BEYOND WHAT WE KNEW: HEALTH AND DISEASE AMONG BLACKS, WITH AN EMPHASIS ON WOMEN IN MEMPHIS, FROM SLAVERY TO EARLY TWENTIETH CENTURY

LETOSHIA FOSTER

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BEYOND WHAT WE KNEW: HEALTH AND DISEASE AMONG BLACKS, WITH AN EMPHASIS ON WOMEN IN MEMPHIS, FROM SLAVERY TO EARLY TWENTIETH CENTURY

by

Letoshia Foster

A Dissertation
Submitted in Partial Fulfillment of the Requirements for the Degree of Doctor of Philosophy

Major: History

The University of Memphis

December 2020
DEDICATION

This dissertation is dedicated to my loving mother Claretta Foster in Los Angeles. Your perseverance and inner strength from day to day makes me stronger. Thank you for never giving up on me. You always ask the big question: “You just about finished?” I cannot leave this page without giving thanks to my aunts, Maglean May in Los Angeles, and Catherine Bradley in heaven, looking down making sure no one bothers her “Taussa.” Claretta, Maglean and Catherine shared common characteristics: telling it like it is, knowing more than you can imagine, and discernment—none of which required a Ph.D. I send you all my love and could not have done it without your prayers.

To Steven and Tuesday, no, I did not forget about the two of you—may God continue to watch over you day by day. I also thank my brother Dedrick, who taught me to read, write and love sports and music. Finally, this dissertation is in memory of my father, O’neill Foster.
ACKNOWLEDGEMENTS

This dissertation is proof that God controls my destiny; he leads me and guides me, because I know “There’s a season for everything and a time for every matter under the heavens.”¹ My time came on September 11, 2020, when my committee members advanced my candidacy and I received a phone call after my defense: Dr. Bond in her sweet voice referred to me as Dr. Foster. I welcome the opportunity to acknowledge my advisor and committee chair Dr. Bond, who put up with me for so many years. I am also grateful, thankful, and blessed to have a committee who supported me and encouraged me through my personal life events. I offer thanks to Dr. Aram Goudsozian, Dr. Charles W. Crawford, and Dr. Cookie Woolner, who graciously agreed to serve on my committee. In the time it took for me to complete my Ph.D., many historians came, left, retired, and moved on, but not Dr. Bond.

I am also appreciative of the historian who mentored me: Dr. James Blythe, who encouraged me to apply for the history programs (I still have the emails). Dr. Blythe thought the idea of sociocultural history and health was a great idea. I also carry with me the lessons I learned in my first history course, taught by Dr. Arwin Smallwood. I want to thank a special historian who opened my eyes to the world of gender ideology and women’s history, Dr. Margaret Caffrey. I must thank my other mentors and faculty, now retired from the University of Memphis anthropology department: Dr. Charles Williams, Dr. Ross Sackett, and Dr. Ruthbeth Finerman.

I wish to thank an outstanding group of people: The University of Memphis history department (Karen Jackett and Karen Bradley), the Benjamin Hooks Library—

¹ Ecclesiastes, 3:1, Common English Bible (CEB).
Shelby County Room, the Meharry Medical College Archives Department (Christyne Douglas), the University of Memphis library staff (Frankie Perry and Sharon Tucker), and the hardworking personnel in the Bursar’s Office.

I learned so much from my church family: that it is not good for one’s health to be alone so much, to problem-solve on my own, or to pray and worship alone. I thank God for all the warm-hearted, sincere, and genuine members and friends at Grace United Methodist Church, Memphis, Tennessee.

I wish to express my professional appreciation for the historians whose area of interest includes enslaved women, medical history, social and cultural history, and Southern history. The field of African American history is diverse, but its focus is on placing African Americans at the center of the topic under discussion. For me, as a nurse, the focus is health (biological, psychosocial, and spiritual), disease, marginalized people, and health disparities. I was encouraged to tell a history that focused on the health of African Americans, with a focus on women. The process was one of sometimes being disappointed, having to reread and add current historiographies, and fine-tuning the ROL section. Yet on my defense date, I was deeply moved after being commended on my research.
ABSTRACT

Letoshia, Foster, Ph.D. The University of Memphis, August 2020. Beyond What We Knew: Health and Disease Among Blacks, With an Emphasis on Women in Memphis, From Slavery to Early Twentieth Century

This dissertation provides a comprehensive analysis of health issues among Black people in Memphis from the antebellum period through the early twentieth century. Throughout this period, slavery and Jim Crow had an inescapable effect on Black Memphians’ lives. Race and gender were strong indicators for poor health outcomes. The topics of morbidity and mortality among Blacks over a seventy-year period is reflected in various types of scholarship, especially medical history and regional histories on race, gender, and disease. By examining primary sources that have been overlooked by historians, this dissertation will detail how gender and race created physical and psychosocial health problems for Black people, especially women.

This study also describes the sociocultural ideologies of racism and segregation that resulted in poor health and early deaths for Blacks. This dissertation situates Blacks as community advocates for racial uplift and agency. I will demonstrate how the Black middle class and healthcare professionals in Memphis addressed health problems, particularly health disparities, in their communities by creating medical institutions, establishing training schools for nurses, and developing alternative institutions to improve care.
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CHAPTER 1 – INTRODUCTION

Then you will know that truth, and the truth will set you free.¹

In the United States, race is a powerful determinant of health outcomes. When health outcomes are considered across racial lines, it becomes clear that those who identify as Black or African American disproportionately experience health complications. Nationally, Blacks ages 18 to 49 are twice as likely to die from heart disease as their White counterparts. For subgroups of Blacks, many develop illnesses and diseases that commonly occur in people of other races only at older ages.² African Americans experience premature deaths caused by events including strokes and coronary artery disease.³

Health disparities for African Americans are historical and institutionalized because slavery continues to have ramifications on today’s health outcomes. The social construction of race remains a cultural norm that fosters a hierarchal system for health services. Race is a dominant discourse in American society. Racially constructed ideologies of inequality and privilege penetrate social institutions including healthcare. Disparities in health are common across American cities. Tennessee is divided into three regions—West, Middle, and East—and is more rural than urban. The largest city in West

¹ John, 8:32 (Common English Bible).


Tennessee is Memphis, located in Shelby County. In Shelby County, Blacks have higher mortality rates than others from heart disease, strokes, diabetes, and all types of cancers. African Americans are twice as likely as Whites to die from the above diseases. In addition, for Blacks, deaths related to HIV infections are triple those of Whites. Data undeniably reveal that “African Americans are more likely to die at early ages from all causes.”

In January 2001, Dr. Rodney G. Hood, President-Elect of the National Medical Association, published “The ‘Slave Health Deficit’: The Case for Reparations to Bring Health Parity to African Americans.” Hood explained that his goal during his tenure was to “emphasize the history, the causes and the solutions for the elimination of racial and ethnic health disparities—especially within the African-American community.” Hood noted that health disparities have persisted from Black enslavement through the beginning of the twenty-first century.

In 1897, a century before Dr. Hood’s comments, African-American scholar W.E.B. Du Bois hosted a two-day conference at Atlanta University, and the findings were

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published as *Social and Physical Condition of Negroes in Cities*. In one of the conference reports, “Proceedings of the Second Conference for the Study of Problems Concerning Negro City Life,” Mr. L.M. Hershaw provided a detailed analysis of data compiled from the Boards of Health in five Southern cities: Atlanta, Baltimore, Charleston, Memphis, and Richmond. Hershaw found that Charleston had the highest disparity of death rates between Whites with Blacks, while Memphis had the lowest disparity between races. Mortality data like Hershaw’s are important for this dissertation because they allow us to glimpse the stark differences between the quality of life among Whites and Blacks.

However, relying exclusively on health records from the antebellum and Reconstruction years can prove problematic because many records are inconsistent or unreliable. Because district health reports and county mortality documents did not always identify the cause of death, determining the impacts of various diseases and ailments is difficult. Still, it is important to use early mortality data for demographics on race and gender. Likewise, statistics about illnesses and diseases among enslaved and free Blacks allow for comparative analyses of racial health disparities. Although the State Board of Health in Tennessee began the process of collecting state registrations of deaths in 1908, several cities compiled reports in the nineteenth century.

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In 1846, Memphis became the first city in Tennessee to document mortality data, followed by Chattanooga in 1873, Nashville in 1874, and Knoxville in 1881. Slavery produced dire health consequences, and early public health reports from Memphis and the 1850 U.S. Census provide relevant data about race and gender. Aside from official government documents, epidemiological data and reports provided by medical institutions, medical journals, and newspapers, as well as plantation, agricultural and planter resources such as DeBow’s Review, serve to give a comprehensive historical view of health issues among Blacks in Memphis. When exploring national and local causes of morbidity and mortality, we must be aware that slavery was an unhealthy institution for Blacks across their lifespan. Demographic information is useful when examining and writing histories about how diseases and illnesses affect different populations. However, while several regional health histories have been written of enslaved people, the history of health in Memphis has yet to be thoroughly explored.

Early medical histories that address the health of enslaved people include the work of historian William Dusineberre on rice plantations in South Carolina. Dusineberre included qualitative data that revealed high infant mortality rates, stillbirths, and epidemics. Another historian, Todd Savitt, described the health conditions of enslaved people in antebellum Virginia, including extensive data about endemic and epidemic


diseases. Savitt explained the various health problems that stemmed from race-based medicine, because Blacks were perceived as being biologically different. Like Dusineberre, Todd Savitt relays dreadful mortality rates on slave plantations.\textsuperscript{13} Although Memphis did not have large plantations, the city nevertheless had a prosperous slave economy. The Memphis slave market was lucrative, but the population of enslaved people and free Blacks was not healthy.

Historians have studied Memphis from its settlement through its transition to a river town. In 1830, few Blacks (slave or free) lived in Memphis.\textsuperscript{14} In 1850 the U.S. Census reported that 126 free blacks and 2,360 enslaved residents lived in Memphis. There were 218 free Blacks and 14,360 enslaved people living in Shelby County.\textsuperscript{15} Historian Gerald M. Capers Jr. reported that by 1860, Memphis had a diverse ethnic population that included many foreign-born individuals. Specifically, most Whites living in Memphis were born outside of the United States. In the city’s booming economy, businesses thrived as retailers invested in raw materials such as flour, cornmeal, and


\textsuperscript{14} Marius Carriere, Jr., “Blacks in Pre-Civil War Memphis,” \textit{Tennessee Historical Quarterly} 48, no. 1 (Spring, 1989): 3-4. Memphis’s growth in population and commerce is well documented. “Of the 22,623 persons in Memphis on the eve of the war, 11,803 were native whites; 4,149 were Irish; 3,882, Negroes; 1,412 Germans; 522, English; 140, British-Americans; 120 French, 113, Scots; and 472, of other foreign stocks,” Gerald M. Capers Jr., \textit{The Biography of a River Town Memphis: Its Heroic Age} (New Orleans: Tulane University, 1966, Reprinted Memphis: Burke’s Book Store, 2003), 107-108.

bricks. More pertinent to my project, Memphis had the “largest slave market of the Central South.”

Many enslaved people arrived in Memphis via boats from areas in Virginia, Kentucky, and Missouri. The other source for Memphis’s participation in the inland slave trading was Louisiana, particularly New Orleans. After railroad expansion, Blacks arrived in Memphis frequently as slave markets extended to various parts of Georgia, Alabama, Arkansas, and Mississippi. After the Civil War, many formed communities, and the population of Blacks continued to increase. Because the population of free Blacks in Memphis and Shelby County increased rapidly from the 1850s (281) through 1870 (36,640), the city of Memphis is ideal for research on racial and sociocultural health conditions. This dissertation covers Memphis medical and health history from the 1850s through the early 1920s.

Chapter 2, “Medicine, Slavery, and Health in Antebellum Memphis,” explores the contrast between slaveholders’ desire to present the humans they enslaved as healthy and happy with the realities of medical care that was actually available to enslaved and free Blacks during the antebellum period. The city of Memphis had few enslaved people when compared to the surrounding areas of Shelby County. Using medical records and

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16 See Gerald M. Capers, The Biography of a River Town (Memphis: Burke’s Book Store, 2003), 99, 101, 111. Earlier narratives of Memphis in relation to growth and development including the rise of a “cotton kingdom,” and the use of free Black women as concubines are documented. It was noted that in the 1840s slaves were not auctioned in Memphis, Carolyn Pittman, “Memphis in the Mid-1840s: Memphis before the Mexican War,” West Tennessee Historical Society no.23 (1962): 38-39. For a concise description see also Beverly G. Bond and Janann Sherman, The Making of America Series: Memphis in Black and White (Charleston: Arcadia Publishing, 2003).


18 United States Bureau of the Census, Table of Sex, at the Census 1870 by States and Territories (Washington DC: 1872).
firsthand accounts, I show how enslaved and free Black people accessed health care in the city of Memphis. Details about medical experimentation on enslaved women and racial health disparities are discovered and challenge previous views of medical care. The focus on race and gender will address the management of diseases among well-known physicians including Lewis Shanks, Ayres P. Merrill, John R. Frayser, and Howell Robards.

Chapter 3, “Memphis In the Era of Reconstruction: Disease and Psychosocial Health,” considers how race, gender, and cultural mindsets generated a gamut of social diseases. In this chapter, I give an account of Black women’s mental health problems in the post-Civil War years in Memphis. Though the available health data on disease and mortality did not consider mental health consequences, historians such as Rob Boddice have shown how primary source materials can be used to explore psychosocial aspects of health and mental health concerns. The Memphis Race Riot of 1866 was traumatic for Black women. Riots, physical assaults, sexual assaults, and mental torture were all part of this traumatic year. Drawing on primary sources such as Congressional Reports and individual eyewitness accounts, I explore psychosocial health issues in relation to race and gender to broaden the study of women and emotional history.

Commenting on the riots of 1866, historian Altina L. Waller notes that “the class structure and ethnic characteristic of the neighborhood coupled with demographic and economic upheaval of the post-war period created fear and frustration which sparked

19 “Once upon a time social disease meant venereal disease, and nothing else. Inaccurately applied the term was only a euphemism. Of genuine diseases of a society, war and rebellion come first, followed by political and economic upheavals—none of which has medical meaning, in the way the alcoholism and drug abuse do,” Journal of the American Medical Association 222, no. 1 (1972):1.

collective violence.” However, fear is rarely discussed in the context of victimization. How was fear evoked in women? What type of fear was it? And how did women express their fears? Was the fear of death present during raging gunfire? In their testimonies, Black women detail physical abuse and emotional terror. The psychosocial health problems of these experiences are sometimes overlooked, but are just as important as physical illness, because both impacted the overall health of the women.

Chapter 4, “Perseverance and Resilience: The Intricate Connections of Health Care,” demonstrates how African Americans in Memphis responded to the ethos of racial segregation in health care during the Progressive Era. Though one historian has identified this period as the “nadir” of the post-Reconstruction era, an examination of the Black community’s efforts to address the looming health crisis shows how even in the midst of a dire period of racial and social unrest, they fought for dignity and agency within their community. In Memphis During The Progressive Era, William Miller describes Memphis as a city that, between 1900 and 1927, moved from having filthy streets and little civic organization to having an organized political structure; however, the ideologies and moral conduct of citizens remained deeply rooted in the tradition of white supremacy.

While acknowledging the general issues of disease, race, gender, and segregation in the South, few studies have considered the health problems of Black people living in

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the city of Memphis during this period. Racism and segregation promoted a health care system that was corrupt, as noted by federal health audits. The historical span of health problems among Blacks in Memphis correlates with national health problems and public health issues. For example, in Memphis, diseases such as tuberculosis caused high mortality rates and required a concerted effort among middle-class Blacks to create easily accessible resources such as health forums, women’s clubs, and tuberculosis campaigns in their communities. Black Memphians created inventive ways to challenge healthcare segregation. Racial discontent advanced solidarity and active participation in public health crusades.

Chapter 5, “Call to Duty: Black Physicians: Benevolent Educators, Instructors and Providers,” focuses on the impact of Black physicians on Memphis and surrounding communities from the late nineteenth century until the second decade of the twentieth century. Historian Darlene Clark Hine notes that “without the parallel institutions that the black professional class created, successful challenges to white supremacy would not have been possible.” To understand the need for training and educating Black physicians, it is important to illustrate the growth and development of universities, training facilities, and hospitals like Meharry in Nashville, Tennessee. This chapter shows how Black physicians in Memphis were inspired by Black racial uplift to create their own medical school, hospitals, and physician specialists. Revisiting the theme from Chapter 4 of Black agency in the struggle for professional legitimacy with White middle-class

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physicians, it explains how black professionals broke down barriers in Memphis.\textsuperscript{25} Several African American medical professionals in Memphis who understood the extent of the health disparities and abysmal mortality rates ravaging the city called for the development of nursing schools. Historian Hine, whose research on Black nurses focuses on the trials and dilemmas of Black women entering the profession of nursing, notes that the training of Black nurses reflected values of racial pride. Memphis Black physicians participated in this training by creating four Black nurse training schools.

Chapter 6, “We Too Are Angels of Mercy: Black Nurses in Memphis,” illustrates the role of Black nurses in Memphis. Studying post-Civil War Memphis is particularly pertinent to developing a history of nursing because the availability of primary sources such as newspapers helps to reconstruct the careers of Black nurses who were paid for their services during critical health crises such as the 1878 yellow fever epidemic. Although Black nurses in the city witnessed disease and profound mortality rates, their contributions are mentioned only briefly. The historical accounts of Black nursing in Memphis are greatly understudied in the cultural and social context of regional histories, and the history of Black nurses in Memphis is overshadowed by historical accounts of White nurses.\textsuperscript{26} Responding to the perception that Black nurses were unskilled and


\textsuperscript{26} The history of public health nurses in Tennessee provides information on various types of public health services in all counties, such as tuberculosis. For example, in 1917, Memphis (Shelby County), there were 10 public health nurses, 3 of which were Black. “A History of Public Health Nursing in Tennessee 1910-1960” Tennessee Nurses’ Association (1960). A historical narrative about Black identical twins Bernice and Maurice Walton who served in the Nurse Army Corp during WWII; Michele Fagan, ‘Time of Empowerment and Transition: Memphis Nurses During Work War II,” Tennessee Historical Quarterly 53,
untrained, Memphis Black nursing schools such as Collins Chapel developed three-year curricula.

Documents show that Black nurses in Memphis were skilled in surgical care of patients and community leaders in public health. Nursing served the goals of racial uplift for their community, and nurses collaborated and trained with Black physicians who operated private segregated hospitals. However, Black nurses were faced with professional and legal impediments, because for years they were denied crucial licensure that became normalized as nursing became professionalized. This chapter shows how Black nurses advocated for access to these credentials by reversing state laws.

Ultimately, this chapter aims to fill the void of information about Black women in the history of nursing, and to dispel racial misconceptions about the profession. For instance, textbooks give credit to the University of Minnesota for establishing the first nursing program in a university in 1909. However, Mary Elizabeth Carnegie notes that Howard University began a nursing school in 1893. In this chapter of my dissertation, I accept the earlier date and place Black nurses at the center of nursing history in order to show the ways in which nursing programs for Black women were instrumental in establishing university training.

no. 3 (Fall 1994): 18. Patricia LaPointe explains the historical development and analysis of nursing in Memphis from 1887-1925. Her original research is an invitation to explore the history of Black nurses. There is a brief discussion about the Jane Terrell Memorial Hospital nursing school for Blacks; Patricia M. LaPointe, From Saddle Bags to Science: A Century of Health Care in Memphis, 1830-1930 (Memphis: The Health Sciences Museum Foundation of the Memphis and Shelby County Medical Society Auxiliary 1984), 68-69.

Chapter 2: Medicine, Slavery and Health in Antebellum Memphis

“Don’t fear, because I am with you; don’t be afraid, for I am your God. I will strengthen you, I will surely help you; I will hold you with my righteous strong hand.”¹

Historians have long looked to sources such as the autobiographies of Fredrick Douglass to understand the conditions of slavery. One of Douglass’s masters, Colonel Lloyd, had a large plantation with 300 to 400 slaves and additional small farms in the surrounding area; however, the grandeur of plantation life was not a part of Douglass’s memories. What the former slave conveyed was the privations of slavery: “I was seldom whipped by my old master, and suffered little from anything else than hunger and cold. I suffered much from hunger, but much more from cold.”² Over time, Douglass learned how to seek out necessities such as food. For instance, Douglass describes letting a horse run away to a nearby plantation on purpose. “My reason for this kind of carelessness, or carefulness,” he writes, “was that I could always get something to eat when I went there. Master William Hamilton, my master’s father-in-law, always gave his slaves enough to eat.”³ On the other hand, Robert Falls, who was born into slavery in 1840, describes his conditions in vivid detail. Falls explains that animals were better fed, stealing food was common, and beatings and punishments were prevalent

¹ Isaiah, 41:10 (Common English Bible).
³ Ibid., 354, 355.
when caught by slave-owners. Using first-person narratives, historians still debate about the health status of slaves.

In a society with enslaved people, descriptions of “healthy slaves” by proslavery commentators sometimes blind us to the realities of human neglect (e.g., hunger, lack of clothing, suffering, poor health, and disease). This dissertation will explore the reality of health for enslaved people in Memphis by examining scholarship on antebellum slavery and the medical history of Memphis, Tennessee. Using demographic data on morbidity and mortality in the city, this chapter will focus on the health of the enslaved. This chapter will also examine how rural and urban settings fostered diverse health problems and how medical practices such as heroic medicine and medical experiments on enslaved people were normative practices at Memphis Medical College. Information on the treatment of Black patients in the city dispensary, hospitals, and private homes provides details about acute and chronic health conditions of people living in and around Memphis. The chapter will also explore how early health reports demonstrate racial disparities for Blacks. Finally, this research will add to the scholarship on Memphis

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5 “Heroic” is a term used for medical treatment and management by many prominent antebellum physicians including Benjamin Rush: “In brief the antiphlogistic method consisted of largely bleeding, blistering, purging, vomiting, and sweating. These measures were not unique to the first half the nineteenth century, but they were applied so drastically at this time the period may well be characterized as the heroic age of medicine. The medical ethos of the time was that “desperate diseases require desperate remedies.” John Duffy, “Medical Practice in the Ante Bellum South,” The Journal of Southern History 25, no.1 (February 1959): 55.
medical history, as the focus includes a broader perspective on the Medical College, gender, race, and health practices.\(^6\)

In the counties of West Tennessee, including Shelby, Fayette, Haywood, Madison, Hardeman and Tipton, 84 percent of enslaved people toiled in the cotton fields. Free Blacks represented only a small proportion of the population. In 1860, the population of antebellum Memphis was 22,623. Blacks totaled 3,822, and less than 200 were Free Blacks. More broadly, 36 percent of enslaved people in the western Tennessee counties (or 16,953) resided in Shelby County. The free Black population was only 276. The distribution and population data for male and female slaves in Shelby County was nearly fifty percent; just over half of the 16,953 slaves were female (8,656).\(^7\) To reconstruct the lives of free Black and enslaved women in Memphis and Shelby County during the mid-nineteenth century, one has to concede that statistically, the numbers were small compared to other antebellum cities such as New Orleans, despite similarities such as the slave market and urbanization, travel and trade on the Mississippi. However, as a hub centrally located on the Mississippi, Memphis became a dual slave market, where enslaved people were trafficked inward and outward for sales.

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\(^6\) Patricia LaPointe McFarland, *From Saddle Bags to Science: A Century of Health Care in Memphis, 1830-1930* (Memphis: The Health Sciences Museum Foundation of the Memphis and Shelby County Medical Society Auxiliary 1984) provides background information about medicine and physicians; however, more research is needed to understand disease patterns and types of visits. When it is discussed, research concerning various diseases and epidemics that affected Memphis typically addresses mortality rates during the Yellow Fever scourge. Many Blacks especially women and children did not leave the city. Also, the historical events about their lives during the epidemic is obscure the mortality rate for Whites was proclaimed to be 75% and for Blacks 7%. S.R. Breusch, “The Disasters and Epidemics of a River Town: Memphis, Tennessee, 1819-1879,” *Bulletin of the Medical Library Association* 40, no. 3 (July 1952): 304.

Slavery, Health Paradigms and Gender Dialect

With slavery existing in Northern and Southern states, it was America’s “peculiar institution.” As a vital part of Southern culture, slavery in the South was peculiar when compared to the North, especially with regard to the South’s long history of chattel slavery. Historian Paul Finkelman provides clarity for understanding slavery as a peculiar institution. This chapter explores Kenneth Stampp’s ideas, and those of other historians who recognize that “on the eve of the Civil War, White Southerners, while extolled the value of slavery, knew their system of organized labor and controlling race relations was unacceptable to much to the world. It was truly peculiar.” However, countering Stampp’s argument is sociologist Orlando Patterson, who clearly demonstrates that the institution of slavery was a social and cultural norm centuries before American slavery.

Patterson discovered slavery and slaveholders throughout the world. Finkelman explains that both views are correct; however, American slavery was a “peculiar

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8 Prominent studies about varied dynamics of race, slavery, and the interpretation of the “peculiar institution” describe slavery as an abusive labor and social system within Southern culture. For descriptions of the day to day labor operations of a plantation, the sale and transport of human property, the rigid structure of a powerful patriarchal regime, morbidity, and mortality, the dynamics of class systems, and the expansive spread of a wealthy business for planters, see Kenneth D. Stampp, *The Peculiar Institution: Slavery in the Ante-bellum South* (New York: Vintage Books, 1984). Other research details how slavery represented the South’s “peculiar institution.” Over time, slavery developed into a unique cultural entity of Southern livelihood. “Masters expressed growing concern for the well-being of their ‘people,’ and the material treatment of most slaves improved. At the same time, slave owners renewed their efforts to promote slave dependence and docility, sharply curtailed manumissions, and imposed new restrictions on the action of both slaves and free blacks.” Specifically, “Antebellum slavery became both more rigid and paternalistic; in the process, it also became increasingly distinctive; Peter Kolchin, *American Slavery: 1619-1877* (New York: Hill and Wang, 2003), 93-94. Details on the reality of Southern slavery were countered by many who opposed slavery, “Abolitionist were committed to the distinctly modern view that the status quo and legacies from the past need not be tolerated, that no beneficial ends or economic benefits could justify a system in which one human being treats another like a domesticated animal or a salable tool or instrument,” David Brion Davis, *Inhuman Bondage: The Rise and Fall of Slavery in the New World* (Oxford: Oxford University Press, 2006), 178.
institution for several reasons.” First, American slavery was based on race. Slavery was legal and institutionalized. The designation of enslaved people was exclusively assigned to Blacks. Second, American slavery developed in a society that promoted ideas of freedom and liberty. Finkelman explains that the rights of life, liberty, and the pursuit of happiness proclaimed in the Declaration of Independence could be universally applied to white Americans precisely because they were not applied to Blacks. By contrast, ancient Rome had no need to define slavery, because inalienable rights and equality were not an ideology or value in their slave society. Race-based societies did exist in other countries such as Brazil and Cuba. However, as Finkelman notes, most countries did not create a highly structured system with rigid racial boundaries. Notably, in many regions of the world, “enslavement could happen to anyone regardless of race or ancestry. All enslaved people in America were African Americans.”

Race relations consisted of a hierarchical system rooted in Southern ideology. Words and labels signified the socio-cultural position of Blacks. Legally, throughout much of the American south, enslaved people were chattel property. Economically, slavery was the nucleus of a vast economic empire that encompassed southern agriculture and northern industry and was the basis of a political system. Enslaved people were

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10 Ibid., 1009-1012

11 The “slave power thesis” was recognized by politician like John Quincy Adams and forwarded by William Henry Seward of New York. He was a leading spokesperson for the Republican Party. Steward detailed the social reality of the United States government using indisputable facts. He substantiated the national leadership via federal officeholders by posing the following questions: “Who sat in the White House: The Speaker’s chair? On the Supreme Court? The answer was the slave masters had far more power than their numbers warranted. In the sixty-two years between Washington’s election and the Compromise of 1850, for example, slaveholders controlled the presidency for fifty years, the Speaker’s for forty-one years, and the chairmanship of the House Ways and Means for forty-two years. The only men to be
human property whose worth was intimately associated with the physical condition of
their bodies. People who owned slaves boasted about the “good health” conditions of
their slaves because Southern tradition and cultural values perpetuated the ideology of a
paternalistic master. Planters viewed the enslaved as family members whom they had a
responsibility to furnish with “a lifetime of food, shelter, clothing, and health care.” The
healthiness of the enslaved was understood to be a vital requisite for profit, but the
conditions of forced labor and other hardships resulting from enslavement meant that few
enslaved people were indeed in good health. The notion of “healthy slaves” was
propaganda used by proslavery advocates and those who owned human property for
profit, social class, and status. Highlighting the “good health” of slaves was done to
downplay the hideous nature of the peculiar institution.

Historian Stephanie Jones-Rogers explores the purchasing strategies and
knowledge of slave-owning white women in the South. Jones confirms that many White
women sold and purchased enslaved people in private settings including homes, estate
sales and women’s auctions. Likewise, some White women preferred to purchase sickly
enslaved people who were treated, cured, and sold for higher prices. Slave-owners took
precautions before purchasing enslaved people; doctors examined them to confirm “a
clean bill of health.”

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12 Kevin Lander and Jonathan Pritchett, “When to Care: The Economic Rationale of Slavery Health Care
Provision,” Social Science History 33, no. 2 (Summer 2009): 158.

13 Stephanie E. Jones-Rogers, They Where Her Property: White Women as Slave Owners in the American
South (New Haven: Yale University Press, 2019), 94-95, 142-145.
Owing to the patriarchal social role of the slave owner, most assumed they knew what was best for their slaves. Slaveholders viewed themselves as the preachers, teachers, and, most importantly for the purposes of this chapter, the medical advisors for their slaves.\(^\text{14}\) Slaveholders determined whether a physician was necessary to treat a slave’s illness. Though medical care was often sought as a last resort, physicians had an indispensable role in the business of marketing slaves and attended slave auctions to sign health certificates and to function as consultants. Doctors gave medical advice and were viewed as expert witnesses by their medical colleagues and slaveholders.\(^\text{15}\) For slave owners, female slaves were an especially lucrative investment—mostly because their offspring had an intrinsic cash value. As might be expected, they often sold for high prices. Historian Jenny Bourne’s research acknowledges that slave prices increased with growth, development, and puberty. Values peaked at age 22 for females and 25 for males. Slave owners paid more for girls than boys until the mid-teens. Gender age and prices continued to vary; for example, “boys aged 14 sold for 71 percent of the price of 27-year-olds, whereas girls aged 14 sold for 65 percent of the price of 27-year-old men. Compared to full grown men, women were worth 80 to 90 percent as much.”\(^\text{16}\)

Gender and labor operations on antebellum plantations were statistically meaningful for enslaved women. For instance, ninety percent of enslaved women toiled in agricultural production on tobacco farms, sugar estates, rice fields, and cotton


As a unique population, enslaved women were responsible for the fortune and success of the Southern gentry class. Enslaved women were unique because as women, they maintained population growth. In addition, enslaved women were unique because only their offspring were predestined to be property and generate income. Without the reproduction of enslaved children, antebellum slavery would have depleted in numbers. Unfortunately, health disparities including early mortality and disproportionate numbers of deaths for women and children are overlooked, especially in Memphis. Enslaved people arrived from other regions, and when they were sold and transported to Memphis, health problems could be correlated with prior types of labor.

The health problems of enslaved and free Black women in an urban community are overshadowed by histories that focus on major epidemics, pseudo-science, and prominent White physicians. Data concerning the health care of free Blacks and enslaved people can often be found in sources like local newspapers and medical journals. Regardless of racial status, health officers in Memphis recorded causes of deaths in weekly newspapers. But these data are often present in the clinical reports of physicians, which describe procedures on Blacks, including only first names or initials as

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17 Ellen Carol Dubois and Lynn Dumenil, Through Women’s Eyes: An American History with Documents (Boston: Bedford/St. Martin’s, 2009), 211. Another prominent study on gender and slave labor explains that on several plantations, most field workers consisted of enslaved women. Slaveowners justified women as more efficient labors: “Slave owners noted that some women displayed greater dexterity than bondmen because of their small hands; this allowed some women to pick cotton faster without leaving excessive amounts of fiber on the boll.” Plantation records reveal that “enslaved women in ditches, threshed straw, and gleaned rice; they also tied, bundled, stacked and dried sheaves. In addition, women managed ginning machines. Thus, the benefit of female labor was cost, childbearing, and diverse skills, Daina Ramey Berry, Swing the Sickle for the Harvest is Ripe: Gender and Slavery in Antebellum Georgia (Urbana: University of Illinois Press, 2007), 16-17, 19, 22.

18 Unique defined as being without a like or equal, unmatched, unparalleled, https://webster-dictionary.org/definition/unique.

identification. Women especially suffered from these clandestine medical practices in a sickly riverfront city. Marginalized by social status and gender, women suffered from not only physical health conditions, but also emotional and psychosocial health problems that were relevant to their overall health.

There are numerous scholarly journals and books about health of enslaved people on plantations. Data from plantation records and slave sales provide primary sources about morbidity and mortality. For example, on rice plantations, “expected probability of infant death was 56% higher among births to women under age 20.”

Children between certain ages experienced high death rates during summer months. Mortality among enslaved people often had seasonal patterns, in addition to environmental causes that induced infectious diseases. Historians emphasize the natural population growth of antebellum slaves, even under the dire circumstances surrounding high disease and mortality rates, and masters promoted the health and resilience of their slaves.

In 1860, the population of enslaved people had climbed to nearly 4 million. Providing health care and maintaining satisfactory health conditions for the enslaved people was improbable for several reasons. First, medical practice varied and was

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21 Ibid., 110. Health inequalities for Blacks began in slavery and remain today. Health disparities are viewed as part of institutional racism and political mainstay in American society. With race as the central theme, disproportionate numbers of early death, higher infant mortality, and access to health care are multidimensional. For example, higher cancer rates among Blacks are attributed to marketing strategies in Black communities. Notably, the origins of health inequities began with the racle based system of slavery. “Estimated longevity at birth for a male slave was 30 years and 32 years for female, at least 5-8 years less than Whites,” Vernellia Randall, Dying While Black: An In-depth Look at a Crisis in the American Healthcare System (Dayton: Seven Principles Press, Inc., 2006), 34-35, 65, 101, 102; Harriet A. Washington, Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present (New York: Doubleday, 2006).
strongly entrenched in the hierarchies of Southern slavery. Second, at least ninety percent of Southern slaves worked on plantations and farms. In 1860, the planter class was a minority. Eighty-eight percent of slaveholders had fewer than twenty slaves. Among those, most had fewer than ten slaves. Many antebellum slave owners could afford only one or two slaves and worked alongside their slaves in the field. Planters who owned large estates were not the norm. It is doubtful whether most slave owners, especially those who managed plantations, maintained healthy slaves and cared for ill slaves.

One aspect of slave care that correlates strongly with health status is nutritional intake, especially an inadequate diet. Mortality rates increased without basic food, clothing and shelter, and, as a result, illness, disease and death occurred over time. People who traveled to the South from the North often described the social reality of health conditions among enslaved people: “On almost every plantation, the hands suffer more or

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less from hunger at some seasons of almost every year.”

Tobias Boudinot traveled frequently from Ohio to the lower South via the Mississippi River. He was astounded at the appearance of enslaved people. “The slaves down the Mississippi, are half-starved, the boats, when they stop at night, are constantly boarded by slaves, begging for something to eat.”

Even a wealthy owner was no guarantee that slaves would be well fed. For example, Wade Hampton openly discussed the treatment of his slaves with his close friends. He detailed how he experimented with food products. Hampton decided to create a mixture of one-fourth cotton seed with three-fourths corn meal. His slaves ate the mixture and had no ill effects. Then Hampton decided to change the mixture to three-fourths cotton seed to one-fourth corn meal, disdainfully stating, “they died like rotten sheep.”

Undernutrition or malnutrition was common among enslaved people; however, neither starvation nor malnutrition appears as a common cause of death in the 1860 census for any race. Linking disease and death to lack of food situates the lives of the enslaved within the lives of American paupers in general. The commonness of starvation corroborates the abolitionist arguments that enslaved people were victims in a racially

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25 Ibid., 28.

26 Ibid., 29. Wade Hampton inherited his wealth from a family with long traditional standings in South Carolina. “He was one of the largest owners and operators of slave labor in the South,” Williams Porcher Dubose, and B.J. Ramage, _The Sewanee Review_ 10, no. 3 (July 1902): 365.

27 Malnutrition, in all its forms, includes undernutrition (wasting, stunting, and underweight), inadequate vitamins or minerals, overweight, obesity, and resulting diet-related noncommunicable diseases. World Health Organization, _Malnutrition_, (February 16, 2018).
divided society. Nutrition and dietary consumption reveal that a basic necessity such as food was often omitted, scarce, or rationed by slave owners.

Just as race was often a determinant of poor health outcomes in the antebellum South, gender also posed risks for morbidity and mortality. Gender issues determined the anomalous cost of health care between female and male slaves. Health maintenance for women, especially gynecological care, and childbirth, was expensive. Historian Marie Jenkins Schwartz examined the cost for medical care when labor complications ensued and postpartum care was provided, as it was on some plantations. In 1857, the prices ranged from $13.00 ($296.52 in 2020) for a night visit to attend to a miscarriage, with subsequent follow-up of $7.00 and an additional $10.00 to administer medication. With the cost of obstetrical and gynecological care, the average slave owner, who was primarily a small farmer, would have to generate surplus revenue to provide basic maternal care for enslaved women.

Also, as shown in William Postell’s research, both obstetrical and gynecological health care was costly. When physicians were called for emergencies such as removing retained placenta, the fee ranged from $5.00 to $10.00. Time of visit and travel were often included in the cost, as one planter received a bill for $10.00, and an additional one for $25.00. For many enslaved women, pregnancies resulted in disease and death. While caesarean sections were rare on plantations, maternal death rates were high across racial

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29 “Retained placenta after vaginal delivery is diagnosed when a placenta does not spontaneously deliver within a designated amount of time.” The duration can vary usually between 18 minutes to 1 hour. In addition, retained placenta is associated with obstetrical morbidity. Nicola C. Perlman and Daniela A. Carusi, “Retained Placenta After Vaginal Delivery: Risk Factors and Management,” *International Journal of Women’s Health* 11 (2019): 527.
and ethnic lines because of puerperal fever.\textsuperscript{30} Unhealthy conditions for women such as long hours in the field during pregnancy and prior to delivery, along with inadequate nutrition and epidemic diseases, directly influenced the health status of their children.\textsuperscript{31}

Data also reveal that infants and young children suffered disproportionate numbers of diseases due to callous acts from slave owners, particularly withholding food and nutritional support. Historian Joseph E. Illick explains the psychological consequences of live as a slave (which affect health and well-being) upon enslaved children. For instance, inadequate daily time was allowed for parental bonding, with enslaved women returning to work weeks after birth. Limitations on feeding patterns developed early for enslaved children, including early weaning from breastfeeding. In addition, at an early age enslaved people had high risk factors for illness and diseases associated with the use of feeding troughs. These factors reflect the inhumane and animalistic practices projected upon Blacks in a racist culture. Obviously, the diet for young children was inadequate for normal growth and development.\textsuperscript{32}

\textsuperscript{30} William Postell, \textit{The Health of Slaves on Southern Plantations} (Gloucester: Peter Smith, 1970), 114-117.

\textsuperscript{31} Undoubtedly, life for enslaved people who cultivated rice endured misery and a painful fate. Their adulthood was reduced by many years due to drudgery and intense labor. “On the Ball family plantations, slaves born between 1800 and 1849 had a life expectancy of 19.8 years for males and 20.5 for females. About half of the children did not live to adulthood.” During epidemics such as cholera the number of deaths among enslaved people were approximately 1,000. Peter McCandless, \textit{Slavery, Disease, and Suffering in the Southern Lowcountry} (New York: Cambridge University Press, 2011), 129-130.

\textsuperscript{32} Joseph E. Illick, \textit{American Childhood} (Philadelphia: University of Pennsylvania Press, 2002), 41. Childhood slavery fostered diseases in infancy and childhood related to poor nutrition that was quantified by height and weight measures. Slave children who were under nourished suffered delayed growth patterns. Selective feeding patterns and minimal quantities of food choices including meats were not deemed as beneficial for slaveowners. Chronological age determined how food was distributed among slave children. However, during adolescences slave children reached a standard level of normal height and weight, Richard H. Steckel, “A Peculiar Population: The Nutrition, Health, and Mortality of American Slaves from Childhood to Maturity,” \textit{The Journal of Economic History} 46, no. 3 (September 1986). For a counter argument to Steckel’s data, see John Komlos and Bjorn Alecke, “The Economics of Antebellum Slave Heights Reconsidered,” \textit{The Journal of Interdisciplinary History} 26, no. 3 (Winter, 1996).
Richard Steckel explains that chronic malnutrition was omnipresent among enslaved children, based on the description of slave owners. For example, “shiny bodies, plump bellies, and glistening ribs of their young slaves” were common physical manifestations of poor nutrition, in which the disease state of protein malnutrition developed. Likewise, although enslaved women and children suffered from diseases and death associated with arduous plantations life, slaveholders continued their rigid schedules for producing staple crops. For enslaved women, their health and well-being, especially during their pregnancy, occupied the spotlight in numerous medical journals, Sunday morning sermons, agricultural newsletters, and editorial columns.

*DeBow’s Review* contained frequent articles on the management of enslaved people and eagerly advised planters on how to care for the females. Masters fashioned themselves as authorities regarding the well-being of their female slaves. Some owners decided the appropriate bedtime for slaves, usually between 9:00 and 10:00 p.m. However, a woman with a sick child had a justifiable reason for being up past 10:00 p.m.; thus, she was not subject to punishment. Slave owners prized pregnancy and motherhood.

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The Southern culture of paternalism granted enslaved women privileges on many plantations, and their individuality was most evident in times of disease, sickness, fecundity, pregnancy, and antepartum events. Certain planters acknowledged the benefits and challenges of differentiating between pregnant and non-pregnant women. One smaller farmer reported that he gave “all females half of every Saturday to wash and clean up.” A slave-owner named Joseph Acklen of Louisiana informed his overseer that pregnancy was not a health problem that required rest-in states as protection for childbirth; pregnancy thus did not guarantee privileges. The rules of his plantation clarified light duty assignments. Pregnant women had permission to perform light labor only before and after confinement; mothers were allowed time to care for their infants until weaned; however, women who were indoors because of pregnancy or recovering from an illness must spin or sew.

P.C. Weston showed appreciation for the enslaved women on his plantation by giving all women who had six living children every Saturday off. Yet he informed his overseer that “pregnant women are always to do some work up to the time of their confinement, if it is only walking into the field and staying there.” In various regions, especially with rice production, the plantation labor system was not conducive to healthy

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pregnancy. Miscarriages and infant mortality were prevalent. Maternity plans by slave-owners were illogical and racially motivated. Such ideas included standing for long periods while performing field tasks instead of time off or shortened workdays. Masters viewed Black women’s bodies as strong and enduring. Enslaved women worked long hours in the field; in the context of Victorian ideologies about “true womanhood,” female slaves were anything but “women.” Pregnant slaves were not seen as delicate and being pregnant did not always guarantee opportunities to rest and prepare for motherhood. Rhetoric about caring and comfort for enslaved women were part a slave society but did not match reality.

It is necessary to consider the misconceptions that masters conveyed in writing, and their own false beliefs concerning the disorders of female slaves. Management and recommendations from planters were often subjective and based on individual experiences of the owners.

Furthermore, slavery was a business. For most plantation

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40 Early Victorian American was a period in which society cast White middle-class females the standard of “womanhood.” White women’s social and gender status included distinguished qualities like, cardinal virtues, piety, purity, submissiveness, and domesticity. Lower class women were the opposite of being pious (of Protestant faith), pure submissive or domestic within the private sphere of home. Female roles and ideals in American society presupposed that working women (especially immigrants), enslaved, free Blacks, Asians, Indians, and those of Mexican origin had a social and cultural status inferior to White women. Victorian ideology remained prominent during the late nineteenth-century. Barbara Welter, “The Cult of True Womanhood: 1820-1860,” *American Quarterly* 18, no. 2 Part 1 (Summer 1966): 152.

41 On the position of Southern slavery and capitalism, slave trading was a profession. Many slaves were purchased in cash and not by credit. The interregional slave trade was a vast network between Upper and Lower States. Slaveowners became wealthy in the business of human trafficking. Tennessee and Georgia had key roles in importing and exporting slaves. Michael Tadman, *Speculators and Slaves: Masters, Traders, and Slaves in the Old South* (Wisconsin: The University of Wisconsin Press, 1996). Human oppression and the self-serving needs of wealthy planters had profound impact on the health of women and children. Slaveowners “used the women they owned to convert their own semen into capital.” Unequivocally, “The cotton must be picked. Their breasts becoming full of milk. Again, we come to the point at which the human being was tailored to the culture of cotton—at which the conversion of milk into live was diverted by the conversion of labor into income and thence, prodigally, into capital,” Walter
owners, increasing revenue from slave labor was the goal at any cost. All enslaved people performed some labor. Pregnancy and protection of the woman and her unborn child were secondary to profit.

**The Health of Black Women in Urban Memphis**

Although cities such as Memphis had a relatively small slave population, slave owners maintained medical histories of enslaved women that enable historians to reconstruct the health conditions of enslaved people. Slavery existed throughout Tennessee, and populations of enslaved expanded in rural west Tennessee and in other areas as cotton production increased, but the enslaved population in Memphis and other urban areas increased slowly, primarily because Memphis did not have a plantation labor system. Too, hiring enslaved people in urban settings was not profitable for slave-owners and business proprietors. Specifically, manufacturers in Memphis needed skilled and unskilled labor; contract labor was cost-effective. In 1830, few Blacks (slave or free) lived in Memphis. In 1850, the city had 2,486 people, and by the year 1860, the numbers of Blacks had increased to 3,882, of which 198 were free.42

Historian Gerald M. Capers Jr. reports that by 1860 Memphis had a diverse ethnic population that included many foreign-born individuals.43 Many antebellum cities

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43 Description of Memphis and its growth in population and commerce is well documented. “Of the 22,623 persons in Memphis on the eve of the Civil War, 11,803 were native whites; 4,1459 were Irish; 3,882, Negroes; 1,412 Germans; 522, English;140, British-Americans;120 French, 113, Scots; and 472, of other
witnessed periods of growth and decline in urban slavery. Consequently, the study of health issues among Black women in cities such as Memphis must focus on what happens when a river town transitions to an urban metropolis. Health problems, social conditions, and gender disparities among free Black and enslaved women are revealed in medical histories. These accounts give insight into how physicians managed and treated Black women.

These accounts uncover a health history of urban free Blacks and enslaved people, especially females, who lived in Shelby County and surrounding regions. The reports of a Dr. Shanks include the ages of several women and their respective causes of death. Physicians Dr. A.P. Merrill and Dr. Lewis Shanks encouraged scientific methodologies and epidemiological studies about health, diseases, and illnesses in the city. Dr. Merrill, likewise, published numerous journal articles on the distinct character of “Negroes,” and women in mid-nineteenth century America faced insurmountable health issues, especially because of slavery and the social consequences of poverty. Antebellum Black women were likely to succumb to disease and death at an early age. In fact, in the decade between 1850 and 1860, the life expectancy for Blacks at age 10 years was 37 years. The mortality rate for Blacks compared to Whites was considerably higher across all ages.


45 Remarkably, “This urban disadvantage in mortality resulted from high mortality from infectious diseases spread through poor water and sanitation systems, and diseases such as tuberculosis and respiratory diseases which are associated with poverty, and crowded, inadequate housing.” Likewise, “For example,
As noted earlier, the overall health conditions (physical and psychosocial) of enslaved and free women in Memphis are revealed in histories of the origins and development of medicine, in short biographies of physicians, and in descriptions of epidemics.\textsuperscript{46} In the history of health and medicine in antebellum Memphis, enslaved and free women were vulnerable within the constructs of medicine, a point I will explore in more detail later. However, Black women created ways to resist the harmful treatments of White physicians and slaveowners. The urban setting for enslaved and free women provides historical considerations about the complex lives and health risks faced by Black women who traveled to riverfront cities.

Historian Beverly Bond describes the lives of enslaved women in Tennessee. She also includes research on Memphis and Shelby County. Women assigned to field duties participated in strenuous plantation labor—plowing, planting, chopping, and cotton-picking. In addition, enslaved women tended to livestock and, if needed, domestic duties of cooking and sewing. However, many enslaved women worked in urban areas such as Memphis. Business proprietors advertised for workers without gender specification. For example, women worked for the United States Corps of Engineering (e.g., building

\textsuperscript{46}J.M Keating, \textit{The History of Yellow Fever Epidemic of 1878 in Memphis, Tennessee} (Westminster: Maryland, 2008), Marcus J. Stewart and William T. Black (ed.), \textit{History of Medicine in Memphis} (Jackson: McCowat-Mercer Press, Inc., 1971); Recent studies by Patricia LaPointe McFarland are especially useful in analyzing the contributions of Blacks in the field of nursing and medicine. In addition, discussion about epidemics that details challenges with medical care and treatment. Therefore, using McFarland’s topics, this research allows for further exploration on specific topics of gender, health, and race in Memphis; Patricia M. LaPointe, \textit{From Saddlebags to Science: A Century of Health Care in Memphis 1830-1930} (Memphis: The University of Tennessee Center for Health Sciences, 1984); Patricia L. LaPointe McFarland, and Mary Ellen Pitts, \textit{Memphis Medicine: A History of Science and Service} (Birmingham: Legacy Publishing Company, 2011).
roads). Enslaved women also performed in gendered occupations such as cook, nurse, and domestic servant, and enslaved women were hired out and negotiated wages and contracts. Illness was a risk for enslaved women who were bound by contract labor. If adequate housing, food, and clothing were not provided by the employer, the likelihood of disease and death was high.\footnote{Beverly Greene Bond, “Ma…Did Not Make a Good Slave,” in African American Women and Slavery in Tennessee, in \textit{Tennessee Women Their Lives and Times}, ed., Beverly Green Bond and Sarah Wilkerson Freeman, (Athens: The University of Georgia Press, 2015), 2: 23-27.}

Memphis’s private businesses and residents advertised for skilled and unskilled labor. When female slaves were auctioned, their multifaceted roles were highlighted. For example, Eliza was part of an auction to settle a debt owed by Aldridge & Company. At age 17 years, she was “an excellent seamstress, and in general a good house servant.”\footnote{Robert L. Smith, “Sheriff’s Sale,” \textit{Memphis Daily Appeal}, \url{http://www.chroniclingamerica.loc.gov/lccn/sm83045160/1858-07-22/ed-1/seq.2/}.} Slave agent and auctioneer A. Wallace described the quality of his new urban “Negro Mart.” Future slaveowners were informed that this slave market participated in a cleaning regimen and was neat and comfortable. He also explained that he adhered to regulation requirements. Specifically, Wallace wanted to convey that his market was “safe, and healthy,” and so were slaves who arrived for selling.\footnote{W. Bradford, \textit{Memphis Daily Appeal}, \url{http://www.chroniclingamerica.loc.gov/lccn/sm83045160/1857-10-01/ed-1/seq.4/}.} Mortality reports reveal there was much fictitious boasting about “healthy” enslaved people who arrived in Memphis.

For example, a 22-year-old woman belonging to slavers Dunlap & Witherspoon died of pneumonia. The undertaker’s report verified that the enslaved woman died prior
to being sold.\textsuperscript{50} Had she not died, she probably would have been auctioned off to the highest bidder, and her “health” guaranteed in the bill of sale. Similarly, a 14-year-old boy owned by established slave traders Neville and Cunningham died from “lung fever.”\textsuperscript{51} The long travel between states was deadly for many children, and names were never given. Another account recorded the death of a 13-year boy from pneumonia while in the possession of slave traders Forrest & Maples.\textsuperscript{52} All of these deaths occurred in 1857. Environmental factors (such as cold weather, high humidity, poor ventilation, unsanitary privies), and the social conditions of city life were risk factors for high mortality rates. For slave traders, the goal was to obtain Blacks for enslavement, trade, sell and make a profit. The reality was that many enslaved people were not examined carefully for “healthiness.”\textsuperscript{53} When slaves were auctioned at a business such as L. Johnson & Co., the proprietors sold goods, real estate, and human property.

The above business disclosed that selling chattel could also take place in the countryside areas or any part of the city for “a very moderate commission.” Their company had daily sales of slaves inside the store; there was no misleading advertisement of soundness, or medical doctor to guarantee healthiness.\textsuperscript{54}


\textsuperscript{51} Ibid.

\textsuperscript{52} Ibid.

\textsuperscript{53} In slave markets, “Buyers would stand by and inspect,” sometimes potential owners would examine teeth and limbs.” In the slave pens in Memphis (owned by Nathan Bedford Forrest) slaves had to maintain certain postures with heads held up and walk with a quick pace backwards and forwards. However, “sometimes a man or woman was taken back to the small house in the yard stripped and inspected, Michael Tadman, \textit{Speculators and Slaves: Masters, Traders, and Slaves in the Old South} (Madison: The University of Wisconsin Press, 1996), 99.

who were bargained for at Chancery Slaves were sold to the highest bidder. Again, there no focus on health.

Historian Richard Wade noted that urban slavery was dependent on a female workforce in cities like Richmond, Baltimore, Charleston, Mobile, Savannah, Louisville, St. Louis, and New Orleans. The “seaports and river towns sent Dixie’s produce to the outside, distributed necessary imports to the countryside, and formed enclaves of cosmopolitan life in a generally agricultural society.” Enslaved women outnumbered enslaved men, and “on the eve of the war, almost every Southern town had a greatly distorted population distribution, with a glaring shortage of men.” Again, Black women regardless of their status (e.g., free or enslaved) maintained traditional roles in a male-dominated society, working as cooks, maids, or in nursing roles such as caring for their owner’s children. Although urban slavery was not as strenuous for enslaved women when compared to the labor-intensive, painstaking regime on rice and cotton plantations, enslaved people who lived in Southern cities often perished early. Environmental factors of urban living resulted in poor health outcomes. Wade describes how Blacks lived in basements and attics, and shared living spaces with animals including dogs contaminated by feces and urine.

Historian Timothy Lockley examines urban slavery in Savannah, Georgia. Enslaved people who worked in cities interacted with free Blacks. Lockley argues that

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56 Ibid., 23- 25.
57 Ibid., 30.
58 Ibid., 137.
enslaved people living in cities “were better fed, housed and dressed than their rural counterparts.” In Savannah, 29.7 percent of slaveholders were women, and most lived alone or in “all-female homes.” Lockley did not discuss the health problems of enslaved people who lived and worked in Savannah. However, it was noted that enslaved people were visible in cities; owners protected their honor by assuring a “higher standard of living” in the city than on plantations. Enslaved people lived in large urban cities including New Orleans, Charleston, Richmond, Mobile, Savannah, and Memphis.\textsuperscript{59}

Memphis, being a river port area with rapid urban growth and a slave importing and exporting region, was overcome with disease and high death rates. The coming and goings and the close contact of strangers in daily life were deadly for all people in Memphis, especially because of the number of people who traveled by riverboat to the city. Historian Gerald M. Capers confirms that Memphis was an industrial city of growth and urban development. By 1860, having expanded from a river town to an industrial city, Memphis’s industrial output totaled four million dollars. Though Memphis was recognized as the largest inland cotton market, other raw materials such as flour, cornmeal, and bricks were also a part of Memphis’s economic boom.

In addition, Memphis had the “largest slave market of the Central South.” Slaves represented an investment to the city.\textsuperscript{60} Rarely were legal sanctions placed against enslaved people, because laborers were a crucial part of urban development. Blacks and other ethnic groups were used in a multitude of occupations in Memphis. As with most


people who traveled from other places to seek work, mortality reports described free Black women as transient or strangers, while enslave women received a description of ownership.

As noted previously, slave retailers in Memphis and elsewhere focused their marketing strategies on physical appearance. Shrewd agents helped to boost profits by applying oil and grease that suggested youth and potential for hard labor. Yet illnesses and diseases did not exclude the slave from working. After sickly slaves recovered, they were purchased, but for a lesser amount.\textsuperscript{61} Unlike with sickness and disease that occurred among slaves on plantations, agents who sold slaves in markets had no concept of how diseases spread. Within the medical practices of the day, the concept of disease transmission, along with communicable and noncommunicable disease, was not common.

William Postell noted that planters were careful to separate newly arrived slaves who appeared unwell. Ill slaves were placed in quarantine stations called forts.\textsuperscript{62} But enslaved people who did not display physical signs of illness, such as those with respiratory disorders and gynecological problems, were not separated. Of course, slave dealers were not above disguising or camouflaging “defective” slaves. However, the camouflaging of defective slaves was not synonymous with “sickly” or diseased slaves. For example, hiding a recent miscarriage or tubal pregnancy could be achieved by having

\textsuperscript{61} Mary Louise Marshall, “Plantation Medicine,” \textit{Bulletin of the Medical Library Association} 26, no. 3 (Jan 1938): 117. Descriptions of how the interstate slave trading forced Black people into the doleful New Orleans slave markets. Enslaved people who were sold in urban markets, arrived for “presentations.” Traders “removed heavy chains and galling cuffs from their slaves; arms and legs and allowed the slaves to wash and rest and heal.” A process that enables slaves to appear “healthy” included rituals like, “increased rations of bacon, mil, and butter.” However, terminally ill slaves including children were still sold as buyers could not recognize diseased slaves, but slave traders and agents could. Walter Johnson, \textit{Soul by Soul: Life Inside the Antebellum Slave Market} (Cambridge: Harvard University Press, 1999),118- 119.

\textsuperscript{62} Richard Postell, \textit{The Health of Slaves on Southern Plantations} (Gloucester: Peter Smith, 1970), 97.
enslaved women walk slowly around the auction block while professing to suffer from menstrual cramps. Slave traders had no way to disguise or perceive that some enslaved women had a disease.

**Slavery and Sexual Exploitation in Memphis**

The Mississippi River supplied accessible transportation day and night. Slaves arrived in Memphis via boats from areas in Virginia, Kentucky, and Missouri. The other region that participated in Memphis’ inland slave trading was Louisiana, particularly New Orleans. After Memphis’s railroad expansion in 1857, slave markets extended. For example, “the railroad from Charleston, via Augusta, Atlanta, Chattanooga, Huntsville and the northeast corner of the Mississippi, it was the best readily accessible market for slaves from the upper Carolinas upper Georgia and most of Tennessee.” Likewise, planters from “Arkansas, southwestern Tennessee, northern and western Mississippi and northeastern Louisiana” had access to Memphis’s slave markets. In order to understand the health conditions of slaves in Memphis and Shelby County, it is first necessary to look at how Memphis functioned as a hub for slave trade.

Isaac Nevill and A.J. Cunningham, who described themselves as “Dealers in Slaves,” had enslaved people readily available for purchase, and they were “fully guaranteed.” The Memphis urban slave trade was an interstate business, and agents such as Bolton, Dickins & Company advertised daily about the slaves who arrived from Georgia. The one company listed in the classified ads that dealt in slave commerce,

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N.B. Forrest, consistently stated that enslaved people in his possession were “sound and perfect in body and mind.” Businesses used enslaved men and women in diverse occupations in Memphis, and often gender was not specified, although there were exceptions based on traditional roles. William Crane was the city engineer and requested forty Blacks for a temporary job that provided thirty dollars and board for the month. For free Blacks who sought gainful employment, Memphis provided a variety of opportunities, and river travel was ideal for non-residents and free blacks regardless of gender. The advertisement of slave trader Byrd Hill described the opportunity of Black urban slave women in antebellum Memphis.

In 1859, Byrd Hill wrote a column to advertise his business that had recently located to Memphis. The ad was titled “If You Want Negroes, Come to Memphis.” Hill explained advantages gained by moving to Bluff City, stating “I have established a Negro Mart.” He advertised the availability of an assortment of enslaved people—boys, girls, men, and women—to meet the needs of a diverse clientele. Enslaved women and girls had been trained for work as cooks, washers, seamstresses, and nurses; the latter could be purchased at private sales and auctions. Purchasing enslaved women at private sales reveals sexual exploitation of enslaved women. The role that enslaved women played in the lives of slaveholders varied, but in the antebellum South, being a concubine was common.


According to historian Walter Johnson, “Whether they were buying these high-priced women to be their companions or simply their toys, these slaveholders showed that they had the power to purchase what was forbidden and the audacity to show it off. To buy a ‘fancy’ was to flirt publicly with the boundaries of acceptable sociability.” Therefore, “when they stepped into the notary’s office to register their stake in the high-priced women they had bought, slaveholders described them not as “mistresses” or “fancies” but as “cooks” or “domestics” or “seamstresses,” or commonly not at all.”

The use of enslaved women for sexual gratification was cloaked in the claim that the woman was purchased to fulfil the more traditional role of cook or seamstress. To unveil sexual exploitation allows us to see the complexity of adverse health risks to Black women.

Sexual abuse and exploitation of enslaved females could occur at any stage of a girl or woman’s life. Katherine Olukemi Bankole used the admission ledger from the Turo Infirmary in New Orleans to address historical details about enslaved women. To understand the problematic admission history and disease status of enslaved women at the Turo Infirmary, we must recognize the complexity of lives of chattel. There were 154 enslaved women at the Infirmary in the period from 1855 to1866. About half had arrived from a variety of southern states including Georgia (11), Kentucky (11), Tennessee (5), and Virginia (50). These enslaved women were diagnosed with multiple medical conditions associated with gynecological disorders, and the lengths of their stays at the Infirmary are disturbing. Syphilis warranted a stay of thirty-one days, while gonorrhea and dysmenorrhea might result in a two-week admission. Enslaved girls and women

receiving medical care for syphilis ranged in age from fifteen to twenty-two. Among the enslaved women who died from a sexually transmitted diseases was 17-year-old Nancy Ann. Other conditions listed in admissions data reflected correlations with gynecological infections. For instance, 18-year-old Louisa Hester died from peritonitis, and 21-year-old Sophia died from anasarca, a medical condition that causes visible swelling over the entire body.69

The most common causes of generalized edema seen by clinicians are heart failure, cirrhosis, renal disease, and pregnancy.70 The other disorder at Turo that corresponds with disease of the female organs was the category of hysteria. Historians Carroll Smith-Rosenberg and Charles E. Rosenberg detail common gender ideologies of nineteenth-century physicians regarding health conditions and diseases among women. These include the notion that “any imbalance, exhaustion, infection or other disorders of the reproductive organs could cause a pathological reaction in parts of the body seemingly remote.” Specifically, hysteria was socially constructed and gendered. The uterus was purportedly connected to the central nervous system. Nervous disorders including hysteria was also racialized and class based.71

According to historian Laura Briggs, “‘hysteria’ and its variants, neurasthenia and nervousness, were part of the lexicon of psychiatry, neurology, obstetrics and gynecology and also of reformers cautioning about the dangers of cities or of women’s education or


labor.” Briggs notes that the relationship of race to medicine, science and the understanding of hysteria is not discussed in historical scholarship. Race enabled medicine and science to view women who were uncivilized or savage (such as African Americans) as “immune to most of the gynecological and obstetrical problems that troubled white women.” Rape and sexual exploitation of Black women unquestionably placed disease burdens on gynecological issues, along with disabilities and chronic health problems. STDs can lead to debilitating and incurable disease, because cures for syphilis and gonorrhea were not available for antebellum physicians, women were frequently hospitalized for weeks and months. Yet even when women were treated for such diseases, treatments probably exacerbated symptoms.

In 1831, physicians used solutions and compounds made from cinchon and pulverized opium. With persistent complaints of gynecological problems and incurable sexually transmitted disease among free Black and enslaved females, most probably suffered from pelvic inflammatory disease. Understanding transmission of STDs in this era requires us to understand that slaveowners, slave traders and male slaves raped enslaved women and exposed them to sexually transmitted infections.

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74 “PID is a serious complication of some sexually transmitted diseases, especially chlamydia and gonorrhea. Complications of PID include, tubo-ovarian abscess, tubal factor infertility, ectopic pregnancy, and chronic pelvic pain.” [https://www.cdc.gov/std/stdfact-pid-detailed.htm](https://www.cdc.gov/std/stdfact-pid-detailed.htm).
The institution of slavery was immoral, and the business aspect of slaving was ruthless. Slave traders promoted the idea of “good health” and “healthy slaves,” as a cunning business strategy. Undoubtedly, many slaveholders attempted to sell unhealthy slaves even though this violated contracts that warranted the slaves as healthy. Healthiness and soundness of slaves were subjective. Enslaved people were on display as exhibits, primarily showing their outward physical appearances. Healthiness was based on false pretense. There are few outward physical manifestations of illness, one being skin disorders. Many diseases that affect the internal organs are not detectable via staring or touching.

Historian Sharla M. Fett, in her book *Working Cures: Healing, Health, and Power on Southern Slave Plantations*, points out that the concept of “soundness” was used to describe not only the health of slaves but the ability to labor and the mental capacity that encompassed character. The four defining attributes of “soundness” were the ability to labor, reproduce, obey, and submit. One can infer by nineteenth-century social and cultural ideations that enslaved females were expected to be “sounder” than male slaves based on Fett’s description, since they produced profit by bearing children. One could argue that female slaves were the most valuable commodities in the South. Yet, realistically, being “sound” placed female slaves at higher risk for illnesses, diseases and mortality, particularly gynecological disorders—especially in the rapidly growing and crowded environments of urban cities.

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In Memphis, Byrd Hill’s slaving business included boarding enslaved people prior to sale. Sickly slaves were linked to decreased profits, and any attempt to sell a sick slave knowingly or unknowingly was considered bad business for the city. However, the opposite also holds true: selling unhealthy slaves was part of the business. While damaged inanimate personal property such as furniture or dishes could be thrown away, unwanted chattel was sold.

**Memphis in the Early 1850s**

Data collected for publication in the W.H. Rainey & Company’s City Directory illustrates population growth for the following years: 1845 (3000), 1850 (6,247), and 1854 (12,687). About 3,172 enslaved people resided in the city. It was projected that by 1856 the city census would report more than 25,000 inhabitants, and by 1890 the city’s population would reach 823,936. However, reporting errors occurred in population data, as this chapter will discuss. In 1852, Memphis’s commercial activity focused on trade via the Mississippi River. Steamers traveled up and down. By 1855, a partial railroad was completed that would connect Memphis to Charleston, South Carolina, “connecting it with the Central South.” However, the city already contained four major railroads, discussed later in this chapter. Real estate profits increased. Architecture designs emerged, and the city boasted of having three-story brick buildings. Along with commerce, trade and prosperity, a less pleasant truth emerged:

The universal impression that Memphis was a very unhealthy place retarded its growth for several years, her citizens, especially new comers, being subject to those fevers peculiar to a southern climate; but as it has extended and been

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improved, so has the health of the city improved, from year to year, until it now may be said to be as health as any city in the union.\textsuperscript{77}

Antebellum Memphians contended that New Orleans and other surrounding cities brought not only slaves and non-residents to the city, but also illnesses, diseases and epidemics. Likewise, the large influx of riverboat workers and travelers tarnished the city’s image because so many people who arrived in Memphis were in poor health, illustrated by the city’s mortality rates. Civic leaders had to convince residents that the city was safe from diseases, especially epidemics, caused by people arriving on flatboats and steamboats \textsuperscript{78} (not to mention the backwoods, and quiet country areas where many traders preferred to sell slaves).\textsuperscript{79} In the business of buying, selling, and auctioning enslaved people, high rates of disease and death among Blacks coincided with high levels of illness among the enslaved populations throughout the South. Understanding local and national statistics allows for interpretation of common diseases during the history of the interstate slave trade.

According to national statistics, the ten leading causes of death among all females in 1860 were consumption, unknown causes, pneumonia, scarlatina, typhoid fever, croup, dropsy, violent deaths, accidents (non-specific), and remittent fever. Geographic regions of importance when compared to national data are District V, which encompassed Kentucky, Tennessee, and Missouri. Mortality for women and children in this region mirrored that in various cities in the Mississippi Valley. In District V, the primary causes


\textsuperscript{79} Michael Tadman, \textit{Speculators and Slaves: Masters, Traders, and Slaves in the Old South} (Madison: The University of Wisconsin Press, 1996), 31, 47, 49.
of death for all women were typhoid fever, fever-remittent, scarlatina, croup, whooping cough, dysentery, fever-intermittent, diarrhea, measles and yellow fever. Census data during the mid-antebellum provided no subcategories for race in relation to disease and death. Still, other sources that compiled health data, such as medical journals and local health reports that were published in newspapers, offer helpful analysis, with limitations.

Historian David K. Patterson explains that the difficulty with quantitative analysis on morbidity and mortality is tracking how it changed over time in relationship to antebellum health issues. To begin with, not all sick people were under the care of physicians. As noted earlier, when it came to the enslaved, slaveholders determined whether to use medical practitioners when slaves became ill. According to historian Deirdre Cooper Owens, enslaved women were among those selected and trained as health care providers on plantations. Enslaved nurses used folk remedies, and some practiced healing and treatments for decades. Physicians’ poor knowledge of the disease process often made it difficult for them to make accurate diagnoses. Also, although outbreaks of epidemics were sometimes relatively well-documented, statistics were not available in many states. For instance, regarding the 1878 yellow fever in Memphis, Patterson explained that certain types of historical data are available:

Contemporary medical and lay accounts of particular areas, towns, plantations, and so forth; statistical reports on small closely observed, but atypical groups, such as soldiers; broad but poorly controlled surveys, such as those included in

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80 The Original Returns of the Eight Census, under the Director of the Secretary of the Interior. U.S. Bureau of the Census. Population of The United States in 1860; Compiled by Joseph C.G. Kennedy, Superintendent.

the mortality returns collected in the 1850 and 1860 decennial censuses; and extrapolation from later medical knowledge.\textsuperscript{82}

Memphis collected and published data concerning the health of the city, but this data was often questioned by local physicians. Collaborative efforts between doctors and the medical college generated reports on people who required hospitalization, but state and local governments had stringent and exclusive criteria for hospital admissions as antebellum hospitals evolved over time.

Historian Charles E. Rosenberg, in his book \textit{In the Care of Strangers}, detailed the development of American hospitals. Individuals who had no friends or family to provide care for them and marginalized members of society occupied hospital beds in the earliest facilities. Some patients required letters of recommendation for admission.\textsuperscript{83} Unlike some antebellum hospitals that received funds from private owners and philanthropists, the Memphis Hospital was controlled by the city with funding from state government. The city managed the hospital and generated annual reports. In addition, Historian Todd L. Savitt notes that plantation-based hospitals were managed by nonprofessionals, but enslaved people, whites and free Blacks in urban areas accessed public and privately owned hospitals. By 1854, the Medical College of Virginia began admitting enslaved people, and within the same year, a private competitor opened Bellevue Hospital. Likewise, three local physicians established a hospital solely for the care of “black


servants.” Such facilities advanced medical education by provided training facilities for
students with an ideal population of chattel.84

Historian Stephen C. Kenney explains that by the early twentieth century, the
number of physicians in urban centers was increasing, and there were more private
infirmaries to care for enslaved people. Hospitals that advertised and exclusively
rendered medical care to enslaved people “were located in major towns and cities with
large populations, developing medical facilities, and multiple slave trading deports and
auction sites servicing the domestic chattel market—slave trading centers such as
Columbia, Charleston, Augusta, Montgomery, Memphis, New Orleans, Mobile and
Savannah.”85 In 1845, the Memphis Hospital published annual reports in the Nashville
Union. The reports indicate that the hospital in Memphis existed to care for the
impoverished, a common mission of many nineteenth-century hospitals. The Nashville
Union reported,

This is an institution of charity—none but the destitute being admitted. It is
substantiated by the State and private contributions, and we regret that the
provisions made for it are not sufficient to give relief to all who may apply for
admissions. The institution has strong claims on the general government for aid,
and we trust that the subject will not be overlooked longer.86

In the annual report, which covered the one-year period from December 31, 1843 through
December 31, 1844, there were 307 patients admitted; 46 died and 220 were treated and
discharged. At the end of the year, 38 patients remained in the wards. Based on the
information given and data collected, two-thirds of the patients, or approximately 205

84 Todd L. Savitt, Medicine and Slavery: The Diseases and Health Care of Blacks in Antebellum Virginia

85 Stephen C. Kenny, “A Dictate of Both Interest and Mercy”? Slave Hospitals in the Antebellum South,

86 Nashville Union, January 16, 1845.
patients, lived outside of the boundaries of Tennessee. The hospital also cared for individuals who were foreign-born—most from Ireland (65) and Germany (22).\textsuperscript{87}

The above is supported by historian Kathleen Berkley, who notes that “between 1848 and 1860 southern cities bent under the weight of heavy influx of immigrants, most of whom were young men.”\textsuperscript{88} The hospital report did not provide information on race or gender; however, the data collected from city officials offers more descriptive information. Physicians in Memphis collected and analyzed data about the health of the city, often at the request of city health commissioners and boards of health. Medical journals served as a venue that allowed physicians to publish and share findings and to share with other colleagues. Physicians who served on the Memphis Board of Health published weekly data on morbidity and mortality rates for citizens—all to reassure residents that Memphis was a healthy city.

**Discernment of Data and Mortality: Adjustments**

Compiling accurate mortality data requires legitimate reports of city and county populations. Interpretation of numbers, documentation of cause of death, and consistency in reporting are all equally important to ensuring accuracy. For this reason, when individuals interpret and analyze data, their conclusions can result in skewed and faulty judgements. According the 1850 U.S. census, the city of Memphis had a population of 8,841 people. The majority were Whites (6,355). There were 126 free Blacks and 2,360 enslaved people. Census information for 1850 based on Shelby County (excluding the city of Memphis) data records included 8,670 Whites, 281 free Blacks, and 14,320

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\textsuperscript{87} Ibid.

enslaved people, bringing the total number to 31,157 individuals. The total number also accounted for the 1,629 foreign-born.\textsuperscript{89}

In 1852, Dr. George R. Grant submitted an article in \textit{The Western Journal of Medicine and Surgery} titled “The Vital Statistics and Sanitary Condition of Memphis, Tennessee.” The original report was delivered at the fifth anniversary of the Memphis Medical Society in February 1852. Prior to addressing mortality rates, Grant stated that “Memphis is a sickly place.” He provided social demographics on class but did not specify residence status. In 1850, The White population totaled 6,389, of which 3,587 were males and 2,782 were females. Memphis had forty-four free Black males and sixty-five free Black females.

Mortality rates for Blacks and Whites were combined, “as the deaths among these 109 free persons of color were not kept separate but included in the returns among the Whites as free persons.” Combined deaths in Memphis for Whites and free Blacks totaled 238 deaths. The above death rate was thirty-six for every 1,000. In addition, Grant provided data about the number of enslaved people and their mortality, although gender was not included. There were 2,362 enslaved people in Memphis and 116 deaths for the year. That means 49 out of every 1000 enslaved persons died. The combined death rate for the free Black and the enslaved populations was four percent. That equates to one death for every twenty-five Blacks living in Memphis.\textsuperscript{90}

\textsuperscript{89} The Seventh Census of the United States Reports: 1850 (Washington: Robert Armstrong, Public Printer, 1853).  

Dr. Grant elected to integrate population statistics from the city and county regions of Memphis. The county had a free population of 10,317 persons. The enslaved population was 11,998, for a total population of 22,315 Blacks. In 1851, 190 free Blacks died, and 279 enslaved died. Specifically, for Blacks who resided outside of the city limits, the mortality rate was one in every forty-seven. The death ratio for Blacks in the city when compared to the county was about two to one. In other words, more urban than rural blacks died in 1850 and 1851, but overall, the enslaved died at a higher rate than free Blacks. The high mortality rates of free Blacks can mean that these individuals were sick upon arriving in the city. Or perhaps, as discussed later by Dr. Todd Quintard, more deaths occurred among people who had no medical care. Continuing with mortality data in Memphis, Dr. Grant detailed the alarming rates at the Memphis Charity Hospital. In 1850 there were 474 admissions and 116 deaths. One out of every four persons died. 91

In the May 16, 1852, issue of the *Boston Medical and Surgical Journal*, Dr. Grant’s research was lauded because he exposed how city officials neglected health issues and the negative consequences for city residents. The article focused on the lack of concern, noting:

“Whoever will traverse the alleys running parallel with our principal streets…will see enough of dirt and filth, not only in these alleys, but in the rear part of most of the improved places in Memphis, to satisfy the most casual observer that cleanliness of our streets and enclosures is not an important matter in our domestic regulations.” 92

In the brief synopsis, the article mentioned the White population; however, information about free Blacks and enslaved people were not included. Although Grant provided

91 Ibid.

pertinent information about disease and death rates, several of Grant’s professional peers questioned the data in his report, discussed below. The health of the city was important to physicians who rendered care to residents and who lived both within and outside the city limits. Also, many physicians in Memphis owned slaves and used them to advance their medical careers, a subject that will be revisited later in this chapter. Leading physicians of Memphis implored members of the Medical Society to gather and analyze data on morbidity and mortality for 1851 and 1852.

On March 15, 1853, nearly a year after Dr. Grant presented his data, the Memphis Medical Society held a special meeting to discuss the mortality and health issues of the city. Dr. A.P. Merrill appointed a committee of five to gather health information about the city and to present a formal report. The committee was headed by Dr. Charles Todd Quintard. In describing the goal of the Memphis Medical Society, Quintard stated, “We are for the present concerned with the types and forms of disease which prevail in our city.” Specifically, there was no way to determine the “exact knowledge of the diseases which have prevailed in Memphis during the past year.”

Quintard acknowledged that the Board of Health kept records of diseases; however, no one could determine the causes of death because the attending doctor did not require a death certificate. The data recorded by the Board of Health were vague and documented haphazardly. All of the information entered into the records was done by the secretary, who was not responsible for the unfamiliar terms that described various diseases. Although monthly mortality reports for 1851 and 1852 provide data for Blacks

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94 Ibid., 10-12.
in Memphis, they do not include information about gender, while death rates for Whites include separate categories for males and females.

Dr. Quintard's analysis included the exact number of White males and females, including the number of increases and decreases for each year. In 1851, there were 717 combined deaths and for 1852, 705. Based on mortality information, 151 Blacks died in 1851. In 1852, 160 Blacks died. The two leading causes of death during those two years were digestive diseases, which accounted for 205 deaths, and febrile disorders accounting for 100 additional deaths. Unlike Grant’s document, the report prepared by Quintard did not list enslaved and free Blacks separately in the demographics. Instead, Quintard focused on correcting population data.

Dr. Quintard stated that according to the 1850 U.S. census, Memphis had a population of 8,840. Dr. Quintard asserted that Dr. Grant added 20 percent for the year 1851 and assumed that the 10,608 figures for 1852 was the correct population. Dr. Quintard began to explain that Grant should have increased the population by 40 percent for the year of 1850. The latter was needed to demonstrate an increase in 1851 and 1852, bringing it up to 12,376 by July 1853. Next, he reported that the data for the city and suburban population were incorrect, and that the total should be raised to 13,876, an increase of 1,500 people. Continuing with his quest to correct data, Quintard included the transient population of flatboat workers who entered the city, bringing the total to 17,530. He calculated that the real population could be as high as 19,030. With all figures scrutinized, Dr. Quintard deduced that Memphis’s mortality rate was less than three percent.
Dr. Quintard was familiar with the transient and impoverished population. He had heard personal accounts of the effects of disease and social consequences among people who sought shelter in Memphis. Further, he alluded to how “the mode of life among the lower classes is such as to render them easy victims.” With Blacks and immigrants in the city, it is not certain which group Dr. Quintard was referring to. Quintard was especially interested in the life circumstances of the poor and destitute in Memphis. He visited people living in homes where residents were ill with typhoid fever, sometimes finding households that consisted of a single room with sixteen people crowded inside and as many as thirty-two people residing in a similar dwelling. In his report, Quintard correlated the presence of poverty in Memphis to disease and mortality, noting that dire social and economic conditions made certain groups vulnerable to adverse health outcomes. Specifically, Quintard’s epidemiological data exposed health disparities.

Likewise, environmental factors of the city contributed to sickness and mortality, as alleys and gutters represented sources of contamination. Diseases such as typhus, bilious fevers, yellow fever, and typhoid could easily spread among urban occupants.


His health report of 1852 also contained insight into Dr. A.P. Merrill’s findings about morbidity and mortality evidence. Merrill made clear that most descriptions and names of diseases were subjective because the Sexton information collected was based on other common reports or statements given by nurses and servants. He also contended that demographics such as age, sex, and color were erroneous. Dr. A.P. Merrill concluded, “it is probable that more than one-half—perhaps not over one-third—of the diseases are incorrectly reported.”

Dr. W.T. Irwin was another person selected by the Memphis Medical Society to review health issues in the city. Dr. Quintard also referred to Irwin’s findings. The data were sporadic and problematic, especially when one attempted to interpret whether slaves who lived in Memphis were exposed to certain epidemics. Irwin prepared a table showing monthly incidences of death by gender for Whites and race for Blacks. Again, isolating individual death rates for Black women was not always possible in health and mortality reports. In 1851, the entire number of deaths in the city was 717 people; Blacks comprised 151 of those deaths. For the year 1852, total deaths were less than 705 people; however, for Blacks, the number increased to 160. In 1852, more people died from digestive diseases (205), febrile diseases (100), and unknown causes (111). Most surprisingly, the gender of children was missing in the official records from the Board of Health.

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100 Ibid., 14.
A useful analysis that Dr. Quintard provided for the city officials, especially those on the Board of Health, was the social reality of health and culture of a growing urban city. The city’s 1850s economic boom in river travel and transport resulted in increased population and improved business prosperity, yet the city had little to offer in terms of healthcare. A.B. Shaw & Company maintained a register of steamboat voyages to Memphis. In 1852, nine steamboats made daily stops for 3,282; each steamer carried about 100 people per day, all of whom worked in the city. In 1852, more than 382,500 people traveled to Memphis. In addition, flatboats crossed the Mississippi from Arkansas and docked in Memphis. The city’s wharf master recorded 857 flatboats, perhaps containing about six individuals each, for an annual sum of 5,154 visitors. Collectively, 333,654 persons arrived in the city by flatboat or steamboat. Quintard concluded that the “records of the board of health are valueless” because “members of the Board have no means of knowing the causes of death.”

Transients to Memphis via flatboats and steamboats comprised a significant number of deaths, and many died without being under the care of a physician. Of the 250 reported deaths in the city between August 1851 and January 1852, 140 did not have a physician of record. Too, from January to October 1852, 234 recorded deaths did not have medical care. In 1853, the number of deaths was 117 among Blacks of all ages, which represented 28 percent of all deaths for the year. Still, Dr. Quintard apologized

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101 Ibid., 25.
102 Ibid., 10.
103 Ibid., 24-25.
because data compilations were not reliable.\textsuperscript{104} For the poor, transient, and river travelers, Memphis Medical College decided to operate a clinic during the morning hours from 8 to 9 a.m.; health information was collected from other sources.\textsuperscript{105} The accounts of medical education and services by doctors who established dispensaries are key to discerning the health problems of the urban working poor.

**Making Healthcare Political**

There was a strong desire to attract people to the city of Memphis. Prominent citizens such as Dr. Charles T. Quintard shared a belief in the importance of economic stability. He noted this as a reason why the health of the city was necessary:

> When we consider the fact of the important interests involved of a fair, candid, and just exhibits of the vital statistics and Hygiene of the town—the at interests of our city are deeply involved, it becomes us to consider just what are the local causes of disease—just what will most easily and readily remove them. Memphis is just now assuming a position. It is geeing to be looked upon as appoint of great commercial importance, as the terminus of a Pacific Railroad; or at all events, as a point whence must eminate [sic] a vitalizing influence.

Blaming non-residents, especially those who arrived by steamers and flatboats, presented a narrative of ill people tainting a healthy city. Blaming the problem on transient sick people coming to die was a way to whitewash the city’s inadequate health. As Dr. Quintard acknowledged, the city had no hospital or dispensary to care for its own impoverished people.\textsuperscript{106}

\textsuperscript{104}Dr. Charles T. Quintard, “Health and Mortality of Memphis,” *Memphis Medical Recorder* 2, no 5. (March 1854): 198.


\textsuperscript{106}Ibid., 25.
According to historian Charles Rosenberg, certain cities witnessed a growth in dispensary visits. Upon examining clinic records from dispensaries in Eastern cities including New York, Philadelphia, Boston, and the Southern city of Baltimore, Rosenberg discovered that most dispensaries maintained comprehensive health records. As the need for dispensaries increased, cities developed regional dispensaries. For instance, New York established a Northern Dispensary in 1827 and an Eastern one in 1832. Rosenberg examined detailed records of dispensaries and developed profiles and commonalities. A profile of an antebellum dispensary found that most patients were women. As noted, regardless of location, “constantly enough, the number of female patients was always greater than that of males, in some instances as much as two to one; working men, that I, had necessarily to tolerate disease symptoms of far greater intensity before feeling able to consult a physician.”

Dispensaries operated on benevolence and were founded on the premise of “stewardship” by providing benevolent care, especially to the poor. They had several common objectives. Dispensaries were supposed to help maintain a healthy labor force, decrease the number of people who required care and long-term residency in almshouses

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107 The antebellum working class’s idea of a hospital was expensive, morally degrading, artificially created, and not important to medical care. Therefore, philanthropist financed outpatient dispensaries as a form of health care. Patients, especially the poor who required medical treatment from a dispensary, required a signed authority who documented the medical necessity. Charles E. Rosenberg, The Care of Strangers: The Rise of America’s Hospital System (New York: Basic Books, Inc., 1987), 21-22, 25.

and hospitals, and function as the primary venue for clinical medicine, as a “de facto residency program”).

The dispensary affiliated with the Memphis Medical College was in operation for one year (1851 to 1852) and recorded 1,104 visits. During that time, nearly half (556) of its patients succumbed to “intermittent and remittent fever.” Race and gender were not tabulated because the focus was on disease and mortality rates. The dispensary data also focused on the number of visits and the type of illness. The physicians in Memphis recognized the complex issues surrounding care for the impoverished residents who visited the city’s dispensary, and members of the Memphis Medical Society clarified the reality of disease and illness. One physician wrote that “the mortality of Memphis has been increased by deaths occurring among persons left here from steamboats.

Because the city was prospering financially, and its riverfront business took precedence over sanitation concerns, the health of drifters and the poor was not an urgent matter within the social, political, and economic climate in Memphis. For example, the value of imported and exported cotton was $6,520,000, equivalent to $202,047,730 in the year 2020. In addition to the medical reports, local residents voiced their opinions about why Memphis was an unhealthy city and how enslaved people exposed other

109 Ibid., 310-315.


residents to disease, effectively racializing the diseases—blaming the poor. On August 23, 1852, the *Memphis Daily Appeal* published a letter written by a resident of Memphis. The person was surprised by an earlier news report in which the mayor and aldermen expressed concerns about the alarming death rates in Memphis over the past two years. Neither gave a reason for such high mortality rates. The citizen offered a more accurate interpretation.

First, he contended that most people died in Memphis because steamboats and flatboats “dropped them off.” There was a hospital in close proximity to the wharf where they could be cared for, but most of the sickly people who arrived in the city were terminally ill. Second, the Memphis resident noted that the city and river served as a gateway for families who relocated from Arkansas and Texas. When sickly families arrived, all generally required medical care. Finally, the letter-writer blamed planters who brought ailing slaves from various regions. This created crisis in the city when an epidemic occurred on the planter’s property, since Memphis was not only a hub for slave trade but also for medical care. The citizen then stated, “our hospital becomes crowded with this class of Memphis citizens and the reports are put out in the country that we are all dying here with cholera, smallpox, & c [sic].”¹¹³ The local physicians affiliated with the Memphis Medical College treated free Black and enslaved women and their children, along with people of other ethnicities, at the City Hospital and dispensary. For example, in July 1853, an African American boy (no name given) age ten years old received medical care for a high fever. Memphis physician Thomas McGown reported that the boy

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died three days later.\textsuperscript{114} In 1853 Dr. Shanks published several case studies on the topic of uterine and constitutional disorders. He records the following narrative:

I shall mention another case, which of a somewhat different class of patients, who have been signally benefitted [sic] by the remedy under considerations. Mrs.\(\ldots\), aged about 22 years, light completion, and medium size, was a resident up to the summer of last year, of the State of Mississippi. She is slightly hysterical and has been for years affected with costiveness to such an extent as to be under the necessity of taking physic every day.

The patient under Dr. Shanks’s care was African American with light skin tone, as he notes. Her social status as free or enslaved is not discussed; this is common in many case studies written by Memphis physicians. Dr. Shanks manufactured a pill to cure the 22-year-old female.\textsuperscript{115}

Numerous scholars have discussed the relationship between medical educations and training and the exploitation of the poor, especially enslaved people.\textsuperscript{116} One of the most harrowing medical practices in port cities such as New Orleans, Charleston, Mobile, and Memphis was the acquisition of human bodies for medical experimentation. Historian Todd L. Savitt uncovered the ways in which medical professionals took advantage of marginalized citizens—the indigent, immigrants, “voiceless slaves” and free Blacks residents. Medical practitioners needed the living and the deceased for clinical training in order to establish modern, creditable, and prestigious teaching institutions. Because Southern medical schools competed with other schools in the region for

\textsuperscript{114} “Absence of Bronze Liver in Remittent Fever,” \textit{Memphis Medical Recorder} 2, no. 2 (September 1853): 59.

\textsuperscript{115} Lewis Shanks, “Uterine and Constitution Disorder,” \textit{Memphis Medical Recorder} 2, no. 3 (November 1853): 132.

students, the racial climate in antebellum America was conducive to using Blacks to advance medical practice. To lure and entice future medical students, colleges advertised the relationship between clinical instruction and such caring for living ill patients at a dispensary. The necessity for postmortem training with cadavers was also important. Likewise, there were benefits to incorporating teaching and instruction in a hospital setting.  

Descriptions of the health conditions of free Black women and enslaved men and women frequently appeared in Memphis medical journals, as noted earlier by Dr. Shanks. Other accounts of the exploitation of enslaved and free Blacks appeared in published in newspapers. These instances of exploitation reveal medicine’s biases and the way it directly targeted Black bodies for research, medicine, and science. Targeting Blacks for medical advancement became common in institutions as early as the 1830s. In 1838, the Medical College of South Carolina advertised an infirmary. The faculty desired “disabled slaves” who would serve as interesting cases. A case’s status as interesting depended on the doctor’s specialty or desire to advance their careers.

Memphis planters and slaveholders from outside the city were enticed by newspaper advertisements that offered medical care for free Blacks and enslaved people. On New Year’s Day of 1857, a local physician, who was also a surgeon, placed an ad in

117 Todd L. Savitt, Race & Medicine in Nineteenth-and-Early Twentieth-Century America (Kent, Ohio: The Kent State University Press), 77-81.

118 In 1852 Dr. H.V. Wooten published an article, “Treatment of Infantile Diarrhea,” in which he described the occurrence of diarrhea that presents with cyclical patterns. Wooten noted that the high infant and childhood mortality was correlated with diarrhea, a condition especially prevalent among Blacks and those with poor living conditions; Memphis Medical Recorder 1, no. 3 (October 1852): 33. Lewis Shanks, “Uterine and Constitution Disorder,” Memphis Medical Recorder 2, no. 3 (November 1855).

the *Memphis Daily Appeal*. The headline read “Dr. Robards[sic] Private Infirmary for Negroes.” He proudly stated that he owned a facility two miles from the city. The infirmary, as he called the facility, was spacious and built primarily to accommodate Blacks laboring under chronic diseases and requiring surgical treatment.

The experience and observation of many years in the profession have convinced me that a large majority of the invalid negroes on plantations and elsewhere, who are worthless to their owners and burdens to themselves might by proper judicious treatment, comfortable quarters, good nursing and regular administration of remedies be cured and made valuable servants. My personal attention will be given to all cases placed under my care at least twice a day, and all operations in surgery performed free of charge, except in capital cases. The charges vary from one dollar to one dollar and a half per day, including prescriptions, washing, board, medicine, and operations. Chronic cases, requiring but little attention from me, are never charged more than a dollar per day. No epidemics or contagious diseases admitted under any circumstances. By notifying me, cases will be taken of the expense of the owner. My office is on Court Street, immediately in the rear of & Grimms brick store.120

The description of Dr. Robard’s private health facility is misleading, especially in relation to slave hospitals. According to Historian Stephen C. Kenny, the reality of treatment centers for antebellum enslaved people was that Southern doctors fabricated stories about stylish and magnificent slave hospitals. As Kenney noted, one physician who gave advice on “slave quarters, hospitals, clothing, weather sheds, food and hygiene” was Memphis physician A.P. Merrill. According to Merrill, hospitals were necessary on all plantations. Hospitals for the enslaved often included an infirmary. Yet these hospitals were usually housed in small buildings, typically cabins, and “they were often unhygienic and poorly managed.”121


Dr. Robard, as noted earlier was an antebellum physician, he wanted to treat enslaved or free Black people in order to advance his surgical practice. Robard, a Professor of Surgery at the Memphis Medical College, appealed to slaveholders outside of the Memphis area because Memphis did not have a large slave population in 1857. He assured these owners that he could cure the debilitated for a low cost, and if surgery were indicated, there would be no additional charges. Owners were promised a means to dispose of unwanted slaves who had become “unproductive, costly, or suffered from debilitating illness.” Robard was not interested in taking care of sickly enslaved people. In fact, he refused to admit and care for those with epidemic diseases; instead, he preferred those in chronic poor health or those who required surgical procedures. Robard did not seek to form a doctor-patient relationship with those who were placed under his care. He just wanted cases and was fully of cognizant of how these vulnerable people could be exploited for medical training and education.

To attract students, medical colleges such as Memphis Medical College needed subjects and faculty like Dr. Lewis Shanks. On September 22, 1852, the trustees of the Memphis Institute relinquished rights to medical education and training. Dr. Lewis Shank reorganized medical training and received support from the city of Memphis. Shanks worked out an agreement with the city, faculty, and local citizens that he felt would draw in students and promising physicians to serve as faculty. He wanted both to recognize

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123 Lewis Shanks, “Mortality in Memphis for the year 1851,” *The Medical Recorder* 1, no.2 (September 1852): 19.
that the medical college had an “abundant means” to study anatomy. The agreement also noted that

the large amount of immigration here, together with the great number of transient sick persons from the river could afford an ample amount of cases for the exhibition of all varieties and forms of diseases, and their treatment, occurring the southwest; and also, for most of the important surgical operations.  

Kathleen Berkeley’s research illustrates Memphis’s racial and ethnic demographics in 1850. There were 5,009 native Whites, 876 people of Irish descent, 470 Germans, 126 free Blacks, and 2,360 enslaved people. Notably, 71.9 percent of Memphians were White (including Native Whites, Irish, and Germans). Blacks comprised 28.1 percent of the population. White physicians were self-serving in preying on groups they considered lower class in status and cultural traits. The agreement between the city of Memphis and the Memphis Medical College is cynical in terms of who was valued. In addition, doctors proclaimed that selected categories of people could be used as “material” for education on anatomy and physiology.

The personal narratives of enslaved and free Blacks as well as immigrants who entered the city of Memphis via riverboats and steamers provide a window into their life experiences that allow historians to personalize Shanks’s “material.” In his book Black Life on the Mississippi: Slaves, Free Blacks, and the Western Steamboat World, historian Thomas C. Buchanan provides accounts of river travel, health, disease, and disasters confronting enslaved and free Blacks who worked on steamboats. Several of his sources claimed Memphis as their home port. Enslaved people who worked on steamboats

124 Medical Education in Memphis,” The Medical Recorder 1, no.3 (October 1852): 42-44.

described hazardous labor in the pre- and post-Civil War Era. Risk of contagious disease and constant exposure to horrific weather conditions were life-threatening. Cholera spread via river travel and was common up and down the Mississippi after the 1830s as steamboat travel increased. Other diseases such as yellow fever, cold, and influenza also resulted in an increased number of sick days. Judy Taylor, an enslaved woman, noted that diseases and epidemics could spread quickly among servants who worked on steamers. ¹²⁶ For non-contagious diseases that solely affected women, physicians in Memphis mimicked other regional doctors by accepting and treating according to racial and class-based prejudices.

In 1854, Dr. Shanks published several cases on “Uterine and Constitutional Disorders.” One of his patients was Julia, a 17-year-old Black woman, who experienced an abortion which Shanks believed was caused by a “sudden fright from over exertion and exposure” from a house fire during her fifth month of pregnancy. Julia was slow to recover, and experienced additional gynecological problems. After treating the woman for a year, Dr. Shanks noted how sensitive her vagina was, and that she also had an enlarged cervix. He explicitly described every aspect of Julia’s genitalia, including the lower portion of the uterus, which was smooth to the touch. Physicians routinely document physical findings with detailed descriptions. ¹²⁷

The problem for enslaved women was that gynecological exams occurred without consent. Shanks was not sure whether he felt a tumor, but Julia was diagnosed


with having an “irritable uterus” and received treatment for about four years. Dr. Shanks believed that Julia could have been cured if she had followed his regimen of pure creosote, acid nitrate of mercury, or nitrate of silver crayon—all mixed with camphor, in a pint of water, with solution and iodide of potassium with the strength of 1-3 grains. Dr. Shanks’s remedy was lethal. Acid nitrate of mercury is mercuric nitrate, “a white crystalline solid. Toxic by inhalation, ingestion and/or skin contact. Prolonged exposure to fire or heat may result in an explosion. It also produces toxic oxides of nitrogen when heated to decomposition. Notably, it is used to make other chemicals and medicine.”

Julia, like most enslaved women, was powerless and defenseless in the presence of physicians surveying her personal health problems. Yet resistance can be gleaned from her subtle non-adherence to the physician’s orders. Julia simply refused to take the prescribed treatment. Enslaved women who were familiar with herbs and other types of medicine often refused harmful treatments when they knew these could mean the difference between living and dying. Dr. Shanks believed that when Julia discontinued her treatment, symptoms reappeared. However, Julia had to return to work, and undoubtedly preferred recurring symptoms rather than adverse treatment. However, many enslaved women, confronted by the combined patriarchal authority of their owners and doctors, were left with little choice about their treatment.

128 Ibid.


The four years that Julia suffered and the gynecological surgeries performed by Shanks are in contrast to the experiences of Anarcha, Betsey, and Lucy, enslaved women who were confined in the Montgomery, Alabama hospital of Dr. James Marion Sims. Their treatment is described in an article titled “The Treatment of Vesico-Vaginal Fistula by J. Marion Sims, MD, of New York (Late of Montgomery, Alabama).” Sims’s peers and colleagues boasted about his surgical accomplishments, because most agreed that doctors usually “have neither time nor inclination to be troubled with such cases.” The power of medicine and White male domination made enslaved women victims. There were no concerns noted about applying a weight of fourteen pounds to open the pelvic region and abdominal muscle, nor did his colleagues comment on a “new suture apparatus that remained permanently embedded in the vagina.” The racial premise was that the enslaved female body was different from that of White females. Enslaved women could endure pain, and gynecological surgeries served as an example in medical practice.

The first three cases, most likely involving Anarcha, Betsey, and Lucy, involved forty unsuccessful operations, but Sims decided to persevere.¹³¹

¹³¹ The Memphis Medical Recorder 2, no. 4 (January 1854): 173-174, 177. Documented cases of the self-serving physician—Dr. James Marion Sims, The Memphis Medical Recorder 2, no. 4 (January 1854): 173-174, 177. Historian Deborah Kuhn McGregor describes how Dr. James Marion Sims used the bodies of enslaved women to advance the field of surgical gynecology. “Four years of repeated surgical experimentation on a core group of women patients who stayed for the duration of the surgeries,” From Midwives to Medicine: The Birth of American Gynecology (New Brunswick: Rutgers University Press, 1998), 43. Known as the father of gynecology, Dr. Sims perfected his surgical technique for vesicovaginal fistula repair on slave women. “Between 1844 and 1849, Sims experimented exclusively on enslaved women’s bodies to aid him in locating the cure for this troublesome gynecological condition,” Deirdre Cooper Owens, Medical Bondage: Race, Gender, and the Origins of American Gynecology (Athens: The University of Georgia Press, 2017), 36. In addition, the importance of vaginal surgeries among enslaved women came at the request of the owners, “Slaveholders were interested in correcting ‘disordered’ vaginas in enslaved women.” Also, physicians could use alternative methods for treatment or without treatment. Other historians support that “Sim’s success in treating vesico-vaginal fistula came after four years of multiple experimental surgeries performed on Anarcha, Betsey, and Lucy, three enslaved women, always without anesthesia,” Marie Jenkins Schwartz, Birthing a Slave: Motherhood and Medicine in the Antebellum South (Cambridge: Harvard University Press, 2006), 229, 237. For a counter argument that discuss how enslaved women’s “willing submitted” to remain under Dr. Sims care, see L.L. Wall, “The
The connection between slavery and medicine was present throughout the Mississippi Valley, as masters sent injured slaves to Memphis for medical treatments that often-included surgeries. In 1858, physician Greensville Dowell, a former member of the Memphis Medical Society, published articles describing several surgeries that he had performed over an eleven-year period. A female slave belonging to a planter M.H. McG., of Panola County, Mississippi, had a nail fungus on her third finger. The condition progressively worsened, causing widespread infection. A local doctor in Panola County (cited only by his first initial, “R.”) removed the second and third finger. The owner requested the services of Dowell because the resulting wounds were not healing and appeared to be more infectious. Dowell explained that with the present state of the enslaved woman’s fingers, she probably had not felt much pain after a second procedure involving another amputation was performed. Dowell’s advice for physicians in slaveholding regions was that “it is best to amputate at once where I did, especially with a cotton picker, a bad stump or any stump being always in the way and never any use.” For this woman, whose age was not provided, enslavement resulted in lifelong frailty as well as deformity and physical disability. However, as “chattel,” she was enabled to return to the duties of plantation labor as “a cotton picker, minus two fingers.”

Medical Ethics of Dr. J Marion Sims: A Fresh Look at the Historical Record,” Journal of Medical Ethics, 32 (2006).

Discussion regarding the myths of the hypersexualized and physically robust bodies of enslaved women perpetuated ideas about inner physiological traits. For example, the misconceptions that Black women did not feel pain or were “impervious to pain.” Slaveowners racialized the Black female body as having the ability to withstand injuries and trauma, Deirdre Cooper Owens, Medical Bondage: Race, Gender, and the Origins of American Gynecology (Athens: The University of Georgia Press, 2017), 44-45.

Injuries and debilitating diseases were common among enslaved people across age groups. In another case, the services of Dr. T. Keefe (described in the Rainey’s Memphis Directory as “The Great Cancer and Rheumatism Exterminator”) was endorsed by slaveowner Arthur Bowen:

A certain negro girl belonging to me has been afflicted with cancerous or ulcerous for over twelve years; that the said disease rendered her almost helpless and unfit for service. She had been under the care of regular talented physicians, who could however, afford her no relief. She had, moreover, been for more than two years under the hands of the celebrated Dr. Gilbert, who, also, failed in doing her any good. The negro was worthless on account of her affliction. Her legs were covered with foul and ravaging ulcers, and she was reduced to a living skeleton. No person would have given fifty dollars for her. Some few months ago I placed her in the care of Dr. Keefe, with but very little faith in his ability to do her any service, and, in less than two months, by his simple, but wonderful working medicine, he not only gave her sound and almost scarless legs but restored her general health. She is now worth every dollar of $800. This extraordinary cure is, I believe, known to many of our citizens, and is considered almost a miracle.134

Another Memphis physician, J. L. Taylor, and R. R. Trezevant, the county’s Deputy Clerk, observed the case and supported Bowen’s testimony. Trezevant wrote:

I saw this woman of Mr. Bowen’s when first put under treatment with Dr. Keefe, and saw her several times over the course of three months and talked briefly with her on the subject of her cure. She certainly has a pair of new legs and is as active as a girl of the most sanguine and temperament, at fifteen years old. What have I have seen I believe, and if exaggerated I assure the public that this is entirely unintentional. I say this for the sake of the public everywhere.135

The statements by Taylor and Trezevant served to legitimize Keefe’s medical practices. Keefe may have had a solution, compound or cream that cured chronic ulcers, but other reports about his practice suggest “quackery.” In 1855, The Nashville and American Newspaper advertised,

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135 Ibid.
Dr. Thomas Keefe of Memphis, who is now creating more excitement as a curer of Cancers and similar diseases, than any man in the U. States, is now in Jackson, on his way to Middle Tennessee to visit a Cancer Case. He has been specially sent for. If Dr. Keefe can’t cure Cancers, some of the most reliable citizens of Memphis are belied[sic].  

Keefe’s treatment for the young, enslaved woman consisted of vegetable-based products. The young, enslaved girl, who on arrival at Keefe’s office was “worthless” with a deteriorating medical condition, received treatment from callous and incompetent physicians and, supposedly, was miraculously cured. She was returned to her owner to resume her most important function as an enslaved woman—labor. Her monetary value had been maintained and possibly even increased by Keefe’s work. Regardless of how highly doctors and community leaders spoke of the young woman’s renewed health and value, she was invisible and lacked even a name.  

The young woman’s illness had progressed, manifesting with sores and ulcerous lesions on her upper and lower extremities, yet no diagnosis was given. It is a reminder that all children born into slavery were legal property, and there was no parental right to intervene in her treatment. In nineteenth-century slave culture, family separation could occur during early childhood. The condition of this enslaved girl’s infected extremities  


137 “Dr. Samuel Gilberts Preparations For The Cure Of All Diseases Of The Skin And Blood,” *Public Ledger*, https://chroniclingameria.loc.gov/lccn/sn85033673/1866-05-01/ed-1/seq-3/.  

138 Historian Steven M. Stowe explains that during the antebellum era, physicians used case studies to document clinical interactions viewed as ethnographies of disease and illnesses. Doctors wrote about personal encounters that included styles such as “first-person tales” and “brief fragments of autobiography.” Printed accounts resembled dairy notes. Physicians in 19th century Memphis also wrote and described clinical events similar to what historian Steven Stowe discovered. Many slaves were completely anonymous in private domains without attachment of friends and families. Steven M. Stowe, “Seeing Themselves at Work: Physicians and the Case Narrative in the Mid-19th-Century American South,” in *Sickness and Health in America: Readings in the History of Medicine and Public Health*, ed. Judith Walzer Leavitt and Ronald Numbers (Madison: The University of Wisconsin Press, 1987), 161-163, 166, 172-173.
and her overall health status paint a picture of neglect. Perhaps Bowen seized the opportunity to reduce the financial burden of his young slave by placing her “under treatment” with physicians who sought incurable slaves. When owners relinquished their chattel for medical treatment, physicians and surgeons sometimes waived the medical cost. In addition, the cost for room and board was discounted.139 Throughout this girl’s young life, she was a valuable subject to the medical community, as seen throughout three years of medical treatment. Her initial value to her master, as he states, “was worthless.” Whether masters decided to surrender their sick slaves to medical schools or private physicians affiliated with medical colleges, there was an incentive for physicians to accept them. Treating slaves could be lucrative for a physician.

Racism and Medical Exploitation in Memphis

Historical accounts show that urban Black patients were used for antebellum medical training and experimentation, including as specimens for postmortem dissection. In their book Bones in the Basement: Postmortem Racism in Nineteenth-Century Medical Training, Robert L. Blakely and Judith M. Harrington discuss the social, cultural, historical and health aspects of race using skeletal remains at the Medical College of Georgia. Over of 9,808 types of bones and other fragments in the basement reflect that cadavers were used in Anatomy courses, but also in surgical clinics. Most cadavers in medical colleges were Black males because the college provided care to the impoverished and prisoners.140 Students experimented with cranial operations, including drilling holes

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139 Todd L. Savitt, Race & Medicine in Nineteenth-and-Early Twentieth-Century America (Kent, Ohio: The Kent State University Press), 79.

through the skull, all while attempting to perfect amputation of limbs. From 1840 to 1880, although African Americans did not exceed 49% of the population, their skeletons comprised 79% of those found in the basement at the Medical College of Georgia.\textsuperscript{141}

Dissection of human cadavers, although illegal in many states, aided in the advancement of surgical techniques and became a source of pseudoscientific inquiry for Southern antebellum physicians regarding diseases.\textsuperscript{142}

When Dr. Joseph Nash McDowell opened a medical school in St. Louis, his teaching methods incorporated “hands-on dissection, lectures and storytelling.” McDowell taught a class on grave robbing and accompanied his students on many such outings.\textsuperscript{143} In 1853, one of the requirements for the Memphis Medical College was a ten-dollar course on Anatomy and Dissection “taken once before graduation.” As in some other medical programs, instruction in dissection and postmortem observations provided insight into diseases of women for students at the medical school.\textsuperscript{144}

Southern medical

\textsuperscript{72} See also, Daina Ramey Berry, \textit{The Price For Their Pound Of Flesh: The Value Of the Enslaved from Womb to Grave, in the Building} (Boston: Beacon Press, 2017).


\textsuperscript{142} The cities of Baltimore and Philadelphia permitted Blacks and poor paupers to oblige medical school with bodies for dissection, “their powerlessness and their marginal social status afforded little protection or their dead in the face of persistent shortage of cadavers needed for medical dissection.” Many newspapers describe body snatching, falsified burial records, and empty coffins, David C. Humphrey, “Dissection and Discrimination: The Social Origins of Cadavers in America, 1760-1915,” \textit{Bulletin of the New York Academy of Medicine} 49, no. 9 (September 1973): 819, 822; E.D. Fenner, “New Orleans School of Medicine: Situated on Common Street Opposite the Charity Hospital,” \textit{Memphis Medical Recorder} 6, no. 5 (March 1958). The affiliation between medical training and grave robbing was straightforward; “Grave robbing was practiced furnishing bodies for three purposes: for instruction in medical colleges, for instruction by preceptors, and for the use of practicing physicians.” Dr. Frederick C. Waite, “Grave Robbing in New England,” \textit{Bulletin of the Medical Library Association} 3, no. 33 (July 1945): 281-282.

colleges competed with Northern medical colleges for students. The medical college endorsed the “value” of education and training in Memphis.

Clinical Instructions is given twice a week at the Memphis Hospital, and a city dispensary Clinique [sic] is held daily at the College at 8:00 o’clock in the morning, at which operations are performed, and upwards of one thousand cases before the student and are prescribed for and lectured upon daily by the Professor during the session. The college possess an ample anatomical Museum and complete superb Chemical apparatus with extensive samples of Materia Medica minerals &c [sic].

The focus of clinical instruction was anatomical structures, especially the positioning of the human body during postmortem changes. To further advance the field of surgery, the medical college probably performed unwarranted operations on destitute people.

Mortality rates of diverse health problems were organized nationally, and local physicians were invited to furnish epidemiological health data for regions. In 1853, the American Medical Association asked for a report on epidemics in Tennessee and Kentucky. Dr. George Grant prepared a similar report, but with a different focus, specifically noting the primary cause of death. The two diseases with the highest mortality were consumption and pneumonia. On April 4, 1855, Dr. W. J. Tuck responded to Dr. A. P. Merrill’s request for a “tabular statement” about Memphis mortality figures for 1854. Tuck reminded Merrill that the data are “partial and imperfect” because classifying diseases was uncertain, and the methods of ascertaining death reports were faulty. Dr. Tuff noted that the total deaths were 526. From the figures

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above, 100 deaths occurred among strangers who were in Memphis for only a brief time.  

Felice Swados has noted analysis of diseases and mortality incidents in antebellum America focus too heavily on epidemics. Most deaths occurred from endemic disease. Diseases that resulted in high mortality or what Swados classified as “special violence” were pneumonia/typhoid pneumonia, dirt eating, abortion/sterility, prolapsed uteri, and infections. In Memphis, Black people of all ages had higher mortality rates from pneumonia/consumption, and the diseases mentioned would not correlate to ongoing medical treatment or surgical intervention. As noted, early physicians at the Memphis Medical College performed over 1,000 operations, and although riverboat accidents happened, the latter could not explain the high number of surgeries.

The surgical cases averaged nearly eighty-three per month. In addition, Swados validated unreliability data from city and county health reports in antebellum America. Unquestionably, Memphis was an antebellum city with unreliable data, as noted earlier. Nonetheless, with national data and comparative studies from other historical documents, there was consistency about endemic disease. However, the topic of women’s health is often overshadowed by epidemic diseases. In the social context of diseases, gender, social conventions, and resistance, the following section will discuss self-managed contraception.


149 Ibid.
Knowledge and Resistance

In 1860, Dr. John H. Morgan of Murfreesboro, Tennessee elected to warn his fellow slave owners about the inappropriate behavior of older slave women. Specifically, he warned that these enslaved women’s promiscuous and excessive sexual activities, along with field work during menstruation and pregnancy, resulted in infertility and spontaneous abortions. As a physician, Morgan noted that some enslaved women concealed their pregnancies, while others worked continuously to produce an abortion. Morgan, himself a slaveowner, was familiar with specific modes and methods used to induce an abortion.

The remedies mostly used by negroes to procure abortion are the infusion of decoction of tansy, rue, roots, and seed for the cotton plant, pennyroyal, cedar berries, and camphor, either in gum or spirit. Single tansy (Tanacetum vulgare) is probably employed more than any other herb, because it is more convenient, and its reputation as an abortive more generally known, being commonly cultivated in our gardens.150

During his studies as a medical student, Morgan discovered that “a negro girl of my stepfather’s, was found by my mother drinking freely of an infusion of tansy, given by her mother, with a large quantity deposited under the bed for repetition. She miscarried and died in a few days, with most horrible shrieks and convulsions.” He admitted that older enslaved women who taught him about the effects of herbs preferred to use Rue (Ruta graveolens) because it was more potent and more effective at producing abortions compared to tansy, which is discussed later. Enslaved women in the South also used cotton plant (Gossypium herbaceum) root because its action generated uterine

contractions. However, certain abortive herbs were too expensive for enslaved women (especially ergot).\footnote{151}{John H. Morgan, “An Essay on the Causes of Production of Abortion among our Negro Population,” *Nashville Journal of Medicine and Surgery*, ed. R.C. Foster and George S. Blackie (Nashville: John T. S. Fall Book and Job Printer, 1860), 118-120. Gossypium herbaceum L., \url{https://www.itis.gov/servlet/SingleRpt/SingleRpt?search_topic=TSN&search_value=506096#null}; also known as Cotton Root, “is mainly used as an abortifacient in place of ergo, being not so powerful but safer; it was used largely in this way by the slaves in the south.” Botanical.com, \url{https://botanical.com/botanical/mgmh/c/cotto109.html}.}

In a letter with a colleague, Morgan noted that a Smith had personal knowledge of a family who had about four to six bondswomen of “the proper age to breed.” During a twenty-five-year period, “only two children had been born on the place at full term.” The owner suspected an older enslaved woman and man of aiding the younger women in aborting fetuses. After a while, the same owner purchased another group of enslaved women who had given birth every eighteen to twenty-four months. However, while on his plantation the women had spontaneous abortions during their fourth month of pregnancy. The enslaved women admitted to taking medication to terminate their pregnancies, and they presented the “weed” to their master. Morgan explained, “The master brought the weed to me, but I do not what it is.”\footnote{152}{John H. Morgan, “An Essay on the Causes of Production of Abortion among our Negro Population,” *Nashville Journal of Medicine and Surgery*, ed. R.C. Foster and George S. Blackie (Nashville: John T. S. Fall Book and Job Printer, 1860), 122.}

Perceived as powerless within the social boundaries of institutional slavery, yet knowledgeable about the intricate social networks on a planation, enslaved women managed to gain control over their own fertility and that of other enslaved women. As mothers, enslaved women cleverly protected their daughters. Enslaved women were successful in preventing pregnancies by using certain types of herbs. As women, they fostered relationships with other free and enslaved women which enabled them to
overcome traditional antebellum medical practice and male power. Herbal roots that became a part of the Southern landscape included some medicinal plants that were introduced to the South from other countries. Historian Sharla Fett examined enslaved women’s their practice of traditional healing on the Southern plantation and enslaved communities to illustrate how healthcare skills “represented the culmination of a lifelong acquisition of skills as mothers and apprentices to older healers.” In addition, slave owners could not police the activities of enslaved nurses or the practice of healing through traditional modes of treatment.  

Tanacetum vulgare (Tansy) is described as an abortifacient herb/plant that “should be entirely avoided during pregnancy and herbal abortion is not a recommended method of intentional pregnancy termination.” Tansy induces miscarriage or abortion. Enslaved women also used Ruta gravelens (Rue) to halt, curtail, or eliminate an unwanted pregnancy. The functional properties of Rue include “stimulating, antispasmodic, stomachic, abortifacient [when] used as an emmenagogue, and for the treatment of cough, colic and flatulence.” The leaf part is used in “amenorrhea, menorrhea, in addition to chest pain, and arthritis.” When taken, it causes uterine contractions. Older enslaved women also coveted the herb Gossypium, which they obtained from the cotton plant. Gossypium is a seed (cotton root bark) and is native to sub-Saharan Africa and Arabia. Based on research studies, “Gossypol poison has also been associated with various manifestations of infertility in monogastric species including humans.” Gossypium benefited enslaved people because both men and women

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were rendered infertile, depending on the amount consumed and the plant’s species.\textsuperscript{154}

All the above plants are classified are abortifacients.

Recommendations for treatments with such herbs and other pharmaceutical remedies appeared in medical journals. A.P. Merrill discussed correspondence from the Berks County Medical Society in Pennsylvania related to the properties of the root of the cotton plant. The “powerful emmenagogue,” and its benefits as a “parturient,” causing abortions, sparked interest. Merrill was skeptical of the plant, and he informed colleagues that the evidence of its effectiveness was vague. However, the physician writing the brief narrative opined that “it may be worthy of trial.”\textsuperscript{155} From a medical standpoint, such an herb could be beneficial during a spontaneous or incomplete mischarge. The side effects were far less than those of a surgical operation or an intervention using heavy metal speculums.

The most powerful way for enslaved women to gain power over their bodies and lives was to run away. There are several reasons why enslaved women ran away. However, one key reason is the desire to parent without slave owners interfering with motherhood. Running away to freedom was risky, and the reasons enslaved women took such a risk during late pregnancy are important to explore. Pregnancy among enslaved women promoted despondent feelings about life in bondage. J. G. Muir of Grand Gulf, Mississippi, advertised that he was looking for an escaped “negro girl” who had “a

\textsuperscript{154}“Emmenagogues are defined in herbal medicine as herbs capable of stimulating the menstrual flow even when it is not due and are also to be avoided during pregnancy. For centuries, they have been colloquially defined as ‘herbs for delayed menses,’—sometimes a euphemism for eliminating an unwanted pregnancy. Many emmenagogic herbs are therefore also abortifacients,” Aviva Romm, “Pregnancy and Botanical Medicine Use and Safety,” in \textit{Handbook of Herbs and Spices} 2 (Philadelphia: Woodhead Publishing Limited, 2012): 1-2, 6-8.

\textsuperscript{155}\textit{Memphis Medical Recorder} 1, no.4. (January 1853): 59.
number of black lumps on her breasts” and was “in a state of pregnancy.” The slave owner was aware of the marking on her breast. Perhaps she ran away to save herself and unborn child from further types of abuse. Also, on August 11, 1837, Charles Craige asked for public help in finding Jane, an enslaved woman “advanced in pregnancy.” For some enslaved woman, running away seemed safer than staying, and the only way to end the slave owner’s power over them. Enslaved women who were owned by medical doctors in antebellum Memphis are rarely mentioned; however, many of Memphis’s distinguished physicians had paradoxical roles as benevolent medical providers and amoral slaveowners.

As an instructor in Principles and Practice of Medicine at the Memphis Medical College, A. J. Merrill took pride in over thirty years of practice in the South. He alluded to his clinical expertise and observations: “the peculiarities in the physiological and pathological developments of the negro race, and the modifications required in treatment of their diseases, having been made special objects of study, will be presented as matters of high importance to the Southern practitioners.” Merrill’s publications about diseases unique to Blacks received much attention in the American medical community and, as a Southern physician; he promoted values and medical interpretation about the health of Southern Blacks consistent with those of his peers. He wrote, “They are distinct[ly] different, and medicine can prove it.”


157 “Announcement and Circular of the Memphis Medical College,” Memphis Medical Recorder 6, no.5 (March 1858) – no page.

Merrill advocated for health services in Memphis; however, like many antebellum physicians, he believed that Blacks, especially “the laboring class,” had distinctive health issues. In the May 1857 issue of *DeBow’s Review*, Merrill published an article that focused on how various illnesses and maladies, particularly fevers, affect Blacks—enslaved and free—and Whites differently. He explained that when Blacks and Whites live in close proximity, Black men and women suffer insidious forms of fevers, particularly between the ages of twenty and forty years. Merrill believed that fevers made Blacks violent, but violence did not occur in Whites who had fevers. Although intermittent and remittent fevers attacked Blacks and Whites, treatment regimens were different for the races. For Blacks with high fevers, the therapy of choice was “Blood-letting”; for a therapeutic effect, Blacks required a large quantity of bloodletting, but for Whites, a lesser amount was required to produce the same effect. Diseases such as yellow fever were viewed as uncommon among Blacks, although “mulattos” who had a mixture of White blood were at risk for Yellow Fever, as were Whites in Southern climates.\(^{159}\)

Merrill adhered to treatments that emphasized human variations among racial groups. Merrill was physician and slave master, and the former was not counter to the peculiar institution. Antebellum physicians presupposed that individuals of various ethnic groups had unusual physiological dynamics, especially enslaved and free Blacks. In the culture of Southern medicine, the outward and inward bodies of Blacks were strange, aberrant, and distinctively subhuman. And enslaved people were forced to submit to medical practices and experimentations by the same physicians who owned them. Given

the opportunity to own Black people and study them in a controlled environment, doctors felt unlimited power.

Records of runaway and rebellious slaves owned by physicians in Memphis reveal the reality of this dynamic. Physician C.C. Tucker’s slave named Cat was arrested on November 30, 1860 for running away and having money ($5.00). Surgeon Dr. W. Rodgers enslaved a man named Theodore who was arrested on June 7, 1860 for having “no pass.” Another example is Hannah, an enslaved woman owned by Dr. Pitman, who ran away on June 6, 1860. For Hannah, Dr. Pitman requested the authorities to “put up with Cossey [sic].” The peculiar institution did not produce happy slaves who enjoyed living with men of prominence and wealth such as physician planters. Doctors who owned slaves anticipated self-gratification and honor among their peers for exploiting slaves. Moreover, doctors needed a ready supply of slaves for economic stability.¹⁶⁰

For instance, Dr. William Beaumont advanced his career and was recognized for his scientific contribution regarding the physiology of digestion and gastric juices. Alexis St. Martin was a poor working man who lived in Canada. Over the course of a year, Dr. Beaumont put objects into St. Martin’s stomach (St. Martin had a previous trauma wound leaving a hole in his abdominal area), including foods and bulb-type catheters. Beaumont examined gastric content and described over 238 experiments. He wrote that “the medical

¹⁶⁰ For example, John Brown (slave name Ned) a fugitive slave from Georgia described the horrors of medical experimentation by Dr. Thomas Hamilton. The medical query was the medical dynamics of sunstroke. John Brown was nude, and placed in a pit, with dried tree bark that was set on fire. His body was buried with head above ground. The goal of the experiment was “to ascertain which of the medicines he administered to me on these occasions, enabled to withstand the greatest degree of heat.” Dr. Hamilton whimsically concluded the combination of crushed pills made from flour mixed with cayenne-pepper tea was a cure for sunstroke. Hamilton “realized a large fortune.” Likewise, Dr. Hamilton’s warped curiosity led him to another undertaking: determining how, deep were the layers of Ned-John’s black skin. F.N. Boney, “Doctor Thomas Hamilton: Two views of a Gentleman of the Old South,” Phylon 28, no. 3 (3rd Qtr., 1967): 289-291.
profession continued to pursue St. Martin into his mid-eighties.”

161 This illustrates the importance of human subjects to experiment on to build a physician’s career. While St. Martin was White, Black subjects were often preferred because they could by more easily mistreated in the service of medicine.

Historians of medicine and science such as Ronald L. Numbers and Todd L. Savitt edited a book that includes articles on the duplicity of slave-owning doctors. Owning Blacks was beneficial not only to planters, but to professionals, who quickly realized the worth of having Southern society create a downtrodden race and class. Specifically, “slaveholding afforded men of medicine and science the financial stability, time to develop their careers, advance science, and publish research.”

162 However, enslaved people continued to engage in a strong form of resistance: running away from physician slaveholders to preserve their dignity and bodies from physical and emotional abuse. The abusive nature of a race-based slavery system contributed to the progress of American institutions, and the medical profession capitalized on exploitation.

Conclusion

After a review of numerous historical health studies in Memphis, it is safe to say that information on to gender is limited in the antebellum period. Even with the statistics collected by the Secretary of the Board of Health and the information gathered by researchers such as Dr. Charles T. Quintard, Dr. W.J. Tuck, and George Grant, an

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162 Sons of wealthy planters like Henry William Ravenel was discouraged from practicing medicine instead his father “provided him with a plantation and slaves.” Yet, Ravenel still pursued his interest in cryptogamic. Joseph and John LeConte were scientists; however, they owned a large rice plantation in South Carolina, William Scarborough, “Science on the Plantation,” in Science and Medicine in the Old South, ed. Ronald L. Numbers and Todd L. Savitt (Baton Rouge: Louisiana State University Press, 1989), 89-90.
accurate picture is not available as evidenced by the presence “outsiders” who requested clarification and additional data. However, deaths related to poverty and marginalization, such as pneumonia and respiratory complications, were widespread. Drs. Grant and Quintard included valuable demographic data about disease and death rates in Memphis, particularly when race, gender and age were reported. Quintard discussed and described the insurmountable task of viewing flawed and incomplete mortuary records in an attempt to formulate reliable data on morbidity and mortality. It was the 1854 report by Quintard that clearly described the complexity of disease in an urban city flanked by the Mississippi River. Dr. Quintard explained the need to accommodate ailing and disabled river workers.

The history of health of free and enslaved Blacks in antebellum Memphis has been obscured, especially in the context of slave trafficking. The city’s diverse environment and influx of people created an environment that valued trade and business but did little to ensure health. Memphis was a river city, and the cultural effects of the peculiar institution dictated medical care and treatment. The Memphis Medical College managed and cared for non-residents and the working poor. Doctors exploited Blacks and other minorities to further student and medical training. The slave status of Black women made them vulnerable to experiments by physicians and surgeons, including gynecological procedures and postmortem dissection. The antebellum façade of health and glamorization of slave hospitals were marketing strategies by self-serving physicians. The history of Black women and resistance to medical hegemony is evident in their refusing lethal treatment, taking measures to induce abortion, and running away.
Physician slave holders represented the sociocultural world of Southern Patriarchy; when the Civil War began, doctors still maintained possession of their coveted chattel.
Chapter 3: Memphis in the Era of Reconstruction: Disease and Psychosocial Health

“Teacher, what is the greatest commandment in the Law?” He replied, “You must love the Lord your God with all your heart, with all your being, and with all your mind. This is the first and greatest commandment. And the second is like it: You must love your neighbor as you love yourself. All the Law and the Prophets depend on these two commands.”

May 1, 1866, the day a race riot took place in Memphis, Tennessee, was a particularly violent day in a year of social distress for Black Memphians, especially women. The violence against Black women that occurred during the Memphis Massacre was made clear in their testimonies before federal committees and in the subsequent work of several historians. Evidence on the physical violence experienced during the massacre can be found in the numerous first-person accounts of women who described the assaults, rapes, burning, and thefts, but the emotional trauma of the terror is described by several historians. Yet the psychosocial consequences to the women’s health are just as important as the physical assaults since both impact the overall health of women. As historian Altina L. Waller explains in her essay “Community, Class and Race in the Memphis Riot of 1866,” “the class structure and ethnic characteristic of the neighborhood [in Memphis], coupled with demographic and economic upheaval of the post-war period,

1 Matthew, 22:36-40 (Common English Bible).
created fear and frustration which sparked collective violence.”³ However, fear is rarely discussed in the context of victimization. How was fear enacted upon women? What type of fear was it? And how did women express the fear? Was the fear of death present during the raging street battles and burnings?

Fear can be as detrimental to a society as epidemics and endemic diseases, and the ordeals of violence and terror can invoke fear. Historian Richard Hofstadter in his essay “Reflections on Violence in the United States” notes that historical research on violence is an intricate matter because of the content, but felt that clarifying and understanding what violence is remains pivotal to studying its broad context in history. Hofstadter considered forms of violence as acts committed by isolated individuals, by small groups, and by large mobs; it is directed against individuals and crowds alike; it is undertaken for a variety of purposes; and in a variety of ways ranging from assassinations and murders to lynching, duels, brawls, feuds and riots; it stems from criminal intent and from political idealism, from antagonisms that are entirely personal and from antagonisms of large social consequences.⁴

As noted above, one of the aims of this chapter is to focus on racial violence. Racial violence is motivated by hatred or animosity. During the Memphis massacre, various types of violence fueled racial and gender aggression that traumatized Black women.

Illnesses and diseases resulting from traumatic events are now recognized under current psychological diagnoses as post-traumatic stress disorders (PTSD). But evaluating the impact of emotional trauma on figures from the past requires caution. The historical methodology used in this chapter differs from those of Chapters 1 and 2, as data


from health departments or census records are not used. Instead, I evaluate firsthand accounts and personal narratives—subjective expressions of the victims’ feelings and emotions. When the effects of a traumatic event remain over time, they can evolve into physical or mental health problems, deemed legitimate diseases according to social constructs within the medical community.

Details of war, riots, and collective violence are horrifying, and such tragedies remain a part of human memory. Indeed, studies have shown how legacies of trauma can be passed down through generations. Jack Debric and Joseph LeDoux, who studied fear in rats, noted that animals show similar responses to fear. These responses include physiological signs such as muscle tension, higher blood pressure readings, and the release of stress hormones. Debric and LeDoux note the benefit of learning about political fear and it does to the brain: “Politics involves social relations, authority, power and decision making. There is no question that fear contributes to these phenomena. Fear has been traditionally recognized as one of the fundamental forces that shape human life.” According to Debric and LeDoux, “Past traumas experienced by individuals and groups are significant factors influencing current and future social interactions.”

Medical histories that consider both the physical and psychosocial health problems of Black women within a sociocultural context must account for this.

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This chapter will examine how race, gender, and cultural mindsets after the Civil War generated a range of social diseases. Racial violence induced fear, and fear was used as a form of control against Black women during the Memphis race riots. Drawing on individual testimonies and eyewitness accounts, I explore psychosocial health issues in relation to race and gender. My goal is to broaden the study of women in local history, especially in relation to race, social status, and social diseases that occurred just after the Civil War during Reconstruction.

In the immediate aftermath of the Civil War, Cynthia Townsend lived on Rayburn Avenue. The formerly enslaved woman managed to purchase her freedom a few days before the Civil War. Her owner may have felt that the impending crisis might disrupt his ownership, or Townsend’s manumission might have been the result of a longstanding agreement between the two. Townsend’s home in postbellum Memphis was in the neighborhood that became the site of the three-day massacre in 1866. During a subsequent interview, she was asked if she witnessed or heard about women being “violated” during the racial conflagration. Her response was that her neighbor, Harriet Merriweather, a married woman, was raped by three or four men while her husband, a soldier, was at nearby Fort Pickering. Townsend testified that “They drew their pistols before her and made her submit. There were as many as three or four men at a time had connexion [sic] with her; she was lying there by herself, and the one of them tried to use her mouth.” The emotional scar from the rape deepened when, in the aftermath of the

6“Once upon a time social disease meant venereal disease, and nothing else. Inaccurately applied the term was only a euphemism. Of genuine diseases of a society, war and rebellion come first, followed by political and economic upheavals—none of which has medical meaning, in the way the alcoholism and drug abuse do,” *Journal of the American Medical Association* 222, no. 1 (1972): 1.
violence, Merriweather’s husband rejected her. Cynthia Townsend described her neighbor as having “sometimes been a little deranged since then.”

As the wife of a Black soldier, Merriweather occupied a precarious position in post-Civil War Memphis. Although the torture and physical abuse as well as the fearful nature of the three days of mass violence were psychologically damaging, the act of rape alone does not explain everything. It necessitates a broader cultural understanding of Black women’s history of sexual abuse, especially in the South. In the antebellum south, the rape of Black women by White and Black men was common. Gender is the central focus of this chapter; while sometimes obscured by race and class in accounts of Black history, gender makes Black women uniquely vulnerable to rape and other forms of violence.

Evelyn Brooks Higginbotham, in her essay “African-American Women’s History and the Metalanguage of Race,” provides a useful feminist analysis of women’s experiences. Researching binaries such as male versus female and even equality contributes to an awareness of gender and class. However, Higginbotham explains that, “feminist scholars, especially those of African-American women’s history, must accept the challenge to bring race more prominently into their analysis of power.” When we consider the rape of Black women during the racial anarchy that took place in 1866 and throughout the post-Civil War south, it is evident that Southern White men and American society in general did not view Black women as women, and certainly not as ladies.

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Black women were thus devalued and dehumanized, while acts of trauma and violence left them without legal protection.

The violation of Black women’s bodies and the sexual misdeeds of White men continued to be sanctioned as custom even in the aftermath of slavery. In medical books, essays, and popular literature Black women’s bodies were labeled and described in animalistic terms as beast-like. Black women also faced the cultural belief that they were unchaste. Higginbotham notes the era’s social preconceptions about sexuality and their implications for Blacks:

Violence figured preeminently in racialized constructions of sexuality. From the days of slavery, the social construction and representation of black sexuality reinforced violence, rhetorical and real, against black women and men. That the rape of black women could continue to go on with impunity long after slavery’s demise underscore the pervasive belief in black female promiscuity.

Historians such as Hannah Rosen, Beverly G Bond and Kidada E. Williams place Black women at the center of post-Civil War violence. The testimonies of Black women enable historians to revisit and rewrite narratives about the subjectivity of emotions as part of women’s health history. It is important to understand this history not as isolated acts, but as the result of race- and gender-based violence and exploitation.

In the world of White aggressive power, rape of Black women is analogous to the lynching of Black men. Historian Jacqueline Dowd Hall acknowledges that “rape is the primary instrument for male terror.” After the Civil War, “rape was not simply an act of

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violence, but a sexual story man told themselves that legitimated others forms of violence, and that rendered that violence peculiarly arousing and pleasurable.” Like other historians, Hall notes the connection between slavery and the Black female body, specifically how the power of masters and their paternalistic views sustained sexual access to and control of their female slaves. As discussed earlier, the suffering of Black women in Memphis during their ordeal during the riots is clearly expressed in various forms of fear that they revealed in their testimonies to the federal committees. Any study of fear necessarily entails understanding the relationship between groups and individuals who incite fear and the unfortunate ones who suffer. Multiple dichotomies of fear revealed in this socio-cultural context include male versus female, Black female versus male, and White male versus all “others.” The following research illustrates such parallels.

Historian Travis D. Boyce and philosopher Winsome M. Chunu in *Historicizing Fear: Ignorance, Vilification, and Othering* address how fear is used on subordinated groups or social “others.” The authors examine the strategies Whites use to engender fear and terror in African Americans. Specific types of fear include face-to-face threats, postings (mostly anonymous) in semi-official sources such as newspapers, and postal mail. These fear campaigns often resulted in Blacks relocating for safety, fearing they would be killed or subjected to other types of harm. Boyce and Chunnu noted that what

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these “various tactics have in common is their shared production of fear and terror among African American populations.”

Jenette Swells, a native-born Engander who described herself as “a Scotch woman,” moved to Memphis six months before the Memphis massacre. During the days of violence, she witnessed John Callahan, a White man, leaving the place where “they burned up a girl.” Callahan was seen carrying a bed in one hand and his pistol in the other. Swell stated, “I was frightened at that time.” Sophia Gary was also a new resident of Memphis, having left Cincinnati and settled in the South Memphis neighborhood where most of the violence occurred. She was German, and her husband Italian. Mrs. Garey saw at least 200 people standing in the front of Callahan’s store. She testified about the shooting death of a twenty-year-old Black girl and informed her interviewer that the rioters were looking for the girl’s father, probably a Black soldier, so that they could kill him. The rioters referred to the Gareys as “Yankee Niggers”; fearing for their lives, Sophia Garey and her husband planned to leave the city as soon as possible.

The Memphis massacre was an extension of racial tension in the post-Civil War South. Whites lost power and status in the community. After the war, more African Americans lived in the area. Black soldiers embodied the idea of manhood; guns provided power and control as Black soldiers protected their South Memphis neighborhood. In addition, Blacks could vote, own property, and marry. Previous social customs and traditions during slavery were upended, and White men felt dishonored.


Too, for some White Memphians, people of German and Italian ancestry were non-native and considered outsiders. Some spoke the truth about White men’s behavior during the riot. German and Italians testified on behalf of Blacks, which angered White men.

Historian Joanna Bourke, in her essay, “Fear Anxiety; Writing about Emotion in Modern History” notes that power is a prevailing theme in the history of emotions. Bourke theorized that that fear has political implications because fear of certain class groups creates social phobias. A function of emotion within a sociocultural and historical setting is that emotions can often generate and produce subordination; however, they can also do the opposite, making people resist subordination.¹⁴ Using this framework for historical inquiries can allow for new and insightful studies on fear within American society, allowing us to ask “who becomes frightened and what is the outcome of their displays?”¹⁵ Fear operated throughout the Memphis riot, and I theorize that racism guided fear via an established hierarchy of power.

Historians suggest various relationships between power on the part of dominant groups and fear elicited in subordinate groups, especially Black women. According to historian Bobby Lovett, in 1866 Black women were part of a unique historical event. As part of a newly established free Black community in Memphis, many women may have been married or involved with Black soldiers in the federal units who patrolled the city.¹⁶


¹⁵ Ibid., 129.

¹⁶ Fort Pickering, a Union military installation on the outskirts of the city. The rioters initially focused their attacks on the former soldiers of the Third United States Colored Heavy Artillery regiment, which had disbanded April 30—the last of three black regiments to be mustered out of the United States service at Memphis,” Kevin R. Hardwick, “Your Old Father Abe Lincoln is Dead and Damned”: Black Soldiers and the Memphis Race Riot of 1866, *Journal of Social History* 27, no. 1 (Autumn 1933): 109.
These women were employed in skilled and unskilled occupations. They were mothers, wives, sisters, or daughters who felt that they could rely on their husbands, brothers, or fathers for protection and circumvent relying on local police in civic matters. The Black community had eight churches, eight stores, and numerous other businesses including saloons and fruit stands. Most Black women in this emerging community had been enslaved less than three years earlier, but they now resided in neighborhoods where 300 Blacks had economic resources ranging from $100 to $500 dollars, and three Blacks had assets of $5,000 or more. Many other signs appeared of economic advancement and freedom, such as the creation of a Black military unit and assistance from the Freedmen’s Bureau.\footnote{Bobby L. Lovett, “Memphis Riots: White Reaction to Blacks in Memphis, May 1865-July 1866,” \textit{Tennessee Historical Quarterly} 36, no. 1 (Spring 1979): 13.}

Historian Hannah Rosen explains that Memphis was a destination for the newly emancipated. The city seemingly offered protection under the watchful command of the Union Army. For Blacks, freedom was synonymous with self-determination and life choices. Black women used their “freedom” to develop religious institutions and participate in forms of economic empowerment by using the Freedmen’s Bureau to collect back wages. But they were not always accepted by fellow citizens. White Memphians routinely characterized Blacks as rowdy, licentious, and criminal in nature.\footnote{Hannah Rosen, \textit{Terror in the Heart of Freedom: Citizenship, Sexual Violence, and the Meaning of Race in the Postemancipation South} (Chapel Hill: The University of North Carolina, 2009), 52.}

The historiography of the Memphis Riots aligns with Whites’ political resistance to change and the social ramifications of changing race relations. Multiple historians describe the events in Memphis on May 1, 1866, and several historians describe the lives
of Black women, and their personal history and anguish. However, the impact of violence and fear on mental illness and psycho-social health status is worth researching. The personal accounts of Black women who lived through this period of racial conflict and massacre reveal a long history of racism and the consequences of a white Southern manhood that tied power to fear, violence, rape, and ultimately murder. Competing themes of manhood and masculinity come to the fore in published documents because of the presence of a Black military unit. In some histories of the Memphis Massacre, the victims’ voices are silent, gender violence is discreetly discussed, and emotional history is abandoned. The events of the massacre encompass several types of history, depending on the viewpoint of the historian. This event can be a narrative about Southern history, women’s history, social history, history of emotions, or Black women’s health. While emotions are often studied from the perspective of biology or individual psychology, emotions that are expressed verbally, and are attached to an event, become a part of group past experience: They are historical.

The women who resided on the south side of Memphis in 1866 shared many commonalities including race and former slave status, though a few were free prior to Emancipation. However, over a two- to three-day course, mayhem, fear, sorrow, and other human emotions consumed their souls. Therefore, addressing the human aspect of history in the lives of Black women during the agonizing episode gives an alternative view of Memphis history.

Lavinia Goodell’s husband Jackson worked in Memphis as a drayman. On May 1, 1866, Jackson left for the store to purchase meal for dinner at the request of Lavinia, who was sick. Later that day, one of Lavinia’s church “sisters” informed her that Jackson had been murdered on Beale street near Hollowell’s Grocery, but when she arrived at the site, Lavinia could hear Jackson groaning. It was difficult for her to move Jackson inside their home since there was no one available to help her. Lavinia had to leave her dying husband, recalling in later testimony the admonition of another person that she “had better go in or they will kill you.” Lavinia Goodell noted, “I did not know what to do…. They told me it would cost me my life if I sta[d] there, and I finally went.” Lavinia’s fears were supported by other black residents who declared that “[t]he policemen were going to kill every negro they could catch.”

Jackson Goodell was, according to his wife, a peaceful, religious man in his mid-twenties, and, obviously intent on giving him the respectful burial service she thought he deserved, Lavinia returned to collect his body, but it was missing from the place where he had fallen. Neighbors recalled seeing four men taking the body and were told that he required medical care at the hospital. Lavinia Goodell went to the police station to inquire which hospital her husband was transported to. She described Jackson, his clothing, and the events that led to his death to the officers who interrogated her and, glancing aside, saw Jackson’s body lying dead at the station. She begged for the release of her husband’s body, but it was never granted. That was the last time Lavinia saw Jackson.

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21 Ibid.
During her interview, Lavinia was asked if she saw other acts of violence, including the murders of Blacks. She could remember some, but not in detail because, as she stated, “I was so badly hurt that he was killed at that time that I did not notice who they were, and do not know.” Lavinia suffered no physical injuries, but the dreadful incident and loss of her husband created irreparable emotional pain. Lavinia had no rights or legal protection as a married woman. As Hannah Rosen notes, Blacks’ legal right to citizenship was a contentious matter. Blacks had freedom and could work, live, and enjoy life in a new established community. Before to the Massacre, Black men were armed with guns and were a visible sign of protection for Black women, especially against abuse. But for white Memphians, these armed black men were a provocation. Reconstruction in Memphis history appears in various books that focus on diverse topics such as the Lost Cause, freedom, a nation divided, and the work of the Freedmen’s Bureau. Some historical writings place women at the center of Reconstruction, discussing the intersection of race, class, gender and violence. Historians have used

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22 Ibid.


numerous sources to capture the social thought of Americans during this most tumultuous time. For instance, slave narratives provide personal accounts that include descriptions of fears of death, abandonment, and loss of family or loved ones. Reports from military personnel and the Freedmen’s Bureau document social upheaval, violence against women, and violence in response to racial unrest. Yet historians often rely on other disciplines to capture the human emotions that are present but less overtly evident. For example, psychology, the study of the human mind and feelings, provides subjective analysis that can help assess the emotions or thoughts of interviewees.

In their testimonies after the Memphis Massacre, Black women described racialized retaliation, ongoing segregation, and the denial of legal protections. The historical context of fear offers a dual lens to explore the health consequences and psychosocial implications for mental health of the Black women who feared violence and other harm in post-Civil War Memphis. Again, the Memphis massacre was an extension of a violent Southern culture, and fear was used as a form of control. Some forms of


27 Emotions are a part of human experience. The emotions in history has the potential, therefore, to shed light on the structural dynamics of gender relations as they were imported by masculine agents of power. Such masculine agents of power include coercion, oppression, and violence, which can induce fear within groups of people. Through history of emotions the visibility “of the effect of power dynamics that emphasized emotional animality [sic] on racial others on the other side of the exclusion boundary.” Humans emotions within the social-cultural dynamics of race are destructive, Rob Boddice, *The History of Emotions* (Manchester, Manchester University Press, 2018), 96, 98. See also, Jan Plamper, *The History of Emotions, An Introduction* (Oxford: Oxford University Press, 2012). Comprehensive Interviews from leading scholars in the field see Nicole Eustace, Eugenia Lean, Julie Livingston, Jan Plamper, William M. Reddy and Barbara H. Rosenwein, “AHR” Conversation: The Historical Study of Emotions,” *The American Historical Review* 117, no. 4 (December, 2012).
violence, including rape, were acceptable and not punished in Southern culture, both before and after slavery. Violence and subjugation were rooted in ideologies of White manhood and supremacy. Historian Bertram Wyatt-Brown describes a code of honor among Southern White men, noting that “honor existed before, during and after slavery in the Southern region,” and that the Civil War was “reduced to a simple test of manhood.” What attitudes and cultural norms around violence permeated Southern White society during the Memphis massacre? 

Unrest, violence, rape, and torture occurred in Memphis during the three-day event, and Black women were targets.

Like hundreds of other enslaved women, Lucy Tibbs, a native of Jackson, Arkansas, arrived in Memphis during the Civil War. Her husband worked on a steamboat. Lucy thought she was about twenty-four years old when the Massacre happened, and her testimony reflects the trauma she experienced. Tibbs saw Black soldiers chased and gunned down by a white man she recognized as John Pendergrast. She also testified to seeing the burned body of a Black girl, who was later identified as Rachel Hatcher. Wagons rode around the city collecting bodies, but some lay dead in the street for almost two days. A police officer identified as Roach shot and killed a Black soldier near Lucy Tibbs’ home. Tibbs’s own brother, Bob Taylor, a former solider of the 59th regiment stationed near Memphis, was among the dead. He tried to run away, but his body was found near Gayoso bayou on May 2nd.

Lucy Tibbs provided one of the most extensive accounts about the Memphis Massacre. At one point, her life was threatened by John Pendergrast’s son. Later during the night, a group of men broke down the door to Tibbs’s shanty. The intruders stole 300 dollars given to her by her brother Bob. When they asked Lucy where her husband was, she replied that she did not know, and the actions that follow were horrifying. “Please do not do anything to me,” she protested, “I am just here with two little children.” Although Lucy Tibbs was also pregnant, the men raped her. She was unable to describe any of the perpetrators because she was “so scared.” The interviewers asked Lucy whether she was dressed when the men broke into her house and had resisted the men’s assault, possibly suggesting that her appearance and behavior may have encouraged her rapists. But Tibbs replied that she was clothed and that she feared she would be killed by the house full of men. Importantly, Lucy testified that during the riot a Black woman had been stabbed and raped. She felt that she was singled out because her brother, Bob Taylor, was in the military and attackers felt she might be hiding some money he had saved. Although there were at least four men in the home, only one man raped Tibbs while the others watched. Tibbs was left with a traumatic memory that she could articulate.

Such acts against Black southerners were not merely personal. W. E. B. DuBois brings awareness to the realities of post-Civil War violence: “many testified that the Southern people seemed to have transferred their wrath at the Federal Government to the colored people.” As a group, Southerners expressed their fury:

29 John Pendergrast was a 24-year-old, ethnicity Irish, who owned a grocery store in South Memphis. He sold food, but also pistol ammunition, Steven V. Ash, A Massacre in Memphis: The Race Riot that Shook the Nation Once Year After the Civil War (New York: Hill and Wang, 2013): 53.

Armed guerilla warfare killed thousands of Negroes; political riots were staged; their causes or occasions were always obscure; their results always certain: ten to one hundred times as many Negroes were killed as whites…. Then differences began to arise. Instead of driving the Negros to work, bands of poor whites began to drive them from work. Private vengeance was taken upon prosperous and hard-working Negroes.”

Lucy Tibbs’s testimony reveals that the connection between displaced anger and the sexual abuse visited on her stemmed from animosity at her fortunate brother. As Rosen explains, “the sexual violence that occurred in the midst of this riot embodied more than extreme brutality.”

Emancipation did not halt the rape and physical abuse of black women that had been so common during the antebellum period. White men continued to exercise dominance over Black women to evoke fear and submission. Simultaneously, social unease about equality and the non-enslaved status of Black women inspired fear in the White Southerners and other citizens. White Southerners continued to use repressive tactics to sustain gender conventions and social norms of racial etiquette.

31 W.E.B. Du Bois, Black Reconstruction in America: 1860-1880 (New York: The Free Press, 1998), 670-671, 673-674. For other historical studies on violence, Klan violence and racial riots during Reconstruction, see Michael Perman, “Counter Reconstruction: The Role of Violence in Southern Redemption,” in The Facts of Reconstruction: Essays in Honor of John Hope Franklin, ed. Eric Anderson and Alfred A. Moss Jr. (Baton Rouge: Louisiana State University Press, 1991); C. Vann Woodward asserts that the New South was more violent than the Old South. For example, when comparing national data Northern states with larger population, including slum and urban areas had less crime than Southern states. Woodward also compared the South to many European nations, and he discovered that “The South seems to have been one of the most violent communities of comparable size in all Christendom,” Origins of the New South: 1877-1913 (Baton Rouge: Louisiana State University Press 1977), 158-159.

Psychosocial Health in Historical Context

Historian and philosopher Theodore Zeldin challenges historians to create unique complementary methodologies to conceptualize human characteristics in history. The idea of one classic style for writing history limits historians’ creativity. The historian’s personal ideas and experiences can advance studies of human emotions. Zeldin explains that “imagination is… as important to historians as new documents. New documents are an easy way to find oneself an illusion of originality.” Zeldin also notes that “human qualities, the capacity for sympathy and sensitivity, will be increasingly valued as historians are expected to reinterpret and recreate the past, and not just add to knowledge.” For example, love “is generally seen as part of the history of marriage, of the family as an institution, or of demography.” Accordingly, historians can research social influences of “fear in the Bronx in the 1890s, or jealousy in the seventeenth century, or varieties of hope among entrepreneurs of the early industrial revolution.”

Likewise, historical studies of human sexuality reveal types of language that differ across time. Zeldin notes the vast number of studies on the topic of fear, including work by Jean Delumeau, whose fear was overwhelming to him after the death of his childhood friend.33

Fear and violence are psychosocial health conditions and are important for constructing how Southern culture used emotions to enact violence against Blacks. In this context, fear becomes the end product of prolonged generational violence enacted by dominant groups and organizations that have historically exercised power over socially subordinate people. Indeed, the history of emotions highlights the significance of male authority and violence. Violence has an ever-present effect that is minimized in historical

studies. Violence among Blacks, especially women, is reported with an emphasis on the physical nature of the wrongdoings, while affective disorders go unnoticed. Subjugation is reinforced by blaming victims, a dynamic commonly seen in sexual assault. For example, perpetrators who commit violent acts may presume the victim was responsible or that they “had it coming to them.” Thus, violence can be deemed as justifiable, depending on the chosen victims (such as African American women), time (slavery and post-Civil War), and place (American South).

This can be seen in the case of Mary Jordon. Jordon was a former slave who testified that a mob set her house on fire. She ran away, fearing for her own life and those of her children. The interviewer asked what other events transpired and Mary replied, “When I was running away with my babe, a man put a pistol to my breast, and said he, ‘What are you doing?’” “I am trying to save my baby.” Mary was ordered to “sit down,” and she complied. Mary stated, “they did not trouble me anymore.” Guns can serve as symbols of power and evoke phallic connotations, especially when placed against a woman’s breast. Guns bestow control and identity irrespective of whether they are used; the gun symbolizes power, and submission becomes a natural response of the targeted victim. The rape of women, especially Black women, was performed to reinforce power dynamics and give White males a high place in the hierarchy of social dominance. Rape and terror are themes in the lives of Black women, and historical research on the emotional aspects of trauma and violence among Black women is valid. For this reason, exploring crimes and injustices that evolved from emotions such as fear is meaningful for studying race through a historical, cultural and social lens.

In the *History of Emotions*, Rob Boddice argues that masculine reasoning is associated with masculine power. Masculinity as political power is accepted as a social norm, particularly in government and leadership, and the dominant discourse of male privilege defines masculine character. Recent work on the history of masculinity “will re-appraise masculine reason as an effective gendered practice.” Furthermore, Boddice explains, “emotions history has the potential... to shed light on the structural dynamics of gender relations as they were imposed by masculine agents of power.” This is especially true as they concern the sociocultural dynamics of emotions in history and their impact on race and ethnicity. For example, power as a form of social control defines racial hierarchies, while reducing social and political power among those deemed less deserving. Oppression and institutional racism these “were enforced through feelings of difference.” Yet Boddice’s research is influential because “taken together, these configurations of power dynamics along gender, class and race lines all add up to a history of humanness to which the history of emotions can materially contribute.” More importantly, historian Michael A. Bellesiles states that in order to examine the depth of violence in our world, particularly interpersonal violence, researchers must examine nations that were involved in civil or social upheaval.

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Racial upheavals such as the Memphis Race Riot involve a change from the established order. Black military men had power and authority, and their uniform symbolized legitimacy, like that of policemen. Black women enjoyed a sense of protection being near male family members and spouses, which had not been the case two years ago during the Civil War, and most definitely not during enslavement. Black children had an opportunity to receive an education; there were missionary or Freedmen’s Bureau schools operating in a city that had never operated public schools for Blacks. As historian Bobby Lovett explains, “the overnight growth of black residents in Memphis took white residents by surprise.” Although Blacks and Whites encountered each other daily during the antebellum era, the social status and class of Blacks changed after the Civil War. No longer enslaved, many Blacks were gainfully employed, politically active, constructing community institutions, and free to explore the city. An inventory of Black prosperity and brokenness was noted after the riot. Specifically, Blacks had four churches and eight schools. Lovett reports the burning of ninety-one homes. In gender terms, five women or girls were raped. Rape, robbery, and murder can be explained simply as events where “someone was angry, and became violent, and types of violent induced fear.”

For Black women who lived through the horrors of a race riot, that violence had lifelong repercussions, and its effect on their mental health is part of psychosocial history.

**Violence: An Emotional History**

The Memphis Massacre was emotionally devastating for many Black women.

Feminist scholarship on violence (including rape) offers multiple theories for understanding the emotional effects of such events. Aisha K. Gill, Gina Heathcote, and

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Emma Williams note that “violence is a key factor in the production, maintenance and legitimization of domination and subordination.” They also bring attention to gender-based violence. In her review of sexual assault as an object of feminist analyses, Suzanne Egan explores feminist post-structural research which argues that despite nuanced difference, these analyses of male violence share a common conceptual foundation and constitute a distinctive type of theoretical work. Male violence against women, whether limited to rape or extended to pornography and sexual harassment, is located within a patriarchal power system, and it is this system that produces, legitimizes, and maintains male dominance and female subordination.

The case of Jane Sneed, a former slave who migrated to Memphis during the Civil War, reflects this feminist analysis. Sneed was about thirty-eight years in 1866. Her daughter Rachel tried to leave the house, insisting that she needed to help their neighbor, Adam Lock, gather his belongings. Sneed pleaded with her daughter to come inside as bystanders shouted, “You had better go in or you will get shot.” Jane Sneed was home when men broke into the house and came upstairs to her rooms. She recognized Mr. Callahan, owner of the grocery market, who was armed with a large pistol. What eventually transpired was the intentional arson of Sneed’s home and the Rachel’s murder. Jane Sneed described the discovery of her daughter’s body: “[s]he was dead and the blood running out of her mouth. . . it scared me more than I had ever been in my life.” Fourteen-year-old Rachel was also partially nude (suggesting she may have been raped),


and her dress and undergarments were found separately. Jane Sneed was later informed that Mr. Callahan had killed the girl. Neighbors removed Rachel’s body and buried her, erecting a headboard with her name.41

When she was interviewed, Jane Sneed was asked whether she had given Mr. Callahan any cause to have ill feelings toward her. She responded “None in the world. I was tending to my own business. I was sending my daughter Rachel to school.”42 For Whites, witnessing Black children attend school could bring discontent. Radical reform and overturning the old tradition of slavery, which had imposed illiteracy on Blacks, was not met with universal acceptance. During the violent mayhem, order and racial hierarchy had to be restored; the latter included gender conventions, as sexual resistance from Black women was unacceptable. It is crucial to understand both the historical context for acts like Mr. Callahan’s murder of Rachel, and the trauma and grief of the victims, which humanizes the invisible women of the Memphis riots.

Pain is subjective feeling. It is what the person says or feels about a painful event. A person’s self-expression of an experience allows for interpretation and analysis. Pain is defined as the opposite of pleasure. It is the sensation that one feels when hurt in body or mind. Pain is synonymous with suffering and distress.43 Historian Joanna Bourke, in her research on histories of pain and fear, calls on historians to recognize the “centrality of suffering in history.” She acknowledged that healthcare researchers grapple with the idea of pain as subjective. And individuals’ accounts of their own pain have not always been


42 Ibid., 99-100.

believed. Specifically, pain has been racialized: “[t]he ability to feel, both in terms of physical sensation, as well as inner sensibilities, have been ranked hierarchically with white men at one end and slaves at the other.”

Many people witnessed and described the excessive acts of the Memphis rioters. Perhaps there was a conscious belief among rioters that the Black body required several forms of torture to feel pain, or maybe the fear and rage of the riots elicited crueler types of punishments and deaths. The need for White supremacists to torture and kill people stems from their own insecurities and fear of losing power. Fear was thus a central part of this experience for both the perpetrators and victims of the riot.

The events of the Memphis Massacre elicited an endless cycle of fear and rage leading to crueler and crueler punishments, some resulting in death. The fear exhibited by the victims motivated higher levels of rage among the perpetrators, and these higher levels of rage raised the stakes on the kinds of punishments (including death) the perpetrators could use to instill more fear in their victims. The words of the Black women victims and witnesses convey the psychological damage they suffered. This can be seen in Cynthia Townsend’s description of the fragile mental condition of her neighbor Harriet Merriweather after the latter’s brutal rape and subsequent rejection by her husband.

According to Townsend, Merriweather had “sometimes been a little deranged since then.”

Attempts to instill raced-based fear through sexual violence have a long history. In her research on gender, race, and sexual violence during Reconstruction, Lisa Cardyn incorporates uses a broad definition of “sexualized violence. Sexualized violence was rape or attempted rape as well as certain types of whippings, most obviously those in which victims were forcibly stripped of some or all of their clothing. Whippings were also sexualized as a form of humiliation. The vigilantes wittingly correlated power and submission within their political infrastructure; therefore, Blacks in all age groups who lived in the South district of Memphis could fall prey to any form of violence.

The decades following the Civil War were challenging for Blacks. Leon F. Litwack explains, “The behavior of white men and women underscored the tacit assumption most of them embraced with a kind of religious zeal—that neither the Civil War nor emancipation had in any way altered the time-honored etiquette of racial relations.” The journey from slavery to freedom did not live up to expectations for many women, because the health risks from physical, sexual, and emotional abuse were inescapable in the lives of Black women in the city. Those who remained in Memphis in the late nineteenth century were caught in a legal system in which race and gender impacted their physical and emotional health status. The Shelby County workhouse


represented an environment where women relived the desolation of slavery. On June 25, 1879, a Grand Jury Report titled “Bad State of Affairs at President’s Island” detailed dirty beds in filthy quarters with insects infesting walls and bedding. The linen had the appearance of having never been laundered, and based on the offensive smell, the report recommended burying all bedding. The overall condition of the workhouse was extremely unclean, inmates were overworked, and there was not enough food for prisoners.

The similarities between the workhouse and the former plantation system were also evidenced by the work duties and long hours of toil. Prisoners (both male and female) began with a wakeup call at 3:00 a.m., and by 4:30 a.m. they started fieldwork. The workday ended at 7:30 p.m., with a one-hour break. Some prisoners worked past their sentences. An explicit recommendation from the task force was “abolish immediately.” Black women who spent time on President’s Island faced another powerless situation of rigid rules, paternalistic control, mental abuse, and despair. The workforce was mostly men, including the guards. There was minimal medical care rendered by the City Hospital. The medical contract furnished medicine, nursing services, and boarding in an isolated area for $1.00 per day. There was no mention of burial expenses for women who died while serving time on the workforce. The only burial services were for white Marines at a cost of $7.50. Yet the workhouse continued to operate, and Black females were a mainstay, because many had court orders to serve time at President’s Island.

By 1879, Black women in Memphis had experienced a little over a decade of freedom in the city. President’s Island, however, was the new plantation home for Blacks, and ill health awaited them. The work island prison was designed and instituted by General Nathan Bedford Forrest to reverse freedom for Blacks, especially impoverished Black women. Forrest had enjoyed his former life of power and dominance as a slaveholder, slave trader, and Grand Wizard of the KKK. Forrest transformed several acres of land to meet his objective of creating a covert plantation system. He constructed a legal form of slavery, with Black convicts (and a few Whites), both men and women working unpaid to grow cotton. Blacks who could not pay fines or court fees and were sentenced to the workhouse farm, thereby providing labor that was less expensive to maintain than the chain gang. Specifically, the cost to operate the chain gang was $40.00 per day, while with Forrest’s plan the city would pay ten cents per day to house prisoners. Convicts would receive room, board, meals, and medical care. The Public Ledger described the benefit and rationale for adopting the latter plan:

The city is full of vagrants, vagabonds and sneak thieves, principally negroes of both sexes. These are carried to the station-house nightly, and they seem to enjoy it, as it gives them food and rest for several days. When the President’s Island work-house is established it will rid the city of this class of people. The depraved and wicked population will either have to leave the city or be forced to work on President’s Island.”

Convicts were thus accused of purposely committing crimes in order to receive free meals and lodging. City officials voiced excitement about President’s Island, writing,


“This plan takes the chain gang from the street, compels women to labor instead of sleeping in a dark cell and saves the city enough to pay an extra clerk or two if they need it.”

President’s Island was located in the Mississippi River about four miles below the city and contained about 6,000 acres of fertile farmland. News about the island plantation was welcomed by former Tennessee slaveholders and planters because another source of free labor was available. The Public Ledger printed information from a Nashville paper stating that John Overton had plans to lease a tract of land to General Forrest on President’s Island in order to institute a county workhouse. In exchange, a certain number of prisoners from the penitentiary would also be transferred to the island to perform work and other duties. Women were placed on the island under various charges. For example, on August 10, 1875, four women were arrested several times, appeared before Esquire Quigley and charged with vagrancy. Quigley sentenced all the women to the President’s Island workhouse.

Criticism of conditions on the island became common. In June 1882, Mandy Grey, convicted of using inappropriate words towards another person, was sentenced to the county workhouse and fined $2.00. Trivial acts like Grey’s were common causes of

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Black women being sent to the county workhouse. In 1881, a Black woman, described as “a pot colored female,” was making unusual noises such as howling. She had a toothbrush in her mouth, and neighbors perceived her as a maniac. She was sentenced for at least thirty days on President’s Island. There is no description of what this unnamed woman experienced while incarcerated at the workhouse, but existing accounts from other witnesses may give us an idea. An 1880 investigation by Attorney General G.P.M. Turner highlighted the “brutalities perpetrated on convicts in the President’s Island workhouse.” Turner reported that some “convict guards”

with a pertinacity of fiendish rancor, seldom equaled, and certainly never surpassed, have been in the habit—not semi-occasionally, but constantly—every day and almost every hour of every day, of ruthlessly beating, bruising, cursing, and vilifying the convicts, white and black alike and I find the only reason for this devilish cruelty and inhumanity is that the poor convicts are physically incapable of performing the enormous amount of labor required of them by their keepers.  

In 1878 (two years before Turner’s report) there were 125 inmates, with no ages given. Of that total, there were 100 Black males, nine Black females, fifteen White males, and one White female; therefore, 87.20 percent of the inmates were Black. Although the island was gendered Black and male, the labor was non-gendered. Plantation symbols and terminology were common; for instance, E. H. Gillen, the prison guard, was described as a “brutish overseer.” Gillen’s actions involved “riding prisoners on a rail, ‘turning them up and giving injections of turpentine,’ and beating miserable wretches with clubs.


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driving them off which sick and disabled.”

Prison life as described in the local papers was depicted as scenic, with good lighting, fire burning, and places to chat, read and sing. In reality, the nine Black women and one White woman were kept in close quarters with chronically ill individuals and at risk of infectious disease. In 1878, several prisoners suffered from frostbite.”

When Turner delivered his report in July 1880, Black women and other assigned to live at the island had planted 1,025 acres of cotton and 175 acres of corn. Clarification regarding the vast amount of cotton is provided by the following: “Seven hundred and fifty belonged to the workhouse, and an additional 150 was produced by sharecroppers who probably lived on the island. There were 110 workers, and 40 were court assigned convicts.” For two weeks, seven prisoners were bedridden, suffering from a bowel disease.

As Douglas A. Blackmon notes in his book Slavery by Another Name: The Re-Enslavement of Black Americans from the Civil War to World War II, by 1877, mass criminalization of Blacks was a social reality. Many laws that placed Blacks in legal jeopardy did not apply to Whites. With the exception of Arkansas and Tennessee, all Southern states passed laws by the end of 1865 “outlawing vagrancy.” Although Black men were most frequently targeted, convicted, and assigned to prison farms, and their

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labor sold to planters, Black women also suffered this fate. Labor agreements between state leaders after the Civil War replicated ideologies of the domestic slave trade of the antebellum South. The trading of inmates between Mississippi and Tennessee was permitted. In 1868, Mississippi donated 241 prisoners to wealthy cotton planter Edmond Richardson. Three years later, those same inmates worked on President’s Island under Nathan Bedford Forrest.

Still, the lives of formerly enslaved women differed vastly from those of formerly enslaved men. This was evident for those women confined to the President’s Island workhouse. For Black women in Memphis who had survived the horrific conditions of slavery, their health conditions included an enormous burden of psychological and mental distress, especially during and after the 1866 Memphis Massacre. For Black women, the loss of freedom with incarceration at the county’s workhouse was the result of a rapid legal and social backlash to Black progress.

For instance, Mary Farmer-Kaiser describes how freedwomen were constantly harassed for walking or wandering the streets. The moral character of Black women was slighted by association with perceived negative character traits, especially in the case of those who worked as prostitutes. Agents of the Freedmen’s Bureau linked vagrancy and prostitution and chastised Black women for what the agents perceived as provocative behaviors. In addition, men in authority blamed vagrant women for directly exposing

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young girls to sinful practices. Social ideals of motherhood placed Black women at a disadvantage for maintaining the legal rights to their children. For example, questioning parenting skills and accusing Black parents of child endangerment were common legal arguments during Reconstruction. The legal separation of children from their mothers inflicted additional emotional turmoil in the lives of freedwomen. Even the presence of supposedly benevolent government entities such as the Freedmen’s Bureau was problematic.

The Freedmen’s Bureau had an office in Memphis. Black women visited this office to arrange labor contracts for themselves and indentures or apprenticeships for their children. For example, on November 16, 1865, Harriett Green signed a contract relinquishing her right to her child, Virginia Ann Shirley (age not stated) to J. T. Shirley and his wife. It is likely that Harriet Greene and her daughter had been enslaved to the Shirleys a few months earlier. Young Virginia was to indenture until she reached the age of eighteen, during which time the Shirleys agreed to train her as a seamstress, provide some education in reading, writing, and mathematics and safeguard the girl’s morals. Upon completion of service, Virginia would receive fifty dollars in cash and a suit of clothes. Virginia Ann’s situation was similar to that of many formerly enslaved children who re-entered a peculiar form of servitude after the Civil War; for children and their parents, freedom was still controlled, restricted and limited. However, unlike with other Black children assigned to the Memphis office of the Freedmen’s Bureau, Harriett Green

63 Mary Farmer-Kaiser, *Freedwomen and the Freedmen’s Bureau: Race, Gender, & Public Policy in the Age of Emancipation* (New York: Fordham University Press, 2010), 89, 90; Black women faced obstacles in providing financial means to support their children.

was listed as Virginia’s mother. Green was a single mother; on the form, a line was drawn across the word “father” for giving parental consent. In this and many other incidents, the emotional losses of slavery continued, and White Northerners and Southerners in Memphis continued the tradition of claiming Black children as “family.” For many Black women in Memphis, as well as other poor women, parenting was a luxury. Wealth and social values were directly linked with ideals of true womanhood and motherhood. For many freed people, the loss of children remained an agonizing memory in the years following freedom, and the severing of those sacred bonds inflicted emotional losses that remained entrenched in the heart and mind many years after slavery.65

In their essay “Of Broken Bonds and Bondage: An Analyses of Loss in the Slave Narrative Collection,” Anna Laurie and Robert A. Niemeyer analyze the emotional and social losses enslaved people experienced. Using numerous WPA transcripts, Laurie and Niemeyer isolated several distinct types of losses. The authors aim to understand in what ways an event from the past can continue to affect a person over time. Their study used historical research to examine “the ways in which loss was experienced and expressed by African American slaves, and there is reason to believe that loss in this group was a unique experience.” For enslaved people, the status as chattel bonds people to whom human rights were denied provides rich data for historical interpretations of situations that existed only among African Americans. Evaluating 2,300 autobiographical

65 The sale of children was difficult for both parent and child, after slavery African Americans sought help from the Freedmen’s Bureau to locate family members. Many bureau agents understand the desire that former enslaved people had to reunite with family, however some agents were not cooperative. Reports from the Freedmen Bureau cite personal accounts, for example, “one woman wanted to rejoin her husband in Memphis,” re recalled, and another to be forwarded to hers in Baltimore,” Heather Andre Williams, Help Me To Find My People: The African American Search for Family Lost in Slavery (Chapel Hill: The University of North Carolina Press, 2012), 27, 145-146.
narratives, Laurie and Neimeyer found that the most difficult losses related to family. “Of all the experiences participants discussed, losses related to family were overwhelmingly the losses recalled with the most pain.” The memories of family members who were beaten or raped were among the most agonizing and tragic. In addition, “the sale of a family member” was an “unbearable loss.” Laurie and Niemeyer’s study demonstrates the psychosocial toll of slavery, often under-researched by historians of slavery.

John Eaton was assigned to manage the Freedmen’s Bureau affairs in Washington, D.C. In addition, he organized contraband camps. Eaton left written accounts regarding events among freed people in Tennessee and Arkansas. A subheading, “Violent Ruptures of Social Relations,” gives an account of feelings of emotional trauma that slaves masked. Enslaved people minimized the violence of forcible separation. According to Eaton, many Blacks did not disclose events related to separation of family. Perhaps newly freed people did not trust Northerners or Whites in general, or perhaps they felt that elaborating on such dreadful circumstances might have consequences. Eaton reached further conclusions about freedmen while working with them in camps and collecting data from former slaves. For some individuals, interpersonal relationships such as marriage were severed multiple times, in slavery, war, and freedom. In 1864, based on Freedmen’s Bureau Registers from Vicksburg, Mississippi, there were 1,500 marriages.


67 Mary Farmer, Freedwomen and the Freedmen’s Bureau, Race, Gender & Public Politics in the Age of Emancipation (New York: Fordham University Press, 2010), 17.
From a total of 3,000 persons, 567 were systematically separated from husbands and wives by the institution of slavery.\textsuperscript{68}

Eaton was appalled when he discovered that children were also dislocated from parents and sent to live in other regions. The latter practice continued after the Civil War ended. Black men and women informed the bureau officers about the children left behind on plantations and farms. Other dissipations and losses occurred when children were sold and their parents left behind. Eaton explained, “Many of these separations were of mere infants from their mothers.”\textsuperscript{69} The year’s loss and suffering, along with attempts of reunite parent and child, was difficult for Black women. Frances Batson remembered the day sorrow fell upon her and her siblings: “We wuzn’t sold but mah mammy went ‘way, en left’ me en I got up one mawnin’ wennt ter may mann’y’s room, she wuz gon’. I cried en cried ferher. Mah Missis wouldn’t let me outa’ de house, fer fear I’d try ter find her.”\textsuperscript{70} Likewise, Sylvia Watkins remembered that her mother and sister were sold from Bedford County, Tennessee, and relocated. “Mah mammy e two ob may sistahs wuz pu on a block, sold en carried ter Alabama. We neber ’yeared fum dem nomo’, en duno whar dey ez.”\textsuperscript{71} Personal affliction and painful losses became enormous over time.

Historian Jacqueline Jones in her work \textit{Labor of Love, Labor of Sorrow: Black Women, Work, and the Family, from Slavery to the Present} indicated that “the lives of


\textsuperscript{69} Ibid., 92.

\textsuperscript{70} Works Progress Administration, \textit{Tennessee Slave Narratives: A Folk History Slave in Tennessee from Interviews with Former Slaves, Tennessee} (Bedford: Applewood Books), 1.

\textsuperscript{71} Ibid., 19, 25, 38, 76.
urban freedwomen reveal variations on larger themes related to post-war political economy. “Slavery inflicted mental as well as physical atrocities upon Black women. Empathy can become blurred in the historian’s mind, and their work sometimes omits the human dimension. John Eaton did not overlook one of the strongest emotions associated with enslaved persons. Instead, he purposely emphasized it as a prevalent theme in the lives of the enslaved. “We ought to remember the continual fear of such disruption of family ties, in which all slaves constantly lived, especially in the Northern slave states.” To Eaton, after listening to freedmen, the losses seemed unreal, particularly as parents discussed the deaths of children. Eaton concluded that if the Civil War had not occurred, slavery would have ended because of the alarming rates of infant mortality.

Many of those born into slavery migrated to Memphis during and after the Civil War. Mortality rates, social suffering, and psychosocial health problems are too often hidden in Memphis history. Yet, as this and previous chapters have revealed, mortality rates remained consistently high from slavery until after the Civil War. There was a great need for medical intervention and treatment in the Black community, as Memphis would experience a migration of African Americans. The next chapter will examine the development of a Black community that responded to health crises such as tuberculosis. Black women created community health resources, and Black leaders embraced the challenges of racial uplift.


74 Ibid., 92.
CHAPTER 4: Perseverance and Resilience: The Intricate Connections of Health Care

I was hungry, and you gave me food to eat. I was thirsty and you gave me a drink. I was a stranger and you welcomed me.¹

On March 2, 1917, Dr. Charles V. Roman, editor of the *Journal of the National Medical Association* from 1908 to 1918, delivered an address at the semicentennial celebration for Howard University. The title, “Fifty Years’ Progress of the American Negro in Health and Sanitation,” was a refutation of Frederick L. Hoffman’s conception of disease as a racial trait of Blacks. Health, as Roman discussed, was “measured in terms of psychology rather than in terms of physiology.”² He added, “The key to the mortality table is to be found in the educational, economic, and political situation.” C. V. Roman, like most Black Americans, was aware of the racial hierarchy that persisted, especially in the South. His speech went to the heart of the issue: “Segregation is the part of disease and the enemy of sanitation.”³

Dr. Roman’s speech reflected the repressive sociocultural and political conditions during a historical period known as the Progressive Era. Historian David W. Southern describes the ethos of progressives. Progressive leaders tended to have some traits in common. Most “were moral informers who wanted to eliminate greed, vice (especially the use illegal drugs and alcohol, gambling, and prostitution), and political corruption. And once they exposed a wrong, the progressive reform invariably proposed a law to

¹ Matthew, 25:35 (Common English Bible).


³ Ibid., 62.

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squelch it.” The Progressives confronted institutions that they identified as detrimental to American life, including national, state, and local governments, private industries, big business, and health and welfare agencies. Specifically, through political parties, progressives “passed laws that regulated railroads and corporations and broke up monopolies such as Standard Oil, and the American Tobacco company.” Likewise, mandates were enacted “to regulate food, drugs, alcohol, child labor and business competition, establishing regulatory oversight agencies such as the Food and Drug Administration and the Federal Trade Commission.”

However, David Southern admits that progressives avoided and dismissed a ubiquitous problem in American society, “the color line.” Notably, “most progressive intellectuals in fact acquiesced in the consolidation of Jim Crow in the South or simply ignored the race problem.” When race is ignored, African Americans continue to inherit social injustices including poverty, segregation, economic instability and political retaliation. All of these spawns racial division, creating separate and unequal populations. Blacks had to circumvent societal and institutional racism.

Historian Kenneth K. Gaines illustrates a key issue for Black people in the Progressive Era: racial uplift:

Whatever the goals of these civic-minded African Americans—to defend “the race” against its enemies, to bolster their own precarious status, or to accomplish both simultaneously—these intellectuals and spokespersons, as an extension of their duties as educators, ministers, reformers, clubwomen, or journalists produced a vast output of essays, sermons, instruction manual, inspirational success literature, novels, historical works, and autobiographical writings on “The Negro problem” and formed organizations committed to promoting thought and

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5 Ibid., 46.
culture; groups self-help through education and self-improvement, and, at times, political protest on behalf of black Americans.\(^6\)

This chapter will focus on public health issues that affected Blacks, especially women, during the late nineteenth century and early twentieth century. Although acknowledging the general issues of disease, race, gender, and segregation in the South, few studies have considered the health problems of Black people living in the city of Memphis during this period. Racism and segregation fostered a corrupt healthcare system, as noted by federal health audits, a point I will revisit in detail later. The historical span of health problems among Blacks in Memphis correlates with national health problems and public health issues. For example, in Memphis, diseases such as typhoid and tuberculosis caused high mortality rates. To address these health threats, such diseases required a concerted effort among Black middle-class people to create resources that the community could access.

**Progressive Era: Racial Dilemmas in Memphis**

In his book *Memphis During the Progressive Era 1900-1917*, historian Gerald Capers describes the changes that took place in Memphis, along with the social and cultural background of a growing urban city. On July 27, 1900, headlines signaled a time of elation for Memphians. The Washington Bureau of the Census in Washington published a momentous figure: The population of Memphis was 102,320, impressive considering that in 1890 there had been only 64,495 people. Within a ten-year time span, the population increased by 58.6 percent. Tens of thousands abandoned the rural farm life for economic opportunities and changes in lifestyle. However, Capers cautions that in 1900, ideologies of race and ethnicity in Memphis were firmly entrenched, in line with

the values of the Old South. Notably, “of these ideals, the most passionately upheld was that of white supremacy.”\(^7\) Demographic changes in Memphis was visible; “by the end of the nineteenth century African Americans were 55 percent of the population in Memphis.”\(^8\) Whites and Blacks comprised most people in the city; thus segregation created a dual society.

Historian Gloria Brown Melton provides an analysis of Black life in Memphis in her 1982 dissertation *Blacks in Memphis, Tennessee, 1920-1955: A Historical Study*. With racial separation, the city developed segregated institutions. For instance, the parallel “independent religious, educational, social, and political ventures presented blacks with responsibilities not otherwise accorded them in the larger society.” Melton explains that “women’s clubs also formed part of the social network for the black middle-class.” One of the most immediate concerns for the Black community was improvement in health outcomes. It was the collective effort of Black middle-class people, especially club women, who uplifted their race, developed health programs, and collaborated with prominent Black leaders and physicians to aid a sickly Black community in Memphis.\(^9\)

As historian Beverly Bond shows, some Black middle-class women embraced their role as reformers and social welfare activists in their communities. Women such as Virginia Broughton and Julia Hooks “blended a sense of shared oppression with a desire to use the moral authority of womanhood to improve conditions for African

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Yet other historians caution against oversimplifying the complex relations within Memphis’s Black community. The Black community was diverse, and complex dynamics could emerge when the middle-class community attempted to help their poor neighbors.

Historians Kenneth W. Goings and Gerald L. Smith describe the evolution of Memphis’s Black communities between 1890 and 1920. With an ever-increasing population of Blacks, the city acquired a diverse population who shared the same race, but different values and customs. Many Blacks migrated from other places. Goings and Smith details how three distinct communities developed within the larger Black community. First, Memphis had a “talented tenth. Most were educated, wealthy and economically stable, and “achieved elite status in the community.” To address racial division, they sought resolution through political structures including judicial legislation. For the talented tenth, their beliefs were embedded in character-building and being viewed by White society in a positive way. Still another group of professionals were visible in the Black community: the accommodationists. For this group, the ideal of separate but equal was tolerable; therefore, they did not confront segregation or racism. The accommodationist knew their place and desired “harmony.” Finally, a group of Black migrants lived in Memphis, and they resisted and objected to the social etiquette of defined spaces and places. Black migrants had little tolerance for racial indignities and disrespect.¹¹


Ultimately, all Blacks in Memphis shared many commonalities including high mortality rates, minimal access to health care, and a segregated society with minimal interest in their lives. The interdependency of each Black community becomes evident later in this chapter. As suggested by William D. Miller’s description of Memphis in the early twentieth century, investigation the era’s social conditions uncover health problems. An accurate description of Memphis at the turn of the twentieth century was “rowdy.” Saloons, more aptly called dives, were numerous; prostitution and illicit drugs defined the character of the city. Cocaine was highly desired. Miller quotes information from the Commercial Appeal newspaper: “few people can appreciate the extensive use of cocaine in Memphis.” The author estimated that eighty percent of the Black population and “a considerable number of whites” used cocaine to the extent that about a dozen drug stores and several corner groceries depended upon it as their chief item of support.”

Recognizing that news can include an element of propaganda in a racially segregated city, we can still infer that substance abuse was common. With high rates of drug addiction and other diseases including tuberculosis, many people had poor health.

In his book Black Tennesseans 1900-1930, historian Lester C. Lamon details issues confronting Black Memphians during the Progressive era. Black leaders in Memphis, including ministers and politicians, “were not well educated; and the significant black middle class emerged after 1910. There were widespread health problems. Areas on Beale street and near the Mississippi River were unhealthy. Diseases

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such as malaria, tuberculosis, and pellagra were deadly for many residents of all races.\textsuperscript{13} But the fate of Blacks was worse because racism fostered health disparities and adverse health outcomes.

**Black Leadership and Healthcare**

Black leaders in Memphis participated in national health campaigns. Black people-initiated grassroots organizations that operated alongside health programs started by and restricted to Whites. Elaborating on the efforts of Black Women’s club, Historian Ann Firor Scott explains how female benevolent societies and mutual aid programs in eighteenth century Philadelphia, Pennsylvania helped counter the racist policies that prevented blacks from receiving adequate health care. These accomplishments magnified collective understanding of racial uplift in the time of Jim Crow segregation, while enabling Black women to implement community-based solutions.\textsuperscript{14}

Again, the years of 1877 to 1917, known as the Progressive Era, was a period of racial upheaval. Historians identify these decades as the “nadir” in African American history.\textsuperscript{15} In cities across the South, Black leaders, understanding the need for public health services in their communities, sought to unify the Black middle class and provide these services. In Memphis, Black residents increased their cohesiveness through

\textsuperscript{13} Lester C. Lamon, *Black Tennesseans 1900-1930* (Knoxville: The University of Tennessee Press, 1977), 221-222.

\textsuperscript{14} Ann Firor Scott “Most Invisible of All: Black Women’s Voluntary Associations,” *The Journal of Southern History* 56, no.1 (February 1990): 5-6, 10.

networks of churches, newspapers, and lectures. In addition, Black women embraced national ideas of sisterhood in undertaking and answering the call for racial uplift to improve health care.16

In the last decades of the nineteenth century, Black women were instrumental in establishing organizations and clubs to provide health services and to campaign against diseases such as tuberculosis.17 Writing about the development of women’s clubs in South Carolina, historian Joan Marie Johnson noted that by the Progressive Era, White and Black Women’s clubs were active in addressing social reform concerns. Through the federated organizations of the National Association of Colored Women’s Clubs (NACW), Black women “combined self-education with social work to varying degrees, as they sought to uplift the race by promoting respectability and pride in African Americans.” Johnson also noted the divisive nature of White club women who supported segregation.18

Like Black women in other southern communities, those in Memphis joined together to provide social services. However, for Black women in Memphis, the

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17 Mary Church Terrell recounts her speech delivered at the Baptist Women’s Missionary Society in Beverly, Massachusetts. She explained to the crowd that humanitarian efforts were needed to address the dismal health condition and mental anguish of Black women who are detailed in the convict lease system. The address reflected the commitment of Black club women to address the health needs of their race, especially among women and children, Debra Newman Ham, “Foreword to A Colored Woman In A White World,” by Mary Church Terrell (New York: Humanity Books, 2005), 207; Earline Rae Ferguson, “The Woman’s Improvement Club of Indianapolis: Black Women Pioneers in Tuberculosis Work, 1903-1938,” *Indiana Magazine of History* 84, no.3 (September 1988).

Progressive era was not first time they engaged in community reform and health programs. According the historian Kathleen Berkeley, in 1867 the Daughters of Zion of Avery Chapel, a Black church, hired Dr. Toles to provide free medical services to sickly members of their congregation.\textsuperscript{19} Memphis’s history in national reforms enabled Black women to use their voting power to mandate community-based health services and to fight for new public policies that would address the health risks of Black women.

As Dr. Charles V. Roman explained, “the key to infant mortality is to be found in adult mortality.”\textsuperscript{20} Roman recognized that understanding the topic of race and disease meant examining the social realities of Black health. “American mortuary returns reveal no lethal diseases peculiar to the colored people. Tuberculosis of the lungs, the various forms of pneumonia, organic heart disease and infant mortality continue as a major part of our excessive death rate. These are all diseases of crowd and stress.” Roman posed questions that would assist in improving racial health disparities: “Why should not the colored people have their proportionate share of public money for educational and sanitary purposes... why should cities with large colored populations not have colored assistants in the health offices?”\textsuperscript{21}

During the early twentieth century, disease and death rates in many Southern cities were startling. As stated previously, Black clubwomen and other lay leaders organized, educated, and worked toward public health improvements in Memphis.


\textsuperscript{21} Ibid., 66.
Nevertheless, inadequate health care, unsanitary living conditions, poverty, and racism continued to be mainstays in Black communities. At the turn of the century, understanding of epidemiological patterns and demographics of illnesses was insufficient, as city officials seemed oblivious to public health issues. Blatant disregard for the health and welfare of residents and social segregation of Blacks meant that the late nineteenth and early twentieth centuries paralleled the antebellum and postbellum eras in Memphis with regard to quality of life. Recognizing the longstanding health problems and horrendous social conditions in their cities, Black leaders in Memphis, as in other American cities, sought to expose the erratic policies and defective leadership in the city.\footnote{In his analysis of research studies regarding health conditions, Kevin K. Gaines focuses on the work of W.E. Dubois in Philadelphia. Race, in isolation, did not cause increase mortality, but the conditions in which Blacks lived: poverty “and its attendant evils.” Uplifting the Race: Black Leadership, Politics, and Culture in the Twentieth Century (Chapel Hill: The University of North Carolina Press, 1996), 163-164; William D. Miller, Memphis During the Progressive Era: 1900-1917 (Memphis: The Memphis State University Press, 1957); Samuel Kelton Roberts Jr., Infectious Fear: Politics, Disease, and the Health Effects of Segregation (Chapel Hill: The University of North Carolina Press, 2009).}

Across the Jim Crow South, Whites did not view improving the community health of Blacks as a priority. Black leaders took it upon themselves to collect health information and to apply the data to develop community-based strategies for health improvement. In Sick and Tired of Being Sick and Tired: Black Women’s Health Activism In America, 1890-1950, historian Susan L. Smith explored the ways in which Blacks began addressing and reforming health care in the Jim Crow Era. Smith noted that although Black men played a large role in programs such as Negro Health Week, it was Black club women who, through government resources, religious organizations, and public health initiatives, played the most important roles in promoting and improving health services in many Black communities. There was an increase in participation and
membership in black women’s clubs as a result of as a result of the community’s concern about Black health. For example, after Booker T. Washington’s death, Nannie Helen Burroughs, a member of The National Business League and also a club woman, developed a plan to continue activities for National Health Week.23

The National Negro Health Week, initiated by Booker T. Washington in 1915, used the statistics of W.E. B. DuBois who, in 1906, edited The Health and Physique of the Negro American. DuBois focused on racial health disparities, including the fact that forty-five percent of all deaths among Blacks were preventable. DuBois scrutinized the limited number of Black health providers and remarked on the low representation of Black doctors. In the early 1900s, there was only one Black physician for every 3,000 Blacks, compared to one White doctor for every 670 Whites.24 Washington’s plan for national health goals developed nearly eighty-five years before a plan similar to Healthy People, a public health campaign that was initiated by Centers for Disease Control and Prevention.25 Washington focused on the most relevant and urgent health needs of a community and challenged cities to address those issues via education and community


25Healthy People “identifies nationwide health improvement priorities. Increase public awareness and understanding the determinants of health, disease, and disability and the opportunities for progress. Provide measurable objectives and goals that are applicable at the national, States [sic], and local levels. Engage multiple sectors to take actions to strengthen policies and improve practices that are driven by the best evidence and knowledge. The first Healthy People was published in 2000,” https://cdc.nchs/healthy_people/index.htm.
programs. The aim of National Negro Health Week was disease prevention, education, and collaboration, as noted by a quote reported in the *Broad Ax*:

Without health, and until we reduce the high death rate, it will be impossible for us to have permanent success in business, in property getting in acquiring education, to show other evidence of progress. Without health and long life all else fails. We must reduce our high death-rate, dethrone disease and enthrone health and long life. We may differ on other subjects, but there is no room for difference here. Let us make a strong, united pull together.26

On April 11, 1915, Booker T. Washington began a “Health Improvement Week.” National Negro Health Week was a collaborative effort to affirm racial pride and support for recognizing and confronting the horrid public health problems of Blacks.27 Black-owned newspapers served as a source for informing Black communities of the events and goals of the Negro Health Week, and cities such as Memphis welcomed the chance to enhance community education and improve health outcomes. Black newspapers such as *The Broad Ax* and other local Memphis newspapers offered details about Negro Health Week.28 *The Broad Ax*’s editor, Julius F. Taylor, used data from the 1916 *Negro Year Book*, writing that at least 450,000 Southern Blacks were “seriously ill all the time.” He estimated the economic cost of diseases and illness at $75,000,000, while the 112,000 Blacks who had ongoing or chronic health problems resulted in lost wages of $45,000,000. He proposed that the Black communities in America unite again for a


28 *Broad Ax* (Salt Lake City, Utah) was founded, published, and edited by Julius F. Taylor a former slave. Taylor’s parents and other siblings had early been sold to different owners but remained in close distance. *The Broad Ax* was published in Salt Lake City and Chicago. The first issue, published on August 31, 1895, carries the motto than remained with the paper unit it ceased in 1931: “Hew to the line.” From Library of Congress. http://www.chroniclingamerica.loc.gov/lccn/sn84024055/.
National Health Movement. The invitation was for all organizations who shared an interest in improving the health of Blacks to participate. Taylor called for the following to partake in disseminating health information:

newspapers, journals, the National Medical Association, the National Association of Colored Graduate Nurses, the National Association of Colored Women’s Clubs, the National League on Urban Conditions Among the Negroes, the National Association of Teachers in Colored Schools, the Negro Press Association, the bishops, and other officers of Colored religious denominations, state medical associations, annual church conferences and associations, secret society organizations, colored insurance companies, farmers’ improvement societies, churches, schools and other local organizations state health officers. 29

On December 22, 1917, nearly one year later, the _Broad Ax_ reported on the success of the 1916 National Health Week: “Short Review of the Annual Report of the National League on Urban Conditions Among Negroes. The Report shows Year of Big Achievement.” For Julius Taylor, the social and health conditions of the Black migration deserved attention—in 1916, more than 300,000 migrated to Northern cities. Taylor’s article informed readers that “A national Negro Health Week was observed in the effort to reduce the high rate of mortality among Colored people.”

The South’s prominent cities received prizes; for example, Atlanta won the first prize for “best organized,” in addition to achieving a large participation rate of close to 40,000 Blacks. Several other cities received special mention, including Memphis. But Taylor remarked that Memphis differed because “Substantial groups of white and Colored citizens are banded together to work for better communities under the League’s

emblems, ‘Not Alms, but Opportunity.’” The onward striving for improvement among Blacks in Memphis focused on women and children. Female religious leaders and clubwomen were a key part of this. Women in Action

Mary Evins’ *Tennessee Women in the Progressive Era, Toward the Public Sphere in the New South* elaborates on several aspects of social reform in the Progressive Era. It adds to various types of history including social religion and the role of women in church movements. Methodist women such as Belle Bennet used lay leadership roles to advance the cause of the Social Gospel movement. The Women’s Missionary Council (WMC) of the Methodist Episcopal Church was like other female organizations such as the YWCA; members of such organizations were often referred to as “clubwomen.” For both clubwomen and those affiliated with the YWCAs, public health along with other social issues that affected children and women emerged as goals of committee leaders. However, the WMC, both Black and White, began in small church settings and broadened social changes that tackled worldly injustices.

The WMC was formed to support families who relocated during the Westward expansion. Highly religious, Bennett understood the necessity for interracial social

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reform that crossed lines of Southern race relations. She taught Bible study classes at an African Methodist Church in Kentucky that had a membership of over 500. Women in the Methodist Episcopal Church (MEC) relied on publications such as *Hour Homes* and *Missionary Voice* to express and encourage “home mission work for blacks.” By 1920, the work of the WMC appeared in publications discussing horrific accounts of lynching and the urgency of developing educational programs at settlement houses sustained by MEC. By 1900, the city of Nashville had the country’s largest population of Southern Methodists. Nashville’s programs that evolved from the WMC included a settlement house known as the Wesley House that supported White workers and immigrants. A Wesley House was also developed in Memphis.  

Established in 1913, the Wesley House in Memphis was supported by the wealthier White philanthropists and contributions from Methodists. Fundraisers often included private concerts. The Wesley House was named after John Wesley, founder of Methodism. Services at the Memphis Wesley House included “the opening of the kindergarten, sewing school, the carpentry club, the mothers’ club, the happy hour cub, and the junior boy’s club.” On May 20, 1920, the Wesley House was in the process of moving to a larger building. The current address on June 23, 1920 was 592 North Second Street.” The Wesley House “ministered to hundreds of families in Memphis, providing a

33 Ibid., 24.
34 Ibid., 26-27.
free kindergarten, a day nursery, and most important a free clinic.”

There were other Wesley Houses in Tennessee. For instance, in 1919 the Women’s Missionary of Wisdom Memorial Church purchased a location for their Wesley House. The goals were to “aid the poor and needy and to brighten their lives.” A news article also noted that “there are Wesley houses in a number of cities where they are doing fine work.”

The mission of the Wesley house was like that of the Hull house, founded by Jane Addams. The Methodists clearly stated that the rationale for these programs was to take up social needs of various communities. The first item that appeared for public disclosure was “$2,850,000 to maintain work among mountain people, negroes, industrial centers, and neglected inhabitants of cities of the South.” Money apportioned for the home mission department, in conjunction with the women’s work, totaled $1,290,000. In addition to the management of Bethlehem Houses, the latter aided in developing new Wesley Houses and improving and enlarging existing Wesley Houses. Due to social conditions, economic plight, and poor health, the neediest groups in Memphis during the early twentieth century continued to be Black women and children. Yet, by criteria of ethnicity, Blacks could not take advantage of these Christian services, because even religious clubs were segregated.


Likewise, the Methodist Episcopal Church founded the Bethany Training School. The training school was located at 901 Chelsea Avenue, and Reverend A. J. Vallery was the superintendent. One campaign effort raised $4,200 for the home and training school, the funding of which allowed for a home that cared for “unfortunate girls [who] would otherwise be thrown upon the streets.” On May 29, 1919, the Bethany Training Home housed approximately fifty unfortunate girls and babies, and there was a waiting list of other young girls who needed a home. The public was asked to donate cots and beds, and, within eighteen months, the training school accommodated 180 forsaken girls and 109 babies. It was noted that many girls had been reformed, several had married, and most had been forgiven by their parents.  

The Bethany Training facility also housed young women who were mentally unstable. For instance, while living at the Bethany school, Elizabeth Hudson, age 18, attempted suicide by ingestion of yellow mercury, or carbolic acid. She later recovered and was transported back to the Bethany Home.  

Clubwomen in Memphis received both formal and informal support through various means. The Board of Directors was gratified by contributions that arrived from local Memphians, along with individuals from Arkansas and Mississippi. It is difficult to determine if the Bethany Training School accepted all races of young women based on advertisements and descriptions. However, in the Jim Crow Era, the mixing of races in social places, spaces, and living quarters


countered Southern racial etiquette. Christianity in the age of segregation exposed racial injustices among Godly people.

Nevertheless, Black civic leaders and middle-class women persisted in answering the challenges of Memphis’s Black community. T. O. Fuller, the pastor of the First Missionary Baptist Church, was described by G.P. Hamilton as “a man of good judgment, prudence, and fearless action in the right. He is not a radical or extreme in any respect but on the contrary his mind leads toward conservatism and tolerance of other people’s opinion besides his own.”

Further, Hamilton explained an attribute that functioned as a prerequisite for educated and respected Black men in Memphis: “The peculiar conditions affecting the races in the South require men that are anxious to promote the spirit of harmony, peace and good will between the two races.” Fuller was, compared to Booker T. Washington, a leading “apostle of peace among the colored leaders of the South, and he has an influence with the good people of other races that is second to no other colored man.”

During the 1920s, Memphis housed no Black newspapers, but The News Scimitar regularly disseminated material about civic events, Black leadership, and club movements.

T. O. Fuller published a column in the city’s The News Scimitar titled “Negro Activities.” The issue of racial segregation in the city permeated social activities, organizations, and gender. Black leaders in Memphis advocated for separate organizations to meet the social, economic, and health concerns of twentieth century Blacks. Numerous White women’s clubs and other organizations provided services to

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42 G.P. Hamilton, The Bright Side of Memphis (Memphis: Burke’s Book Store, 2003), 140.
43 Ibid.
44 Ibid.
White Memphians, and Black clubs and organizations provided similar services to Black Memphians. Black and White clubs shared some common features such as similar names and goals of the organizations, but race nullified the possibility of coming together for the greater good of all residents in Memphis. For example, as the Wesley House and Bethany Training School structured a program for wayward White girls, T.O. Fuller suggested that Black clubs develop a similar program.

On July 27, 1920, Fuller described and praised The Phillis Wheatly Association in Cleveland, Ohio, which was organized by Jane E. Hunter, a Black woman. Fuller explained that the Wheatly Club had a membership of 1,200, with a membership fee that ranged between $1.00 and $100.00. In addition, “they now have a plant valued at $85,000, and cared for 374 girls over a 9-month period.” About 500 girls received placement to improve their lives. Fuller suggested that a similar program was needed in Memphis, and that the Industrial Settlement Home on South Drive under the care of Bessie W. Simon seemed most appropriate. The Industrial Settlement Home began offering services to Blacks in the community in 1915. Like the Bethany Training School, the Industrial Settlement Home provided multiple services in one location. The Industrial Settlement Home solicited the Black community for support of socially and economically disadvantaged Black females. In addition, the school offered industrial classes for Black females.

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boys and girls. Simon traveled to raise money and bring awareness of the benefits of the Industrial School.

The White community celebrated the services of many Black organizations, such as in the editorial “Great Activity Is in Evidence Among Negroes: Local Churches and Schools, and Development Work Among Leaders Show New Era of Well Directed Energy.” The Industrial Settlement Home was organized to improve or better the community and to offer social uplift for young Black boys and girls. Another organization similar in name, The Settlement Home, was on the outer eastern region of the city. Laura Anderson oversaw care for children whose parents worked as domestics. The club received financial support from Black and White individuals.46

**Black Women’s Social and Political Duties**

The social health concerns of Blacks, especially women and children, required the support of all Black communities. The poor health of Blacks was a constant, and addressing this issue required sound plans, objectives, and interventions. As historian Paula Giddings explained, “health conditions among large numbers of Blacks was so perilous that an 1899 conference at Atlanta University concluded that if conditions weren’t improved, the race could actually be destroyed.” Giddings also suggested moral development and education to alleviate poverty, an approach that occupied American social thought during the Progressive Era. Clubwomen who embraced the idea of health improvements included Lugenia Burn Hope. In 1908, Hope organized and united middle-class Black women whose spouses held faculty appointments at Atlanta University into

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the Atlanta Neighborhood Union. The health efforts of the clubwomen in Atlanta emphasized the importance of public health. Such efforts included installing sewers and making improvements to homes as well as starting a health clinic that would treat communicable disease like tuberculosis and offer additional services for women and children. The Black clubwomen in Memphis also energetically formed various groups to unite a struggling race for improved health outcomes.

In 1919, Black women in Memphis established the City Federation of Women’s Clubs. On August 26, Mrs. Isaac Reese delivered an address advocating for better schools and a cleaner community. As the clubwomen embraced their role as civic leaders and health advocates, local physicians offered their private residences as meeting places for Black women. Dr. A.D. Byas, who lived on Ayers Street, invited Black women to assemble in his home. Clubwomen undertook concerns that threatened social advancement for Black Memphians. Promoting healthier lifestyles for underprivileged Black populations was a major goal of all women’s clubs. T.O. Fuller’s December 10, 1919 column announced, “the women’s clubs co-operation in the anti-tuberculosis drive meet at the community center, 401 Beale Avenue, at 2:30 o’clock Thursday afternoon. Among the clubs expected are the Child Welfare, Hiawatha, Ruth Circle, Postal Clerks, Alliance, Rosary Art, Phillis Wheatly, Ladies’ Aid and Industrial and City Federation and all teachers.”

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Many local women’s clubs responded to national pleas for better public health conditions among older African Americans. However, Child Welfare concentrated on children’s health conditions in Memphis. It is necessary to acknowledge how segregation affected the lives of Black children, as well as their physical, social, and mental wellbeing. Though Black children lived in close proximity to White children, the living conditions for Black children were deplorable. Therefore, Black leaders accepted the challenges to enhance the lives of Black children. On December 23, 1919, Madame Bessie Graves requested aid for the Child Welfare Club. Any gifts or works through the organization “gladdened the hearts of needy children.”

A large gathering was expected for a club at a meeting during the summer of 1919 at the home of physician J. T. Wilson, “as there is much to be done at this particular time for the health and happiness of children.” Women’s clubs, like other social institutions in Jim Crow era, were demarcated by race. For example, the Girls Welfare Club, under the patronages of the Nineteenth Century Club, was under the leadership of White middle-class people who rendered charitable contributions. Mr. Clarence Saunders gave $500.00, and Mrs. Thornton Newsum “pledged to collect 10 percent of the $2,500, the amount which the committee has set for its goal.”

The Black middle class of Memphis endeavored to support many club movements; however, the distribution of wealth based on middle-class education and

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careers did not equal the same pay for the same degrees or occupations as for their White counterparts. Even when Black elites responded and supported the economic needs of destitute of their race, Jim Crow was harsh to the Black elite. In addition, the needs of the Black community far exceeded those of Whites due to racial and economic disparities. Likewise, Black club leaders in Memphis sought to care for diverse groups of marginalized people. Black professionals found the population of poor elderly Blacks challenging to assist, as basic equipment was needed. For instance, in 1919, The Old Folks Home located on Hernando Road required basic things such as “two stoves.” T. O. Fuller agreed to have the stoves delivered and requested benefactors to call him directly as even used stoves were appreciated.

Although the Black middle class responded with compassion and strength, the city was a cesspool of disease that had its roots in an inadequate political landscape. The city’s poor suffered astounding health disparities, but all citizens were at risk for developing diseases and illnesses that were largely preventable. The city lacked an organized public health department, when many other Northern and Southern cities moved forward to safeguard the wellbeing of their residents. For instance, the city of Richmond was appalled at mortality rates, especially among its Black residents. The city investigated and hired a full-time Chief Health Officer of the city. Primarily, civic leaders

52 Shomari Wills, describes the violence and disgust that some White people enforced against millionaire Robert R. Church, “he had been pelted with rock by racist for having had the audacity as a black man to be the only man with a sled,” Black Fortunes (New York: Amistad An Imprint of HarperCollins Publisher), 183; Comprehensive research on Robert R. Church see; “The Gentleman from Memphis: Robert R. Church Jr., and the Politics of the Early Civil Rights Movement,” (PhD diss., The University of Memphis, 2011), ProQuest Dissertations & Theses Global.

and government sought to eliminate the image of Richmond’s health status because mortality rates were “higher than that of any city its size in the county.”

The long history of local White newspapers and city officials minimizing, and distorting health records and mortality data led many Progressive-era newspapers to critically reflect on the data these publications and officials delivered. Statistically, homicides were intertwined with mortality rates in most reports instead, of there being a separate category for mortality caused by diseases. Black newspapers ridiculed Memphis’s failure to resolve crime and public health issues. Specifically, The Broad Ax noted that in 1916, although Memphis was in a prohibition state, the city had the highest homicide rate “both for the ten-year period and the year 1914.” The editor explained, “Memphis, which has been notorious in this matter for years, has urged in mitigation, first that she has a large colored population, and second that a great many persons wounded in the feuds of the Mississippi bottom country, of which she is the metropolis, come to her hospitals and die.”

The closing remarks in the Broad Ax explained that Memphis, in the decade of 1904-1913, showed a homicide rate of 63.7 per 100,000. By 1914, the rate increased to 72.2 per 100,000. The historical blaming and scapegoating had been constant since the

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56 Ibid.

57 Ibid.
antebellum era. Memphis was a city that the nation frowned upon as its political leaders
turned away from the visible signs of disease, destitute living conditions, and high death
rates. Health became political.

Men seeking the office of mayor realized this. Edward H. Crump (“Boss Crump”) was known across Tennessee for his refusal to enforce state laws, including probation. Prior to becoming mayor of Memphis, he had served in the Tennessee General Assembly. Memphians and other Tennesseans knew Boss Crump and the mayors who came after him. In Memphis, the 1919 mayoral election featured women voters who demonstrated little tolerance for any candidate who had corrupt political ties to former city mayors. The victor of the election inherited the city’s pitiful health adversities. Health statistics from 1918 give bewildering data compiled by Dr. J. L. Andrews, Superintendent of the Health Department, and by F. A. Mantel, city chemist and bacteriologist in 1918. The explanation of communicable and deadly diseases such as tuberculosis was as follows: “Owing to the loss of two veterinarians to the army service, the tuberculin testing of dairy cattle has been delayed.” Due to ongoing food inspection, over 601,488 pounds of food were condemned and destroyed.

Meats included beef, pork, and pork cuts, many of the latter in cold storage. Unclean milk and milk products were knowingly being sold to the public—two dairymen offered bribes to city personnel, which were later brought to a grand jury. Certain foods, especially butter and country butter, were found to have bacteria and mold, which is particularly disturbing since typhoid and tuberculosis bacilli “can live in butter for

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months and so transmit their respective diseases.”

Memphis was in dire need of political leadership and improved strategies to combat its public health crisis. Mayoral candidate J. Rowlett Paine planned to reveal his plans to revamp and expand healthcare for Memphis’s citizens upon election.

Paine’s political platform committee proclaimed that “The name of this organization shall be ‘The Citizens League of Memphis,’ and all patriotic men and women of this city, who desire to assist in the promotion of the public welfare, are invited to become members.” In addition, “all citizens are vitally concerned in the matter of public health. There shall be adopted modern health measures and an enforcement of health ordinances.” The Citizens League of Memphis functioned as a campaign organization. Paine and those who sought office on his ticket promised that “the Streets, Bridges and Sewers of the city shall be kept in repair and the water and sewages systems should be extended to annexed territories. Public works shall be under the direction of men skilled in these activities, rather than of men appointment for political reason.”

The above promise would be fulfilled, as Paine became mayor because women demanded a change.

The first line in The News Scimitar’s article “Why The Women Demand a New Deal” revealed a change and shift in voting power and politics. According to the article, “One of the chief reasons why the women of Tennessee were granted the suffrage was the belief that they would lift public affairs out of the mire of politics.”

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59 Report of Board of Health, City of Memphis, January 1, 1919, 27.


61 Ibid.
White women in Memphis circumvented the status quo, abandoned traditional political lines, and embraced change for the betterment of public concerns. Given the right to cast their votes, women explained how they would accomplish change, and why they supported candidates who had no previous ties to a city leadership with a history of corruption that disregarded the health of the city. “These good women knew,” according to the article, “they could never attain these ends most dear to them through the old factional alignments and they instinctively revolted at the allure and crookedness of machine politics.”

Voting did not sway White Memphians to include Blacks in the city’s politics and social life. In Memphis, the institutions that cared for the sick and downtrodden showed no sympathy for Blacks, and a new Mayor could not eradicate racism and poverty. Crump created lasting difficulties for Blacks in Memphis. As mayor, Crump blamed Blacks for the city’s high crime rates and vagrancy to the point that “every Negro found on the street after midnight was arrested.”

According to historian William D. Miller, Crump’s administration supported Memphis’s business community and was determined to destroy the vast social upheaval of “sin,” which the mayor considered a “social disease.” Yet Miller pointed to several failures in Crump’s progressive reform program. Essentially, “public health was far from achieved,” and the social conditions of the city remained in turmoil. In 1919, Black clergy regardless of denominations planned to hold a “mammoth meeting in the near

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future to prepare a program for the uplift of their people." There is no exact report about local clergy meeting; however, a crowd gathered on April 22, 1919 at Avery Chapel to hear the famous William Singers. It was also reported that Pastor Vernon was “doing big things” for the church. Black religious leaders recognized the need to discuss race relationships and ways to improve living conditions in the Black community. On January 27, 1919, T. O. Fuller announced that Memphians had “some very important community problems,” listing poverty, ignorance, disease, crime, labor and race relations. The pressing issue for Blacks was the insurmountable task of disease and poverty in a racially divided city. There were no expectations that a change in the political landscape would improve health outcomes for Black Memphians.

Elite White female club members, many belonging to the Nineteenth Century Club, pushed an agenda for Progressive reform. In *Elite Women and the Reform Impulse in Memphis, 1867-1915*, historian Marsha Wedell explained that reform was on the minds of women in relation to social injustices. Organizations such as the Nineteenth Century Club were vehicles for that effort. Like many Southern organizations and institutions, the Nineteenth Century Club developed later than its Northern counterparts. The clubwomen created a wide array of clubs under the auspices of the Woman’s Council. In 1908, the Nineteenth Century Club addressed the moral behavior of White men and considered the establishment of The Civic Progress League part of their agenda for Progressive reform. Interracial collaboration on a limited scale was part of their agenda. Black women such as Julia Hooks were ideal as leaders because she understood the needs of the Black

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community. She organized and collaborated with Black and White leaders. Hook’s passion was the well-being of Black children. When she accepted an invitation to speak at the Nineteenth Century Club, Hooks spoke to her White counterparts about meeting the needs of incarcerated people. Hooks appreciated and thanked White women for addressing the police matron issues. Wedell felt that this reflected shared understanding of women’s issues that crossed racial lines. According to Wedell, Black and White women shared gender issues in a male dominated city.66

Yet female social clubs in Memphis maintained separate memberships, particularly when race problems were evident.67 The joint effort for social betterment transcended race to an extent because clubwomen of multiple races transgressed boundaries set by men to improve the welfare of Memphians. Black men supported many of Black women’s ideas for racial uplift and advancement. Cooperative fundraising events targeted both Black and White communities. Blacks used their music talent. Beale Street was the center of Memphis’s Black entertainment and professional businesses. In 1920, a large crowd attended a concert by W. C. Handy’s blues band to benefit the Child’s Welfare Club at Church’s Auditorium.68 Black Memphians worked together for social advancement, first and foremost for those in need, and with women as leaders.


67Evelyn Brooks Higginbotham describes the problematic issues of race and gender in the Baptist church. Recognizing the importance of their lives as being Black and female women advocated for rights, Higginbotham describes topics that Black women acknowledged and aspired to change including self-help, and segregation. Other organizations emerged including the Women’s Convention (as part of the National Baptist Convention), Righteous Discontent: The Women’s Movement in the Black Baptist Church, 1880-1920 (Cambridge: Harvard University Press, 1993), 74-75; Gerda Lerner, “Early Community Work of Black Club Women,” The Journal of Negro History 59, no.2 (April 1974).

Julia Hooks gave concert performances at the Church Auditorium to raise money for the support of community endeavors, such as a home to care for destitute children and elderly. 69 Black men praised Black women’s clubs for taking the lead in social uplift. The clubs were revered and acknowledged with expressions of gratitude, particularly when providing protection for girls of their race. A considerable number of rural Black girls arrived in Memphis monthly seeking opportunities for employment, and clubwomen often advised adolescent girls about suitable places in the city. As historian Beverly Bond explains, progressive women like Virginia Broughton and Julia Hooks initiated reform programs to improve social welfare within their communities. Black women were change agents within the arduous confines of Jim Crow. 70

**Challenging Racism and Segregation: Health Advocates**

Wedell’s depiction of the Nineteenth Century Club as a vehicle for improvement of health and social reform is well-founded. Elite White women adopted health issues, particularly unhealthy sanitation and tuberculosis, as the focus of their reform activities. The Nineteenth Century Club created a department of philanthropy; its function involved women working with the city’s health board. One of their goals was to make the part-time position of health inspector a full-time appointment. A former health inspector, Dr. Andrews, suggested that a woman health inspector would be beneficial based on gender conventions and ascribed social roles. Women were thought to be naturally skilled at detecting unhealthy and unwholesome environments.

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Beginning in 1916, clubwomen assumed the painstaking task of improving city sanitation, primarily by supporting efforts to educate the public regarding tuberculosis. The Shelby County Tuberculosis Society, a joint effort between clubwomen, the community, and patients, built a new tuberculosis hospital, but with Blacks housed in a separate building.\textsuperscript{71} Despite the impact of the disease on Black communities, neither White women’s clubs nor the city or state government addressed the exclusion of Blacks from treatment for infectious and communicable diseases. The same was true for other cities during the Progressive Era. For example, by 1917, state and county government in Indianapolis, Indiana had three facilities to treat TB patients, but neither cared for Black people. The State Board of Health ignored the death rates for TB that disproportionately affected the Black race.\textsuperscript{72} Within the context of Memphis’s health history and the effects of disease among Blacks, TB deserves special consideration and focus.

Racializing TB in Memphis

In 1920, The Shelby County Treasurers Office was excited about a surplus of $500,000, which included $375,000 earmarked for a TB sanitarium for which the community advocated. The facility would manage and treat patients who had contracted the deadly disease.\textsuperscript{73} Shelby County, like other regions in the state, embraced the national concern for fighting TB, which was given a term “The White Plague.” The following newspapers published in Tennessee highlight the facts of TB within the state. On

\textsuperscript{71} Marsha Wedell, \textit{Elite Women and the Reform Impulse in Memphis, 1875-1915} (Knoxville: The University of Tennessee Press, 1991), 94, 95.


November 14, 1919, the _Camden Chronicle_ informed readers about the extent of tuberculosis in America: “the figures show that each year 150,000 persons die of the disease and that there are approximately 2,000,000 cases of tuberculosis in the United States today.” Similarly, in 1919 the _Greeneville Daily Sun_ disclosed that there were over 45,000 cases and 4,500 deaths annually. At the beginning of the twentieth century the cause of death for one out of every four persons between twenty and fifty was TB. In 1919, tuberculosis “cost the United States in economic waste alone about $500,000,000 annually.”

For some, the dollar value of tuberculosis and the financial burden of the disease brought on a renewed commitment to the defeat of its existence. The article continued to inform local citizens that TB was curable (instead of describing it as preventable), noting that “it is spread largely by ignorance, carelessness and neglect.” The above was a commonly held belief within the circle of the White middle class. It was a part of an erroneous notion that the educated, clean living, and morally upright were immune to the disease. Historian Earline Rae Ferguson points out that state officials asserted that death rates from TB were higher among Blacks because they did not follow sanitary laws like

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Whites. Again, the language of Blacks being ignorant or blatantly disregarding public health laws played a major role in racialized health services.

The influence of race and TB was often examined and documented in research articles by Black physicians during the late nineteenth century. Historian Todd L. Savitt gives a brief biography of Dr. L. L. Burwell that includes clinical observations and rationales for the magnitude of deaths associated with tuberculosis in Blacks. Dr. Burwell’s article appeared in the *Medical Surgical Observer*; a medical journal published by Miles V. Lynk. Although Burwell made assumptions about disease progression and virulence of disease patterns in relationship to miscegenation, his beliefs did not differ from those of other leading medical providers of his time. Still, in his article “Consumption Among the Colored Race,” Burwell discussed tuberculosis within racial and socio-cultural actualities. For Burwell, Black people faced the atrocities of a social disease as much as bodily disease because poverty and segregation hindered their ability to receive adequate medical care. Environmental causes such as poor housing, lack of basic clothing, limited resources for hygiene, and overcrowding from urban living allowed bacilli to spread.

While the nation referred to tuberculosis as the White Plaque, a truthful connotation of TB was that it was a disease of poverty, in that the poor had social and economic conditions that delayed diagnosis and worsened prognosis. Regardless of race, TB contagion found its way through the racially segregated city of Memphis. Education,

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money, and health programs could not eliminate tuberculosis and other contagious diseases that festered in the city. It is crucial to recognize how, in a segregated society, health is politicized, and the social ills of poverty, racism, and poor health are linked.

**Accomplishing Change Through Voting**

Radical political transformation across the nation granted power to Black and White women. Voting had its privileges; therefore, civic changes and betterment of humanity was an agenda that women championed. A caption heading in *The News Scimitar* on October 16, 1919, asserted in capital letters, “Women’s Votes Are Needed to Offset Negro Registration.” The author noted with concern that “in the downtown wards where negro women live unlawful lives, hundreds of negro women are registering by orders of the police, perhaps to coerce and threaten Black women to vote for a particular candidate.”

Many Whites feared that most Black women would vote for the incumbent J. J. Williams. Blacks registered to vote at various types of clubs and saloons in the Sixth Ward and at the DeSoto Hotel. A Black woman, dressed nicely, calmly stated that she would vote for Williams. Word of mouth by friends and other associates encouraged

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80 Eleanor Flexner recognizes how of issues of race, class, and gender shape the social political circumstances of women’s suffrage. Noting that educated Black women like Mrs. Josephine St. Pierre Ruffin. Ruffin graduated from Harvard Law school and was active in the suffrage; in addition, she founded the New Era Club, after being denied delegate status at General Federation of Women’s Club. *Century of Struggle: The Woman’s Rights Movement in the United States, Revised Edition* (Cambridge: The Belknap Press of Harvard University, 1975), 195-196. Research conducted by historian Rosalyn Terborg-Penn placed Black women as active club members, and leaders who worked for suffrage. Black women countered racism among White women and their desire to deny Black women equal participation in voting rights. Racist attitudes towards Black women were expressed in a speech by Mary Church Terrell. Also, Black women were encouraged to support issues over their political parties, *African American Women in The Struggle For The Vote, 1850-1920* (Bloomington: Indiana University Press, 1999), 94, 158.

women to elect J. J. Williams.\textsuperscript{82} Unlike a coalition formed in Nashville between Black and White women associated with religious organizations including the Colored Methodist Episcopal and the Methodist Episcopal Church, these Black women displayed cohesiveness in the public sphere and shared political aspirations to rid the city of corrupt politics. The goal for Black and White women in Nashville was to vote for reform.\textsuperscript{83}

Basically, in Memphis, White middle-class men surmised that Black women, being inherently corrupt due to their lack of moral character, would vote for a crooked mayor. Newspaper headlines discussed Black women in contemptuous tones: “the registration of vicious negro women under orders of the police, continue in the six or weight wards where Blacks mostly live. The votes of the lower classes of negro women, those who ply a trade as old as the world, are being corralled for the Williams ticket, and there will be several hundred such votes.”\textsuperscript{84} For White men, the reality of White female power through voter registration was not entertained until Black females took advantage of the political opportunity that was given to them. Subsequently, uneducated, marginalized Black women were singled out as a threat.

Whites overlooked the fact that middle-class Black leaders were influential in mobilizing poor Blacks to elect a mayor. The vote represented a form of racial and gender equality that was unsettling for White men and women. Most articles published in newspapers omitted authors, and editorials were racial propaganda and served as a


\textsuperscript{84} “Registration Is to Close Friday, \textit{News Scimitar}, October 17, 1919, From Library of Congress. \url{http://www.chroniclingamerica.loc.gov/lccn/sn98069867/1919-10-17/ed-1/seq-1}.
caution and warning about a large group of Black women voters.\textsuperscript{85} Historian, Beverly Bond explains that Blacks recognized “the disfranchisement of black men was, in effect, the disenfranchisement of all African Americans. In the same way, that enfranchisement of women held the potential of bring thousands of black families back to the electorate.”\textsuperscript{86}

Voting districts for Black women in Memphis were published nearly two months before the November 7, 1919, mayoral election. The headline read, “Negro Women Own One Ward In City, First Precinct, Eleventh Ward shows 215 of Them Registered to Vote.”\textsuperscript{87} The public understood that Black females dominated early voting registration in the 11th ward, with 215, and only forty-eight White women completed the voter registration process. However, in a different area, the second precinct of the 17th ward, 292 White women registered, as compared to eighteen Black women. The coverage implies that Black women had a larger voter registration than White women. The interest of women who lived in the county represented additional unease, as their votes mattered. Eighty Black women residing in the West End, specifically the sixth district, registered to vote, yet only six White women were listed for the above district in the county area. The total registration during the earliest months preceding the election was 5,887 White men and women and 1,826 Black men and women.\textsuperscript{88}

\textsuperscript{85} Ibid.


\textsuperscript{88} Ibid.
After the challenger, J. Rowlett Paine, won the election on November 7, 1919, the path to his victory was analyzed by an editor working for *The News Scimitar*. One salient fact was that J. J. Williams had more votes in Wards 1 through 12, described as the old regions of downtown and part of the Pinch precinct. Though as noted by *The News Scimitar* only by a small majority, “in spite of the repeating of the voting of uneducated negro women and various elections frauds.” A total 6,000 women voted, which secured the election for Paine.\(^89\) With a small margin determining the outcome of Williams in predominately Black districts, one can conclude that Black women and White women were eager for change and progress for their race, especially children. Most citizens in Memphis, regardless of race, desired public health, sanitation, and social hygiene.

As discussed earlier, the fear of Black women voting was not limited to Memphis. Nationally, White women opposed mutual respect and were reluctant to cooperate with Black women to achieve political goals, even if sometimes it was inadvertently achieved, as in the election of Paine. Throughout the South, Whites reacted harshly to the right for Black women to vote, especially as Black middle-class women organized voting leagues to assist their race with voter registration. Several states—Alabama, Georgia, Maryland, Florid, Tennessee, and Texas—also aided Black men in maneuvering through the racial barriers for voting. Regardless of their struggles, Black women’s ideas for voting was based on the conviction of “speaking on behalf of the more downtrodden women of their

race.” Even if Black women in Memphis were socially invisible, voting for a candidate who promised to address the needs of Memphians seemed promising.  

When interviewed after the election, Paine explained that he won the mayoral election “by the good men and women of Memphis.” Paine acknowledged the necessity to move forward and to serve as a leader for the city. Putting the 1919 election into context, the News Scimitar reported, “Mr. Paine and our other candidates carried every strictly residence ward in Memphis, and that the wards in which our opponents got their votes were those in which the old political methods could be used for controlling the voters.”  

For the health, welfare, and safety of all citizens, mayor elect Paine undertook the task of addressing public health dilemmas. Within one month of beginning his duties as mayor, Paine traveled to four large cities that developed and implemented departments of public health: Boston, New York, Washington, and Chicago.  

On December 3, 1919, The News Scimitar reminded the city of pre-electoral promises, because Paine “regarded the question of sanitation and public health, and the prevention of disease as one of the most important ones with which he will be called upon to deal during his administration.” With a public health system in havoc, Paine realized that the city needed experts and well-trained personnel. The challenge was finding someone to work for an annual salary of $3,600, a low salary based on the responsibilities. Upon returning, Mayor Paine met with the Memphis and Shelby County Medical societies, which excluded Black physicians. Paine expressed a desire for change,  

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progress, and improvement; interestingly, he was also determined to hire a Southerner as the head of the new department of public health.92 However, he was not determined to include Black physicians in health care reform.

After Paine had served as mayor for less than six months, the city of Memphis received a health inspection from Paul Preble, former Surgeon General of the United States Public Health Services. Preble prepared a written report, and Mayor Paine reacted swiftly. On June 9, 1920, a headline appeared titled “Radical Changes in City’s Health Measures Urged.” Preble recommended a reduction in staff at the public health department and a replacement of current employees, “with better trained and equipped men and women and a more business-like administration of public health work under the direction of a full-time trained health executive.” The first paragraph summed up the city’s dismal health system.

In 1919, Memphis had the highest rate of typhoid fever of any city in America with a comparable population. The overall death rate remained consistent for over twenty years. Distressingly, forty percent of all deaths among citizens in Memphis were classified as preventable. Preble identified why the city differed from other regions: “Complete lack of effective supervision and a wholly unorganized health department, due largely to pernicious political interference.” Public health leadership failed to make basic plans for educating the public. Disease was ever-present in a segregated society with close contact between various races and ethnic groups. Tuberculosis was rampant, and typhoid, malaria, and other diseases were ignored. Some diseases such as typhoid were the direct result of unclean water contaminated by garbage and other waste materials.

Selling fruit on corner stands was declared unsanitary, and Preble immediately shut them down.\textsuperscript{93} The full report was deliberately withheld from the public. Although the federal government appointed Preble to conduct and collect public health data, the Black middle-class community had already begun to implement several public health programs prior to the above survey.

**Black Leaders and Public Health Concerns**

The civic images of disease among poor Blacks were widespread in various districts. However, to truly understand the public health works of Black middle-class professionals, it is necessary to examine all aspects of their public life, including church, civic centers, and residences. In a 1919 editorial appearing in *The News Scimitar*, T.O. Fuller demanded full awareness of a divisive issue in Memphis: racism. “Race Relations Is Big Problem, Unfavorable Conditions to Part of Community Eventually Affect All” exposed socio-cultural attitudes of segregation. Fuller wanted full cooperation from the Black community because professionals and specialists were devoting time to study the problems of “poverty, ignorance, disease, crime, labor and race relations” to develop effective resolutions.\textsuperscript{94} Unfortunately, for many Blacks who lived in Southern cities, the problems of studying and addressing poverty, health and other racial problems usually resulted in segregated and unequal services. This can be illustrated by the Anti-Tuberculosis Association in Atlanta.


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Historian Andrea Patterson explains that Whites acknowledged the inevitability of providing public health services to Black who had TB. Therefore, the Anti-Tuberculosis association rendered care to Blacks, but on different days than Whites. In addition, Black religious, civic and health professionals were requested to provide education on home sanitation and cleaning, because having White middle-class anti-tuberculosis reformers enter the house of Blacks was socially and culturally prohibited. More importantly, many cities did not allow Blacks to participate in leadership roles.\(^5\) Again, the Jim Crow system was adamant about racial separation, while validating civil inequalities of health care; accordingly, Blacks adopted their own approach.

Paul Preble discussed the need for public education; but Black physicians were already providing public health education. By 1919, Black physicians like Dr. Ionia Whipper lectured to girls at the community house, the teachers and community at the Howe Chapel.\(^6\) In the summer of 1919, the Howe Institute initiated a lecture series on diverse interests to local Blacks. Howe was a Practical School established by the Baptist Home Mission Society of Tennessee. A brochure published described the institution’s mission as “settlement work.” The school had free kindergarten for Black children, in addition to Bible classes.\(^7\) Also, Black doctors continued to respond to and advocate for

\(^5\) Andrea Patterson, “Germs and Jim Crow: The Impact of Microbiology on Public Health Policies in Progressive Era American South, Journal of the History of Biology 42, no.3 (Fall, 2009): 543. In 1909, Dr. Lawrence F. Flick of Philadelphia treated Black and White patients in the same facility. However, White patient objected to having Black patients in their presence. A decision was made by the Board of Directors, and Black patient were unable to receive care. Twenty-four years later Black patients with advance TB were admitted to White Haven Sanitorium. Marion M. Torchia, “The Tuberculosis Movement and The Race Question, 1890-1950,” Bulletin of the History of Medicine 49, no.2 (Summer 1975): 155.


improved health, and they often delivered lectures at the Howe summer program. Dr. Cleveland A. Terrell educated the audience about “School Hygiene.” Dr. E. W. Irving focused on “The Health of Children.” Other topics included “The Relations of Banks to a People’s Progress,” provided by B. M. Roddy. The lectures were open to the public.

Black leaders encouraged open lectures and discussion on public health matters; race was not used as an obstacle that forbade any ethnic group from receiving education or participating in events that improved the community.98 Community pride was fomented by offering gifts and prizes to the home with the neatest front and back yards. A prize was also given for the grandest small garden. The idea of environmental cleanliness and promotion of good health was a goal of the committee on civic improvement.99 Black women in Memphis remained active. The Federation of Colored Women’s Club continued to hold monthly meetings on business topics and welcomed others to discuss various topics.100 According to historian Linda Gordon, the two priorities of greatest concern for Black women were education and health. Health was a priority for clubwomen; many established clinics and health education programs, and TB was a major health concern.101


During National Negro Health Week, the first week in April, education focused on broader health topics. From April 4 to 11, 1920, the Black community was busy on its yearly public health mission. T.O. Fuller noted that the “Program should be universally observed by our people.” On April 4, clergy participated in “Sermon and Lecture Day.” Children’s needs were also important, and, on April 5, the public participated in “Health Day in the Schools.” Home safety was discussed on April 6, “Fire Prevention Day.” Likewise, the next day, a community effort for sanitation and hygiene, “Clean House Day,” and on April 8, “Yard Day.” In a combined endeavor, the Black community ended their health week with “Vacant Lot Day.”\(^{102}\) Black leaders in Memphis also utilized the expertise of government personnel. The United States Public Health Services sponsored educational programs for National Negro Health Week. In July 1920, Dr. A.B. Burton, “conducted a campaign among negroes against venereal disease.” He spent four days addressing the sensitive health issue of sex and disease at designated locations in the Black community. Burton used the community center on Beale Street to educate a male audience. Discussion of those topics Avery Chapel Church also hosted a public lecture on the topic. The Women met with Burton at the Palace Theater. The last lecture, at Grant Theater, was for men only. T.O. Fuller described the lectures as, “highly interesting and instructive,” and importantly, they were free.\(^{103}\) Perhaps gender conventions in an era reform governed that male physicians only discuss sexual health issues among men, and not in the presences of women.


\(^{103}\) Ibid.
Public health issues created grassroots movements. Yet, Black and White women did not organize and unite along racial lines. As Karen Blair explains, White Women who joined the General Federation of clubs “had limited sympathy for black and working-class women.” As women’s club increased in membership, racism was more visible.\(^{104}\)

However, women of both races served as health advocates. It was their pressure that made Memphis reorganize its public health department. On July 1, 1929, Dr. J.J. Durrett was appointed to the role of health superintendent. Prior to arriving in Memphis, Durrett was at a health conference in Washington meeting with experts to discuss enactment of the new public health system in Memphis.\(^{105}\) Two important divisions in the health department were the Division of Communicable Diseases, whose staff included seven white public health nurses and three Black nurses, and Venereal Disease Control, which had no personnel listed.\(^{106}\) But to fully understand the rapid and drastic change in health services and public welfare within six months of new civic leadership requires an analysis of Paul Preble’s report.

Paul Preble prepared a document, “A Review of Public Health Administration in Memphis, Tennessee,” of over 104 pages that included pictures. The beginning of the report includes a narrative of the history of the Memphis’s Health Administration. The report was prepared at the request of the city authorities of Memphis and the State Board of Health of Tennessee. Both the state and local government wanted “to make a detailed


survey of public health activities in the Memphis and to make recommendations for a reorganization of the city health department.”

The latter supports the idea that Mayor Paine was serious about improving public health measures in the city. Years of reckless record-keeping and data were uncovered during the survey. Upon reviewing the reports on file with the city of Memphis, Preble noted many errors. This next section will discuss findings such as inconsistencies and discrepancies that appeared in Paul Preble’s report.

**The Reality of Health Issues Among Blacks**

The annual health reports for 1914 and 1915 indicate that “the same totals of cases of the diseases [are found] in both reports, obviously an error.” Similar errors occurred in other reports. Registration of births and deaths were poorly maintained. Records were missing, and documents were not legible. “No special care of attention has been given to correctness of diagnosis or completeness of records.” The records that were available show overall death rates remained unchanged from 1900 to 1919, but the death rate among Blacks steadily increased during the time frame.

Bringing attention to Black health disparities, Preble stated, “This fact should receive serious consideration, and efforts should be made to reduce this increasing mortality among the colored population.” Historically, government leaders in Memphis criticized non-residents for skewing morbidity and mortality rates. However, after reviewing records and ledgers, Preble stated that for the years 1916 through 1917, it was impossible to tell residents from non-residents, as information was incomplete. Memphis had no clearly defined division for non-residents.

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108 The disparities of death rates from tuberculosis was reported in Richmond. “The infection rate and mortality rates among blacks were widely known to be two to three times as high as for whites.” Steven J. Hoffman, “Progressive Public Health Administration in the Jim Crow South: A Case Study of Richmond, Virginia, 1907-1920,” *Journal of Social History* 35, no. 2 (Autumn 2001): 185.
to address communicable diseases, which was the “most important division in the modern health department.”

Along with meager public health services, local hospitals such as The Memphis General Hospital placed patients at risk for infectious diseases. A small building located behind the Hospital was designated as the communicable disease hospital. It was “poorly furnished and heated with open grates.” In addition, the maximum capacity of the communicable disease hospital was fifteen, and as Preble observed, sex, race, and disease determined availability of admission. The Memphis Public Health Department was perplexed because despite being a highly communicable disease with profound mortality rates, especially among Blacks, tuberculosis had no systematic order for tracking. The most troublesome aspect was that the city of Memphis made no effort to reduce the number of cases of tuberculosis, or to control adverse health outcomes or deaths. The 1918 death toll of tuberculosis ought to have raised questions among civil leaders—of the 148 cases, ninety-four people died. Because of socioeconomic conditions, the death rate for Blacks was five times higher when compared to Whites. Preble wrote,

The tuberculosis problem in Memphis is a vital one. The high colored death rate from this disease indicates the necessity for the adoption of drastic measures for early diagnosis, prompt notification of all cases, adequate provision for their isolation and treatment of dangerous open cases, including the necessary public-health nursing services, and a strenuous educational campaign.

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110 Ibid., 27.

111 Ibid., 27, 28.

112 Ibid., 31, 32.

113 Ibid., 33. High mortality rates was the reaity of racism, under the ethos of Jim Crow. In 1900, the annual mortality for Blacks was 450/100,00, which was three times that of Blacks. In addition, the health of Blacks was not a concern, because initially TB managed was targeted at Russian Jews and Italians, Marion
Although the city established a tuberculosis committee and had a proposal to raise $92,000 from December 8 through December 13, 1919, the funding was not specifically tied to those most in need. Tentative plans for the money were “preventatorium [sic], a traveling health center, hiring doctors and dentists, along with a mobile ambulance clinic.”

Perhaps White Memphians were ambivalent about aiding Blacks in order to ward off TB. The question is whether Whites in Memphis perceived any risk to their health. Whites in other cities instituted safeguards and education when they began to fear contacting TB from Blacks. Historian Terra W. Hunter describes the stigma of TB that Black washerwomen, cooks, and other female domestic faced who providing services to Whites in Atlanta. Caricatures and magazine articles portrayed Black women as disease carriers and TB “spreaders.” In addition, anti-TB workers documented the living conditions that were associated with fear of disease-ridden Blacks. Most importantly, pictures and written documents conveyed the hardship and dismal experience of disease among impoverished people.

What Paul Preble’s report signifies is that Black Memphians suffered from high death rates from tuberculosis and typhoid fever related to socio-cultural and environmental factors. Nevertheless, Memphians learned one of the most important facts

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about their city: almost forty percent of the deaths that occurred were classified as preventable.\footnote{117} City officials merely kept numbers, with minimal effort for the improvement of public health. Epidemiology was necessary for the betterment of health. Preble was clear about how the city devoted time for public health concerns: “There has been in Memphis very little attempt to conduct any epidemiologic studies of even the more prevalent diseases. In the proposed reorganization of activities, the activities of the division of communicable diseases must be carefully and thoroughly developed.”\footnote{118}

Health disparities stemmed from segregated health services, and racial attitudes detrimental to the health of people living in Memphis. Paul Preble discussed the issue of not addressing preventable health issues such as early mortality rates, and the risk of spreading deadly infections. However, prominent White citizens targeted one specific communicable disease—tuberculosis. The risk exposure of tuberculosis to White middle-class individuals was associated with having close contacts with Blacks in various occupations.

**Black Solidarity: Agency and Resiliency**

Accepting the data and evidence given by Preble, Blacks were the focus for tuberculosis intervention. TB accounted for more deaths than any other disease within an eight-year period. Yet, when the Shelby County Tuberculosis Society was formed, no Blacks received appointments. Wealthy White Memphians determined the direction of public health efforts. Blacks were excluded from the election. Although several

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\footnote{117}{Paul Preble, Review of Public Health Administration in Memphis, TN,” *Public Health Bulletin* no. 113 (Washington: Government Printing Office, 1921), 44.}

\footnote{118}{Ibid.}
physicians served as society members, it appears that they gained membership in the Shelby County Tuberculosis Society based on their financial status.

W.B. Cleveland was responsible for education. Cleveland was the owner and president of the Cleveland Motor Car Company and vice-president of Austin Cleveland Company. White women also held positions in the tuberculosis society. Mrs. T. J. MacGowan, wife of a local businessman, T. J. MacGowan, a bookkeeper and commissioner of Accounts, Finances, Revenues and Bonds, was director. Mrs. C. N. Grosvenor, an elected board member, was the spouse of C. N. Grosvenor, a realtor, and the mother of C. N. Grosvenor, an attorney in Memphis. The female members of Shelby County Tuberculosis society were typical of White females of the Progressive Era—community leaders and champions of children’s welfare, but open to shared health commitments from Black women.

With racial restrictions on club memberships and societies, Black women piloted their own health programs to combat racial disparity and guide the poorer members of their race into better health. Black women responded to aid and services because Whites considered TB not as a community-wide public health issue, but rather a racial problem. Historian Susan L. Smith described the work of the Tuskegee Women’s Club. Education programs were initiated to provide basic education about typhoid and tuberculosis. The concept of domestic education encompassed members of the women’s

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clubs acting in the role of educators. They encouraged personal grooming, upkeep, cleaning and mothering skills.

Women trained other women on their expected roles, including keeping families healthy.\textsuperscript{121} Basically, Black women were teaching other women about socially prescribed domestic duties. This traditional role had a perceived social benefit to the public sphere in that it could prevent disease. The reality was that even with home improvement, once TB spread, someone had to care for family members; if hospitalized, the segregated wards probably worsened their lives. Still, Black women continued to organize, but many chose to take their cause to the public sphere.

In December 1919, Black women in Memphis orchestrated a large collaborative effort of more than ten women’s clubs. Together these women initiated their own anti-tuberculosis drive. The meeting occurred at the Beale Street Community Center.\textsuperscript{122} Similar to the White anti-tuberculosis society, Blacks formed an anti-tuberculosis committee that included educated professionals. The group was diverse and included women of the Eastern Star, clergy undertakers, physicians, barbers, hairdressers, nurses, dentists, pharmacist, postal workers, and mill workers. The newly established Black TB society was comprised of working class and professional members. The society reflected pride and unity within the Black community. However, with members such as T. O. Fuller, who welcomed the cooperation of White leadership, the anti-tuberculosis committee established by Blacks did not exclude Whites. The Solvent Savings Bank


sponsored the anti-tuberculosis campaign and provided a meeting space for its members.¹²³

Black women’s efforts to raise awareness of common diseases coincided with statewide health promotions advocated by Tennessee Governor Albert Roberts. One goal of Robert’s initiative was to establish community programs and hire public health nurses. Other patronage came from the Tennessee Anti-Tuberculosis Association and the State Departments of Health Charities and Education. With a focus on tuberculosis, the tenth annual gathering wanted to expand the focus to community and public health interests. Program directors lauded public efforts to fight influenza. Organizations and charities distributed pamphlets and health education material on the flu. The purpose of the society was to fight “any condition which lowers the vitality of the public, for it is when folks get worn out and run down that the Tuberculosis germ gets to work.”¹²⁴ Still, prominent Black leaders felt confident that government agencies would have the desire for all people to receive health benefits offered by state and local heads. For instance, T.O. Fuller wrote that “Every Southern state now has some committee at work for better race relations. Tennessee, under Gov. Roberts, is taking the lead.” Fuller acknowledged that Tennessee was slow to respond to health conditions of its Black citizens, especially when


it was understood that the state government could allocate resources at a local level to fight tuberculosis.\textsuperscript{125}

On December 10, 1920, an article titled “Stamp it Out” appeared in The News Scimitar. The article deemed tuberculosis the enemy of America and claimed that “it can be stamped out.” Admitting the social realities of tuberculosis and its impact on race, the commentary provided a truthful analysis. “There is more tuberculosis among the negroes than there is among the white people. As a rule, it is more fatal. We should be narrow-minded and short-sighted indeed, if in the campaign against the plague our consideration should not include the negroes as well as the whites.”\textsuperscript{126} Black physicians reported that the rate of tuberculosis among Blacks was higher than for whites eleven years ago.\textsuperscript{127} The socio-cultural reality of Jim Crow was revealed.

In Memphis, some Blacks and Whites lived near each other. They shared air space—thus, airborne germs like bacilli of tuberculosis was easily spread. Both races walked on the same side of the street. Within occupations, private spaces were shared. The writer warned, “If we cared not one particle what becomes of the negro it would be a binding obligation upon us for our own self-protection [sic] to suppress and drive tuberculosis out of the negro race, just as the health authorities would make a fight to drive out yellow fever or any of the other ailments that are slight and inconsequential in

\textsuperscript{125}T.O. Fuller, “Activities Among Memphisis Negroes,” News Scimitar, April 7, 1920, From Library of Congress. \url{http://www.chroniclingamerica.loc.gov/lccn/sn98069867/1919-12-05/ed-1/seq-18}.

\textsuperscript{126}“Stamp It Out,” News Scimitar, December 10, 1920, From Library of Congress. \url{http://www.chroniclingamerica.loc.gov/lccn/sn98069867/1920-12-10/ed-1/seq-6}.

comparison in the toll they exact.”¹²⁸ White middle-class citizens had a comfort zone—the social construction of the disease fit the needy, impoverished, and Blacks. Poverty shaped the social inequities of TB because basic provisions for survival were taken for granted by the middle class. Segregation cultivated narrowness; therefore, equality and cohesiveness were forgotten while preventable diseases spread through and permeated the city of Memphis. Blacks welcomed any acknowledgment that racial unification was advantageous for Memphians.

**Interracial Support**

The Black middle class formed a committee to focus on the concerns of Black Memphians. Elected by his peers and professional colleagues, T.O. Fuller became the chairman of the Shelby County Interracial Committee, and S W. Broome worked as secretary. However, the largest forum for interracial cooperation for social improvement, together with healthy living, was built by religious women. Memphis held a meeting of various women’s organizations, and Black women attended to voice their concerns about racial issues that had negative effects on Blacks, in addition to racial discourses that ignored the progressive efforts of Black women.¹²⁹

The response to racism and its array of social devastation such as violence and death posed a moral and religious concern. Interracial collaboration in women’s organizations helped to unveil the nuances of Jim Crow. Historian Joan Marie Johnson analyzed race in the context of Southern womanhood in South Carolina. Black women compelled White women to grasp the social reality that as women, they were all


Southerners with a shared history. Black women favored a collaborative relationship with White clubwomen. Although progressive clubwomen operated and worked for the betterment of humanity, organizations were separated by race. Black women worked toward interracial cooperation for the betterment of community life. Even with shared ideas of mutual concern of the races, White women exposed their racial biases via published doctrines. For White clubwomen, their focus was on the “Negro Problem,” but not the effects of racial discourse and power aimed at Black people. Johnson provides an adept perspective of the term “interracial” in relation to ethos of segregation.¹³⁰

The idea of “interracial” effort or activity did not symbolize equality or dissolution of segregation. Within the cultural and social milieu of the South, “interracial” suggested that blacks and whites worked together for a common concern, such as temperance or public health, but within in their own separate spheres. With respect to gender, interracial coalitions formed; Black and White women jointly participated in the Commission on Interracial Cooperation (CIC) to advance social and economic objectives. Uplifting the race inspired Black women to collaborate with women of the CIC because many of them had previous involvement with the YWCA and the Methodist missions.¹³¹ Women connected to Methodist Missionary Councils and similar groups urged women of both races to convene. Memphis agreed to host a Southern Christian women’s conference in which Black and White women would assemble to gain insight concerning racism.

¹³⁰ Joan Marie Johnson, *Southern Ladies, New Women, Race, Region, and Clubwomen in South Carolina, 1890–1930* (Gainesville: University of Florida Press, 2004), 60, 61, 63.

Prior to the scheduled conference on October 6 to 7, 1920, *The News Scimitar* proclaimed, “Expect Many Women at Interracial Meeting.” The city expected nearly 125 women to attend the two-day event at the Hotel Chisca. The opening ceremony on Friday included a banquet. Mrs. Luke Johnson organized the session. Johnson was a board member of the Women’s Missionary Council of the Methodist Episcopal Church South. The clubwomen arrived from Tennessee, Arkansas, and Alabama. According to the editor, Black women would deliver their ideas on how to best approach racial affairs between Blacks and Whites.\(^{132}\) While women of the Progressive Era had gained suffrage, education, and economic stability, gender and racial hierarchy prevailed on the social level. In the foreword of the conference program, titled “Southern Women and Race Cooperation, A Story of the Memphis Conference,” topics included “What It Means To Be A Negro” and “The Difficulties of the Daily Life of the Negro Peoples.” Findings of the conference were divided into sections. Section II, “Constructive Measures,” embodied nine topics. Listed as number three was “Sanitation and Housing.” Speakers were listed included Mrs. Booker T. Washington.

As a Black woman at an interracial conference, Margaret Murray Washington could not represent herself. She was given the title of her husband; perhaps White women wanted Mrs. Washington to convey her husband’s philosophy, such as the purported value of overlooking racial problems, focusing on agriculture, and avoiding institutions of higher learning. After hearing the racial effects of health and disease, White Christian women stated that “Since good housing and proper sanitation are necessary for both physical and moral life, we recommend, that a survey of housing and sanitary conditions

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be made in the Negro sections in each local community, followed by an appeal to the proper authorities for improvements when needed.”

Mainstream thought in the Progressive Era placed high value hygienic control, or social control. The latter is important to unpack, as it relates to class issues among Blacks.

Historian Kevin K. Gaines scrutinizes the ideology of racial uplift. The Black middle-class focused on the need to improve home and sanitary measures among the degraded and maligned poor Blacks. The black middle class bought into the idea of race-based traits that made them prone to diseases, excluding the issue of poverty. Specifically, Gaines notes that middle-class rhetoric popularized “racial differences with pathology and placing a moral stigma on poverty.” Black elites elevated themselves within America’s racial hierarchy, where poor blacks were at the bottom. What evolved was an belief in solving the “Negro Problem.”

Ideas of progress called on poor Blacks to uplift themselves from slavery, to freedom, and out of racism that bequeathed poverty. As they developed educational programs, organized women’s clubs and participated in interracial conferences, class, gender and race issues became clear. Specifically, middle-class White women censored the Christian interracial conference, and Black women in Memphis were not welcome, because the conference was not open to all Black women. Only one educated Black

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133 Commission on Interracial Cooperation, Southern Women and Race Cooperation, A Story of the Memphis Conference, October Sixth and Seventh Nineteen Hundred and Twenty (n.p.) 6, 10.

woman in Memphis served as a member, Lula Crim, who worked for the Department of Negro Education at Shelby County Public Schools.135

Consistent with women of their time, Black middle-class women in Memphis sought support for health issues and social concerns within the ranks of their race. Black women worked together for interracial cooperation within the rigid boundaries of racism and segregation. However, Black women in Memphis chose to adopt political approaches to voice protest and change public conditions. For example, a small committee of seven women associated with the City Federation of Colored Clubs felt compelled to engage civic leaders about crises affecting Black children. A request was made for local citizens to allow children to sit under shade trees to prevent heat exhaustion and provide comfort in a humid region, in addition to providing playgrounds.136 Historian Jacqueline Rouse points out that Black women’s club leader Lugenia Burns Hope and other members conducted a survey to determine what working mothers desired. Like Memphis, Black communities in Atlanta lacked sufficient playgrounds, and safe spaces. Also, there was recognition that many schools needed improvement.137 Moreover, there was an urgency to provide health services and to care for Black women and children in Memphis.

An Objective View of Black Health

Memphis was a city in desperate need of reorganizing public health services and other resources for an impoverished race with grim chances of surviving preventable

135 Commission on Interracial Cooperation, Southern Women and Race Cooperation, A Story of the Memphis Conference, October Sixth and Seventh Seventeen Hundred and Twenty (n.p.) 6, 10.


diseases. In 1920, the city of had a Black resident population of 61,181—38.1 percent of the population. The demographic distribution of Blacks by wards indicates that Blacks comprised 93.3 percent of the people who lived in Ward 4, and 77.6 percent of those in Ward 3, followed by 65.4 percent occupying Ward 14. Photographs were taken of disease-ridden areas where Blacks lived. One picture showed an alley or strip of unsanitary privies. The alley way was piled high with trash and filth; more than 100 Blacks who inhabited that area. Preble recommended that the city condemn several buildings, one being “unfit for human habitation.” A small caption explained, “an ark, housing many families, crowded, poorly ventilated, generally insanitary [sic] and a nuisance; contributing to the excessive death rate among the negro population.”

The city passed several ordinances that were not enforced.

In 1879, it was unlawful for any privy cistern and cesspool to be “made or built” in the city unless governed and authorized by the Board of Health. The broader view of America’s public health situations as they related to poor Blacks seemed insurmountable. Widespread sections of cities posed harm to the entire population. Other historians’ accounts of the relationships between segregation, and racism and the effects of tuberculosis among Black people make clear that Memphis was not alone in having distressing mortality data.

Historian Samuel Kelton Roberts, Jr. analyzes the multiple risk factors of tuberculosis in the background of politics, economics and segregation in Baltimore, Maryland. His data includes TB morbidity and mortality in Baltimore from 1904 through 1940. Roberts also compared mortality rates among Blacks and Whites in Southern

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states, specifically Florida, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, South Carolina, Tennessee, and Virginia. Information about TB in Florida, Louisiana, and Mississippi was partial. For the remaining states, tuberculosis deaths for Blacks were over twice those of Whites.\(^{139}\) Notably, Robert illustrates that Philadelphia was the model city for anti-tuberculosis outreach. Philadelphia gained support from Black leaders in medicine and nursing, as well as collaborative involvement from White volunteers. Conversely, he noted that “New York, Memphis, Houston, and Cincinnati also were known for reformist cross-color cooperation and advanced attitudes in the realm of public health.”\(^{140}\)

Baltimore, like Memphis, had ruinous neighborhoods in which Blacks lived with unkempt streets, alleys, and the presences of open privies. Most importantly, Roberts exposes the sociocultural norms of Jim Crow and its correlation of poverty and other economic inequalities such as inadequate housing to high rates of pulmonary diseases.\(^{141}\) In Baltimore during the years 1903-1923, infections from whooping cough resulted in a mortality rate of 2.6 for White children and 105.5 for Black children. Roberts’s research states that Black women initiated and planned lectures and educational programs to enlighten their community about health problems.\(^{142}\) Historical writings and documents about racial uplift confirm that leadership by Black women was common in many Southern cities. Black women who brainstormed the idea of interracial mutual aid


\(^{140}\) Ibid., 64.

\(^{141}\) Ibid., 70, 81.

\(^{142}\) Ibid., 69, 162.
publicized the existence of social issues, especially diseases that deteriorated the life expectancy of their race. Yet health problems connected to gender could go unnoticed.

**Women’s Health**

The racial and gender component of health disparities associated with tuberculosis were not discovered until years later. In 1953, the Department of Gynecology at John Hopkins University published research on pelvic tuberculosis. Between 1920 and 1950, 158 Black women and thirty-five White women arrived for the treatment of pelvic tuberculosis. Most women were between twenty to twenty-four years of age, followed by a group that were fifteen to nineteen years of age. Lower abdominal pain was the primary symptom occurring in sixty-nine percent of women, and several complained of sterility. Of the 158 women, seventy had prior pregnancies; however, only three of the seventy reported a pregnancy while being diagnosed with pelvic tuberculosis. Pelvic tuberculosis caused sterility. Some women had infection in the fallopian tubes, while over 70.9 percent had tuberculosis involvement in the lining of the uterus.

In addition, 43.4 percent presented with tubercles inside parts of the ovary. The researchers at John Hopkins warned against misdiagnosis of other disease, especially in young girls. For instance, pelvic tuberculosis was diagnosed as gonorrhea, and of those women, forty-three percent Black. Pelvic tuberculosis can present as pelvic inflammatory disease. The researcher explains that in virgins, the first consideration should be pelvic tuberculosis. It was noted that most young girls who never had sexual intercourse were given penicillin for treatment of lower abdominal pain. A high percent of women had

For Black women, ideas of promiscuity and “immoral behavior,” shaped the views of medical practice. For many Black women, complaints about abdominal or gynecological disorders represented problems associated with sexually transmitted diseases. The research cited should raise questions about death rates and low fertility rates among Black women in Memphis, with TB as a primary cause.

As noted earlier, through Paul Preble’s report cited the Shelby County Health Department’s haphazard and questionable data collection, it is nevertheless useful to analyze morbidity and mortality figures. Total births, Black and White, in Shelby County from selected years demonstrate low birth rates among Black women. In 1915, there were 1,438 births for White females and 697 for Blacks, but Black deaths totaled 1,597. The 1916 numbers were 1,580 white births and 715 Black births, with Blacks having a mortality of 1,427. For the year 1917, there was a slight increase of among White women, who had 1,588 births, compared to 773 for Black women, but the number of deaths for Blacks reached 1,559. In the last year that Preble reviewed births and deaths, 1918, White females accounted for 1,480 births, while Black women had 540 births, and the highest total of deaths, 1,732.\footnote{Stewart E. Tolnay’s research supports that venereal disease caused Black infertility. Tolnay reveals that, “from 1880 through 1940 fertility fell persistently and dramatically research a virial reproductive death in the1920s a both black and white total fertility rates dipped below 3 children per woman.” An additional study that Tolnay reviewed (Wright and Pirie (1984) indicates, “that at least 56 percent (and probably more) of the black fertility transition between 1880 and 1940 could be attributed to increasing venereal disease in the black population,” Stewart E. Tolnay, “A New at the Effect of Venereal Disease on Black Fertility: The Deep South in 1940,” \textit{Demography} 26, no. 4 (November 1989): 679-680. For studies on fertility associated with diseases such as genital tuberculosis, Joseph A. McFalls and Marguerite McFalls, Disease and Fertility (Orlando: Academic Press, 1984).} A gender category for tuberculosis deaths was not
recorded; therefore, interpretation of mortalities rates for Black females are not possible.\textsuperscript{145}

**Conclusion**

In Memphis, health disparities and preventable deaths among Blacks, especially women, did not end with a newly elected mayor in 1919. From the antebellum period through the twentieth century, sociocultural and political mores of racism and public segregation continued to place Blacks at risk. Although public health measures were taken to combat infectious and contagious disease, racial health disparities persisted. The leading causes of death for Blacks in 1910 were tuberculosis, pneumonia, and organic diseases of the heart; however, tuberculosis was more prevalent in the Black population than Whites. In 1920, Tennessee data show a death rate of 260.4 for Blacks, and 110.2 for Whites, even with fundraising campaigns, education, and training.\textsuperscript{146} Mortality rates and healthy disparities epitomized the nadir for Blacks in Memphis. However, Blacks remained optimistic about the health of their race. Blacks Memphians had a millionaire, an elite physician, prominent clergy, eminent clubwomen and a relentless working class who responded in multiple ways to racialized health problems, all in accordance as a means for the betterment of race. Most importantly, Black physicians in Nashville and Memphis would personify the benevolence of Black caregivers.

\textsuperscript{145} Preble, 22.

\textsuperscript{146} Ibid.
Chapter 5: Call to Duty: African American Physicians:
Benevolent Educators, Instructors and Providers

And serve each other according to the gift each person has received, as good managers of
God’s diverse gifts.¹

The Journal of the National Medical Association (JNMA), the oldest Black medical journal, has been central to the history of Black medical practice; the journal regularly features historical accounts about Black health professionals addressing the issues of education, training, and the complexity of race relations in medicine. A 1993 JNMA article, “Black Medical Pioneers: African-American ‘Firsts’ In Academic and Organized Medicine,” discusses the importance of Howard and Meharry medical schools, explaining that “For many years, Howard and Meharry schools in the establishment of medical professionals, graduated 80 to 85% of the African-American physicians in the United States.” The two medical schools were formed after the Civil War freed American slaves. Meharry, an HBCU located in Nashville, Tennessee, was specifically founded to educate and train Black physicians.²

It was one of three medical colleges in Tennessee founded before 1900, along with the University of Tennessee and Vanderbilt. There were, however, many other medical colleges in Tennessee whose history and origins are not as well known or recognizable. For example, the following Black medical schools exited in Tennessee

¹ 1Peter 4:10, (Common English Bible).

before 1900: Hannibal Medical College opened in 1889, and closed in 1896. The Knoxville College Medical Department opened in 1895 and closed five years later in 1900. Chattanooga National Medical College, started in 1899, and the school closed in 1904.  

The history of late nineteenth and early twentieth century Black medical colleges and universities in Memphis is overshadowed by the longevity of Meharry, which still exists today. However, it is in these regional accounts of people and events, often hidden or obscured, that important alternative historical perspectives often emerge. For example, Dr. Miles Lynk was born on June 3, 1871, on a farm near Brownsville, Tennessee, to the parents of former slaves. He graduated from Meharry and established a Black medical school. Dr. Lynk relocated to Memphis, and The University of West Tennessee moved from Jackson to Memphis, Tennessee. Dr. Lynk was also credited with forming the National Medical Association. 

Dr. Lynk appreciated the need for an African-American medical school. He observed the number of excellent medical institutions in Tennessee: Vanderbilt, University of Nashville Medical School and University of Tennessee Medical. There was also the Medical School of the University of the South at Sewanee, the Medical Department of former Grant University at Chattanooga, and the Memphis

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Medical College. However, the above institutions were used to train large numbers of White medical students and not African Americans.5

This chapter will explain how Black physicians impacted Memphis and surrounding communities in the aftermath of the Civil War until the second decade of the twentieth century. To understand the need for training and educating Black physicians, it is important to illustrate how Black doctors demonstrated their knowledge about health disparities as they created institutions such as universities, training facilities, and hospitals. Another aim is to describe how Black physicians embraced the national concept of racial uplift, especially by supporting and organizing community health programs. A major issue that must be addressed is the role of Black agency in battling professional discord from White middle-class physicians and how black professionals broke down barriers in Memphis.6

Numerous historical accounts exist about Blacks in medicine. Scholarly research includes data from professionals in various areas of history including medical history, the history of science and medication, education, and Southern history. The commonalities of historical writings are the depth and richness of primary sources, yet histories are written from different perspectives. Still, histories of Black physicians, their medical practice, their professional roles, and the institutions that they created are over often overlooked

5Miles V. Lynk, Sixty Years of Medicine or The Life And Times Of Dr. Miles Lynk: An Autobiography (Memphis: The Twentieth Century Press), 63-64.

and under-researched. For example, Memphis, Tennessee enriched Black culture by founding two proprietary medical schools: Hannibal and The University of West Tennessee. Hannibal lasted for only a few years, with minimal records and documents to preserve their legacy of physician training. While the University of West Tennessee (UWT) trained doctors, lawyers, and nurses, the college survived under strenuous conditions in a society that fostered racial disharmony. Black physicians provided health services to the community and developed collaborative and professional relationships with one another. Most graduated from Meharry Medical College in Nashville, Tennessee, and as fellow Meharry graduates, their relationships as physicians remained collegial.7

Historians such as Todd Savitt have focused on Black medical colleges and universities. Savitt’s research addresses health, illnesses, and diseases as part of slavery. Savitt also addresses racial concerns among Black physicians in a segregated profession. Many Black medical schools closed after being scrutinized by Flexner’s Report.8 Black medical schools and training facilities in Memphis were the target of Flexner’s madness, as he imagined the worst and assumed the worst about professional Black physicians. In Memphis and other communities such as Nashville and South Carolina, Black physicians were visionaries; they will be discussed later. They encouraged one another to build hospitals and advance beyond medicine and specialize in surgery.


Existing histories of Black physicians cover distinct topics. For instance, the work of Thomas J. Ward Jr. considers how race impacted Black physicians in the South. Ward provides a comprehensive view of the difficulties Blacks faced in the medical field, including the barriers to establishing community-based practices and to being accepted as adequate health care providers. According to White America’s belief in the privilege hierarchy of race, Black physicians and their training were inferior to Whites, regardless of which medical school Black physicians attended. Obtaining professional acceptance in the White medical society was onerous. There were physicians who succeeded. Dr. Daniel Hale Williams became the first doctor to operate on the human heart. In addition, he was the only Black surgeon admitted to the American College of Surgeons in 1913. But while intellect, skills and knowledge were visible in the Jim Crow era, seeing past the color line was challenging.

The moral value of training and educating Black doctors to combat Black morbidity and mortality went unseen by White physicians. Instead, the attitude of White physicians was to eliminate competition across race and gender and to eliminate what they perceived as incompetent medical schools and hospitals. There were a few exceptions: philanthropist White elite medical men helped found two schools to train Black physicians that remain open today, Meharry and Howard University.

The work of Wilbur H. Watson encompasses a dynamic history of Black medical education, especially in the state of Tennessee. Black physicians, too, have their own

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9 James W. Ward Jr., *Black Physicians in the Jim Crow South* (Fayetteville: The University of Arkansas Press, 2003), 97, 98,125.

stories to tell about the struggles in American medicine. With numerous obstacles in the profession of medicine, Black physicians managed to complete training and provide health services in the South. American medical schools, especially in the South, did not allow Black physician to join medical association, a policy that limited hospital practice and licensure. Specially, racial politics impeded membership within national medical associations. The history of Black physicians in Memphis affirms the presence of barriers to maintaining and creating medical practices, especially Black-owned hospitals.

Dr. James L. Curtis, a medical doctor, presents an analysis of education and training of Blacks in medicine. His book *Blacks Medical Schools and Society* is useful for understanding the contributions of Blacks in medicine, especially the time period from 1619 to 1812. The history of Blacks in American medicine begins with the history of trans-Atlantic slavery. Slaves often arrived with knowledge and understanding of medicine, and this helped them to form collaborative relationships with American physicians. More importantly, Black physicians gained trust as medical providers. For instance, Lucas Santomee Peters was an African doctor in the American colonies. A former slave, Peters received his medical education and training in Holland. In 1667, he received permission from the colony of New York to practice medicine. Another slave named Cesar was one of the earliest Blacks to receive notoriety via medical publication. In 1792, Cesar’s remedy for snakebites was published in the *Massachusetts Magazine*. A significant contribution to medicine came from another slave named Onesimus. He introduced a standardized treatment for smallpox inoculation. Onesimus eventually

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trained the most prominent physician in Colonial America, Dr. Cotton Mather, on his treatment for smallpox.  

Other slaves gained fundamental skills and knowledge from doctors who were also their owners. For example, James Derham acquired skills in medicine and surgery. Derham, like Onesimus, was a slave. However, most of Derham’s masters were physicians, including John Kearsely Jr., Dr. George West, and eventually Dr. Robert Dove of New Orleans. Derham was able to purchase his freedom, and he continued to practice medicine. Black slaves participated in current medical training, receiving formal and informal training via apprenticeship. Curtis’s history provides a rare glimpse at slavery outside the grueling plantation system, in which freedom was granted, but only to a few select. Dr. James Derham was a rarity as a former enslaved male and a Black physician. His apprenticeship caused no alarm about his being a physician; however, former slaves who became the next generation of Black doctors caused anxiety in the mist of Jim Crow segregation during the Progressive Era.

The end of the Civil War and coming of the Progressive Era came with a notable benefit to historians, in that professional organizations created a legacy of written history. The history of Black physicians of this era is preserved in medical journals. The perceived need to write and rewrite medical history with a focus on Black physicians

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13 Ibid., 5. In 1850, Martin R. Delany was one of three Black physicians admitted to Harvard University, and within one year all were dismissed. Delaney returned to practice medicine in Pennsylvania under an apprenticeship. In 1864, Rebecca Lee was the first Black female awarded a medical degree from the new England Female Medical College. Likewise, in 1869, Rebecca Cole another Black woman received a medical degree for the Woman’s Medical College of Pennsylvania. Most schools prevented Black men and women from receiving medical training. Blacks created other avenues for training-establishing their own schools, Axel C. Hansen, “African Americans in Medicine,” Journal of The National Medical Association 94, no. 4 (April 2002): 266-267.
originates from the idea that we can better tell where we are going based on where we have been. Black medical training was a powerful and symbolic institution. And advances in Black medical training during this era were significant. Hansen emphasizes that “between 1868 and 1907, a total of 14 such schools were organized, all but two in the South, and six in the State of Tennessee.”

**Impact of Race on Health**

In the years following the Civil War, city officials in Memphis acknowledged the limitations of health care for Blacks and the reality of racism. In 1867, Charles W. Pagett was the steward of City Hospital in Memphis. Pagett felt that it was his duty to respond in writing to a public report misrepresenting the hospital’s admission policy. On March 11, 1867, Pagett informed the editor of the *Public Leger* that “In your Saturday’s issue, you stated that the negro who was shot on the wharf boat was taken to the City Hospital. This is a mistake, and as I have frequently noticed similar errors in the city paper, I take this opportunity to say that colored patients are never, in any case admitted to the City Hospital.” The editor acknowledged the error and notified the public that Black patients are taken to the hospital at Fort Pickering.

Segregated health systems became the norm in Memphis, as Blacks continued to be admitted to the county hospital located at Fort Pickering. By the late nineteenth century, American cities were clearly divided by ethnicity, skin color, and race. Signs of racial hierarchy in institutions such as churches, schools, and health facilities became

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ubiquitous. Illnesses that required treatment in infirmaries or hospitals required separate hospitals based on race and gender. The complexity of diseases warranted government agencies’ consideration of multiple variables of health, particularly with respect to race, gender, and geography. In July 1874, Alderman David gave a brief synopsis of health care and social medicine in Memphis:

The accommodation for colored patients at the city hospital are now insufficient, and whereas, the market and hospital committee recommended on the 4th of February 1872, that two wards be erected at the hospital, one for white and one for colored patients, and whereas the ward for white patients has just been finished, while no steps have been taken to erect the ward for colored patients, which is now needed very much, be it resolved, that the mayor is hereby required to advertise for bids to erect the ward according to plans and specifications to be furnished by the city engineer immediately.16

The urgent need to erect a hospital ward for Blacks corresponded to the growth of the city. As populations grew, various Southern cities introduced measures to combat diseases that had previously decimated their cities. Distinguished physicians such as Dr. Gustavus Brown Thornton, who served as President of the Memphis Board of Health, headed local committees and boards created to find solutions.17

In 1882, Thornton used epidemiological studies to compare mortality rates between Memphis and other cities. By this time, health disparities and death rates between Blacks and Whites were already apparent. Within the first nine months of the

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17 University of Tennessee Health Sciences Library, Tennessee Physicians Cards. Thornton studied medicine under Dr. H. R. Robards. He was a professor of surgery at the Memphis Medical College. Dr. Thornton pursued a degree in medicine and graduated from New York University in March of 1860. He returned to Memphis later that year to begin his practice as physician. During the Civil War, he was an Assistant Surgeon in the Tennessee Artillery Corp under William S. Bell. Within the local community of physicians, Dr. Thornton was elected as Assistant Professor of the City Hospital. He regained and accepted an appointment as President of the Board of Health.
year, 520 Blacks died compared to 259 Whites. Most of the Black people died from respiratory diseases, particularly consumption and lung infections. In addition, Black children also faced early deaths, and infants faced high mortality in first nine months: 222 Black children died compared to only 63 White children.\(^{18}\)

Analyzing mortality statistics for Blacks in Memphis, Thornton explained the social factors in late nineteenth century healthcare. He wrote that “A large majority of these deaths occurred among the poorest and most improvident class of people of both races.”\(^{19}\) In the city of Memphis, Blacks had minimal contact with physicians. Often the physician who signed the death certificate had visited and treated the patient only one or two times. For example, in 1882, of the 338 cases of smallpox in the city from January 1 to October 1, the overwhelming majority, 311, were Blacks. Whites accounted for only 27 cases during that time. Thornton noted that all who arrived by steamboat and were brought into the city from surrounding areas to receive care in the county pest house were Black.\(^{20}\)

**Segregating the Diseased and Social Control**

The pest house in Memphis was a treatment facility where many Blacks with contagious diseases were sent. In 1895, there were 1,200 cases of smallpox; some people received care at an emergency hospital, others at the pest house. Of the 600 cases at the hospital, 95% were Black, and most were men (85%). However, when a member of a family was diagnosed with smallpox, sometimes all family members were sent to the pest house.


\(^{19}\) Ibid., 417.

\(^{20}\) Ibid.,” 417.
house, whether they had the illness or not. Outcomes for those admitted could be unpredictable and tragic. While in the pest house, a parent might die while their children lived, or vice versa. Blacks already admitted to the hospital for other reasons soon became victims of the fatal disease. Most Whites received the smallpox vaccine; Black women sometimes agreed to get preventive care with immunizations, but Black men did so rarely. Public response to this low rate of vaccination was punitive. On December 7, 1899 the Board of Health signed the following code:

Any person residing, or found, within any house, block or district declared by the Board of Health to be infected, or subject to infection, and who, at the expiration of five days after the passage of said resolution, shall have failed to be vaccinated, shall be guilty of a misdemeanor, and fined not less than two dollars nor more than fifty dollars for each offense. And any person who refuses to vaccinate as herein required, or resist compulsory vaccine, shall be guilty of a misdemeanor, and shall be fined not less than two dollars nor more than fifty dollars for each offence.

It appears that Blacks, especially men, would risk death rather than receive a vaccine. It is likely that Blacks genuinely mistrusted White physicians, because at the turn of the twentieth century there were still inconsistencies in medical treatment. More horrifyingly, Blacks were still being labeled as subhuman and biologically different than Whites, resulting in often dehumanizing treatment.

Connecting disease with race and physical appearance guided medical practice in Memphis. In 1900, physician E.C. Ellett—eye surgeon at St. Joseph’s Hospital, the City Hospital, the Lucy Brinkley Hospital, The Children’s Home, The Shelby County Poor

and Insane Asylum, and the Lath Orphan Asylum—published an article titled “Some Remarks on Diseases of the Eye, Ear, Nose and Throat in the Negro.” Doctor Ellett encountered Black patients at the County Poor and Insane Asylum, because no other hospital admitted Blacks. His findings were read before the Tri-State Medical Association in November of 1899. Ellett apologized for not having performed “a statistical study” and explained his rationale: “the negro is such a bird of passage and such an unstable patient, that I believe most of us find it hardly worthwhile to keep a record of the average negro patient, unless the case be one of peculiar interest.”

His social and cultural beliefs led him to consider Blacks immune from common diseases: “The negro enjoys a single immunity from catarrhal diseases, acute or chronic, the only explanation for this that I can think of being that he is blessed with a roomy nose and nasopharynx, and the space is so wide as not to be encouraged on to a symptom—producing degree by an ordinary amount of thickening to the tissue.” Dr. Ellett explained to his colleagues that “the negro affords us ample opportunity for the study of the natural history of disease, uninfluenced by treatment.”24 The idea of Blacks’ biological and physical distinctions remained a part of early twentieth century medicine. More alarming was the idea that based on “aberrant features,” medical treatment might not be necessary in cases where a White person with equivalent symptoms would need it.

Some White physicians strongly recommended Black physicians as the sole medical providers for their race, as noted by Dr. Horace Conrad:

Intelligent colored physicians should be scattered all over the South, to drive out the army of quacks, conjurers, root doctors, and voodooists, who, ignorant of the noxious properties of the drugs they handle, have been and are doing much to swell the mortality by the administration of their poisonous compounds. Colored

24Ibid., 17.
physicians are peculiarly fitted for this work; being of the race, they are better able to understand an idiosyncrasies or peculiarities; and again they will always diagnose their cases with more certainty, and administer those remedies which they know will alleviate their sufferings, and not empirically or experimentally, as I know is done in many instances by white physicians in the practice among the negroes.”

Conrad was correct about the existence of intelligent colored physicians in the South during the mid-nineteenth and early twentieth century, due in large part to the establishment of medical schools by religious institutions such as Freedman’s Aide Society, Methodist Missionaries, and American Baptist Home Mission Society. In addition, physicians organized and established proprietary medical institutions for education and training Black doctors. Colleges and universities in Tennessee trained Black men and women, many of whom were born into slavery, received freedom, became educated, obtained medical degrees, and became self-sacrificing providers and leaders within their communities.  

The Need for Black Physicians

During the period of 1876 through 1900, six different medical schools were founded in Tennessee. Other Southern states had larger populations of Blacks, such as the bordering states of Mississippi and Georgia, but few people or institutions had a vested interest in training Blacks in medicine. And when they did receive training, it was segregated. Watson’s analysis shows how Tennessee’s Whites supported the idea of

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25 Horace W. Conrad, “The Health of The Negroes in The South: The Great Mortality Among Them: The Causes and Remedies,” The Sanitarian 18 (1887): 507-508; Although many physicians especially Southern Blacks were not affiliated with large hospitals and specialty clinics, they were symbolic as health educators. Specifically, moving the community away from “folk practices, and patient remedies.” Local community physicians represented modern medicine and healthcare, John C. Burnham, Health Care in America: A History (Baltimore: Johns Hopkins University Press, 2015), 146.

separate schools to advance medical education and training.\textsuperscript{27} Plessy vs. Ferguson was the legal iconic force that created a world of “twos” that contributed to worsening segregation, especially in education and healthcare. In Memphis, Blacks had successfully established religious institutions, but medical training schools and hospitals required more than just a building. A Black hospital was needed in Memphis; according to historian William D. Miller, although the city of Memphis had seven hospitals, only two had modern facilities. The city hospital was relocated on Madison Avenue.\textsuperscript{28}

In 1889, the \textit{Dow Directory} listed seven exclusive schools for Blacks, including perhaps five private schools whose tuition ranged from 70 to 100 dollars. The other two schools were public facilities.\textsuperscript{29} By 1894, Memphis had four public schools. Many social institutions such as churches and societal organizations were founded and supported by Blacks. The idea of Black physicians establishing a facility to produce Black doctors to care for their own race was thus not widely opposed. Specifically, after Meharry’s enrollment of former slaves who were trained in the field of medicine, Black physicians in Memphis sought to emulate their success.

The cities of Memphis and Nashville trained Black physicians who collectively embraced their duties as benevolent medical providers. The two schools—Meharry and the University of West Tennessee—shared faculty, met yearly at conventions, celebrated milestones, met the health needs of impoverished Blacks, and were dedicated to uplifting their race. In the Friday, August 29, 1912, edition of the \textit{Nashville Globe}, the front-line

\textsuperscript{27} Wilbur H Watson, \textit{Blacks in the Profession of Medicine in the United States: Against the Odds} (Transaction Publishers: New Brunswick, 1999), 25, 31-32.


\textsuperscript{29} \textit{Dow’s City Directory of Memphis} (Memphis: Harlow Dow, 1889), 54.
column was titled “Meharry Reunion a Success.” Dr. Charles Victor Roman delivered the welcome address. He included a summary about the history of Meharry Medical College: “To the five Meharry Brothers Hugh, Alexander, Samuel, David and Jesse who so generously aided in establishing in supporting this institution it bears their name the colored people of the south and especially the alumni of Meharry owe a debt of gratitude which can never be repaid.” Reverend Samuel Meharry of Lafayette, Indiana donated an initial gift of $500 to support the college.\(^\text{30}\)

Meharry Medical College trained numerous Black men and women to become physicians, surgeons, educators, mentors, consultants, and community leaders. Some, such as Dr. Robert Fulton Boyd, founded medical universities and hospitals in Memphis. Boyd was born into slavery in 1855. At a young age, he resided in Giles County, Tennessee. He was separated from his mother during most of his childhood, and then reunited in 1866 and moved with his family to Nashville. His academic career included an appointment as Professor of Anatomy, Professor of Surgery and Dean of the Medical Department of University of Tennessee in Nashville.\(^\text{31}\) As practicing physician and community leader, Boyd opened the first hospital in Nashville to serve Blacks, the Boyd Infirmary.\(^\text{32}\)


In the late nineteenth century, disciplines other than medicine including anthropology claimed to provide authoritative knowledge and a voice of scientific reason. Cultural anthropologist Lee Baker notes that theories and ideas by scholars in anthropology shaped social ideas and aided in the rise of institutional racism. Theories of race were as prevalent as pro-slavery arguments about race inferiority during the antebellum period. In the post-Civil War era, ideologies regarding racial hierarchies and civilized groups justified Jim Crow. The ideas of Social Darwinism evolved into race ideologies and eugenic myths.33

In his article “Social Darwinism, Scientific Racism, and the Metaphysics of Race,” Rutledge M. Dennis describes how Herbert Spencer’s concept of Social Darwinism, originally a theory of biological evolution, was later applied to human society. The theories promoted by William Graham Sumner incorporated Darwin’s thoughts and Spencer’s beliefs to support the cultural and social assumptions of slavery. Specifically, Social Darwinism affected race relations and social economics. Dennis explains, “during the last two decades of the 19th century, the belief in natural selection, racial purity, and racial struggle, elevated to a high level by the Social Darwinists, was given new emphasis with the eugenics movement.”34 However, historian David Southern


34 Rutledge M. Dennis, “Social Darwinism, Scientific Racism, and the Metaphysics of Race, The Journal of Negro Education 64 no. 3 (Summer, 1995), 244, 246. The most damaging research on racial inferiority of Blacks was the work compiled by statistician Frederick L. Hoffman. Hoffman believed that he answered America’s social problem, specifically “The Negro Problem.” Data charges from Freedmen’s Hospital records, morbidity and mortality data on the state and national level were used to determine why Blacks were dying, at a rate higher than other humans. As summarized by the author, Hoffman methodically determined by using the tautology, “Negroes died because they were inferior, and they were inferior because they died,” Megan J. Wolf, “The Myth of The Actuary: Life Insurance and Fredrick L. Hoffman’s Race Traits and Tendencies of The American Negro,” Public Health Reports 121 (January-February 2006): 84-85.
suggests that an unintended benefit of segregation was that it gave Blacks exclusive
proprietorship of their own businesses, especially in banking, insurance, and real estate.
Black millionaire Robert Church of Memphis was one person who created a financial
dempire in a world of racial tension and segregation. Still, as the nation believed that
Blacks were destined to die due to their race, Blacks physicians and social scientists
conducted research to address the social interactions of health, poverty and disease.

The level of Black mortality was devastating, particularly in Southern cities such
as Memphis. Many Black physicians who graduated from medical school by the turn of
the century had firsthand knowledge of slavery’s physical destruction of the human body.
Black physicians in Memphis viewed mortality rates in cities as a problem of racism,
social segregation, and lack of healthcare facilities. Black physicians in Memphis realized
that poverty, segregation, and Jim Crow were barriers that created atrocious morality
rates. It was thus imperative for Black physicians to create their own institutions to care
for African Americans. Black Memphians needed institutions to care for their own—
specifically, medical universities and hospitals. One such physician who answered the
call of duty was Dr. C.A. Terrell.

The Esteemed Dr. C.A. Terrell

At the Meharry reunion on August 22, 1913, Dr. Cleveland A. Terrell of
Memphis served as one of the representatives for the graduating class of 1894. Terrell
graduated as a trained surgeon with distinctive honors. His professional colleagues
thought highly of him, as his accolades of professional appreciation were numerous: “A
new star has appeared in the surgical horizon in the person of Dr. C.A. Terrell of

Davidson, Inc., 2005), 85-86.
Memphis.” On March 29, 1907, Dr. Terrell delivered an address before the alumni association of Meharry Medical College in Nashville. He discussed high Black mortality as a social reality in the city of Memphis:

How will we have done; this can easily be shown by the records of our large cities wherein are found a great number of our people. In the city of Memphis, having a population of two hundred thousands, fifty per cent being Negroes, the death rate ten years ago was three times as great as that of the white race, during this period the increase of Negro physicians has been four to twenty-four, and the death rate has decrease in proportion to the increase of the presence of the Negro physicians; so that now, the weekly per cent of death rate is about equally divided among both races. If we can achieve so much without being well organized, and having no hospital advantages, what may be expected in organization Negro medical societies and building hospitals throughout the south-land, where the doors of such needful help are closed against us?

Terrell’s speech focused on Black physicians’ professional commitment to their race. He was aware of mortality discrepancies between the races, and the need for improvements in the health status of African Americans. Terrell certainly realized and recognized that access to health care improved mortality rates as more Black physicians established practice in deprived Black communities. Dr. Terrell was on the forefront among Black physicians in Memphis. Detailed discussion of his career, including the establishment of a Black hospital and professional collaboration, will occur later in this dissertation. However, it is important to discuss the reality of Black healthcare—hospitals were needed for training and treating sick people. Black physicians therefore encouraged peers and colleagues to obtain home or building and convert the structure into a hospital.


For example, in 1900, Daniel Hale Williams explained to Dr. Robert F. Boyd the necessity to secure a building—specifically a house—to convert into a hospital for patient care and for the medical college. Dr. Boyd was one of many physicians in Tennessee to share a commitment to medical training and the improvement of the health of Blacks. Boyd was born a slave. In 1882, he graduated from Meharry with honors. Having a desire to teach and train other physicians, he opened a small infirmary in the basement of his office. Boyd later solicited funds to establish a training hospital for the Blacks. Dr. Robert Boyd owned and operated Mercy Hospital. Still other Black physicians felt a deep commitment to serve and provide health care. In 1900, Dr. Jim Miller completed medical school and relocated back to Greenville, Mississippi to start a medical practice with his brother because the community needed Black physicians.38

During the late nineteenth and early twentieth century, Memphis had nearly forty Black physicians and surgeons who had graduated from medical schools. Their standards conformed to the American Medical Association’s recommendations. Terrell, like other prominent Black physicians and business leaders in Memphis, demonstrated self-pride and confidence by locating his office on Beale street, where nearly 40% of Memphi’s Black physicians established their practice.39 The significance of Dr. Terrell’s service to medicine was based on “a need that existed in West Tennessee, Arkansas and Mississippi for a hospital of class that would meet the demands of the people, where all classes could receive nurses and attention for the best physicians in the county.” Within the Black


community, the middle class and poor required health care, as race and not class determined access to services.\(^\text{40}\)

As a surgeon, Terrell was one of the most successful in Memphis; patients traveled far to receive care at his infirmary.\(^\text{41}\) He discussed the benefit of Black physicians attending state and national meetings. Through medical societies, Terrell promoted a philosophy of professional unity. He persuaded fellow physicians to “lay a foundation for that unanimity and friendship, which is essential to the dignity and usefulness of the profession.” Likewise, he urged doctors to rely on one another through collaborative efforts for the betterment of patient care. He wrote that “In all cases where counsel is requisite, they will assist with each other without reserve.”\(^\text{42}\) In addition, Dr. F.A. Stewart of Nashville spoke at a conference to highlight and acknowledge the need for higher education among Blacks. Stewart emphasized that the South needed more physicians, especially surgeons. For example, in 1910, Mississippi had a Black population of nearly a million, but there were only fifty Black physicians to care for them.\(^\text{43}\) Black physicians took part in meetings and conventions, a practice consistent with Todd L. Savitt’s article “Entering a White Profession.”

Black physicians in the late nineteenth century and early twentieth century faced a multitude of challenges in a predominately White medical profession. These included the


blocking of Black doctors from private practice and hospital privileges. In a divided racial society, Black physicians explored other alternatives and venues to support one another, as historian Darlene Clark Hine demonstrates, Black professionals had agency. Specifically, this was demonstrated through the establishment of medical journals and the coming together for annual meetings and collegial support by physicians in Memphis and at Meharry. The latter was important because historical documents suggest a strong emphasis on providing medical care for poor and needy Blacks in communities such as Memphis.

On July 1, 1910, the *Nashville Globe* featured a front-page column titled “State Meeting-Health in Knoxville Great Success. Negro Doctors Discuss Health Condition.” The consensus among Black physicians was that the city embraced the gathering. Knoxville Mayor Heiskell delivered a welcome address to attendees. One writer deemed it “the greatest meeting in the history of the State Association of physicians, surgeons, dentists, and pharmacists of Tennessee.” Social and medical problems that represented disease burdens and high mortality rates based on African Americans health conditions were read before peers and community leaders. For example, Dr. J. H. Homan presented a paper on hookworm diseases. Dr. A.M. Townsend read his paper on pellagra and included case studies. Three years later, Tennessee would unite a nation of Black healthcare providers as Nashville hosted the 13th Annual Meeting of the National Medical Association. Its co-founder, Myles V. Lynk, had insight, passion, and vision for the future endeavors of Blacks in the field of medicine.

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**The Eminent Dr. Miles V. Lynk**

Dr. Miles Lynk was born June 3, 1871 on a farm near Brownsville, Tennessee, to former slaves. Standard medical practice at the time allowed for student training as an apprentice under a licensed physician. Lynk chose J.C. Hairston, a physician from Brownsville, Tennessee, and spent two years gaining experience and skills in laboratory studies. In 1889, he entered formal training at Meharry Medical College and completed his coursework in 1891. At the age of 19, Lynk graduated second in a class of thirteen other students. As a physician, he demonstrated the importance of community and a sense of obligation. Subsequently, Dr. Lynk began a medical practice in his hometown of Brownsville. His passion for knowledge also enabled him to obtain a law degree at Lane College in Jackson, Tennessee. Likewise, eagerness to train others in medicine guided him toward establishing a university to meet the health care needs of African Americans. For Lynk, medicine was all-encompassing and collaborative. At the time, medicine, nursing, and pharmacy were interdependent in the health care arena. He aspired to educate and train physicians, nurses, dentists, pharmacists, and lawyers at his proprietary school. The University of West Tennessee would produce a cadre of healthcare and community providers.

Dr. Lynk was aware of the daunting task he had set for himself in the early twentieth century. He observed the number of excellent medical institutions in Tennessee: Vanderbilt, the University of Nashville Medical School, the University of

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47 Miles V. Lynk, *Sixty Years of Medicine or The Life and Times of Dr. Miles Lynk: An Autobiography* (Memphis: The Twentieth Century Press), 63-64.
Tennessee Medical, the Medical Department of former Grant University at Chattanooga, and the Memphis Medical College. However, the above institutions were used to train large numbers of White medical students and not Blacks.\textsuperscript{48} The necessity of locating a building, opening a school, recruiting students, maintaining facilities, providing equipment, obtaining faculty members, and acquiring monetary support would probably have discouraged many people. While Lynk appreciated the need for a Black medical school, he also grasped the social reality of the Jim Crow Era for Blacks who wanted to build competent medical schools.

Prior to the establishment of the University of West Tennessee in Memphis, nearly half of the fourteen existing Black medical colleges in the nation had closed. For instance, Lincoln University in Oxford, Pennsylvania closed in 1874, Straight University in New Orleans, Louisiana closed in 1874, Hannibal Medical College in Memphis closed in 1896, Knoxville College closed in 1900, and Chattanooga National Medical College closed in 1904. As documented by Todd Savitt in his history of Black medical schools, proprietary medical schools were considered unique in late-nineteenth century America. They were established by Black physicians and received no support from philanthropists. Usually they operated with financial support from endowments, grants, and state and federal assistance. There were four Black proprietary schools in Tennessee; two were established in Memphis.\textsuperscript{49}

In 1888, Shelby County published the \textit{Tenth Annual Report of the Board of Health}. Accordingly, the Board of Health defended the existing preventive health

\textsuperscript{48} Ibid., 63-64.

\textsuperscript{49} Todd L. Savitt, “Abraham Flexner and the Black Medical Schools,” \textit{Journal of the National Medical Association} 98, no. 9 (September 2006): 1416.
measures by determining the importance of protecting the financial interest of the city. Isolating individuals, mainly Blacks, who posed health risks, saved “many thousands of dollars to the business interest of the city, but more importantly, it would also inspire confidence in the outside world to know that we were fully prepared to handle the disease.” What was evident for Black physicians who traveled to or lived in Memphis was that health care was inadequate for residents. Many Blacks who lived in Memphis had no access to healthcare. The necessity for Black physicians was evident. In Memphis, medical education and training for Black doctors was crucial. The social and cultural climate during Jim Crow corresponded to high disease and illness for Blacks. Black physicians thus undertook the responsibility of establishing their own medical colleges.

**Black Medical Schools in Memphis**

Hannibal Medical College (HMC) was established in Memphis. Although historical accounts of the medical college remain sparse, and the school existed for only a short time, its history should not remain obscure. HMC was a viable medical school, and The *Polk’s Medical Register and Directory of North America* reports that it was open to educate colored students. It lists the school as extinct with no given date for closure. An advertisement from the era records the existence of HMC as a medical college in Memphis. In volume IV of the *R.L. Polk and Co’s Memphis Directory of 1893-1894*, there appears a paid advertisement for the Hannibal Medical College. According to existing sources, the college was chartered on June 3, 1889; J. C. Waters, A.M. D.D., was

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its president. Five physicians, one dentist, two clergymen, and two others comprised the Board of Directors and Faculty for the year 1893-1894. There was also a department of dentistry affiliated with the medical college. Courses were taught on surgery and surgical anatomy, physiology and hygiene, theory and practice of medicine as well as pathology and histology. Dr. T.C. Cottrell is listed as the secretary and dean of Hannibal College.

In his history of medicine in the period, Todd L. Savitt questions the credibility and distinctiveness of this medical school. For example, there was no permanent teaching facility for clinical instruction and lectures. It is not altogether clear whether the teachers at the college had the proper credentials to practice medicine.\(^\text{52}\) Also, Doctor Cottrell reported that he received a medical education and degree from Bethel Medical College at Southwestern University; however, no such medical school existed.\(^\text{53}\) Upon comparing advertisements, the 1894 Polk Directory gives an address of 121 Beale. In 1893, the city directory recorded the college as being located at 446 Main Street in Memphis. These discrepancies may reflect the logistical difficulties associated with operating a Black medical college during the Jim Crow era.

Tuition and other expenses were as follows: matriculation (paid once a year) was $5.00, tuition per semester was $25.00. The graduating cost was $25.00. One of the most important printed statements about Hannibal Medical College was “We respectfully solicit from all regular Physicians of the city any aid they can render. HMC For further information, call on or address, T.C. Cottrell, M.D.”\(^\text{54}\) Hannibal Medical School, like

\(^{52}\) *Memphis City Directory 1894-1895*, (St. Louis: R.L. Polk & Co., 1894), 44.


other Black medical colleges in Tennessee such as Knoxville College Medical
Department, Knoxville Medical College, and Chattanooga National Medical College,
could not survive without financial support from state and local governments. Howard
University survived because of federal funding.\textsuperscript{55}

Dr. Lynk was aware the history of Black medical schools in Tennessee,
specifically the inability of medical schools to remain open. In 1907, Lynk established
the University of West Tennessee. From 1900 to 1907, the University of West Tennessee
was in Jackson, Tennessee. The first session began with the following numbers. Six
students enrolled in medicine, but no one registered for nursing. The total number of
students in medicine was four. There were three in dentistry, pharmacy, and law. All
graduated and attained a state license to practice.

Immediate expansion of the university made it imperative that the school relocate
to a metropolitan center so that clinical amenities would be of the highest quality, with
more faculty and staff.\textsuperscript{56} The University of West Tennessee moved to 1190 South Phillips
Place in Memphis. The North Hall of the university contained the chapel, infirmary, and
the chemical, anatomical, bacteriological, pathological, histological, and dental
laboratories. The southern region of the school consisted of two lecture halls that could
accommodate 300 students.\textsuperscript{57} The medical school made arrangements with the Jane
Terrell Hospital for clinical education and training, so physicians who taught clinical

\textsuperscript{55} Earl H. Harley, “The Forgotten History of Defunct Black Medical Schools in the 19\textsuperscript{th} and 20\textsuperscript{th} Century
and the Impact of the Flexner Report,” \textit{Journal of the National Medical Association} 98, vo. 9 (September

\textsuperscript{56} Miles V. Lynk, \textit{Sixty Years of Medicine or The Life and Times Of Dr. Miles Lynk: An Autobiography}
(Memphis: The Twentieth Century Press), 66-67, 70.

\textsuperscript{57} G.P. Hamilton, \textit{The Bright Side of Memphis} (Memphis: Lightning Source: 2003), 258.
subjects also held faculty appointments in the school.58 Historical debates about the university include whether laboratory and clinical training occurred. One way to authenticate the training involves eligibility for state licensure. The UWT graduated over 200 students. Research conducted by Richard E. Brown emphasizes that obtaining a science building and purchasing medical/clinical equipment is a large operating expense. However, wealthy citizens footed the bill.59 For the wealthy class of men and women living in Memphis, purchasing equipment for the community was not a difficult undertaking.

Lynk focused on the complex health problems existing in Memphis and the need for a diverse group of medical providers. The idea of a surgical training institution was key to meeting this need. He had close ties with renowned Black surgeons, including R.F. Boyd, who also lectured at the University of West Tennessee. Some of the medical seminars that were delivered at this time were Boyd’s lecture, “Abdominal Surgery.” E.E. Francis, M.D., of the Memphis Hospital Medical College discussed “The Surgical Anatomy of Hernia,” and Louis Le Roy, M.D., of the College of Physicians and Surgeons provided clinical information on “The Pathology of Tuberculosis.”60 Dr. C.A. Terrell held a faculty position at the University of West Tennessee as a Professor of General and Orthopedic Surgery. Faculty members’ areas of medical expertise included theory, practice of medicine, anatomy, pediatrics, obstetrics, diseases of the eye, ear, nose and

58 Patricia LaPointe, From Saddlebags to Science: A Century of Health Care in Memphis, 1830-1930 (Memphis: The University of Tennessee Center for The Health Sciences, 1986), 59


60G.P. Hamilton, The Bright Side of Memphis (Memphis: Lightning Source: 1908), 226.
throat, and venereal diseases. As a Black physician, Dr. Lynk focused his medical training on ways to uplift all Black physicians to improve health care.

**Beloved Practitioner and Race Leader**

Historian Darlene Clark Hine suggests that “without the parallel institutions that the black professional class created, successful challenges to white supremacy would not have been possible.” As noted, the most obvious reason for a Black national medical organization was the longstanding history of racism among White providers. For instance, on April 10, 1870 an editorial was printed in the *Memphis Daily Appeal* with the heading “Sambo Again, He is After the Doctors, and Wants Fellowships in the American Medical Society.” Black physicians in D.C. completed medical trainings and passed licensure examinations. With a medical degree, a White physician could apply for membership and be accepted into the state Medical Society. Black physicians also met the criteria for admission into the Medical Society but were denied. Black physicians formed their own society, and White physicians became indignant. Specifically, White physicians opposed Black physicians taking the initiative to establish a separate medical organization. Most vexing was the question of whether the American Medical Association would allow this new society to join; state medical societies in good standing could apply for membership.

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61Ibid., 256.


In 1907, the AMA refused membership to Black doctors. Consequently, Dr. Miles Lynk took several steps that contributed to access to professional growth among Black physicians in Memphis and nationally. First, he assisted with the formation of the National Medical Association to counter the racial exclusion of the American Medical Association. In addition, Lynk published the first Black medical journal, *The Medical and Surgical Observer*. Black physicians had limited access to professional venues that shared and disseminated information on clinical studies and the discussion of Black medical practice. Black physicians were victims of plagiarism by White physicians. When Black doctors discovered new clinical case findings, White doctors would take credit and publish details in well-known medical journals. Unethical practice within the ranks of White practitioners did not deter Black physicians in Memphis.  

Many graduates remained in Memphis to provide ongoing medical care for their communities.

The quality of Black medical instruction could sometimes be a concern. Multiple sources report that Black proprietary medical schools were founded to obtain money from student tuition, with minimal concern for training physicians. However, physicians at the University of West Tennessee (UWT) were conscientious in assuring a high-quality education for their students. Money for fees to increase the founders’ income was not their incentive for teaching and training. Many faculty at UWT were established physicians who had their own private practices, and many were also proprietors of hospitals and infirmaries. Various other physicians (such as L.S. Henderson) had large

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real estate investments. Another physician, Dr. A.D. Byas, owned a drug store.\(^66\) As stated previously, the school did not have an endowment or state funding; no money came from charity or religious organizations. Its faculty and administration believed that “to devote one’s best energies to the welfare of such an institution required a love of the race, and humanity.”\(^67\) Basically, instructors worked for little or no money. Although it may seem outside of the norm that the UWT faculty members worked there part-time, medicine was not then a lucrative field, as noted by Lynk’s quote. White physicians of the era frequently complained about substandard living conditions associated with physicians’ pay.\(^68\)

Black physicians kept abreast of ills than affected their race in Memphis by following publications that documented statistical data about illness and disease in their community. In 1900, Dr. Herbert Jones was appointed President of the Board of Health. Dr. Jones explained that the total number of deaths for 1900 was 998 White and 1,144 Blacks. A significant minority, 490, of the deaths among Blacks were non-residents, while 596 permanently lived in Memphis. Black non-residents had a slightly higher mortality rate compared to residents. Specifically, 20.40 per 1,000 deaths were non-residents and 20.16 were Blacks who were legal residents. Jones proudly explained that “This death rate is decidedly less than any other Southern City,” referencing Nashville,

\(^{66}\)Ibid.,30.

\(^{67}\) Miles V. Lynk, *Sixty Years of Medicine or The Life and Times of Dr. Miles Lynk: An Autobiography* (Memphis: The Twentieth Century Press), 73.

Atlanta, and Richmond. The existence of many non-residents in the city can be explained by the job market; as in the antebellum era, people arrived daily for employment opportunities, especially people from nearby states.

**Power, Control and Exclusion**

Jim Crow segregation continued to define the type of health care that Blacks could access. For example, St. Joseph offered free hospital beds and admissions, but only accepted White patients. The City Hospital, which underwent massive reconstruction and expanded its bed capacity to 130 in 1898 to, “accommodates only the indigent (white and black).” The city hospital had four physicians and a visiting doctor, and the medical superintendent had control over the facility. The yearly operating cost for the facility was $65,000 (the equivalent to $1,831,350 in 2020). The modern City Hospital had elevators, telephones, and improved ventilation with forced heating and air. An amphitheater was used as a show-and-tell teaching venue for surgical cases.

One of the cases taken to the amphitheater was described by Dr. P. M. Farrington, the surgeon in charge at the City Hospital. He was also an Assistant Professor of Physical Diagnosis at the Memphis Hospital Medical College. R.H., a thirty-eight-year old Black male, was admitted to the hospital on July 10, 1898. This patient was not a resident; thus, admission to City Hospital was consistent with its charitable mission. According to the report, R. H. had been working on a railroad in Kentucky. He suffered a fractured skull by a work instrument called a Maddox. Three to four days after the incident, he arrived

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and was admitted to the city Hospital. R.H. became unconscious and his fever spiked to 104°. Brain surgery was required, and after nearly a three-month stay, he was discharged.

This case indicates the great need for City Hospital’s service and the severity of the cases it treated. The new hospital was exclusively erected to care for a select group of Blacks patients who met the criteria for indigent care, but treatment was rendered in segregated wards.  

The newly renovated surgical hospital refused Black physicians admitting and clinical privileges. Although Memphis had remarkable Black surgeons, they could not operate on patients at City Hospital; Black physicians had to refer complex surgical patients to City Hospital to be operated on by White physicians.

Dr. Lightfoot West, a native of Nashville, was one such talented surgeon. He graduated from Meharry Medical College, moved to Arkansas and established a successful practice. In addition, he was a surgeon at the Collins Chapel Hospital in Memphis. West began touring clinical hospitals throughout west Tennessee. He then proceeded to the Mayo Brothers Clinic in Worchester, Minnesota for postgraduate study. Likewise, Dr. J.T. Wilson was noted “to have been doing some special work with the famous Mayo brothers” in Rochester, Minnesota. The skill and level of training of Black surgeons were often exceptional.

Nevertheless, Tennessee lawmakers wanted to eliminate Black physicians. They were perceived as unwanted competition for White physicians. A Nashville source noted


in 1917 that “Tennessee now has one doctor to every five hundred population, and there is no longer shortage in doctors, but an overplus [sic] of them, and the colleges and State Board should raise their standard.” Tennessee physicians had a false perception of overcrowding in the field of medicine, and they were not alone. Frank Billings (1903) wrote that

It has been estimated that there is an average of one physician to 600 of the population of the United States at the present time. The natural increase in the population of the country, and the deaths in ranks of the profession, make room each for about 3,000 physicians, based on the proportion of one physician to 600 of the population. With 5,000 or more graduates each year, a surplus of 2000 physicians is thrown on the profession, crowding it, and steadily reducing the opportunities of those already in the profession to acquire a livelihood. In reality, the ratio of Black physicians in relation to the population they served was inadequate because the total number of graduating physicians was too low. Nationally, the number of Black physicians increased from 909 in 1890 to 3,490 by 1910. However, there remained a vast disparity in doctor patient ratio. The number of Black physicians per patient was 1 to 3,000, and many Black physicians in Memphis and other Southern cities understood that Blacks lacked medical providers. Nevertheless, Black physicians were not welcomed by local and state organizations. National organizations such as the American Medical Association sought to decrease the number of trained physicians and eliminate competition.


During this period, new influences were shaping medical education and practice. Millionaires began to determine the medical model for educating physicians. Abraham Flexner, became the architect of university-based medicine.\(^78\) The Flexner Report enabled the American Medical Association to acquire “independent” educational agencies such as the Carnegie Foundation, and other philanthropists to support specific ideologies of medical training and education.\(^79\) Medical universities were for sale to the highest bidder, driven by endowments and research funding, and political forms of extortion emerged.

Specifically, in 1910, Abraham Flexner’s *Medical Education in the United States and Canada: A Report to the Carnegie Foundation for the Advancement of Teaching* began the process that closed many medical teaching institutions. The Council on Medical Education (CME) of the AMA enabled Abraham Flexner (hired by the Carnegie Foundation) to become the leading “expert” on medical education in the United States. However, Abraham Flexner had been recommended by his brother Dr. Simon Flexner, the director of the Rockefeller Institute. The General Education Board (GEB) was controlled by the Rockefeller Institute.\(^80\) In 1992, Barbara Barzansky and Norman Gevitz published “Beyond Flexner: Medical Education in the Twentieth Century.” They noted that prior to 1908, when Carnegie hired Flexner, the CME had evaluated all medical

\(^78\) Abraham Flexner, was a professional educator who graduate from Johns Hopkins, started a preparatory school in Louisville, and later enrolled in Harvard to advance his studies in the field of education. His brother Dr. Simon Flexner was director of the Rockefeller Institute. Abraham Flexner was selected by the Carnegie Foundation and Rockefeller’s General Education Board to conduct a study on professional education, specifically medical education, E. Richard Brown, *Rockefeller Medicine Men; Medicine and Capitalism in America* (Berkeley: University of California Press, 1979), 144.


schools three times, twice using state medical licensing board results and once through personal visits. Flexner did not visit any medical schools after 1908, because he wrote his report 18 months after visit 155 medical schools.

The AMA wanted to address the perceived threat of “overcrowding” in the profession while pushing to reform education. The AMA increased their membership force by nearly tenfold from 8,400 in 1900 to approximately 70,000 by 1910. Flexner’s report was instrumental in determining how America would produce doctors and at what rate. Only the schools for which Flexner gave favorable recommendations remained viable. For the surviving schools, their cost of producing doctors increased enormously.

In addition, Flexner questioned the need for Black physicians to work in large cities. He intended for Black physicians to return to—in his words— “villages and plantations” to care for rural Blacks. Flexner believed that Blacks would do better to return to the days of forced free labor, rather than using intellectual skills.

Some White medical schools prospered during this time; Vanderbilt University received $8,000,000 from the Carnegie Foundation and the General Education Board. For Black medical schools, the situation was different. Flexner’s report established extreme professional requirements, which ushered in the end of many Black medical schools. The impact on The University of West Tennessee (UWT) and other Black medical schools

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81 Barbara Barzansky and Norman Gevitz, Beyond Flexner (New York: Greenwood Press, 1996), 68.


were tremendous. Social biases and cultural mores about disease and race contamination were present in Flexner’s understanding of medical education and physician training. Flexner detailed how Blacks suffered from hookworm and tuberculosis as if these conditions were isolated to Blacks alone. Despite his power to write recommendations for financial support for Black medical schools such as University of West Tennessee, Flexner preferred to focus on social reform. He expressed concern that nationally; 10 million Blacks lived near Whites. It was therefore necessary to train a limited number of Black physicians to teach Black people basic principles of hygiene to cure disease among the race. He believed the latter goal could be accomplished by maintaining two medical schools: Meharry and Howard.85

At the time of Flexner’s visit to Memphis, Lynk was not narrowly focused on medical education regarding basic hygiene at the University of West Tennessee. Lynk recognized the need for a diverse field of Black physicians, surgeons, and dentists, all of whom were part of the diverse clinical staff at UWT. This was necessary because when it came to managing the care of Blacks in Memphis, lifesaving procedures and treatment were not available without Black physicians. The University of West Tennessee made arrangements with the Terrell-Patterson Infirmary for clinical, education, and training, so physicians who taught clinical subjects also had faculty appointments in the school.86 Flexner’s report indicates that The University of West Tennessee was the only medical school in Tennessee that had 14 physicians as full professors. Notable faculty included


86 Patricia LaPointe, From Saddle Bags to Science: A Century of Health Care in Memphis, 1830-1930 (Memphis: The Health Sciences Museum Foundation of the Memphis and Shelby County Medical Society Auxiliary 1984), 68-69.
Louis Le Roy of the College of Physicians and Surgeons in Memphis. He graduated from Vanderbilt University specializing in pathology and bacteriology and lectured on the pathology of tuberculosis. He is also credited with using the first X-ray machine in Tennessee.  

The University of West Tennessee and Knoxville Medical College were given brief and limited descriptions in Flexner’s report when compared to other medical schools in Tennessee. For example, in November 1909 (no specific date documented), under the section titled “Clinical Facilities for UWT,” Flexner noted: “The students have access to eight or ten beds, twice weekly, in a small hospital close by.... There is a dispensary, without records, in the school building.” If Flexner was the sole source used to authenticate the existence of Black medical schools including University of West Tennessee in Memphis, we might be led to believe that the University produced incompetent Black physicians. Fortunately, other published reports of the University of West Tennessee provide an alternative to Flexner’s report and limited analysis.

From UWT’s inception, Lynk created a four-year university program with evidence-based medical curriculum, laboratories, licensed physicians, clinical facilities, and training hospital. The South Hall had two spaces that served as separate lecture halls, but the space easily converted into a large auditorium when needed. Lynk selected a developing area in the city to erect the university with the goal of “furnishing facilities for the higher education of Afro American youth.” Other Black physicians shared this
goal. The higher education and professional training of Black physicians related to their benevolent call of duty. For example, the Terrell-Patterson Infirmary advertised the following: “All cases needing medical or surgical treatment placed in our care will receive the best attention. Patients within or without the city needing special treatment will find this Infirmary the most desirable place in the lower Mississippi Valley. Well ventilated, Electrical Lights and Bells.” Yet Flexner described medical training in Tennessee in harsh terms: “Tennessee protects at this date more low-grade medical schools than any other southern state.” This claim may reflect the fact that Tennessee had more Black medical colleges and universities than other states, or Flexner’s bias for believing that the state needed only one medical school—Vanderbilt.

Black physicians in Memphis understood the value in creating and establishing their own medical schools and hospitals. Certainly, educated professional Black physicians wanted to control their own destiny and foster health reform. White medical schools controlled and restricted admittance into medical schools. The ability to train physicians and allied health providers including pharmacists, nurses and dentist enabled the Black community to access to health care services that were denied at White hospitals. Whether the Black community elected to have Black physicians care for them is outside the scope of this dissertation. However, many Blacks had no choice.

Black medical universities and colleges faced near extinction by the early twentieth century. In his remarkable contribution to medical history, The Centennial History of the Tennessee State Medical Association from 1830 to 1930, Paul Hamer

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90 G.P. Hamilton, The Bright Side of Memphis (Memphis: Lightning Source: 1908), 228.

describes eighteen schools in the state with goals to develop a medical college or university. Hamer provides a history of the medical association and of how medical practice varied in the three regions of the state, along with a history of each medical college or university. Eleven schools operated simultaneously. For White medical schools in the state, several mergers allowed for expansion, growth, and continuation in the post-Flexner era. The College of Physicians and Surgeons began in 1905 as an independent medical school. After Flexner degraded the college, faculty members and administrators subsequently combined in 1911 with the University of Tennessee to form a cohesive training program. The University of Tennessee was one of three medical universities located in Nashville. Originally, in 1874, the University of Nashville was a part of Vanderbilt’s school of medicine, and the schools shared faculty members; however, Vanderbilt soon overshadowed the University of Nashville. In 1909, the University of Nashville and the University of Tennessee united, and in 1911 they relocated permanently to Memphis.  

 Flexner also destroyed the integrity of several White medical schools in Tennessee, viewing them negatively due to his preconceptions about American medical education. For example, he referred to the College of Physicians and Surgeons as “a stock company, now calling itself the medical department of the University of Memphis, a fictitious affair.” Likewise, Flexner described the University of Nashville as “a university in name only.” Yet he noted that Vanderbilt University’s Medical Department and Meharry Medical College should remain open. Flexner explained that Vanderbilt had “an

organic department of the university,” perhaps meaning that Vanderbilt’s medical school was necessary and essential. Flexner noted that the requirements for entrance into several medical schools were “less than high school graduation, though a fair portion of the students have had some college work.” Also, Meharry’s prerequisites were “less than a four-year high school education.” Flexner’s high standards had a detrimental effect on medical education.

At the time, there were no perfect medical schools in the United States, but many colleges and universities could have received funding to survive and increase medical training and education. With the demise of Black medical schools, Henry S. Pritchett, president of the Carnegie Foundation, “protested the grave injustice done to the negro schools by the de facto policy of not extending to them the same leniency given to white schools in the South.” The reality is that Flexner wanted all medical schools to reflect the status of his Alma Mater, Johns Hopkins. Most medical schools, including Harvard, felt insulted by the report.

Ward provides a synopsis of Black medical schools, including proprietary colleges. For many Blacks, notably those who were one generation removed from slavery, medical education was costly. Black physicians in Memphs were an elite group of professionals who were embraced by their race, but they often came from humble backgrounds. In general, Blacks who studied medicine in the Jim Crow South were poor males who desired to improve the health of their race. Ward also notes that upon


graduation, White medical providers and the public viewed them as less qualified when compared to White physicians. After Flexner’s report, the University of West Tennessee remained opened until 1923.

**Benevolent Physicians**

The early twentieth century represented change for many Blacks, who survived and endured the after-effects of slavery. “Memphis was home to a new-urban 20th century community.” Over forty black physicians, including surgeons, practiced medicine in the Black community, having graduated from The University of West Tennessee, Howard, Knoxville, and Lincoln University. However, most physicians received their medical education and training at Meharry. G.P. Hamilton noted that Black physicians met qualifications to pass and receive licensure from the State Board of Medical Examiners. Community leaders such as Hamilton defended the Black physicians in Memphis as educated professionals, not quacks.

Exceptional graduates from Meharry established a core of Black physicians to improve the health status of Black Memphians. Dr. Lawrence G. Patterson, the nephew of Dr. C.A. Terrell, graduated from Howe Institute in Memphis and attended Rust University in Holly Springs, Mississippi. Like other Black physicians in Memphis, he received his medical education and training at Meharry Medical College. Patterson was a

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95 Thomas J. Ward Jr., *Black Physicians in the Jim Crow South* (Fayetteville: The University of Arkansas Press, 2003), xi, 17.


Professor of Physiology at the University of West Tennessee and worked side by side with his uncle in providing care to people in Memphis. Patterson was instrumental in organizing the Tri-States Fair, which began in 1910. He also served as the President of Bluff City Medical Society and was the Medical Inspector for the Memphis City School System. He also gained expertise, experience, and knowledge via postgraduate work at prestigious institutions such as the Mayo Brothers Clinic in Rochester, Minnesota.\textsuperscript{99}

Robert G. Martin was one of Memphis’ Black physicians and civic leaders in the twentieth century. After graduating from Meharry Medical College in 1893, he practiced medicine in Montgomery County, Tennessee. His name appears in the 1909 American Medical Association Directory, along with his title and affiliation at the University of West Tennessee as Secretary and Professor of the Theory and Practice of Medicine at the University.\textsuperscript{100} He was acknowledged as the official head of the medical fraternity of Memphis and was president of the Bluff City Medical Association.\textsuperscript{101}

Jacob Christopher Hairston (J.C. Hairston), M.D., graduated from Meharry Medical College in 1888 and received his license in 1890. Dr. Hairston’s medical office was located at 327 Beale Avenue. He was Professor of Gynecology and Pediatrics at the University of West Tennessee. In 1905, Dr. Hairston opened a fifteen-bed hospital.\textsuperscript{102} Another member of this cohesive group of Black doctors was A.N. Kittrell, who graduated from Clark Atlanta, obtained a medical degree from Tuskegee, and later served

\textsuperscript{99} Directory of Memphis and Shelby County, \textit{A Classified Directory of Memphis, and Shelby County} (Memphis: The Negro Chamber of Commerce, 1941), 57.

\textsuperscript{100} UT Medical Center website physician cards accessed 1/6/2016.

\textsuperscript{101} G.P. Hamilton, \textit{The Bright Side of Memphis} (Memphis: Lightning Source: 1908), 41, 226.

\textsuperscript{102} \textit{Memphis, Polk City Directory} (1914), 2017.
as secretary at the Hairston Hospital. Dignity is conveyed in a contemporary advertisement for Hairston Hospital, stating that it was “Owned and Controlled by Colored People.” Doctor J.C. Hairston’s hospital was one of two facilities that served the Black community prior to 1909.\textsuperscript{103} Black physicians’ recognition of service and duty to local Black cities was evident in the early and mid-twentieth centuries.

In 1918, Dr. Martin, along with Dr. West, established Mercy Hospital in Memphis. Advertisements for Mercy Hospital show the location at 729 Mississippi Street. It was described as “one of the most modern hospitals in the city for colored patients. The staff is composed of the best physicians and surgeons and nurses, which ensures the best service.”\textsuperscript{104} The other hospital that was established by a Black physician in Memphis was the Terrell Memorial Hospital (TMH). The facility changed names several times, at one point being renamed after Dr. Terrell’s mother, Jane Terrell. TMH had its origins in the trailblazing efforts of Hairston. His colleague and associate, Dr. C.A. Terrell, was inspired to emulate the success of Hairston by opening an additional hospital to provide medical care for Blacks. Dr. Terrell’s hospital was initially referred to as Baptist Hospital at 698 Williams Avenue. TMH remained an important medical center in Memphis for over a half a century.\textsuperscript{105}

Still, racial disparities in healthcare persisted. In 1913, the \textit{Nashville Globe} called attention to “The Need of More Colored Physicians.” In the South and Southwest United States, there were about 1,500 educated Black physicians to care for eight million “of

\textsuperscript{103} G.P. Hamilton, \textit{The Bright Side of Memphis} (Memphis: Lightning Source: 1908), 22, 39, 226.


\textsuperscript{105} \textit{The Negro Yearbook and Directory}, (Memphis: Negro Chamber of Commerce, 1943), 80.
their own race.” Black physicians represented one-tenth of the total number of doctors. A comparison was made to inform the public that most Black children received education from Black teachers, with a small exception in some Northern schools. Black colleges in Memphis sought to remedy this imbalance.¹⁰⁶

The Jane Terrell Hospital’s reputation made it necessary to expand to accommodation more patients. Terrell realized that expansion was required based on the number of applications being received for medical care and treatment¹⁰⁷, and in 1919 he purchased property adjacent to the current hospital on Williams Avenue. Black physicians on staff had a diverse skill set and specialty training: Dr. A.A. White was an x-ray technician, B.F. Cleave managed the physical medicine department, and Dr. W.O. Speight was head of obstetrics. Dr. N.M. Watson, who completed his medical training at the University of West Tennessee, was the Chief Surgeon.¹⁰⁸

Collectively, Black doctors in Memphis banded together to address illnesses and treat acute and emergency health problems. Each doctor provided expertise and shared medical decisions, mixing with other local and out-of-state providers. Black physicians were community leaders. As professionals, they were linked by the tri-states, and they met annually to meet the challenges of disease and social health concerns. On March 29, 1919, T. O. Fuller extended a welcome announcement to the Black physicians of Tennessee, Mississippi, and Arkansas for a meeting on April 8-10 at the Masonic Temple


on Florida Street in Memphis. He explained that the purpose of the meeting was to exchange clinical information and dialogue about issues “vitaly affecting the mortality of their race.”

Physicians would consider the consequences of pellagra, influenza, sleeping sickness, and venereal diseases on the health status of Blacks. The doctors also planned to visit local hospitals such as Jane Terrell for research, training, and teaching clinics. Fuller used his weekly column, “Activities Among Memphis Negroes,” to convey reports about monthly meetings of the Tri-State Medical Association. For example, several papers written by other physicians were shared at meetings. The latter could conduct peer review of articles being considered for publication. Dr. W. J O. Lee of Humboldt, Tennessee wrote a paper titled “The Effects of Strenuous Life,” and Dr. A.C. McCaully from Denmark, Tennessee was the orator. The article “Appendicitis With Reference to Appendiceal [sic] Abscess” was presented by Dr. C.A. Terrell, and Dr. F.T. Jones of Little Rock, Arkansas led the discussion.

Memphis was a city that attracted Black professionals, and Black physicians in Memphis often emerged as civic and business leaders. Black physicians migrated to Memphis with an understanding that success in their profession was not an illusion, regardless of the racial climate and racial ideologies among White state and national medical societies. Black leaders pledged their support for the University of West Tennessee, as made evident by subscriptions that appeared in T. O. Fuller’s news

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column. Dr. L.R. Ross, Dr. William e. Cloud and Dr. J.J. Raines donated $100.00. Companies such as S. L. Lee & Cons, along with the American Snuff Company, each pledged $25.00. Well-known women such as Julia Hooks, the grandmother of civil rights leader Benjamin Hooks, also presented $25.00. Dr. Lynk was a member of the Shelby County Inter-racial committee, which examined social and political concerns among Blacks and Whites. Community action was extended across profession; for instance, Dr. Lynk delivered a Sunday sermon at Collins Chapel Church when pastor M.L. Warfield had a serious illness. In addition, spouses of Black men also engaged in health programs for the community. For Blacks, the University of West Tennessee represented elite medical education and was a source of racial pride.

Conclusion

With Flexner’s rise to power, the authoritarian control of philanthropists and ideations of Black leaders like Booker T. Washington determined which Black medical schools fit the prototype of proper medical training. The University of West Tennessee was advancing in areas of science and surgical skills that ran counter to mainstream beliefs of the era about hygiene improvements, as a foundation for medical training. With

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power over their own social and educational institutions, the Black community
participated in various medical enterprises to care for those in need.114

Black doctors were present on Beale Street, and many others had offices in the
same area. Black physicians in Memphis maintained focus on their race. In a gendered
profession, the wealthy, middle-class, and educated professional Black males in Memphis
uplifted one another for the benefit of their race. Black physicians had a desire to uplift
Black females via nursing training schools. For instance, in 1882 Nathan Francis Mosell
became the first Black man to graduate from the University of Pennsylvania; he received
a medical degree and completed postgraduate training at the Pennsylvania Polyclinic. Dr.
Mosell and several other Black physicians established a hospital for the same purpose in
Nashville and Memphis. Mosell wanted “a hospital where Negro physicians might have
an equal opportunity to practice, where Negro patients could be cared for, and where
Negro nurses might be taught the art of healing the sick.”115 Black physicians spoke
about the high mortality rates in Memphis:

If Jim Crow was present in the medical profession, it was especially prevalent for
Black women in nursing. Black nurses in Memphis were doubly isolated by the social
dynamics of gender and race, and White middle-class women prohibited them from state
licensure. In my final chapter, I move from focusing on physicians to exploring the
professional training and education of Black nurses in Memphis. Black physicians and
the community needed skilled and competent nurses. In his closing remarks on April 5,


1907, Memphis physician Dr. CA. Terrell summed up the importance of nursing to the Black community:

It can then be said that we do not need hospitals? As a race we are well supplied with churches, and partly so with schools, but we are sadly in need of modern up to date hospitals, wherein we can give our patients the best surgical, to say nothing about the medical treatment that each individual case may demand. This is not the only reason why we should build hospitals and help those that are already struggling for existence. It opens the way for the women of our race to become trained nurses and earn a splendid living in having a vocation in which each must lead a busy, useful and happy life, more you cannot expect, a great blessing, the work cannot bestow.116

Chapter 6: We Too Are Angels of Mercy: Black Nurses in Memphis

God didn’t give us a spirit that is timid but one that is powerful, loving, and self-controlled.¹

The documentation of women’s work as nurses before professional training in antebellum America is often appears in sporadic, short narratives that are interwoven with other types of medical history, or history of plantation health care. ² Although biographies and autobiographies exist of Black and White nurses who served during the Civil War, many other historical accounts of enslaved and free Black women remain untold; their voices are silent, and their nursing duties are often trivialized and minimized based on current descriptions and representations of professional nurses.³ Primary and secondary sources reveal that enslaved women often prescribed medications and had assistants to help with complex health care. Black nurses had a respectable status among enslaved and free Blacks, and even Southern Whites.⁴

¹ 2 Timothy 1:7 (Common English Bible).


³ For first-hand accounts of nurses during the Civil War, see Susie King Taylor, Reminiscences of My Camp Life: An African American Woman’s Civil War Memoir, (Athens: The University of Georgia Press, 2006); Letters and correspondence of nursing services during the Civil War, Hannah Ropes, Civil War Nurse: The Diary and Letters of Hannah Ropes, ed. John R. Brumgardt (Knoxville: The University of Tennessee Press, 1989).

⁴ White males were a part of plantation health care. Enslaved women shared herbal treatment and remedies with Black and Whites within their community, Sharla M. Fett, Working Cures: Healing, Health, and Power on Southern Slave Plantations (Chapel Hill: The University of North Carolina Press, 2002), 143. Many enslaved nurses defied their master by sharing herbal remedies, which allowed enslaved people to
Historical accounts of Black women in nursing tend to center on gendered roles in nursing, power dynamics women’s sphere, the evolution of nursing practice, and institutionalized racism and exclusion. However, there are limited histories on the study of Black nurses. Mary Elizabeth Carnegie’s history of Black nursing is essential for understanding how professional Black nursing developed. She provides an excellent background for studies on the history of Black nurses and their role in antebellum medical history. Nevertheless, the history of Black nurses tends to be fragmented, and historical accounts are not always accurate. Carnegie is especially attentive to how the history of Black nurses is fragmented, and historical accounts are not always truthful.

For instance, textbooks give credit to the University of Minnesota for establishing the first nursing program in a university. However, Carnegie notes that Howard University began a nursing school in 1893. This chapter places Black nurses at the center of nursing history in order to show the ways in which Black nurses were instrumental in

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5 Norma E. Anderson, “The Historical Development of American Nursing education, Journal of Nursing Education 20, no.1 (January 1981); Francis L. Hoffman “Feminism and Nursing” 3, no. 1 (Winter 1991); Evelyn L. Barbee, “Racism in U.S. Nursing,” Medical Anthropology Quarterly 7, no. 4 (December 1993); Patricia D’Antonio, American Nursing: A History of Knowledge, Authority, and the Meaning of Work (Baltimore: The John Hopkins University Press, 2010); Susan Reverby gives a chronological account with broad with fundamental thematic issues that analyze health and the social aspects of nursing. Character was a defining attribute in nurses because it was crucial for social change. Ordered to Care: The Dilemma of American Nursing, 1850 – 1945 (Cambridge: Cambridge University Press, 1987); Sandra Beth Lewenson analyzes themes in nursing including traditional roles of women, organization of nurses, and formation of nursing practice, and the power dynamics that operate within gender such as male dominance and male physician power that created and defined nursing. She provides historical analysis that allows for a racial analysis of the misconceptions about Black nurse’s inferiority to White nurses in the early development of professional nursing, Taking Charge: Nursing Suffrage, and Feminism in America, 1873-1920 (New York: Garland Publishing, Inc., 1993).

founding the first university-based training school. In addition, Black nurses addressed segregation within the profession and legal impediments to nursing licensure, ultimately working to reverse state laws. In the early and mid-twentieth century, Black women who worked as nurses in Memphis had the choice to attend one of at least three Black-owned nursing schools. They became skilled in surgical care of patients, and community leaders in public health. They provided racial uplift for their community by collaborating and training with Black physicians who operated private hospitals.

In her examination of Black women in nursing, Historian Darlene Clark-Hine recounts how, in 1879, Mary Eliza Mahoney became the first Black woman to graduate from an American nursing school. Mahoney attended New England’s Hospital for Women and Children. Admission standards in the nursing program stipulated that only one Black and one Jewish student could enroll. Racism was a barrier to nursing education and training; Blacks thus had to create their own health institutions. Black communities accepted the task of developing nursing training programs and defended the graduates’ status as nurses. Black nurses are undoubtedly understudied, yet they are significant.

Norma Erickson shows how the history of African American nurses in Indianapolis intersects with race and class, as the Black elite and middle class were

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financially able to pay for health care; however, Blacks could only receive services at the local City Hospital. Black women in Indiana who desired a career in nursing had to travel to other cities such as Hampton, Virginia, Louisville, or Washington D.C. in order to receive training. Nursing schools in Indiana did not accept Black women until 1909. In her evaluation of the origins of nursing care and health services among African American and Cherokee nurses in Appalachia, historian Phoebe Ann Pollitt presents a study on a diverse and understudied group of women. With racial barriers to education, health care, and economics, Blacks in Appalachia, like those in other regions, embraced their roles as caregivers and agents in developing avenues to improve health outcomes. Pollitt explains that “the history of African American hospitals and schools of nursing in Appalachia includes both African Americans taking care of their own without white involvement and African Americans and whites working together to provide needed health services.”

The development of professional nursing, medicine and other disciplines occurred at the nadir of Black history. Segregation forced Blacks to develop separate nursing schools to train Black women. Few research studies focus on their progress in Southern cities.

The post-Civil-War era in Memphis is particularly pertinent for a history of nursing because it enables historians to construct the careers of Black nurses who were paid for their services during the 1878 yellow fever epidemic. Blacks nurses and residents in Memphis witnessed illness and profound mortality rates. The historical contributions of Black nurses in Memphis are mentioned only briefly as a counter to those of White

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nursing schools. Within the context of women’s history and nursing, this chapter will analyze the historical development of three Black nursing schools in Memphis associated with Black owned hospitals: Jane Terrell Memorial Hospital, Collins Chapel Hospital, and J.T. Wilson Surgical Infirmary.

Another aim of this dissertation is to show that Black nursing schools were neither mediocre nor inadequate. Despite barriers to success, Black physicians and nurses developed competency in training. This chapter offers a critical analysis and evaluation of professional discourse in nursing in relation to the sociocultural dynamics of racism and barriers to practice. Again, this is not a general study of nursing, but a regional history of Black nurses in Memphis, Tennessee during the postbellum, and early twentieth century. Between 1900 and 1956, ten Black nursing schools emerged in Tennessee. Memphis was the location for six of those schools, while Nashville had four. The development of Black nursing schools runs parallel to the emergence of various specialties in the field of health care, including nursing during the late nineteenth

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11 The history of public health nurses in Tennessee provides information on various types of public health services in all counties, such as tuberculosis. For example, in 1917, Memphis (Shelby County), there were 10 public health nurses, 3 of which were Black, “A History of Public Health Nursing in Tennessee. 1910-1960”, Tennessee Nurses’ Association (1960). A historical narrative about Black identical twins Bernice and Maurice Walton who served in the Nurse Army Corp during WWII; Michele Fagan, ‘Time of Empowerment and Transition: Memphis Nurses During Work War II,” Tennessee Historical Quarterly 53, no. 3 (Fall 1994): 184. Patricia LaPointe explains the historical development and analysis of nursing in Memphis from 1887-1925. Her original research is an invitation to explore the history of Black nurses. There is a brief discussion about the Jane Terrell Memorial Hospital nursing school for Blacks, Patricia M. LaPointe, From Saddle Bags to Science: A Century of Health Care in Memphis, 1830-1930 (Memphis: The Health Sciences Museum Foundation of the Memphis and Shelby County Medical Society Auxiliary 1984), 68-69.

12 The Diploma Nursing Programs for Blacks in Memphis: University of West Tennessee, Terrell Memorial Hospital, Collins Chapel Hospital, Negro Baptist Hospital, Mercy Hospital, and City of Memphis Hospital, Mary Elizabeth Carnegie, The Path We Tread: Blacks in Nursing Worldwide, 1854-1994, 3rd ed. (Sudbury, MA: Jones and Bartlett Publishers, 2000), 25.
and beginning decades of the twentieth century. However, to track the history of Black nursing in Memphis, one must begin with the peculiar institution because both enslaved and free women were assigned to nursing duties.

**Respectability: Black Nurses, Free and Enslaved**

Lucy Nichols was enslaved in Mississippi and Tennessee. In 1862, Lucy was twenty-four years old, married, and the mother of a four-year-old daughter, Mona; together, they lived near Bolivar, Tennessee. During the Civil War many enslaved people dreamed of running away, and those slaves who risked their lives for freedom often passed through the farmlands of Bolivar, Tennessee. Lucy discussed how the talk of freedom made her ears burn, her skin tingle, and her legs wobble. Lucy’s heart raced with excitement. However, Miss Prudence, who owned Lucy and other slaves, was anxious about them leaving the plantation and not returning.

Miss Prudence assigned enslaved people tasks that were exhausting to affect their health. Lucy had to fan Miss Prudence during her daytime naps and at night while her owner was sleeping. One day, Lucy, her husband Calvin, and her daughter Mona joined others in an escape towards Gray’s Creek in Tennessee. She was separated from her husband, who was recruited by the Union Army. Lucy pleaded with the Union Army to protect Mona and herself; later, they became the property (contraband) of the 23rd Indiana Volunteer Infantry Regiment of the United States. Lucy requested to wash and iron uniforms, cook, and perform other domestic services. Dr. Magnus Brucker, the head surgeon of the 23rd Regimental unit, approached Lucy. Dr. Brucker complimented Lucy on her services and told her that the men spoke highly of the care she provided for them.

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Dr. Brucker asked Lucy to take on the responsibility of being the hospital nurse. Lucy proudly accepted the position. While her daughter Mona rested on a cot, Lucy began her first day of nursing duties. She recalls the foul smell in the hospital tent, rotting flesh, sickness, and decayed bodies. She had to maneuver around amputated limbs, while resisting the urge to vomit.

Lucy also faced challenges that arose from American culture. Although some soldiers were comfortable with Lucy, racism was present among Northern soldiers. For example, at one point a wounded soldier was bleeding and required pressure on his wound. Lucy was there to aid and care for him. During a painful traumatic event, the soldier mustered enough strength to inform Lucy, “You get the doctor. I don’t want your black hands on me.” Lucy lived in the South, and the power dynamic of White male authority and racism was a part of her daily life, as well as the social etiquette of knowing one’s place. Lucy was tactful with her response to the unnamed soldier: “The doctor is taking off a bad leg, and if you don’t quiet down, he be taking off your arm...I take care to use only the white side of my hands. You rest easy now.”

Lucy was recruited by a White doctor, whose power and authority would not be questioned by subordinate enlisted men. Dr. Brucker understood that Lucy provided outstanding nursing services, and Lucy was like many other enslaved nurses who were deemed worthy of the title of nurse. This title came from a physician or other authority figure: Many slave-owners also referred to enslaved women as a “plantation nurse.”

Black women have a documented history of nursing during slavery. Enslaved women and free Black nurses occupied a position of respect on many plantations; planters and

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community members relied on their expertise in complex health matters. It is also important to acknowledge that Black women were nurses outside of the plantation society. Enslaved women who were assigned to nursing were respected, and many were paid to care and treat Blacks and Whites.

Because of their insight in healing and commitment to caring for the sick, some nurses like Jincey Snow were granted freedom.\textsuperscript{15} Snow, a Virginia woman granted freedom in the 1830s, continued to take care of her people in the community by opening a hospital in Petersburg, Virginia.\textsuperscript{16} Such duties called for Black nurses to furnish treatment and health care to other enslaved people and family members. The title of nurse was applied to enslaved women because they provided nursing services, despite their lack of formal training or title. Caring and nurturing were part of health care in a slave society, and Black women managed those duties. The role of caregiving was gendered female, just as washing, cooking, and cleaning were, but unlike these tasks, nursing was defined as requiring a certain level of skill. Slave nurses learned to deliver health services to various sickly populations, including White families and other slaves. Their skill and background in healthcare delivery included the entire lifespan—from prenatal care to the elderly.

One of the ways enslaved Black women developed competencies in nursing practice was, surprisingly, through their slave masters. For example, Ebenezer Pettigrew was a master who belonged to a line of three generations of slaveowners. The Pettigrew


family owned slaves in Tyrell and Washington County, North Carolina. In the rural region of their plantations, physicians for slaves were not readily available; therefore, Pettigrew, like other planters, studied medicine, acquired knowledge, and became a skillful practitioner. With his guidance and practice, “female slaves became accomplished nurses and midwives.”

Another slaveholder, who had a large estate, clearly distinguished a hierarchy of labor, duties, and allowance awards. Planter P.C. Weston held his nurses in high regard compared to other slaves. Head-carpenters, head millers, head-copper, drivers, watchmen and even cattle-minders were allotted three fish or one and a half pints of molasses each. However, nurses were offered four fish or one and a half pints of molasses. The nurse of planter Alexander Telfair of Savannah was called “the Doctress of the Plantation.” Slave-owners valued nurses.

Enslaved nurses also gained respect among local physicians. Nurses followed treatment regimens and orders left by their masters, overseers, and physicians. Documentation exists that enslaved women and free Blacks understood written orders, validating the claim that nurses were taught to read. Moreover, as historian Sharla Fett explains, midwives and enslaved women administered and prescribed medications. Antebellum nurses prescribed treatments but might also recommend nutritional prescriptions like bland diets. In addition, they had to measure precise amounts of

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compounds for medical treatment.\textsuperscript{20} Slave nurses maintained cleanliness in plantation hospitals, made medicines, and assured that utensils were clean. The hospital on Weston’s plantation and those who worked there was entirely under the control and supervision of the plantation nurse.\textsuperscript{21} These nurses’ roles mimicked those of the first generation of trained nurses in 1873.

Black women, free and enslaved, were revered for their prominent nursing practice as midwives. During antepartum and postpartum care, enslaved women often had midwives assigned to them. The midwives were often enslaved, but some were free Black women. Prenatal care also included nursing assistants who worked at night to monitor the needs of pregnant slave women. There were high expectations for both the overseer and slave nurse. Masters wanted high birth rates, a low rate of infant deaths, and few hospitalizations on their plantations. Enslaved and free Black women worked as midwives and provided obstetric care for Black and White women on numerous plantations. Black midwives also performed caesarean sections with skill and competency.\textsuperscript{22} At their core, the nursing services that these women provided would not be out of place today.\textsuperscript{23}


\textsuperscript{22} William D. Postell, \textit{The Health of Slaves on Southern Plantations} (Gloucester, Peter Smith, 1970), 112-115. On large plantation midwifery was a special skill or “an art,” and “slave as well as free black midwives delivered both white and black children,” and every once in a while, White women delivered black infants. Todd L. Savitt, \textit{Medicine and Slavery: The Diseases and Health Care of Blacks in Antebellum Virginia} (Urbana: University of Illinois Press, 1981), 182.

\textsuperscript{23} One facet of nursing is that “Nursing can be described as both an art and a science; a hear and a mind. At its heart, lies a fundamental respect for human dignity and in intuition for a patient’s need,” \url{https://www.nursingworld.org/practice-policy/workforce/what-is-nursing/}.  

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Historian Deborah Kuhn McGregor argues that African-American midwives adapted their practice roles from traditions of African midwives or granny midwives. Such traditions had evolved through oral custom, and they included spiritual rites and health therapies such as herbal remedies. McGregor describes how the midwifery practice of African Americans was uniquely different from that of other midwives in American society. One reason is that slavery solidified diverse practices and health rituals from numerous African nations. Many physicians used rhetoric to discount the validity and authenticity of practicing midwives and their African-derived practices. For example, doctors stated that nurse midwives were careless and caused high infant mortality rates. Physicians also viewed enslaved midwives as vectors for diseases such as neonatal tetanus.

Slave owners did not want to risk losing an investment of new progeny due to the skills of careless midwives. They calculated birthing cycles and menstrual periods and provided prenatal and postnatal care for enslaved women; it is thus not surprising that a slave owner would also entrust their newborn chattel and future property to someone who

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could guarantee the delivery of a healthy infant: mostly, Black midwives. They would not have relied on their services unless they were skilled and reliable. The disgruntlement of White male physicians and perceived need to carve out their territory in gynecological care from enslaved women occurred because of their desire for medical hegemony.

The antebellum period saw growth in gynecology as a specialty, and with it, the preconception that male physicians knew more about women’s bodies than midwives.26 In this patriarchal culture, it was posited that medical management, the care of pregnant women and their offspring, required male supervision and authority. While physicians demeaned Black nurses and midwives as charlatans, laypeople respected them. Enslaved nurses, because of their roles and qualification, were not referred to as servants.

For example, on May 16, 1867, the Memphis newspaper Public Ledger included a short biography in an obituary of a slave nurse who belonged to a Civil War general. The obituary began, “Stonewall Jackson’s colored nurse died in Jackson, Madison County, Tennessee.” It is remarkable that her obituary appears in newsprint, probably because of her advanced age, but also because she was the nurse to an important Civil War figure. The nurse above was like many enslaved women of her era: her name lost to history, she died at the age of 113, nine months, and twelve days. She began her life as a young slave girl in the Jackson home. She was born in or around 1754 and was twenty-one years old at the time of the American Revolution. Her honors included the informal title of nurse. Disgracefully, Jackson did not grant freedom to the family nurse until she was eighty-

eight years old.⁷⁷ Other accounts of enslaved women who had the title and duties of nurse are provided by oral interviews.

In the *Tennessee Slave Narratives*, part of the Federal Writers’ Project (1936-1938), many former slaves in Tennessee described themselves and others as nurses. Cecelia Chapel, born in Marshall County, Tennessee, was 102 years old when interviewed. Chapel stated that her mistress would not allow anyone to sell her because she “wuz a nuss en house gal.” She continued to work as a nurse after slavery, along with other jobs. She worked fifteen years for the same family without missing a day. Likewise, after slavery Rachel Gaines continued to work as a nurse, a job consistent with her former duties of care giving for others. Mrs. Dickinson paid Rachel $35.00 a year to care for one child and gave Christmas Day off.²⁸

In Memphis, families, and individuals, regardless of social status, required the help of nurses; race sometimes determined their preferences for healthcare. White society respected the knowledge and experience of Black nurses. For instance, in 1857, a family requested immediate services for a Black nurse to care for their children. Experience was required, and the nurses would have a one-year assignment. On September 1, 1858, Dunlap’s Negro Slave Mart requested to hire a nurse: “none need to apply unless they intend to treat her well.” The job paid $6.00 per month.²⁹ To secure quality nursing care, individuals were willing to pay Black women. Although the duties and details of the

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nursing position are not stated, it is evident that Black female nurses were protected based on the instruction to “treat her well.”

Nursing adeptness was not mistaken for housekeeping duties, as illustrated in two job postings in the Public Ledger in 1872: “Wanted a Colored Nurse, apply at 45 Beale Street.” The second was posted by someone who wanted “A colored woman to cook, wash and do general housework”; in the same ad, the services of a “white girl” were requested to work in a kitchen.”

Undoubtedly, the lay public distinguished between hiring individuals to cook and clean and their need for a nurse. Another point to consider is that nursing as a White middle-class female “profession” did not emerge until 1873. Twenty years after that, the Hampton Training School for Nurses—associated with the Dixie Hospital in Virginia—would begin to educate and train Black nurses.

Within the gendered occupations available for women, there was a clear differentiation between nursing and domestic duties. Still, the racial discourse of the time rendered the respect for Black nurses paradoxical. Because society labeled Black women as subhuman and ignorant, they did not meet the social qualification for true womanhood. Yet as nurses, the were paid to care for babies and children; families entrusted them with some of the responsibilities of the lady of the house.


31 Miss Linda Richards was the first American graduate nurse. She completed her studies at the New England Hospital for Women and children. Norma E. Anderson, The Historical Development of American Nursing Education, Journal of Nursing Education 20, no.1 (January 1891): 16.

Yellow Fever and Black Memphians

One way to analyze the contribution of Black women within the history of health care and nursing is in terms of the care they provided throughout periods of disease and epidemics. Memphis, with its long history of epidemic outbreaks, provides many rich examples of this. During the most fatal outbreak of yellow fever in 1878, Black nurses were summoned to provide treatment to large populations of Blacks and ethnically diverse residents. They provided an essential service as they came to the aid of ill and dying residents.

Based on their marginalized situation, Blacks and other poor ethnic groups remained in the city to endure the frightful events of yellow fever. As the middle of September 1878 approached, Blacks accounted for the majority in Memphis. Historian Margaret Humphreys explains that “In the medical literature concerning yellow fever that appeared in the four decades following the Civil War, blacks were largely invisible.” Blacks were mentioned briefly during the 1878 yellow fever epidemic in Memphis, primarily because they were assigned relief committees in the city; they cared for the poor members of their race when White employers fled for safety in other cities. With large populations of people seeking protection from yellow fever, data analysis for Blacks was misleading, especially in terms of mortality rates.


Studies of the 1878 yellow fever crisis in Memphis should focus on Blacks, firstly because they were the majority population, but also because of their fundamental role in addressing the disease. The story of the yellow fever epidemic is the story of how poverty-stricken Blacks survived a catastrophic pandemic. J.M. Keating, editor of The Memphis Appeal newspaper, reported a mortality ratio of seventy percent for Whites and eight percent for Blacks. Keating’s figures are controversial, especially when compared to data from another local newspaper. The reality was that Blacks probably experienced high death rates from yellow fever, but physicians failed to accurately document the cause of death. Almost two months from the first case of yellow fever, it was estimated that 200 new cases were reported in one day, yet the Howard associated recorded about 150 new cases, while the Board of Health documented 36 cases.

Interpreting this variable data involves some guesswork, but one thing is clear: White deaths surpassed those of Blacks. The problem with recording Black deaths during yellow fever is that the data are based on the subjective interpretations of physicians. One newspaper noted that “several physicians are of the opinion that all cases of bilious, malarial and congestive fevers are but clear distinction between such fevers

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36 Keating’s data reveals that most people who remained in the city where Blacks and they total 14,000-whereas there were only 6,000 Whites. J.M. Keating, The History of the Yellow Fever Epidemic of 1878 in Memphis, Tennessee (Westminster: Heritage Books, 2008), 116; J.M. Keating was editor of the Memphis Appeal, Michael Finger, “The Martyrs of Memphis,” Memphis Magazine (April 2019): 3; See also, Dennis Rousey, whose statistical analysis that determines Blacks comprised 70 percent. Significantly, approximately 13,000 Blacks survived the epidemic, “Yellow Fever and Black Policemen in Memphis: A Post-Reconstruction Anomaly,” The Journal of Southern History 51, no. 3 (August 1985): 367.


and yellow-fever; but this is a field of province of the doctors, which our reporter does not desire to trespass or intrude.\textsuperscript{40} Specifically, Blacks who probably died from yellow fever were given other medical diagnoses, which could account for their lower mortality rates; further discussion is needed to parse the flawed data.

On August 25, 1878, \textit{The Memphis Daily Appeal} printed a mortality report. In the category of disease, the entry included seventy-eight for yellow fever; also recorded were demographics such as age, sex, and race/color. Data revealed that fifty-two White males and twenty-two White females died from yellow fever. A total of four Black men succumbed to yellow fever, but no Black females. Physicians knowingly or carelessly failed to list yellow fever as a cause of death, ultimately underreporting and misdiagnosing cases of yellow fever in the Black population. Regrettably, in some newspapers there was minimal correlation between information on mortality in Blacks and the reality of yellow fever as the disease decimated the city.

Analysis of two popular city newspapers, \textit{The Memphis Daily Appeal} and \textit{Public Ledger}, makes clear that reports on causalities from yellow fever are imprecise. In another example, the \textit{Public Ledger} reported 102 deaths from yellow fever on September 1 and 2, 1878. However, \textit{The Memphis Daily Appeal} revealed that 139 people died. Likewise, on September 8 and 9, the \textit{Public Ledger} noted that 204 individuals died, but \textit{The Memphis Daily} claimed 210 deaths. The \textit{Public Ledger} informed the public that the first six reported deaths took place on August 15, but \textit{The Memphis Daily Appeal} reported that people died earlier in the month, with three deaths between August 1 and

\textsuperscript{40} “Suspicous Cases,” \textit{Memphis Daily Appeal}, August 15, 1878. From Library of Congress. \url{http://www.chroniclingamerica.loc.gov/lccn/sn83045160/1878-08-15/ed-1/seq-1}.
Yet another date with discrepancies was September 14, on which the *Public Ledger* announced 91 deaths, while the *Memphis Daily Appeal* announced 127 deaths, and J. M. Keating claimed a death toll of 145, the highest yet. Historian Thomas H. Baker explains that the city and county reported 2,500 burials within six weeks, but many had no family to claim their remains. While it is impossible to know how many actually died, it is certain that families died from living in close quarters.

Caroline Washington, a Black female (age not given), lived at the same residence as three minor children, all with the same surname. Caroline died on August 28, 1878, as did a five-year-old, Eugene Washington, a seven-year-old, Rosa Washington, and a 14-year-old, Cora Washington. As reports about Blacks and yellow fever surfaced, city leaders were forced to address the reality of nursing care for a multitude of ill and dying Black people. The most immediate reaction was to remove Blacks from the city, quarantine and segregate them in an isolated location. Political leaders agreed to an area just outside of the city that would serve as a location for Blacks.

Camp Joe Williams was established outside the city limit to aid destitute and sick Blacks. A question arose regarding appropriate distributions of rations. References to types of people housed in the camps gives indication of their living arrangements. For

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instance, nearly 2,000 rations were provided each day. News reports labeled Blacks residing at Camp Joe Williams as inmates, but individuals at Father Mathew’s camp that served Catholics were described as refugees.\textsuperscript{45} Camp Jo Williams was situated in “the infected district,” and Blacks were coerced to live there whether or not they had yellow fever.\textsuperscript{46}

Historically, understanding of the extent to which yellow fever affected Blacks has been distorted by preconceived ideas about immunity. Historian Rana Asali Hogarth disputes the scholarship of numerous historians who supported the ideology of innate racial immunity, especially among Blacks. It was supposed that Black people’s African ancestry made them immune to yellow fever—not because of previous exposure, but as an inborn phenomenon. Antebellum physicians concluded that distinct traits such as skin and biological difference enabled Blacks to suffer less from yellow fever or prevented the disease from taking hold.\textsuperscript{47} These false doctrines bolstered cultural beliefs about racial immunity and served to justify further ill-treatment of Blacks, including race-based slavery.\textsuperscript{48} Local Whites could not anticipate that Blacks were also susceptible to


\textsuperscript{48} Racial discourse about Black immunity from yellow fever and its pseudo-scientific explanation is extensively researched. In addition, other theories about racial immunity presented by leading physicians were based on climatic rationales, see Rana A. Hogarth \textit{In Medicalizing Blackness: Making Racial Differences in the Atlantic World, 1870-1840} (Chapel Hill: The University of North Carolina Press, 2017), 36-38.
contracting and spreading yellow fever, and forced hundreds of Blacks to live in close
quarters.

Public reports portrayed the camp positively. On August 21, 1878, a report stated
that “there are between 350 to 400 people in camp at this delightful retreat. It is under
rigid military discipline, and everything moves on smoothly.”49 Ironically, within five
days, things changed, as newspapers declared “fever has broken out in Camp Joe
Williams,” and that there were 600 people there.50 The news of yellow fever in Memphis
occupied the front page of the Public Ledger newspaper. The August 26, 1878, headline
stated, “The Scourge, The Fever is Spreading—Increase in Death Rates” and referred to
“in one case a total of one-hundred forty-three new cases and forty-four deaths within
forty-eight hours.” The subheading described a rapid increase in the number of infected
Blacks. The newspaper article noted that the circumstances at Camp Joe Williams
underscored how yellow fever affected Blacks living in Memphis. Jane Brown, a Black
homeless woman, died of the fever. She was found alone in an alley.51 Local physicians
announced that death rates were alarmingly high and increasing. Within a thirty-day time
frame from the first incidence of Yellow Fever, local authorities began to concern
themselves with the health status of Blacks.

The traveling poor, destitute, and homeless were at a disadvantage compared to
the wealthy that could flee the city via steamboats and railways. The economic


51 “The Scourge, The Fever is Spreading—Increase in Death Rates. One-hundred Forty-Three New Cases
and Forty-Four Deaths in Forty-Eight Hours,” Public Ledger, August 26, 1878, From Library of Congress.
circumstances of many Blacks forced them to remain in the city. For example, some were paid to take care of homes and other properties when Whites left the city. Likewise, attempts to reach camps in the city proved futile. The yellow fever outbreaks exposed numerous sociocultural limitations for ethnic minorities. Economic and class status determined who received nursing care.\(^52\) In a racially segregated city during this profound epidemic, leaders were forced to answer the obvious question of who would care for sick and dying Blacks, and nurses were needed.

**The Need for Black Nurses**

Race, class, and privilege shaped the delivery of nursing services during the epidemic of 1878. Historian Simon Bruesch explains that several private organizations came to Memphians’ aid. One such organization, The Howard Association, arranged for health services by sending physicians and nurses. The association’s primary goal during the outbreak of yellow fever was to institute nursing care for the sick and poor. The former mayor of Memphis, John Johnson, was given the position of overseeing all nursing care, which represented a large labor force in Memphis. Bruesch notes that although the Howard Association employed 2,995 nurses, most lived and worked in Memphis. New Orleans and Mobile sent more nurses than any other city. Over 15,000 people received nursing care. Bruesch quotes the Surgeon-General John M. Woodworth: “Everything depends upon nursing; a good attendant and a pail of water will accomplish more than all the medicines in the land.”\(^53\) Nursing services were indispensable for the


poor and marginalized who stayed in Memphis, and Black nurses were summoned and requested.

Georgiana Williams, a Black nurse, arrived to care for victims of yellow fever. She was described as “one of the very best Howard Nurses in this, or any other city.” She was highly praised by Frank Van Horn after she nursed his three children who had yellow fever, and she “remained with him until death.” Black nurses cared for women and children. Mattie Hayes, a Black nurse, worked closely with a local doctor to care for a local woman named Mrs. Kline and a family of four.

The names of Black nurses rarely appear and are often invisible in historical writings on yellow fever. Historian Thomas H. Baker explains that other groups (names not given) also provided nursing services. Baker explains that nursing was not professionalized and that most nurses acted as sitters, caring for ill patients in their homes. Many Civil War nurses performed similar duties. For instance, former slave Susie King provided comfort to soldiers, wanting “to alleviate their sufferings.” Soldiers wanted soup, and with no food supply to meet their request, King made custard pudding. Comforting a patient is still a primary function in nursing, especially in


57 Susie King Taylor, Reminiscences of My Life in Camp: An African American Woman’s Civil War Memoir (Athens: The University of Georgia Press, 2006), 34. Black nurses appointed to work in Civil War hospitals received pay, and they had no formal training. Sojourner Truth was a nurse/counselor, she also urged Congress to provide financial assistance to train nurses and doctors. Likewise, Harriet Tubman was a Civil War nursing in Sea Island South Carolina, caring for the sick and wounded. Mary E. Carnegie, “Black Nurses at the Front,” The American Journal of Nursing 84, no. 12 (October 1984): 1251-1252.
hospice care. Professional development and the images of nurses, practice, and roles were evolving. Expectations about nursing care during a deadly epidemic would involve comfort measures, as the disease was virulent and incurable.

Doctors’ perception of nurses was revealing of power dynamics within health care. Physicians often belittled and degraded nurses because, to them, even the best nurses were subservient and shallow. The primary function of nurses, as seen by physicians, was to follow medical orders and obey orders. Gender and race played a role in how some physicians scrutinized nurses. There were about 2,667 male nurses working at the time. During the yellow fever it is probable that many nurses were Black, because most of the nurses who were hired by the Howard Association lived in Memphis, and Blacks were the majority during this epidemic.  

Historian Randall L. Hall researched the nursing care provided by two White nurses who arrived in Memphis during the yellow fever epidemic. A theme that emerges is mistrust and racism on the part of White nurses. Randall concludes that “Black nurses, thrice disadvantaged by race, class, and gender prejudices, received from middle-class Memphians the most scorn of any group of caregivers.” The friction and resistance did not come from the public sector or the Howard association, but from White nurses. The idea of equality and sharing public spaces was loathsome to many of them. There was resentment when White traveling nurses had to sit at the same table as Blacks, and they


also detested the idea that Black nurses prepared food and ate before Whites. Nonetheless, advertisements solicited Black men and women to work as nurses, because yellow fever was wreaking havoc in the Mississippi Valley, and Black people required aid.

A plea for help appeared in the *Memphis Daily Appeal*, as Canton, Mississippi, was in desperate need of nurses. Leaders of the city wanted other locales to send Black nurses, because the burden of disease and illness from yellow fever among the Blacks was great. Blacks and White shared public space, but the racial taboos of Southern culture forbade White nurses from entering the private domain of Blacks. Social conventions strongly discouraged White nurses touching and caring for Black patients, especially men. If Black nurses were not available, they hired “nurses willing to nurse negroes.” In Canton, the services of White nurses were also needed, because 100 new cases had been diagnosed. In certain circumstances Blacks nurses could not cross the color line even for health reasons and life-threatening illness. Yellow fever did not distinguish between races and classes of people, but segregation continued.

In October 1878, when the fever reached Brownsville, Tennessee, the Howard Association received an urgent request for eight Black nurses. The request was granted; five male and three female nurses were sent and arrived via train during the early morning hours. They received pay to travel and cared for people in the city.

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60 Ibid.
At times, explicit racial beliefs about Black nurses being inferior to White nurses did not occupy daily news correspondence; during the yellow fever epidemic, Black and White nurses were equal. Regardless of race, the Howard Association paid Black and White nurses who resided in Memphis the same wages; they earned $3.00 per day. Nurses who came from other states and regions received $4.00 per day, along with room and board. The care of Black nurses was praised by Memphis residents. For instance, Mrs. Mary Gibbs thanked doctor A.A. Laurence, and a Black nurse with the last name of Williams who cared for her. When discussing gratitude for nursing care, most Whites readily identified the race of their nurse. Mr. W.H. Harris requested to meet with Emma Stephenson, the Black nurse “who cared for his wife in the Jackson block.” In addition to skilled care, some Black nurses contributed financial assistance during the fever epidemic. For instance, Jennie Ridley donated $1.50. During the following year, another yellow fever outbreak took place and Ridley returned to continue her nursing care. Ridley and another Black nurse, Dora Miller, both contributed $2.00 to the Howard corps for “the relief of the sick.”

Whether answering the call to provide direct nursing care, or giving monetary assistance, Black nurses had respectability and social status in the Jim Crow Era. During

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the late nineteenth century, Black nurses in Memphis were still addressed and given recognition for their service. In 1883, Sarah Ann Robertson was referred to as the matron of the Canfield Orphanage. She was described as “a respectable old colored nurse.” Yet within society at large, racial etiquette continued to demand rigid boundaries in health care, including nursing. Black women’s desire to receive nursing training was met by resistance from middle-class White women who sought to exclude other ethnicities and races under the guise of establishing a new type of nurse that was professionally trained. The struggle for Black women who wanted a career in nursing was intensified when professionalism became wielded as blunt instrument that divided Black and White.

**White Womanhood and Nursing**

During the late 1800s, nursing emerged as a profession that was exclusively White and female. Race developed into a social and cultural determinant of professional progress of nursing. The first three nursing schools were founded in Bellevue, New York; West Haven, Connecticut; and Boston, Massachusetts. The training of nurses by physicians was common in all American nursing schools. Nurse historian Patricia D’Antonio explains that the growth of nursing training schools was initially slow. In 1880, there were fifteen hospital-based nursing programs; in 1890, the number increased to twenty-five. By the turn of the century, 432 schools existed, offering advanced training skills in surgery and childbirth. The numbers continued to rise, and in 1910, there were three times as many (1,129), but most did not accept Black nurses. Nursing training

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occurred in specialized settings such as children’s hospitals, tuberculosis sanitariums, and insane asylums. The nurse role focused on traits of discipline and loyalty. Nursing occupied a gendered place within a hierarchical medical and social structure. Newly trained nurses embodied the evolving scientific knowledge that was guiding medicine. To clearly delineate what a nurse ought to be within the developing profession, “trained nurse” or “graduate nurse” became the formal titles of these women upon graduation.

In 1907, several articles appeared in a journal titled *The Trained Nurse and Hospital* discussing reorganization in nursing programs. Dr. Richard Cabot provided the introduction, discussing the Bellevue School of Nursing in New York’s planned dormitory and lecture facility. Dr. Cabot graduated from Harvard Medical School in 1892 and published several clinical books, including *The Physical Diagnosis of Diseases of the Chest*. Dr. Cabot valued student participation and the use of case studies in teaching. In the early twentieth century male doctors envisioned and created the ideal nurse. The professional development of nursing practice adopted the medical model for education and training, but with the addition of some topics not covered in doctors’ education. Nurses would gain experience in domestic science because “every nurse should understand domestic economy, hygiene, sanitation, cooking, marketing, accounts, care of linen, household equipment, as well as hospital supplies.” The first course that Dr. Cabot described was a theory-based nursing course. The first class for student nurses was

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housekeeping.\textsuperscript{73} Although Black and White women trained in separate nursing schools, course content, was similar for both groups. The main hindrance to Black women in nursing, though, was not the domestic skills required, but how race prohibited acceptance into elite training programs.

To tell the story of Black women nurses, it is necessary to tell the parallel story White nurses. Historian Sandra Beth Lewenson discusses key themes in nursing of the era, including gender roles, the organization and formation of nursing as a profession, and the power dynamics between male physicians and female nurses. Lewenson provides a racial analysis of the misconceptions about Black nurses’ inferiority to White nurses in the early development of professional nursing. Prior to 1870, neither Black nor White nurses were formally trained. There was no carefully evaluating the quality of training because the standards of nursing training programs varied so widely. Before the Civil War, nurse was a title that anyone could use, as women defined nursing based on a set of skills, mainly caretaking.\textsuperscript{74} There was not yet a perceived need for a trained or academically prepared nurse.

By the late nineteenth century, nursing training was based on a two-year curriculum, although many envisioned a three-year course. During the opening decades of the twentieth century, most nurses still completed their training in two years. In 1900, less than a third of American nurses had three years of education. Initially, nursing education was founded on the premise that White middle-class women would enter

\textsuperscript{73} Dr. Cabot, \textit{The Trained Nurse and Hospital Review} 39 no. 1 (July 1907): 3-4.

professional training. As the archetypal nurse was constructed, historian Patricia D’Antonio notes that gender and marital status determined admission, and nursing students who had not graduated from high school were required to pass an examination. The ideal nurse was a single White woman between eighteen and forty years old. One’s purity was part of the application, as schools mandated that applicants needed a letter from a clergyman. The trained nurse distinguished herself from the domestics and untrained nurses, as character was a key trait. Nurses were refined, pious, and feminine.

Nursing became synonymous with White womanhood, creating an exclusive domain and profession. D’Antonio remarks that White middle-class women were deciding on the “right kind of woman. Specifically, White women were creating a discipline for themselves. Black women and other women were not worthy to become trained nurses. Remember, middle-class women believed in the socially constructed ethos of womanhood.” An image was being crafted for an American nurse, and sociocultural mindsets determined what class and race of women was included.

As social constructs meshed with the concept of the trained nurse, racial hierarchies discriminated against Black and other ethnic women. Susan Reverby writes that middle-class White woman used nursing as an occupation that enabled them to perform a religious obligation. The ideal nurse held a moral status inherently bestowed on

75 Ibid.


77 Ibid.
middle-class White females but denied to Black and other minority women. Within this ideology, Black women had no merits as trained nurses.

**Evolution of Trained Black Nurses**

The rise of the trained nurse was a response to the growth of modern hospitals. The need to carry out orders, medicate patients, and care for surgical patients mandated that nurses receive training in hospitals. A trained nurse completed hospital-based education and training, with more focus on patient care, and less on theory. Educating and developing respectable Black nurses required formation of a counterculture and alternate norms to those that placed White women as the pinnacle of womanhood. The barriers for Black women prompted Black physicians to educate and advocate for Black trained nurses. Nursing education and formal training for Black women was thus a collaborative effort with Black male physicians.

The need for trained Black nurses was associated with racialized health care, as Blacks and Whites received segregated medical training, hospitalization, and nursing care. Black nurses were vital to improving the health status of Black people. Darlene Clark Hine explains complex ideas of race that affected the development of professional nursing. In 1879, Mary Eliza Mahoney became the first Black woman to graduate from an American nursing school. Mahoney attended New England’s Hospital for Women and Children. Admission standards in the nursing program stipulated that only one Black and one Jewish student could enroll. Within a 20-year time span, only five other Black

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women graduated from the New England’s Hospital for Women and Children. The social reality of racism and poverty in the South was interwoven with poor health. Hines notes that “Nowhere in America was there a greater need for the development of black hospitals and nursing training schools than in the South.”

Southern Whites could reject Black women as professional nurses, especially when the social norm was for Whites to control access to education and economic advancement in medicine and nursing. Few schools trained Black nurses. The institutions with the largest number of trained Black nurses were Tuskegee Institute in Tuskegee, Alabama; the Training School for Nurses in Charleston, South Carolina; Freedmen’s Hospital and Nursing School in Washington, DC; Flint Goodridge Hospital School of Nursing (formerly known as the Phyllis Wheatley Sanitarium and Training School for Nurses in New Orleans); and the Dixie Hospital Training School (part of the Hampton Institute in Hampton, Virginia). The above institutions had to push back against the social conventions about Black women and Black nurses. Several Black nursing schools have historical data that provides research material on nursing coursework, student enrollment, commencements, and faculty appointments.

Patricia Sloan’s article, “Early Black Nursing Schools and Responses of Black Nurses to the Educational Program,” examines the educational experiences of Black nurses. Primary sources include narratives from Black nurses that provide knowledge about curriculum patterns, clinical education in hospitals, and infirmaries. Sloan


81 Ibid.

82 Ibid., 6, 47.
concludes that Black nursing schools established core curricula that sometimes surpassed national standards. The research conducted by Sloan reveals that nutrition, surgery, and gynecological courses were common in Black nursing training schools. The early nursing programs of Spelman, Hampton, and Tuskegee combined clinical nursing practice with academic learning. Prominent surgeon-physician Daniel Hale William lectured to nursing students at Provident Hospital in Chicago. The above schools graduated 250 nurses between 1886 and 1906.  

With regard to admission standards and courses, there were consistencies between Black nursing schools in the North and South; training focused on domestic science and hospital-based care. Nursing school curriculums were similar for Black and White women. Interestingly, in 1922 the American Nurses Association published a document with a list of nursing schools. The document includes a sample nursing curriculum from the Freedmen’s Hospital, Washington, D.C., and Course of Nursing Training. This lends support to Mary Elizabeth Carnegie’s conviction that the first college/university nursing school originated on a Black campus. More importantly, it appears that the Freedmen’s Hospital, being a part of Howard University, served as a three-year prototype for many university-based nursing schools.

The most radical means for opposing racial barriers was to construct Black nursing schools that paralleled White schools, or even surpassed them. Nursing programs in Memphis achieved this, although racism was a serious obstacle. Research shows that

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Black nursing schools in Memphis had varied curriculum, but overall, their training in specialty areas was impressively diverse.

**Memphis Nursing Programs**

In 1887, Memphis established its first nursing school, Maury-Mitchell Nursing School. The school founders, Drs. Robert Wood Mitchell and Richard Brook Maury, were both gynecologists. The training they gave nurses was gendered in multiple ways. First, the nurses were trained to take care of mostly female patients. Ironically, slave nurses and Civil War nurses with much less sophisticated training had cared for male patients. 85 Second, women were affected by institutional shifts as, between 1880 and 1920, births transitioned increasingly from household settings to a controlled environment in hospitals.

Nurses lost authority in obstetrical training as physicians gained access to training facilities, thus relegating nurses to subordinate roles. 86 When Memphis opened its nursing school, courses were taught on various subjects including anatomy, physiology, the practice of medicine, materia medica, and obstetrics. Practical nursing and caring for the sick were conducted at the Sanitarium, a building connected to the training school. Most nurses were young, and on June 22, 1889, four women completed their eighteen-

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month nursing training course and received a diploma from Maury-Mitchell Training School.87

The origins of Memphis’s training school differed little from those of other nursing programs: Middle-class females were answering their religious calling, as piety was constructed as a key trait of White middle-class women. White women were praised for their career choices. For instance, the keynote speaker at the first graduation ceremony, J. M. Keating, declared, “Women have been authorized by regularly conferred diplomas to engage in a noble, and in some respects sacred, calling of nurse.” He believed that nurses fulfilled a calling for public service, not only in Memphis, but in the Christian world. Nursing was juxtaposed with medicine, and the value system of gender and professional hierarchy was applied to nursing. The nurses were given their role, as viewed by middle-class men: “You have chosen a profession of great usefulness, one that pursued to its limits is only second to that of medicine and surgery.”88 The group of four who became the first trained nurses in the state embraced their professional duties.

Lena Angevin(e) was one of the four nurses who pursued advanced skills in nursing. She fostered leadership and developmental accomplishments. She was mentored by a leading nursing educator and professional developer named Isabel Hampton. After marriage and divorce, Lena Angevin(e) kept her married name, Lena Warner. With knowledge and professional commitment to train and cultivate nurses in Memphis, she embraced the growing concerns of professional nursing by training at Cook County

87 Patricia M. LaPointe, From Saddlebags to Science: A Century of Health Care in Memphis, 1830-1930 (Memphis: The Health Sciences Museum Foundation of the Memphis and Shelby County Medical Society Auxiliary, 1984), 65-66.

Hospital in Chicago. Warner was fortunate to receive mentoring and advanced training under the leadership of Isabel Hampton. She returned to Memphis and worked as a surgical nurse and supervisor with Dr. Richard Maury. In 1897-98, the city built a new hospital, Memphis City Hospital. The original nursing training school, Maury-Mitchell, became part of the City Hospital nursing program. Warner was instrumental in establishing a two-year program. She used the book written by Isabel Hampton, *Nursing: Its Principles and Practice* (1893). The Training School was chartered by the state of Tennessee, and the first graduating class in 1900 had ten trained nurses.

In Memphis, nursing was an integral part of caring for the ill and hospitalized patients. There were 24 Black surgeons, and 6 with “gynecological surgeon” listed as their professional medical title. Though classism and racism in Memphis were immutable, Blacks continued to resist the power of racial segregation, and followed various avenues to develop formal nursing programs. As noted earlier, between 1891 and 1898, there were only six Black nursing schools in the country, and four of the schools were in the South. Over time, more Black nursing training programs were established.

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89 Isabel Hampton Robb graduated from the Training-School for Nurses affiliated with Bellevue Hospital in New York. After graduating, she worked in Italy. After returning to America, she was hired as the superintendent at the Illinois Training-School of Chicago. Her most prestigious job was instituting a Training-School for Nurses at Johns Hopkins Hospital in Baltimore. Edith A. Draper, “Isabel Hampton Robb: Late Principal of the Training-School for Nurses of the Johns Hopkins Hospital, Baltimore: Retiring President of the Trained Nurses’ Association Alumnae of the United States,” *The American Journal of Nursing* 2, no. 4 (January 1902): 243-244.


The history of Black nursing programs is often linked to that of Black medical schools, because Black physicians established most of those nursing schools. In David McBride’s research on Black health care in Philadelphia, he discovered that nursing education for Black women was less obtainable than Black medical education in the city. Only two facilities in Philadelphia, Douglass Hospital and Mercy Hospital, accepted and trained Black women; both institutions were Black-owned.\(^{93}\) Limited historical documents exist related to Black nursing programs in major cities, especially those such as Memphis that were not affiliated with well-known universities and colleges. In Memphis, information about smaller nursing schools appears in newspaper clippings, advertisements in city directories, Black newspapers like the *Nashville Globe*, Black business directories, and sometimes books.

Medical historian Phoebe Ann Pollitt has documented professional nursing careers in Tennessee. Between 1907 and 1965, there were 15 hospitals in the Appalachia region where Black women received nursing training. Pollitt specifies that most of the above nursing programs “were small and short-lived.”\(^{94}\) The need to develop institutions that educated Black women in the field of nursing was recognized throughout the state. For many Black women in Memphis, their nursing training was tied in with core middle-class values of religious service for moral improvement, along with health education and hygiene. American nursing training was grounded in institutions affiliated with religious order. Historian Keith Wailoo describes the emergence of Black hospitals that also

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included nursing programs. In 1910, rapidly growing religious-based Baptist and Methodist hospitals had declined to admit Blacks for medical treatment. Rejecting Jim Crow philosophy, Black denominations in Memphis, the African American Baptist church and the Colored Methodist Episcopal, procured funding from residents and churches in other counties to erect infirmaries.

The first Black nursing program in 1909 was at the Colored Baptist Terrell Infirmary. The history of Black nurses in Memphis thus begins with the most prominent institution in Memphis’s Black community, churches.95 The 1900 Polk City Directory listed seven nurses, and three of them were Black, as noted by the caption (c) for colored. Two of the three Blacks listed were male, implying that none of the nurses had received professional training from a school or hospital in Memphis. Two years later, the number of Black nurses doubled to six, but the number of White nurses increased to seventy-one. By 1909, when the first Black training school for nurses opened, there were only four Black nurses classified in the business section of the city directory: Harrie Hill, Annie James, Ella Phillips, and Beatrice Woods.96

**Jane Terrell Hospital Nursing Program**

These new institutions performed the dual role of uplifting Black women in Memphis and assuring that Black patients had adequate care. In 1909, Dr. C.A. Terrell chartered the first Black nursing training program; twelve years later the school received accreditation for the nursing program. By 1921, the hospital was an 80-bed teaching and training institution, with an average daily census of 35. There were two graduate nurses

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96 *1900 Polk City Directory*, (Memphis: R.L. Polk and Company’s Publisher, 1900, 1910), 2039.
listed and twenty-two nursing students. Jane Terrell had fewer students than Baptist Hospital (225), St. Joseph’s (264), or Memphis General (207). The average age of women who entered the program at Jane Terrell was 18, consistent with White nurses entering schools at Baptist Memorial Hospital and St. Joseph’s. Admission criteria varied, because Jane Terrell accepted students with ten years of education, while the other nursing programs in Memphis required high school diplomas.97

The standards were lower at Jane Terrell, but not for other nursing programs in Tennessee, because educational requirements varied within state and out of state. For example, at Dyersburg General Hospital in Tennessee, students must have completed the ninth grade to be admitted. But in Texas, four schools admitted students who completed eighth grade.98 Again, even on a national level, nursing training was inconsistent. Unlike the other nursing schools, in Memphis, Jane Terrell did not list a superintendent of nurses. However, Alice G. Jenkins was referred to as the head of nursing at Jane Terrell Hospital.99

Trained nurses at Jane Terrell Hospital had the responsibility of caring for not only residents of Memphis, but those who arrived for care from outside the state. People traveled from Mississippi, Arkansas, Oklahoma, Missouri, and regions of Western Kentucky for healthcare treatment.100 The nursing program at Jane Terrell evolved


98 Ibid., 39-40.


progressively as the number of Black physicians in Memphis increased. For instance, C.A. Terrell and his nephew L.G. Patterson founded their infirmary and nursing program. Two years prior, Dr. Miles V. Lynk relocated his medical university and nursing training school to Memphis. In the description of the Terrell-Patterson Infirmary, the words printed above the establishment were “An Experienced Head Nurse.” Nursing was not an afterthought to Black physicians; from the onset of patient care, Dr. Terrell worked with a trained nurse.\(^{101}\) The collaborative practice of medicine and nursing flourished, and health services for Black women became more readily accessible.

Memphis was not the only region in which Black doctors created nursing training schools. Dr. Alonzo McClennan desired to train Black physicians and nurses in Charleston, South Carolina. He submitted a proposal to the city requesting to have Black physicians available free of charge to provide health care to Blacks at the Ashley River Asylum. When McClennan explained his desire to establish a nursing training school at the city hospital, the request was denied. The city government instead provided $4,500.00 to establish the Charleston Training School for Nurses, which was Whites-only. Dr. McClennan, like other Black physicians of his era, was compelled to create schools and programs to train and educate Black nurses.\(^{102}\) Simply put, despite segregation and racism, these physicians and nurses had a relentless drive to challenge White social power by creating alternative health institutions, and nursing was part of this.

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\(^{101}\) G.P. Hamilton, *Bright Side of Memphis* (Memphis: Lightning Source, 2003), 228, 256.

A Historical Legacy in Nursing

In Memphis, the first Black nursing program would train and graduate Black nurses over a period of fifty years. One such nurse was Mrs. Fenton Little. A news bulletin published in Shelby County referenced the 100th birthday of former employee Mrs. Fenton Little. Mrs. Fenton was born in 1904 and graduated from Manassas High School. She completed her education and graduated from Jane Terrell Nursing School in Memphis and practiced as a licensed nurse in New York and Tennessee. While she was in New York, her duties and clinical skills enabled her to work in a tuberculosis sanitarium. Upon her return to Memphis, her nursing career spanned thirty years with the Shelby County Health Department. She provided public health services and nursing for mothers and infants.103

Another prominent graduate from Jane Terrell nursing school was Mrs. Mattiedna Johnson. Mrs. Johnson combined church ministry and health as she initiated, planned, and developed course studies in nursing. She was born in Arkansas, and her parents were sharecroppers. In 1940, she completed nursing training and graduated from Jane Terrell Memorial Hospital School of Nursing in Memphis. She later completed postgraduate training at Homer G. Phillips Hospital in St Louis. Johnson helped organizations for African American nurses, such as by developing public preventive clinics to screen for high blood pressure. On October 23, 1990, the Hon. Louis Stokes delivered a speech before the U.S. House of Representatives, “A Salute to a Nursing Pioneer,” lauding the remarkable career of nurse Mattiedna Johnson.104 Nurse Fenton Little and Mattiedna

103 “Shelby County’s Oldest Retiree Celebrates 100th Birthday,” County Lines 6 no. 4 (July/August n.p., 2004).

Johnson were part of a historic nursing training program; seventy-five percent of the nurses who trained and graduated from Jane Terrell Baptist Hospital worked in public health programs.105

Nursing advanced in Memphis because of physicians and prominent businessmen who understood the need for nursing training in hospitals, clinics, and the community. For instance, Dr. Fannie M. Kneeland was a Black physician in Memphis and had several appointments with the University of West Tennessee (UWT). One of her duties was nursing training.106 Dr. Kneeland’s professional career was similar to that of other female doctors including Dr. Marie Zakrzewska, as both female doctors assumed the responsibility of training nurses and doctors.107 Nursing students at UWT received clinical preparation at the Jane Terrell Hospital. Later, Dr. Myles Lynk became dean of the school of nursing at Jane Terrell.108 As noted earlier, medical and nursing services were necessary to accommodate not only Blacks in Memphis, but many who lived in the Mississippi Valley. Perhaps Black clergy and medical providers accepted their spiritual calling, as noted in Deuteronomy: “there will never cease to be poor in the land.

105 The history of the Terrell Memorial Hospital began many years ago when Dr. H.C Harriston who has practiced medicine in Memphis for 69 years, dared to open a ten-bed hospital at his home on Orleans where he still resides. Inspired by the success of this venture, Dr. C.A. Terrell, as associate of Dr. Harriston, organized and opened the Baptist Hospital at 698 Williams Avenue. Some years later the name was changed to Jane Terrell Baptist Hospital; and following the death of Dr. Terrell it was again changed to Terrell Memorial Hospital in honor of its popular and illustrious founder, Negro Book and Directory, ed. T.J. Johnson (Memphis: Memphis Negro Chamber of Commerce, 1943), 80.


Therefore, I command you, you shall open wide your hand to your brother, to the needy and to the poor, in your land.”109 Another institution, The Collins Chapel Hospital, also improved healthcare for the needy to by opening a nursing training school.

Collins Chapel Nursing School

Collins Chapel has historical significance in Memphis, religion, medicine, and nursing. The oldest African American church in Memphis, it was founded in 1841 as part of Wesley Chapel Methodist Church, now First United Methodist Church. At the time, enslaved people were invited to participate in worship service with White members. The parishioners of Wesley Chapel deeded Black members the basement to establish a space for their own church services. In 1859, members of Collins Chapel purchased a site on Washington and Orleans Streets; the name Collins Chapel remained in honor of the first pastor, J.T.C. Collins. Several prominent Black physicians and future clerical leaders were members of the church. Reverend J.C. Martin was a pastor in 1901, and he later became a bishop of the CME church. His brother, Dr. W.S. Martin, founded Collins Chapel Hospital and served as chief officer. Likewise, Dr. John T. Wilson joined the church, and later co-founded a hospital and nursing training program. Other well-known Black physicians of Collins Chapel had leadership roles outside of the church.110

Dr. A.L. Thompson, Dr. J.B. Martin, and Dr. W.A. Lynk were charter members of the Memphis NAACP branch. The first Men’s Day Program was instituted by Dr. Myles V. Lynk and Dr. U.S. Walton. The compassionate giving of Lillie McNeil was also relevant in Memphis’s medical history. McNeil “deeded her two-story home to Collins

109 Deuteronomy, 15:1 (Common English Bible).

Chapel to be used as a hospital.” As a trustee and founder, Dr. W.S. Martin financed the hospital, Collins Chapel Hospital; he later created a nursing training program for Black women. The physicians who devoted their energies to Collins Chapel Hospital endorsed Dr. Martin’s plans for another nursing school in Memphis.\textsuperscript{111}

Completed by the CME in 1910, Collins Chapel Hospital was described as a modern structure, located at 418 Ashlund Court.\textsuperscript{112} When nursing training began, Memphis had twelve Black nurses listed in the Polk Directory. In 1918, Collins Chapel used black newspapers like the \textit{Nashville Globe} to advertise their nursing program. One article read: “A Training School for Nurses is established in connection with the hospital and affords a fine opportunity to those planning a sound course in nurse training.”\textsuperscript{113}

Nurses in Black communities were viewed as caring women, and physicians appreciated their dedication and trustworthiness.

The doctor-nurse relationship at Collins Chapel was genuine and grounded in understanding of race and professional solidarity during the Jim Crow Era. For example, in 1913, Edith Booth, wife of prominent attorney C.O. Booth, filed a lawsuit against Collins Chapel Hospital. The head nurse, Estella Daniels, refused to allow a White physician admission privileges to operate on Mrs. Booth. In the newspaper editorial, race, class, and professional boundaries were revealed. Booth, a Black woman, was willing to have a White physician operate on her body, but such a procedure could occur only at a


\textsuperscript{112} “Collins Chapel Home and Hospital,” \textit{Nashville Globe}, August 29, 1913, From Library of Congress. \url{http://www.chroniclingamerica.loc.gov/lccn/sn86064259/1913-08-29/ed-1/seq-7}.

\textsuperscript{113} “Collins Chapel Home and Hospital,” \textit{Nashville Globe}, August 29, 1913, From Library of Congress. \url{http://www.chroniclingamerica.loc.gov/lccn/sn86064259/1913-08-29/ed-1/seq-7}.
Black hospital. The authority given to nurses as gatekeepers of the hospital signified a collective unity among Black doctors and nurses in the city. The doctors and nurses at Collins Chapel felt compelled to refuse White doctors any authority in the facility, because as Black physicians they were not allowed to perform procedures at private White hospitals or the City Hospital.\(^{114}\)

Other Black-owned hospitals were challenged by double standards of segregation. In Philadelphia, White physicians at the University of Pennsylvania Medical College requested the admission of their Black medical students to Fredric Douglass hospital to fulfill requirements for obstetrics training. The rationale was that White women did not want Black medical students touching or caring for them. Thus, in a segregated society, nursing had to mirror medicine, because Whites opposed the mixing of races in private spaces. Modern hospital accommodations were isolated rooms, and hospital care included nudity and intrusive exams, especially for gynecological care and surgeries. Likewise, nursing care included bathing and comfort support of all patients. The potential for race-mixing in these contexts thus created anxiety for some. Denying Black women nursing training assured White women that White men would avoid close contact with young Black nurses.

Throughout the early and mid-twentieth century, Collins Chapel continued to maintain a nursing program, “School of Nursing of Collins Chapel Connectional Hospital, Memphis, Tennessee.” Physicians at this small training school had a strong desire to compete with schools with higher standards, such as a three-year nursing course. But many details about these early years of Collins Chapel are unknown because there

are limited historical records. Information on authentication of the school and key nursing personnel is preserved in a sample catalog. Documents regarding nursing training at Collins Chapel provide an understanding of courses, theories, ideals of nursing, gender roles, and professional development.

Dr. W.S. Martin served as Superintendent of Hospital, and Eva H. Cartman, R.N. held the position as Superintendent of Nurses. The school had a diverse mix of specialty physicians, eleven of them instructors, and two nurses, Miss Hattie Baker and Eva H. Cartman. The mission statement of Chapel Collins was “to give efficient care to the sick of Memphis and the surrounding country.” The school focused on preparing women in the art and science of nursing. The faculty believed that trained nurses must give efficient care to the sick and provide knowledge and understanding to help physicians. Nursing training promoted the school’s vision “to develop the student’s spiritual and cultural side of life that she may enjoy and give true service.”

Differing opinions about nursing training and the need to promote a domestic skillset via vocational training were voiced among Black leaders. Booker T. Washington described his experience with nursing training at Tuskegee in a 1910 article in The American Journal of Nursing. He noted that Black women “always made [a] good nurse.” Washington explained that with an increasing number of Black physicians, more nursing training was needed, especially in the South. The first-year nursing students at Washington’s Tuskegee Institute enrolled in a course titled Nursing, with the following

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116 School of Nursing Collins Chapel Connectional Hospital Catalog, (Memphis, 1930).
description: “nurses; the sick room; hospital ward; hospital etiquette; beds and bed-making, bed sores; circulation, pulse; temperature, respiration, enemata, urine, and message.” In addition, nurses learned various skills in catherization and ventilation.

Washington proudly explained that “the only colored female nurses employed during the Spanish-American War were five nurses sent out from the Training School at Tuskegee.”

As historian Darlene Clark-Hine notes, Booker T. Washington and Dr. William Hale were pioneers in nursing training schools. The current image of the Black nurse was the “new romantic and idealized image of the Florence Nightingale type nurse.” Black women were transformed into a “self-sacrificing, warm, and devoted mother figure.” However, William Hale, being a surgeon, trained nurses to work in various specialties, as noted by the course description from Freedmen’s Hospital. Likewise, two nursing schools in Memphis focused on a three-year curriculum.

The most reliable primary source is the School of Nursing Catalog from 1930. The Collins Chapel nursing catalog details a three-year training course. However, from the beginning, the program focused on nursing as a profession—a discipline with its own values and ethics. The moral obligations of the training school were evident, as students were not allowed to smoke or drink alcoholic beverages. Violation of the latter rule resulted in expulsion. It was important for nurses to avoid doing harm to patients, and alcohol could cloud nursing judgement and decision-making. Prior to acceptance, the


faculty members invited interested students to visit the school. All students had to include verifying high school transcripts; trustworthiness was vouched for via recommendations from a minister and two other individuals, not relatives. Dental certificates and a negative Wasserman test for syphilis were also benchmarks to gauge moral character and conduct. The costs for training was $50.00, and the books and uniforms totaled $49.25. Collins Chapel paid for room and board for the entire program.¹¹⁹

Nurses completed classes in psychology, mental health and nervous disorders. The nursing program at Collins Chapel included classes with specific lessons and course descriptions. For example, the Director of Nursing taught Nursing Ethics and the History of Nursing, which included content on the origins of nursing from ancient to present day. The course was designed so that a nursing student could “understand and appreciate her profession.” Special lectures on Medical Ethics conveyed “moral aspects and obligations that confront the nurse, patient, doctor relationship.” Community leaders of social and nursing organizations lectured on “Professional Problems” and addressed the nurse’s “responsibilities in the various branches of the profession.”¹²⁰ Collins Chapel sought to encourage a professional understanding of nursing that would enable Black nurses to overcome “Professional Problems” (the title of one course). For most Black nurses, the professional problems were racism within their profession, and the social mindset of inferiority after completing training. The emphasis on professional knowledge, ethics, historical insight, and diverse medical and surgical care of patients was a way to repudiate claims of inferiority in nursing education and training. It also equipped Black

¹¹⁹ School of Nursing Collins Chapel Connectional Hospital Catalog, (Memphis, 1930).

¹²⁰ School of Nursing Collins Chapel Connectional Hospital Catalog (Memphis, 1930).
nurses to understand historical issues in the history and practice of nursing: specifically, race as a barrier, and White women guarding the profession.

Darlene Clark Hine explains that White nurses organized and formed professional organizations including the National League of Nursing Education and the American Nurses Association. Black women were largely banned from joining any nursing organization, and only through specific agreement among White nurses could Black women join national and state organizations. In 1908, fifty-two Black women founded the National Association of Colored Graduate Nurses (NACGN). The Collins Chapel nursing program was instituted to assure Black nurses that upon graduation and successful passing of the state exam, they would have professional recognition. It was difficult to locate primary or secondary sources that validate whether Black nurses in Memphis joined the NACGN or formed a local nursing association. Nonetheless, Blacks nurses in Memphis had an academically based curriculum.

Nursing students received education and training from surgeons and various medical specialists. Specialty clinical skills in surgical areas included ear, eye, nose, and throat, obstetrics and gynecology, and care of the newborn infant. In addition, antiseptic methods and sterilization were part of the curriculum. Black women at Collins Chapel had theoretical and didactic training in diverse clinical areas. The historical information from the course catalog may be difficult to validate in terms of factual clinical experience and classroom instructions. However, the names of four nurses from Collins Chapel including Eva Cartman appear in the 1941 *Classified Directory of Negroes*, labeled in

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large bold print as NURSE (GRADUATE).\textsuperscript{122} The three-year course was consistent with those of White nursing schools. Memphis thus had Black nurses who were equal to White trained nurses regardless of region. Within surgical training, Black nurses under Dr. J.T. Wilson received advanced nursing knowledge and training that probably surpassed many White and other Black programs.

**Nursing Education and Training with Dr. J.T. Wilson**

After surgeon J.T. Wilson relocated to Memphis from Nashville, he traveled across state lines to perform complex surgeries for life-threatening conditions. Black women who completed the training served as on-call nurses. The training of nurses to assist with the care of Black surgical patients made expansion mandatory, especially as Memphis attracted surgeons from other regions. The important area of surgical nursing inspired Dr. John T. Wilson to relocate his medical-surgical practice from Nashville to Memphis, and to continue training and educating Black women in the profession of nursing.

In 1907, he opened the Wilson Infirmary in Nashville, Tennessee. Dr. Wilson was aware of the challenges that individuals faced when pursuing goals. Born in Atlanta, his mother died when he was one year old, and within a few years, his father was deceased. As an orphan, he lived on a farm and found solace in church, and Sunday school provided him an opportunity for learning. Dr. Wilson attended Atlanta University and later pursued courses at Roger Williams University in Nashville. In 1889, he began studying medicine

\textsuperscript{122}A Directory Covering the Business, Civic, Industrial, Professional and Religious Activities of The Colored People of Memphis And Shelby County (Memphis: The Negro Chamber of Commerce, 1941), 86.
at Meharry Medical College. He graduated in 1895, and his career in medicine was diverse, including postgraduate training in various specialties.¹²³

Dr. Wilson encouraged graduate nurses to progress in their careers because backgrounds in science and “fitness” were advantageous.¹²⁴ The founder of the program was a surgeon who identified the amount of clinical training required for nurses. Surgical nurse training, as a specialty, was the focus, as complex procedures required advanced skills and clinical expertise. While he was in Nashville, the first nurses began a training course in 1908 and graduated in 1911. As part of the presentation of diplomas to the recent graduate nurses, Dr. Wilson made a powerful statement: “The increasing discrimination against us in the Northern Post Graduate School has caused us to organize the school to meet the inevitable, which in time will be a complete exclusion from them.”¹²⁵

In 1908, Wilson began postgraduate medical courses in Nashville for various fields in medicine that also enhanced nursing skills and training. There were six specialty training courses: general surgery (four weeks), abdominal surgery (four weeks), venereal surgery (four weeks), operations on cadavers and surgical anatomy (not more than three students to a class). There was also a general course in medicine, surgery and obstetrics. The courses were available to licensed practitioners and graduates from medical schools.


The above training also included a $5.00 fee for physicians who used the operating room for demonstration and instructions.

As a surgeon, Wilson wanted to assure the public that his infirmary performed and managed the care of surgical patients. With the help of “careful well-trained nurses always on hand,” he could boast one-percent mortality for patients admitted for treatment. His infirmary was available to other surgeons, particularly Black surgeons who had no place to operate on their Black patients. In his advertisement, Dr. Wilson frequently noted that “this infirmary offers also a Nurse Training Course of three years.”

In 1913, Dr. Wilson became the surgeon-in-chief at Collins Chapel Home and Hospital. Realizing the need to continue nursing training, and to provide additional opportunities for Black women in Memphis, Dr. Wilson opened the Wilson Hospital, located at 1103 Pearce Street. The communities of Nashville and Memphis continued to support racial uplift, especially for the physical wellbeing and health needs of Black people. There was support and mutual respect for Blacks who embarked in medicine and nursing. For instance, the Nashville Globe on October 19, 1917, announced “Wilson Surgical Hospital and Nurses Training School Opens.” Dr. Wilson granted Dr. W.S. Martin control of the hospital and hired Miss Annie B. Wilson of Philadelphia to assume the position of head nurse. The hospital established a free clinic on Tuesdays and

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With new hospitals and clinics, Black nurses assumed an important role in Black health during the twentieth century, even as race dictated that Black nurses would not receive training in established White nursing schools.

**Tennessee Nursing: Racism and Resistance**

The entrance of Black nurses into professional practice and licensure was related to state laws that inspired Black nurses and Black community leaders to resist the racial constraints of professional practice. For nurses, the hallmark of their professional education was certification granted by state licensure. However, Tennessee banned Black graduate nurses from taking the state examination. Norma Erickson reveals that the Nursing Board in Indiana began the Board of Nursing for examination and registration. Only nurses who were registered by the state could legally use the title trained nurse (T.N.) or graduate nurse (G.N.).

Legal opposition to licensure and certification to practice nursing occupied Tennessee newspapers for nearly two years. Communication concerning racial discrimination of Black nurses in Tennessee was covered in the *Nashville Globe* newspaper. On January 17, 1913, the Tennessee Legislature passed a law creating the State Board of Examiners of Nurses that enacted practice regulations for trained nurses. The bill was devised so that all nurses who passed the exam were granted the title of registered nurse (R.N.). It is difficult to determine whether the first examination board

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consisted of all White nurses and health care professionals. However, one nurse was selected to preserve the nursing practice of White women in Tennessee, Lena Angevine Warner.

Warner was the first chairman of the State Board of Examiners for Nurses in Tennessee. She was also President of the Tennessee Nurses Association (TNA) from 1905 to 1918. In 1898, Warner founded the Memphis Hospital Training School for Nurses. Warner was president of the Tennessee Nurses Association from 1905 to 1918. She is credited with developing “efforts to obtain legislation that would regulate the practice of nursing through a uniform curriculum and prevent the exploitation of student nurse.”132 Tennessee’s legislation benefited White nurses, while it prohibited Black nurses from licensure and professional practice. During Warner’s tenure, the TNA did not allow Black nurses into its membership and denied them access to state examinations. Hine details how most Southern states declined Black nurses’ access to state examinations or developed a separate exam for Blacks.133

Specifically, separate exams perpetuated racial ideologies that Black nurses lacked the training and intellectual capacity to pass a test designed and created by and for White nurses. White nurses had to answer test questions specifically addressing the “poor training” and “inferior knowledge” of Black nurses. Black nurses who passed certification were thus deemed inferior to White nurses by virtue of separate exams. The professional development of nursing in Memphis operated along those same social and

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cultural elements of segregation, because the resistance to having Black nurses with the same professional status as White nurses arose from White middle-class women. Other states such as Georgia consistently denied Black women their professional nursing status. Ludie C. Andrews graduated from Spelman in 1906, and it took 14 years for her to convince the State Board of Nursing to grant Black nurses access to the same exam as Whites. Yet, in Tennessee, Black nurses met the ultimate challenges of professionalization of nurses, including education and career opportunities. Governor Hooper provided a speech for state legislatures to meditate on: “as soon as the Board organized it arbitrarily refused to examine or license any colored nurse, whatever her qualifications might be. No other professional organization had ever denied professional rights to Negro citizen of Tennessee.” With community support, Black women demanded equality and respectability, and their deserved title as nurses.

In Memphis, local citizens addressed the Jim Crow policies that hindered Black advancement in the health industry. Mrs. T.F. Rowlands, responding to an article that appeared in the Nashville Banner on September 19, 1913, argued that the board’s newly established laws were “50 years behind twentieth century progression.” The Banner supported the Board of Examiners by noting that no other Southern State issued licenses to Black nurses or allowed testing for other titles in lieu of R.N. The future of education and training for Black nurses was front-page news in the Globe on September 22, 1911. They reported that Black nurses attended the Board of Examiners meeting and were notified that they were not wanted, and would not have the opportunity to hold the

134 Ibid., 93.

honor and professional qualification of R.N. With this decision, the degree became racialized: the term “registered nurse” would refer only to a White woman. The concerns about legal discrimination necessitated a response from Governor Ben W. Hooper, who did not approve of the board’s action:136

I have not as yet had an opportunity to confer with any member of the examination board, and, perhaps, my views would be merely persuasive. If the board has denied these nurses registration simply on account of their race, as I am reliably informed, they have, their action is illegal. There is nothing in the law which limits its applications to white nurses and excludes colored ones from its benefits. It requires a two-year course of study and training for those that are registered without examination, but these colored nurses have taken a three-year course.137

Hooper was referring to the trained graduated nurses at Meharry Hubbard Hospital. Two years later, the issue had not been resolved, although the Governor expressed condemnation for blatant racial inequity. On September 13, 1913, the Globe acknowledged that the State Board of Examiners of Tennessee would administer nursing exams at the Young Women’s Christian Association (Y.W.C.A.) on October 6 and 7. In addition, the notice stated that it was illegal for any nurse in Tennessee to practice without a license. The exclusion of Black nurses became more legally defined. The editor of the Globe posed an interesting question: “for the nurse who completed training and graduated, how could the courts handle such legality if a Black woman who is a graduate nurse should be arrested for practicing her profession?”138


The state nursing legislation differed from that of Tennessee Medical Association: Black physicians were never denied the opportunity to obtain a license or practice in their profession. The barriers of race did not allow Black physicians admitting privileges at White hospitals. However, Black physicians, especially in Memphis, had private practices and owned hospitals. The trained nurses at Collins Chapel and Jane Terrell had diverse knowledge in specialty areas such as surgery, maternity and public health. Perhaps racial equality was difficult for White women to envision, particularly since Black nurses held respectable positions alongside, and not behind, Black physicians. The remarks that appear in the Globe support the long history of trained nurses in Tennessee. The Black nurses who graduated from programs in Tennessee received educations at reputable institutions; their competency is not in doubt.

The status quo barring Black women from nursing could not last. On October 10, 1913, the headline read, “Globe Wins Another Victory—Nurses Take The Examination.” The first sentence begins by referencing the reality of a racially biased society: “another wall of prejudice has been broken down, and now Negro nurses can take the examination in Tennessee.” Two nurses, Miss Woodard, and Miss Pugh, stated their cases to one of the nurses giving the exam, supported by Dr. J. H. Hale, who accompanied them. Although Dr. Hale, a prominent Black surgeon, appeared before the board, Lena Warner still refused to allow the Meharry nurses to take the state examination. Prior to allowing Miss Woodard and Miss Pugh to take the exam, Mrs. Warner insisted on visiting the school of nursing at Meharry. Warner was introduced to Dr. Hubbard, who discussed the
training facility, and Warner “learned many nurse things she never knew, for he was able to tell her a whole lot about the Negro nurses.”139

It is difficult to determine whether Lena Warner would have allowed the nurses to take the examination if she had not met Dr. Hubbard, a White physician and one of the founders of Meharry Medical School. The outlook of Lena Warner—the preconceived idea that all Black nursing schools were inferior to Whites and that Black nurses lacked the knowledge and skills to function as R.N.’s—was common among White nurses. Darlene Clark Hine notes that White nurses had negative opinions about standards, conduct, and behaviors among Black nurses. Black nurses were perceived as untrustworthy, deceitful and prone to theft, and lacking judgment and analytical skills. White nurse educators believed that the status of graduate nurse was unattainable for Black women. A better option, instead of an educated professional nurse, would be the lower-paid and less prestigious position of a trained attendant. Despite the discipline required to complete training and achieve their proper license as R.N., professional discrimination was widespread for Black nurses.140

The contribution that African American nurses made to professional nursing in Memphis deserves a place in women’s history. Denied recognition by society and viewed as unworthy of careers in nursing, they saw the need to be educated and respond to the needs of the Black community. They answered the call of Black physicians for nursing education and training during racial segregation. African American nurses in Memphis


attained clinical skills and competency, even with unequal clinical facilities when compared to large medical institutions in Memphis with greater resources. Collectively, as Black professional women, they broke down racial barriers in a White middle-class profession. Notably, African American nurses in Tennessee successfully challenged and overturned state legislation by insisting on professional recognition through licensure.

In 1976 an article titled “American History: ANA: Its Record on Social Issues” states that “Almost from its founding the American Nurses’ Association has taken stands and acted on social as well as professional issues.” The article gives credit to nurses like Lillian Wald, who supported organized labor, and Lavinia Dock, who fought for women’s voting rights. Dock was praised for embracing progressive views. However, racial issues within the profession, and the dishonor bestowed upon Black nurses, were obviously not viewed as social issues.

Black nursing schools in Memphis were organized by Black physicians who educated and trained Black women for the profession. As a profession, nursing was still evolving. For those Black nurses who trained in smaller nursing schools such as the three in Memphis, the programs equaled the standards of the time and exceeded many. The nurses who graduated from Jane Terrell, Collins Chapel, and John T. Wilson demonstrated the positive, not the negative, effects of taking a small group of women and making do with available resources.

Black nurses were called to serve in the armed forces during World War I, and many proudly served their country. The uniform was that of the Red Cross, and Black nurses worked on military base hospitals and on battlefields. Black nurses were given the opportunity to work at one of six military units in the American military and aid with care
overseas. They worked with Black soldiers in Black units. By July 25, 1918, there were 35,000 Black troops assigned to American camps. At the time of WWI, America was racially divided, and the war exposed various social taboos. For example, it was neither socially acceptable for White nurses to care for Black patients, nor was it acceptable for White nurses to live and sleep in close quarters with thousands of Black men. After the war’s end, as Black nurses returned to the social reality of their profession and communities, racism and economic hardship was difficult to overcome. Southern cities such as Memphis focused on funding and building nursing institutions that were for White females only.

On December 7, 1918, The News Scimitar informed readers that

our colored people have several hospitals of their own for the care of their sick, in addition to the facilities afford them at the General hospital. They have the Jane Terrell Baptist hospital, the Wilson hospital and Nurse Training schools, the St. Anthony hospital, the Collins Chapel home and hospital, and the Mercy hospital, all of which are liberally patronized.141

The above facilities remained privately operated by Blacks. The city of Memphis did not invest in the training of Black nurses, or in employing Black nurses at White hospitals.

In March 1919, the expansion of Baptist Hospital with a new wing would employ 200 nurses. The new nursing school had a projected opening date of July 1, 1920. The advertisement on March 16, 1920, stated that there was space for 100 additional students. Graduates from Baptist Hospital could work as private duty nurses or in institutions, and special wards. The nurses automatically received acceptance for State Board examination. There was minimal cost for nursing students because textbooks were free; there was a monthly uniform allowance, and the living quarters were maintained by the

hospital. The above demonstrates the benefits offered by a newly established nursing program that was closed to Black females. The Black nurses in Memphis continued to receive training only at Black-owned hospitals.¹⁴²

**Conclusion**

The longevity of racial discrimination among Black nurses in Memphis is demoralizing. By 1940, the city of Memphis still did not allow Black women to receive nursing education and training. Major institutions, including faith-based hospitals such as Baptist, Methodist, and St. Joseph, but also the University of Tennessee did not admit Black women. Collins Chapel and Jane Terrell Memorial Hospital, the two Black nursing schools, no longer existed. To pursue a career in nursing, Black women were forced to travel within or out of state. Options included Meharry in Nashville, Tuskegee nursing school in Alabama, and Hampton Institute. Adding to the grim reality of Memphis in 1940, wealth was required for Black women to complete nursing training, and many who wanted such training could not afford it.

It is crucial to bring visibility to the Jane Terrell, Collins Chapel and J.T. Wilson nurses training schools and programs. They are indispensable to the history of medicine, nursing, and women. Black women faced the obstacles of class, gender and racial discrimination within education and nursing, yet their dynamic legacy lives on.

EPILOGUE

Race remains a dominant discourse in American society. Race is socially constructed, and the cultural phenomenon creates a hierarchy based on privilege. Consequently, the privileges of racism penetrate social institutions including health care, thus politicizing responses to conditions like the current COVID-19 pandemic.

In “Rooted in Racism: An Analysis of Health Disparities in Tennessee,” healthcare researcher Kinka Young examined the way health disparities and health inequities manifest ideologies of racism. Young concluded that discussions of health disparities are incomplete unless health inequalities are also addressed. Unequal access to health care is one form of health inequality that is detrimental to people of color in Tennessee. Early COVID-19 data (ending in May 2020) included over 50 percent of the U.S. population; however, variables of race and ethnicity were not identified and COVID-19 cases in Tennessee were omitted. Still, Kinka Young obtained statistics on the relationship of race and COVID cases the state.

Compared to mostly White neighborhoods, several communities in Nashville and Memphis had delays in testing due to lack of supplies and equipment. Kinka Young, noted that “health disparities exited long before COVID-19, but this pandemic has raised awareness about longstanding, pervasive inequities that have plagued this country.”¹ Specifically, inequality for African Americans has its origins in history. Fundamental inequalities foster health disparities based on race, gender and class; these disparities are more pronounced among Blacks compared to the rest of the population. Historical

¹ Kinka Young, “Rooted in Racism: An Analysis of Health Disparities in Tennessee,” Tennessee Justice Center, (July 2020): 1-3,
inequalities among minority groups are deeply embedded in mistrust of the medical community.

This dissertation focused on the ways in which social and political ideologies of race and cultural norms of segregation resulted in early deaths, health disparities, and unequal access to healthcare. Devaluing the socio-economic status of African American woman made them vulnerable to harmful medical research, and victims of violence and abuse. When we focus on current health problems, it is apparent that blaming racial and ethnic minorities remains a part of the American fabric. For instance, with COVID-19, “communities of color including Asian communities have been blamed for the introduction of SARS-CoV-2 to the U.S. and Black communities… have been blamed for higher fatality rates among Black populations.”\(^2\) This parallels the historical legacy in Memphis, Tennessee of blaming African Americans for spreading diseases such as tuberculosis without clearly understanding how poverty places many communities at higher risk for disease and infections.

This dissertation teaches us that regardless of the crisis racism in healthcare is deadly and detrimental to the health of an entire community. As a city and nation, have we learned from the past? Have we moved beyond politicizing epidemics and viewing them through the lens of outdated ideology? Are we willing to allow research in the disciplines of history and anthropology to assist biomedicine for the good of humanity? Does the following commentary by a newspaper editorialist in 1879 still ring true?

We the people of Memphis and Shelby county are asked to give an infinitesimal sum compared to with what will be accomplished. The economic loss each year

from tuberculosis amounts to half a billion dollars. What it costs in loss of life, loss of loved ones, loss of labor, heartbreaks, sorrow, and despair is incalculable. We know that tuberculosis is spread largely through ignorance. This it is a deadly disease because sufficient importance has not been given to the necessity for scientific treatment.

As historians, “we take it as self-evident that knowledge and understanding of the human past is of incalculable value both to the individual and to society at large, and that the first object of education in History is to enable this be acquired. We stress the importance of historical knowledge.” Knowledge of the history of Black healthcare is more important than ever.

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