

TECHNICAL NOTES

DATA USE AGREEMENT

By using these data, you signify your agreement to comply with the Illinois Health and Hazardous Substances Registry Act (410 ILCS 525/12). Data collected by the Illinois State Cancer Registry (ISCR) are made available to the public; however, identifying or contacting individuals is prohibited.

To exclude identifying information on individual patients, these data (e.g., age, race, Hispanic ethnicity, year of diagnosis, and type of cancer) have been aggregated into categories within individual records, the number of which depends on the size of the geographic area.

These data are provided as a public service for statistical reporting and analysis only. There should be no attempt to learn the identity of any person included in these data. If the identity of any person is discovered inadvertently, no disclosure or other use of the identity will be made.

The use of these data does not constitute an endorsement of the user's opinion or conclusions by the Illinois Department of Public Health, and none should be inferred.

DATA SOURCES

Cancer Mortality Data: The Surveillance Epidemiology and End Results (SEER) program of the National Cancer Institute (NCI) was the source of information on cancer mortality for 1986 through 2023 by race and ethnicity. The underlying cause of death was provided by the National Center for Health Statistics (NCHS). The data presented were released in February 2025.

Population Estimates: The population estimates of the sex- and race-specific, as well as sex- and ethnicity/race-specific groups in five-year age categories, were used as denominators in the formulation of rates. These population estimates for Illinois cover all races categorized as Whites, Blacks, and Asian and all other races from 1986 through 2023. They also include estimates for Hispanics, non-Hispanics, non-Hispanic White, and non-Hispanic Black from 1990 through 2023. The estimates were obtained from both the intercensal files and the Vintage^a 2020 bridged-race postcensal population estimate files. Woods & Poole Economics, Inc. calculated the Vintage 2024 population estimates for the National Cancer Institute (NCI). The estimates include intercensal data for 2000–2009 from the U.S. Census Bureau and for 2010–2019 from Woods & Poole. The Vintage 2024 estimates for 2020–2023 use bridged-race estimates derived from the multiple-race categories in the 2000, 2010, and 2020 censuses and based on the 1997 Office of Management and Budget standards for race and ethnicity data collection. The bridged single-race estimates, and a description of the methodology used to develop them are available on the National Center for Health Statistics website.^b

Woods & Poole Economics used methods that are similar to the U.S. Census Bureau expected methods^c for its population estimates between 2000–2010 and 2010–2020. Earlier estimates, created before the 2010 Census, became less accurate over time. At the national level, the updated estimates are very close to the older numbers. However, at the state and county levels, the differences are larger and

^a “Vintage denotes an entire time series created with a consistent population starting point and methodology. The release of a new vintage of estimates supersedes any previous series and incorporates the most up-to-date input data and methodological improvements.” ([Methodology for the United State Population Estimates: Vintage 2023](#))

^b http://www.cdc.gov/nchs/nvss/bridged_race.htm. For more information on the modifications to county population categorized for each decade, visit <https://seer.cancer.gov/popdata/modifications.html>.

^c The U.S. Census Bureau’s 2000–2010 and 2010–2020 intercensal estimates methodology are published at <https://www2.census.gov/programs-surveys/popest/technical-documentation/methodology/intercensal/>; [U.S. County Population Data 1969–2023 - SEER Population Data](#)

may change some cancer incidence rates compared with earlier reports. Some changes may also come from cases that were reported late.

DEFINITIONS

Cancer Site Coding for Mortality Data. The underlying cause of death was coded using the *International Classification of Diseases (ICD-9)*¹ for all deaths from 1986 through 1998 and the *International Classification of Diseases (ICD-10)*² for all deaths for the year 1999 and later. In the present data, the SEER mortality recode scheme based on ICD-9 and ICD-10 was used to classify cancer death sites.

Because of many changes in ICD-10 as compared to ICD-9, discontinuities in trends for many causes of death, including cancer, may arise. According to a study, compared to using ICD-9 coding, overall, approximately 0.7% more deaths are assigned to cancer when ICD-10 is used, leading to a higher mortality rate for all cancers combined.³ However, this pattern does not hold for specific cancer sites, whose rates may be higher or lower using ICD-10. These discontinuities are relatively small, and the changes in mortality rates across the years of the ICD-9/ICD-10 boundary are still interpretable, especially for major cancer sites.⁴

Cancer mortality rates are available by single year for Illinois only. Deaths among non-residents and deaths of unknown sex or age were omitted from all calculations. Statistics were not calculated for cells containing less than 10 deaths, due to the National Center for Health Statistics (NCHS) policy.

Mortality Rates: The SEER*Stat® software package,⁵ developed by the Information Management Services Inc. for NCI, was used to calculate mortality rates. Rates are expressed per 100,000 population. Age-adjustment of rates was calculated using the direct method, adjusting to the 2000 U.S. standard million population. Rates are rounded to the nearest 10th, and very small rates (e.g., 0.04) are shown as 0.0. They are presented with the lower and upper confidence intervals computed at the 95% level using the Tiwari method.⁶ Algorithms used for calculating standard errors and 95% confidence intervals are displayed in Appendix C of the state incidence report (see [Illinois State Cancer Incidence and Mortality Review and Update](#)). As mentioned above, due to NCHS policy, mortality statistics were not calculated for cells containing less than 10 deaths. This is not the case for incidence rate-associated statistics.

Race-specific Rates: The race-specific categories in these data are “All Races” combined, “White,” “Black,” and “Asian/Other Races.” Cases reported as of unknown race were included in the "All Races" category, but not in any race-specific group.

Ethnicity/Race Rates: Hispanic ethnicity was used as defined in the database. Because there was a considerably large number of cancer deaths with unknown Hispanic ethnicity in the mortality database, the mortality rates calculated for Hispanics may be underestimated. To be consistent with all national reports, categories are reported as "Hispanic (any race)," "Non-Hispanic (any race)," "Non-Hispanic White," and "Non-Hispanic Black."

DATA INTERPRETATION

Observed variations and differences over the years and across sex and race groups in cancer mortality may reflect modifications in the risk factor status of the population or the consequence of participation in screening and early detection programs. Such changes or differences, however, may instead result from random fluctuations and other factors related to the estimation process. Any conclusions should be made only after carefully considering the following factors influencing annual mortality rates.

Random fluctuations in annual rates are usual and may be substantial, especially for rates based on small numbers of counts (i.e., less than 16).

Population estimates used for denominators may be inaccurate or lack precision. The population data for 1990, 2000, 2010, and 2020 (the years of the U.S. decennial census) are the most accurate for all age-, race-, ethnicity-, and sex-specific categories and would, therefore, produce the most accurate mortality rates. Those for other years are not based on actual population counts, but rather on interpolation or extrapolation of estimates based on demographic characteristics of the population. Mortality rates based on these population estimates would be expected to be less accurate than those for 1990, 2000, 2010, or 2020.

The 95% confidence intervals are included with reported rates to help put the rate in perspective and to facilitate rate comparisons over years and across sex, race, and ethnicity/race groups. Observed differences may not be statistically significant. The range between the lower confidence interval and the upper confidence interval defines, with 95% probability, where the “true” rate may fall. The comparison of two sets of confidence intervals is approximately equivalent to statistical significance tests for differences between two rates and is more conservative than the standard significance test when the null hypothesis is true.⁷

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Suggested citation for Mortality Data

Surveillance, Epidemiology, and End Results (SEER) Program (www.seer.cancer.gov) SEER*Stat Database: Mortality - All COD, Aggregated With County, Total U.S. (1969-2023) <Katrina/Rita Population Adjustment> -National Cancer Institute, DCCPS, Surveillance Research Program, Surveillance Systems Branch, released February 2025. Underlying mortality data provided by NCHS (www.cdc.gov/nchs).

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If you have questions about these data, contact the Illinois State Cancer Registry at DPH.ISCRinquiries@illinois.gov.

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