Chapter 33: Deaths

A: Child deaths

Introduction

33.1 High rates of infant and child mortality are a marked feature of the mother and baby homes under investigation. This is especially so in the earlier years of their existence. The numbers of deaths and the level of official knowledge about those deaths are described in the individual institutional chapters. The Commission has had a detailed examination of the deaths in Pelletstown, Bessborough, Castlepollard, Sean Ross, Tuam, and Bethany conducted by statisticians - see associated Statistical Analysis. These are the institutions in which there were a large number of deaths. There were deaths associated with Regina Coeli but the Commission did not conduct a detailed analysis because the available data did not facilitate doing so - see Chapter 21. There were some deaths associated with the other mother and baby homes but the numbers were very small. For example, a small number of children born to mothers who were in Dunboyne died but the children were not admitted to Dunboyne and they died in hospitals. The situation was similar in The Castle and Miss Carr's. The Commission does not have detailed information about deaths in Kilrush or St Gerard's.

Establishing the number and causes of deaths

33.2 The Commission's information on deaths comes from the institutional records and the General Register Office (GRO). The database compiled by the Commission records all deaths which are recorded in the institutional records. The GRO provided the Commission with lists of deaths for Tuam, Bessborough, Castlepollard and Sean Ross. When compiling these lists, the GRO used the place of death and the last address of the deceased as the means of identifying the relevant deaths. The Commission analysed the names from these lists and compared them with the information compiled from the institutional records. There were some differences between them. In some cases, the institution was not mentioned as either the place of death or the last known residence and, as a result, these deaths were not on the GRO lists. Where the Commission was aware of a death which was not on the list provided by the GRO, the online register was checked. The online register covers deaths up to 1969. In the vast majority of cases, the Commission found that the deaths recorded in the institutional records were on the GRO register. The GRO checked the post 1969 deaths on behalf of

the Commission. Again, the vast majority of the deaths recorded in the institutional records were found on the GRO register.

33.3 The Commission examined the cases of children who went to hospital from the institutions and did not return. In some cases, the institutional records record that the child died in the hospital. Where there was no such record, the Commission checked the GRO register to try to establish if any of those children died within a year of their going into hospital. These deaths are included in the total deaths for each institution. (In the vast majority of these cases, the deaths occurred within two months of their going into hospital). In a small number of cases, children who left the institution to go to a place other than a hospital are recorded in the institutional records as having died within a year. These deaths are also included in the total deaths for each institution.

Causes of death

33.4 The institutional records record the cause/causes of death in almost all cases. The GRO register also gives the causes of death. In many cases, there is more than one cause of death recorded and there are minor differences between the causes recorded in the institutional records and those recorded in the GRO register. In analysing the causes of death, the Commission has used the causes as recorded by the GRO. Where multiple causes of death are recorded, the Commission, with the assistance of a paediatrician, has identified the likely most immediate cause of death and classified the death accordingly.

Marasmus

33.5 The term marasmus as a cause of death was common until the 1940s and was used in instances where a child could not absorb enough nutrients from food to thrive. Marasmus was always associated with an underlying health condition or disease which resulted in a failure to thrive. From the 1950s, marasmus was not generally accepted as a cause of death and doctors citing marasmus as a cause of death were asked to investigate and identify the underlying medical condition or disease. Some commentators have concluded that infant deaths which occurred in mother and baby homes due to marasmus indicates that infants were neglected, not appropriately cared for, and/or wilfully starved to death in these institutions. However, marasmus was a frequently cited cause of infant deaths in institutional, hospital and community settings in early twentieth-century Ireland. The Commission considers it unlikely that deaths in hospitals and family homes were

due to wilful neglect and so cannot conclude that the term marasmus denotes wilful neglect in mother and baby homes. The more likely explanation is that marasmus as a cause of death was cited when an infant failed to thrive due to malabsorption of essential nutrients due to an underlying, undiagnosed medical condition.

Explanations of causes of death

33.6 The Commission engaged a paediatrician to assist in its analysis of the various causes of deaths. The words used varied over time and some of the causes given were quite non-specific. The following explanations were provided by the paediatrician.

Cardiac Failure: This is the final outcome of many causes of death, for example, sepsis. Primary failure of the heart would be very unusual and probably confined to children with congenital heart lesions, diphtheria, viral myocarditis or specific severe vitamin deficiency.

Congenital Debility: This is lack of viability 'life force'. The use of 'congenital debility' decreased rapidly from 1921 until it was removed in 1948 in the UK.

Premature Birth: Too vague a cause of death; evolved into more specific entities that actually caused the death.

Gastroenteritis: Infectious (Bacterial or Viral) disease causing diarrhoea, vomiting and dehydration. Fluid and Electrolyte solutions were only used since the 1940s/1950s.

Bronchopneumonia: Infection involving the airways (Bronchi) and the lung proper; can be very severe without antibiotics and/or oxygen. The infection often spread to the bloodstream. Antibiotics started to be used in the 1940s.

Convulsions: Acute onset of chaotic electrical activity in the brain; sudden loss of consciousness; inadequate oxygenation of brain. Death from prolonged convulsions (status), Aspiration of stomach contents into lungs or injury. Medical treatment started with phenobarbitone in the 1920s and phenytoin in the 1940s.

Measles: Serious (400 to 500 deaths in the US each year) common infectious disease until vaccine (1963) reduced the incidence by 98%.

Meningitis: Infection of the lining of the brain and spinal cord (the meninges); bacterial, tubercular and viral. The former two had 100% mortality before the introduction of antibiotics in the late 1940s.

Influenza: Highly contagious airborne virus; local epidemics and pandemics since ancient times (for example, 1918-19 Spanish flu). No vaccine until the 1940s; seasonal vaccines in the late 1960s; subunit vaccines in the late 1970s. Monitoring for Antigenic drift of influenza virus. Crowding of vulnerable children allowed mini epidemics to occur of many infectious diseases.

Gastritis: part of acute gastroenteritis.

Congenital Heart Disease: The most common serious congenital anomaly. 17/10,000 incidence of life threatening disease. Tetralogy of Fallot, Transposition of Great Arteries, Hypoplastic left heart Syndrome. No surgery till the late 1950s.

Hydrocephalus: Part of Spina Bifida; Very common in Ireland before periconception folic acid supplementation was introduced in 1993; poor drainage of cerebrospinal spinal fluid led to its accumulation in the ventricles (fluid filled sacs) of the brain. The ventricles expanded causing the baby's head to grow excessively either before (leading to difficult labour) or after birth causing a huge head and brain damage from stretching of the brain.

Pertussis: (Whooping Cough) Major infectious disease; major cause of death in those less than 20 years; 3.7% of deaths in the Netherlands in this age group before vaccination which dropped to 0.024% with vaccination. Particularly dangerous in infants. 50% need hospital care. Vaccination began in 1952 in Ireland.

TB/Tuberculosis/Phthisis: serious infectious disease involving an initial infection that may become manifest immediately or lay dormant and become manifest years later. Initial portal of entry is through the lungs from contact

with someone with pulmonary TB. TB can then spread to involve almost any part of the body including meninges, bone, kidney, bowel etc. The BCG vaccine was introduced in Ireland in the 1930s and 1940s. Streptomycin as a treatment was introduced in the early 1950s. These resulted in a dramatic decrease in mortality.

Diphtheria: 'The children's plague'; an infectious disease with mortality of 20% in under 5s before treatment introduced. Diphtheria caused obstruction of the airway and the toxin produced by the infection caused nerve paralysis, myocarditis. Antitoxin introduced in the 1930s and penicillin and vaccination in the 1940s.

Syphilis (Tabes): Congenital; 40% of babies born to mothers with untreated syphilis died. Infection spread to bone, bone marrow, liver and spleen, eyes, ears, meninges, skin. Penicillin introduced in the late 1940s.

Sepsis (Septicaemia): Bacterial blood infection that often arose from the spread of infection from primary sites such as pneumonia. Needed antibiotics to improve the desperate mortality.

Atelectasis: Collapse of the small air sacs in the lung. Could be caused by obstruction of the airways with plugs of mucous, enlarged lymph nodes. Asthma/ TB/ pneumonia/ preterm lungs.

Cerebral Haemorrhage: Traumatic and Non Traumatic. The latter divided into the area of brain involved. Sub Arachnoid, Sub Dural or Intra Cerebral. Could be vascular malformation or a severe bleeding tendency from low platelets, vitamin K deficiency.

Asphyxia: Lack of oxygen usually refers to asphyxia during difficult delivery of the baby.

Laryngitis: leading to obstruction of airway from Epiglottis, Diphtheria, Tetany.

Otitis Media: without antibiotics could spread to cause mastoiditis, meningitis and Dural sinus thrombosis.

Icterus Neonatorum: Neonatal jaundice if severe caused kernicterus or acute brain damage. Exchange transfusions as treatment only in the late 1950s. Phototherapy in the 1980s.

Registration of Deaths

33.7 The registration of deaths in the period 1922 - 1998 was governed by the *Registration of Births and Deaths (Ireland) Act 1863* (which was amended by the *Births and Deaths Registration Act (Ireland) 1880*) and by the detailed rules set out in the *Regulations for Registrars of Births, Deaths, and Marriages 1880.* Initially, the poor law unions formed the superintendent registrars' districts for the purpose of registration of births and deaths. The dispensary districts within the poor law unions were the registrars' districts; each was headed by a registrar who reported to the relevant superintendent registrar. The superintendent registrars reported to the Registrar General of Births and Deaths in Ireland. After independence, the poor law unions were replaced by County Boards of Health and in 1942 by the public assistance districts created under the *Public Assistance Act 1939*. The title of the Registrar General was changed to an t-Ard-Chláraithreoir in 1952 under the *Vital Statistics and Birth, Deaths and Marriages Registration Act 1952*. The health boards became the superintendent registrars when they were established in 1970/71.

33.8 The registrar of the district in which a person died was responsible for registering the death. The relatives or people present at the death were required to inform the registrar of the death. In the case of deaths which occurred in institutions, the law provided:

> Where a person dies in a place which is not a house, or a dead body is found elsewhere than in a house, it shall be the duty of every relative of such deceased person having knowledge of any of the particulars required to be registered concerning the death, and in default of such relative, of every person present at the death, and of any person finding and of any person taking charge of the body, and of the person causing the body to be buried, to give to the registrar, within the five days next after the death or the finding, such information of the particulars required to be registered concerning the death as the informant possesses, and in the presence of the registrar to sign the register.

33.9 So, the obligation to inform the registrar was placed, in order, as follows:

(i) every relative having knowledge of any of the required particulars,

(ii) in default of such relative -

a. every person present at the death,

b. any person finding the body,

c. any person taking charge of the body,

d. the person causing the body to be buried.

33.10 In general, the particulars had to be given to the registrar within five days of the death but this could be extended to 14 days in certain circumstances.

33.11 The person who registered the death was known as the informant. The informant was required to sign the register, giving his or her qualification under the Act (for example, mother, son, present at death, responsible for burial) and residence. The registrar would sign and date the entry in the register. If the death took place in a public institution, the former residence of the deceased would also usually be entered.

Medical certification

33.12 Medical certification of the cause of death was not an absolute requirement. If the deceased was attended before death by a registered medical practitioner, the practitioner was required to sign and provide a certificate in relation to the cause of death. The informant was required to deliver that certificate to the registrar who would then insert the cause of death in the register. (This requirement did not apply where an inquest was held, as the certificate of the jury furnished by the coroner was sufficient). The GRO told the Commission that there was no legal requirement to retain these certificates as the registration would have incorporated the cause of death as it appeared on the certificate. The GRO does hold a small number of Medical Cause of Death Certificates from 1989 to 2005.

33.13 If there was no medical certificate from an attending medical practitioner, unless the death was, in the opinion of the Registrar, sudden, violent or suspicious, the Registrar could fill in the cause of death on the basis of the ‘best information’ obtained from the informant, rather than a certificate.

Actual registration of deaths

33.14 The evidence compiled by the Commission suggests that the institutions being investigated did generally comply with the requirements for the registration of deaths. Most deaths in the institutions are recorded as 'certified'.

33.15 In the case of Tuam, the death certificates very often name the informant as Bina Rabbitte who lived and worked in the institution. It has been suggested that she effectively 'certified' the deaths. There is no evidence that this was the case.

33.16 The Medico-Social Research Board was concerned about the failure to certify and register deaths. Its 1971 Annual Report noted that the number of deaths which were registered but not medically certified had dropped from 11.2% in 1948 to 1.9% in 1968. However, there was still a high rate of non-registration and this was a particular problem in the west of Ireland. In 1970, a study on the registration and certification of deaths during the years 1966-69 was undertaken on a random sample of 21 parishes in the west of Ireland.[1] This showed that 86.3% of deaths had been medically certified and registered; 6.2% had been registered but not certified and 7.5% had been neither certified nor registered. A follow up study was carried out on burials in the period 1974-77.[2] This showed that 6.1% were neither certified not registered. The Medico-Social Research Board, while recognising that there had been an improvement, concluded that the certification and registration of deaths in the west of Ireland remained unsatisfactory.

Timeliness of registration

33.17 The deaths in the institutions were generally registered in a reasonably, but not strictly, timely manner. It seems to have been the practice, particularly when the death rates were very high, to register a number of deaths at the same time. For example, in Bessborough, six deaths were registered on 12 May 1941; these occurred between 3 March 1941 and 27 April 1941; nine deaths were registered in 26 August 1943; they occurred between 22 July 1943 and 23 August 1943. There are some examples of quite late registration. There is no obvious explanation in most cases.

[1] G Dean and C J Mulvihill, 'The registration of Births and Deaths in Ireland', in *Journal of the Irish Medical Association* (1972).
[2] Medico-Social Research Board, *Annual Report 1979*

B: Maternal Deaths

Introduction

33.18 The Commission examined the institutional records of Pelletstown, Bessborough, Sean Ross, Castlepollard, Tuam, Dunboyne, Bethany, Denny House, Cork county home, Stranorlar county home and Thomastown county home in order to establish the number and causes of maternal deaths.[3] It identified 200 women who died when resident in one of these homes (no maternal deaths were recorded in Dunboyne). A number of these deaths occurred several years after the woman had given birth. Four women who were admitted to Bessborough in the 1920s, and continued to reside there, died in the 1950s, 1970s, and 1980s (2 deaths). The Commission located GRO death records for 193 women (96.5% of deaths).

33.19 Maternal deaths are defined as a death of a woman while pregnant or within 42 days of the termination of the pregnancy. Maternal deaths are classified into three categories: this classification has been made by an obstetrician.

- **Direct obstetric deaths**: direct obstetric deaths are those resulting from obstetric complications of the pregnancy state (pregnancy, labour and the puerperium), from interventions, omissions, incorrect treatment, or from a chain of events resulting from any of the above.
- **Indirect obstetric deaths**: indirect obstetric deaths are those resulting from previous existing disease or disease that developed during pregnancy and which was not due to direct obstetric causes, but which was aggravated by physiologic effects of pregnancy.
- **Coincidental maternal deaths**. Deaths from unrelated causes which happen to occur in pregnancy or the puerperium.

33.20 Of the 193 deaths where GRO death records have been located, 71 can be classified as direct maternal deaths, and 53 as indirect maternal deaths; 69 were probably coincidental. However, 14 of the 124 deaths that would be classified as direct or indirect maternal deaths, on the basis of the death certificate, occurred more than a year after the birth of a child, and should therefore be omitted from those categories, so the figure is 110. The Commission has taken a decision to exclude only deaths that occurred more than a year following birth; this means that

[3] The maternal deaths in county homes relate only to the unmarried mothers whose records were analysed by the Commission. Married women also gave birth in county homes; their maternal mortality rates have not been examined.

the number of deaths classified as indirectly or directly related to pregnancy is probably overstated.

33.21 Among the direct maternal deaths, the largest cause was puerperal sepsis which accounted for 32 deaths. During the 1920s an average of 105 women died in Ireland each year from puerperal sepsis; in the 1930s an average of 74 women died each year from puerperal sepsis. In the late 1930s it was established that the anti-bacterial drug, sulphonamide, was a highly-effective treatment for this condition, and the death rate from puerperal sepsis fell sharply during the 1940s. In 1950, 20 women in Ireland died from puerperal sepsis and the number continued to decline in the following years.

33.22 The second most common direct cause of maternal deaths in the institutions was eclampsia and its variants such as acute fatty liver of pregnancy. This figure is arrived at by including cases where eclampsia or 'nephritis' or 'albuminuria' or 'toxaemia' is mentioned on the death certificate. They account for 25 deaths; however, two of the deaths where nephtritis or kidney disease is recorded occurred more than a year after the birth. There were eight deaths from haemorrhage/shock/obstructed labour and four from pulmonary embolism. The relatively low rate of death from haemorrhage is probably due to fact that the majority of women were first-time mothers.

33.23 The majority of indirect maternal deaths were due to cardiac disease in pregnancy. This is consistent with the period between the 1920s and 1970s where many women went into pregnancy with underlying cardiac disease due to damage to heart valves caused by rheumatic fever. Deaths due to appendicitis in pregnancy are classified as indirect deaths as pregnancy obscures or delays the diagnosis of appendicitis. Other deaths classified as indirect deaths are deaths from influenza and brain haemorrhage where pregnancy is a precipitating or aggravating factor.

33.24 The commonest cause of coincidental death was infectious disease. Tuberculosis was overwhelmingly the biggest contributor. Many of the 16 deaths due to typhoid, dysentery, diphtheria, measles, scarlet fever and meningitis may have occurred due to institutional outbreaks. Seven deaths due to pneumonia, where no other factors were listed, have been classified as coincidental, although there may have been pregnancy- related factors, which if known would indicate classification as indirect deaths.

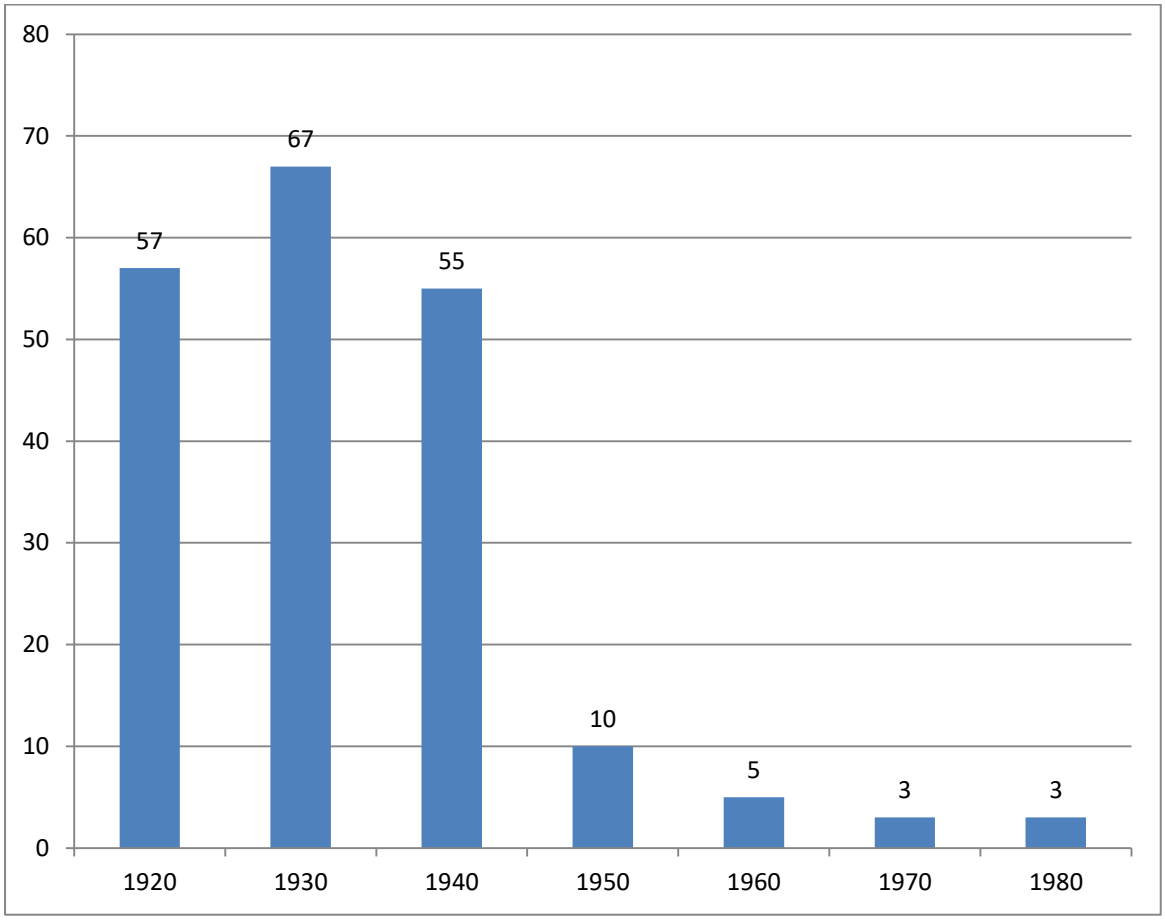
33.25 Maternal mortality in the homes was higher than the national rate until the 1970s. However, as noted earlier, the Commission's figures probably overstate the number of deaths and the excess mortality is much less than in the case of infant mortality in these institutions. The downward trend mirrored the national decline. The significant improvement in maternal mortality during the 1940s both nationally and in these homes contrasts with the spike in infant mortality during that decade.

33.26 The mortality from causes that were not associated with pregnancy, either directly or indirectly is a greater cause of concern. The 16 deaths of women from infectious diseases reflects major shortcomings in these institutions that were also responsible for many infant deaths.

Maternal deaths

	1920s	1930s	1940s	1950s	1960s	1970s	1980s	1990s
Admissions	4307	7520	8525	6160	8337	7714	4607	1481
Deaths	57	67	55	10	5	3	3	0
Maternal deaths (Direct and Indirect)	25	42	30	8	5	0	0	0
Maternal Mortality Rate/1,000	5.8	5.59	3.52	1.3	0.6	0	0	0
National Maternal Mortality Rate/1,000	4.82	4.82	2.36	1.16	0.34	0.19	0.05	0.34

Deaths of women in mother and baby homes and county homes from all causes



Cause of death classified as D (Direct Maternal Death), I (Indirect Maternal Death, C (Coincidental Maternal Death).

Cause of death	
Pulmonary Tuberculosis	16 C
Cardiac Failure	6 I
Typhoid	5 C
Cardiac Failure, Pulmonary Tuberculosis	4 C
Dysentery, Haemorrhage	4 C
Eclampsia	4 D
Phthisis	4 C
Pneumonia	4 C
Puerperal Septicaemia	4 D
Cardiac Failure, Tuberculosis	3 C
Coronary Thrombosis	3 I
Puerperal Sepsis	3 D
Pulmonary Embolism	3 D
Tubercular Meningitis	3 C
Acute Nephritis	2 D
Appendicitis	2 I
Bronchitis, Cardiac	2 I
Bronchopneumonia , Cardiac Failure	2 I
Cardiac Failure, Eclampsia	2 D
Cardiac Failure, Puerperal Sepsis	2 D
Eclamptic Convulsions, Kidney Disease	2 D
Hepatic Failure, Renal Failure, Toxaemia	2 D
Influenza , Pneumonia	2 I
Meningitis, Tuberculosis	2 C
Puerperal Fever	2 D
Puerperal Sepsis, Toxaemia	2 D
Pulmonary Tuberculosis, Cardiac Failure	2 C
Toxaemia, Typhoid	2 C
Tuberculosis	2 C
Abscess of Jaw, Cardiac Failure	1 C
Abscess of Nose, Meningitis	1 C
Acute Bright's Disease	1 D
Acute Leukaemia	1C
Acute Mania, Cardiac Failure	1 I
Acute Nephritis, Cardiac Disease	1D
Acute Venous Sepsis, Cardiac Failure, Toxaemia	1 D
Acute Yellow Atrophy of Liver, Pregnancy, Confinement	1 D
Albino, Myocarditis, Syncope, Post-Parturition	1 I

Anaemia, Cardiac	1I
Anaemia, Myocarditis, Nephritis	1 D
Anaemia, Nephritis	1 D
Antepartum Haemorrhage, Coronary Thrombosis, Post-Partum Debility	1 D
Antepartum Haemorrhage, Pre-Eclamptic Toxaemia	1 D
Appendicitis, Exhaustion, Peritonitis	1 I
Appendicitis, Peritonitis	1 I
Arteriosclerosis, Cardiac Failure	1 I
Ascending Myelitis	1 C
Bronchitis, Cardiac Failure	1 I
Bronchitis, Influenza	1 I
Bronchopneumonia	1 **C**
Bronchopneumonia , CA (L) Breast	1 C
Carcinoma	1C
Carcinoma of Uterus	1C
Cardiac Disease	1 I
Cardiac Failure, Coronary Thrombosis	1 I
Cardiac Failure, Eclampsia, Pulmonary Oedema	1 D
Cardiac Failure, Endocarditis	1 I
Cardiac Failure, Influenza , Pneumonia	1 I
Cardiac Failure, Internal Haemorrhage, Respiratory Failure	1 I
Cardiac Failure, Malignant Ovarian Cyst, Toxaemia	1 D
Cardiac Failure, Mitral Disease, Parturition	1 I
Cardiac Failure, Mitral Stenosis	1 I
Cardiac Failure, Pelvic Cellulitis	1D
Cardiac Failure, Pelvic Cellulitis, Toxaemia	1D
Cardiac Failure, Peritonitis	1D
Cardiac Failure, Pernicious Anaemia	1I
Cardiac Failure, Phthisis	1C
Cardiac Failure, Post-Partum, Diptoria	1 C
Cardiac Failure, Postpartum Haemorrhage	1D
Cardiac Failure, Puerperal Septicaemia	1D
Cardiac Failure, Septicaemia	1 C[4]
Cardiac Failure, Valvular Heart Disease	1I
Cardiac, Pulmonary Tuberculosis, Syncope	1C
Cardiac, Spastic Paraplegia	1 C[5]
Cardiac Shock, Puerperal Sepsis	1D
Cardiac Tamponade, Ruptured Dissecting Aneurysm of Aorta	1I
Cardiorespiratory Failure, Congestive Cardiac Failure, Atrial Fibrillation, Diabetes	1 C[6]
Cardiopulmonary, Kyphoscoliosis	1I

[4] This would normally be classified as 'Direct' but this woman died more than a year after giving birth.
[5] Died more than a year after giving birth.
[6] Died more than a year after giving birth.

Cerebral Embolism, Myocardial Degeneration	1 C[7]
Cerebral Haemorrhage	1I
Cerebral Haemorrhage, Myocarditis	1I
Coma, Puerperal Albuminuria	1D
Confinement, Coronary Thrombosis	1I
Confinement, Influenza	1I
Continued Fever	1 C[8]
Coronary Embolism	1 D
Coronary Embolism, Phlebitis, Pregnancy	1D
Diphtheria	1C
Dysentery	1C
Encephalitis Lethargica, Heart Failure, Hyperpyrexia	1I
Endocarditis, Rheumatism	1I
Enteric	1C
Enteric, Typhoid	1C
Exhaustion, Puerperal Sepsis	1D
Exhaustion, Pulmonary Tuberculosis	1C
Gastroenteritis, Haemorrhage, Puerperal Sepsis	1D
Haemorrhage, Dysentery	1C
Heart Disease	1I
Heart Failure, Puerperal Parametrisis	1D
Heart Failure, Puerperal Sepsis	1D
Influenza , Parturition	1I
Intestinal Haemorrhage, Purpura	1C
Inversion of Uterus, Shock	1D
Kidney Disease	1 C[9]
Lobar Pneumonia, Cardiac Failure	1C
Lobar Pneumonia, Typhoid	1C
Measles, Oedema of Lung, Pneumonia	1C
Meningitis	1C
Myocardial Failure , Obstruction of Labour , Shock	1D
Myocarditis	1I
Nephritis, Cardiac Failure	1D
Nephritis, Cardiac Failure, Tuberculosis	1C[10]
Nephritis, Puerperal Eclampsia	1D
Peritonitis	1D
Phlebitis	1D
Placenta Previa Haemorrhage	1D
Post-Operative Shock (Caesarean), Toxaemia of Pregnancy	1D
Postpartum Haemorrhage	1D
Puerperal Sepsis, Cardiac Failure	1D

[7] Died more than a year after giving birth.
[8] Died more than a year after giving birth.
[9] Died more than a year after giving birth.
[10] Died more than a year after giving birth.

	Puerperal Sepsis, Placenta Praevia, Severe Ante-Partum Haemorrhage	1D		
	Puerperal Sepsis, Pulmonary Congestion	1D		
	Puerperal Sepsis, Typhoid	1D		
	Puerperal Septicaemia, Syncope	1D		
	Respiratory Paralysis, Subarachnoid Haemorrhage	1C[11]		
	Scarlet Fever	1C		
	Septic Pneumonia	1C		
	Septicaemia	1D		
	Shock	1 C[12]		
	Syncope	1I		
	Syncope, Mitral Stenosis	1I		
	Syncope, Pregnancy, Rheumatic Carditis	1I		
	Tabes Mesenterica	1C		
	Tubercular Meningitis, Cardiac Failure	1C		
	Tuberculosis, Confinement	1C		
	Valvular Heart Disease	1I		

[11] Died more than a year after giving birth.
[12] Electrocuted.