

State of Ohio)
) Affidavit
Lorain County)

I, Thomas B. Renz, being first duly sworn, based upon my own personal knowledge
depose and state the following:

- 1) That I am an attorney at law licensed in the State of Ohio;
- 2) That I have conducted extensive research and analysis of the COVID 19 information,
data, statistics, and summaries in the Center for Disease Control (CDC) web site;
- 3) That I have also reviewed COVID 19 data from other sources such as the World Health
Organization and the Ohio COVID 19 sites;
- 4) That I have read and reviewed the attached Exhibit A, a summary of my extensive
research and analysis of COVID 19 from the CDC, and such summary is true accurate
and correct;
- 5) That I make the following Statements of Conclusion:
 - A) The available data relating to the number of COVID-19 deaths being presented by the
CDC is being substantially overstated.
 - B) The data presented by the CDC is being presented in an intentionally misleading way.
 - C) The danger presented by COVID-19 cannot be accurately discerned based on the
incomplete and misleading data available to the public but appears to be far less than it is
being portrayed as.
 - D) There are substantial financial incentives for healthcare providers to have higher numbers
of COVID-19 patients.
 - E) The case fatality rate of COVID-19 will continue to fall substantially as more testing is
done in the general public.

- F) Based on Dr. Ioannidis’s work and other research, the final case fatality rate in the general population will be roughly equal to a flu season with above average case fatality rates.
- G) Unless we believe that the actions that have been taken in the state of Ohio would be Constitutional during an above average seasonal influenza outbreak, which I would disagree with, then they should not be viewed as Constitutional here – particularly in light of Jacobson v. Massachusetts, 197 U.S. 11 (1905).
- 6) That I am competent to testify concerning the matters in this Affidavit and the Attached Exhibit A;

Thomas B. Renz

Sworn to and subscribed to and acknowledged by me a notary public this 21st day of July 2020.

Gerald W. Phillips
Notary Public
No Expiration Date
ORC Section 147.03

EXHIBIT A

Discussion of Data Related to COVID-19

Thomas Renz

The author swears and attests that the information contained herein is based on a good faith belief in its accuracy as well as in the statements of conclusion below.

The year 2020 has been marked by one of the most significant pandemics in human history – COVID-19. This statement is bolstered by the fact that, regardless of the future epidemiological findings regarding the medical impact of COVID-19, the reaction to the disease has resulted in a massive global reaction including the closure of major world economies and lockdowns of entire populations.

While the loss of a single life is too many, the reality is that it is simply an unavoidable part of life. On a yearly basis we see a death toll from the various strains of the flu of roughly 291,000 to 646,000 globally (Centers for Disease Control, 2017) and other outbreaks occurring, such as Ebola, that have death rates as high as 50% (World Health Organization, 2020). This leads to the natural question, is the reaction to this disease warranted?

Since the outbreak of COVID-19 there have been many reports put out in news sources and even by respected sources regarding the danger of COVID-19 and these reports have been used to justify the drastic actions taken by political leaders to protect the population. The politicization of this disease has created a situation where it is now difficult to know the true danger. The original purpose of this paper was to cut through politics and bias by reviewing available data regarding COVID-19 and providing comparisons between key epidemiological

figures of COVID-19 and comparing those figures with seasonal influenza so we can begin to determine if the political reaction was medically warranted. This paper was focus on mortality rates, reproduction rates, and where possible, treatment duration between the diseases largely because concerns of various healthcare systems being overrun was a primary justification for these actions. In recognition of the fact that various strains of influenza have substantially different impacts, this paper was also going to draw comparisons with both the seasonal influenza facts and specifically with H1N1.

The reason much of the last paragraph was written in past tense is that the purpose of this paper had to change. Upon researching these questions, it became clear that the publicly available data on COVID-19 has been so manipulated that it was frankly impossible to make any real comparisons. As this paper will make clear, the data is now being used to promote an agenda other than advancing science.

It was clear from the beginning that finding scientifically substantiated data on these topics that has not been sensationalized would be very difficult. Major sources of data were to include the CDC, WHO, and NIH but the result ended up primarily focused on the CDC. Searches were performed using internal search engines for each of those organizations as well as through external sources such as Google Scholar and online databases such as ProQuest. These searches have used various phrases such as “epidemiology COVID-19”, “epidemiology of influenza”, “COVID-19 mortality rates”, “influenza mortality rates”, “COVID-19 reproduction rates”, “influenza reproduction rates”, “COVID-19 hospitalization duration”, “influenza hospital duration”, and other similar iterations of each.

Please note that this paper was intended to be a typical scientific review of evidence used to provide clarity on the dangers of COVID-19 in comparison to influenza. Despite that intent,

and to facilitate academic and scientific honesty, the new purpose has been to demonstrate the dishonesty in the scientific reporting on this disease. While it is worth stating that COVID-19 is a real disease that can have fatal consequences, and so proper precautions should be taken, there is no reasonable explanation for the consistent, misleading nature of the public guidance and actions being taken due to this disease.

COVID-19 Information Review

As previously noted, the available literature related to COVID-19 has been extremely difficult to review. It frankly appears that a substantial amount of the data available through the CDC has been distributed with a political purpose as it is unlikely that professionals of the caliber that work at the CDC would be unable to produce clear and concise information. Further, there is evidence discussed below that indicates that the data released has been done so in a way that is purposely misleading. Despite that, this discussion of available data will attempt to parse the information available in as clear and unbiased means possible. This discussion focuses on mortality rates and death counts as the clearest demonstration of how the data is being presented in a biased and misleading way.

Literature/Data Review

The first thing to note is the technical notes for the provisional death counts for COVID-19. The notes point out that provisional data on COVID-19 deaths are based on information from the National Vital Statistics System. Because these statistics are then processed and evaluated the results are lagged by 1-2 weeks (Centers for Disease Control and Prevention, 2020).

Critical to understanding CDC statistics is the disclaimer accounting for the differences between CDC data and other sources. CDC reporting includes all laboratory or clinically

confirmed COVID-19 cases. It also includes deaths, “deaths where COVID-19 is listed as a “presumed” or “probable” cause” (Centers for Disease Control and Prevention, 2020). Here probable is defined as “the circumstances were compelling within a reasonable degree of certainty” and further that COVID-19 was the underlying – not primary – cause of death in 94% of the death certificates. This was widely reported and discussed when guidelines were issued in April (National Vital Statistics System, 2020) and may result in the inclusion data suggesting COVID-19 as being the cause of death or underlying cause of death when it was not.

It is also interesting to note that pneumonia deaths are included using multiple cause-of-death codes from the *International Statistical Classification of Diseases and Related Health Problems* (ICD). These codes provide international standards for classifying disease. (Centers for Disease Control and Prevention, 2020) The updated reporting guidance notes that this is because the primary cause of death in many COVID-19 cases is pneumonia and/or acute respiratory distress syndrome – also known as ARDS (National Vital Statistics System, 2020).

This denotes the use of a similar approach in attribution of deaths to COVID-19 to the approach used with ARDS and pneumonia when related to influenza. It is significant to note that with the overlap of symptoms and the fact that both COVID-19 and influenza are essentially grouped together with ARDS and pneumonia as singular causes of death that it would be very difficult to determine the actual underlying cause of death without definitive laboratory testing. Further study should definitely be done to ensure there is no overlap in recorded statistics for the two diseases (this is unlikely since they have different ICD codes) and, once that is determined, whether there is a correlation between the increased death count for COVID-19 and any statistically abnormal decreases in the death count for influenza. This issue is actually noted in the document (Centers for Disease Control and Prevention, 2020).

Data

To further the analysis of COVID-19 a review of the data set itself is warranted. The first issue presenting itself is that the “COVID-19 Deaths” statistic includes “Deaths involving COVID-19 (ICD-code U07.1)” (CDC, 2020). The issue is that the WHO ICD code U07.1 requires confirmation of COVID-19 as a cause of death and uses code U07.2 for probable or suspected COVID-19 cause of death (World Health Organization, 2020). The guidance from the CDC allows for a different standard:

“In cases where a definite diagnosis of COVID–19 cannot be made, but it is suspected or likely (e.g., the circumstances are compelling within a reasonable degree of certainty), it is acceptable to report COVID–19 on a death certificate as “probable” or “presumed.” In these instances, certifiers should use their best clinical judgement in determining if a COVID–19 infection was likely. However, please note that testing for COVID–19 should be conducted whenever possible.” (National Vital Statistics System, 2020)

All of this makes it unclear as to how many of the deaths attributed to COVID-19 are actually from COVID-19.

The question underlying the data and documents from the CDC leads to the natural question, why not simply separate the causes of death in the same way as the WHO? It would take little to no effort to separate the U07.1s and U07.2s during the analysis of the death certificates and should be done as soon as possible to determine a more credible mortality rate and death count for COVID-19.

The convoluted approach to reporting death counts can also be seen in the regularly updated *Daily Updates of Totals by Week and State* document. The tables included in this

document clearly show issues with statistics related to COVID-19 deaths. A copy from June 12, 2020 follows:

Table 1. Deaths involving coronavirus disease 2019 (COVID-19), pneumonia, and influenza reported to NCHS by week ending date, United States. Week ending 2/1/2020 to 6/6/2020.*

Updated June 12, 2020

Week ending date in which the death occurred	All Deaths involving COVID-19 (U07.1) ¹	Deaths from All Causes	Percent of Expected Deaths ²	Deaths involving Pneumonia, with or without COVID-19, excluding Influenza deaths (J12.0–J18.9) ³	Deaths involving COVID-19 and Pneumonia, excluding Influenza (U07.1 and J12.0–J18.9) ³	All Deaths involving Influenza, with or without COVID-19 or Pneumonia (J09–J11), includes COVID-19 or Pneumonia ⁴	Deaths involving Pneumonia, Influenza, or COVID-19 (U07.1 or J09–J18.9) ⁵
Total Deaths	98,695	1,116,797	104	109,291	42,863	6,401	170,596
2/1/2020	1	57,815	97	3,738	0	476	4,215
2/8/2020	1	58,356	98	3,725	0	514	4,240
2/15/2020	0	57,698	98	3,755	0	544	4,299
2/22/2020	4	57,800	100	3,631	1	557	4,191
2/29/2020	5	58,177	101	3,755	3	636	4,393
3/7/2020	32	58,433	101	3,884	16	619	4,518

Week ending date in which the death occurred	All Deaths involving COVID-19 (U07.1) ¹	Deaths from All Causes	Percent of Expected Deaths ²	Deaths involving Pneumonia, with or without COVID-19, excluding Influenza deaths (J12.0–J18.9) ³	Deaths involving COVID-19 and Pneumonia, excluding Influenza (U07.1 and J12.0–J18.9) ³	All Deaths involving Influenza, with or without COVID-19 or Pneumonia (J09–J11), includes COVID-19 or Pneumonia ⁴	Deaths involving Pneumonia, Influenza, or COVID-19 (U07.1 or J09–J18.9) ⁵
3/14/2020	52	57,307	100	3,874	27	608	4,506
3/21/2020	547	57,919	102	4,450	245	539	5,285
3/28/2020	3,036	61,841	111	6,020	1,370	438	8,074
4/4/2020	9,462	70,290	126	9,571	4,529	460	14,741
4/11/2020	15,610	76,652	138	11,632	6,998	464	20,371
4/18/2020	16,207	73,807	136	10,872	6,935	258	20,218
4/25/2020	13,922	69,565	129	9,549	5,968	142	17,549
5/2/2020	11,389	64,159	119	8,039	4,838	57	14,628
5/9/2020	10,262	61,368	116	7,198	4,357	45	13,139
5/16/2020	8,089	57,287	109	6,024	3,378	18	10,751
5/23/2020	5,673	51,381	98	4,814	2,430	15	8,072

Week ending date in which the death occurred	All Deaths involving COVID-19 (U07.1) ¹	Deaths from All Causes	Percent of Expected Deaths ²	Deaths involving Pneumonia, with or without COVID-19, excluding Influenza deaths (J12.0–J18.9) ³	Deaths involving COVID-19 and Pneumonia, excluding Influenza (U07.1 and J12.0–J18.9) ³	All Deaths involving Influenza, with or without COVID-19 or Pneumonia (J09–J11), includes COVID-19 or Pneumonia ⁴	Deaths involving Pneumonia, Influenza, or COVID-19 (U07.1 or J09–J18.9) ⁵
5/30/2020	3,552	42,535	82	3,350	1,414	5	5,493
6/6/2020	851	24,407	46	1,410	354	6	1,913

NOTE: Number of deaths reported in this table are the total number of deaths received and coded as of the date of analysis and do not represent all deaths that occurred in that period. The United States population, based on 2018 postcensal estimates from the U.S. Census Bureau, is 327,167,434.

*Data during this period are incomplete because of the lag in time between when the death occurred and when the death certificate is completed, submitted to NCHS and processed for reporting purposes. This delay can range from 1 week to 8 weeks or more, depending on the jurisdiction, age, and cause of death.

¹Deaths with confirmed or presumed COVID-19, coded to ICD–10 code U07.1

²Percent of expected deaths is the number of deaths for all causes for this week in 2020 compared to the average number across the same week in 2017–2019. Previous analyses of 2015–2016 provisional data completeness have found that completeness is lower in the first few weeks following the date of death (<25%), and then increases over time such that data are generally at least 75% complete within 8 weeks of when the death occurred (8).

³Counts of deaths involving pneumonia include pneumonia deaths that also involve COVID-19 and exclude pneumonia deaths involving influenza.

⁴Counts of deaths involving influenza include deaths with pneumonia or COVID-19 also listed as a cause of death.

⁵Deaths with confirmed or presumed COVID-19, pneumonia, or influenza, coded to ICD–10 codes U07.1 or J09–J18.9.

To ensure a fair evaluation the entire table has been copied and pasted from <https://www.cdc.gov/nchs/nvss/vsrr/covid19/index.htm> including table notes. As you can see in the table headings, the total death tally (and most frequently cited number in the news media) is “All Deaths involving COVID-19” and refers to anything classified under the U07.1 code (CDC, 2020). Again, this is a substantial issue based on the above discussion related to issues in the guidance from the CDC for the use of code U07.1.

Several issues here are particularly noteworthy. The first is that the headings are unclear. They include overlapping codes, and none clearly report deaths attributable singularly to COVID-19. The second issue is the overlap used with influenza. This lack of clarity has created substantial difficulty in determining how much, if any, impact influenza has had on the death count attributable to COVID-19. What is clear is that the total death count for deaths “involving COVID-19” seems to be substantially inflated as demonstrated by that the “Percent of Expected Deaths” is only 4% higher than expected whereas the total deaths involving COVID-19 is stated to be 98,695. An increase of 4% over the expected death number of deaths would yield approximately 44,671 additional deaths which would mean approximately a 9% error in expected deaths for the 98,695 to be correct. This number is also interesting given that it is so close to the number of deaths involving COVID-19 and pneumonia excluding influenza. Further analysis should be completed to determine how many of the 98,695 deaths that are involving COVID-19 actually are influenza related and particularly how many of those COVID-19 attributed deaths were not confirmed in a laboratory environment.

Additional Context for the Data

Another issue with this data stems from a review of the CDC *Crisis Emergency Risk Communication* manual. A key component of crisis communications that is consistently used throughout the manual and other communications documents can be found on page 24 stating that in regards to fear, "... in some cases, a perceived threat can motivate and help people take desired actions" (Reynolds & Seeger, 2014). This quote is admittedly taken out of context but must be looked at in conjunction with the rest of the book and also in light of other information such as a 2004-2005 presentation by Glen Nowak who was, at the time, the Associate Director for Communications for the National Immunization Program at the CDC. In leveraging fear to promote action in public health situations Dr. Nowak specifically recommended:

- "Framing of the flu season in terms that motivate behavior (e.g., as "very severe," "more severe than last or past years," "deadly")" (Nowak, 2004); and
- "Continued reports (e.g., from health officials and media) that influenza is causing severe illness and/or affecting lots of people – helping foster the perception that many people are susceptible to a bad case of influenza" (Nowak, 2004); and using
- "Visible/tangible examples of the seriousness of the illness (e.g., pictures of children, families of those affected coming forward) and people getting vaccinated (the first to motivate, the latter to reinforce)" (Nowak, 2004).

He later goes on to state that, in relation to influenza immunization communications challenges, "Some component of success (i.e., higher demand for influenza vaccine stems from media stories and information that create motivating (i.e., high) levels of concern and anxiety about influenza" (Nowak, 2004).

Ultimately this underlying mindset seems to fit in with the seeming lack of transparency in figures related to COVID-19 deaths. It would appear that by classifying numbers in a way that would allow them to be reported to create "high levels of concern and anxiety" the CDC hopes to

promote action. While the ethics of this are beyond the scope of this document, it does call into question the reliability of the statistics particularly in light of the fact that these statistics seem not to add up. This entire approach could be characterized as a half-truth designed to manipulate reactions.

A final note on the possibility of inaccurate data reporting related to COVID-19 deaths. Section 3710 of the CARES Act increased the amount of payment from Medicare by 20% for patients being treated with COVID-19. While much has been made of whether this number actually covers the costs of treating a COVID-19 patient the simple fact of the matter is that you do make 20% more from a COVID-19 patient suffering from ARDS or pneumonia than an influenza patient with the same issues. Given that no testing is required to list COVID-19 as a cause of death there would appear to be a substantial incentive to use a COVID-19 diagnosis whenever possible to obtain the higher reimbursement rate.

How is COVID-19 Diagnosed/Reported

The primary document of concern related to COVID-19 reporting is the COVID-19 Case Report Form (CDC, 2020). This document is used to report confirmed or probable cases of COVID-19 to the CDC. Related to this document is the COVID-19 Case Report Form Instructions which is an explanation of how to fill out the COVID-19 Case Report Form (CDC, 2020). Both the report form and the instructions are quite comprehensive and collect substantial data; however, core to the issue being discussed here is the diagnosis of COVID-19. In determining whether or not COVID-19 exists in a given patient other guidance is referenced. Before that is discussed it is important to note that the reporting form separates probable cases from confirmed cases and asks that they be reported differently. This is a substantial departure

from death certificate reporting which, as discussed above, classifies both probable and possible deaths under the same code but ultimately has little impact in what is reported.

In determining whether a person has possible or probable COVID-19, the CDC has created CSTE Position Statement Interim-20-ID-01 (CDC, 2020). This document opens with a general discussion of COVID-19 and then moves into the clinical criteria necessary to diagnose a patient with COVID-19. The criteria for a diagnosis are quoted below:

At least two of the following symptoms: fever (measured or subjective), chills, rigors, myalgia, headache, sore throat, new olfactory and taste disorder(s)

OR

At least one of the following symptoms: cough, shortness of breath, or difficulty breathing

OR

Severe respiratory illness with at least one of the following:

- Clinical or radiographic evidence of pneumonia, **OR**
- Acute respiratory distress syndrome (ARDS).

AND

No alternative more likely diagnosis (CDC, 2020)

Laboratory evidence is then discussed to include both presumptive and confirmatory tests. The last part of testing is an epidemiological linkage which is defined as:

One or more of the following exposures in the 14 days before onset of symptoms:

- Close contact** with a confirmed or probable case of COVID-19 disease; **OR**
- Close contact** with a person with:
 - clinically compatible illness **AND**
 - linkage to a confirmed case of COVID-19 disease.
- Travel to or residence in an area with sustained, ongoing community transmission of SARS-CoV-2.
- Member of a risk cohort as defined by public health authorities during an outbreak.

***Close contact is defined as being within 6 feet for at least a period of 10 minutes to 30 minutes or more depending upon the exposure. In healthcare settings, this may be defined as exposures of greater than a few minutes or more. Data are insufficient to precisely define the duration of exposure that constitutes prolonged exposure and thus a close contact. (CDC, 2020)*

Critical to understanding this document is determining which of these various factors must be present to diagnose someone as probable or confirmed. A confirmed diagnosis is defined simply as having met the confirmatory laboratory evidentiary standards. Probable diagnosis means the patient:

- Meets clinical criteria **AND** epidemiologic evidence with no confirmatory laboratory testing performed for COVID-19.
- Meets presumptive laboratory evidence **AND** either clinical criteria **OR** epidemiologic evidence.
- Meets vital records criteria with no confirmatory laboratory testing performed for COVID-19. (CDC, 2020)

In analyzing this it should be noted that the definition of vital records is, “A death certificate that lists COVID-19 disease or SARS-CoV-2 as a cause of death or a significant condition contributing to death.” (CDC, 2020) This means that a death certificate will be counted in the COVID-19 case count even though a death certificate merges probable and confirmed cases into a single code. The result would be both a higher death count (because both confirmed and probable cases are counted) and a higher infection count (because the unconfirmed death cases would be included in the probable case count).

To further bias the count, the clinical criteria for COVID-19 cover nearly any common illness imaginable and an epidemiologic linkage is meaningless since it is defined so broadly. Essentially a person could be classified as a probable COVID-19 case if they had a cough and lived in any nearly any city in the United States. Since the reimbursement rate is 20% higher for

COVID-19 cases this means that there is a substantial incentive for a probable diagnosis, and it is extremely easy to meet the criteria.

In the interest of complete clarity, according to CDC guidance as discussed here, if a person has a cough and dies, and that person lives in any of a majority of the cities in the United States (nearly all of which have a sustained, ongoing community transmission of SARS-CoV-2) then COVID-19 can be listed as either the cause of death or as a significant condition contributing to death. That death certificate can then act as evidence of a probable case of COVID-19 and earn an additional 20% reimbursement rate from Medicare as well as then be reported as a COVID-19 death.

Real Data?

While unbiased data related to COVID-19 is very difficult to find, Doctor John Ioannidis has published information that is truly difficult to dispute. Dr. Ioannidis is the C. F. Rehnberg Professor in Disease Prevention in the School of Medicine, Professor of Medicine, of Health Research and Policy (Epidemiology) and by Courtesy, of Statistics and of Biomedical Data Science at Stanford. He is the recipient of numerous awards and author of many studies. Dr. Ioannidis has published several articles questioning the danger and response to COVID-19 and certainly qualifies as an expert on the subject.

Doctor Ioannidis has published a preprint of his most recent study related to the infection fatality rate of COVID-19 and declared no competing interest in the publication. Infection fatality rate is a critical component to understanding the danger of COVID-19 and is the number of dead out of the number of infected. This study evaluated statistics from a number of regions and nations and, using statistically sound methodology, calculated the infection fatality rate in

various populations. According to the study the following infection fatality rate estimates can be made:

- 0.10% in locations with COVID-19 population mortality rate less than the global average (<73 deaths per million as of July 12, 2020);
- 0.27% in locations with 73-500 COVID-19 deaths per million, and 0.90% in locations exceeding 500 COVID-19 deaths per million; and
- Among people <70 years old, infection fatality rates ranged from 0.00% to 0.57% with median of 0.05% across the different locations (corrected median of 0.04%). (Ioannidis, 2020).

As a comparison, the infection fatality rate of the Spanish Flu was above 2.5% and most flu pandemics are at 0.1% or less (Taubenberger & Morens, 2006). Important to note is that, as a comparison, the original SARS had a mortality rate of 9.5% (nearly 10 times higher) and MERS had a mortality rate of 34.4% (over 34 times higher) (Rajgor, Lee, Archuleta, Bagdasarian, & Quek, 2020).

Estimating the true infection fatality rate is extremely difficult but Dr. Ioannidis appears to have the most credible available estimates. The primary issue is that it is impossible to know how many individuals have actually been infected with COVID-19. Many are asymptomatic and many more have minor symptoms and recover without ever being tested. Because of this, the actual case fatality rate will continue to fall as more people are tested but to ensure any accuracy in a statistical analysis it is critical that laboratory confirmed cases not be counted together with probable cases.

Conclusion

The intention of this paper was to create a fair scientific basis for comparing a new and potentially dangerous disease – COVID-19 – to influenza to allow for an educated discussion about how to handle the disease. Unfortunately, the available data has been manipulated and misreported to an extent that this goal was unachievable. Instead this paper should be viewed as a starting point for a discussion related to why the public is being misled and what the long-term impact on the credibility of the public health professionals in this nation will be.

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