American Nurses' Association.

b. An applicant desiring to join the National League of Nursing Education as an individual member shall make application on a form furnished by the executive director. The form, after being properly filled in, shall be sent with the required dues to the executive director.

SEC. 7. An active member in good standing in any state league who changes her residence to another state may be admitted by transfer, upon request to the executive director of the National League of Nursing Education who will notify the treasurers of both state leagues of such transfer. A member who has paid her dues for the current year before transferring to another state league will receive a membership card from and be granted full membership privileges by the state league to which she has transferred without further payment of dues for the current year. A member who transfers to another state league before she has paid her current dues will pay such dues to the state (or local) league to which she is transferring. A member living in one state and working in another or temporarily located in a state may be permitted to continue her membership in the state of her choice.

SEC. 8. An active member who is not permanently located may retain her membership on an individual basis by paying dues directly to the National League of Nursing Education.

SEC. 9. An active member who has withdrawn from the National League of Nursing Education or whose membership has lapsed on account of nonpayment of dues may be reinstated by paying the regular annual dues for the current year to the state in which she is a resident, except as provided in Section 7 or in Section 8.
ARTICLE II

Officers

Section 1. The officers of the National League of Nursing Education shall consist of a president, a vice president, a secretary, and a treasurer, all of whom shall be nurses. These four officers, and eight directors, one of whom shall always be a lay member, and, as ex officio members, the president of the American Nurses’ Association, the president of the National Organization for Public Health Nursing, the editor of the American Journal of Nursing, and the executive director, shall constitute a Board of Directors.

ARTICLE III

Elections and Voting

Section 1. a. The president, the treasurer, and four directors shall be elected in the even-numbered years to serve for two years. The vice president, the secretary, and four directors shall be elected in the odd-numbered years to serve for two years.

b. All elections of officers and directors referred to in Section 1. a. of this Article and three members of the Committee on Nominations referred to in Article V, Section 2. a. shall be held by mail within two months preceding the annual convention or business meeting. All elections shall be by ballot. All elections shall be had by plurality vote.

c. Each officer shall hold office until the adjournment of the annual meeting at which her successor has been elected.

d. In the event of a vacancy in the Board membership, the Board of Directors shall fill the vacancy until the next election.

Sec. 2. Upon authorization by the Board of Directors, any proposed change in the organizational structure or any proposal for the dissolution of the National League of Nursing Education and the transfer of its assets to a successor corporation may be submitted to the membership for a vote by mail ballot, either in conjunction with or apart from any meeting of the membership. In any such vote upon a proposal for dissolution, the affirmative vote of a majority of the members voting, and in any other vote by mail ballot the affirmative vote of a plurality of the members voting, shall constitute approval of the proposed action.

Sec. 3. a. The president shall appoint the necessary tellers of election.

b. All members whose dues have been received at Headquarters by the first day of the month preceding the month of the annual convention or business meeting shall receive ballots. Ballots, enclosed in special envelopes, shall be returned to Headquarters by the date indicated annually.

c. Tellers shall count and record all votes, and all records shall be checked by an auditor, and a certified and sealed report shall be given to the secretary.

ARTICLE IV

Duties of the Board of Directors and Officers

Section 1. The Board of Directors shall:

a. Act as trustees of the nursing profession for the advancement of nursing education.

b. Establish broad objectives to be achieved by the National League of Nursing Education.

c. Determine basic policies to be followed in achieving the broad objectives.
d. Develop programs outlining general methods to be used by operating staff in executing the approved policies.

e. Select members of the Board to serve on its advisory committees.

f. Review and approve annual budgets.

g. Select an executive director and give her adequate authority to manage and direct activities of the National League of Nursing Education in accordance with established policies and programs.

h. Annually review progress being made by the executive director in executing her responsibilities.

i. Hold an annual meeting and meet at other times at the call of the president or request of five or more members of the Board.

j. Appoint committees as provided for in Article V.

SEC. 2. The president shall:

a. Preside at conventions and at all meetings of the Board of Directors, Executive Committee, and the Council of State Leagues and be a member ex officio of all committees except the Committee on Nominations.

b. Report to the Board of Directors at its meetings and to the membership at the annual convention or business meeting.

c. Perform all duties as may be incident to her office.

SEC. 3. The vice president shall perform the duties of the president in her absence or during her inability to act and such other duties as may be delegated to her by the president.

SEC. 4. The secretary shall:

a. Keep the minutes of the convention or business meeting and of the meetings of the Board of Directors and of the Council of State Leagues.

b. Report at each annual convention or upon request the policies established and action taken at all business meetings of the membership.

c. Send a notice of the annual convention to each member at least one month in advance.

d. Within one month after retiring, deliver to the new secretary all books, papers, and reports of the League in her custody with a supplemental report covering all transactions from January 1 to the close of the annual convention.

SEC. 5. The treasurer shall:

a. Serve as chairman of the Committee on Finance.

b. Report to the membership the financial standing of the League at each annual convention and upon request.

SEC. 6. The executive director shall:

a. Be chief operating executive of all National League of Nursing Education activities.

b. Formulate and recommend policies and programs to the Board of Directors.

c. Carry out policies and programs approved by the Board of Directors.

d. Administer, coordinate, and control the activities of the Headquarters staff.

e. Develop a basic organization plan and select executive personnel.

f. Direct the development of financial budgets for all activities.

g. Be an ex officio member of all committees except the Committee on Nominations.
b. Represent the National League of Nursing Education in planning and checking the results of activities entered into as joint projects with other organizations.

i. Administer programs of the Joint Board of the Six National Nursing Organizations assigned to the League.

j. Appoint members of any committee requested by a department to assist it in carrying out a designated function. She shall select these members from names submitted by the executive officer of the department requesting the committee. She shall dissolve the committee after consultation with the executive officer.

ARTICLE V

COMMITTEES

SECTION 1. Committees of the Board.

a. The Executive Committee shall:
   (1) Consist of five Board members, two of whom shall be the president and executive director.
   (2) Transact Board business that arises between Board meetings except the establishment of policy.

b. The Committee on Finance shall:
   (1) Consist of four Board members, two of whom shall be the treasurer and executive director.
   (2) Act as general financial advisers to the Board of Directors.
   (3) Review the annual budget submitted by the executive director.
   (4) Present the budget, with recommendations, to the Board of Directors.
   (5) Establish general financial policies concerning the handling of funds and the designation of banks in which funds are deposited.
   (6) Determine and supervise the making of investments.
   (7) Review and approve major expenditures before they are made.
   (8) Provide for the annual audit and review the report with the auditor.
   (9) Act in advisory capacity to the executive director.

c. Advisory committees as needed shall:
   (1) Consist of at least two or three Board members. A Board member shall be chairman of each committee.
   (2) Act in advisory capacity to the Board on problems and policies pertaining to any of its functions.

SEC. 2. Committees of the National League of Nursing Education. Committees of the National League of Nursing Education shall be appointed as needed by the Board except as herein provided.

a. The Committee on Nominations. The committee shall consist of five members. The chairman and one other member shall be appointed by the president and three members shall be elected by ballot as provided in Article III, Section 1. b.

On or about September 1 preceding the annual convention, this committee shall issue to each state league a form on which the state league shall submit the name of one nominee for each office to be filled and one for the Committee on Nominations. This form shall be signed by the president or secretary of the state league and returned to the Committee on Nominations of the National League of Nursing Education before December 1 preceding the annual convention.
From the forms returned by the state leagues, the Committee on Nominations shall prepare a ticket consisting of two names of the nominees receiving the highest number of votes for each office, eight names for the office of directors, and six names for the Committee on Nominations. If the list of names submitted is not sufficient to form a ticket, the Committee on Nominations shall have power to add names so that a full ticket may be made up. No name shall be presented to the Board of Directors by the Committee on Nominations unless the nominee has consented and is free to serve if elected. This report shall be in the hands of the secretary by January 1 and the ticket published in the *American Journal of Nursing* when approved by the Board of Directors.

SEC. 3. Each committee shall present a written report of its activities to the annual convention and to the Board of Directors as requested, and keep the executive director informed of its work, as may be indicated, during the year.

**ARTICLE VI**

**DUES**

**SECTION 1.** The annual dues for all active members of the National League of Nursing Education shall be $5.00.

a. In states where there is a state league, dues ($5.00) for all active members shall be paid through the state league on the basis of membership as of March 1 of each year, except for the first year of membership, when dues shall be paid at the time of application.

b. In states where there is no state league, dues ($5.00) shall be paid directly to the National League of Nursing Education. Dues shall accompany application.

**SEC. 2.** The annual dues for sustaining members shall be $13.00, which shall entitle the members to receive pamphlets published by the League during the year, not to exceed $2.50 in value.

a. In states where there is a state league, dues ($13.00) for all sustaining members shall be paid through the state league on the basis of membership as of March 1 of each year, except in the first year of membership, when dues shall be paid at the time of application.

b. In states where there is no state league, dues ($13.00) shall be paid directly to the National League of Nursing Education. Dues shall accompany application.

**SEC. 3.** Any state leagues or individual members failing to pay the annual dues by the first day of April shall receive a notice from the treasurer, and if the dues are not paid within two months, they shall forfeit all privileges of membership. Active members having forfeited their membership may be reinstated upon the payment of dues for the fiscal year.

**ARTICLE VII**

**MEETINGS**

**SECTION 1.** A convention or business meeting of the National League of Nursing Education shall be held annually. In the even-numbered years it shall be held conjointly with the convention of the American Nurses' Association; in the odd-numbered years it shall be held at such time and place as shall be determined by the Board of Directors.
SEC. 2. The business at each convention shall include:
   a. Reading of the minutes
   b. Annual reports of secretary, treasurer, and executive director
   c. Annual reports of presidents of all state leagues of nursing education
   d. Annual reports of committees
   e. Address by the president
   f. Miscellaneous business
   g. Announcement of election of officers and directors and members of the Committee on Nominations

ARTICLE VIII
REPRESENTATION

SECTION 1. The voting body at the annual convention of the National League of Nursing Education shall consist of active and sustaining members of state leagues in good standing, and individual active and sustaining members in good standing.

ARTICLE IX
QUORUM

SECTION 1. A quorum of the Board of Directors shall be eight members.

SEC. 2. A quorum of the Executive Committee shall be three members.

SEC. 3. A quorum of the Council of State Leagues shall be ten members other than the officers.

SEC. 4. Members from fifteen states shall constitute a quorum for the transaction of business at any annual convention.

ARTICLE X
FISCAL YEAR

SECTION 1. The fiscal year of this association shall be the calendar year.

ARTICLE XI
COUNCIL OF STATE LEAGUES

SECTION 1. The officers of the National League of Nursing Education and the presidents of the state leagues shall constitute a Council of State Leagues.

SEC. 2. The duties of the Council of State Leagues shall be to keep the National League informed of the progress of nursing education in the states represented and promote programs of the National League of Nursing Education.

SEC. 3. Meetings of the Council of State Leagues shall be held in connection with each annual convention or business meeting and at any other time as called by the Board of Directors. The members shall report on the work in their respective state leagues.

SEC. 4. In the absence of its president a state league may be represented in the Council of State Leagues by an alternate appointed by the state league.
ARTICLE XII

STATE LEAGUES

SECTION 1. Where the term "state league" is used in these Bylaws, the word "state" shall be understood to apply equally to any state of the United States of America, to the District of Columbia, or to any territory, possession, or dependency of the United States of America, and the rights and privileges, responsibilities and obligations of all members in the states, the District of Columbia, the territories, possessions, or dependencies shall be the same. (See Article I, Sec. 5, Bylaws, American Nurses' Association.)

SEC. 2. A group of League members desiring to form a state league of nursing education shall make application on the form furnished by the executive director. This form shall be properly filled in and, with a copy of the proposed constitution and bylaws, shall be sent to the executive director and shall be referred by her to the Board of Directors for final approval.

ARTICLE XIII

DUTIES OF STATE LEAGUES

SECTION 1. It shall be the duty of each state league:

a. To know that all requirements for membership in the state and local leagues meet the requirements for membership in the National League of Nursing Education.

b. To know that the dues are paid by the first day of April of each year on the basis of membership the first day of March of each year.

c. To send to the executive director of the National League of Nursing Education and to the American Journal of Nursing the names and addresses of all officers immediately after their election or appointment, together with the date and place of the next annual meeting.

d. To report the activities of the state and local leagues at the annual convention and at such other times as may be required.

e. To promote within the state league activities the policies and programs of the National League of Nursing Education.

f. To confer with the executive director regarding changes in the state constitution and bylaws. All proposed changes shall be sent for approval to the executive director in duplicate, together with two copies of the old constitution and bylaws. Upon the adoption of any changes, the state league shall send one copy of the revised bylaws to the executive director.

g. To help organize local leagues, when desired.

h. To provide official representation, as a member of the Council of State Leagues, at each annual convention.

ARTICLE XIV

PARLIAMENTARY AUTHORITY

SECTION 1. Deliberations of all meetings of the National League shall be governed by Robert's Rules of Order Revised.
ARTICLE XV
THE OFFICIAL ORGAN

SECTION 1. The *American Journal of Nursing* shall be the official organ of the National League of Nursing Education.

ARTICLE XVI
AMENDMENTS

SECTION 1. These Bylaws may be amended at any annual convention by a two-thirds vote of the active members present and voting. All proposed amendments shall be in the possession of the secretary at least two months before the date of the annual convention and be appended to the call of the meeting.

SEC. 2. These Bylaws may be amended at any annual convention by the unanimous vote of the active members present and voting, without previous notice.
# LIST OF MEMBERS

## Honorary Members

- **BOLTON, MRS. CHESTER C.** Richmond Road, South Euclid, Ohio
- **BROWN, ESTHER LUCILE** Russell Sage Foundation, 505 Park Ave., New York 22, N. Y.
- **BURGESS, MAY AYRES** St. Andrews Club, Hastings-on-Hudson, N. Y.
- **DEWITT, KATHARINE** 151 College Avenue, Poughkeepsie, N. Y.
- **GOLDMARK, JOSEPHINE** 89 Hillcrest Road, Hartsdale, N. Y.
- **JAMES, MRS. HENRY** 133 E. 64 Street, New York, N. Y.
- **JOHNSTON, MARY E.** Glendale, Ohio
- **LOCKWOOD, MRS. CHARLES** 295 Markham Place, Pasadena, Calif.
- **OSBORN, MRS. WILLIAM CHURCH** 40 E. 36 Street, New York, N. Y.
- **WHEELER, CLARIBEL A.** 1401 Bellevue Avenue, Richmond 22, Va.
- **WINSLOW, C.-E. A.** School of Public Health, Yale University, New Haven, Conn.

## Life Member

- **DOCK, LAVINIA L.** Fayetteville, Pa.

## Active Members

### Key to Symbols

- *Sustaining members*  
- † Lay member  
- ‡ No state league

## ALABAMA—105

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
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<tbody>
<tr>
<td>ALEXANDER, MRS. JULIA L.</td>
<td>P.O. Box 623, Tuskegee Institute</td>
</tr>
<tr>
<td>ALLEN, HELEN K.</td>
<td>553 Springfield Ave., Mobile 16</td>
</tr>
<tr>
<td>ANDERSON, MRS. LEA S.</td>
<td>Apt. F., Stoneleigh Apts., Tuscaloosa</td>
</tr>
<tr>
<td>ATKINSON, VANBON G.</td>
<td>S-B Meredith Manor, Tuscaloosa</td>
</tr>
<tr>
<td>BACHMAN, ESTHER</td>
<td>South Highlands Infirmary, Birmingham</td>
</tr>
<tr>
<td>BARNES, JOHNIE MAE</td>
<td>2559 Dauphin St., Mobile</td>
</tr>
<tr>
<td>BARNEY, CHARLOTTE</td>
<td>2911 Seventh Ave., S., Birmingham</td>
</tr>
<tr>
<td>BEAR, MRS. T. L., JR.†</td>
<td>1846 S. Hall St., Montgomery</td>
</tr>
<tr>
<td>BRENNAN, MRS. SALLY M.†</td>
<td>314 S. St. Andrews St., Dothan</td>
</tr>
<tr>
<td>BROWER, MIRIAM T.</td>
<td>3648 Clairmont Ave., Birmingham</td>
</tr>
<tr>
<td>BROWN, MRS. AVIS M.</td>
<td>1129 S. 22 St., Birmingham</td>
</tr>
<tr>
<td>BRUTON, MRS. FLORRINE E.</td>
<td>1129 Ogleby Ave., Birmingham</td>
</tr>
<tr>
<td>CHANDLER, GOLDIE H.</td>
<td>220 Oak Forest Dr., Montgomery</td>
</tr>
<tr>
<td>CHENEY, MRS. MYRTLE G.</td>
<td>800 Winona St., Montgomery</td>
</tr>
<tr>
<td>CORKEY, CATHERINE</td>
<td>Alabama State Dept. of Health, Montgomery</td>
</tr>
<tr>
<td>CROSSLAND, KATHRYN M.</td>
<td>1227 S. 22 St., Birmingham</td>
</tr>
</tbody>
</table>

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1This list includes those members whose 1951 dues reached NLNE Headquarters by August 1, 1951.
2Bylaws, Article I, Sec. 3: "A sustaining member is an active member interested in furthering the financial welfare of the League, who has paid the dues required of such membership." Article VI, Sec. 2: "The annual dues for sustaining members shall be $15.00, which shall entitle the members to receive pamphlets published by the League during the year, not to exceed $2.50 in value."
DEES, MRS. ETHEL W.
962 Selma St., Mobile

DENISON, MRS. THYRA C.
P.O. Box 2591, Birmingham

EARLEY, JOSEPHINE
768 Tuscaloosa Ave., Birmingham

ELGIN, ZUMA R.
712 S. 30 St., Birmingham 5

ESTES, GLADYS
Veterans Administration Hospital, Montgomery 10

FERRARI, MRS. EMILY
1127-12 Court, N., Birmingham 4

FOLEY, DOROTHY M.
1620 Woodward Bldg., Birmingham

GILMORE, MRS. LAURENE S.
1653—43 St., Central Park, Birmingham

CORE, MILDRED W.
P.O. Box 295, Clanton

GRAF, KATHERINE J.
Veterans Administration Hospital, Montgomery 10

GRIMMETT, MRS. JULIA M.
Veterans Administration Hospital, Box 141, Tuskegee

HAMMETT, FRANCES L.
619 S. 19 St., Birmingham

HARVEY, MRS. LILLIAN H.
Box 126, Tuskegee Institute

HAWKINS, MRS. MARIA B.*
209-D E. Portier Ct., Mobile

HAZEN, MRS. MARY D.
Sylacauga Hospital, Sylacauga

HIXSON, FLORENCE
103 Frederick Court Apts., Tuscaloosa

HOERIG, GERTRUDE
2430—11 Ave., N., Birmingham

HORN, RUTH
5653 Woodlawn Pl., New Orleans, La.

HAUSER, MRS. OMA D.
St. Margaret's Hospital, Montgomery 5

HOLLAND, AMMIE O.
Jefferson-Hillman Hospital, Birmingham 3

JACKSON, MILDRED A.
613—27 St., Birmingham 8

JACKSON, NELLIE F.
8220 Fifth Ave. S., Birmingham 6

JAMESON, FLORENCE M.
Veterans Administration Hospital, Montgomery 10

JENKINS, NANCY D.
Springhill Ave., Mobile

JORDAN, MARY E.
Veterans Administration Hospital, Tuscaloosa

KING, MRS. MARY E.
St. Vincent's Hospital, Birmingham

KONNOLOD, MRS. JANET F.
1128 S. 22 St., Birmingham

LOVELADY, ANNIE L.
Box 932, Tuscaloosa

MARTIN, MRS. FLORA F.
Veterans Administration Hospital, Montgomery

McDONNELL, ELIZABETH T.
1805 Shades Great Blvd., Birmingham 9

McELDERRY, BERTHA
306 South St., Talladega

MEYER, ANNE E.
205 S. Joachim St., Mobile 21

MITCHELL, PEARLE LOU
1719 Fourth Court W., Birmingham

MITCHELL, MRS. SUE O.
505 Tenth St., S.W., Birmingham

MOFFETT, MRS. IDA V.*
Baptist Memorial Hospital, Birmingham 9

MOORE, MRS. JOE G.
45 Greenspring Highway, Birmingham

MOSELEY, MRS. MARY H.
411 N. McDonough St., Montgomery 5

NICHOLSON, MRS. PERRY L.
1418 Seventh St., Tuscaloosa

NICKERSON, MRS. MATTIE E.*
18 Sixth Ave., S., Birmingham 5

O'CURRAN, JESSIE L.
St. Margaret's Hospital, Montgomery

OLIVER, MYRTLE
Jefferson Hillman Hospital, Birmingham 3

PARKER, MRS. MARY L.
201 Holly St., Montgomery 5

PERRY, NAOMI L.
Veterans Administration Hospital, Tuskegee

PHILLIPS, MARY R.
117 Turner Place, Montgomery

PHILLIPS, OLIVE W.
Veterans Administration Hospital, Lake City, Fla.

RALEY, FRANCES
2119 First Ave., N., Birmingham 3

RANDOLPH, LULA C.*
Veterans Administration Hospital, Tuskegee

RENEAU, CAPT. ESTHER, ANC
11th Field Hospital, APO 154, c/o P.M., New York, N. Y.

REYNOLDS, MRS. HILDA F.
Route 6, Box 371, Mobile

REYNOLDS, MRS. RUTH C.
Latham

ROGERS, MINNIE G.
721 S. Perry St., Montgomery

ROSS, MRS. MURLE O.*
Sylacauga Hospital, Sylacauga

SANDERSON, IRENE
2236 Highland Ave., Birmingham 5

SANNER, MARIE
St. Vincent's Hospital, Birmingham 5

SELLARS, RUBY
Norwood Hospital, Birmingham 4

SHIVER, MILDRED E.
Veterans Administration Hospital, Montgomery 10

SISTER AMELIA LENZ
St. Margaret's Hospital, Montgomery 5

SISTER ANNA MARIE
850 St. Andrew St., Mobile 16

SISTER BENIGNA
City Hospital, Mobile 16

SISTER CATHERINE
City Hospital, Mobile 16

SISTER CATHERINE SIRILLE
Providence Hospital, Mobile 17

SISTER DOLORES McGEHEE
City Hospital, Mobile 16

SISTER EMILE
Providence Hospital, Mobile 17

SISTER FLORENCE MEANS
St. Margaret's Hospital, Montgomery 5

SISTER HELEN SONNIER
St. Margaret's Hospital, Montgomery 5

SISTER JANE FRANCES
St. Margaret's Hospital, Montgomery 5

SISTER LOUISE
St. Margaret's Hospital, Montgomery 5

SISTER MARIANA FLYNN
St. Vincent's Infants & Maternity Hospital, Chicago 10, Ill.
SISTER MARIE BREITLING
Providence Hospital, Mobile 17
SISTER MARIE CELINE
Holy Name of Jesus Hospital, Gadsden
SISTER MARY AGNES
St. Vincent's Hospital, Birmingham 5
SISTER MARY ANN
Providence Hospital, Mobile 17
SISTER MARY ELLEN
Providence Hospital, Mobile 17
SISTER MILDRED MARY*
City Hospital, Mobile 16
SISTER ROSANNA WHITE
City Hospital, Mobile 16
SISTER THEODORA PENN
St. Margaret's Hospital, Montgomery 5
SISTER VALERIA
St. Vincent's Hospital, Birmingham 5
SISTER VINCIENT THOMAS
Providence Hospital, Mobile 17
SMART, BONNIE
Veterans Administration Hospital, Tuscaloosa

SMITH, MRS. LILLIAN H.
334 Professional Center Bldg., Montgomery 4
SORGE, MRS. ANNIE L.
919 S. 17 St., Birmingham
SPUDIC, ANN M.
2754 Tenth Ave., S., Birmingham
STEELE, MRS. BENNIE F.
823 S. Marion St., Lake City, Fla.
STUDINKA, MRS. JULIA S.
602 Maple St., Fairfield
THOMAS, MRS. MELBA B.
26 Amos St., Montgomery
THRASHER, MRS. JEWELL W.*
Frazier-Ellis Hospital, Dothan
WELCH, CAPT. ELEANOR
School of Aviation Medicine, USAF, Gunter AFB, Montgomery
WHITTEN, ALMA
Druid City Hospital, Tuscaloosa
WHITTEN, FRANCES
Route 2, Box 536, Birmingham

ARIZONA—42

ALLYN, LUCIA G.
4025 E. Burns St., Tucson
BANKER, MRS. JEANNETTE H.
1697 Longview Ave., Phoenix
BEST, DOROTHY R.
Tucson Medical Center, Tucson
BRIERLEY, ZONA B.
1603 W. Garfield St., Phoenix
BROWN, JEFFERSON I.
4242 E. Vernon, Phoenix
DAVIDSON, MRS. JEAN T.
2090 E. Pierce St., Phoenix
DAVIDSON, LYLLA A.
2332 E. Helen St., Tucson
DUFAUD, MRS. MARQUEEITE
1911 E. Second St., Tucson
ERHARDT, MRS. FRIEDA B.*
P.O. Box 3923, Phoenix
GRAY, CLARA L.
2610 Exeter Dr., Tucson
GREENBERG, LOUISE P.
2315 E. Eighth St., Tucson
HEARN, ANNIE M.
4158 Redwing Pl., Phoenix
HENDRICKSON, ELAINE
Arizona State College, Tempe
HORKAVI, HELEN
State Bldg., 2nd Floor, Phoenix
JENNINGS, CECILE Y.
Box 367, Ajo
LEONG, ELLEN C.
1417 New York Ave., Apt. SE, Brooklyn 10, N. Y.
LEYEF, MARTHA J.
Box 144, Clarkdale
MALEADY, MRS. MARGARET J.
Box 1133, Bisbee
MASON, ETNA M.
309 N. Virginia St., Prescott
MCKINNON, MARY H.
Box 2063, Greenway Station, Tucson
MOKMA, CORNELIA R.
Box 2269, Phoenix
MOORE, KATHERINE H.
1215 N. Maple Blvd., Tucson
NEWTON, DOROTHY
Route 5, Box 143-A, Tucson
RAINES, MRS. ETHEL R.
Veterans Administration Hospital, Tucson
RICCA, ROSE M.
Greenway Station, Tucson
RICE, CAPT. DOROTHY M.
616 Third Medical Group, APO 919, c/o PM, San Francisco, Calif.
ROBINSON, JEANNETTE E.
P.O. Box 18, Whipple
ROGERS, MARTHA E.
702 E. Adams St., Phoenix
RUSSELL, INEZ E.
319 E. Ft. Lowell Rd., Tucson
SHELDON, MRS. HAZEL P.
314 E. Mulberry St., Phoenix
SISTER HELEN FRANCIS*
St. Mary's Hospital & Sanatorium, Tucson
SISTER MARY PIUS
425 N. Fourth, Phoenix
SISTER M. SUSANNA
St. Joseph's Hospital, Phoenix
SISTER MARY ZITA
425 N. Fourth St., Phoenix
STEENHOVEN, ALICE M.
1208 N. Euclid Ave., Tucson
STEWARD, ALOUSE O.
P.O. Box 56, Whipple
SUMMERS, JOYCE E.
2937 N. 35 St., Phoenix
WAGNER, MARY F.
2806 E. Lee St., Tucson
WILLIAMS, MRS. EMMA N.
2612 N. Mountain Ave., Tucson
WORK, FLORENCE O.
2204 E. Hawthorne St., Tucson
ZELLO, ANGELA M.
542 E. Flynn Lane, Phoenix
ZOLLMAN, MRS. JEANNE W.
1048 N. Olsen Ave., Tucson
ARKANSAS—58

ALEXANDER, MABEL L.
115 S. Eye St., Fort Smith
AUSTIN, MRS. E. ABERCROMBIE
4878, N. Col. College, Pine Bluff
BARNES, SARAH N.
156 Rivercliff Apt., Little Rock
BEAUCHAMP, Linnie
2006 N. Van Buren, Little Rock
BELZNER, BARBARA
1906 S. Filmore, Little Rock
BROOKS, MRS. CATHERINE R.
206 N. 15 St., Fort Smith
BUFFALO, RACHEL E.*
St. Joseph’s Hospital, Hot Springs
BURT, MARGUERITE L.
2304 Westwood, Little Rock
CHANLEY, MRS. CLOIS G.
1622 S. Harrison, Little Rock
CHRISTIAN, MRS. ODESSA C.
Trinity Hospital, Little Rock
CROWELL, LT. EVELYN R.
403 Evacuation Hospital, Fort Bragg, N. C.
DODSON, BARBARA L.
22034, Pike Ave., North Little Rock
DOYLE, CATHERINE M.
Veterans Administration Hospital, Little Rock
GOSS, MRS. NETTIE B.
111 Sunset Lane, Hayden Heights,
North Little Rock
HALE, MAMIE O.
P.O. Box 2754, Little Rock
HANCOCK, Verna E.
763 Ridge Rd., North Little Rock
HILL, MRS. ANNA C.
217 Beech St., Little Rock
HOELTZEL, ELIZABETH M.
1100 Barber Ave., Little Rock
HOLLAND, ELVA N.
1123 E. 11 St., Little Rock
HORNET, MYRTLE
1500 Arch, Little Rock
JAMES, LOUISE
State Dept. of Health, Little Rock
KERN, MARY L.*
500 E. Roosevelt, Little Rock
KINCELOE, EDITH
Arkansas Baptist Hospital, Little Rock
KNOX, MRS. EUPHA T.
University Hospital, Fayetteville
LEASE, JUNE M.
Veterans Administration Hospital, North Little Rock
McCASKILL, LYNDIA J.
Arkansas Baptist Hospital, Little Rock
MERRELL, FRANCES F.
1109 Bishop St., Little Rock
MURPHY, ELLIE M.
Veterans Administration Hospital, Bldg. 41,
North Little Rock
NEEDHAM, MRS. CHRISTINE E.
901 W. 27 St., Pine Bluff

ARKANSAS—58

OBERLIES, BETTY S.
2301 West Rd., Little Rock
OWENS, MRS. ARTA
Davis Hospital, Pine Bluff
REEVES, ETHELLE
1515 S. 17 St., Fort Smith
ROCHELLE, R. GLENN
Veterans Administration Hospital, North Little Rock
SIMPSON, RUBY J.
Baptist State Hospital, Little Rock
SISTER CHARLES ELIZABETH
St. Vincent’s Infirmary, Little Rock
SISTER MARY ALPHONSSUS
St. Joseph’s Hospital, Hot Springs
SISTER M. CALLISTA
St. Joseph’s Hospital, Hot Springs
SISTER MARY CONSILIA
Warner Brown Hospital, Eldorado
SISTER MARY DELPHINE
St. Edward’s Mercy Hospital, Fort Smith
SISTER MARY FABIAN
St. Joseph’s Hospital, Hot Springs
SISTER MARY HUGH
Warner Brown Hospital, Eldorado
SISTER MARY KEVIN
St. Edward’s Mercy Hospital, Fort Smith
SISTER MARY LOUIS
St. Vincent’s Infirmary, Little Rock
SISTER M. MILDRED
St. Bernard’s Hospital, Jonesboro
SISTER MARY SEBASTIAN
St. Edward’s Mercy Hospital, Fort Smith
SISTER M. THOMASINA
St. Bernard’s Hospital, Jonesboro
SMITH, EVELYN D.
St. Joseph’s Hospital, Hot Springs
SMITH, MARY E.
2301 W. 16 St., Little Rock
STEINKAMP, ILA W.
2 Ozark Point, Little Rock
SWEETSER, MARION
Veterans Administration Hospital, North Little Rock
TETER, MRS. MARTHA B.
Route 4, Box 129, Fayetteville
VAUGHAN, MARGARET S.
300 W. 16 St., Little Rock
WALDRUM, MRS. ANCIE F.
3704 Chandler St., North Little Rock
WARRICK, SERENA C.
1500 Lincoln Ave., Little Rock
WHIDDEN, MRS. ANN
1116 N. G St., Fort Smith
WHITE, RUTH M.
Veterans Administration Hospital, North Little Rock
WHITEHURST, LYDIA
Veterans Administration Hospital, North Little Rock
WRIGHT, MRS. MARY T.
Baptist State Hospital, Little Rock

CALIFORNIA—500

ABBOTT, MARY E.
Wadsworth General Hospital, Los Angeles 25
ADAIR, BIRDIE M.
4723 College View Ave., Los Angeles 41

CALIFORNIA—500

ADAMS, BETTY J.
1115 Palm Dr., Burlingame
ADAMS, DAPHINE Y.
4509 Pleasant Valley Court, Oakland 11

437
AKERS, Lillian E. 3201 L St., Sacramento 16
ALEXANDER, Margaret B. 3853 Stewart Ave., Los Angeles 45
ALFORD, Marian 470—37 St., Oakland 9
ALLEN, Leolla 119 W. Mariposa Ave., Stockton
ALMGREN, Mary L. Route 5, Box 272, Fresno
ANDERSEN, Anna C. 3304 Hancock, San Diego 10
ANDERSON, Hilda E. 2919 Theresa St., Long Beach
ANDERSON, Mrs. Lois C. 524 Herbert St., Pasadena 6
ANDERSON, Mary L. 1229—46 St., Sacramento 16
ARNAUD, Margaret V. 2912—14 Ave., Oakland 6
ARONSON, Mrs. Bernice F. 2341 Murieta Way, Sacramento
ATKINSON, Beatrice 4058½ Front St., San Diego 3
ATTEBERRY, Maxine 1537 Michigan Ave., Los Angeles 33
ATWOOD, Ruth S. Stanford Convalescent Home, Stanford
AUBREY, Margaret L. 1140 N. Foothill Blvd., Pasadena 8
AUMACK, Veryl E. 507 N. Laurel Ave., Los Angeles 48
AUSTIN, Anne L. 1115 Redondo Blvd., Los Angeles 19
BABICH, Lucille M. 5240 Thorburn St., Los Angeles 45
BAIN, Beatrice 1431—26 St., Sacramento 16
BAIN, Ruby V. 1431—26 St., Sacramento 16
BAKER, L. Louise Children's Hospital of East Bay, Oakland 9
Bartells, Betty Tracy Memorial Hospital, Tracy
BASSETT, Barbara A. 75 Buena Vista Ave., E., San Francisco
BECKER, Sarah 1217 Shatto St., Los Angeles 17
BEEBE, Dr. Elinor L. 10521 Hona Ave., Los Angeles 64
BEHNENS, Edna H. 516 Humboldt St., Santa Rosa
BELDEN, Lela 2282 S. Hope St., Los Angeles 7
Belli, Rose M. St. Luke's Hospital, San Francisco 10
BERCSENY, Mrs. Alice N. 1139 Alma St., Glendale 2
BERKOWITZ, Mrs. Alice B. 427 N. Hubart Blvd., Los Angeles 4
BIGGAM, Jean L. 490 Sixth Ave., San Francisco
BINHAMMER, Hannah M. 1355 Third Ave., San Francisco 22
Birdzell, Dorothy J. Veterans Administration Hospital, Palo Alto
BLACK, Lura 2356 Myrtle Ave., Eureka
BLEVINS, Jean E. 1550 N. Verdugo Rd., Apt. 17, Glendale 8
Blondeau, Mrs. Katherine M. 5134 N. Bartlett, San Gabriel
Bonen, Margaret Children's Hospital, Los Angeles 27
Booth, Juanita A. 12169 San Fernando Rd., Apt. 4, San Fernando
Borchardt, Betty M. 8651 Wakefield, Van Nuys
Borden, Eva L. Box 21, Loma Linda
BorTEx, Ethel C. Fresno General Hospital, Fresno
Boryer, Margaret G. Veterans Administration Hospital, San Francisco 21
Bosworth, Rebecca C. 855 Vermont Ave., Los Angeles
Botsford, Eleanor R. University of California, Department of Nursing, Los Angeles 24
Bouton, Florence L. 1572 N. Grand Oaks Ave., Pasadena 7
Brady, Mrs. Alice W. 3304—62 St., Sacramento 17
Brann, Mrs. Jo Ellen P. 2355 California St., San Francisco
Brown, Bobbie S. R.F.D., Franklin Ave., Saratoga
Brown, Louise M. 768 Glenmore Blvd., Glendale 6
Brown, Mildred 4003 W. Ave. 43, Los Angeles
Buckland, Gertrude M. 5125 La Pasada St., Long Beach 4
Buckley, Mrs. Vivian C. 120 N. Avenue 58, Los Angeles 42
Burcham, Ruth E. 1650 Bush St., San Francisco
Burdi, Hazel F. P.O. Box 136, Clerksburg
Burker, Mrs. Jeannette M. 817—25 St., Sacramento
Burke, Kathryn T. 2210 Golden Gate Ave., San Francisco 18
Burke, Margaret A. Wadsworth General Hospital, Los Angeles 25
BuZzell, Pauline 2609 W. Chapman, Orange
Byberg, Esther 3364 Cardiff Ave., Los Angeles 34
Byers, Elizabeth 275—38 St., Apt. C, Oakland
Caffina, Molly 2340 Clay St., San Francisco 15
Cameron, Mary S. 3632 Clement St., San Francisco 21
Campbell, Alba D. St. Helena Sanitarium & Hospital, Sanitarium
Campbell, Elizabeth F. Bartow Sanitarium, Los Angeles 4
Carlson, Irene E. 1527 Ortega St., San Francisco
Carrick, Mrs. Pansy R. Route 1, Box 145-A, Folsom
Carter, Marnianne W. 4632 Balch Ave., Fresno
Case, Flossie G. Box 101, Loma Linda Sanitarium, Loma Linda
Castile, Pearl I. 5 Maple Ave., Atherton
CATHEDRAL, ALMA F.
Veterans Administration Hospital, Fresno

CHAMBERLAIN, MARY D.
1340 N. Hunter St., Stockton

CHANDLER, EDNA L.
P.O. Box 1090, Stockton

CHAPMAN, NELLIE J.
2340 Clay St., San Francisco 15

CHEYOVICH, MRS. THERESA K.
9334 E. Compton Blvd., Bellflower

CHISUM, CATHERINE G.
993 Jenevein Ave., San Bruno

CHRISTENSEN, MRS. FERN
Pacific Union College, Angwin

CLAPP, MRS. DORIS G.
2823 E. Seventh St., National City

CLARK, BERNADINE G.
P.O. Box 242, Torrance

CLARK, DOROTHY E.
Dept. of Mental Hygiene, 1320 K St., Sacramento

CLARK, MARION E.
2333 De La Vina, Santa Barbara

CLARK, MARY I.
2125 Veteran Ave., Los Angeles 25

CLAY, LILLIAN O.
10754 Wilshire Blvd., Los Angeles 24

COATES, MARY
1856 Veteran Ave., Los Angeles 25

COBB, MRS. DOROTHY H.
Sacramento Junior College, Sacramento 18

COEFIELD, MARGARET
3714 Anza St., San Francisco

COULICI, GLORIA C.
Veterans Administration Hospital, Los Angeles 25

CONNOLLY, MARY E.
2190 Grove St., San Francisco

COOK, VIOLA E.
1200 E. Poplar, Stockton

CORTNEY, RUTH
Veterans Administration Hospital, Oakland 12

COSPER, HELEN G.
216 S. Broadway, Santa Ana

COWGILL, THELMA
Arroyo Del Valle, Livermore

CRAFT, N. BERTHA
2000 S. Griffin Ave., Los Angeles 31

CRAMER, BETTY LOU
6225 Big Creek Pkwy., Bldg. 55, Apt. 11, Cleveland 29, Ohio

CROSBY, MRS. MILDRED O.
702 W. Sixth St., Santa Ana

CROSS, MRS. OLLIE D.
Santa Fe Coast Lines Hospital, Los Angeles 23

CROWLEY, C. FRANCES
1521 Sixth Ave., Belmont

CUBERTSON, NORMA A.
1533 E. Eighth St., Stockton

CULLEN, MRS. ELIZABETH M.
Box 192, DeWitt State Hospital, Auburn

DALBEY, DORA E.
Loma Linda Sanitarium & Hospital, Loma Linda

DANA, FRANK D.
Drawer A, Modesto State Hospital, Modesto

DANIELS, DOROTHIA
Hotel Piedmont, Oakland 11

DAVIS, PAULINE E.
161 N. Third St., Campbell

DE DOES, MRS. RUBY M.
20 Talbot St., Salinas

DEETH, DOROTHY E.
900 Hyde St., San Francisco 9

DENHARD, ALICE
703 Tenth Ave., San Francisco 13

DeTEMPLE, ESTHER J.
1445 S. Redondo Blvd., Los Angeles 19

DEUTSCH, STEPHANIE
2117 Broadrick St., San Francisco 15

DEWEY, PRISCILLA M.
225 W. Emerson Ave., Monterey Park

DICKINSON, NELLIE
25 Miraloma Dr., San Francisco 16

DILLINGHAM, FRANCES I.
2907 Bush St., San Francisco 15

DOUGHERTY, FLORENCE N.
5105—62 St., Sacramento

DOWD, ELEANOR
2911 Paloma, Pasadena 8

DOWNING, VIRGINIA
5662 Bolch Ave., Fresno

DUFOUR, HONOR B.
2551 Ivy Dr., Oakland 6

DUMAS, VERA S.
7700 Geary Blvd., San Francisco 21

DUNBAR, HARRYEAN A.
2045 Cabrillo St., San Francisco 21

DUNNETT, KATHARINE
6281/2 Tenth St., Sacramento 14

DUQUAIN, LYDIA A.
Veterans Administration Hospital, Palo Alto

ECKHART, MRS. SUSAN C.
449 S. Sydney Dr., Los Angeles 22

EDGERTON, ELIZABETH
Drawer A, Modesto State Hospital, Modesto

EILERS, MARTHA E.
1212 S. Shatto St., Los Angeles 14

ELDER, ELIZABETH
2031 Las Colinas Ave., Los Angeles 41

ELLIS, HELEN B.
Veterans Administration Hospital, Box 254, Los Angeles 25

ELMER, MRS. AGNES R.
Agnew State Hospital, Agnew

ERICKSON, HELEN I.
1035 Hayes St., San Francisco 17

ERMOIAN, LUCILLE N.
1200 N. State St., Box 631, Los Angeles 33

ESTES, ALMA C.
2004 Quinby Dr., Bakersfield

FAHY, GERALDINE A.
10754 Wilshire Blvd., Los Angeles

FALCONER, MARY W.
491 Richmond Ave., San Jose 10

FARNWORTH, ADELINE
1920 Michigan Ave., Apt. 102, Los Angeles 53

FIEDE, RUTH E.
1020 N St., Sacramento

FERGUSON, MRS. ADA C.
Veterans Administration Hospital, Los Angeles 25

FERGUSON, CARRIE
1401 E. 81 St., Oakland 2

FERRAND, MARY L.
1619 Midvale Ave., Los Angeles 25

FLOOD, EMMA M.
1010 44 St., Sacramento 16

FOLENDORF, MRS. GERTRUDE R.*
Shriners' Hospital, San Francisco 22

FREDETTE, RITA M.
371-B Hawthorne Ave., Oakland 9
JOHNSON, HANNA
3450 Piedmont Ave., Oakland 11

JOHNSON, KATRINA
2222 Haste St., Berkeley

JOHNSON, LUCILIE J.
2510 “P” St., Sacramento

JOHNSON, MARTHA K.
1814 Orchard Ave., Glendale 6

JOHNSTON, RUTH V.
San Bernardino County Hospital, San Bernardino

JONES, ANNE S.
1236 Shatto St., Los Angeles 14

JORDAN, JEAN
346 E. Empire, San Jose

JORDAN, WILMA K.
1126 Arapahoe St., Los Angeles 6

JORGENSEN, RUTH I.
Fresno General Hospital, Fresno

JORDAN, ANTOINETTE M.
345½ Palmetto Dr., Pasadena 2

JUANITAS, VIOLET
1664 E. Eighth St., Stockton

KAGLER, DOROTHY
3460 Robinson Dr., Oakland 2

KATO, KIYOGE M.
P.O. Box 87, Warm Springs

KERR, MARGARET
557 E. Hargrave St., Inglewood

KERR, VIOLA M.
4181 Front St., San Diego 3

KIEZLE, HELEN
334 Rowell Bldg., Fresno 1

KILSTOFTE, HERDIS B.
2311 Fresno St., Fresno 2

KISH, VELMA K.
10917 Rochester Ave., Los Angeles 24

KLEINMAN, ANTOINETTE
1945—42 Ave., San Francisco 21

KLEINROCK, MRS. JANE K.
3030 Los Feliz Blvd., Apt. 201, Los Angeles 27

KLUMP, OLIVE W.
1922 N. Verdugo Rd., Glendale 8

KNOLL, MILDRED M.
509 N. Golden Gate Ave., Stockton

KOHLRASER, MRS. GRACE G.
1544 Sacramento St., Berkeley 2

KOH R, JESSIE L.
470 S. Los Robles Ave., Pasadena 5

KOSSLER, BLANCHE M.
1411 Divisadero St., San Francisco 15

KREMER, MRS. MAXINE L.
Permanente School of Nursing, Oakland

KRETSCHE, RUTH T.
Palo Alto Hospital, Palo Alto

KURZ, HILDA P.
411 Williams Pl., San Mateo

LANDIN, E. JANET
317 Bush St., Apt. 610, San Francisco 2

LAPINEWSKA, JANINA
1444½ Veteran Ave., Los Angeles 24

LAUFMAN, MRS. SARAH S.
Franklin Hospital, San Francisco 14

LAWRENCE, BESIEE
1330 Greenwich St., San Francisco 9

LEE, MARGARET
2425 Griffin Ave., Los Angeles 31

LEYVOS, MARGARET V.
1381 Michigan Ave., Stockton

LINDBLOOM, ANNA M.
Draver “A,” Modesto State Hospital, Modesto

LINDBLOOM, RUTH
4309 Second Ave., Los Angeles 43

LINDEN, PHYLLIS
288 S. St. Andrews Place, Los Angeles 5

LINDSTROM, RIZPAH
602 S. Tenth St., Jan Jose

LITTLE, EDELL F.
2530 W. Eighth St., Los Angeles 5

LOTSPEICH, RUTH L.
University of California Hospital, San Francisco 22

LOVELAND, DOROTHY K.
1444 Seventh Ave., San Francisco 22

LUCAS, PAULINE
Veterans Administration Hospital, Palo Alto

LUNDQUIST, MABEL C.
4519 C St., Sacramento

LUTZ, FRIEDA
219 S. Anderson, Loma Linda

LYU, MALLIE M.
1915 Virginia Rd., Los Angeles 16

MAAKESTAD, CARRIE E.
2001 Pierce St., Apt. 65, San Francisco 15

MAAS, EVA M.
2845 Forest Ave., Berkeley 5

MacKENZIE, BARBARA
San Francisco Hospital, San Francisco 10

MacKENZIE, CHRISTINE
2075 30 Ave., San Francisco 16

MacLEAN, MARGURITE L.
277 Wayne Ave., Oakland 6

MacOWAN, ASHY
635 Euclid Ave., Berkeley 8

MAGRUDER, DOROTHY M.
1011 Isabel St., Los Angeles 65

MAHONEY, MARIE M.
252 Clinton Park, San Francisco 3

MAHR, BENITA
1620—15 St., Sacramento

MANDT, GLADYCE A.
328½ S. Hope St., Los Angeles 7

MANN, ESTELLA
100 Mira Mar, Apt. 7, Long Beach 3

MAPES, MRS. ELIZABETH
2656 Sixth Ave., Sacramento 17

MARA NTA, MRS. ELSA J.
1704 Locust Rvinse, Bakersfield

MARTIN, EVELYN B.
130 Myson Ave., Manteca

MARTINS, MRS. EDITH V.
163 S. Orange Grove Ave., Los Angeles 35

MATHews, EILEEN
Modesto State Hospital, Modesto

MAXWELL, R. MAUREEN
312 N. Boyle Ave., Los Angeles 33

McALARY, JEAN B.
1328 W. 134 St., Gardena

McALLISTER, MRS. ALICE D.
San Joaquin General Hospital, French Camp

McCAIN, R. FAYE
1230 Amsterdam Ave., Box 32, New York 27, N. Y.

McCANNELL, JENNIE L.
207 S. Berceno St., Los Angeles 4

McCoy, MRS. MARGARET
2509 N. Sutter, Stockton

McDUGGAL, MILDRED K.
4212 Guardia Ave., Los Angeles 32

McDERMOTT, HELEN B.
11659% Montana Ave., Los Angeles 49

McDONALD, MRS. FLORENCE M.
1905 Laguna, Apt. 205, San Francisco 15

441
MCGUIRE, MARGARET J.
10712 Cumpton St., North Hollywood

MCLAIN, MRS. THELMIMA.
151 E. Olive St., San Bernardino

McMAHON, ROMAYNE A.
509 Adams St., Bakersfield

McQUELL, MARY
2630 Westwood Blvd., Los Angeles 34

MELCHING, ANNE C.
16321 Roosevelt Hwy., Santa Monica

Messer, ARLENE F.
BOX 123, Eldridge

MEYER, RUTH C.
6109 Coralite St., Long Beach 8

MICHAL, SYLVIA A.
Veterans Administration Hospital, Los Angeles 25

MILLER, ANNA T.
Letterman Army Hospital, San Francisco

MILLER, ELIZABETH
St. Vincent's Hospital, Los Angeles 5

MILLS, ALDEN B.
751 S. Pasadena Ave., Pasadena 2

MILLS, MATILDA A.
342 S. Boyle Ave., Los Angeles 33

MOBLEY, MERLE E.
1529 Selby, Los Angeles 24

MORI, MASAE
2301 Pine St., San Francisco 15

MORRIL, FLORA
1326 N St., Sacramento

MORROW, MRS. EMMA B.
Veterans Administration Hospital, Palo Alto

MOSHER, HELEN E.
Pacific Colony, Spadra

MOSHER, MRS. MARIAN S.
2335 E. Washington St., Pasadena 7

MOUNT, BETTY LOI
2217 McKinley Ave., Stockton

MUELLER, BARBARA F.
1810 Ninth Ave., Sacramento

MUHS, ETHEL
Sacramento County Hospital, Sacramento 17

MULVANE, MRS. GABRIELLE T.
780 E. Gilbert Ave., San Bernardino

MUNDY, EMMA B.
1760 E. Morada Pl., Altadena

MURPHY, HELEN
Veterans Administration Hospital, Oakland 12

MURPHY, MARIE F.
148 Orange St., San Bernardino

NAGELE, MARGARET
4770 Glenallan Dr., Los Angeles 65

NEAL, PAULINE
312 N. Boyle Ave., Los Angeles 33

NELSON, CLAIRE B.
1550 Smith St., Pomona

NELSON, ELIZABETH R.
395-B Merrill Ave., Glendale 6

NELSON, MRS. KATHRYN J.
College of Medical Evangelists, Loma Linda

NELSON, PAULA M.
Veterans Administration Hospital, Los Angeles 25

NESS, OLIVIA A.
1616 Whipple Ave., Redwood City

NEWHALL, CHRISTABEL M.
P.O. Box 1170, Stockton

NEWTON, CHARLOTTE A.
2100 Balboa St., San Francisco 21

NEWTON, MARJORIE D.
2306 Richelieu Ave., Los Angeles 32

NICHOLS, KATHLEEN A.
Veterans Administration Hospital, West Los Angeles 25

NICHOLSON, HELEN F.
Veterans Administration Hospital, Los Angeles 25

NICKELL, IRIS E.
3901—14 Ave., Sacramento 17

NICOLAS, ZELLA
California Hospital, Los Angeles 15

NOBLE, VERONICA M.
3040 Silver Lon Terrace, Los Angeles 39

NORDQUIST, FRANCES M.
311 Fruitvale Ave., Oakland 2

NORMAN, PHYLLIS I.
158½ Erosas St., Loma Linda

NYE, NEVA E.
San Diego County General Hospital, San Diego 3

OFFENBACH, DOROTHY L.
1947 Dilksadero St., Apt. 4, San Francisco

OGAN, SALOMA L.
1256 Brittania St., Los Angeles 33

OLIVER, MARTHA L.
A.B.C.C., APO 182, c/o PM, San Francisco

OLSEN, BELVA L.
337—22 Ave., San Francisco 10

O'MEARA, KATHERINE A.
8321 Colegro Dr., Los Angeles 45

OSTLUND, BLANCHE C.
280 Rolph St., San Francisco 12

PARISSO, MRS. MYRTLE P.
3021—22 Ave., Oakland 2

PARRSONS, CORINNE
283 Union St., San Francisco

PARRSONS, HELEN
423 Font Blvd., San Francisco

PASILAS, ERLINE G.
2205 Hedge Ave., Fresno

PEARCE, MIRIAM H.
1200 N. State St., Los Angeles 33

PCEK, MARGUERITE J.
Shriner's Hospital, San Francisco 22

PEDDRTTI, MARGARET J.
4925 Anza St., San Francisco

PEIRSON, ELIZABETH D.
320 W. 15 St., Los Angeles 15

PELLETAIRE ALICE
Route 1, Box 1550, Campbell

PETERS, ELEONOR
230 E. Cleveland St., Stockton

PETGSON, FLORENCE J.
553—21 St., San Bernardino

PETGSON, PALMA L.
157 College St., Fresno

PETGSON, R. WILMA
518—25 St., Sacramento

PHelps, MRS. HARRIET C.
17 Cypress Ave., San Rafael

PLANINC, MRS. MARY N.
2103 West Blvd., Los Angeles 16

POFFENBARGER, MRS. LILIAN C.
829 W. Compton Blvd., Compton

POLKINHORN, GRACE I.
715 N. Wilson Ave., Pasadena 6

POTTER, FERN
395-B Merrill Ave., Glendale 6

NOBLE, EL VERONICA M.
2100 Balboa St., San Francisco 21
SCOTT, SARA M.
1741 Robin Whipple Way, Belmont

SCOTT, MRS. VERA L.
608 College Ave., Livermore

SEARS, MARGUERITE E.
550 S. Curson Ave., Los Angeles 36

SEWALL, MARY
1118 Sewall Ave., Pacific Grove

SHANHOLTZER, CLADYS W.
447 Eighth Ave., San Francisco 18

SHATTUCK, EVELYN I.
121 S. Shatto St., Los Angeles 14

SHELTER, MARGUERITE C.
406 S. Fairfax Ave., Los Angeles 36

SHERIDAN, ELIZABETH C.
3325 Chanscy Rd., Santa Rosa

SERRILL, JEANNE C.
5509 Washington Ave., Fresno

SILVERI, MRS. ALICE C.
10667 Tujunga Canyon Blvd., Tujunga

SIMPSON, THELMA L.
5356 La Pasada, Long Beach

SISTER ALICE
2151 W. Third St., Los Angeles 5

SISTER ALPHONSE
Mary's Help Hospital, San Francisco 3

SISTER ANNE ELIZABETH
St. Vincent's Hospital, Los Angeles 5

SISTER AUSTIN
St. Vincent's Hospital, Los Angeles 5

SISTER BARBARA
303 Race St., San Jose 14

SISTER BERENICE
303 Race St., San Jose 14

SISTER CLARA
305 Race St., San Jose 14

SISTER DEPAUL
St. Vincent's Hospital, Los Angeles 5

SISTER DOROTHEA
Mary's Help Hospital, San Francisco 3

SISTER ESTELLE
145 Guerrero St., San Francisco 3

SISTER FIDELIS
St. Vincent's Hospital, Los Angeles 5

SISTRF GENEVIEVE MARIE
12001 Chalon Rd., Los Angeles 49

SISTER GENEVIEVE McARDLE
2181 W. Third St., Los Angeles 5

SISTER GREGORY
St. Vincent's Hospital, Los Angeles 5

SISTER IRENE
St. Vincent's Hospital, Los Angeles 5

SISTER LEANDER
O'Connor Hospital, San Jose 14

SISTER MARIANA
145 Guerrero St., San Francisco 3

SISTER MARY AGNES
St. Joseph's Hospital, San Francisco 17

SISTER M. BAPTIST
Mercy College of Nursing, San Diego 3

SISTER MARY BEATA
Mercy College of Nursing, San Diego 3

SISTER MARY BENIGNUS
Mercy Hospital, Sacramento

SISTER MARY BERMANS
St. Mary's Hospital, San Francisco 17

SISTER MARY JAMES
145 Guerrero St., San Francisco 3
SISTER MARY LAWRENCE  
145 Guerrero St., San Francisco 3

SISTER MARY MARTHA  
St. Mary's Hospital, San Francisco 17

SISTER MARY FLACIDA  
2300 Hayes St., San Francisco 17

SISTER MARY REBECCA  
Mt. St. Mary's College, Los Angeles 49

SISTER MARY SYLVIA  
2200 Hayes St., San Francisco 17

SISTER M. THERESE  
4001 J St., Sacramento

SISTER RITA ZIMMERMAN  
365 Race St., San Jose 14

SISTER ROBERTA CALLAHAN  
St. Vincent's Hospital, Los Angeles 5

SISTER VIRGINIA  
145 Guerrero St., San Francisco 3

SKEHAN, BERENICE D.  
3520—23 St., San Francisco 10

SLEDGE, MRS. DORRIT D.  
490 Sixth Ave., San Francisco

SLOTKIN, MRS. MARGARET  
5303 Satsuma Ave., San Valley

SMITH, BLANCHE G.  
1200 N. State St., Box 1741, Los Angeles 33

SMITH, DORIS E.  
2115—30 St., Sacramento

SMITH, HARRIET O.  
338 S. Boyle St., Los Angeles 33

SMITH, KATHRYN M.  
1044 Irving St., San Francisco

SMITH, MRS. PURCELLE P.  
207 Stanford Ave., Berkeley 8

SMITH, ROMAINE M.  
35 Barcelona Ave., San Francisco 15

SMITH, THELMA C.  
Modesto State Hospital, Modesto

SNEATH, LORAIN£  
2223 Morton Ave., Los Angeles 41

SOMOGYI, MARY M.  
P.O. Box 1290, Stockton

SPANG, JUNNE E.  
Veterans Administration Hospital, San Francisco

SPEES, EVELYN N.  
1457 N. Brenton Way, Los Angeles 26

SPERRY, MRS. JEAN B.  
6222 Tanglewood St., Long Beach 8

SQUIRE, JESSIE  
5078 Miles Ave., Oakland 9

STANTON, CARRIE E.  
1157 Galloway St., Pacific Palisades

STAPLE, GRACE E.  
2200 Post St., San Francisco 15

STEELE, MRS. KATHARINE M.  
State Department of Mental Hygiene, Sacramento

STEFFEN, ANNA M.  
2163 Moreno Dr., Los Angeles 39

STEINMETZ, EDNA A.  
2630 L. St., Sacramento

STEPHENS, JESSIE E.  
2049 Divisadero St., Apt. 1, San Francisco 14

STILSON, GLADYS M.  
1189 Walnut St., Berkeley 8

STOCKONIS, MRS. EVA A.  
606 N. Central Ave., El Monte

STRAHAN, BEULAH A.  
Veterans Administration Hospital, Ward 11, San Fernando

STRAND, EDITH F.  
St. Helena Sanitarium & Hospital, Sanitarium

TAGE, JEANNE M.  
977 Menlo Ave., Los Angeles 6

TAYLOR, ERMA B.  
318 Highland Ave., Patton

TEN BOSCH, WILLEMINA D.  
2355 Clay St., San Francisco 15

THOMAS, FLORENCE A.  
2000 Bell St., North Sacramento 15

THOMPSON, BARBARA A.  
Cottage Hospital, Santa Barbara

THOMPSON, FRANCES M.  
2511 Dana St., Berkeley 4

THOMSON, Elnora E.  
2293 Washington St., San Francisco 15

THORESON, ALICE  
Veterans Administration Hospital, Palo Alto

TITUS, SHIRLEY C.  
753—13 Ave., San Francisco 21

TOSCANO, GLADYCE A.  
150 S. Sycamore Ave., Los Angeles 36

TRACY, MARGARET  
5 Maple Ave., Atherton

TREESLER, KATHLEEN M.  
3401 N. Mission Rd., Los Angeles 31

TUFTS, GRACE C.  
6109 Coralite St., Long Beach 8

TURNBULL, ELIZABETH  
1621—16 Ave., San Francisco 22

VENABLE, MAY  
14693 Senforth Ave., Norwalk

VISINTAINER, LENA  
4613 Freeman Way, Sacramento 16

VOGEL, REGINA A.  
Veterans Administration Hospital, Oakland 12

VOSLOH, LILLIAN  
238 Grant St., Pasadena 5

WAGENER, MRS. HAZEL  
Route 1, Box 84, Ripon

WALDER, ETHEL J.  
Pacific Union College, Angwin

WALLACE, VEDA O.  
1949 Bentley Ave., Los Angeles 25

WALLACK, MOLLY  
1200 N. State St., Box 2133, Los Angeles 33

WALLIN, ANNA W.  
1831 Michigan Ave., Stockton

WARNKE, MRS. FANNIE T.  
282 Eighth St., Oakland 7

WARREN, VIVIAN  
308 S. Boyle Ave., Los Angeles 33

WATKINS, MRS. FRANCES T.  
4365 Eighth Ave., Los Angeles 43

WEBER, ELEONORA A.  
Veterans Administration Hospital, Los Angeles 25

WELCH, JULIA M.  
9518 Irwin St., Inglewood

WELKER, MARTHA A.  
4766 Druid St., Los Angeles 32

WELLER, MABLE V.  
Letterman Army Hospital, Box 173, San Francisco

WELLS, MABEL H.  
1605 La Colondrina, Alhambra

WHITE, CONSTANCE J.  
1322 N. Vermont Ave., Los Angeles 27

444
WOLF, LULU K.
1635 Hills Ave., Los Angeles 24

WOODDELL, ERMA B.
Sutter Hospital, Sacramento 16

WOODWARD, MRS. IDA A.
1355-39 St., Sacramento 16

WOODWORTH, HELEN L.
191 S. Santa Anita Ave., Pasadena 10

WRIGHT, ETHEL M.
1419 S. Sutter St., Stockton

YONEMOTO, EDITH Y.
P.O. Box 265, French Camp

YOUNG, AVIS M.
626 N. Corona del Terrance, Los Angeles 26

YOUNG, VIRNA M.
St. Luke's Hospital, San Francisco 10

ACKLEY, STELLA
4200 E. Ninth Ave., Denver 7

AMES, MARIE
770 Albion, Apt. 304, Denver 7

AMSTUTZ, EDNA M.
La Junta Mennonite Hospital, La Junta

ANKENY, A. FAITH
St. Luke's Hospital, Denver 5

AUSTIN, MRS. LILLIAN M.
264 Commonwealth Bldg., Denver

AYNES, MAJOR EDITH A.
279th General Hospital, APO 660, c/o PM,
San Francisco, Calif.

BARTLE, MRS. MARY A.
3441 Stuart St., Denver 12

BEERY, JENNIE M.
1326 Garfield St., Denver 6

BEHRE, MRS. NORA A.
1627 Washington St., Apt. 23, Denver 5

BERTHAUME, AILEEN B.
756 Colorado Blvd., #4, Denver 7

BILGER, ANNETTA J.
Children's Hospital, Denver 5

BOOTH, SHIRLEY C.
3251 S. Lincoln, Englewood

BOWDEN, VESTA
6 S. Harrison St., Denver 6

BRIGGS, BEULAH A.
3022 S. Paul, Denver 5

BROPHY, MARIE L.*
Veterans Administration Hospital, Fort Logan

BUTTERFIELD, MRS. FRED A.
Veterans Administration Hospital, Salt Lake City, Utah

CARLSON, FLORENCE C.
1350 Ogden St., Apt. 2B, Denver 3

CAROZZA, VIRGINIA J.
1440 E. 18 Ave., Denver 6

CASEY, OPAL
2020 Logan St., Denver 10

CASPER, THELMA A.
4200 E. Ninth Ave., Denver 7

CHASE, SUSANNA L.
770 Albion St., Apt. 304, Denver 7

CHORNEY, ROSE
State Hospital, Pueblo

CHRISTENSEN, BETTY H.
4700 W. 31 Ave., Denver 12

CLAY, HELEN E.
1145 Cherry St., Denver 7

COLESTOCK, RUTH
1121 Garfield St., Denver 6

COULTER, MRS. PEARL P.
University of Colorado School of Nursing, Boulder

CUSHMAN, MRS. OCA
Children's Hospital, Denver 5

DAUGHERTY, EDITH L.
Children's Hospital, Denver 5

DAY, DOROTHY E.
1826 Elm Ave., Grand Junction

DENST, MRS. DOROTHY S.
765 Locust St., Denver 7

DERRYSBERY, MAJ. JEWELL
1013 E. 17 Ave., Denver 5

DEVOL, MRS. MARY S.
5032 Division St., Chicago, Ill.

DICKINSON, MADOLIN R.
2145 S. Gilpin, Denver 10

DUNNING, FRANCES E.
501 E. 19 Ave., Denver 5

EMBERTON, MRS. MARY H.
19 S. Downing St., Denver 9

ERICKSON, JEAN W.
Children's Hospital, Denver 5

ERRICKSON, NELVA M.
1010 E. 17 Ave., Apt. 7, Denver 5

ERWIN, JOY
515 Garfield, Denver 6

FANGER, MRS. VIOLA A.*
1822 Franklin St., Denver 6

FARNsworth, OPAL H.
2836 Gaylord St., Denver 5

FARRINGTON, MRS. LUCILLE B.
1030 Holly St., Denver 7

FASON, MARGUERITE A.*
P.O. Box 16, Ft. Logan

FISHER, DOROTHY E.
4200 E. Ninth Ave., Denver 7

FLEMING, MURIEL M.
634 Pino, Boulder

FLUHARTY, ZELMA L.
Presbyterian Hospital, Denver 6

GERLACK, BERTHA C.
University of Colorado General Hospital, Denver 7

GILLILAND, EVANGELINE
501 E. 19 Ave., Denver 5

COLORADO—162
GOETZ, BARBARA
1718 S. Decatur, Denver 12

GOLDEN, LOUISE
University of Denver School of Nursing, Denver 5

GREEN, ANNA M.
Veterans Administration Hospital, Fort Logan

GREENE, DORIS M.
220 Garfield, Denver 6

GREGG, DOROTHY E.
330 Colorado Blvd., Denver 7

GROVERT, Verna
Veterans Administration Hospital, Nurses Quarters

HALLAN, MABEL B.
2365 S. Knox Ct., Denver 10

HAMES, Verna J.
1035 Pearl St., Denver

HANSEN, VIVIAN B.
4200 E. Ninth Ave., Denver 7

HANSON, MARGARET T.
Veterans Administration Hospital, Fort Logan

HARRIS, MRS. ELIZABETH F.
4610 E. Eighth Ave., Denver 7

HARRIS, FERN
Veterans Administration Hospital, Fort Logan

HARTZLER, LOLA B.
1236 Garfield St., Denver 6

HAYNES, MARGARET
290 W. Eighth Ave., Denver 4

HIGHLEY, BETTY L.
774 Eastor St., Denver 7

HILDENBRANDT, FERN A.
1305 Madison St., Denver 7

HOLLEN, MRS. ADELINA S.
227 Sherman St., Denver

HOLLOWAY, MRS. NORMA
Pioneer’s Hospital, Meeker

HOOK, MARJORIE J.
4017 G St., Lincoln, Nebr.

HUBER, HELEN M.
614 Jackson, Pueblo

JACKSON, MRS. FRANCES M.
2222 Locust St., Denver 7

JOHNSON, MRS. DOROTHY P.
1311 S. Emerson St., Denver 10

JOHNSON, MRS. MARGARET L.
Route 2, Box 70, Arvada

JONES, MRS. WADE G.
364 Grand Ave., Los Animas

KELLY, KATHERINE J.
911 Mapleton Ave., Boulder

KENNEDY, MRS. MABEL O.
1812 Marion St., Denver 6

KISZ, MARY V.
2725 S. Downing St., Denver 10

KOEBKE, ADA
1019 E. 19 Ave., Denver 5

KOHLER, ALICE
2149 S. High St., Denver

KORBE, LITA L.
515 Garfield St., Denver 6

LAGUARDIA, MRS. MARY L.
4556 Alcott St., Denver 11

LASALLE, CATHERINE
1112 N. Cascade St., Colorado Springs

LOCKHART, ELIZABETH J.
1921 Court St., Pueblo

LOUGHRAN, MRS. HENRIETTA A.
856 Ninth St., Boulder

MARTIN, JULIA R.
3526 Clay St., Denver 11

McGARVITY, MARY J.
1730 Gaylord St., Denver

MEADOR, MARIE E.
1136 Logan St., Denver

METZGER, MARGARET E.
1117 Pennsylvania Ave., Apt. 8, Denver

MIEKE, LILLIAN A.
4253 N. Federal St., Denver

MILLER, EDITH E.
1010 E. 15 Ave., Denver 5

MILLER, MRS. JANICE R.
719 Albion St., Denver 7

MINOR, MRS. DOROTHY I.
1049 Corona St., Denver 3

MONARCY, HONORA
1141—11 St., Boulder

MOSSEN, SALLY
4560 Julian St., Denver 11

MOTYLEWSKI, VIOLET A.
Veterans Administration Hospital, Fort Lyon

MOWERY, JANET
777 Ash St., Denver 7

MURCHISON, IRENE
20 S. Ogden, Apt. 206, Denver 9

NEGRI, JENNIE B.
5262 Zuni St., Denver

O’MALLEY, MIAE
220 Garfield St., Denver 6

PAETZIECK, MARGUERITE
1458 Wolff St., Denver 4

PAIR, MRS. NONA T.
215 Fox St., Denver

PERDELWITZ, ELEANORE L.
1235 Grant St., Denver

FERIOTI, LUCILE
1550 Sherman St., Denver 2

PHILLIPS, CAROL C.
9149 Emerson, Apt. 12, Denver 3

PORTER, MRS. HELEN
635 Krameria St., Denver 7

PRITCHARD, HELEN
1601 Franklin St., Denver 6

REEVES, SARAH H.
1460 Jasmine St., Denver

RICK, BERTHA E.
523 E. 12 Ave., Denver 3

ROBERTS, GERTRUDE
1462 Wolff St., Denver 4

ROCKWOOD, ALICE
700 Albion St., Denver 7

RODEMAN, CHARLOTTE R.*
Fitzsimmons Army Hospital, Denver 8

ROGERS, MRS. EULA P.
4173 S. Eti St., Englewood

RUSE, MRS. MAYBELLE B.
Presbyterian Hospital, Denver

RUSH, WILDA M.
1230 E. Eighth Ave., Denver

RYKKEH, LUCILLE T.
602 Marion St., Denver 3

SCHATT, EVA
722 Albion St., Denver 7

SCHIEODS, DORIS L.
704 Fairfax St., Denver 7

SCHMID, AUDREY M.
777 Ash St., Denver
MEMBERS

SCHMIDT, MAE D.
1240 Colorado Blvd. #2, Denver

SCHUERMANN, GLADYS
4290 E. Ninth Ave., Denver 7

SCHWABE, ANNA B.
2300 N. Cascade Ave., Colorado Springs

SHARP, LORETTA R.
1434 Jasmine St., Denver 7

SISTER AGNES
St. Joseph's Hospital, Denver 6

SISTER CYRIL
Mt. St. Joseph, Ohio

SISTER FRANCES CLARE
1905 Franklin St., Denver 6

SISTER MARIE CHARLES
Gleckner-Penrose Hospital, Colorado Springs

SISTER MARY ALEXIUS
St. Joseph's Hospital, Denver 6

SISTER MARY ANSELMO
1619 Milwaukee St., Denver 6

SISTER MARY AURELIA
St. Joseph's Hospital, Denver 6

SISTER MARY CAROLYN
Gleckner-Penrose Hospital, Colorado Springs

SISTER M. DOMINCA
St. Anthony Hospital, Denver 4

SISTER M. GETULIA
St. Francis Hospital, Colorado Springs

SISTER MARY HUGOLINA
St. Anthony Hospital, Denver 4

SISTER MARY JEROME
Mercy Hospital, Denver 6

SISTER MARY KILIAN
1619 Milwaukee St., Denver 6

SISTER M. LAWRENCE
Mercy Hospital, Durango

SISTER MARY MIGUEL
Mercy Hospital, Denver 6

SISTER M. PETRILLA
St. Anthony Hospital, Denver 4

SISTER MARY RAYMOND
Mercy Hospital, Denver 6

SISTER MARY VITUS
Mercy Hospital, Denver 6

SISTER VINCENTIA
St. Joseph's Hospital, Denver 6

SMITH, ALICE E.
2525 S. Downing St., Denver

SNYDER, MARGORIE A.
1238 Josephine St., Denver 6

SORENSEN, LOIRA C.
Colorado State Hospital, Pueblo

STACK, CHARLOTTE
1630 Fillmore, Denver 6

STOLL, CLARICE E.
1640 E. 18 Ave., Denver 6

STORATZ, MILBRED R.
1441 Spruce St., Denver 7

SWARTZENDRUBER, MRS. MAEDE
Mennonite Hospital & Sanitarium, La Junta

TAKAYOHI MOSAKU
4200 E. Ninth Ave., Denver 7

TAYLOR, LOUISE B.
Veterans Administration Hospital, Los Angeles 25, Calif.

TIDD, MRS. ALICE R.
750 Colorado Blvd., Apt. 1, Denver 7

TIONA, IRMA
4200 E. Ninth Ave., Denver 7

TRUMBO, JANE H.
1478 Detroit St., Denver 6

WADE, VIRGINIA K.
2327 Alcott St., Denver 11

WALKER, MARY C.
1315 Cheyenne Pl., Denver 2

WALSH, HENRIETTA C.
3815 Raleigh St., Denver 12

WATKINS, MARY R.
4200 E. Ninth Ave., Denver 7

WEIDMAN, ESTHER E.
2903 E. 18 Ave., Denver 6

WEISENHORN, ANNA E.
2300 N. Cascade Ave., Colorado Springs

WIEBE, ANNE M.
1241 Washington St., Denver

WIEST, RUTH E.
1640 E. 16 Ave., Denver 6

WOOLMAN, PAULINE
2606 S. Cherokee, Englewood

WOON, IRENE
1610 E. 19 Ave., Denver 5

WYNNER, LAURETTE M.
86 Grant St., Apt. 14, Denver 9

ZIEGLER, VERLIE M.*
259 W. Eighth Ave., Denver 4

CONNECTICUT—169

ADAMS, MRS. ROSA L.
Box 29, F.S.H., Newtowm

ALUBUSKAS, HELEN S.
45 Russell St., Waterbury 8

ANASTON, LAURA
330 Mt. Auburn St., Cambridge 38

ANDERSON, FLORECE L.
168 Woodruff Ave., Watertown

ARCOI, MRS. EVELYN R.
1115 Main St., Bridgeport

BARNES, EDITH G.
5119 Second St., N.W., Washington, D. C.

BAUMISTER, HELEN M.
Bridgeport Hospital, Bridgeport 8

BEAMISH, GRACE E.
Box 236, 160 Retreat Ave., Hartford

BEAR, MRS. JULIA
111 Jackson St., Ansonia

BEDUL, JANE J.
Box 361, Middletown

BEST, NELLIANA
129 Rivercliff Dr., Devon

BISSELL, MARGARET A.
37 Jefferson St., Hartford 15

BIXLER, ELIZABETH S.
310 Cedar St., New Haven

BLAIR, MARY E.
350 Ocean Ave., New London

BLAKE, MRS. MARION R.
255 Whitney Ave., New Haven

BRACKETT, MARY E.
19 Avalon Pl., Wethersfield

447
BRIGGS, MRS. CATHERINE C.
1341 Chapel St., New Haven 11

BROOKS, ETHEL A.
Hartford Hospital, Hartford 6

BUSSEY, LOIS E.
Hartford Hospital, Hartford 6

CADDY, MRS. LOUISE L.
161 Maplewood Ave., Hartford

CANTWELL, DOROTHY E.
Box 83, East Haddam

CASTIGLIONE, RITA M.
90 Townsend Ave., New Haven

CLARK, H. MELISSA
45 Hawkins St., New Britain

CLARKE, HELEN L.
21 Washington Manor, West Haven

COLEMAN, MARGUERITE M.
208 Farmington Ave., Hartford

CORNELL, ANNE M.
Norwalk General Hospital, Norwalk

CORKWALL, CLAIRE
392 Main St., Portland

CRABBS, LOIS L.
Box 192, Auburn, Calif.

CRYSTAL, HELEN
116 Blackhall St., New London

CULLEN, MRS. HELEN M.
11 Alyn St., Hartford

DANKERS, EMILY A.
37 Jefferson St., Hartford 6

DAVIS, ALEXINA S.
New Britain General Hospital, New Britain

DEWS, MARY JANE
401½ Crown St., New Haven

DOLAN, JOSEPHINE A.
University of Connecticut, Storrs

DOUGLAS, MARION H.
57 Forest St., Hartford

DOWNEY, MARY C.
Stamford Hospital, Stamford

DUDLEY, MURIEL G.
16 Mountain View Dr., West Hartford

DU MORTIER, MRS. MARGUERITE R.
70 Howe St., New Haven 11

DURKEE, MARION
Norwalk Hospital, Norwalk

EATON, HAZEL A.
Middlesex Hospital, Middletown

ELLIOTT, ETHEL M.
Box U-59, Storrs

FARRELL, HELEN E.
37 Jefferson St., Hartford

FARRELL, VIRGINIA M.
274 Fairfield Ave., Bridgeport 3

FIELDS, THERESA
29 Standish Rd., Stamford

FITZPATRICK, ELIZABETH A.
Danbury Hospital, Danbury

FOGHT, JOAN R.
37 Jefferson St., Hartford

FOX, ELIZABETH G.
Litchfield Turnpike, Bethany

FRANK, MARION L.
100 Price Blvd., West Hartford

GOLDE, ELIZABETH
1523 Chapel St., New Haven

GORHAM, MARY T.
335 Maple Ave., Hartford 6

GRAHAM, MRS. MARGARET B.
Grace-New Haven Community Hospital, New Haven

GRANT, LAURA M.
769 Howard Ave., New Haven

GREY, MRS. HELEN M.
22 Rose Court, New Britain

GROJEAN, MARIE
2605 Main St., Bridgeport

GUILTE, RUTH C.
118 Russwin Rd., New Britain

GURSKI, PAULINE F.
William W. Backus Hospital, Norwich

CUSHING, MARY E.
Box 508, Norwich

HALL, ELEANOR A.
70 Howe St., Apt. 407, New Haven

HAPICH, ROSE C.
72 Fair Harbour Pl., New London

HATCH, BESSIE M.
Bridgeport Hospital, Bridgeport 8

HAVERLAND, MRS. ETHEL D.
25 Sanford Pl., Bridgeport

HEATH, MARY B.
Main St., Yalesville

HOPKINS, MARILYN A.
1 Church Pl., Wethersfield 9

ISAKSON, HELEN
Uncas-on-Thames, Norwich

JAYNE, MARTHA
College of Nursing, Bridgeport University, Bridgeport

JENNINGS, LOUISE A.
95 S. Burritt St., New Britain

JOHNSON, GERTRUDE F.
142 Hunting Hill Ave., Middletown

JONES, ARLENE M.
63 Pleasant St., Danbury

KANE, BARBARA
470 Yale Ave., New Haven 15

KAPLAN, ELEANORE M.
120 Richards Pl., West Haven

KETCHAM, KATHERINE
320 Edgewood Ave., New Haven

KUMMER, PAULINE V.
Main St., R.F.D. 1, Granite Bay, Branford

LEGGETT, GRACE L.
99 Windsor St., Waterbury 29

LEWIS, MRS. EDITH P.
Palmer St. Ext., Cisco Bldg., Norwich

LUSEBRINK, ELSA C.
Bridgeport Hospital, Bridgeport 8

LYNCH, MARTINA C.
156 Woodrow St., West Hartford

LYSS, MARTHA L.
562 Stanley St., New Britain

MACKRIE, MRS. MARION T.
39 Woodland Dr., Laurel Park, Norwich

MACLEAN, JEAN
310 Cedar St., New Haven

MAG, LILLIAN P.
Mount Sinai Hospital, Hartford

MACEE, MARGARET J.
Yale University School of Nursing, New Haven

MAIN, EUNICE
3 Springfield Ave., Middletown

MANFRED, MARGUERITE L.
Institute of Living, Hartford

MARCHANT, HELEN M.
71 Mills Ave., Milford

448
PHIPPS, DOROTHY L.
30 Forest Ave., Ansonia

PODBRASKY, BERNICE M.
R.F.D. 3, Box 249, Bridgeport

PRATT, DEBORAH L.
37 Jefferson St., Hartford 6

RAMSDELL, EVELYN
161 Cook Ave., Meriden

REEVE, IRMA E.
512 Townsend Ave., New Haven 13

REID, MARGARET
R.F.D. 1, Box 127-C, Washington

REILLY, MRS. BETTY D.
267 Cooper Pl., New Haven

REILLY, LILIAN B.
Hospital of St. Raphael, New Haven

RICHARDSON, MILRED A.
Bridgeport Hospital, Bridgeport 8

ROBERTS, DOROTHY M.
72 Fair Harbour Pl., New London

RUPPRECHT, GERTRUDE
28 Crescent St., Middletown

RYCKMAN, ETHEL C.
37 Jefferson St., Hartford 6

SALMONSEN, FLORENCE
17 Foster St., Manchester

SANTARISIO, D. MARIA
301 S. Main St., Waterbury 65

SAWYER, JANET R.
Hartford Hospital, Hartford

SCHOFIELD, MRS. MARY
49 Hillcrest Ave., Naugatuck

SCHUE, ANNE
193 E. Main St., Middletown

SHELDEN, ELOISE A.
Norwich State Hospital, Norwich

SHOLTIS, LILLIAN A.
27 Harrison St., New Haven

SIMONI, MARIE G.
42 Mitchell Ave., Waterbury

SISTER ALICE MARY
114 Woodland St., Hartford

SISTER ANN ELIZABETH
114 Woodland St., Hartford

SISTER ANN MARY
St. Francis Hospital, Hartford 5

SISTER BEATA MARIE
Hospital of St. Raphael, New Haven 11

SISTER CATHERINE ANNE
Hospital of St. Raphael, New Haven 11

SISTER CATHERINE MARIA
Hospital of St. Raphael, New Haven 11

SISTER CECILIA MARY
St. Francis Hospital, Hartford 5

SISTER EVELYN MARIE
1450 Chapel St., New Haven 11

SISTER FRANCES HEALY
2820 Main St., Bridgeport 6

SISTER JAMES FRANCES
St. Mary's Hospital, Waterbury

SISTER JEAN ANNE
Hospital of St. Raphael, New Haven 11

SISTER LOUISE ANTHONY
Hospital of St. Raphael, New Haven 11

SISTER MARGARET DOLORES
114 Woodland St., Hartford

SISTER M. ANNUNCIATA
114 Woodland St., Hartford
SISTER M. CONCEP'TA
St. Francis Hospital, Hartford 5
SISTER MARY DAMIAN
Hospital of St. Raphael, New Haven 11
SISTER M. FLORITA
1450 Chapel St., New Haven 11
SISTER MARY GERTRUDE
St. Mary's Hospital, Waterbury
SISTER MARY MADELEINE
St. Francis Hospital, Hartford 5
SISTER MARY MARGARET
114 Woodland St., Hartford
SISTER MARY MEC'HTILDE
114 Woodland St., Hartford
SISTER ST. CATHERINE
St. Mary's Hospital, Waterbury
SISTER TERESA AUSTIN
St. Francis Hospital, Hartford 5

ARCHANGELO, MRS. RITA L.
18 Lawson Ave., Claymont
ARMINIO, MRS. VIRGINIA
107 W. 17 St., Wilmington
BARR, ISABELLE M.
BAYLIS, FRANCES K.
616 Kings Highway, Lewes
BUTLER, MARGARET M.
608 W. 29 St., Wilmington
BYRNE, MRS. ANNE K.
330 Delaware Ave., McDaniel Crest
CARROLL, MRS. RUTH S.
Christiana
CASEY, HELEN M.
33 Cleveland Ave., Wilmington
COYNE, MADELINE
Veterans Administration Hospital, Wilmington
CROSSAN, DIANA
1502 W. Fifth St., Wilmington
DAVIDSON, KATHERINE E.
405 Hillcrest Ave., Wilmington
DREIBARRES, MARIE L.
P.O. Box 209, Wilmington 99
DILLON, MRS. MILDRED D.
Wilmington General Hospital, Wilmington 14
DOWNES, MRS. GLADYS M.
1098 Delaware Ave., Wilmington
EARLY, MRS. MARY R.
2927 Washington St., Wilmington
ELLISON, MRS. MARGARET W.
221 W. Harrison Ave., Wilmington Manor, New Castle
FAUHABER, MRS. MILDRED F.†
705 W. 52 St., Wilmington
FARNOW, MRS. HELEN M.
110 W. Sixth St., Wilmington
FORD, MRS. CHARLOTTE R.
Parklawn Apts., New York Bldg., Elsmere
GIBSON, SARA F.
3305 Madison St., Wilmington
GINSBURG, SYLVIA
Delaware State Hospital, Farmhurst
HARTMAN, DOROTHY E.†
St. Francis Hospital, Wilmington
HAYES, MRS. JOAN S.
1463-B St. Elisabeth St., Wilmington

SOLOM. LILLIAN C.
1176 New Britain Ave., Elmwood
TAYLOR, DOROTHY I.
37 Jefferson St., Hartford 15
TOELLE, HEDWIG
512 Townsend Ave., New Haven
WALTON, MURIEL L.
45 Hawkins St., New Britain
WATTELL, MARY A.
1416 Chapel St., New Haven 11
WEST, ESTHER I.†
132 Jefferson St., Hartford
WOOD, MRS. CAROLYN L.
University of Connecticut, Storrs
WILSON, DOROTHY
76 Grove St., New Haven 11
ZANG, ARLENE F.
61 Maple Ave., Danbury

DELAWARE—93

HEALY, MARY G.
8 Nesquah Dr., RFD 2, Wilmington
HEALY, MRS. OLIVE L.
1314 Clayton St., Wilmington
HIGGINS, ELIZABETH
3605 Washington St., Wilmington
HILL, GRACE B.
409 Market St., Lewes
HODGSON, VIRGINIA
1901 Van Buren St., Wilmington
HOLLOWAY, MARIE
2712 W. Sixth Street, Wilmington
HYNES, MRS. EVELYN W.
220 W. Grant Ave., New Castle
JASTAK, MRS. SARAH R.
Delaware State Hospital, Farmhurst
JEANS, MRS. ELIZABETH S.†
1108 Berkeley Rd., Wilmington 67
JENKINS, DOROTHY E.
Wilmington General Hospital, Wilmington 14
JESTER, MRS. ELEANOR P.
Harvey Rd., R.F.D. 4, Wilmington
JORDAN, MRS. VIRGINIA B.
1027 Trenton Pl., Wilmington
KAVANAUGH, JEAN P.
1864 Wawaset St., Wilmington
KEFFE, MRS. CHRISTINA H.
142 Bellanca Lane, Collina Park, New Castle
KELLEY, MRS. MARIAN L.
221 Justin Ave., Newport
KELLUM, RUTH I.
30 Third Ave., Claymont
KELLY, MARIE A.
1505 Market St., Wilmington
KENDALL, MRS. EDITH R.
Delaware Ave. & Philadelphia Pike, Holly Oak
KEPHART, CATHERINE M.
1103 Gilpin Ave., Wilmington
KERVER, EDITH A.
51 Glenrice Ave., Wilmington
KETRAN, LOIS V.
1501 Van Buren St., Wilmington
KIRKPATRICK, MRS. AMY C.†
914 Stuart Rd., Wilmington 67
KLAES, MARY M.
141 American Ave., Dover

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### DELAWARE—DISTRICT OF COLUMBIA

<table>
<thead>
<tr>
<th>Name</th>
<th>Address/Location</th>
<th>Phone/Number</th>
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<tr>
<td>SCHRANCK, BERTHA C.</td>
<td>Delaware Hospital, Wilmington 13</td>
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<tr>
<td>SHARP, HAZEL M.</td>
<td>1303 W. du Pont St., Wilmington</td>
<td></td>
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<tr>
<td>SIMMONS, MRS. ALMA W.</td>
<td>24 Lorewood Ave., Richardson Park</td>
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<tr>
<td>SISTER KATHERINE MARIE</td>
<td>St. Francis Hospital, Wilmington</td>
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<tr>
<td>SISTER M. BENNO</td>
<td>St. Francis Hospital, Wilmington 154</td>
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<td>SISTER MIRIAM GERTRUDE</td>
<td>St. Francis Hospital, Wilmington</td>
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<tr>
<td>SMITH, MRS. EMILY D.</td>
<td>400 W. 12 St., Wilmington</td>
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<td>SMITH, MRS. MAE P.</td>
<td>10 Stone Hall Rd., Augustine Hills, Wilmington</td>
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<tr>
<td>SMITH, REBECCA M.</td>
<td>Wilmington General Hospital, Wilmington 14</td>
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<tr>
<td>STERN, MRS. ANNE G.</td>
<td>1434 N. Bancroft Pkwy., Wilmington</td>
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<tr>
<td>STEVENSON, MRS. ALICE L.</td>
<td>309 S. Walnut St., Milford</td>
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<td>STRETTON, MRS. EVELYN B.</td>
<td>5 South Lake St., Wilmington 131</td>
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<td>STRUSOWSKI, MRS. BEATRICE F.</td>
<td>406 W. 14 St., Wilmington</td>
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<td>TEOUL, LOUISE M.</td>
<td>502 N. Union St., Wilmington</td>
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<td>TRUNCK, MRS. ALBERTA P.</td>
<td>Delaware Hospital, Wilmington</td>
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<tr>
<td>WALKER, WILDA A.</td>
<td>55 Thompson Circle, Newark</td>
<td></td>
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<tr>
<td>WELSH, MRS. REBECCA S.</td>
<td>400 Junction St., Wilmington</td>
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<td>WETTER, EMILY M.</td>
<td>Delaware Hospital, Wilmington 13</td>
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<tr>
<td>YODER, EUNICE R.</td>
<td>Veterans Administration Hospital, Wilmington 99</td>
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</tbody>
</table>

### DISTRICT OF COLUMBIA—187

<table>
<thead>
<tr>
<th>Name</th>
<th>Address/Location</th>
<th>Phone/Number</th>
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</thead>
<tbody>
<tr>
<td>ABRAMAH, MRS. GERTRUDE L.</td>
<td>2509 N. Sycamore St., Arlington, Va.</td>
<td></td>
</tr>
<tr>
<td>ADDAMS, RUTH</td>
<td>Windsor Park Hotel, Washington 9</td>
<td></td>
</tr>
<tr>
<td>ANDREWS, GWEN H.</td>
<td>Box 624, Wadsworth, Texas</td>
<td></td>
</tr>
<tr>
<td>ANDRUZZI, MRS. ELLEN A.</td>
<td>3449—24 St., S.E., Washington 20</td>
<td></td>
</tr>
<tr>
<td>APP, MARTINA</td>
<td>2700 Fourth St., N.E., Washington 2</td>
<td></td>
</tr>
<tr>
<td>ARNSTEIN, MARGARET C.</td>
<td>3355—16 St., N.W., Washington 11</td>
<td></td>
</tr>
<tr>
<td>AXEN, FRIEDA</td>
<td>Nurse Home Building E, St. Elizabeth Hospital,</td>
<td></td>
</tr>
<tr>
<td>BAGLIO, MRS. LAURA M.</td>
<td>218 Audrey Lane, S.E., Washington 20</td>
<td></td>
</tr>
<tr>
<td>BAHR, HELEN S.</td>
<td>Barron Hall Residence, St. Elizabeth Hospital,</td>
<td></td>
</tr>
<tr>
<td>BALLARD, RUBY J.</td>
<td>Gallinger Municipal Hospital, Washington 3</td>
<td></td>
</tr>
<tr>
<td>BALTZ, LT. COL. KATHERINE E.</td>
<td>Office of Surgeon General, Rich-</td>
<td></td>
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<tr>
<td>BENJAMIN, MRS. SUSAN L.</td>
<td>Gallinger Municipal Hospital, Washington 3</td>
<td></td>
</tr>
<tr>
<td>BENNETT, OLIVE M.</td>
<td>718 Eric Ave., Takoma Park 12</td>
<td></td>
</tr>
<tr>
<td>BERTAN, ELSE T.</td>
<td>3355—16 St., N.W., Apt 512, Washington 11</td>
<td></td>
</tr>
<tr>
<td>BEVERLEY, CLARA E.</td>
<td>Freedmen's Hospital, Washington 25</td>
<td></td>
</tr>
</tbody>
</table>

451
DURY, MARY T.
34 Boyd Ave., Takoma Park, Md.

EARLE, MRS. ELIZABETH C.
5018 N. 27 St., Arlington, Va.

EDLIN, PAULINE
Gallinger Municipal Hospital, Washington 3

FISH, JANET
1624—32 St., N.W., Washington 7

FISHER, MRS. EVELYN J.
Hotel Roosevelt, Washington 9

FLIPPING, JEANETTE M.
1314 Franklin St., N.E., Washington 17

FORBES, MARY D.
244 Anacostia Rd., S.E., Washington 19

FRANKLIN, EVELYN R.
4319 River Rd., N.W., Washington 16

FULTON, MRS. MARY B.
1703 Kenyon St., N.W., Washington 10

GAHAGAN, MARY E.
Office of Indian Affairs, Washington 25

GEISER, JUNE E.
412 W. South St., Frederick, Md.

GIBSON, CLARISSA F.
3146 Patterson St., N.W., Washington 15

GORDNER, LOIS E.
2990 Quebec St., N.W., Apt. 1219, Washington 8

GOURLEY, MRS. MARY M.
Gallinger Municipal Hospital, Washington 3

GRAPETHIN, LOUISE
District Training School, Laurel, Md.

GREEN, NITA E.
Gallinger Municipal Hospital, Washington 3

GRIFFEE, MRS. LEAH M.
Washington Sanitarium & Hospital, Takoma Park 12

GROSSKOPF, HELEN

HALL, LUCILE
3325—23 St., S.E., Washington 20

HARDWICK, JANE
1150 N. Capitol St., Washington 2

HARRIS, MRS. NANCY E.
1617 Holbrook St., N.E., Washington 2

HARTLEY, ALICE
2430 Pennsylvania Ave., N.W., Washington 7

HASSELBUSCH, CHARLOTTE
637 Ingraham St., N.W., Washington 11

HAYDON, EDITH M.
St. Elizabeth Hospital, Washington 20

HEEDERKEN, LORETTA*
School of Nursing Education, Catholic University of America, Washington 17

HEINTZELMAN, RUTH A.
2220—29 St., N.W., Washington 7

HEISLER, ANNA
5412 Harwood Rd., Bethesda 14, Md.

HELLMAN, FRANCES M.
Veterans Administration, Nursing Division, Washington

HINCKER, ETTA A.
1220 Rhode Island Ave., N.E., Washington 2

HOFSTETTER, MARGARET L.
1504 Park Rd., N.W., Washington 10

HOLLEY, LILLIAN M.
38—53 St., S.E., Washington 19

HUBBARD, MARIE M.
1341—29 St., N.W., Washington 7

HURLEY, MRS. EILEEN D.
523 Knollwood Dr., Falls Church, Va.

BILLMEYER, MARY P.
3900 Hamilton St., Apt. K-2, Hyattsville, Md.

BONNER, EILEEN M.

BOWLING, GERTRUDE H.
600 Albee Bldg., Washington 5

BRADY, MARY J.
56 St., Newcomb St., S.E., Washington 20

BRAWNER, MAJ. SELMA M., ANC, N733302
Delano Hall, Walter Reed General Hospital, Washington 12

BREMEN, CATHERINE M.
7701 Georgia Ave., N.W., Washington 12

BRENNER, GENEVIEVE M.
5217 Georgia Ave., N.W., Washington 11

BROWN, MARION
2601 Cathedral Ave., N.W., Washington 8

BURGESS, MARY L.
3601 Connecticut Ave., N.W., Apt. 518, Washington 8

BURNETT, D. LOIS
6840 Eastern Ave., N.W., Washington 12

CADEL, INEZ L.
805 Albee Bldg., Washington 5

CAULFIELD, MRS. MILDRED V.
2121 H St., N.W., Apt. 709, Washington 7

CAWOOD, MARY ALICE
4520 MacArthur Blvd., N.W., Apt. 201, Washington 7

CHAMPION, MRS. ELIZABETH S.
Glenn Dale Sanitarium, Glenn Dale, Md.

CLARK, MARY L.
4319 River Rd., N.W., Washington 16

COLLIER, ELOISE
325 Anacostia Ave., N.E., Washington 19

CORCORAN, MARY E.
National Institute of Mental Health, Bethesda 14, Md.

COREY, MRS. BONNIE W.
3115 P St., N.W., Washington 7

COWAN, M. CORDELIA
229 Eighth St., N.E., Washington 2

CREED, MRS. SYLVIA S.
3358 Martha Custis Dr., Alexandria, Va.

DARVIN, ANNE B.
400 Mellon St., S.E., Washington 20

DAYWITT, JEANNE
2719 Ordway St., N.W., Washington 8

DeBELLA, ISABELLE D.
4105 Wisconsin Ave., N.W., Apt. 301-S, Washington

De BOW, ALICE
1525 Kearney St., N.E., Washington 17

DENKE, ISADORA
Freedman's Hospital, Washington 25

DONOVAN, LT. PENELope W.
U. S. Army Hospital, Camp Breckenridge, Ky.

DORAN, RUTH
1233—17 St., N.W., Washington 9

DOWNROWICZ, ELIZABETH H.
1201—13 St., N.W., Washington 5

DRIVER, RACHEL A.
2601 Quebec St., N.W., Apt. N-641, Washington 8

DUDLEY, MARGARET H.
3310—14 Pl., S.E., Washington 20

DUNN, HELEN W.
3504 Minnesota Ave., S.E., Washington 20

DUNN, MARGARET A.
4008 Quintana St., Hyattsville, Md.
MEMBERS

IREMAN, HAZEL
4709 River Rd., N.W., Washington
JAMES, MRS. EDYTH T.
Dept. of Nursing Education, Washington Missionary College, Takoma Park 12
JARVIS, MRS. JOYCE B.
Georgetown University School of Nursing, Washington 7
JENNEY, MARY O.
1328 Jefferson St., N.W., Washington 11
JOHNSON, MARY E.
Glenn Dale Sanitarium, Glenn Dale, Md.
JONES, MRS. EILEEN G.
5002 Manchester Rd., Silver Spring, Md.
JORGENSEN, GLADYS
American University, Washington 16
JUNG, ELIZABETH C.
921—39 St., N.W., Washington
JUSTISON, GERTRUDE G.
Georgetown University School of Nursing, Washington 7
KAIN, CATHERINE M.*
Institute of Inter-American Affairs, 499 Pennsylvania Ave., N.W., Washington 25
KAY, MRS. HAZEL B.
1413—48 Ave., S.E., Washington 19
KIGER, SYLVIA R.
Gallinger Municipal Hospital, Box 91, Washington 3
KING, ALMEDA
1632 Park Rd., N.W., Apt. 216, Washington 10
KIZEROW, HELEN C.
2641 S. Walter Reed Dr., Alexandria, Va.
KNAPP, MARGARET F.
3000—39 St., N.W., Washington 16
KNAUFF, MRS. KATHERINE M.
5300—14 St., N.W., Apt. 708, Washington 10
KNOX, CECILIA M.
2101 S. Lynn St., Arlington, Va.
LANSHÉ, BARBARA F.
2303 Southern Ave., S.E., Apt. 103, Washington 20
LARSEN, SOPHIA
3628 Albans Ave., S.E., Washington 20
LOVE, LUCILE L.
219 Audrey Lane, S.E., Washington 20
LYDDANE, MARY F.
3034 Beecher St., N.W., Washington 7
MAKIM, MAJ. ANNA L., ANC.
522—20 St., N.W., Apt. 701, Washington 6
MAISON, MAJ. ISABELLE A. C.
Forest Glen Section, Army Medical Center, Washington 12
MAY, CHARLOTTE K.
Freedmen's Hospital, Washington 1
McCOMMONS, LT. COL. DAISY M., ANC
McDONALD, MRS. CATHERINE N.
27—19 St., S.E., Washington 3
MCINTEEER, RACHEL
Gallinger Municipal Hospital, Washington 3
McIVER, PEARL
5412 Harwood Rd., Bethesda 14, Md.
MCKINLEY, ELEANOR G.
St. Elizabeth Hospital, Washington 20
MCLAUGHLIN, L. MARGARET
3130 Wisconsin Ave., N.W., Washington 16
McMILLAN, DOROTHY L.
Alexandria Hospital, Alexandria, Va.
McNEILL, DORA D.
1150 N. Capitol St., N.W., Washington 2

DISTRICT OF COLUMBIA

McTAGGART, MARGARET
2811 Monroe St., N.E., Washington 18
Mears, MRS. FRANCES W.
3140 Wisconsin Ave., N.W., Washington 16
MonaHan, LT. DOROTHY P., NG, USN
Branch of Nursing, Navy Dept., Nurse Corps Office, Washington 25
Morris, Dorothy
St. Elizabeth Hospital, Washington 20
MOSELEY, LILLIAN E.
Freedmen's Hospital, Washington 25
MOYER, ESTHER L.
Gallinger Municipal Hospital, Washington 3
NEFF, MRS. ALICE S.
Station L, Washington 20
ODEGARD, ETTIEL J.
1507 M St., N.W., Rt. 703, Washington 5
OTT, KATHERINE A.
714 S. 18 St., Arlington 2, Va.
PATTON, SHELBY W.
429 McClung St., Huntsville, Ala.
PERKINS, ERLINE W.
1150 N. Capitol St., Washington 2
PETERSON, ROSALIE L.
3600—39 St., N.W., Washington 16
PETRY, LUCILE*
Public Health Service, Washington 25
POE, VIOLET A.
3800 Aberdeen St., S.E., Silver Hill, Md.
POH, MINNIE E.
2700 Wisconsin Ave., N.W., Apt. 703, Washington 7
PRESCOTT, MRS. JOSEPHINE P.
3209 Worthington St., N.W., Washington 15
RAMSEY, CLARA R.
Veterans Administration Hospital, Montrose, N. Y.
RASMUSSEN, ELLEN M.
2650 Wisconsin Ave., N.W., Washington 7
REDDING, LT. COMDR. ANNA E., NNC
1515 Ogden St., N.W., Washington 10
RITTER, BEATRICE E.
Gallinger Municipal Hospital, Washington 3
ROBINSON, IDA C.
325 Anacostia Ave., N.E., Washington 19
ROYER, HAZEL
Children's Hospital, Washington 9
RYON, KATHERINE
6027 Moorland Ln., Bethesda, Md.
SADLER, MRS. PEARLE G.
516 Ninth St., N.E., Apt. 214, Washington 2
Sakato, Suzy S.
2127 P St., N.W., Washington 7
SAMPSON, DOROTHY M.
317 Greenwood Ave., N.W., Takoma Park 12
SEYFFER, CHARLOTTE
5415 Connecticut Ave., N.W., Apt. 101, Washington 15
Shadle, ZELMA
Children's Hospital, Washington 9
Shalit, Pearl
4703 De Russey Pkwy., Chevy Chase 15, Md.
Shanker, HASSA V.
4403—14 St., N.W., Apt. 5, Washington 11
Shaternick, MRS. JUANITA F.
3324 Tenth Pl., S.E., Washington 20
Shortal, Hazel
3000—39 St., N.W., Washington 7
Sister Angela Maria
Georgetown University Hospital, Washington 7

453
SISTER CONSTANTIA CLARK
Providence Hospital, Washington 3

SISTER JOSEPH BEATRICE
Georgetown University Medical Center, Washington 7

SISTER M. OLIVIA
4801 Sargent Rd., N.E., Washington 17

SISTER M. THEOPHILA
Catholic University of America, School of Nursing Education, Washington 17

SISTER MARY VINCENT
Georgetown University Hospital, Washington 7

SMITH, EVELYN S.
626 Rock Creek Church Rd., N.W., Washington 10

SMITH, MRS. MARY R.
3519—13 St., N.W., Washington 10

SMITH, RUBY D.
1711 New York Ave., N.W., Washington 6

SOLOMON, HELEN
3019 Wisconsin Ave., N.W., Apt. 106, Washington 16

STATTS, HELEN A.
2502 Sherrier Pl., N.W., Washington 16

STEWARD, ELIZABETH V.
5705 Reed St., North Englewood, Md.

STOKES, ELIZABETH F.
1650 Harvard St., N.W., Washington 9

STRAUSS, MRS. LUCIE M.
1432 Shepherd St., N.W., Washington 11

SULLIVAN, MARY M.
2816 Hartford St., S.E., Washington 20

SYMONS, MRS. EVELYN R.
2101 Ravenwood Rd., West Hyattsville, Md.

SZYZSYN, LT. CLARA T.
National Naval Medical Center, Bethesda, Md.

TAYLOR, JEAN W.
2501—16 St., N.W., Washington

TEAGUE, STELLA L.
Veterans Administration Hospital, Lake City, Fla.

THOMAS, MARTHA J.

THOMSON, MRS. LOUISE B.
6998 Bradley Blvd., Bethesda 14, Md.

TILLEY, MRS. ALLIENE N.
3435 Carpenter St., S.E., Washington 20

TORRANCE, KATHRINE E.
Gerfield Memorial Hospital, Washington 1

TORRENS, IVA
121 N. Wayne St., Arlington, Va.

TOTTEN, MRS. NELLE S.
4612 N. 37 St., Arlington, Va.

TREASURE, MRS. EDNA H.
2006 T St., S.E., Washington 20

TUCKER, MRS. MINNIE H.
1255 Jackson St., N.E., Washington 17

TURNER, MARY S.
3919 Illinois Ave., N.W., Washington

VREFELAND, ELLYNNE M.*
3130 Wisconsin Ave., N.W., Washington 16

WAAGEN, LOUISE D.
2130 Wisconsin Ave., N.W., Apt. 115, Washington 16

WALKER, ELIZABETH
1910 Luxerne Ave., Silver Spring, Md.

WATKINS, MARION D.
Gallinger Municipal Hospital, Washington 3

WEIDNER, CAPT. RUTH R., USAFR (AFNC)
211 N. Wayne St., Apt. 6, Arlington, Va.

WHITE, EILEEN M.
2707 Webster St., Mt. Rainier, Md.

WILKINSON, MRS. NETTIE W.
1011 Douglas St., N.E., Washington 11

WILLIAMS, EDITH
1527 N. Stafford St., Arlington 7, Va.

WISLER, MARY C.
Georgetown University, School of Nursing, Washington 7

WITTNER, S. KATHRYN
Children's Hospital, Washington 9

WOOD, ANNABELLE R.
3320 Eighth St., N.W., Washington 11

WRIGHT, MRS. ELIZABETH S.
5467—31 St., N.W., Washington 18

YOUNG, HAZEL C.
468 Lebaum St., S.E., Washington 20

YOUNGER, MRS. ELLA J.
Freedman's Hospital, Washington 1

ZELL, ZELLA
1627 P St., N.W., Washington 6

FLORIDA—109

ALBAUGH, VIRGINIA
635 E. Concord, Apt. 8, Orlando

ALEXANDER, IVA M.
University of Florida Infirmary, Gainesville

ANDERSON, MRS. CLARA S.
Florida A. & M. College, Box 228, Tallahassee

BEATZ, ALMA C.
514 S. Alachua St., Lake City

BEHNER, MRS. EDNA J.
Florida Sanitarium & Hospital, Orlando

BINDRIM, ELEANOR L.
2632 Riverside Dr., Jacksonville 4

BOLDT, MRS. MARTHA B.
P.O. Box 1003, Lake City

BRADLEY, MILDRED
Florida Sanitarium & Hospital, Orlando

BRODERICK, FLORENCE
8394 S. Boulevard, Tampa

BURNHAM, MRS. IRENE W.
Alachua County Hospital, Gainesville

CAMPBELL, MRS. TINY A.
Box 3963, Bay Pines

CARMICHAEL, MILDRED C.
900 N.W. 128 St., Miami

CARNegie, MARY E.
Florida A. & M. College, School of Nursing, Tallahassee

CLARK, MAE T.
Florida State Hospital, Chattahoochee

CLARKSON, LYDIA L.
701—15 Ave., St. Petersburg

COOPER, LOUISE E.
220 N. Lakeside Court, Apt. 2, West Palm Beach

CROOMS, MRS. JONNIE M.
Box 455, Chattahoochee

CROWN, MRS. DOROTHY L.
2407 Clemson Rd., Jacksonville 7

DETYENS, MRS. MARY D.
801—63 St., St. Petersburg

454
MEMBERS

BRINKARD, JACQUELINE S.
St. Luke's Hospital, Jacksonville

DUDLEY, ROSEMARY J.
Box 146, Ocean

DUNK, MRS. MILDRED E.
Veterans Administration Hospital, Coral Gables

DUXBURY, VIVIAN M.
State University, Chattahoochee

ELDREDGE, DORA M.
Jackson Memorial Hospital, Miami 36

FLOYD, M. LEE
Florida State University, Tallahassee

FULCHAM, DORA
Florida State University, Chattahoochee

GODFREY, GLADYS G.
St. Luke's Hospital, Jacksonville 8

GULFORD, AVIS F.
St. Luke's Hospital, Jacksonville

GUTWALD, KATHRYN R.
414-47 St., West Palm Beach

HALVORSEN, EDNA M.
P.O. Box 62, Houston, Minn.

HAZEN, ALMA M.
Veterans Administration Hospital, Lake City

HENRY, EMELINE E.
Box 2469, University Station, Gainesville

HILL, ORLEA H.
1531 Pine Grove Ct., S., Jacksonville

HOWEY, ADELE M.
426 Market St., Jacksonville

HOWARD, DOROTHY G.
3451 Randall St., Jacksonville

HOWINGTON, PEARL
Florida Sanitarium & Hospital, Orlando

HUGHES, MARGARET E.
526 Magnolia Ave., Orlando

HUGHES, MILDRED
736 N St., West Palm Beach

INGLIS, MRS. DELCIE C.
230 W. Forsyth, Jacksonville

JADRIEVIC, MRS. ANNETTE D.
1610 E. Yonge St., Pensacola

JOHNSON, MRS. WILMA P.
Florida Sanitarium & Hospital, Orlando

JOHNSON, IDA M.
263 Main St., Kissimmee

JONES, FLORENCE M.
Brewer Hospital, Jacksonville

JONES, MARTHA R.
Veterans Administration Hospital, Coral Gables

KING, JULIA O.
A Balchus County Hospital, Gainesville

LAWRENCE, MRS. HELEN S.
P.O. Box 2269, Hollywood

LEBENSOBAUM, FRIEDA
4000 Alton Rd., Miami Beach

LUVISI, MARY F.
1 Broadcast Pl., Jacksonville 1

LYDON, ALICE P.
5740 N.W. Fifth Court, Miami

MacleAN, TESTA L.
St. Luke's Hospital, Jacksonville

MARLEY, AGNES M.
Tampa Municipal Hospital, Tampa

MATTHEWS, MARY W.
P.O. Box 2941, West Palm Beach

FLORIDA

MEILWREATH, ATHRIA
Brewer Hospital, Jacksonville 4

MCKENZIE, MRS. DOROTHY B.
Veterans Administration Hospital, Bay Pines

MEIKS, MAE
Box 1411, Lantana

METTINGER, RUTH E.
State Board of Health, Box 210, Jacksonville 1

MIHM, META A.
3605 Pinewoood Ave., West Palm Beach

MILLER, BERTHA G.
Veterans Administration Hospital, Coral Gables

MILLS, HETTIE L.
2625 Myrtle Ave., Jacksonville

MURPHY, MERCEDES
1001 Washington St., Tallahassee

MUSTARD, ALICE I.
Jackson Memorial Hospital, Miami 36

NEAL, ELMOR F.
Brower Hospital, Jacksonville

NICHOLS, MARTHA L.
Veterans Administration Hospital, Coral Gables

OLDHAM, MURIEL
2627 Post St., Jacksonville 4

PALMER, IRENE D.
Route 3, Box 503-A, Jacksonville

PARKER, BERTHA F.
Florida Sanitarium & Hospital, Orlando

PARKINSON, VIOLA M.
Veterans Administration Hospital, Lake City

PEEPLES, HAZEL M.
Mound Park Hospital, St. Petersburg

PRICE, E. LOUISE
St. Luke's Hospital, Jacksonville

RAY, ETHEL M.
Veterans Administration Hospital, Lake City

REEP, LUCINA
Riveroide Hospital, Jacksonville

RESHLAKE, MRS. ELIZABETH M.
612—29 St., West Palm Beach

RESAR, ANGELA
Veterans Administration Hospital, Bay Pines

RILEY, MRS. BEATRICE B.
P.O. Box 159, Altamonte Springs

ROBERTS, MARY A.
P.O. Box 598, Lake City

ROBERTSON, STELLA
2951 S.W. 22 Terrace, Miami 34

ROOD, NANCY N.
4351 Bethwood Circle, Jacksonville 5

ROUSSEAU, ELFY F.
420 Jessamine St., West Palm Beach

SALISBURY, AGNES E.
230 Forsyth St. W., Jacksonville

SALTER, MRS. NINA C.
614 Florida Ave., Orlando

SCHWINN, ELEANOR M.
Veterans Administration Hospital, Bay Pines

SHEARSTON, HELEN E.
315 Calumet Bldg., Miami

SIMMONS, INEZ T.
Florida State Hospital, Chattahoochee

SISTER ANNE VERONICA
St. Francis Hospital, Miami Beach 41

SISTER DOROTHY MARIE
St. Mary's Hospital, West Palm Beach

455
SISTER IRENE
St. Vincent's Hospital, Jacksonville

SISTER JOSEPHINE MARIE
909—19 St., West Palm Beach

SISTER MARIE FRANCINE
St. Francis Hospital, Miami Beach 41

SISTER MARY CLARE
St. Vincent's Hospital, Jacksonville 4

SISTER M. MAGDALENA
St. Francis Hospital, Miami Beach 41

SKIDMORE, MRS. EULA O.
2324 Riverside Ave., Jacksonville 5

SLOAN, TIMOXENA
1268 N.W. 29 St., Miami

SPENCER, LUCY W.
624 N.W. 81 St., Miami 38

STAFFORD, EURADEAN
414—47 St., West Palm Beach

STOLBRAND, MRS. ANNE H.
Duval Medical Center, Jacksonville 8

SUMMERS, FAY G.
4231 First Ave., N., St. Petersburg 6

TARRANT, BETTY JANE
Good Samaritan Hospital, West Palm Beach

GEORGIA—233

ADAMS, MRS. JANE G.
313 W. Glessner St., Americus

ADDIScott, MRS. ANNE C.
Veterans Administration Hospital, Augusta

AKIN, KATHARINE
Box 511, Rome

ALBERGOTTI, MADIE V.
3020 Cardinal Dr., Augusta

ALLISON, GERTRUDE L.
Veterans Administration Hospital, Chambless

ARMSTRONG, KATHRYN
2230 McDowell St., Augusta

ARMSTRONG, MARGARET P.
107 N. Church St., East Point

ARTHUR, LUCY R.
3096 Cardinal Dr., Augusta

ATKINSON, LUCILE
Harbin Hospital, Rome

BABIN, RUTH A.
Piedmont Hospital, Atlanta

BAKER, AUDREY A.
Veterans Administration Hospital, Chambless

BANKE, MRS. FRANCES M.
286 Boulevard, N.E., Atlanta

BAYNES, MRS. Linnie L.
2279 Powell Lane Apt., Decatur

BECK, MRS. ALICE P.
Wheeler Rd., Augusta

BERGLUND, MRS. ELOISE
2352 Forster Ave., Augusta

BINNS, MARY FLUKER
726 Hickman Rd., Augusta

BISCHOFF, LILLIAN M.
Smyrna

BISTLINE, MARY C.
St. Joseph's Infirmary, Atlanta

BLACKISTON, MRS. ELIZABETH M.
Route 2, Hepzibah

BLAKELEY, MRS. MARJORIE
Warren A. Candler Hospital, Savannah

BLANCHARD, CLARE L.
78 Ellis St., N.E., Atlanta

BONNER, MRS. MYRA
State Hospital, Milledgeville

BRANDTNER, HILDA A.
5996 Peachtree Rd., Atlanta

BRANYON, PENASCOLA
University Hospital, Augusta 4

BRYAN, JACQUELINE H.
2007 Central Ave., Augusta

BUFFINGTON, MRS. DOROTHY D.
R.F.D. 2, Marietta

BURKE, MARGARET M.
1045 Oxford Rd., N.E., Atlanta

BYERS, KATHRYN C.
Lincolnton

BYRD, MRS. HASSIE
2223 Central Ave., Augusta

CADLE, MRS. ADELE J.
Veterans Administration Hospital, Augusta

CADWALLADER, MARIAN F.
262 Williams Mill Rd., N.E., Atlanta

CALLAHAN, FLORENCE H.
USFHS, Region VI, 50 Seventh St., Atlanta

CAPEIRS, MRS. EMILY S.
1610 Walton Way, Augusta

CARR, MRS. JANIE T.
1827 Maryland Ave., Augusta

CARTER, MRS. BEULAH R.
1723 King Wood Dr., Augusta

CASHIN, MRS. SARAH M.
1301 Highland Ave., Augusta

CHASTAIN, MRS. LUCIA A.
P.O. Box 1181, Augusta

CHRISTOPHER, MARION
1455 Fairview Rd., N.E., Atlanta

COCKE, MARTHA
Happy Hollow Rd., Doraville

COLLINS, VIRGINIA E.
1616 Pendleton Rd., Augusta
MEMBERS

CILMORE, M. KATE
R.F.D. 6, Milledgeville
GRANT, E. ELOISE
University of Georgia, Dept. of Nursing Education, Athens
GREEN, MARTHA C.
Powderville
GRISCOM, DOROTHY L.
Crawford W. Long Hospital, Atlanta
GULLEDGE, SELITA A.
1813 Ohio Ave., Augusta
HALL, JESSIE
University Hospital, Augusta
HAMBIC, CHRISTINE
1206 Emory Dr., N.E., Atlanta
HAMMETT, MARGARET
Veterans Administration Hospital, Dublin
HAMMOND, MRS. AVIS D.
973 Cunningham Pl., N.W., Atlanta
HAMrick, MRS. MABEL W.
1791 Piedmont Rd., N.E., Atlanta
HANSON, MRS. DURICE D.
4672 E. Conway Rd., N.W., Atlanta
HARGROVE, JUNE B.
University Hospital, Augusta
HARRISON, LT. RUBY H., ANC
97th General Hospital, APO 757, c/o Postmaster, New York, N. Y.
HART, DOROTHY E.
St. Joseph's Infirmary, Atlanta
HARTLEY, MRS. BERNICE B.
1915 Crepe Myrtle Dr., Augusta
HEARN, MRS. SYLVIA P.
University Hospital, Augusta
HENLEY, RUTH N.
2030 N. Decatur Rd., N.E., Atlanta
HOFFMAN, MRS. BLISS P.
Skinner Rd., Augusta
HOGAN, MARY V.
St. Joseph's Infirmary, Atlanta
HOLLAND, MRS. LESSIE W.
2020 Ohio Ave., Augusta
HOOD, MRS. ELIZABETH C.
Batter State Hospital, Rome
HOLWES, M. DOLORES
1359 Clarmont Circle, Apt. 4, Decatur
HUDSON, DANA
Georgia Baptist Hospital, Atlanta
JACKSON, MRS. DOROTHEA
110 Ponce De Leon Ct., Decatur
JENKINS, ANNICE A.
2439 Wrightsboro Rd., Augusta
JENKINS, MRS. ETHEL C.
2506 Lyndale St., Augusta
JOHNSON, LEILA J.
Veterans Administration Hospital, Chamblee
JOHNSON, VIRGINIA W.
2526 Milledgeville Rd., Augusta
JOHNSON, DOROTHY F.
Grady Memorial Hospital, Atlanta
JONES, MRS. MAE M.
321 W. Montgomery St., Milledgeville
JONES, MARIE
Emory University Hospital, Emory University
JORDAN, MARGARET H.
1825 Walton Way, Augusta
KEMP, MRS. E. LUCILLE
1317 Johns Rd., Augusta
KENDALL, IDA S.
106 Pine Grove Ave., N., Augusta

KEY, MRS. ADELE R.
1025 Eustis Dr., Augusta

KILGORE, MRS. ALICE P.
1222 Emory Dr., N.E., Atlanta

KING, MRS. BERNICE H.
Milledgeville State Hospital, Milledgeville

KING, DORIS J.
1206 Emory Dr., N.E., Atlanta

KIRBY, VIRGINIA E.
Crawford W. Long Hospital, Atlanta

KORSELL, MABEL
Columbus City Hospital, Columbus

LAMBIE, JEANIE S.
Crawford W. Long Hospital, Atlanta

LANDRETH, MRS. EVELYN
Cameron, Wis.

LANDRUM, EMMA
325 E. Paces Ferry Rd., Apt. 5, Atlanta

LAWSON, MRS. MARTHA K.
1067 Eustis Dr., Augusta

LEE, EUGENIA
2549 N. Decatur Rd., N.E., Atlanta

LINTON, ELISIE
993 Cordova Dr., N.E., Atlanta

LITTLEJOHN, MRS. MYRTLE W.
Moody Hospital, Dothan

LOTT, MRS. MERLE K.
160 Pryor St., Room 510, Atlanta

LUTES, MRS. IVY V.
941 Meliga St., Augusta

MAHONE, CLADYS
Emory University Hospital, Emory University

MALECKA, ANNA B.
33-41 St., N.E., Atlanta

MARSH, MRS. IRA
Veterans Administration Hospital, Dublin

MASSEY, MARIORIE E.†
1065 Clifton Rd., N.E., Atlanta

McALISTER, MRS. LILLIAN B.
Columbia Theological Seminary, Decatur

McBINDER, MRS. BERTIE S.
2421 Central Ave., Augusta

McCoy, MRS. AGNES
1512 Johns Rd., Augusta

MCRAE, ALMA
State Hospital, Milledgeville

McDANIEL, GEORGIA E.
2350 Williams St., Augusta

MEYER, AMELIA E.
3526 Tushan St., Augusta

McGovern, Patricia
15 Exeter Rd., Avondale Estates

MCEE, LYDIA
875 W. Peachtree St., Atlanta

MCEEE, MRS. Vinnie M.
2323 Northview Ave., Augusta

MCKIE, EDNA E.
Georgia Baptist Hospital, Atlanta

MLEOD, GERTRUDE
Veterans Administration Hospital, Augusta

MCNAB, ELIZABETH A.
University Hospital, Augusta 4

MCNAB, MRS. MARGARET F.
1165 Briarcliff Rd., Macon

MELODY, MRS. MARY M.
Veterans Administration Hospital, Chamblee

METCALF, ELIZABETH F.
2056 Ridgedale Rd., N.E., Atlanta

MILLS, ELIZABETH H.
1473 Rock Springs Circle, N.E., Apt. 3, Atlanta

MONNERAT, MRS. GEORGIA, JR.

MOOG, MRS. ETHEL P.
2207 Breckenridge Ave., Augusta

MORGAN, HELEN
University Hospital, Augusta 4

MULLIS, JOYCE L.
Piedmont Hospital, Atlanta

MURPHY, EVELYN
Roswell

MURPHY, JOSEPHINE M.
456 Telfair St., Augusta

NEFF, S. PEARL
Veterans Administration Hospital, Lake City, Fla.

NELSON, LILLIAN O.
1460 Cameron Ct., N.E., Atlanta

O'CONNOR, MRS. ERIN B.
1504 Myrtle Ln., Augusta

O'CONNOR, MYRTLE B.
2319 Central Ave., Augusta

O'GETTREE, LT. CLYDE, ANC
7th General Hospital, APO 737, c/o Postmaster.
New York, N. Y.

OVERTON, ANNNIE L.
Rm. 214, State Capitol, Atlanta

PARRISH, GERALDINE
Veterans Administration Hospital, Louisville, Ky.

PARRISH, JOYCE
3910 Pine Needle Rd., Augusta

PATTERSON, MRS. HAZEL R.
Veterans Administration Hospital, Dublin 2

PATTERSON, MARY F.
Happy Hollow Rd., Doraville

PEARCE, MRS. RUTH A.
1509 Heath St., Augusta

PENNINGTON, MRS. ISABELLE R.
39 Poplar St., Augusta

PHILLIPS, MRS. DOROTHY Z.
Mills 900 Dean Bridge Rd., Augusta

PIERCE, LOUISE E.
Veterans Administration Hospital, Reno, Nevada

PLATTS, MRS. ESTHER K.
1705 King Wood Dr., Augusta

POLLAK, CYRIL D.
Myrtle Court, Apt. 242, Augusta

POWELL, SADIE M.
University Hospital, Augusta 4

PRESCOTT, L. EVELYN
2400 Williams Ln., Decatur

PRESNELL, LILLIAN
John D. Archbold Hospital, Thomasville

PRISE, MRS. MILDRED
63-41 Ave., N.E., Atlanta

REITER, MARY
State Dept. of Health, 12 Capitol Sq., Atlanta

REVILLE, BONNIE E.
1620 Greene St., Augusta

REYNOLDS, MRS. AGNES L.
517 Anthony Rd., Augusta

RICHERT, MARGUERITE L.
Veterans Administration Hospital, Chamblee

RIVERS, MRS. SALLY M.
University Hospital, Augusta 4

ROGERS, MRS. DOROTHY A.
186 Clifty Pl., Macon

458
MEMBERS

SALE, NANCY E.
Emory University Hospital, Emory University

SANCHEZ, FRANCES
12 Capitol Sq., Atlanta

SANDERS, MAY
1026 Stillwood Dr., N.E., Atlanta

SETZER, MRS. LOUISE L.
247 Howell Dr., S.W., Atlanta

SHEAHAN, ELOISE J.
925 Holden St., Augusta

SIBLEY, MRS. ELOISE N.
1540 Heady St., Augusta

SIMMONS, NELLIE A.
Grady Hospital, Atlanta

SISTER M. ALBERT
St. Joseph’s Hospital, Savannah

SISTER MARY BONAVENTURE
St. Joseph’s Infirmary, Atlanta 3

SISTER MARY BRIAN
St. Joseph’s Infirmary, Atlanta 3

SISTER MARY BRIDE
St. Joseph’s Hospital, Savannah

SISTER M. CAMILLUS
St. Joseph’s Infirmary, Atlanta 3

SISTER MARY CORNILE
St. Joseph’s Infirmary, Atlanta 3

SISTER MARY INCARNATA
St. Joseph’s Hospital, Savannah

SISTER MARY JOSETTA
St. Joseph’s Infirmary, Atlanta

SISTER M. KRISTEN
St. Joseph’s Infirmary, Atlanta 3

SISTER M. LAURENTINE
St. Francis Hospital, Columbus

SISTER M. MELANIE
St. Joseph’s Infirmary, Atlanta 3

SISTER MARY MILDRED
St. Joseph’s Hospital, Savannah

SISTER MARY REDEMPTA
St. Joseph’s Infirmary, Atlanta 3

SISTER M. ROSE
St. Joseph’s Infirmary, Atlanta 3

SISTER M. THECLA
St. Joseph’s Hospital, Savannah

SISTER MAUREEN
St. Joseph’s Hospital, Savannah

SMITH, HELEN M.
625 Upton Rd., N.W., Atlanta

SMITH, MRS. MARTHA C.
Warren A. Chandler Hospital, Savannah

SMITH, VIVIAN L.
Piedmont Hospital, Atlanta

SOMMERMEYER, LUCILLE M.
5040 Blair Circle Apt., Chamblee

SPAHR, MRS. ELEANOR P.
13-D Savannah Terrace Apts., North Augusta, S. C.

STABLING, MERLE
1509–20 Ave., Phenix City, Ala.

STEED, MARGARET I.
1438 Harper St., Augusta

STRIPLING, CHARLEEN G.
907 Sunnydale Dr., Macon

STUNKARD, MRS. ANITA M.
1525 Farrall Court, Apt. 2, Decatur

STURMAN, MRS. LAURA B.
2109 Roosevelt Dr., Augusta

SWAN, MRS. BESSIE F.
State Health Dept., 12 Capitol Sq., Atlanta

TAYLOR, MARY L.
Harris Hall, Emory University

THOMPSON, DOROTHEA
2246 Garley Dr., Columbus

THOMPSON, MARGARET E.
1365 N. Highland Ave., N.E., Atlanta

TURNER, FAY
1020 Greene St., Augusta

VAN DeVREDE, JANE
R.F.D. 1, Smyrna

VANFATTEN, MRS. HELEN E.
Columbus City Hospital, Columbus

WALDRUP, HELEN
Emory University Hospital, Emory University

WARD, MARY F.
20 Ivy St., S.E., Atlanta

WATERS, MRS. JUDITH S.
2125 Cunningham Rd., Augusta

WATSON, MRS. DEAUN R.
2129 Shirley Ave., Augusta

WEATHERS, MRS. ISABELLE C.
726 Hickman Rd., Augusta

WEBB, MRS. MAMIE E.
347 Eighth St., N.E., Atlanta

WELLINGTON, ELIZABETH
849 St. Charles Ave., N.E., Atlanta

WELLS, CHARITY I.
2232 N. Decatur Rd., N.E., Decatur

WEST, JEANNE M.
2235 Woodbine Rd., Augusta

WILLIAMS, VIOLET
748 Elkmont Dr., N.E., Atlanta

WILSON, MRS. THELMA G.
1546 Craig St., Augusta

WINDHAM, VIRGINIA
Crawford W. Long Memorial Hospital, Atlanta

WOODVILLE, LUCILLE
Children’s Bureau, 10 Forsyth Bldg., Atlanta 3

WOOTEN, MRS. NANCY C.
460 H. V. Lee Rd., College Park

WRAY, MAE
Veterans Administration Hospital, Augusta

YOUNG, MYRTIS
1203 Monte Sano Ave., Augusta

YOUNGBLOOD, MRS. GERTRUDE H.
Hardwick

ZIMMERMAN, LUCILE
1193 Clerburn Ave., N.E., Atlanta

TERRITORY OF HAWAII—36

ASATO, MILDRED S.
1944 Keousumoku St., Honolulu

BENSEN, O. DOROTHY*
Territorial Hospital, Kaneoke, Hieia

CAMARA, MRS. ANNE C.
1541-A Wilhelmina Rise, Honolulu

CARLUCCI, ANGELA M.
362-A Seaside Ave., Honolulu

CARPENTER, MYRA L.
2139 Kuhio Ave., Honolulu

CHANG, MRS. ROSIE K.
2032 Alihihani Pl., Honolulu

439
CROMWELL, DR. J. O.*J
500 S. Shilling, Blackfoot

GOSSELIN, VALETA L.
565 E. 20, Idaho Falls

GRINDROD, BARBARA D.
426 W. 16, Idaho Falls

HARRISON, MRS. ESTHER G.
616 Fern St., Nampa

LITZINGER, MRS. BLANCHE E.
Caldwell Memorial Hospital, Caldwell

MEIER, MRS. EMMA A.
2816 Colorado St., Boise

MOGER, RUTH S.
2015 N. 31 St., Boise

RAETHER, ELLEN L.
Idaho State College, Pocatello

MALLEN, MARGARET P.
2233 Manukai St., Honolulu

MARTELON, PATIENCE C.
649 Pekole St., Honolulu 25

MIYAMOTO, MRS. LEILA
2895 Booth Rd., Honolulu

NORMAN, MABELCLAIRE
1609 Ala Wai Blvd., Apt. K, Honolulu

REPETTI, ANGELINA
349 Kealani St., Lanikai, Oahu

RICHARDS, HANNAH
162-A Panakalani St., Honolulu 30

SCHULER, LORETTA T.
3637 Sierra Dr., Honolulu

SISTER FRANCES CABRINI
St. Francis Hospital, Honolulu 17

SISTER MARIE THERESE
St. Francis Hospital, Honolulu 13

SISTER MARY ALBERT
St. Francis Hospital, Honolulu 3

SISTER MARY LAURINE
St. Francis Hospital, Honolulu 3

TEALL, DOROTHY G.
1547 Ala Wai Blvd., Honolulu

THOMPSON, MRS. ARLENE N.
1032-A Ilma Dr., Honolulu 29

TRAINOVICH, SARA J.
233-3 D Ala Wai Blvd., Honolulu

YANO, AIKO
1218 Wilhelmina Rise, Honolulu

CROMWELL, DR. J. O.*J
500 S. Shilling, Blackfoot

GOSSELIN, VALETA L.
565 E. 20, Idaho Falls

GRINDROD, BARBARA D.
426 W. 16, Idaho Falls

HARRISON, MRS. ESTHER G.
616 Fern St., Nampa

LITZINGER, MRS. BLANCHE E.
Caldwell Memorial Hospital, Caldwell

MEIER, MRS. EMMA A.
2816 Colorado St., Boise

MOGER, RUTH S.
2015 N. 31 St., Boise

RAETHER, ELLEN L.
Idaho State College, Pocatello

SISTER MARY CHRISTINA
Mercy Hospital, Nampa

SISTER MARY HERBERT
St. Anthony Mercy Hospital, Pocatello

SISTER MAUREEN
St. Anthony Mercy Hospital, Pocatello

VASSAR, MRS. FRANCES T.
1201 N. Fifth St., Boise

WESCHE, MRS. MABEL A.
123 Holly, Nampa

WHIPPLE, FLORENCE VAN D.
1815 Helen St., Boise

WISE, FRANCES L.
Samaritan Hospital, Nampa

ABDERHOLDEN, DOLORES R.
1439 S. Keller, Chicago

ABLE, LELA T.
3121 W. 60 St., Chicago 29

ABRAHAMSON, JENNIE J.
5825 Newport Ave., Chicago 34

ABRAMS, SARA M.
6037 S. Pauline St., Chicago 20

ACKERMANN, VIRGINIA
1090 Quincy Spring St., Quincy

AHERN, EDNA C.
6104 Woodlawn Ave., Chicago 37

ALLEN, MRS. ALICE B.
6820 Oglesby Ave., Chicago 49

ARNESS, HARRY S.
1538 W. 21 St., Chicago 12

ASHAM, CLAIRE R.
3626 W. 29 St., Chicago 24

ASSAF, ANNA E.
1525 N. 24 St., Chicago 14

ASHLEY, MRS. MARY E.
1802 N. 42 St., Chicago 44

ASHRIDGE, RAELLE
1331 W. 38 St., Chicago 35

ASH, MARIE E.
330 W. 27 St., Chicago 24

ASSAF, RAYMOND J.
3626 W. 29 St., Chicago 24

ASSAF, SAMUEL
1525 N. 24 St., Chicago 14

ASHWOOD, WALTER N.
3117 W. 21 St., Chicago 12

ASHTON, ELEANOR B.
3121 W. 13 St., Chicago 29

ASHWOOD, WALTER N.
3117 W. 21 St., Chicago 12

SISTER MARY CHRISTINA
Mercy Hospital, Nampa

SISTER MARY HERBERT
St. Anthony Mercy Hospital, Pocatello

SISTER MAUREEN
St. Anthony Mercy Hospital, Pocatello

VASSAR, MRS. FRANCES T.
1201 N. Fifth St., Boise

WESCHE, MRS. MABEL A.
123 Holly, Nampa

WHIPPLE, FLORENCE VAN D.
1815 Helen St., Boise

WISE, FRANCES L.
Samaritan Hospital, Nampa

ABDERHOLDEN, DOLORES R.
1439 S. Keller, Chicago

ABLE, LELA T.
3121 W. 60 St., Chicago 29

ABRAHAMSON, JENNIE J.
5825 Newport Ave., Chicago 34

ABRAMS, SARA M.
6037 S. Pauline St., Chicago 20

ACKERMANN, VIRGINIA
1090 Quincy Spring St., Quincy

AHERN, EDNA C.
6104 Woodlawn Ave., Chicago 37

ALLEN, MRS. ALICE B.
6820 Oglesby Ave., Chicago 49

ALLEN, ELEANOR M.
1201 S. Main St., Jacksonville

ALLEN, IRMA M.
334 S. Trumbull, Chicago 24

ALSTON, BEATRICE F.
5022 Vincennes Ave., Chicago 15

AMESBURY, CONSTANCE V.
1500 Indiana Ave., Chicago 5

ANSTEIN, CAROLYN
955 W. 57 St., Chicago 25

ANDERSON, ANNE C.
Blessing Hospital School of Nursing, Quincy

ANDERSON, MABEL M.
Lutheran Hospital, Moline

460
ANDERSON, MRS. MARY
524 Clark St., Elgin
ANDERSON, MARY
St. Mary's Hospital, Quincy
ANDERSON, MARY H.
6229 Fullerton Plwy., Chicago 14
ANGLUM, ESIE
2519 Sherman, Evanston
ANLIKER, ELISE M.*
1222 N. La Salle St., Chicago 10
ANLIKER, MARY E.
530 Arlington Pl., Chicago 14
ANSENERBERGER, GLADYS
Box 12, Wood Dale
ANTE, MARIE C.
1500 Indiana Ave., Chicago 5
ARGY, LINDA
2816 S. Ellis Ave., Chicago 16
ARNOLD, MRS. FLORENC P.
2734 W. 15 St., Chicago 8
ARNOLD, MARGARET
812 N. Logan St., Danville
ARNOLD, PEARL I.
Veterans Administration Hospital, Downey
ARTHUR, ELIZABETH A.
240 E. Delaware Pl., Chicago 11
ASCHILMAN, ADELINE
403 E. First St., Dixon
ASH, MILDRED A.
5421 S. Morgan, Chicago 9
AVELLAR, ELIZA C.
6104 Woodlawn Ave., Apt. 307, Chicago 37
BABCOCK, MRS. RUTH V.†
5553 Kenwood Ave., Chicago 37
BAINES, LT. (jg) LILLIAN, NC, USNR, 451690
USS Haven (T-AH-12) FPO, San Francisco, Calif.
BAKKEN, OLGA J.
2416 Ellis Ave., Chicago 16
BARKER, CHARLOTTE
861 S. Fifth St., Lincoln
BARRA, ROSALIE A.
R.F.D. 3, Peoria 7
BAST, IONA
824 W. 62 St., Chicago 21
BASTIS, GERTRUDE
Veterans Administration Hospital, P.O. Box 2432,
Hines
BATT, MRS. ANNE S.
4122 N. Keeler Ave., Chicago 41
BAUER, SOPHIE A.
210 S. Ashland Blvd., Chicago 7
BAUMANN, MAGDALEN A.
138 E. Armstrong, Peoria
BECKMAN, NORMA C.
Box 2617, Veterans Administration Hospital, Hines
BELL, MRS. BEULAH
1210 Henrietta St., Pekin
BELL, ESTHER
1900 W. Polk St., Chicago 12
BELLY, MRS. MARGARET M.†
174 E. Chestnut, Chicago 11
BELLAM, GWENDALINE
700 W. Fullerton, Chicago 14
BENDER, EDITH D.
208 Pleasant Pl., West De Pere, Wis.
BERNOUDY, MRS. TERESA H.
2738 E. 76 St., Chicago
BIDDINGER, MRS. LUANITA
1904 Lincoln Ave., Apt. 502, Chicago 14
BIGHER, ROSE
6400 Irving Park Blvd., Chicago 34
BIRKET, HELEN B.
619 W. Armstrong, Peoria 5
BISHOP, MRS. LEONA P.
4th Div., Fort Benning, Ga.
BLAGEN, HELEN L.
1910 Lincoln Ave., Chicago 14
BLAKE, FLORENCE G.
6104 S. Woodlawn Ave., Chicago 37
BLOMQUIST, MIRIAM M.
6104 S. Woodlawn Ave., Chicago 37
BOCHAT, PHYLLIS
2220 N. Larned Ave., Chicago 30
BOCKMAN, FLORENCE M.
Marceno
BOGARDUS, MARY L.
6020 Drexel Ave., Chicago 37
BOICE, MARGARET R.
282 Fulton St., Elkhart, Ind.
BOLTE, IRMA M.
1450 Broadway, Quincy
BOSTON, OSRA M.
404 S. Third St., Champaign
BOULTON, MRS. SADIE W.
1326 E. 57 St., Chicago 37
BOWER, MARIAN B.
2420 N. Kedzie Blvd., Chicago 47
BOWERS, JANE
1335 Oak St., Danville
BOYD, EMILY A.
240 E. Delaware Pl., Chicago 11
BRANDING, MRS. JEAN T.
6531 S. Kimbark, Chicago
BRANDT, JOSEPHINE A.
1323½-17 Ave., Moline
BRANDT, MRS. LOUISE M.
1522 S. Michigan Ave., Chicago 5
BRANDT, SENA H.
201 E. Delaware Pl., Chicago 11
BRASSEUR, ANNE
Veterans Administration Hospital, Downey
BREWNER, FRANCES N.
R.F.D. 2, Elmhurst
BRINK, LT. (jg) ANNA R., NC, USNR
Nurses Quarters, U. S. Naval Hospital, Great Lakes
BROADWELL, MRS. LUCILE S.
6108 Normal Ave., Chicago
BROOK, CLARE E.
Decatur & Macou County Hospital, Decatur 10
BROOKS, MARGUERITE N.
Moline Public Hospital, Moline
BROWN, MRS. EVELYN M.
926 Lake Shore Dr., Chicago 11
BRUCK, HELEN O.
531 Fullerton Pkwy., Chicago 14
BRUNNER, WILLIAM C.
2545 W. Catalpa Ave., Chicago 25
BUESCHER, MARGARET A.
514 S. Maple Ave., Oak Park
BULMAN, MARY M.
1100 N. LaSalle St., Chicago 10
BURCHARDI, MARY A.
5451 S. Cornell Ave., Chicago
BURDON, SARAH E.
1430 W. George, Chicago 13
BURNS, MRS. RUTH B.
Mossville
BUTZERIN, EULA B.
American Red Cross Nursing Service, National Headquarters, Washington 13, D. C.

CAMPBELL, BRIDGET M.
7636 Clyde Ave., Chicago 49

CAMPBELL, MAURINE M.
1611 N. Union St., Decatur

CARDEW, EMILY
Rm. 550, Navy Pier, Chicago 11

CARLSON, ESTHER M.
5145 N. California Ave., Chicago 25

CARRINGTON, MARGARET
7225 Phillips Ave., Chicago 49

CARROLL, RUTH M.
1819 W. Polk St., Chicago 12

CARSON, MAUDE B.
339 MacArthur Blvd., Springfield

CASWELL, NANCY L.
924 Hamilton Blvd., Peoria 5

CATRON, FERN
Veterans Administration Hospital, Box 2691, Hines

CAUVINS, ELLEN M.
5503 W. Huron St., Chicago 44

CAVANAUGH, HILARY M.
1417 Addison St., Chicago

CAVANAUGH, MARY H.
1406 W. Park, Urbana

CHAMBERS, EDITH A.
201 E. Delaware Pl., Chicago 11

CHAPMAN, L. BERNICE
201 E. Delaware Pl., Chicago 11

CHARLES, EUNICE G.
2816 Ellis Ave., Chicago 16

CHECWIN, PATRICIA A.
201 E. Delaware Pl., Chicago 11

CHURCH, ELLEN E.
1414 E. 59 St., Chicago 37

CLINE, MRS. THELMA S.
811 S. Euclid Ave., Oak Park

COFFIN, JEAN A.
1500 Indiana Ave., Chicago

COMPTON, MARION E.
904 W. Green St., Urbana

COMSTOCK, ANN
2816 Ellis Ave., Chicago 16

CORCORAN, JOSEPHINE
5720 W. Ohio St., Chicago 44

CORCORAN, MARION
6316 Harper Ave., Chicago 37

CORDEY, LORENE E.
201 E. Delaware Pl., Chicago

COUPE, DORIS
3813 Washington Blvd., Chicago 24

COWAN, FRANCES P.
Allerton Hotel, 701 N. Michigan, Chicago 11

COX, MRS. GEORGIA P.
Veterans Administration Hospital, Downey

CRAWFORD, JANE H.
501 Surf St., Apt. 4 B, Chicago 44

CROUCH, PEARL L.
1668 W. Ogden Ave., Chicago 12

CUBELL, SUSAN B.
309 N. Masterson St., Virden

CURTIS, MRS. LAURA W.
Peoria State Hospital, Peoria

CUSHMAN, LOIS M.
19 Harrison, Oak Park

DAGWELL, M. CLAIRE
1900 W. Polk St., Chicago 12

DALLMAN, ELEANOR B.
4737 N. Hermitage Ave., Chicago 40

DALTON, RUTH Y.
109 S. State St., Danville

DAMA, MRS. ALICE J.
6017 Harvard Ave., Chicago 20

DARMS, FLORENCE D.
1900 W. Polk St., Chicago 12

DAUPHIN, HILDA P.
Box 2637, Hines

DAVIES, MRS. ETHEL M.
1019 Morton Ave., Elgin

DAVIS, CORALYNN A.
5949 W. Circle Ave., Chicago 31

DAVIS, LELIXTH W.
1616 W. Adams St., Chicago 12

DAY, A. CARYL
6615 5. Main St., Canton

DECYK, MRS. TILLIE K.
829 N. Oakley Blvd., Chicago 22

DEL VECCHIO, ANGELA J.
2645 Girard Ave., Evanston

DENNING, CATHERINE E.
14 W. Elm St., Apt. 994, Chicago 10

DeBOSA, EMANUELA C.
1515 N. Sheffield, Chicago

DEVER, ELLEN E.
1900 W. Polk St., Chicago 12

DEVLIN, MARGARET J.
700 W. Fullerton Ave., Chicago 14

DICK, KATHERINE R.
Decatur & Macon County Hospital, Decatur 10

DIDERICH, ESTHER O.
839 Devereux Pkwy., Chicago 14

DIETZ, MRS. LENA D.
Passavant Memorial Hospital, Jacksonville

DILLER, CAROL B.
513 Hopey Ave., Normal

DILLON, MILDRED M.
837 E. 61 St., Chicago 14

DIRKSEN, MARIE R.
Springfield Memorial Hospital, Springfield

DOBBS, MARY E.
1306 W. Governor, Springfield

DORCYCHLOP, SOPHIA J.
1857 W. Armitage Ave., Chicago 22

DOFFERT, MAUD
411 W. Dickens Ave., Chicago 14

DOLL, MRS. HILDEGARDE S.
5418 Woolworth Ave., Chicago

DONALDSON, MRS. IRENE
522 N. Academy, Galesburg

DONOVAN, MRS. SARAH B.
705 North St., Peoria 5

DORWARD, MRS. HELEN B.
3332 Brooklyn Ave., Detroit 2, Mich.

DOVEY, MRS. EDITH N.
1900 W. Polk St., Chicago 12

DRAEGERT, LUCY C.
Victory Knoll Farm, R.F.D. 1, Oreana

DUFFY, HILDA
Shabbona

DUNBAR, ROXA K.
162 W. Ash St., Normal

DUNLAP, MRS. ELLA M.
2020 W. Washington, Waukegan

DUNLAP, MARY M.
5748 Stony Island Ave., Chicago 37
MEMBERS

Dwyer, Alice M.
1231 Lodale Ave., Springfield

Dwyer, Mrs. Margaret
824 S. 14 Ave., Maywood

Dykstra, Mrs. Mabel B.
Washington

Edgeworth, Mrs. Dorotha R.
8549 S. Taroop St., Chicago 29

Eliasson, Jean I.
2816 S. Ellis Ave., Chicago 16

Ellingson, Bertha L.
506 S. Matthews, Apt. 7, Urbana

Emert, Barbara A.
Galesburg State Research Hospital, Galesburg

English, Alvyce
Tomah, Wis.

Erickson, Mrs. Clara B.
4312 N. Greenview Ave., Chicago 13

Erickson, Eva H.
Galesburg Cottage Hospital, Galesburg

Erickson, Evelyn Y.
909—12 Ave., Moline

Ernsdorff, Mary A.
1900 W. Polk St., Chicago 12

Eschbach, Alberta
St. Mary's Hospital, LaSalle

Estes, Frances D.
5010 N. Austin Ave., Chicago

Ettten, Marion
7921 Ingleside Ave., Chicago 19

Falconer, Margaret A.
Veterans Administration Hospital, Bldg. 46, Downey

Fetty, Dorothy
201 E. Delaware Pl., Chicago 11

Field, Fay E.
830 86th S. 13 St., Springfield

Finette, Mrs. Florence D.
356 Lakeview Blvd., Aurora

Fisch, Thelma E.
Veterans Administration Hospital, Danville

 Fitzpatrick, Mary M.
Moline Public Hospital, Moline

Fjostad, Henrietta
1128 N. Leavitt St., Chicago 22

Flessner, Marjorie H.
2028 N. Lamon Ave., Chicago 37

Fletcher, Marcella E.
1201 S. Main St., Jacksonville

Flinn, Ruth E.
1904 W. Congress St., Chicago 12

Flucum, Elphia
1618 W. Adams St., Chicago 12

Flynn, Patricia J.
1940 Lincoln, Chicago 14

Foltz, Dorothy
719 S. Ashland Ave., Chicago 7

Foresman, Mrs. Velma N.
1900 W. Polk St., Chicago 12

 Fowler, Grace R.
121 Westminster, Jacksonville

Frey, Mary
Methodist Hospital of Central Illinois, Peoria 5

Fritz, Adelaide M.
240 E. Delaware Pl., Chicago

Frook, Bertha
9258 S. Bell Ave, Chicago 49

Fuerbringer, Lilian F.
5841 Maryland Ave., Chicago 37

Fulton, Flora
556 W. Webster Ave., Chicago 14

Fyanes, Verne M.
1141 La Graphe, River Forest

Gabler, Margaret H.
5145 N. California Ave., Chicago 25

Gancer, Mabel G.
1900 W. Polk St., Chicago 12

Gardner, Mabel L.
824 Community Dr., La Grange Park

Gardner, Oma M.
1595 N. Church, Decatur 9

Gargantiel, Ethel
955 N. Long St., Chicago 51

Gartland, Rose M.
7545 Jackson Blvd., Forest Park

Gaukroger, Lucille A.
1900 W. Polk St., Chicago 12

Geiger, E. Elizabeth
1900 W. Polk St., Chicago 12

Gerhold, Ella M.
923 Spring St., Elgin

Gillie, Martha
4924 N. Kedzie Ave., Apt. 103, Chicago 25

Glunt, Mrs. Marie
436 N. Homans Ave., Chicago 24

Gold, Gladys
4719 Drexel Blvd., Chicago 15

Conser, Helen R.
229 E. Superior St., Chicago 11

Goodsell, Mrs. Ruba
1316 Charles St., Rockford

Gould, Annie J.
1900 W. Polk St., Chicago 12

Grabski, Theresa
700 W. Fullerton, Chicago 14

Graffam, Shirley
582 Swain Ave., Elmhurst

Graper, Mabel D.
2816 Ellis Ave., Chicago 16

Gray, Phoebe P.
2702 E. Douglas, Wichita 8, Kan.

Greek, Desse M.
1750 W. Congress St., Chicago 12

Green, Maxine E.
1022 Wesley Ave., Evanston

Gressitt, Ruth S.
1900 W. Polk St., Chicago 12

Greico, Donna C.
1507 Broadway, Quincy

Grimm, Emma L.
250 E. Superior St., Chicago 11

Grivest, Mary T.
Veterans Administration Hospital, Box 2547, Hines

Groth, Margaret E.
205 W. Maple St., Lombard

Grou, Mrs. Marguerite T.
2025 W. Main St., Decatur

Gruesbeck, Maryalice
1900 W. Polk St., Chicago 12

Grygiel, Mrs. Charline
9 E. 11 St., Danville

Guldhaug, Alice I.
Veterans Administration Hospital, Dwight

Gullstrand, Lucille K.
6104 Woodlawn, Chicago 37

Gunderson, Mrs. Irene G.
1316—28 Pl., Rockford

463
HOLTSCHLAG, ALMA
41325 N. Sixth St., Springfield
HOPPER, LAURA M.
326 N. Hamlin Ave., Chicago 24
HOWARD, SHIRLEY A.
1201 S. Main, Jacksonville
HAYE, MINNIE B.
201 E. Delaware Pl., Chicago 11
HUBBARD, MRS. BLANCHIE H.
Box 472, Route 1, Centerville Station
HUBBARD, MABEL W.
1700 W. Congress, Chicago 12
HULCHER, MARY
401 E. Stoughton, Champaign
HUNTLEY, MARY M.
Veterans Administration Hospital, Downey
HYDE, LEILA V.
401 E. Stoughton, Champaign
HYLER, SARA K.
325 Park Ave., Springfield
IMSDAHL, HANNAH O.
Veterans Administration Hospital, Downey
JACKSON, MONA
336 Webster, Chicago
JACKSON, RUTH E.
1020 N. Oak St., Normal
JAMES, BRITTA
50 E. Bellevue Pl., Chicago 11
JARCHOW, ANNA L.
318 N. Austin Blvd., Oak Park
JEVNE, GRACE O.
P.O. Box 364, Oak Park
JOHNSON, RUTH E.
320 N. Seventh Ave., Maywood
JOHNSON, ANNA E.
Moline Public Hospital, Moline
JOHNSON, FLORENCE B.
45 S. Virginia Ave., Danville
JOHNSON, HAZEL M.
210 E. Delaware Pl., Chicago 11
JOHNSON, HELEN C.
2244 Cleveland Ave., Chicago 14
JOHNSON, HESTER L.
Southern Illinois University, Carbondale
JOHNSON, MABLE A.
4557 Oakenwald Ave., Chicago 15
JOHNSON, MARTHA S.
1900 W. Polk St., Chicago 12
JONES, MRS. HAZEL S.
2012 Howe St., Chicago 14
JONES, IMOGENE S.
6104 Woodlawn Ave., Chicago 37
JONES, MRS. JESSIE R.
Christian Welfare Hospital, East St. Louis
JONES, MADALENE G.
426 E. 51 St., Chicago 15
JORDAN, FLORABEL G.
1900 W. Polk St., Chicago 12
JUNO, ALICE D.
Veterans Administration Hospital, Downey
JURGEN, MRS. HENRIETTA M.
314 W. Normal Pkwy., Chicago 21
JURGENS, CAROLYN
617 S. 12 St., Pekin
KAHL, JENNIE M.*
420 S. Harlem Ave., Freeport
KAMMERER, ELEANOR G.
702 E. Chestnut, Chicago 11

464
KADASEN, IRENE M. 2516 S. Ellis Ave., Chicago 16
KEKUT, OLGA 640 E. 91 St., Chicago 19
KELLISON, ANN C. 202 W. Ash St., Normal
KELLY, ETHEL C. 1113 N. Glen Oak, Peoria
KELLY, MURIEL J. 240 E. Delaware Pl., Chicago 11
KENEPP, TRESSA L. 2516 Ellis Ave., Chicago 16
KERR, JEAN A. 401 E. Stoughton St., Champaign
KERSKY, GEORGE H. 804 S. 18 Ave., Maywood
KEZAR, VERA R. 2516 Ellis Ave., Chicago 16
Kimball, Lenora 1900 W. Polk St., Chicago 12
KIMMEL, ANNE R. 4314 W. Cortland St., Chicago 39
King, Aileen 1037 W. Woodbury, Danville
KINERY, GLADYS 201 E. Chestnut St., Chicago 11
KINKEAL, MARIE H. 2516 Ellis Ave., Chicago 16
KINNEER, BINNEY H. 513 N. Collett, Danville
Kirchner, Ann* 604 Woodlawn Ave., Chicago 37
Klauser, Bertha E. 427 Dickson Ave., Chicago 14
Klein, Anna M. Veterans Administration Hospital, Bldg. 46, Downey
Klose, Amy E. 120 N. Oak St., Hinsdale
Knight, Gladys L. 705 W. Seminary, Danville
Koch, Mrs. Harriet B. 6320 N. Magnolia Ave., Chicago 40
Kohn, Mrs. Alfred D. 1209 S. LaSalle St., Chicago 23
Kost, Cassie E. 1900 W. Polk St., Chicago 12
Kostyk, Ellen M. 1000 Spring St., Quinney
Koupal, Helen M. 2517 S. Prairie Ave., Chicago 16
Krech, Alma R. 5421 S. Morgan St., Chicago 9
Kreuger, Clara St. Francis Hospital, Freeport
Kyle, Ethel B. Decatur & Mason County Hospital, Decatur 10
Laibd, Ann L. 1819 W. Polk St., Chicago 12
Landreth, Mary J. Landreth Machine Co., Joplin, Mo.
Laper, Mrs. Margaret H. 2010 N. Orleans, Chicago 14
Lapp, Mrs. Agnes P. Memorial Hospital, Springfield
Larson, Clara 604 Woodlawn Ave., Apt. 310, Chicago 37
Latham, Mrs. Chloe B. Galesburg State Research Hospital, Galesburg
Lavi, Aline L. R.F.D. 2, Donegan Rd., Waukegan
Leahy, Catherine M. 7324 Farnell Ave., Chicago 20
Lee, Mrs. Blanche W. 4042 W. Kamerling, Chicago 51
Lee, Muriel J. 527 Elliott St., Kewanee
Leeper, Mrs. Margaret A. 6623 S. Harper Ave., Chicago 37
Lehozy, Aurelia 625 Wrightwood Ave., Chicago 14
Leistra, Rosabel C. 226 W. 105 St., Chicago 26
Lennan, Marion 5455 Everett Ave., Chicago
Lenz, Eunice A. 7015 S. Western Ave., Chicago 36
Leonard, Helen B. 660 Groveland Pl., Chicago 16
Lepien, Myrtle* 3251 Washington Blvd., Chicago 24
Lewis, Eunice M. 211 S. Bowman Ave., Danville
Libotte, Ruth V. Gays
Lieberman, S. Eugenia Grant Hospital, Chicago 14
Lindsay, Dorothy J. 202 N. Kenneth, Chicago
Lindstrand, Thyras D. 4090 N. Ashland Ave., Chicago 40
Lincoln, Lenora 1900 W. Polk St., Chicago 12
Logan, S. Lois 1120 E. 47 St., Apt. B-3, Chicago 15
Longbons, Clara J. 3259 Wrightwood Ave., Chicago 47
Lonnee, Fay 1205 Knoxville Ave., Peoria
Loomis, Harriet 4358 Berkeley Ave., Chicago 15
Lorentz, Mildred L.* Michael Reese Hospital, Chicago 16
Louderman, Carmelita E. 700 W. Fullerton Ave., Chicago 14
Lundblad, Mrs. Rita L. 144 Harrison St., Oak Park
Lunede, Mrs. JoAnn W. 1065 N. Broad St., Galesburg
Mader, Rosemary R. 2043 Cuyler Ave., Chicago 16
Maher, Winfred 3308 Harrison St., Chicago 24
Maliszewski, Florence A. 2596 Balmoral Ave., Chicago 18
Mambourg, Aileen E. Ryburn Memorial Hospital, Ottawa
Mandt, Gertrude 1900 W. Polk St., Chicago 12
Marchetti, Mildred M. 1900 W. Polk St., Chicago 12
Marke, Mrs. Mabelle J. 423 W. Blackhawk, Chicago
Marron, Mary A. 1135 W. State St., Jacksonville
Marshall, Mrs. Beverly M. 3216 W. Haddon Ave., Chicago 51
ILLINOIS

MARTIN, BEATRICE
1507 Cleveland Ave., Evanston

MARTIN, HELEN A.
Memorial Hospital, Springfield

MARTIN, MARGUERITE L.
1900 W. Polk St., Chicago 12

MASEK, SHIRLEY CAROLYN
1804 W. Congress, Chicago 12

MATEO, MRS. GRACE Y.
6186 University Ave., Chicago 37

MATHIES, MARY E.
536 E. Avenue A, Canton

MATHIS, MRS. MARGARET
4144 Mozart, Chicago 18

MAUKSCH, HANS O.†
827 E. 52 St., Chicago 15

MAUKSCH, MRS. INGEBOUR G.
829 E. 52 St., Chicago 15

MAUSHAK, GRACE E.
5841 S. Blackstone, Chicago 37

MAXWELL, LENA
807 N. Main St., Bloomington

McCARTHY, MADELEINE A.
1414 E. 59 St., Chicago

McCONNELL, MADELEINE* 1439 S. Michigan Ave., Chicago 5

McCONVEY, MARGARET M.
Veterans Administration Hospital, Downey

McGULLOUGH, EDNA H.
1750 W. Congress St., Chicago 12

McDONELL, ITA R.*
5115 Washington Blvd., Chicago 44

McELHINEY, MRS. ALMA O.
Lincoln State School & Colony, Lincoln

McGOVERN, CATHERINE E.
4441 W. Monroe St., Chicago 24

MCKENZIE, CAPT. MARGARET E., AFNC
Hotel Windermere West, Chicago 37

McLARREN, DOROTHY S.
615 N. Wabash Ave., Apt. F., Chicago

MCLAUGHLIN, GRAZIELLA
3 Gates Hall, 1010 E. 59 St., Chicago 37

MCMULLEN, MADALYN
2875 W. 19 St., Chicago 23

MCNEILL, MRS. CARRIE H.
618 Prairie Ave., Waukegan

MEAD, BERTHA L.
319 Ridge Ave., Evanston

MEEK, WINIFRED E.
37 N. LaGrange Ave., Chicago 44

MELBY, SYLVIA M.
Presbyterian Hospital, Chicago 12

MENG, DONNA J.
1940 Lincoln Ave., Chicago

MENNING, PATRICIA K.
2354 E. 70 St., Chicago 49

MERNER, SALLIE I.
Dept. of Nursing Education, University of Chicago, Chicago 37

MEYER, MRS. M. LOUISE
1421 S. First St., Springfield

MEYER, MRS. MARY P.
813 Callender Ave., Peoria 5

MIKA, JOSEPHINE
2739 W. 15 Pl., Chicago 8

MILLARD, NELLIE D.
1900 W. Polk St., Chicago 12

MILLER, ALICE H.
4929 S. Lake Park Ave., Chicago 15

MILLER, MILRED J.
3434 W. Franklin Blvd., Chicago 24

MILLER, RUBY W.
Veterans Administration Hospital, Bldg. 46, Downey

MILLS, DARLENE G.
91 Silver St., Galesburg

MINIX, ALICE E.
429 E. 52 Ave., Chicago 14

MINKOFF, CHARLOTTE H.
2816 S. Ellis Ave., Chicago 16

MITCHELL, MRS. RAIDIE P.
6933 Woodlawn Ave., Chicago 37

MITCHELL, VERONICA
1900 W. Polk St., Chicago 12

MOEHL, HILDEGARD
1900 W. Polk St., Chicago 12

MOENCH, MALINDA
4721½ S. Ellis Ave., Chicago 15

MOCAN, VERA
225 W. Crawford St., Paris

MOLBO, DORIS M.
1225 N. Menard Ave., Chicago 51

MONAWEC, RUTH
Southern Illinois University, Carbondale

MONTGOMERY, MARGARET R.
6104 S. Woodlawn Ave., Chicago 37

MORGAN, ALBERTA M.
334½ N. 12 St., Quincy

MORGAN, ELIZABETH M.
2816 Ellis Ave., Chicago 16

MORLEY, MARY L.
1750 W. Congress Ave., Chicago 12

MORTENSEN, FLORENCE E.
751 Revere Rd., Glen Ellyn

MUELLER, DOROTHY M.
5140 Woodlawn Ave., Apt. 110, Chicago 15

MUELLER, MRS. MYRTLE L.
10961 Vernon Ave., Chicago 29

MURARO, FRANCES A.
4917 Drummond Pl., Chicago 39

MURPHY, NAOMI C.*
109 S. Busey, Urbana

MURRAY, MRS. MITZIE H.
1209 S. Third Ave., Maywood

MUKO, MRS. HELEN B.
1716 S. Second St., Springfield

MYERS, ALLISON C.
1506 Indiana Ave., Chicago 5

MYERS, NANCY E.
2816 S. Ellis Ave., Chicago 16

NARANICK, MRS. GLAUDIA S.
619 W. College St., Jacksonville

NARY, MRS. DORIS H.
720½ Gooding St., La Salle

NASH, JEANNE H.
355 Ridge Ave., Evanston

NASTKE, GENEVIEVE M.
1626 N. Harding Ave., Chicago 47

NEHLS, EDNA E.
333 N. Laramie Ave., Chicago 44

NELSON, CONSTANCE W.
4724 N. Virginia Ave., Chicago 25

NELSON, JENNIE M.
201 E. Delaware Pl., Chicago 11

NELSON, MARGARET A.
722 Greenleaf St., Galesburg

NESTEL, EUNICE
2104 N. Hamilton, Chicago 47
NEWELL, FLORENCE E.
430 S. Fifth St., Springfield

NEWMAN, EDNA S.*
201 E. Delaware Pl., Apt. 1606, Chicago 11

NEWTON, MRS. ELIZABETH S.
1900 W. Polk St., Chicago 12

NICKEL, MARTHA R.
1900 W. Polk St., Chicago 12

NOONAN, JOANNE L.
6104 Woodlawn Ave., Chicago 37

NORDQUIST, MRS. BEVERLY V.
4009 N. Kildare Ave., Chicago 41

NORRACONG, MRS. BERNICE W.
4253 N. Hermitage Ave., Chicago

NORRIS, ARA S.
514 Knoxville, Peoria

NUCENT, MARION
225 W. Elna St., Canton

O'BRIEN, DOROTHY S.
4704 S. Fourth St., De Kalb

O'BRIEN, JENNIE A.
1201 S. Main St., Jacksonville

O'BRIEN, MARGUERITE L.
5121 W. Ohio St., Chicago 44

O'CONNOR, MRS. ANNA H.
5324 Monroe St., Chicago 24

O'CONNOR, MARY C.
214 N. Glenwood, Peoria

ODELL, ELIZABETH W.*
Evanston Hospital, Evanston

ODENAL, JOSEPHINE
1300 W. Polk St., Chicago 12

OFFICER, MRS. FRANCES W.
256 N. Waller Ave., Chicago 44

ORHN, VICTORIA
2548 S. Campbell Ave., Chicago 29

 Olsen, ELIZABETH C.
1138 N. Leavitt St., Chicago 22

OLSON, ANNA M.
536 Webster Ave., Chicago 14

OLSON, CLARA R.
5145 N. California Ave., Chicago 25

O'ELILLY, MARGARET M.
P.O. Box 595, Peoria

ORLOWSKI, MRS. ELLEN
1022-34 St., N., Chicago

ORR, HAZEL V.
5735 Midway Pk., Chicago 44

OSBORNE, RUTHANH
310 Waverly St., Palo Alto, Calif.

O'SHEA, LYDA
4785 Drexel Blvd., Chicago 15

OSSAR, SARA L.
1900 W. Polk St., Chicago 12

OSTREM, BEATRICE J.
2440 N. Kedzie Blvd., Chicago 47

OWENS, EVELYN I.
2925 Logan Blvd., Chicago 47

PAETOW, MYRTLE L.
St. Francis Hospital, Evanston

PALM, CECILIA B.
2415 Genera Ter., Chicago 14

PARKER, MARY G.
Pleasant Plain

PARKIN, ROBERT W.
7344 S. Yates Ave., Chicago 49

PARKS, AUGUSTINE L.
1900 W. Polk St., Chicago 12

PAYNE, ANNA M.
Veterans Administration Hospital, Box 2425, Hines

PEARCE, ALICE R.
Box 240, Route 1, Zion 4

PEDEN, MRS. NATHALIE B.
425 E. Church St., Kewanee

PERKINS, DOROTHY
195 Akenside Rd., Riverside

PERRINE, GRACE L.
Veterans Administration Hospital, Danville

PERRODIN, CECILIA M.
133 S. Sixth Ave., Maywood

PETERS, MAXINE W.
222 E. College, Jacksonville

PETERSON, ADA J.
1900 W. Polk St., Chicago 12

PETERSON, RUTH E.
2816 Ellis Ave., Chicago 16

PETTY, RUTH
3632 N. New England Ave., Chicago 34

PHELAN, MARGARET M.
1039 Hollywood Ave., Chicago 40

PHILLIPS, LEONA
1644 W. Jackson Blvd., Chicago 12

PIERCE, MARY J.
1120 E. 28th St., Chicago 17

POTURIC, BARBARA B.
1727 W. 21 Pl., Chicago 8

POWELL, FRANCES L.
1900 W. Polk St., Chicago 12

PRATT, MRS. ELIZABETH T.
5095 Blackstone Ave., Chicago 19

PRICKETT, EDNA A.
244 E. Pearson St., Chicago

PRUTSMAN, LELA D.
1900 W. Polk St., Chicago 12

PUPA, MARIE C.
4563 N. Moody Ave., Chicago 30

PURCELL, MARGARET E.
1900 W. Polk St., Chicago 12

PUTNAM, FRANCES A.*
1515 W. Monroe, Chicago 7

PYNE, EDA H.
219 N. Second Ave., Maywood

QUESTILL, NAOMI L.
1900 W. Polk St., Chicago 12

QUINN, MRS. DELORES T.
Nurses' Quarters 46, Veterans Administration Hospital, Downey

QUINNELL, ADA C.
1940 Lincoln Ave., Chicago 14

RAASCH, EDNA
1044 N. Francisco Ave., Chicago 22

RADEK, ANTOINETTE
1819 W. Polk St., Chicago 12

RAMSEY, JUNE A.
Illinois Nursing Council for War Service,
8 S. Michigan Ave., Chicago 3

RANCK, MARGARET
Box 157, Riverton

RAND, MIRIAM D.
240 E. Delaware Pl., Chicago

RANDALL, SADIE E.
6500 Irving Park Rd., Chicago 34

RASMUSSEN, BETSY
831 Columbian, Oak Park
RATKOWSKI, RUTH R.  
1533 N. Ashland Ave., Chicago 22  
REDMOND, FRANCES  
2047 W. Jackson, Chicago 12  
REEVES, MADELON W.  
1750 W. Congress St., Chicago 12  
RECLEIN, ELSIE  
6116 Kimbark Ave., Chicago 37  
RECHIOLDERFER, MARGARET E.  
100 Restor, Peoria 5  
RENNEY, KATHRYN E.  
4216 S. Berkeley, Chicago 15  
RENTSCHLIER, LUCRETIA  
349 W. Beecher, Jacksonville  
RIBLON, BARBARA K.  
Municipal Tuberculosis Sanatorium. 5601 N. Pulaski, Chicago  
RILEY, MRS. HELEN G.  
426 E. 51 St., Chicago 15  
RIMKUS, HELEN  
6345 S. Maplewood Ave., Chicago 29  
ROAT, ALICE C.  
246 W. Walnut St., Canton  
ROBERTS, F. MARIAN  
1500 Indiana Ave., Chicago 5  
ROBY, LENORE B.  
340 N. Elmwood, Waukegan  
ROCKLIFF, MRS. LORETTA F.  
Methodist Hospital, Peoria 5  
RODEKOH, ADELE E.  
2645 Girard Ave., Evanston  
ROESSLER, MADELINE  
446 Homestead Rd., La Grange  
ROGERS, ANNE  
303 E. Stoughton, Champaign  
ROGERS, ESTELLE  
4341 N. Damen Ave., Chicago 18  
ROGERS, MAYME M.*  
700 Fullerton Ave., Chicago 14  
ROHRER, GERTRUDE F.  
526 Webster Ct., Chicago 14  
ROSCH, MARIE J.  
5137 N. Damen Ave., Chicago 25  
ROTH, ALICE M.  
R.F.D. 1, Morton  
RUCH, HELEN J.  
335 Cornelia, Apt. 409, Chicago 13  
RUDOLPH, ELSA A.  
1439 S. Michigan Ave., Chicago 5  
RUGG, BLANCHE L.  
Veterans Administration Hospital, Danville  
RUPPE, HELEN E.  
614 S. Morris Ave., Bloomington  
RUSHER, ELOISE  
1010 W. Ilsc, Springfield  
RUTHERFORD, HELEN M.  
St. Luke's Hospital, Chicago 5  
RYDER, MRS. ANN K.  
620 Eighth Ave., N., Fargo, N. Dak.  
ST. LEGER, MRS. LA VERN B.  
2065 Warner Ave., Chicago 18  
ST. ONGE, C. JEANNE  
2258 N. Cleveland St., Chicago 14  
SANDBLOOM, HILDUR C.  
4901 Greenleaf, S., Skokie  
SANDING, GLADYS  
2750—15 Pl., Chicago 8  
SAPPINGTON, CHRISTINE L.  
1900 W. Polk St., Chicago 12  
SCHAEFER, ALMA E.  
250 E. Superior St., Chicago 11  
SCHAIL, MRS. RACHEL H.  
518 N. Vine St., Mt. Pulaski  
SCHEFF, MRS. MARTHA M.  
2045 W. Jackson, Chicago 12  
SCHENK, MRS. KATHERINE M.  
John C. Proctor Hospital, Peoria 6  
SCHERER, MRS. MIRIAM  
Methodist Hospital, Peoria  
SCHIERER, BERNICE H.  
1940 Lincoln Ave., Chicago 14  
SCHIVER, FRANCES E.  
600 W. William St., Decatur  
SCHLENER, GRACE M.  
1590 Indiana Ave., Chicago  
SCHMIDT, RUTH E.  
701 N. Michigan Ave., Chicago 11  
SCHMITT, DR. LOUISE M.  
Veterans Administration Hospital, Downey  
SCHMITT, MARY  
1414 E. 59 St., Chicago  
SCHMITT, MARY E.  
1420—70 St., Kenosha, Wisc.  
SCHOLZ, MARIE C.  
Veterans Administration Hospital, Bldg. 2021, Downey  
SCHULER, MRS. MARY L.  
1749 N. McVicker Ave., Chicago 39  
SCHWARTZ, TESS R.  
240 E. Delaware Pl., Chicago 11  
SELLERS, MARY F.  
St. Mary's Hospital, Quincy  
SERBAN, ELIZABETH  
Oak Park Hospital, Oak Park  
SEXAUER, CHARLOTTE E.  
240 E. Delaware Pl., Chicago 11  
SHARP, MRS. HELEN D.  
1810 W. Jackson Blvd., Chicago 12  
SCHICKLER, CATHERINE E.  
5733 University Ave., Chicago 37  
SHELBURG, EDNA M.  
120 N. Oak St., Hinsdale  
SHELTON, THORA  
223 S. Hamilton Ave., Chicago 12  
SHEPHERD, EDITH M.  
414 Walnut St., Maywood  
SHERICK, HELEN W.  
353 Lakeside Pl., Chicago  
SHORT, AUDREY  
Children's Memorial Hospital, Chicago 14  
SIA, MING B.  
Box 1294, Peoria  
SIMON, AUGUSTA H.  
3013 Washington Blvd., Chicago 24  
SINGER, IRENE D.  
6020 W. Raven St., Chicago 31  
SISTER ANGELA  
915 E. Fifth Ave., Alton  
SISTER ANTHONY  
St. John's Hospital, Springfield  
SISTER CARMELINE  
St. John's Hospital, Springfield  
SISTER CHARITAS  
St. John's Hospital, Springfield  
SISTER ELAINE  
St. John's Hospital, Springfield  
SISTER ELIZABETH  
2100 N. Burling St., Chicago 14
SISTER ELVON
St. John’s Hospital, Springfield
SISTER EMMANUEL
St. Mary’s Hospital, Quincy
SISTER ESTHER M. AUS
2236 W. Haddon, Chicago 22
SISTER FRANCIS
St. John’s Hospital, Springfield
SISTER HELEN
St. Joseph’s Hospital, Alton
SISTER HILDA
1130 N. Leavitt St., Chicago 22
SISTER JOHN BAPTIST
St. John’s Hospital, Springfield
SISTER MAGDALENE
1138 N. Leavitt St., Chicago 22
SISTER MARY AGNES
Mercy Hospital, Urbana
SISTER MARY ALTISSIMA
1120 N. Leavitt St., Chicago 22
SISTER MARY OF THE ANGELS
192 S. Fifth Ave., Kankakee
SISTER M. ANYSSIA
1209 Walnut Ave., Freeport
SISTER M. BERNARD
St. Elizabeth Hospital, Chicago 22
SISTER M. BERTRAND
Mercy Hospital, Chicago 16
SISTER MARY CAMILLE
2517 Prairie Ave., Chicago 16
SISTER M. CAMILLE
Little Company of Mary Hospital, Evergreen Park 42
SISTER MARY CHRISTINE
Mercy Hospital, Chicago 16
SISTER M. CLARE ANNE
Our Saviour’s Hospital, Jacksonville
SISTER M. CLAUDINE
Our Saviour’s Hospital, Jacksonville
SISTER M. CLEMENTE
2348 Lakeview Ave., Chicago 14
SISTER MARY CLEMENT STRIEKER
St. Elizabeth Hospital, Chicago 22
SISTER MARY CORNELIA
St. Mary’s Hospital, East St. Louis
SISTER MARY DEPACIS*
St. Therese Hospital, Waukegan
SISTER M. DOROTHEA
St. Mary’s Hospital, East St. Louis
SISTER M. DOROTHEA DWIGHT
Little Company of Mary Hospital, Evergreen Park 42
SISTER M. FABIOLA
St. Elizabeth Hospital, Chicago 22
SISTER MARY FLORENCE
Mercy Hospital, Urbana
SISTER MARY GENEVIEVE
1209 S. Walnut Ave., Freeport
SISTER M. GERTRUDIS
335 Ridge Ave., Evanston
SISTER M. JEANETTE
St. Elizabeth Hospital, Chicago 22
SISTER M. JOHN FRANCIS
Our Saviour’s Hospital, Jacksonville
SISTER M. JULIANA
St. Charles Hospital, Aurora
SISTER MARY LEO
2800 W. 95 St., Evergreen Park 42
SISTER M. LINUS
St. Francis Hospital, Peoria 4
SISTER MARY LOURDES
St. Elizabeth Hospital, Chicago 22
SISTER M. LOYOLA
St. Joseph’s Hospital, Bloomington
SISTER M. MARCE
St. Elizabeth Hospital, Granite City
SISTER M. MARGARITIS
1431 N. Claremont, Chicago 22
SISTER MARY MATILDA
2317 S. Prairie Ave., Chicago 16
SISTER MARY NORINE
St. Anne’s Hospital, Chicago 51
SISTER MARY PRISCILLA
St. Joseph’s Hospital, Joliet
SISTER M. RITA CLARE
St. Francis Hospital, Freeport
SISTER M. ROBERTA
St. Francis Hospital, Peoria 4
SISTER M. THADDEA
St. Francis Hospital, Peoria
SISTER M. THERESA
2675 W. 19 St., Chicago 23
SISTER M. THERESE NETZEL
1125 N. Leavitt St., Chicago 22
SISTER MARY TIMOTHEA
St. Joseph Mercy Hospital, Aurora
SISTER MARY VENARDA
Mercy Hospital, Chicago 16
SISTER MARY VIRGINIA
St. Joseph Hospital, Chicago 14
SISTER MARY WILLIA
St. Anne’s Hospital, Chicago 51
SISTER MELLITENE
St. John’s Hospital, Springfield
SISTER MILDRED L. CHRISTENSON
2236 W. Haddon Ave., Chicago 22
SISTER NELLIE OLESON
1138 N. Leavitt St., Chicago 22
SISTER PATRICE VICKERS
St. John’s Hospital, Springfield
SISTER RENE FISCHER
2100 N. Burling St., Chicago 14
SISTER ROSARIA
2100 N. Burling Ave., Chicago 14
SISTER ST. LAURE
Huber Memorial Hospital, Pana
SISTER ST. TIMOTHY
225 Wisconsin Ave., Oak Park
SISTER VINCENT HONG
2100 N. Burling St., Chicago 14
SKANSE, CATHARINE
6145 N. California Ave., Chicago 25
SKONIEZNA, EVELYN M.
725 N. Ada St., Chicago 22
SKOG, MARY L.
110 Pine St., Danville
SKORUPA, EMILY
1640 W. Adams St., Chicago 12
SLEEPICKA, BERTHA
1900 W. Polk St., Chicago 12
SLETTE, JOSEPHINE C.
5536 Dorchester Ave., Chicago 37
SLOUGH, JEAN M.
1345 Masonic Ave., San Francisco, Calif.
SMILDE, SADIE
318 N. Austin Blvd., Oak Park

469
SMITH, CLARA L.  
2045 Girard Ave., Evanston

SMITH, ELEANOR M.  
1750 W. Congress St., Chicago 12

SMITH, ELIZABETH E.  
1512 Keys Ave., Springfield

SMITH, VIVIAN C.  
153 Floria St., Peoria

SNOW, JUNE  
101 S. Institute, Peoria 5

SNOW, LILLIAN A.  
6658 Orcolo Ave., Chicago 31

SOLBERG, OLGA E.  
427 W. Dickens Ave., Chicago 14

SOOY, HARRIET H.  
809 2/3 S. Spring St., Springfield

SPARMACHER, MRS. DOLLIE L.  
2250 S. Kildare Ave., Chicago 23

SPENCER, MARY S.  
1527 W. Congress St., Chicago 7

SPERANZA, MRS. PHYLLIS J.  
911 W. High St., Urbana

SPIEGEL, MRS. ARTHUR H.*  
2430 Lakeview Ave., Chicago 14

SPODEN, ELIZABETH  
1210 Grant Ave., Danville

STALLINGS, CELIA M.  
1040 Lincoln Ave., Chicago 14

STARRYK, ELIZABETH J.  
608 N. Collot St., Danville

STEIN, ELIDA L.  
2420 N. Kezdie Ave., Apt. 107, Chicago

STEIN, LILLIAN P.  
607 Fullerton Pkwy., Chicago 14

STEINKE, MARIE A.  
St. Luke’s Hospital, Chicago 5

STENSCHE, IRENE L.  
Kenosha Hospital, Kenosha, Wis.

STEVenson, GENEVIEVE R.  
227 Pierce St., Elburn

STEWARD, H. MAGDALENE  
1940 N. Lincoln Ave., Chicago 14

STEWART, MRS. MURIEL  
706 Bellevue Ave., Elgin

STIER, GERTRUDE M.  
Mercy Hospital, Urbana

STILBOWER, HESTER  
Veterans Administration Hospital, Downey

STILWELL, F. GERTRUDE  
1668 W. Ogden Ave., Chicago 12

STOLP, IRENE L.*  
5748 Blackstone Ave., Chicago 37

STRAUSE, IDA E.  
4543 Malden St., Chicago 49

STREETER, VIRGINIA M.  
1500 Indiana Ave., Chicago 5

STRYK, VIOLA  
6130 N. Artesian Ave., Chicago 45

SUAREZ, YOLANDA M.  
2851 N. Elston, Chicago

SUSLICK, MRS. EDITH  
443 Wrightwood, Chicago 14

SWALLEN, MARY E.  
812 N. Logan, Danville

TABER, KATHLEEN  
319 N. Jackson, Danville

TADIE, MABEL J.  
166 Maple Ave., Galesburg

TARRANT, MARY L.  
1149 Lincoln Ave., Decatur

TEETERS, MRS. ALICE M.  
2157 N. Lamon, Chicago 39

THIE, AMELIA L.  
975 Fifth Ave., St. Charles

THIEMBAR, FRANCES G.  
321 Keystone Ave., River Forest

THOMAS, MRS. SIGNA A.  
Graham Hospital, Canton

THOSS, MRS. EDITH H.  
3917 N. Paris Ave., Chicago 34

TIMMONS, FRANCES H.  
21 Stroup St., Danville

TOBIN, MRS. EVELYN M.  
245 Washington Blvd., Oak Park 2

TOZZI, ALFRIEDA M.  
2146 Dayton St., Chicago 14

TRAINOR, LOUISE T.  
201 E. Delaware Pl., Chicago 11

TRAVIS, HETTIE B.  
513 N. Austin Blvd., Chicago

TREPTOW, FRED W.  
4209 N. Leavitt St., Chicago 18

TUCKEE, RUTH  
818 Erie St., Oak Park

TUPPER, JESSIE S.*  
129 N. Oak St., Hinsdale

TURNER, ANNE  
1725 W. Congress St., Chicago 12

TWEEDDALE, RUTH P.  
2429 N. Orchard St., Chicago 14

VALENTA, MRS. MARION U.  
6048 S. Yates Ave., Chicago 17

VAN or STEEG, EVELYN  
1500 Indiana Ave., Chicago 5

VAN DYKE, NELLIE M.  
1900 W. Polk St., Chicago 12

VAN SCHOICK, MILDRED  
1425 E. 50 St., Chicago 37

VAUGHN, FLORENCE K.  
2816 Ellis Ave., Chicago 16

VAUGHN, MARY A.  
2816 S. Ellis Ave., Chicago 16

VERNERS, LAURA A.  
530 Arlington Pl., Chicago 14

VIERNUM, MRS. ANNE L.  
St. Elizabeth Hospital, Chicago 22

VOGEL, IRMA C.  
424 S. Kickapoo St., Lincoln

VON CREMP, ZELLA  
4017 Days Ave., Brookfield

VUGELICH, MILDRED  
Veterans Administration Hospital, Bldg. 46, Downey

WACEK, MARION  
St. Anthony’s Hospital, Rock Island

WAECHTER, MRS. MARY J.  
Arnold Rd., East Peoria

WALEVSKI, FLORENCE  
2875 W. 19 St., Chicago 23

WALLACE, MRS. ELIZABETH B.  
Adams County Tuberculosis Assn., Musselman Bldg., Quincy

WALSH, EDITH C.  
1808 N. Fifth St., Springfield

WAND, PHYLLIS A.  
1102 S. Oak Ave., Freeport

470
WANGAN, CLARE M.  
S. 1125 Perry St., Spokane 16, Wash.  

WATSON, CLAUDINE E.  
640 N. Wabash Ave., Chicago 11  

WATT, THELMA R.  
Peoria State Hospital, Peoria  

WAITS, MRS. ELLEN G.  
2200 N. Monroe St., Decatur  

WAWRYNIK, JANE  
925 E. 61 St., Chicago 37  

WEBBER, VIVIAN G.  
Mercy Hospital, Urbana  

WEDEMEYER, MARGARET R.  
Norwood Heights, Decatur  

WEIDMAN, GLADYS E.  
John C. Proctor Hospital, Peoria  

WEIN, MRS. PAULA F.  
3816 S. Ellis Ave., Chicago 16  

WESTON, MARY L.  
1900 W. Polk St., Chicago 12  

WESTPHAL, MARY E.  
59 E. Monroe St., Chicago 3  

WEYBURN, ROBERT H.  
Monteno State Hospital, Monteno  

WHEELER, ALICE M.  
6 W. 155 St., Harvey  

WHITE, BETTY  
1205 Grant St., Danville  

WHITE, MARY A.;  
Jacksonville State Hospital, Jacksonville  

WHITFORD, MRS. MAE L.  
Alexandria Hotel, Chicago 11  

WHITMAN, MARY B.  
5554 Woodlawn Ave., Chicago 31  

WILCOX, MRS. LAURA C.  
2217 W. Byron St., Chicago 10  

WIEKE, GLADYS R.  
504 W. Elm St., Urbana  

WIESE, ARDITH E.  
3629—16 Ave., S., Minneapolis 7, Minn.  

WIK, EVELYN D.  
120 N. Oak St., Hinckdale  

WILKINS, LILLIAN H.  
1629 N. 77 Ave., Elwood Park 55  

WILL, G. ELSIE  
1163 E. 54 Pl., Chicago 15  

WILLIAMS, BETTY J.  
201 E. Delaware Pl., Apt. 1710, Chicago 11  

WILLIAMSON, MARGARET S.  
Veterans Administration Hospital, P.O. Box 2445, Miness  

WILLS, ANNA M.  
201 E. Delaware Pl., Chicago 11  

WILSON, HELEN A.  
6017 Kimbark Ave., Chicago 37  

WILSON, LOIS J.  
1900 W. Polk St., Chicago 12  

WILSON, LUCRETIA M.  
Veterans Administration Hospital, Danville  

WILSON, MABEL M.  
2000 W. Van Buren, Chicago 12  

WILZESWKE, MARIE K.  
824 W. 62 St., Chicago 21  

WINDTBERG, DAGMAR  
1900 W. Polk St., Chicago 12  

WINSLOW, RUTH  
Navajo Medical Center, Fort Defiance, Ariz.  

WIRT, RUTH  
Fairview Sanatorium, Normal  

WITZ, WINIFRED W.  
2816 Ellis Ave., Chicago 16  

WITZGALL, BETTY C.  
3254 Leland Ave., Chicago 25  

WOLLRAUB, MRS. MARJORIE F.  
Decatur & Macon County Hospital, Decatur  

WOODBURY, EDNA L.  
6102 Woodlawn Ave., Chicago 37  

WOODWARD, MARY Y.  
1537 W. Lawrence Ave., Springfield  

WRIGHT, ELIZABETH H.  
7418 Emerson Ave., Chicago 21  

WRIGHT, MRS. LOUISE B.  
1400 Lake Shore Dr., Apt. 20 F., Chicago 10  

WRIGHT, MARGARET B.  
1201 S. Main St., Jacksonville  

WURTH, THERESE M.  
829 Case St., Evanston  

WYANT, ANNIE LAURIE  
400 Elmwood Ave., Apt. 201, Buffalo, N. Y.  

WYNANT, MARY K.  
5335 Lakewood Ave., Chicago 40  

YENICEK, MRS. BERTHA O.  
631 S. Fourth St., Springfield  

YEOOMANS, SUSAN C.  
1500 Indiana, Chicago 5  

YOUNG, FLORENCE G.  
2816 S. Ellis Ave., Chicago 16  

YOUNG, CTERNIDE  
1810 W. Polk St., Chicago 12  

ZEIS, MRS. HELEN E.  
3719 Southport Ave., Chicago 13  

ZEMLIEKA, PEARL S.  
319 Ridge Ave., Evanston  

ZIPSER, VIOLA  
2645 Girard Ave., Evanston  

ZORN, HELEN  
810 N. Logan Ave., Danville  

INDIANA—202  

ABBOTT, JOY  
3435 Guilford Ave., Indianapolis 5  

ADAMS, EDITH  
P.O. Box 217, La Porte  

ADAMS, MILDRED P.  
Division of Nursing Education, Indiana University, Bloomington  

ALLEN, DOTALINE E.  
Indiana University, Nursing Education Dept., Bloomington  

ALTMANN, HAZEL  
2939 Kessler Blvd., N. Dr., Indianapolis 22  

ANANIA, MRS. BERTHA  
223 Ross Ave Dr., Lafayette  

APPLEMAN, PRUDENCE  
Reid Memorial Hospital, Richmond  

BEAVER, EMMA  
3459 Guilford Ave., Indianapolis 5  

BELL, HARRIET E.  
3043 N. Pennsylvania St., Indianapolis  

471
FOWLES, MRS. SHIRLEY W.  
724 Clarendon Pl., Indianapolis  
FOX, KATHERINE E.  
56 W. Fall Creek Pkwy. 4, Indianapolis 7  
FUCHS, RUTH K.  
Union Hospital, Terre Haute  
GARDNER, KATHRYN L.  
R.F.D. 1, Union Mills  
GECKLER, ROSE I.  
3225 Brookside Pkwy., S. Dr., Indianapolis  
GEHRING, MRS. VIRGINIA R.  
3238 E. Fall Creek Pkwy. 5, Indianapolis  
CENTRY, THORA  
1232 W. Michigan St., Indianapolis 7  
GIFFORD, EMILY M.  
1600 N. Seventh St., Terre Haute  
GILBERT, MRS. OPAL  
2641 Crawford St., Terre Haute  
GILMORE, ELVA Z.  
Irene Byron Sanatorium, Ft. Wayne 8  
GOBEL, MRS. PATRICIA D.  
1702½ Kossuth St., Lafayette  
GREN, MARY L.  
1232 W. Michigan St., Indianapolis 7  
GUENDLING, JOANNE  
125 N. Eddy St., South Bend 17  
HALL, AGNES G.  
4617 Kingsley Dr., Indianapolis 5  
HALSTEAD, CRYSTAL R.  
1232 W. Michigan St., Indianapolis 7  
HARTER, CLEO L.  
1111 W. Darden Rd., South Bend  
HARTLEY, MRS. EDITH K.  
3145 N. New Jersey, Indianapolis 44  
HARTZ, BERNICE M.  
1232 W. Michigan St., Indianapolis 7  
HAUENSTEIN, CAROLINE*  
38 N. Pennsylvania St., Indianapolis  
HAUGK, EDNA  
1232 W. Michigan St., Indianapolis 7  
HAWORTH, MRS. JULIA M.  
22B N. Toft Ave., Evansville  
HECKARD, MARY E.  
1232 W. Michigan St., Indianapolis 7  
HESTER, MARY A.  
Veterans Administration Hospital, Indianapolis 16  
HEUMPHREUS, MRS. MARIETTA T.  
Veterans Administration Hospital, Marion  
HOFFMAN, MRS. HAZEL S.  
Rogers Center, Box 77, Indiana University,  
Bloomington  
HUGHES, MARY J.  
3727 Creston Dr., Indianapolis 22  
JACOBs, ETHEL R.  
410 N. Meridian St., Indianapolis 4  
JOHNSON, MRS. HELEN R.*  
834 W. 43 St., Indianapolis 8  
JOHNSON, LOIS H.  
2315 Broadway, Rockford  
JOHNSON, MARIE A.  
3346 N. Capitol Ave., Indianapolis 8  
JORDAN, THELMA E.  
4015 Broadway, Indianapolis  
KINNEY, MRS. MADELINE  
829 Monroe Ave., Evansville 13  
KLAIBER, MRS. CECILIA  
3551 N. Olney, Indianapolis  
KNOLTS, LESTA  
Veterans Administration Hospital, Indianapolis 18
Koch, Fredericka E.  
Methodist Hospital, Indianapolis 7

Kolter, Marie  
185 Spy Run, Fort Wayne 3

Lamberger, Ruth E.  
3310 N. Meridian St., Apt. 207, Indianapolis

Latham, Helen C.  
2342½ N. Talbot St., Indianapolis

Layton, Helen F.  
219 N. Rural St., Indianapolis

Lehman, Marjorie J.  
Indiana University Medical Center, Indianapolis

Lemieux, Blossom  
James G. Parramore Hospital, Crown Point

Lewis, Myrtle E.  
2126½ N. Talbot St., Indianapolis

Lillard, Mrs. Madonna  
102 N. F St., Marion

Longere, Ruth  
713 Pleasant Run Pkwy., S. Dr., Indianapolis 3

Lutz, Mrs. Mary E.  
1346 N. LaSalle St., Indianapolis 1

Lyons, Mrs. Bernta B.  
300 S. Weinbach Ave., Apt. A-6, Evansville

MacDougall, Edwina  
1125 Circle Tower, Indianapolis 4

Martin, Mary C.  
Logansport State Hospital, Logansport

Maxwell, Maxine  
57 W. 21 St., #403, Indianapolis 2

McCleary, Catherine A.  
2385 N. Meridian St., Apt. 4, Indianapolis 8

McCracken, Mabel C.  
631 First Ave., Evansville 10

McGill, Inez J.  
1229 N. Pennsylvania St., Indianapolis 2

McNerney, Helen L.  
4121 Otterbein Ave., Indianapolis 3

Meehan, Alice R.  
Veterans Administration Hospital, Fort Wayne 3

Meyer, Mrs. Donna S.  
P.P.H.A. 230-3, W. State St., West Lafayette

Miller, Clara M.  
2400 University Ave., Muncie

Millet, Blush  
1338 S. Sherman Dr., Indianapolis 3

Mitchell, Ellen M.  
Veterans Administration Hospital, Fort Wayne

Moore, Rena D.  
Alban Towers, 3700 Massachusetts Ave., N.W., Washington, D. C.

Mosemann, Orpha B.  
1601 S. Eighth St., Goshen

Mounsey, Mrs. L. Catherine  
4430 N. Franklin Rd., Lawrence

Mundy, Lavonne  
1812 N. Capital Ave., Indianapolis

Norman, Elsie  
Protestant Deaconess Hospital, Evansville

O'Donnell, Mildred J.  
4475 Marcy Lu., Apt. 202, Indianapolis

Orem, Dorothea E.  
1330 W. Michigan St., Indianapolis

Osborn, Dorothy E.  
P.O. Box 75, Rogers Center, Indiana University, Bloomington

Palsgrove, Mrs. Ethel H.  
119 E. 19 St., Indianapolis 2

Patterson, Genevieve  
Veterans Administration Hospital, Indianapolis 16

Penrod, Mrs. Grace  
1919½ Garfield, Terre Haute

Perry, Lucy C.  
1415 E. Third, Bloomington

Pfeiffer, Martha E.  
681 Barbour Ave., Terre Haute

Pickett, Harriett J.  
Indianapolis General Hospital, Indianapolis 7

Pickett, Mildred J.  
2840 N. Arlington Ave., Indianapolis

Pierce, C. Marie  
Veterans Administration Hospital, Fort Wayne

Powers, Mary K.  
4015 S. Calhoun, Fort Wayne 6

Reed, Mrs. Phillip B.  
4311 N. Meridian St., Indianapolis 8

Reynolds, Rita A.  
36 E. 14 St., Regis St., Apt. 507, Indianapolis

Robades, Mary A.  
2055 N. Delaware St., Indianapolis 2

Richardson, Mrs. Thelma I.  
3050 Ruckel St., Indianapolis 5

Roehm, Maryanne E.  
1201 N. Sixth St., Terre Haute

Romberg, Vera C.  
431 S.W. Third St., Richmond

Rowan, Mrs. Helen M.  
1325 Barth Ave., Indianapolis 3

Schepper, Waunita B.  
318 N. Ninth St., Terre Haute

Schilmoeller, Elizabeth  
2444 N. Talbot, Indianapolis 5

Schnebelt, Mary T.  
St. Vincent's Hospital, Indianapolis 7

Schoffer, Mrs. Clare H.  
2605 College Ave., Indianapolis

Schweer, Jean  
1919½ Garfield, Terre Haute

Scramlin, E. Nancy  
1125 Circle Tower, Indianapolis 2

Senour, Mrs. Bernice M.  
4320 N. Illinois St., Indianapolis 8

Shaffer, Cecile E.  
St. Vincent's Hospital, Indianapolis 7

Sharp, Carmen  
1812 N. Capitol Ave., Indianapolis 7

Shaw, Genevieve  
1434 N. Delaware St., Apt. 24, Indianapolis

Sholley, Miriam I.  
Logansport State Hospital, Logansport

Short, Beatrice  
224 N. Meridian St., Rm. 401, Indianapolis 4

Silverman, Mrs. Margaret  
22 W. 20 St., Indianapolis

Sims, Virginia  
960 N. Campbell Ave., Indianapolis 19

Sink, Winifred R.  
2218 California Ave., Fort Wayne

Sister Anastasia  
St. Mary's Hospital, Evansville

Sister Andrea  
St. Mary's Hospital, Evansville 10

Sister Carmel  
St. Vincent's Hospital, Indianapolis 7

Sister Casimir  
St. Vincent's Hospital, Indianapolis 7
SISTER CLARE  
St. Vincent's Hospital, Indianapolis 7

SISTER CONSTANCE  
St. Vincent's Hospital, Indianapolis 7

SISTER ELISE  
St. Vincent's Hospital, Indianapolis 7

SISTER FLORIANNE*  
St. Margaret's Hospital, Hammond 1

SISTER FRANCIS  
St. Vincent's Hospital, Indianapolis 7

SISTER GENEVIEVE  
St. Mary's Hospital, Evansville 10

SISTER GEORGIANA  
St. Mary's Hospital, Evansville 10

SISTER JULIA  
St. Mary's Hospital, Evansville 10

SISTER LABOURE  
St. Vincent's Hospital, Indianapolis 7

SISTER LUCILLE  
St. Mary's Hospital, Evansville 10

SISTER MARIA AMADEO  
St. Mary's College, Notre Dame

SISTER MARY ARNOLDA  
St. Elizabeth Hospital, Lafayette

SISTER M. BARBEA  
St. Elizabeth Hospital, Lafayette

SISTER MARY BARTHOLOMEW  
St. Joseph's Hospital, South Bend

SISTER M. BENNOA  
St. Elizabeth Hospital, Lafayette

SISTER M. BERRIMANS*  
Mercy Hospital, Elwood

SISTER M. BERNADETTE  
St. Joseph's Memorial Hospital, Kokomo

SISTER MARY CECILIAN  
St. Joseph Hospital, South Bend 17

SISTER MARY CELESTE  
St. John Hickey Memorial Hospital, Anderson

SISTER MARY FLORINA*  
St. Elizabeth Hospital, Lafayette

SISTER MARY HENRITA  
St. Elizabeth Hospital, Lafayette

SISTER MARY JOSEPH  
St. Mary's Hospital, Evansville 10

SISTER MARY JUDE  
Good Samaritan Hospital, Kokomo

SISTER MARY LOUISE  
St. Vincent's Hospital, Indianapolis 7

SISTER MARY MARCINA  
St. Mary's College, Notre Dame

SISTER MARY NORA  
St. Anthony's Hospital, Terre Haute

SISTER M. ODILLIA  
4211 Fir St., East Chicago

SISTER MARY THEODORITA*  
St. Joseph Hospital, Fort Wayne 2

SISTER M. VITALIS*  
St. Mary's Mercy Hospital, Gary

SISTER MIRIAM DELORES  
St. Joseph Hospital, South Bend

SKOOGLUND, CHARLOTTE C.  
1232 W. Michigan St., Indianapolis 7

SMITH, MRS. JESSIE W.*  
108 S. Grand Ave., Evansville 9

SPENCER, SARA  
3407 S. Fairfield Ave., Fort Wayne 6

SPIEGEL, MRS. MARY B.  
319 N.W. Fifth St., Evansville

SPINKS, MRS. ELIZABETH R.  
Box 334, Butler University, Indianapolis

STEIGERWALT, MILDRED M.  
2720 Broadway, Fort Wayne

STERN, BEATRICE  
1135 Summer Blvd., Hammond

STRIETER, JANE F.  
815 Pierce St., Gary

STUMP, CLEONE B.  
Veterans Administration Hospital, Marion

SUTTON, MRS. RUBY R.  
70 Market St., Southport

TEMPLETON, RUTH E.  
701 West Dr., Apt. 2, Woodruff Pl., Indianapolis

THUMM, HELEN MARIE  
University Apts., E. 213, Bloomington

TRAVIS, SUE T.*  
St. Elizabeth's School of Nursing, Lafayette

TUCKER, OLIVE  
St. Mary's Mercy Hospital, Gary

ULRICH, GERTRUDE  
Indianapolis General Hospital, Indianapolis 7

VAN HUSS, LT. MARY M.  
Nurses Quarters, U. S. Naval Hospital, Great Lakes, Ill.

VAN WIJEN, MRS. KATHRYN K.  
1428 Park Ave., Indianapolis 2

WALL, E. LUCILE  
20 E. 14 St., Apt. 503, Indianapolis 2

WALN, CLARA E.  
604 N. Main St., South Bend

WALTZ, MARTHA L.  
1701 N. Illinois St., Indianapolis 2

WAND, MRS. HELEN A.  
1654 S. Linwood Ave., Evansville

WARD, KATHERINE  
919 Line St., Evansville 13

WARTSLER, MARTHA E.  
850 Grant St., Gary

WEBER, HELEN J.  
Division of Nursing Education, University of Indiana, Bloomington

WEESNER, HILMA L.  
Veterans Administration Hospital, Marion

WINKLER, MARIE T.  
4452 Carrollton Ave., Indianapolis

WIVEL, ELIZABETH G.  
Indianapolis General Hospital, Indianapolis 7

WRIGHT, MRS. ISABEL H.  
Clermont

IOWA—176

ADAIR, ADDIE M.  
605—14 St. Pl., Des Moines

ALKIRE, HESTER  
Veterans Administration Hospital, Fargo, N. Dak.

ANDERSON, AMANDA  
Broadlawns Hospital, Des Moines 14

ARNOLD, WAVE  
Methodist Hospital, Sioux City

BEERS, ADELAIDE P.  
Burlington Protestant Hospital, Burlington

BEMIS, MRS. MAY W.  
717 Fourth St., Des Moines
HABERMAN, LORETTA M.  
917—19 St., Sioux City

HACKBART, WILMA H.  
Allen Memorial Hospital, Waterloo

HATCH, HELEN  
Veterans Administration Hospital, Des Moines 10

HAYES, MRS. LILLIE P.  
293 E. Grand, Des Moines 17

HEDLUND, MRS. ELLA A.  
1020 Virginia St., Sioux City

HEFNER, AUGUSTA J.  
2217 Court, Sioux City

HENDERSON, LAURA  
Broadlawns Polk County Hospital, Des Moines 14

HESTAD, HELEN E.  
625 Alpine St., Dubuque

HUZELMAN, LUCILLE  
7 S. Third Ave., Marshalltown

INMAN, DELPHA M.  
3822—27 St., Des Moines

IRWIN, JEAN E.  
1815 Jackson, Sioux City

JACOBSEN, MARGARET L.  
2117 Nebraska St., Sioux City

JACOBSON, ANNA B.  
Broadlawns Hospital, Des Moines

JAUER, GLADYS J.  
615—38 St., Sioux City 16

JOHNSON, OLIVE  
3323 W. University, Des Moines

KEATING, MARY E.  
Veterans Administration Hospital, Des Moines

KITCHELL, MYRTLE E.  
Westlawn, Iowa City

LANG, LOUISE M.  
1415 W. 20 St., Sioux City 17

LARSEN, ETHEL E.  
Veterans Administration Hospital, Knoxville

MAHONEY, BETTUANE  
317 Van Ness, Ottumwa

MAHONEY, MARIE  
304 Smith Apt., Sioux City

McGURK, BLANCHE C.  
1527 Broad St., Clinton

MEANS, ELIZABETH A.  
445 Garden St., Iowa City

MERRYFIELD, HELEN L.  
2714 Pierce, Sioux City

MOORE, MRS. NINA  
307 Sioux Apts., Sioux City

MORELIUS, JESSIE P.  
917 Locust St., Des Moines

OLESON, MRS. BETTY P.  
5505 Ovid Ave., Des Moines

PATCH, MRS. MARION C.  
405—24 St., Sioux City

PERRINE, MARJORIE  
1117 Pleasant St., Des Moines 14

PERRY, MRS. DORIS K.  
1005 W. Boone St., Marshalltown

PICKERSGILL, LILLIAN M.  
2117 Nebraska St., Sioux City

PIRIE, MARJORIE L.  
501 N. Dubuque St., Iowa City

PLATE, EDITH H.  
761—16 St., Des Moines

POSNER, MRS. VERONICA K.  
131816—34 St., Des Moines

---

BIXLER, MRS. GENEVIEVE K.  
5638 S. Waterbury Rd., Des Moines 12

BOHRER, MRS. ORLEAN E.  
Toddville

BOSSHARDT, LUCY A.  
1610 Franklin St., Des Moines

BRADY, LOUISE M.  
1530 Arlington Ave., Des Moines 14

BROWN, AMY F.  
University of Iowa School of Nursing, Iowa City

BROWN, HANNAH J.  
207 W. Church St., Marshalltown

BROWN, MRS. MINNIE G.  
R.F.D. 3, Ames

BUTLER, MILDRED E.  
Jennie Edmundson Memorial Hospital, Council Bluffs

CADY, LORAIN E.  
617 Kenilworth Ct., Clinton

CALLAHAN, MRS. CATHERINE  
1010—23 St., Des Moines 11

CARLSON, MRS. ELLEN M.  
705 E. University, Des Moines 16

CARRAHAN, ELLEN  
1141 E. Seventh St., Des Moines

COOPER, MRS. RUTH C.  
St. Joseph Mercy Hospital, Mason City

COPPES, ALICE C.  
1117 Pleasant St., Des Moines 14

COUCH, MRS. LAURA J.  
1810 Francis Ave., Des Moines

COX, EDITH E.  
Mercy Hospital, Davenport

CRESSEY, LOIS G.  
2010 S. St. Aubin, Sioux City

CULVER, VIVIAN M.  
4301 Franklin Ave., Des Moines

DERBY, MRS. BARBARA C.  
2722 Ave. B, Council Bluffs

DOLAN, FLORENCE  
2217 Court, Sioux City

EBINGER, LOIS E.  
Iowa Methodist Hospital, Des Moines 14

EISENLAUER, MRS. GRACE B.  
2803 E. Grand, Des Moines

FESSENDEN, JEANETTE H.  
University Hospitals, Iowa City

FEVOLD, SOPHIE E.  
2500 Kingsman Blvd., Des Moines

FLEMING, RUTH M.  
366 Metz Apt., Sioux City

FRANKE, ELAINE M.  
1127 Pleasant St., Des Moines 14

FREDEN, HEDVIG A.  
706 Parnell Ave., Des Moines

FRERIKS, DOROTHY  
215 Euclid, Cherokee

FROEHLIKE, HENRIETTA  
1900 Hickman Rd., Des Moines

CINTZIG, LEON I.  
Veterans Administration Hospital, Knoxville

GLASCOCK, LILLIE  
Box 111, Independence

GOULD, MARJORIE L.  
Westlawn, Iowa City

GREGG, NORMA G.  
1915 Jackson, Sioux City

GUE, MRS. HALLINA B.  
Greater Community Hospital, Creston
SISTER MARY ALOYSIA*
St. Joseph Mercy Hospital, Dubuque
SISTER MARY ANNETTA
Mercy Hospital, Davenport
SISTER M. ANTOINETTE
Mercy Hospital, Council Bluffs
SISTER M. BARBARA ANN
Mercy Hospital, Cedar Rapids
SISTER MARY BRIGID
Mercy Hospital, Iowa City
SISTER M. CARLENE
Mercy Hospital, Cedar Rapids
SISTER MARY CLARICE
Mercy Hospital, Cedar Rapids
SISTER MARY CONCEPTA
Mercy Hospital, Des Moines 14
SISTER M. CONSOLATA
Mercy Hospital, Des Moines
SISTER M. de LELLIS HOLZ
Mercy Hospital, Des Moines
SISTER MARY de LELLIS MELCH
Mercy Hospital, Cedar Rapids
SISTER MARY DOLORES
St. Vincent's Hospital, Sioux City
SISTER MARY DOROTHY
St. Joseph's Mercy Hospital, Sioux City 19
SISTER M. EILEEN
St. Ann Hospital, Algona
SISTER MARY EILEEN
Mercy Hospital, Cedar Rapids
SISTER MARY EUSTACE
420 E. Washington, Council Bluffs
SISTER MARY EVANGELISTA
Mercy Hospital, Iowa City
SISTER M. FRANCIS dE SALES
1600 N. Ash St., Ottumwa
SISTER MARY GERALD
St. Joseph's Mercy Hospital, Mason City
SISTER M. GERALDINE
Mercy Hospital, Des Moines 14
SISTER MARY GERARD HONING
St. Vincent's Hospital, Sioux City
SISTER MARY GERARD ROCHFORD
St. Joseph's Mercy Hospital, Sioux City
SISTER MARY GERTRUDE
St. Ann Hospital, Algona
SISTER MARY IMELDA
St. Joseph Mercy Hospital, Ft. Dodge
SISTER MARY IMMAGULATA
St. Joseph Mercy Hospital, Dubuque
SISTER M. KIERAN
Mercy Hospital, Des Moines
SISTER MARY LASALETTE
St. Joseph's Mercy Hospital, Sioux City 19
SISTER MARY LOYOLA
Mercy Hospital, Cedar Rapids
SISTER MARY MARCELLA
St. Joseph's Mercy Hospital, Sioux City
SISTER M. MARTINA
Mercy Hospital, Council Bluffs
SISTER MARY MAURA
Sacred Heart Convent, Cedar Rapids
SISTER M. MAUREEN
Mercy Hospital, Cedar Rapids
SISTER M. MERCEDES
Mercy Hospital, Cedar Rapids
SISTER M. MICHAELLEEN
St. Vincent's Hospital, Sioux City 10
SISTER WILMA ANITA HULSEBUS
Evangelical Deaconess Hospital, Marshalltown

SITTIG, NANCY C.
Westlawn, Iowa City

SNELL, EFFIE
1311 E. Eighth St., Des Moines

SNYDER, MRS. ANNIE A.
1208 E. High St., Davenport

STAGEMAN, MARY J.
300 W. Oak St., Council Bluffs

STREBEN, ETHEL M.
St. Luke’s Hospital, Davenport

SVEEN, MURIEL E.
1412—34 St., Des Moines

TJELTA, TOMINE
Allen Memorial Hospital, Waterloo

TOMMELA, RACHEL
2965 Pierce St., Sioux City

TUBESING, LUCILE M.
Allen Memorial Hospital, Waterloo

TULLY, CATHERINE M.
2535 Central Ave., Dubuque

WAGNER, HILDEGARDE M.
81 Fremont Ave., Dubuque

WEST, BETTY H.
2117 Nebraska St., Apt. 206, Sioux City

WOZESCHKE, MARGARET A.
7 S. Third Ave., Marshalltown

WORTMAN, JESSIE C.
Jennie Edmundson Memorial Hospital, Council Bluffs

WREN, MAE
3314 University, Des Moines 11

ZIMMERMAN, FRANCES L.
817 E. Pierce St., Council Bluffs

KANSAS—111

ADAMS, AMY L.
614½ S. Fifth St., Salina

ADELMAN, MRS. CAROL
209 Brush Creek Blvd., Kansas City, Mo.

ANDERSON, MRS. IRENE C.
1126 Horne, Topeka

ARNOLD, HARRIET A.
4520 Main St., Kansas City, Mo.

BARE, JEAN
804 Mulvane, Topeka

BENTON, EULA M.
13½ W. Sixth Ave., Emporia

BRENNAN, MRS. BESSIE W.
1030 Washburn, Topeka

BROWN, JESSIE
Bethel College, North Newton

BUNGER, FRANCES M.
2020 Olath Blvd., Kansas City 3

CADY, RUTH C.
William Newton Memorial Hospital, Winfield

CAMPBELL, MABEL S.
University of Kansas Medical Center, Kansas City

COFFMAN, MARGUERITE P.
617 State St., Emporia

DARBY, EDITH H.
212 N. Valley, Kansas City

DORAN, MARGUERITE C.
4106 Wilma, Wichita

ENTZ, MARGARETHA W.
Vail Hospital, Topeka

FOOTE, ROBERTA E.
1325 Garfield, Topeka

FRITZEMEIER, MARTHA H.
207 E. Sixth St., Hutchinson

GESSLER, AURELIA M.
629 Horne St., Topeka

GROVES, RUTH S.*
Hyde Park Hotel, Kansas City, Mo.

HARDSAW, ROSA
223 Woodlawn Ave., Topeka

HARMON, GLADYS C.
William Newton Memorial Hospital, Winfield

HARTUNG, ELSA M.
5811 Locust, Kansas City, Mo.

HILL, E. JEAN
Dept. of Nursing, University of Kansas, Kansas City 3

HUNTLEB, BARBARA L.*
150 N. Erie St., Wichita

JACKSON, MRS. DOROTHY H.
1822 N. Green St., Wichita

JENNINGS, THOMAS R.
1231 Topeka Blvd., Topeka

LAW, IRMA
824 Kansas Ave., Topeka

LIHN, MRS. ESTHER L.
3822 W. 12 St., Topeka

LIND, MRS. ESTELLA L.
Route 2, Box 157, Bonner Springs

477
SISTER M. EMELINE
St. Catherine's Hospital, Garden City

SISTER M. ETHELREDA
Pratt Hospital, Pratt

SISTER M. EULALIA
St. Francis Hospital, Wichita 5

SISTER M. EULALIA
Wichita Hospital, Wichita 12

SISTER M. FREDERICA
Mt. Carmel Hospital, Pittsburg

SISTER MARY HELEN
Mercy Hospital, Fort Scott

SISTER M. IDA
Wichita Hospital, Wichita 12

SISTER M. JEROME
3700 E. Lincoln, Wichita

SISTER M. JUSTA
St. Margaret's Hospital, Kansas City 2

SISTER MARY LEONA
Mt. Carmel Hospital, Pittsburg

SISTER M. LEONILLA
1102 W. Douglas, Wichita

SISTER MARY LUKE
St. Mary Hospital, Manhattan

SISTER M. MIRABELIS
St. Margaret's Hospital, Kansas City 2

SISTER M. MIRIAM
3600 Broadway, Great Bend

SISTER M. RAYMOND
St. Margaret's Hospital, Kansas City 2

SISTER M. REDEMTA
Halstead Hospital, Halstead

SISTER M. ROSE AGNES
St. Joseph's Hospital, Wichita 17

SISTER MARY SYLVIKSTER
St. Francis Hospital, Topeka

SISTER M. THEOPHANE
Marymount College School of Nursing, Salina

SISTER M. THERESITA
St. Francis Hospital, Wichita

SISTER MARY VALERIA
St. Joseph's Hospital, Wichita

SISTER M. VICTOR
300 Grand Ave., Wichita 17

SISTER M. VICTORIA
St. Joseph's Hospital, Wichita

SISTER MARY VINCENT
St. Elizabeth Mercy Hospital, Hutchinson

SISTER M. WINIFRED
St. Anthony Hospital, Dodge City

SISTER MEL BRIDE
Wichita Hospital, Wichita

SISTER ROSE
St. Margaret's Hospital, Kansas City 2

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St. Mary's College, Xavier

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St. Margaret's Hospital, Kansas City 2

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St. John's Hospital, Salina

SISTER THEODOSIA HARMS
Bethel Deaconess Hospital, Newton

SISTER ZITA MARIE
Providence Hospital, Kansas City 2

SMILEY, LILLIAN M.
Veterans Administration Hospital, Nurses' Quarters, Wadsworth

SMITH, MAXINE
1830 Woodland Blvd., Kansas City 3
MEMBERS

SNEED, MRS. EMILY P.
F.G. Box 267, Halstead

STECK, ALETA L.
530 N. Hillsdale, Wichita 6

STEG, ILSE*
Wesley Hospital, Wichita

STOUT, MRS. FRANCES C.
Route 5, Emporia

SUTCLIFFE, ELIZABETH
2030 W. 39 St., Kansas City 3

TITUS, MRS. HELEN
511 Chestnut, Halstead

TRUBSHAW, MRS. PAULINE F.,
Newman Memorial County Hospital, Emporia

KANSAS—KENTUCKY

UNRUH, VIOLA F.
Univ. of Kansas Medical Center, Kansas City 3

WACOONER, MRS. CECILIA E.
802 W. Third, Pittsburgh

WARTEL, SARAH F.
124 Topoka Ave., Topeka

WEISS, MADELINE O.
1634 W. Venango St., Philadelphia 40, Pa.

WERNER, JOSEPHINE F.
St. Catherine’s Hospital, Garden City

WILLIAMS, JENNIE
1641 Falmouth, Manhattan

WORMER, MRS. EVELYN M.
Cushing Memorial Hospital, Leavenworth

KENTUCKY—103

AVERBECK, ROSEMARY
2739 Dakota Ave., Latonia

BALLINGER, JENNIE L.
1132 Mt. Allen Rd., Covington

BASH, FLORENCE B.
Veterans Administration Hospital, Outwood

BECK, MRS. NANCY
Louisville General Hospital, Louisville 2

BISIG, MARY C.
2242 Napoleon Blvd., Louisville

BLAIR, MRS. MABEL T.
815 Bluegrass Ave., Louisville

BOYD, KATHLEEN
2039 Douglass Blvd., Louisville

BRAUN, ADELINE P.
2906 Nappanee Rd., Louisville 7

BRUMON, MRS. JUNE A.
Louisville General Hospital, Louisville 2

BRUTSCHER, CLARA T.
St. Anthony Hospital, Louisville

BURKE, CHRISTIANA
Norton Memorial Infirmary, Louisville 3

CALLENDER, MRS. MARY S.
728 Heywood, Louisville

CAMPBELL, MRS. RUTH M.
Methodist Evangelical Hospital, Louisville

CAPEL, Ida
Louisville General Hospital, Louisville 2

CAUSEY, ZELLA M.
526 W. Breckenridge, Louisville

CLARK, E. ALICE
2226 Walderdale Ter., Louisville 5

COLE, RUTH E.
Murray State Teachers College, Murray

COPPEDGE, RUTH M.
R.F.D. 5, Hopkinsville

CORNISH, PAULINE
Louisville General Hospital, Louisville 2

COUNTS, VERA
Louisville General Hospital, Louisville 2

CULBERTSON, MARY E.
Veterans Administration Hospital, Louisville 2

DUNN, KATHRYN A.
Good Samaritan Hospital, Lexington

DUNN, MRS. LUCILLE C.
Louisville General Hospital, Louisville 2

EAST, MARGARET L.
Cumberland Apts., Apt. 906, Louisville 3

EVESSAGE, DOROTHY
1029 E. Breckenridge, Louisville

FARNESLEY, MRS. JOSEPHINE R.
Louisville General Hospital, Louisville 2

FARR, MRS. DOROTHY R.
3305 Lexington Rd., Louisville

FILBURN, LILLIAN J.
2257 Osage St., Louisville

FOREMAN, VIRGINIA
Louisville General Hospital, Louisville 2

FOSTER, HAZEL M.
Louisville General Hospital, Louisville 2

GAMBLE, MRS. MARGARET Z.
Children’s Free Hospital, Louisville

GIBSON, FLORENCE I.
Box 1911, College Station, Berea

GILMORE, MRS. MARY A.
2415 Concord Dr., Louisville

GIBSON, MRS. MARY F.
615 Erway St., Louisville

GOREY, MARGARET M.
Veterans Administration Hospital, Lexington

CREATHOUSE, JESSIE
604 S. Third St., Louisville 2

GREGORY, BLANCHE C.
315 N. 33 St., Louisville

HARPE, MILDRED S.
Veterans Administration Hospital, Lexington

HAYES, RHEBA M.
672 S. 38 St., Louisville 11

HAYMAN, MRS. ELECTA P.
Louisville General Hospital, Louisville 2

HENNINGER, EDNA
Louisville General Hospital, Louisville 2

HOFFMAN, ELIZABETH E.
Berea College School of Nursing, Berea

JONES, CLEO
1012 S. Brook, Louisville

KELLER, DORIS A.
1011 S. 20 St., Louisville

KEUPER, MRS. VELMA
514 Wallace Ave., Covington

KNIGHT, MRS. ELLA M.
Louisville General Hospital, Louisville 2

LEHRER, EVELYN
1397 S. Third St., Louisville 3

LUSBY, BEATRICE
Louisville General Hospital, Louisville 2

MAY, DORA R.
418 W. Ormsby Ave., Louisville

McCLAIN, LULA
4445 S. Sixth St., Louisville 8

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KENTUCKY—LOUISIANA

MEMBERS

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St. Agnes Hospital, Louisville

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St. Elizabeth Hospital, Covington

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St Anthony Hospital, Louisville

SISTER M. PHILOMENE
St. Elizabeth Hospital, Covington

SISTER MARY PIUS
Sts. Mary & Elizabeth Hospital, Louisville

SKAGGS, GLADYS M.
320 S. Eighth St., Louisville 3

SOMMER, VIVIAN L.
Veterans Administration Hospital, Lexington

SPATIG, MRS. DOROTHY C.
401 Rosewood Ave., Somerset

SPRAGUE, MARION B.
203 S. Limestone, Lexington

SPURLING, MARTHA L.
262 Eastern Pkwy., Louisville 4

STACY, MRS. FRANCES L.
1808 Eastern Pkwy., Louisville

STANLEY, RUTH
Louisville General Hospital, Louisville 2

STAPLETON, MRS. EMMA W.
Spencers Memorial Hospital, Dayton

STEILBERG, LAVONA M.
St. Anthony Hospital, Louisville

STREITBERGER, MRS. LOIS E.
Rm. 17, State House, Des Moines, Iowa

TAYLOR, ANNE D.
Louisville General Hospital, Louisville 2

TROUT, DESSIE M.
1213 Holman St., Covington

TUCKER, CARRIE
210 Brown La., Louisville

TYLER, MRS. MARJORIE C.
Kentucky Baptist Hospital, Louisville 4

VINCENT, HELEN
Kentucky Baptist Hospital, Louisville 4

WHITE, ORA
2214 Slaughter St., Louisville

WIEDMER, LOUISE
Good Samaritan Hospital, Lexington

WILKERSON, OLLIE E.
610 Barrett Ave., Louisville 4

WILSON, BEULAH M.
1 Alberta St., Ludlow

WILSON, MRS. EVELYN T.
Louisville General Hospital, Louisville 2

WILSON, FRANCES T.
247 E. Madison, Louisville

WINNINGHAM, MRS. ELIZABETH M.
1116 S. Brook, Louisville

WYLIE, MARTHA E.
Berea College Hospital, Berea

YOUNG, JANAC
Louisville General Hospital, Louisville 2

ABADIE, ELAINE R.
2529 Pontius St., New Orleans

ALFORD, JOAN
622 Esplanade Ave., New Orleans

AMANN, MRS. ANNA M.
536 Belleville St., Algiers 14

ANDERS, BERTHA M.
Our Lady of the Lake Sanitarium, Baton Rouge

ANDRE, BEVERLY
7135 Erwinada Ave., Reseda, Calif.

ARTHUR, MRS. LILLIAN K.
3287 Dixie Garden Dr., Shreveport

LOUISIANA—266
ATKIN, MRS. ALICE A.  
2220 Cherokee St., Baton Rouge

BAGLEY, SHIRLEY L.  
1127 Louisiana Ave., Baton Rouge 10

BATSON, MRS. ALINE C.  
1315 State St., New Orleans 15

BEAN, MRS. JUANITA H.†  
2304 McCutcheon, Shreveport

BERNARD, LAURENCE  
1316 Milan St., New Orleans 15

BISHOP, MRS. HILDA R.  
Tri-State Hospital, Shreveport

BLOMFIELD, TOMMIE N.  
Tri-State Hospital, Shreveport

BLUE, REGINALD E.†  
Tri-State Hospital, Shreveport

BOOTH, MRS. IVY R.  
941 Ratchiff St., Shreveport

BOURG, CATHERINE M.  
2921 Tulane Ave., New Orleans

BRADY, MRS. LOLA D.†  
4250 Rightway, Shreveport

BRINK, MRS. HENRIETTA B.  
2502 Pine St., Apt. C, New Orleans 18

BRITT, VIRGINIA M.†  
5400 Jefferson Hwy., New Orleans 20

BRITTAINT, TRUDIE  
1233 Murphy St., Shreveport

BROWN, MRS. HELOISE B.  
1731 Goldenrod St., Baton Rouge

BURNHAM, HILDA C.  
1310 Josephine St., New Orleans 13

CAIN, SUE  
Graduate Nurses Home, Charity Hospital, New Orleans 12

CALENDER, MRS. TINY M.  
820 Longwood Dr., Baton Rouge 12

CANDELLA, JOSEPHINE M.  
3807 Gentilly Blvd., New Orleans

CANTLEY, MARGUERITE  
Veterans Administration Hospital, Shreveport

CANTWELL, SOPHIA L.  
4814 Pht St., New Orleans

CAPDEVIELLE, MRS. MABEL F.  
501 Convention St., Baton Rouge 8

CARNAHAN, JULIE M.  
2206 Nashville Ave., New Orleans

CARNES, DORIS  
4506 Evangeline St., Baton Rouge

CARRIERE, THEODA N.  
673½ N. Sixth St., Baton Rouge

CARTENS, NOELIE  
3416 St. Andrew St., New Orleans 13

CARTER, MELBA  
2151 General Taylor St., New Orleans

CAUSEY, CHRISTINE  
3526 Second St., New Orleans 13

CHAPMAN, JIMMIE LOIS  

CHAUDOIR, CATHERINE E.  
7039 Freer St., New Orleans 18

CHOAT, MRS. LOUISE C.  
1014 S. 18 St., Baton Rouge

CLARK, MRS. HAZEL C.  
2427 Honeyuckle Ave., Baton Rouge

COLVIN, MRS. H. J.†  
State Dept. of Education, Baton Rouge

CONRAD, MRS. PEARL M.  
3855 Johnson St., New Orleans 20

DANLEY, HELEN M.  
U. S. Marine Hospital, New Orleans 15

DASPIT, MARY  
3208 Trafalgar St., New Orleans 19

DAVIS, CLARA M.  
2321 Canal St., New Orleans

DELEY, EDNA L.  
1327 Broadway, New Orleans 18

DERRICK, MRS. JANELLA L.  
448 Audubon Blvd., New Orleans

DEWITT, MAREE*  
Veterans Administration Hospital, Shreveport

DOPP, ALTHEA E.  
Touro Infirmary, New Orleans 15

DOYLE, WINNIE  
1526 Louisiana Ave., New Orleans

DUGAS, VIRGINIA M.  
Hotel Dieu, New Orleans

DURAND, CLAIRE C.  
2810 Robert St., New Orleans

EAKIN, MRS. SULA J.  
3014 Louisiana Ave., New Orleans 15

EMERSON, MRS. EDMONIA C.  
4225 S. Tonti St., New Orleans

ENGELS, ANNA M.  
3500 Prytania St., New Orleans 15

FABREGAS, MRS. SUE  
450 S. Claiborne Ave., New Orleans 13

FERNANDEZ, MRS. MILDRED B.  
6553 General Meyers St., Algiers

FLYNN, MRS. MARY E.  
2242 Baronne St., New Orleans 13

FLYNN, MARY J.  
2151 Cедardale Ave., Baton Rouge

FONTENOT, LEVIA  
1541 Tulane Ave., New Orleans 12

FORTE, JOSEPHINE  
507 S. Rendon St., New Orleans

FOX, MARIAN L.  
Veterans Administration Hospital, New Orleans 12

FRY, MRS. LOUISE G.  
302 Merrick St., Shreveport

FUCLER, ELIZABETH F.  
3308 Prytania St., New Orleans 15

GARRITY, RITA A.  
2324 N. Prieur St., New Orleans 17

GEIST, M. ARGENTA, SANO(R)  
U. S. Marine Hospital, New Orleans 18

GERNHAUSER, GLORIA R.  
3421 Canal St., Apt. 1, New Orleans 19

GIBBS, SUE*  
Tri-State Hospital, Shreveport

CINN, MRS. LEONA C.  
1710 Robert, New Orleans

GIROIR, MRS. HATTIE C.  
2820 General Pershing St., New Orleans 15

GRAFTON, GRACE  
3910 Canal St., New Orleans 19

GRANT, MRS. KATHERINE W.  
2716 Coliseum St., New Orleans 13

GRAY, MRS. CLAIRE D.  
5870 Convention St., Baton Rouge

GREEN, MRS. ANNIE M.  
1235 Murphy St., Shreveport

GRIFFIN, MRS. BARBARA B.  
3169½ Esplanade Ave., New Orleans

GRIFFITH, MRS. ANNA†  
2600 Greenwood Rd., Shreveport 2

LOUISIANA
GROSS, SHIRLEY R.
1541 Tulane Ave., New Orleans 12

GUESS, EVELYN J.
2700 Napoleon Ave., New Orleans 15

GUICE, STELLA R.
2700 Napoleon Ave., New Orleans 15

GUIDRY, LOUISE M.
454 Boulevard St., Shreveport

CUITREAU, MRS. DINA J.
7273 Canal Blvd., New Orleans

HALL, RUBY M.
2605 Lillian St., Shreveport

HAMILTON, GERTRUDE
Tri-State Hospital, Shreveport

HARPER, MRS. MARY L.
3754 Convention St., Baton Rouge

HIGGINOTHAM, MARY L.
1921 Doris St., Shreveport

HICNER, AGNES C.
210 State St., New Orleans 15

HIXON, NELWYN
5 Jordan St., Alexandria

HOLLIER, FABIOLA
1541 Tulane Ave., New Orleans 12

HOLLINGSWORTH, MRS. NELLA A.
1728 Tulane Ave., New Orleans

HOLZKNECHT, WILLIE M.
1541 Tulane Ave., New Orleans 13

HOOVER, MRS. MARY R.
2920 Centenary, Shreveport

HOWER, MRS. SHIRLEY C.
235½ S. Gayoso St., New Orleans 19

HUNTER, MRS. LOUISE W.
2440 Willow St., Baton Rouge 7

JANVIER, CELESTE
Touro Shakespeare Home, Algiers 14

JEFFERS, LILLIAN
5520 Hawthorne Pl., New Orleans 14

JOHNSON, MRS. EMERANTE R.
8305 Palm St., New Orleans 18

JOHNSON, MARY E.
1708 Gilbert St., Alexandria

JOHNSON, MRS. MARY L.
Tri-State Hospital, Shreveport

JONES, OLLIE
803 Jordan St., Shreveport

JONES, SARAH
3308 Prytania St., Apt. 6, New Orleans 15

KELLER, ELEANOR
617—20 St., Apt. A, Alexandria

KELLY, MRS. HETTY M.
5774 Burgundy St., Baton Rouge

KOBLEUR, MARY A.
1117 N. Rampart St., New Orleans

KOEHNG, MARY E.
Charity Hospital, New Orleans 13

LAFFLEUR, MARY E.
1541 Tulane Ave., New Orleans

LAMBRKAKIS, MRS. LORIANA
955 W. Carfield St., Baton Rouge

LANDRY, ROSA L.
Our Lady of the Lake Sanitarium, Baton Rouge

LANDRY, SONIA
530 Exchange Pl., New Orleans

LARY, ELSIE M.
Tri-State Hospital, Shreveport

LAWRENCE, MRS. ANNE O.
Veterans Administration Hospital, Alexandria

LAWRENCE, GERALDINE
1541 Tulane Ave., New Orleans 12

LABLANC, MRS. LOREE L.
3135 Jefferson Ave., Baton Rouge

LEONARDOS, MRS. DOROTHY E.
Veterans Administration Hospital, New Orleans

LINDAUER, MRS. ROSE H.
163 E. Oakridge Pk., New Orleans 20

MAILLON, MERYL M.
7039 Frere St., New Orleans 18

MAJCHRAK, VERONICA
Louisiana State University, New Orleans

MARSHALL, MRS. NELL N.
Tri-State Hospital, Shreveport

MASK, MRS. WILLIE I.
Charity Hospital, New Orleans 13

MATHER, HARRIET L.*
Southern Baptist Hospital, New Orleans 15

MAUFFRAY, MRS. TELMA S.
Charity Hospital, New Orleans 13

MC CANTS, CORNELIA
1019 North St., Baton Rouge

MC COY, MRS. ENID E.
728 St. Charles St., Baton Rouge 10

MCGINTY, LENNIE V.
Pines Sanitarium, Route 3, Box 81, Shreveport

MCKAY, MRS. FLORENCE W.
P.O. Box 931, Baton Rouge

MECHE, JEANNETTE J.
2309 Somalia St., Baton Rouge

MELCHERT, LEAH A.
1110 Valmont St., New Orleans 15

MENDOZA, MRS. ROSALIE M.
6314 Peoples Ave., New Orleans

MEYER, HELEN A.
Touro Infirmary, New Orleans

MEYERS, MRS. DELLA E.
935 Government St., Baton Rouge 10

MILLER, MARY M.
2317 Palmyra St., New Orleans 19

MILLER, MRS. RITA E.*
2601 Gentilly Blvd., New Orleans 19

MONTGOMERY, ROBERT R.
4401 Duplessis St., Apt. B, New Orleans 22

MORRISON, MRS. SHIRLEY T.
2609 Napoleon Ave., New Orleans 15

MOLE, MRS. ETHEL J.
2006 Carondelet St., New Orleans 13

NASH, MRS. SAIDE S.
450 S. Claiborne Ave., New Orleans

NEWBIL, MRS. KATHERINE W.
Touro Shakespeare Home, Algiers, New Orleans

NEWELL, AGNES M.
1117 N. Rampart St., New Orleans

NEWMAN, MRS. PEARL M.
Shreveport Charity Hospital, Shreveport 6

NOBLES, NATALIE M.
P.O. Box 1097, Shreveport

NUNZI, CHARLENE P.
4619 Western St., New Orleans

O'CONNOR, STELLA
357 Vincent Ave., New Orleans 20

ODOM, BARBARA W.
3230 Octavia St., New Orleans

OLSTAD, MYRTLE
Veterans Administration Hospital, Alexandria

PARENTY, MRS. MAE M.
2529 Audubon St., New Orleans 18
PAYNE, MOZELLE
604 Metairie Rd., New Orleans 20

PENWELL, NETTIE J.
Our Lady of the Lake Sanitarium, Baton Rouge

FERRUE, MRS. MARJORIE F.
2339 Madison Ave., Baton Rouge 2

FERRIS, MRS. LOUISE A.
Tri-State Hospital, Shreveport

PETERSON, KAREN M.
430 Louisiana Ave., New Orleans 15

PHILLIPS, MARY L.
Tri-State Hospital, Shreveport

PIERCE, HAZEL
11 San Mateo Ave., New Orleans 21

PIERCE, ROWENA
Veterans Administration Hospital, New Orleans

PINSON, MRS. CLADYS B.
Highland Sanitarium, Shreveport

POPHAM, LOUISA
2528 Octavia St., New Orleans 15

PORTER, MRS. JOYCE M.
Caddo-Shreveport Health Unit, Shreveport

POWELL, EUNICE B.
3700 Napoleon Ave., New Orleans 15

PRICE, IDA G.
Northwestern State College, Box 1075, Natchitoches

PRICE, MARGARET A.
5510 Pinedmont Dr., New Orleans 17

PRIMM, MARIE C.
2024 N. Jena St., New Orleans 15

POTOMEY, MRS. ETHEL L.
4752 Lafaye St., New Orleans 17

PURIFOY, MRS. LOUISE R.
Tri-State Hospital, Shreveport

QUINN, THELMA J.
4735 Blue Bonnett Rd., Baton Rouge

RABELAIS, GERTRUDE M.
4155 St. Vincent Ave., Shreveport

RAPPAPORT, JOSEPHINE
1211 Murphy St., Shreveport

RARDIN, PATRICIA
450 S. Claiborne Ave., New Orleans 12

REICH, LOTTIE E.
832 Governor Nicholls St., New Orleans

RICHARD, VERA M.
413 Aurora Ave., Metairie Ridge, New Orleans

ROBERSON, EYE M.
564½ Napoleon Ave., New Orleans 15

ROBERTSON, UNA E.
2728 General Ogden St., New Orleans

RODRIGUE, ROSALIE M.
450 S. Claiborne Ave., New Orleans 12

RODRIQUE, MRS. HILDA L.
2700 Napoleon Ave., New Orleans 15

ROUSELL, ELLA
1541 Tulane Ave., New Orleans 13

RUSELL, MRS. SARAH M.
191½ Napoleon Ave., New Orleans 15

SAMPSON, MRS. JESSIE W.
706 Ratcliff St., Shreveport

SAWYER, MRS. LUCILLE T.
Caddo-Shreveport Health Unit, Shreveport

SCHIFANI, NICKIE M.
1806 N. Gayena St., New Orleans

SHEEHAN, MRS. HELEN W.
2327 Government St., Baton Rouge

SHEPPARD, MRS. ELIZABETH H.
101 E. 73 St., Shreveport

SHORT, FLORENCE H.
126 E. Egan St., Shreveport 18

SICARD, MRS. CATHERINE K.
6146 Catina St., New Orleans 19

SISTER ALOYSIUS
Hotel Dieu, New Orleans 13

SISTER ANGELA
1038 Henry Clay Ave., New Orleans 15

SISTER ANN ELIZABETH
U. S. Marine Hospital, Carville

SISTER BRIGIDA
St. Francis Sanitarium, Monroe

SISTER CAMILLA
Charity Hospital, New Orleans 12

SISTER CARLOS McDONNELL
De Paul Sanitarium, New Orleans 15

SISTER CATHERINE CHERNICK
De Paul Sanitarium, New Orleans 15

SISTER CELESTE
De Paul Sanitarium, New Orleans 15

SISTER CELESTINE
Hotel Dieu, New Orleans 13

SISTER EDITH
2004 Tulane Ave., New Orleans

SISTER EUGENIA
Hotel Dieu, New Orleans 13

SISTER FLORENCE
Charity Hospital, New Orleans 12

SISTER GENEVIEVE
Hotel Dieu, New Orleans 13

SISTER GERALD
Hotel Dieu, New Orleans 13

SISTER GERTRUDE
Charity Hospital, New Orleans 12

SISTER HENRIETTA DEDISSE
Our Lady of the Lake Sanitarium, Baton Rouge

SISTER HENRIETTA GUYOT
Charity Hospital, New Orleans 12

SISTER J. GABRIEL
Hotel Dieu, New Orleans 13

SISTER JULIANA
Charity Hospital, New Orleans 12

SISTER LAURENCE
Charity Hospital, New Orleans 12

SISTER LAURENTIA
Charity Hospital, New Orleans 12

SISTER MARGARET
Hotel Dieu, New Orleans 13

SISTER MARGARET MARY
Charity Hospital, New Orleans 12

SISTER MARGARET M. SUITS
Charity Hospital, New Orleans 12

SISTER MARIE DUBUISON
Hotel Dieu, New Orleans 13

SISTER MARIE EDANA
Our Lady of the Lake Sanitarium, Baton Rouge

SISTER MARIE MAGDALENE
Our Lady of the Lake Sanitarium, Baton Rouge

SISTER MARY AGNES
Mercy Hospital, New Orleans 13

SISTER MARY ALICE
U. S. Marine Hospital, Carville

SISTER MARY ANSELM
T. E. Schumpert Memorial Sanitarium, Shreveport

SISTER MARY CATALDIS
T. E. Schumpert Memorial Sanitarium, Shreveport

SISTER MARY CELESTE
Mercy Hospital-Soniat Memorial, New Orleans 13
SISTER MARY EDMUND
T. E. Schumpert Memorial Sanitarium, Shreveport

SISTER M. ELICIOUS
Charity Hospital, New Orleans 12

SISTER MARY GERTRUDE
St. Francis Sanitarium, Monroe

SISTER MARY HILDA
Mercy Hospital-Soniat Memorial, New Orleans 13

SISTER MARY IMMACULATE
Mercy Hospital, New Orleans 13

SISTER MARY IRENE
Mercy Hospital, New Orleans 13

SISTER MARY JACQUINE
Mercy Hospital, New Orleans 13

SISTER MARY JAMES
Charity Hospital, New Orleans 12

SISTER M. JANE
Mercy Hospital, New Orleans 13

SISTER M. JEANNE
Mercy Hospital, New Orleans 13

SISTER MARY JOHN
De Paul Sanitarium, Box 404, New Orleans 1

SISTER MARY JUSTINA
941 Margaret Pl., Shreveport

SISTER MARY KOSTKA
Mercy Hospital, New Orleans 13

SISTER M. MICHAEL
Our Lady of the Lake Sanitarium, Baton Rouge

SISTER M. PAUL
Charity Hospital, New Orleans 12

SISTER MARY OF ST. FRANCIS
Our Lady of the Lake Sanitarium, Baton Rouge

SISTER MICHAEL
Charity Hospital, New Orleans 12

SISTER PASCAL
St. Joseph’s Hospital, Alton, Ill.

SISTER PATRICIA
Charity Hospital, New Orleans 12

SISTER PAULINE BLALOCK
Charity Hospital, New Orleans 12

SISTER PETRONILLA
Charity Hospital, New Orleans 12

SISTER PHILIMENA
Our Lady of the Lake Sanitarium, Baton Rouge

SISTER RITA BOYLE
Our Lady of the Lake Sanitarium, Baton Rouge

SISTER ROSALIE
Charity Hospital, New Orleans 12

SISTER ST. MICHAEL
Our Lady of the Lake Sanitarium, Baton Rouge

SISTER ST. PATRICK
St. Francis Sanitarium, Monroe

SISTER SCHOLASTICA
Charity Hospital, New Orleans 12

SISTER STANISLAUS
Charity Hospital, New Orleans 12

SISTER TERESA
U. S. Marine Hospital, Carville

SISTER URBAN OBERLE
Charity Hospital, New Orleans 12

SLACK, L. CHRISTINA
Shreveport Charity Hospital, Shreveport

SMITH, MRS. ALMA J.
1705 Tulane Ave., New Orleans 17

SPURGEON, CARRIE M.
1316 Josephine St., New Orleans 13

STARNES, RACHEL R.
7512 Jeannette St., New Orleans 18

STORY, VIVIAN E.
Veterans Administration Hospital, Shreveport

STRAK, MARGARET M.
331 Joseph St., New Orleans 15

STUART, MARY E.
450 S. Glaborne Ave., New Orleans

SUMERAL, MRS. CORINNE F.
9337 Belfast St., New Orleans

TIBO, JULIE C.
1527 Seventh St., New Orleans 15

THOMAS, FRANCES M.
Route 2, Box 360, Port Allen

THOMPSON, NELL
923 N. Boulevard, Baton Rouge

THORNE, ADELE
Charity Hospital, New Orleans 13

THORPE, ANNIE L.
1235 Murphy St., Shreveport

TOYRIEN, DOROTHY P.
Northwestern State College, Box 1075, Nachitoches

TREUTING, EDNA
1128 Congress St., New Orleans

VARNADO, MRS. MARY W.
2006 Madison Ave., Baton Rouge

VAUTIER, MRS. TALLULAH M.
503 Passera Court, New Orleans 19

WALTERS, MRS. M. ORENE
Highland Sanitarium, Shreveport

WARD, MABEL D.
2700 Napoleon Ave., New Orleans

WARD, MRS. MAUDE S.
Tri-State Hospital, Shreveport

WELLMAN, THORA
Southern Baptist Hospital, New Orleans 15

WHEELSS, SADIE L.
Veterans Administration Hospital, Alexandria

WHITESIDE, MRS. GLADYS L.
1816 N. 15 St., Baton Rouge

WHITFIELD, MRS. NAOMA M.
1548 Irving Pl., APT. 5, Shreveport

WILLIS, MRS. EMMA G.
Tri-State Hospital, Shreveport 2

WOOD, MRS. MARIAN M.
7273 Canal Blvd., New Orleans

AUSTRIN, STELLA
76 Enfield St., Thompsonsville, Conn.

BARRON, MRS. EVELYN A.
1151 Brighton Ave., Portland 5

BEAN, MRS. INA G.
130 Longfellow St., Portland 4

BEAN, MARION N.
Maine General Hospital, Portland

BEAUDRY, BETTY A.
Augusta State Hospital, Augusta

BOOTH, MABEL F.
Eastern Maine General Hospital, Bangor

BRENNAN, MARIE J.
161 Pine St., Portland 4

BURNHAM, VIRGINIA M.
42 Orland St., Portland 4

MAINE—54
CHIPMAN, DRUCILLA
Box 926, Bangor

CLOUGH, MRS. FRANCES P.
224 State St., Bangor

CRIMMIN, FRANCES L.
Central St., Hallowell

DERBY, ELIZABETH M.
Augusta State Hospital, Augusta

DOANE, EDITH H.
22 Arsenal St., Portland 4

DUBOWICK, MRS. DOROTHY B.
54 Cash St., South Portland

DUNN, MARION L.
22 Arsenal St., Portland 4

EMERSON, GRACE B.
22 Arsenal St., Portland 4

FLAHERTY, AGNES E.
23 Bradley St., Portland

FRASER, MRS. GERTRUDE P.
Box 256, Bucksport

GERRISH, MARY J.
Eastern Maine General Hospital, Bangor

HILLS, MABEL H.
Central Maine General Hospital, Lewiston

JORDAN, FRANCES E.
79 Bramhall St., Portland

KNOWLTON, BARBARA E.
3046 Grove St., Augusta

KOHL, RUTH J.
284 Main St., Lewiston

LENZ, MILDRED
353 Main St., Lewiston

LERCH, AMANDA I.
Augusta General Hospital, Augusta

MARSHALL, ELIZABETH B.
Maine General Hospital, Portland

MARTINEAU, ALPHERIE J.
Sisters’ Hospital, Waterville

MELLEDY, ELEANOR M.
Central Maine General Hospital, Lewiston

MICHAUD, RITA
23 Clinton Ave., Waterville

MILLET, ARLENE F.
284 Main St., Lewiston

MITTON, ANNE
Eastern Maine General Hospital, Bangor

---

MONAGHAN, GENEVIEVE M.
Mercy Hospital, Portland

MOTT, KATHLEEN F.
Eastern Maine General Hospital, Bangor

MURPHY, DOROTHY
61 Deering St., Portland 4

NAWFEL, MRS. LOUISE K.
Eastern Maine General Hospital, Bangor

O'BRIEN, FRANCES V.
Mercy Hospital, Portland 3

RAGAN, MARY C.
57 Spruce St., Portland

RIDDLE, MRS. CATHERINE A.
27 Buchanan St., South Portland 7

SHANNON, IRENE D.
11 Graham Ave., Bangor

SISTER BINETTE
St. Mary’s General Hospital, Lewiston

SISTER BOUFFORD
St. Mary’s Hospital, Lewiston

SISTER M. ANNUNCIATA
Mercy Hospital, Portland 3

SISTER MARY CONSUELA
97 Military St., Houlton

SISTER MARY EDJUND
Sisters’ Hospital, Waterville

SISTER M. ELIZABETH
Madigan Memorial Hospital, Houlton

SISTER MARY MARCIA
144 State St., Portland 3

SISTER ST. JEAN VIANNEY
St. Mary’s General Hospital, Lewiston

SMYTHE, BERLA M.
Box 926, Bangor

SOUCIE, LORRAINE U.
1 School St., Brunswick

SULLIVAN, JULIA
Sisters’ Hospital, Waterville

WADDELL, EDITH
Presque Isle General Hospital, Presque Isle

WHITMORE, MRS. MARION P.
Augusta General Hospital, Augusta

WILLEY, MRS. ESTHER
8 Highwood St., Waterville

WITHEE, HELOISE E.
22 Arsenal St., Portland

---

ABBOY, MRS. JESSIE U.*
Baltimore City Hospitals, Baltimore 24

ABERNATHY, FRANCES
The Johns Hopkins Hospital, Baltimore 5

ADAMS, MARY S.
Sinai Hospital, Baltimore 5

ADAMSON, JANE
The Home for Incurables, Baltimore

AKERHURST, ALICE J.
2706 Mosher St., Baltimore 16

ALLEN, LETHA S.
1348 Dartmouth Ave., Baltimore 14

BANNHOF, MRS. CATHERINE L.
117 S. Artizan, Williamsport

BARRETT, LILLIAN M.
1213 Light St., Baltimore

BAY, DONNIE M.
3624 Greenmount Ave., Baltimore 18

BENCE, ARLENE
512 N. Washington St., Baltimore 5

BENCHOFF, LILLIAN R.
143 E. Antietam St., Hagerstown

BETZOLD, K., VIRGINIA
The Johns Hopkins Hospital, Baltimore 5

BISHOW, RAE
2208 Eutaw Pl., Baltimore 17

BOLIN, RICHARD E. W.
Springfield State Hospital, Sykesville

BORDANSKY, GOLDIE
1413 Park Ave., Baltimore 17

BOULTER, RUTH E.
1534 Park Ave., Baltimore 17

BOYER, HALCIE M.
The Johns Hopkins Hospital, Baltimore 5

BRADBURN, NAN E.
1560 Montpelier St., Baltimore 18

---

MARYLAND—276
BRADLEY, EVA M.
6 E. Read St., Baltimore 2

BRANNON, MRS. MAIDA S.
1514 Division St., Baltimore 17

BRITAIN, BERNICE E.
Peninsula General Hospital, Salisbury

BROOKS, MRS. GLADYS S.
211 Saratoga St., Cumberland

BROWN, MARGARET F.
2301 Kildaire Dr., Baltimore 14

BROWNLEY, JEAN
1563 Waverly Way, Baltimore 12

BUCHKO, ANNA
3300 Canterbury Rd., Baltimore 18

BUCK, MRS. ANNE K.
5018 Edmondson Ave., Baltimore 29

BUCKINGHAM, DOROTHY
3703 Nortonia Rd., Baltimore 16

BURTON, ALICE
Sheppard and Enoch Pratt Hospital, Towson 4

BUTENAS, MRS. CORDELIA P.
317-A E. Joppa Rd., Towson 4

BYRNES, MARY C.
3417 Ramona Ave., Baltimore 13

CAPLAN, FLORENCE B.
Riviera Apts., Apt. 4H, Baltimore 17

CLEMENTS, RUTH
Woman's Hospital, Baltimore 17

COCHRAN, ANN E.
620 W. Lombard St., Baltimore 1

COE, ELIZABETH B.
1901 E. 32 St., Baltimore 18

COLEMAN, IRENE J.
Sinai Hospital, Baltimore 5

CONLEY, VIRGINIA C.
206 Tunbridge Rd., Baltimore 12

CONRAD, CATHERINE C.
1812 Chilton St., Baltimore 18

COURTNEY, MARGARET E.
1525 E. North Ave., Baltimore 13

COVELL, MRS. CAROL W.
Washington St., Easton

COVER, CATHERINE B.
Hampton House, The Johns Hopkins Hospital, Baltimore 5

COXE, WINNIE A.*
Sinai Hospital, Baltimore 5

CREUTZBURG, FRED A.
Church Home & Hospital, Baltimore 31

CRONIN, ADELINE M.
2307 Cheswolde Rd., Baltimore 9

CUTHBERT, MRS. BETTY L.
512 N. Washington St., Baltimore 5

DALE, RUTH
519 N. Wolfe St., Baltimore 5

DAMPMAN, F. THEODORE
901 Tyson St., Baltimore 1

DARLEY, MRS. EVA F.
University of Maryland Hospital, Baltimore 1

DARNER, ALICE
Lutheran Hospital of Maryland, Baltimore 16

DARNER, DAISY
Frederick Memorial Hospital, Frederick

DASHAW, MRS. REBA G.
115 N. Allison St., Greenscastle, Pa.

DAY, AMY
Frederick City Hospital, Frederick

DEBRULE, MRS. LOIS W.
Maryland General Hospital, Baltimore 1

DeLAWTER, MARGARET T.
U. S. Marine Hospital, Seattle 14, Wash.

DILLER, DORIS
1518 Pentridge Rd., Baltimore 12

DODDS, DORIS I.
624 N. Broadway, Baltimore 5

DOERNER, MRS. ANNE T.
14 N. Johnson St., Cumberland

DOOLEY, MYRTLE
Baltimore City Hospitals, Baltimore 24

DUFFY, IRENE M.
1913 W. Fayette St., Baltimore 1

DUNLOP, MARY L.
Children's Hospital, Baltimore 11

DUNNELS, DOROTHY
Union Memorial Hospital, Baltimore 18

DUYER, ALICE C.
4232 Colborne Rd., Baltimore 29

EARP, MIRIAM O.
Maryland General Hospital, Baltimore 1

EBERLE, MARY E.
1924 Cecil Ave., Baltimore 18

ELDER, SUSAN V.
Children's Hospital, Gardner House, Boston, Mass.

ELGERT, ESTHER M.
Boys Ave., Towson 4

ELLICK, MARGARET
Church Home & Hospital, Baltimore 31

FARRELL, HELEN J.
Baltimore County Health Dept., Towson 4

FEE, RACHEL
1518 Pentridge Rd., Baltimore 12

FENNER, ISABELLE H.
Johnny Cake Rd., Baltimore 7

FETTER, SARA E.
State Dept. of Health, Division of Public Health Nursing, 2411 N. Charles St., Baltimore 18

FINLEY, MRS. DOROTHY J.
R.F.D. 1, Cumberland

FISHER, EMogene
519 N. Wolfe St., Baltimore 3

FISHPAUGH, ANNA E.
3706 N. Charles St., Baltimore 18

FISK, HELEN L.
Terrace Dale, Towson 4

FITZPATRICK, KATHRYN E.
Wards Chapel Rd., Owings Mills

FREEMAN, NORMA L.
3812 Hayward Ave., Baltimore 15

FRENCH, HELEN
1529 E. North Ave., Baltimore 13

FROTHINGHAM, RUTH C.
954 Argonne Dr., Apt. 1C, Baltimore 18

GARDNER, MAUD M.
James Lawrence Kernan Hospital, Baltimore 7

GARRISON, MRS. JESSIE N.
1812 N. Wolfe St., Baltimore 13

GASSAWAY, HELEN M.
Church Home & Hospital, Baltimore 31

GIPE, FLORENCE M.*
University of Maryland Hospital, Baltimore 1

GOLD, LOIS M.
594 Rosedown Ave., Baltimore 12

GOOCHE, ELLA E.
2292 Erdman Ave., Baltimore 13

GORDON, RITA L.*
Children's Hospital School, Baltimore 11

GRANDON, MARIORIE L.
Sinai Hospital, Baltimore 5

486
MEMBERS

GRANVILLE, EDITH
22 E. Madison St., Baltimore 2

GREEN, SARAH S.
4234 Baltimore Ave., Baltimore

GREENFIELD, R. LUCILLE
Box 155, APO 438, c/o PM, San Francisco, Calif.

GROTEFEND, MRS. MARY E.
1202 Longwood St., Baltimore 16

HAIR, KATHRYN N.
2453 W. Mosher St., Baltimore 16

HAMMOND, DORIS V.
206 Adams St., Salisbury

HAND, JEAN
Franklin Square Hospital, Baltimore 23

HARRIS, ELEANOR
Church Home & Hospital, Baltimore 31

HARVEY, FLORENCE M.
Spring Grove Hospital, Catonsville 28

HAWKINS, MARGARET R.
624 N. Broadway, Baltimore 5

HAYES, MARGARET L.
10 W. Biddle St., Baltimore

HEIM, MARCERITE
312 Parish Rd., Maplewood, La.

HILDEBRANDT, MARY A.
Baltimore City Hospital, Baltimore 24

HINES, ADA R.
620 W. Lombard St., Baltimore 1

HIRST, L. ELIZABETH
Richie State Hospital, Cascade

HOFFMAN, BERTHA
1750 E. North Ave., Baltimore 13

HOFFMAN, HARVINE W.
3715 Nortonia Rd., Baltimore 16

HOHNER, LOUISE A.
1560 Montpelier St., Baltimore 18

HOLMES, ANNA E.
597 Rossiter Ave., Baltimore 12

HOLLAND, BARBARA S.
204 W. Monument St., Baltimore 1

HUBBARD, MARIETTA L.
Washington Sanitarium & Hospital, Takoma Park, D. C.

HULSE, EVELYN M.
804 Regester Ave., Baltimore 12

HURT, MRS. ELIZABETH C.
South Baltimore General Hospital, Baltimore 1

INGRAM, DESSIE B.
The Johns Hopkins Hospital, Baltimore 5

JACOBY, ESTHER
624 N. Broadway, Baltimore 5

JOHNSON, MRS. GLADYS H.
850 W. 36 St., Baltimore 11

JOHNSON, MARTHA
The Johns Hopkins Hospital, Baltimore 5

JOHNSTON, MARY E.
Hampton House, The Johns Hopkins Hospital, Baltimore 5

JOSLIN, HELEN R.
126 S. Hilton St., Baltimore 29

KARLSSON, MRS. DORIS N.
3414 Elmora Ave., Baltimore 14

KERR, DOROTHY S.
Route 3, Box 26, Pasadena

KESSLER, ISABEL
513 N. Wolfe St., Baltimore

KING, GLADYS M.
2004 Letitia Ave., Baltimore 30

KIRKWOOD, EDNA K.
Falls Rd. & Benson Mill Rd., Upperco

KNOWLES, GRACE A.
4100 Idaho Ave., Baltimore 6

KRAMER, HELEN V.
28 S. Prospect Ave., Catonsville 28

KRIGEL, MRS. LEILA W.
132 Carroll Ave., Takoma Park 12, D. C.

KUHLMAN, AGNES
Baltimore City Hospitals, Baltimore 24

KUNTZ, MARY N.
624 N. Broadway, Baltimore 5

KVARNES, MARJORIE
412 Athol Ave., Baltimore 29

LANNING, EMMA I.
500 W. Montgomery Ave., Rockville

LARSEN, MAUD J.
U. S. Marine Hospital, Baltimore 11

LAWSON, MRS. ALMA M.
 Sinai Hospital, Baltimore 5

LAYFIELD, MRS. VIRGINIA B.
P.O. Box 46, Princess Anne

LEITHE, MRS. TAMSEY R.
2700 Elsmor Ave., Baltimore 16

LENHEER, ROMAINE
624 N. Broadway, Baltimore 5

LESTER, VIRGINIA B.
101 W. Monument St., Baltimore 1

LEWIS, ELEANOR W.
310 N. Poca St., Baltimore 1

LILLARD, EDITH R.
620 W. Lombard St., Baltimore 1

LINDGREN, MRS. ANNE H.
The Johns Hopkins Hospital, Baltimore 5

LIZER, JULIA R.
821 Maryland Ave., Hagerstown

LOEFLER, CATHERINE
The Johns Hopkins Hospital, Baltimore 5

LOWE, MRS. JULIA B.
1029 St. Paul St., Baltimore 2

LUTZ, RUTH H.
4301 Groveland Ave., Baltimore 13

LUXMORE, NADINE L.
792 Riverside Dr., Apt. 11-D, New York, N. Y.

MALLORY, CYNTHIA
723 N. Broadway, Baltimore 5

MASBACH, FLORES
Stevenson

MASS, M. LOUISE
Washington County Hospital, Hagerstown

MASON, GEORGE W.
Ellenham Rd., Riderwood

MAY, BERNICE
647-41 Ave., San Francisco, Calif.

MAY, DELLA
Baltimore City Hospitals, Baltimore 24

McBRIDE, MRS. DOROTHY F.
2 W. Second St., Frederick

McCARTY, HELEN B.
4940 Eastern Ave., Baltimore 24

McCoy, EILEEN R.
324 Castle Dr., Baltimore 12

MCGOVERN, CLARA M.
4225 Wickford Rd., Baltimore 10

MCKEAN, MIRIAM
369 Evesham Ave., Baltimore 12

MCKINNAN, MRS. MARGARET C.
523 N. Washington St., Baltimore 5
THUMA, MARION E.  
Veterans Administration Hospital, Fort Howard  

TURNER, ETHEL  
11 S. Belle Grove Rd., Baltimore 27  

TYSON, MARGARET C.  
1413 Park Ave., Baltimore 17  

ULRICH, GERTRUDE E.  
2211 Kirk Ave., Baltimore 18  

VANDE GRIFT, MRS. DOROTHY E.  
211 Ridgemede Rd., Baltimore 10  

VAN HORN, LENA E.  
Baltimore City Hospitals, Baltimore 24  

VICKERS, ELIZABETH V.  
Preston  
von MAUCHER, MRS. DOROTHEA S.  
617 N. Augusta Ave., Baltimore 29  

WALKER, CHARLOTTE  
3921 Edmondson Ave., Baltimore 29  

WALLACE, MRS. MARIAN A.  

WALLER, THEO P.  
120 N. Broadway, Baltimore 31  

WALLIS, LUCILLE A.  
300 E. 31 St., Baltimore 18  

WARDER, ANNA M.  
The Johns Hopkins Hospital, Baltimore 5  

WENCER, PHYLLIS A.  
Franklin Square Hospital, Baltimore 23  

WHEATLEY, DOROTHY L.  
2738 Edmondson Ave., Baltimore 23  

WHITE, GLADYS H.  
S. Washington St., Easton  

WHITEHOUSE, MRS. NELLIE H.  
3301 N. Calvert St., Baltimore 18  

WHITESIDE, FAYE  
The Johns Hopkins Hospital, Baltimore 5  

WILLIAMS, ELENA E.  
Preston Apts., Baltimore 2  

WILLIAMS, KATHRYN E.  
620 W. Lombard St., Baltimore 1  

WILSON, EVA G.  
240 E. Montgomery St., Baltimore 30  

WINSTEAD, BETTIE L.  
6501 Maplewood Rd., Baltimore 12  

WOLF, ANNA D.*  
The Johns Hopkins Hospital, Baltimore 5  

WOMER, FRANCES N.  
3428 University Pl., Baltimore 18  

WORTHINGTON, ELIZABETH H.  
3405 Greenway, Baltimore 18  

YAVITZ, MRS. SYLVIA D.  
2204 Bryant Ave., Baltimore 17  

ZEC, B. MARIE  
10 E. Biddle St., Baltimore 2  

ZITKUS, CECILIA M.  
University of Maryland Hospital, Baltimore 1  

---  

MASSACHUSETTS—620  

AIKINS, HELEN L.  
67 Stetson St., Hyannis  

ALBERTI, LOUISE M.  
14 Jaques St., Somerville 45  

ALLEN, MARY P.  
28 Goodrich Rd., Jamaica Plain 30  

AMOROSO, ALMA E.  
209 Bacon St., Natick  

---  

ADAMS, ELIZABETH  
7 Bowers St., Newtonville 60  

ADAMS, ETHEL M.  
Beth Israel Hospital, Boston 15  

ADAMS, RACHEL T.  
The Boston Dispensary, Boston 11  

AHERN, ELIZABETH G.  
48 Beacon St., Arlington 74  

---  

489
AMOS, MARGARET L.  
65 Walter St., Roslindale 31

ANDERSON, ALICE E.  
109 Francis St., Worcester 6

ANDERSON, IRIS  
85 Barber Rd., Framingham

ANDREWS, MRS. MARIE S.  
132 Main St., Watertown

ANKUDOWICZ, MARY A.  
745 Massachusetts Ave., Boston 18

ARMY, MADELINE J.  
110 Massasoit Ave., Worcester 4

ARONSON, MABEL V.  
109 Bellingham St., Chelsea 50

ATTELLA, MARGARET M.  
16 Goulding St., Worcester 2

ATTO, LT. COL. KATHLEEN H.  
Veterans Administration Hospital, Northampton

BACHAND, DOROTHY L.  
352 Riverway, Boston 15

BALDWIN, GERTRUDE L.  
443 Northampton St., Buffalo, N. Y.

BALLAM, RUTH D.  
66 Berkeley St., Boston 16

BARRY, ELIZABETH E.  
376 Riverway, Boston 15

BATCHelder, HILDA  
Newton-Wellesley Hospital, Newton Lower Falls 62

BATES, BARBARA  
729 Chestnut St., Springfield 5

BATTISTA, ANGELA A.  
31 Maple St., Clinton

BEAL, LUCY H.  
40 Hickory Cliff Rd., Newton Upper Falls 64

BEHR, EDYTH V.  
Cooley Dickinson Hospital, Northampton

BEHYMER, ALICE F.  
857 Beacon St., Boston 15

BERG, SERENE  
323 Longwood Ave., Boston 15

BERNARD, ROSE K.  
573 Hood St., Fall River

BERTOZZI, EMMA  
66 Harrison St., Framingham

BETHARD, MARY T.  
460 Huntington Ave., Boston 15

BEVERLY, MARY M.  
29 Chestnut St., Worcester

BICKFORD, GOLDIE M.  
Northampton State Hospital, Northampton

BIGELOW, DOROTHY E.  
157 Richmond Ave., Worcester 2

BILLS, EVELYN E.  
51 Walnut Ave., Andover

BLAISDELL, NELLIE G.  
56 Perham St., West Roxbury

BOGOSIAN, JULIA  
114 Second St., Medford 55

BOMBARD, MRS. PAULINE L.  
Veterans Administration, Quonset 20, Northampton

BOREK, EMILIE M.  
19 Easton St., Brookline 46

BOURASSA, ALICE M.  
10 Seconinut Neck Rd., Fairhaven

BOWEN, ELEANOR P.  
22 Pilgrim Rd., Wellesley 81

BOWEN, FRANCES W.  
113 St. Stephen St., Boston 15

BOWLES, HAZEL H.  
115 Elm St., Northampton

BOYLE, MARGARET L.  
6 Sturges St., Worcester 5

BRACE, MRS. HELEN R.†  
1184 South St., Charles River

BRADY, ALTHEA E.  
586 Lexington St., Waltham 54

BRAGDON, JANE S.  
14 Upland Ave., Bradford

BRAXTON, MABEL B.  
13 Chesterton St., Roxbury 19

BREGA, AMELIA A.  
Veterans Administration Hospital, Rutland Heights

BREEOR, ELIZABETH A.  
Veterans Administration Hospital, West Roxbury

BRIDGES, JEAN  
3 Blackfan St., Boston 15

BRIEF, ANNA S.  
Leominster Hospital, Leominster

BRIGGS, PEARL S.  
Howard St., Norton

BRILLARD, MRS. ELIZABETH  
Beth Israel Hospital, Boston 15

BRISSETTE, MRS. NANCY R.  
223 North St., Salem

BROOKS, ETHEL C.  
125 Myrtle St., Boston

BROPHY, BERENICE E.  
St. Luke's Hospital, New Bedford

BROWN, FLORENCE M.  
330 Mount Auburn St., Cambridge 38

BROWN, GEORGE D.  
235 Beacon St., Boston

BROWN, NORA H.  
Miss Halls School, Pittsfield

BROWN, PAULINE  
221 Longwood Ave., Boston 15

BROWNHILL, HELEN E.  
733 Harrison Ave., Boston 18

BROWNLIE, DR. ROBERT E.†  
1380 Beacon St., Brookline

BRYANT, L. HELEN  
2014 Washington St., Newton Lower Falls 62

BRYANT, MARION E.  
Union Hospital, Fall River

BURGESON, ELSIE M.  
184 Leach Ave., Brockton 32

BURKE, DOROTHY S.  
Briggs Rd., North Westport

BURNS, MARGUERITE E.  
17 Oak St., Hopedale

BUSCH, MARGARET J.  
Springfield Hospital, Springfield 5

CABANA, MRS. MAFFRED W.  
25 Shirley St., Worcester

CAMERON, ETHEL M.  
New England Baptist Hospital, Roxbury 20

CAMPBELL, CAROLYN E.  
443 Summer Ave., Reading, Pa.

CAMPBELL, DORIS E.  
8 Sargent Ave., Fitchburg

CAMPBELL, KATHARINE A.  
25 Evergreen St., Framingham

CARLTON, ELIZABETH G.  
138 Pleasant St., E. Bridgewater

CARNEY, ELEANOR G.  
74 Fenwood Rd., Boston
CARROLL, MATILDA
55 Commonwealth Ave., Boston
CARRUTHERS, ALTHEA H.
352 Eagle St., North Adams
CARTER, LILLIAN F.
Veterans Administration Hospital, Framingham
CARTER, VIOLA K.
Holyoke Hospital, Holyoke
CARTLAND, MILDRED H.
19 Goodway Rd., Jamaica Plain 30
CASHMAN, RAE P.
110 Marlanna St., Lynn
CASS, DR. JOHN W., JR.d
1101 Beacon St., Boston 46
CASS, MRS. MARIE MADELINE S.d
63 Longfellow Rd., Wellesley Hills 82
CASWELL, PHILLIS E.
Peter Bent Brigham Hospital, Boston 5
CHACE, MARION M.
322 St. Paul St., Apt. 2, Brookline 46
CHALMERS, FLORENCE
710 Massachusetts Ave., Boston 18
CHENEY, KATHRYN
3 Blackfan St., Boston
CHISHOLM, ELIZABETH R.
213 Billings St., North Quincy 71
CHRISTIE, JANIE C.
18 Autumn St., Boston 15
CLAPP, MARY J.
128 State St., Shelburne Falls
CLARK, RUTH L.
R.F.D., 7 Heffernan St., Northampton
CLELAND, GERTRUDE V.
206 Riverway, Boston
COE, ALICE B.
Milford Hospital, Milford
COLE, HARRIET E.
125 Greenwood St., Marlboro
COLEMAN, GENEVIEVE C.
Veterans Administration Hospital, Framingham
COLLINS, MARY T.
14 Perkins Ave., Malden 48
COLSON, MRS. MAE D.
57 Massachusetts Ave., Longmeadow 6
CONEY, KATHERINE
9 Howe St., Dorchester
CONGER, SARA M.
New England Sanitarium & Hospital, Melrose 76
COKLIN, MARY C.
Old Randolph St., R.F.D., Canton
CONNOR, ANN B.
McLean Hospital, Waverley
CONNORS, VIOLET E.
12 William St., Wellesley Hills 82
COOK, DR. WARREN F.d
New England Deaconess Hospital, Boston 15
CORBETT, S. DAPHNE
Faulken Hospital, Jamaica Plain 30
CORKUM, ADELE L.
2 Anderson Pl., Boston 14
COUGHLIN, DOROTHY V.
230 Roslindale Ave., Roslindale 31
COURTEMANCHE, MILDRED H.
1137 Center St., Jamaica Plain 30
COUTU, MRS. KATHLEEN C.
6 Ashburnham Rd., Worcester
CRACIN, ELLA O.
Laconia Hospital, Laconia, N. H.
CRAN, MARY L.
46 Somerset Rd., West Newton 65
CREED, CLARA E.
864 Broadway, Chelsea 50
CREPEAU, MRS. ELLA C.
21 Queen St., Worcester 3
CROSS, NEVA K.
Veterans Administration Hospital, Framingham
CROSSLEY, MARYTHA I.
79 Elm St., Worcester
CROSSMAN, DORICE I.
13 Pearl St., Clinton
CROTTY, ANNA M.
32 Fruit St., Boston 14
CROWE, GRACE L.
749 Highland Ave., Malden
CURTIS, HELEN
142 Margin St., Lawrence
DACEY, MARION L.
Veterans Administration Hospital, Framingham
DALLMEYER, MARJORIE
48 Holmes Rd., Pittsfield
DALTON, ALICE R.
Veterans Administration Hospital, West Roxbury 32
DANIEL, MRS. ELIZABETH C.
Westboro State Hospital, Westboro
DAVIS, ALICE L.
19 Grove St., Worcester
DAVIS, DORIS A.
7 W. Oberlin St., Worcester
DAWES, DOROTHY E.
15 Field Rd., Arlington 74
DCECCA, MINNIE B.
105 Stoughton St., Boston
DeCHENE, THERESE R.
120 Cranch St., Quincy 69
DE LONG, BERTHA
Toehy Hospital, Wareham
DEMPSEY, MRS. MARY S.
48 Dunster Rd., Jamaica Plain
DEROCHES, CECILE
Veterans Administration Hospital, Rutland Heights
DEVANE, GRACE C.
274 Lexington St., East Boston 28
DIETER, MARGARET
100 Milton St., Northampton
DIGGON, VIRGINIA O.
102 St. Mary's St., Boston 15
DILL, MADELINE F.
Veterans Administration Hospital, Box 125, Rutland Heights
DILLMAN, VIRGINIA S.
918 Belmont St., Watertown 72
DIXON, DOROTHY E.
20 Cliff St., Malden
DOBBS, C. KENDALL
30 King St., Worcester 3
DODGE, MILDRED E.
Veterans Administration Hospital, Framingham
DOHERTY, KATHRYN
106 Robertson St., Quincy 69
DONAHUE, MARY E.
10 Murray Hill Pk., Malden 48
DONOHUE, MARY C.
48 Eureka St., Worcester
DOWLING, MRS. ANN K.
Carney Hospital, Boston 27
DOWLING, GERTRUDE A.
Massachusetts Hospital School, Canton

MASSACHUSETTS
DOWNING, PHYLLIS G.
319 Commonwealth Ave., Boston

DRISLAM, WINIFRED J.
Cambridge City Hospital, Cambridge

DUFFORD, ESTHER D.
Metropolitan State Hospital, Waltham

DUHUNE, MRS. LIVIA R.
St. Luke’s Hospital, New Bedford

DUKESHE, MELBA
68 Louis Prang St., Boston 15

DUNBAR, CONSTANCE A.
333 Longwood Ave., Boston 15

DUNCAN, ELLEN T.
220 Fisher Ave., Boston 20

DUNN, AMELIA F.
100 Stanley St., Fall River

DUNPHY, BARBARA A.
6 Adella Ave., West Newton 65

DURHAM, GEORGE B.
McLean Hospital, Waverley 79

DYE, GERTRUDE E.
Boston City Hospital, Boston 18

EASTER, ETHEL M.
97 Mt. Vernon St., Boston

EDDY, MARION F.
220 Fisher Ave., Boston 20

EDMUNDS, VERENA H.
52 Hereford St., Boston

EGAN, BRIDGET M.
Veterans Administration Hospital, Framingham

EGAN, SHIRLEY A.
83 Allis St., Nashua, N. H.

EKENGREN, LAURA E.
6 Prospect St., Beverly

ELLIS, CLARA B.
North Reading State Sanatorium, North Wilmington

EMERSON, ELEANOR A.
Salem Hospital, Salem

ENGLUND, HILDUR
270 Brookline Ave., Boston

ENNIS, MILDRED C.
710 Massachusetts Ave., Boston

ENRICHET, EILEEN
48 Oak Square Ave., Newton 35

ERICSON, VIRGINIA M.
Memorial Hospital, Worcester 5

ESTER, MRS. LOIS B.
College Highway, Southhampton

EVERETT, MARION J.
270 Huntington Ave., Boston 15

FAHEY, JANET M.
12 Granite St., Wellesley 81

FALCON, CERTRUDE M.
30 Hancock St., Salem

FARRELL, HONORA K.
24 St. Elmo Rd., Worcester

FARRELL, MARIE*
71 Wingham Rd., Newtonville 60

FARRINGTON, ARLENE L.
Veterans Administration Hospital, Rutland Heights

FARRINGTON, MARGARITA M.
12 Bremore Rd., Newton

FAY, AGNES I.
48 Ashland St., Lynn

FERGUSON, PHYLLIS T.
49 Cedar St., Roxbury 19

FERRIS, GRETA M.
Newton-Wellesley Hospital, Newton Lower Falls 62

FERRIS, LULU E.
Lowell General Hospital, Lowell

FIDDLES, RITA H.
21 Lake St., Webster

FINLAY, DAISY A.
8 Walcott St., Malden

FITZGERALD, ESTHER H.
1323 Broadway, Somerville

FITZGERALD, HELEN E.
Northampton State Hospital, Northampton

FITZGERALD, MARY
37 Prospect St., Northampton

FITZPATRICK, CONSTANCE Y.
University of Massachusetts, C-1, Federal Circle, Amherst

FLEMING, ELEANOR C.
130 University Rd., Brookline

FLETCHER, MELISSA F.
Boston City Hospital, Boston 18

FLORES, FLORENCE
Massachusetts Memorial Hospital, Boston 18

FOLEY, MARY F.
8 Penhallow St., Dorchester 24

FOREST, RITA P.
12 Lewis Ave., Arlington 74

FRANCIS, MRS. GEORGE T.
250 Beacon St., Boston 16

FRATANTONIO, ANNA R.
Quincy City Hospital, Quincy

FULLER, MYRTICE L.*
Newton-Wellesley Hospital, Newton Lower Falls 62

GAFFNEY, ELEANOR A.
Tewksbury State Hospital & Infirmary, Tewksbury

GAIWISKI, MRS. MARY L.
172 Carew St., Apt. 6, Springfield

GALLO, CLARA
Veterans Administration Hospital, West Roxbury

GALLO, JOAN
131 Bridge St., Dedham

GARDNER, WILLETTA
1090 Beacon St., Brookline

GARRIGAN, MARY A.
11 Guernsey St., Marblehead

GARVEY, MARY A.
Somerville Hospital, Somerville 43

GATELY, MARGARET
149 South St., Jamaica Plain 30

GATINS, ALICE L.
710 Massachusetts Ave., Boston 18

GAUTHIER, MRS. VIRGINIA G.
26 Breed St., Lynn

GIBSON, WINIFRED M.
264 Bay State Rd., Boston

GIDDINGS, HELEN
44 Temple St., Boston 14

GIEFFIN, MARGARET C.
85 Osage Rd., Somerville 43

GILL, MRS. ELEANOR K.
65 Rock Meadow Rd., Westwood

GILL, HELEN Z.
222 Newbury St., Boston 16

GILLET, HARRIET M.
927 Walthington St., Springfield 5

GILLIS, VIRGINIA M.
240 Park St., Dorchester 24

GILLIS, M. ADELAIDE
434 Broadway, Lynn

GILMAN, MRS. JEANNETTE K.
Beth Israel Hospital, Boston

492
GILMORE, MARY C.
Beth Israel Hospital, Boston 15

GILMORE, MARY E.
150 Chestnut St., Boston

GILMORE, RUTH E.
65 Westchester Rd., Newton 58

GINSBERG, FRANCES
1441 Commonwealth Ave., Brighton

GOOSTRAY, STELLA
28 Hardy Ave., Watertown 72

COULD, ELIZABETH H.
220 Fisher Ave., Boston 20

COVONI, LAURA E.
19 Central St., Somerville 43

GRADY, FRANCES C.
291 Albion St., Wakefield

GRANEY, MARY W.
Faulkner Hospital, Jamaica Plain 30

GRANFIELD, GERTRUDE A.
1493 Cambridge St., Cambridge 39

GRANT, BEATRICE A.
10 Ethel Court, Malden 48

GREEN, PHYLLIS H.
1 Lancaster Ter., Worcester 2

GREINER, CHARLOTTE E.
New England Sanitarium & Hospital, Melrose 76

GRiffin, ROSE E.
Cooley Dickinson Hospital, Northampton

CRIMES, MRS. MARY C.
P.O. Box 94, Oxford

CRINDI, EDITH L.
Cooley Dickinson Hospital, Northampton

GRING, ANNA
204 Bay State Rd., Boston

CROGAN, ELIZABETH C.
51 Phillips St., Boston

CUT, E. GRACE
233 Beacon St., Boston

Haley, AVIS I.
Veterans Administration Hospital, Bedford

Hall, A. CHARLOTTE
Veterans Administration Hospital, Rutland Heights

HALL, ELIZABETH
Lynn Hospital, Lynn

HALL, ELIZABETH J.
85 Bluehill Pkwy., Milton 87

HANKINSON, KLARA M.
38 Autumn St., Boston 15

HARDEMAN, MARGARET K.*
Massachusetts General Hospital, Boston 14

HARDING, LT. ARLINE W. (Navy #3923)
c/o F.P.O., San Francisco, Calif.

HARDY, FERNE I.
Hospital Rd., Leominster

Harley, Muriel P.
42 Central Ave., Fitchburg

Harper, Eva M.
315 Massasoit Rd., Worcester 4

Harriman, Ione J.
Lawrence Memorial Hospital, Medford

Harrington, Ellenor E.
18 Acton St., Worcester 4

Harsberger, Jane Y.
3 Aberdeen St., Cambridge

Hastings, Marguerite
Pittsfield General Hospital, Pittsfield

Haviland, Barbara
5 Haven Rd., Braintree

Hayes, Janice E.
7 Circuit St., Roxbury

Haynes, Mrs. Una H.
46 N. Main St., South Hadley Falls

Hayward, Mrs. Dorothy S.
7 Garden Court, Cambridge 38

Hayward, Edna M.
Wesson Maternity Hospital, Springfield 2

Healey, Ada M.
8 Whitfield Rd., Somerville 21

Healey, Margaret E.
223 Main St., North Easton

Healy, Eleanor E.
21 Dale St., Worcester

Heath, Mary T.
26 Endicott St., Lynn

Hendicken, Gertrude F.
Newton-Wellesley Hospital, Newton Lower Falls 62

Hendrickson, Ellen J.
15 Ashburton Pl., Boston

Hennen, Henrietta
Peter Bent Brigham Hospital, Boston 5

Heslin, Mrs. Phyllis S.
26 Lynde St., Boston 14

Hester, Alice E.
Chelsea Memorial Hospital, Chelsea

Hill, Ioja I.
9 Bay State Rd., Boston

Hill, Mrs. Margaret L.
Faulkner Hospital, Jamaica Plain

Hilyard, Frances E.
Malden Hospital, Malden 48

Hinds, Doris
364 Bay State Rd., Boston

Hinds, Doris G.
51-A Beach St., Marblehead

Homas, Mrs. Abigail
280 Beacon St., Boston 16

Horton, Vivian
P.O. Box 1511, Fall River

Houghton, Lt. Cmdr. Ruth A.
285 N. Main St., Andover

Howard, Mrs. Anna T.
150 Leonard St., Andover

Howard, Charlotte D.
Newton-Wellesley Hospital, Newton Lower Falls 62

Howland, Ellen D.
18 Autumn St., Boston 46

Howlett, Marjorie V.
Addison Gilbert Hospital, Gloucester

Hubbard, Elaine C.
220 Fisher Ave., Boston 20

Hubbard, Elizabeth B.
18 Day St., Somerville 44

Huey, Dorothy A.
70 Paradise Rd., Northampton

Hunt, Gladys V.
53 Cheshire Rd., West Roxbury 32

Hunting, Fay E.
120 Whitwell St., Quincy 69

Huovinen, Effie K.
91 Nightingale Ave., S. Quincy 69

Hurley, Theresa A.
3 Blackfan St., Boston 15

Hussey, Elma J.
House of the Good Shepherd, Boston 15

Hutchinson, Margaret L.
14 Fairhaven Rd., Concord

493
LANE, MARGARET
Massachusetts General Hospital, Boston 14

LARSON, R. ELISABETH
114 Sanderson Ave., Dedham

LA VES, MRS. HELEN C.
15 Hope Ave., Milton

LAWSON, EDNA F.
Harvard Private Hospital, Inc., Worcester 2

LE BLANC, GEORGINE M.
409 Huntington Ave., Boston 15

LEE, HELENE G.*
36 Aborn St., Peabody

LEE, JEAN C.
69 Franklin St., Peabody

LENHAN, MARY B.
111 Queenberry St., Boston 15

LEPPER, EDNA S.*
Massachusetts General Hospital, Boston 14

LETORNEAU, MARGARET E.
128 Flash Rd., Nahant

LIND, LILLIAN J.
18 Summer St., Everett 49

LINDQUIST, H. CLAIRE
16 Reynard St., Gloucester

LINSKOT, EIZABETH K.
115 Centre St., Jamaica Plain 30

LITTLE, BEATRICE E.
16 Grant St., Milford

LITTLET, MRS. HELEN C.
27 Grigg’s Ln., Milton 87

LOGAN, HELEN F.
18 Autumn St., Boston 15

LOUA, ELEANOR A.
31 Warren Ave., Woburn

LOWE, VIRGINIA B.
226 Commonwealth Ave., Boston

LUMBRA, RUTH B.
3 Blackfan St., Boston 15

MACDONALD, MARY E.
118 Providence St., Worcester

MacDOUGALL, MARY M.
Boston City Hospital, Boston 18

MacDUFFEE, NATALIE A.
15 Frawley St., Boston 13

MaCINNES, ALICE M.
31 Read St., Winthrop 52

MacKAY, HILDA M.
50 Chancery St., New Bedford

MacLEAN, ANNA L.
Hahnemann Hospital, Brighton 35

MACDONALD, MARY E.
118 Providence St., Worcester

MAHANEY, MILDRED E.
1586 Washington St., Boston

MAHER, HELEN C.
7 Elmira St., Brighton 35

MAHER, MARY A.
30 Bennett St., Boston

MAHONE, MARY F.
2 Greenough Ave., Jamaica Plain 30

MARBLE, DR. ALEXANDER
131 Laurel Rd., Chestnut Hill 67

MARIN, ANNE M.
8 Berlin St., Wollaston 70

MARSH, ALICE W.
Worcester County Sanitarium, Worcester 6

494
MARTEL, IRENE L.
721 Huntington Ave., Boston 11

MARTIN, HELEN C.
83 Eleanor St., Chelsea 50

MASON, MERCEDES S.
34 Cascade Rd., Worcester 2

MATHER, MRS. EUGENE H.†
92 Dean Rd., Brookline 46

MATTHEES, HAZEL E.
11 Winthrop St., Milton 87

MATTHIE, MRS. MARGARET M.
213 Commonwealth Ave., Boston 16

McCAIN, BERNARDINE J.
1 Hitchcock Rd., Worcester

McCARROLL, LYNDON M.*
254 Bay State Rd., Boston

McCARTHY, BARBARA R.
19 Fellsway E., Malden

McCARTHY, MARGARET M.
19 Fellsway E., Malden 48

McCLELLAND, MARY B.
University of Massachusetts Infirmary, Amherst

McDONOUGH, MARGUERITE
710 Massachusetts Ave., Boston

McGEE, MRS. MARGUERITE H.
21 Wendell St., Cambridge 38

McGLYRE, GUILA V.
43 McCormack Ave., Medford 55

McGOVERN, RITA E.
Veterans Administration Hospital, Bedford

McGURL, MRS. MARGARET C.
762 Main St., Shrewsbury

McINNIS, DALINA M.
710 Massachusetts Ave., Boston 18

McINTYRE, BARBARA F.
1 Pitts Ave., Wollaston 70

McKEON, ANNE G.
243 Beacon St., Boston

McKINNON, ELIZABETH L.
48 Adams St., Melrose 76

McMAHON, LAURA K.
67 Newfield St., Plymouth

McNAIR, RUTH C.
Haynes Memorial Hospital, Brighton

MEEGAN, MARGARET M.
55 Amory St., Cambridge 39

MERRILL, CHILLA K.
54 Lincoln St., Winthrop

MERSERVE, JOSEPHINE L.
Anna Jaques Hospital, Newburyport

MERSERII, RUTH M.
115 Brush Hill Rd., Milton 86

MITCHELL, DOROTHY A.
43 Symphony Rd., Boston 15

MITCHELL, JEAN C.
83 Goddard St., Quincy 69

MOLESKIE, ALEXANDRIA R.
Springfield Hospital, Springfield 7

MONAHAN, FRANCES E.†
120 Whitwell St., Quincy 69

MOQUIN, MRS. ALICE M.
17 Columbus Ave., Holyoke

MORGAN, EVELYN C.
Whidden Memorial Hospital, Everett 49

MORRIS, MRS. EVANGELINE H.
38 Riverdale Rd., Wellesley Hills 82

MORSE, ELLEN O.
35 Pinehurst Ave., Auburn

MORTON, EVELYN F.
10 Sparkhawk St., Amesbury

MOULTON, BARBARA M.
132 St. Mary's St., Boston

MULLANE, KATHERINE F.
Box 38, Rutland Heights

MULLER, THERESA G.
107-1 Middlesex Rd., Waltham

MULLET, MARIAN G.
Worcester Hahnemann Hospital, Worcester

MURN, MILDRED F.
38 Autumn St., Boston

MURPHY, EVELYN V.
34 Wolcott Park, W. Medford

MURPHY, JEAN A.
4 Field Way, Worcester 2

MURPHY, JEANNE S.
Holyoke Hospital, Holyoke

MURPHY, MRS. KATHERINE G.
87 Francis St., Brookline 46

MURPHY, RUTH A.
303 Read'sdale Rd., Milton 85

MURRAY, MRS. ELEANOR C.
245-67—76 Ave., Bellmere, L. I., N. Y.

NATAWPSKY, LEAH
42 Orkney Rd., Brighton 35

NELSON, HELEN E.
1179 Boynton St., Boston 15

NELSON, KATHRYN M.
Salem Hospital, Salem

NELSON, MILDRED E.
New England Sanatorium & Hospital, Melrose 76

NELSON, OLIVE L.
25 Beachmere Rd., Boston 15

NELSON, SOPHIE C.
200 Berkeley St., Boston 17

NEWHALL, MRS. ALICE J.†
1101 Beacon St., Brookline 46

NORCROSS, MARY E.
129 Washington St., Wellesley Hills

NORTON, IRENE
305 St. Joseph's Hospital, Boston 5

NURSE, AMY C.
1230 Amsterdam Ave., New York 27, N. Y.

O'BRIEN, ANNE L.
Veterans Administration Hospital, Rutland Heights

O'BRIEN, GERTRUDE
Newton-Wellesley Hospital, Newton Lower Falls 62

O'BRIEN, MARY R.
738 Harrison Ave., Boston 18

O'CONNELL, MRS. ABBIE C.
11 Packard Way, Brockton 6

O'CONNOR, MRS. ISABELLE J.
44 Merian St., Greenwood

O'GARA, MARY E.
Quincy City Hospital, Quincy

OGDEN, MRS. MARGARET M.
43 Woodland St., Fall River

OJALA, MARION E.
Salem Hospital, Salem

OLOFSSON, VELMA M.
R.F.D. 1, Lowell

ONEILL, SALLY V.
Main St., Tewksbury

PAINE, MRS. DERYL B.†
430 Centre St., Jamaica Plain 30

PALACZY, MRS. OLIVE D.
20 Queensberry St., Boston 15

495
PAQUIN, MRS. GLADYS T.
25 Acacila St., Fall River

PEABODY, PRISCILLA J.
410 Stuart, Boston

PEABODY, SYLVIA R.
7 Cross St., Wellesley 31

PEARSON, EMILY
Melrose Hospital, Melrose

PECK, JOSEPH N.
228 Chelmsford St., Chelmsford

PEIRCE, MILDRED G.
St. Luke's Hospital, New Bedford

PEKUL, NELLIE H.*
New England Baptist Hospital, Boston 20

PENDLETON, RUTH E.
9 Autumn St., Boston

PENSINGER, ELLA L.
7 Harvard St., Worcester 2

PERKINS, DOROTHY E.
Massachusetts General Hospital, Boston 14

PERKINS, SYLVIA
Massachusetts General Hospital, Boston 14

PERRON, JANET A.
220 Fisher Ave., Boston 20

PETERS, DOROTHY T.
Veterans Administration Hospital, Bedford

PETERS, EDITH V.
21 Elm St., Malden 48

PETERSON, HELEN J.
Lynn Hospital, Lynn

PETKAUSKOS, MARY R.
18 Ware St., Cambridge

PIERCE, MABEL B.
2 Portland St., East Rochester, N. H.

PICKELL, MARGARET M.
79 Westmeadow Ave., Arlington 74

PORTER, ELIZABETH
Sudbury Rd., Concord

PORTER, MRS. RUTH H.
141 Diamond St., New Haven, Conn.

POTTS, LOUISE
101 Page St., New Bedford

PRATT, DOROTHY F.
9 Parramatta Rd., Beverly

PRESTON, LOIS M.
10 Autumn St., Brookline

PRIEST, MARIE J.
26 Whittemore St., Arlington

PRITZ, ROSE E.
Cooley Dickinson Hospital, Northampton

PRYSYODSKI, WANDA A.
46 W. Newton St., Boston

PUTNEY, MARGARET M.
Lawrence General Hospital, Lawrence

QUINLAN, MALVA C.
54 Crescent St., Rockland

RAFUSE, ELLA M.
61 Chatham St., Worcester

RANCOURT, DOROTHEA L.
St. Elizabeth's Hospital, Brighton 35

RANDALL, MRS. ALMA J.
21 Humboldt Ave., Roxbury

RANDLE, JOAN
9 Parramatta Rd., Beverly

RAYNOR, MURIEL L.
78 Adamson St., Allston

REARRICK, MARIE E.
35 N. Anderson St., Boston 14

REILLY, DOROTHY E.
83 Ery St., Brookline 46

REILLY, HELEN C.
292 Common St., Quincy 69

REILLY, MARGARET G.
53 Malvern Rd., Brockton

RENDELL, MRS. GERTRUDE E.
Lynn Hospital, Lynn

RITCHIE, MRS. MARJORIE R.
46 Thackery Rd., Wellesley Hills 82

ROBERTS, MRS. EDNA R.
Transale Hospital, Fall River

ROBINSON, ALICE M.
50 Peterborough St., Boston 15

ROGERS, ANNIE
Brockton Hospital, Brockton

ROOT, MARY A.
721 Hunting Ave., Boston 15

ROSEN, EVELYN R.
20 Walden St., Revere 51

ROSS, JEANNE P.
42 Second St., East Cambridge

ROWLEY, SARAH R.
47 Revere St., Boston

RUTHERFORD, EUNICE A.
Worcester Hahmemann Hospital, Worcester 5

RYAN, HARRIET R.
740 Harrison Ave., Boston 18

RYER, EVELYN I.
Massachusetts Memorial Hospital, Boston 18

SABELBERG, IRENE
210 Boston St., Lynn

Savage, BEATRICE E.
29 Martinack Ave., Peabody

SAWITSKY, HELEN
330 Brookline Ave., Boston 15

SAYLES, MARTHA O.
264 Bay State Rd., Boston

SCANLON, ENS. LOUISE K.
U. S. Naval Hospital, Portsmouth, Va.

SCELSI, JOSEPHINE A.
356 Riverway, Boston

SCHACTER, ADELE
94 Corey Rd., Brighton 46

SCHEN, MARQUETTE C.
Veterans Administration Hospital, Bedford

SCULLY, KATHRYN G.
Worcester City Hospital, Worcester 3

SECORD, HAZEL W.
Cambridge Hospital, Cambridge 38

SHAHEEN, ANNA
336 Washington St., Brookline 46

SHAPLEIGH, MRS. AURILLA L.
Elliot Community Hospital, Keene, N. H.

SHAW, MILDRED E.
Cooley Dickinson Hospital, Northampton

SHEAHAN, ANASTASIA
Veterans Administration Hospital, Rutland

SHELLY, MARY R.
Lowell General Hospital, Lowell

SHENNETT, ANNE E.
29 Mattson St., Quincy

SHEPARD, KATHARINE M.
Household Nursing Association, 22 Newbury St., Boston

SHEPARD, MARY E.
Mt. Auburn Hospital, Cambridge 38

SHERMAN, EMILY P.
119 Belmont St., Worcester
SLEEPER, RUTH*  
Massachusetts General Hospital, Boston 14

SLOAN, ISABELLE W.  
19 Everett St., Allston 34

SLOANE, AMANDA  
New England Sanitarium & Hospital, Melrose 76

SMITH, ANN C.  
3 Sargent Ave., Fitchburg

SMITH, ELIZABETH  
Veterans Administration Hospital, Altoona, Pa.

SMITH, MARtha R.*  
40 Hickory Cliff Rd., Newton 64

SMITHIES, JENNIE K.  
Union Hospital, Fall River

SNOW, ELMINA L.  
Emerson Hospital, Concord

SOWA, ESTELLA C.  
160 Cabrini Blvd., New York 33, N. Y.

SPARGO, BEATRICE C.*  
10 Autumn St., Boston

STANFORD, ELINOR C.  
Massachusetts General Hospital, Boston 14

STANSFIELD, FRANCES A.  
1877 Robeson St., Fall River

STEVENS, MRS. BROOKS, JR.*  
Concord

STEVENS, LEONARD F.  
Cossville, N. H.

STEWARD, JESSIE  
Massachusetts General Hospital, Boston 14

STIMSON, MARIORY  
48 Allie St., Allston 34

STONE, DAVID J.  
7 Linden St., Stoneham 80

STONE, MILDRED N.  
350 Mount Auburn St., Cambridge 38

STORM, ELSA E.  
Peter Bent Brigham Hospital, Boston 5

SULLIVAN, CATHERINE M.  
54 Suwanee Rd., East Weymouth

SULLIVAN, LUCILLE A.  
11 Ruth St., Worcester 2

SULLIVAN, MARGARET A.  
104 Queenberry St., Boston

SULLIVAN, MARGARET M.  
51 Forbes St., Worcester 5

SULLIVAN, MARION C.  
99 Aldrich St., Roslindale 31

SWAIN, ELIZABETH M.  
270 Brookline Ave., Boston

SWEENY, MRS. NANCY M.  
Veterans Administration Hospital, Rutland Heights

SWENSON, IRMA F.  
13 Westbrook Rd., Worcester 2

SZARGOWECZ, CENEVIEVE J.  
15 Caswell St., E. Taunton

SZLOCH, STEPHANIE M.  
44 Oriole St., West Roxbury 32

TAHJIAN, HELEN E.  
363 Prospect St., Greendale Sta., Worcester 6

THOMAS, JEAN  
20 Rockaway Ave., Marblehead

THOMAS, LOIS M.  
21 Seaverns Ave., Jamaica Plain 30

THOMAS, DR. MURIEL L.  
The Memorial Hospital, Worcester 5

THOMPSON, FRANCES A.  
238 Essex St., Beverly
THOMPSON, MRS. MARY B.
Whidden Memorial Hospital, Everett

THOMPSON, MARY E.
Teachers College, Columbia University,
New York 27, N. Y.

THURLOW, JOSEPHINE E.
16 Ware St., Apt. 1, Cambridge 38

TIBBETTS, MARGARET C.
McLean Hospital, Waverley 79

TINGLEY, DOROTHY M.
7 Scottfield Rd., Allston 34

TIPPING, RUTH E.
109 Queechberry St., Boston 15

TOBIN, SARAH A.
St. Luke’s Hospital, New Bedford

TODD, ETHEL A.
U. S. Marine Hospital, Brighton 35

TOMASUNAS, FRANCES T.
27 Suffield St., Worcester 3

TOOMEY, MARY T.
115 Hill St., Brockton 34

TOWNSEND, EDNA J.
20 Ash St., Boston 11

TOWNSEND, MARIE D.
266 Kelton St., Allston 34

TRAFTON, ETHEL M.
3 Blackfan St., Boston 15

TRISTAN, MARGUERITE M.
232 Main St., Lee

TUDBURY, MARY A.
59 Bowdoin St., Newton Highlands 61

TUNGLAND, THELMA
100 St. Mary’s St., Boston 15

TURNER, CHARLOTTE W.
Veterans Administration Hospital, West Roxbury 32

TUXBURY, CATHERINE F.
10 Dalrymple St., Jamaica Plain

TWAROG, ALONNA H.
4 Church Rd., Newton 59

UPDEGRAFF, A. BETTY
70 The Fenway, Apt. 35, Boston 15

UPHAM, GERALDINE
220 Fisher Ave., Boston 20

VADALA, BARBARA A.
53 Radeliffe Rd., Belmont 78

VACSHENIAN, ROSE
28 Woodland St., Worcester 3

VARY, LEONA B.
Boston Lying-In Hospital, Boston

VESEY, MURIEL V.
3 Blackfan St., Boston 15

VILLONE, ELIZABETH R.
20 Milton St., Arlington 74

VOIGHT, HELEN C.
Memorial Hospital, Worcester

WALKER, HAZEL M.
Morton Hospital, Taunton

WALSH, CECILIA E.
14 Bank St., Fall River

WALSH, KATHARINE E.
44 Warren St., Arlington 74

WALTERS, MARGARET
13 Autumn St., Boston

WARD, HELEN G.
4 Earl St., Worcester

WARD, PHYLLIS A.
67 Newcomb St., Arlington 74

WARD, THELMA M.
Melrose Hospital, Melrose

WARDEN, PHYLLIS M.
221 Longwood Ave., Boston 15

WASHBURN, NANCY
Box 235, West Hanover

WEBB, HELEN
21 Third St., Attleboro

WEBSTER, ARLINE M.
102 Pleasant St., Fitchburg

WEINSTEIN, MARGORIE R.
29 Hawthorne St., East Lynn

WELCH, MARGARET B.
710 Massachusetts Ave., Boston

WELCH, MARY T.
Worcester City Hospital, Worcester

WELLS, DOROTHY V.
47 Spring Park Ave., Jamaica Plain 30

WETTERLOW, MRS. EDITH O.
20 Belmont St., Malden 48

WEYMOUTH, LILYAN T.
234 Conway St., Greenfield

WHITE, MRS. EILEEN M.
842 Worcester St., Wellesley

WHITE, LEONA F.
Malden Hospital, Malden 48

WHITE, VERA E.
710 Massachusetts Ave., Boston 18

WHITTON, MRS. CATHERINE J.
Simmons College, Boston 15

WHOLEY, ELIZABETH L.
Veterans Administration Hospital, West Roxbury 32

WILKIE, KATHLEEN R.
New England Hospital for Women & Children, Roxbury 19

WILLIAMS, BARBARA J.
335 Longwood Ave., Boston 15

WILLIS, HELEN L.
191 Commonwealth Ave., Boston 16

WILSON, GERTRUDE A.
91 Crest Ave., Chelsea

WISE, MRS. JENNIE L.
72 Albertina St., Quincy

WOJNAR, FRANCES
721 Huntington Ave., Boston 15

WOLFE, DELIGHT
230 Fisher Ave., Boston 20

WOOD, HELEN
1036 Walnut St., Newton Highlands 61

WOOD, MRS. MARGUERITE W.
220 Fisher Ave., Boston 20

WOODARD, BLOOMA J.
New England Sanitarium & Hospital, Melrose 76

WOODRUFF, MARGARET
220 Fisher Ave., Boston 20

WOODRUFF, NORMA L.
117 Laurel St., Fitchburg

WRIGHT, HONORA
McLean Hospital, Waverley

WRIGHT, CAPT. LILLIAN A.
8055th Mobile Army Surgical Hospital, APO 301, c/o PM, San Francisco, Calif.

YEO, DR. J. WENDELL
11 Brae Burn Rd., Auburndale

YOUNG, MRS. FRANCES P.
50 Lookoff St., Brockton 11

YOUNG, MRS. OLIVE L.
336 Hanover St., Fall River

ZAPENAS, MABEL
288 Lawrence St., Lawrence

ZENDZIAN, HELEN F.
8 Rob Roy Rd., Worcester 2

498
MICHIGAN—589

ADRION, MRS. VERNA O.
2943 Cable St., S.W., Grandville

AIRD, DOROTHY
15703 Northlawn, Detroit 21

ALLEMAND, DORIS M.
6925 E. Jefferson Ave., Detroit 14

ALOSIO, HELEN J.
7470 Byron, Detroit 2

ALSPACH, MYRL T.
699 Greenwood, S.E., Grand Rapids

AMANN, MARILYN
5591 Haverhill, Detroit 2

AMB, MRS. TERESA
1075 Short St., N.E., Grand Rapids

ANDERSEN, EVELYN C.
950 Gladstone, Detroit 6

ANDERSON, ESTHER C.
3704 John R. St., Detroit 1

ANDERSON, FRANCES A.
432 E. Hancock St., Detroit 1

ANDERSON, MARY B.*
Bronson Methodist Hospital, Kalamazoo 5

ANDERSON, MARY M.*
927 S. Washington Ave., Lansing

ARDISON, DOROTHY
19737 Blackstone, Detroit 19

ATKIN, MRS. VIRGINIA M.
3902 Cheyenne Ave., Flint 7

BAIRD, JEANETTE
1206 W. Bethune, Detroit 2

BAYARD, MRS. THELMA S.
3324 Hogarth, Detroit 6

BAYLIS, MRS. MARY K.
2687 W. Grand Blvd., Detroit 8

BEARDSLEE, EUNICE M.
Veterans Administration Hospital, Dearborn

BEEBE, BARBARA A.
234 S. Berkley St., Kalamazoo 50

BEIRD, IRENE
5535 Cass, Detroit 1

BELL, MRS. HARRIETT S.
3740 John R. St., Detroit 1

BENNETT, MRS. LAURA A.
1116 Hemingway St., S.E., Grand Rapids

BERRYMAN, JESSICA M.
319 W. Fifth Ave., Flint

BESEKE, MRS. HELEN M.
9400 Appoline, Detroit 27

BEZILE, DOREEN L.
2025 Plainfield, Grand Rapids

BIBBEE, PHYLLIS
10 Louise, Apt. 10S, Highland Park 3

BIEHL, MRS. HELEN R.
7318 Middlepointe, Dearborn

BLACKBURN, MARY E.
104 S. Forest Ave., Ann Arbor

BLAYER, MRS. ANNA R.
405 W. Savannah, Detroit 3

BLEAM, THELMA T.
2727 Charlestown, S.E., Grand Rapids 9

BOSSEN BROEK, MRS. SARELLA V.
Butterworth Hospital, Grand Rapids 3

BRADFILDE, C. ARLENE
719 S. Lincoln Ave., Bay City

BRADY, ARLINE R.
Veterans Administration Hospital, Dearborn

BRALEY, HELEN L.
1420 St. Antoine, Detroit 26

BRANDENSTEIN, ALICE M.
301 Fillmore, Bay City

BRATKOWSKI, MRS. LEOCADIA J.
2716 Edwin St., Detroit 12

BRAUN, MARY T.
3411 Evamine St., Detroit 12

BREWINGTON, MRS. THELMA T.
18609 Greenlawn, Detroit 21

BRIDY, ALMA L.
3107 Van Alstine Blvd., Wyandotte

BROOK, MRS. GERTRUDE B.
2031 Paris St., S.E., Grand Rapids

BROOKS, HELEN I.
2920 New Port, Detroit 15

BROWN, HAZEL A.
Blodgett Memorial Hospital, Grand Rapids 6

BROWN, JOSEPHINE
101 Gladstone, Detroit 2

BROWN, MYRTLE L.
25612 Currier, Dearborn

BRUCE, PATRICIA J.
1168 Ashland, Detroit 15

BRUMBAUGH, ETHEL
233 E. Willis, Detroit 1

BUCKLEY, ELIZABETH A.
Hackett Hospital, Muskegon

BUCKRIDGE, ANN J.
104 Forest Ave., Ann Arbor

BUEGE, LORRAINE
3245 E. Jefferson, Detroit 7

BUKER, HELENE B.
617 W. Ottawa St., Lansing 15

BULGER, CATHERINE M.
130 W. Grand Blvd., Detroit 7

BUNTEBART, EMMA L.
3245 E. Jefferson, Detroit 7

BURFINDT, MRS. ANNA F.
32 Chadwick Rd., Hillsdale, N. J.

BURKE, MARY A.
30 W. Lanvale, Baltimore 17, Md.

BURNETT, M. ELIZABETH
6326 Bingham, Detroit 27

BUSCHLEN, ESTELLE M.
10956 Nottingham, Detroit 24

BUSHEY, ESTHER M.
1205 Pallister, Detroit 2

BUSHEY, MARGARET
1205 Pallister, Detroit 2

BUSS, FLORA J.
6047 Hamilton Ave., Detroit 2

BYRD, ARLYNE R.
7609 Merrill, Detroit 2

BYRNE, AUDREY E.
212 Sheridan St., Saginaw

CAMERON, JESSIE S.
3750 John R. St., Detroit 1

CAMPBELL, MANILLA
614 E. Ninth St., Flint

CAPUANO, MICHELINA
631 Merrick, Detroit 2

CARNEY, RUTH
1619 Pontiac, Ann Arbor

CARROLL, MARY E.
720 Mason St., Flint
CASTNER, ALVERA C.
229 Rochester Ct., S.E., Grand Rapids

CERUTTI, LEE
6520 Wabash Ave., Detroit 8

CHAMBERS, WILDA
1224 Washtenaw Ave., Apt. 1, Ann Arbor

CHAPLIN, MRS. VIRGINIA
615 W. Second Ave., Flint

CHESNER, WANDA I.
13212 Wyoming, Detroit 4

CHIPMAN, MRS., MARY J.
824 Franklin St., S.E., Grand Rapids

CHRISTIE, RACHEL A.
2102 Cornell Rd., Cleveland, Ohio

CLARK, BEATRICE K.
19178 Stansbury, Detroit 35

CLARKE, PATRICIA
1409 Fischer, Detroit 14

CLAYTON, MILDRED I.
782 E. Russell Ave., Flint 5

CLINE, KITTY D.
St. Luke’s Hospital, Jacksonville, Fla.

CLOW, GRACE L.
3740 John R. St., Detroit 1

COLLINS, GRACE M.
Harley Hospital, Flint 2

CONFER, MRS. MILDRED R.
917 E. Flat St., Jackson

CONLEY, L. ANN
1391 Dorothea, Berkley

CONNALLY, GRACE
1340 E. Grand Blvd., Detroit 11

CONNOLLY, JANE A.
13007 Saratoga St., Detroit 5

CONWAY, MARY E.
1571 Leslie, Detroit 6

COOMBS, MABEL M.
17111 Second Blvd., Detroit 3

CORNELIUS, ESTHER F.
Hackley Hospital, Muskegon 16

COYE, DOROTHY V.
2600 W. Grand Blvd., Detroit 2

CRANDALL, HELEN A.
4545 Benfield, Detroit 13

CRANOR, MRS. REEVA
309 Thames St., Ann Arbor

CRAWFORD, MARY L.
301 Wadsworth St., Traverse City

CRIST, EDITH
812 W. Sixth Ave., Flint 4

CULVERWELL, E. JEAN
226 E. Baker St., Flint 5

CURRAH, SYLVIA L.
9700 St. Paul, Detroit 14

CUSIC, MARY K.
1455 Durand St., Flint

DAVIS, DOROTHY J.
4700 W. Outer Dr., Detroit 21

DAVIS, HARRIET E.
Gerber Products Co., Fremont

DAVIS, MARY C.
4700 W. Outer Dr., Detroit 21

DAY, JOYCE E.
681 Merrick Ave., Detroit 2

DE LOOFF, DOROTHY
2279 Breezy Point Dr., Grand Rapids 5

DEVEREAUX, MRS. MYRTLE G.
106 E. Alexandria, Detroit 1

DEWEY, MRS. JANET S.
2217 E. Grand Blvd., Detroit 11

DEXHEIMER, HARRIET G.
492 Drexel St., Detroit

DICKERSON, MRS. IRENE G.
2782 W. Boston Blvd., Detroit 6

DIECKMANN, GRACE
Veterans Administration Hospital, Dearborn

DIEHL, MRS. MYRTICE C.
235 Crocker Blvd., Mt. Clemens

DIETL, MARTA M.
235 E. Alexandria, Detroit 1

DOTY, RUTH F.
315 Green St., Flint 3

DOWNS, LEONA M.
Davis Home, Saginaw General Hospital, Saginaw

DOYLE, CLARA C.
15037 St. Mary’s, Detroit 27

DRAGE, MARTHA G.
16532 Log Cabin, Detroit 3

DRAVECKY, ANN
3245 E. Jefferson Ave., Detroit 7

DRUH, ELEANOR M.
2292 Blodgett St., Muskegon

DWERK, ALENE B.
399 Glendale, Highland Park 3

DUNAVIN, MYRTIE
Box A, Oakland Dr., Kalamazoo

DUNN, NELLIE C.
218 Rochester Ct., S.E., Grand Rapids 2

DUNWORTH, GENEVIEVE
7470 Byron St., Detroit 2

DYWER, EVARISTA
401 W. Sixth Ave., Flint

EATON, JANE A.
3609 Kalamazoo St., Battle Creek

EDELSON, MRS. RUTH B.
11716 Yellowstone, Detroit 4

EILERS, MRS. ALMA
6465 Sterling, Detroit 2

EILOLA, HELEN H.
3740 John R. St., Detroit 1

Elliott, Dorothea
209 Willow Ave., Tacoma Park 12, D. C.

ELLIOTT, JO ELEANOR
1205 E. University St., Ann Arbor

ELLISON, SHIRLEY J.
9106 Woodland, Detroit 24

ELSTON, MARY J.
707 S. Laurel, Royal Oak

EMERY, JANE E.
27 E. Gigotte, River Rouge 18

ENGSTROM, MRS. RODI M.
18474 Prairie, Detroit 21

ENRICH, MRS. ROBERTA C.
5257 Cass St., Detroit 1

EPPELEBART, EVELYN
14009 Monica, Detroit 4

EVENSON, OVIDIA T.
7934 Normicle St., Dearborn

EYKE, MARY A.
Route 2, Scenic Dr., Muskegon

FALKOWSKI, VLADIMIRA
8611 Warwick, Detroit 20

FARBOGN, MARIE
14515 E. Vernor St., Detroit 15

FARMER, RUTH C.
11197 Lander St., Detroit 27

500
FAVILLE, KATHARINE E.
7645 Byron, Detroit 2
FENGEB, AGNETE
311 S. Division, Apt. 4, Ann Arbor
FEUERSTEIN, CATHERINE M.
736 Ethel Ave., Grand Rapids 6
FIANDT, MRS. REGINA M.
1190 Seward, Detroit 2
FINNIGAN, ELIZABETH
Harper Hospital, Detroit 1
FISHER, VERA M.
Emmanuel Missiondale, Berrien Springs
FITAK, ADELAIDE L.
830 S. Jefferson Ave., Saginaw
FLARITY, ALMEDA C.
555 Hazelwood, Detroit 2
FLYNN, MRS. LEONA
13230 Birwood, Detroit 4
FOX, MARION L.
9230 N. Martindale, Detroit 4
FRANK, BERNICE H.
2327 Drexel, Detroit 13
FRISTOE, PHYLLIS L.
311 W. Williams St., Ann Arbor
FRYE, MARY L.
2045 Wealthy St. S.E., Grand Rapids
GALAGAN, CHRISTINE M.
1414 W. Euclid, Detroit 6
GAUNT, MARIORIE E.
14500 Hene Ave., Detroit 21
GERIERMAN, HILDA
Borgess Hospital, Kalamazoo 6
GEORGE, JULIET A.
Edward W. Sparrow Hospital, Lansing 11
GERBER, KATHRYN E.
3245 E. Jefferson Ave., Detroit 7
GERMAIN, LUCY D.*
Harper Hospital, Detroit 1
GILMAN, RUTH F.
16510 Hene Ave., Detroit 21
GINGRICH, EMMA S.
3740 John K. St., Detroit 1
GRACE, CATHERINE B.
54 Ransom Ave., N.E., Grand Rapids 3
GRAFF, FRANCES
Blodgett Memorial Hospital, Grand Rapids 6
GRANT, JEANNE M.
20735 W. Philadelphia, Detroit 6
GREINER, FREDA
324 Orchard Hill, S.E., Grand Rapids
GRIMM, Verna B.
U. S. Marine Hospital, Detroit 15
GRUBER, S. MARY
1619 Pontiac Rd., Ann Arbor
GUISHBORD, ELEANOR M.
59 Monroe, Pontiac
GUILIANI, MRS. FRANCES B.
1220 Larkmoor Blvd., Berkley
HADLEY, FLORENCE
8045 Piedmont, Detroit 26
HAGELSHAW, ALICE V.
1915 Goddess, Ann Arbor
HAIST, PEARL M.
119 W. Church, Adrian
HALLSTEAD, ELEANOR
7647 Byron Ave., Detroit 2
HALVERSON, LUCILLE
19146 Audette, Dearborn

HAMEL, MARIE H.
Muskogon County Sanatorium, Muskegon
HAMILTON, EVLYN M.
3740 John R. St., Detroit 1
HAMILTON, MARY L.
1216 Greenwood Ave., Kalamazoo 59
HARDIN, MARTHA
Hackley Hospital, Muskegon 16
HARMENS, ANNA
1315 Winton Ave., Kalamazoo
HARMON, LORRAINE
8744 N. Maplewood, Detroit 4
HARPER, HELEN
7470 Byron, Detroit 2
HARRISON, JEAN
25 Coral, River Rouge
HARSEN, ZADA
717 W. Sixth Ave., Flint 2
HAWKINS, ADA
911 S. Fifth St., Ann Arbor
HAWKINS, MRS. CHRISTY T.
637 Cherry Lane, East Lansing
HAWKINS, DORIS M.
Hackley Hospital, Muskegon 16
HEATH, E. ARLINE
Hackley Hospital, Muskegon 16
HEDEGARD, ESTHER M.
16961 Kirkshing, Birmingham
HEMPHILL, CHARLOTTE A.
3740 John R. St., Detroit 1
HENDERSON, HELEN B.
3740 John R. St., Detroit 1
HENDERSON, LINNEA
13726 Rutherford, Detroit 27
HENRIKSON, MARIE P.
U. S. Marine Hospital, Detroit 15
HENRY, ETHEL
16545 Indian Ave., Detroit 21
HERC, MILENKA
1103 LeRoy, Ferndale 20
HERINGHAUS, MARY G.
8200 W. Outer Dr., Detroit 19
HEYSE, MARGARET F.
2140 Cambridge, Berkley
HICKEY, JEANNE
Providence Hospital, Detroit 6
HJU, MRS. EMMA J.
4313 Virginia Pk., Detroit 4
HILBORN, ELIZABETH
600 W. Ferry, Detroit 2
HILLIER, MARGARET
1160 Seward, Detroit 2
HOLLAND, MARGUERITE
20651 Morose Rd., Detroit 24
HOLMES, MRS. ESTHER
2206 Horton, S.E., Grand Rapids
HOMMES, MRS. DORCAS
876 Isabellu Ave., Muskegon
HOUCK, CLARA E.
Pontiac State Hospital, Pontiac
HOWES, IRENE M.
13505 La Salle Blvd., Detroit 6
HUBBARD, MARY H.
Veterans Administration Hospital, Dearborn
HUGHES, MARGARET
471 W. South St., Kalamazoo
HUIZENGA, KATHLEEN E.
1840 Wealthy St., S.E., Grand Rapids 6

501
KRAUSE, ANNA C.  
1440 Field St., Detroit 13
KREIDER, ESTHER  
Box 256, Hastings
KUPKA, MARY E.  
1340 E. Grand Blvd., Detroit 11
LAIRD, ELIZABETH G.  
3750 John R. St., Detroit 1
LAKIN, ISABELLE A.  
1655 Beach St., Muskegon
LAMBERTS, MILDRED F.  
819 Geneva St., S.E., Grand Rapids
LANE, LOYOLA  
2217 E. Grand Blvd., Detroit 11
LANCELON, ILENE  
Highland Park General Hospital, Highland Park 3
LAPointE, RUTH J.  
5933 Longo, Detroit 10
LARSON, BETTY  
194 Tuxedo St., Highland Park 3
LATEG, FLORENCE  
14200 Glenwood St., Detroit 5
LATIMER, ESTHER M.  
1130 E. Huron St., Ann Arbor
LAWRENCE, HARRIET M.  
7470 Byron Ave., Detroit 2
LEBER, MRS. MARIAN R.  
258 Hendrie, Detroit 2
LEE, THEA H.  
30 Martin Pl., Detroit 1
LEITCH, M. ANNE  
Butterworth Hospital, Grand Rapids 3
LEITZKE, ELLA G.  
Veterans Administration Hospital, Saginaw
LESINKI, MILDRED  
13960 Ward St., Detroit 27
LILLY, MARGARET A.  
16649 Princeton, Detroit 21
LING, GERALDINE M.  
1653 Glenvale, Saginaw
LOWE, MRS. MARION S.  
11537 Hamilton, Detroit 2
LUNDHOLM, ETHEL E.  
Heekley Hospital, Muskegon 16
LUSSOW, MRS. BERYL T.  
15324 Fuller Ave., Detroit 4
LYMAN, A. KATHARINE  
601 Merick St., Detroit 1
LYNCH, MARGARET  
2970 Second Blvd., Detroit 1
LYSHAK, OLGA M.  
5121 Reuter St., Dearborn
MACDONALD, LORETTA A.  
Veterans Administration Hospital, Dearborn
MACDONALD, MARY A.  
512 W. Sixth Ave., Flint 2
MACDOUGALL, MRS. LUCILLE M.  
16 Avalon, Highland Park 3
MACKENZIE, JESSIE F.  
3740 John R. St., Detroit 1
MACLEAN, MARGARET  
3740 John R. St., Detroit 1
MACLEAN, MRS. ETHEL P.  
2061 Burnette, Detroit 4
MADLEY, GERTRUDE  
19180 Westmoreland, Detroit 19
MANN, DORIS S.  
Riverside Dr., Sault Ste. Marie
MORAN, ELIZABETH S.* Henry Ford Hospital, Detroit 2
MORGAN, EDITH G. 104 S. Forest Ave., Ann Arbor
MORGAN, MRS. HELEN G. 9041 Esper Blvd., Detroit 4
MOTHER MARY CARMELITA* 8200 W. Outer Dr., Detroit 35
MOTL, DOROTHY W. A. Foote Memorial Hospital, Jackson
MULQUEEN, RITA M. 2828 Woodmere, Detroit 9
MURDIE, ELLA M. Hurley Hospital, Flint 2
MURPHY, HELEN F. 621 Selden St., Detroit 1
MURPHY, MARION 401 Lawrence St., Ann Arbor
MYERS, M. LUCILLE 9366 N. Martinlade Ave., Detroit 4
NAGORKA, HALINA 148 Ransom Ave., N.E., Rm. 101, Grand Rapids 2
NATHE, GERTRUDE E. 220 Cherry St., S.E., Grand Rapids
NEAL, L. ROWENA 120 Eastern, S.E., Apt. 5, Grand Rapids
NEAMAN, MARY L. 222 W. Lapeer, Lansing
NEITHERCUT, MRS. ELIZABETH K. 711 Mary St., Flint
NELSON, IRENE 332 E. Hancock, Detroit 2
NENTWIG, DOROTHY 1653 Glendale Ave., Saginaw
NEWMAN, MARY L. 18918 Alcoy, Detroit 5
NEWTON, EVELYN A. 4459 Pinehurst Ave., S.W., Grand Rapids 8
NICHOLS, ADAH 69 Martin Pl., Detroit 1
NOLL, ANNA M. 5257 Cass Ave., Detroit 1
NTERCOS, ELAINE N. 313 Orchard Hill S.E., Grand Rapids
NULL, VIRGINIA M. 104 S. Forest Ave., Ann Arbor
NUSS, PAULINE H. 3245 E. Jefferson, Detroit 7
O'BRIEN, JEANE M. Butterworth Hospital, Grand Rapids 3
O'HUTH, MRS. FLORENCE 264 Charles Ave., S.E., Grand Rapids 6
ORCUTT, BERTHA E. Box C, Traverso City
OWENS, MARY 3740 John R. St., Detroit 1
PAILOTORPE, MRS. LILLIAN M. 2702 Thomas St., Flint 4
PAINE, DOROTHY Allerton Hotel, Chicago, Ill.
PANAK, MARY 17111 Second Blvd., Detroit 5
PARTRIDGE, ANN C. 1725 Van Dyke, Detroit 14
PASBACH, PATRICIA W. 1721 Godwin, S.E., Grand Rapids 7
PATEE, PATRICIA A. 23145 Murray, Dearborn

MICHIGAN
PATTERSON, WINIFRED L.
108 S. Forest Ave., Ann Arbor
PAVOLNY, MRS. EMMA A.
17110 Third, Detroit 5
PEARSE, MRS. MURIEL F.
22626 Nova Ave., Dearborn
PECK, LAURA E.
15726 Rutherford St., Detroit 27
PEARCE, JEAN
9700 St. Paul, Detroit 14
PELTIER, LEONA
6520 Wabash Ave., Detroit 8
PETER, ERMA
1725 Van Dyke, Detroit 14
PETERSON, MRS. ELEANOR D.
3359 Hazelwood Ave., Detroit 6
PETERSON, EUGENA M.
7539 Dunedin, Detroit 6
PETERSON, GRACE G.
312 Ontario, S.E., Minneapolis 14, Minn.
PIDGEON, VIRGINIA A.
Merrill-Palmer School, 71 Ferry Ave., E., Detroit 2
PIERSON, EDNA J.
Hackett Hospital, Muskegon 16
PINKHAM, ELSIE M.
5115 Devonshire, Detroit 24
PINKOWSKI, NELLIE
Wayne County General Hospital, Eloise
PLACHAN, ANNE M.
211 Corrayway, Tarentum, Pa.
PLATZER, ALYS
St. Joseph Hospital, Mt. Clemens
PLUNKETT, WANDA R.
3740 John R. St., Detroit 1
POILLON, MRS. AGNES K.
1124 W. North St., Kalamazoo
PORTER, MERCEDES
18452 Goulburn St., Detroit 5
PUTNAM, JEANETTE
6925 E. Jefferson Ave., Detroit 7
QUINN, RITA M.
2250 W. Grand Blvd., Detroit 8
QUIRK, ANNE
Receiving Hospital, Detroit 26
RADDEN, THELMA G.*
7739 E. Forest, Detroit 13
RADZIAWSKI, RITA
2036 Evaline, Hamtramck 12
RAGLAND, VIRGINIA
333 John St., Ann Arbor
RAMSEY, JEAN
1360 Seward, Detroit 2
RATH, ELIZABETH H.
15809 Pierson St., Detroit 23
READ, ESTHER H.
660 Seward, Detroit 2
REDDIG, RHODA F.
816 Hill St., Ann Arbor
REESE, SYLVIA
Saginaw General Hospital, Saginaw
REICH, LYDIA F.*
3512 Turner St., Lansing
REIVE, JACQUELINE M.
12073 Littlefield, Detroit 27
RICE, HELEN
1471 Clairmount, Detroit 6
ROBERTS, MRS. MARY M.
4035 Buckingham Rd., Detroit 24
ROCK, MARY
3224 St. Antoine, Detroit 2
ROGERS, JANE
5224 St. Antoine, Detroit 2
ROME, EVELIN D.
501 W. Sixth Ave., Flint 4
RONAN, HELEN
18424 Whitcomb, Detroit 19
RONAN, JANE F.
71 E. Ferry Ave., Detroit 2
ROSS, GRACE
1091 E. Jefferson St., Detroit 7
ROSS, RACHEL R.
12781 Northlawn St., Detroit 4
RUE, MABEL J.
25 Lafayette St., S.E., Grand Rapids 3
RUGG, MADELINE M.
869 Burlingame Ave., Detroit 2
RULE, MRS. RUTH
470 Carpenter Ave., N.W., Grand Rapids
RUPP, MARGARET A.
904 First St., Bay City
RUSH, LILLIAN M.
725 N. Waverly Rd., Lansing
RUSSSELL, HARRIET B.
Harrbor Hospital, Detroit 1
RYE, LILLIAN
80 Martin Pl., Detroit 1
RYER, ISABELLE
260 Gladstone, Apt. 401, Detroit 2
SACKETT, NINA
5224 St. Antoine, Detroit 2
SANDFORD, ELIZABETH
301 W. Sixth Ave., Flint 4
SANDS, MRS. KATHLEEN Y.
12746 Broadstreet, Detroit 4
SANDFORD, MRS. MARGUERITE
375 Seward St., Detroit 2
SARGENT, EMILIE G.
150 Webb, Detroit 2
SCHAEFER, MINETTA
25 E. Palmer, Apt. 36, Detroit 2
SCHLOTTFELDT, ROZELLA M.
1063 Marshfield, Ferndale
SCHMID, LUCILLE
3245 E. Jefferson Ave., Detroit 7
SCHMIDT, NEVA E.
Butterworth Hospital, Grand Rapids 3
SCHNEIDER, IRENE M.
1007 Welch Blvd., Flint 4
SCHNEIDER, MRS. MARIE W.
1125 E. Huron St., Ann Arbor
SCHNEIDER, OLIVE
4057 Louise St., Saginaw
SCOTT, FRANCES G.
235 E. Alexandrine Ave., Detroit 1
SCOTT, MARY E.
St. Mary's Hospital, Saginaw
SCRATCH, THELMA L.
11354 Dalrymple St., Detroit 4
SQUAREMAN, JESSIE M.
246 E. Alexandrine Ave., Detroit 1
SEITZ, JUNE E.
7324 Calahan, Detroit 9
SERRINESQUE, MARY A.
19329 Greenfield, Detroit 35
SERRILL, MARIE E.
Saginaw General Hospital, Saginaw
SISTER MARY ELLEN*  
6071 W. Outer Dr., Detroit 21
SISTER MARY EMILY  
4777 E. Outer Dr., Detroit 34
SISTER MARY ETHELBERT  
1521 Gull Rd., Kalamazoo 17
SISTER MARY EVELYN  
Nazareth
SISTER M. FRANCIS XAVIER  
6071 W. Outer Dr., Detroit 21
SISTER M. FREDERINE  
1521 Gull Rd., Kalamazoo 17
SISTER MARY GERMAINE  
Mercy Hospital, Cadillac
SISTER MARY GILES  
St. Joseph’s Mercy Hospital, Ann Arbor
SISTER MARY GRACE  
Mercy Hospital, Bay City
SISTER M. GUALBERTA  
St. Joseph’s Mercy Hospital, Ann Arbor
SISTER MARY HENRICA  
St. Mary’s Hospital, Grand Rapids 2
SISTER MARY JANICE  
100—15 St., Bay City
SISTER MARY JOSEPHINE  
St. Lawrence Hospital, Lansing 15
SISTER M. JULIITA  
St. Mary’s Hospital, Grand Rapids 2
SISTER M. KIERN  
Mercy Hospital, Muskegon 17
SISTER MARY LEONARD  
Nazareth College, Kalamazoo
SISTER MARY LEONETTA  
632 Varnum St., N.E., Washington 17, D. C.
SISTER MARY MACRINA  
2317 E. Grand Blvd., Detroit 11
SISTER MARY MARK  
1521 Gull Rd., Kalamazoo 17
SISTER M. MAURICE*  
Mercy College, 8200 W. Outer Dr., Detroit 19
SISTER MARY MAURITA*  
6071 W. Outer Dr., Detroit 21
SISTER M. MERCEDA  
Mercy Hospital, Gaylord
SISTER MARY OLIVIA  
1521 Gull Rd., Kalamazoo 17
SISTER M. PATRICE*  
6071 W. Outer Dr., Detroit 21
SISTER MARY PHILIPPA  
St. Joseph’s Mercy Hospital, Pontiac 9
SISTER M. RAYMOND  
Mercy Hospital, Monroe
SISTER M. REGINA  
Mercy Hospital, Bay City
SISTER MARY RICHARD  
St. Mary’s Hospital, Grand Rapids
SISTER MARY ROSALIND  
1521 Gull Rd., Kalamazoo 17
SISTER M. ROSE  
1521 Gull Rd., Kalamazoo 17
SISTER MARY ROSELLA  
2200 E. Grand Blvd., Detroit 11
SISTER M. THEODOSIA LYNCH  
St. Mary’s Hospital, Grand Rapids 2
SISTER MARY THOMASINE  
Mercy Hospital, Muskegon
SISTER M. VALENTINA  
St. Joseph’s Mercy Hospital, Ann Arbor
SISTER MARY VISITATION
326 N. Ingalls St., Ann Arbor

SISTER MARY VITA
St. Joseph's Mercy Hospital, Ann Arbor

SISTER M. XAVIER KINNEY
St. Mary's Hospital, Grand Rapids

SISTER M. XAVIER SHIELDS
6071 W. Outer Dr., Detroit 21

SISTER MAUREEN MCDONALD
Mercy Hospital, Bay City

SISTER PIERRE
23200 W. Michigan, Dearborn

SISTER REDEMPTA
St. Joseph's Hospital, Mt. Clemens

SISTER RITA VOSS
Providence Hospital, Detroit 8

SISTER ROBERT MARY
St. Joseph's Mercy Hospital, Ann Arbor

SISTER ROSE HELENE
St. Joseph's Hospital, Hancock

SISTER VICTORIA
830 S. Jefferson St., Saginaw

SKINNER, GERALDINE
115 Crest Ave., Ann Arbor

SLATER, BARBARA A.
2343 Central Ave., Detroit 9

SLATING, MARGARET L.
120 Seward, Detroit 2

SLEEPER, MRS. LEONA
4907 Commonwealth, Detroit 8

SMITH, MRS. ALICE L.
838 Seward Ave., Detroit 2

SMITH, INEZ T.
702 W. Allegan, Lansing

SMITH, MRS. JULIA D.
1100 Granger St., Ann Arbor

SMITH, MABEL E.
109 Washington Apts., Lansing

SMITH, MARY E.
2375 Glendale, Detroit 6

SPAULDING, GERTRUDE E.
Tecumseh Hospital, Tecumseh

STACEY, MRS. HELEN W.
1122 Wealthy St., S.E., Grand Rapids 6

STACHELSKI, REGINA C.
6200 W. Outer Dr., Detroit 19

STAIR, JEAN
910 W. Kirby, Detroit 2

STECKLEY, MARY E.
7470 Byron Ave., Detroit 2

STEINMETZ, IDA
109 Parsons St., Detroit 1

STEKETEE, MRS. MARGUERITE
421 Fuller St., S.E., Grand Rapids

STENERG, CHARLOTTE H.
St. Mary's Hospital, Saginaw

STEVENS, MRS. BARBARA C.
1962 Florence, Detroit 3

STEVENVSON, ELIZABETH
7450 Byron, Detroit 2

STEWART, CLEO L.
1410 W. Bethune Ave., Detroit 6

STEWART, MRS. DOROTHY D.
490 W. Margaret, Detroit 3

STEWART, MRS. ELSIE K.
434 Kings Highway, Wyandotte

STEWART, MARGARET W.
5224 St. Antoine St., Detroit 2

STIMMEL, FAY
6410 Trumbull, Detroit 2

STRAUB, MARY K.
652 Fulton, East Grand Rapids

STREADWICK, DOROTHY A.
1216 W. Bethune St., Detroit 2

STURTEVANT, CAROL
1522 Pontiac Rd., Ann Arbor

SULLIVAN, MRS. FLORENCE C.
220 Cherry St., S.E., Grand Rapids 2

SUM, ESTHER K.
903 E. Huron St., Ann Arbor

SWEET, LEONE
Bronson Methodist Hospital, Kalamazoo

SYMINGTON, GRETTA
1463 Ferry Park Ave., Detroit 8

SYROID, CLENNIS C.
20442 A Cheyenne, Detroit 35

TANNER, OLGA A.
4309 North St., Flint

TAYLOR, ELEANOR E.
2800 W. Grand Blvd., Detroit 2

TEAT, MRS. ELEANOR L.
1042 Prince St., S.E., Grand Rapids 7

TERRY, BETTY L.
433 Court St., N.E., Grand Rapids

THOMAS, CRYSTAL V.
Box 232, Kent City

THOMAS, MRS. NORMA M.
575 E. Belt Line, N.E., Grand Rapids 6

THOMPSON, GLADYS
8200 W. Outer Dr., Detroit 19

TIBBITS, MRS. ANNA Q.
4380 Larchmont Ave., Detroit 4

TIPTON, IDA E.
933 Hazelwood, Detroit 2

TORR, NORMA R.
12753 Washburn, Romulus

TOWNSEND, EDITH H.
15311 Corun, Detroit 5

TRAINHAM, GENEVIEVE
92 Orchestra Pl., Detroit 2

TREGONING, RUTH
216 W. Grand Ave., Muskegon

TREUSCH, CATHERINE M.
3609 Kalamazoo St., Battle Creek

TROTTER, JEANNETTE E.
93 E. Alexander, Detroit 1

TULLIS, ALICE
801 W. Sixth Ave., Flint 2

TURNER, EDITH J.
18903 Strachmore, Detroit 21

TUTTLE, MILDRED L.
216 N. Mulberry, Marshall

URBAN, HELEN C.
706 N. Walnut St., Bay City

VAN BENSCHOTEN, GLADYS
3825 Brush St., Detroit 1

VANDER LINDE, JOAN M.
2433 E. Main St., Kalamazoo

VANDERWAL, JANINE
Hackley Hospital, Muskegon

VAN HORN, ELLA M.
219 W. Saginaw St., Lansing

VERRY, GERTRUDE E.
633 N. East Ave., Jackson

VIAU, HELEN
1840 E. Grand Blvd., Detroit 11

506
VIGLIONE, AMY
W. K. Kellogg Foundation, Battle Creek

VINCIUERRE, MINNIE
235 E. Alexandrine Ave., Detroit 1

VIZZENA, SYLVA
2128 Pearl St., Hazel Park

WADDELL, DOROTHY I.
1302 Colorado, S.E., Grand Rapids 6

WACAR, MRS. MARYLYN H.
1359 Portage St., Kalamazoo 7

WALKER, MARY V.
600 Cherry St., Lansing

WALLACE, KATE M.
1800 Tuxedo, Detroit 6

WALSH, PATRICIA
2331 Fernwood, Pittsfield Village, Ann Arbor

WALTERS, DENA
Bronson Methodist Hospital, Kalamazoo 5

WALTERS, HELEN M.
Hurley Hospital, Flint 2

WALTON, GLORIA J.
1740 Third Ave., Apt. 209, Detroit 3

WARFIELD, STELLA C.
16510 Ilene, Detroit 21

WARWICK, LORENE M.
Indiana University, Bloomington, Ind.

WATKINS, MRS. MARGARET H.
210 Cloverly Rd., Grosse Pointe Farms 30

WATSON, BARBARA
Beldgett Memorial Hospital, Grand Rapids

WEATHERHEAD, PEARL H.
816 E. Wood St., Flint

WEAVER, RUTH I.
Hurley Hospital, Flint

WEISS, WANDA M.
4963 Second St., Detroit 1

WELCH, HELEN K.
U. S. Marine Hospital, Detroit 15

WELLAND, MRS. HARRIETT K.
910 W. Kirby, Detroit 2

WELLIK, MARY H.
220 Cherry St., S.E., Grand Rapids 2

WELLMINGTOK, MADELYN K.
311 Donald St., Muskegon

WENDT, MRS. EDITH G.
1500 Weiss St., Saginaw

WENNING, HELEN
155 North Ave., Mt. Clemens

WENZEL, KATHRYN E.
574 W. Huron, Pontiac

WESTBROOK, H. FLORENCE
5110 Elmhurst, Detroit 4

WHEELOCK, RUTH V.
Michigan School for the Deaf, Flint

WHITE, MRS. A. E.
2110 Dorset Rd., Ann Arbor

WILEY, ISABELLE
1210 Washentaw Ave., Ann Arbor

WILKINSON, MRS. DOROTHY A.
2024 Glendale, Flint 3

WILLIAMS, CHERALYNE L.
2251 Webb, Detroit 6

WISNER, MRS. GERTRUDE H.
17590 Whitcomb Ave., Detroit 19

WOJATASZEK, JOSEPHINE
901 James St., S.E., Grand Rapids

WOLF, MIRIAM V.
Beldgett Memorial Hospital, Grand Rapids 6

WONN, CATHERINE
617 N. Union, Tecumseh

WOOD, H. FERN
53 Marion Pl., Detroit 2

WOODERS, MARIE A.
Rocking Chair Hospital, Detroit 26

WORRELL, KATHRYN E.
69 W. Washington St., Rm. 200, Chicago, III.

WRIGHT, MARION J.
3825 Brush St., Detroit 1

WUBBENA, CATHERINE E.
801 W. Sixth Ave., Flint 2

WYSOCKI, HELEN
1344 Walker St., N.W., Grand Rapids 4

YETMAN, MRS. IVAH F.
Butterworth Hospital, Grand Rapids

YOUNGS, ANNA L.
158 Ridge Rd., Grosse Pointe Farms 30

ZELNAR, LUCILLE
399 Glendale, Highland Park 3

ZICK, MARIE A.
1479 E. Jefferson Ave., Detroit 7

ZIMMERMAN, ORPHA S.
1706 Peck St., Muskegon

ZUVER, MRS. LORETTA M.
7290 Silvery Ln., Dearborn

ADAMS, ARLONE H.
212 Walnut, S.E., Minneapolis 14

AMDAHL, MURIEL K.
555 Aldine, St. Paul 4

AMEND, LT. LILLIAN C., (NC) USNR
U. S. Naval Hospital, Nurses Quarters,
Great Lakes, Ill.

AMES, ANNA M.
3333 Texas Ave., St. Louis Park

ANDERSON, BARBARA M.
683 E. 59th St., Minneapolis

ANDERSON, JEAN E.
2550 Ninth St., S., Minneapolis 6

ANDERSON, SIGNE E.
Swedish Hospital, Minneapolis

ANDERSON, VIRGINIA L.
200 Earl St., St. Paul 6

BANGHART, MARGARET E.
Colonial Hospital, Rochester

BARBER, H. JOAN
1710 Stevens Ave., Minneapolis

BELL, HELEN E.
992 Dayton Ave., St. Paul 4

BENNETT, AGNES M.
33—14 Ave., N.E., Rochester

BENNETT, MILDRED F.
2717 Elliot Ave., Minneapolis

BENSON, MARGARET E.
3140 Wisconsin Ave., Apt. 308, Washington, D. C.

BENSTON, MARTHA L.
427 Fourth St., S.E., Apt. 205, Minneapolis

BERGER, MRS. LOIS L.*
829 S. Eighth St., Minneapolis 6

507
BERGFALD, C. JEANNE
Naure Hospital, Albert Lea

BERGH, IDA
Lutheran Deaconess Hospital, Minneapolis 4

BERGSAGEL, RUTH T.
2122 Aldrich Ave., S., Minneapolis 5

BESTUL, HARRIET R.
4010—26 Ave., S., Minneapolis

BIBEAU, MRS. DOROTHEE-MAE
378 Fifth Ave., N., Bayport

BILLINGS, GRACE
Charles T. Miller Hospital, St. Paul 2

BIERKE, MRS. MARY P.
1003 E. Ivy, St. Paul 6

BLACK, KATHLEEN
425 Oak St., S.E., Minneapolis

BLANKENBILLER, HARRIET
559 Capital Blvd., St. Paul 1

BLASENA, CATHERINE
1978 Ashland Ave., St. Paul 5

BLODGETT, MRS. HELEN W.
3939 Hubbard Ave., Richsindsdale 22

BLOMBERG, LUCILLE M.
407 W. Myrtle, St. Peter

BLOMQVIST, VERN A.
301 Charles Ave., St. Paul 3

BORMAN, GLADYS M.
825 S. Eighth St., Minneapolis 4

BOWDITCH, MRS. HELEN W.
512 Delaware St., S.E., Minneapolis

BRETHORST, DR. ALICE B.
1599 Hewitt Ave., St. Paul 4

BREZINSKI, GERTRUDE
Kehler Hospital, Rochester

BROOKS, LAURA S.
1385 Grand Ave., St. Paul 5

BROWN, FLORENCE R.
St. Luke’s Hospital, Duluth 5

BRYANT, JEANETTE
1915 Third Ave., S., Minneapolis 4

BUDD, CLADYCE O.
611 E. 14 St., Minneapolis

BURGGREN, EVA H.
120 Summit Ave., St. Paul 2

BURNS, AGNES T.
2163 Carfield Ave., S., Minneapolis 3

BURTON, MRS. ROSALIE D.
1877 Princeton Ave., St. Paul

BUSHEE, RUTH L.
1105 E. Center St., Rochester

CAMPBELL, M. LOIS
3512 Columbus Ave., S., Minneapolis 7

CARDELLI, MRS. VIRGINIA A.
6040 Vincent Ave., S., Minneapolis

CARLSON, AMELIA
904 Lansing Ave., Austin

CARLSON, HELEN M.
1003 Ivy Ave., St. Paul 6

CARTER, EDITH L.
1906 Third Ave., S., Apt. 26, Minneapolis

CASSIDY, LUCILE M.
468 S. Snelling, Apt. 114, St. Paul

CHRISTENSON, LETTIE A.
2064 Niles Ave., St. Paul 5

CHRISTENSON, MILLIE C.
2312 S. Sixth St., Minneapolis 6

COFFIN, ELLA C.
Franklin Hospital, Minneapolis 5

COLEMAN, JEAN
4004—11 Ave., S., Minneapolis

COLESWORTHY, MRS. DOLORES S.
3401 S. Irving, Minneapolis 8

COLLATZ, LEONORA J.
Rm. 331, Nursing Education Residence, Catholic University of America, Washington 17, D. C.

COLLINS, EVALYNE M.
St. Mary’s Hospital, Rochester

CORKISS, IONE E.
4209 Aldrich Ave., S., Minneapolis 9

COUTIER, LULU M.
123—13 Ave., S.E., Rochester

CRAWFORD, ANNIE LAURIE
Oak Grove Hotel, Minneapolis 3

CROWE, CHARLOTTE C.
Glen Lake Sanatorium, Oak Terrace

DAHLEN, ELSIE
3823—11 Ave., S., Minneapolis

DANIELSON, MARY
Mounds Park Hospital, St. Paul 6

DARR, VERA M.
P.O. Box 233, Rochester

DAU, LEONA M.
3242 Girard Ave., S., Minneapolis 8

DENCKLMA, NINA H.
2307—27 Ave., S., Minneapolis 7

DENSFORD, KATHARINE J.*
University of Minnesota, 125 Medical Science Bldg., Minneapolis 14

DIXON, MRS. BARBARA F.
3706 Grand Ave., S., Minneapolis

DODDS, THELMA M.
Charles T. Miller Hospital, St. Paul 2

DOLFE, ROSE L.
St. Mary’s Hospital, Rochester

DONALDSON, SYLVIA
3624 Elliot Ave., S., Minneapolis 7

DOTSETH, ALICE
2202 S. 7½ St., Minneapolis 6

BRUSSEL, LORRAINE M.
U. S. Naval Hospital, Bainbridge, Md.

DUNN, ROSE E.*
4516 Moorland Ave., Minneapolis 16

DURAND, CILBERTA
Hotel Damon, Rochester

EDLUND, DONNIE M.
3216 Fremont Ave., S., Minneapolis 8

EINERSON, EMMA C.
Glen Lake Sanatorium, Oak Terrace

EKKE, ADELINE I.
3321 Fifth Ave., S., Minneapolis 8

ENG, MRS. HAZEL
1500 Elliot Ave., Minneapolis 4

ENGBERG, E. MADELEINE
4304 Abbott Ave., S., Minneapolis 10

ENOS, LUCY D.
394 Harvard, S.E., Minneapolis 14

ERICSON, JANET L.
118 Prospect Blvd., St. Paul 7

ERVEN, MARGARET E.
Veterans Administration Hospital, Clinton, Iowa

FALKESTAD, THELMA
1655 Englewood Ave., St. Paul 4

FELIEN, EDITH I.
2219 Garfield Ave., S., Minneapolis

FIELD, VIRGINIA R.
2069 Watson, Apt. 33, St. Paul 5
HANSON, JOHANNA
2304 S. Sixth St., Minneapolis 6
HANSON, LORRAINE A.
Bethesda Hospital, St. Paul 1
HARRIS, M. ISABEL
1903 Elliot Ave., S., Minneapolis 4
HARSTAD, CLARICE
915 E. 14 St., Minneapolis
HART, HELEN E.
519 Fifth Ave., S., St. Cloud
HAUGE, FLORENCE
3017 E. 24 St., Minneapolis
HAUCUM, ELLA A.
Minneapolis General Hospital, Minneapolis 15
HAYES, DOROTHY E.
2107 Hennepin St., Minneapolis
HEALY, MARCELLA
408 Fountain, Albert Lea
HEDGES, MRS. JENNIE G.
14 Fifth Ave., S.W., Faribault
HEGGENESS, HELEN L.
123 Oak Grove, Apt. 604, Minneapolis
HEIMES, MRS. MARGUERITE D.
18 Norman Ridge, Minneapolis
HELANDER, VIOLET J.
103 E. 16 St., Minneapolis 4
HEMMES, THELMA V.
426 Pierce St., St. Paul 4
HINMAN, AGNES C.
2438-14 Ave., S., Minneapolis 4
HOFF, GERTRUDE V.
2638-16 Ave., S., Minneapolis
HOPFERT, FRANCES
4944 Washburn Ave., S., Minneapolis
HOLM, MRS. RUTH M.
Concordia College, Moorhead
HOLMBERG, RUTH
Bethesda Hospital, St. Paul 1
HOOVER, MRS. PEARL R.
Unit V-7, University Village, Minneapolis 14
HOPPE, MRS. DOROTHY
629 Sherburne, St. Paul 4
HUFFMAN, ZELIA M.
3257 Queenstown Dr., Mt. Rainier, Md.
INGRAM, FLORENCE K.
1003 E. Ivy St., St. Paul 4
JACOBSON, ESTHER A.
829 S. Eighth St., Apt. 3, Minneapolis
JAHRAUS, CHRISTINE C.
1230 Amsterdam Ave., #286, New York 27, N. Y.
JARSHAW, MARIE E.
International Falls
JENSEN, KATHRYN
200 Earl St., St. Paul 6
JOHANSON, CLARA O.
1412 E. 24 St., Minneapolis 4
JOHNSON, ADELE C.
752 E. Montana Ave., St. Paul 6
JOHNSON, HAZEL M.
611 E. 14 St., Minneapolis 4
JOHNSON, MARY A.
2643 Humboldt Ave., S., Minneapolis 8
JOHNSTON, RUTH V.
1000 University Ave., S.E., Minneapolis
JONES, CLARA J.
559 Capitol Blvd., St. Paul
JULIAN, FLORENCE
1903 Elliot Ave., S., Minneapolis 4
KENDALL, KATHERINE  1065 Portland Ave., Minneapolis
KENTTA, RUTH V.  Bethesda Hospital, St. Paul 1
KOENEMAN, GERTRUDE A.  2103 Garfield Ave., S., Minneapolis
KRAFT, ELIZABETH F.  Ashbury Hospital, Minneapolis 4
KRON, MRS. THORA M.  947 Livingston, W., St. Paul 7
KRUG, ELSIE E.  1701 First St., S.W., Rochester
KUITU, HELEN  Gillette State Hospital, St. Paul 6
LANGE, INEZ M.  4234 Pillsbury, Minneapolis 4
LAPHAM, NELLIE I.  Ancker Hospital, St. Paul 1
LA ROSE, LOUISE  2215 Glenwood, Minneapolis 5
LARSON, GLORIA M.  515 Delaware, S.E., Apt. 304, Minneapolis 14
LARSON, MARIORIE S.  820 E. 14 St., Minneapolis 4
LARSON, RUTH E.  3944 Elliot Ave., S., Minneapolis
LEDGER, CECELIA R.  315 Fourth St., S.E., Minneapolis 14
LEE, NINA  5240 Garfield Ave., S., Minneapolis
LEHMANN, RUTH A.  559 Capital Blvd., St. Paul 1
LEONARD, MRS. ALTA M.  110 E. 18 St., Minneapolis 3
LIANE, DOLORES J.  1823 Second Ave., S., Minneapolis 4
LIEB, EVELYN M.  St. Lucas Hospital, Faribault
LINEHAN, MRS. HELEN B.  3023 University Ave., S.E., Minneapolis
LOHE, GRACE  Ziek Apt., #101, Rochester
LORENTZEN, EMMA  2408 Elliot Ave., S., Minneapolis 4
LOVE, AGNES D.  2011 Third Ave., S., Minneapolis
LOVILIMO, ELVIRA E.  2415 Emerson Ave., N., Minneapolis
LOW, MARGERY  University of Minnesota School of Nursing, Minneapolis 14
LUBBERTS, ETTA*  492 Jefferson Ave., S., St. Paul 1
LUNDE, BERTHA  Bethesda Hospital, St. Paul
LUNDE, RUTH  2312 S. Sixth St., Minneapolis
LYNG, CLADYS  Swedish Hospital, Minneapolis 4
MADSON, SIGRID J.  611 E. 14 St., Minneapolis
MAGDANZ, MRS. EMELIE  3019-18 Ave., S., Minneapolis
MALTBY, MRS. EDNA B.  3245 Emerson Ave., S., Minneapolis
MARBURGER, MRS. DOROTHY W.  533 E. Center St., Rochester
MARKUSEN, LYDIA R.  Box 29, Fergus Falls

MEMBERS

MATTSON, CLEO F.  2730 Park Ave., Minneapolis 7
MCCOOLEMAN, EDNA I.  St. Luke's Hospital, St. Paul 2
MCGLONE, MRS. ELIZABETH  Route 1, Box 294, Mound
McKEAN, MARGARET J.  1400 Portland Ave., Minneapolis 4
MEEHAN, MRS. ELIZABETH B.  4445-17 Ave., S., Minneapolis 7
MEGSON, WINIFRED H.*  600 Ninth Ave., S.E., Minneapolis
MERRELL, DOROTHY M.  St. Barnabas Hospital, Minneapolis
MEYER, VERNEIL M.  Bethesda Hospital, St. Paul
MILLER, DORIS I.  4517 Grand Ave., S., Minneapolis 9
MILLS, LAVERNE G.  4915 Woodlawn Blvd., Minneapolis 17
MILLS, ANNE L.  4724 Fourth Ave., S., Minneapolis 9
MILOSEVIC, KATHERINE E.  Star Route 3, Box 355, Hibbing
MISENICK, HELEN  4715 Washburn Ave., N., Minneapolis
MOCK, ELEANOR P.  324 Onida St., St. Paul 2
MOE, MILDRED S.  5649 Harriet Ave., Minneapolis
MOONEY, BEATRICE J.  2096 Eleanor Ave., St. Paul 5
MULLEN, MARION  220 E. 19 St., Apt. 101, Minneapolis
NELSON, ELEANOR  Bethesda Hospital, St. Paul 1
NELSON, VIOLET E.  Mounds Park Hospital, St. Paul 6
NESHIM, JOAN  306 Oak Grove, Minneapolis 3
NESHKE, ANGELINE M.  426 Pierce St., St. Paul 4
NIEDERBAUMER, LYLA  605 E. 17 St., Minneapolis
NINGER, MRS. FRANCES P.  715 Fifth St., N.W., Faribault
NOBLES, GEORGIA G.  Minneapolis General Hospital, Minneapolis 15
NOREM, HARRIET  3427-26 Ave., S., Minneapolis 6
NORRIS, SHYL  83 Ivy St., Brookline 46, Mass.
NYE, LYDA J.  Delano Hall, Rochester
NYVORDET, ESTER  1412 E. 24 St., Minneapolis 4
NYQUIST, ANN S.  Division of Public Health Nursing, University of Minnesota, Minneapolis
OCHS, MARY F.  1042 Hague Ave., St. Paul 4
OIE, ALMA T.  3825-11 Ave., S., Minneapolis
OLSON, BARBARA K.  5109-15 Ave., S., Minneapolis 7
OLSON, HELEN L.  5549-41 Ave., S., Minneapolis
OLSON, M. LYLA  406 Fourth St., S.W., Rochester

510
OLSON, MARJORIE H.
2423—14 Ave., S., Minneapolis 4

OLSON, PHYLLIS A.
623 University Ave., N.E., Minneapolis 10

O’NEIL, MARY L.
506 Grace St., Albert Lea

O’NEILL, CATHERINE M.
2438—14 Ave., S., Minneapolis 4

OSETH, ELEANORE G.
4329 Bloomington Ave. S., Minneapolis

OSTLUND, LUCILLE J.
Midway Hospital, St. Paul 4

PALMER, MELLIE F.
2527 Washburn Ave., S., Minneapolis 16

PASKIEWITZ, LENA R.
1005 Portland Ave., Minneapolis

PAULSON, MRS. CATHERINE T.
407 Seventh Ave., S.E., Minneapolis

PEDRICK, MILDRED
1705 St. Clair, St. Paul

PETERKA, ROSE E.
Box 75, Marion Hall, Rochester

PETERSEN, ALMA H.
1000 University Ave., S.E., Minneapolis 14

PETE RSON, ADA S.
Rochester State Hospital, Rochester

PETERSON, MYRIL L.
533 E. Center St., Rochester

PETERSON, SENA K.
914 S. Eighth St., Minneapolis

PFANENGER, LOTTIE J.
900 S. Broadway, New Ulm

PFEFFER, NELLA H.*
Mount Sinai Hospital, Minneapolis 13

PHILLIPS, ELIZABETH J.
2163 S. Garfield St., Minneapolis 5

PLADSON, NINA O.
Palmar Hall, Rochester

PLAUNT, LOIS
St. Mary’s Hospital, Duluth

PLETT, SARA F.
Rochester State Hospital, Rochester

POWERS, CAROLYN E.
314 Third Ave., S.E., Rochester

PREBIL, MRS. MARIANNE V.
River Terrace Ctr., Minneapolis

PREECE, AWA
2810 Portland Ave., Minneapolis

RAU, MRS. MAGDALENA
St. John’s Hospital, St. Paul 6

ROBERTSON, CAROLYN Q.
Gillette State Hospital, St. Paul 6

ROBERTSON, WANDA M.
515 S.E. Oak St., Minneapolis 14

ROBINSON, MARGARET G.*
420 Fourth St., S.W., Rochester

ROESTI, ESTHER E.
103 Fourth Ave., N.W., Rochester

ROGSTAD, ELIZABETH†
Fairview Hospital, Minneapolis 6

ROUNSVILLE, ETHEL L.
St. Luke’s Hospital, Duluth

RYCH, GLADYS
2537 Elliot Ave., S., Minneapolis

SANDIN, CHARLOTTE M.
Mounds-Midway Hospital, St. Paul 4

SANDIN, NELLIE H.
2135 Ann Arbor, St. Paul 1

SAUBY, MRS. INEZ M.
3015 Arthur St., N.E., Minneapolis

SCHMIDT, MARIE A.
Veterans Administration Hospital, Minneapolis 17

SCHWARZ, HELEN G.
1254 Minnesota Bldg., St. Paul 1

SCHWEPPE, WINIFRED
223 Oak Grove St., Minneapolis 4

SEARS, MRS. GERTRUDE B.
911 Park Ave., Minneapolis

SEATH, DELORES B.
915 E. 25 St., Minneapolis

SHEICK, FERN
Hotel Damon, Rochester

SHEILD, SAVALLAH M.
Veterans Administration Hospital, Minneapolis

SHIRLEY, ALMA O.
Deaconess Hospital, Minneapolis 4

SIDLO, AGNES
426 Pierce St., St. Paul 4

SISTER AGNES LEON
St. Catherine’s College, St. Paul

SISTER DOGORATA
1406 Sixth Ave., N., St. Cloud

SISTER ELEANORE
St. Lucas Hospital, Faribault

SISTER FRANCIS MICHAEL
2500 S. Sixth St., Minneapolis 6

SISTER HELEN CLARE
St. Mary’s Hospital, Duluth 5

SISTER MARGARET FRANCES
St. Mary’s Hospital, Minneapolis

SISTER M. ALETHEA
St. Mary’s Hospital, Rochester

SISTER M. ANCINA
St. Mary’s Hospital, Rochester

SISTER MARY ARTHUR
St. Mary’s Hospital, Duluth 5

SISTER M. BERNARDA
St. Mary’s Hospital, Duluth

SISTER MARY BRIGH
St. Mary’s Hospital, Rochester

SISTER M. CAROLINE
St. Francis Hospital, Breckenridge

SISTER MARY CELINE
2500 S. Sixth St., Minneapolis 6

SISTER MARY CORTONA
St. Gabriel’s Hospital, Little Falls

SISTER MARY DAMIAN
St. Francis Hospital, Breckenridge

SISTER MARY DOMINIC
St. Cloud Hospital, St. Cloud

SISTER M. DOROTHY
St. Joseph’s Hospital, Mankato

SISTER M. ELIZABETH
St. Gabriel’s Hospital, Little Falls

SISTER MARY ERNAN
St. Mary’s Hospital, Rochester

SISTER MARY FRANCIS
St. Mary’s Hospital, Rochester

SISTER MARY GERALD
St. Cloud Hospital, St. Cloud

SISTER M. GIOVANNI
1406 Sixth Ave., N., St. Cloud

SISTER MARY JANE
436 Main St., St. Paul 2

SISTER MARY JUDE
St. Cloud Hospital, St. Cloud
SISTER M. JULIE  
St. Mary’s Hospital, Rochester  
SISTER M. KEITH  
St. Cloud Hospital, St. Cloud  
SISTER M. MARMION  
College of St. Scholastica, Duluth 2  
SISTER MARY MAUREEN  
St. Mary’s Hospital, Rochester  
SISTER M. RAYMUNDA  
St. Mary’s Hospital, Rochester  
SISTER M. VENARD  
2500 Sixth St., S., Minneapolis 6  
SISTER M. VIVIAN  
St. Mary’s Hospital, Duluth 5  
SISTER RITA MARIE  
Hibbing General Hospital, Hibbing  
SISTER ST. FRANCIS  
St. Joseph’s Hospital, St. Paul 2  
SIVERSION, MURIEL D.  
200 Earl St., St. Paul 6  
SKAR, MRS. JEAN R.†  
223 Sixth St., Rochester  
SMITH, MYRTLE O.  
3622—17 Ave., S., Minneapolis 7  
SMITH, RUTH E.  
533 W. Center St., Rochester  
SMITH, MRS. RUTH R.  
Ancker Hospital, St. Paul 1  
SOBOTKA, IRENE A.  
120 W. Summit, St. Paul  
SOLLENBERGER, MARJORIE E.  
Delano Hall, Rochester  
STEEN, REBECCA E.  
3704—17 Ave., S., Minneapolis 7  
STENSETH, JEANETTE  
Glen Lake Sanatorium, Oak Terrace  
STILLAR, EDITH M.  
3442 Elliot Ave., S., Minneapolis 7  
STRAYER, CONSTANCE H.  
314 Third Ave., S.E., Rochester  
STROMBERG, EDNA  
Midway Hospital, St. Paul 4  
SULLIVAN, CATHERINE  
Naeve Hospital, Albert Lea  
SWANSON, ARDIS R.  
1912—15 Ave., S., Minneapolis  
SWANSON, VERA  
1830 Stevens Ave., Minneapolis  
SWENSON, EDITH E.  
1906 Third Ave., S., Minneapolis  
TAYLOR, EUGENIA R.  
1000 University Ave., S.E., Minneapolis  
TAYLOR, MARGARET S.  
16 Norman Ridge, Route 4, Minneapolis 20  
TEISBERG, A. LOUISE  
415 Beacon Ave., St. Paul 4  
TEMPLE, FRANCES A.  
1521 LaSalle Ave., Minneapolis  
TESKE, THELMA  
301 Fischer Apt., Rochester  
TEXLEY, RUTH  
5633 Blairsdell Ave., Minneapolis  
THOMPSON, BERNICE  
4517 Grand Ave., Minneapolis  
THURGSTAD, JOYCE M.  
2224 E. 32 St., Minneapolis 7  
TOFFE, BIRGIT  
587 Grand Ave., St. Paul  
TOLLEFSSON, VALBURG E.  
Veterans Administration Hospital, Quarters 13, S., Minneapolis 17  
TOMASKO, M. CORRINE  
4641 Beard Ave., S., Minneapolis  
TORKELSON, LEVINA  
4529 Bloomington Ave., S., Minneapolis  
TOWN, MARIAN J.  
1816 Third St., N., St. Cloud  
TURNER, MOLLIE  
600 E. 15 St., Minneapolis 4  
ULEBERG, RUTH L.  
Bethesda Hospital, St. Paul  
URCH, DAISY D.  
270 Center St., Winona  
UREN, ELEANORE B.  
5749 Longfellow Ave., Minneapolis  
VAN BEEBBER, ANASTASIA C.  
51 E. Maryland Ave., St. Paul 3  
VENNES, CAROL H.  
843—24 Ave., S.E., Minneapolis 14  
WARNER, LILLIAN A.  
3220 Blaisdell Ave., Minneapolis  
WEBER, MARGARET E.  
120 W. Summit Ave., St. Paul 2  
WEISS, CHARLOTTE J.  
1569 Laurel Ave., St. Paul 4  
WEITENSTEINER, BERTHA C.  
605 E. 17 St., Minneapolis  
WICKLUND, EFFIE M.  
1725 Second Ave., S., Minneapolis 3  
WITTE, MRS. ARLINE A.  
2921 Third Ave., S., Minneapolis 8  
WOLF, MARTHA K.  
201 E. Division St., Faribault  
WOLTMAN, MARIE H.  
3511 S. Lyndale Ave., Minneapolis 19  
YOKIE, DORIS E.  
3121—17 Ave., S., Minneapolis 7  
ZAHLER, ANASTASIA M.  
St. Mary’s Hospital, Rochester  
ZIELKE, LYDIA A.  
2701 E. Minnehaha Pkwy., Minneapolis  
ZILLGITT, LYDIA L.  
St. Lucas Deaconess Hospital, Faribault  
ZIMMERMAN, LILLIAN D.  
1824 Elliot Ave., S., Minneapolis 4

MISSISSIPPI—63

ADAMS, DOVIE  
Methodist Hospital, Hattiesburg  
ALEXANDER, FRANCES  
Mississippi State Tuberculosis Sanatorium, Sanatorium  
BOYD, CLADYS E.  
509 Orlando St., Greencastle  

TESKE, THELMA  
301 Fischer Apt., Rochester  
TEXLEY, RUTH  
5633 Blairsdell Ave., Minneapolis  
THOMPSON, BERNICE  
4517 Grand Ave., Minneapolis  
THURGSTAD, JOYCE M.  
2224 E. 32 St., Minneapolis 7  
TOFFE, BIRGIT  
587 Grand Ave., St. Paul  
TOLLEFSREID, VALBURG E.  
Veterans Administration Hospital, Quarters 13, S., Minneapolis 17  
TOMASKO, M. CORRINE  
4641 Beard Ave., S., Minneapolis  
TORKELSON, LEVINA  
4529 Bloomington Ave., S., Minneapolis  
TOWN, MARIAN J.  
1816 Third St., N., St. Cloud  
TURNER, MOLLIE  
600 E. 15 St., Minneapolis 4  
ULEBERG, RUTH L.  
Bethesda Hospital, St. Paul  
URCH, DAISY D.  
270 Center St., Winona  
UREN, ELEANORE B.  
5749 Longfellow Ave., Minneapolis  
VAN BEEBBER, ANASTASIA C.  
51 E. Maryland Ave., St. Paul 3  
VENNES, CAROL H.  
843—24 Ave., S.E., Minneapolis 14  
WARNER, LILLIAN A.  
3220 Blaisdell Ave., Minneapolis  
WEBER, MARGARET E.  
120 W. Summit Ave., St. Paul 2  
WEISS, CHARLOTTE J.  
1569 Laurel Ave., St. Paul 4  
WEITENSTEINER, BERTHA C.  
605 E. 17 St., Minneapolis  
WICKLUND, EFFIE M.  
1725 Second Ave., S., Minneapolis 3  
WITTE, MRS. ARLINE A.  
2921 Third Ave., S., Minneapolis 8  
WOLF, MARTHA K.  
201 E. Division St., Faribault  
WOLTMAN, MARIE H.  
3511 S. Lyndale Ave., Minneapolis 19  
YOKIE, DORIS E.  
3121—17 Ave., S., Minneapolis 7  
ZAHLER, ANASTASIA M.  
St. Mary’s Hospital, Rochester  
ZIELKE, LYDIA A.  
2701 E. Minnehaha Pkwy., Minneapolis  
ZILLGITT, LYDIA L.  
St. Lucas Deaconess Hospital, Faribault  
ZIMMERMAN, LILLIAN D.  
1824 Elliot Ave., S., Minneapolis 4

BUSBY, ETHEL M.  
908 Grove St., Vicksburg  
COATES, JEAN M.  
King’s Daughters Hospital, Greenville  
DONGIEUX, MRS. ONEITA A.  
528 Will-o-Wisp, Jackson
DEAN, CLARISSE A.
419 Hill St., Apt. 203, Columbia

DERSCH, ESTHER H.
2220 Holmes St., Kansas City 8

DILLE, BETTY G.
4326 Wornall Rd., Kansas City 2

DYER, MARDEL D.
1003 Art Hill Pl., St. Louis 10

ELMORE, MARJORIE
712 E. High St., Jefferson City

EVITTS, MARY S.
416 S. Kingshighway, St. Louis 10

FAULKNER, MABEL M.
1418 W. Truman Rd., Independence

FIEHLER, MARIE
1357 E. McCutcheon Rd., Richmond Heights 17

FITZPATRICK, NANCY E.
Claremont Hotel, Kansas City 3

FOLEY, MARGARET
1438 S. Grand Ave., St. Louis 4

FREY, GLADYS
3025 A Russell St., St. Louis

FRITZ, ALEIDA S.
1204 Francis Pl., Richmond Heights 17

GEUSS, CATHERINE P.
815 E. High St., Jefferson City

GILBERT, FRANCES E.
975 Victoria Ave., Glendale 22

GRABB, MARGARET
5029 Enright Ave., St. Louis 12

GREEN, HESTER P.
81—54 St., S.E., Washington 19, D. C.

GRIFITH, ABICAIL M.
416 S. Kingshighway, St. Louis 10

GRONEMEYER, ANNETTE L.
4643 Carrio Ave., St. Louis 15

GUFFY, NELLIE E.
15-A Oakwood La., Lemay 23

CULMI, DILLIE R.
5049 Arsenal St., St. Louis 9

HAGGMAN, MABEL E.
Trinity Lutheran Hospital, Kansas City 2

HAMILTON, MRS. PAULA C.
Box 230, Salem

HAMSICK, VESTA
416 S. Kingshighway, St. Louis 10

HARRIMAN, MRS. MARIE L.
1301 Ralph Ter., St. Louis 17

HARRIS, EBY M.

HARRISON, VIRGINIA H.
616 Loc St., Columbia

HARTIGAN, HELEN S.
University of Missouri, T13, Rm. 113, Columbia

HEILMAN, IRENE M.
4429 Wornall Rd., Kansas City 2

HEINZER, DELPHINE L.
2925 Missouri Ave., St. Louis 18

HENRY, MARGARET J.
1501-B E. 45, Kansas City

HIGGINS, MRS. HARRIET A.
1083 N. South Rd., University City 5

HILKEMEYER, RENILDA E.
Belvedere Apts., 212 Hiit St., Columbia

HOBITZELLE, LUCY F.
470 Lake Ave., St. Louis 8

HOCHULL, BERTHA
Boone County Hospital, Columbia
MEMBERS

HOLMES, MARY J.
435 W. Evergreen St., Springfield

HORNBEEK, MRS. BESS C.
Route 9, Box 832, Springfield

HOSLER, LA VERGNE
906 E. 30 St., Apt. 202, Kansas City 3

HOUK, MARGARET H.
Box 409, Bolivar

HULSE, RUTH M.
3322 Woodland, Kansas City 3

HUMBERT, LAURA E.
6710 Florence, St. Louis 17

HURLEY, MAXINE
1519 N. Grant St., Springfield

HYBARGER, SUSAN V.
R.F.D. 1, Kimmesswick

JARBOE, LETA C.
Route 3, Box 600, Springfield

JENSEN, MRS. DEBORAH M.
5290 Waterman Ave., St. Louis 8

JONES, FLORENCE T.
436 S. McKnight Rd., St. Louis 24

KACENA, BLANCHE
306 S. Kingshighway, St. Louis

KEHOE, MABEL A.
5335 Delmar Blvd., St. Louis 12

KIEFFER, IRMA E.
4122 W. Florissant, St. Louis

KILHAM, BLANCHE A.
1621 Grants St., St. Louis 4

KING, IMOGENE
4909 Parkview Pl., St. Louis 10

KINNEY, HELEN E.
225 W. McCarty, Apt. F, Jefferson City

KITCHENS, MRS. BARBARA J.
1903a O'Bear Ave., St. Louis 7

KOENNSCHID, ERNA
5861 Maple Ave., St. Louis 12

KNOWLES, CORNELIA S.
6830 Powell Ave., Brentwood 17

KUBLER, LOUISE
Lakeside Hospital, St. Louis 18

KUNZ, GERTRUDE M.
4116 Shenandoah St., St. Louis 10

KUPPINGER, MARIE E.
2312 Huntington, Overland 14

LANFERSIECK, RUTH L.
7512 Hilldale Dr., St. Louis 21

LE COMTE, JOSEPHINE
St. John's Hospital, Springfield

LEE, JULIETTE
2601 N. Whittier, St. Louis 13

LEESE, MRS. VIRGINIA
3444 Ohio Ave., St. Louis

LEICHSENRING, MELBA
5671 Waterman, St. Louis 12

LIBERSTEIN, MRS. GRACE H.
8708 Florence, Brentwood 17

LINDBERG, MRS. SHIRLEY M.
Skagg's Memorial Hospital, Branson

LODGE, MARY P.
3659 Laclede Ave., St. Louis

LOGAN, LAURA R.
1515 Lafayette, St. Louis 4

LORD, PATRICIA A.
6007 Cherry St., Kansas City

MACARTHUR, HULDAH E.
Homer C. Phillips Hospital, St. Louis 13

Mackenzie, BERNICE W.
7357 Burrwood Dr., St. Louis 21

MacNicol, ETHEL
1755 S. Grand Ave., St. Louis 4

Manig, ANNA
5192 Vernom, St. Louis 13

Mason, MRS. KATHERINE A.
405 Ripley, Columbia

McClellan, ROSE A.
305 S. Kingshighway, St. Louis 10

McCrackin, Bess
306 W. 20 St., Hutchinson, Kan.

McDonald, MRS. LOUISE S.
3420 Caroline St., St. Louis 4

Mcintosh, ELIZABETH C.
8710 Florence, St. Louis 17

McKee, ANNE G.
601 E. Capitol, Apt. 105, Jefferson City

McMillan, MILDRED
211 Lafayette, Jefferson City

Megary, MARIE
Veterans Administration Hospital, Poplar Bluff

Meier, EDNA
2648 Potomac, St. Louis 18

Michel, RUTH
6431 Devonshire, St. Louis

Michelson, MARGARET C.
7487 Kingsbury, University

Moody, CLEO
1621 Grattan St., St. Louis 4

Moore, MRS. CLADYS H.
4005 S. Sixth St., Columbia

Morelan, MRS. SHIRLEY H.
3441 Magnolia, St. Louis 18

Morgan, NELLE
1711 Concord Ct., Independence

Mortvedt, MABEL
700 Broadway, Jefferson City

Mushenick, RUBY K.
2623A Natural Bridge, St. Louis 7

Naes, ESTELLE
5010 Ruskin Ave., St. Louis 15

Niday, MIRIAM
4004 Cambridge, Kansas City 3

Northcross, MABEL C.
2316 Goode Ave., St. Louis 13

Nunn, MRS. DOROTHY M.
2326 Central St., Kansas City

O'Donnell, KAY
3419 Hawthorne Blvd., St. Louis 4

O'leary, ALICE M.
4762 Anderson, St. Louis 15

Perkins, OPHELIA
649 S. Florence, Springfield

Peterson, EDNA E.
416 S. Kingshighway, St. Louis 10

Pfaeff, HELEN
113 N. B St., Poplar Bluff

Plese, MRS. JEAN W.
4931A Winona, St. Louis 9

Potter, RUBY M.
416 S. Kingshighway, St. Louis 10

Pranger, ROSEMAY
306 S. Kingshighway, St. Louis 10

Profitt, RUTH
6621 Alamo, St. Louis 5

Quigley, DOROTHY R.
6420 Clayton Rd., St. Louis 17

515
QUITMYER, MRS. MYRTLE G.  
1115 W. White Oak, Independence

RAINS, MARY  
306 S. Kingshighway, St. Louis 10

RAPIER, MRS. DOROTHY K.  
2523 A Dodier, St. Louis 7

REICHMAN, IRENE  
1755 S. Grand Ave., St. Louis 4

REISINGER, VIRGINIA D.  
5017 Nashville, St. Louis 10

REIST, LORETTA  
2020 Olath Blvd., Kansas City, Kan.

RIES, MARGARET M.  
3541 Ashew, Kansas City 3

ROSS, MARY D.  
6150 Oakland, St. Louis 10

ROST, MILDRED A.  
1123 E. High, Jefferson City

RUNZI, OPAL  
4939 St. Louis Ave., St. Louis

RYDER, LAVERO  
Route 2, Box 451, Greve Cour

SACKS, MRS. MARGARET K.  
5522-A Gilmore, St. Louis 20

SANDERSON, MILDRED T.  
35 Municipal Courts Bldg., St. Louis

SANDFORD, ETHEL R.  
U. S. Marine Hospital, Kirkwood

SAYRE, MABEL A.  
4420 Wornall Rd., Kansas City 2

SCHACK, ELAINE D.  
460 Greenwood, Columbus

SCHALL, MARY H.  
605 E. Capitol Ave., Jefferson City

SCHAPERKOTTER, LYDIA  
416 S. Kingshighway, St. Louis 10

SCHMALHORST, MARIE D.†  
1340 E. Eln St., Springfield

SCHUBERT, RUTH  
4426 Wornall Rd., Kansas City 2

SCOPELITE, PAULINE  
8012 Seminole, Clayton 5

SHEAHAN, MARY C.  
4011 Humphrey, St. Louis 16

SHIVELY, VIRGINIA M.  
2415 N. Kingshighway, St. Louis 13

SISTER BAPTISTA  
2415 N. Kingshighway, St. Louis 13

SISTER ELEANOR C. LANNEN  
7500 St. Charles Rd., St. Louis

SISTER ESTELLE*  
Marillac Seminary, Normandy

SISTER EUGENE MARIE  
St. Mary's Hospital, Kansas City 8

SISTER HELEN A. SCHNEIDER  
6150 Oakland Ave., St. Louis 10

SISTER HILDA  
6150 Oakland Ave., St. Louis 10

SISTER HULDA  
6150 Oakland Ave., St. Louis 10

SISTER JAMES MARIE  
St. Joseph Hospital, Kansas City 3

SISTER MARGARET EILEEN  
2510 E. Linwood Blvd., Kansas City 3

SISTER MARIE J. SPRICK  
Evangelical Deaconess Hospital, St. Louis 10

SISTER MARILOU MITCHELL  
Evangelical Deaconess Hospital, St. Louis 10

SISTER MARITA  
St. Joseph Hospital, Kansas City 3

SISTER MARY AGNITA CLAIRE  
6420 Clayton Rd., St. Louis 17

SISTER MARY ANICETA  
6420 Clayton Rd., St. Louis 17

SISTER M. BAPTISTA  
307 S. Euclid, St. Louis 10

SISTER MARY BERTRAND  
307 S. Euclid St., St. Louis 10

SISTER MARY BRENDAN  
307 S. Euclid, St. Louis 10

SISTER MARY CHRYSOSTOM  
1015 N. Main, Springfield 1

SISTER M. CONSUELA  
St. John's Hospital, Springfield

SISTER MARY EDGAR  
St. John's Hospital, St. Louis 10

SISTER MARY FABIAN  
St. Joseph Hospital, Kansas City 3

SISTER MARY GERALDINE  
6420 Clayton Rd., St. Louis 17

SISTER MARY GERTRUDE  
De Paul Hospital, St. Louis 13

SISTER M. GREGORY  
St. Mary's Hospital, St. Louis 17

SISTER MARY HENRIETTA  
6420 Clayton Rd., St. Louis 17

SISTER MARY JOVITA  
3520 Chippewa St., St. Louis 18

SISTER MARY JUANITA  
1548 Papin St., St. Louis 3

SISTER MARY PASCHAL  
1015 N. Main, Springfield 1

SISTER MARY PULCHERIA  
St. Anthony's Hospital, St. Louis 18

SISTER M. QUINTIN  
1015 N. Main St., Springfield 1

SISTER MARY RENE  
St. John's Hospital, St. Louis 10

SISTER MARY SEBASTIAN  
St. Mary's Hospital, Kansas City 8

SISTER MARY SERAPHICA  
St. Mary's Hospital, St. Louis 17

SISTER OLIVIA DRUSCH  
Evangelical Deaconess Hospital, St. Louis

SLATER, MRS. DORA G.  
6306 Enright, St. Louis 5

SMITH, A. EILEEN  
718 Clara Ave., St. Louis 12

SPALDING, LUCILLE  
4961 LaClede Ave., St. Louis 8

STANDIFORD, MRS. LEOTA G.  
3000 Grand Ave., Kansas City

STEVENS, MRS. BERTHA B.  
527 E. Walnut St., Springfield 4

STROBEL, MINNIE J.  
Rockport

STULTS, BESSIE L.  
5573 Clemens, St. Louis 12

SULLIVAN, MARY E.  
3962A Botanical Ave., St. Louis

TABER, ELIZABETH  
1735 S. Grand Ave., St. Louis 4
TETTLETON, MRS. LINDELL K.
716 Kentwood Ave., Springfield
THOMPSON, JOYCE E.
201 Brush Creek, Kansas City 2
TODD, MRS. VERNETTA W.
7633 Foster, Overland Park, Kan.
TROT, LONA L.
4715 W. Pine Blvd., St. Louis 8
VALENTINE, HELEN B.
509 W. 46 St., Kansas City 2
VETTER, VIVIAN M.
4432 Washington Ave., St. Louis 8
WAGGONER, HELEN
5192 Vernon, St. Louis 13
WALSH, JOAN E.
502 Rollins St., Columbia
WARD, FRANCES E.
6234 Delmar Blvd., St. Louis 12
WATSON, RUTH K.
St. Joseph Hospital, Kansas City 3
WEGENER, ESTHER H.
4907 Canterbury Rd., Kansas City
WELLS, MAXINE
1015 E. 27 St., Kansas City 8
WHIDDEN, ABbie G.
1919 S. Grand Ave., St. Louis 4

WHITE, MRS. HELEN P.
2707 Forest Ave., Kansas City
WHITEHEAD, EDITH M.
627 E. Elm St., Springfield
WHITFORD, HELEN S.
Robert Koch Hospital, Koch
WILEY, MRS. RUTH B.
1447 N. Summit St., Springfield
WILHITE, EUNICE A.
5707 McPherson Ave., St. Louis 12
WILLIAMS, MRS. EFFIE P.
5561 Waterman Ave., St. Louis 12
WILLIAMS, LETTIE J.
919 N. Taylor Ave., St. Louis 8
WILLIAMS, MARY L.
1621 Grattan St., St. Louis 4
WILLIAMSON, MAXINE
4116 Charlotte, Kansas City 4
WILMORE, ARDIS A.
420 Maple Blvd., Kansas City 2
WYNE, MARGARET R.
1621 Grattan St., St. Louis 4
YOUNG, MINTA S.
2250 Holmes, Kansas City 8
ZSCHOCHE, JEANETTE
3323 Chippewa St., St. Louis 18

AVERY, MRS. GAIL F.
Galen, Route 1, Deer Lodge
BECKWITH, ANNA T.
302 State Capitol, Helena
BRUGER, CAROLINE
Veterans Administration Hospital, Fort Harrison
CHISHOLM, MRS. FLOSSIE P.
Box 196, Augusta
DIXON, WAVA L.
822 Sixth Ave., Helena
ERICKSON, MRS. ELLA S.
21 Nimitz Dr., Billings
FIELD, HARRIET A.
124 N. 24 St., Billings
GEORGE, O’CONNOR
407 Hart Albin Bldg., Billings
GHRING, LYDIA
Montana Deaconess Hospital, Great Falls
HAECELE, HELEN O.
317—16 Ave., Helena
HRUSKA, BEATRICE
822 Fifth St., Helena
HUBERT, MRS. JANE S.
525 Cleveland St., Missoula
JOHNSON, PATRICIA A.
311 N. Tenth St., Miles City
LIVINGSTON, EUGENIA
428 Power St., Helena
LOEWES, MERAL L.
817 W. Storey, Bozeman
McCORMACK, LEOLA R.
122 S. Eighth Ave., Bozeman
MULVANEY, BETTY S.
536 Euclid, Helena
PRENTICE, DAISY
1301 Ninth Ave., Helena

SHERICK, ANNA P.
Montana State College, Bozeman
SISTER EUGENE TERESA
St. John’s Hospital, Helena
SISTER FRANCES MAUREEN
Columbus Hospital, Great Falls
SISTER MARIE EPHREM
St. Joseph’s Hospital, Lewistown
SISTER MARY BETH
St. Patrick Hospital, Missoula
SISTER MARY FANAHAN*
Holy Rosary Hospital, Miles City
SISTER M. GERARD
St. Joseph’s Hospital, Lewistown
SISTER M. GERMAINE
Sacred Heart Hospital, Havre
SISTER MARY MADELEINE
Holy Rosary Hospital, Miles City
SISTER M. NORBERT
Holy Rosary Hospital, Miles City
SISTER MARY THARSILLA
Sacred Heart Hospital, Havre
SISTER MARY THOMASINE
St. James Hospital, Butte
SISTER PROVIDENCE
Columbus Hospital, Great Falls
ULRICH, PATRICIA G.
Veterans Administration Hospital, Fort Harrison
WALLS, ALTA C.
Route 2, Box 410, Porterville, Calif.
WOLFE, MRS. URSULA K.
507 Peosta Ave., Helena
YUHAS, GERALDINE R.
Fort Harrison

MONTANA—35
ACHEN, LORETTA M.
1232—16 St., Santa Monica, Calif.

BABBB, MRS. WANDA K.
2111 N. Lafayette St., Grand Island

BAKER, ROSE C.
1908 S. 11 St., Lincoln 2

BELL, JANE
840 N. Kansas St., Hastings

BENTLEY, ESTHER L.
3222 S. 27 St., Omaha 7

BOOTH, AUDREY J.
Children's Memorial Hospital, Omaha

BORNEMEIER, CAROL
301 S. 42 St., Omaha

BOYCE, MARGARET
St. Elizabeth Hospital, Lincoln

BRADFORD, MILDRED
Veterans Administration Hospital, Grand Island

BRADY, MRS. RUBY B.
841 S. 30 Ave., Omaha

BREDEHOEFT, MRS. PHYLLIS
865 N. 26 St., Lincoln

BREEN, MERCEDES M.
119 S. 35 St., Omaha

BRICKLEY, EMILY
1222 S. 14 St., Apt. 5, Lincoln 2

BRODERSON, EDNA
1821 C St., Lincoln

BULIN, ADA
1512 Second Ave., Scottsbluff

CAHOY, MRS. LYDIA M.
West Nebraska Methodist Hospital, Scottsbluff

CASWELL, LUCILE
131 N. 34 St., Omaha

CHASE, CAROLYN C.
1625 D St., Lincoln

CLARK, GENEVIEVE
Veterans Administration Hospital, Grand Island

CLIFFTON, MRS. HELEN
1315 W. Fifth St., Hastings

COKER, MRS. BRIDIE
630 Park Ave., Apt. 4, Omaha 5

COLLISON, ALICE
3420 Mason St., Omaha

CRAMER, BERNECE F.
1230 Amsterdam Ave., New York 27, N. Y.

DAVIDSON, MRS. BESS D.
521 N. St. Joe Ave., Hastings

DOUGHTY, MRS. ZOE
1650 H St., Apt. D-4, Lincoln

DUNN, MARION E.
Veterans Administration Hospital, Lincoln

EISENOCH, MINNIE B.
546 S. 31 Ave., Omaha

ENGELHARDT, PEARL I.
2632 Harney, Omaha

ENGELHARDT, SHIRLEY L.
Hastings State Hospital, Ingleside

ERICKSON, STELLA
4020 Iowa St., Omaha

FAGAN, MARGARET
Nebraska Methodist Hospital, Omaha

FISHER, IRENE E.
1404 Sherwood, Omaha

FORNEY, MRS. EVA
156 S. 35, Omaha

GIBSON, MRS. VERNITA G.
Bryan Memorial Hospital, Lincoln

GILMORE, ESTHER
115 E. Court, Grand Island

GRAVES, BLANCHE
1610 J St., Lincoln

GROGAN, RITA D.
4520 N. 37 St., Omaha

GULLEY, MRS. JOAN R.
2636 Everett St., Lincoln

HAAS, PHYLLIS C.
6542 Baldwin Ave., Lincoln

HALPINE, THERESA
314 N. 41 Ave., Omaha

HANSEN, JUNE E.
5002 N. 23 St., Omaha

HARLAN, ROSANNA
506 E. Sixth St., Hastings

HARVEY, BEATRICE
Coring Hotel, Gering

HASKINS, MRS. CAROL
1602 S. 50 St., Lincoln

HAUBROE, BARBARA
1113 Park Ave., Omaha 5

HEDLUND, MRS. BETHEL A.
728 N. Lincoln Ave., Hastings

HERIN, MAZIE G.
Union College School of Nursing, Lincoln

HILLIER, MARY J.
10S S. 33 St., Omaha

HOLMES, LILLIAN
614 W. Tenth St., Hastings

HONZ, MRS. JOAN S.
3217 Peppleton St., Omaha

JACKS, MRS. L. V.
1502 S. 91 Ave., Omaha 4

JENSEN, ALICE P.
1142 Rose St., Lincoln

JIRAK, MRS. DORIS
3319 Dodge St., Omaha

JOHNSON, MRS. FLOYD E.
1333 S. 14 St., Lincoln 2

JOHNSON, NORMA G.
3519 Cuming St., Omaha

JOHNSTON, MABEL H.
Bryan Memorial Hospital, Lincoln

JOYNT, JUSTINE
731 N. St. Joe Ave., Hastings

KEEGAN, FLORENCE R.
St. Elizabeth Hospital, Lincoln

KENTOPP, MRS. ELIZABETH F.
University Hospital, Omaha 3

KOONS, KATHRYN G.
301 S. 42 St., Omaha 5

KRAUSE, MRS. BETTY M.
1021 S. 30 Ave., Omaha

KYLE, IRMA M.
301 S. 42 St., Omaha 5

LAIBA, MARIE H.
2634 S. 11 St., Lincoln

LEININGER, FRANCES C.
1234 S. 11 St., Omaha

LEININGER, MADELEINE M.
1234 S. 11 St., Omaha

LICKING, RUTH C.
2440 St. Mary's Ave., Lincoln

518
LINDELL, MRS. DELTA C.  
1120 N. Williams, Hastings  

LINDSAY, LOLA  
Douglas County Hospital, Omaha  

MACKIN, CLARE  
103 S. 50 Ave., Omaha 3  

MARET, FLORENCE R.  
1428 A St., Lincoln  

MARS, HELEN C.  
Creighton Memorial St. Joseph’s Hospital, Omaha  

MASON, MRS. VELMA S.  
University Hospital, Omaha 3  

MERRITT, DORA E.  
2722 S. Ninth St., Omaha  

MEYER, MRS. HAZEL W.  
6315 N. 36 Ave., Omaha  

MILLER, MRS. AGNES  
905 S. 26 St., Omaha  

MILLER, AMELIA  
Mary Lanning Memorial Hospital, Hastings  

MOON, MRS. PATRICIA A.  
1907 W. College; Grand Island  

MORRIS, MRS. RUTH W.  
2736 S. 13 St., Omaha 9  

NALLEY, MRS. CHARLOTTE O.  
1622 Prospect, Lincoln  

NELSON, MARTINA S.  
West Nebraska Methodist Hospital, Scottsbluff  

NEUHAUSEN, MARY E.  
1145 W. Charles St., Grand Island  

NORUM, ALMA  
536 S. 16, Apt. A-1, Lincoln  

NOVAK, ROSE A.  
1345 H St., Lincoln  

PAVELKA, MRS. MARGARET  
Ingleisde  

PEDERSON, BETTY M.  
4101 Woolworth Ave., Omaha 5  

PEIRCE, MRS. SABIE M.  
4736 N. 62 St., Omaha  

PETERS, PATRICIA A.  
921 S. 36 St., Omaha  

PETRIM, MRS. MILDRED H.  
Children’s Memorial Hospital, Omaha  

RADZIEWICZ, FLORENTINE  
1129 S. 32 St., Omaha  

RASMUSSON, BETTY M.  
2326 B St., Lincoln  

REICHA, ANNA M.  
1712 Ryuns St., Lincoln  

ROBINS, SHIRLEY M.  
910 N. 50 Ave., Omaha 3  

ROERDEN, FRIEDA J.  
R.F.D., Seward  

ROHLSF, MRS. LAVONNE  
2525½ Ames Ave., Omaha 11  

SCHAEFFER, MRS. ALICE  
1913 S. 39 St., Omaha  

SCHAEFFER, MINNIE M.  
8312 Bedford Ave., Omaha 2  

SCHILD, FRANA M.  
554 S. 25 Ave., Omaha 2  

SCHILD, MRS. MARTHA L.  
Bishop Clarkson Memorial Hospital, Omaha 5  

SCHLECHT, CLARA  
1844 S. 50 St., Lincoln  

SCHMIDT, HANNA  
St. Francis Hospital, Grand Island  

SCHOLDER, MRS. AVIS P.  
846 Park Ave., Omaha  

SCHROPP, LENORE  
Hastings State Hospital, Ingleisde  

SCHULTZ, MRS. CHARLOTTE R.  
3328 California St., Omaha  

SECHSER, MADELYNE  
818 N. 40 St., Omaha  

SHAW, ETHEL M.  
1701 L St., Lincoln  

SHEAHON, MRS. MARTHA H.  
554 S. 23 Ave., Omaha  

SHELTON, MARTHA H.  
923 N. St. Joe St., Apt. 3, Hastings  

SHEOMAKER, MRS. RUTH D.  
730 N. Lincoln, Hastings  

SHULL, MRS. DOROTHY B.  
554 S. 23 Ave., Apt. 315, Omaha  

SIES, HELEN C.  
1053 Park Ave., Omaha 5  

SISTER FRANCES ANN  
St. Francis Hospital, Grand Island  

SISTER IRENE DANIELSON  
Immanuel Deaconess Institute, Omaha 11  

SISTER M. ANN FRANCES  
St. Elizabeth Hospital, Lincoln 2  

SISTER MARY ANTONETTE  
Creighton Memorial St. Joseph’s Hospital, Omaha  

SISTER M. EDWARDA  
Creighton Memorial St. Joseph’s Hospital, Omaha 8  

SISTER MARY EYMARD  
3200 N. 60 St., Omaha  

SISTER MARY FRANCES CLARE  
St. Catherine’s Hospital, Omaha 8  

SISTER M. FRANCESCA  
St. Elizabeth Hospital, Lincoln 2  

SISTER MARY GEORGETTE  
Creighton Memorial St. Joseph’s Hospital, Omaha 8  

SISTER M. CEREONA  
St. Francis Hospital, Grand Island  

SISTER M. GERHARDA  
St. Francis Hospital, Grand Island  

SISTER MARY JAMES  
Creighton Memorial St. Joseph’s Hospital, Omaha 8  

SISTER M. JOHN  
St. Catherine’s Hospital, Omaha 8  

SISTER M. JOSEELDA  
St. Elizabeth Hospital, Lincoln 2  

SISTER M. JOSEPHIA  
St. Elizabeth Hospital, Lincoln 2  

SISTER M. JUSTA  
St. Francis Hospital, Grand Island  

SISTER MARY KEVIN  
St. Catherine’s Hospital, Omaha 8  

SISTER MARY LORRAINE  
St. Catherine’s Hospital, Omaha 8  

SISTER MARY LOUIS  
Creighton Memorial St. Joseph’s Hospital, Omaha 8  

SISTER MARY LUELLA  
St. Catherine’s Hospital, Omaha 8  

SISTER MARY MARCELLA  
St. Catherine’s Hospital, Omaha 8  

SISTER M. ODOLINA  
Creighton Memorial St. Joseph’s Hospital, Omaha 8  

SISTER M. PASCHALINA  
St. Francis Hospital, Grand Island  

SISTER M. ROMANA  
St. Elizabeth Hospital, Lincoln 2  

NEBRASKA

519
SISTER M. ROSE ELLEN
St. Catherine's Hospital, Omaha 8

SISTER M. ROSINE
St. Catherine's Hospital, Omaha 8

SISTER MARY SIMEON
St. Catherine's Hospital, Omaha 8

SISTER MARY STANISIA
3300 N. 60 St., Omaha

SISTER MARY THEODORE
St. Catherine's Hospital, Omaha 8

SISTER MINNIE CARLSON
Immanuel Deaconess Institute, Omaha 11

SISTER OLIVE CULLENBERG
Immanuel Deaconess Institute, Omaha 11

SISTER RUTH E. KAUFFMAN
Immanuel Deaconess Institute, Omaha 11

SOLDANI, MRS. HERMAGE
1047 South St., Lincoln

SOPHER, PAULINE
115 N. Vine, Grand Island

STACK, KATHLEEN
St. Francis Hospital, Grand Island

STEELE, MARIAN
609 N. Briggs Ave., Hastings

STICE, MRS. MARY
2537 S. Tenth St., Omaha 3

TAYLOR, MARGARET E.
1010 W. Charles St., Grand Island

THOMPSON, ARDINE
3340 Taylor St., Omaha 11

THOMPSON, FLORENCE M.
504 S. 37 St., Omaha

VAN ACKEREN, MRS. JEAN A.
502 S. 12 St., #706, Lincoln

VAN CLEAVE, MRS. MARIE
Orthopedic Hospital, Lincoln

VOSIKA, ANNE M.
1345 H St., Lincoln

WAGNER, LAVERNE
3150 Mason St., Omaha

WALLING, FRANK J.
3808 Randolph St., Lincoln 8

WALTER, MRS. MARGUERITE B.
1810 Harrison St., Lincoln

WARNER, VERA F.
102 N. 55 St., Omaha

WENDELIN, DORA
2010 S. 26 St., Lincoln

WESTERVET, PHYLLIS J.
4250 Harney St., Omaha

WICHMANN, EVA C.
4210 Decatur St., Omaha

WILKINSON, MRS. CARRIE
Lincoln General Hospital, Lincoln

WILLS, CATHERINE A.
Hastings State Hospital, Ingleside

WILTBANK, BYRLE
Nebraska Methodist Hospital, Omaha 3

WOLANIN, MRS. MARY B.
122 N. 40 St., Omaha 3

YACKEY, GRACE L.
Douglas County Hospital, Omaha

ZAROBA, BETTY
Hastings State Hospital, Ingleside

RECORDS, RUTH V.
609 Imperial Blvd., Reno

SPRAUGE, FLORENCE G.
Walker River Hospital, Schurz

ALLEN, MARY
308 Orange St., Manchester

AMBURY, MARGARET M.
Veterans Administration Hospital, Manchester

BACHMAN, MARGARET P.
Notre Dame de Lourdes Hospital, Manchester

BAGLEY, RUTH E.
Elliot Hospital, Manchester

BARANOWSKI, VERONICA
69 Walnut St., Nashua

BEANE, LYDIA
382-B S. Main St., Laconia

BREENE, DOROTHY
New Hampshire State Hospital, Concord

BROWN, LOIS L.
Hollis

BURTON, DOROTHY
Mary Hitchcock Memorial Hospital, Hanover

CARD, RALPH F.
421 Webster St., Manchester

CLORE, KATHLEEN J.
116 Warren St., Concord

DAVIS, EDITH M.
918 Gilley Rd., Manchester

DAVIS, KATHERINE
Mary Hitchcock Memorial Hospital, Hanover

DAVIS, MRS. MARY D.
37 Cass St., Manchester

DOWLER, MARIE V.
Mary Hitchcock Memorial Hospital, Hanover

DUMONT, EVANGELINE R.
12 Clark's St., St. Johnsbury, Vt.

DUSSAULT, FERNANDE V.
1190 Gay St., Montreal 26, Canada

FERNALD, MARY L.
Memorial Hospital, Nashua

FONTAINE, MRS. GERMAINE M.
P.O. Box 165, Hooksett

HODGKINS, WINNIRED L.
Concord Hospital, Concord

HOITT, LESLEY
Wentworth Hospital, Dover

HUSSEY, BARBARA
2 Maynard St., Hanover

JANSEN, HENRIETTA

LARRABEE, M. GLADYS
Beatrice D. Weeks Memorial Hospital, Lancaster

LEAZER, MRS. ELIZA F.
Laconia Hospital, Laconia

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MEMBERS

MADDEN, MRS. MARY T.
26 Merrimack St., Penacook

MARCOUX, CHRISTINE P.
27 Eastman St., Nashua

McGINNIS, MRS. CAROLYN P.
345 Union St., Manchester

O’NEIL, CLAIRE E.
52 Perley St., Concord

O’NEILL, DORIS J.
44 Merrimack St., Concord

PIEKARSKI, MAJ. LEONE, ANC
Veterans Administration Hospital, Manchester

REED, BERNICE P.
Laconia Hospital, Laconia

RICH, MRS. ARLINE D.
Farman Ave., West Lebanon

SELLVAAG, MRS. HARRIET J.
27 Austin St., Portsmouth

SINCLAIR, CECELIA*
21 Tremont St., Concord

SISTER AURORE
Notre Dame de Lourdes Hospital, Manchester

SISTER LARIVEE
Notre Dame de Lourdes Hospital, Manchester

NEW HAMPSHIRE—NEW JERSEY

SISTER M. BERNARDUS
Sacred Heart Hospital, Manchester

SISTER M. JOSEPH OF THE CHILD JESUS
Rivier College, Nashua

SISTER M. MARIAN
Sacred Heart Hospital, Manchester

SISTER MARY VIRGINIA
Sacred Heart Hospital, Manchester

SISTER VIRGINIA HADLEY
1575 Cambridge St., Cambridge, Mass.

SISTER YVETTE AUBERT
St. Louis Hospital, Berlin

SMALL, JANET E.
105 Pleasant St., Concord

STONE, BARBARA J.
Laconia Hospital, Laconia

TETRAULT, MRS. ARLENE B.
Concord Hospital, Concord

THOMAS, GERTRUDE J.
24 Loring St., Lowell, Mass.

YOUNG, EILEEN M.
333 Main St., Nashua

NEW JERSEY—577

ABARY, EDITH E.
549 W. 113 St., New York 25, N. Y.

ACKERMAN, CECILE
102 De Mott Ave., Clifton

ADLER, FRIEDA E.
114 Clifton Pl., Jersey City 4

ALDEN, LINDA K.
P.O. Box 461, Long Branch

ALLEN, MARGARET B.
Orange Memorial Hospital, Orange

ALLIOTE, GRACE T.
14 S. Reid St., Elizabeth

ANTROBUS, EDNA M.
16 Evergreen La., Haddonfield

ARGUE, MRS. EDITH G.
333 Central Ave., East Orange

ARMSTRONG, DOROTHY V.
706 Chestnut St., Roselle

ASHMUN, MARGARET*
Orange Memorial Hospital, Orange

ATCHLEY, MRS. AMY P.
2281 Pennington Rd., RFD, Trenton

AUDETTE, LAURA E.
426 Central Ave., Orange

AXEN, ANITA
229 Hall Ave., Perth Amboy

BAER, IRENE F.
Elizabeth General Hospital, Elizabeth 4

BAIRD, HELEN L.
436 W. William St., Delaware, Ohio

BAKER, CLADYS A.
Hackensack Hospital, Hackensack

BALDWIN, MRS. DONALD R.
377 Rarine Dr., South Orange

BALDWIN, JESSIE E.
St. Barnabas Hospital, Newark 2

BARBER, RUTH M.
759 E. 25 St., Paterson 4

BARNAS, ANNA M.
7 Liberty St., Garfield

BARWICK, MRS. MARGARET S.
Monmouth Memorial Hospital, Long Branch

BASARA, STEPHANIE C.
Monmouth Memorial Hospital, Long Branch

BAUMANN, HENRIETTE E.
165 Temple St., Paterson

BAUMANN, LYDIA
Orange Memorial Hospital, Orange

BAYER, MARGARET E.
114 Clifton Pl., Jersey City 4

BEAM, MRS. RUTH H.
New Jersey State Hospital, Greystone Park

BEDFORD, GENEVA E.
260 Gregory Ave., Passaic

BEERY, NAOMI
East Orange General Hospital, East Orange

BEHRMAN, I. ELLIS
201 Lyons Ave., Newark 8

BELL, MIRIAM 1.
782 Keny Ave., Arlington

BELT, MRS. NORMA G.
128 Beaver Ave., Cranford

BENZONI, ROSELYN M.
880 Madison Ave., Paterson 3

BERCHIER, JEANNE M.
49 Montague Pl., Montclair

BERGEN, DR. CATHARINE
68 Van Reypen St., Jersey City 6

BERGMAN, MRS. JENNIE S.
Muhlenberg Hospital, Plainfield

BIANTCO, FLORENCE E.
2229 S. 15 St., Philadelphia 45, Pa.

BIEN, RUTH V.
P.O. Box 227, Fordy

BINDAS, MARY
213 Green St., Boonton

BIRNEY, ELIZABETH
Cooper Hospital, Camden

BLACKMAN, LUCILLE B.
18 Leslie St., Newark

521
BLOOM, JEAN L.  
Community Hospital of Northern Valley, Englewood

BLUMENAU, IRIS W.  
176 Shepard Ave., Newark 8

BOBECK, MRS. MARY K.  
12 Clark St., Glen Ridge

BOLWELL, MRS. SUZANNE P.  
139 Halsted St., East Orange

BORMAN, VIRGINIA L.  
Somerset Hospital, Somerville

BORN, MRS. JANE K.  
22 W. Maple Ave., Merchantville 8

BOUWHUUS, CLARA  
Veterans Administration Hospital, Montrose, N. Y.

BOWMAN, ANNE  
Hospital Pl., Hackensack

BOYD, EVELYN  
Passaic General Hospital, Passaic

BRATNIK, HELENE  
163 Vine Reid St., Elizabeth 4

BREEN, MARY A.  
20 Oak Knoll Rd., Glen Rock

BROWER, SARA M.  
417 Gordon St., South Amboy

BROWN, E. ELIZABETH  
10 Wall St., Trenton 9

BRUNNER, CLARA M.  
Middlesex General Hospital, New Brunswick

BRUNNER, MIRIAM L.  
221 Willow Ave., Ext., North Plainfield

BRYAN, MARY V.  
665 High St., Newark 2

BUCHER, MARIA A.  
1317 Princess Ave., Camden

BURNS, ALICE P.  
317 Newton Ave., Collingswood

BURNS, FLORENCE P.  
Somerset Hospital, Somerville

BUSHMAN, THERESA  
62 Washington Pl., Totowa Boro

CADDY, EVA  
260 S. Orange Ave., Apt. 4, South Orange

CAHILL, EMMA A.  
116 Jacques St., Elizabeth 4

CALLAHAN, MRS. VIRGINIA F.  
New Jersey State Hospital, Greystone Park

CANARELLI, MRS. HELEN K.  
99 N. Sixth St., Newark 7

CANNON, MARION  
6 Morris Ave., Summit

CAREY, ELEANOR B.  
105 Clifton Pl., Jersey City

CAREY, AGNES A.  
38 Hayward Ave., Carteret

CARR, MARY E.  
111 Claremont Rd., Ridgewood

CARR, PATIENCE  
476 W. State St., Trenton 8

CARRATO, NELLIE M.  
709 Jersey Ave., Elizabeth

CARVER, EVELINE M.  
Essex County Hospital, Belleville 9

CASEY, MRS. JENNIE M. A.  
Brisbane Child Treatment Center, Farmingdale

CASPERSON, ELSIE M.  
Atlantic City Hospital, Atlantic City

CAULEY, BERNICE S.  
116 Fairmount Ave., Newark

CECCARELLI, JULIA R.  
30 Eighth Ave., Passaic

CHALMERS, MRS. STARR R.  
Elizabeth General Hospital, Elizabeth

CHAMPAGNE, CECILE A.  
302 Henry St., Orange

CHRISTMAN, LUTHER L.  
233 Haines Ave., Barrington

CINELLI, RITA M.  
12 Riggs Pl., South Orange

CLARK, ANNA L.  
48 Hill St., Bloomfield

CLARKE, ALICE R.  
175 Union Ave., Rutherford

CLAY, LYDIA A.  
East Orange General Hospital, East Orange

CLAYTON, MRS. ARLENE L.  
40 Audubon Ave., Jersey City 5

COBB, MRS. HOPE B.  
304 Chambers Ave., Camden

COBIN, RHODA R.  
36 W. 56 St., New York 19, N. Y.

COHEN, ESTEBELLE B.  
227 Brighton Ave., Perth Amboy

COLEMAN, MRS. DOROTHY R.  
30 Brookwillow, West Long Branch

COLEMAN, FRANCES C.  
161 N. Day St., Orange

COMSTOCK, FRANCES R.  
103 Maryland Ave., Paterson 3

CONNELLY, MARTHA A.  
556 Westside Ave., Jersey City 4

CONNELLY, MRS. RUTH H.  
Box 215, Greystone Park

CONNOR, HELEN  
114 Clifton Pl., Jersey City 4

CONROY, EILEEN  
130 W. Kingsbridge Rd., New York 63, N. Y.

CONWAY, MILDRED C.  
169 Lyons Ave., Newark 8

COOK, DOROTHY F.  
813 N. Third St., Camden

COOK, HARRIET B.  
18 Manor Dr., Red Bank

COOKE, KATHERINE E.  
Jersey City Medical Center, Jersey City 4

COOPER, KATHRYN E.  
219 Broad St., Red Bank

CORBETT, MARGARET M.  
St. Mary's Hospital, Hoboken

CORNWELL, SELENA E.  
Muhlenberg Hospital, Plainfield

COSGROVE, DR. SAMUEL A.  
88 Clifton Pl., Jersey City

COSTIGAN, PAULINE D.  
215 Cambridge Ave., Englewood

COUGHLIN, MRS. EILEEN E.  
Perth Amboy General Hospital, Perth Amboy

COURTNEY, MRS. THELMA B.  
726 A West Side Ave., Jersey City

COWINS, ADELAIDE M.  
Bayonne Hospital, Bayonne

COVERT, FRANCES L.  
157 S. Center St., Orange

COX, MARY D.  
114 Clifton Pl., Jersey City

COXED, MARGARET V.  
41 Macopin Ave., Upper Montclair

522
<table>
<thead>
<tr>
<th>Name</th>
<th>Address 1</th>
<th>Address 2</th>
<th>City, State, Zip</th>
</tr>
</thead>
<tbody>
<tr>
<td>COYLE, ROSE A.</td>
<td>83 Clifton Pl., Jersey City 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>COYNE, JANE N.</td>
<td>66 McLaren St., Red Bank 3</td>
<td></td>
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<tr>
<td>COYNE, MARY L.</td>
<td>114 Clifton Pl., Jersey City 4</td>
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<tr>
<td>CRANE, JOHN F.</td>
<td>Paterson General Hospital, Paterson 3</td>
<td></td>
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</tr>
<tr>
<td>CRAWFORD, MRS. DOUGLAS</td>
<td>784 Park Ave., New York 21, N. Y.</td>
<td></td>
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<tr>
<td>CRAWFORD, MARGARET F.</td>
<td>Cooper Hospital, Camden</td>
<td></td>
<td></td>
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<tr>
<td>CRESSMAN, MARY A.</td>
<td>1610 Park Rd., N.W., Washington 10, D. C.</td>
<td></td>
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<tr>
<td>CROWEL, MARTHA A.</td>
<td>124% S. Ninth St., Newark 7</td>
<td></td>
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</tr>
<tr>
<td>CUCHURAL, MRS. CONSULA L.</td>
<td>New Jersey State Hospital, Marlboro</td>
<td></td>
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<tr>
<td>CUDDIH, ROSEMARY</td>
<td>1210 Park Ave., Hoboken</td>
<td></td>
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<tr>
<td>CUNNINGHAM, FRANCES K.</td>
<td>Murdoch Hall, Clifton Pl., Jersey City 4</td>
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<tr>
<td>CURRY, DAWN C.</td>
<td>Elizabeth General Hospital, Elizabeth 4</td>
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<tr>
<td>DARE, ELEANOR M.</td>
<td>34 Washington Ave., Little Ferry</td>
<td></td>
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<tr>
<td>DARRAH, WINONA</td>
<td>9 N. Sunny Crest Dr., Little Silver</td>
<td></td>
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<tr>
<td>DAVENPORT, CHARLOTTE F.</td>
<td>221 Willow Ave. Ext., North Plainfield</td>
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<tr>
<td>DAVID, MAXIE</td>
<td>173 Grant St., Perth Amboy</td>
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<tr>
<td>DAWSON, MARY</td>
<td>Mills Home, Montclair</td>
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<tr>
<td>DAY, ALICE E.</td>
<td>St. Francis Hospital, Jersey City 2</td>
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<tr>
<td>DAY, JEAN M.</td>
<td>183 Broad Ave., Leonia</td>
<td></td>
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<tr>
<td>DECKER, CHARLOTTE L.</td>
<td>54 Queen Anne Rd., Bogota</td>
<td></td>
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<tr>
<td>DEERINGER, RUTH M.</td>
<td>18 Austin Pl., Bloomfield</td>
<td></td>
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<tr>
<td>DELTZ, CORNELIA</td>
<td>12 Howd Ave., Clifton</td>
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<tr>
<td>DELANEY, MARIE T.</td>
<td>108 Berkeley Ave., Bloomfield</td>
<td></td>
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<tr>
<td>DE RITTER, MRS. AURELIA H.</td>
<td>Jacob Ford Village, Blvd. 15, Apt. 7B, Morristown</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DERMER, MADELINE</td>
<td>130 Milland Ave., Montclair</td>
<td></td>
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<tr>
<td>DeVEY, MARGARET H.</td>
<td>Orange Memorial Hospital, Orange</td>
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<tr>
<td>DICKINSON, ELIZABETH V.</td>
<td>822 Second Pl., Plainfield</td>
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<tr>
<td>DIERKING, HANNAH</td>
<td>Orange Memorial Hospital, Orange</td>
<td></td>
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<tr>
<td>Dr. GREGORIO, SANTA</td>
<td>114 Linden St., Camden</td>
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<tr>
<td>DILINSKI, MARY C.</td>
<td>175 Chadwick St., Paterson 3</td>
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<tr>
<td>DILWORTH, LULA P.</td>
<td>175 W. State St., Trenton 8</td>
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<tr>
<td>DINEEN, MARY C.</td>
<td>Mountainside Hospital, Montclair</td>
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<tr>
<td>DOCHERTY, MARY E.</td>
<td>Essex County Hospital, Belleville 9</td>
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<tr>
<td>DOVER, MRS. EDNA W.</td>
<td>Overlook Hospital, Summit</td>
<td></td>
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<tr>
<td>DRAKE, JEFFIE</td>
<td>1311 Walton St., Houston 9, Texas</td>
<td></td>
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<tr>
<td>DUNN, KATHRYN S.</td>
<td>645 Summer Ave., Newark 4</td>
<td></td>
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<tr>
<td>DURELL, MARIAN</td>
<td>Woodbine, R.F.D., Belleplain</td>
<td></td>
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<tr>
<td>EBERLE, MRS. RUTH M.</td>
<td>685 High St., Newark 2</td>
<td></td>
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<tr>
<td>EDMISON, MARY L.</td>
<td>302 Henry St., Orange</td>
<td></td>
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<tr>
<td>EDSALL, KATHRYN</td>
<td>114 Clifton Pl., Jersey City 4</td>
<td></td>
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<tr>
<td>ELEY, MARTHA K.</td>
<td>East Orange General Hospital, East Orange</td>
<td></td>
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</tr>
<tr>
<td>ELSENFELDER, MAXINE M.</td>
<td>Monmouth Memorial Hospital, Long Branch</td>
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<tr>
<td>EMLET, ESTHER L.</td>
<td>Margaret Hague Maternity Hospital, Jersey City</td>
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<tr>
<td>ENGLAND, ELIZABETH M.</td>
<td>409 Broadway, Apt. 4, Camden 3</td>
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<tr>
<td>ENNIS, LUCIE R.</td>
<td>Mountainside Hospital, Montclair</td>
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<tr>
<td>ERRICKSON, MRS. SARA</td>
<td>148 Cedar Ave., West End</td>
<td></td>
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</tr>
<tr>
<td>ESWOOD, MRS. FRANCES M.</td>
<td>947 E. 25 St., Paterson</td>
<td></td>
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<tr>
<td>FABER, MATHILDE F.</td>
<td>135 Chestnut Dr., Packanack Lake</td>
<td></td>
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<tr>
<td>FABIANO, MARIE A.</td>
<td>90 Orange St., Newark</td>
<td></td>
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<tr>
<td>FANNING, MARY C.</td>
<td>710 Park Ave., Hoboken</td>
<td></td>
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<tr>
<td>FARMER, MARY</td>
<td>343 Vine St., Elizabeth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FASANO, MRS. JOSEPHINE D.</td>
<td>223 Broadway, Long Branch</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FFENNY, LT. ELIZABETH C., NC, USN</td>
<td>2701 Webster St., Mt. Rainier, Md.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SELLINS, MRS. EVA S.</td>
<td>Monmouth Memorial Hospital, Long Branch</td>
<td></td>
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<tr>
<td>FENNESSEY, JEANNE M.</td>
<td>151 Orchard Rd., Maplewood</td>
<td></td>
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</tr>
<tr>
<td>FERGUSON, RACHEL O.</td>
<td>4 Green Acres Dr., Apt. 19, Verona</td>
<td></td>
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<tr>
<td>FERRAZZANO, C. CELESTE</td>
<td>34 Dey St., Paterson 3</td>
<td></td>
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<tr>
<td>FERRY, PATRICK J.</td>
<td>285 Stegman Pkwy., Jersey City 5</td>
<td></td>
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<tr>
<td>FINKBOHNER, EMMA K.</td>
<td>St. Peter's Hospital, New Brunswick</td>
<td></td>
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<tr>
<td>FINKELSTEIN, MRS. RUTH G.</td>
<td>259 Montgomery St., Jersey City 2</td>
<td></td>
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<tr>
<td>FITCHETT, RUTH</td>
<td>207 E. 15 St., New York 3, N. Y.</td>
<td></td>
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</tr>
<tr>
<td>FITZSIMONS, RUTH L.</td>
<td>114 Clifton Pl., Jersey City 4</td>
<td></td>
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<tr>
<td>FLANAGAN, MRS. HATTIE D.</td>
<td>737 Bergen Ave., Jersey City 6</td>
<td></td>
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<tr>
<td>FLYNN, ANNE F.</td>
<td>St. Mary's Hospital, Passaic</td>
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<tr>
<td>FODOR, NINA W.</td>
<td>822 Second Pl., Plainfield</td>
<td></td>
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<tr>
<td>FORBES, MARGARET A.</td>
<td>Hackensack Hospital, Hackensack</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
FORTUIN, MARGRETTA N.  
Paterson General Hospital, Paterson

FOQUET, LILY A.  
5 Rigs Pl., West Orange

FOURNIER, ETHEL  
R.F.D. 1, Oakland

FOURNIER, MARY A.  
694 River Dr., East Paterson

FOX, MRS. ETHEL A.  
16 Ridgedale Ave., Morristown

FOX, RUTH C.  
1742—42 St., Camden 8

FRANZ, ESTHER  
301 Central Ave., Orange

FREER, MARIAN C.†  
Hackensack Hospital, Hackensack

FREISE, MARION E.  
Elizabeth General Hospital, Elizabeth 4

FRESE, ANNA L.  
522 Brookline Blvd., Pittsburgh 26, Pa.

FREY, MARION M.  
222 Dodd St., East Orange

FRISBIE, MARY A.  
114 Clifton Pl., Jersey City 4

FROST, JEANNETTE A.  
Route 4, Stillwater, Minn.

FRIY, HAZEL M.  
14 Voorhees St., Newark 8

FRIERST, ELINOR V.  
219 Prospect Ave., Cliffside Park

FUNK, MRS. ELEANOR M.‡  
16 Erwin Park Rd., Montclair

GALIA, LENA  
37 Duncan Ave., Jersey City 4

GALLAGHER, PATRICIA  
428 Lawria St., Perth Amboy

CANYL, LILLIAN E.  
52—53 Ave., Paterson 4

CARA, KATHRYN  
Bayonne Hospital, Bayonne

GARDNER, MRS. LILLIAN M.  
116 Magnolia Ave., Maywood

GARNER, CATHERINE M.  
125 E. Clinton Ave., Apt. 1A, Bergenfield

GARY, MRS. GOLDE L.  
New Jersey State Hospital, Greystone Park

GAYTON, ANITA E.  
Paterson General Hospital, Paterson

CELBAH, MARTHA H.  
1320 York Ave., Box 656, New York 21, N. Y.

GEMEROY, MRS. MARIE G.  
22 E. Chief St., Somerville

GESSNER, DORA H.  
D.B.C., Apt. 3, Greystone Park

GILL, SOPHIA K.  
4315 Veleny Ave., Merchantsville 8

GLASSTON, MIRIAM S.  
Elizabeth General Hospital, Elizabeth 4

GLESSNER, A. RACHEL  
Orange Memorial Hospital, Orange

GRATZ, PAULINE‡  
44 W. 33 St., Bayonne

GRAY, PHYLLIS L.  
Box 117, Murdoch Hall, Jersey City 4

GREEN, GLADYS C.  
New Jersey State Hospital, Greystone Park

GRISWOLD, MARGARET F.  
216 Kearny Ave., Perth Amboy

GROSVENOR, MARJORIE L.†  
188 S. Essex Ave., Orange

GRUNAU, MRS. DAISY L.  
R.F.D. 2, Morristown

GUTTMAN, YOLAN R.  
New Jersey State Hospital, Greystone Park

GUTTRIDGE, HELEN M.  
1222 E. Seventh St., Plainfield

GYURKO, ELIZABETH  
559 Court St., Elizabeth 1

HAINES, ANNA J.  
122 W. State St., Trenton

HAINES, SELMA E.  
140 N. 15 St., East Orange

HALBASCH, Verna M.  
252 Lehigh Ave., Apt. 31, Newark

HALDEMAN, FLORENCE  
The Cooper Hospital, Camden 3

HALFPENNY, ANNA M.  
114 Clifton Pl., Jersey City 4

HALL, AGNES C.  
Newark Beth Israel Hospital, Newark 8

HALL, FLORENCE M.  
364 Valley Rd., West Orange

HANGCOCK, LILLY G.  
1279 Brunswick Ave., Trenton

HANRATTIE, MRS. ALICE  
85 Market St., Perth Amboy

HARGREAVES, W. K.†  
176 Pulisade Ave., Jersey City 6

HAROLD, ELEANOR  
Good Samaritan Hospital, Lebanon, Pa.

HARRISON, SARAH  
446 Bellevue Ave., Trenton 8

HART, MARGARET B.  
Somasct Hospital, Somerville

HARRT, FLORENCE A.  
114 Clifton Pl., Jersey City 4

HASENJAEGER, ELLA  
Escola do Entermagem do Sao Paulo, Av. Ademar de Barros, 440, Sao Paulo, Brazil

HAWKES, FLORENCE E.  
300 Carteret Pl., Orange

HAYHOW, DR. EDGAR C.†  
East Orange General Hospital, East Orange

HEFFERAN, MRS. ELIZABETH W.  
166 Grand Ave., Apt. 1B, Englewood

HEGE, ESTHER E.  
West Jersey Hospital, Camden

HEGEWOLD, FLORENCE  
200 Grant Ave., Jersey City 5

HEINZMANN, AUGUSTA  
523—41 St., Union City

HENLEY, MARGARET  
231 Prospect Pl., Rutherford

HENSON, MRS. MILDRED J.  
359-A Biedeman Ave., Camden

HEURMAN, HENRY†  
1 Wall St., New York 5, N. Y.

HEURMAN, MRS. HENRY†  
P.O. Box 264, Elberon

HERTZOG, KATHRYN A.  
601 Hamilton Ave., Trenton

HEVENTHAL, LOUISE  
127 Avondale Ave., Haddonfield

HILLMAN, MARY M.  
65 Cooper St., Woodbury

HIMS, BERTHA  
74 Mitchell St., West Orange
Hoffman, Leah M.
Veterans Administration Hospital, Lebanon, Pa.
Hogg, Jean F.
114 Clifton Pl., Jersey City 4
Holland, Ruth M.
Newark Beth Israel Hospital, Newark 8
Hontz, Annette A.
The Cooper Hospital, Camden
Hoppler, Mrs. Angelina T.
148 E. Main St., Rockaway
Hosking, Elizabeth E.
114 Clifton Pl., Jersey City 4
Houvig, Mrs. Mary D.
916 Belmont Ave., Collingswood
Hovanec, Martha
103 Prospect Ave., Bayonne
Howard, Grace M.
Orange Memorial Hospital, Orange
 Hoyt, Henry H.*
53 Park Pl., New York, N. Y.
Hudson, James L.
Medical Center School of Nursing, Jersey City 4
Hufcut, Dorothy L.
Veterans Administration Hospital, Lyons
Hughes, Wilkie
N. J. State Nurses' Association, 17 Academy St., Newark 2
Huse, Mrs. Pauline C.
43-C Leland Gardens, Plainfield
Hymer, Helen L.
The Cooper Hospital, Camden
Infante, Angelina
3 Wellington Ave., West Orange
Ingersoll, Margaret M.
138-33 St., Fair Lawn
Irwin, Dr. Forrest A.*
President, State Teachers College, Jersey City 5
ivan, Regina
68 Kovar St., Fords
Jacaruso, Genever
60 Decatur Ave., Spring Valley, N. Y.
James, Muriel E.
800 Madison Ave., Paterson 3
Janco, Mrs. Rebecca W.
769 Lee St., Perth Amboy
Jaylock, Lottie T.
166 Sharpe Ave., Wyoming, Pa.
Jeffeer, Alice
Paterson General Hospital, Paterson 3
Jefferson, louisa
Monmouth Memorial Hospital, Long Branch
Jensen, Besse C.
Orange Memorial Hospital, Orange
Johnston, Evelyn G.
25 Gifford Ave., Jersey City
Johnston, Helen R.
Mountainside Hospital, Montclair
Johnston, Ruth E.
Orange Memorial Hospital, Orange
Jones, Anna M.
Greyston Apts. A-4, 101 S. Roosevelt Pl., Atlantic City
Jones, Mrs. Mary B.
Orange Memorial Hospital, Orange
Jordan, Marilyn A.
114 Clifton Pl., Jersey City 4
Joule, Dorothy M.
St. Joseph Hospital, Paterson
Kaine, Mabel M.
166 Manchester Ave., Paterson
Kakosh, Peggy
417 Riverside Dr., Box 174, New York 25, N. Y.
Kaye, Selma
17 Lincoln Park, Newark
Kehoe, Margaret A.
68 Knickerbocker Ave., Paterson 3
Keidel, Gladys C.
New Jersey State Hospital, Greystone Park
Kelleher, Gladys M.
10 Baldwin Ave., Jersey City
Keller, Mabel M.
Mountainside Hospital, Montclair
Kelley, Maude C.
114 Clifton Pl., Box 506, Jersey City 4
Kern, Alvin B.
New Jersey State Hospital, Marlboro
Kindt, Helen G.
261 Hale St., New Brunswick
King, Sherry R.*
800 Madison Ave., Paterson 3
Kinkel, Evelyn E.
87 Duer St., North Plainfield
Kivett, Edith S.
359 W. Third St., Clifton
Klebausius, Julia R.
Elizabeth General Hospital, Elizabeth 4
Klein, Helen S.
Orange Memorial Hospital, Orange
Klein, Mrs. Ruth A.
P.O. Box 501, Red Bank
Klucz, Helen
291 Squaw Brook Rd., Wyckoff
Knack, Helen
433 Lincoln Ave., Orange
Koog, Stacia
605 High St., Newark 2
Kochin, Helen V.
442 E. 31 St., Paterson
Koenig, Lt. Kathryn A.
256-B Princeton Rd., Barrington
Konyk, Mary
R.F.D. 1, Box 155, New Brunswick
Koplar, Pauline M.
Veterans Administration Hospital, Box 26, Lyons
Korolenka, Mrs. Henrietta G.
Townley Gardens, 1977 Morris Ave., Apt. 111, Union
Koski, Gwendolyn R.
1103 Union Ave., Delair
Krakowski, Sophia
New Jersey State Hospital, Greystone Park
Kruk, Helen
901 Liberty Ave., Union
Kuebler, Mrs. Eleanor S.
308 Cooper Ln., University Heights, New Brunswick
Kurta, Olga
615 Almon Ave., Woodbridge
Kushnick, Arline T.
109 Lyons Ave., Newark 8
Kuzio, Mrs. Margaret
R.F.D. 5, Foothill Rd., Somerville
Lamb, Loni
252 Boulevard, Kenilworth
Landew, Carrie
P.O. Box 25, Somerville
Larkin, Margaret M.
New Jersey State Hospital, Greystone Park
LAYTON, MARY G.
122 Jacques St., Elizabeth 4

LEY, MRS. DANIEL A.
213 Elmwood Dr., Oradge

LECKEY, ANNIE H.
188 S. Essex Ave., Orange

Lemon, MRS. RHODA W.
685 High St., Newark 2

LEVIN, SHIRLEY B.
333 Lake Ave., Lynnhurst

LEWIS, EVELYN
76 Sherman Pl., Irvington 11

LEWIS, FRANCES
270 Union Ave., Apt. 9, Rutherford

LEVHAN, MARGARET J.
35 King St., Morristown

LIBONATI, THERESA J.
12 S. Harrison St., East Orange

LIGHMAN, MRS. CECILE
45 Spier Dr., South Orange

LICHMAN, HARRY
241 Frelinghuysen Ave., Newark 5

LIMING, MRS. ROSAMOND S.
Essex County Hospital, Cedar Grove

LINGQUIST, CLARA
471 Laurie St., Perth Amboy

LIND, BERTHA
860 Madison Ave., Paterson

LITTLEFIELD, MRS. CHARLES W.
96 High St., Montclair

LOEW, MRS. GLADYS B.
Englewood Hospital, Englewood

LONG, PATRICIA H.
New Jersey State Hospital, Greystone Park

LORENZ, JANICE M.
75 Linden St., Passaic

LOSEWSKI, THERESA D.
583 Elizabeth St., Perth Amboy

LOUGHERY, ANNE M.
617 Edgewood Ave., Trenton

LOVELL, MRS. ELIZABETH S.
216 Bryant Ave., Springfield

LUHR, MRS. KATHRYN S.
120 Hemlock Ter., South Orange

MACFADYEN, KATHARINE
598 Amboy Ave., Perth Amboy

MAGIELNICKA HARRIET
305 Fulton Ave., Jersey City

MAHLMAN, LORNA M.
Muhlenberg Hospital, Plainfield

MAHON, CLAIRE M.
114 Clifton Pl., Jersey City 4

MARTIGNETTI, RELLA C.
571 Lincoln Ave., Orange

MARTIN, FLORENCE
8 Wood Ave., Menlo Park

MARTINEZ, ANGELA
21 Scudder St., Garfield

MASKREY, MARGARET S.
Theesen Grotto Home, 127 Mountain Ave., Caldwell

MAXWELL MARIE
2928 Benson St., Camden 5

MAY, DOROTHY
210 Seaman St., New Brunswick

MAZURKIEWICZ, MARIA
128 Magnolia Ave., Elizabeth

MAZZA, MARGARET M.
183 Shrewsbury Ave., Red Bank

MCAHRENS, AGNES H.
84 Linden Ave., Springfield

MCCUE, MRS. ELIZABETH D.
New Jersey State Hospital, Station "A", Trenton 8

MCFADDIN, MRS. ELSIE S.
270 Broadway, Long Branch

MCGARRY, MARIE K.
Orange Memorial Hospital, Orange

McGOREY, RUTH T.
40 Clifton St., Newark

MCLROY, VIRGINIA M.
49 S. Ninth St., Easton, Pa.

MCINTYRE, CLAIRE
114 Clifton Pl., Jersey City 4

MCKEAN, BEATRICE
114 Clifton Pl., Jersey City 4

MCKENNA, CATHERINE A.
St. Mary's School of Nursing, Orange

MCKISSACK, BONNIE
958 Mountain Ave., Berkeley Heights

McLAUGHLIN, FRANCES M.
76 Newfield St., East Orange

McNEAL, RUTH W.
313 S. Sixth St., Camden

MEAD, MRS. GRACE H.
14 Revere Rd., Morristown

MEEHAN, MARY A.
114 Clifton Pl., Jersey City 4

MELICK, JEAN M.
302 Henry St., Orange

MERCER, RUTH A.
Perth Amboy General Hospital, Perth Amboy

MERRICK, SHIRLEY M.
103 Hamilton Rd., Ridgewood

METLY, MARY V.
Essex County Hospital, Belleville 9

MILEY, A. JANET
Christ Hospital, Jersey City 6

MILICI, MRS. MARGARET H.
39 MacArthur Ave., Lodi

MILLARD, FRANCES L.
Orange Memorial Hospital, Orange

MILLER, BEATRICE L.
114 Clifton Pl., Jersey City 4

MILLER, CLARA B.
Bayonne Hospital & Dispensary, Bayonne

MILLER, MARY R.
Mercer Hospital, Trenton 8

MILLER, MYRTLE M.
114 Clifton Pl., Jersey City 4

MINKER, DOROTHY
193 Garden Ave., Belleville 9

MIRKOVICH, MARIA
106 President St., Passaic 9

MITCHELL, MRS. MARIAN G.
24 Patton Dr., Bloomfield

MITCHELL, RUTH L.
Muhlenberg Hospital, Plainfield

MODORO, ROSE
124 Bloomfield St., Hoboken

MOLINARI, CATHERINE J.
11 Court House Pl., Newark

MOORE, MRS. ELIZABETH R.
Box 192, Greystone Park

MORICI, JO ANN
40 Flaget Ave., Clifton

MORRIS, LILLIAN
Essex County Hospital, Belleville 9

526
MUCIARIELLO, SYLVIA
372 Engle St., Englewood
MULLIN, MRS. KATHRYN K.
Newark Memorial Hospital, Newark 3
MURDOCH, JESSIE M.
Jersey City Medical Center, Jersey City 4
MURPHY, ANNE M.
Medical Center, Jersey City
MURPHY, FLORENCE
106 Clifton Pl., Jersey City 4
MURPHY, MRS. LILLIAN H.*
1631 Hudson Blvd., Apt. 5E, North Bergen
NELSON, MRS. ELIZABETH H.
104 Franklin Ave., Long Branch
NEVIN, MARY F.
17 Oxford St., Newark 5
NELSEN, ETHEL K.
45 Brunswick Ave., Metuchen
NICH, LOUISE W.
19 Belmont Ave., Jersey City
NORTHWOOD, MRS. OLIVE M.
Mountainside Hospital, Montclair
NOVAK, SUSAN C.
114 Clifton Pl., Jersey City 4
NUNN, FRANCES C.
834 Highland Ave., Palmyra
NYWENING, MARGARET
1184 Belmont Ave., North Haledon
OGILVIE, NELLIE
Route 1, Alexandria, Va.
OKERSON, ELIZABETH C.
Mercer Hospital, Trenton 8
OLSEN, ANNA K.
45 Emerson St., Carteret
ONUSKA, ROSE
731 Donald Ave., Perth Amboy
ORCHARD, WILLIAM J.*
50 Sagamore Rd., Maplewood
ORR, MARGUERITE V.
Bayonne Hospital, Bayonne
ORTMANN, RUTH M.
63 Olds St., Rochelle Park
OSSENWARDE, MARTHA E.
Mountainside Hospital, Montclair
PALICHAK, MARGARET
293 New Brunswick Ave., Perth Amboy
PATTERSON, MRS. ANNE
637—21 Ave., Paterson
PATTERSON, JANE G.
St. Joseph's Hospital, Paterson
PATTERSON, JEAN E.
913 Clinton St., Philadelphia 7, Pa.
PAUL, HENRIETTE
59 Bleecker St., Jersey City 7
PERault, MRS. KATHERINE M.
115 Washington Ct., Trenton 9
PETRELLI, MRS. IONA C.
169 Vroom St., Jersey City
PHILLIPS, KANELLA T.
Mountainside Hospital, Montclair
PIERKARSKY, SYDEL M.
276 High St., Passaic
PIERC, MRS. GRAYCE R.
72 Barlow St., Winookski, Vt.
PLUNTICKI, JEANETTE F.
337 Ave. E, Bayonne
POIGNIER, BARBARA D.
219 Turrell Ave., South Orange

POLICE, FLORENCE C.
114 Clifton Pl., Jersey City 4
PONE, MARIE
1415 Chambers St., Trenton
PRITCHARD, MRS. EDITH F.
Essex County Hospital, Belleville
PUNKO, ELIZABETH
R.F.D., Bloomsbury
QUAGLIARILO, GERTRUDE B.
R.F.D. 1, Box 272A, Metuchen
QUIGLEY, KATHRYN
416 Bellevue Ave., Trenton 8
RAUFFENBART, MARY
The Cooper Hospital, Camden
RECE, ANNE E.
825 First Pl., Plainfield
RIEHM, MARY A.
3128 S. Congress Rd., Camden
ROBINSON, LAURA
Muhlenberg Hospital, Plainfield
ROE, LAETITIA M.
New Jersey State Hospital, Greystone Park
ROGERS, VIRGINIA L.
114 Clifton Pl., Jersey City 4
RUMSEY, MARGARET
365—12 Ave., Paterson 4
RUNNERSTROM, MRS. LILLIAN
114 Clifton Pl., Jersey City 4
RUPP, EUGENIA M.
25 Carson Ave., Metuchen
RYBNIKAR, ANNA
Box 593, 114 Clifton Pl., Jersey City 4
SACCO, RUTH
41 E. Third St., Clifton
SACHS, MRS. LOIS B.
115 Woodland Rd., Madison
SALERNO, DOROTHY
4 Althea St., Clifton
SALTER, EDNA L.
Presbyterian Hospital, Nurses Home, Newark 7
SAVICK, ANNE M.
R.F.D. 3, Freehold
SAYRE, MIRIAM E.
302 Henry St., Orange
SCHAFFER, CLIFFORD W.
53 Old St., Bernardville
SCHETTZ, MATHILDA
120 Grand Ave., Englewood
SCHTHAUER, CLARA H.
114 Clifton Pl., Jersey City 4
SCHICKS, DR. GEORGE C.*
Hospital of St. Barnabas & for Women & Children, Newark 2
SCHILD, SARAH L.
22 Melrose Ave., North Arlington
SCHIRMER, MARGARET M.
301 B. N. Broad St., Hillside
SCHLEEING, EDITH
839 N. 50 St., Camden 5
SCHLEY, MRS. MARY B.*
104 Wesley Ave., Ocean City
SCHLIEHTING, LOUISE J.
Orange Memorial Hospital, Orange
SCHMEEYER, VIVIAN M.
1022 Rose St., Plainfield
SCHMIDT, LORENA
Newark City Hospital, Newark 7
SCHMIDT, MILDRED S.
31 Silverton Ave., Little Silver

SCHULTZ, DOROTHY A.
Mountainside Hospital, Montclair

SCHWARTZ, MRS. CAROLINE E.
40 Clinton St., Newark 2

SCHWARTZ, LILLIAN
49 N. Broadway, Long Branch

SCHWARTZ, LOUISE
76 Sherman Pl., Irvington 11

SCHWETZER, RITA M.
114 Clifton Pl., Jersey City 4

SEGEL, NORMA
Apt. 7H, Bldg. 1, 43 & McLean Blvd., Paterson

SIEBEL, ELIZABETH
114 Clifton Pl., Jersey City 4

SEREDA, LA VERNE
75 Kempson Pl., Metuchen

SHELDON, VERA
65 Belgrade Ave., Clifton

SINCHOCK, MARY
Muhlenberg Hospital, Plainfield

SISTER AGNES CARLITA
St. Joseph’s Hospital, Paterson 3

SISTER ALICE EUGENIA
All Souls Hospital, Morristown

SISTER ALICE REGINA* *
204 S. Broad St., Elizabeth 2

SISTER ANITA MARGARET
211 Pennington Ave., Passaic

SISTER ANNA RITA
703 Main St., Paterson 3

SISTER AUGUSTA
St. Francis Hospital, Jersey City 2

SISTER BONAVITA
506 High St., Newark

SISTER CASILDA
St. Francis Hospital, Jersey City 2

SISTER CECELIA
St. Elizabeth Hospital, Elizabeth 2

SISTER CECELIA ELLENN
St. Joseph’s Hospital, Paterson 3

SISTER ELLENN TERESA
St. Mary’s Hospital, Passaic

SISTER ELIZABETH
St. Francis Hospital, Jersey City 2

SISTER GEORGETTE
St. Peter’s Hospital, New Brunswick

SISTER JEAN VINCENT
St. Mary’s Hospital, Passaic

SISTER JOSEPHINE ANN*
St. Joseph’s Hospital, Paterson 3

SISTER KUNGUNDE
St. Mary’s Hospital, Hoboken

SISTER LAMBERTA
St. Clare Hospital, Schenectady, N. Y.

SISTER LOYOLA
St. Mary’s Hospital, Hoboken 2

SISTER MARIA LAWRENCE
St. Elizabeth Hospital, Elizabeth

SISTER MARIAN THERESE
St. Francis Hospital, Trenton 9

SISTER MARIE BERNICE
211 Pennington Ave., Passaic

SISTER MARIE CELESTE
St. James Hospital, Newark

SISTER MARIE CLAUDIA
St. Joseph’s Hospital, Paterson 3

SISTER MARY ANDREW
St. Joseph’s Hospital, Paterson 3

SISTER MARY ANNE
St. Francis Hospital, Trenton 9

SISTER MARY CAMILLUS
St. Joseph’s Hospital, Paterson 3

SISTER M. CANICE
Holy Name Hospital, Teaneck

SISTER M. CATHERINE
Holy Name Hospital, Teaneck

SISTER MARY CLARE MONICA
St. Francis Hospital, Trenton 9

SISTER M. CLARENCE
St. Francis Hospital, Trenton 9

SISTER M. DOLORES
St. Joseph’s Hospital, Bellingham, Wash.

SISTER MARY EDMUND
Holy Name Hospital, Teaneck

SISTER M. ELAINE
St. Francis Hospital, Trenton 9

SISTER M. ERNESTINE
St. Mary’s Hospital, Passaic

SISTER MARY ESTHER
St. Joseph’s Hospital, Paterson 3

SISTER MARY FIDELIS
703 Main St., Paterson 3

SISTER MARY GEMMA
St. Francis Hospital, Trenton 9

SISTER M. IMELDA
143 Jefferson St., Newark 5

SISTER MARY MABEL
St. Francis Hospital, Trenton 9

SISTER M. PULCHERIA
Holy Name Hospital, Teaneck

SISTER M. ST. DENISE
St. Francis Hospital, Trenton 9

SISTER MARY SHEILA
143 Jefferson St., Newark 5

SISTER MELIC
St. Mary’s Hospital, Hoboken 2

SISTER PATRICIA
St. Michael’s Hospital, Newark 2

SISTER REDEMPHA
St. Michael’s Hospital, Newark 2

SISTER SABINA
St. Mary’s Hospital, Hoboken

SISTER SIMON PETRA
St. Mary’s Hospital, Hoboken

SISTER TERESA ANGELICA
703 Main St., Paterson 3

SMITH, ARTHUR W.†
Overlook Hospital, Summit

SMITH, ELMERTA
66 Runyon Ave., Deal

SMITH, ELIZABETH V.
Walnut St., Keypport

SMITH, HARRIET E.
4300 Park Ave., Weehawken

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Overlook Hospital, Summit

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33 S. Grove St., East Orange

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WILLIAMS, FLORENCE 74 Hamilton Ave., Fords
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WOOD, RUTH B. 119 Ridge St., Newark 4
YASTREMSKI, IRINE Elizabeth General Hospital, Elizabeth 4
YATES, ONA B. Essex County Hospital, Belleville 9
YOFFA, ESTHER R. 118 Pleasant St., Brookline, Mass.
YOST, MRS. GLADYS B. Muhlenberg Hospital, Plainfield
ZADLOCK, SHIRLEY E. 335 Keene St., Perth Amboy
Zengerle, ANNF 45 S. Tenth St., Newark 7
ZIEGENBUSCH, CATHERINE 45 S. Tenth St., Newark 7
ZITANI, MRS. ADELIN C. 73 Bloomfield St., Hoboken
ZONDLO, BARBARA 23 Stoles Ave., Clifton
ZULAUF, MARIE E. 133 Chestnut Dr., Hackensack Lake
ZWEIMAN, ADELE 275 Grattan St., San Francisco, Calif.

NEW JERSEY

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CLOGEE, FLORENCE L.
Veterans Administration Hospital, Albuquerque
GREENLEAF, ALICE
5412 E. Alice Ave., Albuquerque
MATTHEWS, VIVIAN
Veterans Administration Hospital, Albuquerque
SISTER ANDREW
St. Joseph Hospital, Albuquerque
SISTER MARY THEOPHANE
417 E. Palace Ave., Santa Fe

NEW YORK—1,367

ABBOTT, WENONA
260 Crittendon Blvd., Rochester 7
ABEL, DORIS M.
41½ Albert St., Johnson City
ABRAMARIS, MRS. CECILIA T.
644-A Madison Ave., Albany 8
ACKERMAN, JEAN G.
65 Hodge Ave., Buffalo 22
ADAMS, MRS. MARGARET M.
425 W. 205 St., New York 34
AKERS, MARTHA L.
Brooklyn Hospital, Brooklyn 1
ALDER, BERTHA L.
Grasslands Hospital, Valhalla
ALDRICH, MRS. ELEANORA
Alfred University, Box 974, Alfred
ALICANDRI, GLORIA
68 Rolling St., Lynbrook
ALLANACH, MARY E.
170 Ft. Washington Ave., New York 32
ALLEN, OLIVET J.
69 Lakeview Park, Rochester 13
AMBERSON, KATHARINE G.
545 Third St., Brooklyn 15
AMBROSINI, MRS. CATHERINE M.
1036 Lexington Ave., New York 21
AMES, HELEN L.
4604 S. Salina St., Syracuse 5
ANDERSON, ASTRID
1086 Lexington Ave., New York 21
ANDERSON, ELISE E.
87 W. 16 St., Bayonne, N. J.
ANKER, MRS. DOROTHY K.
57 Princeton Blvd., Kenmore 17
APPIO, MRS. COSETTE P.
16 Morris St., Albany 3
ARCHIBALD, MRS. MARIE U.
Main St., Bedford Hills
ARMSTRONG, EVA M.
Veterans Administration Hospital, Canandaigua
AUGUSTON, EIDITH M.
766-42 St., Brooklyn 32
AUSTIN, VIVIAN E.
503 Washington St., Watertown
BABCOCK, NANCY H.
206 Second Ave., Troy
BACHMAN, ALMA E.
581 Potomac Ave., Buffalo 13
BAILEY, BETTY R.
69 Fifth Ave., Troy
BAILEY, MARY V.
312 Union St., Brooklyn 31
BAILEY, SARAH M.
345 W. 50 St., New York 19
BAILEY, VERA
Veterans Administration Hospital, Martinsburg, W. Va.
BAILINGER, MRS. SHIRLEY A.
40 W. 74 St., New York 23
BAKER, EVELYN C.
ANA, 2 Park Ave., New York 16
BAKER, LUCILLE
161 Thayer St., Jamestown
BALDWIN, GLADYS
Albany Hospital, Albany 1
BALDWIN, MRS. VIOLA J.
83-79 St., Brooklyn 9
BALL, CORA L.
5 E. 98 St., New York 29
BANDTEL, BERTHA I.
318 Strathmore Rd., Haverstraw, Pa.
BANKER, ELEANOR
20 Morgan St., Rochester 11
BANKS, LORETTA D.
204 E. 35 St., New York 16
BABBIERI, FLORA
39-56-59 St., Woodside, L. I.
BARCLAY, ROSEMARY M.
643 W. 64 St., New York 55
BARDEWELL, MAJORIE S.
823 Knox St., Ogdensburg
BARENS, FLORENCE C.
70 Haven Ave., Apt. 6E, New York 32
BARKER, RUTH M.*
Metropolitan Hospital, Welfare Island, New York 17
BARKER, SYLVIA M.
111 W. 24 St., New York 25
BARNES, MARION A.
43 Clinton Ave., Albany 10
BARRETT, JEAN
185 Parkway Dr., Syracuse 7
BARRETT, MARY V.
Veterans Administration Hospital, New York 63
BARROWS, FRANCES H.
165 Ft. Washington Ave., New York 32
BARTENSTEIN, ROSEMARY A.
515 Sixth St., Niagara Falls
BARTUS, MRS. LENA K.
Deaconess Hospital, Buffalo 8
BARVIAN, FRANCES A.
1609 Western Ave., Albany 5
BASILE, JOSEPHINE V.
41-75 St., Brooklyn 9
BATES, GERTRUDE S.
The Sanitarium, Clifton Springs
BAUMANN, DORIS M.
2182 Tomlinson Ave., New York 61
BAUMANN, MRS. MARY D.
2182 Tomlinson Ave., New York 61
BAZAK, MRS. ELIZABETH R.
701 Second Ave., North Troy
BEAN, HELEN
300 E. 57 St., Apt. 2A, New York 22

530
BREWER, FRANCES H.
419 W. 114 St., New York 25

BROCKMAN, RUTH M.
3345 Agar Pl., New York 61

BRODIE, STELLA L.
467 Wyoming Ave., Buffalo

BROOKS, ELIZABETH C.
430 E. 63 St., Apt. 1-K, New York 21

BROPHY, CATHERINE C.
144 Gibbs St., Rochester 5

BROWN, BIRDIE E.
145-17 South Rd., Jamaica 4

BROWN, LILLIAN C.
165 Ft. Washington Ave., New York 32

BROWN, MRS. MARY
133 E. 80 St., New York 21

BRUCE, MARGARET E.
101 Perry St., Apt. 2C, New York 14

BRYAN, FRANCES E.
50 Grosvenor Rd., Rochester 10

BUCKLEY, HELEN M.
49 Granite St., Saratoga Springs

BUCKLEY, MILDRED B.
124 Clinton St., Watertown

BUCKLEY, NORA
121 DeKalb Ave., Brooklyn 1

BUDD, ESTHER
590 Comstock Ave., Syracuse

BUDDENHAGEN, DOROTHY C.
127 E. Chester St., Kingston

BURDICK, S. MARTINE
47 Cedar St., Binghamton

BURKE, MARGARET R.
Rockland State Hospital, Orangeburg

BURNHAM, JOHN A.
Van Rensselaer Rd., Ogdensburg

BURNS, MRS. EMMA R.

BURNS, MRS. MILDRED F.
103 Brandon Rd., Syracuse

BURNS, PATRICIA E.
61 St. Johns Ave., Kenmore 17

Burr, Mary D.*
Wagner College, Staten Island 1

BURRAGE, RUTH
10908 Magnolia Dr., Cleveland 16, Ohio

BURLILL, MARGARET S.
143 Hale Ave., White Plains

BURLROUGHS, MRS. BEATRICE W.
25 Niagara Sq., Buffalo

CADY, JANET S.
91 E. Jewett Ave., Buffalo 14

CAFFERTY, KATHRYN W.
NLNE, 2 Park Ave., New York 16

CALLAGHAN, MRS. MARGUERITE
57 Culver Rd., Buffalo 20

CALVER, CHARLOTTE M.
69 Rensen St., Brooklyn 2

CAMDEN, LOUISE R.
Veterans Administration Hospital, Northport

CAMERON, BETH L.
165 Ft. Washington Ave., New York 32

CAMERON, MARGARET E.
419 W. 114 St., New York 25

CAMPBELL, ELSIE L.
Keuka College, Keuka

CAMPBELL, JEAN
535 Parkside Ave., Apt. 4-P, Brooklyn 26

CAMPBELL, MRS. MAXINE D.
515 Sixth St., Niagara Falls

CAPEL, SUSAN S.
648 Concord Ave., Williston Park

CAPUANO, MARY J.
447 W. 56 St., New York 19

CARRBERY, MURIEL R.
117-12—197 St., St. Albans 12

CAREY, GLENNES M.
Binghamton City Hospital, Binghamton

CARINI, ESTA M.
1 Jane St., New York 14

CARLING, FLORENCE E.
73 Cherian Ave., Toronto, Canada

CARLSON, ELEANOR M.
39-26—62 St., Woodside

CARLSON, JEANETTE V.
Samaritan Hospital, Troy

CARMODY, HELEN F.
1163 St. John's Pl., Brooklyn 13

CARN, IRENE
303 E. 21 St., New York 10

CARNES, MARION E.
1497 Mt. Hope Ave., Rochester 20

CARR, CAPT. RHEA
320th General Hospital, Fort Lewis, Wash.

CARRINGTON, BERNICE R.
1320 York Ave., New York 21

CARROLL, MRS. AILEEN L.
Buffalo General Hospital, School of Nursing, Buffalo 3

CARROLL, MARY P.
1086 Lexington Ave., New York 21

CARTER, MRS. EDW. C.
215 E. 72 St., New York 21

CASEY, CLARE M.
Beth Israel Hospital, New York 3

CASHMAN, VICTORIA S.
P.O. Box 66, Albany

CASSIDY, ANNE
17 Farley Rd., Short Hills, N. J.

CAUFIELD, EVA L.
807 Elizabeth St., Ogdensburg

CECLAREK, MARIE M.
1230 Amsterdam Ave., New York 27

CHADWICK, HELEN R.
106 Morningside Dr., New York 27

CHAMBERLAIN, GLADYS J.
1230 Gerard Ave., New York 52

CHAMBERLAIN, MAY M.
Ellis Hospital, Schenectady

CHAMBERLAIN, MRS. SENA
Memorial Hospital, Ithaca

CHANDLER, ETHEL M.
663 N. Oak St., Buffalo 3

CHAPMAN, MILDRED L.
421 W. 21 St., New York 11

CHAYEY, MARY E.
208 Whitehall Rd., Amebury, Mass.

CHELINO, CARMELLA A.
146 Cardinal Ave., Albany 9

CHESTON, CAROL
165 Ft. Washington Ave., New York 32

CHINNERY, KATHRYN F.
5995 Riverside Ave., New York 71

CHRISTIANA, MRS. ISABEL H.
Vassar Brothers Hospital, Poughkeepsie

CHRISTOFFERSEN, MRS. LOIS H.
91-03—222 St., Queens Village 8

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CLANCY, ANN E. 63 Hodge Ave., Buffalo 22
CLARK, ALTHEA F. 397 W. 79 St., Rm. 516, New York 24
CLARK, MRS. GENEVIEVE Y. 327 Second Ave., Albany 9
CLARK, GERTRUDE E. 1508 E. 58 St., Brooklyn 34
CLARKE, MRS. WINIFRED R. White Plains Hospital, White Plains
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CLAWSON, GERTRUDE 722 W. 168 St., New York 32
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CLEVELAND, MARION D. 23 Haven Ave., Apt. 105, New York 32
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COLE, VERA D. 196-88-89 Ave., Hollis 7
COLEMAN, MRS. MARGARET M. 345 E. 68 St., New York 21
COLETTI, ANGELINA C. 101-17-46 Ave., Corona
COLHOUN, ROSALIE N. Medical Section, Hdg. First Army, Governors Island
COLLINS, GNA 455 E. 69 St., Apt. 5B, New York 21
COLLISON, JANE L. 108 Fernhill Ave., Buffalo 15
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CONNER, MARY C. Columbia University, Teachers College, New York 27
CONRAD, MARGARET E. 59 Bacon St., Orange, Mass.
CONSTANTINE, MILDRID Hospital of the Good Shepherd, Syracuse 10
COOPER, MARIAN W. 2816 Eighth Ave., House 8, Apt. 2V, New York 30
COOTE, AGNES J. 1989 Morris Ave., New York
COPE, MRS. RUTH G.† 83 Arnold Ave., Amsterdam
CORBIN, HAZEL 118 E. 54 St., New York 22

CROCORAN, AGNES 130 W. Kingsbridge Rd., New York 63
CORTHIGAN, ELEANOR M. 121 Westchester Ave., White Plains
COVELL, CECILE 23 Haven Ave., New York 32
COYLE, MARY W. 615 Main St., Greenport
CRANDALL, HAZEL W. Surf Route, Castle Creek
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CRAWFORD, ANNA N.* 1645 St. John's Pl., Brooklyn 13
CREAMER, ELLEN C. 20 Whitney Ave., Portland, Me.
CREEVY, EMILY L. 170 Washington Ave., Albany 10
CROLL, MILDRED M. 780 Greenwich St., Apt. 4M, New York
CROSSWHITE, NETTIE 86 Thayer St., New York 34
CROUCH, HOWARD E. Veterans Administration Hospital, Brooklyn 9
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DAMMANN, GLORIA A. 117 Sterling St., Watertown
DANA, MARY R. 2832 Main St., Buffalo
DANIELS, VIRGINIA 1520 York Ave., New York 21
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DAY, GRACE A. 9245—55 Ave., Elmhurst

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DEAKINS, ELIZABETH
Ellis Hospital, Schenectady

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419 W. 114 St., New York 25

DE CLUE, JAYNE F.
110-15—212 St., Queens Village 9

DELABARRE, HELEN C.
710 W. 168 St., New York 32

DE LAP, KATHERINE A.
2709 Fifth Ave., Troy

DEMAREST, MRS. ELSIE N.
121 Dekalb Ave., Brooklyn 1

DENNARD, LORAINE
333 Southern Blvd., New York 54

DENISON, LOUISE
University of Rochester, Rochester 7

DENNISON, CLARE
Strong Memorial Hospital, Rochester 20

DERICKS, VIRGINIA C.
1520 York Ave., New York 21

DERRELL, MRS. CONSTANCE M.
35-15—98 St., Corona

DEUTCH, MRS. BARBARA M.
419 W. 119 St., New York 27

DEUTSCH, NAOMI
145 E. 33 St., New York 16

DE YOUNG, GRACE E.
824 Washington St., Watertown

DIBLE, EILEEN F.
Samaritan Hospital, Troy

DICARO, ELEANOR M.
Meadowbrook Hospital, Hempstead, L. I.

DIEFENDORF, CATHERINE A.
134 E. Warrington Rd., Syracuse

DI GENNARO, CATHERINE
93½ Grove St., Amsterdam

DILL, ISABEL H.
Jefferson High School, Rochester 6

DILLON, EDNA
5 E. 98 St., New York 29

DILLON, MRS. RUTH M.
89 Somerset St., Rochester 11

DINEEN, MARY A.
1890 Niagara Ave., Niagara Falls

DINES, ALTA E.
114 E. 54 St., Apt. 8-N, New York 22

DIO RIO, MINNIE R.
Willow Tree Rd., Milton

DI SIENA, MRS. ANGELA J.
115 Round Lake Ave., Mechanicville

DISOSWAY, KATHERINE
45 Plaza St., Brooklyn 17

DODD, NATALIE M.
129 E. 69 St., New York 21

DOMBROSKE, ANNA E.
St. Joseph's Hospital, Syracuse 3

DONELLY, MRS. AGNES M.
St. Mary's Hospital, Troy

DORCANN, ANAMAE
Neposith Beach Hospital, Rockaway Park

DOWNEY, MARTHA H.
184 W. Buffalo St., Warsaw

DUFFY, HELEN C.
106 Clarkson Ave., Brooklyn 26

DUNAWAY, MARION E.
568 Park Ave., Albany 8

DUNBAR, VIRGINIA M.*
1320 York Ave., New York 21

DUNN, ELIZABETH A.
70 Garden St., Kingston

DUNN, FLORENCE E.
207 S. Plymouth Ave., Rochester 8

DURBIN, MARY N.
Station H, Home 4, Central Islip

DUSTAN, LAURA C.
330 E. 63 St., New York 21

Dwyer, MRS. MAMIE C.
20 N. Goodman St., Rochester 7

Dwyer, SHEILA M.
Division of Nursing Education, Teachers College, New York 27

DYER, A. TEMPLE
Glenmont

EADY, MRS. CAROL M.
10 Edgehill Ter., Apt. 2, Troy

EARLES, EVELYN E.
71 Pineapple St., Brooklyn 2

EASTMAN, DOROTHY
108-17—66 Ave., Richmond Hill 18

EBERHARDT, MARIE E.
63 Surf Road, W., Copiague, L. I.

EBERLE, CATHERINE
1884 Watt St., Schenectady 4

ECKELBERRY, GRACE
728 S. Crouse Ave., Syracuse

EDGAR, MARY C.
440 E. 26 St., New York 10

EDGERTON, BERTHA E.
Station A, Ogdensburg

EDWARDS, BLANCHE E.
416 E. 26 St., New York 10

EGBERT, MRS. MARGARET W.
252 Deems Ave., Staten Island 14

EGO, VIRGINIA K.
7 Latona Ct., Buffalo

EHRHART, ALICE M.
106 W. 45 St., New York 19

EIG, EMMA
200 W. 15 St., New York 11

EILTZER, THERESA A.
1230 Genard Ave., New York 52

EIMANN, MARY
Willard Parker Hospital, New York 9

EKNEY, F. MARY
Grasslands Hospital, Valhalla

ELIOT, MARGARET
179 Ft. Washington Ave., New York 32

ELKAN, MAXINE
55 Morton St., Apt. 6-H, New York 14

ELLIOIT, ASA B.*
G. P. Putnam's Sons, 2 West 45 St., New York 19

ELLIOIT, FLORENCE E.
169-15—118 Ave., Jamaica 5

ELMER, EDYTH M.
Mt. Vernon Hospital, Mt. Vernon

ENNIS, JEANNE L.
1086 Lexington Ave., New York 21

ESAU, MARGARET C.
1416 Brooklyn Ave., Brooklyn

ESPOSITO, DOLORES R.
13 Fairview Ave., Baldwin

EWING, CLARA L.
15 Blakeley Ct., Troy

FALCON, YVONNE L.
130 W. Kingsbridge Rd., New York 63

FALLON, BARBARA R.
124 Shotwell Park, Syracuse 6
FALLON, MRS. EDITH M.
303 E. 20 St., New York 3

FALLS, CAROLINE E.
210 E. 68 St., New York 21

FANJOY, CAPT. BERTHA J., ANG
Field Station, 8064th AAU, APO 843, c/o PM,
New York

FARHI, BLANCA
115 Valentine Pl., Ithaca

FAVREAU, CLAIRE H.
695 Park Ave., New York 21

FAY, ALICE M.
295 Flatbush Ave. Ext., Brooklyn

FAY, RITA
116-33—222 St., Cambria Heights

FEDDER, HELMA
530 E. 63 St., Apt. 21, New York 21

FEDERKO, MARY
443 E. 92 St., Apt. 2A, New York 23

FEENEY, MARY E.
St. Joseph's Hospital, Syracuse 3

FERENC, ANNA
5500—97 St., Corona

FERGUSON, EVELYN A.
44-14 Newton Rd., Astoria 3

FERGUSON, MARGARET W.
Queens General Hospital, Jamaica 2

FERGUSON, SARAH M.
311 E. 72 St., New York 21

FERRARA, MRS. ESTHER A.
2837 Valentine Ave., New York 58

FERRARA, FLORENCE E.
107 Joralemon St., Brooklyn 2

FEUERSTEIN, SYLVIA
150 W. Kingsbridge Rd., New York 63

FIELDS, FLORENCE M.
Pleasantdale, R.F.D. 2, Troy

FINGER, BERNICE
244 Bay 11 St., Brooklyn 28

FINK, IRMA N.
R.F.D. 2, Ridge Rd., Scotia

FIRTH, MRS. KAZMIER K.
Pilgrim State Hospital, Brentwood

FISH, HELEN D.
121 Westchester Ave., White Plains

FISHER, DOROTHY J.
330 Park St., Albany

FISHER, HELEN C.
636 Linwood Ave., Buffalo 9

FLANAGAN, MRS. LIDA K.*
536 Third Ave., Watervliet

FLETCHER, MILDRED E.
450 Linwood Ave., Buffalo 9

FLICKER, HELEN M.
560 Park Ave., Albany 8

FLIEGEL, JEAN M.
29 Kingsboro Ave., Gloversville

Foley, ROSE R.
113 Holland Ave., Albany 1

FOOTE, ELIZABETH K.
Alfred University, Box 694, Alfred

FORBES, ELISE M.
305 E. 18 St., New York 3

FORD, MYRTLE M.
315 E. 68 St., New York 21

FORTUNIE, FLORENCE E.
Mary McClellan Hospital, Cambridge

FOX, THEDA L.
315 E. 68 St., New York 21

FRASER, EVELYN G.*
Roosevelt Hospital, New York 19

FREDERICK, LILLIAN
500 East Ave., Rochester

FREDERICKS, LOIS M.
1086 Lexington Ave., New York 21

FREW, MAJ. EDITH L.
U. S. Army Hospital, Camp Edwards, Mass.

FREY, ALICE O.
1117 S. Plymouth Ave., Rochester 8

FRIEDE, MARY F.
Veterans Administration Hospital, Brooklyn 9

FRIEDMAN, IDA G.
239 Ocean Ave., Brooklyn 25

FRITZ, EDNA L.
330 E. 63 St., New York 21

FROJIN, OLGA B.
132 E. 48 St., New York 17

FRY, MRS. VERA
51 Wilson Ave., Amityville

FUENTES, ANA
Columbia Memorial Hospital, Hudson

FULLER, LILLA M.
217-21—49 Ave., Bayside, L. I.

FULLER, MARION A.
79 Chestnut St., Cooperstown

GALANTOWICZ, WANDA R.
Winthrop Rd., Elma

GARDNER, EMILY I.
596 Sixth St., Brooklyn 15

GAST, MARGARET H.
722 University Ave., Syracuse

GAW, ANNA
118 Humber Ave., Buffalo

GAYNOR, GENEVIEVE E.
U. S. Marine Hospital, Staten Island

CEICER, HARRY J.
208 Park St., Canandaigua

GELINAS, AGNES*
303 E. 20 St., New York 3

GENNER, RITA M.
1320 York Ave., New York 21

GESNER, F. PAULINE
302 E. 88 St., Brooklyn 15

GESSIN, MRS. BETSY R.
1042 E. 31 St., Brooklyn 10

GESTWICK, KATHERINE
557 Prospect Pl., Brooklyn 16

GIBBS, MARTHA E.
134 Linden St., Rochester

GIBNEY, MARY A.
1326 Madison Ave., New York 28

GILES, ANNE E.
Seq View Hospital, Staten Island 21

GILL, ELIZABETH S.
179 Ft. Washington Ave., New York 32

GILL, JUNE M.
42 W. 56 St., New York 19

GILL, VIRGINIA A.
165 Ft. Washington Ave., New York 32

GILMARTIN, MRS. MABEL E.
Fourth St., P.O. Box 47, Brentwood, L. I.

GINTE, KATHERINE C.
560 W. 165 St., Apt. 4H, New York 32

GISHER, RUTH B.
440 E. 78 St., New York 21

GLAZIER, DOROTHY S.
116 E. Castle St., Syracuse 5

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NEW YORK

GLEDHILL, BEATRICE G., Biggs Memorial Hospital, Ithaca
GLENNING, ELLA
Fordham Hospital, New York 53
GLIENKE, FRANZISKA
Panamerican Sanitary Bureau (WHO), Washington, D. C.
GLUZA, AMELIA H.
R.D. 2, Watervliet
GNAU, INEZ
1308 York Ave., New York 21
GODEK, ADELAIDE M.
110 E. 39 St., Brooklyn 3
GODEK, ISABELLE
Nurses’ Home, St. Vincent’s Retreat, Harrison
GOEBEL, RUTH
5 E. 98 St., New York 29
GOFF, HAZEL A.
National Nursing Accrediting Service, 2 Park Ave., New York 16
GOKEY, RUTH E.
Albany Hospital, Albany 1
GOLDBLATT, ROSE S.
567 Prospect Pl., Brooklyn
GOLDER, GRACE
3103 Fairfield Ave., Apt. 2G, New York 63
GONSKI, ALICE F.
52 W. 36 St., New York
GONOW, MARY E.
New York Hospital, Westchester Div., White Plains
GOODAL, HELEN C.
920 Riverside Dr., New York 32
GOODMAN, GERTRUDE B.
424 E. 76 St., New York 21
GOODMAN, KATHRYN S.
1919 Madison Ave., New York 35
GOODRICH, ANNE M.
160 E. 38 St., New York 16
GORDON, E. DOROTHY
397 State St., Albany 10
GORMAN, MINNIE
Binghamton City Hospital, Binghamton
GOTTDANK, MILDRED
65 Morton St., Brooklyn 11
GOURLAY, MARGARET
Hermann M. Biggs Memorial Hospital, Ithaca
GRAHAM, MARIORIE R.
260 Crittenend Blvd., Rochester 26
GRAHAM, THALLA A.
St. Luke’s Hospital, Newburgh
GRAJEWSKI, MRS. MARY B.
122 Lampert Blvd., Staten Island 5
GRAUER, MARY T.
Fordham Hospital, New York 53
GRAUL, MRS. ANN L.
1214 Lemoyne Ave., Syracuse
GRAVELLE, ELLEN F.
621 Academy St., Watertown
GREENWOOD, LILA L.
200 E. 16 St., New York 3
GRIERSON, LOIS F.
62 Chestnut St., Albany 6
GRIMES, MARY C.
140 Cabrini Blvd., New York 33
CROSSMAN, MRS. JENNIE
512 Eastern Pkwy., Brooklyn 25
GRUBE, BLANCHE J.
650—77 St., Brooklyn 9

GUBERSKY, BLANCHE D.
121 W. 105 St., New York 25
GUGLIUZZA, MARY
1010 Delamont Ave., Schenectady 7
GUINEE, MRS. KATHLEEN K.
3543—84 St., Jackson Heights
GUNTERT, MURIEL E.
2050 East Ave., Rochester 10
GURIAN, ESTHER R.
320 Rockaway Pkwy., Brooklyn 12
GUYDES, MRS. GLADYS C.*
264 Bay 19 St., Brooklyn 14
GUYETTE, ISABEL J.
Veterans Administration Hospital, New York 63
HADDAD, ARIFIE
130 W. 125 St., New York 63
HADSELL, MRS. HELEN N.
130 Glen Ave., Amsterdam
HAGNER, DOROTHY K.
Hudson View Gardens, New York 33
HALEY, HELENA M.
566 Third Ave., North Troy
HALL, EDITH D.
345 W. 50 St., New York 19
HALL, ELIZABETH
328 State St., Albany 6
HALL, MOZELLA
209 W. 135 St., New York 30
HALL, REINA F.
57—81 St., Apt. F-3, Jackson Heights
HALL, RUTH G.
290 Freeman Rd., Orchard Park
HALLOCK, MILDRED C.
1068 Lexington Ave., New York 21
HALSTED, ELIZABETH A.
645 E. 14 St., New York 9
HALSTED, KATHARINE E.
645 E. 14 St., New York 9
HAMON, CONSTANCE
463 First Ave., Pelham 65
HANAFORD, VIRGINIA A.
72 Mill St., Newburgh
HANE, ANNA H.
1249 Fifth Ave., New York 29
HANES, MRS. NELLIE C.
2259 S. Park Ave., Buffalo 20
HANLEY, BERNADETTE J.
2709 Fifth Ave., Troy
HANNAN, ELIZABETH J.
526 Washington St., Ogdensburg
HANOVER, LILLIAN M.
812 Elmwood Ave., Buffalo
HANSON, ELIZABETH M.
251 Bedford Ave., Buffalo 16
HANSON, LOUISE A.
St. Francis Hospital for Practical Nursing, New York 54
HARLEY, RUTH S.*
16 Kilburn Rd., Garden City
HARLFINGER, ANNA M.
385 Morris St., Albany 8
HARMON, ELIZABETH
1320 York Ave., New York 21
HARPER, MRS. RUTH W.
770 St. Marks Ave., Brooklyn 16
HARRINGTON, HARRIET R.
1116 Elmwood Ave., Buffalo
HARRISON, ETHEL F.
250 W. 22 St., New York 11

536
HILLEN, ELSIE W.
Cruise-Irving Hospital, Syracuse 10

HILLS, MRS. ETHEL T.
569 Myrtle Ave., Albany 8

HILLS, THIRZA L.
1330 York Ave., New York 21

HIRSCH, MRS. LYDIA
15 Central Park West, New York 23

HOAGLIN, GENEVIEVE E.
13 S. Gordon St., Gouverneur

HOBBS, MARY A.
521 W. Main St., Rochester 8

HODGES, JUSTINA
949 State St., Schenectady 7

HODGMAN, GERTRUDE E.∗
109 Caroline St., Saratoga Springs

HOLCOMB, KATHRYN L.
St. Luke's Hospital, Newburgh

HOLDMAN, CALVIN
221 N. James, Peekskill

HOLER, KATHERINE T.
733 E. 237 St., New York 66

HOLMAN, LOIS H.
Long Island College Hospital, Brooklyn 2

HOLMES, MARGUERITE C.
7-13 Washington Sq. N., New York

HOPSON, GEAN M.
12 Highland Park, Massena

HORNE, JANET C.
701 Union Ave., Schenectady 5

HORTON, IRMA
5 Washington Park, Troy

HOTCHNER, HELEN
110 Remsen St., Brooklyn 2

HOUSTON, HAZEL L.
196 Hackett Blvd., Albany 3

HOWARD, MRS. MARIE B.†
350 S. Tenth St., Mt. Vernon

HOWARTH, MRS. FLORENCE S.
59 S. Adelaide Ave., Highland Park, N. J.

HUDSON, LILLIAN A.
525 W. 120 St., New York 27

HUDSON, MARIE E.
521 W. Main St., Rochester

HUFF, ROWENA
Wilson Memorial Hospital, Johnson City

HUGER, MARGARET
553 E. 82 St., Apt. 4C, New York

HUGHES, ADELAIDE A.∗
8343—88 St., Woodhaven, L. I.

HUGHES, ANNE E.
480 E. 63 St., New York 21

Hugo, MARY A.
201 W. 79 St., New York 24

HULBERT, MARGARET
3435 Bailey Ave., Buffalo

HULBERT, MRS. RUTH B.
62 Steele Ave., Gloversville

HUNT, MARGUERITE
Staten Island Hospital, Staten Island

HUNTER, GREETA V.
824 Washington St., Watertown

HUNTLEY, MARGARET F.
103 Dorset Rd., Syracuse 10

HURY, NELLIE A.
509 Catherine St., Syracuse

HUTCHINSON, MARGARET E.
269 Mt. Vernon Ave., Rochester 20
HUTCHINSON, MARY E.
Fordham Hospital, New York 58

HYDER, KATE
622 W. 141 St., New York 31

IDANK, AGNES M.
1101 Howard St., Schenectady 3

IERVALINO, ISABELLA C.
539 Elm St., Buffalo 3

IGOE, MARGARET
2965 Marion Ave., New York 58

ILLING, FLORENCE L.
82 Chestnut St., Albany 6

INCAVO, SHIRLEY M.
413 University Ave., Syracuse

INGRAHAM, DOROTHY L.
19 W. 67 St., New York 24

INGRAM, MADELENE E.
2627 River St., Rockville Center

IVERS, LEONE N.
604 Franklin St., Wausau, Wisc.

JACKSON, FLORENCE I.
121 DeKalb Ave., Brooklyn 1

JACOBS, MARION L.
Nassau Hospital, Mineola

JACOBSON, MRS. FRANCES M.
111 W. 165 St., New York 63

JACOBSON, MRS. MIMI P.
101 E. Hartsdale Ave., Hartdale

JAFFEE, MRS. DOROTHY B.
19 E. 98 St., New York 29

JAKOBI, GERARD
Sea View Hospital, Staten Island 14

JAMES, MRS. VIRGINIA P.
19 Florence Ave., White Plains

JANSEN, MARGUERITE P.
165 Ft. Washington Ave., New York 32

JAQUAY, BERTHA
540 Park Ave., Albany 8

JENKINS, MRS. ELDA H.
385 Morris St., Apt. 33, Albany 8

JENKINS, MARY A.†
220 Herald Pl., Syracuse

JENSKIEVIECE, BERNICE A.
119 Holland Ave., Albany 1

JENNINGS, MRS. ROSE M.
22 Jefferson Ave., Massapequa Park, L. I.

JOHNSON, ANNE
Kings County Hospital, Brooklyn 3

JOHNSON, FLORENCE M.
215 E. 73 St., New York 21

JONES, BETTY B.
600 W. 165 St., New York 32

JONES, MRS. GERALDINE F.
157 Spruce Ave., Rochester 11

JORDAN, ETHEL M.
57-14—217 St., Bayside

JORDAN, MINNIE H.
244 W. 72 St., New York 23

JORDHEIM, MRS. ANNE F.
c/o Falkenstein, 356 W. 140 St., New York 51

JORGENSEN, MARIE D.
Samaritan Hospital, Troy

JOSEPH, MRS. THERMA L.
385 Morris St., Albany

JOWETT, MRS. CLARA E.
4 Madison St., Springville, Me.

JUDGE, MRS. JEANETTE J.
59—15 St., Brooklyn 15

JULIEN, JOSEPH L.
412 University Pl., Syracuse 10

JULIEN, JULIETTE
179 Second St., Troy

KAISER, GENEVIEVE F.
163 Kingsley St., Buffalo 8

KANE, SHIRLEY M.
5 Maple Ave., Stop 37, Schenectady Rd., Albany 5

KAP, ELIZABETH J.
1086 Lexington Ave., New York 21

KARIN, JOSEPHINE
124 E. 24 St., New York 10

KASIEROWSKY, JOSEPHINE M.
39 Auburn Pl., Brooklyn 1

KEATING, MARY L.
43 Brewster St., Kingston

KEATING, MAY
477 St. John's Pl., Brooklyn 16

KEENAN, ELLEN G.
Lock Haven Hospital, Lock Haven, Pa.

KEENEN, AGNES K.
Mercy Hospital, Watertown

KELLEGREW, LOUISE S.
147 N. Broadway, Yonkers 2

KELLER, CAROLINE
146 E. 63 St., New York 21

KELLEY, EDNA L.*
850 E. 29 St., Brooklyn 10

KELLOGG, LAURA
135 W. High Ter., Rochester 11

KELLY, MRS. AGNES B.
15-A-1 Sheridan Village, Schenectady

KELLY, MRS. CORDELIA K.
440 W. 24 St., New York 11

KELLY, MARGARET D.
1359 York Ave., New York 21

KELLY, MARILYN A.
8641—127 St., Richmond Hill

KENNEDY, DOROTHY M.
117 Remsen Ave., Ogdensburg

KENNEDY, MARY
75 Earl St, City Island, New York 64

KENNEDY, MAY

KENT, LOUISA M.
165 Ft. Washington Ave., New York 32

KENT, MARIAN G.
26 Park Ave., New York 16

KERINS, MARY F.
Kings County Hospital, Brooklyn 3

KERR, HELEN
183 Eighth Ave., Brooklyn

KERR, CHARLOTTE
c/o F. Robinson, Jacksonwald, Pa.

KESNER, ELAINE S.
99 Grand Ave., Staten Island 1

KIAH, LILLIAN M.
416 Patterson St., Ogdensburg

KIBBE, MRS. ELSA M.
58 W. 57 St., New York 19

KIERNAN, ELLEN D.
1515 York Ave., New York 21

KIMBLE, LEAH
1086 Lexington Ave., New York 21

KIMPTON, BARBARA
1086 Lexington Ave., New York 21

KINCH, ALICE M.
5101—39 Ave., Apt. F64, Long Island City 4
KING, MARY M.
321 E. 15 St., New York 3

KINLOCH, MRS. ELIZABETH E.
59 Cooper Ave., Troy

KINNEY, MRS. BEATRICE G.
82 Chestnut St., Albany 6

KINTON, GRACE E.
75 Elizabeth Rd., New Rochelle

KIRCHNER, AUGUSTA N.
132 E. 45 St., New York 17

KIRSCHEN, MRS. ADA R.
20-32—19 St., Long Island City 5

KLANK, HERTA F.
St. John's Riverside Hospital, Yonkers

KLANT, JULIA P.
222 Linden St., Brooklyn 21

KLASSEN, HELENA
Columbia Memorial Hospital, Hudson

KLEIN, HARRIET
345 E. 68 St., New York 21

KLEIN, MARY E.
1220 York Ave., New York 21

KLEIN, MRS. TESSA M.
1016 Amherst St., Buffalo 16

KLENK, MARION E.
113 Kenwick Dr., Syracuse

KLOSTER, MRS. RUTH
140-20 Poplar Ave., Flushing

KNOPKE, MRS. LAZELLE S.
2616 Arlington Ave., New York 63

KODERLE, MARQUERITE
856 Lincoln Pl., Brooklyn 16

KONECKY, MRS. CYRENA P.
737 N. Broadway, Hastings-on-Hudson

KOPSCHE, GERTRUDE
250 E. 78 St., New York 21

KORNEBERG, MRS. LORE F.
309 E. 18 St., New York 3

KORNAUSER, FRIEDA
1901 Lincoln Pl., Brooklyn 13

KOSTRZEWOR, FLORENCE
130 W. Kingsbridge Rd., New York 63

KOZA, JOSEPHINE
156 John St., Staten Island 2

KRAITZMAR, RACHEL
Beth Israel Hospital, New York 3

KRAUSS, MARY M.
Auburn City Hospital, Auburn

KRAZINSKII, OLGA I.
5 E. 98 St., New York 29

KREBS, ESTHER E.
Meadowbrook Hospital, Hempstead

KRIVIT, ADRIENNE
395 E. 35 St., Brooklyn

KROWINSKI, ADELINNE J.
1610 Main St., Buffalo

KUCHANEK, MRS. MARY ANN S.
41 Burroughs Dr., Snyder 21

KUEHNER, GRACE B.
330 Summit Ave., Mt. Vernon

KULIBERT, MRS. LEILA A.
1355 Second Ave., New York 21

LACEY, EDITH M.
415 Main St., Onontoa

LADD, HELEN J.
67 Earl St., Rochester 11

LADUE, ALBERTA L.
72 Augustine St., Rochester 13

LAINE, RUTH C.
65 Catskill Ave., Yonkers

LAMPKE, VICTORIA
858 Fillmore Ave., Buffalo

LANDAGO, CLOTILDA
2265 Sedgwick Ave., New York 53

LANDE, SYLVIA
567 Prospect Pl., Brooklyn 16

LANDER, MARILYN
Samaritan Hospital, Troy

LANDRY, RUTH D.
124 Proctor Ave., Ogdensburg

LANZISERIA, FLORENCE R.
109-28—113 St., Ozone Park 16

LARSEN, A. MARGARET
33 Highland Ave., Buffalo 9

LATTANZIO, ELEANOR M.
63 Ferry St., Beacon

LATTIMER, MRS. CECILIA J.
Nathan Littauer Hospital, Gloversville

LAUBE, WILHELMINA C.
J. N. Adam Memorial Hospital, Poughkeepsie

LAURER, MADELYN J.
936 Buffalo Rd., Rochester 11

LAURY, ELIZABETH P.
333 Southern Blvd., New York 54

LAYERON, MRS. GERALDINE M.
1515 Metropolitan Ave., New York 62

LEVINE, HILDA
Bashville Hospital, Brooklyn

LAWTON, MONICA A.
1585 S. Geddes St., Syracuse 4

LEACH, SARAH C.
49 Beach St., New York 13

LEAHY, RITA
365 Fourth St., Troy

LEAVELL, LUTIE C.
509 W. 121 St., New York 27

LEE, ELEANOR
179 Ft. Washington Ave., New York 32

LEHR, MRS. SOPHIA M.
3706—69 St., Woodside

LEINO, AMELIA
417 W. 120 St., Apt. 6W, New York 27

LEITICH, RUTH A.
104 DaBois St., Newburgh

LEKASHMAN, CARYL L.
5129 Post Rd., Riverdale, New York 71

LEMEANDOSKI, MARGARET E.
273 Ravenwood Ave., Rochester 11

LEMAT, ALINE F.
15 Stone Ave., Ossining

LEMKE, AUDREY T.
38 Ericson Ave., Buffalo 15

LEVAN, KATHARINE
235 E. 45 St., Apt. 4E, New York 17

LEVIN, DOROTHY
701 W. 177 St., New York 33

LEWIS, ANN M.
85 Bushwick Ave., Brooklyn 11

LEWIS, GERTRUDE E.
Methodist Hospital, Brooklyn 15

LEWIS, LAURA F.
370 Bird Ave., Buffalo 9

LEWIS, RUTH L.
333 Westminster Rd., Rochester 7

LEWIS, SHIRLEY J.
146 Eighth St., Troy
LIBBEY, MRS. RUTH C.† 93 Paine Ave., New Rochelle
LIDDLE, EVELYN 425 E. 86 St., New York 28
LILIENTHAL, FREDRICKA 10 Washington St., Apt. 2A, Hempstead
LINCOLN, HELEN M.† 2432 Webb Ave., New York 63
LINDE, FLORENCE A. Wells College, Aurora
LINDROOS, ANNEROSE S. 428 E. 67 St., New York 21
LINDVALL, DOROTHY B. Wheeler Rd., Hauppauge
LINEHAN, PATRICIA 501 Prospect Ave., Syracuse 3
LIPMAN, MRS. INEZ R. 521 W. Main St., Rochester 8
LIPPERT, EILEEN M. 5 West St., Albany 6
LISTON, MARY F. 111 W. 183 St., New York 53
LOFTHOUSE, ELEANOR M. 14 Maria St., Rochester 5
LOGAN, MRS. LEONA C. 1863 E. Main St., Peeksill
LOGOTHETIS, CLEANTHE E. 321 E. 42 St., New York 17
LONGHURST, GRACE Mount Morris Tuberculosis Hospital, Mount Morris
LORICH, INEZ C. 26 N. Cayuga Rd., Williamsville 21
LOVE, MRS. ANNA E. 175 Jay St., Albany 6
LUBITZ, MARY 5 E. 98 St., New York 29
LUCIA, CONSTANCE C. 501 W. Main St., Rochester 8
LUHR, MRS. ROSEMARY H. Mercy Hospital, Watertown
LUKACS, KATHERINE 299 Steckles Ave., New Rochelle
LUNDE, MILDRED S. Central Nurses’ Residence, Welfare Island 17
LUNDGREN, GRACE M. 20 Chestnut St., Bergenfield, N. J.
LYMAN, E. EVELYN 1601 Jacob St., Troy
LYNCH, MRS. ELEANOR 815 E. 223 St., New York 66
LYNCH, RUTH A. 179 Fl. Washington Ave., New York 32
LYNCH, SARAH R. 101 Elm Ave., Mt. Vernon
LYONS, A. VERONICA 1303 York Ave., New York 21
LYONS, GERTRUDE A. 5 Tryon St., Albany 3
MACAULAY, MARY 219 Brinkerhoff St., Plattsburg
MacCAMBRIDGE, MRS. ALAMEDA B. 111 East 36 St., New York 16
MacDONALD, ANNETTE Veterans Administration Hospital, Montrose
MacDONALD, IDA M. 806 Irving Ave., Syracuse
MacDONALD, MARY M. 567 Prospect Pl., Brooklyn 16
MacINTYRE, MARGARET E. 41-11 Gleane St., Elmhurst
MACKNEY, ELIZABETH F. Nassau County Tuberculosis Hospital, Farmingdale
MacLAY, CATHERINE* 116 Bungalow Ter., Syracuse
MacLEAN, H. ROSALIND 205 E. 72 St., New York 21
MADDEN, MRS. JOAN D. R.F.D. 1, Rensselaer
MADDICK, HARRIET 301 E. 20 St., New York 3
MAFFEO, MRS. RITA T. 334 Hudson Ave., Albany 10
MAGUIRE, BRIDGET 523 E. 78 St., New York 21
MAGUIRE, ROSE A. 2954 Marion Ave., New York 58
MAHON, INA T. Grasslands Hospital, Valhalla
MAJOR, MARIORIE B. 767 Irving Ave., Syracuse 10
MALCOLM, ALICE F. 936 Buffalo Rd., Rochester 11
MALONEY, LT. ELEANOR G. 4037 Lewiston Rd., Niagara Falls
MANDICO, SARAH A. Coney Island Hospital, Brooklyn 35
MANGAN, WINIFRED C. 1269 Grand Concourse, New York 52
MANLEY, FLORENCE 718 Madison Ave., Albany 3
MANLEY, MARY E. 360 E. 55 St., Apt. 8H, New York 22
MANTEL, C. HARRIET 179 Fl. Washington Ave., New York 32
MARCIA, CLARA M. 1453 Clifton Ave., Rochester 21
MARCUS, ROSE* 339 E. 10 St., New York 3
MARTLIN, ALMA 1230 Amsterdam Ave., Rm. 356, New York 27
MARR, GRACE E. 65 Ten Broeck St., Albany 10
MARSH, BOYDE C. Crownsville State Hospital, Crownsville, Md.
MARBELK, KATHLEEN 592 N. Oak St., Buffalo
MARTIN, ANITA 4110 Broadway, New York 33
MARTIN, JULIA L. 377—91 St., Brooklyn
MARTY, DORTHEA B. 1427 Second Ave., New York 21
MATHENEY, RUTH V. 23 Beacon Ave., Albany
MATTHEWS, GRACE J. St. Luke’s Hospital, New York 25
MATTHEWS, MRS. THELLES M. 58 Highgate Ave., Buffalo 14
MATZ, MRS. ANNA V. 40 E. 10 St., New York 3
MAYHAN, EVALENE P. 161 N. Pearl St., Albany
MAZURKIEWICZ, FRANCES R. 529—83 St., Brooklyn
McALLEN, MRS. HELEN J. 1305 St. Nicholas Ave., New York 33

540
MEMBERS

MCALLISTER, VIRGINIA M.
Riverside Dr., Ogdensburg

MCCABE, MARGARET
567 Prospect Pl., Brooklyn 16

MCCARRON, IRENE M.
423 W. 59 St., New York 19

MCCARTHY, EILEEN T.
3105 Roberts Ave., New York 61

MCCARTHY, HELEN K.
1086 Lexington Ave., New York 21

MCCARTHY, ROSE
440 E. 26 St., New York 10

MCCLELLAND, ANNA T.
39 Morris St., Albany 8

McCUIRE, SYLVIA E.
Station H, Central Islip

McCUSKEY, AUDREY M.
340 E. 66 St., New York 21

McCOACH, MRS. DOROTHY E.
17 Crescent Pl., Middletown

McCORD, GERTRUDE M.
544 Madison Ave., Albany 3

McCUBBIN, MRS. EDITH BUTLER
64 Center St., Pearl River

McDONALD, CLARE A.
1939 Ridge Rd., Ebenizer

McDONELLL, MARGARET
31-03-93 St., Jackson Heights

McDOWELL, MRS. MADELINE O.
1078 Sunset Ave., Utica

MCECHETTE, MRS. SOPHIA B.
77 S. Lake Ave., Albany 3

MCEWAN, DORA E.
N. Y. State Rehabilitation Hospital, West Havenstraw

MCINTYRE, MARY F.
3421 Country Club Rd., New York 61

MCGUIRE, MARY E.
355 Lenox Rd., Brooklyn 26

MCKEE, MRS. BEATRICE
425 E. 72 St., New York 21

MCKEON, IRENE
150-02-88 Ave., Jamaica

MCKEOWN, ELIZABETH M.
1921 York Ave., Apt. 1-A, New York 21

MCKEVITT, ANNA M.
411 Canisteo St., Hornell

MCLAUGHLIN, ANNETTE L.
Albany Hospital, Albany 1

MCLAUGHLIN, MRS. DOROTHY D.
Central Islip State Hospital, Central Islip

MEMANUS, MRS. R. LOUISE*
106 Morningside Dr., New York 27

MCMULLAN, DOROTHY
434 E. 70 St., New York 21

MCNULTY, MRS. MARTHA L.
11-2 Blatchford Dr., Troy

MCPHAIL, RUBY G.
515 E. State St., Rhacal

McSWEENEY, ELIZABETH
951 Woodycrest Ave., New York 52

MEDWID, MRS. IRENE G.
23 Teller St., Amsterdam

MEIER, CHARLENE
101-31—223 St., Queens Village 9

MEIGS, FLORENCE J.
238 Bryant St., Buffalo 22

MELANDER, ALICE T.
221 Hudson Ave., Hampton Manor, Rensselaer

MELLOR, MRS. JOSEPHINE E.
165 Ft. Washington Ave., New York 32

MELLOR, MARJORIE
385 Morris St., Albany 8

MENCHINI, HELENA M.
470 N. Oak St., Buffalo 3

MENGES, MARYANN J.
191 Woodland Ave., New Rochelle

MENZIE, MRS. CECILIA C.
North Highlands, R.F.D. 1, Cold Spring

MERCER, MARY C.
107 Lorraine Ave., Buffalo 20

MERRILL, BESSIE S.
824 Washington St., Watertown

MERRILL, FLORENCE G.
224 Alexander St., Rochester 7

MESSINGER, JOY A.
8701 Shore Rd., Brooklyn

MESSMER, AMANDA
1086 Lexington Ave., New York 21

METZGER, ALICE M.
New York Ave., Smithtown Branch, L. I.

MEYER, DORA
337 E. 16 St., New York 3

MEYER, MRS. OLIVE P.
130 W. Kingsbridge Rd., New York 63

MICHAEL, JEANNETTE
"Hickoryhurst," Derby

MICHelson, LIBBY
40 Monroe St., New York 2

MILLER, CAROLYN L.
329 Powell Ave., Newburgh

MILLER, MRS. DORETTA E.
130 W. Kingsbridge Rd., New York 63

MILLER, ELSIE K.
Kingston Avenue Hospital, Brooklyn 3

MILLER, HAZEL
Veterans Administration Hospital, Batavia

MILLER, JEAN K.
124 Lincoln Ave., Orchard Park

MILLER, JULIA M.*
NLNE, 2 Park Ave., New York 16

MILLER, RUTH M.
295 Columbus Ave., Rochester 8

MOE, JUNE
Oneida City Hospital, Oneida

MOLE, ELEANOR W.
361 Clinton Ave., Brooklyn

MONAGHAN, MARGARET A.
53 Robbie Ave., Buffalo 14

MONGEON, PAULINE E.
541 E. 86 St., New York 28

MONTAG, MILDRED
46 Killburn Rd., Garden City

MOORE, MRS. AGER B.
123 Maple Ave., Mt. Kisco

MOORE, ANNA J.
224 Alexander St., Rochester 7

MOORE, MRS. LAURA R.
503 Lafayette Ave., Brooklyn 16

MOORE, LELIA*
480 Herkimer St., Brooklyn 13

MOORE, SUSAN B.
165 Ft. Washington Ave., New York 32

MOOS, HELENE
315 W. 91 St., New York 24

MOREAU, HECOTRETTE M.
600 E. 125 St., New York 35
MORGAN, EDITH E.
515 W. 148 St., New York 32

MORIARTY, DOLORES G.
91 St. Johns Parkside, Buffalo 10

MORRISON, ESTHER
400 E. 59 St., New York 22

MORRISON, LOTTIE M.
165 Ft. Washington Ave., New York 32

MORSE, EDNA C.*
605 Morningside Dr., New York 27

MORSE, EVELYN N.
396 Broadway, Kinison

MOSER, RUTH K.*
419 W. 114 St., New York 23

MOSS, IRENE
South Dayton

MOUR, MRS. MARIE H.
57 Wall St., Rochester 20

MOUCHA, BLANCHE E.
39-26-62 St., Woodside, L. I.

MUHS, ELEANOR J.
1303 York Ave., Apt. 6-D, New York 21

MULCAHY, CATHERINE
13 Delaware St., Cooperstown

MULEN, MARY E.
249 E. 57 St., Brooklyn 3

MULLER, ISABELLE M.
229 E. 79 St., New York 21

MULVANY, MARY C.
708 Bushwick Ave., Brooklyn 21

MURADI, MRS. DOROTHY D.
582 N. Oak St., Buffalo

MURPHY, ALICE V.
St. Luke's Hospital, Newburgh

MURPHY, JOAN
337-12 St., Niagara Falls

MURPHY, KATHERINE T.
1802 Oneida St., Utica 3

MURPHY, KATHRYN D.
401 Vestal Ave., Endicott

MURPHY, SALLY
2691 Chili Rd., Rochester 11

MURRAY, JOSEPHINE B.
311 Sixth St., Union City, N. J.

MURRAY, MADELEINE R.
245 E. 21 St., New York 10

MUSCATINE, ROSE
354 E. 19 St., New York 3

MUTCH, J. MARGARET
617 W. 168 St., New York 32

MUZZULIN, ELAINE M.
New York Hospital, Westchester Division,
White Plains

MYERS, HILDEGARDE
Box 52, Summoun

NAGLER, MILDRED
316 Beach 19 St., Far Rockaway

NAHM, HELEN
33-15-81 St., Jackson Heights

NAIR, GERTRUDE
337 E. 16 St., New York 3

NANTKES, LILLIAN
6717 Eighth Ave., Brooklyn 20

NEILL, KATHERINE C.
82 Melba St., Rochester

NELSON, KATHERINE R.*
525 W. 120 St., New York 27

NEWLAND, MRS. MARGARET A.
156 Master St., Buffalo 8

NEWMAN, GERTRUDE
321 W. Main St., Rochester 8

NEWTON, KATHLEEN
1303 York Ave., New York 21

NICHOLS, JEANETTE L.
Veterans Administration Hospital, New York 63

NIEDZIAKOWSKA, CYNTHIA M.
70 Germain, Buffalo 7

NIELSEN, LT. ALICE
U. S. Naval Hospital, Jacksonville, Fla.

NIELSEN, EDITH M.
1320 York Ave., New York 21

NOLAN, BREDA T.
85 Bushwick Ave., Brooklyn 11

NOLAN, HELEN J.
1601 Beverly Rd., Brooklyn 26

NOTTER, LUCILLE E.
530 E. 20 St., New York 9

NUGEN, MRS. MARY G.
345 Clinton Ave., Apt. 11-E, Brooklyn 5

NUHN, BENJAMIN J.
Station B, Poughkeepsie

NUNZIATO, ANTOINETTE G.
1391 W. Sixth St., Brooklyn 4

O'CONNELL, MARGARET K.
266 Cornell St., Plattsburg

OLANDT, HELENE*
Queens General Hospital, Jamaica 2

O'LEARY, ELSIE M.
2224 Niagara Ave., Niagara Falls

OLSON, ELSIE
121 Seaman Ave., New York 34

O'NEILL, MARGARET
St. Luke's Hospital, Newburgh

ORLANDO, PETRA
144-23 Charter Rd., Apt. D, Jamaica 2

OSHEA, MRS. ANNE F.
56 Quintard Dr., Port Chester

OVERHOLSER, MRS. MARGERY T.
445 E. 65 St., Apt. 5-B, New York 21

OYEN, GIRD
16 Guion Pl., New Rochelle

PAGE, FLORENCE A.
34 Pine Woods Ave., Troy

PAINTON, NORMA J.
397 State St., Albany 6

PARK, BEATRICE K.
95 Howell St., Camadigua

PALM, SARAH I.
Graeslands Hospital, Valhalla

PALMER, ELSIE
2544 Valentine Ave., New York 58

PALKUSZAK, JULIA B.
Hotel Taft, New York 19

PAONESSA, DOROTHY J.
3558 Livingston Ave., Niagara Falls

PARFITT, R. EUNICE
20 Portsmouth Ter., Rochester 7

PARKER, BESSIE R.*
Cragmoor, Ulster County

PARKER, MARY E.
56 S. Swan St., Albany 10

PARROTT, GERTRUDE E.
39 Palmer Ave., Bronxville

PARRY, MRS. LOIS G.
Oneida City Hospital, Oneida

542
PASSORELLO, ANNA  
2375 Sedgwick Ave., Apt. 2E, New York

PATCHIN, JANET  
Samaritan Hospital, Troy

PATTEN, MRS. MARGARET M.  
121 Westchester Ave., White Plains

PAUSSA, INEZ E.  
St. Joseph's Hospital, Syracuse

PAYNE, LULU B.  
Meadowbrook Hospital, Hempstead

PEARSE, EILEEN M.  
187 Lowell Rd., Kenmore 17

PECK, HELEN E.  
412 University Pl., Syracuse

PEKINS, MARION A.  
St. Luke's Hospital, Newburgh

PELL, IDA M.  
467 Wyoming Ave., Buffalo 15

PENLAND, ANNE  
52 W. 168 St., New York 32

PETER, SOPHIA C.  
Lenox Hill Hospital, New York 21

PEELAU, HILDEGARD E.A.  
322 W. 8th St., New York 24

PETERSEN, MYRTLE W.  
419 W. 114 St., New York 25

PETERSON, MRS. RUTH F.  
1949 Genesse St., Buffalo 11

PETO, MARJORIE*  
1235 Sussex Rd., West Englewood, N. J.

PETRAS, MAY T.  
U. S. Naval Hospital, Camp LeJeune, N. C.

PETRIE, CECILIA M.  
227 Columbus Ave., Buffalo 20

PETTIT, HELEN F.  
179 Ft. Washington Ave., New York 32

PFAFF, ANNA E.  
Degräff Memorial Hospital, North Tonawanda

PFAHL, MARJORIE B.  
112 Edgehill Terr., Troy

PHANEUF, MADELEINE Y.  
910 Commonwealth Ave., Newton Center 59, Mass.

PHILLIPS, ELISABETH C.  
Visiting Nurse Assn., 500 East Ave., Rochester 7

PHILLIPS, LOTTIE M.  
Arnot-Ogden Memorial Hospital, Elmira

PICKARD, HELEN  
Mt. Vernon Hospital, Mt. Vernon

PIERCE, EVELEAN G.  
70 Haven St., Apt. 3-F, New York 32

PINNER, MRS. MILDRED M.  
255 Bryant St., Buffalo 9

PISE, ELEANOR M.  
106 Morningside Dr., New York 27

PITMAN, AVIS J.  
121 Westchester Ave., White Plains

PITOU, HOPE L.  
345 E. 60 St., New York 21

PIVARNIK, KATHRYN F.  
3221 Henry Hudson Pkwy., New York 63

PLIKUNAS, AGNES A.*  
105 Bond St., Hartford 6, Conn.

PODERESKEY, MRS. ARLENE W.  
331 E. 71 St., Apt. 4F, New York 21

POHALA, HELEN L.  
Flower & Fifth Avenue Hospitals, New York 29

POHL, MARGARET L.  
532 E. 82 St., New York 28

POPE, EMMA  
Veterans Administration Hospital, Brooklyn 9

PORRECA, MRS. EMELINE D.  
109 Fordham Rd., Syracuse

PORTER, ALMENA A.  
Kingston Hospital, Kingston

PORTER, MODESTINE L.  
27 W. 136 St., New York 30

POTTS, EDITH M.*  
Psychological Corporation, 522 Fifth Ave., New York 18

POWER, CARMELITA  
821 University Ave., Syracuse 10

POWER, MRS. LOIS M.  
U. S. Marine Hospital, Staten Island 4

POWER, MARGARET L.†  
Kings County Hospital Nurses Home, Box 799, Brooklyn 3

POYET, EVANGELINE A.  
100-20—210 St., Queens Village

PREMINGER, LILLIAN E.  
154 Peersall Dr., Mt. Vernon

PRENDERGAST, MARY J.  
United Hospital, Barrow Hall, Port Chester

PRINCE, MRS. ETHEL G.  
1 Hanson Pl., Brooklyn 17

PROGER, EVELYN  
161 Clarkson Ave., Brooklyn 26

PROSSER, ILEEN  
163 E. Utica St., Buffalo

QUACKENBUSH, MILDRED I.  
575 W. Main St., Rochester 8

QUEENNEY, FLORENCE  
1749 Avenue B, Schenectady 8

QUEREAU, CLAIRA†  
7 Lawringer Ave., Albany 3

QUINN, ELLEN G.  
225 Elmwood Ave., Buffalo 22

QUINN, RITA M.  
4315—69 St., Woodside, L. I.

RACZ, MARGARET  
711 W. 171 St., New York 32

RALEIGH, MRS. HELEN G.  
514 Sedgwick Dr., Syracuse

RANSOM, MRS. DOROTHY K.  
121 Westchester Ave., White Plains

RASMUSSEN, MYRTLE J.  
45-22—49 St., Woodside, L. 1.

RATH, HELEN  
18 E. Can Hill Rd., New York 67

RATHMANN, MYRTLE J.  
85 Charleston Ave., Kenmore 23

RAU, THELMA F.  
110-27—15 Ave., College Point

RAY, ELIZABETH H.  
422 E. 11 St., Apt. 12A, New York 3

RAY, MRS. MABLE T.  
2 Irvington Rd., Rochester 20

RAYMO, MRS. MARION G.  
231 Proctor Ave., Ogdensburg

REAP, MRS. MARY K.  
16 Polhemus Pl., Brooklyn 15

REDDINGTON, DOROTHY A.  
44 Alliance Ave., Rochester 20

REED, DOROTHY A.  
1600 South Ave., Rochester 7

REED, MILDRED M.  
112 Goodrich St., Buffalo 3
REEDER, KATHERINE E.
32 Robin St., Albany 5

REICH, MITHYLDI J.
5 E. 98 St., New York 29

REID, GRACE L.
120 Amity St., Brooklyn 2

REILLY, CECILIA M.
Syracuse General Hospital, Syracuse 5

REITER, FRANCES*
325 W. 120 St., New York 27

REITZ, LYDIA
23 Niagara Sq., Buffalo

RENDER, MARION
251 Brunswick Blvd., Buffalo 3

REUTER, HILDEGARD*
Amsterdam City Hospital, Amsterdam

REUTER, MAGDA
Brooklyn Hospital, Brooklyn 1

REYNOLDS, MARY
Kinderhook

RICHARDS, MRS. REGINA R.
31 Pennsylvania Ave., Dunkirk

RICHARDSON, GENEVIEVE F.
69 Palmetto St., Brooklyn 21

RICHARDSON, GLADYS S.
1225 Clencombe Rd., Syracuse 6

RICHARDSON, MRS. MARY
2444 Western Ave., R.F.D. 2, Altamont

RICHARDSON, MARY M.*
Lenox Hill Hospital, New York 21

RICHMOND, CLARA E.
155 E. 51 St., New York 22

RICHTER, LAURIAN M.
419 W. 114 St., New York 25

RICKETS, OLIVE A.
451 Clarkson Ave., Box 755, Brooklyn 3

RIEDEL, IONA B.
43 Crowley Ave., Buffalo 7

RILEY, JENNIE M.
121 Westchester Ave., White Plains

RINCK, HANNA F.
436 Highland Ave., Mt. Vernon

RING, VIVIAN A.
2301 Bellevue Ave., Los Angeles 26, Calif.

RIORDEN, BARBARA A.
840 S. Crouse Ave., Syracuse 10

RIVES, RUTH E.
43 Jewett Pkwy., Buffalo 14

ROBB, GENEVIEVE J.*
Grasslands Hospital, Valhalla

ROBERTS, EDITH*
243 E. 71 St., New York 21

ROBERTS, MARY M.
5009-91 St., Woodhaven

ROBINSON, DOROTHY E.
165 Ft. Washington Ave., New York 32

ROBINSON, CAPT., DOROTHY M.
U. S. Army Hospital, Ft. Leonard Wood, Mo.

ROBINSON, FALKNER N.
721 Faile St., Apt. 5E, New York 59

ROBINSON, MABEL L.
396 Broadway, Kingston

ROCK, MARIORIE J.
1066 Lexington Ave., New York 21

ROCKHOLD, ELIZABETH E.*
Methodist Hospital, Brooklyn 15

RODMAN, RUTH R.
899 Montgomery St., Brooklyn 13

RODGERS, DOROTHY
179 Ft. Washington Ave., New York 32

ROGERS, JEANNE E.
820 Glenwood Ave., Buffalo 11

ROGERS, D ILL A.
Southampton Hospital, Southampton

ROLFE, DAPHNE
Binghamton City Hospital, Binghamton

RORABAUGH, SARA K.
12 Watervliet Ave., Albany 5

ROSE, MRS. VERA M.
21 Elliot Pl., New York 32

ROSNER, MRS. BERTHA F.
345 E. 77 St., New York 21

ROSS, ANNE S.
161 Woodland Ave., Yonkers 3

ROTHMAYER, RUTH A.
8404-96 St., Woodhaven 21

ROTHSTEIN, JOAN M.
1775 E. 18 St., Brooklyn 29

RUBINO, EDITH
72 Seaman Ave., New York 34

RUFD, MRS. JESSIE S.
32 Rosemont Blvd., White Plains

RUFD, LOUISE M.
364 E. 20 St., New York 3

RUSBY, DOROTHY I.
7 E. 86 St., New York 28

RUSSELL, CLARICE M.
1523 E. 33 St., Baltimore 18, Md.

RUSSELL, FRED D.
Kingston Avenue Hospital, Brooklyn 3

RYAN, HELEN
124 E. 24 St., New York 10

RYAN, LILLIAN A.
Grasslands Hospital, Valhalla

RYAN, MARY L.
Children's Hospital, Albany 7

RYAN, THELM A J.
330 E. 63 St., Apt. 2N, New York 21

RYLE, ANNA E.
Westchester Hall, Grasslands Hospital, Valhalla

RYMAN, MRS. BETTY LOU
20 New Scotland Ave., Albany 8

SAAMANEN, ELENA
165 Ft. Washington Ave., New York 32

SAAMS, MRS. BEULAH R.
212 W. Kingsbridge Rd., New York 63

SABIA, ASSUNTA
1320 York Ave., New York 21

SABLE, MRS. MARY H.
Sub Station #60, Queens Village 8

SABLESKI, HELEN A.
Veterans Administration Hospital, Nurses' Quarters, Castle Point

SACK, ELEANOR
507 Prospect Pl., Brooklyn 16

SALIS, MYRTLE A.
R.F.D. 3, Troy

SALSMAN, LILLIAN V.*
Hotel Wellington, Albany

SALZMANN, RUTH
514 W. 110 St., New York 25

SAMUEL, EMMA J.
121-07 Farmers Blvd., St. Albans

SANFORD, M. LOUISE
Columbia Memorial Hospital, Hudson
SCANLON, ENDA M. 303 Alexander Ave., New York 54
SCHADE, BARBARA J. 236 Plymouth Ave., S., Rochester 8
SCHAEFER, LEAH D. 396 Broadway, Kingston
SCHER, LILLIAN 475 Linden Blvd., Brooklyn 3
SCHERMERHORN, ESTHER J. 34-35—29 St., Astoria
SCHILLING, HELEN 30-33 St., Astoria 2
SCHINDLER, MRS. CATHERINE M. 435 Washington Hwy., Snyder 21
SCHMIDT, CHARLOTTE R. 130 W. Kingsbridge Rd., New York 63
SCHMIDEL, GRACE C. 10 Stebbins Ave., Tuckahoe 7
SCHMITT, EDITH Wagner College, Staten Island 1
SCHMITT, MRS. RUTH M. 524 E. 82 St., New York 28
SCHMUCKER, MRS. ANNA K. 88-32-188 St., Hollis 7
SCHNITZER, DOROTHY 100 E. 39 St., Brooklyn 3
SCHWIER, MILDRED E. NLNE, 2 Park Ave., New York 16
SCOTT, MRS. EILEEN O. 225 E. 39 St., New York 16
SCOTT, GLADYS 501 W. 113 St., New York 25
SCOTT, HELEN L. 600 W. 165 St., New York 32
SCOTT, MARION E. 529 Sixth St., Brooklyn 15
SEAMAN, MAXENE H. 320 Corliss Ave., Johnson City
SAGE, GRACE A. 365 Morris St., Albany 8
SAGNER, HAZEL M. 2767 Main St., Apt. 22, Buffalo 14
SEHL, KATHERINE 1330 Amsterdam Ave., Box 319, New York 27
SEIDEN, MRS. HELEN 32-70—30 St., Long Island City 6
SEILER, RUTH M. 467 Wyoming Ave., Buffalo 15
SENBUSCH, MRS. ANNE W. 40 Charleston Ave., Kenmore 23
SENGSTAKEN, MRS. RUTH Q. 175 Lindberg St., Manhasset
SEWERYNEK, MARGARET P. Box 42, Latona
SHALCROSS, ALICE E. 736 Irving Ave., Syracuse
SHARPE, IRENE L. 115 E. 61 St., New York 21
SHARROCKS, THEODORA 801 Riverside Dr., New York 32
SHAUGHNESSY, MRS. MADELEINE L. 2443 Broadway, Huntington Park, Calif.
SHAVIA, CHARLOTTE M. 713 State St., Watertown
SHAW, CORA L. 600 W. 165 St., New York 32
SHAY, MRS. MARGARET T. Adelphi College, Garden City, L. I.

SHEAHAN, MARION W. NLNE, 2 Park Ave., New York 16
SHEEHAN, CATHERINE M. 19 Aberdeen St., Brooklyn 7
SHELDON, RACHEL D. 116 Rosa Rd., Schenectady
SHEPPARD, MARIE G. 55 Brownell St., Staten Island 4
SHERWOOD, MRS. JULIA Albany Hospital, Albany 1
SHORE, OLLIE V. 29 Lockwood Ave., New Rochelle
SIDER, HELEN T. Willard Parker Hospital, New York 9
SILCOX, MRS. MARY 1365 York Ave., New York 21
SILVERSTEIN, MRS. ANASTASIA B. 418 St. John's Pl., Brooklyn 17
SIMMONS, ELIZABETH M. 1320 York Ave., New York 21
SIMMS, LAURA L. 341 W. 50 St., New York 19
SIMONTON, WILLETTE E. 162 W. 17 St., New York 11
SIMPSON, RUTH E. College of Mt. St. Vincent, New York 63
SISTER AASTA 4520 Fourth Ave., Brooklyn 20
SISTER AGNES MIRIAM 153 W. 11 St., New York 11
SISTER ANN FRANCIS St. Joseph's Hospital, Syracuse 3
SISTER ANN MAURICE 555 E. Market St., Elmira
SISTER ANNE MARY 153 W. 11 St., New York 11
SISTER BERNADETTE ROSAIRE St. John's Long Island City Hospital, Long Island City 1
SISTER BERNARD OF THE CROSS Champain Valley Hospital, Plattsburg
SISTER BERTILLA St. Mary's Hospital, Troy
SISTER CELESTE St. Francis Hospital, New York 54
SISTER CHRISTINE 89 Genesee St., Rochester 8
SISTER EDWARD MARY St. Joseph's Hospital, Yonkers 2
SISTER EDWARD PATRICIA St. Mary's Hospital, Amsterdam
SISTER ELLEN MARY College of St. Rose, Albany 3
SISTER FLORENCE MIRIAM 25-01 Jackson Ave., Long Island City 1
SISTER FRANCES MICHAEL Sisters of Charity Hospital, Buffalo 14
SISTER FRANCIS IMMACULATE St. John's Long Island City Hospital, Long Island City 1
SISTER FRANCIS PAMPEL St. Vincent's Hospital, Jacksonville 4, Fla.
SISTER FRANCIS XAVIER 320 Porter Ave., Buffalo
SISTER FREDERICK St. Mary's Hospital, Amsterdam
SISTER IRENE MARIA New York Foundling Hospital, New York 21

545
SISTER JOHN BERMANS
A. Barton Hepburn Hospital, Ogdensburg

SISTER JULIA
St. Mary's Hospital, Troy

SISTER JULIA MARIE
St. Francis Hospital, Poughkeepsie

SISTER LORETTA BERNARD
153 W. 11 St., New York 11

SISTER MACDA MARIE
133 Bushwick Ave., Brooklyn 6

SISTER MARGARET CARMELA
135 W. 12 St., New York 11

SISTER MARGARET MARIE*
133 Bushwick Ave., Brooklyn 6

SISTER MARGARET MARY
Nazareth College, Rochester 18

SISTER MARGARETTA MARIE
St. Joseph's Hospital, Yonkers 2

SISTER MARIE EDMUND
St. John's Long Island City Hospital, Long Island City 1

SISTER MARIA ROSAIRE
St. Joseph's Hospital, Yonkers 2

SISTER MARIAN CATHERINE
St. Vincent's Hospital, New York 11

SISTER MARIAN THOMAS
St. Joseph's Hospital, Yonkers 2

SISTER MARIE CONSIGLIO
153 W. 11 St., New York 11

SISTER MARIE LEGRAS
St. Vincent's Retreat, Harrison

SISTER MARIE MACDONALD
St. Mary's Hospital, Troy

SISTER MARIE MICHAEL
St. Vincent's Hospital, New York 11

SISTER MARIE RENEE
600 Ridge Rd., Lackawanna 18

SISTER MARIE VINCENT*
St. Vincent's Hospital, West New Brighton, S. I.

SISTER MARTHA MARIE
415 W. 51 St., New York 19

SISTER MARY AGATHA
A. Barton Hepburn Hospital, Ogdensburg

SISTER M. AMATA
St. Joseph's Hospital, Syracuse 3

SISTER MARY ANDREW
427 Guy Park Ave., Amsterdam

SISTER MARY ANNETTE
St. Peter's Hospital, Albany 8

SISTER MARY BERTRAND
St. Joseph's Hospital, Syracuse 3

SISTER MARY BRIGID
St. Mary's Hospital, Amsterdam

SISTER MARY BRIGIDA
153 W. 11 St., New York 11

SISTER MARY CALLISTA
Benedictine Hospital, Kingston

SISTER MARY CANDIDA
St. Mary's Hospital, Amsterdam

SISTER MARY CARMEN
Champlain Valley Hospital, Plattsburg

SISTER MARY CEPHAS
St. Peter's Hospital, Albany 8

SISTER MARY CHARLES
Benedictine Hospital, Kingston

SISTER M. COLETTA
Our Lady of Victory Hospital, Lackawanna 18

SISTER M. CYRIL
215 Sixth St., Niagara Falls

SISTER MARY DAVID
St. Joseph's Hospital, Syracuse 3

SISTER MARY DE PAZZI
St. Mary's Hospital, Amsterdam

SISTER MARY ELLEN
16 Bank St., Bataha

SISTER MARY ENDO
218 Stone St., Watertown

SISTER MARY ETHEL
565 Abbott Rd., Buffalo 20

SISTER M. EUCARISTA
515 Sixth St., Niagara Falls

SISTER MARY EUGENE
515 Sixth St., Niagara Falls

SISTER MARY EVANGELISTA
St. Elizabeth's Convent, Allegany

SISTER MARY FIRMINA
218 Stone St., Watertown

SISTER MARY FLORA
218 Stone St., Watertown

SISTER MARY FLORA
St. Joseph's Hospital, Elmira

SISTER MARY FREDERICK
A. Barton Hepburn Hospital, Ogdensburg

SISTER MARY GABRIEL
515 Sixth St., Niagara Falls

SISTER MARY GERALD
218 Stone St., Watertown

SISTER M. ILDEPHONSE
Mary Immaculate Hospital, Jamaica 2

SISTER M. ISABEL
St. Joseph's Hospital, Elmira

SISTER M. JAMES*
152-11 89 Ave., Jamaica 2

SISTER MARY JANETTE
St. Mary's Hospital, Amsterdam

SISTER MARY JEROME
Mt. St. Mary's Hospital, Niagara Falls

SISTER MARY KEVIN
College of St. Rose, Albany 3

SISTER M. LEONA
St. Joseph's Hospital, Elmira

SISTER M. LIGOURI
St. Francis Hospital, Poughkeepsie

SISTER M. LIGOURI
St. Joseph's Hospital, Elmira

SISTER MARY LORETTA
Champlain Valley Hospital, Plattsburg

SISTER MARY LOUISE
218 Stone St., Watertown

SISTER MARY MALACHY
218 Stone St., Watertown

SISTER MARY ORIL
Mercy Hospital, Watertown

SISTER MARY PATRICK
St. Agatha's Home, Nannet

SISTER MARY PAULA
565 Abbott Rd., Buffalo 20

SISTER MARY RENEE
218 Stone St., Watertown

SISTER M. RICARDO
565 Abbott Rd., Buffalo 20

SISTER M. ST. CAMILLUS
St. John's Long Island City Hospital, Long Island City 1

SISTER M. ST. MACDALEN
25-01 Jackson Ave., Long Island City 1

SISTER MARY SILVERIA
St. Mary's Hospital, Brooklyn 13

546
MEMBERS

SISTER MARY SILVERINE
1292 St. Mark's Ave., Brooklyn 13

SISTER M. SILVINA
218 Stone St., Watertown

SISTER MARY SPORRER
Anthony N. Brady Maternity Home, Albany 5

SISTER MARY STELLA
218 Stone St., Watertown

SISTER M. THEOPHANE
800 Ridge Rd., Lackawanna 18

SISTER MARY THERESA
St. Mary's Hospital, Amsterdam

SISTER MARY THOMAS
St. Vincent's Hospital, Staten Island

SISTER M. WILHELMINA
St. Joseph's Hospital, Syracuse 3

SISTER MAUREEN
St. Joseph's Hospital, Syracuse 3

SISTER MAUREEN
515 Sixth St., Niagara Falls

SISTER MIRIAM ANNE
159 W. 12 St., New York 11

SISTER MIRIAM GERTRUDE
153 W. 11 St., New York 11

SISTER REGINA LORETTA
2501 Jackson Ave., Long Island City 1

SISTER ROBERTA MARIE
133 Bushwick Ave., Brooklyn 6

SISTER ROMANUS MARIE
The Mary Louis Academy, Jamaica 3

SISTER ROSALIE
D'Youville College, Buffalo 1

SISTER ROSE MARY
St. Peter's Hospital, Albany 8

SISTER ST. LUKE
A. Barton Hepburn Hospital, Ogdensburg

SISTER ST. PAUL
A. Barton Hepburn Hospital, Ogdensburg

SISTER SENANA JOYCE
St. Francis Hospital, Jersey City, N. J.

SISTER THOMAS FRANCIS
St. John's Hospital, Long Island City 1

SISTER WALTER MARIE
301 Prospect Ave., Syracuse 3

SKINNER, CHARLES H.*
18 E. Main St., Norwich

SLOCUM, JANICE R.
1829 Highland Ave., Troy

SMITH, MRS. DOROTHY P.
290 Spring St., Huntington

SMITH, EDITH H.*
University School of Nursing, Syracuse

SMITH, ELLEN C.
165 Ft. Washington Ave., New York 32

SMITH ESTHER C.
116 Rosa Rd., Schenectady 8

SMITH, FLORELLA F.
563 Riley St., Buffalo 8

SMITH, GERALDINE
440 E. 26 St., New York 16

SMITH, LAURA D.
2780 University Ave., New York 63

SMITH LILLIAN M.
43-22 49 St., Long Island City

SMITH, MRS. VIRGINIA B.
240 E. Palisade Ave., Englewood, N. J.

SMYER, EDWINE A.
2265 Fifth Ave., Apt. 6H, New York 35

SNELL, MRS. GLADYS B.
305 First St., Scotia 2

SOMMER, HELEN
86 Sterling Ave., Buffalo 16

SOUTH, JEAN
35-14 77 St., Jackson Heights

SPALDING, MRS. EUGENIA K.
8 Lockwood Ave., Briarville

SPAN, EMMA
121-09 134 Ave., South Ozone Park 20

SPARKS, MRS. ESTHER
3409 Broadway, New York 31

SPINK, RUTH E.
5 E. 98 St., New York 29

SPROGELL, CAROLINE A.
New York Hospital, Westchester Division, White Plains

STAFFORD, WILHELMINA
Binghamton City Hospital, Binghamton

STANTON, MRS. GLADYS
129 E. Colvin St., Syracuse 5

STARK, ELLEN
99-11 200 St., Hollis

STEFFENS, GLORIA M.
181 City Island Ave., City Island 64

STEPHEN, MARGARET
224 Alexander St., Rochester 7

STEVENS, MARION
756 Irving Ave., Syracuse 10

STEWARD, ISABEL M.*
21 Clermont Ave., New York 27

STICH, EDA W.
130 W. Kingsbridge Rd., New York 63

STILLMAN, LUCY R.
1603 N. Riverside Dr., Neptune, N. J.

STINSON, H. LOUISE
1219 Fifth Ave., New York 29

STIRLING, CHARLOTTE B.
1320 York Ave., New York 21

STORO, ELIZABETH C.
18 King St., Ardsley

STOUC, MARIE T.
98 Bernard St., Rochester 21

STOGEL, CATALINA
425 Jerome St., Brooklyn 7

STOKES, FLORENCE M.
1320 York Ave., New York 21

STOKES, GERTRUDE A.
Strong Memorial Hospital, Rochester 20

STRACHAN, MARION
3A Old Wood Rd., Edgewater, N. J.

STRATHIE, JEANIE U.
425 Madison Ave., Room 701, New York 17

STRATTON, EDNA F.
1410 York Ave., New York 21

STROHMeyer, LILIAN D.
601 W. 113 St., New York 25

STRUTHERS, MINNIE H.
5 E. 98 St., New York 29

SUCCOP, HELEN J.
1046 E. Ferry St., Buffalo 11

SUCHOMEL, LOUISE M.
124 W. 74 St., New York 23

SUFRIN, MRS. JOYCE K.
355 E. 82 St., New York 28

SUILESKY, FELIX A.
Veterans Administration Hospital, Framingham, Mass.

547
SULLIVAN, ELIZABETH K.
210 E. 64 St., New York 21
SULLIVAN, MARGARET H.
Crouse-Irving Hospital, Syracuse 10
SUKA, STELLA T.
36 Rensselaer St., Brooklyn 2
SUZCLIFFE, HELEN L.
Memorial Hospital, Albany 4
SUTHERLAND, JEAN E.
37-06 81 St., Jackson Heights
SWANWICK, MARY H.
716 Madison Ave., New York 21
Sweeney, HELEN C.
130 W. Kingsbridge Rd., New York 63
Sweeney, JULIA R.
New Rochelle Hospital, New Rochelle
SWIFHAS, ANNA M.
St. Joseph's Hospital, Syracuse 3
SYERSKI, MRS. FLORENCE B.
731 W. Ferry St., Buffalo 9
SZAROWICZ, HELEN M.
Veterans Administration Hospital, Albany
TANNAHILL, JULIE
111 Granger Rd., Syracuse 9
TATE, BARBARA L.
419 W. 114 St., New York 25
TAYLOR, MELBA S.
2220 16 St., Troy
TAYLOR, RUTH
150 E. Hartsdale Ave., Hartsdale
TENNANT, MARY E.*
49 W. 49 St. Room 5500, New York 20
TENNEY, HARRIETTE L.
518 Clinton Ave., Albany 6
TERRY, MARGARET H.
1320 York Ave., New York 21
THOMAS, LUNA
320 Cumberland St., Brooklyn 5
THOMAS, MYRA L.
Veterans Administration Hospital, Albany
THOMAS, MRS. RUTH W.
200 E. 66 St., New York 21
THOMPSON, ELLA M.
26 W. Ninth St., New York 11
THOMPSON, ESTHER M.
74 Briar La., Rochester
THOMPSON, LA VERNE R.
106 Morningside Dr., New York 27
THOMSON, LILLIAN R.
Aneram
TIGE, MRS. MILDRED G.
824 Washington St., Watertown
TIERNAN, ELIZABETH J.
220 Congress St., Brooklyn 26
TIERNEY, IRENE B.
245 Lark St., Albany 6
TINKLER, MRS. IVY N.
357 Edgecombe Ave., New York 31
TOMPKINS, IDA M.
Binghamton City Hospital, Binghamton
TORN, MARY T.
3003 Fairfield Ave., Apt. 2-G, New York 63
TOPALIS, MARY
23 Beacon Ave., Albany.
TORCHIA, EMMA A.
116-01 205 St., St. Albans 11
TORKE, FLORENCE M.
107 Fenimore St., Brooklyn 25
TORLEY, MRS. MARY R.
175 Quail St., Albany 3
TORREY, FLORENCE M.
440 E. 70 St., New York 21
Tourtillott, ELEANOR A.
149 Pine Tree Dr., RFD 2, North Syracuse.
TRASKAS, MARGUERITE B.
43 Van Derveer Ave., Amsterdam
TRAYSER, PATRICIA S.
28 Emerson Pl., Watertown
TRENHOLME, BERNICE S.
345 Lenox Rd., Brooklyn 26
TREUTLER, MARIE W.
2220 Rose St., Schenectady 6
TROWBRIDGE, HAZEL M.
39 Palmer Ave., Bronxville 8
TRUNTZ, MRS. ELIZABETH P.
106 Linden Blvd., Brooklyn 26
TSCHIDA, ETHEL M.
1326 York Ave., New York 21
TUCKER, MARGARET P.
301 E. 20 St., New York 3
TUFFLEY, EDNA E.
245 Avenue C, New York 9
TURNER, ELIZA
New York Polyclinic Hospital, New York 19
TURNQUEST, MAGGIE L.
1620 Sedgwick Ave., New York 53
TURULA, HELENA
55-49 63 St., Jackson Heights
TWOKEY, MARY
333 Southern Blvd., New York 54
ULRICH, PHYLLIS E.
RFD 4, Box 208, Amsterdam
UNGER, MRS. GRACE D.
8 Stuyvesant Oval, New York 9
UNGER, VERA M.
106 Highland Ave., Yonkers
UNWIN, FLORENCE R.
681 Clarkson Ave., Brooklyn 3
VALINTCOURT, MRS. ALICE M.
Veterans Administration Hospital, Batavia
VALLAR, ROSALIND M.
Innsley St., Demarest, N. J.
VALLIER, MYRLE S.
580 Mill St., Watertown
VALLON, MRS. PEARL R.
63 Perry St., New York 14
VAN ARSDALE, MARTHA L.
1320 York Ave., New York 21
VAN AUKEN, ELIZABETH A.
Wood's Edge, Delmar
VANCE, CATHERINE A.
11 E. 100 St., New York 29
VAN CORTLANDT, EVE
10 E. 78 St., New York 21
VANDERBILT, FLORENCE N.
179 Ft. Washington Ave., New York 32
VAN LEW, AVIS M.
U. S. Marine Hospital, Staten Island
VARLEY, MARJORIE T.
52 Riverside Apt., Watertown
VASTOLA, EILEEN M.
Montefiore Hospital, New York 67
VAUGHAN, EDMUNDA L.
769 St. Marks Ave., Brooklyn 13
VAXMONSKY, ELEANOR M.
567 Prospect Pl., Brooklyn 16
MEMBERS

VEDDER, MRS. GRACE H.
18 Brown Ct., Rensselaer

VERSTROM, DOROTHY A.
Ocean Rd., Narragansett, R. I.

VEETOICH, ELEANOR M.
Veterans Administration Hospital, Castle Point

VICKERY, HELEN L.
287 Elmford Ave., Rochester 11

VINES, VIRGINIA E.
421 Rensselaer Ave., Ogdensburg

VISKOVICH, DOROTHY A.
324 E. 48 St., New York 17

VLOSKY, EDNA
545 W. 161 St., New York 32

VOETSC, CATHERINE
1230 Amsterdam Ave., New York 27

VOLLMER, ELBETH
121 Westchester Ave., White Plains

VOORHEES, VIRGINIA
8950 219 St., Queens Village 8

VOORSANGER, ESTHER L.
575 W. Main St., Rochester 8

VREELAND, VIVIAN V.
132 E. 45 St., New York 17

WABERSICH, ROSE
1066 Lexington Ave., New York 21

WAICLAWICZ, MRS. ELIZABETH
254 Willis Ave., Hawthorne

WAGNER, MRS. ERMA A.
91 E. Jewett Ave., Buffalo 14

WAGO, HELEN
95 Lexington Ave., New York 16

WAHLBERG, CAPT. LILLY E., N244074
U. S. Army Hospital, Camp Edwards, Mass.

WAINWRIGHT, LUCY M.
121 Westchester Ave., White Plains

WALLER, MRS. EVA S.
345 E. 63 St., New York 21

WALTERS, JEANETTE
1320 York Ave., New York 21

WANG, MAMIE H.W.K.
70 Haven Ave., New York 32

WARD, DOROTHY R.
Beth-El Hospital, Brooklyn 12

WARMAN, GRACE A.*
5 E. 98 St., New York 29

WARREN, MRS. RUTH B.
Station A, Ogdensburg

WEATHER, HELEN E.
1790 Broadway, New York 19

WEATHER, JESSIE
29 Chestnut St., Bergenfield, N. J.

WEBBER, CLADYS E.
Box 137, Church St. Annex, New York 8

WEDDIE, DOROTHY
20-35 20 St., Astoria 5

WELCH, THELMA V.
707 Montgomery St., Ogdensburg

WELLS, MARGARET
165 Ft. Washington Ave., New York 32

WENTHIN, MARY P.
508 E. 79 St., New York 21

WERTZ, MRS. HANNAH Z.
407 Central Park West, New York 23

WESCOTT, MURIEL R.
419 W. 114 St., New York 25

WESTON, ALICE A.
Highland Hospital, Rochester 7

WETTEN, GRACE W.
31 Wakefield Ave., Buffalo 14

WHALEN, KATHRYN T.
20 Mitchell Ave., Binghamton

WHALEN, KATHLEEN
511 New York Ave., Ogdensburg

WHARTON, MARNETTA S.
Brooklyn Hospital, Brooklyn 1

WHEELER, DOROTHY V.
217-21 49 Ave., Bayside

WHITAKER, MRS. JUDITH G.
315 W. 105 St., Apt. 3R, New York 25

WHITAKER, MRS. MARY G.
331 E. 71 St., New York 21

WHITCOMBE, ALICE C.
697 Walnut Ave., Syracuse

WHITE, GERALDINE M.
1909 Morris Ave., New York 53

WIEDEBACH, ERNESTINE
201 E. 68 St., New York 21

WIERZBECKI, FRANCES T.
34 Barthol St., Buffalo 11

WILDE, DELPHINE
3312 Giles Pl., New York 63

WILLECKE, MRS. ELEANOR J.
11 E. Raleigh Ave., West Brighton, Staten Island 10

WILLIAMS, MRS. MARGUERITE M.
15 Sylvan Pl., Valley Stream

WILLIAMS, MARTHA L.
140 Bradhurst Ave., New York 30

WILLIAMS, ROSEMARY C.
121 Westchester Ave., White Plains

WILLIFORD, WILLIAM A.
113 Holland Ave., Albany 3

WILLOUGHBY, MURIEL M.
250 Kennedy Ave., Hempstead

WILLSON, GORDO
177 Grand St., Apt. 3M, White Plains

WILSON, EVELYN M.
Veterans Administration Hospital, Framingham, Mass.

WILSON, MRS. RUTH J.
36 Walnut St., Dobbs Ferry

WINDROW, MARY E.
920 Riverside Dr., New York 32

WINSTEAD, ELIZABETH C.
Draper Hall, Welfare Island, New York 17

WITZK, CAPT. ANN M.
Hgs. & Hqs. Det., 1st Medical Group,
APO 407, c/o FM, New York

WITZEL, MRS. ANNA F.
4 Van Reunenlaer St., Saratoga Springs

WOLF, MRS. EDITH S.
25 E. 98 St., New York 29

WOLF, MARGUERITE
P.O. Box 311, Beacon

WOLFE, MRS. KATHRYN B.*
88 Morningside Dr., New York 27

WOLFF, KATHERINE
2209—15 St., Troy

WOLFF, LUIVERNE
20 VerPlank St., Albany 6

WOLFF, MARGARET H.*
Veterans Administration Hospital, Montrose

WOLFSON, BESSIE I.
5 E. 98 St., New York 29

WOOD, MARION S.
355 Morris St., Albany 3

NEW YORK
WOODBURY, MRS. MARGARET C.,
St. John’s Riverside Hospital, Yonkers 2
WOODFALL, RUTH E.
311 E. 72 St., New York 21
WOODS, CALLIE B.
765 E. 166 St., New York 56
WOODWORTH, DOROTHY
24 Victoria Blvd., Kenmore 17
WORAM, JANICE E.
Veterans Administration Hospital,
White River Junction, Vt.
WRIGHT, ALICE M.
714 Madison Ave., Albany 8
WRIGHT, EDITH E.
R.F.D. 1, Randolph
WRIGHT, ELIZABETH U.
1320 York Ave., New York 21
WRIGHT, HARRIET B.
165 E. Washington Ave., New York 32
WRIGHT, MRS. HELENA M.
1345 Broadway, Watervliet
WRIGHT, MILDRED E.
99 Park Pl., Canandaigua
YASEN, MRS. SYLVIA S.
82 Vanderveer St., Brooklyn 7
YOST, DOROTHY
336 Leland Ave., New York 61

ADAMS, RUTH M.
Duke Hospital, Durham
BAISE, BETTIE R.
North Carolina Baptist Hospital, Winston-Salem 7
BALLANCE, MRS. PRISCILLA D.
303 N. Tarboro St., Wilson
BARKER, MAE
Martin Memorial Hospital, Mt. Airy.
BARNES, MRS. RUBY M.
507 E. 13 St., Lumberton
BASHER, MARY J.
Charlotte Memorial Hospital, Charlotte
BASON, BETTY G.
2100 Erwin Rd., Durham
BEA, THELMA C.
4923 Oleander Dr., Wilmington
BENJAMIN, MRS. ESTHER H.
N. C. College at Durham, Durham
BOESSER, DESETTA A.
Babies’ Hospital, Route 3, Box 329-A,
Wilmington
BOWIN, MRS. ETHEL S.
Box 2906, Duke Hospital, Durham
BOYLAN, LUCY L.
528 S. Hawthorne Rd., Winston-Salem
BOYLES, RUTH M.
University of North Carolina, Drawer 31,
Chapel Hill
BRAME, ELLA C.
Charlotte Memorial Hospital, Charlotte 3
BRITT, BEADIE E.
James Walker Memorial Hospital, Wilmington
BROWDER, MARION
James Walker Memorial Hospital, Wilmington
BROWN, MRS. CORA O.
1500 Kenilworth Ave., Charlotte 3
BUNN, MRS. MARGARET S.
1431 Sunset Ave., Rocky Mount

YOUNG, DORIS A.
617 LaSalle Ave., Buffalo 15
YOUNG, ELLEN P.
Memorial Hospital, Albany 4
YOUNG, HELEN
617 W. 108 St., Apt. 4K, New York 32
YOUNG, PHYLLIS M.
280 Haven Ave., New York 33
YOUTZ, MRS. IRENE R.
440 E. 26 St., New York 10
ZABRISKIE, LOUISE
332 E. 67 St., New York 21
ZACCAGNINI, KATHERINE
319 E. 78 St., New York 21
ZACHARI, ANNA A.
1086 Lexington Ave., New York 21
ZANNI, IDA M.
Bloomington, New York
ZAVINSKY, MARY
75 Lenox Rd., Brooklyn 26
ZETZSCHIE, LYDIA M.
U. S. Marine Hospital, Stapleton, Staten Island 4
ZIMMERMANN, ESTHER D.
504 E. 29 St., New York 3
ZUKAITIS, NELLIE M.
Willard State Hospital, Willard

BURGESS, MRS. BESSIE P.
Watts Hospital, Durham
BURREN, ETHEL F.
Charlotte Memorial Hospital, Charlotte 3
BYERS, EDITH E.
1400 Scott Ave., Charlotte 3
CADDILL, ELINOR B.
2121 Charlotte Dr., Charlotte 3
CARRINGTON, MRS. ELIZABETH S.
110 Piedmont Way, Burlington
CARTER, NAOMI R.
Box 2923, Duke Hospital, Durham
CASE, MRS. ELIZABETH B.
9 Woodlawn Ave., Wilmington
CHAFFIN, EMMA L.
1019 Eighth St., Durham
CHAMBERLAIN, EDITH M.
James Walker Memorial Hospital, Wilmington
CHEEK, MARGARET M.
City Memorial Hospital, Winston-Salem
CLARK, LELIA R.
Duke Hospital, Durham
CLARY, MINNIE
 Rex Hospital, Raleigh
COOK, MARTHA S.
510 N. Cedar St., Lumberton
CORDARO, MRS. KATHERINE E.
R.F.D. 1, Archbold, Ohio
COSTELLO, GLADYS
413 S. 17 St., Wilmington
COUNCIL, RUTH
300 Thurston St., High Point
COX, LOIS B.
16 Rogerson Dr., Chapel Hill
COX, PAULINE L.
407 West Ave., Ayden
CRAIG, MRS. LOYCE C.
1016 Church St., Wilmington

NORTH CAROLINA—184

550
CRAWLEY, HATTIE M.
Box 2931, Duke Hospital, Durham

CREASMAN, MRS. ESTHER I.
Memorial Mission Hospital, Asheville

DALRYMPLE, RUTH
1011 Spring Garden St., Greensboro

DAUGHTRY, MIRIAM
Box 2129, Raleigh

DOLAN, MRS. MARGARET B.
School of Public Health, Chapel Hill

ELLWANGER, MARY E.
Presbyterian Hospital, Charlotte

ERVIN, MRS. MAY S.
15 Rosewood Ave., Asheville

FALLS, RUTH O.
Charlotte Memorial Hospital, Charlotte

FARThING, FRANCES
Cabarrus County Hospital, Box 1123, Concord

FLEMING, JULIA
Box 2968, Duke Hospital, Durham

FOX, EUNICE E.
Route 2, Asheville

FRAZER, MRS. EMILY J.
123 W. Avondale, Greensboro

GIFFORD, MRS. ALICE J.
P.O. Box 732, Chapel Hill

GOODRUM, MARGARET L.
Veterans Administration Hospital, Fayetteville

GREGORY, HAZEL E.
207 Hawthorne I.A., Charlotte

HAIRE, VIRGINIA C.
Rutherford Hospital, Rutherfordton

HARKEY, W. LOUISE
Cabarrus County Hospital, Concord

HARRISON, HILDRED D.
North Carolina Baptist Hospital, Winston-Salem

HART, MINNIE H.
Veterans Administration Hospital, Oteen

HATOS, MRS. VERNIECE N.
North Carolina Sanatorium, McCain

HAUPT, LILLIA M.
Highsmith Hospital, Fayetteville

HAY, RUTH W.
University of North Carolina, Box 229, Chapel Hill

HAYDUKE, MRS. CATHERINE L.
Castle Hayne

HENSON, LILLIE M.
Charlotte Memorial Hospital, Charlotte

HILL, ELIZABETH
Davis Hospital, Statesville

HOGGOOD, MRS. REBECCA B.
1003 Toisnot Ave., Wilson

HOUSE, Mildred
127 N. Spring, Winston-Salem

HOUSTON, MRS. LUVEAN H.
Lincoln Hospital, Durham

HOUSTON, MRS. ZONIE C.
Grace Hospital, Morganton

HOVIS, MRS. GENEVA E.
1949 Greene St., Charlotte

HOWARD, EDNA H.
Rowan Memorial Hospital, Salisbury

HUGHES, MABEL
James Walker Memorial Hospital, Wilmington

INABINETT, MRS. ALLENE M.
P.O. Box 143, Wilson

INGLES, THELMA
Box 2974, Duke Hospital, Durham

IRVING, CHRISTINA
Veterans Administration Hospital, Oteen

JACKSON, IRENE
Shelby Hospital, Shelby

JARVIS, DOROTHY B.
459 S. Hawthorne Rd., Winston-Salem

JEFFORDS, DAPHNE B.
219½ S. 16 St., Wilmington

JEFFORDS, MRS. DOROTHY P.
206 A N. 12, Wilmington

JENKINS, MRS. CARLEE B.
Roanoke Rapids Hospital, Roanoke Rapids

JOHNSON, BEATRICE E.
Guthery Apt. 201, Charlotte

JOHNSON, BETH
Graduate Hall, State Hospital, Raleigh

JOHNSON, C. MARGARET
Box 521, Roxboro

JOHNSON, EVELYN E.
2331 Byrd St., Raleigh

JOHNSON, HAZEL I.
246 Boulevard, High Point

JOHNSON, MARY L.
100 W. Tenth St., Lambertson

KELLY, AGNES
904 Arsenal Ave., Fayetteville

KEMBLE, ELIZABETH L.
P.O. Box 625, Chapel Hill

KERR, JOSEPHINE
1130 Buchanan St., Charlotte

LANDAUER, BARBARA
Veterans Administration Hospital, Oteen

LARGE, IRIS H.
Charlotte Memorial Hospital, Charlotte

LAWRENCE, MRS. JANE
2448 Maplewood Ave., Winston-Salem

LAXTON, AUGUSTA A.
Grace Hospital, Morganton

LEONARD, MRS. MYRTLE F.
Lee County Hospital, Sanford

LOYD, MRS. JULIA J.
Shelby Hospital, Shelby

LOWDER, GLADYS M.
Mountain Sanatorium & Hospital, Fletcher

LUTZ, ANNE C.
2204 Erwin Rd., Durham

MABE, MARY J.
512 Guilford Ave., Greensboro

MASSEY, LUCY E.
Box 3439, Duke Hospital, Durham

MASTEN, LUCY
James Walker Memorial Hospital, Wilmington

MATTHEWS, AUDREY G.
803 Halifax St., Petersburg, Va.

MAXWELL, MYRA R.
Carolina General Hospital, Wilson

MAY, MARY B.
Presbyterian Hospital, Charlotte

McCASKILL, MRS. GILBERT M.
Box 217, Carthage

McDUFFIE, MARY L.
315 Grace St., Wilmington

MEEDER, MARY E.
465 S. Hawthorne Rd., Winston-Salem

MENSCER, MRS. GAYNELL H.
712 Louise Ave., Charlotte

MITCHELL, MRS. DOROTHY S.
1948 Kennesaw Ave., Winston-Salem

551
SISTER MARY CARMEL
Mercy Hospital, Charlotte 4
SISTER MARY EVANGELIST*
Mercy Hospital, Charlotte 4
SISTER MARY JAMES
St. Joseph's Hospital, Asheville
SISTER MARY PATRICIA
Mercy Hospital, Charlotte 4
SISTER MARY PETER
Mercy Hospital, Charlotte 4
SISTER MARY XAVIER
St. Joseph's Hospital, Asheville
SISTER MIRIAM
Mercy Hospital, Charlotte 4
SISTER VINCENT
St. Leo's Hospital, Greensboro

SMITH, DOROTHY M.
Duke Hospital, Box 3237, Durham

SNEILING, AMY A.
1301 Duxwood Dr., Charlotte 3

SOLOMON, HAZEL M.
325 Grandin Rd., Charlotte 3

STARNES, ROXANN F.
1400 Scott Ave., Charlotte 3

STEPHENS, ELEANOR M.
Hamlet Hospital, Hamlet

STURGIS, MRS. CLARA H.
1519 S. Fifth St., Wilmington

SUDDS, RACHEL M.
Gaston Memorial Hospital, Gastonia

TAYLOR, FANNIE S.
Person County Memorial Hospital, Roxboro

TAYLOR, VIRGINIA L.
Rutherford Hospital, Rutherfordton

THAMES, MRS. ESTELLE C.
Clayton Clinic, Clayton

THOMAS, MRS. MILDRED M.
Kate Bitting Reynolds Memorial Hospital, Winston-Salem

THOMPSON, MRS. ZELLA P.
227 N. Robertson St., Chapel Hill

VINCENT, BLANCHE L.
1930 Smallwood Dr., Raleigh

WARLICK, DOROTHY H.
Grace Hospital, Morganton

WARREN, MRS. EVA W.
1204 Sixth St., Durham

WARREN, JOYCE
P.O. Box 2129, Raleigh

WATSON, BERTIE M.
Carolina General Hospital, Wilson

WATTS, MARY A.
Watts Hospital, Durham

WELLS, MRS. MYRTLE B.
James Walker Memorial Hospital, Wilmington

WESCUE, FREDERICK H.*
Grovemont St., Swannanoa

WESTMORELAND, RACHEL B.
Lowrance Hospital, Mooresville

WHITE, ANNE P.
Presbyterian Hospital, Charlotte 4

WHITE, J. ELIZABETH
Charlotte Memorial Hospital, Charlotte 3

WHITEHEAD, MRS. GEORGE W.
Gillette Woods, Tryon

WHITLEY, SADYE T.
Nurses Home, Oteen
MEMBERS

WHITWORTH, MARY N.
Charlotte Memorial Hospital, Charlotte 3

WILBURN, GERTRUDE
Charlotte Memorial Hospital, Charlotte 3

WILLIAMS, MRS. LIDA B.
1225 S. Main St., Greenwood, S. C.

WILLIAMS, MRS. LUCILLE Z.
Lincoln Hospital, Durham

WILLIARD, RUTH B.
1102 Johnson St., High Point

WILSON, FLORENCE K.*
Box 3714, Duke Hospital, Durham

NORTH CAROLINA—NORTH DAKOTA

WILSON, HETTY M.
106 Draper St., Charlotte

WILSON, IRENE M.
2922 Jefferson St., Wilmington

WINEBARGER, LUOLA V.
Charlotte Memorial Hospital, Charlotte 3

WINGFIELD, MRS. MARY S.
Charlotte Memorial Hospital, Charlotte 3

WOODCOCK, DORIS L.
James Walker Memorial Hospital, Wilmington

YOUNT, FRANCES L.
1106 Grace St., Wilmington

NORTH DAKOTA—62

ALDRICH, MARGARET M.
1706 Washington Ave., St. Louis 3, Mo.

ANDERSON, RUTH M.
St. Luke's Hospital, Fargo

BAILIE, MRS. IRENE V.
St. John's Hospital, Fargo

BAUMLER, LEONA
St. John's Hospital, Fargo

BISCHOF, ESTHER M.
718 Sixth St., Bismarck

BRODIN, MAVIS G.
912 Eighth St., Fargo

DAHL, MINNIE M.
Trinity Hospital, Minot

GALVIN, MILDRED C.
Bottineau

HEPPERLE, LYDIA
St. Luke's Hospital, Fargo

HOFTO, MRS. CLARA
321 N. Fourth St., Grand Forks

HOKE, HERTHA R.
1504 Oak St., Grand Forks

HORSEY, BEATRICE M.
2900 University Ave., Grand Forks

HOSTED, MRS. RUTH F.
1246 12 St., N., Fargo

HUGELEN, RUTH J.
130 S. Main St., Danville, Va.

JARMON, S. MARGERY
Jamestown Hospital, Jamestown

JOHNSON, MRS. MILDRED U.
New England

KEHN, PHYLLASEE D.
Trinity Hospital, Minot

KELLER, MIRIAM L.*
Division of Nursing Education, University of North Dakota, Grand Forks

KINDIG, FLORENCE E.
Mercy Hospital, Devil's Lake

LEWIS, CLARA G.
417½ Fifth St., Bismarck

MURRAY, MARY K.
1509 Sixth Ave., S., Fargo

OLSON, Meredyth C.
Trinity Hospital, Minot

PAULSON, LUCILLE V.
Deaconess Hospital, Grand Forks

POTTER, SELMA E.
Trinity Hospital, Minot

RAUGUST, MARTHA K.
Veterans Administration Hospital, Fargo

REID, JEAN A.
Mercy Hospital, Valley City

RIGHETER, MARALYN
New Rockford

RONSOS, MARIE
Trinity Hospital, Minot

RYAN, OLGA M.
Good Samaritan Hospital, Rugby

SAF, MYRTLE
Veterans Administration Hospital, Fargo

SCHULER, MRS. MARIE O.
217 Avenue C., W., Bismarck

SCHWAN, MARIE J.
417 Ninth Ave., S., Fargo

SCOTT, FLORENCE L.
1003 Sixth St., Bismarck

SISTER ANGELE
St. Alexius Hospital, Bismarck

SISTER CARITA
Trinity Hospital, Jamestown

SISTER ENID
St. John's Hospital, Fargo

SISTER HELEN MARIE
St. Andrew's Hospital, Bottineau

SISTER JANE MARGARET
St. Michael's Hospital, Grand Forks

SISTER JOEL
St. Alexius Hospital, Bismarck

SISTER MARIE LOYOLA
St. John's Hospital, Fargo

SISTER MARY AMADEA
St. Joseph's Hospital, Minot

SISTER MARY AQUINAS
St. Michael's Hospital, Grand Forks

SISTER MARY CATHERINE
St. Alexius Hospital, Bismarck

SISTER MARY EUGENE
Mercy Hospital, Williston

SISTER M. OLIVE
St. John's Hospital, Fargo

SISTER MARY RICARDA
Mercy Hospital, Devil's Lake

SISTER M. RITA HUGHES
Mercy Hospital, Devil's Lake

SISTER MARY RITA TRIGGS
St. John's Hospital, Fargo

SISTER MARY SCHOLASTICA
Mercy Hospital, Valley City

SISTER M. THEOLA
St. Joseph's Hospital, Minot

SISTER SYLVIA MURRAY
St. John's Hospital, Fargo

SMITH, LOIS R.
St. Joseph's Hospital, Minot
WENTLAND, GLADYS E.
305½ Main Ave., Bismarck

WILLIAMS, MRS. RUTH W.
Washburn

WILLIAMSON, JANYE K.
2104 Avenue D, Bismarck

WOLF, ELEANORA H.
323 Sixth St., Bismarck

WOOLCOTT, MRS. GERALDINE S.
St. Andrew's Hospital, Bottineau

ABEL, BETSY R.
315 Spahr St., Pittsburgh, Pa.

AGERTER, CARLOTTA H.
2247 Cunningham Rd., Cleveland 6

AITKEN, JANET
9117 Roschell Ave., Cleveland

ALLEN, LUCY E.
1636 Maywood Rd., South Euclid 21

ALLISON, MRS. LUCILLE M.
2830 Bryden Rd., Columbus 9

ALTHOFF, MARCELLA E.
3259 Elhard Ave., Cincinnati 29

ANDERSON, EDNA L.
1803 Valentine Ave., Cleveland 9

ANDERSON, ELIZABETH M.
2715 E. 116 St., Cleveland 4

ANDERSON, MABLE G.
2460 Valley View Dr., Rocky River

ANDERSON, PAULINE M.
3161 Harvey Ave., Cincinnati 29

ANSLEY, REBECCA
1134 Fifth Ave., Akron 6

ANTHONY, MRS. CATHERINE P.
1065 Eric Cliff Dr., Lakewood 7

ARMSTRONG, ETHEL B.
3161 Harvey Ave., Cincinnati 29

ARNDT, LYDIA C.
1903 Monroe St., Toledo 2

ARNDT, WANDA
11100 Euclid Ave., Cleveland 6

ARNOLD, MRS. LOIS H.
656 16 St., N.E. Massillon

AUBREY, MRS. RUTH N.
134 Mathews Rd., Youngstown 12

AUKERMAN, MRS. SUSANNAH J.
202 Nassau St., Dayton 10

AUL, H. LOUISE
Massillon State Hospital, Massillon

BAKER, JENNIE A.
Mansfield General Hospital, Mansfield

BANCOFT, M. CORINNE
7 Clemency Ave., Cincinnati 29

BARIETEAU, NORMA J.
2230 Benton Ave., Dayton 6

BEAL, CARRIE A.
Youngstown Hospital Asstn., South Side Unit, Youngstown

BAY, F. EVELYN
Middletown Hospital Asstn., Middletown

BEDINGHAUS, AUDREY S.
1815 Sylvania Ln., Green Township

BELLIS, GERTRUDE S.
220 Fowdark St., Cincinnati 19

BENDOFF, OLGA C.
1900 Florida Ave., N.W., Washington 9, D. C.
MEMBERS

BROTHER LOUIS SAELETLU
University of Dayton, Dayton 9

BROUSE, CLARA F.
905 S. Cassingham Rd., Columbus

BROWN, A. MARCELLA
1318 Cedar Rd., Cleveland 18

BROWN, MARGARET M.
Elyria Memorial Hospital, Elyria

BROWN, RUTH I.
11415 Hessler Rd., Cleveland 6

BRUBAKER, MRS. ESTHER
RFD 1, South Vienna

BRYAN, HELEN M.
11501 Shaker Blvd., Cleveland

BUELL, ELLEN L.
2053 Adelbert Rd., Cleveland 6

BUKOVINA, ELEANO R. K.
2179 E. 116 St., Cleveland 4

BUNGE, HELEN L.*
2053 Adelbert Rd., Cleveland 6

BURGESS, ORPHEA A.
3414 Gladstone St., Toledo

BURGIE, ELEANOR
147 Craig Ave., Pittsburgh 13, Pa.

BURKHARDT, DOLORES C.
2351 W, 231 St., North Olmstead 15

BURNS, ANNE
2355 Andover Rd., Columbus

BURTON, ALICE A.
1267 Copley Rd., Akron 20

BUSH, S. GERTRUDE
931 S. Remington Rd., Columbus 9

BUXK, JEANNE
1610 N. Dixon Circle, Cincinnati 24

CABLE, JANE
2026 Abington Rd., Cleveland 6

Caldwell, Louise
230 Diamond St., Ravenna

Callahan, MRS. GLADYS M.
150 Parkview Dr., Hubbard

Camin, Marie E.
1470 E. 24th St., Euclid 17

CAMPBELL, EDITH
3544 Burnett Ave., Cincinnati 29

CANDON, MARION W.
246 E. 214 St., Cleveland 23

Carbonneau, HELEN M.
3239 E. 82nd St., Cincinnati 29

Carley, Marie A.
Root Rd., North Ridgeville

CARTMELL, HELEN M.
1903 Valentine Ave., Cleveland 9

Carver, MRS. DOROTHY S.
653 Rogers St., Toledo 5

Catterllic, Elizabeth E.
6402 Stover Ave., Cincinnati 12

Cellar, Florence C.
2264 E. 130 St., Cleveland 20

Chambers, Colista M.
642 Dana Ave., Lima

Channell, Mrs. Wanda C.
132 Park Dr., Dayton 10

Chapman, Mrs. Velva R.
Veterans Administration Hospital, Cleveland 29

Cheney, Mary E.
Toledo State Hospital, Toledo

Clark, Eva L.
Miami Valley Hospital, Dayton 9

Cleary, Margaret T.
2701 Oatis Ave., Toledo 6

Cooper, Mary B.
2216 Bellfield Rd., Cleveland 6

Cordrey, Leila
Bethesda Hospital, Zanesville

Cottrell, Kathryn
Children's Hospital, Columbus

Cox, MRS. HELEN W.
Box 5, 208 Seaman Rd., Toledo

Coyer, Mary
Lorain County Health Dept., Oberlin

COyle, Winifred G.
3419 Iddlewood Ave., Youngstown

Craig, Marguerite
3259 Elland Ave., Cincinnati 29

Crzan, Celia*
City Hospital, Akron 4

Crawford, Mary J.
1899 E. 93 St., Cleveland 6

Creech, Etta A.
2525 Euclid Ave., Cleveland 15

Cunningham, Frances
2603 Adelbert Rd., Cleveland 6

Curran, H. Kathleen
128 Hopeland St., Dayton 8

Custer, Eleanor W.
14603 Milverton Rd., Cleveland 20

Dangers, Mary S.
Bethesda Hospital, Cincinnati 6

Darrington, Mable I.
3259 Elland Ave., Cincinnati 29

Davis, Mrs. Sarah E.*
425 W. Fifth St., East Liverpool

Deatherage, R. Fern
3520 Pembroke Ave., Cincinnati 8

Deeds, A. Catherine
11483 Hessler Rd., Cleveland 6

Derflinger, Lillian
Route 4, Lancaster

Desaulniers, MRS. Frances R.
1143 Brewster Ave., Cincinnati 7

DeSelm, MRS. Mary H.
148 W. Norwich, Columbus

Devine, Mrs. Kathleen W.
Veterans Administration Hospital, Chillicothe

Dickman, Helen M.
2352 Lawrence Ave., Toledo 6

Dolkan, Genevieve J.
421 Oak St., Toledo 5

Donley, Patricia J.
256 W. Cedar St., Akron 7

Dorian, Alice
3305 Franklin Blvd., Cleveland 13

Downey, Eileen
Ohio State University, School of Nursing, Columbus

Downey, MRS. Gertrude H.
62 Lincoln Ave., Cuyahoga Falls

Dudley, Margaret E.
3161 Harvey Ave., Cincinnati 29

Duerrk, Evelyn E.
2701 Oatis Ave., Toledo 6

Dukes, Alice M.
1812 E. 105 St., Cleveland 6

Duncan, Grace M.
732 Orchard Ave., Barberton

Dunlap, Muriel L.*
Youngstown Hospital, Youngstown 1.
FLYNN, ROSE M.
1803 Valentine Ave., Cleveland 9
FOGLE, MRS. FLORENCE L.
232 Montrose Way, Columbus 2
FOLCKEMER, ELIZABETH M.
2157 Euclid Ave., Cleveland 15
FORD, MRS. ELIZABETH D.
21300 Brantley Blvd., Shaker Heights 22
FORTUNE, ELLA L.
731 Wells St., Cincinnati 5
FORTUNE, ELLEN G.
11483 Hessler Rd., Cleveland 6
FOX, GERALDINE L.
706 E. Kirby Ave., Lima
FREEMAN, MRS. JESSIE M.
2635 Maplewood Ave., Cuyahoga Falls
FRETT, MYRA C.
White Cross Hospital, Columbus 8
FREIR, MARIE
3259 Elland Ave., Cincinnati 29
FRETTER, LEONA
14291 Detroit Ave., Lakewood 7
FROOME, JANET H.
747 Froome Ave., Cincinnati 32
FURNISH, EVELYN
The Christ Hospital, Cincinnati 19
GALLOWAY, A. ELIZABETH
111 Nagel St., St. Mary's
GANTZ, MRS. JOSEPH M.
3565 Bayard Dr., Cincinnati 8
GAVIN, MARY A.
1617 N. Argyle Pl., Cincinnati 23
GAZAWAY, RENA M.
294 Kemper Rd., Springdale, Glendale
GEBAUER, HELEN
2367 Canterbury Rd., Cleveland 18
GELTER, ADA M.
3161 Harvey Ave., Cincinnati 29
GEORGE, NELLIE
15317 First Ave., East Cleveland 12
GESTEL, CLARA E.
3259 Elland Ave., Cincinnati 29
GETTMAN, LEE
11109 Euclid Ave., Cleveland 6
GILCHRIST, CLARA M.
305-1 Teachers College, University of Cincinnati, Cincinnati 29
GILLIS, M. ANNA
P.O. Box 5, Fenelon Falls, Ontario, Canada
CLEASON, ANAMAE
3421 Brookline Ave., Cincinnati 20
GORDON, BERTHA N.
3259 Elland Ave., Cincinnati 29
GORDON, EDNA
625 Fairgreen Ave., Youngstown
GRAFTON, ELLA M.
105 McKnight Dr., Middletown
GRANDE, IRMA
The County Home & Chronic Disease Hospital, Cincinnati 15
GRAY, MRS. FLORENCE H.
R.F.D. 2, Pataskala
GRIFFEN, MRS. FRANCES R.
Children's Hospital, Akron
GRiffin, MARY M.
2701 Otis Ave., Toledo 6
GRiffith, Annabel
3072 Livingston Rd., Cleveland 20

DURKIN, ANGELA M.
1301 W. 85 St., Cleveland 2
DURSO, ANGELINE
St. John's College, Cleveland
DUSINI, MARIE
2363 Stratford Ave., Cincinnati 19
EATON, MRS. GLADYS A.
101 W. Center St., Akron 3
EDELEN, JANE
1066 Elbur Ave., Lakewood 7
EDSON, RUTH E.
1303 Valentine Ave., Cleveland 9
EDWARDS, MARY E.
921 Woodland Ave., Van Wert
EELLS, ADELE C.
2012 Denton Dr., Cleveland 6
ELBERFELD, ELNOR C.
25 E. University Ave., Cincinnati 19
Eldredge, Lura B.
2038 Cornell Rd., Cleveland 6
ELLIOTT, EFFIE
41 S. Fourth St., Zanesville
ELLIS, AGNES
478 E. Torrence Rd., Columbus
ELLISON, MRS. BESSIE V.
11125 Lake Ave., Cleveland 7
ELSE, MRS. HAZEL S.
2220 Jefferson Ave., Toledo
ERF, CORNELIA A.
11100 Euclid Ave., Cleveland 6
ERNST, SOPHIA
703 W. Market St., Lima
EUER, MARY E.
3259 Elland Ave., Cincinnati 29
EVANS, MRS. ELVA H.
2155 N. Taylor Rd., Cleveland Heights 12
EVANS, RUTH
1645 E. 115 St., Cleveland 6
FADDIS, MARGENE O.
2065 Adelbert Rd., Cleveland 6
FARRIS, MARY A.
1006 Pennsylvania Ave., Columbus 1
FAULKNER, GRACE M.
Mercy Hospital, Hamilton
FAWCETT, MARJORIE M.
1900 Shaftesbury Rd., Dayton 6
FEINAUER, MILDRED E.
Veterans Administration Hospital, Cleveland 9
FELDMAN, MRS. SARAH
16508 Euclid Ave., Cleveland 12
FETH, MARJORIE H.
Samaritan Hospital, Ashland
FINFROCK, H. REBECCA
Waynesboro
FINKE, ANN S.
3828 Burwood, Norwood 12
FISCHAUGH, MRS. JULIA B.
Peoples Hospital, Akron 7
FITZ, ELIZABETH L.
1067 E. 171 St., Cleveland 19
FITZPATRICK, LEAH
4716 Guerley Rd., Cincinnati 38
FLECK, M. KATHERINE
1872 Ansel Rd., Cleveland 6
FLUENT, MRS. MARION A.
2203 Barrington Rd., University Heights 6
FLYNN, LOUISE E.
Children's Hospital, Cincinnati 29

556
GROVER, MARBLE E.
631 E. Broad St., Columbus 15

GHISI, LOIS E.
313 Ruth Ave., Mansfield

HAAS, S. JEAN
876 Amherst Rd., Massillon

HADACK, MRS. AGNES M.
3552 Tolland Rd., Cleveland 22

HALL, MRS. MARION W.*
1566 Marlowe Ave., Lakewood 7

HALL, PRISCILLA K.
Lancaster-Fairfield Hospital, Lancaster

HALLFORS, HELEN E.
10706 Deering Ave., Cleveland 6

HAMBROUGH, MRS. HAZEL C.
110 Arch St., Akron 4

HAMMOND, ELI M.
708 Monroe St., Newport, Ky.

HANCE, MARY J.
3547 Harvey Ave., Apt. 32, Cincinnati 29

HARPER, JEAN
2316 Grant Ave., Cuyahoga Falls

HARRISON, HELEN L.
1812 E. 105 St., Cleveland 6

HARSTINE, E. BLANCHE
270 Village Dr., Columbus 2

HART, A. JOAN
815 N. High St., Apt. 20, Columbus

HART, ELIZABETH L.
11415 Hessler Rd., Cleveland 6

HART, MARCEL
502 S. Galloway St., Xenia

HARTWELL, LILLIAN M.
Box 56, Farmersville

HAUBEHL, MRS. MARGARET W.
Veterans Administration Hospital, Chillicothe

HAVASY, MRS. HELEN B.
1671 Westwood Ave., Apt. D, Columbus

HAWK, HAZEL M.
41 Arch St., Akron 4

HEELS, MARY O.
2743 Sagamore Rd., Toledo 6

HEFT, MONICA
15541 Hilliard Rd., Lakewood 7

HEIL, MRS. BETTY C.
2357 Beasley Park Rd., Columbus 9

HEINBAUGH, AUDY E.
2609 Franklin Blvd., Cleveland 15

HEINICKE, GABRIELLE M.
3269 Ellard Ave., Cincinnati 29

HENNESSEY, FLORENCE D.
Veterans Administration Hospital, Chillicothe

HENRY, VIRGINIA G.
2351 Burnet Ave., Cincinnati 19

HERMAN, ALBERTA I.
8211 Salisbury Dr., Parma 29

HESLAR, FLORENCE
Christ Hospital, Cincinnati 19

HEYOB, MARIORIE A.*
2441 Kentwood Ave., Norwood 12

HILLIARD, MILDRED J.
Mansfield General Hospital, Mansfield

HUTT, MARTHA
3219 Ellard Ave., Cincinnati 29

HITCHCOCK, MRS. LAWRENCE†
2257 Dolame Dr., Cleveland Heights 6

HOELSCHER, MARY M.
725 Indiana Ave., Dayton 10

HOFMAN, H. MARGUERITE
Nurses Home #1, Veterans Administration Hospital, Dayton

HOFRICHTER, JUNE E.
3305 Franklin Ave., Cleveland 13

HOGAN, AILEEN L.
10706 Deering Ave., Cleveland 6

HOLDER, MRS. PATRICIA C.
2023 Highland Ave., Cincinnati 19

HOLIBAUGH, ANN
1290 Pinck Ave., Akron 10

HOLWAY, MARY R.
612 N. Main St., Hubbard

HOMEIER, KATHRYN M.
411 Grand Ave., Akron

HOOVER, JOSEPHINE
Shelby Memorial Hospital, Shelby

HOPKINS, ETHEL M.*
1029 Ford Ave., Youngstown 4

HORNING, IRENE L.
482 Glenwood Ave., Akron

HORRIGAN, MARY E.
St. Elizabeth Hospital, Dayton 8

HOTZ, RITA M.
3547 Harvey Ave., Apt. 27, Cincinnati 29

HOUCK, ANNA V.
1312 Massachusetts Ave., N.W., Washington, D. C.

HOWERD, MARGARET C.
Mount Sinai Hospital, Cleveland 6

HOWELL, ALICE D.
2701 Oasis Ave., Toledo 6

HOWELL, MARION C.
3301 Fifth Ave., Beaver Falls, Pa.

HULI, CLEO
Samaritan Hospital, Ashland

HUMPHREY, MRS. SIEBERT†
River Rd., Chagrin Falls

HURLBURT, HAZEL M.
1001½ Sullivant Ave., Columbus

HURY, ELIZABETH
2410 Brooklyn Ave., Dayton 7

HUTZEL, MRS. MARGARET B.
2011 Shroyer Rd., Dayton 9

JACKSON, GRACE
302½ S. Belmont Ave., Springfield

JAMES, MARY M.
3525 Rushland Ave., Toledo 6

JAMIESON, ESTHER V.
1803 Valentine Ave., Cleveland 9

JARC, SOPHIA A.
21206 Naumann Ave., Euclid 23

JENKINS, EMMA D.
2810 Stratford Ave., Cincinnati 20

JENKINS, LILLIAN E.*
Massillon City Hospital, Massillon

JOHNSON, MARIE ESTHER
35 E. Burton Ave., Dayton 5

JOHNSON, MRS. RUTH M.
300 Piedmont Ave., Cincinnati 19

JOHNSON, MRS. SYDNEY P.
2141 Overlook Rd., Cleveland 6

JOHNSTON, FLORENCE B.
270 E. State St., Columbus

JORSTAD, ESTHER O.
Children's Hospital, Cincinnati 29

JUDD, MRS. MAVIS L.
13504 First Ave., Apt. 25, East Cleveland 12

KAIZDAN, JANE S.
2295 S. Merland Blvd., S.W., 15, Cleveland 20
KEARNS, MARTINE
Mercy Hospital, Toledo

KELLER, HELENE C.
29 Ashwood Ave., Dayton 5

KELLEY, MRS. OLIVE V.
4400 Homelawn Ave., Cincinnati 11

KERCHNER, DOROTHY B.
5898 O'Meara Pl., Cincinnati 13

KESSEL, MRS. MARY K.
1147 Main St., Wellsville

KETCHUM, ELLA A.
R.F.D. 5, Box 517, Akron

KIESSELBACH, THERESA
1258 Beach Ave., Lakewood 7

KIROWSKI, MARY S.
860 Carver St., Toledo 7

KINDIG, MARY M.
R.F.D. 3, Canfield

KINKEL, MRS. GRETCHEN M.
412 Monterey Ave., Dayton 9

KIRBY, EDITH E.
3339 Burnet Ave., Cincinnati 29

KIRKER, JESSIE
47 Lakewood, Cincinnati 20

KLEPPE, VIRGINIA T.
33 College Pl., Oberlin

KLIN, ALICE
St. Thomas Hospital, Akron 10

KLING, G. LOUISE
41 Arch St., Akron 4

KLINGLER, BEHLAH
2701 Oasis Ave., Toledo 6

KNAPP, MARY J.
P.O. Box 3523, North Hill Station, Akron 10

KNOEDLER, MRS. EVELYN L.
3569 W. 159 St., Cleveland 11

KOLLARIK, MARY A.
St. Vincent's Hospital, Toledo 8

KORTGARDNER, RUTH F.
519 Anderson Ferry Rd., Cincinnati 38

KRAEMER, MRS. GERTRUDE B.
139 Ridgeway Rd., Cincinnati 15

KREUTZIGER, SUSAN
Bethesda Hospital, Cincinnati

KRUMHANSI, CATHERINE
1087 Elban Rd., Cleveland Heights 21

KUCZEWSKI, LAURA J.
1431 Neil Ave., Columbus

KUHL, DOROTHY T.
843 Bow St., Dayton 7

KUEHLKE, BARBARA
305 Merriman, Akron 3

LAMBERT, MILDRED L.
Bethesda Hospital, Cincinnati 6

LAMBRIGHT, MARIAN
1202 Park Ave., S.W., Canton 6

LANGSETH, CLARA
Children's Hospital, Akron 8

LAUGHLIN, MRS. ANNA
515 Melish Ave., Cincinnati 29

LAWRENCE, RUTH E.
14222 Potomac Ave., Cleveland 12

LAWSON, NANCY
City Hospital, Akron

LEA, RUTH F.
1613 Ashland Ave., Columbus

LEDGER, HELEN M.
1736 Superior Ave., N.E., Cleveland 14

LEHTI, MARIE A.
147 N. Pleasant St., Oberlin

LEHIGEBER, ESTHER M.
2994 Cornell Rd., Cleveland 6

LENZ, MARY B.
Reid Memorial Hospital, Richmond, Ind.

LEONARD, VIVIAN
11540 Williams St., Maple Heights

LESS, MARY A.
R.F.D. 5, Salem

LEUPP, DOROTHY B.
1185 Lockbourne Rd., Columbus

LEWE, M. CHRISTINE
Good Samaritan Hospital, Dayton 6

LIEB, CONSTANCE
6001 Force Ave., Cleveland 5

LINCROEN, ELIZABETH M.
1450 E. 260 St., Euclid 17

LLOYD, DOROTHEA
St. Luke's Hospital, Cleveland

LONG, MRS. HERALDINE H.
56 Aqueduck St., Akron

LOTT, MRS. JOSEPH K.
3259 Elland Ave., Cincinnati 29

LOUCKS, LT. PHYLLIS S.
W.O.B.C. #16; M.F.S.S., B.A.M.G.
Lt. Sam Houston

LOVEY, MRS. DOROTHY S.
R.F.D., Rushtown

LOWER, MARY F.
42 N. Central Ave., Fairborn

LOWERY, MARGARET E.
Samaritan Hospital, Ashland

LOWNIE, ANNA T.
760 Northwest Blvd, Grandview Heights

LUCAS, JULIA
715 N. Broadway, Dayton 7

LUCAS, MARY L.
1803 Valentine Ave., Cleveland

LUDLOW, CATHERINE E.
2538 Eric Ave., Cincinnati 8

LYNCH, BEATRICE R.
2325 Euclid Ave., Cleveland 3

MacINTOSH, MRS. JESSIE S.
2507 Putnam St., Toledo

MADARAS, ANNE D.
St. Vincent's Hospital, Toledo 8

MANTHEY, G. ALLEN
Christ Hospital, Cincinnati 19

MARTIN, HELEN H.
1539 Yarmouth Ave., Cincinnati 37

MARTIN, RUBY M.
Benjamin Franklin Hospital, Columbus 7

MATHIEWS, EMMALINE R.
Christ Hospital, Cincinnati 19

McBAIN, JESSIE A.
1803 Valentine Ave., Cleveland 9

McCAIIE, MRS. LOREE M.
387 Carpenter St., Columbus

McClyMON, RUTH L.
3305 Burnet Ave., Cincinnati 29

McCORMICK, MRS. ALBERTA E.
3119 Silver Lake Blvd., Gahanna Falls

McCRARY, MRS. MARTHA E.
2556 Overlook Rd., Cleveland Heights 6

McDERMOTT, MRS. ANNE M.
319 Howell Ave., Cincinnati 20

MCGALLAIRD, VIVA
2610 Burnet Ave., Cincinnati 19

558
MEMBERS

MCHALE, HELEN A.
508 Herbert Pl., N.W., Canton 3

MCKENNA, FRANCES M.
240 W. Eighth Ave., Columbus

MCMASTER, MARTHA A.
Hosier Hospital, Gallipolis

McNEELEY, ESTA H.*
Mount Sinai Hospital, Cleveland 6

McNISH, LOIS
13317 First Ave., East Cleveland 12

MEAVY, RUTH A.*
Massillon City Hospital, Massillon

MEAKIN, JANET D.
Apt. 3, Quadrangle, Oberlin

MERKEL, MRS. HULDA M.
1634 Forest Hills Blvd, East Cleveland 12

MERRILL, ISABEL
11415 Ressler Rd., Cleveland 6

MERRIN, VERN A.
2474 Paris St., Apt. 3, Cincinnati 19

MEYER, DORA L.
Deaconess Hospital, Cincinnati

MILES, MARGUERITE L.
229 Garfield St., Middletown 21

MILLER, ELINOR L.
Haroon Road Hospital, Cleveland 12

MILLER, MRS. HARRETT A.
2210 Eldred Ave., Lakewood 7

MILLER, MRS. MILRED S.
3302 Cleveland Ave., N.W., Canton 9

MILLER, V. MILRED
3321 Felicity Dr., Cincinnati 11

MINNIEAR, WILMA A.
2069 Cornell Rd., Cleveland 6

MINNING, EDITH
2923 Vaughn St., Cincinnati 19

MINTER, RUTH
210 W. Eighth Ave., Columbus

MOEHRING, ELEANOR R.
3014 Walton Ave., Cleveland 13

MOORE, ILEAN
Springfield City Hospital, Springfield

MORISON, LUELLA J.
1006 Pennsylvania Ave., Columbus 1

MORRIS, BETTY J.
3161 Hartley Ave., Cincinnati 29

MORRIS, CERITRUDE
3259 Eldred Ave., Cincinnati 29

MORRIS, MRS. MARIAN R.
1156 Churchhill Rd., Lyndhurst 24

MUGAVIN, ALICE J.
6752 Hampton Dr., Cincinnati 36

MUNFORD, CONSTANCE G.
Dunham Hospital, Cincinnati 5

MUSSELMAN, MARTH
Bethesda Hospital, Cincinnati 6

NEEL, MARIE
2701 Oasis Ave., Toledo 6

NEWELL, MARIANNA
Lima Memorial Hospital, Lima

NEWTON, MILDRED E.
Ohio State University School of Nursing, Columbus

NICKERSON, IRMA W.
Ohio State University Hospital, Columbus 10

NIELSEN, RUTH U.
1793 Wilton Rd., Cleveland Heights 18

NIENABER, HELEN
2268 Harrison Ave., Cincinnati 11

NIXDORF, MARYLOU
Dunham Hospital, Cincinnati 5

NIZNICK, HELEN G.
3204 Benham Ave., Cleveland 5

O'BRIEN, BERNICE E.
Mount Carmel Hospital, Columbus

O'BRIEN, MRS. LULA H.
2552 Madison Rd., Cincinnati 8

OLSON, RUTH J.
3338 Burnet Ave., Cincinnati 29

OVERLAND, ANNA E.
2925 Vaught St., Cincinnati 19

OWENS, MAXINE
258 E. 19 St., Columbus

PALISKIS, MRS. HELEN R.
727 River Dr., Willoughby

PAMPUSH, RUTH G.
1502 Belle Ave., Lakewood 7

PANEG, MRS. ELIZABETH K.
4117 E. 133 St., Cleveland 5

PATTON, FRANCES M.
3259 Elland Ave., Cincinnati 29

PEASE, MRS. FRANCES M.
1661 Elmwood, Columbus 12

PERRY, ANNA M.
719 Patterson Rd., Dayton 9

PETCHNER, MIRIAM
Grant Hospital, Columbus 15

PETER, GLENN M.
3259 Elland Ave., Cincinnati 29

PETERSON, MURIEL E.
2561 E. 116 St., Apt. 405, Cleveland 20

PFLUEGER, MARYTHA M.
Bethesda Hospital, Cincinnati 6

PFOST, LELIA C.
Scott

PHILLIPS, ELIZABETH
19 Tower St., Cincinnati 20

PICKENPAUGH, DOROTHY
628 Shinnick St., Zanesville

PIERCE, ELIZABETH
6401 Beechmont Ave., Cincinnati

PIERSON, ZETTA M.
3636 Hutchinson Ave., Cincinnati 29

PIOTROWSKI, STELLA J.
3838 Lockwood St., Toledo 12

PLATT, ETHEL
1639 Eddington Rd., Cleveland Heights 18

PODKALAN, MRS. DOROTHY F.
4327 Root Rd., Cleveland 6

POLLOCK, MRS. HELEN B.
2301½ N. High St., Chillicothe

PONIKVAR, JOSEPHINE
9325 Union Ave., Cleveland 5

PONTIOUS, RUTH
Martins Ferry Hospital, Martins Ferry

PORTER, MRS. ELIZABETH K.
Frances Payne Bolton School of Nursing, Western Reserve University, Cleveland 6

PRATT, EDITH E.
2601 E. 116 St., Cleveland 4

PUGH, HATTIE E.
Dunham Hospital, Cincinnati 5

PUGH, MOLLY C.
1363 W. Sixth Ave., Columbus 12

RANDALL, CAROL E.
1231 Elmwood Rd., Rocky River 16

RANDELL, GRACE E.
285 E. 15 Ave., Columbus 1

559
SCOTT, JANET C.
11415 Hessler Rd., Cleveland 6

SEEGER, Elnora J.
9611 Clifton Rd., Cleveland 21

SEGILLER, MARY C.
Deaconess Hospital, Cincinnati 20

SEYMOUR, PAULINE
3335 Burnet Ave., Cincinnati 29

SHANCK, MRS. ANN H.
335 Blenheim Rd., Columbus

SHANK, HELEN
983 S. Cassingham Rd., Columbus

SHARRITT, EDNA E.
2701 Oasis Ave., Toledo 6

SHEAFFER, JERALDINE A.
1762 Chapman Ave., East Cleveland 12

SHEARER, JUDITH
2219 Madison Ave., Toledo 2

SHELDON, MRS. DORA
601 St. Leger Ave., Akron 5

SHELINGE, MRS. LOLA K.
2612 W. Detroit Ave., Toledo

SHELTON, NOREEN
38 Ashley St., Dayton 9

SHENK, MARY
3421 Middleton Ave., Cincinnati 20

SHOEMAKER, GRACE
664 N. Park St., Columbus 8

SHOWERS, MARY J.
2125 Eleanor Pl., Cincinnati 19

SISTER ADELAIDE
San Antonio Hospital, Kanton

SISTER AGNES MICHELLA
1425 W. Fairview Ave., Dayton 6

SISTER AGNES ROSAIRE
Good Samaritan Hospital, Cincinnati 20

SISTER AGNES THERESE
7911 Detroit Ave., Cleveland 2

SISTER ALMA
Good Samaritan Hospital, Cincinnati 7

SISTER ANNA
Good Samaritan Hospital, Cincinnati 10

SISTER ANN MIRIAM
Mt. Carmel Hospital, Columbus

SISTER ANNETTE
1190 Guy St., Montreal 25, Canada

SISTER AQUINA BEGLIN
St. Elizabeth Hospital, Dayton 8

SISTER BEATRIX
Good Samaritan Hospital, Cincinnati 20

SISTER BERTHA
49 Hopeland St., Dayton 8

SISTER DE CHANTAL
College of Mt. St. Joseph, Mount St. Joseph

SISTER DOROTHY ANN
Good Samaritan Hospital, Cincinnati 20

SISTER DOROTHY REESE
St. Vincent's Hospital, Toledo 8

SISTER FELICITAS
49 Hopeland St., Dayton 8

SISTER FLORENCE MARIA
Good Samaritan Hospital, Cincinnati 20

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Good Samaritan Hospital, Dayton 6

SISTER HELEN MARIE
Mt. Carmel Hospital, Columbus 8

SISTER JOAN MARIE
Mt. Carmel Hospital, Columbus 8

560
SISTER JOHN
Good Samaritan Hospital, Cincinnati 20
SISTER JOHN PATRICK
Good Samaritan Hospital, Cincinnati 20
SISTER LUCY FARRELL
St. Elizabeth Hospital, Dayton 8
SISTER MARGARET LOUISE
St. Elizabeth's Hospital, Youngstown 4
SISTER MARGARET MARY
3058 N. 51 St., Milwaukee 10, Wis.
SISTER MARIA COMPASSIONATA
Mt. Carmel Hospital, Columbus 8
SISTER MARIA CORONA
Mount St. Joseph College, Mt. St. Joseph
SISTER MARIE BERNARD
49 Hopeland St., Dayton 8
SISTER MARIE FIDE LIS
Good Samaritan Hospital, Cincinnati 20
SISTER M. ALVERA
St. Alexis Hospital School of Nursing, Cleveland 4
SISTER M. AMATA
7911 Detroit Ave., Cleveland 2
SISTER MARY AGUIN
Mercy Hospital, Toledo 2
SISTER MARY BAPTIST
2221 Madison Ave., Toledo 2
SISTER MARY BENIGNIS
Our Lady of Mercy Hospital, Cincinnati 27
SISTER MARY CAMILLE
Mercy Hospital, Springfield
SISTER MARY CAROLINE
Mercy Hospital, Toledo 2
SISTER M. COLUMBRIA
Mt. Carmel Hospital, Columbus 8
SISTER M. CORONATA
311 E. State St., Columbus 15
SISTER M. DELPHINA
St. Alexis Hospital, Cleveland 4
SISTER MARY EDITH
St. John College Division of Nursing, Cleveland 14
SISTER M. ELEANOR
7911 Detroit Ave., Cleveland 2
SISTER M. ELOISE
St. Joseph's Hospital, Cleveland
SISTER MARY ELVA
Mercy Hospital, Canton
SISTER M. ESTHER
7911 Detroit Ave., Cleveland 2
SISTER MARY EUSTELLE
Mercy Hospital, Toledo 2
SISTER MARY FLORENCE
Good Samaritan Hospital, Cincinnati 20
SISTER M. FRANCETTA
St. Vincent Charity Hospital, Cleveland 15
SISTER M. GENEVIÈVE
7911 Detroit Ave., Cleveland 2
SISTER MARY GRACE
Our Lady of Cincinnati College, Cincinnati 6
SISTER MARY HUMBELINE
Kinney's Lane, Portsmouth
SISTER M. IGNATIUS
Good Samaritan Hospital, Zanesville
SISTER MARY IMMACULEEN
Mt. Carmel Hospital, Columbus 8
SISTER MARY JOHN
Mercy Hospital, Canton 2
SISTER M. JOSANNE
St. Vincent Charity Hospital, Cleveland 15
SISTER M. JOSINA
Mt. Carmel Hospital, Columbus 3
SISTER MARY LAURETTA
St. Elizabeth’s Hospital, Youngstown 4
SISTER M. LIBORIA
750 Laurel Ave., Zanesville
SISTER MARY LOLITA
Mt. Carmel Hospital, Columbus 8
SISTER M. LUCIA
Providence Hospital, Sandusky
SISTER M. MARCELLA
St. Rita's Hospital, Lima
SISTER MARY MARTIN
Good Samaritan Hospital, Dayton 6
SISTER MARY MEDONOUCH
Mt. Carmel Hospital, Columbus 8
SISTER MARY MERCEDE
St. Thomas Hospital, Akron
SISTER M. NICOLAS
Mt. Carmel Hospital, Columbus 8
SISTER M. PACHOMIUS
Mercy Hospital, Portsmouth
SISTER M. RAYMOND
St. Vincent Charity Hospital, Cleveland 15
SISTER MARY REGINA
Mercy Hospital, Hamilton
SISTER M. REPARATA
801 W. High St., Lima
SISTER MARY ROMULA
Mt. Carmel Hospital, Columbus 8
SISTER MARY RONALDA
Mt. Carmel Hospital, Columbus 8
SISTER M. RUTH
1918 Hayes Ave., Sandusky
SISTER M. RUTH
2315 E. 22 St., Cleveland 15
SISTER M. SYLVIA
Mercy Hospital, Hamilton
SISTER M. THEOPHANE
St. Joseph Hospital, Lorain
SISTER M. TIMOTHY
St. Thomas Hospital, Akron 10
SISTER M. VENARD
Good Samaritan Hospital, Zanesville
SISTER M. VICTORINE
7911 Detroit Ave., Cleveland 2
SISTER M. WAVERNA
3409 Woodlawn Ave., Cleveland 15
SISTER M. WILHELMA
St. Elizabeth Hospital, Dayton 8
SISTER MIRIAM
St. Rita's Hospital, Lima
SISTER REMY
Good Samaritan Hospital, Dayton 6
SISTER ROSE EILEEN
St. Joseph Infants Home, Cincinnati 29
SISTER ST. BARBARA
Good Samaritan Hospital, Zanesville
SISTER THERESA
311 E. State St., Columbus 15
SISTER THERESA DE PAUL
St. Mary's of the Springs College, Columbus 3
SISTER TERESA CARRABOTTA, MARTHA
3011 Tate Ave., Cleveland 9
SITITCH, CAROLINE V.
Bethesda Hospital, Cincinnati 6

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<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smith, Faith W.</td>
<td>701 Parkwood Dr., Cleveland 8</td>
</tr>
<tr>
<td>Smith, Hazel M.</td>
<td>529 Bates Rd., Toledo 10</td>
</tr>
<tr>
<td>Smith, Kathryn H.</td>
<td>6090 Wade Park St., 32, Cleveland 3</td>
</tr>
<tr>
<td>Smith, M. Ruth</td>
<td>8311 Euclid Ave., Cleveland 3</td>
</tr>
<tr>
<td>Smith, Victoria</td>
<td>143 Chittenden Ave., Columbus 1</td>
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<tr>
<td>Snoek, Joanne</td>
<td>Mercy Hospital, Toledo 2</td>
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<tr>
<td>Soeder, Lucille S.</td>
<td>3574 Tullamore Rd., Cleveland 18</td>
</tr>
<tr>
<td>Sommer, Dorothy M.</td>
<td>1714 Fifth St., Portsmouth</td>
</tr>
<tr>
<td>Spehek, Sophie M.</td>
<td>881 Cordova Ave., Akron 2</td>
</tr>
<tr>
<td>Spengler, Helen</td>
<td>2488 E. 127th St., Cleveland 20</td>
</tr>
<tr>
<td>Stackhouse, Jean</td>
<td>1759 Holyoke Ave., East Cleveland 12</td>
</tr>
<tr>
<td>Steinert, Beverly A.</td>
<td>1762 Chapman Ave., Cleveland 12</td>
</tr>
<tr>
<td>Steimler, Mrs. Mildred M.</td>
<td>103 W. McMillan St., Cincinnati 19</td>
</tr>
<tr>
<td>Stevenson, Margaret</td>
<td>15915 Clifton Blvd., Lakewood 7</td>
</tr>
<tr>
<td>Stevenson, Mrs. Neva M.</td>
<td>40 E. Fountain Ave., Glendale</td>
</tr>
<tr>
<td>Stewart, J. Marion</td>
<td>2379 Woodward Ave., Lakewood 7</td>
</tr>
<tr>
<td>Streb, Louise L.</td>
<td>Bethesda Hospital, Cincinnati 6</td>
</tr>
<tr>
<td>Streiter, Mrs. Ida S.</td>
<td>2063 Adelbert Rd., Cleveland 6</td>
</tr>
<tr>
<td>Stringham, Mary L.</td>
<td>2102 Cornell Rd., Cleveland 6</td>
</tr>
<tr>
<td>Stroube, M. Jeannette</td>
<td>3521 Fidelity Dr., Cincinnati 11</td>
</tr>
<tr>
<td>Stuart, Lillian C.</td>
<td>Sunny Acres, Cleveland 22</td>
</tr>
<tr>
<td>Stubbs, Betty L.</td>
<td>1705 Aberdeen Ave., Columbus</td>
</tr>
<tr>
<td>Sullivan, Elizabeth M.</td>
<td>135 Hopeland St., Dayton 8</td>
</tr>
<tr>
<td>Sutherland, Evelyn</td>
<td>Rm. 329, Secor Hotel, Toledo</td>
</tr>
<tr>
<td>Swartz, Eleanor</td>
<td>21 W. Broad St., Rm. 905, Columbus 15</td>
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<tr>
<td>Swinehart, Esther M.</td>
<td>1017 Midway St., Middletown</td>
</tr>
<tr>
<td>Tague, Mrs. Mary C.</td>
<td>1868 Bonham, Columbus 3</td>
</tr>
<tr>
<td>Taylor, Mrs. Annabelle J.</td>
<td>292 King Ave., Apt. A, Columbus 1</td>
</tr>
<tr>
<td>Taylor, Mildred E.</td>
<td>Veterans Administration Hospital, Brocksville</td>
</tr>
<tr>
<td>Terbeck, Marie</td>
<td>2118 Brown Rd., Cleveland 7</td>
</tr>
<tr>
<td>Thaxton, Mrs. Margaret R.</td>
<td>720½ Second Ave., Gallipolis</td>
</tr>
<tr>
<td>Thompson, Dorothy Z.</td>
<td>2441 Ravenwood Ave., Dayton 6</td>
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<td>Thompson, Helen L.</td>
<td>The Jewish Hospital, Cincinnati 29</td>
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<tr>
<td>Tidd, Mrs. Anna R.</td>
<td>130 E. Friend St., Columbusiana</td>
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<tr>
<td>Tooker, Mrs. Louise K.</td>
<td>625 Miami Ave., Terrace Park</td>
</tr>
<tr>
<td>Torrance, Mrs. Jane T.</td>
<td>746 Etcut Rd., Akron 3</td>
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<tr>
<td>Tovey, Evelyn M.*</td>
<td>Akron City Hospital, Akron</td>
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<tr>
<td>Trapp, Mrs. Elizabeth B.</td>
<td>8710 Beech Ave., Brooklyn</td>
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<tr>
<td>Traylor, Charlotte F.</td>
<td>604 Five Oaks Ave., Dayton 6</td>
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<tr>
<td>Tropp, Mrs. Gladys H.</td>
<td>1117 Buckingham Ave., Cleveland 20</td>
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<tr>
<td>Yangader, Mrs. Clara E.</td>
<td>Bethesda Hospital, Zanesville</td>
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<tr>
<td>Van Gorp, Lt. Dympna M., NC USN, MATS</td>
<td>1453, Medical Evacuation Squadron, APO 953,</td>
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<td>Veitch, Arleen L.</td>
<td>1855 Garfield Rd., Cleveland 12</td>
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<td>Villing, Marie</td>
<td>3264 Broadwell Ave., Cincinnati 11</td>
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<td>Wachsmuth, Ursula M.</td>
<td>1276 Sunset Ave., Cincinnati 5</td>
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<td>Wadsworth, Ivy M.</td>
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<td>Wagner, Mary L.</td>
<td>745 Park Ave., Hamilton</td>
</tr>
<tr>
<td>Wall, Mathilda</td>
<td>3405 Burnett Ave., Cincinnati 29</td>
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<td>Wallace, Mildred</td>
<td>Children's Hospital, Cincinnati 29</td>
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<td>Wallinger, Elgie M.</td>
<td>Children's Hospital, Columbus 5</td>
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<td>Walsh, Mrs. Mary</td>
<td>44 Zeller Ct., Berea</td>
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<td>Walton, Marijorie</td>
<td>U. S. Marine Hospital, Cleveland 20</td>
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<td>Washinka, Olga</td>
<td>12117 Angelus Ave., Cleveland 5</td>
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<tr>
<td>Wayman, Mrs. Carolyn S.</td>
<td>907 Grandview Ave., Bellevue, Ky.</td>
</tr>
<tr>
<td>Webster, Alice Y.</td>
<td>14016 Ardenall Ave., East Cleveland 12</td>
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<td>Weiland, Magdaline T.</td>
<td>2320 E. 24 St., Cleveland 6</td>
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<tr>
<td>Wellman, Emelia D.</td>
<td>1433 Neil Ave., Apt. 1, Columbus 1</td>
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<td>Wenzel, Jessie E.</td>
<td>3335 Burnett Ave., Cincinnati 29</td>
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<tr>
<td>Werner, Ruth</td>
<td>1433 Neil Ave., Columbus 1</td>
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<td>West, Hazel</td>
<td>1812 E. 105 St., Cleveland 6</td>
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<tr>
<td>Weyhmuller, Helen H.</td>
<td>Children's Hospital, Cincinnati 11</td>
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<tr>
<td>White, Myrtle M.</td>
<td>381 E. Town St., Columbus 15</td>
</tr>
<tr>
<td>Whitney, Christine</td>
<td>3259 Eiland Ave., Cincinnati 29</td>
</tr>
<tr>
<td>Wilch, Mildred L.</td>
<td>3968 Rush Ln., Cincinnati 11</td>
</tr>
<tr>
<td>Wilkinson, Effie F.</td>
<td>515 Melish Ave., Apt. 25, Cincinnati 29</td>
</tr>
</tbody>
</table>
WILLIAMS, ADDA L.
Lima Memorial Hospital, Lima

WILLIAMS, MRS. DOROTHY R.
2257 Tudor Dr., Cleveland 6

WILLIAMS, MARY M.
1471 E. 112 St., Cleveland 6

WILSON, MAY V.
98 Bottles Ave., Columbus

WILSON, PRINCESS L.
Franklin County Tuberculosis Hospital, Columbus

WINKELMAN, MRS. EVELYN C.
233 Cummings Rd., Cleveland 6

WISNIEWSKI, VALENTA L.
Riverside Hospital, Toledo 11

WOLFERT, RUTH L.
15317 Grooved, Cleveland

WOLPERT, FLORA
293 E. Burgess St., Columbus 4

WOODWORTH, MARGARET A.
1851 Belmore, Cleveland 12

WYLAND, HULDIAH M.
Robinson Hospital, Toledo 10

YAKO, JULIA A.
St. Vincent Charity Hospital, Cleveland 11

YEATER, LUZETTA
243 Sandusky St., Ashland

ZIMMERMAN, DOROTHY
664 N. Park St., Columbus

ZINGER, MARIAN E.
1690 W. 31 Pl., Apt. 113, Cleveland 12

ZUBER, FRANCES
239 Oak Park Ave., Columbus 2

ANDERSEN, MILDRED V.
3318 E. Fourth St., Tulsa

BAZES, DORA R.
203 E. King, Tulsa 6

BENAGE, OPAL
1316 S. Detroit, Tulsa 14

BERRY, MARGUERITE R.
615 E. Okmulgee Ave., Muskogee

BIDDLER, THELMA M.
Enid General Hospital, Enid

BLUSH, DOROTHY A.
Leary Hall, University of Washington, Seattle 5, Wash.

BONHAM, WINIFRED B.
Box 172, Kcota

BONNEAU, HELENE M.
3400 N. Eastern, Oklahoma City 5

BOVETT, CHRISTINE
335 Denison Ave., Muskogee

BROOK, EDITH L.
290 Colburnton Dr., Oklahoma City 4

BROWN, CLAIRE
Hillcrest Memorial Hospital, Tulsa 6

CAMPBELL, MARY J.
1207 Euclid Ave., Oklahoma City

CARAWAY, DORA D.
Kiowa Indian Hospital, Lawton

CARON, MRS. MARY R.
606 N. E. 12 St., Oklahoma City 4

CHURCH, DARYL E.
218 N. Quincy, Enid

COOLEY, MRS. RACHEL L.
2050 E. 12 St., Tulsa

COSTELLO, MARCELLA R.
St. Anthony Hospital, Oklahoma City 3

COTTON, JESSIE R.
636 East Dr., Oklahoma City

DANIEL, JOSEPHINE L.
3400 N. Eastern, Oklahoma City 5

DE SHETTER, MARY A.
Taibina Indian Hospital, Taibina

EDMONDS, THELMA
Kiowa Indian Hospital, Lawton

ELLIOTT, MRS. MARIE S.
5209-19, N.E., Seattle 5, Wash.

FLEMING, KATHERINE
Wesley Hospital, Oklahoma City 3

FUTRELL, MARY J.
1624 N.W. 27, Oklahoma City 6

GRENZW, MRS. LUELLA B.
Hillcrest Memorial Hospital, Tulsa 5

HAMIL, EVELYN M.
University Hospital, Oklahoma City

HAZLETON, MARIE
3400 N. Eastern, Oklahoma City 5

JOHNSON, MAY A.
1602½ W. Easton St., Tulsa

KANAI, M. A.
Kiowa Indian Hospital, Lawton

KEATON, MARTHA E.
2295 Columbus, Muskogee

KENNEDY, SARAH M.
St. Anthony Hospital, Oklahoma City 3

KIRK, ODIE M.
Kiowa Indian Hospital, Lawton

KNOTT, KATHARINE L.
Kiowa Indian Hospital, Lawton

LAMBERT, IRMA M.
St. Anthony's Hospital, Oklahoma City

LANGSTON, MRS. IVA R.
Hillcrest Memorial Hospital, Tulsa

LIVINGSTON, EDNA C.
Wm. W. Hastings Hospital, Tahlequah

MAYES, FAYRENE B.
1132 E. Park, Oklahoma City

McLENDON, MARY
St. John's Hospital, Tulsa

McMAHON, MARY A.
Mercy Hospital, Oklahoma City 3

MILLER, BETTYE B.
1315 E. Tenth, Tulsa 5

MILLSAP, MRS. JUANITA G.
Wesley Hospital, Oklahoma City 3

MOORE, ELANORE
211 E. Hazel, Poncea City

NICH. PANSY
311 N.E. 13 St., Oklahoma City

OBERHOLTZER, RUTH M.
Taibina Medical Center, Taibina

O'CONNOR, CATHERINE M.
Kiowa Indian Hospital, Lawton

OLDFIELD, BEULAH
Box 554, Anadarko

PATTERSON, HELEN E.
800 N.E. 13 St., Oklahoma City

PEDEERSEN, SIGRID
Clinton Indian Hospital, Clinton
PEREZ, MRS. MARY A.*
535 Dennison, Muskogee
PHILLIPS, MARGARET L.
University Hospital, Oklahoma City
PIGGOTT, BESS M.
1432½ S. Rockford, Tulsa
PITTS, SYBIL
220 E. Duke St., Hugo
POPE, ERNEST F.
1114 N.W. 55, Oklahoma City 6
POWELL, THRIZA
University Hospitals, Oklahoma City
QUINN, GERALDINE E.
Talihina Indian Hospital, Talihina
ROBERTS, MRS. W. RUTH
2216 E. 20 St., Tulsa 4
SANDERS, ELIZABETH M.
Talihina Medical Center, Talihina
SCHAEFFER, NORMA C.
Western Oklahoma State Hospital, Clinton
SHILLINGTON, HYLDA F.
5401 N. Portland Ave., Oklahoma City 12
SISTER M. AGNES
St. John’s Hospital, Tulsa 6
SISTER MARY AGNES
St. Anthony Hospital, Oklahoma City 3
SISTER M. BENEDICTA
502 E. Oklahoma, Enid
SISTER M. COLETTA
511 N.W. 12 St., Oklahoma City 3
SISTER M. GRATIANA
St. John’s Hospital, Tulsa 6
SISTER M. IRMA
St. John’s Hospital, Tulsa 6
SISTER M. LUCILLE
St. Mary’s Hospital, Enid

SISTER MARY MARCELLINE
St. Joseph’s School of Nursing, Ponca City
SISTER MARY PANCRATIA
St. Anthony Hospital, Oklahoma City 3
SISTER MARY ROSINA
St. Anthony Hospital, Oklahoma City 3
SISTER MARY STELLA
Ponca City Hospital, Ponca City
SISTER MARY VINCENTIA
St. Anthony Hospital, Oklahoma City 3
SLIEF, GOLDA B.
705 N.E. 16 St., Oklahoma City 4
STRONG, WILLIAMINA H.
Wesley Hospital, Oklahoma City 3
TERRELL, LUCILLE H.
2400 N. Eastern, Oklahoma City 5
TOMER, ALICE M.
Oklahoma Baptist Hospital, Muskogee
VAN BEEKUM, MARGARET
Talihina Medical Center, Talihina
WADKINS, OPALINE D.
1333 N.E. Eighth St., Oklahoma City 4
WARD, IDA K.
1725 N. Indianapolis, Tulsa
WEBSTER, ELIZABETH K.
803 Perrine Blvd., Oklahoma City 2
WESTROPE, GRACE L.
1109 N.E. 17 St., Oklahoma City
WINTERS, ODESSA
507 S. Allegheny, Tulsa 12
WOOD, SUE E.
Talihina Indian Hospital, Talihina
WRIGHT, DORIS B.
3409 N. Eastern, Oklahoma City

BOUFFORD, MRS. M. JOHNSON
16697 S.E. Hampshire Ln., Portland 22
BROWN, INA M.
Veterans Administration Hospital, Camp White
CARMAN, GRACE C.
Station A, Salem
CLARK, MARGARET L.
1011 N.W. Couch St., Portland 9
CONDON, KATHLEEN
2114 S.E. Hemlock, Portland 14
DALY, EILEEN G.
10601 N.E. Sandy Blvd., Portland 20
DAVIS, EVA A.
University of Oregon Medical School, Department of Nursing, Portland 1
DEUTSCH, GERTRUDE
520 N.E. Fargo St., Portland 12
DOLTZ, HENRIETTA
2217 N.E. Multnomah, Portland 12
DORASH, MRS. LOIS C.
1816 S.E. 24 Ave., Portland 15
DUERKSEN, TINA
Oregon State Hospital, Salem
EGGERS, JOHANNA
3417 S.W. 12 Ave., Portland 1
FARCHI, MRS. EMMA P.
3610 S.E. Franklin, Portland 2
FITZPATRICK, WILMA G.
1186 Ferry St., Eugene

Funnell, Charlotte K.
402 S.E. 52 Ave., Portland 15
Galbreth, VioLET
2025 N.E. 16 Ave., Portland 12
Gowan, Naomi M.
Walla Walla College, Portland 16
Gregerson, Lucille
3211 S.W. Tenth Ave., Apt. 206, Portland 1
Hamilton, Jean E.
Route 5, Box 331, Vancouver, Wash.
Hart, Lois M.
1517 N.E. Eighth Ave., Portland 12
Hayden, Chesta
Route 2, Box 396, Springfield
Heidel, Alice A.
233 N. Broadway, Portland 12
HeWitt, MRS. CAROL M.
715 S.W. King Ave., Portland 10
Higby, Lucille M.
Oregon State Hospital, Salem
Hinds, Hazel
2292 N.W. Northrup St., Portland 10
Humphrey, Letha
2421 N.E. Irving St., Portland 12
Johnson, Alpha L.
259 E. 15 St., Apt. 306, Eugene
Kraabel, R. Eline
2800 N. Commercial, Portland 12

Oregon—70

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LEE, GERTRUDE M. 1876 N.W. Ramsey Dr., Portland 10
LIGGETT, MARTHA J. 4635 E. Burnside St., Portland 15
LOGSDON, GLADYS B. 2346 N.W. Gilsan, Portland 10
MARTIN, LEONORA E. 2800 N. Commercial Ave., Portland 12
MCCUIRE, MRS. MARIE L. Emanuel Hospital, Portland 12
MITCHELL, VERDA 8220 S.W. Third Ave., Portland 1
MONKMAN, DONNA M. 1523 S.E. Madison, Portland 14
MOORE, DOREEN E. 3211 S.W. Tenth Ave., Portland 1
MOULD, BETTE 2336 S.W. Osage St., Portland 5
MURPHY, JULIANNE G. 935 Gaines St., Salem
MURR, JUANITA 3181 S.W. Sam Jackson Park Rd., Portland 1
NEWTON, EATHEL A. 2475 N.W. Raleigh, Portland
NICHOLS, DOROTHY M. 3628 S.E. Harrison St., Portland 15
OLSON, APOLLONIA F. Oregon State Board of Health, 1022 S.W. 11 Ave., Portland 5
OLSON, GUHLI J. 3503 N.E. Stanton St., Portland 13
ORWIG, BERNICE I. 1215 N.W. 21 Ave., Apt. 203, Portland 9
OSBORN, HARRIETTE E. 1529 N.E. Knott St., Portland 12
PALMQUIST, ELEANOR E. 4118 S.W. View Point Ter., Portland 1
PHILLIPS, GRACE R.F.D. 7, Bloomington, Ind.
RICHER, ROBERTA Emanuel Hospital, Portland 12
SCOTT, ESTHER H. 1104 Washington, Oregon City

OREGON—PENNSYLVANIA

SELTER, HILDA A. 5535 S.E. Stark St., Portland 15
SISTER ELIZABETH ANN Providence Hospital, Portland 13
SISTER ERNESTINE MARIE University of Portland, College of Nursing, Portland 10
SISTER MARY MARTHA Sacred Heart General Hospital, Eugene
SISTER THEODORE MARIE Sacred Heart General Hospital, Eugene
SLOCUM, OLIVE A. 542½ Washington St., Eugene
STEPHENS, DORIS M. 3211 S.W. Tenth Ave., Portland 1
STEULDNER, CELENE A. 715 S.W. King St., Portland 5
SWANMAN, ALICE E. 2209 N. Commercial St., Portland 12
TAYLOR, PHYLIS 4051 N.E. 23 St., Portland 12
TROESTER, WILLA D. 2475 N.W. Westover Rd., Portland 10
UTZ, SARAH W. 3027 N.E. 12 Ave., Portland 12
VALENTINE, LOIS A. 239 S.W. Whittaker St., Portland 1
VOSSEN, DOROTHY 2486 N.W. Westover Rd., Portland 10
VREELAND, JOHANNA R. 1230 S.W. Columbia, Apt. 8, Portland 1
WELLS, GERALDINE 7218 N. Jordan St., Portland 3
WHITE, MRS. OLIVE 1077 S.W. Park Ave., Portland 1
WILSON, MRS. AILEEN D. 1206 S.W. Gibbs St., Portland 1
WIMER, FLORENCE 6014 S.E. Yamhill St., Portland 15
WOLFE, CLARA E. 553 S.E. 71 Ave., Portland 16
WOLFE, WINIFRED 3211 S.W. Tenth, Portland 1

PENNSYLVANIA—1,023

ABBOTT, RUTH D. Pennsylvania Hospital, Philadelphia 7
ACKERMAN, MARTHA M. 1141 Green St., Allentown
A'HIRABAH, MRS. MARY K. Warren State Hospital, Warren
AHLMSTROM, ADELE Wellington Apts., 245 Melwood St., Pittsburgh 13
ALLISON, ELLA W. Surrey Hall, 42 & Pine Sts., Philadelphia 4
AMSLER, MAE H. R.F.D. 2, Sewickley
ANDERSON, MILDRED A. 2203 Arthur St., McKeesport
ANDERSON, MILDRED N. Box 276, Bentleyville
ANDROS, PAULINE 7 Quarry St., North Braddock
ANGELSTEIN, CATHERINE E. 129 N. 17 St., Allentown
ANTONELLI, DOLORES 573 Ridge Rd., Ambridge

APPLEGATE, MRS. GEORGE 640 Academy Ave., Sewickley
ASH, JOAN R. Coatesville Hospital, Coatesville
ATON, MARY B. 5230 Centre Ave., Pittsburgh 32
AVERY, MARGARET L. Municipal Hospital, Pittsburgh 13
BAILEY, MRS. EDNA D. The Graduate Hospital, Philadelphia 46
BAILEY, OLGA E. 115 S. 14 St., Allentown
BAKER, RUTH E. Abingdon Memorial Hospital, Abington
BALDRIDGE, ANNA M. 532 W. Pittsburgh St., Greensburg
BALLAMY, EMMA S. Wilkes-Barre General Hospital, Wilkes-Barre
BALLIEET, MRS. BLANCHE P. Skattered
BANNON, ANNA E. 4 Hope Ave., Coatesville
BARBERO, MARY L.  
732 McClellan St., Portage

BARRON, MADEL A.  
Elizabeth Steel Magee Hospital, Pittsburgh 13

BARTLETT, CLARA  
320 S. 34 St., Philadelphia 4

BASKIN, MRS. ANNA S.  
Box 332, Marion Center

BASSART, ORPHA F.  
106 Pennsylvania Ave., Oakmont

BAUMGARTEN, HILDA G.  
Philadelphia General Hospital, Philadelphia 4

BEACH, JANET  
4900 Friendship Ave., Pittsburgh 24

BEALER, NETTIE E.  
Indiana Hospital, Indiana

BEAN, ESTHER M.  
4000 N. Front St., Philadelphia 60

BEARDSLEY, CATHERINE  
Jewish Hospital, Philadelphia

BEATTY, RITA T.  
826 E. Dusert St., Philadelphia 19

BEAUDRY, DORIS A.  
Proctor Star Route, Williamsport

BECHTELE, MADELINE I.  
5436 Kinseid St., Pittsburgh 6

BECK, ALMA E.  
St. Luke's Hospital, Bethlehem

BECK, BETTY J.  
1151 Whyttman St., Pittsburgh 17

BEISSER, MIRIAM  
Abington Memorial Hospital, Abington

BELL, CHERYL D.  
Reading Hospital, Reading

BELL, SARAH C.  
Philadelphia General Hospital, Philadelphia 4

BENDUS, MRS. HARRIET M.  
1613 Tilton St., Allentown

BENFIELD, RUTH E.  
Citizens General Hospital, New Kensington

BENNET, MRS. HAZEL L.  
320 N. 14 St., Allentown

BENNET, A. REGINA  
1106 S. 46 St., Philadelphia 43

BENNET, AUBA A.  
Veterans Administration Hospital, Bldg. 3, Butler

BENNET, EMILY  
319 Hemlock St., Pittsburgh 12

BENNINGHOFF, MRS. CATHERINE T.  
Tuberculosis League Hospital, Pittsburgh

BERCENT, PHILLIS A.  
Main St., Universal

BESORE, HELEN M.  
Frankford Hospital, Frankford 24

BEVAN, MABEL  
Elizabeth Steel Magee Hospital, Pittsburgh 13

BICKEL, RUTH  
Easton Hospital, Easton

BICKLE, MRS. HELEN E.  
Easton Hospital, Easton

BIERY, MRS. MARGARET T.  
584 Club Ave., Allentown

BIONAZ, MRS. MARY G.  
1306 Jefferson Ave., Portage

BIRO, BLANCHE  
1104 13 St., McKees Rocks

BISHOP, MRS. THELMA Y.  
2901 Sixth Ave., Altoona

BLACK, VIVIAN J.  
1124 North Ave., Pittsburgh 21

BLAIR, ETHEL H.  
329 Ashcroft Ave., Cresson

BLAYDELL, FAUSTINA  
549 N. Neville St., Pittsburgh 13

BLAKE, MARY M.  
Veterans Administration Hospital, Aspinwall 15

BLASER, LYDIA  
103 S. 36 St., Philadelphia 4

BLOODWORTH, GRACIE P.  
Harrisburg State Hospital, Harrisburg

BLOOM, MRS. EDNA W.  
695 W. Oak St., Norristown

BLUMENSTINE, ELEANORA  
325 Tampa Ave., Pittsburgh 16

BLUMENSTOCK, CHRISTINE K.  
R.F.D. 5, Box 303, Lancaster

BOANDL, MRS. MARGARET N.  
1411 Main St., Bethlehem

BOECKERMAN, MARY G.  
7141 Churchland St., Pittsburgh 6

BOLGER, MRS. CECILIA Q.*  
305 S. Brown St., Lewistown

BOLLINGER, MRS. DOROTHY D.  
Harrisburg Polyclinic Hospital, Harrisburg

BOLTZ, MARY K.  
218 S. Sixth St., Lebanon

BOND, MRS. RUTH F.  
2347 Allen St., Allentown

BOOKE, ELEANOR L.  
5450 Centre Ave., Pittsburgh 32

BOVARD, MARY E.  
The Harrisburg Polyclinic Hospital, Harrisburg

BOWER, C. RUTH*  
Concord Hall, Philadelphia 4

BOWERS, CECILE R.  
Bradford Hospital, Bradford

BOYD, MARY E.  
South Side Hospital, Pittsburgh

BOYLE, ADA D.  
Box 240, Warren

BRASSI, MRS. ANNA S.  
350 Mcrose St., Keiser

BREDENBERG, MAI. VIOLA C.  
Valley Forge Army Hospital, Phoenixville

BRENNAN, EVELYN M.  
5290 Fifth Ave., Pittsburgh 6

BRENNAN, MRS. RHEA A.  
7 Prospect St., Warren

BRESLIN, FREDERICA W.  
Mercy Hospital, Wilkes-Barre

BRESLIN, MAE C.  
Veterans Administration Hospital, Wilkes-Barre

BREWSTER, MRS. C. BARTON  
8715 Shawnee St., Philadelphia 18

BREZ, PAULINE M.  
330 Greenlee Rd., Pittsburgh 27

BRIGGS, MRS. EVA W.  
5913 Nussu St., Philadelphia 31

BRINTON, JANE  
Oil City Hospital, Oil City
CUNNINGHAM, MARTHA N. 
Montevista Apts., 45 & Oxford Sts., Philadelphia 31

CUPPELS, ANITA J. 
Hahnemann Hospital, Scranton

CURRY, RUTH J. 
Moses Taylor Hospital, Scranton 10

CUSHING, ADELAIDE B. 
Eye & Ear Hospital, Pittsburgh 13

DAHLGREN, GAIL H. 
McKeesport Hospital, McKeesport

DAILEY, SARA 
Hahnemann Hospital, Scranton 10

DARRAS, MARGARET A. 
230 S. Elekid, Pittsburgh 6

DARSIE, MRS. KATHRYN G. 
221 Penn Ave., Pittsburgh 21

DAVIES, ANNE L. 
51 N. 39 St., Philadelphia 4

DAY, ETHEL W. 
223 W. Coragas Lz., Philadelphia 19

DEAKER, HELEN 
230 N. Broad St., Philadelphia 2

DEBNEDDE, MRS. ALICE K. 
519 Smithfield St., Pittsburgh 27

DECKER, MARY E. 
115 Spring St., Clarks Green

DEEMER, MRS. CLEO 
5007 Penn Ave., Pittsburgh 6

DEELEHART, DOROTHY 
137 Lindsay Rd., Carnegie

DiLONG, ESTHER M. 
203 S. Fourth St., Emus

DEMEY, MRS. INEZ J. 
1466 Dennison Ave., Pittsburgh

DENGLER, MRS. DOROTHY K. 
892 Third St., Fullerton

DENMAN, LORETTA 
5314 Ellisworth Ave., Pittsburgh 32

DENNIS, EVELYN 
406 E. Penn, Butler

DERR MEYERS, MATHILDA A. 
257 S. Farragut Ter., West Philadelphia 39

D’ESTEL, ERNESTINE K. 
Philadelphia General Hospital, Philadelphia 4

DEYARMAN, MRS. CLONA B. 
Bigler Ave., Spangler

DICKER, ANNA M. 
111 Pearl St., Pittsburgh 24

DIEBEL, MARGARET E. 
Northeastern Hospital, Philadelphia 31

DIEHL, JANE N. 
St. Luke’s Hospital, Bethlehem

DFINE, MARY A. 
1306 S. Tenth St., Philadelphia 47

DILWORTH, AVA S. 
Middle Road, Glenshaw

DIMOCK, LOIS H. 
Moses Taylor Hospital, Scranton 10

DIRENZO, ROSE M. 
202 S. Trenton Ave., Wilkinsburg

DITCHFIELD, ALDA L. 
6203 Germantown Ave., Philadelphia

DOBRUSHIN, DOROTHY L. 
5900 Baum Blvd., Pittsburgh 32

DOBSON, RUBY B. 
Box 89, Shady Aisle Hospital, Pittsburgh 6

DOCK, BESSIE 
Philadelphia General Hospital, Philadelphia 4

DOHERTY, MARGARET M. 
4907 Catherine St., Philadelphia 43

DONCEZ, MRS. BEATRICE H. 
St. Luke’s Hospital, Belsheim

DONOUGH, MARY J. 
Good Samaritan Hospital, Lebanon

DORN, MRS. RUTH 
1302 Highland Bldg., Pittsburgh 6

DOROTINSKY, ESTHER 
17 Summit Ave., Unionside

DORRELL, ELIZABETH M. 
7042 Greenwood Ave., Upper Darby

DOUGAN, MRS. MARION A. 
251 N. Craig St., Pittsburgh 13

DOUGHERTY, JANE 
Latrobe Hospital, Latrobe

DOUJE, MRS. ADELINE 
Bryn Mawr Hospital, Bryn Mawr

DOUT, EDITH A. 
Allentown Hospital, Allentown

DRUMM, CATHERINE E. 
Geisinger Memorial Hospital, Danville

DUFFY, HAZEL M. 
South Side Hospital, Pittsburgh 3

DUMM, MRS. MARY A. 
Box 601, Spangler

DUNMORE, MILDRED V. 
Veterans Administration Hospital, Pittsburgh 15

DUTTER, HANNAH E. 
10 W. Dorence St., Kingston

DYSON, ELEANOR B. 
1566 Duffield St., Pittsburgh 6

D’ZMURA, GABRIELLE 
4117 Lydia St., Pittsburgh 7

EAGLESON, EILEEN H. 
273 S. Wingfield Ave., Pittsburgh 24

EAKLE, MARY M. 
Seidersville Rd., R.F.D. 4, Bethlehem

EARLEY, MRS. EVELYN | 
Box C. Cherrytree

EBLE, MARTIN J. 
4401 Market St., Philadelphia 4

ECK, REGINA M. 
Veterans Administration Hospital, Butler

EDelman, MARIE A. 
Route 1, Nazareth

EDGAR, DOROTHY J. 
2629 Delancy St., Philadelphia 7

EDGAR, HELEN M. 
Philadelphia State Hospital, Box 6600, Philadelphia 14

EDGAR, RUTH L. 
214 Plymouth St., Allentown

EDMONDSON, MRS. AGNES S. 
520 New St., Allentown

EICHEL, ETHELYN L. 
Allentown Hospital, Allentown

EICHER, RUTH 
Eye & Ear Hospital, Pittsburgh 13

EISNER, MRS. ELIZABETH G. 
281 Western Ave., Aspinwall

EISSLER, MARION M. 
Sewickley Valley Hospital, Sewickley

EITEL, MATILDA 
102 Holmes Rd., Holmes

ELIOTT, MARY C. | 
Ligonier, New Florence

ELLIS, GERALDINE L. 
203 Tece Ave., Pittsburgh 2

568
EMBREY, MABEL  
Methodist Episcopal Hospital, Philadelphia 48

ENGLEBERT, LT. MARY F., N797494  
Station Hospital, U. S. Army, Ft. Eustis, Va.

ENGLISH, MRS. BEATRICE M.  
St. Luke's Hospital, Bethlehem

ENOS, SUZANNE E.  
Montgomery Hospital, Norristown

ERB, ALMA E.  
Veterans Administration Hospital, Montrose, N. Y.

ERBE, LILLIAN  
Hazleton State Hospital, Hazleton

ERDELEY, FLORENCE M.  
Episcopal Hospital, Philadelphia 25

ERICKSON, FLORENCE  
6109 Howe St., Pittsburgh 6

ERICKSON, GERTRUDE M.  
924 Wallace St., Erie

ERIKSON, MRS. EDITH M.  
Philadelphia General Hospital, Philadelphia 4

ERVING, MRS. MILDRED L.  
825 Miller St., Easton

ESHELEMAN, FANNIE  
Henry Phipps Institute, Philadelphia 7

EVANS, MRS. DOROTHY O.  
Williamsport Hospital, Williamsport

EVANS, G. WINIFRED  
Williamsport Hospital, Williamsport

EVERETT, MRS. EMILY B.  
3548 N. Broad St., Philadelphia 40

EWEN, MARARET A.  
Phoenixville Hospital, Phoenixville

EWING, RUTH E.  
Washington Hospital, Washington

FAFONE, ANGELINE T.  
325 N. Fourth St., Indiana

FAGAN, ANN T.  
328 N. Main St., Plains

FAGAN, MARGARET M.  
119 High St., Mauch Chunk

FAGLER, C. MARGARET  
Washington Hospital, Washington

FARRELL, MRS. ELIZABETH M.  
St. Luke's Hospital, Bethlehem

FAUST, ELEANOR S.  
R.F.D. 2, Middletown

FEAR, DOROTHY L.  
Moses Taylor Hospital, Scranton 10

FEINAUER, MARCELLA M.  
Children's Hospital, Pittsburgh 13

FERGUSON, MAUREEN C.  
223 W. Burgess St., Pittsburgh 14

FERRARO, ROSE G.  
4820 Interboro Ave., Philadelphia 7

FIGULSKI, GERTRUDE M.  
1609 Cedar St., Turtle Creek

FINDEISEN, ISADORA  
1233 Grenox Rd., Wynnewood

FISHER, ANNA M.  
6204 Fifth Ave., Pittsburgh 52

FLACK, MRS. JOSEPHINE D.  
Box 312, Republic

FLECKENSTEIN, AMELIA M.  
Montefiore Hospital, Pittsburgh 13

FLETCHER, CATHERINE S.  
Sunny Hill, Leesdale

FLINNER, EMMA K.  
Allegheny Valley Hospital, Tarentum

FLITTER, HESSEL H.  
7244 Guyer Ave., Philadelphia 42

FLOREK, ELIZABETH A.  
110 Virginia Ave., Pittsburgh 15

FLOWERS, ALICE F.  
Veterans Administration Hospital, Aspinwall 15

FORD, T. BLANCHE  
Friends Hospital, Philadelphia 24

FORSYTHE, MRS. FLORENCE M.  
314 Chalmey La., Sewickley

FRANCIS, SUSAN C.  
Chancellor Hall, 13 & Walnut St., Philadelphia 7

FRANZ, ANNETTE  
617 Hope St., Pittsburgh 20

FRANZEN, ALVENA D.  
Bradford Hospital, Bradford

FREY, LAVONNE M.  
3610 O'Hara St., Pittsburgh 13

FRIEDRICH, MRS. ELEANOR C.  
409 Peebles St., Wilkinsburg 25

FRIEND, MRS. HELEN D.  
Scranton State Hospital, Scranton 3

FROST, HARRIET  
The Fairfax, 439 Locust St., Philadelphia 4

FULLERTON, MRS. EDITH K.  
R.F.D. 1, Cochranville

FUREY, ELIZABETH M.  
Veterans Administration Hospital, Aspinwall 15

FUSAN, REGINA E.  
67 Prospect St., Pittsburgh 23

GALLO, GLORIA M.  
3800 Walnut St., Philadelphia 39

GALLO, JENNIE  
319 Hemlock St., Pittsburgh 12

CANS, ELIZA F.  
820 Jackman Ave., Pittsburgh 2

GARDNER, MARY E.  
Mercy Hospital, Wilkes-Barre

GARLAND, MRS. CATHERINE L.  
2 S. 19 St., Harrisburg

GARRECHT, CAPT. CLAIRE, N-76233B  
Officers Mail Unit, Sampson Air Force Base, Geneva, N. Y.

GARRISON, RUTH D.  
118 S. 46 St., Philadelphia 39

GASTON, MARGARET A.  
Veterans Administration Hospital, Aspinwall 15

GATES, ELIZABETH  
439 Windsor St., Reading

GATES, MRS. THOMAS S.†  
St. Martins & Gravers La., Chestnut Hill, Philadelphia 18

GAUKER, SUSAN  
Uniontown Hospital, Uniontown

GEBHARD, KATHARINE  
R.F.D. 6, Box 30, W. Newton Rd., Greensburg

GEITZ, ELAINE M.  
118 Warner St., Woodbury, N. J.

GEORGE, FRANCES L.  
University of Pittsburgh, Pittsburgh 13

GEROSKY, MARY  
4900 Friendship Ave., Pittsburgh 24

GERWIG, MABEL  
Leech Farm Hospital, Pittsburgh 6

GILBERT, DOROTHY R.  
55 Elizabeth St., Hartford, Conn.

GILL, MARGARET M.  
349 Taylor Ter., Chester

569
HART, FRANCES E.
Mt. Odin Heights, R.F.D. 6, Greensburg

HARTLEY, ANASTASIA M.
100 N. Chester Pike, Glenolden

HARTNETT, MARIE I.
Mont Alto, South Mountain

HARTZ, THERESA K.
5503 Germantown Ave., Philadelphia 44

HARVEY, IVY F.
714 Mill St., Tarentum

HARVEY, MRS. MILDRED
Nicktown

HAUSKNICHT, MABEL C.
Abington Memorial Hospital, Abington

HAWES, ETHEL P.
Loesch Farm Hospital, Pittsburgh 6

HAWTHORNE, HELEN R.
611 S. 43 St., Philadelphia 43

HAY, MRS. FLORENCE A.
6212 Howe St., Philadelphia 6

HEARN, LILLIAN K.
505 E. Pittsburgh St., Greensburg

HEATH, MRS. JEAN R.
539 Carley Ave., Sharon

HELFICH, ALICE K.
Allentown Hospital, Allentown

HELGER, JANE
St. Luke's Hospital, Bethlehem

HELMSTAEDTER, FLORA L., R.F.D. 1, Transfer

HENDRICKS, MRS. GERTRUDE F.
632 E. Gerhard St., Philadelphia 25

HENDRICKS, MARTHA L.
West Side Hospital, Scranton 4

HERRICK, BEATRICE L.
Children's Hospital, Pittsburgh

HERRINGTON, ALMA
Veterans Administration Hospital, Aspinwall 15

HESIDENCE, MRS. MARION R.
205 Onyx Ave., Pittsburgh 10

HESLOP, MRS. RITA D.
732 Ferndale Ave., Johnstown

HESS, MRS. HELEN E.
University of Pennsylvania, Philadelphia 4

HESS, MRS. MARY A.
St. Luke's Hospital, Bethlehem

HETKO, ETHEL M.
Veterans Administration Hospital, Lebanon

HEYDE, EDNA D.*
Greenville, Ill.

HILES, BETTY JANE
Remerdale, R.F.D. 1, Oakdale

HINCH, ALFRED M.
Box 88131, Aber Rd., R.F.D. 1, Verona

HOPFINGER, NELLIE
Grand View Hospital, Sellersville

HOPFERT, MAY S.
51 N. 39 St., Philadelphia 4

HOFFMAN, MARY
45 S. Main St., Ashley

HOFFMEISTER, MRS. GLADYS V.
St. Luke's Hospital, Bethlehem

HOFFMAN, MARY E.
East Valley Green Rd., Whitemarsh

HOLMOUST, EMILY W.
315 Melwood St., Pittsburgh 13

HORAN, ANNA M.
6620 Paschall Ave., Philadelphia 42
LEWIS, MRS. ELOISE R.  
3913 Walnut St., Philadelphia 4

LIGGETT, LUCY J.  
529 S. Franklin St., Wilkes-Barre

LINDBERG, RUTH E.  
339 S. Juniper St., Philadelphia 7

LINDEN, MRS. MARJORIE C.  
712 Chestnut Ave., Barnesboro

LINK, MARCELLA M.  
St. Francis Hospital, Pittsburgh

LINTON, JANE E.  
51 N. 39 St., Philadelphia 4

LIOTTA, ANNA  
218 E. Summit St., Norristown

LITTLE, MRS. MARY S.  
9 Huber St., Glenside

LOBAS, HELEN  
111 Mt. Lebanon Blvd., Pittsburgh 28

LOCKE, GOLarie I.  
619 Ridge Ave., Sharpsville

LOCKWOOD, ANNA M.  
St. Joseph’s Hospital, Philadelphia 30

LOEB, MRS. HOWARD A.†  
Elkins Park, Philadelphia 17

LOFTUS, NELLIE G.  
Kirby Health Center, Wilkes-Barre

LOGAN, MARGARET†  
135 S. 18 St., Philadelphia 3

LOH, MARGARET  
Allona General Hospital, Altoona

LONG, ALTON F.  
Harrisburg State Hospital, Harrisburg

LOUGIK, ZDENKA  
2700 Louisiana Ave., Pittsburgh 16

LOUGHMAN, EVALYN C.  
395 Donnan Ave., Washington

LOVELAND, FLORENCE  
132 Ashby Rd., Upper Darby

LOWE, VIRGINIA P.  
Wyoming Valley Hospital, Wilkes-Barre

LOZZARINE, CHRISTINE  
Germantown Hospital, Philadelphia 44

LUBARSKY, ROCHELLE L.  
5653 Columbo St., Philadelphia 6

LUDWIG, HAZEL A.  
Allegeny Valley Hospital, Tarentum

LUKENS, HELEN W.  
818 13 Ave., Prospect Park

LUNARIN, EDITH  
2259 Spokane Ave., Pittsburgh 10

LUSHER, MRS. BERYL W.  
Philadelphia General Hospital, Philadelphia 4

LUTTON, MRS. MARY J.  
715 Brookline Blvd., Pittsburgh 26

LUTZ, MARGARET S.  
2209 S. Fulton St., Philadelphia 42

LYNCH, THERESA L.*  
University of Pennsylvania, Dept. of Nursing Education, Philadelphia 4

LYTLE, NANCY A.  
701 Filbert St., Pittsburgh 32

MACHLAN, IRIS A.  
251 S. 44 St., Philadelphia 4

MACIAG, HELEN  
376 E. Hector St., Conshohocken

MACKENZIE, C. CATHERINE  
746 Tuckerton Ave., Temple

MacLAUGHLIN, DOROTHY R.  
819 Glen Ter., Chester
NELSON, CATHERINE L.  
1310 Van Buren St., Allentown
NETZEL, EMMA C.  
Nesbitt Memorial Hospital, Kingston
NEWTON, MILDRED B.  
Episcopal Hospital, Philadelphia 25
NEY, ANNA M.  
528 N. Lime St., Lancaster
NISLEY, ELIZABETH  
Allona Hospital, Altoona
NOHRS, DOROTHY A.  
Philadelphia State Hospital, Philadelphia 14
NOWAKOWSKI, AURELIE J.  
2005 Carson St., Pittsburgh 3
NYE, MRS. EMMA A.  
325 N. George St., Millersville
O'BRIEN, MYRA E.  
5219 Center Ave., Pittsburgh 6
OGLESBY, MILDRED  
Chester Hospital, Chester
OKAL, ANNE  
Allentown Hospital, Allentown
OLIVER, EMILY C.  
704 Locust Ave., Philadelphia 44
OLIVER, MARY C.  
107 Meadowcroft Ave., Mt. Lebanon 16
O'NEILL, CECILIA E.  
St. Francis Hospital, Pittsburgh 1
O'REOURKE, MRS. MARGARET B.  
3320 Angora Ter., Philadelphia 43
ORTH, LILY E.  
Conemaugh Valley Hospital, Johnstown
OSHEKA, MRS. LORRAINE M.  
1010 Madison Ave., Pittsburgh
OSTROW, SADIE  
1450 N. Franklin St., Philadelphia 22
OTT, MRS. HELEN M.  
3603 N. Broad St., Philadelphia 40
OUTRID, FLORENCE E.  
615 East St., Warren
PAINE, MRS. ESTHER W.  
226 W. Seymour St., Philadelphia 44
PAINTER, RUBY H.  
1500 Fifth Ave., McKeesport
PANIGAL, MARY M.  
Latrobe Hospital, Latrobe
PAPPENFUSS, GRACE M.  
Veterans Administration Hospital, Aspinwall 15
PARKER, MRS. DOROTHY P.  
Apt. 3, Amherst Garden, 4 Bayard Rd., Pittsburgh 13
PARRISH, LOLA C.  
Nesbitt Memorial Hospital, Kingston
PARRY, MRS. CHASTINA A.  
202 Lee Circle, Bryn Mawr
PARTRIDGE, MRS. CAROLYN H.  
Scranton State Hospital, Scranton
PASTOR, MRS. ESTHER S.  
514 Woodland Ave., Cheltenham
PAVLICK, S. MARY  
4628 Bayard St., Pittsburgh 13
PAYNE, AUGUSTA L.  
Methodist Episcopal Hospital, Philadelphia 48
PAYNE, EDITH D.  
5565 Wellesley Ave., Pittsburgh 6
PEARS, LAURA S.  
6118 Gallery St., Pittsburgh
PECORA, EDYTHE A.  
2931 Perryville Ave., Pittsburgh 14
PEELER, MARGARET C.
5800 Ridge Ave., Philadelphia 28

PENSAK, MATILDA P.
Philadelphia General Hospital, Philadelphia 4

PERROTTA, JOSEPHINE M.
417 E. Lutton St., New Castle

PERRY, MARY A.
3345 N. Howard St., Philadelphia

PERUNKA, PAULINE
1720 Bainbridge St., Philadelphia 46

PETOK, MARY L.
Box 8, Wildwood

PETRAITS, MARTHA C.
25716 Ave., Homestead

PETRUSAK, STELLA
546 Jefferson Ave., Jermyn

PHILLIPS, OHA K.
Allentown Hospital, Allentown

PHY, KATHRYN
4521 N. 20 St., Philadelphia 40

PIDICK, MINERVA
511 River St., Scranton

PIERSOL, ELIZABETH
1612 Spruce St., Philadelphia 7

PIETRO, ELEANOR R.
Philadelphia General Hospital, Philadelphia 4

PIRSCENOK, ANNA A.
1438 E. Fifth St., Bethlehem

PIVARNIK, ANNA E.
172 Oakland Ave., Uniontown

PLUMACHER, MRS. KATHARINE M.
5293g Rural Ave., Williamsport

POIAROFF, MARY
305 Third St. W., Aliquippa

PONAS, MRS. MOVENE L.
716 Barclay St., Johnstown

POPOVICH, DOROTHY
327 Baker St., Johnstown

POSWISTILIO, MARIAN
1309 Lansdowne Ave., Darby

PRASATEK, GENEVIEVE D.
807 Spruce St., Philadelphia 7

PRATT, ANNA C.
8 N. State St., Box 103, North Warren

PREVOST, MABEL C.
5631 Chew St., Philadelphia 38

PROWELL, MYRA R.
Harrisburg Hospital, Harrisburg

 Pryce, Doris E.
5013 Schuyler St., Philadelphia 44

PUETT, MARTHA
2233 Adams St., Natoma Heights

PURDY, FRANCES L.
Elisworth Center, University of Pittsburgh, Pittsburgh 11

PUTT, ARLENE M.
1429 W. Erie Ave., Philadelphia 40

RANCK, DOROTHY B.
1012 Spruce St., Philadelphia 7

RAPPE, JOAN C.
2419 Maple Ave., Pittsburgh 14

RAU, MILDRED B.
Newitt Memorial Hospital, Kingston

RAWE, VIOLA
Philipsburg State Hospital, Philipsburg

RAYMOND, MRS. CLARA L.
612 Taylor Way, Pittsburgh 21

REACAN, MARY E.
Chester Hospital, Chester

REATH, MRS. B. BRANNAN
711 S. Highland Ave., Merion

REICHEGRT, WILHELMINE
Montgomery County Hospital, Norristown

REID, MRS. NELLIE J.
804 Delafield Rd., Aspinwall 15

REYNOUR, JEAN M.
Presbyterian Hospital, Philadelphia 4

REINHART, SARAH
Wilson College, Chambersburg

REISNER, MRS. BETTY C.
109 N. 13 St., Allentown

REITER, MARGUERITE
224 N. 17 St., Allentown

REND, ENIS C.
Scranton State Hospital, Scranton 10

RENDINE, THERESA M.
411 W. Pike St., Canonsburg

RENVERS, MARIE
125 Binsmore Ave., Pittsburgh 5

REPLOGLE, EMMA
433 Park Ave., New Castle

RETZLER, CATHERINE M.
St. Joseph's Hospital, Reading

REUSS, LT. ELISE H., ANC, N505035
Delano Hall, Army Medical Center, Washington 12, D. C.

REYNOLDS, CHARLOTTE B.
245 N. 13 St., Philadelphia 2

RHODES, JEANNETTE
Chester Hospital, Chester

RICHARD, EMMA B.
4522 Walnut St., Philadelphia 4

RICHARDS, DOROTHY M.
51 N. 39 St., Philadelphia 4

RICHARDS, JEAN F.
Veterans Administration Hospital, Butler

RICHARDSON, E. MARGUERITE
R.F.D. 3, Langhorne

RIDINGER, MRS. ESTHER
513 Tenth St., Irvin

RIGG, MRS. ELSE P.
320 Pennsylvania Ave., E., Warren

RIESSER, MARY S.
3911 Walnut St., Philadelphia 4

RINELL, EDITH J.
1720 Bainbridge St., Philadelphia 46

RINGAWA, JULIE B.
Jewish Hospital, Philadelphia

ROACH, MRS. ELEANOR M.
1476 Keefer Ave., Pittsburgh 5

ROBBINS, ARTEMIS G.
500 City Line Ave., Philadelphia 31

ROBERTS, ELIZABETH L.
15 High St., Moorestown, N. J.

ROBERTSON, MYRTLE M.
Allegheny Valley Hospital, Tarentum

ROBERTSON, VERA C.
Sewickley Valley Hospital, Sewickley

ROCHE, PATRICIA A.
228 Chestnut St., Sewickley

ROGERS, MARGORIE E.
Box 191, Russell

ROOD, DR. DOROTHY
2000 Cathedral of Learning, Pittsburgh 13

ROTE, MRS. RUBY E.
311 California Ave., Avalon 2

ROTHROCK, ELEANOR C.
320 S. 34 St., Philadelphia 4

575
ROTHROCK, MARY A.
Dept. of Public Instruction, Harrisburg

ROWAN, KATHLEEN
Bryn Mawr Hospital, Bryn Mawr

ROWE, HAROLD R.
7244 Gayer St., Philadelphia 42

ROWSE, EUNICE D.
70 E. Wheeling St., Washington

RUSSELL, ETHEL M.
31 N. Emily St., Crafton 5

RUTH, VERA P.
Woman's Hospital, Philadelphia 4

SACHS, ELIZABETH J.
Municipal Hospital, Pittsburgh 33

SAMAS, ANNA L.
4315 Baltimore Ave., Philadelphia 43

Sammul, MRS. H. PHYLLIS
30 Packard Ave., Greenville

SANTILLO, HELEN M.
Homestead Hospital, Homestead

SARICKS, MRS. EVELYN S.
St. Luke's Hospital, Bethlehem

SARSFIELD, KATHERINE V.
2974 Elder St., Pittsburgh 32

Savage, LOUISE
5320 Centre Ave., Pittsburgh 6

SAVILLE, JUDITH
Palmer Hospital, Palmerston

ScaRSELLATO, FLORENCE
312 Eucid Ave., Canonsburg

SCHEPARTZ, MRS. IRENE F.
5700 Ellsworth Ave., Pittsburgh 32

Scheuer, MATHILDA
Lentex Apts., Apt. 7-A, Philadelphia 7

Schina, YOLANDA
2112 S. 16 St., Philadelphia 45

Schmalbach, MRS. HILDA O.
1300 W. Sterigere St., Norristown

Schray, VERONA M.
33 S. Tenth St., Allentown

SCHRECK, MARIAN E.*
Philadelphia Hospital for Contagious Diseases, Philadelphia 40

SCHREFFLER, F. PAULINE
4341 Spruce St., Philadelphia 4

SCHROCK, KATHERINE M.
Wilkes-Barre General Hospital, Wilkes-Barre

Schutt, BARBARA C.
2724 Green St., Harrisburg

Schwalm, Verna I.
4240 Onge Ave., Philadelphia 4

Schweitzer, ARLENE D.
140 W. 24 St., Erie

SCHWENK, MERTIE B.
R.F.D. 3, Pottstown

Scott, EDNA W.
444 Old Lancaster Rd., Haverford

Scott, JESSIE M.
4107 Chester Ave., Apt. 2-D, Philadelphia 4

Scott, MRS. SHEILA M.
5852 Brush Rd., Philadelphia 38

Sculiffe, PATRICIA
423 Second St., Braddock

Sechriest, MRS. LOIS E.
Lancaster General Hospital, Lancaster

Seidel, ELEANORA S.
340 Henry St., Brooklyn 2, N. Y.

SETZLER, LORRAINE
Box 845, Paoli

SHaffer, MRS. FLORENCE F.
Ogontz Manor Apts., F-11, 5600 Ogontz Ave., Philadelphia 41

SHARPLESS, MARGARET I.
George F. Geisinger Memorial Hospital, Danville

Shaw, LOUISE V.
707-14 Ave., Munhall

Shay, Ethel A.
Box 44, Neffs, Lehigh County

SHELLENBERGER, MILDRED H.
Presbyterian Hospital, Philadelphia 4

Shelly, MRS. DOROTHY G.
16 Sanford Ave., Belleville 9, N. J.

Shepos, MARIE A.
1024 Bank St., Bridgeville

Sherman, DOHIS A.
Montefiore Hospital, Pittsburgh 13

Sherrick, ELLEN
5437 Ellsworth Ave., Pittsburgh 6

Shields, ALLETA
2600 N. Lawrence St., Philadelphia 33

Shields, LT. EVELYN B.
19 Alfred St., Pittsburgh 16

Shields, THERESA E.
200 E. Logan St., Bellefonte

Ship, ESTHER L.
Chester Hospital, Chester

Shira, ADA A.
183 E. Bissell Ave., Oil City

Sholly, ESTHER M.
Philadelphia State Hospital, Philadelphia 14

Shultz, CLARICE
Municipal Hospital, Pittsburgh 13

SHUMYLA, ANNE
4900 Friendship Ave., Pittsburgh 24

Siebers, GRACE A.
1720 Bainbridge St., Philadelphia 46

Siedle, MRS. ANNA B.
260 Woodhaven Dr., Pittsburgh 16

Siewers, FLORENCE
Bradford Hospital, Bradford

Silfies, MRS. JEANETTE K.
925 N. Seventh St., Allentown

Sims, ANNA M.
Veterans Administration Hospital, Coatesville

Sister Amelia
Lankenau Hospital, Philadelphia 30

Sister ANN ELIZABETH
St. Joseph’s Hospital, Philadelphia

Sister Anna Marie
Mercy Hospital, Johnstown

Sister Cor MARIE
St. Joseph’s Hospital, Carbondale

Sister Eileen Marie
476 Pine St., Meadville

Sister E. LOUISE BURROUGHS
2100 S. College Ave., Philadelphia 30

Sister HELEN CLAIRE
St. Vincent's Hospital, Erie

Sister HELEN M. FURMAN
2100 S. College Ave., Philadelphia 30

Sister Irma
St. Mary’s Hospital, Scranton

Sister T. LOIS
2100 S. College Ave., Philadelphia 30

Sister Lawrence Mary
New Castle Hospital, New Castle

Sister Madonna
St. Joseph’s Hospital, Reading

576
SISTER MARGARET ALACOQUE
St. Mary's Hospital, Philadelphia 25

SISTER MARIANA BAUER
St. Francis Hospital, Pittsburgh 1

SISTER MARIE ALICIA
St. Vincent's Hospital, Erie

SISTER MARIE CLAIRE
420 Sassafras St., Erie

SISTER MARIE ELISE
Mercy Hospital, Scranton 10

SISTER MARIE EYMAND
Penceer Hospital, Meadville

SISTER MARIE HELEN
90 Adams Ave., Scranton

SISTER MARIE ADRIAN
Fitzgerald-Mercy Hospital, Philadelphia 43

SISTER M. AGNES ANGELA
700 S. Broad St., Philadelphia 45

SISTER MARY ALACOQUE
Matericordia Hospital, Dallas

SISTER MARY ALBERT
420 Sassafras St., Erie

SISTER MARY ALBINA
St. Joseph's Hospital, Reading

SISTER M. ALMA
Matericordia Hospital, Philadelphia 43

SISTER M. ALOYISIA
1900 S. Broad St., Philadelphia 45

SISTER M. AMADEUS
St. Joseph's Hospital, Pittsburgh 21

SISTER M. ANASTASIA
Penceer Hospital, Meadville

SISTER MARY ANDREW
Penceer Hospital, Meadville

SISTER MARY ANICETA
St. Francis Hospital, Pittsburgh 1

SISTER MARY ANSELM
Mercy Hospital, Wilkes-Barre

SISTER M. ANTONETTE
Sacred Heart Hospital, Allentown

SISTER MARY ARTHUR
Penceer Hospital, Meadville

SISTER M. BAPTISTA
St. Joseph's General Hospital, Pittsburgh 12

SISTER MARY BERNARDITA
St. Joseph's Hospital, Reading

SISTER MARY BERTIN
St. Francis Hospital, Pittsburgh 1

SISTER MARY BLANCHE
1601 Eighth Ave., Altoona

SISTER M. BONIFACE
Mercy Hospital, Pittsburgh 19

SISTER MARY BOYLE
St. Vincent's Hospital, Erie

SISTER MARY CARLOTTA
Mercy Hospital, Pittsburgh 19

SISTER M. CAROLINE
4420 Sassafras St., Erie

SISTER M. CATHERINE
St. Mary's Hospital, Philadelphia 25

SISTER M. CLARE THERESIA
St. Joseph's Hospital, Reading

SISTER M. CLEMENTINE
Braddock General Hospital, Braddock

SISTER M. CLEMENTINE
Mercy Hospital, Scranton 10

SISTER MARY CONCILITA
St. Mary's Hospital, Philadelphia 25

SISTER MARY CRESCENTIA
Mercy Hospital, Wilkes-Barre

SISTER M. DAGIA
Sacred Heart Hospital, Allentown

SISTER M. DANIEL
Providence Hospital, Beaver Falls

SISTER MARY de CHANTAL
Mercy Hospital, Johnstown

SISTER M. eloURODES
St. Joseph's Hospital, Carbondale

SISTER MARY DOMINIC
St. Joseph's Hospital, Reading

SISTER M. DOROTHY
Mercy Hospital, Pittsburgh 19

SISTER M. DYMPLA
St. Joseph's Hospital, Pittsburgh 3

SISTER MARY EDITH
Ohio Valley Hospital, McKees Rocks

SISTER M. FELICITAS
3335 McClure Ave., Pittsburgh 12

SISTER M. FENTON
Matericordia Hospital, Philadelphia 43

SISTER MARY FRANCIS
Mercy Hospital, Wilkes-Barre

SISTER M. FRANCIS DOLOROSA
St. Mary's Hospital, Philadelphia 25

SISTER M. FRANCIS XAVIER
3335 Fifth Ave., Pittsburgh 13

SISTER M. GILBERT
St. Joseph's Hospital, Carbondale

SISTER M. HELEN ELIZABETH
St. Joseph's Hospital, Reading

SISTER M. HELEN MARGUERITE
St. Joseph's Hospital, Lancaster

SISTER M. INCARNATA
St. Joseph's Hospital, Carbondale

SISTER M. INEZ
Mercy Hospital, Pittsburgh 19

SISTER MARY INEZ
Fitzgerald-Mercy Hospital, Darby

SISTER M. JOHN
Mercy Hospital, Wilkes-Barre

SISTER M. JOELLA
St. Joseph's Hospital, Reading

SISTER MARY JOHN JOSEPH
1020 Franklin St., Johnstown

SISTER MARY KATERI
Mercy Hospital, Wilkes-Barre

SISTER M. KATHLEEN
2117 Carson St., Pittsburgh 5

SISTER M. LEONA
Fitzgerald-Mercy Hospital, Darby

SISTER M. LOYOLA
Mercy Hospital, Pittsburgh 19

SISTER M. LUCIDIA
Sacred Heart Hospital, Allentown

SISTER MARY LUCY
St. John's General Hospital, Pittsburgh 12

SISTER M. MARCELLA
St. John's General Hospital, Pittsburgh 12

SISTER MARY MARGARET
St. Joseph's Hospital, Philadelphia 30

SISTER MARY MARGARET AGNES
St. Mary's Hospital, Philadelphia 25

SISTER MARY MARTINA
Mercy Hospital, Scranton 10

SISTER M. MAUREEN
1900 S. Broad St., Philadelphia 45

577
SISTER M. MAURICE  
Braddock General Hospital, Braddock

SISTER M. MICHAEL  
Misericordia Hospital, Philadelphia 43

SISTER M. MONICA  
Misericordia Hospital, Philadelphia 43

SISTER M. MONICA  
St. John’s General Hospital, Pittsburgh 12

SISTER M. NARCISE  
Spencer Hospital, Meadville

SISTER MARY NATALIE  
St. Mary’s Hospital, Scranton

SISTER MARY PHILIP  
St. Francis Hospital, Pittsburgh 1

SISTER M. PLAGIDE  
Mercy Hospital, Pittsburgh 19

SISTER M. REBECCA  
St. Mary’s Hospital, Scranton

SISTER M. REBECCA  
St. Vincent’s Hospital, Erie

SISTER M. RITA CARMEL  
St. Joseph’s Hospital, Lancaster

SISTER M. RITA DOLORES  
Misericordia Hospital, Philadelphia 43

SISTER M. ROBERT  
Mercy Hospital, Wilkes-Barre

SISTER M. ROSALITA  
Spencer Hospital, Meadville

SISTER M. ROSEMOND  
St. Francis Hospital, Pittsburgh 1

SISTER MARY THELMA  
Providance Hospital, Beaver Falls

SISTER M. WILLEMENE  
Braddock General Hospital, Braddock

SISTER MIRIAM FRANCIS  
Pittsburgh Hospital, Pittsburgh 6

SISTER MIRIAM J. OKUM  
Lankenau Hospital, Philadelphia 30

SISTER PAUL GABRIEL  
Pittsburgh Hospital, Pittsburgh 6

SISTER ROSE EVELYN  
2420 Sassafras St., Erie

SISTER ROSE MARY  
New Castle Hospital, New Castle

SISTER SUZANNE MARIE  
1215 Walnut St., Reading

SISTER VIRGINIA MARY  
St. Francis Hospital, Pittsburgh 1

SKINNER, MRS. ELEANOR O.†  
116 W. Mermaid La., Philadelphia 18

SKOFF, ANNE U.  
Route 1, Oakdale

SMITH, DOROTHY J.  
State Hospital, Philadelphia

SMITH, EILEEN C.  
703 Stanton St., Greensburg

SMITH, ESTHER P.  
270 Welsh Ave., Wilmerding

SMITH, ETHEL R.  
Temple University Hospital, Philadelphia 40

SMITH, EUNICE E.  
St. Luke’s Hospital, Bethlehem

SMITH, HELEN M.  
Allentown State Hospital, Allentown

SMITH, JOHN H., JR.  
4716 Chestnut St., Philadelphia 39

SMITH, LOUISE C.  
104 Kenmore Rd., Upper Darby

SMITH, MRS. MARIE H.  
1152 Howertown Rd., Catawauqua

SMITH, NINA A.  
Robert Packer Hospital, Sayre

SMOGORZEWSKI, MRS. MARY B.  
1029 Oley St., Reading

SNYDER, LILLIAN E.  
930 N. 19 St., Allentown

SNYDER, LOUISE M.  
Riverview Manor, Apt. 6, Harrisburg

SNYDER, MARGARET  
George F. Geisinger Hospital, Danville

SOWER, SARAH R.  
220 Broad St., Spring City

SPAHR, PHYLLIS M.  
Philadelphia General Hospital, Philadelphia 4

SPALLA, MARY L.  
213 Bon Air Ave., Pittsburgh 10

SPARE, MARY E.  
325 N. Front St., Harrisburg

SPENGLER, JOSEPHINE C.  
508 S. 41 St., Philadelphia 4

STACHNIEWICZ, STEPHANIE A.  
2593 E. Eckhart St., Philadelphia 34

STAHL, JEAN M.  
Mercy Taylor Hospital, Scranton 10

STARKEY, ESTHER E.  
Episcopal Hospital, Philadelphia 25

STAUB, MARTHA  
322 Second St., Pittsburgh 15

STAUFFER, MARY J.  
5323 Magnolii St., Philadelphia 44

STEAD, DOROTHY  
7710 Cheswade Ave., Philadelphia 42

STEELER, MARGARET S.  
708 Grove Ave., Johnstown

STEIN, LOIS  
317 S. Camac St., Philadelphia 7

STEINBERG, MRS. SARAH W.  
5415 Fifth Ave., Pittsburgh 32

STELTZER, MRS. BLANCHE  
West Monterey

STEWART, JANE R.  
3356 Park Ave., Philadelphia 40

STEWART, MARY L.  
2851 Bedford Ave., Pittsburgh 19

STEWART, RUTH E.  
Indiana Hospital, Indiana

STICKEL, MRS. ALMA J.  
Box 14, Manor

STINE, SARAH S.  
2025 Eater Ave., Easton

STINELY, MARY A.  
1018 Backnell Ave., Johnstown

STOKES, MRS. J. STODDELL†  
Box 182, Bryn Mawr

STOLP, HILDA  
2681 Oakland Ave., Pittsburgh 13

STONER, BESSE V.  
1151 S. 20 St., Pittsburgh 3

STRANG, MARGARET G.  
Homestead Hospital, Homestead

STRAUSS, MRS. MARY F.  
St. Luke’s Hospital, Bethlehem

STRAUSSER, MRS. CHARLOTTE K.  
Germanstown Dispensary & Hospital, Philadelphia 44

SUGA, BEN T.  
4401 Market St., Philadelphia 4
MEMBERS

SUMMERS, MARGARET
1012 Spruce St., Philadelphia 7

SUMMERVILLE, AGNES E.
264 S. Winfield, Pittsburgh 24

SUNDAY, HELEN M.
1506 E. Philadelphia St., York

SWARTZ, MRS. BEYA L.
340 Grant Ave., Pittsburgh 13

SWEENEY, ELIZABETH J.
932 Hartel Ave., Philadelphia 11

TADOWSKY, HELENE I.
Veterans Administration Hospital, Butler

TALBOT, MRS. EMILY H.
2123 Cypress St., Philadelphia 3

TALMADGE, JULIA
4634 Spruce St., Philadelphia 4

TAMES, ELIZABETH E.
2610 Mahon St., Pittsburgh 19

TANCHER, PATRICIA A.
Children’s Hospital, Philadelphia 16

TAYLOR, MRS. ETHEL L.
4929 Walnut St., Philadelphia 4

TAYLOR, HAZEL E.
469 E. Washington St., New Castle

TAYLOR, MARY E.
1609 W. Cheltenham Ave., Philadelphia 26

TEELEY, FRANCES M.
53 St. Nicholas, Mahoning City

THOMA, ANNAMARIE B.
304 E. 29 St., New York 3, N. Y.

THOMAS, EDITH R.
Sewickley Valley Hospital, Sewickley

THOMAS, GWLADYS
Hahnemann Hospital, Scranton

THOMPSON, IRENE M.
Leech Farm Hospital, Pittsburgh 6

TILLOTSON, BONNIE R.
Hamot Hospital, Erie

TINKEY, MRS. JEANNE A.
500 Beechwood Ave., Carnegie

TOGASAKI, YAYE
Veterans Administration Hospital, Coatesville

TOLAND, MRS. AUGUSTINE V.
Church Rd., Whitemarsh

TORPER, CLAUDINE
St. Joseph’s Hospital, Lancaster

TORGANCE, JANE
4623 Bayard St., Pittsburgh 13

TRESCOTT, MRS. MARGARET W.
Esyp

TRIMBLE, JANE
St. Luke’s Hospital, Bethlehem

TROPPMAN, ELLEN
1401 Chelton Ave., Pittsburgh 26

TROUTMAN, ELIZABETH V.
4918 Walton Ave., Philadelphia 43

TSCHERU, AMELIA
1122 Barbara Ave., Duquesne

TUCKER, PEARL E.
The Harrisburg Polyclinic Hospital, Harrisburg

TURNER, SALLY
Arnciffe, Apt. 3, Bryn Mawr

UHLE, MRS. CHARLES A.
E. Valley Green Rd., Whitemarsh

ULSHAFER, MRS. KATHARINE M.
Philadelphia General Hospital, Philadelphia 4

URFFER, ALMA M.
Allentown Hospital, Allentown

URQUHART, JESSIE G.
Streetville Rd., R.R. 1, Streetville, Ontario, Canada

VACENDAK, MRS. MARTHA P.
627 Tenth Ave., Bethlehem

VANDER KAM, MRS. MARGARET H.
603 Kirtland St., Pittsburgh 8

VAN KIRK, ANNA S.
Harristown State Hospital, Harrisburg

VAN SICKEL, MILDRED
Norristown State Hospital, Norristown

VARION, DOROTHEA M.
3015 Chestnut St., Philadelphia 4

VENCLL, MRS. A. L.
572 Briar Cliff Rd., Pittsburgh 21

VENCER, MARY J.
Uniontown Hospital, Uniontown

VESCHIO, ISABEL M.
Irvin

VOLKAR, ANNA M.
1321 Union St., Allentown

VOGEL, JOSEPHINE A.
227 Grant St., Pittsburgh 9

VOITILA, TERESA
Veterans Administration Hospital, Aspinwall 15

VOYTKO, MRS. FRANCES R.
Miners Hospital of Northern Cambria, Spangler

VYRONA, VERA
121 S. 16 St., Allentown

WAGNER, VERA N.
Frankford Hospital, Philadelphia 24

WALDER, MARGERITE J.
17 Welles St., forty Fort, Luzerne County

WALKER, ANNA G.
531 Sycamore Ave., Merion Station

WALKINSHAW, DOROTHY A.
3601 Walnut St., Philadelphia

WALL, MRS. JENNIE O.
R.F.D. 4, Allentown

WALTER, GLENN C.
Hotel Webster Hall, Pittsburgh 13

WANAMAKER, MRS. EVELYN S.
221 S. Main St., Sharon

WARDROP, ANNA I.
32 W. Fifth St., Mt. Carmel

WARGO, SUSAN
130 S. First St., Duquesne

WEEKS, MRS. CATHERINE P.
316 Collfax Ave., Scranton 10

WEILER, JOAN
401 Conewango Ave., Warren

WEIRICH, MRS. JEAN B.
629 N. Duke St., Lancaster

WELD, ALICE M.
Moses Taylor Hospital, Scranton 10

WELSH, ELIZABETH A.
144 Duffield St., Pittsburgh

WENK, ELIZABETH F.
Ashland State Hospital, Ashland

WENRICH, MARIAN
159 Hill Rd., Wernersville

WERNER, ELFRIEDA H.
1220 Washington Ave., Monaca

WESTON, MARIAN L.
Ogontz Manor Apts., 5600 Ogontz Ave., Philadelphia 41

WETHERBEE, ETHEL H.
Lock Haven Hospital, Lock Haven

579
WETZEL, ELEANOR M.  
St. Luke's Hospital, Bethlehem

WEYEL, JEANNETTE A.  
306 Beulah Rd., Pittsburgh 35

WHITBECK, HELEN M.  
Harrisburg State Hospital, Harrisburg

WHITE, KATHRYN R.  
Veterans Administration Hospital, Wilkes-Barre

WHITE, MRS. LIDA S.  
177 E. Bissell Ave., Oil City

WHITE, RENA L.  
Temple University Hospital, Philadelphia 40

WHITE, MRS. THOS. RAEBURN*†  
1807 D Lancye Pl., Philadelphia 3

WHITEHEAD, MRS. STELLA R.  
214 S. Fourth St., Youngwood

WHITTAKER, MRS. ELIZABETH E.  
York Hospital, York

WILDONGER, FRANCES  
200 E. Broad St., Scranton

WILHELM, MARY E.  
Veterans Administration Hospital, Pittsburgh 15

WILKINS, MRS. GLADYS N.  
4028 Bayard St., Apt. 415, Pittsburgh 13

WILLETS, LILLIAN E.  
553 S. Negley Ave., Pittsburgh 6

WILLIAMS, ARMEDA J.  
Box 915, Mt. Pleasant, Scottsdale

WILLIAMS, ELENOR A.  
230 Dunshee St., Pittsburgh 13

WILLIAMS, MRS. FRANCES H.  
1546 Franklin Ave., Franklin

WILLIAMS, MARY E.  
4629 Bayard St., Pittsburgh 13

WILSON, ALBERTA B.  
5620 Fifth Ave., B-16, Pittsburgh 32

WILSON, LETITIA  
4101 Market St., Philadelphia 4

WOELFEL, ARCOLA M.  
Montgomery Hospital, Norristown

WOLCOTT, MARY L.†  
518 Grove, Sewickley

WOLFE, MRS. CAROLINE A.  
1416-B Derry St., Harrisburg

WOLFE, MRS. DORIS S.  
1731 Chew St., Allentown

WOLFF, ELIZABETH L.  
3602 Fifth Ave., Pittsburgh 13

WOLFGANG, ANNA M.  
7117 Gillespie St., Philadelphia 35

WOOD, MRS. ISABELLA B.  
William Penn Hotel, Harrisburg

WOODRING, VIRGINIA E.  
St. Luke's Hospital, Bethlehem

WRAY, ANNA C.  
210 Cumberland St., Harrisburg

WRIGHT, MARGARET M.  
Veterans Administration Hospital, Coatesville

WRZESKINSKI, MRS. FRANCES  
7211 Erdrick St., Philadelphia 35

WUNDERLY, MARY A.  
Meadeville City Hospital, Meadeville

YAGER, ELIZABETH A.  
Pennsylvania Hospital, Philadelphia 7

YARNICK, DOROTHY S.  
909 Franklin St., Johnstown

YINGST, EDITH E.  
Woman's Hospital, Philadelphia

YOCUM, MRS. IRMA S.  
St. Luke's Hospital, Bethlehem

YODER, MARY A.  
Moses Taylor Hospital, Scranton 10

YORI, NATALIE P.  
Hazleton State Hospital, Hazleton

YOUDEN, JANE E.  
4730 Ferryville Rd., Pittsburgh 29

YOUNG, HARRIET F.  
Visiting Nurse Assn., Wilkes-Barre

YOUNG, MARIAN  
4625 Woodland Ave., Drexel Hill

YOUNKEN, MARY M.  
St. Luke's Hospital, Bethlehem

YOUNT, DOROTHY J.  
240 W. Penn St., Butler

YOWLEH, GRACE E.  
Harrisburg State Hospital, Harrisburg

ZAGULA, WANDA E.  
Eye & Ear Hospital, Pittsburgh 13

ZAHOBSKY, FRANCES  
4900 Friendship Ave., Pittsburgh 24

ZAKUTNY, BERNARDE T.  
522 N. Fourth St., Allentown

ZAVONIA, MARTHA C.  
230 Lotthrop St., Pittsburgh 13

ZENN, BERTHA K.  
Shadyside Hospital, Pittsburgh 32

ZETTER, EVELYN  
234 Melwood Ave., Pittsburgh

ZIEGLER, ELSIE T.  
Philadelphia General Hospital, Philadelphia 1

ZIEMKE, DOROTHY E.  
1933 Antietam St., Pittsburgh 6

ZIMMERMAN, MRS. JANET M.  
1497 Highland Rd., Sharon

ZUMWINKLE, JEANNE  
3117 Pine St., Philadelphia 4

ZUBROWSKA, MARY W.  
1516 Lutetne St., Scranton 4

---

AMARAL, JOSEFINA F.  
San Patricio Hospital V.A., San Juan

APONTE, ELENA  
St. Luke's Memorial Hospital, Ponce

APONTE, IGNACIA M.  
School of Tropical Medicine, San Juan

APONTE DE ROSARIO, MRS. MAXIMINA  
Federico Garcia St. 205, Fajardo

BESOSA, AGUSTINA B.  
Clínica Dr. Pila, Ponce

BLANCO, GILDA  
San Patricio Hospital V.A., San Juan

BONILLA, ELENA  
San Patricio Hospital V.A., San Juan

BORST, ETHEL M.  
San Patricio Hospital V.A., San Juan

BROWER, OLIVE C.  
St. Luke's Hospital, Ponce

CAMACHO DE GOMEZ, MRS. JUDITH  
Ponce District Hospital, Ponce

---

580 PUERTO RICO—53
ORDANZA, PROVIDENCIA
Municipal Hospital, Santurce

ORRACA, MRS. VIOLETTA V., DE
Bayamon District Hospital, Bayamon

OSORIO, ERNESTINA
Tanama 6, Hato Rey

PIETRI, AIDA M.
6 America Capo St., Ponce

RIVERA, MRS. HILDA V., DE
B D 13, Puerto Nuevo

RIVERA VALLES, GUILLERMINA
Veterans Administration Center, Stop 8, Santurce

RODRIGUEZ, DOMINGA RODRIGUEZ
Arecibo District Hospital, Arecibo

RODRIGUEZ, FRANCISCO
Municipal Hospital, Santurce

RODRIGUEZ, LUCILE
Box 6743 Loiza, Santurce

RODRIGUEZ, ZULEMA R., DE
B M 57, Puerto Nuevo

ROJAS, GLORIA
Clinica Dr. Julia, Hato Rey

SANTIAGO, LUZ MARY
San Patricio Hospital V.A., San Juan

SEDA, R. RODRIGUEZ, LYDIA V.
San Patricio Hospital V.A., San Juan

SOR CLOTHILDE, DE RIO
Hospital de Damas, Ponce

SOR JULIA ANDIA
Hospital de Damas, Ponce

SOR LUISA RIVERA RIVERA
Hospital de Damas, Ponce

SOR MARIA TEODORA GONZALEZ
Hospital de Damas, Ponce

SOR ROSA DEL CARMEN CANDIA
Hospital de Damas, Ponce

TALAVERA, JUANITA
Hospital San Patricio V.A., San Juan

TALAVERA, RITA
Ashford 1471, Santurce

TORRES, MONSERRATE R.
Hospital San Patricio V.A., San Juan

ZAYAS, MRS. JUANITA S.
Isabel la Catolica 399, Rio Piedras

RHODE ISLAND—160

ABBATEMATTEO, LOUISE R.
229 Lexington Ave., Providence

ARCHAMBAULT, MURIEL L.

AUGEN, LILLIAN B.
305 Blackstone Blvd., Providence 6

BAILLE, EDITH L.
409-A Elmgrove Ave., Providence 6

BAKER, MARY V.
8 Easton St., Lawrence, Mass.

BARDEN, MARTHA E.
223 Ohio Ave., Providence 5

BARRY, ELIZABETH A.
State Hospital, Howard

BEAMS, ROSALIE
Rhode Island Hospital, Providence 2

BEGOR, MRS. HELEN C.
33½ Newport Ave., Newport

BLAKE, BARBARA M.
109 Fort Ave., Edgewood 5

BONDS, MRS. EMMA W.
Route 1, Box 348, Ringgold, Ga.

BRENNAN, MARY G.
Roger Williams General Hospital, Providence 8

BRYANT, PRISCILLA M.
288 Lafayette St., Pawtucket

BUDLONG, EDITH M.
39 Oswald St., Pawtucket

BUNNELL, MARGARET
198 Armington St., Edgewood

BURRELL, NORMA F.
47 McKinley St., Providence

CALLAHAN, EMMA M.
50 Maude St., Providence 8

CAPPUCILLI, MARY L.
31 Harrison Ave., Newport

CARLO, ANTONETTA E.
99 Russo St., Providence 4

CARVISIGLIA, FLORENCE
35 Rankin Ave., Providence

581
CASSIMATIS, GEORGE A.
26 Prairie Ave., Providence

CICCARONE, CECILIA
138 Knight St., Providence

CLARK, MYRLEE E.
Memorial Hospital School of Nursing, Pawtucket

COCO, AGATHA C.
50 Maude St., Providence 8

CONNERY, CATHERINE T.
112 Church St., Bristol

COOPER, MRS. FLORENCE W.
1091 Westminster St., Providence

COSTELLO, LOUISE B.
91 Raymond St., Providence 8

COTTAM, EILEEN D.
25 Lennon St., Providence

COTTER, HELEN J.
813 Hope St., Providence 6

CROSS, MRS. GAMMEL t
112 Benevolent St., Providence 6

DAILEY, MARGARET M.
823 Chalkstone Ave., Providence 6

DAVIDSON, E. RITA
258 Waterman St., Apt. 4, Providence 6

DAVIS, MRS. HAZEL C.
Mary Fletcher Hospital, Burlington, Vt.

DICKSON, ANNIE M.
50 Maude St., Providence 8

DILLON, NELLIE R.
157 Waterman St., Providence

DITTMAR, MRS. DORIS B.
3 King St., Pontiac

DONOVAN, MRS. PAULA O.
Newport Hospital, Newport

DOUGHERTY, ELSIE E.
50 Maude St., Providence 8

DUNFIELD, BARBARA A.
6 Bafin Ct., Providence 5

DUTTER, MRS. ELIZABETH S.
508 County Rd., Barrington

DWYER, JOHANNA E.
322 St. Paul St., Brookline, Mass.

EASDON, JANET E.
36 Forest Ave., Cranston 10

EATON, CHARLOTTE
7 North Ave., Providence 6

EDWARDS, DORIS R.
South County Hospital, Wakefield

EDWARDS, ELIZABETH G.
Providence Lying-In Hospital, Providence 8

EMERY, DEBORAH N.
54 Moore St., Providence

FAIRBROTHER, MARIAN
553 Blackstone Blvd., Providence 6

FENLASON, ELIZABETH M.
198 Armitage St., Edgewood

FERGUSON, MARGARET E.
Box 5, Howard

FIDRYCH, LEONA F.
87 Armington Ave., Providence

FITZGERALD, MADELINE
56 Lockwood St., Providence 3

FLOOD, FRANCIS R.
81 Poplar Dr., Cranston 10

FLYNN, EILEEN M.
21 Waverly St., Providence 7

FOX, MARIE F.
Veterans Administration Hospital, Providence 8

GARDNER, MARY S.
302 Angell St., Providence

GERARD, CHARLOTTE W.
145 Potters Ave., Providence 5

GILLIS, MARION L.
320 Elmwood Ave., Providence

GRUESER, ANN L.
Providence Lying-In Hospital, Providence 8

HARDY, ALICE B.
767 Chalkstone Ave., Providence 8

HASKINS, REVA M.
Veterans Administration Hospital, Providence 8

HATTORN, MRS. MILDRED L.
157 Waterman St., Providence 6

HAUP, CHARLOTTE M.
120 Smith St., Riverside

HOGAN, MARTHA S.
76 Spring St., Pawtucket

HOLANETZ, MATILDA
34 Atlantic Blvd., Centredale 11

HOLMES, MARGARET R.
105 Nelson St., Providence 8

HODGER, AGNES V.
Newport Hospital, Newport

HUGHES, E. NELLIE
56 Lockwood St., Providence 3

JACKSON, FRANCES
Bourne, Mass.

JONES, BARBARA
26 Prairie Ave., Providence

JONES, MRS. MARY M.
62 Newark St., Providence

JUTRAS, BERTHA E.
109 Woodbine St., Cranston

KAL TENBACH, WINIFRED
Charlestown

KEEFE, CATHERINE T.
14 Lawnview St., Providence 9

KELLEHER, MARGARET C.
63 Waban Ave., Providence 8

KELLEHER, RITA V.
63 Waban Ave., Providence 8

KENNEDY, MARY L.
9 Lynch St., Providence 8

KNUTSEN, RUTH J.
Veterans Administration Hospital, Providence 8

KRAFT, MRS. GRACE W.
553 Pleasant St., Pawtucket

LABORDE, HELEN
Pawtucket Memorial Hospital, Pawtucket

LACROSS, CAROLYN J.
139 South Ave., Attleboro, Mass.

LAN DREY, KATHERINE C.
Veterans Administration Hospital, Providence

LEDDY, CLAIRE A.
Providence Lying-In Hospital, Providence 8

LENTELL, A. MAY
Newport Hospital, Newport

LESSARD, MRS. GENEVIEVE N.
220 Willow St., Woonsocket

LEWIS, MRS. ELSIE A.
49 George St., Norwood 7

LITTLE, MARY E.
305 Blackstone Blvd., Providence 6

LOCHMAN, MRS. SABRA E.
7344 Yates Ave., Chicago 49, Ill.

LOUTHIS, ANNIE
825 Chalkstone Ave., Providence 8
MEMBERS

RHODE ISLAND

ROBERTS, BERTHA M.
Roger Williams General Hospital, Providence 8

ROWEN, MARGARET E.
State Hospital, Howard

RYAN, ROSE M.
60 Maude St., Providence 8

SALVATORE, CARMELA
50 Dexeon Ave., Warwick

SCHINZEL, IRENE F.
50 Maude St., Providence 8

SIMOENS, ALINE J.
Butler Hospital, Providence 6

SISTER MARY AUGUSTINE
Ochre Point Ave., Newport

SISTER M. BARBARA
St. Joseph's Hospital, Providence

SISTER MARY PAUL
St. Joseph's Hospital, Providence

SISTER MARY PAULA
St. Joseph's Hospital, Providence

SISTER M. WILMA
St. Joseph's Hospital, Providence

SISTER MARIAM FRANCIS
St. Joseph's Hospital, Providence

SKEFFINGTON, MARY C.
90 Benevolent St., Providence

SMITH, BEVERLY M.
9 Westminster St., Westerly

SMITH, HARRIET E.
100 Charles Field St., Providence

SMITH, KATHLEEN L.
Kingsland Ter., Burlington, Vt.

SMITH, MRS. MARGARET H.
68 Tiffany St., Attleboro, Mass.

STEEVES, CLAIRE M.
60 Health Ave., Providence 8

STEVENS, LILLIAN I.
54 Parker Ave., Newport

STEVENS, RUBY G.
50 Maude St., Providence 8

SULLIVAN, CATHERINE R.
State Health Dept., State Office Bldg., Providence

SULLIVAN, VERONICA C.
35 Huxley Ave., Providence 8

SWEEDBURY, MRS. HELEN R.
224 Harris Ave., North Providence

SZAJNAR, ANITA K.
Veterans Administration Hospital, Providence 8

TAMER, JULIA B.
59 Westminster St., Westerly

TANZI, SUSAN
24 Queen St., Cranston 9

TETREAUT, ALICE I.
151 Sheffield Ave., Pawtucket

TRACY, MRS. CATHERINE O.
345 Lloyd Ave., Providence

VALE, MRS. AGNES W.
1065 Narragansett Pkwy., Providence 5

WALKER, ELIZABETH
1111 Washington St., South Attleboro, Mass.

WATSON, ESTHER A.
Pawtucket Memorial Hospital, Pawtucket

WATT, MRS. MURIEL B.
325 Chalkstone Ave., Providence 8

WEBSTER, DOROTHY L.
Providence Lying-In Hospital, Providence 8

WHITAKER, RUTH W.
Eml St., Rehoboth, Mass.

583
SOUTH CAROLINA—76

ALLEN, MRS. PAULINE S.
824 Munson Spring Dr., Columbia 5

ANDERSON, LEILA W.
Veterans Administration Hospital, Columbia

ASHLEY, MILDRED
Greenville General Hospital, Greenville

BAKER, STELLA L.
220 Brandon Ave., Columbia

BALLENTINE, MRS. AUTUMN T.
South Carolina State Hospital, Columbia B

BENTON, CLARICE E.
McLeod Infirmary, Florence

BIRTHRIGHT, MRS. RUTH H.
Anderson Memorial Hospital, Anderson

BLEASE, MRS. MINNIE H.
Silverstreet Rd., Saluda

BOLIN, SUDIE B.
Crippled Children's Hospital, Florence

BOZARD, MRS. BETTY S.
Tri-County Hospital, Orangeburg

BRADLEY, MARTHA M.
South Carolina State Hospital, Columbia B

BROWN, E. ALMA
Truemy Hospital, Sumter

BROWN, MRS. MARTHA S.
Spartanburg General Hospital, Spartanburg

BROWN, MATTIE D.
409 Highland Ave., Johnson City, Tenn.

BRUNSON, MRS. HELEN C.
470 Rembert St., Orangeburg

BURGESS, FRANCES A.
Columbia Hospital, Columbia 4

CALHOUN, MRS. BEULAH R.
R.F.D. 5, Box 164, Sumter

CHAMBERLIN, RUTH C.
Roper Hospital, Charleston 16

CLEMENTS, CAROL J.
1501 Fairview Dr., Columbia

CRAWLEY, MRS. ELVEREE H.
130 S. Converse St., Spartanburg

CUNNINGHAM, NELLIE C.
Carolina Life Building, Room 409, Columbia

DAVIS, BERTHA E.
South Carolina Baptist Hospital, Columbia 49

DaweYER, ROSE M.
Columbia Hospital, Columbia

DeyOUNG, MRS. HELEN K.
2306 Wheat St., Columbia

DIXON, IRENE A.
Roper Hospital, Charleston 16

FARIS, MRS. MARGARET L.
16 Lynn St., Greenville

GARDNER, BEULAH L.
South Carolina State Hospital, Columbia B

GARRISON, ELBA P.
Route 4, Easley

GRAHAM, BESSIE H.
Veterans Administration Hospital, Columbia

GRAHAM, NINA
York County Hospital, Rock Hill

GREENE, ALLIE
Ridgewood Tuberculosis Camp, Route 1, Columbia

GUENTER, EDITH
Anderson County Memorial Hospital, Anderson

HARDIN, LILY M.
South Carolina Baptist Hospital, Columbia 49

HARRIL, LALA B.
943 N. Church St., Spartanburg

HARRIS, MRS. MARIE R.
Greenville General Hospital, Greenville

HIGH, LUCY B.
Tri-County Hospital, Orangeburg

HIGGS, MRS. ELEANOR D.
10-D Woodward Tr., Columbia

HOLCOMBE, VIRGINIA T.
Roper Hospital, Charleston

JOHNSON, EULA M.
Route 2, Box 273, Opportunity School, West Columbia

JONES, MARIE P.
P.O. Box 44, Ridgeway

JONES, MILDRED L.
Spartanburg General Hospital, Spartanburg

LAMY, RUTH G.
Tri-County Hospital, Orangeburg

LANE, IRA D.
948 N. Church St., Spartanburg

LAWRENCE, MATTIE
Spartanburg General Hospital, Spartanburg

LAYTON, JEAN C.
Spartanburg General Hospital, Spartanburg

LINNEAL, GRACE M.
McLeod Infirmary, Florence

MAGEE, ROSINA I.
Veterans Administration Hospital, Columbia

MATHENY, PERRINE
Columbia Hospital, Columbia

MAYER, ROSALYN
Roper Hospital, Charleston

McADAMS, MRS. RUBY M.
Fair Play

McCOWN, VIANA
University of South Carolina, Columbia

McNEILL, IONA
10-D Woodland Ter., Columbia

MEDHURST, MRS. EUNICE R.
Lexington Highway, West Columbia

MOSS, MRS. NELLIE T.
York County Hospital, Rock Hill

O'CAIN, MRS. ELIZABETH
Tri-County Hospital, Orangeburg

PADGETT, SARAH M.
Columbia Hospital, Columbia 59

PITT, ANNIE L.
Veterans Administration Hospital, Columbia

POE, ISADORA R.*
727 Meadow St., Apt. D, Columbia

PUEHLER, RUTH M.
McLeod Infirmary, Florence

RAYFIELD, MRS. EVA L.
1812 Queen City Ave., Tuscaloosa, Ala.
MEMBERS

REARDEN, MARY
Columbia Hospital, Columbia 59

RICKETT, MRS. HETTIE H.
South Carolina State Board of Health, Columbia

ROBERTS, OUIDA
Tri-County Hospital, Orangeburg

ROOF, MRS. ALICE C.
Columbia Hospital, Columbia

SALVO, ELSA
Roper Hospital, Charleston

SICION, MRS. BERTIE M.
Winthrop College, Box 41, Rock Hill

SNYDER, ADA S.*
Tuomey Hospital, Sumter

TRUESTALE, MRS. HATTIE L.
York County Hospital, Rock Hill

SOUTH CAROLINA—SOUTH DAKOTA

WALDRON, MAGGIE S.
Veterans Administration Hospital, Columbia

WALLACE, JULIA V.
37-B Charlotte St., Charleston

WARNCKE, MARIE A.*
Greenville General Hospital, Greenville

WENTZKY, MRS. PAULINE M.
Anderson County Memorial Hospital, Anderson

WILKES, MRS. WINNETTA F.
McLeod Infirmary, Florence

WILLIAMS, HAZEL C.
Spartanburg General Hospital, Spartanburg

WOODSIDE, MRS. GRACE B.
Greenville General Hospital, Greenville

ZEIGLER, FLORENCE
1814½ Green St., Columbia

SOUTH DAKOTA—39

ARBOCAST, MRS. MARGERY R.
419 S. Main St., Apt. 6, Aberdeen

BENHAM, CARRIE A.
State Board of Nurse Examiners, Box 836, Mitchell

BERDAHL, MRS. ANNA H.
Sioux Valley Hospital, Sioux Falls

BIDWELL, MRS. CORINNE A.
1701½ S. Cliff Ave., Sioux Falls

BLAKE, GRACE J.
Veterans Administration Hospital, Hot Springs

BREWICK, MRS. FAYE
Methodist State Hospital, Mitchell

BURKE, DOLORES M.
Veterans Administration Hospital, Sioux Falls

COLES, DORIS M.
Whittier Hall, Box 326, Columbia University, New York 27, N. Y.

COOK, MRS. MARY R.
State Board of Health, Selby

COPPEY, CATHERINE A.
221 W. Sixth St., Sioux Falls

CORCORAN, MYRTLE K.
Box 430, Mitchell

CRAVEN, CARMELITA F.
Veterans Administration Hospital, Fort Meade

CRAW, MAVIS C.
517 Mulberry St., Yankton

DUNN, FLORENCE
State Health Department, Pierre

ERICKSON, R. ESTHER
South Dakota State College, Brookings

FLYNN, MRS. ANASTASIA M.
McKennan Hospital, Sioux Falls

FULLER, SHIRLEY J.
Sioux Valley Hospital, Sioux Falls

GROTH, LAURA J.
1610 W. 22 St., Sioux Falls

HAGBERG, MARION B.
709 S. Samborn St., Mitchell

HAGGAR, CATHERINE M.
1230 E. Ninth St., Sioux Falls

HALVORSON, EVELYN O.
Sioux Valley Hospital, Sioux Falls

HANNA, JEAN L.
709 S. Samborn St., Mitchell

HANSON, BETH L.
Waukab

HARRIS, MRS. MARGARET E.
710 S. Minnesota Ave., Sioux Falls

HAUG, GENA M.
704 E. First St., Canton

HUBBS, HAZEL L.
Barron Hospital, Watertown

HUNHOFF, ROSEMARY
616 Locust St., Yankton

JOHNSTON, CORA L.
St. Luke's Hospital, Aberdeen

KELLER, LYDIA H.
908 S. Lake Ave., Sioux Falls

KILDREW, MRS. GERTRUDE R.
Box 465, Spearfish

KNUTSON, MARTHA T.
Veterans Administration Hospital, Sioux Falls

KVERNES, ANNA M.
1012 S. Euclid St., Sioux Falls

MacMILLAN, KATHERINE M.
Yankton State Hospital, Yankton

MANN, EVA I.
Barron Hospital, Watertown

McKILLOP, KATHERINE
Methodist Hospital, Mitchell

McLEAN, MRS. DAISY E.
Veterans Administration Hospital, Hot Springs

McLEAN, DOROTHY H.
604½ E. Eighth St., Sioux Falls

MORIARTY, LOIS
Sacred Heart Hospital, Yankton

MOTHER M. WILLIAM
St. Luke's Hospital, Aberdeen

NOVAK, VIVIAN V.
1001 Locust St., Yankton

ODLAND, MARVEL L.
217 S. Spring St., Sioux Falls

OLSON, ALICE B.
State Board of Health, Pierre

OLSON, LORRAINE M.
Sacred Heart Hospital, Yankton

PATTIE, VERNE M.
510 Fourth Ave., S.E., Aberdeen

PAULA, ELEANOR M.
410 W. 11 St., Sioux Falls

RENTER, MARLENE
1104½ W. 18 St., Sioux Falls

RITCHIE, ROBERTA
1347 W. St, Joseph St., Rapid City

SCHLICHT, SYBIL M.
Methodist State Hospital, Mitchell

585
SISTER JANE FRANCES
St. Luke's Hospital, Aberdeen

SISTER MARIE THERESE
St. Joseph's Hospital, Mitchell

SISTER M. AGATHA
Sacred Heart Hospital, Yankton

SISTER MARY ALCUIN
St. John's McNamara Hospital, Rapid City

SISTER M. ALOYSIUS ANN
St. John's Hospital, Huron

SISTER M. ALOYZYLLA
St. John's Hospital, Huron

SISTER MARY AMABLES
St. John's Hospital, Huron

SISTER MARY BASIL
St. John's Hospital, Huron

SISTER MARY BERNADETTE
St. Joseph's Hospital, Mitchell

SISTER M. BERNARD
St. Luke's Hospital, Aberdeen

SISTER M. BLANCHE
Sacred Heart Hospital, Yankton

SISTER M. BONAVENTURE
St. Luke's Hospital, Aberdeen

SISTER MARY BRIGID
St. Michael's Hospital, Tyndall

SISTER MARY CHARLES
St. Joseph's Hospital, Mitchell

SISTER M. COLETTE
St. Mary's Hospital, Pierre

SISTER MARY CONCESSION
St. Luke's Hospital, Aberdeen

SISTER M. DESIDERIA
Sacred Heart Hospital, Yankton

SISTER MARY DOMINIC
McKennon Hospital, Sioux Falls

SISTER M. EMERENTIA
St. Benedict Hospital, Parkston

SISTER M. EVAHISTE
McKennon Hospital, Sioux Falls

SISTER MARY HARRIET
Sacred Heart Hospital, Yankton

SISTER M. IMMACULATA
St. John's Hospital, Rapid City

SISTER M. INEZ
Sacred Heart Hospital, Yankton

SISTER MARY INNOCENTIA
Mother of Grace Hospital, Gregory

SISTER MARY LEONILLA
St. John's Hospital, Huron

SISTER M. MELANIA
Sacred Heart Hospital, Yankton

SISTER MARY NATALIA
St. John's Hospital, Huron

SISTER M. QUENTIN
Sacred Heart Hospital, Yankton

SISTER MARY RENE
St. Joseph's Hospital, Mitchell

SISTER MARY RICHARD
St. Joseph's Hospital, Mitchell

SISTER MARY ROSALIE
St. Mary's Hospital, Pierre

SISTER MARY SERAPHICA
St. John's Hospital, Huron

SISTER M. VINCENT
St. Luke's Hospital, Aberdeen

THOMPSON, AGNES B.
Sioux Valley Hospital, Sioux Falls

ULBERG, OLGA
Sioux Valley Hospital, Sioux Falls

UNDERWOOD, MARION N.
Veterans Administration Hospital, Hot Springs

WESTRUM, DELORES
Sacred Heart Hospital, Yankton

WHITESIDE, VERLEY
817 N. Daft, Mitchell

WILTGEN, MONICA
Sacred Heart Hospital, Yankton

WUEBBEN, ROSE E.
Sacred Heart Hospital, Yankton

YOCKEY, MILDRED A.
Veterans Administration Hospital, Box 182, Fort Meade

AKERS, WILMA F.
114 Fountain Ave., Knoxville

ALLEN, OLIVIA R.
1919 Broadway, Nashville

ANDERSON, AGATHA A.
Meharry Medical College, Nashville 8

ANDERSON, GERTRUDE M.
Veterans Administration Hospital, Memphis 15

ANDERSON, MRS. LEONA K.
Sevierville Pike, Knoxville

BAILEY, JANE L.
Robert E. Lee Apt., 46, Nashville

BALLYN, LUCILLE E.
1831 Nelson, Memphis

BARABY, GERTRUDE V.
Veterans Administration Hospital, Mountain Home

BARRINGER, MRS. ELIZABETH W.
934 National St., Memphis

BARTON, ETHEL
Veterans Administration Hospital, Murfreesboro

BASHAM, MRS. NINA M.
23 S. Pauline, Memphis

BASSETT, WILLARD D.
1374 N. Lexington Circle, Memphis

BEHRENS, GRACE E.
2200 State St., Apt. C-3, Nashville

BLAZER, ANNA M.
560 Lamont St., Johnson City

BLOSE, MRS. JEAN F.
1621 Lodgerwood Ave., N.E., Knoxville

BRACKETT, ETHEL K.
Veterans Administration Hospital, Box 126, Memphis 15

BREWER, INA M.
2137 Acklen Ave., Nashville

BROWN, BETTIE P.
3-E Hillsboro Manor, Nashville

BROWN, MARY L.
Meharry Medical College School of Nursing, Nashville

BROWN, WINIFRED M.
Veterans Administration Hospital, Memphis 15

BUCKLEY, MARIE E.
3-E Hillsboro Manor, Nashville

586
BURROWS, LILLIAN W.
1403–18 Ave. S., Nashville 4

CAHILL, IMOGENE D.
Hillsboro Garden Apt., A-6, Nashville

CALLAWAY, LULA
1206 Oak Park, Maryville

CARTER, MARY O.
103 W. Millard St., Johnson City

CAWTHON, MRS. BRIDE L.
1634 N. Parkway, Memphis 12

CLARK, MRS. ELIZABETH W.
1511 Grand View Dr., Nashville

CLUTCH, BEATRICE M.
1221 Battleford Dr., Nashville 4

COLE, LUCILLE
Meharry Medical College, Nashville 3

CONAWAY, EMILY
2122 Rose Ave., Knoxville

CORBETT, MRS. CLARICE L.
11 N. Camilla St., Memphis

COSTON, HARRIET M.
1239 Amsterdam Ave., New York 27, N. Y.

CRESHAW, VIRGINIA P.
Vanderbilt University School of Nursing, Nashville 4

CUMMINS, MARY I.
4707 Granny White Pike, Nashville

DAVIS, TOMMYE H.
St. Barnabas Guild House, Cleveland 6, Ohio

DOUGLASS, D. HENRI
Box 11, Collegedale

DURHAM, CLAUDIA M.
Meharry Medical College, Nashville 3

DYER, KATHLEEN D.
2208 Island Home Ave., S.E., Knoxville

EGGENA, EMILIA B.
Veterans Administration Hospital, Mountain Home

ENCHES, HELEN G.
Galior Memorial Hospital, Memphis

ENGLES, MRS. HELEN T.
Nashville General Hospital, Antioch

FAINTER, EMMA L.
East Tennessee Tuberculosis Hospital, Knoxville 18

FINNEY, MRS. MAURINE C.
930 Maple Dr., Memphis

FISH, M. LORENE
2001 Church St., Nashville

FLEMING, ELIZABETH C.
Veterans Administration Hospital, Memphis 15

FOREMAN, GEORGIA
Tuscaloosa Rd., Greenville

FRISZ, MARY L.
2179 Poplar, Memphis

GAULT, ALMA E.
Meharry Medical College, Nashville

GILLIE, JUANITA F.
1925 W. Clinch Ave., Knoxville 16

GODFREY, ANNE E.
Battleground Apts., Apt. B-3, Nashville

GOFF, HAZEL L.
Fort Sanders Hospital, Knoxville 16

GRAHAM, ALMA L.
36 Middleton Ave., Nashville 10

GREENE, MRS. LELIA H.
Dante Rd., Knoxville

GRIZZLE, MRS. MARY B.
1533 Lamar Cove, Memphis

GUNTER, LAURIE M.
1711 S. Johnston Ave., Nashville 4

HAND, RUTH E.
Veterans Administration Hospital, Memphis

HARRISON, MRS. NANCY J.
1681 Autumn Ave., Memphis

HAYNES, MRS. MARY W.
1817 Lake Ave., Knoxville

HEREFORD, JULIA
Vanderbilt University School of Nursing, Nashville 4

HIPPEY, MARGARET*
Veterans Administration Hospital, Box 126, Memphis 15

HOCKER, DOROTHY L.
1030 W. Clinch Ave., Knoxville

HOCKS, SARAH M.
2001 Grand Ave., Nashville

HOPPER, RUTH E.
Madison College, Madison College

HUMPHREY, EMMA B.
809 Madison Ave., Memphis

HUNTLEY, MARY F.
477 Marianna, Memphis 11

HUNTLEY, MRS. RUTH D.
477 Marianna, Memphis 11

JOHNSON, MRS. EILEEN
Memorial Hospital, Johnson City

JOHNSON, MRS. GRACE B.
Riverside Dr., Route 6, Knoxville 15

JOHNSTON, MRS. SARAH T.
605 Magnolia St., Johnson City

KELLER, JANE
Knoxville General Hospital, Knoxville 17

KILLEFFER, ELIZABETH H.
Fort Sanders Hospital, Knoxville 16

KILPATRICK, GOLDA C.
699 Monroe, Memphis 3

KIMBRELL, BIVIAN L.
23 S. Pauline, Memphis

KING, FRANCES
Vanderbilt University Hospital, Nashville 4

KINGHORN, ALICE D.
Veterans Administration Hospital, Altoona, Pa.

LAUX, DOBOTHY C.
757 Argyle Ave., Nashville 4

LEWIS, EDNA
George Peabody College, Nashville

LOGAN, MATTIE E.
Box 53, Veterans Administration Hospital, Nashville 5

LUSK, LILY L.
1907 York, Memphis

MACDONALD, MRS. CONSTANCE G.
Veterans Administration Hospital, 888, Memphis

MADISON, PEARL L.
Meharry Medical College, Nashville 8

MALONE, MATTIE E.
Baptist Memorial Hospital, Memphis 3

MANNING, MRS. ALMA S.
Nashville General Hospital, Nashville

McCORMICK, IRENE
615 S. Camilla, Memphis

MCANIN, BEATRICE
Baroness Erlanger Hospital, Chattanooga 3

McISAAC, HARRIET C.
Veterans Administration Hospital, Box 126, Memphis

McMACKIN, GENE
Robert E. Lee Apt., Apt. 46, Nashville 5

McMARTIN, ISABELLE
2109 Capers Ave., Nashville
SISTER M. AMANDINA
St. Joseph’s Hospital, Memphis

SISTER MARY ASSISIUM
St. Mary’s Hospital, Knoxville

SISTER MARY BENEDICT
St. Mary’s Hospital, Knoxville

SISTER MARY BORROMEI
St. Mary’s Hospital, Knoxville

SISTER MARY CELESTE
St. Mary’s Hospital, Knoxville

SISTER MARY ELAINE
St. Mary’s Hospital, Knoxville

SISTER MARY FRANCES
St. Thomas Hospital, Nashville

SLEDGE, MARGARET
23 S. Pauline, Memphis

SMITH, ADA T.
1115 Glenwood Ave., Nashville

SMITH, MRS. DEE R.
1965 Bernard Ave., Nashville

SMITH, MRS. MARY
Baptist Memorial Hospital, Memphis

SPEARS, ANNA D.
2101 E. Emoriland, Knoxville

STAFFORD, MRS. RUTH F.
Riverside Sanitarium & Hospital, Nashville

STERLING, CATHERINE
23 S. Pauline, Memphis

STEVENS, JESSIE L.
Mary Kirkland Hall, Nashville

SULLIVAN, MRS. JANE F.
1113 Stratford Ave., Nashville

SWARTZ, VESTA L.
Memorial Hospital, Johnson City

TARVER, MAURINE
Veterans Administration Hospital, Box 126, Memphis

THIGPEN, LORNA W.
880 Monroe St., Memphis

TIPTON, MAXINE W.
3340 Kingston Pike, Knoxville

TURNER, DOROTHY
23 S. Pauline, Memphis

VAN CAMPEN, JESHER G.
Madison Rural Sanitarium & Hospital, Madison

WALKER, FRANCES M.
Meharry Medical College, Nashville

WALKER, VIRGINIA H.
John Gaston Hospital, Memphis

WALLACE, MRS. GRACE M.
372 N. Avalon, Memphis

WALTERS, MRS. NANNIE L.
R.F.D. 3, Jonesboro

WHARTON, ANNE L.
Baroness Erlanger Hospital, Chattanooga

WILLIAMS, GOLDEN
Knoxville General Hospital, Knoxville

WILLIAMS, MARY
2501 Sherrod Rd., Knoxville

WINDER, MRS. ELEANOR H.
Meharry Medical College, Nashville

WINTERS, MRS. MARGARET C.
Vanderbilt University School of Nursing, Nashville

WISSWELL, MRS. RACHEL W.
832 Goodwyn St., Memphis

WOOTTON, NINA E.
615 Warner Bldg., Nashville
ADAMS, IMogene R.  
3721 Kenwood, Dallas

ALBOLD, MARGARET  
506½ W. Myrtle, San Antonio

ALDER, WINNIE S.  
1413 Eighth Ave., Fort Worth

ALLEN, MRS. MARY F.  
Route 6, Box 362A, Waco

ALLWARDT, BERTHA L.  
3700 Ross St., Dallas

AMIDON, ELIZABETH B.  
834 N. Mailsal St., Apt. 511, Dallas

ANDERSON, MRS. ENID S.  
1011 Ninth St., Galveston

ANDERSON, MRS. MARIE H.  
Box 276, Texas Christian University, Fort Worth

ARRINGTON, BARBARA L.  
2319 Volga Ave., Dallas 16

ASHER, MRS. MARY C.  
110 E. Ave. G, Temple

BANE, CATHERINE A.  
5107 Phillips, Dallas

BARTHOLF, MARJORIE  
John Sealy College of Nursing, Galveston

BASS, LILLIE E.  
Memorial Hospital, Houston

BEAUCHAMP, PAULINE  
Veterans Administration Hospital, Temple

BEERY, RUTH  
Veterans Administration Hospital, McKinney

BEIKERT, MARY E.  
815 Mechanic, Galveston

BELK, MAUD  
308 Featherstone, Cleburne

BELL, ADELINE T.  
3750 Station Hospital, Sheppard Field

BELL, MRS. LOLA R.  
State Dept. of Health, Austin 2

BELL, MARY C.  
1515 Tenth St., Wichita Falls

BENSON, MRS. STELLA T.  
1613 S. Farola Dr., Dallas

BERGHAUSER, WANDA Z.  
740 Dallas St., Jacksonville

BERNARDT, MRS. HELEN R.  
634 W. Kings Highway, San Antonio 1

BEWLEY, JESSIE P.  
2314 Knight St., Dallas

BINDER, RUTH  
Box 192, Kearney, Neb.

BLACK, BERNICE L.  
Box 1087, Alice

BLACK, BESSIE C.  
944 Garden St., Kerrville

BLACK, MRS. DETA J.  
Veterans Administration Hospital, Temple

BOHLS, EVELYN M.  
902 S. 11 St., Temple

BONDS, CHRISTINE  
1725 Colcord Ave., Waco

BOORE, ALICE G.  
Box 100, USPHS Hospital, Fort Worth

BOSWELL, MRS. GENE T.  
2006 N. Boulevard, Houston

BOWIE, MRS. B.  
706-A N. Grant St., Amarillo

BRANSON, NADINE F.  
3415 Junius St., Dallas

BRATTON, J. KATHERINE  
Harris College of Nursing, Fort Worth

BREIHAN, DOLGA M.  
Baylor University Hospital, Dallas

BREWER, MARY F.  
Veterans Administration Hospital, Houston

BREWSTER, VALERA D.  
3732 Forbes St., Fort Worth

BRIDWELL, MAURINE  
Shannon Hospital, San Angelo

BROCK, MRS. AMELIA S.  
3838 Southmore Blvd., Houston

BROWN, MRS. MARA Y.  
3802 N.E. 18, Amarillo

BROWN, MARY L.  
Baptist Memorial Hospital, San Antonio

BROWN, MRS. MAXINE M.  
Box 595, Canyon

BRUCKNER, MARGARET E.  
Veterans Administration Hospital, Waco

BRUSH, FRANCES  
122 S. 21 St., Temple

BRYAN, MRS. FLORENCE B.  
1724 Morrow, Waco

BUCK, FRANCES S.  
5638 Lovers Ln., Dallas

BUCK, VIRGINIA R.  
118 Hathaway Dr., E., San Antonio 9

BURGDORF, FLORA  
1639 Branard, Houston

BURKE, SOPHIE H.  
1302 E. 29 St., Austin

BURNS, ALLIE M.  
Box 551, Abilene

BURROWS, AMY  
Baptist Memorial Hospital, San Antonio

CALHOUN, EVELYN C.  
602 Lamar Ave., Houston

CAMERON, MRS. VERDA S.  
Veterans Administration Hospital, Temple

CARLTON, NORA E.  
1209 Morrow Ave., Waco

CHAMBERS, MARY F.  
834 N. Mailsal St., Apt. 509, Dallas 8

CHANLEY, LUCILLE  
Veterans Administration Hospital, McKinney

CLARK, MATTIE M.  
216 Taft Blvd., San Antonio

CLYNCH, MARGARET C.  
1614 Blonde, Wichita Falls

COFFEE, MARGARET M.  
1223 Van Buren, Amarillo

COLBATH, LOUISE  
900 W. 7th Ave., Austin

COLE, ANNA L.  
Scott & White Hospital, Temple

COLEMAN, ESTELLE O.  
Veterans Administration Hospital, McKinney

COLLIER, CHARLOTTE V.  
707 E. 14 St., Austin

COLLINS, SARAH  
Veterans Administration Hospital, McKinney

COTTON, RUBY B.  
1008 S. 43 St., Temple
<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>FOX, FANNIE</td>
<td>Texas Elks Crippled Children’s Institution, Box 7</td>
<td>Online</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FOX, MRS. MARTHA E.</td>
<td>5831 Prospect, Dallas</td>
<td>Dallas</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FRANKE, GESIVE A.</td>
<td>5014 W. Purdue, Dallas</td>
<td>Dallas</td>
<td></td>
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<tr>
<td>GALLMAN, LAVERNE</td>
<td>Scott &amp; White Hospital, Temple</td>
<td>Temple</td>
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<tr>
<td>GALLOWAY, BERNICE B.</td>
<td>Veterans Administration Hospital, Waco</td>
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<tr>
<td>GARRETT, MILDRED E.</td>
<td>State Dept. of Health, Austin</td>
<td>Austin</td>
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<tr>
<td>GARRETT, ROSSI</td>
<td>Hermann Professional Bldg., Houston</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>GAY, MRS. ELIZABETH K.</td>
<td>1018 S. 27, Temple</td>
<td>Temple</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GIBSON, MRS. BERYL S.</td>
<td>Box 210, Mansfield</td>
<td>Mansfield</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GILBERT, MRS. RUBY B.</td>
<td>King’s Daughters Hospital, Temple</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>GROSS, MRS. LOIS B.</td>
<td>1917 S. Ninth St., Temple</td>
<td>Temple</td>
<td></td>
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</tr>
<tr>
<td>GROVES, EWEN DYN</td>
<td>4238 S. Cherry Ln., Dallas</td>
<td>Dallas</td>
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<tr>
<td>GURNEY, CHARLES A.</td>
<td>Veterans Administration Hospital, Temple</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>HAMMESLEY, MRS. MARY LOU</td>
<td>4418 Sycamore St., Dallas</td>
<td>Dallas</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HARRIS, LUCY*</td>
<td>3257 Waits, Fort Worth</td>
<td>Fort Worth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HAYES, ELEANOR K.</td>
<td>Box 1921, 4332 Faith Rd., Wichita Falls</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HEALY, IRENE</td>
<td>109 Sutton Hall, University of Texas, Austin</td>
<td>Austin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HECTOR, MARY L.</td>
<td>Pasadena Courts, Apt. 24, San Angelo</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HELM, ELEANOR M.</td>
<td>Foundation Apts., C-8, Galveston</td>
<td>Galveston</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HENDERSON, MRS. MARTHA R.</td>
<td>3222 Ave. I, Fort Worth 5</td>
<td>Fort Worth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HENRY, MRS. ODELIA B.</td>
<td>Medical &amp; Surgical Bldg., Galveston</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Total:** 590 entries
HENZE, MRS. GRACE S.  
4210 Jackson, Amarillo

HEREFORD, DAISY T.  
1511 S. 15 St., Temple

HERRINGTON, CATHERINE  
Baylor University Hospital, Waco

HEYLAND, DOROTHY N.  
Box 573, Kerrville

HINES, MRS. INEZ  
2204-22 St., Lubbock

HITCHCOCK, MARGARET J.  
1014 N. 15 St., Waco

HIX, GLORIA N.  
1949 W. Dallas St., Houston 6

HOFFMAN, MRS. CLARA G.  
5619 W. Purdue, Dallas

HOGAN, CAPT. ANN E., ANC  
532 Pershing Ave., San Antonio

HOLLEY, MARIE  
Veterans Administration Hospital, Kerrville

HOLT, MILDRED L.  
Adolphus Hotel, Room 711, Dallas

HOOD, KATHRYN P.  
612 W. Third St., Fort Worth

HOPKINS, JEANNETTE  
Veterans Administration Hospital, Houston

HOUSTON, LUCILE  
1029 S. Lake, Fort Worth

HUGHES, JEANETTE  
Veterans Administration Hospital, Temple

HUGHES, MILDRED H.  
Santa Rosa Hospital, San Antonio

HUTCHESON, MRS. CHARLOTTE M.  
Veterans Administration Hospital, McKinney

INGRAM, MRS. MARY M.  
2792 Pine Ave., Waco

JACOBS, BLANCHE E.  
Veterans Administration Hospital, Big Springs

JAMESON, MRS. J. H.  
Midwestern University, Wichita Falls

JOHN, FRIEDA P.  
Veterans Administration Hospital, Temple

JOHNSON, BERNICE R.  
707 Graham Pl., Austin

JOHNSON, MRS. HAZEL H.  
Veterans Administration Hospital, Temple

JOHNSON, SERENA  
Hillcrest Memorial Hospital, Waco

JONES, MRS. BETTY K.  
2037 ½ W. Alabamas, Apt. D, Houston

JONES, MRS. GRACE I.  
Veterans Administration Hospital, Temple

JOSCELYN, MARY E.  
USPHS Hospital, Fort Worth

JOSEPH, MRS. RUTH R.  
717 W. 35 St., Austin

KASMEIER, JULIA C.  
1208 W. Sixth St., Austin

KATZ, MRS. MERLE M.  
6330 Lupton Ave., Dallas

KEMP, MRS. MARIE F.  
1316 Gambrell St., Fort Worth

KENNEDY, MARY A.  
Veterans Administration Hospital, Kerrville

KILLEN, MRS. FRANCES J.  
P.O. Box 1412, Wichita Falls

KILMER, DORIS E.  
Veterans Administration Hospital, McKinney

KINCHELOE, MRS. INEZ  
2424 Alexander Ave., Waco

KING, EUNICE B.  
922 Bowie, Amarillo

KING, LEONA M.  
Jefferson Davis Hospital, Houston

KIRCHHOFF, NETTY L.  
Public Health Nursing Division, State Dept. of Health, Austin

KONRAD, CARRIE J.  
924 Southern Standard Bldg., Houston

KRUST, JANETTE  
2942 W. Ashby Pk., San Antonio

KURILECZ, MRS. BETTY S.  
6601 Athens, Dallas

LANCASTER, VIRGINIA M.  
3415 Junius St., Dallas

LANDERS, EMMA B.  
Southwestern General Hospital, El Paso

LANG, SELMA A.  
King’s Daughters Hospital, Temple

LARUE, CAROLYN P.  
1002 E. 43 St., Austin

LATTIMORE, MRS. CORINE I.  
1723-32 St., Lubbock

LEBECK, CLARA C.  
Veterans Administration Hospital, Temple

LEHMANN, MRS. HELEN H.  
3921 Potomac St., Dallas

LEMONS, MARY M.  
1203 W. 19 St., Amarillo

LINDSEY, ODESSA M.  
1907 McAdams St., Dallas

LITTLEPAGE, MRS. MARY L.  
Box 555, Seguinville

LOFT, BESSIE  
6411 Fannin St., Houston

LORING, BOBBIE G.  
4127 Ave. L, Galveston

LOTT, BEATRICE  
2831 S. Ervay, Dallas

LOUDBOROUGH, MRS. WANDA C.  
5627 Goodwin, Dallas

LOYA, MARY  
Baptist Memorial Hospital, San Antonio

LUPOPPD, MARIE L.  
Methodist Hospital, Houston

LYLES, MRS. ALICE C.  
1519 May St., Fort Worth 4

LYNN, MARIE  
Shannon Hospital, San Angelo

MACH, MARTHA M.  
3919 Charleston, Houston

MACIAS, ROSE B.  
Veterans Administration Hospital, Temple

MAHAN, MRS. JOHNNE B.  
3421 Wade St., Fort Worth

MANESS, AVA A.  
Veterans Administration Hospital, Dallas 2

MANN, LURA C.  
Veterans Administration Hospital, McKinney

MASTER, MRS. KATHLEEN F.  
420 Roberts Cutoff Rd., Fort Worth

MAXSON, MRS. RUTH A.  
430 Archer, Houston

MAYNARD, PHOEBE S.  
Dept. of Health & Welfare, Fort Worth

McCARLEY, MRS. ODELLA B.  
Route 11, Box 358, San Antonio

TEXAS

591
McGAY, OTHA M.
1818 S. Ninth, Temple

McCLESKEY, OLA
3921 Rawlins, Dallas

MCCLOSKEY, ZITA
Sheppard Air Force Base, Sheppard Field

MCCLUSKY, MARGARET
St. Paul's Hospital, Dallas

MCCELLOUGH, STELLA
604 Rio Grande, Austin

McCUNE, MRS. DORIS K.
Hendrick Memorial Hospital, Abilene

McDERMOTT, CATHERINE M.
315 E. Melrose Dr., San Antonio 1

McCONAGLE, MILDRED D.
5726 Richmond Ave., Dallas

McGUIRE, CLAIRE
1514 Lavaca St., Austin

McGUIRE, MYRTLE M.
2810 Maryland, Dallas 16

McKAY, MAJ. HORTENSE K.
Medical Field Service School, Fort Sam Houston

McLEAN, MRS. GLENNIA F.
327 Hathaway, Houston 4

McNEESE, MRS. IVY H.
Box 300, Wichita Falls

MERSHON, MRS. ILA M.
650 S. Henderson, Fort Worth

MESUSE, FRANCES
Veterans Administration Hospital, McKinney

MIDDLETON, CHARLENE
Route 1, Box 148, Belton

MILLER, MRS. LORNA
2216 First St., Lubbock

MILLER, MRS. MARY J.
1201 S. 19 St., Temple

MONIER, MRS. BARBARA S.
4322 Live Oak St., Dallas

MONROE, MRS. VYNTLE B.
Wichita General Hospital, Wichita Falls

MOORE, DAISY R.
602 Lamar Ave., Houston 2

MOORE, RUTH J.
State Dept. of Health, Austin 2

MORGAN, MRS. JESSYE J.
Route 5, McKinney

MORGAN, MRS. MOIVELINE M.
Veterans Administration Hospital, Waco

MORRIS, MRS. BETTIE I.
1719 Overhill Ln., Dallas

MORRIS, JULIA S.
2630 Gramercy Blvd., Houston 5

MORRIS, MAUD P.
Shannon Memorial Hospital, San Angelo

MORRISON, RUBY A.
2993 Yale Blvd., Dallas

MOTHER MARY OF LOURDES
Santa Rosa Hospital, San Antonio

MOULLE, JULIET P.
Veterans Hospital, Martin

MOYNAHAN, MRS. GENEVA J.
605 Westwood Dr., San Antonio 1

MUMME, SADIE A.
1400 W. Mistletoe Ave., San Antonio 1

MUNSON, MARY G.
Veterans Administration Hospital, Kerrville

NELSON, EMMA M.
1904 Polk St., Wichita Falls

NICHOLS, MRS. ELIZABETH L.
Jefferson Davis Hospital, Houston

NICHOLS, PANSY
208 E. Ninth, Austin

NICHOLSON, EMMA A.
1238 W. Bell, Houston

NIELL, OLTAL P.
Veterans Administration Hospital, Temple

ODEE, BERTHA
5711 Berkshire Ln., Dallas

OETKEN, ELVIRA
5006 W. Myrtle, San Antonio

O'FALLON, MRS. FLORENCE L.
506 E. Eighth St., Dallas 8

O'REILLY, SARAH B.
St. Paul's Hospital, Dallas

ORR, MYRTLE L.
1303 N. Church, McKinney

OSER, EILEEN E.
1522 Marshall St., Houston 6

OWENS, MRS. EUNICE
316 Tenth, Galveston

PANNELL, FAYE
7615 Kenwell, Dallas

PARKER, CECILIA S.
612 Georgia, Amarillo

PATTER, ELLA
State Dept. of Health, Austin

PAYNE, DOROTHY B.
5603 Truett, Houston

PEACOCK, MARY A.
2407 W. Eighth St., Amarillo

PECOVERN, LENA E.
2019 Santa Rosa, Houston 12

PEDERSON, EVELYN M.
7646 Edna St., Houston 17

PETERSON, BERNICE H.
1609 S. Seventh, Temple

PIKE, MRS. LORRAINE B.
716 N. Seventh St., Temple

PITTMAN, MARY H.
3997 Brem St., Houston

PIXLEY, ADRAH P.
3411 Swiss Ave., Dallas

POTTER, MRS. CATHERINE T.
1063 Neces, Apt. 4, Austin

PRATHER, MRS. RUBY E.
1407 Pruitt St., Fort Worth

PRICE, MRS. ESTALEE M.
Box 438, Lemerque

PRYOR, WILLIAM M.
12-2 Third St. Dr., Temple

PULLEN, EULAH
3506 Blodgett, Houston

PULLIG, MARY R.
Veterans Administration Hospital, McKinney

QUICKSALL, GEORGIA J.
1801 S. Ninth St., Temple

RADCLIFFE, ROSE M.
611 Kentucky St., Amarillo

RALSTON, HELEN S.
3923 Hartford, St. Louis, Mo.

RANDOLPH, MRS. JANE
710 N. Stanton, El Paso

RANKIN, MRS. EDYTHE M.
209 S. Montclair Ave., Albuquerque, N. M.

REA, MARGUERITE
Hillcrest Memorial Hospital, Waco
SISTER MARIE MONTES
Hotel Dieu, El Paso

SISTER MARIE JOSEPH
1910 Crawford St., Houston 3

SISTER MARY AGNESITA
Hotel Dieu, Beaumont

SISTER M. ASCENSION
St. Mary's Hospital, Port Arthur

SISTER M. AUGUSTINA
745 W. Houston St., San Antonio 7

SISTER MARY BRIAN
745 W. Houston St., San Antonio 7

SISTER M. CHRISTIANA
Incarnate Word College, San Antonio

SISTER MARY DIGNA
745 W. Houston St., San Antonio 7

SISTER M. EVANGELIST
St. Anthony's Hospital, Amarillo

SISTER MARY FIDELIS
St. Joseph's Infirmary, Houston 3

SISTER M. GERMAINE
St. Joseph's Infirmary, Houston 3

SISTER MARY ISABELLE
1910 Crawford St., Houston 3

SISTER M. JULIA
Hotel Dieu, Beaumont

SISTER MARY MARTINA
1910 Crawford St., Houston 3

SISTER MARY MICHAEL
St. Joseph's Hospital, Fort Worth

SISTER MARY ROSINA
St. Joseph's Infirmary, Houston 3

SISTER PAULA ANSEL
Hotel Dieu, El Paso

SISTER PETER GERARD
745 W. Houston St., San Antonio 7

SISTER REGINA
600 W. 26 St., Austin

SISTER ROSE FRANCIS
745 W. Houston St., San Antonio

SISTER VIOLA
3121 Bryan St., Dallas 1

SMITH, A. IMogene
State Dept. of Health, Austin 2

SMITH, ANN B.
805 S. Jackson St., Jacksonville

SMITH, CHARLOTTE E.
Veterans Administration Hospital, Waco

SMITH, MARY P.
Methodist Hospital, Dallas

SMYTHE, OLIVIA
317 S. Montreal St., Dallas 8

SNELL, ESTHER E.
1314—34 St., Lubbock

SNELL, LT. GRACE B.
Box 476, Carswell AFB, Fort Worth

SPENCER, MARY B.
900 Dale St., Dallas 8

SPERRY, RUTH E.
3629 Ave. M, Fort Worth

STECK, MRS. ANN F.
P.O. Box 1121, Wharton

STOCKBRAND, MARY L.
Dallas County Health Dept., Dallas

STRASNER, MRS. M. JEAN
Box 61, Rogers

STRAWN, MRS. ANITA J.
4026 Holland, Dallas

593
WALTERS, MRS. FRANCES S.  
Northwest Texas Hospital, Amarillo

WALTERS, LILLIE  
1091 Market St., Galveston

WANDLIT, MABEL A.  
Veterans Administration Hospital, Kerrville

WATERS, MRS. BREGETHA B.  
967 Legion Branch, Kerrville

WEAVER, PEARL V.  
2425 Goldsmith, Houston

WEIMER, MRS. LOIS B.  
602 Fulton Ave., San Antonio

WHITE, MRS. DELPHINE F.  
1211 Remora Dr., Austin

WHITEHURST, MRS. JO LENE C.  
1092 Ave. C, Galveston

WHITING, MRS. VADA P.  
2211 Seventh St., Lubbock

WILLERS, AURELIA C.  
1202 1/2 Ave. G, Galveston

WILLIAMS, ANNA R.  
Veterans Administration Hospital, Waco

WILLIAMS, HARVALEA  
1002 Gleason, Cleburne

WILLIAMS, STELLA M.  
3720 Rawlins St., Dallas 4

WILSON, RUTH  
2211 E. 39 Pl., N.W., Washington, D. C.

WOLFFE, MRS. ADA M.  
910 Avenue of Oaks, Houston

YARBROUGH, LA VELLE H.  
2400 Kemp, Wichita Falls

ZECK, MRS. MARTHA J.  
209 Adams, San Antonio

BARKER, ALICE J.  
2921 Van Buren Ave., Ogden

BARRETT, FERN A.  
305 E. Fourth N., Logan

BLAKEMORE, OMA I.  
440 E. Third S., Apt. 47, Salt Lake City

BRIM, KATHERINE  
1145 S. 15 St., E., Salt Lake City 5

BRUIJTON, LUCILLE T.  
2213 Jackson Ave., Ogden

BURT, ADA L.  
2120 S. Tenth E., Salt Lake City 5

COPE, MRS. MAXINE J.  
2239 Wilmington Circle, Salt Lake City

CORDER, ANNA F.  
2035 S. Third E., Salt Lake City

CURTIS, CYNTHIA  
P.O. Box 270, Provo

D'YOUNG, LILLIAN  
130 Second Ave., Salt Lake City

DOBMEIER, MARY A.  
325 Hollywood Ave., Salt Lake City 5

DUPAIX, LUCILLE  
1550 S. Main St., Salt Lake City 4

EATCHEL, ETHEL L.  
210 Wasatch Ave., Salt Lake City 5

ERNST, JANE L.  
430-12 Ave., Salt Lake City

FALLS, OLGA E.  
Utah Valley Hospital, Provo

FARR, GLORIA K.  
510 E. Fourth N., Logan

FELKNER, DELLA U.  
601 S. 12 E., Salt Lake City

FUJIKI, SUMIKO  
R.P.D., Layton

FUNK, ANNA C.  
2478 Monroe St., Ogden

HOGENSCH, DOLORES  
431 E. St., Salt Lake City

HOWARD, LOIS M.  
557 Fifth Ave., Salt Lake City 3

HOWARTH, AGNES J.  
603 Coatesville Ave., Salt Lake City

HYATT, LUELLA  
144 W. 17 S., Salt Lake City 4

JOHANNESEN, LUCILE  
134 E. Second N., Provo

JOHANNESEN, VERONICA D.  
134 S. First St., Tooele

JOHNSON, EDLA  
32 E. Sixth S., Salt Lake City 1

JOHNSON, MARIA  
153 E. Fourth N., Springville

KAHL, F. RUTH  
1678 Laird Ave., Salt Lake City

LEACH, MRS. FRANCES G.  
557 Fifth Ave., Salt Lake City 3

LEAVITT, CHERRY B.  
45 W. Wilson, Murray

594
SHELDON, ELEANOR C.  
851 S. 14 E., Salt Lake City 5
SISTER M. ANN PATRICE  
1015 E. First S., Salt Lake City 2
SISTER M. BERNO  
St. Benedict's Hospital, Ogden
SISTER MARY BRENDON  
Holy Cross Hospital, Salt Lake City
SISTER M. CASSIAN  
St. Benedict's Hospital, Ogden
SISTER M. EDICTA  
St. Benedict's Hospital, Ogden
SISTER M. HILARY  
1045 E. First S., Salt Lake City 2
SISTER MARY LAURENT  
1045 E. First S., Salt Lake City 2
SISTER MARY MARGARET  
St. Benedict's Hospital, Ogden
SISTER M. RAPHAEL  
1045 E. First S., Salt Lake City 2
SISTER M. ROSE ANGELA  
1045 E. First S., Salt Lake City 2
SISTER M. THEODORA  
1045 E. First S., Salt Lake City 2
SISTER M. XAVIER  
1045 E. First S., Salt Lake City 2
SMALL, MARJORIE  
1428—28 St., Ogden

TREW, ELAINE  
117 E. 21 S., Salt Lake City 5
THOMAS, ARVILLA  
463 C St., Salt Lake City 3
THOMAS, MAXINE A.  
112 S. State St., Salt Lake City
THYRET, BEVERLY A.  
181 Fourth Ave., Salt Lake City
WEBB, MARY V.  
802—25 St., Ogden
WILDER, HELEN G.  
1321 E. S. Temple, Salt Lake City
WILLIAMS, ANNA G.  
Shriners' Hospital for Crippled Children, Salt Lake City 3

VERMONT—43

AHERN, BERTHA J.  
151 Loomis St., Burlington
BEATTIE, ISABEL E.  
214 King St., Burlington
BOLDOSER, MARION E.  
Mary Fletcher Hospital, Burlington
BRUSO, MRS. MARY P.  
Washington County Sanitarium, Barre
BURNS, ALTHEA W.  
306 Colchester Ave., Burlington
BUTTOLPH, GRACE M.  
60 Colchester Ave., Burlington
CHASE, MRS. M. PATRICIA  
207 Park St., Burlington
CRABBE, FAYE  
University of Vermont, Burlington
DYKE, MRS. ELEANOR H.  
Barre City Hospital, Barre
EVANS, MURIEL A.  
151 Loomis St., Burlington

FATHER WILLIAM A. CROWLEY†  
243 N. Prospect St., Burlington
FERRY, MARY M.  
7 Heaton St., Montpelier
FOX, GRACE R.  
University of Vermont, Burlington
FRECHETTE, BERENICE E.  
19 Saratoga Ave., Burlington
GRANDON, MRS. JEAN G.  
13 College Pkwy., Winooski
GOODWIN, CAPT. ELIZABETH A., N-730458  
Murphy Army Hospital, Waltham, Mass.
GORTON, EDNA W.  
Heaton Hospital, Montpelier
HATCH, CAROLINE G.  
Heaton Hospital, Montpelier
HOAG, DOROTHY J.  
23 Patchen Rd., South Burlington
HRABSKY, NELLIE  
106 Colchester Ave., Burlington

995
DICKERSON, B. MAE
Stuart Circle Hospital, Richmond 20

DOOLEY, MRS. MILDRED W.
Lewis-Gale Hospital, Roanoke

EAGLETON, MARJORIE
Leigh Memorial Hospital, Norfolk 7

ELLIS, MRS. PEGGY L.
414 Church St., Clifton Forge

FALLEN, MRS. VIRGINIA D.
2309 Fontaine Ave., Charlottesville

FARIS, MRS. JESSIE W.
5300 New Kent Rd., Richmond

FARMER, MRS. GLADYS W.
66 Gross Ave., Richmond 24

FAULKNER, OLIVE J.
3924 Alma Ave., Richmond

FERRELL, TIFFANY
3877 Coulter Ct., Richmond

FERRIS, BEULAH M.*
200 Elm St., Salem

FORD, MRS. BARBARA S.
Box 1105, University Station, Charlottesville

FORMAN, MRS. MARGARET P.
2412 Grandin Rd., S.W., Roanoke 15

FOX, VERA V.
406 Worster Ave., Hampton

FRIEND, CORNELIA P.
100 Parkway, Kingsport, Suffolk

CARR, J. VIOLET
Memorial & Crippled Children's Hospital, Roanoke

GARY, KATHERINE R.
615 Central National Bank Bldg., Richmond 19

GEE, MRS. HELENA C.
101 E. 39 St., Richmond 24

GIRTSON, GLADYS
2510 Monument Ave., Richmond

GLASS, SUSANNE J.
552 Valley Rd., Charlottesville

GLENN, MARY D.
Veterans Administration Hospital, Richmond 19

GORDON, FRANCES
606 N. Nansomed St., Apt. 3, Richmond

GREEK, MRS. MARGARET B.
2529 Colos St., Richmond 24

GREEN, MARY L.
Norfolk General Hospital, Norfolk 7

GWALTNEY, BETTY H.
3065 Monument Ave., Richmond

HABEL, MARY L.
Riverside Hospital, Newport News

HAHN, C. VIOLA
1222 E. Marshall St., Richmond 19

HALL, MARY V.
234 Duncan Ave., Norfolk

HAMNER, MRS. M. MAE
Johnston-Willis Hospital, Richmond 20

HARDT, MRS. MARY W.
1815 Maiden Ln., Roanoke

HENRY, LILLIAN E.
St. Philip Hall, Richmond 19

HENRY, SARA M.
1301 Franklin Rd., Roanoke 16

HERITAGE, ELIZABETH V.
1407 Stanhope Ave., Richmond 27

HIGBEE, HAZEL
6218 Clover La., Richmond

HOKE, LILLIE R.
Winchester Memorial Hospital, Winchester

HOOVER, FERMA E.
142 S. Main St., Danville

HORNBERGER, MARGARET S.
University of Virginia Hospital, Charlottesville

HUTCHISON, ISABEL M.
Memorial Hospital, Danville

JONES, BESS
Cabaniss Hall, Richmond 19

JONES, NELLIE A.
Alexandria Hospital, Alexandria

JONES, MRS. SELMA S.
5 Milford Rd., Hilton Village

JORDAN, CHARLOTTE
Crippled Children's Hospital, Richmond

KEPHART, EVEL L.
57 Brandon Rd., Richmond 24

KILLINGER, MRS. HELEN H.
Route 7, Box 565, Roanoke

KING, MRS. PAULINE H.
University of Virginia Hospital, Charlottesville

KING, LT. THELM A. (NC) USN
U. S. Naval Hospital, Box 6, Navy 926, c/o FPO, San Francisco

KITE, LINDA R.
1065 Lewis Mountain Rd., Charlottesville

KNIBB, MAUDE H.
1017 Central Nat'l Bank Bldg., Richmond

KRAHR, MURIEL A.
Johnston Memorial Hospital, Abingdon

LA FON, MRS. IRENE
Blue Ridge Sanatorium, Charlottesville

LAMP, MRS. LUCY F.
301 S. Braedock St., Winchester

LANCASTER, SARA R.
McKim Hall, Charlottesville

LANFORD, ELOISE M.
Veterans Administration Hospital, Clarksburg, W. Va.

LEAKE, MRS. CAROLYN S.
7104 River Dr., Newport News

LEWIS, MRS. LETITIA C.
Box 101, Hampton Institute, Hampton

LIGON, BELLE A.
4225 Old Brook Rd., Richmond

LINCOLN, MRS. HANNAH B.
Veterans Administration Hospital, Richmond 19

LOZOWICKA, ANNA F.
Veterans Administration Hospital, Richmond 19

LUCAS, AGNES C.
Veterans Administration Hospital, Richmond 19

MacLEAN, SYBILL*
Medical College of Virginia, Cabaniss Hall, Richmond 19

MANNING, MARION A.
4016 Maury St., Richmond 19

MASON, MILDRED A.
Leigh Memorial Hospital, Norfolk

MATTHEWS, MRS. JEANETTE R.
Lake County Medical Center, Inc., Ennis, Fla.

MATTONE, EDYTHE C.
Veterans Administration Hospital, Richmond 19

MCAULIFFE, VIRGINIA C.
Cabaniss Hall, Richmond 19

McCONE, MARY J.
Winchester Memorial Hospital, Winchester

McCRAW, DORIS E.
C. & O. Hospital, Clifton Forge

MCDONALD, MARGARET M.
Route 10, Box 317, Richmond 24

VIRGINIA
ROSSER, ROSALIE  
Virginia Baptist Hospital, Lynchburg

ROSSEL, IRENE M.  
113 N. Peyton St., Alexandria

ROWELL, MRS. DORIS D.  
Diezel Housing Unit, Bldg. 2, Apt. 15, Richmond

RUSSELL, DORSYE E.  
1230 Amsterdam Ave., New York 27, N. Y.

SADLER, MRS. SABRINA S.  
1521 Avondale Ave., Richmond 22

SANNER, MARGARET C.  
211-14 St., Charlottesville

SAUNDERS, MRS. VIRGINIA L.  
Narbon General Hospital, Norfolk 7

SCHLESINGER, STEFANIE  
Veterans Administration Hospital, Richmond 19

SCHMIDT, LT. ESTHER L. (NC) USN  
U. S. Naval Hospital Corps School, Portsmouth

SCHMIDT, MARIE W.  
27 W. Lock Ln., Apt. 1, Richmond

SEIBERT, WILLIAM C.  
1202 E. 45 St., Richmond 24

SELLER, HELEN M.  
Hampton Institute, Hampton

SHELTON, MRS. MILDRED V.  
St. Philip Hospital, Richmond 19

SHELTON, MRS. OLLIE P.  
Route 8, Box 121, Richmond

SHUMATE, LOUANA M.  
1810 Cambridge Ave., S.W., Roanoke

SILBERT, EVELYN E.  
Veterans Administration Hospital, Richmond 19

SIMMONS, MARTHA R.  
1103 E. 45 St., Richmond 24

SISTER ELIZABETH OF THE DIVINE HEART  
Maryview Hospital, Portsmouth

SISTER GERALDINE OF THE PASSION  
Maryview Hospital, Portsmouth

SIZER, ESTHER A.  
R.F.D. 6, Lynchburg

SMITH, MRS. FRANCES N.  
23 Rolando Rd., Richmond 24

SMITH, SARAH M.  
Lewis-Gale Hospital, Roanoke 11

SNEAD, GLADYS V.  
2230 Park Ave., Richmond 20

SPINDLE, MRS. CLARICE B.  
151 W. Valley St., Abingdon

SPRADLIN, DORIS M.  
1206 W. Main St., Charlottesville

STANLEY, REBA G.  
Lewis-Gale Hospital, Roanoke 11

STILWELL, MARY O.  
Alexandria Hospital, Alexandria

STOUT, EMMETT M.  
St. Luke's Hospital, Richmond 20

STYRON, MRS. ELIZABETH B.  
139 Chesapeake Ave., Newport News

SWAIM, MRS. DORIS B.  
216-14 St., Charlottesville

SWIFT, MRS. CHARLOTTE R.  
3939 Caulder Ct., Richmond

TERRILL, MRS. LOUISE O.  
Veterans Administration Hospital, Kecoughtan

THOMPSON, EVELYN E.  
Cabaniss Hall, Richmond 19
ACKERMANN, HELEN C.
E. 1118 Heroy, Spokane 14

ADAMS, MARY E.
514 Medical Arts Bldg., Seattle

ADAMS, REGINA T.
1101-17 Ave., Seattle

AJHNIUS, RACHEL B.
Children's Orthopedic Hospital, Seattle 9

ALFSEN, LOUISE E.*
Department of Licenses, Olympia

AMICK, MRS. ERNESTINE B.
Deaconess Hospital, Spokane 9

ANDERSON, MRS. BETTY M.
1301 N. Sheword, Spokane

ANDERSON, EFFIE I.
Route 2, Colbert

ANDERSON, MRS. GLADYS
100 Crockett St., Seattle

ANDERSON, HELEN C.
3655 W. Mercer Way, Mercer Island

ANGOVE, JANE
1102 Eighth Ave., Seattle 1

ASKOV, MURIEL E.
Veterans Administration Hospital, American Lake

BAKER, MRS. KATHERINE K.
Virginia Mason Hospital, Seattle 1

BEAUDOUIN, MRS. ROBERTA G.
Virginia Mason Hospital, Seattle 1

BELCHER, HELEN C.
326 Ninth Ave., Seattle

BLACKBURN, CONSTANCE G.
818 Orcas St., Seattle 8

BLACKMAN, HELEN M.
1794 E. 150 St., Seattle

BLEVINS, MARY C.
2104 W. York Ave., Spokane

BOERHAVE, HILDA
1212 Maiden Lane, Pullman

BORUM, VAUNDA M.
Veterans Administration Hospital, Vancouver

BOYLE, JEAN E.
University of Washington, Seattle 5

WEST, J. ELIZABETH
1123 Mercer Ave., N.W., Roanoke 17

WEST, LULA
Dixie Hospital, Hampton

WHEELER, MRS. MARY D.
202 Park Pl., Charlottesville

WILHOIT, MRS. MARY K.
402 Brandon Ave., Charlottesville

WILLIAMS, VIRGINIA L.
3526 Wythe Ave., Apt. 2, Richmond

WILLIAMS, WILMA P.
1020 Leckie St., Portsmouth

WILLIAMSON, MRS. LAURA T.
238 Douglas Ave., Portsmouth

WILSON, MAYME B.
1222 E. Marshall St., Richmond 19

WILSON, VIRGINIA W.
2600 Kensington Ave., Richmond

WINSTEAD, ANN G.
1207 W. Franklin St., Apt. 12, Richmond

WRIGHT, VERNIE V.
6714 Kensington Ave., Richmond

WASHINGTON—189
DAIGLE, DOROTHY H.
210 Harton, Spokane 9

DAVIS, BERTHA M.
1017 W. Chestnut St., Walla Walla

DEAN, RUTH W.
Puget Sound Naval Memorial Hospital, Bremerton

EBORRA, ELAINE L.
Veterans Administration Hospital, Seattle

DILLON, CLAIRE
 Gonzaga University, Spokane 11

DUNCAN, GERALDINE H.
1018 Ninth Ave., Seattle 4

DUNNUM, MRS. ZETA M.
316 W. McGraw, Seattle 99

EDCERTON, DOROTHY L.
3708-41, S.W., Seattle 6

EKLUND, HERINA D.
Swedish Hospital, Seattle 4

ELWOOD, EVELYN B.
Harborview Hall, Seattle 4

FAFY, MRS. MARIE M.
Children's Orthopedic Hospital, Seattle 9

FARROW, HARRIET P.
2052 S. I st St., Seattle 88

FEKK, MRS. IRJA
1337 Boren Ave., Seattle 1

FEINLER, MARIE S.
58 W. 25 Ave., Spokane 10

FELTON, VIRGINIA
1544 Palm Ave., Seattle 6

FERGUSON, VIRGINIA S.
516 E. Union, Seattle 22

FILER, ILADENE H.
1713 E. Cherry St., Seattle 22

FISHER, MRS. ALICE L.
P.O. Box 4, Bothell

FORSBERG, LEONA
Tacoma General Hospital, Tacoma 3

FOURHMAN, DORIS V.
1722 E. Thomas St., Seattle 2

GLYNN, DOROTHY E.
Harborview Hospital, Seattle

GOEMAI RE, MRS. NATHALIE D.
Virginia Mason Hospital, Seattle

GRAY, FLORENCE I.
Harborview Hospital, Seattle

GRENZ, MRS. PHYLLIS M.
2550 Sixth Ave. W., Seattle 99

GRESHET, MAXINE M.
10709-19 S., Seattle 66

GUNDERSEN, MRS. BERGIT G.
St. Luke's General Hospital, Bellingham

GUSTAFSON, DOROTHY D.
W. 2210 Sharp Ave., Spokane

HALL, MARY B.
1500 Columbia Way, Longview

HANSEN, JULIA A.
1317 N. 45 St., Seattle 3

HANSON, FREDERICK R.
Walla Walla College, College Place

HAYES, VERNA
Veterans Administration Hospital, Spokane

HAYNES, MARY A.
3526 Colby, Everett

HEITMAN, SALLY
Harborview Hall, Seattle

HITZROTH, MRS. GLADYS S.
Route 4, Box 16, Kirkland

HOFFMAN, KATHERINE J.
University of Washington, Seattle 5

HUTCHINS, CAROL L.
R.F.D. 2, Box 446, Renton

HYMOM, GERTRUDE
Swedish Hospital, Seattle 4

IRVING, MRS. JEANNE M.
Route 1, Box 1140c, Edmonds

JAHNKE, GLADYS A.
State Dept. of Health, Smith Tower Bldg., Seattle 1

JAMISON, LAURA M.
1212 Fairview Ave., Yakima

JEWETT, HELEN M.
1112 N. Tenth St., Tacoma

JOHNSON, ELVA L.
108 E. 12 Ave., Spokane

KAWAFUNE, LAURA
905 Spruce St., Seattle 4

KERY, CHARMY G.
1911 Linden Ave., Seattle 33

KING, DOROTHY M.
15 W. Bostman St., Seattle 99

KINNAMAN, HELEN E.
3602 W. Landcr, Seattle 6

KINNEY, CAROLYN E.
University of Washington, Seattle

KOSCHEIDER, JULIA F.
516 E. Union, 209, Seattle

LANKFORD, MRS. MARGARET A.
10 Valley St., Apt. 35, Seattle 45

LEAHY, KATHLEEN M.
University of Washington, Seattle 5

LEAVITT, MRS. HELEN B.
7 Harrison St., Apt. 14, Seattle

LEWIS, GARLAND K.
2441 Eighth Ave., N., Seattle 9

LYSNE, AGNES T.
Everett General Hospital, Everett

MacIVOR, VIRGINIA
100 Crockett St., Seattle

MANN, MARY L.
St. Joseph's Hospital, Tacoma 3

MANSBERGER, MARGUERITE
Virginin Mason Hospital, Seattle

MARSHALL, MARY A.
St. Luke's Hospital, Spokane

MATSON, MRS. MYRTLE
42 W. 28 Ave., Spokane 9

MAY, CAROLYN A.
1000 Seneca, Seattle 2

MEEKER, VERA J.*
Deaconess Hospital, Spokane 9

MELIN, ETHEL L.
734 Broadway, N., Seattle 2

MELTON, MARIAN E.
Veterans Administration Hospital, American Lake

METCALF, MARION L.
1114-17 Ave., Seattle 22

MILLER, IDABELLE G.
418 S. Lincoln St., Spokane

MILLER, MARIE E.
7710 Rieves Ave., Seattle 5

MITCHELL, HAZEL L.*
E. 1416-12 Ave., Spokane 10

MOORE, ANNA R.
Dept. of Health, Smith Tower Bldg., Seattle 1

MORGAN, TIRZAH M.
University of Washington, School of Nursing, Seattle 5
SISTER CARMELINA  
St. Peter's Hospital, Olympia  

SISTER ELIZABETH CLARE  
Mt. St. Vincent, Seattle  

SISTER GENEVIEVE  
1715 E. Cherry St., Seattle 22  

SISTER GIACOMINA*  
Columbus Hospital, Seattle 1  

SISTER GUSTAVE MARIE*  
St. Elizabeth Hospital, Yakima  

SISTER JOHN GABRIEL  
Sacred Heart Hospital, Spokane 9  

SISTER JOSEPH  
Anchorage Hospital, Anchorage, Alaska  

SISTER MARIE CARMEN*  
St. Mary's Hospital, Walla Walla  

SISTER M. BEATRICE  
St. Joseph's Hospital, Bellingham  

SISTER M. EVARD  
St. Joseph's Hospital, Tacoma 3  

SISTER MARY F.C.S.P.  
Mt. St. Vincent, Seattle  

SISTER MARY GONZAGA  
St. Joseph Hospital, Vancouver  

SISTER MARY IGNATIUS  
Mater Misericordiae Hospital, Roseland, B. C., Canada  

SISTER MARY JUSTIN  
Our Lady of Lourdes Hospital, Pasco  

SISTER MARY MAGDALENA  
Sacred Heart Hospital, Spokane 9  

SISTER MARY MILDRED  
Our Lady of Lourdes Hospital, Pasco  

SISTER MIRIAM  
Sacred Heart Hospital, Spokane 9  

SISTER MONICA  
St. Elizabeth Hospital, Yakima  

SISTER REINE  
St. Elizabeth Hospital, Yakima  

SISTER RITA MARY  
St. Joseph's Hospital, Bellingham  

SISTER RUTH MARIE  
Providence Hospital, Everett  

SMITH, ELIZABETH M.  
Children's Orthopedic Hospital, Seattle 9  

SMITH, HARRIET H.  
University of Washington, Seattle 9  

SMITH, LAURA B.  
Seattle Pacific College, School of Nursing, Seattle  

SOULE, MRS. ELIZABETH S.  
Dept. of Nursing Education, University of Washington, Seattle 5  

SPAELSTRA, RUBY E.  
1119 Lombard St., Everett  

SPRY, MRS. CECELIE T.  
General Hospital of Everett, Everett  

STALEY, GRACE E.  
733 W. Fourth St., Spokane  

STARTUP, JUSTINE  
1704 E. 150 St., Seattle 5  

STEPHENSON, MRS. SHIRLEY S.  
St. Luke's Hospital, Spokane  

STOLESON, HELEN E.  
1733 W. 61 St., Seattle  

STRANATHAN, DORIS J.  
Veterans Administration Hospital, American Lake  

SUMPTION, MRS. KATHLEEN Q.  
Route 1, Box 146D, Bellevue
WASHINGTON—WEST VIRGINIA

SVELANDER, MRS. KATHARINE C.
Swedish Hospital, Seattle 4

SWEENEY, FAY E.
630 W. Fourth St., Spokane 9

THOMPSON, JEAN
Harborview Hospital, Seattle 4

THOMPSON, LILIAN M.
Children’s Orthopedic Hospital, Seattle 9

TSCHUDIN, MRS. MARY O.
University of Washington, Seattle

UHRIG, CATHERINE L.
1019 Madison St., Seattle 4

WEST VIRGINIA—61

ADAIR, JEAN B.
1032 Laird Ave., Parkersburg

BABCOK, MRS. VIDA R.*
Alderson-Broaddus College, Philippi

BINGAMAN, JOSEPHINE C.
Kanawha Valley Hospital, Charleston

BLAND, MRS. CECEL W.
420 S. Third, Clarksburg

BLOOMHEART, ELLA
1424-28 St., Parkersburg

BURROUGHS, CLIFFORD L.
Alderson-Broaddus College, Philippi

CAMPION, ORA A.
Memorial General Hospital, Elkins

COLEMAN, MRS. JURHETTA N.
Box 22, Institute

CORBITT, ALMA C.
Charleston General Hospital Charleston

CORDER, ELEANOR G.
107 Maple Grove Addition, Morgantown

COX, MRS. MILDRED
Davis Memorial Hospital, Elkins

DOE, FLORENCE M.
City Hospital, Martinsburg

DOUGLAS, MRS. FRANCES N.
144 Wainsman St., Morgantown

DUFFY, MARGARET B.
Veterans Administration Hospital, Martinsburg

DuNEZ, MARIORIE E.
408 Davidson Blbg., Charleston 1

DYE, ELIZABETH
2220 Broad St., Parkersburg

ELLENWOOD, CATHERINE E.
Camden-Clark Memorial Hospital, Parkersburg

ELLIFRITT, EVELYN D.
2001½ Plum St., Parkersburg

FAHRAR, MARY F.
Monongalia General Hospital, Morgantown

FLANAGAN, MRS. ALICE J.
Camden-Clark Memorial Hospital, Parkersburg

GARDINER, ANN H.
119 N. Maple Ave., Martinsburg

GARRITY, HELEN
1108 Virginia St., Charleston

GAUSEMAN, ELIZABETH
2015 Adams Ave., Huntington 4

GILMORE, ELIZABETH E.
Camden-Clark Memorial Hospital, Parkersburg

GURNEY, ELIZABETH
Alderson-Broaddus College, Philippi

HALL, DORA T.
Fairmont General Hospital, Fairmont

HAYMOND, MARGARET S.
358 Lincoln St., Fairmont

HOKE, MRS. CUSSEY H.
922 Overlook Way, S.W., Charleston

JOBE, DOROTHY L.
Homewood Addition, Fairmont

JONES, MRS. EVANGELINE B.
McMillan Hospital, Charleston

JONES, MARY R.
Laird Memorial Hospital, Montgomery

LANG, INEZ C.
1513 Staunton Ave., Parkersburg

MALONEY, MAY M.
47 Capitol City Bldg., Charleston

MASSEY, W. ANNETTE
239 Fifth Ave., Huntington

MOTZNO, BILIHAY N.
Camber-Clark Memorial Hospital, Parkersburg

OSWALD, C. JEANETTE
College of Arts & Sciences, West Virginia University, Morgantown

PARKER, MRS. MADELINE
933 Lakeview Dr., Parkersburg

PROBSTNER, DOLORES
Fairmont General Hospital, Fairmont

RALPH, MRS. EMMA J.
Stewartstown Rd., Morgantown

ROSIER, ALBERTA L.
Fairmont General Hospital, Fairmont

SCHNEIDEL, HELEN M.
1122 Marshall St., MeMechen

SCOTT, VIEVA P.
2064 Beech St., Parkersburg

SIENS, LEAH V.
2724 First Ave., Huntington

SISTER M. CAROLA
St. Mary's Hospital, Huntington 2

SISTER M. CHANTAL
St. Mary's Hospital, Clarksburg

SISTER MARY ELLEN
St. Mary's Hospital, Clarksburg

SISTER M. FRANCES
St. Mary's Hospital, Huntington 2

SISTER M. PALMATIA
Sacred Heart Hospital, Richwood

SISTER MARY PAUL
St. Francis Hospital, Charleston

SISTER M. PIA
Vincent Pallotti Hospital, Morgantown

SISTER MARY RUTH
St. Mary's Hospital, Clarksburg
WISCONSIN—215

COE, RUTH L.
211 N. Carroll St., Madison 3

COLLINGS, IDA A.
1010 Mound St., Madison 3

COLOMB, BESSIE B.
Bellin Memorial Hospital, Green Bay

COOPER, SIGNE S.
416 N. Park St., Madison 6

CORRIGAN, HAZEL
3623-A W. Maple St., Milwaukee

COTTRELL, RUTH K.
4147 N. Craner St., Milwaukee 11

CRAWFORD, JOAN V.
71 Vincent St., Fond du Lac

CRUMP, MARGARET C.
Wisconsin General Hospital, Madison

CYZAK, CHARLOTTE M.
5207-72 St., Kenosha

DAGNON, M. LUCILLE
570 N. Washington St., Janesville

DANDOY, LORRAINE B.
Veterans Administration Hospital, Wood

DELSMAN, MRS. MILDRED M.*
2922 W. Juneau Ave., Milwaukee 3

DOEHLER, MARY S.
1321-A N. 43 St., Milwaukee 8

DUDDLESTON, LEON C.
1218 Spring St., Madison

DUFFY, MARGERY
2563 N. 12 St., Milwaukee

DUNN, MARION J.
201 N. Randall Ave., Madison

DYE, HELEN H.
935 N. Cass St., Apt. 6, Milwaukee

EMANUEL, MARGARET
217 N. Orchard, Madison 5

ERNSTES, KATHRYN B.
4306 N. Teutonia, Apt. 101, Milwaukee 9

ESVAL, SIGRID
Luther Hospital, Eau Claire

EVANS, ELLEN M.
925 Mound St., Madison 5

FARRELL, CHARLOTTE P.
229 N. Hilsabe Terr., c/o Mrs. Muriel Wagner, Madison

FIELD, BONNIE J.
3321 N. Maryland Ave., Milwaukee 11

FINK, ELIZABETH
3056 N. 51 St., Milwaukee

FINN, CAPT. FLORENCE F., AFNC
Air Force School of Aviation Medicine, Gunter AFB, Montgomery, Ala.

FLETCHER, LILA B.
Wisconsin General Hospital, Madison 6
FLYNN, MARY D.
416 McKinley, Eau Claire

FOX, ELIZABETH
620 N. 17 St., Milwaukee 3

GESSELL, MARGARET
3151 N. Second St., Milwaukee 12

GEYER, ANNE M.
323 W. Washington Ave., Madison

GIEHARH, OLGA L.
2912 S. Wentworth Ave., Milwaukee 7

GOTTSCHAL, CAROLYN L.
3302 N. 25 St., Milwaukee 6

GRANT, DOROTHY L.
1024 Main St., Racine

GRANZOW, ELIZABETH R.
Mount Sinai Hospital, Milwaukee

GREZINSKI, VICTORIA L.
2150-A S. 19 St., Milwaukee 7

GRUBE, AGNES M.
5427 Winnequah Rd., Madison

GUETZLOW, MARY G.
3554-A E. Cudahy Ave., Cudahy

GUNDERSON, MRS. ARLEEN S.
1218 Spring St., Madison

GYANT, LOIS B.
Luther Hospital, Eau Claire

HAMERLY, MRS. MARY C.
321-42 St., Menomonie

HARDER, FLORENCE L.
4217 W. Fon du Lac Ave., Milwaukee

HARTTEL, MRS. ALICE C.
3231 N. Maryland Ave., Milwaukee 11

HASSELLS, ANNA
7740 W. North Ave., Wauwatosa 13

HAUBRICK, SYLVIA E.
742 S. Webster, Green Bay

HELMLE, HERTHA P.
1302 College Ave., Racine

HENDRICKSEN, MRS. L. KATHLEEN
2224 W. Junear Ave., Milwaukee 3

HENSHEL, CARMEN
755 N. 29 St., Milwaukee

HERIN, BERNICE
4114 W. Martin Dr., Milwaukee

HILL, MARGARET L.
742 S. Webster St., Green Bay

HOFFMAN, CLARA
3035 W. Wisconsin Ave., Milwaukee 8

HOGAN, MARY C.
3421 W. Wells St., Milwaukee 9

HOLLISWANDER, CAROLINE H.
3050 N. 51 St., Milwaukee 10

HOPPER, RUTH J.
Winnebago State Hospital, Winnebago

HOWE, VIDABELLE D.
920 Barstow, Oshkosh

HUBBARD, MAGDALENE T.
538 N. 63 St., Wauwatosa

JENNY, MARTHA R.
2217 University Ave., Madison

JENSEN, ALICE
3019 N. Farwell Ave., Milwaukee 11

JIMENEZ, TRINIDAD
170 Oak St., Oshkosh

JOHNSON, GLADYS L.
Veterans Administration Hospital, Wood

JOHNSON, MRS. JANET T.
1821 W. Wisconsin Ave., Milwaukee 3

JORDHEIM, OLGA M.
St. Luke’s Hospital, Racine

JORGENSEN, GRACE T.
1617 Taylor Ave., Racine

JOYE, MARJORIE E.
331 N. Madison St., Green Bay

KAHN, FLORENCE
2310 W. Kilbourn Ave., Milwaukee 3

KERWIN, DORIS
1018 N. Jefferson St., Milwaukee 2

KRUEGER, LEONA
940 N. 23 St., Milwaukee 3

KULZICK, MRS. MAXINE H.
312 Butternut Rd., Madison 4

LARSON, BERNICE E.
St. Luke’s Hospital, Milwaukee

LAWTON, MRS. WEALTHY
926 N. 24 St., Milwaukee 3

LEE, MRS. MARIAN K.
1431½ Newton St., Eau Claire

LOCKE, MRS. EBBY O.
317 N. Murray, Madison

LUBINA, LILLIAN C.
909 N. Milwaukee St., Milwaukee 2

LUNDMARK, MRS. MARGARETA H.
3011 N. 40 St., Milwaukee 10

LUTOVSKY, DOROTHY
3068 N. 27 St., Apt. 202, Milwaukee 10

MacLACHLAN, MARGERY*
University of Wisconsin, School of Nursing, Madison 6

MANNARD, MRS. BERNICE I.
3250 W. Meinecke Ave., Milwaukee 10

McBRIDE, ELIZABETH
Veterans Administration Hospital, Wood

McDERMOTT, GRACE M.
613 Center Ave., Janesville

MERCER, M. EVELYN
8900 W. Wisconsin Ave., Milwaukee

METZKER, AMALIA L.
Luther Hospital, Eau Claire

MEYER, MRS. MARY E.
3703 W. Scott St., Milwaukee 15

MICKRITZ, MRS. STELLA M.
827 Lake Ave., Racine

MILLER, GENEVA E.
Bollin Memorial Hospital, Green Bay

MULANEY, GERTRUDE S.
624 N. 32 St., Milwaukee 8

NAGLER, RUBY M.
615 N. 14 St., Milwaukee 3

NICKEL, LINDA D.
2910 N. Richards St., Milwaukee 12

O’KEEFE, MARY E.
2822 N. First St., Milwaukee

OLEJNICKA, VERNA
3321 N. Maryland Ave., Milwaukee 11

ORMSON, LORRAINE
433 Lorch St., Madison 5

PAQUIN, MARJORIE C.
434 N. Randall Ave., Madison

PEABODY, MRS. MARION P.
1218 Spring St., Madison

PHENIX, FLORENCE L.
2557 N. Booth St., Milwaukee 12

PLATH, MRS. LYDIA
Luther Hospital, Eau Claire
SISTER M. CORINNE
St. Agnes Hospital, Fond du Lac
SISTER M. DIGNA
475 Gillette St., Fond du Lac
SISTER MARY DOLORITA
570 N. Washington, Janesville
SISTER M. EDITH
St. Joseph's Hospital, Marshfield
SISTER MARY ETHELREDA
3000 W. Chambers St., Milwaukee 10
SISTER M. FABIANA
1415 S. 32 St., Milwaukee 4
SISTER M. FORTUNA
St. Joseph's Hospital, Beaver Dam
SISTER M. FRANCITA
St. Francis Hospital, La Crosse
SISTER M. IRENAE
Mercy Hospital, Oshkosh
SISTER M. IRENE
St. Agnes Hospital, Fond du Lac
SISTER MARY JOSEPHINE
475 Gillette St., Fond du Lac
SISTER MARY LAWRENCE
Holy Family Hospital, Manitowoc
SISTER M. LOUIS
5000 W. Chambers St., Milwaukee 10
SISTER M. OTTONELLA
Sacred Heart Sanitarium, Milwaukee 4
SISTER M. PHILOMENA
St. Agnes Hospital, Fond du Lac
SISTER MARY REDEMPTRA
Mercy Hospital, Janesville
SISTER M. REGULA
St. Francis Hospital, La Crosse
SISTER M. SILVANA
Holy Family Hospital, Manitowoc
SISTER M. THOMAS
St. Joseph's Hospital, Milwaukee 10
SISTER MARY VICTIMA
Holy Family Hospital, Manitowoc
SISTER M. VIRGINIA
3038 N. 51 St., Milwaukee 10
SISTER M. WILFREDA
St. Agnes Hospital, Fond du Lac
SISTER MERCEDES
2320 N. Lake Dr., Milwaukee 11
SISTER ROSE
St. Mary's Hospital, Milwaukee 11
SISTER M. MILDRED
Misericordia Hospital, Milwaukee
SISTER ST. ODILON
2224 W. Juneau Ave., Milwaukee 3
SLUPINSKI, ELIZABETH C.
1717 E. Kane Pl., Milwaukee
SMITH, ROSE A.
567 N. 63 St., Wauwatosa
SMITH, RUTH L.
3015 N. Farwell Ave., Milwaukee
SMITH, SANE
3910 N. Walnut St., Milwaukee 8
STAHL, ADELE C.
605 W. Lakeside, Madison
STAMPER, OPAL
1329 Villa St., Racine
STEINKRAUSS, MARCELLA
2651 N. 38 St., Milwaukee 10
STEWART, MARGARET S.
315 N. Pinekney St., Madison 2
STOCKS, BERNETTE C.
1010 Mound St., Madison 5

STOLARCZYK, DELPHINE
1927 S. 32 St., Milwaukee 15

STOOPS, FRANCES M.
431 W. Main St., Platteville

SWATSLEY, DOLORES E.
1728 Van Hise Ave., Madison 5

TAYLOR, AGNES J.
844 N. 12 St., Milwaukee 3

TEASDALE, HELEN
Methodist Hospital, Madison 3

TEICHEN, MRS. WILHELMINA F.
2318 S. 38 St., Milwaukee 14

TeLinde, RUTH E.
1206 E. Kane Pl., Apt. 102, Milwaukee

TOPZANT, ALICE
2163 N. 73 St., Milwaukee 13

TOUTENHOOFD, KOREEN E.
Veterans Administration Hospital, Wood

TURCK, A. SYLVIA
1203 S. 60 St., Milwaukee 14

VAKOS, MRS. DORIS
610 State St., Racine

VOLKMANN, LAURA M.
2324 W. Mineral St., Milwaukee 4

VOPAL, MRS. ARLENE D.
5602 W. Grant St., Milwaukee

WATSON, SHIRLEY
409 N. Charter St., Madison

WEISS, ROSE M.
St. Mary's Hospital, Milwaukee 2

WELLER, MRS. ELLEN M.
2102 N. 71 St., Wauwatosa 13

WELLINGTON, BERTHA J.
Veterans Administration Hospital, Waukesha

WIITA, VIOLETTE V.
Mendota State Hospital, Mendota

WILHELM, MARGARET A.
4544 W. Leon Ter., Milwaukee 10

WINTER, MARGARET
3321 N. Maryland Ave., Milwaukee

WYATT, MARGARET
7915 W. Center St., Milwaukee

ZABLOCKI, MABEL D.
1010 Mound St., Madison 5

ZELLMER, CAROL
5333 N. 64 St., Milwaukee 9

ZIEBELL, DOROTHY C.
4779-A N. Hopkins St., Milwaukee 16

ZIECEL, ERNA E.
434 N. Randall Ave., Madison

ZINZOW, MRS. ROSELINE
1377 N. 54 St., Apt. 204, Milwaukee 8

‡WYOMING—6

BATTIN, MRS. DOROTHY F.
Veterans Administration Hospital, Sheridan

BORDEAUX, MRS. ESTHER P.
123 E. College Ave., Sheridan

HILL, ELIZABETH J.
Box 244, Jackson

‡ALASKA—4

DINGMAN, RITA
Box 386, Valdez

DUNCAN, ANN M.
c/o General Delivery, Fairbanks

CAVALCANI, MRS. MARIA D.
137 Ave., Franklin D. Roosevelt, 5 Andar—S.511, Rio de Janeiro

‡BRAZIL—2

CAMPBELL, MARY C.
R.R. 3, Emerald Junction, Prince Edward Island

HART, MARGARET E.
448 Rosterdale Ave., Winnipeg, Manitoba

KESSLER, EVELYN
4150 Ridgevale Ave., Montreal

‡CANADA—6

PENHALE, HELEN E.
University of Alberta, Edmonton, Alberta

PULLEN, BERTHA L.
700 Bennett Ave., Winnipeg, Manitoba

WRIGHT, ALICE L.
1101 Vancouver Block, Vancouver, B. C.

‡CANAL ZONE—1

LIZOTTE, ALBERTA E.
Box 1095, Ancon

‡ALASKA—4

HANSON, HAZEL
Box 162, Nome

REYNOLDS, ELIZABETH O.
Seward Sanatorium, Bartlett

‡BRAZIL—2

CURTIS, MRS. CLARA W.
Caixa Postal 1264, Rio de Janeiro

‡CANADA—6

PENHALE, HELEN E.
University of Alberta, Edmonton, Alberta

PULLEN, BERTHA L.
700 Bennett Ave., Winnipeg, Manitoba

WRIGHT, ALICE L.
1101 Vancouver Block, Vancouver, B. C.

‡CANAL ZONE—1

LIZOTTE, ALBERTA E.
Box 1095, Ancon
MEMBERS

CRAWFORD, MARTHA H.
109 Regent St., Colombo

CASE, PEGGY ANN
A. P. Mission & Sangli, B. P., India

FULTON, JANET
American Hospital, Teheran

ALT, GRACE E., N724122

BOWMAN, MRS. HELEN D.
American University Hospital, Beirut
MOSER, ELIZABETH
American University Hospital, Beirut

COOPER, MRS. JEANNETTE L.
Liberian Government Hospital, Monrovia
MOORE, ELLEN M.
P.O. Box 16-B, Monrovia

MONTEITH, MRS. MARY C.
Apartado 16, Montemorelos, N. L.

MURPHY, MARY E.
Lago Hospital, Aruba, Curacao

NAUDE, PHILLIPINA M.
Philippine Union College, P.O. Box 1772, Manila

GARDINER, LILLIAN A.
ECA-STEM, American Embassy, Bangkok

HOWITT, HELEN*
c/o American Embassy, Montevideo

BLANCHETTE, FLORA L.
Queen St., Christiansted, St. Croix

CEYLON—INDIA—IRAN—OTHERS

‡CEYLON—1

‡INDIA—2
MARTYN, FLORENCE H.
12, Boulevard Rd., c/o Bishop J. W. Pickett, Delhi

‡IRAN—1

‡JAPAN—2
WHITE, MRS. SARAH G.
St. Luke's Hospital, 19 Akashi Cho, Chuoku, Tokyo

‡LEBANON—3
PEARSON, MAUD
American University Hospital, Beirut

‡LIBERIA—3
MURRAY, ETHEL R.
St. Timothy's Hospital, Monrovia

‡MEXICO—1

‡NETHERLANDS WEST INDIES—2
STAMBAUGH, RUTH E.
Lago Oil & Transport Co., Ltd., Medical Dept., Aruba, Curacao

‡PHILIPPINES—1

‡THAILAND—1

‡URUGUAY—1

‡VIRGIN ISLANDS—2
FINLEY, ESTHER M.
Dept. of Health, Charlotte Amalie, St. Thomas
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*No state league
### Members

#### Total Membership August 1, 1951

(Continued)

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<th>State</th>
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</table>

*No state league

---

**Deceased Members**

Names from 1893 to October 1, 1950, are given in previous annual reports. The names of members whose deaths have been reported since October 1, 1950, follow:

- **Byrne, A. Isabelle** November 21, 1950
- **Calderwood, Carmelita** October 9, 1951
- **Cundiff, Ruth H.** April 7, 1951
- **McKay, Angela M.** January 17, 1951
- **Sizer, Mrs. Ed. R.** September 27, 1950
- **Theilstad, Inez** February 3, 1951

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