

Rochester State Hospital (Minn.). Patient Case Books.

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BOOK

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Respectfully,

Egbert, Fidler & Chambers.

Andersm	Augusta A	161	
Arnold	Mary	237	
Anderson	Mabel	321	Lem from Oct - Dec. '95
Hughes	Lydia B	381	

A B C D E F G H I J K L M Mc N O P Q R S T U V W Y Z

Boyles	Maggie	49	think here name is Maggie Dorman
Bottesm	Carrie	61	brother here (?)
Brandt	Ella	169	
Blomquist	Anna	177	
Blumentritt	Mary	193	
Bratz	Augusta	257	
Blodgett	Dorothy	269	
Bugs	Carrie	301	
Belina	Rosa	369.	

Conlin	Nora G.	9	
Conhaim	Lillie	81	was at Hudson Sanitarium
Carlson	Hilda	97	
Clement	Mary	297	(second admission here)
Carlson	Susan	337	
Caplazi	Christine	385	

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Evans'	Leda Josephine	201						

Dutteim	Inga	357	4th admission hue.	
Fredericks	Mamie	373		

Gallagher	Christina	5	
Grau	Frederika	25	
Gill	Alice Francis	293	
Ginise	Ellen	379	

Hoffmann	Elizabeth nee	1	
Harris	Nattie E.	141	was at Battle Creek Sanitarium

Iverson	Grete	265		

Johnson	Mary #1	65.		here before Sept - Dec 92 - also in Thomas hist
Johnson	Johanna #2	149		
Johnson	Anna G	281		
Jordan	Kate	325		
Jensen	Eline	341		
Judd	Lucinda	361	here twice before.	
Judge	Mary	389		

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Kovars	Mary	165	
Korstens	Margaretha	189	
Kress	Pauline	209	
Korhmel	Victoria	261	
Koch	Julia	365	

La Fortune	Mary	13	
Lewis	Belle	69	
Lawler	Nora	141	X
Lutgens	Hattie L.	181	
Lucas	Eliza	185	2nd ad. here.
Lawler	Nora	205	X 2nd ad. here
Lindquist	Carrie	329	
Leddy	Mary	397	

Meaney (mary)	Shamiah	37	2nd ad.
Madsen	Elfreda	53	
Maxwell	Jennie	77	
Murphy	Nellie #2	113	2nd ad.
Marsland	Rose	125	2nd ad
Miller	M. Maria	145	(was at St Lukes Hospital St Paul)
Moran	Sarah	173	here 3 times before.
Merz	Anna	273	
Morton	Elizabeth	289	(was at St. Peter 8 yrs.)
Meyers	Amelia	349.	

Mc Cloud	Maudana. F.	17	
Mc Namara	Martha J.	109	(was at St Peter years ago)
Mc Cullough	Anna M.	153	
Mc Ginnis	Catherine	197	

Nelson	Augusta	93	
Nelson	Mary G.	225	(was at Sanitarium, Hudson, Mrs.)
Nelson	Annie	333	

Olson	Betsey #3	89	

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Rodgers	Rosa		29	
Rabb	Rosie	(2nd ad.)	133	here before Feb - March/95
Robinson	Milton		217	
Renick	Emma		253	
Ryan	Clara		277	
Rathmund	Lizzie		305	here before fr. Apr. '94 to Apr '95
Russell	Agnes		317	here as inebriate fr. Apr. '89 to July 91

R S T U V W Y Z

Sullivan	Bridget	21	4th ad. here.
Schuster	Emma	45	
Saudeen	Mrs. Chas E. (Ida)	57	from H.C. Hospital - St Paul
Storley	Anna	73	
Savage	Emily 2nd	85	(Rerebefore — 89/90 —
Steiner	Hannah	101	
Schwetke	Annie	105	
Sperel	Anna	117	from Goodhue Co. Alms House
Skjordol	Eliza	121	
Schunemann	Minna	129	
Sinbach	Rosa	137	
Simons	Sarah A.	221	Transferred from St Peter
Scanlan	Bertha	249	
Small	Maria	285	
Swenson	Christine	309	here from Oct. 85 to Sept. 87
Swenson	Anna	353	
Sibenaler	Emma	393	

Tschide	Theresia	33	2ter ad.
Troppman	Barbara	157	
Thelander	Eva Fredrika	213	2nd ad.

Williams	Hettie Belle	229		
Wimer (or Wimar)	Maria	233		
Woehrle	Caroline	241	2nd ad.	
Williamson	Henrietta	245		
Worthington	Lucy	313	School Feeble Minded Faribault	
Wagner	Augusta	345	here from Dec. to Oct '83	

Personal and Medical History of Elizabeth Hoffmann #2

LOBERT, FISCAR & CHARLES, DAVENPORT, IOWA.

Whole No. 4233.
Residence, St Paul, Minnesota.
Date Admission, 22nd October 1895. —
Admitted by, D. Phelps Hour, 6.45 P.M.
How Sent, G. Willrich, Jof P. Ramsey County
Sex, Female
Age, 33 years
Civil Condition, married
Children, Three (3)
Age Youngest Child, 14 months
Occupation, Housewife: Husband works for Street Car Co.
Degree Education, fairly educated
Profession Religion, Catholic
Habits, not intemperate —
Nativity, Germany: (Parents also born there)
Physicians Committing, Gustav. A. Reuz and John. A. Verigge
Correspondents, none given in "Papers"

No. for Year, 61.
Insane Relatives, not known
Cause Exciting, Childbirth, at first
Cause Predisposing, previous attacks
Form,
Accompanying Bodily Disorder, not definitely stated.
Suicidal or Not, — not —
Date of this Attack, 3 months ago
Duration, — 3 months —
No. of Attack, 3rd —
No. of Admissions, 1st —
Age First Attack, about 28 —
Time of Leaving, Aug. 11. 1896
Time in Hospital, 9 mos 20 da.
Result, Improved. Discharged 12/12/96

EXAMINATION ON ADMISSION
MENTAL CHARACTERISTICS.

Examined by

MENTAL ACTIVITY:
~~Clear~~ or Confused, Quick —
Quick or ~~Sluggish~~, Confused
MEMORY: Fairly good
Past Events, " "
Recent Events, " "
Special Subjects, " "
PERCEPTIVITY:
Alert or Dull, Partially correct
Correct or Illusive,
REASONING POWER:
Ordinary Subjects,
Own Mental State, Impaired
Special Subjects,
GENERAL DESCRIPTIVE REMARKS:

EMOTIONAL STATE:
Normal, Calm, calm
Indifferent,
Exalted,
Depressed,
DELUSIONS: Said to have delusions
Systematized or Not,
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION: Seems mostly coherent
Coherent or Incoherent, talks willingly
Voluble or Reticent, Quite pleasant in manner

Personal and Medical History of Elizabeth Hoffmann #2

EXAMINATION ON ADMISSION, CONTINUED.
PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 1½ WEIGHT, not taken NUTRITION, Fair
WOUNDS OR ABNORMALITIES, None
TONGUE, Tremors, None Coatings, none Promptness Movement, Normal
PUPILS, Equality, Equal Size, Normal
Response Light, Normal Accommodation, "
SIGHT, Good
HEARING, "
COORDINATION, Arms, Normal
Legs, "
TREMORS, Hands, None Tongue, None
Facial Muscles, General, "
REFLEXES, Patellar,
Other Both 8 to 9
ARTICULATION, Normal
Slurred,
Hesitating,
FACIAL EXPRESSION,
Normal
SENSIBILITY,
HEART, Normal
LUNGS, Seems in good condition
TAKEN,

EXAM. URINE, Nov. 1895
Color Reddish yellow
Character Flaky deposit
Amt. in 24 hrs 3 XXV
Sp. Gr. 1032
Reaction acid
Albumen trace by Tan. sts.
Sugar none
Under microscopical
Amorph. urates
Ox. lime crystals
Bladder epithelial cells.

GYNAECOLOGICAL EXAM., Nov 25 '95. Uterus in position. Endometritis & profuse discharge. Extension of erosion
MENSTRUATION, Absent for past year
OPHTHALMOSCOPIC EXAM.,
HABITS, Dirty, Clean, ✓ Careless,
BOWELS, Normal, Constipated, ✓ Irregular,
APPETITE, Good, ✓ Medium, Poor,
SLEEP, Good, ✓ Poor, Irregular,
PULSE, Normal Resp., Normal Temp.,
CRANIAL MEASUREMENTS,
HISTORICAL,
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations,
Father or Pat. Relations,
Brothers or Sisters,

Personal and Medical History of Elizabeth Hoffmann #2

1895

This patient was brought here by Deputy-Sheriff M. N. Goss, attended by Mrs Akers, with following history. Patient is in fair physical condition. There is no history of consanguinity: As to in-laws relatives, not known. This is not 1st attack: she had attack in 1890. & 1892; the first lasting 3 months; the second, one month. had not been sent to hospital. First symptoms of this attack were manifested 3 months ago, by melancholia & erratic behavior, fixed ideas: disease appears to be increasing, with rational intervals, but not at regular periods. Derangement now shown in that she pays no attention to offspring; will not stay at home; has a fixed idea she must start a store; thinks she is persecuted; tendency to give things away: Patient is not disposed to injure others, nor suicidal, nor filthy nor destructive. Before accession of disease, she was rather irritable. There is no history of intemperance in self or family. She has not been restrained or confined. Cause of disease is childbirth, at first. She has had no medical treatment. Nothing further learned beyond what is stated above.

Oct 22 On admission, was put on B. ✓ (G.H.N. Rpt. Complexion fair: hair brown: eyes brown: condition of skin normal: no marks, scars or bruises noticed: is very dirty: behavior quiet; has some delusions about husband & children.) Nurses Notes Oct 23 Quiet. Has delusions Appetite good. In bed today. Sleeps well. Bowels regular. Pul. 87. Resp. 22. Temp. 98.8 Oct 24 Quiet. Appetite good. Slept all night. Has delusions. Up on ward. Tem. 98.6 Resp. 22. Puls 86 Oct 25 Quiet. Appetite good. Slept all night. Has delusions. Assists in dining room. Tem. 98.6 Resp. 21 Puls. 86 Oct. 26 Sang. was slightly noisy. Appetite good. Slept well. Oct. 27 Quiet. Appetite good. Sleeps well. Oct 28 Has delusions. Quiet. Leave to B.1. Slept 5 hr. Puls. 78 Resp. 20 Slept well. Oct 29 Trypestless all all day. Quiet in behavior. Tried to take the Keys. Has delusions Appetite good. Bowels moved. Puls. 82. Resp. 22. Oct 30 Fought nurse for keys this morning. Trans. to B. 2, Oct 31 Quite excited Has delusions Fought while bathing this A.M. Appetite good. Bowels moved. Nov 1 Quiet during day. Appetite very good. Nov. 2. Sleeps well. Bowels moved Has delusions Appetite good.

Nov 3 Fought nurses for keys tries to get out at every chance. Appetite good Sleeps well. Nov 4 Rather restless at times. No change. Nov 5 Fought for keys. Tried to get out of door when opened. Appetite good Sleeps well. Bowels regular.

Summary Patient is quite excited most of the time. Trys to get the Keys from nurses. Also tries to go out when the door is opened. Has delusions. Bowels are usually regular Sleeps well. Appetite very good

Nov 8 Very restless & disturbed at times. Tries to get keys & also to get out. Occasionally fights nurses. Appetite good; sleeps well; bowels regular. Has a cut on nose given by Annie Peterson. Has delusions. Nov 17 Fought this A.M. Tried to get away. was quite disturbed. Nov 21 Fought today. Nov 25 Opium treatment given. Nov 28 Very much disturbed, in seclusion 3 hours. Dec 4-6 Fought nurses. Dec. 21 Carried knife out of dining room. Has to be undressed at night. Jan. 10 Quite violent. Jan 12 Fought In seclusion 20 minutes Jan 21 Went walking & tried to get away. Jan 27 Fought. Appetite good. Bowels irregular. Extremely noisy. Jan 28 Trans. to C 4.

Feb 19 Appetite quite good. Sleeps well usually. Quite violent at times Always trying to get out. Noisy most of time. Bowels regular

Personal and Medical History of Elizabeth Hoffman. #2

Mar 30 Appetite good. Sleeps quite well. Habits clean. Very violent at times. Bowels constipated usually. Is always trying to get out. May 18 Goes riding & walking. When struggling it generally takes two to hold her.

July 20. Appetite usually good. Sleeps well. Requires constant watching - Is violent & destructive: at times tries to run away: Has to be undressed by force every night: Bowels usually regular. Aug. 11 '96 No change. Taken Home.

Discharged.

Personal and Medical History of Christine Gallagher.

LEBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4231+.
Residence, St. Paul, Minnesota
Date Admission, 24th October 1895.—
Admitted by, D. B. B. Ehy — Hour, 5 40 P.M.
How Sent, G. Willrich, Jof P. Ramsey County
Sex, — Female —
Age, — 40 years —
Civil Condition, — married —
Children, None
Age Youngest Child, —
Occupation, Housewife
Degree Education, not Educated
Profession Religion, Lutheran
Habits, Not intemperate —
Nativity, Denmark (parents also born there).
Physicians Committing, W. D. Kelly and C. Eugene Riggs.
Correspondents, Chas Gallagher — Smith Ave St Paul (Husband)

No. for Year, 62.
Insane Relatives, not stated
Cause Exciting, not known
Cause Predisposing, — Chronic —
Form,
Accompanying Bodily Disorder, None mentioned
Suicidal or Not, — not —
Date of this Attack, 18 months ago
Duration, Some 18 months.
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, about 38+
Time of Leaving, Nov. 23. 1894
Time in Hospital, 3 yrs. 1 mo. 29 d.
Result, Died. General Paresis

EXAMINATION ON ADMISSION
MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Sluggish & confused
Quick or Sluggish, Very
MEMORY:
Past Events, Very poor
Recent Events, Very much impaired
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Dull.
Correct or Illusive,
REASONING POWER:
Ordinary Subjects, None
Own Mental State,
Special Subjects,
GENERAL DESCRIPTIVE REMARKS:

EMOTIONAL STATE: Very demented
Normal, Calm,
Indifferent,
Exalted,
Depressed,
DELUSIONS:
Systematized or Not,
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,
Not Talking. Seems like profound dementia

Personal and Medical History of Christine Gallagher

EXAMINATION ON ADMISSION, CONTINUED.
PHYSICAL CHARACTERISTICS.

HEIGHT, 4 ft 10 in WEIGHT, not taken NUTRITION, Good.

Mrs. Christine Gallagher. (Dem 1/95 ret this hosp 1/96)

30/5

A letter from the husband states that about two years ago she commenced to show symptoms of her present trouble; that her trouble in walking and refusing to talk was always somewhat periodical, and hysterical; that there were a few occasional delusions along with these spells but they were mostly shown by perverse and queer behavior. She complained a good deal of pain in her head during the early periods.

Other
ARTICULATION,
Slurred, Slurred
Hesitating,
FACIAL EXPRESSION, Demented
SENSIBILITY,
HEART, Sounds are normal
LUNGS, Seem in good condition

TAKEN,

movements Oct 31/95

Urine not free ZXX
Colon Bacillus Coli
Character Heavy yellowish red granular deposit
Sp Gr 1030
Reaction Acid +
Albumen
Sugar
Urea
Sediments Blood cells, amm urates + Bladder cells, few casts Granular + Hyaline

GYNAECOLOGICAL EXAM., Nov 13 95. Uterus retroverted. Some cystic degeneration of cervix.
MENSTRUATION,
OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty, Dirty	Clean,	Careless,
BOWELS, Normal,	Constipated, ✓	Irregular,
APPETITE, Good,	Medium, ✓	Poor,
SLEEP, Good,	Poor,	Irregular,
PULSE, 108 Regular	Resp.,	Temp.,

CRANIAL MEASUREMENTS,
HISTORICAL,
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations,
Father or Pat. Relations,
Brothers or Sisters,

Personal and Medical History of Christine Gallagher.

LEBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4231+.
Residence, St. Paul, Minnesota
Date Admission, 24th October 1895.—
Admitted by, D. B. Ely — Hour, 5 10 P.M.
How Sent, G. Wilbric
Sex, Fem
Age, 40
Civil Condition, M
Children,
Age Youngest Child,
Occupation, Ho
Degree Education, N
Profession Religion, L
Habits, Not intem
Nativity, Denmark (pare
Physicians Committing, W. D. Kelly and C. Eugene Riggs.
Correspondents, Chas Gallagher Smith Ave St. Paul (Husband)

No. for Year, 62.
Insane Relatives, not stated
Cause Exciting, not known
Cause Predisp

EXAMINATION ON ADMISSION
MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Sluggish & confused
Quick or Sluggish, Very
MEMORY:
Past Events, Very poor
Recent Events, Very much impaired
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Dull.
Correct or Illusive,
REASONING POWER:
Ordinary Subjects, None
Own Mental State,
Special Subjects,
GENERAL DESCRIPTIVE REMARKS:

EMOTIONAL STATE: Very demented
Normal, Calm,
Indifferent,
Exalted,
Depressed,
DELUSIONS:
Systematized or Not,
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,
Not Talking. Seems like profound dementia

Personal and Medical History of Christine Gallagher

EXAMINATION ON ADMISSION, CONTINUED.
PHYSICAL CHARACTERISTICS.

HEIGHT, 4 ft 10 in — WEIGHT, not taken — NUTRITION, Good
WOUNDS OR ABNORMALITIES,
TONGUE, Tremors, Tremor — Coatings, Slight — Promptness Movement,
PUPILS, Equality, Equal — Size, Normal
Response Light, — Accommodation,
SIGHT, Seems good
HEARING, Probably poor. Wont answer.
COORDINATION, Arms, Impaired
Legs, Much impaired
TREMORS, Hands, general course — Tongue,
Facial Muscles, — General, Every part of body Irregular movements
REFLEXES, Patellar, Both 9 — EXAM. URINE, Oct 31/95
Other
ARTICULATION,
Slurred, Slurred
Hesitating,
FACIAL EXPRESSION, Demented

Urine not free ℥ XX
Color Brownish Red
Character Heavy yellowish red granular deposit
Sp Gr 1030
Reaction Acid +
Albumen
Sugar
Urea
Sediments Blood cells, amm urates + Bladder cells, few casts Granular + Hyaline

SENSIBILITY,
HEART, Sounds are normal
LUNGS, Seem in good condition
TAKEN,
GYNAECOLOGICAL EXAM., Nov 13 95. Uterus retroverted. Some cystic degeneration of cervix.
MENSTRUATION,
OPHTHALMOSCOPIC EXAM.,
HABITS, Dirty, Dirty — Clean, — Careless,
BOWELS, Normal, — Constipated, ✓ — Irregular,
APPETITE, Good, — Medium, ✓ — Poor,
SLEEP, Good, — Poor, — Irregular,
PULSE, 108 Regular — Resp., — Temp.,
CRANIAL MEASUREMENTS,
HISTORICAL,
LENGTH OF INVASION, — ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations,
Father or Pat. Relations,
Brothers or Sisters,

Personal and Medical History of Christine Gallagher.

1895

This patient was brought here by Deputy Sheriff Kinney, attended by Wm Hart, with the following history. Patient is in fair physical condition. As to consanguinity or heredity, there is nothing stated. This is the 1st attack: first symptoms manifested 8 months ago. Disease appears to be increasing. There is now manifested a strong hysterical element in the case. Patient is not disposed to injure others, nor suicidal, but there is, apparently, a tendency to filthy & destructive habits. No peculiarities as was previously shown. There is no history of intemperance in self or parents, nor of any severe disease &c. She has not been restrained or confined. Cause of disease is not known. She has had no medical treatment.

Oct 24 On admission, was put on B'd G.S.H.N. Rpt. Complexion fair: hair brown, streaked with gray: eyes gray: condition of skin normal: scars on both sides of neck from suppurating glands: on thumb & fingers of right hand: also, both knees bruised. Is very dirty: little toe on right foot overlaps the second toe & seems to grow farther up on foot & she walks lame. Behavior quiet: is very stupid & will not talk).

Oct 26 Nurses Notes. Quiet. Does not talk. Appetite fair. Does not sleep. Bowels moved.

" 26 Quiet at times. Seems lame & will not walk. Appetite fair. Has delusions. Slept 4 hrs. Restless & out of bed most of time. Oct 27 Very nervous. Appetite poor. Quiet this morning. Slept six hours. Bowels regular. Oct 28 Quiet in behavior. Weak & paretic & will not stand on her feet. Slept about 3 hrs. Appetite improved a great deal. Oct 29 Quiet in behavior. Does not express any delusions. Seems deaf. Answers when spoken to. Bowels moved.

Oct 30 Quiet in behavior. Appetite quite good. Slept 4 hrs. Bowels regular.

" 31 More noisy than usual today. Appetite fair. Sleeps same as usual. Bowels regular. Struggled when dressed. Nov 1 Quiet in behavior. Appetite fair. Very restless. Knocked on door all night did not sleep. Nov 2 Quiet in behavior. Appetite fair. Out of bed & very noisy 5 hrs. Bowels regular. Nov 3 Quiet today. Appetite good. Slept on floor all night. Would not keep blanket on. Nov 4 Very noisy this afternoon. Seems to be sick. Mouth washed out twice. Temp. 102.2 Appetite good. Did not sleep.

Nov 5 Noisy. In bed all day. Appetite very good. Awake all night. Rolled out of bed several times lay on floor all night. Nov 6 Noisy in behavior. In bed & very excited. Appetite fair. Did not sleep. Nov 7 Quiet in behavior. In bed. Appetite fair. Did not sleep. Bowels constipated.

Summary Very nervous & noisy at times. Has delusions. Does not sleep well. Appetite fair. Bowels are generally constipated. Mouth was washed out several times. Seemed feverish fourth & fifth days. Temp. 102.2 & 100.

Nov 8 In bed & quiet. Appetite poor; does not express any delusions. Bowels irregular; gives cathartic. Does not sleep well. Has bruises from falling from her bed. Bed on floor at present. Mouth washed out several times. Nov 17 Temp. 99. Resp. 23 Pulse 85. Patients seems rather weak today very noisy at times. Bowels moved. Appetite rather poor. Nov 18 In bed. Rather quiet. Quite excited. Nov 26 Upon ward. Dirty in habits; sleeps very poorly; has to be spoon fed. Bowels irregular.

Dec 4 Noisy & stupid at times. Appetite fair. Fed on ward. Dirty in habits. Bowels usually constipated. Sleeps poorly. Sleeps on floor as she falls out of bed.

Personal and Medical History of Christine Gallagher.

Body bruised from falling down. Dec 6. Trans. to E 3. Dec 8 Catheterized & 100.8 P. 80 Does not sleep well. Appetite poor. Very restless. Dec 9 Has erysipelas in face. In seclusion. Is out of bed most of time. Dec 10. Bowels very constipated. Gave a cathartic. Dec 11 Gave Enema. Dec 12 Gave Enema. Bowels moved. Has a sore on right foot. Has dressed antiseptically.

Dec 13 Face much better. Is very restless. Appetite poor. Bowels constipated.

Jan 3 4 5 Has a large boil on back. Boil dressed. Jan 6 Extremely noisy. In seclusion all day. Jan 13 Out of bed all night. Extremely noisy during day. Boil looks much better. Jan 14 Awake 8 hrs. Slept 1 hr. Extremely noisy during night. In seclusion 6 hrs. Feb 4 Did not sleep any. Out of bed all night. Quite noisy. Feb 29 Quite weak. Right hand swollen quite badly. Appetite fair: Bowels constipated. Habits dirty. Extremely noisy at times.

Mar 6 Very restless during night. Very untidy in habits. Secluded most of day. Bowels constipated. Sleeps on floor. May 9 Improving in flesh. Appetite good. Very restless nights. On ward most of time. Takes out door exercise.

June Summary Nurse's Notes by Dr. S.L. Phelps:- Habits dirty: eats on ward: genl health good: Nov. 96 Quite noisy at times: fed on tray on hall: At times violent genl health good: Mar 97 More quiet & more easily managed the last few weeks: much cleaner in habits. Kept on hall most of time: Genl health somewhat better: June 97 No Special change: Aug 7 97 Put to bed 2.99 Pulse 94 Resp. 24. Aug 8 97 T. 100. T. 104. R. 26: Aug 10 97 Up on ward. Temp. normal - Continued by Dr. R.M. Phelps. Nov 2 97 Is quite irritable & inclined to be violent: gets into trouble with other patients. Talks a great deal in an incoherent way.

Nov 3 98 Patient noted as being rather helpless of late & is to day unable to move. Temp. found to be 101. Nov 4 Still more weak: pulse weak & rapid. Nov 6 Lies in a rather stuporous condition: has a bedsore. Nov 16 Still in bed: Trans. to Infirmary.

Nov 23 98 Died at 11:30 AM. Intervening notes show a very slight rise of temperature but considerable increase of respiration & general weakness & difficulty in swallowing. A diagnosis was made of general paresis in a tentative way & after a very considerable consideration. In the intervening time, however, there have been practically no paretic signs - Nothing except a quiet, dull dementia - This failure toward the last, however, is quite paretic in character.

Died.

Personal and Medical History of Nora G. Conlin

LESCHT, FIDLAR & SHAMBERG, DAVENPORT, IOWA.

Whole No. 4236.
Residence, St. Paul. Minnesota
Date Admission, 26th October 1896.
Admitted by, Dr. C. B. Ely. Hour, 6 PM
How Sent, G. Wilbish. Sh. Ramsey County
Sex, Female
Age, - 29 years -
Civil Condition, married
Children, - 2 -
Age Youngest Child, 4 months
Occupation, Housekeeper (Husband, bookbinder)
Degree Education, Common School
Profession Religion, Yes: Catholic
Habits, not intemperate
Nativity, Illinois: (parents born in Ireland).
Physicians Committing, E. Eugene Riggs and C. R. Ball
Correspondents, none given in papers
1 J Conlin 170 yr 9th St. St Paul. (Husband)

No. for Year, 64.
Insane Relatives, - none -
Cause Exciting, confinement.
Cause Predisposing, not given
Form,
Accompanying Bodily Disorder, none mentioned
Suicidal or Not, not -
Date of this Attack, about 4 months ago.
Duration, about 4 months -
No. of Attack, 1st -
No. of Admissions, 1st -
Age First Attack, about 29
Time of Leaving, Sept. 14. 1896
Time in Hospital, 10 mo 24 da
Result, Discharged Mar. 14. 1897. Rec.

EXAMINATION ON ADMISSION
MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Confused & incoherent
Quick or Sluggish,
MEMORY:
Past Events, Blurred by Insania
Recent Events,
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Dull & incorrect.
Correct or Illusive,
REASONING POWER:
Ordinary Subjects,
Own Mental State, } Very poor almost none
Special Subjects,

GENERAL DESCRIPTIVE REMARKS:
A typical case of Acute Mania, Noisy incoherent & struggling

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted, & maniacal
Depressed,
DELUSIONS:
Systematized or Not,
Special Subjects,
Transitory ~~or Not~~, delusions about everything & anything
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

Personal and Medical History of Nora G. Conlin

EXAMINATION ON ADMISSION, CONTINUED.
PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 1in WEIGHT, not taken NUTRITION,
WOUNDS OR ABNORMALITIES, None
TONGUE, Tremors, Coatings, Slight Promptness Movement,
PUPILS, Equality, Equal Size, Dilated
Response Light, Sluggish Accommodation,
SIGHT,
HEARING, Seems good.
COORDINATION, Arms, Can not test
Legs,
TREMORS, Hands, Tongue,
Facial Muscles, General,
REFLEXES, Patellar, Can not test
Other
ARTICULATION,
Slurred,
Hesitating,
FACIAL EXPRESSION, Wild but intelligent
SENSIBILITY,
HEART, Sound Seems Normal
LUNGS,
GYNAECOLOGICAL EXAM., Normal position of uterus. Some endometritis & hypertrophia of cervix
MENSTRUATION, Menstruates normally
OPHTHALMOSCOPIC EXAM.,

TAKEN,

EXAM. URINE, Nov 8/95
Urine in hrs 3/XIX
Color Yellow
Character Cloudy
Sp Gr. 1030
Reaction Acid +
Albumen
Sugar
Urea
Sediments: A few epithelial cells & amor urates & amor phosphates

HABITS, Dirty,		Clean,	Careless,
BOWELS, Normal,	Normal	Constipated,	Irregular, Very poor
APPETITE, Good,	Good	Medium,	Poor,
SLEEP, Good,		Poor,	Irregular,
PULSE,		Resp.,	Temp.,

CRANIAL MEASUREMENTS,
HISTORICAL,
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations,
Father or Pat. Relations,
Brothers or Sisters,

Personal and Medical History of Nora G. Conlin.

1895

This patient was brought here by Deputy-Sheriff Kinney, attended by Wm Jones and Miss Sweeny, with following history. Patient is in a very excited condition. There is no history of Consanguinity or heredity. This is 1st attack: one week after confinement puerperal mania developed. Disease seems Stationary: not variable: no rational intervals, though she has had one lucid interval of four hours. This is a simple case of puerperal mania. She is violent, at times. Has not attempted suicide: As to personal habits, she is better, in this regard. No peculiarities &c used previously shown. There is no history of intemperance in self or parents, nor of any severe disease &c. Patient has had hospital care. Supposed cause of the disease is confinement. treatment given usual for such cases.

Oct 26 On admission, was put in B2 W. (G.H.N. Rpt. Complexion fair: hair auburn: eyes gray: Condition of skin normal: bruises noticed under right eye. on both limbs & right arm: She is dirty: very excited and noisy: incoherent).

" 27 Nurses Notes. Extremely noisy. Appetite good. Did not sleep. Bowels regular Pulse 98. Resp. 22 Temp. 99.9

" 28 Very noisy. Good appetite. Did not sleep. In restraint night & day. Bowels regular " 99 " 22 " 99.9

" 29 Extremely noisy. Appetite good, Struggled all night. Bowels moved. Temp. 100.2 In restraint all night & day

" 30 Very noisy. Appetite good. Has a great many delusions. Bowels regular. Slept 5 hrs. Struggled 2 hrs.

" 31 Noisy. Appetite good. Quite noisy 2 hrs. In restraint night & day. Bowels regular

Nov. 1 Noisy. Appetite very good. Did not sleep. In restraint night & day. Struggled 3 hrs. steadily

" 2 Very noisy Eats well. In restraint day & night. awake & struggled 6 hrs. Noisy. Has delusions.

" 3 Very noisy. Appdte good Does not sleep. In restraint night & day. Bowels irregular

" 4 Extremely noisy Appetite very good. Does not sleep. Struggled all night in restraint

" 5 Noisy Appetite good. Bowels irregular In restraint continually Does not sleep.

" 6 Extremely noisy. Appetite good. Does not sleep. In restraint Bowels regular Has delusions

" 7 Noisy. Appetite good. Does not sleep Bowels regular. In restraint day & night.

" 8 Noisy. Appetite not as good as usual. Did not sleep well In restraint day & night

" 9 More quiet. Appetite improved Slept fairly well Bowels moved freely

Summary Patient extremely noisy. Talks about everything. Appetite good Does not sleep. Bowels generally regular. In restraint night & day.

Nov 14 In restraint. Appetite good; bowels moved. Nov 16 Taken out of restraint sheet Very much disturbed; had to be held but back in sheet after 3 hours.

" 17 In restraint sheet all day. Nov 18 Out 2 hrs. very much excited Nov 19 & 20. Out part of day

" 24 Bowels moved. In restraint sheet most of time Nov 25 Taken out of restraint. Extremely noisy & quite violent. Appetite good; sleeps poorly. Nov 26 Trans. to C. H.

Nov 26 Out of restraint 9 hrs. Very noisy most of time, had to be held. Appetite good. Violent at times. Nov 27 Out of restraint all day Very noisy - Appetite good.

" 28 In seclusion the greater part of day. Quiet most of time. Has diarrhoea

" 29 Extremely noisy at times, diarrhoea better. Nov 30 Some quieter. Appetite very good

Dec 30 Appetite good. Habits dirty. Violent at times & Extremely noisy night & day. Visited by husband a couple of times during month. Jan 20 Extremely noisy all night & was out of bed. Destructive. Jan 20 Visited by Mrs. McGrath

Personal and Medical History of Nora G. Conlin.

Left eye black. Jan 21 Face scratched by A.J. Peterson. Feb 26 Remains very noisy

March 30 Still an Ct Noisy and restless. Visited by daughter and a former nurse. They were anxious to take her operated upon. Apr 5 Remains Very Noisy.

April 18 Operation done for removal of haemorrhoids. Circumcised also done. Took kitten well. Relation good. Put her in a restraint sheet after operation as she was so restless that could not keep her in bed.

May 2 Recovery prompt but is still restless and at times very noisy. May 5 Trans to C. 3. May 29 Very noisy & restless Defunction of times & quite untidy. Takes tonic. Appetite good. Fed by nurses Goes walking & riding. Bowels regular. June 5 Patient fought nurse. Very noisy.

June 16 Patient steadily restless, mischievous, maniacal. July 14 Visited by relatives

Aug 1 Has quieted down & is much improved Mentally. Neat & helpful with other patients Appetite fair. Sleeps well lately. Goes walking & riding & has attended Chapel once. Still has many delusions but memory is good. Aug. 14 Patient seems to improve daily. Sept 5 Improved mentally; physically seems quite well. Has no delusions. Works some on ward. Helps do the mending. Goes riding & walking Trans. to B'. Sept 9 Quiet in behavior: bowels regular: Appetite good: Takes out door exercise. Trans. to A'. Sept 12. Went Home was quiet & pleasant in appearance. Talked sensibly; Appetite good. Slept well.

Discharged

Personal and Medical History of Mary La Fortune

LOBERT, PILLAR & SCHARBER, DAVENPORT, IOWA.

Whole No. 4237.
Residence, Dodge County, Minnesota.
Date Admission, 28th October 1895.
Admitted by, D.C.B.S. Ely Hour, 6.35 P.M.
How Sent, Severt Olson, Jo P. Dodge County
Sex, Female
Age, — 35 —
Civil Condition, Single
Children, none
Age Youngest Child, —
Occupation, has none: (farmer's daughter)
Degree Education, Common School.
Profession Religion, Yes: Catholic
Habits, Probably good.
Nativity, Wisconsin: (parents born in New York).
Physicians Committing, J. H. VanBlew and J. Berent
Correspondents, B. La Fortune Claremont Dodge Co. Minn Register

No. for Year, 65.
Insane Relatives, none
Cause Exciting, not stated
Cause Predisposing, not stated
Form, Paranoia
Accompanying Bodily Disorder, None mentioned.
Suicidal or Not, not: but has tried to set fire to house.
Date of this Attack, 6 months ago
Duration, — 6 months —
No. of Attack, not 1st (this probably 1st Continuous).
No. of Admissions, 1st
Age First Attack, 34 past.
Time of Leaving, June 20 — 1902
Time in Hospital, 6 yrs 7 mos 23 ds
Result, Died: Pulmonary Tuberculosis

EXAMINATION ON ADMISSION
MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, considerably confused
Quick or Sluggish, Fairly quick
MEMORY:
Past Events, Cannot tell accurately. her speech
Recent Events, gets incoherent.
Special Subjects,
PERCEPTIVITY:
Alert or Dull,
Correct or Illusive, Incorrect
REASONING POWER:
Ordinary Subjects, Poor
Own Mental State, Very poor
Special Subjects, Poor

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed, Somewhat depressed
DELUSIONS: about being married her idea is
Systematized or Not, half systematized.
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent, Wandering — at times incoherent
Voluble or Reticent, Thinks she was married last Spring. Knows they think her insane

GENERAL DESCRIPTIVE REMARKS: Has had Convulsions of Intiginous attacks.

Personal and Medical History of Mary La Fortune

EXAMINATION ON ADMISSION, CONTINUED.
PHYSICAL CHARACTERISTICS.

HEIGHT, not taken WEIGHT, not taken — 113 lbs, NUTRITION, Slightly impaired
WOUNDS OR ABNORMALITIES,
TONGUE, Tremors, None of note Coatings, Sluggish Promptness Movement, Prompt
PUPILS, Equality, Equal Size, Normal
Response Light, Yes Accommodation,
SIGHT, Eyes squint Nystagmus Acuns. Senses &c. Sight good.
HEARING, Good.
COORDINATION, Arms, Fairly good
Legs,
TREMORS, Hands, Slight Tongue,
Facial Muscles, General,
REFLEXES, Patellar, Eq. normal - 6
Other Grasp
ARTICULATION,
Slurred,
Hesitating, Good
FACIAL EXPRESSION, Slightly troubled melancholic
SENSIBILITY,
HEART, No murmurs
Arteries Atheromatous.
LUNGS, Exp has asthma
GYNAECOLOGICAL EXAM., Nov 13'95. Normal condition.
MENSTRUATION,
OPHTHALMOSCOPIC EXAM.,

TAKEN,

EXAM. URINE, Nov 1/95
Urine 24 hrs 3 ~~xx~~
Color Red yellow
Character Hazy flaky, red yellow dep
Sp Gr 1032
Reaction Acid +
Albumen 0
Sugar
Urea
Sediment Amor urates, a few squamous bladder cells.

HABITS, Dirty, Clean, Clean Careless,
BOWELS, Normal, Constipated, slightly Irregular,
APPETITE, Good, says is good Medium, Poor,
SLEEP, Good, usually ~~but~~ not for past 3 months ~~Poor~~ Somnambulism, Dreams &c. Irregular,
PULSE, Resp., Temp.,
CRANIAL MEASUREMENTS,
HISTORICAL,
LENGTH OF INVASION, Seems about 6 months from this attack ONSET GRADUAL OR SUDDEN, Melancholy, Inebriety, paralysis, Epilepsy &
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") consumption
Mother or Mat. Relations, M. Healthy had heart trouble — Mother's sister said to be a little insane.
Father or Pat. Relations, F. healthy
Brothers or Sisters, 4 brothers 2 sisters

Personal and Medical History of Mary La Fortune

1895

This patient was brought here by Deputy Sheriff Joel Tucker, attended by father & sister of patient. She is in fair physical condition. There is no history of consanguinity or heredity: - this is probably 1st attack. (Continuous); She has not been in hospital. First symptoms were manifested 6 months ago and the disease appears to be increasing: not variable: no rational intervals. Derangement now manifested upon Everything. Patient is dis posed to injure others: has not attempted suicide, but has tried to set fire to the house. No filthy or destructive habits: no peculiarities &c had been previously shown. There is no history of intemperance in self or parents, nor of any severe disease in patient's case. She has not been restrained or confined. Cause of the disease is not given. She has had no medical treatment. - On personal Examination she was found to be violent.

Oct 29 On admission, was put on B.W. G.H.N. Rpt. Complexion dark: hair dark-brown; eyes brown; condition of skin normal: round marks noticed between shoulders: right arm bruised: is clean: behaving quiet: has delusions.

" 29 Nurses Notes. In bed - quite noisy. Has delusions. Appetite good. Awake all night & slightly noisy. Bowels regular. Pulse 73. Resp. 21, Temp. 98.6

" 30 In bed in morning. Quite excited & noisy rest of day. Has a great many delusions. Appetite good. Bowels regular. Slept 3 hrs. Oct 31 Up on ward. Very much excited. Has delusions. Appetite good. Slept 2 hrs. Nov 1 On ward noisy all day. Appetite good. Has a great many delusions. Slept 3 hrs. Bowels regular. Refuses tonic.

Nov 2 Slightly Noisy. Appetite good. Has delusions. Noisy 2 hrs. Slept 1 hr. Tries to get out when door is opened. Nov 3 Noisy A.M. Eats well. Has delusions. Slept 3 hrs.

Nov. 4 Quite Noisy. Appetite good. Slept 2 hrs. Noisy 4 hrs. Has delusions. Fought nurses. Tried to get Keys. Nov 5 Very noisy today. Appetite good. Slept 4 hrs. Bowels regular. Refuses Tonic. Nov 6 Quite noisy. Appetite good. Does not sleep well. Bowels regular. Has a great many delusions. Nov 7 Quite noisy at times. Appetite good. Sleeps well. Fought nurses. Tried to get Keys.

Nov. 8 Quiet most of day. Bowels regular. Sleeps well. Tries to get out when door is opened.

" 9 Quiet. Talks sensibly some times. Sleeps well. Appetite good. Bowels regular. Fought nurses. Nov. 10 Quiet. Slept well. Appetite good. Bowels regular.

" 11 Quite restless. Has delusions. Tries to get keys.

SUMMARY Patient rather restless most of time. Has a great many delusions. Appetite very good. Generally sleeps well. Does not go out walking says she will run away. Refuses to take tonic. Tries to go out when door is opened. Often cries when spoken to. Talks a great deal on religion.

Nov 13 Quite disturbed. Cries & scolds most of time. Appetite fair; sleeps poorly -

" 24 Tries to get out. Extremely noisy. Dec. 14 Extremely Noisy - Fought.

Dec 19 Visited by friends. Dec. 28 Very Noisy & quite Violent. Jan 8 Noisy & violent.

Jan 21 Visited by sister. Tried to get away when out walking. So noisy & violent

" 31 Appetite poor. Complains of not feeling well. Feb 1 Extremely noisy most of

Personal and Medical History of Mary La Fortune.

1896

time. Feb 23 Extremely noisy most of time - Tries to get out whenever door is opened

Mar 10 Very noisy & quite violent. Has delusions. Apr 27 Very violent & fighting with the other ladies. Sleeps well. Bowels regular. Menses May 18 Usually very cross & disagreeable. Appetite poor. Noisy at times. Bowels constipated

July Summary Nurse's Notes by Dr. L.L. Phelps: Extremely noisy most of time: Has many delusions: Habits clean: personal appearance usually neat: goes walking: July 30 '96 Visited by sister: complains of being treated badly: appetite poor: usually fed by nurses: usually resists when put to bed: Scratches & bites: Nov. 96 No change.

1897 Jan. Appetite irregular: Bowels regular: very noisy especially when nurses try & do any thing for her: very incoherent: fights nurses: Mar. 97 No change: July 97 Extremely noisy most of time: violent at times - Gen'l health Good.

Continued by Dr. A.M. Phelps Visited by father & mother Was extremely noisy Jan 29 98 Visited by brother. Feb 27 98 Wt. 102# Mch 25 Trans. to C3. Oct 25 Trans. to C2. Nov 10 to C1. Dec 24 Visited by brother. Feb. 27 Patient practically unchanged during period.

1899 Sept Always very noisy, & inclined to be violent. (Sent by Dr. P.A. Best) March to General health good: extremely disagreeable: bites & scratches when at all disturbed: often necessary to put him in seclusion. Is noisy greater part of time: cries a great deal: Was struck by Ida Nelson: received slight cut over eye. Sept 1. - Feb 28 1900 Very disagreeable on ward: noisy at times & resistive Scratches & bites when disturbed: frequently refuses to eat: Strikes head against wall bruising nose: Injury slight. Jan 20 to 96 Wt. Mch 1 - Aug 31 1900 (Dr. Linton) Extremely noisy most of time: Very resistive & difficult to manage: untidy & careless: Expectorates all over floor: usually noisy at night. Scratches & bites at times: Sometimes refuses meals: Appetite fair: Bowels constipated. Does not take outdoor exercise July 16 Vaccinated. Sept 1 - Nov 30 1900 Sometimes requires mechanical feeding: Does not sleep well: habits clean: Violent & noisy often: Is seldom quiet. Oct 18. Put in restraint. Oct 24. Refused to eat: Fed by tube: Nov 17 Wt. 95# Dec 1 - Feb 28 1901 No change. Feb 28 Wt. 85#

Mar 1 - June 1 - 1901 No change in mental or physical condition. Does no work: menstruates. May 29 Wt. 80#, June to Sept. Is mentally unchanged, physically seems to be loosing ground is thin and pale. Sept. 2 Wt. 80#.

Sept. to Dec. Appetite poor often refuses to eat. Nov. 23 Wt. 82#.

Patient becoming quite weak and poorly: is quite emaciated: feet and hands badly swollen: occasionally expectorates blood: trans. to Inf. West. June 10: mental condition unchanged: is noisy and disturbed: is very untidy: is becoming gradually weaker and died June 20 at 6:00 A.M. of Pulmonary Tuberculosis tubercular bacilli found in sputum.

Dead.

Personal and Medical History of Mandana F. McCloud.

LEIGHT, FISCHER & SAUNDERS, DAVENPORT, IOWA.

Whole No. 4239.
Residence, Clinton Falls, Steele Co. Minn.
Date Admission, 4th November 1895.
Admitted by, Dr Linton-Phelps Hour, 11 1/2 Am.
How Sent, M. B. Chadwick. Jail. State County.
Sex, - Female -
Age, - 82 -
Civil Condition, Married
Children, - Six -
Age Youngest Child, - 40 -
Occupation, Housewife (Husband, farmer).
Degree Education, - Moderate -
Profession Religion, - Baptist -
Habits, not intemperate
Nativity, Vermont. (Nat of Parents is not known).
Physicians Committing, Theo L. Hatch & M. B. Curtis
Correspondents, Item Given in Papers - "See Office Register" -

No. for Year, 67.
Insane Relatives, None
Cause Exciting, Probably age.
Cause Predisposing, old Age (probably).
Form,
Accompanying Bodily Disorder, Great feebleness -
Suicidal or Not, - Not -
Date of this Attack, 3 Years ago
Duration, - 3 years -
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, about 81 -
Time of Leaving, June 17th 1896.
Time in Hospital, 7 mo. 13 das.
Result, Died apoplexy

EXAMINATION ON ADMISSION
MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Confused
Quick or Sluggish, Somewhat sluggish
MEMORY:
Past Events, Probably poor
Recent Events, "
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Dull.
Correct or Illusive,
REASONING POWER:
Ordinary Subjects, Poor
Own Mental State, "
Special Subjects,

EMOTIONAL STATE:
Normal, Calm, Calm
Indifferent, Indifferent
Exalted,
Depressed,
DELUSIONS: none noted. Demented
Systematized or Not,
Special Subjects,
Transitory or Not,
HALLUCINATIONS: none.
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent, Reticent, very deaf. Talks rather incoherently. Acts discontented & surly. Says no need of her coming here.

GENERAL DESCRIPTIVE REMARKS: Mental state that of a mild dementia. Lacks any realizing sense of her state or condition. Dulled though in appearance intelligent. Dementia of a vague senile type.

Personal and Medical History of Mandana F. McCloud

EXAMINATION ON ADMISSION, CONTINUED.
PHYSICAL CHARACTERISTICS.

HEIGHT, not taken WEIGHT, not taken NUTRITION, Fairly good.
WOUNDS OR ABNORMALITIES, None.
TONGUE, Tremors, About normal Coatings, Slight Promptness Movement, About normal
PUPILS, Equality, Equal Size, Normal
Response Light, Normal Accommodation,
SIGHT, Fair Slight Arcus Senilas.
HEARING, Impaired
COORDINATION, Arms, Impaired
Legs, Impaired Staggers from weakness
TREMORS, Hands, Slight Tongue, Slight
Facial Muscles, General, Marked on Standing.
REFLEXES, Patellar,
Other 8 equal.
ARTICULATION,
Slurred,
Hesitating, fairly prompt
FACIAL EXPRESSION, Very dull
SENSIBILITY,
HEART, Sounds are normal.
Arteries Normal.
LUNGS,
GYNAECOLOGICAL EXAM. Uterus retroverted & atrophied. External genitals red & excoriated
MENSTRUATION, Ceased.
OPHTHALMOSCOPIC EXAM.,

TAKEN,

EXAM. URINE, Nov 8/95
Urine as sent 3 XXVIII
Color Yellow
Character Cloudy with white flaky deps
Sp Gr 1019
Reaction Alkaline
Albumen
Sugar
Urea
Sediments A few epithel cells amon uratis triple phosphates

HABITS, Dirty,	Dirty	Clean,	Careless,
BOWELS, Normal,	Regular	Constipated,	Irregular,
APPETITE, Good,	good	Medium,	Poor,
SLEEP, Good,	Seems quiet	Poor,	Irregular,
PULSE,		Resp.,	Temp.,

CRANIAL MEASUREMENTS, 22 1/2
HISTORICAL,
LENGTH OF INVASION, Said to be three years (probably more) ONSET GRADUAL OR SUDDEN, Gradual
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations,
Father or Pat. Relations,
Brothers or Sisters,

Personal and Medical History of Mandana F. McCloud.

1895

This patient was brought here by Sheriff J.C. Barncard & attended by her daughter Mrs Reynolds, with following history of case. Patient is in very feeble condition. There is no history of consanguinity or heredity. This is the 1st attack, first symptoms manifested 3 years ago; was unable to recognize; incoherent in talk. Disease appears to be increasing; is not curable: no rational intervals: Derangement now shown in that he is unable to recognize friends; talks incoherently; destroys clothing. Patient is disposed to injure others, but is not suicidal. Is of filthy habits, also. Before accession of the disease, no peculiarities observed shown: there is no history of intemperance, nor of any severe disease &c. She has been confined to her room for 3 months. Cause of the disease not known: She has had no medical treatment. By personal examination she is found unable to recognize her children. ——-.——

Nov 4 On admission, was put on B3W (G.H.N. Rpt. Complexion fair: hair gray: eyes gray: Condition of skin normal: left cheek, both hands & limbs bruised: skin is quite clean. She fought & while being bathed: no delusions noticed).

Nov 5 Nurses Notes. Fought nurses. Quite noisy. Was put to bed. Talks incoherently. Appetite good. Bowels constipated. Pulse 96. Resp 20. Temp. 99.

Nov 6 Very restless & noisy. Dirty in habits. Quite hard to manage. Appetite good Bowels constipated. Temp. 98. Pulse 84 Resp 20 Nov 7 Quite restless. Does not talk very much. Bowels moved. Appetite good. Temp. 98 Resp 18 Pulse. 80

Nov 8 Moor quiet. Appetite good bowels regular. Pulse 80.

Nov 9 Up on ward. Is quite unsteady on her feet. Appetite good. Bowels constipated. Quiet Pulse 82. Nov. 10 Appetite good. Dirty in habits. Quiet in behavior Pulse 82

Nov 11 Appetite good. Habits dirty. Does not talk much. Pulse 80.

" 12 Has delusions. Moor restless during day. Appetite good. Habits dirty. Pulse 80

" 13 Moor quiet today. Does not talk much. Appetite good. Bowels regular Pulse 82

" 14 Very quiet in behavior. Habits dirty during night Appetite good. Pulse 78

" 15 Appetite good. Bowels constipated. Quiet in behavior Pulse 80

" 16 Appetite good. Quiet in behavior. Sleeps well. Talked some during day. Pulse 78

" 17 Was quite restless during day. Habits very dirty Bowels regular.

" 18 Moor quiet today. Appetite good. Bowels regular. Sleeps quite well. Pulse 80

SUMMARY. Patient is very quiet in behavior some days others was quite restless. General health good. Appetite good. Bowels constipated most of the time. Has delusions & talks incoherently. Is quite hard to manage at times. Resists when being undressed. Temp. 99 the first day. 98 second Pulse 96 first day, normal after that. Respiration normal.

Nov 19 Very restless. Complains of pain in left hip. Appetite good. Habits dirty. Bowels regular Talks incoherently. Nov 22 Fell & bruised head. Is very unsteady on feet.

Dec 8 General health good. Appetite good. Sleeps well. Very dirty.

Jan 27 Choked while eating. Quite stupid afterwards. Jan. 29 Awake 7 hrs. Slept 2 hrs Out of bed & quite noisy. Feb. 19 Quite feeble. Leans forward left when sitting or walking. Put to bed. Appetite good. Seemed more helpless.

Personal and Medical History of Mandana F. McCloud.

than usual Feb 25 Still in bed. Appetite fairly good. Habits dirty. Talks incoherently Quite noisy at times. Very stupid most of the time.

Mar 6 Up on ward- Appetite good- Habits dirty Very restless at night. Apr 6 Very feeble. Habits very dirty. Appetite good. Seems to be losing flesh. Sleeps quite well. May 9 Appears to be failing in flesh- Appetite good Sleeps quite well. Habits extremely dirty. May 25 Patient showed symptoms of brain trouble again. Put to bed. Temp. 103. Milk & eggnogs given May 27 102 Milk & eggnog given. May 28 Temp went down. May 30 Still in bed- failing rapidly in flesh. Habits very dirty June 1 Still sick in bed- Appetite quite good. Still loosing flesh. June 13 Had a very bad looking heel. June 16 Suddenly taken with stroke. Seemed to be in a comatose state all night & next day June 17 Visited by husband-

Died June 17th 1896 1 P.M.

(From p. 24)

Bridget Sullivan

June 22. A.M. T. 98⅘ P. 89 R. 22 P.M. T. 100⅘ P. 100 R. 25. Appetite poor: milk given often. Egg nog twice a day: cough medicine given, also cathartics: Alcohol bath: Has bed sore on left hip: seemed unable to pass urine: very helpless: June 25th T. 99. P. 90. R. 22. Appetite poor. milk & Eggnog given: wine every 2 hours: bowels did not move: Head ache & back ache: Slept most of night: June 26-30 Temp. averaged about 99. Appetite poor: milk & eggnog given: bowels constipated: Complained of back ache every day: bed sores dressed: alcohol baths given: wine given every 3 hours daily: visited daily by son or daughter: July 1st 99 Very weak since last note: has slept a great deal: very helpless. Temp has ranged from 98.4 to 100 until the 8th when it was 101⅖ P. 118 R. 22. July 9 a.m. T. 102⅕ P. 114 R. 24 P.M. T. 103⅗ P. 116 A. 18: July 10. 9 a.m. T. 100⅖ P. 110. R. 23. P.M. T. 100. P. 90. R. 20. Pulse intermittent. Brandy given every hour daily: bed sores dressed: alcohol baths given: Appetite poor milk given: bowels regular: visited once by son. June 16 Brandy every hour continued: alcohol baths given bed sores dressed: complains of aching: very restless & moaning when awake Slept quite well: bowels regular. T. from 98⅘ to 100. P. 72 to 105. R. 16 to 32. July 23 Since last note Temp. has ranged from 98 to 101. P. 74 to 125. R. 18 to 26. Appetite poor. Wine given every 3 hrs: visited by daughter: Slept well: moaning & restless when awake Complained of aching all over. July 24 a.m. T. 101⅘ P. 100 R. 25 P.M. T. 103⅖ P. 130 R. 40. Appetite very poor: milk given: brandy every 2 hrs. bowels moved twice: Pulse weak & intermittent: cannot take solid food: Seems rather stupid: Slept most of night: July 25 T. 104 P. 124 R. 50. Unable to swallow: brandy given often: bowels moved twice: pulse intermittent: patient very weak- Died Daily sick record kept.

Died

Personal and Medical History of Bridget Sullivan

LARKEY, PUGLAR & RASMUSEN, DAVENPORT, IOWA.

Whole No. 4241.
Residence, Rosemount, Dakota Co. Minn
Date Admission, 5th November 1895.
Admitted by, D. Phelps - Hour, 6.45 P.M.
How Sent, Thos. P. Moran. Jo. P. Dakota Co.
Sex, Female
Age, - 67 -
Civil Condition, widowed
Children, Three
Age Youngest Child, about 28 years
Occupation, Housewife (husband was farmer).
Degree Education, none
Profession Religion, Yes: Catholic.
Habits, not intemperate
Nativity, Ireland: (Parents also born there).
Physicians Committing, A VanBeeck and J.C. Hitch
Correspondents, David Sullivan Rosemount Dakota Co Minn.

No. for Year, 69.
Insane Relatives, — none —
Cause Exciting, Not known
Cause Predisposing, Previous attacks
Form,
Accompanying Bodily Disorder, Some weakness.
Suicidal or Not, not -
Date of this Attack, About 1st September
Duration, over 2 months
No. of Attack, 6th: (Probably more).
No. of Admissions, 4th here: (twice in St. Peter).
Age First Attack, 45 (about)
Time of Leaving, July 25. 1897
Time in Hospital, 1 yr. 8 mos. 20 da.
Result, Died. Heart Failure in Chronic Dementia.

EXAMINATION ON ADMISSION
MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Confused
Quick or Sluggish, Quite active
MEMORY:
Past Events, Fair
Recent Events, "
Special Subjects,
PERCEPTIVITY:
Alert or Dull,
Correct or Illusive,
REASONING POWER:
Ordinary Subjects, Rather poor
Own Mental State, "
Special Subjects, "
GENERAL DESCRIPTIVE REMARKS: Mental state A silly mildly maniacal attack on a substratum of mild dementia.

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted, Exalted typsily.
Depressed,
DELUSIONS:
Systematized or Not, Not prominent
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent, Incoherent
Voluble or Reticent, Voluble
Rambles along in a silly tipsy way about everything. No delusions

Personal and Medical History of Bridget Sullivan

Nov 11/95
Dec 3/95

Mrs. Ann Bridget Sullivan. (Dec 4/95 rec'd this memo) pm

Letter from a son states during her early life she was well behaved and showed no symptoms of eccentricity or insanity. There is no history of insanity, as far as he knows, in the family.

About 21 years ago, after the death of a son, she became depressed and talked of suicide. She seemed to get well again, however, hu but has been up and down ever since. Has seemed quite well for from two to three years at a time. Her parents are said to have been cousins.

REFLEXES, Patellar,
Other
ARTICULATION, Peculiar -
~~Slurred~~, Jerky - Irish brogue
Hesitating,
FACIAL EXPRESSION, Exalted
SENSIBILITY,
HEART, Sounds somewhat blurred. Arteries vaguely sclerosis if any.
LUNGS,



TAKEN,

EXAM. URINE,

GYNAECOLOGICAL EXAM., Nov 20/95. Uterus small & retroverted. Hyperaemia of os & surrounding tissues. Meatus & all external parts red & inflamed. Several retention cysts in labia majora.
MENSTRUATION,
OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean, Clean	Careless,
BOWELS, Normal, Normal	Constipated,	Irregular,
APPETITE, Good, Good.	Medium,	Poor,
SLEEP, Good,	Poor,	Irregular, Restless part of night
PULSE,	Resp.,	Temp.,

CRANIAL MEASUREMENTS,
HISTORICAL,
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations,
Father or Pat. Relations,
Brothers or Sisters,

Personal and Medical History of Bridget Sullivan

LEIGHT, FISCHER & SCHAMBERG, DAVENPORT, IOWA.

Whole No. 42
Residence, Ro
Date Admission, 5
Admitted by, D
How Sent, Thos
Sex, Fe
Age, –
Civil Condition,
Children,
Age Youngest Child,
Occupation,
Degree Education,
Profession Religion,
Habits, not intemperate
Nativity, Ireland: (Parents also born there).
Physicians Committing, A VanBeeck and J.C. Ritch
Correspondents, David Sullivan Rosemount Dakota Co Minn.

Time of Hearing, [illegible]
Time in Hospital, 1 yr. 8 mo. 20 da.
Result, Died. Heart Failure in Chronic Dementia.

EXAMINATION ON ADMISSION
MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Confused
Quick or Sluggish, Quite active
MEMORY:
Past Events, Fair
Recent Events, "
Special Subjects,
PERCEPTIVITY:
Alert or Dull,
Correct or Illusive,
REASONING POWER:
Ordinary Subjects, Rather poor
Own Mental State, "
Special Subjects, "
GENERAL DESCRIPTIVE REMARKS: Mental state A silly mildly maniacal attack on a substratum of mild dementia.

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted, Exalted Typsily-
Depressed,
DELUSIONS:
Systematized or Not, Not prominent
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent, Incoherent
Voluble or Reticent, Voluble
Rambles along in a silly tipsy way about everything; no delusions

Personal and Medical History of Bridget Sullivan

EXAMINATION ON ADMISSION, CONTINUED.
PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 2 in WEIGHT, not taken NUTRITION, Fairly good
WOUNDS OR ABNORMALITIES, None noted
TONGUE, Tremors, Coatings, None of note Promptness Movement, Fairly good.
PUPILS, Equality, Equal Size, Normal
Response Light, Fair Accommodation,
SIGHT, Says good for her age Slight arcus senilis
HEARING, Good
COORDINATION, Arms, Weakness + jerky
Legs,
TREMORS, Hands, Not much of any Tongue, None
Facial Muscles, General,
REFLEXES, Patellar, EXAM. URINE,
Other
ARTICULATION, Peculiar -
~~Slurred~~ jerky - Irish brogue
Hesitating,
FACIAL EXPRESSION, Exalted



SENSIBILITY,
HEART, Sounds somewhat blurred. Arteries vaguely sclerosis if any-
LUNGS,
GYNAECOLOGICAL EXAM., Nov 20/95. Uterus small + retroverted. Hyperaemia of os + surrounding tissues. Walls + all external parts red + inflamed. Sebaceous retention cysts in labia majora.
MENSTRUATION,
OPHTHALMOSCOPIC EXAM.,
HABITS, Dirty, Clean, Clean Careless,
BOWELS, Normal, Normal Constipated, Irregular,
APPETITE, Good, Good Medium, Poor,
SLEEP, Good, Poor, Irregular, Restless part of night
PULSE, Resp., Temp.,
CRANIAL MEASUREMENTS,
HISTORICAL,
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations,
Father or Pat. Relations,
Brothers or Sisters,

Personal and Medical History of Bridget Sullivan

1895

This patient was brought here by Deputy-Sheriff Highlen, attended by her Son & daughter, with following history. Patient is in fair physical condition. Parents or grand parents not related: no insane relatives. She has had many such attacks and has been in Hospitals as below: at St. Peter Augs 0/76. and again Jany 6/80; and at Rochester, March 10/83: April 1/85: & again May 4/88. Attacks were, generally, of comparatively short duration, and she received benefit from treatment. First symptoms of this attack was manifested about 1st of September by excitation. Disease seems to be increasing, but variable & with rational intervals, but these do not occur at regular periods. Derangement now shown in that she imagines abuse by her Son. Her is disposed to injure others; but is not suicidal: has destroyed some furniture. No peculiarities of habit have been previously shown. There is no history of intemperance in self or parents, nor of any severe disease &c. Has only been confined & restrained as above. Cause of disease is not known: has had only asylum treatment. On personal examination, there is a rapid flow of thought, incoherency: she is excited & revengeful.

Note × There is some discrepancy, above, as to dates of her Commitment here. Our records show as follows. 1st Committment, April 2/85 to June 27/85: (Vol 5 p 166 No 885) - At that time, she was, after coming, noisy & pugnacious; attacking others, without cause or provocation: She quickly improved & was in good condition on leaving: 2nd Committment, May 16/88 to May 31/90: (Vol 10 p 146 No 1766). This time, she was quiet, contented & cheerful, for sometime after coming. Pulse recently, "had a very nervous spell" and said "she was unable to control herself": sedatives given pressed & have no effect. Was restrained once. Became quieter, for a time, but was still subject to these "nervous spells" & was noisy, scolding & dirty in habits. Began to improve & was very much so, at time of leaving. 3rd Committment, May 28/91 to Nov 26/93: (Vol 16 p 321 No. 2719). For several months, was usually quiet; talking only to herself: she seemed to realize her condition: at times, had "her nervous spells": showed some delusions, "offear" & had a spell of melancholia. Complained a good deal of constipation & some, of headache. began to menst: talked quite rationally. Improvement kept up & time of her going home. -

Nov 5 On admission, was put on B4 (G.H.R. Rpt. Complexion fair: hair gray: eyes blue: condition of skin normal; small scar on left hip: Is very clean. Talks quite sensibly, but behavior very noisy).

" 6 Nurses Notes. Very noisy. Appetite good. Has a very bad cough & expectorates. Bowels regular. Pulse 80. Resp. 20 Temp. 98. Nov 7 Talks quite sensibly but very noisy. Appetite fairly good. Bowels regular. Quite noisy 2 hrs. during night. Nov 8 Very noisy all day. Appetite good. Very quiet during night. Slept 5 hrs.

" 9 Very noisy. Has very bad cough. Takes medicine for cough. Bowels regular. Appetite fair. Expectorates a good deal. Nov 10 Appetite good. Very noisy all day. Bowels regular. Nov 11 Very noisy all day. Takes medicine for cough. Appetite good. Bowels regular. Nov 12 Went out walking today. Appetite good. Noisy all day. On coughing is unable to control her urine.

" 13 Went out walking today. Eats & sleeps quite well. Bowels regular. Very noisy.

" 14 Appetite good. Slept quite well during night. Nov 15 Eats & sleeps well. Noisy.

" 16 Appetite good. Bowels constipated today. Has taken Cathartic.

" 17 Noisy part of day. Appetite good. Nov 18 Eats & sleeps well. Nov 19 Appetite good. Quite noisy. Bowels constipated took Cathartic. Slept quite well during night.

Personal and Medical History of Bridget Sullivan.

Summary Patient talks quite sensibly but behaves noisy. Has very bad cough & expectorates a great deal: & in coughing is unable to control her urine. Takes medicine for cough. Appetite good. Bowels not regular. Takes cathartics. Went walking several times. Sleeps quite well. Temp. 98 Resp. 20 Pulse 80

Nov 27 Appetite good - Bowels constipated. Takes cathartics. Very noisy most of time. Coughs some & expectorates a good deal - Dec 4 Has cough & expectorates a great deal. Takes medicine - Noisy part of time - Appetite good. Bowels constipated. Takes cathartics. Dec 10 Trans. to C 3. Dec 27 Appetite fairly good. Extremely noisy all the time. Coughs & expectorates - Bowels constipated - Takes cough medicine. Dec 25 Fought nurses - Refused medicine. Dec 26 Refused to go to dining room. Trans. to C 3. Jan 15 Appetite fairly good - Bowels irregular - Expectorates some. Noisy at times & disagreeable. Jan 18 Complains of dizziness in head. Falls over when trying to walk - Jan 25 Trans. to B 1. Jan 26 Coughs a great deal. Complains of dizziness. Noisy & disagreeable at times - Bowels constipated. Takes cathartics - Appetite fair. Trans. to B 3. Feb 28 Has become very quiet in behavior - Habits occasionally dirty. Still coughs - Appetite good. Bowels constipated. Takes cathartic. Mar. 6 Quiet in behavior. Habits tidy. Appetite good. Bowels constipated. Does not work any. May 30 Quiet. Takes out door exercise. General health good. Takes tonic. Sleeps well. Takes no interest in ward.

1896 July Summary Nurses Notes by Dr. S.L. Pleas:- Appetite fair: bowels regular. Goes out of doors for exercise: sleeps quite well: talks incoherently: Nov 96 Appetite good: bowels constipated: coughs & expectorates: cough medicine given. Mar 97 At present is sensible & agreeable but often becomes excited & scolds: gen'l health fairly good:

1897 Apr. Refuses to go out of doors: coughs & expectorates: talks a good deal to self:

May 3 complains of feeling dizzy: fell when getting out of bed this morning.

May 18 Dizzy in morning: after being up a while is better: Appetite fair bowels constipated: sleeps well. June 1 97: Patient has been growing weaker past few days: dizzy: bowels usually constipated: coughs & expectorates: cough medicine given: June 9 97 Not able to get up: complains of pain in back: appetite poor: Slight emesis after meals: June 10 97 Up & dressed: Head better: Still has pain in back: emesis after eating breakfast: Transf. to Inf. June 12 Complains of headache & backache: plaster applied to back: coughs considerable: Has incontinence: slept well: June 13 97 Alcohol back given: complains of aching all over, especially back: quite noisy at times during night: June 14 Sleeping quite well: moaning & restless when awake: A.M. T. 100.6 P. 100. R. 26. P.M. T 101.8. P. 22 R 24

June 16 A.m. T. 100.6 P. 104 R 26 P.M. T 100.2 P. 98 R 22. Appetite poor: complains of thirst: also of aching: coughs some: cough med. given. Very drowsy: bowels regular. June 19 Appetite poor: T. 100.8 P. 88 R 24. Sleeps a great deal. June 21 97 a.m. T 100 P 97 R 18 P.M. P 87 T 98.8 R 22 Moaning & restless when awake: still complains of backache: Alcohol back

(See p. 20)

Personal and Medical History of Frederika Grau

LESLEY, FISLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4259.
Residence, Rice County Minnesota
Date Admission, 29th November 1895.
Admitted by, D. Luther Phelps Hour, 3 PM.
How Sent, R. A. Mott. J. of P. Rice County
Sex, Female
Age, Unknown 40?
Civil Condition, Single
Children, none
Age Youngest Child,
Occupation, Laborer; Fathers also laborer
Degree Education, None
Profession Religion, Lutheran
Habits, Not known.
Nativity, Germany; (Parents also born there).
Physicians Committing, D. M. Cool and W. A. Laug
Correspondents, None given in papers

No. for Year, 8th.
Insane Relatives, Not known
Cause Exciting, Age & want of mental Capacity
Cause Predisposing, probably age
Form,
Accompanying Bodily Disorder, feebleness
Suicidal or Not, Not
Date of this Attack, Not Stated
Duration, Probably some time
No. of Attack, 1st.
No. of Admissions, 1st.
Age First Attack, (?)
Time of Leaving, July 18-'96
Time in Hospital, 7 mos. 19 da.
Result, Discharged Nov. 10 '96- Improved.

EXAMINATION ON ADMISSION
MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Confused
Quick or Sluggish, Sluggish
MEMORY:
Past Events, Can not test
Recent Events,
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Dull
Correct or Illusive, Illusive
REASONING POWER: Impaired
Ordinary Subjects, "
Own Mental State, "
Special Subjects,
GENERAL DESCRIPTIVE REMARKS:
Mental condition that of dementia

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed, Depressed.
DELUSIONS:
Systematized or Not, Seems to have
Special Subjects, delusions
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent, Does not talk
Voluble or Reticent, excepting at times a few words & ask questions
Prowls a good deal

Personal and Medical History of Frederika Grau

EXAMINATION ON ADMISSION, CONTINUED.
PHYSICAL CHARACTERISTICS.

HEIGHT, 4 feet 10 in. WEIGHT, not taken NUTRITION, Impaired
WOUNDS OR ABNORMALITIES, Feet very much deformed and covered by hard crust of dirt and old skin
TONGUE, Tremors, Coatings, Promptness Movement,
PUPILS, Equality, Size,
Response Light, Accommodation,
SIGHT, Prob. impaired
HEARING, Seems impaired
COORDINATION, Arms, Impaired
Legs, Impaired
TREMORS, Hands, Irregular movements Tongue,
Facial Muscles, General, Limbs deficient of shape
REFLEXES, Patellar, Can not test
Other
ARTICULATION,
Slurred,
Hesitating,
FACIAL EXPRESSION, Demented
SENSIBILITY,
HEART,
LUNGS,
GYNAECOLOGICAL EXAM., Normal condition Exam Dec 20-95.
MENSTRUATION,
OPHTHALMOSCOPIC EXAM.,

TAKEN,

EXAM. URINE, Dec 3/95
Urine 24 hrs 3 XXIV
Color Red yellow
Character Cloudy
Sp. Gr. 1014
Reaction Acid
Albumen T
Sugar
Urea
Sediments Casts of tissue epithelial cells pus & blood Casts Granular & Hyaline

HABITS, Dirty, Dirty Clean, Careless,
BOWELS, Normal, Constipated, Irregular,
APPETITE, Good, Medium, Poor, Poor
SLEEP, Good, Poor, Poor Irregular,
PULSE, Resp., Temp.,
CRANIAL MEASUREMENTS,
HISTORICAL,
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations,
Father or Pat. Relations,
Brothers or Sisters,

Personal and Medical History of Fredericka Grau

1895

This patient was brought here by Sheriff Stewart, and a lady attendant, with following history. Patient is in very [illegible] This is 1st attack. has not been in Hosp wild notions about rational intervals, disposed to injure o were previously shown. No any history of intemperance, no any disease of head - injury; has been restrained by watching & shutting her in the house. Supposed Cause of the disease is Hyp and want of mental capacity. Nothing has been given by way of medical relief. All particulars given above: this is a clear case of dementia, with temporary insanity.

Fredericka Grau.

Mar. 13th, '96.-- Brother states that she has always been somewhat peculiar; had habits of lying and stealing and seemingly generally unreliable. About two years ago, seemingly, the more active troubles commenced, since which time she has had occasional melancholy spells.

Nov 29 On admission, was put on B3 (G.P.M. Hyst. Complexion dark; hair brown; eyes blue: condition of skin hot & dry: right leg, both feet and hand & sore & callosed: both knees bruised. She is very dirty; both hands & feet deformed: behavior quiet: does not speak English).

30 Patient very restless. Appetite poor. Did not sleep any. Constipated. Complains of head & feet Pulse 78 Resp. 18 Temp. 98.

Dec. 1 Patient drank one glass of milk. Took no other nourishment. Feet were poulticed twice. Sores on hand dressed. Was very restless.

2 Appetite poor. Bowels regular. Complains of pain in head & back. Feet poulticed. very restless. T. 98.6 P. 78 R. 20

3 Quite noisy. Appetite poor. Bowels regular. Lesion in habits took Tonic. Feet poulticed T. 97.6 P. 78 R. 28

4 12 M. Temp. to Inf. R. Appetite quite good. Foot dressed. Noisy & restless for 2 hrs. Slept remainder of night

5 T. 98 P. 78. R. 27. Salts given. Bowels moved freely. Tonic given. Very noisy all day. Fed by nurse. Resists a good deal. Foot dressed

Dec 6 Very noisy sitting up most of afternoon. Morphine Hyp. gr. 1/8 more quiet since. Bowels moved. P80. Feet dressed. Resists feeding

7 Quite noisy most of day. Feet dressed. Bowels moved. Complains of headache & nausea. Still resists about being fed

8 4 P.M. T. 99 P. 76 R. 18 Feet dressed. Noisy greater part of day. Bowels moved. Fed by nurse - resisted

9 5 P.M. T. 99.8 P. 72. R. 16 Appetite fair. Salts given. Bowels moved freely. Noisy part of day. Feet dressed.

10 Appetite about same T. 99.8 P. 76 R. 16. Bowels moved. Crying & noisy most of day "

11 Resisted being fed. Feet dressed. Bowels constipated, Castor oil given. T. 99.8 P. 76 R. 20

12 T. 98. P. 76. R. 16. Appetite fair still has to be fed. Feet dressed. Castor oil given. Bowels moved freely. Slept quite well. Dec 13 Resists being fed. Crying & noisy greater part of day P. 76. Feet dressed. Tonic given. Slept well.

Summary Quite noisy Most of time. Can not talk English. Has to be fed by nurse & resists a great deal. Feet dressed daily.

Dec 22 Patient slept 7 hrs. Talked at times. Dec. 23 Slept 6 hrs. Sat up in bed 1 hr.

" 30 Appetite very good of late. Takes tonic. Very noisy. Feet dressed daily & Body Bath

Jan 3 Violent in behavior. Refuses tonic. Untidy in habits. still noisy. T. 99. & P. as R. 26. Coughs & expectorates. Bowels usually constipated. Jan 6 Refuses solid food. but drinks plenty of milk. Bowels quite loose last few days. Body bathed with solution of carbolic acid & Glycerine & water. Very noisy 99.8 P. 101, R. 29 Jan 10 T. 98.6 P. 104, R. 24. Jan 11 Very noisy at times. Feet

Personal and Medical History of Fredericka Grau.

T. 98.8. Ointment applied. Jan. 12 Body bathed & dusted with bismuth - very noisy T. 98.4 C. 96 - R 20. Jan 15 T. 99.6 P. 108. R. 23. Jan 16 T. 99.2 P. 104. R. 22. Jan 22. Feet dressed daily. Body rubbed with ointment daily. Quite noisy at times. Appetite good. Bowels regular. Feb 24 Noisy & crying most of day Feb 26. Quiter today. Moved to B4. Feb 27 Appetite good. Bowels regular March 2 Eats & sleeps well. Bowels regular. Has spells of crying & is very anxious to go home. Apr. 10 Has a sore leg - dressed with balm every few days.

May 28 Complains of headache this afternoon. Temp. 102.2 P. 100. R. 30. Took pill bowels moved. May 29 9 A.M. T. 102.2 P. 100 R. 40. Sponge baths given at 9.30 & 11 a.m. Refused dinner. Sponge bath at 3 P.M. at 4.30 T. 104 R. 36 P. 110 5.30 P.M. ½ cup milk. Trans. to Inf - sick record kept. Lungs examined.

May 30 Some portion of right lung exhibited rales: cotton jacket applied: put to bed. Nourishment consists of milk given every two hours: Cathartic given, bowels moved freely. May 31 A.M. T. 102.4 P.M. T. 102.7 Same treatment continued. May 26 Temp. remains 102.4 P. 104 R 34. 11.30 A.M. T. 105.6 P. 108 R. 28. Sponge baths every hour or so for reduction of temp. May 27 A.M. T. 103. P. 108 R. 30. Same treatment continued P.M. T. 104.4 May 28 A.M. T. 101. P. 104 R. 28 P.M. T. 102.4 P. 84 R. 32 Sleeps quite well: milk continued every two hours: Sponge baths continued

May 29 A.M. T. 102 P. 85 R. 33. P.M. T. 102.2 P. 80 R. 30 May 30 T. 99 R. 26 P. 80. Same treatment continued. May 31 T. 99 P. 78 R. 29. A little oatmeal gruel given for breakfast. June 1 T. 99.7 P. 78 R. 21. Beginning to eat soft food, cream toast, oatmeal, etc: June 6 Has improved steadily each day & is now able to sit up a short time. June 9 Up & dressed. Each day since last note: is now taking regular diet: improving. June 17 Patient about same as usual was taken out riding yesterday: Temperature normal: appetite good: bowels regular

July 18. Patient has gained steadily: is now in as good health as usual.

Went Home. :-For further notes refer to nurses record.—

Discharged

Personal and Medical History of Frederika Grau

1895

This patient was brought here by Sheriff Stewart, and a lady attendant, with following history. Patient is in very feeble condition. As to consanguinity or heredity, unknown. This is 1st attack, has not been in hospital before. When first symptoms were manifested, is not stated: patient had wild notions about chickens, and in cows starving. Disease seems increasing, but variable & with rational intervals, at irregular periods. Derangement now shown in above manner. She is not disposed to injure others, nor suicidal, but is offilthy and destructive habits. No peculiarities were previously shown. As to any history of intemperance, nothing known. She has had no severe diseases or head-injury; has been restrained by watching & shutting her in the house. Supposed Cause of the disease is Age and want of mental capacity. Nothing has been given by way of medical relief. All particulars given above: this is a clear case of Dementia, with temporary insanity.

Nov 29 On admission, was put on B² (G.H.N. Hpt. Complexion dark: hair brown; eyes blue: condition of skin hot & dry: right leg, both feet and hand & sore & callosed: both knees bruised. She is very dirty; both hands & feet deformed: behavior quiet: does not speak English).

Nov 30 Patient very restless. Appetite poor. Did not sleep any. Constipated. Complains of head & feet. Pulse 78 Resp. 18 Temp. 98.

Dec. 1 Patient drank one glass of milk. Took no other nourishment. Feet were poulticed twice. Sores on hand dressed. Was very restless.

2 Appetite poor. Bowels regular. Complains of pain in head & back. Feet poulticed - very restless. T. 98.6 P. 78 R. 20

3 Quite noisy. Appetite poor. Bowels regular. Clean in habits but Tonic. Feet poulticed. T. 97.6 P. 78 R. 28

4 12 M. Temp. 98 Resp. 20. Appetite quite good. Feet dressed. Noisy & restless for 2 hrs. Slept remainder of night

5 T. 98 P. 78. R. 27. Salts given. Bowels moved freely. Tonic given. Very noisy all day. Fed by nurse. Resists a good deal. Feet dressed.

Dec 6 Very noisy sitting up most of afternoon. Morphine Hyp. gr 1/8 more quiet since. Bowels moved. Ate. Feet dressed. Resists feeding.

7 Quite noisy most of day. Feet dressed. Bowels moved. Complains of headache & nausea. Still resists about being fed.

8 4 P.M. T. 99 P. 95 R. 18 Feet dressed. Noisy greater part of day. Bowels moved. Fed by nurse - resisted.

9 5 P.M. T. 99.8 P. 72. R. 16. Appetite fair. Salts given. Bowels moved freely. Noisy part of day. Feet dressed.

10 Appetite about same. T. 99.8 P. 76 R. 16. Bowels moved. Crying & noisy most of day. "

11 Resisted being fed. Feet dressed. Bowels constipated, castor oil given. T. 99.8 P. 76 R. 20

12 T. 98. P. 76. R. 16. Appetite fair still has to be fed. Feet dressed. Castor oil given. Bowels moved freely. Slept quite well. Dec 13 Resists being fed. Crying & noisy greater part of day. P. 76. Feet dressed. Tonic given. Slept well.

Summary Quite noisy most of time. Can not talk English. Has to be fed by nurse & resists a great deal. Feet dressed daily.

Dec 27 Patient slept 5 hrs. Talked at times. Dec. 29 Slept 6 hrs. sat up in bed 1 hr.

" 30 Appetite very good of late. Takes tonic. Very noisy. Feet dressed daily. Body Rash

Jan 3 Violent in behavior. Refuses tonic. Untidy in habits. still noisy. T. 99.2 P. 88 R. 26. Coughs & expectorates. Bowels usually constipated. Jan 6 Refuses solid food but drinks plenty of milk. Bowels quite loose last few days. Body bathed with solution of Carbolic acid & Glycerine & water. Very noisy. T. 99.8 P. 101. R. 29 Jan 10 T. 98.6 P. 104 R. 24. Jan 11 Very noisy at times. Feet

Personal and Medical History of Frederika Grau.

T. 98.8. Ointment applied. Jan. 12 Body bathed & dusted with bismuth - Very noisy T. 98.4 P. 96 R. 20. Jan. 15 T. 98.4 P. 108 P. 22 [illegible] P. 104. R. 22.

[illegible] daily Quite noisy [illegible] & crying most of day [illegible] Bowels regular [illegible] ing & my anxious to go very few days.

May 28 Complains of headache this afternoon. Temp. 102.2. P. 100. R. 30. Took pill bowels moved. May 29 A.M. T. 102.2. P. 100 R. 40. Sponge baths given at 9.30 & 11 a.m. Refused dinner. Sponge bath at 3 P.M. at 4.30 T. 104 P. 36 P. 110 5.30 P.M. ½ cup milk. Temp. to stay - Sick record kept. Lungs examined.

May 30 Lower portion of right lung exhibited rales: cotton jacket applied: put to bed. Nourishment consists of milk given every two hours: Cathartic given, bowels moved freely. May 31 A.M. T. 102.4 P.M. T. 102.7 Same treatment continued. May 26 Temp. remains 102.4 P. 104 R. 34. 11.30 a.m. T. 105.6 P. 108 R. 28. Sponge baths every hour or so for reduction of temp. May 27 A.M. T. 103. P. 108 R. 30. Same treatment continued P.M. T. 104.4 May 28 A.M. T. 101. P. 104 R. 24 P.M. T. 102.4 P. 84 R. 32 Sleeps quite well: milk continued every two hours: Sponge baths continued

May 29 A.M. T. 102 P. 85 R. 33. P.M. T. 102.2 P. 80 R. 30 May 30 T. 99 R. 26 P. 80. Same treatment continued. May 31 T. 99 P. 78 R. 29. A little oatmeal gruel given for breakfast. June 1 T. 99.7 P. 78 R. 21. Beginning to eat soft food, cream toast, oatmeal, etc: June 5 Has improved steadily each day & is now able to sit up a short time. June 9 Up & dressed. Each day since last note: is now taking regular diet: improving. June 12 Patient about same as usual was taken out riding yesterday: Temperature normal: appetite good: bowels regular

July 8 Patient has gained steadily: is now in as good health as usual.

Went Home. :-For further note refer to nurse record. —

Discharged

Personal and Medical History of Rosa Rodgers

LIBERT, FISCHER & BROWNLEE, DAVENPORT, IOWA.

Whole No. 4261

Residence, Highland Minnesota.

Date Admission, 30th November 1895. —

Admitted by, Dr. C. B. Eby Hour, 2.25 P.M.

How Sent, Malcolm Kennedy, Jo. P. Wabasha County.

Sex, — Female —

Age, — 40 years —

Civil Condition, single

Children, None

Age Youngest Child,

Occupation, House-keeper

Degree Education, Not stated

Profession Religion, Catholic

Habits, both temperate & moral

Nativity, Norristown, Penn.

Physicians Committing, J. A. Slocumb and E. S. Muir

Correspondents, James Rogers, Highland, Minn

No. for Year, 89.

Insane Relatives, None

Cause Exciting, No apparent cause known.

Cause Predisposing, not stated

Form,

Accompanying Bodily Disorder, None mentioned

Suicidal or Not, — not —

Date of this Attack, probably recent

Duration, probably short.

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, — 40 —

Time of Leaving, February 7th 1896.

Time in Hospital, 2 mo. 8 da.

Result, Improved Disc. Aug. 12' 96.

EXAMINATION ON ADMISSION
MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused,

Quick or Sluggish, Quick

MEMORY:

Past Events, Normal

Recent Events, Normal

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Alert

Correct or Illusive,

REASONING POWER: Fairly good

Ordinary Subjects,

Own Mental State,

Special Subjects,

GENERAL DESCRIPTIVE REMARKS:

EMOTIONAL STATE:

Normal, Calm, Calm

Indifferent,

Exalted,

Depressed, Somewhat depressed

DELUSIONS:

Systematized or Not,

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent, Coherent

Voluble or Reticent, Talks willingly and quite sensibly

Personal and Medical History of Rosa Rodgers

EXAMINATION ON ADMISSION, CONTINUED.
PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 2in WEIGHT, Not taken NUTRITION, Good.

WOUNDS OR ABNORMALITIES, None

TONGUE, Tremors, Coatings, Heavy yellow fr down along side Promptness Movement,

PUPILS, Equality, Equal Size, Normal

Response Light, Normal Accommodation,

SIGHT, Not good Pterygium on left eye & one beginning on right.

HEARING, Normal

COORDINATION, Arms,

Legs, Uncertain

TREMORS, Hands, No special tremors Tongue,

Facial Muscles, General,

REFLEXES, Patellar, Equal & Normal

~~Other~~ Vertigo. Dizzy at times

ARTICULATION,

Slurred,

Hesitating,

FACIAL EXPRESSION, Some what worried.

SENSIBILITY,

HEART, No murmurs but very tumultuous

LUNGS, Some what hollow chested

GYNAECOLOGICAL EXAM., Dec 9' 96 Uterus in position. Slight erosion of os. Tenderness of both internal and external parts. Some hypertrophy.

MENSTRUATION,

OPHTHALMOSCOPIC EXAM.,

TAKEN,

EXAM. URINE, Dec 5/95

Urine 24 hrs 3 XXXII

Color Yellow

Character Flaky white dep

Sp. Gr. 1015

Reaction acid

Albumen #

Sugar

Urea

Sediments. Epithelium {Squamous / Round cells / Columnar} Casts {Granular / Epithelial} from a few blood & pus cells. Amorphous phosphates and uric acid crystals.

HABITS, Dirty, Clean, ✓ Careless,

BOWELS, Normal, Constipated, ✓ Irregular,

APPETITE, Good, Medium, Poor, Impaired

SLEEP, Good, Poor, Irregular, Not well.

PULSE, Irregular 110 Resp., Temp.,

CRANIAL MEASUREMENTS, 20

HISTORICAL,

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,

HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")

Mother or Mat. Relations,

Father or Pat. Relations,

Brothers or Sisters,

Personal and Medical History of Rosa Rodgers

1895

This patient was received here at the hands of Deputy Sheriff D.C. McKenzie, attended by Mrs D.C. McKenzie with following history. Patient is in fair physical condition. There is no history of heredity: no apparent cause known for the disease. Form is acute delusional & constant somewhat depressed. No accompanying bodily disorder. First symptoms manifested by hallucinations. This is 1st attack. She is now quite rational, at times but of very short duration. Much mutterings and delusions. Patient is not disposed to injure others, nor suicidal, nor filthy nor destructive in habits. There is no history of any severe disease &c or head-injury. During last few days, moderate restraint has been used, patient simply being confined to her room & not allowed freedom of the house. Has had medical treatment and drugs used to quiet. Has had employment as housekeeper & not moved at all in society & has been alone, most of the time.

Nov 30 On admission, was put on B.T. (G.A.H. Supt. Complexion fair, hair auburn, eyes blue: condition of skin normal: bruise on left arm: is clean: eyes very much inflamed. Quiet & talks sensibly)

Dec 9 Gynaecological examination made today. Found parts very tender & hyperaemic put upon treatment. Put also upon general tonic treatment. Upon admission patient's throat & mouth were quite sore she was put upon special treatment for this trouble of spray & mouth wash & kept upon it for about 2 weeks. Dec 29 Throat trouble improved. Mentally patient has been very quiet & well behaved, seems very sensible in talk when addressed, has manifested no delusions, is very pleasant in manner & works on ward every day. Jan. 7 Was visited by brother; although she was very quiet & well behaved yet he did not seem to want to take her home. Jan. 28 Patient remains very quiet & agreable talks quite sensibly. Appetite is good: sleeps well. Much improved in general health Continues to work every day.

Feb 7. Brother came today & took her home. During her stay here she exhibited a slightly feeble-minded condition. She was always very well behaved during the time of her stay & worked all the time. Went Home.

Nurses Notes (omitted above) Dec. 1 Quiet. In bed all day. Talks quite sensibly Appetite poor. Slept three hours. Bowels moved several times during day. P.100 R.22 T.100.2

Dec " 2 Quiet in behavior. Bowels moved. Slept 4 hrs. T.100.2 P.100 R.22. Appetite poor. Takes tonic. Mouth washed out with Listerine & Bismuth.

" 3 Very quiet. Talks sensibly. Bowels moved. Slept 2 hrs. Menstr. Appetite fair. Urine 3 XXXII T. 99. P. 90 R. 19. Dec. 4 Quiet in behavior Bowels constipated. Mouth washed with listerine & bismuth. Takes tonic

" 5 No delusions noticed. Talks sensibly. Works some in dining room. Slept 7 hrs. Menstr. Appetite fair. Bowels constipated. Dec. 6 Trans. to A 1 Dyn. Treatment given. Dec 8 During second week. Was quiet in behavior. no delusions noticed. Talked sensibly. Appetite quite poor. Sleeps fairly well

Personal and Medical History of Rosa Rodgers.

Mouth & throat still very sore, washed frequently with listerine & bismuth.

Summary Patient has been very quiet on ward. Seldom speaks except when spoken to. Talks sensibly. Appetite poor usually. Generally sleeps fairly well. Bowels generally constipated.

Discharged

Maggie Boyles

Up to Feb. 1st, 1903. General health good: bowels regular: sleeps well: exercises: does no work: is at times noisy and restless; runs about the ward aimlessly: is delusional: at times violent. Admitted Wt. 127 lbs.

Personal and Medical History of Theresia Tschida

LIBERT, FIDLAR & GUNDLACH, DAVENPORT, IOWA.

Whole No. 4262.
Residence, St Paul: Minn.
Date Admission, 30th November 1895.
Admitted by, Dr. Herzog Hour, 7 P.M.
How Sent, G. Wilbrich, Jo P. Ramsey County
Sex, Female.
Age, — 20 —
Civil Condition, single
Children,
Age Youngest Child,
Occupation, Father a laborer
Degree Education, Common School.
Profession Religion, Yes: Roman Catholic.
Habits, not Stated
Nativity, Hungary: (Parents also born there).
Physicians Committing, C. Eugene Riggs and A. B. Ancker
Correspondents, none given in papers

No. for Year, 90.
Insane Relatives, a cousin of her father died insane
Cause Exciting, Unknown
Cause Predisposing, heredity & previous attack
Form,
Accompanying Bodily Disorder, None mentioned
Suicidal or Not, Suicidal & propensity active
Date of this Attack, Last night
Duration, about one Day.
No. of Attack, Not 1st: (had one last July).
No. of Admissions, 2nd
Age First Attack, 19 past
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION
MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Confused
Quick or Sluggish, Sluggish
MEMORY: Probably impaired
Past Events,
Recent Events,
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Dull
Correct or Illusive, Illusive
REASONING POWER: Much impaired
Ordinary Subjects,
Own Mental State,
Special Subjects,
GENERAL DESCRIPTIVE REMARKS:
Cross and snarly and will not allow a thorough examination

EMOTIONAL STATE:
Normal, Calm,
Indifferent, Indifferent
Exalted,
Depressed,
DELUSIONS: Seems to have many
Systematized or Not, but no definite ones
Special Subjects, determined
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent, Very incoherent
Voluble or Reticent, Reticent

Personal and Medical History of Theresia Tschida

EXAMINATION ON ADMISSION, CONTINUED.
PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 3 in WEIGHT, not taken NUTRITION, Good
WOUNDS OR ABNORMALITIES,
TONGUE, Tremors, Coatings, Heavy Promptness Movement,
PUPILS, Equality, Equal Size, Normal
Response Light, Accommodation,
SIGHT, Normal
HEARING, Normal
COORDINATION, Arms, Impaired
Legs, Gait uncertain
TREMORS, Hands, Slight Tongue,
Facial Muscles, General, Gait uncertain
REFLEXES, Patellar,
Other
ARTICULATION,
Slurred,
Hesitating,
FACIAL EXPRESSION,
Dull & Worried
SENSIBILITY,
HEART, No murmurs
LUNGS, Normal
GYNAECOLOGICAL EXAM., Normal
MENSTRUATION,
OPHTHALMOSCOPIC EXAM.,

TAKEN,

EXAM. URINE, Jany 6/96
Mixed 24 hrs 7 oz V-iij
Color Brown Red
Character Heavy brownish flaky dep
Sp Gr 1015
Reaction Alkaline
Albumen 0
Sugar
Urea 1329
Sediments Sand fine # Round-bladder cells
Amor urates

HABITS, Dirty,	Clean, ✓	Careless,
BOWELS, Normal,	Constipated, ✓	Irregular,
APPETITE, Good,	Medium,	Poor,
SLEEP, Good,	Poor,	Irregular,
PULSE, about 90	Resp.,	Temp.,

CRANIAL MEASUREMENTS, 21¾
HISTORICAL,
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations,
Father or Pat. Relations,
Brothers or Sisters,

Personal and Medical History of Theresia Tschida

1895

This patient was received here at the hands of Sheriff's Deputy George L. Rochats, and attended by Miss Akers, with following history. Patient is in fair physical condition. There is no history of Consanguinity, but some of heredity: (Mary Fleischacker, a cousin of patient's father died at Rochester, some time in March). This is not the 1st attack: She had one last February, when she was sent to this (Rochester) Hospital & discharged in May '95. First symptoms of this attack were manifested by a maniacal outburst, last night. Disease seems increasing: no rational intervals, at present. Derangement now shown by acute mania. She is not disposed to injure others, but is suicidal; tried to butt her head on Jail-floor. Propensity now active. No filthy or destructive habits. As to any peculiarities see previous history. There is no history of intemperance in self or parents, no of any severe disease or a head injury. Supposed cause of the disease is unknown. Has only had hospital treatment. On Examination Patients hands were encased in muff: She was maniacal & had to be under constant care of attendant. As above stated, patient was here before, from Feb 1/95 to May 8/95: was discharged improved — just previous to her then coming here. She had been in C & C Hospital, St Paul, for one month & 4 days. While there, had an attack of Scarlatina: was also noisy & violent & had to be restrained: also had to be fed by tube: showed delusions: after coming here, she remained in bed for a time. was dull & stupid: refused food: would not talk: cried frequently: During latter part of January, she became brighter & talked quite sensibly: worked in dining room & later, in Laundry. At times she was silly, egotistical and childish in manner. Her father visited her, & he being very anxious to take her home on trial, as he also needed her services, she was allowed to go.

* Note. Vol 28 - Pg 39 No 3979

Nov 30 On admission, was put on B.7. (L.S.A.R.Hft. Complexion dark: hair brown: eyes blue: condition of skin normal: no marks scars or bruises noticed: is quite dirty: behavior rather noisy: silly).

Dec 1 Nurses Notes. Behavior silly. Pounded head on floor. Has delusions, Appetite poor. Slept six hrs. Bowels constipated. Pulse 90, Resp. 22 Temp. 99.8.

" 2 Quite excited. Appetite poor. Difficult to feed herself. Slept 5 hrs. Menstr. Temp. 99 Pulse 90. Resp. 20. Takes tonic. Bowels moved by cathartic. Dec 3 Some quieter. Behavior silly. Untidy in appearance. Bowels moved. Takes tonic. Appetite poor. Slept six hrs. Temp. 98.8 P. 90 R. 19. Menstr. Dec 4 Has delusions that someone is tracing about her. Very silly. Bowels constipated. Slept seven hrs: appetite poor.

Dec 5 Quite noisy & silly. Takes tonic. Bowels moved. Slept 9 hrs. Urinates regularly

6 No change in patient. Appetite poor. Slept 8 hrs. Bowels irregular. Takes tonic

7 More quiet in behavior. Has delusions. Refuses to feed herself. Slept 7 hrs. Bowels constipated

8 Quiet in behavior. Appetite very poor. Has delusions. Bowels moved freely. Slept 6 hrs.

Dec 9 to 14 Quiet. Appetite poor. Talks silly. Talks little. Bowels constipated. Urinates regularly. Slept from 6 to 8 hrs on an average. Is working in laundry.

Summary. Quite excited at first, more quiet of late but silly in behavior. Menstr. Appetite poor; bowels irregular. Will not talk readily. Works in laundry. Sleeps well. Untidy in personal appearance. Dec. 16-17-20-22 Fed with tube. Takes tonic. Jan 8. Appetite improved some. Works a little on ward. Is some better. Does not talk very readily. Jan 13. Complains of toothache. Is some

Personal and Medical History of Theresia Tschida

1896

quieter. Jan 23. Much quieter. Works some on ward. Has delusions that worms are crawling on her. Feb 5. Gyn. treatment. Feb. 17 Has delusions - very nervous. Feb 19 Appetite poor - No change. Mar 19 Very stupid at times. Takes tonic. Appetite quite poor. Bowels constipated at times. Takes cathartics. Apr 15 Very stupid at times. Takes tonic. Tried to hurt one of the ladies at table with her fork. Appetite poor. May 11. Appetite poor. Bowels regular - Takes tonic. Seems some brighter of late. May 30 Is stupid. Appetite good.

June Summary Nurse's Notes by Dr. S. E. Phelps: Appetite fair: Has spells of crying: rather demented: Nov. menstr. regular: very noisy at times: works in mending room: appetite good: bowels irregular: Jan 97 Quite noisy at times: Habits dirty: appearance untidy: silly: May 97 no change 1897 appetite fair: untidy: works in laundry: gen'l health good: talks & acts silly. Aug. Continued by Dr. M. Phelps. Nov 29-97 Patient rather restless: sings a good deal: Is silly & incoherent: Very demented in manner. Feb 9 '98 Wt. 156# Aug 30 Thaws to 6°. was found to be rather restless & noisy for a week. Feb 28 General health good. Is rather stupid & at times restless & sullen. Mar. to Sept '99 (Cont. by Dr Webb) General health quite good: appetite poor: bowels usually regular: takes out door exercise: Is filthy, destructive & quite violent at times: quite noisy at night.

Sept 1 - Feb 28 1900 (At Hayesdale) Dirty: Bowels regular: Sleeps well: Violent & destructive & takes out door exercise: Appetite good: Feb 28 - May 30 1900. General health good: Does not look well: altho complains of no special trouble: Appetite fair: sleeps well: occasionally violent: Does not converse: Takes out door exercise somewhat untidy: Nov. 20 Wt. 115½#. Dec 1 - Feb 28 1901 General health good: Feb 15 Wt 110 No change. Mar. to June 1901 No change in mental or physical condition May 28 Wt. 111#. June to Sept. Patient not as well as usual, is pale, appetite poor, bowels regular, takes regular out door exercise daily, is unoccupied. Wt. 101# Sept to Dec. Patient is unoccupied, will answer questions, habits clean, takes out door exercise, menstruates regularly, does not attend amusements, Nov. 23 Wt. 100#.

Dec to Feb. 1, '03 No change. Wt about 91#.

Personal and Medical History of Johannah Meaney (or Maney)

LEBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4267.
Residence, Wabasha, Co. Minnesota
Date Admission, 5th December 1895.
Admitted by, Dr. C.B. Eby — Hour, 2.20 P.M.
How Sent, Malcolm Kennedy, Jof P. Wabasha County.
Sex, Female -
Age, — 30 - (32)
Civil Condition, Single
Children,
Age Youngest Child,
Occupation, Domestic
Degree Education, Common School
Profession Religion, Yes: Catholic
Habits, not intemperate
Nativity, Ireland: (Parents also born there).
Physicians Committing, H. Adams & Wm F. Wilson
Correspondents, Michael Meaney (bro) Lake City. Minn
(address given in previous Commitment)

See Telegraph address Vol 28 page 141

No. for Year, 95.
Insane Relatives, none, so far as known.
Cause Exciting, not given; (homesickness previously stated)
Cause Predisposing, previous attack.
Form,
Accompanying Bodily Disorder, None mentioned
Suicidal or Not, - not -
Date of this Attack, about 3 weeks since
Duration, about 3 weeks -
No. of Attack, 2nd
No. of Admissions, 2nd
Age First Attack, - 30 - (32)
Time of Leaving, Oct 23. 1896
Time in Hospital, 10 mo. 18 da.
Result, Died -
Tubiculosis Pulmonalis.

EXAMINATION ON ADMISSION
MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Confused
Quick or Sluggish, Sluggish
MEMORY: Impaired
Past Events,
Recent Events,
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Dull
Correct or Illusive, Only partially correct
REASONING POWER, Impaired
Ordinary Subjects,
Own Mental State,
Special Subjects,
GENERAL DESCRIPTIVE REMARKS:
Dull + stupid in actions

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed, Depressed
DELUSIONS: Seems to have
Systematized or Not, but none determined
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION: Talks very little
Coherent or Incoherent,
Voluble or Reticent, Very dull and resists a good deal

Personal and Medical History of Johannah Meaney.

EXAMINATION ON ADMISSION, CONTINUED.
PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 6in WEIGHT, Not Taken NUTRITION,
WOUNDS OR ABNORMALITIES, Suppuration middle ear
TONGUE, Tremors, Coatings, Promptness Movement,
PUPILS, Equality, Equal Size, Normal
Response Light, Accommodation,
SIGHT,
HEARING, Probably good
COORDINATION, Arms, Seems fair as far as we can test. She is rather stuporous
Legs, in behavior
TREMORS, Hands, Tongue,
Facial Muscles, General, No marked tremors noted.
REFLEXES, Patellar, Normal - equal
Other
ARTICULATION, good. but unwilling
Slurred, ing & Talk.
Hesitating,
FACIAL EXPRESSION, Melancholy
SENSIBILITY,
HEART, Beats rapidly in a tumultuous manner
LUNGS, Expiration prolonged. No cough
GYNAECOLOGICAL EXAM., Dec 23-'95-U. normal position - Endometritis & profuse discharge
MENSTRUATION,
OPHTHALMOSCOPIC EXAM.,
HABITS, Dirty, Clean, Had lice on admission Careless,
BOWELS, Normal, Constipated, ✓ Irregular, ✓
APPETITE, Good, Medium, Poor, Wont eat much. Fed by tube
SLEEP, Good, Probably fair Poor, Irregular,
PULSE, Resp., Resp. 36 - but probably normal Temp.,
CRANIAL MEASUREMENTS,
HISTORICAL,
LENGTH OF INVASION, Probably quite long. ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Denies any heredity but her testimony is not reliable
Mother or Mat. Relations,
Father or Pat. Relations,
Brothers or Sisters,

TAKEN,

EXAM. URINE, Dec 19/95
Urine 24 hrs 3 V III
Color Red Yellow
Character Reddish granular dep
Sp Gr 1010
Reaction Acid +
Albumen T
Sugar
Urea
Sediments # Uric acid crystals

Personal and Medical History of Johannah Meaney

1895

This patient was received here at the hands of Michael Meaney, with following history — Patient is in fair physical condition. No consanguinity nor heredity, so far as known. This is not first attack: appears to be the 2nd: had one in the early part of this year, lasting about 4 months, when she was sent to this [Rochester] Hospital; temporary amendment there. The first symptoms of this attack were manifested about 3 weeks since, by apathy, anorexia, insomnia & depression. Disease seems increasing; not variable. Derangement now shown in that she is very silent; talks some to herself, but little to the family. Is not disposed to injure others, nor suicidal, nor of filthy or destructive habits. Previously, no peculiarities were shown, so far as can be ascertained. There is no history of intemperance in self or parents: has had no severe disease or head-injury: has not been restrained or confined (except as above stated). Can't say what is cause of disease this time, though "homesickness" was given as previous reason. She has had no treatment during this attack. At present, is of a morose disposition. —

*Note. As stated, patient was here before from Jany 8/95 to April 27/95. For some weeks after coming, she persistently refused food & had she fed by tube: bowels were badly constipated, at times, & required powerful cathartics to move them. She was very resentive & scolding, when any one was about her. Was sick in bed, as "infirmary ward", during February: was there given several injections of salt & water, as an anti-toxic remedy; effects (immediate) were good, and she was aroused from her stupor, & later, became much more active. She gained slowly and steadily, & during April, was much improved. She was much troubled with discharges from Ears, which made her quite deaf. Went home, recovered. (See Vol 28 page 41 No 3965.)

Dec 5 On admission, was put on B3 (G H U. Kpt. Complexion fair: hair dark-brown: eyes blue: condition of skin normal: no marks scars or bruises noticed: rather dirty & has vermin on her: quiet: talks sensibly).

Nurses Notes

" 6 Quiet in bed all day. No delusions noticed. Appetite poor. Slept 7 hrs. Bowels constipated. Gave Cathartic. Ear suppurates. Washed daily with listerine. Dec 7 In bed all day. Quite resistive. Refuses medicine. Appetite poor. Bowels constipated. Cathartic given. Refuses tonic. Ear washed with listerine. Mouth washed. Dec 8 In bed. Refuses medicine. Appetite very poor. Ear washed out 3 times a day. Dec 9 In bed. Refuses tonic. Appetite poor. Ear washed out 3 times a day. Bowels constipated.

Dec 10 In bed. Refuses tonic. Will not eat. Bowels constipated. Has delusions. Ear washed out 3 times.

" 11 In bed. Refuses tonic. Sleeps well. Will not eat meals. Bowels constipated. Ear washed out.

" 12 Quite resistive. In bed. A discharge from ear & similar one from mouth. Refuses tonic. Appetite very poor. Slept 8 hours. Bowels constipated. Refuses cathartic.

" 13 Appetite poor. Ear & mouth washed with listerine. Salt bath given. Slept 7 hrs. Given enema. Bowels moved twice — some blood with each movement.

" 14 In bed refuses food. Slept 8 hrs. Ear syringed. Salt bath. Bowels constipated. Last part of month for bowels. Dec 15 Fed with tube. Vomited most of food. Slept 7 hrs. Salt bath. Ear syringed. Mouth washed. Bowels constipated. Dec 16 Fed with tube. Ear & mouth washed with listerine. Salt bath. Full bath. Slept 7 hrs. Bowels constipated.

Dec 17 Fed with tube (gruel) 9 times. Salt bath also salt injection given. Ear & mouth washed with listerine. Urine in 24 hrs. ℥XIII Dec 18 & 19 Fed with tube. 9 times. Salts ℥ ½ ss. Salt bath. Ear &

Personal and Medical History of Johanna Meaney.

mouth washed out.

Summary Behavior quiet. Talks sensibly. Refuses food & medicine. A discharge from ear & mouth; washed daily with a solution of warm water & listerine. Salt baths & salt injection daily. So very resistive fed daily with tube. Urinates regularly. Urine ℥VIII in 24 hrs.

Dec 18 Salt baths given Dec 18, 22, 23, 24, 25. Fed with tube. Dec 26 & 27 Ate a little. Appt A discharge from ear & similar one from mouth. Cleansed daily with a solution of water & listerine. Daily salt baths given. Sleeps well. Appetite poor. Refuses tonic. Bowels constipated. In bed. Has delusions. Dec 30 Trans. to Inf.

Jan 6 Has to be fed with spoon. Bowels usually constipated. Enemas given. Douches. Salt baths & ear cleansed daily. T. 99. P. 84. R. 24. Jan 26 Same treatments continued. Appetite poor. Still fed with spoon. Enemata given. Bowels free again. Jan. treatment given. Feb 22 Visited by brother.

Feb & Mar 8 Sitting up on ward. Feb 28 Salt baths given daily. Mar 6. Visited by friends. Minute. Mar 26 In bed. T. 101. P. 80. R. 19. Refused food. Mar. 29 Coccis enlarged. Ate but one meal today. Mar. 30 Refused food. Takes tonic 4 times daily.

April Out on ward. Takes tonic 3 times daily. Very cross at times. Apr. 30 Appetite considerably better. May 20 Scolds a great deal. Does not want to sit up. Appetite poor. Takes tonics after meals. May 30 Urines on bed for past week. Bowels constipated. Salts given. Quite noisy at times.

June Summary Nurses Notes by Dr. S. L. Phelps: — Very disagreeable & wants to lie in bed all the time: appetite poor: bowels usually constipated: Transf. to B4: Aug. 96 Visited by brother: extremely noisy at times: Oct. 6 In bed to day. Takes medicine for cough: T. 100 P. 100 R. 40. Oct. 8: Lungs examined: find tubular breathing over whole area of left lung: Some flatness of percussion note in lower 1/3 left lung: Right lung breathing about normal: respiration much increased: coughs & expectorates a yellow sputa: Complains of pain in lower 1/3 of left lung. Oct. 9th T. 103. P. 110. R. 40. Refuses to take medicine Oct. 10 Fed with tube: Oct. 12th 96 Death to Inf. Oct. 13th 96 T. 104.2 P. 86. R. 36. Sponge bath given: coughs a great deal: cough medicine given:

Oct. 17 T. 104 3/4 P. 120. R. 30. Coughs & expectorates: Hands & feet swollen: Oct. 73/96 Has failed constantly: very weak: refused food. Died 7:30 p.m.

Died.

Personal and Medical History of Nattie E. Harris

LEIGHT, FISLER & KAMBERG, DAVENPORT, IOWA.

Whole No. 4270.
Residence, Stewartville Minn.
Date Admission, 12th December 1895.
Admitted by, Dr. Herzog — Hour, 8 PM.
How Sent, Thomas Fraser, Jof P. Olmsted County
Sex, Female
Age, 34
Civil Condition, married
Children, None
Age Youngest Child, —
Occupation, Housewife; husband a farmer.
Degree Education, Common School
Profession Religion, Seventh Day Adventist.
Habits, not intemperate.
Nativity, New York State (parents also born there).
Physicians Committing, J. K. Moses and Chas. T. Granger
Correspondents, J. M. Harris
Stewartville Minn

No. for Year, 98
Insane Relatives, None
Cause Exciting, Irritation from distasteful associate & her (Husbands): worry over limited income.
Cause Predisposing, "Chronic"
Form,
Accompanying Bodily Disorder, None mentioned.
Suicidal or Not, Not: but disposed to injure others
Date of this Attack, About 2 years ago
Duration, about 2 years
No. of Attack, 1st (seemingly Continuous)
No. of Admissions, 1st here (was at Battle Creek Sanitarium)
Age First Attack, about 32
Time of Leaving, Feb. 28' 96.
Time in Hospital, 2 mo. 14 da.
Result, Improved Disc. Aug. 12 96

EXAMINATION ON ADMISSION
MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Confused
Quick or Sluggish, Fairly quick an ordinary subject
MEMORY:
Past Events, Good
Recent Events, Good
Special Subjects, Good
PERCEPTIVITY:
Alert or Dull, Alert
Correct or Illusive, Mostly correct
REASONING POWER: Impaired
Ordinary Subjects,
Own Mental State, Impaired
Special Subjects,
GENERAL DESCRIPTIVE REMARKS:

EMOTIONAL STATE:
Normal, Calm,
Indifferent, Indifferent
Exalted,
Depressed,
DELUSIONS: Has delusive ideas
Systematized or Not,
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent, Talks quite willingly
Voluble or Reticent, about her condition
Thinks it is unjust to keep her here that John will never be any better

Personal and Medical History of Nattie E. Harris

EXAMINATION ON ADMISSION, CONTINUED.
PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 5½ WEIGHT, Not Taken NUTRITION, Seems fair
WOUNDS OR ABNORMALITIES,
TONGUE, Tremors, Coatings, Some yellow coatings Promptness Movement,
PUPILS, Equality, Equal Size, Normal
Response Light, Respond Accommodation,
SIGHT, Good
HEARING,
COORDINATION, Arms,
Legs,
TREMORS, Hands, at times Tongue,
Facial Muscles, General, Feels it in arms
REFLEXES, Patellar, Probably normal
Other
ARTICULATION,
Slurred, Good
Hesitating,
FACIAL EXPRESSION, Good
SENSIBILITY,
HEART, No murmurs, Normal size.
LUNGS, Normal

TAKEN,

EXAM. URINE, Dec 27/95
Urine 32 hrs
Color Pale yellow
Character Heavy granular white dep
Sp Gr 1026
Reaction Alkaline +
Albumen
Sugar
Urea 11 Gr
Sediments: Amor urates, triple phosphates & epithelia of Lines

GYNAECOLOGICAL EXAM., Dec 20-96 Endometritis Extensive erosions of cx. Profuse discharge
MENSTRUATION,
OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated,	Irregular,
APPETITE, Good,	Medium,	Poor,
SLEEP, Good, Usually fairly well.	Poor,	Irregular,
PULSE,	Resp.,	Temp.,

CRANIAL MEASUREMENTS,
HISTORICAL,
LENGTH OF INVASION, Two years ONSET GRADUAL OR SUDDEN, gradual
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, Living invalid Chronic dyspepsia Neurotic. Had Congestion of Brain once
Father or Pat. Relations, Died "Healthy" Creeping paralysis
Brothers or Sisters,

Personal and Medical History of Nattie E. Harris.

1895

This patient was received here at the hands of Sheriff C.N. Stewart + attended by J.M. Harris with the following history. Patient is in good Physical condition. No history of heredity. This is 1st attack, (seemingly Continuous): has been at Battle Creek Sanitarium, Michigan: result, negative; no improvement under treatment. First symptoms of this attack manifested about 2 years ago; Dissatisfied with her surroundings; thought she was overworked: thought she was abused by her husband: left home. Disease seems increasing; variable with rational intervals, but these not at regular periods. Derangement now shown in that she bemoans her lack of income: has delusions regarding business. Patient is disposed to injure others, but not suicidal, unfilthy and destructive in her habits. Previously, she showed peculiarities; showing dislike to her husband. There is no history of intemperance in self or parents, nor of any severe disease or head-injury. She has not been restrained or confined, except as above stated. Supposed cause of the disease is irritation from distasteful associate to her (her husband); worry over limited income. She is now inclined toward irritability; shows great hatred toward her husband.

Dec 9 On admission, was put on B1 (G.A.R. Ward. Complexion dark: hair brown; Eyes brown. Condition of skin normal: a small scar on left leg: is clean: resisted being bathed. Lunch ordered).

" 24 Visited by husband + lady friend. Dec 29 Visited by L. Breckenridge. Dec. 31 Visited by lady friends. Jan 2-3 Menstr. In bed all day. Got up during afternoon. Jan 7 Visited by husband + lady friends. Jan 11 Refused to bathe - Had to be taken by force.

Jan 22 Visited by lady friends. Jan 26 Menstr. In bed all day dec. 27-28-29-30-31

" 30 Visited by husband. Feb 4 Visited by friends. Feb. 5-7-10-12-14-17 Gyn. treatment given. Feb 6-8 Massage + salt sponge bath given. Feb. 19 Gyn. treatment + massage.

Feb 20 Menstr. In bed part of day. Feb 26 Gyn. treatment + massage. Feb 28 Gyn. Treatment. Appetite fair. Bowels quite regular. Refused medicine. Sleeps well. Quiet. Feb. 28 Went Home

Nurses Notes (omitted above) Dec. 13 Quiet in bed all day. Talks sensibly. Appetite fair. Slept 7 hrs. Bowels constipated. Complains of headache. P. 77. R. 18 T. 98+. Dec 14 Quiet. Talks sensibly. Appetite fair. Bowels constipated. Slept 4 hrs. Trans. to B1. P. 78. R. 18 T. 98.6 Dec. 15 Quiet in behavior. Appetite poor. Bowels did not move. Slept about 4 hrs. Talks sensibly.

Dec. 16 Quiet. Appetite fair. Bowels moved. Slept about 4 hours. Lying down most of day. Complains of feeling very tired. P. 76 R. 18. Dec. 17 Quiet. Appetite poor. Bowels did not move. Slept about 4 hrs. Talks very little. Talks sensibly. P. 78. R. 16. Dec. 18 Very quiet in behavior. Talks very little. Appetite fair. Bowels constipated. Refused to take medicine. Slept about 4 hrs. P. 78 R. 18 Dec 26 During second week, patient remained quiet in behavior. Slept quite well. Appetite poor. Talks very little but sensibly as we'll as usual. Visited by husband + lady friend. Refuses to take out door exercise. Objects to being bathed. Bowels irregular

Personal and Medical History of Nattie E. Harris.

Summary. Patient is quiet in behavior. Clean in habits. Neat in personal appearance. Does not work on ward but crochets for self. Appetite fair. Refuses to take any medicine. Refuses to take out door exercise. Complains of feeling very faint & weak also of being very tired. Bowels very irregular. No delusions noted. Talks sensibly. Amt of urine in 24 hrs 1½ pt.

Discharged

Personal and Medical History of Emma Schuster

LORENZ, FIDLAR & SCHARBERG, DAVENPORT, IOWA.

Whole No. 4271.
Residence, Alton, Minnesota
Date Admission, 13th December 1895.
Admitted by, Dr. B. Eby Hour, 5:40 P.M.
How Sent, E.G. Butts. Sh. P. Washington County
Sex, Female
Age, — 25 — (born July 4th 70)
Civil Condition, single
Children, none
Age Youngest Child, —
Occupation, Housework; father, farmer.
Degree Education, Common School.
Profession Religion, Yes, Lutheran. —
Habits, not intemperate. —
Nativity, of parents Germany: Patient's not given
Physicians Committing, J.C. Clark and G.E. Clark
Correspondents, none given in papers

No. for Year, 99.
Insane Relatives, None
Cause Exciting, Unknown
Cause Predisposing, not given.
Form,
Accompanying Bodily Disorder, None mentioned.
Suicidal or Not, has threatened to drown herself —
Date of this Attack, 6th December 1895
Duration, — about a week —
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, — 25 —
Time of Leaving, July 5th 1899.
Time in Hospital,
Result, Died - Tuberculosis Pulmonalis

EXAMINATION ON ADMISSION
MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Confused
Quick or Sluggish, Sluggish
MEMORY: Probably impaired,
Past Events, Will not talk
Recent Events,
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Dull
Correct or Illusive,
REASONING POWER: Much impaired
Ordinary Subjects, " "
Own Mental State, " "
Special Subjects,
GENERAL DESCRIPTIVE REMARKS:
Very stupid. Takes no interest in anything

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed, Depressed and indifferent
DELUSIONS:
Systematized or Not, Probably has
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent, Refuses to talk
Voluble or Reticent,

Personal and Medical History of Emma Schuster

EXAMINATION ON ADMISSION, CONTINUED.
PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 3 in WEIGHT, Not taken NUTRITION, Good - somewhat emaciated.
WOUNDS OR ABNORMALITIES,
TONGUE, Tremors, Slight Coatings, Heavy Promptness Movement, Many sores
PUPILS, Equality, Equal Size, Normal
Response Light, Accommodation,
SIGHT, Seems normal - will not test Skin dry.
HEARING, Normal
COORDINATION, Arms, Cannot test as she is in constant motion: Probably good
Legs,
TREMORS, Hands, None of note Tongue,
Facial Muscles, General,
REFLEXES, Patellar, 5 Equal
Other
ARTICULATION,
Slurred,
Hesitating,
FACIAL EXPRESSION, Sad and indifferent
SENSIBILITY,
✓
HEART, Beat 120 on standing - rather weak
LUNGS, Action quite good.



TAKEN,

EXAM. URINE, January 6
Urine 24 hrs 7 1/4 oz
Color Brown Red
Character Heavy brownish flaky dep
Sp. Gr. 1036
Reaction Alkaline
Albumen
Sugar
Urea 184 gr
Sediments Blood, amor. urates, a few waxy casts

GYNAECOLOGICAL EXAM., Dec. 23'95 - Normal condition
MENSTRUATION, menstruating now
OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty, ✓	Clean,	Careless,
BOWELS, Normal,	Constipated, ✓	Irregular,
APPETITE, Good,	Medium,	Poor,
SLEEP, Good,	Poor, Slept 1 hr. last night.	Irregular,
PULSE, 90. some what weak.	Resp.,	Temp.,

CRANIAL MEASUREMENTS,
HISTORICAL,
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations,
Father or Pat. Relations,
Brothers or Sisters,

Personal and Medical History of Emma Schuster

1895

This patient was received here at the hands of Sheriff Fazendine, and attended by Mrs Fazendine, with following history. Patient is in good physical condition. There is no history of Consanguinity or hereditty. This is the 1st attack; symptoms manifested Dec 6/95: appeared naked, at bed, in night & said the Lord would provide clothing: imagined she saw persons. Disease appears to be decreasing: variable, with rational intervals, but not at regular periods. - Derangement now shown by general delusions. She is not disposed to injure others; has not attempted suicide, but has threatened to drown herself: not filthy or destructive in her habits: before accession of the disease, she liked to read religious books: was rather religious. There is no family history of intemperance: has not had any severe disease or head injury: has not been restrained or confined. Supposed cause of the disease is unknown: no treatment known to have been given her. Now, she is nervous, restless; gives irrelevant answers: mind morbid: feelings of sinfulness. She is physically weak & emaciated. Patient is of such mental & physical condition as to require treatment in a hospital for the insane. ———— ———— ————

Dec 13 On admission, was put on B³ W (G.A.N.Rpt. Complexion dark: hair brown: eyes dark blue; condition of skin normal: has a few bruises on her legs: is quite clean: verycurious: does not talk sensibly). Up on ward today. Very quiet. Quite weak. Temp. normal. Jan 2 In bed today Complains of bowels, very constipated. Cathartics given. Sexual enormities but not free. Jan 7 In bed. Dirty in habits. Bowels move often. Has haemorrhoids. Appetite poor. Sleeps well. Talks quite sensibly. Takes Tonic Massage given 10 minutes. Jan 12 Up on ward. Jan. 15-1-7-20-27-28-Feb 4. Massage given. Jan 16 Salt bath given Jan. 23 Very stubborn. Appetite fair. Cathartics given. Bowels constipated Feb 6 Hot bath with cold applications to head. daily. Tonic given. Feb 20 Quite dirty in habits. Feb 24 Appetite much better. Bowels regular. Sleeps well.

Nurses Notes (omitted ~~from~~ above) Dec 14 Quite excited. Talks incoherently. Appetite fair. Slept 1 hour. Bowels constipated. P. 97. R. 24 T. 101 Dec 15 Quite excited & nervous. Appetite fair Bowels constipated. Slept 7 hours. Complains of headache P 97 R 20. T 99.4 Dec 16 Quite excited. Appetite poor. Gave ℥ss enemas for bowels. very constipated. Not a free movement. Gave cathartic. Pulse 72 Urinated. Hot bath. cold applications to head. Dec 17 In hot baths with cold applications to head. Bowels moved a little. Violent at times. In bed Appetite fair. Slept 2 hrs. Out of bed most of night. Dec. 18 In hot baths with cold applications to head. Bowels constipated Slept very little. Appetite fair. T 100.4 P. 108 R. 17. Dec 19 Quite excited Hot baths Quiet her for a time. Has delusions. Bowels constipated T. 98.8. P. 100 R 18 Has delusions. Bowels constipated T 98.8 P. 100 R. 18. Refuses tonic & cathartic. Takes about ℥iv urine daily During record week was excited first day but after that quieted down. Kept steadily in bed. Bowels constipated cathartics & tonic given. Urine given daily Appetite fair Sleeps better than at first.

Personal and Medical History of Emma Schuster.

Summary. Quite excited & nervous. Temp 101- P. 97 - R. 24. Complains of headache Appetite irregular. Bowels constipated Urinates regularly. Violent at times. In bed. In enemas for bowels - Second week - Quieter in behavior In hot baths daily given with cold applications to head. Takes tonic & urine daily Temp 98.6.

May 1 Takes tonic. Very untidy in habits. Appetite fairly good. Bowels regular. Noisy at times. May 30 Dirty in habits. Appetite good. Bowels regular. Apr 30 Appetite good. Bowels regular. Sleeps well. Menses regularly. " 16 Noisy at times. Goes jading & walking. Dirty in habits. May 11 Appetite good. Bowels regular. Sleeps well. More neat in habits of late.

Aug 14 Summary Nurse's Notes by Dr. D.L. Phelps: Rather stupid: appetite good: bowels regular: takes out door exercise: does no work: Aug 14 Transf. to annex. Oct 7 Appetite poor: general health fair: no mental change: Jan 97 Generally silly: rather dull: usually quiet: genl health seems good: May 97 Appetite good: genl health seems fair: Aug 97 Does not talk: Is quiet & rather dull & stupid: somewhat emaciated: Does not look well but does not complain of being sick. Continued by Dr. W.M. Phelps. Oct 21 97 Visited by brother. Nov 21 Health fair: Is rather emaciated. Rather dull & quiet in manner. Feb 9 Wt. 101 lbs Feb 12 99 Condition practically unchanged during period. Taken by Dr. R. A. Bibb / Mar 99. Appetite quite good: sleeps well. rather stupid, slow to move. sits in one position most of time: rarely speaks: physically there is a gradual failure: some emaciation: expectorates a great deal. June 13 Has become much more stupid: appetite impaired: expectorates very profusely: never complains: Temp. 104 to Pulse 120: R. 28: Is constipated: For several days condition has remained about the same: temp. elevated: pulse rapid: June Trans. to Inf.: Sick record kept: June 23 to July 5 99 Physical failure very rapid Temp. 100 to 106: P. 95 to 176. Resp. 22 to 38: takes liquid nourishment every two hours: egg nogs every 4 hrs. Refuses medicine: inclined to be constipated: usually sleeps quite well: appetite impaired: at times refuses nourishment: July 3 Seems very weak: coughs & expectorates: refused nourishment nearly all day: July 4 1 Very restless. Still refuses to eat: failing: July 5 5:45 am Died. Cause of death Tuberculosis pulmonalis.

Died

Personal and Medical History of Maggie Boyles

Thinks her maiden is Maggie Dorman.

LIBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4280.

Residence, Merton, Minn.

Date Admission, 2nd January 1896.

Admitted by, Dr. Steele Hour, 7 P.M.

How Sent, M. B. Chadwick, J.P. Steele County

Sex, Female

Age, - 24 -

Civil Condition, married

Children, none

Age Youngest Child, —

Occupation, Housework

Degree Education, Common School

Profession Religion, not a church member

Habits, not intemperate —

Nativity, Merton, Minn: (father's, New York: mother's, Canada).

Physicians Committing, F.W. Emerson & A.B. Stewart

Correspondents, None given in papers

No. for Year, 114.

Insane Relatives, none

Cause Exciting, not known

Cause Predisposing, not stated

Form,

Accompanying Bodily Disorder, none mentioned

Suicidal or Not, not —

Date of this Attack, not stated

Duration, not given

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, (?)

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION

MENTAL CHARACTERISTICS.

Exam by

MENTAL ACTIVITY:

Clear or Confused, Somewhat confused

Quick or Sluggish,

MEMORY: Seems very good

Past Events,

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Alert

Correct or Illusive,

REASONING POWER: Impaired to considerable extent

Ordinary Subjects,

Own Mental State,

Special Subjects,

GENERAL DESCRIPTIVE REMARKS:

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted,

Depressed, Rather depressed

DELUSIONS: Some delusions of persecution

Systematized or Not,

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION: Talks quite willingly

Coherent or Incoherent, Thinks less effort

Voluble or Reticent, much impaired upon

Personal and Medical History of Maggie Boyles

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 7 in WEIGHT, Not taken NUTRITION, Fair

WOUNDS OR ABNORMALITIES, None noted

TONGUE, Tremors, Coatings, Slight Promptness Movement, Prompt.

PUPILS, Equality, Left slightly larger Size, dilated

Response Light, Accommodation,

SIGHT, Near sighted - not strong Left eye cross eyed.

HEARING, Good

COORDINATION, Arms, Normal

Legs, Normal

TREMORS, Hands, None Tongue,

Facial Muscles, General,

REFLEXES, Patellar, 8-9 Equal

Other

ARTICULATION, Good

Slurred,

Hesitating,

FACIAL EXPRESSION, Fair

Paresis - no.

SENSIBILITY,

HEART, No murmurs

Circulation not good

LUNGS,



TAKEN,

EXAM. URINE, Jany 6/96

Quantity 3 - XIV

Color Yellow

Character Flaky whites dep

Sp Gr 1033

Reaction Acid

Albumen

Sugar

Urea

Sediments Triple phosphates, amorphous urates

Sodium urates + Vaginal epithelium

GYNAECOLOGICAL EXAM., Jan. 6-96 Uterus normal size, Some hypertrophy

MENSTRUATION, Regular - no pain

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean, ✓	Careless,
BOWELS, Normal, Regular	Constipated,	Irregular,
APPETITE, Good, ✓	Medium,	Poor,
SLEEP, Good, ✓	Poor,	Irregular,
PULSE, Not strong 120 now	Resp.,	Temp.,

CRANIAL MEASUREMENTS,

HISTORICAL, Married 1½ yrs. No children

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN, Gradual

HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Heredity denied

Mother or Mat. Relations, Healthy

Father or Pat. Relations, "

Brothers or Sisters,

Father & Mother divorced. Mother always ugly to her - she claims her name is Dorman - Denied being married. She says now she did it because she was to marry another man

Personal and Medical History of Maggie Boyles

1898

This patient was received here at the hands of Sheriff Barnard, and attended by Wm Cox Warren with following history. Patient is in fair physical condition. There is no history of consanguinity or heredity. This is the 1st attack. When first symptoms were manifested, is not stated. She discovered her parents, use of abusive & obscene language. Disease appears to be increasing; variable with rational intervals. but these, not at regular periods. Derangement now shown, as stated above. She also denies being married. Patient is not inclined to injure others, nor suicidal, nor filthy nor destructive in habits. No peculiarities were previously shown. no history of intemperance in self or parents, nor of any severe disease or head-injury. She has not been restrained or confined, nor under medical treatment. Don't know cause of the disease. Nothing, on examination, specially noticed but language and actions. ——"——

Jan 2 On admission was put on B2 (G.H.N.R.P.P.). Complexion fair; hair light-brown; eyes gray. Condition of skin normal: no marks scars or bruises noticed: is clean: very restless, but not violent: has delusions).

Jan 18 Patient is quiet in behavior. Neat in personal appearance. Takes out door exercise. Has exaggerated ideas. Appetite fair. Bowels usually constipated. Sleeps well. Does no work. Leave to A. 1. Jan. 19 Menstr. Jan 28 Careless in habits. Does no work. Appetite good. Sleeps well. Has morbid ideas. Physical health fair. Takes out door exercise. Talks silly - also has delusions.

Feb 28 Menstr. Feb. 28 Quiet on ward. Takes no interest in work. Appetite fair. Goes riding & walking. Still holds to her delusions. Receives Gyn. treatments.

The following notes were misplaced & omitted -

Nurses Notes. Jan. 3 Quiet. Has delusions. Appetite fair. Slept 5 hours. Bowels constipated. P. 72. Resp. 18 Temp. 98.4. Jan. 4 Behavior quiet. Seems to have delusions. Appetite fair. T. 98.6 P. 73 R. 18. In bed. Jan 5 No change in patient. Talks quite sensibly. Urine in 24 hrs. 3 XIV Slept 6 hrs. Up on ward.

Jan 6 Quiet in behavior. Temp. 98.4. P. 72. R. 18 Bowels moved. Slept 7 hrs. Cathartic given. Trans. to B 1. Jan 7 Quiet. Appetite fair. Bowels constipated. Slept 7 hrs. P. 78. R 18. Jan. 8 Quiet. Appetite fair. Bowels constipated. Cathartic given. Went out walking. Talks quite sensibly on some subjects.

Jan 16 During second week patient remained quiet. Has delusions. Sleeps well. Appetite fair. Bowels generally constipated. Takes out door exercise.

D.W.M. Mary Patient is quiet in behavior. Neat in appearance. Clean in habits. Takes out door exercise. Talks very silly on some subjects while on others talks sensibly. Has delusions, also exaggerated ideas. Appetite good. Bowels usually constipated. Takes cathartics. Sleeps well. General health good. Does no work.

Mar 13 Apr 14 Menstr. Apr 15 Sits quietly about on ward. Has delusions & talks very foolishly. Appetite good. Sleeps well. Takes out door exercise. Physical health fair. Apr 18 Patient escaped Apr. 16. Brought back today and put on B 2. Apr 16. Sits quietly about on ward. Goes out walking &

Personal and Medical History of Maggie Boyles.

1898

riding. Has delusions. May 16 Very quiet. Bowels regular. Appetite good. Menstr. regularly. Summary Nurse's Notes by Dr. E. L. Phelps:- June 12 Appetite good: bowels regular: rather dull: quite sullen in manner since her return. No change: Feb 99 Keeps steadily the same: sits idly about: talks when disturbed: genl health good: May 99 No change: July 99 Lungs & heart examined: Chest expansion good: percussion note normal: breath sounds normal: Resp. 20: Heart sounds:- No murmur: pulse 76. regular. Augo Menstr. regularly.

Nov. Continued by Dr. W.M. Phelps. Oct 15 99 General health fairly good: is always obstinate: talks in a restless & profane way. Visited Oct 9 by mother. Oct 16 Trans. to B3. June 11 98 Visited by mother. Feb 28 99 Seems to be practically unchanged in any way during period. Is very profane & vulgar. (cont. by Dr. P. A. Bibb) Mar. to Sept 99 Genl health & appetite good: sleeps well: bowels regular: goes riding & walking: clean & tidy: Has a great many delusions & expresses them freely. very noisy at times: menstr. regular: very profane: is very vain: particularly proud of her hair with which she takes great pains. Sept 1- Feb 28 1900 (Dr. Heyerdahl) Sits on floor a great deal: Profane at times: Sleeps well: Appetite good. Bowels regular: Has delusions: takes out door exercise: Nov. 7 Bought today Jan 18 Wt. 116# Mch 1 - Sept 30 (Dr. Newton) Mst & tidy Talks much to herself: Scolds & occasionally fights & sometimes is very disagreable: Eats & sleeps well: Bowels regular: Menstruates regularly: Takes out door exercise. Mch 8. Fought & struck Mrs Rush. July 16 Vaccinated.

Sept 1- Nov 30 1900. No change: Does not usually converse & seldom responds to questions & if she does is often profane: Menstruates regularly. Nov 16 - Wt. 118#. Nov 29 Visited by mother. Dec 1- Feb 28 1901 General health good: no change in behavior. Speech incoherent: has delusions of grandeur & talks to imaginary bingo: Mch 3 Wt. 121½# Mar. 1 - June 1 - 1901 Considerable improvement mentally: is quieter and does not run about so much on the ward, assists with dining room work: attends amusements in chapel. Physically very well: appetite good: sleeps well, habits clean: neat in personal appearance, menstruates. Does not always answer questions when addressed. April 5 visited by sisters and brother, May 29 visited by friends. May 29 Wt. 124½ #

June to Sept. June 4 has not seemed very well for the past few days, talks to herself using profane language, wanders aimlessly about, has many delusions and illusions, takes out door exercise, attends amusements, trans. to D 3. Latter part of the summer began to improve, assists occasionally with the work, attends chapel. Sept. 3. Wt. 119#. Sept. to Dec. Nov. 30 Wt. 123#. Dec. 10 menstruating Dec. 18 visited by brother, Jan. 22 menstruating, still works occasionally, seems more quiet and sometimes answers questions intelligently. Feb. 17-18-19 visited by father and friend and taken home Feb. 20, 1902.

Continued Page 32.

Personal and Medical History of Elfreda Madsen

LUBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4296.
Residence, 555 Park Avenue, St Paul.
Date Admission, 10th January 1896.
Admitted by, Dr. Shelks Hour, 6.45 P.M.
How Sent, G. Willrich, Jof P. Ramsey County
Sex, Female.
Age, 35.
Civil Condition, married
Children, Three
Age Youngest Child, 6 years.
Occupation, Housewife (husband, bricklayer)
Degree Education, Common School.
Profession Religion, not a church member
Habits, not intemperate
Nativity, Denmark (parents also born there).
Physicians Committing, C. Eugene Riggs and John C. Nelson
Correspondents, none given in papers

No. for Year, 121.
Insane Relatives, None
Cause Exciting, Puerperal
Cause Predisposing, previous attacks
Form,
Accompanying Bodily Disorder, none mentioned
Suicidal or Not, Suicidal, by hanging.
Date of this Attack, about Jany 3rd 1896
Duration, about one week.
No. of Attack, 3rd
No. of Admissions, 1st
Age First Attack, about 24.
Time of Leaving, Mar. 7 '96.
Time in Hospital, 1 Mo. 26 da.
Result, Dism. Apr. 30/96 Rec.

EXAMINATION ON ADMISSION
MENTAL CHARACTERISTICS.

Family

MENTAL ACTIVITY:
Clear or Confused, Clear.
Quick or Sluggish, Quick
MEMORY:
Past Events, Good
Recent Events,
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Somewhat dull.
Correct or Illusive, Mostly correct.
REASONING POWER:
Ordinary Subjects, Fairly good.
Own Mental State, Fairly good.
Special Subjects,
GENERAL DESCRIPTIVE REMARKS:
Was out of mind about one month after birth of first child, 12 yrs. ago. Not well since. Has had frequent attacks since. when worried.

EMOTIONAL STATE:
Normal, Calm, Calm.
Indifferent,
Exalted,
Depressed,
DELUSIONS:
Systematized or Not,
Special Subjects,
Transitory or Not,
HALLUCINATIONS: of hearing at times
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent, Coherent
Voluble or Reticent, Talks quite sensibly. Answers questions quite promptly.

Personal and Medical History of Elfreda Madsen

EXAMINATION ON ADMISSION, CONTINUED.
PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 3½ WEIGHT, Not taken NUTRITION, Good.
WOUNDS OR ABNORMALITIES, Scars on fingers of right hand, Last phalanx & half of middle phalanx of middle finger of left hand gone. Little toe of each.
TONGUE, Tremors, Fine tremor Coatings, Heavy white Promptness Movement, Normal
PUPILS, Equality, Equal. Size, Normal
Response Light, Normal Accommodation, Normal
SIGHT, Impaired in left eye
HEARING, Normal
COORDINATION, Arms, Normal
Legs, Normal.
TREMORS, Hands, None Tongue, Fine tremor
Facial Muscles, None. General, None.
REFLEXES, Patellar, Equal + 5
Other
ARTICULATION, Normal.
Slurred,
Hesitating,
FACIAL EXPRESSION,
Somewhat dull.
SENSIBILITY,
HEART, Tumultuous in action no murmurs. Not very good use of upper part of lungs. Fine rales heard at apices
LUNGS,
TAKEN,

EXAM. URINE, ~~Jany~~ 13/96
Quan 24 hrs 3 XXXV ozs
Color Red yellow
Character Yellow flaky dep
Sp Gr 1037
Reaction Acid
Albumen 0
Sugar
Urea
Sediments Vaginal cells & Mucus bands
Urates & oxalate of Lime

GYNAECOLOGICAL EXAM, Jan. 13-'96 Uterus retroverted. Cervix somewhat hypertrophied. A great deal of mucus
MENSTRUATION, Slight & regular. Laceration of cervix. Slight subinvolution of uterus
OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean, ✓	Careless,
BOWELS, Normal,	Constipated, ✓	Irregular,
APPETITE, Good,	Medium,	Poor, ✓
SLEEP, Good,	Poor,	Irregular,
PULSE, Regular 94	Resp., 22	Temp.,

CRANIAL MEASUREMENTS,
HISTORICAL,
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, Mother was not quite right. Sister & brother of Mother were insane
Father or Pat. Relations, Father living & are right
Brothers or Sisters,

Personal and Medical History of Elfreda Madsen

1896

This patient was brought here by Deputy-Sheriff Kinney, attended by her husband, with the following history. Patient is in fair physical condition. No history of consanguinity or heredity. This seems to be 3rd attack (one 11 years ago and once since; duration about a week). First symptoms of this attack manifested about Jany 3rd 1896. Disease seems increasing; variable rational intervals, but not at regular periods. Derangement is now shown by delusions as to electricity, fear. She is not disposed to injure others, but has attempted suicide by hanging & propensity now active. No filthy or destructive habits. No peculiarities were previously shown. There is no history of intemperance in self or parents, nor of any severe disease or head-injury. She has not been restrained or confined; no under medical treatment. Supposed cause of the disease is puerperal. On personal examination, she shows fear, delusions; thinks house is full of detectives.

Jan 10. On admission, was put on B.V. (G.H.N. R'pt. Complexion fair: hair light; eyebrows; Condition of skin normal: scarce right hand fingers and 2nd finger of left hand has 1st joint off: has also small goitre: no bodily peculiarities noticed: is clean: behavio quiet & talks sensibly).

Jan 11 Quiet in bed all day. Talks sensibly; appetite fair; slept six hours. Bowels constipated. Pulse 80. Resp. 22. Temp. 99.6.

Jan 12 Quiet in bed today. Appetite poor. Bowels constipated. Slept 7 hrs. ℥XIJ in 24 hrs. Temp 98.8 Pulse 82. Resp 20.

Jan 13 Up on ward. Gyn. treatment. Worked a little in dining room. Slept fairly well. Took tonic. Cathartic. Bowels moved.

14 Quiet in behavior. Works some in dining room. Talks quite sensibly. Bowels moved. Slept very little. Very restless while awake.

15 Gyn. treatment. Tonic. Trans. to B 1. Appetite fair. Bowels constipated.

16 Quiet in behavior. Appetite fair. Bowels constipated. Took tonic. Cathartic. Worked in dining room. Pulse 88. Resp. 22.

17 Quiet in behavior. Talks sensibly. Appetite fair. Bowels moved. Takes tonic. Complains of pain in stomach. Pulse 80. Resp. 20.

18 Quiet in behavior. Appetite good. Bowels moved. Slept 3 hrs. after 12 A.M. during night. Complained of headache in morning. Took tonic. Helps on ward. P.80 R.20.

19 Quiet but quite nervous during day. Has delusions. Thought everyone was laughing at her. Appetite good. Bowels moved. Slept 6 hrs. Pulse 78 Resp 18.

20 Quiet in behavior. Clean in habits. Appetite fair. Bowels irregular. Takes tonic. Cathartic. Assists with work. Has strange ideas. Talks sensibly on most subjects. Gyn. treat. Trans. to A 2.

21 Quiet in behavior. Talks sensibly. Appetite good. Takes tonic.

22 Very quiet in behavior. Appetite good. Takes tonic. Works in laundry. Urine ℥XXXVIII (sleeps well) in 24 hrs.

23 Quiet in behavior. Appetite good. Bowels constipated. Works in laundry. Sleeps well.

24 Quiet. Appetite good. Bowels moved freely. Takes tonic. Gyn. Treatment.

Summary. Mrs Madsen has been very quiet in behavior during past fourteen days. Physical health seems quite good. Bowels are usually constipated. She talks quite sensibly. Pulse & respiration have been about normal.

Personal and Medical History of Elfreda Madsen

Feb 1 Very quiet in behavior. Has delusions. Appetite good. Sleeps well. Bowels constipated. Takes out door exercise. Takes tonic. Works in employes dining room. Takes Gyn. treatments. Menstr. ~~Feb. 17. 19. 24 24. 26.~~ Gyn. treatments Feb 26 Menstr. Patient has erysipelas on face. Trans. to B 3. Mar 2 Patient up on ward. Appetite good. Mar 4 Up & on the ward. Appetite good. Bowels regular. Trans. to A 2. Mar 7 Gone Home.

Discharged

Mrs. Chas C. Sanders

(From p 60)

1896

June Summary Nurses Notes by Dr S I Phelps: Appetite fair: bowels usually constipated: massage & electrical treatment given 3 times a week: July 9 Electrical treatments 3 times a week.

July 30 Catheterized the past four days: complains of headache & dizzy feeling: Aug. 5-9 catheterized daily: passes a small amount of urine: medicine given: Salt baths given: takes egg nog twice daily: Aug. 30 No special change noticed: Still requires to be catheterized: passes a normal amount of urine: pulse weak: Strychnia 1/40 gr. given every 4 hours: Sept 9 Very depressed most of time: appetite fair: bowels usually constipated: Cathartics given: electrical treatments given: pulse very weak & slow: brandy every two hours: Oct 9 In bed most of time: Appetite quite good: has delusions: pulse still quite weak: Local treatment given: Salt baths 3 times a week: Nov 9 Very anxious to go home: No special change: Jan 1 - Daily sick record has been kept: Sits on ward part of time: talks quite sensibly at times: tonics given: pulse rather weak: still has delusions: Feb 97 Appetite poor: bowels very constipated: obliged to give cathartics & enemeta: Apr 97 Appetite good: bowels regular: sleeps well: takes out door exercise: works some on ward: May 30 Works in dining room: physical condition quite good: Still has some delusions:

1897

June 16 Menstr. regular: Appetite quite good: bowels regular: takes out door exercise & works in dining room: talks quite sensibly but has a few delusions:

July 15 Was visited by her husband who took her Home: Physical condition was very good: was in good flesh: Habits were regular: was working daily on ward: Menstr. regularly: Had improved very much in her mental condition although she still had some peculiar ideas which she manifested occasionally.

Discharged

Personal and Medical History of Mrs Charles E Sandeen. (Ida Sandeen)

LIBBEY, PIDLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4301
Residence, St Paul. Minnesota.
Date Admission, 15th January 1896.
Admitted by, Dr. Herzog Hour, 6th P.M.
How Sent, G. Wilbrick, Jof P. Ramsey County
Sex, Female
Age, — 33 —
Civil Condition, married
Children, — 7 —
Age Youngest Child, born January 1st 1896
Occupation, Housewife
Degree Education, fair: reads + writes
Profession Religion, Lutheran
Habits, not stated —
Nativity, Norway; (Parents also born there)
Physicians Committing, C. Eugene Riggs and A.B. Ancker
Correspondents, Chas E. Sandeen (husband) -
912 Margaret St. St Paul

No. for Year, 129.
Insane Relatives, not known
Cause Exciting, Pregnancy
Cause Predisposing, Not stated
Form, Acute mania Puerperal
Accompanying Bodily Disorder, weakness &c
Suicidal or Not, propensity & suicide now active
Date of this Attack, about 10 Days before going to the Hosp.
Duration, about 25 Days.
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, about 33
Time of Leaving, July 15. 1897
Time in Hospital, 1 yr. 6 mo.
Result, Discharged Nov 5. 1897.
Much Improved.

EXAMINATION ON ADMISSION
MENTAL CHARACTERISTICS.

Exam. by

MENTAL ACTIVITY:
Clear or Confused, Confused & incoherent
Quick or Sluggish, Quick

MEMORY:
Past Events,
Recent Events,
Special Subjects,
} too Confused & maniacal to test

PERCEPTIVITY:
Alert or Dull, At times alert but very
Correct or Illusive, confused & incorrect

REASONING POWER:
Ordinary Subjects, Does not reason Talks incessantly
Own Mental State,
Special Subjects,

GENERAL DESCRIPTIVE REMARKS:

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed, Depressed

DELUSIONS:
Systematized or Not,
Special Subjects,
Transitory or Not, Transitory Religious ideas

HALLUCINATIONS: Not noted

ILLUSIONS:

CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent, Voluble - Rambles along on Religious or chance ideas

Personal and Medical History of Mrs Charles E. Sandeen.

DR. ARTHUR B. ANCKER,
Superintendent and Physician and Surgeon in Charge.

Form No. 5.

Register No. 13127

THE CITY AND COUNTY HOSPITAL,
SOCIAL HISTORY SHEET.

Hour 5.30 P. M. ST. PAUL, MINN. DEC-20- 189 5
Name Mrs Chas. E Sandeen Sex Female Age 33 yrs
Nationality Norwegian Color White
Occupation Housewife Religion Lutheran ~~Single~~, Married, ~~Widowed~~.
Resident of St. Paul or Ramsey County for 7 years
Former Residence Minneapolis (5th St + 23rd Ave So)
Address at time of admission 912 Margaret St St Paul.
Employment at time of admission, name of employer and wages Housewife
No wages.
Amount of wages due, income or other means None
Insurance or other benefits None
Money or personal effects left in charge of Chas. E Sandeen (Husband)
912 Margaret St St Paul.
Address of nearest relatives or friends Same Above.

If in Hospital before, when? No.
Cause of admission Pregnancy complicated by insanity
Admitted by Dr. Ancker Assigned to Dr. Ritchie.
Brought to the Hospital by Private carriage
From Home Chas Sandeen (Husband)
Persons in charge of patient
Cash, $ None Watch No. None Baggage check No. None
Other valuables None

REMARKS: If non-resident, state cause of admission. If hospital account to be paid, state rate, etc.
Showed signs of mental derangement about 5 days before admission; delivered of female child Jan-1-96.

J.B.J. Interne

HISTORICAL,
LENGTH OF INVASION, Short - Dec. 22, 1895 ONSET GRADUAL OR SUDDEN, Sudden
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Heredity denied by husband
~~Mother or Mat. Relations~~, Cause Puerperal state supposably
Father or Pat. Relations,
Brothers or Sisters,

. URINE, Jany 14/96
XXXIV
yellow
Cloudy
1030
Acid
#
0
3+ gr
rod amor urates &c
cells
ne hypertrophy

by good. - Pallid

Personal and Medic

LEBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4301

Residence, St Paul.

Date Admission, 15th Janua

Admitted by, Dr Henry

How Sent, G. Wilbrick, J

Sex, Fem

Age, — 3

Civil Condition, ma

Children, -

Age Youngest Child, born

Occupation, 1

Degree Education, fair

Profession Religion,

Habits, not

Nativity, Norway

Physicians Committing, (

Correspondents, Cha

Exam. by

MENTAL ACTIVIT

Clear or Confused

Quick or Sluggis

MEMORY:

Past Events,

Recent Events

Special Subje

PERCEPTIVI

Alert or Di

Correct or

REASONING POWER:

Ordinary Subjects, Does not reason

Own Mental State, Talks intensely

Special Subjects,

GENERAL DESCRIPTIVE REMARKS:

Coherent or I

Voluble or Reticent, Talkable - on Religious or chance ideas

Personal and Medical History of Mrs Charles E. Sardeen

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 1 in WEIGHT, Not Taken NUTRITION, Fairly good - Pallid

WOUNDS OR ABNORMALITIES, None noted

TONGUE, Tremors, Not noted Coatings, Dry, cracked, red Promptness Movement,

PUPILS, Equality, Equal Size, Normal

Response Light, Accommodation,

SIGHT, Probably good

HEARING, Seems good.

COORDINATION, Arms, } Probably good but cant test

Legs, }

TREMORS, Hands, Probably none. Tongue,

Facial Muscles, General,

REFLEXES, Patellar,

Other

ARTICULATION,

Slurred, Fairly good.

Hesitating,

FACIAL EXPRESSION, Depressed

SENSIBILITY,

HEART, Weak
no atheroma

LUNGS, Probably good struggles

TAKEN,

EXAM. URINE, Jany 17/96

Mixed with Urs Z XXXIV

Color Rudyellow

Character Cloudy

Sp Gr 1030

Reaction acid

Albumen #

Sugar 0

Urea 437 gr

Sediments # Pus + blood amon urates and a few epithelium cells

GYNAECOLOGICAL EXAM., Uterus retroflexed - Laceration of cervix, erosion of os - some hypertrophy

MENSTRUATION,

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,		Clean, ✓	Careless,
BOWELS, Normal,	Dont Nuor-	Constipated,	Irregular,
APPETITE, Good,	will not eat	Medium,	Poor,
SLEEP, Good,	None last night	Poor,	Irregular,
PULSE,		Resp.,	Temp., 99.6

CRANIAL MEASUREMENTS,

HISTORICAL,

LENGTH OF INVASION, Short - Dec. 22, 1895 ONSET GRADUAL OR SUDDEN, Sudden

HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Heredity denied by husband

~~Mother or Mat. Relations~~, Cause Puerperal state supposably

Father or Pat. Relations,

Brothers or Sisters,

Personal and Medical History of Mrs Charles E. Sandeen.

1896

This patient was brought here by Deputy-Sheriff M. N. Goss, attended by Miss Akers, with following history: Patient is in fair physical condition. As to consanguinity or heredity nothing known:— This is 1st attack; first symptoms manifested about 10 days before going to C & C. Hospital: was maniacal: disease seems increasing: she is never absolutely rational. Derangement now shown by being maniacal. Is disposed to injure others and propensity to suicide is now active. Is not filthy or destructive in habits. No peculiarities as were previously manifested. Supposed cause of the disease is pregnancy. She has been under Dr. Riggs and Sweeney's care at C & C Hospital. Was delivered of a child on January 1st 1896. (See C & C. Hospital record attached)—

Jan 15 On admission, was put on B.W. (G.H.N. Rft. Complexion fair: hair light-brown: eyes blue: cuticle & skin normal: no scars noticed: bruise on upper part of right arm: is clean: very nervous: Speech incoherent + she shows delusions). Note. On admission, the following notes made by Dr. Phelps: "Child born New years: about 22d of last month. She grew mentally bad: (about 1 week before): husband states that there was absolutely nothing till one week before birth of child; got quite violent before birth; better after birth: a "spell" again, last week: denies anything of heredity: denies anything before last December".

Jan 16 Quite excited. Out of bed most of time. Has delusions. Fed with tube. Did not sleep. Was out of bed often; Slept 2 hrs. during afternoon. Bowels constipated. Pulse weak. Temp. 99.6

17 In bed. Refuses to eat, fed with tube. Bowels constipated. Urine ℥ XXIV in 24 hrs. Resisted as could not take Temp. Has delusions. Did not sleep during night. Slept 1 hr. in afternoon. Jan 18. In bed. Urinates regularly. Hyp. Strychnine three times daily as Tonic. Fed with tube. Did not sleep during night. Bowels constipated. T. 99.8 P. 90. R 20

19 Quite excited this A.M. fed with tube. Given warm bath with cold app. to head. Took Cathartic, Salts; Bowels moved. Quiet after baths. Talked sensibly.

20 Very excited. Fed with tube. Menstr. Hyp. Strych. 3 times. Very quiet this P.M. 8 P.M. Salt bath 15 mins. Patient seemed weak. Pulse 88 + very weak. Temp. 99.8 R. 28. Washed mouth + sprayed throat. Complains of throat.

21 Temp. 99.8 Pulse 80. Resp. 18 Quite nervous + excited. Fed twice with tube. 3 Hyp. Strych. Two baths; Hot + salt, given.

22 Very excited this morning. Fed with tube. Hot salt bath with Cold applications to head. Has delusions that worms etc. are in water. Very excited. Drank 2 cups beef-juice. 3 Hyp. Strych. given. In restraint for six hours.

23 Fed with tube twice. Excited. Bowels moved. Hot + salt bath given. T. 99. P. 100. R. 19. Slept 5 hrs.

24 Quiet part of time. Fed with tube once. Drank 2 cups beef-juice. Bowels constipated. Slept 2 hrs. 3 Hyp. Strych. given. Hot Bath + Salt bath given.

25 Very quiet most of day. Drank milk. Fed in P.M. Took bath. Slept 5 hours. In restraint part of night. Menstr. Salt bath.

26 In restraint 8 hrs. Very excited. Hyp. Strych. given. Fed in P.M. with tube. Hot + salt baths given. Slept 2 hrs. Bowels constipated. Temp. 99.2. Pulse 90 Resp. 24

27 Quiet most of day. Given cathartic + salt bath. Takes quite a little milk + beef juice. 3 Hyps. Strych. given. Has delusions that there are worms around her

Jan 28 Quiet most of day. Salt bath given. In restraint 12 hrs. Slept 5 hrs. Takes quite a little nourishment. Menstr. Bowels moved. Talks quite sensibly at times

29 Quite excited this A.M. Took nourishment. Salt bath. In bed. Slept 5 hrs. Has delusions.

Summary. Patient very weak, excited + nervous. Hot baths with cold applications to head given; much quieter after baths. Salt baths given every night. 3 Hyps. Strych. per day given. In restraint part of time. Fed with tube part of time; takes quite a little liquid but no solid food. Menstr. Temp. above normal. Takes Puls. + Resp. Complained of sore throat. Mouth washed + bismuth dusted in. Does not sleep well. Jan 30 Hyp. Strychnine 3 times daily. Hot salt bath. Appetite poor. Feb. 1 Has delusions that there are worms around her. Feb 2 Complains of headache. Feb 4 Fed with tube. Feb 11 Appetite poor. Still in bed. Salt baths daily. Slept fairly well. Hyp. Strych. T. 99.2. Feb. 12. Fed with tube. Given Cathartic Feb. 14-15-16-17. Ditto Feb 17 T. 98.4. Pulse very weak. R. 28 Expectoration considerably

20 No Change. Bowels usually constipated. Fed daily with tube. Strych. by mouth. Daily salt baths given. In bed. Sleeps quite well. Feb 27-28 Resisted by husband—was not fed. Feb 28 drank milk + tea. Feb 29 Drank milk. Mar. 8 Very excited Talking + restless. Slept 4 hrs. restless during night. * Mar. 9 Talking + noisy most of day. Salt bath given daily. Cathartics given for bowels. Apr. 1 Sick record of patient has been kept. Has been up on ward about a week. Bowels constipated. Castor oil given nearly every morning. Apr. 10 Has to be coaxed to eat. Cascara given daily. Bowels constipated. Apr. 14 Very much better. Eats without being coaxed. Bowels constipated. Menstr. Apr. 30 Appetite quite good. Talks a good deal at times. Massage treatments given 3 times a week also electric Gyn. Treatments. May 19 Menstr. Very cross during period. Visited by husband. May 25 Appetite fair. Takes tonic after meals. Is quite nervous + disturbed at times. Has delusions. Bowels constipated. Cathartics given. Neat + tidy in habits. * (Physicians note omitted) May 10th Moved to Infirmary. put to bed; put upon milk diet. given glass every two hrs: Castor oil given for bowels; bowels moved freely: salt bath given in evening. May 11th Temperature, pulse + respiration normal: patient in bed, quite restless: takes tonic: salt sponge bath given: very noisy, singing + talking. May 16 Treatment has kept up steadily: salt baths given daily: milk diet continued: is becoming more quiet: slept all night. May 23 Patient has remained steadily in bed: massage given every other night. salt sponge baths given daily: takes tonic: beginning to eat light food; sleeps well at night. Gynecological treatments given. Able to be up + dressed: out on lawn. Is eating fairly well: takes tonic; massage + hot salt baths. May 28 massage + hot douche given. May 29 Put on very light diet: tonic given. Went out walking for first time today: Still has delusions: sleeps most of night: food is still mostly milk: takes tonic. Apr. 3 Now goes to her regular meals: goes out nearly every day: is much better mentally + talks at times quite sensibly. Is anxious to go home but still has a few delusions

(See p. 56).

Personal and Medical History of Carrie Bottleson

LEBERT, PECAN & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4302.
Residence, Town of Bath: Minnesota.
Date Admission, 16th January 1896.
Admitted by, Dr Phelps Hour, 6.45 PM
How Sent, Herman Blacknw, Jail. Freeborn County
Sex, Female
Age, — 46 —
Civil Condition, Single
Children,
Age Youngest Child,
Occupation, None, for the last 2 years: Father, farmer
Degree Education, Low: Can't read.
Profession Religion, Yes: Lutheran
Habits, no history of intemperance.
Nativity, Norway: (Parents also born there).
Physicians Committing, G.W. Barck and Henrik Nissen
Correspondents, (Gets mail at Geneva, Minn).

No. for Year, 130.
Insane Relatives, Has a brother idiotic
Cause Exciting, Unknown
Cause Predisposing, Heredity -
Form, Paranoid
Accompanying Bodily Disorder, None mentioned
Suicidal or Not, — Not —
Date of this Attack, about 2 years ago
Duration, about 2 years
No. of Attack, 1st —
No. of Admissions, 1st —
Age First Attack, — about 44 —
Time of Leaving, Nov. 8, 1897
Time in Hospital, 1 yr. 9 mos. 23 d.
Result, Discharged May 4 1898 Unimproved

EXAMINATION ON ADMISSION
MENTAL CHARACTERISTICS.

Exam. by

MENTAL ACTIVITY:
Clear or Confused, Clear on ordinary subjects
Quick or Sluggish, Quick & accurate
MEMORY:
Past Events, Good
Recent Events, Good
Special Subjects, Good
PERCEPTIVITY:
Alert or Dull, Alert.
Correct or Illusive, Correct except for poisoning
REASONING POWER:
Ordinary Subjects,
Own Mental State, Thinks all right
Special Subjects,
GENERAL DESCRIPTIVE REMARKS:
Cannot see as well as formerly.
Dont think she is insane, Neighbors say

EMOTIONAL STATE:
Normal, Calm, Normal
Indifferent,
Exalted,
Depressed,
DELUSIONS:
Systematized or Not, Systematized - thinks that her
Special Subjects, Mother poisoned her; that she was
~~Transitory or Not~~, kind of obliged to.
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent, Coherent
Voluble or Reticent, Talks quite composedly & rationally also quite intelligently

Personal and Medical History of Carrie Bottleson

EXAMINATION ON ADMISSION, CONTINUED.
PHYSICAL CHARACTERISTICS.

HEIGHT, 4 ft 11 in WEIGHT, not taken NUTRITION, Not very good.
WOUNDS OR ABNORMALITIES, lost first phalanx & index R. from felon.
TONGUE, Tremors, deviates to Right Coatings, None Promptness Movement, fairly prompt.
PUPILS, Equality, Equal Size, Slightly dilated
Response Light, Respond Accommodation,
SIGHT, Internal strabismus both eyes.
HEARING, Hears fairly well.
COORDINATION, Arms, Probably good - In bed
Legs, "
TREMORS, Hands, Slight Tongue,
Facial Muscles, General,
REFLEXES, Patellar, Normal
Other
ARTICULATION,
Slurred,
Hesitating, Good
FACIAL EXPRESSION, Rather poor



TAKEN,

SENSIBILITY,
HEART, Normal
LUNGS, Normal. Resp. shallow

EXAM. URINE, January 18/96
Urine 24 hrs 3 XXXVI
Color Yellow
Character Cloudy
Sp Gr 1012
Reaction Acid
Albumen 0
Sugar 0
Urea 216 gr
Sediments # Pus blood, amor. urates, triple phosphates. Bladder cells from deep layers

GYNAECOLOGICAL EXAM., Jan 21 - Extreme hyperaesthesia of parts. External genitals red & excoriated
MENSTRUATION,
OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean, ✓	Careless,
BOWELS, Normal, ✓	Constipated,	Irregular,
APPETITE, Good,	Medium, Fair	Poor,
SLEEP, Good, Quite good.	Poor,	Irregular,
PULSE, Normal	Resp.,	Temp.,

CRANIAL MEASUREMENTS, Head seems small; somewhat sloping
HISTORICAL, Had dizzy & heavy & headaches - Dizziness only 2 months.
LENGTH OF INVASION, Said to be 2 yrs. ONSET GRADUAL OR SUDDEN, Gradual.
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, ?
Father or Pat. Relations, Denies any insanity except one brother idiotic
Brothers or Sisters,

Personal and Medical History of Carrie Bottleson

1896

This patient was received here at the hands of Deputy Sheriff John Gustaveson and attended by Ann Thompson, with following history. Patient is in fair physical condition. There is no history of consanguinity, but some of heredity (?). She has a brother Idiotic. This is the 1st attack: symptoms manifested about 2 years ago; "her mother wanted to get her out of the way, by putting poison in her clothes & in her food": the disease seems stationary but variable & with rational intervals. Derangement now shown, as above stated: "she feels sick after eating, thinks this is due to poison administered by her mother; therefore she prepares her food": "thinks her mother puts poison in her stockings, towels &c". Patient is not dis-posed to injure others, nor suicidal, nor filthy nor destructive in her habits. She has read many religious books, lately. There is no history of intemperance in self or parents, nor of any severe disease &c, or head-injury. She has not been restrained or confined. Cause of the disease is unknown. No medical treatment given her. On personal examination, she talks rational but sticks to her illusions about her mother trying to poison her.

Jan 16 On admission, was put on B.r.W. (G. St. N. Rpt. Complexion fair: hair light: eyes brown: condition of skin normal: ~~she has strabismus of the eyes~~ and has 1st Joint of 1st finger of right hand off: Caused by felon:- Is clear: quiet and talks sensibly).

17 Quiet in bed all day. Has delusions. Appetite fair. Slept 5 hours. Bowels constipated. Gave cathartic. Pulse 100. Resp. 21 Temp. 99.4

18 Urine ʒXXXV In 24 hrs. Tonic & Cathartic given. Bowels constipated. Has delusions. Slept 5 hours; quite restless. Worked a little in dining room.

19 Quiet in behavior. Appetite fair. Slept all night. Bowels constipated. Given cathartic & tonic. Urinates regularly. Resisted so that Temperature could not be taken.

20 Quiet in behavior. Worked a little in dining room. Gym. treatment. Thinks she is going to be hurt when we try to take temperature. Trans. to B1. Slept 6 hrs.

21 Quiet. Appetite fair. Bowels moved. Slept 6 hrs. Has delusions. Takes tonic. Takes out door exercise. Pulse 88. Resp. 20

22 Appetite fair. Takes tonic. Bowels did not move. Slept 6 hrs. Quiet in behavior. Has delusions. Neat in personal appearance. Assists some with work.

23 Quiet. Appetite fair. Takes tonic; slept 3 hrs. Trans. to A. 2.

24 Quiet. Appetite fair. Takes tonic. Slept about 4 hrs. Bowels moved. Has delusions.

25 Quiet. Appetite fair. Takes tonic. Bowels constipated. Given cathartic.

26 Quiet. Appetite quite good. Sleeps fairly well. Works in mending room.

27 Very quiet. Appetite quite good. Slept fairly well. Worked in mending room. Refused tonic

28 Appetite quite good. Slept quite well. Refused tonic. Worked in mending room.

29 Quiet in behavior. Has delusions. Slept well. Refused tonic. Appetite fair. Bowels gen. Const.

30 Appetite good. Slept quite well. Refused tonic. Worked in mending room.

Summary. Very quiet during the past 14 days. Has delusions. Appetite is quite good & she sleeps fairly well. Bowels usually constipated. She refuses tonic. Takes Gym. treatments. Works in mending room.

Feb 17 19-21-24-26-28. Gym treatments given. Mar. 4 Neat in habits. Quiet in behavior. Appetite fair. Sleeps well. Bowels regular. Takes out door exercise. Assists

Personal and Medical History of Carrie Bottleson

at times with ward work. Refuses tonic. Apr. 17 Menses. Apr. 28 Gym. treatments given from 5th to 28th every other day. May 16 Complains of dizziness & headache. Appetite quite good. Misses a meal occasionally. Sleeps well. Bowels regular.

Summary Nurses Notes by Dr. S. L. Phelps:- Habits neat: behavior quiet: sleeps well: appetite quite good: occasionally has dizzy spells: Oct '96 Talks incoherently: quite health good: Feb '97 Appearance quite imbecile: Has grown to be quite disturbed since coming: Apr. 14 '97: Habits dirty: Appetite only fair: quite disagreeable: Cough & expectorates a good deal: July '97 Lungs & heart examined: Quite nutrition impaired: Chest concave: Chest expansion impaired: Resp. 22: Breath sounds very weak: Heart: no murmurs sounds are somewhat weak: 1st sound prolonged & roughened: Pulse 70 & weak

Continued by Dr. P. M. Phelps. Oct 30 '97 Patient today complaining of being weak & was put to bed. Nov 4 Noted as having a weak spell again this afternoon. Nov 8 Taken home on trial.

Discharged Unimproved.

Personal and Medical History of Mary Johnson #1 Lillehagen

LIBBEY, FISHER & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4308.
Residence, Arendahl, Fillmore Co. Minnesota
Date Admission, 22nd January 1896.
Admitted by, Dr. C. B. Coy Hour, 3 1/2 PM
How Sent, E. V. Farrington, Jo. P. Fillmore County
Sex, Female
Age, - 50 -
Civil Condition, Married
Children, one
Age Youngest Child, - Dont Know -
Occupation, Housekeeper: husband a farmer
Degree Education, Some: Can read & write.
Profession Religion, Yes: Lutheran
Habits, not intemperate. —
Nativity, Norway: (Parents also born there). -
Physicians Committing, J. H. Phillips 2nd T. A. Love
Correspondents, none given in papers
Austin Lillehagen Arendahl Fillmore Co (Husband)

No. for Year, 136.
Insane Relatives, None
Cause Exciting, originally, Death of child by drowning
Cause Predisposing, previous attacks.
Form, melancholia acute
Accompanying Bodily Disorder, "nervousness"
Suicidal or Not, - Not -
Date of this Attack, about 2 weeks ago
Duration, about 2 weeks -
No. of Attack, several -
No. of Admissions, 2nd here (live before Sept 1st Dec '92 was taken in hosp in Norway
Age First Attack, unknown -
Time of Leaving, October 2nd 1901
Time in Hospital, 5 yr 8 mos. 10 ds
Result, Died: heart failure -

EXAMINATION ON ADMISSION
MENTAL CHARACTERISTICS.

Examined by

MENTAL ACTIVITY:
Clear or Confused,
Quick or Sluggish, Sluggish & deluded
MEMORY:
Past Events,
Recent Events,
Special Subjects,
PERCEPTIVITY:
Alert or Dull,
Correct or Illusive,
REASONING POWER:
Ordinary Subjects,
Own Mental State,
Special Subjects,
GENERAL DESCRIPTIVE REMARKS:
Dull. Extremely Melancholy - wont talk
Cant eat much. Breathes quick - probably from nervous cause - Slightly feverish

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed, Depressed
DELUSIONS: Patient probably much deluded
Systematized or Not, but will not talk about
Special Subjects, them
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

Personal and Medical History of Mary Johnson #1

EXAMINATION ON ADMISSION, CONTINUED.
PHYSICAL CHARACTERISTICS.

HEIGHT, 4 ft 10 in WEIGHT, Not taken NUTRITION, Fair
WOUNDS OR ABNORMALITIES,
TONGUE, Tremors, None Coatings, No coatings, dry Promptness Movement,
PUPILS, Equality, Equal Size, dilated
Response Light, Accommodation,
SIGHT, Probably Normal
HEARING, "
COORDINATION, Arms, Dull & depressed - Did not try tests
Legs,
TREMORS, Hands, None Tongue,
Facial Muscles, General,
REFLEXES, Patellar, Equal - 6
Other
ARTICULATION, Won't talk
Slurred,
Hesitating,
FACIAL EXPRESSION,
Depressed considerably
SENSIBILITY,
HEART, Normal
LUNGS, Normal



TAKEN,

EXAM. URINE, Jany 29/96
Urine 24 hrs 3 I I
Color Red yellow
Character Yellow ropy dep
Sp Gr 1038
Reaction Alkaline
Albumen 0
Sugar
Urea 380 grs
Sediments Triple phosphates & Urates

GYNAECOLOGICAL EXAM., Jan 29 Uterus in 1st degree of prolapsus - Extensive laceration & cervix
MENSTRUATION, Ceased Regular
OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean, ✓	Careless,
BOWELS, Normal,	Constipated, ✓	Irregular,
APPETITE, Good, ✓	Medium,	Poor,
SLEEP, ~~Good~~, Fair last night	Poor,	Irregular,
PULSE, 54 & weak	Resp., 40	Temp.,

CRANIAL MEASUREMENTS,
HISTORICAL,
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Cant find out
Mother or Mat. Relations,
Father or Pat. Relations,
Brothers or Sisters,

Personal and Medical History of Mary Johnson #1

1896

This patient was received here at the hands of Deputy Sheriff Edward Erickson attended by Mrs Blogsvedt, with following history. Patient is in fair physical condition. There is no history of consanguinity or heredity. This is not 1st attack: one occurred 3 years ago, & before then, she had several attacks. (last one 6 months). Has been in hospitals, in Norway & Rochester, & was sent home apparently cured. First symptoms of this attack were manifested about 4 weeks ago: began by pain in head, & then her mind began to leave her. Disease appears to be stationary; not variable; no rational intervals. Derangement now shown in that she will not stay at home (in house); her talk is foolish & meaningless. Patient is not disposed to injure others, nor suicidal: propensity not active: no filthy or destructive habits: No many previous peculiarities &c not known. There is no history of intemperance in self or parents. No of any head-injury &c. Was in Norway; also in Rochester Hospital for five (5) months from Sept to Feby 1893 (?). Supposed cause of the disease, originally, death of child by drowning; no known cause for this attack. Has had no treatment, except in hospital. On personal Examination, patient is found to be melancholic and depressed.

Note. As stated, patient was here before, from Sep 15/92 to Dec 3/92. (Vol 21 page 81/10 3128) For some days, after then coming, she was much depressed; restless & walking the floor, a great portion of the time: talking continually: afterwards, became more quiet & helped some with work: became less depressed: was neat & tidy in her habits: while there here, she made 2 attempts to strangle herself. Continued to improve & was taken home by a relative.

Jan 22 On admission, was put to B² W (G.A.N. Rpt. Complexion fair: hair light: eyes gray: Condition of skin normal: no marks, scars or bruises noticed: is clean: quiet, but nervous: will not talk: is stupid).

Jan 23 Nurses Notes. Behavior quiet & nervous. Does not talk English. Appetite fair. Slept 6 hrs. Restless at times. Bowels constipated. Pulse 90. Resp. 28. Temp. 99.8.

" 24 Quiet. Bowels constipated. Gave cathartic. Appetite fair. Slept 6 hrs. In bed. Bowels moved. Pulse 82. Resp. 19. Temp. 99.6 Jan. 25 Up on ward. Quiet. Worked a little in dining room. Bowels moved. Slept well. Jan 26 Very quiet in behavior. Appetite fair. Trans. to B1. Jan 27 Appetite fair. Bowels constipated. Slept 6 hrs. Quiet in behavior. Will not talk. P. 78. Resp. 25. Takes tonic.

" 28 Appetite fair. Bowels constipated. Slept six hours. Quiet in behavior. Assisted some with ward work. Takes tonic. Pulse 82 Resp 20.

" 29 Quiet in behavior. Muscle. Quite nervous & restless. Appetite fair. Bowels constipated. Gave cathartic. Takes tonic. Jan. 30 Quiet in behavior. Appetite fair. Bowels moved. Slept. Assists some with ward work. Pulse 78. Resp. 20

31 Quiet in behavior. Appetite fair. Bowels moved. Slept well. Assists with ward work.

Feb. 1 Appetite fair. Bowels moved. Slept 6 hrs. Very quiet in behavior. Talks very little. P. 76 R. 18

" 2 Quiet in behavior. Appetite. Constipated. Slept 6 hrs. P. 82. Resp 20

" 3 Quiet in behavior. Appetite poor. Bowels constipated. Slept 6 hrs. Assists some with ward work. Pulse 78. Resp. 18. Feb 4 Very quiet in behavior. Appetite fair. Bowels constipated. Gave cathartic & tonic. Assists some with

Personal and Medical History of Mary Johnson #1

1896

the work. Slept 7 hrs. P. 78. Resp. 18. Feb 5 Quiet. Appetite fair. Takes tonic. Bowels moved. Slept well. Assisted some with ward work. P. 78. Resp. 20

Summary. Very quiet in behavior. Clean in habits. Neat in personal appearance. Assists some with ward work. Takes out door exercise. Does not talk English. Complains of headache at times. Appetite fair. Takes tonic. Bowels irregular. Sleeps quite well. Takes treatments.

Feb. 3-7-10-12. Gym. treatments given. Mentally she is quite melancholy. Worries & has delusions that someone is going to harm her. Always looks anxious - just as if ready to cry. Genual health is good (Phy) Feb. 14, 17. Gym. treatments. Feb 19. Menses.

Feb 26-28 Gym. treatment. Mentally very quiet. Does not talk English. Worries a great deal. Appetite good. Bowels irregular. Sleeps well. Mar. 2 to Apr. 3 Gym. treatments given every other day. Apr 26 Very resistive & nervous all the time. Takes treatments. Sleeps fairly well. May 30 Visited by son. Very nervous.

June Summary Nurse's Notes by Dr. S. L. Phelps: Appetite good: assists with work: Has been quite agitated: at times is melancholy - more sometimes than at others: Seems to have many delusions: Nov 96 Genl Health fairly good: no mental change:

1897 Jan. Very cross: fights a good deal: melancholy - worries over delusive ideas: works a little in the morning: Always asks to go home: Very incoherent in talk: May 97 No change: Aug 97 Fights other patients at times: cries a good deal: assists some with work: Bowels regular.

Continued by Dr. Phelps. Patients genual health good: usually quiet altho has spells of being noisy & is also quarrelsome. Feby Wt. 125#. Jan 1899 Condition practically unchanged during period. Cont. by Dr. R. A. Bell) Mar. to Sept. 99 General health & appetite good: sleeps well: takes out door exercise: clean & tidy: has many delusions: Is very excitable & appears to be afraid at times: at these times asks about going home, cries & talks a great deal to herself: can not speak English: works in dining room part of time: never converses at any length: answers questions: May 23 Two nails on right foot became very sore & swollen: lanced & compresses applied: recovered in a few days. Aug 18 Wt. 118#. Thinks she has committed a crime & cannot go to heaven.

Sept 1- Feb 28/1900. (Dr Reynolds). Quite destructive: Complains that head feels badly. Appetite poor: seems afraid. Nervous & distractive & restless. Given medicine regularly. Neat in habits: Expresses delusions: Takes out door exercise. Jan 12 Wt. 115#. Feb 27 Seems somewhat better: Does not complain. March - Sept (Dr Linton) Careless in appearance: Stupid & quite resistive at times: Sometimes has to be fed by nurse. Genual health good: Appetite poor: on special diet Apr 9. Complained of pain in abdomen. Enema given: also cathartics. Apr 10 Visited by 3 friends. July 2 3 Vaccinated Aug 17 Left side of face swollen: Hot applications prescribed. Sept - Nov 30 No change: Nov 28 Wt. 118#

Dec Feb 28/1901. Appetite poor: given specials: No delusions: Bowels require laxatives & enemas March 3. Wt. 119#. Has to be dressed & undressed by nurse.

See page 144

Personal and Medical History of *Belle Lewis*

LEBERT, FISLAR & SAMBERG, DAVENPORT, IOWA.

Whole No. 4309.

Residence, St. Paul. Minn. 430 Goodrich

Date Admission, 27th January 1896.

Admitted by, D. Hennessy Hour, 7 P.M.

How Sent, G. Willrich. Jo P. Ramsey County

Sex, Female

Age, about 21 years

Civil Condition, single

Children,

Age Youngest Child,

Occupation, Seamstress (father's, not known).

Degree Education, Limited

Profession Religion, not known if Church member

Habits, - not known -

Nativity, St. Paul. Minnesota (that of parents not known)

Physicians Committing, G. Hamm and J.B. Barnhall

Correspondents, none given in papers.

No. for Year, 137.

Insane Relatives, not known

Cause Exciting, Trouble at home

Cause Predisposing, probably previous attack

Form,

Accompanying Bodily Disorder, none mentioned

Suicidal or Not, not known

Date of this Attack, one year ago

Duration, - one ye

No. of Attack, not known

No. of Admissions, 1st

Age First Attack, (?)

Time of Leaving, June 15

Time in Hospital, 5 mo. 1

Result, Discharged No

MENTALLY UNBALANCED.

Miss Belle Lewis Will Be Examined in the Probate Court.

Miss Belle Lewis, aged eighteen, is at the county jail, suffering apparently from mental derangement. She was taken to the central police station Saturday evening at 7 o'clock by Officer Pat Smith. The officer had been called to the dressmaking parlors of Mrs. Edward Espey, 128 West Sixth street, where the girl had been employed for the past two years. Mrs. Espey became alarmed at the serious turn in Miss Lewis' mental condition. Smith took the girl to the central station. Dr. Brimhall was called, but could make little of the case. Miss Lewis refused to talk. The doctor called again yesterday morning and advised that the patient be taken to the county jail to await a hearing in the probate court. It is said that the girl has been acting strangely for a year or more. She would stand for hours at a time gazing vacantly upward. The girl's parents live at 430 Goodhue street.

EXAMINATION ON ADMISSION

Exam. by R.M. Phelps - Dr Phelps & M.B. Hall

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Confused.

Quick or Sluggish, Sluggish

MEMORY:

Past Events,
Recent Events,
Special Subjects, } Can't tell accurately

PERCEPTIVITY:

Alert or Dull, Dull.

Correct or Illusive, Incorrect.

REASONING POWER:

Ordinary Subjects,

Own Mental State,

Special Subjects,

GENERAL DESCRIPTIVE REMARKS:

Hard work to learn to read. Never was a very good scholar. Is apparently a feeble-minded girl. Can't get her to quite acknowledge it however.

EMOTIONAL STATE:

Normal, Calm,

Indifferent, & quiet

Exalted,

Depressed,

DELUSIONS: None noted though general-

Systematized or Not, ized delusional ideas

Special Subjects, Answers irrelevant usually

Transitory or Not, & vague,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

Personal and Medical History of *Belle Lewis*

Belle Lewis.

Combined Temperature Weight and Sleep Chart
use a sharp lead pencil. "Inking in" can be done in office

GRAPHIC CLINICAL CHART. DESIGNED BY J. P. CROZER GRIFFITH, M.D.

Name, Belle Lewis Age, 21 Residence, St. Paul

Disease, Insanity Case No. Date, Jan. 27 96

DAY OF MONTH: 27 28 29 30 31 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

DAY OF DISEASE:

TIME OR DAY: A.M. P.M.

PULSE RESP. TEMP.

Sleep

Temperature

Weight continued Treatment.

Centigrade Scale.

Clinical Notes.

PULSE Urine Contains
RESP Sp. Gr.

Oz. 84 68 64 64 74 70 72 78 74 80 76 74 74

Sp. Gr. 18 17 20 19 21 18 16 16 18 18 19 18 18

BOWELS.

WEIGHT.

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HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")

Mother or Mat. Relations,

Father or Pat. Relations, Father living

Brothers or Sisters, Chased her out, she says. Born in St Paul

Personal and Medical History of Belle Lewis

LABERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4309.
Residence, St Paul. Minn. 430 Goodrich
Date Admission, 27th January 1896.
Admitted by, Dr. Henry. Hour, 7 P.M.
How Sent, G. Willrich. Jo P. Ramsey County
Sex, Female
Age, about 21 years
Civil Condition, single
Children,
Age Youngest Child,
Occupation, Seamstress (father's, not known).
Degree Education, Limited
Profession Religion, not known if Churchmember
Habits, - not known -
Nativity, St Paul. Minnesota (that of parents not known)
Physicians Committing, G Hamm and J B. Burchall
Correspondents, none given in papers.

No. for Year, 137.
Insane Relatives, not known
Cause Exciting, Trouble at home
Cause Predisposing, probably previous attack
Form,
Accompanying Bodily Disorder, none mentioned
Suicidal or Not, not known
Date of this Attack, one year ago
Duration, - one year -
No. of Attack, not known
No. of Admissions, 1st
Age First Attack, (?)
Time of Leaving, June 15 - 1896
Time in Hospital, 5 mo. 17 da.
Result, Discharged Nov. 10 '96. Improved.

EXAMINATION ON ADMISSION

Exam. by R M. Phelps - Dr Phelps & Mc Burchall

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Confused.
Quick or Sluggish, Sluggish
MEMORY:
Past Events,
Recent Events, } Can't tell accurately
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Dull.
Correct or Illusive, Incorrect.
REASONING POWER:
Ordinary Subjects,
Own Mental State,
Special Subjects,
GENERAL DESCRIPTIVE REMARKS:
Hard work to learn to read. Seems was a very good scholar. Is apparently a feeble-minded girl. Can't get her to quite acknowledge it however.

EMOTIONAL STATE:
Normal, Calm,
Indifferent, & quiet
Exalted,
Depressed,
DELUSIONS: None noted though general
Systematized or Not, ugly delusional ideas
Special Subjects, Answers irrelevant usually
Transitory or Not, & vague.
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

Personal and Medical History of Belle Lewis

EXAMINATION ON ADMISSION, CONTINUED.

Feb.
comi
in



Belle Lewis.

Combined Temperature Weight and Sleep Chart
use a sharp lead pencil, "sinking in" can be done in office

GRAPHIC CLINICAL CHART. Designed by J. P. Crozer Griffith, M.D.

Name, Belle Lewis Age, 21 Residence, St Paul
Disease, Case No. Date, Jan. 27 96

MARK: PULSE, RESP., TEMP.

DAY OF MONTH: 27 28 29 30 31 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

Sleep

Temperature

Weight continued

Centigrade Scale.

PULSE	Oz.		84	68	69	64			74	72	72	78	74	86	76	74	74			
URINE	Contains																			
RESP.	Sp. Gr.		18	17	20	17			21	17	16	16	15	15	17	18	18			

BOWELS.
WEIGHT.

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HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations,
Father or Pat. Relations, Father living
Brothers or Sisters, Chased her out, she says. Born in St Paul

Personal and Medical History of *Belle Lewis*

LIBBEY, FISLAR & SAUNDERS, DAVENPORT, IOWA.

Whole No. 4309. No. for Year, 137.

Resider

Date A

Admitt

How S

Sex,

Age,

Civil C

Childre

Age Y

Occupa

Degree

Profess

Habits,

Nativit

Physici

Corresp

Exam. by D

MENT

Clear

Quicl

MEMO

Past

Recer

Speci

PERCE

Alert

Corre

REASC

Ordir

Own

Speci

GENEI

Hard

Very good scholar. Is apparently a feeble-minded girl. Can't get her to quite acknowledge it however.

Personal and Medical History of *Belle Lewis*

Belle Lewis.

Feb.10th,'96.--- Father states earliest symptoms appeared six years ago, coming on gradually: No insanity known on either side and no consumption in the family.

Response Light, Responds — Accommodation,

SIGHT, Probably good. } Wont talk

HEARING, " " }

COORDINATION, Arms, Probably good - Notesto - wont talk

Legs,

TREMORS, Hands, None — Tongue,

Facial Muscles, — General,

REFLEXES, Patellar, Normal

Other

ARTICULATION, Probably good,

Slurred, Wont Talk except a few

Hesitating, Mumbled words.

FACIAL EXPRESSION,

SENSIBILITY,

HEART, Normal as far as noted

LUNGS, Normal as far as noted

GYNAECOLOGICAL EXAM.,

MENSTRUATION, Regular

OPHTHALMOSCOPIC EXAM.,

TAKEN,

EXAM. URINE, Jany 31/96

Quant 24 hrs 3 X j

Color Brownish Red

Character " flaky dep

Sp Gr 1031

Reaction Acid +

Albumen 0

Sugar

Urea 231 gr

Sediment. Amor urates + Rec + blood

Bladder epithelium + Cholesterin + crystals

I am 2 g. Uterine left-lateroversion + bound down firmly by adhesions on left side & fibroma.

HABITS, Dirty,	Clean, ✓	Careless,
BOWELS, Normal,	Constipated, ✓	Irregular,
APPETITE, Good,	Medium,	Poor, ✓ Poor today
SLEEP, Good, ✓ Good 7 hrs.	Poor,	Irregular,
PULSE, Normal	Resp.,	Temp., Normal

CRANIAL MEASUREMENTS,

HISTORICAL,

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,

HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")

Mother or Mat. Relations,

Father or Pat. Relations, Father living

Brothers or Sisters, Chased her out, she says. Born in St Paul

Personal and Medical History of *Belle Lewis*

ALBERT, FISLAR & DAMBERG, DAVENPORT, IOWA.

Whole No. 4309.

Reside

Date A

Admitt

How S

Sex,

Age,

Civil C

Childr

Age Y

Occupa

Degree

Profess

Habits

Nativit

Physic

Corresp

MENT

Clear

Quic

MEMO

Past

Rece

Speci

PERCI

Alert

Corre

REASO

Ordi

Own

Speci

GENE

Had

Very good scholar. Is apparently a feeble-minded girl. Can't get her to quite ac-knowledge it however.

Personal and Medical History of *Belle Lewis*

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft. —— WEIGHT, Not taken NUTRITION, Good.

WOUNDS OR ABNORMALITIES, None

TONGUE, Tremors, Mont petit act Coatings, Promptness Movement,

PUPILS, Equality, Equal Size, Normal

Response Light, Responds Accommodation,

SIGHT, Probably good. } Mont Falk

HEARING, " " "

COORDINATION, Arms, Probably good - Rotates - mont Falk

Legs,

TREMORS, Hands, None Tongue,

Facial Muscles, General,

REFLEXES, Patellar, Normal

Other

ARTICULATION, Probably good

Slurred, Mont Falk except a few

Hesitating, Mumbled words.

FACIAL EXPRESSION,

SENSIBILITY,

HEART, Normal as far as noted

LUNGS, Normal as far as noted

GYNAECOLOGICAL EXAM. Jan 29 - Uterus in left lateral version & bound down firmly by ad-

MENSTRUATION. hesions on left side & painless. Regular

OPHTHALMOSCOPIC EXAM.,

TAKEN,

Mr EXAM. URINE, Jany 31/96

Urine 24 hrs 3 X

Color Brownish Red

Character " flaky dep

Sp Gr 1031

Reaction Acid +

Albumen 0

Sugar

Urea 231 gr

Sediment: Amor urates + Rec + blood

Bladder epithelium & Cholesterin crystals

HABITS, Dirty,	Clean, ✓	Careless,
BOWELS, Normal,	Constipated, ✓	Irregular,
APPETITE, Good,	Medium,	Poor, Poor today
SLEEP, Good, ✓ Good 7 hrs.	Poor,	Irregular,
PULSE, Normal	Resp.,	Temp., Normal

CRANIAL MEASUREMENTS,

HISTORICAL,

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,

HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")

Mother or Mat. Relations,

Father or Pat. Relations, Father living

Brothers or Sisters, Chased her out, she says. Born in St Paul

Personal and Medical History of *Belle Lewis.*

1906

This patient was received here at the hands of Deputy Sheriff F. W. Kinney & attended by Wm F. W. Kinney, with following history. Patient is in fair physical condition. As to any consanguinity, or hereditary history, nothing known. Not known if this is 1st attack or not. First symptoms of this attack were manifested one year ago, according to reports: has shown a demented condition. Disease seems increasing; not variable: no rational intervals. Derangement now shown in that she refuses to talk, even to tell name & residence: refuses to eat & drink. Was found walking the streets, late at night. If suicidal, is not known. She has no filthy or destructive habit: as to any previous peculiarities & habits of self or parents, if ever subject to any severe disease or head injury, nothing can be learned. She has been confined, since Saturday night, in County Jail (Jany 25th to 27th). Supposed cause of the disease is trouble at home. She asked no medical relief. She is well nourished: has a bad tooth.

Jan 27 On admission, was put on Bd (G.F.N. R.R. Co.) Complexion fair: hair brown: eyes brown: condition of skin normal: no marks, scars or bruises noticed, though there is a small swelling on right side of chest. Is clean: quiet: talks rather silly).

Jan Nurses Notes. Behavior quiet in bed. Has delusions. Appetite fair. Slept 9 hrs. Bowels constipated. Pulse 84. Resp. 18. Temp. 98.6

29 Up on ward. Appetite poor. Slept 6 hrs. Talks quite sensibly at times. Bowels constipated. Slept 7 hrs. Temp. 99.4. Pulse 68. Resp. 19.

30 Up on ward. Did not eat today. Urine 3. XI. Quiet in behavior. Has delusion. Slept 6 hrs. Bowels constipated. Gave cathartic. T. 98.3. P. 64. R. 20

31 Fed with tube. Slept 7 hrs. Rather silly. Mentally quiet in behavior. Bowels constipated. Slight movement. Appetite poor. Slept 6 hrs.

Feb 1 Quiet in behavior. Appetite poor. Gave cathartic. Slept 6 hrs. T. 98.4 P. 64 R. 19. Talks rationally at times. Feb 2 Quiet. Bowels moved. Appetite a little better. Bowels moved. Slept 6 hrs. Feb 3 Went walking. Behavior good. T. 98.2 P. 74. R. 21. Complains of toothache. Gave cathartic: bowels moved. Slept 6 hrs. Mentally amount of beauty. Feb 4 Behavior quite silly. Takes off her underclothing. Talks sensibly at times. Slept 6 hrs. Bowels moved. Appetite fair. Feb 5 Gym. Examination. Fed with tube. Gave cathartic. Bowels moved freely. Hot salt bath with cold application to head. 10 minutes. Effects good. Feb 6 Appetite poor. Quiet in behavior rather impudent at times. Slept 4 hrs. Tonic. Feb 7 Gym. Treatment. Hot bath. Cold application to head. Answers questions fairly well. Temp. 97.4 P. 74. R. 20. Feb 8 Hot bath. Eats some better. Quite impudent at times. Slept 5 hrs. Appetite fair. Bowels moved. Temp 99.4 P. 74. R. 19. Tonic & cathartic given. Bowels constipated.

Feb 9 Ans. questions fairly well. Quiet in behavior. Slept 5 hrs. Appetite fair. Bowels moved. Temp 97.4. T. 74. R. 19. Feb 10 Quiet. Hot bath with cold applications. Gym. Treatment. Bowels irregular. Slept 6 hrs. Temp. normal.

Summary. Behavior silly quiet most of time. Bowels irregular. Cathartic & Tonics given. Fed with tube twice. Daily hot bath with cold applications

Personal and Medical History of *Belle Lewis.*

to head given. Temp. below normal when taken ax. Normal by rectum. Sleeps fairly well. Mentally. Urine 3. XI. Feb 12 Gym. treatment 14, 17, 19, 21.

Feb 13 to 21 Visited by Mother. Had swelling on jaw. Had gum lanced. Complains of it when eating. Feb 26 Poultices several times daily. Feb 28 Opened on the cheek. discharged pus. Feb 29 Cleansed with peroxide. Dressed with iodoform Gauze. Appetite very poor. Mar 1 Check with Per. of Hyd. daily & dressed with iodoform gauze. Discharges quite freely. Mar 6 Poultices daily also 7-8-9-10-11 Mar 11 Up on ward. Mar 22 Sleeps well. Bowels regular. Appetite poor. Takes cathartics occasionally. Takes tonics. Mar 30 Appetite poor. Bowels constipated most of time. Takes cathartics. Takes tonics & treatments.

April 6 Appetite poor. Takes tonic - Constipated most of time. Takes cathartics quite often.

" 16 Very quiet. Appetite good. Very resistive. Mentally. regularly. May 11 Quiet. Talks quite sensibly. Resistive. Appetite poor. Bowels constipated. Takes cathartics.

May 6 Appetite poor. Very disagreeable at times. May 30 Appetite quite good. Bowels regular. June 1 Appetite quite good. Goes riding & walking. June 12 Appetite good. June 15 Went Home with father. Rather brighter of late yet quite dull & feebleminded on the whole

Discharged

Personal and Medical History of Anna Storley

LIBERT, PUDLAN & SAUNDERS, DAVENPORT, IOWA.

Whole No. 4312.
Residence, Woodville, Minnesota.
Date Admission, 29th January 1896.
Admitted by, Dr. C.B. Eby. Hour, 6th P.M.
How Sent, Geo. A. Wilson, Jof. Wascca County
Sex, Female.
Age, 27.
Civil Condition, married.
Children, Two.
Age Youngest Child, Eighteen months.
Occupation, Housewife: (husband farmer)
Degree Education, very little: can read & write.
Profession Religion, Lutheran.
Habits, Not stated definitely.
Nativity, Norway: (Parents also born there).
Physicians Committing, A. Young and G.A. Swartwood.
Correspondents, None given in papers.

No. for Year, 140.
Insane Relatives, Father died in Asylum: Aunt- Insane.
Cause Exciting, - Heredity.
Cause Predisposing, Heredity & previous attacks
Form,
Accompanying Bodily Disorder, None mentioned
Suicidal or Not, Threatens to kill herself —
Date of this Attack, About 1st November —
Duration, Some 3 months —
No. of Attack, Not 1st: has had them, past 4 years.
No. of Admissions, 1st.
Age First Attack, about 23.
Time of Leaving, Nov. 1. 1877
Time in Hospital, 1 yrs. 9 m. 2 d.
Result, Discharged May 4. 1878 Improved.

EXAMINATION ON ADMISSION

Examined by Drs. P.M. & Ch. Phelps & Dr. Parker.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Silly in manner
Quick or Sluggish, Sluggish
MEMORY:
Past Events, Seems fairly good.
Recent Events, Fairly good.
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Rather dull.
Correct or Illusive,
REASONING POWER:
Ordinary Subjects, Impaired
Own Mental State, Impaired
Special Subjects,
GENERAL DESCRIPTIVE REMARKS:

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed, Slightly depressed.
DELUSIONS:
Systematized or Not,
Special Subjects, None determined
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent, Talks quite willingly but rather slowly. Hesitates a good deal.

Personal and Medical History of Anna Storley

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, not taken WEIGHT, not taken NUTRITION, Good. Color good.
WOUNDS OR ABNORMALITIES, None. Right wrist.
TONGUE, Tremors, Coatings, Yellowish cracked Protruded at 2 degrees. Promptness Movement, Slightly hesitating
PUPILS, Equality, Equal. Size, Normal
Response Light, Normal Accommodation, Normal
SIGHT, Impaired
HEARING, Seems impaired
COORDINATION, Arms, Normal
Legs, Normal.
TREMORS, Hands, None Tongue, None.
Facial Muscles, None General,
REFLEXES, Patellar, About
Other Normal.
ARTICULATION,
Slurred,
Hesitating, Hesitating
FACIAL EXPRESSION,
Rather dull.
SENSIBILITY,
HEART, No murmurs- Rems Normal



TAKEN,

Urine natural XXXIX
Color yellow EXAM. URINE, Jany 31/96
Character-Yellow flaky dep. Sp G 1015 Reaction Neutral
Urea 3½ gr. Sediments-Triple phosphates amorphous & Bladder & Vaginal & Epith +
Lungs- Respiration impaired over both lungs. Chest expansion very poor. Right apex crepitant rales- Percussion note flat. Right lung slightly more impaired. Left Subclavicular region some rales flat percussion. Posteriorally no definate phys. symptoms

Right apex breathing tubular.
LUNGS, Respiration impaired
GYNAECOLOGICAL EXAM, Jan 31-'96- Uterus normal position - Extensive laceration of cervix.
MENSTRUATION, Very irregular and painful
OPHTHALMOSCOPIC EXAM,

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated, ✓	Irregular,
APPETITE, Good, very	Medium,	Poor,
SLEEP, Good,	Poor, ✓	Irregular,
PULSE, Reg. 84	Resp.,	Temp., Normal

CRANIAL MEASUREMENTS, Horizon. Circum. 22½; Nasa occip. Arc. 14½ Binaural arc 12.5 Ant. post. diam 7.6
~~HISTORICAL~~, " Transverse diam. 6.1 Binaural diam. 5.3 Fac. Length 11 Triangle {7.0 / 6.6} Intra Mental circ 26.
LENGTH OF INVASION, Long duration ✓ ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations,
Father or Pat. Relations, died insane
Brothers or Sisters, bad temper Thinks her three brothers were insane at times

Personal and Medical History of Anna Storley

1896

This patient was brought here by Deputy Sheriff Geo. H. Goodspeed attended by Ole Hogansen, with following history. Patient is in fair physical condition. As to Consanguinity, not known but there is history of heredity; father died in an Asylum: aunt is insane: this is not 1st attack: she had them 4 years ago & every winter since; duration, from fall till Spring: first symptoms of this attack were manifested 1st November, by sleepless nights & strange actions. Disease seems increasing, but is variable; rational periods do not occur at regular intervals. Derangement now shown on no particular subject: she destroys her clothing & wanders about nights. Patient is disposed to injure others: has not attempted suicide, but she states, from time to time, that she will kill herself: filthy & destructive in habits. Patient has been, for years, subject to strange actions &, at times, received medical treatment for same. There is no history of intemperance, except excessive use of tobacco & strong coffee: both parents use them. And no history of any severe disease so far as we can learn. Nothing has been employed, except home restraint. Supposed cause of the disease is heredity. She has had no particular treatment.

Jan 29 On personal Examination, the following are noted. viz: defective nutrition; indigestion; — Temp. 100: pulse rate 90: variable nervous conditions: she is also pregnant 2 or 3 months. On admission, was put on B.W.(G.A.N. Kpt. Complexion fair: hair Sandy: eyes blue: Constitution & skin normal: wrist & right hand has been injured by a fall: is enlarged: is clean: behavior quiet: talks sensibly).

Nurses Notes

31 Behavior quiet but silly. Slept 7 hrs. Bowels constipated. P. 84 R. 19 T. 98.4 Up on ward. Bowels moved. Urine 3 XXIX Behavior silly Appetite good Slept 6 hrs Temp. 98.6 P. 84. R. 23.

Feb 1 Silly in behavior. Bowels moved. Appetite good Slept six hrs. Talks quite sensibly at times. Temp. 98.8 Pulse 78. Resp. 21

2 Works some in dining room. Quite silly. Appetite good. Sleeps fairly well. 4 hrs. Gave cathartic. Temp. 98.4 Pulse 74. Resp. 20.

3 Very untidy. Takes off underclothes. Works in dining room. Talks sensibly at times. T. 98.6 P. 78. R. 21 Slept 5 hrs. Noisy 1 hr.

4 No change in behavior Appetite fair Bowels moved. Rather silly. Slept 5 hrs.

5 Very silly. Dirty in habits. Bowels moved. Appetite fair. Slept well. Works some in dining room.

6 Gave cathartic. Talks quite sensibly at times. Very untidy Slept 5 hrs. slightly noisy 1 hr. Salt bath given.

7 No change in behavior. Slept 4 hrs. Noisy 2 hrs. Bowels moved. Appetite fair. Works some in dining room.

8 Out riding. Very restless & silly. Eats well. Answers questions fairly well. Slept 4 hrs. out of bed often.

9 Silly & childish. Untidy in appearance Dirty in habits. Appetite fair Bowels moved. Slept 2 hrs Out of bed 4 hrs. Noisy 2 hrs

10 No change in behavior. Gave cathartic. Slept 4 hrs. Noisy at times.

11 Behavior same. Slept 3 hrs. Out of bed 4 hrs. Is very mischievous. Bowels moved

12 Behavior silly. Appetite fair. Does not work in dining room. Laughs talks to herself.

Summary Behavior is silly. Talks quite sensibly at times. Appetite fair. Bowels irregular. Does not sleep very well. Goes riding & walking. Urine 3 XXIX Dirty in habits. Temp. about normal. Given several cathartics

Personal and Medical History of Anna Storley

1896

Feb 14 Gyn. treatments. Feb 15 In seclusion 5 hrs. Very excited. Very untidy in personal appearance & dirty in habits. Sleeps poorly. Appetite fair most of time. Pulse 83 to 123. Feb 16 & 17 Gyn treatments given. Was visited by husband. Very silly in behavior. Habits dirty. Mar 1 Very untidy. Appetite good. Sleeps well. Goes walking & riding. Takes treatments. Mar 10 Fought nurses.

Apr 5 Very noisy all day. Fought nurses. Apr 9 Pulse 83 to 123. Apr 11 Visited by brother

" 27 Taken for a walk & made a hard effort to escape nurses. Very mischievous & dirty in habits. Appetite good. Rests well nights. Goes riding. Bowels regular. Takes treatments. Apr 29 Was visited by her husband. May 29 Remains about the same. Requires constant watching. Gyn. treatments given every other day.

June Summary Nurses Notes by Dr. S. L. Phelps: Slowly improving: works some but very mischievous & not usually out of lower bay: quite silly & incoherent:

July 4 Visited by relatives: Nov. 14 '96: Very silly most of time: has laughing spells: kept in lower bay most of time: Mar '97 Gen'l health good: rather demented & silly: At times will answer questions: Has violent spells: Aug '97 Mental condition seems to improve slowly: appetite good: bowels regular: takes outdoor exercise: goes to chapel & entertainments. Continued by Dr. Ann Phelps. Nov 6 '97 Patient about as usual. Today went home: has been fairly quiet of late altho there have been times when she was inclined to be violent. However, on the whole she has improved very much in behavior.

Personal and Medical History of Jennie Maxwell.

LEGLEY, FISLAR & GUMBLE, DAVENPORT, IOWA.

Whole No. 4313.
Residence, St. Paul, Minnesota
Date Admission, 30th January 1896
Admitted by, Dr. Herzog Hour, 6 1/4 P.M.
How Sent, G. Willrich, Jof P. Ramsey County
Sex, Female
Age, 25
Civil Condition, married
Children, one (still birth)
Age Youngest Child, Nov 27/95
Occupation, Housewife; (husband, printer).
Degree Education, limited: for a few years
Profession Religion, not a church member
Habits, not known
Nativity, Canada; (parents also born there).
Physicians Committing, John B. Darling and Talbot Jones
Correspondents, George E. Maxwell, husband
246 Martin St. St Paul

No. for Year, 1141.
Insane Relatives, None known
Cause Exciting, aggravated by pregnancy
Cause Predisposing, "chronic"
Form,
Accompanying Bodily Disorder, none mentioned
Suicidal or Not, not
Date of this Attack, Just after married: July '95
Duration, about a year
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, about 24
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION

Examined by Drs P.M. & St. Phipps & Jpt E. Bassett.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, somewhat confused
Quick or Sluggish,
MEMORY:
Past Events, Normal
Recent Events, Normal
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Alert.
Correct or Illusive, Mostly Correct.
REASONING POWER:
Ordinary Subjects, Fair
Own Mental State, Impaired
Special Subjects,
GENERAL DESCRIPTIVE REMARKS:

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed, Depressed.
DELUSIONS:
Systematized or Not, Thinks her husband is going
Special Subjects, to marry her sister
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent, Talks freely - thinks she ought not to have been brought here

Personal and Medical History of Jennie Maxwell

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, not taken WEIGHT, not taken NUTRITION, Good. Pale.
WOUNDS OR ABNORMALITIES, None.
TONGUE, Tremors, None. Coatings, Slight yellow Promptness Movement,
PUPILS, Equality, Equal. Size, Dilated
Response Light, Sluggish Accommodation, Sluggish
SIGHT, Good
HEARING, Good.
COORDINATION, Arms, Normal
Legs, Normal Standing on foot, no difficulty
TREMORS, Hands, None Tongue, None
Facial Muscles, General,
REFLEXES, Patellar, Both 8
Other
ARTICULATION, Prompt
Slurred,
Hesitating,
FACIAL EXPRESSION, Normal

SENSIBILITY,

HEART, Apex beat normal - Treakery ular, but no murmur. Normal sounds
LUNGS, Normal. Chest expansion 3in.
GYNAECOLOGICAL EXAM. Uterus retroverted & bound down - Erosion of os. Laceration of cervix
MENSTRUATION, Regular - usually. None about since child was born
OPHTHALMOSCOPIC EXAM.,

TAKEN,

EXAM. URINE, Feb. 1 '96.
Color Light yellow.
Character pinkish flaky sediment
Quant. in hrs. 3 XXIX
Sp. Gr. 1.020
Reaction Acid
Albumen Found by heat & Nitric Acid
Sugar ? None -
Microscopical Large quant. of amorph urates.

HABITS, Dirty,	Clean, ✓	Careless,
BOWELS, Normal, ✓	Constipated,	Irregular,
APPETITE, Good, fairly	Medium,	Poor,
SLEEP, Good,	Poor,	Irregular, ✓
PULSE, 68 Irreg.	Resp.,	Temp.,

CRANIAL MEASUREMENTS, 1 circ. 21 in, 3- 11 in., 7- 13 in., 15- 24 7/8 in, 8- 14 5/8 in., 9- 18' 13-10.8 11-13+
~~HISTORICAL.~~ 3.4 / 1.8 17.5 / 15.3
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, healthy
Father or Pat. Relations, "
Brothers or Sisters, 1 brother & 2 sisters all healthy

Personal and Medical History of Jennie Maxwell.

1895

This patient was brought here by Deputy Sheriff M. N. Goss, attended by Mr Green, with the following History. Patient is in fair physical condition. There is no history of consanguinity nor of heredity, so far as known. This is 1st attack; Symptoms manifested just after being married, Jany '95. Disease seems to be uterine axiety; variable with rational intervals: but these, not at regular periods. Derangement now shown by various delusions. Patient is not disposed to injure others, nor suicidal; propensity not active; but is of filthy & destructive habit. Husband said she appeared "queer" for a number of years. As to any history of intemperance nothing known. Has had no severe disease &c or head injury: has not been restrained or confined. Cause of Disease aggravated by pregnancy: has had no medical relief. Skin now found to be very restless, indifferent; irresponsibility.

Jan 30 On admission, was put on B'W (G.H.N.Rpt. Hair brown: eyes blue: condition of skin normal: no marks scars or bruises noticed: is very dirty. Quiet & talks sensibly).

Jan 31 Nurses Notes Quit in bed all day. Talks rather sensibly - Appetite fair. Slept 5 hrs; restless at times. Bowels constipated. P. 89. Resp. 19. Temp. 98.7.

Feb 1 Up on ward. Talks quite sensibly. Bowels constipated - gave cathartics & tonic. Slept 4 hrs. Quite hysterical this morning. Urine 3 XXIX

2 Quiet in behavior. Talks quite sensibly. Bowels moved. Appetite fair. Slept 6 hrs. Temp. 98.4 Pulse 64 Resp. 20 Menstruating

3 About wishing today. Seems anxious to get away. Slept 4 hrs. T. 98 P 74 R. 22. Bowels constipated gave cathartic & tonic.

4 Quiet in behavior. Talks about getting home. Bowels moved; eats well; Slept 5 hrs. Tonic given. Menstual flow rather scanty. Feb 5 Gyn. - examination. Rather nervous. Tonic given. Slept 4 hrs. No change in behavior. Appetite fair.

6 Rather nervous. Quite impudent. Gave cathartic & tonic. Slept 5 hrs. Seems anxious to get away. Feb 7 No change in behavior. Gyn. treatment. Talks sensibly at times. Appetite fair. Slept 4 hrs. Restless at times.

8 Mut riding. Quiet in behavior. Slept 4 hrs. Took tonic - Bowels moved.

9 Gyn. treatment. Bowels moved. Tonic - Is easily excited. Very untidy - Slept 4 hrs.

10 Quiet in behavior. Slept 6 hrs. Gave cathartic. Appetite quite good. Tonic. Has delusions. Seems to be jealous of her husband. Gyn. treatment given.

11 No change in behavior. Talks rather sensibly. Bowels irregular. Untidy in person.

12 Visited by husband. Talked sensibly - wanted to go home. Has delusions. Says she is not insane. Slept 7 hrs. Gyn. treatment. Feb 13 No change in behavior. Takes tonic. Appetite fair. Talks rationally. Slept 6 hrs. Bowels moved by cathartic.

Summary Behavior quiet. Will walk up and down hall talking to herself & making motions with her hands; Quite often makes faces & bothers other patients. Is quite impudent at times. Temp. Normal. Urine 3 XXIX Bowels usually constipated. Appetite good. Gyn. Treatments. Takes tonics. Menst. Visited by husband.

Feb 14-17-19-21-24-26-28 Gyn. Treatments. Feb 23 Is some better. Helps on ward. Takes tonic. Sleeps well usually. Appetite quite good.

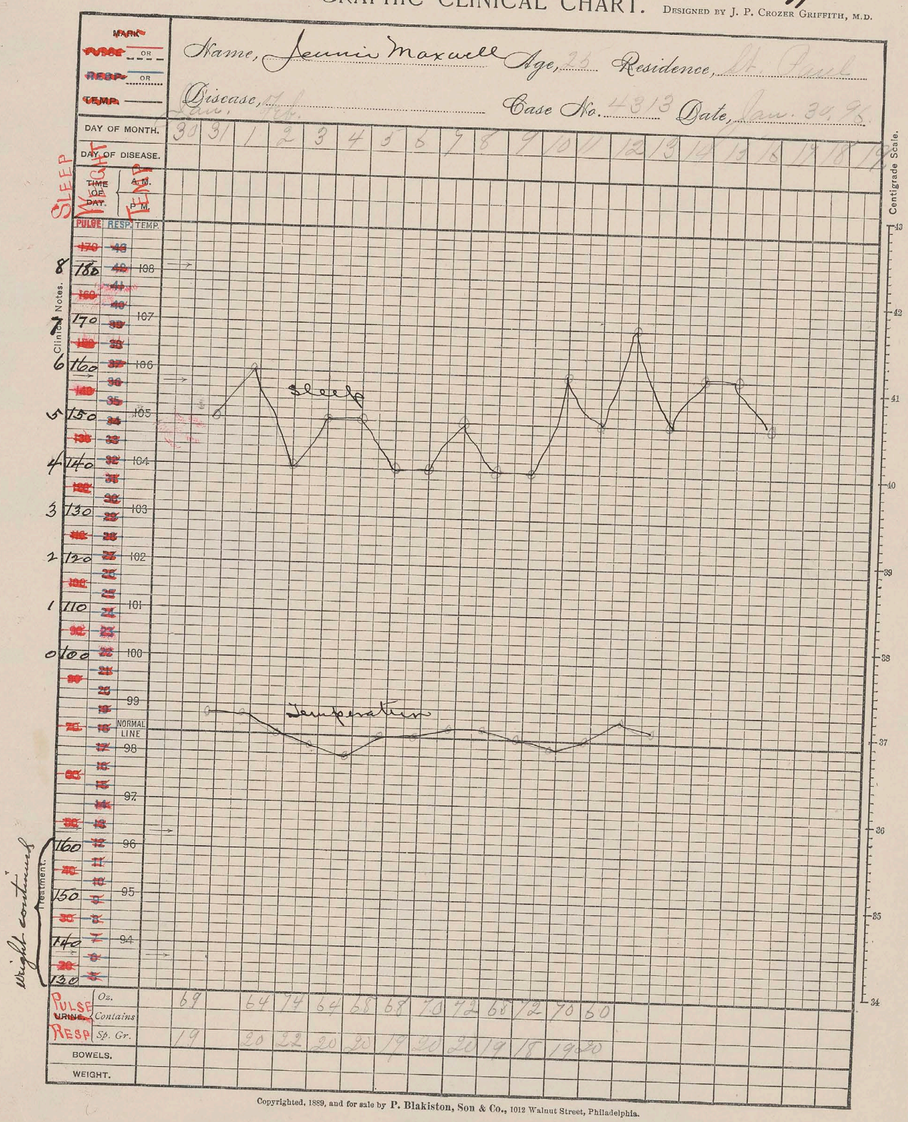
Personal and Medical History of Jennie Maxwell.

Combined Temperature Wright and Sleep Chart
use a sharp lead pencil - Inking in can be done in office

GRAPHIC CLINICAL CHART. Designed by J. P. Crozer Griffith, M.D.

Name, Jennie Maxwell Age, 33 Residence, St. Paul

Disease, ? Case No. 4813 Date, Jan. 30 95



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sometimes attacks other patients: is destructive. Tor 2 p.

Personal and Medical History of Jennie Maxwell.

1896

This patient was brought here by Deputy Sheriff M. H. Goss attended by Mrs Green, [illegible] of [illegible] and just [illegible] trovals: [illegible] not [illegible] habits. [illegible] pearance [illegible] or Con- [illegible] found [illegible] al: no [illegible] ther at [illegible] nic [illegible] is [illegible] Pyn [illegible] hes [illegible] tion [illegible] ite fail [illegible] t [illegible] d. [illegible] hes. [illegible] Has [illegible] y in person [illegible] ns [illegible] ge in [illegible] med by cathart [illegible] elf & [illegible] patients

Jan 30 Jan 31 Feb 1 2 3 4 6 8 9 10 11 12

Is quite independent at times. Temp Normal. Urine 3XXXIX Bowels usually constipated. Appetite good. Gyn. Treatments. Talks Tonics. Menstr. Visited by Husband. 1

Feb 14 17-19-21-24-26-28. Gyn. Treatments. Feb 23 Is some better. Helps on ward- takes Tonic. Sleeps well usually. Appetite quite good.

Personal and Medical History of Jennie Maxwell.

1896

May 10 Visited by husband. May 22 Very untidy in appearance. Noisy at times. Has delusions at times. Sleeps well. Appetite good. Takes tonic. May 30 Very noisy at times. Appetite good. Bowels regular. Very untidy in habits. Apr 10 Has delusions. Very noisy at times. Appetite good. Bowels regular. Takes treatments. Apr 16 Appetite good. Goes out walking & riding. Apr 26 ~~Sept~~ Has delusions. Very noisy at times. Visited by husband 18 of April. May 26 Treatments 27 & 29 May 1-4-11-13-15-18-20-25-26

May 30 Visited by husband. May 31 Went home somewhat improved. Returned

Aug 31 Quiet: occupies her time in reading & crocheting for herself: seldom does any work: sleeps well: bowels regular: Nov 96 Destroys clothing at times: Has delusions: untidy in personal appearance: genl health good: Jan 97 Appetite good: bowels regular: works in dining room: very incoherent. At times scolds & fussy: has delusions: sits in her room most of time: Apr 97 no change

1897 Aug. At times strikes other patients: appetite good: bowels regular: very stubborn of late: untidy in appearance

Oct 8'97 Continued by Dr. R.M. Phelps. Patient in fairly good health: is rather irritable & inclined to be destructive: is noisy & incoherent in talk & scolds a good deal. Feb 20 99 Patients condition continues practically unchanged. General health good. (Cont. by Dr. R.A. Bibb)

1899 Mar. to Sept. Appetite good: physical health good: bowels regular: takes out door exercise: neat in habits: does no work: Has delusions & is incoherent.

Sept. - Feb 28 1900 (Dr. Heyerdale) Has delusions: Nat. Menstruates regularly: Eats & sleeps well. Bowels regular: Goes out for exercise. Jan 20 Wt. 123# Does no work.

Mch 1 - Aug 31 1900. (Dr Linton) Is at times very noisy & destructive: Incoherent: has delusions: General health good. Appetite good: usually sleeps well: Takes out door exercise. Menstruates regularly. July 16 Vaccinated. Sept. - Nov 30 Works in dining room: No change in condition. Nov 17. Wt. 133# Dec 1 - Feb 28 1901. Appetite good: sleeps well. Bowels regular: Goes out for exercise: Habits clean but careless in appearance: Noisy & incoherent at times: Given occasional cathartics. Mch 3 Wt. 129#

Mar 1 - June 1 - 1901 no change in mental or physical condition: menstruates. Does no work. The only delusion expressed is that she is surrounded by negroes: converses incoherently. May 29 Wt. 137#.

June to Sept. Does no work, takes out door exercise, general health good, no change in mental condition, Sept. 2 Wt. 135#. Sept. to Dec. Menstruates regularly. Nov. 23 Wt. 131#.

Dec to Feb. 1, 1903 General health good: eats & sleeps well: menstruates regularly: bowels regular exercises occasionally: assists with the work: rather careless in appearance: does not converse or answer questions & sometimes attacks other patients: is destructive: Nov 29, Wt. 129#.

Personal and Medical History of *Lillie Conhaim*

LIBBEY, FIDLAR & CHANDLER, DAVENPORT, IOWA.

Whole No. 4315.
Residence, St. Paul. Minnesota
Date Admission, 31st January 1896.
Admitted by, Dr. B. B. Ebys Hour, 6.55 P.M.
How Sent, G. Wilbrick, Jof P. Ramsey County
Sex, Female.
Age, — 20 —
Civil Condition, Single
Children,
Age Youngest Child,
Occupation, None given: (Father Wholesale Cigars-Dealer)
Degree Education, moderate: 8th grade. —
Profession Religion, Yes: W. Zion Congregation
Habits, Probably Good
Nativity, Stillwater, Minn: (Parents born in Poland).
Physicians Committing, G. Hamm & C. Eugene Riggs
Correspondents, (Father) Morris Conrad Conhaim
274 Ramsey St. St Paul

No. for Year, 143
Insane Relatives, Yes; on both sides.
Cause Exciting, overtaxed in her music
Cause Predisposing, heredity
Form,
Accompanying Bodily Disorder, None mentioned
Suicidal or Not, — Not —
Date of this Attack, 8 Months ago
Duration, — 8 months —
No. of Attack, 1st
No. of Admissions, 1st here (was at Hudson, Wis)
Age First Attack, about 19th
Time of Leaving, June 7. 1897
Time in Hospital, 1 yr. 1 mo. 4 d.
Result, Discharged Nov. 3. 1897
Much Improved.

EXAMINATION ON ADMISSION
MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused,
Quick or Sluggish, Quick

MEMORY:
Past Events, Good
Recent Events, "
Special Subjects, "

PERCEPTIVITY:
Alert or Dull, Alert
Correct or Illusive, incorrect

REASONING POWER:
Ordinary Subjects, Rather poor.
Own Mental State, Poor: Has no idea anything is the matter.
Special Subjects, Love + men.

GENERAL DESCRIPTIVE REMARKS: Mother was quite eccentric. Girl was always "foolish" "silly" in the way of talking about men + love etc. would write or talk to any man. Would talk about any chance male acquaintance. Was bright enough otherwise to keep house for her father; & learn music very well. Had some slight trouble in learning otherwise.

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted, Some
Depressed,

DELUSIONS:
Systematized or Not, Not
Special Subjects, Random + reckless talk silly tipsy talk
Transitory or Not, Illusions are transitory but silliness remains
HALLUCINATIONS: Said to have spoken of her sisters hair as fine etc.
ILLUSIONS:
CONVERSATION: Talk is of a hysterical, reckless
Coherent or Incoherent, rambling kind. Statements
Voluble or Reticent, are more often exaggerations than True delusions

Became very melancholy last March, at about time her father married again. Was taken to Anderson + Sept 4 mths. Brought home she gained 40 pounds. But finally tended toward the other way became excited, tipsy like, with exaggerated + delusive ideas. Appetite enormous. Lately growing worse, reckless, erratic + unreliable in every way

Personal and Medical History of *Lillie Conhaim*

EXAMINATION ON ADMISSION, CONTINUED.
PHYSICAL CHARACTERISTICS.

HEIGHT, not taken WEIGHT, not taken 145 NUTRITION, Good.
WOUNDS OR ABNORMALITIES, Bone notes
TONGUE, Tremors, No Coatings, Yellow coating Promptness Movement, Prompt
PUPILS, Equality, Equal Size, Normal
Response Light, Respond. Accommodation,
SIGHT, Good
HEARING, "
COORDINATION, Arms, Good
Legs, "
TREMORS, Hands, Tongue,
Facial Muscles, General,
REFLEXES, Patellar, Eq. 9
Other
ARTICULATION, Good voluble
Slurred, not
Hesitating,
FACIAL EXPRESSION,



TAKEN,

SENSIBILITY,
HEART, Normal ~~Expansion 2in~~
LUNGS, Normal Expansion 2in

EXAM. URINE, Libby 1/96
Color Yellow
Character Heavy yellow sediment
Amt. in 24 hrs. 3 XXIV
Sp. Gr. 1037
Reaction Alkaline
Albumen
Sugar a trace by Bismuth
Micro. Large amt. of amor. urates
Triple phosphates.
Epithelial cells

GYNAECOLOGICAL EXAM. Feb 3-'96 Uterus normal position Ext. Os normal
MENSTRUATION, Regular - No especial pain
OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean, ✓	Careless,
BOWELS, Normal, ✓	Constipated,	Irregular,
APPETITE, Good, ✓	Medium,	Poor,
SLEEP, Good,	Poor, ✓	Irregular,
PULSE, Normal	Resp.,	Temp., Normal

CRANIAL MEASUREMENTS, Greatest Trans. Ant. Cir.
HISTORICAL,
LENGTH OF INVASION, Slow ONSET GRADUAL OR SUDDEN, Gradual
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, Eccentric Died of heart disease at age of 38
Father or Pat. Relations, Living - healthy
Brothers or Sisters,

Personal and Medical History of Lillie Conhaim

1895

This patient was brought here by Deputy Sheriff Kinney, attended by Mrs. Morris Cohnaim Jr. with following history. Patient is in fair physical condition: There is history of consanguinity; husband & wife, (father & mother), first Cousins: also of heredity, both sides. This is 1st attack; She was in Hospital, at Hudson, from June to Sept 1895; unimproved: first symptoms of this attack manifested by melancholia, 8 months ago. The disease appears to be stationary, but variable & with rational intervals, & irregular periods. — Derangement now shown in that she is first depressed, then confused & lastly excited. Patient is not disposed to injure others, nor suicidal, nor of filthy & destructive habits. No peculiarities as were previously shown. There is no history of intemperance in self or parents, nor of any severe disease &c or head injury. Being overtaxed in her music is only known cause. No further particulars are given. ———

Jan 31 On admission, was put on B'd. G.H.N. R'pt. Complexion dark: hair black: eyes brown: Condition of skin normal: no marks scars or bruises noticed: is clean: very excited & has delusions). —

Feb 1 Nurses Notes. Very noisy; secluded in room: Has delusions; ate no breakfast, fair appetite at dinner & supper: slept 4 hrs. Bowels did not move P. 88. R. 18. T. 98.6 Feb. 2 Very noisy: has delusions: appetite good, bowels moved; very excited. Did not sleep; extremely noisy all night P. 88 T. 98 R. 18

" 3 More quiet: noisy part of day Appetite fair: takes tonic & cathartics Bowels moved Slept 5 hrs. Temp. 97.4 R. 18 Pulse 82. Feb. 4 Very noisy & excited all day Talks very vulgar, has delusions: appetite fair, takes tonic; bowels moved: slept 4 hrs. Pulse 82, Resp. 20. Temp. 97.6 Feb 5 Very Noisy & excited all day Talking & laughing very loudly. Tries to pick locks; slept 4 hrs. Appetite good Bowels moved P. 82 Resp. 18 Feb 6 Very noisy & excited all day. Appetite good; Takes tonic; bowels regular; slept 4 hrs, extremely noisy 2 hrs. P. 88 R. 22.

Feb 7 Very noisy & excited all day. Appetite good; bowels regular; slept 5 hrs Talks incoherently; has delusions. P. 90 R. 20. Feb 8 Noisy & excited all day. Appetite good; bowels regular; slept. P. 90. R 20. Feb 9 Quite noisy most of day. Very excited. Appetite good; Bowels regular; slept 6 hrs. Takes tonic P. 88 R. 18

" 10 Man quiet today. Appetite good. Takes tonic Bowels regular. Slept 5 hrs. T. 98 1/8

" 11 Talking & laughing loudly. Incoherently. Quite excited at times. Has delusions Appetite fair; Bowels regular: slept 5 hrs. P. 95 R. 18. Feb. 12 Quiet part of day Appetite good. Takes tonic. Bowels regular. Feb. 13 Quiet part of day Appetite good. bowels regular - slept quite well. P. 95 R. 18.

" 14 Quite nervous most of day. Menstr. Appetite good: bowels regular; P. & R. 18

Summary Very noisy & excited at times. Very careless about personal appearance. Amuses herself playing & singing & crocheting. Does no work on ward. Takes out door exercise. Has delusions: Appetite good: takes tonic bowels regular: Complains of headache at times.

Feb 14 Menstr. Very noisy & quarrelsome. Feb 21 Noisy most of time. Quarreling with ladies. Very untidy in appearance. Talks very foul & vulgar swearing

Personal and Medical History of Lillie Conhaim

& laughing loudly at times. Appetite good. Bowels regular. Sleeps quite well. Takes tonic - Does no work. Takes out door exercise. Has delusions

Feb 22 Trans. to B. V. Feb. 28 Extremely noisy at times - No change in behavior

Mar 10 Very noisy most of time. Impudent. Mar. 22 Noisy at times - Sleeps well. Bowels regular - Appetite good. Mar. 30 Very noisy most of time. Bowels regular Appetite good. Apr. 16 Bowels constipated Takes cathartics. Goes out riding & walking Trans. to B1. Apr. 22 Menstr. Apr. 25 Visited by father & mother May 30 Is quite noisy at times. Is very impudent & makes herself disagreeable in a great many ways. Appetite good. Bowels irregular Takes Cathartic: Sleeps well Takes out door exercise. Complains of headaches a great deal.

June Summary Nurses Notes by Dr. S.L. Phelps:- Impudent & at times rather noisy: Trans. to B2. Appetite good: bowels regular: very easily excited: rather feebleminded: July 5'96 Very nervous: very noisy: was put to bed: noisy all day: took sleeping dose: July 11'96 Much better: stays in bed: does not eat solid food: takes milk & eggnog: Salt baths given 3 times a week: Fed by nurses at present: Aug 1'96 Salt baths continued 3 times a week: Aug 28'96: Very nervous all day: extremely noisy at times: Aug 31'96 Very restless & noisy all the Time Appetite poor: takes tonic: Sept 5'96 Out of bed during night: awake nearly all night:

Sept 17 Awake all night: Sept 26'96 Awake all night: quite noisy: very destructive.

Oct 96 Menstr. regular: Salt baths have been continued regularly 3 times a week:

Nov. 96 Very untidy: quite noisy: melancholy at times: Has delusions: takes tonics & Cathartics: Salt baths given: Dec. '96 Salt baths 3 times a weeks: takes tonics: Jan'97 Salt baths continued: Jan 19 Transf to B1: Much improved:

1897 Jan. 28 Very uncertain in behavior & Quite troublesome in disturbing things on ward: rather careless about appearance: Has many delusions: Appetite quite good: takes cathartics: Mar. '97 Very quiet: rather melancholy: talks quite incoherently: has many delusions: sleeps quite well: takes outdoor exercise:

June 3. Very quiet & agreeable on ward: appetite good: bowels irregular: sleeps well:

" 4 Physical Health Good. June 7'97 Went Home to day with father: much improved both mentally & physically:

Discharged

Personal and Medical History of *Emily Savage*

LEBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4316.
Residence, Jamesville, Minnesota.
Date Admission, 1st. February 1896.
Admitted by, E. Phelps Hour, 6 40 PM
How Sent, Geo. A. Wilson, Jo. Co. Waseca County.
Sex, Female.
Age, 26. (30)
Civil Condition, Single
Children, none
Age Youngest Child,
Occupation, Has none: father was farmer
Degree Education, Common School.
Profession Religion, Yes: Episcopal
Habits, not intemperate
Nativity, Okaman, Minnesota: (parents born in England).
Physicians Committing, M. J. Taylor and D. E. Cummings
Correspondents, (prior) Mrs. R. W. Smith Jamesville Minn

No. for Year, 144.
Insane Relatives, Parents, 2nd Cousins: father was insane
Cause Exciting, Don't know: Love?
Cause Predisposing, Heredity & previous attacks
Form,
Accompanying Bodily Disorder, Head trying depressed
Suicidal or Not, — Not —
Date of this Attack, about a Year ago
Duration, — about a year —
No. of Attack, 3rd
No. of Admissions, 2nd (was here in 1889-90).
Age First Attack, 21 Years
Time of Leaving, June 4-96
Time in Hospital, 4 mo. 3 da.
Result, Discharged Nov. 10 '96. Improved

EXAMINATION ON ADMISSION
MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Very confused
Quick or Sluggish,
MEMORY:
Past Events,
Recent Events,
Special Subjects,
PERCEPTIVITY:
Alert or Dull,
Correct or Illusive, Incorrect
REASONING POWER:
Ordinary Subjects, Poor
Own Mental State,
Special Subjects,

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted, Exalted
Depressed,
DELUSIONS: Wandering, vague ideas
Systematized or Not,
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent, Voluble & incoherent

GENERAL DESCRIPTIVE REMARKS: Found in room fantastically tied up with torn clothing - Not very vivid but wandering & erratic. Sister said patient always dull & feeble-minded to some extent - not called "feeble minded" but dull - After first discharge she seemed to have forgotten her previous knowledge had to learn over again. Later was quite well for a time - since then there have been many slight attacks

Personal and Medical History of *Emily Savage*

EXAMINATION ON ADMISSION, CONTINUED.
PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 2 in WEIGHT, not taken NUTRITION, Good.
WOUNDS OR ABNORMALITIES,
TONGUE, Tremors, Good Coatings, Promptness Movement, Good
PUPILS, Equality, Equal Size, Normal
Response Light, Respond Accommodation, Respond
SIGHT, Probably good
HEARING, Good
COORDINATION, Arms, Probably good - Wont try tests well.
Legs,
TREMORS, Hands, Tremor Tongue,
Facial Muscles, General,
REFLEXES, Patellar, Equal & Other
ARTICULATION, Fairly good
Slurred, no.
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, Normal
LUNGS, Normal
GYNAECOLOGICAL EXAM.,
MENSTRUATION,
OPHTHALMOSCOPIC EXAM.,

TAKEN,

EXAM. URINE, Mar. 20 '96
Color. Brownish red.
Character Heavy dark copy deposit
Quant. 24 hrs.
Sp. Gr. 1023.
Reaction Acid
Albumen None.
Sugar "
Microscop. Amor. urates - Large quantity
Ox. lime Crystals large no. Bladder
& vaginal Epith. cells. Some
Pus cells.

HABITS, Dirty, ✓ Clean, Careless,
BOWELS, Normal, ✓ Constipated, Irregular,
APPETITE, Good, ✓ Medium, Poor,
SLEEP, Good, Poor, Last night Irregular,
PULSE, Ordinary normal Resp., Temp.,
CRANIAL MEASUREMENTS, 1=54, 3=32, 7=31, 8=14½, 9=18½, 11=13⅝, 13=10.8, 12 {13.5 / 12}, 14 {16.5 / 14 / 17.5}, 15=62
HISTORICAL, Cousin committed suicide - Father sometimes was out of head & died 3 yrs. after.
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations,
Father or Pat. Relations,
Brothers or Sisters,

Personal and Medical History of *Emily Savage.*

1896

This patient was brought here by a Deputy Sheriff & attended by Mrs Anna Smith, with following history. Patient is in fair physical condition. Parents were 2nd Cousins. There is also some history of heredity, as in previous commitment. Father was stated to be insane. This is not 1st attack: it seems to be the 3rd; others occurring in 1889 - 90; duration 3½ months (?); was treatment to this (Rochester) Hospital, where she got better. First symptoms of this attack were manifested about a year ago, by melancholia. The Dementia seems increasing; variable with rational intervals, but these, not at regular periods. Derangement now shown by restlessness, Con- -duct Talking & whistling &c. Patient is not disposed to injure others, nor suicidal, but is of filthy & destructive habit. Complaint &c had been previously shown: There is no history of intemperance in self or parents, nor of any severe disease &c. Cause of disease not known. (Love?)

Note ⊛ Has had no medical treatment this time. NOTE. As stated, patient was here before from Jany 15/89 to April 9/90, when she was taken home by her sister. Her history, at that time, states that she had an injury to her head, at some time. Her sister stated that patient had always been dull & thought that the reason was in her being born after the death of her father, who was insane for a year before he died. She also said this girl went to school for a good while, but did not learn much. After

then admission & for some weeks afterward patient was restless, noisy & quite often destructive of clothing: had to be kept in a corner of the ward & required constant watching to keep her in a presentable shape: continually writhing & climbing about: was also suicidally inclined, tying strips about her neck. Gradually, she became quieter; talked quite rationally, though, at times, in a very childish & peculiar way. Was improved in bearing. (Vol 13. Page 92. No 2252)

Feb 1 On admission, was put on B² W. (G.P.R. Rpt. Constitution fair; hair brown; eyes blue: Condition of skin normal: has a scar on left thigh: is quite dirty: is very restless: incoherent in her talk).

Feb. 2 Nurses Notes Noisy - Very restless - Has delusions - Talks incoherently - Appetite fair. Did not sleep - Destroyed her clothing & bed. Bowels moved. P 86 R 19 T 98.6

" 3 Destructive & dirty in habits - Talks incoherently - Tries to get out. Taught nurses Out of bed six hrs. during night Noisy five hrs. Slept 7 hrs.

" 4 Out of bed 7 hrs. Slept 7 hrs. Slightly noisy three hrs (N.W.) Quite noisy during day - very destructive - has delusions - Appetite poor. Feb 5 Behavior very restless all day destructive, violent & noisy at times - Slept 5 hrs. Feb 6 Quiet most of time - Menses. Slept 3 hrs. Feb 7 Quiet. Appetite poor Is destructive Complains of pain in chest & back. Slept 15 hrs. Feb 15 During 2nd week quiet all but two days. Dirty & destructive Bowels regular Appetite irregular Of late speaks when spoken to.

Summary Behavior very noisy first six days. destructive & violent at times. Appetite poor. Slept very little. Bowels regular. For the past ten days quieter. Appetite usually poor. Bowels regular - Is quite destructive Complains of pain in arms & head. Habits usually dirty.

Feb 29 Appetite poor. Quite destructive day & night. Goes riding. Bowels constipated Requires constant watching. March 3 Patient quite noisy most of time. Is quite destructive night & day. Requires constant care. Has to be dressed & undressed.

Personal and Medical History of *Emily Savage.*

also fed. Mar 6 Trans. to B. 3. Mar 24 Very noisy & untidy. Destructive at times - Fed by nurse Apr. 29 Improving in habits but very incoherent in speech. Mischievous & apt to start a quarrel but will not resist in a fight. Patient now eats alone also dresses & undresses. Quite poor appitite. Goes walking & riding. Bowels regular. Lacks activity. Sleeps quite & well nights.

May 30 Seems perfectly well mentally. Works on ward. Good appetite. Neat & tidy. Menstruates regularly. General health apparently improved. June 23. Trans to B1. June 4 Quiet & agreeable. Appetite fair. Bowels regular. Sleeps well. Takes out door exercise. Visited by her brother this morning Went Home this afternoon. Much improved in mental condition.

Discharged

Personal and Medical History of Betsey Olson #3

LIBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4321.
Residence, Bristol, Minnesota.
Date Admission, 12th February 1896. —
Admitted by, Dr. Phelps Hour, 3.30 PM
How Sent, E. V. Farrington, Jo. P. Fillmore County
Sex, Female.
Age, 38 Years
Civil Condition, single
Children, none
Age Youngest Child,
Occupation, Housework: father was a farmer
Degree Education, Can read & write in Norwegian & English
Profession Religion, Lutheran
Habits, not intemperate -
Nativity, Bristol, Fillmore Co: (Parents born in Norway).
Physicians Committing, J. H. Phillips and G. A. Lowe
Correspondents, Annon Olson, Bristol, Minn
Mails rec'd a day; no tel'p. Sta at Bristol
Peter Olson - giving Norway.

No. for Year, 149.
Insane Relatives, none
Cause Exciting, Grippe - 4 years ago
Cause Predisposing, "Chronic"
Form,
Accompanying Bodily Disorder, None mentioned.
Suicidal or Not, No: Makes threats of injuring others.
Date of this Attack, about 4 years ago
Duration, — about 4 years —
No. of Attack, 1st —
No. of Admissions, 1st
Age First Attack, about 34
Time of Leaving, May 11th - 1901
Time in Hospital, 5 yrs 2 mos. 29 days.
Result, Died - Mitral regurgitation with oedema of lungs and nephritis.

EXAMINATION ON ADMISSION
MENTAL CHARACTERISTICS.

Exam.

MENTAL ACTIVITY:
Clear or Confused, Confused.
Quick or Sluggish, Quick
MEMORY:
Past Events, Very uncertain
Recent Events, " Impaired
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Dull.
Correct or Illusive, Illusive
REASONING POWER:
Ordinary Subjects, Impaired
Own Mental State, "
Special Subjects,
GENERAL DESCRIPTIVE REMARKS:

EMOTIONAL STATE:
Normal, Calm, Calm.
Indifferent,
Exalted,
Depressed,
DELUSIONS: Has many.
Systematized or Not,
Special Subjects, Varied.
Transitory or Not, Thinks she married G. Washington a few days ago - says she is 3 years old.
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION: Talks willingly but in a very childish way
Coherent or Incoherent,
Voluble or Reticent, Has many delusion ideas

Personal and Medical History of Betsey Olson #3

EXAMINATION ON ADMISSION, CONTINUED.
PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 7 in WEIGHT, not taken NUTRITION, Fair but anaemic
WOUNDS OR ABNORMALITIES, None.
TONGUE, Tremors, Inactive Coatings, Slight Promptness Movement,
PUPILS, Equality, Equal. Size, Normal.
Response Light, Normal. Accommodation, Normal.
SIGHT, Seems good.
HEARING, " "
COORDINATION, Arms, Normal.
Legs, "
TREMORS, Hands, None of note. Tongue, None of note
Facial Muscles, " General, "
REFLEXES, Patellar, Both Normal
Other
ARTICULATION,
Slurred,
Hesitating, Prompt.
FACIAL EXPRESSION, Childish, feeble.
SENSIBILITY,
HEART, Mitral regurgitant Murmur
LUNGS, Resp. Shallow. Hollow chest, round shouldered
GYNAECOLOGICAL EXAM., Uterus retroverted - Otherwise normal condition
MENSTRUATION,
OPHTHALMOSCOPIC EXAM.,



PHOTOGRAPH TAKEN,

EXAM. URINE, Feb. 17 '96
Color. Reddish - yellow
Character. Heavy yellow deposit
Amt. in 24 hrs. 3 XXV
Sp. Gr. 1029
Reaction Acid
Albumen amount by Esbach. Trace by heat + HNO3 large
Sugar. None.
Microscop. Large amt. of pus.
Amor. urates - Bladder epith. cells.

HABITS, Dirty; Clean, ✓ Careless,
BOWELS, Normal, ✓ Constipated, Irregular,
APPETITE, Good, Medium, ✓ Put upon tonics, Poor,
SLEEP, Good, ✓ Poor, Irregular,
PULSE, 110 Resp., Temp.,
CRANIAL MEASUREMENTS,
HISTORICAL,
LENGTH OF INVASION, 4 years ago - after "La Grippe" ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Brother came with her, denied any heredity
Mother or Mat. Relations,
Father or Pat. Relations,
Brothers or Sisters,

Personal and Medical History of Betsey Olson #3

1896

This patient was received here at the hands of Arnon Olson, attended by Henry Nepsen, with the following history. Patient is in fair physical condition. There is no history of consanguinity or heredity. (Brother says: father died: was healthy: mother living: healthy). This is 1st attack: - first symptoms manifested about 4 years ago. (Brother denies any preceding trouble, at least none, as far as he knows). Disease seems increasing: variable & with rational intervals: she is much more rational at times, but never fully rational. Derangement now shown in that she says she is married to the Prince of Wales: does not know her own people: says her name is Buchanan: says her age is one year, 6 months & 11 days: not disposed to injure others; only makes threats: has not attempted suicide: is of filthy & destructive habits. No peculiarities previously shown: there is no history of intemperance in self or family, nor of any severe disease &c or head-injury. She has not been restrained or confined, nor under medical treatment. Supposed cause of the disease is "Grippe" four years ago. Patient has all kinds of Delusions. —

Feb 12 On admission, was put on B. W. (G. P. N. Ept. Complexion fair: hair light: eyes blue: condition of skin normal: no marks, scars or bruises noticed: is rather dirty: quiet: has many delusions)

13 Nurses Notes Quiet in behavior: has delusions: appetite good: slept 7 hrs., bowels constipated. Pulse 88- R. 20 - T. 98.4. Feb. 14 Quiet in behavior: has delusions - says she is three years old & is the president's wife etc. Bowels constipated; appetite good. Took tonic. T. 98.6 P. 100 R. 20 Feb 15 Quiet: rather childish. Slept 6 hrs. Bowels moved. Takes tonic: Appetite fairly good. Up on ward 1.99. P. 108 R. 24

16 No change in behavior: appetite good: Bowels moved: Slept 6 hrs: talks quite readily. Works some in dining room: Took tonic. Feb. 17 Quiet. Has not as many delusions as at first: appetite fair: Slept well: Bowels irregular: took cathartic & tonic.

18 Works in dining room: Quiet: has delusions: took tonic: bowels moved: slept 7 hours.

19 Quiet: bowels moved: appetite fair: slept 7 hrs: works in dining room. Is not as silly as she was.

20 to 26 During second week patient remained quiet & was not so silly: talked quite sensibly: appetite fair: took tonic: slept well: worked in dining room: went once for diet: bowels irregular: took cathartic. Feb 26 Menses.

Summary Patient is quiet but has many delusions; thinks she is 3 yrs old, is the president's wife etc. Appetite fair: sleeps well: Goes riding & walking: Takes tonic: Talks more sensibly of late: is menstruating.

Feb 27 Quiet in behavior. Appetite fair. Takes tonic. Bowels regular. Talks quite sensibly. Menses. Mar. 17 Very quiet. Neat in habits. Appetite fair: sleeps well: bowels regular. Does no work. Takes tonic. Apr. 4 Menses. Apr. 8 Trans to D. W. Apr. 28 No change in any way. May 5 Menses. May 27 Appetite much better - No other change. Summary Nurse's Notes by Dr. A. Phelps: June 1 Appetite good. Habits clean: quiet: rather emaciated: gen'l health fair. July 1 Gen'l health better: does not take tonic: Nov. 1 Gen'l health poor: no mental change:

1897 Jan. 13 Dull & usually quiet: talks some: manner suggests somewhat of imbecility much like chronic mania: rarely says anything: fairly neat in habits:

May no change: Aug 1 Appetite good: clean: works in laundry: emaciated but does not complain of being sick

Personal and Medical History of

1897

continued by Dr. A. Phelps. Nov 1 '97 General health good. Is comparatively quiet: is emaciated & seems in rather poor health: No particular failure noted. Feb 9 Wt. 117# Works in the laundry some. Feb 9 '99 Practically no change in condition during period. (Cont. by Dr. Bell)

1899 to June 30: Very quiet: talks quite sensibly, but only when questioned: Very pale & thin: health has been much impaired for some time: never has complained before: today complains of headache; coughs considerably & is often found lying on benches & floor. appetite quite good: does not seem well enough to work in laundry: May 20 Looks worse than usual: Heart & lungs examined: Gross valvular lesion noted, also evidences of secondary lung trouble: Trans. to Inf. Sick record kept: Apr. 1 Remains in bed: has elevation of Temp: pulse 90 to 112. Resp. 30. to 38. Appetite good: bowels regular: takes medicine: sleeps well: no special change during rest of her illness: rest in bed slowly and gradually restored heart action to some extent & condition of lungs improved: Gradually became able to sit up part of each day: Is very quiet, neat: assists some with work: June 17 Trans. to A.: was very much displeased with this move & was quite disturbed for a few days: July 17 Bought nurses: Daily 19 Trans. to Annex: no recent change to report: At times seems to feel weak & sits down on the benches: Aug. 18 '99 Wt. 111 #. Sept 1 - Feb 28 1900 (Dr. Heyendale) Neat. Works in dining room: Obstinate at times: Does not converse: Has delusions: sometimes answers questions: Takes out door exercise: General health good: menstruates regularly Jan 1st Wt. 118# Mch 1 - Aug 31 1900 Stubborn: does not talk much: quiet on ward: General health & appetite fair: Bowels regular: Assists some in dining room May 21 Visited by friends July 23 Vaccinated. Sept 1 - Nov 30 1900 Did no work during quarter no other change. Nov 24 Wt. 116# Dec 1 - Feb 28 1901 Untidy in habits & appearance, Does not attend amusements. Does not talk. Mch 1 Wt. 117# May 1st. patient untidy in appearance but clean in habits. Takes out door exercise riding but seldom walking, attends no amusements; takes no interest in anything. Does not converse but will answer questions. Appetite fair; sleeps quite well. May 7 patients limbs were noticed to be badly swollen. Temperature 100.4 Transferred to Infirmary. Examination of chest showed valvular heart lesions, mitral regurgitation and from them also this produced oedema of the lungs causing a very congested appearance to the face and difficult respiration. The examination of the urine revealed large quantities of albumin pointing to nephritis. Patient complained of intense pain over the heart; respiration became very difficult was given diuretic stimulant with an ice pack over the heart. Patient died May 11th, 1901 at 11:40 P.M.

Died

Personal and Medical History of Augusta Nelson.

LEGGET, PIGLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4325.
Residence, St Paul. Minnesota
Date Admission, 19th February 1896.
Admitted by, Dr. Stevens Hour, 12:30 PM
How Sent, G. Willrich, Jo P. Ramsey County
Sex, Female.
Age, 28 years.
Civil Condition, single
Children,
Age Youngest Child,
Occupation, Working-girl
Degree Education, Common School.
Profession Religion, Yes. Lutheran.
Habits, not intemperate
Nativity, Sweden: (Parents also born there).
Physicians Committing, Olof Sohlberg and C. Eugene Riggs.
Correspondents, none given in papers

No. for Year, 153.
Insane Relatives, none
Cause Exciting, Love affair
Cause Predisposing, Chronic
Form,
Accompanying Bodily Disorder, None mentioned
Suicidal or Not, think propensity to suicide active
Date of this Attack, a year ago
Duration, about a year
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, 27 Years.
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION
MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Somewhat confused.
Quick or Sluggish,
MEMORY:
Past Events, Says impaired
Recent Events,
Special Subjects,
PERCEPTIVITY:
Alert or Dull,
Correct or Illusive, Mostly correct.
REASONING POWER:
Ordinary Subjects, Impaired.
Own Mental State,
Special Subjects,
GENERAL DESCRIPTIVE REMARKS: Pain in stomach a good deal of time. She said she had a good deal of headache for years.

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed, ✓
DELUSIONS:
Systematized or Not, Not definite ones
Special Subjects, determined upon
Transitory or Not, examination
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION: Talks fairly well on
Coherent or Incoherent, ordinary subjects though
Voluble or Reticent, hesitates a good deal in answering questions.

Personal and Medical History of Augusta Nelson

EXAMINATION ON ADMISSION. CONTINUED.

Augusta Nelson.

March 29th'96.-- A letter from sister states disease commenced in November '94, with depressed state of mind but not noticed very much until May '95 when she talked about suicide. In novemner,'95, she lost her place and came home and grew gradually worse. It is denied that there was any insanity in the family.

Legs,
TREMORS, Hands, None.
Facial Muscles,
REFLEXES, Patellar,
Other
ARTICULATION,
Slurred,
Hesitating, Hesitates somewhat.
FACIAL EXPRESSION, Pleasant
SENSIBILITY,
HEART, Normal.
LUNGS, Seem in good condition.
GYNAECOLOGICAL EXAM., Cribriform hymen intact
MENSTRUATION, Irregular & painful; always sick in bed.
OPHTHALMOSCOPIC EXAM.,

Tongue, None
General,



TAKEN,

EXAM. URINE, Feb 20.
Color Reddish Yellow
Character Heavy Yellow, Flaky deposit
Amt in 24 hrs. 3 XXIV
Sp. Gr. 1032
Reaction Acid.
Albumen Trace by Tanrets.
Sugar None.
Microsc. Amor. urates. Epis
phosphates - some pus - a large amount of blood cells

HABITS, Dirty,	Clean, ✓	Careless,
BOWELS, Normal,	Constipated,	Irregular,
APPETITE, Good, ✓	Medium,	Poor,
SLEEP, Good, ✓	Poor,	Irregular,
PULSE, Reg. 80	Resp., Normal	Temp., Normal.

CRANIAL MEASUREMENTS,
HISTORICAL,
LENGTH OF INVASION, One year ONSET GRADUAL OR SUDDEN, Gradual
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, Healthy
Father or Pat. Relations, Has a cough.
Brothers or Sisters, Healthy Sister Headaches sick in bed at times

Personal and Medical History of Augusta Nelson.

LESLEY, FIDLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4325. 153

Residence, St Ba

Date Admission, 19th Febr

Admitted by, Dr Ste

How Sent, G. Hillrich, Jr

Sex, —

Age, —

Civil Condition, —

Children,

Age Youngest Child, —

Occupation, Working-girl

Degree Education, Common School.

Profession Religion, Yes: Lutheran.

Habits, not intemperate.

Nativity, Sweden: (Parents also-born there).

Physicians Committing, Olof Sohlberg and C. Eugene Riggs

Correspondents, none given in papers

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, 27 Years

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Somewhat confused.

Quick or Sluggish,

MEMORY:

Past Events, Says impaired

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull,

Correct or Illusive, Mostly correct.

REASONING POWER:

Ordinary Subjects, Impaired.

Own Mental State,

Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Pain in stomach a good deal of time. She said she had a good deal of headache for years.

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted,

Depressed, ✓

DELUSIONS:

Systematized or Not, Not definite ones

Special Subjects, determined upon

Transitory or Not, examination

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION: Talks fairly well on

Coherent or Incoherent, ordinary subjects though.

Voluble or Reticent, Hesitates a good deal in answering questions.

Personal and Medical History of Augusta Nelson

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, not taken WEIGHT, not taken NUTRITION, Good.

WOUNDS OR ABNORMALITIES, None

TONGUE, Tremors, Coatings, Slight Promptness Movement,

PUPILS, Equality, Equal Size,

Response Light, Prompt Accommodation,

SIGHT, Says impaired

HEARING,

COORDINATION, Arms, Normal

Legs, "

TREMORS, Hands, None. Tongue, None

Facial Muscles, " General, "

REFLEXES, Patellar,

Other

ARTICULATION,

Slurred,

Hesitating, Hesitates somewhat.

FACIAL EXPRESSION, Pleasant



TAKEN,

SENSIBILITY,

HEART, Normal.

LUNGS, Seem in good condition

GYNAECOLOGICAL EXAM., Cribri form hymen intact

MENSTRUATION, Irregular & painful; always sick in bed.

OPHTHALMOSCOPIC EXAM.,

EXAM. URINE, Feb 20.

Color Reddish Yellow

Character Heavy Yellow Flaky deposit

Amt in 24 hrs. 3 XXIV

Sp. Gr. 1032

Reaction Alk.

Albumen Trace by Tsuretts.

Sugar None.

Microsc. Amor. urates Trips

Phosphates - Some Pus - a large amount of blood cells

HABITS, Dirty,	Clean, ✓	Careless,
BOWELS, Normal,	Constipated,	Irregular,
APPETITE, Good, ✓	Medium,	Poor,
SLEEP, Good, ✓	Poor,	Irregular,
PULSE, Reg. 80	Resp., Normal	Temp., Normal.

CRANIAL MEASUREMENTS,

HISTORICAL,

LENGTH OF INVASION, One year ONSET GRADUAL OR SUDDEN, Gradual

HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")

Mother or Mat. Relations, Healthy

Father or Pat. Relations, has a cough.

Brothers or Sisters, Healthy Sister Headache sick in bed at times

Personal and Medical History of Augusta Nelson

1896

This patient was brought here by Deputy-Sheriff F. W. Kinney, attended by Alice Kinney, with the following history. Patient is in good physical condition. There is no history of insanity or heredity. This is the 1st attack: first symptoms manifested a year ago by melancholia. The disease appears to be increasing, but variable with rational interval: there is melancholia with delusions of persecution. Derangement now shown in that she thought her sister wanted her lover: she is very suspicious of her friends. Patient has threatened to injure others: she has not attempted suicide but we think propensity is now active. No filthy & destructive habits. If any peculiarities &c noted previously known, is not known. There is no history of intemperance in self or parents, nor of any severe disease &c. She has not been restrained or confined. Supposed cause of the disease is a "Love affair". She has had no medical treatment.

Feb 19 On admission, was put on B. & W. (G. H. N. Rpt. Complexion fair: hair dark brown: eyes blue: condition fairly normal. has a small scar on left wrist: is quite clean: quiet & talks sensibly).

Feb. 19 Nurses Notes 4th P.M. T. 98.6 P. 78. R. 18. Appetite good. Cathartic given - Slept 5 hrs. Talks sensibly - Bowels did not move. Bath - quiet in behavior.

" 20 A. 97.8. P. 78. R. 18 Tonic given 3 times daily - Appetite good - Bowels moved. Slept 5 hrs - Talks sensibly - Quiet in behavior Assists with the work.

" 21 A. 97.2 P. 75. R. 18. Ate well. Tonic given 3 times - Bowels moved - Slept 5 hrs - Talks sensibly. Quiet in behavior. Feb 22 A. 98.2 P. 75. R. 20 Appetite good - Urine in 24 hrs XXIV Slept 5 hrs. Complained of headache most of day - Quiet in behavior - Talks sensibly. Feb 23 A. 99 P. 78. R. 18. Took tonic & cathartic. Ate well - Slept 6 hrs. Quiet in behavior. Talks sensibly Assists with work Bowels moved Complained of headache. Feb. 24 A. 99 P. 72, R. 18 Took Tonic Bowels moved. Quiet in behavior. Talks sensibly. Feb. 25 A. 99.2 P. 80, R. 21. Appetite good - Took Tonic Quiet in behavior. Talks sensibly. Works on ward - Takes out door exercise.

Mar. 3 During second week patient was quiet in behavior - Had a good appetite Talked sensibly expressing no delusions. Complained of headaches at times Took out door exercise - Tonic given 3 times daily. Works in sewing room.

Summary Patient quiet in behavior. Talks sensibly - Shows no delusions Appetite good - Sleeps fairly well - Bowels irregular - Tonic given 3 times daily. Cathartics given Takes out door exercise & assists with work.

Mar 6 Menstr. Somewhat nervous & irritable. Mar. 30 Usually very quiet in behavior Talks sensibly. Occupies her time reading & playing games. Assists some with ward work. Complains of headaches quite often. Appetite fair Takes Tonic Bowels regular. Sleeps well Takes out door exercise.

Apr 5 Complains of headache & earache a great deal. Appetite fair. Takes some out door exercise. Assists some with work. Apr 16 Menstr. May 30 Quiet - assists some with work. Does not take out door exercise. Bowels regular Takes cathartics. Appetite fair Sleeps well. Complains of headache & earache a great deal.

Personal and Medical History of Augusta Nelson

1896

June Summary Nurse's Notes by Dr. D. L. Phelps:- Seems somewhat better physically: talks to herself & laughs a great deal: bowels usually constipated: menstr. regular Nov. 9 Appetite good sleeps well: constipated: seldom takes out door exercise: Feb 97 Physical health somewhat impaired: has delusions: thinks people are talking about her: appetite not good: bowels constipated. July 97: Genl health good: assists with work: no other mental change. Continued by Dr. A. M. Phelps Oct 8 97 Trans. to A. Patient very quiet & agreeable in behavior: appears very well but on talking with her some dullness with feebleness of mind & occasional delusions are found. Mch 1 Wt 148# Feb 4 99 Patients condition is practically unchanged during period. (Cont. by Dr. P. A. Fields) Mar. 1 Sept. 99 Genl health good: appetite very good: takes out door exercise: neat & tidy: quiet & agreeable: talks incoherently: attends chapel: menstr. regular: works on ward.

Sept 1- Feb 28 1900 (Dr. Heysdale) Neat: appetite good: works on ward: Bowels regular: Menstruates regularly: Takes daily outdoor exercise: Jan 19 Wt. 148# Mch 1- Nov 30 1900 Quiet: Assists with work: appetite good: Bowels regular: May 15 Neat: Quite languid & lacks ambition: Very dull, will not always answer when spoken to: At times cross. July 17. Vaccinated unsuccessfully. Menstruates regularly. Sept 2. Not well remained in bed during day. Nov 16 Wt. 139# Dec 1- Mch 1 1901 Refuses to get up mornings: Does not go out for exercise: Dec 6. Menstruated. Jan 7. Much disturbed: Refused to change clothes. Jan 10. Fought nurses when bathed. Transferred to D. Quite obstinate at times. Takes little interest in surroundings: Gradually losing in weight: Makes no complaints: says she feels well. Wt 135#

Mar 1- June 1- 1901 No change in physical or mental condition. Does no work. Menstruates. May 30 Wt. 133#. June to Sept. June 13. menstruating, takes no interest in work, does not attend amusements, answers questions, but does not voluntarily converse, Sept. 2 Wt. 132½#. Sept. to Dec. No change during quarter, Nov. 30 Wt. 134#.

Up to Feb 1, 1913 General health good: eats & sleeps well: goes out for exercise: assists with the work generally quiet: does not voluntarily converse: usually answers questions: neat & clean in habits and appearance: occasionally becomes disturbed and attacks other patients. Dec. 1st, Wt. 132#.

Personal and Medical History of Wilda Carlson

LOBLEY, FIDLAR & SAARBERG, DAVENPORT, IOWA.

Whole No. 4326.
Residence, Houston, Minnesota
Date Admission, 19th February 1896
Admitted by, D. C. A. Ely Hour, 7.45 PM
How Sent, Thomas Ryan, Jr. Houston County
Sex, Female
Age, about 20
Civil Condition, Single
Children, —
Age Youngest Child, —
Occupation, Housework
Degree Education, Common School
Profession Religion, Lutheran
Habits, Probably good
Nativity, Sweden: (Parents also born there)
Physicians Committing, E. B. Johnston & W. W. Freeman
Correspondents, none given in papers
Family Physician: D. Rhines Houston Minn.

No. for Year, 1574.
Insane Relatives, one sister and father
Cause Exciting, not known
Cause Predisposing, Heredity
Form,
Accompanying Bodily Disorder, some eye trouble
Suicidal or Not, has talked of committing suicide
Date of this Attack, August 1895.
Duration, some 6 months
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, 19+
Time of Leaving, May 17. 1898
Time in Hospital, 2 yr. 2 mo. 28 d.
Result, Died Tuberculosis Pulmonalis

EXAMINATION ON ADMISSION
MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Confused
Quick or Sluggish, Very sluggish
MEMORY: Very sluggish & uncertain
Past Events,
Recent Events,
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Very dull.
Correct or Illusive,
REASONING POWER: Very much impaired.
Ordinary Subjects,
Own Mental State,
Special Subjects,
GENERAL DESCRIPTIVE REMARKS: Left Ear suppurating. Discharges — Feet swollen slight puffiness about eyes. A kind of pastic manner sluggishness of face. Also of speech & actions.

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed. ✓
DELUSIONS: Seems to have many.
Systematized or Not,
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent, Will not talk

Personal and Medical History of Wilda Carlson

EXAMINATION ON ADMISSION, CONTINUED.
PHYSICAL CHARACTERISTICS.

NOTE -- FOR HISTORY.

WILDA CARISON.

Brother states that her trouble commenced about one year ago, but that was never very good, not exactly feeble-minded, but rather dull, or quiet,-slow. Has had running at ear since seven or eight years of age. Sister in old country, now thirty years old, in about same condition as she. Father living "and healthy". Mother died consumption.

10/13/96. Another sister since committed here.

TREMORS, Hands,
Facial Muscles,
General,
REFLEXES, Patellar, 8 equal
Other
ARTICULATION, Will say nothing to-
Slurred, except a few half audible words
Hesitating, in response to urging.
FACIAL EXPRESSION,
Melancholy
SENSIBILITY,
HEART, Regular- no murmurs.
LUNGS, Resp. shallow. Fallen Chest.
TAKEN,

EXAM. URINE, Feb 20'96
Color. Brownish Red.
Character Heavy brown flaky sed.
Amt 24 hrs. 3 XIII
Sp. Gr. 1031
Reaction Acid.
Alb. None
Sugar "
Micros. Amor. urates
Triple phosphates Cystine plaques
& bladder epithe. Cells.

GYNAECOLOGICAL EXAM. Uterus in normal position External genitals normal
MENSTRUATION,
OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean, ✓	Careless,
BOWELS, Normal,	Constipated, ✓ (Probably)	Irregular,
APPETITE, Good,	Medium, ✓	Poor,
SLEEP, Good,	Poor, (Slept 2 hrs.)	Irregular,
PULSE, Jr	Resp.,	Temp.,

CRANIAL MEASUREMENTS,
HISTORICAL,
LENGTH OF INVASION, Said 6 to six months ONSET GRADUAL OR SUDDEN, Gradual.
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations,
Father or Pat. Relations,
Brothers or Sisters,

Personal and Medical History of Wilda Carlson

LEIGHT, FISHER & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4326.
Residence, Houston, Minnesota
Date Admission, 19th February 1896
Admitted by, D. C. A. Ely Hour, 7.45 PM
How Sent, Thomas Ryan. Jo P. Houston County
Sex, - Female -
Age, about 20
Civil Condition, Single
Children, —
Age Youngest Child, —
Occupation, Housework
Degree Education, Common School
Profession Religion, Lutheran
Habits, Probably good —
Nativity, Sweden: (parents also born there)
Physicians Committing, E B Johnston & W W Freeman
Correspondents, none given in papers.
Family Physician: D Rhines Houston Minn.

No. for Year, 1574.
Insane Relatives, one sister and fa
Cause Exciting, not Known
Cause Predisposing, Heredity
Form,
Accompanying Bodily Disorder, some eye trouble
Suicidal or Not, has talked of committing suicide
Date of this Attack, August 1895.
Duration, some 6 months
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, 19+
Time of Leaving, May 17. 1898
Time in Hospital, 2 yrs. 2 mo. 28 d.
Result, Died Tuberculosis Pulmonalis

EXAMINATION ON ADMISSION
MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Confused
Quick or Sluggish, Very sluggish.
MEMORY: Very sluggish & uncertain
Past Events,
Recent Events,
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Very dull.
Correct or Illusive,
REASONING POWER: Very much impaired.
Ordinary Subjects,
Own Mental State,
Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Left Ear suppurating - Discharge - Feet & wrists slight puffiness about eyes. A kind of pathic dazed sluggishness of face - Also of speech & actions.

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed, ✓
DELUSIONS: Seems to have many.
Systematized or Not,
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent, Will not talk

and Medical History of Wilda Carlson

EXAMINATION ON ADMISSION, CONTINUED.
PHYSICAL CHARACTERISTICS.

, 5ft 2 in WEIGHT, not taken NUTRITION, Somewhat impaired.
OUNDS OR ABNORMALITIES,
TONGUE, Tremors, Not noticeable Coatings, Promptness Movement, Sluggish
PUPILS, Equality, Equal Size, Normal
Response Light, Responds. Accommodation,
SIGHT, Must talk - Probably good.
HEARING, Says some deaf - Probably good.
COORDINATION, Arms, Probably good. Very sluggish in all actions
Legs,
TREMORS, Hands, Tongue,
Facial Muscles, General,
REFLEXES, Patellar, 8 Equal
Other
ARTICULATION, Will say nothing les-
Slurred, except a few half audible words
Hesitating, in response to urging.
FACIAL EXPRESSION,
Melancholy
SENSIBILITY,
HEART, Regular - no murmurs -
LUNGS, Resp. shallow. Fallen chest
TAKEN,

EXAM. URINE, Feb 20 '96
Color. Brownish Red.
Character. Hazy Some Flaky Sed.
Amt 24 hrs. 3 XIII
Sp. Gr. 1031
Reaction Acid.
Alb. None
Sugar "
Micros-ec. Amor. Urates
Triple phosphates Cystine plaques
& bladder Epith: Cells.

GYNAECOLOGICAL EXAM. Uterus in normal position External genitals normal
MENSTRUATION,
OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean, ✓	Careless,
BOWELS, Normal,	Constipated, ✓ (Probably)	Irregular,
APPETITE, Good,	Medium, ✓	Poor,
SLEEP, Good,	Poor, (slept 2 hrs.)	Irregular,
PULSE, Jr	Resp.,	Temp.,

CRANIAL MEASUREMENTS,
HISTORICAL,
LENGTH OF INVASION, Said to be six months ONSET GRADUAL OR SUDDEN, Gradual.
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations,
Father or Pat. Relations,
Brothers or Sisters,

Personal and Medical History of Wilda Carlson

1896

This patient was brought here by Deputy Sheriff N. A. Forsyth, attended by Mr. C. A. Read with the following history. Patient is in good physical condition. There is no history of Consanguinity but some of Heredity: one sister, and father have been insane: father was also a moderate drinker. This is the 1st attack: first symptoms manifested in August 1895: first symptoms were noticed after taking an eyewash, which seemed to have produced delirium, trembling & weakness. The disease seems to be increasing: no rational intervals. Derangement now shown on the subject of religion: by walking about the house; crying & hallooing: does not want to feed herself. Patient is not disposed to injure others: has not attempted suicide, but has talked of committing it. No filthy or destructive habits. No peculiarities of voice previously known. She has been under treatment for eye trouble; has not been restrained or confined. Cause of the disease not known: She has seen several physicians. On personal Examination, there is noted, a deterioration (?) of the hair. She said nothing: would not answer questions. Appearance & manner were those of dementia. Is committed here because she might run away, and she has to be watched continually. ——— ·

Feb 19 On admission, was put on B² (G.H.N. Rpt. Complexion fair: hair brown: eyes blue: condition of skin normal: no marks, scars or bruises noticed. Is clean. Behavior quiet. does not talk.)

" 20 Nurses Notes. P. 72 R. 20. Appetite good. Cathartic given. Did not sleep. Quiet. Answers questions fairly well. Bowels constipated. Limbs swollen. Feb 21 T. 98.6 P. 72. R. 18 Rather excited. No delusions noticed. Bowels moved very little. Appetite good.

22 T. 101.4. P. 100 R. 24 Very excited. Talking & crying. Limbs swollen. Urine ℥ XIIj Ate breakfast. refused dinner. drank milk & ate piece of cake for tea. Tonic given. Feb. 23. T. 100. P. 96 R. 23. Refused breakfast but ate dinner & tea. Tonic refused. Very much disturbed, rather violent at times. Seems to have pain in toes. Bowels constipated.

24 Very nervous & excited. Takes off clothing. Limbs swollen. Appetite good. Tonic given. Feb. 25 T. 98.6 P. 94. R. 28 Appetite good. Tonic & cathartic given. Quite violent. Tries to get out. Very untidy. Dirty in habits.

26 T. 98.6 P. 90 R. 24 Appetite fair. Tonic given. More quiet today. Limbs swollen. Toes blue & seem tender. Feb 27 T. 98.6 P. 88. R. 24. Appetite fair. Tonic given. Slept 5 hrs. Quite disturbed. pain in toes. Talks sensibly.

March During second week patient was quiet in behavior. Dirty in habits & untidy in appearance. Appetite fairly good. Quite resistive. Toes sore. Slept fairly well. Bowels usually constipated.

Summary Patient very agitated during part of first week but has since become quieter. Bowels usually constipated. Appetite fair. Tonic given daily. Cathartic occasionally. Limbs swollen & toes sore. Talks quite sensibly. No delusions noted. Dirty in habits & untidy in appearance.

Mar 10 Complains of toes. Little toe on right foot sore. Washed in Bichloride solution & dressed antiseptically. Put to bed. Mar. 15 Appetite good. Sleeps fairly well. Takes Tonic. Mar. 30 Appetite fair. Rather stupid at times. Out of bed. some nights for several hours at a time. Apr. 9 Very nervous at times. Out of bed at night knocking on door. Dirty in habits. Appetite poor.

Personal and Medical History of Wilda Carlson.

1896

Bowels constipated at times. Takes cathartics quite often. Hypodermic given Apr. 16 Very nervous & struggles all the time when held. Appetite rather poor. Apr. 29 Hypodermic given only Apr. 30. Has to be held most of time. Has suppuration of internal ear. Syringed out twice daily with antiseptic solution. May 2 Hypodermics given in morning & afternoon. Patient very nervous & struggles a great deal. Hypodermics given on 7th 9th & 10th inst.

May 16 Appetite quite good. Is very restless & nervous most of time. Hypo. given.

June Summary Nurses Notes by Dr. L. L. Phelps: — Appetite good: has grown a little more active. yet is silly & depressed: Nov. 14 96 Visited by brother: menses regular very resistive: takes her clothes off if not watched: fed on wood: Jan 97 Very obstinate & mischievous: resists whenever nurses try to do anything with her: Gen'l health seems good: May 97 Very untidy in habits & dress: very obstinate in every way: June 20 97 Out of bed most of time during night: appetite fair: Aug 97 Physical health has been failing decidedly: appetite very poor: Does not sleep well at night: Habits very untidy: very troublesome on ward. Continued by Dr. P. W. Phelps

Sept 1897 Health is failing & patient is growing weaker: Has lung trouble. Sept 28 98 Trans. to Infirmary. Oct 4 Temp. about 100 in Am. 101 in Pm. Typical signs of consumption noted. Coughs a good deal. Dec 6 97 Condition as to pulse, Temp. & resp. about same. Is, however, quite weak & expectorations are occasionally streaked with blood. Jan 10 98 Temp. More variable but will occasionally go down to 99 & up to 102. General condition one of gradual, slow failure. March 8 Temp. ranges from 101 to 103. Is quite restless, remains in bed: shows extreme emaciation & failure. Apr. 10 Condition practically unchanged. Fails steadily & slowly. Symptoms about same. May 17 Patient died at 11:30 Has been extremely weak & emaciated for a good many months.

Died.

Personal and Medical History of Hannah Steiner

LUBERT, FIDLAR & SAMBERG, DAVENPORT, IOWA.

Whole No. 4330
Residence, St. Paul, Minnesota
Date Admission, 24th February 1895.
Admitted by, D. L. B. Eby - Hour, 6.45 P.M.
How Sent, G. Wilbrich, Jail. Ramsey County
Sex, Female
Age, - 45 -
Civil Condition, married
Children, - 4 -
Age Youngest Child, 22 Years
Occupation, Housewife: (Husband a traveling-man)
Degree Education, Probably limited
Profession Religion, Yes: Methodist.
Habits, not intemperate.
Nativity, New York: (Parents born in Prussia)
Physicians Committing, H. J. O'Brien and K. B. Burnhall
Correspondents, None given in Papers

No. for Year, 158.
Insane Relatives, Great Grandfather & 1st Cousin on same side.
Cause Exciting, No Knowledge
Cause Predisposing, previous attk & heredity
Form,
Accompanying Bodily Disorder, Nondescript Convulsions
Suicidal or Not, Not.
Date of this Attack, 8 Years ago
Duration, - 8 years -
No. of Attack, 2nd (Seemingly).
No. of Admissions, 1st here (was in Elgin hospital).
Age First Attack, about 37 (?)
Time of Leaving, Apl. 24. 1897
Time in Hospital, 1 year 2 mo.
Result, Died - General Paresis

EXAMINATION ON ADMISSION
MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Confused.
Quick or Sluggish,
MEMORY:
Past Events, Very much impaired
Recent Events,
Special Subjects,
PERCEPTIVITY:
Alert or Dull,
Correct or Illusive,
REASONING POWER:
Ordinary Subjects,
Own Mental State,
Special Subjects,
GENERAL DESCRIPTIVE REMARKS:

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed,
DELUSIONS:
Systematized or Not, Not.
Special Subjects, Worth millions etc.
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent, Voluble.
Wanders happily along. Has no sense of shame - No realizing sense of things

Personal and Medical History of Hannah Steiner

EXAMINATION ON ADMISSION, CONTINUED.
PHYSICAL CHARACTERISTICS.

HEIGHT, 4 ft 10 in WEIGHT, not taken NUTRITION, Good.
WOUNDS OR ABNORMALITIES,
TONGUE, Tremors, Considerable Coatings, Promptness Movement, Sluggish
PUPILS, Equality, Size, Normal.
Response Light, sluggish Accommodation,
SIGHT, Good.
HEARING, Seems good.
COORDINATION, Arms, Much impaired
Legs, Impaired.
TREMORS, Hands, Tongue,
Facial Muscles, General,
REFLEXES, Patellar, Equal. g
Other
ARTICULATION,
Slurred, ✓
Hesitating, ✓
FACIAL EXPRESSION,
Rather dull.
SENSIBILITY,



TAKEN,

EXAM. URINE,
Color
Character
Amt. 24 hrs.
Sp. Gr.
Reaction
Albumen
Sugar.
Microsc.

HEART, Normal.
LUNGS, Seems in good condition
GYNAECOLOGICAL EXAM. Uterus in right Right lateral version, freely movable. Otherwise normal
MENSTRUATION, Regular Normal Leucorrhea Irregular 4 children
OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty, ✓ Very	Clean,	Careless,
BOWELS, Normal,	Constipated,	Irregular,
APPETITE, Good,	Medium,	Poor, ✓
SLEEP, Good,	Poor,	Irregular, ✓
PULSE,	Resp.,	Temp.,

CRANIAL MEASUREMENTS,
HISTORICAL,
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Statements unreliable
Mother or Mat. Relations,
Father or Pat. Relations,
Brothers or Sisters, 3 Cousins are insane she says

Personal and Medical History of Hannah Steiner

1896

This patient was brought here by Deputy Sheriff M. N. Goss & attended by I. Steiner with following history. Patient is in a nervous condition. There is no consanguinity, but there is history of heredity; her great grand father, and 1st Cousin on same side, having been insane. This is not 1st attack; she occurred 3 years ago, when she was sent to hospital at Elgin & was improved. First Symptoms of this attack were manifested 8 years ago: Disease appears to be in about the same state: variable & with rational intervals but these, not at regular periods. Derangement now shown in that she believes herself wealthy. Patient is not disposed to injure others, nor suicidal; no filthy or destructive habits. No peculiarities &c were previously shown: No history of intemperance. Patient is subject to non descript Convulsions. She was at Elgin hospital for 6 months & received treatment only when there. No knowledge of cause of disease. She woman is, at times, much excited; then, much depressed, and, at times, there is difficulty of speech. ——

Feb 24 On admission, was put on B[MC] G.H.N.R.Pft. Complexion dark: hair black: eyes brown: Condition of skin normal: right arm & both legs bruised: is dirty: very restless & violent has delusions).

Feb 25 Nurses Notes 1896 P80. R20. Appetite good- Bowels regular- Full bath given Has many delusions- Dirty in habits: Quite violent- Temp. to 63. Feb 26 1896 P78 R19 Appetite good- Bowels moved- Violent, fought patients & attendants. Habits dirty. Leg bruised by Mrs Hunt. Feb 27 1898 P80 R20. Very troublesome all day. Annoyed other patients also destroyed clothing. Feb 28 Appetite good Patient in seclusion- Talks very vulgar & profane. Will not keep clothing on

Feb 29 Appetite good. Bowels regular - Struck Mattie Hinds in face.

Mar 1 Appetite fair. Slept 7 hrs during night- Bowels moved. Mar 2 Slept 6 hrs. during night. In seclusion nearly all day- Very dirty & vulgar Appetite fair.

Mar 3 P. 98.6. P. 80 R. 20 Appetite fair. Slept 8 hrs. during night. In seclusion 9 hrs.

" 4 Will not keep clothing on- Cries & sings alternately- In seclusion all day. Slept six hrs. during night. Appetite fair. Bowels regular. Mar. 5 1894. P78 R 19 Full bath given 3 times - In seclusion & constantly asking for unreasonable things - Slept 4 hrs. during night. Mar 6-7-8 In seclusion nearly all the time. Full bath given daily - Slept well at night. Very dirty - Language vulgar profane On Mar 8 vomited after dinner.

Mar 30 Summary Patient Violent fought nurses & patients - in seclusion last few days most of time. Appetite fair. Sleeps fairly Well. Bowels regular Habits dirty Language vulgar & profane - Has many delusions. Noisy, Dirty, destructive & meddlesome - In seclusion when nurses are busy, also at meal times - Fed by nurses. Ravenous appetite & does not Masticate properly: often vomits soon after eating. Bowels regular. Goes riding & walking. Rests well at night. Has many delusions. Dec. 9 Was struck several times. Temp. 1/2 B. 3. Apr. 17 Visited by husband. May 9 Very destructive. Appetite good - Takes out door exercise

Personal and Medical History of Hannah Steiner

1896

Very restless most of time Also quite noisy. Bowels regular. Very dirty in habits

May 26 Patient still quite destructive. Eats well. Takes out door exercise Seems to be gaining in flesh. Very restless nights. Quite clean in habits

June Summary Nurses Notes by Dr. L.L. Phelps:- Very destructive: takes out door exercise: General health good: habits dirty. Sept '96 Very nervous at times: assists some with work occasionally. Jan '97 Appetite good: bowels constipated: takes cathartics: Very incoherent & childish in talk: Has delusions of grandeur: Has general tremor of whole body & at times becomes very nervous in talk & actions: wants to write letters every day

1897 Mar Very stupid: appetite poor: refuses to eat: very weak: Mar. 13 '97 Put to bed: Fed with tube: Mar. 30 '97 Had a convulsion: Apr. 2 '97 Transf. to Inf. Fed with tube:

Apr. 8 Fed with tube daily: Has bed sores: Is very helpless: Apr. 15 Fed daily with tube: refuses all medicine Apr. 24 '97 Has failed & become steadily weaker: fed with tube daily: Pulse has become very weak: vomited this morning 7:30 pm. Died.

Died

Personal and Medical History of Annie Schroetke

Whole No. 4332.
Residence, Winona County, Minnesota.
Date Admission, 25th February 1896.
Admitted by, Dr. Phelps Hour, 7 45 P.M.
How Sent, H. L. Buck, Jo P. Winona County
Sex, Female
Age, 52
Civil Condition, Widow
Children, 7
Age Youngest Child, 7 (years?)
Occupation, Housewife: (husband, saloon keeper, before death)
Degree Education, Slightly educated.
Profession Religion, Yes: Lutheran.
Habits, not intemperate
Nativity, Germany: (parents also born there).
Physicians Committing, Edward D. Keyes and W. J. English
Correspondents, none given on papers

No. for Year, 160
Insane Relatives, None, so far as known
Cause Exciting, not known
Cause Predisposing, not given
Form,
Accompanying Bodily Disorder, None mentioned
Suicidal or Not, Not.
Date of this Attack, about 2 years ago
Duration, about 2 years
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, about 50
Time of Leaving, Sept. 10. 1896.
Time in Hospital, 6 mo. 15 days.
Result, Died
Organic Brain Disease

EXAMINATION ON ADMISSION
MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Confused.
Quick or Sluggish, Sluggish
MEMORY:
Past Events,
Recent Events,
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Dull - apparently deluded
Correct or Illusive,
REASONING POWER:
Ordinary Subjects,
Own Mental State,
Special Subjects,
GENERAL DESCRIPTIVE REMARKS:

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed, ✓
DELUSIONS:
Systematized or Not,
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent, Wont Talk
Daughter says she has been off for 2 yrs. Worse the past 2 wks - gave no special details.

Personal and Medical History of Annie Schroetke

EXAMINATION ON ADMISSION, CONTINUED.
PHYSICAL CHARACTERISTICS.

HEIGHT, Not taken WEIGHT, Not taken NUTRITION, Somewhat impaired
WOUNDS OR ABNORMALITIES,
TONGUE, Tremors, Normal Coatings, None noticed Promptness Movement, Fairly so
PUPILS, Equality, Equal Size, Fairly normal
Response Light, Yes. Accommodation,
SIGHT, Probably good
HEARING,
COORDINATION, Arms,
Legs,
TREMORS, Hands, Yes Some Tongue, None
Facial Muscles, General,
REFLEXES, Patellar,
Other
ARTICULATION, Seems well, rarely say anything
Slurred, Can talk clearly.
Hesitating,
FACIAL EXPRESSION,
Depressed - anxious
SENSIBILITY,

HEART, Rather weak - Second sound muffled.
LUNGS, Resp. shallow. Expiratory murmur prolonged. Sounds harsh in front.
GYNAECOLOGICAL EXAM., Slight retroversion of uterus - Slight laceration of os
MENSTRUATION, External Genitals normal Absent Menopause past
OPHTHALMOSCOPIC EXAM.,

TAKEN,

EXAM. URINE, Mar. 6'96.
Color. Yellow
Character Light flaky deposit
Amt 24 hrs.
Sp. Gr. 1019.
Reaction Acid
Albumen None
Sugar. "
Microscop. Amor. urates - large amt. Triple Phosphates. Few pus corpuscles. Bladder + Vaginal Epith. Cells.

HABITS, Dirty,	Clean, ✓	Careless,
BOWELS, Normal, ✓	Constipated,	Irregular,
APPETITE, Good, ✓	Medium,	Poor,
SLEEP, Good,	Poor, None last night.	Irregular,
PULSE,	Resp.,	Temp.,

CRANIAL MEASUREMENTS,
HISTORICAL,
LENGTH OF INVASION, 2 years duration ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Her daughter denies any heredity
Mother or Mat. Relations,
Father or Pat. Relations,
Brothers or Sisters,

Personal and Medical History of Annie Schroetke

1896

This patient was brought here by Deputy-Sheriff Jno. Goltz, and attended by Amelia Schroetke, with following history of case. No history of consanguinity or heredity, so far as known. This is 1st attack; symptoms manifested about 2 years ago: She became restless, apathetic. The Disease seems to be increasing: not variable: no rational interval. She is now demented. Patient is not disposed to injure others, nor suicidal, but has filthy & destructive habits. No peculiarities were previously shown. There is no history of intemperance in self or parents: nor any severe disease or head-injury. The family have had to maintain complete charge over her. Cause of disease not known. She has had no medical treatment. Patient sits, without word or motion, or other evidence of intelligence.

Feb 15 On admission was put on B[ay] St. G.H.N.R[y]. Complexion dark: hair brown streaked with gray: eyes gray: condition of skin normal: no marks scars or bruises noticed: Is clean: was quite nervous and resisted being bathed: did not speak English.

Feb 16 Nurses Notes. T. 98.8 P 80. R 20. Slept 4 hrs. Does not talk any english. Appears sad. Quite excited this evening. Dirty in habits. Spoon fed. Feb 17 Refused supper this evening. Cathartic given. Feb 18 Appetite good. Feb 19 T. 98. P. 76 R 20 Appetite good. Slept six hrs. Dirty in habits. Mar. 1 T. 97½. P 86 R. 18. Appetite good. Had an Epileptic fit. Mar. 2nd T. 98. P. 74. R 20. Does not talk any english. Quite excited at times. Very dirty in habits. Tonic given.

Mar 3 T. 97. P 80 R 18. Tonic given. Bowels constipated. Untidy in appearance. Spoon fed. Mar 4 Appetite fair. Tonic given. Seems disturbed. Complains of her head aching. Mar 5 to Appetite fair. Spoon fed. Tonic given daily. Sleeps well. Dirty in habits. Walks the floor most of time & nervous & rather stupid. Walks rather one sided.

Summary Patient is quiet. Rather nervous & stupid. Does not speak English. Walks the floor most of time. Appetite fair. Sleeps fairly well. Has one epileptic fit on Mar 1st. Tonic given three times daily. Bowels usually constipated. Cathartic given. Fed by nurse part of time. Habits dirty.

Mar 8 Had a fit at 6:10 A.M. Dirty in habits. Appetite not very good. Fed by nurse. Temp. 4 P.M. 2. Mar. 16 Had a fit this morning.

Apr. 9 Had two hard fits this A.M. Very stupid for some time after.

" 30 Appetite fair. Bowels constipated. Untidy in appearance. Dirty in habits. Very uneasy. Tears her clothes. May 18 Had a fit this A.M. Was stupid for some time after. Appetite fair. Bowels regular. Dirty in habits. Very uneasy. June 18 Appetite quite good: Bowels regular. Takes outdoor exercise: June 20 Very nervous: Natters at night. July 13 No change.

Aug 4 Had a fit this A.M. Aug 15 In bed: refuses food: Temp. 99.3 Aug 18 Up on ward: Appetite quite poor. Sept. 1 Appetite very poor: So very weak: Was put to bed. Temp. 97.8

Sept 2 Wine given every two hours. Tonic 3 times daily. Temp. 99.2 Sept. 3 Constipated - powder & enema given: bowels moved: Was visited by children. Sept 4 Very weak: T. 98.2

Personal and Medical History of Annie Schroetke.

Sept 5 Temp. & Dy. Sept. 10 Died

Physician's note:— Patient failed very gradually. Evidently by all paretic signs there was some organic brain trouble, but it was not definitely located. A haematoma of Dura was fairly probable: A general paresis or syphilitic form of Brain trouble was perhaps more probable.

R. W. Phelps.

Personal and Medical History of Martha Mc Namara (J)

ALBERT, FOLEY & SAUNDERS, DAVENPORT, IOWA.

Whole No. 4335.
Residence, Rice County, Minnesota
Date Admission, 29th February 1896
Admitted by, Dr Phelps Hour, 3 P.M.
How Sent, R. A. Mott. Jail. Rice County
Sex, Female
Age, 29.
Civil Condition, unmarried
Children,
Age Youngest Child,
Occupation, Housework & general farm-overseer
Degree Education, Common School
Profession Religion, Yes: Catholic
Habits, not intemperate
Nativity, St Lawrence Co. NY. (parents born in Ireland)
Physicians Committing, M. L. Maylund and D. M. Cook
Correspondents, (Brother) Jas Mc Namara Faribault Minn

No. for Year, 163.
Insane Relatives, none known
Cause Exciting, family complications & worry.
Cause Predisposing, previous attacks
Form,
Accompanying Bodily Disorder, Nervousness
Suicidal or Not, Threatens suicide & propensity active
Date of this Attack, about New-years
Duration, about 2 months -
No. of Attack, 3rd (seemingly)
No. of Admissions, 1st here (2 x been at St Peters)
Age First Attack, about 16.
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION
MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Confused.
Quick or Sluggish, Quick
MEMORY:
Past Events, Seems fairly good.
Recent Events,
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Dull - at least on some subjects
Correct or Illusive,
REASONING POWER:
Ordinary Subjects, not very good.
Own Mental State, Poor
Special Subjects, "

GENERAL DESCRIPTIVE REMARKS: Has story of starting of lungs - the first time 23 years ago from fright, could feel it tickling it down under her ribs, fell into her stomach - she vomited it up - This happened again lately. Has belonged to Masons for 20 yrs. A young man dying gave her his sing - that is how she got in -- All full of exaggerated ideas

EMOTIONAL STATE:
Normal, Calm, Calm
Indifferent,
Exalted,
Depressed,
DELUSIONS: Delusion ideas rather than
Systematized or Not, delusions.
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent, Somewhat incoherent
Voluble or Reticent,
Talks willingly - manner quiet. Talks some what at random - Gives queer reasons

Personal and Medical History of Martha Mc Namara.

EXAMINATION ON ADMISSION, CONTINUED.
PHYSICAL CHARACTERISTICS.

HEIGHT, Not taken WEIGHT, Not taken NUTRITION, Good

Copy of notice of hearing petition of Thos. Random for appointment of guardian for Martha Mc Namara served Nov. 17 1899 & filed with commitment papers.

Other
ARTICULATION,
Slurred,
Hesitating, Good
FACIAL EXPRESSION,
Nearly Normal
SENSIBILITY,



TAKEN,

HEART, No Murmurs - Strong.
LUNGS, Rales upper part right lung
GYNAECOLOGICAL EXAM., Uterus in normal position & genitals normal
MENSTRUATION,
OPHTHALMOSCOPIC EXAM.,

Reacting Promptness Movement, Prompt
Normal.
Accommodation,

EXAM. URINE, Mar. 20 '96
Color. Yellowish Red.
Characte. Many Waxy deposit.
Amt 24 hrs. 3.
Sp. Gr. 1025
Reaction Acid
Albumen None
Sugar. "
Microscop. Large ant. amos. mates a few bladder cells Ox. lime Crystals

HABITS, Dirty,	Clean, ✓	Careless,
BOWELS, Normal, ✓	Constipated,	Irregular,
APPETITE, Good, ✓	Medium,	Poor,
SLEEP, Good,	Poor, ✓	Irregular,
PULSE, Good. Normal	Resp.,	Temp.,

CRANIAL MEASUREMENTS,
HISTORICAL,
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Heredity denied.
Mother or Mat. Relations, Died consumption
Father or Pat. Relations, Died heart failure
Brothers or Sisters, Healthy -

Personal and Medical History of Martha Mc (J)

LIBBEY, FISCAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4335.
Residence, Rice County, Minnesota
Date Admission, 29th February 1896.
Admitted by, Dr. Phelps Hour, 3 PM.
How Sent, R. A. Mott. Jopl. Rice County
Sex, Female
Age, 39
Civil Condition, unmarried
Children, ——
Age Youngest Child, ——
Occupation, Housework & general farm-overseer
Degree Education, Common School.
Profession Religion, Yes: Catholic
Habits, not intemperate —
Nativity, St Laurence Co. NY (parents born in Ireland)
Physicians Committing, M. L. Mayhew and D. M. Cook
Correspondents, (Brother) Jos. McNamara Faribault Minn

No. for Year, 163.
Insane Relatives, none k
Cause Exciting, family Compli
Cause Predisposing, Spreviou
Form,
Accompanying Bodily Disorder, N
Suicidal or Not, Threatens suicide
Date of this Attack, about M
Duration, about 2 months —
No. of Attack, 3rd (Seemingly)
No. of Admissions, 1st here (Taken at St Peter)
Age First Attack, about 16.
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION
MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Confused.
Quick or Sluggish, Quick
MEMORY:
Past Events, Seems fairly good.
Recent Events,
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Dull - at least on some subjects
Correct or Illusive,
REASONING POWER:
Ordinary Subjects, not very good.
Own Mental State, Poor
Special Subjects, "

GENERAL DESCRIPTIVE REMARKS: Has story of thinking of lungs - the first time 23 years ago from fright could feel it tickling it down under her ribs, fell into her stomach - she vomited it up - Has happened again lately Has belonged to Masons for 20 yrs. A young man dying gave her his ring - That is how she got in -- All full of exaggerated ideas

EMOTIONAL STATE:
Normal, Calm, Calm
Indifferent,
Exalted,
Depressed,
DELUSIONS: Delusive ideas rather than
Systematized or Not, delusions.
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent, Somewhat incoherent
Voluble or Reticent,
Talks willingly - Manner quiet. Talks some what at random - Gives queer reasons

Personal and Medical History of Martha Mc Namara.

EXAMINATION ON ADMISSION, CONTINUED.
PHYSICAL CHARACTERISTICS.

T, Not taken WEIGHT, Not taken NUTRITION, Good
NDS OR ABNORMALITIES,
TONGUE, Tremors, Normal Coatings, Considerable coating Promptness Movement, Prompt
PUPILS, Equality, Equal. Size, Normal.
Response Light, Respond Accommodation,
SIGHT,
HEARING, Good
COORDINATION, Arms, Seems good
Legs, "
TREMORS, Hands, Some Tongue,
Facial Muscles, General,
REFLEXES, Patellar, 7 - 8
Other
ARTICULATION,
Slurred,
Hesitating, Good
FACIAL EXPRESSION,
Nearly Normal
SENSIBILITY,
HEART, No Murmurs - Strong.
LUNGS, Rales upper part right lung



TAKEN,

EXAM. URINE, Mar. 20 '96
Color. Yellowish red.
Character. Heavy flaky deposit.
Amt in hrs. 3.
Sp. Gr. 1025
Reaction Acid
Albumen None
Sugar. "
Microscop. Large amt. amorphous a few Epithelial cells & Lime Oxylate

GYNAECOLOGICAL EXAM., Uterus in normal position External genitals normal
MENSTRUATION,
OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean, ✓	Careless,
BOWELS, Normal, ✓	Constipated,	Irregular,
APPETITE, Good, ✓	Medium,	Poor,
SLEEP, Good,	Poor, ✓	Irregular,
PULSE, Good Normal	Resp.,	Temp.,

CRANIAL MEASUREMENTS,
HISTORICAL,
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Heredity denied.
Mother or Mat. Relations, Died consumption
Father or Pat. Relations, Died heart failure
Brothers or Sisters, Healthy -

Personal and Medical History of Martha McNamara.

1896

This patient was received here at the hands of Sheriff's Deputy Mr. Hutchinson; (Gary attendant having failed to catch the train): Patient is in fair physical condition. The following is history of case. No history of consanguinity or heredity so far as known. This is not 1st attack. She had one about 23 years ago; this the 1st lasted about 7 months: was then sent to St Peters Hospital & she seemed straight for about 5 years afterwards. First symptoms of this present attack were manifested about New-Years: She then became sleepless, restless & violent. The disease seems to be unmanning: but variable with rational intervals, but these at periods irregular. Derangement now shown in that she seems to hate every member of her family - Threatens to injure her best friends: has not attempted suicide but threatens it & propensity now active. Is also disposed to destroy property, in spite. No peculiarities had been previously shown. There is no history of intemperance in self or parents, nor of any other severe disease &c (Was also further confined 8 or 9 weeks (?)) - Supposed cause of the disease is family complications and worry. Has only had treatment when committed as aforesaid. This appears to be a quarrel with some of the family and a high & ungovernable temper on both sides.

Feb 29 On admission was put on T B.H. (G.H.N.R.R.) Complexion dark: hair black: eyes brown: Condition of skin normal: no marks scars or bruises noticed: is clean: behavior quiet: talks quite sensibly).

Mar 1 Nurses Notes 98.6 R 20. Appetite good. Bowels regular. Confined on door. Very noisy & hus. Noisy & disturbed all day. Has many delusions. Coughs a little & Complains of pain in side. Mar 2 Appetite good. Resisted so did not take temperature Very noisy - Quite violent. Mar. 3 Extremely noisy violent at times. Noisy all night Could not take temperature. Says she will die surely if she has to stay here

Mar 4 P. 98.8 R. 18 Appetite fair. Bowels moved, Cathartic given. Noisy & violent Destructive has delusions. Did not sleep any. Noisy 4 hrs. Out of bed all night

" 5 Appetite good. Bowels regular. Noisy greater part of day. Destructive & violent at times. Extremely noisy 2 hrs. Out of bed greater part of time & quite noisy.

" 6 A little quieter. Complains of pain in side. Out of bed. Extremely noisy 6 hrs

" 7 Refused Medicine. Bowels regular - Appetite good. Very noisy all day. Habits dirty. Noisy greater part of night

" 14 During second week Appetite good. Bowels regular - Noisy part of every night & nearly all day. - Destructive & violent Habits dirty Complains of pain in side. Summary Patient has been very noisy, violent & destructive ever since admission - up part of nearly every night & very noisy. Complains of pain in side & occasionally of headache. Habits dirty Bowels quite regular. Appetite good - Sleeps rather poorly.

Mar 21 Appetite good. Extremely noisy from two to five hours each night quite noisy during day. So violent & destructive at times. Bowels regular. Apr 30 Extremely noisy during night pounding & kicking on door. No restraint for nights during month. No change otherwise

July Summary Nurse's Notes by Dr. S L. Phelps. - Appetite very good very noisy most of time during day & noisy at night destructive & violent: Habits dirty. July 25 visited by Sister.

Personal and Medical History of

Sept Very noisy: appetite & gain health good: May 5th Visited by friends: very noisy: Aug 31 97 Has delusions: very noisy on ward: very incoherent: Physical health good.

Continued by Dr. A.W. Phelps. Oct 5 97 Rather noisy & restless: health good but rather unreliable in behavior: Trans. to 3. Dec 9 Wt. 202 lbs. Talks very noisily. Feb 9 99 Condition practically unchanged during period: Has been recently at Annex: Talks almost incessantly. (Cont. by Dr. R.A. Bell) Mar to Sept. 99: Gen'l health good eats & sleeps well: takes outdoor exercise: neat & tidy: has delusions. Is incoherent: usually quiet: at times noisy using profane & obscene language: July 27 Visited by friends Aug. 16 Wt. 235 lbs Sept 1 Feb 28 1900 (Dr Heyndale) ~~Not to Attacked nurses: & threw dishes:~~ Is neat Has delusions: Talks incoherently: Vulgar & profane: Violent at times General health good: Takes outdoor exercise: ~~Feb 14 Attacked nurses: Is restless at times~~ assists with work: Eats & sleeps well: Jan 15, Wt. 231 lbs.

Mch 1 - Aug 31 1900. Noisy at times also profane & vulgar: General health good: Assists with work. Apr 11 Visited by friends July 23 vaccinated. Sept 1 - Feb 28 1901 Patient shows little change. at times agreeable & pleasant but often noisy & profane Health good Nov 23 Wt 214. Mch 3. Wt. 198 lbs

Mar 1 - June 1 - 1901

May 7 visited by friends. Works on the ward. No change in mental or physical condition. May 31 Wt. 190 lbs

June to Sept. Takes out door exercise, assists with work, attends no amusements, neat and clean, not quite so disturbed as formerly, Sept. 3 Wt. 180 lbs.

Sept. to Dec. During the winter has lost very much in weight, looks pale and thin, has diminished resonance, has indications of becoming tubercular, Nov. 30 Wt. 135 lbs.

1902 to Feb. 1 1903. Has failing health physically: expectorates a great deal: appetite fair: assists with the work: takes exercise: attends no amusements: is usually quiet: sometimes scolds to herself: uses vulgar & profane language: very delusional especially about her clothing and property: when disturbed is incoherent. Dec 1st Wt. 148½ lbs.

Personal and Medical History of Nellie Murphy #2

LIBBEY, PIGLER & GARNELSS, DAVENPORT, IOWA.

Whole No. 4339.
Residence, Faribault, Minn
Date Admission, 2nd March 1896.
Admitted by, Dr. Phelps Hour, 6.15 PM
How Sent, R. A. Mott. Jo. P. Rice County
Sex, Female
Age, Twenty one (21).
Civil Condition, Single
Children, None
Age Youngest Child,
Occupation, Dress-maker
Degree Education, Common School.
Profession Religion, Yes: Catholic
Habits, Probably Good -
Nativity, Erin, Rice Co. Minn (Parents born in Ireland).
Physicians Committing, C. H. Wagner MD D. M. Cool
Correspondents, None given in Papers

No. for Year, 167.
Insane Relatives, None Known; Sist Father Drunk
Cause Exciting, "Grippe"
Cause Predisposing, Previous attack.
Form,
Accompanying Bodily Disorder, None mentioned
Suicidal or Not, Threatens Suicide -
Date of this Attack, In Dec 1893
Duration, over 2 years.
No. of Attack, 2nd: (was in March 1895)
No. of Admissions, 2nd
Age First Attack, about 19
Time of Leaving, Jan. 27. 1900
Time in Hospital, 3 yr. 10 m. 25 d
Result, Discharged May 2. 1900
Died since leaving.

EXAMINATION ON ADMISSION
MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Fairly Clear
Quick or Sluggish, " quick
MEMORY:
Past Events, Seems good
Recent Events, "
Special Subjects, "
PERCEPTIVITY:
Alert or Dull, Fairly alert.
Correct or Illusive, Correct on ordinary subjects
REASONING POWER:
Ordinary Subjects, Fair
Own Mental State, Poor
Special Subjects, poor

GENERAL DESCRIPTIVE REMARKS: Raw feeling + something seems in top of her head. Has been out to work nearly all the time since leaving. Sister says she came home was not much better. At home ideas became prominent, would not stay - went out to work. People where she was did not know anything was the matter. She got along all right - thought not very well. Finally she went to a lawyer with some crazy story. At home these ideas were prominent, had ideas they were strange about her people + did not want to stay. Patient herself now states that these ideas do not bear her at any time. At times are very "fine" - Seems to fairly size up her own condition as any other would do + is quite melancholy.

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed, Depressed
DELUSIONS:
Systematized or Not, Systematized
Special Subjects, When asked if delusions were real said
Transitory or Not, ought not to be but they were
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

Personal and Medical History of Nellie Murphy #2

EXAMINATION ON ADMISSION, CONTINUED.
PHYSICAL CHARACTERISTICS.

HEIGHT, Not taken WEIGHT, Not taken NUTRITION, Good
WOUNDS OR ABNORMALITIES,
TONGUE, Tremors, None Coatings, Slight Promptness Movement, Prompt
PUPILS, Equality, Equal Size, Normal
Response Light, Respond Accommodation,
SIGHT, Good
HEARING, Good.
COORDINATION, Arms, Probably good
Legs,
TREMORS, Hands, None Tongue,
Facial Muscles, General,
REFLEXES, Patellar, Exg. 3-4
Other
ARTICULATION, Fairly Good
Slurred, hour + depressed
Hesitating,
FACIAL EXPRESSION,
Depressed
SENSIBILITY,
HEART, Seem good
LUNGS, Resp. shallow, Ralos supra right Apex. Says she has no cough.
GYNAECOLOGICAL EXAM., Normal condition
MENSTRUATION, Regular - Normal
OPHTHALMOSCOPIC EXAM.,

PHOTOGRAPH TAKEN,

EXAM. URINE, Mar. 14 '96
Color. Yellow.
Character. Many White flaky deposit
Quant. in hrs. 3 XXX
Sp. Gr. 1020.
Reaction Acid.
Albumen None.
Sugar "
Microscop. Ammonium + Amor. Urates Triple Phosphates Crystals + Few blood Corpuscles + Bacteria

HABITS, Dirty, Clean, Clean Careless,
BOWELS, Normal, Constipated, Irregular,
APPETITE, Good, At times ravenous ~~Medium,~~ Irregular Poor,
SLEEP, Good, Says usually sleeps good. Poor, Irregular,
PULSE, Regular Resp., Temp.,
CRANIAL MEASUREMENTS,
HISTORICAL,
LENGTH OF INVASION, 2 years. ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, M. died
Father or Pat. Relations, F. was a drunkard— paper states
Brothers or Sisters, Sister denies any heredity

Personal and Medical History of Nellie Murphy #3

1895

This patient was received here at the hands of her sister, with following history. Patient is in fair physical condition. There is no history of Consanguinity; no insane relatives as known. This is not 1st attack: one occurred in March 1895, duration about 2 months; was then sent to this (Rochester) X Hospital. First symptoms of attack manifested Dec. 1893 following an attack of "Grippe". The Disease seems stationary; variable: rational periods at irregular intervals. Derangement now shown by morbid apprehensiveness. Has shown no disposition to injure others: has threatened suicide, but never made the attempt: No filthy or destructive habits: No peculiarities had been previously shown. Father drank: She has had no severe Disease or head injury. Has not been (otherwise) restrained or confined. Supposed cause of the Disease is "Grippe". No treatment of late. is melancholic, tearful, reticent.

Note X Patient was here before (see Vol 28 page 137 No 4032), from March 13/95 to April 26/95. On her then Coming, She was quiet & well-behaved; complained much of feeling weak & exhausted; no delusions or were noticed. was given Massage treatment; partial, at first: afterward full treatment. She, in course of time, gained slowly in strength, yet Continually Complained of that "tired feeling". Patient was quite neurasthenic & weakly in appearance to the time of going: had improved very greatly, however. Inferred that she claimed herself better than she really was in order to get away.

Mar 7 On admission, was put on B1 (G.A.N.Hpt. Complexion fair: hair dark brown: eyes gray: Condition of skin normal: no marks scars or bruises noticed: is clean: behavior quiet: talks sensibly, but: (Shows delusions) T 98.6 P.70 R.18. Slept 5 hrs. Mar. 3 T 98.4 P.60 R.16 Ate very little today. Tonic given 3 times. Cathartic given. Quiet. In bed all day

Mar 4 T 98.4 R 18 P.65 Appetite very poor. Tonic given. Urine XXX 24 hrs. Quiet until 5 PM. Complained of severe headache. Slept 4 hrs. Mar 5 T. 98.6 P.60 R.16 Appetite very poor - drinks a good deal of milk. Tonic given. Up all day but very weak - Quiet. Slept 3 hrs. Fainted at 12 PM - Very nervous - Cold & has cold emats. Mar 6 T 99 P.60 R.16 Appetite rather poor. Tonic & cathartic given. In bed all day. Very weak & quite nervous. Slept 5 hrs. Mar 7 T 99.2 P.68 R.16 Appetite fair. Tonic given 3 times. Med. 5 hrs. Very quiet. Up all day but nervous & weak. Slept 6 hrs. Mar 8 T 98 P.60 R.18 Appetite fair. Tonic & Med. given. Bowels regular. In bed all day & seemed quite weak. Slept 4 hrs. Mar 11 Sick in bed - Seems very weak. Mar 13 Has a fair appetite - Bowels usually constipated. Takes Tonic & cathartic. Does not sleep very well - is quite restless during night. Very weak. Complains of feeling Cold most of time. Very quiet mentally. Physical health poor. Has severe headaches quite often. Urine 1/4 A. 1/4

Apr 3 Electrical Treatment given. Apr 7 Menses. Apr. 29 Physical health improved. So quiet & pleasant in manner. Rather melancholy. Appetite fair. Sleeps well. Takes out door exercise & at times works for self. Talks sensibly. Bowels constipated. May 30 At times irritable also stubborn. Usually talks quite sensibly. Is inclined to be

Personal and Medical History of Nellie Murphy.

1896

Nervous & quite often complains of headache. Somewhat troubled with constipation. Summary Nurse's Notes by Dr. S.L. Phelps:- June 9/96 Being examined:- Inspection - a marked flatness of chest anteriorly: Quite stoop shouldered: Resp. shallow: prolonged Expiratory murmur: No other signs noted: Heart - no organic disease. Heart sounds about normal: Has been worried thinking she had disease of lungs & heart: June 17/96 Electrical treatments given: July 9/96 Now quiet & pleasant: occupies most of time reading & working for herself: menses regular.

Oct 9. Has been rather nervous for past week or more: became much excited in dining room: broke dishes. Oct. 10-11-12 Sick in bed. Oct 14-21-24 In bed. Nov 5 - up on ward menstruating: Jan 97 Growing gradually more peculiar in behavior: Very irritable & excitable: health seems fair: Mar 3 97 Sick in bed: appetite very poor:

1897 Mar 5 Very nervous: fainted at noon Mar. 6-7-8 In bed all day: July 97 Appetite poor: sleeps quite well: disagreeable: at times destructive & violent: Has many delusions - Continued by Dr. S.L. Phelps. Oct 30 97 Usually quiet in behavior: Now on B1. At times quite stubborn: Is very reserved. Dec 25 Visited by sister. Feb 9 98 Wt. 90. Febr 99 Patient varies some in behavior: at times talking quite reasonably, at others quite irritable. (Cont. by Dr. R.A. Bebb) Mar 1 to October 99 General health impaired: appetite quite good: inclined to be constipated requiring laxatives occasionally: menses regular: occasionally goes out of doors. Is very irritable most of time: inclined to be excited: Screeds & laughs: very disagreeable & when angry becomes very nervous, sometimes trembling so that she can scarcely control herself: Has ulcer which is dressed daily:

1899 July 4 Visited by sister: opened fruit her sister brought & was very disagreeable since Sept. Has failed a great deal: has spent much time in bed: Often has considerable rise of temp. Oct 10 Temp 101 2/5 P. 112. R. 33: Nov 2 T 103 2/5 P. 112. R. 25 = Complains of feeling weak & chilly: coughs some & complains of pain in lungs: After remaining in bed for some days temp. was reduced & is really normal & she was able to be up on ward. Still has some rise each day. Dec. 1/99: Disagreeable at times & very irritable: neat in habits & appearance: Appetite poor: coughs a great deal: medicine given: Jan 2/1900 Complains of feeling ill: sometimes remains in bed for several days: temp. 101 2/5 P. 112. Jan. 13: Visited by sister who remained here for several days: was very anxious to go home with her & her sister decided to give her a trial. Before her sister came she was very desirous of going & for some weeks appeared brighter & more amiable, until she learned her request would not be granted, then became very impatient: Physical condition very much impaired at time of leaving: gradually failing in weight: abscess on neck still discharging: Tubercular process extending involving lungs. Went with sister Jan. 28th, to live in country.

Discharged.

Personal and Medical History of Anna Sperel

LEIGHT, FIDLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4343.
Residence, Alms-House, Goodhue County
Date Admission, 4th March 1896. —
Admitted by, Dr. Herzog Hour 6.45 PM
How Sent, Axel Haller. J.P. Goodhue County
Sex, Female
Age, — 66 —
Civil Condition, Married
Children, — 4 —
Age Youngest Child, — 32 —
Occupation, — None —
Degree Education, limited: can read —
Profession Religion, Cps: Catholic Church
Habits, — not known —
Nativity, Germany. (Parents also born there)
Physicians Committing, B. Dearborn and J.O. Andreen
Correspondents, None seen in papers.

No. for Year, 171.
Insane Relatives, one son died in the asylum
Cause Exciting, — not known —
Cause Predisposing, probably age.
Form,
Accompanying Bodily Disorder, Paralysis agitans —
Suicidal or Not, — not —
Date of this Attack, about a week ago
Duration, about a week —
No. of Attack, 1st —
No. of Admissions, 1st
Age First Attack, — 66 —
Time of Leaving, Feb. 14. 1899
Time in Hospital, 2 yr. 11 m. 10d
Result, Transferred to Fergus Falls.

J.C. Spw

EXAMINATION ON ADMISSION
MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Slightly confused.
Quick or Sluggish, Sluggish
MEMORY: In most conversations says they good
Past Events,
Recent Events,
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Rather dull.
Correct or Illusive,
REASONING POWER:
Ordinary Subjects, Feeble but in fair form
Own Mental State,
Special Subjects,
GENERAL DESCRIPTIVE REMARKS:

EMOTIONAL STATE:
Normal, Calm, Calm
Indifferent,
Exalted,
Depressed,
DELUSIONS:
Systematized or Not,
Special Subjects, Thinks something was put in food
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION: Talks willingly & partially
Coherent or Incoherent, Correct on most things but
Voluble or Reticent, becomes excited when talking of the food at the Poor Farm & manifests delusions.

Personal and Medical History of Anna Sperel

EXAMINATION ON ADMISSION, CONTINUED.
PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 2in WEIGHT, Not taken NUTRITION, Fair
WOUNDS OR ABNORMALITIES, Small goitre
TONGUE, Tremors, Trivial Coatings, Thick yellow Promptness Movement, Sluggish
PUPILS, Equality, Equal Size,
Response Light, Ry sluggish Accommodation,
SIGHT, Much impaired, cross in right eye
HEARING,
COORDINATION, Arms, Much impaired in all movements
Legs,
TREMORS, Hands, General tremor of whole body Tongue,
Facial Muscles, General,
REFLEXES, Patellar, Much exaggerated
Other Both
ARTICULATION,
Slurred,
Hesitating, ✓
FACIAL EXPRESSION,
Dull
SENSIBILITY,
HEART,
No murmur
LUNGS, Seems in good condition
TAKEN,

EXAM. URINE, Mar. 5'96
Color, Yellowish red.
Character, Yellow flaky deposit
Amt. 24 hrs. 3 XII
Sp. Gr. 1027.
Reaction Acid.
Albumen None.
Sugar "
Microscop. Amor. urates - large
Quantity Lime phosphates - large
Quantity Mus. Some blood corpuscles.

GYNAECOLOGICAL EXAM., Aug '96. Uterus somewhat atrophied - normal position but some adhesions. Slight haemorrhoids - otherwise normal.
MENSTRUATION,
OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean, ✓	Careless,
BOWELS, Normal,	Constipated, ✓	Irregular,
APPETITE, Good,	Medium,	Poor, ✓
SLEEP, Good,	Poor,	Irregular, ✓
PULSE, Somewhat weak	Resp.,	Temp.,

CRANIAL MEASUREMENTS,
HISTORICAL,
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations,
Father or Pat. Relations,
Brothers or Sisters, Son died insane - taken at 16 - died at 20 - Says all other people as far as known are all right

Personal and Medical History of Anna Sperel

1896

This patient was brought here by Sheriff's Deputy Adolph Grosse, attended by Mrs Hans Johnson, with following history. Patient is in poor physical condition. As to any consanguinity, not known. One son died in the Asylum. This is 1st attack; symptoms manifested about a week ago: refused food, because she was afraid people would poison her. Disease seems to be increasing: not variable: no rational intervals. Derangement now shown in that she is afraid of being poisoned. Patient is not disposed to injure others, nor suicidal, nor filthy nor destructive in her habits. Previously was quarrelsome. Data as to any history of intemperance, not known. Patient has paralysis agitans. Do not know cause of disease. Has had no medical treatment. She now has the impression, & insists, that people have put poison in her food & wishes to poison her.

March On admission, was put on B.W. G.H.N. Rft. Complexion dark: hair brown, streaked with gray: eyes gray: right eye crossed: condition of skin normal: 2 small moles on left side of face: a few small scars on lower part of back: Tongue clean: has a small goitre & a general tremor of all the body. Is quiet. Answers questions sensibly, but has delusions).

Mar 5 Nurses Notes. T. 98 P. 72. R. 18. Appetite fair: slept fairly well: quiet in behavior: bowels constipated.
" 6 T. 98.4 P. 76. R. 18 Appetite fair. Tonic 3 i p.c. given Cathartic given Slept quite well. Bowels moved.
" 7 Appetite quite good: Tonic given 3 times Slept well during night: bowels constipated
" 8 T. 98. P. 72 R. 19. Appetite fair: tonic given Slept well during night.
" 9 T. 98.2 P. 74 R. 18 Appetite fair: takes tonic: Cathartic given Slept well
" 10 Appetite fair Takes tonic Slept well Bowels moved.
" 11 Appetite good - Takes tonic - Sleeps well. March 18 During second week patient has been quiet in behavior: talked sensibly: appetite fair: takes tonic daily slept well at night: Cathartic given once.

Summary Patient has been very quiet during past fourteen days: no delusions noted: Appetite quite good. Sleeps fairly well: Bowels usually constipated

March Quiet in behavior. Neat in habits. Appetite quite good. Sleeps well. Bowels constipated. Does no work - Takes tonic. March 22 Sick in bed. Has a severe cold. Mar 25 Still in bed. but seems much better.
" 26 Up on ward again. May 3 In bed two days. May 15 In bed past 4 days
May 3 In bed all day - Complains of head & side aching.
June Summary Nurses Notes by Dr. L. L. Phelps: Quiet in behavior: works a little at times: Quite often in bed: complains of pain in left side: Nov. 22'96 In bed: Has stomach trouble: Jan '97 Complains much of time of feeling weak & inclines to want to stay in bed: Quil tremor of body very marked: refuses to take medicines: rather demented & feeble in mind.
Continued by Dr. A.M. Phelps. Sept 19'97 Patient in bed very weak: Has had from time to time considerable heart weakness, at one time pulse being as high as 200. Feb 9 Wt. 158# Has senile tremor sufficient to be extent to be called paralysis agitans. Is despondent & full of vague delusions. Feb 14'99
Feb 14 99 Trans. to Fergus Falls. Has been of late quite noisily scolding & talkative.

Personal and Medical History of

Personal and Medical History of Eliza Skjordal

LESLEY, FOLEY & SAUNDERS, DAVENPORT, IOWA.

Whole No. 4344.
Residence, Austin, Minnesota
Date Admission, 5th March 1896.
Admitted by, Dr. Phelps Hour, 11 A.M.
How Sent, C. S. Washburn. Jo P. Mower County
Sex, Female
Age, — 26 Years —
Civil Condition, married
Children, Two
Age Youngest Child, Five weeks
Occupation, Housewife: Husband, Laborer.
Degree Education, very moderate.
Profession Religion, Not attached
Habits, Not intemperate
Nativity, Norway: (parents also born there) —
Physicians Committing, C. S. Washburn and A. Macdonald
Correspondents, O. P. Peterson (in same house)
Family Physician, Alex. Macdonald M.D. Bx 492. Austin. Minn
Husband Ole Skjordal London P.O. via Austin, Mower Co. Minn.

No. for Year, 172
Insane Relatives, Says "father insane for 5 years"
Cause Exciting, Childbirth
Cause Predisposing, Heredity
Form,
Accompanying Bodily Disorder, None mentioned
Suicidal or Not, Propensity active: has talked of self destruction
Date of this Attack, Shortly after delivery
Duration, — about 5 weeks —
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, — 26 —
Time of Leaving, Apl. 23. 1897
Time in Hospital, 1 yr. 1 mo. 19 da.
Result, Died Sub. acute Meningitis.

Exam. by RM & L.L. Phelps - 3/5/96

EXAMINATION ON ADMISSION
MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Seemingly clear though yet weak
Quick or Sluggish, Fairly quick now yet
MEMORY:
Past Events, } Seems quite good
Recent Events, }
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Fairly alert
Correct or Illusive,
REASONING POWER:
Ordinary Subjects, At present seems good - is weak
Own Mental State, " feels slightly depressed
Special Subjects,
GENERAL DESCRIPTIVE REMARKS:
Complains of head as weak - Has had feelings since in this country 6 yrs. ago - Had a child was not well cared for - was said to have Septic poisoning - became insane.

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed, Slightly
DELUSIONS:
Systematized or Not,
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

Personal and Medical History of Eliza Skjordal

Apr. 14' 97.
Patient went out on trial January 8' 1897.
Returned Apr. 14' 97 with new Commitment papers from Freeborn Co. which are filed under this number. (4344) with old papers.

EXAMINATION ON ADMISSION, CONTINUED.
MENTAL CHARACTERISTICS.

NUTRITION, Fairly good
Promptness Movement, Prompt
ze, Normal
ccommodation,
t well Test

TREMORS, Hands, Some
Facial Muscles,
REFLEXES; Patellar, 2-3
Other
ARTICULATION,
Slurred,
Hesitating, Good.
FACIAL EXPRESSION,
Slightly depressed
SENSIBILITY,
HEART, Normal
LUNGS, Normal
GYNAECOLOGICAL EXAM., Uterus retroverted and immovable. Slight erosion
MENSTRUATION, Complains of Same endometritis - Separation of perineum & cervix - a good deal of tenderness - Menstruation regular
OPHTHALMOSCOPIC EXAM.,

Tongue,
General,

TAKEN.

EXAM. URINE, Mar 7' 96
Color Yellow.
Character, Cloudy.
Amt. 24 hrs. 3 XVI
Sp. Gr. 1018
Reaction Slightly Acid.
Albumen None
Sugar "
Microscop. Amor urates. Tripe phosphates - a few pus cells - Uterine & bladder Epith. Cells

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated,	Irregular,
APPETITE, Good,	Medium,	Poor,
SLEEP, Good,	Poor, Says poor	Irregular,
PULSE,	Resp.,	Temp.,

CRANIAL MEASUREMENTS,
HISTORICAL,
LENGTH OF INVASION, Not long it is said ONSET GRADUAL OR SUDDEN, Fairly Sudden
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, died When she was 8 yrs old -
Father or Pat. Relations, " " " " 8 " "
Brothers or Sisters, one in this Country

Personal and Medical History of Eliz[illegible]

LEBERT, FIDLAR & SCARBERG, DAVENPORT, IOWA.

Whole No. 4344.
Residence, Austin, Minnesota.
Date Admission, 5th March 1896.
Admitted by, Dr. Phelps Hour, 11 40 Am.
How Sent, S. S. Washburn. Jo. P. Mower County.
Sex, Female
Age, — 26 Years —
Civil Condition, Married
Children, Two
Age Youngest Child, Five weeks
Occupation, Housewife: Husband, Laborer.
Degree Education, Very moderate.
Profession Religion, Not stated
Habits, Not intemperate
Nativity, Norway: (Parents also born there) —
Physicians Committing, S. S. Washburn and A. Macdonald
Correspondents, O. P. Peterson (in Same House)
(Family Phys.) Alex Macdonald M.D. Bx 492 Austin, Minn
(Husband Dr. Stafford London P.O. or Austin, Minn. — 4/14/97)
Exam. by R.M. & S.S. Phelps - 3/5/96

No. for Year,
Insane Relatives,
Cause Exciting,
Cause Predisposing,
Form,
Accompanying Bodily Disorder, None
Suicidal or Not, Propensity active: has m[illegible]
Date of this Attack, Shortly after
Duration, — about 5 weeks —
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, — 26 —
Time of Leaving, Apl. 23. 1897
Time in Hospital, 1 yr. 1 mo. 19 da.
Result, Died Sub-acute Meningitis

EXAMINATION ON ADMISSION
MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Seemingly clear though yet mak
Quick or Sluggish, Fairly quick now yet
MEMORY:
Past Events, } Seems quite good
Recent Events, }
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Fairly alert
Correct or Illusive,
REASONING POWER:
Ordinary Subjects, At present seems good - Is mak
Own Mental State, & feels slightly depressed
Special Subjects,
GENERAL DESCRIPTIVE REMARKS:
Complains of head as mak - Has had feelings
Came to this country 6 yrs. ago - Had a child
Was not well cared for - was said to have
Septic poisoning - became insane.

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed, Slightly
DELUSIONS:
Systematized or Not,
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

Personal and Medical History of Eliza Skjordal

EXAMINATION ON ADMISSION, CONTINUED.
PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 7½ WEIGHT, not taken NUTRITION, Fairly good
WOUNDS OR ABNORMALITIES,
TONGUE, Tremors, No Coatings, None Promptness Movement, Prompt
PUPILS, Equality, Equal Size, Normal
Response Light, Respond Accommodation,
SIGHT, Good - Near sighted
HEARING, Seems good.
COORDINATION, Arms, Probably good - Can't well test
Legs,
TREMORS, Hands, Some Tongue,
Facial Muscles, General,
REFLEXES; Patellar, 2-3
Other
ARTICULATION,
Slurred,
Hesitating, Good.
FACIAL EXPRESSION,
Slightly depressed
SENSIBILITY,
HEART, Normal
LUNGS, Normal
GYNAECOLOGICAL EXAM., Uterus retroverted and immovable. Slight erosion
MENSTRUATION, Complains of a good deal of tenderness. Menstruation regular
OPHTHALMOSCOPIC EXAM.,

TAKEN,

EXAM. URINE, Mar 7/96
Color Yellow.
Character, Cloudy.
Amt. 24 hrs. 3 XVI
Sp. Gr. 1018
Reaction Slightly Acid.
Albumen. None
Sugar "
Microscop. Amor urates. Tripe phosphates - a few pus cells - Vaginal & bladder epith. cells.

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated,	Irregular,
APPETITE, Good,	Medium,	Poor,
SLEEP, Good,	Poor, Days poor	Irregular,
PULSE,	Resp.,	Temp.,

CRANIAL MEASUREMENTS,
HISTORICAL,
LENGTH OF INVASION, Not long if is said ONSET GRADUAL OR SUDDEN, Fairly Sudden
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, died When she was 8 yrs old -
Father or Pat. Relations, " " " " 8 " "
Brothers or Sisters, one in This Country

Personal and Medical History of Eliza Skjordal.

1896

This patient was brought here by Sheriff's Deputy Ira Padden & attended by Mr. Peterson, with following history: patient is in fair physical condition. As to consanguinity, not known. This is 1st attack; symptoms manifested shortly after delivery, during an attack of regular blood-poisoning. The Disease seems increasing: not variable: no rational intervals. If any particular manifestation can be claimed it is a sense of being a lost soul, but the vagaries are innumerable. Patient is not disposed to injure others: has not attempted suicide, but propensity is active, and she has talked of self-destruction. No filthy or destructive habits. She says that her father was insane for 5 years". No peculiarities etc had been previously shown. Patient has not been intemperate: don't know anything of parents. Has not had any severe disease nor head-injury. She has had day & night watchers for several weeks. Supposed cause of Disease is Childbirth. Has had no treatment for mental trouble. Her Commitment recommended on account of aberrant religious ideas; medical treatment under restraint is necessary for her recovery. -

Mar 5 On admission was put on B.W. Note by R.P. Baby 10 weeks old; said to be all right before baby was born. (G.N.R.R.Pt. Complexion fair. hair light, eyes gray: condition of skin normal: no marks scars or bruises noticed: is clean: behavior quiet: shows delusions).

" 6 Nurses Notes. T. 100 P 69 R. 18 Very quiet. Complains of her head & of feeling dizzy. Mar. 7 P. for T 98 R. 18 Appetite fair. Does not talk English but talks quite sensibly. Bowels moved. Mar 8 T. 98 P. 70 R. 19 Tonic given. Appetite Good. Bowel regular. Very quiet. Complains of pain in left side.

" 9 T. 98 P. 70. R. 18 Appetite fair. Tonic given. Patient very quiet & talks sensibly in her own language. Does not work. Mar. 10 T 98.6 P. 70. R. 18 Complains of headache. Bowels moved. Appetite fair. Tonic given. Mar. 11 T. 98.1 P. 70 R. 18 Ate quite well. Tonic refused last time. Very quiet. Complains of headache a great deal. Slept very poorly last night. Refused tonic.

" 14 T. 97.6 P. 70 R. 18 Refused tonic. Bowels moved. Complains of headache - Very quiet. Visited by husband.

Mar. Very quiet. Rather untidy in habits. Appetite not good. Bowels constipated. Takes cathartics. Sleeps fairly well. Mar. 30 Complains of pain in right side.

" 30 Sick in bed three days. Bowels constipated. Cathartics & tonic given.

Apr. 10 Appetite not very good. Cathartics given quite often. Apr. 16 Bowels constipated most of time. Sleeps rather poorly. Appetite not very good. Apr. 26 Seems to be rather stupid most of time. Treatments given. Appetite fairly good. Sleeps poorly. May 8 Appetite good. Bowels quite regular. Sleeps fairly well. Treatments Apr. 27-29 May 1-4, 11 & 13. May 16 Quiet - Appetite quite poor - Constipated - pills given

May 25 Appetite quite good - Bowels constipated. Requires cathartics.

June 4 Summary Nurse's Notes by Dr. S.L. Phelps. - Visited by husband & little girl: Gym treatment given every other day: June 10-14-17 Electrical treatment: July 11 massage & electrical treatment continued: July 20 '96 Salt baths - also massage & electrical treatment: Egg nog given twice a day: Oct. 96 Quiet in behavior: Appetite fair: goes walking & riding:

Personal and Medical History of

1896

Sleeps well: works in dining room: Nov. 24 '96 Quiet in behavior: bowels regular: works in Dining room: transf. to Inf. Dec. 8 '96 Operation done: Curettement & repair of cervix & perineum - Repair of cystocele: took ether poorly at first but condition was good when removed from table: reaction good: Dec 26 '96 Up on ward: made an uneventful recovery: Jan 8 '97 Husband came & took her Home - Has recovered so as to be quite normal mentally & in good physical condition:

1897 April Returned: Bath given & put to bed: Apr. 15 Up on ward: Appetite very poor: bowels very constipated: looks very emaciated & pale: Apr. 16 '97 Burned both feet on heater during night: was put to bed: very restless all day: Obliged to put her in restraint sheet: Apr. 17 '97 Ate breakfast: drank egg nog: feet dressed: Appetite very poor bowels constipated: Apr. 18 '97 Fed with tube: struggled some: Apr. 19 Refused to talk: Hypodermic every 3 hours: fed with tube. T. 101 2/5 P. 108. R. 36. Apr. 21 T. 103. Fed with tube in restraint: very quiet & stupid: Apr. 22 T. 102 2/5 P. 116 R. 27. Fed with tube: still in restraint: Feet dressed: Died at 2:25 A.M.

Patient came in in an acute delirious condition with suicidal tendencies On the night of the 15th was very restless & in the morning nurse found that feet had been burned: patient said she burned them during night: Ate very little during next day. Put to bed in restraint sheet: refused all food so that it was necessary to feed her with a tube: After the second day temp began to rise & ranged from 99 to 103: Refused to talk most of time: Sordes on her teeth & tongue very marked: Failed steadily until she died at 2:25 a.m. Apr 22nd.

Died

Personal and Medical History of Rose Marsland

LEBERT, FIDLAR & SAARBECK, DAVENPORT, IOWA.

Whole No. 4351.
Residence, Monona Minn
Date Admission, 11th March 1896.
Admitted by, Dr. Lilbourne Hour, 7.40 P.M.
How Sent, H.L. Buck. Jo P. Monona County
Sex, Female
Age, 30 years
Civil Condition, married
Children, one
Age Youngest Child, (none living)
Occupation, Housewife: (husband, laborer)
Degree Education, Common school
Profession Religion, Yes: Catholic
Habits, probably good
Nativity, Bohemia: (parents also born there)
Physicians Committing, E.F. Gamble and H. Lichtenstein
Correspondents, Kay Marsland
252 East 3d Street Monona

No. for Year, 179.
Insane Relatives, None
Cause Exciting, not known
Cause Predisposing, previous attacks
Form,
Accompanying Bodily Disorder, none mentioned
Suicidal or Not, not
Date of this Attack, about a month ago
Duration, about a month
No. of Attack, 2nd (one, 2½ years ago)
No. of Admissions, 2nd (three before in '93)
Age First Attack, about 29
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION
MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Confused
Quick or Sluggish, Sluggish
MEMORY:
Past Events, Impaired
Recent Events, "
Special Subjects, "
PERCEPTIVITY:
Alert or Dull, Dull
Correct or Illusive, Illusive
REASONING POWER:
Ordinary Subjects, Much impaired
Own Mental State, " "
Special Subjects, " "
GENERAL DESCRIPTIVE REMARKS:

EMOTIONAL STATE:
Normal, Calm,
Indifferent, Indiff and dull
Exalted,
Depressed,
DELUSIONS: Has many and
Systematized or Not, varied
Special Subjects, Imagines that her husband is not the
Transitory or Not, husband
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent, Incoherent
Voluble or Reticent,
Talks when addressed in a dull listless manner
Mind wanders & is incoherent

Personal and Medical History of Rose Marsland

No 4351
30/175

M Rose Marsland

Copy of Order for Hearing Petition of Mary McGill
for appointment of
Mary McGill or some other suitable person as guardian for
Dat Rose Marsland insane; served and
service admitted admitted original returned to Brown and Abbott, Monona filed 29 July 1902 at 7 PM
(Papers filed with commitment papers.)
Hearing on 14th Aug 1902 at Probate office Monona

MISSION, CONTINUED.
ACTERISTICS.

NUTRITION,
Promptness Movement,
Size, Normal
Accommodation,

COORDINATION, Arms, Normal
Legs, "
TREMORS, Hands, None
Facial Muscles, None
REFLEXES, Patellar,
Other
ARTICULATION, Perfect
Slurred,
Hesitating,
FACIAL EXPRESSION,
Dull
SENSIBILITY,
HEART, Normal
LUNGS, Normal
GYNAECOLOGICAL EXAM. Uterus retroverted and bound down - Cervix lacerated Extensive e- rosion of os.
MENSTRUATION,
OPHTHALMOSCOPIC EXAM.,

Tongue,
General,



TAKEN,

EXAM. URINE, Mar. 14 '96
Color Reddish-yellow
Character Yellowish ropy deposit
Amt in hrs. 3 XXV
Sp. Gr. 1026
Reaction Acid
Albumen Trace by heat + H.NO.3
Indicanuria by Jaffes
Sugar. none.
Microsc. Trip phosphates - pus cells large amount Amor. urates + Mucine bands + a few bladder Epith. Cells

HABITS, Dirty,	Clean, Clean	Careless,
BOWELS, Normal,	Constipated,	Irregular,
APPETITE, Good, Good	Medium,	Poor,
SLEEP, Good,	Poor,	Irregular,
PULSE,	Resp.,	Temp.,

CRANIAL MEASUREMENTS,
HISTORICAL,
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations,
Father or Pat. Relations,
Brothers or Sisters,

Personal and Medical History of R

LEGGET, PIDLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4351.
Residence, Winona Minn
Date Admission, 11th March 1896.
Admitted by, Dr. Kilbourne Hour, 7.40 P.M.
How Sent, H.L. Buck. Jo.P. Winona County
Sex, Female.
Age, 30 years.
Civil Condition, married.
Children, one
Age Youngest Child, (none living)
Occupation, Housewife: (husband, laborer)
Degree Education, Common School.
Profession Religion, Yes: Catholic
Habits, probably good.
Nativity, Bohemia: (parents also born there).
Physicians Committing, E.J. Gamble and H. Lichtenstein
Correspondents, Kay Marsland Father.
752 East 3d Street Winona

No.
Insane Rela
Cause Exciting,
Cause Predisposing,
Form, /
Accompanying Bodily Disorder, none m
Suicidal or Not, not.
Date of this Attack, about a month ago
Duration, about a month.
No. of Attack, 2nd (one, 7½ years ago).
No. of Admissions, 2nd (three before in 93)
Age First Attack, about 29.
Time of Leaving,
Time in Hospital,
Result,

4/4/96

EXAMINATION ON ADMISSION
MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Confused
Quick or Sluggish, Sluggish
MEMORY:
Past Events, Impaired
Recent Events, "
Special Subjects, "
PERCEPTIVITY:
Alert or Dull, Dull
Correct or Illusive, Illusive
REASONING POWER:
Ordinary Subjects, Much impaired
Own Mental State, " "
Special Subjects, " "
GENERAL DESCRIPTIVE REMARKS:

EMOTIONAL STATE:
Normal, Calm,
Indifferent, Indiff- and dull
Exalted,
Depressed,
DELUSIONS: Has many and
Systematized or Not, various.
Special Subjects, Delusions Imagines that her husband is not her
Transitory or Not, husband
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent, Incoherent
Voluble or Reticent,
Talks when addressed in a dull listless manner
Mind wandering & is incoherent

Personal and Medical History of Rose Marsland

EXAMINATION ON ADMISSION, CONTINUED.
PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 3½ WEIGHT, not taken NUTRITION,
WOUNDS OR ABNORMALITIES, Right inguinal hernia, 2 years, standing
TONGUE, Tremors, Coatings, Promptness Movement,
PUPILS, Equality, Equal Size, Normal
Response Light, Accommodation,
SIGHT, Seems normal
HEARING, " "
COORDINATION, Arms, Normal
Legs, "
TREMORS, Hands, None Tongue,
Facial Muscles, None General,
REFLEXES, Patellar,
Other
ARTICULATION, Prompt
Slurred,
Hesitating,
FACIAL EXPRESSION,
Dull
SENSIBILITY,
HEART, Normal
LUNGS, Normal
GYNAECOLOGICAL EXAM., Uterus retroverted and bound down - Cervix lacerated. Extensive e-rosion of os
MENSTRUATION,
OPHTHALMOSCOPIC EXAM.,



TAKEN,

EXAM. URINE, Mar. 14 '96
Color Reddish-yellow
Character: Yellowish ropy deposit
Amt 24 hrs. 3 XXV
Sp. Gr. 1016
Reaction Acid
Albumen Trace by heat + H.NO.3
Sugar. Tested but by Fehlings none.
Microsc. Triple phosphates - pus cells large amount Amor. urates + Mucus bands + a few bladder Epith. Cells

HABITS, Dirty, Clean, Clean Careless,
BOWELS, Normal, Constipated, Irregular,
APPETITE, Good, Good Medium, Poor,
SLEEP, Good, Poor, Irregular,
PULSE, Resp., Temp.,
CRANIAL MEASUREMENTS,
HISTORICAL,
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations,
Father or Pat. Relations,
Brothers or Sisters,

Personal and Medical History of Rose Marsland.

1896

This patient was brought here by Deputy Sheriff A. W. Fuhrman + attended by Annie Fuhrman with following history. Patient is in fair physical condition. There is no history of consanguinity, or heredity. This is not 1st attack; one occurred 2½ years ago; duration continuous: was taken to Rochester Hospital, in Aug. 1893, but there only 3 weeks. First symptoms of this attack manifested a month ago, by hallucinations, religious + concerning her dead child. Disease seems stationary; variable + with rational intervals, at regular intervals. Derangement now shown in that she thinks child that died, was stolen + is now in possession of neighbor. Patient is not dis- posed to injure others, nor suicidal, but is destructive of furniture. No peculiarities had been previously shown. No history of intemperance in self or parents, nor of any severe disease or of head-injury. Don't know cause of disease. No medical treatment. Except as stated. She is now given to talking incoherently, + great excitement: talking at delusions of her.

Note. As above stated, patient was here before. (Vol 14 Page 169 No 3457), + discharged "Recovered". Here, from Aug 31/93 to Sept 20/93: Was improved on leaving. On her first coming, was somewhat excited + restless: slept rather poorly: appetite not very good: after a time, (a few days), she became quiet: ate + slept better: was visited by husband + talked quite freely with him. She however, showed delusions + also hallucinations "of hearing", while here.

Mar 11 On admission, was put on T.D. W. (G. N. R. R't. Complexion fair; hair light: eyes blue: Condition of skin normal: no marks scars or bruises noticed: is clean: behavior quiet: Shows delusions).

Mar 16 Local examination made and treatment given. March 18 - Treatment given. March 23-26th 29th treatments given. April 1-3 treatments given. Improved in mental condition but still has delusions. Has been working on the ward for some time.

April 18 Operation done for repair of cervix. Ether given. Reaction was good. Has been in bed eight days. Apr. 26 up on the ward.

May 2 Patient made a good recovery and is now working every day.

Mar. 14 Where of Note on admission (omitted) Appetite fair. Patient quiet during night. T 98 P 72 R 20. Mar 13 T 98.6 P 74 R 20. Appetite rather poor. Tonic given. Bowels moved. Patient talks quite sensibly at times - Very quiet - Tidy in habits.

" 14 T 98.4 P 72 R 18 Appetite good. Tonic given. Patient sleeps well. Has delusions. Talks a great deal. Bowels moved. Mar 15 98.6 - 72 - 18 Appetite good. Tonic given. Talks to herself a great deal. Mar 16 98.6 - 70 - 18 Sleeps well. Appetite good. Quite noisy at times + has delusions. Neat in habits. Tonic given.

Mar 17 T 98.6 P 72 R 18 Tidy in habits. Talks to herself a great deal at times.

" 18 Appetite good. Tonic given. Patient has delusions. Talks quite sensibly when asked questions. Mar. 24 Assists with work. Takes tonic. Appetite good. Bowels regular. Mar. 30 Has delusions. Quite noisy at times - sleeps well. Menstr. regularly. Apr. 2 Appetite good. Bowels regular. Works on ward. Takes tonic. Apr. 10 Quiet most of time. Goes riding + walking. Has

Personal and Medical History of Rose Marsland.

1896

delusions. Appetite good. Sleeps well. Apr. 18 Put to bed. Operation performed - (See preceding page.) May 15 Appetite fair. Bowels usually constipated. Cathartic given.

Summary Nurse's Notes by Dr. S. L. Phelps:- June 7 Up on ward all the time. Works in dining room: Appetite fair: neat + tidy in habits: threatens to kill herself. July 4 76 Visited by husband: was very cross: became quite desperate: Transf to 64.

Nov. 1897 Works on ward: Quiet: quite melancholy: Jan'97 Usually quiet: rather dull: says little: mildly melancholy: Apparently in fair health: May 97 no special change.

Aug. Assists with ward work: quite melancholy at times: Appetite fair: bowels usually constipated: menstr. regular. Oct 2 Is very restless: Temp. + pulse normal:

Oct 6 Has had some rise of temperature in afternoon; has been put upon tonic: Coughs + expectorates a good deal: Oct 8 Appetite seems good: Coughs + expectorates: Looks quite pale + thin: Put upon eggnogs. Oct 10 Temp. + pulse normal in morning also in afternoon: Eggnog taken: Sitting up in bed part of time. Visited by husband but had very little to say to him: Oct 11 No change.

Oct 15 Temp. + pulse normal: Appetite good: Bowels regular: Up on ward all day: Seems quite melancholy. Continued by Dr. Rm. Phelps. Nov 6 Trans. to 64. Aug 6 98 Temp. Aug 30 98 Trans. to Annex. Feb. 28 99 Condition has been unchanged for the most part during period. Recently became rather restless at annex + was transferred to 52.

1899 June to Sept. Gen'l health fair: appetite usually good: sleeps well: takes out door exercise: neat in habits: very violent at times: works at times on ward.

Sept 1 - Feb 28 1900. Neat + clean: Appetite good: Sleeps well: Violent at times: Has many delusions of persecution: Takes out door exercise: Jan 17. Wt. 113#. Works some on ward. Mch 1 - Aug 31 1900 Violent + destructive at times: usually sleeps well: Bowels usually regular: Works some on ward. July 17 Vaccinated. Sept 1 - Nov 30. No change. Nov. 20 Wt 117½# Dec. - Feb 28 1901 General health good: Wt. 110.# Mar. to June 1901 No change in general condition May 29 Wt. 117#. June to Sept Patient's condition both mental and physical remain unchanged. Aug. 31 Wt. 114#.

Sept to Dec. Patient is in fairly good general health, somewhat emaciated, has enlargement of the Thyroid, eats and sleeps well, menstruates regularly, is vulgar and impudent in her language, has delusions and hallucinations, thinks the nurses have her property, at times will spring upon them without warning, is frequently resistive, occasionally assists a little with work, takes out door exercise, attends no amusements, Nov. 24 Wt. 114#.

December to Feb. 1, '03 No change. Wt about 119#.

Personal and Medical History of Minna Schuremann.

LEIGHT, FICHLER & CHARLES, DAVENPORT, IOWA.

Whole No. 4355.

Residence, St. Paul - Minn:

Date Admission, 17th March 1896.

Admitted by, Dr. B. Eby — Hour, 6:30 P.M.

How Sent, D. Wilrich, Jo. P. Ramsey County.

Sex, Female -

Age, 37

Civil Condition, married

Children, - 5 -

Age Youngest Child, 4 years

Occupation, Housewife: (husband, a tailor)

Degree Education, not educated -

Profession Religion, not a church - member.

Habits, not stated -

Nativity, Germany: (parents also born there)

Physicians Committing, A. G. Nippert & B. L. Paxton

Correspondents, Wm A. Schuremann (Husband)
647 Charles St St Paul



No. for Year, 183.

Insane Relatives, mother's father showed tendency to insanity
father drank heavily —

Cause Exciting, puerperium initial Coitus

Cause Predisposing, probably heredity —

Form,

Accompanying Bodily Disorder, none mentioned

Suicidal or Not, very suicidal

Date of this Attack, 10 years ago

Duration, 10 years off & on

No. of Attack, 3rd (seemingly).

No. of Admissions, 1st

Age First Attack, about 27.

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION

Exam. by Dr. R. M. Phelps 3/19/96 **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:

Clear or Confused, Clear aside from delusions

Quick or Sluggish, Fairly quick

MEMORY:

Past Events, Recent Events, Special Subjects, } fair to all but except delusions.

PERCEPTIVITY:

Alert or Dull, Fairly quick except for

Correct or Illusive, delusions -

REASONING POWER:

Ordinary Subjects, not very poor

Own Mental State, Poor

Special Subjects, Poor

GENERAL DESCRIPTIVE REMARKS:

Has puffiness of hands & slightly under eyelids. Talks only german but answers quietly & intelligently. Talks at times however of need of killing self & claims to think husband is wishing to get rid of her to take another woman.

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted,

Depressed, ✓

DELUSIONS:

Systematized or Not, Fairly Systematized

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

Personal and Medical History of Minna Schuremann.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 2 in WEIGHT, not taken NUTRITION, Appears fair flesh - pale - puffiness of hands & legs

WOUNDS OR ABNORMALITIES,

TONGUE, Tremors, no. Coatings, slight yellow coat Promptness Movement,

PUPILS, Equality, Equal Size,

Response Light, Response Accommodation,

SIGHT, Says good.

HEARING, good

COORDINATION, Arms,

Legs,

TREMORS, Hands, No Notable tremors Tongue,

Facial Muscles, General,

REFLEXES, Patellar, 7-8 equal

Other

ARTICULATION,

Slurred,

Hesitating, Fair

FACIAL EXPRESSION,
Slight melancholia

SENSIBILITY,

HEART, No murmurs. sounds good

LUNGS, Seem normal

TAKEN,

EXAM. URINE, Mar. 19 '96

Color Reddish yellow

Character Flaky deposit

Amt. 24 hrs. XVIII ℥

Sp. Gr. 1031

Reaction Acid

Albumen None

Sugar "

Microsc. Large amount amor. urates. Large amount pus a few blood corpuscles. Large amt. of bladder & vaginal Epith. cells.

GYNAECOLOGICAL EXAM., Uterus pointing normal position Laceration of cervix Erosion of os Laceration of perineum

MENSTRUATION, Very irregular

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal, Not moved since coming (3/19/96)	Constipated,	Irregular,
APPETITE, Good,	Medium,	Poor,
SLEEP, Good,	Poor, 6 hrs. last night	Irregular,
PULSE,	Resp.,	Temp.,

CRANIAL MEASUREMENTS,

HISTORICAL,

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,

HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") denied.

Mother or Mat. Relations, dead

Father or Pat. Relations, dead

Brothers or Sisters, 7 children 5 living two dead

Personal and Medical History of Minna Schunemann

1896

This patient was brought here by Deputy Sheriff W. N. Goss + attended by Wm. Schunemann, with following history. Patient is in fair physical condition. Parents or grand-parents not related. This is not 1st attack: others occurred 10 years + 2 years ago: Duration 2 months and 3 months; never sent to hospital. First Symptoms of this attack manifested 10 years ago, after Confinement: wanted to leave home. Disease appears to be increasing; variable with rational intervals: formerly they occurred at regular intervals, but not now. Derangement now shown by melancholia: Suicidal tendency: Patient is not disposed to injure others, but has attempted Suicide by drowning + with knife: propensity now active. She shows a tendency to destruction of furniture and clothing. Her mother's father showed a tendency to insanity: father drank heavily. No peculiarities had been previously shown: there is no history of any severe disease + no head-injury. She has not been restrained or confined. Puerperium initial cause of the disease. She has been treated by Cold-baths, bromides — On personal Examination, it is found that she is averse to husband: think him untrue: tried Suicide to get away from him.

Mar 17 On admission, was put on B.W. (G.S.W. Kpr. Complexion dark: hair brown, streaked with gray: eyes light blue: condition of skin normal: some bruises about shoulders: is rather dirty: quiet: has delusions)
Mar 18 Nurses Notes — P98 R18 P70 Appetite not very good. Talks quite sensibly when asked questions. Cannot talk English. Did not sleep well. Mar. 19 T 98. P 80 R. 18. Appetite rather poor. Cathartic given — bowels moved. Neat in appearance. Quiet in behavior. Complains some of headache. Mar 20 T 98 P 70 R. 18 Appetite fair. Tonic given 3 times. Appears quite bright. Talks sensibly when asked questions. Has delusions at times. Mar 21 T 98.8 P 72 R 18 Tonic + cathartic given. Appetite fair. Tidy in habits. Very quiet. Mar 22 T 98 P 72 R 18 Appetite fair. Tonic given 3 times. Complains of headache + of being quite nervous. Quiet in behavior. Mar 23 - 98.8 - 72 - 18 Appetite fair. Tonic given. Very quiet in behavior. Seems to feel rather down cast. Mar 24 98.8 - 72 - 18. Appetite very good. Cathartic + tonic given. Tidy in habits. Complains of headache. Seems to talk quite sensibly. Mar. 31 During second week Tonic given 3 times daily. Appetite good. Bowels regular. Very quiet. Neat in appearance. Does not talk much. Seems rather downhearted. Sleeps quite well.
Summary Patient very quiet + rather melancholy. Talks very little — does not speak English. Appetite good — Tonic given daily. Complains of headaches at times. Very neat in habits + appearance. Bowels rather irregular. Sleeps well.
Apr. 10 Very quiet. Assists with work some. Appetite good. Sleeps rather poorly. Menstr. regular. Apr 26 Seems to feel rather depressed most of time. Does not talks much. Sleeps fairly well. Appetite good.
May 8 Quiet. Seems to feel depressed. Sleeps well. Appetite good. Bowels to A.1. Treatments Apr 27 - 29 May 1 - 4. May 16 Menstr. May 29 menstr.
" 30 Seems depressed. Talks very little but sensibly. Physical health good

Personal and Medical History of Minna Schunemann.

1896

Appetite fair. Sleeps well. At times wanders a little onward. Goes riding + walking. Treatments every other day during month.

June Summary Nurse's Notes by Dr. L. L. Phelps: Inclined to be melancholy: speaks only when addressed: of late refuses to go out of doors: Appetite fair: physical health good.
Nov. Very melancholy: no special change: Jan '97 Appetite rather poor: very melancholy: At times very cross + stubborn: resists all treatments: never works or takes any interest in anything: May '97 No change: Aug '97 Fights at times: refuses to go out of doors: very stubborn. Continued by Dr. R. M. Phelps. Patient violent today in dining room: broke dishes. Always quiet + dull but rather uncertain in behavior. Feb 4 '98. Wt. 115.
Aug 6 '98. Wt 115. Sept. 1 Trans. to B 3. Is very apt to be violent occasionally. Feb 25 Wt. 116. Behavior always uncertain + irritable. (Rept. by Dr. R. A. Bebb) Mens. to Sept '99 General health fair: appetite usually good: sleeps well: takes out door exercise: menses regular: careless in appearance: resists when bathed + wipes hair is combed: talks + scolds to self at times + is quite noisy: July 26 - Aug 2. Refused to eat + fed with tube: very much depressed. Aug. 29 Wt. 115#
Sept 1 - Feb 28 1900. Untidy in appearance: at times destructive: Takes out door exercise: Menstruates regularly. Noisy + violent when disturbed. Jan 17 Wt 117#
Mch 1 - Aug 31 1900. Usually noisy + resistive when bathed: very stubborn. General health good: eats + sleeps well. July 21 Vaccinated. Sept 1 - Nov 30, No change. Wt. 107# Dec 1 - Feb 28 1901 - No change. Health fair: behavior the same.
Mar. to June 1901 Shows no change in general condition. May 29 Wt. 109½#. June to Sept Patient's mental and physical condition remains the same. Aug. 30 Wt. 101#.
Sept to Dec. Patient is thin and pale, does not complain of any sickness, appetite fair, sleeps well, seldom takes out door exercise, untidy in habits, menstruates regularly, is quarrelsome and resistive and sometimes disturbed mentally. Nov. 30 Wt. 106 3/4#
Dec. to Feb. 1 '03 No change. Wt about 107. #

Personal and Medical History of Rosie Rabel

LIBBEY, PISLAR & EGGBERS, DAVENPORT, IOWA.

Whole No. 4357.
Residence, Rochester, Minn.
Date Admission, 25th March 1896.
Admitted by, D. Phelps. Hour, 11 Am.
How Sent, Thomas Fraser. (of P. Olmsted County
Sex, Female
Age, 54.
Civil Condition, single
Children,
Age Youngest Child,
Occupation, Housekeeper (father's farmer)
Degree Education, Common School.
Profession Religion, Yes: Catholic.
Habits, probably good.
Nativity, Germany. (Parents also born there)
Physicians Committing, H. H. Witherstine & Chas. Graham
Correspondents, The "Sisters"

No. for Year, 185.
Insane Relatives, not known
Cause Exciting, Do not know.
Cause Predisposing, chronic: previous attk.
Form,
Accompanying Bodily Disorder, none mentioned
Suicidal or Not, — not —
Date of this Attack, about Feby 1st
Duration, — about 6 weeks —
No. of Attack, not 1st (1st Continuous?)
No. of Admissions, 2nd.
Age First Attack, about 52.
Time of Leaving, July 25. 1896
Time in Hospital, 4 mo.
Result, Discharged Feb. 3 '97. Unimproved

EXAMINATION ON ADMISSION

Exam by R. M. Phelps & Ed. Phelps 3/26/96

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Fairly clear.
Quick or Sluggish, Quick
MEMORY:
Past Events, } Seems good
Recent Events, }
Special Subjects, }
PERCEPTIVITY:
Alert or Dull, Alert
Correct or Illusive, Incorrect at times
REASONING POWER:
Ordinary Subjects, Fair
Own Mental State, Poor
Special Subjects, "
GENERAL DESCRIPTIVE REMARKS:
Atheroma - Quite decided.
Headaches.
Claims not sick. Talks quite clearly. Has no sickness known of "Only my trouble" - Paranoia

EMOTIONAL STATE:
Normal, Calm, Calm or Slightly depressed
Indifferent,
Exalted,
Depressed,
DELUSIONS:
Systematized or Not,
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

With atheroma seems a fairly correct diagnosis

Personal and Medical History of Rosie Rabel

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, Not Taken WEIGHT, Not Taken NUTRITION, Fair
WOUNDS OR ABNORMALITIES,
TONGUE, Tremors, Coatings, Promptness Movement, Prompt. Slight deviation to left.
PUPILS, Equality, Equal Size, Normal
Response Light, Respond - Slight Sluggishness Accommodation,
SIGHT, Uses glasses for near sight
HEARING, Thinks good.
COORDINATION, Arms, Good
Legs, "
TREMORS, Hands, Some days is worst Tongue,
Facial Muscles, General,
REFLEXES, Patellar, Normal Right
Other Cremasteric most.
ARTICULATION,
Slurred, Fairly clear & prompt
Hesitating,
FACIAL EXPRESSION,
Slightly depressed.
SENSIBILITY,
HEART, Normal.
LUNGS, Normal.
GYNAECOLOGICAL EXAM.,
MENSTRUATION, Ceased.
OPHTHALMOSCOPIC EXAM.,

TAKEN,

EXAM. URINE, Mar. 27/96
Color, Brownish Red.
Character, Cloudy
Amt. 24 hrs. XVIII
Sp. Gr. 1030
Reaction, Acid.
Albumen, None
Sugar, "
Microsc. Large Amt. Amor. urates a few pus & bladder cells.

HABITS, Dirty,	Clean, Clean	Careless,
BOWELS, Normal,	Constipated,	Irregular,
APPETITE, Good,	Medium,	Poor,
SLEEP, Good,	Poor, Very	Irregular,
PULSE,	Resp.,	Temp.,

CRANIAL MEASUREMENTS,
HISTORICAL,
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Denies any insanity
Mother or Mat. Relations, Died stomach trouble.
Father or Pat. Relations, Dead
Brothers or Sisters,

Personal and Medical History of Rosie Rabel.

1896

This patient was brought here by Sheriff Stewart, attended by "Sisters", with following history. — Patient is in fair physical condition. There is no history of consanguinity; as to heredity, not known: This is not 1st attack: She had one in Feby 11th 1895, lasting about 5 weeks: was at this (Rochester) Hospital & was dismissed, through request. First symptoms of this attack were manifested about Feby 15th: became very suspicious: the disease seems increasing: variable & she has rational intervals, but not at regular interval. Derangement now shown in that she complains of ill-treatment and insufficient food. Patient is disposed to injure others, but not suicidal: no filthy or destructive habits. Previously, she showed religious impressions: as to any history of intemperance &c do not know, nor as to any severe disease &c or head-injury. She has not been restrained or confined, (this time). Do not know cause of disease. Has had no particular treatment, during this attack: Nothing further in particular observed during her personal examination —

Note. Patient here before, from Feby 11/95 to March 19/95: (See Vol. 28 Pg 81 No 3997): At that time supposed cause of disease was given as Melancholy: In former attack was chronic, depressed, paranoiacal, delusional: It was 1st attack, continuous there for 4 years: She also showed "hallucinations" of hearing", at that time. For some days, after then coming, she slept very poorly: was quite nervous: depressed, & had frequent "Crying spells": kept in her room most of the time: (was often visited by "Sisters"): Showed delusions of persecution" — after a time, she began to make some improvement, and was then taken home, by request. —

Mar 25 On admission was put on A.W.G.H.N.R'ft. Complexion dark: hair dark & partly gray: eyes brown: Cognition of Kin normal: no marks, scars or injuries noticed: is clean: behaves quiet: talks sensibly.

Mar 26 Nurses Notes Quiet. Appetite poor - Talks sensibly. Did not sleep any during night.

" 26 T 99.4 P. 78. R. 18 Quiet. appetite poor - slept about 5 hrs. during night. Mar 27 T 99 P. 80 R 18 T 99.4 80 - 20. Slept most of night Appetite Poor - talks sensibly - Bowels generally constipated Takes tonic & cathartic Mar 28 T 98.6 P 76 R 20. Appetite poor Talks sensibly. Takes tonic Slept well during night. T 99. P 84 R 20.

Mar 29 T 98.8 P 84. R 20 Appetite very poor Quiet - sensible - Tonic given. Slept well - Bowels constipated.

" 30 98.6 P 78 R. 20 Appetite very Poor. Takes tonic Slept well. T 99.2 P 82 R 18

" 31 99 - 80 - 18 Appetite very poor takes tonic sleeps well. 99.8 - 78 - 20

Apr 4 During second week no change noted. Appetite poor usually sleeps well. tonic given. Bowels usually constipated.

Summary Since admission patients' appetite has been very poor - Tonic given daily - Sleeps well - Bowels usually constipated. Cathartics given Very quiet & talks sensibly. Wants same on ward.

Apr 5 Very quiet & Melancholy in behavior. Appetite very poor, sleeps fairly well Bowels constipated. Takes tonic. Apr. 20 Visited by Sisters of Charity.

May 7 Visited by the Sisters Ate but one small meal today. May 8 Visited by Sisters ate three small meals. May 12 Fed with tube. Is growing thin Works in sewing room most of times June 1 Quiet & Melancholy: Appetite poor Usually takes a mixture of egg & milk instead of meals. Has delusions. Bowels constipated - Sleeps well. Takes out door exercise. Takes Tonic. Visited

Personal and Medical History of Rosie Rabel.

by Mother Matilda

July 4 In bed - is very weak: Has bowel trouble. July 17 Still in bed: seems a little better: Visited by the Sisters July 18 Visited by Sisters July 22 Electrical treatment Bath given. 25 Electrical treatment. July 27 Up on ward but is very weak - diet consists chiefly of milk - Takes eggnogs twice a day.

1895 Went Home.

Discharged

Personal and Medical History of Rosa Sinbach

LEIGHTY, PUGLAR & GARRETSE, DAVENPORT, IOWA.

Whole No. 4358

Residence, St. Paul Minnesota

Date Admission, 25th March 1896

Admitted by, Dr. Seeger — Hour, 5 PM.

How Sent, G. Wilbrich. Supt. Ramsey County.

Sex, - Female -

Age, - 20 -

Civil Condition, Single

Children,

Age Youngest Child, —

Occupation, Domestic

Degree Education, Fairly educated

Profession Religion, R. Catholic

Habits, not intemperate

Nativity, U.S. (parents born in Germany)

Physicians Committing, E. C. Eckelby and A. B. Ancker

Correspondents, nine given in papers

No. for Year,

Insane Relatives,

Cause Exciting,

Cause Predisposing

Form,

Accompanying Bod

Suicidal or Not,

Date of this Attack

Duration,

No. of Attack,

No. of Admissions,

Age First Attack,

Time of Leaving,

Time in Hospital,

Result, Disch

EXAMINATION ON ADMIS

MENTAL CHARACTERISTICS

MENTAL ACTIVITY:

Clear or Confused, Appears clean but

Quick or Sluggish, Sluggish

MEMORY:

Past Events, Seems good

Recent Events, " "

Special Subjects, " "

PERCEPTIVITY:

Alert or Dull, Somewhat dull

Correct or Illusive, Seems correct

REASONING POWER: Fair

Ordinary Subjects, "

Own Mental State, "

Special Subjects, "

GENERAL DESCRIPTIVE REMARKS:

Has a good deal of headache -
Seems clear but dreamd - Holds something back
Wont speak freely - Will not speak of jumping off
bridge - Denies that she did - Denies knowing

EMOTIONAL STA

Normal, Calm,

Indifferent,

Exalted,

Depressed,

DELUSIONS:

Systematized or N

Special Subjects,

Transitory or Not,

HALLUCINATION

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent, reluctantly

When any of brothers + sisters are -
2 Brothers + 4 Step-sisters

SEEKS DEATH ON HIGH BRIDGE

2/1/96

UNKNOWN GIRL STRUGGLES WITH HER RESCUER.

Matt Rulim Prevents a Maiden From Dashing Herself to Certain Death —She Desired to Imitate "Dottie" Lamb, Who Leaped From the Bridge Recently—The Would-Be Suicide Refused to Disclose Her Identity or the Reasons for Her Rashness.

The suicidal craze among women is spreading. Last evening another member of the sex, who imagined that her burdens were greater than she could bear, attempted to end all by jumping from the high bridge. She had read about Dottie Lamb, and wished to imitate her. The attempt was unsuccessful. Matt Rulim, a driver for the American stove repair works at 188 West Seventh street, saved her. The girl's name is unknown.

It was about 6:30 o'clock last night when Rulim drove up to the door of the central police station. Perspiration was rolling off the man's face and he puffed like a porpoise. In the wagon was a girl of about twenty years, dark eyed and handsome. Rulim had been struggling with her. Officers gave the driver a helping hand and the young woman was placed in the women's department of the cell room. Then Rulim told his story. He said that a few minutes before 6 o'clock he was driving across the high bridge after making a delivery on the West side. It was not very dark and as he looked ahead he saw a woman sitting astride of the railing on the east side of the structure. She was facing the other way and did not see him. Rulim whipped up his horse and soon came within a few rods of the figure. She did not appear to hear him. Every moment the driver thought she would take the fatal plunge. He was in agony for fear he would be too late to save her. Quickly dismounting from his wagon he rushed upon the girl and seized her around the waist. She struggled fiercely. He pulled her from the railing and after much effort placed her in his wagon. During the struggle the girl was was exclaiming, "I shall do it in spite of you. I shall kill myself." But she didn't, Rulim was too strong for her.

Putting the whip to his horse he started on a brisk pace for the police station. When he arrived the woman was put under the charge of Matron Cummings. Lieut. Murphy interviewed her with far more success than the reporters. She told him that she had been employed as a domestic by a Mrs. Berkman, who lived in the Berkman block on Sixth street. Unfortunately, her story ran, she had broken a watch and could not pay for the repairing of it. She had lost her position, but another had been offered her if she could provide herself with a dress for dining room work. That dress, and all others, were in her trunk, which was being held for the payment of the damage to the watch. Such was the girl's story to the lieutenant.

Careful investigation discloses that there is no Berkman living in either of the Berkman blocks on Seventh street. Neither is there a woman who has just discharged a domestic answering this girl's description. So that part of the story

Seems to Be a Myth.

The girl at first would not talk to the Pioneer Press reporter. She kept her face averted and refused to answer all questions. "I have nothing to say," was all that could be elicited. Finally, however, she looked at Mrs. Cummings, the matron, who was sitting in the room. That lady was smiling at the efforts of the newspaper man, and seeing it the girl burst into a merry laugh. That broke the ice. [illegible] took her hands from her face for the

Personal and Medical History of Rosa Sinbach

DR. ARTHUR B. ANCKER, Superintendent and Physician and Surgeon in Charge.

Form No. 5.

Register No. 13418

THE CITY AND COUNTY HOSPITAL,

SOCIAL HISTORY SHEET.

Hour 3 P. M. ST. PAUL, MINN. Mar 19th 1896

Name Rosa Sinbach Sex Female Age 20 years

Nationality U.S. Color White

Occupation Domestic Religion Catholic Single, ~~Married, Widowed.~~

Resident of St. Paul or Ramsey County for (Six) 6 years

Former Residence Wisconsin, (Arcadia)

Address at time of admission 474 Wabasha St. St. Paul, Minn.

Employment at time of admission, name of employer and wages

Nurse girl for Mrs Grock. $10.00 per month.

Amount of wages due, income or other means None

Insurance or other benefits None

Money or personal effects left in charge of Mrs Anne Grock (Friend)
474 Wabasha St.

Address of nearest relatives or friends See above.
Address of Relatives unknown

If in Hospital before, when? No

Cause of admission

Admitted by Dr. Ancker Assigned to Dr. Riggs

Brought to the Hospital by St Car

From County Jail

Persons in charge of patient Mrs Eccles "Matron of Jail"

Cash, $ 0 Watch No. 0 Baggage check No. 0

Other valuables 0

REMARKS: If non-resident, state cause of admission. If hospital account to be paid, state rate, etc. This woman had been arrested - the 2nd time - for an alleged attempt to jump

Interne

HISTORICAL;

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,

HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")

Mother or Mat. Relations, died Typhoid fever.

Father or Pat. Relations, Dead

Brothers or Sisters, 7 brothers.

by good.

prompt

d

URINE, Mar. 27'96.
dish Yellow.
ts flaky Sediment
1022
Acid.
Acid.
8/10.03 + by Esmarchs
None.
matics. large amount

ceramics and
ndian Ro Jam

Personal and Medical History of Rosa Sinbach

LIBBEY, PUSLAR & GOSSRICH, DAVENPORT, IOWA.

Whole No. 4358.
Residence, St. Paul Minnesota
Date Admission, 25th March 1896
Admitted by, Dr. Herzog — Hour, 5 P.M.
How Sent, G. Wilbrich Supt. Ramsey County
Sex, Female
Age, 20
Civil Condition, single
Children,
Age Youngest Child, —
Occupation, Domestic
Degree Education, Fairly educated
Profession Religion, R. Catholic
Habits, not intemperate
Nativity, U.S. (parents born in Germany)
Physicians Committing, E. C. Eckelby and A. B. Ancker
Correspondents, none given in papers

No. for Year, 186
Insane Relatives, unknown.
Cause Exciting, not stated.
Cause Predisposing, not stated
Form,
Accompanying Bodily Disorder, head injury (?)
Suicidal or Not, very suicidal: (also homicidal).
Date of this Attack, about 3 weeks ago (?)
Duration, about 3 weeks.
No. of Attack, unknown
No. of Admissions, 1st then (has been in St C Hospt)
Age First Attack, (?)
Time of Leaving, Dec. 7-96
Time in Hospital, 9 mo 12 da.
Result, Discharged May 5-97. Improved.

EXAMINATION ON ADMISSION
MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Appears clean but
Quick or Sluggish, sluggish
MEMORY:
Past Events, Seems good
Recent Events, " "
Special Subjects, " "
PERCEPTIVITY:
Alert or Dull, Somewhat dull
Correct or Illusive, Seems correct
REASONING POWER: Fair
Ordinary Subjects, "
Own Mental State, "
Special Subjects, "

EMOTIONAL STATE:
Normal, Calm, Calm
Indifferent,
Exalted,
Depressed,
DELUSIONS:
Systematized or Not, None detected
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent, Coherent Talkative
Voluble or Reticent, reluctantly

GENERAL DESCRIPTIVE REMARKS:
Has a good deal of headache -
Seems clear but dreamd - Holds something back
Wont speak freely - Will not speak of jumping off
bridge - Denies that she did - Denies knowing
Where any of brothers + sisters are -
2 Brothers + 4 Step-sisters

Personal and Medical History of Rosa Sinbach

DR. ARTHUR B. ANCKER
Superintendent and Physician and Surgeon

THE [illegible] COUNTY HOSPITAL,

Register No. 13418

SHEET.

ST. PAUL, MINN. Mar 19th 1896

Hour 3 P.
Name Rosa S[illegible]
Nationality U.S.
Occupation Domes[illegible]
Resident of St. Paul or Ra[illegible]
Former Residence W[illegible]
Address at time of admiss[illegible]
Employment at time of ad[illegible]
Nurse girl f[illegible]
Amount of wages due, inc[illegible]
Insurance or other benefits
Money or personal effects
474 Waba[illegible]
Address of nearest relati[illegible]
Ad[illegible]
If in Hospital before, whe[illegible]
Cause of admission
Admitted by Dr. An[illegible]
Brought to the Hospital b[illegible]
From Comm[illegible]
Persons in charge of pati[illegible]
Cash, $ 0
Other valuables 0
REMARKS: If non-resi[illegible]
has arrest[illegible]
to jump

Sex Female Age 20 years
[illegible]ite
[illegible]atholic Single, ~~Married, Widowed.~~
6 years
[illegible]dress)
[illegible]a St. St. Paul. Minn.
Wages $10.00 per month
[illegible]e
[illegible]e
[illegible]me Gooch (Friend)
[illegible]bor,
[illegible]tives unknown
Signed to Dr. Riggs
[illegible]les Matron of Jail
Baggage check No. 0
paid, state rate, etc. This woman had
for an alleged attempt
Interne

first time and looked at the reporters defiantly. "I shall not tell you my name," she said in very good English—she admitted that she was a Bohemian—"for then no one in the city would hire me." Those present tried to convince her that her name would be learned anyway, and the best plan was to tell it. But that she would not do.

By dint of much questioning she made a few statements regarding herself. She had known Dottie Lamb, the girl who threw herself from the high bridge some weeks ago. It was a year or so ago that she had met Miss Lamb. Rosa—that was one of the several names she gave as hers—had worked for a family living a mile or so east of Castle Rock. It will be remembered that Miss Lamb's parents resided near the village. From certain things that Rosa dropped it seemed possible that she had lived in that part of the state. She would not say when nor with whom.

Had she relatives in the city? Rosa said not. She had neither kith nor kin to care whether she jumped to death from the high bridge or kept on living. But she had a friend; a very dear lady friend to whom she had written a letter telling all. Rosa did not know exactly what had become of that letter. She had intended to mail it, but remembered that she had it in her hand as she sat upon the iron rail of the bridge. It had fluttered down when the struggle with Rollin began. Lieut. Murphy sent Officer Haggerty to look for it. He searched for two hours with a lantern and gave up the search.

Rosa said that she had addressed the letter to the friend mentioned. It contained the story of her troubles. It also contained a most peculiar request—that the friend would attend the funeral and see that she (Rosa) was dressed right. If that letter is ever found, the secret of the girl's identity will come out. The young woman said that she had never had a lover in her life. She would not tell her age.

Awaits Identification.

The woman spent the night at the central station. It is exceedingly doubtful if a charge of any sort will be preferred against her. She appears to be about nineteen or twenty years of age. Her hair and eyes are black. She has regular features and a rich brunette complexion. Her teeth are somewhat irregular, the two incisors of the upper jaw being somewhat prominent. A dimple appears in each cheek when she smiles, as she did frequently while being interviewed last night. Taken all together, she is a pretty girl. Her height is, perhaps, a little above the average, and her weight about 130 pounds. She was dressed in a black felt hat, tan colored jacket, short in length, with dark pearl buttons and lining of brown woolen goods. Her waist was of some light material of rather yellowish color. It resembled crepon. The sleeves of both the dress and the jacket were full. Rosa's skirt was black. She had on a pair of almost new shoes with diamond-shaped patent leather tips. She also wore black gaiters. The front yoke of her dress was of bright red silk. The belt was of black web, with a small buckle. There was a white silk handkerchief around her neck, but it bore no initial. In the small inner pocket of her jacket was a neat imitation morocco purse, square and fastened with a clasp. It contained a piece of silk, a point to a glass stylus and three pennies. The young woman was very neat in appearance.

During the evening she told several conflicting stories about herself. Upon being interrogated she said that she had read all about the suicide of Dottie Lamb. If Dottie felt the way she did, she remarked, then there was justification for self-destruction. Rosa admitted that she firmly intended to kill herself. She had thought about it for months, she said, and had even taken several trips across the high bridge. The point that seemed best suited for her purpose was between the road which runs along the flats and the edge of the river. She did not want to jump onto the ice for fear it would break. When asked why she did not jump when she had once climbed upon the railing she replied that it was not dark enough. It was her plan to stand on the rail and then jump. The girl talks in a seemingly rational way.

[illegible] URINE, Mar. 27/96.
[illegible]dish Yellow.
[illegible]e flaky Sediment
[illegible]022
[illegible]drot.
[illegible]Acid.
[illegible]Nos + by Lancets
None.
[illegible]crates. Large amount
[illegible]ceanine and
[illegible]culum No pain

HISTORICAL,
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, died Typhoid fever.
Father or Pat. Relations, Dead.
Brothers or Sisters, 2 brothers.

Personal and Me

LIBBEY, PISCAR & RAMBERG, DAVENPORT, IOWA.

Whole No. 4358

Residence, St. P

Date Admission, 25-

Admitted by, Dr L

How Sent, G W

Sex,

Age,

Civil Condition,

Children,

Age Youngest

Occupation,

Degree Ed

Professior

Habits,

Nativ

Phy

Cr

Recent

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Somewhat dul

Correct or Illusive, Seems correct

REASONING POWER: Fair

Ordinary Subjects, "

Own Mental State, "

Special Subjects, "

GENERAL DESCRIPTIVE REMARKS:

Has a good deal of headache-
Seems clear but dreamd- Holds something back
Wont speak freely- Will not speak of jumping off
bridge - Denies that she did - Denies knowing

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During the evening she told several conflicting stories about herself. Upon being interrogated she said that she had read all about the suicide of Dottie Lamb. If Dottie felt the way she did, she remarked, then there was justification for self-destruction. Rosa admitted that she firmly intended to kill herself. She had thought about it for months, she said, and had even taken several trips across the high bridge. The point that seemed best suited for her purpose was between the road which runs along the flats and the edge of the river. She did not want to jump onto the ice for fear it would break. When asked why she did not jump when she had once climbed upon the railing she replied that it was not dark enough. It was her plan to stand on the rail and then jump. The girl talks in a seemingly rational way.

Slips on No. 1 Nothern recorded being a 60%c
[illegible] difference of 2 under. Also Jones was fifty

Personal and Medical History of Rosa Sinback

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 4½in WEIGHT, not taken NUTRITION, Fairly good.

WOUNDS OR ABNORMALITIES,

TONGUE, Tremors, No. Coatings, White coating Promptness Movement, Prompt

PUPILS, Equality, Equal Size, Normal

Response Light, Responds Accommodation, Responds

SIGHT, Near used glasses

HEARING, Says can hear well.

COORDINATION, Arms,

Legs,

TREMORS, Hands, None noted Tongue,

Facial Muscles, No General,

REFLEXES, Patellar, Normal

Other

ARTICULATION,

Slurred, Good

Hesitating,

FACIAL EXPRESSION,

Near Normal

SENSIBILITY,

HEART, Normal

LUNGS, Normal

TAKEN,

EXAM. URINE, Mar. 27'96.

Color Reddish Yellow.
Character White flaky Sediment
Amt. 24 hrs. 1022
Sp. Gr. Varies.
Reaction Acid.
Albumen Trace by HNO_3 + by Tanrets
Sugar. None.
Microsc. Amor. urates. large amount pus.

GYNAECOLOGICAL EXAM., Uterus in normal position Some hypersemia and discharge External genitals excoriated
MENSTRUATION, Menstruation irregular No pain

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean, ✓	Careless,
BOWELS, Normal,	Constipated, ✓	Irregular,
APPETITE, Good, ✓	Medium,	Poor,
SLEEP, Good, 4 hrs. last night	Poor,	Irregular,
PULSE,	Resp.,	Temp.,

CRANIAL MEASUREMENTS,

HISTORICAL,

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,

HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")

Mother or Mat. Relations, died Typhoid fever.

Father or Pat. Relations, Dead.

Brothers or Sisters, 7 brothers.

Personal and Medical History of Rosa Sinback

Personal and Medical History of

1896

This patient was received here, at the hands of Deputy Sheriff M. N. Goss, attended by Drs. F. J. Decker, with following history. Patient is in fair physical condition. As to consanguinity or heredity, unknown. Of 1st attack, is unknown. Was in the City & County Hospital from Mar 20/96, until today. (See attached Hospital Record). First Symptoms of attack manifested by an attempt to jump off the High Bridge. Derangement now shown by her having a homicidal mania: is not disposed to injure others. Has attempted suicide as above, & propensity now active. There is no disposition to filthy or destructive habits. Examiners are not familiar with her history. There is no history of intemperance in self or parents, nor of any severe disease &c. Supposed Cause of disease not given. She has had no medical treatment. On her examination she was non-communicative, though she said she fell off a Cable-Car, 3 years ago, & hurt her head: laid in bed, ten weeks.

Mar 25 On admission, was put on B³ W (G.H.N.R.P.). Complexion dark: hair dark brown: eyebrows. Condition of skin normal: no marks, scars or bruises noticed: is rather dirty: no bodily peculiarities noted. Behavior quiet: talks sensibly).

Mar 26 Nurses Notes T. 98.8 P. 80 R. 20 Appetite fair. Is very quiet. Bowels constipated
" 27 T. 98 P. 74 R. 18 Appetite fair. Cathartic & tonic given. Complains of being quite nervous also of headache. Does not sleep very well. Mar. 28 98.8 P & R. 18
Appetite good. Tonic given 3 times daily Bowels moved. Patient very quiet. Cries a great deal & feels downcast. Very nervous. Mar. 29 Appetite good. Tonic given Bowels moved. Very neat in habits. Very quiet. Sleeps very poorly. Mar. 30 Appetite good. Tonic given. Does not like to have anyone talk to her. Mar. 31 T. 98.6 P 72 R 18. Appetite good
Apr 1 Tonic & cathartic given Talks very sensibly. Sleeps very poorly. Very nervous at times Neat & tidy. Very quiet Sleeps poorly Bowels moved. Apr. 8 During second week. Appetite good. Tonic given. Cathartic given once. Bowels irregular. Very quiet & talks sensibly. Sleeps fairly well. Went out walking once.

Summary Patient is very nervous at times. Reticent, talks sensibly but very little. Appetite fair. Tonic given daily. Cathartics occasionally. Bowels irregular. Sleeps fairly well. Stays in room a good deal.

Apr 30 Nurses Notes. May 14 Quiet. Talks sensibly. Assists some with work. Takes out door exercise. Appetite good. Sleeps well. Bowels irregular Takes cathartics. Temp. & P. 1. May 30 Quiet & agreeable on ward. Talks sensibly. At times walks a little on ward. Appetite good. Sleeps well. Takes out door exercise. Gym. treatment during month. Every other day. Summary Nurses Notes by Dr. S. L. Phelps:
June Quiet & pleasant on ward: talks sensibly: works some on ward: appetite good: Nov. 96 Quiet health good. no change: Dec. 96 Went Home Was apparently well both physically & mentally: Appetite was good: slept well: Worked some in dining-room.

Discharged.

Personal and Medical History of Nora Lawler

LESLEY, FOLLAN & GAMBERTS, DAVENPORT, IOWA.

Whole No. 4367

Residence, St. Paul Minnesota.

Date Admission, 27th March 1896.

Admitted by, Dr. Phelps Hour, 6 (11th) P.M.

How Sent, G. Willrich, Jo P. Ramsey County

Sex, Female

Age, - 33 -

Civil Condition, married

Children, Three

Age Youngest Child, one year, in March 29/96.

Occupation, - Housewife - (husband, clerk)

Degree Education, Common School.

Profession Religion, Yes: Catholic.

Habits, Probably good.

Nativity, Ireland: (Parents also born there)

Physicians Committing, Vincent J. Hawkins & W. L. Briggs

Correspondents, none given in papers

No. for Year, 190.

Insane Relatives, None

Cause Exciting, Worry

Cause Predisposing, not given

Form,

Accompanying Bodily Disorder, None mentioned

Suicidal or Not, - Not -

Date of this Attack, a week ago

Duration, - a week -

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, - 33 -

Time of Leaving, Apr. 16'96

Time in Hospital, 20 da.

Result, Disc. Apr 3/96 Rec.

EXAMINATION ON ADMISSION

MENTAL CHARACTERISTICS.

Exam. Dr. Phelps 3/29/96

MENTAL ACTIVITY:

Clear or Confused,

Quick or Sluggish,

MEMORY:

Past Events,

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull,

Correct or Illusive,

REASONING POWER:

Ordinary Subjects,

Own Mental State,

Special Subjects,

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted,

Depressed,

DELUSIONS:

Systematized or Not,

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Quiet mentally + fairly clear just now. Calm - Claims to not know much of her excitement of last night - Is suspicious of us however + claims her husband is only a soul - She is deaf - Was extremely excited on admission last evening. Was put in restraint sheet. Is quiet + fairly composed today. Thursday evening she went to church seeming fairly well - Suddenly she got excited + noisy in church - Thinks her husband is killed - that some of her relations are against him + her etc. Husband says these suspicious ideas date back a week or more but they had not thought of her as crazy

Personal and Medical History of Nora Lawler

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, Not taken WEIGHT, Not taken NUTRITION, Good

WOUNDS OR ABNORMALITIES,

TONGUE, Tremors, None of note Coatings, Promptness Movement,

PUPILS, Equality, Equal Size, Slightly dilated

Response Light, Accommodation,

SIGHT, Good

HEARING, Good

COORDINATION, Arms, Probably good - in bed

Legs,

TREMORS, Hands, None of note Tongue,

Facial Muscles, General,

REFLEXES, Patellar,

Other

ARTICULATION,

Slurred,

Hesitating, Good

FACIAL EXPRESSION, Good

SENSIBILITY,

HEART, Sounds good

LUNGS, Good

TAKEN,

EXAM. URINE, Mar. 31/96

Color Yellowish, Sed.

Character Pinkish flaky deposit

Sp. Gr. 1030

Reaction Acid

Albumen None

Sugar "

Microsc: Amor. urates - large amount of blood, pus + bladder cells.

GYNAECOLOGICAL EXAM., Normal Question of criteria. Normal condition in many. Has three children. Labors easy -

MENSTRUATION, Normal, -

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean, ✓	Careless,
BOWELS, Normal,	Constipated,	Irregular,
APPETITE, Good,	Medium,	Poor,
SLEEP, Good,	Poor,	Irregular,
PULSE,	Resp.,	Temp.,

CRANIAL MEASUREMENTS,

HISTORICAL,

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,

HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") denied by self + husband -

Mother or Mat. Relations,

Father or Pat. Relations,

Brothers or Sisters,

Personal and Medical History of Nora Lawler.

1906

This patient was received here at the hands of Deputy Sheriff M. N. Goss & her husband with following history of case. Patient is in fair physical condition. No history of consanguinity or heredity. This is 1st attack: symptoms manifested a week ago: by worry: suspicional homicidal: (this as written in Commitment papers). The Disease seems increasing: not variable: no rational intervals. Derangement now shown in regard to religion: she became violent and destructive at Church, last evening. She is disposed to injure others, but not suicidal: no filthy habits. No peculiarities had been previously shown. There is no history of intemperance in self or parents, nor of any severe disease &c. She has not been restrained or confined. The supposed cause of the disease is worry. No medical treatment. She is violent & abusive.

Mar 27 On admission was put on C.W. (G. Str. Rt. Complexion fair: hair auburn: eyes gray: condition of skin normal: no marks noticed - Rather dirty. Very maniacal - (was brought there in Muff). Was incoherent last night, but talks more sensibly (this am).

" 27 Nurses Notes Refused food. Very disturbed, noisy & violent. Hot bath given - seemed quieter after. Quiet all night in restraint. Mar. 28 In bed and out of restraint: Quiet all day Refused to eat but drank a glass of milk - Has delusions - Quiet all night. Bowels moved. Mar. 29 Ate slice of toast & drank cup of tea: Bowels constipated: Quiet during the day - Rested well all night. Mar. 30 98.6 P. 72. R. 20 Refused food - Quiet all day. Habits clean: Has delusions - Does not care to have anyone in her room. Rested well during night. Mar. 31 98.6 P. 72 - R. 18 Refused food - Fed with tube; did not resist but vomited about 20 minutes after feeding. Bowels moved. Rested well during night. Apr. 1 Refused food. Fed with tube Vomited while being fed - Quiet all day Fed with tube at 6.30 Vomited some: In bed. Quiet all night. Apr. 2nd Refused food. Fed with tube - Quiet all the time: Has delusions - In bed - Quiet all night. Apr. 3 Refused food Drank glass of lemonade & cup of tea. Seems some brighter & talks rationally In bed - Rested well during night. Apr. 4 Refused food. In morning ate dish of rice & supper: Talks very rationally - 10.30 Visited by husband's father seemed much better after he left. said she wanted eat now - 1.30 Up & dressed - Went out for short walk in afternoon. Has. & B. 1. Slept about 2 hours - Quite restless & nervous. Apr. 5 Up on ward - Talks very rationally Bowels constipated - Slept & ate well. Apr. 6. Cathartic given - Quiet & pleasant in appearance Appetite good - Slept well during night. Bowels moved. Apr. 7 Has very much improved: So agreeable & pleasant. Talks sensibly - Appite good - Sleeps well.

Apr. 8 Cathartic given. Slept well - Appetite good - Talks rationally.

Apr. 9 Patient mentally much improved. Quiet & pleasant in manner

" 11 Visited by relatives. So cheerful & agreeable on ward. Talks rationally. Appetite good. Sleeps well. Seems interested in work.

" 13 Went home with husband. (Phys. note.) Recovery was prompt & complete Was sensible & quiet in her talk. Reasoning powers seemed normal,

Discharged

Personal and Medical History of Mary Johnson #1 from 66

Mar 1 - June 1 - 1901 General condition unchanged. Apr. 20 right eye was inflamed and a pterygium crassum formed. this was irrigated with boric acid, boro glycerine until May 7. At that time was touched daily with copper sulphate pencil, again used boric acid irrigation and boro glycerine. May 28 growth entirely disappeared. This growth was situated at the inner canthus of the right eye. May 31 Wt. 119 #

June - 1 to Sept 1901. Patient received daily treatment of eye until July 2. when trouble was entirely removed. Is quiet and agreeable: talks but little: laxatives frequently given: appetite poor has special diet: sleeps fairly well: assists with ward work: occasionally goes riding and walking. Aug. 27 Wt. 117.

Sept. 23. 1901 Complained of pain in back and severe pain in abdomen: enema given bowels moved freely: patient seemed quite weak Tem 101.3 transfered to Infirmary Sept. 26. Breath seemed quite foul stomach washed out twice daily and kept on liquid diet. Oct. 1st was troubled with diarrhoea: still complains of pain in the stomach and over the abdomen generally. Oct. 2 became very restless: during the night still complained of pain in abdomen: died at 5:50 A.M.

— Died —

Post mortem Examination showed lungs, stomach, bowels, liver and kidneys, in fact all the abdominal and thoracic organs in fairly normal condition, except the heart. The heart was encased in fat. The muscle was very thin: especially of the right chamber. There are indications of old inflammatory conditions about the common duct which was surrounded by a growth of connective tissue: the gall bladder seemed quite normal with no indications of stones. A diagnosis of Heart failure was made.

Personal and Medical History of M. Maria Miller

LEIGHT, FISLAR & RAMBUSCH, DAVENPORT, IOWA.

Whole No. 4364.
Residence, North Franklin, Delaware Co. New York
Date Admission, 30th March 1896.
Admitted by, D. Phelps Hour, 6th P.M.
How Sent, G. Wilbrich. Jo. P. Ramsey County
Sex, Female.
Age, 55.
Civil Condition, widowed
Children, Three
Age Youngest Child, Twenty.
Occupation, Not given: husband (or father) farmer
Degree Education, well educated.
Profession Religion, Congregationalist
Habits, not intemperate.
Nativity, New Hartford, Oneida County, New York
Physicians Committing, C. Eugene Riggs & R. A. Wheaton
Correspondents, none given in papers unless some patients at St Lukes Hosp. St Paul

No. for Year, 192.
Insane Relatives, None
Cause Exciting, Mental worry & ?
Cause Predisposing, probably epilepsy
Form,
Accompanying Bodily Disorder, Epilepsy
Suicidal or Not, Suicidal, by trying to cut herself
Date of this Attack, about 1½ years ago
Duration, about 1½ years
No. of Attack, 1st
No. of Admissions, 1st here (was in St Lukes, St Paul)
Age First Attack, 53 past
Time of Leaving, May 12. 1898
Time in Hospital, 2 yr. 1 m. 12 d.
Result, Discharged Aug. 10. 1898 Unimproved.

EXAMINATION ON ADMISSION
MENTAL CHARACTERISTICS.

Exam. by R.M. & D.L. Phelps. 4/1/96

MENTAL ACTIVITY:
Clear or Confused, Seems clear
Quick or Sluggish, Sluggish
MEMORY:
Past Events, Can't tell accurately - Seems good as far answers
Recent Events, meant.
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Seems good as far as tested -
Correct or Illusive, Probably on some subjects is not
REASONING POWER:
Ordinary Subjects,
Own Mental State,
Special Subjects,
GENERAL DESCRIPTIVE REMARKS: Brought down by Miss. McJones - Has been 7 months at St Lukes Hospital, St Paul. Seems to have been in a rather stationary condition - Is now quiet, slightly suspicious - Answers shortly & suspiciously somewhat melancholy in manner -

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted, Slightly
Depressed,
DELUSIONS:
Systematized or Not, Says she has been abused
Special Subjects, Is much can't answer us
Transitory or Not, anything.
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent, Unwilling to talk freely - History states has epilepsy

Personal and Medical History of M. Maria Miller

EXAMINATION ON ADMISSION, CONTINUED.
PHYSICAL CHARACTERISTICS.

HEIGHT, Not taken WEIGHT, not taken NUTRITION, Seems good
WOUNDS OR ABNORMALITIES, None noted
TONGUE, Tremors, No. Coatings, Reddish - tinged at tip Promptness Movement,
PUPILS, Equality, Equal Size,
Response Light, Respond Accommodation,
SIGHT, Uses glasses.
HEARING, Seems good.
COORDINATION, Arms, Tested today - indications that coordination is good - Detailed tests
Legs, not made today
TREMORS, Hands, No tremors noted Tongue,
Facial Muscles, General,
REFLEXES, Patellar, Normal - Equal
Other
ARTICULATION, good.
Slurred,
Hesitating,
FACIAL EXPRESSION,
Somewhat depressed.
SENSIBILITY,
HEART, Normal - No atheroma noted.
LUNGS, Normal
GYNAECOLOGICAL EXAM., Normal condition
MENSTRUATION, Menopause - Passed
OPHTHALMOSCOPIC EXAM.,

Taken,

EXAM. URINE, Apr. 2'96
Color Yellowish red.
Characte. Heavy flaky deposit
Amt. 24 hrs. 3 VIII
Sp. Gr. 1035
Reaction Alk.
Alb. None
Sugar "
Microsop. Amor. & sodium urates large amount pus & a few bladder cells

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated, ✓	Irregular,
APPETITE, Good,	Medium,	Poor, ✓
SLEEP, Good, 4-6 hrs. last night -	Poor,	Irregular, ✓
PULSE,	Resp.,	Temp.,

CRANIAL MEASUREMENTS,
HISTORICAL,
LENGTH OF INVASION, 1½ yrs by history ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations,
Father or Pat. Relations,
Brothers or Sisters,

Personal and Medical History of M. Maria Miller

1896

This patient was received here at the hands of Deputy Sheriff. Kinney, attended by Wm. Jones, with following history. Patient is in fair Physical Condition. No relationships between parents or grand parents: No insane relatives. This is 1st attack: She has been at St Lukes Hospital, St. Paul, Minn, for seven months prior to this day. First Symptoms of the attack manifested about a year & a half ago, by believing there was "Some plot against her." The Disease appears to be slightly increasing: She is clearer, at times: She does not have entirely rational intervals, but, at times, is better. She is very gloomy & always thinks everything is cloaked in any story. Derangement is manifest now by her thinking that some great plot is being carried on against her & her family. She is disposed to injure others: Has attempted Suicide, by trying to cut herself, but think propensity not now active. She is sometimes destructive. No peculiarities had been previously shown. There is no history of intemperance in self or parents. Patient has Epilepsy. Supposed cause of the disease is mental worry (?). She has been under Dr. Riggs' care at St Lukes Hospital.

Mar 30 On admission, was put on B.M. G.H.N. R.F. Complexion dark: hair brown, streaked with gray: Eyes blue: condition of skin normal: No marks, scars or bruises noticed: is clean: behavior quiet: (No hallucinations).

" 30 Nurses Notes Mar. 31. 97. T. P.90 R.20 Ate Nothing - Drank ½ glass milk for dinner. Slept 6 hrs - Quiet in bed all day. Apr 1st 98 P.60 R.20 Appetite very poor. Cathartic given Required to take Tonic - Quiet in bed all day - Slept 5 hrs at night restless at times Apr 2 98 P.72 R.21 Ate Nothing, Drank 3 glasses milk - Enema given - Bowels moved. In bed all day. Apr 3 98 P.64 R.18 Appetite a little better Up on Ward. Quiet in behavior. Bowels constipated

Apr 4 Appetite improving 98. P.68 R.20. Cathartic given. Quiet in behavior Neat in appearance - Tidy in habits. Slept about 6 hrs. Quite Nervous at night. Apr 5 98 P.64 R.18 Cathartic given - Appetite fair. Bowels moved - Quiet in behavior. Does not talk very rationally. Not out walking Slept about 6 hrs. Seems quite nervous. Apr. 6 98 P.72. R.21 Appetite fair Restless & nervous but quiet. Does not talk rationally.

Apr 12 Evening Rpt Not eat. Appetite poor. Very quiet in behavior but restless & nervous. Says she wishes some one would Kill her - Sleeps fairly well Does not talk rationally. Refuses Tonic.

Summary. Patient nervous & restless - Very quiet in behavior Neat & tidy in habits. Sleeps quite well. Appetite poor - Bowels generally constipated. Does not talk rationally.

Apr 13 Clean. & Cl. Apr. 30 Usually quiet in behavior but very annoying at times Memory poor. Appetite very poor. Bowels regular. Sleeps well. Health apparently good. May 30 Has been cross & contrary occasionally of late. Has many delusions. Is neat & clean in dress & habits Memory poor. Refuses to go riding & walking. Appetite poor. Bowels regular. Sleeps well. General health apparently good.

Personal and Medical History of

1896

June Summary Nurse's Notes by Dr. L.L. Phelps: Usually quiet in behavior: contrary occasionally: neat & clean in dress & habits & seldom speaks: Nov 9'97: Visited by friends: Appetite quite poor: bowels regular: does some mending & crocheting: Has delusions: Jan 2'97: Quite quiet: sits in room a good deal: rather better than during summer: talks very little: June'97 No change: Aug'97 Appetite good: bowels regular: Very seldom goes out doors: tidy in habits & appearance: violent at times. Continued by Dr. W.M. Phelps. Nov 10 Visited by friend: Patient quite talkative but not, however very reasonable: Is inclined to be somewhat irritable. Jan 16 Visited by friend.

Feb 4/98 M. 135th May 6 12 '98 No change in condition, Was taken home to Newyork, not having a residence in this State, by State agent Gates

Discharged.

Personal and Medical History of Johanna Johnson #2

LIBERT, PUSLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4366.
Residence, 750 Wells St. St. Paul. Minn
Date Admission, 1st April 1896 -
Admitted by, D. C. B. Eby - Hour, 6.45 P.M.
How Sent, G. Willrich, Jof P. Ramsey County
Sex, Female -
Age, - 39 -
Civil Condition, married
Children, - 5 -
Age Youngest Child, 11 months
Occupation, Housewife
Degree Education, - None -
Profession Religion, Yes: Lutheran
Habits, not stated
Nativity, Sweden: (parents also born there)
Physicians Committing, E. M. Lundholm and John C. Nelson
Correspondents, Husband - (new given in papers) -

No. for Year, 1911.
Insane Relatives, None
Cause Exciting, Fright
Cause Predisposing, not stated
Form,
Accompanying Bodily Disorder, None mentioned
Suicidal or Not, Very suicidal: propensity active.
Date of this Attack, 3 or 4 Days ago
Duration, - 3 or 4 Days -
No. of Attack, 1st -
No. of Admissions, 1st -
Age First Attack, - 39 -
Time of Leaving, Aug. 12 1896.
Time in Hospital, 4 mo. 11 da.
Result, Discharged Feb. 3'97. Improved

EXAMINATION ON ADMISSION

Exam. R. N. - Sh. Phelps 4/6'96

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused,
Quick or Sluggish,
MEMORY:
Past Events,
Recent Events,
Special Subjects,
PERCEPTIVITY:
Alert or Dull,
Correct or Illusive,
REASONING POWER:
Ordinary Subjects,
Own Mental State,
Special Subjects,

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed,
DELUSIONS:
Systematized or Not,
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS:

Patient had suicidal ideas on coming threw self down after climbing on heater. Actions half aimless then - More so now. Restlessly & deliriously tossing self about. Temp rising now. A condition resembling meningitis - Undoubtedly has some meningitis. No coherent talk, or movement On the other hand attention was gained enough to put out Tongue.

Personal and Medical History of Johanna Johnson #2

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 4½ WEIGHT, not taken NUTRITION,
WOUNDS OR ABNORMALITIES,
TONGUE, Tremors, Coatings, Promptness Movement, Prompt & straight out
PUPILS, Equality, Equal Size, Normal
Response Light, Sluggish Accommodation,
SIGHT,
HEARING,
COORDINATION, Arms, In bed. Considerable
Legs,
TREMORS, Hands, Tremulous some in Nervous ~~Tongue,~~ delirious movement
Facial Muscles, General,
REFLEXES, Patellar,
Other
ARTICULATION,
Slurred,
Hesitating,
FACIAL EXPRESSION, Half look of attention restless look - Wandering aimlessly about.
SENSIBILITY,

EXAM. URINE, Apr. 24'96
Color - Yellowish Red
Character: Hazy Sediment
Amt. 24 hrs. 3 XXXII
Sp. Gr. 1016
Reaction Acid
Albumen None
Sugar "
Microscop. Triple phosphates or. urine Crystals - Some pus Cells.

TAKEN,

HEART, No murmurs noted acts normally
LUNGS,
GYNAECOLOGICAL EXAM., Aug 1/96. Uterus Normal position - Endometritis, hypertrophy, erosion of cervix. Hyperaemia of parts.
MENSTRUATION,
OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated,	Irregular,
APPETITE, Good,	Medium,	Poor,
SLEEP, Good,	Poor,	Irregular,
PULSE,	Resp.,	Temp.,

CRANIAL MEASUREMENTS,
HISTORICAL,
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations,
Father or Pat. Relations,
Brothers or Sisters,

Personal and Medical History of Johanna Johnson #2

1896

This patient was received here at the hands of Deputy Sheriff Kinney, attended by Edward Johnson, (Husband), with following history. Patient is in quiet condition. No history of consanguinity or heredity. This is 1st attack; first symptoms manifested 3 or 4 days ago: became frightened during a violent storm, accompanied with thunder & lightning. Disease appears to be increasing; not variable & no rational intervals. Derangement now shown by being excited, delusions, fears of death; sees departed friends and relatives: quite pugnacious: & has suicidal tendencies. Is disposed to injure others. Has attempted suicide in every conceivable way: propensity now active: destroys clothing. Previously, showed a rather violent temper. There is no history of intemperance in self or parents, nor of any severe disease &c or head-injury: she has not been restrained or confined. Supposed cause of the disease is Fright. She has had no medical treatment.

Apr 1 On admission, was put on B[ed] (G.H.N. Dept). Complexion fair: hair light: eyes blue: condition of skin normal: no marks scars or bruises noticed: is dirty: behavior quiet: She has delusions)

Apr 2 Nurses Notes. T. 98.6 P. 71 R. 20 Appetite fair. Violent at times - Rather dirty in habits - noisy at times - In bed. Apr. 3 T 100 P. 95 R. 23 Appetite good - Cathartic given. Bowels moved. Very violent at times - Limbs bruised from tumbling around on floor Sick in bed. Apr 4 T 101 P 90 R 20 Appetite good - Tonic given 3 times Patient in bed in restraint. Struggles considerably Very noisy at times - Restless during night

Apr 5 T 101. P 95 R 23 Appetite good. Tonic given Very noisy at times. Struggles a great deal. In restraint Dirty in habits - Back bruised very badly.

" 6 T 105. P 130. R ?? Cathartics given Bowels moved - Slept 2 hrs. last night. Quite restless. Sponge bath 9 A.M. 11 A.M. - Every half hour from 7 until 4 P.M. Slept 11 A.M. until 2 P.M. Apr 7 Jan T 102 - P 122 - R ?? - 9 A.M. T 101 - 100 - 23 4:30 P.M. T 102. 110 24 Drank 3 glasses Milk & 1 eggnog. Tonic given. Sponge bath 8 A.M. Back dressed. Sponge bath 11 A.M. 1 P.M. Out of restraint during morning - In restraint in afternoon face & hands sponged - quite violent.

" 8 8 A.M. T 100.2 P 100 R ?? - 4 P.M. T 101 P 132 R 26 Drank milk & eggnog. Tonic & castor oil given - Slept 5 hrs. last night. Quite violent at times In restraint part of time. Pulse very weak. Talking & noisy at times

" 9 A.M. 103.2 T 120 R ?? In P.M. 101 - 120 - 26 - 4:10 P.M. 102 - 122 - ?? Milk & Eggnog given. Tonic & castor oil given. Very violent at times Out of restraint from 7 to 12 P.M. In restraint. Back dressed - Sponge bath given. Slept 4 hrs. last night. Apr 10 7:30 A.M. 103.2 - 120 - 26 P.M. 12:10 101 - 120 - 24 - P.M. 5:10 T 103 - 122 - 26 Took milk & eggnog. Tonic & castor oil. Bowels moved freely Cold cloths on head. Face & hands sponged off. Has blisters on left foot. Apr. 11 8 A.M. 101½ - 122 - ?? 1 P.M. 103 - 120 - 22 4 P.M. 102 - 122 - 26 Milk & Eggnog given. Tonic & powders given. In restraint. Sponge baths given as needed Cold cloths on head Chipped ice given. Very violent at times. Dirty in habit

Apr 12 8:10 A.M. 100.2 - 100 - 23 4 P.M. 101 - 100 - ?? Took eggnog & milk. Tonic & castor oil given. Bowels moved. Slept 7 hrs. last night. In restraint. Cold cloths on head & chipped ice given Feet dressed antiseptically.

Personal and Medical History of Johanna Johnson

Apr 13 8:10 A.M. 100 - 100 - 22 Milk & Egg nog given - Took tonic T.P.M. 1:00 P 122 R 20 Tonic given also cathartic Slept 4 hrs. In restraint. Has spells when she seems to act stupid. Feet dressed daily - antiseptically Apr 14 7:15 A.M. 100.1 - 120 - 22 Milk & eggnog given. Took tonic Very restless 3 hrs. last night. Sponge baths as needed In restraint. Very violent at times. Apr 15 8:10 A.M. 100.3 - 122 - 22 Egg nog & milk given Tonic & cathartic. Slept 4 hrs. In restraint. Has stupid spells. Feet dressed daily antiseptically.

Summary -

Apr 16 In restraint in bed. Very violent Apr 20 Up on ward - Out of restraint. Catheterized 19. 20 - 21. Very violent at times. Apr. 26 Noisy at times: Has delusions, Sleeps well. Appetite fair May 8 Violent at times. Goes walking & riding Appetite quite good. Takes cathartics May 16 Menstrates. Appetite poor. Bowels regular. May 30 Assists with work. Appetite good. Goes walking & riding. June 1 Appetite better of late: assists some with work: June 29 Appetite quite good: Goes riding & walking: Assists with work: July 1 Visited by husband: Wants to go home: speaks of it every day Appetite good: Bowels regular: Works in laundry: Talks sensibly: July 21 Quiet Talks sensibly: works in laundry: Sleeps well: Appetite good: Bowels regular. Treatments given July 31 - Aug 5 & 7. 10 Aug 8 Assists some with work. Appetite good: Sleeps well: Menstrates regularly.

Aug 12 Went Home.

Discharged

Personal and Medical History of Anna W. McCullough

LIBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4376.
Residence, Rice County Minnesota.
Date Admission, 17th April 1896.
Admitted by, Dr. Phelps Hour, 4 oc P.M.
How Sent, R.A. Mott J of P. Rice County.
Sex, Female.
Age, — 34 —
Civil Condition, Single
Children, —
Age Youngest Child, —
Occupation, Dress-making
Degree Education, Good Common education
Profession Religion, Yes: Catholic
Habits, Probably good
Nativity, Faribault, Minn: (Fathers) Canada: (Mothers) Ireland
Physicians Committing, Roscoe N. Jackson and D.M. Cole
Correspondents, None given in papers

No. for Year, 2014.
Insane Relatives, none
Cause Exciting, nervous disorder
Cause Predisposing, "Chronic"
Form,
Accompanying Bodily Disorder, Headaches
Suicidal or Not, has threatened suicide: Propensity apparently active
Date of this Attack, about 3 years ago
Duration, — about 3 years —
No. of Attack, 1st —
No. of Admissions, 1st —
Age First Attack, — about 31 —
Time of Leaving, June 16 Th 1897.
Time in Hospital, 1 year 1 mo. 30 da.
Result, Discharged June 16 Th 1897
Unimproved

EXAMINATION ON ADMISSION

Exam. by L.L. & R.M.P. 4/20/95

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Fairly clear on some subjects
Quick or Sluggish, Fairly quick
MEMORY:
Past Events, Seems good
Recent Events,
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Alert on ordinary subjects
Correct or Illusive,
REASONING POWER:
Ordinary Subjects,
Own Mental State,
Special Subjects,
GENERAL DESCRIPTIVE REMARKS:
Worrying for 2 yrs. back - Dont want to say what about - Patient rather fussy Indignant about being here - Paranoiac in form.

EMOTIONAL STATE:
Normal, Calm, About Normal now.
Indifferent,
Exalted,
Depressed,
DELUSIONS:
Systematized or Not, Yes.
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

Personal and Medical History of Anna W. McCullough

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 Ft 4 in WEIGHT — NUTRITION, Rather thin
WOUNDS OR ABNORMALITIES, None
TONGUE, Tremors, None Coatings, None Promptness Movement, Prompt
PUPILS, Equality, Equal Size, Normal
Response Light, Normal Accommodation,
SIGHT, Good
HEARING, Good
COORDINATION, Arms, Good
Legs, Good -
TREMORS, Hands, None Tongue, None
Facial Muscles, None General, None
REFLEXES, Patellar,
Other
ARTICULATION, Normal
Slurred,
Hesitating,
FACIAL EXPRESSION,
Rather staring & blank.
SENSIBILITY,
HEART, Normal - No murmurs.
LUNGS, Normal
TAKEN,

EXAM. URINE, Apr. 20 '96
Color, Very light yellow.
Character, Watish flaky deposit
Amt. in hrs. XVI 3
Sp. Gr. 1026
Reaction Alk.
Albumen None
Sugar "

GYNAECOLOGICAL EXAM., Uterus pretty well bound by adhesions. Ovaries normal
MENSTRUATION, Normal No pain or symptoms
OPHTHALMOSCOPIC EXAM.,
HABITS, Dirty, Clean, ✓ Careless,
BOWELS, Normal, ✓ Constipated, Irregular,
APPETITE, Good, ✓ Medium, Poor,
SLEEP, Good, ✓ Poor, Irregular,
PULSE, Resp., Normal Temp.,
CRANIAL MEASUREMENTS,
HISTORICAL,
LENGTH OF INVASION, 2 years. ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, Healthy
Father or Pat. Relations, Nervous chills & severe headaches.
Brothers or Sisters, Heart trouble

Personal and Medical History of Anna M. McCullough.

1896

This patient was brought here by Deputy-Sheriff R. K. Hutchinson, attended by Miss Hutchison, with following history. Patient is in fair physical condition. There is no history of consanguinity or heredity. This is 1st attack: has not been in hospital: first symptoms manifested about 3 years ago. She imagines some one or more persons, (she don't know who) were trying to destroy her character. The disease seems increasing. There are not any rational intervals at that point. Derangement now shown in the subject that she is the subject of vile defamation. Threatens often to injure others. She has threatened suicide, and propensity now active, apparently. No filthy or destructive habits. Patient was always stubborn and high tempered. No history of intemperance in parents or self. Has had no severe disease etc or head injury: only subject to headache. She has not been restrained or confined. Supposed cause of the disease is nervous disorder. The treatment given her has been, principally, care & nursing. She refuses to receive medical treatment. ———

April 17 On admission, was put on T3' (G. H. N. R'y's). Complexion dark: hair black: eyes gray. Condition of skin normal: no marks scars or eruptions noticed. Clean: Quiet: would not answer any questions but says "her people put her here for revenge".

April 18 Nurses Notes Ate supper. Bath given. Slept 7 hrs - quite nervous. April 19 Tgg. Pg. P 18 Appetite good. Bowels constipated. Slept 6 hrs. Talks sensibly - complains of headache. In bed all day. Apr. 19 Tg8.4. Pg8. P.18 Appetite good - Cathartic given. Bowels moved - Slept 6 hrs - In bed all day. Apr. 20 Tested by thermometer 98.8 P.78. R.18 Appetite good - Bowels moved - In bed during morning - Up on ward rest of day Slept 6 hrs. Apr. 21 Appetite fair. Tonic given 3 times. Talks sensibly - Neat in habits & appearance. Slept 6 hrs. Bowels regular. Apr. 22 Appetite fair Tonic 4 times Bowels constipated. Slept 6 hrs. Appeared to be somewhat nervous during the day - Quiet & ladylike on ward. Talks sensible.

Apr. 23. Appetite fair. Cathartic given. Tonic 3 times daily. Bowels moved - Is interested in reading. During second week - appetite fair. Tonic given 3 times daily Slept well. Morbid but quiet & agreeable & talks some. Takes out door exercise. Bowels regular.

Summary. Patient has had a fair appetite. Bowels irregular - Cathartics given occasionally - Tonic three times daily during second week. Quiet & ladylike in appearance though rather morbid. Talks sensibly & is quite nervous. Goes riding & walking & is interested in work & reading - Very anxious to go home though more contented than at first

April 29 Minute. May 1st Has morbid ideas. At times talks quite sensibly. Appetite good Sleeps well. Takes out door exercise. Is interested in work. Electrical treatment given on 4th. 6th & 11th Massage on 4th - 6th & 8th. May 7th Minute. May 30 Patient has many delusions & is at times very impolite. Appetite fair. Sleeps well. Takes out door exercise. Occupies most of time reading & working for herself. Takes tonic three times daily.

Personal and Medical History of

1896

June 8 Summary Nurse's Notes by Dr. L. L. Phelps:- Electrical treatments given: June 9 Massage: June 10: Elect. treatments & massage given every other day: irritable & at times very impolite in manner: Has delusions: Aug 31'96 Very irritable: many delusions very disagreable: occupies time in reading & writing & at times sewing: Jan 1 Appetite not very good: Very changeable in actions: talks quite sensibly one day but may be scolding in a very incoherent manner the next: Does no work excepting her own mending: Mar. '97 No change: June 16 '97 Visited by father & Taken Home - Unimproved.

Discharged

Personal and Medical History of Barbara Troppman

LAMBERT, FISCHER & SAUNDERS, DAVENPORT, IOWA.

Whole No. 4377. Winona, Minn
Residence,
Date Admission, 20th April 1896.
Admitted by, Dr. Phelps Hour, 4th PM
How Sent, H. L. Buck, Jo P. Winona County.
Sex, Female
Age, 25 years.
Civil Condition, married
Children, Three
Age Youngest Child, 7 months
Occupation, Housewife: Husband a laborer.
Degree Education, Some: reads & writes
Profession Religion, Yes: Catholic
Habits, Not Stated
Nativity, Germany: (Parents also born there).
Physicians Committing, Franklin Staples & E. D. Leys
Correspondents, 668 Grand Street Winona Minn

No. for Year, 205.
Insane Relatives, None
Cause Exciting, Unknown
Cause Predisposing, "Chronic"
Form,
Accompanying Bodily Disorder, None mentioned.
Suicidal or Not, — Not —
Date of this Attack, One years ago
Duration, One year —
No. of Attack, 1st —
No. of Admissions, 1st
Age First Attack, — ? —
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION
MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Confused as to cause
Quick or Sluggish, Fairly quick
MEMORY:
Past Events,
Recent Events, Good.
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Fairly alert.
Correct or Illusive,
REASONING POWER:
Ordinary Subjects, Fair
Own Mental State,
Special Subjects,
GENERAL DESCRIPTIVE REMARKS:
"Feels Well" Speaks coherently & fairly well In german - Slow & dull - Preoccupied

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed, Slightly depressed.
DELUSIONS:
Systematized or Not,
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

Personal and Medical History of Barbara Troppman

EXAMINATION ON ADMISSION, CONTINUED.
PHYSICAL CHARACTERISTICS.

HEIGHT, 4 ft 9 in WEIGHT, Not taken NUTRITION, Good.
WOUNDS OR ABNORMALITIES, None. was nursing baby.
TONGUE, Tremors, Coatings, Promptness Movement, Deviates to left.
PUPILS, Equality, Equal Size, Normal
Response Light, Respond. Accommodation,
SIGHT, Good
HEARING, Good
COORDINATION, Arms,
Legs,
TREMORS, Hands, None of note Tongue,
Facial Muscles, General,
REFLEXES, Patellar, 6 Equal
Other
ARTICULATION, Good
Slurred,
Hesitating,
FACIAL EXPRESSION,
Slightly depressed
SENSIBILITY,
HEART, Normal
LUNGS, Normal



TAKEN,

EXAM. URINE, Apr 22 '96
Color Reddish Yellow
Char. Flaky deposit
Amt 24 hrs. 3 XXVII
Sp. Gr. 1027
Reaction Acid
Albumen Large amount.
Sugar None.
Micros. Triple phosphates - pus cells & mats of ammon. Crystals

GYNAECOLOGICAL EXAM. Uterus in normal position. Evidence of a Slight laceration of perineum - 3 children / Same endometritis
MENSTRUATION, Menstruation regular
OPHTHALMOSCOPIC EXAM.,
HABITS, Dirty, Clean, Careless,
BOWELS, Normal, ✓ Constipated, Irregular,
APPETITE, Good, ✓ Medium, Poor,
SLEEP, Good, ✓ Poor, Irregular,
PULSE, Normal Resp., Temp.,
CRANIAL MEASUREMENTS,
HISTORICAL,
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, living & healthy
Father or Pat. Relations, " "
Brothers & Sisters, all Well.

Personal and Medical History of Barbara Troppman

1896

This patient was brought here by Deputy-Sheriff A. W. Fuhrman, attended by Mrs Rosalia Lorenzy with following history. Patient is in fair physical condition. There is no history of Consanguinity nor heredity. This is 1st attack: Symptoms manifested some years ago; gradual onset of irritable period. Disease appears to be increasing: variable & with rational intervals: these do occur at regular intervals formerly, but do not now. Derangement now shown by hallucinations on various subjects & excessive irritability: Especially towards husband & children. Is disposed to injure members of family. Has not attempted suicide: no filthy or destructive habits as to any previous peculiarities, not known. There is no history of intemperance in self or parents, nor of any severe disease or head-injury. She has not been restrained or confined, nor under medical treatment. Cause of the disease is unknown. There are now noted indifference, incoherence & peculiar rolling of eyes.

Apl 20 On admission, was put on P.D. (G.H.N.Rft. Complexion light: hair brown: eyes blue: condition of skin normal: No marks scars or bruises noticed: Is quite dirty: Behavior quiet: talk very incoherently.

Apl 21 Nurses Notes Ipg Pyr R18. Appetite rather poor Bowels regular - Patient quiet. Does not talk very sensibly when spoken to. Apl 22 Ipg Pyr R18 - Appetite poor - Tonic given Very quiet. Talks silly - Talks a good deal about going home. Bowels regular

Apl 23 Ipg Pyr R18 Appetite improving Tonic 3 times daily Quiet & silly - Sleeps well Wants to go home - Apl 24 Ipg Pyr R18. Appetite good. Tonic given Neat in habits. Quiet - Sleeps well. Does not talk sensibly. Apl 25 Ipg Pyr R18 Appetite good. Tonic given Bowels regular Quite noisy at times - Has delusions - Neat in appearance. Apl 26 97.4-72-18 Appetite good - Tonic given - Noisy at times - Does not Talk sensibly: seems to run from one subject to another - Neat in habits.

Apl 27 Ipg. Pyr R18 Ate breat fast - Tonic given Quiet most of time - Talks of wanting to go home - Bowels regular. May 1st During second week. Appetite good - Tonic given 3 times daily - Bowels irregular - Quiet some days & slightly noisy ow others. Talks of wanting to go home. Sleeps fairly well Has delusions on certain subjects & at times talks silly Neat in habits. Gyn. Treatments given 2nd May 1st Month.

Summary Patients appetite poor at first better of late - Tonics given 3 times daily Sleeps fairly well. Was quiet at first but has had several rather noisy days Talks silly & a good deal about going home. Has delusions on certain subjects - Neat in habits. Months. Bowels irregular

May 13 Gyn. Treatment given. May 16 Patient has been very noisy Tonic 3rd aftr Meals - Goes walking & riding - Gyn treatments on 18-20-24-26

June Summary Nurses Notes by Dr. G.L. Phelps: Works in dining room: very agreeable: good riding when well: Gyn. treatment given every other day: Jan '97 Gen'l health good: refuses to work at present: talks to imaginary people: Has many delusions: At times is noisy & cross: appetite fair. bowels regular: Mar '97 No change: July 11 '97 Visited by husband & Taken Home: Aug 5 Returned: could not keep her at home: behavior quiet here: appetite

Personal and Medical History of

1897

good: Aug 15 Extremely noisy at times: works in dining room as usual:
Continued by Dr. Geo. Phelps. Sept. 10 '97 Patient inclined to be somewhat noisy & restless: At times will scold a good deal & at others is quiet & helps with work, Feb 3 '98 Wt 113# July 18 Trans. to Infirmary. Oct 16 Trans. to B.2 Feb 25 '99 Wt. 102#. Condition & behavior average about the same as for two or three years past.

1899 Nov 1 to Dept. (Cont. by Dr. P.A. Bekh) Gen'l health & appetite good. Bowels & meals regular: Takes out door exercise: Has disturbed periods when is exceedingly noisy talking & scolding to herself: comparatively quiet at other times: Has many delusions: neat & tidy: reads occasionally: Aug 29 Wt 100# Sept 1 - Feb 28 1900 (Dr Heyerdale) Has delusions: Neat. Most of time sits quietly on ward: but noisy at times during night. Bowels regular. Eats & sleeps well: Nov. 1 Trans. to B1: Jan 18 Wt 99# Talks to herself a great deal.

Mch 1 - Aug 31 1900 (Dr Linton) At times noisy & profane - also scolds to herself: Appetite good Sleeps well: Menstruates regularly: attends chapel & amusements
Sept. 1 - Nov. 30. No change. Much disturbed at times. Nov 16 Wt. 104# "
Dec 1 - Feb 28. 1901. Physically well except occasional headaches Appetite good: Assists with work: Generally speaks German. Mch 1 Wt 100.

Mar. 1 - June - 1 - 1901 No change in mental or physical condition. Assists with work on ward. May 29. Wt. 102 1/2#. June to Sept.
Assists with ward work, attends amusements, takes out door exercise, menstruates regularly, does not converse, is usually quiet but sometimes noisy and violent, Sept. 2 Wt. 100#. Sept. to Dec. No change Nov. 22 Wt. 122 1/2#.

Wk to Feb. 1, 1903. General health good: appetite good: bowels regular sleeps well: exercises: assists with the work: attends chapel: scolds a great deal and is rather noisy at times: sometimes answers questions intelligently and is pleasant and agreeable; at other times scolds and talks noisily to herself: Nov. 24 ch, Wt. 102#.

Personal and Medical History of Augusta A. Anderson

LEGGET, PIDLAR & BACHRACH, DAVENPORT, IOWA.

Whole No. 4378.
Residence, St Paul. Minnesota
Date Admission, 20th April 1896.
Admitted by, D. Phelps Hour, 6.45 PM.
How Sent, G. Wilbrich, Jol P. Ramsey County
Sex, - Female -
Age, 26
Civil Condition, married
Children, one
Age Youngest Child, 14 mos.
Occupation, Housewife; husband a fine-maker
Degree Education, not educated
Profession Religion, not a church member
Habits, not intemperate
Nativity, Sweden: (parents also born there).
Physicians Committing, E. M. Lundholm and John C. Nelson
Correspondents, none given in papers

No. for Year, 206.
Insane Relatives, father + mother 1st cousins: one of his relatives has been insane
Cause Exciting, hereditary + intermarriage
Cause Predisposing, Heredity
Form,
Accompanying Bodily Disorder, None mentioned.
Suicidal or Not, propensity active.
Date of this Attack, 6 months ago
Duration, 6 months
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, 25+
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION
MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused,
Quick or Sluggish, Seems quick
MEMORY:
Past Events, Seems good
Recent Events, " "
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Alert
Correct or Illusive,
REASONING POWER:
Ordinary Subjects, Fair
Own Mental State,
Special Subjects,
GENERAL DESCRIPTIVE REMARKS:
States Headaches - Dizzy at times - Intelligent in appearance. Quiet + composed - After a time thinks of baby + commences to cry. Talks quite clearly. Says not sick at all. Can't get history very well.

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed, Slightly
DELUSIONS:
Systematized or Not,
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION: Smiley - Interprets
Coherent or Incoherent, Seemingly coherent
Voluble or Reticent,

Personal and Medical History of Augusta A. Anderson

EXAMINATION ON ADMISSION, CONTINUED.
PHYSICAL CHARACTERISTICS.

HEIGHT, Not taken WEIGHT, Not taken NUTRITION, Fair - somewhat pale.
WOUNDS OR ABNORMALITIES,
TONGUE, Tremors, No Coatings, Promptness Movement,
PUPILS, Equality, Equal Size, Normal
Response Light, Respond Accommodation,
SIGHT, Good
HEARING, Good
COORDINATION, Arms, In bed - seemingly good.
Legs,
TREMORS, Hands, No. Tongue,
Facial Muscles, General,
REFLEXES, Patellar, ? equal
Other
ARTICULATION, Good.
Slurred,
Hesitating,
FACIAL EXPRESSION, Good
SENSIBILITY,
HEART, Normal
LUNGS, Normal



TAKEN,

EXAM. URINE, Apr 22 '96
Color. Reddish yellow
Character. Flaky deposit
Amt 24 hrs. ℥ 35½.
Sp. Gr. 1021
Reaction Acid.
Albumen Large amount.
Sugar. None.
Microscop. Large amount of bladder Epith.

GYNAECOLOGICAL EXAM., Uterus retroverted + bound by adhesions external genitals normal.
MENSTRUATION, Yes. Regular.
OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal, ✓	Constipated,	Irregular,
APPETITE, Good, ✓	Medium,	Poor,
SLEEP, Good,	Poor, ✓	Irregular,
PULSE,	Resp.,	Temp.,

CRANIAL MEASUREMENTS,
HISTORICAL,
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, dead
Father or Pat. Relations, living
Brothers or Sisters,

Personal and Medical History of Augusta A. Anderson

1898

This patient was brought here by Deputy Sheriff M. N. Goss, attended by husband, with following history. Patient is in fair Physical Condition. Father + mother first Cousins and are of her relatives has been insane. This is first attack; Symptoms manifested 6 months ago, by delusions. The Disease seems increasing but variable + with rational intervals, but these, not at regular intervals. Derangement now shown in that she imagines her husband in the cellar at all times, although he may be miles away. Patient is not dictated to injure others, has not attempted suicide, but propensity is active: no filthy or destructive habits. Previously she showed peculiarities of disposition &. There is no history of intemperance in self or parents, nor of any Severe Disease &c or head-injury. She has not been restrained or confined, nor under medical treatment. Supposed cause of the Disease is hereditary + intermarriage. She now thinks she hears the fire-bells ringing continually: imagines herself one of the leading characters in "Fairy-Tales"

Apr 20 On admission, was put on B.r. (G.S.H. & P.). Complexion light: hair light: eyes blue: Condition of skin normal: no marks scars bruises &c noticed. Is clean. Behavior quiet (can't talk English)

Apr 21 Nurses Notes- T. 98.4 P. 74 R. 19. Appetite good. Patient sings + is quite noisy at times. Bowels regular. Apr 22 T. 98.6 P. 72 R. 18 Ate no supper. Neat + tidy: sings + is noisy at times. Bowels moved. Apr 23 Sings + cries a great deal. Has delusions. Appetite good. bowels regular T. 97.4 P. 72 R. 18 Apr 24 Very noisy at times. Has delusions. Neat in appearance. Appetite good. T. 97.8 P. 74 R. 20. Mentally. Apr 25 Sleeps rather poorly. Cries + sings a good deal. Has delusions. Bowels regular. Appetite good. T. 98 P. 71 R. 18. Apr 26 Neat. Noisy at times. Aside from delusions seems quite sensible. Appetite good. T. 99.2 P. 70 R. 18. Apr 27 T. 98. P. 70 R. 18 Ate no dinner nor supper. Crying + noisy at times. May 3 During second week patients appetite was good. bowels regular. Slept rather poorly. Had many delusions. Neat in habits. Assisted a little with work. Quiet one day. Quite noisy the others.

Summary Patients appetite good. Bowels regular. Does not sleep very well. Quite noisy at times - crying + singing. occasionally quiet + rather downcast. Has many delusions. Neat in habits.

May 4 Visited by husband. Very noisy + cries a great deal. May 8 Somewhat quieter for past week or so. Treatments Apr. 27-29- May 1-4-8 May 11 Appetite good. Bowels regulgr. Sleeps quite well. Talks loudly + cries at times. Has delusions. Sometimes refuses Medicines May 16 Cries a great deal. Is very disagreeable at times. May 18 Treatments May 18-20-24-26

June 12 Summary Nurse's Notes by Dr S.L. Phelps: Appetite good: bowels regular: assists some with work: rather dull + melancholy: Nov. 96 No change: Jan 97 Appetite variable: bowels regular: works in dining room: at times asks for things in a sensible manner, but otherwise talks little: May '97 No change: Aug '97 Appetite fair: bowels regular. violent at times: assists with work. Continued by Dr. P.M. Phelps. Sept. 13 97 Rather restless + inclined to be violent. Has tried to hurt other patients. Feb 6 98 Wt. 107#. Apr 19 Trans. to Annex. Feb 20 99 Patient's

Personal and Medical History of Augusta A. Anderson.

1898

Dec condition practically unchanged during period. (Cont. by Dr. R.A. Belt) March 6 Appetite good. inclined to be constipated, requiring laxatives: sleeps well: neat: usually pleasant + quiet: occasionally noisy + irritable. Answers questions readily when addressed but has many delusions + frequently talks to self. Has ulcer on left leg which requires dressing daily: May 22 to 31 Remained in bed: both legs badly affected with eczema: limbs dressed daily.

Nov 6 Dec 99: Appetite quite good: menstr. regular: sleeps well: neat in habits + appearance: takes out door exercise: quiet. seldom talks, but answers questions quite sensibly: does no work: Apr 5 Complained of headache: face red + swollen: red blotches on arms + shoulders. T 99 2 P. 80 Transf. to Inf. Dept (see sick record) Apr 11 Up on ward: Apr 12 Transf. to Annex: July 4, 26th Pulse very weak: remained in bed a few hours. Aug 8 Wt. 107#

Sept (- Dec 28 1900 (Dr Heyendale). Neat + quiet. Does not converse: Appetite fair. Sleeps well. General health fair: Takes out door exercise: Menstruates regularly. Oct 24 2 teeth 2 extracted. Jan 1 01 Wt. 107# Mch 1- Aug 31- Quiet + agreeable: talks very little: General health good: appetite fair: bowels regular: Assists in dining room. July 23 Vaccinated

Sept 1- Nov 30 1900 No change Nov. 23 Wt. 117# Dec 1- 26 28. Still gaining in wt. Wt 120 1/2# Mch 4th 1901- Quiet. Health good: sleep well: does not attend amusements or chapel. Mar 1- June 1- 1901 - Mar 2 - Apr. 1 - May 2 - menstruated. Does no work. May 31 Wt. 121 1/2 #

Mar 1- Sept 1- 1901. attends amusements and chapel, does no work, July 17 menstruating, Sept. 3. Wt. 126#. Sept. to Dec. 1901. menstruating Nov. 20, no change in mental or physical condition. Nov. 30 Wt. 126 1/2 #. Up to Feb. 1, 1903. General health good: eats and sleeps well: exercises: assists with the work: attends amusements: is neat and clean: doesn't converse or answers questions intelligently: is incoherent: generally quiet but sometimes scolds to herself.

Personal and Medical History of Mary Kovars

LAMBERT, FISCHER & CHARRIER, DAVENPORT, IOWA.

Whole No. 4387.
Residence, Steele County. Minnesota
Date Admission, 24th April 1896.
Admitted by, D Shelby Hour, 9 30 Asm.
How Sent, Wm B Hazlewick, Jof P. Steele County
Sex, - Female -
Age, - 66 -
Civil Condition, married
Children, - 3 -
Age Youngest Child, about 25 -
Occupation, Housewife. Husband, farmer
Degree Education, Fairly educated -
Profession Religion, Catholic
Habits, not stated -
Nativity, Germany (parents also born there)
Physicians Committing, A B. Stewart M.D. of St. Adair
Correspondents, none given in papers

No. for Year, 210.
Insane Relatives, not as known
Cause Exciting, not known
Cause Predisposing, — probably age —
Form,
Accompanying Bodily Disorder, Sad ovarian tumor
Suicidal or Not, not
Date of this Attack, 6 months ago
Duration, — 6 months.
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, 65 past
Time of Leaving, June 8 '96
Time in Hospital, 1 mo. 15 da.
Result, Died — Exhaustion in senile Dementia with Intercapsular fracture of hip.

EXAMINATION ON ADMISSION

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused,
Quick or Sluggish, Answers quite quickly.

MEMORY:
Past Events,
Recent Events, Seems slow but fairly accurate
Special Subjects,

PERCEPTIVITY:
Alert or Dull, Quite dull only accurate
Correct or Illusive,

REASONING POWER:
Ordinary Subjects, Somewhat poor
Own Mental State, Yes
Special Subjects,

GENERAL DESCRIPTIVE REMARKS:
Note by Dr P. (on admission). In County-keeps house: has been living alone: husband living, but Divorced: daughters where knows not somewhere, who do not take any care: no other relatives or friends. Has a general tremor probably "senile" Chronic motion of eyes - Says came here because had to - Says son is here - says is well & strong as a horse - Was operated on for tumor removed 3 wks. ago Tumor of ovaries removed. Typical case of Senile Dementia - at least apparently senile - A slow mild feebleminedness

EMOTIONAL STATE:
Normal, Calm,
Indifferent, ✓
Exalted,
Depressed,

DELUSIONS:
Systematized or Not,
Special Subjects, "Son is here"
Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

Personal and Medical History of Mary Kovars

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 4 ft 10 in WEIGHT, not taken NUTRITION, Not much impaired
WOUNDS OR ABNORMALITIES,
TONGUE, Tremors, Trembles Coatings, No. Promptness Movement, Fairly prompt
PUPILS, Equality, Equal Size, Normal
Response Light, Yes Accommodation,
SIGHT, Says can see well
HEARING, Good
COORDINATION, Arms, Weak & tremulous - says her back is always lame - Bent position
Legs, Good. Gait probably good.
TREMORS, Hands, Yes. Tongue, Yes -
Facial Muscles, General, Senile
REFLEXES, Patellar, 7-8 Equal
Other
ARTICULATION,
Slurred,
Hesitating, Fair
FACIAL EXPRESSION,
SENSIBILITY,
HEART, Regular - no murmurs
LUNGS, Good
GYNAECOLOGICAL EXAM., Ovariotomy performed on admission.
MENSTRUATION,
OPHTHALMOSCOPIC EXAM.,

TAKEN,

EXAM. URINE, May 1 '96
Color, Yellow
Character, Flaky sediment
Amt. in 24 hrs, not
Sp. Gr. 1013
Reaction Acid
Albumen Large Amt.
Sugar, None
Microscop. Pus. Triple phosphate, Bladder Epith.

HABITS, Dirty,	Clean, ✓	Careless,
BOWELS, Normal, ✓	Constipated,	Irregular,
APPETITE, Good, ✓	Medium,	Poor,
SLEEP, Good, ✓	Poor,	Irregular,
PULSE,	Resp.,	Temp.,

CRANIAL MEASUREMENTS,
HISTORICAL,
LENGTH OF INVASION, Considerable time ONSET GRADUAL OR SUDDEN, Gradual
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations,
Father or Pat. Relations,
Brothers or Sisters,

Personal and Medical History of *Mary Kovars*

1896

This patient was brought here by Dr. Stewart + attended by Mrs. Stewart, with following history. Patient is in fair physical condition. No history of consanguinity or heredity, as known. This is 1st attack: has not been in hospital: first symptoms of this attack manifested six months ago with beginning dementia. Disease appears to be increasing; variable + with rational intervals, but these not at regular intervals. There are now, the usual symptoms of senile dementia. Patient is not disposed to injure others, nor suicidal, but has destructive habits. No peculiarities had been previously shown. So far as known. There is no history of intemperance in self or parents. She has had ovarian tumor. She has not been restrained or confined. Cause of the disease is not known. Ovariotomy performed 3 weeks ago: no change in mental troubles. Patient is inclined to restless wandering + subject to attacks of sudden anger, when restrained.

Apl 24 On admission was put on B[d] (G.H.N.Rft. Complexion light: hair light brown: eyes blue: Condition of skin normal: Scar on abdomen, from operation. Sc. bran: feet sore).

Apr 24 Nurses Notes. Appetite good. Sitting up in bed part of time. Out of bed some
" 25 T. 99.3 P. 66 R 22 Appetite good. Bowels en o'rd. Out of bed part of time very quiet in behavior. Apr 26 T. 99 P. 68 R. 24 Appetite fair Tonic given up on ward. Very restless walking up + down a good deal. Talks some asks to go home a Great many times during day. Apr. 27 T. 98. P. 64 R 20 Appetite good. Tonic given Complains of Backache. Slept 6 hrs. Very restless Apr. 28 T. 98.6 P. 66. R 20 Appetite good. Tonic given Very quiet in behavior Bath taken. Slept 5 hrs. Is very helpless. Apr 29 T. 98.4 P. 66 R 22 Very restless Walking a great deal. Talks some. Slept 5 hrs. Apr. 30 T. 98.4 R 20 P. 64 Appetite good. Bowels regular. Complained of Backache this morning
May 1 Very little change during second week. Appetite good Sleeps on an average of six hrs. Talks but little. Very restless. Takes no out door exercise. Urine examined twice. Bowels regular

Summary Patient feeble + restless Talks to self but converses but little. Complained of backache during first week Urine examined. Bowels regular. Tonic given daily. Coughs some

June Patient is old + very helpless. Habits very dirty. Takes but little out door exercise. Appetite good. June 3 Patient fell + received intercapsular fracture of hip. Put to bed. Seemed very weak. June 4 Patient still in bed. Appetite poor. June 6 No change. June 7 Was taken with a spell of heart trouble. Did not seem to understand anything when spoken to. Remained in a comatose condition all night
June 8 Still in comatose state. Visited by priest.

Died. June 8[th] 96.

Personal and Medical History of

Personal and Medical History of Ella Brandt

LESLEY, FIDLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4391
Residence, St. Paul Minnesota
Date Admission, 12th May 1896. —
Admitted by, Dr. Phelps Hour, 6 1/2 P.M.
How Sent, G. Wilrich. Jo. P. Ramsey County.
Sex, Female
Age, 43
Civil Condition, Widow
Children, One
Age Youngest Child, — 22 —
Occupation, Music-teacher: (father a Merchant)
Degree Education, Very good
Profession Religion, Yes; Episcopal
Habits, Probably good
Nativity, Ted Wing Minn (Parents born in Maine).
Physicians Committing, Park Ketchie and Alex. Arnold.
Correspondents, None given as papers

No. for Year, 219
Insane Relatives, None
Cause Exciting, Menopause?
Cause Predisposing, not stated
Form,
Accompanying Bodily Disorder, None mentioned
Suicidal or Not, No
Date of this Attack, 6 Days
Duration, — 6 —
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, — 43 —
Time of Leaving, Sept 29. 1897
Time in Hospital, 1 yr. 4 mo. 17
Result, Discharged May 4 1898 Improved.

Thinks She's Harry Hayward.

Mrs. Ella Brandt, a widow forty-three years old and a resident of Hamline, was adjudged insane yesterday and committed to the Rochester asylum. She created quite a scene in court. She imagines herself to be Harry Hayward.

EXAMINATION ON ADMISSION

Exam. by P.M. Phelps M.D. 5/4/98

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused,
Quick or Sluggish,
MEMORY:
Past Events,
Recent Events,
Special Subjects,
PERCEPTIVITY:
Alert or Dull,
Correct or Illusive,
REASONING POWER:
Ordinary Subjects,
Own Mental State,
Special Subjects,
GENERAL DESCRIPTIVE REMARKS:
Talks incoherently & profusely - rather too active to make a satisfactory examination. Very rapid flow of incoherent talk runs on exalted ideas. Is given of the world etc. Is now in restraint. No physical ailments noted. Has no meningeal signs nor signs of exhaustion from activity

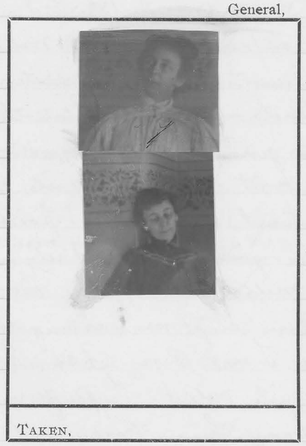
EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed,
DELUSIONS:
Systematized or Not,
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

Personal and Medical History of Ella Brandt

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, not taken WEIGHT, not taken NUTRITION, Not very bad but seems to have failed some
WOUNDS OR ABNORMALITIES,
TONGUE, Tremors, little dry probably from talking Coatings, Promptness Movement,
PUPILS, Equality, Size, Somewhat enlarged
Response Light, Accommodation,
SIGHT,
HEARING, Has suppuration of left ear
COORDINATION, Arms,
Legs,
TREMORS, Hands, Tongue,
Facial Muscles, General,
REFLEXES, Patellar,
Other
ARTICULATION,
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART,
LUNGS,
GYNAECOLOGICAL EXAM., Aug. '96 Uterus in normal position but immovable - bands of adhesion on left side
MENSTRUATION, Very irregular. External genitalia normal.
OPHTHALMOSCOPIC EXAM.,



TAKEN,

EXAM. URINE, June '96
Color, Red.
Character. Flaky deposit
Amt. in 24 hrs. 7 XXXVIII
Sp. Gr. 1014.
Reaction Acid.
Albumen Trace of - by Tannet.
Sugar. None
Microscop. Mor. urates pus & blood cells - bladder epithe - triple phosphates.

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated, Has not moved bowels since coming	Irregular,
APPETITE, Good,	Medium,	Poor, Looks sick chiefly
SLEEP, Good,	Poor,	Irregular,
PULSE,	Resp.,	Temp.,

CRANIAL MEASUREMENTS,
HISTORICAL,
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations,
Father or Pat. Relations,
Brothers or Sisters,

Personal and Medical History of Ella Brandt

LEIGHT, FIDLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4391
Residence, St. Paul. Minnesota
Date Admission, 12th May 1896.
Admitted by, Dr. Phelps Hour, 6.45 P.M.
How Sent, G. Wellrich. Jolt. Ramsey County.
Sex, Female
Age, 43
Civil Condition, Widow
Children, One
Age Youngest Child, — 22 —
Occupation, Music-teacher: (father a Merchant)
Degree Education, Very good —
Profession Religion, Yes: Episcopal
Habits, Probably good
Nativity, Ped Mng. Mun. (Parents born in Maine).
Physicians Committing, Parkhurst and Alex. Arnold.
Correspondents, None given in papers

No. for Year, 219
Insane Relatives, None
Cause Exciting, Menopause?
Cause Predisposing, not stated
Form,
Accompanying Bodily Disorder, None mentioned
Suicidal or Not, No
Date of this Attack, 6 Days ago
Duration, — 6 Days —
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, — 43 —
Time of Leaving, Sept. 29. 1897
Time in Hospital, 1 yr. 4 mo. 17
Result, Discharged May 4. 1898 Improved.

EXAMINATION ON ADMISSION
MENTAL CHARACTERISTICS.

Exam. by P.M. Phelps M.D. 5/14/96

MENTAL ACTIVITY:
Clear or Confused,
Quick or Sluggish,
MEMORY:
Past Events,
Recent Events,
Special Subjects,
PERCEPTIVITY:
Alert or Dull,
Correct or Illusive,
REASONING POWER:
Ordinary Subjects,
Own Mental State,
Special Subjects,

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed,
DELUSIONS:
Systematized or Not,
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS:
Talks incoherently & profusely - rather too active to make a satisfactory examination - Ideas created. Words come rapidly & then incoherent talk runs on exalted ideas. Is given of the world etc. Is now in restraint No physical ailments noted. Has no meningitic signs nor signs of exhaustion from activity

Personal and Medical History of Ella Brandt

EXAMINATION ON ADMISSION, CONTINUED.
PHYSICAL CHARACTERISTICS.

HEIGHT, not taken WEIGHT, not taken NUTRITION, Not very bad but seems to have failed some
WOUNDS OR ABNORMALITIES,
TONGUE, Tremors, little dry probably from talking Coatings, Promptness Movement,
PUPILS, Equality, Size, Somewhat enlarged
[illegible] Light, Accommodation,
Has suppuration of left ear
COORDINATION, Arms,
Legs,
TREMORS, Hands, Tongue,
Facial Muscles, General,
REFLEXES, Patellar,
Other
ARTICULATION,
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART,
LUNGS,
GYNAECOLOGICAL EXAM., Aug. 1/96 Uterus in normal position but immovable - bands of adhesion on Left side
MENSTRUATION, Very irregular. external genitales normal.
OPHTHALMOSCOPIC EXAM.,
HABITS, Dirty, Clean, Careless,
BOWELS, Normal, Constipated, Have not moved since coming Irregular,
APPETITE, Good, Medium, Poor, Takes milk chiefly
SLEEP, Good, Poor, Irregular,
PULSE, Resp., Temp.,
CRANIAL MEASUREMENTS,
HISTORICAL,
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations,
Father or Pat. Relations,
Brothers or Sisters,


TAKEN,

EXAM. URINE, June 1/96
Color, Red.
Character. Flaky deposit
Amt. in 24 hrs. 3/4 XXXVIII
Sp. Gr. 1014.
Reaction Alk.
Albumen Trace of - by Tannic.
Sugar. None
Microscop. Mor. urates few - blood cells - bladder epithe - triple phosphates.

...ounce at ... Burlington road, ten miles south of ...erne, was robbed last night. The safe ...s blown open and $40 in cash secured, ...ides a small quantity of stamps, some ...thing, shoes, etc. For over a year work

Personal and Medical History of Ella Brandt

1897

This patient was brought Here by Deputy Sheriff Kinney, attended by Medico of Jail, with following History. Patient is in fair physical condition. There is no history of consanguinity or hereditary. This is first attack; has not been in hospital before. Six Days ago became deranged. The Disease seems increasing: variable & with rational intervals; at first recurring: two days past, not rational. Derangement now shows as subject of Spiritualism. Showed a disposition to injure others, but only mod. yesterday. Is not suicidal: no filthy & destructive habits. No peculiarities has been previously shown. There is no history of intemperance in self or parents, or of any severe Disease or head-injury. She has been restrained, but for a few days only. Supposed Cause of the Disease is Menopause? She has been treated by Control & relatives (a case of acute mania)

May 12 On admission, was put on B² (G.H.R. Rft. Complexion light: hair brown, gray: Straked. eyes gray: condition of skin normal: bruise on left knee: also on arms: Scar on left knee: No eruptions &: Is clean: very noisy: talks incoherently & has Delusions)

May 13 Nurses Notes Rest on ward & put to bed. Very noisy & out of bed most of night. May 13 Ate small breakfast. Was quite violent. Very noisy & out of bed most of day. Talks incoherently & refuses to eat. Put in restraint at 8 P.M. Was awake & struggling most of night. Menses. May 14 Ate nothing but drank cup of milk Taken out of restraint. Enema given - bowels moved slightly. Ear washed out. Tonic given - Put in restraint at 1 P.M. Was quite violent. Slept about 2 hrs. during night. May 15 In restraint. Enema given - porridge given - bowels moved slightly. Took three glasses milk. Tonic given 3 times daily. Ear & mouth washed daily. Very noisy - still menses.

May 16 In restraint. Drank 4 glasses milk & one eggnog. Bowels moved. Struggling & very noisy - Slept 4 hrs. Salt bath given, slept none during night - Very noisy, Expectorates a little - T 100.8 P. 72 R 34. May 17 Ear & mouth washed. Up on ward - very noisy & quite violent. Hypo. given. Took glasses milk & Hypo given - slept about 2 or 3 hrs - Noisy most of night slept about 1 hr. T. 99. P. 72 R 34. May 18 Mouth & ear washed - Hot bath with cold applications to head given drinks milk & eggnog. T 98.4 P 74 R 32 Slept 3 hrs. during night. May 19 Salt bath given In restraint. Very noisy & quite violent - 4 glasses milk. Slept about 3 hrs. Tonic given 3 times daily. Ear & mouth washed three times a day. Hypo given.

May 20 Taken out of restraint. Very noisy & quite violent. Hot bath given - cold cloths to head & put in restraint. Took one eggnog & 3 glasses milk - Dose castor oil given. Ear & mouth washed. Tonic given. May 21 Taken out of restraint Quite violent - Takes Tonic 3 times daily. Ear & mouth washed - Bed sore dressed Took two eggnogs & 3 glasses milk. Put in restraint. Slept 3 hrs. noisy most of night

May 22 Out of restraint most all day. Took 2 eggnogs 3 glasses milk & one of clam juice Very violent. Bed sore dressed. Put in restraint. Slept 5 hrs.

May (vomited) In restraint most of day - Very noisy - Bed sore dressed - Ear & mouth washed Ate nothing. May 24 Very violent & noisy. Put in restraint at 3 P.M. Took three Eggnogs Slept 4 hrs. during night. Salt sponge bath given. Bed sore dressed. Ear & mouth washed

Personal and Medical History of Ella Brandt.

May 25 Out of restraint & in seclusion during day. Restraint at night. Hot salt bath with cold at head given. Ear & mouth washed. Took 3 eggnogs - slept 6 hrs. during night Castor oil given

Summary - Patient very noisy & violent ever since admission - In restraint every night & nearly every day - Ate no solid food but took milk & eggnogs. Tonic given daily - Sleeps poorly - Bowels constipated - Cathartics & enemas given. Hot & salt baths given almost daily - Ear & mouth washed & bed sore dressed daily.

May 30 Out of restraint all day for first time in a week. Seems quiet & mentally improved. Took some solid food for dinner. Trans. to B. 2. May 30 Ate Supper - Was very quiet May 31 Refused breakfast & dinner. Was very violent & was transferred to No 3.

Summary Nurse's Notes by Dr. L. L. Phelps: - Aug 96 - Appetite poor: bowels constipated: Nov 96 Refuses to go to Dining room for meals at times rather erratic in behavior: quite health good: Feb 97 Massage given every other day: behavior very uncertain: does no work: May 97 Salt baths given three times a week: very noisy at times: usually quiet: Has improved some on the whole:

1897 Aug 7 Sought nurses: Aug 21 Assists some with work: bowels regular: appetite good: careless about her hair: otherwise personal appearance fairly neat.

Sept 12 Sought nurses: Sept. 19 Visited by father who took her home: She was quite careless in habits & personal appearance: Quite restless at night; Sleeping on floor later found in bed: Do was a very uncertain state of mind when taken away: General health good. Continued by Dr. P.M. Phelps.

Sept 26 '97 Visited by father & taken home on trial. Has been recently more quiet than before, altho there is still some incoherence in her manner & speech.

Discharged.

Personal and Medical History of Sarah Moran

LARKEY, PUELAR & SCAMBLER, DAVENPORT, IOWA.

Whole No. 4394.
Residence, Olmsted County, Minn.
Date Admission, 14th May 1896.
Admitted by, Dr. Phelps Hour, 3:00 PM.
How Sent, Joseph A. Bear, Ct Comm. Olmsted Co.
Sex, Female
Age, 29
Civil Condition, Single
Children,
Age Youngest Child, —
Occupation, Has none. (father, a laborer)
Degree Education, Common School.
Profession Religion, Yes. Catholic
Habits, Probably, not good.
Nativity, Cyota, Minn. (parents born in Ireland).
Physicians Committing, Christopher Graham and C. J. Gauper.
Correspondents, None given in papers

No. for Year, 222.
Insane Relatives, None
Cause Exciting, Menstrual irregularities
Cause Predisposing, Previous attacks
Form,
Accompanying Bodily Disorder, Menstrual irregularities
Suicidal or Not, not.
Date of this Attack, About a week ago
Duration, about a week.
No. of Attack, Many.
No. of Admissions, 4th here
Age First Attack, about 18.
Time of Leaving, May 29. 1897
Time in Hospital, 1 yr. 15 d.
Result, Discharged Dec. 1. 1897 Recovered.

EXAMINATION ON ADMISSION
MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused,
Quick or Sluggish,
MEMORY:
Past Events,
Recent Events,
Special Subjects,
PERCEPTIVITY:
Alert or Dull,
Correct or Illusive,
REASONING POWER:
Ordinary Subjects,
Own Mental State,
Special Subjects,
GENERAL DESCRIPTIVE REMARKS: Physical health good for some 10 years has had recurrent attacks.

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed,
DELUSIONS:
Systematized or Not,
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,
Excitable. silly rather loud in talk & manner. easily excited - fears her own condition.

Personal and Medical History of Sarah Moran

EXAMINATION ON ADMISSION, CONTINUED.
PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 4in WEIGHT, not taken — NUTRITION, Good.
WOUNDS OR ABNORMALITIES,
TONGUE, Tremors, Coatings, Flaky Promptness Movement,
PUPILS, Equality, Equal Size, Normal.
Response Light, Respond. Accommodation,
SIGHT, Fair
HEARING, Good
COORDINATION, Arms, Normal
Legs,
TREMORS, Hands, Normal Tongue,
Facial Muscles, General,
REFLEXES, Patellar,
Other
ARTICULATION, Good.
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, Normal.
LUNGS, Normal.

TAKEN,

EXAM. URINE, June 1 '96
Color Light yellow
Characte Flaky White Sediment
Amt. in hrs. 24
Sp. Gr. 1017
Reaction Acid
Albumen None.
Sugar. "
Microscop. Triple Phosphates.

GYNAECOLOGICAL EXAM., Slight hyperaemia of the cervix - otherwise Normal.
MENSTRUATION,
OPHTHALMOSCOPIC EXAM.,
HABITS, Dirty, Clean, Careless,
BOWELS, Normal, Constipated, Irregular,
APPETITE, Good, Medium, Poor,
SLEEP, Good, Poor, Irregular,
PULSE, Resp., Temp.,
CRANIAL MEASUREMENTS, Circ. (h) 55 (f.m) 63 Naso oc. 33 Bimast 36 Auriporic. 18.8 Fronto. 15 Bimast. 13-10 Fr. 16
HISTORICAL,
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations,
Father or Pat. Relations,
Brothers or Sisters,

Personal and Medical History of *Sarah Moran.*

Personal and Medical History of

This patient was brought here by Sheriff Stewart, with following history: patient is in fair physical condition. There is no history of consanguinity or heredity. This is not 1st attack: first one occurred Eleven years ago & she has had several attacks since, duration of each several weeks, (and some much longer time). She has been at this, Rochester State Hospital before: treatment beneficial. First symptoms of this attack manifested about a week ago, by loud, boisterous talking: leaves her home. Disease seems increasing: variable and with rational intervals, but these, not at regular intervals. Derangement now shown by loud, profane talking: excitability. Is disposed to injure others, but is not suicidal. No filthy or destructive habits. Before the accession of the disease, she showed peculiarities. There is no history of intemperance in self or parents, nor of any severe disease or head injury. Has been confined only as above stated. Supposed cause of the Disease is menstrual irregularities. She has only received treatment, as above stated (in Hospital).

May 14 On admission, was put on 1/3 G.H.N.R.pt. Complexion sallow: hair black: eyes blue: Condition of skin normal: no marks scars or bruises noticed: is clean: behavior very good).

* Note. As stated, patient has been here 3 times before (1st time: May '86 to June '87: 2d time, from June '89 to Dec '92: & 3d time, from 7 June '94 to June 1895 (for this, see Vol 26 pp 435 to 437). her condition, at each time of coming, seems to be about the same.

May 14 Nurses Notes Recind on ward. May 15 Appetite good - Bowels constipated pills given & bowels moved - May 16 Quiet - talks very sensibly - Tonic given 3 times daily. May 17 Complains of headache. May 18 Appetite good. Bowels regular. Talks very sensibly. May 19 Trans. A 1 Appetite good. Tonic 3 times daily May 20 Patient slept well during night. Is very loud & talkative on ward. Trans. to C+. May 21 Appetite good. Bowels moved. Quiet most of time. Complains of pain in head. Complains of noise. Trans. to B1. May 22 Ate dinner & supper. Quiet during morning. Quite noisy in evening & during night. May 23 Ate dinner & supper. Very noisy all day. Slept very little at night. Trans. to B2.

May 24 Appetite good. Noisy & restless. Also untidy in habits. May 25 Appetite good. Quiet greater part of day. Tidy in habits - May 26 Appetite good. Very noisy & untidy in habits. May 27 Appetite good. Patient quiet in behavior. Trans. to B1.

Summary Patient quiet & talked sensibly at first. behavior variable since. Sometimes very noisy, & untidy in habits on other days quiet & neat. Appetite good. Complained of pain in head. Tonic given daily. Does not sleep well. Bowels rather irregular.

May 29 Appetite good. Very quiet. Neat in habits & personal appearance. " 31 Quiet & agreeable. Summary Nurse's Notes by Dr. S.L. Phelps: June 9 Takes tonic: Appetite fair: sleeps well: assists some with work: Nov. 9 Quiet & pleasant: physical health good: talks sensibly: Feb. 97 Gen'l health very good: Mental condition normal: Has been quite well for several months: talks sensibly. May 21 Went Home Recovered.

Discharged

Personal and Medical History of Anna Blomquist

LEIGHT, FIDLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4395.
Residence, 876 Sims St: St Paul.
Date Admission, 16th May 1896.
Admitted by, Dr. Eby — Hour, 6.45 PM.
How Sent, G Wilbrink. Jo P. Ramsey County
Sex, Females.
Age, 37 years
Civil Condition, married
Children, one
Age Youngest Child, 4 years
Occupation, Housewife (husband, laborer).
Degree Education, — Common School —
Profession Religion, not a church-member
Habits, Probably good.
Nativity, Sweden: (parents also born there).
Physicians Committing, Olaf Ohlberg and F.B. Brimhall.
Correspondents, — none given in papers —

No. for Year, 223.
Insane Relatives, — None — father Inebriate.
Cause Exciting, Rheumatism & its results.
Cause Predisposing, — previous attack —
Form,
Accompanying Bodily Disorder, Rheumatism & heart complications
Suicidal or Not, not
Date of this Attack, one month ago
Duration, — one month —
No. of Attack, 2nd —
No. of Admissions, 1st
Age First Attack, — about 33 —
Time of Leaving, July 11 '96.
Time in Hospital, 11 mos. 18 da.
Result, Recov. Disc. July 30/96.

EXAMINATION ON ADMISSION
MENTAL CHARACTERISTICS.

Exam. C.M. Phelps 5/8/96

MENTAL ACTIVITY:
Clear or Confused, Not very clear
Quick or Sluggish, Dull - sluggish
MEMORY:
Past Events, Seems clear
Recent Events, "
Special Subjects, "
PERCEPTIVITY:
Alert or Dull, Dull
Correct or Illusive,
REASONING POWER:
Ordinary Subjects, Not very poor.
Own Mental State, slightly confused.
Special Subjects,
GENERAL DESCRIPTIVE REMARKS:
Seemingly a case of Melancholia & quite possibly caused by the heart trouble.
Seems unwilling or dull about talking

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed, sits about with head hanging down
DELUSIONS: Will not talk enough to bring them out.
Systematized or Not,
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

Personal and Medical History of Anna Blomquist

EXAMINATION ON ADMISSION, CONTINUED.
PHYSICAL CHARACTERISTICS.

HEIGHT, Not taken WEIGHT, Not taken NUTRITION, rather poor, not emaciated
WOUNDS OR ABNORMALITIES,
TONGUE, Tremors, red point Coatings, Promptness Movement,
PUPILS, Equality, Size, normal
Response Light, Respond Accommodation,
SIGHT, Probably good
HEARING, Seems good
COORDINATION, Arms,
Legs,
TREMORS, Hands, Tongue,
Facial Muscles, General,
REFLEXES, Patellar,
Other
ARTICULATION,
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, No murmur. Sound plain clear. irregular very + slow
LUNGS, Normal so far as noted.
GYNAECOLOGICAL EXAM., Uterus in left latero version Adhesions on left side: Considerable tenderness - Some chg
MENSTRUATION,
OPHTHALMOSCOPIC EXAM.,

TAKEN,

EXAM. URINE, June 1/96
Color Reddish yellow
Char. Heavy White deposit
Sp. Gr. 1018
Reaction Acid
Albumen None
Sugar "
Microscop. Triple phosphates Amor. urates.

HABITS, Dirty, Clean, Careless,
BOWELS, Normal, Have not moved since coming Constipated, Irregular,
APPETITE, Good, Medium, Poor, Eats only a little by urging
SLEEP, Good, Poor, little or none Irregular,
PULSE, 48 Resp., Temp.,
CRANIAL MEASUREMENTS, Ant. Post 19.5 Transverse 14.6 Biauric. 12.2 Facial length 12.8 Circum. 54.3 N. occip. arc 37
~~HISTORICAL.~~ Biauric. arc 31 Vertico mental arc 41
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations,
Father or Pat. Relations,
Brothers or Sisters,

Personal and Medical History of Anna Blomquist

1896

This patient was brought here by Deputy Sheriff Emanuel Johnson attended by Mr. Blomquist, with following history. Patient is in fair physical condition. There is no history of consanguinity nor of any insane relatives, but father inebriate. She had a slight attack 4 years ago; lasted a few days: was not sent to hospital: First symptoms of this attack manifested one month ago, by melancholia. Disease seems increasing: variable & with paternal intervals, but these at irregular intervals. Confusional insanity is now shown. Patient is not disposed to injure others, nor suicidal, nor filthy, nor destructive. No peculiarities had been previously shown. She has been subject to rheumatism & heart complications. She has not been restrained or confined. Supposed cause of the disease is rheumatism and its results. She has been under treatment by Tonics, Bromides, rest. On personal examination there found to be anaemic, weak & has valvular disease of the heart.

May 16 On admission, was put on B² (G.A.R. Pfp. Complexion light: hair brown: eyebrows: Condition of skin normal: no marks scars or bruises noticed. Decban: Quiet: has delusions)

Nurses Notes Retired on ward. Full bath & put to bed. Out of bed most of night - crying & pounding on door & screen. May 17 Seems very nervous has delusions - Ate dinner & supper. Sat up in bed most of night - Out of bed several times. T. 98. P 74 R 24 May 18 Eats quite well. Is very nervous - Takes tonic T 98.2. P 60 R 24 Out of bed most of night - Slept 4 hrs. T 98.2 P 60 R 24.

May 19 Eats quite well. Takes tonic T 98.4 P 80 R 24. Slept about 3 hrs during night

" 20 Appetite quite good. Takes tonic T 98.-45-26 Slept 5 hrs. during night

" 21 Appetite good. Bowels regular. Takes tonic T. 98. 48. 25

" 22 About the same - May 24 During second week remained about same. Appetite good. Sleeps well. Bowels usually constipated. Tonic given.

Summary Patient is quite nervous - has delusions. Was very restless & noisy at first but has grown quieter of late Tonic given daily - Sleeps well - Appetite good. Bowels rather irregular.

May 30 Appetite good. Takes Tonic Goes walking & riding.

June 1st Appetite Quite good: Takes Tonic + 2 eggnogs each day: Seems quite weak.

" 11th Appetite better of late. Seems to B.I. June 14 + 17 Electrical treatments given

" 13-17 Massage. June 19.22.24-29 Gym. Treatments. June 29 Electrical Treatment. Takes Tonic & eggnog every day Appetite quite good. Sleeps well. Bowels regular: Assists with work. Takes out door exercise: Seems very well & strong. July 4 Treated by husband & daughter. Went Home

Discharged

Personal and Medical History of

Personal and Medical History of Hattie L. Lutgens

LABERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 44404.
Residence, Meriden, Steele County, Minn
Date Admission, 25th May 1896.
Admitted by, D. Herzog Hour, 6 1/4 P.M.
How Sent, W. B. Chadwick, Jo. P. Steele County
Sex, Female
Age, 25
Civil Condition, married
Children, Three
Age Youngest Child, 2 months.
Occupation, Housewife (husband a farmer)
Degree Education, at Common School, until 15 years of age.
Profession Religion, Lutheran. Ger.
Habits, Probably good
Nativity, Meriden, Minn (Parents born in Prussia, Germany).
Physicians Committing, B. M. J. Corlis and J. P. Johnson
Correspondents, H. Rosenau (father) Meriden Minn
Ernst Lutgens (husband) Owatonna. Minn

No. for Year, 232.
Insane Relatives, None
Cause Exciting, Overwork: Child bearing & probable abuse
Cause Predisposing, (not stated). - Do -
Form,
Accompanying Bodily Disorder, Weakness.
Suicidal or Not, — Not —
Date of this Attack, May 21st.
Duration, — 4 Days —
No. of Attack, 1st.
No. of Admissions, 1st.
Age First Attack, — 25 —
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION
MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Very confused
Quick or Sluggish,
MEMORY:
Past Events, Impaired
Recent Events, "
Special Subjects, "
PERCEPTIVITY:
Alert or Dull,
Correct or Illusive, Illusive
REASONING POWER:
Ordinary Subjects, Much impaired
Own Mental State, "
Special Subjects, "

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted, Exalted
Depressed,
DELUSIONS:
Systematized or Not,
Special Subjects, Delusive ideas
Transitory or Not, Transitory
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Very restless & excited talking in very incoherent manner most of time. At times fights quite violently when it requires several nurses to hold her. Behavior that of Acute mania. It is puerperal - being two months after child birth.

Personal and Medical History of Hattie L. Lutgens

EXAMINATION ON ADMISSION, CONTINUED.
PHYSICAL CHARACTERISTICS.

HEIGHT, not taken WEIGHT, not taken NUTRITION, Fair.
WOUNDS OR ABNORMALITIES,
TONGUE, Tremors, Coatings, White coat. Promptness Movement, Pale
PUPILS, Equality, R. larger Size, Dilated
Response Light, Accommodation,
SIGHT, Seems good.
HEARING, Seems good -
COORDINATION, Arms,
Legs, Cannot test
TREMORS, Hands, None Noted Tongue,
Facial Muscles, General, None noted
REFLEXES, Patellar, EXAM. URINE, June 1/96
Other Color Red
ARTICULATION, Normal Character Flaky, Sediment
Slurred, Sp. Gr. 1031
Hesitating, Reaction Acid
FACIAL EXPRESSION, Albumen Trace by Tests
Sugar None.
Microsc. Ammon. urates
Pus cells - Bladder Epith.



SENSIBILITY,
HEART, No murmurs
Sounds normal
LUNGS, Normal - Breath sounds good
TAKEN,
GYNAECOLOGICAL EXAM., Uterus retroverted & bound down Cervix lacerated External genitals normal
MENSTRUATION,
OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated, ✓	Irregular,
APPETITE, Good,	Medium,	Poor, ✓ Very restless & noisy at night
SLEEP, Good,	Poor, Very poor	Irregular,
PULSE,	Resp.,	Temp.,

CRANIAL MEASUREMENTS, Long. horizontal 65½ Long. vert. to ment. 66½ Nasion. arc 35 - Biauric. 34½ Ant. post. diam 19.1 Transv. diam 14.2 (Biauric. diam 11.6 Facial length 10-
HISTORICAL, Very prominent diseases.
LENGTH OF INVASION, Short ONSET GRADUAL OR SUDDEN, Sudden
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations,
Father or Pat. Relations,
Brothers or Sisters,

Personal and Medical History of Hattie L. Lutgens

1896

This patient was brought here by Sheriff J. Z. Barnard, attended by A. Rosenau (father) with following history. Patient is in fair physical condition. There is no history of consanguinity or heredity. This is 1st attack: no treatment instituted. First symptoms of this attack were manifested May 21st: wanted to leave her children alone & go to his mother; and she had delusions. Disease seems increasing; variable with rational intervals, but these not at regular intervals. Derangement now shown in that she thinks she was made to work too hard and her mother-in-law was not satisfied, and jealous of her husband. Patient is not disposed to injure others, nor suicidal; nor filthy nor destructive in her habits. No peculiarities had been previously shown. There is no history of intemperance in parents or self, nor of any severe disease or head injury. She has not been pregnant or confined. Supposed cause of the disease is overwork for the last 3 or 4 years, rapid child bearing and probable abuse. No treatment was given her before May 22d: then, bromides. Patient is also suffering from General Debility. —

May 26 On admission, was put on B3 (Ward's Island Reception Hospital). Complexion light: hair light brown: eyes gray: condition of skin normal: no marks scars or bruises noticed: is quite dirty: no bodily peculiarities noted: Behavior noisy & she has delusions).

May 26 Nurses Notes. Ground on ward & put to bed. Awake pounding on door most of night. Slept none. May 26 Breasts milked & medicine applied. Takes tonic. Salt bath given. Slept about 3 hrs. Took 3 glasses of milk & ate supper. Was put in restraint at 10 P.M. Struggled & tried to get out. Attempted to fight. May 27 Ate breakfast. Powder given. Bowels moved. Salt bath given. Was very violent & put in restraint. Breasts milked & medicine applied. Awake most of night. T. 98.6 P. 67 R. 24. May 28 Refused breakfast. T. 99. P. 67. R. 25 Hot salt bath given & breasts milked & medicine applied. Put in restraint. Took one eggnog & 3 glasses milk. Takes tonic. Menstr.

May 29 Ate part of breakfast. Hot bath given. Tonic given. T. 99. P. 70 R. 24. Menstr.

" 30 Takes tonic 3 times a day. Try noisy. Took one glass eggnog & two glasses of milk. In restraint at night. Slept one hour. T. 98.6 P. 68 R. 23

" 31 Refused breakfast. Took two glasses of milk. Bowels constipated. Took castor oil - Bowels moved. In restraint at night. Slept 3 hrs.

June 1 Refused breakfast. Very noisy all day. Bowels moved. Took 3 glasses milk. In restraint at night awake all night. June 2 Took one eggnog 2 glasses milk. In restraint at night. Slept about one hour. June 3 Was fed with tube. Salts given - bowels did not move. In restraint at night slept four hours. June 4 Fed with tube & salts given. Bowels moved. In restraint slept 3 hrs. June 5 Two glasses of milk & eggnog given. Slept quite well at night. In restraint at night. Bowels moved. June 6 2 glasses milk, 1 glass tea. In restraint at night slept 2½ hrs. June 7 2 glasses milk 1 cup tea. Bowels moved. In restraint at night. Slept 5 hrs.

June Summary Nurses Notes by Dr. B.L. Phelps. Rather restless & maniacal: restless at night appetite irregular. Shows some impairment of nutrition: Nov. 19 Menstr. regular.

Personal and Medical History of

1896

no special change since admission: Jan'97 Appetite good: bowels regular: works in dining room. At times talks audibly but usually is incoherent: has many & varied delusions: Mar'97 no change: Aug'97 At times destructive: Aug 8 Fought nurses: Habits clean but rather untidy about clothes & hair: Appetite fair: Has improved some in Genl mental condition. Continued by Dr. B.L. Phelps. Oct 997 Patient has been rather restless & inclined to be violent at times. Oct 13 Trans. to B3. Nov 18 Visited by father: Has been troubled with a boil on her left arm. Nov 24 Complains the last few days of being sick. Temp. today 102. Nov 28 Trans. to Infirmary. Complains of severe pain in abdomen: also of backache. Dec. 7 Temp. gradually going down to normal. has been sick to 102-103. Dec 14 Visited by husband. Dec 19 Trans. to B1. Feb 8 Wt. 128# Apr 4 Trans. to B3. Apr 18 To Annex. May 13 to 6 June 7 to B3. Feb 28 99 condition remains practically unchanged during intervening period.

1899 Mar 1 to Sept (Cont. by Dr. R. A. Bell) General health & appetite good: bowels regular: sleeps well: untidy at times & rather careless in personal appearance: Has delusions & expresses them freely: at times is noisy & quite violent attacking both nurses & patients. Sept 1 - Feb 24 1900 (Dr. Reynolds) Assists with work: Eats & sleeps well: Takes outdoor exercise: Talks little. Mens. June 18 Wt. 123#. Mch 1 - Aug 31. (Dr. Linton) Neat: Has many delusions uses profane language & occasionally fights: Takes outdoor exercise: June 27 Picked lock on screen: July 4 Visited by husband, brother, 3 children, & 2 sisters. July 16 Vaccinated - Sept 1 - Nov 30 Assists with ward work: no change in general condition, at times cross & disagreeable & aggressive. Nov 16 Wt. 125#.

Dec 1 - Feb 28 1901. Quite well physically: Talks & laughs to herself & has many delusions: Does not converse nor answer questions. Mens. Wt. 117½#

Mar 1 - June 1 - 1901 No change in mental or physical condition: menstruates. Assists with work on ward. May 29 Wt. 110 ½#. June to Sept. July 4 visited by relatives, assists with work, attends amusements, is often violent, Sept. 2 Wt. 106½#. Sept. to Dec. Nov. 29 Wt. 113#. No change in general condition.

Up to Feb. 1, 1903. General health good: eats and sleeps well, takes exercise: assists with the work: bowels regular: menstruates regularly: neat and clean: very delusional: at times disagreeable and violent. Wt. Nov. 25th. 113#.

Personal and Medical History of *Eliza Lucas*

Whole No. 4406.
Residence, St. Paul. Minnesota
Date Admission, 27th May 1896.
Admitted by, Dr. Eby — Hour, 6.45 P.M.
How Sent, G. Wilbrick. Jail. Ramsey County.
Sex, - Female -
Age, - 60 -
Civil Condition, married
Children, - 6 -
Age Youngest Child, nine years.
Occupation, Housewife: husband a printer.
Degree Education, Common School
Profession Religion, Yes: Catholic
Habits, - Probably Good -
Nativity, Ireland: (parents also born there).
Physicians Committing, A.W. Dunning 2nd & E. Eugene Riggs
Correspondents, Miss B.M. Lucas 765 Congress St. St Paul Minn

No. for Year, 234.
Insane Relatives, None
Cause Exciting, not given. (previous Cause Climacteric).
Cause Predisposing, Previous attack
Form,
Accompanying Bodily Disorder, None mentioned
Suicidal or Not, - Not -
Date of this Attack, - Not stated -
Duration, - not stated -
No. of Attack, 2nd
No. of Admissions, 2nd
Age First Attack, - 52 -
Time of Leaving, July 29-1897
Time in Hospital, 1 yr. 3 mo. 2d.
Result, Discharged Nov. 3. 1897 Unimproved

EXAMINATION ON ADMISSION

MENTAL CHARACTERISTICS.

Exam. by P.M. - Dr. Phelps 6/7/96

MENTAL ACTIVITY:
Clear or Confused, Confused on some subjects
Quick or Sluggish, Quick
MEMORY:
Past Events, } Good
Recent Events, }
Special Subjects, }
PERCEPTIVITY:
Alert or Dull, Alert
Correct or Illusive, Usually correct.
REASONING POWER:
Ordinary Subjects, Fair
Own Mental State,
Special Subjects, On electricity + influences

GENERAL DESCRIPTIVE REMARKS: A very intelligent polite lady. Talks well except in mentioning "influences" by which foot was hurt or other sensations produced. As to cause no definite one is noted. Arterial degeneration is most suggested but cannot be demonstrated. The state is Paranoiac in form - quite typically so. Previous grade was probably good.

EMOTIONAL STATE:
Normal, Calm, Usually quiet
Indifferent,
Exalted,
Depressed, Slightly depressed on some subjects
DELUSIONS:
Systematized or Not,
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

Personal and Medical History of *Eliza Lucas*

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, not taken WEIGHT, not taken NUTRITION, Fair.
WOUNDS OR ABNORMALITIES, Contraction tendon middle finger right hand - 1st + 2nd phalanx
TONGUE, Tremors, Coatings, No coating Promptness Movement,
PUPILS, Equality, Equal Size, Normal
Response Light, Fairly good - Accommodation,
SIGHT, Has glasses - Fairly good
HEARING, Good
COORDINATION, Arms, Good
Legs,
TREMORS, Hands, None of special Note Tongue,
Facial Muscles, General,
REFLEXES, Patellar, L.9-R.8.9
Other Some inequality,
ARTICULATION,
Slurred, Good
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, No Notable Signs
LUNGS,
GYNAECOLOGICAL EXAM., Rectocele - some laceration of Perineum Uterus normal. Fair. External genitalia somewhat irritated
MENSTRUATION,
OPHTHALMOSCOPIC EXAM.,

TAKEN,

EXAM. URINE, June 1/96
Color Reddish Yellow
Characte Hazy Sediment
Sp. Gr. 1026.
Reaction Acid
Albumen None
Sugar "
Microsc. Uratic Tripe phosphates

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated,	Irregular,
APPETITE, Good,	Medium,	Poor,
SLEEP, Good,	Poor,	Irregular,
PULSE,	Resp.,	Temp.,

CRANIAL MEASUREMENTS, Circ (H) 54.5 Circ (Vert) 46.5 Ross No. 31 Biau. 35 Ant.p.d. 19 Transv.d 12.5 Biz.d 12.5 Facial L. 10.

HISTORICAL,
LENGTH OF INVASION, Years. ONSET GRADUAL OR SUDDEN, Gradual
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Denies any insanity
Mother or Mat. Relations, Died 7 yrs. ago of pneumonia - Healthy
Father or Pat. Relations, Died when she was 14 of accident - Healthy
Brothers or Sisters, "None now" (cries) 1 sister

Personal and Medical History of *Eliza Lucas.*

Personal and Medical History of

1896

This patient was brought here by Deputy Sheriff Emanuel Johnson, attended by Miss B M Lucas. with following history. Patient is in fair condition. There is no history of consanguinity or heredity. This is not 1st attack: one occurred 2 years ago; duration several months: was sent to this (Rochester) Hospital in January '95. First symptoms of this attack manifested by a delusion of electrical phenomena: persecution. The disease seems stationary: not variable: no rational intervals. Derangement now shown by the delusion of strange women in the house & infidelity of husband. Patient is not disposed to injure others, nor suicidal; propensity not active: no filthy or destructive habits. No peculiarities had been previously shown: there is no history of intemperance in parents or self. She has not been subject to any severe disease nor had any head injury. Has been confined as above. Supposed cause of the disease not stated: (No previous commitment. Same was given as clinical note)

*Note. Patient was here before, as above stated, from Jany 29-95 to March 23/95; (see Vol 28 (Page) 73 No 3903); On this coming She complained some of headaches & of not sleeping well. Talked some to herself. Was nervous. Was quiet & well-behaved, but had delusions: "thinking her husband was working against her". Did not understand why she was sent here. Ordinary remarks, however, were quite sensible. Went home improved in her mental condition. — ——

May 27 On admission, was put on A[1] G H R. Rpt. Complexion light: hair gray: eyes gray: condition of skin normal: no marks, scars or bruises noted: is clean: no bodily peculiarities noted: behavior quiet).

" 27 Nurses Notes- Ate light supper. Rested well during night

" 28 D 97.8 P. 77 R 18 Appetite fair. Tonic 3 times daily. Patient very quiet & agreeable on ward. Talks quite sensibly Slept well during night

" 29 Quiet & pleasant in appearance. Talks very little Appetite good. Sleeps well. Tonic 3 times daily. Bowels regular. May 30 Sits about quietly on ward Does no work Physical health good Sleeps well.

" 31 Went for a walk No change. Rested well during night. June 1 Quiet & pleasant in appearance Somewhat nervous during night. Did not sleep well. June 2 Continues about same appetite good Bowels regular Tonic given 3 times daily. Slept well during night. June 3 Appetite fair Bowels regular. Quiet & pleasant in appearance. Talks sensibly Sleeps well. June 9 No noticeable change in patient during second week She remained quiet & pleasant. Slept well. Appetite fair Bowels regular. Took out door exercise.

Summary Patient quiet & pleasant in manner. Talks very little Has delusions. Is nervous at times usually sleeps very well. Appetite fair Tonic given 3 times daily. Summary Nurses Notes by Dr. S.L. Phelps. June 9: Quiet & pleasant in behavior: talks quite sensibly: appetite good: sleeps well: physical health good: Nov. 96 Behavior quiet: Jan 97 Appetite rather poor: bowels regular. Usually remains quietly in her room: Generally talks & answers questions sensibly, but at times is incoherent & talks to self. Gen'l health good. July 30 97 Visited by daughter & Went Home- Has been quiet & well behaved but seemed to retain delusive ideas.

Discharged

Personal and Medical History of Margaretha Korstens

LEBERT, FIDLAR & SAMBERG, DAVENPORT, IOWA.

Whole No. 4408.
Residence, Belvidere. Goodhue Co. Minn
Date Admission, 28th May 1896.
Admitted by, Dr. Phelps Hour, 7:30 PM
How Sent, Axel Haller, Jo P. Goodhue County
Sex, Female
Age, 76
Civil Condition, widowed
Children, 9
Age Youngest Child, 42
Occupation, Housekeeper: (Husband was laborer)
Degree Education, Common School.
Profession Religion, Yes, Lutheran.
Habits, not Intemperate
Nativity, Germany: (Parents also born there).
Physicians Committing, L. Dearborn and J. O. Anderson
Correspondents, (Son (M. Korstens - Belvidere Mills: Goodhue Co.

No. for Year, 236.
Insane Relatives, not known
Cause Exciting, from losing a son.
Cause Predisposing, "chronic"
Form,
Accompanying Bodily Disorder, is aged & feeble
Suicidal or Not, not known
Date of this Attack, about 6 years ago
Duration, about 6 years
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, about 70.
Time of Leaving, Jan. 28. 1898
Time in Hospital, 1 yr. 8 mo. 22.
Result, Died. Exhaustion after Apoplectic attack

EXAMINATION ON ADMISSION

Exam. by Drs. Rhe & H Phelps 6/3/96

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, very confused
Quick or Sluggish, Sluggish
MEMORY:
Past Events,
Recent Events, Dull & confused no memory pumingly.
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Dull.
Correct or Illusive,
REASONING POWER:
Ordinary Subjects, Extremely dull & stupid.
Own Mental State,
Special Subjects,
GENERAL DESCRIPTIVE REMARKS:
A senile dement in appearance. The atheroma, pupil signs suggest as causal Brain atheroma, atrophy & progressive cortical impairment as causal factors. Of previous grade & has no clue. Extremely dull now

EMOTIONAL STATE:
Normal, Calm,
Indifferent, Dull
Exalted,
Depressed,
DELUSIONS:
Systematized or Not, Dull & Mording unrealizing
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

Personal and Medical History of Margaretha Korstens

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, not taken WEIGHT, not taken NUTRITION, Rather poor
WOUNDS OR ABNORMALITIES, Bruises on face, back & arm - an abrasion
TONGUE, Tremors, Coatings, Promptness Movement,
PUPILS, Equality, Unequal Size, Large & irregular
Response Light, Sluggish Accommodation,
SIGHT, Senus senilis
HEARING, Seems dull
COORDINATION, Arms,
Legs,
TREMORS, Hands, Yes. Tongue,
Facial Muscles, General, Tremulousness
REFLEXES, Patellar,
Other
ARTICULATION, Only a few
Slurred, Sluggish words can be
Hesitating, obtained.
FACIAL EXPRESSION,
SENSIBILITY,
HEART, No Murmurs - regular.
LUNGS, Very slight action No deposits
GYNAECOLOGICAL EXAM., Aug 3/96. Uterus atrophied - slightly retroflexed & bound by adhesions - External genitals normal
MENSTRUATION,
OPHTHALMOSCOPIC EXAM.,

TAKEN,

EXAM. URINE, June 1'96
Color Yellow
Character Clowdy
Sp. Gr. 1021
Reaction Acid
Albumen None -
Sugar "
Microscop. Mates of ammon-Triple Phosphates.

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated,	Irregular,
APPETITE, Good,	Medium,	Poor,
SLEEP, Good,	Poor,	Irregular,
PULSE, Fairly regular	Resp.,	Temp.,

CRANIAL MEASUREMENTS,
HISTORICAL, Circ. h. 55. Circ. v. m. 54 Naso of. 37. Bmaur. 30 Ant. post. d. 19.1 Transv. d. 15.3 Bmaur. d. 13.8 Facial L. 11.3
LENGTH OF INVASION, 5 years or more ONSET GRADUAL OR SUDDEN, Gradual
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations,
Father or Pat. Relations,
Brothers or Sisters,

Personal and Medical History of Margaretha Korstens.

1896

This patient was brought here by Sheriffs' Deputy Adolph Gross, attended by Miss Gross, with following history. Patient is in aged & feeble condition. No history of Consanguinity: as to heredity, not known. This is 1st attack: symptoms manifested about 6 years ago: came on suddenly, at night: she appeared without being dressed: irrational. Disease seems increasing: not variable: no rational intervals. Derangement now shown in that she does not recognize her friends: imagines that she sees people: runs away & hides. Patient is not disposed to injure others: as to attempting suicide, do not know. Is filthy & destructive in habits. No peculiarities &c had been previously shown: there is no history of intemperance in parents or self: as to any severe disease &c, not known. She has been restrained & confined, having been locked in her room, whenever she could not be watched. Supposed cause of the disease is from losing a son. No treatment given. She now talks incoherently, when spoken to: does not know her own name.

May 28 On admission, was sent on B# (G.H.N.Dpt. Complexion light: hair gray: eyes blue: condition of skin normal: finger on right hand cut: bruises on arms & limbs; also on back: no hernia. Is quite dirty: no bodily peculiarities noted: Quiet: Cannot talk English.

" 28 Nurses Notes Patient old & feeble. Out of bed part of time. May 29 Appetite good. Pill given. Bowels moved. Habits very dirty. May 30 Appetite good. Bowels regular. May 31 Appetite good. Bowels regular. June 1 99. P80. R22 Appetite good. Bowels regular. Habits dirty. Patient old & feeble.

June 2 Appetite good. Has diarrhoea. June 3 Appetite good. Very restless walking constantly. June 4 During recent visit no change in patient. She is old & feeble. Unsteady on her feet. Talks no english. Very dirty in habits. Takes out door exercise.

Summary Appetite good. Bowels loose. Sleeps fairly well. Old & feeble & unsteady on feet. Talks no English. Very dirty in habits. Quiet but restless.

June Summary Nurse's Notes by Dr. L.L. Phelps: Old & very helpless: Appetite poor. Very demented: Nov 96 Very feeble both physically & mentally: Jan 97

1897 Very senile & demented: failing slowly: April 97 No noticeable change.

May Up & around the ward as usual: no special change: July 5 Seems very feeble. Put to bed: Face bruised by another patient: July 19 Has been steadily in bed. Transf. to Inf. July 22 Visited by son.

Aug. 31 Appetite quite good: Has improved some: very noisy most of time: entirely in bed. Continued by Dr. A.M. Phelps. Sept. Trans. to B3. Quite feeble, dull & thoroughly demented. Oct 20 Trans. to Annex. Quite feeble & dull: Left side found to be bruised & arm dislocated. Nov 30 Patient had very little trouble from the above injuries, but is quite helpless & demented. Feb 14 Patient moaning a good deal: Seems to be in pain today. Has vomited several times. Feb 21 Has not been at all well the last few days. Is weak & feeble circulation. Jan 26 Patient Died at 7:45 P.M.

Died.

Personal and Medical History of

Personal and Medical History of Mary Blumentritt

LEBERT, FICLAR & SAUNDERS, DAVENPORT, IOWA.

Whole No. 4409.
Residence, Minnesota County. Minnesota
Date Admission, 1st June 1896 —
Admitted by, S. Phelps Hour, 4 00 P.M.
How Sent, H.L. Buck. Jail. Minnesota County
Sex, - Female.
Age, - 35 -
Civil Condition, Married
Children, - 3 -
Age Youngest Child, 5 Years
Occupation, Housewife (Husband, Miller & farmer).
Degree Education, Reads & writes in German
Profession Religion, Yes. Evangelical.
Habits, not intemperate —
Nativity, Wisconsin (Parents born in Germany).
Physicians Committing, J.B. McGaughey and E.J. Ganeste
Correspondents, Frank Blumentritt
- Minnesota Co. - New Hartford, Minn

No. for Year, 237.
Insane Relatives, Father (Daniel Hartz) was hus. insane -
Cause Exciting, Religious impressions
Cause Predisposing, Heredity
Form,
Accompanying Bodily Disorder, Subject to sick headaches.
Suicidal or Not, — not —
Date of this Attack, about 2 weeks ago
Duration, — about 2 weeks. —
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, — 35 —
Time of Leaving, Oct. 28. 1896.
Time in Hospital, 4 mos. 28 ds.
Result, Discharged Feb. 3 '97. Improved

EXAMINATION ON ADMISSION
MENTAL CHARACTERISTICS.

Exam. by A.M. & S.L. Phelps

MENTAL ACTIVITY:
Clear or Confused, Fairly quick - not very clear
Quick or Sluggish,
MEMORY:
Past Events, Seems clear
Recent Events, "
Special Subjects, "
PERCEPTIVITY:
Alert or Dull,
Correct or Illusive,
REASONING POWER:
Ordinary Subjects, Not very poor
Own Mental State, Slightly Confused
Special Subjects,
GENERAL DESCRIPTIVE REMARKS:
Flat footed - Some tendency to enlarged veins.
No evidence of weakness of mind except thats in her statements - No physical impairment of special note found.

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted, Slightly exalted.
Depressed,
DELUSIONS: Some delusions but
Systematized or Not, Expresses them Says
Special Subjects, "imaginings"
Transitory or Not,
HALLUCINATIONS: Seems like Earth was jarring
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

Personal and Medical History of Mary Blumentritt

EXAMINATION ON ADMISSION, CONTINUED.
PHYSICAL CHARACTERISTICS.

HEIGHT, 4ft 5in WEIGHT, Not taken NUTRITION, Very good
WOUNDS OR ABNORMALITIES, Slight bruises on left side of head & left arm.
TONGUE, Tremors, Coatings, Promptness Movement,
PUPILS, Equality, Equal Size, Normal
Response Light, Accommodation,
SIGHT, Good
HEARING, Good
COORDINATION, Arms, Seems good
Legs,
TREMORS, Hands, None of note Tongue,
Facial Muscles, General,
REFLEXES, Patellar, & Equal
Other
ARTICULATION,
Slurred,
Hesitating, Good
FACIAL EXPRESSION,
SENSIBILITY,
HEART, No murmurs. Sounds good. Regular
LUNGS,
TAKEN,

EXAM. URINE, June 4 '96.
Color Red.
Characte- Heavy pink deposit.
Sp. Gr. 1031
Reaction Acid
Albumen Trace by heat & by Tests
Sugar None.
Microscop. Large ant. amor. urates - Granular casts
Pus cells.

GYNAECOLOGICAL EXAM., Uterus retroverted & endometritis os eroded cervix lacerated Complains of bearing down feeling worse on her feet a good deal - Has had 3 children - had tubes.
MENSTRUATION, Regular.
OPHTHALMOSCOPIC EXAM.,
HABITS, Dirty, Clean, Careless,
BOWELS, Normal, (She says) Constipated, Irregular,
APPETITE, Good, Medium, Poor,
SLEEP, Good, Poor, Irregular,
PULSE, Resp., Temp.,
CRANIAL MEASUREMENTS, Circum. h. 56c Long. verton. 36 Bias. Occ. 35c Biauric. 31 Ant.p. diam 19 Transv. diam 15c Biauric. d 145 Fac. L. 118
HISTORICAL, Father insane Heredity undoubtedly prominent cause though nominally (& really acute) possibly a precedent Melancholia
LENGTH OF INVASION, Said 2 or 3 mos. ONSET GRADUAL OR SUDDEN, Rather sudden
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, ~~65~~
~~Father~~ or ~~Pat. Relations,~~ here - Paternal relatives - denied
Brothers or Sisters,

Personal and Medical History of Mary Blumentritt

1906

This patient was brought here by Deputy Sheriff H.W. Fahrman & attended by Frank Blumentritt, with following history. Patient is in fair physical condition. No history of Consanguinity: but there is, of heredity: her father was insane: Committed to Rochester, 4 years ago, from Houston County. (name Daniel Harlow). This is the 1st attack. Symptoms manifested about two weeks ago, by great religious excitement: believed Satan was "pursuing her". Disease seems Stationary: variable and with rational interval, but these are irregular. Derangement now shown in that she believes she is "pursued and that House Shakes: hides garments &c. Patient is not disposed to injure others, nor suicidal, nor of filthy or destructive habits. Patient was always nervous and quick-tempered: subject to pronounced religious impressions. There is no history of intemperance in parents or self. And she has had no severe disease &c, except sick headaches. Has not been restrained or confined. Supposed cause of the disease is religious impressions. She has had no "treatment". She now says, "parties were looking for her yesterday and that house Shakes": She appears uneasy and restless.

June On admission, was put on B2 (G.H.N. Rpt. Complexion light: hair brown: eyebrows: condition of skin normal: has a sore on left foot: left side of face bruised: also arm: no hernia: Is clean: No bodily peculiarities noted: Behavior quiet.)

June1 Nurses Notes Ate small supper. Put to bed at 5 P.M. Put in restraint at 9 P.M. Slept 2 hrs. June 2 T98 P72 R24 Appite rather poor. Bowels constipated - Up on ward. Refuses to take medicine. June 3 T98 P72 R22 Appetite poor. Was catheterized. Worries a great deal about home. Tries to get out. Slept 3 hrs. June 4 T98.4 P72 R24 Sat up in bed crying most of night. Slept 2½ hrs. June 5 T98.2 P72 R28 Appetite poor. Tonic & enema given. Bowels moved. Slept well during night. June 6 Appetite poor. Slept 5 hrs. during night. Bowels moved. June 7 Appetite poor. Bowels moved. Slept 4½ hrs. Was quiet most of time. Talks a good deal about going home. June 8 Worries a great deal. Slept well at night.

June13 During second week Appetite improved a little. Bowels very irregular. Seemed a little more contented. Slept well at night.

Summary Patient has worried a good deal about home. Slept very little at first but is improving. Appetite has not been very good. Bowels very irregular. Has been more contented of late.

June14 Patient talks freely though in a rather silly & feeble way. Appears a chronic case although history is of acute trouble. Treatments given June 15 & 18. Trans. to B1.

June18 Minute. July 8 Visited by husband. July 9 Visited by husband - Spent day in town with him. Returning in evening. July 20 & 21 Visited by husband. Spent the 2 days out with him. Aug1 Appetite good: Bowels constipated: Salts given: Works at laundry.

Aug28 Works at laundry. Takes Gym. Treatments. Has delusions. Bowels irregular: Appetite good: Refuses medicine: Worries a good deal: Patient menstruating.

Sept5 Appetite good. Bowels usually constipated. Refuses medicine - Worries a good deal. Has delusions. Has been impudent for a few days past & inclined to be slightly

Personal and Medical History of Mary Blumentritt.

violent. Trans. to B2. Works at laundry. Sept 7-9-14 Gym. Treatments.

Sept15 Transferred to Infirmary - Sept. 16 Operation done - Curettment & Trachaelorraphy. Recovery good - put to bed. Sept 25 Has been somewhat depressed in mental condition but physically has done well. Able to be up on ward: bowels gaining each day. Appetite is good. Sept. 29 Trans. to B2. Oct. 1 Visited by husband.

Oct2 Appetite good: Quiet in behavior: Neat in habits: Has a few delusions. Interests the greater part of time. Sleeps well: Bowels rather constipated: Trans. to A1.

Oct28 Has delusions: Quiet in behavior: Sleeps well: Assists in dining room. Was visited by husband. Went Home.

Discharged

Personal and Medical History of Catherine McGinnis

LIBERT, FIDLAR & KAMMERER, DAVENPORT, IOWA.

Whole No. 4410.
Residence, Jacksville, Minn.
Date Admission, 4th June 1896
Admitted by, Dr. Phelps Hour, 7.30 P.M.
How Sent, Geo. A. Wilson. Jo. P. Wasca County.
Sex, Female
Age, 35.
Civil Condition, single
Children, none
Age Youngest Child,
Occupation, None.
Degree Education, Some: Common School
Profession Religion, Yes: Catholic.
Habits, Probably good.
Nativity, Wisconsin (Parents born in Ireland)
Physicians Committing, J. A. Swartwood and H. P. Young.
Correspondents, None given in papers

No. for Year, 238.
Insane Relatives, None
Cause Exciting, Shock, when Her father Died: Malarial fever following the shock.
Cause Predisposing, — Chronic —
Form,
Accompanying Bodily Disorder, Shock (probably epileptic)
Suicidal or Not, Not
Date of this Attack, about 20 years ago
Duration, — about 20 years —
No. of Attack, 1st (Continuous)
No. of Admissions, 1st
Age First Attack, about 15
Time of Leaving, Feb. 13, 1901
Time in Hospital, 4 yrs. 8 mos. 9 da.
Result, Died Pulmonary Tuberculosis

EXAMINATION ON ADMISSION
MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Confused.
Quick or Sluggish, Very Sluggish
MEMORY:
Past Events, Very poor.
Recent Events, Much impaired
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Dull.
Correct or Illusive, Very Illusive
REASONING POWER:
Ordinary Subjects,
Own Mental State,
Special Subjects,
GENERAL DESCRIPTIVE REMARKS:
Patient epileptic - has gross dementia & Motor signs.

EMOTIONAL STATE:
Normal, Calm,
Indifferent, Indifferent
Exalted,
Depressed,
DELUSIONS:
Systematized or Not,
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

Personal and Medical History of Catherine McGinnis

EXAMINATION ON ADMISSION, CONTINUED.
PHYSICAL CHARACTERISTICS.

HEIGHT, 4 ft 5½ WEIGHT, not taken NUTRITION, Rather impaired
WOUNDS OR ABNORMALITIES, None
TONGUE, Tremors, Coatings, Promptness Movement, Normal
PUPILS, Equality, Unequal. Left larger Size,
Response Light, Sluggish Accommodation, Sluggish
SIGHT,
HEARING,
COORDINATION, Arms, Poor
Legs, Impaired
TREMORS, Hands, Fibrial incoordination Tongue,
Facial Muscles, General,
REFLEXES, Patellar, Normal equal
Other
ARTICULATION,
Slurred, Slow: Very slurred
Hesitating, Hesitating
FACIAL EXPRESSION,
SENSIBILITY,
HEART, Mitral regurgitant murmur,
LUNGS, In fair condition
TAKEN,

EXAM. URINE, June Aug. 3/96
Color Reddish yellow
Character Clear.
Sp. Gr. 1017
Reaction Acid.
Albumen Trace by Purets
Sugar. None.
Microscop. Small amount of blood & pus corpuscles - Amorphous.

GYNAECOLOGICAL EXAM., Aug 3/96. Uterus normal position - so somewhat patulous. Ex. genitals normal
MENSTRUATION,
OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated,	Irregular,
APPETITE, Good,	Medium, ✓	Poor,
SLEEP, Good,	Poor, ✓ Apt to have fits during night	Irregular,
PULSE,	Resp.,	Temp.,

CRANIAL MEASUREMENTS, Bric. Bj 54.3 (auto m) 62.3 Naso Oc. 35 Briam 33.2 Ant. p. di. 19.2 Transv. di 14.7 Bim. 13 Fac. 10.9
HISTORICAL,
LENGTH OF INVASION, 20 years ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Has had epileptic fits for 20 years
Mother or Mat. Relations,
Father or Pat. Relations,
Brothers or Sisters,

Personal and Medical History of Catherine Mc Ginnis

1896

This patient was brought here by Sheriff Geo. Goodspeed, attended by brother + sister, Miss Mc Donough, with following history. Patient is in fair physical condition. There is no history of consanguinity or heredity. This is 1st attack. Symptoms manifested 20 years ago. Continuous since. Was never sent to hospital. First symptoms manifested by excessive grief over her father's death. The Disease seems increasing: variable: but no atrivial intervals. Derangement now shown on no particular subject: she wanders about aimlessly; sometimes excited by. She is disposed to injure others at times: but is not suicidal: no filthy or destructive habits. No peculiarities or habits previously shown. There is no history of intemperance in parents or self. Patient is subject to shocks, probably Epileptic, pains her father (Dead). Home confinement has been employed. Supposed cause of the disease is shock when her father died: malarial fever following the shock. She has had medical treatment without effect. Speech now incoherent talk: incoordination.—

June 5 On admission. Weight on 6[2] (G.H.N.R.R.) Complexion Dark: hair dark-brown: eyes gray. Condition of skin, normal. No marks scars or bruises noticed. Is quite clean: no bodily peculiarities noted. Behavior quiet: talks in a silly manner).

" 5 Nurses Notes Appetite good. Bowels regular. Had a fit. Slept five hours.

" 6 Appetite good. Head ached all night: Out of bed very often disturbing room mate. Had five fits during night. June 7 Appetite good - Bowels regular. Had a fit at 11 P.M. another they had one at 11:15 P.M. Out of bed often during night disturbing room mate.

" 8 Quiet all day: at night slept four hours. June 9 Appetite good. Bowels regular. Slept five hours. Quiet. Fought nurses at 2 P.M. June 10 Slept quietly 5 hrs. Appetite good. Bowels regular. June 11 Slept 6 hrs. Fought nurses in evening.

" 12 Appetite not very good. Bowels regular. Had a fit at 8:30 P.M. Fought nurses several times to day. Takes out door exercise.

" 19 During second week had only one fit. Slept quite well. Appetite good. Bowels regular. Had out door exercise. Habits clean. Talks incoherently. Was quiet generally but frequently fought with nurses.

Summary. Appetite good. Bowels regular. Was very wakeful first few nights but is sleeping better of late. Had nine fits during first week. all at night, during second only one. Has been quiet most of time but fought nurses almost daily. Takes out door exercise.

June Summary Nurses Notes by Dr. S.L. Phelps: Sleeps very poorly: appetite good: occasionally fights nurses: July 27 Has fits quite often: very bad convulsions: usually in bed for several days: Nov 9 Still has fits very often: no change:

1897 Jan. Silly + demented: at times resistive: very irritable + obstinate: Genl physical health about the same. May '97 No change: June '97 Fits very often: Still is irritable + at times resistive. Augt Had several fits during night: Genl physical condition as good as usual. Continued by Dr. R.M. Phelps. Sept 2/97 Visited by mother + sisters. Oct. 15 Had four fits during day. Nov 9 Fell + cut right eye + bruised her head. Was put in restraint. Nov 17 Again up on ward. Very dull + demented. Has frequent fits. Jan 1'99 Visited by brother. Has been very dull + has had

Personal and Medical History of Catherine Mc Ginnis.

1896

March Sept. Appetite fairly good: sleeps quite well: bowels regular: Has frequent convulsions especially at night: quite often after these is quite weak + stupid for days at a time: sometimes being unable to take any nourishment, also slight rise of temp.

April Had one of these spells. Frequently irritable, annoying other patients by interfering with them + their belongings: when not irritable inclined to be silly, laughing + talking foolishly: July 7 Fell during convulsion + bruised forehead:

Aug 24 Wt. 103½ lbs. Sept. 7th 1900 (Dr. Heyerdale) Has frequent convulsions, night + day. Oct 9 Remained in bed. Seemed very stupid: Refused to take nourishment. Oct 11 Very restless: Fell out of bed: Put in restraint to protect her from injury. Oct 19 Trans. to Infirmary. Oct 20. Remained in bed on infirmary until Nov 9. Quite stupid but not very sick. At times violent + frequently fought nurses. Jan 13. Untidy: Quiet + stupid: Speech incoherent: Does no work: Appetite good. Bowels regular: Sleeps well: Trans. to B[1]. Jan. 18 106th Feb 27. Appetite poor: Has frequent convulsions frequently attacks nurses. March - Aug 31 (Dr. Linton) Appetite variable: usually sleeps well: Menstruates regularly. On March 23 Had two convulsions, one accompanied by haemorrhage of lungs. Apr. 5 Fought Aug. Trapp. No injuries Apr 13-17-22-23 Fought nurses Apr. 28. Fell out of bed during convulsions cutting bruise over eye. Had 7 convulsions Sick in bed until May 4th. Seems to be failing. July 16. Vaccinated.

(Sept. - Nov. 30, 1900. Sept 9. Fought when put to bed. Oct 8 Remained in bed: Seems very stupid Refused to take nourishment. Oct 11. Very restless. Fell out of bed. Put in restraint to protect her from injury. Oct 19 Trans. to Infirmary. Oct 20 - Nov 9 In bed. Somewhat stupid.) Sept - Nov. 30 1900 Coughs a good deal: urine shows drugs reaction. Suspected tuberculosis: Dirty in habits: Speech incoherent: Disagreeable to nurses + patients: Does not menstruate. Nov 16 Wt 111th Dec. 29 Has occasional convulsions: Physical condition rather poor. Jan 19. Sick: put to bed: Seems stupid Jan 25. Trans. to Infirmary. Feb 17. Remains in bed: coughs + expectorates Failing rapidly: Feb 13. Died at. 5 10 AM.

Died.

Personal and Medical History of Leda Josephine Evans.

Examination made 26th May - Warrant dated June 2d. See letter from Asst. Atty General, also one from S.S. Washburn placing the case. Both of these letters filed with Commitment papers - 5th

LIBBEY, PERLEY & SAWYER, DAVENPORT, IOWA.

Whole No. 4414.
Residence, Mower County, Minn.
Date Admission, 6th June 1896.
Admitted by, D.C.B. Eby Hour, 7.55 P.M.
How Sent, S.S. Washburn, Jof P. Mower County
Sex, Female (Warrant Dated June 2/96)
Age, - 21 -
Civil Condition, married
Children, one (Dead).
Age Youngest Child, would be 5 months, if living -
Occupation, Farmer's wife.
Degree Education, Poor Common School.
Profession Religion, Yes. Lutheran.
Habits, Not intemperate
Nativity, Albert Lea, Minn. (Parents born in Norway).
Physicians Committing, Fannie Kimball Porter & B.F. Lockwood
Correspondents, None given in papers -
Family Physician, Dr Cobb. Lyle, Minn.

No. for Year, 242.
Insane Relatives, None
Cause Exciting, Childbirth
Cause Predisposing, Not given
Form,
Accompanying Bodily Disorder, Laceration of Cervix & Perineum.
Suicidal or Not, Suicidal & perhaps homicidal.
Date of this Attack, Probably Recent
Duration, Probably Short Duration
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, - about 21 -
Time of Leaving, July 25. 1896
Time in Hospital, 1 mo. 19 da.
Result, Discharged Nov. 10'96. Improved.

EXAMINATION ON ADMISSION

Exam. by P.M. & H. Phelps June 8 96

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Slightly confused
Quick or Sluggish,
MEMORY:
Past Events, Seems good
Recent Events, "
Special Subjects, "
PERCEPTIVITY:
Alert or Dull, Fair.
Correct or Illusive,
REASONING POWER:
Ordinary Subjects,
Own Mental State, Seems impaired
Special Subjects, Probably good

GENERAL DESCRIPTIVE REMARKS: Patient very hysterical in actions. Complains a good deal of pain in her abdomen & chest. Upon the ward part of time. Inclined to magnify her ailments. Circulation not good. Face becomes flushed upon least exertion. Seems to think it was a scheme of her husband & his mother & to have her committed as a patient to get her out of the way.

EMOTIONAL STATE:
Normal, Calm,
Indifferent, Nervously irritable
Exalted,
Depressed,
DELUSIONS: Has delusive ideas.
Systematized or Not,
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

Personal and Medical History of Leda J. Evans

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, Not taken WEIGHT, Not taken NUTRITION, Fair - slightly anaemic
WOUNDS OR ABNORMALITIES,
TONGUE, Tremors, Coatings, Slight coat Promptness Movement,
PUPILS, Equality, Equal Size, Normal
Response Light, Accommodation,
SIGHT, Less normal Says good -
HEARING, Seems good.
COORDINATION, Arms, Normal
Legs, Normal.
TREMORS, Hands, None Tongue,
Facial Muscles, Normal General,
REFLEXES, Patellar,
Other
ARTICULATION, Normal
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, No murmurs size normal.
LUNGS, Normal

TAKEN,

EXAM. URINE, June. 9'96
Color Red -
Charactr. Hazy deposit
Amt. 24 hrs.
Reaction Acid
Sp. Gr. 1033
Albumen Trace by heat - Trace by Tanrets
Sugar None
Microscop. Small amt - pus
Mucus bands - some bladder epith. a few lime crystals

GYNAECOLOGICAL EXAM., Uterus retroverted & bound down by adhesions - cervix extensively lacerated
MENSTRUATION,
OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,		Clean,	Careless,
BOWELS, Normal,	Regular	Constipated,	Irregular,
APPETITE, Good,		Medium,	Poor,
SLEEP, Good,		Poor, ✓	Irregular,
PULSE,		Resp.,	Temp.,

CRANIAL MEASUREMENTS,
HISTORICAL,
LENGTH OF INVASION, About 6 Mos. ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother, or Mat. Relations, Died of dropsy - kidney
Father or Pat. Relations,
Brothers or Sisters, 6 Brothers & 2 sisters - all healthy. 1 died at 9 weeks.

Personal and Medical History of *Leda J. Evans.*

Personal and Medical History of

This patient was brought here by Deputy Sheriff John C. Johnson Jr. attended by Sarah Johnson with following history. Patient is in fair condition. There is no history of consanguinity whereby this is 1st attack; when symptoms manifested, is not stated. She showed lack of self Control; witness jealousy. Disease seems increasing & growing worse. Derangement now shown by unwarrantable jealousy; is said to be suicidal & perhaps homicidal. (has got a razor in night & said she was about to use it on husband) She has not attempted suicide, but talks some of it. No filthy or destructive habits. Patient has always been obstinate. There is no history of intemperance in parents or self, no of any severe disease &c or head injury. She has not been restrained or confined. Supposed cause of the disease is Child birth. — Treatment has been entirely medical. On personal examination, there is noted laceration of cervix & perineum. Conversation is incoherent, & she becomes excited: has hysteria. Her Commitment is recommended because she requires treatment which her family do not give her, which she would receive in a Hospital. On admission, was pulse B2. (G.H.N.R.Ff. Complexion light: hair light brown: eyes blue: Condition of Skin normal: no marks scars or bruises noticed. Person: No bodily peculiarities noted. Is quiet & talks sensibly).

June 6 Nurses Notes Rec'd. on B 2. Met. Was Menstruating. Seemed very weak. Hot douche given. June 7 T. 99. P 80 R. 22 Appetite poor. Tonic & enema given. Bowels regular. Complains of pain in chest & abdomen. Sponge bath given.
" 8 T. 98.2 P. 76 R 30 Appetite poor. Tonic given. Complains of pain. Hot douche given. Slept about six hours during night. June 9 T. 98.4 P. 72 R 22 Appetite fair. Tonic given. Seems very weak. Leave to Infirmary. Slept all night.
" 10 Appetite good. Tonic & enema given. Bowels moved. Salt bath given also Salts 3ss given. Complains of cold feet. Sand bag applied. Slept this. Complains of pain in bowels June 11 T. 99. P. 76 R. 24 Appetite good. Tonic given. Salt bath given. Complains of earache. Hot sand bag applied. Slept well all night
" 12 T. 97.8. P. 74 R 23 4 P.M. T. 97.6 P. 78. R. 30. Appetite good. Tonic & Cyctacol given Bowels moved. Abdomen seems bloated. Complains of earache. Sand bag applied. Some emesis. Slept quite well during night. June 13 During second visit. appetite good. Bowels rather irregular. Tonic in milk given daily. Slept well at night Complained of pain in side & ear also in bowels. Seems quite nervous at times.

Summary. Patient Menstruating & quite weak when received. Complained of pain in chest & abdomen. Hot douches given several times. Is quiet but very nervous & hysterical. Appetite has been fair. Tonic given daily. Bowels irregular. Cascara, Salts & enemas given. Has complained of pain in ear & side. Sleeps quite Well. Has been on Infirmary for past few days.

June 20 8:30 a.m. Operation done. Curettment & trachelorrhaphy. Took ether well: reaction good
July 10 Remained quietly in bed for about ten days. Up & dressed now. Made an uneventful recovery
July 25 Has been taking out door exercise: talks sensibly. July 25. Visited by husband & went Home much improved in mental condition. Physical health was fairly good. Discharged.

Personal and Medical History of *Nora Lawler*

LESLEY, PUGLAN & CRAWFORD, DAVENPORT, IOWA.

Whole No. 4422.
Residence, St Paul Minn.
Date Admission, 13th June 1896 —
Admitted by, Dr. Eby Hour, 6.45 PM.
How Sent, G Wilbrick Jof P. Ramsey County
Sex, Female —
Age, — 30 — (33)
Civil Condition, Married
Children, — Three —
Age Youngest Child, One year in March 29/96.
Occupation, — Housewife — (Husband's, Clerk)
Degree Education, Common School.
Profession Religion, Yes. Catholic
Habits, Probably good
Nativity, Ireland: Parents also born there —
Physicians Committing, F.P. Canac-Marquis & A. Sweeney
Correspondents, None given in papers

No. for Year, 250.
Insane Relatives, — None —
Cause Exciting, Unknown: (worry previous time)
Cause Predisposing, Not given
Form,
Accompanying Bodily Disorder, None mentioned.
Suicidal or Not, — not —
Date of this Attack, 4th March 1896.
Duration, — about 3 months —
No. of Attack, 1st (Continuous)
No. of Admissions, 2nd
Age First Attack, — 30 — (33)
Time of Leaving, Oct. 20. 1896
Time in Hospital, 4 mo. 7 ds.
Result, Rec. Discharged Apl. 20. 1897.

EXAMINATION ON ADMISSION
MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
~~Clear or~~ Confused,
~~Quick or~~ Sluggish, Sluggish
MEMORY: Impaired
Past Events,
Recent Events,
Special Subjects,
PERCEPTIVITY:
~~Alert~~ or Dull, ✓
~~Correct~~ or Illusive, ✓
REASONING POWER:
Ordinary Subjects, Impaired
Own Mental State, Realizes partly her condition
Special Subjects,
GENERAL DESCRIPTIVE REMARKS:

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed, ✓
DELUSIONS:
Systematized or Not, Many & varied
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
~~Coherent or Incoherent,~~ At times talks incoherently
Voluble or Reticent, At times refuses to speak & lies looking at ceiling: At times quite excited & confused

Personal and Medical History of *Nora Lawler*

EXAMINATION ON ADMISSION, CONTINUED.
PHYSICAL CHARACTERISTICS.

HEIGHT, Not taken WEIGHT, Not taken NUTRITION, Good.
WOUNDS OR ABNORMALITIES, None.
TONGUE, Tremors, None Coatings, Promptness Movement, Normal.
PUPILS, Equality, Equal Size, Normal.
Response Light, Accommodation,
SIGHT, Good.
HEARING, Normal.
COORDINATION, Arms, Normal
Legs,
TREMORS, Hands, None. Tongue, None
Facial Muscles, General,
REFLEXES, Patellar,
Other
ARTICULATION,
Slurred, Prompt.
Hesitating,
FACIAL EXPRESSION,
Dull & sad.
SENSIBILITY,
HEART, Normal: No murmurs
LUNGS, Seem in good condition
GYNAECOLOGICAL EXAM., Normal condition
MENSTRUATION, Regular.
OPHTHALMOSCOPIC EXAM.,

TAKEN,

EXAM. URINE, Aug. 3/96
Color. Reddish yellow
Character. Cloudy deposit
Amt. 24 hrs.
Sp. Gr. 1032
Reaction Acid
Albumen Trace by Tanrets
Sugar. Trace by Haines.
Microscop. Small amount of pus & bladder epith. cells.

HABITS, Dirty,	Clean, ✓ Clean	Careless,
BOWELS, Normal, ✓	Constipated,	Irregular,
APPETITE, Good,	Medium,	Poor, ✓
SLEEP, Good,	Poor,	Irregular, ✓
PULSE,	Resp.,	Temp.,

CRANIAL MEASUREMENTS,
HISTORICAL,
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations,
Father or Pat. Relations,
Brothers or Sisters,

Personal and Medical History of Nora Lawler

1896

This patient was brought here by Deputy-Sheriff Emanuel Johnson, attended by F.H. Lawler, with following history. Patient is in fair condition. No history of Consanguinity or Heredity. This is 1st attack; (a continuation of 1st attack): She was at this hospital, (Rochester) before. First symptoms of attack was manifested by an acute maniacal outbreak in Church in March 1896. Disease seems stationary; variable & with rational intervals, but these not at regular intervals: Derangement now shown by general delusions of persecution by Freemasons; and religious topics. No disposition to injure others, except by striking & throwing things. Is not suicidal. Is of filthy & destructive habits. No peculiarities had been previously shown. No history of intemperance in parents or self. Cause of attack unknown. Uterus curetted and kept in St. Joseph's Hospital for a few days. On personal Examination, she talks loudly & incoherently, about devils, Freemasons &c. Note. As above stated, patient was here before, (recently), from Mar 17/96 to Apl 16/96 — 20 days — Was then maniacal & brought here in muff: noisy & violent: refused food: put in restraint, for the night. Refused food quite often, during her stay & was fed by tube: Was kept in bed. Soon quieted down & continued so; became brighter & talked more rationally — Was got up on Apl 4th: much improved: ate voluntarily: went home with her husband. Her recovery was prompt & complete. (see Vol 30 p 141 No 4362).

Note *

June 13 On admission, was put on B.Z. (G.H.N. R.P.A. Complexion light: Hair auburn: eyes blue: Condition of skin normal: no marks scars or bruises noted: is clean: no bodily peculiarities noted. is quite Excited: has delusions).

" 14 Nurses Notes Slept 5 hrs. last night. very nervous at times & restless. Eat in bath.

" 15 T 98. P 74 R 18 Drank milk & tea - no solid food. Sleeping dose & tonic given. Took a bath in morning: quiet most of forenoon - restless in afternoon; pounded on door.

" 16 T 98. P. 72. R. 18. Ate dinner - drank milk & tea. Refused tonic. Patients mental state peculiar. Is quite rational at times then seemingly loses her grasp on things - Sometimes this seems by reason of exciting talk at others without any cause.

" 17 A T. 97.8 P. 72 R. 18 Drank milk & tea; ate slight dinner: refused tonic. Patient seems to talk quite sensibly today. Seems rather sleepy & dull. June 18 T 98 P 72 R 18 Appetite improving - Refused tonic - very nervous most of time today - Does not talk very sensibly. Took a bath this A.M. June 19 T 98. P 72 R 18. Appetite fair. Quiet & sleeps a great deal today. Talks very sensibly today so far.

" 20 T 98. P 72 R 18 Appetite good - Refused tonic - Patient has delusions at times. Reads a great deal & is very easily excited at times. June 21 Appetite good. Refused tonic. Patient in bed - quiet. Has delusions on certain subjects. Took a bath this A.M. June 22 Patient quiet in bed today. Sleeps well. Talks quite sensibly today.

" 23 Upon ward today about 6 hrs. Complained of her back. rubbed with alcohol.

" 24 Appetite generally good. Will not take medicine. Bowels moved. Bought nurses this A.M. Meals. Sleeps well. June 25 Seems excited today - & rather impatient at times. Back rubbed with alcohol. Sleeps well. June 26 Appetite not very good. Quiet today. Refused to take medicine - says there is poison in it. Reads a great deal.

" 27 Quiet today but easily excited. Talks sensibly when asked questions

Personal and Medical History of Nora Lawler.

Summary Patient during past 3m weeks remained most of time in bed. Has been nervous & easily excited but for the most part quiet. Has delusions on certain subjects: at times talks very sensibly but on growing excited or trying to convince becomes mixed & incoherent. Appetite very poor first few days - better of late. Complained several times of her back - rubbed with alcohol. Has refused medicines claiming that they contained poison. Sleeps fairly well - Bowels generally regular. June 24 Quiet most of time: Appetite good: bowels regular: sleeps well.

July 7. Quiet on ward: Goes walking & riding - Transd. to A'. July 16 Visited by friends.

" 30. Appears to be improving both physically & mentally: Appetite fair: Usually sleeps well: Salt baths given 3 times a week. Bowels at times constipated: Often refuses to go out doors.

Aug. 29. Mentally appears to be quite well: Talks sensibly: Appetite good: Sleeps well: Prefers to stay in her room: Menstruates regularly. Does no work: At times complains of headaches. Bowels usually constipated: Takes cathartics: Salt baths three times a week during month.

Sept. 17. Complains of nervous feeling: Is now menstruating. Oct 13 Menstruating - is somewhat nervous, as usual during menstrual period - Physical health good. Bowels at times constipated. Takes cathartics: Appetite good: Usually sleeps well.

Oct. 19. Assists with work on ward: Seems strong - Appetite good: Takes out door exercise. Visited by husband. Oct 20 Went Home.

Discharged

Personal and Medical History of Pauline Kress.

Whole No. 4473.
Residence, Red-Wing, Minn
Date Admission, 16th June 1896.-
Admitted by, D. Phelps Hour, 1:00 P.M.
How Sent, Axel Haller, J.P. Goodhue County
Sex, Female.
Age, — 16 —
Civil Condition, Single
Children, —
Age Youngest Child, —
Occupation, None
Degree Education, — Common School -
Profession Religion, German Methodist
Habits, — Not known -
Nativity, Kansas: (father's, Iowa. mother's, not known)
Physicians Committing, B. Jacking and A.W. Jones
Correspondents, none given in papers

No. for Year, 251.
Insane Relatives, Sister shows weak intellect
Cause Exciting, amenorrhoea?
Cause Predisposing, probably some heredity
Form,
Accompanying Bodily Disorder, Meatness -
Suicidal or Not, threatened suicide: would not trust her.
Date of this Attack, about 2 week ago
Duration, about 2 weeks
No. of Attack, — 1st —
No. of Admissions, 1st
Age First Attack, — 16 —
Time of Leaving, Mar. 21 - 1904
Time in Hospital, 7 yr 9 m. 5 d
Result, Died - Pul. Tuberculosis

EXAMINATION ON ADMISSION
MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Confused - deluded.
Quick or Sluggish,
MEMORY:
Past Events, Recent Events, Special Subjects, } mind taken up by confused ideas & delusions.
PERCEPTIVITY:
Alert or Dull, Dull
Correct or Illusive, Incorrect
REASONING POWER:
Ordinary Subjects, Own Mental State, Special Subjects, } Very poor.
GENERAL DESCRIPTIVE REMARKS: Behavior age & history indicate a feebleminded state, with furious paroxysms

EMOTIONAL STATE:
Normal, Calm, Dull, Silly, Obstinate
Indifferent,
Exalted,
Depressed,
DELUSIONS: Probably many: wont say a word.
Systematized or Not,
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS: Very dull & silly.
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

Personal and Medical History of Pauline Kress

EXAMINATION ON ADMISSION, CONTINUED.
PHYSICAL CHARACTERISTICS.

HEIGHT, Not taken WEIGHT, Not taken NUTRITION, Good.
WOUNDS OR ABNORMALITIES, Some slight bruises etc. Skin - Good - Fleshy - clean
TONGUE, Tremors, — Coatings, Slight coatings Promptness Movement,
PUPILS, Equality, Equal Size, Normal.
Response Light, Wont test Accommodation,
SIGHT, Good. Eyes - Normal.
HEARING, Wont talk - Probably good.
COORDINATION, Arms, Probably good
Legs,
TREMORS, Hands, No not able to tell tremors Tongue,
Facial Muscles, General,
REFLEXES, Patellar,
Other
ARTICULATION,
Slurred, Wont say a word
Hesitating, Now.
FACIAL EXPRESSION,
SENSIBILITY,
HEART, Sounds are good - Normal.
LUNGS, Normal.
GYNAECOLOGICAL EXAM., Normal.
MENSTRUATION,
OPHTHALMOSCOPIC EXAM.,

TAKEN,

EXAM. URINE, June 19: 96
Color Red.
Character White Cloudy sediment
Sp Gr 1025
Reaction Acid
Albumen Trace by Tauret's
Sugar None
Microscop. Amor. urates - bladder cells - a few blood & pus Corpuscles.

HABITS, Dirty, Clean, Careless,
BOWELS, Normal, Has not passed urine since coming 18 hrs - ~~Constipated~~, Irregular,
APPETITE, Good, Medium, Poor,
SLEEP, Good, Poor, Irregular,
PULSE, Resp., Temp.,
CRANIAL MEASUREMENTS, Nose (h) 53 (m) 62. Naso oc. a 33 Bin. a. 31 Aur. p. d. 185 Transv. d 135 Fac. l. 11
HISTORICAL,
LENGTH OF INVASION, From Reform School. ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations,
Father or Pat. Relations,
Brothers or Sisters,

Personal and Medical History of *Pauline Kress*

1896

This patient was brought here by Mr. Sundquist + attended by Miss M. Dawson, with the following history. Patient is in fair physical condition: No history of Consanguinity: sister shows weak intellect. This is 1st attack: Symptoms manifested about 2 weeks ago, by Chorea: Disease appears to be increasing: not variable: no rational intervals. Derangement now shown by religious illusions: She is not disposed to injure others: has not attempted suicide: but threatened to do so. would not trust her. No filthy or destructive Habits. Before the accession of the disease, she showed violent temper: was difficult to manage at home, + at times, showed strong religious impressions. As to history of intemperance &c in Parents or self, not known: has had no severe disease &c or head injury. She has been restrained by straight-jacket for the last 3 days. Suppressed Caused of disease is amenorrhoea? Has been treated by tonics: would take no medicine or food, during the last few days. Superficial examination. She acts stupid: gives no satisfactory answers to questions put to her: apparently does not understand the object of this investigation. ——— ——— ———

June 16 On admission, was put in Ct (G. H. N. Dept. Complexion light. hair brown: eyes hazel: Condition of skin normal: scars on right wrist: no eruptions or ulcers noticed: right arm bruised: No hernia: Is clean: no bodily peculiarities noted: Is quite excited).

June 16 Nurses Notes Bathed + put to bed. Was quite noisy for a few hours during night. Bowels constipated. June 17 Refused to eat. Refused cathartic. Quite noisy at times. Enema given. Noisy 8 hrs. during night. Bowels moved. June 18 Appetite fairly good. Quite noisy at times. Takes her clothing off several times a day. Slept well during night. June 19 Appetite fair. Very noisy part of the time. Out walking - tried to run away. Is destructive + violent at times. Slept well during night. June 20 Appetite fair. Very noisy + violent at times. Tried to run away while out walking - Says she will hang herself.

June 21 Refused breakfast. Quite noisy part of time. Violent + destructive at times - Appetite good. Slept well during night. June 22 Quiet most of time. Works on ward some. Slept well during night.

June 23 During second week patient was quite noisy + violent at times, also destructive: very seldom speaks when addressed: Appetite fair. Bowels quite regular. Sleeps well. Tried once to run away when out walking. Habits dirty: Assists a little with work. on 22d had finger bitten by A. Watson.

Summary:- Patient has been very noisy violent + destructive at times. Habits dirty: Seldom answers when spoken to: Appetite fair: Bowels regular: Sleeps well. Tries to escape when out walking.

Aug. Summary Nurse's Notes by Dr. G. L. Phelps: Appetite good: Sleeps well: Quite noisy usually. Habits dirty: Nov. No change: Jan '97 Much better than when admitted: talks quite well at times: Mar. '97 No change: July '97 Quite noisy most of time. Appetite Good: violent + destructive at times. Continued by Dr. A. M. Phelps. Nov 2 '97 General health good: Inclined to be violent + destructive: Very uncertain in behavior:

Feb 20 Wt. 146 Feb 20 '99 Patient at times quite violent has been in restraint at times. Is always uncertain + not to be depended upon. (Cont. by Dr. R. A. Pfaff)

Personal and Medical History of *Pauline Kress*

1899

Mar. to Sept. Appetite good: bowels regular: sleeps well great[illegible] part of time: filthy + destructive + at times extremely violent: violent attacks come on suddenly + without provocation, often without any warning. She attacks nurses or patients + fights desperately, growling like an animal: is very quick in movements: kicks strikes + bites - Sept 1- Feb 28 1900 Sept 9- Fought - held by several nurses. When fighting bites, kicks + strikes + it is difficult to handle her. Sept 2-4 In restraint Oct 22 Fought. In restraint until 25th. Nov 29 Appetite good: usually noisy part of night. Habits dirty. Is dangerous as she springs upon nurses without warning: Takes out-door exercise: Feb 7 Attacked nurses threw her to floor + sprung upon her. Put in restraint for six hours. Very troublesome + quarrelsome. Mch 1- Aug 31 1900 (Dr Hinton) Habits dirty: Violent + destructive: wears muff most of time: Appetite variable: Bowels usually regular: General health good: Apr. 5 Fought nurses also struck A. Peterson: In restraint 5 days. Apr 30 Refused to keep clothes on - July 17 Vaccinated. Sept 1- Nov 30 No change. Sept 28 Very destructive. Put in muff. Sept 30 Very noisy + incorrigible Nov 30 Wt. 125½ Dec 1- Feb 28 1901 Feb 15 Wt 129 General health good. Very destructive + violent at times.

Mar. to June 1901. Patient is in fair physical condition and quite thin, eats on tray in bay, appetite fair, sleeps rather poorly, has suppuration and discharge of ear, is incoherent in language, very active and violent, frequently attacks nurses and other patients, destructive and requires muffs to keep her from destroying all of her clothing, ears treated regularly. Wt. 127# June to Sept. Patient continues extremely restless and noisy, destructive and violent, takes out door exercise daily, habits filthy, conversation incoherent, ears still continue to discharge, kept in muffs. Aug. 31 Wt. 122#. Sept. to Dec. menstruates regularly shows no change in mental or physical condition, Nov. 23 Wt. 120#

Dec. to Feb. 1 '03 No change. Wt about 120#.

Personal and Medical History of Eva Fredereka Thelander

LOBERT, FIGLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4426.
Residence, Washington Co.
Date Admission, 23rd June 1896.
Admitted by, D. Phelps Hour, 6:45 P.M.
How Sent, E. G. Butts, J.P. Washington County
Sex, Female
Age, 44
Civil Condition, married
Children, 5.
Age Youngest Child, 3
Occupation, Housewife: (husband's farmer)
Degree Education, Common School
Profession Religion, Yes: Lutheran
Habits, — probably good —
Nativity, Sweden: (Parents also born there)
Physicians Committing, W. H. Pratt and Theo. Clark
Correspondents, none given in papers

No. for Year, 254.
Insane Relatives, Yes: Two brothers —
Cause Exciting, Family trouble yes
Cause Predisposing,
Form, Chronic Mel
Accompanying Bodily Disorder,
Suicidal or Not, — su
Date of this Attack, about
Duration, — about
No. of Attack, 3rd
No. of Admissions, 2nd
Age First Attack, 4
Time of Leaving,
Time in Hospital,
Result,

MERRILL & CLARK, Druggists,

Returned to the Asylum.

Miss Eva Fredereka Thelander was examined today in the probate court as to her mental condition and found to be slightly deranged intellectually, and was committed to the asylum at Rochester.

In March, 1895, she exhibited similar indications of aberration and was sent to Rochester, where she remained until Nov. 6, 1895, when she was legally discharged, which is supposed to mean that she had recovered her mental equipoise.

Her malady develops in a mild form and seems a queer blending of the melancholic and religious. She is 44 years of age and the mother of five children.

EXAMINATION ON ADMISSION

Exam. by Drs. Pratt & Phelps June 24th

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused,
Quick or Sluggish, Dull, sluggish - Depressed

MEMORY:
Past Events, } Nice not Facts
Recent Events, } about anything.
Special Subjects,

PERCEPTIVITY:
Alert or Dull, Dull or incorrect - Wont Talk
Correct or Illusive, enough to show mind, however, what is said

REASONING POWER:
Ordinary Subjects, } Probably controlled by delusive ideas
Own Mental State, }
Special Subjects, }

GENERAL DESCRIPTIVE REMARKS: Patient was taken home was quiet for a time. People trusted her but followed her out one day & she jumped in a well. Her brother rescued her & one month later was seen to be crazy himself. Later on taken to St Peter & died in two weeks. Another brother in old country has had two attacks of insanity but is said to be now well. No definite knowledge of parents

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed, Dull & depressed.

DELUSIONS:
Systematized or Not,
Special Subjects,
Transitory or Not,

HALLUCINATIONS: None Noted.
ILLUSIONS:

CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

Personal and Medical History of Eva Fredereka Thelander

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 4 ft 5 in WEIGHT, NUTRITION, Poor - bloated anaemic
WOUNDS OR ABNORMALITIES, Skin whitish - Bloated - oily.
TONGUE, Tremors, Coatings, Promptness Movement,
PUPILS, Equality, Size,
Response Light, Accommodation,
SIGHT,
HEARING,
COORDINATION, Arms,
Legs,
TREMORS, Hands, None of note Tongue,
Facial Muscles, General,
REFLEXES, Patellar, 5 Equal
Other
ARTICULATION,
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART,
No murmurs noted
LUNGS,



TAKEN,

EXAM. URINE, June 27 '96 Aug.
Color Yellow
Character Cloudy
Amt 24 hrs. 3 XXXII
Sp. gr 1006
Reaction Acid
Albumen None
Sugar None.
Microsc. Amorphous urates. Small amount of pus - bladder Epithelial - blood Corpuscles.

GYNAECOLOGICAL EXAM. Aug. 1896. Uterus normal position - hypertrophied - perineum lacerated - some pelvic tenderness / external genitals / cervix eroded.
MENSTRUATION, Regular.
OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated,	Irregular,
APPETITE, Good,	Medium,	Poor,
SLEEP, Good,	Poor,	Irregular,
PULSE,	Resp.,	Temp.,

CRANIAL MEASUREMENTS, Circ. 55 (1) 64 Naso oc. a. 35 Bimast. 31 Ant-p.d. 19.7 Transv. d. 14.2 Bzy. d. 13.2 Facial height 11.6
HISTORICAL,
LENGTH OF INVASION, Years - since 93 or 94 ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, Died when she was young -
Father or Pat. Relations, Insane - drank.
Brothers or Sisters, 1 Brother insane recovered - 1 Brother insane & died

Personal and Medical History of Eva Fredereka Thelander

LIBERTY, FISLAR & BLANCHERE, DAVENPORT, IOWA.

Whole No. 4426.
Residence, Washington Co.
Date Admission, 23rd June 1896.
Admitted by, D. Phelps Hour, 6:45 P.M.
How Sent, E. G. Butts. J.P. Washington County
Sex, Female
Age, 44
Civil Condition, married
Children, - 5.
Age Youngest Child, - 3 -
Occupation, Housewife: (husband's farmer)
Degree Education, Common School
Profession Religion, Yes: Lutheran
Habits, - probably good -
Nativity, Sweden: (parents also born there)
Physicians Committing, W. H. Pratt and Theo. Clark.
Correspondents, none given in papers

No. for Year, 254.
Insane Relatives, Yes: two brothers -
Cause Exciting, Family trouble developed a hereditary tendency
Cause Predisposing, Heredity
Form, Chronic Melancholia
Accompanying Bodily Disorder, (Right Inguinal hernia)
Suicidal or Not, - Suicidal -
Date of this Attack, about Jany 1/96
Duration, - about 6 months -
No. of Attack, 3rd
No. of Admissions, 2nd
Age First Attack, 41+
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION
MENTAL CHARACTERISTICS.

Exam. by Drs R.M. & D. Phelps June 24th

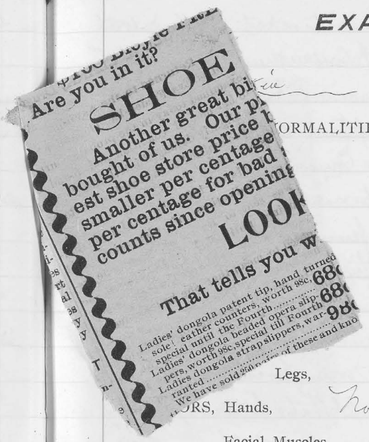
MENTAL ACTIVITY:
Clear or Confused,
Quick or Sluggish, Dull, sluggish - Depressed
MEMORY:
Past Events, Recent Events, Special Subjects, } Will not talk about anything.
PERCEPTIVITY:
Alert or Dull, Dull or incorrect - Wont Talk
Correct or Illusive, enough to show mind, however, what is said
REASONING POWER:
Ordinary Subjects, Own Mental State, Special Subjects, } Probably controlled by delusive ideas

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed, Dull & depressed.
DELUSIONS:
Systematized or Not,
Special Subjects,
Transitory or Not,
HALLUCINATIONS: None Now.
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Patient was taken home was quiet for a time. People trusted her but followed her out one day & she jumped in a well. Her brother rescued her & one month later was seen to be crazy himself. Later on taken to St Peter & died in two weeks. Another brother in old country has had two attacks of insanity but is said to be now well. No definite knowledge of parents

Personal and Medical History of Eva Fredereka Thelander

EXAMINATION ON ADMISSION, CONTINUED.
PHYSICAL CHARACTERISTICS.



WEIGHT, NUTRITION, Poor - bloated anaemic

FORMALITIES, Skin whitish - Bloated - oily.
Coatings, Promptness Movement,
Size,
Accommodation,
Legs,
FEATURES, Hands, None of note
Facial Muscles, Tongue,
General,
REFLEXES, Patellar, 5 Equal
Other
ARTICULATION,
Slurred,
Hesitating,
FACIAL EXPRESSION,



TAKEN,

SENSIBILITY,

HEART,
No murmurs noted
LUNGS,

EXAM. URINE, June Aug 27/96
Color Yellow
Character Cloudy
Amt 24 hrs. 3 XXXII
Sp. gr 1006
Reaction Acid
Albumen None
Sugar None.
Microsc. Amorphous urates. Small amount of pus - bladder epithelial. blood corpuscles.

GYNAECOLOGICAL EXAM. Aug. 1/96. Uterus normal position - hypertrophied - fundus & external genitals excoriated. Cervicum lacerated - some pelvic
MENSTRUATION, Regular.
OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty, Clean, - Careless,
BOWELS, Normal, Constipated, Irregular,
APPETITE, Good, Medium, Poor,
SLEEP, Good, Poor, Irregular,
PULSE, Resp., Temp.,
CRANIAL MEASUREMENTS, Circ. 55 Ft. 64 Naso oc. a. 35 Bi. au. 31 Ant. p. d. 19.7 Fronto occ. 14.2 Bi. d. 13.2 Facial height 11.6
HISTORICAL,
LENGTH OF INVASION, 4 years - since 93 any way ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, Died when she was young -
Father or Pat. Relations, Insane - drank.
Brothers or Sisters, 1 Brother insane recovered - 1 Brother insane & died

Personal and Medical History of Eva Frederika Thelander

1896

This patient was brought here by Sheriff's Deputy. Wm. B. Thelander + attended by Son, with following history. Patient is in fair physical condition. No history of Consanguinity. This is not 1st attack: seems to be 3rd: others occurred in 1893 + '94; respective duration 3 mos + about a year; was sent to this (Rochester) State Hospital: result of treatment, improvement. First Symptoms of this attack were manifested about Jany 1/96: She returned to the condition of her former Commitment. The Disease seems stationary: not variable: nor at usual intervals. Derangement now shown as above stated. Patient is not disposed to injure others: has attempted Suicide: jumped into a well, 50 feet deep, (twice leaving here): propensity not now active. No filthy or destructive habits. She has had 2 brothers insane - (Dr. P's notes: 1 brother in old Country: 2 attacks: but now well: one brother, last summer; after she jumped in well, he got crazy: sent to St. Peter + died in 2 weeks: twice leaving here, she has been dull + quiet: mostly in room or on porch: wont go out. Dull + mildly depressed). No peculiarities had been previously shown, except that she was of a very religious turn of mind. There is no history of intemperance in parents or self, nor of any severe disease or head-injury. She has not been restrained or confined. Supposed Cause of the Disease is family trouble, which developed a hereditary tendency. Has had no treatment, except at Rochester. No facts learned on personal examination, except as previously stated. —

Note. Vol 28 page 125 No. 4025, shows that patient was here before, from Mar 4/95 to June 15/95. For some time, after then coming she was part of time, in bed: complaining of "feeling tired". Was given electrical treatment; also massage. She had a few "Spells" of excitement and was very resistive, at times: much depressed + made 2 or 3 attempts to choke herself: Quite often had to be fed by tube. She was taken away by relatives, against our advice; they wishing to see if she could not improve at home. She was a typical case of melancholia.

June 3 On admission, was put on B. W. (G.H.N. R.R.) Complexion dark: hair brown + partly gray: eyes blue: Condition of skin normal: has right inguinal hernia: is clean: both feet + legs swollen + very hard. Is very quiet: would not talk.

June 24 Nurses Notes Pgs. P 97 R 18 Appetite fair: seems quite emaciated: Took a bath: Sleeps well.
" 25 Quiet in behavior: does not talk unless spoken to: Appetite good. Pgs P 97 R 18
" 26 Menstr. Rather stupid. Bowels regular. Appetite good. June 27 Up on ward: Quiet: does not say much to anyone. Tidy in habits. June 28 Appetite good Has diarrhoea: is stupid most of time. June 29 Took boiled Milk: Quiet in behavior: Still menstruating; Takes no solid food. June 30 Pgs P 94 R. 18
July 1 Living on boiled milk: Tonic given Takes little exercise: tidy in habits
Patient has had diarrhoea all week. Kept on boiled milk - no solid food given. Tonic + Medicine given: Is quite resistive when asked to do anything Rather stupid does not speak unless addressed: is quiet in behavior. Seems to be quite weak today.

Summary. Patient has been quiet: rather stupid: speaks only when spoken to: is quite resistive when asked to do anything. Has delusions: Tidy in habits: Appetite was good during first week: has had diarrhoea since June 28 + has been kept exclusively on boiled milk. Tonic + medicine given daily. Temperature, pulse + respiration normal. Seems quite weak at present.

Personal and Medical History of Eva Frederika Thelander.

1896

Summary Nurses Notes by Dr. S.L. Phelps: Sept. Behavior quiet: takes out door exercise: sleeps well: bowels regular: does no work: Gyn. treatments given every other day: Jany 30'97 Appetite good: bowels regular: quite pale: refuses medicine: Gyn. treatment 3 times a week: May 97 Uterine treatments continued 3 times a week: no special change.

1897 Aug Lungs + heart examined:- Chest expansion normal: percussion note normal: breath sounds normal: Resp. 18: Heart sounds normal: pulse 72 + regular. Continued by Dr. P.M. Phelps. Nov 1897 Patient rather dull + demented: talks little. Does not seem to be failing in health. Stands about in a stupid way. Frog Wt. 168#

June 1 Patient has sore on right leg: Trans. to Infirmary. June 26 Trans. to Annex.
Aug 19 Trans. to A. Foot has been badly swollen of late because of standing about so much. Feb 20'99 Patients condition in general unchanged. (Cont. by Dr. P. A. Bebb)

1899 Mar 1 Sept. Gen'l health quite good: appetite good: sleeps well: bowels regular: goes walking + riding: assists some with work: talks quite sensibly: is very much interested in every thing that goes on on ward + reports to nurses + physicians when she thinks anything goes wrong. Very anxious to go home

Sept 1- Feb 28 1900. (Dr. Heyerdale) Assists with ward work: Eats + sleeps well: Goes riding + walking: Menstruates regularly: tidy in appearance but habits neat. Is agreeable on wards but peculiar in manner + expresses some delusions. Mchs - Nov 30 Still assists with work: June 1 - Varicose ulcer on right leg which she scratches causing sore: Treated daily: July 23 vaccinated: Health good Sep. 19. Had a cold. Temp. 103. Pulse 105 Resp. 20. Sick for 2 days. Ulcer still dressed daily. Bathed with bichl. solution + ointment applied. Generally agreeable but scolds a great deal. Is very stubborn + resistive: has delusions Nov 6 Mnt homeon trial Dec 18. Returned. Gneral health + appetite good: Bowels regular: Does a little work: Ulcer treated with boracic application. Expresses no delusions: answers questions intelligently, never violent. Seems to have inclination to rip + tear up clothing + make them over, stockings into mittens, sheets into handkerchiefs etc. Feb 28 Wt. 143½#.

Mar 1 - June 1 - 1901 No change in mental or physical condition. Assists with work on ward. May 28 Wt. 148#. June to Sept. No change in general condition Aug 31 Wt. 134#. Sept. to Dec. Assists with work on ward, attends chapel and amusements, is still troubled with varicose ulcers. though they seem better than formerly. Nov. 30 Wt. 148#.

Up to Feb. 1 1903. Gen'l health good: never has any trouble except from occasional varicose ulcers of the legs: assists with the ward work: in dining room: goes out for exercise: attends amusements: very delusional: expresses her delusions freely: rather mischief loving: interferes with the other patients: complains about things generally: converses readily and sometimes quite intelligently.
Dec 1 at. Wt. 153⅓#.

Personal and Medical History of Miltena Robinson

LEGGET, PICKER & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4438.
Residence, Winona, Minn
Date Admission, 3rd July 1896.
Admitted by, J.C. Phelps Hour, 4:30 PM
How Sent, H.L. Buck. Jail. Winona County
Sex, - Female -
Age, - 43 -
Civil Condition, - Married -
Children, Three
Age Youngest Child, 12 years
Occupation, Housewife (husband's Mail-Carrier)
Degree Education, High - School.
Profession Religion, Yes: Catholic.
Habits, Not intemperate.
Nativity, Wisconsin: (father's Michigan; mother's Ill).
Physicians Committing, J.B. McGaughey & N.S. Lane
Correspondents, - Husband -

No. for Year, 266.
Insane Relatives, not so far as known.
Cause Exciting, approaching menopause
Cause Predisposing, not stated.
Form,
Accompanying Bodily Disorder, Nervousness -
Suicidal or Not, Suicidal, by poisoning -
Date of this Attack, about May 1st 1896.
Duration, Over 2 months
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, - 43 -
Time of Leaving, Apl. 2. 1897
Time in Hospital, 8 mos 30 ds.
Result, Died Tuberculosis Pulmonales

EXAMINATION ON ADMISSION

Exam. C.N. - H.L. Phelps - 7/4/96

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Not very confused.
Quick or Sluggish, Fairly quick

MEMORY:
Past Events, Recent Events, Special Subjects, Seems quick & reliable.

PERCEPTIVITY:
Alert or Dull, Slightly dull.
Correct or Illusive,

REASONING POWER:
Ordinary Subjects,
Own Mental State, Doubtful
Special Subjects, of birth (thinks negro birth)

GENERAL DESCRIPTIVE REMARKS:
Patient describes previous health as good. For three years it has been failing. For last year has been troubled by people talking against her. People tell her she imagines it. She says she is a negress. Has bad feelings in her head. Worries about her head

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed,

DELUSIONS:
Systematized or Not,
Special Subjects,
Transitory or Not,

HALLUCINATIONS: Hears voices "overheard saying things against her." she says.
ILLUSIONS:

CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,
& these slanderers. Feels poorly otherwise no very prominent symptoms. Knows how people think her. These things seem real to her she says.

Personal and Medical History of Miltena Robinson

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, _____ WEIGHT, _____ NUTRITION, Somewhat impaired
WOUNDS OR ABNORMALITIES, None - a couple of scars where vaccinated.
TONGUE, Tremors, Coatings, White coating Promptness Movement, Prompt- not tremulous
PUPILS, Equality, Equal Size, Rather small.
Response Light, Fair Accommodation, Fair.
SIGHT, Says failing lately - Piling before eyes. Eyes - slight arcus Senilis.
HEARING, Poor. Running from Right ear last Winter
COORDINATION, Arms, ✓
Legs, ✓
TREMORS, Hands, Yes - steady - quite fine. Tongue, Quite steady.
Facial Muscles, General,
REFLEXES, Patellar, 8-9 - Equal.
Other
ARTICULATION,
Slurred,
Hesitating, Hesitating
FACIAL EXPRESSION,
SENSIBILITY,
HEART, No Murmurs - Fairly strong.
LUNGS, Sounds as good. Resp. 1 type shallow
TAKEN,

EXAM. URINE, July 7' 96
Color Yellow
Charactr Light Flaky Sediment
Amt. 24 hrs. ℥ XXVI
Sp. Gr. 1014
Reaction Acid
Albumen Trace by heat - trace by Esbach's
Sugar None -
Microsc. Large Amt. Pus. Bladder & Vaginal Epith. Amor. Urates.

GYNAECOLOGICAL EXAM., Uterus slightly retroverted - some laceration of perineum endometritis & hypertrophy of cervix some hemorrhoids.
MENSTRUATION,
OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated,	Irregular,
APPETITE, Good,	Medium,	Poor,
SLEEP, Good,	Poor. ✓	Irregular,
PULSE,	Resp.,	Temp.,

CRANIAL MEASUREMENTS, Circ. (h) 53 (fr-m) 60 Naso-ac. 32 Bi-e. a. 31 Ant. p. d. 18 Transv. 14½ Bor. diam. 13 Fac. ∠ 11.6
HISTORICAL, No severe sicknesses until last three yrs. Has been coming on for 3 yrs. Head-troubles. Last Oct. stiff neck headache - gathering in head. Seemed to get over but a little later mind began to trouble her. Thought people talked against her. Delusional insanity ca
LENGTH OF INVASION, 9 months at least. Complained first of ONSET GRADUAL OR SUDDEN, Gradual.
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,"), No insanity in family that is known of
Mother or Mat. Relations, Mother married again & left for California. Has not known her since
Father or Pat. Relations, Father died consumption when she was a baby.
Brothers or Sisters, Two children & three miscarriages

Personal and Medical History of Miltena Robinson

1896

This patient was brought here by Sheriff Fuhrman, attended by Mr. Robinson, with the following history: Patient is in fair physical condition: No history of consanguinity; No insane relatives, as far as known: This is 1st attack: Symptoms manifested about May 1st 1896, by nervous manifestation & delusions. Disease seems increasing; variable & with rational intervals, but these not regular, but delusions worse at menstrual periods. Derangement now shown by various delusions: She thinks neighbors charge her with being part negro. Patient is not disposed to injure others, but has attempted suicide by poisoning & propensity is now active. No filthy or destructive habits. She has been always wilful & nervous. There is no history of intemperance in parents or self, nor of any severe disease or head injury. She has not been restrained or confined. Supposed cause of the disease is approaching menopause. She has been treated by rest tonic and anti-spasmodic: no benefit: She is now pale, ill at ease and depressed; with tendency to suicide, as she states herself.

Note by D. Phelps: Husband states - came on slowly & gradually: for 9 mos: had had La Grippe Sciatica &c, & mind been somewhat confused. F. died; M. living. Don't know them."

July 3 On admisson, was put on B² W (G.H.R. Rft. Complexion dark: hair brown: eyes brown: Condition of skin normal: small red mark on top of head: two scars on right arm. Clean: behavior quiet: has delusions).

July 4 Nurses Notes. Patient in bed: Appetite fair: Nervous & easily excited.

" 5 T. 98 P. 80 R. 18. Tonic & cathartic given = Appetite good: Very nervous most of time. Has many delusions. Talks about her troubles a great deal.

" 6 T. 98 P 84 R. 20. Appetite good. Tonic & cathartic given. Still very nervous & displaying many delusions. July 7 T. 98.2 P. 80 R 18. Ate meals took eggnog: Tonic 3 times daily. Very nervous. Goes walking & riding. Salt bath & massage given

" 8 T. 98. P 82. R 18 Tonic & Eggnog given: (Appetite good: Very nervous. Took bath & electric treatment. Bowels regular. July 9 T. 98. R 18 P 80. Appetite good: Tonic given. Has delusions & imagines all kinds of things: Very nervous. July 10 T. 98.4 P. 84. R 18. Takes out door exercise: Still very nervous: Talks a great deal today: Salt bath & Massage given. July 17 During second week Appetite quite good: Tonic given daily. Cathartics twice: Sleeping doses several times; slept quite well after taking doses. Still very nervous though improving slightly: Tidy in habits: Salt baths, Electrical treatments & massage given.

Summary. Patient extremely nervous: Has many delusions which trouble her: Appetite good: Tonic given three times daily: Salt baths & electrical treatments given: Bowels irregular; cathartics given: Sleeping doses given several times after taking them patient slept fairly well, at other times slept very little.

Aug 4 Summary Nurse's Notes by Dr S. L. Phelps:- Lungs & heart examined: Percussion note very flat over the whole anterior surface of left lung: Large & small gurgling rales over the whole anterior surface & in the upper half posteriorly: Some rales in lower part of right lung: Breath sounds very shallow. Very irritating & distressing cough: Sputa yellow & tenacious: Complains of

Personal and Medical History of

sharp pain in right side of abdomen extending up to lower border of liver:

1897 Apr. 1 Transf. to Inf. & put to bed. T. 103⅖. P. 98. R. 22. Put upon tonics & cough medicine:

Apr. 2 Has remained in bed steadily since last note: Failed steadily from the first: Had a very distressing cough: expectorated a great deal & complained of a great deal of pain: Obliged to keep her under the influence of morphia toward the last: Seemed very sensible in talk & seemed to realize her condition during her whole sickness: Visited once by daughter & husband: was able to make plans for her burial: Failed gradually until she died 11 A.M. Apr. 2 nd. Daily sick record kept.

Died.

= Transferred from St Peter =

Personal and Medical History of Sarah A. Simons

LEIGHT, PERLES & SAUNDERS, DAVENPORT, IOWA.

Whole No. 44439.
Residence, Janesville, Minn.
Date Admission, 6th July 1896 — (original admission — May 7/96 —)
Admitted by, Dr. Phelps Hour, 10.00 Am.
How Sent, Geo. A. Wilson, Jap. Waseca County
Sex, — Female —
Age, not given
Civil Condition, Married
Children, — 3 —
Age Youngest Child, 5 months. (7 mos. now).
Occupation, Housekeeper (Husband, farmer)
Degree Education, Common School.
Profession Religion, not a church member.
Habits, Probably good —
Nativity, Minn. (Father, Ohio. Mother, don't know)
Physicians Committing, D. A. Swartwood and H. J. Taylor
Correspondents, Henry Simons Janesville Minn

No. for Year, 267.
Insane Relatives, None
Cause Exciting, Child-birth & results.
Cause Predisposing, not stated.
Form,
Accompanying Bodily Disorder, Nervousness &c.
Suicidal or Not, Not but Tendency Suicidal since
Date of this Attack, 5 months ago after child was born
Duration, 5 months (7 - now).
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, (?)
Time of Leaving, Feb. 19. 1898
Time in Hospital, 1 yr. 7 m. 13 d
Result, Discharged Aug. 10. 1898 Much Improved.

EXAMINATION ON ADMISSION
MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Clear on most subjects
Quick or Sluggish,
MEMORY:
Past Events, } Seems good.
Recent Events, }
Special Subjects, }
PERCEPTIVITY:
Alert or Dull, Alert.
Correct or Illusive,
REASONING POWER:
Ordinary Subjects,
Own Mental State,
Special Subjects,
GENERAL DESCRIPTIVE REMARKS: Mind is a little slow in action but seems correct. Talks freely & sensibly. Genual physical condition a little impaired.

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed, Somewhat depressed
DELUSIONS:
Systematized or Not, None at present
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

Copy.

T-12-05-2000

St. Peter State Hospital,
St. Peter Minnesota,

June 30th, 1896.

To the Board of Trustees:

I herewith recommend the transfer of Sarah A. Simons who was illegally committed to this Hospital from Waseca County which is in the Rochester Hospital District.

H. A. Tomlinson,
Superintendent.

APPROVED:

J. W. Mason, :
J. H. Block, :-for the Board.
C. L. Wells. :

May 23rd | Soily & tears clothing. Must be held in bed. Eats & sleeps kindly. Says she is going to be harmed. There has been no improvement in condition of gastro-intestinal tract. Sleeps about 2 hours in 24.

May 26th | Continues filthy in habits. Refuses food: bowels have a tendency to move too freely.

May 29th | She has been more quiet during the past two days, remaining quietly in bed: frequently asks for her clothing: has taken her food voluntarily, body. Bowels move three times daily: Stools loose and quite offensive. Sleeps an average of 4 hours a night.

June 1st | Soils clothing. Has a poor appetite & must be fed by nurse. Eats slowly. Is quiet & depressed: eyes are dull, expression vacant. At times, tries to injure herself. Says life is not worth living and that she wishes to die. Says "She is possessed of the Devil and that he tells her to do everything wrong."

June 9th | Is more disturbed & constantly attempts to get out of bed. Seldom replies when spoken to, but will shout & tell everyone to leave the house at once, as there will be a flood or a fire, and they must get out, in order to save themselves. Tongue is heavily coated, lips are dry & parched. Appetite is poor: bowels sluggish. Sleeps poorly.

June 11th | Continues to be very much disturbed. At times, refuses food. Sleeps an average of four hours a night.

June 20th | Sneaks about the ward. Seldom speaks. Attempts to get out whenever a door is opened. Does not disarrange toilet. Appetite is poor: sleeps poorly.

over

– Transferred from St. Peter –

Personal and Medical History of

LEGLEY, FULLER & SHAMBERG, DAVENPORT, IOWA.

Whole No.	41139	N	
Residence,	Janesville, Minn.	Ins.	
Date Admission,	6th July 1896 – (original admission – May 7/96 –)	Caus	
Admitted by,	Dr. Phelps Hour, 10:00 Am	Cause	
How Sent,	Geo. A. Wilson, Sh. P. Waseca County	Form,	
Sex,	Female	Accompan	ss, Nervousness – etc.
Age,	not given	Suicidal or	ut: but Tendency Suicide since
Civil Condition,	Married	Date of this Attack,	5 months ago – after Child was born
Children,	3	Duration,	5 Months (7 – now).
Age Youngest Child,	5 months: (7 Mos. now).	No. of Attack,	1st
Occupation,	Housekeeper (Husband, farmer)	No. of Admissions,	1st
Degree Education,	Common School	Age First Attack,	(?)
Profession Religion,	not a church Member	Time of Leaving,	Feb. 19. 1898
Habits,	Probably good	Time in Hospital,	1 yr. 7 mo. 13d
Nativity, Minn:	(Father's, Ohio: Mother's, don't know)	Result,	Discharged Aug. 10. 1898
Physicians Committing,	D. A. Swartwood and W. J. Taylor		Much Improved.
Correspondents,	Henry Inmans Janesville Minn		

EXAMINATION ON ADMISSION
MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
- Clear or Confused, Clear on most subjects
- Quick or Sluggish,

MEMORY:
- Past Events, } Seems good.
- Recent Events, }
- Special Subjects, }

PERCEPTIVITY:
- Alert or Dull, Alert.
- Correct or Illusive,

REASONING POWER:
- Ordinary Subjects,
- Own Mental State,
- Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Mind is a little slow in action but seems correct. Talks freely & sensibly. Gen'l physical condition a little impaired.

EMOTIONAL STATE:
- Normal, Calm,
- Indifferent,
- Exalted,
- Depressed, Somewhat depressed

DELUSIONS:
- Systematized or Not, None at present
- Special Subjects,
- Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:
- Coherent or Incoherent,
- Voluble or Reticent,

Synopsis of History
That came with patient on transfer to D. J. Hospital

1896

May 12th – Is careless in habits. Is depressed: restless: does not converse freely, but answers questions readily. Her appetite is good: tongue has a thin grayish coat: bowels are sluggish. Sleeps well. Weight 109 lbs.

May 15th – Refuses to keep clothing on: is restless: agitated: often attempting to get out of bed: struggles violently: refuses to speak: refuses food: tongue is heavily coated and usually dry: Lodes collect on teeth: Lips are packed: breath offensive: bowels are moved by cathartics & enemata. At night, she is very restless and sleeps poorly.

May 20th – There has been no improvement since last note. She continues to be very much agitated & often is delirious. Talks about the great crimes she has committed and says "all people will have trouble for them" and "that the world is coming to an end". Pupils are dilated. eyes sunken: tongue dry & heavily coated. Lodes on teeth: refuses all nourishment. Sleeps an average of 3 hours a night. —

May 23rd – Sobs & tears clothing: must be held in bed: talks & shouts loudly – says "She is going to be harmed". There has been no improvement in condition of Gastro-intestinal tract. Sleeps about 2 hours in 24. —

May 26th – Continues filthy in habits. Refuses food: bowels have a tendency to move too freely. —

May 29th – She has been more quiet during the past two days remaining quietly in bed: frequently asks for her clothing: has taken her food voluntarily. Body. Bowels move three times daily: Stools loose and quite offensive. Sleeps an average of 4 hours a night. Soils clothing. Has a poor appetite & must be fed by nurse. Eats slowly. Is quiet & depressed: eyes are dull: Expression vacant. At times, tries to injure herself. Says "life is not worth living" and "that she wishes to die". Says "She is possessed of the devil and that he tells her to do everything wrong."

June 1st – Is more disturbed & constantly attempts to get out of bed. Seldom replies when spoken to, but will shout & tell everyone to leave the house at once, as there will be a flood or a fire, and they must get out in order to save themselves. Tongue is heavily coated, lips are dry & parched. appetite is poor. bowels sluggish. Sleeps poorly.

June 6th – Continues to be very much disturbed. At times, refuses food. Sleeps an average of four hours a night. —

June 11th – Is up & about the ward. Seldom speaks. attempts to get out whenever a door is opened. Does not disarrange toilet. Appetite is poor. Sleeps poorly.

Over

Personal — Jr

LIBERT, FIDLAR & CHAMBERS, DAYENPORT

Whole No.

Residence,

Date Ad

Admit

How

Se

(Continued)

July 1st	Is neat & cleanly. Rabbit. Does no work. Quite lame, at times. Talks freely. Says she is well enough to go home; that she will not attempt suicide again. That she was afraid of losing Fortune (when she first came here". She is dull & depressed. Expression vacant. Does not appear to take any interest in her surroundings. Will speak of nothing but herself & her home. Her appetite is good. Tongue is fairly clean. Bowels are moved by enemata. She sleeps well. Wt. 121 lbs.

3d
0. 1898

EXAMINATION ON ADMISSION
MENTAL CHARACTERISTICS

at depressed

None at present

NS:

ION:

Incoherent,

or Reticent,

Or

Own Mental S

Special Subjects,

GENERAL DESCRIPTIVE REMARK

little slow in action but se
Talks freely & sensibly. Genera
Physical condition a little impaired

Personal and Medical History of Sarah A. Simms

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 5½ WEIGHT, ——— NUTRITION, Somewhat impaired

WOUNDS OR ABNORMALITIES,

TONGUE, Tremors, Coatings, Clean Promptness Movement,

PUPILS, Equality, Equal Size, Normal.

Response Light, Accommodation,

SIGHT,

HEARING,

COORDINATION, Arms,

Legs,

TREMORS, Hands, Fine Tongue, None

Facial Muscles, None General, None.

REFLEXES, Patellar, Normal

Other

ARTICULATION, Normal

Slurred,

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY, Normal

HEART, No Murmurs.

Bounds Normal

LUNGS, Normal.

TAKEN,

EXAM. URINE, July 19'96

Color Yellow

Character Clear

Amt. in hrs. XL

Sp. Gr. 1017

Reaction Acid

Albumen Trace by heat & Tannets

Sugar None.

Mic. Amor. urates Ox. lime a few Bladder & Vaginal Epith.

GYNAECOLOGICAL EXAM., Uterus retroverted. Endometritis. Slight erosion of os. Slight laceration of perineum

MENSTRUATION, Formerly Regular — Has been absent since birth of last child

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated, ✓	Irregular,
APPETITE, Good,	Medium,	Poor, Irregular
SLEEP, Good,	Poor, ✓	Irregular,
PULSE,	Resp.,	Temp.,

CRANIAL MEASUREMENTS, Circ. (h) 50½ (fm) 60½ Naso oc. a 33½ Bin. a. 34½ Aur. p. d. 19. Fronto. d. 15.4 B. d. 13.1 F. L. 12.9

HISTORICAL, Thinks she had sunstroke a few years ago. Trips always at times & nervous headaches

LENGTH OF INVASION, About six months ONSET GRADUAL OR SUDDEN, Sudden

HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")

Mother or Mat. Relations, Died Cancer

Father or Pat. Relations, Very nervous.

Brothers or Sisters,

Personal and Medical History of Sarah A. Simons.

1896

This patient is transferred here from St Peter Hospital: she is brought here by Miss Peterson. A copy of the Original "Warrant" also of the "Certificate of Insanity", also synopsis of history came with patient. Also copy of the "examination and mission" to St Peter Hospital. The copy of original history read as follows: no consanguinity, or heredity mentioned. This is 1st attack. Symptoms manifested 5 months ago, after the child was born. The Disease seems stationary: variable, with rational intervals, but there do not occur regular. She now manifests derangement by saying "that Medicine has made her crazy". Patient is not disposed to injure others: has not attempted Suicide: (Interne history on transfer): no filthy or destructive habits, then. Hopelessness had been previously shown: There is no history of intemperance in parents or self, nor of any severe disease &c or head injury. Some confinement has been employed. Supposed cause of the disease is Child birth & results. Nerve sedatives have been given her. Before the examination, she feared that she would be sent to St Peter & that Medicine was being given for the purpose of causing insanity.

July 6 On admission here, was put on B2 G. H. N. R. ft. Complexion dark: hair brown: eyes brown: Condition of skin normal: a few bruises on left leg: Is clean: behavior quiet: talks sensibly.

July 7 Nurses Notes Appetite good: Cathartic given: Is quiet in behavior but quite troublesome at times. July 8 T. 98 P. 72 R. 18 Appetite good: Bowels moved: Sleeps well. Takes out door exercise daily. July 9 T. 99. P. 72 R. 18 Appetite good: Quiet on ward. Does not talk as much as usual today. July 10 T. 98 P. 72 R. 18 Quiet on ward: Talks sensibly when spoken to: Tidy in habits. July 11 T. 98. P. 72 R. 18 Patient works on ward: Neat in appearance: Quiet today: Goes out walking: Talks sensibly but acts rather silly at times. Sleeps well. July 20 During second week no change in patient. Appetite continues good: Bowels irregular: She refused pills thinking they were poison: Complains occasionally of pain in stomach.

Summary. Patient quiet in behavior: Talks sensibly but acts rather silly at times: Sleeps well: Bowels irregular: Is neat & tidy in habits & appearance: Works some on ward: Goes walking & riding daily. Appetite good

July 15 Visited by sister. July 28 Talks sensibly when spoken to. Works in dining room. Is very neat about person: Sleeps well: Appetite good: Goes walking & riding.

July 31 Quiet on ward: Assists with work: Complains of pain today. Trans. to A2.

Aug. 10. 12, 14 & 17 Gym. Treatments given. Aug. 17 Visited by Husband. Aug. 18 Trans. to B1.

" 30 Gym. Treatments given: Patient sings a good deal: Seems quite sensible: Bowels regular: Appetite good: Takes tonic: Takes out door exercise. Sept. 1 Visited by Husband & Friend. Sept. 9. Gym. Treatments given. Quiet in behavior but rather noisy at times, singing often. Appetite good: Takes tonic bowels regular. Takes out door exercise.

Sept. 15 Transferred to infirmary. Sept. 16 Operation performed. Curettment & Trachelorraphy took ether well, put to bed. Takes light nourishment. Sept. 19 Sat up in bed to take her meals. appetite good: bowels regular. Sept. 26 Up on ward: Made good recovery.

Sept. 29 Trans. to B1. Oct. 2. Teeth extracted. Oct. 6. Still sings a good deal. Oct. 22 Much quieter.

Personal and Medical History of Sarah A. Simons

Appetite good: Bowels regular: Takes out door exercise: Oct. 23 Went Home with husband & sister. Retd Nov. 28. 1896

1897 Jan. Summary Nurses Notes by Dr. S. L. Phelps: Seems quite melancholy: Appetite poor: Behaves quite well, but has a mysterious introspective air: At times is evidently not quite right: Does not, however, talk of the hallucinations & delusions she had at the time of coming: physical health fair: takes tonic. May 10 '97 Went Home Quiet & pleasant in appearance: talks quite sensibly: Appetite good.

Continued by Dr. Ren Phelps. June 5 Visited by Husband: Very uncertain in behavior Tried to escape. Feb 14 Trans. to B1. Feb 9 '98 Went home on trial with sister.

Personal and Medical History of Mary G. Nelson

LEIGHT, FISLAR & RASMUSSEN, DAVENPORT, IOWA.

Whole No. 4445.
Residence, St Paul, Minn
Date Admission, 8th July 1896
Admitted by, Dr Hershey Hour, 6.15 P.M.
How Sent, Benn Davis, Court Comm. Ramsey Co.
Sex, Female
Age, 48
Civil Condition, Widow
Children, 5
Age Youngest Child, 11
Occupation, Housewife
Degree Education, Fair: Common School
Profession Religion, Yes: Lutheran
Habits, probably good
Nativity, Sweden: (parents also born there)
Physicians Committing, J. Stymm and C. A. Wheaton
Correspondents, Henry Johnson
(Bro-in-law) 639 - 641 Jackson St St Paul Minn

No. for Year, 273.
Insane Relatives, none
Cause Exciting, Grief
Cause Predisposing, not stated
Form,
Accompanying Bodily Disorder, Nervous excited
Suicidal or Not, has strong desire to commit suicide: propensity active
Date of this Attack, Two days ago
Duration, 3 weeks
No. of Attack, 1st
No. of Admissions, 1st Adm
Age First Attack, 48
Time of Leaving, July 5. 1897.
Time in Hospital, 11 mos. 27 ds.
Result, Discharged Nov. 3. 1897
Much Improved.

EXAMINATION ON ADMISSION

Exam'd. H. M. Phelps M.D. July 28 '96.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Confused.
Quick or Sluggish, Sluggish.
MEMORY:
Past Events, Recent Events, Special Subjects, } Can remember many things well - uncertain.
PERCEPTIVITY:
Alert or Dull, Dull.
Correct or Illusive, Incorrect.
REASONING POWER:
Ordinary Subjects, Poor
Own Mental State, "
Special Subjects, "

GENERAL DESCRIPTIVE REMARKS: Patient has passed through a state of Acute Delirium, is now quiet & like ordinary mania. Lies in bed, recalls some. Talks somewhat at random, some confusion. Physically is quite weak. Heart is weak, but fair flesh & in other ways fair. Is stubborn & will not allow much examining; has been almost too weak to get up & has not been up until today.

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed, Depressed - Confused.
DELUSIONS:
Systematized or Not, Not.
Special Subjects,
Transitory or Not, Transitory
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

Personal and Medical History of Mary G. Nelson

EXAMINATION ON ADMISSION, CONTINUED.

Examination incomplete because no bed, & peaceful.

PHYSICAL CHARACTERISTICS.

HEIGHT, Not taken WEIGHT, Not taken NUTRITION, Fairly good.
WOUNDS OR ABNORMALITIES,
TONGUE, Tremors, Coatings, Coated some Promptness Movement,
PUPILS, Equality, Size, Dilated
Response Light, Accommodation,
SIGHT, Went Test
HEARING, "
COORDINATION, Arms, Went Test.
Legs,
TREMORS, Hands, ?
Facial Muscles, Tongue,
REFLEXES, Patellar, ? General,
Other
ARTICULATION,
Slurred,
Hesitating,
FACIAL EXPRESSION,



TAKEN,

SENSIBILITY,

HEART, No Murmurs - Regular - weak
LUNGS, Good condition

EXAM. URINE, July 27 '96
Color Reddish Yellow
Character Cloudy.
Amt 24 hrs 3 XXX
Sp. Gr. 1014
Reaction Acid
Albumen Trace by heat HNO3 large
Sugar Amt. by Fanets None
Microsc. Large Amt. fat globules & fine - Amor. urates
Bladder & Vaginal Epith. & pus cells.

GYNAECOLOGICAL EXAM., Aug 1/96 Uterus normal position - some adhesions on right side with tenderness - Perineum lacerated - otherwise normal.
MENSTRUATION, Regular
OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated,	Irregular,
APPETITE, ~~Good~~, Growing better	Medium,	Poor,
SLEEP, Good,	Poor, first of stay: Fair now.	Irregular,
PULSE,	Resp.,	Temp.,

CRANIAL MEASUREMENTS,
HISTORICAL, Will not face to give any history 1st no.
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations,
Father or Pat. Relations,
Brothers or Sisters,

Personal and Medical History of Mary G. Nelson.

This patient was brought here by Deputy Sheriff Emanuel Johnson attended by Mr. L. J. Johnson and Henley Johnson, with following history. Patient is in fair physical condition. No history of consanguinity or heredity. This is 1st attack: She has been confined at Sanitarium at Hudson, Wis. for about ten (10) Days: no benefit. First symptoms of this attack manifested 3 weeks ago. Disease seems increasing: variable & with rational interval, but these variable. Derangement now shown in that she feels she is, in some way, responsible for her husband's death (who suicided), and there is nothing else to live for. Patient is not disposed to injure others. Has not attempted suicide, but a desire to suicide is constantly talked of & propensity very active. No filthy or destructive habits. No peculiarities had been previously shown. There is no history of intemperance in parents or self, nor of any severe disease &c or head injury. Supposed cause of the disease is Grief: no treatment has been given patient, except restraint.

July 8 On admission, was put on C.H. (G.A.R.R.P.). Complexion dark: hair brown: eyes blue: Condition of skin normal: one large bruise on right arm & several small ones on feet & legs: Is very dirty very excited: did not talk English.

" 8 Nurses Notes Patient fed. Bathed & put to bed in restraint: Limbs quite badly bruised. Cathartic given. Noisy all night & struggled most of time.

" 9 T. 102.8 P. 100. Appetite fair. Medicine & sleeping dose given. Bowels constipated. Enema given. moved freely. In restraint during day: Tried to choke herself. Quite noisy: Slept 7 hrs. during night after taking sleeping dose.

" 10 T. 101 ½. Refused food: drank about 2 pts. of milk during day. Medicine & cathartic given. Struggled considerably all day: In restraint: Quite noisy at times. Slept 3 hours during night. Sleeping dose given at 10 o'clock.

" 11 5 A.M. T. 101½. P. 89. 2 P.M. 103.8 P. 100. 4 P.M. T. 103.4. 6 P.M. T. 102.6 Refused food. Drank milk during day. Medicine & cathartic given. Struggled continually all day. In restraint part of time. Sexual sponge baths during day. Slept 1½ hrs. Sleeping dose given. July 12 7 A.M. T. 103. Fed with tube at 9 A.M. & 5 P.M. 10 A.M. T. 102.6 3 P.M. T. 103.4 6 P.M. 104.8 7.15 P.M. T. 102. Medicine & cathartic given. Bowels moved several times. Quite restless greater part of forenoon. Very restless in afternoon. Sexual sponge bath given during day & one cold tub bath. Eight minutes in each. July 13 3:40 A.M. 104½ 5 A.M. 102.6 6 A.M. 102 9 A.M. 101½ P. 100. 1 P.M. 103.4 P. 108 4 P.M. T. 103. Fed with tube twice during day. Sponge baths & medicine given also sleeping dose. Bowels moved. Patient very restless & struggles greater part of time. Sexual sponge baths given during day & one cold tub bath. Slept one hour during night.

" 14 5 A.M. 103 6 A.M. 102½ 9 A.M. P. 109 9:20 A.M. T. 102.8 P. 112. 4 P.M. T. 103 P. 108. 8 P.M. T. 103. Fed with tube 9 A.M. & 8:30 P.M. Sponge baths & medicine given also 1 cold tub bath. Patient some quieter: Slept 1 hour: Slept 4½ hrs. during night. Restless & noisy two hours. July 15 5 A.M. T. 103 9 A.M. T. 102 P. 96 1 P.M. 101½ 6 P.M. 100 P. 98 Fed with tube twice during day. Sponge bath. medicine. Brandy given. Patient seems much better this morning: Quiet all day. Slept 1½ hrs. in afternoon: Quiet

Personal and Medical History of Mary G. Nelson.

T. 54.

all night but did not sleep any. July 16 5 A.M. 101½ 10 A.M. T. 100. 2 P.M. 102.4 4 P.M. P. 110 6:30 P.M. T. 100 P. 108. Fed with tube twice. Drank about pint of beef tea. Sponge baths given. Patient seems quite weak. Has taken considerable nourishment during day. July 17 6 A.M. T. 101 P. 104. 10 A.M. 101½ R. 24 2 P.M. 101½ P. 106. R. 38 6 P.M. T. 102. P. 108 R. 40. Fed with tube. Drank 2 glasses of milk. Bathed with alcohol several times a day. Brandy given. Very weak: Seems quite rational & quiet & seemed to sleep most of night. July 18 9 A.M. 101 P. 100. 6 P.M. T. 102 P. 98 R. 30. Drank cup of coffee & ate a little toast also took milk & beef tea. Bathed with alcohol & brandy given several times a day. Some better today. Took considerable nourishment during night. Slept very well most of night. July 19 T. 101. P. 102. R. 24 9 A.M. 101 P. 104 2 P.M. T. 101½ R. 20 7 P.M. T. 102. Took Milk, beef tea, chicken broth & a little toast. Brandy given. Quiet during morning: Quite restless in afternoon & slightly noisy. Bowels moved several times during night. July 20 6 A.M. T. 101. P. 92 9 A.M. 101 R. 20. 10 A.M. 101 P. 96 R. 18. 2 P.M. 101½ Took milk beef tea a little toast, bread pudding & bread & butter. Brandy given. Bathed with alcohol. Patient quiet all day. Took considerable nourishment during day & slept about 4 hrs. during day.

July 21 11 A.M. T. 101. R. 24. 1 P.M. 101 6 P.M. T. 101 P. 98 R. 24. Took milk beef tea toast & little oatmeal. Bathed with alcohol. Patient seems quite well. Rested all night though restless in afternoon.

Nov. Summary Nurse's Notes by Dr. S.L. Phelps:- Appetite good: very noisy & destructive at times: Jan 99 Appetite good. bowels constipated: pale & rather sluggish in bodily condition: talks incoherently: May 99 No change: July 3rd 99 Went Home:- Quiet most of time: was working on wood and in sewing room: mentally much improved.

Discharged

Personal and Medical History of Hettie Belle Williams

LIBERT, FIDLAR & GRAWBERG, DAVENPORT, IOWA.

Whole No. 4453.
Residence, St Paul. Minn.
Date Admission, 20th July 1896.
Admitted by, Dr. C. B. Eby. Hour, 6 P.M.
How Sent, Benn Davis, Court Comr. Ramsey County
Sex, Female.
Age, 24.
Civil Condition, Single
Children,
Age Youngest Child,
Occupation, Student (father retired produce merchant)
Degree Education, 2 years of College
Profession Religion, Yes. Episcopalian.
Habits, Probably good.
Nativity, Pierpont. N.Y. (father's name. Mother's Fiberville N.Y.)
Physicians Committing, Ja. C. Markoe and B. Brinkhall
Correspondents, None given in papers

No. for Year, 281.
Insane Relatives, None
Cause Exciting, Grief
Cause Predisposing, previous attack.
Form,
Accompanying Bodily Disorder, Non
Suicidal or Not, —
Date of this Attack, 17th [illegible]
Duration, — 3 [illegible]
No. of Attack, Not 1st. Dec
No. of Admissions, 1st here.
Age First Attack, about
Time of Leaving, June 17. 1897
Time in Hospital, 10 mo. 30 da.
Result, Discharged Sept. 28 97
Recovered.

THRICE INSANE.

Miss Williams Is Again Sent to an Asylum.

Court Commissioner Benn Davis heard a sad case of insanity yesterday. The victim was Miss Hettie Belle Williams, who had twice been committed to the insane asylum, though she is now only twenty-three years of age. Miss Williams was a bright, intelligent girl, who first became insane in 1889 in consequence of the death of her mother in the State of New York. She was committed to the asylum in that state, but was finally released as cured. Two years ago she again became insane in Wisconsin and was committed to an asylum there. Again she recovered her reason, and came to St. Paul to live with her sister. A few days ago, while attending a funeral, she again became insane, and as a result of yesterday's hearing she was ordered sent to the asylum at Rochester. The case puzzles the doctors, as they have been unable to find any trace of insanity in the family and the girl shows no signs of disease otherwise.

EXAMINATION ON ADMISSION

Exam. by Drs. C. Mc L. Phelps 7/25/96

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Active but Confused.
Quick or Sluggish,

MEMORY:
Past Events,
Recent Events, } Gone
Special Subjects,

PERCEPTIVITY:
Alert or Dull, Alert
Correct or Illusive, Very illusive & incorrect

REASONING POWER:
Ordinary Subjects,
Own Mental State, } Rather uncertain & erratic on all subjects
Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Patient is a young appearing woman in fair health apparently with a chronic of any was obtained
appearing, quite wild mania. Evidently in school she has shown considerable quickness & brightness though possibly always feeble or unstable mentally. The cause would evidently be some inherited weakness but no history

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed,

DELUSIONS:
Systematized or Not,
Special Subjects,
Transitory or Not, Transitory for most part.

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

Personal and Medical History of Hettie Belle Williams

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 4in WEIGHT, 119lbs NUTRITION, Fairly good.
WOUNDS OR ABNORMALITIES, Condition of skin good.
TONGUE, Tremors, Coatings, Normal. Promptness Movement, Normal
PUPILS, Equality, Eyes Normal. Size, Normal
Response Light, Accommodation,
SIGHT, Good.
HEARING, Good.
COORDINATION, Arms, Probably good
Legs, "
TREMORS, Hands, Fairly steady Tongue, Fairly steady.
Facial Muscles, " General, "
REFLEXES, Patellar, 2-3
Other
ARTICULATION,
Slurred, } Good.
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, No murmurs. Regular. Strength sounds fair
LUNGS, Slightly hollow chested. Breath sounds & expansion good.
GYNAECOLOGICAL EXAM., Uterus in Normal position some hypertrophy - Endometritis. External genitals normal.
MENSTRUATION,
OPHTHALMOSCOPIC EXAM.,

TAKEN,

EXAM. URINE, July 23 96
Color. Pale yellow
Character White flaky deposit
Amt - 24 hrs 7½ Lt
Sp. Gr. 1008
Reaction Acid
Albumen None
Sugar "
Microsc. Large amt. amorphous - bladder & vaginal cells

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal, Good.	Constipated,	Irregular,
APPETITE, Good,	Medium,	Poor,
SLEEP, Good, ✓	Poor,	Irregular,
PULSE,	Resp.,	Temp.,

CRANIAL MEASUREMENTS,
HISTORICAL, At age of 19 was at Utica has had a recap - Couple of years later at Winnipeg. Thinks had walking typhoid at Utica Hospital. Nurses pounded her. Was about 19. Discusses Trig. Has coughed ever since at Utica & Winnipeg.
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN, Gradual
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, Mother died 51 - Enlargement of heart.
Father or Pat. Relations, Thinks father is healthy
Brothers or Sisters,

Personal and Medical History of Nettie Belle Williams

LEGLEY, FIDLER & GOMBERG, DAVENPORT, IOWA.

Whole No. 4453.
Residence, St Paul. Minn.
Date Admission, 26th July 1896.
Admitted by, Dr. C B. Eby. Hour, 6 P.M.
How Sent, Benn Davis Court Conv. Ramsey County
Sex, Female.
Age, 24
Civil Condition, single
Children,
Age Youngest Child,
Occupation, Student (father retired produce merchant)
Degree Education, 2 years of College
Profession Religion, Presbyterian.
Habits, probably good.
Nativity, Pierpont N.Y. (Fathers Fam. Mothers Fiberville N.Y.)
Physicians Committing, Ja. C. Markus and B. Brimhall
Correspondents, None given in papers

No. for Year, 281.
Insane Relatives, None
Cause Exciting, Grief
Cause Predisposing, previous attacks.
Form,
Accompanying Bodily Disorder, None mentioned.
Suicidal or Not, not
Date of this Attack, 17th July 1896.
Duration, 3 Days.
No. of Attack, Not 1st: Seems to be 3d.
No. of Admissions, 1st here.
Age First Attack, about 18.
Time of Leaving, June 19. 1897
Time in Hospital, 10 mos. 30 da.
Result, Discharged Sept. 28 '97
Recovered.

EXAMINATION ON ADMISSION

Exam. by Drs. P. Mc D. Phelps 7/25/96

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Active but Confused.
Quick or Sluggish,

MEMORY:
Past Events,
Recent Events, } Gone
Special Subjects,

PERCEPTIVITY:
Alert or Dull, Alert
Correct or Illusive, Very illusive & incorrect

REASONING POWER:
Ordinary Subjects,
Own Mental State, } Rather uncertain & erratic on all
Special Subjects, subjects

GENERAL DESCRIPTIVE REMARKS: Patient is a young appearing woman in fair health apparently with a chronic appearing, quite wide mania. Evidently in school she has shown considerable quickness & brightness though possibly always fickle or irritable mentally. She came would evidently be some inherited weakness but no history of any was obtained

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed,

DELUSIONS:
Systematized or Not,
Special Subjects,
Transitory or Not, Transitory for most part.

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

Personal and Medical History of Nettie Belle Williams

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 4 in. WEIGHT, 119 lbs. NUTRITION, Fairly good.
ABNORMALITIES, Condition of skin good.
rs, Coatings, Normal. Promptness Movement, Normal
Eyes Normal. Size, Normal
ight, Accommodation,
Probably good
Legs,
TREMORS, Hands, Fairly steady Tongue, Fairly steady
Facial Muscles, " General, "
REFLEXES, Patellar, 2-3
Other
ARTICULATION,
Slurred, } Good.
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, No murmurs. Regular. Strength sounds fair
LUNGS, Slightly hollow chested. Breath sounds & expansion good.
TAKEN,

EXAM. URINE, July 23 '96
Color. Pale cyclon
Character White flaky deposit
Amt - 24 hrs 32 Oz
Sp. Gr. 1008
Reaction Acid
Albumen None
Sugar "
Microsc. Large amt. amorphous - bladder & vaginal cells

GYNAECOLOGICAL EXAM., Uterus in Normal position some hypertrophy - Endometritis. External genitals normal.
MENSTRUATION,
OPHTHALMOSCOPIC EXAM.,

HABITS,	Dirty,	Clean,	Careless,
BOWELS,	Normal, Good.	Constipated,	Irregular,
APPETITE,	Good,	Medium,	Poor,
SLEEP,	Good, ✓	Poor,	Irregular,
PULSE,		Resp.,	Temp.,

CRANIAL MEASUREMENTS,
HISTORICAL, Attack of 19 was at 16 yrs. has had a couple of years later at seventeen & go. Thinks had walking typhoid at Ellen Hospital Nurses pounded her. Was about 19 - Dreams being very roughly used at Utica & Rome hosp.
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN, Gradual
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, Mother died 51 - Enlargement of heart.
Father or Pat. Relations, Thinks father is healthy
Brothers or Sisters,

Personal and Medical History of Hettie Belle Williams

1896

This patient was brought here by Deputy Sheriff E. J. Horst, attended by F. M. Williams, with following history. Patient is in fair condition. No history of consanguinity or heredity. This is not 1st attack. (It seems to be the 3rd) other occurring in 1890 & 1892; duration 8 months and 7 months: has been in hospital at Utica, State of New York & at the State hospital located at Binnsboro. Was made a good recovery, both times. First symptoms of this attack manifested the 17th of July 1896: very talkative & excitable. The Disease seems increasing: not variable & no rational intervals. Derangement is now shown by entire confusion of intellect. Patient is not suicidal: very slight disposition to filthy & destructive habits. No peculiarities has been previously shown: no history of intemperance in parents or self, nor of any severe disease &c & head-injury. Has been confined as stated above. Supposed cause of the disease is Grief: has received hospital treatment. On personal examination, there are noted a tendency to tinnle, & indefinite dilatation of eyes. —

July 20 On admission, was put on B3M G.H.N.R.P.M. Complexion dark: hair brown: eyes brown: condition of skin normal: small scar on neck & on left hand: tongue clean: behavior quiet: talks sensibly). —

July 21 Bowels 1. 98.2 P. 72. R. 18. Appetite good. Patient quiet on ward: neat in appearance: Has delusions & talks considerable at times July 22 P 98. 3. 72 R. 18. Appetite good: Tonic given: Quiet today Tidy in habits: Talks a great deal about her "husband" July 23 T. 98.2 P. 74 R 18 Appetite good: Tonic given. Seems rather feebleminded: Quiet on ward today.

July 24 T 97.6 P. 72 R 18 Sings a great deal & is noisy at times: Has delusions: Neat in appearance Tonic given: Appetite good. Bowels irregular.

July 25 T 98 P. 72 R 18. Appetite good: Tonic & cathartic given: Patient quite uneasy today Sings & is noisy. Goes walking & riding daily. Patient imagines she is married - Talks a great deal about it. August 3: During Record week very little change in patient. Appetite good: Tonic given daily. Cathartic once during week: Bowels irregular: Meals come with work at time. Noisy & sings loudly. Treatments given. Fought nurses today.

Summary:- Patient very noisy & excitable: sings loudly. Temp. Resp. & Pulse normal. Appetite good: Bowels irregular: Tonics & cathartics given. Has delusions; imagines she is married & talks a great deal about her "husband". Seems rather feebleminded.

Physicians Notes - Patient quite young: Adolescent case. This is second attack. Seemingly a strong heredity, of which, however, we have no details. Is incoherent & silly. At her best can play & sing well & answers questions fairly well In her spells she is hysterical, wild & maniacal in form of behavior.

Aug. Oct. Summary Nurse's Notes by Dr S.L. Phelps: Takes Gym. treatments 3 times a week: Electrical & Gym. treatments regularly: Nov '96 Very noisy at times & very much excited: Inclined to be violent at these times: Has delusions: Appetite good takes tonic: sleeps quite well: bowels usually regular: takes out door exercise

1897 Jan. Appetite good: bowels irregular: works some on ward: usually quiet & pleasant but at times excited & incoherent in talk: May '97 No change: Very agreeable on ward works in dining room: talks & acts sensible: June 1st '97. Went Home alone Recovered mentally.

Discharged

Personal and Medical History of

Personal and Medical History of Maria Wimer
of Winona

LIBBEY, PIDLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4456.
Residence, Hastings, Minn.
Date Admission, 22nd July 1896 -
Admitted by, D. Hedges Hour, 6:45 P.M.
How Sent, Thos. P. Moran. Jo. P. Dakota Co
Sex, Female
Age, about 70
Civil Condition, widowed
Children, Eight
Age Youngest Child, Thirty-nine
Occupation, Housewife (husband: Farmer)
Degree Education, Common School.
Profession Religion, Yes: Baptist
Habits, not intemperate -
Nativity, Pennsylvania: (father's, Ireland: mother's, England)
Physicians Committing, A. VanBeeck and J.C. Fitch.
Correspondents, Mrs. Palmer, Coates Grove, Minn
Mrs Adolph Matthews - Hastings Minn friend.

No. for Year, 284.
Insane Relatives, None
Cause Exciting, advanced age
Cause Predisposing, — probably age —
Form, Senile Dementia
Accompanying Bodily Disorder, Negligence -
Suicidal or Not, not attempted: but propensity active
Date of this Attack, Early last Winter
Duration, about 8 months
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, about 70.
Time of Leaving, Oct 27. 1896.
Time in Hospital, 3 mo. 5 da.
Result, Died - Heart Failure

Family Phys. W. Steen

address of Son: Henry Wimer Hastings Minn

Exam. by Drs. P.M. & Sh. Phelps 7/24/96

EXAMINATION ON ADMISSION
MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Much confused.
Quick or Sluggish,
MEMORY:
Past Events, Much impaired
Recent Events,
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Dull
Correct or Illusive, Illusive
REASONING POWER: Very much impaired
Ordinary Subjects,
Own Mental State,
Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Patient evidently a senile case, & the impairment coincident with senile changes - So demented & easily irritated Has transient delusions firmly held - Has mal heart Feble circulation & atheroma of arteries - Gives age 76. Previous mental state entirely unknown.

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted, Excitable
Depressed,
DELUSIONS: Has many.
Systematized or Not,
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

Personal and Medical History of Maria Wimer

EXAMINATION ON ADMISSION, CONTINUED.
PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft WEIGHT, 95½ lb NUTRITION, Fair.
WOUNDS OR ABNORMALITIES, None. Condition of Skin fair
TONGUE, Tremors, Coatings, Slight white coat Promptness Movement,
PUPILS, Equality, Size, Contracted
Response Light, Accommodation,
SIGHT, Much impaired. Sight of right eye almost gone. Left impaired - Knew no comma of right eye. Acc. Im. marked
HEARING, Impaired.
COORDINATION, Arms,
Legs,
TREMORS, Hands, Considerable senile Tongue,
Facial Muscles, None General, Some general.
REFLEXES, Patellar, Slightly exaggerated
Other
ARTICULATION,
Slurred, Slurred.
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, No murmurs - Sounds rather weak.
LUNGS, Slightly hollow chested - Breath sounds fairly clear.
GYNAECOLOGICAL EXAM., Uterus atrophied - bound by adhesions: External genitals normal.
MENSTRUATION,
OPHTHALMOSCOPIC EXAM.,

TAKEN,

EXAM. URINE, July 24 96
Quantity 24 hrs. Scanty -
Sp. G. 1021
Albumen - Trace
Sugar - None
Sediment, casts - None.
Crystals Ox lime
Small quantity of pus & blood.

HABITS, Dirty, Clean, Careless,
BOWELS, Normal, Constipated, ✓ Irregular,
APPETITE, Good, Medium, Poor,
SLEEP, Good, fairly good - Poor, Irregular,
PULSE, Resp., Temp.,
CRANIAL MEASUREMENTS, Circ. (h) 5½ (vm) 6¾ - Naso, oc. 33 Bin. a. 31 Ant. p. diam 187 Front. diam 15 Bin. diam 127 Fac. l. 11.8
HISTORICAL,
LENGTH OF INVASION, Long ONSET GRADUAL OR SUDDEN, Gradual -
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations,
Father or Pat. Relations,
Brothers or Sisters,

Personal and Medical History of Maria Miner

1896

This patient was brought here by Deputy Sheriff J.H. Highland attended by wife, with the following History. Patient is in fair physical condition. There is no history of Consanguinity or Heredity. This is 1st attack: has not been in hospital: first symptoms manifested Early last winter with cramps in Stomach, following which she attempted to kill her attendants. Disease seems increasing: not variable: no rational intervals. Derangement now shown in that she continually talking about Dr. Steen; very talkative: attempts violence to her attendants: wanders from home: little sleep during night; and is noisy, creating disturbance at night: is a very hearty eater. Patient is disposed to injure Others. She has not attempted Suicide, but propensity is now active: is also disposed to filthy habits, last winter destroyed her clothing. She always had a violent temper. There is no history of intemperance &c, nor of any severe disease &c or head injury: has not been restrained or confined. Supposed cause of the Disease is advanced age. Has had no treatment.

July 23 **On admission**, was put on B 2 W. (G.H.R. Rpt. Complexion fair: hair gray: eyes brown: condition of skin normal: Scars on abdomen & right leg: Is clean: Quiet: Has delusions). —

July 23 Nurses Notes— 98: P.74. R.18. Appetite quite good: Patient quite restless during night: Has delusions Quite noisy & easily excited at times July 24 T.98.4 R.18 P.86 Appetite quite good: Tonic given Has delusions: Easily excited: Fights at times - Never wants to go to bed or to get up in morning. July 25 T.98.6 P.90 R.18 Appetite good: Tonic given. Seems tidy in habits: Quite nervous today. Talks a good deal about wanting to go home & says her boys are down stairs. July 26 T.98.2 P.72. R.18. Appetite quite good: Tonic given. Patient quiet today but seems slightly excited.

July 27 T.98. P.72 R.18 Appetite quite good. Refused Tonic - Patient quiet today. Has delusions Neat in habits. July 28 T.98. P.72. R.18. Appetite quite good. Refused tonic Cathartic: Bowels irregular: Quiet & very good natured today - Is very quick tempered at times July 29 T.98 P.74 R.18 Appetite good: Refused tonic. Patient insists going to bed nights & getting up mornings: has delusions. Aug 5. Patient during Record week has been on the Whole quiet, though excited at times: Seems rather feeble minded. Undresses herself during day if not closely watched. Coughs & expectorates Some Complains of pain in side. Refuses medicines. Bowels irregular.

Summary— Patient generally quiet in behavior though easily excited: Appetite good: Bowels irregular. Sleeps Well. Coughs & expectorates some. Has delusions: Undresses herself during day if not closely watched.

Aug 8 10 Very easily excited at times - Appetite good: Sleeps well: Bowels regular: Tranq. to B.H. Tonic prescribed but refuses to take it. Aug. 27. In bed. Is weak & complains of pain in right limb: Appetite fair: Bowels regular: Has specials.

Sept 10 Eats & sleeps Well: Takes out door exercise & goes riding Bowels regular

Personal and Medical History of

Has delusions: Talks incessantly: Oct. 19 Complains of pain in right limb undressed & put to bed: Is very weak: Temp. 97.4. Pulse weak Resp. not taken. Refuses to take very much nourishment. Sleeps nearly all the time. Bowels constipated. Takes cathartics: Appetite poor.

Oct 27 96 Died

CLINICAL REPORT.

Patients Name Maria Miner Case Number 7465 Record Commences Sept. 96

DATE.

Sept 10 96
Patient Eats and sleeps Well.
Has out of door exercise and goes riding.
Bowels regular. Has delusions.
Talks incessantly.

Oct 19 Complains of pain in right limb
Was undressed and put to bed.
Is very weak. Temp 97.4 Pulse weak
Resp not taken. Refuses to take very
much nourishment. Sleeping near all the
time. Bowels constipated.
Takes Cathartics. Appetite poor.

Oct 27 Died

L. Randall

DIRECTIONS TO NURSES: Make a note every month for those who have been here less than one year; for others, one every three months. But also, and in ALL CASES, make additional notes AT THE DATE of any unusual occurrence, such as suicidal attempts, attempts to elope, changes of behavior, visits of relatives, friends, or clergy, injuries or struggles, weights when taken, beginning of course of medicine, medical applications Also any prominent physical symptoms.

The monthly or tri-monthly summary should cover the apparent general physical condition, mode and character of talking with trend of prominent delusions or h[illegible]nations, if known; behavior, kind and activity, appetite, sleep, cleanliness, work; any prominent physical symptoms of lungs, digestion, heart kidneys and bladder, skin, c[illegible] character Any drug or medical treatment. Make notes short and concise, like telegrams.

Personal and Medical History of Mary Arnold

LABERT, FISCAS & BAARDSEN, DAVENPORT, IOWA.

Whole No. 4460.
Residence, Rochester, Minn.
Date Admission, 29th July 1896.
Admitted by, Dr. Phelps Hour, 12:00 M.
How Sent, Thomas Fraser, Jof P, Olmsted County
Sex, Female
Age, - 47 -
Civil Condition, married
Children, one (six dead)
Age Youngest Child, - Eleven -
Occupation, Housewife: (Husband, clerk).
Degree Education, Common School
Profession Religion, Yes, Lutheran
Habits, Probably good
Nativity, Bergen, Norway: (Parents born in Norway).
Physicians Committing, Chas. S. Granger and Christ Graham
Correspondents,

No. for Year, 288.
Insane Relatives, None
Cause Exciting, Don't know
Cause Predisposing, not given
Form, Chronic Mania
Accompanying Bodily Disorder, Unremembered
Suicidal or Not, - Not -
Date of this Attack, A year a two ago
Duration, - a year a two -
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, about 45
Time of Leaving, July 3. 1897.
Time in Hospital, 11 mos. 4 d.
Result, Discharged Feb. 9. 1898
Unimproved

EXAMINATION ON ADMISSION

MENTAL CHARACTERISTICS.

Exam. P. M. by Dr. Phelps July 30/96

MENTAL ACTIVITY:
Clear or Confused, - Weak more than Confused.
Quick or Sluggish, Quick

MEMORY:
Past Events,
Recent Events, } Apparently Normal
Special Subjects,

PERCEPTIVITY: On most subjects correct
Alert or Dull, but has delusive ideas.
Correct or Illusive,

REASONING POWER:
Ordinary Subjects, Much impaired
Own Mental State, "
Special Subjects, "

GENERAL DESCRIPTIVE REMARKS: Calls real parents adopted & King of Sweden "real father" has known this for six years. Brother told her - Has told Mr. Arnold. Thinks that is reason he stays away. Has been about so for years - mental trouble is probably many years ago - Rumor that she was insane after birth of one of children - Does feeble minded things - Summer clothing in winter weather - Wandering about - Not eating enough etc. etc.

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed, Mildly depressed (at first confined)

DELUSIONS:
Systematized or Not, Yes - Thinks the daughter
Special Subjects, of the King of Sweden.
Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

Personal and Medical History of Mary Arnold

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 6 in WEIGHT, 114 lbs NUTRITION, Not very good.
WOUNDS OR ABNORMALITIES, Bulging of ribs right side sternum Red blotches on skin
TONGUE, Tremors, Coatings, slight coatings Promptness Movement, prompt.
PUPILS, Equality, Equal Size, Normal.
Response Light, Poor. Accommodation, Sluggish
SIGHT, Fairly good.
HEARING, Fair.
COORDINATION, Arms, Probably good
Legs, "
TREMORS, Hands, None. Tongue, None noticable
Facial Muscles, General,
REFLEXES, Patellar,
Other
ARTICULATION, Good.
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, No murmurs. Sounds. Normal. Regular & full.
LUNGS, A quite prominent bulging forward of ribs at edge of sternum.
GYNAECOLOGICAL EXAM., Aug 3/96. Uterus retroverted & immovable. os lacerated. extensive erosion.
MENSTRUATION, Regular until past two months. Now absent.
OPHTHALMOSCOPIC EXAM.,

TAKEN,

EXAM. URINE, ~~July~~ Aug. 3/96.
Color - yellowish red.
Character, Cloudy copy deposit
Amt, 24 hrs, 2 XX
Sp. Gr. 1012
Reaction. Acid
Albumen, Trace by Tanrets.
Sugar. None
Microsc. -

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated, ✓ Rather.	Irregular,
APPETITE, Good, ✓	Medium,	Poor,
SLEEP, Good,	Poor,	Irregular,
PULSE,	Resp.,	Temp.,

CRANIAL MEASUREMENTS, Circ. H. 53.5 (7.m) 63 Naso oc. 33 Bi. a. 31.5 Ant. p. diam 18.5 Trans. d. 14.6 Bi. d. 13. Face h. 10.4
HISTORICAL, Had lung fever two yrs. ago.
LENGTH OF INVASION, Years probably ONSET GRADUAL OR SUDDEN, at least one year
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Denies it but can't rely on it
Mother or Mat. Relations, Mother dead - killed by Indians.
Father or Pat. Relations, Patterson is dead - adopted father - Six years ago in Wisconsin
~~Brothers or Sisters,~~ (Calls Mr. & Mrs. Patterson "adopted" parents & King of Sweden real father)

Personal and Medical History of *Mary Arnold*

1896

This patient was brought here by Sheriff Stewart, with following history. Patient is in fair physical condition. No history of consanguinity, or heredity. This is 1st attack; symptoms manifested a year or two ago, exalted idea of her paternity. Disease seems stationary, not variable; no rational interval. Derangement now shown in that she imagines she is the daughter of the King of Sweden. Patient is disposed to injure others: is not suicidal: no filthy or destructive habits: As to any previous peculiarities, do not know; There is no history of intemperance, nor of any severe disease or head-injury. She has not been restrained or confined. Cause of the disease, do not know: no treatment: On personal examination, she declares that her father was King of Sweden & her mother a person of royal birth. Patient is committed here for reasons (3) that she wanders about & is exposed to want of food, and shelter: (4) She is ill-treated & neglected by relatives and friends. ——

July 29 On admission, was put on B'k G H N. Rpt. Complexion dark: hair brown: eyes blue: condition of skin normal; marks, one on each arm, in form of a cross: Is clean: behavior quiet: She talks sensibly.

July 30 Nurses Notes. Appetite fair: Tonic given Seems quite sensible: Restless during night July 30 1896 P. 80 R. 20. Appetite fair. Tonic & salts given. Very quiet all day. Talks sensibly - Bowels irregular. July 31 1896 P. 80 R. 21. Appetite good. Tonic given Bowels regular. Behavior about same.

Aug 1 T. 97.2 P. 76 R. 21 Appetite good. Tonic given. Bowels moved. Talks sensibly - Seems quite nervous. Aug 2 T. 97.8 P. 78 R. 21 Appetite good. Tonic given Bowels moved. Behavior about same. Aug 3 1896 T. 98.2 P. 78 R. 21 Appetite good. Tonic given. Is constipated & complains of headache & pain in abdomen.

Aug 6 Appetite fair. Tonic given. Bowels moved. Cathartic given. Patient in bed.

Aug 9 During second week patient was in bed several days. Gyn. treatments given three times Tonic given. Complained of sore throat liniment applied Appetite fair: Tonic given.

Summary. Patient quiet in behavior: sensible in talk. Appetite good. Bowels rather irregular: cathartics given: In bed several days during second week. Complained of sore throat & not feeling well. Liniment applied to neck.

Nov. Summary Nurse's Notes by Dr. S. L. Phelps:- Gyn. treatment every other day: 1897 Rather demented: quiet: Feb. 9th Mental condition that of demented: Has been May quite confused of late: Has many delusions: Still on uterine treatments. Continues about the same: Went Home July 3 with Husband.

Discharged.

Personal and Medical History of

Personal and Medical History of Caroline Woehrle

LIBBEY, FISLAR & HAMMERS, DAVENPORT, IOWA.

Whole No. 4461

Residence, Rope Town

Date Admission, 29th July 1896-

Admitted by, Dr. Phelps Hour, 6 30 P.M.

How Sent, Benn. Davis. Court Commr. Ramsey County

Sex, Female

Age, 27 Years

Civil Condition, Single

Children,

Age Youngest Child, —

Occupation, Farmer

Degree Education, Some: Common School.

Profession Religion, Yes. Lutheran

Habits, Not intemperate

Nativity, Germany: (Parents also born there)

Physicians Committing, Dr. Stamm and J. Hage

Correspondents, None given on papers

No. for Year, 289.

Insane Relatives, none

Cause Exciting, not stated

Cause Predisposing, previous attack

Form,

Accompanying Bodily Disorder, None mentioned.

Suicidal or Not, not

Date of this Attack, 5 Years ago

Duration, — 5 years -

No. of Attack, not 1st (one, 5 years ago)

No. of Admissions, 2nd

Age First Attack, about 22 -

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION

Exam. Dr. Phelps 7/30/96

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Confused.

Quick or Sluggish, Very sluggish

MEMORY:

Past Events,

Recent Events, Very much impaired

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Very dull.

Correct or Illusive,

REASONING POWER:

Ordinary Subjects,

Own Mental State, Absent

Special Subjects, "

GENERAL DESCRIPTIVE REMARKS: Very stupid depress & fair- Will not answer questions- Very dull in perspectivity. Takes no interest in anything going on around her. Patient has been here before. Mental state is one of chronic dementia- By history is always of low mental power.

EMOTIONAL STATE:

Normal, Calm,

Indifferent, Very indifferent

Exalted,

Depressed,

DELUSIONS: None manifested

Systematized or Not,

Special Subjects,

Transitory or Not,

HALLUCINATIONS: None Manifested

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

Personal and Medical History of Caroline Woehrle

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 4½in WEIGHT, 147 lbs NUTRITION, Pale but fleshy-

WOUNDS OR ABNORMALITIES, Condition of skin sluggish

TONGUE, Tremors, Coatings, Coated Promptness Movement,

PUPILS, Equality, Equal Size,

Response Light, Accommodation,

SIGHT, Good.

HEARING, Good.

COORDINATION, Arms, Good

Legs, "

TREMORS, Hands, None. Tongue,

Facial Muscles, General, None.

REFLEXES, Patellar, EXAM. URINE, July Aug 3. '96.

Other Color Reddish yellow

ARTICULATION, Will not talk at all. Character Cloudy ropy deposit.

Slurred, Amt. in 24 hrs. —

Hesitating, Sp. Gr. 1030

FACIAL EXPRESSION, Reaction Acid

Albumen Trace by Tanrets.

Sugar None.

SENSIBILITY, Microsc. Bladder & vaginal epith. cells pus & blood corpuscles.

Amor. urates.

HEART, No murmurs.

LUNGS, Sym. Good. Breath sounds strangulated. Bronchial & harsh- has a cough

TAKEN,

GYNAECOLOGICAL EXAM., Nov. 20. Uterus normal position: os patulated & slight erosion: external genitals normal

MENSTRUATION,

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated,	Irregular,
APPETITE, Good,	Medium,	Poor, ✓
SLEEP, Good,	Poor,	Irregular,
PULSE,	Resp.,	Temp.,

CRANIAL MEASUREMENTS,

HISTORICAL,

LENGTH OF INVASION, Long ONSET GRADUAL OR SUDDEN, Gradual (Continuous for yrs)

HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")

Mother or Mat. Relations,

Father or Pat. Relations,

Brothers or Sisters,

Personal and Medical History of Caroline Woehrle

1896

This patient was brought here by Deputy Sheriff A. J. Horst, attended by Miss Akers, with following history. Patient is in fair condition. There is no history of consanguinity or heredity. This is not 1st attack: other occurred 5 years ago; duration 4 years. Was sent to this (Rochester) Hospital: a little better, by treatment. First symptoms of this attack manifested, five years ago; melancholia: disease seems stationary: not variable: no rational intervals. Derangement now shown by singing, swearing against her parents, loss of memory &c. Patient is not disposed to injure others, nor suicidal, no filthy nor destructive in habits. She was as child of low intellect. There is no history of intemperance, nor of any severe disease &c, or head-injury. As stated, she was at Rochester. Cause of Disease, not stated. Has been treated, as above mentioned.

Note. Our records (Vol 19. Page 361. No 3064) show that patient was here before, from July 7/92 to Dec 7/95. On their coming, was very much excited and noisy, for the first days or so; then became quiet: complained some of being sick: was dull: seen speaking unless spoken to, then answered in an intelligent manner. During November, she seemed to brighten up some. Was usually quiet & half melancholy. She gradually became more demented; dirty & untidy in habits. Was taken home by sister: was unimproved.

July 29 On admission, was put on ☐ IV (G.H.N. Rpt). Complexion fair: hair light: eyes gray: condition of skin normal: no marks, scars or bruises noted: Dexterity: behavior quiet: answers questions, but is very dull)

July 30 Nurses Notes. Appetite fair. July 31 T 99. P 61. R 20. Appetite fair Bowels regular Slept 5 hrs. Coughs a little: Does not expectorate: Stupid: cried some during night.

Aug 1 T. 99.8 P. 90 R 18 Appetite fair: Bowels regular: Slept 6 hrs: Very quiet. Aug. 2nd 3rd & 4th no change.

Aug 5th 6th & 8th no change in patient Aug. 9 T. 98.2 P 61. R. 19. Slept well: Bowels regular Quiet in behavior; cried for a short time this P.M. Aug. 10 Cried for an hour during night Soiled clothing this P.M. Aug 11 & 12 No change.

Aug 13 Physicians Note Patient is returned to us quite fleshy & without much sign of poor health. There seems to be a remission of symptoms. Is usually pallid & white.

Aug. 19 1897 Summary Nurse's Notes by Dr. B. L. Phelps:- Appetite fair: Habits clean: sleeps quite well: Gen'l health good: demented: Feb '97 Dull & listless: May '97 no change

Aug. Quiet most of time: occasionally has crying spells: Gen'l health good: takes out door exercise: Continued by Dr. B.M. Phelps. Nov 1st General health as good as usual. Cries some. Sits in a stupid, even stuporous way. Feb 9/98 Wt. 129 lbs

Feb 12 '99 Patient unchanged in any essential way, (Report by Dr. R. A. Brett)

Mar. to Sept. '99: Appetite good: general health good: sleeps well: seldom goes out of doors very untidy & quite stupid: usually very quiet: occasionally noisy during night: does not converse, but has crying spells. Aug 11 Wt. 137 lbs

Sept 1- Feb 7 8 1900 (Dr. Keyesdale) Nurses Untidy, stupid. Cries at times. Does not talk: Does not sleep well. General health good. Takes outdoor exercise: Menstruates regularly. Jan 12. Wt. 147 lbs. March 1- Aug 31 Generally health good: sleeps well: quiet in behavior: Menstruates regularly. Takes outdoor exercise. July 23 - Vaccinated. Sept 1- Nov. 30 Appetite fair

Personal and Medical History of Caroline Woehrle

Takes out door exercise: Habits very dirty: cries a great deal at times: does not converse or answer questions: Nov 13 went home with brother

May 1- June 1- 1901 No change in mental or physical condition. Does no work. May 31 Wt. 146 ½ lbs.

June to Sept. Extremely noisy at times, untidy and careless, takes out door exercise, does no work attends no amusements Sept. 3 Wt. 139 lbs. Sept to Dec. no change Nov. 30 Wt 145 lbs.

Up to Feb 1st 1903 General health good: appetite good: takes exercise does no work: habits very dirty: appears careless: does not converse or answer questions: at times is very noisy. Dec. 1st Wt. 132 lbs.

Personal and Medical History of Henrietta Williamson

LEBERT, FISLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4462.
Residence, South St Paul.
Date Admission, 29th July 1896.
Admitted by, W. Phelps Hour, 6:30 P.M.
How Sent, Thos. P. Moran, Supt. Dakota County
Sex, Female
Age, 18 years
Civil Condition, single
Children,
Age Youngest Child,
Occupation, Student
Degree Education, Attending high school
Profession Religion, Not a church member
Habits, — not stated —
Nativity, Brownsville, Ohio (father, Brownsville, Ohio; Mother, Virginia)
Physicians Committing, J. C. Fitch and A. VanBeeck
Correspondents, Henry & Mary Williamson (father & mother) South St Paul. Minn

family Physician Dr. H. C. Johnson West St Paul Minn Cor. Plate

No. for Year, 290.
Insane Relatives, Grandmother on father's side. father intemperate —
Cause Exciting, overwork at school.
Cause Predisposing, Heredity
Form,
Accompanying Bodily Disorder, had chorea, 6 years ago apparently active
Suicidal or Not, — Suicidal —
Date of this Attack, Middle of last June
Duration, — about 6 weeks —
No. of Attack, not 1st (one, about 6 years ago)
No. of Admissions, 1st
Age First Attack, about 12
Time of Leaving, Nov. 6. 1896
Time in Hospital, 3 mos. 8 da.
Result, Discharged May. 6. 1897. Rec.

EXAMINATION ON ADMISSION

MENTAL CHARACTERISTICS.

Exam. P.M. — W. Phelps July 30/96

MENTAL ACTIVITY:
Clear or Confused, Confused.
Quick or Sluggish,

MEMORY:
Past Events, Very inaccurate.
Recent Events,
Special Subjects,

PERCEPTIVITY:
Alert or Dull, Very dull & illusive.
Correct or Illusive,

REASONING POWER:
Ordinary Subjects,
Own Mental State, Absent
Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Had Chorea 6 yrs ago. Seemed to entirely recover & was sent to school. Passed examination in High School in June but was ailing some before that time — Now pale & choreic. The choreic not very pronounced, not many involuntary movements but choreic character of

EMOTIONAL STATE:
Normal, Calm, Easily excited - demented - silly.
Indifferent,
Exalted,
Depressed,

DELUSIONS:
Systematized or Not, None Noted.
Special Subjects, Weak & Confused mental state
Transitory or Not, None Noted.

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent, Incoherent ones. Mind jerky - imbecile in form - silly.

Personal and Medical History of Henrietta Williamson

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 3in WEIGHT, 105 lbs NUTRITION, Slightly impaired
WOUNDS OR ABNORMALITIES, Condition of skin Pale - moist.
TONGUE, Tremors, Coatings, Brownish yellow coat. Promptness Movement, Very heavy.
PUPILS, Equality, Equal. Size, Slightly dilated
Response Light, Prompt. Accommodation,
SIGHT, Seems Good
HEARING, "
COORDINATION, Arms, Has choreic movements of whole body.
Legs,
TREMORS, Hands, Jerky movements upon oral - effort. Tongue,
Facial Muscles, General, Choreic movements.
REFLEXES, Patellar, Upon reinforcement about normal.
Other "
ARTICULATION,
Slurred, Slurred & hesitating
Hesitating,
FACIAL EXPRESSION,

SENSIBILITY,

HEART, No murmurs. Sounds rather muffled.
LUNGS, Normal.

TAKEN,

EXAM. URINE, Aug. 19'96
Color Yellow.
Character Cloudy
Amt in hrs. XII ℥
Sp. Gr. 1028
Reaction Alkaline
Albumen None
Sugar "
Microscopical Amor. urates Super phosphates a few pus cells.

GYNAECOLOGICAL EXAM., Aug 3/96. Uterus retroverted. Some adhesions - External genitals Normal.
MENSTRUATION,
OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated, Very.	Irregular,
APPETITE, Good,	Medium,	Poor,
SLEEP, Good,	Poor, Very restless & sleeps very poorly.	Irregular,
PULSE,	Resp.,	Temp.,

CRANIAL MEASUREMENTS, Lat. (R) 53½ (L) 61 Nas-oc. 37 Bi-a. 33½ Ant. p. diam 19.1 Trans. d. 14.5 Bi-m. d. 12.3 Fac. Ind. 89
HISTORICAL, Slight Tendency to Goitre. Had chorea 6 yrs. ago. Loss of power of right hand.
LENGTH OF INVASION, 3 months ONSET GRADUAL OR SUDDEN, Gradual.
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, Maternal Grandmother had imbecile child.
Father or Pat. Relations, Father inebriate
Brothers or Sisters, Unknown.

Personal and Medical History of Henrietta Williamson

This patient was brought here by Deputy Sheriff J. J. Grisim, attended by patients mother, with following history. Patient is in fair condition. No consanguinity. This is not 1st attack. She had one about six years ago; duration nearly 6 months; was not sent to hospital: first symptoms of this attack manifested the middle of last June; incoherency of speech; inability to pronounce words distinctly; excitement; loss of sleep; loss of appetite. Disease seems increasing; variable and with rational intervals, but these not regular. Derangement now shown by laughing and crying "Spells": unable to speak plainly; twitching of limbs: loss of muscular power especially of right side; dribbling of saliva: canca sores in mouth. Patient is not disposed to injure others. Has attempted suicide, by trying to choke herself with her hands: propensity is now active. Is destructive of clothing. Patients grandmother on father's side had 3 mild attacks of insanity. She always was a very independent girl. Father addicted to intemperance. She had Chorea 6 years ago. Has not been restrained or confined. Supposed cause of the disease is overwork at School. Girl has been treated by several physicians: no good results. On personal Examination, She has symptoms of chorea; has "Spells" of laughing and crying; appearance & manner restless: no other facts, except as stated above. Physicians hereby certify that said Henrietta Williamson is insane & a proper person for care & treatment & further find that her disease is of such a nature & in such a stage as to require for her recovery, care & treatment, while under legal restraint. ———

July 29 On admission, was put on B½ (T. 4 h. R. p.m. Complexion fair: hair black: eyes brown: Condition of skin normal: no marks, scars or bruises noticed: is dirty: right side seems as if it was slightly paralyzed. Very nervous & noisy, at times: incoherent).

July 30. Nurses Notes. T. 98.8 P. 92 R. 18. Appetite fair. Cathartic given. Patient out of bed all day: Has bruised her limbs considerably by tumbling & knocking about room. July 31 T. 98.8 P. 100 R. 20. Appetite fair Cathartic given: used spray on throat. Restless all night Sleeping draw given: did not sleep any. Is menstruating: Fights at times & is quite violent to day. Slept until 11 a.m. Aug 1st T. 99 P. 98 R. 20. Appetite fair: Spray used for throat: Complains of sore throat today: Very untidy in habits. Aug. 2nd T. 100.7 P. 108 R. 20 Appetite fair: spray used: still complains of throat: Fights at times & is quite violent & noisy

Aug 3 T. 99.7 P. 90 R. 20. Appetite quite good: Pills given three times a day. Bowels irregular Seems some quieter to-day. Complains of headache. Aug 4th T. 100.2 P. 104 R. 28 Appetite quite good. Pills given: spray used in throat. Patient very uneasy & excited today. In seclusion at meal times. Sacs back given: Aug 5th T. 100 P. 106 R. 21 Appetite quite good: pills given & spray used 3 times a day: very violent at times & excited: Complains of headache. Salt baths given Aug 6 Appetite quite good Pills given & spray used on throat: Patient excited & noisy most of time During night did not sleep any until 3 A.M. Bowels irregular Aug. 7 Appetite good: Violent at times very restless all the time: Slept last night: Pills given & spray used on throat. Aug 8th to 12th. Patient growing more quiet & rational: sleeps better: tries to undress herself & frequently removes shoes & stockings Electrical Treatments given: seems to be gaining both physically & mentally

Personal and Medical History of

Summary First 14 Days. Temperature shows some slight elevation, due probably to a very considerable chorea which she has. Her appetite has continued quite good: received some sedative medicines & cathartics, also a spray for the throat. Physical symptoms of disease were chiefly those of the chorea: complained at various times of headache & of sore throat. In behavior upon admission was rather restless & even slightly violent. Was somewhat bruised from her tumbling about: was rather untidy. After the first week patient began to quiet down a little, but at the end of the two weeks is still very restless & haly maniacal.

Physicians Note. Patient mildly maniacal in behavior & incoherent in speech. Is a young & seemingly adolescent case. This is a recurrent attack as regards the active phase. Has evidently been very brightly active when not in this paroxysm, as her education, manners and musical ability so indicate.

Sept. 30 Summary Nurse's Notes by Dr. E. L. Phelps:- Receives Salt baths every day: Said treatment every day. Nov. 6'96 Went Home with mother: was somewhat excitable & unstable mentally: Her talk was at times somewhat choreic but she was sensible & well behaved & worked daily in the Center Dining room: physical Health was never improved: Had gained decidedly in flesh & gen'l health was good: was very anxious to go home.

Discharged

Personal and Medical History of Bertha Scanlan

LEIGHTY, FISLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4463. St. Paul
Residence,
Date Admission, 29th July 1896. —
Admitted by, Dr. Phelps — Hour, 6 30 PM
How Sent, Benn. Davis, Court Commr. Ramsey County
Sex, Female
Age, — 29 —
Civil Condition, married
Children, Three
Age Youngest Child, 5 Years
Occupation, Housewife
Degree Education, Compmon School.
Profession Religion, Yes. Catholic.
Habits, Probably good.
Nativity, Norway. (Parents also born there) —
Physicians Committing, J. B. Brimhall and A Sweeny
Correspondents, Husband's name Wm Scanlan
585 Arkwright St. Paul

No. for Year, 291.
Insane Relatives, none
Cause Exciting, unknown
Cause Predisposing, not given
Form,
Accompanying Bodily Disorder, None mentioned
Suicidal or Not, not: propensity not active.
Date of this Attack, not stated
Duration, not stated
No. of Attack, — 1st —
No. of Admissions, — 1st —
Age First Attack, ?
Time of Leaving, Sept. 20. 1896
Time in Hospital, 1 mo. 22 da
Result, Recovered. Discharged Mar. 20 '97.

EXAMINATION ON ADMISSION

MENTAL CHARACTERISTICS.

Exam. P. M. + Dr. Phelps 7/29

MENTAL ACTIVITY:
Clear or Confused, Confused -
Quick or Sluggish,
MEMORY:
Past Events, Impaired
Recent Events, "
Special Subjects, "
PERCEPTIVITY:
Alert or Dull,
Correct or Illusive, Delusion about herself.
REASONING POWER:
Ordinary Subjects, Impaired
Own Mental State, "
Special Subjects, "

GENERAL DESCRIPTIVE REMARKS: Talks ~~some~~ of a kind of instrument which she calls a "drone" that would read her thoughts + tell them around. This was what caused her so much trouble.

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed, Slightly depressed.
DELUSIONS:
Systematized or Not, Thinks Neighbors abuse her by
Special Subjects, talking about her.
Transitory or Not,
HALLUCINATIONS: Hears voices at night
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

Personal and Medical History of Bertha Scanlan.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 6½ in WEIGHT, 119½ lbs NUTRITION, Fairly good.
WOUNDS OR ABNORMALITIES, None. Condition of skin normal.
TONGUE, Tremors, Coatings, Promptness Movement,
PUPILS, Equality, Equal Size,
Response Light, Accommodation,
SIGHT, Complains of cloudiness at times
HEARING, Normal.
COORDINATION, Arms, Normal
Legs, "
TREMORS, Hands, Considerable fine tremors Tongue,
Facial Muscles, General,
REFLEXES, Patellar, Normal.
Other
ARTICULATION, Normal.
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, No. murmurs.
LUNGS, Normal. Bronchial breathing + harsh left apex
GYNAECOLOGICAL EXAM., Aug 7/96. Uterus Normal position Endometritis Large erosion + extensive laceration in cervix.
MENSTRUATION,
OPHTHALMOSCOPIC EXAM.,

TAKEN,

EXAM. URINE, Aug. 3'96
Color Reddish yellow
Characts. Cloudy White flaky deposit
Amt in hrs. XXX oz
Sp. Gr. 1029
Reaction Acid.
Albumen None
Sugar "
Microscop. Oxalate of lime - mucus bands amorphous urates. Pus & Epithelial + bladder Epith. cells.

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated, ✓	Irregular,
APPETITE, Good, ✓	Medium,	Poor,
SLEEP, Good,	Poor,	Irregular,
PULSE,	Resp.,	Temp.,

CRANIAL MEASUREMENTS, Circ. 56 (cm) 60 Nas. ac. 35½ Bi. a 31½ Ant. p. diam 18½ Trans. diam 14. Bimd. 13.4 Fac. 119
HISTORICAL, Typhoid fever 4 yrs. ago. Light.
LENGTH OF INVASION, 2 or 3 months ONSET GRADUAL OR SUDDEN, Gradual
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Denied
Mother or Mat. Relations, Dead.
Father or Pat. Relations, Dead
Brothers or Sisters, Healthy

Personal and Medical History of Bertha Scanlan

1896

This patient was brought here by Deputy Sheriff A. J. Horst attended by Miss Akers, with following history. Patient is in fair condition. As to consanguinity unknown. This is 1st attack. Has not been in hospital. First symptoms manifested by delusions of persecution & injury to her reputation, with hallucinations of abusive talk. Disease seems stationary. No lucid intervals. Derangement now shown in that she believes that people are talking of her & are ruining her reputation. Is not disposed to injure others, nor suicidal propensity not active: no filthy & destructive habits. No insane relatives. Previously, was rather nervous and quick-tempered: no history of intemperance, nor of any severe diseases or head injury. She has not been restrained or confined. Cause of the disease, unknown.

July 29 Has had no treatment:- On admission, was put on B'w'r (G.H.N. Rft. Complexion fair; hair light; eyes blue: Condition of skin normal: no marks, scars or bruises noted; is rather dirty. Quiet. Talks sensibly)-

July 30 Nurses Notes J. 98 P. 73 R. 18. Appetite good: Cathartic & Tonic given: Patient quiet in bed today. Has delusions on certain subjects. July 31 J. 98. P. 80 R. 19. Appetite good. Tonic given - Bowels moved. Up on ward today: Seems to talk sensibly when spoken to or asked questions. Aug 1. J. 98 P. 70 R. 18. Appetite good. Tonic given. Patient quiet on ward: very neat in appearance: Seems to feel rather down hearted at times. Aug. 2 J. 97.6 P. 72 R. 18. Appetite good: Tonic given. Quiet on ward: Seems to talk sensibly. Treatment given. Aug 3 J. 98 P. 72 R 18. Appetite good. Tonic & cathartic given. Bowels moved. Complains of noise a great deal. Aug. 4 J. 97.6 P. 74 R. 18 Appetite good. Tonic - pill given. Quiet & sensible on ward. Goes riding & walking. Aug. 5 J. 98 P. 72 R 18. Appetite good. Tonic & pill given. Complains of headache: seems rather depressed today.

Aug 2. During second week patients appetite good. Tonic given daily: Bowels irregular. Quiet on ward; neat in appearance; Appears quite sensible: Assists a little with work. Sleeps well. Takes out door exercise.

Summary.- Patient has been quiet & pleasant in manner & sensible in talk: exhibits delusions on some subjects: Assists some with work: Takes out door exercise: Sleeps well, appetite good; bowels very irregular: Tonics & cathartics given also Gynaecological treatments.

Sept 1. Patient was operated upon today. curettement & trachelorrhaphy done: reaction was good. Sept. 10 Remained quietly in bed causing little trouble, made an uneventful recovery: up on ward today. Sept 20 Patient has been very quiet, pleasant & well behaved in every respect: visited by husband today: Delusions have all disappeared. Went Home-

Discharged

Personal and Medical History of

Personal and Medical History of Emma Remick

LIBBEY, PIDLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4465.
Residence, Rochester, Minn.
Date Admission, 31st July 1896 -
Admitted by, D. Linton Phelps Hour, 12.30 PM
How Sent, Thomas Fraser, Sh. Olmsted County
Sex, Female.
Age, - 37 -
Civil Condition, Single
Children, Two
Age Youngest Child, Two years
Occupation, Servant Girl (father, farmer)
Degree Education, None
Profession Religion, Yes: Methodist.
Habits, Unknown: (seemingly not good).
Nativity, Minn: (Parents born in Maine).
Physicians Committing, H.H. Untherecine and Chas. J. Granger
Correspondents, none given in papers

No. for Year, 293.
Insane Relatives, yes: sister died in hospital here in Rochester.
Cause Exciting, - Unknown -
Cause Predisposing, probably heredity
Form,
Accompanying Bodily Disorder, None mentioned
Suicidal or Not, not: propensity not active.
Date of this Attack, one week ago
Duration, - one week -
No. of Attack, not 1st (at intervals, for several years).
No. of Admissions, 1st
Age First Attack, - ? -
Time of Leaving, Sept. 26. 1897
Time in Hospital, 1 yr. 1 mo. 27 d.
Result, Discharged May 4. 1898 Unimproved

EXAMINATION ON ADMISSION
MENTAL CHARACTERISTICS.

Exam. Dr. H. D. Phelps July 30/96

MENTAL ACTIVITY:
Clear or Confused, Confused
Quick or Sluggish,
MEMORY:
Past Events,
Recent Events, Much impaired.
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Dull.
Correct or Illusive,
REASONING POWER:
Ordinary Subjects, Impaired
Own Mental State,
Special Subjects, Impaired
GENERAL DESCRIPTIVE REMARKS:
General feebleness imbecile.

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed, Depressed.
DELUSIONS:
Systematized or Not,
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

Personal and Medical History of Emma Remick

EXAMINATION ON ADMISSION, CONTINUED.
PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 4 in WEIGHT, 154 lbs NUTRITION, Good.
WOUNDS OR ABNORMALITIES, Right knee joint anchylosed. Right leg shorter than left.
TONGUE, Tremors, Coatings, Cracked slight yellow coat Promptness Movement,
PUPILS, Equality, Equal Size, Slightly dilated
Response Light, Accommodation,
SIGHT, Impaired in right eye.
HEARING, Good.
COORDINATION, Arms, Normal.
Legs, Good.
TREMORS, Hands, None Tongue, None.
Facial Muscles, " General, None
REFLEXES, Patellar,
Other
ARTICULATION,
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, Mitral regurgitant murmur
Arteries, Pulmonary Coronal atheroma
LUNGS, Normal.
GYNAECOLOGICAL EXAM., Aug. 7/96 Uterus normal position endometritis + hypertrophy + hyperaemia of os. Laceration of os.
MENSTRUATION,
OPHTHALMOSCOPIC EXAM.,

TAKEN,

EXAM. URINE, Aug 19/96
Color Yellow
Character White flaky Deposit.
Quantity 24 hrs. XVIII ℥
Sp. Gr. 1031
Reaction Alkaline
Albumen Ats None
Sugar "
Microsc. Amor urates Triple Phosphates + Sodium urate Crystals

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated,	Irregular,
APPETITE, Good,	Medium,	Poor,
SLEEP, Good,	Poor,	Irregular,
PULSE, Regular 65	Resp.,	Temp.,

CRANIAL MEASUREMENTS, Circ. (Horiz.) 55 (Vert.) 63½ Fasc. oc. a 35 Bi. a. 33½ Auto-post. d. 19.2 Front. d. 14.7 Bin. de. B. Zy. 11
HISTORICAL, Has had pneumonia + typhoid fever twice.
LENGTH OF INVASION, Long ONSET GRADUAL OR SUDDEN, Gradual
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations,
Father or Pat. Relations,
Brothers or Sisters,

Personal and Medical History of Emma Remick

1896

This patient was brought here by Sheriff C.N. Stewart, attended by A.L. Money Supt of Poor Farm, with following history. Patient is in good physical condition. As to consanguinity unknown. This is not 1st attack; others occurred at intervals for several years: duration two days to two weeks. First symptoms of this attack manifested one week ago, by attempts to injure others. Disease seems increasing: variable with rational intervals, but these at irregular intervals. Derangement now shown in that she becomes violent if opposed. Is disposed to injure others; not suicidal: propensity not active: no filthy or destructive habits: her sister died in the hospital here, in Rochester. No peculiarities etc had been previously shown as to any history of intemperance, unknown; not known if she has been subject to any severe disease &c, or head injury. She has not been restrained or confined. Supposed cause of the Disease is unknown: no treatment given. On personal examination, nothing in particular found out, except as reported by witnesses as above. —

July 30 On admission, was put on A²W (G.H.N. Kpt. Complexion dark: hair brown, streaked with gray; eyes blue: condition of skin normal: no marks scars or bruises noted: Is clean: right leg shorter than left, caused by rheumatism. Is quiet: Talks sensibly).

July 30 Nurses Notes Quiet in behavior: Appetite good: Slept well during night.

" 31 T. 98 P. 70 R. 20. Quiet: Appetite good: Assists sick ward work: Talks sensibly: Slept well during night: Urine for 24 hrs. XVII Aug. 1. T. 98 P. 72 R. 18. Quiet in behavior: Talks quite sensibly: Appetite good: Sleeps well: Aug 2. Appetite good: Sleeps well: Takes out door exercise: Assists some with ward work: Is menstruating

Aug 3 T. 99 P. 80 R. 20. Quiet: Appetite good: Takes out door exercise: Aug 4 Talks quite sensibly: Sleeps well: T. 98.4 R. 18 P. 74 Appetite good: Bowels regular: Sleeps well.

Aug 5 No change in patient Aug 6. During second week patients appetite good: Bowels regular: Sleeps well: Quiet in behavior: Takes out door exercise: Gynaecological treatments given: Works in employes dining room.

Summary Patient has been uniformly quiet & pleasant in manner: Appetite good: Bowels regular Sleeps well: Takes out door exercise: Gynaecological treatments given: Works in employes dining room.

Nov. 1897 Summary Nurse's Notes by Dr S.L. Phelps:- No change since last note.

Jan. Quit physical health good: Mental condition that of an imbecile: works in dining-room: menstr. regular: May 97 no change: Aug '97 Works in dining room. Is quite silly in behavior. Imbecile.

Oct 28 Patient is at times disagreable on ward: Is neat in habits: Mental condition is that of an imbecile: Menstruation regular: Takes outdoor exercise: Oct 25 Was today sent back to poor farm, in good physical health, mental condition is imbecile: At times is quite irritable & becomes very angry, tho usually causes no trouble. Continued by Dr. B.M. Phelps.

Sept 25 97 Patient sent out on Trial to the poor farm. Rather imbecile but usually well-behaved.

Personal and Medical History of

Personal and Medical History of Augusta Bratz

LEGGET, PUDLAR & SAWBRIDGE, DAVENPORT, IOWA.

Whole No. 11467.
Residence, Winona County,
Date Admission, 31st July 1896.
Admitted by, Dr. Phelps Hour, 4 P.M.
How Sent, H.L. Buck, Jof P. Winona County
Sex, Female.
Age, 42 years
Civil Condition, married
Children, seven.
Age Youngest Child, 5 Years
Occupation, Housewife: husbands, farmer.
Degree Education, reads & writes in German
Profession Religion, Yes: Lutheran
Habits, not stated.
Nativity, Germany: (father's & mother's same)
Physicians Committing, Dr Hans Lichtenstein & J.B. McGaughey
Correspondents, none given in papers

No. for Year, 295.
Insane Relatives, not as far as known
Cause Exciting, Don't know
Cause Predisposing, not given
Form,
Accompanying Bodily Disorder, restlessness &c
Suicidal or Not, — not.
Date of this Attack, 5 days ago
Duration, — 6 Days.
No. of Attack, 1st —
No. of Admissions, 1st —
Age First Attack, — 42 —
Time of Leaving, Sept. 19 '96.
Time in Hospital, 1 mo. 19 da.
Result, Discharged Jan. 5 '97. Rec.

EXAMINATION ON ADMISSION

Exam. by Dr. Phelps Aug 1 '96

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Seems quite clear.
Quick or Sluggish,
MEMORY:
Past Events, Good
Recent Events,
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Alert.
Correct or Illusive,
REASONING POWER:
Ordinary Subjects,
Own Mental State,
Special Subjects, Fairly good.

GENERAL DESCRIPTIVE REMARKS: Pincal physical health is impaired - is pale & complains of pain in left side & across abdomen. Actions are at times hysterical. Jerks her limbs & when anyone is near often breathes in a very rapid & hysterical manner.

EMOTIONAL STATE:
Normal, Calm, Somewhat excitable
Indifferent,
Exalted,
Depressed,
DELUSIONS:
Systematized or Not, None exhibited
Special Subjects,
Transitory or Not, Transitory at present.
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

Personal and Medical History of Augusta Bratz

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, Not taken WEIGHT, not taken NUTRITION, Thin but pale.
WOUNDS OR ABNORMALITIES,
TONGUE, Tremors, Coatings, Yellow coat Promptness Movement, Heavy.
PUPILS, Equality, Equal Size, Normal
Response Light, Normal Accommodation, Normal Eyes Weak -
SIGHT, Says sometimes a blurred sensation
HEARING, Not good of late.
COORDINATION, Arms, Normal
Legs, "
TREMORS, Hands, None Tongue,
Facial Muscles, General, At times jerks arms & legs in hysterical manner
REFLEXES, Patellar, EXAM. URINE, Aug 1 96
Other
ARTICULATION, Good
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, Murmurs - sounds weak apex beat very weak
LUNGS, Normal - breath sounds good.
TAKEN,

Quantity 24 hrs. ℥ XXV
Sp. G. 1030.
Color Yellow red.
Reaction Acid
Sugar None.
Microscop. Exam. Sodium & Amon. Urates - Fat globules & triple phosphates.

GYNAECOLOGICAL EXAM., Aug 5/96 Uterus Normal position. Hypertrophy & endometritis, laceration of cervix slight laceration of perineum.
MENSTRUATION, Menstruation regular.
OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated.	Irregular,
APPETITE, Good,	Medium,	Poor, Past four weeks.
SLEEP, Good,	Poor, of for 4 years.	Irregular,
PULSE,	Resp.,	Temp.,

CRANIAL MEASUREMENTS, Circ. 53 (F-M) 60 Fron. oc. a. 31 Bri. a. 31 Aur. p. d. 18 Fronv. d. 14½ Bimd. 12.5 Fac. h. 11.2
HISTORICAL, Four years ago had a very nervous spell. Fever in old country.
LENGTH OF INVASION, Short ONSET GRADUAL OR SUDDEN, Sudden
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Denied
Mother or Mat. Relations, Died old age
Father or Pat. Relations, Died Pneumonia
~~Brothers~~ or Sisters, Children healthy

Personal and Medical History of Augusta Bratz.

1896

This patient was brought here by Deputy Sheriff A. W. Fuhrman, attended by Carl Bratz husband, with following history. Patient is in fair condition. No history of insanity; No insane relatives, so far as known. This is 1st attack; symptoms manifested 5 Days ago; - thought she was bewitched by a woman; twitched & rushed & leave home. Dessise seems increasing. Is variable, but no regular intervals. Derangement now shown in that she thinks she is bewitched and there is religious excitement; Sleepless. Patient is not disposed to injure others, unsuicidal nofilthy or destructive habits. She was always hysterical & sensitive. In the last six months, she had profound religious impressions; always pious. There is no history of intemperance, no severe disease &c, except hysterical seizures. Has not been restrained or confined. Cause of the Disease, dont know. No only treatment was for restlessness, insomnia. On personal examination there is considerable twitching & uncertainty in answering; is reticent & suspicious.

July 31 On admission, was put on B'n (G. H. N. K'ps). Complexion fair; hair light brown; eyes gray; condition of skin normal; no marks, scars or bruises noted. Is clean. Quiet and talks sensibly).

Aug 1 Nurses Notes T 98 P 73 R 18 Appetite fair. Patient quiet in bed. Complains of pain across her stomach. Aug 2 Appetite fair. Tonic given Bowels regular. Quiet today; Complains of headache. Seems to talk sensibly. Apr. 3 T 97.7 P 72 R 18 Appetite fair - Quiet on ward. Talks sensibly. Pulse very weak today. Aug 4 T 98 P 88 R 18. Appetite not very good. Took Tonic. Powder 3 times, one pill. Complains of headache wants to go home. Complains of noise. Aug 5 Appetite fair. Tonic & pill given. Bowels moved. Complains of stomach trouble. Talks sensibly. Slept well during night. Aug 6 Appetite fair Tonic, powder 4th times Patient about same. Slept well. Apr 7 Still complains of a distressed feeling in stomach. Somewhat nervous during night did not sleep well. Aug 8 Quiet & agreeable. Talks sensibly. Takes out door exercise. Slept well during night. Aug 9 Appetite fair Tonic, cathartic & powder still given. Complains of pain in left side & stomach. Did not sleep well first part of night. Aug 10 Some better today. Slept well latter part of night. Aug 11 Complains of weak & tired feeling. Aug 12 Appetite poor. Tonic, powers & cathartic given, bowels moved, Had chills during day. Also complains of a dizziness in head & pain in left side. Aug 13 Appetite poor. Patient appears nervous. Still complains of pain in left side, also of a drowsy feeling. Slept fairly well during night. 14th Appetite better. Is feeling better today. Slept well. Tonic & powders still given daily.

Aug 14 Physician's Note Patient is a quiet melancholy case. Health apparently fair No prominent delusions. Owns up to some crazy behavior however as the cause of her being sent here. Claims to be fairly free from it now.

Aug 30 Summary Nurse's Notes by Dr L. L. Phelps. Has been upon Gyn. treatment 3 times a week. Quiet & pleasant in manner. Appetite fair, usually sleeps well. Complains a good deal of neuralgia in left side & head ache.

Sept 9. Went Home with husband. Was quiet & agreeable. talked quite sensibly. complained of neuralgia as she had done for some time.

Discharged.

Personal and Medical History of

Personal and Medical History of Victoria Koelmel

LOBERT, FULLAS & GAMBERS, DAVENPORT, IOWA.

Whole No. 4478
Residence, Wabasha, Minn.
Date Admission, August 7th 1896.
Admitted by, Dr Linton Phelps Hour, 7 P.M.
How Sent, Malcolm Kennedy J of P. Wabasha Co.
Sex, - Female -
Age, - 50 -
Civil Condition, Widowed
Children, - 3 -
Age Youngest Child, Twenty-one years
Occupation, Housewife
Degree Education, Reads & writes
Profession Religion, Church of Rome
Habits, Probably good.
Nativity, Germany (Parents Germany)
Physicians Committing, W.H. Lincoln & P.N. Nell.
Correspondents, None given in papers.

No. for Year, 11
Insane Relatives, No
Cause Exciting, Not known.
Cause Predisposing, Not given.
Form, Melancholia
Accompanying Bodily Disorder, None mentioned
Suicidal or Not, Not attempted but expresses desire
Date of this Attack, July 1' 1896.
Duration, - about 5 mos -
No. of Attack, 1st.
No. of Admissions, 1st
Age First Attack, - 50 -
Time of Leaving, Oct. 10. 1896.
Time in Hospital, 3 mo 3 da.
Result, Discharged Feb. 3. '97. Unimproved.

EXAMINATION ON ADMISSION

Exam. P.M. + Sh. Phelps Aug 8th

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Quick - some confusion
Quick or Sluggish,
MEMORY:
Past Events,
Recent Events, Fairly good.
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Somewhat dull
Correct or Illusive,
REASONING POWER:
Ordinary Subjects, Fair.
Own Mental State, Somewhat confused
Special Subjects, " "
GENERAL DESCRIPTIVE REMARKS: Insists that she is worried over insanity of 21 year old daughter + is not insane herself at all. Came because she was nervous + worried hears now at imputation that she is insane

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed, Slightly depressed.
DELUSIONS:
Systematized or Not,
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

Personal and Medical History of Victoria Koelmel

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, WEIGHT, NUTRITION, Somewhat impaired
WOUNDS OR ABNORMALITIES, Condition of skin - Fairly good.
TONGUE, Tremors, Coatings, Promptness Movement, Fairly Normal. Deviates to left.
PUPILS, Equality, Equal Size, Normal
Response Light, Accommodation,
SIGHT, Both eyes are weak - Uses glasses to read.
HEARING, Left ear somewhat deaf.
COORDINATION, Arms,
Legs,
TREMORS, Hands, Fair tremor Tongue,
Facial Muscles, General,
REFLEXES, Patellar, Equal - Normal
Other
ARTICULATION, Fair.
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, Murmurs - normal.
Chest symmetry slightly atrophied Expansion
LUNGS, Fair. Resp. slightly shallow
TAKEN,

EXAM. URINE, Aug 13.
Color Reddish yellow
Character Cloudy.
Microsc. Some pus cells oxalate of lime bladder + vaginal epith. + amor. urates.

GYNAECOLOGICAL EXAM., Aug 9/96. Uterus retroverted + immovable. Hypertrophy, length of cavity ons 3 in. Cervix lacerated extensively - external genitals normal.
MENSTRUATION,
OPHTHALMOSCOPIC EXAM.,

HABITS,	Dirty,	Clean,	Careless,
BOWELS,	Normal,	Constipated,	Irregular,
APPETITE,	Good,	Medium,	Poor,
SLEEP,	Good, usually	Poor,	Irregular,
PULSE,	Full 90	Resp.,	Temp.,

CRANIAL MEASUREMENTS, Long.(l) 56.3 (r.m.) 64 Naso.oc.a. 36 Bin.a. 33. Aur.Fd. 19.9 Front.d. 15.2 Biad. 13 Fl. 12.1
HISTORICAL, Does not have headaches. No dizziness Fairly good shape somewhat unsteady in joints except as usual.
LENGTH OF INVASION, Probably — ONSET GRADUAL OR SUDDEN, Probably gradual.
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Denies any insanity in family
Mother or Mat. Relations, Died of old age,
Father or Pat. Relations, Died of dropsy.
~~Brothers or Sisters~~, Children - daughter insane, 3 children.

Personal and Medical History of Victoria Roelmer.

1896

This patient was brought here by Sheriff D.C. McKenzie, attended by niece, with the following history: Patient in in fair physical condition: no history of Consanguinity or heredity: This is first attack: first symptoms were manifested about July 1'96 by idea that one of her daughters was insane: disease seemingly increasing: Variable with rational intervals. Patient has shown no disposition to injure others: has not attempted suicide but expresses a desire to do so: no filthy or destructive habits: No peculiarities have been previously shown: There is no history of intemperance in parents or self, nor of any disease or injury to head: Has not been restrained or confined: Cause of disease not known: No treatment given. No further information obtained on personal exam. On admission put upon Br W.

Aug 7'96 Nurses Notes Pt'd on ward. Bathed & put to bed. Slept most of night.

Aug 8. T. 98.2 P. 86 R 23. Appetite fair. Bowels regular: Patient quite nervous: awake & singing most of night. Is asking to take poison Aug 9 Appetite fair, tonic given: Trans. to Br Seems very nervous. has spells when she shakes all over & cannot control herself.

Aug 10 T. 99.2 P. 98 R 22 Appetite very good: Tonic after meals: Bowels regular: Says she cannot sleep on account of noise at night. Says she feels better when she can be at work, wants to go home. Aug 11 T. 98.9 P. 86 R. 20 Appetite very good. Tonics & Sleeping dose given. Bowels regular Does not sleep well. Very nervous Quiet. Likes to keep busy because she does not get so nervous. Aug. 12 T. 98.9 P 86 R 21 Appetite good: Tonic after meals: Slept but little: Nervous, quiet: Talks sensibly Wants to go home. Aug 13 T. 98.5 P. 88 R 20 Appetite poor. Tonic, Sleeping dose & cathartic given: Awake all night sitting up in bed & walking floor: Began to be very despondent at 11:30 A.M. saying she wanted to die & would eat no more. Aug 14 Appetite better. Bowels regular. Seemed to feel better this morning. Is quiet: Wants to go home: Quite restless all night. Aug 15 Ate no breakfast nor dinner. Tonic refused. Says medicine will do her no good & that she will never be well. Very despondent. Awake all night, out of bed 2 hrs.

Aug 16 Ate no breakfast but ate other meals. Bowels moved. Will not keep her clothing on Slept quite well. Tonic refused. Aug 17th 18th 19th & 20th Improved. Behavior quiet most of time but very nervous & restless at times. Talks quite sensibly. Takes out door exercise. Assists some with dining room work. Sleeps better Appetite fair. Tonic given 3 times daily: Bowels regular.

Aug 20 Physicians Note Patient in coming judged her situation quite clearly, as simply nervous & despondent. A quite simple melancholia. Was agitated & sleepless. Had worried over illness of her daughter. Part of time has been very melancholy & at times excited & suicidal.

Sept 4 Summary Nurse's Notes by Dr. E.S. Phelps. - Gym. treatment given 3 times a week: Elec. treatments every other day: Oct 10'96 Went Home: Was quiet & agreeable: talked quite sensibly although still had some delusions: Had worked in Laundry.

Discharged.

Personal and Medical History of

Personal and Medical History of Grete Iverson.

LIBBEY, FISLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4484.
Residence, Wilmington Minn.
Date Admission, August 11th 1896
Admitted by, Dr R.M. Phelps Hour, 430 P.M.
How Sent, Thos. Ryan - Jos P. Houston Co.
Sex, -Female-
Age, -45-
Civil Condition, Married
Children, Seven.
Age Youngest Child, About 18 Months
Occupation, Housewife (Husband farmer)
Degree Education, Can read & write Well.
Profession Religion, -Lutheran-
Habits, Good.
Nativity, Norway. (Parents to Norway)
Physicians Committing, E.B. Johnston & W.W. Freeman
Correspondents, Dr Iverson, Spring Grove. (Family Physician.
Christian Iverson Caledonia Minn (Husband)

No. for Year, 17
Insane Relatives, -None-
Cause Exciting,
Cause Predisposing, Not known.
Form, Chronic mania or terminal dementia
Accompanying Bodily Disorder, None Mentioned
Suicidal or Not, -Not-
Date of this Attack, About 5 years ago
Duration, - about 5 years -
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, -40-
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION

Exam. by R.M. & A.L. Phelps Aug. 14 '96

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Fairly quick
Quick or Sluggish, Clear on many subjects
MEMORY:
Past Events,
Recent Events, } Seems fair.
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Fairly alert.
Correct or Illusive, Answers ordinary questions
REASONING POWER:
Ordinary Subjects, Fair.
Own Mental State,
Special Subjects, Dull on some.

EMOTIONAL STATE:
Normal, Calm,
Indifferent, Dull & indifferent
Exalted,
Depressed,
DELUSIONS:
Systematized or Not, None determined
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Talks little English here. Would do queer things when up to time of coming here. Has only nervous. For six years not very well. Children - youngest 18 mo. Though she answers questions & is intelligent in form, is yet rather dull & has slow progression. History states that for 6 years has been queer & troublesome, but of late could not manage

Personal and Medical History of Grete Iverson.

44841.
M Grete Marie Iversan
Copy of Order for Hearing Petition of Christian Iverson
for appointment of
as guardian for
Grete Marie Iverson insane; served and
service ~~admitted~~ made by Sheriff June 8/28/03.
(Papers filed with commitment papers.)
Hearing for 16th Sept 1903, at Probate Office Caledonia Houston Co Minn

MISSION, CONTINUED.

RACTERISTICS.

NUTRITION, Fair
n mark on left wrist & on either side of abdomen
pall. Promptness Movement,
Size, Normal.
Accommodation, —

COORDINATION, Arms,
Legs,
TREMORS, Hands, Tongue,
Facial Muscles, General,
REFLEXES, Patellar,
Other
ARTICULATION,
Slurred, Slurred fairly good
Hesitating, No.
FACIAL EXPRESSION,
SENSIBILITY,
HEART, None murmurs. Regular
LUNGS, Normal.
TAKEN,

EXAM. URINE, Aug 14' 96
Color Reddish Yellow
Character Ropy Sediment.
Amt. 24 hrs VIII Z.
Sp. Gr. 1032
Reaction Acid.
Albumen Trace by Tanrets.
Sugar Trace by Bismuth
Microscop. Mucine bands, Amor. mates bladder & Vaginal Epith. Cells.

GYNAECOLOGICAL EXAM., Aug 15/96 Uterus Normal position - Extensive hypertrophy, Endometritis, Laceration of cervix - erosion of os. Rectocele - Cystocele & Laceration of perineum.
MENSTRUATION,
OPHTHALMOSCOPIC EXAM.,
HABITS, Dirty, Clean, Careless,
BOWELS, Normal, she says Constipated, Irregular,
APPETITE, Good, Medium, Poor, ✓
SLEEP, Good, Poor, Irregular,
PULSE, Resp., Temp.,
CRANIAL MEASUREMENTS, Circ.(h) 54.5 (r.m) 62.5 Nasio.a. 31 Bim.a. 31 Aut.p.d. 18.7 Fronto.d. 15.9 Bi.z.d. 13.1 F.L. 11
HISTORICAL, Has headaches occasionally
LENGTH OF INVASION, 2-6 years. ONSET GRADUAL OR SUDDEN, Gradual.
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations,
Father or Pat. Relations, Died - Brain trouble - apoplexy. Grandmother "Cramp" (Convulsions)
Brothers or Sisters,

Personal and Medical History of

LIBERTY, FIDLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4484.
Residence, Wilmington Minn.
Date Admission, August 11th 1896
Admitted by, R.R.M. Phelps Hour, 4:30 P.M.
How Sent, Thos. Ryan. J. of P. Houston Co.
Sex, -Female-
Age, -45-
Civil Condition, Married
Children, Seven.
Age Youngest Child, About 18 Months
Occupation, Housewife (Husband farmer)
Degree Education, Can read & Write Well.
Profession Religion, -Lutheran-
Habits, Good.
Nativity, Norway (Parents Norway)
Physicians Committing, E.B. Johnston & W.W. Freeman
Correspondents, Dr Jenson, Spring Grove. Family Physician.
Christian Iverson Caledonia Minn (Husband)

No. for Year,
Insane Relatives, -
Cause Exciting,
Cause Predisposing, Not
Form, Chronic mania or terr
Accompanying Bodily Disorder, None m
Suicidal or Not, -Not-
Date of this Attack, About 5 years ago
Duration, - about 5 years -
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, -40-
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION

Exam. by R.R.M. & A.L. Phelps Aug. 14 '96 **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:
Clear or Confused, Fairly quick
Quick or Sluggish, Clear on many subjects
MEMORY:
Past Events, Recent Events, Special Subjects, } Seems fair.
PERCEPTIVITY:
Alert or Dull, Fairly alert.
Correct or Illusive, Answers ordinary questions
REASONING POWER:
Ordinary Subjects, Fair.
Own Mental State,
Special Subjects, Dull on some.

EMOTIONAL STATE:
Normal, Calm,
Indifferent, Dull & indifferent
Exalted,
Depressed,
DELUSIONS:
Systematized or Not, None determined
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Talks fair English. Tells only nervous. For six years not very well. Children. youngest 18 mo. Though she answers questions & is intelligent in form, is yet rather dull & has slow progression. History states that for 6 years has been queer & troublesome, but of late could not manage

Personal and Medical History of Grete Iverson.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 3 in. WEIGHT, 130 lbs. NUTRITION, Fair
WOUNDS OR ABNORMALITIES, Small bruise on lip. Brown mark on left wrist & on either side of abdomen
TONGUE, Tremors, Coatings, Flaky & pale. Promptness Movement,
PUPILS, Equality, Equal Size, Normal.
Response Light, — Accommodation, —
SIGHT,
HEARING, Seems good.
COORDINATION, Arms,
Legs,
TREMORS, Hands, Tongue,
Facial Muscles, General,
REFLEXES, Patellar,
Other
ARTICULATION,
Slurred, Slurred fairly good
Hesitating, No.
FACIAL EXPRESSION,
SENSIBILITY,
HEART, Nonexamined. Regular
LUNGS, Normal.

EXAM. URINE, Aug 14' 96
Color, Reddish yellow
Character, Ropy Sediment.
Amt. 24 hrs VIII — 3.
Sp. Gr. 1032
Reaction, Acid.
Albumen, Trace by Tanrets.
Sugar, Trace by Bismuth
Microscop. Mucine bands, Amor. mater. bladder & Vaginal Epith. Cells.

TAKEN,

GYNAECOLOGICAL EXAM., Aug 15/96 Uterus Normal position - Extensive hypertrophy, endometritis, laceration of cervix - erosion of os. Rectocele - Cystocele & laceration of perineum.
MENSTRUATION,
OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal, she says	Constipated,	Irregular,
APPETITE, Good,	Medium,	Poor, ✓
SLEEP, Good,	Poor,	Irregular,
PULSE,	Resp.,	Temp.,

CRANIAL MEASUREMENTS, Circ. (h) 54.5 (y.m) 62.5 Base to a. 31 B'ma 31 Ant. f. d. 18.7 Trans. d. 15.9 Bi. d. 13.1 F.L. 11
HISTORICAL, Has headaches occasionally
LENGTH OF INVASION, 2-6 years. ONSET GRADUAL OR SUDDEN, Gradual.
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations,
Father or Pat. Relations, Died - brain trouble - apoplexy. Grandmother "Amp." (Convulsions)
Brothers or Sisters,

Personal and Medical History of Grete Iverson

1896

This Patient was brought here by George Ekrund with following history: Patient is in fair physical condition: No history of consanguinity or heredity: Has up quiet attack: first symptoms were manifested about five years ago by being afraid to be left alone: Disease seems to be increasing & is stationary with no rational intervals. Derangement was manifested in religion, talks constantly upon it. Patient has shown a disposition to injure others & to filthy & destructive habits: is not suicidal: No insane relations: no peculiarities previously shown: no history of intemperance in self or parents: no severe disease or injury to head: has never been restrained or confined but has had to be watched continuously: Cause of disease not known: practically no treatment has been pursued. On personal examination patient said she talked with the prophets: She is stupid & listless in manner & is sent to hospital because for her recovery she needs care & treatment.

Aug 11 On admission wore suit on B.2 W. (G. & N. Ry. complexion dark: Hair light: Eyes blue: Condition of skin normal: Brown mark on left wrist & on each side of abdomen: Small bruise on hip: very dirty: quiet, talks sensibly: no delusions noticed)

Aug 11 Nurses Notes Reid on ward: bathed & put to bed. Aug 12 T 98 P 72 R 19. Appetite fair: Tonic after meals: Slept very little: Seems rather nervous. Does not stay in bed. Milk drawn from breasts twice. Aug. 13 T. 97.4 P 74 R 17. Appetite fair: Tonic: Milk drawn from breasts twice a day & belladonna applied. Complains of pain in head. Slept quite well at night. Aug 14 T 98.5 P. 75 R 19 Appetite good: Tonic & Cathartic given. Does not stay in bed: Seems quite nervous. Milk still drawn twice daily. Slept nearly all night. Complains of pain in head. Aug 15 T 97.5 P 80 R 18. Quite nervous, very restless. Milk drawn: Slept very well. Still complains of pain in head. Aug 16 T 98. P. 74 R 20 Appetite good Tonic & cathartic given. Quite nervous & restless. no change.

Aug 20 During record week appetite fair Tonic given daily: Bowels regular: Slept fairly well. Behavior quiet but very restless & nervous. Takes out door exercise Assists a little with work.

Aug 27 Physicians Note Patient very quiet & melancholy. More dull than melancholy. Appears chronic mania or terminal dementia.

Sept 7 Summary Nurse's Notes by Dr. E.L. Phelps. - Gym. treatment every other day:

Oct. 5 Transf. to Inf. Oct. 9 Operation done - Curettement, trachelorraphy, cystocele & perineorraphy: Oct. 21 Sitting up most of day: Has made a good & uneventful recovery: Dec. 21 Physical health fair mental condition apparently a chronic one: wanders aimlessly about in a quiet way: Talks only Swedish: Is incoherent: May 99 Quiet in behavior: no special change:

1899 Aug Takes out door exercise: appetite good: bowels regular: assists with work. Continued by Dr. R.M. Phelps. Patient often leaves to go home: Is quiet in behavior: Dull & quite silly. Does not often speak now Feb 4 Wt. 144# Feb May 30 Visited by friends. Sept 1 Trans. to B3. Feb 1899 Patient helps on the ward at other times sits about having own heater: Talks a little to herself but seems to take little interest in anything

Personal and Medical History of Grete Iverson

1899

Mar to Dec. (Cont. by Dr. R. A. Belt) Appetite good: bowels regular: dresses take out door exercise: assists with work: Does not speak English: has delusions about the Bible & the prophets: usually quiet but rather noisy at times & at such times appears to be angry

Sept 1- Feb 8 1900 (Dr. Ingersoll) Noisy, scolds, assists with work: Bowels regular: Takes out door exercise: appetite poor: Jan. Wt 145# Does not talk English Tidy in habits. Mch 1- Nov 30 1900 Quite hysterical at times also noisy July 21 Vaccinated: Scalds at times & is occasionally destructive: Sleeps well. Appetite fair. Menstruates regularly. Wt. 145#. Dec 1- Feb 8 1901 Patient not very well. Complains of pains & aches has rise of temperature probably tuberculous. Feby Wt. 135½#

Mar. to June 1901 Patient failing in health, very much emaciated, transfered to Infirmary West Mar. 4., complained of general ill feeling, patient in bed, neat in habits, sleeps well, May. 31 patient improved very much, Wt 121#. June to Sept. June 3 transferred to B. 3. Aug. 31, appetite good, bowels regular, takes out door exercise, at times is somewhat noisy, untidy in appearance, is unoccupied. Sept. to Dec. No change in general condition Nov. 30 Wt. 129#.

Jan to Feb. 1st 1903. General health good: appetite good: bowels regular: assists with the work: takes exercise: does not attend amusements: is neat and clean: does not converse or answer questions: is usually quiet: sometimes scolds and talks to herself noisily: Nov. 28th Wt 136# Jan. 18 visited by daughters. Jan. 17, visited by friend.

Feb. 6-1902 Visited by friends. Wt. 136.#

Personal and Medical History of Dorothy Blodgett.

LOEBER, FULLER & EVANBERG, DAVENPORT, IOWA.

Whole No. 4485

Residence, 284 W. 3rd St. St. Paul, Minn.

Date Admission, Aug 11th 1896.

Admitted by, Dr. R.M. Phelps Hour, 6:45 PM

How Sent, G. Millrich Jof P. Ramsey Co. Minn.

Sex, — Female -

Age, -49-

Civil Condition, Married

Children, -six-

Age Youngest Child, Seventeen years.

Occupation, — (Husband printer)

Degree Education, -Common-

Profession Religion, -No-

Habits, -probably good-

Nativity, England. (parents England)

Physicians Committing, J. Hamm - Eugene Hubbell.

Correspondents, A.C. Blodgett (Husband)
284 W. Third St. St. Paul-Minn.

No. for Year, 18

Insane Relatives, father, uncle & two cousins.

Cause Exciting, Not known

Cause Predisposing, - Heredity -

Form, Melancholia, acute

Accompanying Bodily Disorder, -None noted-

Suicidal or Not, Yes (with knife) propensity at times

Date of this Attack, About 5 months ago.

Duration, About 5 months.

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, -44-

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION
MENTAL CHARACTERISTICS.

Exam by Dr. R.M. Phelps 8/14/96

MENTAL ACTIVITY:

Clear or Confused, Clear except in regard to depression

Quick or Sluggish, Nervousness own state.

MEMORY:

Past Events,
Recent Events, } Seems good.
Special Subjects,

PERCEPTIVITY:

Alert or Dull, Alert.

Correct or Illusive, Fairly correct on many subjects

REASONING POWER:

Ordinary Subjects, Fair

Own Mental State, Somewhat poor in realizing own condition

Special Subjects, Fair now

GENERAL DESCRIPTIVE REMARKS: Talks pleasantly. Answers all questions promptly. Seems coherent & manifests no delusions. Physically somewhat impaired in health

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted,

Depressed,

DELUSIONS:

Systematized or Not, Melancholic depressions at times

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

Personal and Medical History of Dorothy Blodgett.

EXAMINATION ON ADMISSION, CONTINUED.
PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 4 in. WEIGHT, 104 lbs. NUTRITION, Not - -

WOUNDS OR ABNORMALITIES, None - Condition of skin Fairly good

TONGUE, Tremors, Somewhat tremulous Coatings, Yellow. Promptness Movement,

PUPILS, Equality, Equal Size, Normal.

Response Light, Hardly any Accommodation, Hardly at all.

SIGHT, Uses glasses

HEARING, Fair - less in R. ear.

COORDINATION, Arms, Not much impaired

Legs, Impaired

TREMORS, Hands, Not much - some fine tremor Tongue,

Facial Muscles, General,

REFLEXES, Patellar, Normal.

Other

ARTICULATION,

Slurred, Fair in every resp

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART, Sounds muffled-indistinct- Apex beat downward & left. Fairly regular

LUNGS, Fair - somewhat emaciated

GYNAECOLOGICAL EXAM., Aug 15/96 Uterus in normal position - some adhesions on left side causing uterus to be immovable - Pain most of time on left side of pelvis & left ovarian region some hypertrophy of cervix - slight erosion of os. External genitals normal.

MENSTRUATION, Menopause passed 2 years.

OPHTHALMOSCOPIC EXAM.,

TAKEN,

EXAM. URINE, Aug 14/96

Color Reddish yellow.

Character Cloudy with white flaky dep.

Amt. 24 hrs. XVII Z.

Sp. Gr. 1017

Reaction Acid

Albumen Trace by Tsuretz

Sugar None -

Microscop. Amor. crystals a few Fat globules, Pus corpuscles - Bladder epith. cells.

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated slightly.	Irregular,
APPETITE, Good,	Medium,	Poor,
SLEEP, Good,	Poor,	Irregular,
PULSE,	Resp.,	Temp.,

CRANIAL MEASUREMENTS, Circ (c) 53 (cm) 60.5 N.O.a 30 Bin.a. 31 Auto.a. 18+ Transv.a. 14.4 Bin.a. 12.4 Fac.a. 11.2

HISTORICAL, Typhoid fever in 1891 Lung fever good while ago. Spinal meningitis at 22 years of age - Sick headaches all her life

LENGTH OF INVASION, Says 6 months probably longer ONSET GRADUAL OR SUDDEN, Gradual

HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Father + cousin insane

Mother or Mat. Relations, Died abscess.

Father or Pat. Relations, + cousin insane Father at home.

Brothers or Sisters,

Personal and Medical History of Dorothy Blodgett.

This patient was brought by D. McE Johnson, attended by Miss M. F Needham with the following history: Patient is in fair physical condition: As to Consanguinity, unknown: This is first attack: First manifested itself about 5 months ago by abnormal exhaltation: disease appears to be increasing, is stationary with no rational intervals: Derangement is now manifested by attempts to commit suicide & by sleeping constantly. Patient has shown no disposition to injure others; has shown no disposition to filthy or destructive habits: Father, uncle & two cousins insane. Patient was violent before accession of disease. No history of intemperance in patient or parents: no severe disease or injury to head. No restraint or confinements has been employed: Cause of disease heredity no treatment has been pursued. ———

On admission Put on B2 w. (Asst Phy. Complexion Fair: Hair gray: Eyes blue: Condition of skin normal: Large bruises & small scars on both arms: left eye somewhat smaller than right: Behavior quiet; talks sensibly but says when excited she tries to injure herself.)

Aug 11 Nurse's Notes Patient received on ward Aug 12 T. 97.8 P. 75 R 17 Appetite fair bowels regular. Slept about 2 hrs. Talks quite sensibly: Is rather nervous: Sleeping this PM. Aug 13 T. 98.8 P 75 R 17. Appetite fair: Slept about one hour at night: Very nervous & restless. Out of bed & trying to get out of room Complains of pain in small of back. Aug 14 T. 98.9 P. 90 R 28. Appetite good. Tonic given Bowels moved: Still complains of backache: Sitting up today. Cries to herself quite a good deal. Eyes are quite weak. August 15 T 99.3 P 100 R 21 Appetite Good. Tonic & Cathartic given. Has a headache: Is very quiet: Slept one hour: Quiet when awake. Aug 16 Slept greater part of night: very quiet: bowels constipated: Complains of headache Aug 24 Appetite good during second week: Tonic given daily: bowels irregular: Sleeps very poorly: Nervous & restless but quiet in behavior Talks to herself a good deal also cries. Clean in habits & neat in appearance. Has delusions. Says at times that someone is trying to kill her.

Aug 24 Physicians Note Patient plain case of melancholia. Is also somewhat senile Can answer quite clearly even when most nervous & depressed.

Aug 31 Summary Nurse's Notes by Dr. L.L. Phelps:- Gyn. treatment every other day: Massage & electrical treatment: Sept. 3-4 Refused to eat: Sept. 10-14 Fed with tube: Local treatment. Elect. treatment every other day: Quite melancholy: Nov 14. Local & elect. treatment every other day since last note: Very much excited most of time: Jan 97 Resists treatment a good deal Salt baths every other day: May 97 Salt baths continued: July 97 Assists some with work: very talkative: talks to self a good deal very noisily & incoherently: Continued by Dr. P.M. Phelps. Nov 28 Patients general health fairly good. Talks in a noisy profane way at times: is rather emaciated but does not seem to have any failure of general health. Feb 4 Wt. 110.th Feb 7 Trans. to Annex. Mch 5 Visited by friend. June 24 Trans. to B2. July 18 To Infirmary. Aug 28 To B1. Feb 27 Patient restless & irritable & scolds a good deal. but usually is not violent. (Cont by Dr. Bell

Personal and Medical History of Dorothy Blodgett.

Mar 1 & Dept. Physical condition only fair: appetite good: sleeps well: bowels regular: Takes out door exercise: Pat has many delusions & is very insolent. scolds a great deal: Is often irritable & noisy.

Sept 1- Feb 28 1900 Dr Hayes & Dr Lindsley: Noisy at times: Appetite good: sleeps well: Takes out door exercise occasionally. Trans. to B2. Jan 17 Wt. 108.th. Scolds a great deal

March 1- Aug 31 1900. Dr Hayes Patient disturbed & aggressive at times & inclined to be violent Has delusions: Talks incoherently. Appetite good: Bowels regular: Sleeps well. May 28 Fought G. Dailey & struck at other patients: July 25 Vaccinated July 19 Threw a chair at patient. Sept 14 Struck Mrs Hosford & broke window secluded 3 hrs. Appetite fair: Bowels regular. Oct 2 Trans. to B2. Oct 30. Violent Nov 15 Very disagreeable & language profane. Wt 115.th Dec 1- Feb 28. No change in condition or behavior: General health good. Mar to June 1901 Patient very noisy and troublesome, frequently strikes other patients, is destructive, will throw dishes, very profane in her language, general health good, takes out door exercise, is unoccupied May 29 Wt. 111 #. June to Sept. Patient's condition shows no mental or physical change, Aug 31.

Sept to Dec. No change in her mental or physical condition Nov. 15 Wt. 111 3/4 #.

Dec to Feb 1/03 No change in mental or physical condition. Wt. about 115 #.

Personal and Medical History of Anna Merz.

LARRABEE, PUSCH & SCHARBERG, DAVENPORT, IOWA.

Whole No. 4488
Residence, St. Paul, Minn.
Date Admission, Aug. 13'1896.
Admitted by, Dr. R.M. Phelps Hour, 7 PM
How Sent, by H. Millich, J of P. Ramsey Co.
Sex, -Female-
Age, -38-
Civil Condition, Single
Children, —
Age Youngest Child, —
Occupation, Dressmaker.
Degree Education, -common-
Profession Religion, R. Catholic.
Habits, -Good - probably-
Nativity, St. Paul, Minn (Parents Germany)
Physicians Committing, Park Ritchie + W.S. Biggs.
Correspondents, Miss Barbara Merz, 445 Rondo St. St. Paul, Minn.

No. for Year, 21
Insane Relatives, -None-
Cause Exciting, -Not known-
Cause Predisposing, -Not known-
Form, Acute Delusional Melancholia.
Accompanying Bodily Disorder, none mentioned
Suicidal or Not, Never attempted but has threatened to take Poison
Date of this Attack, Two weeks ago.
Duration, Two weeks.
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, -38-
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION

Exam. R.M. + S.L. Phelps Aug. 14'96

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Somewhat Confused.
Quick or Sluggish,
MEMORY:
Past Events,
Recent Events,
Special Subjects,
PERCEPTIVITY:
Alert or Dull,
Correct or Illusive,
REASONING POWER:
Ordinary Subjects, Only fair.
Own Mental State, Impaired.
Special Subjects,
GENERAL DESCRIPTIVE REMARKS: Thinks there is nothing the matter with her + feels that it is an injustice to have been sent here. Acts in an indifferent manner. Physically she is not in very robust condition. Pale + nutrition impaired.

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed,
DELUSIONS:
Systematized or Not, Thinks someone tried to
Special Subjects, poison her or shoot her
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

Personal and Medical History of Anna Merz.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 3 in. WEIGHT, 97 lbs. NUTRITION, Impaired - pale.
WOUNDS OR ABNORMALITIES, None.
TONGUE, Tremors, Coatings, Promptness Movement,
PUPILS, Equality, Equal Size, Normal.
Response Light, Normal Accommodation,
SIGHT, Uses glasses
HEARING, Good.
COORDINATION, Arms, Normal
Legs, "
TREMORS, Hands, Fine tremor Tongue,
Facial Muscles, None General, None.
REFLEXES, Patellar, Both exaggerated - 9
Other
ARTICULATION, Normal.
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, No murmurs. Sounds mark Regular.
LUNGS, Bad cough some years ago Breath Sounds Quickened + somewhat shallow
GYNAECOLOGICAL EXAM., Aug. 15/96 genitals normal
MENSTRUATION, Regular.
OPHTHALMOSCOPIC EXAM.,

TAKEN,

Uterus + appendages normal-retroversion

EXAM. URINE, Aug 19'96
Color Brownish red.
Character Heavy brown copy deposit
Amt. 24 hrs. XX ℥
Sp. gr. 1024
Reaction Alkaline
Albumen Large quantity by Heat
" " " " HNO3
" " " " Tanrets.
Sugar Trace by Haines
Microscop. fat globules, large quantity, large quantity Amor. urates
" " triple phosphates + pus.
Bladder cells + fatty casts.

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal, ✓	Constipated, (at present)	Irregular,
APPETITE, Good,	Medium,	Poor, ✓ for year or two
SLEEP, Good,	Poor, ✓	Irregular,
PULSE, Rather weak	Resp.,	Temp.,

CRANIAL MEASUREMENTS, Circ. (C) 54 (Vm) 61½ Naso oc. a. 33 Bm. a 32½ Aut. p. d. 18½ Fronto. d. 15.2 Bi. d. 12.5 Fae. l. 11.6
HISTORICAL, Fell down stairs 14 years ago + hurt head. For some time nervous + out of mind afterward - sick 2 years after with type Maniacal fever.
LENGTH OF INVASION, Short ONSET GRADUAL OR SUDDEN, Sudden
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, dead.
Father or Pat. Relations, Died paralysis sick 9 weeks.
Brothers or Sisters, 2 brothers

Personal and Medical History of Anna Merz.

This patient was brought by Dep. Sh. W.H. Springer attended by Miss Barbara Merz, with the following history: Patient is in fair physical condition: no history of consanguinity. This is 1st attack & was first manifested about 2 wks ago by severe headache with delusions: Disease appears to be stationary but is variable with rational intervals. Derangement is now manifested by delusions that Han gives & are giving her poison: Patient has shown no disposition to injure others, nor to filthy or destructive habits: has never attempted suicide but has threatened to take poison: No history of insane relations: No peculiarities shown previous to access ion of disease: No history of intemperance in parents or self - but patient has taken much medicine. Fourteen years ago patient fell down stairs & hurt her head - two days later ran away - was unconscious 24 hrs & after this for two days delusions then ran away. Went to Kansas City & for one months was in hospital there sick with typhoid fever - After coming out of hospital seemed well until 2 wks ago when overcome by heat. No confinement or restraint has been employed: cause of disease unknown: no treatment given - On personal examination - patient exhibited delusions that relatives will take her life -

On admission - Put on B[2] W. (Gt. N. Ry. Complexion dark: hair light: eyes gray: Condition of skin normal: No marks scars or bruises noted: Is clean, quiet & talks sensibly on most subjects but has some delusions)

Aug 13 Nurses Notes - Rec'd on ward, bathed & put to bed. Aug 14 T. 98.3 P. 82 R. 20 P. 86. Appetite poor. Tonic given: Bowels regular: Slept 3 hrs. very quiet when awake: up & dressed this P.M. Has delusions. Does not want to take medicine: complains of stiff neck.

Aug 15 T. 98.4 P. 96 R. 20 Appetite poor. Very quiet: Says stomach is out of order: some emesis this morning. Refuses medicine; says she has had enough poison: Awake all night & quite restless. Aug. 16 T. 99.2 P. 90 R. 20 Appetite a little better: Slept quite well: Very quiet: Tonic refused. Aug. 17 T. 97.3 P. 88 R. 25 Appetite poor: Tonic refused very quiet: Sleeps fairly well. Aug. 18th - 19th no change in patient - refuses to take outdoor exercise. Aug 20 Patient about same during 2nd week. Consented to take tonic again but complains that she feels sick after taking it. Moved to A' on 21st. Pleasant in manner. behavior quiet: Talks sensibly but has delusions: Sleeps fairly well. Bowels regular. Summary Nurse's Notes by Dr. B.L. Phelps:- Nov 30 '96 Quiet & pleasant in manner: Has delusive ideas: Physical health good: sleeps well Assists with work: Feb '97 Appetite good: bowels regular: Gen'l health good: no mental change: May 97 Has delusions - no change. Aug. 97 Very quiet & agreeable: physical health good. Continued by Dr. B.L. Phelps. Patient very quiet in behavior: neat in appearance: Talks almost none: Answers questions intelligently but is rather vague in general conversation. Feb 1 98 Wt. 104th Aug 28 Wt. 100.

Feb 3 99 Visited by sister: For the last few months has looked somewhat pale altho no special illness has been apparent. (Continued by Dr. A.A. Bess)

Mar. 1st Dec. Gen'l health quite good: appetite fair: receives specials: takes out door

Personal and Medical History of Anna Merz

exercise: attends chapel: neat at times very excitable & quarrelsome: occasionally uses profane language: Sept 27 Transferred to B[3] because irritable & quarrelsome. Occasionally complains of being weak & of pain in limbs: Imagines her people tried to kill her. Sept 1 - Feb 28 1900 (Dr. Heyerdahl) Neat: Does no work: Appetite good: Sleeps well: Goes out for exercise: Very quiet in manner: Jan 5. Wt. 114th. Expresses some delusions: Occasionally quarrels with other patients. Mch 1 - Nov 30 1900. Mch 3 Complained that bun was swollen: Usually quiet but irritable at times: Complains of pain in back & abdomen: May 20 in bed during day. July 21 Vaccinated. Aug 26 Assists some with ward work: Quiet but easily excited. Sept 1 - Sick in bed.

Sept - Feb 28 1901. Wt. 106th General health good: Has some delusions of persecution: Occasionally troubles other patients. Mar. to June 1901 Patient neat in habits and appearance, agreeable as a rule, takes out door exercise, appetite good, bowels regular, converses readily, is almost wholly unoccupied May 28 Wt. 108th. June to Sept. menstruates regularly, no change in general condition, Aug. 28 Wt. 107th Sept. to Dec. Patient is at times quite disturbed during which time she expresses delusions and is very disagreeable. Nov. 30 Wt. 110th.

Dec. to Feb. '03 No change in physical or mental condition. Wt. about 106th.

Personal and Medical History of Clara Ryan.

LOBERT, FULLER & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4489.
Residence, Wabasha Co. Minn.
Date Admission, August 14th 1896.
Admitted by, Dr. R. M. Phelps Hour, 1:45 P.M.
How Sent, Malcolm Kennedy. Jog P. Wabasha Co.
Sex, - Female -
Age, - 21 -
Civil Condition, - Single -
Children, - -
Age Youngest Child, - -
Occupation, Housewife -
Degree Education, - Common -
Profession Religion, - Catholic -
Habits, - Probably good -
Nativity, Wabasha Co. Minn. Parents Ireland
Physicians Committing, Wm. J. Milligan + J.S. Cole -
Correspondents, None given in papers

No. for Year, 22.
Insane Relatives, - None -
Cause Exciting, - Some female disease -
Cause Predisposing,
Form,
Accompanying Bodily Disorder, Hysteria -
Suicidal or Not, Yes - propensity active
Date of this Attack, About 3 years ago.
Duration, About three years -
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, - 18 -
Time of Leaving, Sept. 1. 1897
Time in Hospital, 1 yr. 17 da
Result, Discharged Feb. 9. 1898 Unimproved.

EXAMINATION ON ADMISSION
MENTAL CHARACTERISTICS.

Exam. by. R. M. Phelps Aug 14th 96.

MENTAL ACTIVITY:
Clear or Confused, Confused + rambling
Quick or Sluggish,
MEMORY:
Past Events, Seems impaired
Recent Events,
Special Subjects,
PERCEPTIVITY:
Alert or Dull,
Correct or Illusive, Only partially correct.
REASONING POWER:
Ordinary Subjects, Much impaired
Own Mental State,
Special Subjects,
GENERAL DESCRIPTIVE REMARKS: Very simple + childish in Talk. A general Feeblemindedness. Physical health somewhat impaired - Thin + pale

EMOTIONAL STATE:
Normal, Calm, Simple
Indifferent,
Exalted,
Depressed,
DELUSIONS:
Systematized or Not, None determined
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS: Very feeble minded
CONVERSATION: Talks in simple Manner
Coherent or Incoherent,
Voluble or Reticent,

Personal and Medical History of Clara Ryan.

EXAMINATION ON ADMISSION, CONTINUED.
PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 4½ in. WEIGHT, 114½ lbs. NUTRITION, Good but pale.
WOUNDS OR ABNORMALITIES, None.
TONGUE, Tremors, Coatings, Heavily Coated Promptness Movement,
PUPILS, Equality, Equal Size, Normal
Response Light, Normal Accommodation,
SIGHT, Good.
HEARING, Good.
COORDINATION, Arms,
Legs, At times staggers + falls
TREMORS, Hands, None. Tongue, None.
Facial Muscles, General,
REFLEXES, Patellar, Both about 3
Other
ARTICULATION, Normal.
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, No murmurs. Regular
LUNGS, Breath sounds + expansion fair. Chest rather hollow
GYNAECOLOGICAL EXAM., Aug 15/96. Uterus + appendages normal.
MENSTRUATION, Regular.
OPHTHALMOSCOPIC EXAM.,



TAKEN,

EXAM. URINE, Aug. 17'96
Color Yellowish red.
Character Clear
Amt. 24 hrs. XXVII ℥
Sp. gr. 1029
Reaction Alkaline
Albumen None
Sugar "
Micros c. Sodium + Amon. urates large quantity, quantity
Triple phosphates - large quantity
Pus -

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal, ✓	Constipated,	Irregular,
APPETITE, Good, ✓	Medium,	Poor,
SLEEP, Good, ✓	Poor,	Irregular,
PULSE,	Resp.,	Temp.,

CRANIAL MEASUREMENTS, Circ. (f) 54 (r.m.) 62 Naso-oc.a. 32 Bin.a. 32 Aur.p.d. 189 Fronto-d. 144 Bin.d. 12. Fac.l. 12.2.
HISTORICAL, Faints + has dizzy spells. Had a fever for a month once.
LENGTH OF INVASION, Long. ONSET GRADUAL OR SUDDEN, Gradual.
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, Ailing a great deal.
Father or Pat. Relations, Quite healthy.
Brothers or Sisters, One brother died of rheumatism

Personal and Medical History of Clara Ryan.

This patient was brought here by Mrs. Nora Ryan with the following history: Patient is in fair physical condition. There is no history of consanguinity, no insane relatives as far as known. This is first attack: was first manifested about 3 years ago & patient was worse during hot weather; insanity manifested by nervousness - spells of crying & singing - and quick temper: disease appears to be increasing; is variable, being worse during summer: derangement shown on no particular subject. but patient has shown disposition to injure others; has never attempted suicide but propensity is now active: no filthy or destructive habits: no history of intemperance in parents or self. No injury to head - has shown some form of hysteria: has not been restrained, but never allowed to go away from home alone. The supposed cause of disease is female trouble. Patient has had some medical treatment "don't know what" On Personal examination patient repeats conversation of her mother; her memory is very poor.

On Admission. - Put upon B.2 w. (G.H.N.Pt. Complexion fair: hair brown: Eyes blue: Condition of skin normal: No marks, scars, or bruises noticed: Is very dirty; quiet, talks silly & is always asking questions.)

Aug 14 Aug 15 Nurses Note T 99.8 P. 112 R. 25 Rec'd on ward. Very talkative: Appears to be weak minded: T 99.1 P 76 R 18 Resisted when temperature was taken, was afraid thermometer would be inserted under skin: Awake all night but quiet: Says she is not crazy: Is afraid of patients: Aug. 16 T. 98.2 P 76 R 20. Appetite fair Tonic given after meals Bowels regular: Complains of pain in chest: Troubled with rupture: Slept all night

Aug 17. T. 97.6 P 76 R 23. Slept 8 hrs: Very quiet while awake: Behavior quiet; Takes out door exercise: Talks rather silly: Aug 18 T 97.6 P 76 R. 18 Appetite good: Tonic given Bowels regular: Rested well all night: Very quiet: Talks silly clear in habits.

Aug 19th & 20th No change in patient Aug 21 During 2nd week Appetite good: Tonic given 3 times daily; Bowels regular: Sleeps well: Very talkative & at times noisy - laughing & singing: Massage given on 20th

Aug 26 Physician's Note Rather silly: Probably an element of feeblemindedness though the weakness is growing: Answers appear silly & rather incoherent. Something like some cases of chronic mania.

Nov. 10 Summary Nurse's Notes by Dr. L.L. Phelps:- Massage & Gym. Treatments given Cold treatment every ~~other~~ day through Sept. Oct & Nov. Jan 19 Has improved much in gen'l physical condition: Appetite better: Under cold treatment steadily for past 3 mos: 3 oz. warm Lard worked thoroughly into the surface of the body every other day: Has gained in flesh: Helps with work: Sept 1-97 Went Home much improved in mental condition: Her state of mind is that of an imbecile.

Discharged

Personal and Medical History of

Personal and Medical History of Anne G. Johnson.

LESLEY, PUBLIS & DAWSELL, DAVENPORT, IOWA.

Whole No. 4492.
Residence, Manchester, Minn.
Date Admission, August 15' 1896
Admitted by, Dr. R.M. Phelps · Hour, —
How Sent, Herman Blackmer, Jg. Freeborn Co.
Sex, — Female —
Age, — 29 —
Civil Condition, Single
Children, —
Age Youngest Child, —
Occupation, Farmer's daughter.
Degree Education, Can read but not write much.
Profession Religion, — Lutheran —
Habits, — probably good —
Nativity, Minn. (Parents Norway)
Physicians Committing, G.M. Buck - J.A. Blackmer.
Correspondents, Chas. Johnson, Manchester Minn
Mrs Lubeck, Manchester Minn

No. for Year, 25
Insane Relatives, — None —
Cause Exciting, Was shot in 1892 - supposed cause. —
Cause Predisposing, Not known —
Form,
Accompanying Bodily Disorder, None mentioned
Suicidal or Not, — Not —
Date of this Attack, — 1892 —
Duration, — 4 years —
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, — 25 yrs. —
Time of Leaving, Dec. 13 1899
Time in Hospital, 3 yr. 3m. 28 d.
Result, Discharged Aug. 8, 1900 Improved

EXAMINATION ON ADMISSION

Exam. by R.M. & G. Phelps Aug. 17 96

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Rather confused. +
Quick or Sluggish, sluggish
MEMORY: Impaired.
Past Events,
Recent Events,
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Dull.
Correct or Illusive, Illusive
REASONING POWER:
Ordinary Subjects, } Impaired
Own Mental State, }
Special Subjects, }
GENERAL DESCRIPTIVE REMARKS: Incoherent in talk - Does not answer promptly or very correctly. Mind wanders + seems uncertain. Statements unreliable - Does not seem to worry said "Pimpin" was what worried her. Seems like a defective.

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted, Exalted at times
Depressed,
DELUSIONS:
Systematized or Not,
Special Subjects, Delusion ideas
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

Personal and Medical History of Anne G. Johnson

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 2½ in. WEIGHT, 105 lbs. NUTRITION, Fair - in fair flesh.
WOUNDS OR ABNORMALITIES, No marks, scars or bruises noticed.
TONGUE, Tremors, Coatings, Coated + edge indented Promptness Movement,
PUPILS, Equality, Equal Size, Normal.
Response Light, Normal Accommodation, Normal.
SIGHT, Impaired
HEARING, "
COORDINATION, Arms, Normal
Legs,
TREMORS, Hands, Fine Tongue,
Facial Muscles, General, None.
REFLEXES, Patellar,
Other
ARTICULATION,
Slurred,
Hesitating, Hesitating
FACIAL EXPRESSION,
SENSIBILITY,
HEART, No murmurs.
LUNGS, Normal Has cough
GYNAECOLOGICAL EXAM., 12/27/96 hymen very close & that thorough exam. could not be made without rupture - as patient seems normal, not deemed best to examine further - External genitals normal.
MENSTRUATION, painful at times.
OPHTHALMOSCOPIC EXAM.,

TAKEN,

EXAM. URINE, Aug. 19'96
Color Reddish brown
Character Heavy brownish copy deposit
Amt. 24 hrs. XIV ℥
Sp. Gr. 1030
Reaction Neutral.
Albumen. Large quantity by heat, by HNO_3 + Tanrets.
Sugar. Trace by Bismuth
Microscop. Large quantity amor. & sod. urates - & triple phosphates small amount of blood & pus corpuscles & bladder epith. cells.

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated, ✓	Irregular,
APPETITE, Good,	Medium,	Poor,
SLEEP, Good,	Poor, ✓	Irregular,
PULSE, Weak	Resp.,	Temp.,

CRANIAL MEASUREMENTS, Circ.(h) 53 (fm) 59½ F.o.c.a. 34 Bi.a. 33 Ant.p.d. 19 Transv.d. 14 Bi.d. 12.2 Fac.h. 10.8
HISTORICAL, Vertigo often
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, living — healthy.
Father or Pat. Relations, "
Brothers or Sisters,

Personal and Medical History of Anna G. Johnson

1896

This Patient was brought here by E. H. Ellickson, attended by Sienna Opeal with the following history: Patient is in fair physical condition: no history of consanguinity or heredity This is first attack + insanity was first manifested in 1890 when patient[illegible] shot, + is supposed to be the result of the accident: Disease has appeared stationary; variable with irregular rational intervals: manifested on no particular subject but patient has shown a disposition to injure others - Is not suicidal + shows no disposition to filthy or destructive habits no severe diseases nor injury to head: history of intemperance (no particulars given) Patient has not been restrained or confined: Supposed cause of disease is injury, as stated above; patient has received some treatment - without being benefitted by it. On Personal examination patient talked incoherently - Committed "because she is insane"

On admission: Put upon B[2] w (Asst. N. Pyt. Complexion fair; hair light: eyes blue: No marks scars or bruises noticed: Is clean: quiet; has delusions)

Nurse's Notes

Aug. 15 Observed on ward, bathed and put to bed - Did not sleep, sitting up in bed greater part of the night.

Aug. 16 T 99.4. P. 88. R. 17. Appetite good. Cough medicine and cathartic given. Bowels regular. In bed part of the day. Behavior quiet. Did not sleep, sitting up in bed part of the night.

Aug. 17 T 98.3. P. 76. R. 18. Appetite good. Cough medicine given. Vomited quite a little this A.M. Behavior quiet. Up and dressed. Slept one hour, awake sitting up in bed rest of the night.

Aug. 18 T 98.2. P. o. R. 20. Appetite good. Refused medicine. Slept 2 hrs. sitting up in bed rest of the night. Has delusions. Behavior very quiet. Coughs quite a little.

Aug. 19 T 97.6. P. 80. R. 21. Appetite fair. Refused medicine. Bowels regular. Visited by her sister Behavior very quiet. Awake most of night, sitting up in bed. Coughs.

Aug. 20 T 97.6 P. 78. R. 21. Appetite fair. Tonic given after meals. Behavior very quiet. Seems to have strange ideas about her medicine. Slept 2 hrs: Very quiet when awake

Aug. 21 T 98.2. P. o. R. 17. Appetite good. Slept three hours. Quite nervous and restless, sitting up in bed at times. Behavior quiet. Tonic given after meals.

Aug. 22 During 3rd week appetite fair. Tonic given daily after meals. Bowels regular - Behavior very quiet. Habits clean. Refuses to take out door exercise. Assists some with work. Massage treatment given once, resisted some. During first of week slept 3 or 5 hrs a night, sitting up in bed at times. Latter part of week slept nearly all night.

Sept. 12 Summary Nurse's Notes by Dr. S.L. Phelps: Electrical treatment given: Has many delusions: talks incoherently: refuses to take out door exercise:

Nov. 28 Appetite fair: bowels irregular: refuses medicine: Apr. 97 No change: Aug. '97 Lungs + Heart examined: Resp. 18: Chest expansion good: breath sounds normal: Heart sounds normal: pulse 72: regular. Continued by Dr. Wm. Phelps.

Dec. 7 '97 Visited by father Nov. Visited by sister: General health fairly good: Usually quite tidy + well behaved: Looks intelligent altho she will say almost nothing. Dec 6 '97 Condition

Personal and Medical History of Anna G. Johnson

practically unchanged during period. (Cont. by Dr. R. G. Pettit) Mar. to Sept. '99 General health + appetite good: sleeps well: takes out door exercise: neat + clean: quiet: will seldom speak: expresses no delusions. Aug. 1900 Wt. 120 lbs Nov. 1900 Neat + clean: Does not talk: Eats + sleeps well: Does not take out door exercise: Quiet when not disturbed - then irritable: Dec 13 No change. Taken home by sister.

Discharged

Personal and Medical History of Maria Small.

LOBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4494.
Residence, 877 Reany St, St. Paul, Minn.
Date Admission, August 17th 1896.
Admitted by, Dr. H. Herzog. Hour, — 6.40 PM
How Sent, Ch. Millick, Jo of P. Ramsey Co.
Sex, Female.
Age, — Not given.
Civil Condition, Married.
Children, 2.
Age Youngest Child, 4 years old.
Occupation, Housewife (husband Motorman)
Degree Education, None.
Profession Religion, Catholic.
Habits, Probably good.
Nativity, New Jersey (Parents. Ireland)
Physicians Committing, J. J. Baker & Jno. A. Nelson
Correspondents, James Small. E 17th St. Pome House (Car Barns) St. Paul, Minn.

No. for Year, 27
Insane Relatives, Mother.
Cause Exciting, Not known.
Cause Predisposing, Heredity.
Form, Acute mania.
Accompanying Bodily Disorder, None Mentioned
Suicidal or Not, Not.
Date of this Attack, Not stated. Recent.
Duration, — not given. Probably short.
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack,
Time of Leaving, Mar. 23, 1904
Time in Hospital, 7y. 7m 6d
Result, Died. Chr. Nephritis.

EXAMINATION ON ADMISSION

Exam. by L. L. Phelps Aug. 18'96. **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:
Clear or Confused, Has spells of confusion then is
Quick or Sluggish, clear & realizes everything.

MEMORY:
Past Events, } Good.
Recent Events, }
Special Subjects, }

PERCEPTIVITY:
Alert or Dull, Alert.
Correct or Illusive,

REASONING POWER:
Ordinary Subjects, Fair
Own Mental State,
Special Subjects, Fair

GENERAL DESCRIPTIVE REMARKS: Patient is at present coherent & sensible. Talks freely & answers all questions. This morning was in a dazed condition. very incoherent & did not precieve anything apparently.

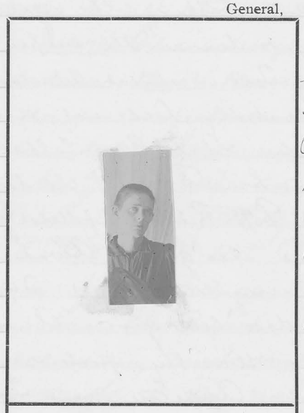
EMOTIONAL STATE:
Normal, Calm, Normal.
Indifferent,
Exalted,
Depressed,
DELUSIONS: Says she has delusions
Systematized or Not, When in her spell.
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

Personal and Medical History of Maria Small.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 9 in. WEIGHT, 162 lbs. NUTRITION, Fair - pale.
WOUNDS OR ABNORMALITIES, None
TONGUE, Tremors, Coatings, Heavily coated Promptness Movement,
PUPILS, Equality, Equal Size, Normal
Response Light, Accommodation,
SIGHT, Normal
HEARING, Slightly impaired in right ear.
COORDINATION, Arms, Normal
Legs,
TREMORS, Hands, Fine Tongue,
Facial Muscles, General,
REFLEXES, Patellar, Both 5
Other
ARTICULATION,
Slurred,
Hesitating, Normal
FACIAL EXPRESSION,
SENSIBILITY,
HEART, Is murmurs.
LUNGS,



TAKEN,

EXAM. URINE, Nov. 3
Color Reddish Yellow.
Character Cloudy + copy deposit
Amt. in hrs. Not Taken
Sp. gr. 1026
Reaction Acid.
Albumen. Trace by heat, large quantity by HNO_3 + by Tannets.
Sugar. None
Mic. a few pus corpuscles. amor. urates - a few bladder + epith. cells.

GYNAECOLOGICAL EXAM., Aug 19/96. Uterus normal position - Hypertrophy + extensive erosion - Laceration of cervix. Complains of fruitiness through uterus. Slight haemorrhoids otherwise
MENSTRUATION, Menopause passed 7 years. external genitals normal.
OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated, ✓	Irregular,
APPETITE, Good, ✓ usually.	Medium,	Poor,
SLEEP, Good,	Poor, ✓	Irregular,
PULSE,	Resp.,	Temp.,

CRANIAL MEASUREMENTS,
HISTORICAL, Six weeks ago had Pneumonia. Two weeks ago had first mental symptoms.
LENGTH OF INVASION, Short ONSET GRADUAL OR SUDDEN, Sudden
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, Died dropsy.
Father or Pat. Relations, Died cancer.
Brothers or Sisters, One brother Heart Trouble - Children healthy.

Personal and Medical History of Maria Small.

This patient was brought here by Deputy Sh. M. K. Williams attended by Jas. Small, with the following history: Patient is in poor physical condition: No history of consanguinity: patients Mother was insane. This is first attack: first symptoms manifested by delusions + hallucinations; disease seems to be increasing; is variable with irregular rational intervals - Patient now thinks she has committed murder, shows no disposition to injure others, is not suicidal: Has no filthy or destructive habits except to expose person in public no previous manifestations shown: No history of intemperance: No injury to head: Has just recovered from Lobar Pneumonia. No restraint, Confinement now Treatment has been employed; Cause of disease is unknown.

On Admission:- Put on B.2 W. (Goth. Rep. Complexion dark: hair brown; eyes blue: Condition of skin normal: No marks scars or bruises noticed: Clean; rather noisy, talks sensibly at times)

Aug. 17 Nurses Notes - Received on ward, ate no Supper. Bathed and put to bed; awoke all night, Sitting up in bed and talking the greater part of the time. Aug. 18 - T 98. P. 88. R. 18. Ate no breakfast or dinner. Ate supper. Tonic given after meals. During forenoon patient slightly noisy. Talk incoherent; delusions of different kinds - Bowels regular. 2 p.m. Quiet. Talks sensibly - Did not sleep any. Aug. 19. T 98.6 P 90 R 24. Appetite good. Bowels regular. Until 9 a.m. talked incoherently, imagining some one was trying to kill or hurt her. Rest of the day, quiet, Talk sensible, Coughs a good deal. Aug. 20. T. 97.6. P. 78. R. 26. Appetite good. Tonic given after meals - Cathartic and Cough medicine also given. Awoke all night; very quiet; coughed a good deal all day - Bowels irregular. Aug. 21 T 98.6. P. 78. R 24. Appetite Good. Tonic after meals, Cascara, + dose Salts given. Awoke nearly all night but very quiet. Behavior quiet. Talks sensibly; Quite nervous. Coughs: bowels constipated. Aug. 22. T. 98.2. P. 76. R. 22. Appetite good. Tonic given after meals. Bowels moved. From 8 a.m. - patient very noisy at times; delusions of different kinds. Talk very silly; Slept 3 hrs., Very quiet when awoke. Aug. 23. T. 97.8. P. 84. R. 24 Ate no breakfast; ate dinner + supper. Refused medicine: Bowels regular Quite noisy at times during the day; talk very silly; delusions of different kinds; Slept 3 hrs; very quiet when awoke. Aug. 30 During second week Appetite was poor; tonic given after meals, but refused most of time. Powder for bowels and cathartic given; bowels irregular; Slept very little, sometimes quiet when awake, sometimes noisy, sitting up in bed talking to herself. Restless, nervous and noisy most of time during day; talking to herself; has delusions, talks very silly most of the time, but at times quite sensibly. Thinks some one is going to kill her + at times thinks she has wronged someone very much.

Physicians Note - Patients behavior is very erratic, one day very excited, walks up and down, wringing her hands + crying a great deal of the time, troubled with many delusions. Occasionally for a few hours or half a day at a time becomes very quiet, talks sensibly and delusions seem to leave her. She has changed back and forth this way ever since Admission.

Personal and Medical History of Maria Small.

1896

Sept 1 Moved to Infirmary Curettment + tracheloorhaphy done: Pulse was slow + during operation hypo. strych. gr. 1/40 was given on Table. Rather weak when taken from table but responded to stimulants readily: After coming out from ether Complained of pain in back first two days. Sept. 2 Was very restless at night. Sept 3 Continued quite restless in bed, has to be watched a good deal: Takes milk diet + some toast. Sept 6 Has been very nervous + quite excited most of time since in bed. + it has been necessary to watch her almost constantly to keep her in bed. Aug 9 She has been so nervous that it was necessary to move her to B2 today: Appetite is fair: Takes tonic: Bowels rather constipated but move.

Oct 8 Summary Nurses Notes by Dr. L. L. Phelps:- Laid treatment given. Oct 10 Visited by husband: Oct. 16 Bought nurses: Nov. 9 Laid treatment continued daily: Jan '97 Very emaciated + pale: coughs + expectorates a good deal: Appetite variable + very poor: Has many delusions: worries + talks to self almost constantly: Has been steadily on Laid treatments for past 5 months: Feb 27 97 Oil + massage treatment given: coughs + expectorates a good deal: very noisy at times: Mar '97 Massage + oil treatment continued daily: 1897 Seems to be losing flesh: coughs + expectorates a great deal: very emaciated: Aug. Still noisy + incoherent in talk. Continued by Dr. Rem Phelps. Sept 1 Visited by Husband: Patient seems to be failing both mentally + physically: So thin + pale Coughs a great deal + expectorates: So recklessly maniacal at times. Dec 8 Visited by husband. Jan 30 '99 Wt. 118# Feb 25 '99 Wt. 118# Patient coughs a great deal. always looks as if she was failing but on the whole has lost little if any during the last year, neither has she gained. Temp. and pulse usually normal.

Mch 1 - Aug 31 '99 Cont. by Dr. Bibb. Physical condition much impaired: Still coughs + expectorates: but does not lose much in weight: Is very noisy + extremely untidy + destructive when disturbed: Is in seclusion much of time: Bowels regular: during May put in restraint because exceedingly destructive, destroying a large amount of clothing in a day: Has days when very much disturbed + profane. On following day is usually quiet, neater in habits + appearance + usually out on hall + at times goes riding + walking: Much of time these good + bad days alternate. At times complains of pain in chest. Aug 29 Wt. 117½. Sept 1 Feb 28 1900 (Dr. Reynolds) Noisy + destructive In seclusion most of time: Very profane: Appetite quite good: Does not sleep well: Trans. to Infirmary - Mch 1 - Nov 30 1900 (Dr. Linton) Appetite fair: Sleeps fairly well: Coughs + expectorates a great deal: Is very destructive of clothing exceedingly noisy at times + vulgar - Kept in seclusion constantly Incoherent: has delusions: often requires Cathartics: Fed from tray: Sometimes disturbed at night. Sleeps fairly well. Takes no exercise Has periods of a day or two at a time when she answers questions + is quiet: Has delusions + mistakes one person for another.

Jan 3 Trans. to B2 Feb 25 1901 Wt. 123# General health poor: no change in behavior. Mar. to June 1901 Patient is at times extremely noisy, destructive

See Page 296

Personal and Medical History of Elizabeth Morton.

LEIGHT, FICKAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4497.
Residence, St. Paul, Minn.
Date Admission, Aug. 19th 1896.
Admitted by, Dr R. M. Phelps Hour, 6.45 Pm
How Sent, D. Willrich, Jap. Ramsey Co.
Sex, - Female -
Age, - 65 -
Civil Condition, - Widowed -
Children, - Three -
Age Youngest Child, Thirty years old -
Occupation, - Housewife - (Husband was farmer)
Degree Education, - Common School -
Profession Religion, - Baptist -
Habits, - Good -
Nativity, United States (parents also U.S.)
Physicians Committing, A. Macdonald & J.A. Quinn.
Correspondents, Miss Marion Morton
655 Rice St. St Paul, Minn.

No. for Year, 30
Insane Relatives, One of her daughters now Confined at St Peters
Cause Exciting, Worry.
Cause Predisposing, Not Known.
Form,
Accompanying Bodily Disorder, Very feeble.
Suicidal or Not, Not.
Date of this Attack, 8 years ago.
Duration, 8 years.
No. of Attack, 1st
No. of Admissions, 1st admission here, at St Peters 8 yrs.
Age First Attack, 57
Time of Leaving, October 8' 96.
Time in Hospital, 1 mo. 17 da.
Result, Died - Tuberculosis Pulmonalis.

Exam. by Dr. M. Phelps.

EXAMINATION ON ADMISSION
MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Confused
Quick or Sluggish, Sluggish.

MEMORY:
Past Events, } Impaired.
Recent Events, }
Special Subjects, }

PERCEPTIVITY:
Alert or Dull, Dull.
Correct or Illusive,

REASONING POWER:
Ordinary Subjects, } Much impaired
Own Mental State, }
Special Subjects, }

GENERAL DESCRIPTIVE REMARKS:
Very unwilling to answer questions. Cross when disturbed. Can not walk at all. Remains in bed constantly: unable to help herself. Very demented in mind. Organic Dementia with gross physical changes in Kidneys, Lungs & elsewhere.

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed, ✓

DELUSIONS:
Systematized or Not,
Special Subjects,
Transitory or Not, Delusive ideas

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

Personal and Medical History of Elizabeth Morton.

EXAMINATION ON ADMISSION, CONTINUED.
PHYSICAL CHARACTERISTICS.

HEIGHT, WEIGHT, NUTRITION, Very much emaciated
WOUNDS OR ABNORMALITIES, Condition of skin dry
TONGUE, Tremors, Coatings, Promptness Movement,
PUPILS, Equality, Equal Size,
Response Light, Accommodation,
SIGHT, Impaired. Uses glasses.
HEARING, Impaired.
COORDINATION, Arms,
Legs, Loss of power of right leg.
TREMORS, Hands, Tongue,
Facial Muscles, General, General weak condition.
REFLEXES, Patellar, Right somewhat exaggerated
~~Other~~
ARTICULATION,
Slurred,
Hesitating, Hesitating & unwilling
FACIAL EXPRESSION,
SENSIBILITY,
HEART, No Murmurs. Sounds weak. Rapid but regular. Arteries Atheromatous.
LUNGS, Coughs. Rales on right side. TAKEN,

EXAM. URINE, Aug. 26.
Color Reddish yellow
Characters Cloudy.
Amt 24 hrs. Not Taken
Sp. Gr. 1017
Reaction Acid.
Albumen Large Quantity by heat. Trace by Tannic.
Sugar None.
Microscop. Large amt. pus. bladder cells & renal granular casts.

GYNAECOLOGICAL EXAM., Aug 26/96 Uterus retroverted & fixed by adhesions - Hyperaemia of cervix - Endemetritis Labia minora - hypertrophy. Profuse foul discharge.
MENSTRUATION, Menopause passed.
OPHTHALMOSCOPIC EXAM.,
HABITS, Dirty, Clean, Careless,
BOWELS, Normal, Constipated, ✓ Irregular,
APPETITE, Good, ✓ Medium, Poor,
SLEEP, Good, Poor, ✓ Irregular,
PULSE, Resp., Temp.,
CRANIAL MEASUREMENTS,
HISTORICAL, At St Peters for years.
LENGTH OF INVASION, Long. ONSET GRADUAL OR SUDDEN, Gradual.
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, Says healthy
Father or Pat. Relations, Says he was healthy
Brothers or Sisters, 3 children.

Personal and Medical History of Elizabeth Morton.

New patient was received here at hands of Deputy Sheriff E. Johnson, attended by Mrs S.V. Root & Ed Hoxt, with the following history:- Patient is bedridden: Eight years ago was committed to St Peters & remained there Continuously insane for eight years, was expected & discharged & sent home & subsequently discharged: disease seems stationary with no rational intervals: Patient speaks intelligently on certain themes derangement now manifested in delusions that those about her desire to poison her; she refuses all treatment & at times nourishment also: No history of consanguinity; has daughter now confined at St. Peters Patient shows no disposition to destructive habits - has lost control of Sphincters: No peculiarities previously shown beside being nervous & fretful: No history of intemperance in self or parents; no serious disease or head injury - Was confined in St. Peters Hospital - as above stated: for eight years Cause of disease supposed to be worry. On personal examination patient was found a very feeble old lady - cannot properly be cared for by children at home.

On Admission:- put on Infirmary (A.M. Rpts Complexion fair: hair dark brown, streaked with gray: Eyes blue: Condition of skin normal: No marks scars or bruises noted: Is clean: Right side of body seems partially paralyzed: Is quite noisy at times: (would not talk much.)

Aug. 19 Nurse's Notes:- 5 a.m. T. 98.4 P. 93. R. 30. - 5 p.m. T. 99. P. 76. R. 32. Appetite good. Awake all night. Very quiet. Urinated several times: bowels constipated. Back looks sore and quite red in parts. Aug. 20. - 5 a.m. T. 98.4 P. 95. R. 30. - 5 p.m. T. 99. P. 76. R. 32. Appetite good Slept very little. Moaned considerably for part of night: Coughed some. Back bathed with alcohol. Aug. 21 5 a.m. T. 98.4 P. 95. R. 30. - 5 p.m. T. 100.2 P. 92 R. 30. Appetite good, Slept very little: Moaned some: bowels very constipated: talks quite sensibly. Aug. 22 - 5 a.m. T. 98.3 P. 95. R. 33 - 5 p.m. T. 98.6 P. 92 R. 28. Appetite good: castor oil given: Slept about three hours: glass of lemonade 11 p.m. Baths given. Slept about 4 hrs. Aug. 23 - 5 a.m. T. 98. P. 95 R. 35. - 5 p.m. T. 99 P. 90. R. 30. Appetite good. Asked to go home: talks but little: Enema given: untidy in habits: Slept about 6 hrs: coughed a great deal. Apl. 24. 5 a.m. T. 98.4 P. 86 R. 24. - 5 p.m. T. 97.8 P. 98. R. 28. Appetite good: tonic given: castor oil given: coughed most of night: slept about 5 hrs. Aug. 25: 5 a.m. T. 98. P. 92. R. 28. Appetite good: tonic given: bowels moved freely. Feet swollen, one more than other: Slept about 4 hrs. Moaned and coughed & expectorated. Aug. 26. 5 a.m. T. 98.6 P. 95 R. 32. - 5 p.m. T. 99.4 P. 100. R. 34. Appetite poor. Tonic given. Bowels regular. very bad discharge - yellow & a disagreeable odor. Bichloride douche (1-8000) given. Awake all night. Back bathed & dusted with boracic acid. Aug. 27. 5 a.m. T. 98.4 P. 100. R. 40. - 5 p.m. T. 96.2 P. 94. R. 30. Appetite poor. Tonic given after meals. Bowels regular: Complains of back: Coughs some: Slept about five hours. Moaned some: coughs considerably: Urinates often. Aug. 28. T. 97.5 P. 94. R. 28. Appetite poor. Tonic given after meals. Dull bath given: patient fed by nurse. Awake most of night: Coughed and moaned all night. Aug. 29. T. 97.8 P. 95. R. 30. Appetite poor. tonic given after meals: coughs and expectorates, yellowish in color: back dressed. vaseline & boracic acid applied: bichloride douche 1-8000

Personal and Medical History of

given. Aug. 30 - 5 a.m. T. 99.5 P. 95. R. 30. - 5 p.m. T. 99. P. 104. R. 33. - Appetite poor in morning - Good at night. Tonic given after meals. Coughs and expectorates: yellowish in color, back dressed, vaseline & boracic acid applied: bichloride douche 1-8000 given

Aug. 31. T. 99. P. 99 R. 33. Appetite good: Tonic given after meals. bowels regular. moaned considerably during night: back dressed with vaseline & boracic acid: slept six hrs: moaned some: Urinates often: douche given. Sept. 1 - 5 a.m. T. 98. P. 97 R. 28. 1 p.m. T. 100. P. 102. R. 33. Appetite good: bowels regular: tonic given after meals: talks quite sensibly: very helpless: carbolic douche given. Slept 5 hrs - moaned about one hour.

Sept. 2 T. 102⁶ P. 103. R. 35 Appetite fair: Tonic after meals: Awake most of night: noisy at times: Sept. 16 Since last note Temp. has ranged from 98⁸ to 100⁶ P. 78 to 117. R. 21 to 36. Appetite fairly good: Tonic given: bowels regular: usually awake & restless at night:

Sept. 12 T. 98. P. 89 R. 32: Appetite poor: refuses tonic: bed sore dressed: feet swollen: does not sleep well: Sept. 27 T. 100 P. 80 R. 32: brandy given: very noisy during night: bowels regular:

Oct. 1. T. 101. P. 98. R. 30. Appetite poor: brandy & milk given: very restless: moans considerably: Quite weak: slept only 3 hours: Oct. 4 T. 101. P. 120. R. 42: Takes no solid food but drinks milk: pulse very weak & rapid: Respiration difficult: Sponge bath given takes milk often: very weak: very noisy: refuses tonic: brandy given every 3 hours: Oct. 5 T. 100 P. 118 R. 38: a.m. T. 101. P. 120. R. 40 p.m. Takes little nourishment pulse weak & intermittent: brandy given: Limbs cold: bed sore dressed: mouth & teeth very coated: Failing fast. Oct. 6 T. 100 P. 118 R. 42: Refuses food: brandy given every 2 hours - Died at 3¹⁵ p.m. (Daily sick record kept.

Physicians Note:- Patient showed signs of tuberculosis much more during the past few days; failing rapidly - She coughed considerably & showed much distress - This was the immediate cause of death: Her daughters came & buried her in the City Cemetery. (A.M. Rpts)

Died

Personal and Medical History of Allie Francis Gill

Whole No. 4504.
Residence, Redwing, Minn.
Date Admission, August 26th 1896.
Admitted by, Dr. R. M. Phelps Hour, 6 45 P.M.
How Sent, Ambl. Hallen J. of P. Goodhue Co.
Sex, - Female -
Age, - 17 yrs - 10 mo -
Civil Condition, - Single -
Children, —
Age Youngest Child, —
Occupation, - Domestic - (father a cooper)
Degree Education, - Common School -
Profession Religion, - Roman Catholic -
Habits, - Probably good -
Nativity, Min. (Father New York; Mother Ohio)
Physicians Committing, N. Quell & A.W. Jones.
Correspondents, none given in papers.

No. for Year, 37
Insane Relatives, None -
Cause Exciting, - Not known -
Cause Predisposing, - Not known -
Form,
Accompanying Bodily Disorder,
Suicidal or Not, - Not -
Date of this Attack, Aug 21st 1896.
Duration, - 5 days -
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, - 17 years -
Time of Leaving, Dec. 23. 1897
Time in Hospital, 3 mo. 27 da.
Result, Discharged. May 5. 1897 Improved.

EXAMINATION ON ADMISSION

Exam. by A.W.J. & Sh. Phelps Aug. 27/96.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Confused
Quick or Sluggish, Sluggish
MEMORY:
Past Events, Impaired
Recent Events, "
Special Subjects, "
PERCEPTIVITY:
Alert or Dull, Dull
Correct or Illusive, Illusive
REASONING POWER:
Ordinary Subjects, Impaired
Own Mental State, "
Special Subjects, "

GENERAL DESCRIPTIVE REMARKS: Exhibits a general feeble mental state. Collects her thoughts very slowly. Confused in her ideas. General physical condition is impaired Pale & anaemic.

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed, ✓ somewhat
DELUSIONS: Seems to have many
Systematized or Not,
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

Personal and Medical History of Allie Francis Gill.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, WEIGHT, NUTRITION, Impaired. Pale & anaemic
WOUNDS OR ABNORMALITIES, Condition of skin - normal.
TONGUE, Tremors, Coatings, White coat Promptness Movement, Sluggish
PUPILS, Equality, Equal Size, Normal.
Response Light, Normal Accommodation, Normal.
SIGHT,
HEARING,
COORDINATION, Arms, Normal.
Legs, "
TREMORS, Hands, None Tongue, None
Facial Muscles, " General,
REFLEXES, Patellar, Equal - normal.
Other
ARTICULATION,
Slurred,
Hesitating, ✓ Slow.
FACIAL EXPRESSION,
SENSIBILITY,
HEART, Sounds normal - no murmurs. Regular.
LUNGS, Seem in good condition
GYNAECOLOGICAL EXAM., Aug 28 96. Uterus normal position - os patulous & eroded - External genitals normal.
MENSTRUATION, Irregular.
OPHTHALMOSCOPIC EXAM.,

TAKEN,

EXAM. URINE, Sept 3 96
Color Yellow
Character Cloudy, copy deposit.
Amt. in 24 hrs. XXXII ℥
Sp. Gr. 1011
Reaction Acid.
Albumen Trace by Tanrets.
Sugar None.
Microscop. Large amt. Amor. urates
Bladder & vaginal epith. cells.
Triple phosphates & pus corpuscles.

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated, ✓	Irregular,
APPETITE, Good,	Medium,	Poor, ✓
SLEEP, Good,	Poor, ✓	Irregular,
PULSE,	Resp.,	Temp.,

CRANIAL MEASUREMENTS, Length 55.7 (c.m) 62.5 N. ac. a. 35 Bin. ar. 34.5 Ant. p. d. 19.3 Trans. d. 14.9 Bi. d. 12.2 Ht. 11.6
HISTORICAL,
LENGTH OF INVASION, Long. ONSET GRADUAL OR SUDDEN, Gradual.
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations,
Father or Pat. Relations,
Brothers or Sisters,

Personal and Medical History of Alice Francis Gill.

This patient was brought in by Dep. Sheriff P.J. Lundquist attended by mother of patient with the following history:- Patient is in fair physical condition: no history of consanguinity or heredity: this is 1st attack - first symptoms were first manifested August 21 '96,- patient woke out of sleep with violent delirium: disease appears stationary; not curable: with no rational intervals. Derangement is now manifested by incoherent speech & acute mania: Patient has shown a disposition to injure others but is not suicidal: Has filthy & destructive habits. Regarding peculiarities previously shown, has been very irritable for past year & for last 2 or 3 months religious impressions have been prominent. No history of intemperance in self or parents: No severe diseases or injury to head - During this attack has had to be tied in bed at times, new sedatives have been given to no effect. Cause of disease is not known. On personal examination: Patient irrational in speech violent if restraint is attempted; continually occupied in an irrational manner.

On Admission:- put on B.T.W. (W.F.N. Rep. complexion dark: hair black: Eyes blue: Condition of skin normal: No marks, scars or bruises - Is clean: quiet: has delusions)

Summary of Notes-first 14 days. During first 14 days had pulse, respiration & temperature practically normal throughout: Appetite a little impaired at first, but on the whole quite good: As medicine received tonic regularly, together with several enemas and cathartics. No physical symptoms of very great importance were noted; was lowerre, very nervous and complained of head aches at times. Slept nearly all night most of the time, although rather restless during the day: in her talk was rather incoherent at first, not expressing usually any definite delusions, talked to herself some what the second week and had hallucinations which were not noticed the first week: became rather stupid - rather worse at end of time than before. Original record preserved. Physicians notes. Patient a young girl, quite anaemic, with confused look & conversation, & silly expressions: Has manifold delusive ideas however and some hallucinations.

Sept. 30 Summary Nurse's Notes by Dr. B.L. Phelps:- Has received salt baths & gym. treatment every other day: Elec. treatment 3 times a week during whole month:

Oct. 1 Visited by mother: Quiet in behavior: Has some delusions: talks to herself: complains of head ache quite often: Appetite fair: Is on tonic: Oct. 29 Has been upon Gym. treatments every other day - also massage & electrical treatment: Very stupid & untidy in habits: bowels regular: appetite very poor. Nov. 9 Treatments still continued: no change: Dec. 20 Quiet in behavior: rather stupid at times: Sometimes untidy in habits: Takes tonic & out door exercise: Failed considerably in mental state after coming: Has recently been quite stationary: Quite stuporous most of time: but of late has been some what brighter & has been working some in Centre Dining room.

Dec. 28 Visited by Mother who took her Home considerably improved both physically & mentally:

Discharged

Personal and Medical History of Maria Small.

Mar. to June 1901 and occasionally strikes at nurses and other patients, is incoherent and very profane in her speech, coughs and expectorates a great deal, very much emaciated, habits dirty bowels regular, is noisy for two or three days then quiets down for two or three days when she becomes noisy again, following out this cycle constantly. May 29 Wt. 115#. June to Sept. July 20 + 22 visited by husband, sister and daughter, no change in general health Wt. 109#.

Sept. to Dec. Patient's condition shows no change in either mental or physical condition. Nov. 25 Wt. 106#.

No change from Dec. to Feb. 1-03. Wt about 105#.

Personal and Medical History of Mary Clement.

Whole No. 4506

Residence, Wasseca, Minn.

Date Admission, August 27th 1896.

Admitted by, Dr. R M. Phelps. Hour, 7 PM.

How Sent, Geoge A Nelson. Jof P. Wasseca Co.

Sex, - Female -

Age, -23-

Civil Condition, Single

Children, —

Age Youngest Child, —

Occupation, House wife (Father - Machine dealer)

Degree Education, - Common School -

Profession Religion, - Congregational -

Habits, - Probably good -

Nativity, Minn - (Father N. Hamp. Mother N York)

Physicians Committing, H. J. Young & L A. Smallwood

Correspondents, None given on papers.
H. S. Clement Wasseca Minn

No. for Year, 39

Insane Relatives, - None -

Cause Exciting, Catarrh, menstrual disturbances, Nervous prostration

Cause Predisposing, Previous attack

Form,

Accompanying Bodily Disorder, Nervousness, insomnia.

Suicidal or Not, - Not -

Date of this Attack, 2 months ago.

Duration, Two months.

No. of Attack, 2nd

No. of Admissions, 2nd

Age First Attack, 18 yrs.

Time of Leaving, Dec. 18. 1877

Time in Hospital, 5 mo 22 da

Result, Discharged Aug. 11. 1897. Improved

EXAMINATION ON ADMISSION

Exam. by RM & S.L. Phelps 8/28/96

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:

Clear or Confused, Fairly clear on exact subjects today

Quick or Sluggish, Quick.

MEMORY:

Past Events, }
Recent Events, } Seems good.
Special Subjects, }

PERCEPTIVITY:

Alert or Dull,

Correct or Illusive,

REASONING POWER:

Ordinary Subjects, } Slightly impaired
Own Mental State, }

Special Subjects, Considerably impaired.

GENERAL DESCRIPTIVE REMARKS:

Patient is young. Insanity first definite about 5 years ago. Was at Hospital then - since then has been part of time fairly well but about once a there have been symptoms usually in Summer. Patient puberscent case - no heredity ascertained. Probably the severe fever might have had some causative effect

EMOTIONAL STATE:

Normal, Calm, Normal today - easily emotional

Indifferent,

Exalted,

Depressed,

DELUSIONS:

Systematized or Not,

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

Personal and Medical History of Mary Clement.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 1 in. WEIGHT, Not Taken. NUTRITION, Fair

WOUNDS OR ABNORMALITIES, None. Condition of skin good.

TONGUE, Tremors, Coatings, None Promptness Movement, Prompt.

PUPILS, Equality, Equal Size, Normal

Response Light, Responds Accommodation, Responds -

SIGHT, Good -

HEARING, Good

COORDINATION, Arms, Normal

Legs, "

TREMORS, Hands, Slight fine tremor Tongue, None notable.

Facial Muscles, Fairly steady General,

REFLEXES, Patellar, Exaggerated

Other

ARTICULATION,

Slurred, } Normal.
Hesitating, }

FACIAL EXPRESSION,

SENSIBILITY,

HEART, No murmurs.

Arteries - all right

LUNGS, Fairly good.

TAKEN,

EXAM. URINE, Aug 27'96

Color	Yellow.
Character	Pink flaky deposit
Quant. 24 hrs.	-
Sp. Gr.	1030
Reaction	Acid
Albumen	Trace by Tanrets
Sugar	Trace (Bismuth)
Microscop	Amor. urates, a few
	Few corpuscles Bladder epith. cells

GYNAECOLOGICAL EXAM., Aug 27/96 Uterus normal position Endometritis & Erosion of os. Tenderness on pressure.

MENSTRUATION, Regular Complains of pain & back-ache if on feet much.

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated, ✓	Irregular,
APPETITE, Good, ✓	Medium,	Poor,
SLEEP, Good, ✓ usual. Poor a few days ago	Poor,	Irregular,
PULSE,	Resp.,	Temp.,

CRANIAL MEASUREMENTS, Circ. (h) 55 (v.m) 61 Ro. ac. an. 34 Ant. p. d. 18.6 Trans. d. 14.4 Bin. d. 12.4 Fac. L. 11.2

HISTORICAL, Had typhoid fever when Ten years old - severe attack of spinal meningitis Defore at 14 yrs.

LENGTH OF INVASION, 5 years periodically ONSET GRADUAL OR SUDDEN, Gradual.

HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Denied

Mother or Mat. Relations, Mother died Typhoid fever - Dont know.

Father or Pat. Relations, Healthy.

Brothers or Sisters, 4 bros. not strong - 1 sister not strong.

Personal and Medical History of Mary Clement.

1896

This patient was brought here by Mr. Goodspeed with following history:- Patient is in fair physical condition: No history of consanguinity or heredity, so far as known. This is not first attack: appears to be 2nd: had one in Fall of 1891 lasting about 3 months when she was sent to this (Rochester) 1st Hospital: tempory amendment there. The first symptoms of this attack were manifested about two months ago in irritibility & wanting to run away from home: Disease appears to be increasing & is variable with irregular rational intervals. Derangement now manifested in imagining her family abuse her & are planning against her: She has shown disposition to argue others & to filthy & destructive habits: Not suicidal: no peculiarities previously shown: No history of intemperance in parents or self: no severe disease or head injury. Patient has had home & asylum restraint for several weeks past: cause of disease is supposed to be catarrh, menstrual disturbances & nervous prostration. On personal examination patient was found nervous excitable emotions. She claims herself to be sane & the rest of family insane & sick. ——

Note. As stated, patient was here before from Sept 26, 1891 to Oct 28, 1891 - After a day or two of silly & incoherent behavior she became quiet: talked clearly: health seemed good but she could not quite understand that much had been the matter with her. Went home improved (See Vol. 17 page 357, No 2827.) On admission was put on B2 ward. (Gen. Hosp.) Complexion dark: hair brown: eyes gray: condition of skin normal: small scar on left side of abdomen. Is dirty; quiet in habits, talks rather sensibly.)

Aug 27 to Sept 10 Summary first 14 days. During the fourteen days patients temperature, pulse and respiration showed only slight variations from normal. Her appetite was good throughout. Medicine was prescribed in the form of a tonic, & cathartics, but was refused uniformly. No symptoms of prominent physical disease were found. Patient quite intelligent although somewhat irritable & impudent at times, rather silly also. Behaved on the whole in a fairly quiet way with the exception of slightly mischievious actions. Was slightly troubled with constipation and with headache. Dairy clean & tidy. Original records preserved.

Physician's Note- Patient of uncertain mental states - Will answer quite brightly, but is a trifle & acts at times very mischievous. Health fairly good.

Sept 16 Gen. Operation done - Curettement of uterus: Patient took Ether: recovery good, put to bed.

" 17 Was quite restless during night: dressing changed. Sept. 18 Took light nourishment for each meal: Quiet today, slept well during night. Sept 26 Patient has remained very quiet & has gained steadily: Is now up on ward: Made a good recovery.

Nov. Summary Nurse's Notes by Dr. S.S. Phelps: Has been quite well for some time mentally: more tidy in appearance: works in Centre dining room: Jan 97 Mental condition much improved: Works every day: pleasant & sensible in talk: Appetite good: Feb. 18 Went Home: was quiet & agreeable: talked sensibly: worked every day: Gen. Health was good.

Discharged.

Personal and Medical History of Mary Clement.

Personal and Medical History of Carrie Berge.

LOBERT, FISCHER & SAUNDERS, DAVENPORT, IOWA.

Whole No. 4508.
Residence, Steele Co. Minn.
Date Admission, August 29th 1896.
Admitted by, Dr. R. M. Phelps. Hour, — 9:45 AM
How Sent, M. B. Chadwick, Jo. P. Steele Co.
Sex, - Female -
Age, not given
Civil Condition, - Married -
Children, - Three -
Age Youngest Child, Four years -
Occupation, Housewife (Husband. farmer)
Degree Education, - Common school -
Profession Religion, Lutheran
Habits, Good.
Nativity, Minn - (Parents Norway)
Physicians Committing, J. Adair & W. B. Curtis.
Correspondents, none given in papers - See file

No. for Year, 41 (June 1'97)
Insane Relatives, - None - (2 aunts + 1 cousin in hospitals - Uncle + Mother kept at home)
Cause Exciting, Possibly pelvic trouble.
Cause Predisposing, Not known. Heredity.
Form, Mania acute
Accompanying Bodily Disorder, Pelvic trouble
Suicidal or Not, - No -
Date of this Attack, 2 years ago -
Duration, 2 years -
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, not given
Time of Leaving, 26th February 1901.
Time in Hospital, 4 yrs 5 mos 28 Ds
Result, Recovered: Discharged Mar 29/1901.

EXAMINATION ON ADMISSION

Exam. by R. M. & L. L. Phelps 8/29/96

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused,
Quick or Sluggish,
MEMORY:
Past Events,
Recent Events,
Special Subjects,
PERCEPTIVITY:
Alert or Dull,
Correct or Illusive,
REASONING POWER:
Ordinary Subjects,
Own Mental State,
Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Husband states every menstrual epoch she is bad - Fairly well between times. She thinks she is not quite right at times. Thinks all right just now. Patient does not give very full information is rather vague & reticent in talk - Mental state a chronic one.

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed, & Suspicious
DELUSIONS:
Systematized or Not,
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

Personal and Medical History of Carrie Berger.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, WEIGHT, NUTRITION, Fairly good.
WOUNDS OR ABNORMALITIES, Condition of skin good.
TONGUE, Tremors, Coatings, some white coating Promptness Movement,
PUPILS, Equality, Equal Size, Dilated moderately
Response Light, Accommodation,
SIGHT, Probably good. Eyes. normal.
HEARING, Good.
COORDINATION, Arms,
Legs,
TREMORS, Hands, None of note Tongue,
Facial Muscles, General,
REFLEXES, Patellar, 6-7 Normal.
Other
ARTICULATION,
Slurred, Normal
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, No murmurs. Pulse weak & compressible.
LUNGS, Fairly good. Some what stopped Percussion not very resonant.
GYNAECOLOGICAL EXAM., Sept 7/96 Uterus normal position - some adhesions on left side - endometritis & erosion of os.
MENSTRUATION, Profuse - very painful.
OPHTHALMOSCOPIC EXAM.,

TAKEN,

EXAM. URINE, Sept 1'96
Color Yellowish red.
Character Cloudy sopy deposit
Quant. 24 hrs. XXII ℥
Sp. gr. 1033
Reaction Acid.
Albumen Trace by Tests
Sugar None
Microscop. Amor urates large quantity - large amount uric acid crystals " " Pus corpuscles.

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated,	Irregular,
APPETITE, Good,	Medium,	Poor, Not very good.
SLEEP, Good,	Poor, at times	Irregular,
PULSE,	Resp.,	Temp.,

CRANIAL MEASUREMENTS, Circ. [illegible] 54.5 F. to M. 60.5 Naso ac. a. 32 Bina. 31 Ant. p. d. 18.8 Transv. d. 14.5 Bizyg. 12.5 Fac. L. 11.5
HISTORICAL, Typhoid fever long time ago. Has headaches at times
LENGTH OF INVASION, For several years more at menst. ONSET GRADUAL OR SUDDEN, Gradual
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, "Some folks say Mother is crazy"
Father or Pat. Relations,
Brothers or Sisters, None.

Personal and Medical History of Marie Berge.

This patient was received here at the hands of Sheriff Bancard, attended by husband & Mrs Lee - with the following history:- Patient is in fair physical condition: No history of heredity or consanguinity. This is 1st attack: first symptoms being manifested about 2 years ago by violent & abusive language: Disease appears increasing; variable with rational intervals midway between menstrual periods. spells lasting from one to two weeks & coming on monthly. Derangement is now manifested in low spirits, is jealous of husband, worries a great deal & is restless. Patient has shown no disposition to injure others: is not suicidal: No disposition to filthy or destructive habits: No previous peculiarities shown: no history of intemperance in parents or self: has had no severe disease or injury to head. Cause of disease is possibly pelvic trouble. Patient has been seen by local physicians but has not been restrained or confined.

On personal examination:- Patient bears the usual evidence of overwork found in farmers wives, suffering from the depressed form of mental trouble.

On admission put on B2 M. (2 Ft. Rpt. Complexion fair: hair light: Eyes gray: Condition of skin normal: Bruised left arm. Is clean: Results being taken & ward: Remarks are sensible at times.)

Summary first 14 days. Temperature, Pulse & Respiration are shown to be practically normal, without exception: Appetite uniformly good: Tonic was prescribed & taken after meals, also several cathartic doses. No symptoms of prominent physical disease are found. Patient slept only from 3 to 5 hours at first, but fairly well toward the last. Behaved rather quietly at first but became somewhat more melancholy later. Patient is neat and tidy and makes no especial trouble. Original records preserved.

Oct 15 Summary Nurse's Notes by Dr. B.L. Phelps.- Visited by husband: Spent part of afternoon out with him: Oct 25 Transf. to Inf. Operation done: curettement, trachelorraphy, removal of haemorrhoids by Thermo-cautery: took ether: reaction good: put to bed: Nov 1 Sitting up on ward: Has made a good & uneventful recovery: Jan 97 Seems to have paroxysmal tendency in behavior: at times rather silly: menstr. regular: Feb 8 97 Visited by husband: May 26 97 Visited by sister & uncle who took her home: was rather melancholy & still had many delusions at time of leaving: Gen'l health seemed good:

1897 Aug 20. Returned: feared not get along along at home: Seems quiet & agreeable on ward: bowels constipated: Has a great many delusions: Coughs a good deal: works some in dining room

Continued by Dr. B.M. Phelps. Nov 30 97 Patient usually appears quite neat: Is well behaved most of time, however, will answer questions only in a vague silly way.

Feb 7 99 Wt. 117. Condition practically unchanged since last note.

Mch 1 - Aug 31 99 Cont. by Dr Bibb. Appetite good: Takes outdoor exercise: Assists with work on ward: Is usually quiet, but irritable at times. Is quite sarcastic when addressed Also answers in an evasive manner: Has many delusions & conversation is incoherent & irrelevant. June 6 Ill during night. Pulse weak & complained of pain in abdomen. Sept 1 Feb 7 & 8 1900 (for hysterectomy) Neat in habits & appearance: Takes outdoor exercise. Appetite fair: Is very irritable: Has many delusions: Menstruates regularly. Jan 19. Wt. 116 lbs. Mch 1 - Nov 30 1900 Patient generally cross & irritable: but at times is pleasant & converses sensibly: Sleeps well: Takes outdoor exercise. Apr 23. Trans. to B3. July 21. Vaccinated: Nov 21 Neat in habits & appearance: Appetite good: Takes outdoor exercise: Assists with ward work: Quite agreeable converses readily: Thinks she hears people talking about her: Worries somewhat disturbed Wt. 120 lbs. Dec 1 Feb 7 & 8 1901 General health good: Feb 8 Visited by sister: Much improved mentally: Feb 25 Visited by sister & brother Feb 26 Went home with them

Personal and Medical History of

Personal and Medical History of Lizzie Rothmund.

LEBERT, PICKAS & CAMBERS, DAVENPORT, IOWA.

Whole No. 4509.
Residence, St. Paul, Minn.
Date Admission, Aug. 29' 96.
Admitted by, Dr. L. B. Eby. Hour, 5:45 P.M.
How Sent, J. Mellick + J. of P. Ramsey Co.
Sex, - Female -
Age, Not given. (29 years)
Civil Condition, Single
Children, —
Age Youngest Child, —
Occupation, — — (Father Merchant)
Degree Education, - Common School -
Profession Religion, — Roman Catholic -
Habits, Probably Good.
Nativity, Minn. (Parents Germany)
Physicians Committing, Pride Martel + G Stamm
Correspondents, Notice given in papers.

No. for Year, 42
Insane Relatives, - None -
Cause Exciting, - Not Known -
Cause Predisposing, Previous Attack
Form,
Accompanying Bodily Disorder, None mentioned
Suicidal or Not, Never attempted - Propensity active now.
Date of this Attack, About 5 yrs. ago.
Duration, About 5 yrs.
No. of Attack, 1st
No. of Admissions, 2nd
Age First Attack, Not given
Time of Leaving, Sept. 18. 1900
Time in Hospital, 4 yr. 20 d.
Result, Died. Peritoneal Tuberculosis

EXAMINATION ON ADMISSION
MENTAL CHARACTERISTICS.

Exam. by D. L. Phelps M.D. 8/29/96

MENTAL ACTIVITY:
Clear or Confused, Confused + dull.
Quick or Sluggish,
MEMORY:
Past Events, Impaired
Recent Events, "
Special Subjects, "
PERCEPTIVITY:
Alert or Dull, Dull.
Correct or Illusive, Illusive.
REASONING POWER:
Ordinary Subjects, Impaired
Own Mental State, "
Special Subjects, "
GENERAL DESCRIPTIVE REMARKS: Sits in a dull manner, looking down. Picks her face into sores. Careless in habits + appearance.

EMOTIONAL STATE:
Normal, Calm,
Indifferent, Indifferent.
Exalted,
Depressed,
DELUSIONS:
Systematized or Not,
Special Subjects,
Transitory or Not, Probably has.
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION: Answers questions very reluctantly
Coherent or Incoherent,
Voluble or Reticent, Very dull + listless

PISTOL SHOT ENDS HIS LIFE

LOUIS ROTHMUND IS DESPONDENT OVER MISFORTUNE.

He Shoots Himself Through the Heart in the Presence of His Three-Year-Old Daughter—His Ill Health Prevented Him From Working—His Career.

Louis Rothmund was despondent over years of continuous sickness and inability to get work to support his family. He was found dead at 11 o'clock yesterday morning in his room in the Schurmeier block, 272 East Seventh street. He was shot through the heart.

Mrs. Rothmund was out working yesterday and three of the four children were at school. A three-year-old daughter was at home with him. Rothmund got an old-fashioned revolver and fired a shot through his heart in the presence of the little girl. She ran to Mrs. Haynie, a tenant in the building, saying:

"Papa is asleep and won't wake up."

Dr. J. C. Nelson was called, but the man was dead when he arrived. Coroner Miller had the body taken to the morgue and will hold a post mortem examination to-day.

The revolver was found on a shelf in a cupboard, and the body was near the door some distance from the cupboard.

Mr. Rothmund was forty-four years old. He was born in Germany. He practiced law in Henderson and Gaylord, Minn., and came to St. Paul three years ago. He worked as a harnessmaker and afterward opened a restaurant at 230 East Seventh street, but he closed the place a few months later. He has been in ill health since coming to the city, and his wife was obliged to support the family. Mr. Rothmund had been confined to his house for several months.

ROTHMUND FUNERAL—Louis Rothmund, who was found dead in his rooms at 272 East Seventh street Tuesday morning with a bullet in his heart, will be buried this morning from Willwerscheid's undertaking rooms. Rothmund was a member of the Catholic Order of Foresters.

Personal and Medical History of Lizzie Rothmund.

EXAMINATION ON ADMISSION, CONTINUED.
PHYSICAL CHARACTERISTICS.

...ew WEIGHT, 90 lbs. NUTRITION, Impaired.
...ALITIES, A few places on forehead - look as if picked.
Coatings, — Promptness Movement, —
Size, —
Accommodation, —
... good
..., Normal.
... None Tongue, None
General, "

SENSIBILITY,

HEART, No murmurs. Sounds normal. Regular.
LUNGS, Sounds x stopped - Expansion very poor. Sounds fair. Coughs + expectorates.
GYNAECOLOGICAL EXAM., Normal condition
MENSTRUATION,
OPHTHALMOSCOPIC EXAM.,

TAKEN,

EXAM. URINE, Sept 18' 96
Color Yellow.
Character White Flaky deposit.
Quant. 24 hrs. XXII
Sp. Gr. 1029
Reaction Acid.
Albumen None.
Sugar None.
Microscop. Amor. urates, triple phos. a few pus corpuscles - Large amount bladder epith. cells.

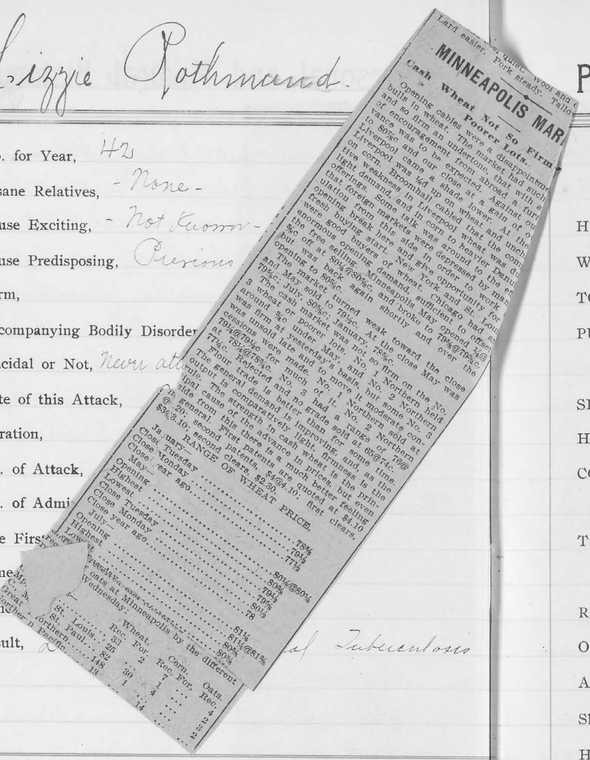
HABITS, Dirty, Clean, Careless,
BOWELS, Normal, ✓ Constipated, Irregular,
APPETITE, Good, Medium, Poor, ✓
SLEEP, Good, Normal. Poor, Irregular,
PULSE, Resp., Temp.,
CRANIAL MEASUREMENTS,
HISTORICAL,
LENGTH OF INVASION, Long. ONSET GRADUAL OR SUDDEN, —
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") —
Mother or Mat. Relations, —
Father or Pat. Relations, —
Brothers or Sisters, —

Personal and Medical History of Lizzie Rothmund.

LIBERTY, FISLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4509.
Residence, St. Paul, Minn.
Date Admission, Aug. 29' 96.
Admitted by, Dr. L. B. Coy. Hour, 6:45 P.M.
How Sent, G. Millick, Jail? Ramsey Co
Sex, - Female -
Age, Not given. (24 yrs)
Civil Condition, Single
Children, —
Age Youngest Child, —
Occupation, — (Father merchant)
Degree Education, - Common School -
Profession Religion, — Roman Catholic -
Habits, Probably Good.
Nativity, Minn. (Parents Germany)
Physicians Committing, Oside Mastel, + G Stamm
Correspondents, Name given in papers.

No. for Year, 45
Insane Relatives, - None -
Cause Exciting, - Not known -
Cause Predisposing, Previous
Form,
Accompanying Bodily Disorder
Suicidal or Not, Never attempted
Date of this Attack,
Duration,
No. of Attack,
No. of Admi
Age First
Time
Time
Result, Perpetual Intercurrent


MINNEAPOLIS MAR
Cash Wheat No. 1 So
Poorer Lots
Opening cables here and
bulls in wheat. The
and so did
van encouraged
Broomhall
Liverpool
the weather
Broomhall
other markets
light demand
Broomhall
Liverpool
Broomhall
Liverpool
Broomhall
Liverpool

Personal and Medical History of Lizzie Rothmund.

This patient was brought here at the hands of Dep. Sheriff Chas Ruchow attended by John Rothmund with the following history:- Patient is in fair physical condition: No history of consanguinity or heredity: This is first attack but second admission here. Patient manifested first symptoms of disease about five years ago & was sent to this [Rochester] Hospital where she improved & was sent home. Disease seems stationary & variable: Derangement is now manifested by melancholia with intervals of mania. Patient has shown no disposition to injure others & no disposition to filthy or destructive habits: Suicide has never been attempted but propensity is active: There is no history of intemperance in parents or self: No peculiarities previously shown & no injury to head: patient had convulsions when young: Patient was confined at Rochester for one year, as above stated. The cause of disease is not known - Nothing further learned on personal examination - - — — — — — —

Note* As above stated, patient was here before from April 16 1894 to April 30 1895 during stay here was very quiet & generally agreeable in manner. Talked very little & took little interest in anything around her: Went home improved - (See Vol. 26 page 77 No. 3692)

On admission was put on A & W. (G & N Ry) Complexion fair - Hair Brown; Eyes blue: Condition of skin normal: Is clean; behavior quiet; talks sensibly but is reticent.)

Condensed Fourteen Day Record - Temperature, respiration and pulse taken first week seemed normal. Appetite has been quite uniform, though not very good. Physical symptoms of disease generally those noted when here before. Has quit shoulders, pale complexion, and consumptive appearance. Consumption was diagnosed in preceding stay. Patient sits around, picks face & hands and is rather dull & stupid. Can answer questions, however, with fair intelligence. Original records preserved.

Physician's Note. Patient quiet & melancholy as before. Sits bent & doubled up in chair all day long. Won't talk much. Some of her answers clear.

Oct. 1897 Jan. Summary Nurse's Notes by Dr. E. L. Phelps:- Appetite not very good: takes tonic Dull & depressed: Has some signs of lung trouble: Quite emaciated and pale: May 97 Genl health seems impaired: appetite fair: Habits untidy: noisy & cries a good deal: Aug 97 Appetite good. Genl health seems fairly good: Has crying spells quite often. Continued by Dr Wm. Phelps. Sept. 2 97 Visited by brother. Patient was returned here showing some signs of failure in condition but there seems to be, however, no progressiveness to the trouble. Feb 98 Wt. 100.# Feb 11 99. Condition practically unchanged during period. Mch 1 - Aug 31 99 (by Dr Bliss) Appetite fair. Takes outdoor exercise: Neat in habits & careless in appearance: Usually quiet in behavior but at times is very much excited & has spells of crying at night usually inactive, never talks: Sleeps quite well: Menstr. regular. Wt 88.# Sept 1 Feb 28 1900 (Dr Huyerdahl) Dor Untidy: Quiet: Does not converse: Cries at times Appetite fair: Bowels regular: Sleeps well: General health fair

Personal and Medical History of Lizzie Rothmund.

Takes outdoor exercise: Feb 16. Is becoming emaciated: appetite poor: will not feed herself: Feb 17. Trans. to Infirmary: Feb 28 Remains in bed: Is febrile: Appetite poor: Requires laxatives: Sleeps quite well: Failing.

Mch 1 - Aug. 31 1901 (Dr H.) May 1 Dressed & up on ward: Previous to this kept in bed & fed with tube. May 30. Untidy: Does not converse: Appetite very poor. Bowels moved by cathartics. June 23 Receiving massage & electrical treatments June 24 Visited by brother. July 11 Vaccinated Sept 1-18 (Dr Linton) Sept 1 - Patient confined to bed: Appetite very poor: Part fed by tube. Very much emaciated. Urine shows diazo reaction. Pupils very much dilated & this with the anaemia & very large abdominal muscles point to peritoneal tuberculosis Is growing weaker & has running temperature: Requires frequent laxatives Sleeps very ill: Does not converse & will not answer questions Sometimes somewhat depressed. Expresses no delusions.

Sept 18 Died.

Died.

Personal and Medical History of Christine Swenson

LEGGET, PIDLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4512.
Residence, Wauganing. Minn.
Date Admission, September 2 1896
Admitted by, Dr. R. M. Phelps. Hour, 4 P.M.
How Sent, R. A. Mott. Jay P. Rice Co.
Sex, — Female —
Age, — 25 —
Civil Condition, Single
Children, None —
Age Youngest Child, —
Occupation, Inmate School Feeble Minded (Father farmer)
Degree Education, — None —
Profession Religion, — No —
Habits, Not intemperate —
Nativity, Minn. (parents Norway)
Physicians Committing, Pascoe N. Jackson. & J. M. Bailey —
Correspondents,

No. for Year, 45
Insane Relatives, Mother was insane
Cause Exciting, Feeble minded,
Cause Predisposing, — Heredity —
Form,
Accompanying Bodily Disorder, None mentioned.
Suicidal or Not, — Not —
Date of this Attack, Not stated
Duration, Not stated
No. of Attack, 1st
No. of Admissions, ~~2nd~~ 1 Rec. (Has been in school for Feeble Minded at Faribault)
Age First Attack, Not stated
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION

MENTAL CHARACTERISTICS.

Exam. by R. M. & L. L. Phelps.

MENTAL ACTIVITY:
Clear or Confused, Confused.
Quick or Sluggish, Sluggish.
MEMORY:
Past Events,
Recent Events, Impaired
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Dull.
Correct or Illusive,
REASONING POWER:
Ordinary Subjects,
Own Mental State,
Special Subjects, Much impaired
GENERAL DESCRIPTIVE REMARKS:
Refuses to talk. sits with fingers in her ears & mouth. Has been imbecile for years.

EMOTIONAL STATE:
Normal, Calm,
Indifferent, Indifferent
Exalted,
Depressed,
DELUSIONS: Can not determine.
Systematized or Not,
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

Personal and Medical History of Christine Swenson

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, Not taken - below 5 ft. WEIGHT, 82 lbs. NUTRITION, Very Poor.
WOUNDS OR ABNORMALITIES, Extreme antero posterior & lateral curvature spine.
TONGUE, Tremors, Coatings, Nil not shown Promptness Movement,
PUPILS, Equality, Unequal. Size, Left dilated
Response Light, Accommodation,
SIGHT, Seems good.
HEARING, " "
COORDINATION, Arms,
Legs, Lame.
TREMORS, Hands, None Tongue,
Facial Muscles, " General,
REFLEXES, Patellar,
Other
ARTICULATION, Will not talk
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, Whole heart displaced toward meridian line.
LUNGS, Very much deformed.
GYNAECOLOGICAL EXAM., Uterus retroverted otherwise normal.
MENSTRUATION,
OPHTHALMOSCOPIC EXAM.,



TAKEN,

EXAM. URINE, Sept 4 '96
Color Yellow.
Character Cloudy copy deposit.
Quant. 24 hrs. XII ℥
Sp. gr. 1025
Reaction Neutral.
Albumen Trace by Tannets
Sugar None.
Microscop. Large amt. bladder epith. cells oxalate lime. amor. urates.

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated, ✓	Irregular,
APPETITE, Good,	Medium,	Poor, ✓
SLEEP, Good, ✓	Poor,	Irregular,
PULSE,	Resp.,	Temp.,

CRANIAL MEASUREMENTS, Circ. H. 51 (Fron.) 50½ Nas. oc. a. 31 Bin. a. 30½ Aur. p. d. 18.2 Front. d. 14.2 Biz. d. 12.1 Th. 7½ 16ths
HISTORICAL,
LENGTH OF INVASION, Long ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations,
Father or Pat. Relations,
Brothers or Sisters,

Personal and Medical History of Christine Swanson.

This patient was received here at hands of Miss Radcliffe attended by Miss Sharp & Miss Puff. with the following history: Patient is in fair physical condition. No history of congenity so far as known. This is patients 1st attack; second admission. Was at this (Rochester) Hospital; was removed to Faribault School for Feeble Minded & has been there for past 11 years. First symptoms were manifested in screaming & striking persons near at times & by being very reticent at others: Disease seems to be increasing: is more violent of late, there are no rational intervals. Patient now manifests derangement by shrinking away into a corner, then strikes or attacks some one. Will attack attendant & endeavor to claw her with nails. Shows disposition to injure others: is not suicidal: Is filthy & destructive. Mother of patient was insane: Nothing known concerning previous peculiarities - patient feeble minded - No history of intemperance in parents or self. Father uses tobacco: There has been no severe disease or head injury (patient has curvature of spine) according to papers. Patient has been confined when most violent: an inmate of School for Feeble Minded as above stated.

Note* Patient was committed to this Hospital October 16'1885 & remained until Sept. 10'1887 when she was taken to Faribault School for Feeble Minded (for further records see Vol 6 page 98 No. 998.)

On admission

8

Summary first 14 days. Patient an imbecile, transferred here from Faribault School for Imbeciles, because of violence, noise, & disturbance. During the first two weeks here, although occasionally noisy and disagreeable, usually fairly quiet: Seems to feel well and is in good health. Original Records Preserved.

Patient a quiet imbecile patient. It is difficult to see on what grounds she was transferred. Is rather untidy, not often noisy - occasionally restless.

Oct 17 Summary Nurse's Notes by Dr. S.L. Phelps:- Very disagreeable in manner: At times strikes other patients: menstr. regular: Appetite fair: untidy at times: Mar '97 Genl health as good as usual though not at all strong: 1897 thin & pale: Very demented & silly: resists a good deal: Apr. 97 No change July Recently in bed: has one finger removed in bed several days: July 20'97 Now up on ward: quite noisy & at times violent. Continued by Dr. Asst. Phelps.

Nov 30 97 Very restless & at times very noisy: General health does not seem to fail.

Febr 98 Patient kept in bed of late as best way of caring for her, she being restless & noisy. Mch 10 Trans. to Infirmary. Apr. 16 to B3 Sept 3 To Infirmary.

Febr 99 Remains most of time in bed. Condition unchanged.

Mch - Aug. 31'99 Cont. by Dr. Bebb. Physical condition fair: Appetite quite good. Bowels constipated: requires laxatives: Remains in bed. So untidy in habits & at times destructive: usually quiet in behavior but is inclined to be somewhat violent and apt to interfere with other patients. Throws dishes at times.

Personal and Medical History of Christine Swanson.

Sept 1- Feb 28'1900. (Dr. Heyerdale) Kept in bed constantly: untidy & destructive & often very noisy: Talks incoherently. Appetite fair. Bowels moved by laxatives. Sleeps well: If not watched strikes other patients.

Jan 5 Wt. 63# Often screams loudly. Mch 1 - Nov. 30'1900 (Dr. Linton). Untidy in appearance & very destructive: Does not converse nor answer questions: Sometimes fights & strikes others. Kept in seclusion: Screams when angry: Throws food from tray which she often throws on floor. Appetite fair: Laxatives frequently required. Sleeps well. Takes no exercise. Has marked curvature of spine & is quite deformed. Dec 1 - Feb 28'1901. Condition same as usual. Jan. 3 Trans. to B3 & thereafter has been up on ward & dressed. Seems physically well considering her deformity: Has a good appetite: Sleeps well: Has disturbed times when she screams & cries. Dirty in habits. Cannot talk so as to be understood. Mch 1 - Wt. 65#. Mar 1 - June 1 - 1901 No change in mental or physical condition May 29 - Wt. 59#

June to Sept. July 18 suppuration of left ear, abscess lanced and treated for some time, Sept 2 Wt. 60#. Sept. to Dec. Ear still discharging, no change in mental or physical condition Nov. 27 Wt. 57#.

Up to Feb. 1st 1903. Patient is physically well: has had no ailment for some years: appetite good: bowels regular: sleeps well: takes no exercise: attends no amusements: does no work: is very untidy in habits and careless in appearance: is destructive and noisy most of the time during the day: is like a baby in deportment: realizes but little: is unable to converse or answer questions but cries a great deal. Nov. 30th. Wt. 60#.

Personal and Medical History of Lucy Worthington

LIBERTY, FISCHER & HOAGBOTEL, DAVENPORT, IOWA.

Whole No. 4513.
Residence, Winona, Minn.
Date Admission, September 2 96.
Admitted by, Dr R.M. Phelps Hour, 4 PM.
How Sent, A.A. Mott. Jap P. Rice Co. Minn.
Sex, - Female -
Age, - 35 -
Civil Condition, Single
Children, None.
Age Youngest Child, —
Occupation, Inmate School Feeble minded
Degree Education, - None -
Profession Religion, Not a church member.
Habits, - Not Intemperate -
Nativity, Minn (parents U. S.)
Physicians Committing, Roscoe R Jackson, J.M. Bailey
Correspondents, None given in papers.

No. for Year, 146
Insane Relatives, None known in family.
Cause Exciting, Developmental -
Cause Predisposing,
Form,
Accompanying Bodily Disorder, None mentioned
Suicidal or Not, Not.
Date of this Attack, May 1895.
Duration, - Over a year -
No. of Attack, 1st
No. of Admissions, 1st time -
Age First Attack, 34 -
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION

Exam. by Dr. Sh + RM. Phelps 9/3/96 **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:
Clear or Confused, Confused -
Quick or Sluggish, Sluggish.
MEMORY:
Past Events, Impaired
Recent Events, "
Special Subjects, "
PERCEPTIVITY:
Alert or Dull, Very dull.
Correct or Illusive,
REASONING POWER:
Ordinary Subjects,
Own Mental State,
Special Subjects,
GENERAL DESCRIPTIVE REMARKS:
Pale + Thin - Same - imbecile for years.

EMOTIONAL STATE:
Normal, Calm,
Indifferent, Indifferent
Exalted,
Depressed,
DELUSIONS:
Systematized or Not,
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION: Very dull at times noisy
Coherent or Incoherent,
Voluble or Reticent,

Personal and Medical History of Lucy Worthington.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. WEIGHT, 104 lbs. NUTRITION, Impaired
WOUNDS OR ABNORMALITIES, Paralysis + contractures of left side.
TONGUE, Tremors, Coatings, Slight White coating Promptness Movement,
PUPILS, Equality, Equal Size, Dilated
Response Light, Normal Accommodation, Normal.
SIGHT, Seems good.
HEARING, Good.
COORDINATION, Arms, Impaired.
Legs, "
TREMORS, Hands, in left side Tongue,
Facial Muscles, General,
REFLEXES, Patellar, Much exag. 92.96
Other
ARTICULATION,
Slurred, Talks very little
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, No murmurs.
Pulse weak.
LUNGS,



TAKEN,

EXAM. URINE, Sept 4 '96
Color Yellow.
Character White copy deposit.
Quant 24 hrs. XVII ℥
Sp. gr. 1013
Reaction Slightly acid.
Albumen Trace by Tanrets.
Sugar None.
Microsop. Large ant. pus corpuscles - Large ant. bladder + vaginal epith. amor urates - oxalate of lime.

GYNAECOLOGICAL EXAM., Normal Uterus retroverted - profuse foul discharge - external genitals red + excoriated.
MENSTRUATION,
OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated, ✓	Irregular,
APPETITE, Good, ✓	Medium,	Poor,
SLEEP, Good,	Poor, + Noisy at night	Irregular,
PULSE,	Resp.,	Temp.,

CRANIAL MEASUREMENTS, Length 50½ (c.m.) 57.3 Nas-occ. a. 31½ Bin. a. 30 Aur. p. d. 17.9 Front. d. 13½ Bi. d. M. F. L. 9.7
HISTORICAL,
LENGTH OF INVASION, Long ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations,
Father or Pat. Relations,
Brothers or Sisters,

Personal and Medical History of Lucy Worthington.

1896

This patient was received here at hands of Miss Radcliffe, attended by Miss Sharp & Miss Cuff (of Faribault School) with following history: Patient is in fair physical condition: No history of consanguinity or heredity as far as known. This is 1st attack & first symptoms were manifested in May, 1895 by Illusions & Hallucinations - Patient was retained at school for Feeble Minded. The disease seems stationary (Tendency toward dementia) not variable & with no rational intervals. Patient imagines she is holding child; sees rats & mice: is dining team of horses. She has shown disposition to injure others but is not suicidal: has filthy & destructive habits. Patient was feeble minded previous to attack & had convulsions soon after birth: There is no history of intemperance in parents or self. Patient was confined in a room for eight months: sedatives given with but temporary effect. On personal examination a partial right hemiplegia found.

On admission

Summary First 14 Days. Patient sent here from Faribault School markedly imbecile: Sent here chiefly, it seems, on account of the noise & disturbance she made: Is very disagreeable in behavior and very noisy. Her health seems good and there are no physical symptoms of importance. Original Records Preserved.

Physician's Notes. Patient from Faribault School - a quite noisy untidy imbecile - Has silly, hysterical, maniacal behavior.

Oct. Summary Nurse's Notes by Dr. S. E. Phelps:- Menstr. regular: mental condition that of an imbecile: Nov. 16 Visited by brother & sister: Mar 4 More quiet of late:
1897 Very silly & demented: dirty in habits: General health impaired: May 97 no change
July Gen'l health fairly good: no mental change. Continued by Dr. R. M. Phelps.
Nov. 97 Patient at times very noisy: cries & talks to herself: Ht 4 Wt 149# Sept 30 Incon. & A. Feb 98 Patient has improved somewhat in behavior during period: Talks rather more intelligently. Behavior however, is thoroughly imbecile.

Feb 1- Aug 31-99. Cont. by Dr. Bett. General health good. Appetite good: sleeps well: bowels regular: goes riding. Is crippled & walks with difficulty: Clean in habits: rather careless in appearance. Menstr. regular. Sept 1- Feb 28 1900 (Dr. Hagerdale) Quiet & childish in manner: Memory very poor: Fairly neat: Eats & sleeps well: Takes outdoor exercise: usually happy & contented but occasionally cries. Dec 28 Nail on toe became sore. Removed. Jan 18 197# General health good. March 1- Aug 31 1900 (Dr. Linton) Tidy & neat: usually quiet & agreeable: eats & sleeps well: bowels regular: Menstruates regularly: May 20 became angry & scratched forehead which was treated. July 23 Vaccinated. Aug 6 Became excited, pumped up & fought A. Johnson scratching her arms. Sept 1- Feb 28 1901 No change in patient: General health good: Answers questions intelligently at times &

Personal and Medical History of Lucy Worthington

seems to understand when spoken to but cannot readily converse. So at times excited & talks loudly. Memory seems very poor. Wt 28 Wt. 170#

Mar-1 - June 1 - 1901 No change in mental or physical condition. menstruates. May 28 Wt 173# June to Sept. No change in any respect Aug. 31 Wt. 170#. Sept. to Dec no change Nov. 30 Wt. 175#

Dec to Feb 1st, 1902 General health good: sleeps well: bowels regular: Takes exercise: attends amusements occasionally: habits clean: appearance rather careless: seems somewhat brighter of late: talks considerably to the nurses but generally in a rather childish way: is sometimes impatient and rather disagreeable: at times has rather childish outbursts of temper but is usually pleasant and agreeable. Nov. 26th, Wt. 177#.

Personal and Medical History of Agnes Russell.

LEBERT, FISLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4515
Residence, St. Paul, Minn.
Date Admission, September 4' 1896.
Admitted by, Dr. R.M. Phelps Hour, 7 PM.
How Sent, G. Mellick J. of P. Ramsey Co.
Sex, -Female-
Age, -37-
Civil Condition, Married.
Children, -Three-
Age Youngest Child, Eleven years.
Occupation, Not stated.
Degree Education, -Common School.
Profession Religion, Not a church member.
Habits, Very Intemperate.
Nativity, United States (Parents Ireland)
Physicians Committing, C.G. Meade. R.S. Bolt
Correspondents, None given in papers.

No. for Year, 48
Insane Relatives, -None-
Cause Exciting, Inebriety
Cause Predisposing, not known.
Form,
Accompanying Bodily Disorder, None mentioned
Suicidal or Not, -Not-
Date of this Attack, Sept 3 1896.
Duration, 1 day.
No. of Attack, 1st
No. of Admissions, 1st as insane. (Has been here as inebriate)
Age First Attack, -37-
Time of Leaving, Nov 25. 1896.
Time in Hospital, 2 mo. 21 da.
Result, Recovered. Discharged Nov 25'96.

EXAMINATION ON ADMISSION

Exam. by R.M. & S.L. Phelps 9/5/96 **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:
Clear or Confused,
Quick or Sluggish, Fairly quick
MEMORY:
Past Events,
Recent Events, Says good.
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Fairly good.
Correct or Illusive,
REASONING POWER:
Ordinary Subjects,
Own Mental State,
Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Claims fair physical condition except as somewhat run down at present. Denies delusions & did not detect any. Has been a woman of fair appearance, but of decided such, moral perversion to liquor & immorality as to suggest calling her a defective or pervert. Has been helped many times & by all the friends & charitable organizations she could call on. Sent to work house many times. Brought here by Mrs S.V. Root with request to "keep her for the sake of humanity."

EMOTIONAL STATE:
Normal, Calm, Quiet & about as when here before.
Indifferent,
Exalted,
Depressed,
DELUSIONS: None found.
Systematized or Not,
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

Personal and Medical History of Agnes Russell.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 1 in. WEIGHT, 137½ lbs. NUTRITION, Fair
WOUNDS OR ABNORMALITIES,
TONGUE, Tremors, Coatings, Slight coating Promptness Movement, Prompt.
PUPILS, Equality, Equal Size, Dilated
Response Light, Accommodation,
SIGHT, Good.
HEARING, Good.
COORDINATION, Arms, Seemingly fair
Legs,
TREMORS, Hands, Some fine tremors Tongue,
Facial Muscles, General, Says in legs also
REFLEXES, Patellar, R. exaggerated L. equal
Other
ARTICULATION, Normal
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, No murmurs
LUNGS, Normal.
TAKEN,

EXAM. URINE, Sept 18'96
Color Pale Yellow
Character Cloudy flaky deposit
Sp. gr. 1012
Reaction Acid
Albumen Trace by heat & Tests
Sugar None.
Microscop. Large ant. bladder epith. cells, oxalate of lime & amor. urates.

GYNAECOLOGICAL EXAM., Sept 7/96. Uterus retroverted but movable. Slight erosion of os.
MENSTRUATION, Regular but painful.
OPHTHALMOSCOPIC EXAM.,

HABITS,	Dirty,	Clean,	Careless,
BOWELS,	Normal, Says good	Constipated,	Irregular,
APPETITE,	Good,	Medium,	Poor,
SLEEP,	Good,	Poor,	Irregular,
PULSE,	Rather weak	Resp.,	Temp.,

CRANIAL MEASUREMENTS, Circ. h. 53 (7 m.) 63½ Naso oc. a. 33 Bin a. 31 Ant. p. diam. 18.5 Transv. d. 14.8 Bid 13. Fh 12.8
HISTORICAL, Drinks Whisky, Brandy, Sherry.
LENGTH OF INVASION, Moderately long ONSET GRADUAL OR SUDDEN, Gradual.
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Denies
Mother or Mat. Relations, Died heart disease
Father or Pat. Relations,
Brothers or Sisters, 2 brothers 2 sisters.

Personal and Medical History of Agnes Russell.

This patient was brought here by Deputy Sheriff E. Johnson attended by Miss. L. V. Root, with the following history: Patient is in fair physical condition This is first attack, first symptoms being manifested yesterday: Patient has been a hard drinker for seven years & was here on inebriate warrant from April 2nd 1889 to July 2nd 1891. No information given concerning consanguinity: no history of lunacy: Disease seems to be increasing & is variable with irregular rational intervals: Derangement is now shown by "alcoholic delusions" There is no disposition to injure others nor to filthy or destructive habits. Patient is not suicidal: no peculiarities previously shown. Patient has been a hard drinker for years. Has been confined 4 months: Cause of disease alcoholic. No treatment has been pursued. On personal examination disease found to be chronic alcoholism.

On Admission Put on B'W. (Gft N. Rpt Complexion fair - Hair brown streaked with gray: Eyes gray: Condition of skin normal: No marks, scars or bruises noticed. Deity, Behavior quiet: Talks sensibly)

Summary First 14 Days. Temperature taken for a few days indicates no disturbance of any kind: Appetite good from the first. No medicine seemed called for and she had no especially bad feelings except nervousness: Sat about and read quietly & behaved in a quiet rational way. Original Records Preserved

Physicians Note. Patient has manifested no delusions or incoherence since coming: denies that she had any idea that she was coming on an insane warrant. Says was about her menstrual period; that she took a bath and going out on street was dizzy and confused. They arrested her and advised her to come down here "to rest up". Patient has led a dissipated life for years, even while maintaining an innocent and well meaning manner. So that (according to Miss Root) she has been the object of charitable effort, by nearly all the charitable organizations. It was wished that we keep her here.

Summary Nurse's Notes by Dr S.L. Phelps:- Pleasant & agreeable on ward: Appetite fair: gym. treatment given every other day: Nov. 9th Sick in bed: complains of cramps in stomach: Nov. 25 Went Home: was quiet & pleasant: neat in appearance: talked sensibly & took some interest in work: Appetite was good: usually slept well: Had received gym. treatments steadily every other day since admission: went home much improved in every respect.

Discharged.

Personal and Medical History of

Personal and Medical History of Mabel Anderson

LEBERT, FOLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4516

Residence, Winona, Minn.

Date Admission, Sept. 8' 1896

Admitted by, Dr Linton Phelps Hour, — 6:45 Pm.

How Sent, H.L. Buck Jo P. Winona Co.

Sex, — Female -

Age, — 19 -

Civil Condition, — Single -

Children, None -

Age Youngest Child, -

Occupation, Has none (father dead)

Degree Education, — Common school -

Profession Religion, Central Methodist

Habits, Intemperate

Nativity, Rochester, Minn

Physicians Committing, W. J. English + D.A. Stewart.

Correspondents, None given in papers (mother in Winona)

No. for Year, 49

Insane Relatives, Father + Sister

Cause Exciting, Not stated.

Cause Predisposing, — Heredity -

Form,

Accompanying Bodily Disorder, None mentioned

Suicidal or Not, Not,

Date of this Attack, 2 years ago. (Home last 10 days)

Duration, about 2 years.

No. of Attack, 1st

No. of Admissions, 2nd

Age First Attack, — 17 years -

Time of Leaving, Jan. 25. 1897.

Time in Hospital, 4. mos. 17 da.

Result, Discharged May 5. 1897 Unimproved.

EXAMINATION ON ADMISSION

Exam. by Linton Phelps 9/10/96. **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:

Clear or Confused, Confused.

Quick or Sluggish, Quick + excitable

MEMORY:

Past Events, Fairly good.

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Alert.

Correct or Illusive,

REASONING POWER:

Ordinary Subjects, Impaired

Own Mental State,

Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Very excitable + noisy - Laughing + talking in a rambling way - Mind flies from one thing to another

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted, ✓

Depressed,

DELUSIONS: None determined.

Systematized or Not,

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

Personal and Medical History of Mabel Anderson.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 3½ in. WEIGHT, 115½ lbs. NUTRITION, Good.

WOUNDS OR ABNORMALITIES, None Circulation of skin - Good

TONGUE, Tremors, None. Coatings, Promptness Movement,

PUPILS, Equality, Equal Size, Normal.

Response Light, Accommodation,

SIGHT, Good.

HEARING, "

COORDINATION, Arms, Normal

Legs,

TREMORS, Hands, Tongue, None.

Facial Muscles, General,

REFLEXES, Patellar, Normal

Other

ARTICULATION, Normal

Slurred,

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART, No Murmurs. Sounds Normal, Regular

LUNGS, Normal.

TAKEN,

EXAM. URINE, Sept 11 '96

Color Pale Yellow

Character White Flaky sediment

Amt. 24 hrs. XXXI ⅞

Sp. gr. 1016.

Reaction Alkaline.

Albumen Trace by Tests

Sugar None.

Microscop. Large amt. Amor. urates + Triple Phos. Some pus. corpuscles some bladder epith.

GYNAECOLOGICAL EXAM., Retroversion of uterus Otherwise normal

MENSTRUATION,

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal, ✓	Constipated,	Irregular,
APPETITE, Good, ✓	Medium,	Poor,
SLEEP, Good, ✓	Poor,	Irregular,
PULSE,	Resp.,	Temp.,

CRANIAL MEASUREMENTS,

HISTORICAL,

LENGTH OF INVASION, Long. ONSET GRADUAL OR SUDDEN,

HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")

Mother or Mat. Relations, Sickly + Nervous.

Father or Pat. Relations, Drinks

Brothers or Sisters, Healthy

Personal and Medical History of Mabel Anderson.

This patient was brought here by Sheriff Fuhrmann attended by Mrs. Fuhrmann, with the following history:- Patient is in good physical condition:- No history of consanguinity as far as known: This is first attack but second admission here*: it has been continuous for two years variable with rational intervals,+ for past few days patient has been uncontrollable: Derangement shown in continuous condition of imaginary ideas, especially on subject of marriage. Patient has shown no disposition to injure others or to filthy or destructive habits: Is not suicidal. Her father + sister Anna both insane: No peculiarities previously shown: Father was a habitual drunkard + patient also drinks hard at times: There has been no recent disease or head injury. Patient was confined here at Rochester for several months (see note*) has received no further treatment. On personal examination patient found very excitable, talks continuously + incoherently, has hallucinations.

Note* As stated patient was here from Oct. 8. 1895 to Dec 5/95. Was very noisy + excitable during entire stay:- Went home at request of sister - still very wild + noisy.

On admission (G.H.N.Rep) Complexion dark; hair light brown; eyes blue; Condition of skin Normal = No scars or marks but bruises noticed on both knees - Is clean; quiet. Talks sensibly at times but is very loud + boisterous.

Summary First 14 days: Temperature, respiration and pulse taken first week are normal: appetite uniformly good: no medicine seemed called for except for cough: Seemed thoroughly healthy and in behavior mildly maniacal: excited, and talkative most of the time Noisy by reason of talk, sometimes during the night: Is young: This is second attack: Is evidently an adolescent case, or one in which heredity is very strongly marked, and is simply all the time vacillating up and down across the border line of insanity

Original records preserved.

Physicians note- Patient noisily mischievous + troublesome as before Ideas at times incoherent often silly + febrile.

Oct. 93 Summary Nurse's Notes by Dr. S.L. Phelps:- Very noisy: bowels regular: assists some with work: Oct. 94 Ran away while out walking: Dec. 94 Quiet but excitable at times Appetite good: gen'l health good: Jan 95 Has become much more quiet + sensible in talk: Does no work: reads at times: Jan 15 95 Went Home.

Discharged

Personal and Medical History of

Personal and Medical History of Katie Jordan.

LIBBEY, FISHER & GUARDIUS, DAVENPORT, IOWA.

Whole No. 4518.
Residence, Taopi, Mower Co, Minn.
Date Admission, 9th September 1896.
Admitted by, Dr Luton Phelps. Hour, —10 a m
How Sent, E.S. Washburn, J of P. Mower Co.
Sex, Female.
Age, Not given
Civil Condition, Single
Children, None
Age Youngest Child, —
Occupation, Housework.
Degree Education, Common School.
Profession Religion, Yes. Catholic
Habits, Not intemperate.
Nativity, Iowa (Parents Ireland)
Physicians Committing, A. W. Allen. E. H. Washburn,
Correspondents, Dr A. MacDonald, Austin Family Physician

No. for Year, 51.
Insane Relatives, No.
Cause Exciting, Illness.
Cause Predisposing, Rx Previous Attack.
Form,
Accompanying Bodily Disorder, None mentioned
Suicidal or Not, Not.
Date of this Attack, About 1 yr. ago.
Duration, About 1 year.
No. of Attack, 2nd
No. of Admissions, 1st
Age First Attack, Not known (1884)
Time of Leaving, Feb. 14. 1899
Time in Hospital, 2 yr 5 mo. 5 d.
Result, Transferred to Fergus Falls

EXAMINATION ON ADMISSION

MENTAL CHARACTERISTICS.

Exam. by S. L. Phelps 9/10/96

MENTAL ACTIVITY:
Clear or Confused,
Quick or Sluggish, Sluggish
MEMORY:
Past Events, Poor
Recent Events,
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Dull
Correct or Illusive, Partially correct.
REASONING POWER:
Ordinary Subjects,
Own Mental State,
Special Subjects, Insane

GENERAL DESCRIPTIVE REMARKS:
Quite dull & slow of preception. Answers questions very slowly. Only half realizes things

EMOTIONAL STATE:
Normal, Calm,
Indifferent, ✓
Exalted,
Depressed,
DELUSIONS: Delusive Ideas.
Systematized or Not,
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

Personal and Medical History of Katie Jordan.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, Not taken WEIGHT, not taken NUTRITION, Fair but pale.
WOUNDS OR ABNORMALITIES, None Condition of skin Normal.
TONGUE, Tremors, Coatings, Slight coating Promptness Movement,
PUPILS, Equality, Equal Size, Normal.
Response Light, Normal Accommodation, Normal.
SIGHT, Says good.
HEARING, Says impaired
COORDINATION, Arms, Seems Normal
Legs, "
TREMORS, Hands, Very slight Tongue, Normal
Facial Muscles, None General, None
REFLEXES, Patellar, Both exag. 10
Other
ARTICULATION,
Slurred, Not clear
Hesitating, Slow
FACIAL EXPRESSION,
SENSIBILITY,
HEART, No Murmurs
Sounds 1st muffled - not distinct
Regular
LUNGS, Region breasted exam in good condition
GYNAECOLOGICAL EXAM., Sept. 15/96. Uterus in normal position - Some endometritis with discharge external genitals excoriated.
MENSTRUATION, Regular.
OPHTHALMOSCOPIC EXAM.,

TAKEN,

EXAM. URINE, Sept. 10 '96
Color Yellow
Character Flaky Sediment
Amt. in hrs. XX VIII — 3
Sp. gr. 1020
Reaction Alkaline
Albumen None
Sugar "
Microscop. Large amt. Amor. urates +
Triple phos. Bladder epith. cells.

HABITS, Dirty, Clean, Careless,
BOWELS, Normal, Constipated, ✓ at times Irregular,
APPETITE, Good, ✓ Medium, Poor,
SLEEP, Good, ✓ Poor, Irregular,
PULSE, Resp., Temp.,
CRANIAL MEASUREMENTS, Circ(h) 52½ (r.m) 66½ N.oc.d 33. Bm.a. 31 Aut.p.d. 18.6 Lauv. d. 14.5 Bm.d 13. F.h. 11.2.
HISTORICAL, Had Typhoid fever
LENGTH OF INVASION, Long ONSET GRADUAL OR SUDDEN, Gradual.
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, died dropsy
Father or Pat. Relations, Dead.
Brothers or Sisters,

Personal and Medical History of Katie Jordan.

This patient was brought here by Sheriff Jas. A. Johnson, attended by Sarah Johnson with the following history: Patient in good physical condition. No history of consanguinity or heredity: This is second attack, - first occurring in 1894 & lasting 3 months: First symptoms of present attack were manifested about a year ago after a spell of sickness called Typhoid Fever: disease seems increasing, not variable & with no rational intervals, - she seems fairly rational all the time. Derangement is manifested by walking about in dangerous places on Railroad tracks & she has been removed with train dangerously near: has also started fire in room at home. Three years ago patient would chase & threaten visitors, no disposition at present to injure others: In habits patient is not suicidal or filthy; has set fire to clothing No peculiarities previously shown: No history of intemperance in parents or self. Patient was very ill in Fall of 1895, called Typhoid fever: No restraint, confinement or treatment known: Cause of disease is supposed to be sickness of 1895. On personal examination Does not appear bright; wants to go to poorhouse & live: Answers most questions intelligently others she refuses to answer: Patient committed to Hospital because thought unsafe for her to be out. On admission put on B² W. (Gth. R.) Complexion fair: hair brown: Eyes blue: Condition of skin normal. No marks, scars or bruises noticed. Is clean, quiet but objected to being bathed: Is pigeon breasted. Answers questions sensibly but would not talk freely - seems absent minded.)

Summary First 14 Days. Temperature, Respiration & Pulse taken during first week practically normal: Appetite good throughout: Received cathartic & tonic regularly: There are no symptoms of any prominent physical disease. In behavior shows a quite uniform dullness, although able to answer somewhat accurately: Seems rather deaf: During latter part of time was talking to herself more & was rather more noisy.

Nov. 7 Summary Nurse's Notes by Dr. E. L. Phelps: Violent at times: talks to herself: works in the Laundry: appetite quite poor. Dec 96 Appetite poor: refuses to take tonic: quite
1897 noisy: habits untidy: Jan 14 97 Seems a chronic, stationary case: Transf. to Annex:
Apr. 9 Visited by friend did not recognize her. July 22 97 Appetite good: works in Laundry: Genl health good, but no mental change. Continued by Dr. W. M. Phelps Oct 31 97 General health good. Is usually fairly quiet, at times irritable. Feb 9 98 Wt. 117 lbs. May 6 Visited by friends: Feb 14 99 Trans. to Fergus Falls. Condition apparently unchanged.

Discharged.

Personal and Medical History of

Personal and Medical History of Carrie Lindquist

LEIGHT, FIGLAS & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4520.
Residence, St. Paul, Minn.
Date Admission, 10th September 1896.
Admitted by, C. B. Eby M. D. Hour, 6:45 PM.
How Sent, G. Milnick J. of P. Ramsey Co.
Sex, - Female.
Age, - 48 -
Civil Condition, Single
Children, None
Age Youngest Child, —
Occupation, Servant & seamstress (Farm Farmer)
Degree Education, Common School
Profession Religion, Lutheran.
Habits, Not intemperate.
Nativity, Sweden.
Physicians Committing, E. M. Lundholm & Olof Sohlberg.
Correspondents, None given in papers.

No. for Year, 53
Insane Relatives, Father's brother.
Cause Exciting, Not known.
Cause Predisposing, Probably heredity
Form, Mania Chronic -
Accompanying Bodily Disorder, None mentioned.
Suicidal or Not, Not.
Date of this Attack, 3 years ago.
Duration, 3 years.
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, - 45 -
Time of Leaving, Aug. 26-1904 - Died.
Time in Hospital, 7 yr. 11 m. 16 d.
Result, Tubercular abscess of stomach.

EXAMINATION ON ADMISSION

Exam. by S. L. Phelps 9/11/96.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, appears clear.
Quick or Sluggish, Quick
MEMORY:
Past Events, Good.
Recent Events, "
Special Subjects, "
PERCEPTIVITY:
Alert or Dull, Alert
Correct or Illusive,
REASONING POWER:
Ordinary Subjects,
Own Mental State, Seems somewhat impaired
Special Subjects,
GENERAL DESCRIPTIVE REMARKS:

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed, somewhat.
DELUSIONS:
Systematized or Not, No definite ones.
Special Subjects, Probably delusive ideas
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

Slightly melancholy. Would not stay in house. Worked out of doors.

Personal and Medical History of Carrie Lindquist.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 7 in. WEIGHT, 127 lbs. NUTRITION, —
WOUNDS OR ABNORMALITIES, None. Condition of skin - Normal.
TONGUE, Tremors, Coatings, White coat. Promptness Movement,
PUPILS, Equality, Equal. Size, Normal.
Response Light, Normal Accommodation, Normal.
SIGHT, Says good.
HEARING, " "
COORDINATION, Arms, Normal
Legs, "
TREMORS, Hands, None. Tongue, None
Facial Muscles, " General, "
REFLEXES, Patellar,
Other
ARTICULATION,
Slurred, Normal
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,



TAKEN,

EXAM. URINE, Sept. 12'96
Color Yellow
Character Clear
Quant. 24 hrs. XXXIII3
Sp. gr. 1020
Reaction Acid.
Albumen Trace by Tanrets
Sugar None
Microscop. Large quant. Uric acid Crystals. Few pus Corpuscles, a few bladder & vaginal Epith cells. Amor. urates.

HEART, No murmurs. Regular.
LUNGS, Seem normal.
GYNAECOLOGICAL EXAM., Sept. 13/96. Uterus retroverted toward right side - External genitals normal.
MENSTRUATION, absent the past year.
OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated,	Irregular,
APPETITE, Good,	Medium,	Poor,
SLEEP, Good,	Poor,	Irregular,
PULSE,	Resp.,	Temp.,

CRANIAL MEASUREMENTS, Circ. (H) 56 (V.) 64 Nasa 3¼ Bin. a. 31 Aur. p. d. 19.4 Sagitt. d. 15.7 Biod. 12.9 F.L. 12.1
HISTORICAL, 1883. Had Catarrh Stomach: Brain fever when six years old + was very sick in 1884 was sick at home 5 weeks then went to hospital for a month. Had Rheumatism in 1883 - took massage treatment for it.
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN, —
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, Very nervous + sick for years - dead now
Father or Pat. Relations, died pneumonia - Father's brother Epileptic
Brothers or Sisters, 2 strong + well.

Personal and Medical History of Carrie Lindquist

This patient was brought here by Sheriff Chas Ruckow, attended by Miss Julia A. Axes, with the following history: Patient is in fair physical condition. First symptoms of attack manifested three years ago; - wandering about, spending nights outside, sleeplessness etc: Disease appears stationary, not variable + with no rational intervals. Derangement is now shown by patients refusing to enter house, sleeping outside, + taking no food unless brought to her. She does no work except crocheting. Patient has shown no disposition to injure others + no filthy, destructive or suicidal habits; before accession of disease was very quick-tempered + passionate + very religious. There is no history of intemperance in self or family + none of severe disease or head injury. Cause of disease unknown: No restraint confinement or treatment employed. On personal examination - Patient was very talkative.

On admission - was put on B[2] W. (3 H.H. Rpt. Complexion fair: hair light: eyes blue Condition of skin normal. No marks, scars or bruises noticed - Very dirty; quiet, talks sensibly; no delusions noticed)

Summary First 14 days - Temperature, pulse + respiration practically normal during first week: Appetite uniformly good: tonic prescribed for her but for the most part uniformly refused by her. Awake considerably at night: for the most part during the day quiet and listless. The general seems to be a quiet, dull case, with considerable dementia. Original Record Preserved.

Physicians Note - Patient quiet + listless: looks as if knew quite well things going on, but makes no comments + is quite inert. no work. no reading. Talks little: Health shows no special impairment.

Oct. Summary Nurses Notes by Dr. S. L. Phelps: Gym. treatments every other day: Very noisy at times: scolds a good deal: Nov. 17. Very noisy at times, talking to self: bowels regular: Sleeps fairly well: transf. to annex: Feb '97: Genl health good: uniformly dull: usually quiet: rather demented: Apr. '97 Appetite good: genl health good: Very disagreeable: Has delusions: July '97 Talks incoherently: very disagreeable: genl health good. Continued by Dr. Ann. Phelps. Nov 8 General health fairly good: incoherent in talk + somewhat troublesome in behavior at times. Feb 9 Wt. 130.[#] Feb 7 '99 Condition practically unchanged since former note. Mch 1 - Aug 31 '99 Cont. by Dr Bibb. General health good: Appetite good sleeps well: Takes outdoor exercise: Clean in habits: Does not converse but sometimes answers questions quite sensibly: At times obstinate + inclined to be violent but usually quiet. Aug 18 Wt. 121½[#]

Sept 1 - Feb 28 1900. (Dr Heysdale) Appetite good: Bowels regular. Menstruates regularly. General health good: Very noisy + at times resistive: Does not speak English Jan 1st Wt. 119½[#] Takes outdoor exercise.

Mch 1 - Nov 30 1900. (Dr Ryan) Neat: Scolds some + is disagreeable + resistive: Appetite good: Sleeps well: General health fair: Appetite good: Menstruates regularly: Takes outdoor exercise but does no work

Personal and Medical History of

1900

July 20 Vaccinated Nov 14 Wt 128[#] Dec 1 - Feb 28 1901 General Health good: Quite disturbed at times: Scolds + talks loudly: Takes no interest in anything Mch 1 Wt. 130[#] Mar 1 - June 1 - 1901 No change in mental or physical condition. Does no work. May 30 Wt. 127[#]

June to Sept. Does no work, takes out door exercise, Sept. 3 Wt. 125[#].

Sept. to Dec. no change Nov. 30 Wt. 125[#].

up to Feb 1, 1903. General health good: appetite good: sleeps well: bowels regular: takes exercise: occasionally assists with the work: is at times very noisy and disturbed and inclined to be violent: walks restlessly about the ward: talks to herself in her own language: doesn't speak English: is untidy in appearance; neat in habits Dec 1st. Wt. 121½[#].

Personal and Medical History of Annie Nelson.

LEIGHT, FISHER & SCHNEIDER, DAVENPORT, IOWA.

Whole No. 4521
Residence, St. Paul, Minnesota
Date Admission, September 12. 1896.
Admitted by, Dr. R. M. Phelps Hour, 6:45 PM.
How Sent, St. Willich Jail Ramsey Co.
Sex, -Female-
Age, Not given
Civil Condition, Single
Children, none
Age Youngest Child, —
Occupation, Laundress (Father Carpenter)
Degree Education, -Common-
Profession Religion, Yes Baptist.
Habits, Not intemperate.
Nativity, Sweden (Parents Sweden)
Physicians Committing, G. Stamm, V. J. Hawkins -
Correspondents,

No. for Year, 54
Insane Relatives, - None -
Cause Exciting, Unknown -
Cause Predisposing, Not Known.
Form,
Accompanying Bodily Disorder, None mentioned
Suicidal or Not, - Not -
Date of this Attack, Sept. 1 1896
Duration, 12 days.
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, Not stated.
Time of Leaving, Sept. 27. 1896.
Time in Hospital, Two weeks
Result, Died - Meningitis

EXAMINATION ON ADMISSION

Exam. by R. M. & L. L. Phelps 9/14/96. **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:
Clear or Confused, Confused - deluded.
Quick or Sluggish,
MEMORY:
Past Events,
Recent Events, } Illusions prevent any test
Special Subjects,
PERCEPTIVITY:
Alert or Dull, Dull.
Correct or Illusive, Incorrect.
REASONING POWER:
Ordinary Subjects, Poor
Own Mental State, "
Special Subjects, "

GENERAL DESCRIPTIVE REMARKS: Hangs helplessly back - will hardly say anything. Dull & despondent Breathes irregularly in a voluntary way - Has been noisy & excited since coming part of time - Seems in fair health. No prominent physical symptoms noted at this examination.

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed, ✓ Depressed
DELUSIONS: Won't talk
Systematized or Not, History - praying in -
Special Subjects, uncleanly, etc.
Transitory or Not, Many & Varied.
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

Personal and Medical History of Annie Nelson.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, WEIGHT, NUTRITION, Fair.
WOUNDS OR ABNORMALITIES, Condition of Skin - Some anaemia
TONGUE, Tremors, Coatings, Yellow coating Promptness Movement,
PUPILS, Equality, Left larger - Size, Dilated
Response Light, Accommodation,
SIGHT, Seems good.
HEARING, Says hears well.
COORDINATION, Arms, Probably good
Legs, "
TREMORS, Hands, None Tongue,
Facial Muscles, General,
REFLEXES, Patellar, 8 - Equal. EXAM. URINE,
Other
ARTICULATION, Want talk now.
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, No murmurs.
Probably hypertrophied - Sounds rather muffled -
LUNGS, Normal -
GYNAECOLOGICAL EXAM., Not examined
MENSTRUATION,
OPHTHALMOSCOPIC EXAM.,

TAKEN,

HABITS, Dirty, Clean, Careless,
BOWELS, Normal, Constipated, ✓ Irregular,
APPETITE, Good, Medium, Capricious Poor,
SLEEP, Good, Poor, ✓ Irregular,
PULSE, 80 Resp., Temp., F. 11:2
CRANIAL MEASUREMENTS, Circ. (Horiz.) 21.5 in Circ. (Vert.) 25 in Nasal 11 in Bizygomatic 13.5 in Ant. Post. 19 Cm. Cor. Transverse 15 Cm. Bimastoid 13.2 Cm.
HISTORICAL,
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations,
Father or Pat. Relations,
Brothers or Sisters,

Personal and Medical History of Annie Nelson.

This patient was brought here by Deputy Sheriff M. K. Williams, attended by M.E. Williams with the following history:- Patient is in fair physical condition: No history of consanguinity or heredity: This is first attack & first symptoms were manifested Sept. 1 1896 by pain in stomach,- Dyspepsia. Delirious. Disease seems increasing. Not variable & no rational interals: Derangement shown in religion - is praying continually for relatives: In habits patient is not suicidal, filthy or destructive: No peculiarities previously shown: No history of intemperance in self or parents or of severe disease or injury to head. Cause of disease is supposed to be worry. No treatment pursued. As to confinement - no particulars given. On personal examination patient is constantly praying.

On admission

Nurses Notes. Sept 12: Patient received on ward, bathed & put to bed Very restless. Slept 1½ hrs. Noisy when awake. Sept 13. Temperature 99.8. P. 104. R. 30. Appetite good: sleeping dose given. In room all day: restless & noisy: bowels constipated: Slept 4 hrs. Sept 14. T. 99.6. P. 90. R. 18: Appetite good: cathartic given: did not sleep: noisy most of night: struggles most of time: quite violent: destroyed clothing: Sept 15: T. 101. P. 98. R. 20. Appetite good: cathartic given: Slept one hour. extremely noisy most of night: quite violent: very excited: bowels constipated: In room all day: Sept 16. Appetite Good. Slept 4 hrs: Quite violent: very excited: bowels constipated: Transferred to C 1.

Sept 17 T. 101. Appetite good: powder given. Slept 3 hrs: out of bed most of night: enema given: Slight movement: struggles a great deal: quite noisy: Hot bath with cold applications to head. Sept 18. Appetite good: hot bath given with cold applications to head: Quiet 1 hr. Very excited & noisy: In restraint 12 hrs. Slept 4 hrs. Sept 19. Ate breakfast- refused dinner: was given milk. Bowels regular Slept three hrs: two hot baths given with cold applications to head. Quite disturbed: In restraint 18 hrs.: refuses to swallow solid food. Sept 20 T. 8 a.m. 100. 4 p.m. 100.2: Ate a little breakfast: milk & egg nog given. also Castor oil given: In restraint 14 hrs. Alcohol bath: cold applications to head: In bed all day: Mouth washed with Sol. of Listerine: disturbed & violent at times. Sept 21. T. 98.8 P. 90. R. 20. Milk & egg nog given: also powder given: Slept 4 hrs.: Alcohol baths given with cold applications to head: bowels moved freely: In restraint 18 hrs: Mouth cleansed with Listerine. Sept 22. T. 10 a.m. 99.8. 5 p.m. 100.4 P. 98 R. 20. Ate dish of oat meal, also took milk, gruel & egg nog. Hyp. Str. given. Did not sleep. In restraint 16 hrs.: Alcohol bath: very excited: mouth

Personal and Medical History of

washed with Listerine. Sept 23. T. 101. Appetite improving: hyp. str. given, also powder very excited: hot bath with cold applications to head: pulse very weak. Patient very weak after bath: Slept 4 hrs.: mouth washed Listerine. Sept. 24. 9 a.m. T. 100.4. P. 100. 4 p.m. T. 100.2. Given milk, egg nog & beef juice. Also given hyp. str. & powder. In restraint 19 hrs. Slept 3 hrs.: very weak. but struggles a great deal when out of restraint: Slight movement of bowels: alcohol baths. Sept 25: T. 101. P. 100.: milk & egg nog given. also hyp. str. & digitalis: Slept none: enema given: slight movement: very weak: alcohol bath: back dusted with bor. acid: Pulse very rapid. Sept 26. T. 101.6. Given egg nog & beef juice: also digitalis, hyp. str. & brandy. Alcohol bath: very weak, restless, pulse rapid & weak: mouth washed: Back dusted with bor. acid: did not sleep any. Sept 27. Very weak, but restless. refuses any nourishment. 12:45 p. m. Died.

Physician's note Patient died in Acute delirious mania though there was more of the element of exhaustion in it than is usual. She did not take nourishment well. Most of treatment & the course of the disease given above. There was no prominent physical ailment.

Died

Personal and Medical History of Susan Carlson

LEIGHT, FISHER & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4526
Residence, Houston, Minn.
Date Admission, September 15 1896.
Admitted by, Dr. R.M. Phelps. Hour, 11 A.M.
How Sent, Thomas Ryan, J. of P. Houston Co.
Sex, - Female -
Age, - 33.
Civil Condition, Single.
Children, none.
Age Youngest Child, - -
Occupation, Housekeeper (Father farmer)
Degree Education, limited (can read & write)
Profession Religion, Yes. Lutheran
Habits, Not intemperate.
Nativity, Sweden (Parents also born there)
Physicians Committing, E.B. Johnston & W.M. Freeman.
Correspondents, N.H. Forsyth & Mrs Parish. Guardians.
Physician Outguard.

No. for Year, 59.
Insane Relatives, 2 sisters insane Father mal minded
Cause Exciting,
Cause Predisposing, Heredity.
Form, Acute Mania
Accompanying Bodily Disorder, Headaches, sleeplessness, weakness
Suicidal or Not, - Not -
Date of this Attack, Not stated (recent)
Duration, Not stated (short)
No. of Attack, 1st.
No. of Admissions, 1st
Age First Attack, 33 probably
Time of Leaving, Nov. 12. 1900
Time in Hospital, 4 yrs. 1 mo. 28 d.
Result, Died Tuberculosis Pulmonalis.

Exam. by R. Phelps 9/17/96

EXAMINATION ON ADMISSION
MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Very mild & confused.
Quick or Sluggish,
MEMORY:
Past Events, Impaired
Recent Events, "
Special Subjects, "
PERCEPTIVITY:
Alert or Dull,
Correct or Illusive, Illusive
REASONING POWER:
Ordinary Subjects, -
Own Mental State,
Special Subjects, Impaired

GENERAL DESCRIPTIVE REMARKS:
Very maniacal, noisy & wild. Incoherent in talk - Many delusions. Thinks she is going to be killed.

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed,
DELUSIONS: Very many
Systematized or Not,
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent, Very wild & incoherent
Voluble or Reticent, Maniacal

Personal and Medical History of Susan Carlson

EXAMINATION ON ADMISSION, CONTINUED.
PHYSICAL CHARACTERISTICS.

HEIGHT, 4 ft. 10 in. WEIGHT, 116 lbs. NUTRITION, Impaired - pale.
WOUNDS OR ABNORMALITIES, None Condition of skin - Hot & dry.
TONGUE, Tremors, — Coatings, Coated Promptness Movement,
PUPILS, Equality, Equal Size, Dilated
Response Light, Accommodation,
SIGHT, Seems good.
HEARING,
COORDINATION, Arms, Seems normal
Legs, "
TREMORS, Hands, — Tongue, —
Facial Muscles, — General, —
REFLEXES, Patellar, Could not be taken
Other
ARTICULATION,
Slurred, Prompt.
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, No Murmurs. Regular. Very rapid.
LUNGS, Normal


4526

TAKEN,

EXAM. URINE, Sept. 17'96
Color Yellowish red.
Character Cloudy flaky sediment
Amt per hrs. XXXVIII 3/4
Sp. gr. 1012
Reaction Acid
Albumen Trace by Tanrets
Sugar None.
Microscop. Amor. urates, some pus & few blood corpuscles, large amt. bladder epith. cells & oxolate of lime crystals.

GYNAECOLOGICAL EXAM., Uterus retroverted & immovable. Otherwise normal.
MENSTRUATION,
OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated, ✓	Irregular,
APPETITE, Good,	Medium,	Poor,
SLEEP, Good,	Poor, Restless & disturbed at night	Irregular,
PULSE,	Resp.,	Temp.,

CRANIAL MEASUREMENTS, Circ. (h) 54 - (v.m.) 63½ R. oc. a. 34 Bin. a 32. Ant. p. d. 19.2 Lr. d. 15.2 Bin. d. 13.8 Tr. d. 9

HISTORICAL,
LENGTH OF INVASION, — ONSET GRADUAL OR SUDDEN, —
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, —
Father or Pat. Relations, —
Brothers or Sisters, —

Personal and Medical History of Susan Carlson.

This patient was brought by Chief N. H. Forsyth, attended by Mrs. Parish, with the following history:- patient is in fair physical condition:- First symptoms of this attack were manifested by headache sleeplessness, weakness & constant prayer: Disease seems increasing: is unable with rational intervals. Derangement now shown on religion. Patient has shown no disposition to injure others or to filthy or destructive habits. Father of patient was weak-minded & easily excited to anger & two sisters are insane. Before accession of disease patient avoided company. There is no history of intemperance in ley or family; no severe disease or head injury. During past week patient has been watched has also been seen by physician - On personal examination patient much depressed. On admission was put on B2 w. (G.H.R. Rpt Complexion dark; hair brown; eyes gray; Condition of skin normal; No marks or scars but bruises noticed on both legs. It is clear there is a protrusion on back of head as if skull had been fractured - Is very disturbed. resisted being bathed - Has delusions, thinks people want to kill her.)

Summary First 14 Days. Patients temperature taken irregularly; for the first three days about normal - Sept. 19th goes up to 103 3/5°. Has been rather maniacal from the start: approximates acute delirium at this stage, increasing in violence, struggling, & has had to be fed several times with tube. Has received medicine which she has occasionally refused. Has had hot bath with cold to the head and other treatment. On the 19th was put in restraint. Sept 20. Temperature 102: patient ate a little: less noisy: Sept 21. Temperature ranged from 102 - & 103: Out of restraint: received sponge baths: rather noisy. Sept. 22-25. Temperature ranged 101-102: Up & around the ward a good deal of the time: rather maniacal in behavior, although growing more quiet. Slept better. Original Record Preserved.

Physician's Note - Patient quite deserves the name Acute Delirious mania. Is getting more quiet. Physical state, aside from the mental, shows no marked symptoms.

Oct. 30 Summary Nurse's Notes by Dr. L. L. Phelps: Quiet: eats & sleeps well: Habits clean: bowels constipated: Very stubborn & refuses to go riding & walking: Nov 7th No change.
Dec. 9th Habits clean: no mental change: Jan. 7th Appetite poor: bowels constipated: Pale & has been losing flesh: very cross & obstinate: Answers questions but otherwise
1899 will not speak: Does no work: Jan. 15th 99 Fed with tube the past few days:
Feb. 8 Transf. to B2: Behavior very stubborn: appetite fair: Feb. 18th 99 Transf to B1: menstr. regular: Appetite fair: stubborn: May 9th: Appetite fair: bowels regular: Does no work: Quiet: Aug 11th 99 Transf to Inf.: Appetite has been very poor: Has been fed by nurses: takes no out door exercise: Seems to be failing: emaciated & pale: coughs & expectorates a great deal. Continued by Dr. P. M. Phelps. Patient will not talk. Coughs & expectorates at times: rather stupid in behavior. Feb 14 '99 Fed by tube. Apr 21 Wt. 109# Aug 6 Wt. 109#

Personal and Medical History of

1899
Sept 16 98 Trans. to C3. Sept 27 Visited by brother. Jan 28 99 Still quite stupid & demented in behavior, will talk almost none, appears, however, in usual health.
1899 Mch 1 - Aug 31 99. Cont. by Dr. Bebb. General health has failed somewhat: Appetite poor: sometimes refuses to eat meals & is fed by nurses: Does not sleep well & occasionally out of bed all night. Appears to be sleeping standing up at times but refuses to go to bed: Takes out door exercise: Rather untidy in habits but fairly neat in appearance: Is very quiet if not disturbed but is inclined to resist & even become violent when requested to do anything she does not wish. May 2-3 Complained of nausea & diarrhoea & refused meals: Took fair amount of milk: Patient talks very little: Usually sits on corner of bench all day & Expectorates profusely on floor: Menstr. regular: Frequently requires sleeping dose.
Sept 1 - Feb 28 1900. Dr. Feyerdale) Neat, appetite fair, will eat when watched by nurses: Bowels regular: Takes out door exercise: Coughs some: Jan 14 1900 Attempted to escape when out riding. Jan 13. Attempted to steal nurses keys - Feb 28 Refuses medicine: Is failing somewhat in health.
Mch 1. Nov 30 1900. Dr. Coughs & expectorates: Talks only when angry: Appetite quite good: Very stubborn at times - Mch 14 Attempted to escape when nurse opened door & when brought back fought nurses. Apr 17. Again attempted to escape: June 6 Visited by brother: Attempted to escape July 1 - do. July 21 Vaccinated Aug 9 Attacked nurses when undressed. Bowels regular: coughs & expectorates a great deal - Oct 21 Appetite very poor: Very much emaciated. Nov 8 Failing rapidly: Put to bed - Nov 9. Took but little nourishment. Nov 11 Growing rapidly weaker. Nov 17. Died at 9 AM - Tuberculosis Pulmonalis

Died

Personal and Medical History of Eline Jensen.

LEIGHTY, PICKLER & CHAMBERLIN, DAVENPORT, IOWA.

Whole No. 4530.
Residence, St Paul, Minn.
Date Admission, 17 September, 1896.
Admitted by, A. R. M. Phelps Hour, 6.45 PM.
How Sent, S. Milnich, J. of P. Ramsey Co.
Sex, Female.
Age, 38.
Civil Condition, Married.
Children, Five living (3 dead also)
Age Youngest Child, 5 years.
Occupation, Housewife.
Degree Education, Common School.
Profession Religion, Not a church member
Habits, Not intemperate.
Nativity, Sweden (Parents Swedes)
Physicians Committing, Jno. C. Nelson + Talbot Jones.
Correspondents, J.P. Jensen St. Paul Minn.

No. for Year, 63.
Insane Relatives, None.
Cause Exciting, Not known.
Cause Predisposing, — —
Form,
Accompanying Bodily Disorder, None mentioned.
Suicidal or Not, Never attempted - propensity active.
Date of this Attack, Seven months ago.
Duration, Seven months.
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, 38.
Time of Leaving, Nov. 13, 1896.
Time in Hospital, 1 mo. 26 da.
Result, Discharged May 5: 97. Improved.

EXAMINATION ON ADMISSION

MENTAL CHARACTERISTICS.

Exam. by A.R.M. + Jno. Phelps. 9/17/96.

MENTAL ACTIVITY:
Clear or Confused,
Quick or Sluggish, Quite quick.
MEMORY:
Past Events, Apparently fair.
Recent Events,
Special Subjects,
PERCEPTIVITY:
Alert or Dull,
Correct or Illusive,
REASONING POWER:
Ordinary Subjects, Apparently fair
Own Mental State,
Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Patient said to have worried about coming to this country for 13 yrs. ever since coming over. Is has been somewhat melancholy for years + lately full of ideas of jealousy. Has heart murmur but physically does not show any impairment resulting from same. Can't get her to talk freely. She accused her husband of something + he said she was crazy.

EMOTIONAL STATE: —
Normal, Calm,
Indifferent,
Exalted,
Depressed,
DELUSIONS:
Systematized or Not, Won't tell them in detail to-
Special Subjects, day. Evidently about her
Transitory or Not, husband.
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent, Reticent

Personal and Medical History of Eline Jensen.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5ft 3in. WEIGHT, 150 lbs. NUTRITION, Seems fair.
WOUNDS OR ABNORMALITIES, None noted. Condition of skin good.
TONGUE, Tremors, Coatings, White coatings, indented edges. Promptness Movement,
PUPILS, Equality, Equal. Size, Normal.
Response Light, Responds. Accommodation, Responds.
SIGHT, Good. Eyes - Normal.
HEARING, Good.
COORDINATION, Arms, —
Legs,
TREMORS, Hands, Some fine tremor Tongue,
Facial Muscles, General,
REFLEXES, Patellar,
Other
ARTICULATION, Normal.
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART,
Mitral regurgitant.
LUNGS, Normal.
TAKEN,

EXAM. URINE, Oct 1896
Color Reddish yellow
Character Cloudy
Amt. 24 hrs. XXI oz
Sp. gr. 1030
Reaction Acid
Albumen Trace by Tanrets
Sugar None.
Microscop. Amor. urates, bladder + vaginal Epith. cells - Triple phos. crystals.

GYNAECOLOGICAL EXAM., Dept. M. Pregnant about 2 months. Troubled nausea + vomiting - Constipation
MENSTRUATION, absent since July.
OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated,	Irregular,
APPETITE, Good,	Medium,	Poor, ✓
SLEEP, Good,	Poor, Last night.	Irregular,
PULSE,	Resp.,	Temp.,

CRANIAL MEASUREMENTS, Circ. (H) 56 (F.M.) 67. Naso. oc. arc 36 Fm.a. 32. Aup.d. 19.5 Trans.d. 15.6 Bimd. 13.4 Zy. 12.6
HISTORICAL, Has headaches a good deal - Very hard - Dizzy at times.
LENGTH OF INVASION, Melancholy for years ONSET GRADUAL OR SUDDEN, Very gradual.
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Denies any - Sister has headaches as child.
Mother or Mat. Relations, dead
Father or Pat. Relations, Healthy
Brothers or Sisters, Brother + 2 sisters - are right - 5 children 5 to 15 yrs.

Personal and Medical History of Elise Jensen.

This patient was received at the hands of Cheney Chapel, attended by husband of patient with the following history:- Patient is in fair physical condition:- This (first) attack was manifested seven months ago by jealousy + delusions of spirits. The disease seems stationary + variously with irregular rational intervals. Derangement is now shown by "delusions in general unfounded jealousies". Patient has shown no disposition to injure others or to filthy or destructive habits: Patient has been melancholy for many years; was never satisfied to make her home in America: Her father was intemperate. There is no history of severe disease or head injury Cause of disease not known: No treatment, restraint or confinement has been employed. On personal examination nothing further mentioned.

On admission was put on B 2 W. (Ht N. Pat Complexion dark: Hair partly gray: Eyes gray: Condition of skin normal- No marks scars or bruises noticed: Is clean: Behavior quiet: Has delusions.-)

Summary First 14 Days. Temperature taken during first week practically normal: Appetite uniformly good: Considerable medicine taken for constipation, including Cascara, also received tonic daily: Patient in bed the first few days: vomited several times + seemed somewhat sick: was able to answer questions fairly well and with fair accuracy, though was uniformly quite melancholy. Slept poorly the first two nights but during the last part of the time quite well. Second week became quite neat took out door exercise, seemed to feel quite well in every way. Delusive ideas do not appear at all prominent. Original record preserved.

Physician's note. Patient on ward + behaving quietly + well. Has a certain reserve + melancholy. However. Has probably some delusions in reserve, though says not + seems fairly clear. Has very much improved. Was crying + melancholy at time after entrance.

Nov. Summary Nurses' Notes by Dr. S. L. Phelps:- Quiet + agreeable on ward: talks quite sensibly: no delusions noted: Nov. 13'76 Went Home: mentally appeared to be quite well: appetite very good: usually slept well: at times complained of head ache.

Discharged.

Personal and Medical History of

Personal and Medical History of Augusta Wagner.

LIBERTY, FISHER & HOAGWORTH, DAVENPORT, IOWA.

Whole No. 4536.
Residence, Moorestown, Minn.
Date Admission, 22nd September 1896.
Admitted by, Dr. R.M. Phelps Hour, 6:45 PM.
How Sent, R.A. Mott. Jof C. Rice Co.,
Sex, Female.
Age, - 38 -
Civil Condition, Married.
Children, Eight.
Age Youngest Child, 17 months.
Occupation, Housewife (Husband farmer)
Degree Education, - Common school -
Profession Religion, - Evangelical -
Habits, Not intemperate.
Nativity, Minn. (Parents' Germany)
Physicians Committing, Roscoe N Jackson, + D.M. Cool.
Correspondents, None given on papers.

No. for Year, 69
Insane Relatives, - None.
Cause Exciting, Suppressed Menstruation
Cause Predisposing, Probably previous attack.
Form,
Accompanying Bodily Disorder, Suppressed menstruation
Suicidal or Not, Yes - (attempted to cut throat)
Date of this Attack, One week ago.
Duration, About one week.
No. of Attack, 2nd
No. of Admissions, 2nd
Age First Attack, 25 years old.
Time of Leaving, Nov. 8, 1899
Time in Hospital, 3 yr. 1 mo. 17 d.
Result, Discharged May 2, 1900 Improved

EXAMINATION ON ADMISSION

Exam. by R.M. + S.L. Phelps 9/25/96. **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:
Clear or Confused, Confused
Quick or Sluggish, Sluggish
MEMORY: Impaired
Past Events,
Recent Events,
Special Subjects,
PERCEPTIVITY:
Alert or Dull,
Correct or Illusive, Partially correct.
REASONING POWER:
Ordinary Subjects,
Own Mental State, Impaired.
Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Most of time is very quiet - Has brn during periods of 1 to 3 hrs. very Maniacal - Quiet + rational in form now. Says sometimes, she feels mean in her head + is afraid she will hurt someone. Seemingly her impression idea is to hurt someone - but she also injures herself.

EMOTIONAL STATE: Sudden spells of evil
Normal, Calm, + maniacal behavior.
Indifferent,
Exalted,
Depressed,
DELUSIONS:
Systematized or Not,
Special Subjects,
Transitory or Not, Many + varied.
HALLUCINATIONS: Of sight.
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

Personal and Medical History of Augusta Wagner.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 5 in. WEIGHT, 113 lbs. NUTRITION, Fair.
WOUNDS OR ABNORMALITIES, Arms + knees bruised.
TONGUE, Tremors, Coatings, Coated Promptness Movement,
PUPILS, Equality, Equal. Size,
Response Light, normal Accommodation,
SIGHT, Seems good -
HEARING,
COORDINATION, Arms, Normal.
Legs,
TREMORS, Hands, None Tongue,
Facial Muscles, General,
REFLEXES, Patellar, Normal.
Other
ARTICULATION, Normal.
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, No Murmurs - Sounds fair. Regular.
LUNGS, Breath sounds Bronchial
TAKEN,

EXAM. URINE, Sept 30/96
Color. Pale yellow.
Character Cloudy flaky deposit
Amt. 24 hrs. 3 XXX
Sp. Gr. 1017
Reaction Acid
Albumen Trace by heat + Lactic -
Sugar None.
Microscop. Amon. urates, triple phosphates a few pus corpuscles + bladder epith. cells.

GYNAECOLOGICAL EXAM., Oct 28' Uterus in normal position but bound firmly by adhesions on left side - Endometritis - slight Ovarian cysts - otherwise normal.
MENSTRUATION, Menstruation absent 2 years.
OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated, ✓	Irregular,
APPETITE, Good, ✓	Medium,	Poor,
SLEEP, Good,	Poor, ✓	Irregular,
PULSE, 108	Resp.,	Temp.,

CRANIAL MEASUREMENTS, Circ. (h.) 52 (r.m.) 50½ R. c. a. 34 Bi. a. 32½ Ant. p. d. 17.8 Trans. d. 15 Bi. d. 108 F. h. 10.8
HISTORICAL, Had typhoid fever when young.
LENGTH OF INVASION, Chronic case ONSET GRADUAL OR SUDDEN, Gradual.
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, living - healthy
Father or Pat. Relations, died Consumption.
Brothers or Sisters, 4 sisters + 1 brother - Children healthy

Personal and Medical History of Augusta Wagner

This patient was received at hands of Sheriff Jno T. Wagner with the following history:- Patient is in fair physical condition. This is apparently 2nd attack, a former one occurring in 1883 when patient was in this (Rochester) Hospital for eight months. First symptoms of this attack are manifested about a week ago by hallucinations + illusions; disease seems increasing, Variable with irregular rational intervals. + is manifested by hallucinations + illusions - sees the Devil + hears voices. Patient has attempted to injure others + also to cut her throat. suicidal propensity is active: is not filthy or destructive. No history of heredity or consanguinity: No peculiarities previously shown: No history of intemperance or of severe disease or head injury. Cause of disease supposed to be Suppression of menses; patient has not been confined + has received no Treatment. On personal examination:- Patients lips are bitten + swollen: throat marked by hands. Violent outbreaks of struggling to escape from the Devil.

Note As above stated patient was confined in this Hospital from Feby until October 1883. during first part of stay was very noisy violent + troublesome - gradually quieted down + was finally discharged recovered. (For further notes see Vol. 3 page 32, No. 393)

On admission was put on B2 M. (Gen. Rpt) Complexion dark: hair brown: Eyes gray Condition of skin normal. Bruises on arms + knees. Is rather dirty: Quiet but at times is violent: Has delusions.)

Summary First 14 Days. Temperature taken during first week is practically normal, ranging from 98 to 99 4/5: appetite is good through out: received several cathartics, also a tonic to be taken regularly: no Symptoms of physical impairment are noted: As regards behavior, patient is not so very nervous: had spell of violence at 5 a. m. was put in restraint: next night awoke all night: in restraint: talked quite sensibly during next day: was kept in restraint all night for several nights, behavior being usually quiet during the day. About 5th day was up + ~~what up~~ and was out of doors. Behavior fairly good during the rest of the two weeks. Original records preserved.

Physicians Report. Patient had several maniacal spells in the first 2 or 3 days: In them would struggle to extreme to harm herself or some one else: These came suddenly and without warning: lasted several hours. Was in constant constraint when out of them for fear would hurt some one: was seemingly clear however except for this fear: Lately has been quiet: rather melancholy and reserved, though without definitely expressed delusions: possibly has some, possibly only sorrow at her trouble.

Oct 28 Summary Nurses Notes by Dr. S. L. Phelps:- Gyn. examination made + treatment given
Oct 31 Very bad this afternoon: put in seclusion. Oct 31 In seclusion all day: quite noisy + violent:

Personal and Medical History of Augusta Wagner

1896
Nov 1 In seclusion the last two days: transf. to 6th. Appetite good: bowels irregular: Dec 9 Very noisy night + day: Fights nurses: requires 4 or 5 nurses to manage her: Jan 12 97 much quieter than on
1897 admission but at times is very violent + cannot be trusted: occasionally talks sensibly:
Mar. Appetite good: noisy part of time: habits dirty: works on ward some: very violent at times
Mar 30 In restraint during night: May 1st 97 Quite noisy part of night: violent + destructive at times:
Appetite good: July 97 About the same: Aug 97 Visited by sister + daughter: behavior very good
Aug 1 Mental condition seems to be slowly improving: Appetite good: works on wards some
also in dining room: sleeps quite well + goes riding + walking. Continued by Dr. Wm. Phelps
Continued by Dr. Rm. Phelps. Oct 30 97 General health fairly good: Works some: behavior
good + is fairly rational. Dec 23 Visited by husband: Dec 24 Taken home.
Dec 25 98 Returned to day: very violent on way home. Face + arms were bruised
Dec 29 98 lip + about ward again today. Behavior about as before leaving. June 4 Abscess
which formed on side of face lanced. Feb 24 M. 122 Visited by husband + sister
Trans: to 6s. Sept 23 Visited by husband + daughter. Nov 20 No working in
ward. Feb 6 99 During past year patient has become a little cleaner in mind +
talks more freely. but is rather queer in manner + husband is still afraid to
try her at home. (Cont. by Dr. P. A. Bibb) May 16 - 22 - 28 Visited by husband:
May 18 By daughter. Apr 2 Menstr: Apr 19 Mild attack of diarrhoea: neat in
habits and appearance: assists in kitchen: complains a great deal of not feeling well: appetite good: sleeps well: quiet: takes out door exercise: Apr 30 Visited by friend: Apr 27 Complained of pain in chest + head: Assist in Steward's
kitchen: Quite agreeable: Trans. to A2 W. Quiet + cheerful: converses readily:
Appetite good: bowels constipated. May 30 - 31 Visited by husband: June 15 By friend:
July 4-5 By husband: July 13 No change: When transferred to infirmary became quite
excited: for few hours was irritable and resistive attacked nurses and tried to siege
razor: was quite composed in conversation + was found chewing razor: This disturbed state was again manifested after operation: inclined to interfere with
dressings unless closely watched. July 14 Trachelorraphy + perineorraphy done: first week
much of time complained of considerable distress in stomach: nausea + emesis:
also complained of considerable pain in back: dressings changed very frequently:
later distress in stomach subsided: still complained at times of pain in abdomen:
Aug. Stitches removed from perineum: commenced to sit up: Second operation
- Ventrofixation - performed Aug 7 - Both ovaries were diseased and removed:
Reaction from this operation better: retained nourishment better: complained
of some pain in head and stomach, but on the whole rested quite well during day + slept well at night: occasional emesis: Sept 7 Slight in-
flammation noticed about some of the stitches: Wet compresses applied:
Sept 10 Commenced to sit up: Sept 18 Dressed + out on ward: Gradually becoming
stronger physically: appetite good: bowels quite regular: sleeps well.

(See p. 356)

Personal and Medical History of Amelia Meyers.

Whole No. 4545.
Residence, Winona, Minn.
Date Admission, October 2nd 1896.
Admitted by, Dr H.H. Kryog Hour, 4 P.M.
How Sent, H. L. Buck J of P Winona Co.
Sex, - Female -
Age, - 60 -
Civil Condition, Married.
Children, Seven -
Age Youngest Child, -19 yrs old.
Occupation, Housewife (Husband was Footmaker, now in Soldiers Home.
Degree Education, Fairly good.
Profession Religion, Yes Congregational.
Habits, Not intemperate.
Nativity, Ohio (Parents Germany)
Physicians Committing, Franklin Staples + J.B. McGaughey
Correspondents, Millard Meyers (Son) 116 W. Mark St. Winona, Minn.

No. for Year, 78
Insane Relatives, Brother insane.
Cause Exciting, Not known.
Cause Predisposing, Probably Heredity
Form,
Accompanying Bodily Disorder, None mentioned.
Suicidal or Not, Not.
Date of this Attack, Not stated.
Duration, not given (a number of years)
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, not given.
Time of Leaving, Sept. 24, 1897
Time in Hospital, 11 mo. 25 da
Result, Died. Exhaustion in Chronic Mania.

EXAMINATION ON ADMISSION
MENTAL CHARACTERISTICS.

Exam. by P.M. + L.L. Phelps 10/5/96.

MENTAL ACTIVITY:
Clear or Confused, Very Confused.
Quick or Sluggish,
MEMORY:
Past Events, Impaired.
Recent Events, "
Special Subjects, "
PERCEPTIVITY:
Alert or Dull,
Correct or Illusive,
REASONING POWER:
Ordinary Subjects, Much Impaired
Own Mental State, "
Special Subjects, "
GENERAL DESCRIPTIVE REMARKS:
Maniacal + excited. Talks in an incoherent manner - almost constantly. Noisy + has many delusions.

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted, ✓
Depressed,
DELUSIONS:
Systematized or Not,
Special Subjects,
Transitory or Not, Many + various.
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

Amelia Meyers.

In case of death of Amelia Meyer - Telegraph Mrs. W. H. Taylor. Winona - 5th Wash. St.

...ION, CONTINUED.
...ERISTICS.

NUTRITION, impaired.
Promptness Movement,
...mmodation,
...ecific.
HEARING, Says good.
COORDINATION, Arms, -
Legs, -
TREMORS, Hands, None
Facial Muscles, "
REFLEXES, Patellar, Normal.
Other
ARTICULATION,
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, No murmurs Sounds mak+ disp+ated one chest. Size enlarged. Apex beat rem+d toward mid line. Chest. Hollow.
LUNGS, Breath sounds somewhat bronchial
Tongue, None
General, "
TAKEN,

EXAM. URINE, Oct 8'96
Color Reddish Yellow.
Character. Heavy pink flaky deposit
Amt. 24 hrs. XXXIX ℥
Sp. Gr. 1028
Reaction. Acid.
Albumen Trace by Tauretz
Sugar None.
Microscop. Large quantity Amor. urates + Mucine bands - ox. of lime Bladder + vaginal Epith. cells.

GYNAECOLOGICAL EXAM., Nov. 20. Uterus retroverted + bound on both sides + posteriorly by adhesions - urethritis. rectum prolapsed at times
MENSTRUATION,
OPHTHALMOSCOPIC EXAM.,
HABITS, Dirty, Clean, Careless,
BOWELS, Normal, ✓ Constipated, Irregular,
APPETITE, Good, Medium, Poor, ✓
SLEEP, Good, Poor, ✓ Irregular,
PULSE, 108 - Mark. Resp., Temp.,
CRANIAL MEASUREMENTS, Circ (h) 55½ (v.m) 63 N.-o.a 33 Z-a. 32½ Ant.-p.d. 19 Transv.d. 15.3 Bi-a.d. 13.2 L.d. 10.5 (No Teeth)
HISTORICAL,
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Can't tell us.
Mother or Mat. Relations,
Father or Pat. Relations,
Brothers or Sisters,

Personal and Medical History of Amelia M[illegible]

Whole No. 4545.
Residence, Winona, Minn.
Date Admission, October 2nd 1896.
Admitted by, Dr H.K. Herzog Hour, 4 P.M.
How Sent, H. L. Buck J of P Winona Co.
Sex, - Female -
Age, - 60 -
Civil Condition, Married.
Children, Seven -
Age Youngest Child, -19 yrs old.
Occupation, Housewife (Husband was bookseller, now in Soldiers Home.
Degree Education, Fairly good.
Profession Religion, Yes Congregational.
Habits, Not intemperate.
Nativity, Ohio (Parents Germany)
Physicians Committing, Franklin Staples + J.B. McGaughy
Correspondents, Millard Meyers (Son) 116 W. Mark St. Winona, Minn.

No. for Year, 78
Insane Relatives, Brother insane.
Cause Exciting, Not known.
Cause Predisposing, Probably Heredity.
Form,
Accompanying Bodily Disorder, None mentioned.
Suicidal or Not, Not.
Date of this Attack, Not stated.
Duration, not given (a number of years)
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, not given.
Time of Leaving, Sept. 29, 1897
Time in Hospital, 11 mos. 25 da
Result, Died. Exhaustion in Chronic Mania.

EXAMINATION ON ADMISSION

Exam. by A.M. + E.A. Phelps 10/5/96. **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:
Clear or Confused, Very Confused.
Quick or Sluggish,
MEMORY:
Past Events, Impaired.
Recent Events,
Special Subjects,
PERCEPTIVITY:
Alert or Dull,
Correct or Illusive,
REASONING POWER:
Ordinary Subjects, Much Impaired
Own Mental State,
Special Subjects,
GENERAL DESCRIPTIVE REMARKS:
Maniacal + excited. Talks in an incoherent manner - almost constantly. Noisy + has many delusions.

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted, ✓
Depressed,
DELUSIONS:
Systematized or Not,
Special Subjects,
Transitory or Not, Many + various.
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

Personal and Medical History of Amelia Meyers.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 4½ in. WEIGHT, 130 lbs. NUTRITION, impaired.
WOUNDS OR ABNORMALITIES, —
TONGUE, Tremors, Coatings, Dry Promptness Movement,
PUPILS, Equality, Size,
Response Light, Accommodation,
SIGHT, Impaired. Eyes. Arcus senilis.
HEARING, Says good.
COORDINATION, Arms, —
Legs, —
TREMORS, Hands, None Tongue, None
Facial Muscles, " General, "
REFLEXES, Patellar, Normal.
Other
ARTICULATION,
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, No murmurs Sounds weak + disputed on chest. Size enlarged. Apex beat removed toward mid line Chest. hollow.
LUNGS, Breath sounds somewhat bronchial

TAKEN,

EXAM. URINE, Oct 8'96
Color Reddish Yellow.
Character. Heavy pink flaky deposit
Amt. 24 hrs. XXXIX ℥
Sp. gr. 1028
Reaction. Acid.
Albumen Trace by Tsuretc
Sugar None.
Microscop. Large quantity Amor. urates + mucine bands - ox. of lime bladder + vaginal epith. cells.

GYNAECOLOGICAL EXAM., Nov. 20. Uterus retroverted + bound on both sides + posteriorly by adhesions - urethritis. rectum prolapsed at times
MENSTRUATION,
OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal, ✓	Constipated,	Irregular,
APPETITE, Good,	Medium,	Poor, ✓
SLEEP, Good,	Poor, ✓	Irregular,
PULSE, 108 - Weak.	Resp.,	Temp.,

CRANIAL MEASUREMENTS, Circ (h) 55½ (v) 37½ 63 N. o. a. 33 Bi a. 32½ Aur. p. d. 19 Front. d. 15.3 Bi. d. 13.2 F. l. 10.5 (no Fritsch)
HISTORICAL,
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Can't tell us.
Mother or Mat. Relations,
Father or Pat. Relations,
Brothers or Sisters,

Personal and Medical History of Amelia T. Meyers.

This patient was brought here by Sheriff A.N. Fuhrman, attended by Mildred Meyers, with the following history:- Patient is in fair physical condition. Symptoms of insanity were first manifested a number of years ago by wandering about without design + incoherent language. Disease appears increasing + variable + with no fully rational intervals: Derangement now shows itself in wandering away from home without object - says she is engaged in casting out devils the things attempts are made to poison her. No tendency toward filthy, destructive or suicidal habits or toward injuring others. Before accession of disease patient showed very strong religious impressions. No history of intemperance in family or self: No severe disease or head injury. Patient has not received treatment or been restrained or confined: Cause of disease is unknown. On personal examination Patient is excited - talks incoherently: says she is engaged in a religious war casting out devils etc. On admission. was put on B'r W. (G.H.N. Rpt) Complexion dark; Hair brown partly gray: Eyes brown: Condition of skin normal. On back scar- appearance of burn - Arms + legs bruised - Is dirty: behavior excited + nervous: has delusions.)

Summary First 14 Days - Temperature during first week practically normal: Appetite very capricious, even refusing meals; no symptoms of any especial physical disease were noted, although some impairment: there were a fair bruise on admission: She is very talkative and maniacal: was out of bed for the most part during the night + was very noisy: was very noisy all day, + the night of the 3rd day was out of bed all night: was slightly noisy: Night of the 5th slept 5 hrs: extremely noisy at times: very noisy + violent all day: for the rest of the two weeks ~~her~~ notes show her to be awake more or less at night: Is be extremely noisy at times + to be quite active violent + maniacal during the day: was in restraint some little portion of the time: + refused all medicine + in general seems to be in rather poor condition.

Original Record Preserved.

Oct. 19 Summary Nurse's Notes by Dr. E.L. Phelps:- Transf. to 6: Is troubled with prolapsed rectum: necessary to replace it often: Is too weak physically to have an operation for it: Nov. 19: noisy + destructive: Appetite somewhat better: bowels irregular: Nov. 30 Seems much quieter: Sleeps well: Destroys clothing during day: Set on ward: Dec. 18'96 Has developed inguinal hernia on left side: Examined in operating room: found left inguinal hernia which was easily reduced upon pressure: Jan. 6'97 Very violent + noisy, vulgar + profane in talk: usually requires close watching in the lower bay: Appetite good: bowels regular:
1897 Mar. 11 Health very poor: very emaciated + pale: In bed most of time at present: Very restless: needs watching all the time during day: In restraints at night:
May 12 Has a swelling on leg. In bed at present. May 17 Able to be up on the ward

Personal and Medical History of Amelia Meyers.

5-97

again: July 8: Visited by daughter: Was quite angry + violent in actions: Very destructive of clothing: strikes other patients: Aug. 8 Has diarhoea at present: put upon boiled milk: Aug. 8 Up + as well as usual. Sept. 1 Gradually failing: very emaciated + pale: exceedingly restless: needs watching all the time: Very incoherent in talk: Sept. 20 Failing fast: Is in bed all the time: Sept. 22 Taken out of restraint: quiet + sleeps well: Sept. 24: As usual all day: took her regular meals: Sept. 27. 97 5:25 a.m. Died.

Died

Personal and Medical History of Anna Swenson.

LARRABEE, PUSLEY & GUMBERTS, DAVENPORT, IOWA.

Whole No. 4547.
Residence, Vasa, Goodhue Co. Minn.
Date Admission, October 2nd 1896.
Admitted by, Dr. H.H. Kruzog. Hour, 7 P.M.
How Sent, Axel Hallin, J. of P. Goodhue Co.
Sex, - Female -
Age, - 52 -
Civil Condition, Married.
Children, Four.
Age Youngest Child, Sixteen years -
Occupation, Housekeeper (Husband farmer)
Degree Education, Can read -
Profession Religion, Not a church member -
Habits, Not known.
Nativity, Sweden (Parents Swedes)
Physicians Committing, E. Allen & J.V. Anderson
Correspondents, Miss Hilma Swenson (Daughter)
Box 173 Vasa, Goodhue Co. Minn.

No. for Year, 80
Insane Relatives, Not known.
Cause Exciting, Not known.
Cause Predisposing, ?
Form,
Accompanying Bodily Disorder, None mentioned.
Suicidal or Not, - Not -
Date of this Attack, About 12 years ago.
Duration, About 12 years.
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, 40 years.
Time of Leaving, Aug. 3 1899.
Time in Hospital, 2 yr. 10 ms. 1 d.
Result, Died Peritonitis Septicemia.

EXAMINATION ON ADMISSION

Exam. by R.M. & H. Phelps 10/5/96

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused,
Quick or Sluggish, Sluggish.

MEMORY:
Past Events, Impaired
Recent Events, "
Special Subjects, "

PERCEPTIVITY:
Alert or Dull, Dull.
Correct or Illusive, Illusive.

REASONING POWER:
Ordinary Subjects, Impaired
Own Mental State, "
Special Subjects, "

GENERAL DESCRIPTIVE REMARKS: Very dull & confused. Cannot carry on conversation - Mental condition evidently impaired - demented. As she speaks English very little, cannot tell accurately about her ideas.

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed, ✓

DELUSIONS:
Systematized or Not, Has many - thinks folks
Special Subjects, are trying to poison her.
Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

Uterine hemorrhages (recorded as "menstruation") occurred on the following dates - Dec. 8 - 1898. Jan. 10 - 1899. Feb. 12 - 1899.

Examination June 22 - 1899.
Urethral orifice inflamed - Laceration of perineum - External genitals otherwise normal. Uterus fixed - Bound firmly by adhesions which are numerous on left side and posteriorly. - Fewer in number but present on right side. Cervix atrophied - Hyperaemia and lateral laceration of cervix present - Uterine tissue is quite firm - and extreme tenderness is manifested over body & uterus on palpation. Exam by Dr. W.J. Mayo June 28 99. Pelvic Condition due to senile changes - advised non-interference unless uterine hemorrhages recur.

FACIAL EXPRESSION,

SENSIBILITY,

HEART, No murmurs. Sounds - extra loud.

LUNGS, Normal.

TAKEN,

GYNAECOLOGICAL EXAM., Oct 28. Uterus normal position - some endometritis & erosion of os - External genitals excoriated

MENSTRUATION, Menopause passed 5 years.

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated, ✓	Irregular,
APPETITE, Good, ✓	Medium,	Poor,
SLEEP, Good, ✓	Poor,	Irregular,
PULSE,	Resp.,	Temp.,

CRANIAL MEASUREMENTS, Cir. (h) 53½ (m) 62½ N. o. a. 32½ Bi. a. 32½ Ant. p. d. 17⅞ Transv. d. 15½ Bi. d. 13⅝ Zh. 10.7

HISTORICAL, Slight goitre on right side.

LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN, Onset

HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Cannot determine.

Mother or Mat. Relations,

Father or Pat. Relations,

Brothers or Sisters,

E, Oct 5/96
yellow

Urine 24 hrs. XXVIII 3.
Sp. Gr. 1021
Reaction Acid.
Albumen Large quantity by heat
Tannic & HNO_3 -
Sugar None.
Microscop. Amor. urates - large quantity of fus. corp. ox. of lime crystal, bladder & vaginal epith cells & trace of casts.

Personal

LIBBEY, FOLAN & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4547.
Residence, Vasa, Goo
Date Admission, October 2
Admitted by, Dr H.K. Herzog.
How Sent, Axel Hallin, J. of P. G
Sex, - Female -
Age, - 52 -
Civil Condition, Married.
Children, Four.
Age Youngest Child, Sixteen years -
Occupation, Housekeeper (Husband farmer)
Degree Education, Can read -
Profession Religion, Not a church member.
Habits, Not known.
Nativity, Sweden (Parents Sweden)
Physicians Committing, G. Allen & J.V. Anderson
Correspondents, Miss Hilma Swanson (daughter)
Box 183 Vasa, Goodhue Co, Minn.

oned.
ears ago.
ers.

No.
Age Firs. 0 years.
Time of Leavi. Aug. 3 1899.
Time in Hospital, 3 yr. 10 mo. 1 d.
Result, Died Peritonitis Purulent.

EXAMINATION ON ADMISSION

Exam. by A.M. & L. Phelps 10/5/96

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused,
Quick or Sluggish, Sluggish.
MEMORY:
Past Events, Impaired
Recent Events, "
Special Subjects, "
PERCEPTIVITY:
Alert or Dull, Dull.
Correct or Illusive, Illusive.
REASONING POWER:
Ordinary Subjects, Impaired
Own Mental State, "
Special Subjects, "
GENERAL DESCRIPTIVE REMARKS: Very dull & confused. Cannot carry on conversation - Mental condition evidently impaired - demented. As she speaks English very little, cannot tell accurately about her ideas.

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed, ✓
DELUSIONS:
Systematized or Not, Has many. thinks folks
Special Subjects, are trying to poison her.
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

Personal and Medical History of Hilma Swanson.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 1 in. WEIGHT, 141½ lbs. NUTRITION, —
WOUNDS OR ABNORMALITIES, None.
TONGUE, Tremors, — Coatings, — Promptness Movement, —
PUPILS, Equality, Robust Size, Normal.
Response Light, Accommodation,
SIGHT, Blind in left eye.
HEARING, Seems normal.
COORDINATION, Arms, -
Legs, -
TREMORS, Hands, None Tongue, None
Facial Muscles, " General, "
REFLEXES, Patellar, Both 9.
Other
ARTICULATION, Indistinct.
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, No murmurs.
Sounds - extra loud.
LUNGS, Normal.
GYNAECOLOGICAL EXAM., Oct 28. Uterus normal position - some endometritis & erosion of os - external genitals excoriated
MENSTRUATION, Menopause passed 5 years.
OPHTHALMOSCOPIC EXAM.,
HABITS, Dirty, Clean, Careless,
BOWELS, Normal, Constipated, ✓ Irregular,
APPETITE, Good, ✓ Medium, Poor,
SLEEP, Good, ✓ Poor, Irregular,
PULSE, Resp., Temp.,
CRANIAL MEASUREMENTS, Cir. (H) 53½ (Om) 62½ N. to a. 32½ Bi. a. 32½ Ant. p. d. 17.8 Transv. d. 15.2 Bi. d. 13.5 Fl. 10.7
HISTORICAL, Slight goitre on right side.
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN, Onset
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Cannot determine.
Mother or Mat. Relations,
Father or Pat. Relations,
Brothers or Sisters,

TAKEN.

EXAM. URINE, Oct 5/96
Color. Reddish yellow
Character. Cloudy.
Amt. in 24 hrs. XXVIII Z.
Sp. Gr. 1021
Reaction Acid.
Albumen Large quantity by heat & Nitric acid
Sugar None.
Microscop. Amor. urates - large quantity of fus. corp. ox. of lime crystal, bladder & vaginal epith cells & casts of uterus.

Personal and Medical History of Anna Swenson.

This patient was brought here by Sheriff P.G. Lundquist, attended by Hjelma Swanson, with the following history:- Patient is in fair physical condition. Symptoms of this (Insane) attack were first manifested about 12 years ago by running away from home & being quarrelsome: Disease seems increasing with irregular rational intervals, variable. Derangement is shown by suspicions that drinking water is poisoned - Says that there is a gas which comes into room & puts out her eyes. Patient has shown disposition to injure others. Is not filthy or destructive: No peculiarities previously shown: No information concerning history of intemperance - No severe disease or injury to head - Patient has not been restrained or confined & has received no treatment. On personal examination Very excitable, crying & laughing by turns. Tried to run away from the sheriff while under examination - Says she thinks the folks try to poison her through her drinking water.

On Admission. (Was put on B[3] W (Gt. N. Ry.) Complexion dark: hair brown, partly gray: eyes brown: Condition of skin normal: No marks, scars or bruises: Is rather deaf. Fluid in left eye. Is quiet: has delusions.)

Summary First 14 Days. Temperature taken during first week is normal: appetite good throughout the two weeks. Medicine was prescribed regularly, also several doses of Castartics. No especial physical disease is noted: was awake at night at first but later slept fairly well: was rather excited on admission: behavior later quite quiet throughout the two weeks. Soon worked some in the mending room the latter part of the time.

Original Records Preserved.

Nov. 15 1897 Summary Nurse's Notes by Dr. E. E. Phelps:- Complains of pain in shoulders: Nov. 18-19 In bed: Complains of stomach: Nov. 22-23 In bed: Very much disturbed at times. Appetite fairly good: Gen'l Health much impaired: Has albuminuria & casts in urine & complains a good deal of pain in limbs: Often sick in bed: When able helps with work: Seems very anxious to go home: Feb. 12 In bed: complains of rheumatic pains: Apr. 97 Usually quiet in behavior: neat in habits: Has delusions & at times is quite disturbed: Appetite good: Sleeps well: takes out door exercise: assists with work: Aug. 97 At times quite disturbed & talks [illegible] to self. Appetite good: Sleeps well: Gen'l Health not very good. Continued by Dr. Phelps Nov. 97 Patient doing quite well. Is comparatively quiet: Assists with ward work. Is not so stubborn as she was. Jan. 5 98 Wt. 120. July 7 Trans. to Infirmary.

Feb. 98 to Sept. 7. Patient's up on ward: appetite good: bowels regular: sleeps well: uses fair language: Menstr: Is weaker & more noisy & irritable of late: Dec. 98 to Mar. 99: In bed: complained of pain in abdomen Dec. 2: neat: at times noisy & irritable: Nov. 17 Transferred to C[3]. Assists some with ward work: conversation is incoherent, but frequently answers questions sensibly: no particular changes: July 1st Again complained of pain in abdomen: July 4 Transferred to Infirmary: Sick record kept.

Personal and Medical History of Anna Swenson

At this time showed indications of chronic Bright's disease: Has advanced heart disease with gross lesion & gross murmur: July 6 Urinalysis made revealing excessive albumen by all tests: has corpuscles & granular casts. Specific gravity 1.013. Temp. until July 18 almost continuously sub-normal - from 96[4] to 99[8] * See below. rest very much disturbed sleeping but a few hours at a time & requiring frequent sedatives for that: July 7-8 Sat up all night - coughing & expectorating: July 7-8 to Aug 3rd: No special change except gradual physical failure as condition progresses: Abdomen & limbs swollen & painful: on account of general impaired condition it was thought best not to perform paracentesis abdominalis: became more & more restless: appetite failed: lungs became involved: coughed & expectorated a great deal: obliged to sit up much of time, altho very weak: Died Aug 3rd '99 at 10:45 a.m. Was visited by daughter during illness: very melancholy & irritable: asked frequently to see daughter & daughter was sent for. * Pulse about normal: resp. rather rapid - 18 to 22 - Appetite at this time fairly good: bowels regular: receives laxatives, enemata &c. as needed: usually sleeps quite well: July 4 to 7th Complained frequently of pain in abdomen & of nausea: very restless: also complained of much pain in head: July 7 & 8th Sat up in bed most of day: slept little & moaned a great deal. July 9-18 up on ward part of each day: frequent emesis: July 15 On liquid diet: takes nourishment fairly well: complained of pain in feet: moaned a great deal. During following week temp. slightly elevated each afternoon: swelling in abdomen & limbs increasing & becoming quite painful: hot applications to abdomen & sleeping doses given as needed & liniment: also elevated & bandaged.

Died.

Augusta Wagner.

From p. 348. No 4536.

Takes out door exercise: very agreeable. Oct. 6 Trans. to A[3]: Oct. 26. Later abdominal wound did not heal well: a few stitches necessary: Dressings applied: Works in long dining room: Nov. 6-7 Visited by husband: stitches removed from abdomen & patient taken home Nov. 8. '99 in quite good physical condition: mentally much improved since Operation.

Discharged

Personal and Medical History of Inga Fretteim.

LOBERT, FIDLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4548

Residence, Kenyon, Goodhue Co, Minn.

Date Admission, October 5th 1896.

Admitted by, Dr Hotherzog. Hour, 1.45 PM.

How Sent, Axel Haller J. of P. Goodhue Co.

Sex, - Female -

Age, - Thirty - Eight -

Civil Condition, - Married.

Children, Eight

Age Youngest Child, Two Months.

Occupation, Housewife (Husband Farmer)

Degree Education, - Common School -

Profession Religion, Ev. Lutheran.

Habits, Not intemperate.

Nativity, Norway (Parents Norway)

Physicians Committing, G. C. Millum, A. W. Jones

Correspondents, None given in papers.

No. for Year, 81

Insane Relatives, Brother (no others known)

Cause Exciting, Blow upon head (supposed cause of first attack)

Cause Predisposing, Previous attack probably.

Form, Chronic Mania.

Accompanying Bodily Disorder, None mentioned.

Suicidal or Not, Not.

Date of this Attack, Two Weeks ago.

Duration, About two weeks.

No. of Attack, 5th

No. of Admissions, 4th

Age First Attack, 23 years.

Time of Leaving, Jan. 28. 1899

Time in Hospital, 2 yr. 3 m. 23d.

Result, Discharged May 3. 1899

Much Improved.

EXAMINATION ON ADMISSION

MENTAL CHARACTERISTICS.

Exam. by Dr. S. L. Phelps.

MENTAL ACTIVITY:

Clear or Confused, Confused.

Quick or Sluggish,

MEMORY:

Past Events, Impaired.

Recent Events, "

Special Subjects, "

PERCEPTIVITY:

Alert or Dull,

Correct or Illusive, Illusive

REASONING POWER:

Ordinary Subjects, Impaired.

Own Mental State, "

Special Subjects, "

GENERAL DESCRIPTIVE REMARKS: Very excitable. Mild & maniacal & incoherent in Talk.

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted, Mild & maniacal.

Depressed,

DELUSIONS: Many & various.

Systematized or Not,

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

Personal and Medical History of Inga Fretteim.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, WEIGHT, NUTRITION, Good

WOUNDS OR ABNORMALITIES, None.

TONGUE, Tremors, Slight coat ~~Coatings,~~ Promptness Movement,

PUPILS, Equality, Equal. Size, Dilated

Response Light, Accommodation,

SIGHT, Good

HEARING, Good.

COORDINATION, Arms, Normal

Legs, "

TREMORS, Hands, None. Tongue, None,

Facial Muscles, " General, "

REFLEXES, Patellar,

Other

ARTICULATION, Normal.

Slurred,

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART, No murmurs. Sounds good

LUNGS, Normal

TAKEN,

EXAM. URINE, Oct 1896

Color Yellowish red.

Character Cloudy.

Amt. in hrs. Not Taken

Sp. gr. 1021

Reaction Acid.

Albumen. Trace by heat & Nitric Acid

& large quantity by Tannic

Sugar. None.

Microsp. Large quantity Amor. Urates.

Bladder Epith. cells & pus.

GYNAECOLOGICAL EXAM., Oct 28 Uterus retroverted & bound down by adhesions. Endometritis. Lacerations of Internal laceration of perineum. Rectocele.

MENSTRUATION,

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty, Clean, Careless,

BOWELS, Normal, Constipated, ✓ Irregular,

APPETITE, Good, Medium, Poor, ✓

SLEEP, Good, Poor, ✓ Irregular,

PULSE, Fairly strong & regular. Resp., Temp.,

CRANIAL MEASUREMENTS,

HISTORICAL, Has been here several times before.

LENGTH OF INVASION, Long ONSET GRADUAL OR SUDDEN, Gradual.

HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")

Mother or Mat. Relations,

Father or Pat. Relations,

Brothers or Sisters,

Personal and Medical History of Inga Fretheim

This patient was received here at hands of Sheriff P.J. Lundquist, attended by Elling Fretheim (husband) with following history:- Patient is in poor physical condition. This is 5th attack, first coming on 15 years ago, duration of attacks from four to six months each. Patient has been admitted to this Rochester hospital three times previous to this, being discharged improved each time. First symptoms of present attack were manifested about 2 weeks ago when patient became suspicious of people, laughed incordinately & had crying spells: Disease seems increasing, variable with irregular rational intervals: Derangement is now shown by noisy, boisterous, & uncontrollable behavior, & on all subjects - no one in particular - Patient has shown disposition to injure others; is not suicidal, filthy; not destructive of clothing but has broken dishes. Patient was quick tempered before accession of disease No history of intemperance in self or parents. Cause of present attack not stated - Blow upon head supposed cause of first attack. Patient has had to be watched of late but has received no treatment. On Personal Examination - patient is irrational, excited, incoherent in speech, noisy & boisterous. Her pulse is rapid, pupils dilated, & is constipated. Four of the five attacks have followed confinements. (For further particulars on case see. Vol. 7. Fol. 173. Vol 24 Fol 365. & Vol 28 Fol. 277.) On admission Put on Br.

Summary First 14 Days. Temperature taken during entire two weeks was about normal: Appetite uniformly quite good, although first 2 or 3 days she refused food to a certain extent: refused medicine frequently, part of the time taking it: no especial physical disease was noted: Upon admission she slept quite well the first night but was rather noisy & destructive during the next two or three days: Habits were dirty: about the 8th day she was quiet for a while: During the next few days she was quiet for the most part, although had noisy spells: Has been in restraint 2 or 3 times on account of noisiness & destructiveness. Original Records Preserved

Nov. 15 Summary Nurse's Notes by Dr. S.L. Phelps:- Works on ward: Habits clean usually: Appetite good: usually very noisy during part of night: Nov. 16 Went to laundry this afternoon: Nov 24th Complains of severe headache & back ache: put to bed: Nov. 25 - bowels constipated & enema given. Nov. 28 Much better & up on the ward again: Dec. Works in laundry: mental condition improved: Jan. 12 Genl physical condition good 1899 Appetite good: Anxious to go home: works daily: talks fairly well:
Feb. 3. Went Home - Feb. 8 Returned: quite excited for a few hours: Feb. 10 Quite noisy during night: Feb. 23 Quiet most of time: able to work in laundry: appetite good: Sleeps well: Mar. 30 In bed with rheumatism: Apr. 6 Menstr. regular: no change: May 2 Quite disturbed at times: Habits neat: Appetite good: Sleeps fairly well: assists with work: Aug. 97 At times quite disturbed: no change. Continued by Dr. P.M. Phelps.
Nov. 14 97 Trans. to Annex. Rather easily excited & disturbed. Coughs some, but on the whole is

Personal and Medical History of

doing fairly well. Feb 9 Wt. 136. Sept. 27 98 Trans. to Infirmary has coughing & seemed sick the last few days. Oct. Patient expectorating considerably some dyspnoea. Nov. Patient seems to be gaining quite rapidly from her trouble July 1 98. Works in dining room. Jan 28 99 Went home on trial with brother. Has seemed less maniacal of late. Genral health fairly good.

Discharged.

Personal and Medical History of Lucinda Judd.

Whole No. 4553

Residence, Wells, Rice Co, Minn.

Date Admission, October 16th 1896.

Admitted by, Dr H. Herzog. Hour, 3:40 PM.

How Sent, R.A. Mott, Jy P. Rice Co.

Sex, - Female -

Age, - 62 -

Civil Condition, Married.

Children, - Seven -

Age Youngest Child, - 22 years -

Occupation, Housewife (Husband Farmer)

Degree Education, - Common School.

Profession Religion, Yes Episcopalian.

Habits, Not intemperate

Nativity, New York (Parents New York)

Physicians Committing, J. M. Rose & M. L. Mayland.

Correspondents, A.C. Judd, (Husband) Faribault, Minn

No. for Year, 86

Insane Relatives, Grandfather, brother & one son

Cause Exciting, Not stated.

Cause Predisposing, Heredity

Form,

Accompanying Bodily Disorder, None mentioned

Suicidal or Not, yes, propensity active.

Date of this Attack, About 3 weeks ago

Duration, About 3 weeks.

No. of Attack, 3rd

No. of Admissions, 3rd

Age First Attack, - 56 -

Time of Leaving, June 21. 1897

Time in Hospital, 7 mo. 5 da.

Result, Discharged Nov. 3. 1897 Improved.

EXAMINATION ON ADMISSION

Exam Oct. 20'96 by R.M. & L. Phelps. **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:

Clear or Confused, Confused.

Quick or Sluggish, Sluggish

MEMORY:

Past Events, Good.

Recent Events, "

Special Subjects, "

PERCEPTIVITY:

Alert or Dull,

Correct or Illusive, Correct on ordinary subjects.

REASONING POWER:

Ordinary Subjects,

Own Mental State,

Special Subjects, impaired.

GENERAL DESCRIPTIVE REMARKS: Very melancholy. Worries a great deal: Thinks she is very wicked. Worries about her children.

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted,

Depressed, very.

DELUSIONS:

Systematized or Not, Thinks she is very wicked.

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

Personal and Medical History of Lucinda Judd.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 7 in. WEIGHT, 130 lbs. NUTRITION, fair.

WOUNDS OR ABNORMALITIES, None.

TONGUE, Tremors, - Coatings, brown coating Promptness Movement,

PUPILS, Equality, Equal. Size, Small.

Response Light, very sluggish Accommodation,

SIGHT, Uses glasses. Slight arcus senilis.

HEARING, Fairly good.

COORDINATION, Arms,

Legs,

TREMORS, Hands, None. Tongue, None.

Facial Muscles, " General,

REFLEXES, Patellar,

Other

ARTICULATION,

Slurred,

Hesitating, a little.

FACIAL EXPRESSION,

SENSIBILITY,

Arteries, slight atheroma

HEART, No murmurs.

Sounds clear & distinct.

LUNGS, Normal.

TAKEN,

EXAM. URINE, Oct 30 '96.

Color Reddish yellow.

Character Cloudy & ropy deposit

Amt. 24 hrs. XVI. 3

Sp. gr. 1035

Reaction Acid

Albumen Trace by Esbachs

Sugar Large quantity by Haines & Bismuth

Microscop. Renal & vesical epith. cells & pus. Amor. urates - Large quantity

GYNAECOLOGICAL EXAM., Oct 28 Uterus normal position some atrophy - not freely movable considerable discharge. External genitals excoriated.

MENSTRUATION,

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated, ✓	Irregular,
APPETITE, Good,	Medium,	Poor, ✓
SLEEP, Good, fairly.	Poor,	Irregular,
PULSE,	Resp.,	Temp.,

CRANIAL MEASUREMENTS, Circ(h) 53 (xm) 61/2 N.o.e.a. 32 Bi.a. 32 Aur.p.d. 17.9 Fmax.d. 14.7 Bi.d. 12 Fac.l. 11.

HISTORICAL, Some headache no especial disease

LENGTH OF INVASION, Long. ONSET GRADUAL OR SUDDEN, Gradual.

HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")

Mother or Mat. Relations, dead - Mother's father insane.

Father or Pat. Relations, living. 85.

Brothers or Sisters, One brother & one son insane.

Personal and Medical History of Lucinda Judd.

This patient was brought here by A.B. Judd, her husband, with the following history:- Patient is in fair physical condition. This is apparently 3rd attack + first symptoms were manifested three weeks ago in worrying about children. Patient has been confined twice before in this Rochester hospital. Disease seems increasing, variable - usually growing worse at night. Derangement now manifested in delusions that someone is lying in wait to kill her children - she waits to sit up at night + watch for them. Patient is suicidal, - attempted to jump out of chamber windows - threatened to kill herself yesterday. There is no deposition to injure others or to filthy or destructive habits. Patient has a happy disposition when normal. No history of intemperance in self or parents - none of acute disease or injury to head. Patient has not been confined + no medical remedies administered for this attack. On personal examination, - apparently no bodily ailment: her appearance corroborates the foregoing record. (For particulars see Vol. 15 Fol. 113 No. 2567 + Vol. 21 F. 65. No. 3117) On Admission was put on B 2.10 (G.H.N.Pitt) Complexion dark: Hair brown partly gray: Eyes gray: Condition of skin normal; No marks, scars or bruises: Is rather dirty Quiet; has delusions - thinks she will be injured by someone.)

Summary First 14 Days. Patient's temperature taken during the first week is normal: Appetite is very capricious, eating very little at any time. Received tonic and various doses of cathartics. No marked physical symptoms were noted: was very melancholy at time of coming + continually thinks herself so wicked as to deserve death: This is a quite persistent form of delusion: Was fed by the nurse several times toward the last being quite unwilling to eat: Is quiet + melancholy.

Original Records Preserved.

Nov. 2 Summary Nurse's Notes by Dr. E.S. Phelps:- Gyn. treatment given every other day: Quite melancholy: Has delusions: Has to be fed with spoon at times: Quite nervous: bowels irregular: takes tonics + cathartics: Dec '96 Gyn. treatments continued: Jan '97 Appetite poor: bowels regular: Has been on local treatment + has improved so that she needs no more: Worries over delusive ideas: Feb. 97 Visited by brother + friends: March Quiet in behavior: Quite melancholy: worries over delusions: Does no work: talks quite sensibly at times: Apr '97 About the same: June '97 Eats + sleeps well: goes riding + walking: Is always talking about going home: bowels regular.

1897 June 12 Went Home.

Discharged -

Personal and Medical History of

Personal and Medical History of Mrs. Julia Koch.

LIBBEY, FIDLAR & SHAMBERG, DAVENPORT, IOWA.

Whole No. 4554
Residence, Prairie Island, Goodhue Co., Minn.
Date Admission, October 16' 1896.
Admitted by, Dr. H.H. Herzog. Hour, 6:45 P.M.
How Sent, Axel Haller, J. of P. Goodhue Co.
Sex, - Female -
Age, - 38 -
Civil Condition, Married -
Children, - Eleven -
Age Youngest Child, Eight months.
Occupation, Housewife (Husband laborer)
Degree Education, - Common School.
Profession Religion, Yes Ev. Lutheran.
Habits, Not intemperate.
Nativity, Germany (Parents Germany)
Physicians Committing, Otis J. Brown + H.L. McKinstry
Correspondents, None mentioned in papers.

No. for Year, 87.
Insane Relatives, -None-
Cause Exciting, Not known.
Cause Predisposing, Probably previous attack
Form, Simple. chr -
Accompanying Bodily Disorder, None mentioned
Suicidal or Not, -Not.
Date of this Attack, Second week in July 1896.
Duration, Since Middle of July '1896.
No. of Attack, 2nd
No. of Admissions, 1st
Age First Attack, 37.
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION

Exam. Oct. 19'96 by R.M. + L.L. Phelps. **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:
Clear or Confused, Confused.
Quick or Sluggish, dull.
MEMORY:
Past Events, - Say fair
Recent Events, - poor
Special Subjects, - fair.
PERCEPTIVITY:
Alert or Dull, - dull + confused.
Correct or Illusive, -
REASONING POWER:
Ordinary Subjects, Impaired.
Own Mental State,
Special Subjects,
GENERAL DESCRIPTIVE REMARKS: Patient answers questions readily + with seemingly fair accuracy. Some dullness.

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed, ✓
DELUSIONS:
Systematized or Not, Many + Varied
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

Personal and Medical History of Julia Koch.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 4 ft. 10 in. WEIGHT, 102 lbs. NUTRITION, fair.
WOUNDS OR ABNORMALITIES,
TONGUE, Tremors, Coatings, White coating. Promptness Movement, Prompt.
PUPILS, Equality, Equal. Size,
Response Light, Accommodation,
SIGHT, Says wrap - appears fair.
HEARING, Slightly poor
COORDINATION, Arms, Good
Legs, "
TREMORS, Hands, None Tongue, None
Facial Muscles, " General, "
REFLEXES, Patellar, Both 0
Other
ARTICULATION, Foreign - seems fairly clear.
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART, No murmurs. Sounds fair
LUNGS, Left side - Expans. normal. More supraclavicular depression on
GYNAECOLOGICAL EXAM., Oct 28'96. Normal position - not freely movable. Slight laceration of cervix
MENSTRUATION,
OPHTHALMOSCOPIC EXAM.,

TAKEN,

EXAM. URINE, Oct 20'96
Color Yellowish red.
Character Ropy deposit
Amt. w/his XVI Z.
Sp. gr. 1035.
Reaction Acid.
Albumen Trace by heat + Nitric Acid
Large quantity by Tanrets.
Sugar. None.
Microscopical - Amor. urates large quantity, bladder + vaginal epith. cells. Ox. of lime - large quantity of pus.

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated,	Irregular,
APPETITE, Good,	Medium,	Poor, ✓
SLEEP, Good,	Poor,	Irregular, ✓
PULSE,	Resp.,	Temp.,

CRANIAL MEASUREMENTS, Circ (H) 54 (Occ) 61 N.o.a. 35 - Bi.a. 30½ Ant.p.d. 18.3 Trans.d. 17.4 Bi.d. 12.3 Fac. length 10.8
HISTORICAL, Dizzy at times since Summer.
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations,
Father or Pat. Relations,
Brothers or Sisters,

Personal and Medical History of Julia Koch

This patient was brought here by Sheriff A.J. Lundquist, attended by Mrs. Eva Lundquist, with the following history: Patient is in fair physical condition. This is second attack first having occurred in April 1895. The first symptoms of present attack appeared in July 1896, Patient wandering away from home & neglecting children. Left youngest out of doors & it almost died from exposure. Disease seems stationary; remains with rational intervals occurring monthly. Derangement now manifested by insane actions & conduct, on no especial subject. Patient has shown no disposition to injure others: not suicidal. So filthy & destructive in habits. Patient was excitable before accession of disease. No history of intemperance in self or parents or of severe disease or head injury. Cause of disease unknown. No confinement, restraint or medical treatment has been employed.

On personal examination - Irregular contraction of pupils; excited heart, irregular pulse.

On Admission put on B[r] W. (A.H. N. Dept. Complexion dark: hair brown: Eyes gray; condition of skin normal. Small scratch on right knee. So very dirty: behavior quiet: Speaks very poor English could not understand her.

Summary First 14 Days. Shows temperature to have been practically normal during the first week, although rising to 100.5 at one time. The appetite was quite good at all times: Cod Liver Oil was prescribed to gether with other medicines: no marked physical disease was discovered: Its behavior shows herself to be somewhat absent-minded, seemingly somewhat afraid & somewhat stupid during first few days: Later was somewhat melancholy: Slept fairly well, however and seemed more natural during the Second week Was quite nervous during the night all of the time. Original Record Preserved.

Nov 24 Summary Nurse's Notes by Dr. B.L. Phelps:- Walks the floor & cries a good deal: very nervous: bowels usually constipated: takes cathartics & tonics: Transf. to annex:
Dec. Extremely noisy at times: Dec 29 Visited by husband: Jan 20 Visited by friend: Quite demented: no special complaints or ailments: Apr. 27 Quit health good bleau in habits: noisy & restless: May 26-27 Visited by husband: became very much excited: June 9 Very much disturbed: July 25 27 Appetite good: habits untidy: extremely noisy & restless: works on sleeping flat a little: quit health good. Continued by Dr. B.M. Phelps

Nov 8 9 Feb 9 Patient quiet: Rather restless, untidy at times in habits Seems in good health: Wt. 104[#]. Feb 21 99 No notable change in patients condition up to date:

March 1 - Aug 31 99 Cont. by Dr. Bibb. General health good: Appetite good: Sleeps well: Takes outdoor exercise: So untidy in appearance: Has delusions & scolds & is extremely noisy at times. So very active: Works on sleeping flat. Aug 18. Wt 95[#]

Sept 1 - Feb 28 1900 (Dr. Heyrdale) Restless & extremely noisy at times: Works some on ward: Eats & sleeps well: General health good: Takes outdoor exercise Menstruates regularly: Dec. 16 Visited by husband. Feb 12 Wt 95[#]

Personal and Medical History of Julia Koch.

1900.

March - Nov 30 1900 Neat tho careless in appearance: Restless, quite stubborn & violent at times: General health fair: Appetite good: Bowels regular: Sleeps well: Menstruates regularly: Takes out door exercise but does no work. July 20. Vaccinated: Does not speak English Nov 24 Wt. 93[#].

Dec. - Feb 28 1901. No change: General health good: Wt. 94[#].

Mar 1 - June 1 - 1901 Menstruates, Does no work, Condition unchanged May 30 Wt. 100[#]. June to Sept. July 17, Aug 7 menstruating, taxed out door exercise, assists with work, Sept. 3 Wt. 89[#].

Sept. to Dec. Nov. 30 Wt. 93[#].

Dec. to Feb. 1/03 No change. Wt. about 85-[#].

Personal and Medical History of Rosa Belina.

LOBLEY, FISCAL & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4555

Residence, Owatonna, Minn.

Date Admission, 19 October, 1896.

Admitted by, Dr. R.M. Phelps. Hour, 10:15 A.M.

How Sent, M.B. Chadwick, J of P. Steele Co, Minn.

Sex, Female.

Age, - 34 -

Civil Condition, - Married -

Children, - five -

Age Youngest Child, nine months.

Occupation, Housewife (Husband farmer)

Degree Education, - Fair -

Profession Religion, Yes - Catholic -

Habits, Not intemperate.

Nativity, Bohemia (Parents Bohemian)

Physicians Committing, J.P. Johnson & P.L. Hatch.

Correspondents,

No. for Year, 88

Insane Relatives, None - (Father & mother second cousins)

Cause Exciting, Probably Domestic trouble.

Cause Predisposing, Not known

Form, Incl. acute

Accompanying Bodily Disorder, None mentioned.

Suicidal or Not, Not.

Date of this Attack, 9 months ago.

Duration, 9 months.

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, 34

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION

Exam. Oct. 20/96 by R.M. & P.L. Phelps **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:

Clear or Confused, Confused.

Quick or Sluggish, Sluggish.

MEMORY:

Past Events, Can not determine.

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Dull.

Correct or Illusive,

REASONING POWER:

Ordinary Subjects, Impaired.

Own Mental State,

Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Patients past history has not yet come & she will not answer questions. Rather obstinate about trying or doing as told. Seems afraid of something. Tending toward Melancholy.

EMOTIONAL STATE:

Normal, Calm, Cross.

Indifferent,

Exalted,

Depressed,

DELUSIONS: Probably has.

Systematized or Not,

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

Notice of hearing petition for appointment of W. A. Dynes as guardian for Rosa (Zimbrick) Belina. received & same admitted March 4th 1899.

...ON, CONTINUED.

...RISTICS.

NUTRITION, Good.

...ing.

Promptness Movement, Normal.

...mmodation, —

SIGHT, Wont talk

HEARING,

COORDINATION, Arms, will not test - is cold & obstinate

Legs,

TREMORS, Hands, —

Facial Muscles, -

REFLEXES, Patellar,

Other

ARTICULATION, spoke only 2 or 3

Slurred, words - No paretic

Hesitating, slurring.

FACIAL EXPRESSION,

Tongue, —

General, Nervous & tremulous now.

EXAM. URINE, ~~Oct~~ Nov. 4'96

Color Yellowish red

Character Flaky deposit

Amt. in hrs. Not taken

Sp. gr. 1028

Reaction Acid.

Albumen Trace by heat & Nitric acid Large quantity by Tanrets.

Sugar None.

Microscop Amor. urates - Large quantity of pus - ox - of lime crystals uric acid.

TAKEN,

SENSIBILITY,

Arteries - No radial impairment noted.

HEART, No murmurs.

Sounds fair - Regular.

LUNGS, Good.

GYNAECOLOGICAL EXAM., Nov. 20 Uterus Os lacerates & eroded - profuse discharge - external Genitals red & excoriated.

MENSTRUATION, Menstruating now. Menstruation regular

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated, ✓	Irregular,
APPETITE, Good,	Medium,	Poor, ✓
SLEEP, Good,	Poor, ✓	Irregular,
PULSE,	Resp.,	Temp.,

CRANIAL MEASUREMENTS, Not taken - obstinate.

HISTORICAL, Says she has headaches.

LENGTH OF INVASION, No history. ONSET GRADUAL OR SUDDEN,

HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") wont talk

Mother or Mat. Relations, No history

Father or Pat. Relations, "

Brothers or Sisters,

Personal and Medical History of Rosa Delina.

LAMBERT, FISCHER & HAMMERER, DAVENPORT, IOWA.

Whole No. 4555

Residence, Owatonna, Minn.

Date Admission, 19 October, 1896.

Admitted by, Dr. R.M. Phelps. Hour, 10:15 A.M.

How Sent, M.B. Chadwick, Jof P. Steele Co, Minn.

Sex, Female.

Age, - 34 -

Civil Condition, - Married -

Children, - five -

Age Youngest Child, Nine months.

Occupation, Housewife (Husband farmer)

Degree Education, - Fair -

Profession Religion, Yes - Catholic -

Habits, Not intemperate.

Nativity, Bohemia (Parents Bohemian)

Physicians Committing, J.P. Johnson & P.L. Hatch.

Correspondents,

No. for Year, 88

Insane Relatives, None. (Father & mother Second Cousins)

Cause Exciting, Probably Domestic trouble.

Cause Predisposing, Not known

Form, Mel. acute

Accompanying Bodily Disorder, None mentioned.

Suicidal or Not, Not.

Date of this Attack, 9 months ago.

Duration, 9 months.

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, 34

Time of Leaving,

Time in Hospital,

Result,

EXAMINATION ON ADMISSION

Exam. Oct. 20/96 by R.M. & L. Phelps **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:

Clear or Confused, Confused.

Quick or Sluggish, Sluggish.

MEMORY:

Past Events, Cannot determine.

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull, Dull.

Correct or Illusive,

REASONING POWER:

Ordinary Subjects, Impaired.

Own Mental State,

Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Patients past history has not yet come & she will not answer questions. Rather obstinate about testing or doing as told. Seems afraid of something. Tending toward Melancholy.

EMOTIONAL STATE:

Normal, Calm, Crees.

Indifferent,

Exalted,

Depressed,

DELUSIONS: Probably has.

Systematized or Not,

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

Personal and Medical History of Rosa Delina

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 5 WEIGHT, 125. NUTRITION, Good.

WOUNDS OR ABNORMALITIES, Slight bruises only on coming.

TONGUE, Tremors, — Coatings, White coating Promptness Movement,

PUPILS, Equality, Equal Size, Normal.

Response Light, Responds Accommodation, —

SIGHT,

HEARING, Wont talk

COORDINATION, Arms, Will not test - in bed & obstinate

Legs,

TREMORS, Hands, — Tongue, —

Facial Muscles, — General, Nervous & tremulous mood.

REFLEXES, Patellar,

Other

ARTICULATION, Spoke only 2 or 3

Slurred, words - No paretic

Hesitating, Slurring.

FACIAL EXPRESSION,

SENSIBILITY,

Arteries - No radial impairment noted.

HEART, No murmurs.

Sounds fair. Regular.

LUNGS, Good.

GYNAECOLOGICAL EXAM., Nov. 20 Uterus Os lacerated & eroded - profuse discharge - external Genitals red & excoriated.

MENSTRUATION, Menstruating now. Menstruation regular

OPHTHALMOSCOPIC EXAM.,

EXAM. URINE, ~~Oct~~ Nov. 4'96

Color Yellowish red

Character Flaky deposit

Amt. 24 hrs. Not taken

Sp. gr. 1028

Reaction Acid.

Albumen Trace by heat & Nitric acid Large quantity by Tauretc.

Sugar None.

Microscop Mucus. urates - Large quantity of pus - ox - of lime crystals uric acid.

TAKEN,

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated, ✓	Irregular,
APPETITE, Good,	Medium,	Poor, ✓
SLEEP, Good,	Poor, ✓	Irregular,
PULSE,	Resp.,	Temp.,

CRANIAL MEASUREMENTS, Not taken - obstinate.

HISTORICAL, Says she has headaches.

LENGTH OF INVASION, No history. ONSET GRADUAL OR SUDDEN,

HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Wont talk

Mother or Mat. Relations, No history

Father or Pat. Relations, "

Brothers or Sisters,

Personal and Medical History of Rosa Belina

This patient was brought here by Sheriff's Deputy M.A. McAndrews, attended by Jno. Watson + husband of patient: Gives the following history: Patient is in fair physical condition. First symptoms of attack were manifested 9 months ago by jealousy + suspicions that her husband poisoned her: Disease seems increasing, not variable, with no rational intervals: Derangement now manifested by thinking husband is poisoning her: ran away at night. No disposition to injure others: Is not suicidal, filthy or destructive: No history of hereditary or intemperance in self or parents: No peculiarities previously shown: no severe disease or injury to head, as far as known. Has not been confined until within last 24 hours. Patient has received no treatment. On personal examination Talks incoherently + insists that her husband has repeatedly poisoned her. On Admission put on D.W. G.H.N.Rpt Complexion fair; hair light brown; eyes blue: Condition of skin normal: No marks, scars: Emission of feet + body. Is dirty: Behavior quiet: Talks very little, but sensibly.)

Summary First 14 Days. Temperature taken for the two weeks is normal; appetite is very poor, at times refusing to eat anything. Refused medicine; no physical disease of importance noted: Patient is in behavior, stubborn + resistive, refusing to talk, sleeping very poorly, complaining of pain in head + stomach: Fought when temperature was taken at times; braced herself against the door in her room at one time, had to take the door off the hinges: Was transferred to C.4. The next three or four days was noted as quite quiet for the most part. Oct. 25th became very noisy, however, habits were dirty + was violent. During the next days she was part of the time quiet, even working some upon the ward; was once in seclusion: a general tendency toward quieting down, however, prevailed. Original Records Preserved.

Nov. 16 Summary Nurse's Notes by Dr. L.L. Phelps:- Complains of pain in head + chest. 299. P.50 quite weak: put to bed: Refused medicine: Nov 19 Still complains of pain in head + chest: Appetite good: Nov 20 Up + around the ward part of day: Dec 31 Very dull + stupid

1897 all the time: Seldom speaks: Appetite quite good: Pulse 50 to 55: Quite weak:

Jan. 7 Appetite good: bowels constipated: complains of headache: answers questions only occasionally: otherwise will not talk: sits in a stupid way upon the hall: habits clean: pulse very slow + weak: Feb. 3 97 Appetite poor: Feb 19 Fed with tube:

Feb. 28 Has been eating quite well since fed with tube.

Mar. 24 Appetite good: sleeps well: Habits clean: still has delusions: very quiet: Apr 97 no change: May: Quite noisy, especially at meal times: Thinks there is poison in food: Gen'l health seems good: June 97 No special change: July 3 Visited by husband + friend:

Aug. 20 Quite noisy at times: Appetite good: sleeps well: habits dirty: bowels constipated. Continued by Dr. L.L. Phelps Nov 30 '99 Very quiet: rather dull + stubborn in behavior: Resists at times: but is at most times very listless + inactive. Feb 20 '98 Wt. 107# Sept. 15 Trans. to C.3 Condition unchanged in any respect. March '99 - Aug 31 '99 Cont. by Dr. Bffs. Gneral health fair Appetite fair: Sleeps well: Refuses to take out door exercise: Is neat in habits: Is very obstinate

Personal and Medical History of Rosa Belina

Occasionally fed by tube: Bowels regular. Talks very little but reads a great deal: Often sits unoccupied for hours, with head on hand; sometimes scolding when people approach her + spitting at them: Sometimes very violent. Jan 7 Broke dishes etc. + fought nurses: Sometimes strikes other patients without provocation.

Sept 1- Feb 28 1900 (Dr. Heyerdale) Neat: appetite good: Bowels regular: Takes outdoor exercise: Talks very little: Very melancholy: Somewhat stubborn: Generally sits with hands over face Jan 17 Trans. to annex Feb 27 Cries a great deal. Mch 1- Aug 31 1900 (Dr. Linton) Neat: Quiet on ward: Scolds at times but talks very little Mays 8 fought nurses when bathed. July 23 Vaccinated

Sept 1- Nov 30 1900 Still complained of severe pain in stomach: Cathartics given: trouble proved to be a case of diarrhoea with hemorrhagious discharge Trans. to Infirmary Sept. 10. Sept. 11 Visited by friend. Remained on Infirmary until Sep. 26 - was on boiled milk diet with gruels + egg-nogs. Given medicine + enemata to control diarrhea Temp. as high as 103°. Pulse 100. Resp. 24. Stools bloody part of time + much mucus passed. By 26 stools had become well formed + temp. about normal Trans. to D.1 Nov 27. Tooth extracted. Nov 28 Wt. 115# Quiet + not resistive will answer questions when addressed, usually by shaking her head. Physical condition fair: appetite fair: Bowels regular: Takes out door exercise

Dec 1- Feb 28 - Appetite fair: Very disagreeable + noisy at times. Scolds + is profane: Has habit of biting finger nails + during Feb. had bitter solution put on hands to break her of habit. Mch 3 107#.

Mar 1- June 1- 1901 Works in sewing room: no change in mental or physical condition June 1 Wt. 127 ½ # June to Sept. Assists with work, takes out door exercise, does not attend amusements Sept. 4 Wt. 100#. Sept. to Dec. No changes Nov. 30 Wt. 124#.

1902 to Feb. 1, 1903. General health good: appetite good: usually sleeps well: takes exercise: works in the sewing room: neat in habits: rather careless in appearance at times. While usually quiet, is at times extremely noisy and at such times uses vulgar and profane language and scolds a great deal: at other times is pleasant and agreeable and can answer questions intelligently but does not as a rule voluntarily converse. Dec 1 st. Wt. 126#.

Personal and Medical History of Mamie Fredericks.

LEGGAT, FISLAR & SCAMBLER, DAVENPORT, IOWA.

Whole No. 4564
Residence, St. Paul, Minn.
Date Admission, October 28' 1896.
Admitted by, H.H. Heyzog M.D. Hour, 6 40 P.M.
How Sent, G. Willrich, Jo of P. Ramsey Co.
Sex, -Female-
Age, -29-
Civil Condition, -Married-
Children, -3-
Age Youngest Child, Ten months.
Occupation, -house wife-
Degree Education, -Common school-
Profession Religion, -Yes Presbyterian.
Habits, " Not intemperate.
Nativity, St. Paul, Minn.
Physicians Committing, Talbot Jones & Arthur Swaney.
Correspondents,

No. for Year, 97
Insane Relatives, None.
Cause Exciting, Pregnancy & Neurotic tendency
Cause Predisposing, -
Form, Mani. Acute -
Accompanying Bodily Disorder, None mentioned.
Suicidal or Not, Not. (Homicidal?)
Date of this Attack, 6 months ago.
Duration, 6 months.
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, 29
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION

Exam. Oct. 29 96 by A.M - H.Pres.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused, Fairly clear.
Quick or Sluggish, Quick.
MEMORY:
Past Events, Seems good.
Recent Events,
Special Subjects,
PERCEPTIVITY:
Alert or Dull,
Correct or Illusive,
REASONING POWER:
Ordinary Subjects, Somewhat impaired
Own Mental State, Impaired
Special Subjects, Somewhat impaired-
GENERAL DESCRIPTIVE REMARKS: History makes her gradually suspicious with loss of mental power in other ways a mild dementia. Her examination shows this also though rather imperfectly as we cannot confirm or deny her stories. Is not serious or troubled - Is careless & indifferent.

EMOTIONAL STATE:
Normal, Calm,
Indifferent, ✓
Exalted,
Depressed,
DELUSIONS: None noted unless the suspicions of her husband are such.
Systematized or Not,
Special Subjects,
Transitory or Not,
HALLUCINATIONS: Denies any.
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

Mamie Fredericks.

Copy of Notice of hearing petition for appointment of Joseph Claffey as guardian for Mamie Fredericks served upon Dr. A. J. Kilbourne, & filed with Committment papers May - '99 -
S

...ON, CONTINUED.

...RISTICS.

NUTRITION, Good.

Promptness Movement, widely dilated.
...modation,

...ING, Good.
COORDINATION, Arms, Good.
Legs, "
TREMORS, Hands, None of note.
Facial Muscles, "
Tongue, None of note.
General, "
REFLEXES, Patellar,
Other
ARTICULATION,
Slurred, prompt.
Hesitating,
FACIAL EXPRESSION,

SENSIBILITY,
Arteries, Normal
HEART, Murmurs slight in following first sound.
LUNGS, Normal.

TAKEN,

EXAM. URINE, Oct. 31 '96.
Color Reddish yellow.
Character Copy deposit
Amt in hrs. XX Oz.
Sp. gr. 1020.
Reaction Acid.
Albumen Trace by Esbachs.
Sugar None-
Microscop. Amor. urates - a few pus corpuscles & triple phosphate crystals.

GYNAECOLOGICAL EXAM., Nov 2. Normal position large erosion of os. laceration of cervix - endometritis cystocele, slight rectocele - laceration of perineum.
MENSTRUATION, Menses Regular - no pain.
OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal, ✓	Constipated,	Irregular,
APPETITE, Good, ✓	Medium,	Poor,
SLEEP, Good, ✓	Poor,	Irregular,
PULSE,	Resp.,	Temp.,

CRANIAL MEASUREMENTS, Circ (f) 53½ (cm) 60.7 F. o.c.a. 35 Bim.a. 31 Ant.p.d. 18 Trans.d. 14.8 Bim.d. 11.5 Fac.l. 10.5
HISTORICAL, Denies any severe disease. Habits good.
LENGTH OF INVASION, One year or more ONSET GRADUAL OR SUDDEN, Gradual.
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") All heredity denied.
Mother or Mat. Relations,
Father or Pat. Relations, died of cancer.
Brothers or Sisters,

Personal and Medical History of Mamie [illegible]

LOBLEY, PUHLER & SCHAEBERLE, DAVENPORT, IOWA.

Whole No. 4564
Residence, St. Paul, Minn.
Date Admission, October 28' 1896.
Admitted by, A.H. Hayes M.D. Hour, 640 P.M.
How Sent, G. Willrich, Jo of P. Ramsey Co.
Sex, -Female-
Age, -29-
Civil Condition, -Married-
Children, -3-
Age Youngest Child, ten months.
Occupation, -house-wife-
Degree Education, -Common school-
Profession Religion, -Yes Presbyterian.
Habits, " Not intemperate.
Nativity, St. Paul, Minn.
Physicians Committing, Talbot Jones & Arthur Swaney.
Correspondents,

No. for Year, 97
Insane Relatives, None.
Cause Exciting, Pregnancy & [illegible]
Cause Predisposing, -
Form, Mania. Acute -
Accompanying Bodily Disorder, None mentioned.
Suicidal or Not, Not. (Homicidal?)
Date of this Attack, 6 months ago.
Duration, 6 months.
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, 29
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION

Exam. Oct. 29 96 by A.H. Hayes. **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:
Clear or Confused, Fairly clear.
Quick or Sluggish, Quick.

MEMORY:
Past Events, Seems
Recent Events, fair.
Special Subjects,

PERCEPTIVITY:
Alert or Dull,
Correct or Illusive,

REASONING POWER:
Ordinary Subjects, Somewhat impaired
Own Mental State, Impaired
Special Subjects, Somewhat impaired-

GENERAL DESCRIPTIVE REMARKS: History makes her gradually suspicious with loss of mental power in other ways a mild dementia. The examination shows this also though rather imperfectly as we cannot confirm or deny her stories. Is not serious or troubled - Is careless & indifferent.

EMOTIONAL STATE:
Normal, Calm,
Indifferent, ✓
Exalted,
Depressed,

DELUSIONS: None noted unless the suspicions of her husband are such.
Systematized or Not,
Special Subjects,
Transitory or Not,

HALLUCINATIONS: Denies any.
ILLUSIONS:

CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

Personal and Medical History of Mamie Friederichs.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. WEIGHT, 95 NUTRITION, Good.
WOUNDS OR ABNORMALITIES, None.
TONGUE, Tremors, Coatings, Fairly clean. Promptness Movement,
PUPILS, Equality, Equal. Size, widely dilated.
Response Light, Accommodation,
SIGHT, "Good"
HEARING, Good.
COORDINATION, Arms, Good.
Legs, "
TREMORS, Hands, None of note. Tongue, None of note.
Facial Muscles, " General, "
REFLEXES, Patellar,
Other
ARTICULATION,
Slurred, prompt.
Hesitating,
FACIAL EXPRESSION,

SENSIBILITY,
Arteries, Normal
HEART, Murmurs slight in following first sound.
LUNGS, Normal.

TAKEN,

EXAM. URINE, Oct. 31 '96.
Color Reddish yellow
Character Ropy deposit
Amt in hrs. XX 24.
Sp. gr. 1020.
Reaction Acid.
Albumen Trace by Tests.
Sugar None-
Microscop. Amor. urates - a few pus corpuscles & triple phosphate crystals.

GYNAECOLOGICAL EXAM., Nov. 2. Normal position large erosion of os. laceration of cervix - endometritis cystocele, slight rectocele - laceration of perineum.
MENSTRUATION, Menses regular - no pain.
OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal, ✓	Constipated,	Irregular,
APPETITE, Good, ✓	Medium,	Poor,
SLEEP, Good, ✓	Poor,	Irregular,
PULSE,	Resp.,	Temp.,

CRANIAL MEASUREMENTS, Circ. (h) 57½ (cm) 60.7 N. o. a. 35 Bin. a. 31 Ant. p. d. 18 Trans. d. 14.8 Bin. d. 11.5 Fac. l. 10.5
HISTORICAL, Denies any severe disease. Habits good.
LENGTH OF INVASION, One year or more ONSET GRADUAL OR SUDDEN, Gradual-
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Acc. heredity denied.
Mother or Mat. Relations,
Father or Pat. Relations, died of cancer.
Brothers or Sisters,

Personal and Medical History of Mamie Fredericks.

This patient was brought here by Sheriffs Deputy M.K. Williamson attended by Mrs. Chas Sylvester - with the following history:- Patient is in fair physical condition - First symptoms of attack were manifested 6 months ago by insane jealousy. Disease seems increasing. Variable with rational intervals except for delusions in regard to her husbands infidelity. Patient is insanely jealous of husband, neglected her children, followed husband about & attacked him several times with a knife & has also threatened & attempted to shoot him. She is irrelevant & flippant in regard to serious matters, unstable in her decisions, whimsical & irresponsible - Has been cared for by friends & relatives who have been unable to control her in the least - Has shown disposition & attempted to injure others: Is not filthy or destructive but is negligent about appearance. No history of consanguinity, heredity or intemperance in life of parents. No previous peculiarities shown - Patient has been worse since birth of last baby. No severe disease or injury to head. Has not been confined or restrained. Has received no treatment - Cause of disease supposed to be pregnancy & neurotic tendency. On personal examination patient talks well but is flippant, irrelevant & at times incoherent & unstable. On admission put on B^2 W.C.S.H. Rpt Complexion dark; hair dark brown; Eyes gray; Condition of skin normal: No marks, scars or bruises noticed. Is rather tidy: behavior quiet; talks sensibly)

Summary First 14 Days. Temperature normal: appetite good throughout: received tonic & other medicines; was rather nervous on admission. talks in a sensible manner although rather silly & illusive; is rather quiet during all of the two weeks, although somewhat careless in appearance & about herself: seemed to be forgetful: quarreled some with some of the other patients. Original Records Preserved.

Nov. 98 Summary Nurses Notes by Dr. S.L. Phelps:- Has morbid ideas, although usually talks quite sensibly: careless in habits: often refuses to get up in the morning: physical health good: takes gym. treatments every other day: Dec 21: In a quiet primary dementia & steady quiet decline in which the appearance of ordinary intelligence keeps up late: According to letters received decline commenced some 2 or 3 years ago. Dec 29 Transf. to Inf. Operation done - Curettement & trachelorraphy: took ether poorly at first but condition improved: Jan 11 Remained quietly in bed for about ten days: caused no trouble: now up on ward: put upon tonic: Jan 25 Transf. to B': Feb 27 99 Usually quiet in behavior but impudent at times: careless in dress: At times talks quite sensibly for a short time: gen'l health good: Apr 99 No change: July 20 Careless in personal appearance: usually very quiet on the ward: appetite ~~poor~~: Aug 25 99 Visited by brother: appetite good: no mental change. Continued by Dr. J.M. Phelps Nov 30 99 Rather restless: at times violent & destructive: Appetite at times poor. In general is rather restless. Oct 25 98 Transf. to C^3. Dec. 29 98 Patient still rather violent & at times destroys her clothing. Is very uncertain & stubborn in behavior Mch 1 - Aug 31 99 Cont. by Dr. Bibb General health good: Appetite good: Sleeps well: Quite neat in habits: Takes out door exercise: Very destructive at times but usually quiet: Attacks nurses when trying bathed always objecting at this time to State clothing which she is obliged to wear:

Personal and Medical History of Mamie Fredericks.

1899

Oct 15 Visited by friends: Seldom speaks & when she does talks incoherently. Seldom says more than "Please bring me my satchel & let me go home."

Sep Nov. 27. (Dr Kingsbury) Neat. Quiet in manner: occasionally becomes pugnacious & fights nurses. Appetite good: Bowels regular: Takes out door exercise.

Dec 14 Visited by friend. Dec. 30 Fought nurses. Jan 7 1901. Pulled nurses hair. Held in bay. July 13. Wt. 107½ #. Feb 27 & 28 Fought nurses. Br seclusion

Mch 1 - Nov 30 1900. Neat. Occasionally attacks nurses: Takes out door exercise: usually answers questions: Appetite good: Sleeps well: June 1 Visited by brother: June 4. Attacked nurses when asked to put on shoes July 21 vaccinated Sept 16. untidy & very stubborn: Takes no interest in surroundings: Appetite fair: occasionally laughs to herself. Nov 21 Wt 110

Dec 1 - Feb 28 1901 General health good: No change. Feb 27 Wt. 110 #

Mar to June 1901. No change in mental or physical condition, May 29 Wt. 111 #.

June to Sept. Menstruates regularly, patient shows no change in mental or physical condition, Aug. 30 Wt. 110 #. Sept. to Dec. Nov. 27 visited by lady and gentleman friends, is irritable mentally, does not converse, is unoccupied, tidy in habits, at times is destructive, physically is well, eats and sleeps well, takes out door exercise, menstruates regularly. Nov. 25 Wt. 115½ #.

Dec to Feb. 1st 1903 No change in condition. Wt about 121 #.

July 6 - 02 visited by a friend.

Personal and Medical History of Ellen Grimse.

Whole No. 4568.
Residence, Winona, Minn.
Date Admission, November 2nd 1896.
Admitted by, R.M. Phelps, MD. Hour,
How Sent, H.L. Buck, J.of P. Winona, Minn.
Sex, Female.
Age, 34.
Civil Condition, Married.
Children, 2.
Age Youngest Child, 2 years.
Occupation, Housewife.
Degree Education, Common School.
Profession Religion, Yes. Free Mission.
Habits, Not intemperate.
Nativity, Norway.
Physicians Committing, JB McGaughey & JLS. Tracy.
Correspondents, M. Grimse (Husband)
618 Broadway St, Winona, Minn.

No. for Year, 101
Insane Relatives, One brother.
Cause Exciting, Religious excitement.
Cause Predisposing, not stated.
Form, Acute Delirious Mania.
Accompanying Bodily Disorder, Discharge from middle ear.
Suicidal or Not, Not.
Date of this Attack, one week ago.
Duration, about 1 week.
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, 34.
Time of Leaving, Nov. 8. 1896
Time in Hospital, 6 da.
Result, Died. Uremia and Bright's Disease.

EXAMINATION ON ADMISSION
MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
- Clear or Confused,
- Quick or Sluggish,

MEMORY:
- Past Events,
- Recent Events,
- Special Subjects,

PERCEPTIVITY:
- Alert or Dull,
- Correct or Illusive,

REASONING POWER:
- Ordinary Subjects,
- Own Mental State,
- Special Subjects,

GENERAL DESCRIPTIVE REMARKS:

EMOTIONAL STATE:
- Normal, Calm,
- Indifferent,
- Exalted,
- Depressed,

DELUSIONS:
- Systematized or Not,
- Special Subjects,
- Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:
- Coherent or Incoherent,
- Voluble or Reticent,

Personal and Medical History of Ellen Grimse.

EXAMINATION ON ADMISSION, CONTINUED.
PHYSICAL CHARACTERISTICS.

HEIGHT, WEIGHT, NUTRITION,
WOUNDS OR ABNORMALITIES,
TONGUE, Tremors, Coatings, Promptness Movement,
PUPILS, Equality, Size,
Response Light, Accommodation,
SIGHT,
HEARING,
COORDINATION, Arms,
Legs,
TREMORS, Hands, Tongue,
Facial Muscles, General,
REFLEXES, Patellar,
Other
ARTICULATION,
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
HEART,
LUNGS,
GYNAECOLOGICAL EXAM.,
MENSTRUATION,
OPHTHALMOSCOPIC EXAM.,

TAKEN,

EXAM. URINE,
Color. Reddish brown.
Character. Cloudy, heavy deposit.
Amt per hrs.
Sp gr.
Reaction.
Albumen Large quantity hyaline casts
Sugar. None.
Microscop. Loaded with blood & waxy casts.

HABITS, Dirty, Clean, Careless,
BOWELS, Normal, Constipated, Irregular,
APPETITE, Good, Medium, Poor,
SLEEP, Good, Poor, Irregular,
PULSE, Resp., Temp.,
CRANIAL MEASUREMENTS,
HISTORICAL,
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations,
Father or Pat. Relations,
Brothers or Sisters,

Personal and Medical History of Ellen Grimes.

This patient was brought here by Sheriff A.W. Fuhrmann attended by M. Grimes with the following history:- Patient is in a somewhat exhausted physical condition. No history of consanguinity. First symptoms of this (1st) attack were manifested about a week ago: Patient became excited while at prayer; talked incoherently, etc. Disease appears increasing; not variable & with no rational intervals. Derangement now manifested by incoherence & restlessness & on subject of religion. Patient has shown no disposition to injure others: is not suicidal, filthy or destructive: No previous peculiarities; serious disease or injury to head. (Except discharge of pus from middle ear for 3 weeks) One brother was insane - One Scandinavian - who died there in 1895. Patient has been confined to house for one week - as to treatment - nothing known. On personal examination patient shows great excitement, restlessness, continual movement, incoherent talk. On admission put upon B.W. (Phn. Rpt.) complexion dark: hair brown: eyes blue. Condition of skin normal: Face scratched on right side & left arm & right leg bruised - Is dirty: Very maniacal & talks incoherently)

Summary First 14 Days.- Admitted in a state of maniacal exaltation: Temperature taken Nov. 3rd. 98 4/5: resisted every thing: ate very little: was in restraint almost from time of coming here. On the 4th Temperature was 103.9, going down to 101.6. in the evening. Ate nothing except a couple of glasses of milk: Received two doses of cathartic & a hypodermic. Nov. 4th Hot baths given at 9:40 a.m. 3 and 7 p.m. Nov. 5. Temperature 104.7 in the morning, gradually sank to 101.4 in the evening: was fed with tube at 9:30 & at 4 p.m. & an enema was given: Hot baths given 3 or 4 times during the day: patient very restless & noisy. Nov. 6. Ate breakfast: fed with tube in the evening: had to be catheterized every four hours: Received Strychnine several times: was very restless: Slept half an hour at night, but was evidently growing weak and into a Stuporous condition: very restless for a couple of hours in the afternoon, then more stupid from 5:20 to 6:30: received Hasping dose & slept 5 hrs. Nov. 7. Temperature 101. Fed with tube twice during the day. Strychnine given every 3 hours: was very restless: face swollen on the right side: growing weak: was catheterized every four hours. In restraint 9½ hours. Patient died at 6:20 a.m. Nov. 8th from Exhaustion in acute delirious mania and Bright's disease.

Original record preserved.

Physicians Note- When admitted in an acute delirious condition & remained so during the whole time until she died. Amount of Urine was very scanty & exhibited a large quantity of albumen & full of casts, bloody & waxy. Was quite emaciated and general physical condition poor. Talked constantly in an incoherent delirious manner. Never became conscious.

Died

Personal and Medical History of

Personal and Medical History of Lydia B. Angier

LEBERT, FISLAR & SAUNDERS, DAVENPORT, IOWA.

Whole No. 4577

Residence, Dale & Dapping Sts. St. Paul, Minn.

Date Admission, November 13th 1896

Admitted by, Dr. H. H. Herzog Hour, 7 P.M.

How Sent, G. Willrich. J. of P. Ramsey Co.

Sex, Female.

Age, Not given. (she says 53)

Civil Condition, Widowed.

Children, 1 (Dead.)

Age Youngest Child, 33 when he died.

Occupation, Selling papers.

Degree Education, Very good.

Profession Religion, Not a church member.

Habits, Not intemperate.

Nativity, New York (Parents Mass)

Physicians Committing, G. A. Reny & Angus Macdonald

Correspondents,

No. for Year, 110.

Insane Relatives, None

Cause Exciting, Not known

Cause Predisposing, " "

Form,

Accompanying Bodily Disorder, None mentioned

Suicidal or Not, Not.

Date of this Attack, Several months ago.

Duration, " "

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, Not stated.

Time of Leaving, Feb. 14. 1899

Time in Hospital, 2 yr. 3 m. 1 d.

Result, Transferred to Fergus Falls.

EXAMINATION ON ADMISSION

Exam. Nov. 14/96 by R. M. & S. L. Phelps. **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:

Clear or Confused,

Quick or Sluggish, Quick but deluded.

MEMORY:

Past Events, Seems good

Recent Events, "

Special Subjects, "

PERCEPTIVITY:

Alert or Dull, Alert.

Correct or Illusive, Correct on ordinary subjects.

REASONING POWER:

Ordinary Subjects,

Own Mental State, Impaired

Special Subjects, "

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted,

Depressed,

DELUSIONS:

Systematized or Not, of persecution, a true

Special Subjects, Paranoiac

Transitory or Not,

HALLUCINATIONS: None noted.

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Says was in trouble 8 years ago. Was working for Griggs, Cooper & Co. for $50. a month quit work. was accused of embezzlement. Was innocent & this was only a persecution she says. She started a store & made after a while $50. a month. Accuses Griggs & Co. of boycotting & breaking up her business. They got the City Engines to turn water onto her store. She sued the city. got finally $600. She gave Chapel a bill of her son's wages to collect & he let it outlaw. Last week she sued Chapel & then they sent her here. Has quarrelled with relations. According to her account has had on most nothing & own Savings & independent about everything. See accompanying account written by her.

Swindled out of over $300 cash. by the false promises of D K Noyes. Tom Cochran et. al.

Robbed of my home. and the means of earning a living. Through the neglect of their sworn duties. by Engineer Kundett Sheriff Chapel et al

Boycotted on all sides. Through the influence of Millionaire christians (!) all because I would not "Keep still" and allow them to turn houses of prostitution near me To avoid the penalty of their misdeeds. they have hunted in vain for a hole in Uncle Sam's mail pouch. whereby they might send the defrauded woman to Stillwater Hutchins & Jackson. as "poodles" — evidently employed to protect the church "pimp" & prostitute. have done all they can to discredit me. and get me to the poor-house The trouble killed my son. and after eight years of such vindictive persecutions. death by starvation or cold. has no terrors for me

Judas may not have cared for the poor. but his words were truth. while after Teaching the absurdity of formal religion. for three years. to accept the "annointing". was. for the Nazarine. a "fall from Grace". showing the sublime egotism of the average man. in accepting woman's adoration

If she has the ability to "get there" A woman may sit in the Presidents chair but in my opinion she has a higher mission

Brothers or Sisters, 4 brothers & 3 sisters. all living Don died 2 years ago. 2 children dead.

Personal and Medical History of Lydia B. Angier

LEBERT, FISCHER & SCHROEDER, DAVENPORT, IOWA.

Whole No. 4577

Residence, Dale & Topping Sts. St. Paul, Minn.

Date Admission, November 13th 1896

Admitted by, Dr. H.H. Herzog Hour, 7 P.M.

How Sent, G. Willrich - Jr. of P. Ramsey Co.

Sex, - Female -

Age, Not given (she says 53)

Civil Condition, - Widowed -

Children, 1 - (Dead.)

Age Youngest Child, 33 when he died.

Occupation, Selling papers.

Degree Education, Very good.

Profession Religion, Not a church member.

Habits, Not intemperate.

Nativity, - New York - (Parents Mass)

Physicians Committing, G.A. Reny & Angus Macdonald.

Correspondents, -

No. for Year, 110.

Insane Relatives, None

Cause Exciting, Not known

Cause Predisposing, " "

Form,

Accompanying Bodily Disorder, None mentioned

Suicidal or Not, Not.

Date of this Attack, Several months ago.

Duration, " "

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, Not stated.

Time of Leaving, Feb. 1st. 1899

Time in Hospital, 2 yr. 3 m. 1 d.

Result, Transferred to Fergus Falls.

EXAMINATION ON ADMISSION

Exam. Nov. 14 '96 by P.M. & S.L. Phelps. **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:

Clear or Confused,

Quick or Sluggish, Quick but deluded.

MEMORY:

Past Events, Seems good

Recent Events, "

Special Subjects, "

PERCEPTIVITY:

Alert or Dull, Alert.

Correct or Illusive, Correct on ordinary subjects.

REASONING POWER:

Ordinary Subjects,

Own Mental State, Insane

Special Subjects, "

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted,

Depressed,

DELUSIONS:

Systematized or Not, of persecution, a true

Special Subjects, - paranoiac

Transitory or Not,

HALLUCINATIONS: None noted.

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent,

Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Sons was in trouble 8 years ago. Was working for Griggs, Cooper & Co. for $50 a month - quit work - was accused of embezzlement - was innocent & this was only a persecution she says. She started a store & made after a while $60. a month. Accuses Griggs & Co. of boycotting & breaking up her business. They got the City Engineer to turn water onto her store. She sued the city - got finally $600. She gave Chapel a bill of her sons wages to collect & he let it outlaw. Last week she sued Chapel & then they sent her here. Has quarrelled with relations - According to her account has kind on most nothing - Low, saucy & independent about everything - See accompanying account written by her.

National life is the strength of the Jew. A man without a country or language - his tenacity wins my admiration. I am proud of my Hebrew origin. Revolutionary ancestry is a "fad" of the American. The religion "built" upon the immorality of the Jew - born in a stable - fostered by ignorance - is the condensation of the most enormous swindle ever perpetrated on a suffering world. The theory of the innocent dying for the guilty is diabolical - very convenient for scoundrels - but too flexible to suit me. Corruption and cruelty has marked its progress from the cradle. Jew Saracen Roman Catholic Protestant or heathen - each in their turn - as each happened to be most helpless - became the victim. The blood sacrifice to the christians cruel God of Love (!)

"Part of the part am I. which at the first was all"

I claim a kinship with the "renowned Snake" - with the "mask" to prove my lineage - I "kick" the skin from my toes every summer - (a painful disease that has baffled the doctors for more than forty years) I read the bible as I read a novel - finding the whole story in a few verses of Genesis and Revelation - the introduction in Revelation.

I see an omniferious. omnific - omnipotent. Omnipresent. Omniscient and omnivorous God - a progressive "Mollusk" creating and destroying - until Lilith - the Mother of Adam resisted. With the creation of Eve progression ceased - but ambitious. ignorant Eve - never "caught on" to Gods little joke. Her daughters are too busy sending "Top boots" and blankets to the heathen to see it now.

Jew or gentile - great or small

The "Tree of Life" is free to all Genesis 3:21

"Lost in Jesus". man becomes a soulless animal - a log - whose entire

Brothers or Sisters, [illegible] Don died 2 years ago - 2 children dead.

Pers

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Admitte
How Se
Sex,
Age,
Civil Co
Children
Age Yo
Occupati
Degree
Professio
Habits,
Nativity,
Physicia
Correspo

Exam. Nov. 18

MENTA
Clear or
Quick o
MEMORY
Past Ev
Recent
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PERCEP
Alert o
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REASON
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Own M
Special
GENERA
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a-while $150.
owns her sto
ered Shape
ing + Sum.

He eats - drinks - dies and the worms eat him = Satisfied

"Ye are Gods" - Smash the unjust laws - To hades with your fraudulent churches - their beggarly auxilliaries and circumlocution offices = Nothing has ever been lost but Truth - were the lessons taught by Jesus of Nazareth The Morbidly insane "Tramp - of Galilee

Loving his unfortunate Mother - trying to spare her - his teachings were not clear - and scheming priests again took the ignorant people by the nose

Tax church property - make the basement of every school - house a place of amusement - theatrical - intellectual and theological - open to all classes - no salaries - = So far I am a Socialist = Earth would soon be Eden - every man a God - and woman would not care to vote The Constitution of the United States is my creed - and Justice all the God I need

Lydia E. Angier
Brought in on admission
Nov. 18 '97
Ill with Grippe

Brought up
a Universalist
knows God knows
Who without food or fuel
Pass to Heaven

Born a Quaker - Universalist - Theosophist - Christian Scientist - would like much to be "Different mind Cure" When you think on any one too - it helps him "

I am now living at Saint Francis to start a self supporting business at home Can you do anything to help me ? L E Angier

50 a month
made after
in water
week she
most noth

Personal and Medical History of Lydia E. Angier.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 7. WEIGHT, 105 3/4 lbs. NUTRITION, Somewhat poor.

WOUNDS OR ABNORMALITIES, Blind in right eye. Condition of Skin - Fair for age.

TONGUE, Tremors, Coatings, Normal Promptness Movement, Normal.

PUPILS, ~~Equality,~~ One pupil Size, Fair size.

Response Light, Accommodation,

SIGHT, Right eye removed several years ago - Said to have had cancer in eye. Seems to have fair sight in left eye.

HEARING, Good

COORDINATION, Arms, Fairly good.

Legs,

TREMORS, Hands, Some. Tongue, Slight.

Facial Muscles, General,

REFLEXES, Patellar,

Other

ARTICULATION, Normal -

Slurred,

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

Arteries - Tortuous + atheromatous radial

HEART, No murmurs - Sounds normal Regular.

LUNGS, Normal

GYNAECOLOGICAL EXAM., Now Uterus retroverted + bound by firm bands of adhesions - Slight erosion of os. Cystocele - some urethritis. Adnexa, normal

MENSTRUATION, Menopause passed ten years.

OPHTHALMOSCOPIC EXAM.,

TAKEN,

EXAM. URINE, Exam. Nov. 18 '97

Color yellow
Character Cloudy
Amt 24 hrs. XXX ℥
Sp. gr. 1020
Reaction Acid
Albumen Trace by heat + HNO_3 - large quantity by Tsuretz.
Sugar None.
Microscop. Large quantity Amor. urates. few pus corpuscles + bladder + vaginal cells.

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal, ✓	Constipated,	Irregular,
APPETITE, Good,	Medium,	Poor,
SLEEP, Good, ✓	Poor,	Irregular,
PULSE,	Resp.,	Temp.,

CRANIAL MEASUREMENTS, Circ. (h) 52^3 (vm) 61 Occ.a 34.5 Bm.a 33 Ant.p.d. 16.8 Trans.d. 14.1 Bin.d. 11.6 Fac.h. 10

HISTORICAL,

LENGTH OF INVASION, 8 or more years ONSET GRADUAL OR SUDDEN, Gradual.

HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Relations long lived - denies insanity or inebriety

Mother or Mat. Relations, Died at 61 - Sudden death Paralysis (2) Heart Disease (3)

Father or Pat. Relations, Died at 77 Paralysis.

Brothers or Sisters, 4 brothers + 3 sisters. all living Don died 2 years ago - 2 children dead.

Personal and Medical History of Lydia B. Angier.

1896

This patient was brought here by Sheriffs deputy P. C. Haas, attended by Miss Akers, with the following history:- Patient is in fair physical condition. No history of consanguinity or heredity: First symptoms of insanity manifested several months ago: Disease appears increasing: is stationary, not variable + with no rational intervals: Manifested by delusions of persecution in many ways. Patient not disposed to injure others: Is not suicidal, filthy or destructive. Previous peculiarities not known. No history of intemperance in parents or self, or of severe disease or head injury. Patient has not been confined or restrained; has received no treatment. On personal examination subject to hallucinations, ideas of persecution + delusions of many things. On Admission put upon B^{r} 10 (A.H.N. Spt. Complexion dark, hair brown, part gray: Eyes blue: No scars or bruises noted: Is blind in right eye: Is rather dirty: Behavior quiet: has delusions) Summary First 14 Days.- Patients temperature normal: appetite good uniformly: was seemingly quite healthy: very bright + talkative and in a typical paranoiac condition: no especial physical disease or even symptom was apparent: behaved quite well: answered questions quite accurately: in appearance was uniformly in good health during the first two weeks: Her delusions were, generally, those noted in the papers accompanying her: did not talk to the nurses. Original Record Preserved.

Dec. 3 Summary Nurse's Notes by Dr. S. L. Phelps:- Quiet in behavior: neat in appearance: talks quite sensibly: Appetite good: sleeps fairly well: Transf to A': Jan 5'97 Very quiet: Spends most of time writing letters + reading: Thinks she is unjustly kept here + is anxious to go away: Talks sensibly on ordinary subjects: Mar '97 At times becomes quite excited: Very disagreeable + quarrelsome at times: Appetite good: sleeps well May Has shown many delusions: Gen'l health good: June 8 Very disagreeable at times Quite sensible on some subjects but has delusions: Aug^{t} Very noisy + disagreeable on ward: talks very vulgarly when out working: Appetite good: bowels regular: Transf to B^{2}: Refuses to go out of doors: uses vulgar language at times. Continued by Dr. Wm. Phelps. Nov 28 98 Rather more quiet of late. Is inclined to "taunt" + excite other patients: is rather complaining: a very peculiar mind: delusions as usual. Feb 1'98 Wt. 141^{lbs} Feb 14'99 Transf. to Fergus Falls. During all of time past has written many notes + letters + has complained. She has had very many spells of quite excitable + hysterical behavior. Is very vulgar in talk + shows ideas at times which are quite delusive.

Transferred to Fergus Falls.

Personal and Medical History of

Personal and Medical History of Christine Caplazi

LEIGHTY, FISLER & SCANDRETT, DAVENPORT, IOWA.

Whole No. 4578
Residence, Washington County, Minn.
Date Admission, November 17th 1896.
Admitted by, Dr. P.M. Phelps. Hour, 7 P.M.
How Sent, E. G. Butts J. of P. Washington Co.
Sex, -Female-
Age, -54-
Civil Condition, -Widowed-
Children, -3-
Age Youngest Child, -21 years.
Occupation, Housewife. (Husband was Carpenter)
Degree Education, Common School.
Profession Religion, Lutheran.
Habits, Not intemperate.
Nativity, -Germany.
Physicians Committing, Geo. M. Watin & D.C. Cluck.
Correspondents, Telegraph & Rosa Caplazi
57 E. 10th St. St. Paul.

No. for Year, 111.
Insane Relatives, None.
Cause Exciting, Man assaulted her causing nervous prostration.
Cause Predisposing, Not given.
Form, Mania. Acute.
Accompanying Bodily Disorder, Nervous prostration.
Suicidal or Not, Threatens it.
Date of this Attack, About 8 months ago.
Duration, about 8 months.
No. of Attack, 1st
No. of Admissions, 1st
Age First Attack, 54.
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION

Exam. by P.M. & St. Phelps. 11/17/96. **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:
Clear or Confused, Quick but confused at times as to her
Quick or Sluggish, own condition.

MEMORY:
Past Events, Good.
Recent Events,
Special Subjects,

PERCEPTIVITY:
Alert or Dull, Alert.
Correct or Illusive, Fairly correct just now.

REASONING POWER:
Ordinary Subjects,
Own Mental State,
Special Subjects,

GENERAL DESCRIPTIVE REMARKS: Patient always healthy until past few weeks. Taken suddenly with religious delusions. Fears of being harmed in some way. Says these ideas come on at times & then leave her. Talks quite freely about her condition. Says it began by fear. The cause being an assault by a man nearly a year ago. Occasionally & quite suddenly her heart will palpitate & produce uncomfortable sensations. Will then be fearful & full of "funny ideas."

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed,

DELUSIONS:
Systematized or Not, Many.
Special Subjects, Thinks someone will harm her.
Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

Personal and Medical History of Christine Caplazi.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft 2 in. WEIGHT, present 95 lbs. NUTRITION, Impaired.
WOUNDS OR ABNORMALITIES, None. Condition of skin good.
TONGUE, ~~Tremors,~~ Normal. Coatings, Promptness Movement,
PUPILS, Equality, Equal Size, Normal.
Response Light, Accommodation,
SIGHT, Uses glasses - Slight arcus senilis.
HEARING, Seems good.
COORDINATION, Arms, Normal.
Legs, "
TREMORS, Hands, None. Tongue, None
Facial Muscles, " General, "
REFLEXES, Patellar, Both Normal.
Other
ARTICULATION, Normal.
Slurred,
Hesitating,
FACIAL EXPRESSION,
Arteries - Senile change - some atheroma
SENSIBILITY,

HEART, No Murmurs. Size about Normal. Regular.
LUNGS, Normal Expansion & Resonds. Moist
GYNAECOLOGICAL EXAM., Uterus in normal position; somewhat atrophied. Laceration of perinæum - rectocele & cystocele. pelvimeter external genitals normal.
MENSTRUATION, Menopause passed 12 years.
OPHTHALMOSCOPIC EXAM.,

TAKEN,

EXAM. URINE, Nov. 18 96.
Color. Brownish red.
Character Ropy & flaky deposit - Cloudy
Amt. 24 hrs. XXV Oz
Sp. Gr. 1020.
Reaction Alkaline
Albumen Trace by heat & HNO³. Large Quantity by Esbachs.
Sugar None
Microscop. Amor. sodium & Ammonium urates. Triple phosphates. Oxalate of lime & mucine bands

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated, ✓	Irregular,
APPETITE, Good, ✓	Medium,	Poor,
SLEEP, Good,	Poor, ✓	Irregular,
PULSE,	Resp.,	Temp.,

CRANIAL MEASUREMENTS, Circ (H) 53.3 (V) 48.8 Fr.o.a. 33.5 Bi.a. 32.5 Ant.p.d. 18.5 Lat.o.d. 14.5 Bi.d. 11.6 Ex. 10.3
HISTORICAL,
LENGTH OF INVASION, Short ONSET GRADUAL OR SUDDEN, Sudden
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations, Nervous - died of Tuberculosis.
Father or Pat. Relations, Died at 62. Enlarged veins
Brothers or Sisters, 1 brother & 1 sister. Children healthy.

Personal and Medical History of Christine Caplazi.

1896

This patient was brought here by her daughter with the following history:- Patient is in fair physical condition: No history of consanguinity or heredity, or of intemperance in self or parents. First symptoms of this (1st) attack were manifested about 8 months ago when patient had nervous prostration - Disease seems increasing: is variable with irregular rational intervals: Derangement now manifested by idea that she is doomed to go to hell. Is not disposed to injure others but has threatened to take her own life: Is destructive of her clothing. No previous peculiarities except that she was of a very religious disposition. No severe disease or injury to head: Has not been confined or restrained. Cause of disease supposed to be assault made upon her by a man, causing nervous prostration. On personal Examination patient is easily frightened, erratic in talk, despondent; wishes the physicians to give her poison as in that event she would go to heaven, while if she takes her own life she would go to hell. ——

On admission put upon Dr. W. Ward Pat. Complexion dark: Hair brown: Eyes brown: Condition of skin normal: No marks scars or bruises noted. Is dirty behavior quiet: Talks sensibly but has some delusions)

Summary First 14 Days- Temperature taken first week normal; appetite good throughout the two weeks: Tonic & other medicines received: No marked physical ailment noted although patient seems somewhat senile and with sound appearances of a decline: Patient quite quiet at first but the second day very nervous, & talker noisily crying: Slept well at times, but at other times poorly: During the two weeks the patient would at times be very excited & noisy in a state of agitated melancholia, walking up & down the hall, crying & wringing her hands. Original Records Preserved.

Dec. 1 Summary Nurse's Notes by Dr. E.S. Phelps:- Very noisy at times sitting up in bed greater part of night: Dec. 21 Sleeps very poorly: Has quieted down some what but at times is extremely Agitated; walking up & down, wringing her hands & crying: Jan. 99 No change: has many delusions: Assists with dining-room work: Mar. 99 Still very noisy:

1897 June Genl health fairly good: May 21 '97 Very destructive & noisy: cries a good deal: No special change: July 8 Very noisy: In seclusion part of time: Aug. 2nd: Was pushed by one of the other patients: struck eye against heater causing a bruise: Aug. 31 Very nervous & destructive: Has fair appetite: Does not sleep well: Has delusion: Sept. 2 No special change: was taken Home this morning against advice of physicians. Rptd. Sept 6 '99.

Continued by Dr. W.M. Phelps. Nov. 29/97 Rather nervous & destructive at times noisy: Is in a state of agitated melancholia of mild form: Apr. 18 Face bruised: Struck by another patient:

Sept 1 '98 Patient picks her face in a very persistent, disagreeable way. Nov. 28/98 Still picks face unless watched or kept occupied. Still has some delusions & shows no change in behavior Nov 1 '98 - Aug 31 '99 Cont. by Dr. Bliss. Appetite good: Bowels regular: Sleeps well: Takes out door exercise: Is noisy much of time & extremely restless & active

Personal and Medical History of Christine Caplazi.

Habits extremely filthy & repulsive: She is very destructive to clothing & picks skin from face & ear until ear is badly disfigured: Hands restrained by muff most of time to prevent her injuring herself. Apr. 17 Was struck on side of head by Sadie Golden & remained unconscious for 20 minutes: Complained of pain in abdomen for some days.

May 6 Was Trans. to B'. Is very mischievious, extremely troublesome watching her opportunity when nurses are busy to meddle with ward furnishings, plants etc. She answers simple questions quite sensibly: Talks almost constantly about going home: Does not have agitated spells as a year or two ago however & seems much more contented of late & is beginning to assist with ward work.

Sept 1- Feb 28/1900 (Dr. Heyerdale) Hands kept in muff most of time to prevent picking face & ears: Appetite good: bowels regular: Sleeps well: Has many delusions & expresses them freely. Jan 18 Wt 112 lbs very dirty in habits & appearance: Chews rags. Mch 1- Aug 31/1900 (Dr. Linton) Dirty & untidy: Inclined to disfigure face & tear clothing: Thinks she is not in her own body & can never die: Thinks she has no soul. Appetite good: Bowels regular Sleeps well: Mch 9- Sick with headach & severe cold: Received medical treatment June 17 Visited by two friends July 1st do. July 16 Vaccinated: Aug 29 Urine examined: abdomen found also vaginal examination revealed inoperable carcinoma of uterus. Sept 1- Feb 28/1901 No change in behavior: General health fair: Converses quite intelligently but does not read nor attend amusements Constantly begs to be sent home: Kept in bed & fed on tray most of time. Bowels inclined to be loose: Very restless & constantly moving about. Oct 16 Visited by friend Nov 16 110½ lbs. Jan 19 1901- Ran away. Staid in barn 1½ hrs. (about dusk) & was recaptured when she attempted to escape. Feb 1 Wt. 115 lbs.

Mar. 1 - June 1 - 1901 no change in mental or physical condition does no work. May 29 Wt. 116 #. June to Sept. Aug 9 visited by daughters, Sept. 2 Wt. 115 #. Sept to Dec. No changes in either mental or physical condition Nov. 23 Wt. 108 #.

Sept to Feb. 1, 1903. Patients general health quite good: eats & sleeps well: bowels regular: does no work as a rule but takes exercise: untidy in appearance and habits: very delusional: still has a habit of picking her face and neck which are generally covered with sores. Is generally agreeable: at times converses quite intelligently aside from her delusions. Nov. 29 th. Wt. 94 #.

Personal and Medical History of Mary Judge

Whole No. § 4586
Residence, St. Paul, Minn.
Date Admission, November 20th 1896.
Admitted by, Dr. R.M. Phelps Hour, 7 P.M.
How Sent, G. Willrich. J. of P. Ramsey Co.
Sex, Female.
Age, Not given. (30)
Civil Condition, Not known. (single)
Children, Not known
Age Youngest Child, Not known.
Occupation, House-wife.
Degree Education, Can read & write
Profession Religion, Yes - Catholic.
Habits, Not intemperate.
Nativity, Canada - (Parents unknown)
Physicians Committing, J.J. Bacon & G. Stamm
Correspondents,

No. for Year, 119.
Insane Relatives, None.
Cause Exciting, Not known
Cause Predisposing, Not known.
Form,
Accompanying Bodily Disorder, None mentioned.
Suicidal or Not, Not.
Date of this Attack, 5 weeks ago.
Duration, about 5 weeks.
No. of Attack, Not known
No. of Admissions, 1st here (has been in St Peter.
Age First Attack, –
Time of Leaving, June 2. 1897
Time in Hospital, 6 mo. 13 d.
Result, Discharged Dec. 2. 1897 Recovered.

EXAMINATION ON ADMISSION

Exam by Rm. & L.L. Phelps 11/21/96.

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY: ?
Clear or Confused,
Quick or Sluggish,
MEMORY: ?
Past Events,
Recent Events,
Special Subjects,
PERCEPTIVITY: ?
Alert or Dull,
Correct or Illusive,
REASONING POWER: ?
Ordinary Subjects,
Own Mental State,
Special Subjects,

EMOTIONAL STATE:
Normal, Calm,
Indifferent,
Exalted,
Depressed, Depressed.
DELUSIONS:
Systematized or Not, Probably
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Patient at present in fair physical condition apparently depressed & silent. Was not induced to say a word. Nothing is known as to cause or previous history. Clothing marked as if from another hospital - Perhaps ran away.

Personal and Medical History of Mary Judge.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, WEIGHT, NUTRITION, Fair.
WOUNDS OR ABNORMALITIES, Condition of skin fair.
TONGUE, Tremors, Coatings, Fairly clear. Promptness Movement, Sluggish
PUPILS, Equality, Equal. Size, Normal.
Response Light, Yes. Accommodation,
SIGHT, ?
HEARING, ?
COORDINATION, Arms, Arms good
Legs, "
TREMORS, Hands, None Tongue, None
Facial Muscles, " General, "
REFLEXES, Patellar,
Other
ARTICULATION, ?
Slurred,
Hesitating,
FACIAL EXPRESSION,

SENSIBILITY,
Arteries - no impairment noted.
HEART, No murmurs. Sounds fair. Size normal: is regular.
LUNGS, Normal.

TAKEN,

EXAM. URINE, Nov. 27' 96
Color. Pale yellow.
Character Flaky deposit.
Amt 24 hrs. XXIX Oz.
Sp. Gr. 1025
Reaction Acid
Albumen. Trace by heat Nitric + Heat
Sugar None.
Microscop. Large quantity pus + blood.
Amor. urates large amount of fat. Oxalate of lime. bladder + Vaginal cells.
Urea 435 grs. 24 hrs.

GYNAECOLOGICAL EXAM., 12/8/96 Uterus anteflexed, otherwise normal.
MENSTRUATION, Regular, normal.
OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated,	Irregular,
APPETITE, Good,	Medium,	Poor,
SLEEP, Good, Slept none last night.	Poor,	Irregular,
PULSE,	Resp.,	Temp.,

CRANIAL MEASUREMENTS, Circ(h) 55.5 (m) 62.5 Nas.a 35 Bin.a 33.5 Ant.p.d. 19 Trans.d. 16. Bin.d. 12.5 Fac.L. 11.
HISTORICAL,
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,") Will not take at all.
Mother or Mat. Relations,
Father or Pat. Relations,
Brothers or Sisters,

Personal and Medical History of Mary Judge.

1897.

This patient was brought here by Sheriff deputy E. Johnson attended by Miss Ackus. with the following history: Patient is in fair physical condition: Nothing known as to consanguinity, heredity or intemperance in parents or self. First symptoms of present attack were manifested four or five weeks ago. Disease appears stationary - not variable with no rational intervals. Derangement now shown by fear of impending evil. Is not disposed to injure others, not suicidal, filthy or destructive. Patient morose & melancholic & will not talk. Nothing known as to severe disease-injury to head. or confinement. Think she has received no treatment. Cause of disease not known. No further particulars on personal examination. On admission put upon B & W. C.H.N. Rpt. Complexion dark: hair & eyes brown: condition of skin normal. No marks, scars or bruises noticed. Eruption on back & foot. Is clean: behavior quiet: Refuses to talk.

Summary First 14 Days:- Temperature normal during the two weeks: Appetite good at all times: No physical symptoms noted: Medicine received regularly: Refused to talk in any way during these two weeks & behaved very quietly: Sat around in a rather dull, melancholy way: Seems to be intelligent however, in appreciating what is going on. Original Record Preserved.

Dec. 28 Summary Nurse's Notes by Dr. S. S. Phelps: Ever since coming here has been uniformly quiet, refusing to talk & apparently mildly depressed: Has said nothing since coming: Neat usually in habits & appearance: Apparently appreciates everything: Gen'l health good: Jan. 31 '97 Assists some with work: bowels regular: menstr. regular: takes tonic & out door exercise: Feb 7/97 No special change: Sleeps well: June 5 '97 Very quiet & agreable on wards: Appetite fairly good: bowels regular: Sleeps well: Went Home

Discharged.

Personal and Medical History of

Personal and Medical History of Emma Sibenaler.

LESLEY, FULLER & GOODRICH, DAVENPORT, IOWA.

Whole No. 4591

Residence, Winona County, Minn.

Date Admission, November 23rd 1896.

Admitted by, Dr. R. M. Phelps Hour, 4 P.M.

How Sent, H.H. Buck, J. of P. Winona Co.

Sex, - Female.

Age, - 33 -

Civil Condition, - Married.

Children, - 5 -

Age Youngest Child, 2½ months.

Occupation, Housewife.

Degree Education, Can read & write.

Profession Religion, Cyps Catholic.

Habits, Not intemperate.

Nativity, Wisconsin.

Physicians Committing, H. Lichtenstein & L. Gates.

Correspondents, Nic. Sibenaler, Elba, Minn.

No. for Year, 124.

Insane Relatives, None.

Cause Exciting, Not known.

Cause Predisposing, Not known

Form,

Accompanying Bodily Disorder, Some headaches.

Suicidal or Not, Not.

Date of this Attack, 4 days ago.

Duration, 4 days.

No. of Attack, 1st

No. of Admissions, 1st

Age First Attack, 33.

Time of Leaving, Apr. 9. 1897

Time in Hospital, 3 mo 17 d.

Result, Discharged Aug. 11. 1897 Improved.

EXAMINATION ON ADMISSION

Exam. 11/24/96 by R.M. & L. Phelps. **MENTAL CHARACTERISTICS.**

MENTAL ACTIVITY:

Clear or Confused, Confused.

Quick or Sluggish,

MEMORY:

Past Events, Confused.

Recent Events,

Special Subjects,

PERCEPTIVITY:

Alert or Dull,

Correct or Illusive, Illusive

REASONING POWER:

Ordinary Subjects,

Own Mental State,

Special Subjects, Gone

EMOTIONAL STATE:

Normal, Calm,

Indifferent,

Exalted, ✓

Depressed,

DELUSIONS: Many & varied.

Systematized or Not,

Special Subjects,

Transitory or Not,

HALLUCINATIONS:

ILLUSIONS:

CONVERSATION:

Coherent or Incoherent, Talks steadily

Voluble or Reticent,

GENERAL DESCRIPTIVE REMARKS: Patient has been in an incoherent raving state ever since admission. Has been getting evidently furnish. Has been in restraint for her own protection. Child 2½ mo. old. Breasts swollen. Nervous history not known. Examination very difficult. Will not talk rationally & will make no tests. Noisy & restless. Requires 2 nurses to hold her.

Personal and Medical History of Emma Sibenaler.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, WEIGHT, NUTRITION, Fair.

WOUNDS OR ABNORMALITIES,

TONGUE, Tremors, Coatings, Furred - dry. Promptness Movement,

PUPILS, Equality, Equal Size, Normal.

Response Light, Sluggish Accommodation,

SIGHT, Can - not test.

HEARING, Seems normal.

COORDINATION, Arms, Seems normal

Legs, "

TREMORS, Hands, No tremors noted but keeps hands Tongue,

Facial Muscles, Constantly moving back & forth unless held General,

REFLEXES, Patellar,

Other

ARTICULATION,

Slurred,

Hesitating,

FACIAL EXPRESSION,

SENSIBILITY,

HEART, No murmurs - Sounds good Rapid - Regular.

LUNGS, Sounds normal.

GYNAECOLOGICAL EXAM., 11/25/96 Uterus normal position Endometritis, Erosion of os. Interstitial laceration of

MENSTRUATION, Suspended since birth of last child. Perineum - external genitals normal -

OPHTHALMOSCOPIC EXAM.,

HABITS, Dirty, Clean, Careless,

BOWELS, Normal, Constipated, ✓ Irregular,

APPETITE, Good, Medium, Poor, ✓

SLEEP, Good, Poor, Very restless Irregular,

PULSE, Resp., Temp.,

CRANIAL MEASUREMENTS,

HISTORICAL,

LENGTH OF INVASION, Short. ONSET GRADUAL OR SUDDEN, Sudden

HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")

Mother or Mat. Relations, Unknown

Father or Pat. Relations, "

Brothers or Sisters,

EXAM. URINE, Nov. 27' 96.

Color Yellow.

Character Clear.

Amt 24 hrs. XV Z.

Sp. Gr. 1030

Reaction Acid.

Albumen Trace by heat HNO^3 & Tannic

Sugar None.

TAKEN,

Personal and Medical History of Emma Sibernales.

This patient was brought here by Sheriff A. W. Fuhrmann, accompanied by husband Mic Sibernales. with the following history. Patient is in fair physical condition - raving) No history of consanguinity, heredity or intemperance in parents or self: First symptoms of this (1st) attack manifested 4 days ago when patient ran to neighbors claiming husband was crazy - talking incoherently: disease seems increasing, variable with irregular rational intervals. Derangement now manifested by general incoherency - no particular subject. Patient not disposed to injure others: not suicidal: is filthy & destructive when delirious. No previous peculiarities shown. Has suffered from headaches; had brain fever 15 years ago. Patient has been given sedatives & has been confined in her home for 4 days. On personal examination - dilated pupils - excited pulse - incoherent talk. On Admission put upon B^r W. (G.H. & Pr. Complexion dark, hair brown; eyes brown. skin normal: a few small bruises on arms. Is very dirty. behavior maniacal & incoherent.)

Summary First 14 Days:- Temperature taken during whole two weeks was at first quite high being up to 102 and even up to 103.4 at one time: during the last few days, however, it was practically normal: Patient received various doses of medicine - enemas, Strychnine, hy podermics &c. Patients breasts had milk in them & medicine was applied for that reason. It was found necessary to catheterize several times: was active, violent: with an agitated melancholy manner: was in restraint part of the time. Struggled a good deal: Hot baths were given and during the last of the two weeks she gradually quieted down, although not becoming very coherent or free from delusions: was fed with tube during these two weeks. Original Records Preserved.

1896
Dec. 9 Summary Nurse's Notes by Dr. B.L. Phelps:- Gyn. treatment given: Has improved in mental condition: talks sensibly at times: Worries about her children a good deal: Dec. 11'96 Put upon Lard. treatment: Gyn. treatment every other day: Dec. 13, - 13-14 Salt baths given: also Lard. treatment & massage: Very unstable mentally: destroys clothing & refuses to eat: Dec. 21 Lard treatment, massage & gyn. treatment continued.
Dec. 29 Transf. to Sup. - Operation done: Curettment, trachelorrhaphy & perineorrhaphy: took ether: reaction good: Jan. 16'97 Up on ward: made an uneventful & good recovery: Jan. 28'97: Appetite irregular: bowels irregular: rather pale: Still worries & cries a good deal: has many delusions: Feb. 27'97 Salt baths, massage & oil treatments given throughout the whole month: Still worries & cries a good deal: Assists some with dining-room work: Mar. 29'97 Salt baths massage & oil treatments given steadily: Patient improving mentally & physically: tidy & neat: works some in dining-room: Apr. 1-3-6 Salt baths given. Apr. 9'97 Went Home much improved mentally & physically.

Discharged

Personal and Medical History of

Personal and Medical History of Mary Leddy.

LEIGHT, FIDLAR & CHAMBERS, DAVENPORT, IOWA.

Whole No. 4802.
Residence, Oak Wood Asylum.
Date Admission, November 2. 1896.
Admitted by, Dr. P.M. Phelps. Hour, P.M.
How Sent, Malcolm Kennedy, J. of P. Wabasha Co.
Sex, Female.
Age, 40.
Civil Condition, Married
Children, 2.
Age Youngest Child, 13.
Occupation, Housekeeper.
Degree Education, Common school.
Profession Religion, Catholic.
Habits, Not intemperate.
Nativity, Penna. (Parents Ireland.
Physicians Committing, F.A. Low + Chas. W. Bray.
Correspondents,

No. for Year, 125.
Insane Relatives, None. Father drank some.
Cause Exciting, Domestic worry.
Cause Predisposing, Previous attacks.
Form, Man chr.
Accompanying Bodily Disorder, None mentioned.
Suicidal or Not, Not.
Date of this Attack, One year ago.
Duration, 1 year
No. of Attack, not first.
No. of Admissions, 2nd here.
Age First Attack, about 27.
Time of Leaving,
Time in Hospital,
Result,

EXAMINATION ON ADMISSION

Exam. by D. L. Phelps M.D. Dec 8/96

MENTAL CHARACTERISTICS.

MENTAL ACTIVITY:
Clear or Confused,
Quick or Sluggish,
MEMORY:
Past Events, Impaired
Recent Events,
Special Subjects,
PERCEPTIVITY:
Alert or Dull,
Correct or Illusive, Illusive
REASONING POWER:
Ordinary Subjects, Impaired
Own Mental State,
Special Subjects,
GENERAL DESCRIPTIVE REMARKS: Silly + incoherent in talk. Has delusive ideas. Rather demented

EMOTIONAL STATE:
Normal, Calm,
Indifferent, Indifferent.
Exalted,
Depressed,
DELUSIONS:
Systematized or Not, Many + varied
Special Subjects,
Transitory or Not,
HALLUCINATIONS:
ILLUSIONS:
CONVERSATION:
Coherent or Incoherent,
Voluble or Reticent,

Personal and Medical History of Mary Leddy.

EXAMINATION ON ADMISSION, CONTINUED.

PHYSICAL CHARACTERISTICS.

HEIGHT, 5 ft. 5 in. WEIGHT, 157 lbs. NUTRITION, Good
WOUNDS OR ABNORMALITIES, None. First joint of left index finger gone. Skin normal
TONGUE, Tremors, Coatings, Yellow coat. Promptness Movement,
PUPILS, Equality, Equal. Size, Dilated slightly.
Response Light, Normal Accommodation, Normal.
SIGHT, Says good
HEARING, "
COORDINATION, Arms, Normal.
Legs, "
TREMORS, Hands, Tongue, None.
Facial Muscles, None General, "
REFLEXES, Patellar, Exag. both
Other
ARTICULATION, Normal.
Slurred,
Hesitating,
FACIAL EXPRESSION,
SENSIBILITY,
Arteries. Normal.
HEART, No murmurs. Sounds Normal Regular
LUNGS, Symmetry good. Sounds normal.
GYNAECOLOGICAL EXAM., 1st 2/3/97 Uterus normal position endometritis. erosion of os. laceration of perineum Rectocele + cystocele.
MENSTRUATION, irregular
OPHTHALMOSCOPIC EXAM.,

TAKEN,

EXAM. URINE, Dec. 30/96.
Color. Light yellow.
Character Cloudy - copy deposit.
Amt 24 hrs - —
Sp. gr. 1019
Reaction Acid.
Albumen Trace by Sanchez.
Sugar None.
Microscop. A few blood corpuscles.
Amor Urates + bladder Epithelium

HABITS, Dirty,	Clean,	Careless,
BOWELS, Normal,	Constipated, ✓ Somewhat	Irregular,
APPETITE, Good, ✓	Medium,	Poor,
SLEEP, Good, ✓	Poor,	Irregular,
PULSE,	Resp.,	Temp.,

CRANIAL MEASUREMENTS, Ant p. diam 18.3 Transv. d. 13.5 Bin. diam 12.5 Fac. length 11.8
HISTORICAL, Has headache a good deal of the time.
LENGTH OF INVASION, ONSET GRADUAL OR SUDDEN,
HEREDITY (Specify—"Insanity," "Hysteria," "Epilepsy," "Paralysis," or "Inebriety,")
Mother or Mat. Relations,
Father or Pat. Relations, Very nervous.
4 Brothers or 3 Sisters, 2 daughters grown

Personal and Medical History of Mary Leddy.

This patient was brought here by Sheriffs Deputy D.L. Mc Kenzie attended by Mrs McKenzie in fair physical condition, with the following history. No information as to heredity. Patient has had previous attacks. First symptoms of present attack appeared about one year ago: Disease seems increasing, variable with rational intervals every 3 or four days first symptoms of insanity manifested 12 or 13 years ago after desertion by husband: has been insane ever since. Patient not disposed to injure others: not suicidal - but is filthy & destructive: No peculiarities previously shown: No severe disease or head injury. Four years ago patient was confined in this (Rochester) Hospital for six months: during this attack nothing known as to treatment received. On Personal examination her condition indicates insanity: she talks incoherently & gets very much excited at times. (Note - for particulars see Vol. 14 Fol. 117 No 2457.)

On admission put upon B.W. (Q.H.R. Rpt. Hair brown, eyes blue, Skin normal No marks, scars or bruises. Is clean, quiet: has delusions)

Summary First 14 Days. Admitted December 5th, 1897. Temperature was practically normal: Appetite was good throughout the fourteen days and nothing of Event occurred: Is evidently a chronic case, Leaving Brain Sick before and having shown something of her present behavior for many years: Answers ordinary questions in a quiet, dull sort of way: has very few requests: seems to have little care or anxiety about anything: Is in fact, some what deluded. Original Records Preserved.

Dec. 30/97 Summary Nurses Notes by Dr. L.L. Phelps: Put upon Gym. treatment every other day: inclined to be rather stubborn & restless at night: bowels constipated: put upon tonic: Jan. 28 97 Visited by Son: on Gym. treatment steadily: Feb. 18 Mental condition much improved: quiet & well behaved: appetite good: usually sleeps well: often expresses delusive ideas: Feb. 19 Transf. to Inf. Feb. 20: Operation done: Curettement: trachelorrhaphy: cystocele: perineorrhaphy: took ether well:
1897 Mar. 6 Remained quietly in bed: made a good recovery: now up on ward: July 18 '97 talks to herself most of times: Appetite good: Sleeps well: bowels regular: takes out door exercise: does no work. Continued by D.L. Phelps Nov. 30/97 Patient now over at Annex: Is quite incoherent & rambling in talk: Very silly in manner. Apr. 27/99 Trans. to Infirmary: Has sore on hand. Nov. 1 Patient is about the same in every way: very incoherent: Works in laundry. Jan. 1 - Aug. 31 1899 Cont. by Dr. Bibb. General health good: Appetite good: Sleeps well: Takes outdoor exercise: Is neat in habits & appearance: Works in laundry part of time: Has delusions & talks incoherently - talks to herself a great deal usually quiet but inclined to be talkative. Sept. 1 - Feb. 28 1900 (Dr. Heyerdale) Neat in Appetite fair. Takes some outdoor exercise Irritable at times: ~~Talks a great deal & mutters to herself~~: expresses delusions. Jan. 19 Wt. 159 lbs.
Mch. 1 - Aug. 31 1900 Dr. Linton/ Has delusions & at times very disagreeable: General health good. Appetite fair: Sleeps well: Takes outdoor exercise: Assists some with work in dining room: Apr. 9 Sick in bed Cold & sore throat. June 9 Visited by friends. July 23 Vaccinated Sept. 1 - Feb. 28 1901 Appetite good: Sleeps well: Sometimes assists with work: occasionally disagreeable on ward. Very talkative but is incoherent: Continually changes subject during conversation & does not give intelligent answers. Nov. 23 Wt. 155 lbs. Feb. 12 Visited by mother & brother - Mch. 3 Wt. 147½ lbs.
Mar. 1 - June 1 - 1901. Works in dining room. No change in mental or physical condition. May 31 Wt. 159½ #
June to Sept. Assists with work, attends no amusements, takes out door exercise, Sept. 3 Wt. 155¼ #. Sept. to Dec. Nov. 30 Wt. 159 #.
Up to Feb. 1, 1903 - General health good: appetite good: bowels regular: sleeps well: exercises: attends amusements: works in the dining room: neat and clean in habits and appearance: is quite incoherent and talks almost incessantly at times uses vulgar and profane language. Dec. 1st Wt. 164 #.

