

Going Public

CHILDBIRTH, THE BOARD OF HEALTH, AND MONTANA WOMEN, 1860–1920



by Jennifer J. Hill



Sophia Kempton (second from left) was likely pregnant with her daughter Fern when this photograph was taken on July 22, 1906. The other family members are (left to right) Maria Gerry Kempton, J. B. Kempton, Esther Kempton, Lily Kempton, Jim Kempton, and Sarah Kempton. Sophia could expect the support and companionship of her female relatives during her upcoming delivery. Trained assistance was likely more difficult to obtain, and the Kempton women, like other new Montana residents of their era, adapted their birthing practices to a sometimes stressful reproductive environment.

Evelyn Cameron, photographer, MHS Photograph Archives, Pac 90-87.N045

Before hospital services were widely available, women delivered their babies at home, surrounded by family and friends. For immigrants to the American West, these customs of social birth changed during a brief sixty-year period, from the 1860s through the 1920s. Settlers faced new challenges in an isolated environment, and the often harsh realities of frontier geography, weather, and economic constraints had a direct effect on the process of childbirth as women and men adapted to altered living situations and scarce resources.

Nascent territorial and state governments scrambled to develop public health infrastructure to measure, assess, and remedy the complications of labor and delivery for pregnant women. In the 1860s, few public resources existed to combat maternal and infant mortality. But by the 1920s, public health institutions began to bear a collective responsibility for the nation's mothers and children. The realities of childbirth in Montana, documented in private domes-

tic accounts as well as the annals of the Montana State Board of Health, reflect a significant expansion of public concern over reproductive mortality and, consequently, a growth in public services to address reproductive issues.

The efforts of early twentieth-century public health departments illuminated the private act of giving birth and brought it to the public view. In Montana, the work of the State Board of Health revealed the harsh realities of childbirth and the very real costs of settling the state. Extracting the wealth of the West was accomplished, in part, through the reproductive investment of immigrant women, who shouldered the responsibility of care for the region's most vital natural resource, its newborn citizens.

The Reality of Reproduction

Euro-American women entered the American West during all stages of the western migration. Living



American Heritage Center, University of Wyoming

Anna Finrock settled in Laramie, Wyoming, and gave birth to her first child, Eddie (center), in 1865. Henry (right) followed in 1871, Mary Catherine (not pictured) in 1873, and Albert (left) in 1875. A two-year interval between births, often caused by decreased fertility during breastfeeding, was typical. In the absence of reliable and consistently procurable contraception, women of childbearing age often experienced numerous and closely spaced pregnancies.



Cynthia Jane Capron, a skilled artist, sketched numerous images during her western travels, including this one of Fort Laramie, Wyoming Territory, circa 1873. While her access to medical care at Fort Laramie was limited and her living conditions austere, she was far less isolated than other women residing in the area at the time.

with her new husband William at his Dakota Territory military post, Anna Finfrock became pregnant and gave birth to her first child in 1865. After a move to what would become Laramie, Wyoming, she had three more children. With births approximately two years apart—Henry in 1871, Mary Catherine in 1873, and Albert in 1875—Anna’s pregnancies followed the typical every-other-year reproductive pattern of the time. Like Finfrock, Cynthia Jane Capron traveled with her husband Thaddeus to his military posting. On the night of June 9, 1868, she experienced intense labor pains, worrisome, as Thaddeus explained, because “it [was] not time for our birth.” Fortunately, the pains subsided, and in July, Capron delivered a healthy baby boy. Over the course of her marriage to Thaddeus, she gave birth to four more children.¹

In the 1860s, the frontier was expanding as the U.S. Congress approved the boundaries of Dakota

Far from family and friends, Capron experienced early labor pains in June of 1868. After a time of worry and concern, the contractions ceased, and she delivered a healthy infant in July.



This page: Thaddeus Hurlbut Capron Collection, American Heritage Center, University of Wyoming

Territory in 1861, Idaho Territory in 1863, Montana Territory in 1864, and Wyoming Territory in 1868. Families like Cynthia Jane Capron's and Anna Finfrock's were among the thousands drawn westward by economic opportunities and the adventures of mining, homesteading, cattle ranching, and military campaigns.² These new settlers established homes, sowed gardens, and put down roots in burgeoning communities.

In Montana Territory, as in other places in the

West, residents began to act on the need for health facilities as the population mushroomed. In St. Ignatius, the Sisters of Charity of Providence, operating with meager funds and supplies, provided general health care assistance for Native Americans and white immigrants in the area. Mother Caron, head of the order, also initiated the establishment of St. Patrick's Hospital in Missoula during her tenure in western Montana.³ The call for hospital services and formal medical care also resulted in the creation of small

Early hospitals were often small and unassuming and were sometimes housed in former residences. The Miners Hospital in Helena (original site pictured at right) opened in 1866 and was representative of early medical institutions. Over the years, hospital facilities, such as the St. James Hospital in Butte (below), expanded and established a significant presence in urban areas.



MHS Photograph Archives, 953-518



MHS Photograph Archives, 946-103



Laurentza Koch and her husband Peter moved to Bozeman in 1874. Laurentza's extended family remained in Mississippi, and while she lamented their absence during her pregnancy, she relied on a local midwife, Mrs. Rich, for care before, during, and after the delivery. Laurentza also consulted Dr. Whitefoot, a military physician stationed in the area.

hospitals throughout the state. The Miners Hospital in Helena, founded in 1866, was soon followed by the establishment of two small hospitals in Deer Lodge in 1870, and the Sisters of Charity of Leavenworth completed the St. James Hospital in Butte in 1881.⁴ Despite the growing number of medical facilities, settlers and Native Americans living in rural areas outside the reach of urban hospitals continued to struggle to access medical care.

Women residing in the more settled parts of the territory typically hired physicians, nurses, or midwives to assist in childbirth. Laurentza Koch married her cousin Peter, a Danish immigrant, in 1874 and moved to Bozeman, Montana, where Peter worked as an attorney and banker. In 1875, Laurentza wrote to her mother, Annette, that she felt “rebellious and ugly” when she realized she was pregnant, and she dreaded the frequent nausea. Unlike many of her contemporaries, Koch had access to a doctor, as well as the services of a midwife. The military post



Courtesy of the Yellowstone Gateway Museum of Park County, Montana

Elizabeth Rae trained in Scotland as a nurse and midwife. In the 1890s, she opened a maternity home in Livingston, Montana, and provided health care services in a variety of settings—in her own home, as a private duty nurse, in her work with local physicians, and as a midwife delivering babies. She was an integral part of the community, and her neighbors relied on her for consistent care and support.

physician, Dr. Whitefoot, administered calomel, a common purgative at that time, to alleviate her frequent stomach discomfort. The midwife, Mrs. Rich, attended Koch in her “sickness” and provided “advice and assistance” as the pregnancy progressed.⁵

Elizabeth Rae trained as a nurse and midwife in Scotland, and after settling in Livingston, Montana, she opened a maternity home. Rae offered midwifery services and cared for premature babies that required specialized attention. Her neighbors called her “Aunty Rae,” and she furnished essential care in the community, where people remembered her warming infants on the open door of her stove.⁶ Women like Rich and Rae worked in conjunction with physicians but also



Katherine Sweeting, pictured here with her baby, Phyllis, in 1922, worked as a midwife in northern Montana. Nurses and midwives assisted in deliveries across the state, and rural communities, in particular, depended on their services.

maintained their own independent practices, serving the reproductive needs of Montana’s residents.

Some pregnant women could choose from a number of overlapping providers and birthing locations. In the community of Malta, Montana, in the 1890s, Mrs. Clanton provided help to local women who were ready to give birth. For women planning to deliver at home, Clanton would travel to assist at the birth and

then stay for up to two weeks, performing necessary housekeeping chores like meal preparation and cleaning for which she received a salary of one dollar a day. Local women gained an additional delivery option when Mary Robertorye, a community midwife, moved to town in 1907 and opened her home to maternity patients.⁷ Birth patterns in Malta reflected a national trend, with many women delivering at home, rather than in a hospital, well through the 1920s.⁸

Nurses and midwives worked with physicians, but they often oversaw routine deliveries on their own. Anna Karstedt advertised her midwifery practice in Helena in 1891, but she eventually moved to



In 1901, the Montana legislature created the State Board of Health, which began tabulating births and deaths in the state. That same year, Louisa Waite (center) posed for this photograph with her son Charles (in buggy) and some friends on the street of Utica, Montana. Only two doctors served the town of Utica, leaving women to locate additional delivery services when physicians were called to emergency cases. Busy doctors spent a great deal of time treating the symptoms of infectious diseases such as tuberculosis, smallpox, diphtheria, and typhoid.

Butte, where she continued to assist with deliveries. While Karstedt interacted with other health care professionals in the course of her work, she offered her services independent of other physicians, hospitals, or maternity homes.⁹

As the population of mining cities like Butte and Helena boomed, contagious epidemics were difficult to control. The rapid spread of infectious diseases highlighted the absence of an official health care infrastructure, and in 1901 the Montana legislature created the State Board of Health to assist in containing tuberculosis, smallpox, diphtheria, and typhoid.¹⁰ As the state's populations grew, city and county municipalities hired health officials to systematize and regulate sanitation and public health.

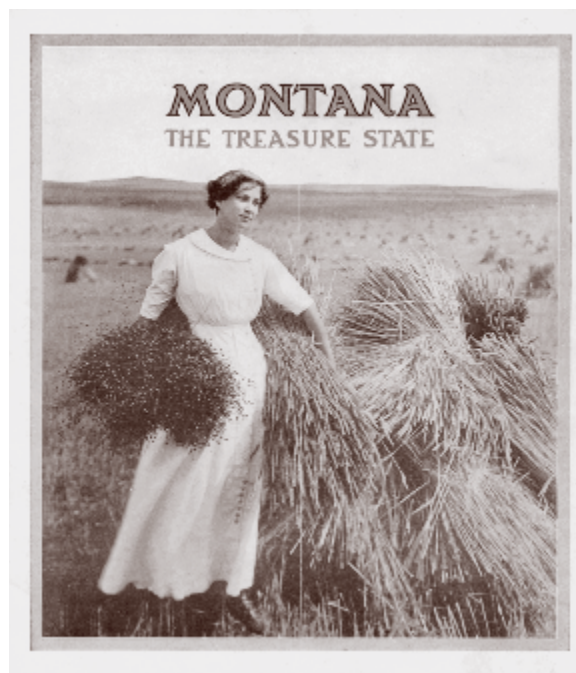
Hospitals provided training sites and urban locations for more specialized medical procedures and the treatment of contagious diseases, but many of the health care facilities in Montana were spread great distances away from each other. By the 1920s, approximately five hundred doctors served the state population of 550,000. While the national average was one doctor for every 726 persons, Montana's rate—one doctor for every 1,061 residents—fell well below the national norm.¹¹ The statistics highlighted an ongoing issue for the state, which was faced with a sparse population spread over a great expanse of empty country. Urban inhabitants could access health services, but the provision of basic care to outlying residents remained inconsistent.

The lack of available nurses made it difficult to staff hospitals with skilled personnel. To remedy that shortage, nursing schools were formed early in the state's history to train nurses for round-the-clock patient care in hospitals. From 1894 to 1927, nineteen nursing schools opened in Montana, with locations that spread from Great Falls to Bozeman and Missoula to Miles City.¹²

The focus on public health coincided with increased immigration, and especially female settlement, of the state. Governments and railroads actively recruited women through such literature as this 1915 railroad brochure. Answering the call, from roughly 1900 through 1920, an estimated two hundred thousand new residents came to Montana, many of them women of childbearing age. While a significant number of women staked their own homestead claims, many eventually married, became pregnant, and delivered babies in their new homes.

Yet, even when women were able to access medical care, pregnancy and childbirth could be troubling and stressful. On October 13, 1905, just as Idora Guthrie and her husband finished wallpapering their bedroom, Idora “was in such pain [she] could scarcely work all the time.” That evening she began to hemorrhage. The doctor arrived soon after, but Guthrie miscarried. While Guthrie received medical care at the time of her miscarriage, many women were not so fortunate. Faye Hoven, born in 1894, lived near Hobson, Montana. During her first pregnancy, from conception through delivery, she received no pregnancy-related professional care and advice. Hoven lived thirty-five miles from the nearest physician and used a team and wagon for transportation. Medical attention, especially in the absence of any troubling symptoms, did not rate a trip to town.¹³

The growth of public health efforts coincided with an increase in immigration, and especially female settlement, of the region. Ultimately, the success of homesteading in the West depended on the creation of homes, the tilling of lands, and the accompanying cultivation of communities. This community-building process required the presence of women, and governments and railroads actively recruited female participation in the westward Euro-American migration. “Montana—The Treasure State” announced a 1915 railroad brochure featuring a wistfully determined woman on its cover. “Free Land, Fertile Soil . . . Sure



MHS Archives, Helena, PAM 359

Crops” proclaimed another publication advertising the state’s bounties. Similar advertisements portrayed Montana as a rich, welcoming, and bounteous land. Other literature detailed the profits to be made in homesteading, explained projected crop yields, and extolled the benefits of settlement.¹⁴

Absent from the profit calculations but present in the migration, women—of all ages and in all stages of reproduction—headed west. The homestead boom, from roughly 1900 through 1920, brought an estimated two hundred thousand new residents to Montana, many of them women of childbearing age.¹⁵ In the arid plains, obtaining basic necessities like water and fuel required a tremendous expenditure of energy. Functioning homesteads needed a continuous supply of water—for drinking, cooking, washing dishes, laundering clothes, bathing, housecleaning, and gardening. Given the scarcity of wood, many immigrant residents of the high plains burned coal as fuel, but the coal had to be dug, loaded, and transported. Basic survival required the procurement, hauling, and management of essential—and weighty—raw materials.

Homesteading women, confronted with the confluence of intense physical labor, austere living conditions, and, most significantly, the scarcity of supportive family and friends, often found them-

selves depleted and alone as they encountered the stresses of pregnancy, labor, delivery, and the postpartum period.¹⁶ Giving birth on a Montana homestead proved to be more dangerous than delivering in the urban east. Montana women avoided the risks of widespread infectious disease, dense population, and industrialization, but they encountered new and more debilitating conditions.¹⁷

Evidence suggests that some rural Montana women chose to leave the state and give birth closer to family, often traveling in the later stages of pregnancy and typically returning four to six months after delivering. Annie Knipfer moved to Montana in 1919. She and her husband lived on their ranch forty-two miles from Baker, Montana, and during her first pregnancy she utilized the services of the local physician. He recommended that ranch women relocate to town prior to delivery to rest up and gain strength, and Knipfer followed his directives. While she gave birth to a healthy infant, the doctor used forceps in the delivery, and the injuries Knipfer sustained required a lengthy recuperation. During her second pregnancy, she chose to visit family in Massachusetts for the birth and returned to the ranch near Baker approximately five months later. Annie Knipfer was not alone. A U.S. Children’s Bureau study conducted in the eastern part of the state in 1919 found that one in four childbearing women relocated to more urban areas or to be near family as their due dates approached.¹⁸

While Euro-American immigrant women often chose to forego prenatal medical care, they rarely chose to give birth alone. Women planned for and depended on the presence and support of other women whenever possible. The Children’s Bureau study, one of the few statistical resources available, counted the total deliveries in a Montana county from 1912 through 1917. Over the course of the study, 13 percent of births occurred with just the mother and father present. Only a few births, 1 percent, took place without any assistance at all. Those women who delivered alone did so as a result of conspiring circumstances—sometimes the baby’s father left to fetch the doctor and neither father nor doctor returned in time, or the mother delivered unexpectedly early.



The Children’s Bureau compiled statistics that linked infant mortality to poverty—not parental race or class. The Bureau published these posters in 1916.

In its study of childbirth in Montana, the Children's Bureau published these photographs of homestead life. The study counted the total deliveries in a Montana county from 1912 through 1917. Over the course of the study, 13 percent of births occurred with just the mother and father present. A few births, 1 percent, took place without any assistance at all.

Especially in the absence of prenatal care, turn-of-the-century delivery dates lacked the precision of current date-specific projections. While 36 percent of birthing women in the study called on the services of physicians, by far the largest group, 51 percent, depended on the help of female attendants such as friends and midwives.¹⁹

The Children's Bureau determined that there were at least forty-five thousand midwives practicing across the United States in the late 1910s and early 1920s. Living near Malta, Montana, Clarabel Bogut's mother "delivered babies in the community. . . . She was a school teacher, she was an organizer, and she served as a midwife. . . . She was more or less kind of the health center that people would come to." Bogut's mother exemplified the full range of duties women often engaged in, from teaching school to assisting with births.²⁰

Some midwives assisted at hundreds of births during their careers, and they claimed various levels of expertise. European immigrants came from a long heritage of institutional midwifery training, and a number of European-educated midwives settled in the West and put their expertise to use. Aino Puutio trained in Finland and carried her diploma to Montana, along with her straw birthing basket, delivery materials, and midwifery textbooks. She practiced as a professional midwife in Butte from 1913 to 1916 and then relocated to Red Lodge, where she served as midwife to the local Finnish population. Over the course of her career, Puutio dispensed recommendations about nutrition and exercise to her clients during their pregnancies, traveled to and attended births in all weather, and remained after the deliveries to assist with household chores and ensure proper rest and recuperation for both mothers and infants. Puutio remained in the Red Lodge area until her death in 1947, marrying, raising two children, and continuing to assist birthing women.²¹

If a community lacked a professional midwife like Puutio, women looked to their friends and neighbors



Viola Isabel Paradise, Maternity Care and the Welfare of Young Children in a Homesteading County in Montana (Washington, D.C., 1919), 64



MHS Photograph Archives, Pac 91-23

The Children's Bureau study determined that by far the largest group of birthing women, 51 percent, called on the services of female attendants—such women as Catherine Murphy, pictured here standing near her home in Jordan, Montana, 1920. Murphy helped neighbors during childbirth and gave birth to ten children of her own.

Women like this grandmother could call on a lifetime of practical skills, both in the actual delivery process and in the care of infants and children. The support of extended family sometimes meant the difference between an ill and struggling infant and a thriving, healthy baby.

for help and chose from women with differing skill levels. While some women could only call upon their personal knowledge of childbirth, others had assisted at a number of deliveries and accumulated a store of experiential knowledge. Annie Knipfer worked as an infant care and delivery nurse in Massachusetts prior to her relocation to Montana. Knipfer drew upon the memories of the births of her own children and her nursing work on the rare occasions when neighbors called for her assistance. During the decades she lived on her ranch near Baker, Knipfer attended the delivery of four infants.²²

The birth rate in the early 1900s indicates that women delivered an average of four children, and the personal experience of multiple pregnancies meant that many women claimed significant practical birthing knowledge. In addition to their own deliveries, women gained more exposure to the birthing process as they watched or helped family members, friends, and neighbors. Despite limited formal training, these



Merrill G. Burlingame Special Collections, Montana State University Libraries, Bozeman

informal delivery attendants had knowledge of and implemented high standards of cleanliness. Sanitary agents such as Lysol, boric acid, and carbolic acid topped the list of products used by birth assistants. Children's Bureau staff noted that homesteading birth attendants "realize[d] their limitations, and



MHS Photograph Archives, PAC 82-3-3

Besides assisting with childbirth, women helped new mothers with daily chores and livestock duties. This neighborly aid was invaluable, as a family's basic needs required round-the-clock planning and preparation, leaving little time to rest and heal. Above, a woman identified as Aunt Bina plucks a chicken and watches baby Adeline Carlson in 1915. Such support from friends and neighbors, when available, allowed childbearing western women to regain their strength and resume their work.

[did] not attempt to interfere with the natural course of delivery or to ‘doctor’ their patients with herbs.”²³

While they refrained from active doctoring, Annie Knipfer and other women of her era did offer a service not available from physicians: women helped new mothers with household chores and livestock duties to provide them with respite from the demands of day-to-day household maintenance and stock raising. The support of friends and neighbors, when available, allowed childbearing western women to regain their strength and resume their work. Informal female support networks continually evolved as families settled and relocated, and most women depended on the voluntary and unrecognized delivery assistance of local women who offered their knowledge to neighbors in need.

Women in urban centers could choose from a wider range of birthing options than pregnant women in more rural parts of the state, but delivery experiences, both urban and rural, retained a common thread. Women assisted in all facets of the birthing process, from hospital nurses to physicians and from professional midwives to well-intentioned neighbors.²⁴ Access to varied help—or any help—characterized their individual circumstances, but the birth process proved to be an important and, in an age of limited contraception, recurring theme in the lives of Montana women.

The Public Health Response

Many women who gave birth did so without complications, but even in smooth deliveries, the process itself still presented potential dangers. Peggy Czyzeski delivered a healthy eleven-pound baby girl but could not expel all of the afterbirth. Over the course of several days her condition worsened; she developed a high fever and severe infection and eventually became convinced that she had retained some placenta.²⁵ Fortunately, Czyzeski recovered and resumed the care of her infant daughter. Beatrice Kaasch’s family story did not have such a happy ending. Beatrice’s mother lost an infant son in 1910, a daughter in 1911, and twins in 1916. As Kaasch remembered, the male twin “died on the day of birth and my little sister, Marie, lived for a week.”²⁶

From its inception in 1901, the Montana State Board of Health began to collect mortality data from

families like Kaasch’s in order to assess death and birth rates across the state. Officials instituted standardized birth and death certificates, formulated procedures for compiling public health data, and began the process of determining the rates of infectious disease and causes of death. The scarcity of registrars, particularly in rural and sparsely populated areas of the state, hindered the collection of public health data. But the Board of Health persisted in its efforts to accurately record births and deaths in the state and concluded in its 1910 report: “The registration of births and deaths in Montana has proceeded very satisfactorily. . . . The records in this office are now practically complete, both as regards births and deaths.” The Board of Health continued to improve its collection and processing capabilities, but as state officials perused the compiled information, they noted a discrepancy between the accuracy of the birth and death records. While state law required a burial permit and accompanying death certificate prior to interment, no such sequence existed for issuing birth certificates. A requirement to obtain a birth permit prior to delivery would have been distinctly unenforceable.²⁷

The Board of Health expressed its frustration with recordkeeping: “The births that we fail to get and that we have the greatest trouble in getting are those attended by midwives, or people who do not even pose as midwives, but simply act in a neighborly capacity.”²⁸ These neighbors, helping out when skilled assistance proved inaccessible, did not familiarize themselves with the requirements of the State Board of Health or perceive their assistance as providing medical care. While research from the late 1900s indicated comparable success and mortality rates from physician and midwife-assisted births, no records from the early 1900s analyzed the effectiveness or safety record of neighborly assistance versus the services of trained midwives or physicians.²⁹ The Board of Health also noted, “Many of the doctors are careless about sending in the birth certificates,” so the board continued its efforts to educate local officials about proper documentation and registration procedures.³⁰

Assembling birth rates and mortality statistics, which was seen as a necessary function of a competent state government, also allowed states to compare rates with other jurisdictions.³¹ Montana officials participated in this cross-border competition, and



The Montana State Board of Health reported that nearly nine thousand women and infants died during childbirth from 1911 through 1919—a staggering toll. Photographer Evelyn Cameron documented one small life lost near Terry, Montana, circa 1911. Families grieved the death of infants and often referred to them in diaries and correspondence, remembering their passing even years later.

they proudly reported in 1909, “Only two States show a death rate lower than in Montana.”³²

Montana’s overall death rate may have ranked favorably against other jurisdictions, but when it came to women giving birth, aggregated numbers revealed that, regardless of the type of attendant, Montana women were in trouble. For the years 1911 through 1919, Montana reported the highest maternal death rate of all participating states across the nation.³³ Over this nine-year period, nearly nine thousand women and infants died during childbirth, resulting in a maternal mortality rate that averaged just under 11 deaths per thousand births.³⁴ By comparison, the U.S. Census Bureau listed the national maternal mortality average at 7.4 deaths per thousand live births for the year 1919, well below Montana’s rate.³⁵

Before the widespread collection of public health data, anecdotal evidence indicated high mortality rates, but the tabulation and comparison of maternal and infant mortality statistics painted an unequivocal

picture—an unfortunate result for Montana officials, who prided themselves on besting their competition in the mortality rate stakes. To their credit, Board of Health officials accepted the indictment, interpreted the statistics as “a distinct shock to [their] self-complacency,” and began to search for the causes of such high death rates.³⁶

The State Board of Health concluded that Montana women needed more health information. The board’s conclusion gives pause because women surveyed in the Children’s Bureau project had stated clearly that the lack of assistance at birth and limited access to health care were their most significant obstacles, not the absence of printed information. One young Montana mother to be, pregnant with her first child, “found herself absolutely alone at childbirth and for two days after.” Upon her husband’s return, he discovered the new mother and infant hungry for both food and human companionship. While mother and child survived the solo delivery, the young



In an effort to give Montana women additional information, the State Board of Health distributed educational materials, including this pamphlet. Board of Health publications contained basic instructions about diet and cleanliness and because they were available by mail even the most isolated women could obtain their own copies.



mother was ailing for six months, unable to perform much of her regular work routine. Perhaps a printed pamphlet from the health department would have given her some welcome information, but no doubt a public health nurse, a local trained birth attendant, and navigable roads would have done more to meet her real needs.³⁷

With multiple pregnancies during their reproductive years, women in the early 1900s usually shared the birth process with each other in their own homes, and they knew the intimate details of pregnancy, childbirth, and nursing. While birthing abnormalities and unusual complications would have been outside the purview of their routine exposure, they still claimed an extensive knowledge of the process of normal deliveries, both through their own experience and from watching, assisting at, and discussing other births. Additional information certainly would not worsen their situation, but the implication that Montana women needed educating about childbirth—a process a majority of women possessed authoritative and intimate familiarity with—dismissed their accumulated wisdom and collective technical expertise.

In their search for pragmatic solutions to the state reproductive crisis, Montana officials continued to lay the blame on pregnant women themselves. The State Board of Health's 1921–1922 report stated that the deaths of both mothers and infants could be attributed to the mothers' ignorance of "the hygiene of childbearing and childrearing."³⁸ This conclusion contradicted the documented research detailing women's attention to cleanliness and near antiseptic environments in matters related to childbirth, as well as women's own explanations of their real birthing dilemmas.³⁹ Women's voices and choices testified to the birthing struggles they encountered, and while mothers certainly worked to keep overcrowded dirt-floor dwellings clean, common sense would dictate that malnutrition, delivery injuries, and intense physical exertion might have posed more substantive health risks than maternal ignorance.

Katie and Charles Lynch weigh their baby circa 1900. Health officials struggled to get parents, midwives, and physicians to complete and submit birth certificates. Eventually, registrars were appointed in individual counties to record births and deaths and to oversee the gathering of demographic information.



Some rural Montana women relocated in order to be closer to medical services. As her delivery approached, Mary Stephenson felt uneasy about staying on her isolated homestead, so she moved into Glendive where she had ready access to doctors and also Grace Hospital.



The Montana legislature created the Child Welfare Division in 1917. The division oversaw public health nurses across the state, worked with local women's organizations, and created educational exhibits, which it loaned out for conferences, fairs, and schools. The posters on display at this Stockett and Sand Coulee school gathering gave information about "care after birth," "development through exercise," "prenatal care benefits the child," "prenatal care saves the mother," "the expectant mother needs," and "when the baby comes."

Some women did relocate in order to procure the birthing assistance they needed and desired. Concluding that she could not obtain the necessary care for her pending delivery, Mary Stephenson moved into town to be near the doctor. As she recalled, “Out here there was no doctor within miles. . . . I thought it would be better to be living with some friends in Glendive.”⁴⁰ Women made arrangements depending on their circumstances, and they availed themselves of safer alternatives when possible.

For women who were homebound, the health department made educational materials available by mail, but infrequent mail service meant that many individuals who requested information faced long delays in acquiring health pamphlets. Yet, even though they might have preferred other remedies, Montana women did request copies of Board of Health publications. At the height of its informational campaign, the board sent out 350,000 pieces of educational material and continued to revise and update its publications regarding maternal and infant health.⁴¹

Additionally, and of more relevance in the lives of childbearing women, the Montana legislature created the Child Welfare Division in 1917. The division oversaw public health nurses across the state and worked with local women’s organizations to address issues of concern to area residents. Community organizations took the lead in identifying specific health matters and, at times, even engaged professionals to tackle particular problems. The Woman’s Club of Billings hired, at its own expense, a specialist in infantile paralysis, with the State eventually assuming the responsibility for Miss Fox’s one hundred and twenty-five dollar per month salary.⁴² Other groups throughout the state, like the Montana League of Women Voters and the Business and Professional Women’s Clubs, drew attention to specific community health

issues by encouraging public support for intervention and also by initiating health-related campaigns.⁴³

Like activist women in Montana and across the nation, Montana Congresswoman Jeannette Rankin followed the work of the U.S. Children’s Bureau and concluded that reproductive care deserved increased national attention. Rankin introduced a bill aimed at protecting maternal and infant health in 1918, but it gained few congressional supporters. However, the enfranchisement of women in 1920 presented legislators with a new voting bloc that prioritized public health. Rankin’s bill found legs as Morris Sheppard, a senator from Texas, and Horace Towner, a representative from Iowa, incorporated her concerns into drafted legislation. Faced with a changing political environment and the threat of retribution from women’s groups, members of Congress passed the Sheppard-Towner Act in 1921 with a wide margin of support.⁴⁴

The Sheppard-Towner Act provided federal funds to states that allocated additional monies to support education, training, and the provision of sterile birthing supplies to childbearing women. The Montana legislature earmarked \$1,238 for fiscal year 1922 and \$8,702 for the year ending June 1923,



MHS Photograph Archives, Lot 30 B2 F9 01

The Sheppard-Towner Act passed in 1921 and allocated federal funds to support education, training, and the provision of sterile birthing supplies to childbearing women. With the increased funding, the State Board of Health continued to work with voluntary women’s organizations in such efforts as health clinics like the one pictured here, which took place in Corvallis.

Birth Data, 1910–1920

Data compiled from Biennial Reports published by the Montana State Board of Health, MHS⁴⁸

Year	Total Births	Birth Rate	Infant Deaths	Infant Mortality Rate	Maternal Deaths	Maternal Mortality Rate
1910	6,124	16.2	714	116.6	62	10.1
1911	7,542	19.0	717	95.1	78	10.3
1912	8,133	19.6	660	81.2	75	9.2
1913	8,682	20.1	812	93.5	80	9.2
1914	9,969	22.1	834	83.7	100	10.0
1915	11,132	23.8	816	73.3	91	8.2
1916	11,300	23.2	970	85.8	108	9.6
1917	11,600	23.0	1,090	94.0	143	12.3
1918	11,800	22.6	1,027	87.0	184	15.6
1919	12,017	22.3	962	80.1	141	11.7
1920	11,862	21.6	862	72.7	104	8.8

amounts equal to the federal allocation. Individual states directed efforts within their jurisdictions, and in Montana, the State Board of Health appointed Dr. J. J. Sippy to head the Child Welfare Division in anticipation of its expanded role in implementing the legislation.⁴⁵

While the Child Welfare Division officially spearheaded Sheppard-Towner efforts in the state, women’s groups continued to coordinate with the division—so much so that board officials took notice. Upon Dr. Sippy’s resignation in 1923, all voting members of the board agreed to search for a female physician as a replacement. Board members gave credit for the success of child welfare work to voluntary women’s organizations, and they stated that choosing a female director of the Child Welfare Division would be “proper recognition of the valuable services the [women’s] clubs have rendered in health work.”⁴⁶

In Montana, and across the nation, the spotlight on maternal and infant health, as well as strategic efforts to reduce mortality rates, heralded the importance of reproductive policy as a part of public dialogue and governmental responsibility. The Sheppard-Towner Act returned benefits well beyond the actual dollars spent because it drew attention to public health efforts to improve the living conditions for women, infants, and children.⁴⁷

Questioning Statistical Accuracy

Inquiry into the reproductive rigors in the American West, while essential for an accurate rendering of history, also requires posing difficult questions: Was the maternal and infant mortality situation as dire as the numbers indicated? How thorough and verifiable were public health statistical computations? Could the data be interpreted differently?

Unfortunately, the original Montana State Board of Health documents necessary for a full and complete recalculation of early 1900s data no longer exist. But while we cannot determine the absolute margin of error present in early health department reports, the context of public health data does shed light on Montana’s mortality situation. With the infrastructure necessary for the collection of public health statistics within state boundaries still in its infancy, officials continued to refine their procedures and recordkeeping. It seems unjust to criticize Montana’s early efforts at calculating the birth and death rates of its residents; a pass for good intentions could be deemed appropriate. But Montana’s maternal mortality numbers did not follow the pattern of other early regional records. For example, Colorado’s maternal mortality rate exceeded Montana’s in 1910 but then dropped dramatically, resting near the national average by 1915. Over the same period of time, presumably while the Montana State Board of Health increased its



A fierce snowstorm engulfs a Richland County homestead in 1910. Women delivered in shacks like this one, and the combination of frequent blizzards and poor roads often made travel out of the question. Without ready access to delivery assistance, some women gave birth entirely alone or with only their husbands in attendance.

information-gathering accuracy, the maternal mortality rate in Montana did not decrease at all, but instead rose precipitously.⁴⁹

Lending additional credence to the relative accuracy of the mortality data, the birth and death registration system in Montana received the support and trust of the very health department officials who were embarrassed by their state's performance in the maternity rankings. Beginning with its 1910 report, the Board of Health stated: "The registration of births and deaths in Montana has proceeded very satisfactorily in most localities," and "the records in this office are now practically complete." Two years later, the board characterized its death records as "quite complete." While officials continued to express their dissatisfaction with birth certificate cooperation—mothers, midwives, and physicians alike did not seem overly concerned with Board of Health requirements to file birth certificates—official consternation at the high levels of maternal mortality in the state appeared genuine. The State Board of Health lamented that, based on maternal mortality statistics, "There is an urgent need for a campaign for the prevention of infant and maternal mortality in Montana," and the board provided no deflection of responsibility or excuse for the state's poor performance.⁵⁰

In addition to its own self-criticism, Montana health department officials endured the reprimand of the federal government. In its analysis of the rates, the Children's Bureau reported, "[Montana's] showing is again unfortunate," and continued by emphasizing that, at times, Montana's maternal mortality rate "was over twice as great as the lowest rates" for reporting states and "more than five times as high as Italy's."⁵¹ Absolute rate comparisons, especially across national

lines, were somewhat indefinite, as varied jurisdictions reported mortality per hundred thousand births and others per thousand births, and many held differing criteria for the treatment of stillbirths. Regardless of Montana's true international ranking, federal and state officials assessed its reproductive conditions as undeniably bleak.

While the absolute technical veracity of early twentieth-century mortality rates in Montana can be debated, the statistics did capture the essence of a dangerous birthing situation. Miners and lumber workers prospered at the whim of market and industry interests, and Montana's farmers and ranchers dealt with insects, heat, fire, and drought. Residents also grappled with impassable roads, limited assistance, and austere and uncompromising environmental conditions. The consequences for the most vulnerable of Montana's population—children and pregnant women—proved tragic. Women believed the birthing conditions to be intolerable, public health officials concurred with the need for a remedy, and out-of-state observers concluded that Montana women and infants faced an inflated risk of dying in childbirth.

Expanding the Western Narrative

Historians have explored the experience of pregnancy and childbirth in the American West and documented both the stark realities of reproduction and the involvement of women in efforts to garner public support for contraception, maternal and infant health, and public health programs. And studies examining women's public activism, the Sheppard-Towner Act, and the U.S. Children's Bureau suggest

the changing political landscape at the turn of the century.⁵²

While academic exploration of women's experience has highlighted certain contributions—notably the participation of women in expanding the social welfare functions of national, state, and local governments—recognition of the critical role women have played by providing for the reproductive needs of communities has failed to enter the general public consciousness. Pregnancy, childbirth, and delivery affected women, men, and families alike, in ways both quantifiable and intangible. From nursing, cooking, providing food, and tending to myriad physical and emotional ailments, women often performed the work of a nascent state and federal infrastructure. Though government entities failed to calculate the dollar value of such community service, their oversight did not alter the fact that the process of building a profitable

economic base and attracting settlers to the American West depended heavily on the efforts of civic-minded women.

Assistance during delivery represented just one of the important and often overlooked components of those voluntary and uncalculated efforts. Childbirth and parenting added much to the lives of Euro-American immigrants to Montana. The opportunity to love and be loved, to pass on land, and to find one's place in the community of caring made childbirth a salient event in the lives of many women and men in growing Montana cities, towns, and counties.

Along with a multitude of positive benefits, the experience of reproduction was intertwined with deeply personal constraints. From a purely monetary perspective, women who were concerned about the conditions and concomitant safety issues of birth in Montana had relatively few options. Relocating to a safer locale might appear to be the obvious choice for women about to give birth, but for many families, travel was simply not a viable option.

Successful homesteading operations, in particular, depended on the labor of women, and their production, both paid and unpaid, contributed an essential variable in an otherwise unworkable equation. Women arranged food preparation, nurtured children, planted gardens, harvested food crops, preserved fruits and vegetables, and dealt with the daily necessities of laundry, sewing, household maintenance, and the care of livestock. Without their efforts, the cash crops of the homestead—flax, oats, barley, wheat, and peas—could not be efficiently planted, tended, harvested, or marketed. Additionally, the proceeds from the sale of butter and eggs, operations typically supervised by women, often financed the acquisition of farm equipment or kept the family fed during poor crop years. For the Susag family, homesteading near Kahle, Montana, Alice Susag's butter and egg money paid their share in a cooperative purchase of a fanning-mill during their first year in Montana.⁵³ Well before they received a return on established crops, Alice's skill in setting hens, collecting eggs, milking, and churning butter allowed them to make a significant capital investment. If she had left the state for childbirth during that time, her family would have faced the loss of both her unpaid domestic labor and the absence of her substantial and regular monetary income.



Evelyn Cameron, photographer, MHS Photograph Archives, PAC 90-87.G011-005

Women like Mrs. Peterson, pictured in 1912 with her daughter Maude Inez Peterson, managed a full list of essential responsibilities, including food preparation, childcare, gardening, harvesting, and preserving.

Many immigrants endured the harsh conditions of western settlement because of the potential rewards, especially for their children, like this unidentified baby on a homestead near Terry, Montana, in 1910. Sadly, the intended beneficiaries of the western migration often faced the highest death rates.

Even if a family could afford to lose the contribution of a woman's work, the cost of travel and medical care rendered outside assistance financially out of reach for most settlers. Physicians' fees ranged from twenty-five to fifty dollars, and with that expense added to the cost of long-distance or out-of-state travel—estimated at one hundred and fifty dollars—the total outlay for an assisted delivery could easily reach two hundred dollars.⁵⁴ At a time when the materials to build a homesteading dwelling could be purchased for about the same cost, making do at home with the help of a neighbor seemed to be one of the few realistic birthing options available to many western women.

The history of reproduction in an ever-changing North American West provides a potent case study in the costs of marginalizing and devaluing the experience and circumstances of women's lives. In Montana and the West, the costs associated with childbirth—in inconvenience and discomfort to women, loss of life, and monetary outlay—did not factor into the public debate until the consequences of ignoring the problem loomed large. While the value of women's work had escaped public policy calculations, the rate of their deaths did not.

Just as public officials neglected to calculate the implications of westward expansion for women and infants, so have many historians. Family relationships and progeny often furnished the motivation for the work of the West, but a western narrative without the inclusion of birthing conditions and



Evelyn Cameron, photographer, MHS Photograph Archives, PAC 90-87.6058-011

costs fails to acknowledge a crucial component of human experience. The historical invisibility of women shrouds that most uniquely female event—childbirth—in a haze of ambiguity. With their reproductive experiences appearing as mortality statistics but otherwise excluded from the historical record, women in Montana and the West still expended much of their time, energy, and emotion in both settling new communities and in populating them.

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Notes

Abbreviations used in the notes include Archives and Special Collections, Maureen and Mike Mansfield Library, University of Montana, Missoula (UM); Collection (Coll.); Montana Historical Society Research Center, Helena (MHS); Montana State Board of Health (MSBH); Montana State Historic Preservation Office, Helena (SHPO); *Montana The Magazine of Western History* (Montana); Public Lands History Center, Colorado State University, Fort Collins, CO (PLHC). Unless otherwise noted, all newspapers were published in Montana.

1. Fldr 15, bx 1, Finrock Family Papers, Coll. 00007, American Heritage Center, Cody, WY; fldr 11, bx 1, Thaddeus Hurlbut Capron Family Papers, Coll. 01694, *ibid*.

2. The American West saw an increasing number of settlers from the territorial era on. With the formation of Dakota Territory in 1861, Idaho Territory in 1863, Montana Territory in 1864, and Wyoming Territory in 1868, institutional efforts, while initially paltry, were steadily expanded to address the needs of residents.

3. Paul Phillips, *Medicine in the Making of Montana* (Missoula, MT, 1962).

4. Pierce Mullen, "Frontier Nursing: The Deaconess Experience in Montana, 1890–1960," in *Disease and Medical Care in the Mountain West: Essays on Region, History, and Practice*, ed. Martha L. Hildreth and Bruce T. Moran (Reno, NV, 1998); and Paul Phillips, *Medicine in the Making of Montana* (Missoula, MT, 1962).

5. Laurentza Koch to Annette Koch, Feb. 1875, Christian D. Koch Family Papers, Coll. 2230, Merrill G. Burlingame Special Collections, Montana State University, Bozeman. Mercury chloride, also known as calomel, is a toxic compound that was used by doctors throughout the eighteenth and nineteenth centuries to make patients regurgitate and release "impurities" from their body.

6. Tom Lutey, "Pioneering Nurses: Old Stories of Nursing in Montana Hard to Find," *Bozeman Daily Chronicle*, Mar. 1, 1998.

7. Gladys Costello, "Olden Times," *Malta Phillips County News*, Dec. 9, 1976. Costello identified Mrs. Clanton as a local midwife, and census records listed a Percy Clanton, married to George and eventually widowed, as residing in Malta. 1900 Census, Malta, Valley County, Montana, roll 915, p. 4B, enumeration district 0141, FHL microfilm, 1240915; 1940 Census, Malta, Phillips County, Montana, roll T6272226, p. 2A, enumeration district 36-18C.

8. Richard W. and Dorothy C. Wertz, *Lying-In: A History of Childbirth in America* (New York, 1977), 133.

9. *U.S. City Directories, 1821–1989* (Provo, UT, 2000).

10. Ellen Leahy, "'Montana Fever': Smallpox and the Montana State Board of Health," *Montana*, 53 (Summer 2003): 32–45.

11. Frances S. Bradley, "Why a Child Welfare Division in the State Board of Health?" remarks to the Annual Meeting of the Medical Association of Montana in Lewistown, July 8–9, 1925, in *Northwest Medicine* 25:3 (1926), 147–50.

12. Alma Gretchen McNeely, "From Untrained Nurses toward Professional Preparation in Montana, 1912–1989" (PhD diss., University of San Diego, 1993).

13. Idora Z. Smith Guthrie Diaries, fldr 1, bx 3, MC 201, MHS; Faye Hoven, interview with Laurie Mercier, Mar. 30, 1982, Hobson, MT, OH 252, MHS.

14. Chicago & Milwaukee Railroad brochure, 1915, PAM 359, MHS; Great Northern Railway brochure, 1900, PAM 421, MHS.

15. Gary D. Libecap, "Learning About the Weather: Dryfarming Doctrine and Homestead Failure in Eastern Montana, 1900–1925," *Montana* 52 (Spring 2002): 24–33.

16. Nanci Langford, "Childbirth on the Canadian Prairies, 1880–1930," *Journal of Historical Sociology* 8:3 (1995): 278–302.

17. See Viola Isabel Paradise, *Maternity Care and the Welfare of Young Children in a Homesteading County in Montana* (Washington, DC, 1919), 96, for a comparison of mortality rates by state for the years 1910 to 1915.

18. Annie Knipfer, interview with Kathy White, Aug. 25, 1976, Billings, MT, OH 49-28, UM. As part of their continuing efforts to tabulate and describe the actual living and birthing conditions of women and children across the nation, Children's Bureau staff selected counties throughout the country as sites for extensive analytical surveys. A rural Montana homesteading community played host to bureau staff during the summer and fall of 1917 as the staff interviewed the mothers of all children born in the county in the previous five years. Children's Bureau policy dictated anonymity for survey respondents since staff solicited personal information and identifying details. Published in 1919, the report revealed the details surrounding 463 separate births, including specific characteristics about living environment, birthing context, home size and sanitation, and death rates. See Paradise, *Maternity Care*.

19. Paradise, *Maternity Care*.

20. Dorothy E. Bradbury and Mar-

tha M. Eliot, *Four Decades of Action for Children: A Short History of the Children's Bureau* (Washington, DC, 1956); Clarabel Bogut, interview with John Terreo, Dec. 6, 1989, Dillon, MT, OH 1305, MHS.

21. Arlene Harris, "An Early-Day Montana Midwife," n.d., ms., Carbon County Historical Society, Red Lodge, Montana. The substance of this material was also published by Arlene Harris in "Midwife Aino," *Missoula Borrowed Times*, Sept. 1, 1974.

22. Knipfer interview.

23. Paradise, *Maternity Care*, 33.

24. A number of female physicians lived and worked in Montana, among them Dr. Sadie Lindeberg. After graduating from the University of Michigan Medical School, she returned to Miles City in 1884. Lindeberg delivered more than eight thousand babies in the Miles City community in the sixty years she practiced there. Malcolm D. Winter Jr. and Malcolm D. Winter Sr., *Miles City Medical History, 1876–2009* (Miles City, MT, 2010), copy in Miles City Public Library.

25. Thelma Marie Dobson Czyzeski, interview with Laurie Mercier, May 21, 1982, OH 285, MHS.

26. Beatrice Kaasch, interview with John Terreo, Nov. 16, 1989, Laurel, MT, OH 1300, MHS.

27. MSBH, *First Biennial Report of the State Registrar of Births and Deaths, 1907 and 1908* (Helena, MT, 1908), 56; MSBH, *Second Biennial Report of the State Registrar of Births and Deaths, 1909 and 1910* (Helena, MT, 1910), 69.

28. MSBH, *Third Biennial Report of the State Registrar of Births and Deaths, 1911 and 1912* (Helena, MT, 1912), 105.

29. Studies comparing midwifery-assisted home birth and hospital physician-assisted deliveries proliferated in the late twentieth and early twenty-first centuries. See, for example, Eileen K. Hutton, Angela H. Reitsma, and Karyn Kaufman, "Outcomes Associated with Planned Home and Planned Hospital Births in Low-Risk Women Attended by Midwives in Ontario, Canada, 2003–2006," *Birth: Issues in Perinatal Care* 36:3 (2009), 180–89. Additionally, the Midwives Alliance of North America Statistics Project collected detailed pregnancy and delivery results from a sample of over fifteen thousand births. Results from the project are now available from MANA.

30. MSBH, *Fourth Biennial Report of the State Registrar of Births and Deaths, 1913 and 1914* (Helena, MT, 1914), 39.

31. Sandra Schackel, in *Social Housekeepers: Women Shaping Public Policy in New Mexico, 1920–1940* (Albuquerque, NM, 1992), 14, described the perceived

significance of public health statistics in assessing jurisdictions and quoted the explanation of Dr. S. Josephine Baker, who served as a public health official in the early 1900s: “The infant mortality rate is the most sensitive index of municipal housekeeping of a community. It is more than that; it is an index of civic interest, cooperation, consciousness, and worth.”

32. MSBH, *Third Biennial Report*, 107.

33. Territorial and state governments in the West formed agencies to oversee public health. Accurate collection and tabulation of mortality statistics required infrastructure, procedures, and funding, with each state participating in national reporting according to its own timetable.

34. According to the reports, 7,888 infants and 1,000 women died in childbirth from 1911 through 1919. Data compiled by the author from the MSBH biennial reports 1911–1919.

35. United States Public Health Service, National Office of Vital Statistics, *Vital Statistics Rates in the United States 1900–1940* (Washington, DC, 1947), table 36—Maternal Mortality Rates: Birth-Registration States and Each State, 1915–1940.

36. MSBH, *Eleventh Biennial Report of Montana State Board of Health, 1921 and 1922* (Helena, MT, 1922), 7.

37. Paradise, *Maternity Care*, 28.

38. MSBH, *Eleventh Biennial Report*, 7.

39. Paradise, *Maternity Care*.

40. Mary Stephenson, interview with Laurie Mercier, Oct. 29, 1981, Circle, MT, OH 209, MHS.

41. MSBH, *Fourteenth Biennial Report of Montana State Board of Health, 1927 and 1928* (Helena, MT, 1928).

42. State Board of Health meeting minutes, Apr. 6, 1918, fldr 2, bx 1, Montana State Board of Health Records, RS 238, MHS.

43. MSBH, *Tenth Biennial Report of the Montana State Board of Health, 1919–1920* (Helena, MT, 1920); *Thirteenth Biennial Report of the Montana State Board of Health, 1925–1926* (Helena, MT, 1926).

44. J. Stanley Lemons, “The Sheppard-Towner Act: Progressivism in the 1920s,” *The Journal of American History* 55:4 (1969): 776–86.

45. State Board of Health meeting minutes, Jan. 11, 1922, and Oct. 6, 1921, fldr 3, bx 1, RS 238, MHS.

46. *Ibid.*, Jan. 8, 1923.

47. Opponents of the Sheppard-Towner Act successfully brought about its demise in 1929, but the Montana legislature, in anticipation of the cessation of the act, approved an allocation of \$18,800 in state funds. Operating with a 25 percent budget cut, the Child Welfare



Library of Congress, LC-DIG-npcc-31704

In 1912, the United States Congress voted to form the Children’s Bureau, a federal department tasked with addressing the needs of the nation’s children. The new director of the Children’s Bureau, Julia Lathrop (above), initiated a study in the eastern part of Montana that found that one in four childbearing women relocated to more urban areas or to be near family as their due dates approached.

Division continued to function, albeit with a slightly diminished role. MSBH, *Fourteenth Biennial Report*.

48. The Montana State Board of Health has published mortality statistics from 1910 through the present. Statistical analysis demonstrates that over the course of Montana history, the dangers of being born far exceeded the risks of childbirth. As recently as 2011, five women died in childbirth in Montana, while there were sixty-nine birth-related infant fatalities. Infants faced a risk of death fourteen times greater than that of their mothers. Maternal mortality statistics from 1920 through 2009 show a steady downward trend in the number of women dying from birth-related causes, dropping to fewer than ten annually by 1952 and declining even further to five or less by 1965.

49. Paradise, *Maternity Care*, appendix A, table 4, 96.

50. MSBH, *Second Biennial Report*, 68; MSBH, *Fourth Biennial Report*, 39; MSBH, *Eleventh Biennial Report*, 8.

51. Paradise, *Maternity Care*, 42, 46.

52. Mary Melcher’s body of work, from “‘Women’s Matters’: Birth Control, Prenatal Care, and Childbirth in Rural Montana, 1910–1940,” *Montana* 41 (Summer 1991): 47–56, to *Pregnancy, Motherhood, and Choice in Twentieth-Century Arizona* (Tucson, AZ, 2012), offers an excellent example of existing research on the topic. Nanci Langford’s article, “Childbirth on the Canadian Prairies, 1880–1930,” and Dawn Nickel’s 2009 article, “Dying in the West, Part I,” *Montana* 59 (Fall 2009): 25–45, both contributed to knowledge about the

health care and reproductive experiences of women and men in the West. These academics explored childbirth and health care in the region and focused on the particular geographic and economic conditions endemic to the area. Their efforts addressed the West as a specific birthing environment and subtly posited the unique milieu of regional reproduction. Molly Ladd-Taylor, in *Mother-Work: Women, Child Welfare, and the State, 1890–1930* (Urbana, IL, 1994), and Kriste Lindenmeyer, in “‘A Right to Childhood’: The U.S. Children’s Bureau and Child Welfare, 1912–1946” (Urbana, IL, 1997), provide foundational research informing the relationship between women and public health efforts at the national level.

53. Alice N. Susag Diary, 1917–1918, fldr 2, bx 1, Alice N. Susag Papers, MC 348, MHS.

54. Paradise, *Maternity Care*.