Affidavit – Submitted by Craig Paardekooper

Testifying to the observations that following vaccination with Covid 19 vaccines–

1. there are significant variations in serious adverse effects between the different states of the USA – including –
    a. death
    b. disability

2. death and disability increase in direct proportion to numbers vaccinated – suggesting a causal link

3. 5 states stand out – showing a far greater number of deaths than would be expected from this direct proportion relationship – namely Kentucky, Tennessee, Michigan, Minnesota and Georgia.

4. Deaths predominate in the over 60s, whilst disabilities predominate in the over 40s, the reason being that the younger age groups are able to survive the fatal effects of the vaccine, but it leaves them with chronic injuries instead – and most likely a shorter lifespan.

5. The higher fatalities observed in Kentucky, Tennessee, Michigan, Minnesota and Georgia, are due to a second peak of delayed deaths following vaccination.

6. This excess mortality is consistent with the use of a self-amplifying vaccine, which persists in the body for a greater length of time, and generates excessive amounts of toxic spike proteins through a process of self-amplification - flooding the circulatory system. Such a vaccine was in development by Pfizer in November 2020 and was one of three “platforms” being developed for vaccine delivery.

Using a self-amplifying vaccine to instruct cells to make a spike protein, (which has been demonstrated to cause blood clotting) , and in addition instructs the cells to make more of the RNA leading to an exponential increase in spike protein concentration, which is cause for extreme concern.

Anyone subjected to such a vaccine is likely to suffer diminished health, severe pain, disability or death.

Signed

Craig Paardekooper

Qualifications (Craig Paardekooper)

- BSc Psychology Middlesex University, UK
- Higher Certificate Life Sciences Allied to Medicine – Birkbeck College, London University, UK

Variation in Vaccine Effects Between States in the USA

Deaths by State for Total Vaccinated over 2021

If the numerous deaths and disabilities following vaccination are caused by the vaccine, then we would expect the number of deaths and disabilities to increase in direct proportion to the number vaccinated. We have just seen how the number of deaths per number vaccinated varies over time. However, if we take the entire year of 2021, and sum up the total deaths for each State in the USA, and the total vaccinated for each State in the USA, then we get some very interesting results.

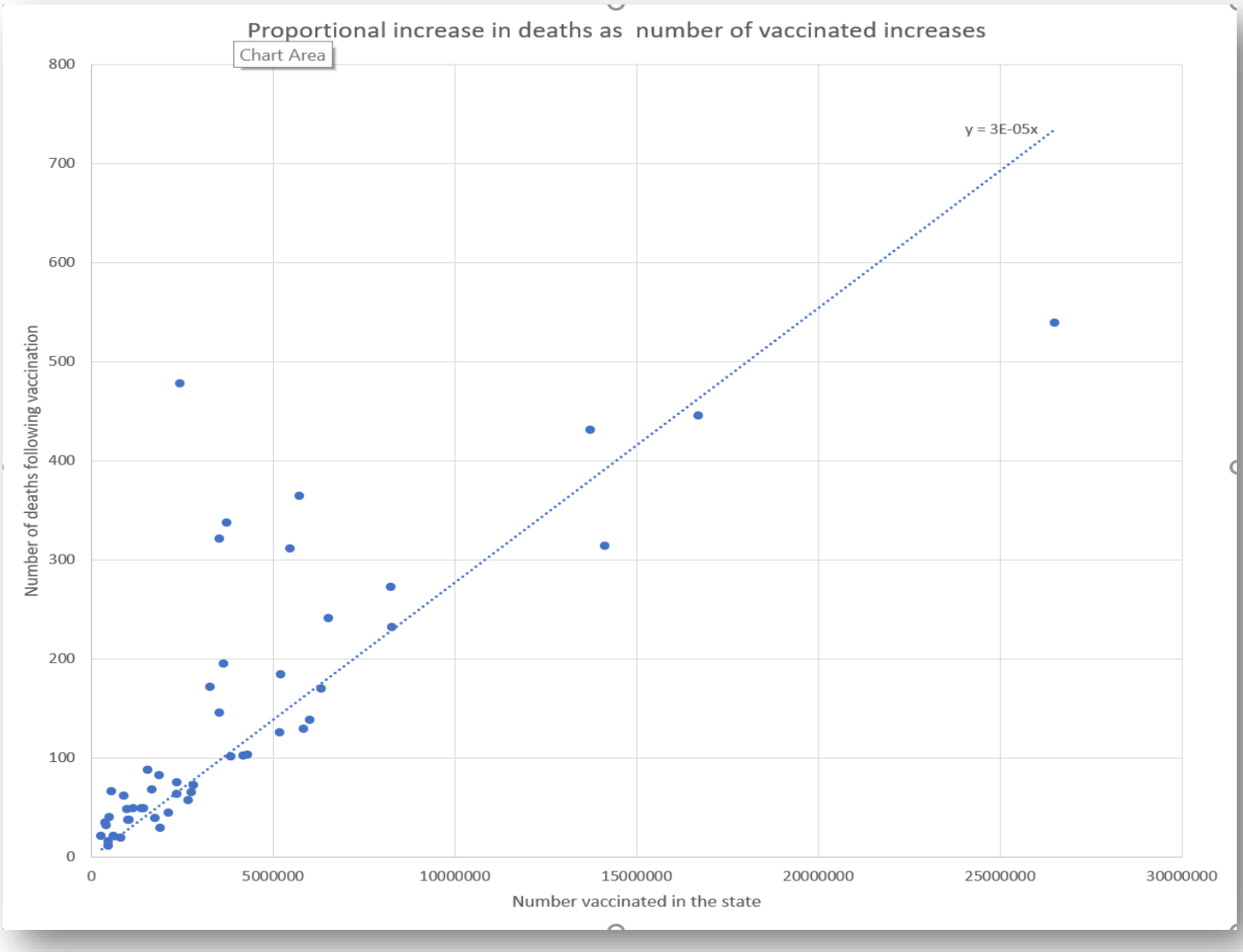
Here is a table showing the number vaccinated in each state of the USA, and the number of deaths following vaccination.

[I filtered VAERS for **all COVID vaccines**, then for **DIED = Y**, then for each USA State in turn]

State	Deaths	Name	Blue	Red	Num Vacc	Deaths per 100,000
KY	478	Kentucky			2446657	19.5
MT	66	Montana			581848	11.3
TN	321	Tennessee			3542558	9.1
MN	337	Minnesota			3732963	9.0
ND	34	North Dakota			405235	8.4
SD	40	South Dakota			511966	7.8
AK	32	Alaska			416173	7.7
WY	21	Wyoming			278260	7.5
NH	61	New Hampshire			922250	6.6
MI	364	Michigan			5737156	6.3
GA	311	Georgia			5495289	5.7
AR	87	Arkansas			1563487	5.6
WI	195	Wisconsin			3648131	5.3
MO	171	Missouri			3285699	5.2
WV	48	West Virginia			995507	4.8
IA	82	Iowa			1879386	4.4
NE	49	Nebraska			1170992	4.2
IN	145	Indiana			3533415	4.1
KS	68	Kansas			1681521	4.0
OH	241	Ohio			6535591	3.7
ME	37	Maine			1030026	3.6
WA	184	Washington			5226744	3.5
HI	37	Hawaii			1054993	3.5
NM	49	New Mexico			1405836	3.5
MS	49	Mississippi			1453639	3.4
DE	21	Delaware			632523	3.3
IL	272	Illinois			8249223	3.3
AL	75	Alabama			2363643	3.2
FL	431	Florida			13744395	3.1
DC	15	Columbia			483001	3.1
PA	232	Pennsylvannia			8284852	2.8
LA	63	Louisiana			2362987	2.7
NJ	169	New Jersey			6343694	2.7
TX	445	Texas			16727778	2.7
CO	101	Colorado			3855340	2.6
OR	72	Oregon			2827692	2.5
AZ	102	Arizona			4207031	2.4
MA	125	Massachusetts			5198480	2.4
MD	103	Maryland			4310596	2.4
SC	65	South Carolina			2768707	2.3
RI	19	Rhode Island			822567	2.3
NC	138	North Carolina			6020048	2.3
VT	11	Vermont			488,977	2.2
NY	314	New York			14162994	2.2
NV	39	Nevada			1762527	2.2
VA	129	Virginia			5867830	2.2
CT	57	Connecticut			2693093	2.1
OK	44	Oklahoma			2141228	2.1
CA	539	California			26526203	2.0
UT	29	Utah			1906748	1.5

Data from VAERS for 2021 USA for Pfizer, Moderna and Janssen vaccines
Column 2 = Number of deaths following vaccination
Column 6 = Number of people vaccinated
Column 7 = Deaths per 100,000 vaccinated
Number vaccinated by State as of 14th Jan 2022 : Source

When this data is plotted on a graph the result is a straight line. As vaccination increases so do the number of deaths. They are in direct proportion, because the vaccinations are causing the deaths.



So size obviously matters. The more people vaccinated, the greater the number of deaths, by state.

But what about disability?

Here is a table showing the number vaccinated in each state of the USA, and the number of disabilities following vaccination.

[I filtered VAERS for **all COVID vaccines**, then for **DISABILITY = Y**, then for each USA State in turn]

State	Disability	Name	Blue	Red	Num Vacc	Disability per 100,000
NH	76	New Hampshire			922250	8.2
AZ	308	Arizona			4207031	7.3
WY	20	Wyoming			278260	7.2
OR	202	Oregon			2827692	7.1
WA	361	Washington			5226744	6.9
CO	258	Colorado			3855340	6.7
NV	117	Nevada			1762527	6.6
OH	421	Ohio			6535591	6.4
ME	66	Maine			1030026	6.4
IN	219	Indiana			3533415	6.2
VT	30	Vermont			488,977	6.1
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MI	343	Michigan			5737156	6.0
DE	37	Delaware			632523	5.8
MN	214	Minnesota			3732963	5.7
TN	203	Tennessee			3542558	5.7
FL	780	Florida			13744395	5.7
SD	29	South Dakota			511966	5.7
VA	330	Virginia			5867830	5.6
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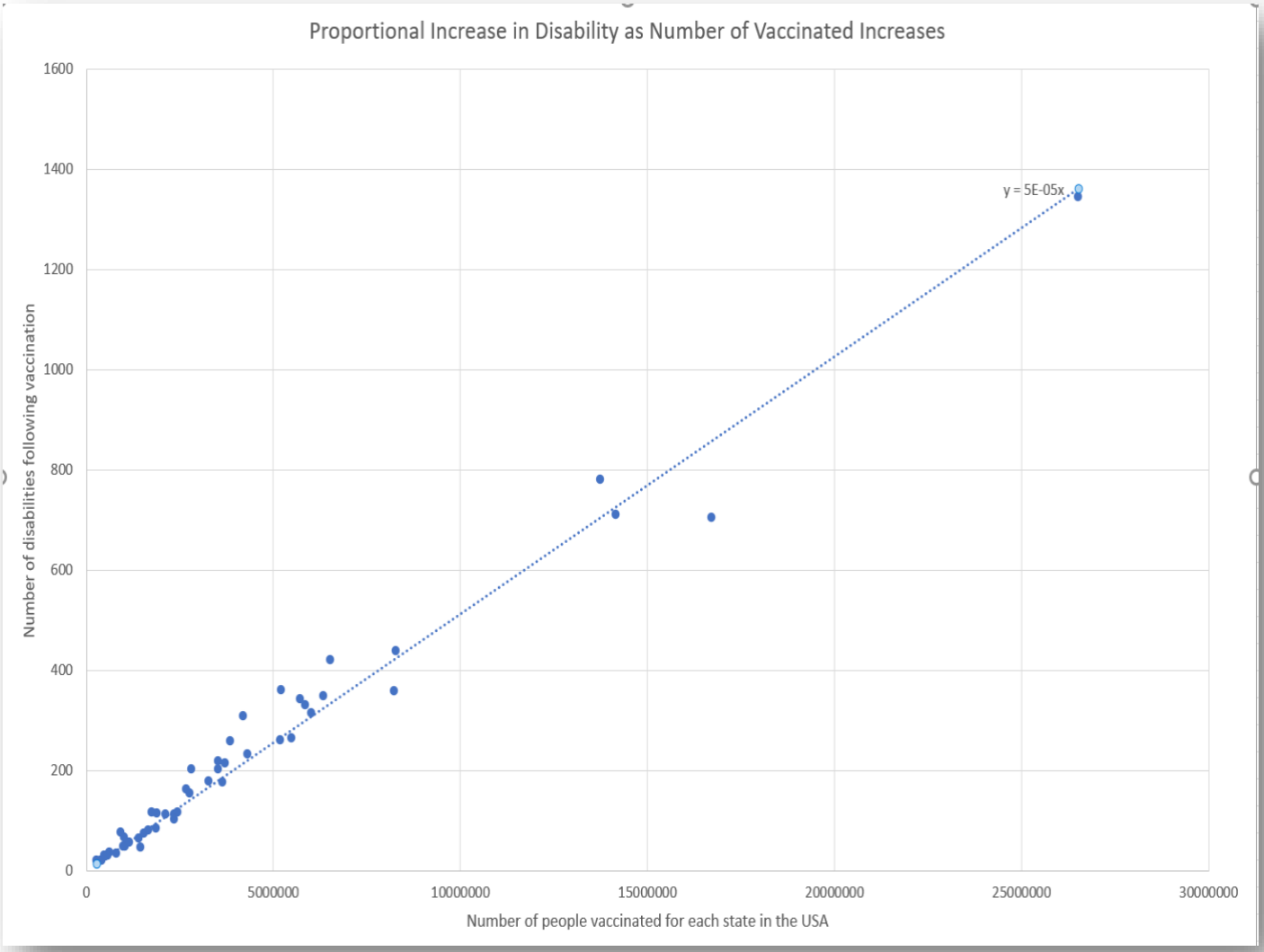
NC	315	North Carolina			6020048	5.2
OK	112	Oklahoma			2141228	5.2
MT	30	Montana			581848	5.2
CA	1344	California			26526203	5.1
AK	21	Alaska			416173	5.0
MA	261	Massachusetts			5198480	5.0
NY	711	New York			14162994	5.0
ND	20	North Dakota			405235	4.9
WV	49	West Virginia			995507	4.9
NE	57	Nebraska			1170992	4.9
WI	177	Wisconsin			3648131	4.9
GA	265	Georgia			5495289	4.8
AR	75	Arkansas			1563487	4.8
AL	113	Alabama			2363643	4.8
KS	80	Kansas			1681521	4.8
KY	116	Kentucky			2446657	4.7
NM	65	New Mexico			1405836	4.6
HI	48	Hawaii			1054993	4.5
IA	85	Iowa			1879386	4.5
LA	103	Louisiana			2362987	4.4
IL	358	Illinois			8249223	4.3
RI	35	Rhode Island			822567	4.3
TX	704	Texas			16727778	4.2
MS	46	Mississippi			1453639	3.2

Data from VAERS for 2021 USA for Pfizer, Moderna and Janssen vaccines
Column 2 = Number of disabilities following vaccination
Column 6 = Number of people vaccinated
Column 7 = Disabilities per 100,000 vaccinated
Number vaccinated by State as of 14th Jan 2022 : Source

When this data is plotted on a graph the result is a straight line. As vaccination increases so do the number of disabilities. They are in direct proportion, because the vaccinations are causing the disabilities.



In fact the "Disability" graph is so close to a straight line, that we can create an equation relating number vaccinated to number of disabilities that will follow. This is because the ratio between vaccination and disability is a constant.

Disability = Vaccinated x 1/20,000

e.g. if 5,000,000 are vaccinated, this will produce 250 disabled people. (**This formula has predictive power**)

In comparison, the equation describing the "Death" graph above is -

Deaths = Vaccinated x 1/33,000

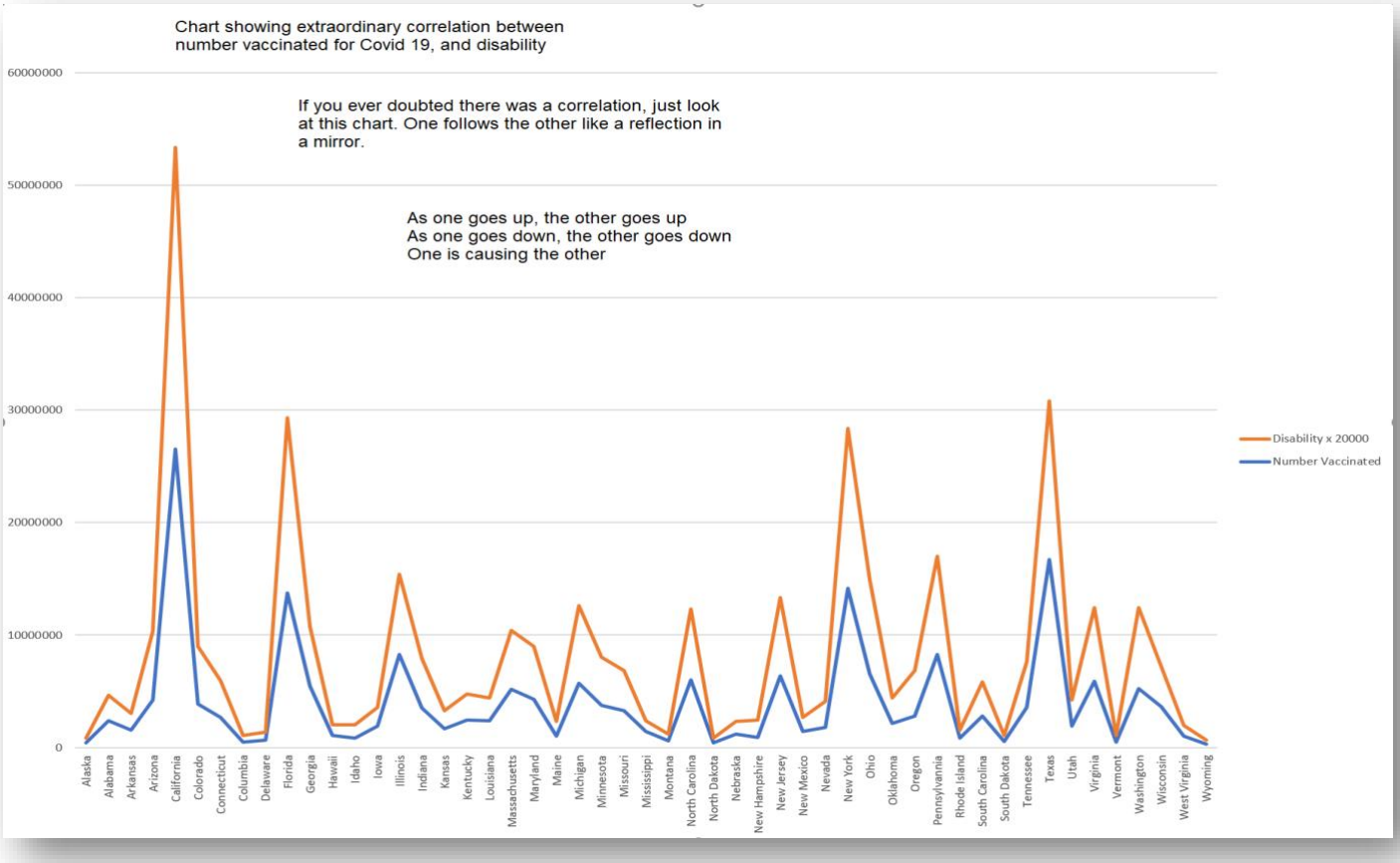
which means that the ratio of disabilities to deaths will be 5 : 3; for every 5 people disabled, there will be 3 others dead.

The consistency with which death and disability occur, is demonstrated by their conformity to these equations. However, we should realise that the outcomes of death and disability are just tips of an "iceberg" - even though many escape death and disability, they may still undergo significant internal damage at a sub-clinical level, resulting in reduced physical or mental capacity and increased discomfort.

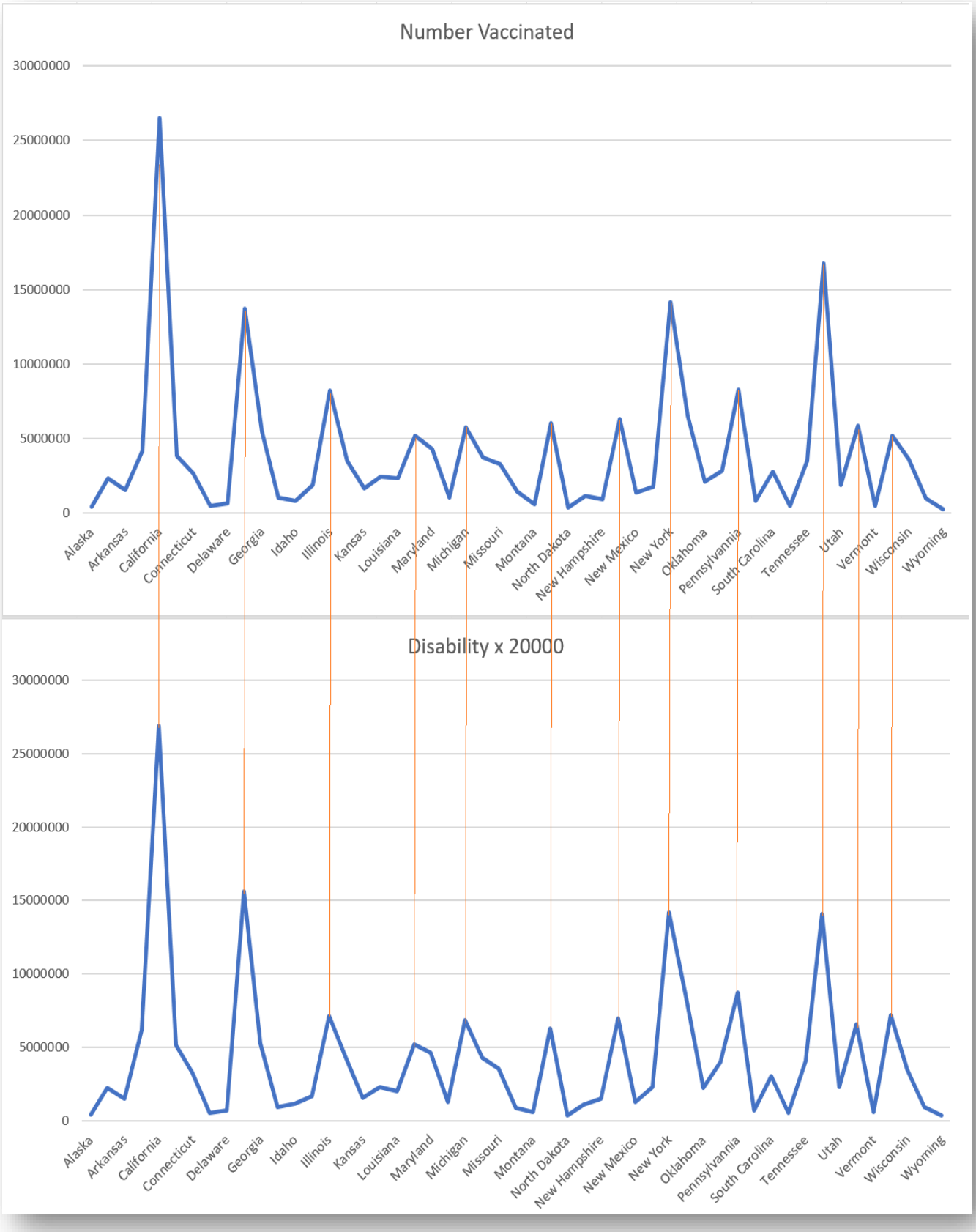
Size really does matter - states with more vaccinated have more disabilities following vaccination. This is strong evidence of the causal relationship between the vaccine and the resulting disabilities and deaths.

Just To Reinforce the Point

Here is a chart showing how number of disabilities changes as number of vaccinated changes for each state. One follows the other with uncanny synchronicity - like a reflection in a mirror.



To make this clearer here are the separate graphs for number vaccinated by state, and for number of disabilities by state printed one on top of the other. The strength of correlation is absolutely extraordinary.



In the light of this degree of correlation there can be absolutely no doubt that these vaccinations are the singular cause of these devastating injuries. It follows that persistence of the government, medical authorities and employers in enforcing vaccination, despite the obvious evidence of harm caused, is prima facie evidence of intent to harm - for which there is no evasion of liability under EUA.

The Under-Reporting Factor

The under-reporting factor in VAERS is estimated to be about 40 x. This means that only one 40th of the deaths and disabilities are being reported to VAERS. If this is correct then the figures become a tad more scary.

- **Deaths :** 1 in 825 = 1200 per million
- **Disabilities :** 1 in 500 = 2000 per million

What about time-wise?

Is it true that the more often you take the vaccine, the more you are injured? Even Pfizer's own data support the idea that the more often you take the vaccine, the worse the effects become - see -

Repeated injection

Lot Size

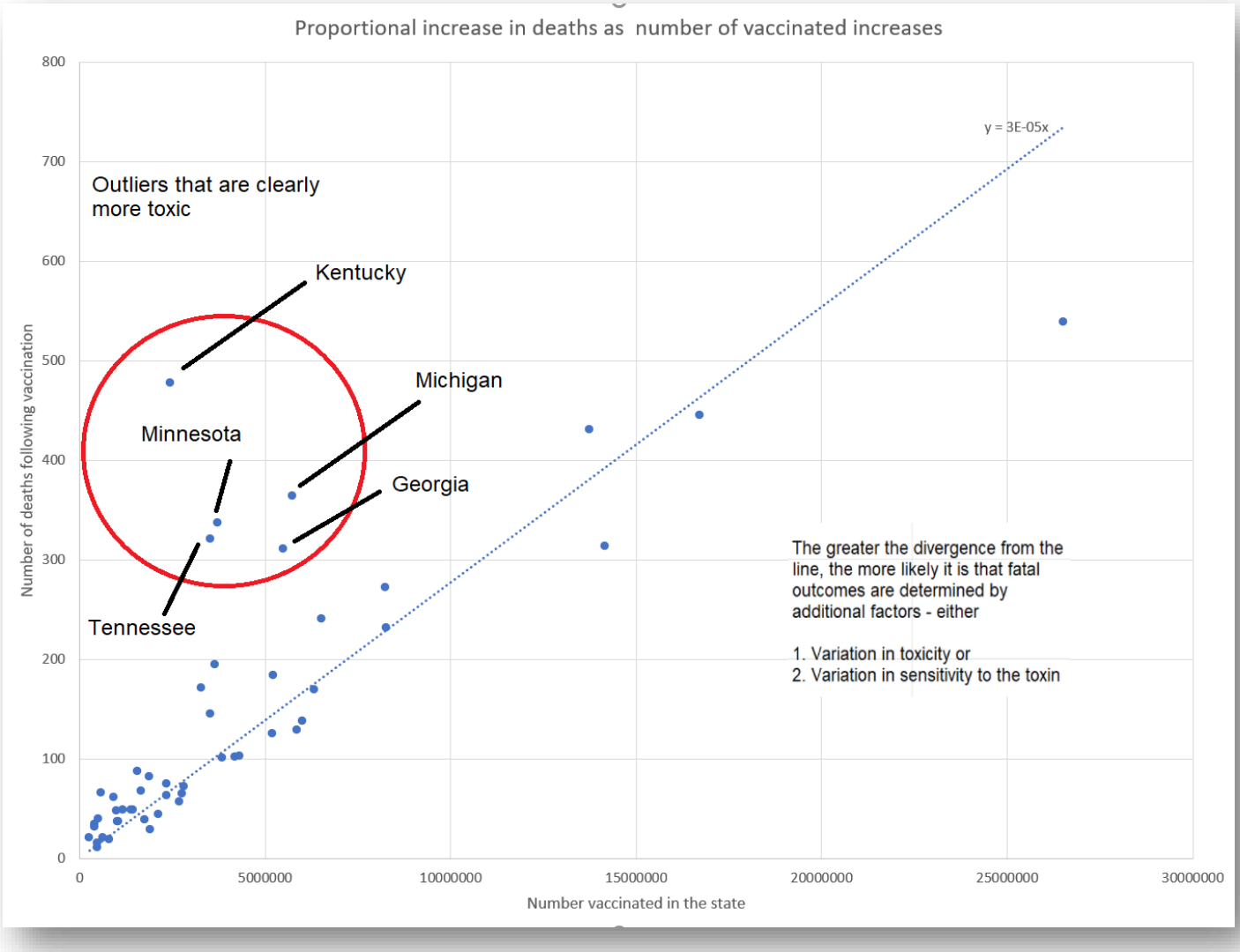
Lot size is another index of the number of people vaccinated. Bigger lot sizes mean that more people have been vaccinated with that lot. Consequently we find that lots with larger sizes are strongly associated with higher numbers of adverse reactions, deaths and disabilities.

Currently we only know the lot sizes for 33 lots. When we plot the number of deaths and disabilities against the lot sizes for each of these lots, we find that there is a strong linear correlation of 0.86. The bigger the lot, the higher the number of injuries.

Size matters, size matters, size matters.

Other Factors Besides Size

Please take another look at the chart for deaths. You will see that some states are expressing far higher numbers of deaths than would be expected for the number vaccinated in those states.



- For Tennessee and Minnesota, deaths are 3 times higher than expected
- For Georgia and Michigan deaths are about 2 x higher than expected
- For Kentucky deaths are about 6 x higher than expected

Data Sources

- VAERS provided the number of deaths following vaccination with Pfizer for each state in the USA.
- The number of vaccinated in each state as of January 14th 2022 was provided by - number vaccinated. So I was able to calculate the number dying in each state per 100,000 vaccinated.

Observations

- There is considerable variation in the number dying per 100,000 vaccinated. Some states have 16 x the death rate compared to others.
- Red states tend to cluster towards the top of the chart, whilst blue states cluster towards the bottom.
- Red states occupy 6 of the 7 highest ranking positions for deaths per 100,000 vaccinated

Safety Signal

Some states, in particular Kentucky, Tennessee, Minnesota, Michigan and Georgia are experiencing a far higher the number of deaths per 100,000 vaccinated compared to other states. Such a situation should be raising a safety signal, and requires investigation. The higher death rate in these states following vaccination suggests that they may be receiving more toxic batches, or being administered to more vulnerable people.

State	Deaths	Name	Blue	Red	Num Vacc	Deaths per 100,000
KY	281	Kentucky			2446657	11.485059
MT	37	Montana			581848	6.359049099
NH	52	New Hampshire			922250	5.638384386
AK	22	Alaska			416173	5.286263165
TN	171	Tennessee			3542558	4.827020475
ND	18	North Dakota			405235	4.441867065
SD	22	South Dakota			511966	4.297160358
MN	160	Minnesota			3732963	4.286139455
GA	167	Georgia			5495289	3.038966649
WI	96	Wisconsin			3648131	2.631484451
WV	25	West Virginia			995507	2.511283195
MI	144	Michigan			5737156	2.509954409
AR	36	Arkansas			1563487	2.302545528
MO	70	Missouri			3285699	2.130444694
IA	39	Iowa			1879386	2.075145819
WA	103	Washington			5226744	1.970634108
DE	12	Delaware			632523	1.897164214
OH	123	Ohio			6535591	1.882002714
KS	30	Kansas			1681521	1.784099039
IL	139	Illinois			8249223	1.685007182
IN	54	Indiana			3533415	1.528266564
NE	17	Nebraska			1170992	1.451760559
PA	120	Pennsylvannia			8284852	1.448426598
WY	4	Wyoming			278260	1.437504492
VT	7	Vermont			488,977	1.431560176
AL	33	Alabama			2363643	1.396149926
TX	232	Texas			16727778	1.386914628
NM	19	New Mexico			1405836	1.351508995
FL	185	Florida			13744395	1.346003225
ME	13	Maine			1030026	1.262104063
NJ	78	New Jersey			6343694	1.229567504
MS	17	Mississippi			1453639	1.169478805
MA	57	Massachusetts			5198480	1.096474354
AZ	44	Arizona			4207031	1.045868214
HI	11	Hawaii			1054993	1.042660947
NY	147	New York			14162994	1.037916136
DC	5	Columbia			483001	1.035194544
MD	44	Maryland			4310596	1.020740519
VA	59	Virginia			5867830	1.005482436
CO	38	Colorado			3855340	0.985645883
OK	19	Oklahoma			2141228	0.887341283
CA	232	California			26526203	0.874606893
NC	52	North Carolina			6020048	0.863780488
NV	15	Nevada			1762527	0.851050792
RI	7	Rhode Island			822567	0.850994509
OR	23	Oregon			2827692	0.813384202
LA	19	Louisiana			2362987	0.804067056
UT	15	Utah			1906748	0.786679729
SC	21	South Carolina			2768707	0.758476791
CT	19	Connecticut			2693093	0.705508499

Data from VAERS for 2021 USA for Pfizer vaccine only
Column 2 = Number of deaths following vaccination
Column 6 = Number of people vaccinated
Column 7 = Deaths per 100,000 vaccinated

Repeating the Analysis for All Covid Vaccines

Based on the findings for Pfizer, I decided to repeat the analysis, but this time for all of the covid vaccines together. Here is what I found.

State	Deaths	Name	Blue	Red	Num Vacc	Deaths per 100,000
KY	478	Kentucky			2446657	19.5
MT	66	Montana			581848	11.3
TN	321	Tennessee			3542558	9.1
MN	337	Minnesota			3732963	9.0
ND	34	North Dakota			405235	8.4
SD	40	South Dakota			511966	7.8
AK	32	Alaska			416173	7.7
WY	21	Wyoming			278260	7.5
NH	61	New Hampshire			922250	6.6
MI	364	Michigan			5737156	6.3
GA	311	Georgia			5495289	5.7
AR	87	Arkansas			1563487	5.6
WI	195	Wisconsin			3648131	5.3
MO	171	Missouri			3285699	5.2
WV	48	West Virginia			995507	4.8
IA	82	Iowa			1879386	4.4
NE	49	Nebraska			1170992	4.2
IN	145	Indiana			3533415	4.1
KS	68	Kansas			1681521	4.0
OH	241	Ohio			6535591	3.7
ME	37	Maine			1030026	3.6
WA	184	Washington			5226744	3.5
HI	37	Hawaii			1054993	3.5
NM	49	New Mexico			1405836	3.5
MS	49	Mississippi			1453639	3.4
DE	21	Delaware			632523	3.3
IL	272	Illinois			8249223	3.3
AL	75	Alabama			2363643	3.2
FL	431	Florida			13744395	3.1
DC	15	Columbia			483001	3.1
PA	232	Pennsylvania			8284852	2.8
LA	63	Louisiana			2362987	2.7
NJ	169	New Jersey			6343694	2.7
TX	445	Texas			16727778	2.7
CO	101	Colorado			3855340	2.6
ID	24	Idaho			937444	2.6
OR	72	Oregon			2827692	2.5
AZ	102	Arizona			4207031	2.4
MA	125	Massachusetts			5198480	2.4
MD	103	Maryland			4310596	2.4
SC	65	South Carolina			2768707	2.3
RI	19	Rhode Island			822567	2.3
NC	138	North Carolina			6020048	2.3
VT	11	Vermont			488,977	2.2
NY	314	New York			14162994	2.2
NV	39	Nevada			1762527	2.2
VA	129	Virginia			5867830	2.2
CT	57	Connecticut			2693093	2.1
OK	44	Oklahoma			2141228	2.1
CA	539	California			26526203	2.0
UT	29	Utah			1906748	1.5

Data from VAERS for 2021 USA for Pfizer, Moderna and Janssen vaccines
Column 2 = Number of deaths following vaccination
Column 6 = Number of people vaccinated
Column 7 = Deaths per 100,000 vaccinated

A clearer pattern emerges. Red states are almost completely clustered at the top, and blue states at the bottom. Number of deaths per 100,000 vaccinated is much higher for red states.

The only possible reasons for this are either -

1. red states are receiving batches of higher toxicity OR
2. the uptake in red states is predominantly amongst the elderly and frail.

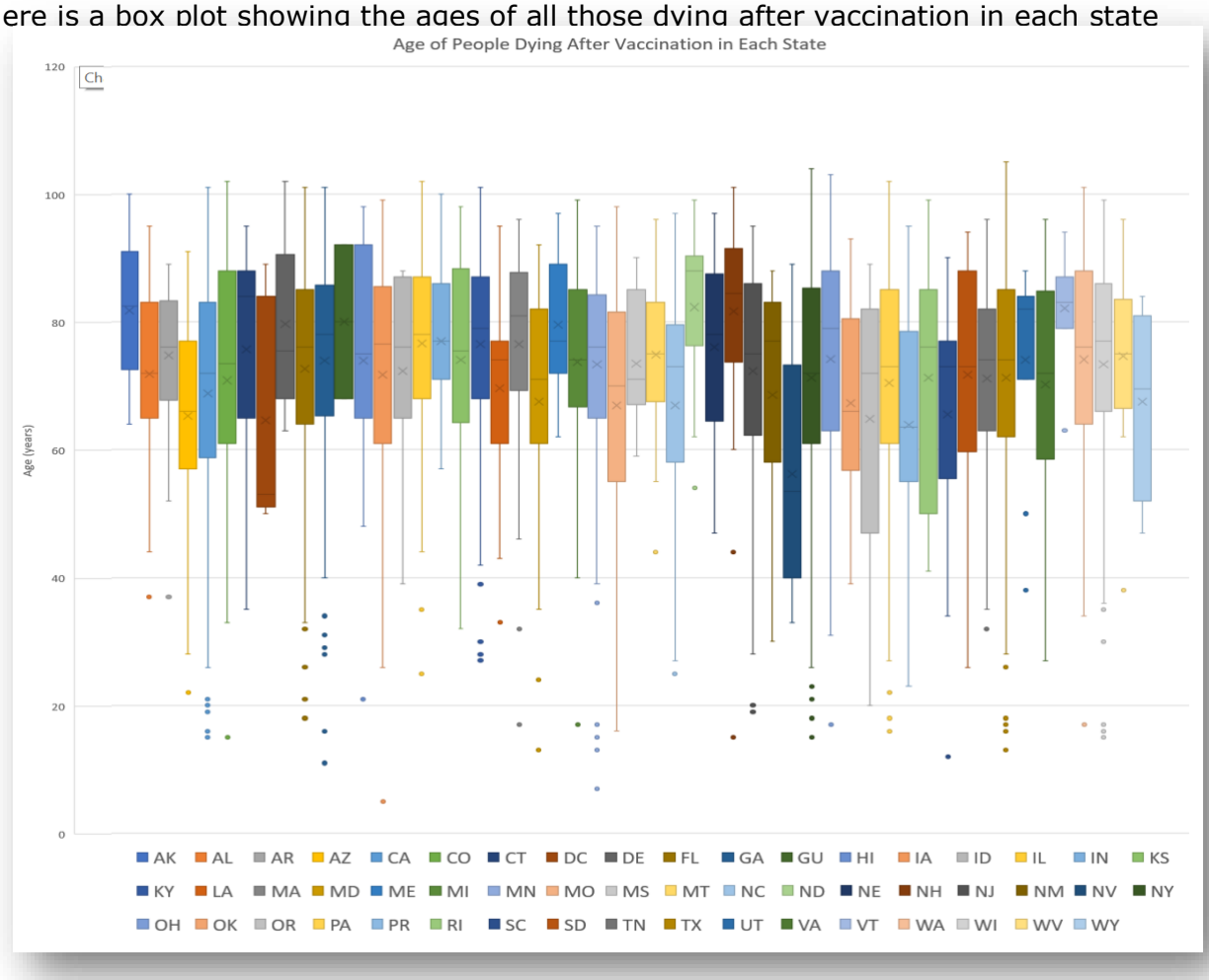
Testing the Age and Frailty Factors

I will have to investigate this further - by analysing the spread of ages for vaccinated between states. VAERS also provides a list of comorbidities for each recipient's report, so I can test for frailty also.

(Note: If age and frailty are responsible for the increased deaths following vaccination in red states, then this is an admission that the aged and frail must be more vulnerable to the fatal effects of the vaccine - since red states have upto 19 x the fatality rate. And if the aged and frail are more vulnerable to this medication then they should be **protected from it,** and exempt from it. If any demographic is excessively vulnerable to a medication, then they should not be exposed to it - continuing the medication betrays an intent to harm.)

Age

Here is a box plot showing the ages of all those dying after vaccination in each state



The Aged Are Definitely More Vulnerable

As you can see, the **average age** for those dying after vaccination is over 60 years old in all states, except for Nevada and Columbia. Broadly speaking 25% are aged 40-60, 75% are aged 60 +. So age is definitely a factor - old people are vulnerable to the effects of the vaccine across all states - the vaccine kills them far more readily than it kills young people. For this reason, old people should not be exposed to the vaccine, but rather should be protected from it. This is a major safety signal.

Differences in Disability Following Vaccination

These vaccines tend to afflict the old with death (terminal disability), and to afflict younger age groups with severe injury or chronic illness (non-terminal disability). After all, death is just extreme disability, so the young and strong may survive but with disability instead.

In the box plot below, I have plotted the age ranges for all people acquiring disability in each state of the USA following vaccination. As you can see, the age range is definitely lower. About 25% of the disabilities occur in the age range 20-40, and 75% occur in the age range 40+. So the age range of vulnerability has dropped by about 20 years.

Distribution of Disability Across States

When we look at the distribution of disability across states we find a reversal of the previous spread. Now there is a concentration of blue states at the top, and red states at the bottom. A larger number of younger age groups are being vaccinated in blue states compared to red states, so there is a correspondingly larger number of people becoming disabled.

In some states the absolute number of cases of disability following vaccination is very high. For example California has had 1344 cases.

Curiously, in the District of Columbia the vaccine kills younger people than in other states, and also causes more disabilities amongst younger people

State	Disability	Name	Blue	Red	Num Vacc	Disabilities per 100,000
NH	76	New Hampshire			922250	8.2
AZ	308	Arizona			4207031	7.3
WY	20	Wyoming			278260	7.2
OR	202	Oregon			2827692	7.1
WA	361	Washington			5226744	6.9
CO	258	Colorado			3855340	6.7
NV	117	Nevada			1762527	6.6
ID	62	Idaho			937444	6.6
OH	421	Ohio			6535591	6.4
ME	66	Maine			1030026	6.4
IN	219	Indiana			3533415	6.2
VT	30	Vermont			488,977	6.1
CT	163	Connecticut			2693093	6.1
UT	115	Utah			1906748	6.0
DC	29	Columbia			483001	6.0
MI	343	Michigan			5737156	6.0
DE	37	Delaware			632523	5.8
MN	214	Minnesota			3732963	5.7
TN	203	Tennessee			3542558	5.7
FL	780	Florida			1.4E+07	5.7
SD	29	South Dakota			511966	5.7
VA	330	Virginia			5867830	5.6
SC	154	South Carolina			2768707	5.6
NJ	349	New Jersey			6343694	5.5
MO	178	Missouri			3285699	5.4
MD	233	Maryland			4310596	5.4
PA	438	Pennsylvannia			8284852	5.3
NC	315	North Carolina			6020048	5.2
OK	112	Oklahoma			2141228	5.2
MT	30	Montana			581848	5.2
CA	1344	California			2.7E+07	5.1
AK	21	Alaska			416173	5.0
MA	261	Massachusetts			5198480	5.0
NY	711	New York			1.4E+07	5.0
ND	20	North Dakota			405235	4.9
WV	49	West Virginia			995507	4.9
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LA	103	Louisiana			2362987	4.4
IL	358	Illinois			8249223	4.3
RI	35	Rhode Island			822567	4.3
TX	704	Texas			1.7E+07	4.2
MS	46	Mississippi			1453639	3.2

The Second Peak - Long term / Delayed Effects of the Vaccines

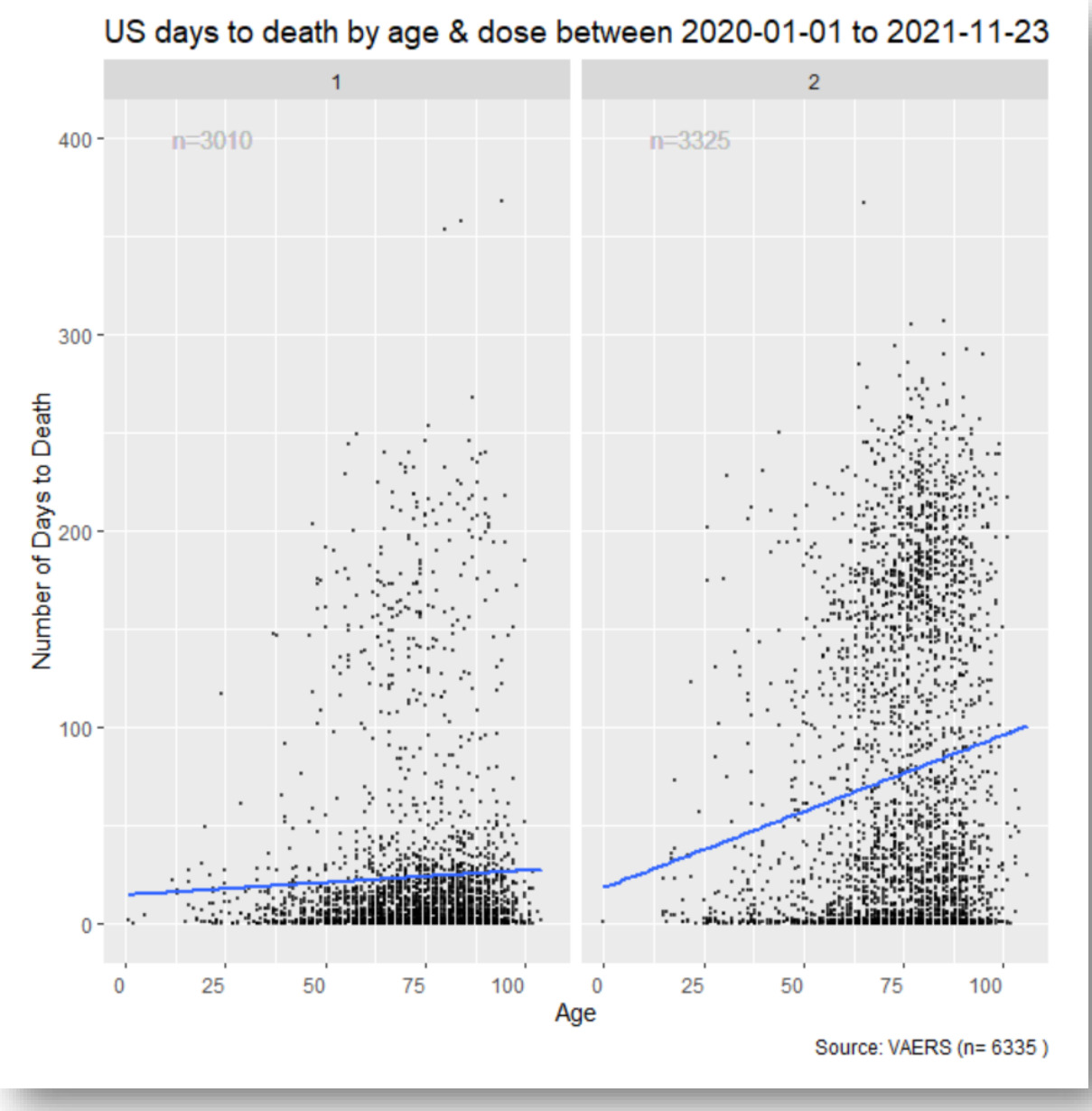
Immediacy of Severe Reactions

On a previous page, here, we looked at the time till onset of adverse reactions, and we found that there was a strong clustering of adverse reactions immediately after vaccination. This constitutes the first peak. We could think of this as the immediate or acute effects of the vaccines.

What you are about to read, is that there is a second peak, occurring at a defined time after the first peak, which we might regard as the chronic or long-term effects of the vaccine.

In order to show this, we will look at the distribution of deaths and hospitalisations following the first and second doses

FIG 1 : Deaths following Vaccination



The first chart shows the effects of the first dose. Notice that most of the deaths after the first dose occur within 30 days, and peter out after that - so the first dose mostly produces an acute, immediate reaction. Also notice that the occurrence of death persists for longer in the older age groups, suggesting that the active ingredient/s causing the death persists for longer in their bodies.

Now look at the second chart, which shows the effects of the second dose. Here the greatest concentration of deaths is still immediately after the vaccine, and declines exponentially as each day passes, until the frequency of death reaches a minimum at about 100 days post vaccination. It then starts to rise again, and there is a second peak at about 180 days post vaccination. Notice that the second peak is only apparent for people over 50.

FIG 2 : Graphs showing Second Peak

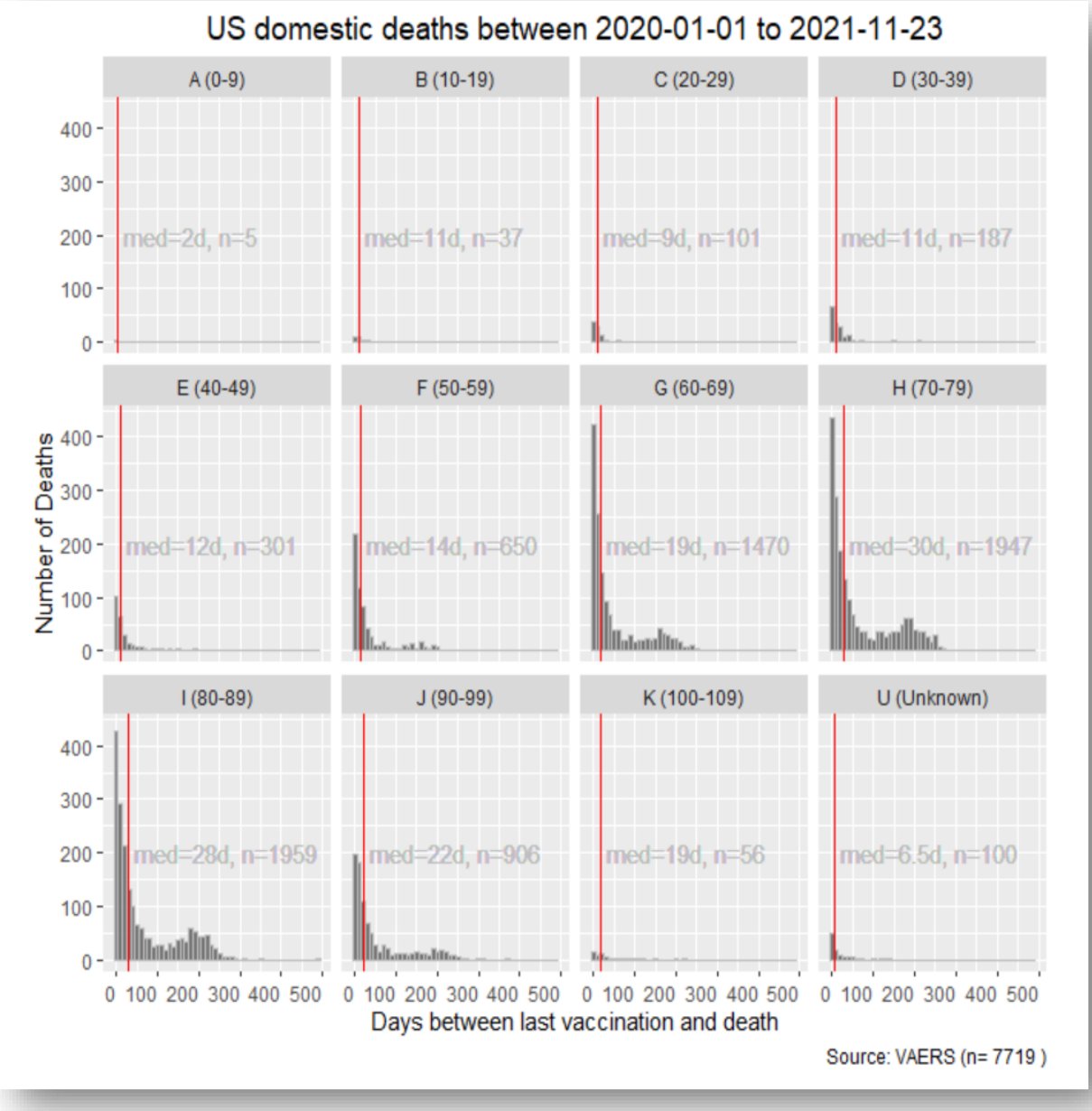
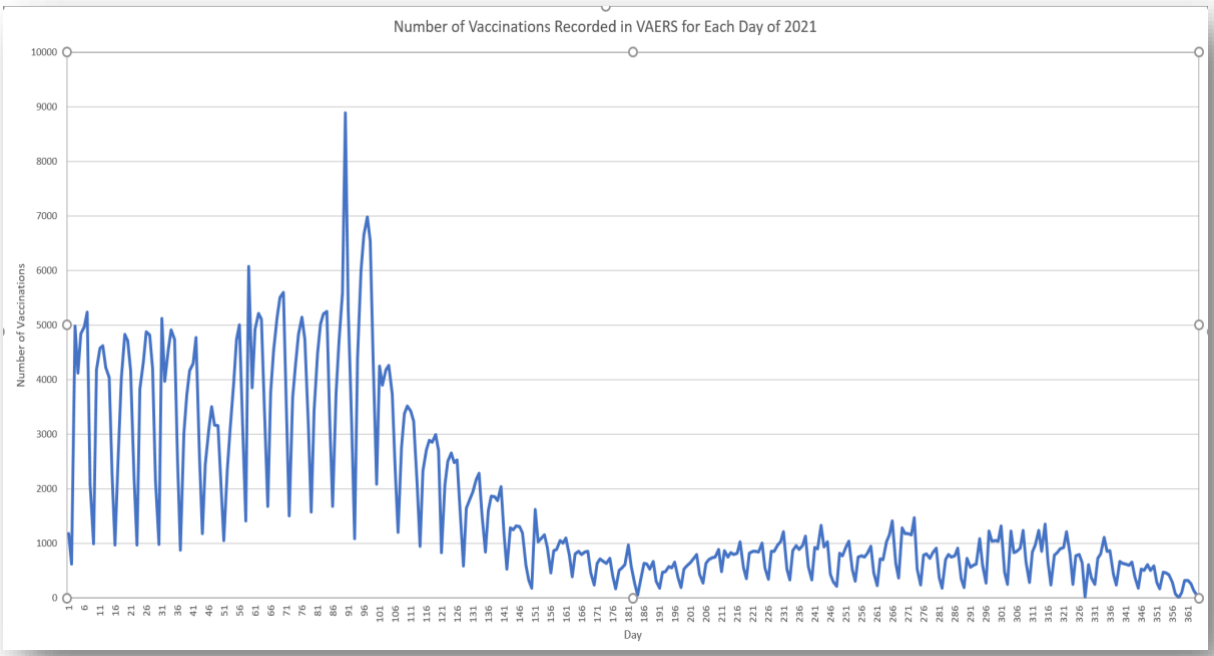


FIG 3 : Hospitalisations following Vaccination

These two charts show the number of hospitalisations following vaccination. They show a similar pattern to the charts for death - except that the second peak is far more apparent. Once again, the second peak seems to mainly effect the over 50s.

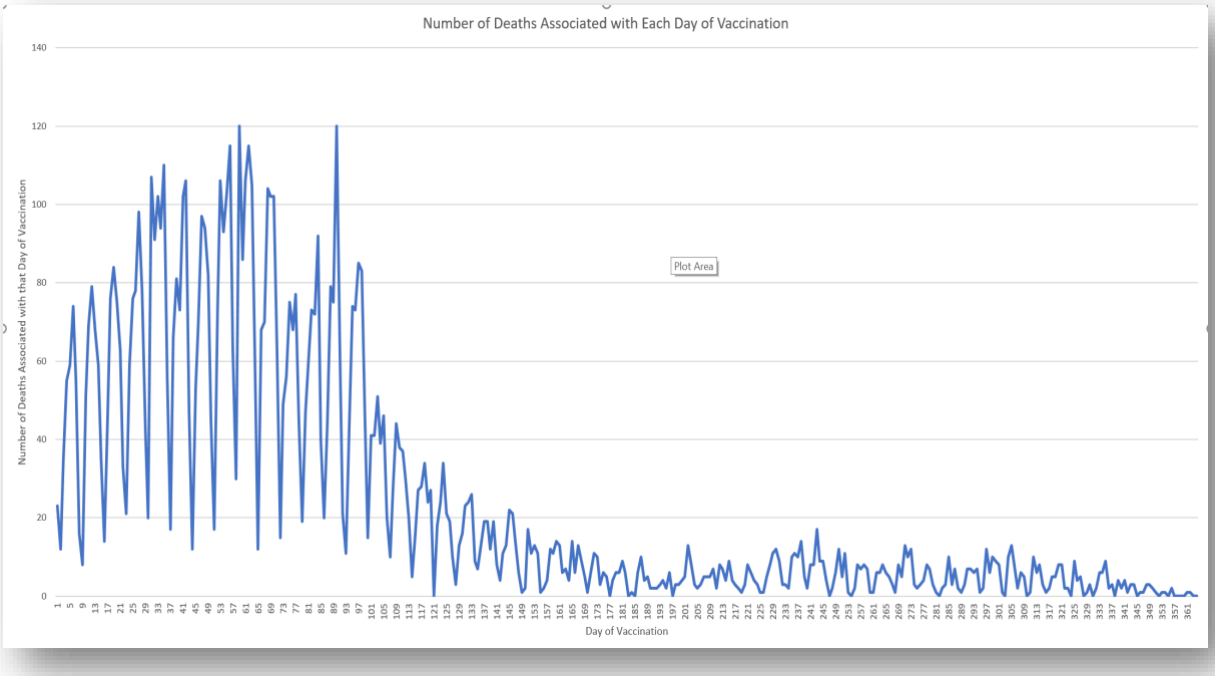
Decrease in Lethality over 2021

Here is a chart showing the number vaccinated on each day of 2021, as recorded in VAERS. This replicates the findings of Jason Morphett, but uses a different source of data (I used VAERS to count number vaccinated on each day, whilst Jason used the governments recorded vaccination numbers obtained from a separate CDC database.)



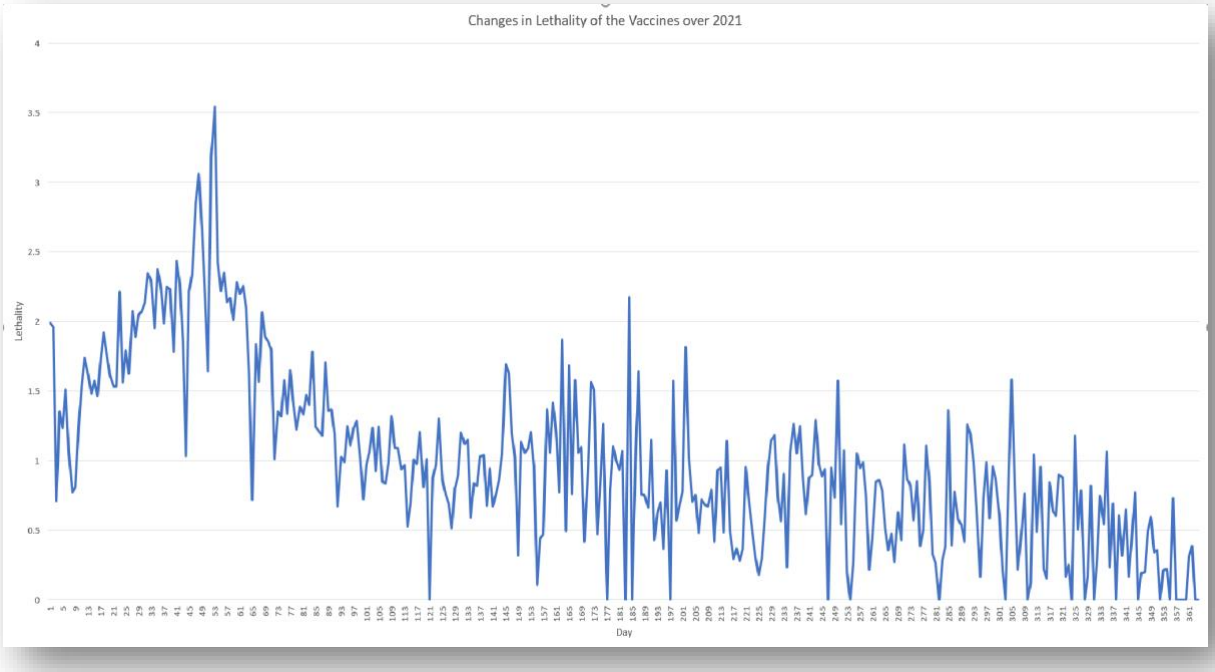
A minimum is found to occur every 7 days, because fewer people are vaccinated on Sundays

When I counted the number of deaths associated with the vaccinations given on each day, I obtain this graph - again based on VAERS data for USA for 2021. This is the same as the graph produced by Jason Morphett



Notice again that the number of deaths associated with each day of vaccination also follows a periodic 7 day oscillation.

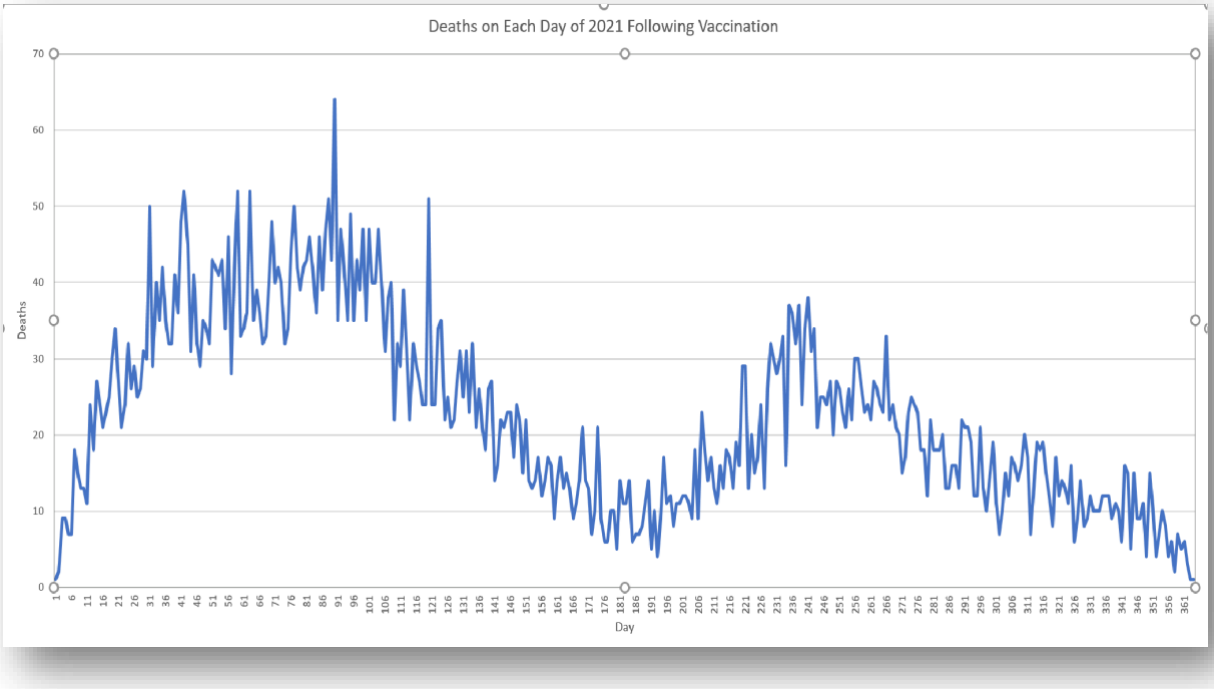
When number of deaths associated with a particular day is divided by the number of vaccines given on that day, we obtain the lethality - a measure of toxicity. Graph 3 shows that lethality declines over 2021.



So the vaccines have actually decreased in toxicity over 2021. The vaccines were twice as lethal in the first quarter compared to the third quarter of 2021. They reserved the worst shots for the aged in the first quarter (eugenics/ cost saving on social care?)

Curious Distribution of Death

The deaths associated with the vaccines given on a particular day, do not occur on that day. Rather, these deaths are spread out over many days following vaccination. When we look at the actual dates of death and plot these on a graph for each day of 2021, we obtain the following -



What can account for the rather large second peak of deaths? The deaths show a large bulge in the third quarter which is not expected, since we have seen that numbers vaccinated was falling, and so was toxicity.

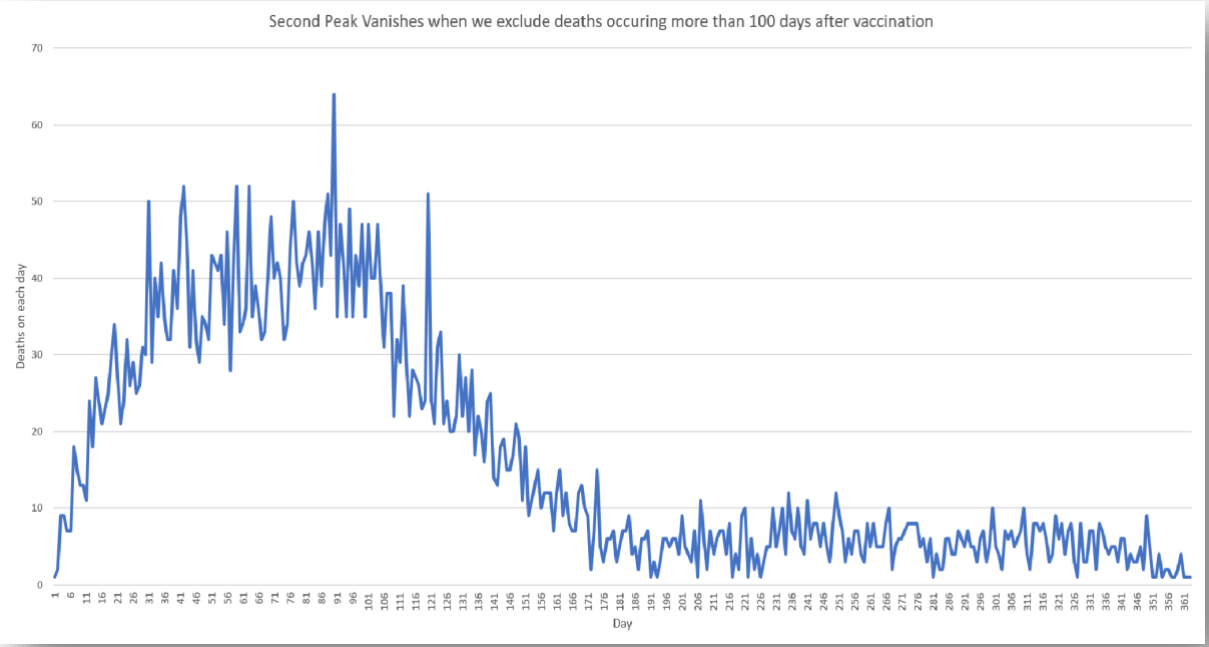
The two peaks are out of phase by approximately 180 days

At the beginning of this page I showed that following the vaccination of the aged, there are two peaks, and the second peak starts 180 days after vaccination. I therefore propose that this large bulge in deaths is primarily the result of vaccines given in January, February and March. It is the second peak - 180 days after vaccination - the long-term effects of the vaccine.

Testing the Idea

In order to test the idea that the second peak (occurring in the third quarter of 2021) was due to the long term effects of the initial vaccinations in the first quarter of 2021, I simply counted the number of deaths on each day, but filtered out those records where the deaths were taking place more than 100 days after vaccination. I wanted to see if the second peak disappeared when I did this.

The results are shown below, and confirm that the second peak arises due to long term effects of the vaccination - resulting in a second maximum of deaths 180 days after vaccination



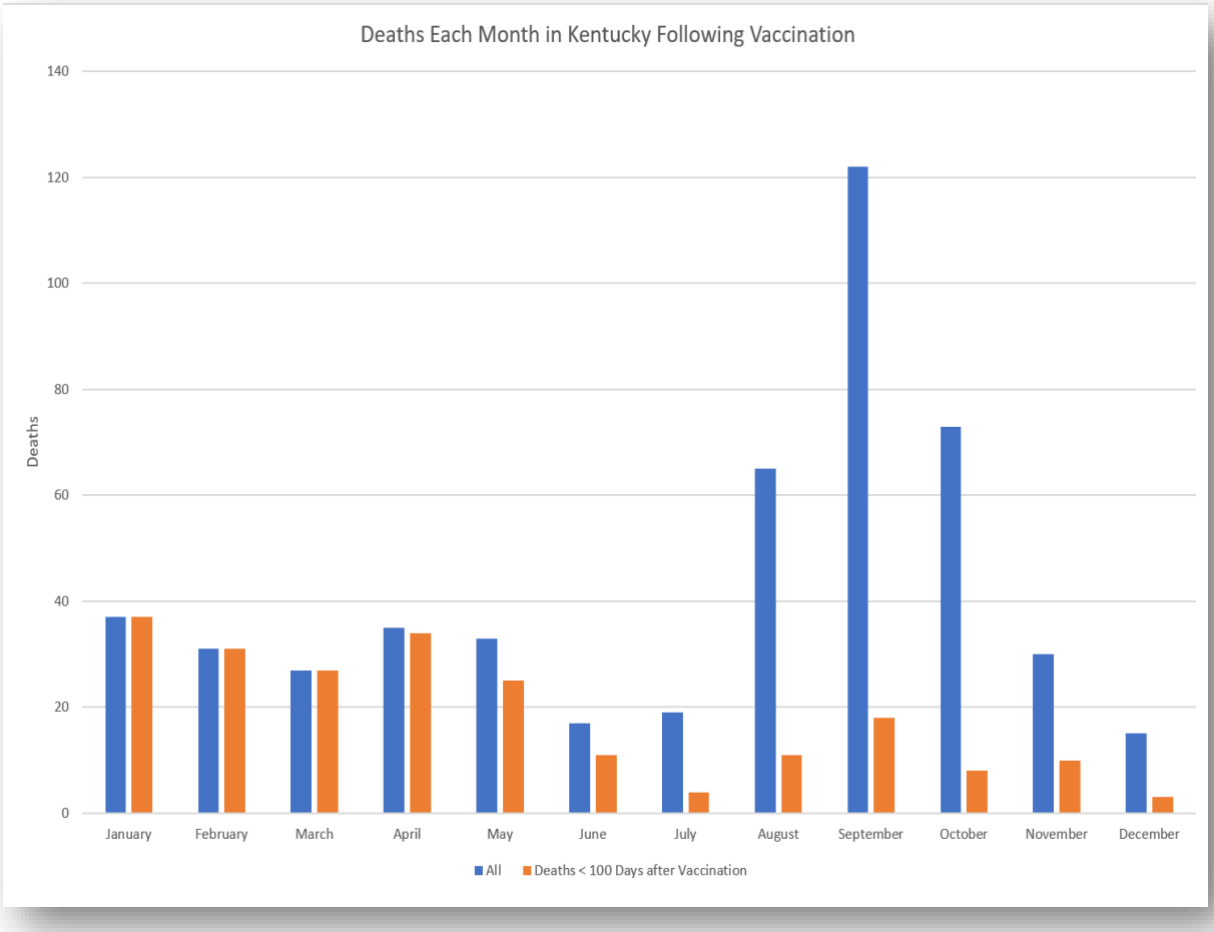
In order to find out the precise cause of the second peak, I will need to look at what the people died from. This will tell me if it was immune deficiency or something else - and will tell us about the mechanism of long-term vaccine effects.

Kentucky

VAERS data for deaths in Kentucky shows a very large increase in mortality in the third quarter following Covid 19 vaccinations. Scientists have been wondering what could possibly give rise to such a large increase.

I decided to carry out a test to see if the large Q3 peak might be the second peak caused by the initial vaccines given in Q1, rather than from vaccines given in Q3.

So, first I plotted all deaths (shown in blue). Then I plotted only deaths occurring less than 100 days after vaccination (shown in orange)

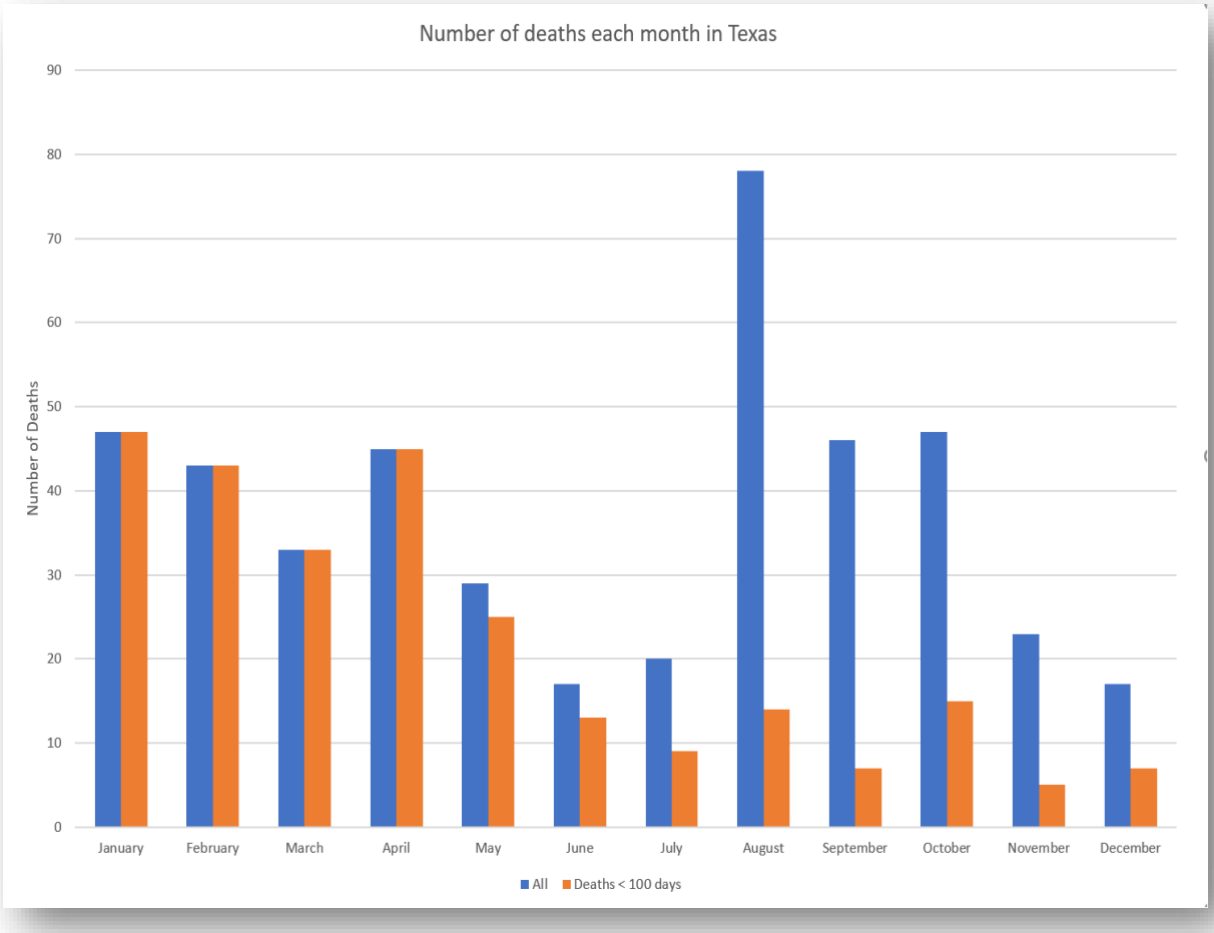


As you can see, 83% of the Q3 peak has nothing to do with the vaccines deployed in the third quarter, but consists of the delayed deaths from at least 100 days earlier. Consequently the Q3 peak is actually **the delayed effects of the Q1 and Q2 vaccines**

What is really scary is the magnitude of Q3 - it is 3 times that of Q1. The vaccine appears to act like a time bomb - its destructive power is delayed with a fuse lasting at least 100 days !!

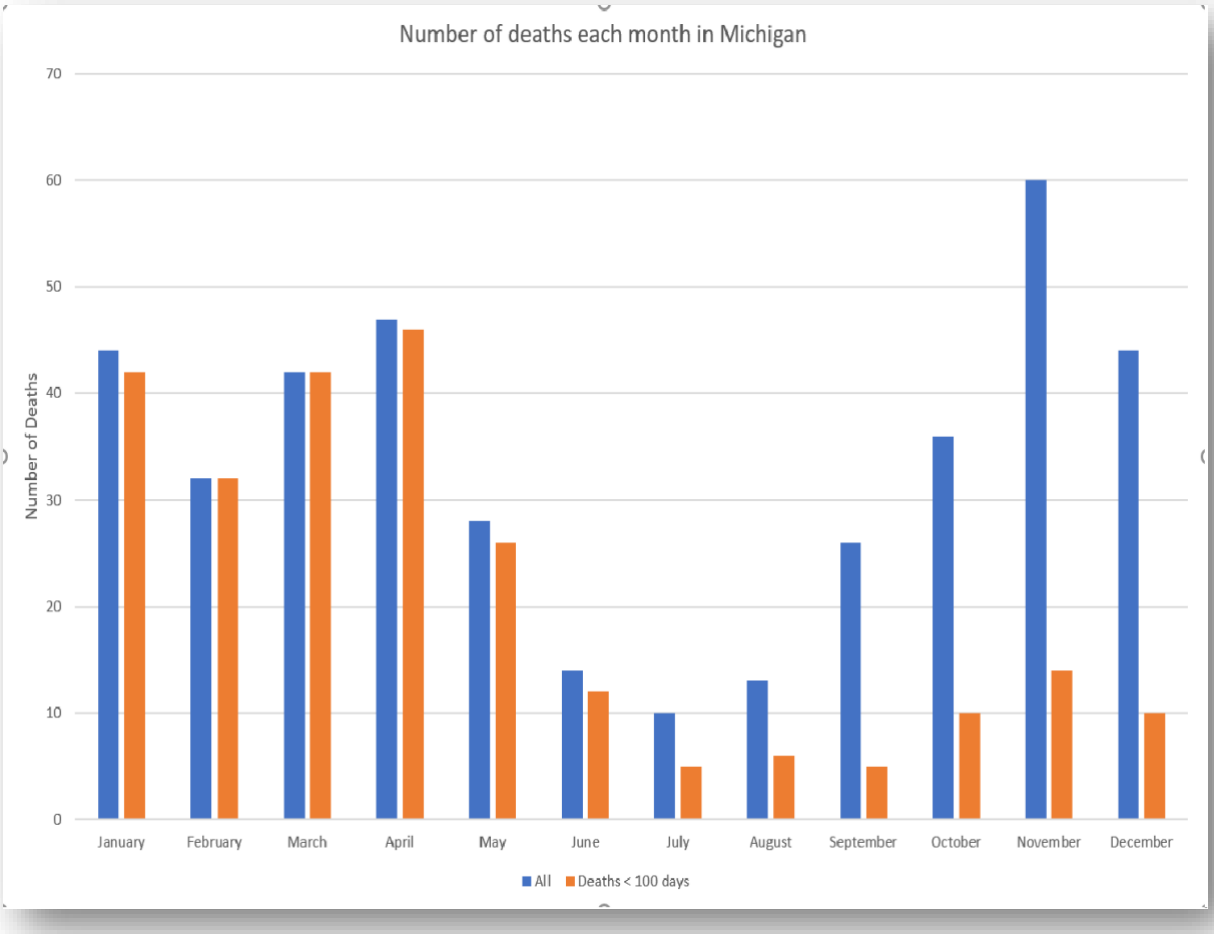
Texas

Here is the VAERS data for Texas - showing the number of deaths each month (blue). The orange columns show number of deaths each month when date of death is less than 100 days after vaccination. When we remove all deaths greater than 100 days after vaccination, the peak in Q3 disappears completely - showing that the Q3 peak is comprised entirely of the effects of vaccines given in Q1 and Q2 - the delayed effect. Once again the delayed effect accounts for 80+% of the Q3 peak



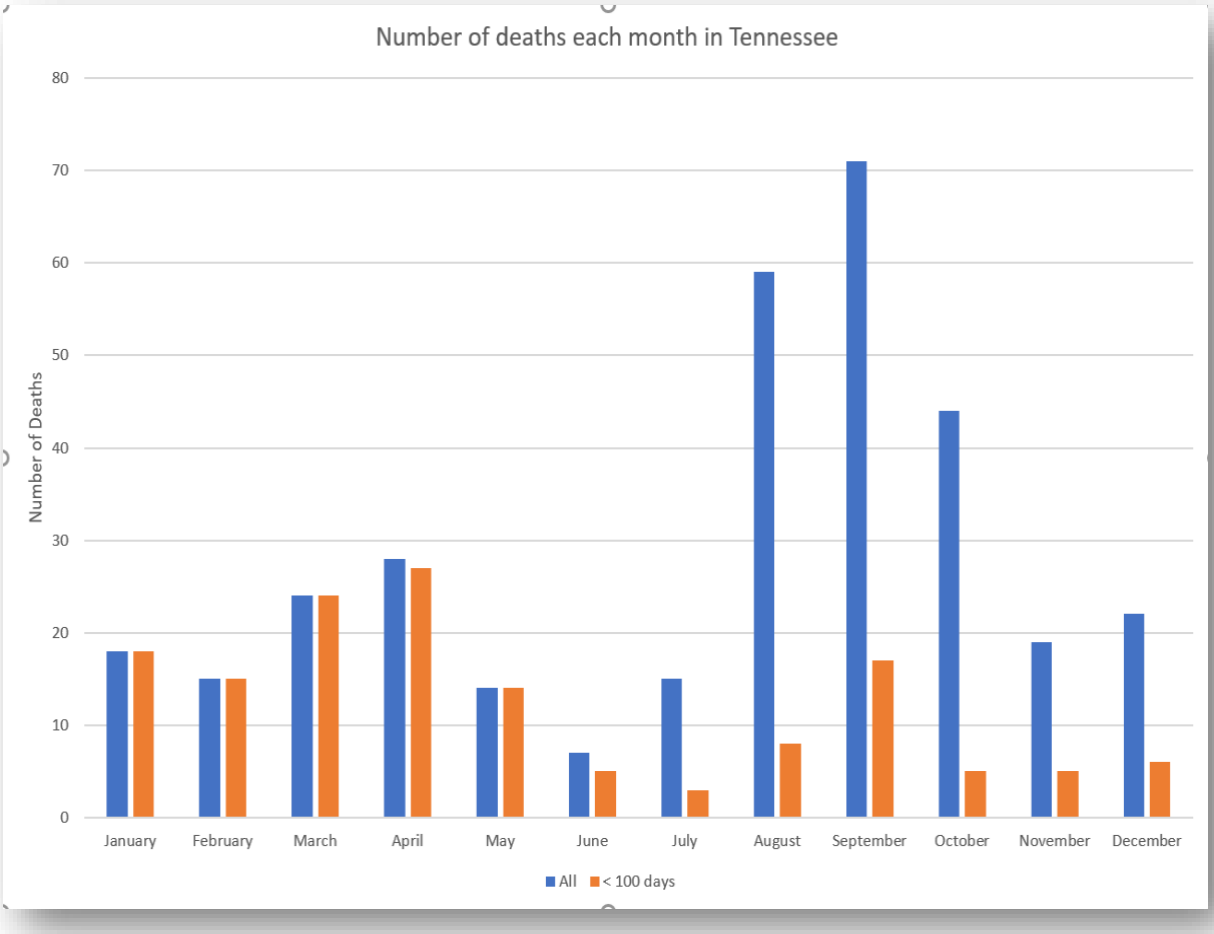
Michigan

Here is the graph for Michigan. Notice that the third quarter peak (Q3) is once again comprised mostly of the delayed deaths resulting from vaccines given in Q2 and Q1.



Tennessee

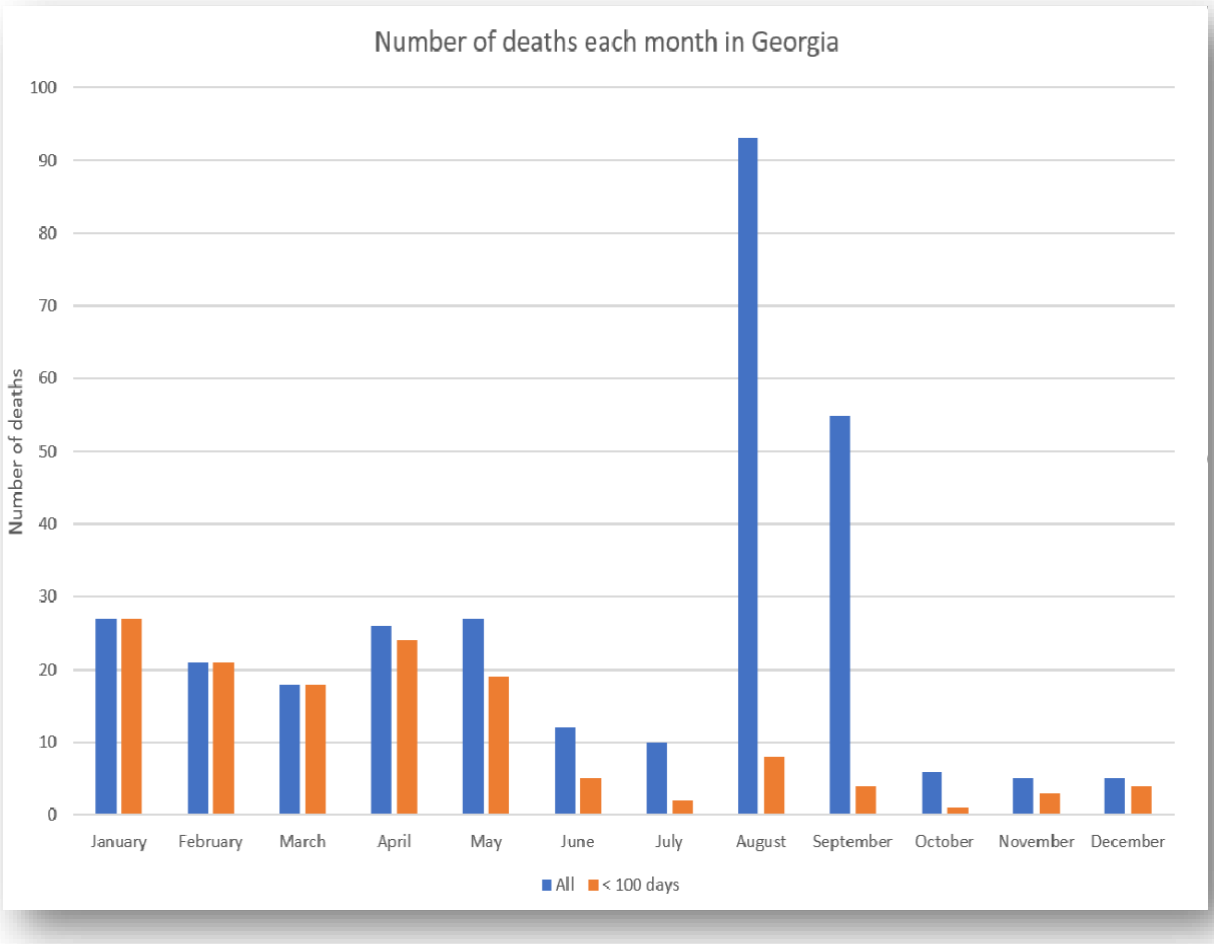
Here is the graph for Tennessee. Notice that the third quarter peak (Q3) is once again comprised mostly of the delayed deaths resulting from vaccines given in Q2 and Q1.



Georgia

Here is the graph for Georgia. Notice that the third quarter peak (Q3) is once again comprised mostly of the delayed deaths resulting from vaccines given in Q2 and Q1. Georgia demonstrates the most pronounced effect.

(Georgia is also renowned for its monument, an inscribed monolith describing a worldwide depopulation)

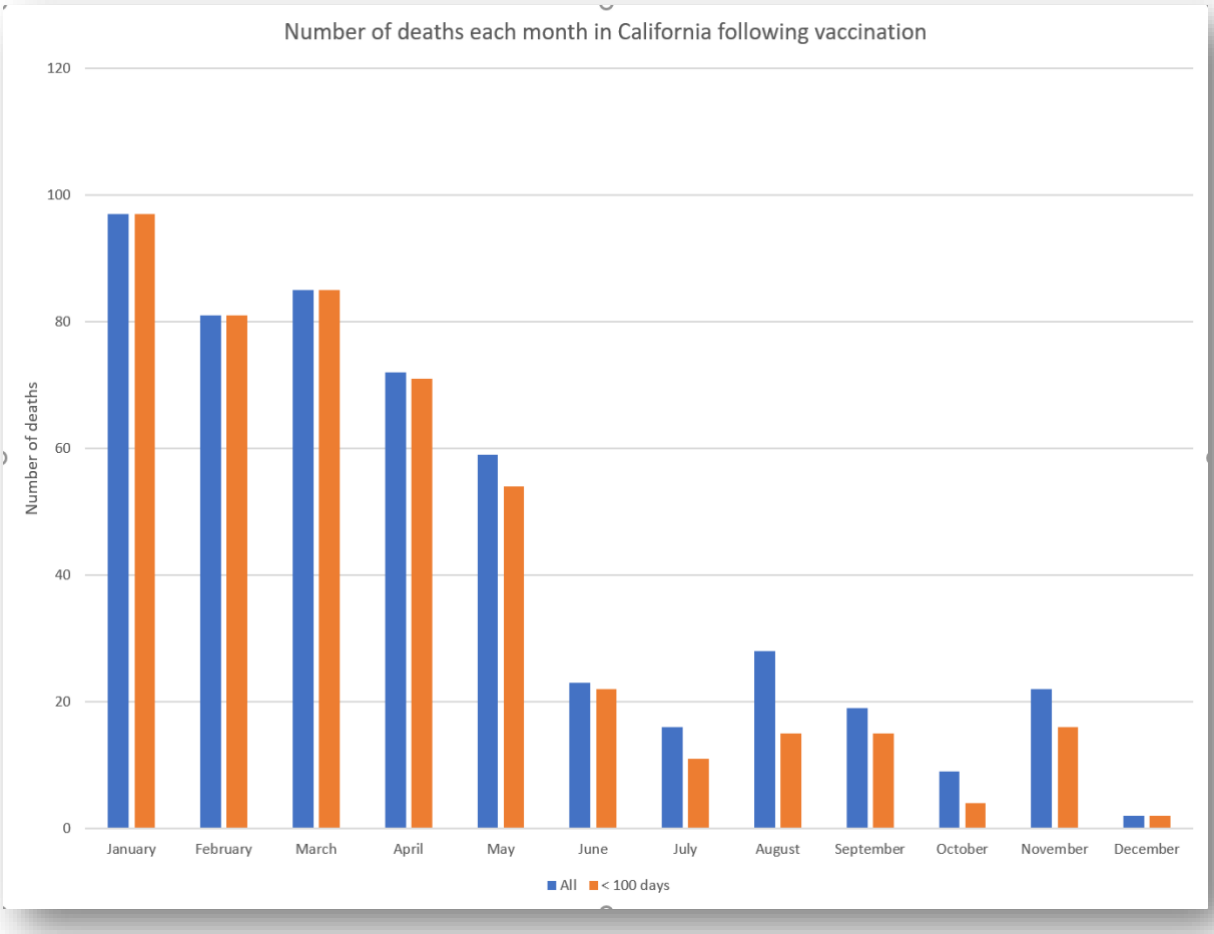


Does this pattern hold for all States?

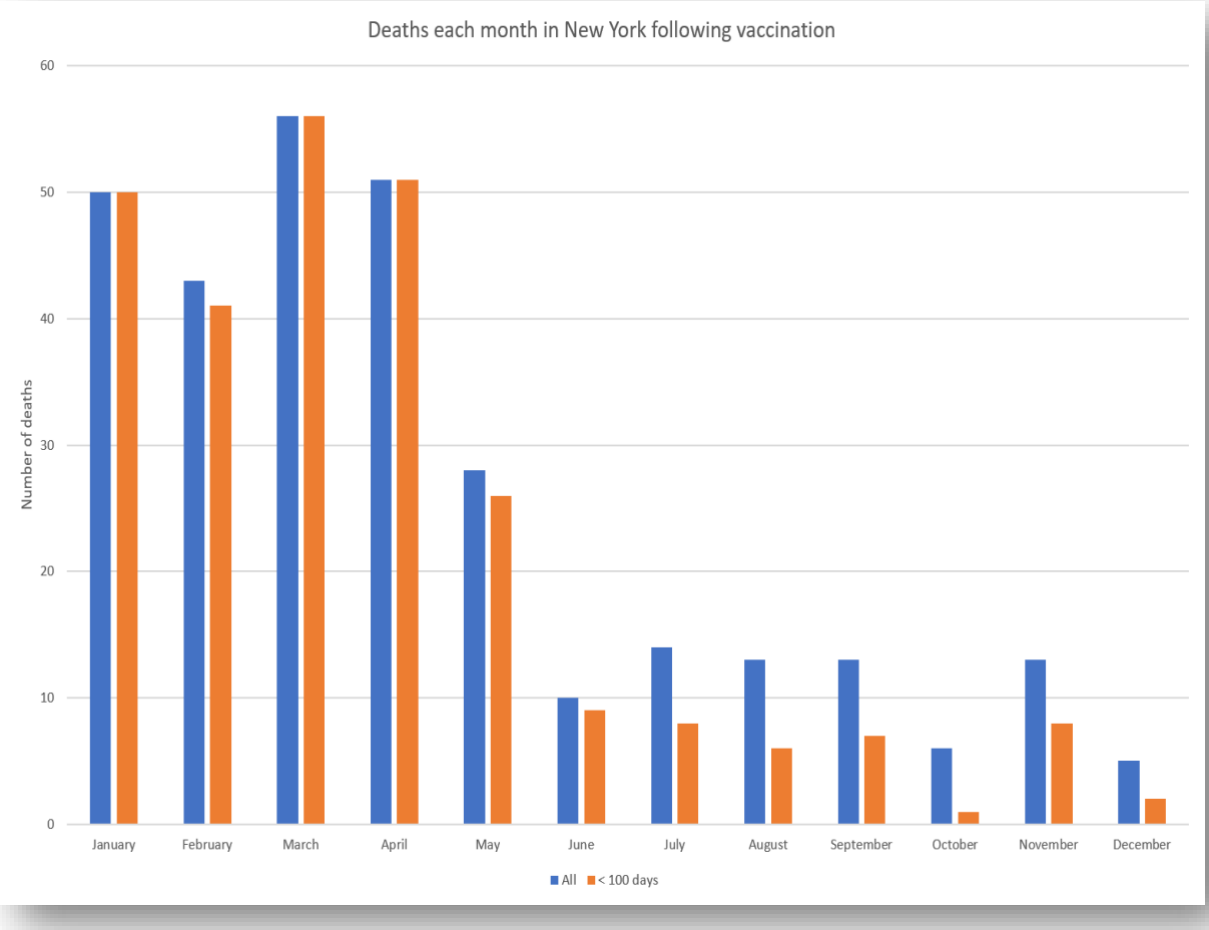
The explosion of mortality in Q3 is confined to select states - Michigan, Tennessee, Texas, Kentucky, Georgia, Florida and Ohio. These are all mainly in the South East of the USA. What's more, this mortality explosion is confined to people of working age. Other states such as New York, California and Pennsylvania, do not show this explosion of mortality.

It is incredible that many states do not show this delayed effect - the only explanation I can think of is that the vaccines may have been adulterated to test this delayed effect in select states, and on a younger age range.

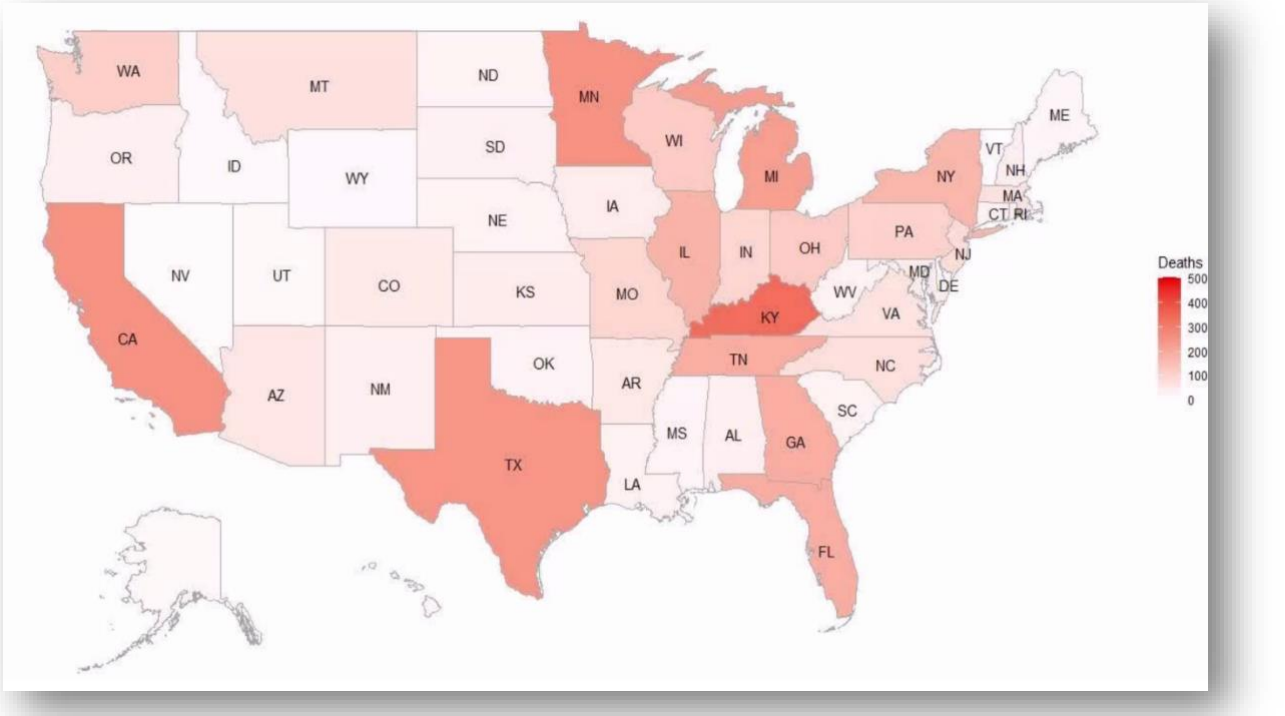
For example, here are the results for California - there is barely any second peak. Considering that California has the highest number of vaccinated, this is remarkable. The sharp distinction between the California result and the results for the states above suggests that the delayed effect may be produced by an adulteration



And here are the results for New York



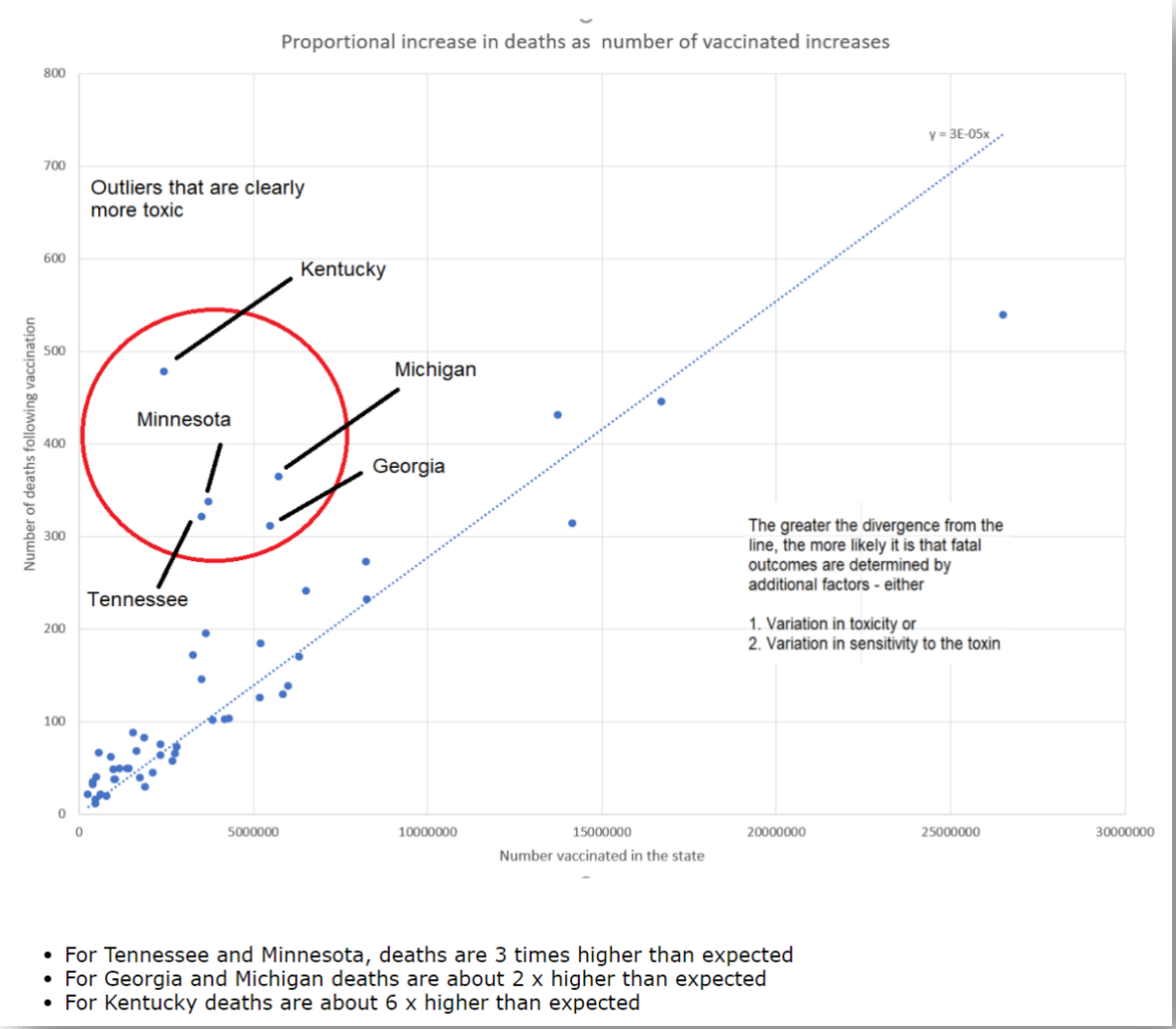
Almost all of the states in the USA showing high deaths following vaccination, just happen to be the same states where the delayed death phenomenon has been found. Notice that Kentucky (KY), Michigan (MI), Minnesota (MN), Tennessee (TN), Georgia (GA), Florida (FL), and Texas (TX) have a dark shade.



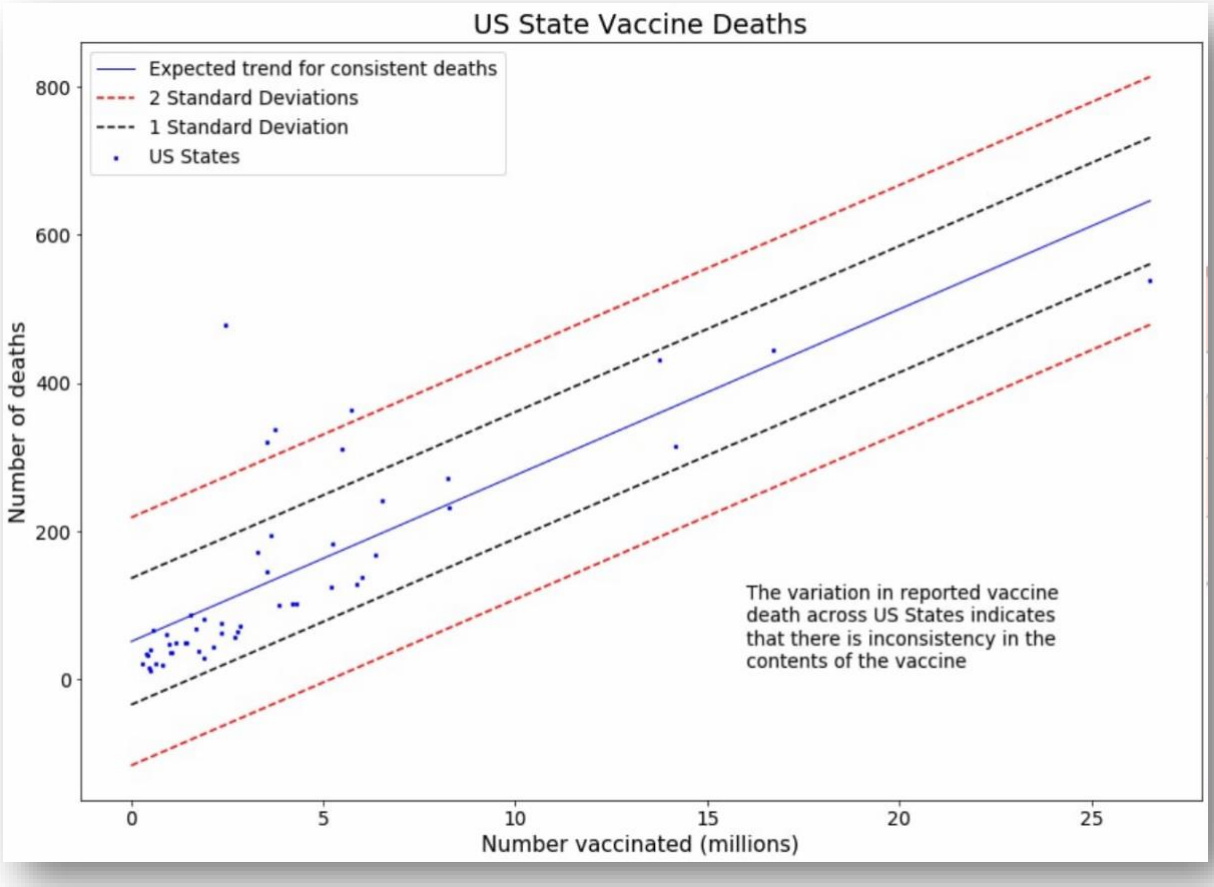
"I started looking at this, and I am finding that the 7 states that we have identified have 3 times more late deaths (onset after 120 days) vs the rest of the US. The lots responsible are mostly Pfizer EN, EM, EL, ER series." Alexandra Latypova

Excess Deaths in States of KY, MI, MN, GA, TN

We had noticed excess deaths in these states a few months back, but did not know the cause.

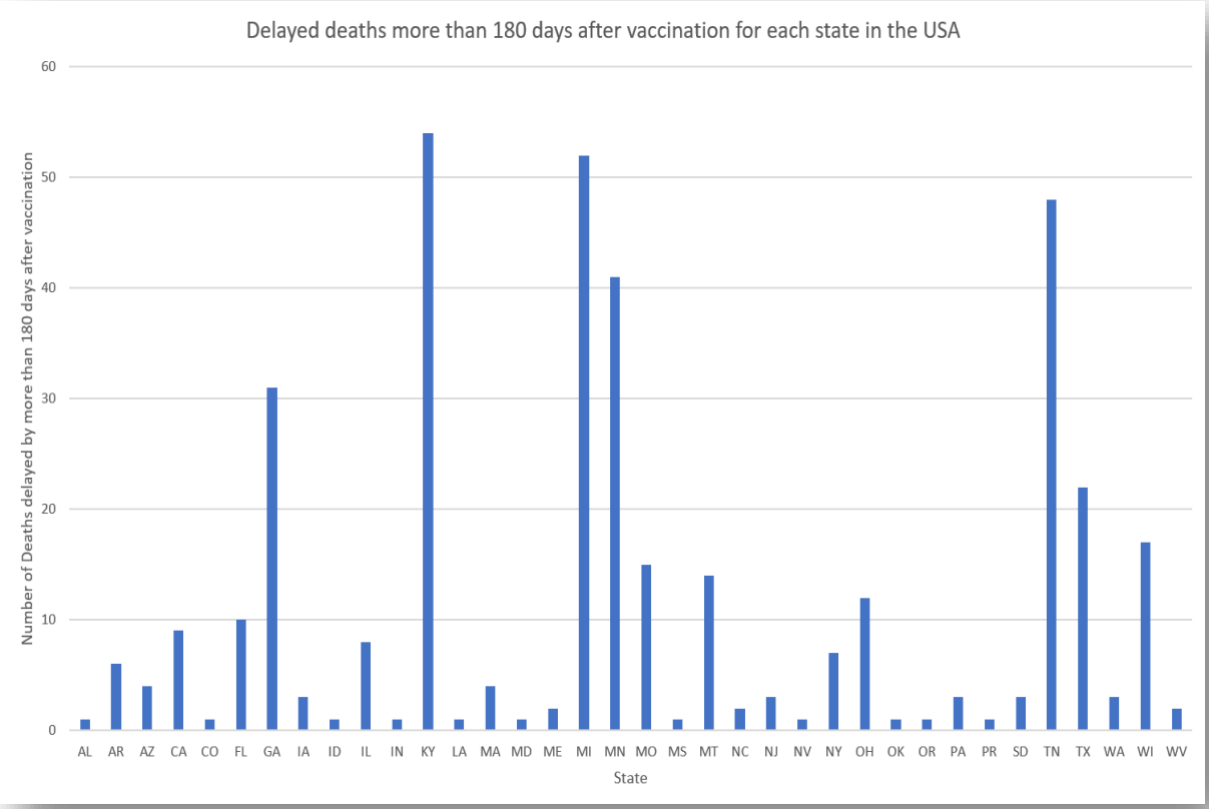


If you want the statistical calculations for these outliers, then we have found that deaths for Kentucky is more than 4 standard deviations from the mean - which means that it is way higher than expected. And Michigan, Minnesota and Tennessee all lie outside of the 95% confidence interval.

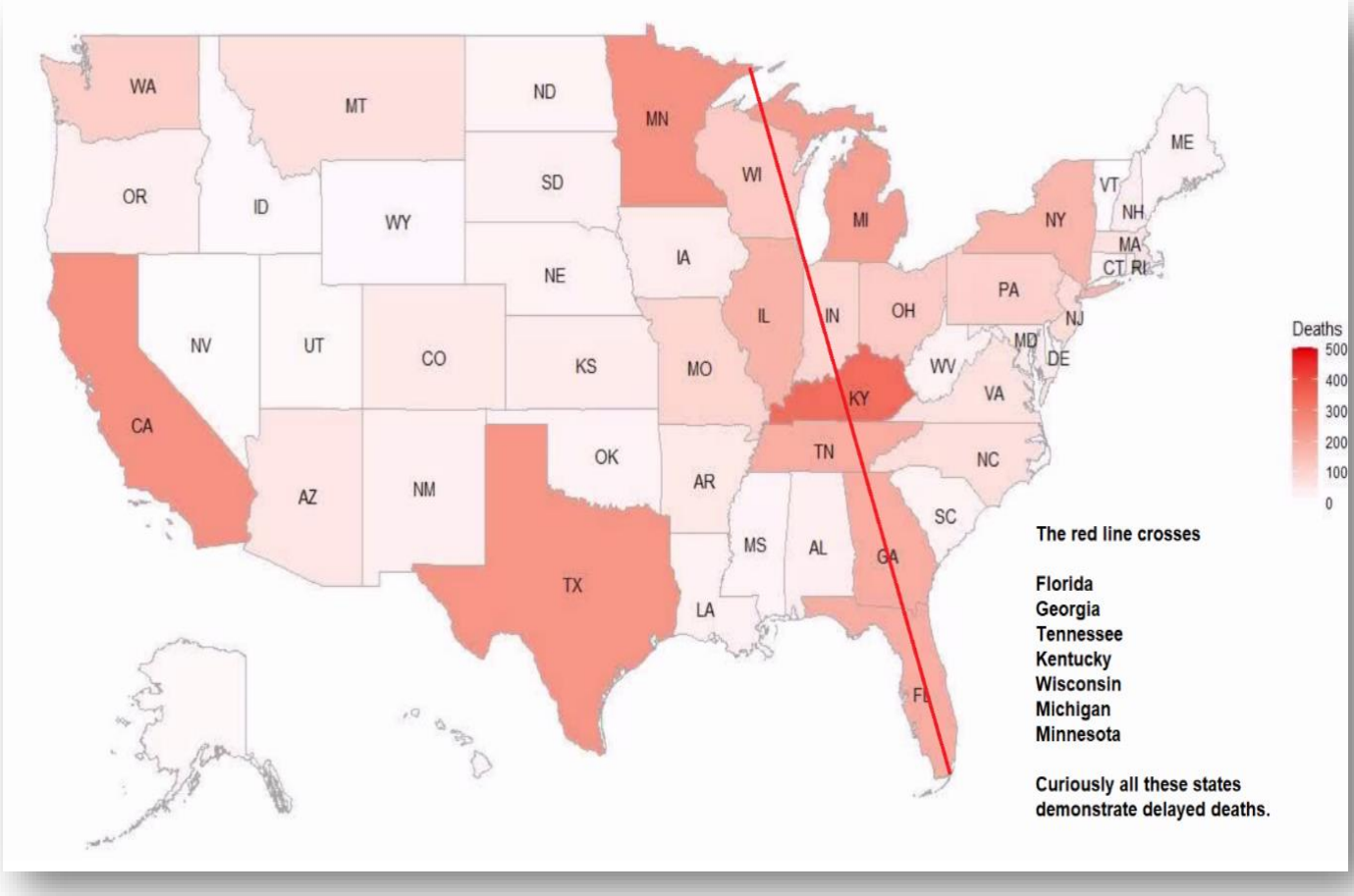

US State Vaccine Deaths
Expected trend for consistent deaths
2 Standard Deviations
1 Standard Deviation
US States
Number of deaths
800
600
400
200
0
0
5
10
15
20
25
Number vaccinated (millions)
The variation in reported vaccine death across US States indicates that there is inconsistency in the contents of the vaccine

The States with Excess Deaths are the States with Delayed Deaths

The chart below shows the absolute number of deaths occurring more than 180 days after vaccination for each state in the USA. (Those states not shown have zero deaths after 180 days). This chart clearly shows that the 5 states with most delayed deaths are the very same 5 states found to have excess deaths in the above chart. Consequently, we can hypothesise that the excess deaths are due to people dying over an extended period of time.



The 5 states with most delayed deaths, KY, TN, GA, MI, and MN, all are located on an axis running in a south-southeast direction, roughly corresponding to Interstate 75 - this must have been the distribution route.



Possible Mechanism

In all of the states showing the second peak effect, deaths persist for much longer after the vaccination date. In fact, the rate of death over time is a straight line. This suggests that the active ingredient is not diminished over time.

In comparison, in all the states not showing this effect, deaths decrease exponentially from the time of vaccination - suggesting that the active ingredient is diminishing in quantity as time passes

If the concentration of the active ingredient does not diminish over time then either it is not being broken down and excreted, or it is being replaced at the rate at which it is excreted

In pharma terms we would say they have either extended the half life of the drug, or found a way to make the body generate more of it

Self-Amplifying RNA

The use of **self-amplifying mRNA** would account for the greater persistence of the toxin. Back in November 2020, BionTech published a report.

BionTech Report : see p 10

In this report they mention that 3 different platforms are under development by BioNTech -

- *non-modified uridine containing mRNA (uRNA),*
- *nucleoside-modified mRNA (modRNA) and*
- *self amplifying RNA (saRNA)*

Self-amplifying RNA causes the body to manufacture more of the RNA - it reproduces itself - consequently the toxic spike protein is replenished and remains in the body far longer.

So, on the very eve of release of the vaccine in November 2020, they were working on these 3 platforms - some of the vaccines would be uRNA, some would be modRNA, and some would be saRNA.

- Nucleoside-modified RNA (modRNA), is so modified to evade the innate immune system, by replacing uridine with pseudo-uridine - something which renders the foreign mRNA invisible to our natural defences.
- Self-amplifying RNA (saRNA) turns the body into a factory for yet more mRNA, causing the body to generate the toxic spike protein over a longer period. Those states unlucky enough to get the saRNA would experience prolonged exposure to the toxin, and consequently an elevated number of deaths.

So you can see, just from this alone, that not all vaccines are equal - there are at least 3 types developed. One can evade your defences, and the other can reproduce itself, so even if some are caught by your defences they are simply replaced by more. You can think of these 3 types of vaccines as 3 different soldiers - the second soldier is invisible to your defences, and the third can clone or multiply itself. It is immediately obvious that these 3 types of vaccine will result very different levels of fatality.

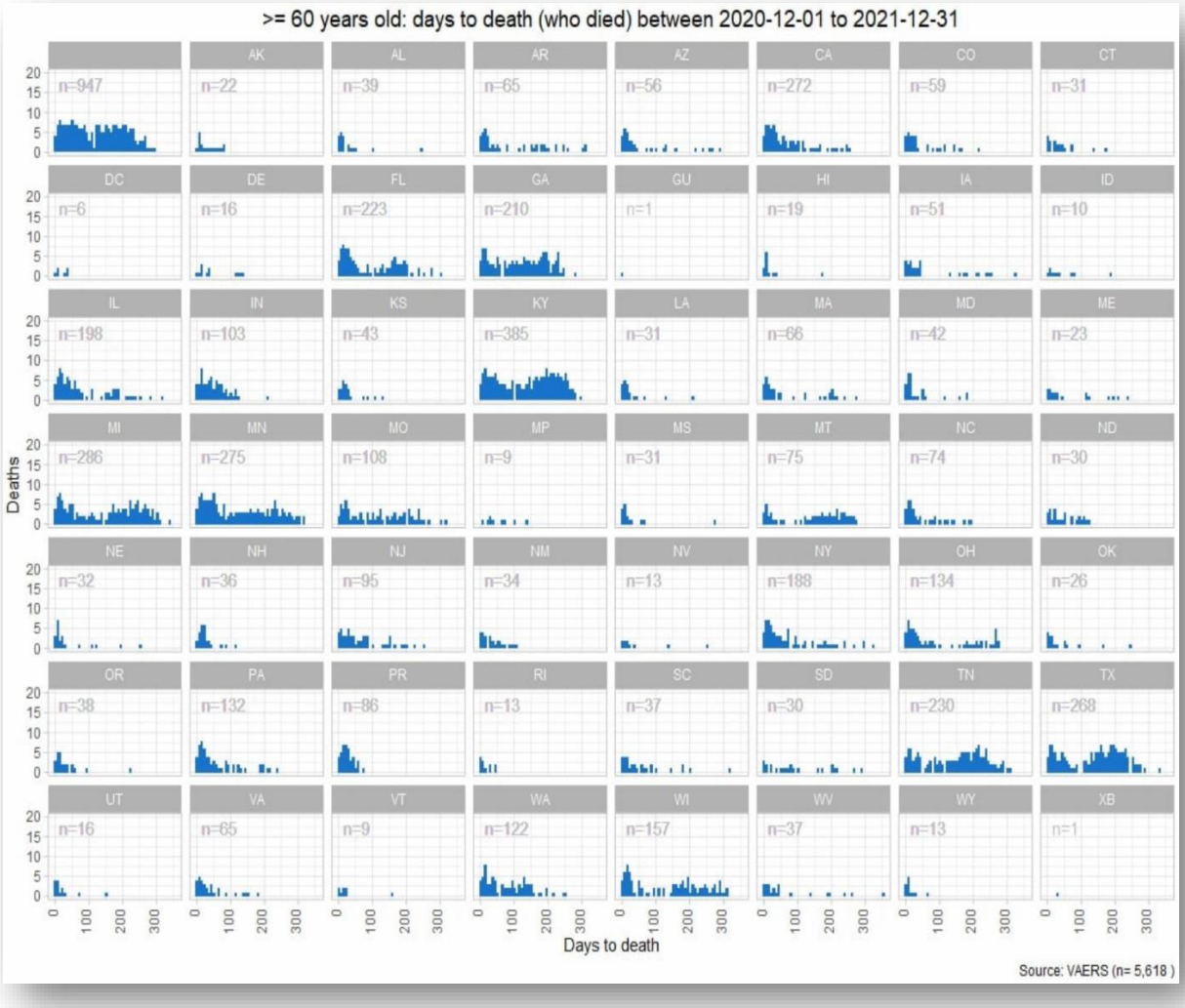
See Self Amplifying RNA

In some states the absolute number of cases of disability following vaccination is very high. For example California has had 1344 cases.

Curiously, in the District of Columbia the vaccine kills younger people than in other states, and also causes more disabilities amongst younger people

Graphs Showing Degree of Delayed Deaths in Each State

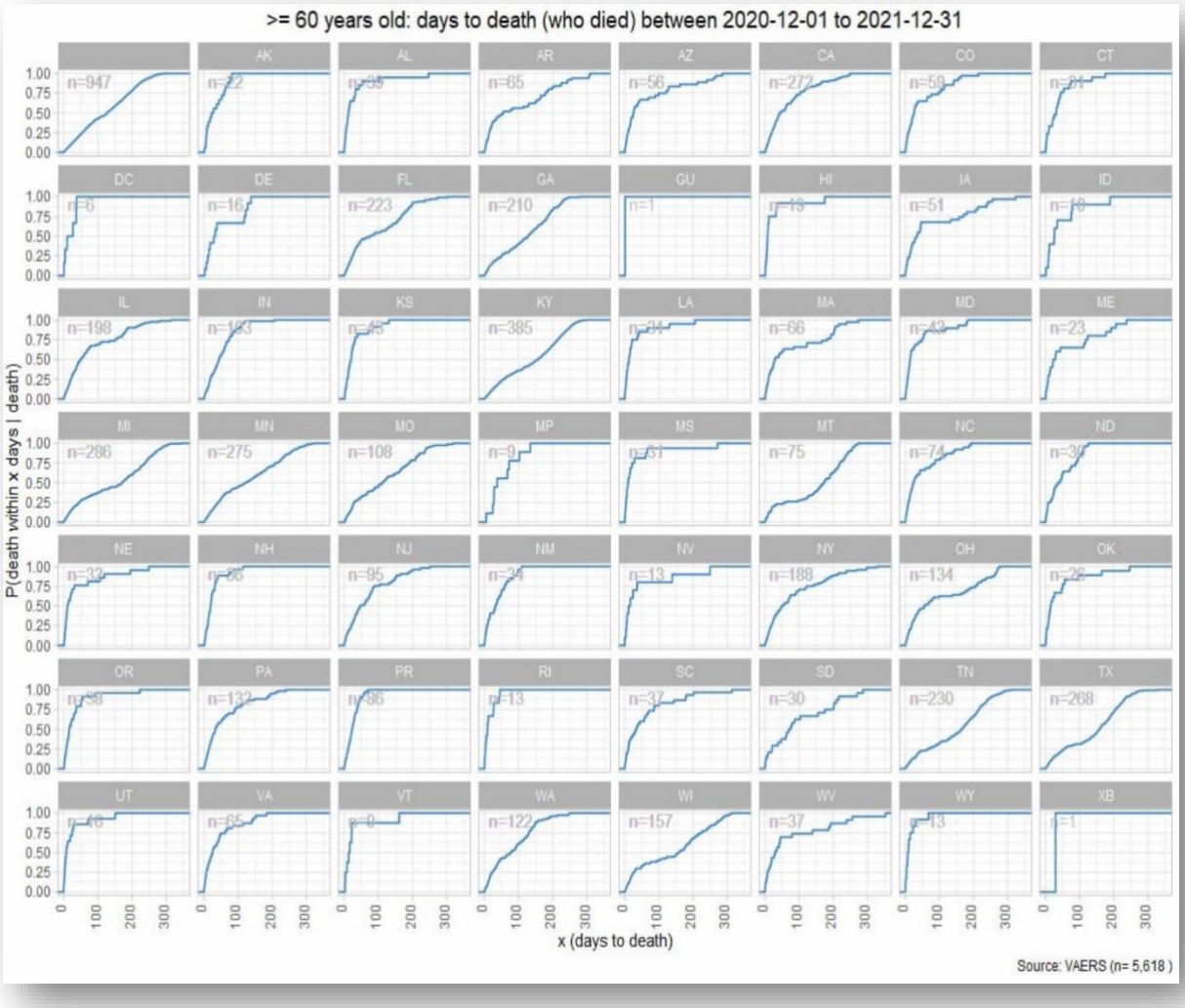
In the graphs below, you can clearly see all the states where deaths persist over a much longer time following vaccination. These are the very ones where the second peak is so large and is made up of delayed deaths. The horizontal axis is number of days since vaccination, and the vertical axis is number of deaths.



Graphs Showing Rate of Death in Each State

In the graphs below, the horizontal axis is days since vaccination. The vertical axis is % of total number of deaths. The states with delayed death have a profile that approximates to a straight line, indicating that the rate of deaths is constant over a longer time. In contrast, states not showing a second peak of delayed deaths have profiles that rise rapidly then flatten out - indicating that most of their deaths occur immediately after vaccination, then peter out..

It is hard to believe that the same vaccine would have such different effects across different states.



How Did They Die?

What we need to do now is look at the way the people died in the second peak. This will provide more clues as to the mechanism.

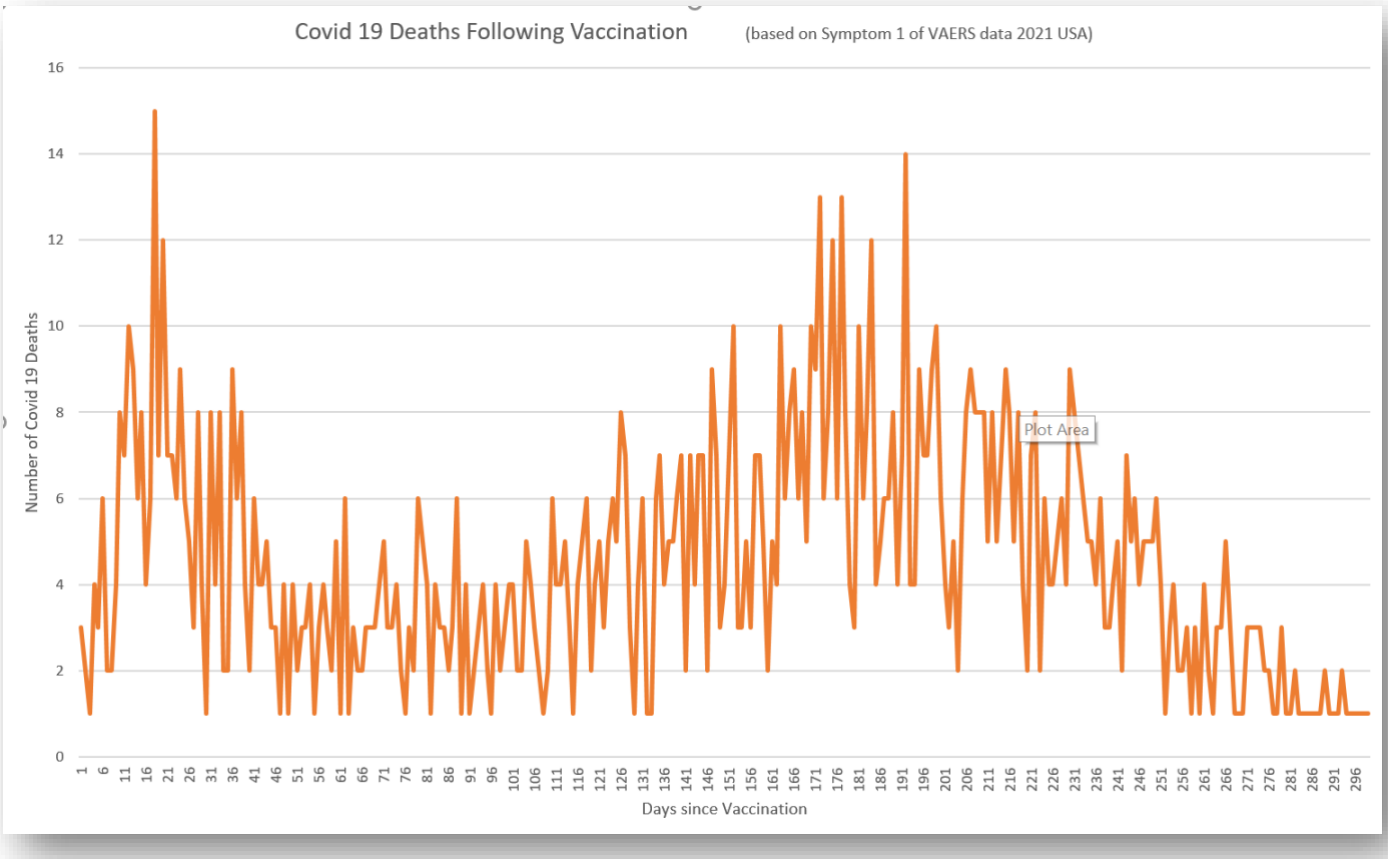
In order to determine this, I took all the records for VAERS USA for 2021, and looked at deaths more than 100 days after vaccination. I used the 5 symptoms columns from the VAERS symptoms table, and counted the frequency of each symptom. In this way I was able to get a list of the most frequently occurring symptoms accompanying the delayed death phenomenon. Here are the results -

Symptom 1	Freq	Symptom 2	Freq	Symptom 3	Freq	Symptom 4	Freq	Symptom 5	Freq
COVID-19	878	COVID-19	256	SARS-CoV-2 test positive	211	SARS-CoV-2 test positive	100	Dyspnoea	89
Acute respiratory failure	177	COVID-19 pneumonia	118	COVID-19	140	Dyspnoea	88	SARS-CoV-2 test positive	76
Acute kidney injury	135	Asthenia	59	Dyspnoea	92	Vaccine breakthrough infe	64	Cough	45
Asthenia	95	Cough	58	COVID-19 pneumonia	84	Cough	63	Endotracheal intubation	39
COVID-19 pneumonia	47	Acute respiratory failure	54	Cough	70	COVID-19 pneumonia	57	COVID-19	29
Acute respiratory distress syn	38	Dyspnoea	44	Vaccine breakthrough infec	45	COVID-19	54	Hypoxia	28
Abdominal pain	35	Cardiac arrest	33	Chest X-ray abnormal	29	Endotracheal intubation	39	General physical health det	27
Cardiac arrest	28	SARS-CoV-2 test positive	31	Cardiac arrest	22	Chest X-ray abnormal	25	COVID-19 pneumonia	23
Acute myocardial infarction	24	Condition aggravated	30	Endotracheal intubation	22	General physical health d	21	Fatigue	23
Anticoagulant therapy	21	Atrial fibrillation	29	Pneumonia	21	Condition aggravated	20	Chest X-ray abnormal	21
Atrial fibrillation	18	Chest X-ray abnormal	23	Atrial fibrillation	19	Hypoxia	17	Decreased appetite	15
Cerebrovascular accident	18	Anticoagulant therapy	18	Chills	18	Confusional state	16	Intensive care	15
Cough	15	Confusional state	16	Hypoxia	18	Cardiac arrest	14	Pyrexia	14
Acidosis	11	Chest pain	13	Malaise	18	Respiratory failure	14	Condition aggravated	13
Agitation	11	Pneumonia	13	Anticoagulant therapy	17	Diarrhoea	13	Mechanical ventilation	13
Anaemia	11	Chills	11	Condition aggravated	17	Fatigue	13	Diarrhoea	10
Autopsy	11	Cardio-respiratory arrest	10	Asthenia	16	Intensive care	12	Oxygen saturation decreas	10
Chest X-ray	11	Acute myocardial infarction	9	Confusional state	15	Cardio-respiratory arrest	11	Pneumonia	9
Blood test	10	Angiogram pulmonary abnc	9	Cardio-respiratory arrest	14	Pneumonia	11	Vaccine breakthrough infec	9
Ageusia	9	Chest X-ray	9	Respiratory failure	13	Pyrexia	10	Fall	8
Asymptomatic COVID-19	8	Acute respiratory distress sy	8	Chest pain	12	Anticoagulant therapy	8	Laboratory test	8
Aphasia	7	Bilevel positive airway press	8	Diarrhoea	12	Chest pain	8	Nausea	8
Arthralgia	7	Cardiac failure congestive	8	Laboratory test	12	Computerised tomogram	8	Cardio-respiratory arrest	7
Cardiac failure	7	Vaccine breakthrough infect	8	Acute respiratory failure	10	Cerebrovascular accident	7	Chills	7
Cerebral haemorrhage	7	Acute kidney injury	7	Fatigue	9	Mental status changes	7	Anticoagulant therapy	6
Condition aggravated	7	Bradycardia	7	General physical health det	9	Asthenia	6	Cardiac arrest	6
Abdominal distension	6	Cerebrovascular accident	7	Cerebrovascular accident	8	Blood creatinine increase	6	Delirium	6
Atelectasis	6	Diarrhoea	7	Decreased appetite	8	Chills	6	Positive airway pressure th	6
Bilevel positive airway pressu	6	Intensive care	7	Intensive care	8	Decreased appetite	6	Asthenia	5
Bradycardia	6	Ageusia	6	SARS-CoV-2 test	8	Dementia	6	Atrial fibrillation	5
Chest pain	6	Agitation	6	Chronic obstructive pulmoi	7	Fall	6	Chest tube insertion	5
Angiogram pulmonary abnorı	5	Anosmia	6	Computerised tomogram	7	Lethargy	6	Lung opacity	5
Anxiety	5	Blood culture positive	6	Fall	7	Malaise	6	Mental status changes	5
Back pain	5	Chronic obstructive pulmon	6	Pyrexia	7	Positive airway pressure t	6	Respiratory failure	5
Cardiac failure congestive	5	Endotracheal intubation	6	Back pain	6	Atelectasis	5	Sepsis	5
Abdominal pain upper	4	Laboratory test	6	Bilevel positive airway pres	6	Chest X-ray	5	Blood lactic acid	4
Activated partial thromboplas	4	SARS-CoV-2 test	6	Chemotherapy	6	Computerised tomogram	5	Cardiac failure	4
Agonal respiration	4	Abdominal pain	5	Mechanical ventilation	6	Encephalopathy	5	Cellulitis	4
Amnesia	4	Back pain	5	Cardiac failure congestive	5	Hypotension	5	Computerised tomogram th	4
Angiogram abnormal	4	Blood creatinine increased	5	Exposure to SARS-CoV-2	5	Mechanical ventilation	5	Deep vein thrombosis	4

As you can see, COVID-19 is listed as the most frequently occurring symptom - which is odd - considering that the vaccine is supposed to protect people from infection.....a case of vaccine failure. However, it is not so odd when we consider that both the virus and the vaccine produce the spike protein, so both generate similar symptoms. The dominant symptoms are like COVID-19, loss of energy, difficulty breathing, kidney failure and heart attack.

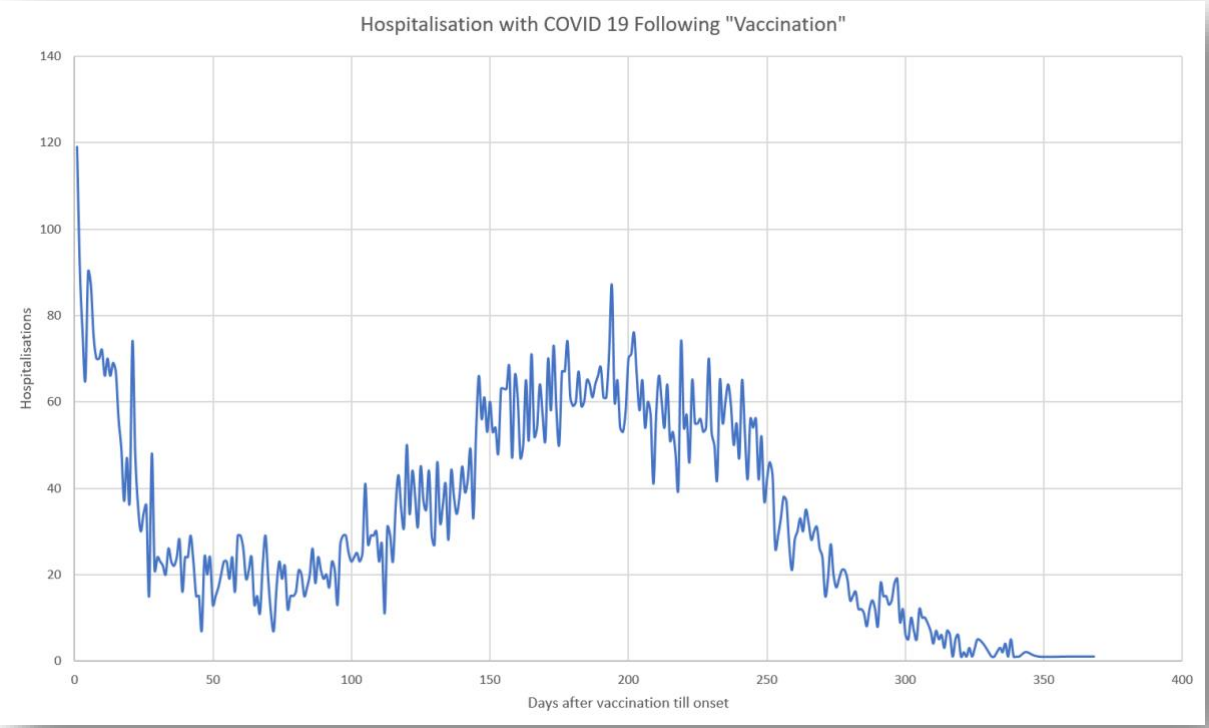
Here is the distribution of COVID 19 deaths for all States and all ages following vaccination -

Y



You can see an initial peak immediately after vaccination, and a second peak about 180 days after vaccination/

And here is the distribution of COVID 19 hospitalisations for all States and all ages following vaccination. To get this data I took VAERS for 2021 USA and filtered for all records where hospitalisation = Y and where Symptom 1, 2, 3, 4 or 5 = COVID 19.



What is interesting is that there appears to be an initial incidence of COVID 19-like symptoms immediately following the vaccine - these symptoms being severe enough to require hospitalisation. These symptoms then drop off exponentially during the subsequent 30 days after vaccination. There then follows a gradual build-up of COVID 19 like symptoms over the next 5 months. This reaches a peak at 6 months post vaccination.

[My interpretation of the shape of this graph is that initially at the time of the vaccination there are intense adverse effects, which drop off exponentially for each day post vaccination. During this phase, metabolism and excretion of the toxin is dominant. However, at about 100 days post vax, the self-amplification of the vaccine becomes dominant over excretion, and there is a resultant rise in symptoms]

It should be stressed that VAERS is only a small sample of the actual incidence of these events. The real incidence is about 40 times greater - so about 40 x 60 = 2400 hospitalisations each day at the peak. Since the peak level persists for 100 days, therefore a total of approximately 2,400 x 100 = 240,000 USA citizens were effected.

Since both the virus (COVID 19) and the vaccine generate spike proteins, and since the spike proteins are largely responsible for the symptoms, it follows that the vaccine will have similar symptoms to COVID 19. So the distribution of hospitalisation shown in this graph is most likely the result of the proliferation of spike proteins produced by the vaccine, which mimics the effects of COVID 19.

An alternative explanation would be that the second peak is caused by immune suppression. If this is the case then we would expect that -

- other viral and bacterial infections should also peak at the same time. Illnesses such as pneumonia, influenza, herpes, sepsis,etc
- there should be evidence of immune suppression such as lower counts of immune cells, inhibition of DNA repair etc

PDF : Symptoms Associated with Immediate vs Delayed Deaths

Are any particular lots responsible for the delayed death effect?

In order to answer this, I compared Kentucky with California, and looked at the Pfizer batch series beginning with "EN62".

- Kentucky has 375 records where batch begins with EN62 - 30 deaths (8% of records) - 23 of those deaths were more than 100 days post vaccination (6% of records)
- California has 1883 records where batch begins with EN62 - 18 deaths (1% of records) - 1 of those deaths was more than 100 days post vaccination (0.05% of records)
- Kentucky has 375 records where batch begins with EN62 - 97 involve hospitalisations (26% of records), and 59 of these hospitalisations are more than 100 days post vaccination (16% of records)
- California has 1883 records where batch begins with EN62 - 112 involve hospitalisations (6% of records), and 17 of these hospitalisations are more than 100 days post vaccination. (0.9% of records)

So you can see that the same batches were administered to both states, but it appears that the Kentucky batches were adulterated to generate -

- 8 x the number of deaths per record
- 120 x the number of delayed deaths per record.
- 4 x the number of hospitalisations per record
- 7 x the number of delayed hospitalisations per record

The batches were labelled the same - with the same code, yet the ones reaching Kentucky were adulterated, and the ones reaching California were not.

When did this adulteration take place

Most of the delayed deaths have been found to be associated with EL, EM and EN Pfizer series. This enables us to determine the time of deployment - Dec 2020, Jan 2021, Feb 2021. So in early 2021 EL, EM and EN batches distributed to Kentucky were adulterated, whilst the same batches distributed to California were not. Adulteration could have taken place in the manufacturing plant, if the ingredients were kept secret from the workers (which they were - see Whistle-blowers), and if a vaccine was available with extended activity (which was - BNT162c, a self-amplifying vaccine, was available to replace BNT162b for the Kentucky run).

It is likely that Interstate 75 was used as the distribution route, since Georgia, Tennessee, Kentucky and Michigan are located on this route, and Minnesota is adjacent.

The Mortality Bomb

I use the phrase "mortality bomb" to describe a biologically active ingredient that produces a delayed death 6 months after exposure. It describes a situation where there is an "explosion" of deaths - larger than any preceding levels.

It is worth bearing in mind that the delayed effect, apparent in these south eastern states, could have been a trial run. It was carried out in a small number of select states, and probably on a small number of people. Now that they know it works, it can be used on far larger populations - possibly as a means of significant depopulation.

VIDEO : Mortality Bomb

The Georgia Guidestone

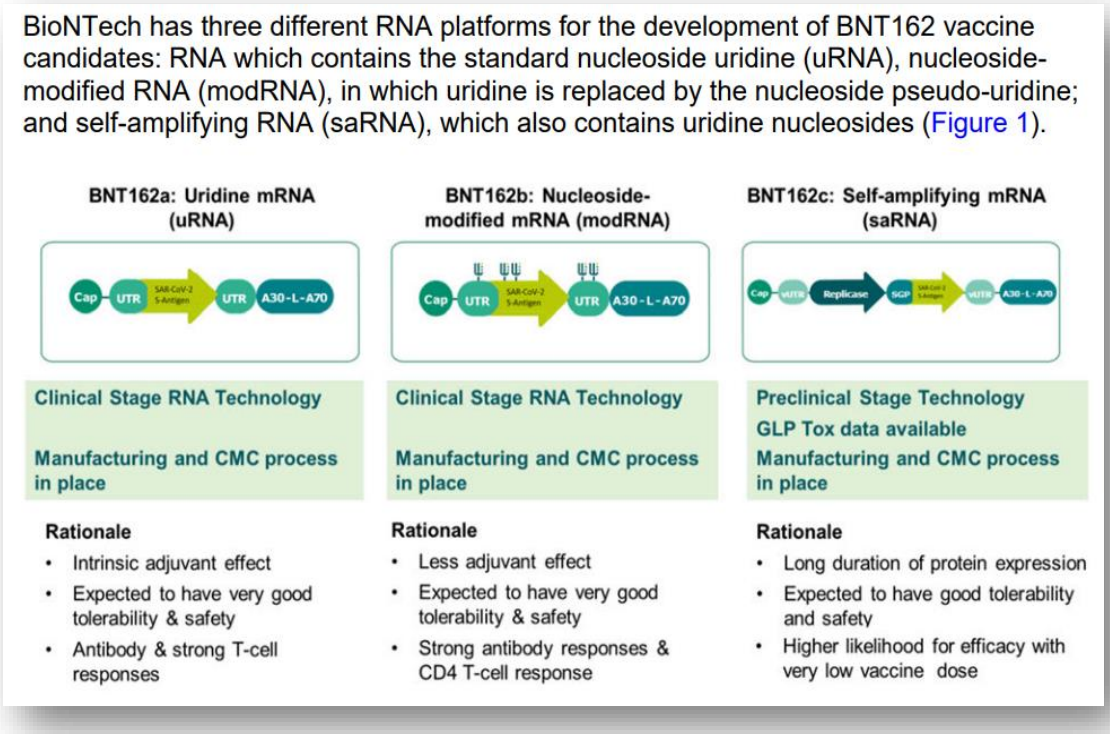
The Georgia Guidestone is an obelisk inscribed in 8 different languages and was erected on 22nd March 1980, 40 years before the first lockdowns. It purports to prophecy a coming decimation of the worlds population. It is curious that this location (Georgia) should form part of a south eastern axis running from Florida through Georgia, then Tennessee, then Kentucky, then Wisconsin, Michigan and Minnesota - all of these states demonstrating delayed deaths and therefore probable deployment of self-amplifying "vaccine".

Self-Amplifying RNA

In August 2020, BioNTech published an Investigator's brochure - BioNTech August 2020 - see p 13 - in which they describe the development of 3 different vaccine platforms labelled a, b and c -

- BNT162a : Uridine mRNA
- BNT162b : Nucleoside modified mRNA
- BNT162c : Self-amplifying mRNA

BNT162c is noted for having a ***"long duration of protein expression"***



In November 2020, BioNTech published a report.

BioNTech November 2020 : see p 10

In this report they mention that 3 different platforms are under development by BioNTech -

- *non-modified uridine containing mRNA (uRNA),*
- *nucleoside-modified mRNA (modRNA) and*
- *self amplifying RNA (saRNA)*

3 INTRODUCTION

3.1 Background

In December 2019, an outbreak of pneumonia of unknown cause in Wuhan, Hubei province in China started. The disease spread rapidly and in January 2020, the agent was identified. By 1 April 2020, infection with the novel coronavirus (SARS-CoV-2) was confirmed in approximately 820,000 people with more than 40,000 casualties[1]. A vaccine is urgently needed and BioNTech decided to develop a rapid vaccine project (BNT162) with the surface or spike protein (S protein) of the virus as the viral antigen.

The development of *in vitro* transcribed RNA as an active platform for the use in infectious disease vaccines is based on the extensive knowledge of the company in RNA technology, which has been gained over the last decade. The core innovation is based on *in vivo* delivery of a pharmacologically optimized, antigen-coding RNA vaccine to induce robust neutralizing Abs and accompanying/concomitant T-cell responses to achieve protective immunization with minimal vaccine doses (Vogel et al. 2017, Moyo et al. 2018, Pardi et al. 2017).

At BioNTech, three different RNA platforms formulated with lipid nanoparticles (LNPs) are under development, namely non-modified uridine-containing mRNA (uRNA), nucleoside-modified mRNA (modRNA) and self-amplifying RNA (saRNA). In the present study, an LNP-formulated modRNA encoding luciferase was used representatively to investigate the *in vivo* biodistribution and the immune response of the vaccine candidates.

LNP formulations from a third party provider (Acuitas) were tested in comparison to the in-house formulation (b) (4) Acuitas (b) (4) (b) (4) (b) (4) Acuitas also provided an LNP formulation that is cGMP-ready, namely LNP8, which contains two proprietary lipids (ALC-0159 and ALC-0315) and has the identical composition as the LNP formulation used in the BNT162 program.

3.2 Objectives

The objective of this study was to investigate the biodistribution of luciferase expressed by the LNP-formulated modRNA using bioluminescence measurements in BALB/c mice, as well as innate immune system activation, formation of antibodies against luciferase and T-cell activation.

[1] Coronavirus disease (COVID-2019) situation report 72, World Health Organization; /www.who.int/emergencies/diseases/novel-coronavirus-2019/situation-reports

There are ongoing clinical trials using self-amplifying COVID 19 "vaccines" with human subjects. One of these trials is with 500 subjects in Germany. This is a phase 2 trial, and its completion date is set for April 2023.. This is the type of vaccine that they plan to release next. Evidence outlined below suggests that they may have already released it on a small scale in 7 states of the USA. It is reasonable to assume that they want to release it on a larger scale soon. This is the next phase.

What are these 3 types of vaccine, and how do they differ in effects ?

1. **Non-modified uridine containing RNA (uRNA) :** RNA consists of a string of letters A C U or G. Where A = adenine, C = Cysteine, U = Uridine and G = Guanine. Non=modified RNA (uRNA) contains these 4 letters. Our innate immune system can detect non-modified RNA and destroy it.

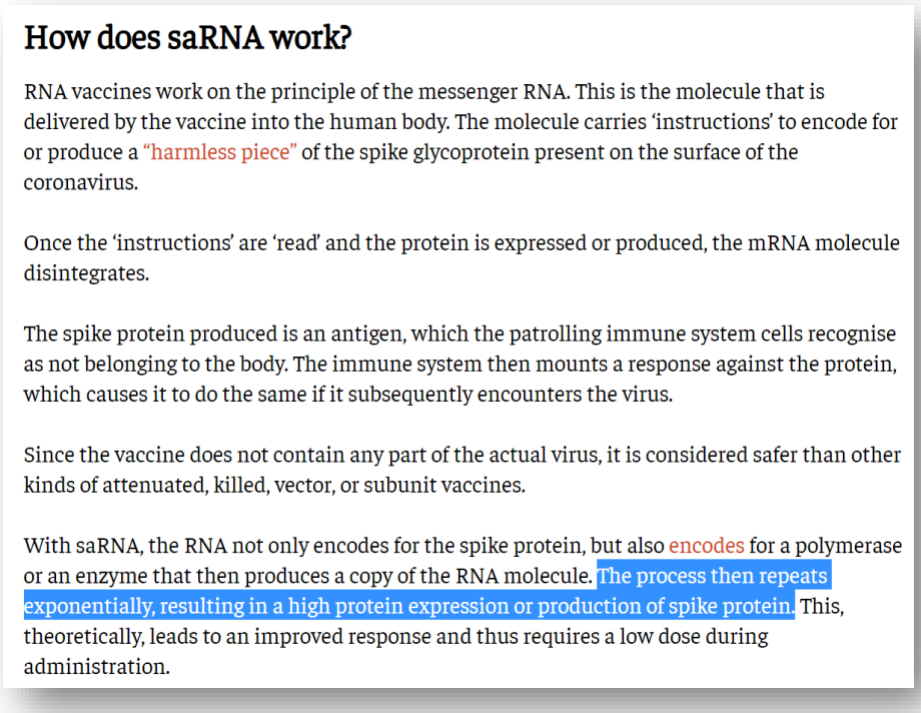
2. **Nucleoside Modified RNA (modRNA) :** In this RNA, the Uridine is replaced with Pseudo-Uridine, so our immune system can nolonger detect it.

3. **Self-amplifying RNA (saRNA) :** Self-amplifying mRNA (saRNA) vaccines are similar to conventional mRNA vaccines, with the exception, that saRNA vaccines also self-replicate their mRNA. The self-amplifying mRNA has two open reading frames. The first open reading frame, like conventional mRNA, codes for the antigen protein of interest. The second open reading frame codes for an RNA-dependent RNA polymerase (and its helper proteins) which self-replicates the mRNA construct in the cell and creates multiple self-copies. Wiki. Self-replicating RNA generates 64 times the amount of antigen (spike) compared to non-amplifying RNA, and as a consequence produces a much stronger immunogenic response - see - Study. Besides producing more antigen, self-amplifying RNA produces antigen over a longer time. See - Study

An exponential increase without limit?

With self-amplifying RNA, the RNA codes for the Spike protein, but also codes for a polymerase that then produces a copy of the RNA molecule. The process then repeats exponentially. But what stops the process? If it is self-amplifying but not self-stopping, then we would expect an unceasing production of spike protein over time, causing continuous and cumulative damage until organ failure results. There does not seem to be any internal control limiting production of the Spike. This would mean that the effect of self-amplifying RNA is equivalent to taking repeated doses indefinitely !

From the manufacturer's point of view BNT162c requires less initial dosage, but due to self-amplification within the body, the eventual amount of circulating spike protein may be much higher than with BNT162b. It undergoes an exponential increase where the circulating spike amount doubles each time - 2 raised to the power n



How does saRNA work?

RNA vaccines work on the principle of the messenger RNA. This is the molecule that is delivered by the vaccine into the human body. The molecule carries 'instructions' to encode for or produce a "harmless piece" of the spike glycoprotein present on the surface of the coronavirus.

Once the 'instructions' are 'read' and the protein is expressed or produced, the mRNA molecule disintegrates.

The spike protein produced is an antigen, which the patrolling immune system cells recognise as not belonging to the body. The immune system then mounts a response against the protein, which causes it to do the same if it subsequently encounters the virus.

Since the vaccine does not contain any part of the actual virus, it is considered safer than other kinds of attenuated, killed, vector, or subunit vaccines.

With saRNA, the RNA not only encodes for the spike protein, but also encodes for a polymerase or an enzyme that then produces a copy of the RNA molecule. The process then repeats exponentially, resulting in a high protein expression or production of spike protein. This, theoretically, leads to an improved response and thus requires a low dose during administration.

This paper - here states that self-amplifying vaccines can replicate for up to 2 months.

Here are 2 videos by Doctors for Covid Ethics -

VIDEO 1 : Self Amplifying Vaccines

VIDEO 2 : Self Amplifying Vaccines

How Much Self Amplifying Vaccine is Necessary to Flood Your Circulation with Spikes?

If each mRNA codes for an antigen + the enzymes necessary to replicate the mRNA 100 times, and then those mRNAs themselves go on to produce 100 antigens + the enzymes necessary to replicate each of the 100 mRNAs 100 times, you can see that the tiniest amount of self-amplifying RNA could flood your circulation with spike proteins. It does not have to be as much as a single injection or even a single drop from that injection. The tiniest amount getting into your system would be effective.

In addition to generating a higher spike load, self-amplifying vaccines may facilitate "shedding". This is because it would only take a tiny amount of the mRNA to transfer from a close contact to just one of your cells, and the multiplication effect would ensure your complete infection

Given the microscopic amount needed to infect, it is also important to avoid any invasive medical procedure where you suspect harmful intent, i.e - nasal swabbing, or any other coerced medical treatment. For example, as a student of pharmaceutical science, I learned about solvents that can penetrate the dermal layers of skin carrying

a payload of active ingredients. If such a solvent were carrying LNPs containing saRNA, and a drop of this was applied to a nasal swab....

How Long Does it Take for Each Cycle of Replication

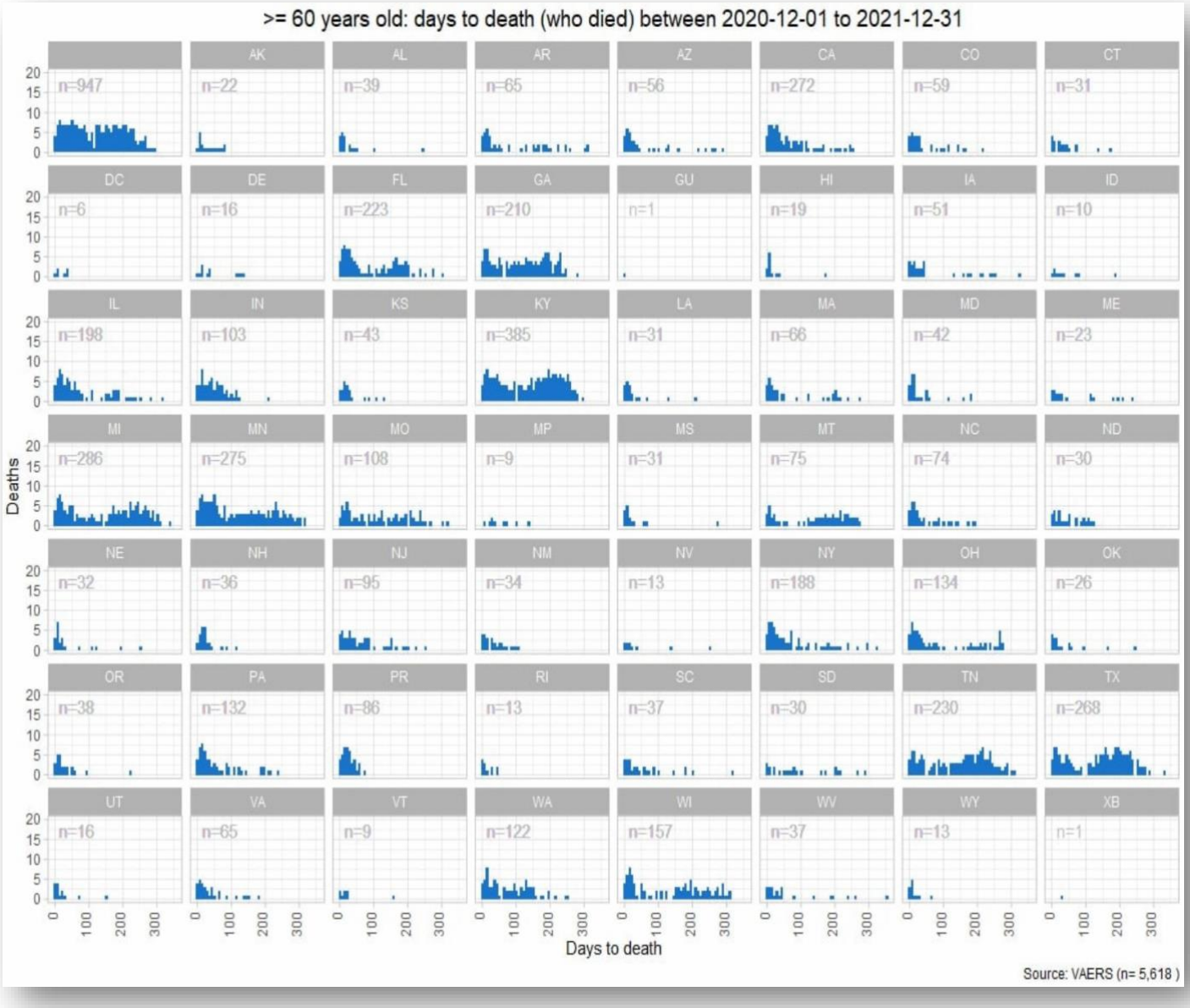
Since the number of deaths and injuries are proportional to the concentration of spike proteins, then we can determine the replication time from the time taken for deaths to double.

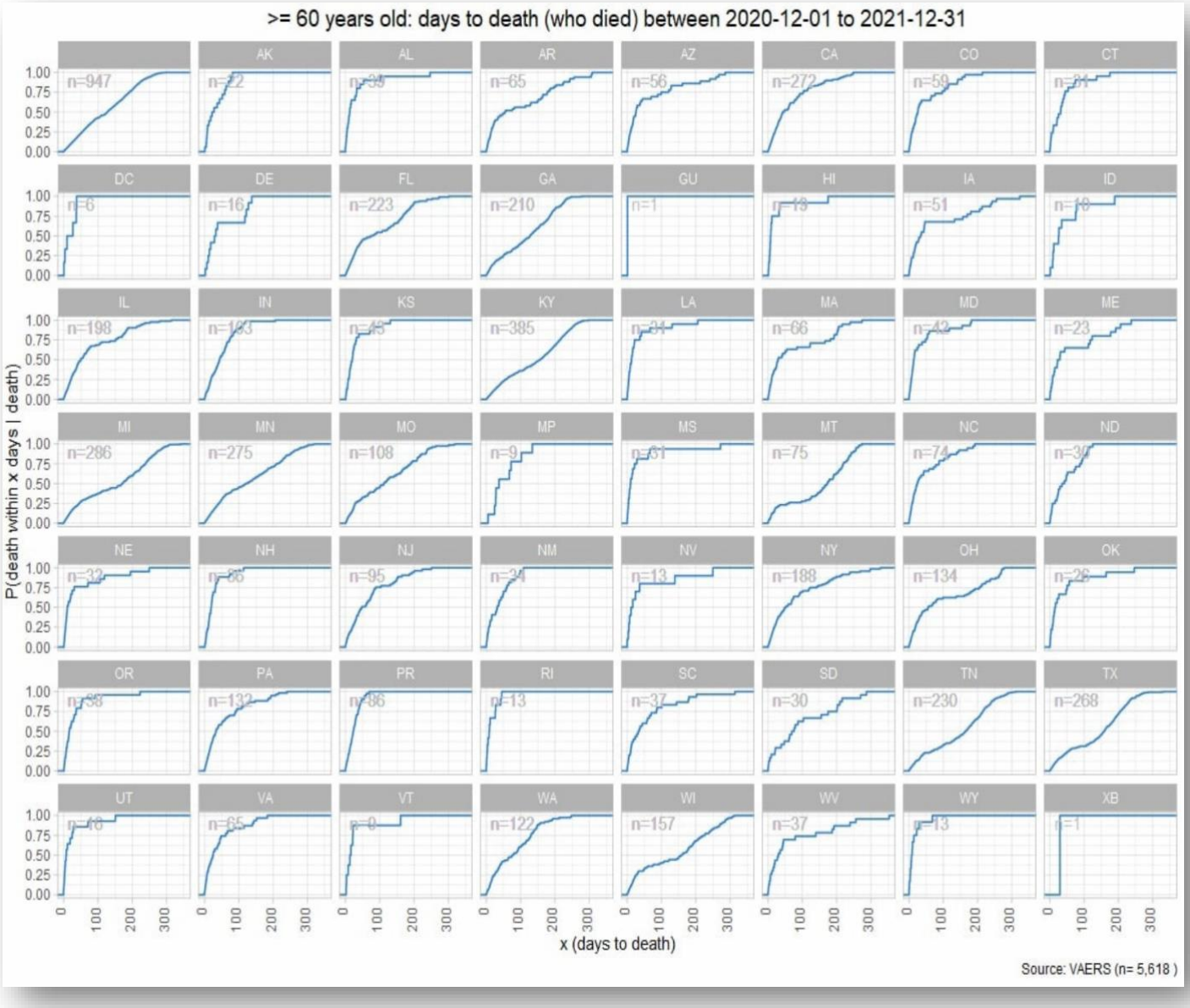
Making Sense of the Vaccine Drug Profiles for Different States in the USA

We can now look at profiles for different states showing the vaccine drug effect plotted against time. For most states, the profile shows deaths concentrated into a short time following vaccination, with deaths tapering off quickly as each day passes after vaccination. This would be expected with BNT162b, since the body metabolises and excretes the drug, so its concentration is decreasing with time. Since the concentration of the drug determines its effect (number of deaths), consequently the number of deaths decreases rapidly with time - following an exponential decrease.

However, some states (MI, TX, FL, TN, KY, MN, GA) have a more extended response to the vaccines - deaths occur with greater frequency, and over a longer time period of about 6 months, When we look at the profile for these states, we see that it more closely resembles a straight line - suggesting that the rate of deaths does not change over time - which in turn suggests that the concentration of the toxin remains constant over time. Presumably the toxin is being metabolised and excreted, so its persistence over time must be due to it being regenerated and replaced. This would be expected with BNT162c. Consequently, it is proposed that in the States of MI, TX, FL, TN, KY, MN and GA, self-amplifying vaccines have been deployed. This would account for both the higher frequency, and extending duration of deaths

The effect of a self-amplified vaccine would be the same as constant re-exposure to the toxin. Since each exposure generates damage, it follows that damage will increase with time until it eventuates in organ collapse and death. Injury and death reach a maximum at 180 days, so it may be the case that self-amplifying vaccines are only active for 6 months. So taking a booster every 6 months would ensure the continuance of damage.


>= 60 years old: days to death (who died) between 2020-12-01 to 2021-12-31
Deaths
Days to death
Source: VAERS (n= 5,618)
AK n=22
AL n=39
AR n=65
AZ n=56
CA n=272
CO n=59
CT n=31
DC n=6
DE n=16
FL n=223
GA n=210
GU n=1
HI n=19
IA n=51
ID n=10
IL n=198
IN n=103
KS n=43
KY n=385
LA n=31
MA n=66
MD n=42
ME n=23
MI n=286
MN n=275
MO n=108
MP n=9
MS n=31
MT n=75
NC n=74
ND n=30
NE n=32
NH n=36
NJ n=95
NM n=34
NV n=13
NY n=188
OH n=134
OK n=26
OR n=38
PA n=132
PR n=86
RI n=13
SC n=37
SD n=30
TN n=230
TX n=268
UT n=16
VA n=65
VT n=9
WA n=122
WI n=157
WV n=37
WY n=13
XB n=1



Summary

So, on the very eve of release of the vaccine in November 2020, BioNTech were working on these 3 platforms - some of the vaccines would be **uRNA** , some would be **modRNA** , and some would be **saRNA** .

- Nucleoside-modified RNA (modRNA), is so modified to evade the innate immune system, by replacing uridine with pseudo-uridine - something which renders the foreign mRNA invisible to our natural defences.
- Self-amplifying RNA (saRNA) turns the body into a factory for yet more mRNA, causing the body to generate the toxic spike protein over a longer period. Those states unlucky enough to get the saRNA would experience prolonged exposure to the toxin, and consequently an elevated number of deaths.

So you can see, just from this alone, that not all vaccines are equal - there are at least 3 types developed. One can evade your defences, and the other can reproduce itself, so even if some are caught by your defences they are simply replaced by more. You can think of these 3 types of vaccines as 3 different soldiers - the second soldier is invisible to your defences, and the third can clone or multiply itself. It is

immediately obvious that these 3 types of vaccine could result very different levels of fatality.

Sources :

FIGS 1, 2 and 3 above are taken from the work of Jason Morphett, whose substack articles you can find referenced below.

- Jason Morphett article1

  Jason Morphett article 2

- Geoffrey Freissen Phd - investigated excessive mortality in Q3 - and collected together some very interesting data here - Geoffrey Freissen article - Q3 Mortality

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