Medical Murder is the #1 Cause of Death in the U.S. – By Design

(People Are Too Expensive – Satan's Big Lie)

What? The Culture of Death

We've been programmed to believe lies – from all sides and angles

Facts:

- Historical facts – pre-COVID
  - Annual deaths: 700K heart disease; 600K cancer; 400K medical "malpractice" (3rd leading cause of death)

https://www.statnews.com/2021/08/04/medical-errors-accidents-ongoing-preventable-health-threat/#:~:text=Injury%20or%20illness%20caused%20by,under%20wraps%20%E2%80%94%20and%20they%20are

- Current facts – COVID Era and Post COVID
  - All cause mortality increase of 24% in vaccinated

https://www.israelnationalnews.com/news/317091

  - All cause mortality cumulative increase since January 2020 – weekly graph

https://ourworldindata.org/grapher/cumulative-excess-mortality-p-scores-projected-baseline?tab=chart&facet=none&country=~USA

Eugenics

What is Eugenics?

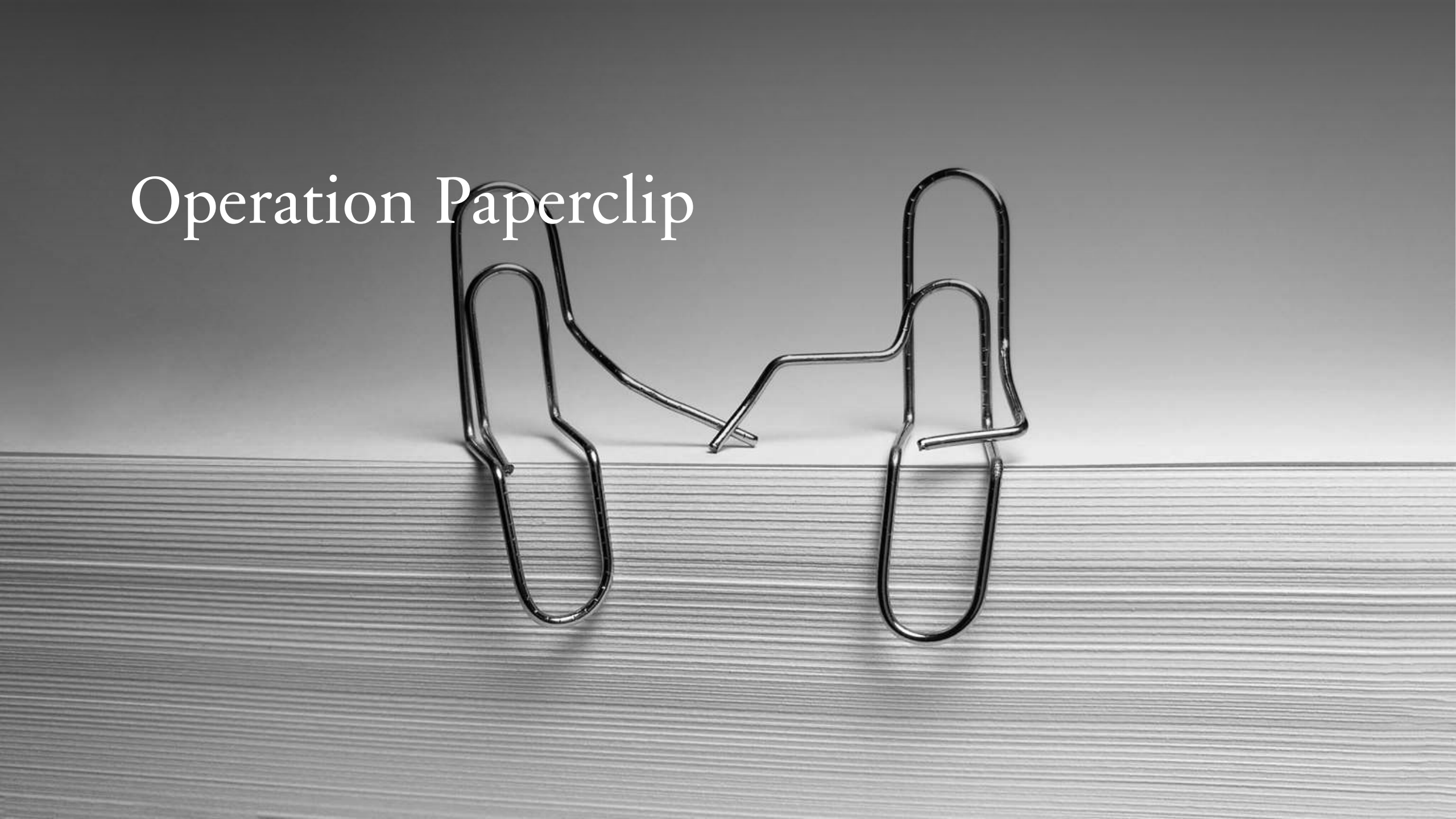
- Eugenics: Excluding people and groups judged to be inferior or promoting those judged to be superior. "Survival of the fittest" has been proactively practiced since ancient times.
- In one of Plato's (died 348 BC) best-known literary works, *The Republic*, he wrote about creating a superior society by procreating high-class people together and discouraging coupling between the lower classes. He also suggested a variety of mating rules to help create an optimal society.

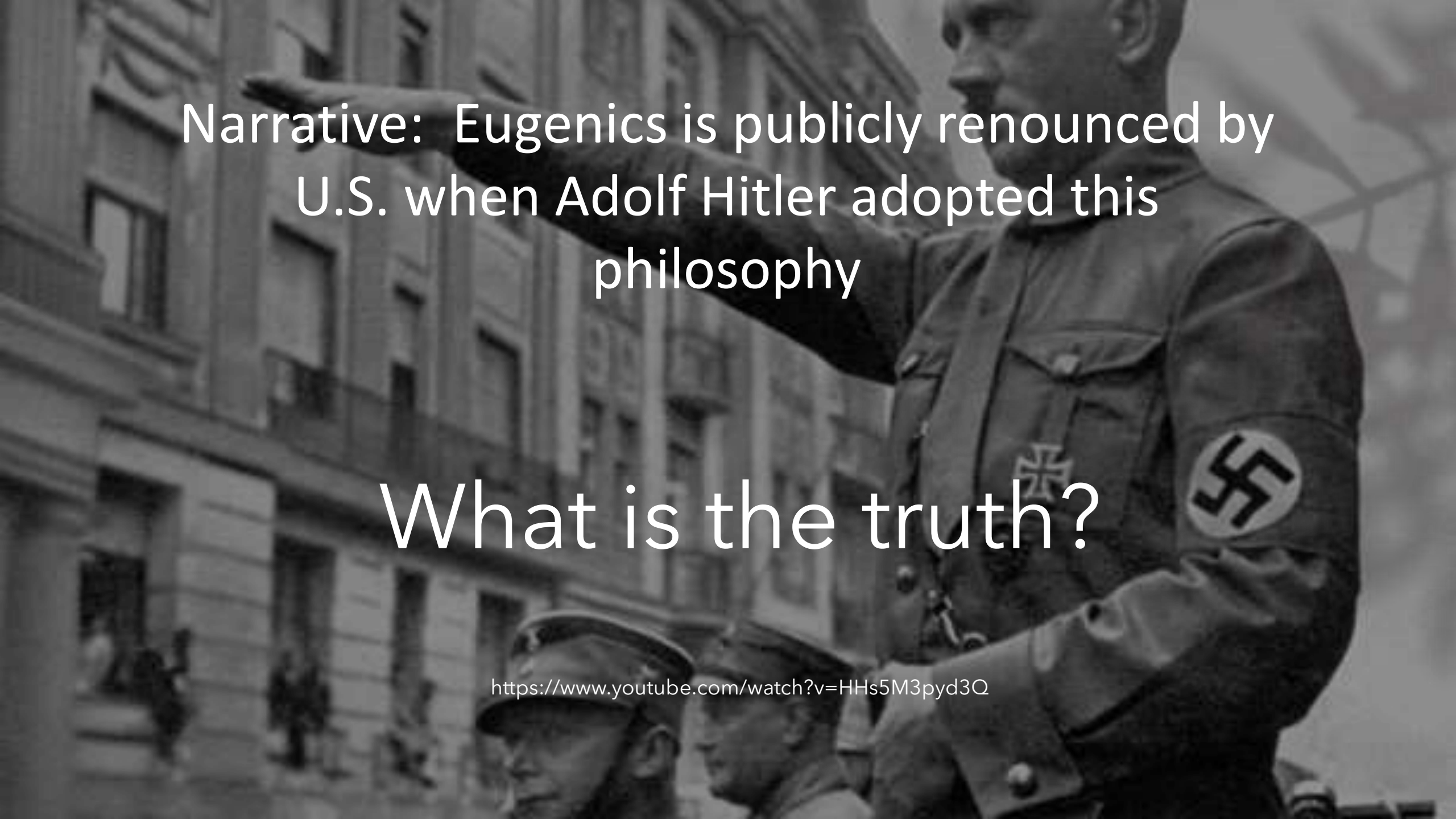
Current Roots

- “The Rockefeller Foundation helped fund the German eugenics program and even funded the program that Josef Mengele worked in before he went to Auschwitz.”
- Hitler proudly told his comrades just how closely he followed the progress of the American eugenics movement. "I have studied with great interest," he told a fellow Nazi, "the laws of several American states concerning prevention of reproduction by people whose progeny would, in all probability, be of no value or be injurious to the racial stock."

Conclusion: Eugenics ideas are part of our sin nature.

Operation Paperclip





Narrative: Eugenics is publicly renounced by U.S. when Adolf Hitler adopted this philosophy

What is the truth?

https://www.youtube.com/watch?v=HHs5M3pyd3Q

Conclusion: The U.S. continues to be the eugenics leader of today.

Banality of Evil

Introduction

Where did the idea originate?
https://www.youtube.com/watch?v=8Km0LQCK-9I

Has the eugenics philosophy become part of our culture, so we are blind to it?

Banality of Evil in the U.S.

- Disabled abortion culture
- Nursing home culture
- School (fool) system training out critical thinking
- The state taking the place of the family
- Collectivism
- Moral Relativism – Milgram's Obedience Experiment vs. The Hippocratic Oath

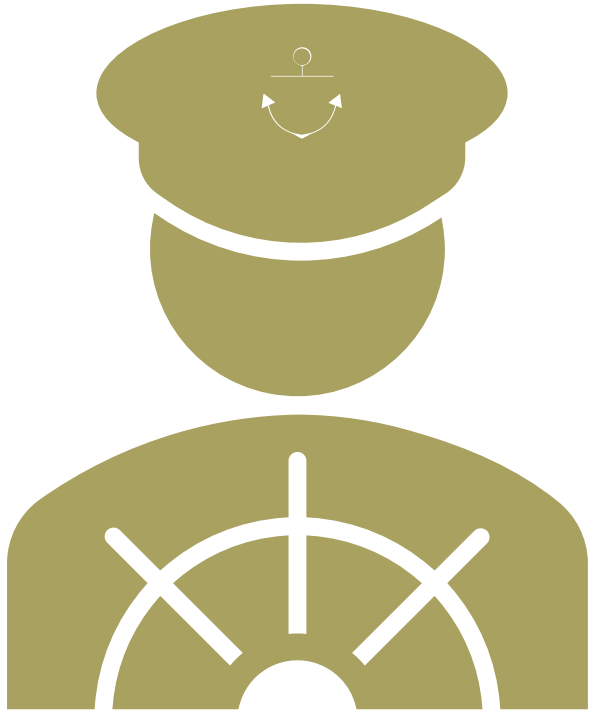
https://ouramazinggrace.net/Tragedy-Money-Hospital-Killings-Following-Rules

Conclusion: The slippery slope of evil has taken hold of our culture.

Medical murder of elderly and disabled - recent history

Ezekiel Emanuel, one of the country's most influential bioethicists and a prime architect of Obamacare, wrote as far back as 1996 that health care "services provided to individuals who are irreversibly prevented from being or becoming participating citizens are not basic and should not be guaranteed."

The Affordable Care Act (ACA), a/k/a Obamacare, was signed into law on March 23, 2010. Obamacare laid the groundwork for the current degradation of healthcare set in motion over 100 years ago by the Rockefellers.



SEC. 1553. PROHIBITION AGAINST DISCRIMINATION ON ASSISTED SUICIDE. 42 USC 18113.

(a) IN GENERAL.—The Federal Government, and any State or local government or health care provider that receives Federal financial assistance under this Act (or under an amendment made by this Act) or any health plan created under this Act (or under an amendment made by this Act), may not subject an individual or institutional health care entity to discrimination on the basis that the entity does not provide any health care item or service furnished for the purpose of causing, or for the purpose of assisting in causing, the death of any individual, such as by assisted suicide, euthanasia, or mercy killing.

(b) DEFINITION.—In this section, the term "health care entity" includes an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan.

(c) CONSTRUCTION AND TREATMENT OF CERTAIN SERVICES.—Nothing in subsection (a) shall be construed to apply to, or to affect, any limitation relating to—

(1) the withholding or withdrawing of medical treatment or medical care;

(2) the withholding or withdrawing of nutrition or hydration;

(3) abortion; or Abortion.

(4) the use of an item, good, benefit, or service furnished for the purpose of alleviating pain or discomfort, even if such use may increase the risk of death, so long as such item, good, benefit, or service is not also furnished for the purpose of causing, or the purpose of assisting in causing, death, for any reason.

(d) ADMINISTRATION.—The Office for Civil Rights of the Department of Health and Human Services is designated to receive complaints of discrimination based on this section.

SEC. 1554. ACCESS TO THERAPIES. 42 USC 18114.

Notwithstanding any other provision of this Act, the Secretary of Health and Human Services shall not promulgate any regulation that—

(1) creates any unreasonable barriers to the ability of individuals to obtain appropriate medical care;

(2) impedes timely access to health care services;

(3) interferes with communications regarding a full range of treatment options between the patient and the provider;

(4) restricts the ability of health care providers to provide full disclosure of all relevant information to patients making health care decisions;

(5) violates the principles of informed consent and the ethical standards of health care professionals; or

(6) limits the availability of health care treatment for the full duration of a patient's medical needs.

COVID exposed the reality of medical murder – the disabled

VIEWPOINTS

The terrible toll of COVID-19 on people with intellectual disabilities

Patients with intellectual disabilities are six times more likely to die from COVID-19 than other people. An expert weighs in on how we must improve their care both during the pandemic and down the road.

By Wendy Ross, MD

April 20, 2021

PALLIATIVE CARE NETWORK OF WISCONSIN

FAST FACTS AND CONCEPTS #243
PALLIATIVE CARE FOR PATIENTS WITH DOWN SYNDROME

Jane E Loitman MD and Gail Gazelle MD

Background Down syndrome (DS), or Trisomy 21, is the most common chromosome abnormality among liveborn infants, characterized by dysmorphic features, impaired intellectual ability, various cardiac septal defects, short stature, and a reduced life expectancy. This *Fast Fact* discusses the natural history of DS and issues specific to palliative and end-of-life care for patients with DS. *Fast Facts* #192 & 193 discussed end-of-life care for patients with developmental disabilities in general.

Causes of Morbidity and Death in DS Patients with DS frequently live to 60 years of age, men somewhat longer than women.

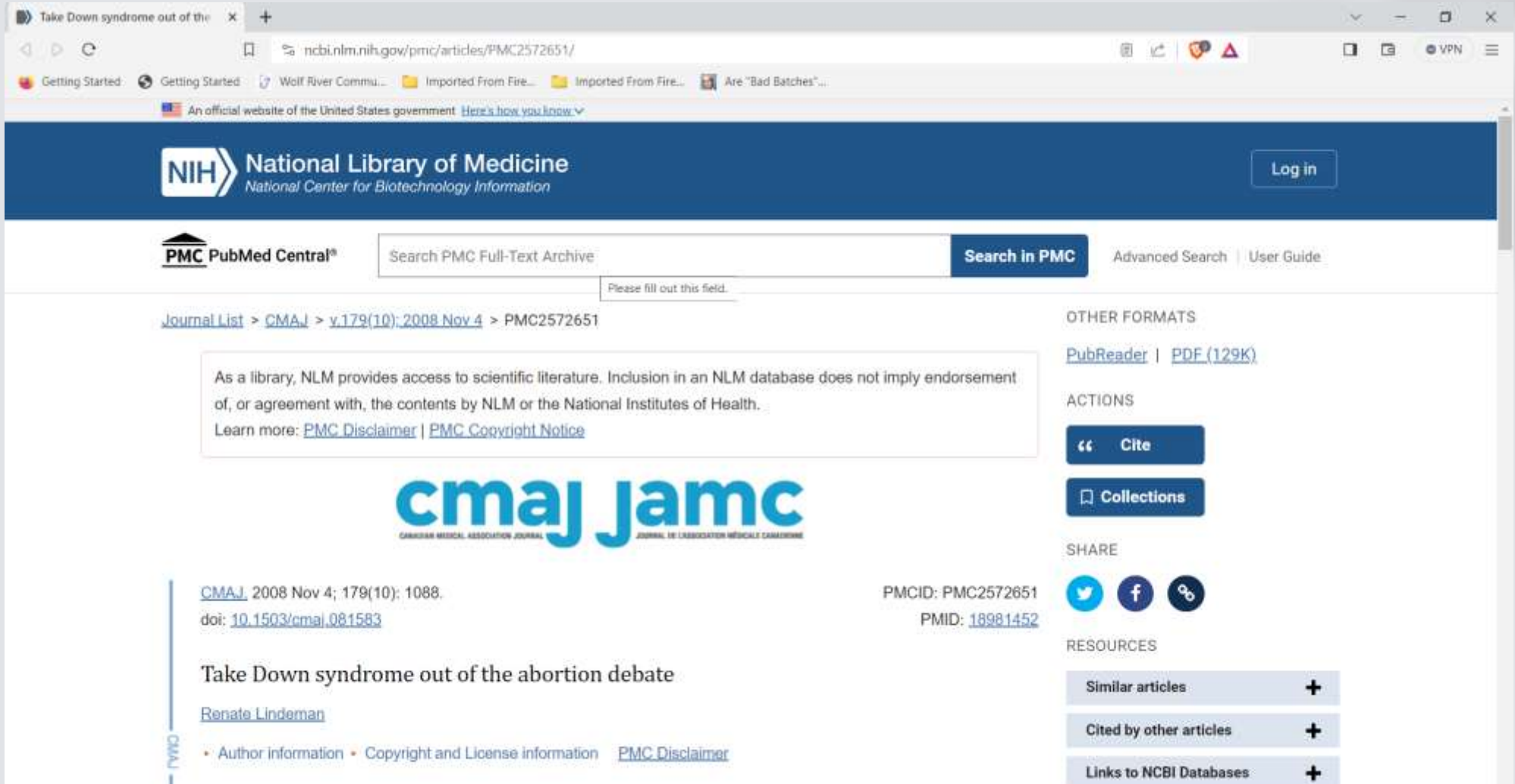
- Childhood mortality is most often associated with congenital heart defects or leukemia. The risk of developing childhood acute lymphoblastic leukemia is ten to twenty times higher in DS than the general population. Leukemia is treatable, although recurrences typically occur with an aggressive and terminal course (3-5).
- Midlife mortality is associated most often with pulmonary disease and problems related to congenital cardiac defects. The incidence of coronary artery disease and solid-tumor malignancies is actually lower in people with DS than in the general population.
- People with DS have a much higher incidence of dementia of the Alzheimer's type (DAT) than the general population, and tend to develop DAT in their 40s and 50s. By age 60, 75% of individuals with DS have developed DAT. Brain autopsies reveal amyloid plaques and neurofibrillary tangles; this may be due to chromosome 21 housing the amyloid precursor protein gene.
- In addition to cognitive issues, other common medical issues may include hearing impairment, cataracts, sleep apnea, dental issues, congenital cardiac septal defects, thyroid dysfunction, seizures, arthroses, osteoporosis, chronic constipation, GERD, incontinence, congenital hip dislocation, behavioral issues, and recurrent respiratory infections (6).
- Partial or tonic-clonic seizures are most common in the first year of life and in or after the third decade (7,8). Once seizures occur, the pace of functional decline often increases.
- Routine symptom management principles apply to patients with DS, acknowledging communication limitations that can limit comprehensive assessment. Polypharmacy can contribute to or exacerbate issues so rigorous care must be paid when medications are started or stopped.

Psychosocial issues Psychosocial domains include communication, self-care, grief, and family circumstances. In addition, there are unique issues that may complicate end-of-life decision making.

- Patients with DS and their loved ones and caregivers have experienced a lifelong disease trajectory, which includes mental retardation, medical, and psychosocial issues. The lifelong toll on families is high. Part of a robust plan of care includes acknowledgment of this toll by healthcare providers.
- Many people with DS reside in institutional settings where the primary caregivers are not family members. Many have lost parents to death and sometimes have no contact with other family. While it is not known how people with DS process these losses, maximal supports regarding grief and loss should be put in place.
- Issues such as guardianship and advance care planning should be addressed as early as possible with caregivers of people with DS.
- Whenever possible, decision makers for people with DS should be encouraged to use substituted judgment to make key palliative care decisions. All efforts should be made to determine the preferences of the patient, however because of lifelong cognitive impairment, the views of the person with DS may not be known. There may also be disability rights concerns that make proxies/ guardians wary of not instituting all life-sustaining measures. Intensive education needs to be provided regarding the benefits and burdens of any medical interventions, with particular emphasis on how these will impact quality of life. Healthcare providers need to make sure that their own views about quality of life do not interfere with respecting the wishes of designated decision-makers – see *Fast Fact* #193.

Key teaching points

Palin said she was “devastated and shocked” to receive a prenatal diagnosis of Down syndrome. With abortion rates hovering around 90% after Down syndrome is diagnosed, she isn't the only one who has feared the unknown.



Elderly Financial Statistics: 105X increase in Medicare/Medicaid costs in 49 years – over 10,000%!

Table HExpPers. Personal health care expenditures, by source of funds and type of expenditure: United States, selected years 1960–2019

Excel version (with more data years and standard errors when available): https://www.cdc.gov/nchs/hus/contents2020-2021.htm#Table-HExpPers

[Data are compiled from various sources by the Centers for Medicare & Medicaid Services]

Type of personal health care expenditure and source of funds	1960	1970	1980	1990	2000	2005	2009	2015	2017	2018	2019
						Amount (current dollars)					
Per capita	124	297	930	2,412	4,103	5,749	6,874	8,394	9,025	9,346	9,787
						Amount (billions) (current dollars)					
All personal health care expenditures[1]	23.1	62.4	214.3	611.9	1,156.9	1,697.6	2,106.5	2,686.2	2,928.3	3,048.3	3,207.0
Out-of-pocket payments	12.8	24.2	55.2	133.5	193.4	265.0	296.5	353.8	374.5	388.8	406.5
Health insurance	6.6	29.4	130.9	398.2	832.4	1,264.2	1,611.6	2,080.1	2,269.9	2,367.4	2,494.3
Private health insurance	4.9	13.8	60.3	200.2	394.3	589.8	709.5	874.5	967.5	1,009.9	1,064.1
Medicare	…	7.3	36.3	107.1	216.3	326.3	470.1	606.2	658.9	696.2	742.6
Medicaid	…	5.0	24.7	69.7	186.9	287.6	346.3	484.2	518.1	531.3	549.6
Federal	…	2.7	13.7	40.3	109.3	165.5	230.7	304.5	323.6	331.7	347.9
State and local	…	2.3	11.0	29.4	77.6	122.1	115.6	179.7	194.5	199.6	201.7
CHIP[2]	…	…	…	…	2.5	6.4	9.5	12.1	15.1	15.6	16.6
Federal	…	…	…	…	1.8	4.5	6.7	9.0	13.8	14.4	15.0
State and local	…	…	…	…	0.8	2.0	2.8	3.1	1.3	1.2	1.6
Other health insurance programs[3]	1.7	3.3	9.6	21.2	32.3	54.1	76.2	103.0	110.3	114.4	121.3
Other third-party payers and programs[4]	3.8	8.8	28.2	80.2	131.1	168.4	198.4	252.3	283.9	292.1	306.2
						Deflator					

Elderly Financial Statistics: 216X increase in nursing care facility costs in 59 years – over 20,000%!

Table HExpType. National health expenditures, average annual percent change, and percent distribution, by type of expenditure: United States, selected years 1960–2019

Excel version (with more data years and standard errors when available): https://www.cdc.gov/nchs/hus/contents2020-2021.htm#Table-HExpType

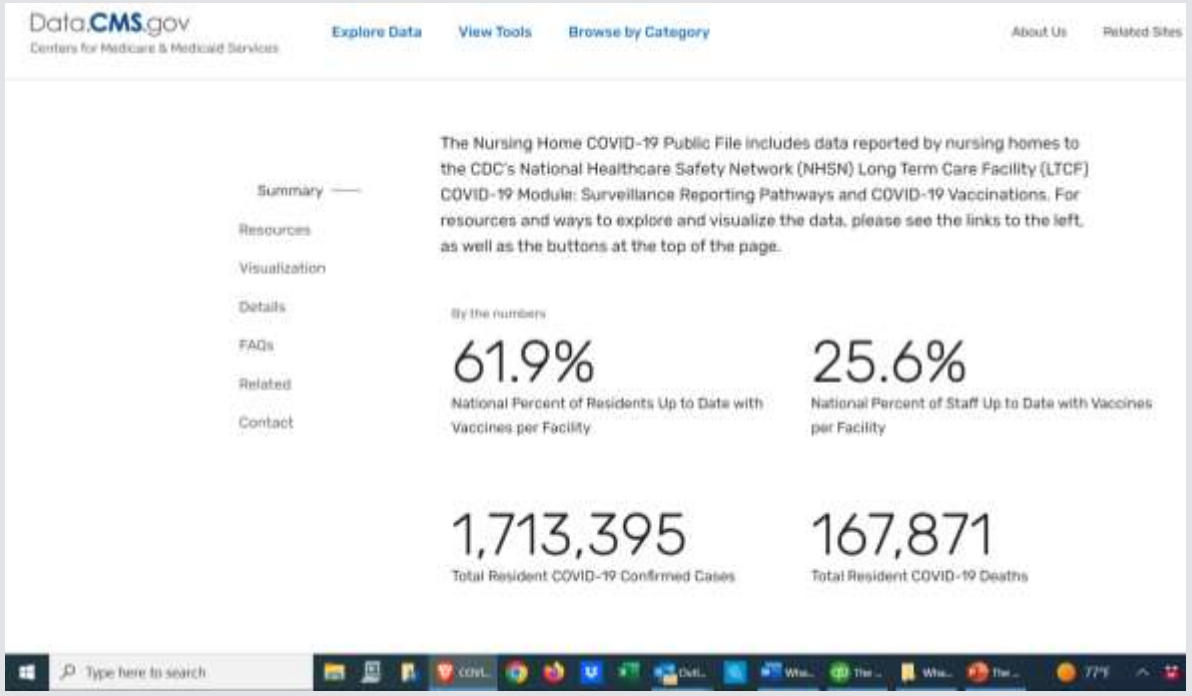
[Data are compiled from various sources by the Centers for Medicare & Medicaid Services]

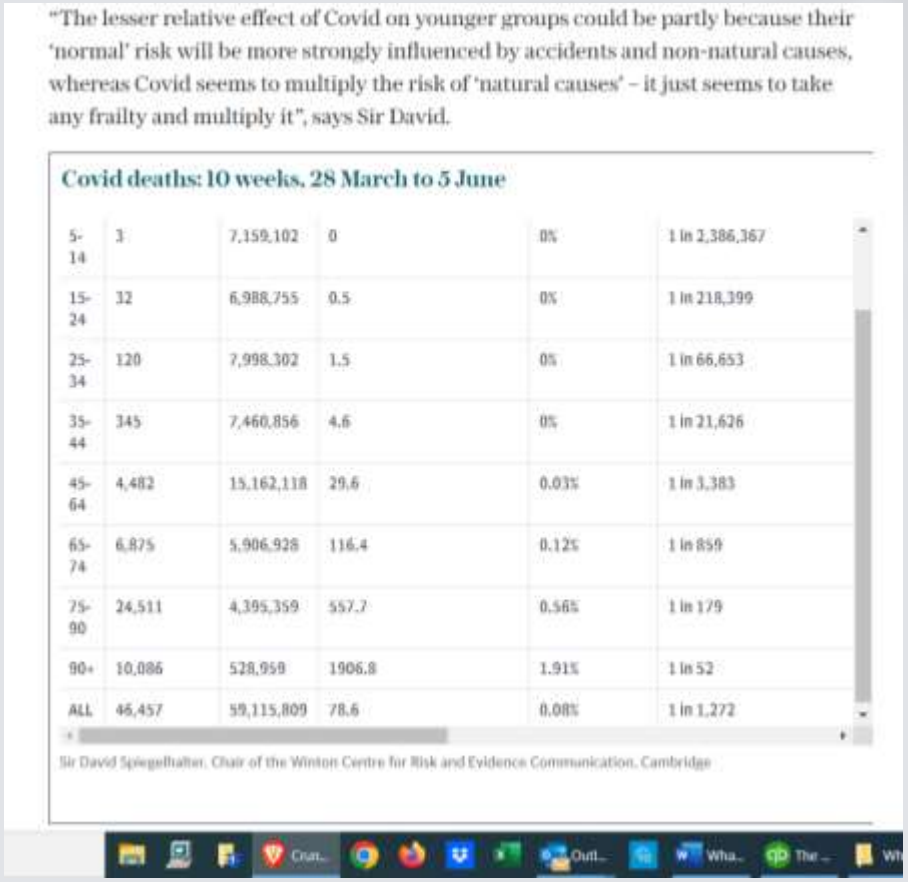
Type of national health expenditure	1960	1970	1980	1990	2000	2005	2009	2015	2018	2019
					Amount (billions)					
National health expenditures	27.1	74.1	253.2	718.8	1,365.6	2,029.5	2,492.8	3,177.7	3,629.7	3,795.4
Health consumption expenditures	24.6	66.3	232.7	670.2	1,279.9	1,904.0	2,345.6	3,013.7	3,439.5	3,593.7
Personal health care	23.1	62.4	214.3	611.9	1,156.9	1,697.6	2,106.5	2,686.2	3,048.3	3,207.0
Hospital care	9.0	27.2	100.5	250.4	415.5	608.6	771.0	989.0	1,122.5	1,192.0
Professional services	7.9	19.8	64.5	207.8	386.9	553.0	668.1	843.3	979.4	1,025.9
Physician and clinical services	5.6	14.3	47.7	158.9	288.2	413.0	497.7	635.9	738.2	772.1
Other professional services	0.4	0.7	3.5	17.3	36.6	52.8	67.0	87.4	103.9	110.6
Dental services	2.0	4.7	13.3	31.6	62.1	87.2	103.4	120.0	137.4	143.2
Other health, residential, and personal care[1]	0.4	1.3	8.4	23.8	63.9	95.1	122.0	165.4	191.3	193.6
Home health care[2]	0.1	0.2	2.4	12.5	32.3	49.3	67.0	89.9	105.4	113.5
Nursing care facilities and continuing care retirement communities[2,3]	0.8	4.0	15.3	44.7	85.0	111.4	135.2	156.2	167.2	172.7
Retail outlet sales of medical products	4.9	9.9	23.2	72.5	173.2	280.1	343.1	442.4	482.4	509.3
Prescription drugs	2.7	5.5	12.0	40.3	122.0	208.6	254.3	324.4	349.8	369.7
Durable medical equipment	0.7	1.7	4.1	13.8	26.0	36.0	41.2	48.8	54.8	57.6
Other nondurable medical products	1.5	2.6	7.1	18.5	25.2	35.5	47.6	69.3	77.7	82.1
Government administration[4]	0.1	0.7	2.8	7.2	17.1	28.2	29.6	42.8	47.3	48.9
Net cost of health insurance[5]	1.0	1.9	9.1	31.1	62.9	120.9	135.3	199.1	249.5	239.9
Government public health activities[6]	0.4	1.4	6.4	20.0	43.0	57.3	74.2	85.7	94.5	97.8
Investment	2.6	7.7	20.6	48.6	85.7	125.5	147.2	164.0	190.2	201.7
Research[7]	0.7	2.0	5.4	12.7	25.5	40.3	45.3	46.4	53.6	56.6
Structures and equipment	1.9	5.8	15.1	35.9	60.2	85.2	101.9	117.6	136.6	145.1

- An estimated 12 million Americans needed long-term care in 2007.[2] **[Updated February 2015]**
- Most but not all persons in need of long-term care are elderly. Approximately 63% are persons aged 65 and older (6.3 million); the remaining 37% are 64 years of age and younger (3.7 million).[3]
- The lifetime probability of becoming disabled in at least two activities of daily living or of being cognitively impaired is 68% for people age 65 and older.[4]
- By 2050, the number of individuals using paid long-term care services in any setting (e.g., at home, residential care such as assisted living, or skilled nursing facilities) will likely double from the 13 million using services in 2000, to 27 million people. This estimate is influenced by growth in the population of older people in need of care.[5]
- Of the older population with long-term care needs in the community, about 30% (1.5 million persons) have substantial long-term care needs (three or more ADL limitations). Of these, about 25% are 85 and older and 70% report they are in fair to poor health.[6]
- In 2012, 14.8% of the 65+ population were reported to be below the poverty level. [7] **[Updated February 2015]**
- Among the population aged 65+, 69% will develop disabilities before they die, and

COVID death numbers in nursing homes make no sense – 10% vs. 1% reality

https://rumble.com/v1dzhh9-mel-k-with-scott-schara-and-vera-sharav-on-medical-tyranny-then-and-now.html
https://rumble.com/v1do9gx-july-22-2022-scott-schara-and-vera-sharav.html




"The lesser relative effect of Covid on younger groups could be partly because their 'normal' risk will be more strongly influenced by accidents and non-natural causes, whereas Covid seems to multiply the risk of 'natural causes' – it just seems to take any frailty and multiply it", says Sir David.

Covid deaths: 10 weeks, 28 March to 5 June

5-14	3	7,159,102	0	0%	1 in 2,386,367
15-24	32	6,988,755	0.5	0%	1 in 218,399
25-34	120	7,998,302	1.5	0%	1 in 66,653
35-44	345	7,460,856	4.6	0%	1 in 21,626
45-64	4,482	15,162,118	29.6	0.03%	1 in 3,383
65-74	6,875	5,906,928	116.4	0.12%	1 in 859
75-90	24,511	4,395,359	557.7	0.56%	1 in 179
90+	10,086	528,959	1906.8	1.91%	1 in 52
ALL	46,457	59,115,809	78.6	0.08%	1 in 1,272

Sir David Spiegelhalter, Chair of the Winton Centre for Risk and Evidence Communication, Cambridge

Conclusion: The disabled and the elderly are the low hanging fruit of the eugenics mindset the culture has adopted. Hastening death is murder.

History never stopped repeating itself:

https://ouramazinggrace.net/Videos/News/Genocide%20Then%20and%20Now.mp4

Eugenics doesn't just apply to the disabled and the elderly

A convergence of attacks on the entire population

Medical murder (the lane I'm in) is only one tentacle of the depopulation agenda – wars, famine, food shortages, China threats, climate manipulation, poisoning (food and water), controlling the power grid, buying and selling with fake money, 5G, phone radiation, fluoride in water, mercury fillings, organ harvesting, child sacrifice, child trafficking, open borders, trans movement; CBDC – a convergence that is all part of the ultimate control grid!

1967 – Plan to Depopulate the U.S.

PROPOSED MEASURES TO REDUCE FERTILITY, BY UNIVERSALITY OR SELECTIVITY OF IMPACT IN THE U.S.

UNIVERSAL IMPACT	SELECTIVE IMPACT DEPENDING ON SOCIO-ECONOMIC STATUS		
Social Constraints *	Economic Deterrents/Incentives	Social Controls	Measures Predicated on Existin Motivation to Prevent Unwanted Pregnancy
Restructure family: a) Postpone or avoid marriage b) Alter image of ideal family size	Modify tax policies: a) Substantial marriage tax b) Child tax c) Tax married more than single d) Remove parents' tax exemption e) Additional taxes on parents with more than 1 or 2 children in school	Compulsory abortion of out-of-wedlock pregnancies	Payments to encourage sterilization
Compulsory education of children	Reduce/eliminate paid maternity leave or benefits	Compulsory sterilization of all who have two children except for a few who would be allowed three	Payments to encourage contraception
Encourage increased homosexuality	Reduce/eliminate children's or family allowances	Confine childbearing to only a limited number of adults	Payments to encourage abortion
Educate for family limitation	Bonuses for delayed marriage and greater child-spacing	Stock certificate permits for children	Abortion and sterilization on demand
Fertility control agents in water supply	Pensions for women of 45 with less than N children	Housing Policies: a) Discouragement of private home ownership b) Stop awarding public housing based on family size	Allow harmless contraceptives to be distributed nonmedically
Encourage women to work	Eliminate Welfare payments after first 2 children		Improve contraceptive technology
	Chronic Depression		Make contraception truly available and accessib'e
	Require women to work and provide few child care facilities		Improve maternal health care, with family planning as a core element
	Limit/eliminate publicly financed medical care, scholarships, housing, loans and subsidies to families with more than N children		

* The measures tabulated here are derived primarily from Davis, Science, 11/10/67; Michael Young's remarks at NIH Conference 6/67; L.&A. Day, Too Many Americans; J. Blake in Shops & Ridley, Public Health & Population Change; and W. Shockley, Speech in Ontario, 12/67.

Plans to depopulation the U.S. were formalized in 1967 - Berelson and Jaffe would work together on the 1972 Rockefeller Commission Report

MyChart® proxy access for adult-to-teen accounts

myChart
Ascension Wisconsin

Parents who have proxy access to medical information of a child age 0-11 years will automatically have that access removed by the system when the patient turns age 12. This is due to legal guidelines in place for proxy access to teen's medical information.

Teens at age 12 or older can request their own MyChart account.

- Patients must have their own email address and cannot share an email address used by another person.
- Clinic staff can assist in sending the invitation for access to MyChart.
- Teens can grant proxy access to parents or other individuals:
  - If the proxy has an active MyChart account
  - Proxy access can be granted by the patient from within MyChart (preferred option).
  - The teen has control over who can access their information, so no consent needs to be signed.
    - Log into MyChart.
    - Scroll to the section: ***Invite Friends & Family*** and follow the steps to manage access for other individuals.
  - Proxy can be granted in the clinic.
    - Both the patient and proxy need to be present.
    - A consent for proxy access needs to be signed by the teen.
    - Clinic staff can then grant proxy access.

Adult-to-teen proxy access has some limitations on what the proxy can access. When the patient turns 18, proxy access is again revoked automatically by the system and the patient has the ability to grant adult-to-adult proxy access which provides expanded access.

Adult-to-teen proxy access provides the following:

- View and edit information on the Personal Information page.
- Receive alerts and notifications.
- View and update Family, Medical, Surgical, Allergy, Medication and Immunization historical information.
- Send a message to the doctor or member of the Care Team:
  - Teens can manually select an option to exclude a proxy from receiving a message being sent to the doctor or care team by deselecting the proxy when creating the message. This exclusion will only apply to the specific message.
- View lab and radiology results (some sensitive results are automatically excluded from going to MyChart due to legal requirements).
- View medication information and send a request for refills.

Adult-to-teen proxy access does NOT provide the following:

- Social history information such as sexual activity, substance use, etc.
- Ability for proxy to schedule, cancel, view and confirm appointments and view past appointments
- View sensitive lab and radiology reports that are blocked for all patients based on legal restrictions

Let's get the kids in on it

Conclusion: You're next!

No consequences for murder

An Example…

Think about this statement of motive – ‘we need to limit liability for doctors, or they won’t come to our State’ is the basis for a law which ends up targeting the citizens impacted by medical malfeasance. Do good doctors need liability protection? <u>This game has been implemented by the “health care” lobby to facilitate the culture of death.</u>

II. PLAINTIFFS’ LAWSUIT ARISES OUT OF ALLEGED MEDICAL NEGLIGENCE AND SO IT IS GOVERNED BY CH. 655, STATS.

The plaintiffs assert or attempt to assert several causes of action, but all their causes of action arise out of the same core set of alleged facts. They claim that Grace Schara received negligent medical care between October 7 and 13, 2021, including care that was provided without her parents’ consent; specifically, that the defendants collectively over-sedated Grace, and then refused to resuscitate her because of a DNR order of which Scott was unaware.

Claims for injury or death on account of medical malpractice are governed exclusively by Ch. 655, Stats. *See* Wis. Stat. § 655.007; *Andruss v. Divine Savior Healthcare, Inc.*, 2022 WI 27, ¶ 26, 401 Wis. 2d 368, 973 N.W.2d 435. The Legislature’s purpose in enacting a statutory scheme to govern claims for damages arising out of alleged medical negligence was to encourage health care providers to remain in Wisconsin by imposing certain limits on the causes of action that a patient or her family member can pursue, and on the types and amount of damages that can be recovered. *Wisconsin Patients Compensation Fund v. St. Paul Fire & Marine Ins. Co.*, 116 Wis. 2d 537, 544, 342 N.W.2d 693 (1984).

The purpose of this motion is to enforce certain limits on claims for medical negligence that are clearly articulated in Wisconsin law.

III. SCOTT SCHARA CANNOT RECOVER FOR NEGLIGENT INFLICTION OF EMOTIONAL DISTRESS.

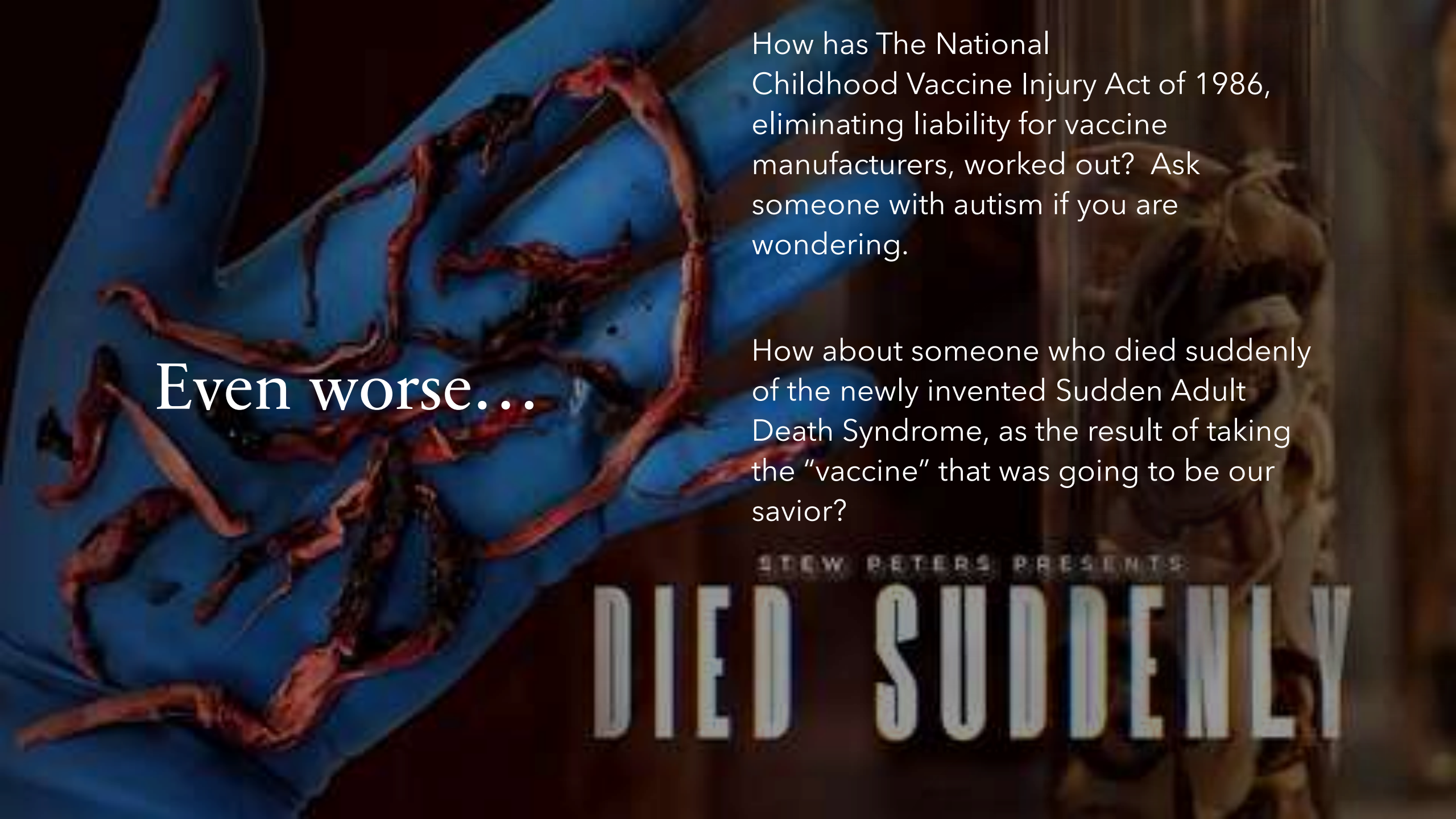
Scott Schara pleads a claim for Negligent Infliction of Emotional Distress (Doc 12, p. 21). He fails to state a claim upon which relief may be granted because claims for bystander emotional distress are unavailable as a matter of law in cases arising out of alleged medical negligence.

Mr. Schara does not allege that he personally received negligent medical care or that he was a patient of Dr. Marada or the other defendants. The factual basis for his claim of emotional

Even worse…

How has The National Childhood Vaccine Injury Act of 1986, eliminating liability for vaccine manufacturers, worked out? Ask someone with autism if you are wondering.

How about someone who died suddenly of the newly invented Sudden Adult Death Syndrome, as the result of taking the “vaccine” that was going to be our savior?



Conclusion: God's economy has consequences for choices. When the consequences are removed, by law, the effects are catastrophic.

Medical Murder is the #1 Cause of Death in the U.S. – By Design

(People Are Too Expensive – Satan's Big Lie)

Up Next…

Where? Mystery Babylon